

Care Management

This section provides information on care management programs available for your CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst) patients.

Per the terms of the Participation Agreement, all providers are required to adhere to all policies and procedures contained in this manual, as applicable.

If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this section and notify you through [email](#) and [BlueLink](#), our online provider newsletter.

Specific requirements of a member's health benefits vary and may differ from the general procedures outlined in this manual. If you have questions regarding a member's eligibility, benefits or claims status information, we encourage you to use one of our self-service channels; [CareFirst Direct](#) or [CareFirst on Call](#). Through these channels, simple questions can be answered quickly.

Read and print the [Guidelines for Provider Self-Services](#).

Quality improvement (QI) program

The goal of the quality improvement (QI) program is to continuously improve the quality and safety of clinical care, including behavioral health care, and the quality of services provided to members within and across health care organizations, settings and levels of care. CareFirst strives to provide access to health care that meets the Institute of Medicine's aim of being safe, timely, effective, efficient, equitable and patient-centered.

QI program goals and objectives

1. Support and promote all aspects of the CareFirst Patient-Centered Medical Home (PCMH) program and the Total Care and Cost Improvement (TCCI) programs as a means to improve quality of care, safety, access, efficiency, coordination and service.
2. Maintain a high-quality network of providers and practitioners to meet the needs of the population we serve.
3. Implement methods, tracking, monitoring, and oversight processes for all TCCI programs to measure their value and impact for appropriate patients with complex health care needs.
4. All elements of the CareFirst TCCI program will be operating at targeted levels.
5. Establish collaborative partnerships to proactively engage clinicians, providers and community hospitals and organizations to implement interventions that address the identified (medical and behavioral) health and service needs of our membership throughout the entire continuum of care and those who are likely to improve desired health outcomes.
6. Deliver data and support to clinicians to promote evidence-based clinical practice and informed referral choices and members to use their benefits to their fullest.

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7. Maintain a systematic process to continuously identify, measure, assess, monitor and improve the quality, safety and efficiency of clinical care (medical and behavioral health) and quality of service.
8. Assess the race, ethnicity, language, interpreters, cultural competency, gender identity and sexual orientation needs of our diverse populations while considering such diversity in the analysis of data and implementation of interventions to reduce health care disparities, improve network adequacy and improve cultural competency in materials and communications.
9. Monitor and oversee the performance of delegated functions.
10. Develop and maintain a high quality network of health care practitioners and providers who meet the needs and preferences of the membership by maintaining a systematic monitoring and evaluation process.
11. Operate a QI program that is compliant with and responsive to federal, state, and local public health goals and requirements of plan sponsors, regulators and accrediting bodies.
12. Provide insight based on SearchLight data to increase the knowledge base of the medical panels in the evaluation of their outcome measures.
13. Address health needs of all patients along the health care continuum, including those with complex health needs (advanced developmental, chronic physical and/or behavioral illness or complicated clinical situation).
14. Support quality improvement principles throughout the organization; acting as a resource in process improvement activities.

CareFirst recognizes that large racial and ethnic health disparities exist and communities are becoming more diverse. Racial, ethnic and cultural background influence a member's view of health

care and its results. CareFirst uses member race, ethnic and language data to find where disparities exist, and we use the information in quality improvement efforts.

QI committees

CareFirst's multi-disciplinary committees and teams work closely with community physicians to develop and implement the QI program.

Clinical practitioners, including designated behavioral health care practitioners, provide input and feedback on quality improvement program activities through participation in the following committees:

Committee	Purpose
Quality Improvement Advisory Committee (QIAC)	A multi-specialty committee of practitioners who advise the insurer about standards of medical and behavioral health care
Quality Improvement Council (QIC)	Evaluates the quality and safety of clinical and behavioral health care and the quality of services provided to members
Credentialing Advisory Committee (CAC)	Reviews the credentials of practitioners and other providers applying for initial or continued participation in the plan
Care Management Committee (CMC)	Monitors and analyzes the care management program and promotes efficient use of health care resources by members and practitioners
Delegation Oversight (DOC)	Monitors and analyzes performance of all delegates performing functions on behalf of CareFirst

Performance data

A status of performance and evaluation of meeting goals of the QI program can be found at [carefirst.com](https://www.carefirst.com). CareFirst and CareFirst BlueChoice retain the right, at their discretion, to use all provider and/or practitioner performance data for QI activities including but not limited to, activities to increase the quality and efficiency to members (or employer groups), public reporting to consumers and member cost sharing.

National Committee for Quality Assurance (NCQA)

All CareFirst's health maintenance organization (HMO) and preferred provider organization (PPO) products are accredited. Accreditation is awarded to plans that meet NCQA's rigorous requirements for consumer protection and quality improvement.

NCQA is an independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed Care Plans. NCQA's Accreditation standards are publicly reported in five categories:

- **Access and service**—do health plan members have access to the care and service they need?
- **Qualified providers**—does the health plan assess each doctor's qualifications and what health plan members say about its providers?
- **Staying healthy**—does the health plan help members maintain good health and detect illness early?
- **Getting better**—how well does the health plan care for members when they become sick?
- **Living with illness**—how well does the health plan care for members when they have chronic conditions?

Patient-Centered Medical Home (PCMH) program

CareFirst's PCMH program is designed to provide primary care providers (physician or nurse practitioner) with a more complete view of their

patients' needs and services they receive from other providers to better manage their individual risks, keep them in better health and produce better outcomes. The program requires greater provider-patient engagement and it meaningfully compensates providers for that engagement.

As part of CareFirst's PCMH program, the chronic care coordination program provides coordination of care for patients with multiple chronic illnesses and is carried out according to care plans developed under the direction of the PCP. While care plans may result from a case management or HTC episode, they also originate from a review of the trailing 12 months of health care use by an attributed member who is identified as likely to benefit from a care plan.

Care coordination for these patients is carried out through the local care coordinator (LCC) who is assigned to each provider/practice within a panel. The LCC assists the PCP in coordinating all elements of the patient's health care, ensuring all action steps in the plan are followed up and carried out. CareFirst provides online tailored care plan templates that are suitable for the needs of members with various chronic diseases (i.e., diabetes, asthma, COPD, coronary artery disease, congestive heart failure, hypertension, childhood obesity), or for members with condition clusters (i.e., a member with diabetes, obesity and congestive heart failure; or a member with coronary artery disease with myocardial infarction and hypertension).

The vast majority of patients for whom care plans are most appropriate have multiple morbidities. Each care plan template is based on the latest evidence-based clinical care guidelines for the condition or cluster.

The PCMH program has a significant upside for the provider, for the patient and CareFirst as a steward of its members' health care dollars. For more specific program information, including eligibility and how to get started, visit [carefirst.com/pcmhinfo](https://www.carefirst.com/pcmhinfo).

Disease management programs

CareFirst offers **disease management** programs designed to reinforce and support the physician's plan of care. All programs are voluntary and confidential.

CareFirst uses claims data to identify members with the following chronic conditions who are eligible for disease management: asthma, diabetes, coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), heart failure, chronic low back pain, osteoarthritis, atrial fibrillation, irritable bowel syndrome (IBS), and fibromyalgia. The programs help educate members about their diseases and how to manage them, which will improve medical outcomes and quality of life. Services range from quarterly educational mailings to case management and access to a support nurse by phone 24 hours a day, seven days a week.

To obtain more information or to enroll patients into one of these programs administered by Sharecare, call 800-783-4582.

Please note: These programs are not currently available to all members. Please verify the member's benefits.

Respiratory diseases (asthma, COPD)

CareFirst offers comprehensive disease management programs for members with asthma and chronic obstructive pulmonary disease (COPD). These confidential, voluntary programs:

- Help members learn how to self-manage their condition
- Reinforce the physician's plan of care
- Are administered by Sharecare

Enrolled members:

- Can access a nurse by phone 24-hours a day, 7 days a week
- Are assigned a nurse care manager, if disease is severe
- Receive educational materials, including condition-specific workbooks, action plans and newsletters.

To obtain more information, refer a patient or if you are a member and want to self-refer, call the asthma management program at 800-783-4582.

COPD resources/related links

CareFirst follows the Asthma and COPD guidelines established by National Heart Lung and Blood Institute and World Health Organization. The COPD guidelines can be obtained from goldcopd.org.

Diabetes

CareFirst offers a comprehensive disease management program for members with diabetes. This confidential, voluntary program:

- Provides routine updates to keep physicians informed about patients' progress and adherence to the plan of care
- Reinforces the physician's plan of care
- Is administered by Sharecare

Enrolled members:

- Can access a nurse by phone 24 hours a day, seven days a week
- Are assigned a nurse care manager
- Receive educational materials, including condition-specific workbooks, action plans and newsletters.

To obtain more information or to refer a patient, please call the diabetes management program at 800-783-4582.

Diabetes resources/related links

The following information/journals can be found at <http://care.diabetesjournals.org/>.

- Standards of medical care in diabetes
- Nutritional recommendations and interventions for diabetes

Heart disease

CareFirst offers a comprehensive disease management program for members who have or are at risk for congestive heart failure (CHF) and coronary artery disease (CAD). This confidential, voluntary program:

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- Provides routine updates to keep physicians informed about patients' progress and adherence to the plan of care
- Takes note of the high rate of heart disease among persons with diabetes
- Reinforces the physician's plan of care
- Is administered by Sharecare

Eligible members:

- Can reach a nurse by phone 24 hours a day
- Are assigned a nurse care manager (if greater disease severity exists)
- Receive educational materials, including condition-specific workbooks, action plans and newsletters

To obtain more information or to refer a patient, please call the CHF/CAD management program at 800-783-4582.

CareFirst supports the American Heart Association Clinical Guidelines. You may obtain a copy of these guidelines at americanheart.org.

Heart disease resources/related links

- [Clinical guidelines for the management of heart failure](#)
- [ACC/AHA/HFSA Focused Update of the ACCF/AHA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines and the Heart Failure Society of America](#)
- [AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol](#)
- [AHA/ACC guideline on lifestyle management to reduce cardiovascular risk](#)
- [ACC/AHA guideline on the assessment of cardiovascular risk](#)

Note: Additional heart health resources and links can be found in the clinical guidelines section of provider.carefirst.com.

Oncology

CareFirst's cancer management program seeks to ensure the best possible outcomes for members with cancer.

Enrolled members are assigned to an experienced oncology care manager who:

- Monitors their progress in conjunction with the physician's plan of care
- Provides educational and emotional support
- Is available by calling 888-264-8648, Monday-Friday from 8:30 a.m. to 4:30 p.m.

Providers may refer a member to the oncology program by calling 888-264-8648.

Clinical resources

Clinical resources are developed under our QI program and support our providers in treating chronic disease and conditions and providing preventive care. These resources include [clinical practice guidelines](#) and [preventive service guidelines](#).

Medical record documentation standards

The following resources are developed under our QI program and support our providers in maintaining office operations.

- [Medical record documentation standards](#)
- [Practitioner office standards](#)

Complex case management (CCM)

CareFirst has assembled a team of highly qualified registered nurses who work directly with our sickest members to manage the care of their complicated conditions. Using the web-based care management system, case managers have the ability to create a care management plan in our online portal. Recognizing the need for targeted capabilities for complex conditions, CareFirst has developed specialized case management for the following patient needs:

- Adult oncology
- Pediatric oncology

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- Complex medical
- Trauma/rehabilitation
- Special needs/complex pediatrics
- High risk obstetrics
- Hospice/palliative/end of life care

Health care providers, patients, family members, employers or anyone familiar with the case may refer candidates for CCM by calling 888-264-8648.

Outpatient pre-treatment authorization plan (OPAP)

OPAP is a pre-treatment program that applies to outpatient physical, speech and occupational therapy. Providers should use [CareFirst Direct](#) to enter their pre-treatment authorizations.

Coordinated home care and home hospice care

The coordinated home care and home hospice care programs allow recovering and terminally ill patients to stay at home and receive care in the most comfortable and cost-effective setting. To qualify for program benefits, the patient's physician, hospital or home care coordinator must submit a treatment plan to CareFirst. Authorization requests should be submitted via [CareFirst Direct](#). A licensed home health agency or approved hospice facility must render eligible services. Once approved, the home health agency or hospice is responsible for coordinating all services.

Hospital transition of care (HTC)

HTC monitors admissions of CareFirst members to hospitals anywhere in the country. Locally, it relies on specially trained nurses who are stationed in hospitals throughout the CareFirst region. The HTC program assesses member need upon admission and during a hospital stay with focus on post discharge needs. It begins the care plan process for members who will be placed in the complex case management (CCM) or chronic care coordination (CCC) programs. The HTC process also categorizes members based on the level of their severity of need and the nature of their illness or condition so they can be placed in the best possible track for

follow-up care coordination services. Cases that will likely result in high costs will be flagged to ensure the member receives the attention they need to avoid costly breakdowns in care.

Comprehensive medication review (CMR) program

The CMR program seeks to review and mitigate the potential for medication-related issues in high-risk and high-cost members. The program engages a specialized pharmacist to review a member's medication profile and identify medication recommendations. The pharmacist will evaluate for drug compatibility and interactions to ensure each drug is as effective as possible. Any medication recommendations and the reasons for the changes are communicated to the prescribing physicians.

Behavioral health and substance use disorder program (BSD)

CareFirst's BSD program is designed with a patient-advocacy focus. Our licensed behavioral health professionals provide behavioral health and substance use disorder care coordination to members in need. Services under this program include: BSD care coordination, transition of care services, needs assessment, assistance with locating providers and setting initial appointments. For more information visit [carefirst.com/pcmhguidelines](https://www.carefirst.com/pcmhguidelines).

Intake, Assessment and Appointment team

CareFirst's Intake, Assessment and Appointment team assists members and providers seeking medical, behavioral health and/or substance use disorder support. Services offered includes crisis intervention, needs assessment, program referrals, as well as assistance with locating providers and setting initial appointments.

Mandatory second surgical opinion program (MSSOP)

MSSOP is aimed at containing costs by reducing unnecessary diagnostic and surgical procedures. It also provides reassurance to patients having elective surgery by either confirming the need for the surgery or advising them of other forms of treatment. Some employer groups elect voluntary second surgical opinion (VSSOP), while others choose MSSOP for certain procedures. If a subscriber's contract requires MSSOP, a penalty is applied if the VSSOP is not obtained. A practitioner who is qualified to perform the surgery must perform the VSSOP. The program applies to a specific list of diagnostic and surgical procedures when they are performed on an elective, non-emergency basis. The procedures on the MSSOP list vary from account to account.

Utilization Control Program (UCP)/ Utilization Control Program Plus (UCP+)

These programs feature pre-admission review, admission review, continued stay review, retrospective review, and discharge planning. A notification of admissions to the CareFirst utilization management department is required. This notification is done in **CareFirst Direct**.

