CareFirst
The CareFirst BlueCross BlueShield family of health care plans

PCMHConnector
Patient-Centered Medical Home

Volume 4, Issue 1

Improved Patient Outcomes Start Here

Launched in 2011, CareFirst's Patient-Centered Medical Home (PCMH) Program was created to help your patients with the greatest health needs get focused support and assistance to better manage their health.

With new incentives, online tools and resources, the program has continued to develop since its inception with nearly 4,000 primary care physicians (PCPs) and nurse practitioners (NPs) joining the program to date.

Whether you are new to the program or already engaged, *PCMHConnector* is your online, PCMH-specific newsletter created to help you and your Panel:

- **Understand Program elements**
- **Identify patients who would benefit from more focused care**
- **EARN MORE**

In this issue, we focus on care coordination, Care Plan development and the positive patient outcomes that result. Get the most out of this issue and be sure to click on each link in this issue to access more information.

***PCMHConnector:* improved patient outcomes start here.**

In This Issue

Outcome Incentive Awards (OIAs) for Performance Year 3 have been announced.
How to view yours inside.

PCMH Spotlight

Care Coordination = Positive Outcomes

Within the PCMH Program, you work with your health care team to identify patients who may benefit from care coordination.

Click on the questions below to hear Kathryn Fiddler, Senior Director of Regional Care Coordination for PCMH, explain the role of the Local Care Coordinator (LCC) and how their clinical experiences and assistance can support you, your Panel and your patients.

What is the role of the LCC?	*Watch video*
How does the LCC support a provider in the Program?	*Watch video*
What would you say to both engaged providers and those thinking about joining PCMH?	*Watch video*

Trust Your Local Care Coordinators (LCCs)

Clinical Experts Trained to Support You in PCMH

We are committed to having the best care coordinators in place to help you manage your patients most in need of care coordination.

Our Local Care Coordinators (LCCs) are a team of experienced, registered nurses who help improve patient care by providing efficient care coordination to CareFirst members. Each LCC brings a wealth of prior clinical experience and a passion for what they do.

The clinical expertise of the LCCs coupled by ongoing PCMH Program training – including an intensive four week training class, monthly team educational sessions, shared best practices, and advanced clinical education programs – helps support you in identifying and accessing the right resources at the right time for your patients.

As you lead the direction of care for your patients with chronic and multiple, complex conditions, the nursing support through PCMH and your assigned LCC complement your clinical efforts.

SearchLight Reports

Shine a Light on Patient Data

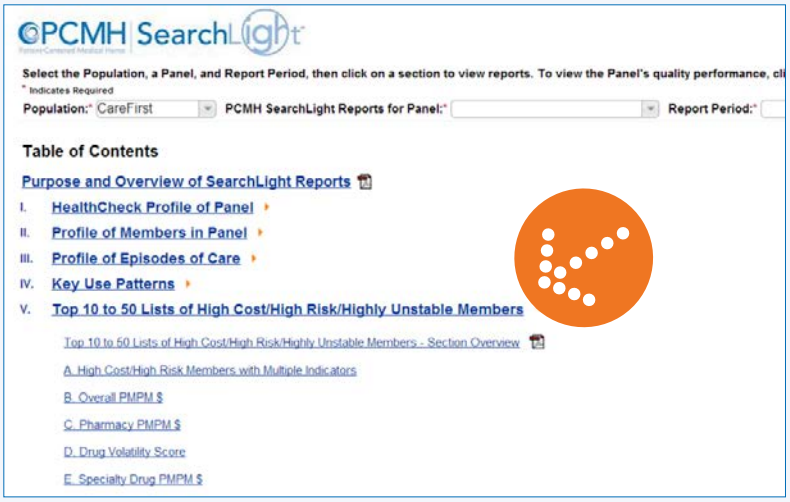
Within the PCMH Provider Portal (iCentric), **SearchLight Reports** are available online 24/7 that show the cost, quality, illness and demographic patterns for your member population in the Program and compared to other Panels.

These reports help you and your LCC work together to identify patients that would benefit from the Program. Most importantly, the **Top 10 to 50**.

Top 10 to 50 Report

How to Find It

- Login to the PCMH Provider Portal (iCentric) at **www.carefirst.com/providers**
- Click on the SearchLight tab at the top.
- Then, click on V—**The Top 10 to 50 Lists of High Cost/High Risk/Highly Vulnerable Members**.



How to Use It

This report highlights your top 10 to 50 patients who have high-risk or multiple chronic diseases based on a number of different categories from high prescription utilization to significant hospital admissions.

With your patients identified, you can introduce them to the Program. (For materials to help you start this dialogue, read *Where to Go? PCMHinfo* in this issue.)

Questions?

Reach out to your PCMH Program Consultants if you have any questions about the data provided in the SearchLight Reports.

Definition:

pro . gram
con . sul . tant
(noun)

The go-to person in your region who can look at your complex patient data with you, help you understand what you're seeing in SearchLight, and answer any questions you may have.

Get the Maximum Benefit Out of the PCMH Provider Portal

If you do not currently use the PCMH Provider Portal (iCentric), your Panel is missing out.

Join us for an upcoming training webinar to discuss:

- the role of the Portal Administrator
- how to view panel information and the roster
- how to search for a patient, update their election to participate form and create a referral
- how to navigate and important points about the member health record
- best practices for user management

New to the PCMH Provider Portal (iCentric)?

We've developed several provider portal user guides for your Portal Administrator to use to set-up access for your Panel.

- Create a New User
- Reset a Password
- Grant Access to Your Practice
- Activate a Care Plan—***NEW***

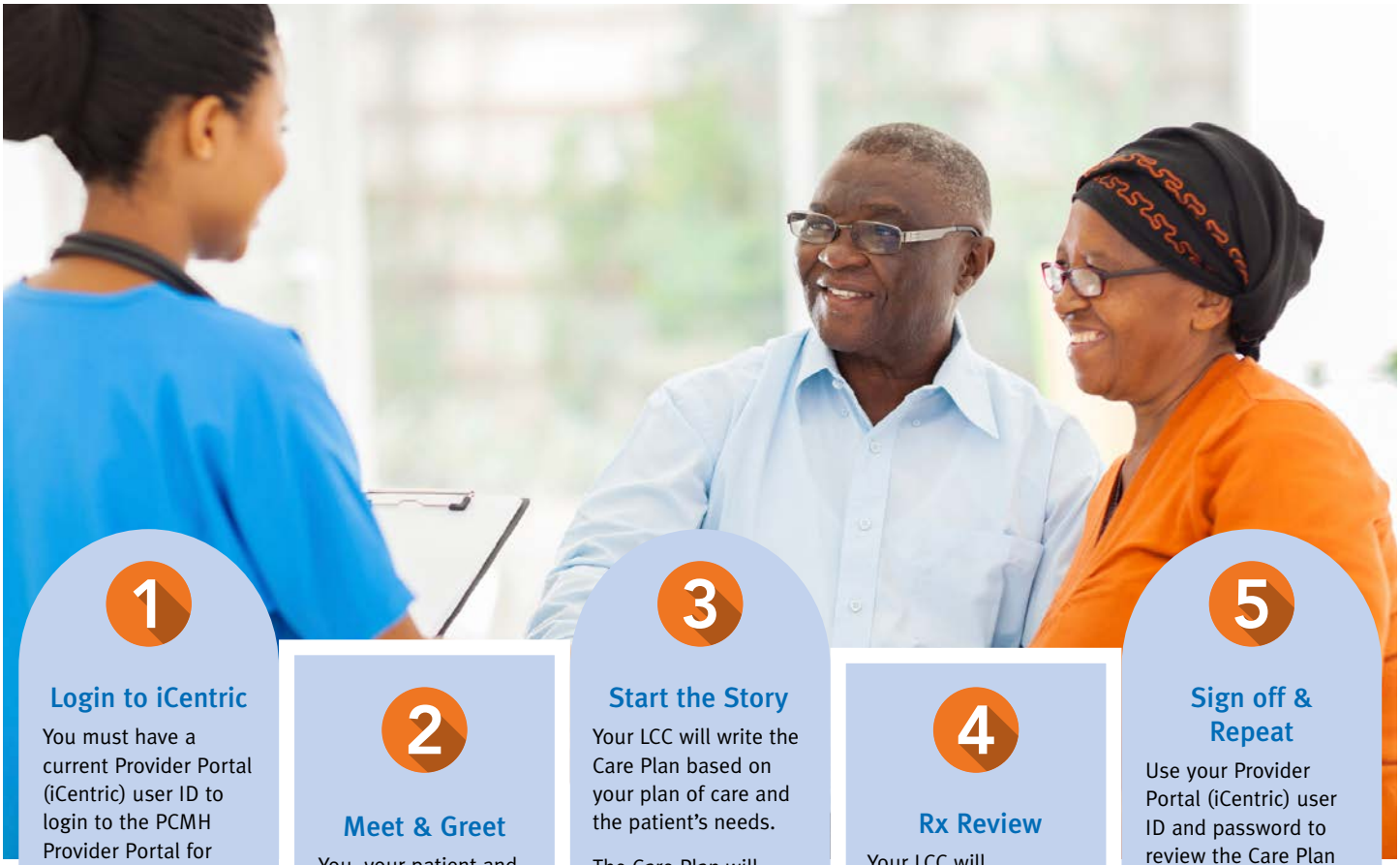
Has your Portal Administrator changed?

If so, your new Portal Administrator needs to take this training. Visit www.carefirst.com/cpet to register for the next webinar.

Outcome Incentive Award (OIA) notifications were mailed on May 30, 2014. How did your Panel fare? Use these steps to login to the Provider Portal (iCentric) to view your SearchLight Report data and OIA for Performance Year 3.

Care Plan Success in Five Easy Steps

Follow the steps below and listen to Kathryn Fiddler, Senior Director of Regional Care Coordination, define a Care Plan and explain how this record of treatment can help lead to positive health outcomes for your patients.



1 Login to iCentric

You must have a current Provider Portal (iCentric) user ID to login to the PCMH Provider Portal for Care Plan access.

Contact your Program Representative or LCC to support you with this process.

Or, use the link above to Create a New User.

2 Meet & Greet

You, your patient and your LCC will meet to discuss:

- The role of the LCC
- The process of care coordination, and
- How the patient will benefit from the Program.

3 Start the Story

Your LCC will write the Care Plan based on your plan of care and the patient's needs.

The Care Plan will include the patient's medical history, current problems and future goals.

4 Rx Review

Your LCC will complete medication reconciliation in the patient's Care Plan by:

- developing a comprehensive list of the medications the patient is taking,
- discussing the list with the patient, and
- completing a review of the medical records.

5 Sign off & Repeat

Use your Provider Portal (iCentric) user ID and password to review the Care Plan and sign-off on it.

Your sign-off means the Care Plan has been activated.

TIP

Be sure to maintain the Care Plan on an ongoing basis.

TCCI Program: 12 Supporting Elements Help Panels "Win"

The Total Care and Cost Improvement (TCCI) Program, comprised of 12 elements, offers additional support services to help your patients achieve the highest level of recovery and stabilization.

The TCCI elements give you access to additional programs and services to further support your patients and their varying care needs, and help you and your Panel achieve the goals of improving care quality and lowering overall care costs.

The core PCMH model is supported by all twelve of the TCCI elements.

Click each box below to learn more.

Patient-Centered Medical Home Program (PCMH)

- Hospital Transition of Care Program (HTC)
- Home Based Services Program (HBS)
- Pharmacy Coordination Program (RxP)
- Urgent Care & Convenience Access Program (UCA)
- Complex Case Management Program (CCM)
- Enhanced Monitoring Program (EMP)
- Expert Consult Program (ECP)
- Centers of Distinction Program (CDP)
- Chronic Care Coordination Program (CCC)
- Comprehensive Medication Review (CMR)
- Community-Based Programs (CBP)
- Substance Abuse and Behavioral Health Program (SBH)

Share the Wealth

Help Your Colleagues Earn More, Too

In addition to improving patient outcomes, the PCMH Program significantly rewards PCPs and NPs with fees and incentives for actively coordinating and managing patient care.

If someone in your practice or a neighboring practice wants more information about the PCMH Program, invite them to join us at an upcoming Town Hall meeting for dinner and details.

Attending a PCMH Town Hall is the best way for your colleagues to:

UNDERSTAND…

how to earn substantial rewards for coordinating and managing care

LEARN…

how dedicated support and resources can help improve their patients' health outcomes

RECEIVE…

information on enrollment and discuss any questions with Program Representatives and other providers who are already participating

Get Paid Faster

After all, it's your money… claim it now.

1 Update your PCMH Provider Information.

If there has been a change to your PCMH information. Complete the *Changes in PCMH Provider Information* form and send to **PCMH@carefirst.com**.

2 Take advantage of our self-service tools to check eligibility, submit pre-authorization requests or receive email updates.

Watch this short video for CareFirst's 6 easy online tools that can help you do just that.

3 Register for electronic fund transfer and electronic claim submission.

Visit **www.carefirst.com/electronicclaims**.

4 Know your PCMH Provider Representative.

If you are unsure of the PCMH Provider Representative for your area, visit **www.carefirst.com/providerrep**.

Spread the word.

Encourage your colleagues to register to attend the next PCMH Town Hall meeting. Visit **www.carefirst.com/joinpcmh**, email **PCMHTownHall@carefirst.com** or contact our PCMH Enrollment Coordinator at (410) 872-3519 today.

As a reminder, enrollment materials and additional program resources can also be found online at **www.carefirst.com/pcmhinfo**.

Where to Go? PCMHinfo

www.carefirst.com/pcmhinfo

Are you looking for care coordination materials like the Election to Participate form, program talking points or portal user guides? Check out our PCMH provider website, www.carefirst.com/pcmhinfo.

Here, along with up-to-date provider materials, like the recently updated **Program Description and Guidelines**, are Member resources to encourage your patients to participate in the Program and how they can benefit, including:

- Member Talking Points – use these to discuss the program with your patients
- Member Template Letter – edit and print, or use the copy on your letterhead as a basis for a customized personal letter
- Member Website (www.carefirst.com/memberpcmh) – links, information and resources to help your patients understand the benefits of PCMH

Calling On Your Expertise

We need your advice

Have you found a particular resource especially helpful?

Are you looking for PCMH information that you can't find?

What did you like or not like about this issue of *PCMHConnector*?

You expertise could help us craft our next issue. Email your comments to pcmhinfo@carefirst.com.

Stay Connected.

It matters for your patients.

When you register to receive PCMH emails, you receive updates when materials (like those mentioned above) are revised and when new materials are available. PCMH emails also share program details, new program elements, and support tools for you and your patients.

What else are you missing if you don't receive PCMH emails?

- **Care Plan tips and best practices**
- **The results of your annual Outcome Incentive Award**
- **Targeted information based on your role in the program**

Don't delay—visit www.carefirst.com/stayconnected.

IT'S AS EASY AS...

Register to receive PCMH specific emails

Open the email when it comes to your inbox

Read the content and put it to use