OPTIMUM HealthCare, Inc.

# Care Plan Manual

2024

www.youroptimumhealthcare.com

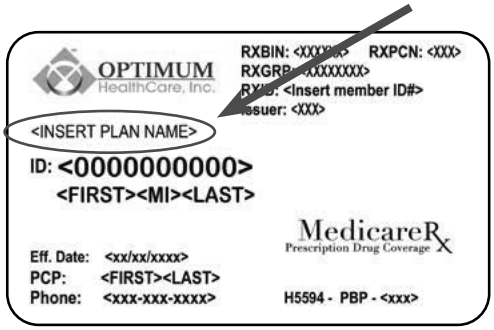
**Dear Optimum HealthCare Provider,**

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

**To Determine which of your Optimum HealthCare Members is in a SNP:**

To determine which of your Optimum HealthCare patients is in a SNP please refer to the plan name on the member's 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.

| 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 enrollees 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 enrollees move from high risk to lower risk on the care continuum. 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 enrollees.

**What SNP conditions are included?**

Within our SNP, Optimum HealthCare has identified four major disease states represented most frequently: Diabetes, Cardiovascular Disease, Congestive Heart Failure, and Pulmonary diseases including COPD and Asthma.

**What are the CMS requirements for SNP's?**

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.
- Optimum HealthCare must gather information, as available, from the patient, the patient's caregivers and the patient's physicians.
- An interdisciplinary care team which develops a care plan specifically tailored to each SNP member must review the information.
- Coordinated Care must be provided through transitions from Hospital to SNF to Home.
- To monitor effectiveness and improve the care plan, CMS requires that Optimum HealthCare create a quality improvement program.

An initial and yearly comprehensive assessment is also required for SNP members.

The plan initiates this through the use of the following two types of plan-developed Health Risk Assessment Tools:

- Initial/General Health Risk Assessment Tool (HRAT)
- Disease Specific Health Assessment Tool (DS-HAT)

**What is a General Health Risk Assessment Tool (HRAT)?**

The HRAT is sent to all SNP members at the time of enrollment and annually thereafter. The Plan makes multiple attempts to get both an initial HRAT (within 90 days of enrollment) and updated HRAT responses at least annually. The HRAT is a set of questions developed and reviewed annually by the medical team at Optimum HealthCare with the purpose of gathering general health information about our members. It includes questions to capture member perception of health and self-management skills, cognitive, emotional, and physical health and safety/environmental concerns, as well as member familiarity and understanding of our PCP Medical Home model among other topics. This tool helps us identify the most vulnerable members for additional care management screening and intervention.

Here is the example of the HRAT:

OPTIMUM HealthCare, Inc.

PO Box 15804, Tampa, FL 33684-9846
**Health & Wellness Material**

**OPT24HRATP1**

## Health Risk Assessment Tool (HRAT)

Please complete this annual survey. This information will help us understand your health needs. Your answers WILL NOT affect your benefits. We may share your information with your primary care provider(s). If you have any questions regarding this form, please call 1-866-245-5360. TTY: 711

**Please disregard this request if you have recently mailed a completed Health Risk Assessment Tool.**

Date: _____

Name: _____

Address: _____

City:_____ State:_____ Zip: _____

DOB:_____ Age: _____ Gender: ____

Phone number: _____

Member ID:_____

### A. Physical Health Rating

1. On a usual basis, how do you rate your health? (check one) ❑ Excellent ❑ Good ❑ Fair ❑ Poor

2. What is your height? (whole numbers) _____ Feet _____Inches 3. What is your weight? (whole numbers) _____lbs.

### B. Health History & Treatment

4. Please check whether you have any of the following: (CHECK ALL THAT APPLY)

| | | | | | |
|---|---|---|---|---|---|
| ❑ | Alzheimer's Disease/Dementia | ❑ | Diabetes | ❑ | Hospice |
| ❑ | Arthritis or pain in joints | ❑ | Lung Disease (Emphysema, Chronic Obstructive Pulmonary Disease (COPD) or Chronic Bronchitis) | ❑ | Kidney Problems/Dialysis |
| ❑ | Asthma | ❑ | Frequent Falls | ❑ | Leaking urine or stool |
| ❑ | Cancer | ❑ | Heart Attack or blocked arteries | ❑ | Organ Transplant |
| ❑ | Congestive Heart Failure/Foot, Ankle, Leg Swelling | ❑ | High Blood Pressure | ❑ | Skin Ulcer/Nonhealing Wound |
| ❑ | COVID-19 | ❑ | High Cholesterol or Triglycerides | ❑ | Stroke |
| ❑ | Depression or Other Mental Health Issues | ❑ | HIV/AIDS | ❑ | Other _____ |

5. When did you last see your Primary Care Physician? (check one) ❑ Less than 6 months ❑ More than 6 months ❑ 12 months ago or greater
**If you have not seen your Primary Care Physician in the last 6 months, please call the office to schedule an appointment.**

6. Do you currently use any assistive devices and/or medical equipment (such as wheelchair, walker, cane, raised toilet seat, oxygen, or electric bed)? ❑ Yes ❑ No

7. Are you receiving any nursing, therapy or home health care in your home? ❑ Yes ❑ No

8. Do you have blindness or trouble seeing even when wearing glasses? ❑ Yes ❑ No

9. Do you have deafness or trouble hearing even when wearing a hearing aid? ❑ Yes ❑ No

10. Have you received: (check all that apply) ❑ Flu shot in the past year ❑ Pneumonia shot in the past 5 years ❑ Unsure

11. **A.** If you are currently bothered by pain, please tell us how bad the pain is, with 1 being very little pain, 5 being moderate pain and 10 being severe pain: ❑ I have no pain ❑ 1 to 3 ❑ 4 to 6 ❑ 7 to 10
**B.** If you have ongoing pain, are you working with a doctor on pain control? ❑ Yes ❑ No

**OPT24HRATP2**

12. Have you seen a Dentist in the past 12 months? ❑ Yes ❑ No
**If you have not seen your Dentist, please call your dental provider to schedule an appointment.**

13. Have you had a colon cancer check in the last 10 years? ❑ Yes ❑ No ❑ Unsure

14. Have you received an eye exam (with dilation) in the past year? ❑ Yes ❑ No ❑ Unsure

15. If you are concerned about your health, do you know what steps you can take to improve your health? (check one)
❑ I am not concerned about my health. ❑ I am concerned and know steps that I can take.
❑ I am concerned, and my doctor is working with me. ❑ I am concerned and would like information on steps to improve my health.

16. Is there anything preventing you from taking steps to improve your health? (check one)
❑ No ❑ Yes, and I would like a call to discuss. ❑ Yes, and I am working on it.

## C. Activities of Daily Living

17. Do you need help with any of the following tasks? (Check all that apply):
❑ Bathing or dressing yourself ❑ Preparing meals ❑ Feeding yourself ❑ Using the bathroom ❑ Walking
❑ Getting up from a chair or bed ❑ Taking medication as prescribed ❑ Remembering and decision making

18. Do you have someone in your life that can provide you assistance with the tasks in Question #17 if you need help?
❑ No, I do not need help ❑ Yes, I have the help I need ❑ No, I need help that I don't have

## D. Lifestyle & Well-being

19. Do you use tobacco? (smoke, chew, snuff, vape or in any other form) ❑ Yes ❑ No ❑ Want to quit

20. Does drinking alcohol interfere with your personal or work life? ❑ Yes ❑ No ❑ I Don't Drink ❑ Want to quit

21. Do you feel you get enough physical activity/exercise? ❑ Yes ❑ No ❑ Want to improve

22. Do you feel that your diet supports a healthy lifestyle? ❑ Yes ❑ No ❑ Want to improve

23. Do personal or family health issues result in loss of work/daily activities? ❑ Yes ❑ No ❑ Unsure

24. What is your living situation today? (check one)
❑ I have a steady place to live.
❑ I have a place to live today, but I am worried about losing it in the future.
❑ I do not have a steady place to live. (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

25. Do you feel safe where you live? (check one) ❑ Yes ❑ No

26. Within the past 12 months, have you worried that your food would run out before you got money to buy more? (check one)
❑ Often true ❑ Sometimes true ❑ Never true

27. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? ❑ Yes ❑ No

28. Over the past 2 weeks, how often have you been bothered by any of the following feelings?
**A.** Feeling down, depressed or hopeless ❑ Not at All ❑ Several Days ❑ More than Half the Days ❑ Nearly Every Day
**B.** Little interest or pleasure in doing things ❑ Not at All ❑ Several Days ❑ More than Half the Days ❑ Nearly Every Day

29. Are you experiencing any of the following common effects or feelings of stress?
(Check all that apply): ❑ Anxiety ❑ Drug/Alcohol Abuse ❑ Irritability/Anger ❑ Sadness /Depression ❑ Social Withdrawal
❑ Chest Pain ❑ Headache ❑ Muscle tension/Pain ❑ Sleep Problem ❑ Upset Stomach
***If you have any of the above symptoms or feel that you are depressed, please set up an appointment with your PCP.***

30. Would you like information on how you can get help for these feelings? ❑ Yes ❑ No

31. Would you like information on Health Care Advance Directives such as a Living Will? ❑ Yes ❑ No

## E. Demographics

32. Do you identify with a particular cultural or spiritual group? ❑ Yes, _____ ❑ No ❑ Do not wish to answer

33. What is your preferred language? ❑ English ❑ Spanish ❑ French Creole ❑ Other: _____

34. What is your ethnicity? ❑ Hispanic ❑ Non-Hispanic ❑ Other: _____ ❑ Decline to Answer

35. What race do you belong to? ❑ African American ❑ Alaskan Native ❑ American Indian ❑ Asian ❑ Caucasian
❑ Pacific Islander or Native Hawaiian ❑ Other: _____ ❑ Decline to Answer

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

Our Disease Specific Health Assessment Tool or DS-HAT is a set of questions developed by the medical team at Optimum HealthCare specific to a disease. These tools are sent to C-SNP members based on their verified disease and D-SNP members based on self-reported disease on returned HRATs. The Plan uses a disease hierarchy developed by our medical team to ensure members only receive one DS-HAT based on Plan-determined priority. The chronic conditions covered in our SNP in lower to higher disease hierarchy include — Diabetes, Cardiovascular Disease, Congestive Heart Failure and Pulmonary Care. The questions in all the DS-HAT tools are designed based on a member's self-knowledge of their condition. Like the general HRAT, these tools help us identify the most vulnerable members for additional care management screening and intervention.

Here are the examples of DS-HATs:

# Cardiovascular Assessment Form

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

Date: _____

Name: _____

DOB: _____ Age: _____ Gender: ____

Address: _____

Phone number: _____

City: _____ State: _____ Zip: _____

Member ID: _____

Please complete the following assessment and return to us in the supplied envelope. These answers will help us determine your health status and ensure you are properly managing your health.

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 health condition, 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 Coronary Artery Disease.**

| |
|---|
| **1. Do you experience shortness of breath?** ❑ Yes ❑ No<br>**If yes, then how often do you get short of breath?**<br>(check one) ❑ Rarely ❑ Sometimes ❑ Very Often ❑ Always |
| **2. Do you experience chest pain?** ❑ Yes ❑ No<br>**If yes, how often do you have chest pain?**<br>(check one) ❑ Rarely ❑ Sometimes ❑ Very Often ❑ Always |
| **3. Do you have the following:** ❑ Swelling in feet, ankles or legs ❑ Poor circulation<br>**If you have swelling, how often do your feet, ankles or legs swell?**<br>(check one) ❑ Rarely ❑ Sometimes ❑ Very Often ❑ Always |
| **4. Have you ever had a Heart Attack?**<br>(check one) ❑ Yes ❑ No |
| **5. If yes, how long ago was your Heart Attack?**<br>(check one) ❑ Less than 1 year ❑ 2-3 years ago ❑ More than 3 years ago |
| **6. Have you ever had heart surgeries, ex. bypass, stents?** ❑ Yes ❑ No |
| **7. Does your Blood Pressure usually run higher than 140/90?**<br>(check one) ❑ Yes ❑ No ❑ Don't Know |

H5594_2024_DSHAT_CVD_C

# Cardiovascular Assessment Form *(continued)*

**8. Do you have any of the following?** (check all that apply)
❑ High Cholesterol ❑ Diabetes ❑ Hypertension

**9. Do you use tobacco (smoke, chew, snuff, vape or in any other form)?** ❑ Yes ❑ No

**10. What type of diet do you follow?**
(check one) ❑ Low Salt ❑ Low Fat ❑ Heart Healthy ❑ No specific diet

**11. Do you use Oxygen at home?** ❑ Yes ❑ No

**12. How often do you exercise per week?**
(check one) ❑ 1-2 days ❑ 3-4 days ❑ 5-7 days ❑ Don't exercise regularly

**13. Does your heart condition prevent you from enjoying your life?**
(check one) ❑ Never ❑ Rarely ❑ Sometimes ❑ Very Often ❑ Always

**14. How often have you seen your PCP in the last year for your heart condition?**
(check one) ❑ 0 ❑ 1 time ❑ 2 times ❑ 3-4 times ❑ More than 4 times

**15. How often have you seen your Cardiologist in the last year?**
(check one) ❑ 0 ❑ 1 time ❑ 2 times ❑ 3-4 times ❑ 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) ❑ 0 ❑ 1 time ❑ 2-3 times ❑ More than 3 times

**17. How often in the past year have you been hospitalized due to your heart condition?**
(check one) ❑ 0 ❑ 1 time ❑ 2-3 times ❑ More than 3 times

**18. Do you think your heart condition has become better or worse over the past year?**
(check one) ❑ Better ❑ Worse ❑ Stayed the same

**19. How would you rate your ability to take care of yourself with the support you have in place?**
(check one) ❑ Excellent ❑ Good ❑ Fair ❑ Poor

**20. What is your living situation today?** (check one)
❑ I have a steady place to live
❑ I have a place to live today, but I am worried about losing it in the future.
❑ I do not have a steady place to live. (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

**21. Within the past 12 months, have you worried that your food would run out before you got money to buy more?**
(check one) ❑ Often true ❑ Sometimes true ❑ Never true

**22. In the past 12 months, has lack of reliable transportation kept you from medical appointment, meetings, work, or from getting things needed for daily living?** ❑ Yes ❑ No

# Diabetes Health Assessment Form

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

Date: _____

Name: _____

Address: _____

City:_____ State:_____ Zip: _____

DOB:_____ Age: _____ Gender: ____

Phone number: _____

Member ID:_____

Please complete the following assessment and return to us in the supplied envelope. These answers will help us determine your health status and ensure you are properly managing your health.

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 health condition, 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 Diabetes.**

| |
|---|
| **1. Which type of medication do you take for your Diabetes?**<br>(check one) ❑ Pills only ❑ Insulin only ❑ Both pills and insulin ❑ Other medicine by shot ❑ None |
| **2. If you take insulin, how often do you take it:**<br>(check one) ❑ 1 time a day ❑ 2-3 times a day ❑ More than 3 times a day ❑ On an insulin pump |
| **3. How many times in the past year have you had to go to the hospital due to your Diabetes?**<br>(check one) ❑ 0 ❑ 1 time ❑ 2-3 times ❑ More than 4 times |
| **4. How often do you see your doctor about your Diabetes?**<br>(check one) ❑ 0 ❑ 1 time a year ❑ 2 times a year ❑ 3 times a year or greater |
| **5. How often do you have your blood HbA1c checked?**<br>(check one) ❑ 0 ❑ 1 time a year ❑ 2 times a year ❑ Never ❑ Don't know what this is? |
| **6. What was your last HbA1c result?**<br>(check one) ❑ 6.5 or less ❑ Between 6.6 and 7.5 ❑ 7.6 to 9.0 ❑ More than 9.0 ❑ Don't know |
| **7. Do you use a glucometer (blood sugar testing device)?** ❑ Yes ❑ No |
| **8. On a daily basis, how often do you check your blood sugar?**<br>(check one) ❑ 1 time ❑ 2 times ❑ 3 times ❑ 4 times ❑ 5 times or more ❑ Never |
| **9. What does your fasting (first one in the morning) blood sugar usually run?**<br>(check one) ❑ 110 or less ❑ 111-120 ❑ 121-140 ❑ More than 140 ❑ Don't know |
| **10. What does your blood sugar usually run if taken 2 hours after eating?**<br>(check one) ❑ 110 -120 ❑ 121-140 ❑ 141-180 ❑ More than 180 ❑ Don't know |

H5594_2024_DSHAT_DM_C

## Diabetes Health Assessment Form *(continued)*

**11. During a week, how often does your blood sugar drop below 70?**
(check one) ❑ Never ❑ 1 time a week ❑ 2 times a week ❑ 3 times or more a week ❑ Don't know

**12. How do you change your diet in order to control your blood sugar?**
(check one) ❑ Limit carbohydrate intake ❑ Limit sugar intake ❑ Don't follow a diet

**13. When was the last time you attended Diabetes self management education classes?**
(check one) ❑ Less than 1 year ago ❑ 1-2 years ago ❑ 3-5 years ago ❑ More than 5 years ❑ Never

**14. Do you have any wounds that are not healing properly?** ❑ Yes ❑ No

**15. Do you have any of the following problems:** (check all that apply)
❑ Cramping/pain in legs or buttocks after walking ❑ Pins/needles/burning to legs and/or feet
❑ Redness/swelling in legs ❑ Lack of feeling in fingers or toes

**16. How often do you have your feet checked?** ❑ 1 time a year ❑ 2 times a year ❑ Never

**17. How often do you have a dilated eye exam?** ❑ 1 time a year ❑ Never

**18. How often do you have your urine checked?** ❑ 1 time a year ❑ 2 times a year ❑ Never

**19. How often do you exercise?**
(check one) ❑ 1-2 days a week ❑ 3-4 days a week ❑ 5-7 days a week ❑ Not routinely

**20. Do you take any medicine for high blood pressure?** ❑ Yes ❑ No

**21. Does your blood pressure usually run higher than 140/90?** ❑ Yes ❑ No ❑ Don't know

**22. Do you take any medicine for high cholesterol?** ❑ Yes ❑ No

**23. Do you take any medicine for chest pain?** ❑ Yes ❑ No

**24. If yes, has your chest pain been getting worse or more often?** ❑ Yes ❑ No

**25. Do you think your Diabetes has become better or worse over the past year?**
(check one) ❑ Better ❑ Worse ❑ Stayed the same

**26. How would you rate your ability to take care of yourself with the support you have in place?**
(check one) ❑ Excellent ❑ Good ❑ Fair ❑ Poor

**27. What is your living situation today?** (check one)
❑ I have a steady place to live
❑ I have a place to live today, but I am worried about losing it in the future.
❑ I do not have a steady place to live. (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

**28. Within the past 12 months, have you worried that your food would run out before you got money to buy more?**
(check one) ❑ Often true ❑ Sometimes true ❑ Never true

**29. In the past 12 months, has lack of reliable transportation kept you from medical appointment, meetings, work, or from getting things needed for daily living?** ❑ Yes ❑ No

# Congestive Heart Failure Assessment Form

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

Date: _____

Name: _____

Address: _____

City:_____ State:_____ Zip: _____

DOB:_____ Age: _____ Gender: ____

Phone number: _____

Member ID:_____

Please complete the following assessment and return to us in the supplied envelope. These answers will help us determine your health status and ensure you are properly managing your health.

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 health condition, 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?**<br>(check one) ❑ Never ❑ Rarely ❑ Sometimes ❑ Very Often ❑ Always |
| **2. Do you get tired or short of breath when walking?**<br>(check one) ❑ Never ❑ Rarely ❑ Sometimes ❑ Very Often ❑ Always |
| **3. Do you have swelling in your feet, ankles, or legs?** ❑ Yes ❑ No |
| **4. If you answered yes to #3, how deep a depression does it leave?**<br>(check one) ❑ ¼ inch ❑ ½ inch ❑ More than ½ inch ❑ None |
| **5. Do you experience stomach pain or swelling?**<br>(check one) ❑ Never ❑ Rarely ❑ Sometimes ❑ Very Often ❑ Always |
| **6. Does your Blood Pressure usually run higher than 140/90?**<br>(check one) ❑ Yes ❑ No ❑ Don't Know |
| **7. Do you weigh yourself daily?** ❑ Yes ❑ No<br>**If no, do you have access to a scale?** ❑ Yes ❑ No |
| **8. How much does your weight change in a week?**<br>(check one) ❑ 1 lb. ❑ 2 lbs. ❑ 3-4 lbs. ❑ More than 4 lbs. |
| **9. Do you take a Diuretic? (i.e: water pill)**<br>(check one) ❑ Once a day ❑ Twice a day ❑ More than twice a day ❑ None |

H5594_2024_DSHAT_CHF_C

## Congestive Heart Failure Assessment Form *(continued)*

**10. How often in the past year have you been to the Emergency Room due to your Congestive Heart Failure (CHF)?**
(check one) ❑ 0 ❑ 1 time ❑ 2-3 times ❑ More than 3 times

**11. How often in the past year have you been hospitalized due to your CHF?**
(check one) ❑ 0 ❑ 1 time ❑ 2-3 times ❑ More than 3 times

**12. What type of diet do you follow?**
(check all that apply) ❑ Low Salt ❑ Low Fat ❑ High Potassium ❑ High Fiber ❑ No specific diet

**13. Do you use tobacco (smoke, chew, snuff, vape or in any other form)?** ❑ Yes ❑ No

**14. Do you use oxygen at home?** ❑ Yes ❑ No
**If yes:** ❑ 1-2 liters ❑ 3-4 liters ❑ greater than 4 liters

**15. How often have you seen your PCP in the last 6 months?**
(check one) ❑ 0 ❑ 1 time ❑ 2 times ❑ 3-4 times ❑ More than 4 times

**16. How often have you seen your Cardiologist in the last year?**
(check one) ❑ 0 ❑ 1 time ❑ 2 times ❑ 3-4 times ❑ More than 4 times

**17. Does your Congestive Heart Failure interfere with your daily activities?**
(check one) ❑ Never ❑ Rarely ❑ Sometimes ❑ Very Often ❑ Always

**18. Do you think your Congestive Heart Failure has become better or worse over the past year?**
(check one) ❑ Better ❑ Worse ❑ Stayed the same

**19. Who treats you for your Congestive Heart Failure?**
(check all that apply) ❑ PCP ❑ Cardiologist ❑ Both

**20. How would you rate your ability to take care of yourself with the support you have in place?**
(check one) ❑ Excellent ❑ Good ❑ Fair ❑ Poor

**21. What is your living situation today?** (check one)
❑ I have a steady place to live
❑ I have a place to live today, but I am worried about losing it in the future.
❑ I do not have a steady place to live. (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

**22. Within the past 12 months, have you worried that your food would run out before you got money to buy more?**
(check one) ❑ Often true ❑ Sometimes true ❑ Never true

**23. In the past 12 months, has lack of reliable transportation kept you from medical appointment, meetings, work, or from getting things needed for daily living?** ❑ Yes ❑ No

# COPD Assessment Form

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

Date: _____

Name: _____

Address: _____

City:_____ State:_____ Zip: _____

DOB:_____ Age: _____ Gender: ____

Phone number: _____

Member ID:_____

Please complete the following assessment and return to us in the supplied envelope. These answers will help us determine your health status and ensure you are properly managing your health.

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 health condition, 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 COPD.**

| |
|---|
| **1. How often do you experience shortness of breath?**<br>(check one) ❑ Never ❑ Rarely ❑ Sometimes ❑ Very Often ❑ Always |
| **2. Do you have an ongoing cough?**<br>(check one) ❑ Never ❑ Rarely ❑ Sometimes ❑ Very Often ❑ Always |
| **3. Has the doctor ordered Oxygen for you to use at home?** ❑ Yes ❑ No |
| **4. If you answered yes to question #3, how often do you use your Oxygen?**<br>(check one) ❑ Never ❑ Occasionally ❑ During the day ❑ Only at night ❑ All the time |
| **5. If you answered yes to question #3, do you use oxygen as ordered by your doctor?** ❑ Yes ❑ No |
| **6. If you answered yes to question #5, how many liters of Oxygen do you use?**<br>(check one) ❑ 1-2 liters ❑ 3-4 liters ❑ More than 4 liters |
| **7. Do you use a hand-held nebulizer at home?** ❑ Yes ❑ No |
| **8. Do you use different breathing methods (ex. pursed-lips) when short of breath or anxious?**<br>(check one) ❑ Never ❑ Rarely ❑ Sometimes ❑ Very Often ❑ Always |
| **9. How many inhalers do you use?**<br>(check one) ❑ 1 inhaler ❑ 2-3 inhalers ❑ More than 3 inhalers ❑ Don't use an inhaler |
| **10. Do you use tobacco (smoke, chew, snuff, vape or in any other form)?** ❑ Yes ❑ No |

H5594_2024_DSHAT_COPD_C

## COPD Assessment Form *(continued)*

**11. Does anyone in your household smoke/vape?** ❑ Yes ❑ No

**12. How many times in the past year have you seen your doctor for your COPD?**
(check one) ❑ 0 ❑ 1-2 times ❑ 3-4 times ❑ More than 4 times

**13. How many times in the past year have you been to the Emergency Room due to your COPD?**
(check one) ❑ 0 ❑ 1-2 times ❑ 3-4 times ❑ More than 4 times

**14. How many times in the past year have you been hospitalized due to your COPD?**
(check one) ❑ 0 ❑ 1-2 times ❑ 3-4 times ❑ More than 4 times

**15. Does your COPD prevent you from enjoying your life?**
(check one) ❑ Never ❑ Rarely ❑ Sometimes ❑ Very Often ❑ Always

**16. Does your COPD prevent you from getting a good night's sleep?**
(check one) ❑ Never ❑ Rarely ❑ Sometimes ❑ Very Often ❑ Always

**17. Have your eating habits changed over the last year?**
(check one) ❑ Better ❑ Worse ❑ Stayed the same

**18. Do you think your COPD has become better or worse over the past year?**
(check one) ❑ Better ❑ Worse ❑ Stayed the same

**19. How would you rate your ability to take care of yourself with the support you have in place?**
(check one) ❑ Excellent ❑ Good ❑ Fair ❑ Poor

**20. What is your living situation today?** (check one)
❑ I have a steady place to live
❑ I have a place to live today, but I am worried about losing it in the future.
❑ I do not have a steady place to live. (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

**21. Within the past 12 months, have you worried that your food would run out before you got money to buy more?**
(check one) ❑ Often true ❑ Sometimes true ❑ Never true

**22. In the past 12 months, has lack of reliable transportation kept you from medical appointment, meetings, work, or from getting things needed for daily living?** ❑ Yes ❑ No

# Asthma Disease Management Assessment

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

Date: _____

Name: _____

Address: _____

City:_____ State:_____ Zip: _____

DOB:_____ Age: _____ Gender: ____

Phone number: _____

Member ID:_____

Please complete the following assessment and return to us in the supplied envelope. These answers will help us determine your health status and ensure you are properly managing your health.

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 health condition, 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?**<br>(check one) ❑ Daily ❑ 1-2 times a week ❑ 1-2 times a month ❑ Never |
| **2. How often do you experience wheezing?**<br>(check one) ❑ Daily ❑ 1-2 times a week ❑ 1-2 times a month ❑ Never |
| **3. In the past 4 weeks, how often did your Asthma interfere with your daily activities?**<br>(check one) ❑ Never ❑ Rarely ❑ Sometimes ❑ Very Often ❑ Always |
| **4. Does your Asthma prevent you from getting a good night's sleep?**<br>(check one) ❑ Never ❑ Rarely ❑ Sometimes ❑ Very Often ❑ Always |
| **5. How many medications do you take for your Asthma?**<br>(check one) ❑ None ❑ 1 ❑ 2-3 ❑ 4 or more |
| **6. How often do you use a rescue inhaler (ex. Albuterol or ProAir)?**<br>(check one) ❑ Daily ❑ 1-2 times a week ❑ 1-2 times a month ❑ Never |
| **7. Are you on a daily inhaled steroid (ex. Advair or Pulmocort)?** ❑ Yes ❑ No |
| **8. How many times in the past year did you need to take steroids by mouth (ex. Prednisone)?**<br>(check one) ❑ Daily ❑ 1-2 times a week ❑ 1-2 times a month ❑ Never |
| **9. What doctor takes care of your Asthma?**<br>(check all that apply) ❑ Primary Care Physician ❑ Allergist ❑ Pulmonologist |
| **10. How many times in the past year have you seen your doctor for your Asthma?**<br>(check one) ❑ None ❑ 1-2 times ❑ 3-4 times ❑ 5 times or more |

H5594_2024_DSHAT_ASTHMA_C

# Asthma Disease Management Assessment *(continued)*

**11. How many times in the past year have you been to the emergency room due to your Asthma?**
(check one) ❑ None ❑ 1-2 times ❑ 3-4 times ❑ 5 times or more

**12. How many times in the past year have you been hospitalized due to your Asthma?**
(check one) ❑ None ❑ 1-2 times ❑ 3-4 times ❑ 5 times or more

**13. How often do you use your peak flow meter?**
(check one) ❑ Never ❑ Rarely ❑ Sometimes ❑ Very Often ❑ Always

**14. How often do you have to give yourself a breathing treatment with a nebulizer?**
(check one) ❑ Never ❑ Rarely ❑ Sometimes ❑ Very Often ❑ Always

**15. Do you use tobacco (smoke, chew, snuff, vape or in any other form)?** ❑ Yes ❑ No

**16. Does someone in your household smoke/vape?** ❑ Yes ❑ No

**17. Do you think your Asthma has become better or worse over the past year?**
(check one) ❑ Better ❑ Worse ❑ Stayed the same

**18. Do you have a written plan from your doctor of what to do when you start to wheeze?** ❑ Yes ❑ No

**19. How would you rate your ability to take care of yourself with the support you have in place?**
(check one) ❑ Excellent ❑ Good ❑ Fair ❑ Poor

**20. What is your living situation today?** (check one)
❑ I have a steady place to live
❑ I have a place to live today, but I am worried about losing it in the future.
❑ I do not have a steady place to live. (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

**21. Within the past 12 months, have you worried that your food would run out before you got money to buy more?**
(check one) ❑ Often true ❑ Sometimes true ❑ Never true

**22. In the past 12 months, has lack of reliable transportation kept you from medical appointment, meetings, work, or from getting things needed for daily living?** ❑ Yes ❑ No

**What is a Care Plan and how it is developed?**

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, HRAT and DS-HAT responses, and as needed additional member assessments depending on the available information and level of engagement.

**What are the Clinical Practice Guidelines used to develop the care plan?**

The Plan utilizes clinical practice guidelines to assist practitioners and members to make decisions regarding appropriate health care for specific clinical circumstances. Practice guidelines are from nationally and professionally recognized sources and are selected based upon the considered needs of the enrolled population. The national guidelines are:

| | **Guidelines** |
|---|---|
| **Asthma** | CDC's National Asthma Control Program 12/12/2022. https://www.cdc.gov/asthma/nacp.htm<br><br>Global Strategy for Asthma Management and Prevention – Global Initiative for Asthma, 2023. https://ginasthma.org/reports/ |
| **Cardiovascular Disease** | 2019 ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines, September 2019. https://www.jacc.org/doi/10.1016/j.jacc.2019.03.010<br>2023 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Patients With Chronic Coronary Disease: A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Clinical Practice Guidelines, August 2023. https://www.jacc.org/doi/10.1016/j.jacc.2023.04.003 |
| **Chronic Obstructive Pulmonary Disease** | Global Initiative for Chronic Obstructive Lung Disease (GOLD);2024 GOLD Reports - 2024 *Global Strategy for Prevention, Diagnosis and Management of COPD*. https://goldcopd.org/2024-gold-report/ |
| **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. https://www.ahajournals.org/doi/abs/10.1161/CIR.0000000000000509<br><br>2021 Update to the 2017 ACC Expert Consensus Decision Pathway for Optimization of Heart Failure Treatment: Answers to 10 Pivotal Issues About Heart Failure With Reduced Ejection Fraction: A Report of the American College of Cardiology Solution Set Oversight Committee. February 2021. https://www.jacc.org/doi/10.1016/j.jacc.2020.11.022 |
| **Diabetes** | Standards of Medical Care in Diabetes – American Diabetes Association, January 2024. https://professional.diabetes.org/standards-of-care |
| **Preventive Health** | Recommendations of the U.S. Preventive Services Task Force. https://uspreventiveservicestaskforce.org/uspstf/ |

QMSC Approved 03/2024 Last Reviewed/Updated: 01/2024

For a comprehensive and most updated list of Clinical Practice Guidelines, please visit Optimum HealthCare's website at www.youroptimumhealthcare.com and under the Provider tab, click on Clinical Health Resources.

**Tier 1 Care Plans**

Tier 1 Care Plans are developed and assigned to all SNP members based on their verified qualifying disease (C-SNP) and /or dual-eligible status (D-SNP). SNP Members receive a disease-specific Tier 1 Care Plan that is appropriate for all individuals with the same or a similar diagnosis. For Dual Members without a known disease stratifying into Tier 1, the Health Plan has developed a Dual-eligible 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, 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 Risk Assessment Tools.

The next 10 pages are the Plan developed Tier 1 Care Plans.

# 2024 CARDIOVASCULAR DISEASE CARE PLAN

**Problems**

Patient has Cardiovascular Disease.

**Interventions, Goals and Legend**

HP = High Priority
MP = Medium Priority
LP = Low Priority
ST = Short Term
LT = Long Term
Goal Measurement Frequency: Semi-Annual

**PCP MEDICAL HOME**

1. Member/Patient will understand their medical home as evidenced by at least two Primary Care Physician (PCP) visits/calendar year, one of which will occur within 6 months of the calendar year. (**HP, ST**)
2. Member/Patient will obtain annual lipid profile for effective provider monitoring for calendar year. (**MP, LT**)
3. Member/Patient will see PCP for HEDIS® Adult's Access Preventive Ambulatory Health Services visit in calendar year. **(LP, LT)**

*Prioritized Interventions:*

- *The Plan will publish PCP Medical Home Brochure on Corporate website and mail to members who indicate knowledge deficit of Medical Home on completed general health assessment tool.*
- *The Plan will complete Transition of Care calls and/or letters for applicable events.*
- *The Plan will mail applicable preventive screening letter (based on HEDIS® measure inclusion) at least twice a year beginning by August of calendar year for qualifying members.*
- *The Plan will mail educational packet four times a year and/or newsletters at least twice a year containing information regarding importance of and how to use PCP Medical Home.*

**MEMBER/PATIENT ENGAGEMENT:**

1. Member will complete at least one health risk assessment tool (HRAT) and/or disease specific health assessment tool (DS-HAT) annually. **(MP, ST/LT)**

*Prioritized Interventions:*

- *The Plan will mail a HRAT within 60 days of enrollment effective date (OR approximately 3 months prior to annualized due date) and mail up to 2 additional HRAT (one per subsequent month) for non-response.*
- *The Plan will mail a DSHAT within 60 days of enrollment effective date (OR approximately 3 months prior to annualized due date) and mail up to 2 additional DSHAT (one per subsequent month) for non-response.*

**DISEASE EDUCATION:**

1. Member will receive initial cardiovascular disease education packet from Plan within 90 days of enrollment effective date as long as SNP disease verification was available. (**MP, ST**)
2. Member will receive routine (assuming full quarter eligibility) cardiovascular disease education quarterly throughout the calendar year. (**LP, LT**)

*Intervention:*

- *The Plan will mail cardiovascular disease educational packet four times a year and/or newsletters at least twice a year containing the following information: Importance of medication adherence Importance of blood pressure control, Importance of diet, Importance of exercise, Importance of weight control, and Importance of smoking cessation.*

QMSC Approved 03/2024

**Evidence Based Guidelines and Other Plan Recommendations**

Evidence Based Guidelines

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

- 2019 ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines, September 2019. https://www.jacc.org/doi/10.1016/j.jacc.2019.03.010
- 2023 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Patients With Chronic Coronary Disease: A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Clinical Practice Guidelines, August 2023. https://www.jacc.org/doi/10.1016/j.jacc.2023.04.003
- Monitor timely and appropriate medication refills.
- Monitor laboratory data for with above guidelines as applicable.
- Monitor progress to determine if further interventions need to be developed and addressed.
- Monitor Emergency Department and inpatient hospital admissions and encourage more frequent patient Medical Home visits and interventions.

Other Plan Recommendations

- Ensure your patient is seen 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
  - Behavioral Health, Substance Abuse and Mood Disorders

**Care Plan Assistance/Feedback**

Contact the Health Plan Case and Disease Management for help with your patient. Referral forms can be found in the Provider Tools and Resources section on the Health Plan website and can be faxed to 1-888-314-0794.

The Health Plan welcomes your feedback or modification to this care plan via the above fax number or by calling the Case and Disease Management Department at 1-888-211-9913.

# 2024 CONGESTIVE HEART FAILURE CARE PLAN

**Problems**

Patient has Congestive Heart Failure (CHF).

**Interventions, Goals and Legend**

HP = High Priority
MP = Medium Priority
LP = Low Priority
ST = Short Term
LT = Long Term
Goal Measurement Frequency: Semi-Annual

**PCP MEDICAL HOME**

1. Member/Patient will understand their medical home as evidenced by at least two Primary Care Physician (PCP) visits/calendar year, one of which will occur within 6 months of the calendar year. **(HP, ST)**
2. Member/Patient will have no emergency room, observation or hospital stays due to CHF for the calendar year. **(MP, LT)**
3. Member/Patient will see PCP for HEDIS® Adult's Access Preventive Ambulatory Health Services visit in the calendar year. **(LP, LT)**

*Prioritized Interventions:*

- *The Plan will publish PCP Medical Home Brochure on Corporate website and mail to members who indicate knowledge deficit of Medical Home on completed general health assessment tool.*
- *The Plan will complete Transition of Care calls and/or letters for applicable events.*
- *The Plan will mail applicable preventive screening letter (based on HEDIS® measure inclusion) at least twice a year beginning by August of calendar year for qualifying members.*
- *The Plan will mail educational packet four times a year and/or newsletters at least twice a year containing information regarding importance of and how to use PCP Medical Home.*

**MEMBER/PATIENT ENGAGEMENT:**

1. Member will complete at least one health risk assessment tool (HRAT) and/or disease specific health assessment tool (DS-HAT) annually. **(MP, ST/LT)**

*Prioritized Interventions:*

- *The Plan will mail a HRAT within 60 days of enrollment effective date (OR approximately 3 months prior to annualized due date) and mail up to 2 additional HRAT (one per subsequent month) for non-response.*
- *The Plan will mail a DSHAT within 60 days of enrollment effective date (OR approximately 3 months prior to annualized due date) and mail up to 2 additional DSHAT (one per subsequent month) for non-response.*

**DISEASE EDUCATION:**

1. Member will receive initial congestive heart failure disease education packet from Plan within 90 days of enrollment effective date as long as SNP disease verification was available. **(MP, ST)**
2. Member will receive routine (assuming full quarter eligibility) congestive heart failure disease education quarterly throughout the calendar year. **(LP, LT)**

*Intervention:*

- *The Plan will mail congestive heart failure disease educational packet four times a year and/or newsletters at least twice a year containing the following information: Importance of medication adherence Importance of blood pressure control, Importance of diet, Importance of exercise, Importance of weight control, and Importance of smoking cessation.*

QMSC Approved 03/2024

**Evidence Based Guidelines and Other Plan Recommendations**

Evidence Based Guidelines

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. https://www.ahajournals.org/doi/abs/10.1161/CIR.0000000000000509
- 2021 Update to the 2017 ACC Expert Consensus Decision Pathway for Optimization of Heart Failure Treatment: Answers to 10 Pivotal Issues About Heart Failure With Reduced Ejection Fraction: A Report of the American College of Cardiology Solution Set Oversight Committee. February 2021. https://www.jacc.org/doi/10.1016/j.jacc.2020.11.022
- Monitor timely and appropriate medication refills.
- Monitor Emergency Department and inpatient hospital admissions and encourage more frequent patient Medical Home visits and interventions.
- Monitor progress to determine if further interventions need to be developed and addressed.

Other Plan Recommendations:

- Ensure your patient is seen 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
  - Behavioral Health, Substance Abuse and Mood Disorders

**Care Plan Assistance/Feedback**

Contact the Health Plan Case and Disease Management for help with your patient. Referral forms can be found in the Provider Tools and Resources section on the Health Plan website and can be faxed to 1-888-314-0794.

The Health Plan welcomes your feedback or modification to this care plan via the above fax number or by calling the Case and Disease Management Department at 1-888-211-9913.

# 2024 DIABETES CARE PLAN

| **Problems** |
|---|
| Patient has diabetes identified by HbA1c/Glucose management indicator (GMI) value. |
| **Interventions, Goals and Legend** |
| HP = High Priority<br>MP = Medium Priority<br>LP = Low Priority<br><br>ST = Short Term<br>LT = Long Term<br>Goal Measurement Frequency: Semi-Annual |

**PCP MEDICAL HOME**

1. Member/Patient will understand their medical home as evidenced by at least two Primary Care Physician (PCP) visits/calendar year, one of which will occur within 6 months of the calendar year. **(HP, ST)**
2. Member/Patient will obtain two HbA1c/Glucose management indicator (GMI) tests during the calendar year. **(MP, LT)**
3. Member/Patient will see PCP for HEDIS® Adult's Access Preventive Ambulatory Health Services visit in the calendar year. **(LP, LT)**

*Prioritized Interventions:*

- *The Plan will publish PCP Medical Home Brochure on Corporate website and mail to members who indicate knowledge deficit of Medical Home on completed general health assessment tool.*
- *The Plan will complete Transition of Care calls and/or letters for applicable events*
- *The Plan will mail applicable preventive screening letter (based on HEDIS® measure inclusion) at least twice a year beginning by August of calendar year for qualifying members.*
- *The Plan will mail educational packet four times a year and/or newsletters at least twice a year containing information regarding importance of and how to use PCP Medical Home.*

**MEMBER/PATIENT ENGAGEMENT:**

1. Member will complete at least one health risk assessment tool (HRAT) and/or disease specific health assessment tool (DS-HAT) annually. **(MP, ST/LT)**

*Prioritized Interventions:*

1. *The Plan will mail a HRAT within 60 days of enrollment effective date (OR approximately 3 months prior to annualized due date) and mail up to 2 additional HRAT (one per subsequent month) for non-response.*
2. *The Plan will mail a DSHAT within 60 days of enrollment effective date (OR approximately 3 months prior to annualized due date) and mail up to 2 additional DSHAT (one per subsequent month) for non-response.*

**DISEASE EDUCATION:**

1. Member will receive initial diabetes education packet from Plan within 90 days of enrollment effective date as long as SNP disease verification was available. **(MP, ST/LT)**
2. Member will receive routine (assuming full quarter eligibility) diabetes education quarterly throughout the calendar year. **(LP, LT)**

*Intervention:*

- *The Plan will mail diabetes educational packet four times a year and/or newsletters at least twice a year containing the following information: Importance of adhering to medication regimen, Importance of an annual eye exam, foot care, blood glucose, and blood pressure control, Importance of smoking cessation, Importance of dietary compliance, and Information of use of Medical Home.*

QMSC Approved 03/2024

| Evidence Based Guidelines and Other Plan Recommendations |
|---|
| Evidence Based Guidelines<br>Physician monitoring of outcomes for compliance with regimen goals following guidelines:<br>• Standards of Medical Care in Diabetes – American Diabetes Association, January 2024. https://professional.diabetes.org/standards-of-care<br>• Monitor timely and appropriate laboratory data for compliance and recommended testing of HbA1c/Glucose management indicator (GMI), LDL-C level, and other profiles as needed.<br>• Monitor Emergency Department and inpatient hospital admissions and encourage more frequent patient Medical Home visits and interventions.<br>• Monitor progress to determine if further interventions need to be developed and addressed. |
| Other Plan Recommendations<br>• Ensure your patient is seen within 7 days of all inpatient hospitalizations.<br>• Complete medication reconciliation during follow-up visit. Include documentation that the medications prescribed/ordered at discharge were reconciled with the patient's current medications.<br>• At least annually, address the following with your patients and document in patients' records:<br>o Advance Care Planning<br>o Medication Review<br>o Functional Status Assessment<br>o Comprehensive Pain Screening<br>o Behavioral Health, Substance Abuse and Mood Disorders |
| **Care Plan Assistance/Feedback** |
| Contact the Health Plan Case and Disease Management for help with your patient. Referral forms can be found in the Provider Tools and Resources section on the Health Plan website and can be faxed to 1-888-314-0794.<br><br>The Health Plan welcomes your feedback or modification to this care plan via the above fax number or by calling the Case and Disease Management Department at 1-888-211-9913. |

# 2024 DUAL ELIGIBLE MEMBER CARE PLAN

**Problems**

Patient is socioeconomically disadvantaged which may negatively impact patient's ability to access needed and preventative healthcare services.

**Interventions, Goals and Legend**

HP = High Priority
MP = Medium Priority
LP = Low Priority
ST = Short Term
LT = Long Term
Goal Measurement Frequency: Semi-Annual

**PCP MEDICAL HOME**

1. Member/Patient will understand their medical home as evidenced by at least two Primary Care Physician (PCP) visits/calendar year, one of which will occur within 6 months of the calendar year. **(HP, ST)**
2. Member/Patient will see PCP for HEDIS® Adult's Access Preventive Ambulatory Health Services visit in the calendar year. **(LP, LT)**

*Prioritized Interventions:*

- *The Plan will publish PCP Medical Home Brochure on Corporate website and mail to members who indicate knowledge deficit of Medical Home on completed general health assessment tool.*
- *The Plan will complete Transition of Care calls and/or letters for applicable events.*
- *The Plan will mail applicable preventive screening letter (based on HEDIS® measure inclusion) at least twice a year beginning by August of calendar year for qualifying members.*
- *The Plan will mail educational packet four times a year and/or newsletters at least twice a year containing information regarding importance of and how to use PCP Medical Home.*

**MEMBER/PATIENT ENGAGEMENT:**

1. Member will complete at least one health risk assessment tool (HRAT) and/or disease specific health assessment tool (DS-HAT) annually. **(MP, ST/LT)**

*Prioritized Interventions:*

1. *The Plan will mail a HRAT within 60 days of enrollment effective date (OR approximately 3 months prior to annualized due date) and mail up to 2 additional HRAT (one per subsequent month) for non-response.*
2. *The Plan will mail a DSHAT within 60 days of enrollment effective date (OR approximately 3 months prior to annualized due date) and mail up to 2 additional DSHAT (one per subsequent month) for non-response.*

**BENEFIT EDUCATION:**

1. Member will receive routine (at least 2/year assuming at least 6 months eligibility) benefit education through Plan mailed member newsletters. **(LP, LT)**

*Intervention:*

- *The Plan will mail benefit education packet twice times a year and/or newsletters at least twice a year containing the following information: Education of Plan benefits, Information of use of 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, and Importance of dietary compliance.*

QMSC Approved 03/2024

| Evidence Based Guidelines and Other Plan Recommendations |
|---|
| Evidence Based Guidelines<br>Physician monitoring of outcomes for compliance with regimen goals following the selected evidence-based clinical guidelines:<br>• Recommendations of the U.S. Preventive Services Task Force. https://uspreventiveservicestaskforce.org/uspstf/<br>• Additional considerations:<br>o Monitor timely and appropriate medication refills.<br>o Monitor Emergency Department and inpatient hospital admissions and encourage more frequent patient Medical Home visits and interventions.<br>o Monitor progress to determine if further interventions need to be developed and addressed. |
| Other Plan Recommendations<br>• Ensure your patient is seen within 7 days of all inpatient hospitalizations.<br>• Complete medication reconciliation during follow-up visit. Include documentation that the medications prescribed/ordered at discharge were reconciled with the patient's current medications.<br>• At least annually, address the following with your patients and document in patients' records:<br>o Advance Care Planning<br>o Medication Review<br>o Functional Status Assessment<br>o Comprehensive Pain Screening<br>o Behavioral Health, Substance Abuse and Mood Disorders |
| **Care Plan Assistance/Feedback** |
| Contact the Health Plan Case and Disease Management for help with your patient. Referral forms can be found in the Provider Tools and Resources section on the Health Plan website and can be faxed to 1-888-314-0794.<br><br>The Health Plan welcomes your feedback or modification to this care plan via the above fax number or by calling the Case and Disease Management Department at 1-888-211-9913. |

# 2024 PULMONARY CARE PLAN

**Problems**

Patient has poor, intermediate, or at-risk pulmonary health.

**Interventions, Goals and Legend**

| | |
|---|---|
| HP = High Priority | ST = Short Term |
| MP = Medium Priority | LT = Long Term |
| LP = Low Priority | Goal Measurement Frequency: Semi-Annual |

**PCP MEDICAL HOME**

1. Member/Patient will understand their medical home as evidenced by at least two Primary Care Physician (PCP) visits/calendar year, one of which will occur within 6 months of the calendar year. **(HP, ST)**
2. Member/Patient will obtain Flu Shot within calendar year. **(MP, LT)**
3. Member/Patient will see PCP for HEDIS® Adult's Access Preventive Ambulatory Health Services visit in the calendar year. **(LP, LT)**

*Prioritized Interventions:*

- *The Plan will publish PCP Medical Home Brochure on Corporate website and mail to members who indicate knowledge deficit of Medical Home on completed general health assessment tool.*
- *The Plan will complete Transition of Care calls and/or letters for applicable events.*
- *The Plan will mail applicable preventive screening letter (based on HEDIS® measure inclusion) at least twice a year beginning by August of calendar year for qualifying members.*
- *The Plan will mail educational packet four times a year and/or newsletters at least twice a year containing information regarding importance of and how to use PCP Medical Home.*

**MEMBER/PATIENT ENGAGEMENT:**

1. Member will complete at least one health risk assessment tool (HRAT) and/or disease specific health assessment tool (DS-HAT) annually. **(MP, ST/LT)**

*Prioritized Interventions:*

1. *The Plan will mail a HRAT within 60 days of enrollment effective date (OR approximately 3 months prior to annualized due date) and mail up to 2 additional HRAT (one per subsequent month) for non-response.*
2. *The Plan will mail a DSHAT within 60 days of enrollment effective date (OR approximately 3 months prior to annualized due date) and mail up to 2 additional DSHAT (one per subsequent month) for non-response.*

**DISEASE EDUCATION:**

1. Member will receive initial pulmonary care disease education packet from Plan within 90 days of enrollment effective date as long as SNP disease verification was available. **(MP, ST)**
2. Member will receive routine (assuming full quarter eligibility) pulmonary care disease education quarterly throughout the calendar year. **(LP, LT)**

*Intervention:*

- *The Plan will mail pulmonary care disease educational packet four times a year and/or newsletters at least twice a year containing the following information: Importance of medication adherence Importance of blood pressure control, Importance of diet, Importance of exercise, Importance of weight control, and Importance of smoking cessation.*

QMSC Approved 03/2024

| Evidence Based Guidelines and Other Plan Recommendations |
|---|
| Evidence Based Guidelines<br>Physician monitoring of outcomes for compliance with regimen goals following the selected evidence-based clinical guidelines:<br>• Global Initiative for Chronic Obstructive Lung Disease (GOLD); Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Lung Disease, 2024 Report. https://goldcopd.org/2024-gold-report/<br>• Monitor timely and appropriate medication refills.<br>• Monitor Emergency Department and inpatient hospital admissions and encourage more frequent patient Medical Home visits and interventions.<br>• Monitor progress to determine if further interventions need to be developed and addressed. |
| Other Plan Recommendations<br>• Ensure your patient is seen within 7 days of all inpatient hospitalizations.<br>• Complete medication reconciliation during follow-up visit. Include documentation that the medications prescribed/ordered at discharge were reconciled with the patient's current medications.<br>• At least annually, address the following with your patients and document in patients' records:<br>o Advance Care Planning<br>o Behavioral Health, Substance Abuse and Mood Disorders |
| **Care Plan Assistance/Feedback** |
| Contact the Health Plan Case and Disease Management for help with your patient. Referral forms can be found in the Provider Tools and Resources section on the Health Plan website and can be faxed to 1-888-314-0794.<br><br>The Health Plan welcomes your feedback or modification to this care plan via the above fax number or by calling the Case and Disease Management Department at 1-888-211-9913. |

**Supplemental Tier 1 Care Plans: Health Appraisal Profiles**

Personalized Health Appraisal Profiles (HAPs) are generated for members completing and returning a general Health Risk Assessment Tool. On average, over the last several years, the plan has obtained a 90%+ Health Risk Assessment Tool Response Rate for SNP members. The profile includes member-specific responses, identified risk factors and suggested activities to achieve wellness. The Plan mails the profile to the member and encourages them to bring it to their doctor for discussion.

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. Furthermore, the profile includes an overview section that provides a comparison of current and previous responses to highlight member progress toward health goals. 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. The cover letter that accompanies the member's HAP encourages the member to review the HAP and engage with their PCP on the suggested interventions. The ultimate goal is for the PCP and member to connect for active care planning.

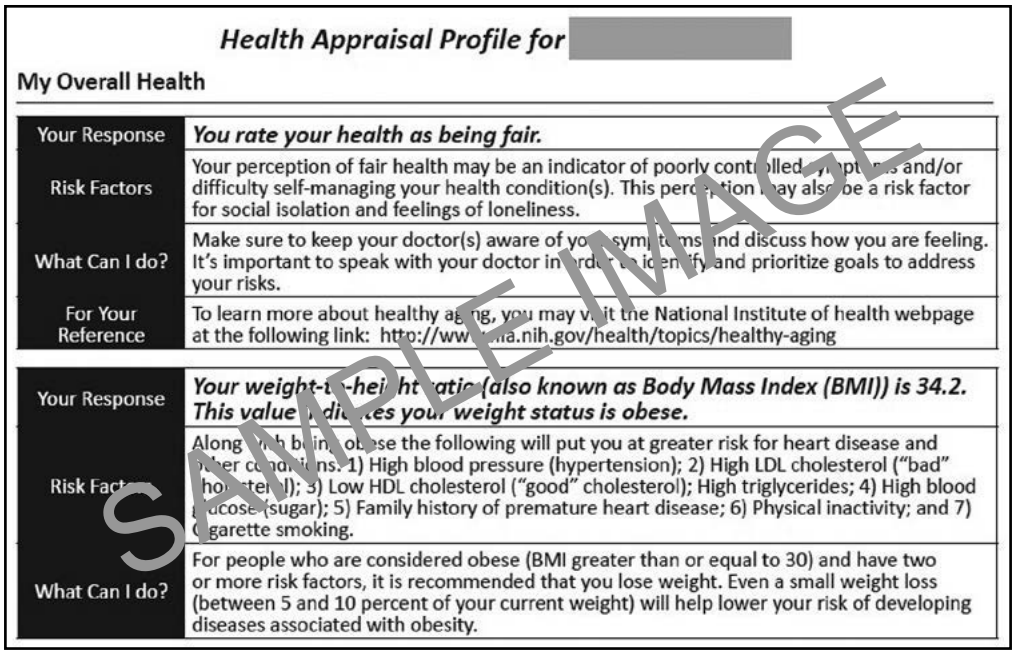
The following are sample excerpts from a Health Appraisal Profile.

**Overview Section to Compare Current and Previous Responses (when available):**

**Overview of your Health Status**

| Previous Response Receive Date: 05/17/2020 | Current Responses Receive Date: 06/02/2021 |
|---|---|
| You rate your health as being good. | You rate your health as being fair. |
| Your weight-to-height ratio (also known as Body Mass Index (BMI)) is 35.2. This value indicates your weight status is obese. | Your weight-to-height ratio (also known as Body Mass Index (BMI)) is 34.2. This value indicates your weight status is obese. |
| You reported wanting to improve the amount of physical activity/exercise that you get. | You reported getting enough physical activity/ exercise. |
| You have indicated your diet may need to be improved to support a healthy life style. | You have indicated your diet supports a healthy life style. |
| You reported seeing your Primary Care Physician less than 6 months ago. | You reported seeing your Primary Care Physician less than 6 months ago. |
| You have indicated that in the past 12 months, you have not visited the emergency room and/or have been admitted to the hospital. | You have indicated that in the past 12 months, you have not visited the emergency room and/or have been admitted to the hospital. |
| You indicated you do not need help with bathing. | You indicated you do not need help with bathing. |
| You indicated you do not need help with dressing. | You indicated you do not need help with dressing. |
| You indicated you do not need help with eating. | You indicated you do not need help with eating. |
| You indicated you do not need help with getting out of bed or chair. | You indicated you do not need help with getting out of bed or chair. |
| You indicated you do not need help with preparing meals. | You indicated you do not need help with preparing meals. |
| You indicated you do not need help with taking your medicine. | You indicated you do not need help with taking your medicine. |
| You indicated you do not need help with using the bathroom. | You indicated you do not need help with using the bathroom. |
| You indicated you do not need help with walking. | You indicated you do not need help with walking. |
| You reported the following symptoms commonly associated with stress: | Information is not available regarding whether you are experiencing common effects of stress. |
| Social Withdrawal | |
| You have indicated that you feel safe in your home. | You have indicated that you feel safe in your home. |
| You have indicated that you always wear a seat belt when you are in a car. | You have indicated that you always wear a seat belt when you are in a car. |

**Personalized Profile with Responses, Risk Factors, Guidance and References:**



***Health Appraisal Profile for*** [redacted]

**My Overall Health**

| | |
|---|---|
| Your Response | ***You rate your health as being fair.*** |
| Risk Factors | Your perception of fair health may be an indicator of poorly controlled symptoms and/or difficulty self-managing your health condition(s). This perception may also be a risk factor for social isolation and feelings of loneliness. |
| What Can I do? | Make sure to keep your doctor(s) aware of your symptoms and discuss how you are feeling. It's important to speak with your doctor in order to identify and prioritize goals to address your risks. |
| For Your Reference | To learn more about healthy aging, you may visit the National Institute of health webpage at the following link: http://www.nia.nih.gov/health/topics/healthy-aging |

| | |
|---|---|
| Your Response | ***Your weight-to-height ratio (also known as Body Mass Index (BMI)) is 34.2. This value indicates your weight status is obese.*** |
| Risk Factors | Along with being obese the following will put you at greater risk for heart disease and other conditions: 1) High blood pressure (hypertension); 2) High LDL cholesterol ("bad" cholesterol); 3) Low HDL cholesterol ("good" cholesterol); High triglycerides; 4) High blood glucose (sugar); 5) Family history of premature heart disease; 6) Physical inactivity; and 7) Cigarette smoking. |
| What Can I do? | For people who are considered obese (BMI greater than or equal to 30) and have two or more risk factors, it is recommended that you lose weight. Even a small weight loss (between 5 and 10 percent of your current weight) will help lower your risk of developing diseases associated with obesity. |



**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 a number of sources including demographic data, claims, pharmacy, and lab data.

## OPTIMUM HEALTHCARE CARE PLAN

| | | | |
|---|---|---|---|
| Provider: | Mbr Name: | | **Run Date:** |
| | | | **DS-HAT Date:** |
| Provider County: | Home Phone: | Gender: | DOB: |
| PCP Phone: | Subscriber ID: | Plan: | |

### CVD

Freedom Health'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 CVD, we reference the following:

2019 ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines, September 2019 http://www.onlinejacc.org/content/74/10/e177

2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol: Report of the American College of Cardiology Foundation/American Heart Association Task Force on Clinical Practice Guidelines, November 2018. https://www.acc.org/latest-in-cardiology/ten-points-to-remember/2018/11/09/14/28/2018-guideline-on-management-of-blood-cholesterol

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

| HAT # | Problem | Interventions | Goals |
|---|---|---|---|
| 1A | Frequent Symptom: shortness of breath. | Assess etiology of symptom and treat as necessary. | Member/Patient will understand their medical home as evidenced by at least two PCP visits/year allowing for provider evaluation of member reported symptoms. (HP, ST) |
| 6 | History: Heart Surgeries. | Minimize cardiac risk factors and ensure appropriate post-operative therapy. Educate member with information regarding health maintenance after incident. | Member will receive routine (at least 1/ quarter assuming full quarter eligiblity) cardiovascular disease education throughout the calendar year from the Health Plan. (LP, LT) |
| 9 | Diet Regimen: Low Salt. | Evaluate diet regimen used by member and modify as necessary. | Member will receive routine (at least 1/ quarter assuming full quarter eligiblity) cardiovascular disease education throughout the calendar year from the Health Plan. (LP, LT) |
| 9 | Diet Regimen: Heart Healthy. | Evaluate diet regimen used by member and modify as necessary. | Member will receive routine (at least 1/ quarter assuming full quarter eligiblity) cardiovascular disease education throughout the calendar year from the Health Plan. (LP, LT) |
| 13 | Significant Impact by Condition on Quality of Life. | Assess Member's daily activities impacted by CVD | Member/Patient will understand their medical home as evidenced by at least two PCP visits/year allowing for provider evaluation of member reported symptoms. (HP, ST) |
| 14 | Non-compliance with PCP treatment plan. | Schedule at least 2 appointments / year for treatment planning | Member/Patient will understand their medical home as evidenced by at least two PCP visits/year allowing for provider evaluation of member reported symptoms. (HP, ST) |
| 15 | Cardiology Consults: 4+ times/year. | Coordinate care management with Cardiology | Member/Patient will understand their medical home as evidenced by at least two PCP visits/year allowing for provider evaluation of member reported symptoms. (HP, ST) |
| 19 | Concerns noted RE: Ability to self-manage. | Assess self-management concerns | Member/Patient will understand their medical home as evidenced by at least two PCP visits/year allowing for provider evaluation of member reported symptoms. (HP, ST) |



### GOAL LEGEND

HP = High Priority
MP - Medium Priority
LP = Low Priority
ST = Short Term
LT = Long Term
Goal Measurement Frequency: Semi-Annual

### 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 MEMBER'S 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 HEALTHCARE CARE PLAN**

Provider: Mbr Name: **Run Date: 1/20/2023**
Provider County: Home Phone: Gender: **DS-HAT Date: 01/01/2023**
PCP Phone: Subscriber ID: Plan: DOB: MM/DD/YYYY

**Self Reported Health Assessment** **Confidential and Proprietary**

**CVD**

1. Member has experienced shortness of breath.
1. Member very often experiences shortness of breath.
2. Member does not experience chest pain.
4. Member had a heart attack.
5. Member had a heart attack 2 - 3 years ago.
6. Member has had heart surgeries, ex. bypass, stents.
7. Member's blood pressure does not run higher than 140/90.
9. Member is on a low salt diet.
9. Member is on a Heart Healthy diet.
10. Member does not smoke.
11. Member uses oxygen at home.
12. Member exercises 3+ days per week.
13. Member states that heart condition very often prevents him/her from enjoying life.
14. Member has not seen PCP in the last year for Heart condition.
15. Member has seen Cardiologist more than 4 times in the last year.
16. Member has not been to the Emergency room due to his/her heart condition in the past year.
17. Member has not been hospitalized in the past year due to his/her heart condition.
18. Member thinks his/her heart condition has stayed the same over the past year.
19. Member has a fair ability to take care of themselves.



**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 MEMBER'S 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 claims information. The report includes: Eligiblity History, and Claim Activity for primary care physician, speciality, hospital pharmacy and lab.

**OPTIMUM HEALTHCARE CARE PLAN**

Provider: Mbr Name: **Run Date: 12/22/2023**
**DS-HAT Date**: 12/06/2023

Provider County: Home Phone: Gender: DOB:
PCP Phone: Subscriber ID: Plan:

**Member Summary** **Confidential and Proprietary**

**Eligiblity History**

| Year | Effective Range |
|---|---|
| 2018 | 01/01/2018 - 12/31/2018 |
| 2019 | 01/01/2019 - 12/31/2019 |
| 2020 | 01/01/2020 - 12/31/2020 |
| 2023 | 11/01/2023 - 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. Also, please refer to the HEDIS/MRA Portal for complete HCC member specific data.

**Claim Activity - PCP/Specialty**

| DOS | ICD10 | ICD10 Description | CPT/Rev | CPT/Rev Description | Specialty |
|---|---|---|---|---|---|
| 11/28/2023 | Z00.01 | Encounter for general adu | 1101F | PATIENT SCREENED FOR FUTURE FALL RISK DOCUMENTATION OF NO FALLS IN THE PAST YEAR OR ONLY 1 FALL WITH | GENERAL PRACTICE |
| 11/28/2023 | Z00.01 | Encounter for general adu | 1125F | PAIN SEVERITY QUANTIFIED PAIN PRESENT (COA) (ONC) | GENERAL PRACTICE |

**Claim Activity - Other Health Care Providers**

| DOS | ICD10 | ICD10 Description | CPT/Rev | CPT/Rev Description | Specialty |
|---|---|---|---|---|---|

**Claim Activity - Hospital**

| DOS | ICD10 | ICD10 Description | CPT/Rev | CPT/Rev Description | Specialty |
|---|---|---|---|---|---|

**Claim Activity - Skilled Nursing Facility (SNF)**

| DOS | ICD10 | ICD10 Description | CPT/Rev | CPT/Rev Description | Specialty |
|---|---|---|---|---|---|

**Claim Activity - Pharmacy**

| DOS | Supply | Drug Name | Prescriber | Generic |
|---|---|---|---|---|
| 12/05/2023 | 30 | LANTUS SOLOS INJ 100/ML | | INSULIN GLARGINE SOLN PEN-INJE |

**Claim Activity - Lab**

| DOS | Vendor | Result Name | LOINC | Result |
|---|---|---|---|---|

## 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 HRAT/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. These Care Plans are dynamic in nature, often changing more than weekly.

## Individualized Care Plan sharing with Primary Care Providers

Tier 1, Health Appraisal Profiles (Supplemental Tier 1) 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. Active Tier 1 and Tier 2 Care Plans will receive at least one update per year. Any updates will be made available to the member's current PCP in the Health Plan's MRA/HEDIS® Portal.

Tier 3 Care Plans are faxed to the PCP at the time of creation, after material updates and upon case closure.

## What Next?

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

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

More specifically:

- Review all claims to ensure that all the members' diagnoses have been recorded in the current year.
- Review prescriptions for appropriateness.
- Review the problem list and consider 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 HealthCare to discuss any patients you feel could benefit from additional resources.

Sincerely,

**Optimum HealthCare**

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