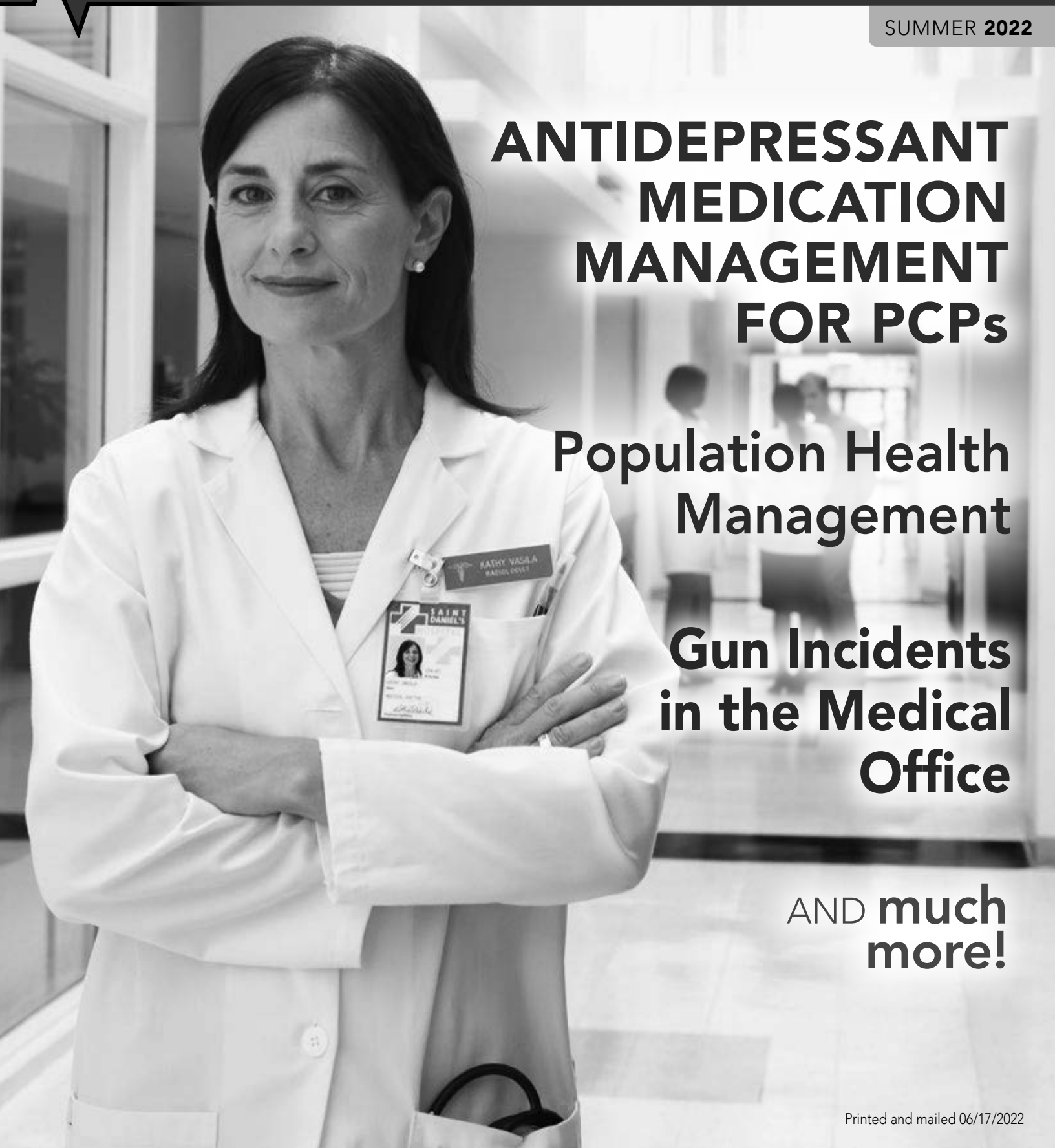
# providerNEWS

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

SUMMER **2022**




## ANTIDEPRESSANT MEDICATION MANAGEMENT FOR PCPs

## Population Health Management

## Gun Incidents in the Medical Office

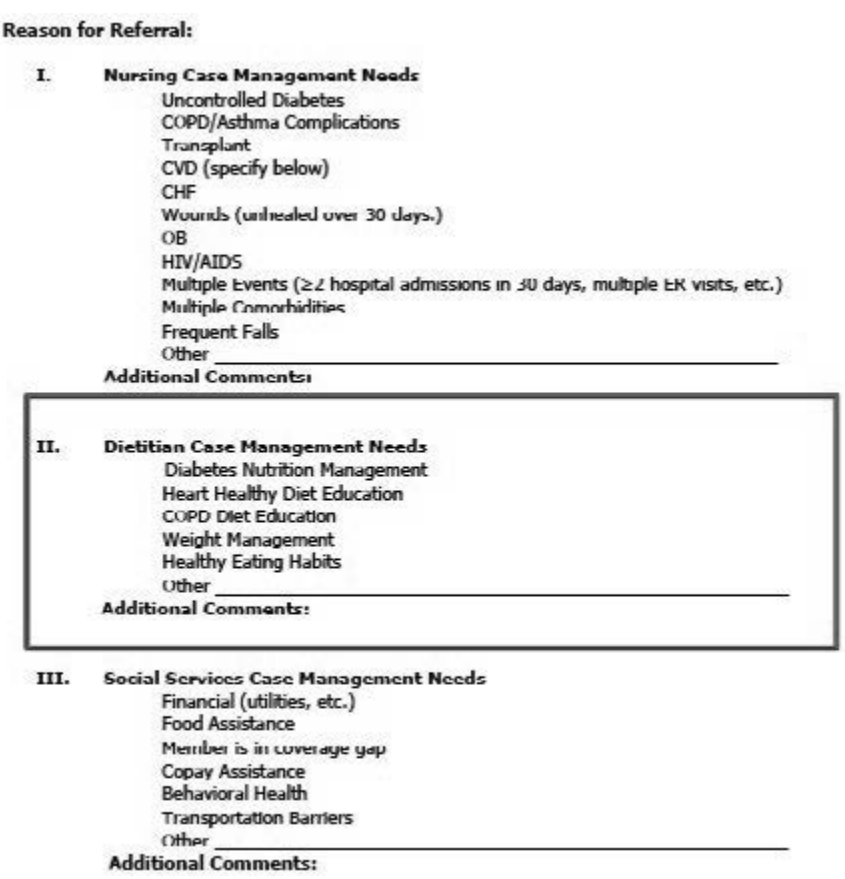
AND **much more!**

Printed and mailed 06/17/2022

# Updated CM/DM Referral Form for Providers

As previously mentioned in our Spring Newsletter, we are pleased to announce the addition of a registered dietitian to our Case Management Department and thus an update to our CM/DM Referral Form. Aneesa is a licensed and registered dietitian who has earned a bachelor's in psychology and master's in nutrition from the University of Illinois at Chicago. She is here to help with any food and nutritional concerns or questions that your patients may have regarding management of conditions (diabetes, hypertension, cardiovascular disease, etc.) or if they are seeking general nutrition advice!

To help facilitate referrals to the dietitian we have updated the Case/Disease Management Referral Form to include a section for referral to the dietitian. You can access this form via the Provider Portal. The preferred route for referral to the Plan is the Provider Referral Form. Please familiarize yourself with this form and use it to refer your patients for assistance with Nurse Case Management, Disease education, Nutrition education, and Social Service needs. If the Plan can be of assistance to you or your patients, please use the Case/Disease Management Referral Form. You may also have your patients contact the Disease and Case Management Department directly by phone: 888 211 9913, or by fax: **888-314-0794** from 8:00 am to 4:00 pm EST Monday through Friday.



**Reason for Referral:**

**I. Nursing Case Management Needs**
- Uncontrolled Diabetes
- COPD/Asthma Complications
- Transplant
- CVD (specify below)
- CHF
- Wounds (unhealed over 30 days.)
- OB
- HIV/AIDS
- Multiple Events (≥2 hospital admissions in 30 days, multiple ER visits, etc.)
- Multiple Comorbidities
- Frequent Falls
- Other _____

**Additional Comments:**

**II. Dietitian Case Management Needs**
- Diabetes Nutrition Management
- Heart Healthy Diet Education
- COPD Diet Education
- Weight Management
- Healthy Eating Habits
- Other _____

**Additional Comments:**

**III. Social Services Case Management Needs**
- Financial (utilities, etc.)
- Food Assistance
- Member is in coverage gap
- Copay Assistance
- Behavioral Health
- Transportation Barriers
- Other _____

**Additional Comments:**

# Evidence-based Clinical Practice Guidelines

The Plan reviews and adopts Evidence-based Clinical Practice guidelines in consultation with the Plan's Manager Medical Director and/or Medical Director(s), a panel of physicians, an interdisciplinary care team of board-certified specialists and the Quality Management Steering Committee.

The Plan utilizes evidence-based clinical practice guidelines on which it bases its management of members' health care needs, including the development of all disease-based assessments, education of members on suggested self-care, condition monitoring and care plans.

The Plan updates its practice guidelines periodically and reviews them at least annually. National agencies and medical specialty societies also adopt evidence-based clinical practice guidelines. They are based on reasonable medical evidence or the consensus of physicians in a particular field.

Adapted to the needs of the Plan's members, the guidelines are included in the Care Plan Manual sent to primary care providers.

They are available to members when appropriate and upon request. A copy of the evidence-based clinical practice guidelines and the links to their sources are available on the Plan's websites at:

*www.freedomhealth.com -> Providers -> Tools & Resources - > Clinical Healthcare - > Clinical Practice Guidelines*

*www.youroptimumhealthcare.com -> Providers -> Tools & Resources - > Clinical Healthcare - > Clinical Practice Guidelines*

# ADVANCE DIRECTIVES

## *A Patient's Right to Decide*

**According to state and federal laws, patients have the right to decide how they are medically treated, even if they are not able to speak or make their wishes known. The Plan does not base treatment on whether or not a patient has executed an advance directive. We expect our contracted providers to uphold this standard of non-discrimination as well.**

In order to prepare for these situations in advance, we encourage our members to express their wishes by filing advance directives. It is a patient's individual choice whether or not to file an advance directive. Common types of advance directives include Living Wills, Health Care Surrogates and Anatomical Donations.

Remember, a patient's medical record must contain documentation of whether or not the individual has executed an advance directive; documentation is to be displayed in a prominent location in the record. The Plan and its providers are not required to provide care that conflicts with a Member's advance directives.

If your patients are interested in learning more about advance directives, you can refer them to the following resources:

### Donate Life Florida
Website: http://www.donatelifeflorida.org/
This site offers information on organ and tissue donation as well as the option to register as a donor online.

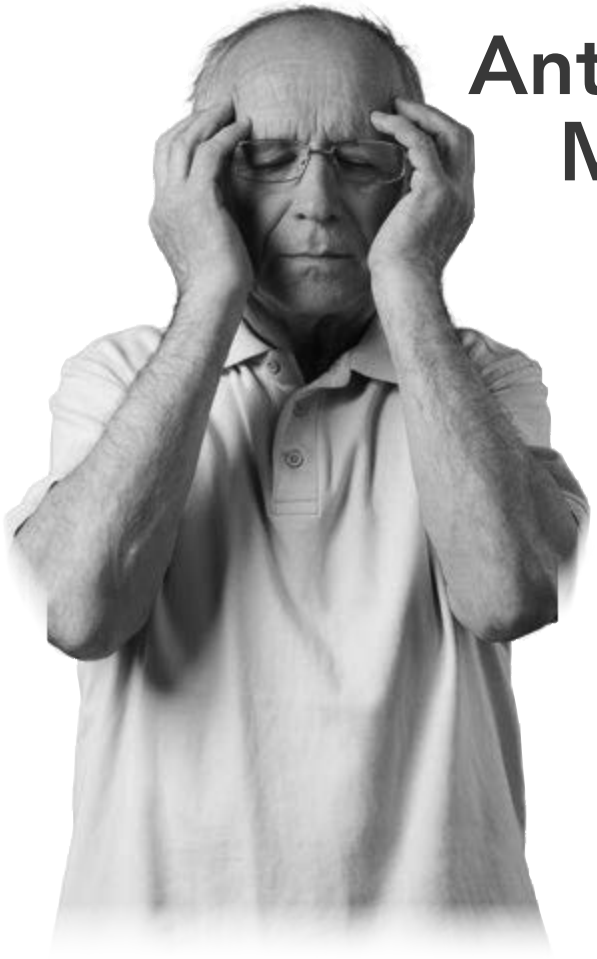
### Florida Agency for Health Care Administration
Website: http://ahca.myflorida.com
This official website has a Health Care Advance Directives Publication called The Patient's Right to Decide. This publication provides helpful information on Advance Directives, forms, and other resources.

### Florida Department of Elder Affairs
Website: https://elderaffairs.org/
**Phone: 1-800-963-5337**
Their website offers many resources for seniors including the Senior Legal Helpline: **1-888-895-7873**, a free legal consultation for seniors.

### The Florida Bar Association
Website: http://www.floridabar.org
The Florida Bar provides information for the public on certain general areas of law. This includes Advance Directives, Living Wills, and Health Care Surrogates. They provide helpful brochures, forms, and other useful information for healthcare planning.

### Aging with Dignity
Website: http://www.agingwithdignity.org
**Phone: 888-5-WISHES (594-7437)**
This organization has a document called Five Wishes. This document allows you to express how you want to be treated if you are seriously ill and unable to speak for yourself. This document meets the legal requirements of an Advance Directive in most states.

### Caring Connections
Website: http://www.caringinfo.org
**Phone: (800) 658-8898**
Caring Connections is a program of the National Hospice and Palliative Care Organization (NHPCO). This organization works to improve care at the end of life. Their website provides many resources for planning ahead. You can also download your state-specific Advance Directives.



# Antidepressant Medication Management for PCPs

**Many people with depression are seen and treated in the primary care setting. Therefore, it is important for primary care physicians (PCPs) to screen patients for depressive symptoms.**

**In addition to hallmark symptoms, many people with depression have vague somatic complaints, for which there's no disease explanation. Left untreated, comorbid depression can lead to poorer outcomes and prognosis of other diseases as well.**

For more information about various behavioral health topics, consult Beacon Health Options' PCP toolkit by visiting https://providertoolkit.beaconhealthoptions.com/.

### Common symptoms of depression

- Two weeks of persistently depressed mood
- Inability to feel pleasure
- Sleep difficulties
- Appetite and energy level changes
- Lost interest in activities
- Guilt and suicidal thoughts

## Choosing the right medication

Deciding which antidepressant medication to use can be challenging. Three important factors help determine medication efficacy:

1. COMPLIANCE. About 42 percent of patients discontinue their antidepressants during the first 30 days.
2. DURATION OF TREATMENT. An antidepressant can take 4-6 weeks to have a full effect, and a treatment episode should be at least six months after remission of symptoms or longer, depending on patient history.
3. ADEQUATE DOSING. Many antidepressants will need dosage adjustments to see full therapeutic effect. If seeing partial response, try increasing the dose before switching

Presenting symptoms, comorbid conditions, and possible drug interactions should drive treatment decisions. If a person has had a prior good response to a medication, that medication should be initiated first. There are several classes of antidepressant medications: SSRIs, SNRIs, Tricyclics, MAOIs and atypical antidepressants. SSRIs and SNRIs, the most commonly prescribed antidepressants, have varying side effects, but nausea and headache are most common. To mitigate these transient side effects, start your patient at a low dose and titrate up as side effects subside. Always see patients within a few weeks of initiating a medication to assess side effects, medication adherence and to screen for thoughts of self-harm. If a patient has thoughts of self-harm, refer that patient for immediate assessment. Beacon can help with referrals to both inpatient and outpatient providers by calling **(888) 273-3710.**

# AUTHORIZATION REVIEW & DETERMINATION

**IN THIS ISSUE,** we would like to address one of the biggest requests we received from our providers on our provider survey – tell me more about Medicare guidelines that influence an authorization review and determination.

The Utilization Management (UM) department, including clinical staff, is available for all pre- certification requests and questions, Monday through Friday from 8:00 a.m. to 5:00 p.m. EST. Our staff is also on call after hours and on weekends to handle discharge planning requests from facilities and other emergent needs.

The UM Department uses the following criteria when making a determination for our Medicare members:

- Medicare National and Local Coverage Guidelines
- State Statutes, Laws, and Regulations
- InterQual Criteria
- Hayes Medical Technology
- Policy/Benefit Coverage
- Medical Director professional judgment based on review of literature, evidence-based guidelines, & other Managed Care Organizations

**FOR DUAL MEDICARE/ MEDICAID MEMBERS** the UM Department also uses the Agency for Healthcare Administration (AHCA) and Medicaid Coverage and Limitation Guidelines.

In addition to using its own Medical Directors, the UM Department uses board-certified consultants as appropriate to assist in making medical necessity determinations.

TIMEFRAMES:

**For standard requests**, the Health Plan processes authorization requests as quickly as possible. Many of our requests are completed on the same day received, and our average turnaround time for all requests for service is less than 2 days. We urge our providers to include all necessary medical records when submitting a request in order to avoid unnecessary delays.

**STANDARD REQUESTS MAY BE SUBMITTED BY FAX: 866-608-9860 OR 888-202-1940**

**For expedited requests**, the review must be completed, including a notification to the member, within 72 hours from the time received at the Health Plan. Please note that a request should only be submitted as expedited if it is felt that waiting up to the standard time for a decision would place the patient's life, health or ability to regain maximum function in serious jeopardy.

**EXPEDITED REQUESTS MAY BE SUBMITTED BY PHONE: 888-796-0947 OR BY FAX: 866-608-9860 OR 888-202-1940**

**HOW TO CHECK THE STATUS OF A REQUEST**

- Call the UM Department during normal business hours, 8:00 a.m. to 5:00 p.m. EST on weekdays, to check the status of a request; or
- Access the Health Plan's Provider Portal, where you can review the status of a member's authorization request. If you have questions regarding the Provider Portal or would like access, please contact your Provider Relations representative for assistance.

# All About MEMBER CARE PLANS

Every Spring, we distribute the Plan's Care Plan Manual Guide to our Primary Care Physicians (PCPs). Every member enrolled in a Special Needs Plan (SNP) receives an Individualized Care Plan (ICP) developed specifically for them. Risk stratification and resulting ICPs are generated based on member specific information, Health Assessment Tool (HAT) and Disease Specific Health Assessment Tool (DS-HAT) responses, and as needed additional member assessments, depending on the available information and level of member engagement. These Care Plans are described below.

## Tier 1 Care Plans

Tier 1 Care Plans are developed and assigned to all SNP members based on their verified qualifying disease and/or dual-eligible status. These Care Plans are especially helpful during initial care transitions prior to receiving clinical assessment, updates, and subsequent claims, as well as for new members.

## Supplemental Tier 1 Care Plans (Health Appraisal Profiles)

Health Appraisal Profiles (HAPs) are personalized Supplemental Care Plans generated for members completing and returning a general Health Assessment Tool (HAT). The HAP serves as a self-management Care Plan and allows members to track their health status and associated risk factors based on their responses to several health-related topics, such as overall health, emotional health, healthy behaviors, and preventive health activities. The HAP offers members improvement opportunities and additional resources on varied healthcare topics which empower them to take an active role in their health in collaboration with their Primary Care Physician (PCP) Medical Home.

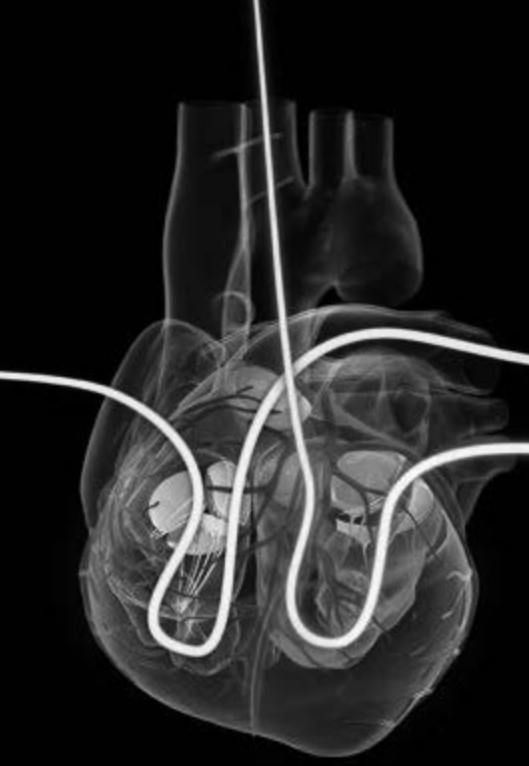
## Tier 2 Care Plans

Tier 2 Care Plans are developed utilizing member input, pharmacy data and claims experience. The member's answers to the Disease Specific Health Assessment Tool (DS-HAT) generate disease-specific problems with corresponding interventions and goals. The Care Plan includes the disease specific problem statement(s), interventions and goals, the self-reported disease health assessment, and the Member Summary. The Member Summary is developed from several sources including demographic data, claims, pharmacy, and lab data.

## Tier 3 Care Plans

Tier 3 Care Plans are generated following telephonic interviews and assessments between at-risk members and specific Nurse/Social Work Case Managers. This in-depth assessment results from the HAT/DS-HAT responses or other Case Management/Disease Management referral triggers. The Care Plan is developed, discussed, and shared with the PCP, member/caregiver and other necessary providers during finalization and ongoing updates. Tier 3 Care Plans are in addition to Tier 1 and 2 Care Plans. They represent the highest level of care for the most vulnerable enrollees.

Tier 1, HAP and Tier 2 Care Plans are all available to the member's current PCP on the Health Plan's MRA/HEDIS® Portal in the Care Plan section. Tier 3 Care Plans are faxed to the PCP at the time of creation, after material updates and upon case closure.



# DON'T FORGET THE STATINS!

American College of Cardiology and American Heart Association (ACC/AHA) guidelines recommend moderate or high-intensity statins for adults with clinical atherosclerotic cardiovascular disease (ASCVD). Likewise, there are related quality measures that promote statin use in the CMS Medicare 2022 Part C & D Star Ratings.

The NCQA HEDIS® measure, "Statin Therapy for Patients with Cardiovascular Disease (SPC)," aims to encourage providers to prescribe the most effective drugs to treat high cholesterol in members with heart disease.

Specifically, this measure calculates the percentage of males 21-75 years of age and females 40-75 years of age in your patient population with clinical ASCVD, who were dispensed at least one high or moderate-intensity statin medication during the measurement year. The goal is to reduce major cardiovascular events in members who have been diagnosed with ASCVD.

**The measure excludes members who:**

- Were diagnosed with ESRD during the measurement year or the year prior.
- Were diagnosed with cirrhosis during the measurement year or the year prior.
- Were diagnosed with myalgia, myositis, myopathy or rhabdomyolysis during the measurement year.
- Had palliative care during the measurement year.
- Members in hospice or using hospice services during the measurement year.

**Other exclusions which may not apply to many Medicare Advantage-age members are:**

- Pregnancy or in vitro fertilization during the measurement year or the year prior.
- Members who were dispensed at least one prescription for clomiphene (Estrogen Agonist Medication) during the measurement year or the year prior.

Diabetics are another group at a higher risk for developing heart disease. The "Statin Use in Persons with Diabetes (SUPD)", which is adapted from the measure concept developed by the Pharmacy Quality Alliance (PQA), indicates most diabetics should take cholesterol medication to lower high cholesterol. Members between 40-75 years old who received at least two diabetes medication fills and received a statin medication fill during the measurement period are included in this measure. The measure excludes members who, during the measurement period:

- Were enrolled in hospice.
- Were diagnosed with ESRD or had dialysis coverage.
- Were diagnosed with rhabdomyolysis or myopathy.
- Were diagnosed with cirrhosis.
- Were diagnosed with pre-diabetes.

**Other exclusions which may not apply to many Medicare Advantage-age members are those who:**

- Were diagnosed with polycystic ovary syndrome (PCOS).
- Were pregnant, lactating or undergoing fertility treatments.

**These generic statins have a $0 co-pay and are covered through the gap or "donut hole". They are also covered up to a 100-day supply:**

- Atorvastatin
- Rosuvastatin
- Simvastatin
- Lovastatin
- Pravastatin

You prescribe the most effective medications because you care about your patients and want to help them avoid cardiovascular events and stay as healthy as possible. Proactive prescribing can also raise your HEDIS® scores and Star ratings. Do the best for your patients and your practice – don't forget the statins!

# MRA Coding and Documentation Best Practices

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. We are offering Physician to Physician MRA Education. Requests can be emailed to riskadjustment@freedomh.com. The following are best practices for common areas of documentation improvement.

- Only conditions properly addressed and documented during either a face-to-face encounter or a telehealth visit with real-time audio and **video** communication will meet risk adjustment requirements.
- All MRA diagnoses submitted must be **active** (not resolved), **documented, evaluated, addressed**, and **supported** within each portion of the S.O.A.P note.
- Document diagnoses addressed during the visit with respective dated diagnostic test results incorporated in the note. Some examples include the most recent:

✓ HgbA1c for DM
✓ GFR for CKD
✓ Platelet count for thrombocytopenia
✓ EF (with test) for CHF
✓ Vascular study for PAD
✓ PHQ-9 for Major Depressive Disorder

- Causal relationships between conditions should be reported using linking verbiage. For example, Chronic Kidney Disease Stage 3 due to Type 2 Diabetes.
- Progress notes should clearly indicate a unique record for each date of service with the absence of cloning or sections copied from previous notes.
- Substance Use Disorder documentation must support 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.**

- Acute codes including strokes and unstable angina are only to be coded on the date of the acute event. Other non-acute or late effect codes may be applicable after the acute date of service.
- Active cancer codes should only be assigned when the cancer is present and under active treatment or watchful waiting. Personal history codes should be assigned for excised or resolved cancers that are no longer receiving active treatment.

We look forward to our continued partnership in striving to achieve greater specificity in coding and proper documentation required to support diagnoses submitted for risk adjustment.

# Population Health Management

The Health Plan has a comprehensive Population Health Management (PHM) Strategy with member programs and services spanning the care continuum of health promotion and wellness for acute care, post-acute care, disease and chronic illness management.

The cornerstone of our Population Health Strategy is an established primary care medical management model with patient centered medical homes. In this model, you, our providers as the member's personal physician are "in charge of overseeing and coordinating" the member's care are key contributors.

**Our PHM Strategy addresses member needs in the following four areas of focus:**

- Keeping members healthy
- Managing members with emerging risk
- Patient safety or outcomes across settings and
- Managing multiple chronic illnesses.

Members are informed about our PCP Medical Home Model in Sales and Marketing material, in the Plan Overview and in their EOC. The Plan supports and reinforces the PCP Medical Home Model throughout the organization. For example, when specialists or members approach the Plan directly to access services through authorization requests, the Plan reaches out to the PCP to facilitate PCP engagement and awareness of service requests. Similarly, all approved authorizations, regardless of the service provided, are communicated to the PCP as informational.

The Health Plan's PHM Strategy is supported by programs and activities that address member needs across the continuum of care and promotes 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. And, to make this possible, we have a shared responsibility to identify every opportunity to remediate care gaps.

Freedom Health and Optimum HealthCare work hard to help our members and providers overcome barriers to promote optimized health outcomes. We are proud of the many initiatives we have in place to provide fair access to health. To assure we are actively promoting and succeeding with our PHM Strategy, the Plan has annual goals tied to each of the program components. These goals collectively facilitate member/provider interaction and ongoing health plan support to both.

# PREPARING YOUR PATIENTS FOR DISCHARGE

Freedom Health and Optimum HealthCare are here to help our most vulnerable members negotiate the healthcare system, and to help you by providing them with direction and guidance. We wanted to let you see a short article which was in our last member newsletter regarding what happens at hospital discharge. It's a complicated process, more so after an illness or injury, and we want our members to be prepared. The article details what to expect from the discharge planner and discharging provider, what questions to ask and how to make sure there will be help once at home. Our Case and Disease Managers, Social Workers and Dietitian are always available to you for referrals for even more personalized assistance. Please call 888-211-9913 or fax 888-314-0794.

We would also love your feedback on our member materials - please contact your Plan Provider Relations representative or our Case Management Department with any comments or suggestions for other member article ideas.

## When You Leave the Hospital

You may need additional help after discharge. While in the hospital your case manager or discharge planner helps you plan for going home. You and your home caregiver need to take part in the planning process. Everyone involved needs to know the discharge plan so it can work. This includes what to expect. Don't hesitate to speak up and ask questions. You need to know what help will be provided to you once you are home, if any. This could be a home health nurse visit or wound supplies. It could also be a walker or the delivery of ready to eat meals.

Make sure to ask questions before you leave the hospital. Your understanding of the instructions can affect how well you do at home. It could also help you to avoid problems once you are home.

**Things to know before you leave the hospital:**

1. The date when you are expecting to leave the facility. Plan ahead for the discharge home. Do you have a ride?
2. What to expect when you get home. What will you be able to do? It's great to have a second person there when the nurse reviews the instructions with you.
3. Who will support you at home?
4. How will you manage grocery shopping, cooking and getting medications filled?
5. Ask before you go home, what type of problems should you call for? The nurse or doctor will review this with you before you leave.
6. The name and phone number of who you should get in touch with, in case there is a problem with what was planned. Your PCP will want to know too.
7. Understand your medicines before you leave the facility. This includes understanding why they changed, why you are taking them, when to take them and side effects of which to be aware.
   a. If you can't afford to pay for your medicine or can't get to the pharmacy, let the hospital nurse or discharge planner know before you go home.
   b. Call your doctor if you stop taking medicines for any reason. The PCP will want to know if you are nauseous, or they make you dizzy.
   c. Do you have the needed supplies for dressing changes?
8. Any discharge tasks for you or your caregiver. This could be dressing changes or weighing yourself daily. Know how to do them. Make sure you can do the task. Let the hospital nurse know if you don't think you can do it.
9. Make a follow-up appointment with your PCP within 7 days of going home. Your PCP will want to see you. The PCP will want to review your plan of care too and review your medications with you. It is very important for your doctor to review the medications with which you were discharged. They may need to be adjusted. You should know when to call to report problems.

# **2022** MTM PROGRAM **INFORMATION**

Medication Therapy Management (MTM) is a star score measure and we are on our way to 5 stars, but we are asking for some additional help from our providers to achieve our goal.

The Health Plan offers an MTM program for all its members who qualify based on specific eligibility criteria. The program includes a broad range of healthcare services provided by Clinical Pharmacists; including helping patients overcome barriers to adherence, addressing gaps in therapy, education on medications and disease states, reducing the use of unnecessary therapy, assessing for adverse effects, and advising on preventative measures.

MTM eligibility criteria is comprised of having a minimum of three (3) chronic diseases, eight (8) covered chronic/maintenance Part D drugs and incurring one-fourth ($1,174) of the specified annual cost threshold of $4,696 of Part D covered medications in the previous three months.

Our objective is to complete the member's comprehensive medication review within the first 60 days of MTM enrollment with the plan. Any member who chooses to opt-out of the MTM program within the 60-day timeframe will not count towards the denominator at the end of the year. Therefore, it is imperative to make outreach to those members who become eligible as soon as possible and remove opted out members from the program during this window of opportunity.

MTM eligibility files are released on a monthly basis, and you can find your members who remain eligible to complete their CMR for the year on the HEDIS portal.

We ask that you make outreach to your eligible members and advise of the importance of completing this medication review with one of our Health Plan pharmacists, and then transfer or provide them with our MTM department contact information (813-506-6064) to complete the medication review.

**CMS cut points below:**

| Type | Year | 1 Star | 2 Stars | 3 Stars | 4 Stars | 5 Stars |
|---|---|---|---|---|---|---|
| MAPD | 2022 | < 54 % | >= 54 % to < 72 % | >= 72 % to < 82 % | >= 82 % to < 89 % | ≥ = 89 |

# PARTNER WITH CASE & DISEASE MANAGEMENT NURSES

**THE PLAN CAN COLLABORATE WITH** you to help provide members the services they need to better manage their health or plan of care. You can refer a patient to Case Management, Disease Case Management or Social Work with just a phone call or written referral. Our 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 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 services, and reduce readmissions.

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

**MEMBERS ENROLLED INTO ONE** of our Case and Disease Management programs, 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 members' concerns or issues. We appreciate when providers support member participation in these programs as a collaborative effort to maximize health and wellbeing. Provider communication efforts are also enhanced via a care plan developed by the nurse and/or managed care coordinator along with the member, highlighting mutually agreed-upon goals and interventions. Updates to the care plan are provided as well when initiatives change.

## CONTACT

### Call us toll-free at

**1-888-211-9913**

from 8:00 a.m. to 4:00 p.m. 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**

Summer 2022

# CREDENTIALING CORNER

## The Plan Accepts CAQH Proview Credentialing applications.

Please continue to keep your credentialing application information and attached documentation current in the CAQH Proview database. When logging into your ProView Provider Sign-in, please take note of the informational banners that CAQH uses to announce updates to their system, as well as the monthly emailed CAQH ProView Updates. 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 should be current:**

- 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 the 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 re-credentialing, as well as the deadline for the submission of all current information.

Active provider status is dependent upon completion of the re-credentialing process prior to the three-year expiration date.

*Thank you for your timely submission!*

……and just a quick reminder, please promptly notify us of any change in your credentials.

# GUN INCIDENTS IN THE MEDICAL OFFICE

Guns are pervasive and threats of gun violence are a reality. As a medical provider, one of your foremost duties is patient and staff safety. An effective office safety program involves identifying hazards, developing a plan to mitigate them, and having practice drills, thereby protecting people and premises. Certain factors may act as catalysts for gun incidents in medical offices:

- an anxious or angry patient or family member.
- long wait times, especially as the day progresses.
- patients/family left in waiting or exam rooms with no information or attention from staff.
- provider use of cell phones or computers, giving the impression of unconcern.

## PLAN

- Call the police before a situation turns violent.
- Recognize that an incident might occur; formulate a plan for dealing with it.
- Review your plan with staff. Train staff to recognize signs of patient or family stress, including nonverbal language – and to defuse the situation with simple strategies: calming talk, a bottle of water or a separate waiting area.
- Evaluate the physical setup of the office and make changes if needed.
- Keep doors between waiting and exam areas locked, including the back door.
- Secure the reception area with a glass or heavy-duty plastic partition.
- Install cameras in waiting rooms and hallways.
- Give the front-desk person a code or alarm with which to alert others, and a list of emergency numbers.
- Ask a police officer to speak to staff about office security and de-escalation tactics.
- Post signs in the office that violence of any kind will not be tolerated and will be reported to the police.

## PRACTICE

- Hold safety drills according to your written plan; change the plan as needed.
- Keep a record of your drills.

**For more tips and guidelines, see OSHA's "Preventing Workplace Violence in Healthcare:"**
***www.osha.gov/dsg/hospitals***

# **Reducing Readmissions for Members with CHF:** Chronic Care Improvement Program

Medicare Advantage (MA) organizations are required to conduct a Chronic Care Improvement Program (CCIP) initiative every three years. The Health Plan's 2022-2024 CCIP is focusing on promoting effective management of members that have incurred an inpatient readmission where Congestive Heart Failure (CHF) was listed as a primary or secondary diagnosis.

Members are identified for inclusion into our CCIP based on medical claims. The target population is Medicare members (individuals aged 65 or older or disabled) with a readmission having occurred within the past two years. The CCIP will be carried out over a three-year period.

CHF affects nearly 5 million Americans and is responsible for more hospitalizations than all forms of cancer combined. The disease is responsible for 11 million physician visits each year and contributes to approximately 287,000 deaths annually. The incidence of CHF approaches 10 per 1,000 persons after the age of 65.

In total, our MA Plans have 28,646 members with a diagnosis of CHF. This accounts for approximately 22% of the total membership. In 2020, the Plans had 4,200 inpatient admissions where CHF was listed as a diagnosis. This accounts for 12.7% of all 2020 admissions. During 2020, 459 members experienced at least one readmission into an inpatient facility, and in total 508 unique readmissions occurred that had a listed diagnosis of CHF.

The Health Plan's goal is to reduce the potential for these members to need a readmission into an acute care inpatient facility.

As an included benefit, members have access to nurses that can provide Disease Management services at no additional cost. As part of the Plan's Disease Management model, nursing staff provide ongoing self-management education and support to the member and help to coordinate medical and social service needs. The goal is to keep members healthy and happy.

CCIP progress will be measured by advancement toward a target goal approved through the Plan's Quality Program up to and including the Board of Directors. The goal is derived from review of the prior admissions and readmissions where a diagnosis of CHF was included.

If you have a member that you feel could benefit from participation in this program please complete the Case/ Disease Management Referral Form found in your provider manual or on the Plan website under the 'Tools and Resources' page.

# REQUEST FOR ADDITIONAL INFORMATION on Organizational Determinations

When the Utilization Management (UM) Department receives a PCP's organizational determination request, complete clinical information from the member's health record is necessary to determine whether clinical guidelines for specific requested services are met.

UM uses phone and fax communication to reach out to providers. UM has a process and policy in place that mirrors CMS guidance, emphasizing that outreach be made as early in the coverage decision process as possible.

In order to assure rapid authorization turnaround times, the PCP should respond on the same day to information requests from UM. This is especially critical if the request is expedited. Quick response times from PCP's contribute significantly to our goal of completing all standard organizational determinations within 5 days.

This same process of PCP outreach occurs when requests for services are received from a provider other than a member's PCP. In these cases, UM will notify the member's PCP about the request, including the clinical information received with the request, and seek PCP review and input on the request.

If a PCP does not respond to an information request in a timely manner, the request and information will be forwarded to the health plan's Medical Director for a final decision. Having all relevant information available leads to more informed, accurate decisions, so timeliness of PCP response is important. A PCP's quick response to UM requests assure the Plan has relevant PCP medical records and clinical opinions for UM decision-making.

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FREEDOM HEALTH

OPTIMUM HealthCare, Inc.

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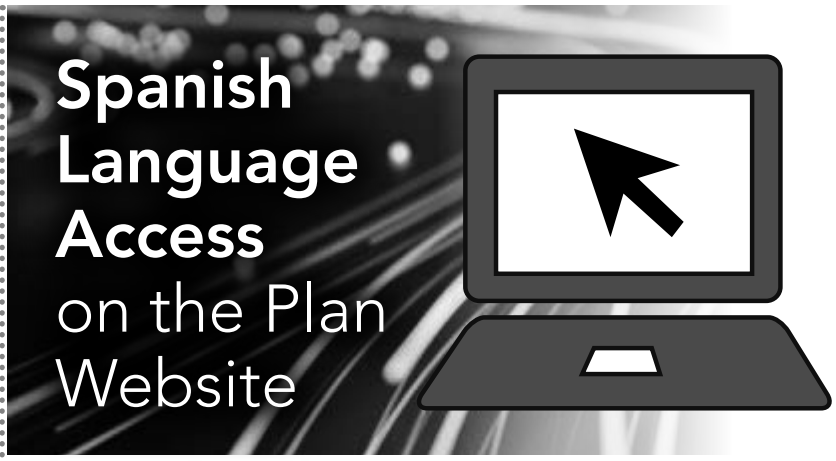
# provider NEWS

SUMMER 2022

## IN THIS ISSUE





## Spanish Language Access on the Plan Website

Our Spanish-speaking members account for the Plan's highest preferred language other than English. With that in mind, last year we made changes to our Plan websites to help ensure that our members are equipped with the necessary tools to navigate the health care system.

We are proud that Freedom Health and Optimum HealthCare strive to have a more bilingual website presence. Our Plan websites at www.freedomh.com or www.youroptimumhealthcare.com are Spanish language enabled, making it easier to navigate to the information the members need. We continue to identify opportunities to make health plan information more accessible to all our members and look forward to sharing more about our achievements with our valued providers.