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BlueCross BlueShield of South Carolina and BlueChoice HealthPlan are proud to support the patient-centered medical home (PCMH), an innovative concept backed by national medical societies and the Blue Cross and Blue Shield Association.

The National Committee for Quality Assurance (NCQA) defines a patient-centered medical home as a “health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient’s family. Care is facilitated by patient registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.”

A PCMH redesigns the way primary care is delivered and financed. Studies have demonstrated that PCMHs provide enhanced quality and safety by using evidence-based medicine and clinical decision-support tools to guide decision-making. More importantly, PCMHs improve health outcomes overall by managing chronic illness, improving compliance, reducing gaps in care, delivering preventive services and reducing health disparities.

Joining our initiative

CRITERIA FOR PARTICIPATION

During this initial phase of our PCMH initiative, participation is limited to targeted practices that have demonstrated readiness to transform to a PCMH model. We anticipate expanding our PCMH participation in 2012. For interested contracted practices, we will make the criteria and process for applying for participation available on SouthCarolinaBlues.com.

To participate in our PCMH initiative, providers must demonstrate their ability to support the tenets of the medical home concept through NCQA’s 2011 Patient-Centered Medical Home recognition program. The program reflects the input of the American College of Physicians (ACP), American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP) and American Osteopathic Association (AOA), as well as other interested stakeholders. The 2011 program reflects a stronger focus on patient-centeredness and alignment with CMS Meaningful Use Requirements.

> The NCQA 2011 PCMH recognition program consists of standards that are scored on a scale of 100 points. There are six standards, including six must-pass elements.

> Practices seeking PCMH recognition complete a Web-based data collection tool and provide documentation that validates responses. The six standards and their respective must-pass elements are:

1. Enhance access and continuity
   - Access during office hours
2. Identify and manage patient populations
   - Use data for population management
3. Plan and manage care
   - Care management
4. Provide self-care and community support
   - Support self-care process
5. Track and coordinate care
   - Track referrals and follow-up
6. Measure and improve performance
   - Implement continuous quality improvement

The NCQA PCMH recognition program has three levels of achievement:

> Level I is awarded to practices that score between 35 and 59 points and must include all six must-pass elements.

> Level II is awarded to practices that score between 60 and 84 points and must include all six must-pass elements.

> Level III is awarded to practices that score between 85 and 100 points and must include all six must-pass elements.

Eligible providers must receive at least Level I NCQA 2011 PCMH accreditation within six months of contract execution, and Level II NCQA 2011 PCMH accreditation within 18 months. For a readiness assessment and other resources to assist you with your application process, please see Appendices 4 and 5.
Getting started

Preparing for launch

Before launching a medical home, we will work with you to identify eligible patients and targeted diseases. We will also establish fees and services that will be covered for you, based on your capabilities and strengths.

The BlueCross and BlueChoice HealthPlan PCMH program is currently designed for patients with diabetes, congestive heart failure or hypertension. Actively treated BlueCross and BlueChoice HealthPlan members with one of the International Classification of Diseases 9th edition (ICD-9) codes in Appendix 1 may be considered eligible for participation.

Patient identification

Near the time of your contract implementation date, we will give you a list of your patients who are eligible for participation in the PCMH program. This information will be sent electronically in a HIPAA-compliant, secure format and will include these fields:

> Subscriber ID number
> Database number
> Patient ID number
> Patient’s full name
> Full address
> Date of birth
> Patient’s sex
> Qualifying condition (diabetes, congestive heart failure or hypertension)
> Practice’s name and TIN
> Primary care physician NPI
> Last appointment date
> Primary health coverage
> Secondary health coverage
> Employer group’s name
> Risk score
> Emergency Room (ER) and hospital admit utilization data

We consider these patients eligible for PCMH participation:

> Insured members for whom we provide primary health coverage.
> Medicare Advantage members for whom BlueCross provides primary health coverage.
> State Health Plan (SHP) members for whom we provide primary or secondary health coverage.
> Federal Employee Program (FEP) members for whom we provide primary health coverage and who are participating in either the diabetes or CHF programs only. FEP members are not eligible for the hypertension program.
> Any other self-funded group members for whom we provide primary health coverage.
> South Carolina Health Insurance Pool (SCHIP) members.

These patients are NOT eligible for participation in any PCMH at this time:

> Excluding the State Health Plan, any member for whom we do not provide primary health coverage.
> Any members for whom we perform administrative services only (ASO) on behalf of another Blue Plan.
> Any members who are receiving care from a provider through the BlueCard® national program (ITS Home or Host).
> Any BlueCross or BlueChoice HealthPlan self-funded group that wishes to exclude its employees/dependents from the program.
> Any BlueChoice HealthPlan Medicaid MCO members.

Where coverage discrepancies exist, we will work with you to resolve.

Additional eligibility considerations

> Patients who are not currently being treated or whose treatment has lapsed are NOT eligible for participation, and PCMHs will not be provided monthly fees until the provider resumes treatment for them.

– Patients with lapses in treatment are those who have no contact with the provider in the prior 365 days, or other appropriate time frame, as in the case of patient relocations, opt outs, etc.

– Patients may opt out of the program by notifying you or us.

> During the first year of the PCMH program, we encourage PCMHs to re-establish patient/provider relationships with patients who have not had visits in the last 12 months. After this initial period (first 12 months), we will assist the PCMH in identifying patients who may have moved or selected another primary care physician. You should remove these patients from your rosters and discontinue billing monthly fees for them.
Getting paid

Reimbursement methodology

The reimbursement methodology for PCMH may be subject to change and may vary based on unique strengths/characteristics of contracted practices. Participating practices should refer to their specific contract amendments for details.

Our PCMH program compensation has three components:

1. Fee-for-service payment for services you provide to members, including payments for some services that may not be covered under a traditional contractual relationship (e.g., electronic visits, pharmacist consultations).

2. A per-member, per-month care coordination fee to compensate the practice for the additional or enhanced services it provides to eligible members with targeted chronic diseases.

3. After each performance year, you will be eligible for bonuses based on improvements on the quality measures established in your contract. Bonus reimbursement is provided as an adjustment to the per-member, per-month care coordination fees for the following performance year.

IMPORTANT NOTE: Nothing in this manual should be construed as a change to preauthorization or utilization management requirements in the underlying contractual agreement.

Billing guidelines

We will pay you a monthly per-patient fee in recognition of the services provided by your care teams that are not covered under traditional fee-for-service payments. We may also reimburse you for additional negotiated services not included in a standard fee schedule. You should refer to PCMH contract amendments for details.

To receive payment for the care coordination fee for each eligible patient, you must submit HIPAA-compliant 837 claim transactions to us, following these instructions:

- Service date: First calendar day of the billing month.
- Procedure code: G9008 (Coordinated care fee, physician coordinated care services for either diabetes or congestive heart failure).
- Procedure code: G9002 (Coordinated care fee, physician coordinated care services for hypertension).
- Patients with primary diagnosis (as appropriate for the condition):
  - 250.90  Diabetes with unspecified conditions, unspecified type
  - 428.9  Heart failure, unspecified
  - 401.9  Hypertension, unspecified

Patient-Centered Medical Home: Compensation Model

Blended Payment Methodology

Fee-for-service (FFS) payment

Such as:
- Office visits

Monthly payment

Such as:
- Case coordination
- Proactive outreach services
- Technology and infrastructure

Pay for Results

Bonus payment for quality outcomes

Such as:
- Clinical processes and outcomes
- Patient experience of care
– Billing provider NPI number.
– Rendering provider NPI number (registered physician for the patient).
– Total charge: Contracted care coordination fee.
– Reimbursement for the per-member, per-month coordination fee is not subject to member copayments or deductibles.
– Reimbursement is contingent upon the HCPCS code and an eligible and appropriate diagnosis code and is subject to the member’s continued eligibility and coverage for the month. If it is subsequently determined that a member was not eligible for coverage for the month, we may recoup any payments made.

> For members whose participation in the program begins after the first day of the month and the patient list has been sent by PCMH to us:

– The initial payment for these members will be made the beginning of the following month.
– Also, no refunds will be required for members who opt out of participation after the first of each month.

**Special instructions for FEP (if applicable)**

To receive reimbursement for the monthly per-patient fee for federal employee program (FEP) members, the PCMH submits a monthly roster of participating patients to BlueCross. BlueCross in turn submits the roster to FEP for reimbursement and subsequent payment to PCMH.

**Important billing and payment notes**

> If a claim is filed under a participating PCMH provider number with HCPCS code G9008 or G9002 and any diagnosis other than the ones outlined in this guide, it will reject with the code RPINC. (The allowance for this procedure is included in the allowance for medical care, consultations or surgical care, including pre- and postoperative care. Based on our reimbursement policies, we cannot allow additional benefits for this procedure.) The member’s hard copy Explanation of Benefits (EOB) will be suppressed.

> If a claim for the monthly patient fee is filed under a PCMH provider number for any members in groups/lines of business that are ineligible, it will be rejected RPINC. The EOB will not be suppressed and the provider liability will be 100 percent.

> Each PCMH should only bill for patients who have primary health coverage through us, with the exception of the State Plan, which allows billing for both primary and secondary coverage.

> Other Health Insurance (OHI) requirements apply to claims submitted by you, for members who are required to certify annually that they have no other coverage. You may wish to capture these certifications at the point of care to avoid payment delays.

**Additional reimbursable services related to PCMH**

Depending on the list of services that are established in your contract, additional codes that may be used for billing purposes are included as Appendix 2.
Coordinating care

Team Approach

> We will collaborate and share health data with each PCMH care team to maximize care and improve patient outcomes. Health data can be customized for each individual PCMH.

> We have disease management coaches who work with members who have certain chronic diseases.

> These coaches can also help work with those members, who have any chronic comorbid conditions as well.

> The disease management coaches will serve as the primary clinical contact between you and the Plan.

> Our coaches collaborate with the PCMH and can provide clinical disease management expertise, participate in PCMH care coordination conferences and assist in maximizing insurance benefit coordination.

> The coaches also support you in their efforts to coordinate patient care across the continuum of necessary health care services.

Implementation/Start-Up Activities

> Establish secure mechanism for access to electronic health records for BlueCross and BlueChoice HealthPlan targeted members/patients.

> Establish secure process for exchanging email messages as necessary.

Process Flow for Care Coordination/Care Management

> Establish target patient list.

> Share information related to member assessment and disease specific engagement and educational resources.

> Stratify patients/members based on risk factors (For Plan definition of “high risk,” see next page.).

> Determine if any of the members are currently enrolled in BlueCross or BlueChoice HealthPlan programs.

> Determine communication/outreach process for members: 1. How will patients/members be prioritized. 2. Who will practice contact. 3. Who will be contacted by health plan(s). 4. Establish time line for initial contacts. 5. Determine frequency of contacts.

> Establish and document methodology for identification and assignment of new patients/members for outreach.
Documentation and Reporting

> Establish enhanced standard reporting process for practice and health plan to include:
  - Number of (attempted) outreach calls.
  - Number of successful contacts.
  - Number of members engaged (agree to health coaching, develop action plan, show efforts to comply with recommended behavioral changes).
  - Outcomes for “engaged” patients for those not reached and/or who decline to engage.

Plan Care Management

> BlueCross and BlueChoice HealthPlan have similar, but somewhat different, procedures for outreach, documentation and reporting. They may also use different patient education materials and assessment tools. All care management activities by health plan(s) should be coordinated with and complement practice care coordination activities.

> Binders of resource materials, used by BlueCross and BlueChoice HealthPlan for members with targeted conditions, will be created to share with patient-centered medical home practices.

BlueChoice HealthPlan Methodology for Risk Level

**Very High Risk:** counseling calls scheduled at least three times per year
  - Hospital admission or ER visit for diabetes in the last 12 months
  - Foot ulcer or cellulitis diagnosis in the last 12 months
  - Most recent A1c >12 percent

**High Risk:** counseling calls scheduled at least two times per year
  - Most recent A1c 9.5–11.9 percent
  - Most recent LDL >130 mg/dl
  - BMI >40

**Medium Risk:** counseling calls scheduled at least one time per year
  - Most recent A1c 8.5–9.4 percent
  - No primary care physician visit within the last year
  - Retinopathy with no follow-up in the last year
  - Uses tobacco products

BlueCross Methodology for Risk Level

**DISEASE MANAGEMENT (DM) IDENTIFICATION CRITERIA:**

**DM High/DM Low**
  - If member has HbA1c greater than 9.5 percent, assign to DM High
  - If member has 1+ inpatient admissions with ICD9 from above as the primary diagnosis, assign as DM High
  - If member has 1+ ER visits with ICD9 from above as the primary diagnosis, assign as DM High
  - In subsequent processing, if stratification in current month changes case from DM Low to DM High
    - Send Record Type 1 (New Identification Claims)
    - Update Stratification ID to DM High
  - Clinical A1c >8 percent will automatically enroll member as High Risk for DM for FEP in medical home projects. All other High Risk Stratification will include an A1c of >9 percent.
Measuring success

Baseline measures

> Patient registries are valuable tools that will help you establish your baseline and measure your successes. Shortly after you receive your initial patient list from us, you should begin building your patient registry by pulling relevant clinical information from your EMR/patient charts and adding it to your patient list.

> Send your patient list back to us with the following information included as soon as possible, so your baseline measures for each targeted disease state can be established.

- **DIABETES**
  - Last HbA1c test result
  - Last HbA1c test date
  - Last blood pressure reading
  - Last blood pressure reading date
  - Last LDL result
  - Last LDL test date
  - Last microalbumin reading
  - Last microalbumin test date
  - Last annual eye exam date
  - Height, weight to calculate BMI
  - Height, weight and BMI date

- **CONGESTIVE HEART FAILURE**
  - Date of LVF assessment
  - If EF< 40%, is patient on ACEI or ARB
  - If EF < 40%, is patient on beta-blocker
  - Date of last pneumococcal vaccine
  - Date of last flu vaccine
  - Number of patient visits with weight and measurement recorded

- **HYPERTENSION**
  - Last blood pressure reading
  - Last blood pressure reading date
  - Height, weight to calculate BMI
  - Height, weight and BMI date
  - Generic prescriptions
  - Last annual Chem 7 date
  - Documentation of smoking status
  - Last visit advising to quit smoking and/or counseling

> In consultation with the PCMH practice, we will use the health data to generate a baseline health report for all PCMH participants within 30 days of the implementation date.

> The baseline report will include:
  - Total population, average age, age range, median and mode.
  - Average test result, test range, median and mode.
  - Number and percentage of participants for whom health data is available.
  - Total and percentage of the population who had an eye exam in the past year.

Baseline updates and program participant data

**PCMH PRACTICE**

> On a quarterly basis, you will provide us quarterly baseline update data for PCMH program participants in a mutually agreeable, HIPAA-compliant, electronic format. A template for the required format for data field is included as Appendix 3.

> Reports are due to us by the 15th of the month following the end of the calendar quarter.

**BLUE CROSS AND BLUE CHOICE HEALTH PLAN**

> Upon request and where permitted, we will provide you with participant data to include prescription drug and hospital utilization, emergency room visits, specialist visits and lab values for program participants in a mutually agreeable electronic format.

> We can provide other information, as appropriate and relevant to the patient’s treatment, upon request.
Engaging patients

**Patient notification**
You should determine the method of notification appropriate for your practice and patient population:

> You may consider telephone or written outreach, or a combination of the two.

> Mailings may be co-branded with BlueCross and BlueChoice HealthPlan logos (with approval from our Communications department), if your practice desires.

> You may find that calling patients in advance of any mailings is more effective in educating patients about the program.

> A sample outreach letter is provided as Appendix 5.

**Patient tools and resources**

> Patient materials that you may want to consider developing, along with several third-party resources, are provided as Appendices 6 and 7.

How to build a medical home

Becoming a PCMH requires practice transformation. Change is hard enough; transformation to a PCMH may require epic whole-practice reengineering and redesign. This transformation will include, but may not be limited to:

> New scheduling and expanded access arrangements.

> New coordination arrangements with other parts of the health care system (e.g., our care managers and health coaches).

> Group visits.

> Quality improvement activities.

> Development of team-based care and patient care “huddles.”

> New strategies for patient engagement, patient education and medication adherence.

> Multiple new uses of information systems and technology.

Appendix 8 contains various resources that may assist your practice with this transformation.
Annual evaluations

SUMMARY OF THE ANNUAL EVALUATION

Outcomes measurement

We will review the patient baseline update at the completion of each PCMH year for all continuously enrolled participants. Depending on the patient outcomes, we may modify the monthly per-patient, per-month care coordination fee up to 20 percent depending on measurable improvement in each of the categories, as appropriate to the targeted disease state:

### DIABETES
- Percentage of diabetes patients with an HbA1c test
- Percentage of diabetes patients with an HbA1c less than 8
- Percentage of diabetes patients with blood pressure reading at baseline
- Percentage of diabetes patients with blood pressure managed to less than 130/80
- Percentage of diabetes patients with LDL test
- Percentage of diabetes patients with LDL levels less than 100
- Percentage of diabetes patients with mAB or mAB/creatinine ratio test
- Percentage of diabetes patients with an annual eye exam
- Percentage of diabetes patients with BMI measurements
- Net percentage of diabetes patients with an improved BMI since baseline

### CONGESTIVE HEART FAILURE
- Percentage of heart failure patients with LVF assessment
- Percentage of heart failure patients with EF ≤40 percent on ACEI or ARB
- Percentage of heart failure patients with EF ≤40 percent on beta-blocker therapy
- Percentage of heart failure patients with pneumococcal vaccine within the past five years (if <65) or ever (if 65 or older)
- Percentage of heart failure patients with flu vaccine given within the past nine months
- Percentage of patient visits for patients with heart failure with weight and measurement recorded

### HYPERTENSION
- Percentage of hypertension patients with blood pressure recorded at each visit
- Percentage of hypertension patients with blood pressure < 140/90
- Percentage of hypertension patients with BMI recorded
- Percentage of hypertension patients with BMI < 30
- Generic prescription rate for target population
- Percentage of hypertension patients with annual Chem 7 completed
- Percentage of hypertension patients with documentation of smoking status
- Percentage of hypertension patients who are smokers advised to quit and/or provided counseling at time of visit

Patient satisfaction survey

We will survey PCMH participants to measure their satisfaction with each PCMH. Before conducting the survey, we will provide a sample survey for input to each PCMH.
Our PCMH program currently focuses on patients who are diabetic, have congestive heart failure or have hypertension. We use these diagnosis code(s) to identify eligible patients.

**DIABETES**
- 250.0 Diabetes mellitus without mention of complication
- 250.1 Diabetes with ketoacidosis
- 250.2 Diabetes with hyperosmolarity
- 250.3 Diabetes with other coma
- 250.4 Diabetes with renal manifestations
- 250.5 Diabetes with ophthalmic manifestations
- 250.6 Diabetes with neurological manifestations
- 250.7 Diabetes with peripheral circulatory disorders
- 250.8 Diabetes with other specified manifestations
- 250.9 Diabetes with unspecified conditions
- 357.2 Polyneuropathy in diabetes
- 362.0 Diabetic retinopathy
- 366.41 Diabetic cataract
- 648.0 Diabetes mellitus complicating pregnancy, childbirth or puerperium

**CONGESTIVE HEART FAILURE**
- 402.01 Hypertensive heart disease, malignant, with heart failure
- 402.11 Hypertensive heart disease, benign, with heart failure
- 402.91 Hypertensive heart disease, unspecified, with heart failure
- 404.01 Hypertensive heart and renal disease, malignant, with heart failure
- 404.03 Hypertensive heart and renal disease, malignant, with heart and renal failure
- 404.11 Hypertensive heart and renal disease, benign, with heart failure
- 404.13 Hypertensive heart and renal disease, benign, with heart and renal failure
- 404.91 Hypertensive heart and renal disease, unspecified, with heart failure
- 404.93 Hypertensive heart and renal disease, unspecified, with heart and renal failure
- 428.0 Congestive heart failure, unspecified
- 428.1 Left heart failure
- 428.20 Systolic heart failure, unspecified
- 428.21 Systolic heart failure, acute
- 428.22 Systolic heart failure, chronic
- 428.23 Systolic heart failure, acute on chronic
- 428.30 Diastolic heart failure, unspecified
- 428.31 Diastolic heart failure, acute
- 428.32 Diastolic heart failure, chronic
- 428.33 Diastolic heart failure, acute on chronic
- 428.40 Combined systolic and diastolic heart failure, unspecified
- 428.41 Combined systolic and diastolic heart failure, acute
- 428.42 Combined systolic and diastolic heart failure, chronic
- 428.43 Combined systolic and diastolic heart failure, acute or chronic
- 428.9 Heart failure, unspecified
### Eligible Diagnosis Codes

#### Hypertension

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<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>401.0</td>
<td>Hypertension, malignant</td>
</tr>
<tr>
<td>401.1</td>
<td>Hypertension, benign</td>
</tr>
<tr>
<td>401.9</td>
<td>Hypertension, unspecified</td>
</tr>
<tr>
<td>402.00</td>
<td>Hypertension heart disease w/o heart failure, malignant</td>
</tr>
<tr>
<td>402.10</td>
<td>Hypertension without heart failure, benign</td>
</tr>
<tr>
<td>402.90</td>
<td>Hypertension without heart failure, unspecified</td>
</tr>
<tr>
<td>403.00</td>
<td>Hypertension with renal involvement, malignant</td>
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<td>403.01</td>
<td>Hypertension with cardiorenal failure, malignant</td>
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<td>Hypertension with renal involvement, unspecified</td>
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<tr>
<td>403.91</td>
<td>Hypertension with stage V or end stage renal disease</td>
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<td>404.00</td>
<td>Hypertension, heart and renal disease</td>
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<td>404.02</td>
<td>Hypertension with stage IV or end stage renal disease</td>
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<td>404.93</td>
<td>Hypertension, stage V and end stage renal disease, unspecified</td>
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<td>405.9</td>
<td>Secondary hypertension due to aldosteronism or Cushing’s disease, primary, malignant</td>
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<tr>
<td>405.11</td>
<td>Hypertension, renovascular, malignant</td>
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<td>405.19</td>
<td>Secondary hypertension due to aldosteronism, primary, benign</td>
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<td>405.91</td>
<td>Hypertension, unspecified</td>
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<td>405.99</td>
<td>Hypertension, unspecified</td>
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### Other service codes reimbursable for PCMH participants

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<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>G0108</td>
<td>Diabetes outpatient self-management training services, individual, per 30 minutes</td>
</tr>
<tr>
<td>G0109</td>
<td>Diabetes outpatient self-management training services, group session (two or more), per 30 minutes</td>
</tr>
<tr>
<td>99250</td>
<td>Fundus photography diabetic retinal test</td>
</tr>
<tr>
<td>99078</td>
<td>Physician led group educational services</td>
</tr>
<tr>
<td>99444</td>
<td>Online medical evaluation (e-visit) by physician, established patient</td>
</tr>
<tr>
<td>98969</td>
<td>Online medical evaluation (e-visit) by non-physician, established patient</td>
</tr>
<tr>
<td>99339</td>
<td>Care plan oversight – home or assisted living rest home visit 15–29 minutes within a calendar month</td>
</tr>
<tr>
<td>99340</td>
<td>Care plan oversight – home or assisted living rest home visit 30 minutes or more within a calendar month</td>
</tr>
<tr>
<td>99341</td>
<td>Home visit new patient by MD</td>
</tr>
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<td>99342</td>
<td>Home visit new patient by MD</td>
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<td>Home visit new patient by MD</td>
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<td>Home visit established patient by MD</td>
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<td>99349</td>
<td>Home visit established patient by MD</td>
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<tr>
<td>99350</td>
<td>Home visit established patient by MD</td>
</tr>
<tr>
<td>99605</td>
<td>Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, new patient.</td>
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<td>99606</td>
<td>Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, established patient.</td>
</tr>
<tr>
<td>99607</td>
<td>Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, each additional 15 minutes. (List separately in addition to code for primary service.)</td>
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This template includes the required data elements for baseline, quarterly and annual reports.

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<th>Field Name</th>
<th>Format</th>
<th>DB2 Format</th>
<th>Length</th>
<th>Example</th>
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</tbody>
</table>
The American Academy of Family Physicians recommends that providers build their medical home with a strong foundation in family medicine by applying this checklist to their practices.

**Quality measures**

*Are you using these clinical information systems?*
- Registries
- Referral tracking
- Lab result tracking
- Medication interaction alerts
- Allergy alerts

*Your practice is a culture of improvement if you and your staff:*
- Establish core performance measures
- Collect data for better clinical management
- Analyze the data for quality improvement
- Map processes to identify efficiencies
- Discuss best practices

*Does your practice use these checklists and reminders?*
- Evidence-based reminders
- Preventive medicine reminders
- Decision support

*Do your care plans reflect … ?*
- An updated problem list
- A current medication list
- Patient-oriented goals and expectations

**Patient experience**

*Which of the following are you using to improve your patients’ access to care?*
- Same-day appointments
- Email
- Web portal for Rx, appointments or information
- Referral to online resources
- Non-visit based care and support

*Does your practice support patient self-management through … ?*
- Motivational interviewing
- Shared goal-setting
- Home monitoring (when appropriate)
- Group visits and support groups
- Family and caregiver engagement

*Clear communication requires …*
- Patient language preference
- Cultural sensitivity
- Active listening
- Plain language, no jargon
- Patient satisfaction surveys

*Do you and your patients share in the decision-making process by … ?*
- Discussing treatment options in an unbiased way
- Considering the patient’s priorities
- Creating and revisiting follow-up plans
Health information technology

Are you taking advantage of these e-prescribing technologies?
- Medication interaction checking
- Allergy checking
- Dosing alerts by age, weight or kidney function
- Formulary information

Do you have these evidence-based medicine supports in place?
- Templates to guide evidenced-based treatment recommendations
- Condition-specific templates to collect clinical data
- Alerts when parameters are out of goal range
- Home monitoring

Does your practice use a registry to facilitate ... ?
- Population health management
- Individual health management
- Proactive care
- Planned care visits

Do you have the access you need to these clinical decision support tools?
- Point-of-care answers to clinical questions
- Medication information
- Clinical practice guidelines

Is your practice connected to the health care community in these important ways?
- Internet access
- Quality reporting tools

Practice organization

Rigorous financial management is essential. Are you ... ?
- Budgeting for forecasting and management decisions
- Contracting with health plans from a selective and informed position
- Managing the practice’s cash flow
- Staying on top of accounts receivable

Does your practice offer individuals and teams opportunities for development through ... ?
- Ongoing education
- Leadership training
- Team meetings
- Roles and responsibilities that are stimulating and rewarding
- Shared vision and responsibility for quality of care
- Value for the contributions of all individuals

Does the practice rely on data to drive decisions to ... ?
- Continuously improve quality and efficiency
- Monitor supply and demand
- Ensure adequate and fair distribution of work

Family medicine core values

Does your practice value ... ?
- Continuous healing relationships
- Whole person orientation
- Family and community context
- Comprehensive care

For more information, visit www.aafp.org/pcmh and www.transformed.com.
We’ve gathered suggestions for “first steps” from our established PCMH practices.

> Engage leadership

> Identify transformation leaders – “Champions”
   Ideal Champion teams should include a physician, clinical coordinator and administrative coordinator.

> Update your active patient list
   Have a standardized process for inactivating patients.

> Begin reviewing “Must-Pass” elements from the NCQA 2011 Standards
   Select your three “important conditions.” Remember, one of the three has to be related to unhealthy behaviors or mental health or substance abuse (Standard 3A)

> Explore your EMR system capabilities:
   – Reporting
   – Data extraction
   – Flowsheeting
   – Patient registry

> Explore your lab, imaging and referral tracking systems.
   If you don’t currently have one, begin creating a tracking log (NCQA Standard 5A and 5B).

> Create logs to track clinical advice given by phone during and after business hours. This can include electronic clinical advice as well if your practice has this capability.
   This log will help you monitor response times and documentation in the medical record (NCQA Standard IA).

> Identify resources for patient education, self-management support and community programs such as:
   – Brochures.
   – Self-management support tools.
   – Online links to resources.
   – Disease management education classes.
   – Financial assistance resources for help with prescription costs, etc.

> Make sure check-in staff is collecting all necessary data from patients, such as:
   – DOB, gender, race, ethnicity.
   – ID card number.
   – Preferred language.
   – Telephone number and email address.
   – Other information you choose to collect from Standard 2A.
Month Year

Dear Patient:

Thank you for allowing us to serve as your health care partner. We value the trust you place in us and want to make sure you get the quality health care you need. That’s why we are announcing a new program in partnership with <name of health plan> — the medical home program.

With the medical home program, your primary doctor keeps an eye on the big picture — you and your health! Your doctor will lead a health care team devoted to helping you manage your <disease> and improving your health. You’ll have <title(s)> who will work with you one-on-one to help you set your health goals and take the steps you need to reach them. Your <title> will also help you schedule your appointments and lab work, as well as any referrals and education classes you may need. Your <title(s)> will help you talk with your doctor and health plan to make sure you get the care you need, when and where you need it. And as an added bonus, you can also take advantage of discounts on <discount programs>.

Best of all, these new services and discounts will be provided at absolutely no cost to you! Although your health plan will pay us <$> each month for these services, you’ll owe nothing for them. These services can help you save money. They can also help you improve your health. Better health means savings for everyone.

Please visit our website <URL> to learn more about services. Coming soon, we’ll also have a page dedicated to our medical home program. This page will include links to valuable resources and information including a secure website where you can request medical records, schedule appointments and refill prescriptions. You can also send us messages, upload any test results and pay any bills.

We hope you share our excitement about our new program. We’ll be calling you shortly to talk about the program, but in the meantime, feel free to contact your <title(s)> with any questions you may have at these numbers:

<NAME, NUMBER>

Sincerely,

<Patient Physician Signature Block>

<Name of Health Plan> is an independent licensee of the Blue Cross and Blue Shield Association.
Third party resources

- American Association of Diabetes Educators, 800-338-3633, www.diabeteseducator.org
- American College of Physicians, www.acponline.org/running_practice/pcmh/
- American Dietetic Association, 800-877-1600, www.eatright.org
- American Heart Association, www.heart.org/HEARTORG/Conditions/HighBloodPressure/High-Blood-Pressure-ATH_UCM_002020_SubHomePage.jsp
- American Society of Hypertension, www.ash-us.org/
- Center for Advancing Health, www.cfah.org
- Centers for Disease Control and Prevention, 800-232-4636, www.cdc.gov/diabetes
- The Commonwealth Fund, www.commonwealthfund.org
- Palmetto Primary Care Physicians Patient-Centered Medical Home, www.palmettoprimarycare.com/patient-centered-medical-home/
- Patient-Centered Primary Care Collaborative, www.pcpcc.net
- Primary Care Development Corporation, www.pcdc.org/resources/patient-centered-medical-home/

Pharmaceutical companies are a great source of tools and information to assist both practices and their patients. Topics include staff development, patient engagement and disease-specific materials. Contact your pharmaceutical representatives and discuss what resources they can provide to help you develop and maintain your patient-centered medical home.
Sample patient survey for PCMH

Introduction: Staying healthy can be difficult when you have a chronic condition like diabetes, congestive heart failure or hypertension. Your health plan is engaged with your personal physician at (name of practice) to help you improve your health. We would like to ask a few questions so we can better understand the type of help you currently receive from your personal physician and his or her support staff. This may include your personal physician as well as other professionals in the practice, such as nurses, physician assistants, patient educators or others. We will keep your specific answers confidential. We will combine all results and will share them as a summary with the practice so we can continue our ongoing effort to improve your care and the overall performance of the practice.

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<tr>
<th>Category</th>
<th>Question</th>
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<tbody>
<tr>
<td><strong>Introductory Questions</strong></td>
<td>Are you currently seeing a physician who is part of the &lt;practice name or name of physician&gt;? (And who is your personal physician?)</td>
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<td>How long ago did you start seeing this physician? (Recently, This Year or More Than a Year)</td>
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<td></td>
<td>How many times have you visited this physician in the past year? (Once, Several Times or More Than Four)</td>
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<tr>
<td><strong>Access</strong></td>
<td>When I need care, my personal doctor’s office is able to get me an appointment in a timely manner.</td>
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<tr>
<td><strong>Communication</strong></td>
<td>How satisfied were you with your physician’s ability to answer all of your questions?</td>
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<td><strong>Coordination (pre-visit)</strong></td>
<td>In general, did you feel that your physician’s office was well prepared for your visits?</td>
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<tr>
<td><strong>Coordination (follow-up care)</strong></td>
<td>After your appointment, did your physician’s office contact you to check in and see how you were progressing?</td>
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<tr>
<td><strong>Medication Management</strong></td>
<td>Did your physician tell you that you had a specific condition?</td>
</tr>
<tr>
<td></td>
<td>Did your physician provide you with information on your condition?</td>
</tr>
<tr>
<td></td>
<td>Has your physician prescribed any medications to help manage your condition?</td>
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<td></td>
<td>Did your physician speak with you about the importance of taking this medication as prescribed?</td>
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<tr>
<td><strong>Patient Engagement</strong></td>
<td>Having clear, achievable goals can really make a difference in managing and improving your health. Did your physician help you set goals?</td>
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<tr>
<td></td>
<td>Did any of these goals involve making lifestyle changes such as eating healthy and getting more physical activity?</td>
</tr>
<tr>
<td></td>
<td>Did your physician encourage you to take advantage of specific resources related to your condition, such as classes and information on the Web?</td>
</tr>
<tr>
<td></td>
<td>Do you feel that you have been able to make any lifestyle changes that have improved your health?</td>
</tr>
<tr>
<td><strong>Overall Experience</strong></td>
<td>How would you rate your overall experience with the care and support provided by your doctor and his or her support staff?</td>
</tr>
<tr>
<td></td>
<td>How would you rate any improvements in your ability to manage your health in the last year?</td>
</tr>
<tr>
<td></td>
<td>For this question, please think about your overall work experience, which can include how productive you have been and how much work you’ve had to miss due to illness. How much do you feel the overall quality of your work experience has improved since seeing this physician?</td>
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<tr>
<td></td>
<td>Compared to past experience with medical treatment, how would you rate the treatment and services provided by your physician and his or her staff?</td>
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<tr>
<td></td>
<td>How likely is it that you would recommend this practice to others with the same health condition?</td>
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<td></td>
<td>Outside of your office visits, have you talked to a health coach or diabetic educator?</td>
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Guide to Practice-Based Care Management (PBCM)

WHY PBCM?
Create team of professionals to support physicians and spend time ensuring patients have the right level of information and care.

WHAT IS PBCM?
May be many different things:
>
- Resource coordination
- Utilization management
- Follow-up
- Patient education and self-management
- Optimized clinical management

CRITICAL ELEMENTS OF PBCM
>
- Identify patients
- Assessment
- Individual care plan
- Implement care plan
- Monitor outcomes

WHICH PATIENTS ARE CANDIDATES FOR PBCM?
>
- Use registry/EMR to find high-risk patients
- Who is high risk?
  - Last visit
  - Clinical parameter (i.e., A1c greater than 9)
  - Overdue for screening
  - Low self-management skills
  - Depression or family dysfunction
  - May be tailored for each practice

PBCM TOOLS
>
- Share treatment guidelines with patient
- Set goals
- Identify needs/barriers
- Develop action plan

FEATURES OF EFFECTIVE PBCM
>
- Assess disease control, adherence and self-management status
- Adjust treatment or communicate need to physician for input
- Provide self-management support
- Provide intense follow-up
- Assist with navigation through health care process
delivery system

QUALITIES OF A GOOD CARE MANAGER
>
- Independent thinker
- Good listener with communication skills
- Patient-centered
- Passionate/empathic
- Problem-solver — and able to support patients and families in solving their own problems

Example: Care Manager Role (Clinical/non-clinical):
RN
>
- Chronic illness management
- Care coordination across continuum and specialty providers
- Comprehensive health assessment
- Symptom management
- Transitional care support (from hospital, nursing home, etc.)
- Assessment and management of functional risk (frail elderly)
- Medication titration and management
- Management of increased visit/encounter frequency
- Support patient self-management and self-care
- Assessment of patient’s motivation to change and set health behavioral change goals in collaboration with the patient/member
- Effective (standardized) communication and documentation between practice, health plan and member

Non-RN
>
- Monitoring of self-care (by telephone, email, in person)
  - Progress in goals
  - Patient data/signs
  - Adherence to plan of care
- Medication reconciliation
- Monitoring of lab data and home testing data
- Referral management
- Referral to community programs
- Oversight by the MD and RN
Sample practice-based care manager/care coordinator description

**Job purpose**

Physician office-based position. Ensures continuity and coordination of care for patients with a focus on coordination of care with the practice, other providers and the community for members identified with complex needs or chronic conditions. Identifies patient barriers and “whole person needs” of the members including medical, behavioral, pharmaceutical and social needs. Develops a comprehensive care plan that includes prevention, member self-management education and clinical standards of care. Provides individualized and group education for patients, their families and other interested caregivers. Coordinates with the health plan medical management and other departments to provide additional support to the practice and members.

**Minimum requirements**

**EDUCATION/KNOWLEDGE REQUIREMENTS:**

- Experience in coordinating care for individuals with complex needs, which includes medical, behavioral, pharmacy, home care, discharge planning, patient education and social needs
- Experience in a managed care environment preferred
- Ability to interact with physicians and other health care professionals in a professional manner
- An understanding of health care disparity issues and an ability to interact with members from diverse backgrounds in a culturally appropriate manner
- Ability to adapt to a changing environment and function effectively as a part of a multidisciplinary team
- Excellent oral and written communication and interpersonal skills
- Ability to use independent judgment and compassion when carrying out tasks
- Flexibility in work schedule and an ability to travel between provider offices, the health plan office and other network providers
- Flexibility to work within the hours established by the practice
- Organized and detail oriented
- Computer proficiency, including experience with Microsoft Word and email

**LICENSURE/CERTIFICATION:**

- Valid RN licensure (optional)
- Diabetes, congestive heart failure or hypertension educator certification a plus

**Essential functions and responsibilities**

- Perform duties and responsibilities in accordance with the philosophy and standards of the practice, including conveying courtesy, respect, enthusiasm, and a positive attitude through contacts with staff, health plan members, peers and external contacts
- Follow protocols for care management
- Conduct outreach to members identified by the health plan or practice who have complex needs, chronic conditions, or who require preventive services
- Conduct comprehensive assessments that include the medical, behavioral, pharmacy and social needs of the member
- Review health plan data for services the member has received and identify gaps in care based on clinical standards of care
- Based on assessment of member needs and environment, identify applicable barriers, problems, goals and interventions that will address those needs and improve or maintain the health status of that member
- Provide member education on prevention, early intervention and self-management of identified conditions (on an individual basis or in a group setting)
- Coordinate the development and implementation of an effective care plan with the provider, other health plan care management, pharmacy, health promotion departments, behavioral health managed care organization and community agencies
- Engage the family or other supports for the member as appropriate
- Collaborate with the health plan’s care management staff and the practice in the development of timely discharge plans and follow-up to ensure a smooth transition of care from an acute or emergency room setting
- Establish short- and long-term member goals that support the improvement or maintenance of the member’s health status
- Follow up with the member and monitor the member’s progress and adjust care plan as needed
Before, during and after the visit

Help patients understand their central roles in managing their conditions.

Before the visit

Make time for self-management by gathering clinical and patient experience data in the chart.

Ask patients to bring questions and concerns and health monitoring information.

During the visit

Develop a visit agenda with the patient and family, handling as many concerns as possible, and plan return visits as appropriate.

Engage the entire practice team in supporting patients, use “warm handoff” introductions and explain team member roles to patients.

Ask about patient goals to improve their health and help them make action plans to reach these goals.

Prepare a written care plan or visit summary that includes goals and action plans to ensure patients and families know what to do when they leave the visit.

After the visit

Organize follow-up support to help patients sustain healthy behaviors between visits.

Extend care into the community by linking patients to community programs.

Build a team

Assign responsibility for self-management tasks to all team members, extending the work out from the physician.

Use daily team huddles to review the schedule of patient charts, anticipate care needs and enhance the flow of care.

Patient self-management

SKILLS AND TOOLS TO TRANSFORM THE PATIENT/CAREGIVER RELATIONSHIP INTO A COLLABORATIVE PARTNERSHIP

> Communicate progress to the patient and to the health plan

> Access health plan tools that provide member profile information that could assist in the assessment and development of effective care plans

> Share appropriate member information with the practice for its members to support its care decision-making

> Document activities in the practice’s patient medical record according to the practice’s policies and procedures

> Assist the health plan and practice in the development and implementation of efficient workflow processes that can better support care coordination and education of health plan members

> Identify trends and opportunities for improvement based on information obtained from interaction with members and providers

> Provide reports on case management cases or activities as requested

> Perform other duties as requested

Resources

> www.pcpcc.net/content/tools-resources
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