CareFirst BlueChoice
CareFirst BlueCross BlueShield

PCMHConnector
Primary Care Medical Home

Volume 1, Issue 1

Welcome to *PCMHConnector*

Welcome to *PCMHConnector*, CareFirst's online newsletter designed to help you better understand our Primary Care Medical Home (PCMH) program.

We're glad that so many of you have joined PCMH – at last count, more than **2,800** primary care physicians and nurse practitioners had joined. We look forward to working with you as you work with us to improve the quality and efficiency of care delivered to CareFirst members.

PCMHConnector is dedicated to providing meaningful support to all participating PCMH physicians and health care providers. In this and future issues of *PCMHConnector*, you will find helpful articles on what's happening in the PCMH community, important messages from CareFirst Medical Directors, care coordination team updates, PCMH seminars, online tools and more. You will also be able to offer suggestions on topics for future *PCMHConnector* articles.

Simply put, *PCMHConnector* wants to give you access to additional resources and information to help you get the most out of the program.

We hope you enjoy reading *PCMHConnector* and look forward to working with you. Look for the next edition of *PCMHConnector* this fall.

In This Issue

Your PCMH Care Coordination Team

The Support You Need, When You Need It

As a PCMH participant, a critical component of your success is the engagement and communication that you have with your PCMH Care Coordination Team. This team consists of Registered Nurses (RNs) in your community who will help you effectively coordinate the care of your patients who need it the most.

Led by **Cindy Friend**, Vice President of Regional Care Coordination, the **Care Coordination Team** includes a Regional Care Coordinator (RCC) and Local Care Coordinator (LCC) within your area who will work closely with you and your office staff. This team will assist with care coordination and help your

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Your PCMH Care Coordination Team

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patients receive the services, education and support that you feel would most benefit them in managing their chronic condition(s).

Eighteen RCCs with extensive experience in care management have been recruited for the PCMH program. To date, we have trained 13 highly qualified RCCs. They, along with your designated LCC, will help you with the clinical standards of quality for care plan documentation and care coordination for the PCMH program are met. The RCC will also be able to assist in resolving any PCMH issues that may arise. According to Cindy Friend, the goal is to introduce the RCCs and LCCs to all Medical Panels participating in the PCMH program by May 1, 2011.

"Our Provider Relations Representatives are coordinating meetings with the 230 Medical Panels, which consist of more than 2,800 PCPs, to introduce the RCCs and LCCs. We hope to complete the introductions between now and May," Friend said. "Once the introduction is established, the RCC will work with each PCP in that panel to identify patients that would benefit from care coordination. Our goal is to meet with all PCPs participating in the PCMH program by the end of the third quarter."

After the initial introduction, you will work closely with your RCC to identify a care plan eligible patient within your practice. With the help of your designated LCC, you will develop and manage a comprehensive care plan based on the particular needs of that patient.

"By the end of this year, we will have helped the PCPs develop 12-15 individualized care plans for their high-risk patients," Friend said. "Our overall goal is to have more than 20,000 active care plans in place by the end of 2011."

Serving as your day-to-day, front-line support, the LCC will help facilitate timely follow-ups for care plan eligible patients and seeks to ensure that they adhere to your plan of care. The LCC can help patients understand the importance of following your plan of care and identify additional services needed to meet the goals outlined by you in their individual care plan.

This type of working relationship will allow you to remain the "quarterback" in delivering care to your patients. Having a LCC within the community provides you with a RN that is readily available to support your patients, identify local services and have face-to-face interactions to discuss the progress of each patient and determine if any modification to the care plan or additional follow-up with the patient is needed. Establishing a strong communication channel between you and your LCC will allow you to have a more hands-on approach with your patient and can help engage your patients so they can better manage their medical problems before they become medical crises.

We are working hard to provide you with the tools and proper support you need to be successful in this program. With day-to-day interactions with your Care Coordination Team, we'll work together to address barriers to care and work to produce better results and lifestyle outcomes for your patients, our members, over time.

For more information about the Care Coordination Team, click here.

(Left to Right): Zina Kendell, Mary Roberts, Qui Noh, Dee Jones, Eileen Pencek, Molly Dice, Joann Wilson, Lynn Moratis, Sheverly Nail, Carla Gates, Sandra Toon, Georgette Moderacki, and Cindy Friend (Not pictured: Kimberly Dyson-Lomax, Kathryn Fiddler, Belinda McNealey, Ellen Dieujuste, Heather Williamson, and Stephanie Messersmith)

Get a Head Start as a PCMH

Register for Training Today

You may have already received an email* from us regarding our new PCMH training opportunities, if not – keep reading.

We believe that one of the first steps to your PCMH success is ensuring that you have opportunities to learn about the many aspects of the program. To help you, we have created 30 minute web-based seminars (webinars) to help you transform to a PCMH. All opportunities are listed in the **Provider Education and Training Opportunities** section of the **CareFirst** website.

If you are a Portal Administrator: Register today

As a Portal Administrator, you play a vital role in helping your PCMH get started. To begin using the online tools we have created to make program participation easy, you must enroll in our training. Once you have completed training, you will be able to use your CareFirst Direct log-in to access the PCMH Online Services (Portal). You will then be able to grant and manage access within your practice.

IMPORTANT: Please be sure you have access to CareFirst Direct prior to the webinar. If you do not have access, click here to register.

*To sign-up for our PCMH news via email **click here**.

If you are a Panel Administrator:

There is also a webinar available for Panel Administrators. Office Managers or Practice Administrators may also find it beneficial to complete this training. In addition, we offer a variety of training classes for others within the practice. This includes an Introduction to PCMH, A PCMH Online Services Overview, The PCMH Consent Process and Entering a Referral.

How will I know which class to attend?

For a complete description of each module, **click here**.

How do I register?

To register, **click here**.

Once registered, you will receive an e-mail the day prior to your training. It will include log-in information and a copy of all materials used during the session.

Whether you are a Portal Administrator, a Panel Administrator, a provider or an office administrator/staff member, we encourage you to take advantage of the training opportunities available. We will add additional webinars throughout the year and send updated information through our PCMH newsletter, *PCMHConnector*, the web and emails.

Not sure of your role within the PCMH?

Click here or contact your Provider Relations Representative.

Where are My CareFirst PCMH Emails?

If you've signed up for our Primary Medical Home (PCMH) emails, but haven't been receiving them — check your spam. With an initiative as important as PCMH, you do not want to miss our updates.

To ensure our communications make it to your inbox, we've put together instructions on how to add our email address, pcmhinfo@carefirst.com, to your "safe sender" list. By placing **pcmhinfo@carefirst.com** on this list, your email service provider will know to trust our emails and place them in your inbox.

For step-by-step instructions on how to make CareFirst's pcmhinfo@carefirst.com a "safe sender", click here.

PCMH Provider Online Services (Portal)

Top Five Things You Need to Know

CareFirst has launched new PCMH Provider Online Services, specifically for PCMH participants like you. This secure section has the same capabilities you had with CareFirst Direct, but also allows you to see:

- A complete roster of your CareFirst patients
- A general depiction of your patients' health risk status
- Whether a patient has consented to participate in PCMH
- If a patient has a care plan
- Complete care plan details

Wondering where to start?

Here are five things you should know:

1. We have created online training opportunities for you.
To receive your log-in information and begin using PCMH Online Services, your Portal Administrator will need to attend our Portal Administrator Training. This 30-minute webinar will teach the Portal Administrator how to navigate the PCMH Online Services portal. Upon completion and receipt of log-in information, they will also be able to grant and manage access to users within the practice.

For more information, refer to *"Get a Head Start as a PCMH"* in this issue.

IMPORTANT: Please be sure your Portal Administrator has access to CareFirst Direct prior to the webinar. If they currently do not have access, click here to register.

2. All PCMH Online Services are Health Insurance Portability and Accountability Act (HIPAA) compliant and secure.
Our PCMH program promotes information sharing between patients and their physicians/providers so that both have a complete picture of existing and potential health risks, with the goal of improving health outcomes. Security restrictions on this patient health information will allow your panel to see information only on patients who have been attributed to your medical panel and have given consent for data sharing. Patient information will be shared, but only among those providers in your panel who are also treating the patient. This will allow you to make informed decisions as you work with your Care Coordination Team to monitor care plan progress.

3. Members are attributed monthly.
During every month of the PCMH program, CareFirst attributes members to the PCP the patient has either selected or actually visited based on claims history. This attribution then appears in your member roster so that you can manage all of the patients in your panel.

In addition to basic patient information, such as name and date of birth, we also provide you with their **Illness Burden Score**. This score is characterized by a color in the roster that corresponds to how healthy they appear based on claims data, as well as age and gender.

- Red = Advanced Illness
- Orange = Multiple Chronic Conditions
- Yellow = At Risk for Multiple Chronic Conditions
- Light Green = Stable
- Dark Green = Healthy

4. Your patients must consent to participate.
By signing an Authorization and Consent for Participation **form**, your patients agree to participate and authorize the release and sharing of medical information through the program's online tools accessible to care team members.

If a patient signs the consent form in your office, you can enter this information online and begin a care plan, if warranted. **Consenting to participate will not change your patient's benefits**

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PCMH Provider Online Services (Portal)

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in any way or affect the rules of your contracted coverage plan with CareFirst. Patients will, however, benefit from coordinated care from a provider who knows them.

At any time, a patient can choose to not participate by completing the **Revocation of Authorization for Consent** form and will continue to receive care with no adverse consequences. However, we recommend that all patients consent to participate. Having consent on file for all patients will allow the member of your panel to review patient data and share it. This will help determine gaps in care and help the panel work as a team to provide needed care and enhance quality metric scores that affect Outcome Incentive Awards.

5. Patient Health Record/Care Plans – What Will Be Shared?
The information in the Patient Health Record is only what is available through CareFirst claims data (rolled up to an episode of care) and other information received by CareFirst. It will include rendering provider information, when available; however, it will not include pricing information or any notes, observations or additional information that is available in your practice's electronic health records.

If your practice already has an electronic health record system or practice management system in place, we will work with you to facilitate the exchange of information in a standardized format.

The care plan provides a template for nationally recommended care **guidelines**. Care plans are only developed for those patients with the most serious illnesses who have completed a **consent form**. All care plan information that is entered and maintained for a particular patient will also be available. This includes all notes, referrals and other information entered into the record by the PCP and the Care Coordination Team.

The information above should help you get started with our online services. We will continue to provide updates through training, the web and email communications.

We want to ensure that the PCMH program is a partnership and that we are available for you as we work towards making the program the best it can be for you and our members. If you still need help, please refer to the contacts below.

For general questions	Enrollment or overall program questions	Technical issues with our online services
Please contact your Provider Service Representative.	Should be directed to your enrollment coordinator at 888-646-2604.	Can be resolved by the CareFirst help desk at 877-526-8390, Monday – Friday 7 a.m. – 6 p.m. and Saturday 7 a.m. – 1 p.m.

PCMH SPOTLIGHT

A message from **Dr. Jon Shematek**, Senior Vice President and Chief Medical Officer

"We're in this together."

As Chief Medical Officer at CareFirst BlueCross BlueShield, I again welcome you to the CareFirst PCMH program. We are well into the second quarter, and are gratified with the interest and commitment of the primary care physicians and nurse practitioners in our network—with over **2,800 program participants in a short period of time**.

My role is to oversee the clinical aspects of the PCMH program – from medical guidelines and quality measures to ensuring your care coordination team is the best available—as we gradually implement the program. Over the course of time, our goal is to focus on the whole patient, improve quality and access for all of our members – while reducing care costs.

As we work to achieve this goal, **my message** is simple – we are partners.

Audio Note: LCCs are not employed by CareFirst.

PCMH Helpful Tips

Have a question? Do you want to see an article on a specific topic or have a helpful tip that your colleagues may benefit from? This section will give you important information beneficial to your PCMH based on questions/comments we have received from participants.

If you have suggestions for future tips, please email **newsletter.editor@carefirst.com**.

What is the CareFirst PCMH Care Plan?

The CareFirst PCMH care plan is a longitudinal, dynamic, electronic record documented and maintained in a web-based proprietary application by the Local Care Coordinator (LCC) in collaboration with the Primary Care Provider (PCP). The care plan details plans for managing a patient's identified chronic medical condition(s) based upon evidence-based medicine. In order to minimize the work effort required by the PCP/PCMH, this documentation is completed by the LCC and other members of the team, with direction from the PCP; however, the PCP is responsible for the plan being carried out under his or her direction.

The care plan is tailored to a specific patient's needs and diagnoses and is developed upon evidence-based care guidelines, which assists the PCP in establishing clinical goals. The PCP maintains responsibility for the care plan implementation and follow-through, with assistance from the LCC.

Who qualifies for a care plan[1]?

Each month, the Illness Burden Scores (IBS) for attributed members are calculated and the members are stratified across the five illness burden bands. We use an industry standard methodology that calculates the IBS based on members' age, gender and diagnosis codes.

How will I know who qualifies for a care plan?

The Patient Roster will indicate patients who may benefit from a care plan and focus on the patients within Bands 2 and 3 who have one of the nine targeted clinical conditions selected for the PCMH program that, when managed, can reduce costs and improve outcomes. These conditions include the following:

- Diabetes
- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Artery Disease (CAD) with or without myocardial infarction (MI)
- Congestive Heart Failure (CHF)
- Hypertension (HTN), generally as a co-morbid condition
- Osteoarthritis (hip, knee, other joint conditions)
- Childhood Obesity
- Back Pain

The PCP may also identify patients with one of the nine clinical conditions who may benefit from a care plan. The PCPs can work with their LCC to ensure the patient is right for a care plan and to begin care plan development.

It is important to note that not all members in Bands 2 and 3 will qualify.

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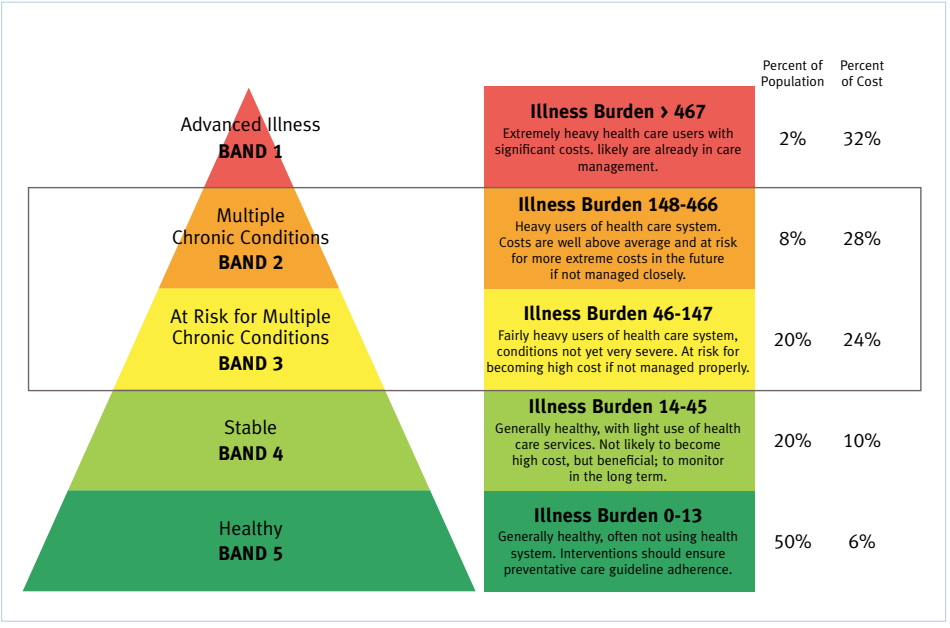

[1] Care plans will focus on the patients within Bands 2 and 3 who have one of the nine targeted clinical conditions selected for the PCMH program.

PCMH Helpful Tips (continued)

What is the role of the Designated Provider Representative?

The designated provider representative (DPR) is the individual assigned by each panel to act as primary point of contact between the panel and CareFirst for medically related discussions. For example, if the DPR has questions on the quality measures or needs further clarification, they can reach out to the RCC for additional guidance.

For efficient and effective discussions and decision-making, each panel should select only one DPR.

In the event that a practice is comprised solely of Nurse Practitioners (NP)[2], a NP may serve as the DPR.

The DPR provides leadership on behalf of the panel for the following:

- Ensuring provider compliance with all requirements of the PCMH program
- Disseminating medically related information and PCMH updates to the panel providers
- Collaborating closely with the RCC and LCC to maintain an open line of communication that facilitates quality care and PCMH program development
- Monitoring quality measure progress and serving as the primary spokesperson for disseminating information about the Outcome Incentive Award to the panel

[2] To practice as an independent PCP, NPs must be certified by their relevant approved National Certification Board and meet all licensing certification guidelines of the state in which the NP practices. NPs must also file an attestation that they have a written collaborative agreement with a physician of the same specialty who is in good standing in the same CareFirst provider networks.

Tell Us What You Think

How are we doing? How has *PCMHConnector* helped you? Let us know how *PCMHConnector* has made an impact.

Please tell us about your experience(s) with *PCMHConnector.* Let us know what you think – what we're doing right and what we could do better.

Our goal is to provide you with the best articles possible and your feedback is vital.

Email your comments to newsletter.editor@carefirst.com.