

USE CASE 1

Rhonda is a 30-year-old Enrollee who recently learned that she was pregnant after visiting the Emergency Room, by ambulance, with severe nausea and dehydration. She has a history of high-risk pregnancies. Of 5 pregnancies she has experienced one (1) live birth, three (3) miscarriages occurring early in the second trimester, and one (1) abortion in her teens. In addition to her history of complicated pregnancies she smokes a half pack of cigarettes per day and drinks approximately 2 -3 beers /week.

During her pregnancies, Rhonda sporadically kept prenatal visits and had a history of noncompliance with routine care instructions. Rhonda was shocked to learn that she was pregnant since she delivered a baby girl ten (10) months earlier. Her daughter, Amanda, was born at 32 weeks and was in the NICU for three (3) weeks. Amanda is feeding well and is steadily gaining weight. With that pregnancy, Rhonda experienced post-partum depression and was concerned whether she could care for Amanda. Rhonda's closet family is in Texas, but visits are infrequent. She recently separated from an abusive partner who provides minimal financial and emotional support. Rhonda and Amanda sought safety in a family shelter on three (3) different occasions after her partner threatened to harm Amanda.

Rhonda became upset upon learning she was pregnant again and kept telling the ER nurse that it could not be true. She explained that she just moved out her apartment after splitting with her partner and was staying temporarily with friends. Rhonda does not have reliable transportation and often relies on friends to provide rides to the pediatrician and grocery shopping.

The ER nurse recommended that Rhonda talk with her OB/GYN and her MCO about her options. Rhonda's electronic medical record was updated, and a referral was made to her OB/GYN.

Describe how the Vendor would address Rhonda's situation including a detailed description of prenatal programs and Quality Improvement Initiatives. At a minimum, address the following programs and services:

- a. Applicable evidence-based Care Management practices;
- b. High risk pregnancy initiatives;
- c. Health Risk Assessment and Care Planning;
- d. Environmental assessment;
- e. Behavioral Health Services;
- f. Family planning;
- g. Enrollee and family engagement;
- h. Linkage to community resources and support;
- i. Social Determinants of Health;
- j. Provider engagement; and
- k. Transportation

Passport’s Innovative Population Health Management Approach

In our 22-years of providing population health management services to the Commonwealth, Passport has remained firmly committed to improving the health and quality of life for our members – it is our mission. We have earned the trust of our members by:

- Providing whole-person care that integrates physical, behavioral, social and emotional wellbeing into an evidence-based self-management and empowerment approach
- Building a trusting relationship between care teams and members who require personalized attention and no “cold handoffs” or “fend for yourself” referrals
- Engaging providers across specialties to ensure a singular treatment plan and continuity of care

For members like Rhonda, these principles are core to their ability to take control of their own health and the health and wellbeing of their families. They are woven into the following description of how Passport would address Rhonda’s situation, from identification and initial assessment to delivery of integrated services.

Timely Connection to Rhonda through Emergency Department Navigators

Rhonda’s situation is urgent. Her newly revealed pregnancy, her history of miscarriages, her post-partum depression, her lack of connection to the health care system and her unstable housing situation place her at great risk of falling through the cracks. The Emergency Department (ED) where Rhonda sought care has an assigned Passport Emergency Department Navigator, who connects with Rhonda while she is in the ED and refers her to Passport’s Care Management team. The ED Navigator opens a new case in IdentifiSM, Passport’s integrated information system, which includes Rhonda’s responses to an assessment, case notes and updated contact information. This action triggers an alert for Passport’s Care Team Lead who will begin the intake process.

Passport’s Real-Time IdentifiSM Platform Stratifies Rhonda as High-Risk

Although she has not recently accessed care, Rhonda had previously received many services from Passport. Through the real-time integration of prior program participation, assessment, clinical, and claims data, we had already identified Rhonda as high-risk if she were to become pregnant again. Prior to her daughter Amanda’s birth and admission into the neonatal intensive care unit (NICU) ten months ago, Rhonda and Amanda were enrolled in the **Mommy Steps Maternity and Newborn Care program**, Passport’s maternity program to support women through their pregnancy. The program has a primary focus on **high risk pregnancy** with initiatives to address low birth weight and infant mortality. Through this program, Rhonda developed a trusting relationship with her Mommy Steps Care Advisor, who helped stabilize Amanda’s health during the first 28 days of her life and safely transitioned Rhonda and Amanda from the hospital to home. Through this interaction, information on Rhonda’s smoking and drinking habits and her noncompliance with routine care was captured in IdentifiSM through the program’s comprehensive assessment.



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Our advanced machine learning algorithms had categorized Rhonda as “high-risk” for future pregnancies in our IdentifiSM system because of the following risk-factors:

- Recency of prior live birth (within last year) with NICU admission
- History of adverse outcomes in pregnancies (3 miscarriages)
- History of smoking and drinking (from Mommy Steps assessment)
- Low socioeconomic indicators based on her current address (e.g. income and education)

This information is stored within the IdentifiSM platform so when the Care Manager Lead opens the referral from the ER Navigator, she can see the information from the ED Navigator, Rhonda’s past history and the output of the stratification algorithms identifying Rhonda for Passport’s **Mommy Steps Maternity and Newborn Care program. For high-risk pregnancies** like Rhonda’s, Mommy Steps focuses on prevention of complications by providing support, connection to the community, and care coordination between the member and provider to increase compliance with Passport’s Perinatal Care Clinical Practice Guidelines. These **evidence-based guidelines are based on the American College of Obstetricians and Gynecologists (ACOG) Guidelines.**



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Personalized Outreach and Comprehensive Assessment to Understand Rhonda’s Medical, Behavioral and Social Needs

Once we identify Rhonda as a member who would benefit from our Mommy Steps Maternity and Newborn Care program, we continue the outreach process, including telephonic outreach and “boots on the ground” case finding. Given that Rhonda had developed a close relationship with her previous Care Advisor, we assigned Rhonda’s case to the same Care Advisor within IdentifiSM, who attempted outreach to Rhonda using the updated contact information from the ED Navigator. Unable to reach Rhonda after repeated attempts, we were able to successfully contact her designated emergency contact – her sister in Texas – sourced from her Mommy Steps case report within IdentifiSM. Through this connection, we learned that Rhonda had moved again since her ED admission and we were able to get a new cell phone number. **Rhonda was glad to hear from her Care Advisor, on whom she had once relied so heavily,** and re-enrolled into the Mommy Steps Maternity and Newborn Care program.



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Our Care Advisor meets with Rhonda by phone to complete a comprehensive **health risk assessment (HRA)**. Because Rhonda’s previous assessments and case notes are available through Identifi, her Care Advisor can shorten the intake and assessment process by using her time with Rhonda to make updates to her previous responses. In addition to understanding Rhonda’s current pregnancy symptoms, including the dehydration and nausea that brought her to the ED recently, this process uncovers the following:



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- **Behavioral health:** Through valid and reliable screenings such as the Patient Health Questionnaire 2 and 9 (PHQ-2, PHQ-9) for depression; Generalized Anxiety Disorder -7 (GAD-7) for anxiety; and CAGE-AID, for alcohol and drug use, we learn that Rhonda is:

- experiencing post-partum depression and anxiety related to her ability to care for Amanda
- smoking and drinking in quantities that have increased over time
- suffering from emotional stress from recently separating from an abusive partner
- **Environmental Assessment:** We learn through a home visit that she just moved out of her apartment after splitting with her partner and is staying temporarily with friends, living on couches with no safe place to remain during the day and limited access to high quality food and water ✓ Req C.29-1.d
- **Other social determinants of health:** Rhonda does not have reliable income or transportation ✓ Req C.29-1.i
- **Nutritional habits:** We learn that Rhonda is not taking prenatal vitamins and is not getting the nutrition she and her baby need to maintain a healthy pregnancy

In addition to assessing Rhonda’s needs, our Care Advisor also assesses the needs of Amanda who was born at 32 weeks' gestation. She is now ten months old and needs **early and periodic screening, diagnosis and treatment (EPSDT) and good preventative care**. Assessing Rhonda and Amanda together through the same Care Advisor ensures that we can effectively coordinate both Rhonda’s and Amanda’s care. ✓ Req C.29-1.a

Coordinated Execution of a Holistic Care Plan for Rhonda and Amanda


The initial assessment triggers several action items for specific members of our Mommy Steps interdisciplinary care team. All actions are coordinated through our RN Care Advisors, who have an average of 15 years of experience in perinatal nursing and have been trained in **Trauma Informed Care**. All documentation will be captured in IdentifiSM and made available for the entire care team to ensure seamless coordination with Rhonda and her providers. These action items are summarized in **Exhibit C.29-1** below and described in more detail in the sections that follow: ✓ Req C.29-1.a


Exhibit C.29-1. Summary of Katy’s Action Plan to Address Her Immediate Needs


Action Item	Team Member	Follow-up
Engage Providers & Family	Mommy Steps RN Care Advisor (Team Lead)	Notify Rhonda’s PCP and OB/GYN, obtain input on her Care Plan and schedule follow-up pre-natal appointments; engage Amanda in care
Refer to Behavioral Health	BH Care Advisor /Licensed Clinical Social Worker (LCSW)	Address interpersonal safety concerns, depression and substance use
Provide Education & Coaching	Mommy Steps RN Care Advisor	Provide education and coaching on proper nutrition, medications, prenatal vitamins
Refer to Social Work	Social Worker / Community Health Worker (CHW)	Locate and facilitate stable housing and transportation; explore employment opportunities; educate on how to sign up for Supplemental Nutrition Assistance Program (SNAP) food benefits and assess

Action Item	Team Member	Follow-up
		for eligibility for community resources for child’s needs (ex. clothing, diapers)
Provide education and coordination on EPSDT	Care Coordinator	Assist Rhonda in following through with any outstanding developmental screenings and immunizations for Amanda

Engage Providers & Family

Rhonda does not live near family, and she does not have a strong support system, therefore, **strong engagement with all of her providers** is critical. As a provider led organization, we understand the importance of working *with* providers. Passport’s Care Advisor would immediately **contact Rhonda’s OB/GYN** through written notice of engagement in the program and a direct phone call. Together, they ensure Rhonda has all pre-natal appointments scheduled and initiate a high-risk protocol with perinatology involvement and progestin therapy (e.g. 17-Progesterone). **Passport’s Progestin Therapy Program, developed in 2015 by our Maternity Medical Director using evidence based guidelines**, in collaboration with community OB/GYN providers on our Women’s Health subcommittee, supports practitioners and members in educating them about the benefits of progestin therapy to reduce the incidence of further premature births. This program was vetted by the Women’s Health Committee, approved by the Quality Medical Management Committee and accepted by the physician led Partnership Council.  Req C.29-1.j

The program includes an active surveillance process to evaluate members by physical exam, history, and/or ultrasound cervix measurement to identify members who have had spontaneous preterm deliveries and/or are identified with a shortened cervix. Passport pays an additional fee to the OB/GYN for evaluation of cervical length. Rhonda, who has a history of preterm delivery with a current singleton pregnancy, will be offered weekly 17-Progesterone injections from 16-37 weeks of gestation, administered in the provider’s office or at home. Rhonda will also be monitored for shortened cervix to evaluate for the need for cerclage. Our Care Advisor will share the team’s plan for addressing her barriers to care **including stable and safe housing, transportation and nutrition**. Additionally, the Care Advisor will identify and **engage a Primary Care Physician (PCP) to ensure continuity of care** for Rhonda post-partum. Through close collaboration with her providers, we ensure a single treatment and care plan for Rhonda that is holistic and coordinated to enable a healthy pregnancy and delivery.  Req C.29-1.j

Although Rhonda’s closest family is her sister in Texas, our Care Advisor will encourage Rhonda to reach out to her for support. During this conversation, Rhonda reveals that she shares a cell phone with her roommate, making it difficult to call her sister for support or make calls when she would like. Rhonda’s Care Advisor discusses **Passport’s free SafeLink phone resource**, which allows her to get a free smart phone with 350 minutes monthly and helps her fill out the application. This will allow **Rhonda to call and text her sister more frequently for support and companionship** during and after her  Req C.29-1.g

pregnancy. This will also create a much safer situation for Rhonda, as she will be able to call her provider if something were to go wrong in her pregnancy.

Integrate Behavioral Health Services to Address Psychosocial Barriers to Care

We recognize the relationship that exists between a member’s state of mind (e.g., depression, anxiety, addictions) and physical health status. Our Model of Care is founded on the understanding that human health and welfare are strongly influenced by behavior and social circumstances. As a critical member of our multi-disciplinary team, **our Behavioral Health (BH) Care Advisor, a licensed clinical social worker,** works together with the RN Case Advisor and Rhonda to address her interpersonal safety concerns, depression and substance use. Rhonda’s case is brought to Passport’s Integrated Care Rounds, consisting of licensed psychologists, licensed clinical social workers, and obstetricians to finalize her integrated care plan. With oversight from Passport’s Behavioral Health Advisory Committee, Rhonda’s BH Care Advisor takes the following actions:

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C.29-1.e

- **Interpersonal safety:** To address Rhonda’s emotional stress from her abusive partner, our BH Care advisor facilitates her engagement with the Kentucky Coalition Against Domestic Violence (KCADV) and the Center for Women and Families. Through this connection, Rhonda joins a women survivor of domestic violence group to talk with others about her experience in her most recent relationship.

- **Stable housing:** Through KCADV, the BH Care Advisor is able to immediately secure emergency shelter – a temporary, safe space that houses adults and their dependent family members who are fleeing an intimate partner violence situation – as she initiates the longer-term process of finding stable housing. The BH Care Advisor works with the Center for Women and Families and the Coalition for the Homeless to ensure Rhonda is on the waiting list for Housing and Urban Development housing options.

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- **Depression and Substance Use:** Once Rhonda has/acquires a safe and secure living space, our BH Care Advisor begins to address Rhonda’s depression and related smoking and alcohol use. The BH Care Advisor creates a non-judgmental space for Rhonda to share her concerns and support Rhonda in finding better ways to cope with her feelings, solve problems, set realistic goals and respond to situations in a positive way. Through working with Rhonda, our BH Care Advisor identifies several interventions that could help Rhonda, including:

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- **Peer support:** Engaging with other pregnant mothers who are experiencing similar symptoms is an important component to Rhonda’s healing. The BH Care Advisor works through the RN Care Advisor to engage Rhonda’s OB/GYN (to ensure one point of contact for the provider) and identify any internal groups or workshops about behavioral health needs during pregnancy. She identifies an upcoming workshop at the provider’s office and helps Rhonda secure transportation and arrange for her friend to watch Amanda so she can attend.
- **Specialized Counseling:** Rhonda’s BH Care Advisor has also connected her with a therapist with extensive experience working with women who have behavioral health issues during pregnancy. The therapist believes Rhonda would benefit from a medication consult for her depressive symptoms. In coordination with the RN Care Advisor, Rhonda’s therapist communicates back to the OB/GYN about the symptoms she is seeing and why she recommends considering use of medication. Together, Rhonda and her OB/GYN discuss the risks, benefits, and side effects of antidepressants during pregnancy and agree to start Rhonda on a low dose of sertraline as it has

- fewer side effects, she has taken it in the past with a positive response, and it is one of the safest antidepressants for an expectant mother.
- **Smoking Cessation & Alcohol Abstinence:** Through her counseling sessions, Rhonda realizes that her smoking and drinking habits are intimately tied to her feelings about her former partner. Using the **5A's model for current or recent tobacco use or substance misuse**, the BH Care Advisor provides education on risks to her unborn child as well as Amanda's risk for Sudden Infant Death Syndrome (SIDS) and lung infections with smoke exposure. The Care Advisor also lets Rhonda know about 1-800-QUIT-NOW, the Kentucky Quit Now Support Line, and with Rhonda's permission, refers her to a cessation program in her area. Her **BH Care Advisor also engages Rhonda's sister** in Texas to create a natural support system for Rhonda to use when she feels like smoking or drinking.

Rhonda's current depressive symptoms increase the likelihood that she will experience post-partum depression after her second birth. Knowing this, her Care Advisor sets a reminder in IdentifiSM to rescreen for symptoms post-delivery with periodic re-screenings thereafter. Once Rhonda's depressive symptoms begin to resolve during pregnancy, her Care Advisor will encourage her to talk with her therapist about how to prepare for a possible recurrence after the baby is born so she has a plan of action ready. By addressing Rhonda's mental *and* physical state, she will be more open and responsive to education and coaching aimed at improving her own physical health and wellbeing.

Provide Tailored Education & Coaching to Empower Rhonda in Her Own Health

In addition to medical and behavioral services, a critical component of Rhonda's care plan is rooted in building self-management skills to ensure long-term success. Through **evidence-based care - management practices**— such as **Motivational Interviewing, Positive Affect Induction, and Attribution Retraining** – our Mommy Steps RN Care Advisor works with Rhonda to develop a **Care Plan that identifies personalized goals and a symptom response plan**. For Rhonda, who has a history of missing prenatal visits and noncompliance with routine care instructions, our Care Advisor works with Rhonda to set small and achievable goals, empowering Rhonda to improve adherence with prenatal vitamins and proper nutrition. For example, Rhonda knows the importance of taking her prenatal vitamins but often forgets or cannot afford refills. To empower her, our Care Advisor sets a goal of taking vitamins every day for 1 week. She helps Rhonda set a time of day that works with her schedule. To support adherence, they collectively come up with a plan to put her vitamins on her nightstand with a glass of water the night before and set an alarm on her phone for 9am. The Care Advisor also sets a reminder for herself in IdentifiSM to help Rhonda refill her vitamins, working with her OB/GYN, before her 90-day supply runs out. Through each goal, our Care Advisor meets the member where they are to teach them how to take control of their health.

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C.29-1.c

Address Social Determinants of Health to Ensure Rhonda's Adherence to Care

The link between **social determinants of health (SDoH)** and health outcomes is well established. Accordingly, our Mommy Steps care team includes a social worker, who has been intimately

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involved in the local community for eleven (11) years and has a deep understanding of available resources to support Rhonda. Passport has also developed the Social Needs Index, which identifies the most critical social needs for someone like Rhonda to prevent an adverse birth outcome – transportation to prenatal care and access to high quality food. Additionally, we have adopted the Healthify Social Service Directory, which provides our care team with the most reliable community resources that have been thoroughly vetted and updated. Through these resources, intimate knowledge of the community, and coordination with Rhonda’s involvement with the KCADV, our social worker was able to address these needs:

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C.29-1.h

- **Access to high quality food:** We enrolled Rhonda in the Kentucky Food Benefits/Electronic Benefit Transfer (EBT), which helps people buy enough food for healthy meals. Rhonda was provided an EBT card that can be used to buy food at participating stores located near her, increasing Rhonda's food buying power.
- **Transportation:** For Rhonda to keep her prenatal visits, attend her peer support groups, and buy healthy foods, she needs reliable transportation. Our social worker/CHW enrolled Rhonda in local **transportation assistance program**, through Leslie Knott Letcher Perry Community Action Council, Inc. (LKLP Community Action Council), that offers non-emergency Medicaid transportation to prenatal visits and public transportation through monthly discounted or free Transit Authority of River City (TARC) passes for Louisville and surrounding areas.
- **Income:** The social worker knew that for long term success Rhonda would need to find additional sources of income. Rhonda shared some of her employment desires and barriers. It was determined that the first step would be for Rhonda to enroll in a job program that would help build skills and assist with seeking employment, like one of the programs offered through Kentuckiana Works.

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C.29-1.k


As an additional resource, Rhonda will also be made aware of community baby showers in her local area. These events offer Rhonda baby clothes and supplies that she will need to take care of her child. Rhonda has lost much of the equipment she used previously due to her unstable housing and lack of transportation.

Long-Term Planning and Continuity of Care for Rhonda and Amanda

Once Rhonda’s current situation is stable and she is progressing, the care team can begin to address Rhonda’s longer term needs to ensure continuity of care for her and Amanda and prevention of a similar situation in the future. This includes post-partum visits with **family planning**, social support resources, and prevention efforts for Amanda.

- **Post-partum visits & family planning:** The Care Advisor will educate Rhonda about family planning options to prevent another unplanned pregnancy with regular post-partum visits and long-acting reversible contraception (LARC). She will work with Rhonda’s OB/GYN to reinforce these messages during prenatal visits with the goal of starting LARC before she leaves the delivery hospital. If that is not possible, we will continue to share options with Rhonda during post-partum visits, where she will be screened and treated, if necessary, for post-partum depression.
- **Additional social support:** Rhonda, like all members engaged in the Mommy Steps program, would be referred to **Health Access Nurturing Development Services (HANDS)**, if appropriate, which will provide Rhonda support for the first two (2) years of the baby’s life. If Rhonda qualifies for the Healthy Start program and gives consent, she would be referred and assessed for participation during follow up interactions.

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C.29-1.f

- **Early and Periodic Screening, Diagnosis and Treat (EPSDT) Program:** Our care coordinator would support the Mommy Steps Care Advisor in coordinating Amanda’s participation in Passport’s EPSDT program to ensure she has all the preventive high-risk prematurity and early intervention developmental screenings she needs to assess her developmental progress. Amanda would have a separate case that is linked to Rhonda’s within the IdentifiSM platform, allowing for the same care team to communicate with Rhonda about both hers and Amanda’s care plans, to build trust and to keep actions, visits and call schedules coordinated.  Req C.29-1.g

We will continue regular check-ins with Rhonda and her children for six (6) months post-delivery, or as needed. The bond between the Care Advisor and member is often so strong after going through the pregnancy together that Rhonda will likely continue to call her when she has questions, which is welcomed. During this period, the Care Advisor is also actively coordinating with Rhonda’s PCP and Amanda’s pediatrician to ensure a smooth transition from her OB/GYN.

As a Kentucky provider-led organization and member of the community, we understand the diverse and ever-changing needs of our members like Rhonda. To meet those needs, we are continually evolving our population health model and care management programs – including expanding our member engagement strategies to meet members wherever they seek care, using better data and analytics to identify members with multiple needs earlier, case finding techniques rooted in our knowledge of the community, comprehensive assessments with evidence-based screenings, and integrated care plans that are executed in partnership with our multi-disciplinary care teams and providers.