

MAC Binder Section 9 – Good News Stories

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Located online at <http://chfs.ky.gov/dms/mac.htm>

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The MCOs submit good news stories to DMS on a monthly basis. These stories reflect the positive impact of managed care and demonstrate the diligence of the MCOs efforts at the improved and continued health care for KY Medicaid members.

2 – Good News_Feb2015:

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January 2015 MCO Good News Reports

MCOs Going Above and Beyond

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



Humana

A middle-aged member and was recently discharged from the hospital. He had been in the hospital twice in the past year. The first hospital stay was in January, for four days and the second was at the end of March, for five days. When the Case Manager called the member, he informed her that he was nauseous and had an elevated blood sugar. He also informed her that he was out of his prescription. He stated that when he went to the pharmacy, they told him that the prescription would not be covered by his insurance until Monday.

The case manager instructed the member to go to the emergency room. He stated that he had just gotten out of the hospital and refused. She contacted the pharmacy and was told a new prescription was needed to override the previous order. She contacted Henry's provider and left a message regarding the need for another prescription.

The case manager contacted the member again who stated that he was still sick and his blood sugar was still elevated. She again instructed him to go to the emergency room, but he refused. The case manager contacted the provider's office again and left a second message for the physician.

After a third attempt, the case manager was able to make contact with the provider's office and spoke with staff, who stated that she had received both messages and the physician would address the concern as soon as possible. The case manager contacted the pharmacy again and spoke with the Pharmacy Manager. He stated that there was a refill for the prescription and no co-pay applied. She then contacted the member again and informed him that his refill was at the pharmacy. The member stated that he would have a friend pick the prescription up on their way home that day



A member who is a medically fragile infant was in the foster care system. A new family in a neighboring state had finalized his adoption, but transporting the infant, while maintaining his tube feeding, proved to be a major obstacle causing a delay to the member's new life with his adoptive family. Equipment providers in Kentucky and his new home state disagreed on whose medical equipment should be used in the member's transportation. The Humana – CareSource Foster Care Case Manager was contacted by DCBS for assistance with infant's transfer.

The case manager coordinated with DCBS, his adoptive mother, the doctors, and the equipment companies to arrange for all equipment and prescriptions to be transferred to his new home. After days of phone calls, information gathering, arranging for authorization of services, and following a court appearance for final approval, the boy's adoptive mother was able to take him home, feeding tube and all.

The case manager continues to work with the member's adoptive mother, case worker, doctors, and other providers to see that all of his needs are met until his coverage is transferred to his new home state.



A middle-aged member was recently hospitalized and had a colostomy. A Case Manager reached out to him following his hospitalization to ensure that he understood his discharge instructions. As part of his discharge, Home Health instructed him on the care of his new colostomy and dressing changes. Through their conversation, he expressed some concerns regarding the care and maintenance of his colostomy. He was concerned because he was going to need supplies to have clean products for his dressing changes.

To help this member, the case manager contacted a DME company that was willing to send the member samples of a few different products. The company was also willing to work with his doctor to obtain the order for the products that worked best for him after he tried some of the samples. In addition to helping the member obtain the proper supplies, he also needed to maintain his colostomy. The case manager assisted him in setting up his follow-up appointments and also confirmed that he was getting his prescriptions filled without any difficulty.



Passport

At 10 days old, a newborn Passport member was living in a halfway house with her mother. She was not gaining the appropriate weight and had thrush infection (an infection of the mouth). Her mother was completely overwhelmed with trying to calm her fussy baby, get her to eat, and maintain a comfortable living situation when being surrounded by strangers she was unable to rely on for help.

The baby's primary care provider (PCP) was concerned, and sought help from Passport's Embedded Case Manager. Together they determined that there were no home health agencies in the area to provide the low acuity care the PCP wanted for weight checks and ongoing education. The case manager also double-checked but found the mother did not qualify for HANDS, a county health initiative to provide education. Filling the gap, the case manager referred the family to Passport's Mommy Steps program where a nurse was able to reach out and provide ongoing education and support to the mother and newborn. The mother now knows she has a source for resources and support, and the PCP was pleased with the creative solution to fill a care gap for this family in need.

The newborn is one of 2,165 members enrolled in our Mommy Steps Program from January through October 2014 for ongoing antepartum and postpartum education and support.



A new Foster Care Liaison at Passport was previously an employee at a local therapeutic foster care agency when he emailed the Passport Out of Home Placements Manager concerning a Passport foster care member. The member had completed a vision exam and received eyeglasses in May 2014, prior to entering custody with the Department for Community Based Services (DCBS). The liaison stated the prescription for the lenses did not seem to be correct and were causing the member discomfort and difficulty seeing. The foster family had taken the member to an optometrist's office and was told the service would not be covered by Passport because she had obtained the exam so recently. Seeking a second opinion, the foster parents found a different optometrist who said the exam would be covered, but new lenses would not be covered.

Armed with this background knowledge, the placements manager contacted Passport's Vision Program. A Passport Vision Program member explained the new lenses would be covered if the prescription varied by at least 0.5 diopters. She contacted the member's provider to explain the benefit and ensure she would not experience any further barriers to getting necessary care and treatment and relayed all of the information to the foster care program and the foster parents.

Thanks to this quick collaboration and open communication among all parties, the member obtained another vision exam and received new lenses with the proper prescription and new frames. She is no longer experiencing discomfort, and she feels confident wearing her new frames.

In October, the placements manager received this email from the foster mom: *Just wanted to take a minute to thank you and the liaison for all the hard work/ time you put into getting new eye glasses for our foster child. I took her this morning for an exam at 9:15 a.m. and we walked out of the office at 10:00 a.m. with new lenses and frames. Once again it has always been a pleasure working [with] both of you, sure you will make a great team [sic]. Passport is blessed to have both of you working for them.*

These are just a few of Passport's interventions towards our mission to improve the health and quality of life of our members. Between January and November 2014, we actively assisted a total of 1,315 foster care members.



Every time a six-year old Passport foster child was presented with a new set of glasses, he promptly destroyed them. His foster mother was at her wits end when Passport Foster Care Liaison learned of her desire to obtain an expensive "flexible" and virtually indestructible frame. In his former employee role, the liaison had witnessed first-hand another foster child with extreme behaviors who had greatly benefited from the same type of eyeglass frame.

With that knowledge, the foster care liaison contacted Passport Health Plan's Vision Program Liaison. The latter learned that the claim had not been submitted correctly the first time, and that the frames could indeed be paid. The vision program liaison reported back to the foster care liaison, who forwarded the good news back to the specific state social worker on the case. This all happened in less than 24 hours!

By the very next morning, the member was able to receive his special frames, which hopefully will decrease the number of glasses destroyed and help him with school and other quality of life issues.

These types of efforts have helped Passport assist 1,315 foster care members between January and November 2014.



When a Passport member arrived home after having a heart bypass, the only habit she started changing was to stop smoking. She had no idea that she had just had a major heart attack. Her Case Manager helped her understand the full extent of her situation and then suggested life changes the member was encouraged to make, such as diet and exercise. He also made sure her incisions were healing well, that the home health nurses were coming as scheduled, and that she was taking her medicines and following up with her providers as necessary.

As a result, the member did not have any other inpatient admissions, although she did visit the ER after following the case manager's advice to be wary of any chest pain. It turned out she had developed redness of her incision, and was prescribed a round of antibiotics. During their last call, the member did not have any signs of infection and had follow-up appointments with both her surgeon and cardiologist.

The Healthy Heart Program has provided educational mailings, outreach, and case management services to an average of 4,000 members in 2014.



It was a long road before a member found herself in the emergency room with a severe anxiety attack and critical blood alcohol level. Over the years, she had developed diabetes, heart disease, depression, psychosis and methicillin-resistant Staphylococcus or MRSA infection (an infection of various tissues in the body). She had also undergone electroconvulsive therapy and skin grafts for burns, used tobacco and alcohol.

When a Passport Embedded Case Manager met the member in the ER, she knew the member needed more help than she alone could provide. The case manager referred the member to a member of our Behavioral Health Team, who began by finding behavioral health providers in the member's area who specialize in trauma. She also took the time to listen and discovered that transportation was a major barrier to care. The member had a non-functioning car registered in her name, which prevented her from using her Medicaid transportation benefits. The case manager explained the steps to take to resolve this issue, and helped the member contact the transportation agency to get started.

In the coming weeks, case manager checked in regularly. Within two months, the member reported she had made transportation arrangements, had a positive experience with her new behavioral health provider, and had satisfactory results with her new medications. Perhaps more important, the member has shown increased insight regarding how her behaviors (specifically related to missed pain management appointments) will affect her, and how she can remedy the situation.

These efforts have provided a great start towards long-term behavior change, which will ultimately improve the member's health and quality of life. She is just one of approximately 375 members our Behavioral Program serves every month.



When a Kentucky senator learned that one of his constituents had been inadvertently transitioned to a different Medicaid managed care organization (MCO), he sought the help of the Passport Director of Government Relations. It was a Friday afternoon, and member desperately needed a medication which was not covered by the other MCO.

The Director immediately contacted our Director of Member Services who worked with the Department for Medicaid Services to resolve the issue. A representative from our Member Services team contacted the member directly, and he was able to obtain his prescription that same day! Later, the senator wrote: *"I wanted to let you know how appreciative we are of your efforts in assisting the (member) with his Passport issue. I'm sure you know that it is resolved, but I wanted to thank you personally for your attention to this matter."*

This is one of 33,802 calls handled by our Member Services team in 2014.



In early 2014, a member's parents were at a loss for how to help their adult child with a mental health diagnosis and who had lost all ability to manage their functions of daily living. They were housing their child, helping them eat, care for themselves and perform household tasks. Despite the parents' efforts to care for their

child, the member ended up being rapidly admitted twice to an inpatient psychiatric hospital when their outpatient therapist and psychiatrist were unable to help the member achieve stability.

A Passport Behavioral Health Team Member came to member's aid by enrolling them into Intensive Case Management services. The Team Member made 4-6 monthly contacts with the member to offer support, ensure treatment compliance and provide information about additional resources. The Team Member was also a source of support and compassion for the member's father, who had begun to feel the emotional strain of continually caring for his child.

As a result, the member has experienced a great deal of tangible, positive change in a relatively short amount of time! The member has avoided inpatient readmission, continues to regularly access medical management services and outpatient therapy services with providers, and reports feeling stabilized. The member's quality of life has also vastly improved. In the fall of 2014 they were able to move into their own apartment (with support from the member's parents, who check in daily to ensure medication compliance and proper nutrition). The member has increased involvement with their own child and is working for their brother as a freelance graphic designer. The member has even experienced a newfound hope and shares a long-term goal of returning to college and completing a degree in graphic design!

This member is just one of approximately 375 members our Behavioral Program serves every month.



Every year, a Passport member family moves back and forth between Kentucky and another state for horse racing seasons. When the mother's child was identified as having a genetic syndrome, she became very active in learning how to care for the child's needs and navigate the Kentucky Medicaid and First Steps systems. The situation became more complex, however, when the time approached for the family to relocate temporarily for the season. Complicating matters even further, the mother did not speak English and required the use of a translator.

A Passport Embedded Case Manager was in the office the day the mother brought these concerns to her primary care provider (PCP). The case manager was able to identify and provide contact information for the mother to find a PCP and Medicaid office in the other state, and the process for cancelling/reinstating Kentucky Medicaid. She also discussed the need for child to receive their 12-month EPSDT (child well care) and dental visits, and gave the mother information on how to access transportation with her Kentucky Medicaid benefits and health/contact information for Passport in her native language.

These types of efforts have helped Passport to obtain the following rankings for national HEDIS[®]** in 2014: Six or more well-child visits with a PCP the first 15 months of life: 70.34% (50th percentile)



WellCare

A 64-year-old, homeless WellCare of Kentucky Medicaid member, who has hypertension and Chronic Obstructive Pulmonary Disease (COPD), was sent to an out-of-state hospital to treat their intestinal blood clots. Following treatment, the hospital wanted to release the member with support from home health services. But, because the member was homeless, there was no place to receive those services. The member was estranged from their family and did not have any friends who could take them in.

When a WellCare of Kentucky field service coordinator was notified about the member's situation, she immediately got to work to find a safe place where the member could receive the health services needed to fully recover. The coordinator turned to WellCare's HealthConnections Referral Tracker (HCRT), which is a database with more than 9,000 Kentucky-based community organizations that WellCare can refer its members to for social services support. It helped the coordinator to locate multiple homeless shelters in the area. Unfortunately, the shelters did not have the resources to support someone with the member's health issues. Then she contacted skilled nursing facilities, but the member didn't qualify because they had good mobility.

Having exhausted her options, the coordinator held a "POD" meeting – where WellCare associates from different areas, including case managers, social workers, nurses, community outreach advocates and managers brainstorm to solve difficult situations. During this meeting, it was decided that a personal care home, which offers housing, food and personal care services would be the best option for the member. The team made this decision despite the fact that the member would have to leave WellCare and sign up for the state Medicaid program, because personal care homes are not a managed care benefit.

After extensive research, the coordinator found a facility close to the member's hometown. A WellCare case manager met with the member to explain why they needed to transition to the state Medicaid program. The member understood why it was necessary and was happy with the facility that was selected because they were familiar with it.

The coordinator then needed to find a way to get the member from the out-of-state hospital to the personal care home which was 135 miles away. She tried several options, but none of them worked for the member. Once again, the coordinator had to use the HCRT to solve the problem.

The distance and the member's medical condition made the trip more expensive than a typical member transport. WellCare of Kentucky's medical director approved the additional cost because he knew it would keep the member off of the street during their recovery.

Because of the coordinator's efforts and the support of a cross-functional WellCare team, the member was safely placed in a facility where they could receive the care needed to recover. The coordinator and the support team never wavered from doing what was best for the member's health and well-being, even when they realized that they would have to transfer them to the state plan to provide the best opportunity for a long-term, positive outcome.



A WellCare of Kentucky field service coordinator recently visited a 59-year-old WellCare of Kentucky Medicaid member who had just gone home following two months of hospitalization to treat colon cancer. To make the difficult situation even worse, the member's spouse died while the member was in the hospital. Both the death and the inability to attend the funeral caused the member to be severely depressed.

The coordinator immediately got to work on the member's behalf, scheduling an appointment for them to begin receiving behavioral health counseling to deal with their grief and to treat depression. The coordinator also got the member a referral so to have a case manager assigned specifically to oversee their behavioral health.

During their conversation, the member mentioned that they had recently missed a medical appointment doctor because their son uses their only car to travel to and from work. The coordinator 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 obtain transportation to and from doctor's appointments. The coordinator also used the tracker to connect the member with organizations that could assist with the winter utility bills and provide the family food.

Due to the coordinator's quick actions, the member will receive the support needed to get through this very difficult time, and improve their health and well-being.



Anthem

An adult Anthem Medicaid member suffered a ruptured esophagus that required multiple surgical procedures and an extended hospital stay at a large university medical center. After their four-month stay, hospital case managers began planning the member's discharge. They identified specialized care needs that were consistent with the type of care typically provided in institutional settings such as nursing homes. The member would need to be fed through a feeding tube, and he would require assistance with daily living activities, including bathing, dressing, and more. The Anthem clinical team, led by an Anthem case manager, engaged in several discussions with the member's family and hospital clinicians to communicate options and create a care plan. It was determined that the most appropriate post-discharge care for the member could be delivered in the comfort of his own home, so Anthem arranged home health services through our network providers.

The member received daily visits from partnering home health aides who provided physical and occupational therapy as well as education and help with medication therapy management. Through local partners that provide infusion services, Anthem arranged for clinicians to visit the member at home to help with feedings and to teach the member how to feed himself using a gastrostomy tube. Additionally, through a durable medical goods partner, Anthem arranged for a wheelchair and feeding tube supplies to be delivered to the member's home.

With the home services and supports facilitated by Anthem, the member regained his strength and completed the recovery program within a month. The member continues to make progress and has not experienced complications or hospital readmissions.



An Anthem member was challenged with complications that resulted from several complex and chronic conditions. This member was hospitalized after suffering from diabetes complications that impacted the ability to walk. The member also had to have a tracheostomy after being put on a ventilator for respiratory failure. The hospitalization was lengthy and was followed by admission to a rehab facility. After rehab, the member was readmitted to the hospital for deep vein thrombosis and gastrointestinal bleeding. When the hospital was preparing to discharge the member, they had to take into account the extensive care needs, including the need for tracheostomy care and intravenous antibiotics. The member also needed support to manage diabetes and be educated about the blood thinners.

An Anthem case manager contacted the hospital discharge planner and the member's mother to assist with discharge plans. The family expressed that they would prefer for the member to receive post-discharge care at home rather than institutionalized care at a skilled nursing facility. Thus, the Anthem case manager was able to identify a home health agency that could support the member while recovering comfortably at home. Anthem coordinated regular visits by a home health nurse so the member could receive physical and occupational therapy at home. Anthem arranged for a durable medical equipment provider partner to deliver needed medical equipment and tracheostomy supplies to the member's home. Anthem also helped the member to get a diabetic meter and a device that would assist in the prevention of blood clots. The Anthem case manager also arranged for regular meetings with the home health services partners to ensure the member was receiving appropriate care and medication.

With support from Anthem, the member continues to receive support from home health services and is making positive progress with her recovery.



This is a success story of managed healthcare that was provided to two new Kentucky Anthem Medicaid members to improve the quality of their lives and promote continued wellness. A young first time mom, excited that she was having twins, was filled with apprehension due to premature labor. The small local hospital anticipated they would not be equipped with a Neonatal ICU for these premature babies.

The expectant mom continued in labor as she was admitted to a larger hospital for a caesarian section and care for her newborns. The babies arrived early at 34 weeks gestation, each weighing a little over 4lbs. The babies progressed slowly but steadily as they received warmth from the incubator, nutritional support, and medications to prevent infection. Finally, 14 days later, both babies were ready to go home. They were still very small and the first time mom was inexperienced in caring for a new baby, much less two. The discharge planners at the hospital gave discharge instructions and appointments for follow-up but there was a lot of information for the mom to remember.

The new mom was contacted by one of Anthem's nurse case managers who assisted the new mom with questions, concerns and resources that were available to her. The case manager referred her to the HANDS program, which provides information and support for first time moms. The case manager also scheduled an appointment for her with WIC so she could receive supplemental nutrition for her babies and provided the contact information for the mom to request food stamps so that she could also maintain her own nutritional status. She was going to receive two free portable cribs for her infants through the Anthem Cribs and Car Seats program and after completing six or more well child visits before the babies are 15 months old, she will receive a \$50 Wal-Mart gift card for each baby. This is an example of Anthem Medicaid maintaining trust, being accountable and caring for our members.



At a recent Greater Louisville Medical Society/Anthem IIRC meeting, Anthem was questioned about our initiative for Sports Physicals. The question included whether Anthem was currently, or planning to, undertake collaboration with DMS to assist in guiding the other MCOs on same or similar tasks. The attendee emphatically stated to the committee that it was a wonderful initiative and that Anthem provided the most clear and concise information about the benefit while giving talking points on how to submit claims for those services. The attendee closed on that topic by saying she hoped we would be working collaboratively with DMS to help smooth various processes associated with our fellow MCOs.



CoventryCares

A member is a 25 year old who was referred to a high-risk OB nurse from a phone call about the CRIB program. The member has had multiple pregnancies. She has delivered two children early at 31 weeks due to health issues and was diagnosed with a protein deficiency. She received injections during two prior pregnancies to assist with carrying babies until delivery.

The member has been receiving prenatal care early in this pregnancy and her doctor did not feel she needed the injections during this pregnancy. She explained this concern to her case manager and voiced that she wanted to change doctors but did not think there were any locally that would accept her insurance.

The case manager provided the member with a list of participating physicians. She attempted to contact one and left a message. The case manager contacted the office and was able to make an appointment with a new physician. When the member saw this new physician, she was started on the injections, underwent some other medical tests, and participated with the physician in planning for the duration of her pregnancy. She was very happy with the change and assistance provided by the case manager.

Positive outcomes:

- Collaboration between case manager, member and OB office
- Positive communication between member and case manager



The member is a 17 year old female with the history of Type I Diabetes with poor management. The member was placed in foster care in August 2014. The member was also in need of behavioral health assistance as she has a history of self-harm actions and suicidal/homicidal ideations. The member presented to the case management program via a referral from a DCBS nurse. The nurse case manager collaborated with the DCBS nurse, Commission for Children with Special Healthcare Needs nurse, DCBS ongoing worker, social worker with Community Mental Health Center, foster parent, and the member herself.

The member showed improvement as evidenced by lowering her HgbA1c from 11.0 in August 2014 to 8.2 in November 2014. The member has attended a clinic and workshops in regards to diabetes education and can now repeat back appropriate information regarding her diagnosis. The member is attending therapy sessions to include both individual and family therapy. The member is reportedly not participating in self-harm actions and verbalizes that she does not have or feel the need to harm self or others. The member is becoming more active in school and has just recently joined the softball team.

Results:

- Positive rapport and collaboration with multiple disciplines to include Commission for Children with Special Health Care Needs, DCBS social worker and nurse, healthcare providers, foster parent and member
- Member continues to do well as evidenced by improved labs and blood sugars and positive behaviors both in school and at home
- Member will now most likely learn and continue life-long healthy habits
- Member is learning to have and maintain positive resources for continued good health for both medical and behavioral health
- Member is less likely to be admitted to hospital for either medical and/or behavioral health issues



February 2015 MCO Good News Reports

MCOs Going Above and Beyond

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



Passport

Last month, a Passport member called into our Care Connectors call center to check on the status of her member rewards. While speaking to a Case Management Technician, she expressed sincere gratitude for the gift card she had just received from Passport for getting her mammography.

The member also stated that in all her years of having to pay hundreds of dollars for insurance, Passport was by far the nicest and friendliest organization she has ever dealt with. She thanked our entire organization over and over again for being so friendly. She was also extremely thankful for the free coverage through Kentucky's Expanded Medicaid. She expressed that times have been difficult since the death of her husband, and that the health insurance came at a very important time in her life.

"It warmed my heart to know that we are really helping our members and that she took the time to express her gratitude to Passport. It makes our job all worth it."

These types of efforts have helped Passport to obtain the following ranking for 2014 Adult Medicaid Quality Compass® Member Satisfaction Survey in 2014:

- Getting Needed Care: 85.29 (75th percentile)
- Customer Service: 90.48 (90th percentile)



After experiencing chest pain for 11 months, a Passport member was admitted to the hospital for heart bypass surgery. After being discharged and sent home, the Passport Case Manager contacted her to see how she was doing. The member reported that she was doing well but was struggling with fully understanding all of the many life changes that would be important for her to make in order to hopefully avoid a second heart attack.

The case manager stressed the importance of attending all provider follow-up visits and watching for signs of infection, discussed her current medications, and educated her on how to start living a heart healthy lifestyle with diet and exercise. The case manager also performed a depression screening and sent her educational information in the mail after their call.

The member is one of 4,000 touched by Passport's Healthy Heart Program in 2014.



A Passport infant with serious chronic health issues whose family speaks a very uncommon language (non-English). After being released from the NICU on a vent, the member was receiving home infusion injections by a home health agency with plans to continue for many months. Unfortunately, her Medicaid eligibility was due to lapse in less than one week and the home health providers would be unable to continue to provide services. Without these critical injections, the infant would most likely be re-hospitalized. In addition to these concerns, the family was experiencing severe financial hardships. The member's father had lost his job while she was being hospitalized, and he and his wife were unable to pay the rent and provide housing to the infant's many siblings.

When the infant showed symptoms of being ill, her parents brought her to a local emergency room and shared their concerns with staff using a translator. The staff contacted a Passport Embedded Case Manager, who immediately launched a series of multiple phone calls using a telephone interpreter to clarify and resolve the eligibility issue and the family's comprehension of what was occurring. That day, the case manager made a two-hour conference call with the father and an interpreter to resolve the issue with the Department for Community Based Services (DCBS) and the Department for Medicaid Services (DMS). The next day she made a point to double-check the system and noted that the member's eligibility was still scheduled to lapse. The case manager took the time to care and made another 40 minute call to DCBS and DMS, enlisting the help of Passport's Special Support team.

Thanks to the case manager's diligent efforts, the member's eligibility issue was resolved the day before it was due to lapse. The case manager updated the home health nurse and was assured her important services would not be interrupted. The father was very grateful for the case manager's assistance, and admitted he would not have been able to navigate the system without her help.

Going a step above and beyond, the case manager also confirmed the family's upcoming PCP appointment and updated the Passport Embedded Case Manager (who works onsite at that location). He rearranged his schedule in order to be present during the family's appointment to assist with their financial hardships. Lastly, the case manager referred them to Case Management for ongoing assistance with the infant's chronic disease. The member and her family are just one of 4,374 members served by our Embedded Case Managers in 2014.



A Passport member had Post Traumatic Stress Disorder (PTSD) and severe paranoia, but refused to get help or treatment for her multiple mental health issues. Her primary care provider (PCP) referred her to Passport's 24-Hour Behavioral Health Crisis Hotline, but she didn't believe our representatives were who they said they were, and refused to speak with them. Concerned, her PCP contacted a Passport Embedded Case Manager for assistance. The case manager determined when the member's next PCP appointment was and made plans to meet her face to face to legitimize Passport's concerns and the help we could offer. Touched by his concern, the member opened up to the case manager and shared details of her struggles.

"I was happy to know I helped her overcome her fear of connecting with the help she needed," says the case manager. After building this foundation of trust, he was able to successfully connect the member with Passport's Behavioral Health Program. These caring representatives began the process to further connect the member with the help she needed. They also spoke with the PCP about prescribing additional medications to address the member's paranoia.

This member is just one of over 3,000 members our Care Coordination department referred to our Behavioral Health Program in 2014.



A Passport associate and grandparent is raising her 16-year old grandson. Despite her best efforts, the grandmother could not convince him to take the time to go for his annual physical and dental checkups. Hoping a monetary incentive might change his mind, the grandmother obtained information from a Passport Member Incentive Coordinator and passed the information on to her grandson.

"I was a little leery of the incentive approach when it was first introduced," admits the grandmother, "as it doesn't seem to be enough money to each individual to really make any difference. I was clearly wrong!" Her grandson went to his PCP for a physical. The same day he got his gift card in the mail from Passport, he asked his grandmother to schedule his dentist appointment so he could get another one!

"I work with lots of members who ask me about their incentive cards or tell me what they are going to do with them," says the grandmother, "but when I saw the smile on my grandson's face holding that gift card and telling me he wanted to go to the dentist...I became a believer." These types of efforts have helped Passport to obtain the following rankings for national HEDIS® in 2014: Annual Dental Visit - Total 2-21 Years: 65.48 (75th percentile)



When a mother took her son, a Passport youth, to the emergency room for the 6th time this year for a non-life-threatening encounter, a Passport ER Navigator asked an Embedded Case Manager to meet with the family at their primary care provider appointment the next day and help them overcome any potential barriers.

After discussing the boy's health concerns with his mother and grandmother, the case Manager uncovered that they were just unsure of how to care for the boy's health at home. They had been going to the emergency room under the mistaken assumption that they could only obtain a PCP appointment several days out. The case manager educated them about the PCP's triage nurse, who was available to help them with advice and obtaining a same day appointment if necessary. He also told them about Passport's free 24-Hour Nurse Hotline which is available to support these services.

Thanks to these efforts by Passport staff members, the boy has decreased his visits the ER and his caregivers now know the proper steps to take before taking him to the ER for a true emergency. These types of efforts have helped Passport to obtain the following rankings for national HEDIS® in 2014: Ambulatory Care - Outpatient Visits/1000: 398.89 (50th percentile)



On the verge of adulthood, a Passport foster child was on the waiting list for an organ transplant when her immigration status came into question.

A Passport Foster Care and Guardianship Liaison immediately referred the child for case management services. The liaison also spoke with Passport's Health Equity Educator to learn more about the child's immigration status. Over the next few months, multiple Passport associates would become involved in multiple conversations with the Department for Community Based Services (DCBS) and Department for Medicaid Services (DMS) in a desperate attempt to resolve the questions surrounding the child's ongoing Medicaid eligibility.

In August, our Out of Home Placements Manager received confirmation that the child is considered a documented immigrant and will qualify for Medicaid as long as she continues to meet other eligibility criteria. Luckily, she was also able to remain on the transplant list and the Placement Manager was able to confirm to DCBS that her transplant authorization period would remain active until May 2015.

In December, the child received a transplanted organ. DCBS reported that recovery was going better than expected and the prognosis was positive. The DCBS worker also thanked Passport for always being available, answering the phone and providing quick answers when needed.

The member's life was saved thanks to the collaboration and problem-solving of multiple associates from multiple teams at Passport, caring DCBS staff workers, and dedicated Kentucky providers.

This case is one of 595 issues we helped to resolve and one of 433 service plan reviews we completed for foster care members in 2014.



A Passport Community Engagement Coordinator recently received the following note from a Passport member:

"Passport Health Plan has been wonderful! A little over 3 years ago on a Friday afternoon I was told that after 25 years my job had been eliminated. I was told not to worry about insurance; that I could get Cobra. The monthly amount that Cobra wanted to charge was over 3 times the amount I had been paying for my husband and my insurance.

"Being that I was the main income provider there was no way we could afford to get Cobra! Thankfully my husband was able to go to the VA for his health needs. I thankfully was able to go to the local health department and a local clinic. However doing this, you never saw the same doctor and it was usually a long waiting time to get in.

"After the laws changed in Kentucky last year we were now qualified for Medicaid and were able to choose different Insurance providers. After researching and talking with other people I tried Passport. I'm so glad I did! Since the beginning of the year I have been able to see the same doctor and referred to specialists if needed. Passport covers everything thing you could possibly need including dental cleanings and checkup as well as eye exams! They also have an incentive gift card program. Let them know you've been to the doctor or had your teeth cleaned and they'll send you a \$10 gift card to either Wal-Mart or Krogers (sic), your choice! I had many local physicians to choose from that all took Passport. I didn't have to drive over an hour away to be seen. I already have and would again recommend Passport to anyone who is looking for Health Insurance."

These types of efforts have helped Passport to obtain the following rankings for national HEDIS® in 2014: Member satisfaction data and/or Annual Dental Visit - Total 2-21 Years: 65.48 (75th percentile)



WellCare

A WellCare of Kentucky field service coordinator recently visited a 57-year-old WellCare of Kentucky Medicaid member who falls frequently, resulting in numerous visits to the emergency room.

During an in-home visit, the coordinator discovered that the member's chronic pain was causing her falls. The coordinator immediately contacted the member's primary care doctor to get approval for a special quad cane. She then contacted a medical equipment company to order the cane for the member.

Since receiving the cane, the member told the coordinator that she was walking more steadily and had not experienced any falls. Having the new cane was helping the member maintain a better quality of health and reduced her visits to the emergency room.



A 23-year-old WellCare of Kentucky Medicaid member who was new to the plan has a genetic disorder that attacks the liver and other internal organs from the inside out. The disease had already caused damage to the member's heart and kidneys, and his specialist planned for him to start dialysis treatment in the next couple of months.

A WellCare of Kentucky field service coordinator conducted a home visit with the member, who told her that his father had died from the same disease when he was 40. His younger brother also has it. Although the member sees specialists for his heart and kidneys, he told the field coordinator that he did not have a primary care doctor. He also told her that he was depressed and thought about suicide.

The coordinator immediately got the member a referral for psychological counseling and helped him schedule his first appointment. She also referred him to WellCare behavioral health, so he could have a case manager monitor his depression and counseling needs.

She then helped him choose a primary care doctor and made an appointment for him. Additionally, the coordinator learned that he did not have a way to check his blood pressure, so she ordered him a blood pressure monitor and educated him on the importance of using it daily. She also explained how to report the results to both his primary care doctor and his cardiologist.

The field coordinator then turned to WellCare's HealthConnections Referral Tracker (HCRT), which includes a database with more than 9,000 Kentucky-based community organizations that WellCare can refer its members to for social services support. She started with Kentucky Vision and helped him fill out an application for glasses. She told him about a resource where he could receive a free cell phone and she helped him fill out the application. She also told him about available support for housing, utilities and food banks, and provided the contact information for each.

The coordinator also educated the member about additional benefits available to him, including a behavioral crisis line and a 24-hour nurse line. Through the coordinator's efforts, the member will receive the care and monitoring he needs to better manage his behavioral and physical health. The member is also now aware of the social services available to help him with his basic needs. Before the coordinator left, he told her that both her visit and the resources she provided helped improve his outlook, which will help him find the strength to meet the demands of dealing with his illness.



A WellCare of Kentucky field service coordinator recently visited a 40-year-old WellCare of Kentucky Medicaid member who has severe hypertension. Although he was addicted to drugs, the member had been in recovery for more than two years. However, because he was homeless he was staying in a drug treatment facility temporarily.

During an in-person visit with the member, he told the field service coordinator that he had severe Post Traumatic Stress Disorder (PTSD), but that in the past he had been reluctant to talk to anyone about it. Through the coordinator's convincing, the member agreed to speak to a behavioral health case manager about his PTSD. The member also told him that he did not have a blood pressure cuff to monitor his hypertension.

The coordinator immediately ordered a blood pressure monitor for the member and set up an appointment for him to meet with a behavioral case manager. Then the behavioral case manager set up an appointment for the member to meet with a psychologist.

Due to the coordinator's actions, the member began regularly monitoring his blood pressure and reporting the results to his doctor. He also began attending appointments with the psychologist and said he felt optimistic about his treatment. Both of these actions will help the member regain both medical and behavioral independence.



A 52-year-old Staywell member, who was new to the plan, made several visits to the emergency room (ER) complaining of neck and back pain. A Staywell community health worker contacted the member to determine his needs and to understand why he was using the ER so much. During their discussion, she learned that he has chronic pain from an accident. He told her that he did not understand his health plan coverage, did not think he could afford to see a doctor and did not have reliable transportation to get to appointments.

Staywell's community health worker immediately began working to coordinate a referral to a local pain management specialist and secured an appointment for the next week. She helped the member understand his Staywell health benefits and explained the process for requesting transportation assistance for his medical appointments.

Because the Staywell community health worker took the time to educate the member about his benefits, and located and scheduled an appointment with the appropriate health care provider, he is able to have his care proactively managed, which should keep him from using the ER as his primary source of health care.



Anthem

A member was enrolled in case management after review of the daily in-patient census. This member had been in rehabilitation due to a stroke that affected his ability to walk. He was discharged home from rehabilitation with medication for his blood pressure.

Before the monthly case call the Case Manager (CM) reviewed his prescription list and noted that the member had not refilled his blood pressure medication the previous month. When asked about his blood pressure, the member admitted that it had been higher recently, and on this day was especially elevated. He told the CM that his doctor hadn't mentioned the medication at his last appointment. The CM educated the member on the importance of good blood pressure control with his stroke history. She also called the MD to verify his medications and the doctor confirmed to the CM that the member's high blood pressure was the reason he had a stroke and confirmed that the member was to take the medication. The CM called the pharmacy and learned that the member had called in the meantime for the refill on the medication.

The CM followed up with the member the following week. He gave the CM permission to speak with his partner about his health and she verbalized understanding of the importance of the medication and the reason for his previous stroke was due to uncontrolled blood pressure. The member has been following his medication regime and the CM will continue to follow up to ensure compliance.



Our vision vendor, eyeQuest, was faced with a case in which a child was in need of a specialty frame requiring medical pre authorization (MPA). eyeQuest assisted the treating provider with the process of obtaining an expedited MPA and guided them through every step of the process. Both the office and the member's guardian were extremely thankful for eyeQuest's assistance in ensuring the MPA was approved.



An Anthem Community Relations representative was at a library refilling our brochure holder when a woman stopped her and asked about Anthem. She initially thought the representative worked for the commercial plan and stated that she felt she had no choice but to obtain insurance, even though she could not afford it. The representative explained to her that she worked for the Medicaid plan and asked the woman if she had ever applied for Medicaid. The woman stated she was not interested in Medicaid because she and her husband had worked all their lives and they didn't have much but wanted to keep what they have. Through further conversation, the representative learned that she had heard Medicaid will mean individuals would have to sell their homes in order to pay Medicaid back. The representative explained to her that that is a process known as estate recovery and that it is isolated to certain situations for those involved in vendor payments for long term care services. The woman was very surprised and when the representative explained to her how Medicaid managed care works, she seemed more open to applying for assistance. The representative explained that she could either apply online or call the kynect number.



CoventryCares

Member is a 63-year-old female with a new diagnosis of diabetes. She also has a history of other chronic diseases that include high blood pressure, depression as well as chronic obstructive pulmonary disease (COPD).

Member enrolled in case management with a Coventry RN. During her assessment, the RN found out that the member was not checking her blood sugar regularly, had a hemoglobin A1C of 8 (this is a blood test that calculates a 3-month average—normal is less than 6), and weighed 232 pounds. She is only 4'11", which makes the member's body mass index (BMI) 46.9 (normal BMI would be between 18-24).

The RN educated the member on proper diabetes monitoring which included checking her blood sugar 3 times a day. Member was educated on appropriate diet, which included carbohydrate counting, the importance of exercise, and the importance of good foot care. While working with the RN, she agreed to start an exercise program. She started slowly and advanced to walking further. She began self-monitoring her blood sugar and saw a decrease in her blood sugar levels to within normal range. With her exercise program and diet, the member was able to lose weight down to 199 pounds (a loss of 33 pounds). With follow-up with her doctor, the member reported her hemoglobin A1C is now at 6.6 (down from 8) and her cholesterol has gone from 300 to 150 with diet and medication.

Positive Outcomes:

- Collaboration between member and case manager
- Member able to self-manage her newly diagnosed diabetes



Member is an 8 year old identified for case management as possible utilizer of the emergency department instead of going to her primary care physician.

Member enrolled in case management in January with a history of multiple chronic illnesses that include asthma and obesity. During the previous 12 months, she was seen in the emergency department 7 times for non-urgent needs that include colds and abdominal pain. She lives with her grandmother who is her guardian. A Coventry RN educated the member's grandmother on appropriate use of the emergency department, when to contact her primary care physician, and how to use the 24-hour nurse line. Since her enrollment in case management, she has been to the emergency department two times. Prior to going to the emergency department the member's grandmother called her primary care physician or specialist (if related to her asthma) to try to get an appointment, as these needs came up during regular office hours. Her grandmother spoke with the physician who decided, upon hearing the symptoms, to send the child to the emergency department.

Positive outcomes:

- Positive communication between member and case manager
- Reduction in emergency department use



Humana

A Humana – CareSource (HCS) member enrolled in High Risk Case Management Program. He has a history of medication non-compliance and needs assistance with transportation. When HCS Case Manager, reached out to him, he was unable to identify all the medications he was prescribed. As a result, the case manager contacted his Primary Care Provider (PCP) to obtain a complete list of medications.

In order to insure that the member was able to get all his necessary medications, despite not being able to drive, the case manager contacted his pharmacy and confirmed that the pharmacy offered delivery or mail services for their customers. Unfortunately, he lives outside of the pharmacy's delivery range. To further assist the member, the case manager coordinated an arrangement with the pharmacy to mail the necessary medications to him at no additional cost. The case manager gave the pharmacy the exact list of medications that the PCP had provided.

The case manager contacted the member to explain the arrangement and to let him know that his medications would be mailed to him. She also provided him with information related to transportation services available to HCS members for future appointments. He was very pleased with this news and thanked the case manager for assisting him.

A member who was recently hospitalized with stomach pain was having trouble finding transportation to her appointments. A Humana – CareSource (HCS) Social Worker spoke with her. The member needed to see a Primary Care Physician (PCP) and a Gastro-Enterologist after her hospital stay. She needed assistance finding transportation to and from doctor visits as well as getting information about Food Stamps.

The member did not have an identified Gastro-Enterologist to follow up with after discharge from the hospital. The social worker talked with the member about her need for a PCP and Gastro-Enterologist. During a phone call with the member the case worker conferenced in the member’s PCP and helped set up an appointment. She then assisted the member in finding transportation that would take her to and from the PCP appointment.

The social worker then called the Gastro-Enterologist recommended to the member after her hospital stay and made an appointment for the first available time. She then educated the member on the process for applying for the free Medicaid transportation. The social worker confirmed that she would apply for transportation through a regional transportation service in her area and also provided her with the phone number to her local Food Stamp office. The member was happy to have assistance scheduling her appointments.

