MetroPulse provider newsletter

AUTUMN 2019

Encourage all your patients to get the flu vaccine as clinically appropriate. MetroPlus members can get a free flu shot at any of the following locations:

- *their doctor's office*
- *a CVS store*
- *most participating pharmacies*
- *New York City Health + Hospitals facilities*

VACCINATIONS FOR ADULTS

All adults should be fully vaccinated, but patients may not know *which* vaccines they need to receive. Talk with your patients about getting the vaccines they need to keep healthy, including:

- **Pneumococcal vaccine:** The pneumococcal vaccine is recommended for all adults over 65 years old, and for adults younger than 65 years who have certain chronic health conditions.
- **Tdap or Td vaccine:** Every adult should get the Tdap vaccine once if they did not receive it as an adolescent to protect against pertussis, and then a Td (tetanus, diphtheria) booster shot every 10 years. In addition, women should get the Tdap vaccine each time they are pregnant, preferably during weeks 27 – 36 of pregnancy.
- **Shingles (Zoster) vaccine:** The shingles vaccine is recommended for all adults 50 years of age and older. There are two shingles vaccines available: Shingrix and Zostavax. The Centers for Disease Control and Prevention (CDC) recommends that healthy adults ages 50 years and older receive two doses of Shingrix, which is the preferred vaccine. Zostavax requires only one dose and may be used in healthy adults ages 60 and older.

THE IMPORTANCE OF COORDINATION OF CARE FOR PCPS

When a patient receives care elsewhere, it is important for PCPs to play an active role in facilitating that care. Care coordination is a vital aspect of patient-centered care, as it places doctors and other participants concerned with a patient's care in the best position to work together, and helps provide appropriate, effective, and safe care to our patients.

If a patient requires specialist care, work with them to find a specialist and, if possible, assist in scheduling their appointment. Remain up-to-date on the care they've received from other providers. Actively sharing relevant information between the health care professionals is one of the best ways to improve both outcomes for patients as well as their experience with the health care system.

Visit www.ahrq.gov/ncepcr/care/coordination.html for additional information and resources.

APPOINTMENT AVAILABILITY AND MEMBER SATISFACTION

Appointment availability is a critical component of Patient Experience, as it is often the first step in developing the patient-provider relationship. As stronger associations are formed between positive patient experience, improved patient outcomes and key financial indicators, doctors and other health care professionals alike are making Patient Experience their top priority.

NYC Health+Hospitals (H+H) is committed to providing the best patient experience possible and has made substantial progress in improved appointment availability. By implementing open access scheduling at Bellevue's adult primary care clinic, average wait times for an appointment have plummeted to 14 days from 52, on average. Additionally, patients are seeing their PCP almost 20% more often. With this success, H+H will be rolling out open access scheduling to its roughly 70 clinics in the months to come.

Open access scheduling may seem contradictory to traditional scheduling techniques, but its success is difficult to argue. Rather than booking each doctor's time well in advance, this model leaves about half of the day available for same-day scheduling. Here are a few tips to help you get started:

- Accurately measure supply and demand.
- Establish a team of providers to first test out the new scheduling system.
- Reduce the backlog of appointments.
- Simplify appointment types and standardize appointment length. If possible, minimize complexity by limiting the practice to three appointment types:
  - **Personal**, where the patient is seeing his or her physician;
  - **Team**, where the patient is seeing someone else on the clinical team; and
  - **Unestablished**, where the patient has not yet been assigned a specific physician.
- Develop a contingency plan for days, or parts of the day, when demand exceeds the availability of physicians. Identify individuals who can supplement or substitute for each physician if needed. Also be proactive about planning for times of high demand, such as visits for school physicals or flu shots.
- Reduce demand for one-on-one visits with patients. A few helpful tactics include:
  - identifying and addressing sources of unnecessary visits based on outdated clinical protocols.
  - implementing group visits to better manage care for patients with the same chronic condition.
  - use of phone and email to effectively address concerns that do not require a visit.
- Once implemented, continuously measure appointment availability.

And don't forget, physician extenders are another great way to reduce the burden on doctors and free-up scheduling.

OFFICE WAITING TIME STANDARDS

It's important to remember that excessive office waiting time significantly affects members' overall satisfaction, with both the provider and the health plan. Please follow these standards, which are listed in our MetroPlus *Provider Manual* under "Office Waiting Time Standards":

- **Waiting room times must not exceed one (1) hour for scheduled appointments. Best practice is to let the patient know they can expect to wait an hour. Everybody is busy and waiting an hour with no communication will lead to dissatisfied patients! Consider calling patients before they arrive to let them know you are running behind and reschedule if needed.**
- **Members who walk in with urgent needs are expected to be seen within one (1) hour.**
- **Members who walk in with non-urgent "sick" needs are expected to be seen within two hours or must be scheduled for an appointment to be seen within 48 to 72 hours, as clinically indicated.**

REMINDER: FLU SEASON IS HERE

Influenza has a high disease burden, but if the proper steps are taken, there is the potential to greatly reduce the impact. The flu vaccine is recommended for all patients 6 months of age and older and vaccinations can reduce flu-related hospitalizations by 71%. Last year, over 49 million people in the United States were sick with the flu. The yearly flu vaccine is the best way to reduce the number of people affected.

Patients who have not yet gotten the flu shot should be encouraged to receive their vaccinations at every clinical encounter during flu season. This is especially important for those at greater risk — pregnant women, those who will be more severely impacted if they get sick, and those more at risk of encountering the flu in the course of their life and work. Vaccinating eligible patients also helps to protect those who cannot be vaccinated.

Patients may believe outdated or inaccurate information about the flu vaccine. Some common reasons why they may refuse a vaccine are:

- **"THE VACCINE WILL MAKE ME SICK OR GIVE ME THE FLU."**
  - » Explain to patients that there is no way to get the flu from the flu vaccine. But, let them know that they may experience muscle soreness after getting the shot, and any other anticipated side effects that are a normal part of the process.
- **"THE FLU ISN'T SERIOUS."**
  - » Patients may not know, but 79,000 people died of the flu during the 2017-2018 flu season. The symptoms of the flu can keep even a healthy person bedridden for days—isn't it better to avoid the risks?
- **"I'M PREGNANT AND DON'T THINK IT'S SAFE."**
  - » It's doubly beneficial for pregnant women to get vaccinated—not only are they protected (avoiding illness while pregnant), but their baby is also protected for the first few weeks of their life.

MEMBER REWARDS

Members in our Medicaid, CHP, HIV SNP, HARP, EP, QHP, and Medicare plans are automatically enrolled in the MetroPlus Rewards Program. The program allows members to earn points for participating in fitness challenges, receiving cancer screenings, and refilling medications. These points can be redeemed for athletic equipment, toys, personal care items, and more.

MetroPlus is committed to keeping our members healthy. Encourage your patients to visit **www.metroplusrewards.org** for more information and to redeem rewards. If you are interested in learning more about the MetroPlus Member Rewards Program, please contact Provider Services.

INFERTILITY SERVICES EFFECTIVE OCTOBER 1, 2019

As of October 1, Medicaid Managed Care (MMC) benefits will include medically necessary ovulation enhancing drugs and medical services related to prescribing and monitoring the use of such drugs for individuals 21 through 44 years of age experiencing infertility. This applies to MMC plans, including mainstream MMC plans, HIV Special Needs Plans (HIV SNPs), and Health and Recovery Plans (HARPs).

FFS and MMC infertility benefits include office visits, hysterosalpingograms, pelvic ultrasounds, blood testing, and ovulation enhancing drugs included in the Medicaid formulary.

The ovulation enhancing drugs included in the Medicaid formulary are bromocriptine, clomiphene citrate, letrozole, and tamoxifen. FFS and MMC infertility benefits will be limited to coverage for three (3) cycles of treatment per lifetime.

For Medicaid purposes, infertility is a condition characterized by the incapacity to conceive, defined by the failure to establish a clinical pregnancy after twelve (12) months of regular, unprotected sexual intercourse for individuals 21 through 34 years of age, or after six (6) months for individuals 35 through 44 years of age.

HOW TO HELP DIABETIC PATIENTS START HEALTHY HABITS

Adopting a healthy lifestyle is a key factor in managing diabetes, but many patients have difficulty sticking to new habits. Here are some tips on how to coach your patients to achieve healthy lifestyles:

- **Teamwork:** When trying to make changes, it's easier if a patient has the support of friends and family. Cooking one meal for the family is easier than making separate healthy dishes, and if a workout is scheduled with a friend it may be more likely to happen.
- **Set realistic fitness goals:** Many patients need to add exercise to their daily routine, but it's important to take their current fitness level into account and be specific when suggesting exercise. Telling a sedentary patient to exercise is a broad recommendation, and they can become overwhelmed and give up. Encourage them to take more steps every day, or go for a walk, and increase their activity level over time.
- **Progress as motivation:** While the ultimate goal for a patient — better test results, large weight loss — may take a long time to achieve, setting smaller, intermediate goals may actually be more effective. Losing the first five pounds can make the next goal seem more achievable.
- **Knowledge is power:** Once a patient leaves your office, they may still have questions. Provide patients with the reputable sources they can access on their own if they want more information.
  - » MetroPlus offers members access to a health library with information about health issues.
  - » The American Diabetes Association offers information about diabetes, fitness and nutrition tips, and more.

SCREENINGS

COLORECTAL CANCER: TALK TO YOUR PATIENTS ABOUT THEIR OPTIONS

Most providers recommend that their patients be screened for colorectal cancer (CRC), but it is often difficult to get patients to agree to testing. Patients may not understand the need for screenings, or may be afraid that the tests are painful or uncomfortable. It's important that at-risk patients be screened.

Some methods are more effective in getting patients to agree to testing, including explaining the risks of CRC, up to and including death. Offering multiple methods of testing, such as fecal occult blood testing, flexible sigmoidoscopy, and colonoscopy, as equally acceptable options also helps. If a patient raises a specific issue or problem, try to work through it with them by explaining more about the test or offering a different option.

For a simple way to speak with patients about their options, the American Cancer Society has developed conversation cards with easy to understand information about different screening methods. Click here to view and download them for use.

For more information, and to access clinical practice guidelines, see your provider manual or log into the provider portal.

BREAST CANCER SCREENINGS

According to the Centers for Disease Control and Prevention (CDC), breast cancer in the United States is the most common cancer in women, no matter race or ethnicity. Each year in the United States, about 245,000 cases of breast cancer are diagnosed in women and about 41,000 women die each year from breast cancer. Over the last decade, the rate of getting breast cancer has not changed for women overall, but the rate has increased for black women and Asian and Pacific Islander women.

For prevention and early detection of breast cancer, patients should start receiving mammograms to check for cancer before there are signs or symptoms of the disease. Regular mammograms are the best tools to find breast cancer early. Patients should be reminded of the importance of early detection, and the need to schedule their regular screening based on the current screening recommendations. For more information and to review specific guidelines please click here.

All women need to be informed by their health care provider about the best screening options for them, as there may be many factors (previous history of breast cancer, family history of breast cancer, and age) that will determine how often and at what age they need to obtain a mammogram.

A special focus should be given to women who are at a higher risk for breast cancer and may be recommended for a mammogram annually and, if indicated an MRI. These include women with prior breast cancer diagnosis, genetic variants such as BRCA 1 or 2 gene mutation or family history (close relatives with early onset of breast cancer). For more information, click here.

CERVICAL CANCER SCREENINGS

According to the Centers for Disease Control and Prevention (CDC), cervical cancer used to be the leading cause of cancer death for women in the United States. However, in the past 40 years, the number of cases of cervical cancer and the number of deaths from cervical cancer have decreased significantly. This decline largely is the result of many women getting regular Pap tests, which can find cervical pre-cancer before it turns into cancer.

All women are at risk for cervical cancer. It occurs most often in women over age 30. Long-lasting infection with certain types of human papillomavirus (HPV) is the main cause of cervical cancer.

Types of screening tests that can help prevent cervical cancer or find it early:

- **The Pap test** (or Pap smear) looks for precancers, cell changes on the cervix that might become cervical cancer if they are not treated appropriately.
- **The HPV test** looks for the virus (human papillomavirus) that can cause these cell changes.

For more information and to review specific guidelines please click here.

It is also important to maintain accurate documentation of these visits, including proper coding. If a member has had a bilateral total hysterectomy, providers should document it in the member's medical record.

For more information, click here.

SCREENINGS

LEAD SCREENING TESTING

Any childhood exposure to lead can impair intellectual function and cause lifelong behavior problems. Providers should be vigilant about testing children for lead. Screening children for lead can help to decrease the risks for delayed or disordered developmental trajectory and ensure that kids are on track when it is time for them to enter school.

New York State law requires all children to be tested for lead at age 1 and again at age 2 by their health care provider. Providers must also assess children for exposure to lead until age 6 and test them if a risk of exposure is found. These results must be submitted to the New York State Department of Health.

If a child has an elevated lead level, it is important to make sure that they have follow-up testing. Guidance on lead poisoning prevention, risk reduction and nutritional counseling should also be given to the parent or caregiver. All parents of children under six years old should receive information and anticipatory guidance on lead as part of routine care.

Click here for additional information and resources.

For additional information on reporting, please contact the DOH Lead Poisoning Prevention Program at 518-402-7600 or email: LPPP@health.ny.gov.

ADOLESCENT WELL CARE VISIT RECOMMENDATIONS AND DOCUMENTATION

MetroPlus uses **Bright Futures** as its cornerstone for clinical recommendations for delivering care to adolescents. Bright Futures specializes in prevention and health promotion for children and young adults, with a strong set of Adolescence Tools to support and guide providers.

The core tools, available in both English and Spanish, are broken down into three age groups (11–14 years old, 15–17 years old, and 18–21 years old). They consist of:

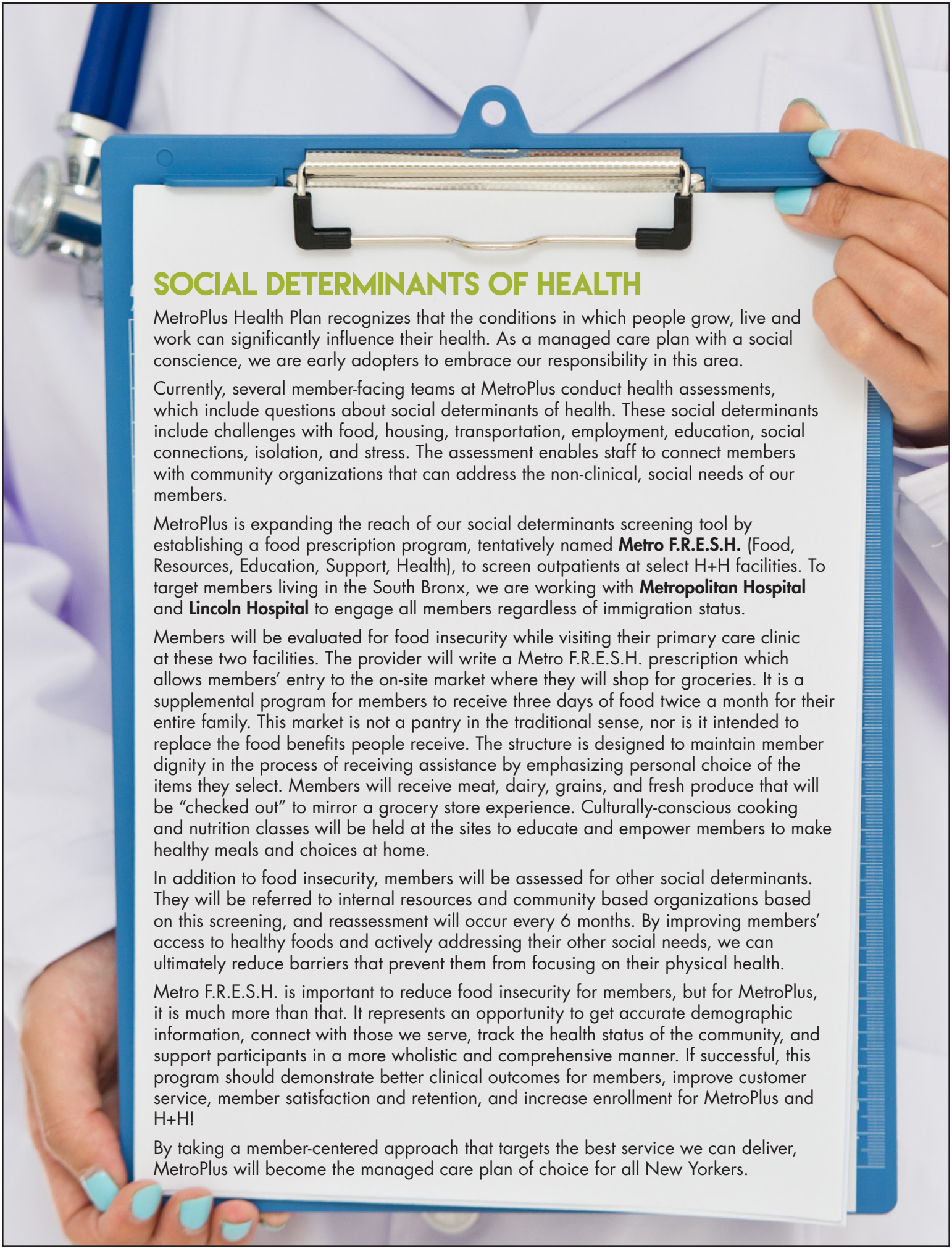
- **Pre-visit Questionnaires:** to determine what the family or adolescent would like to discuss during the visit, assist in initiating recommended medical screening for integrating risk assessment questions, and aid in obtaining development surveillance information.
- **Visit Documentation Forms:** to provide a convenient resource to document activities during a typical health supervision visit, simplify proper coding, and help secure appropriate payment for each visit's activities.
- **Parent/Patient Education Handouts:** to summarize Bright Futures anticipatory guidance, written for readers with limited literacy skills.

In addition, the Bright Futures toolkit includes Medical Screening Reference Tables for Clinicians — user-friendly MSR tables to compile history, risk-assessment questions and actions to take. There are also supplemental and medical-screening questionnaires specific to different age groups.

To see these materials and learn more about Bright Futures, please click here.

Bright Futures™

prevention and health promotion for infants, children, adolescents, and their families™



SOCIAL DETERMINANTS OF HEALTH

MetroPlus Health Plan recognizes that the conditions in which people grow, live and work can significantly influence their health. As a managed care plan with a social conscience, we are early adopters to embrace our responsibility in this area.

Currently, several member-facing teams at MetroPlus conduct health assessments, which include questions about social determinants of health. These social determinants include challenges with food, housing, transportation, employment, education, social connections, isolation, and stress. The assessment enables staff to connect members with community organizations that can address the non-clinical, social needs of our members.

MetroPlus is expanding the reach of our social determinants screening tool by establishing a food prescription program, tentatively named **Metro F.R.E.S.H.** (Food, Resources, Education, Support, Health), to screen outpatients at select H+H facilities. To target members living in the South Bronx, we are working with **Metropolitan Hospital** and **Lincoln Hospital** to engage all members regardless of immigration status.

Members will be evaluated for food insecurity while visiting their primary care clinic at these two facilities. The provider will write a Metro F.R.E.S.H. prescription which allows members' entry to the on-site market where they will shop for groceries. It is a supplemental program for members to receive three days of food twice a month for their entire family. This market is not a pantry in the traditional sense, nor is it intended to replace the food benefits people receive. The structure is designed to maintain member dignity in the process of receiving assistance by emphasizing personal choice of the items they select. Members will receive meat, dairy, grains, and fresh produce that will be "checked out" to mirror a grocery store experience. Culturally-conscious cooking and nutrition classes will be held at the sites to educate and empower members to make healthy meals and choices at home.

In addition to food insecurity, members will be assessed for other social determinants. They will be referred to internal resources and community based organizations based on this screening, and reassessment will occur every 6 months. By improving members' access to healthy foods and actively addressing their other social needs, we can ultimately reduce barriers that prevent them from focusing on their physical health.

Metro F.R.E.S.H. is important to reduce food insecurity for members, but for MetroPlus, it is much more than that. It represents an opportunity to get accurate demographic information, connect with those we serve, track the health status of the community, and support participants in a more wholistic and comprehensive manner. If successful, this program should demonstrate better clinical outcomes for members, improve customer service, member satisfaction and retention, and increase enrollment for MetroPlus and H+H!

By taking a member-centered approach that targets the best service we can deliver, MetroPlus will become the managed care plan of choice for all New Yorkers.

MEDICATION THERAPY MANAGEMENT PROGRAM FOR SENIORS

MetroPlus Medicare members have access to the Medication Therapy Management (MTM) program. Members who take eight or more Medicare Part D covered maintenance drugs, have three or more chronic health conditions, and reach $4,044 in total yearly prescription drug costs are automatically enrolled in this free, voluntary program. Participants in the MTM are provided with a comprehensive medication review (CMR) and a targeted medication review (TMR).

A CMR is when a patient has a one-on-one discussion with a pharmacist about all the medications they take (prescription, OTC, and any supplements, vitamins, or herbal medicine) and how to best manage their health using those medications. A CMR review takes about 30 minutes and is usually offered once each year. At the end, the pharmacist will give the patient a Personal Medication List with the medications discussed during the CMR as well as a Medication Action Plan, with suggestions from the pharmacist of things the patient should discuss with their doctor.

With a TMR, MetroPlus will mail or fax suggestions to providers every three months about prescription drugs that may be safer, or work better than the current drugs a member is taking. As always, the prescribing doctor will decide whether to consider our suggestions. The prescription drugs will not change unless doctor and patient decide to change them.

Please encourage your patients to take advantage of this important service provided by MetroPlus and contact us if you would like additional information about our MTM Program.

HYPERTENSION MANAGEMENT

All patients with hypertension should have a plan of care that is clear, detailed, and current. The goal of the plan of care should be the achievement of treatment and self-management goals, along with the management of any comorbid conditions.

The patient's adherence to medication instructions is important, but encouraging self-management is a crucial part of the process. Managing hypertension only works when the patient and provider work together.

Patients are more likely to stick to the plan if their needs are taken into account when it is developed. Ideally, the plan should consider the patient's preferences and any other health conditions or needs they may have. It's important to be specific when giving patients suggestions such as a specific physical activity regimen, diet advice, and lifestyle recommendations (sleep, etc.). It's also important to find out about any environmental factors that may prevent a patient's follow through, such as a lack of reliable transportation to appointments or difficulty food shopping.

For more information, click here.

Access and Availability Standards

MetroPlus members must secure appointments within the following time guidelines:

Emergency Care	Immediately upon presentation
Urgent Medical or Behavioral Problem	Within 24 hours of request
Non-Urgent "Sick" Visit	Within 48 to 72 hours of request, or as clinically indicated
Routine Non-Urgent, Preventive or Well Child Care	Within 4 weeks of request
Adult Baseline or Routine Physical	Within 12 weeks of enrollment
Initial PCP Office Visit (Newborns)	Within 2 weeks of hospital discharge
Adult Baseline or Routine Physical for HIV SNP Members	Within 4 weeks of enrollment
Initial Newborn Visit for HIV SNP Members	Within 48 hours of hospital discharge
Initial Family Planning Visit	Within 2 weeks of request
Initial Prenatal Visit 1st Trimester	Within 3 weeks of request
Initial Prenatal Visit 2nd Trimester	Within 2 weeks of request
Initial Prenatal Visit 3rd Trimester	Within 1 week of request
In-Plan Behavioral Health or Substance Abuse Follow-up Visit (Pursuant to Emergency or Hospital Discharge)	Within 5 days of request, or as clinically indicated
In-Plan Non-Urgent Behavioral Health Visit	Within 2 weeks of request
Specialist Referrals (Non-Urgent)	Within 4 to 6 weeks of request
Health Assessments of Ability to Work	Within 10 calendar days of request

Medicaid Managed Care PCPs are required to schedule appointments in accordance with the aforementioned appointment and availability standards. Providers must not require a new patient to complete prerequisites to schedule an appointment, such as a copy of their medical record, a health screening questionnaire, and/or an immunization record. The provider may request additional information from a new member if the appointment is scheduled at the time of the telephonic request.

MetroPlus Health Plan
plan ahead.
METROPLUS.ORG 1.855.809.4073
160 Water Street, 3rd Floor, New York, NY 10038

CHANGES TO YOUR DEMOGRAPHIC INFORMATION

Notify MetroPlus of any changes to your demographic information (address, phone number, etc.) by directly contacting your Provider Service Representative. You should also notify us if you leave your practice or join a new one. Alternatively, changes can be faxed in writing on office letterhead directly to MetroPlus at **212.908.8885**, or by calling **1.800.303.9626**.

METROPLUS COMPLIANCE HOTLINE

MetroPlus has its own Compliance Hotline: **1.888.245.7247**. Call this line to report suspected fraud or abuse, possibly illegal or unethical activities, or any questionable activity. You may choose to give your name, or you may report anonymously.

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