providerNEWS

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

SPRING **2020**

The Importance of COMMUNICATION AS A HEALTH PROVIDER

FALL PREVENTION: What Health Care Professionals Can Do To Help

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

Spring 2020 - CREDENTIALING CORNER

AND **much more!**

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The Importance Of **COMMUNICATION** as a **Health Care Provider**

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.

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

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

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

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

continue on next page

Office Cleanliness

> "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 member satisfaction. One of the questions that **continually** has an impact on member satisfaction is Doctor's Office Cleanliness. ***The Health Plan has found that poor member satisfaction with office cleanliness often coincides with lower overall scores on PCP and specialist rating for our Member Satisfaction Survey.***

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

- Keep the office area as germ-free as possible to prevent infection and cross contamination;
- Get new furniture if your office furniture needs updating;
- Add a small amount of updated magazines which can also help create a fresh, minimalist environment;
- Keep the waiting room tidy by picking up coffee cups and tissues that may have been left behind; and
- Soothing décor, soft lighting and a friendly and comforting office staff can create an overall satisfying experience as well at a medical office practice.

If your office may be thinking of things to improve upon in 2020, please take into consideration that an office that is not clean may be sending the wrong message to a patient. This is a very simple adjustment that can greatly influence patients' overall satisfaction!

Printed patient education material or instructions are also helpful to send home with the patient.

Communication with Other Providers (PCP to Specialists):

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

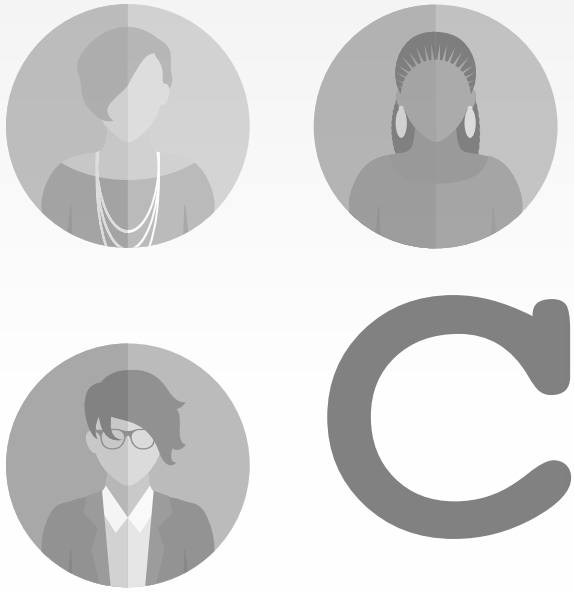
When patients transition between facilities or other providers, it is difficult to ensure continuity of care. By working together as a provider team, the patient is more likely to receive the best health care possible.

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

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

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 711) 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.

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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 practitioners by enhancing awareness, knowledge and skills of cultural competency, and by informing practitioners of opportunities for improvement both at the individual and organizational levels.

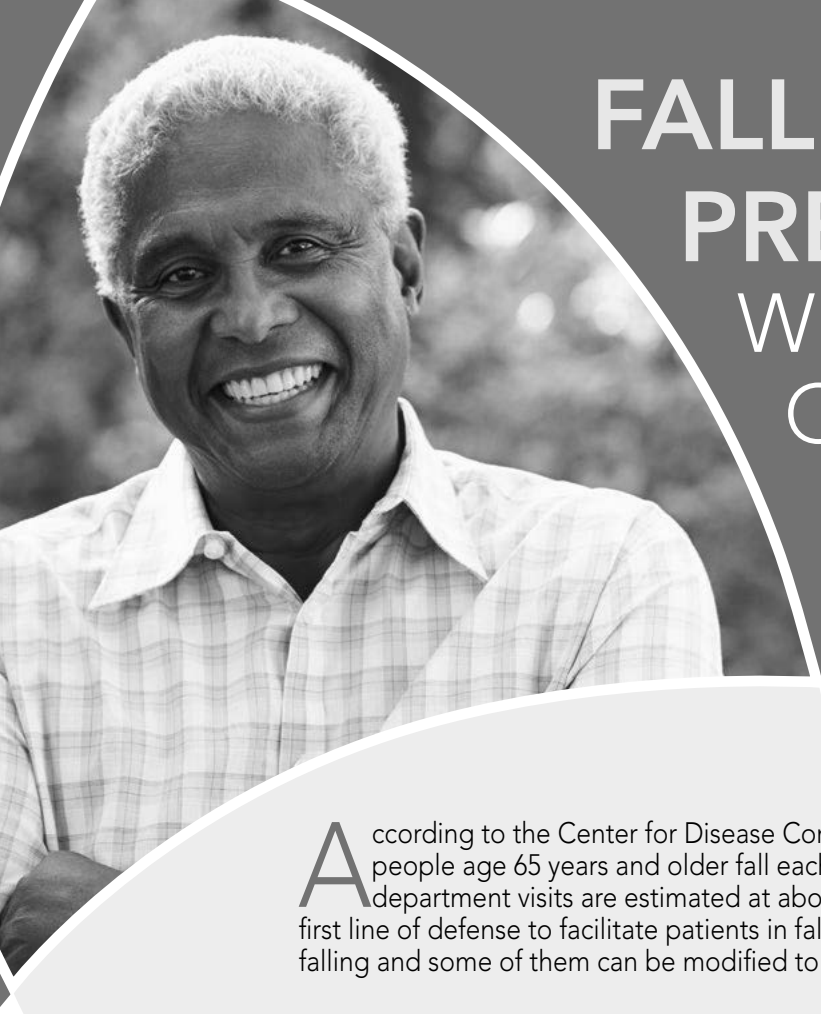
You can download the tool at *https://nccc.georgetown.edu/assessments/*.

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

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

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

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



FALL PREVENTION: WHAT HEALTH CARE PROFESSIONALS CAN DO TO HELP

According to the Center for Disease Control and Prevention (CDC), one fourth of people age 65 years and older fall each year and fall-related emergency room department visits are estimated at about 3 million per year. As providers, you are the first line of defense to facilitate patients in fall prevention. There are many risk factors for falling and some of them can be modified to help prevent these dangerous occurrences.

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

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

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

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

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

PARTNER WITH CASE & DISEASE MANAGEMENT NURSES

THE PLAN 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, enhance self-management and reduce 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 WORKERS 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 in which the member might benefit.

MEMBERS ENROLLED INTO ONE OF OUR Case and Disease Management programs, and their physicians, receive ongoing support from nurses on staff. Members may choose not to participate in the program at any time and it does not affect their benefits.

MANY TIMES, NURSES OR SOCIAL WORKERS WILL NEED to engage the PCP to resolve members concerns or identified issues. We appreciate providers supporting Member participation in these programs as a collaborative effort to maximize health and wellbeing. Provider communication efforts are also enforced via a care plan developed by the nurse and/or managed care coordinator, along with the member, highlighting mutually agreeable goals and interventions. Updates to the care plan are provided as well when initiatives change.

CONTACT

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

from 8:00 a.m. to 4:30 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

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

Additional benefits of the 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.

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.

It is important that members understand how to directly communicate with the PCP's office. They sometimes 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 from 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 members can provide the added connection/benefit to members to continue to strive to meet their health care goals.

Case and Disease Management staff 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.

COMPLIANCE CORNER

As a Medicare Advantage Plan (MA), we are required to conduct oversight of our First Tier, downstream and related entities (FDRs). Medicare program requirements apply to FDRs to whom the sponsor has delegated administrative or health care service functions relating to the sponsor's Medicare Parts C and D contracts.

In order to establish an effective system for monitoring and auditing, the Plan utilizes a Risk Assessment Tool that considers the entity's nature of services performed, past performance, open corrective action plans, financial and Stars Impact including regulatory notices of non-compliance.

Since risks change and evolve with new regulations, program requirements and operational changes, the Plan performs a comprehensive annual risk assessment and conducts an ongoing review throughout out the year to identify and address risks associated with the plan's participation in Federal Health Care Program. The Plan then selects a reasonable number of First Tier Entities to conduct audits of the Compliance program requirements.

The most common findings associated with the Plan's compliance audits are as follows:

- Entities are unable to provide evidence to support the distribution of Code of Conduct and/or Compliance Policies & Procedures within 90 days of hire and annually thereafter. The Code of Conduct and Polices & Procedures must be distributed to employees who support the sponsor's MA Plans Medicare business contract. 42 CFR § 422.503(b)(4)(vi)(A), § 423.504(b)(4)(vi)(A)

- Entities are unable to provide evidence to support the OIG/GSA Exclusion Database Screenings are conducted on all employees, governing body members and entities which your organization partners/contract with prior to hire or contracting and monthly thereafter. 42 CFR § 422.503(b)(4)(vi)(F), § 423.504(b)(4)(vi)(F), 42 CFR 1001.1901

- Entities are unable to provide evidence to support General Compliance and Fraud, Waste and Abuse education is being provided to your organization's applicable employees within 90 days and annually thereafter. 42 CFR 422.503(b)(4)(vi)(C), 423.504(b)(4)(vi)(C)

- Entities are unable to provide evidence to support they have a current process to ensure reporting of Fraud, Waste and Abuse and Compliance concerns that involve our members are reported to the Plan. 42 CFR § 422.503(b)(4)(vi)(A), § 423.504(b)(4)(vi)(A), § 422.503(b)(4)(vi)(D), § 423.504(b)(4)(vi)(D), § 164.530 (d)(1)

SNP Program Evaluation

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

The 2019 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. The Plan met approximately 70% 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 2020 programming for improved member experience and outcomes. Goals are also reviewed to determine if more challenging goal metrics should be established moving forward. Overall, 29 of 44 goals were adjusted due to either changes in National Benchmarks or internal improvement opportunities.

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FREEDOM HEALTH

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provider NEWS

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IN THIS ISSUE

Financial BARRIERS to Medication Compliance

Medication adherence is often a key component in most treatment plans. Being able to adhere to a medication regimen involves factors such as financial constraints, the ability to administer the medication, and the patient's ability to understand the need for the medication. It has been well documented that the inability to pay for medications is a common barrier to medication adherence.

Understanding your patient's ability to afford his or her medication can be a great benefit when it comes to prescribing. The promises associated with newer, often brand name medications, need to be carefully considered against established and proven treatment regimens. While the new medication may provide an effective therapy, the inability to afford the co-pay can lead to the patient not filling the prescription and ultimately failure of the treatment plan.
The Plan has a team of pharmacists and pharmacy technicians ready to assist you in identifying cost-effective medications to treat your patient. 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.