

## USE CASE 2

Katy is a 20-year old female who is taking classes at a local community college while living at home with her mother to help take care of her younger brother. Katy's mother works two (2) jobs and has difficulty finding time to shop for and prepare healthy meals. Katy does not assist with grocery shopping or meal preparation. Katy is significantly overweight and rarely exercises. Most of her meals are from fast food restaurants and she only occasionally eats vegetables or fruit. Recently, Katy became light-headed after eating lunch and was taken to an urgent care center by a friend. The provider asked Katy about her symptoms and whether this has happened before. Katy stated that the dizziness happens frequently after meals and she is always thirsty. The provider asked Katy if she has diabetes and Katy stated she did not think so. She told the provider that she has not seen a doctor since she was in middle school. The nurse took Katy's vital signs and a blood glucose reading. Katy's blood glucose reading was elevated, and her blood pressure was 162/90. Her BMI was computed to be 32.6. The provider recommended that Katy contact her MCO to find a PCP as soon as possible before her condition worsened and she ended up in the Emergency Room. Katy contacted her MCO's Enrollee Call Center and explained her situation. Describe the Vendor's Enrollee engagement process and Care Management. At a minimum, address the following:

- a. Evidenced based practices for Care Management;
- b. Health Risk Assessment and Care Planning and monitoring;
- c. Provider engagement;
- d. Cultural competency;
- e. Patient engagement and education;
- f. Community resources; and
- g. Social determinants of health

Katy’s story is one that is too often heard across the Commonwealth. Many Kentuckians, like Katy, have gaps in care that are often not treated appropriately or go untreated and many also lack the understanding of the importance of routine preventive care, regular visits with a primary care provider (PCP), and health-promoting behaviors. To support these members on their paths to better health and wellbeing, we focus on ensuring that there is “no wrong door” for members when asking for help; activating members in their health; and engaging providers to collaborate on care plan development and execution.

Passport has a critical opportunity to engage Katy and initiate her health journey through her inbound call to Passport’s Call Center, which triggers several actions that must be tightly coordinated and action-oriented to gain Katy’s trust and provide her with the confidence she needs to take control of her health. These interactions and downstream interventions are described in more detail below.

## Taking Immediate Action Upon Katy’s Call for Help

Our no wrong door approach to ensuring members can access the services they need, when they need them, regardless of the type of service being requested, is important to our whole-person care model. Katy’s initial call to Passport’s Call Center is answered by one of our Care Connectors (CC) – a member of our Member Services team – who thoroughly assesses Katy’s needs and makes each one a priority for immediate action or follow-up. After verifying Katy’s identity and eligibility, our CC creates a safe, judgement-free space for Katy to voice her concerns and needs. Through **active listening and empathetic responses**, the CC recognizes that Katy has an acute medical issue that needs attention, that she hasn’t seen a doctor in approximately six (6) years, and she was frightened by her recent dizzy spell that landed her in the urgent care center and the mention of “diabetes” by the provider.

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The CC is also aware that engaging with the health care system for the first time in her (near) adult life can be overwhelming and it will be easy for Katy to return to old habits if she isn’t engaged in a way that works for her. Hearing the sympathy in the CC’s voice for what she experiences, the praise the CC gives her for taking the first step, and the promise that the CC can help connect her to the care she needs, **puts Katy at ease**. To **build trust**, the CC knows that an **early ‘win’ with Katy** is needed to show that together they can make progress, so the CC quickly moves to addressing her first ask, which is to find a primary care provider (PCP) as the urgent care provider had requested.

## Identifying a Primary Care Provider (PCP) and Scheduling an Appointment

Our CC confirms her current address and phone numbers and finds that Katy has moved to another address. The CCH also adds Katy’s mother as her additional contact/support person. Within the Identifi™ platform, the CC is able to see that Passport’s Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) team had attempted to outreach to Katy’s mother (using the old phone number) to confirm Katy received her well-child exams. The CC also confirms that she does have an assigned PCP, Dr. John Smith, that her mother likely chose on enrollment, but realizes that his office is quite far from her current home. Katy also indicates that she would prefer a female doctor. Our CC quickly identifies a female PCP nearby who is accepting new patients. With Katy on the line, the CC conferences in the **PCP office to schedule an appointment** in one week that works with Katy’s class and home schedule. After disconnecting with the

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provider office, our CC confirms with Katy that she has reliable transportation to attend her PCP visit and there are no other barriers to her keeping her appointment. Our CC documents these changes and makes notes in the Identifi™ platform to ensure the information can be shared with anyone who is part of Katy's care team.

Once the PCP visit is scheduled, our CC can hear the anxiety in Katy's voice begin to diminish. The CC takes this as an opportunity to more deeply assess the other aspects of her health through Passport's **Health Risk Assessment (HRA)**, a Medicaid-specific tool specifically designed to determine the following:

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- Demographic information including current contact information, culture, race, ethnicity, education level, language preferences and living arrangements
- Physical health status regarding activity levels, use of assistive devices and assistance with daily living activities
- Medical history addressing diagnosed chronic conditions, medication use, dental care, and any recent emergency room visits
- Behavioral health status for identification of behavioral health conditions (i.e., bipolar disorder, schizophrenia, depression, and anxiety) and medication use
- Lifestyle conditions regarding a history of smoking, alcohol use or substance abuse
- Barriers to health including safety, accessing medications, getting to doctor appointments and the ability to manage personal finances
- Social determinants of health – food, housing, clothing, employment, and transportation needs

Katy is pleased to hear that she will **receive a \$15 gift card** in the mail for completing the HRA today and makes sure to answer the questions as accurately and completely as possible. Our CC listens carefully to ensure that he clearly documents all of Katy's responses are clearly documented and starts to gather appropriate next steps. While the CC realizes that Katy does not have a documented diagnosis of diabetes, her current symptoms, recent urgent care visit, and poor eating habits, make her a good candidate for Passport's Condition Care program. The CC explains that there is an

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**evidenced-based care management** program specifically designed for her that focuses on **health education, self-management support, and care coordination**, all in close collaboration with her PCP. Katy is intrigued and wants to learn more about the program. The CC offers to conference in a member of the care management team, but Katy must get started on her homework so they pick a time tomorrow that a Condition Care Health Coach can follow up with her. Our CC sends an action item through Identifi™ to our Care team to ensure a member of the care team follows up with Katy at the specified time.

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Before ending the call, the CC lets Katy know to watch for a new member ID card in the mail with her new PCP listed and makes sure she knows that the Passport contact phone numbers for the Call Center and the 24/7 Nurse Advice line are on the back of her ID card, in case she has any questions or is feeling dizzy again especially before her upcoming PCP visit. The CC also mentions the Passport enrollee website and online

member handbook and offers to mail her a hard copy that provides information on access and coverage for medical visits and medications to support her healthcare needs.

## Engaging Katy In Our Condition Care Diabetes Program

A Health Coach (HC) from our Condition Care program receives the alert to follow-up with Katy. Prior to reaching out to her at the agreed upon time, the HC accesses Identifi™ to review Katy’s information (including her new PCP), her responses to the HRA, and the CC’s case notes, which include her upcoming PCP visit and her concern around a future diagnosis of diabetes. The HC determines that Katy is likely a good candidate for our evidence-based diabetes care management program that also addresses pre-diabetes. The HC determines Katy’s specific care gaps, including a few immunizations, and gathers pre-diabetes-specific educational materials to share when Katy is ready.

At the scheduled time, Katy receives a call from our HC, who mentions the CC by name (to show continuity) and explains that the HC is a health coach whose job is to **help Katy understand her medical issues and symptoms, help her overcome barriers to good care, and help her feel better**. The HC explains the role of the care teams at Passport, and how the HC will coordinate with Katy’s PCP so that everyone is working together to help Katy meet her goals. Katy agrees to enroll in the program and the HC completes the informed consent process.

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## Comprehensive Assessment and Personalized Goal Setting

The HC reviews his/her understanding of Katy’s case – Katy is glad that she doesn’t have to repeat her story and HRA responses. As she’s doing so, the HC is asking more detailed questions to **further assess her physical, behavioral (including a Patient Health Questionnaire-2 (PHQ-2) screening for depression), social, environmental, and nutritional needs**. Through this comprehensive assessment, the HC identifies the following areas of focus: increasing activity levels, access to healthy foods, and assessing her home environment as a barrier to good self-care. Through **Motivational Interviewing and other evidence-based techniques**, the HC elicits a few personalized goals from Katy that are meaningful, yet attainable changes. For example, it’s hard for Katy to go to a gym because when she’s not in class, she is watching her little brother. So together, Katy and her HC agree that she will park on the other side of campus and walk to her classes for the next week and then check back in to see how she felt.

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The HC follows up with Katy the next week to hear that Katy met her goal of walking across campus to class and feels great about it. The HC encourages her to do it again this week and mentions that every 3rd Tuesday of the month is ‘Tasty Tuesday’ at her **local YMCA during which they hold FREE cooking classes** where everyone may participate in preparing, cooking, and eating healthy foods. The HC offers a waiver for Katy and her little brother who can come with her and play basketball while she is taking the class. Katy has never really cooked much before but is willing to try it. During the conversation, Katy admits that she is nervous about her PCP visit the following day. She has never gone to the doctor alone before and is not sure what to expect from an adult clinic.

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The HC walks her through what to expect and lets her know there will be paperwork to fill out and questions to answer, similar to the questions she answered during their initial call. The HC also offers to have one of Passport’s Community Health Workers meet her at the office to help with whatever she needs. While Katy declines the offer, she does agree to the HC calling the practice in advance to share any relevant details. The HC **calls the PCP office** to let them know that Katy is coming in the next day and is feeling a little overwhelmed. She also **shares the relevant components of Katy’s history** and lets the practice manager know that she will be following up after the visit to see how it went.

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## Collaborating with Our Providers on an Integrated Care Plan

After Katy’s PCP appointment, her HC follows up to understand the **PCP’s clinical assessment of Katy and the recommended treatment plan**. The PCP feels that she is pre-diabetic, but that both her pre-diabetes and high blood pressure can be turned around if she truly engages in an aggressive low salt, healthier whole food diet and exercise regimen. It will be a big lifestyle change, but the alternatives are medications and a definitive diagnosis of diabetes. The PCP asks for help in to getting her going and helping her stick with it. The PCP will follow up with Katy in 3 and 6 months to see how she is tracking.

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At her next check-in with Katy, the HC hears a similar message – Katy is ready to make a change but doesn’t know exactly how to get started. The HC assures her that she already has begun by walking to class and attending the cooking class at the YMCA (which she really enjoyed!). The HC is encouraged by Katy’s early self-motivation but understands that without initial intense education, intervention, and regular follow up, Katy is unlikely to make the necessary changes needed to prevent a diagnosis of diabetes.

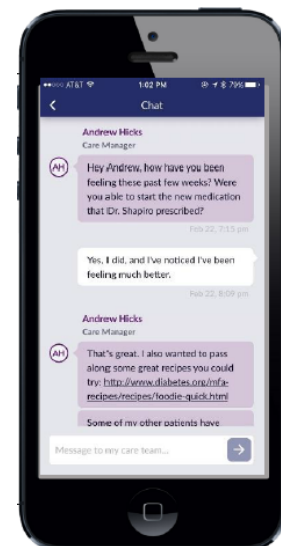
Together, they **update Katy’s care plan** with the following components:

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- Consultation with a registered dietitian to help Katy build on her enjoyment of the cooking class through heart healthy, low sodium recipes and answer questions about how food choices impact her symptoms
- Daily food journal to document eating intake, types of foods, exercise duration and activity, and weekly vitals including weight and blood pressure
- Weekly coaching check-ins for one month (1) moving to every other week for three (3) months to review her journal, solve problems or barriers, and log vitals, which are shared with her PCP
- Community engagement to support weight loss and nutritional support

### Exhibit C.29-2. Identifi<sup>SM</sup> Engage

Katy prefers texting so to facilitate communication, her HC sets her up on Identifi<sup>SM</sup> Engage, Passport’s mobile application that support bi-directional communication through a chat function (see **Exhibit C.39-2**). In addition,



connecting Katy with local resources to support these goals is critical to her success in achieving improved health and quality of life.

## Partnering with Our Communities to Ensure Sustainability

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Passport is deeply embedded within our communities with literally thousands of interactions that have taken place in local counties, cities, and townships to address the full spectrum of health and wellness. In addition to leveraging Passport’s established partnerships across the state, our HC can use our online social service directory that consists of thoroughly vetted local resources that offer the most reliable services to our members. Using this tool, the HC identifies the following local resources for Katy in eastern Kentucky:

- **Pikeville YMCA:** Katy goes back to the YMCA for Tasty Tuesdays and meets a friend who is also trying to lose weight and eat better. They agree to try YMCA group Zumba classes together. The HC arranges for a highly discounted membership based on her Medicaid and student status.
- **Farmacy:** Passport joined a unique local movement through provider group Mountain Comprehensive Health Corporation and local community partners in Eastern Kentucky to implement an innovative program called Farmacy. With Farmacy, members diagnosed with diabetes, obesity, and/or hypertension (and falling below 100% of the Federal Poverty Guidelines) can receive a prescription from their doctor for fresh fruits and vegetables.

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The HC also takes time to understand the cultural dynamics of Katy’s household and understands the sense of obligation Katy feels to her mother and brother that often result in putting her own health last on her list or priorities. The HC introduces her to several options for childcare that she can share with her mother to create opportunities for Katy to focus on her health. Passport adheres to the national culturally and linguistically appropriate services (CLAS) standards for cultural competence in Health Care settings, and Passport’s Diversity and Inclusion team are available for consultation with the HCC if he/she needs to better understand factors specific to Katy’s situation.

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## Monitoring Katy’s Progress to Successfully Graduate from Our Program

While we understand that not all members can successfully graduate from care management, we strive to empower our members to achieve their personalized and program goals within a specified time frame. Prior to graduation, we ensure Katy’s PCP is informed on her progress and needs to ensure continuity of care and after graduation, we monitor Katy’s progress and if needed, will offer her a “booster” to get back on track.

## Continuity of Care Through Continual Provider Engagement

Our HC actively coaches and monitors Katy for four (4) months. The goal of the sessions is for **Katy to teach back the information shared in each meeting** and verbalize the effect of the information on her weight loss goals. Successful completion of the program is demonstrated by the Katy’s dedication to making healthier decisions in her diet and exercise habits. The sessions also address any questions, concerns, or new barriers Katy is experiencing related to her healthcare needs. **The outcomes of these sessions are regularly communicated to her PCP** along with her post-graduation symptom response plan. Katy also sees her PCP upon completion of the program to have her weight, blood pressure and blood sugar checked. The PCP also suggests Katy seek routine dental care. Katy calls our Member

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Services team using the 1-800 number on her Passport ID to better understand her dental benefits and schedule an appointment.

### Active Monitoring of Katy Through Data Analytics and Quality Reporting

After Katy successfully graduates from the program, Passport has several systems and processes in place to **monitor needs and prompt outreach** to Katy if she needs additional support:

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- **Risk Stratification:** Now that Katy has been an active participant in our care program, any unplanned utilization or out-of-range lab values will trigger a re-stratification into our program
- **Primary Care Engagement:** Administrative data is continuously to identify whether Katy is staying engaged with her PCP through regular appointments
- **Quality Care Gaps:** Standard quality gaps (e.g., well visits or screenings) are continuously reported to our PCPs so that they can reach out to Katy when she needs preventive care.

At Passport we recognize the importance of the member in this case study who reaches out to us for help and who isn't actively engaged in the provider health care system. We understand that this unique responsibility and opportunity falls to us, and we are committed to identifying those members and providing high quality care and services to support them in their journey to better health.