

**UNIVERSITY OF KENTUCKY**  
*Kentucky Homeplace*

**January 1, 2015-March 31, 2015**

**Quarterly Report**



*Photo by: Tina Fields*

**Kentucky Homeplace**  
<http://www.kyruralhealth.org/homeplace>

*Funding for this program is made possible in part by the Cabinet for Health and Family Services.*



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# Kentucky Homeplace

My Fellow Kentuckians:

Kentucky Homeplace emphasizes education for clients on chronic disease management, healthier lifestyles and stressing preventative care. Kentucky Homeplace recently underwent a revision of the program activities. The focus is now on health coaching and care coordination of our clients to improve the overall health of the people of the commonwealth. Our database was revised effective December 1<sup>st</sup>, 2014 to reflect this change with a focus on care coordination in addition to number of services, service values and medication values. Our goal is to assist clients to maintain the best health possible by assisting them while they navigate the often complicated healthcare system. Core physical measures (height, weight, blood pressure, A1C and random glucose levels) are now being collected and clients are provided education on their particular disease process or illness. The following pages of data collected during this quarter provide a summary of the activities of CHWs and also collective information on the health status of our clients.

## *Quarterly Summary*

For the period January 5, 2015-March 31, 2015 the number of Community Health Worker hours per activity were as follows: Agency contact **3,559** hours, Care Coordination **1,850** hours, Non-client time **1,807** hours, Homeplace enrollment **1,685** hours, Education of clients **965** hours, Follow-up **954** hours and travel was **116** hours. Total CHW hours equal **10,937** hours with a service value of **\$274,312**. (Exempt from this service value total is medical equipment and other goods or items obtained for clients by Kentucky Homeplace). The amount of medications accessed total **\$1,021,254** for a combined total of **\$1,295,566**.

The entire quarterly report is posted on the UK Center of Excellence in Rural Health's web page at <http://kyruralhealth.org/homeplace>. The report is found under the Reports tab, Quarterly Reports and then click on January-March 2015. If you wish to have a printed copy, please call 1-855-859-2374 or email me at [mace.baker@uky.edu](mailto:mace.baker@uky.edu).

Sincerely,

*William Mace Baker*

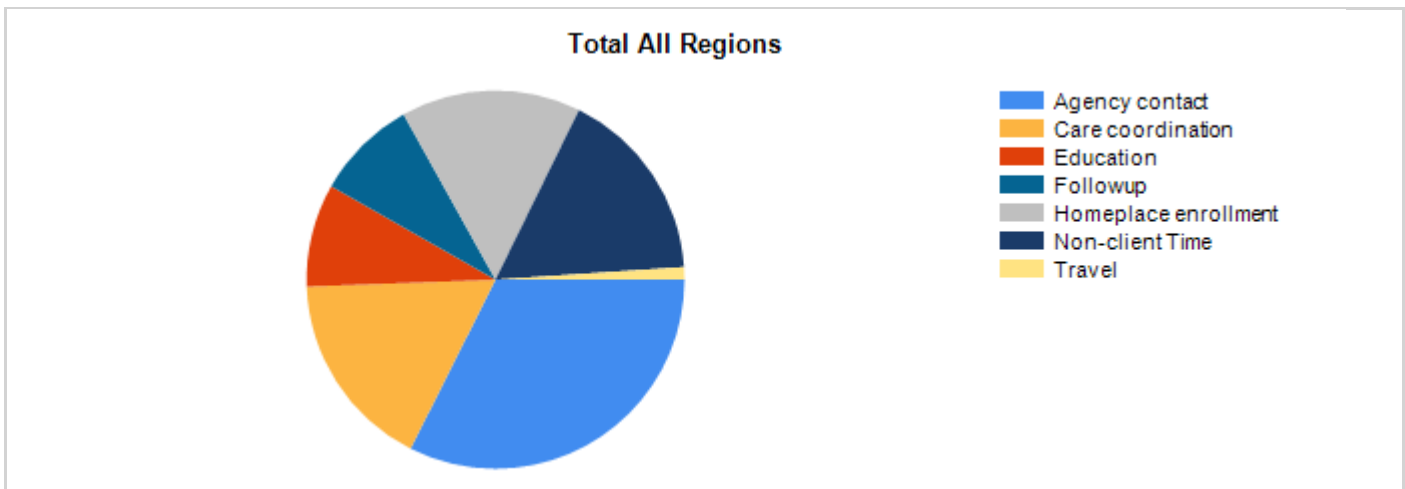
William Mace Baker, RN  
Director, Kentucky Homeplace Program



## Activity Summary

(Clients visited: 01/01/2015-03/31/15)

Activity	CHW Hours
Agency contact	3,559.65
Care coordination	1,850.43
Non-client Time	1,807.08
Homeplace enrollment	1,684.75
Education	964.85
Followup	954.33
Travel	116.40
<b>Grand Total:</b>	<b>10,937.49</b>

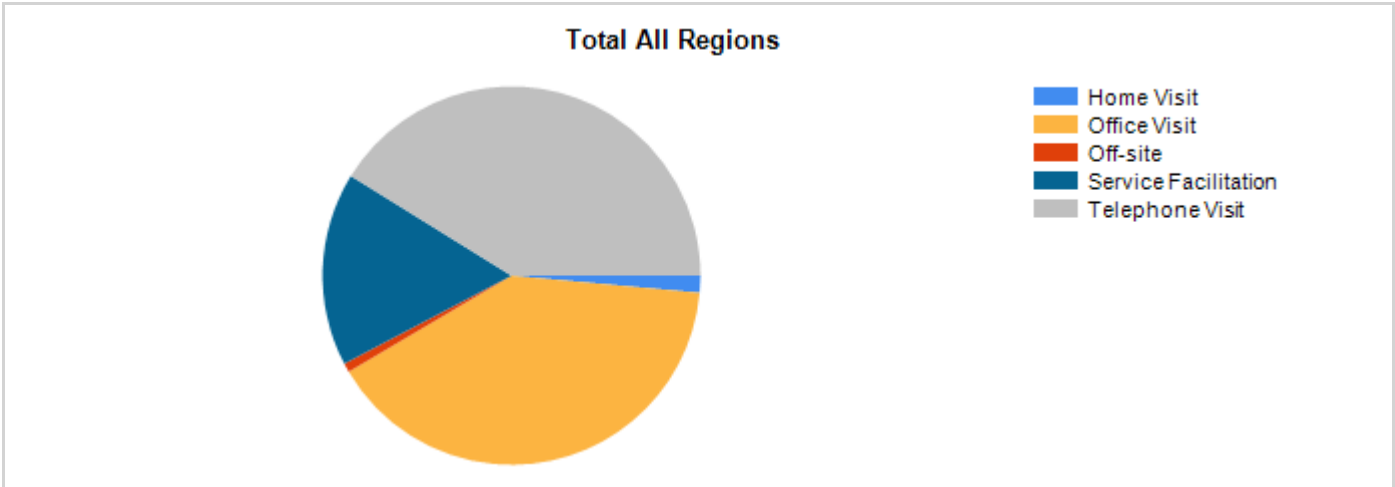


**Total service value for 10,937 hours equals \$274,312.**

## Visit Summary

(Clients visited: 01/01/15-03/31/15)

Visit Type	Client Visits
Telephone Visit	1,170
Office Visit	1,139
Service Facilitation	470
Home Visit	41
Off-site	22
<b>Grand Total:</b>	<b>2,842</b>

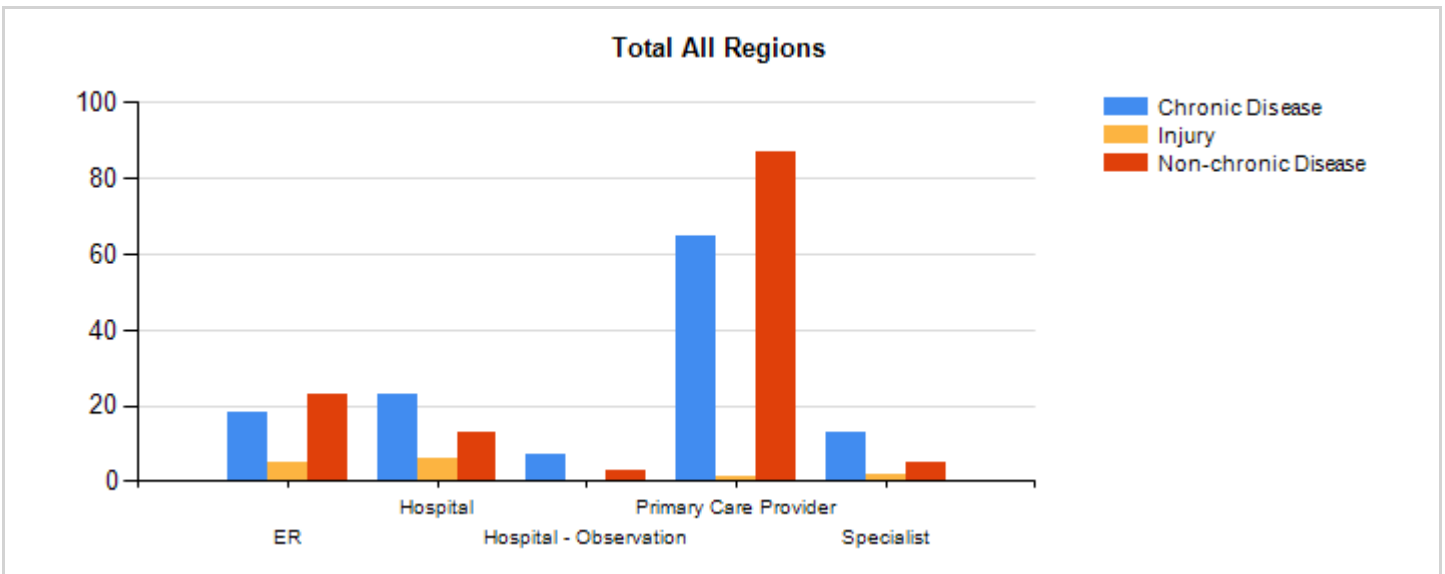


\*Due to inclement weather travel was limited during this quarter.

# Hospital-ER Summary

(Clients visited: 01/01/15-03/31/15)

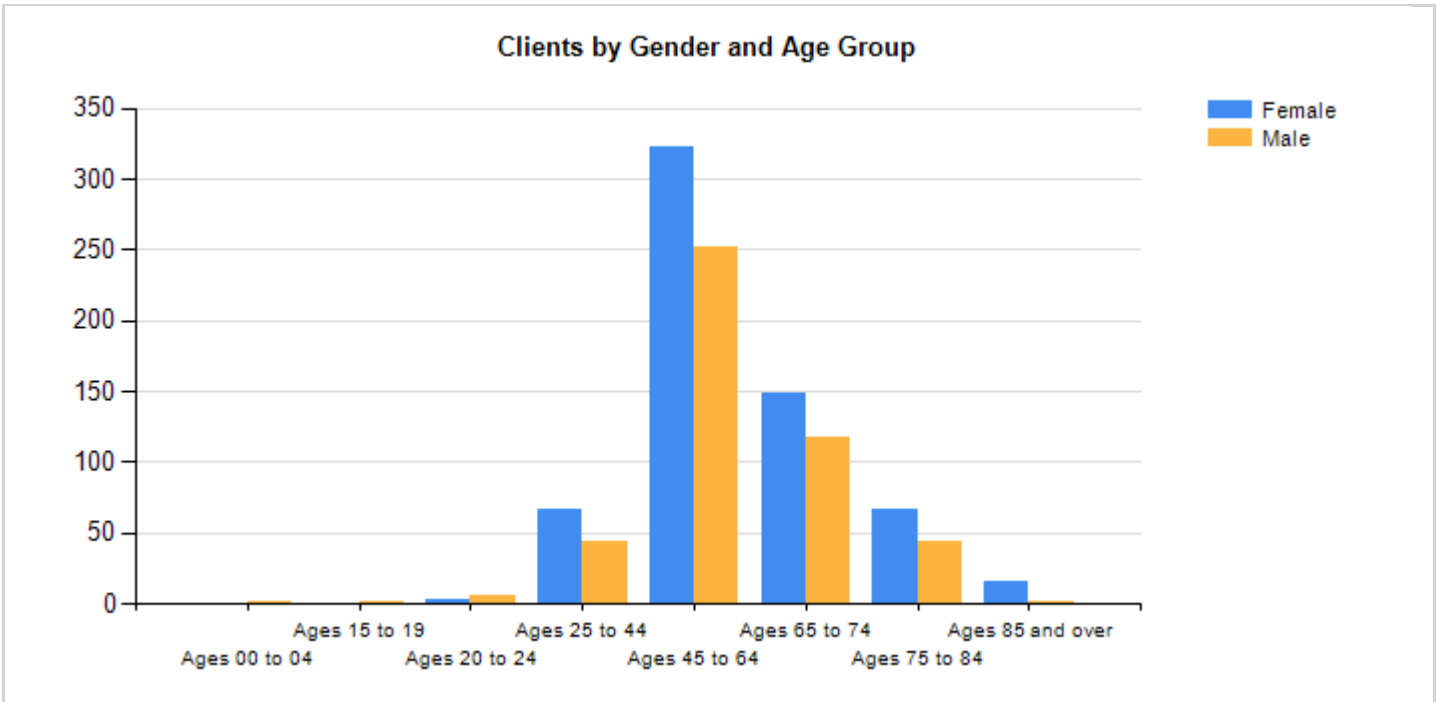
Episode Type	Reason	Episodes	Days Stay
ER	Chronic Disease	18	0
ER	Injury	5	0
ER	Non-chronic Disease	23	0
Hospital	Chronic Disease	23	145
Hospital	Injury	6	15
Hospital	Non-chronic Disease	13	65
Hospital - Observation	Chronic Disease	7	0
Hospital - Observation	Non-chronic Disease	3	0
Primary Care Provider	Chronic Disease	65	0
Primary Care Provider	Injury	1	0
Primary Care Provider	Non-chronic Disease	87	0
Specialist	Chronic Disease	13	0
Specialist	Injury	2	0
Specialist	Non-chronic Disease	5	0
<b>Grand Total:</b>		<b>271</b>	<b>225</b>



## Age Gender Summary

(Clients visited: 01/01/15-03/31/15)

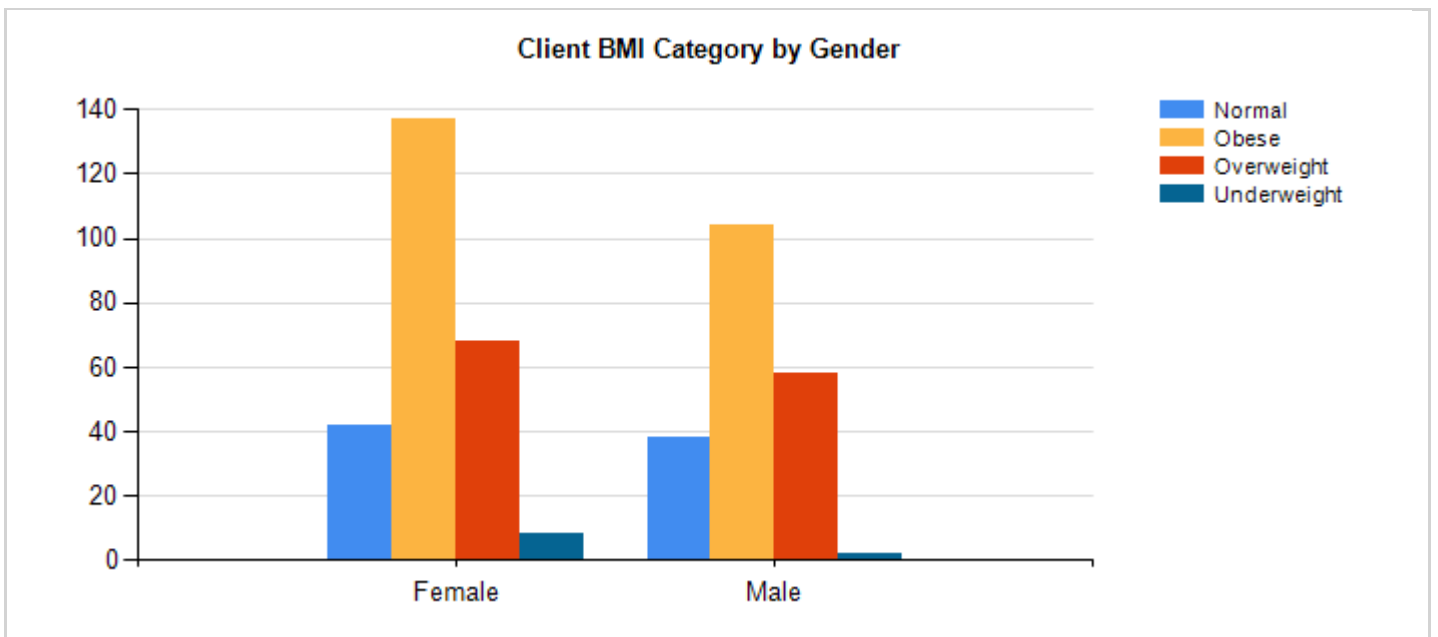
Age Group	Female	Male
Ages 00 to 04	0	1
Ages 15 to 19	0	1
Ages 20 to 24	3	6
Ages 25 to 44	66	44
Ages 45 to 64	322	252
Ages 65 to 74	148	117
Ages 75 to 84	67	44
Ages 85 and over	15	2
<b>Totals</b>	<b>621</b>	<b>467</b>
<b>Median Age</b>	<b>60</b>	<b>60</b>



## BMI Category Summary

(Clients visited: 01/01/15-03/31/15)

Gender	BMI Category	Clients
Female	Normal	42
	Obese	137
	Overweight	68
	Underweight	8
	<b>Total:</b>	<b>255</b>
Male	Normal	38
	Obese	104
	Overweight	58
	Underweight	2
	<b>Total:</b>	<b>202</b>
	<b>Grand Total:</b>	<b>457</b>

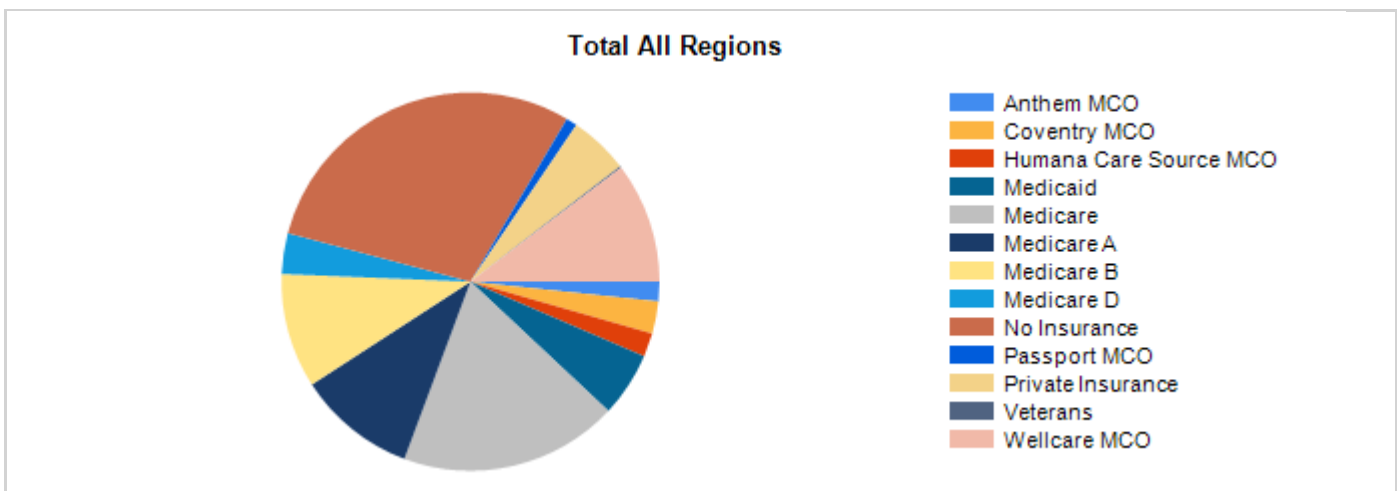




## Insurance Summary

(Clients visited: 01/01/15-03/31/15)

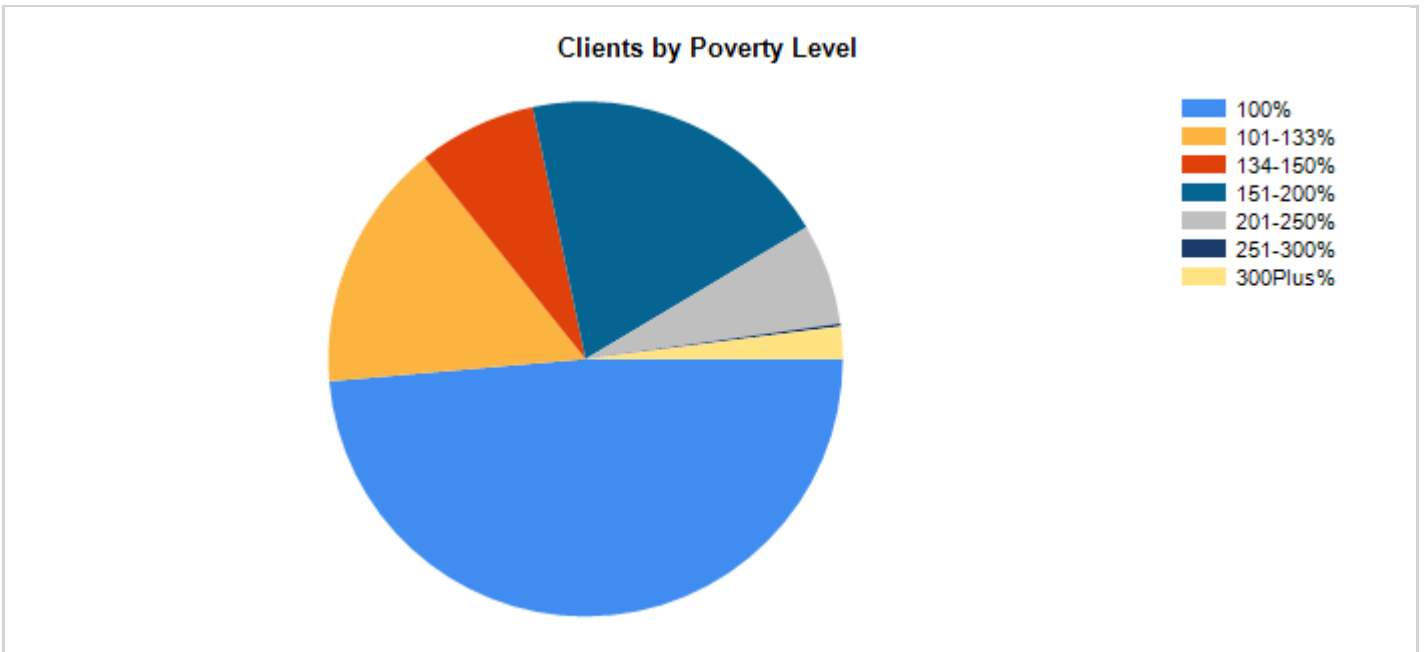
Insurance Type	Clients
No Insurance	405
Medicare	258
Wellcare MCO	142
Medicare A	140
Medicare B	135
Medicaid	76
Private Insurance	70
Medicare D	48
Coventry MCO	38
Humana Care Source MCO	28
Anthem MCO	23
Passport MCO	13
Veterans	2
<b>Grand Total:</b>	<b>1,378</b>



## Poverty Level Summary

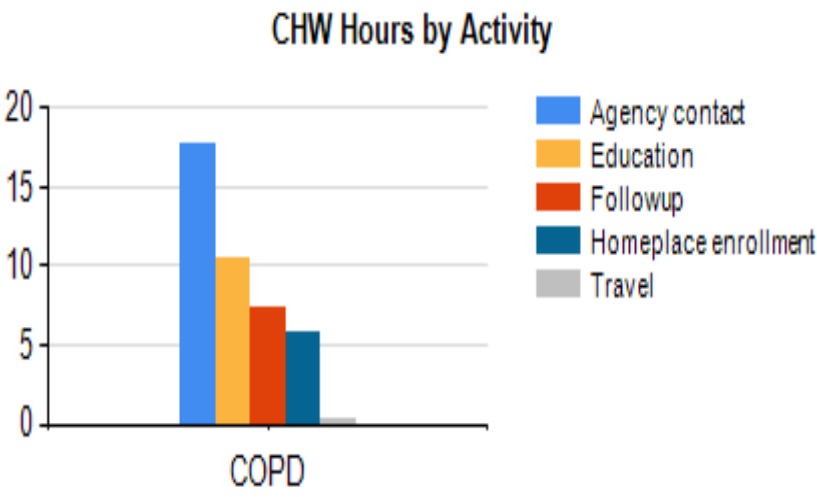
(Clients visited: 01/01/15-03/31/15)

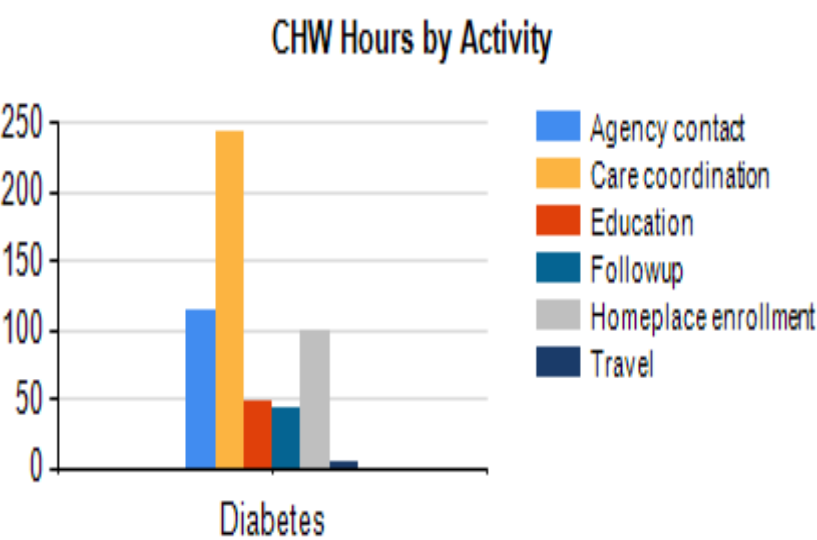
	100%	101-133%	134-150%	151-200%	201-250%	251-300%	300Plus%	Total
Clients	529	170	81	215	69	2	22	1,088



## Need Activity Summary-Disease

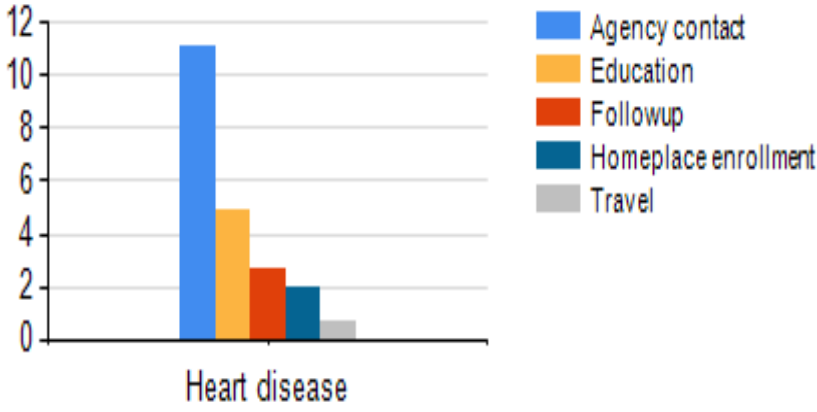
(Clients visited: 01/01/15-03/31/15)

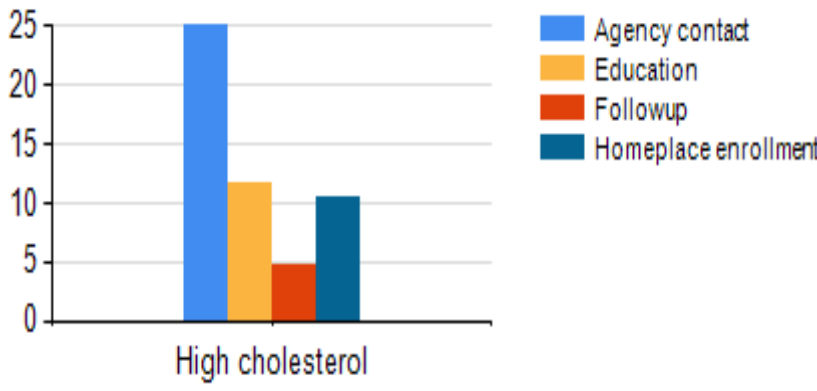
Need	Activity	CHW Hours
 <p>CHW Hours by Activity</p>	Agency contact	17.72
	Education	10.53
	Followup	7.33
	Homeplace enrollment	5.83
	Travel	0.25
	<b>Total:</b>	<b>41.66</b>

Need	Activity	CHW Hours
 <p>CHW Hours by Activity</p>	Care coordination	242.57
	Agency contact	114.68
	Homeplace enrollment	99.37
	Education	47.30
	Followup	42.32
	Travel	3.08
	<b>Total:</b>	<b>549.32</b>

## Need Activity Summary-Disease

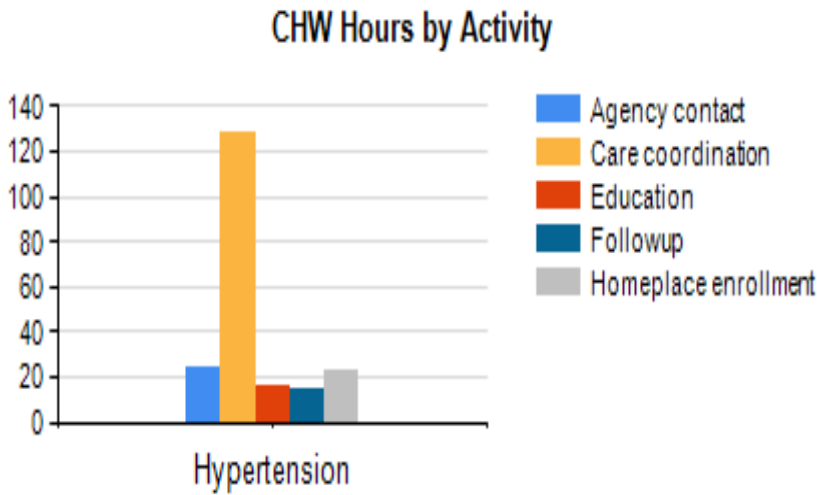
(Clients visited: 01/01/15-03/31/15)

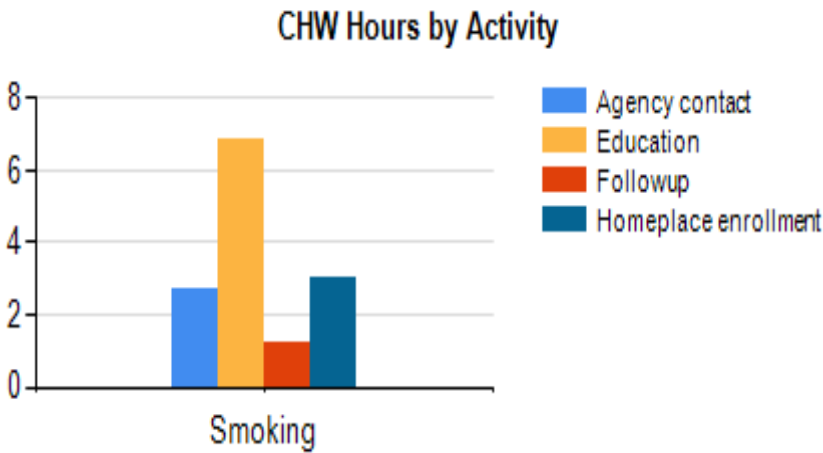
Need	Activity	CHW Hours
<p><b>CHW Hours by Activity</b></p>  <p>Heart disease</p>	Agency contact	11.08
	Education	4.92
	Followup	2.70
	Homeplace enrollment	1.92
	Travel	0.67
	<b>Total:</b>	<b>21.29</b>

Need	Activity	CHW Hours
<p><b>CHW Hours by Activity</b></p>  <p>High cholesterol</p>	Agency contact	24.97
	Education	11.57
	Homeplace enrollment	10.50
	Followup	4.58
	<b>Total:</b>	<b>51.62</b>

## Need Activity Summary-Disease

(Clients visited: 01/01/15-03/31/15)

Need	Activity	CHW Hours
	Care coordination	128.68
	Agency contact	23.92
	Homeplace enrollment	22.33
	Education	15.73
	Followup	14.37
	<b>Total:</b>	<b>205.03</b>

Need	Activity	CHW Hours
	Education	6.83
	Homeplace enrollment	3.00
	Agency contact	2.75
	Followup	1.25
	<b>Total:</b>	<b>13.83</b>
<b>Grand Total:</b>		<b>923.04</b>



## 27 County Service Area

**Restored Service Area (855) 859-2374**

**Southern Region (888) 220-3783**

**Southeast Region (855) 253-0910**

**Northeast Region (888) 223-2910**

# Regional Summaries

## Northeast Region

<b>Janet Kegley</b>	<b>Regional Coordinator</b>
<b>Judy Bailey</b>	<b>CHW (Johnson &amp; Magoffin)</b>
<b>Kala Gilliam</b>	<b>CHW (Rowan)</b>
<b>Terra Kidd</b>	<b>CHW (Boyd)</b>
<b>Angela McGuire</b>	<b>CHW (Lawrence &amp; Martin)</b>
<b>Shirley Prater</b>	<b>CHW (Morgan &amp; Elliott)</b>
<b>Alexandra Robinson</b>	<b>CHW (Greenup)</b>
<b>Elizabeth Smith</b>	<b>CHW (Carter)</b>

The Northeast Region held a retirement party for the Greenup Community Health Worker, Lana Bailey. In January 2015 Lana retired after seven years and six months of service to Kentucky Homeplace. We would like to thank Lana for her dedication and hard work she has given to this organization. We wish Lana the best!

The Northeast Region would like to welcome Alexandra Robinson, Greenup County CHW; Terra Kidd, Boyd County CHW; and Kala Gilliam, Rowan County CHW to our team.

The NE Region attended database training in Hazard along with other regions to stay updated on the new process of care coordination. Janet Kegley along with Director Mace Baker and Johnnie Lovins traveled to Our Lady of Bellefonte Hospital and Kings Daughters Medical Center to present an overview of the new care coordination process that Kentucky Homeplace is now implementing.

Judy Bailey attended the following meetings: A Community Luncheon at the Magoffin County Extension office and the Diabetes Support Group monthly meeting at the Magoffin County Health Department.

Terra Kidd and Alexandra Robinson attended the training for new Community Health Workers and each attended the Greenup County Interagency meeting along with their Regional Coordinator, Janet Kegley.

Angela McGuire attends the interagency meetings in both Lawrence and Martin counties. She is a member of the Lawrence County Diabetes Coalition, and the Health Advisory Team (HAT).

Shirley Prater attended the Bridges to Home orientation at St. Claire Regional Hospital along with Kala Gilliam. Shirley attended the Community Meeting along with the Elliott County Extension agent along with several agencies Shirley attends the Morgan County Interagency meeting. Shirley is a member of the Elliott County FEMA board.

Beth Smith attended the following meetings: The Carter County Council meetings and the Carter County Wellness meetings. She also attended the Carter County Interagency meetings.



## **Southern Region**

<b>Helen Collett</b>	<b>Regional Coordinator</b>
<b>Michelle Ledford</b>	<b>CHW (Clay)</b>
<b>Samantha Bowman</b>	<b>CHW (Lee, Owsley)</b>
<b>Paul Frederick</b>	<b>CHW (Knox)</b>
<b>Kathy Slusher</b>	<b>CHW (Bell)</b>
<b>Ratisha Roberts</b>	<b>CHW (Estill)</b>
<b>Harlan</b>	<b>Vacant</b>

This quarter the Southern Region welcomed Kathy Slusher, Ratisha Roberts and Vanessa Fields as Community Health Workers for Bell, Estill and Leslie Counties. Kathy and Ratisha have attended training in Hazard and with Paul Frederick, CHW for Knox County and Samantha Bowman, CHW for Lee and Owsley. Vanessa has been with Michelle, Paul and Samantha for training and will attend training in Hazard during April.

In order to better serve our clients we will be implementing Care Coordination for client diseases. We hope to help clients manage their symptoms and improve their lives more effective. This quarter we have attended trainings at the Center to learn more about Care Coordination and our database.

Samantha Bowman and Ratisha Roberts attended a 3 day diabetic self- management training that was held in March at the Lee County Health Department. Samantha had 4 clients in attendance as well.

Paul Frederick, CHW Knox County along with Regional Coordinator Helen K. Collett met with Barbourville Family Health to discuss care coordination. Paul also met with Faith Family Medical and Baptist Family Health.

Michelle Ledford met with the staff of Medical Associates of Southeast Kentucky and informed them of our care coordination plans.

## **Southeast Region**

<b>Ralph Fugate</b>	<b>Regional Coordinator</b>
<b>Pollyanna Gilbert</b>	<b>CHW (Wolfe, Powell)</b>
<b>Barb Justice</b>	<b>CHW (Pike)</b>
<b>Katherina Hamilton</b>	<b>CHW (Floyd)</b>
<b>Beverly Blackburn</b>	<b>CHW (Knott)</b>
<b>Cecily Spicer</b>	<b>CHW (Breathitt)</b>
<b>Devon Potter</b>	<b>CHW (Letcher)</b>

This quarter was a special quarter for our SE region. We have added two additional CHWs that have joined our team. Cecily Spicer was hired for our Breathitt County CHW position with her office being in Jackson. Cecily attended the new employee CHW training at the Center in Hazard. Cecily hosted a diabetic shoe day at the UK extension office in Jackson.





Devon Potter accepted the Letcher County position and her office is in the health department in Whitesburg. Devon is working diligently building a client base as it has been several years since Kentucky Homeplace has had a CHW in Letcher County. Devon attended a career fair and a health fair and visited many doctor's offices in her county promoting care coordination.

In addition to the new faces, all our CHW's were very active once again in their individual counties.

Barb Justice attended the following: Pike County coalition meetings, Allender Medical-diabetic community health day, BSCAP interagency meetings and healthy living workshop and a career fair at Shelby Valley High School.

Beverly Blackburn attended the following this quarter: Knott County Extension Council, Senior Citizen Diabetic Group, Knott County Food Bank Meeting and the Knott County LKLP Community Action Council.

Katherina Hamilton attended the Interagency Meeting hosted by Community Action Program. She also attended a Career Fair and a Healthy Living Workshop hosted by Community Action

We had 2 CHWs from our Big Sandy region attend the Big Sandy agency coalition meeting which includes several other neighboring counties as well. All CHWs attended a care coordination training in Hazard. Overall, it was a very active quarter for our SE region as they continue to enhance their role in helping maintain healthy outcomes for the clients they serve.

# Client Encounters

## Actual situations encountered by Community Health Workers

January 5, 2015-March 31, 2015

- A couple came into my office, they told me they had just moved here from Tennessee and that they both have health issues. I asked what all they had done as far as finding a new doctor and pharmacy. They have been to one of the local clinics; however their insurance is not valid in Kentucky, since it is TennCare (Tennessee Medicaid). I looked at their cards and made suggestions on how to get help to change over to Ky Medicaid. I looked up the medications that she was out of and they were both on the \$4.00 plan at Campton Discount Drug. I told them about other services available in the area and they were very appreciative for the information. They were prepared to make a trip back to Tennessee to get her medication filled again but this way they got it for \$8.00.
- During the past quarter I have worked with clients that have the Kynect Insurance. I have found out that many of them are having to pay for the insurance and can't afford the premiums and the ones that received Medicaid though the Kynect Insurance are having problems getting brand name medicines. I have worked with them to explain brand name medicines usually have to be pre-authorized by the doctor with the insurance company. Some of the doctors will change the medicines to keep from having to do the pre-authorization. Several of the clients said the Kynect only covers the doctor visit and will not cover their medicines. It has been a difficult couple of months working with this and finding out everyone has been so confused by the process. There are too many different ways the insurance companies have to process the claims and the doctors, clients and family can't get the proper process for them. I have still been working with clients to get their medicines, glasses, hearing aids, and equipment. The Patient Assistance Programs are working with our clients but are making them get denial letters from Medicaid and Extra Help with Medicare.
- A local doctors office referred a patient that had applied for Kynect Insurance but has not received his insurance at this time. I was able to get his medicines to help until he is able to get insurance. I am finding several clients that need help with their medicines and are on low or no income. This client was going to have to pay over 500.00 for his medicines and is waiting for his disability to get approved. His doctor has told him he can't go back to work and has been getting help from his family. I will be able to help him with his medicine until he gets an answer from Kynect or Medicaid.
- As a member of my community, I have seen first-hand how difficult daily living can be through my clients here at KY Homeplace, they are faced with simple needs that a lot of people often never have to deal with in their lifetime. I have served a lot of clients in my time here at Homeplace and one woman in particular made a lasting impression on me. She was a newly diagnosed diabetic who was referred to Homeplace by her optometrist for our program to help obtain glasses at low cost. She was so humbled by our program and all the services

we could offer her. I helped her get glasses and also recommended our new program care coordination which she was more than happy to participate in she stated “I don’t know anything about diabetes, my doctor gave me a prescription and diagnosed me with it.” She is now enrolled in care coordination and has received her glasses and is currently waiting on diabetic shoes, which she ordered during our diabetic shoe day!

- I have been working with a client that was referred to me through her physician; she is a new diabetic and didn't understand the effects of the disease or the type of life style changes that needed to be made so she could control the diabetes. Through Care Coordination I have helped her understand how diabetes affects her body as well as the food she puts in it. We came up with a schedule to review and discussed the remaining Care Coordination Modules so that she is fully informed on her disease and feels fully competent to manage her disease on own. I feel truly blessed being able to help someone that was so scared with this disease to become so confident and knowledgeable with her diabetes. I was also able to get her a pair of diabetic shoes and help with her medication.
- I have recently become a member of the Kentucky Homplace team and I'm astounded by the need in my community for the services that Homeplace has to offer. I am proud to say that I have helped a number of community members receive help with medication, glasses, hearing aids as well help educate them on hypertension and Diabetes. This job has been both rewarding and fulfilling. I am over-joyed to be able to help my clients with whatever means necessary in their time of need. I hope I get to continue my journey here in Homeplace and serve my community.
- My client arrived at my office for his scheduled appointment for assistance with glasses. During the interview he shared about his neighbor getting assistance with glasses and medication. He also shared about his wife of over 50 years had passed away nine months ago. He began telling me stories about their lives together and how he missed her. He even shared how depressed and lonely his life was without her. I mentioned several programs and events in our county that might interest him. He lives in town in walking distance of our local Senior Citizen Center. I shared with him their monthly calendar of events. His comment was he didn't want people to think he was looking for a girlfriend. I was scheduled to attend a meeting at the Center the first of next week, I asked him to meet me there and I would introduce him to the Director. He simply smiled and replied, maybe. Surprisingly he was outside waiting on me when I arrived at the Center the following week. When I called him about the approval voucher for his new glasses he thanked me for my help with glasses but also thanked me for encouraging him to visit the Center. He shared stories of making the short walk to the Center to meet several old friends and new ones too.
- This quarter I have had several clients that still don't have insurance and need help with getting their medicine. I also have several clients that have insurance and their insurance will not pay for the medicine that they need. I have one client that moved to Floyd County from Fayette County to live with family. She was working and was about to be evicted from her home. She was not making enough money there to survive. She moved to Floyd County and has been living back and forth between family members since September. She had no home doctor, income, home, or sense of self-worth. I discussed with her several of her issues and

find out that she was Diabetic also. I educated her about Diabetes and discussed getting help through a few other agencies that I work closely with. She called back to update me on her situation and she is doing much better.

- During this quarter I have worked with many individuals with many different needs but one client in particular that stands out the most. A client that came into the office because she needed help choosing a Medicare Prescription Drug Plan. My client was not taking her medications because she was experiencing financial hardship and having issues affording her diabetic medications and diabetic supplies. After only a few moments in my office I was able to get her enough samples from her primary care doctor to last her until she could start receiving low income subsidy assistances through Social Security to help cover some of the cost with her premium and copays with her Medicare Prescription Drug Plan. Several visits later with my client and she still talks about how the help and guidance from Kentucky Homeplace not only kept her out of the hospital but also helped to improve her quality of life because of the assistances and education that she received and because she is no longer doing without her diabetic medications.
- With the changeover to Care Coordination for KY Homeplace Clients I received a referral from a local doctor's office on a diabetic client. This individual had uncontrollable sugar levels and was not taking their insulin as directed due to trying to make the insulin last longer. With the Care Coordination initial enrollment we did a home visit with the client and their spouse who allowed us to see firsthand how the client was coping in their home with diabetes and other health issues. I introduced KY Homeplace to let the client know we wanted to work with them and their doctor to see a noticeable improvement in their health. I gave diabetic education and explained their medications in depth so they understood why they could not sparingly use their insulin. I contacted their insurance company and was placed as an advocate for them so we could be sure they were able to get their medication through their pharmacy. The client did not understand about the deductibles they had on their policy either. I instructed the client to keep a running log of their blood sugar levels for 2 weeks and I took that to the Doctor to review the concerns they had with extra high sugar levels. The Doctor had the client to come back into the office and started a new regiment of insulin therapy. We have seen a significant change for the better in the client's response to the insulin. Also they have COPD and had not seen a pulmonologist in over 2 years. They had discussed with us problems with sleep deprivation and we have brought this to their Doctor's attention. The Doctor's referral to KY Homeplace has brought a greater awareness to how the patient's compliance works with the treatment they have been prescribed. We are following up bi-weekly to help with other diabetic educational material with the client.
- The other day I saw a client that is Diabetic, has high blood pressure, and high cholesterol. He is a simple man but one that fends for himself. I was there to do a home visit and talk with him about his diabetes. He pulled up his pant legs, he had fallen that morning, both of his shins were red, bloody, scabs and just open wounds. I suggested that he needed to go to the doctor for them to see. He stated that there was no sense in it. I explained to him that his legs could get infected and he could possibly lose one from it. He got quite and stated he couldn't afford to go to the doctor. I told him he couldn't afford not to go and have that checked out. I feel like if I hadn't been there at that point that this client would not have gone to get

anything checked out but after talking to him and telling him the facts and possibilities of what could happen, he softened a little bit and started thinking about his injury a little differently. By the time he left he was talking as if he would go see his medical doctor about the places on his legs. I am so glad I got to talk with him and explain the importance of him getting his injuries checked out. Fortunately he did have insurance and his copayment came out to be \$20 each visit.

- I had a client that called about signing back up for help with medication once he is in the donut hole with Medicare. I went on a home visit to see my client and it was a very cold winter day. The door in which I entered was located at the kitchen. There was about ½ inch around the door that didn't meet the door frame. He took me into a living room in which he had a coal stove, gas heater and ceramic heater going. There were 4 doorways out of the living room and each one had a quilt or a blanket hung up to block out the coldness. I talked to my client about weatherization. He said he didn't know what he was going to do, he was out of coal and wood and had a propane gas bill owed of \$483.00. I told him I would check with an agency in town to see if any funding was available for heating assistance. He signed a letter for me to talk with this agency on his behalf. I completed re-enrollment and came back to the office. I took the gas bill and letter to the agency. They stated they were out of funding at this time. I went on to tell the story about how cold it was and what such horrible conditions this family was living in. The lady at this agency took my information and called her corporate boss and got the ok for the gas bill to be paid. When I called this client to let him know, the sound of such relief was unmeasurable. Within three days we were able to get another load of propane gas for heat and he was added to the weatherization list with our local weatherization agency. He said thank you twenty times!!
- I had an inactive client to come to the office to try to get help with dental services. He did not have dental insurance and couldn't travel very far for assistance. We talked over everything that was available and decided that we would send him to a dentist in the next county that would discount his prices for Kentucky Homeplace clients. We continued on with re-enrollment and I mentioned to my client that we had some emergency funds for our county residents for cases like this. I told him the group and that I would request a check from them for his dental needs. He said he would personally thank them and said that when he walked into my office he was out of options and had nowhere else to go for help. He said we have saved his life. He was in so much pain but he knew there was nowhere for him to get the funding for what he needed done. He said he will forever be grateful for what we were doing for him.
- This quarter my story refers to a young lady currently attending college. My client was dropped from her parent's insurance plan, after turning 26. My client applied through the state insurance and received insurance at no cost. The only unfortunate thing was most of her medications were not covered by her plan. I was able to navigate her through several Pharmaceutical Programs to help her get the medications she needed and help with getting her new glasses. Hopefully keeping her health in good order will help with her future of becoming a nurse.

- I had a gentleman call for an appointment for medications. His situation was unique; he had retired but was unable to receive any social security benefits until his 65th birthday which isn't until June. This was due to a mix up in his records on the state level. He was asking for help with his arthritis and stomach medications. I did his applications and in conversation he said that his ex-wife needed help also, I told him to have her call. The next week she called for an appointment, her health was very poor. She has heart problems, thyroid, respiratory, etc. and like her ex-husband, no insurance. She previously received SSI and had Medicaid, but once she turned 62.5, someone told her that she had to sign up for Social Security. They told her that she would receive her ex-husband's social security because they were married for more than 10 years. The problems started when the paperwork went in to social security, she stopped getting her SSI and she has received no income for two months. With her not having income or insurance, she hasn't been able to get her much needed medications, the social security department told her that the problem was because there was a problem with her ex-husbands account and it was in Frankfort's hands. This is where I come in, I reviewed her medications which were a lot, if she had been able to buy them, and her cost would have been over \$1200 a month. I asked if she had signed up for the new health insurance she said she "called that number" and they told her to take her proof of income to her local DCBS office which she did do, but she hadn't heard anything. I asked if she cared if I called the insurance so I could check her status and she said yes. Once this was done, I reviewed her case and she had already been approved for Medicaid and didn't know it. They had given her an MCO that isn't widely accepted in this area and she wanted to change to another MCO and I made that change for her. She had to keep the current MCO for 30 days so I called the pharmacy to see if the billing would go through for the current MCO and they needed more information that we didn't have (she hadn't received any information about insurance). I called her current MCO provider and got the needed information and called the pharmacy back, her prescriptions could now be filled! She needed refills called in on the others but she was able to pick up three of them on her way home. She was very grateful that I was able to do all that for her, she said you have helped me more in 30 minutes than anyone else that she had talked to! Made my day!