

November 20, 2014 MAC Binder
Section 9 – Good News
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MCOs Going Above and Beyond



Passport

Years of financial and health struggles had taken their toll both physically and mentally on Mia*, a Passport member with diabetes. Luckily, when Kentucky chose to expand its Medicaid coverage this year, she was one of the lucky thousands who qualified for coverage.

While visiting her new primary care provider (PCP) last month, Mia met and poured her heart out to Tara Watts, one of Passport's embedded case managers (ECM). Tara listened with compassion and praised her willingness to ask for help. "It is often difficult to ask for help, especially regarding behavioral health issues," says Tara. "It's inspirational to meet members who are so appreciative of their health benefits and who are actively trying to improve their health in all possible ways."

Before she became eligible for Expanded Medicaid, Mia had been unable to afford testing strips. As a result, her blood sugar had been severely out of control. She developed a severe depression and had nowhere to turn.

When Tara explained that Passport covered testing strips and offered a special Behavioral Health program, Mia was thrilled. She enthusiastically embraced Tara's suggestions to consider behavioral and medical case management through Passport, to allow Passport to speak with her daughter if unable to reach her on the phone, and to schedule a needed dental visit, mammography, and Pap smear. Before she left, Tara helped Mia complete forms for Passport's diabetes member reward and a referral for assistance with a disability application. She also gave her contact information for a local community ministry offering financial assistance.

Mia thanked Tara numerous times, through tears, and said her diabetes is better controlled now that she has Passport. Since this meeting, Mia has begun working with Passport's Behavioral Health program and called Tara with her new landline phone number.

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

- Comprehensive Diabetes Care-HbA1c Testing PHP 84.08 (50th percentile)
- Comprehensive Diabetes Care –LDL-C Screening PHP 76.99 (75th percentile)

Gwen* is one of the increasing number of young women who experienced a heart attack well before her 30th birthday. Although her mother had also suffered from a heart attack when she was young, Gwen never thought it could happen to her. Passport's Disease Manager Ron Keene comforted Gwen after she was released from the hospital. They reviewed her medications and doctor appointments, and talked about things she could start doing immediately to avoid the chances of another heart attack occurring.

Gwen was particularly interested to learn about the effects of smoking and heart disease, and plans to speak with her PCP during their next visit now that she knows more about Passport's smoking cessation coverage.

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

- Advising to quit: 81.54 (90th percentile)
- Discussing cessation medications: 49.28 (50th percentile)
- Discussing tobacco cessation strategies: 40.65 (50th percentile)

Nancy*, a Passport member with a rare neurological disorder, had a dire need to see her neurologist that same day. While she was making her way to the office, the provider staff proactively recognized that billing would be an issue because the neurologist was new to the area and had not completed their credentialing process. They spoke with Provider Services Manager Vickie Blevins, who launched her team into action. She made several phone calls to Passport's claims, utilization management (UM) and provider enrollment department. Luckily the teams were able to connect on an interim process that would allow Nancy to see the neurologist as a nonparticipating provider.

Vickie called the provider office back and explained the extra work that would be required on their end. They were thrilled with Passport's ability to make an exception for their patient and agreed to follow the process Vickie had outlined. Thanks to this quick collaboration between Passport staff, the provider was very thankful and Nancy was able to receive her same-day appointment without any delay. This call was one of the 37,612 calls Provider Services received in 3rd quarter 2014.

If left untreated, upper respiratory infections (URI) in young children can have very serious effects on their long-term health. When Passport youth Bobby showed ongoing signs of URI, his mother Teresa* scheduled and brought him into his primary care provider's (PCP) office. When they arrived, the office staff told them Bobby was showing up as inactive for Medicaid in the system. Luckily, Passport's embedded case manager Robert Beatty was onsite that day and came to their assistance.

He got on the phone with Teresa and called the Department for Medicaid Services and Kynect, who were able to verify Bobby's eligibility. Although the system was not able to be immediately updated, the provider agreed to see Bobby that same afternoon so that he wouldn't have to go to the emergency room (ER). Robert also followed up with Passport's Member Services to let them know what was going on.

Teresa was very happy that her concerns were addressed on the spot, and that she did not have to relocate her son to the ER for his potentially serious condition. Robert is one of our many embedded case managers who have helped 2,109 members in the providers' offices through 2nd quarter 2014.

Passport member Mitch* hadn't seen a doctor in 35 years. Up until his recent heart attack and onset of emphysema, he seemed to be doing fine. Now that he was released with mountains of paperwork, follow-up appointments, complex medications and strict dietary/exercise recommendations, Mitch was completely overwhelmed. Passport's Disease Manager Ron Keene slowly helped him through the healthcare maze with frequent phone calls over the next several months. With Ron's help, Mitch was able to obtain a new primary care provider (PCP) and understand the referral process for specialists. He also cut down on his smoking (although he still wasn't ready to quit completely), and improved his diet and exercise. Ron also helped Mitch avoid a large out-of-pocket payment for the non-formulary drug his specialist had prescribed. He found a combination of formulary medicines that his specialist felt comfortable with. Thanks to these efforts, Mitch now has access and better understands how to obtain health care for the management of his chronic condition.

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

- Annual Monitoring Persistent Medications: Ace Inhibitors/Angiotension II Receptor Blockers 91.01 (75th percentile)

After working with Passport Disease Manager Sharon Owens for many years to manage her diabetes, Passport member Sherry* successfully lost over 60 pounds and stopped using insulin. As with so many women, however, her improved diet and exercise did not stop the onset of a nearly fatal heart attack. After she was released from the hospital, Disease Manager Ron Keene helped to reinforce Sharon's important diet and exercise recommendations. He helped her to understand her heart disease and the process for obtaining doctor appointments and specialized medicines to promote compliance with her post heart attack regimen.

These types of combined disease management efforts have helped Passport to obtain the following ranking for national HEDIS[®] in 2013:

- Ambulatory Care: Outpatient visits per 1,000, PHP score of 469 (75th percentile)

For the birth of her first two children, Passport member Lisa* had undergone C-sections for preeclampsia. Now several months into a new pregnancy, Lisa was determined to bring her unborn child as close to full term as possible. She wanted the best for her son, and for her that meant avoiding the life-long risks associated with a baby being born too early. A Passport Mommy Steps Disease Manager (DM) allowed her to vent her fears. She agreed that 40 weeks is best if both mom and baby are healthy, but cautioned Lisa that the extremely high blood pressure she had been experiencing could be dangerous for both her and her son. In fact, after verifying Lisa's extremely high blood pressure and other symptoms such as increased pain and decreased urine, our Mommy Steps nurse instructed Lisa to seek care immediately. Since her OB's office was closed, Lisa went to the nearest hospital.

When they next spoke, Lisa thanked our Mommy Steps nurse for encouraging her to not take no for an answer if she thought something was wrong. She confessed she might have stayed home and probably died if it hadn't been for their conversation. The hospital had kept her overnight and added more high blood pressure medicine to her regimen. She was then discharged by her OB to stay at home on strict bed rest and several follow-up appointments that week. Her family checked her blood pressure hourly and understood when to call the OB or go to the hospital.

Our Mommy Steps nurse called Lisa again on Thursday and could hear the other children playing loudly in the background. She encouraged Lisa to move into a darkened, cool, quiet room with minimal stimulation to help keep her blood pressure within limits.

Several weeks later, Lisa delivered a healthy big boy near term and without any issues. She was readmitted back to the hospital for an enlarged heart that was not pumping effectively due to her preeclampsia, but was very thankful for the assistance Passport and her OB had given her in helping birth her newborn son. "It was amazing how much love this mom showed her unborn son," our Mommy Steps nurse says. "She risked her life to ensure he wasn't born extremely premature."

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

- Frequency of ongoing prenatal care-81 +percent PHP 78.08 (75th percentile)
- Prenatal and Postpartum Care: Timeliness of Prenatal Care PHP 85.91 (50th percentile)

When Passport member Zelda* had a heart attack nine years ago, she changed her life around. She stopped smoking and started eating healthier. Things were looking good until the arthritis in her knees began to limit her daily exercise routine. Her plans for a knee replacement surgery were put on hold when a serious colon rupture led to another heart attack. She had a heart bypass and surgery for the colon, and was successfully released from the hospital. Back at home, however, Zelda struggled to recover.

Passport Disease Manager Ron Keene offered words of encouragement and praised her continued efforts to lead a healthy lifestyle. He made sure she understood her heart disease and how to obtain her important medicines and follow-up doctor appointments. He also encouraged her to speak with her doctor about low impact exercises until she could have her knee surgery.

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

- Annual Monitoring Persistent Medications: Ace Inhibitors/Angiotension II Receptor Blockers 91.01 (75th percentile)

Passport member John* was living in a local homeless shelter when he had a heart attack. After he recovered and was released from the hospital, he was overwhelmed by the process of obtaining medicines, scheduling and finding transportation to his doctor's office, and keeping track of his ID cards and other paperwork. When Passport Disease Manager Ron Keene was able to reach John on the shared phone at his homeless shelter, John was confused and scared. Ron went above and beyond the everyday health education by setting up a joint conference call with the state transportation system to assist with getting John's information loaded into their system. He also helped John obtain a new Passport ID card and gave him the State's information to obtain a new Medicaid ID card.

Thanks to these efforts and the member's active interest, John now understands that his heart disease is a chronic, ongoing condition and is well on his way to managing his disease for years to come.

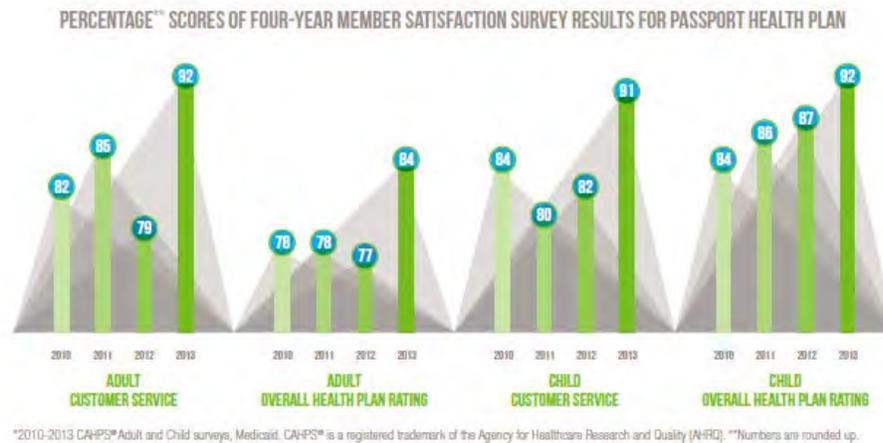
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- Annual Monitoring Persistent Medications: Ace Inhibitors/Angiotension II Receptor Blockers: 91.01 (75th percentile)

Charles* hadn't seen a dentist in so long that his teeth were severely decayed. He had trouble eating and those teeth which needed to be pulled were already destroying his nasal cavity. Perhaps even worse, his complex chronic diseases were out of control because he couldn't afford the doctor visits.

All of that changed when Governor Steve Beshear ruled to expand Medicaid in Kentucky under the Affordable Care Act (ACA), and he became a member of Passport Health Plan in early 2014.

After recently receiving a routine call from Passport’s Case Management Technician Jessica Cordova reminding him to have his cholesterol checked, Charles let Jessica know how much he appreciated Passport. He said Passport had made a huge difference just by helping one person who has not had fortunate circumstances in life to visit the doctor. He stated numerous times how happy he is and how Passport is just a great healthcare plan. Since having Passport he has not had any problems at the doctor or pharmacy. As they were hanging up, Charles mentioned his gratitude that Passport is able to help people who truly need healthcare under the ACA.

Charles is one of the 22,960 members that our Rapid Response team has helped since January 1, 2014. These types of efforts have helped Passport to obtain high member satisfaction rates for many years:



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Thanks to these efforts and the member’s active interest, John now understands that his heart disease is a chronic, ongoing condition and is well on his way to managing his disease for years to come.

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**Members’ names changed for privacy.*

***Healthcare Effectiveness Data and Information Set (HEDIS)*



WellCare

A 43-year-old Kentucky Medicaid member lives with and cares for his elderly mother. The member contacted WellCare when his vascular surgeon prescribed a compression stocking to treat two blood clots that had formed in a deep vein in his leg.

The member was worried that he wouldn’t be able to get the compression stocking and contacted WellCare for help. When Gale, a WellCare field service coordinator met with the member, she noted that the clots had caused his leg to swell and become cool to the touch. As part of her evaluation, she also noted that he suffered from blindness in his right eye and lacked transportation to get to his medical appointments.

Gale immediately went to work to help the member get the approval he needed for the compression stocking. She also scheduled a vision care appointment and secured door-to-door transportation for his medical appointments.

Due to Gale's efforts, the member received his compression stocking, which significantly reduced his discomfort and the potential for complications. Additionally, the transportation service not only helps to ensure he keeps his appointments; it enables the member to stop worrying and reduce his stress levels. Importantly, by improving the member's quality of life, Gale also helped to ensure his mother's safety and security.

Before moving to Kentucky, a 62-year-old WellCare of Kentucky member received treatment for HIV and colon cancer in Tennessee. While there, he had surgery to remove the cancer and had chemotherapy. When he moved to Kentucky, he established a primary care provider through WellCare of Kentucky.

Delores, a WellCare of Kentucky field service coordinator, met with the member. He requested help to locate a specialist to manage his HIV treatments and to get his medications approved. He also wanted to get a dermatologist and an ophthalmologist. Delores was able to put the member at ease, which prompted him to share that he had already found a clinic in Owensboro and had made an appointment to see someone regarding his HIV treatment. He was hesitant to follow through with the appointment because of his unfamiliarity with the facility. Delores encouraged him to be positive and reserve judgment about the clinic until after his initial appointment.

The member took Delores' advice and kept his appointment at the clinic in Owensboro. When Delores followed up with the member, he expressed how impressed he was with the care he received and the ease with which he obtained his prescription. In addition, he made appointments with both the dermatologist and the ophthalmologist she had located.

While this member was active in the management of his own health care, Delores' assistance helped the member to gain confidence in his medical decisions. This confidence will help to prevent any lapse in his treatment. He also feels comfortable knowing that if he has future questions or concerns, he can turn to Delores.

A 53-year-old WellCare of Kentucky Medicaid member with lung cancer, recently had part of her left lung surgically removed. Unfortunately, it was not in time to keep the cancer from spreading to her right lung and doctors scheduled surgery to remove part of that lung, too.

Lee, a WellCare of Kentucky clinical social worker, found out during a home visit that the member was not only worried about the cancer and her pending operation, but that she was also very concerned about not having enough food to eat and about the possibility that her electricity could be shut off because she owed \$143 to the electric company.

While the utility company had given her an extension, the member had not been able to raise the money. To complicate matters, she had tried to get help with food and utilities, but needed a photo I.D. to apply. She had unfortunately lost it during her last hospital stay. While the member was in the process of getting another one, she had not received it yet. During the home visit, the member recalled that she still had an expired Lexington Housing Authority photo I.D.

Using WellCare's Health Connections Referral Tracker (HCRT), Lee quickly shared the member's story with the Lexington Salvation Army and a social worker there agreed to accept the expired I.D. as proof of identity, which enabled her to pay the member's electric bill. In addition, Lee arranged for God's Pantry, a local food bank, to deliver a box of food on that same day. The pantry also accepted the expired photo I.D.

Through his quick actions, Lee was immediately able to help alleviate the member's stress by helping her access food and get support to maintain her electricity. This allowed the member to focus on her health. The member also expressed that her spirits were instantly lifted with the knowledge that there were people willing to help her, which could also positively impact her recovery.

An insulin-dependent, 57-year-old WellCare of Kentucky Medicaid member who suffers from chronic obstructive pulmonary disease (COPD) was about to be forced to live on her own. Her sister, with whom she was currently living, was relocating to a new city in a matter of weeks.

When Vivian, a WellCare of Kentucky field service coordinator, visited the member at her sister's home, she discovered the member had frequent COPD attacks that made it very difficult for her to breath. She was also oxygen dependent and even minimal exertion caused her to become short of breath. Because of this, the member expressed concern because she did not think she would be able to properly care for herself or take care of a home on her own

Vivian immediately referred the member to the Kentucky Department of Medicaid Services to have her assessed for Consumer Directed Options (CDO). CDO provides the Medicaid members with resources to hire their own provider of non-medical services, like housekeeping and personal care. In addition, Vivian knew that once the member moved into her new home, she would need a way to communicate, even though she couldn't afford a cell phone. Vivian helped the member apply for a free cell phone so that she could stay connected and easily access help when she needed it.

Through Vivian's efforts, the member was able to hire an in-home care facilitator so that she could avoid having to move into an assisted living facility. With her new cell phone, the member is able to reach out to Vivian if she needs further assistance.



Anthem

Anthem Case Manager Becky recently had the opportunity to work with our member Michelle* after a hospitalization. Michelle has been hospitalized four times with issues related to her diabetes, which with she was diagnosed at age four. Becky learned Michelle had not received any formal diabetic education, and that her diet consisted primarily of soft drinks, barbecued chicken wings, and snacks. Her other health conditions included obesity, skin abscesses, and depression. Through collaboration with the member's primary care doctor and her local health department, Anthem has been able to connect Michelle to education on self-management, diet, medications and exercise. She has also developed a self-care plan with goals to improve her overall health. Following our involvement, Michelle's blood sugar level has improved to nearly normal. In addition, she has set goals for weight loss through dietary changes and the addition of exercise. Michelle was also connected with our behavioral health unit and is now receiving assistance through counseling and medication. While Michelle knows that she has only just begun to make changes, she has already started to enjoy her improved quality of life.

Anthem prides itself on living its core values, which include *Caring* and *Easy to Do Business With*. Our Case Managers work to help members be actively engaged in improving their health and wellness and connect them with available resources, such as behavioral health and health education.

Anthem member Sam* was recently admitted to the hospital for a cardiac condition. As an immigrant, Sam was uncertain about navigating the healthcare system. After discharge from the hospital, Sam was unable to get his prescription filled. The situation was serious - his medication had been ordered for his cardiac condition, and he only had two days of samples left. Through collaboration with the pharmacy and the doctor's office, Anthem Case Manager Becky expedited obtaining the prior authorization needed for Sam to obtain his medication.

Sam called Becky to express his gratitude for the assistance he received in getting his medication, telling her that he was pleasantly surprised to have someone from Anthem step in so quickly to assist him.

Anthem prides itself on living its core values, which include *Caring* and *Easy to Do Business With*. Our culturally-sensitive Case Managers work to ensure that our members can navigate what can sometimes be a complex health care system and access the services they need.

*member's names have been changed to protect their privacy



CoventryCares

Sarah Smith is a member who was admitted to hospital on 07/22/2014-08/08/2014 for pneumonia. Upon discharge home, a transitional care nurse outreached to assess her needs. Due to Sarah's condition, she is unable to speak. Sarah's mom and dad spoke with me over the next several weeks about their concerns and needs in order to care for her.

Sarah has been bedbound since she was approximately eleven years old. She is now 25 years old and family feels just as strongly about providing care for her in their home. Mother still refers to her as "my baby". The nurse assessed her needs and it was revealed that during hospital stay she had developed, for the first time ever, pressure ulcers. It was also noted that though she has a large family, primary responsibility for her care falls largely on her mother and father.

Sarah is incontinent of bowel and bladder, is tube fed, and has a trach tube. Her regular doctor is out of the office due to medical issues of his own and she has not followed up by him since hospitalization. Sarah lives less than 5 minutes from the nearest hospital, but mother states they have taken Sarah there for treatment, but they have refused citing they do not accept her health plan. The next nearest wound care clinic would be a 2.5 hour ambulance ride one way for Sarah and her family. Home health is currently visiting her at the time of my first call, but mother states they have now completed their visits with her and will not be seeing her any longer as family knows how to provide wound care.

With mother's permission, I began research regarding possibilities of assistance for her and her family. I reached out to several other employees within the plan to assist to see what other options were available. I also made a referral to the social worker in her community who called mother and began the process for waiver service approval for Sarah. Sarah receives multiple types of supplies from several different agencies, and mother is concerned that switch of medical card type will affect her receiving these supplies. Phone calls were made to verify there would be no interruption of these services if accepted into waiver. Sarah meets the requirements for acceptance into waiver program.

I called her primary care office and spoke to the nurse practitioner in the office who agreed to see her during her doctor's interim leave of absence. Mother declined seeing the nurse practitioner and office agreed to contact doctor regarding Sarah's needs such as oxygen prescription and other medication refills. Mother agrees to call me if she requires any assistance with filling these needs.

In collaboration with research from other employees in office, the hospital wound care center was contacted, a letter of agreement was negotiated and Sarah was seen for treatment.

Mother expresses her gratitude by relaying, "God bless you all. You are wonderful people". Wound care clinic expresses interest in further relationship with health plan. Sarah's needs were met with wound care clinic visits approved and process for waiver initiated.

I say this sincerely--It is an honor and great pleasure to be part of a company who puts member needs as priority. I also feel fortunate to work with a team who, without question, takes time out of their day and their own duties, to assist with procuring the services a member may require. My deepest thanks to all.



Humana

A DCBS foster parent of a 1 month-old medically fragile child, who was recently assigned to Humana - CareSource (HCS) contacted HCS case management requesting assistance with pharmacy benefits and scheduling of appointments with a pediatrician. The child had been in Kosair Hospital on a ventilator suffering from seizures for almost 4 weeks and was recently discharged to the foster parent. The child suffers from frequent seizures due to head injuries and was on several medications. The foster parent was having difficulty getting the needed medications. The HCS case manager contacted the Humana - CareSource pharmacist and then conferenced in the foster parent to determine what issues were being encountered. The foster parent shared the difficulties she was experiencing when trying to get refills at the local pharmacy. The pharmacist contacted the pharmacy directly in order to understand the issues and ensure that the needed medications would be available and covered when needed. The edits were reviewed and approvals provided for fills for

Keppra, Nystatin, and Ranitidine. The foster parent was assured that she should now have the ability to get the refills that are needed. As this inquiry occurred after 5 pm on a Friday, the foster parent was also given the Humana - CareSource pharmacist and case manager's contact information so that she could contact either directly in case there was an issue that occurred over the weekend. The foster parent lives in a rural area approximately 2 ½ hours from the Kosair facility and expressed concern about coverage of life flight if the child began to have continuous seizures. The case manager assured the foster parent that if there was an emergency and the child required emergency transport through life flight this was a covered benefit. The case manager followed up with the foster parent on Monday to offer assistance in obtaining a single case agreement with the pediatrician this foster parent would like to take the child to. This child's care will be followed by the case manager/foster care liaison to assist with further coordination of care.

HCS Social Worker, Pam spoke with HCS member Steven regarding his need for assistance in paying for eye glasses as he is unemployed. Pam and Steven discussed the New Eyes for the Needy program. Steven stated that he had not received glasses from this organization in the past. Pam assisted Steven with filling out the application and submitted it to the New Eyes for the Needy organization. Pam received the voucher for new eye glasses from the New Eyes for the Needy organization this week and sent it to Steven. Steven expressed tremendous gratitude for this assistance. Steven reported he has recently gotten a part time job and the new glasses will be a big help to him and assist him in his work.

Paul is a middle aged member who is in the process of applying for SSI and living temporarily with a friend. Paul's only source of income is Food Stamps. Paul told Pam, the Social Worker, that he needed clothes. Pam provided the member with several community resources for clothing. Paul has reported back to Pam that he was able to obtain some "second hand" clothes from one of the community resources she had provided him.



October 2014 MCO Good News Reports

MCOs Going Above and Beyond



WellCare

After her primary care physician retired, a 51-year-old WellCare of Kentucky Medicaid member with depression, anxiety, bipolar disorder, and panic attacks ran out of her medications and was unable to refill them.

During an in-home visit, Patricia, a WellCare of Kentucky field service coordinator, discovered that the member's depression caused her to cry frequently. In addition, she was experiencing paranoid thoughts. The member revealed that she had recently become too afraid to drive following a minor traffic accident. Because of this, the member had not attended her counseling sessions in the last four months. Patricia noted that the lack of medication and therapy was causing the member's anxiety and panic attacks to increase.

Patricia quickly found the member a new doctor and scheduled an appointment. Using WellCare's Health Connections Referral Tracker (HCRT), she secured transportation for the member's medical and counseling visits. Patricia also shared the community resources that were available to the member and left her with a list of contact information for the services she may need, such as utility assistance, home repair and food pantries.

Through Patricia's work, the member was connected with a new doctor whose schedule permitted an almost immediate appointment. The member also now has transportation to ensure she can attend all of her scheduled counseling sessions and medical appointments. Finding the member the right services to meet her medical and behavioral needs should help her start to feel better again and provide an improved quality of life.



Linda, a WellCare field service coordinator, visited a 64-year-old WellCare of Kentucky Medicaid member suffering from arthritis, hypertension, high cholesterol and depression. During the visit, Linda discovered that the member's rheumatologist had recently ordered some blood tests. But, when the member tried to get the tests done, the lab refused to do them because the member had not paid for services he received several years ago before he became a WellCare member.

Linda immediately researched labs in the area, found another option located near the member's home and made an appointment for him for the following week. The member, who lives in a two-story rented house with his wife and granddaughter, told Linda that they must keep the upper floor blocked off to cut down on the cost of their utilities. The member also expressed an interest in getting a wheelchair or a walker to increase his mobility around the first floor. Finally, he said that despite his hypertension, he did not have a blood pressure monitor and he needed new glasses, but couldn't afford them.

Linda contacted the member's doctor about the request for a walker or a wheelchair. The doctor requested an appointment for the member to discuss these options and Linda secured the appointment for him. Linda also provided the member with an application for glasses from the Kentucky Vision Project, ordered him a blood pressure monitor and shared information regarding food and utility assistance.

Through Linda's efforts, the member has now completed the blood tests as prescribed by his doctor and has an appointment to discuss mobility options. He also has a blood pressure monitor to help him better manage his hypertension and potentially avoid an emergency room visit. The member expressed relief in having the possibility of new glasses and help with his utility bills.



Linda, a WellCare of Kentucky field service coordinator, visited a 60-year-old WellCare of Kentucky Medicaid member to assess his needs. He has high blood pressure, heart disease, osteoarthritis and a history of stroke. During the visit, the member, who lives with his two adult daughters and his granddaughter, stated that he managed his medications on his own.

Linda noticed that the member's medication bottles were in disarray and that he had as many as five different bottles containing the same medication. In addition, some of the member's pills were in the wrong bottles and there was one prescription bottle that had mismatched pills inside.

Linda immediately organized the member's prescription bottles, throwing away empty bottles, checking expiration dates and making sure all prescriptions were current. Linda then spoke to the member at great length about the importance of properly managing his medications, as well as the dangers of having the bottles filled with the wrong medication. She explained that having so many pills left in multiple bottles meant the member was not taking his medications as prescribed. She told him how dangerous this was, especially with his history of stroke and high blood pressure.

She followed up with one of the member's daughters to discuss these issues. Together, they came up with a plan to ensure the member would take his medications properly by preparing a weekly pill box. In addition, Linda contacted the member's doctor to make him aware of the medication issues.

During her conversation with the member, Linda also discovered that he did not have a blood pressure monitor and that he needed new eyeglasses, but couldn't afford them. In addition, the member expressed concern about his inability to pay his utility bills. She helped him complete an application for eyeglasses with the Kentucky Vision Project, ordered him a blood pressure monitor and provided him with information about utility assistance.

Due to Linda's dedication, the member and his family were not only educated about the dangers of improperly managing medications, but were empowered with a plan to address it. Having his medications well managed, along with regular blood pressure monitoring, could help the member avoid emergency room visits, inpatient hospital admissions and other serious outcomes. In addition, the member expressed relief knowing he would receive new eyeglasses, and that he had the resources for utility assistance, which will improve his quality of life.



Delores, a WellCare field service coordinator, visited a 41-year-old WellCare of Kentucky Medicaid member who had recently broken her right leg and left foot in a fall. During the home visit, Delores found that the member was feeling depressed because of her inability to get around. To make matters worse, the member enjoyed reading, but she was unable to read during her rehabilitation because she couldn't afford new eyeglasses.

Delores asked the member if she had requested a wheelchair from her home medical provider and she said yes. But, a representative from the medical provider told the member it wasn't worth putting in the request because she was sure it would be denied. Delores was persistent in her efforts and was finally able to convince the provider to submit the request. It was approved. In addition, Delores provided the member with resource information to get eyeglasses through the Lions Club International.

When she followed up, Delores was pleased to see that the added mobility and new eyeglasses had significantly buoyed the member's spirits. Being able to read medication labels helped the member comply with necessary prescriptions and take charge of her own health. Through Delores' efforts to secure a wheelchair, the member will be able to get around at home and more easily get to doctor's appointments. This assistance helped the member to embrace her recovery with a more positive outlook.



Anthem

Community Liaison Jennifer was on the way to Louisville when she stopped at a gas station in an Anthem-branded vehicle. She was approached by a gentleman, Matt*, who advised her that he was a new member and asked about when he would receive his member ID card. Jennifer and Matt spoke for about five minutes, at which time Matt said "I won't keep you, but I just thought you might be able to answer my question. I really appreciate you taking the time to do that because now I don't have to worry about calling anyone and staying on the phone all day." Matt clearly appreciated the ability to speak with a local Anthem representative in person.

As their conversation wrapped up, Jennifer gave Matt her business card and encouraged him to contact her if he needed anything in the future.

Anthem prides itself on living its core values, which include *Caring* and *Easy to Do Business With*. Our Community Liaisons, like Jennifer, provide excellent customer service (regardless of where they may encounter a member) and help our members easily get the information they need.



Anthem Behavioral Health (BH) Case Manager, Crystal, recently received a referral from an Anthem Case Management Specialist. Member Johnny's mother, Janice* had called with concerns about her son's health coverage. Johnny* is a 7 year old male diagnosed with autism and currently on Michelle P. Waiver and Medicaid managed care. Janice stated she had been unable to receive the Waiver' MAP 552 benefits since July 1, 2014. She reported that she had exhausted her savings and was concerned because Johnny had several appointments at a local children's hospital scheduled for the next week. Janice also expressed that she wasn't sure where she was going to get the gas money to transport her son to his appointments, as she is a single mother and cares for her son full time.

BH Case Manager Crystal initiated a conference call with the Department for Medicaid Services (DMS) and the Department for Community Based Services (DCBS). Together, Crystal and Janice spent nearly 4 hours on the phone with DMS and DCBS to resolve the MAP 552 benefits issue. At the conclusion of the call, DCBS confirmed that the issue had been corrected and benefits would be applied retroactively, but was unable to provide a reinstatement date. BH Case Manager Crystal followed the meeting with a phone call to Frankfort and the MAP 552 benefits were reinstated the next business day.

Johnny's mother was very thankful and advised Crystal that she would now be able to transport her son to his medical appointments. In addition, Crystal's efforts helped connect Johnny with expanded waiver benefits, as he is moving to Michelle P. Waiver only.

Anthem prides itself on living its core values, which include *Caring* and *Accountable*. Our Behavioral Health Case Managers, like Crystal, actively work to help members navigate sometimes complex health care systems to access the most appropriate services for their needs.



Anthem began working with a 9 year old male diagnosed with Autistic disorder when he was hospitalized at Kosair Children's Hospital on August 29, 2014. Precipitant to admission, the child required ambulatory transport to Kosair from far western Kentucky due to unsafe behaviors; however, the child became too aggressive and unsafe which required the use of sedative medication before flying him medevac to Kosair.

The child's mother was able to stay at the Ronald McDonald Children's House during this time in order to be an active participant in his treatment. Kosair worked with the child to get the appropriate medication regimen and recommended use of a weighted vest to assist in managing symptoms associated with Autism. Anthem Behavioral Health Case Manager Monica* was in contact with Kosair providers and the child's mother to coordinate discharge planning while arranging outpatient therapy and psychiatric services in the child's area. The child was discharged home on September 11, 2014. Anthem utilized physical health utilization manager resources to secure approval for a DME weighted vest at this time. The child was prescribed PRN medication in order to best meet his and others' safety needs when escalated. This medication was denied at the pharmacy requiring prior authorization when the child's mother attempted to fill the prescription on September 12, 2014. The mother contacted the Anthem Case Manager who communicated with the pharmacy and the appropriate medication was filled on the same day.

This family will continue learning how to best address the multiple needs associated with Pervasive Developmental Disorders. However, Anthem behavioral and physical health case management will make this learning curve much smaller for the family by continuing to educate the family and coordinate care in order to best meet the needs of the member.

Anthem prides itself on living its core values, which include *Caring* and *Accountable*. Our Behavioral Health Case Managers, like Monica, 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.



Anthem Case Manager Rebecca often comes across members with multiple needs. She recently spoke to a member who was discharged from the hospital after developing cellulitis, a serious infection in her feet. She has a history of multiple sclerosis, and her activity is limited. She had been going to a free health clinic because she could not afford insurance and was no longer able to see her specialists. She was pleasantly surprised to learn that having a nurse case manager call her is part of her Anthem Medicaid benefit, at no charge.

Her immediate needs included:

- 1) Assistance in finding network providers for a primary care physician and a neurologist.
- 2) Assistance in obtaining a walker, transfer bench, and an ongoing assessment of any other equipment needs.
- 3) Discussing her medications, and making sure she understood the purpose, right dosage, and right times for each one. Contact her pharmacy and informing her they will deliver her medications free of charge.
- 4) Listening to the member talk about her concerns, her fears, and her feelings of isolation. Providing a listening ear and emotional support is important for the member's overall health.
- 5) This member calls Rebecca often, and they have developed a good rapport. Rebecca feels grateful to have helped the member navigate her health care needs and become more independent.

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

**names have been changed for privacy reasons*



CoventryCares

Mr. Jones was referred to case management by a Medical Director referral following a denial for out of network services.

Mr. Jones is a 48 year old with heart disease and obesity. He also has a past medical history of high blood pressure, diabetes, and a previous stroke.

We received an initial request for mitral valve replacement to be performed at Ohio State University Hospital. Mr. Jones was diagnosed with heart disease and heart failure in 2006. He has already undergone heart bypass surgery and now his health requires valve replacement surgery.

Member was enrolled in case management. The RN case manager (CM) worked with the patient and provided education on in-network versus out-of-network. CM searched for available in-network providers who could perform this same procedure. Multiple providers were found. After discussion with Mr. Jones, the CM assisted in making the appointment for Mr. Jones to see an in-network provider located at University of Kentucky. Mr. Jones was seen by the surgeon on 9/25/14 and underwent surgery on 10/8/14.

This story is a success as the RN CM was able to find an in-network facility and in-network cardiac surgeon.

Successes:

- 1) CM assistance provided care that was closer to home
- 2) CM was able to identify cardiac surgeons who are able to perform same procedure as OHIO
- 3) Continuity of care
- 4) Transportation convenience



Humana

John is a forty-nine year old man who qualified for Medicaid through expansion and chose HCS. He could not afford health care in over ten years, even though he has long term health problems. He is illiterate and authorized his spouse to speak on his behalf. He developed neck pain so severe that he was forced to seek health care through one of the Family Health Centers. He was started on Physical Therapy and felt it was working well for him. His Case Manager, Alice, helped John find a PCP to help him manage his health care long term. He was given prescriptions for his chronic lung condition, which had gone untreated for many years. In addition, John was provided with resources by his PCP and Case Manager to help him stop smoking. John also told Alice about his history of a coronary artery blockage that was diagnosed over ten years ago; working with his PCP and CM, John now has an appointment time with a cardiologist. Alice also provided John and his wife information for a local literacy program. John and his wife expressed their appreciation for the information and caring.

Several months later... John is well controlled on all of his medications and has accessed his dental benefits because he was having so much pain with his teeth that he was having trouble eating. Unfortunately, the literacy program he enrolled in has been put on hold due to the instructor having an accident that left him

with a broken neck but John and his wife are anxiously awaiting his recovery to begin the class. John is receiving support with his tobacco cessation and is down to one cigarette per day. He had heart surgery and was found to have Hepatitis C and is now also under the care of a Gastroenterologist. John and his wife have built confident and lasting relationships with all of John's physicians. They have experienced unforeseeable setbacks but remain optimistic about John's health and quality of life with the help of their Case Manager, Alice.



James is a forty-three year old male who was recently hospitalized with pyelonephritis from October 8, 2014 to October 12, 2014. Prior to that, he had a hospital stay from August 8, 2014 to August 12, 2014 for a urinary tract infection. The case manager spoke to him on October 16, 2014 and engaged him into the Bridge to Home Program. James stated that he needed a PCP and the case manager gave him three names of physicians to choose from and informed the member that she would send an ID card with correct PCP.

James was discharged from the hospital home with Infusion Company. He has IV antibiotics infusing via a PICC Line (form of intravenous, IV, access that can be used for a prolonged period of time). Member states he is infusing three times daily and the case manager instructed him to report signs and symptoms of infection to his physician. She instructed him to watch for signs and symptoms including fever, redness, inflammation, hardness, and any yellow drainage to which he verbalized his understanding.

James also is diagnosed with diabetes type II and as a result the case manager educated the member regarding testing used to monitor the status his diabetes. Due to this education, the member revealed that he had the HgbA1C test done on October 8, 2014, while in the hospital, which was 6.5. The case manager instructed James that HgbA1C is a three month average of his blood glucose and informed member of importance of having a Dilated Retinal Exam yearly for to detect any signs or symptoms of retinopathy.



Jennifer is a twenty-one year old female diagnosed with cellulitis and abscess of right stomach area. She suffered a spider bite which abscessed and required surgery. The abscess has resulted in a wound about the size of a baseball in her right side. She initially went to the Emergency Room and was instructed to come back several times for assessment of the wound. Since her surgery, she requires wound care twice daily and that wound care and assessment is handled by a Home Health Agency.

Jennifer states she has to pay for the Dakin's Solution that she uses from Medline. The case manager checked with one of HCS's pharmacists who stated that if she received a prescription for the Dakin's Solution, it will be covered by her plan. The case manager notified Jennifer, who stated that she would get a prescription from her surgeon at her appointment on Tuesday, October 14.

Jennifer informed the case manager that she does not have transportation to or from her physician's appointments. The case manager provided Jennifer with assistance regarding the Medicaid transportation benefit criteria and further explained the appropriate means to address the criteria specific to "Free transportation which is appropriate for the recipient's medical needs is not available or use of an appropriate and operational household vehicle is not available."

Jennifer also stated that she needed a Primary Care Physician. The case manager gave her three names to choose from and will send a new ID card when she selects a PCP.

Jennifer informed the case manager that she has had Asthma since she was a child and the case manager discussed the importance of disease management relevant to Asthma. She stated that she has an emergency inhaler, Albuterol HFA and that she can use two puffs every four hours as needed for shortness of air. The case manager also discussed having a long acting control medication and suggested she speak to her Pulmonologist about this. The case manager will discuss Disease Management on next call with Jennifer who stated that she is interested in participating in the Bridge to Home Program.



Passport

During his first medical visit in many years, Passport Medicaid Expansion member John* learned he has bladder cancer and a multitude of other problems. He soon had surgery and left the hospital with a long tube draining urine from his kidney (called a bilateral nephrostomy).

When Passport Case Manager Susan Heibert started working with him, John was having some difficulty obtaining supplies to properly care for his nephrostomy. Susan was able to consult with her case management peers and implemented a plan to help John get the supplies he needed. John was so thrilled that he said he was thinking about calling Bill Lamb at the TV station to let him know what a good company Passport is and how much they helped him! He was especially happy to be able to go to church now that he was able to go out of the house again. These types of efforts have helped Passport to obtain high member satisfaction rates for many years:



*2010-2013 CAHPS® Adult and Child surveys, Medicaid. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ). **Numbers are rounded up.

Joseph*, a Passport member from a foreign country, was new to the American health care system when he had open heart surgery earlier this year. After he was released from the hospital, he continued going to the emergency room for ongoing checkups. Passport Disease Manager Ron Keene explained the medical home concept and convinced Joseph to start seeing his primary care provider for follow-up visits instead of the ER. He also gave him information for obtaining transportation because he was having difficulty getting to his various appointments.

These types of efforts have helped Passport to obtain the following ranking for national HEDIS®** in 2013: Ambulatory Care: Outpatient visits per 1,000: 469 (75th percentile)



For the seventh year in a row, Passport sponsored and brought volunteers to the highly successful Healthy Hoops® Kentucky on Saturday September 20. This special, community-based initiative uses basketball and fun to focus on the needs of kids with asthma. Under the guidance of celebrity basketball coaches and medical experts, 128 children between the ages of 7 and 13 and their families participated in a full day of health awareness, entertainment, asthma screenings, breathing treatments, and basketball drills and skills workshops.

"I would pull [my child] out of sports due to his asthma, but as I learned more about taking control of his asthma and the resources, I felt more comfortable with letting him participate in extracurricular activities," said one parent.

As a main sponsor to the Healthy Hoops Kentucky coalition, Passport brought 63 volunteers to help set-up on Friday night, coordinate and participate in the events on Saturday, and tear-down afterwards. These types of efforts have helped Passport to obtain the following ranking for national HEDIS®** in 2013:

- The percentage of members 5-64 years of age who remained on an asthma controller medication for at least 50% of their treatment period: 70.03% (90th percentile)
- The percentage of members 5-64 years of age who remained on asthma controller for at least 75% of their treatment period: 44.65% (90th percentile)



Imagine having diabetes and needing daily insulin to control your blood sugar, but having a terrible fear of needles – compounded by a deep-set depression and lack of self-worth. For Passport member Tony*, this

reality was all too familiar. This year, things got out of control as he reached out to sweets for comfort. When Passport Case Manager Ron Keene spoke with him last month, the culmination of these issues had led Tony to the hospital with a heart attack.

Ron and Tony spent a long time talking through everything, focusing particularly on the effects of uncontrolled blood sugar. Although Tony knows all about nutrition after years of working as a chef, he admitted struggling to control his desire for sweets. By the end of their conversation, Tony was relieved to have a plan of action. He had an appointment scheduled to speak with his specialist about taking oral medications in lieu of insulin injections, but understood the importance of continuing injections if his provider felt that option wasn't best. Ron also contacted Passport's Behavioral Health department to make sure they would follow-up with Tony about his depression.

These types of efforts have helped Passport to obtain the following ranking for national HEDIS[®] in 2013: The percentage of members 18-75 years of age with diabetes type 1 and type 2 who had a HbA1c control of less than 8%: 54.12% (75th percentile)

☺☺☺

Trish* is a Passport foster care member in a rural area of Kentucky with limited access to behavioral health services. Her DCBS worker, Linda*, recently contacted Passport's Manager of Out of Home Placements, Stephanie Stone, requesting help in locating a psychiatrist near Trish's foster home. Trish has a history of instability in foster home placements and Linda wanted to get supports in place as soon as possible. Linda requested a specific behavioral health provider who not only wasn't participating with Passport, but had very strongly expressed disinterest in contracting with Passport or seeing any Passport members.

Stephanie reached out to Passport Provider Relations Specialist Cynthia Bundy for assistance. Cynthia reached out to the office and was able to change their mind. Three days later she reported the behavioral health provider decided to become a participating provider with Passport. In the meantime, the provider was willing to enter into a Single Case Agreement to provide treatment to Trish. Stephanie immediately contacted Passport's Behavioral Health program to work with the Department for Community Based Services (DCBS) and the provider on a Single Case Agreement.

Within two weeks of the initial call from the DCBS worker, Trish' Single Case Agreement was in process. Trish is now able to see a local psychiatrist, which increases her stability in the foster home setting.

"This story is important because we've had difficulty in the past finding behavioral health providers to serve children in therapeutic foster care," says Stephanie. "Due to contractual obligations, private foster care agencies cannot send their members to Community Mental Health Centers for services. With Cynthia's success in getting this provider to enter into an agreement with Passport, we are not only helping this one member, but we are filling a needed gap in behavioral health services for Passport foster care members in that region."

Passport's Behavioral Health network currently meets all Kentucky Department for Medicaid Services (DMS) GeoAccess requirements, with 381 statewide behavioral health providers and all Kentucky community mental health centers.

☺☺☺

Tiffany*, a Passport member recently diagnosed with HIV, was recently seen at a clinic. Her primary care provider (PCP) wanted to prescribe a new combination drug called Triumeq. Triumeq is the first FDA-approved single-tablet regimen (STR) that does not contain tenofovir (Viread), a widely used antiretroviral drug linked with bone and kidney problems in some susceptible HIV-positive individuals. The PCP was unaware of Passport's coverage level.

Luckily, Passport's Embedded Case Manager Robert Beaty was onsite at the PCP's office and was able to intervene. He contacted Passport's Pharmacy program and determined the PCP's ability to complete a prior authorization for Tiffany to obtain the new drug. Shortly thereafter, Tiffany was able to successfully get her prescription filled and start her potentially life-saving medication with little to no side effects.

During their interview, Robert also noticed Tiffany showed a need for mental health services. With her permission, he referred her to Passport's behavioral health program for more help.

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 member Mike* was considered obese on the BMI range for his young age, but it didn't seem so bad until kids at school started calling him "fat." Distraught and not knowing how to help him, Mike's mother Tara* reached out to Disease Manager and Registered Dietician Laura Walsh for help.

Laura reviewed the main goals of Passport's SCORE (Shrinking Childhood Obesity with Real Expectations) Program with Tara to let her know we are not focused on a number on the scale, but actually helping Mike and their whole family make healthy lifestyle changes. Passport wants them to make long-term changes to help in preventing certain types of diseases like diabetes, high blood pressure, heart disease, and sleep apnea.

Tara was unsure about joining, but Laura convinced her to give it a try. Over the next 12 months, Laura built a very strong rapport with Tara so that she became engaged and willing to change some of her own behaviors that led to Mike's being obese. She asked about other events happening in their lives. Tara expressed that she felt like Laura was more than a case manager – she was a friend concerned about the health of her child.

After 12 months of ongoing support and encouragement, Mike has lost 3% on the BMI chart and engages in 60 minutes of physical exercise most days of the week! He is no longer obese and has abandoned his sedentary lifestyle with the help of Tara and Laura.

Mike's story is just one of the many successes from Passport's SCORE program, which is one of the ways we support the Governor's kyhealthnow goal to reduce obesity rates among Kentuckians by 10 percent. SCORE helps 1,557 children and adult members identified as obese. We also offer ongoing support and outreach for 570 and one-on-one counseling for 81 members considered to be high risk. Satisfaction rates for our SCORE program are above 90%.



Although he was a bit overweight, Passport member Sam* lived a relatively healthy lifestyle in Western Kentucky. He even successfully stopped smoking in May 2014. Unfortunately, it wasn't enough to stop a heart attack from striking. After complaining of chest pain, Sam was recently admitted to the hospital and had a heart bypass surgery.

Afterwards, Passport Disease Manager Ron Keene checked in on Sam to see how he was doing post-surgery. Sam reported all of his doctor visits were in order, he had lost some weight from the surgery and was eating less and walking more as instructed by his provider. Ron reinforced these behaviors and gave him more in-depth education on heart healthy behaviors for him to consider. During their conversation, Ron also performed a depression screening. Although it came up negative, Sam admitted his anxiety levels were high following a major surgery. Ron encouraged Sam to continue monitoring his feelings and to speak with his primary care provider (PCP) at the next visit if he felt like increasing his dose of anti-anxiety medication might help.

Sam's story is just one example of members served by Passport's Healthy Heart Disease Management Program, which was developed to support the Governor's kyhealthnow goal of reducing cardiovascular deaths by 10 percent. The program promotes a healthy lifestyle, including diet and nutrition, weight management, physical activity, and smoking cessation. Currently, there are 3,152 members enrolled in the program. Anxiety and depression screening occur during each member contact and referrals are made to our behavioral health service routinely.

**Members' names changed for privacy.*

***Healthcare Effectiveness Data and Information Set (HEDIS)*

