# Passport Advantage
# Provider Manual
# Section 8.0
# Additional Benefits and Programs

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# 8.0 Additional Benefits and Programs

## 8.1 Special Programs

Passport Advantage has several programs, each of which works with members with special health care needs to improve members' access and use of all available health care services.

Passport Advantage's Model of Care (MOC) promotes care coordination of both the physical and behavioral health needs of our members. Passport Advantage utilizes the talents and knowledge of our associates (professional and non-professional), as well as those of our providers within the community to provide an interdisciplinary team approach for our members in order to deliver the highest quality of healthcare. This interdisciplinary team includes (but is not limited to) a board-certified medical director, director of medical management, care coordinator/case managers, licensed clinical social workers, and outreach staff in conjunction with the member, his or her Provider of Choice, specialists, community resources, and/or caregiver(s).

Within our MOC, the Plan has Utilization Management, Complex and Special Needs Case Management, Behavioral Health Care Coordination, Transition Triage Team, targeted disease management programs, and health and wellness initiatives. Care management supports improvement in the member's physical and behavioral health status through improved independence and self management, improved mobility and functional status, improved pain management, improved quality of life perception, and/or improved satisfaction with health status and healthcare services.

Initial welcome calls and an outreach for completion of Health Risk Assessments (HRA) are performed upon identification of a new member. Components of the HRA include review of the medical, functional, cognitive and psychosocial status of the member. Following completion of the initial HRA, the Triage Team review and refers members to the appropriate care coordination team.

An individualized plan of care is developed based on the member's identified needs. The care plan is developed in conjunction with the member, member's support system, Provider of Choice and specialist as feasible. Members are also identified for program inclusion based on targeted diagnoses, pharmacy and medical claim data. To supplement these activities, a predictive modeling tool is utilized on a monthly basis.

Updates to the plan of care and referrals to a care coordination team will be made based on this activity as well. Each member's plan of care and HRA are reviewed and updated at a minimum of annually.

Upon discharge from a care coordination team, a satisfaction survey and a quality of life survey are sent to the member. Survey results are reviewed, analyzed and reported on a quarterly basis to the Quality Medical Management Committee.

Passport Advantage's Transition Triage Team manages transitions of care from setting to setting, provider to provider and provider to facility. The goal of the team is to facilitate smooth transitions between each care setting, facility and provider. The Plan utilizes an integrated approach for tracking and trending, analyzing and reporting of both planned and unplanned transitions of care.

## 8.1.0 Care Coordination Program

## 8.1.1 Introduction

Care Coordination assists members in obtaining and coordinating needed medical and social services. The Care Coordinator, who is either a Registered Nurse or a Social Worker, contacts members and performs an assessment to identify specific needs. The Care Coordinator then creates a plan that works in conjunction with the medical plan and the member. The member's Provider of Choice receives a copy of the goals of the care coordination plan along with the name and telephone number of the assigned Care Coordinator. Providers may contact the Care Coordinator with any questions or concerns.

## 8.1.2 Target Population

Members who may benefit from care coordination are those with ongoing complex medical and/or psychosocial needs. The following is a list of reasons for which members may warrant care coordination; however, these are not all-inclusive. Members may qualify for care coordination if they:

- need ongoing rehab services
- have spinal cord or brain injury
- have had a recent cerebral vascular accident
- are candidates for an organ or bone marrow transplant
- are HIV+ or have AIDS
- have pain management issues
- need extensive and persistent wound care
- have frequent hospitalizations or emergency room visits
- have complex psychosocial issues

## 8.1.3 How to Request Care Coordination Services

Providers, as well as members and other interested parties, may request care coordination. Providers may contact the Care Coordination department at (800) 578-0636, ext. 7915 or (502) 585-7915. (If the provider would like to speak with the Care Coordinator once the member is assigned, the provider should notify the intake coordinator of this when he/she makes a care coordination request.)

Members with complex medical or psychosocial needs may be identified at the time of the health risk assessment or may be referred to care coordination by their Provider of Choice, a specialist, the Member Services department, the Utilization Management department, a medical director, or through self-referral. At that time the member will be enrolled in Care Coordination. The member has the right to decline any or all parts of the program.

### 8.1.4 Behavioral Health Care Coordination

The Passport Advantage Behavioral Health Care Coordination (BHCC) Program is designed to improve the health status and quality of life of Passport Advantage members with behavioral health conditions while decreasing unnecessary hospitalizations and emergency room visits by improving member self-management skills and by increasing provider adherence with Passport Advantage's Clinical Practice Guidelines, which are based on current scientific data. Care coordination is aimed at proactively assisting members who have experienced an event or new diagnosis needing assistance navigating the behavioral health care system.

Behavioral Health Care Coordination processes support improvement in beneficiary behavioral health status through improved:

- Independence and self management;
- Mobility and functional status;
- Improved pain management;
- Quality of life perception; and
- Satisfaction with health status and healthcare services.

The goal of the Passport Advantage BHCC Program is to:

- Proactively identify members with the need for behavioral care coordination;
- Promote appropriate interventions and alternatives as behavioral health care services are rendered;
- Manage utilization of behavioral health care services in the most appropriate and cost effective manner that maintain high quality outcomes.
- Monitor, evaluate and optimize the use of behavioral health care resources;
- Promote collaborative practice among all disciplines to assure continuity of care and high quality services;
- Improve the health status and quality of life of members as evidenced by member scores and comments in the satisfaction survey;
- Improve member self-management and self-advocacy; and,
- Identify events and patterns of care in which outcomes may be improved through efficiencies in behavioral health care coordination, and institute actions to improve performance.

## 8.2 Health and Disease Management Programs

### 8.2.1 Introduction

As general health care focuses more on preventive care, Passport Advantage is working with providers to help keep our members healthy. One way to do this is through health management programs. Ideally, these programs prevent or decrease exacerbation of an illness by a comprehensive, integrated approach to care. Passport Advantage health management programs include the Diabetes Disease Management Program, Chronic Obstructive Pulmonary Disease (COPD) Management Program and, the Coronary Artery Disease (CAD) Management Program. Providers are informed about the programs through various methods, including the Provider Newsletter and office site-visits. Current program initiatives and contact information for the

Diabetes, COPD, and CAD Management Programs are available on the Member Center of our web site, www.passportadvantage.org.

## 8.2.2 Purpose of Programs

Each health management program strives to improve health outcomes for its participating members through program-specific provider and member interventions. These programs are intended to complement and assist the care given by the provider. Clinical and non-clinical interventions are based on well established and professionally recognized guidelines. Clinical guidelines are specific to each program and are updated at least every two years and when new scientific evidence or national standards are published. Guidelines are available in the Provider Manual, located on the Provider Center of the Passport Advantage web site, www.passportadvantage.org.

## 8.2.3 Evaluation of Programs

The objectives, activities, and outcomes of each health management program are continually evaluated and measured against national standards. Updates and revisions are made as needed. The programs are reviewed at least annually, with reviews consisting of:

- evaluating the overall effectiveness of the programs;
- exploring and removing barriers to and limitations of the programs; and
- revising areas as needed to improve effectiveness of the programs.

## 8.2.4 Diabetes Disease Management Program

### 8.2.4.1 Diabetes Disease Management Program - Objective

The objectives of the Diabetes Disease Management Program are to improve the health status and decrease complications of adult members with diabetes through improved member and practitioner compliance with the American Diabetes Association (ADA) standards of care by:

- Increasing practitioner adherence to American Diabetes Association (ADA) Guidelines regarding HbA1c testing, LDL-C testing and results, nephropathy monitoring, dilated retinal exams (DRE), blood pressure control; and,
- Increasing member compliance with ADA guidelines regarding HbA1c testing, LDL-C testing, nephropathy monitoring, DREs, and blood pressure treatment.

### 8.2.4.2 Member Identification

All Plan members 18 years of age and older with a diagnosis of diabetes or gestational diabetes are eligible for the program, regardless of length of enrollment. Members are identified for the program through:

- Data collected through the Utilization Management (UM) process. Examples include, but are not limited to, hospital census report, pre-certification data, Health Risk Assessment (HRA), claims, pharmacy data, and concurrent review data;
- Referrals from other Passport Advantage departments. Examples include, but are not limited to, Case Management, Member Services, and other disease managers;
- Referrals from providers; and

- Self-referrals from members.

### 8.2.4.3 Diabetes Disease Management Program - Member Interventions and Benefits

Diabetes is a complex condition with multiple comorbidities; therefore, actions are directed to multiple areas. In addition, the Plan's population often has unique behavioral and psychosocial areas of concern that must be addressed along with the medical condition(s). Specific member interventions and benefits may include the following:

- Educational mailings regarding diabetes self-management and related topics.
- Biannual postcard reminders to members who are delinquent in the recommended ADA testing based upon claims data.
- Telephonic outreach based on non-compliance with recommended ADA testing.
- Annual postcard reminders for members to get their flu/pneumonia vaccines.
- A disease specific assessment to complete and return to the Diabetes Disease Care Manager via mail, or it may be completed telephonically if the member chooses.
- Additional written and/or verbal diabetes related information based on their individual needs. This includes self-management counseling, resources and coorindation of care.
- Diabetes Disease Care Manager is available by telephone for questions and counseling on diabetes self-management and assistance with appointments, transportation and other coordination of care needs.
- For members identified as being high-risk or having an inpatient admission, a Diabetes Disease Care Manager initiates one-on-one phone contact with the member for diabetes education. The Diabetes Disease Care Manager:
  - Assesses the member's needs including a disease specific assessment and develops an individualized plan of care for the member.
  - Coordinates care with the practitioner involved in the member's care and ensures follow-up with a specialist, if appropriate.
  - Provides the member with additional written and/or verbal information targeted to the member's specific needs.
  - Arranges home health visit(s) for diabetes education and/or diabetes education classes as needed if the member and the practitioner agree to either of these interventions.
  - Maintains ongoing follow-up contact with the member to evaluate and revise the plan of care as needed.

### 8.2.4.4 Diabetes Disease Management Program - Assistance to Providers

The program works to assist the provider by:

- Educating providers about the Diabetes Disease Management Program and making available samples of the educational materials provided to members;
- Distributing Kentucky Diabetes Network (KDN) flow charts to providers' offices for their use in quality tracking of patient testing as recommended by the Passport Advantage Clinical Practice Guidelines, which are based on the ADA Standards of Care;
- Notifying providers of their members identified with diabetes and providing periodic updates of each member's status regarding ADA recommended testing, diabetic

medications, member's adherence to established treatment plan, and other related co-morbidities;
- Providing information from the Plan’s pharmacy benefits manager regarding member-specific prescribing patterns of diabetic agents and associated medications; and
- Providing Clinical Practice Guidelines based on the ADA Standards of Care (see Section 15).

## 8.2.5 Coronary Artery Disease (CAD) Management Program

### 8.2.5.1 CAD Management Program - Objective

The objective of the CAD Management Program is to improve the health status of adult members with CAD, while decreasing complications. Passport Advantage works toward this objective through improved member and provider compliance with American Heart Association and the American College of Cardiology Guidelines for Preventing Heart Attack and Death in Patients with Atherosclerotic Cardiovascular Disease by:

- increasing the provider and member adherence to screening of LDL levels for members with known coronary artery disease;
- increasing provider adherence to Passport Advantage CAD Guidelines regarding the use of appropriate lipid management treatment;
- increasing provider adherence to Passport Advantage CAD Guidelines regarding the use of lipid lowering medications in those members with known coronary artery disease;
- increasing provider adherence to Passport Advantage CAD Guidelines regarding the use of ACE inhibitors post myocardial infarction (M) in those members with known coronary artery disease;
- increasing provider adherence to Passport Advantage CAD Guidelines regarding beta-blocker use in all post MI and acute ischemic syndrome patients unless contraindicated;
- increasing member adherence to the use of lipid lowering and anti-hypertensive drug therapy;
- increasing member awareness of those risk factors that increase the risk of CAD; and
- promoting healthy lifestyles through diet and nutrition, weight loss, physical activity, and smoking cessation.

### 8.2.5.2 Member Identification

All Plan members 18 years of age* and older with a diagnosis of CAD are eligible for the program. Members are identified for the program through:

- hospital census report;
- referrals from other Passport Advantage departments;
- referrals from providers;
- self referrals from members;
- medical claims with diagnosis related to CAD; and/or
- Health Risk Assessment (HRA) form responses.

*Plan members under age 18 are referred to the Plan’s Case Management program.

### 8.2.5.3 CAD Management Program - Member Interventions and Benefits

Specific member benefits and interventions may include but are not limited to the following:

- Plan-wide interventions promoting healthy lifestyle via smoking cessation, physical activity, and nutrition;
- Members receive CAD related educational mailings at least quarterly;
- CAD Manager is available by phone for questions, counseling on CAD self-management and assistance with scheduling appointments, arranging transportation or other coordination of care needs; and
- Members also receive additional written and/or verbal CAD related information based on their individual needs. This includes self-management counseling, resources and coordination of care.

### 8.2.5.4 CAD Management Program - Assistance to Providers

The program works to assist providers by:

- Conducting provider outreach visits by the CAD Disease Manager;
- Educating providers about the CAD Management Program and making available samples of the educational materials provided to members;
- Informing providers through quarterly reports of their panel members eligible for the program, and the members' involvement in the program and members adherence to the established treatment plan including medication regimen; and
- Providing clinical practice guidelines based upon the American Heart Association and the American College of Cardiology Guidelines.
- For those members identified as high-risk or having an inpatient admission with a CAD related procedure, a CAD Care Manager initiates one-on-one phone contact with the member for CAD education. The CAD Care Manager:
    - Assesses the member's needs and develops an individualized plan of care with the member.
    - Coordinates care with the practitioners involved in the member's care and ensures follow-up with a specialist, if appropriate.
    - Provides the member with additional written and/or verbal information targeted to the member's specific needs.
    - Arranges home health visit(s) for CAD education and/or CAD education classes as needed if the member and the practitioner agree to either of these interventions.
    - Maintains ongoing follow-up contact with the member.

## 8.2.6 Chronic Obstructive Pulmonary Disease (COPD) Management Program

### 8.2.6.2 COPD Management Program - Objective

The objective of the COPD Management Program is to improve the health status of adult members, while decreasing complications. Passport Advantage works toward this objective through improved

member and provider compliance with the National Heart, Lung and Blood Institute standards of care by:

- increasing the use of Spirometry testing for new diagnosis and the newly active COPD to confirm the diagnosis;
- increasing provider adherence to the Passport Advantage COPD Clinical Practice Guidelines, based on Global Initiative for Chronic Obstructive Lung Disease Report (GOLD) from the National Institutes of Health and the National Heart, Lung and Blood Institute (NHLBI) guidelines regarding the use of bronchodilator medications;
- increasing provider adherence to GOLD guidelines regarding the use of inhaled glucocorticosteroid medications;
- increasing the administration of flu and pneumonia vaccinations to members; and
- promoting healthy lifestyles through exercising, avoiding cigarette smoke and other air pollutants, and eating well.

### 8.2.6.1 Member Identification

All Plan members 18 years of age and older with a diagnosis of COPD are eligible for the program. Members are identified for the program through:

- hospital census report;
- referrals from other Passport Advantage departments
- referrals from providers;
- self-referrals from members;
- pharmacy claims identifying members who received COPD-related prescriptions;
- medical claims with COPD diagnosis; and/or
- Health Risk Assessment (HRA) form responses.

### 8.2.6.3 COPD Management Program - Member Interventions and Benefits

Specific member benefits and interventions may include (but are not limited to) the following:

- availability of a COPD Disease Manager to answer members' questions concerning COPD self-management and to assist members with coordination of care between providers and specialists;
- mailing of quarterly disease specific educational materials, including information regarding peak flow, action plans, medications and, disease process;
- distribution of COPD Program action plans;
- dissemination of member self-management educational materials, including self-instruction video, through high volume provider offices;
- mailings of annual postcard reminders for flu/pneumonia vaccines;
- telephone calls from a COPD Disease Manager to assess needs, develop plan of care, and evaluate effectiveness when needed;
- telephone or in-person member contact to evaluate and revise care plan as needed;
- coordination with the behavioral health care coordinator for psychosocial needs/concerns as needed;

- distribution of educational materials to individual members specific to identified medical or social needs; and
- home visits by a trained home health nurse for environmental assessment, as needed.

### 8.2.6.4 COPD Management Program - Assistance to Providers

The program works to assist providers by:

- educating providers about the COPD Management Program and making available samples of the educational materials provided to members;
- informing providers through quarterly reports of their members eligible for the program, and members' involvement in the program, the members' adherence to established treatment plan including medication regimen, flu and pneumonia vaccines; and
- providing clinical practice guidelines from the GOLD (Global Initiative for Chronic Obstructive Lung Disease) Report from the National Institutes of Health and the National Heart, Lung and Blood Institute (NHLBI). COPD Guidelines are updated and distributed to providers at least every two years.

## 8.2.7 Smoking Cessation Program Yes, You Can!

### 8.2.7.1 Yes, You Can! Smoking Cessation Program - Objectives

- To reduce the health risks and illnesses associated with tobacco use and secondhand smoke.
- To reduce preventable and premature deaths attributed to tobacco use.
- To decrease the risk for lung and other types of cancer.
- To provide support to members who desire to quit by assisting them in becoming and remaining smoke-free.

### 8.2.7.2 Yes, You Can! Smoking Cessation Program – Member Identification

Eligibility criteria for the program include all members who meet the following selection criteria:

- Members age 18 years of age or older;
- Members who are not pregnant; and
- Members who are currently enrolled in Passport Health Plan.

Members are also referred from the following sources:

- Referrals from other Passport Health Plan departments (including but not limited to: Case Management, Member Services, and other disease management programs);
- Referrals from providers;
- Self-referrals from members;
- Referrals from hospital asthma educators; and
- Data collected through the Personal Information Form (PIF).

### 8.2.7.3 Yes, You Can! Smoking Cessation Program - Member Interventions

- Participation is voluntary and the member has the right to decline the program.
- Readiness assessment is completed.
- Brief current health assessment including medications is completed.
- Member signs a contract agreement to be available for program outreach.
- Provider is contacted to agree with the member entering the program and to prescribe the covered nicotine replacement or smoking cessation medication.
- Weekly telephonic support during the initial phase of the program.
- Educational material regarding smoking cessation with monthly targeted mailings to offer support and assistance in smoking cessation.
- Information of available smoking cessation resources.
- Contact information for their assigned smoking cessation care manager.

### 8.2.7.4 Yes, You Can! Smoking Cessation Program - Provider Interventions

All providers of identified program members are contacted telephonically at the initiation of the program to determine agreement with prescribing pharmaceuticals for nicotine replacement and/or cessation product and behavioral support of the member.

All providers treating identified program members receive monthly reports detailing their members that include the following:

- Compliance with the established treatment plan, attendance at cessation support programs, and refills of nicotine replacement and/or cessation products; and
- Summary information regarding member outcomes. Did the member complete the 12 week program and remain smoke free for 6, 9, and 12 months.