The Advantage

A Newsletter for Providers

Diabetic foot care exams

According to the American Diabetes Association, the lifetime risk of a person with diabetes developing a foot ulcer may be as high as 25 percent. Up to 50 percent of older patients with type 2 diabetes have one or more risk factors for foot ulceration. A number of component causes, most importantly peripheral neuropathy, interact to complete the causal pathway to foot ulceration. The principal contributory factors that might result in foot ulcer development are:

- Previous amputation.
- Past foot ulcer history.
- Peripheral neuropathy.
- Foot deformity.
- Peripheral vascular disease.
- Visual impairment.
- Diabetic nephropathy (especially patients on dialysis).
- Poor glycemic control.
- Cigarette smoking.

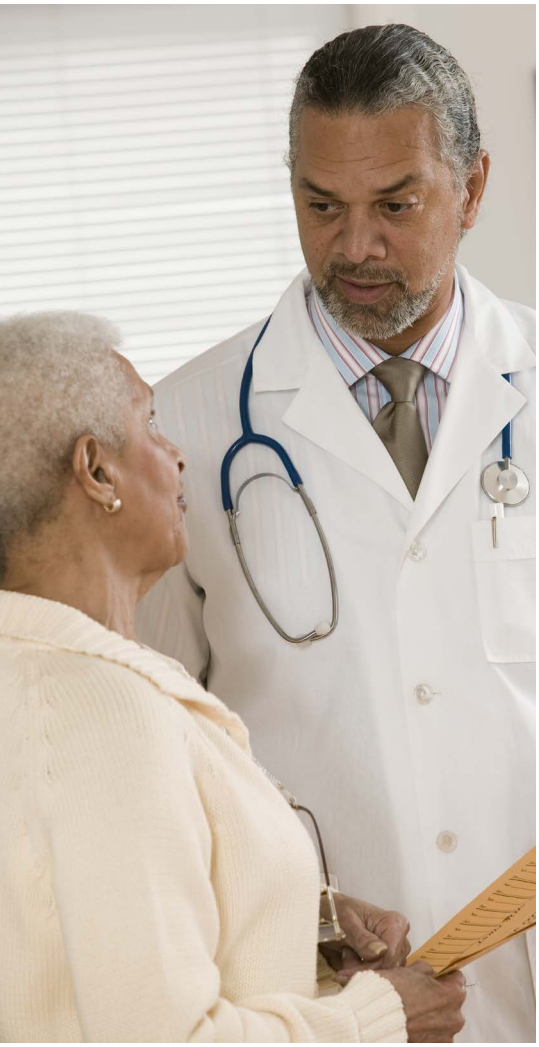
The most common triad of causes that interact and ultimately result in ulceration has been identified as neuropathy, deformity, and trauma. Identifying those patients at risk for foot problems through diabetic foot exams is the first step in preventing such complications.

Medicare coding requirements for the diabetic foot care exam:

While there can be many components to a diabetic foot exam, completely capturing the encounter and reporting the G9226 Medicare measurement code requires the foot examination to include visual inspection, sensory exam with monofilament, and pulse exam. It is very important to also submit the measurement code so we can accurately track which of our diabetic members are receiving foot exams.

Summer 2016

Table of contents



Adult BMI assessment

Body mass index (BMI) is now an important indicator which providers can use to screen for weight categories that may lead to health problems. In recent years, more and more providers have been assessing and recording their patients' BMI values not only in their office records, but also in the hospital record.

Also recognizing the importance of gathering BMI data, the National Committee for Quality Assurance (NCQA) has included BMI as a Healthcare Effectiveness Data and Information Set (HEDIS®) measurement for patients age 20 and older. For a provider's documentation of BMI to meet HEDIS requirements, the provider must have recorded the weight and BMI value in the medical record during the measurement year or year prior to the measurement year. The weight and BMI must be from the same data source. For appropriate claims coding, the guidelines are as follows*:

Common Procedural Terminology (CPT®) codes	Healthcare Common Procedure Coding System (HCPCS) codes	Revenue codes	International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) codes
99201 – 99205, 99211 – 99215, 99241 – 99245, 99341 – 99345, 99347 – 99350, 99381 – 99387, 99391 – 99397, 99401 – 99404, 99411, 99412, 99420, 99429, 99455, 99456	G0402, G0438, G0439, G0463, T1015	0510 – 0517, 0519 – 0523, 0526 – 0529, 0982 – 0983	Z68.1 – Z68.45

*HEDIS guidelines

Here are some obesity facts according to the Centers for Disease Control and Prevention (CDC):

Obesity is common, serious, and costly

- BMI greater than or equal to 30 (obese status) has greatly increased since the 1970s, but has recently leveled off, except for women age 60 years and older, for whom it continues to increase.
- More than one-third (36.5 percent) of U.S. adults are obese.
- Obesity-related conditions include heart disease, stroke, type 2 diabetes, and certain types of cancer, some of the leading causes of preventable death.
- The estimated annual medical cost of obesity in the United States was $147 billion in 2008 U.S. dollars; in 2006, the average overall medical costs for an obese person were $1,429 higher than medical costs for a person of normal weight.

Obesity affects some groups more than others

- Non-Hispanic blacks have the highest age-adjusted rates of obesity (48.1 percent).
- Hispanics (42.5 percent).
- Non-Hispanic whites (34.5 percent).
- Non-Hispanic Asians (11.7 percent).
- Obesity is higher among middle-aged adults ages 40 – 59 years (40.2 percent) and older adults age 60 and over (37.0 percent) than among younger adults ages 20 – 39 (32.3 percent).

Obesity and socioeconomic status

- Among non-Hispanic black and Mexican-American men, those with higher incomes are more likely to have obesity than those with lower incomes.
- Higher income women are less likely to have obesity than lower-income women.
- There is no significant relationship between obesity and education among men. Among women, however, there is a trend — those with college degrees are less likely to have obesity than less educated women.

Results from the 2016 Provider Satisfaction Survey

We would like to extend a sincere thank you to all the practices that participated in the 2016 Provider Satisfaction Survey. We value your insight and appreciate the time you took to participate in the survey. We are analyzing the results, reinforcing areas in which you indicated we do well and developing action plans to address areas identified as needing improvement.

While we are still delving into the data, we are very pleased that our continued collaboration and partnership with our providers is reflected in the 82.3 percent of those who responded they would recommend First Choice VIP Care Plus to their colleagues. Additionally, 86.1 percent felt our overall claims reimbursement process was good to excellent, and overall satisfaction with the plan was at 84.7 percent. 87.5 percent of providers were satisfied with our plan's facilitation and support of appropriate clinical care for patients. For our first year as a plan, we are proud of those numbers, but we certainly want to continue to reinforce that we are here to support you in caring for our members. While we will strive to improve all the results, the survey dentified areas of particular focus for improvement, including:

- The knowledge, accuracy, and helpfulness of responses to phone inquiries.
- The prior authorization process for both medical and pharmacy.

We look forward to working with you to address these issues and welcome your ideas and comments. We encourage you to share them at **VIPProviderComm@amerihealthcaritas.com** or with your Provider Network Management Account Executive.

Let's work together to prevent hospital readmissions

Defining a hospital readmission

A hospital readmission occurs when a patient is admitted to a hospital within 30 days of being discharged from an earlier (initial) hospitalization. This includes readmission to any hospital, not just the hospital at which the patient was originally hospitalized. Medicare uses an "all-cause" definition of readmission, meaning that hospital stays within 30 days of a discharge from an initial hospitalization are considered readmissions, regardless of the reason for the readmission.

Penalties to increase in 2017

In 2017, the Centers for Medicare & Medicaid Services (CMS) has increased the number of medical conditions that it considers in calculating the readmission penalty to include coronary artery bypass grafting (CABG) and the expansion of pneumonia diagnoses to the list of initial diagnoses eligible for assessing hospital performance on readmissions. This is expected to result in total fines increasing this year, in the amount of a 0.58 percent reduction in base Medicare payments across all hospitals for all inpatient admissions.

How can we help you minimize the risk of incurring fines while improving care for our members?

Hospitalizations can be stressful, especially when they result in subsequent readmissions. Hospitals can engage in several activities to lower their rates of readmissions, such as clarifying patient discharge instructions, coordinating with specialty care providers and each patient's primary care provider (PCP), and working with our Care Management team. Our Care Management team can support you in the following ways:

- Work with your case management team to coordinate each member's discharge.
- Reconcile medications after discharge in the member's home.
- Ensure home-based services, such as durable medical equipment (DME), home health, and therapies, are in place.
- Help the member follow up with a specialist or PCP by scheduling, before discharge, an appointment with the appropriate provider within seven days.
- Update the member's individualized care plan to address barriers to recovery, providing education needed to manage health and help prevent readmissions.

Medicare Advantage risk adjustment

What is risk adjustment?

Risk adjustment is an essential mechanism used in health insurance programs to account for the overall health and expected medical costs of each individual enrolled in a health plan.

Accounting for the health status of beneficiaries for payment purposes is called risk adjustment and is intended to ensure Medicare Advantage (MA) plans have adequate resources to reimburse providers treating MA beneficiaries, including individuals with complex chronic diseases.

In turn, MA plans rely on risk adjustment to maintain predictable and actuarially sound payments from CMS to provide benefits to all enrollees.

Risk adjustment accounts for beneficiary differences by adjusting payments to the MA plan. Payments reflect the specific characteristics of each enrolled beneficiary, including demographics, Medicaid eligibility, and health status.

What methodology is used for risk adjustment?

CMS pays MA plans on a per-enrollee capitated basis for medical care and separately for prescription drug benefits. MA benchmark base rates are determined for each county and then are risk-adjusted by CMS for each enrollee to account for the cost differences associated with various diseases and demographic factors. In other words, CMS modifies the payments to MA plans to reflect the health of each beneficiary.

CMS uses a disease model to determine a risk "score" for each member. The model takes individual diagnosis codes and combines them into broader diagnosis groups, which are then refined into hierarchical condition categories (HCCs). HCCs, together with demographic factors such as age and gender, are used to predict beneficiaries' total care costs.

Each January starts a "clean slate" for HCCs. A non-resolving chronic condition diagnosis (such as diabetes) must be reported on a claim denoting a face-to-face visit with an acceptable type of provider, in an acceptable setting, at least once during the calendar year. If such an encounter is not reported, this is called "falling off," and the MA plan's payments from CMS would not accurately reflect the member's actual condition.

This system is prospective, which means it uses a beneficiary's diagnoses from one year to calculate a risk adjustment factor used to establish a payment for the following year.

How can this help beneficiaries?

Risk adjustment is much more than a regulatory requirement. It actually improves quality of care in several ways. Accurate identification of patient health status allows us to:

- Understand patient needs, so we can develop new programs and interventions.
- Identify high-risk patients for disease and intervention management programs.
- Integrate clinical efforts with providers and offer more robust data.

How can providers help?

- Become familiar with the principles of risk adjustment and the impact it has on the health care system.
- Because risk adjustment depends on diagnosis coding, document all chronic, acute, and stable conditions during each face-to-face encounter.
- Submit all encounters to the health plan and code all diagnoses to the highest specificity.
- Document clearly and concisely how the conditions coded were assessed, monitored, or treated, or how they affected the patient's care or your medical decision-making during the visit.
- Make sure all medical record entries have a valid signature with credentials (e.g., "M.D.") and dates for each encounter per CMS guidelines.
- Become familiar with standard coding principles for your specialty and make sure all reported diagnosis codes are clearly supported in the medical record to survive audit scrutiny and avoid concerns of potential fraud.
- Be prepared to quickly provide medical records to the MA plan when CMS does a risk adjustment data validation (RADV) audit. This is the process of verifying that diagnosis codes submitted for payment are supported by medical record documentation.

Advance directives

An advance directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under state law, relating to providing health care when an individual is incapacitated.

Member rights under federal law:

- To decide what medical care they want to receive, if in the future they are unable to make their wishes known.
- To choose an individual to act on their behalf to make health care decisions in the event they are unable to make these decisions on their own.

Provider responsibilities:

- Discuss and offer to assist with facilitating members' advance directives.*
- Maintain written policies and procedures concerning advance directives for all adults receiving care.
- Provide information regarding advance directives to the following facilities or services as required by federal regulations:
  - Hospital — at the time of the individual's admission as an inpatient.
  - Skilled nursing facility — at the time of the individual's admission as a resident.
  - Home health agency — before the individual comes under the care of the agency or at the time of the first home visit, as long as the information is furnished before care is provided.
  - Personal care services — before the individual comes under the care of the personal care services provider or at the time of the first home visit, as long as the information is furnished before care is provided.
  - Hospice program — at the time the individual initially receives hospice care from the program.

* Must be in compliance with 42 C.F.R. 489.100.

Helpful tips from our Prior Authorization department

Clinical documentation

- Please always submit clinical documentation when requesting a prior authorization. Without clinical documentation, the prior authorization process cannot be completed.

Expedited requests

- Expedited review should only be requested if you determine that applying the standard time frame of 14 days to making a determination could seriously jeopardize the life or health of the member or their ability to regain maximum function. When faxing requests and/or clinical documentation, do not check "urgent" or "ASAP" unless it is an expedited request. Incorrectly marked requests can delay determination on requests which truly require expedited review.

Fax cover sheet

- Please utilize our plan's prior authorization fax cover sheet when faxing in requested documents or prior authorization requests. The fax cover sheet is available on our website under **Provider > Resources > Prior authorization**.

Peer-to-peer reviews

- Providers may only request a peer-to-peer review during initial outreach by the Clinical Care Reviewer notifying the provider that the request does not meet medical necessity criteria and will be pended to the Medical Director for determination. The peer-to-peer review must occur before the Medical Director renders a decision.

Write legibly. Help us to process your requests for prior authorization accurately and efficiently while protecting our members' protected health information (PHI).

- Write legibly when you fax your request for prior authorization. We value our members' privacy but risk incorrectly sharing member PHI by responding to the wrong fax number if the request for prior authorization is not written legibly.
- Take advantage of our online prior authorization request tools. Eliminate legibility issues by submitting your prior authorization requests securely online. Medical prior authorization forms are located at **Provider > Resources > Prior authorization** and online pharmacy prior authorization forms are available at **Member > Self-service tools > Search for a prescription drug > FAQs**.
- Make sure your contact information is updated in our records. Check your listing in our online provider directory to ensure we have your most up-to-date contact information. If you are not listed in the provider directory or your contact information is incorrect, please contact your Provider Network Management Account Executive.

The data book on beneficiaries dually eligible for Medicare and Medicaid

The Medicaid and CHIP Payment and Access Commission (MACPAC) and the Medicare Payment Advisory Commission (MedPAC) produce a data book which presents information on the demographic and other personal characteristics, expenditures, and health care utilization of individuals who are dually eligible for Medicare and Medicaid coverage.

Per the data book:

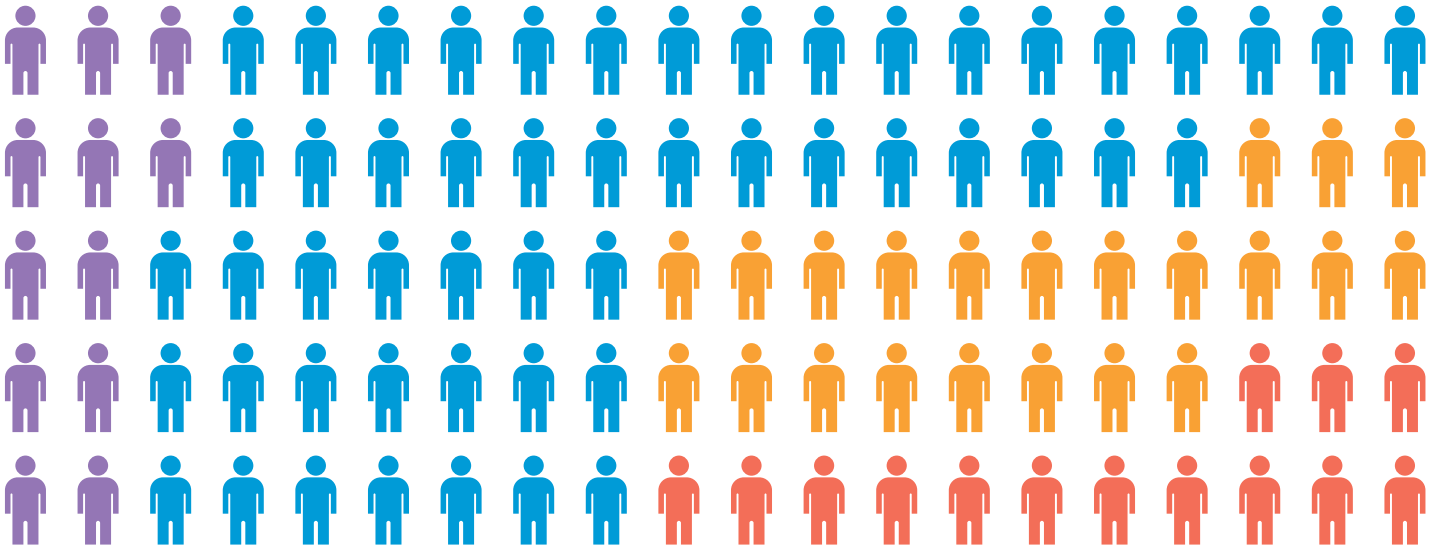
> This population is diverse and includes individuals with multiple chronic conditions, physical disabilities, and cognitive impairments such as dementia, developmental disabilities, and mental illness. Policymakers have expressed particular interest in dual-eligible beneficiaries because of the relatively large expenditures by both Medicare and Medicaid for this relatively small group of individuals. Concerns have also been raised as to how the existence of separate funding streams creates barriers to coordination of care and the extent to which lack of coordination increases costs and leads to poor health outcomes. Because these issues are of concern to both commissions, we thought it prudent to combine resources and conduct a joint analysis of federal Medicare and Medicaid data. This data book, the fourth in a series, is an effort to create a common understanding of the characteristics of dual-eligible beneficiaries and their use of services*.

The data book is available on the MACPAC website and offers valuable and interesting information on this particular population.

* **www.macpac.gov/wp**-content/uploads/2017/01/Jan17_MedPAC_MACPAC_DualsDataBook.pdf

Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. [USDHHS]

Health care professionals have their own culture and language. Many adopt the "culture of medicine" and the language of their specialty as a result of their training and work environment. This can affect how health professionals communicate with the public. [USDHHS]



Proficient

Can find the information required to define a medical term by searching through a complex document.

Intermediate

Can accurately interpret and understand a prescription drug label.

36%

of Americans possess basic or below basic health literacy, inhibiting their ability to remain engaged in and successfully manage their health.

Basic

Can read and understand medical information in a short, simple document.

Below basic

Can identify and correctly circle the date on a medical appointment slip.

of Americans recently discharged from the hospital could not tell researchers what medications they were prescribed, nor how often they should take them or in what amounts.

$75 – $125 BILLION

estimated annual cost for low health literacy

Let's give caregivers some respite

Did you know that more than 65 million people, or 29 percent of the U.S. population, provide care for a chronically ill, disabled, or aged family member, spending an average of 20 hours per week providing that care to a loved one? In fact, family caregivers are the foundation of long-term care nationwide.

However, the stress of family caregiving can take a toll on the caregiver — financially, emotionally, and physically:

- The average family caregiver for someone over 50 years old spends about $5,500 per year in out-of-pocket caregiving expenses, and almost half of working caregivers report using all or most of their savings to pay for caregiving expenses.
- About one-quarter of family caregivers caring for loved ones for at least five years report their health as fair or poor.
- The stress of caring for a family member with dementia has been shown to impact a caregiver's immune system for up to three years after their caregiving ends, increasing their chances of developing a chronic illness.

First Choice VIP Care Plus recognizes that serving our members includes assisting their family caregivers, too. Our members and their caregivers can benefit from a service that assists family members who are taking care of their loved ones and need some temporary respite from these caregiving activities.

This service is called respite care, and it offers temporary, periodic relief from caregiving responsibilities by providing a qualified substitute caregiver. This substitute caregiver can provide needed services and supervision to the member while the family caregiver enjoys "time off". Respite care can be provided to a First Choice VIP Care Plus member and his or her family caregivers either in the home or in a licensed, participating nursing home, depending upon the needs of the member and the family caregiver.

If you know of patients with caregivers within your practice who may need this service, please contact Care Management at **1-888-244-5440**.

If you are a licensed nursing home and would like to be a First Choice VIP Care Plus provider of respite services, please contact Provider Services at **1-888-978-0862**.

If you are a home health agency or in-home services provider and would like to provide respite services, please contact Provider Services at **1-888-978-0862**.

National Alzheimer's Awareness and Family Caregivers Month

November is National Alzheimer's Awareness and Family Caregivers Month. Most people are "aware" of Alzheimer's disease, but, because Alzheimer's affects approximately half of all families, it is important to also inform your patients of certain facts that most individuals do not know about this disease:

- Alzheimer's is generally detected at the end stage of the disease.
- Memory loss is not a part of normal aging.
- Current Alzheimer's drugs are probably more effective than people think.
- Taking good care of the heart will help the brain stay healthy.
- Alzheimer's disease can be treated.
- The Alzheimer's drug pipeline is full, so it is possible that an effective agent for the treatment of Alzheimer's is on the way.
- Managing risk factors may delay or prevent cognitive problems later in life.

Also celebrated in November is Family Caregivers Month, which seems fitting, as many Alzheimer's patients rely on the aid of family caregivers. November is a time to recognize and honor family caregivers across the country. Doing so enables all of us to:

- Raise awareness of family caregiver issues.
- Celebrate the efforts of family caregivers.
- Educate family caregivers about self-identification as a "caregiver."
- Increase support for family caregivers.

If your organization would like to help with either of these important initiatives, you may visit the Alzheimer's Association website at **www.alz.org** and the Caregiver Action Network website at **www.caregiveraction.org**.

First Choice VIP Care Plus supports these initiatives by offering a no-cost five-session course for individuals who care for people with Alzheimer's disease or related dementias, called Dementia Dialogues. The course is especially beneficial to social workers, nurses, nursing assistants, personal care assistants, activity directors, and caregivers, but anyone may attend. At the end of the course, individuals will be awarded the Dementia Specialist Certificate and a total of seven and a half continuing education (CE) hours through the South Carolina Department of Health and Human Services (SCDHHS). If your organization would like to participate in or host one of these events, please reach out to our Provider Services department at **1-888-978-0862**.

Annual training requirements

Model of Care

First Choice VIP Care Plus' Model of Care is an integrated care management approach to health care delivery and coordination for dual eligible (Medicare and Medicaid) individuals. The Model of Care is a program that involves multiple disciplines coming together to provide input and expertise for a member's individualized plan of care. This plan is designed to maintain the member's health and encourage the member's involvement in their health care.

CMS requires providers who care for our beneficiaries to annually participate in and attest to completing our Model of Care training. Annual Model of Care training is also a contractual requirement for all participating providers. This required training can be accessed in any of the following ways:

- Through the online interactive Model of Care training module on our website at **amerihealthcaritas.adobeconnect.com/_a1050101005/firstchoicemoc**.
- In person from a First Choice VIP Care Plus Provider Network Management Account Executive or training seminar. Provider Network Management Account Executive contact information is available online at **www.firstchoicevipcareplus.com**. Training seminar information will be faxed out when one is available in your area.
- By requesting electronic Model of Care training materials from Provider Services at **1-888-978-0862** or calling your First Choice VIP Care Plus Provider Network Management Account Executive.

Providers may find information on the Model of Care and the annual training requirement in the Provider Manual.

Other required Medicare annual training

- Compliance — CMS requires all persons who provide health care or administrative services to Medicare enrollees to satisfy general compliance training requirements. Medicare Parts C and D General Compliance Training is available on the CMS website.
- Fraud, Waste, and Abuse (FWA) — CMS requires our first tier, downstream, and related entities (FDRs, which include network providers) to complete annual Medicare FWA training. To fulfill this requirement, you must use CMS Fraud, Waste, and Abuse online training or incorporate the content of the CMS standardized training modules from the CMS website into your organization's existing compliance training materials and systems.

Other important training tracked by our plan — cultural competency

As a participating provider, you must do your part by participating in annual Cultural Competency training. The Office of Minority Health, part of the U.S. Department of Health and Human Services, offers the following accredited continuing education programs, which can help our providers take the first step in serving diverse populations:

- A Physician's Practical Guide to Culturally Competent Care, for physicians, nurses, nurse practitioners, and pharmacists.
- Culturally Competent Nursing Care: A Cornerstone of Caring, for nurses and social workers.

Both programs provide CE credits and are available online at no cost to participants.

The CMS Medicare-Medicaid Coordination Office (MMCO), which is dedicated to ensuring beneficiaries enrolled in Medicare and Medicaid (dual eligibles) have access to seamless, high-quality health care that includes the full range of covered services in both programs, also offers many training resources on working competently with the dual eligible population. These resources can be found at their **Resources for Integrated Care website**.

We also offer Disability Cultural Competency training on **our website**.

Improper billing

As part of the Healthy Connections Prime program, First Choice VIP Care Plus applies no deductibles, coinsurance, or copays to its members for medical services. Both First Choice VIP Care Plus and providers are responsible for ensuring that our members are not improperly billed. Using the South Carolina Medicaid Web-Based Claims Submission Tool (also known as "WebTool") can help providers confirm that a patient is a member of a Healthy Connections Prime plan.

First Choice VIP Care Plus members can be billed for:

- Medicaid copay amounts for long-term services and supports.
- Medicaid copay for Medicaid-only covered DME items.
- Nursing facility services for a Medicaid-sponsored long-term care (LTC) stay. Members may also be responsible for some payment based on their income.

How First Choice VIP Care Plus resolves improper billing issues with providers

- First Choice VIP Care Plus informs the provider that a member has been improperly billed and educates the provider on improper billing.
- If the member has paid an improperly billed Medicare amount, First Choice VIP Care Plus will request the provider reimburse the member. The plan also has the option to reimburse the member for the Medicare amount. If the plan reimburses the member, the provider will be notified and the plan will recoup this amount from the provider.
- If, after outreach and education efforts to the provider, First Choice VIP Care Plus identifies ongoing inappropriate billing activities, First Choice VIP Care Plus may take disciplinary action up to and including termination of the Provider Agreement.

Claim inquiry form

If you are questioning reimbursement on a claim or a claim denial, you may complete a claim inquiry form. We have recently updated the claim inquiry form to simplify it and to add a new inquiry mailing address. The form can be found on our website in the Provider Resources section.

Provider manual updates

From time to time, we update our provider manual. Since the provider manual is an integral part of your contract with our plan, we want to remind you of some additional 2017 updates:

- Referrals language.
- Peer-to-peer review language.

Report suspected fraud, waste, or abuse to First Choice VIP Care Plus

Providers who suspect a First Choice VIP Care Plus provider, employee, or member is committing fraud, waste, or abuse should notify the First Choice VIP Care Plus Special Investigations Unit as follows:

- By phone at **1-866-833-9718**.
- By U.S. mail at:
  First Choice VIP Care Plus
  Special Investigations Unit
  200 Stevens Drive
  Philadelphia, PA 19113

The First Choice VIP Care Plus Special Investigations Unit supports the efforts of local and state authorities in the prosecution of reported cases of fraud, waste, and abuse. Reports of suspected fraud, waste, and abuse related to First Choice VIP Care Plus may also be sent directly to the U.S. Department of Health and Human Services by calling 1-877-7SAFERX (772-3379).

Information may be left anonymously.

Important phone numbers

Provider Services: **1-888-978-0862**

Prior authorizations: **1-888-244-5410**
1-888-257-7690 (Fax)

Pharmacy Services: **1-855-327-0512**

Language Line: **1-888-978-0862**
• After hours: **1-877-693-8275**

Fraud and Abuse Hotline: **1-866-833-9718**

NaviNet: **1-888-482-8057**

Change Healthcare

• Electronic billing and electronic remittance advice (ERA): **1-877-363-3666**

• Electronic funds transfer (EFT) enrollment: **1-866-506-2830**

Just for fun — Alzheimer's word search

Y S G A R V Q P E B I L L N E S S R N Z T
Z T B S U S Z C R G X P V D I O L Y M A S
N I U S B E D O R E H A B I L I T A T E R
M S N I W E E M A M Q G N I P O C F N O U
H I C S R R M P T M G T R E A T M E N T B
Y V E T T G E L I U E C I P S O H R W U T
Y I R A F E N E C D E T A C H M E N T X U
T Y T N E D T X D E C N A V D A X P R T O
I G A C A G I E M O H G N I S R U N Y R N
L O I E Q O A Y D I Z E H S T S E T O W R
A L N O A L R T R I U P I L L S I T A E F
N O B U E O A E S R S E E F V L C N C J T
O I V V T T M S O Y V E O Z I O D A R S H
S S F S E I A L P I L R A B D E L E I I S
R Y I R E C O R T E G R A S R L V P Y M E
E H T H H G N A E E M N A I E I A Y R P S
P P Z R I B B A T D I S N E G R H A O A P
G L W C R M L F I E O G H E E F M Z M I A
A S A A O A U O G L O M R H O L W B E R N
X L I C R L M A S F E A T A W X T B M E Y
D N T U A Y W B F S C R G R A D U A L D S

ADVANCED
AGE
ALZHEIMER
AMYLOID
ASSISTANCE
BRAIN
CAREGIVER
COMBATIVE
COMPLEX
COPING
DEGREES
DEMENTIA
DETACHMENT
DISEASE
DOCTOR
EARLY STAGE
ERRATIC
FORGETFUL
GRADUAL
HISTORY
HOSPICE
ILLNESS
IMPAIRED
INABILITY
LASPE
LOSS
MEMORY
MODERATE
NEUROLOGICAL
NURSING HOME
OUTBURST
PERSONALITY
PHYSIOLOGY
PILLS
RECALL
REHABILITATE
RELIANCE
SYNAPSES
TESTS
THERAPIST
TREATMENT
UNCERTAIN
VISITS
WANDERING OFF
WARY

FirstChoice VIP CARE PLUS by Select Health of South Carolina | Healthy Connections PRIME

FCVIPCPSC-17525

All images are used under license for illustrative purposes only.
Any individual depicted is a model.

www.firstchoicevipcareplus.com

FirstChoice VIP CARE PLUS by Select Health of South Carolina | Healthy Connections PRIME

The Advantage

A Newsletter for Providers

Summer 2017

P.O. Box 40849
Charleston, SC 29423

FirstChoice VIP CARE PLUS by Select Health of South Carolina | Healthy Connections PRIME