

SPRING 2019


# AFC CONNECT

HMO Provider Newsletter



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**F**ederal 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:**

- Allowing extra time with patients for whom English is a second language.
- Posting signs and providing educational materials with easy-to-read text, written in common languages encountered in your service area.
- Using nonverbal methods of communication (e.g., pictographic symbols) with patients who cannot speak English or whose primary language may not be English.
- Speaking slowly and clearly, using terms the patient will understand.
- Accommodating and respecting patients' unique values, beliefs and lifestyle choices when customizing treatment plans.
- Being aware that direct or prolonged eye contact is considered disrespectful or aggressive in some cultures.
- Being 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.

**C**



# Cultural Competency

## **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/cultural-competence/index.html>

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



# Office Cleanliness

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

**P**atients 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.

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 things you can do:

- 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 2019, 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.

## SNP Program Evaluation

Every Special Needs Plan (SNP) plan has a specific SNP Model of Care 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 Model of Care program is reviewed for effectiveness through the SNP Program Evaluation process.

The 2018 SNP Program 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. Our outcomes indicated a majority of met goals and 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 2019 programming for improved member experience and outcomes.



## PARTNER WITH CASE & DISEASE MANAGEMENT

# NURSES

**T**HE 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 the Case and Disease Management program. Our Social Worker staff works in conjunction with Care Coordinators and Nursing 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 social worker, 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



## Testing for A1C

With all the delicious and decadent foods that tempt us every day, managing diabetes can be a difficult challenge. A

healthy diet, medication plan, and physician recommended exercise regimen can help keep your patient's disease under control. A good reference measure to have in your patient's chart is a history of their Hemoglobin A1c levels.

Consider informing your patients that a Hemoglobin A1c is a simple blood test that can provide an estimate of their average blood sugar over the past three months. Providing this

information will help the patient to understand how their body handled its sugar intake and will help keep them informed and on track with their treatment plan.

Please consider ordering a Hemoglobin A1c as part of a routine work-up for any patient at risk of, or currently managing, diabetes. Encouraging patients to use the Plan's approved vendor will ensure that the results get communicated without any additional effort.

## 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.

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. 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.



## The plan accepts CAQH Proview Credentialing applications

Please continue to keep your credentialing application information and attached documentation current in the CAQH Proview data base. When logging into your ProView Provider Sign-in, please take note of the informational banners that CAQH uses to announce updates to their system, as well as the monthly emailed CAQH ProView Updates. Also, please ensure the following items are updated and current:

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

## For Providers Not Part of CAQH Proview:

The plan sends notification and re-credentialing applications by mail four months in advance of a providers credentialing expiration date. The notification cover letter specifies the steps and documents needed for re-credentialing, as well as the deadline for the submission of all current information.

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

*Thank you for your timely submission!*

## 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. In a recent article the FDA indicated the inability to pay for medications as 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.



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## LAB REMINDER



**Quest Laboratory**  
www.questdiagnostic.com **866-697-8378**

**Solstas** www.solstas.com **888-664-7601**

**Laboratory Services of America (LabCorp)**  
www.labcorp.com **800-432-6078**

**TIP:** Lab and pathology tests for America's 1st Choice members performed at a participating facility can improve HEDIS® scores.

## Provider Relations Directory

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