Positive Practice

NEWS AND EDUCATION FOR POSITIVE HEALTHCARE PROVIDERS Issue 25 Fall 2022

In this Issue

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PHP FL: www.php-fl.org

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The Provider Relations Department Thought That You Should Know...

Authorization Process

PHP always has its members and providers in mind. We are consistently working to develop & strengthen these relationships through open lines of communication and various strategic initiatives that align us together for unprecedented growth potential. We heard you. Recently, PHP announced our revised Authorization process for PHP-FL & PHP-CA. This will allow our network providers to perform many routine services & screenings without a necessary authorization submission. Our Provider Relations team sent out a Provider Bulletin in June of this year detailing the various routine services & screenings that no longer require submission of an Authorization. If for some reason you did not receive the Provider Bulletin and you would like more information regarding the New Authorization Process, please visit the PHP website and click on the Provider Notice section, and/or simply contact our Provider Relations Department.

2023 Medicare Open Enrollment

Medicare Open Enrollment Period for 2023 is quickly approaching and will run from October 15, 2022, to December 7, 2022. During the Medicare Open Enrollment Period, eligible members can make changes to their Medicare health and drug coverage that will take effect on Jan. 1, 2023. As a reminder, many of our network providers may begin to see new PHP patients. Please be mindful to convey this information as well as established PHP Network affiliations via contractual agreements to all staff who are patient-facing. Our goal is to ensure member & provider satisfaction. We can achieve this by working collectively to ensure that we provide the best experience to our patients.

Member Advisory Committees

PHP would like to know if you are interested in attending one of our advisory committee meetings. We currently hold a meeting for the members of PHC California. This meeting is known as the Public Policy and Community Advisory Committee (PPCAC). The PHP plans have the Member Advisory Committee (MAC). The PPCAC & MAC Committees include plan staff, members, providers, and community advocates. We come together to discuss and help shape PHP and PHC California's policy and operations. The PPCAC & MAC meetings guide the plan to better serve our PHP and PHC California communities throughout Florida and California. We are excited to include our network providers. Your involvement is an integral and important piece of the success of these committee meetings.

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The PPCAC & MAC groups meet quarterly (via Zoom) with a standard agenda which includes but is not limited to;

- Discussion of policy and procedure changes that impact our plan and members
- Presentation of important health education materials
- Reporting of plan updates and trends. We talk about areas such as provider network access, utilization management timeliness, grievances, etc.
- Sharing of member experiences that will help the plan improve operations and delivery of services

Again, this is a great opportunity for the plan to collaborate with our providers & members to discuss important topics that influence day-to-day decisions, impact health outcomes, & provide the critical insight needed to collectively strengthen our relationship & align our purpose. If you are interested in learning how you can get involved with PPCAC or MAC and/or be a guest speaker, please reach out to our Health Education Department for more information at HealthEducation@aidshealth.org

Provider Spotlight

Meet Dr. William D. King!

Dr. King is a board-certified internal medicine and AAHIVM credentialed HIV specialist. He is currently in private practice in the Crenshaw area of Los Angeles, approximately 5 minutes away from where he grew up in Baldwin Hills, California.

Dr. King graduated with a degree in Cellular/Molecular Biology from California State University at Northridge. Dr. King obtained a dual degree in medicine and law from the University of Illinois at Urbana-Champaign as part of the Clinical Scholars Program. He completed an internal medicine residency at Harvard Medical School's Cambridge Hospital, where he was Chief Resident. He returned to Los Angeles, to complete two fellowships at the University of California at Los Angeles, one the Robert Wood Johnson Clinical Scholars Program, the other a combined HIV clinical research fellowship in the Department of Infectious Diseases.

Dr. King is certified as an HIV specialist by the American Academy of HIV Medicine and certified as a fellow within the American College of Legal Medicine. He is an associate professor in the Department of Internal Medicine at Charles R. Drew University of Medicine and Science. He has been reappointed by the Los Angeles Board of Supervisors to the Los Angeles County Commission on HIV, which serves as the local planning council for the planning, allocation, coordination, and delivery of HIV/AIDS services. He serves on the Priorities, Planning, and Allocation Committee; the Black African American Work Group, and the Prevention Planning Workgroup. Dr. King also serves on the Academy Council for Racial Equity of the American Academy of HIV Medicine. He is known nationally and internationally for his work in HIV/AIDS which includes lectures, publishing several peer-reviewed manuscripts and book chapters, and clinical trial investigations. Dr. King has received numerous awards for leadership, volunteerism, and community support. His work and lectures have been recognized both nationally and internationally in South Africa, Uganda, and Ghana. Dr. King is married and has two young daughters.

The location of Dr. King's practice is important to him because, he wanted to bring his internal medicine training from Harvard University and HIV specialty training from UCLA to one of the areas in greatest need, the Crenshaw area. South Central, California has very high rates of diabetes, hypertension, chronic pain, and HIV/STIs. Dr. King saw this unmet need for personalized HIV/STI prevention and treatment delivered by an African-American provider. He then sought to meet that need through partnerships with medical organizations such as AHF and PHP/ PHC California.

His goal is for patients to be able to receive quality, informed, and up-to-date clinical care in their neighborhoods. Dr. King's private practice welcomes new patients and they look forward to providing quality care to everyone in the community!

CAHPS® Rates

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey measures members' overall experiences with the delivery of health care. Data for this survey was collected from PHP and PHC members between the months of March and May of 2022 and it addresses topics that help drive member satisfaction with overall health care such as communication skills of providers and ease of access to health care services.

The CAHPS® member survey consists of approximately 70 questions and measures the satisfaction of the member with the health plan, provider accessibility, patient/provider relationship, and communication. Several questions related to member satisfaction with the provider are included and may provide opportunities for improvement in the everyday routine of the practice. These questions include:

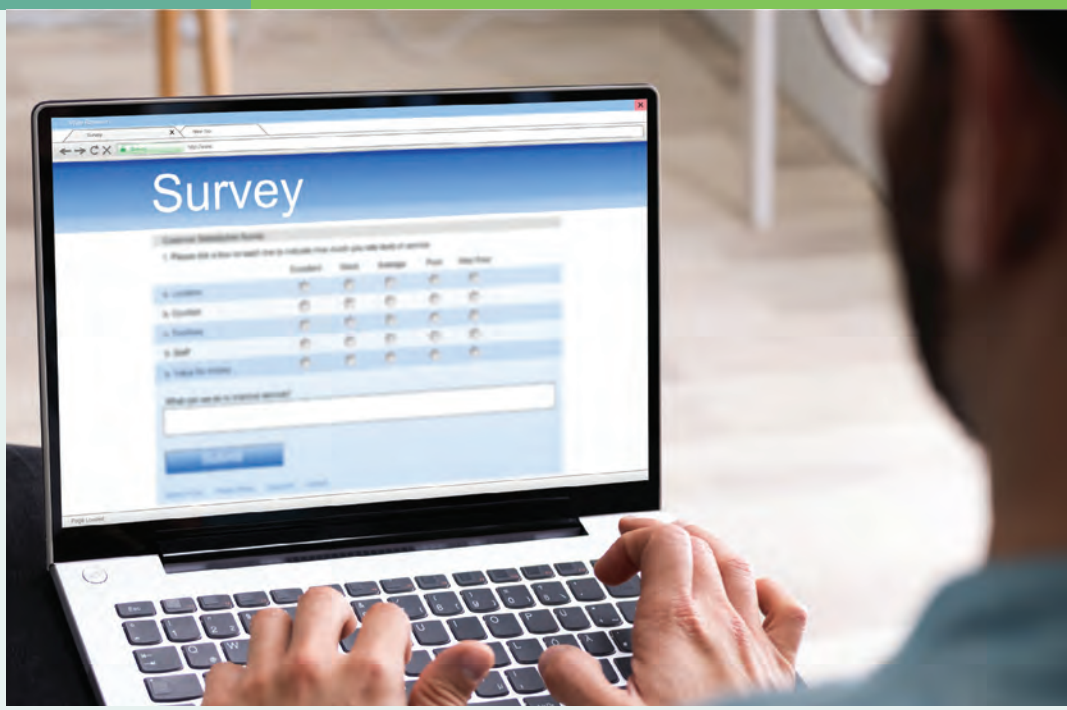
Shared decision making: Measures the patient's experiences with physicians in discussing the best choice of treatment and including the patient in deciding the best treatment for the patient.

Health promotion and education: Measures the patient's satisfaction with the physician in discussing ways to prevent illnesses.

Coordination of care: Measures the patients' perceptions of the physician's knowledge and whether the physician was aware of all care received from other physicians.

How well the physician communicates: Measures the patient's perception of whether the physician listened, explained, spent adequate time, and respected what the patient stated.

Getting care quickly: Measures satisfaction with the amount of time spent in receiving care or services including the time spent waiting to see the provider.



Getting needed care: Measures satisfaction with the ability to obtain care and services from physicians including tests and treatments.

Rating of health care: Measures overall satisfaction with the care received by the primary physician within the last 12 months.

Rating of personal physician: the overall performance of the primary physician within the last six to 12 months.

Rating of specialist: Measures the overall performance of any specialist seen within the last six to 12 months.

Ratings of health plan: Measures the overall satisfaction with the health plan within the last six to 12 months. This question is not related to the provider/physician.

Below are the 2022 CAHPS® Survey results. The survey return rate was less than 25% even with many improvement efforts. The Quality Improvement department will be addressing the results of this survey throughout 2022 and 2023.

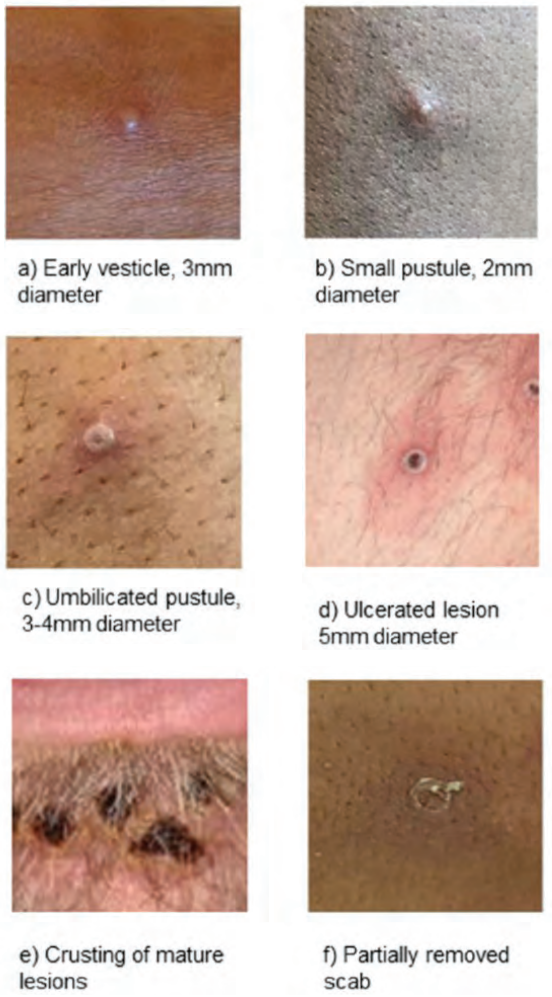
2021 Medicare CAHPS Results

Key CAHPS Questions	Medicare CAHPS Ratings PHP FL	Benchmarks* 2019 CMS National Data
Getting Needed Care	80.5%	83.7%
Getting Care Quickly	80.5%	78.2%
Doctors Who Communicate Well	91.9%	91.7%
Customer Service	90.5%	90.3%
Coordination of Care	87.5%	86.0%
Rating of Health Plan	89.4%	87.3%
Annual Flu Vaccine	82.5%	75.3%
Rating of Drug Plan	91.4%	86.1%
Getting Needed Prescription Drugs	92.1%	90.4%

Key Characteristics for Identifying Monkeypox

Examples of Monkeypox Rashes

Photo credit: UK Health Security Agency



a) Early vesticle, 3mm diameter

b) Small pustule, 2mm diameter

c) Umbilicated pustule, 3-4mm diameter

d) Ulcerated lesion 5mm diameter

e) Crusting of mature lesions

f) Partially removed scab

- Lesions are firm or rubbery, well-circumscribed, deep-seated, and often develop umbilication (resembles a dot on the top of the lesion).
- During the current global outbreak:
  - Lesions often occur in the genital and anorectal areas or in the mouth.
  - Rash is not always disseminated across many sites on the body.
  - Rash may be confined to only a few lesions or only a single lesion.
  - Rash does not always appear on palms and soles.
- Rectal symptoms (e.g., purulent or bloody stools, rectal pain, or rectal bleeding) have been frequently reported in the current outbreak.
- Lesions are often described as painful until the healing phase when they become itchy (crusts).
- Fever and other prodromal symptoms (e.g., chills, lymphadenopathy, malaise, myalgias, or headache) can occur before rash but may occur after rash or not be present at all.
- Respiratory symptoms (e.g. sore throat, nasal congestion, or cough) can occur.

Lesions typically develop simultaneously and evolve together on any given part of the body. The evolution of lesions progresses through four stages—macular, papular, vesicular, to pustular—before **scabbing over and desquamation**.

The incubation period is 3-17 days. During this time, a person does not have symptoms and may feel fine.

The illness typically lasts 2-4 weeks.

The severity of illness can depend upon the initial health of the individual and the route of exposure. The West African virus genetic group, or clade, which is the clade involved in the current outbreak, is associated with milder disease and fewer deaths than the Congo Basin virus clade.

ENANTHEM THROUGH THE SCAB STAGE

Stage	Stage Duration	Characteristics
Enanthem		• Sometimes, lesions first form on the tongue and in the mouth.
Macules	1–2 days	• Macular lesions appear.
Papules	1–2 days	• Lesions typically progress from macular (flat) to papular (raised).
Vesicles	1–2 days	• Lesions then typically become vesicular (raised and filled with clear fluid).
Pustules	5–7 days	• Lesions then typically become pustular (filled with opaque fluid) – sharply raised, usually round, and firm to the touch (deep seated). • Finally, lesions typically develop a depression in the center (umbilication). • The pustules will remain for approximately 5 to 7 days before beginning to crust.
Scabs	7–14 days	• By the end of the second week, pustules have crusted and scabbed over. • Scabs will remain for about a week before beginning to fall off.

*This is a typical timeline, but timeline can vary.

Rash resolved

Pitted scars and/or areas of lighter or darker skin may remain after scabs have fallen off. Once all scabs have fallen off and a fresh layer of skin has formed, a person is no longer contagious.

Source: CDC

Guidance for Influenza Vaccination 2022-2023

This report updates the 2021–22 recommendations of the Advisory Committee on Immunization Practices (ACIP) concerning the use of seasonal influenza vaccines in the United States. Routine annual influenza vaccination is recommended for all persons aged ffl6 months who do not have contraindications. For each recipient, a licensed and age-appropriate vaccine should be used. Except for vaccination for adults aged ffl65 years, ACIP makes no preferential recommendation for a specific vaccine when more than one licensed, recommended, and an age-appropriate vaccine is available.

All seasonal influenza vaccines expected to be available in the United States for the 2022–23 season are quadrivalent, containing hemagglutinin (HA) derived from one influenza A(H1N1) pdm09 virus, one influenza A(H3N2) virus, one influenza B/Victoria lineage virus, and one influenza B/Yamagata lineage virus. Inactivated influenza vaccines (IIV4s), recombinant influenza vaccine (RIV4), and live attenuated influenza vaccine (LAIV4) are expected to be available. Trivalent influenza vaccines are no longer available, but data that involve these vaccines are included for reference.

Influenza vaccines should be available as early as July or August, but for most persons who need only 1 dose of influenza vaccine for the season, vaccination should ideally be offered during September or October. However, vaccination should continue after October and throughout the season as long as influenza viruses are circulating and an unexpired vaccine is available.

Guidance for Influenza Vaccination in Specific Populations and Situations

Populations at Higher Risk for Medical Complications Attributable to Severe Influenza

All persons aged ffl6 months who do not have contraindications should be vaccinated annually. However, vaccination to prevent influenza is particularly important for persons who are at increased risk for severe illness and complications from influenza and influenza-related outpatient, emergency department, or hospital visits. When vaccine supply is limited, vaccination efforts should focus on vaccination of persons at higher risk for medical complications attributable to severe influenza who do not have contraindications. These persons include the following (no hierarchy is implied by order of listing):

- All children aged 6 through 59 months.
- All persons aged ffl50 years.
- Adults and children who have chronic pulmonary (including asthma), cardiovascular (excluding isolated hypertension), renal, hepatic, neurologic, hematologic, or metabolic disorders (including diabetes mellitus).
- Persons who are immunocompromised due to any cause (including but not limited to immunosuppression caused by medications or HIV infection).
- Persons who are or will be pregnant during the influenza season.
- Children and adolescents (aged 6 months through 18 years) who are receiving aspirin- or salicylate-containing medications and who might be at risk for experiencing Reye syndrome after influenza virus infection.
- Residents of nursing homes and other long-term care facilities.
- American Indian or Alaska Native persons.
- Persons who are extremely obese (body mass index ffl40 for adults).

An IIV4 or RIV4 (as appropriate for the recipient's age) is suitable for persons in all risk groups. LAIV4 is not recommended for certain populations, including certain of these listed groups. Contraindications and precautions for the use of LAIV4 are noted (Tables 2 and 3).

Reference: https://www.cdc.gov/mmwr/volumes/71/rr/rr7101a1.htm?s_cid=rr7101a1_w

What is HEDIS®? (Healthcare Effectiveness Data and Information Set)

HEDIS is an acronym that stands for Healthcare Effectiveness Data and Information Set. It is a widely used set of performance measures in the managed care industry. HEDIS was developed and is maintained by the National Committee for Quality Assurance (NCQA). HEDIS has become more than a set of performance measures and has evolved into an integral system for establishing accountability in managed care.

HEDIS reporting is mandated by the Centers for Medicare & Medicaid Services (CMS) for regulatory compliance. HEDIS data is collected through a combination of surveys, provider medical record audits, and insurance claims data. To ensure the validation of HEDIS results, the data is rigorously audited by certified auditors using NCQA's process design. Health care providers and staff must become familiar with HEDIS to understand what health plans are required to report to demonstrate the quality of patient care performed by the Plans Network Providers.

Data collection for HEDIS begins with queries of the claims or encounter data. If claims data does not include evidence that a service was provided within the required time frame, then the health plan must review the medical record to determine if care was provided. For some measures, data is only collected from claims. There are measurement sets for different types of insurance the provider may accept which are categorized as Commercial, Medicare, and Medicaid. Currently, AHF Managed Care processes Medicare and Medicaid HEDIS however, every physician practice may have several other insurance contracts that require HEDIS submission.

Health care providers can significantly improve HEDIS scores by submitting accurately coded claims for services provided and by maintaining accurate, legible, and complete medical records. Claims must reflect documentation within the medical record. Claims are the most efficient method for reporting HEDIS measures and decreasing the number of medical record reviews needed.

We need your help to increase our HEDIS scores and show the great work that our providers are doing for our members!

The Positive Healthcare Quality Department promotes and fosters accountability of network and affiliated health personnel for the quality and safety of care and services provided to Positive Healthcare members.

One of the ways to evaluate the effectiveness of our quality improvement activities in producing measurable improvements in the care and services provided to our members/your patients is evaluated by HEIDS ratings.

HEIDS ratings for selected Measures by plan for the 2022 (2021 reporting year) measurement year.

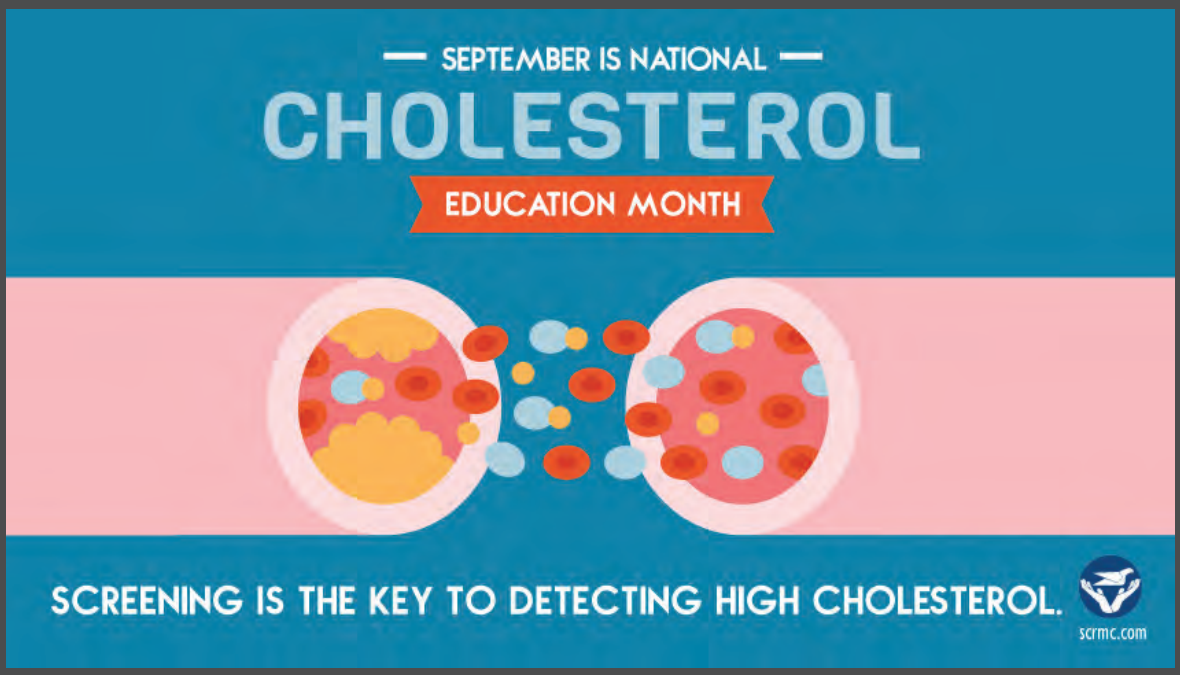
As health care providers you can help improve the members' health and the HEDIS rates with these tips. You can also help by outreaching out to patients to schedule follow-up appointments, and diagnostic tests and stressing the importance of medication adherence to improve their overall health outcomes.

For a complete list please refer to the NCQA website at www.ncqa.org

HEIDS ratings for selected Measures by plan for the 2022 (2021 reporting year) measurement year.

Screening	Name of Screening	Gender and Age Range for Screening	How Often	PHP-FL Compliance Rates
Breast Cancer Screening	Mammography	Women 50 through 74 years of age	Every 2 Years	60.69%
Colo-Rectal Cancer Screening	Colonoscopy Or Cologuard	All members 50 through 75 years	Every 10 Years or Every 3 Years	74.21%
Controlling Blood Pressure	Blood Pressure	All members 18 years of age and older	Last One Taken in Calendar Year	70.32%
Medication Reconciliation after Discharge from Hospital (Transition of Care)	Notation of medications prescribed or not upon discharge	All members 66 years of age and older who had an acute or non-acute inpatient discharge	30 days after every hospital discharge	64.98%
Advance Care Directive	Advance directive, five wishes, living will or surrogate decision maker	All members 66 years of age and older	Every Year	68.86%
Pain Assessment	Standardized pain assessment tool	All members 66 years of age and older	Every Year	94.16%
Functional Status Assessment	Notation of Activities of Daily living (ADL)	All members 66 years of age and older	Every Year	91.48%
Medication Review	Medication review conducted by a prescribing practitioner.	All members 66 years of age and older	Every Year	91.48%
Below are screening only for members with a diagnosis of diabetes				
HgA1c Test	Glycated hemoglobin &glycosylated hemoglobin test	All members 18-75 years of age with diabetes	Every Year	95.91%
HgA1c less than 8	Glycated hemoglobin &glycosylated hemoglobin test	All members 18-75 years of age with diabetes	Every Year	72.64%
Nephropathy Screening	Microalbumin or urine test for protein	All members 18-75 years of age with diabetes	Every Year	97.48%
Retinal Eye Exam	Dilated eye exam	All members 18-75 years of age with diabetes	Every year or year prior if negative for retinopathy	52.52%

September is National Cholesterol Education Month!



National Cholesterol Education Month should hold great importance to healthcare providers, and more increasingly so to the general public, because of the lack of knowledge surrounding this particular bodily compound. For this reason, providers must recognize their power to influence the lives of their patients through raising awareness, emphasizing early screening and prevention methods, and treatment when necessary.

Although cholesterol screening is one of the most frequently used practices within medical offices around the country, many people still do not have a fundamental understanding of what the molecule is and how it can directly affect one's body. Cholesterol is a waxy lipid that is in healthy amounts by the body and is present in many of the foods that we eat on an everyday basis, such as red meat, eggs, dairy products, desserts, and fried foods. Cholesterol helps to protect our body against metabolic diseases, assists in the breakdown of fats and helps with the maintenance of bone density. However, it is the diagnosis of having high cholesterol that everyone should be actively trying to avoid!

Because cholesterol is present in many of the foods previously mentioned, it can be extremely easy for people to fall victim to high cholesterol. As indicated by the CDC, over 94 million adults have high cholesterol, which is an area of concern for medical providers because of the long-term effects that it can have on the body. As a direct result of this condition, plaque can begin to build up within arteries and prevent regular blood flow, which can lead to even worse diseases such as Coronary Artery Disease, Carotid Artery Disease, and Peripheral Artery Disease. Because of this, having high cholesterol can also lead to high blood pressure. These diseases will cause greater strain on the heart and this would lead to a gradual decrease in its functionality over time. Heart disease is the Number One leading cause of death in the United States

Even though heart disease and high cholesterol have a great burden on the human population, this does not mean that all hope is lost! Healthy People 2030 suggests that it is important to stress that poor everyday choices can begin to lead to worse health outcomes in the long run to prevent the incidence of high cholesterol in patients. So, providers must be proactive in informing patients of the great importance of eating a healthy diet and exercising regularly to maintain a healthy weight. In addition, the shedding of unhealthy habits such as excessive drinking and smoking should be emphasized as well.

During National Cholesterol Education Month, everyone over the age of 20 needs to have been tested within 5 years to ensure that we prolong the long-term health of the masses and prevent the interaction between high cholesterol and HIV.

The United State of America National HIV/AIDS Strategy 2022-2025

The vision, goals, objectives, and other components of the Strategy were developed and approved by a dedicated Steering Committee, composed of subject matter experts from across the federal government, with input from numerous and varied interested parties and organizations in the field. The Strategy is designed to be accessible to and useful for a broad audience, including people working in public health, health care, government, community-based organizations, research, private industry, and academia. It serves as a roadmap for all sectors of society to guide the development of policies, services, programs, initiatives, and other actions to achieve the nation's goal of ending the HIV epidemic by 2030. The Strategy is designed to facilitate a whole-of-society national response to the HIV epidemic in the United States that accelerates efforts to end the HIV epidemic in the United States by 2030 while supporting people with HIV and reducing HIV-associated morbidity and mortality. While not every objective or strategy will speak to or be actionable by all readers, the intent is that individuals and organizations from all sectors of society can find opportunities Building on lessons learned and progress made in the past 40 years, the United States now has the opportunity to end the HIV epidemic. This opportunity has been made possible by tireless advocacy, determined research, and dedicated delivery of diagnostic, prevention, care, treatment, and supportive services. The nation's annual new HIV infections have declined from their peak in the mid-1980s, and people with HIV in care and treatment are living longer, healthier lives. In 2019, the estimated number of new HIV infections was 34,800 and 1.2 million people were living with HIV in the United States. However, not all groups have experienced decreases in HIV infections or improvements in health outcomes. Centers for Disease Control and Prevention data show that new HIV infections fell 8% from 2015 to 2019, after a period of general stability in new infections in the United States. This trend represents a hopeful sign of progress. But gains remain uneven, illuminating opportunities for geographic- and population-focused efforts to make more effective use of the powerful HIV prevention, care, and treatment tools now available. This National HIV/AIDS Strategy (the Strategy), the nation's third national HIV strategy, updates the HIV National Strategic Plan (2021). The Strategy sets forth bold targets for ending the HIV epidemic in the United States by 2030, including a 75% reduction in new HIV infections by 2025 and a 90% reduction by 2030. For interested parties and organizations across the nation, the Strategy articulates goals, objectives, and strategies to prevent new infections, treat people with HIV to improve health outcomes, reduce HIV-related disparities, and better integrate and coordinate the efforts of all partners to achieve the bold targets for ending the epidemic. The Strategy also establishes evidence-based indicators to measure progress, with quantitative targets for each indicator, and designates priority populations. The Strategy establishes the following vision:

The United States will be a place where new HIV infections are prevented, every person knows their status, and every person with HIV has high-quality care and treatment, lives free from stigma and discrimination, and can achieve their full potential for health and well-being across the lifespan. This vision includes all people, regardless of age, sex, gender identity, sexual orientation, race, ethnicity, religion, disability, geographic location, or socioeconomic circumstance.

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The Strategy is designed to facilitate a whole-of-society national response to the HIV epidemic in the United States that accelerates efforts to end the HIV epidemic in the United States by 2030 while supporting people with HIV and reducing HIV-associated morbidity and mortality. While not every objective or strategy will speak to or be actionable by all readers, the intent is that individuals and organizations from all sectors of society can find opportunities where they can support necessary scale-up, expansion, and refinement efforts. All communities, regardless of HIV prevalence, are vital to ending the HIV epidemic in this country and private- and public-sector partners must work together with community-based, faith-focused, and advocacy organizations; governmental public health; mental health and substance use disorder treatment services; the criminal justice system; and providers of housing, food and nutrition, education, and employment services because we all have a role in reducing new HIV infections, improving outcomes and quality of life for people with HIV, and eliminating HIV disparities.

Interwoven throughout the Strategy are approaches to address the individual, community, and structural factors and inequities that contribute to the spread of HIV, such as stigma and social determinants of health. The Strategy highlights opportunities to integrate HIV prevention, care, and treatment into prevention and treatment for sexually transmitted infections, viral hepatitis, mental health and substance use disorders, and other public health efforts by leveraging capacity and infrastructure across the domains and breaking down operational and funding silos. A recurring theme is the need to bring to scale innovative solutions and data-driven approaches to address the ongoing and emerging challenges to HIV prevention, care, and treatment, including expanding the types of community and clinical sites that address HIV to help reach and engage people in need of services; supporting retention in HIV prevention and care services; continuing research into the development of better prevention tools, therapeutics, and vaccines; and understanding how to make the best use of available tools in real-world settings. Throughout this document, the term "care" is used as an umbrella term meant to encompass holistic services including treatment and supportive services.

To ensure implementation and accountability, a Federal Implementation Plan that documents the specific actions that federal partners will take to achieve the Strategy's goals and objectives will be developed in early 2022. Progress toward meeting the Strategy's goals will be monitored and reported annually.
The Strategy and the Ending the HIV Epidemic in the U.S. (EHE) initiative are closely aligned and complementary, with EHE serving as a leading component of the work by the U.S. Department of Health and Human Services (HHS), in collaboration with local, state, tribal, federal, and community partners, to achieve the Strategy's goals. The EHE initiative focuses on scaling up four strategies in the communities most affected by HIV. The Strategy covers the entire country, has a broader focus across federal departments and agencies beyond HHS and all sectors of society, and addresses the integration of several key components that are vital to our collective work, including stigma, discrimination, and social determinants of health.