FALL 2018

NETWORK INSIDER

Cigna-HealthSpring news you can use

THE OPIOID EPIDEMIC

Information for prescribers

In 2015, opioids, including all prescription options and heroin, killed over 33,000 people — more than any previous year recorded.[1] It's been estimated that nearly half of all opioid overdose deaths involved a prescription.[1] As a result, providers are seeking alternatives to help address their patient's acute and chronic pain needs. So when should providers prescribe these "controversial" medications?

continued on next page

IN THIS ISSUE

1 THE OPIOD EPIDEMIC

5 OBESITY

8 STATIN USE IN DIABETIC PATIENTS

10 NEW CLARITHROMYCIN WARNING

11 REMOTE MONITORING FOR CHF PATIENTS

12 BEHAVIORAL HEALTH UNIT

13 CIGNA-HEALTHSPRING BEHAVIORAL HEALTH 2019 BENEFIT UPDATES

14 AMBULATORY SURGERY CENTERS

15 LEARN AND EARN

15 CAHPS AND HOS SEASON IS HERE

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THE OPIOID EPIDEMIC *continued*

When should a prescriber consider prescribing opioids[2]?

Type of Therapy	Definition	Rationale for Opioid Prescribing	How to Initiate	Suggested Duration
Acute Pain Therapy	Pain lasting < 3 months.	Based on prescriber discretion, patient history, type and severity of pain.	Prescribers should initiate the lowest effective dose of immediate-release opioids for the shortest therapeutic duration of time.	Suggested duration of use is ≤ 3 days, but > 7 days is rarely needed.
Chronic Pain Therapy	Pain lasting > 3 months or past the time of normal tissue healing.	Primarily for active cancer, palliative and end-of-life care.	Before considering opioids for chronic pain, prescribers should determine how effectiveness will be evaluated and should establish treatment goals with patients.	Determined on a case-by-case basis.

Chronic pain considerations[2,3]

In general, it is not recommended to prescribe opioids as first-line treatment for chronic pain (> 3 months) for adults age 18 or older (excluding active cancer, palliative care or end-of-life care). However, there are times when opioids are the most appropriate choice for this subset of patients. Consider the following.

- Non-opioid pharmacologic and/or non-pharmacologic therapies are preferred in addressing chronic pain; however, prescribers should consider the utilization of opioids only if both the expected benefits for function and pain outweigh the risks to the patient. If a prescriber chooses to utilize an opioid, it should be combined with both non-opioid pharmacologic and/or non-pharmacologic therapies as appropriate to help the patient reach their therapeutic goals.

THE OPIOID EPIDEMIC *continued*

- Prior to initiating opioid therapy for chronic pain in a patient, prescribers must establish realistic treatment goals for pain and function. In addition, a discontinuation plan must be considered in the event that the benefits do not outweigh risks. Opioids should only be continued if there is clinical improvement in pain and function, and will not cause harm to the patient.
- Prior to initiating opioid therapy and also periodically during the course of therapy for chronic pain, prescribers should discuss the risks and realistic benefits of this therapy, and establish responsibilities between both the patient and prescriber to promote the best possible outcome.

Opioid dosing[2,4]

Higher opioid dosages have not been shown to reduce pain long term, yet, they are associated with a higher risk of overdose and death. When opioids are initiated, prescribers should prescribe the lowest effective dosage; in addition, immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids should be considered if initiating for chronic pain. Overall, caution should be used when prescribing opioids at ANY dosage. Prescribers should carefully reassess individual benefits and risks when looking to increase dosages to ≥50 morphine milligram equivalents (MME) per day, as well as avoid increasing/titrating a dosage to ≥90 MME/day unless there is ample justification. There are a number of online MME calculators to help calculate the total dosage of opioids.

Tapering opioids[5]

Care should be taken when tapering opioids to avoid withdrawal and/or unwanted physical sequelae. Turn to the next page for an excerpt from an article by Kral and colleagues, taken from Table 2, in "A Practical Guide to Tapering Opioids."

THE OPIOID EPIDEMIC *continued*

Suggested opioid-tapering guidelines[5]

American Academy of Pain Medicine (2009)	Veterans Affairs/ Department of Defense (2010)	Canadian National Opioid Use Guideline Group (2010)	ASIPP (2012) Agency Medical Directors Group (2010)
Slow • 10% reduction weekly **Rapid** • Rapid 25% to 50% reduction every few days • Anecdotal evidence of rapid tapering at oral morphine doses > 200 mg daily • Slow taper of oral morphine equivalent doses of 60 to 80 mg daily	**Variable** • Taper by 20% to 50% weekly • Slower tapering may be warranted **Rapid Tapers** • Decrease by 20% to 50% daily until 30 mg daily **Methadone** • Decrease to 30 mg daily • Then reduce by 5 mg daily every 3–5 days until 10 mg daily • Then reduce by 2.5 mg daily every 3–5 days until discontinued **Morphine** • Decrease to 45 mg daily • Then decrease by 15 mg daily every 2–5 days until discontinued **Oxycodone** • Decrease to 30 mg daily • Then reduce by 10 mg daily every 2–5 days until discontinued	**Slow** • Taper by 10% of the total daily dose every 1–2 weeks **Rapid** • Taper by 10% of the total daily dose every day • Once 1/3 of original dose is reached, reduce rate of taper by at least 50% • Consider switching patient to morphine if previously experienced addiction with hydromorphone or oxycodone. Use 50% of the calculated equianalgesic dosage to begin the tapering process	• Decrease by 10% of the original dose per week • Some patients may be weaned more rapidly over 6–8 weeks

References:

1. https://www.cdc.gov/drugoverdose/index.html
2. https://turnthetiderx.org/treatment/#
3. https://www.cdc.gov/drugoverdose/prescribing/guideline.html
4. https://www.cdc.gov/drugoverdose/pdf/Guidelines_Factsheet-a.pdf
5. Kral LA, Jackson K, Uritsky T. A practical guide to tapering opioids. Ment Health Clin [Internet]. 2015;5(3):102-8. DOI: 10.9740/mhc.2015.05.102.

IMPORTANT: The literature has not clearly outlined the best course for opioid tapers. As observed in the table above, dosage schedules and reductions are variable across each of the published guidelines referenced. Prescribers are encouraged to use their best judgment regarding which guideline to adhere to.

OBESITY

Obesity is a chronic disease with global epidemic prevalence, and clinicians are encouraged to screen patients on an annual basis.[1]

Facts

- Affects 35% of people age 65 and older.[2]
- Comorbid manifestations may include diabetes, cardiovascular disease and cancer.
- Linked to a reduction in life expectancy.
- Health care for obese people costs approximately $147 million dollars.[3]

Risk factors

- Sedentary lifestyle.
- Less than seven hours of sleep – leads to increased hunger.
- Preexisting physical or mental illnesses.
- Smoking cessation – can cause food intake to replace cigarettes.
- Low socioeconomic status – can lead to the cheaper, calorie-dense foods.
- Medication classes that include:
  - Antidepressants/epileptics/psychotics.
  - Beta-blockers.
  - Glucocorticoids.
  - Insulin.
  - Sulfonylureas.

Subjective questions

Like other chronic illnesses, the diagnosis of obesity needs to be supported through appropriate documentation. Clinicians should know the answer to questions such as:

- How long has the patient been obese?
- Has the patient undergone any treatment strategies to reduce their body weight?
- Are there any comorbid conditions that are related to being obese?

continued on next page

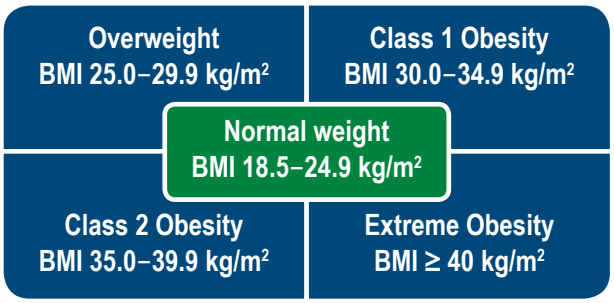
OBESITY *continued*

Objective measurements

The diagnosis of obesity is further supported by:

- Waist circumference.
- Body mass index (BMI).

The ICD-10 nomenclature utilizes the term morbid obesity and the NHLBI uses a classification method to define the severity of obesity. The National Health and Lung Blood Institute (NHLBI) transitioned away from the term morbid obesity and classified the disorder in the following stages.



Patients who have class 2 obesity are considered to be a higher mortality risk when they acquire the following conditions.[4]

- Coronary artery disease.
- Peripheral vascular disease.
- Abdominal aortic aneurysm.
- Carotid artery disease.
- Diabetes mellitus, Type 2.
- Sleep apnea.
- Hypertension.
- Hyperlipidemia.

Clinicians have the option of electively linking one of the comorbid manifestations above to the primary diagnosis of class 2 obesity by using the linking word "with" or "in" when the BMI is documented concurrently. For example, Obesity in a BMI of 37.0 kg/m² with diabetes mellitus type 2. Clinicians need to remember that a chronic disease needs to have at least one associated treatment plan, such as:

- Diet
- Referral
- Medication
- Monitoring and/or
- Diagnostic lab.

Documentation of BMI without clarifying the patient's nutritional status of obesity alongside the application of a specific treatment plan(s) is not acceptable. The ICD-10 codes below represent the BMI calculations (Z68.-) and for classifying obesity (E66.-).

ICD-10-CM code	ICD-10-CM description	Coding tip
E66.01	Morbid (severe) obesity due to excess calories	Use additional code to identify BMI, if known (Z68.-)
E66.1	Drug-induced obesity	
E66.2	Morbid (severe) obesity w/alveolar hypoventilation (Pickwickian syndrome)	
E66.3	Overweight	
E66.8	Other obesity	
E66.9	Obesity, not otherwise specified (NOS)	

OBESITY *continued*

ICD-10-CM code	ICD-10-CM description	ICD-10-CM code	ICD-10-CM description
Z68.25	Body Mass (BMI) 25.0–25.9, adult	Z68.35	Body Mass (BMI) 35–35.9, adult
Z68.26	Body Mass (BMI) 26–26.9, adult	Z68.36	Body Mass (BMI) 36–36.9, adult
Z68.27	Body Mass (BMI) 27.0–27.9, adult	Z68.37	Body Mass (BMI) 37–37.9, adult
Z68.28	Body Mass (BMI) 28–28.9, adult	Z68.38	Body Mass (BMI) 38–38.9, adult
Z68.29	Body Mass (BMI) 29–29.9, adult	Z68.39	Body Mass (BMI) 39–39.9, adult
Z68.30	Body Mass (BMI) 30.0-30.9, adult	Z68.41	Body Mass (BMI) 40.0–44.9, adult
Z68.31	Body Mass (BMI) 31–31.9, adult	Z68.42	Body Mass (BMI) 45–49.9, adult
Z68.32	Body Mass (BMI) 32.0–32.9, adult	Z68.43	Body Mass (BMI) 50.0–59.9, adult
Z68.33	Body Mass (BMI) 33–33.9, adult	Z68.44	Body Mass (BMI) 60–69.9, adult
Z68.34	Body Mass (BMI) 34–34.9, adult	Z68.45	Body Mass (BMI) 70 or greater, adult

References:

1. United States Preventive Services Task Force [USPSTF]. (2012, June). Obesity in adults: screening and management. Retrieved from [webpage] https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/obesity-in-adults-screening-and-management
2. Fakhouri, T., Ogden, C., Carroll, M., Kit, B., Flegal, K. (2012). Prevalence of obesity among older adults in United States 2007 to 2010. NCHS Data Brief 106. Accessed on 3/23/15 via weblink address http://www.cdc.gov/nchs/data/databriefs/db106.pdf
3. Flegal, K.M., Kit, B.K., Orpana, H., Graubard, B.I. (2013) *Association of all-cause mortality with overweight and obesity using standard body mass index categories: A systematic review and meta-analysis*. Journal of the American Medical Association, 309(1), 71–82.
4. Finkelstein, E. A., Trogdon, J. G., Cohen, J. W., & Dietz, W. (2009). *Annual medical spending attributable to obesity: payer- and service-specific estimates.* Health Affairs, 28 (5), w822–w831.
5. Jensen, et al. (2013). AHA/ACC/TOS Guideline for the Management of Overweight and Obesity in Adults. Journal of the American College of Cardiology, 63 (25 Part-B), 2985–3023. Retrieved from http://circ.ahajournals.org/content/circulationaha/early/2013/11/11/01.cir.0000437739.71477.ee.full.pdf
6. National Heart and Lung Blood Institute [NHLBI]. (2000). *NHLBI obesity education institute: the practical guide identification, evaluation, and treatment of overweight and obesity in adults.* Retrieved from https://www.nhlbi.nih.gov/files/docs/guidelines/prctgd_c.pdf

STATIN USE IN DIABETIC PATIENTS

Provider updates affecting Star Quality Ratings

The American College of Cardiology/American Heart Association Guidelines recommend moderate- to high-intensity statin therapy for primary prevention in diabetic patients age 40–75.

Q: What CMS changes are expected to affect the SUPD Star Quality measure?

A: CMS has indicated their intent to:

- Make SUPD a triple-weighted Star measure for 2018 dates of service.
- CMS confirmed results from 2017 dates of service will count as a single-weighted measure for Star Ratings released in October 2018.

Q: How is the SUPD measure fulfilled?

A: One fill of a statin medication per calendar year satisfies the SUPD measure.

Remember: The SUPD measure does NOT assess all diabetic patients.

PATIENTS ASSESSED

Patients age 40 to 75 who used their insurance coverage to fill diabetes medication(s) two or more times during the measurement year.

PATIENTS NOT ASSESSED

Patients who control diabetes without prescription medications or do not use their insurance coverage to pay for them.

Patients who had only one fill of diabetes medication in measurement year.

Patients in hospice or who have documented ESRD.

Q: Which diabetic patients are most likely to benefit from statin therapy?

A: According to the ACC and AHA, statin therapy for the primary prevention of Atherosclerotic Cardiovascular Disease (ASCVD) is strongly recommended for individuals with diabetes age 40–75 with LDL 70 to 189 mg/dL and without clinical ASCVD.[1]

Q: What is the leading cause of death for individuals with diabetes?

A: ASCVD is the leading cause of morbidity and mortality for individuals with diabetes, and the largest contributor to the direct and indirect costs of diabetes.[2]

continued on next page

STATIN USE IN DIABETIC PATIENTS *continued*

Diabetic adults without CVD

Moderate-intensity statin therapy reduced the risk for CVD by 27%[1]

Diabetic adults with one or more CVD risk factors

Moderate-intensity statin therapy reduced the risk for CVD by 37%[1]

Q: What if a patient shows intolerance to a statin medication?

A: Consider options such as:

- A different statin medication.
- Alternate-day dosing.
- A coenzyme (CoQ10) supplement
- Increased water intake.

Q: What statin medications does Cigna-HealthSpring cover?*

A:

High-intensity statin therapy	Moderate-intensity statin therapy	Low-intensity statin therapy
Daily dose lowers LDL-C by ≥ 50%, on avg.	Daily dose lowers LDL-C by 30–50%, on avg.	Daily dose lowers LDL-C by < 30%, on avg.
TIER 1: Atorvastatin 40 mg–80 mg **TIER 2:** Rosuvastatin 20 mg–40 mg **TIER 1:** Crestor** 20 mg–40 mg	**TIER 1:** Atorvastatin 10 mg–20 mg Simvastatin 20 mg–40 mg Pravastatin 40 mg–80 mg **TIER 2:** Rosuvastatin 5 mg–10 mg Lovastatin 40 mg **TIER 3:** Livalo** 2 mg–4 mg **TIER 4:** Crestor** 5 mg - 10 mg	**TIER 1:** Simvastatin10 mg Pravastatin 10 mg–20 mg Lovastatin 20 mg **TIER 3:** Livalo** 1 mg

*C-HS MAPD 5-tier formulary.

DEFINITIONS
ACC = American College of Cardiology;
ADA = American Diabetes Association;
AHA = American Heart Association;
ASCVD = Atherosclerotic Cardiovascular Disease;
CMS = The Centers for Medicare & Medicaid Services;
CVD = Cardiovascular Disease;
LDL = Low-density Lipoprotein

References

1 Stone N.J., Robinson J., Lichtenstein AH, et. al. 2013 ACC/AHA Guidelines on Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults: A Report of the American College af Cardiology/American Heart Association Task Force on Practice Guidelines. Cirulation. 2014; 129 (25 suppl 2): S1–45.
2 American Diabetes Association. Standards of Medical Care in Diabetes – 2015. Diabetes Care. 2016; 39 (Suppl.1): S1–S112.

NEW CLARITHROMYCIN WARNING

Potential for increased long-term risks in patients with heart disease

February 22, 2018 - The FDA released a drug safety communication cautioning use of clarithromycin in patients with heart disease.[1] This warning is based on a 10-year follow-up study of the CLARICOR trial, which demonstrated an unexpected increase in deaths among patients with coronary heart disease who received a two-week course of clarithromycin.

This increase in deaths became apparent after patients had been followed for one year or longer, and increased cardiovascular mortality was demonstrated for up to three years after clarithromycin administration.[2,3] These observations have warranted addition of a new warning about this increased risk of death in patients with heart disease, as well as addition of the study results to the clarithromycin drug labels.[1]

Macrolide antibiotics, such as clarithromycin, erythromycin and azithromycin, already carry warnings regarding QT prolongation and Torsades de pointes (TdP); however, these new warnings are unrelated to these established effects of QT prolongation and TdP. Researchers have no clear explanation of the mechanism leading to increased cardiovascular events and deaths after short courses of clarithromycin. There is currently no evidence to suggest that azithromycin or erythromycin increases long-term cardiovascular risk.[1,4]

The benefit of using clarithromycin in patients with heart disease should be weighed against the risks, and alternative antibiotics should be used, if possible. Patients taking clarithromycin should be made aware of signs and symptoms of worsening cardiovascular problems and advised to report these symptoms, if they were to develop. If clarithromycin is required

in a patient with coronary artery disease, prescribers should document the need for the medication and ensure the patient is prescribed other evidence-based therapies to reduce cardiovascular risk, such as HMG-CoA reductase inhibitor (statin) therapy. Clarithromycin and other macrolides should continue to be avoided, if possible, in patients with QT prolongation or taking other medications with QT-prolonging potential.[1,4]

1. Food and Drug Administration. FDA Drug Safety Communication: FDA review finds additional data supports the potential for increased long-term risks with antibiotic clarithromycin (Biaxin) in patients with heart disease. Available at: https://www.fda.gov/Drugs/DrugSafety/ucm597289.htm. Accessed on March 21, 2018.
2. Winkel P, Hilden J, Fischer Hansen J, et al., Clarithromycin for stable coronary heart disease increases all-cause and cardiovascular mortality and cerebrovascular morbidity over 10 years in the CLARICOR randomized, blinded clinical trial. International Journal of Cardiology 2015; 182:459–465.
3. Jespersen CM, Als-Nielsen B, Damgaard M, et al. Randomized placebo controlled multicenter trial to assess short term clarithromycin for patients with stable coronary heart disease: CLARICOR trial. BMJ 2006;332:22–7.
4. Article, *Manage New Warnings About Clarithromycin and Cardiovascular Risk*, Pharmacist's Letter, April 2018.

REMOTE MONITORING FOR CHF PATIENTS

New national heart health program

Now it's possible to monitor patients at home to help avoid health care over-utilization. Using Medtronic Care Management Services (MCMS) – at no added cost to patients - Cigna-HealthSpring's Congestive Heart Failure Solution offers:

- Daily health monitoring.
- Personal telephone outreach.
- Additional remote patient monitoring technology to be added in 2019.

How it works:

1. The patient's phone, tablet or computer facilitates symptom and biometric monitoring.
2. Date is securely transmitted to Medtronic.
3. A Medtronic nurse reviews alerts and calls the patient to discuss any concerns.
4. If there is a biometric measurement outside predetermined clinical parameters, or a symptom score above a set threshold, Medtronic contacts provider's office via phone or fax.
5. The provider determines the course of treatment and contacts patient with instructions.

Provider benefits:

- Improved clinical outcomes
- Improved identification of patient needs
- Optimized operational efficiency
- Provide health-check data, which allows providers to focus resources on those who need it most

Who qualifies for this program?	Who does NOT qualify?
Your Medicare Advantage and Dual-Eligible Cigna-HealthSpring patients with Congestive Heart Failure in all markets.* *Program not offered in Arizona and Leon Medical Center	Medicaid only, ESRD, AIDS, institutionalized for 30 days or more, hospice, SNF, awaiting or received a recent organ transplant, unable to cognitively understand written or spoken questions in English and Spanish.

To learn more:

- Call your Network Operations Representative.
- Email CHS National Health Services Clinical Programs, attention to **Jessica.Kinowski@Cigna.com**.
- Contact MCMS Patient Advocacy Support Services at **pass@medtronic.com** or **1-866-569-2843**. MCMS is a pioneer in innovative remote patient monitoring, currently servicing more than 95,000 patients at any given time with over 20 disease management protocols with comorbid capabilities.

BEHAVIORAL HEALTH UNIT

Innovative, individualized care

The Cigna-HealthSpring Behavioral Health Unit provides innovative, individualized and integrated behavioral health solutions to our customers through two programs.

Community-based Care Coordination (CBCC)

Community-based care coordinators are licensed behavioral health professionals who work directly with patients during home and hospital visits and ongoing telephone contact.

To help support the goal of enhancing patients' quality of life, community-based care coordinators will:

- Promote quality, cost-effective outcomes.
- Facilitate the provision of services in the appropriate setting.
- Coordinate with providers, hospital staff and community resources on behalf of patients with complex behavioral health needs.

Disease Management

Multi-week educational coaching programs provide participants with telephone support and printed resources available to patients at no cost.

- Depression Disease Management Program offers prevention, detection and education about available treatments and services for managing depression. Self-referrals, physician- and caregiver-referrals accepted.
- The Substance Use Coaching Program offers early intervention, education, support group information and referrals to in-network providers. Self-referrals, physician- and caregiver-referrals accepted.

To learn more or to refer a patient, please call the Behavioral Health Unit at **1-866-780-8546**, Monday through Friday, 8 am to 5 pm, CST.

CIGNA-HEALTHSPRING BEHAVIORAL HEALTH 2019 BENEFIT UPDATES

Behavioral Telehealth is expanding

- Beginning January 2019, Cigna-HealthSpring is expanding its Behavioral Telehealth benefit offerings to include more patients in AL, AR, FL, GA, IL, KS, MO, MS, PA and TN. Behavioral Telehealth in the affected states will no longer be limited by CMS' telehealth coverage policies.
- Behavioral Telehealth is the delivery of therapy and medication management sessions via interactive audio and video telecommunications technologies. Providers must utilize a real-time, secure, video-based technology in order to render telehealth services.
- Providers licensed in the state in which the patient is being treated will be able to provide telehealth services in accordance with the patient's Cigna-HealthSpring benefit plan.
- If you offer telehealth services, please complete the Attested Specialty Form found on CignaforHCP.com. On receipt, "telehealth" will be added as a specialty to the provider's Cigna-HealthSpring profile. There are no additional contracting or credentialing requirements for delivering telehealth services.
- Providers should bill telehealth sessions per CMS guidelines. There will not be a cost differential to the patient for in-office versus telehealth services.
- Prior authorization guidelines for telehealth services will be the same as in-office prior authorization requirements.

Remember to verify eligibility and benefits

- It is important to remember that a patient's eligibility and benefits can change frequently, especially at the beginning of a new calendar year. Please ensure that you are verifying eligibility and benefits by calling the Provider Services phone number listed on the back of your patient's card. You may also verify eligibility and benefits through Cigna-HealthSpring's online portal, HSConnect, at https://healthspring.hsconnectonline.com/HSConnect.

ATTENTION:
AMBULATORY SURGERY CENTERS
Accepted claim forms have changed

Effective January 1, 2019 – To ensure the timely processing of submitted claims, Cigna-HealthSpring requires ASC providers to use the forms listed in the left column. CHS will not accept forms listed in the right column. Remember: inaccurate information in the claim fields may cause denial or incorrect payment.

CLAIM FORMS ACCEPTED	CLAIM FORMS *NOT* ACCEPTED
☑ Form 837p	☒ Form 837I
☑ Form CMS 1500 › List the NPI for the ASC in box 24J › List ONLY the name of surgeon and NPI in box 17 and 17b	☒ Form UB-04

Cigna-HealthSpring is consistent with CMS coding and billing guidelines. Chapter 14 Section 10.1 of the CMS Medicare Claims Processing Manual instructs ASC providers that meet the CMS requirements for an Ambulatory Surgery Center to bill the Medicare contractor using the ASC X12 837 professional claim format or, in rare cases, Form CMS-1500.

LEARN AND EARN

Education and CME credits through *Valuable Insights*

Valuable Insights, by CareAllies, is a free, online education series designed to help you:

- Earn AMA PRA Category 1 credits with *Valuable Insights* on-demand webcasts.
- Learn quickly and on the go with *Valuable Insights* podcasts, which feature physicians sharing success stories and best practices.
- Get industry updates from subject matter experts with *Valuable Insights* alerts.

You can register at bit.ly/RegisterVI to receive future email communications, or you can access past resources on the CareAllies Insights page at bit.ly/CAInsights. Resources include webcasts and podcasts such as:

- *Valuable Insights* webcast: "Medicare Advantage and Part D Star Ratings." Evet Rodrigues, director of customer perceptions for Cigna-HealthSpring, discussed how to win by improving your patient experience. (1 CME credit)
- *Valuable Insights* podcast: "Medication Adherence." William Torkildsen, MD from Port Isabel Health Clinic, and Rickie Cruz, LVN, an embedded care coordinator for CareAllies, discussed how they implemented a medication adherence tracker that helped make patients 20 times more likely to fill their prescriptions. (15 min)

Have questions? Email **info@careallies.com**.

CAHPS AND HOS SEASON IS HERE

These three tools encourage patient engagement

It's that time of year. CAHPS and HOS are live in your area. Your patients are providing feedback on their experience with you, their health plan, and their health outcomes.

Encourage patients to provide honest feedback of their experience in your office. Use our helpful tools to improve recall and prompt important patient/doctor conversations.

Remember: Ask your patients six important questions:

1. Are you having any issues with Urinary Incontinence?
2. Have you fallen recently or have any concerns about falling?
3. What are you doing to stay active?
4. Are you feeling sad or depressed or have you suffered a traumatic experience recently?
5. Do you have any questions about any tests or blood results you have had recently?
6. Do you have any questions about any medications you are taking?

If your local Network Operations representative has not reached out to you with these tools, please ask for more information. Thank you for your partnership. Working together works.

NETWORK INSIDER

Fall 2018

<Name>
<Address>

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Cigna HealthSpring®

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