



PROVIDER BULLETIN

JANUARY 2021 - ISSUE 11



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MEDICARE WELLNESS VISITS:

Get Your Patients
Off to a Healthy
Start in 2021



**The AWV, or “Yearly Wellness Visit”,
focuses on preventive health:**

- Develop or update a personalized prevention plan
- Perform a health risk assessment
- Complete and submit the Annual Health Assessment (AHA)

For more information, go to

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo>
and access these valuable resources:

- Medicare Wellness Visits educational tool
- Medicare Preventive Services educational tool
- Preventive Services webpage

You can also see MMM resources and tools on our website,
at www.mmm-fl.com, or in the provider portal: **InnovaMD**.

HEDIS® Measure in Focus: Transitions of Care (TRC)

Monitoring your patient's admissions and providing post-discharge follow-up, including medication reconciliation, is critical to involve them in their treatment, ensuring their safety while preventing a future readmission. The HEDIS® Transitions of Care measure (TRC) helps us assess how well you are performing on these key care management activities. We work with you by providing information, data and tools to ensure your success in achieving the best health outcomes for your patients; our members.



The TRC measure has 4 components:



**NOTIFICATION
OF INPATIENT
ADMISSION**



**RECEIPT OF
DISCHARGE
INFORMATION**



**PATIENT
ENGAGEMENT
AFTER INPATIENT
DISCHARGE**



**MEDICATION
RECONCILIATION
POST-DISCHARGE**

MMM partners with you to ensure you are successful in addressing all 4 indicators above. Be sure to access InnovaMD daily to:

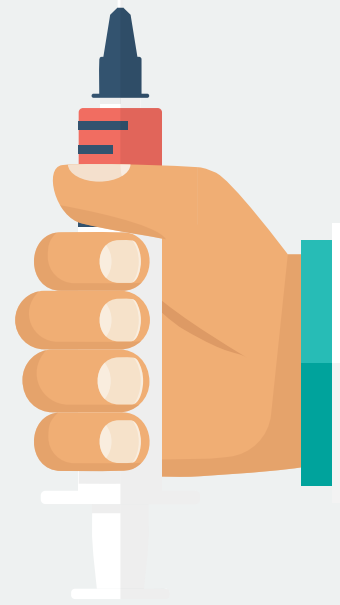
- Access and review your Inpatient Census. Document in the patients' medical record with the date and time that you were notified of the admission.
- Discharge information is also provided on InnovaMD, and our TRC coordinator contacts your office to share information about the discharge and ensure you engage the patient within 30 days of the discharge date.
- Patient engagement not only means a face-to-face office visit. Home visits, a well-documented telephone assessment, a telehealth visit using audio and video, or an e-visit/virtual check-in, count.
- You can use the Smart Paper at InnovaMD to review and reconcile the patient's medications prescribed pre and post-discharge. Medication reconciliation must be well documented in the medical record, including the date it occurred, and list of current medications with discharge medications (if any were prescribed) identified.

The TRC measures endeavors to capture the comprehensive management of your patients' admissions, post-discharge care and medications. Your diligence and efforts won't be reflected in our HEDIS rates if there is no medical record documentation, accurate coding and encounter data submissions. Submit any questions about TRC or request more information at providers@mmm-fl.com.

ENCOURAGE FLU SHOTS THROUGH JANUARY & BEYOND

Medicare and MMM cover flu shots during the flu season and additional flu shots, if medically necessary.

Vaccinate as long as the flu activity continues, in January or even later. The CDC recommends annual flu shots for everyone who is 6 months and older.



For information on flu and vaccinations go to: www.cdc.gov/flu/

GLAUCOMA AWARENESS MONTH



January is Glaucoma Awareness Month!

MMM would like to encourage all our providers to educate our shared members about this condition and the importance of having regular eye exams, especially those members who have a high risk for developing this condition. MMM is here to support you in serving our members.

Eye Management Inc. (EMI) is MMM's delegated entity for providing vision services to our members. They have numerous vision specialists throughout the tri-county area in which our members reside. Our network directory is the best resource for locating a vision specialist within a member's residing area.

MODEL OF CARE OUTCOMES FROM 2019-2020 & OPPORTUNITIES FOR IMPROVEMENT



In April of 2020, MMM of Florida completed its annual evaluation of the Model of Care (MOC). Part of the overall evaluation of our Quality Improvement Program assists us in determining the effectiveness of the MOC to reach the established goals.

Some of the requirements of a MOC that MMM addresses within our Special Needs Program (SNP), a D-SNP for members with Medicare and Medicaid include:

- Staff & Provider Training on the MOC
- Network Access & Availability
- Health Risk Assessments (HRA) & Individualized Care Plans (ICP)
- Care Coordination including Behavioral Health
- Medication Management

The evaluation demonstrated that MMM reached the MOC goals related to:

- Improving access to affordable care through a robust provider network
- Ensuring appropriate utilization of services and cost-effective health service delivery
- Engaging members in medication management, education and adherence

Additionally, the evaluation identified opportunities for improvement that we worked on in the latter half of 2020:

- Improving the completion rate of HRAs
- Ensuring members discharged from an acute care setting see their PCP within 7 days
- Decreasing emergency room utilization
- Increasing preventive screenings and care

The MMMFL Quality Improvement Committee (QIC) reviewed the 2019 MOC evaluation and these outcomes. The 2020 MOC will be evaluated early in 2021 and the results will be shared with the QIC in April 2021.