



Managed Care Newsletter

... AND FROM THIS CORNER

Yes, December is upon us! In this issue, Account Manager **Tina Blades** provides us an update of **Florida Blue MyBlue** Exchange plan on p. 2, which also includes a Contracting Update and news about UF Health's two new service locations in Marion County. Population Care Manager **Cindy Hare, RN**, puts the spotlight on Internal Medicine at Medical Plaza's *Transitions of Care Clinic* on p. 3. ...And we could think of no finer message for the holidays and New Year than two recent ones from our organization's leaders. If you missed them in previous publications, we hope you will thoughtfully review these excerpts. Best wishes from all of us in Managed Care. —Kathryn Michael, Editor

...My prayer is that I and every UF student, faculty, and staff member will always be known for humanity, kindness, and leadership. I have three aspirations for all Gators.

First, that we denounce all forms of hate. I hope even shy and introverted individuals like me will speak up and replace hate with active love...It is my hope that each of us, in our words and actions, demonstrates our support for those who feel threatened and defends the rights of all.

Second, that we commit to always listening to each other, even when the message is hard to hear. This is a community of learners and educators. We will not benefit from our rich diversity if we do not understand one another.

Third, I ask that each of us work to improve the lives of all people. We can do this individually in how we live our lives and as a university overall through our scholarship, teaching, and engagement with society.

I ask that you join me in making our university, state, and nation stronger and better for all.

—Dr. W. Kent Fuchs,
President, University of Florida



...We are committed to achieving our missions of education, research, and patient care in a supportive environment of respect for one another, and in an atmosphere of genuine hospitality for our patients, academic guests and other visitors.

Following an election where a clear message was the need to listen better to one another, to hear what is truly being said, and to show empathy and respect for each other's experience and viewpoint, we at UF Health can redouble our efforts at communication, teamwork, empathy and hospitality with every patient, student and guest we serve, and with every research study we undertake.

...We can make sure that everyone we meet on a daily basis, whether patient, colleague or visiting guest, feels respected and heard. And simply by doing so, we can set an example that just might make a positive contribution in ways greater than we may ever realize.

—David S. Guzick, M.D., Ph.D.
Sr. Vice President for Health Affairs, UF
President, UF Health





Account Management Updates

FLORIDA BLUE MYBLUEHMO IS IN-NETWORK FOR UF HEALTH GAINESVILLE, EFFECTIVE NOVEMBER 1, 2016

Managed Care is happy to announce that **myBlue** HMO is now **in-network** for UF Health Gainesville facilities, effective November 1, 2016. We are working on executing amendments for FCPA/College of Medicine within the next two weeks. During open enrollment, **Florida Blue** will be offering **myBlue** HMO as a plan option for Alachua County residents with an effective date of January 1, 2017. The EPIC ID assigned is 1200001031 (**BCBS** Exchange **myBlue** HMO), member number alpha prefixes will be VMG and VMY. In the Northern Region of Florida, **myBlue** will only be offered to residents of Alachua and Duval County.

What is **myBlue**?

myBlue is a managed care, referral-based product. Primary care physicians (PCP's) are responsible for coordinating access for all medical services for myBlue members. UF Health PCP's will be assigned members for the 2017 benefit period and will be exclusive providers for this product within Alachua County.

What this means to UF Health Gainesville

Although Alachua County residents will not have access/coverage under **myBlue** HMO until January 1st, 2017, UF Health specialists can now accept referrals from other counties without a Patient Specific Arrangement (PSA).

A global communication is forthcoming.

—Tina Blades, Account Manager



CONTRACTING UPDATES

Last month **Tina Blades** finalized the following amendments with **Florida Blue**:

- 8th Amendment to the HomeCare Letter of Agreement (LOA), which incorporates language from the Facility LOA and modifies rates, retroactively effective 10/1/15.
- 12th Amendment to the Hospital Services Agreement— **Health Options**, which adds **myBlue** HMO product for Vista, Rehab, and the Florida Recovery Center, effective 11/1/16.

UF HEALTH ADDS TWO NEW LOCATIONS IN MARION COUNTY

UF Health is adding two new locations in Marion County, scheduled to open in January.

UF Health Ocala Heath Brook will offer multiple specialty services beginning with cardiology, including interventional cardiac catheterization procedures and imaging services five days a week. Additional services will be offered over time.

UF Health Villages will also be a multispecialty practice, beginning with orthopaedics five days a week and cardiology twice per week. Additional services will be offered over time.

Closing on these locations is anticipated at the end of the year, and staff throughout UF Health are using this time to prepare.

Many thanks to the Finance/Legal/Managed Care/Revenue Cycle Work Group and **Stacy Beers**, Marketing, for helping craft the announcement our account managers have sent to payors. Thanks to **Lisa Bruck**, Cardiology; **Gwen Werner**, Orthopaedics; and **Andrew Baldwin**, Radiology, for providing the physician data for the provider database to our Provider Enrollment team—**Eddie Bush** and **Earlene Thomas**—to update and package for sending to payors.





Population Health Management Initiatives

SPOTLIGHT: TRANSITIONS OF CARE CLINIC



We are spotlighting a series of *Best Practices* used in our clinics. These programs are unique to each practice and have been developed to address the needs of a specific population. The first in our

series features the Internal Medicine practice group at Medical Plaza.

The Internal Medicine group at Medical Plaza began a new initiative called the *Transitions of Care Clinic* this year to address patients who have been hospitalized. Every patient that has been in the hospital the week prior is scheduled to be seen during this weekly clinic. One of the unique aspects of this clinic is that it is staffed not only by the physician and office staff, but by an interdisciplinary team, including **Ryan Nall, MD; Melanie Hagen, MD, FACP; Maryann Grottano, RN, BSN, health coach; Katherine Vogel Anderson, Pharm.D., BCACP; Stephanie G. Smith, Ph.D.; Lee Collopy, LCSW; Tiffany Phillips, MSW, RCSWI;** and **Andrew Courtney**, Homecare business development representative. In addition, residents, medical students, physician assistant students, and pharmacy students rotate participation regularly.

The process of this clinic is also unique. Before the clinic begins, a pre-clinic team huddle is held to discuss the needs of the patients and the plan for the visit.

I had the pleasure of sitting in on one of the team huddles and watched this team in action. Everyone participated, discussed individual patients and the needs they presented as well as the approach they would use to best assist the patient and address individual needs. This clinic is very focused on the individual patient and optimizing the plan of care.

In addition, I was able to interview **Drs. Nall and Hagen**, and **Katherine Vogel Anderson, Pharm.D., BCACP**, to ask questions about this clinic:

1.) How was this clinic started?

With a growing focus nationally on reducing hos-

pital readmissions Internal Medicine at Medical Plaza and Tower Hill began to focus on what could be done in our clinic to reduce hospital readmissions and improve the transition of care between the hospital and clinic. Initially, an interdisciplinary group reviewed approximately half of the clinic's 30-day readmissions from the year prior to determine common trends. We noted that many patients did not have timely follow-up appointments with our clinic following hospital discharge. We developed the transition clinic to help improve timely access for our patient.

2.) What were the thoughts that led to its creation?

To follow-up with primary care to reconcile medications and follow-up on symptoms and testing from hospitalization as well as to address psychosocial needs that might help to prevent readmissions.

3.) Why did you choose to use an interdisciplinary approach vs. physician follow-up alone?

When we reviewed the clinic's 30-day hospital readmissions we realized that the patients being readmitted weren't only medically complex, but



Recently participating on the Transitions of Care team are, from left to right, front row: Maryann Grottano, RN, BSN, health coach, & Melanie Hagen, MD, FACP. Second row: Stephanie G. Smith, Ph.D.; Sally Kasseem, pharmacy student; Katherine Vogel Anderson, Pharm.D., BCACP; Belin Kassu, medical student; Lee Collopy, LCSW; & Tiffany Phillips, MSW, RCSWI; social worker. Back row: Andrew Courtney, Homecare business development representative; Sean Moore, PA student; & Daniel Cordiner, MD, PGY-1 resident. Not pictured: Ryan Nall, MD



Population Health Management Initiatives

TRANSITIONS OF CARE CLINIC CONTINUED

were also extremely complex from a psychosocial perspective. Very often the issues leading to readmission weren't being prescribed the correct antibiotic or antihypertensive, but rather having transportation to follow-up, home care services to help monitor symptoms, understanding which medications to take after discharge, reviewing a low salt diet, or treatment of the patient's underlying depression and anxiety. The interdisciplinary team is critical to rapidly and effectively addressing these issues. Each member of the team brings a skill set that is invaluable and allows us to take fantastic care of our patients. Currently, our team consists of a registered nurse, pharmacist, social worker, home health representative, psychologist, physician, medical resident, medical student, pharmacy students, and physician assistant student. Seeing patients as a team is far more rewarding than seeing patients alone.

4.) Is this model based on research?

The clinic isn't modeled after another clinic specifically. That being said, many models aimed at reducing readmissions utilize interdisciplinary teams to improve the transition of care and reduce readmissions.

5.) Are you conducting any research on the outcomes for the patients?

Now that the clinic has been active for six months, we will be evaluating its effectiveness. In other words, does the clinic actually reduce readmission and ED utilization for the patients it serves? We will also be reviewing how the interdisciplinary nature of the clinic impacts work satisfaction and burnout.

6.) Do you feel that the patients that come to this clinic are better served because of the care they receive?

I certainly can't speak for all clinics and physicians, but I do feel this interdisciplinary clinic provides better care to this cohort of psychosocially complex patients than an individual physician can alone. Social workers are far better at figuring transportation and coverage issues,

pharmacists are much better at identifying drug-related problems and access to medications, nurses are able to spend a longer period of time educating on dietary restrictions, the home care representatives can set-up much needed services at home, the psychologist can begin to help the patient develop better coping strategies, and the list goes on and on. Each of us playing to our strengths as a team provides better care than any of us individually.

7.) What is the benefit of seeing the patients within one week of discharge?

The data supporting a specific time frame to see a patient after discharge to prevent readmission is spotty, but we generally believe that the faster we can connect with the patient in the outpatient clinic and identify any problems the better. All our patients receive a phone call by a registered nurse or pharmacist within 48 hours of discharge to make sure a follow-up appointment has been scheduled within the appropriate time frame, review medication changes, and identify any ongoing issues or new symptoms. CMS has also developed billing codes for Transitional Care Management (TCM) which can be utilized if the patient receives contact from the clinic in the first 48 hours after discharge and follow-up within 14 days for moderate complexity and 7 days for high complexity.

8.) Who within the organization has supported your plan?

Our group has been supported across the board by clinic and department leadership. Without their support this wouldn't have been possible.

9.) How do you think the replication of this model could benefit the community we serve?

We will be able to answer this question better in the next month after our review has been completed. Personally, I can say working in an interdisciplinary team has been so much fun and fantastic for job satisfaction. —Ryan Nall, MD



Ryan Nall, MD



Population Health Management Initiatives

TRANSITIONS OF CARE CLINIC CONTINUED

10.) *Are you presenting this at a conference?*

We hope to present this model at the upcoming Primary Care Innovations Conference at UF on March 10th. The conference is bringing together teams from the southeast who are innovating in primary care with the hopes of sharing and learning from each other to improve the care we provide

our patients. The conference is open to anyone and everyone working to improve primary care.

This program is an example of innovations that are happening here at UF Health to address the ever changing needs of our population. It is a shining example of our vision and values as an organization.

—Cindy Hare, RN, Population Care Manager



JOIN US AT THE PRIMARY CARE INNOVATIONS CONFERENCE

When

March 10th, 2017 from 8 a.m. to 5 p.m.

Where

Harrell Medical Education Building
1104 Newell Drive Building, Room 214
Gainesville, FL 32610

Price

Prices range from \$30 for residents/fellows/students - \$125 physicians.

Description

This won't be your typical conference. Sessions will be interactive and centered around the sharing of ideas. This conference is for anyone and everyone working to improve primary care – medical assistants, nurses, nurse practitioners, pharmacists, administrators, students, residents, fellows, IT specialists, receptionists, physical and occupational therapists, physician assistants and physicians. Together, we can make primary care better.

Our aim is to create a collaborative space in which the primary care community can share and learn from each other's innovative practices and ideas. With your participation we strive to:

- Share primary care practice innovations which improve access, quality, and coordination of care
- Think beyond our current traditional medical culture/framework to push the status quo in primary care forward
- Bring all members of the interdisciplinary primary care team together to innovate
- Build a community of innovators in primary care who will have the opportunity to continue to collaborate into the future

Register here: <http://PrimaryCareInnovations.cme.ufl.edu/>



Account Assignments

A	Aetna	Joyce Odom	I	Inmate Health Services, LLC	Dawn Fitch
	Aetna transplants	Gwen Porter		Interlink (transplants)	Gwen Porter
	Alachua County Sheriff/Corizon	Joyce Odom	L	LifeTrac (transplants)	Gwen Porter
	Alachua County Social Services	Sarah Gause		Magellan Complete Care (Medicaid)	Toika Lee
	Ameriplus Preferred Care	Tina Blades	M	Magellan Healthcare	Toika Lee
	Archbold Medical Center	Sarah Gause		Marion County School Board Insurance	Sarah Gause
	Averde Health PPO	Toika Lee		MedSave USA TPA	Dawn Fitch
	AvMed HMO	Dawn Fitch		Mental Health Associates (BH)	Toika Lee
	Buena Vista LAA (Medicaid) <i>(tertiary)</i>	Joyce Odom		Molina HealthCare of Florida (Medicaid)	Toika Lee
	Bradford County Sheriff	Tina Blades		MultiPlan (MPI)/PHCS PPO	Sarah Gause
B	Capital Health <i>(tertiary)</i>	Tina Blades	N	National Transplant Network (NTN) (Humana)	Gwen Porter
	Choice Care Network PPO	Sarah Gause		(NEFEC) Fringe Benefit Coordinators	Tina Blades
	CIGNA	Toika Lee	O	NovaNet PPO	Toika Lee
	CIGNA Behavioral Health (BH)	Toika Lee		Optimum Medicare Advantage LAA	Tina Blades
	CIGNA LifeSource (transplants)	Gwen Porter	P	Optum Health (United transplants)	Gwen Porter
	Clear Health Alliance LAA (Medicaid)	Toika Lee		Palm Beach County	Dawn Fitch
	Concordia	Joyce Odom		Positive Health Partners	Tina Blades
	CorVel (WC)	Sarah Gause		Prestige Health Choice (Medicaid)	Tina Blades
	Coventry PPO	Joyce Odom		Premier Eye Care of Florida (Medicaid)	Toika Lee
	C	Disney Cruise Lines		Dawn Fitch	S
Evolutions Healthcare		Joyce Odom	Prime Health Serv.– FL Sherriff’s Mult. Emp. Trust	Gwen Porter	
Envolve Benefit Options		Joyce Odom	T	PsychCare (AvMed only) (Medicaid) (BH)	Dawn Fitch
First Health PPO		Joyce Odom		SRI (transplants)	Gwen Porter
Florida Blue		Tina Blades	U	Simply Healthcare LAA (Medicaid)	Toika Lee
Florida Blue transplants		Gwen Porter		Staywell / WellCare (Medicaid)	Sarah Gause
Blue Distinction Centers for Transplant (BDCT)		Gwen Porter		Sunshine State Health Plan (Medicaid)	Joyce Odom
Florida Health Care Plan HMO <i>(tertiary)</i>		Tina Blades		Tethys (transplants)	Gwen Porter
Florida Hospital Health Care <i>(tertiary)</i>		Sarah Gause		UF Peds Ped-i-Care (Medicaid)	Joyce Odom
Freedom Health Medicare Adv. LAA		Tina Blades		USA Senior Care	Sarah Gause
D	Global (Freedom/Optimum) (Medicaid)	Tina Blades	V	United Behavioral Health/Optum Health (BH)	Dawn Fitch
	GENEX (WC)	Dawn Fitch		United Healthcare of FL	Dawn Fitch
	Haven Hospice of NC FL	Toika Lee	W	University Athletic Association	Dawn Fitch
	Healthchoice/Orlando Health <i>(tertiary)</i>	Tina Blades		Value Options (BH)	Toika Lee
	Health First Health Plan <i>(tertiary)</i>	Sarah Gause	Vista Summit Medicare Advantage <i>(tertiary)</i>	Joyce Odom	
	Humana	Sarah Gause	Veterans (VA) Provider Agreement Program	Joyce Odom	
	Humana Behavioral (BH)	Sarah Gause	Volusia Health Network PPO	Joyce Odom	
			WellCare Medicare Advantage	Sarah Gause	

Primary (large volume) accounts are in bold, BH: Behavioral Health, LAA: Limited Access Agreement, WC: Workers Comp Patient-Specific Agreements (PSA’s) have been assigned to Leola Hart, Associate PSA Account Manager.

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Joyce Odom	265-8490	odomjg@shands.ufl.edu	627-4096
Gwen Porter	265-8491	porteg@shands.ufl.edu	627-4116

Celebrations

Work Anniversary:

December Birthday:



Eddie

24 Years



Brandon

13th



UF HEALTH'S VISION

Together we strive to create unstoppable momentum toward the goal of improving individual and community health through discovery, clinical, and translational science and technology, exceptional education and patient-centered, innovative, high-quality health care.

Managed Care

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Managed Care Team

Leadership

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Earlene Thomas
Information Associate
Web Maintenance
265-8480

Account Management

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Senior Account Manager
265-8364

Joyce Odom
Senior Account Manager
265-8490

Tina Blades
Account Manager
265-8486

Dawn Fitch
Account Manager
265-8483

Toika Lee, CSMC
Account Manager
265-8493

Leola Hart
Assoc. PSA Account Manager
265-8487



Best wishes to **Kim Cash**, who is now working in Revenue Cycle. Thank you for seven great years in Managed Care!

The *Managed Care Department Newsletter* is produced for the **UF Health** family in Gainesville. As our providers seek new and improved ways to promote and sustain the health of our community, we seek new and improved ways to financially and operationally support their valiant effort. Communicating regularly, especially in the midst of health care reform and a rapidly changing industry, is an essential part of our commitment.

Editor: Kathryn Michael, MS

Production: Brandon Peckham

Note: Contents for internal use only