

C. Technical Approach

29. USE CASE 2 (KATY)



Katy, a 20-year-old Humana Kentucky Medicaid Enrollee, places a call to our state-based Member Services Call Center to explain her situation. When the receiving Member Services Representative (MSR), Eric, enters Katy's identifying information into our Customer Relationship Management (CRM) system, he receives a system alert that Humana has been unable to contact Katy to complete the annual Health Risk Assessment (HRA) to determine eligibility for our care management services or to otherwise engage her in preventive care. After Katy explains her situation and relays what her urgent care provider told her, Eric educates Katy about Humana's care management programs and asks if he can warm transfer her to our care management team for further assessment; Katy agrees.

Before the transfer, Eric helps Katy schedule an appointment with her Primary Care Provider (PCP) through a three-way call. When Eric provides the contact information for Katy's PCP, Katy relays that she has moved and her PCP is now more than 50 miles away. Eric uses Humana's online Provider Directory to help Katy select a new PCP that meets her geographic, cultural, and schedule preferences (e.g., after hours and evening care). In addition, Eric asks Katy to confirm the contact information on file, noting Humana has been unable to reach her in the past. Katy provides a new phone number and address that is then logged in our system and shared with her PCP.

Eric notes the information Katy provides about her circumstances and recent urgent care visit in her case file and shares it with the care management team upon transfer. We train our MSRs to identify and refer Enrollees who may benefit from assessment for additional support, including Enrollees, like Katy, who have called with health concerns.

Humana regularly undertakes call campaigns to reach Enrollees with care gaps. In the first quarter of 2019 alone, we contacted **1,159** households of Kentucky Medicaid Enrollees out of compliance with the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) periodicity schedule, making **181** successful contacts.

Unable to Contact Process

At this point, Katy has not seen a provider for several years. Throughout the course of her enrollment in Humana, we have tried to engage Katy to close her gaps in care, complete the HRA, and engage in regular preventive care through call and text messaging campaigns and mailings. After 30 days without any successful contact attempts, we identified Katy as unable to contact (UTC). One of our Humana Kentucky Medicaid associates had mined data (including clinical data feeds from participating providers, online search engines, and claims data) and contacted Katy's assigned PCP and partnering Community-Based Organizations (CBO) to try to locate updated contact information for Katy. Ultimately, these attempts were unsuccessful, and we placed a UTC flag on Katy's file so any Humana associate coming into contact with her would attempt to engage her in care and complete the HRA. Even as Katy was flagged as UTC, we continued to attempt outreach to close gaps in care, including providing her contact information on file to her assigned PCP to encourage outreach.

a. Evidenced based practices for Care Management

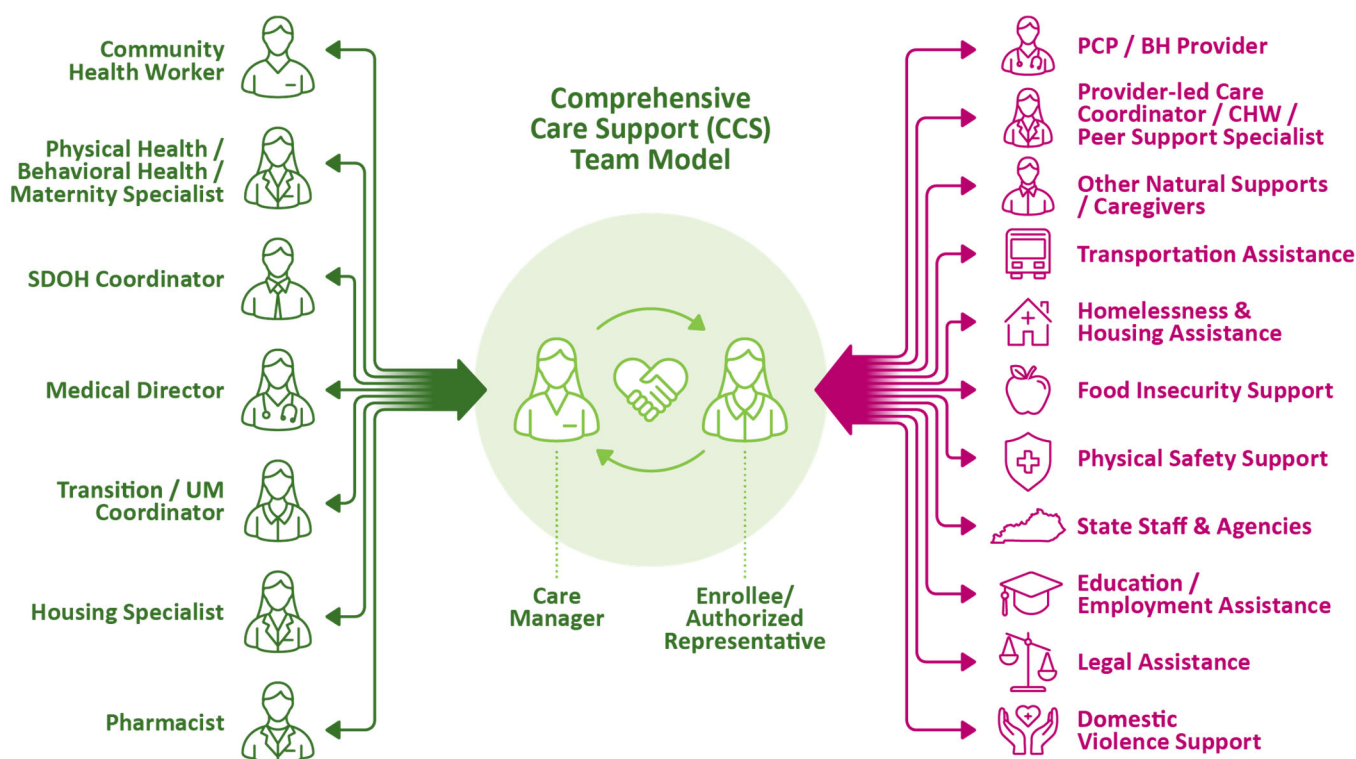
After being assessed for and agreeing to participate in care management, Katy is assigned to Beth, a Humana registered nurse (RN) Care Manager (CM). Using the results of her HRA, Enrollee Needs Assessment (described further below), and Katy's Medicaid severity score as a guide, **Beth determines Katy will benefit most from Intensive Care Management, our second-highest Population Health Management (PHM) risk level** offered to our Kentucky Medicaid Enrollees. Throughout her engagement with Katy, Beth applies evidence-based practices

taught in her CM training to ensure Katy receives comprehensive, integrated, whole-person support that helps her achieve her goals. Specific evidence-based practices applied to Katy's case include:

Individualized care management: While Humana establishes contact minimums for all PHM risk levels, we recognize the importance of tailoring the frequency and type of contact to our Enrollees' specific needs and preferences. Recognizing Katy's disconnect from the healthcare system and escalating symptoms, Beth arranges to check in with Katy every two weeks at the beginning of her engagement in Intensive Care Management to monitor her care and provide support. As Katy demonstrates compliance with her care plan and a better understanding of her conditions, Beth reduces these contacts to once every quarter. In addition, Beth provides Katy with the option of a telephonic or face-to-face visit for the assessment and care planning session at a location most comfortable to Katy. Beth also offers to meet with Katy face-to-face during future contacts, if warranted by Katy's needs or preferences.

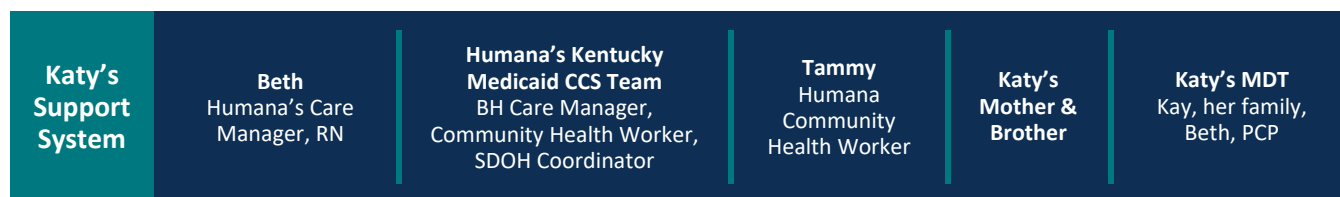
Integrated care teams: Rather than handing Katy off to different Humana associates to meet each of her needs, Beth serves as Katy's single point of contact for all of her care needs [physical health, behavioral health (BH), and Social Determinants of Health (SDOH)], while ensuring access to her Multidisciplinary Team (MDT). Through our Comprehensive Care Support (CCS) team model depicted below in Figure I.C.29.Katy-1, Beth can receive guidance and support from a BH specialist (if needed), an SDOH coordinator, and a Housing specialist, as well as our **Kentucky Medicaid Medical Director, Lisa Galloway, MD**, and **Kentucky Medicaid Pharmacy Director, Joseph Vennari, PharmD** to address Katy's full set of current and future needs.

Figure I.C.29.Katy-1 Comprehensive Care Support (CCS) Team Model



Further supports for Katy are included below in Figure I.C.29.Katy-2.

Figure I.C.29.Katy-2 Katy's Support System



Person-centered care planning: As described below, Beth applies the tenets of person-centered care planning to work with Katy and her support system to design a care plan that works toward Katy's goals, preferences, and priority needs.

Motivational interviewing and the Transtheoretical Model: Katy's chronic conditions will necessitate behavior change. Rather than overwhelming Katy with information and making her feel ashamed of her current behaviors, Beth applies **motivational interviewing** techniques including the **Transtheoretical model (TTM)**, also known as the **Stages of Change model**, to her communications with Katy. While most strategies focus on only one dimension of the problem, TTM combines the most effective techniques from several areas of study to gradually create long-lasting behavior change. These evidence-based techniques, taught during Beth's Humana CM training, help Katy resolve any ambivalence she feels about adopting new behaviors and allow Beth to tailor educational and self-management interventions to Katy's willingness and readiness to change.

Clinical practice guidelines: When providing education and guidance to Katy, Beth draws upon our online **Healthwise®** library, which provides easy-to-read, accessible content based on clinical practice guidelines (CPGs).

Community Health Worker support: In addition to the lack of engagement in her own healthcare for several years, Katy is coping with possible new diagnoses. Beth offers to link Katy with a Humana CHW who can help her understand provider directions, accompany her to appointments, and link her with community resources. Katy consents, and Beth connects her to Tammy. Tammy lives in Katy's region and her own experience as a former Medicaid beneficiary (as well as being a caregiver for a relative with diabetes) creates common ground on which she can build a trusting relationship with Katy.

Figure I.C.29.Katy-3 CHW Functions



b. Health Risk Assessment and Care Planning and monitoring



Humana conducts an ongoing review of Katy's care needs, utilization of services, and other health and well-being factors to generate a quantifiable level of risk. The primary predictive model we use is our proprietary **Medicaid Severity Score Model**. This allows us to create a severity score for Katy based on her physical health, BH, pharmacy claims, SDOH needs, and other data to identify a change in care needs. Our **Readmission Predictive Model (RPM)** uses more than 50 variables to assess the probability of a readmission to a facility within 30 days of discharge, if Katy were to experience such an event. To identify if Katy is likely to use the ED, become a high ED utilizer, and/or use the ED for non-emergent reasons, we use our **ED Predictive Model**. Our **Opioid Predictive Model** reviews pharmacy claims data to identify if she is at risk of opioid use disorder. We discuss these tools in more detail in our response to I.C.24 of the RFP.

Health Risk Assessment: Upon transfer to the care management team from our Member Services Call Center, Beth administers an HRA for Katy to understand her physical health, BH, and SDOH needs. During the HRA, Katy reports her health has worsened in the past year and was most recently told that her blood pressure and blood glucose level were elevated. Based upon Katy's answers to the HRA, as well as information provided by Eric upon transfer from the Member Services call center, Beth confirms Katy could benefit from additional support from the plan.

Beth teaches Katy how to sign up for our **Go365® Enrollee incentive platform** so she can receive a reward for completing the HRA, as well as rewards for completing preventive care visits and certain recommended screenings.

Welcome Kit: Upon enrollment, Katy also received a copy of the HRA in her **Humana Kentucky Medicaid Welcome Kit**, along with a pre-addressed envelope with return postage. The Welcome Kit also included her Welcome Letter listing next steps to take toward better managing her health, Enrollee Handbook, a description of our value-added services, and a consent for release of medical information form.

Enrollee Needs Assessment: Beth's next step is to administer the Enrollee Needs Assessment and create Katy's individualized care plan. Beth works with Katy to identify members of her support system she would like to include in the assessment and care planning process (such as her mother). The Enrollee Needs Assessment gives Beth a complete picture of Katy's situation and addresses all elements required by the Commonwealth, including additional elements (**in bold type below**), upon DMS approval, to ensure we fully understand Katy's background, needs, goals, and preferences.

Elements of our Enrollee Needs Assessment for Katy include:

- Goals and preferences
- Review of SDOH needs, including housing, food insecurity, physical safety, transportation, education, and employment
- Assessment of psychosocial, functional, and cognitive needs
- Health status, including condition-specific issues and ongoing needs requiring treatment or monitoring
- BH status, including screening for clinical depression, substance use disorder (SUD), serious mental illness (SMI), and tobacco usage, among others
- Clinical history, including prescribed drugs and over-the-counter medications
- Current services, including durable medical equipment (DME) and treatment plans
- Evaluation of caregiver resources, including adequacy, involvement, and level of decision-making
- **Assessment of the home environment**
- **Cultural and linguistic preferences**
- **Life planning activities, covering advance directives, legal assistance, financial planning, and family planning**

- **Hearing and visual preferences or limitations**
- **Service delivery preferences**
- **History of adverse childhood experiences (ACEs) that may impact health**

Supplemental Assessments: To identify more complex conditions, care needs, and specialized services and supports for Katy, Beth administers the supplemental surveys below to further understand Katy's identified risks.

- *Social Needs Assessment:* Beth conducts this survey to screen for Katy's SDOH needs.
- *Environmental Survey:* Administered as needed, Beth is trained to perform this survey to identify and document risk factors in Katy's home (i.e. safety concerns) that could adversely impact health and well-being outcomes. This important tool will help Beth arrange services and supports that alleviate these factors when possible.

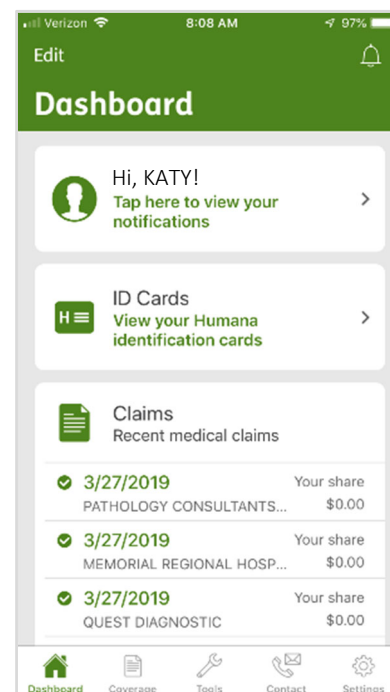
Care Planning: Through both initial training and ongoing coaching, Beth is able to use communication techniques and behavior strategies to gather critical information needed to determine the most appropriate levels of care and engagement with Katy. These assessments confirm Katy's initial assignment to our Intensive Care Management risk level. Beth applies Katy's assessment results to the development of Katy's care plan. Using the **person-centered planning** techniques taught in her CM training, Beth designs the care plan around Katy's goals, preferences, and priority needs. Katy states that her key priorities are to manage her blood pressure and blood sugar, lose weight, and earn her degree. She is overwhelmed with the possibility that she may be hypertensive or diabetic and wants to understand what it means for her health and future. However, Katy is not confident she knows how to manage her health or eat a balanced diet, and she does not like being physically active.

Beth and Katy discuss several interventions that can best help Katy achieve her goals. Beth documents these on Katy's care plan and helps to arrange the necessary services. Katy's priority interventions include: (1) seeing a PCP for preventive care and condition management; (2) learning about the causes of her high blood pressure and elevated glucose level, possible risks associated with them, and steps that she can take to improve her health; and (3) connecting with Humana-provided services and CBO resources that can help Katy address her priority needs and achieve her goals, both for her health and education.

Upon completion, Katy can access her care plan via **Humana's Enrollee portal, MyHumana** (see interface example I.C.29.Katy-4 MyHumana Mobile App), with a printed copy provided upon request, while Katy's PCP can access her care plan via our provider portal, **Availity**. Annually, with a change in condition or current level of care, or upon request from Katy or a member of the MDT, Beth updates the care plan based on Katy's needs and ensures to communicate the revised plan to her PCP. During subsequent care management meetings, Beth discusses Katy's progress toward her goals and identifies any additional needed services.

Care Plan Monitoring: Throughout Katy's engagement in care management, Beth conducts regular check-ins with Katy (in accordance with the schedule described above) to ensure she is engaged with her PCP and to monitor her progression toward the goals on her care plan. Beth provides her phone number to Katy and encourages her to reach out at any time, particularly if she experiences a change in her condition. If Katy is diagnosed with diabetes, Beth educates her on our **WellDoc®** diabetes remote monitoring program and helps her sign up if interested. WellDoc® (further described in our response to subsection I.C.29.Katy.e of the RFP) will help Katy self-manage her condition and enable Beth to monitor her symptoms and blood sugar levels electronically, intervening as needed.

**Figure I.C.29 Katy-4
MyHumana Mobile App**



c. Provider engagement

Beth contacts Katy's PCP to inform them of Katy's engagement in care management, provide her contact information, and invite them to join Katy's MDT to provide input on Katy's care plan. In addition, she makes sure Katy's PCP knows how to access her care plan, assessment, and service history via our provider portal (Avality), so they can stay up to date on Katy's needs and the services she is receiving. This includes those services that do not appear through claims data, such as nutrition counseling through **Humana's Medicaid Nutritional Counseling program**, the Diabetes Prevention Program, and other services by community resources.

In addition to having her symptoms assessed by her PCP, Katy should also receive other age-appropriate services, including a Pap smear, HPV testing, a breast exam, and family planning education and services. Because Katy has not seen a PCP for several years, she likely has several care gaps that will be important for her PCP to address, including potential gaps in her recommended immunizations (e.g., HPV and meningococcal vaccinations). Katy's PCP can view Katy's EPSDT and Healthcare Effectiveness Data and Information Set (HEDIS) gaps in care through Avality, enabling swift closure of these gaps during Katy's office visit. This information is populated by claims and data pulled from the Kentucky Immunization Registry.

EPSDT Services

Katy's PCP can access **Humana's Medicaid EPSDT Provider Toolkit** to support the provision of EPSDT services to Katy and the rest of their patient panel. This toolkit is an educational, well-child visits reference guide that outlines the preventive services covered under the EPSDT program, the EPSDT exam frequency, Kentucky-specific requirements, billing tips, referral codes, and other references. The toolkit will be made available to our providers via our public website. Please see **Attachment I.C.29.Katy-1** Kentucky Medicaid EPSDT Provider Toolkit at the end of our response for a copy of this toolkit.

BH Screening

While Katy does not have any noted BH needs, we encourage screening for depression as a routine part of care for all of our adolescent and adult Enrollees. **Through our value-based payment models, Humana incentivizes Katy's PCP to conduct a depression screening and refer for further assessment and treatment as indicated.** Our Provider Services staff provide in-person and web-based training on the Screening, Brief Intervention, and Referral to Treatment (SBIRT) approach to help our network providers gain the knowledge and skills to adhere to this important aspect of preventive care.

SDOH provider education

Humana works with our providers to address social determinants and health-related social needs at the local level. Knowing physicians and clinicians continue to be the most trusted source for care, we equip our providers with screening tools and educational materials that care for the whole person – both inside and outside of the clinical setting. We educate providers, like Katy's PCP, on Humana's **zoom in™ SDOH visualization tool** (for details, please see our response to subsection I.C.24.a.i of the RFP), and offer resources such as our **Food Insecurity Toolkit** and **Food Insecurity Quick Guide** (see **Attachment I.C.29.Katy-2** Physician Quick Guide to Addressing Food Insecurity) to enhance the care planning process. These informational documents can be accessed online at populationhealth.humana.com.



Through our provider incentive for **extended hours appointment availability**, we will increase access to care for our Kentucky Medicaid Enrollees and provide more flexibility in appointment times for Enrollees, like Katy, who are balancing multiple responsibilities.



d. Cultural competency

Culturally Competent Services

During the Enrollee Needs Assessment, Beth evaluates any cultural beliefs, preferences, or barriers that may prevent Katy and her family from accessing appropriate care, including their comfort level and impression of the healthcare system. She notes these on Katy's care plan, so she can take them into account when interacting with Katy and her family and providing educational materials (in addition to any needs related to Katy's reading level, hearing, or vision). Beth also ensures Katy's communication preferences have been updated in our CRM system, so we communicate materials in the format she prefers, whether that is via mail, telephone, or text. Katy has access to a network of engagement supports, such as **translation services for over 200 languages and American Sign Language (ASL) in person or via video**, that can mitigate barriers to her care resulting from language and cultural factors.

Culturally Competent Training

Beth, like all Humana associates, has completed cultural competency training. This is a requirement upon hire and annually thereafter, to include supplemental training tailored to the Medicaid population. Beth has completed training topics such as Health Literacy and Numeracy and Cross-Cultural Negotiation. We make a best effort to match Katy with a CHW (like Tammy) who can meet her cultural preferences, if needed or desired. Allowing a CHW whom she trusts to accompany her to provider appointments may help her become more comfortable and open to visiting with her provider.

When choosing Katy's new PCP, Beth ensured her selected provider met her cultural preferences. We mandate that all of our network providers complete Humana training on cultural competency to promote appropriate Enrollee communication and engagement.

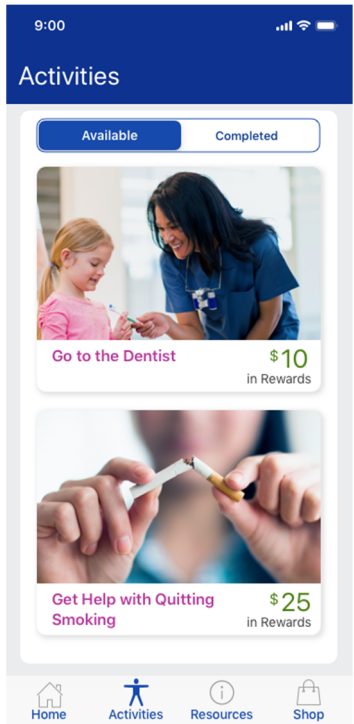
e. Patient engagement and education

We have designed our Enrollee engagement and education activities to help our Enrollees take control of their health by accessing appropriate preventive services, managing chronic conditions, and leading a healthy lifestyle. Until now, Katy's health has shifted to the background as she is focused on taking care of her brother and going to school. Beth wants to help Katy prioritize her health again.

Accessing preventive care: Beth begins by assessing Katy's motivations and goals, including understanding why Katy has not seen her PCP since she was in middle school. From our experience serving Medicaid Enrollees, we recognize there may be a variety of reasons why Katy has not been engaging in preventive care, including transportation barriers, conflicting priorities, discomfort with visiting a PCP, not knowing how to seek care, or not recognizing its importance to health. Whatever Katy's reason, Beth applies motivational interviewing to promote change in care-seeking behaviors and devises strategies to help Katy overcome barriers. For example, Beth teaches Katy how to use the Commonwealth's **Non-Emergency Medical Transportation (NEMT)** subcontractors if she faces transportation challenges, helps her find a PCP with extended evening and weekend hours, or asks Tammy (her assigned Humana CHW) to accompany her to appointments if she does not feel comfortable going on her own.

Enrollee Incentives: Beth helps Katy sign up for **Humana's Go365® program** (see interface example I.C.29.Katy-5 Go365® Mobile App) so she can receive gift cards

**Figure I.C.29 Katy-5
Go360® Mobile App**



in exchange for preventive care, including annual PCP visits, women's preventive screenings, and diabetes care (if diagnosed). Upon completion of key activities, Katy can earn and redeem gift cards to popular retailers, such as Walmart, Shell, and Amazon.com, which we can deliver via email or mail.

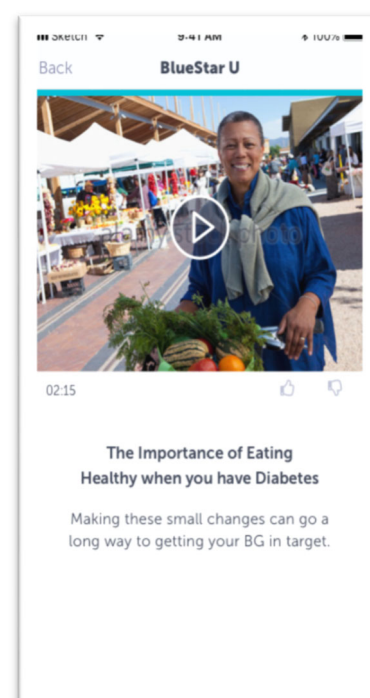
Chronic conditions management: During their regular check-ins, Beth helps Katy understand the causes of hypertension, diabetes, and obesity and discusses how Katy can get these conditions under control.

As proper nutrition and physical activity will be key to helping Katy improve her health, she is also invited to engage in **Humana's Medicaid Nutritional Counseling program**. Through this program, Katy can receive group and individual nutrition counseling from a dietitian to help her learn nutritional basics and how to maintain a balanced diet. Obesity is one of the top issues facing our Kentucky Medicaid Enrollees today. In 2018, over 23,600 of our Enrollees were obese, and obesity is one of the top four health issues facing our Enrollees across every region. Therefore, we are committed to putting measures in place to help Enrollees who are obese, like Katy, improve their health and well-being.

In addition to the telephonic or face-to-face counseling employed by our CMs, Humana offers a variety of digital alternatives to provide our Enrollees with options that meet their learning preferences. Given Katy's age, Beth recognizes she may particularly benefit from the following digital tools:

- **KidsHealth®:** Katy uses our **KidsHealth®** platform to access adolescent- and young adult-friendly content on her health conditions, including videos and written materials on topics like Food & Fitness and Hypertension. Katy can navigate this content at her own pace and on her own time through the KidsHealth® web-based platform, accessible via our Enrollee website.
- **WellDoc®:** Through **WellDoc®**'s smartphone application (see interface example I.C.29.Katy-6 to the right), Katy can track her blood sugar levels, exercise and sleep habits, diet, stress levels symptoms, and medication adherence. Beth can view the information Katy has logged into the application, and reach out telephonically or through WellDoc®'s two-way chat functionality if she sees any concerning behaviors or symptoms. If Katy does not have a smartphone or has limited data that may restrict her ability to use WellDoc®, Beth helps her access Humana's **value-added service of unlimited data and minutes for Tracfone mobile devices**.

Figure I.C.29 Katy-6
WellDoc® Mobile App



Leading a healthy lifestyle: Management of Katy's conditions is not only a matter of medication; to resolve her hypertension and possibly reverse her pre-diabetic symptoms, she will need to change her lifestyle. Through our broad experience, we recognize the significant impact lifestyle choices have on the health of our Enrollees, and (through Humana's Bold Goal program) we have invested in personnel and community resources that can help our Enrollees and communities in Kentucky adopt healthier habits. Katy can visit one of our **Humana Neighborhood Locations** in the Bluegrass – one site in Louisville and one in Covington.

In addition to providing one-on-one education, Beth and Tammy encourage Katy to attend events held by our **Kentucky Medicaid Community Engagement team** (led by our **Kentucky Medicaid Culture & Community Engagement Director, Bryan Kennedy**) across the Commonwealth, such as classes on weight management or physical activity opportunities, such as Zumba classes.

f. Community resources



Beth accesses the **Kentucky Community Resource Directory (CRD)**, powered by **United Way**, to identify community resources that can supplement those offered by Humana and support Katy's goals. If Katy lives in the Louisville area, Beth accesses the innovative **Unite Us** platform to facilitate closed-loop referrals to participating CBOs that can meet Katy's needs. Through this platform, Beth can confirm that Katy was connected to those resources for which she was referred, resolving a common gap in community resource systems. If Beth needs assistance identifying the right community resources for Katy, the specialized SDOH coordinator and Housing specialist on her CCS team provide support. Whenever possible, Beth leverages Katy's existing support system, including financial, educational, or physical fitness services offered by her community college, church, or neighborhood. Beth and Tammy help Katy learn how to access and use these resources, and Tammy offers to accompany Beth when she is seeking community services for the first time if she needs support.

Diabetes Prevention and Support: Beth locates several resources available across the Commonwealth and online that can help Katy manage her pre-diabetes or Type 2 diabetes, depending on her diagnosis from her PCP. Beth presents these options to Katy, so Katy can decide what she thinks would work best for her:

- **Diabetes Prevention Program:** If Katy is not diagnosed with diabetes during her initial visit with her provider, Beth works with Katy's PCP to arrange a referral to **Centers for Disease Control and Prevention (CDC)-recognized Diabetes Prevention Program (DPP)** location closest to her. If there is not one that is accessible for Katy, she can also engage in the online version of the program. Through DPP, Katy will receive support to change her lifestyle and prevent development of Type 2 diabetes, including CDC-approved education, motivational support from a lifestyle coach, and linkage with others at risk of Type 2 diabetes without appropriate lifestyle change.
- **Diabetes Self-Management Education and Support Services:** If Katy is diagnosed with diabetes, Beth helps her find and connect with the nearest **Diabetes Self-Management Education and Support Services program** for additional support in managing her condition and changing her lifestyle, including classes related to proper nutrition and exercise. These referrals are noted on Katy's care plan.
- **American Diabetes Association Online Options:** Katy may wish to engage in online, self-directed learning about her condition. If so, Beth directs her to the **American Diabetes Association's free 12-month program, "Living with Type 2 Diabetes"**, for individuals newly diagnosed with Type 2 diabetes.

Humana has partnered with the Kentucky Primary Care Association and the YMCA to pilot the National Diabetes Prevention Program at YMCA locations. In addition to the diabetes education and lifestyle change support, Enrollees who actively participate in the program receive up to a six-month YMCA membership for themselves, an additional adult, and their dependents under the age of 25.

Healthy Eating: Recognizing that the well-being of the family unit is closely linked to the well-being of the individual Enrollee, Beth and our SDOH coordinator can also assist Katy's family with referrals to community resources. This may include employment supports for her mother or childhood services for her brother. Beth also aims to find classes or supports that can get the entire family involved in supporting Katy's healthy lifestyle, such as **Cooking Matters**. Through Cooking Matters, Katy and her family can take cooking classes and grocery store tours tailored for low-income families. Humana is partnering with **Share our Strength** and **Feeding Kentucky** to expand their Cooking Matters program in Kentucky to reach more families like Katy's.

g. Social determinants of health

Beth also references United Ways's CRD and/or the Unite Us platform to find resources that can meet Katy's SDOH needs, as identified through the HRA and Enrollee Needs Assessment.



Access to healthy food: Ensuring Katy maintains a healthy diet is essential for management of her elevated blood pressure, weight, and pre-diabetic symptoms, in addition to the improvement of her overall health. Beth wants to help Katy become more comfortable and motivated to make healthy food choices, go grocery shopping, and be physically active. Beth and Katy discuss any financial challenges that may affect her ability to purchase healthy food. If needed, Beth helps Katy and her mother apply for **Supplemental Nutrition Assistance Program (SNAP)** benefits and helps her understand how to use them, including at her local farmer's market for fresh food. If Katy lives in Louisville, Beth suggests she sign up to be a shareholder through **New Roots**, giving her and her family access to affordable produce throughout the growing season.

Childcare support: Assistance in taking care of her brother can free up more time for Katy to focus on school, grocery shopping, and meal preparation, in addition to alleviating stress on her family. If Katy and her mother are interested in further assistance, Beth helps them apply for the **Child Care Assistance Program**.



Employment Assistance: If Katy wishes to seek employment while she is in school or after she graduates, Beth encourages her to contact her community college's job office for support. If additional supports are needed, Beth also assesses Katy for **Humana's Workforce Development program** if her Medicaid eligibility continues after she turns 21. Our voluntary, holistic workforce development program is designed to assist Enrollees, like Katy, find dignified, stable work that affords increased self-efficacy and self-sufficiency for themselves and their families. This program will provide Katy with up to 12 months of assistance to help her plan for the future (e.g., education, training, financial counseling) and engage in and maintain meaningful work (e.g., job support and retention coaching). We will seek to build access to a network of CBOs with expertise in providing these services by rewarding those organizations who successfully place and stabilize employees. Through these supports, Katy can find a job that allows her to use her degree, as she desired, and gain increased financial independence.

To support female Enrollees seeking employment, Humana is excited to offer a direct referral process with **Dress for Success – Louisville**, which serves job-seeking women through career mentoring, financial education, and professional career attire in the greater Louisville metro area. If Katy lives in Louisville, Beth connects her to this resource when she is ready to seek employment. Tammy (Katy's CHW) is available to attend with Katy if requested to make her feel more at ease and serve as her advocate and trusted advisor throughout this process.



Transportation Assistance: Beth teaches Katy how to access the Commonwealth's NEMT service through her local broker, and evaluates any transportation barriers that may be affecting her ability to access a grocery store, farmer's market, or any community resources. If so, Beth teaches Katy how to use the low-cost public transportation service offered by her NEMT broker or any public transportation resources available in her area. In addition, given the impact of Katy's access to healthy food on her chronic conditions, Beth helps Katy sign up for Humana's **transportation benefit**, which will provide up to three round trips per month to a grocery store or other community resource to support a healthy lifestyle.

Financial Literacy: To further improve Katy's financial independence, Beth can also connect her with the Metro United Way's pilot financial literacy and training program to see if she qualifies to participate, if interested. This program is designed for families and their residents experiencing economic distress and provides financial literacy coaching and social services.



Physical Safety: Beth assesses the physical safety of Katy and her family to determine any resources or supports needed. Our CCS team has resources at their disposal to address the range of physical safety issues that can affect Enrollees, like Katy, including support for domestic violence, self-harm, child abuse, and natural disasters. In the event of a natural disaster within the Commonwealth, we leverage geographic data to identify Enrollees in flood and tornado evacuation zones and reach out to provide assistance. Beth also helps Katy develop a disaster plan, including where she and her family can go in the event of a disaster and supplies to pack (e.g., prescription medications, potable water).

OTHER PROGRAMS AND SERVICES

Family Support: Through our integrated clinical platform, **Clinical Guidance eXchange**, Beth determines whether Katy's brother and mother are also Humana Medicaid Enrollees. If so, Beth reviews their profiles to determine if they, like Katy, are out of compliance with their recommended preventive care services. Beth contacts Katy's mother to offer assistance in scheduling appointments for her or her son.

Cabinet for Health and Family Services (CHFS) Ombudsman: The **Ombudsman** can serve as an advocate for our Enrollees, reviewing and working to resolve customer issues with programs operated through CHFS departments. Beth educates Katy on how to contact the Ombudsman in our Enrollee Handbook. Humana's MSRs and other Enrollee-facing staff are also on point to refer Katy to the Ombudsman upon request.

Eligibility: Once Katy turns 21, she may qualify under Affordable Care Act expansion to keep her Medicaid managed care eligibility. If she does not qualify under the expansion population, Beth works with her to understand her other options for continued healthcare coverage, including purchasing a plan from the marketplace or connecting her with CBOs in her area where she can access low-cost healthcare services.