

December 2014 MCO Good News Reports

MCOs Going Above and Beyond

All MCO staff and members' names have been changed to protect member privacy.



Anthem

Recently Anthem attended a migrant family event held at an elementary school with 40-50 Hispanic families in attendance who did not speak English. While waiting to begin the program, the new director informed us that the interpreter canceled. Fortunately, one of our Anthem associates attending the event spoke Spanish. Anthem was first on the agenda and the associate went through the value added benefits and the advantages of being an Anthem Medicaid member. Once Anthem's presentation was finished, the Director asked the associate to interpret the entire program. At the end of the program, the Anthem associate interpreted several questions regarding Anthem Medicaid and assisted the Director with questions for other programs.



Anthem Case Manager N. contacted a member undergoing chemotherapy for a rare type of leukemia. N. worked with the member to locate a transplant specialist and maintain their health during chemotherapy. The member is hoping to be able to have a stem cell transplant when their health improves.

Recently, this member started on treatment for Hepatitis C. N. helped the member to understand its proper use and was able to help get the medication shipped early in order to avoid it running out. N. also worked with the pharmacy to increase the quantity of the next shipment as prescribed, and move up the shipment date. N. then confirmed that the member received the requested medications. The member was very grateful for having this much-needed assistance and is eager to get the best results from the medication. N. will continue to monitor the members' progress and help with needs as they occur.



CoventryCares

A mother was referred for High Risk OB when she was admitted to the hospital for threatened early labor. The mother participated in case management prior to her delivery.

The mother had an estimated delivery date but delivered the baby early. After delivery, the baby was admitted to the NICU. The family was told the baby had a birth defect and will need a special formula. The family was having a hard time affording the special formula because WIC would not cover it.

A RN reached out to a local WIC Coordinator and discussed not covering the formula. The Coordinator explained the process for covering the special formula. An account was set up and the family now receives the special formula.



M. was admitted to hospital for several days for pneumonia. Upon discharge home, Transitional Care outreached to assess member needs. Due to the numerous medical conditions, M. is unable to speak. M's parents spoke with the CoventryCares RN over the next several weeks about their concerns and needs in order to care for member.

M. has been bedbound since she was a preteen. M. is now a young adult and the family feels just as strongly about providing care for M. in their home. The mother still refers to M. as "my baby". The CoventryCares RN assessed needs and it was revealed that during hospital stay member had

developed, for the first time ever, pressure ulcers. It was also noted that though the member has a large family, primary responsibility for their care, falls largely on the parents.

M.'s PCP is out of the office due to their own medical issues, and has not followed up with PCP since hospitalization. The family lives less than 5 minutes from nearest hospital, but the mother states they have visited the hospital and asked them to see M., but the hospital refused due to not accepting the current health plan.

M. completed the Transitional Care program, but the mother declined follow up from further case management. The RN had contacted a social worker from the local waiver program and they were following up with M. regarding possibility of providing services for member in the home.

After disenrolling from transitional care, the mother states the mattress was not approved and M. needs to alleviate pressure on ulcers. The RN reviewed claims and discussed them with the medical director. The RN also submitted the required information missing from previous prior authorizations. The medical director requested the provider resubmit with the additional information provided by the RN. The RN coordinated this with and enhanced case management RN so the member could receive the mattress.

Additionally, the waiver social worker made home visit with M. and the family. M. qualified and was enrolled for waiver services. M. will transfer to state Medicaid that is accepted by the facility less than 5 minutes from home. A local MD has agreed to see M. at the facility when the new card received. M. and their family will now be eligible for respite services and personal care via waiver. M. will no longer have to travel over one hour via ambulance to her medical appointments. M. will also continue to receive wound care center services because a provider is now available to assist with any issues that are discovered.

Overall, M. is better served, has received the services their condition requires, is kept closer to home, and less stress is placed upon the member and family members.



Humana

R. is a member who was referred to case management by a local hospital. It was reported that R. had bed bugs and lice causing skin irritation, which became infected resulting in hospitalization.

A Humana – CareSource case manager reached out to R. and engaged them in case management. R. had an immediate need because they did not have enough supplies for dressing changes to last through the weekend. Home Health was ordered but the hospital was unable to locate an agency that would go to the house due to the issue of bed bugs and lice in which the member denied having any problems with bugs. R.'s spouse learned to do the dressing changes before they left the hospital. The case manager then worked with R. and the doctor's office to get additional supplies for the weekend. The case manager also found a supplier who mailed her supplies directly to their house.

While talking with R. about medications, the case manager learned R. had stopped taking their diabetes medication because of unwanted side effects. The case manager explained the importance of blood sugar control and regular testing, as well as Hgb A1c and annual eye exams to encourage positive health outcomes for R. (Healthcare Effectiveness Data and Information Set measures). R. expressed their understanding and willingness to be compliant with the treatment, so the case manager helped R. make an appointment with the primary care physician who updated the medication.



O. is a member who was recently hospitalized with nausea and vomiting. Upon arrival, O. had a very high blood sugar level and was sent to the Intensive Care Unit. O. had a history of substance use and had previously been diagnosed with diabetes and heart and lung disease. Despite the diabetes, O. did not have a blood glucose monitor.

A Humana – CareSource case manager reached out to O. and engaged them in case management. The case manager also referred them to Behavioral Health case management for coordination of care. The case manager and the Behavioral Health case manager were able to get O. the necessary appointments with a primary care physician and a psychiatrist. O. expressed that they understood the medications and the importance of monitoring their blood sugar on a regular basis and has agreed to continue to work with the case managers and doctors.



Passport

During a Utilization Review call, a Passport Behavioral Health Team Member learned that a Passport foster child's braces were bothering them. The team member followed up with the foster placement agency and found they had been unable to obtain the name of the previous orthodontist. The team member worked with two colleagues on our Out of Home Placements team and a person from our subcontractor oversight area to locate the orthodontist the member had seen. The caseworker shared this information with their contact at the placement agency, who was thrilled. Because of this quick communication and collaboration across departments, the member was able to experience continuity in their care by seeing the same orthodontist for ongoing needs related to their braces. Ultimately, the member will experience less discomfort and have better dental health.

These types of efforts have helped Passport to rank as the #9 Medicaid health plan in the nation (in the 75th percentile) for Annual Dental Visits, according to 2014 Quality Compass Medicaid. Passport has also placed a special focus on improving dental care through several ongoing dental performance improvement plans (PIPs).



While at the primary care provider (PCP) office, a Passport member confessed that their complicated health status and lack of employment were causing great difficulty with transportation to medical appointments and getting prescriptions filled and picked up. Although the member was very intelligent and well-informed on their disease, they were new to Kentucky and was unaware of many local resources.

Upon learning of the member's barriers to care, the Passport Case Manager took an extra step to meet with them in person outside of the PCP office in an attempt to resolve some of these issues. They helped the member complete an application for transportation, changed the pharmacy to a local pharmacy offering free home delivery of medications, and set up an appointment with a job coach who eventually found an employer within easy walking distance from home. The member was very relieved. The transportation to medical appointments has helped better manage their chronic conditions, they have direct access to medications without the need to travel to the pharmacy (which was a huge barrier and interfered with their access to better health), and now has stable employment to improve their quality of life.

This story is one of the many successes of our Embedded Case Management program, which provided care to 2,109 members through the second quarter 2014.



A Passport youth was frequently admitted to the emergency department due to a chronic condition. During their last visit, a Passport Clinical Health Educator met with the member and their mother to discuss all of the programs Passport offers and how they could assist them as a health educator. The member's services were offered as part of a new Passport program called the Discharge Education Team, which aims to educate and empower members in certain disease categories before they leave the hospital. The educator helped the member and their mother understand the discharge plan developed by the hospital. The educator also collaborated with the hospital, provider staff, and internal Passport departments to ensure they would be able to get any new medications and attend

follow-up provider appointments after discharge. The educator also provided a special Passport discharge booklet complete with personalized education specific to the members' needs and details on how to contact our dedicated voicemail.

When the member became ill several weeks later, the mother contacted the educator for advice. The educator instructed her to call their PCP, even after-hours, and to hopefully prevent an emergency room visit or possible admission if the child was to become worse.

As a result, the child did not go to the ER and became much better. It was one less ER visit, one less admission, and one member's trust we have gained through our new program.

"The Discharge Education Team is a new program and every success, is a big success," says the educator. "I like to think that our bedside education and open line of communication after discharge is making a larger impact than we know. We are offering our members a service that has never been offered before and the positive response lets us know we are making progress toward lowering ER utilization, readmits, and creating a more health literate community for our members."

Since September 2014, the Discharge Education Team has already reached 78 members while they were inpatients.



With no income, very limited resources, and living with her adult children, a Passport member had not obtained an eye exam for many years. One month after she became eligible for Medicaid, she went to a vision provider and learned that she was barely able to see without glasses. Unfortunately, she was not able to afford the prescription.

Several months later, a Passport Embedded Case Manager learned of the member's dilemma while she was at her primary care provider (PCP) appointment. The case manager assisted the member with the completion of an application for eyeglass assistance through an out-of-town program and she agreed to mail in the application, along with her eyeglass prescription.

Several weeks later, the case manager contacted the member with the news that her application was approved and the voucher had come in. The case manager also helped the member find a facility near her home that would accept the voucher.

The member became very emotional and promised to go right away to pick up her new glasses. Before hanging up, she expressed her sincere gratitude for Passport's help, stating, "You have been extremely helpful!"

The Embedded Case Managers in over 30 offices have made 3,130 contacts with members through the 3rd quarter 2014.



One evening, a Passport Embedded Case Manager received a frantic email from a primary care provider. "I have a young Passport member with a serious medical issue and his mom explained she is having difficulty with their Passport enrollment. It is important for the member to be seen at the clinic tomorrow and get all of their medicines. Is there any way you can contact the mother and help expedite the process of reinstating the insurance?"

Even though it was after hours, the case manager immediately checked the member's file and talked with our Member Services team to ensure there was nothing wrong with their eligibility. The next morning the case manager called the mother right away to let her know there were no issues, and that the member could be seen that day. The case manager also asked what led her to think there was something wrong with the member's insurance. The mother revealed that she thought a letter about open enrollment meant the member did not have insurance. She speaks English as a second language and had trouble understanding the official document.

Thankfully, the case manager had intervened and cleared up the misconception in enough time for the member to successfully receive vital treatment for his illness that day. This is one example of the 3,130 members served by our Embedded Case Management program to date in 2014.



In 11 months, a Passport youth N. had been readmitted 7 times to a psychiatric hospital. Upon being assigned to provide case collaboration, a Passport Behavioral Health Team Member discovered N. had never received intensive in-home behavioral health services, even though he qualified at any point over the past year. N. has an extensive trauma history and his grandparent is the legal guardian. During the member's inpatient hospitalization, Passport staff assisted in connecting the member and his grandparent with intensive in-home services through a local behavioral health provider.

As a result, the member has not been in the hospital since their last visit. His grandparent reports services are going well and N. is doing well since being released from the hospital.

This is an example of how investigation into the cause of a child's rapid readmissions to hospitals can lead to a less restrictive treatment that will hopefully prevent the need for future inpatient admissions. The member is one of over 700 adolescents offered care coordination services through Passport's Behavioral Health program in 2014.



WellCare

A pediatrician contacted WellCare on behalf of a very young WellCare of Kentucky Medicaid member who has brain disease, seizures, and vision loss due to brain damage. The doctor was concerned that a language barrier was keeping the member's mother, who did not speak any English, from understanding the complexity of her daughter's medical needs.

The member had a surgically-created hole through the front of the neck and into the windpipe to breathe, a feeding tube running through the abdominal wall to eat, and relied on oxygen therapy. The member's doctor also told WellCare that transportation issues were preventing the member from keeping scheduled medical appointments.

WellCare of Kentucky field service coordinator D., immediately scheduled a home visit to assess the situation and brought a translator for assistance. Upon arrival, D. discovered that the member and her mother were living in an apartment with three other families, which increased the member's risk of infection. D. explained the severity of this to the member's mother, who said the other families would soon be moving out. D. also contacted the pediatrician to arrange a referral for home health services to monitor infection control, assess ongoing needs and provide continued communication with the doctor.

Then, using WellCare's Health Connections Referral Tracker (HCRT), a database with more than 6,500 Kentucky-based community organizations that WellCare can refer its members to for social services support, D. secured transportation to provide rides to and from the member's appointments, even those located 90 minutes outside of town.

Thanks to D.'s efforts, the member now is able to easily get to critical medical appointments, receive better quality care between those visits, and reduce her overall chance of infection. This will ultimately help provide for a better quality of life for the member and her mother.



A WellCare of Kentucky Medicaid member, who suffers from hypertension, high cholesterol and depression, contacted WellCare because she was unhappy with her current primary care doctor. She also asked for help finding a gynecologist. WellCare of Kentucky field service coordinator D., visited the member at her home to conduct an assessment.

During their conversation, the member told D. that she also lacked reliable transportation, which caused her stress every time she scheduled a medical appointment. In addition, the member expressed interest in getting counseling because she had recently been having terrible nightmares that increased her feelings of depression. She also shared that she smoked a pack of cigarettes a day.

D. immediately began researching doctors for the member and found a primary care doctor for her within a Women's Health Clinic, where she could also see a gynecologist. She then submitted a

referral for the member to receive behavioral health counseling, so that the member could get treatment for her depression. D. also worked with WellCare of Kentucky's transportation vendor to provide the member with rides to and from her doctor's appointments. Finally, D. educated the member regarding the importance of monitoring and treating her hypertension, the benefits of quitting smoking, as well as the resources available to help her quit.

Thanks to the face-to-face assessment of the member, D. was able to holistically evaluate her medical, behavioral and social needs. D.s' efforts will help the member proactively address her overall health and improve her quality of life.



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Anthem

Anthem Community Liaison A. met with a KYNector supervisor who praised the Customer Service of Anthem Medicaid. He stated that he had been working with a couple who had been pretty difficult. They had called him several times regarding their insurance cards and when they would be received. The supervisor said he contacted our Customer Service and spoke with an amazing representative. She was very sweet, kind and understanding and he was blown away with how she handled the members because they were pretty demanding.

He further said that he has been impressed with Anthem and was very happy once we signed an agreement with St. Elizabeth as they are the only hospital in north Kentucky and operate most of the physician offices.

Anthem prides itself on living its core values, which include *Caring* and *Easy to Do Business With*. Our associates, like A., understand the importance of excellent customer service for all individuals, regardless of the situation, and the importance of providing everyone with needed information.



Case Manager C. received a call from a provider's office requesting an interpreter for a 58 year old female Anthem member. She needed an interpreter to assist with the language barrier at the physical therapy office. C. was able to assist with setting this up for her, and the member was able to attend her physical therapy sessions while asking questions in her native language. The member and her family were very pleased with the language service provided by Anthem and called to express their gratitude.

Anthem prides itself on living its core values, which include *Caring*. Our Case Managers, like C., actively work to help members navigate sometimes-complex health care systems to access the most appropriate services for their needs as well as work with their families to provide much needed support and education.



CoventryCares

D. is a 3 month old 6.6 pound preterm baby with drug withdrawal syndrome and congenital birth defects. He was discharged to DCBS foster care parents on day 35 of life taking food by mouth via pigeon nipple.

Case manager E. became involved when invited by DCBS to attend individual health plan (IHP) meeting. After the telephonic meeting, she outreached the foster parents for any concerns and/or needs. During the assessment, it was discovered that the foster parent was having difficulty obtaining/locating the pigeon nipple/bottles for the baby.

After many phone calls to multiple medical equipment suppliers, E. was able to locate a provider who was able to obtain and deliver pigeon nipple bottle system to the baby's foster parent. D. is enrolled in case management and being followed at this time. He is also receiving WIC for formula and has a planned repair surgery tentatively scheduled for approximately 9 months of age.

Positive outcomes:

- Collaboration between Case manager, DCBS social workers, Foster parent
- Positive communication between foster parent and case manager

- Member now more likely to continue to gain weight without the added stress of adjusting to a new nipple system
- Member now more likely to have a more successful navigation of planned surgery with the assistance of case manager



J. is a female who is pregnant and was referred to the case management department by her OB/GYN office with a request for Subutex.

J. had of a miscarriage at 20 weeks and a 24-week stillbirth later that year. J. is a recovering addict, who has been addicted to Methadone for 10 years. J. is having cravings and thinks she should get on Subutex as she is terrified she will relapse into using again. J. was on Subutex during one of her pregnancies and the baby was born full term and did not have neonatal abstinence syndrome – drug withdrawal syndrome.

J. also has a history of depression. She thinks she suffered from postpartum depression after her first child was born but no one diagnosed it or treated it. Her depression worsened after each pregnancy loss. The OB nurse practitioner has prescribed Zoloft, but J. is afraid to take it.

J. needed assistance in trying to get back on Subutex. the case manager suggested that J. discuss her desire to use Subutex her OB doctor or nurse practitioner and ask for a possible referral to an outpatient treatment center. J. discussed with her doctor and a referral was made Subutex was started along with counseling.

The case manager discussed with J. the pros and cons of taking Zoloft. J. started Zoloft and has been feeling better.

Positive outcomes:

- Collaboration between Case Manager, member and OB office
- Positive communication between member and case manager
- Member now more likely to stay drug-free during remainder of pregnancy



Humana

D. was referred to HCS Case Management by his behavioral health case manager following a hospitalization where he was diagnosed with bipolar disorder. Their concern was that he was experiencing a lot of back pain and had no PCP and possibly needed a pain management specialist. HCS Care Manager called him and engaged him in case management.

D. lives in a very rural area and was having difficulty finding providers. Both case managers worked together with the member to find a PCP, a behavioral health practitioner, and a pain management provider.

D. now is established with a PCP for ongoing care, a pain management doctor for his back, and a behavioral health provider via telnet. He is seeing all of his providers on a regular basis and reports to Maria that his is doing well, seeing his doctors when he is scheduled, and feels much better.



L. is a 46-year-old woman who was recently hospitalized for Obstructive Chronic Bronchitis; she is also a diabetic. Her HCS Case Manager spoke with her several times in the weeks following her discharge to be sure Laura completely understood her discharge instructions. She also used these calls to teach L. what to look for as indications that she was having an exacerbation so she could have early intervention and avoid readmission to the hospital. L. expressed concern with her blood sugar level rising so the case manager helped her understand the medications she was on for her lungs have the side effect of elevated blood sugar and how important it is to use her insulin properly while she is temporarily on this medication.

When L. went to see her PCP to follow-up after her hospitalization, the doctor confirmed that her blood glucose was elevated due to the medication recommended to continue doing exactly what she was doing. She showed improvement and even was able to have her oxygen decreased.

The case manager continues to talk with L. about the importance of regular Hgb A1C testing and the importance of having a dilated retinal examination every year (HEDIS measures).

(Definitions: Obstructive Chronic Bronchitis is a type of obstructive lung disease characterized by chronically poor airflow; diabetic is a metabolic disease in which there are high blood sugar levels over a

prolonged period; Hgb A1C is a blood test doctors use to determine how high your blood sugar has been in the past few months; dilated retinal examination is recommended for patients who are receiving a comprehensive eye exam, have never had a dilation, are very near sighted, are symptomatic (seeing light flashes or floaters) or suspected of having eye disease or injury. Commonly, the Optometrist puts dilating drops into your eyes as part of our comprehensive eye exam to open your pupils so he/she can get a better look at the health of your lens, optic nerve, macula and peripheral retina.)



M. is a Type I Diabetic who requires continuous insulin who was previously insured through Kentucky Health Cooperative and was using an Omni-pod insulin pump. When she switched to a HCS she wanted to continue using the same product so she was referred to HCS Case Management. Working as a team with her physician and the DME company, she was approved to continue with the pump she had already been using and with which she was comfortable. HCS approved the otherwise non-covered pump because it was the best conclusion for Mary and her physician made sure there was no lapse in insulin coverage.



Passport

While visiting her primary care provider (PCP) recently, Passport member J. told a Passport Embedded Case Manager that she was having trouble obtaining a prescription to control her Chronic Obstructive Pulmonary Disease (COPD). She did not know why it was being denied at the pharmacy, and did not have an appointment to see the pulmonologist who prescribed it for another month.

The Case Manager researched the medicine for J. and was able to contact her pulmonologist before she left her PCP's office that day to suggest a therapeutic equivalent that was covered under the plan formulary. Thanks to the Case Managers quick actions, the pulmonologist wrote a revised prescription for her and J. was able to get her important medicine, preventing possible complications.

This story is one of the many successes of our Embedded Case Management program, which provided care to 2,109 members through the second quarter 2014.



It's been a difficult year for Passport member G. Earlier this summer she noticed a strange feeling and worried about her heart. After speaking with her PCP, she was referred to a cardiologist and found that she had recently experienced a heart attack which damaged one of her coronary arteries. She was also diagnosed with high blood pressure and high cholesterol. G. was quickly scheduled for heart bypass surgery, and although the surgery was a success, she was completely overwhelmed with what lay ahead.

Thankfully, she received a call from a Passport Disease Manager who helped her walk through everything from her medications to diet. He helped educate her about her heart disease and reinforced her efforts to stop smoking. Most importantly, he reminded her to call and follow up with her PCP and cardiologist – steps she had forgotten in the harrying turn of events.

These types of efforts have helped Passport to obtain the following rankings for national HEDIS® in 2013:

- Ambulatory Care-Outpatient visits: 398.89 (75th percentile)
- Advising to quit: 81.54 (90th percentile)
- Discussing tobacco cessation strategies: 40.65 (50th percentile)



When Passport member S. became pregnant again, she was nervous for the health of her unborn child. In the past she had experienced miscarriages and preterm deliveries. Would this child be born healthy and without complications?

At 12 weeks, S. was admitted to the hospital after experiencing difficulties. She was soon released to go home, but was placed on strict bed rest and received 17P (progesterone) shots weekly from a home health agency in an attempt to prevent another preterm delivery. That's when she first came into contact with our High Risk OB Case Manager who would become her coach, support, and confidante over the next few months.

During a routine appointment at 22 weeks, S.'s OB provider discovered that her lower uterine segment was bulging and had her re-admitted into the hospital. The hospital quickly gave her multiple medications to try to stop delivery, and planned to keep her for another 6 weeks. S. called her case manager in despair, exclaiming

that she never wanted to be pregnant again. The case worker offered comfort in addition to the support of the hospital staff and chaplain. Thanks to their combined efforts, Susie pulled through and by the end of July she was doing well, despite being on multiple medications.

When S. was discharged from the hospital this time, however, things did not go so well. Her home health services were not resumed post hospital discharge, and she was having trouble resting with small children at home. Although church friends came to help, her husband worked during the day and her family lived too far away to help. When her case manager called in several days after her discharge, S. admitted to being exhausted and feeling pressure/pain with fetal movement. The case manager was alarmed to find that she had missed several 17P injections during the transition home, and made sure she would be getting back on track at her OB appointment the next day. The case manager also spent a long time educating S. on warning signs of when to go to the emergency room. After they hung up, the case manager sought her manager to investigate why S.'s home health services were not resumed. The Manager of Mommy Steps in concert with Passport's Utilization Management department verified that the home health services were still authorized and coordinated the resumption of services with the home health agency and provider.

After all of these combined efforts between S. and her family/friends, Passport's Care Coordination and UM departments and her many providers, she delivered a healthy full-term baby.

These are a few of many interventions Passport has undertaken to realize decreases in the number of babies who are born that are low birth weight and very low birth weight of 9.8% and 1.44% respectively in the 3rd quarter 2014. Here are other examples of interventions taken:

- Through the 3rd quarter 2014, 962 newly identified pregnant members received a letter and information regarding the Mommy Steps program, the importance of obtaining prenatal care, WIC sites (Women, Infant and Children nutrition program), community resources, transportation services, the HANDS program (Health Access Nurturing Development Services, a statewide program providing education to first time parents), and telephone numbers to call for assistance.
- 1,046 all-inclusive Maternity Management booklets, "A Guide to Healthy Pregnancy, Delivery and Baby Care" were mailed to pregnant members. English and Spanish versions were mailed as appropriate.



In 2008, Kentucky Medicaid Expansion Passport member J. had two mini strokes and was diagnosed with high blood pressure. For the next six years, everything seemed to be going fine. He was slowly trying to cut back on smoking and live a healthier lifestyle. Unfortunately, he fell back into old habits and was soon struck by a massive heart attack. After successfully undergoing a triple bypass, J. was discharged and received a call from a Passport's Disease Manager.

The Disease Manager talked through J.'s situation thoroughly, making sure that his incisions were healed and that he was going to all provider follow-up visits. The Disease Manager also educated J. about his heart disease, appropriate nutrition and exercise, and the importance of making long-term healthy changes. The member said he wanted to quit smoking for good but needed help. He also expressed a desire to begin exercising and go back to work soon, even though he performed manual labor. The Disease Manager gave J. extensive information on Passport's benefits coverage for smoking cessation medications and outpatient rehab, and suggested J. talk to his new primary care provider (PCP) about these options at his upcoming visit.

Thanks to these efforts, J. was better prepared to begin a much healthier lifestyle.

These types of efforts have helped Passport to obtain the following rankings for the national 2014 HEDIS® measure: Assistance with Smoking and Tobacco Cessation:

- Advising to Quit: 82.52 (90th percentile)
- Discussing Cessation Strategies: 51.64 (90th percentile)



Vocal cord dysfunction (VCD) is a disease that can make breathing difficult. Although it's completely separate from asthma, both diseases cause the same symptoms such as coughing, wheezing, and throat tightness/hoarseness.

Passport youth J., had been unfortunately diagnosed with *both* of these health issues. Anytime she had trouble with breathing or other flare-ups, it became extremely difficult for her and her mother to determine whether it was caused by her VCD or asthma. As a result, they ended up in the emergency room 11 times and were admitted to the hospital 3 times in 2014 alone.

Passport's ER Navigator noted this trend and worked to educate them on the appropriate use of the ER, but felt they needed additional education and ongoing support from our case management team.

She spoke with a Passport Case Manager (a respiratory therapist), who reached out to J. and her mother during their next PCP visit. The Case Manager carefully listened to their story and quickly recognized a communication gap in J.'s care coordination. J. and her mother had visited so many different ER doctors and specialists that they had become confused on the basics of the members conditions and what treatment options and medications were available.

So the Case Manager started back at the beginning. He re-educated them on VCD and asthma, and clarified many of the questions they had. He also discovered and addressed one of the reasons J. ended up back in the ER. Apparently the member and her mother were confused by differing daily medications prescribed by the hospital and PCP, so when J. ran out she just stopped taking anything and ended up back in the hospital. The Case Manager clarified the medications' similarities; made sure the PCP's prescription was covered under Passport's formulary, and reinforced the importance of taking it daily as directed.

While listening to J.'s story, he also paused when the mother said she had ceased taking J. to speech therapy because they did not think it was working. The Case Manager explained how speech therapy could lessen the effects of J.'s VCD over time, and encouraged her to reconsider approaching the topic during their PCP appointment.

Before they left that day, J. and her mother expressed gratitude for the education provided. The mother was relieved to know she could easily obtain a regular medication to help control J.'s asthma symptoms. Thanks to the excellent communications by multiple agencies, all of their concerns were finally addressed in one centralized location. Even better, this member has not been to the emergency room to date due to her asthma/VCD!

This story is one of the many successes of our Embedded Case Management program, which provided care to 2,109 members through the second quarter 2014.



Passport's Community Engagement Coordinator L. was recently set up at a community baby shower in Region 2. Passport member P. came by the table with her husband and newborn. She mentioned she had Passport coverage and needed to get their baby on Passport, but was waiting on the birth certificate and Social Security card. Coordinator L. advised that she didn't have to wait for either and that she should call Passport first thing the next day to advise her baby had been delivered. Needless to say, she and her husband were very relieved to hear they didn't have to wait and their baby could receive early preventive screening and developmental testing.

These types of efforts have helped Passport to obtain the following ranking for national HEDIS® in 2014:

- Six or more well child visits in the first 15 months of life: 75.47% at the 50th percentile



WellCare

C., a WellCare of Kentucky field service coordinator, recently met with a 60-year-old WellCare of Kentucky Medicaid Member who has hypertension, diabetes and Chronic Obstructive Pulmonary Disease (COPD). She also suffers from depression. The member requested assistance getting clothes for her 5-year-old grandson, who she has raised since he was just 3-days-old.

The member's health was declining, causing her additional worry about her grandson's welfare, which in turn, worsened her depression. During their conversation, the member asked for information about potentially adopting her grandson, so she could have the legal ability to make decisions on his behalf, including providing him with a guardian in case anything happened to her.

C. immediately worked to alleviate the member's worry by finding a clothing bank on WellCare's Health Connections Referral Tracker (HCRT); a database with more than 6,500 Kentucky-based community organizations WellCare can refer its members to for social services support. The tracker helped her to identify a convenient resource that could meet their clothing needs. She gave the member the organization's location and hours of operation. C. also provided the member with contact information for Legal Aid where she could get free

legal guidance and resources to advise her on adopting her grandson. She made sure to also give the member some additional resources for food and utility assistance.

Finally, C. discovered that the member's blood pressure and blood sugar monitors did not work. So, she ordered new monitors to help the member control her hypertension and diabetes. Due to C.'s dedication, the member not only received the medical tools she needed, but she also received resources and information to help her better take care of herself and her grandson, which will improve her ability to help them both get and stay healthy.



P., a WellCare of Kentucky field service coordinator, recently visited a 64-year-old WellCare of Kentucky Medicaid member who had all of her teeth, tongue and part of her throat muscle removed following a diagnosis of throat and tongue cancer. At the time of their visit, the member was recovering from reconstructive surgery that was needed to create a new tongue from muscle that doctors removed from her upper arm. The member was experiencing severe weakness in her arm, which prevented her from raising it or using it to lift anything. She expressed concern that she was losing her independence and becoming a burden to her family.

During their conversation, the member told P. that she had lost 46 pounds because she was having difficulty eating following her surgery. Concerned for the member's dietary health, P. immediately contacted the member's primary care doctor and coordinated the authorization needed for the member to begin getting nutritional shakes delivered to her home. She also coordinated the request for physical therapy to strengthen her arm. Next, P. conducted research on the member's behalf and found a physical therapist located just a few miles from the member's home. She scheduled an appointment for the member.

P. also used WellCare's Health Connections Referral Tracker (HCRT), a database with more than 6,500 Kentucky-based community organizations that WellCare can refer its members to for social services support, to connect the member with resources that could help her obtain dentures once her mouth healed. She then walked her through the process to apply for this assistance.

Due to P.'s actions, the member will receive needed liquid nutrition to maintain her health and weight, dentures to transition to a more normal lifestyle and support to regain the use of her arm. This will help the member to regain independence and better enjoy her life.



L., a WellCare of Kentucky clinical social worker, visited a 4-month-old WellCare of Kentucky Medicaid member to access his needs. The infant was recently discharged from the hospital after a long stay due to complications from his premature birth.

During their discussion, the member's parents told Lee that they had a \$212 past-due electric bill that they could not afford to pay. Their concern was that it had been due for two months. The member's father had recently started a new job, but he was afraid the electricity would be cut off before he received his first check.

L. began researching available resources for the member and his family. Through WellCare's Health Connections Referral Tracker (HCRT), he found three organizations that would collectively help the member's family get the support they needed. He informed them that the Salvation Army was able to contribute \$50 toward the bill. In order for the remainder of the bill to be paid, one of the parents would have to visit two different churches that could provide additional help. L. explained the processes required and provided the member's mother with the contact information for the organizations.

Due to L.'s efforts and the help of the HCRT, the member and his family are able to pay their past due electric bill. This will enable the family to provide the infant with a safe and secure home, and allow them to focus on providing the care and attention needed for a premature infant to thrive

