Florida Health Care Plans®

An Independent Licensee of the Blue Cross and Blue Shield Association

FLORIDA HEALTH CARE PLANS NEWSLETTER

myFHCP Rx Mobile App

NEW LOCATION

New Palm Bay Clinic

New Year. New Start.

FHCP Pharmacy News

FHCP Pharmacy is launching the myFHCP Rx Mobile App.

You can text the word "APP" to 33490 to receive a direct link to download the myFHCP app

Or the app can be downloaded using the QR Code below:

The app lets members see all of their FHCP Pharmacy prescription history in one place and allows them to easily request a prescription refill. Members will also be able to set up refill and medication reminders to help with medication adherence. In addition, the pharmacy will be able to communicate with our members, for the first time, by text message.

FHCP Provider Portal

In order to keep your account access active, please login to your account at least every 60 days. If you need assistance logging back into your account, please contact Customer Service at (877) 814-9909. Thank you for your understanding and remaining compliant with Florida Health Care Plans Security Policy.

www.fhcp.com

From the Director's Corner

Stephen Keen, M.D.
Medical Director of Quality, Utilization, and Case Management

The Value of Prior Authorizations

Prior authorizations have been an increasingly discussed topic in healthcare the last several years at both the national and local level. Recently our state legislature considered a bill which proposed to effectively ban prior authorization requirements by payers. At their worst, prior authorizations are inefficient, wasteful, and present unnecessary barriers to medical care needed by patients. When used selectively, and appropriately, authorization requirements can be useful tools to ensure appropriate, evidence-based care is delivered to patients, and help avoid unnecessary and potentially harmful therapy. Appropriate use of authorizations can also help address one of the biggest challenges in society today, the ever increasing cost of medical care.

FHCP is a membership based managed care organization. Our mission to provide high quality, low cost health coverage to our members compels us to be good stewards of our members' resources. If FHCP covers unnecessary, or non-evidenced based care, the costs of those decisions are felt by all of our members and does nothing to help "bend the cost-curve" for healthcare in our local community. Balancing the need to be good stewards of healthcare resources and avoiding being over-burdensome to healthcare provider offices is very important and FHCP tries to make those decisions very thoughtfully.

Authorization requirements for coverage of medical services not only helps to address appropriate resource utilization, but also can protect patients' health. The variation in medical care across specialties and geographic area is immense, and as we all know communication between healthcare providers is frequently less than adequate. I recently reviewed a case where a provider was requesting an extremely specialized medication to treat a very rare illness in a patient. Previously, multiple tertiary specialists had evaluated this patient and ruled out the patient having the rare condition. The requesting provider was treating an illness based on one spurious test result and patient report alone and did not have access to the information from the previous tertiary evaluation. Treating the absence of illness with an expensive therapeutic can at best have a neutral outcome, as the patient cannot improve, and at worst can have very negative outcomes due to side effects and complications from treatment.

Additionally there are numerous examples of therapies that are exponentially more expensive but do not produce exponential increases in positive outcomes, if any positive outcome at all. We are all aware of this most commonly in the pharmaceutical space. To give one example, Vimovo is branded naproxen/esomeprazole. It costs $800 month. The active ingredients in that drug can be bought for a fraction of the price of the drug and will provide the same treatment effects of this reformulated branded version of generic over the counter medications. The $800 drug provides no level, at all, of increased efficacy or safety.

Appropriately creating formularies and requiring some authorizations for services helps to protect patients and ensure good resource utilization. FHCP formularies and prior authorization information can be found in the "For Providers" section of our website: www.fhcp.com.

Virta Treatment Program for Type 2 Diabetes

Virta's treatment is delivered by a physician-led care team and consistently helps patients to lower blood glucose and weight while simultaneously reducing diabetes medications. Patients are assisted in implementing a personalized and sustainable nutrition plan involving carbohydrate restriction, facilitated by high-touch health coach support and medical supervision. Virta functions as a specialty diabetes clinic and coordinates with the patient's primary care team to keep them up-to-date on progress and changes to the treatment plan, sent via secure fax.

Extensive research evidence demonstrating the clinical benefits of low carbohydrate nutrition therapy, including Virta's own research, led to its inclusion in the American Diabetes Association (ADA) Standards of Medical Care (1) as a first-line therapy for type 2 diabetes. An expert consensus statement from the ADA also states that this eating pattern does not appear to increase cardiovascular disease (CVD) risk (2). Here, we'll share some of Virta's research on those topics.

The Virta Treatment delivers rapid and sustained improvements in clinical markers of metabolic health

Participants in Virta's prospective clinical trial saw rapid metabolic health improvements (3) and sustained them over one (4) and two years (5, Figure 1). Retention was high — 83% and 74% at one and two years, respectively — compared to other trials (6,7,8), lifestyle interventions (9,10), and even diabetes medication persistence (11). Understanding the long-term sustainability of this approach is a priority, so we've extended our original two-year trial to five years (12). Preliminary results from participants completing 3.5 years of the trial were presented at ENDO 2020 (13), and we observed sustained improvement in multiple metabolic risk factors. We look forward to publishing five-year results in 2021.

Broad Metabolic Health Improvements Sustained among Virta Patients Treated Two Years

		VIRTA	STANDARD CARE
Insulin Resistance and Obesity	A1c	-1.0	+0.5
	Weight	-12%	+5%
	HOMA-IR	-32%	+49%
Inflammation	hsCRP	-35%	-13%
Cardiovascular	Systolic Blood Pressure	-5%	0%
	Diastolic Blood Pressure	-4%	0%
	Triglycerides	-22%	-12%
	HDL-cholesterol	+18.8%	+7.5%
	LDL-cholesterol	+13.5%	-9.2%
	non-HDL-cholesterol	+3.4%	-2.8%
	ApoB	-2.5%	-2.3%
Liver	NAFLD: Liver Fat Score	-74%	+20%
	NAFLD: Fibrosis Score	-71%	+75%
Medications	Proportion of Patients Prescribed:		
	• Diabetes-Specific Medications*	-52%	+18%
	• Insulin	-62%	+18%
	• Blood Pressure Medications	-14%	+11%

Markers of cardiovascular risk improve in Virta's patients

Expert consensus on nutrition from ADA (2) cited Virta's one-year outcomes as evidence of no apparent change in CVD risk (14, white paper). While clinical care often relies on LDL-C as a marker of CVD risk, it may not tell the whole risk story (read more on our website). Results of the trial indicate that increased LDL-C was due to a shift in the LDL particle distribution from pro-atherogenic small LDL to less-atherogenic large LDL particles (15), with no change in ApoB. We are excited to share that *Cardiovascular Diabetology* recently accepted the manuscript describing these improvements observed in the atherogenic lipoprotein profile of Virta-treated patients over two years. A preprint is available, and we look forward to sharing the final, published manuscript with you soon.

Continued on next page.

Virta's novel continuous remote care model enables safe medication deprescription

The provider-led continuous remote care model through which the Virta Treatment is delivered is a key safety feature. Patients record blood glucose and beta-hydroxybutyrate at a prescribed frequency depending on their medication and medical history to allow providers to monitor patient response to treatment and adjust medications as indicated, with the primary goal of patient safety. In our clinical trial, no severe hypoglycemic events requiring assistance attributable to the intervention were reported (4,5).

In summary, Virta's nutritional intervention and treatment are clinically validated in peer-reviewed literature and cited in the ADA guidelines. This treatment can help FHCP physicians by rapidly improving blood glucose while reducing medication burden. For questions or inquiries, please contact us at research@virtahealth.com.

Wishing you and your patients good health,
Virta's Science and Medicine Team

FHCP has partnered with a vendor called Virta (https://www.virtahealth.com/) to offer an interactive telemedicine based intervention to help patients with Type II Diabetes achieve control or even remission.

What is Virta?

- A company dedicated to helping patients with T2 Diabetes achieve their goals through diet and lifestyle interventions
- Program is supported by a randomized clinical trial and multiple peer reviewed published papers
- Program is medically supervised by Virta physicians and Endocrinologists
- Program works through telephonic engagement and coaching of patients (Avg. x5 contacts daily) via a smartphone app and personalized Medical Nutrition Therapy (MNT)

Why is FHCP using Virta?

- Virta adds another tool to portfolio of interventions FHCP offers for T2 Diabetes
- Virta's compensation is tied to meaningful changes in outcomes
- Pilot results were promising, and FHCP is expanding the program

How will Virta impact my practice?

- Virta will contact you if your patient authorizes contact
- Virta provides progress notes and updates on deprescribing events
- Virta will supplement the care you already provide

How can I refer Patients into the Virta Program?

- Members qualify for participation in Virta if all the following criteria has been met
  - ◊ Patient has Type II Diabetes
  - ◊ Patient must have a smart device to use the Virta App
  - ◊ Hemoglobin A1C (HbA1c) greater than 8
  - ◊ Body Mass Index (BMI) greater than 30
  - ◊ Between the ages of 18 and 79
- FHCP Staff Providers may refer using the EHR system
- Contracted Provider may send referral to Central Referrals Department requesting Virta along with clinical documentation

Please direct any questions to Product Manager, Ron Barnard, Director of Analytics at rbarnard@fhcp.com

Florida Health Care Plans®
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FHCP Continues to Grow...

NEW LOCATION

Palm Bay Clinic

5151 Babcock Street NE, Palm Bay, FL 32905

Florida Health Care Plans®

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Florida Health Care Plans continues to grow as we celebrate the opening of our newest facility in Palm Bay. This facility opened December 1st and offers Primary Care, X-Ray, Ultrasound, lab and Infusion Clinic Services. The Pharmacy opened December 17th along with sales. FHCP is known for having multiple services under one roof to make it a one-stop shop for our members!

February is American Heart Month

Article provided by our FHCP Diabetes/Health Education department

Heart disease is the leading cause of death for men, women, and people of most racial and ethnic groups in the United States. One person dies every 36 seconds in the United States from cardiovascular disease. Nearly half of American adults have high blood pressure and many don't know they have it.

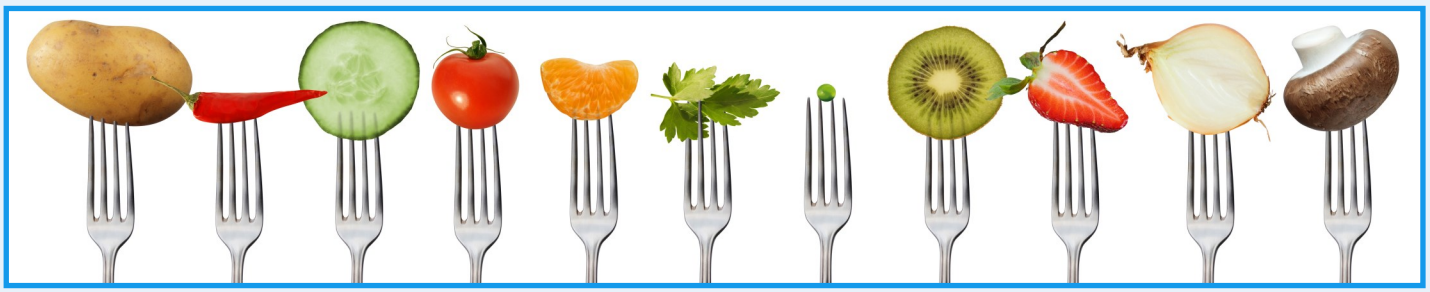
By adopting a heart-healthy lifestyle, reduction of high blood pressure can prevent or delay the development of hypertension, enhance the effectiveness of blood pressure medications, and lower the risk of heart attack, stroke, heart failure, kidney damage, vision loss and sexual dysfunction.

The Florida Health Care Plans Diabetes/Health Education department can offer your patients a "Heart Health Program" to improve their knowledge and self-management surrounding cardiovascular health. Included in the program is information related to healthy eating (such as the DASH and Mediterranean diets), blood pressure and lipid management, exercise, stress reduction, and risk factors for heart disease

Individual appointments are offered after class is completed to develop a specific meal plan for our members and review other related programs, such as diabetes, prediabetes, and Eat Right Move Right (weight loss), which are offered in our department with no copays.

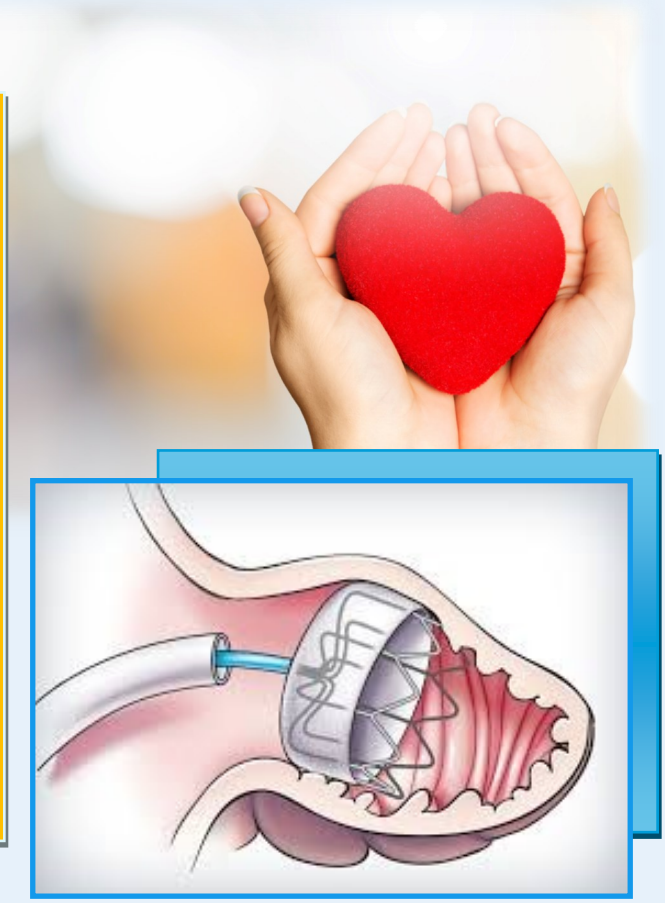
If your patient has hyperlipidemia or hypertension, please send a referral to the department and we will call the member to schedule an appointment. Members can also self-refer by calling the department to schedule an appointment.

For more details, please call (386) 676-7133 or toll free 1-877-229-4518 or email deducation.com .



Atrial Fibrillation

Atrial fibrillation is the most common abnormal rhythm facing our patients, by age 65, 9% of the population has Atrial fibrillation and it complicates a wide range of cardiac diseases such as hypertension, coronary artery disease and congestive heart failure. It is a significant cause of morbidity with at least 200,000 strokes/year in the US. AF is associated a 4-5 fold increased risk of ischemic strokes and causes 1/7 strokes. (American Heart Association Statistics Committee and Stroke Statistics Committee, 2017) Treatment of Atrial fibrillation costs $6 billion annually and drug alone costs are $400 million. Though over the last decade studies have improved our treatment of Atrial fibrillation with the advent of DOACs, improvements in AF ablation techniques, devices such as Watchman - a key management issue in Atrial fibrillation remains anticoagulation and how we can reduce the risk of stroke and by so doing decrease morbidity.



Anticoagulation in Patients with AF:

It has long been known that patients with AF are at a 4 to 5fold increase risk of ischemic stroke. Patients with moderate risk for stroke ≥ 2 on CHA2DS2VASC score benefit from anticoagulation while weighing their risk for bleeding via the HAS-BLED score. Though for over 50 years Warfarin was used Direct Oral Anticoagulants (DOACs) such as Dabigatran, Rivaroxaban, Apixaban and Edoxaban have been shown to be non-inferior to warfarin in prevent thromboembolic complications and generally superior in reducing bleeding. In, 2013 multiple meta-analysis were showing that Direct Oral Anticoagulants (DOACs) has a lower rate of stroke and systemic embolization, as well as a lower rate of intracranial hemorrhage in patients with non-valvular AF. Important additional advantages of the DOAC include convenience, no requirement for routine testing, lack of dietary interactions, reduced drug interactions and reduced risk of intracranial hemorrhage. Disadvantages include high cost, monitoring of blood levels for compliance and lack of safety data in patients with chronic kidney disease.

There are several questions that arise when it comes to anticoagulation including what if my patient is elderly and at a fall risk? or what if duration of AF documented is short (30 seconds or less than 6 hours)?

It turns out as physicians we are prescribing less and less anticoagulation for our elderly patients because of a fear of falls. As a matter of fact, studies show that in patients above 75 years age only 40-60% of patients who require anticoagulation for stroke prevention in AF are receiving appropriate therapy. Data shows that in a study of older adults with nonvalvular atrial fibrillation, a history of falls was associated with a risk of intracranial hemorrhage which was 1.9 times higher. Importantly, this risk did not differ among patients treated with warfarin, aspirin or no antithrombotic therapy. (Gage BF, 2005). In another study (Man-Son-Hing M, 1999), it was estimated that an individual would have to fall 295 times in 1 year in for the risk of fall-related major bleeding to outweighs the benefit of warfarin in reducing risk of stroke. Let us not forget there are contraindications to anticoagulation which include intracranial hemorrhage, recent neurosurgical procedure, low stroke risk and recurrent bleeding, as well as poor prognosis. This remains a sensitive issue and will require a team-based approach between physicians and families.

Continued on next page.

The next question that arises is duration of documented AF for initiation of anticoagulation. There are many ways to define AF burden such as duration of the longest AF episode, number of episodes or percentage of time patient is in AF. Current guidelines (Chen LY, 2018) define the presence of AF as electrocardiographic documentation of absolutely irregular RR interval with no discernible P waves lasting for at least 30 seconds. We are seeing more and more patients with documented AF based on better monitoring with implantable devices, apple watches, remote monitoring and implantable loops. Independent of duration of AF, current guidelines recommend determining anticoagulation based on CHA2DS2-VSCc score and not duration of AF. Data from implantable devices suggests that even short AF episodes >5 minutes are associated with an increased risk. (Link, 2019).

Indications for Watchman

Previous studies have reported that >90% of cardiac emboli in nonvalvular atrial fibrillation (NVAF) originate in the Left Atrial Appendage (LAA). Left atrial appendage occlusive devices such as the Watchman has thus emerged as an alternative for stroke prevention in such patients with an elevated stroke risk (based on CHA_2DS_2-VASc score) who have appropriate rational for avoiding oral anticoagulation. In the initial 45 days after implant patients need to be on coumadin for endothelialization of the left atrial appendage occlusive device and currently indications for Watchman are Class IIb. Though Watchman is more expensive than Warfarin and the DOACS, one study has show that when considering long term quality-adjusted life years within 10 years, LAAC has lower total costs than DOACs (Reddy VY, 2018). For now we focus our attention on reducing the risks of stroke by proper anticoagulation and when there are contraindications to anticoagulation look at Left atrial appendage occlusive devices such as the Watchman. We are honored to help with the management of patient and look to serve our cardiac community of patients.

Niloufar Wilson, M.D.

Cardiologist

Warm Regards,

Niloufar Tabatabaei Wilson, MD., MS., MHA., FACC

References

American Heart Association Statistics Committee and Stroke Statistics Committee. (2017). Heart Disease and Stroke Statistics - 2017 Update: A Report from the American Heart Association. *Circulation*, e1-e458.

Chen LY, C. M. (2018). Atrial fibrillation Burden: Moving Beyond Atrial Fibrillation as a Binary Entity: A Scientific Statement from the American Heart Association. *Circulation*, e623-e644.

Gage BF, B.-D. E. (2005). Incidence of intracranial hemorrhage in patients with atrial fibrillation who are prone to fall. *Am J Med*, 612–617.

Link, M. (2019). Are Patients with Short-Duration Atrail Fibrillation at Risk for Stroke? *Circulation*.

Man-Son-Hing M, N. G. (1999). Choosing antithrombotic therapy for elderly patients with atrial fibrillation who are at risk for falls. *Arch Intern Med* , 677–685.

Case Management

Coordination of Care Programs

Case Management Coordination of Care programs are member and family-centered, team-based services designed to assess and meet the needs of members, while helping them navigate effectively and efficiently through the health care system. Additionally, the case mangers act as advocates and educators. Members can rely on their case managers to work in partnership with their healthcare team and between healthcare settings, to identify needs, link to available resources, and provide recommendations of proactive lifestyle practices that will support health and wellbeing. The Case Management Coordination of Care programs utilize evidence-based clinical guidelines to complete a thorough assessment of the member's condition, evaluate available benefits and resources, develop healthcare goals with the member, and develop a plan for monitoring and follow up. Case Management is a voluntary program and all eligible members have the right to decline participation.

Criteria for enrollment

In Case Management, Coordination of Care includes but not limited to members with new diagnoses, acute or uncontrolled chronic diseases, critical events that require extensive use of resources, significant barriers of psychosocial/financial concerns (social determinants of health) that limit access to care, or identified from proactive data screening, who may require any of the following:

- Assistance navigating the health care system
- Assistance with monitoring and treatment
- Assistance with barriers related to psychosocial/financial concerns
- Education on health condition (s) and health coaching
- Education supporting practitioner plan of care
- Coordinate appropriate resources, programs, or benefits
- Coordinate measures to improve quality of life and disease-specific outcomes

The Case Manager will determine which services are appropriate to assist the member

- **Chronic Complex Care-** assists members with complex and chronic health conditions to reduce disease progression and gain empowerment through improved lifestyle practices that aims to improve quality of life. Members would benefit from advocacy, education, and navigation to access appropriate care, link to resources, benefits, or programs. Program includes transplant case management.
- **Interactive Health at Home-** remote patient monitoring provides a tablet and equipment such as scale, blood pressure cuff, and pulse oximetry. The program targets members who would benefit from health sessions, monitoring of members' vital signs, and management of symptoms. Reports are provided to the member's physician to help enhance the treatment plan.
- **Short Term Program-** assists members with new onset of health diagnoses, support when coming home from the hospital and skilled nursing facilities, or link members to FHCP and community resources. Members would benefit from frequent contact for monitoring and education to understand signs and symptoms important to report to their doctor and lifestyle practices that will support health and wellbeing.

- **In-Home Providers-** the RN Case Manager coordinates member care with the in-home provider services to assist homebound members that would benefit from primary care services in the home or transitional care when ability is limited to attend appointments after discharge home from the hospital or skilled nursing rehabilitation facility. The in-home provider services help to reduce need for emergency department, hospitalization, and urgent care by providing primary care or transitional care services at home. In-Home Providers promote health and wellbeing through follow up care and medication management.
- **FHCP New Member Transition of Care Program-** The goal of the Transition of Care team is to assist new members transitioning into our network of providers, pharmacies, and covered medications. The member would benefit from clinical review of health history and medications to coordinate care with available resources, benefits, and participating providers or services to make the transition as seamless as possible. The RN Navigator assists existing members that are experiencing a change in benefits, providers, or services, or moving into another county served by FHCP or change of employers that offer FHCP insurance.
- **Community Resource Program-** Community Resource Coordinators partners with members and providers/ referral sources to address the barriers to social and economic factors related to health care needs that effect access to healthcare through use of agencies and community partners. Community Resource Coordinators complete individualized needs assessments to link members with appropriate and available resources. CRCs do not address urgent placement or home safety evaluations; physicians would continue to refer members with urgent needs to Home Health Skilled Nurse and Medical Social Worker or Department of Children and Families. Skilled Nurse Facility placement continues to be directed to Utilization Management Department 386-676-7187

Members and Providers are informed about available Case Management Programs by:

- Florida Health Care Plans website (www.fhcp.com)
- Member or Provider Resource Guide
- Quarterly newsletters
- Department Brochures

Members may be referred by:

- Practitioners
- Member or Caregiver
- Discharge Planners
- Medical Management Programs
- Proactive Data Claims Review
- Member Services

The New Member Transition of Care Program additional referral sources include:

- Marketing Agents
- Employer Groups

There are various methods to refer to the Case Management Coordination of Care Department:

Case Managers or Community Resources Coordinator Services:
Telephone Contact: Toll Free 855/205-7293 or 386/238-3284
Email: cmanagement@fhcp.com

Transition of Care Program:
Telephone Contact: Toll Free 855/205-7293 or 386/615-5017
Email: toc@fhcp.com

Case Management Coordination of Care Department Fax: 386/238-3271
Website: www.fhcp.com
For Providers- Internal: E.H.R. Task

Monday - Friday 08:00 AM to 5:00 PM

We'd like to take this opportunity to recognize the crucial role that our dedicated physicians play in helping us to meet the medical needs of our members and improve the health of our community. Since our beginnings in 1974 the FHCP model has been to recruit the very best doctors to deliver high-quality, affordable healthcare to our members. Only through your compassionate care and unyielding commitment to excellence are we able to fulfill this important mission. What you bring to FHCP has spread our positive reputation throughout our 5-county area and been the best advertisement for our model of care. Thank you for all that you do. You're very much appreciated!

Sincerely,

The FHCP Administration & Staff

WE Thank YOU!

HAPPY DOCTOR'S DAY

March 30, 2021

NCQA Update

Florida Health Care Plans Renews NCQA Accreditation

The National Committee for Quality Assurance has awarded Florida Health Care Plans an accreditation status of Accredited for service and clinical quality that meet the basic requirements of NCQA's rigorous standards for consumer protection and quality improvement. NCQA Health Plan Accreditation evaluates how well a health plan manages all parts of its delivery system—physicians, hospitals, other providers and administrative services—in order to continuously improve the quality of care and services provided to its members.

NCQA is a private, nonprofit organization dedicated to improving health care quality. NCQA accredits and certifies a wide range of health care organizations and recognizes clinicians in key clinical areas. NCQA's HEDIS ®is the most widely used performance measurement tool in health care. NCQA's website, www.ncqa.org, contains information to help consumers, employers, and others make more informed health care choices.