providerNEWS

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

SPRING **2022**

READMISSION RATES IN THE CHF POPULATION

Risk Adjustment Provider Education

Registered Dietitian Introduction

AND **much more!**

Printed and mailed 3/21/2022

CREDENTIALING CORNER

The Plan Accepts CAQH Proview Credentialing applications.

When logging into the CAQH ProView Provider System to update or re-attest to your information, please review the informational banners used by CAQH to announce system updates and be sure to review the monthly ProView updates CAQH sends out via email.

Also, please continue to keep your credentialing application and attached documentation current in the CAQH ProView database.

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

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

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

For Providers Not Part of the CAQH Proview:

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

Readmission Rates in the CHF Population

2022 marks the time for starting a new Chronic Care Improvement Project (CCIP). As you may already know, a CCIP is a CMS required project. The CCIP runs for three years, and its intent is to identify best practices for improving care to those with an identified ch onic medical condition. This cycle of the CCIP will focus on decreasing readmission rates for those members with a congestive heart failure diagnosis (CHF).

The CCIP will look at members that have recently been readmitted into a hospital within 30 days of a previous discharge. The members will be reviewed for a qualifying diagnosis of CHF. Members will receive a call post-discharge and be offered an opportunity to enroll into the Disease Management CCIP. The CCIP will also look at active members with similar CHF Readmission history in the prior 2 calendar years. These members will also receive outreach calls to have the opportunity to enroll in this CCIP program opportunity.

Once enrolled, members will receive a telephonic assessment by a Registered Nurse. The nurse will review the members medical status, complete a review of their current medications, offer a referral to our Registered Dietitian (RD), and review any available over the counter (OTC) benefits. As the provider, you will be notified hat the member is now active with the Plan's Case Management department. Our nurses will work with you to ensure that your treatment plans are being followed.

The intent of the CCIP is to decrease the potential for any further hospitalizations or readmissions. In addition to the CCIP, we also have a host of other care management services available to your patients, all at no additional cost. We encourage you to refer your members over to the Plan. The Plan has Complex Case Mangers that help members with acute care issues; Disease Case Managers that help with chronic disease management; Social Workers that can assist with financial and food disparities and have also recently added a Dietician for dietary support.

Cultural Competency

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

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

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

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

THESE THOUGHTFUL APPROACHES PROPOSED BY CULTURAL COMPETENCY STANDARDS ALLOW THE PLAN AND THE PROVIDERS WHO CARE FOR OUR MEMBERS TO:

- Improve health outcomes;
- Enhance the quality of services;
- Respond appropriately to demographic changes;
- Eliminate disparities in health status for people of diverse backgrounds;
- Decrease liability/malpractice claims; and
- Increase member and provider satisfaction.

ADDITIONAL TOOLS/ RESOURCES TO ASSESS CULTURAL COMPETENCY:

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

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

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

Office of Minority Hea th website featuring Communication Tools and Education Resources: *https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=1&lvlid=6*

Health Resources and Services Administration (HRSA) of the U.S. Department of Health & Human Services website for Culture, Language and Health Literacy: *https://www.hrsa.gov/about/organization/bureaus/ohe/health-literacy/culture-language-and-health-literacy*

Providers may request a hard copy of the Cultural Competency Plan from the Plan at no charge to the provider.

> “Oftentimes, things like wait time, rude office staff and **office cleanliness** are reported more than a physician’s medical decisions or competency”

Patients tend to complain most about things that they can relate to or understand. Oftentimes, things like wait time, rude office staff and office cleanliness are reported more than a physician’s medical decisions or competency. These are the things patients remember and have a large outcome on patient satisfaction. Annually, the Health Plan conducts a Member Satisfaction Survey in order to determine satisfaction with the Plan and their providers.

The Plan analyzes those responses at the end of the year. Last year on the Health Plan’s Member Satisfaction Survey, there were a few questions that had a statistically significant influence on membe satisfaction. One of the questions that **continually** has an impact on member satisfaction is Doctor’s Office Clean iness even despite an increase in telehealth appointments. ***The Health Plan has found that poor member satisfaction with office cleanliness often coincides with lower overall scores on PCP and specialist rating for our Member Satisfaction Survey.***

A large amount of how patients perceive their quality of care is based on the cleanliness of their physician’s office. A pa ient’s first impression on a medical practice is the waiting room area. Now even more so with the global COVID pandemic, it is important to create a clean environment in order to affect patient outcomes and promote patient health. It is also important to make patients feel safe during these uncertain times.

Here are some tips to creating a cleaner office area:

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

If your office may be hinking of things to improve upon in 2022, please take into consideration that an office hat is not clean may be sending the wrong message to a patient. This is a very simple adjustment that can greatly influence patients’ overall satisfaction!

SNP Program Evaluation

Every Special Needs Plan (SNP) has a specific SNP Model of Ca e (MOC) program that addresses care coordination strategies, SNP policies and procedures and stipulates quality metrics and goals. Goals are set based on National benchmarks and CMS Star Score thresholds. Routinely, the Health Plan reviews and discusses results and opportunities with the SNP Interdisciplinary Care Team (IDCT) consisting of key administrative and clinical personnel and a small group of network Physicians. The SNP MOC program is reviewed for effectiveness through the SNP MOC Quality Improvement (QI) Work Plan Evaluation process.

The 2021 SNP MOC QI Work Plan Evaluation has been completed and indicated a successful year for all our SNP MOCs. Quality metrics, health outcomes and utilization were discussed and compared against our previously established goals, prior performance, and National Benchmarks. While 2021 was again a challenging year due to the pandemic, the Plan met many of the SNP MOC QI Work Plan Evaluation goals and continued to make good progress towards others. Any unmet goals were re-evaluated to assure the targeted performance was appropriately set and to consider any additional improvement opportunities to include in our 2022 programming for improved member experience and outcomes and to address changing SNP population needs and barriers. Goals were also reviewed to determine if more challenging goal metrics would need to be established moving forward. Overall, many goals were adjusted due to either changes in National Benchmarks or internal improvement opportunities.

Helping You Through Member Education

Member education is a priority at Freedom Health and Optimum Healthcare. We believe that educating our members helps not only them but also you as a provider. We highlight member education in newsletters, as well as through our Case and Disease Managers and CareNet, our 24-hour nurse advice line.

Below we are highlighting a recent newsletter article as an example of the material we send, instructing members in how to decide where to seek medical care when they feel they need it urgently. We know your time with patients is limited. Our member newsletters can supplement in written words what you've already told your patients face-to-face.

The Doctor, the Emergency Room or the Urgent Care Clinic?

How do you decide? How can you take care of yourself and avoid the emergency room?

It is best to have a plan on how and where to seek treatment before you need to make the decision. Provided below are descriptions of the types of care provided and where they are provided. It is important to use the right provider for the right injury/illness to avoid unnecessary cost.

DOCTOR OR PRIMARY CARE OFFICE

What it is: Primary care doctors are available during regular office hours. Some imes they offer evening appointments and some allow walk-in visits. You will have better care if you see the same doctor regularly since your doctor will know you and your health conditions. It also helps if your medical records are readily available.

When to go: For preventive care, or when you have a medical problem or concern. When a minor illness or injury strikes, you should first seek treatment from a primary care doctor at his or her office. Most doctors' offices o fer same day visits when you are sick. When you call for an urgent visit, make sure you explain your medical situation or how it has changed since you last were seen in the office. Don t wait until you feel really bad to call. You might feel better sooner.

Consider the cost: This is the lowest cost option for most routine care and preventive services.

EMERGENCY ROOM

What it is: An Emergency Department is there to save lives. An emergency is any medical problem that could cause death or permanent injury if not treated quickly. An emergency department is open 24 hours a day, seven days a week, 365 days a year.

When to go: During a health episode that can lead to death or permanent injury. Some examples of medical emergencies are:

- Chest pain with sweating, nausea, vomiting, shortness of breath, radiating pain that moves to the arm or neck, dizziness, or feeling that your heart is beating irregularly or too fast
- Choking
- Severe bleeding that doesn't stop after 15 minutes of direct pressure
- Fainting
- Broken or displaced bones
- Swallowing poison
- Burns
- Suddenly not being able to walk, speak, or move a portion of your body
- Shortness of breath or difficu ty in breathing

Many visits to the emergency room aren't true "emergencies". An Emergency Department is there to treat the critically ill and injured first. Patients seeking treatment of minor illnesses and injuries will wait longer to be seen by a doctor. Some examples of non-emergencies are:

- Cold or flu symptom
- Sore throat
- Earache
- A fever that is relieved with over-the-counter medication
- Toothaches
- Minor cuts, scrapes and abrasions
- Muscle sprains
- Sunburn

Consider the cost: The copay alone may be costly. Other costs may be included depending on the care you need.

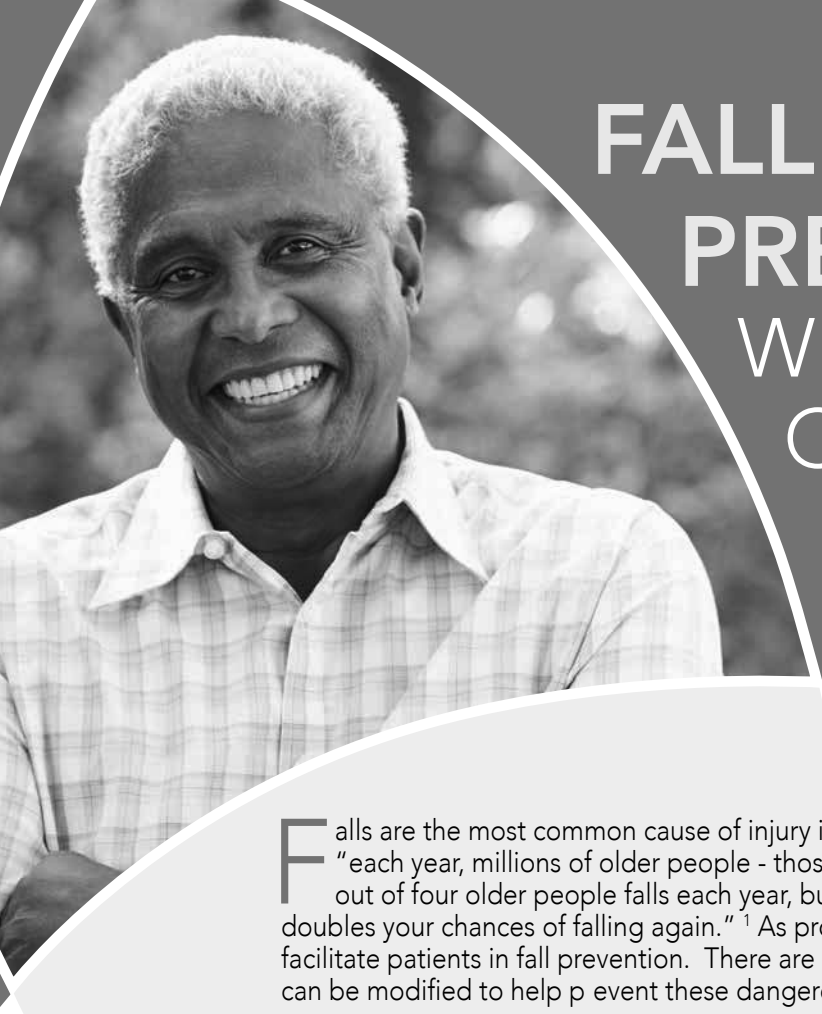
URGENT CARE CENTER

What it is: These are clinics with doctors where you can walk-in without an appointment. They are open during the day, have evening hours and can see you on weekends.

When to go: Urgent Care centers are setup to help with an illness or injury that does not appear to be life –threatening, but also can't wait until the next day, or for the primary care doctor to see them. Urgent medical conditions are not considered emergencies but still require care within 24 hours. Some examples are:

- Accidents and falls
- Sprains and strains
- Moderate back problems
- Breathing difficu ties (i.e. mild to moderate asthma)
- Bleeding/cuts -- not bleeding a lot but requiring stitches
- Diagnostic services, including X-rays and laboratory tests
- Eye irritation and redness
- Fever or fl
- Vomiting, diarrhea or dehydration
- Severe sore throat or cough
- Minor broken bones and fractures (i.e. fingers, toes
- Skin rashes and infections
- Urinary tract infections

Consider the cost: It will cost a little more than the doctor's office but <u>much less</u> than emergency room care. Other costs may be included depending on the care you need.



FALL PREVENTION: WHAT HEALTH CARE PROFESSIONALS CAN DO TO HELP

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

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

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

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

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

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

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

PARTNER WITH CASE & DISEASE MANAGEMENT NURSES

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

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

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

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

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

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

Our Nurses and Social Workers also remind members who see Behavioral Health providers to fi l out a Release of Information form, giving those providers permission to share information with the PCP. You can facilitate this process by providing members with a copy of the form, which is in the Beacon Health provider toolkit (***https://providertoolkit.beaconhealthoptions.com/***).

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

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

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

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

Providers → Tools and Resources → Case/Disease Management Referral Form

A *Reminder* About Medical Records Standards

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

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

The Plan's Provider Manual describes the medical record standards required for contracted providers. As a reminder, ALL providers must follow these standards and cooperate with the Plan in activities related.

Financial Barriers to Medication Compliance

Medication adherence is a key component of the patient's treatment plans. Being able to adhere to a medication regimen involves factors such as financial constraints, he ability to administer the medication, and the patient's understanding of the need for the medication.

It has been well documented that the inability to pay for medications is a common barrier to medication adherence, therefore, understanding your patient's ability to afford his or her medication can be of great benefit when it comes to prescribing. The promises associated with newer, Brand name medications, need to be carefully considered against established and proven treatment regimens. While the new medication may provide an effective therapy, the inability to afford the co-pay can lead to the patient not fi ling the prescription and ultimately failure of the treatment plan.

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

The Importance of Communication as a Health Care Provider

COMMUNICATION WITH PATIENTS

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

Providers should be prepared for patient visits and encourage them to ask questions. The Health Plan continually reminds members to be prepared for appointments by arriving on time, bringing updated medication lists and asking questions about their health care. However, patients oftentimes feel that they are bothering their provider or that their doctor is too busy to answer questions. While this may be true, it is important to always take the time to talk with your patients. This includes maintaining eye contact and exhibiting good listening skills.

Educate your patients on their health conditions. Teach them which changes in their health condition need to be reported to you and how quickly to call. Your patients should know if their symptoms can be addressed in an offic visit or when emergency treatment may be necessary.

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

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

COMMUNICATION WITH OTHER PROVIDERS (PCP TO SPECIALISTS):

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

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

The Health Plan considers a **PCP** the **medical home** and any pertinent changes in the patient's care plan should be communicated and

accessible to PCPs, especially upon post-care transition. This would include any changes in health status, diagnoses, medications, lab or test results, and those noted on a discharge report.

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

SILENCE IS *NOT* AN OPTION

ABUSE, NEGLECT& EXPLOITATION

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

WHO IS A MANDATORY REPORTER?

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

WILL THERE BE ANY CONSEQUENCES?

According to Florida Statute 415.111 under Adult Protective Services, "a person who knowingly and willfully fails to report a case of known or suspected abuse, neglect, or exploitation of a vulnerable adult, or who knowingly and willfully prevents another person from doing so, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083."

WHAT DOES IT LOOK LIKE?

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

- Trouble Sleeping
- Seems depressed, confused, agitated, violent or withdrawn
- Unexplained bruises, scars or accidents
- Develops sores or other preventable conditions
- Makes concerning statements about caregiver withholding money or medication
- Loses weight for no reason
- Displays signs of trauma

HOW DO I MAKE A REPORT?

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

Remember, an investigator wants to speak with the person who observed the abuse, neglect or exploitation firs hand.

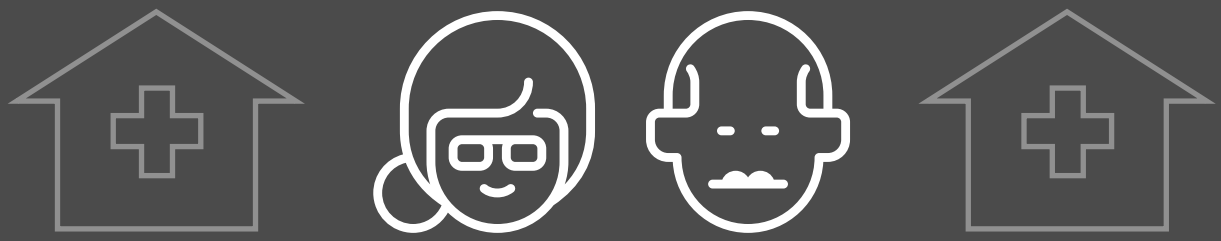
If you suspect it, report it!

Risk Adjustment Provider Education

In a joint effort for quality documentation improvement for risk adjustment, the MRA Department for Freedom Health and Optimum Healthcare works closely with partnering providers to improve both coding and documentation accuracy. We offer a sampled progress note documentation review, providing feedback regarding areas of opportunity identified for imp ovement, along with a tailored Physician-to-Physician MRA education presentation.

Requests for MRA Education can be emailed to riskadjustment@freedomh.com. We look forward to collaborating with you.

WELCOME HOME: Member Engagement with the Patient-Centered Medical Home



For Primary Care Physicians, the Patient-Centered Medical Home (PCMH) represents a philosophy of providing coordinated, comprehensive care that is patient-centric and team-based. As the American College of Physicians notes, the PCMH "is a care delivery model whereby patient treatment is coordinated through their primary care physician to ensure they receive the necessary care when and where they need it, in a manner they can understand." The Plan embraces this philosophy.

The PCMH philosophy means our members will receive safe, quality care, including services and treatment plans which address their unique health concerns and goals. The PCMH includes medication reconciliation, coaching and education to help members meet these goals.

Additional benefits of he Medical Home model include:

- **A reduction in emergency department visits;**
- **Decreased delays in members seeking treatment;**
- **Closer management of chronic diseases;**
- **Improved communication with patients regarding their role in the plan of care.**

It is important that members understand how to directly communicate with the PCP's office. They some imes ask the Plan to intercede with the PCP on their behalf, which causes fragmentation and delays in care. Members should have a copy of the plan of care and know who to call with questions. To maximize the effectiveness of the Medical Home, the PCP office should inform members f om the outset of expectations on both sides.

- **Medication review helps members understand the medications they are taking and how they are affected by taking or not taking them.**
- **A personalized plan of care allows for mutual goal setting and evaluation of progress to goals by the provider and the member.**
- **Coaching and education focus on the information members need to manage their unique health care needs. Team support such as community resources, Plan social work or case management staff, and family support systems can provide the added connection needed to help members continue to strive to meet their health care goals.**

↘ contact

Provider can contact the Case and Disease Management department to refer members for assistance. Qualified sta f members are available to support members who need extra coaching and support related to their chronic condition or current treatment plan. Referrals can be sent to the department via fax at **1-888-314-0794** or by calling **1-888-211-9913**.

PROVIDER RELATIONS DEPARTMENT 2022

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Network Management Rep, Sr. - Vision, Dental, Hearing, Transportation, Chiro, Podiatry	Debbie Nix	(813) 506-6000	11949	dnix@freedomh.com
Network Management Rep - Gym, Vision, Lab, Dental, Hearing, Trans, Chiro, Podiatry	Kenneth Daniels	(813) 506-6000	11417	kdaniels@freedomh.com
Provider Network Manager II - Behavioral Health	Alba Rivera	(813) 506-6000	11958	acrivera@freedomh.com
Provider Network Manager I - DME	Maureen Shillingford	(813) 506-6000	11913	mshillingford@freedomh.com
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Provider Network Manager I - IV Infusion, Urgent Care	Fatemeh Sanchez	(813) 506-6000	11553	fsanchez@freedomh.com
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West Florida

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Provider Network Manager II - PCPs in Pasco County	Jennifer Beaton	(813) 506-6000	11272	jbeaton@freedomh.com
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Provider Network Manager II - PCPs in Pinellas County	Travis Nipper	(813) 506-6000	11959	tjnipper@freedomh.com
Provider Network Manager II - Specialists in Hills and Polk Counties	Ted Esteves	(813) 506-6000	11716	testeves@freedomh.com
Provider Network Manager II - Specialists in Pinellas and Pasco Counties	Harshit Patel	(813) 506-6000	11464	hpatel01@freedomh.com
Provider Contract Specialist Sr.	Dennis Samuels	(813) 506-6000	11858	dsamuels@freedomh.com
Provider Contract Specialist I	Harshida Patel	(813) 506-6000	19190	hpatel@freedomh.com
Provider Contract Specialist	Tara Fisher	(813) 506-6000	11465	tfisher@freedomh.com
Director, Network Relations - West Coast Region	Lisa Myers	(813) 506-6000	22051	lmyers@freedomh.com
Provider Network Manager I - Specialists for Citrus/Hernando	Tara Fisher	(813) 506-6000	11465	tfisher@freedomh.com
Provider Network Manager II - PCPs for Citurs/Hernando	Kristen Doherty	(813) 506-6000	22060	kdoherty@freedomh.com
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Gulf Coast

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Provider Network Manager I - PCPs for Sarasota County	Latiesha Nevils	(813) 506-6000	22168	lnevils@freedomh.com
Provider Network Manager I - PCPs for Charlotte, Lee, and Collier Counties	Amber Skulina	(813) 506-6000	N/A	askulina@freedomh.com
Provider Network Manager I - Specialists for Manatee and Sarasota Counties	Caitlin Riley	(813) 506-6000	22162	criley@freedomh.com
Provider Network Manager I - PCPs for Charlotte, Lee, and Collier Counties	Amber Skulina	(813) 506-6000	N/A	askulina@freedomh.com
Provider Network Manager I - Specialists for Collier, Lee and Charlotte Counties	Mike Munzert	(813) 506-6000	N/A	mmunzert@freedomh.com

East Florida

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Provider Network Manager I - Specialists in Marion County	Cheryl Haley	(352) 237-2351	22006	chaley@freedomh.com
Provider Contract Specialist I	Nicholas Belen	(407) 965-2684	22118	nbelen@freedomh.com
Provider Network Manager I- PCP's in Lake & Sumter Counties	Caitlin Mercado	(407) 965-2684	22111	cmercado@freedomh.com
Provider Network Manager I- PCP's Marion County	Rochelle Randall	(352) 237-2351	22007	rrandall@freedomh.com
Provider Network Manager I- Specialists in Lake & Sumter Counties	Shannon Bethea	(352) 857-6739	N/A	sbethea@freedomh.com
Provider Network Manager I- PCP's in Lake, Marion & Sumter Counties	Racheal Larramore	(352) 237-2351	22005	rlarramore@freedomh.com
Provider Contract Specialist I	Julneh Hernandez	(352) 237-2351	22008	hernandezj@freedomh.com

Central Florida

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Network Development Analyst Ld- HEDIS/PCPs - Central Florida Region	Dawn Smith	(407) 965-2684	22114	drsmith@freedomh.com
Provider Contract Specialist	Nidia Viloria	(407) 965-2684	22109	nviloria@freedomh.com
Provider Network Mgr I - PCP/Complete Health IPA/ Specialists - Brevard and Volusia Counties	Jennifer Solano Lucas	(407) 965-2684	22117	jslucas@freedomh.com
Provider Network Mgr I - Specialists - Orange and Seminole Counties	Juanita DeJesus	(407) 965-2684	22107	Jdejesus@freedomh.com
Provider Network Mgr I - PCPs Brevard County	Phyllis Gold	(407) 965-2684	22116	pgold@freedomh.com
Provider Network Mgr I - PCPs and Specialists for Osceola County	Suhelie Rodriguez	(407) 965-2684	22106	Rodriguezs@freedomh.com
Provider Network Mgr I - PCPs - Seminole and Volusia Counties	Laude Rodriguez	(407) 965-2684	22110	lmrodriguez@freedomh.com
Provider Network Mgr I - PCPs - Volusia County	Oscar Iturrizaga	(407) 965-2684	11713	oiturrizaga@freedomh.com
Provider Network Mgr I - Specialist - Brevard, Seminole and Volusia Counties	Eric Kingsley	(407) 965-2684	19121	ekingsley@freedomh.com

South Florida

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Director, Network Relations	Adrian Goluch	(813) 506-6000	11354	agoluch@freedomh.com
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Provider Network Mgr I - PCPs for Palm Beach	Mercedes Ortega	(813) 422-8468	N/A	Mortega@freedomh.com
Provider Network Mgr I - PCPs for Broward County	Christian Sirven	(813) 399-0131	N/A	CSirven@freedomh.com
Provider Network Mgr I - Specialists for Dade, Broward, Palm Beach, Martin, Indian River, St. Lucie	Yvette Mills	(813) 347-7522		Ymills@freedomh.com

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Title	Name	Office Number	Ext	E-mail
Provider Network Manager Sr. - St Lucie, Indian River, Martin County	Belkys Vargas	(561) 880-7712	N/A	bvargas@freedomh.com

FREEDOM HEALTH

OPTIMUM HealthCare, Inc.

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provider NEWS

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IN THIS ISSUE

Registered Dietitian INTRODUCTION

We are pleased to announce the addition of a registered dietitian to our case management department. Aneesa is a licensed and registered dietitian who has earned a bachelor's in psychology and master's in nutrition from the University of Illinois at Chicago. She is here to help with any food and nutritional concerns or questions that your patients may have regarding management of conditions (diabetes, hypertension, cardiovascular disease, etc.) or if they are seeking general nutrition advice!

Aneesa has an "all foods fi " and "everything in moderation" philosophy so she will never ask your patients to cut out their favorite foods. Instead, she uses a gentle and compassionate approach to help them make small changes that align with their health goals and values and that feel manageable. She understands that food plays many roles in our lives. It not only fuels us physically, but it is also a source of pleasure, socialization and creating bonds with loved ones. Her goal is to empower our members to be able to make food choices that not only nourish their body, but also their mind and soul. If the dietitian can be of assistance to you or your patients, please contact the disease and case management department directly by phone: 888 211 9913, or by fax: 888-314-0794.