providerNEWS

A Newsletter for **Freedom Health** & **Optimum HealthCare** Providers

SPRING **2023**

FALL PREVENTION

Growing Problem of Heart Failure

Financial Barriers to Medication Compliance

Silence is Not an Option

AND **much more!**

Printed and mailed 03/20/2023

CREDENTIALING CORNER

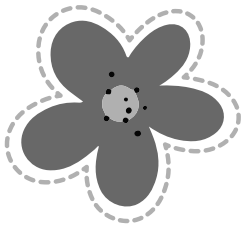
The plan accepts CAQH Proview Credentialing applications.

When logging into the CAQH ProView Provider System to update or re-attest to your information, please review the informational banners used by CAQH to announce system updates and be sure to review the monthly ProView updates CAQH sends out via email. **Please be sure all documents uploaded to CAQH indicate "Pass" and are legible including the Attestation Form.**

Also, please continue to keep your credentialing application and attached documentation current in the CAQH ProView database including the "Release and Attestation" form.

Any provider choosing to not carry or renew a DEA Certificate must provide information to the Plan in this connection. Please complete the Prescribing Protocol form which is on the health plan website under - Providers - Tools & Resources - Forms - Provider Forms – DEA Protocol Form and give the completed form to your Provider Relations Representative.

The following items are of much importance in the credentialing process:



- **State Medical License(s) please include expiration date(s)**
- **DEA Certificate**
- **Valid Insurance Information**
- **Practice locations**
- **Hospital Admitting privileges OR if you are a PCP and you do not have hospital admitting privileges, please ensure the Hospital Admitting Arrangements Supplemental Form is fully completed**
- **Partners/Covering Colleagues**
- **Questionnaire responses and explanations as required**

For Providers Not Part of CAQH Proview:

The plan sends notification and re-credentialing applications by mail four months in advance of a providers credentialing expiration date. The notification cover letter specifies the steps and documents needed for recredentialing, as well as the deadline for the submission of all current information. Maintaining Active provider status is dependent upon completion of the re-credentialing process prior to the three-year expiration date.

Documentation and Coding for Risk Adjustment

The MRA department is dedicated to partnering with our providers in a joint effort to improve documentation and coding quality and accuracy for risk adjustment. Our goal is to achieve greater specificity in coding through the proper documentation required to support diagnoses submitted for risk adjustment.

To meet risk adjustment requirements, diagnoses reported must be active (not resolved), documented, evaluated, addressed, and supported within the S.O.A.P (Subjective, Objective, Assessment, and Plan) note during either a face-to-face encounter or a telehealth visit with real-time audio and video communication. The following are best practices for proper documentation:

- Document diagnoses addressed during the visit with pertinent support, such as respective dated diagnostic test results. For example, HgbA1c for Diabetes.
- Document causal relationships between conditions using linking verbiage. For example, Chronic Kidney Disease Stage 3 due to Type 2 Diabetes.
- Avoid conflicting/contradicting documentation within the progress note.
- Progress notes for each date of service should clearly indicate a unique record.
- Document support for Substance Use Disorder diagnoses with the diagnostic criteria as outlined in the DSM-5 Manual, including manifestations showing a problematic pattern of substance use leading to clinically significant impairment or stress. It is important to note this criterion is not considered to be met for those taking medications as prescribed.
- Document acute diagnoses including strokes and unstable angina only on the date of the acute event. Sequelas, late effects or other non-acute codes may be applicable after the acute date of service.
- Document active cancer diagnoses only when the cancer is present and under active treatment or watchful waiting. Assign personal history codes for excised or resolved cancers that are no longer receiving active treatment.

We are offering Physician to Physician MRA Education. Requests can be emailed to riskadjustment@freedomh.com. We look forward to our continued partnership.

Cultural COMPETENCY

Federal regulation requires that all physicians deliver healthcare services in a culturally competent manner. The Health Plan expects its network physicians to provide information and services to members in a manner that is respectful and responsive to unique cultural and linguistic needs. Physicians must also assure that individuals with disabilities are furnished effective communication when making treatment option decisions.

Should you notice any potential cultural or linguistic barriers when communicating with your patients, let the Health Plan know. The Health Plan's Member Services department is available to arrange free language interpreter services for its non-English speaking members. You may also contact Member Services to obtain information on our teletypewriter TTY/TDD connections.

THE FOLLOWING ARE SOME EXAMPLES OF WAYS TO INCORPORATE CULTURAL COMPETENCY INTO YOUR PRACTICE:

- Allow extra time with patients for whom English is a second language.
- Post signs and provide educational materials with easy-to-read text, written in common languages encountered in your service area.
- Use nonverbal methods of communication (e.g., pictographic symbols) with patients who cannot speak English or whose primary language may not be English.
- Speak slowly and clearly, using terms the patient will understand.
- Accommodate and respect patients' unique values, beliefs and lifestyle choices when customizing treatment plans.
- Be aware that direct or prolonged eye contact is considered disrespectful or aggressive in some cultures.
- Be aware that personal space requirements vary by culture.

The Bureau of Primary Health Care (BPHC), the Health Resources and Services Administration (HRSA), and the U.S. Department of Health and Human Services (DHHS), in conjunction with Georgetown University, have created a tool for providers to assess their practice for cultural competency. The self-assessment tool benefits practitioners by enhancing awareness, knowledge, and skills of cultural competency, and by informing practitioners of opportunities for improvement both at the individual and organizational levels.

You can download the tool at **https://nccc.georgetown.edu/assessments/.**

There are also many other free resources online which offer accredited continuing education programs on culturally competent practices. There are also additional PDF's and assessments available that are specific to age, environment or needs. The following sites identify needs and opportunities in your practice, as well as how to implement cultural and linguistic appropriate services.

- Office of Minority Health website featuring Communication Tools and Education Resources: **https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=1&lvlid=6**
- Health Resources and Services Administration (HRSA) of the U.S. Department of Health & Human Services website for Culture, Language and Health Literacy: **https://www.hrsa.gov/about/organization/bureaus/ohe/health-literacy/culture-language-and-health-literacy**
- Providers may request a hard copy of the Cultural Competency Plan from the Plan at no charge to the provider.

These thoughtful approaches proposed by cultural competency standards allow the Plan and the providers who care for our members to:

✓ Improve health outcomes

✓ Enhance the quality of services

✓ Respond appropriately to demographic changes

✓ Eliminate disparities in health status for people of diverse backgrounds

✓ Decrease liability/ malpractice claims; and

✓ Increase member and provider satisfaction.

FALL PREVENTION:

WHAT HEALTH CARE PROFESSIONALS CAN DO TO HELP

Falls are the most common cause of injury in senior citizens. In fact, the CDC website states that, "each year, millions of older people—those 65 and older—fall. In fact, more than one out of four older people falls each year, but less than half tell their doctor. Falling once doubles your chances of falling again." [1] As providers, you are the first line of defense to facilitate patients in fall prevention. There are many risk factors for falling and some of them can be modified to help prevent these dangerous occurrences.

As you are aware, a patient will be at risk for falling if they have lower body weakness, dizziness, or difficulty with balance. However other things like poor vision, use of certain medications and even foot or shoe problems can also contribute to a patient's fall risk. In addition to physical exams and annual hearing and vision exams, there are some other things to consider:

- A review of the patient's medications is necessary to rule out any drug-drug interactions or drugs that may be more likely to cause falls.
- Recommendations such as an exercise program that focuses on balance and stretching as well as a footwear assessment are also beneficial.
- A home safety assessment and suggestions for adaptive aids may also be necessary recommendations.

1. *https://www.cdc.gov/falls/facts.html*

For elderly patients, fall prevention education is critical. Some strategies for fall prevention to talk to your patients about include:

- Attending a fall prevention program in your area
- Working on exercises for strength and balance; and
- Changing the environment in their home. This can be very difficult for your patients. You have to assess their readiness to change much like in smoking cessation and weight loss programs. It is important to discuss and address any barriers to change they may have.

Many elderly patients feel that falling is just part of life when you are older, but there is no reason that anyone has to fall and endure life-changing consequences. The key is prevention and providers are the first line of defense!

Social Determinants of Health

Social determinants of health (SDOH) is a term that is becoming more commonly used in the healthcare industry. The World Health Organization defines social determinants of health as "the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels."[1] Social determinants are important predictors of health care access and engagement. It is estimated that medical care accounts for 10% of health outcomes. The remaining 80-90 percent is attributed to social determinants of health.[2]

With SDOH accounting for 80% of health outcomes, the collection of social, economic, and environmental data is key for providers to identify psychosocial and economic hardships faced by their patients. The use of SDOH-specific Z codes helps in the collection of this data and has long been underutilized. These specific Z codes help to identify care gaps related to barriers to care, social support needs, and delivery of resources. The top five Z codes submitted by Plan physicians in 2022 were:

- Z59- Problems related to housing and economic circumstances
- Z60- Problems related to social environment
- Z63- Other problems related to primary support group, including family circumstances
- Z56- Problems related to employment and unemployment
- Z55- Problems related to education and literacy

For a complete listing of available Z codes, and to help you better understand the use of Z codes, please visit **https://www.cms.gov/files/document/zcodes-infographic.pdf.**

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OFFICE CLEANLINESS

Patients tend to complain most about things that they can relate to or understand. Oftentimes, things like wait time, rude office staff and office cleanliness are reported more than a physician's medical decisions or competency. These are the things patients remember and have a large outcome on patient satisfaction. Annually, the Health Plan conducts a Member Satisfaction Survey in order to determine satisfaction with the Plan and their providers. The Plan analyzes those responses at the end of the year. Last year on the Health Plan's Member Satisfaction Survey, there were a few questions that had a statistically significant influence on member satisfaction. One of the questions that **continually** has an impact on member satisfaction is Doctor's Office Cleanliness even despite an increase in telehealth appointments. ***The Health Plan has found that poor member satisfaction with office cleanliness often coincides with lower overall scores on PCP and specialist rating for our Member Satisfaction Survey.***

A large amount of how patients perceive their quality of care is based on the cleanliness of their physician's office. A patient's first impression on a medical practice is the waiting room area. It is important to create a clean environment in order to affect patient outcomes and promote patient health. Here are some tips to creating a cleaner office area:

- Keep the office area as germ-free as possible to prevent infection and cross contamination. Disinfecting surfaces and wiping down chairs in between patients have become common practice. This may also include disinfecting the front desk of the office including pens, clipboards, and credit card machines that multiple patients may use.
- Get new furniture if your office furniture needs updating and keep chairs socially distant. If you are unable to space out the furniture to maintain social distance, many offices continue to have their patients remain in their cars and the office staff can call them in once the doctor is ready.
- Throw out old magazines and brochures to help create a fresh, minimalist environment.
- Keep the waiting room tidy by picking up coffee cups and tissues or masks that may have been left behind; and
- Soothing décor, soft lighting and a friendly and comforting office staff can create an overall satisfying experience as well at a medical office practice.

If your office may be thinking of things to improve upon in 2023, please take into consideration that an office that is not clean may be sending the wrong message to a patient. This is a very simple adjustment that can greatly influence patients' overall satisfaction!

Lab Results As Quickly And Conveniently As Possible

At Labcorp, we want to make it easy for physicians to obtain lab results so that critical conversations about care plans happen early and often.

Results are reported to physicians after testing is completed and released by the lab. Routine tests are typically reported by 8:00 a.m. the next morning or within a few business days after specimen collection. Depending on the nature of the test(s), labs may take additional time if esoteric testing (e.g. genetic testing) is required.

Convenient ways to retrieve lab results

Dial the Labcorp customer service number (800-877-5227)

Select prompt for health care provider

Select prompt for test results

Enter Labcorp account number

Speak the patient name, date of birth and date of service when prompted

Results can be faxed to the number on file. At any time during the call, an agent can be readily available to assist. We value your feedback and have included an optional customer survey to rate your experience with our new service.

Growing Problem of Heart Failure

Heart failure is a growing problem in the United States. According to the Centers for Disease Control and Prevention (CDC) there are about 6.2 million Americans that have heart failure. In 2018 a diagnosis of heart failure was mentioned in 13.4% of all death certificates in the United States, a total of 379,800 lives lost. The CDC estimated the cost of care in 2012, a culmination of health care services, missed workdays, and medication was at 30.7 billion dollars. And the incidence of heart failure is expected to continue to grow. For more information on heart failure, see the CDC at **https://www.cdc.gov/heartdisease/heart_failure.htm.** Speak with your patients and take time to stress the consequences of unhealthy behaviors such as:

- Smoking or using tobacco products
- Diets high in fat, cholesterol, and sodium
- Sedentary lifestyles
- Excessive alcohol intake

As a Health Plan we participate in the Chronic Care Improvement Program (CCIP) through the Centers for Medicare and Medicaid (CMS). This year our CCIP has a focus on preventing readmissions for members with heart failure. Participation in the program is open to all members, at all Plan levels, and is provided at no additional cost. Members participating in the program will have access to our Plan Dietitian, Registered Nurses for telephonic Case Management, a Social Worker, Silver Sneakers, and of course any additional benefits provided in their individual plan type.

A Health Plan representative is available Monday through Friday from 8:00AM to 4:00PM EST at **1-888-211-9913** or **TTY/TDD 711,** to assist members in being referred to the CCIP. As a provider you can place a referral through the Provider portal using the **Case Disease Management Referral Form.**

SNP PROGRAM EVALUATION

Every Special Needs Plan (SNP) has a specific SNP Model of Care (MOC) program that addresses care coordination strategies, SNP policies and procedures and stipulates quality metrics and goals.

Goals are set based on National benchmarks and CMS Star Score thresholds. Routinely, the Health Plan reviews and discusses results and opportunities with the SNP Interdisciplinary Care Team (IDCT) consisting of key administrative and clinical personnel and a small group of network Physicians. The SNP MOC program is reviewed for effectiveness through the SNP MOC Quality Improvement (QI) Work Plan Evaluation process.

The 2022 SNP MOC QI Work Plan Evaluation has been completed and indicated a successful year for all our SNP MOCs. Quality metrics, health outcomes and utilization were discussed and compared against our previously established goals, prior performance, and National Benchmarks. While 2022 was again a challenging year due to the pandemic, the Plan met many of the SNP MOC QI Work Plan Evaluation goals and continued to make good progress towards others. Any unmet goals were re-evaluated to assure the targeted performance was appropriately set and to consider any additional improvement opportunities to include in our 2023 programming for improved member experience and outcomes and to address changing SNP population needs and barriers. Goals were also reviewed to determine if more challenging goal metrics would need to be established moving forward. Overall, many goals were adjusted due to either changes in National Benchmarks or internal improvement opportunities.

Financial Barriers to Medication Compliance

Medication adherence is a key component of the patient's treatment plans. Being able to adhere to a medication regimen involves factors such as financial constraints, the ability to administer the medication, and the patient's understanding of the need for the medication.
It has been well documented that the inability to pay for medications is a common barrier to medication adherence, therefore, understanding your patient's ability to afford his or her medication can be of great benefit when it comes to prescribing. The promises associated with newer, Brand name medications, need to be carefully considered against established and proven treatment regimens. While the new medication may provide an effective therapy, the inability to afford the co-pay can lead to the patient not filling the prescription. Subsequently, the newer, expensive, Brand name prescription will consume the member's total drug spend and push the member into the coverage gap, which can ultimately lead to failure of the new drug treatment plan and other drug treatment regimens the member is prescribed as well.

The Health Plan has a team of pharmacists and pharmacy technicians ready to assist you in identifying cost-effective medications to treat your patient. They can be reached at **1-888-407-9977** from 8:00 a.m. to 6:00 p.m. EST. Monday through Friday. Case Management and Social Workers are also available to assist the patient in identifying co-pay assistance programs to help facilitate medication compliance when indicated.

The Importance of Communication as a Health Care Provider

COMMUNICATION WITH PATIENTS

An effective doctor-patient relationship is important and can only exist if there is trust and good communication. It is well known that when patients feel they can openly talk to their doctor, they will experience improved health results and overall well-being.

Providers should be prepared for patient visits and encourage them to ask questions. The Health Plan continually reminds members to be prepared for appointments by arriving on time, bringing updated medication lists and asking questions about their health care. However, patients oftentimes feel that they are bothering their provider or that their doctor is too busy to answer questions. While this may be true, it is important to **always** take the time to talk with your patients. This includes maintaining eye contact and exhibiting good listening skills. Educate your patients on their health conditions. Teach them which changes in their health condition need to be reported to you and how quickly to call. Your patients should know if their symptoms can be addressed in an office visit or when emergency treatment may be necessary.

During each visit with a patient, verify their current medication list, including supplements. Ask if the patient is taking all of their medications as directed. It is surprising how many patients stop taking their medications for various reasons. This is especially pertinent when a patient transitions between facilities, has been seen in the ER or by different providers and specialists.

It is also important to review any new lab results and discharge reports. Any changes should be updated in the patient's care plan. **Care Plan's are available via the Plan's MRA/ HEDIS® Provider portal.** Lastly, make sure patients have your contact information before leaving the appointment. They should know when to contact your office if questions come up after their visit or how to explain the urgency of their request. Printed patient education material or instructions are also helpful to send home with the patient.

COMMUNICATION WITH OTHER PROVIDERS (PCP TO SPECIALISTS):

Successful coordination of care requires open communication with other providers. This involves other PCPs, hospital and ER doctors, and specialists. It could also include Health Plan team members.

When patients transition between facilities or other providers, it is difficult to ensure continuity of care. By working together as a ***provider team***, the patient is more likely to receive the best health care possible.

The Health Plan considers a **PCP** the **medical home** and any pertinent changes in the patient's care plan should be communicated and accessible to PCPs, especially upon post-care transition. This would include any changes in health status, diagnoses, medications, lab or test results, and those noted on a discharge report.

Since a follow-up visit is scheduled with a PCP following a care transition, communication of the patient discharge summary or discharge instructions is necessary to update and to maintain the patient's health care plan, as well as continue meaningful communication with the patient about their health care.

SILENCE IS *NOT* AN OPTION

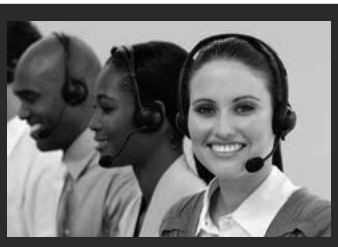
ABUSE, NEGLECT& EXPLOITATION

Elder abuse, neglect or exploitation does not usually end on its own - someone must report it! A victim may not reach out for help for various reasons such as shame or fear. As a mandatory reporter, you can take the first step to end the abuse.

WHO IS A MANDATORY REPORTER?

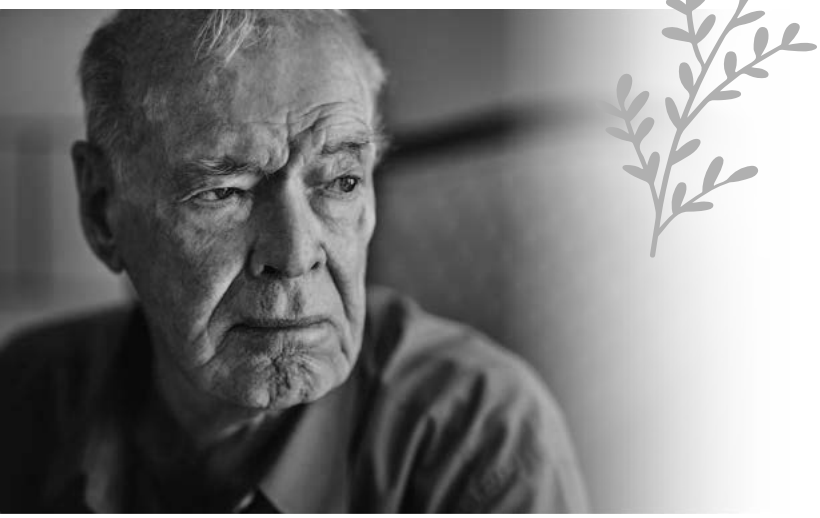
Health care providers, including nurses, are mandatory reporters of abuse, neglect or exploitation of the elderly, children and vulnerable adults. According to Florida Department of Children and Families, a vulnerable adult is a person age 18 or older whose ability to perform the normal activities of daily living, and/or to provide for his or her own care or protection, is impaired due to a mental, emotional, sensory, long-term physical, or developmental disability or dysfunction, or brain damage, or due to the infirmities of aging.

↘ report it!



HOW DO I MAKE A REPORT?

Call 1-800-962-2873
or online at: *ReportAbuse.dcf.state.fl.us*



WHAT DOES IT LOOK LIKE?

Abuse or neglect is not always easy to spot but there are signs to look out for:

- Trouble Sleeping
- Seems depressed, confused, agitated, violent or withdrawn
- Unexplained bruises, scars or accidents
- Develops sores or other preventable conditions
- Makes concerning statements about caregiver withholding money or medication

PARTNER WITH CASE & DISEASE MANAGEMENT NURSES

THE PLAN'S CASE AND DISEASE MANAGERS AND SOCIAL WORKERS can collaborate with you to help provide each member the services they need to better manage their health or plan of care. Physicians and providers can refer a patient to one of our programs with just a phone call or written referral. Our overall goal is to support the member's success in implementing his or her plan of care. The referral form can be found on the Plan's website or in your Provider Manual.

DISEASE CASE MANAGERS CAN OFFER education and coaching programs for members based on chronic conditions such as Diabetes and Cardiovascular Disease. These programs are built around national evidence-based guidelines. The focus is on preventing complications and/or exacerbations, enhancing self-management and reducing acute episodes.

COMPLEX CASE MANAGERS CAN ASSIST members with urgent or acute events and coordination of services. The goal is to enhance coping and problem-solving capabilities, assist in appropriate self-direction, support proper and timely needed services and reduce readmissions.

SOCIAL SERVICES SUPPORT IS INTEGRATED into our Case and Disease Management program. Our Social Workers work in conjunction with our Nurses in identifying health and community resources which might benefit the member.

MEMBERS ENROLLED IN CASE OR DISEASE MANAGEMENT and their physicians receive ongoing support from Nurses on staff. Members may choose not to participate in the program at any time and it does not affect their benefits.

MANY TIMES, NURSES OR SOCIAL WORKERS WILL NEED to engage the PCP to resolve member concerns or issues. We appreciate providers supporting Member participation in these programs as a collaborative effort to maximize health and wellbeing. The Nurse or Social Worker, along with the member, develop a care plan which they send to the PCP, highlighting mutually agreed upon goals and interventions. They provide updates to the care plan when initiatives change.

Our Nurses and Social Workers also remind members who see Behavioral Health providers to fill out a Release of Information form, giving those providers permission to share information with the PCP. You can facilitate this process by providing members with a copy of the form, which is in the Carelon Behavior Health provider toolkit (***http://www.carelonbehavioralhealth.com/providers/resources/provider-toolkit***

Thank you for all you do to help keep the channels of communication open and to provide the best care for our members!

Call us toll-free at
1-888-211-9913

from 8:00 a.m. to 4:00 p.m. EST Monday through Friday.

To access the referral form on the internet visit the Plan website and follow this path:

Providers → Tools and Resources → Case/Disease

A *Reminder* About Medical Records Standards

All of Our Members Benefit from the Safeguards Established by Federal and State Guidelines

The Plan strives to provide the best quality of care to its members and expects all providers who service our members to adhere to stringent Federal and State standards regarding documentation, confidentiality, maintenance and release of medical records, as well as personal health information (PHI).

The Plan's Provider Manual describes the medical record standards required for contracted providers. As a reminder, ALL providers must follow these standards and cooperate with the Plan in activities related to quality assurance monitoring of medical records. Meeting these requirements applies to both electronic and paper medical records.

PROVIDER RELATIONS DEPARTMENT 2023

Administration

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provider NEWS

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Awareness is increasing that medical care alone cannot adequately improve health outcomes. Prioritizing and placing value on social determinants of health has the potential to remove some of the fundamental barriers that impact health and inequity. The Health Plan prioritizes health equity by closing care gaps that are unjust or avoidable. We want every member to have the opportunity to achieve the highest level of health possible. The Plan works hard to overcome barriers.

Did you know that the Health Plan has a team of social workers available to your patients? The social workers can connect your patients with needed community resources that may help address barriers to care issues including transportation, financial gaps, food assistance, housing, and environmental safety. The Plan also supports members in filing for Medicaid and the renewal process through our trusted vendor partner. We encourage you, as the PCP, to reach out to the Plan so we can get in touch with your neediest patients. Patients may also self-refer via the Member Portal or by calling the Member Services number on the back of the Plan I.D. card and asking for Case Management or Social Services.

[1] *https://www.who.int/initiatives/action-on-the-social-determinants-of-health-for-advancing-equity*

[2] *https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/*