



OPTIMUM
HealthCare, Inc.

CPM

Care Plan Manual
2018

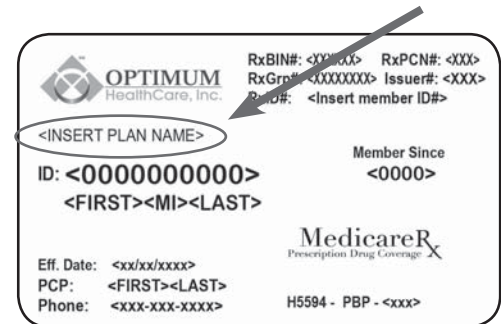
Dear Optimum HealthCare Provider,

You currently have members that have chosen a Special Needs Plan (SNP) offered by Optimum HealthCare Plan. As part of the requirements for administering a SNP, Optimum HealthCare must complete a number of administrative tasks. This package is part of the administrative tasks required of Optimum HealthCare by the Centers for Medicare & Medicaid Services (CMS).

To Determine which of your Optimum Members is in a SNP/ID Card:

To determine which of your Optimum HealthCare patients is in a SNP please refer to the plan name on their member identification card as illustrated below. The associated table shows the type of SNP by plan name. As the patient's treating physician you know which chronic disease is applicable to your patient. Whenever possible please review the Care Plan with patients during office visits.

Plan Name	Plan Type	Disease
Optimum Diamond Rewards	Chronic SNP	CHF; CVD, Diabetes
Optimum Diamond Rewards COPD	Chronic SNP	Pulmonary Disease
Optimum Emerald Partial	Dual SNP	Not applicable
Optimum Emerald Full	Dual SNP	Not applicable



What is a SNP?

Under the Medicare Modernization Act of 2003 (MMA), Congress created a new type of Medicare Advantage coordinated Care Plan focused on individuals with special needs. Special needs plans (SNPs) were allowed to target enrollment to one or more types of special needs individuals identified by Congress as: 1) institutionalized; 2) dually eligible; and/or 3) individuals with severe or disabling chronic conditions.

SNPs offer the opportunity to improve care for Medicare beneficiaries with special needs, primarily through improved coordination and continuity of care. Dual-eligible SNPs also offer the opportunity of enhanced benefits by combining those available through Medicare and Medicaid. SNPs focus on monitoring health status, managing chronic diseases, avoiding inappropriate hospitalizations and helping beneficiaries move from high risk to lower risk on the care continuum. Specific legislative and regulatory provisions allow SNPs to focus on specific subsets of the Medicare population with the intent to improve care and control costs for these beneficiaries.

What are included in SNP Condition?

Within our SNP, Optimum has identified five major disease states represented most frequently. These include: Diabetes, Cardiovascular Disease, Congestive Heart Failure, and Pulmonary diseases such as COPD and Asthma.

What are the CMS requirements for SNP's?

Centers for Medicare & Medicaid Services (CMS) require Plans to provide individualized Care Plans for each member enrolled in a SNP in order to help the member maintain/improve their health.

In addition to the Care Plan, CMS has created a number of administrative requirements to offer a SNP program:

- SNPs must have a Model of Care. This is the Plan's document delineating how it will deliver the specialized services and benefits to our SNP members.
- SNPs are required to have specialized providers necessary to meet the intensive needs of these patients.
- An initial and yearly comprehensive assessment of the member is also required.
- Optimum must gather information, as available, from the patient, the patient's caregivers and the patient's physicians.
- The information is to be reviewed by an interdisciplinary care team that develops a Care Plan specifically tailored to each SNP member.
- Coordinated Care must be provided through transitions from Hospital to SNF to Home.
- To monitor the effectiveness and improve the Care Plan, CMS requires that Optimum create a quality improvement program.

What is a Care Plan and how it is developed?

Every member enrolled into a Special Needs Plan (SNP) has a Care Plan developed specifically from the responses given on the Disease Specific Assessment. Member responses on the Initial Health Assessment Tool will also provide the Plan with information regarding their health as well as functional and emotional needs. From those responses, members are placed into one of three “tiers”.

Tier 1 Care Plans

Tier 1 Care Plans are assigned to all SNP members due to their qualifying disease (C-SNP) and /or dual-eligible status (D-SNP). Members stratifying into Tier 1 receive a disease-specific Care Plan that is appropriate for all individuals with the same or similar diagnosis as these individuals share similar healthcare challenges. For Dual Members without a known disease stratifying into Tier 1, the Health Plan has developed a Dual-eligible specific Care Plan that addresses common barriers and challenges incurred by Members sharing similar socio-economic backgrounds (unmet transportation needs, difficulty with copays, etc.). Tier 1 Care Plans are especially helpful during initial care transitions prior to receiving clinical assessment, updates, and subsequent claims experience as well as for new members. These Care Plans also serve as a safeguard to those members we are unable to contact, and those not completing Health Assessment Tools.

The next 5 pages are the Plan developed Tier 1 Care Plans.

CARDIOVASCULAR DISEASE CARE PLAN

Problems

1. Patient has Cardiovascular Disease

Interventions

1. Plan will mail educational packet four times a year and newsletters twice a year containing the following information:

- Importance of adherence to medication regimen
- Importance of blood pressure control
- Importance of diet
- Importance of exercise
- Importance of weight control
- Importance of smoking cessation
- Information of use of their Medical Home

2. Physician monitoring of outcomes for compliance with regimen goals following the selected evidence-based clinical guidelines:

- AHA/ACCF Secondary Prevention and Risk Reduction Therapy for Patients With Coronary and Other Atherosclerotic Vascular Disease. *Circulation*. November 2011.
<http://circ.ahajournals.org/content/124/22/2458>
- 2013 ACC/AHA Guidelines on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. *Circulation*. November 2013.
<http://circ.ahajournals.org/content/early/2013/11/11/01.cir.0000437738.63853.7a>
- Monitor timely and appropriate medication refills
- Monitor laboratory data for compliance with above recommended testing
- Monitor results to determine if further interventions need to be developed and addressed
- Monitor Emergency department and inpatient hospital admissions and encourage more frequent patient office visits and interventions

3. Other important interventions: See your patient within 7 days of all inpatient hospitalizations. Complete medication reconciliation during follow-up visit. Include documentation that the medications prescribed/ordered at discharge were reconciled with the patient's current medications.

At least annually, address the following with your patients and document in patients' records:

- Advance Care Planning
- Medication Review
- Functional Status Assessment
- Comprehensive Pain Screening

Goals

1. Maintain timely and appropriate medication refills
2. Primary care provider visit at least two (2) times a year
3. Obtain annual lipid profile, LDL-C
4. Patient understands use of their Medical Home
5. Decrease use of hospital emergency department
6. Decrease inpatient admissions

Revised 03/2018

CONGESTIVE HEART FAILURE CARE PLAN

Problems

1. Patient has Congestive Heart Failure

Interventions

1. Plan will mail educational packet four times a year and newsletters twice a year containing the following information:

- Importance of daily weights
- Importance of blood pressure control
- Importance of reducing salt intake
- Importance of smoking cessation
- Early signs of exacerbation of condition
- Importance of dietary compliance
- Information of use of their Medical Home

2. Physician monitoring of outcomes for compliance with regimen goals following the selected evidence-based clinical guidelines:

- 2017 ACC/AHA/HFSA Focused Update of the 2013 ACCF/AHA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines and the Heart Failure Society of America. Circulation. April 2017. <http://circ.ahajournals.org/content/early/2017/04/26/CIR.0000000000000509>
- Monitor timely and appropriate medication refills
- Monitor Emergency department and inpatient hospital admissions and encourage more frequent patient office visits and interventions
- Monitor results to determine if further interventions need to be developed and addressed

3. Other important interventions: See your patient within 7 days of all inpatient hospitalizations. Complete medication reconciliation during follow-up visit. Include documentation that the medications prescribed/ordered at discharge were reconciled with the patient's current medications.

At least annually, address the following with your patients and document in patients' records:

- Advance Care Planning
- Medication Review
- Functional Status Assessment
- Comprehensive Pain Screening

Goals

1. Maintain timely and appropriate medication refills
2. Obtain a baseline ejection fraction measurement
3. Obtain annual lipid profile, LDL-C
4. Primary care provider visit at least two (2) times a year
5. Patient understands use of their Medical Home
6. Decrease use of hospital emergency department
7. Decrease inpatient admissions

Revised 03/2018

DIABETES CARE PLAN

Problems
1. Patient has diabetes identified by HbA1c value
Interventions
<p>1. Plan will mail educational packet four times a year and newsletters twice a year containing the following information:</p> <ul style="list-style-type: none"> • Importance of adhering to medication regimens • Importance of an annual eye exam, foot care, blood sugar, and blood pressure control • Importance of smoking cessation • Importance of dietary compliance • Information of use of their Medical Home
<p>2. Physician monitoring of outcomes for compliance with regimen goals following guidelines:</p> <ul style="list-style-type: none"> • Standards of Medical Care in Diabetes – American Diabetes Association, January 2018. http://professional.diabetes.org/content/clinical-practice-recommendations • Monitor timely and appropriate laboratory data for compliance and recommended testing of HgbA1c, LDL-C level, and other profiles as needed • Monitor Emergency department and inpatient hospital admissions and encourage more frequent patient office visits and interventions • Monitor results to determine if further interventions need to be developed and addressed
<p>3. Other important interventions: See your patient within 7 days of all inpatient hospitalizations. Complete medication reconciliation during follow-up visit. Include documentation that the medications prescribed/ordered at discharge were reconciled with the patient's current medications.</p> <p>At least annually, address the following with your patients and document in patients' records:</p> <ul style="list-style-type: none"> • Advance Care Planning • Medication Review • Functional Status Assessment • Comprehensive Pain Screening
Goals
<ol style="list-style-type: none"> 1. Obtain HgbA1c at least two (2) times a year 2. Maintain HgbA1c at less than 7.0 percent <ol style="list-style-type: none"> a. HgbA1c poor control > 9.0% b. HgbA1c limited control ≥ 7.0% and ≤9.0% c. HgbA1c control < 7.0% 3. Maintain timely and appropriate medication refills 4. Primary care provider visit at least two (2) times a year 5. Obtain annual lipid profile, LDL-C 6. Maintain LDL-C level, < 100mg/dL 7. Obtain annual retinal exam, retinopathy 8. Obtain annual screen for micro albuminuria, nephropathy 9. Obtain annual foot exam, neuropathy 10. Patient understands use of their Medical Home 11. Decrease use of hospital emergency department 12. Decrease inpatient admissions/ readmissions

Revised 03/2018

DUAL ELIGIBLE MEMBER CARE PLAN

Problems
<p>1. Patient is socioeconomically disadvantaged which may negatively impact patient's ability to access needed and preventive healthcare services.</p>
Interventions
<p>1. Plan will identify the chronic condition. When the condition is diagnosed, the plan will provide accessibility, via mail, point of contact (PCP, and service providers), and other communication methods, such as an educational packet four times a year and newsletters twice a year containing the following information:</p> <ul style="list-style-type: none"> • Information of use of their Medical Home, which includes access and support to Social and Behavioral Services • Importance of smoking cessation • Importance of immunization • Importance of medication adherence • Early signs of exacerbation of condition • Importance of dietary compliance <p>2. Physician monitoring of outcomes for compliance with regimen goals following the selected evidence-based clinical guidelines:</p> <ul style="list-style-type: none"> • The Guide to Clinical Preventive Services: Recommendations of the U.S. Preventive Services Task Force (2014) http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/guide/ <p>Additional considerations:</p> <ul style="list-style-type: none"> • Monitor timely and appropriate medication refills • Monitor Emergency department and inpatient hospital admissions and encourage more frequent patient office visits and interventions • Monitor results to determine if further interventions need to be developed and addressed <p>3. Other important interventions: See your patient within 7 days of all inpatient hospitalizations. Complete medication reconciliation during follow-up visit. Include documentation that the medications prescribed/ordered at discharge were reconciled with the patient's current medications.</p> <p>At least annually, address the following with your patients and document in patients' records:</p> <ul style="list-style-type: none"> • Advance Care Planning • Medication Review • Functional Status Assessment • Comprehensive Pain Screening
Goals
<ol style="list-style-type: none"> 1. Maintain timely and appropriate medication refills 2. Primary care provider visit at least two (2) times a year 3. Obtain annual influenza immunization 4. Obtain pneumococcus immunization 5. Patient understands use of their Medical Home 6. Assist with Social Services and Behavioral Services 7. Educate patient on the program Eligibility requirements 8. Decrease use of hospital emergency department 9. Decrease inpatient admissions

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PULMONARY CARE PLAN

Problems
1. Patient has poor, intermediate, or at-risk pulmonary health
Interventions
<p>1. Plan will mail educational packet four times a year and newsletters twice a year containing the following information:</p> <ul style="list-style-type: none"> • Importance of smoking cessation • Importance of immunization • Importance of medication adherence • Early signs of exacerbation of condition • Importance of dietary compliance • Information of use of their Medical Home
<p>2. Physician monitoring of outcomes for compliance with regimen goals following the selected evidence-based clinical guidelines:</p> <ul style="list-style-type: none"> • Global Initiative for Chronic Obstructive Lung Disease (GOLD); <i>Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Lung Disease, 2017.</i> http://goldcopd.org/gold-2017-global-strategy-diagnosis-management-prevention-copd/ • Monitor timely and appropriate medication refills • Monitor Emergency department and inpatient hospital admissions and encourage more frequent patient office visits and interventions • Monitor results to determine if further interventions need to be developed and addressed
<p>3. Other important interventions: See your patient within 7 days of all inpatient hospitalizations. Complete medication reconciliation during follow-up visit. Include documentation that the medications prescribed/ordered at discharge were reconciled with the patient's current medications.</p> <p>At least annually, address the following with your patients and document in patients' records:</p> <ul style="list-style-type: none"> • Advance Care Planning • Medication Review • Functional Status Assessment • Comprehensive Pain Screening
Goals
<ol style="list-style-type: none"> 1. Maintain timely and appropriate medication refills 2. Primary care provider visit at least two (2) times a year 3. Obtain a baseline Spirometry measurement 4. Obtain annual influenza immunization 5. Obtain pneumococcus immunization 6. Patient understands use of their Medical Home 7. Decrease use of hospital emergency department 8. Decrease inpatient admissions

Revised 03/2018

Tier 2 Care Plans

Tier 2 Care Plans are developed utilizing member input, pharmacy data and claims experience. First, members were sent a disease specific assessment questionnaire specific to their reported condition. The answers to the self-assessment questionnaire are translated into the self-reported problem statements. Next, the answer to a particular question on the Health Assessment Tool (HAT) generates a disease-specific problem with an intervention and a goal. The Care Plan includes the disease specific problem statement, interventions and goals followed by the self-reported health assessment and lastly the Member Summary. The Member Summary was developed from a number of sources including demographic data, claims data, pharmacy data, and lab data.

What is a Disease Specific Health Assessment Tool (DS HAT)?

Disease Specific Health Assessment Tool or DS HAT is a set of questions developed by the medical team at Optimum Health specific to a disease. These questions are designed keeping in mind that a member will be answering them based on their self-knowledge of their condition. As part of our SNP program requirements, we send CMS required health assessments to our members. These questionnaires both address general health issues, and, if a member reported a chronic condition, members were sent an assessment specific to their reported condition. The chronic conditions covered in our SNP include — Diabetes, Cardiovascular Disease, Congestive Heart Failure and Pulmonary Care.

Here are the examples of DS HATs:

Diabetes Health Assessment Form *(continued)*

11. During a week, how often does your blood sugar drop below 70? (check one) <input type="checkbox"/> Never <input type="checkbox"/> 1 time a week <input type="checkbox"/> 2-3 times a week <input type="checkbox"/> More than 3 times a week <input type="checkbox"/> Don't know
12. How do you change your diet in order to control your blood sugar? (check one) <input type="checkbox"/> Control my carbohydrate intake <input type="checkbox"/> Control only my sugar intake <input type="checkbox"/> Don't follow a diet
13. When was the last time you attended Diabetes self management education classes? (check one) <input type="checkbox"/> Less than 1 year ago <input type="checkbox"/> 1-2 years ago <input type="checkbox"/> 3-5 years ago <input type="checkbox"/> More than 5 years <input type="checkbox"/> Never
14. Do you have any wounds that are not healing properly? <input type="checkbox"/> Yes <input type="checkbox"/> No
15. Do you have any of the following problems: (Check all that apply) <input type="checkbox"/> Cramping/pain in legs or buttocks after walking <input type="checkbox"/> Pins/needles/burning to legs and/or feet <input type="checkbox"/> Redness/swelling in legs <input type="checkbox"/> Lack of feeling in fingers or toes
16. How often do you have your feet checked? <input type="checkbox"/> 1 time a year <input type="checkbox"/> 2 times a year <input type="checkbox"/> Never
17. How often do you have a dilated eye exam? <input type="checkbox"/> 1 time a year <input type="checkbox"/> Never
18. How often do you have your urine checked? <input type="checkbox"/> 1 time a year <input type="checkbox"/> 2 times a year <input type="checkbox"/> Never
19. Does having Diabetes keep you from being active or socializing as much as you would like? <input type="checkbox"/> Yes <input type="checkbox"/> No
20. Does having Diabetes make you feel depressed? <input type="checkbox"/> Yes <input type="checkbox"/> No
21. How often do you exercise? (check one) <input type="checkbox"/> 1-2 days a week <input type="checkbox"/> 3-4 days a week <input type="checkbox"/> 5-7 days a week <input type="checkbox"/> Not routinely
22. Do you take any medicine for high blood pressure? <input type="checkbox"/> Yes <input type="checkbox"/> No
23. Does your blood pressure usually run higher than 140/90? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
24. Do you take any medicine for high cholesterol? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Do you take any medicine for chest pain? <input type="checkbox"/> Yes <input type="checkbox"/> No
26. If yes, has your chest pain been getting worse or more often? <input type="checkbox"/> Yes <input type="checkbox"/> No
27. Do you think your Diabetes has become better or worse over the past year? (check one) <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> Stayed the same
28. How would you rate your ability to take care of yourself with the support you have in place? (check one) <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor

Cardiovascular Assessment Form *(continued)*

11. Do you use Oxygen at home? <input type="checkbox"/> Yes <input type="checkbox"/> No
12. How often do you exercise per week? (check one) <input type="checkbox"/> 1-2 days <input type="checkbox"/> 3-4 days <input type="checkbox"/> 5-7 days <input type="checkbox"/> Don't exercise regularly
13. Does your heart condition prevent you from enjoying your life? (check one) <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Very Often <input type="checkbox"/> Always
14. How often have you seen your PCP in the last year for your heart condition? (check one) <input type="checkbox"/> 0 <input type="checkbox"/> 1 time <input type="checkbox"/> 2 times <input type="checkbox"/> 3-4 times <input type="checkbox"/> More than 4 times
15. How often have you seen your Cardiologist in the last year? (check one) <input type="checkbox"/> 0 <input type="checkbox"/> 1 time <input type="checkbox"/> 2 times <input type="checkbox"/> 3-4 times <input type="checkbox"/> More than 4 times
16. How often in the past year have you been to the Emergency Room due to your heart condition? (check one) <input type="checkbox"/> 0 <input type="checkbox"/> 1 time <input type="checkbox"/> 2-3 times <input type="checkbox"/> More than 3 times
17. How often in the past year have you been hospitalized due to your heart condition? (check one) <input type="checkbox"/> 0 <input type="checkbox"/> 1 time <input type="checkbox"/> 2-3 times <input type="checkbox"/> More than 3 times
18. Do you think your heart condition has become better or worse over the past year? (check one) <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> Stayed the same
19. How would you rate your ability to take care of yourself with the support you have in place? (check one) <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor

Congestive Heart Failure Assessment Form

P.O. Box 153178, Tampa, FL 33684
Health and Wellness Material

<Date>

<Member Name>

<Member Address>

<City> <State> <Zip>

|||||

Date of Birth <DOB>

Phone # <Phone #>

ID # <ID #>

To ensure you are properly managing your disease, please complete the following and return to us in the supplied envelope. These answers will help us to determine your disease status.

Have you been admitted to or been to a clinic at a VA (Veteran's Affairs) Hospital in the last 12 months? Yes No

If you received this form in error and don't have this disease, check the box and return the form to us in the supplied envelope without answering any of the questions below. No, I don't have Congestive Heart Failure.

1. Do you experience shortness of breath? (check one) <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Very Often <input type="checkbox"/> Always
2. Do you get tired or short of breath when walking? (check one) <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Very Often <input type="checkbox"/> Always
3. Do you have swelling in your feet, ankles, or legs? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. If you answered yes to #3, how deep a print does it leave? (check one) <input type="checkbox"/> ¼ inch <input type="checkbox"/> ½ inch <input type="checkbox"/> More than ½" <input type="checkbox"/> None
5. Do you experience abdominal pain or swelling? (check one) <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Very Often <input type="checkbox"/> Always
6. Does your Blood Pressure usually run higher than 130/80? (check one) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
7. Do you weigh yourself daily? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, do you have access to a scale? <input type="checkbox"/> Yes <input type="checkbox"/> No
8. How much does your weight change in a week? (check one) <input type="checkbox"/> 1 lb. <input type="checkbox"/> 2 lbs. <input type="checkbox"/> 3-4lbs. <input type="checkbox"/> More than 4 lbs.
9. Do you take a Diuretic? (i.e: water pill) (check one) <input type="checkbox"/> Once a day <input type="checkbox"/> Twice a day <input type="checkbox"/> More than twice a day <input type="checkbox"/> None
10. How often in the past year have you been to the Emergency Room due to your Congestive Heart Failure (CHF)? (check one) <input type="checkbox"/> 0 <input type="checkbox"/> 1 time <input type="checkbox"/> 2-3 times <input type="checkbox"/> More than 3 times
11. How often in the past year have you been hospitalized due to your CHF? (check one) <input type="checkbox"/> 0 <input type="checkbox"/> 1 time <input type="checkbox"/> 2-3 times <input type="checkbox"/> More than 3 times
12. What type of diet do you follow? (check all that apply) <input type="checkbox"/> Low Salt <input type="checkbox"/> Low Fat <input type="checkbox"/> High Potassium <input type="checkbox"/> High Fiber <input type="checkbox"/> No specific diet

Congestive Heart Failure Assessment Form *(continued)*

13. Do you smoke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14. Do you use Oxygen at home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes:	<input type="checkbox"/> 1-2 liters	<input type="checkbox"/> 3-4 liters
	<input type="checkbox"/> > 4 liters	
15. How often have you seen your PCP in the last 6 months?	(check one) <input type="checkbox"/> 0 <input type="checkbox"/> 1 time <input type="checkbox"/> 2 times <input type="checkbox"/> 3-4 times <input type="checkbox"/> More than 4 times	
16. How often have you seen your Cardiologist in the last year?	(check one) <input type="checkbox"/> 0 <input type="checkbox"/> 1 time <input type="checkbox"/> 2 times <input type="checkbox"/> 3-4 times <input type="checkbox"/> More than 4 times	
17. Does your Congestive Heart Failure interfere with your daily activities?	(check one) <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Very Often <input type="checkbox"/> Always	
18. Do you think your Congestive Heart Failure has become better or worse over the past year?	(check one) <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> Stayed the same	
19. Who treats you for your Congestive Heart Failure?	(check all that apply) <input type="checkbox"/> PCP <input type="checkbox"/> Cardiologist <input type="checkbox"/> Other	
20. How would you rate your ability to take care of yourself with the support you have in place?	(check one) <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	

Asthma Disease Management Assessment

P.O. Box 153178, Tampa, FL 33684
Health and Wellness Material

<Date>
 <Member Name>
 <Member Address>
 <City> <State> <Zip>
 |||

Date of Birth <DOB>

Phone # <Phone #>

ID # <ID #>

To ensure you are properly managing your disease, please complete the following and return to us in the supplied envelope. These answers will help us determine your disease status.

Have you been admitted to or been to a clinic at a VA (Veteran's Affairs) Hospital in the last 12 months? Yes No

If you received this form in error and don't have this disease, check the box and return the form to us in the supplied envelope without answering any of the questions below. No, I don't have Asthma.

1. How often do you experience shortness of breath? (check one) <input type="checkbox"/> Daily <input type="checkbox"/> 1-2 times a week <input type="checkbox"/> 2-4 times a month <input type="checkbox"/> Never
2. How often do you experience wheezing? (check one) <input type="checkbox"/> Daily <input type="checkbox"/> 1-2 times a week <input type="checkbox"/> 2-4 times a month <input type="checkbox"/> Never
3. In the past 4 weeks, how often did your Asthma interfere with your daily activities? (check one) <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Very Often <input type="checkbox"/> Always
4. Does your Asthma prevent you from getting a good night's sleep? (check one) <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Very Often <input type="checkbox"/> Always
5. How many medications do you take for your Asthma? (check one) <input type="checkbox"/> None <input type="checkbox"/> 1 <input type="checkbox"/> 2-3 <input type="checkbox"/> 4 or more
6. How often do you use a rescue inhaler (ex. Albuterol or ProAir)? (check one) <input type="checkbox"/> Daily <input type="checkbox"/> 1-2 times a week <input type="checkbox"/> 2-4 times a month <input type="checkbox"/> Never
7. Are you on a daily inhaled steroid? (ex. Advair or Pulmocort) <input type="checkbox"/> Yes <input type="checkbox"/> No
8. How many times in the past year did you need to take steroids by mouth (ex. Prednisone)? (check one) <input type="checkbox"/> Daily <input type="checkbox"/> 1-2 times a week <input type="checkbox"/> 2-4 times a month <input type="checkbox"/> Never
9. How many pills do you take for your Asthma? (check one) <input type="checkbox"/> 0 <input type="checkbox"/> 1-2 pills <input type="checkbox"/> 3-4 pills <input type="checkbox"/> More than 4 pills
10. What doctor takes care of your Asthma? (check all that apply) <input type="checkbox"/> Primary Care Doctor <input type="checkbox"/> Allergist <input type="checkbox"/> Pulmonologist
11. How many times in the past year have you seen your doctor for your Asthma? (check one) <input type="checkbox"/> None <input type="checkbox"/> 1-2 times <input type="checkbox"/> 3-4 times <input type="checkbox"/> 5 times or more
12. How many times in the past year have you been to the emergency room due to your Asthma? (check one) <input type="checkbox"/> None <input type="checkbox"/> 1-2 times <input type="checkbox"/> 3-4 times <input type="checkbox"/> 5 times or more
13. How many times in the past year have you been hospitalized due to your Asthma? (check one) <input type="checkbox"/> None <input type="checkbox"/> 1-2 times <input type="checkbox"/> 3-4 times <input type="checkbox"/> 5 times or more
14. How often do you use your peak flow meter? (check one) <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Very Often <input type="checkbox"/> Always
15. How often do you have to give yourself a breathing treatment with a nebulizer? (check one) <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Very Often <input type="checkbox"/> Always
16. Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No
17. Does someone in your household smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No
18. Do you think your Asthma has become better or worse over the past year? (check one) <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> Stayed the same
19. Do you have a written plan from your doctor of what to do when you start to wheeze? <input type="checkbox"/> Yes <input type="checkbox"/> No
20. How would you rate your ability to take care of yourself with the support you have in place? (check one) <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor

What are the National Guidelines used to develop the Care Plan?

To further help guide care for our SNP member, Optimum HealthCare's Medical Advisory Committee has adopted a number of nationally accepted care guidelines. The guidelines are:

Disease Process	Guidelines
Asthma	National Asthma Education and Prevention Program Expert Panel Report 3, Guidelines for the Diagnosis and Management of Asthma; Summary Report (2007) http://www.nhlbi.nih.gov/guidelines/asthma/asthsumm.pdf
Cardiovascular Disease	AHA/ACCF Secondary Prevention and Risk Reduction Therapy for Patients With Coronary and Other Atherosclerotic Vascular Disease. Circulation. November 2011. http://circ.ahajournals.org/content/124/22/2458 2013 ACC/AHA Guidelines on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. Circulation. November 2013. http://circ.ahajournals.org/content/early/2013/11/11/01.cir.0000437738.63853.7a
Chronic Obstructive Pulmonary Disease	Global Initiative for Chronic Obstructive Lung Disease (GOLD); <i>Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Lung Disease</i> , 2017. http://www.goldcopd.com/
Congestive Heart Failure	2017 ACC/AHA/HFSA Focused Update of the 2013 ACCF/AHA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines and the Heart Failure Society of America. Circulation. April 2017. http://circ.ahajournals.org/content/early/2017/04/26/CIR.0000000000000509
Diabetes	Standards of Medical Care in Diabetes – American Diabetes Association, January 2018. http://professional.diabetes.org/content/clinical-practice-recommendations
Preventive Health	The Guide to Clinical Preventive Services: Recommendations of the U.S. Preventive Services Task Force (2014) http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/guide/

Approved QMSC 02/2018

How to read a Tier 2 Care Plan

The Care Plan is comprised of the following 3 sections: 1) individualized Care Plan, 2) Self-Reported Problems and 3) Member Summary Report.

I. INDIVIDUALIZED CARE PLAN

The Care Plan for each member is based on their disease. Each Care Plan includes the reference to the Optimum HealthCare's Medical Advisory Board Committee's adopted and nationally accepted care guidelines, which define normal or optimal targets.

The Care Plan has four headers:

1. HAT #
2. Problem
3. Interventions
4. Goals

1. HAT # references the question number on the self-reported disease-specific Health Assessment Tool (HAT). Disease Specific Health Assessment Tool is a set of questions with possible answers developed by the Medical Team at Optimum HealthCare and answered by the member with best information they have about their condition and disease (Please see the attached DS HAT for reference).

2. Problem is the self-reported answer to the HAT question stating the member problem/condition.

3. Interventions are designed by our medical staff informing you of the possible measures and adherence to National Guidelines to be considered for the member's health status.

4. Goals are finally what are expected of the member's health after a possible intervention.

OPTIMUM HEALTH CARE PLAN

 Provider:
 Provider
 PCP Phone:

 Mbr Name:
 Home_Phone:
 Subscriber ID:

 Run Date:
 HICN:
 Gender: DOB:
 Plan:

DIABETES

Optimum HealthCare's Medical Advisory Committee has adopted a number of nationally accepted care guidelines, which define normal or optimal targets referenced in the below care plan. For Diabetes, we reference the following:

Standards of Medical Care in Diabetes – American Diabetes Association, 2016
<http://professional.diabetes.org/content/clinical-practice-recommendations>

All problems listed below are self-reported by member on a Diabetes Health Assessment Tool and should be validated by PCP.

HAT #	Problem	Interventions	Goals
6	Lack of Diabetes Control	Review latest HbA1c result or order HbA1c test and review with member.	Diabetes Control
9	Self-reported fasting blood sugar > 140	Evaluate Diabetes management plan	Glucose control
12	Knowledge deficit: Appropriate dietary regimen to control blood sugar level	Educate regarding dietary regimen to control blood sugar level	Member understands role of diet in Diabetes treatment plan
13	Diabetes Management Class completed > 1-2 years ago	Evaluate need to attend diabetes management class. If so, schedule for member.	Member understands guidelines for diabetes control (diet, exercise & monitoring)
15	Symptom: pins / needles / burning to legs and/or feet	Assess etiology of symptom and treat as necessary	Effective Diabetes management plan
20	Verbalization of depression	Evaluate and treat for depression. Facilitate referral to Mental Health Network.	Decrease feelings of depression
21	Lack of Exercise	Provide education on appropriate exercise/activities	Increase Activity/Exercise by Member
23	Knowledge deficit: Blood Pressure status	Educate Member on blood pressure role in Diabetes	Confirmation of Co-morbid condition: Hypertension. Improve member understanding of cardiac risk factors

SELF REPORTED PROBLEM STATEMENTS

The self reported problem statements are the answers to the question on DS HAT as reported by the member regarding their health.

Please be aware—THIS DOCUMENT IS DEVELOPED FROM MEMBERS SELF-REPORTED RESPONSES. ALL RESPONSES MUST BE CONFIRMED WITH THE MEMBER AND INTERVENTIONS AND GOALS ARE PLAN-GENERATED SUGGESTIONS. FURTHERMORE, THIS INFORMATION IS A ONE-TIME SNAPSHOT WHICH CAN CHANGE. PLEASE VERIFY ALL INFORMATION WITH YOUR PATIENT.

OPTIMUM HEALTH CARE PLAN

 Provider:
 Provider County:
 PCP Phone:

 Mbr Name:
 Home_Phone:
 Subscriber ID:

Run Date:
 HICN:
 Gender: DOB:
 Plan:

Self Reported Health Assessment
Confidential and Proprietary
DIABETES

- | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ol style="list-style-type: none"> 1. Member takes both pills and insulin for Diabetes. 2. Member takes insulin 2 - 3 times a day. 3. Member has not been to the hospital with diabetes in the past year. 4. Member sees doctor 2 times a year for Diabetes. 5. Member checks HbA1c twice a year. 6. Member's last HbA1c result between 7.6 and 9.0. 7. Member uses a glucometer. 8. Member checks blood sugar 2 times per day. 9. Member's fasting blood sugar usually runs more than 140. 10. Member's blood sugar usually runs between 141 - 180 if taken 2 hours after eating. 11. During a week, members blood sugar never drops below 70. 12. Member controls carbohydrate intake in order to control blood sugar. 12. Member controls sugar intake in order to control blood sugar. 13. Member attended a Diabetes Self Management class 1 - 2 years ago . | <ol style="list-style-type: none"> 14. Member does not have any wound(s) that are not healing properly. 15. Member has pins/needles/burning to legs and /or feet. 16. Member gets feet checked twice per year. 17. Member gets dilated eye exam once per year. 18. Member gets urine checked twice per year. 20. Diabetes does make the member feel depressed. 21. Member does not exercise routinely. 22. Member does not take any medicine for high blood pressure. 23. Member does not know if blood pressure usually runs more than 130/80. 24. Member does not take any medication for high cholesterol. 25. Member does not take any medicine for chest pain. 26. Member's chest pain has not been getting worse or more often. 27. Member's diabetes has stayed the same over the past year. |
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SELF REPORTED HEALTH ASSESSMENT

The self reported problem statements are the answers to the question on DS HAT as reported by the member regarding their health.

Please be aware—THIS DOCUMENT IS DEVELOPED FROM MEMBERS SELF-REPORTED RESPONSES. ALL RESPONSES MUST BE CONFIRMED WITH THE MEMBER AND INTERVENTIONS AND GOALS ARE PLAN-GENERATED SUGGESTIONS. FURTHERMORE, THIS INFORMATION IS A ONE-TIME SNAPSHOT WHICH CAN CHANGE. PLEASE VERIFY ALL INFORMATION WITH YOUR PATIENT.

MEMBER SUMMARY

This includes member's past diagnosis, prior date of service, any medications prescribed to the member, their continuity to the specified regimen, and any surgery or treatment provided.

The information on the Member Summary is pulled from the claims information. The report includes:

1. HCC Group History & Disease Type
2. Eligibility History
3. Claim Activity – Primary Care Physician
4. Claim Activity - Specialty
5. Claim Activity - Hospital
6. Claim Activity - Pharmacy
7. Claim Activity – Lab

1. HCC Group History & Disease Type: CMS pays Medicare Advantage plans based on the age/sex, demographic, county, and disease conditions of each particular member. This payment model is called the DCG/HCC Model and uses diagnoses identified for a patient within a given year to predict health risks for the following years along with potential resource utilization. A member's HCCs identify the type of disease the member was treated for in the past.

2. Eligibility History showing the effective date of election of the plan and its past history with the HMO.

3. Claim Activity – Primary Care Physician with ICD-10 Codes and CPT Codes

4. Claim Activity – Specialty with ICD-10 Codes and CPT Codes

5. Claim Activity – Hospital with ICD-10 Codes and CPT Codes

6. Claim Activity – Pharmacy

7. Claim Activity and Results – Lab

OPTIMUM HEALTH CARE PLAN

 Provider:
 Provider County:
 PCP Phone:

 Mbr Name:
 Home_Phone:
 Subscriber ID:

 Run Date:
 HICN:
 DOB:
 Gender:
 Plan:

Member Summary **Confidential and Proprietary**
CMS HCC History

HCC GROUP	DISEASE TYPE
HCC018	Diabetes with Chronic Complications
HCC022	Morbid Obesity

Eligibility History

Year	Effective Range
2015	01/01/2015 - 12/31/2015
2016	01/01/2016 - 12/31/2016
2017	01/01/2017 - CURRENT

Information and data included in claims based records relating to sensitive health conditions including, drug, alcohol or substance abuse, mental health, sexually transmitted diseases, HIV/AIDS have been suppressed. There may, however, be the inclusion of some information regarding sensitive conditions.

Claim Activity - PCP/Specialty

DOS	ICD10	ICD10 Description	HCC Grp	CPT/Rev	CPT/Rev Description	Specialty
3/6/2017	Z00.00	Encounter for general adu		1157F	ADVANCE CARE PLAN OR SIMILAR LEGAL DOCUMENT PRESENT IN THE MEDICAL RECORD (COA)	INTERNAL MEDICINE
3/6/2017	Z00.00	Encounter for general adu		3077F	MOST RECENT SYSTOLIC BLOOD PRESSURE GREATER THAN OR EQUAL TO 140 MM HG (HTN CKD CAD) (DM)	INTERNAL MEDICINE
3/6/2017	Z00.00	Encounter for general adu		3079F	MOST RECENT DIASTOLIC BLOOD PRESSURE 80-89 MM HG (HTN CKD CAD) (DM)	INTERNAL MEDICINE
3/6/2017	Z00.00	Encounter for general adu		94760	NONINVASIVE EAR OR PULSE OXIMETRY FOR OXYGEN SATURATION SINGLE DETERMINATION	INTERNAL MEDICINE
3/6/2017	Z00.00	Encounter for general adu		1159F	MEDICATION LIST DOCUMENTED IN MEDICAL RECORD (COA)	INTERNAL MEDICINE
3/6/2017	Z00.00	Encounter for general adu		1160F	REVIEW OF ALL MEDICATIONS BY A PRESCRIBING PRACTITIONER OR CLINICAL PHARMACIST (SUCH AS PRESCRIPTION	INTERNAL MEDICINE

Claim Activity - Other Health Care Providers

DOS	ICD10	ICD10 Description	HCC Grp	CPT/Rev	CPT/Rev Description	Specialty
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Claim Activity - Hospital

DOS	ICD10	ICD10 Description	HCC Grp	CPT/Rev	CPT/Rev Description	Specialty
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Claim Activity - Skilled Nursing Facility (SNF)

DOS	ICD10	ICD10 Description	HCC Grp	CPT/Rev	CPT/Rev Description	Specialty
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Claim Activity - Pharmacy

DOS	Supply	Drug Name	Prescriber	Generic
02/10/2017	19	NOVOLIN R INJ RELION		INSULIN REGULAR (HUMAN) INJ 100 UNIT/ML
02/10/2017	30	INSULIN SYRG MIS 1ML/31G		INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"
02/10/2017	30	METFORMIN TAB 1000MG		METFORMIN HCL TAB 1000 MG

Claim Activity - Lab

DOS	Vendor	Result Name	LOINC	Result
11/03/2016	QUEST	ABSOLUTE BASOPHILS	704-7	37
11/03/2016	QUEST	ABSOLUTE EOSINOPHILS	711-2	291
11/03/2016	QUEST	ABSOLUTE LYMPHOCYTES	731-0	2065
11/03/2016	QUEST	ABSOLUTE MONOCYTES	742-7	440
11/03/2016	QUEST	ABSOLUTE NEUTROPHILS	751-8	3367
11/03/2016	QUEST	RDW	788-0	14.6

Tier 3 Care Plans

Tier 3 Care Plans are generated following telephonic interview and assessment between at-risk members and specific Nurse/Social Work Case Managers. The in-depth assessment results from the HAT/DSHAT responses or other CM/DM 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 additive to Tier 1 and 2 Care Plans. These Care Plans are the highest level of care and is for the most vulnerable beneficiaries. These Care Plans are dynamic in nature, often changing more than weekly.

What Next?

Optimum HealthCare is required by CMS to work with the SNP population in an individualized fashion to improve their health status. This document was created with that goal in mind. Please be aware the majority of this information is based on self-reported member information. Thus, its accuracy needs to be confirmed. As such, our goals and interventions must be verified and then implemented if necessary.

We ask that you review the information that we have provided as a resource to help improve the health status of our members. More specifically, please:

- Review all claims to ensure that all of the members' diagnoses have been recorded in the current year.
- Write prescriptions for any therapeutic interchanges listed in the pharmacy section that are indicated.
- Review the problem list and considering the interventions suggested. If needed, please schedule an appointment with the member to discuss any issues.
- Review the plan-suggested goals both now and in the future to ensure the member has maximally improved their health status.
- Review the self-reported answers the member supplied to all questionnaires to gather a comprehensive picture of the member's perception of their disease.
- Communicate with Optimum to discuss any patients you feel could benefit from additional resources.

Sincerely,

Optimum HealthCare

