Dr. Moroney Joins Network Innovation

BlueCross BlueShield of Tennessee is pleased to share some exciting news for the Provider Network Management division. Dr. David Moroney, current Chief Medical Officer for BlueCare Tennessee, has accepted a newly created role as Medical Director of Provider Network Innovation.

In this new position, Dr. Moroney will provide medical oversight for innovative BlueCross network programs including new provider partnerships, Patient-Centered Medical Homes, and the state’s Tennessee Health Care Innovation Initiative. He will supply clinical direction for the advancement of high-quality, cost-effective ways to improve health care for our members.

Most recently, Dr. Moroney served for six years as Chief Medical Officer of BlueCare Tennessee, providing critical leadership and clinical guidance during a time of intense growth for the division. He has a long history with the company, having joined BlueCross in 1998 as medical director of the Chattanooga region.

In his many clinical leadership roles, Dr. Moroney has shown a passion for finding more effective ways to bring affordable, high quality care to our members. The insights he brings from his career – which has included 18 years of private practice as a pediatrician – are invaluable to the Network Innovation team as they develop new and better ways of delivering health care.

Please join us in congratulating Dr. Moroney on his new role in our organization.

Update: Tennessee Healthcare Innovation Initiative

The Tennessee Healthcare Innovation Initiative (THCII) was launched in 2013 by the State of Tennessee to begin a shift from a payment system based on volume to one based on value of care. BlueCross is one of three TennCare Managed Care Organizations (MCOs) to participate in this joint statewide program for TennCare Participants. THCII is comprised of three key elements designed to change the way healthcare is paid for. These elements include Episodes of Care, Primary Care Transformation and Long-term Services and Supports. The current focuses for key stakeholders are Episodes of Care and Primary Care Transformation, while Long-term Services and Supports will be addressed at a later date.

Episodes of Care

Episodes of Care payment seeks to align incentives with successfully achieving a patient’s desired outcome during an “episode of care;” a clinical situation with predictable start and end points. Each episode of care has an assigned Principle Accountable Provider, or Quarterback, who has the most influence on the overall cost of a patient’s treatment. It is the responsibility of the Quarterback to coordinate patient care and choose the appropriate treatment path for the patient. In turn, the Quarterback is incentivized to help members achieve high-quality and cost-effective health care outcomes. Quarterbacks who succeed will be financially rewarded, while those who do not will have to compensate the state with a portion of the excess costs associated with the care given.

Continued on the next page.
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In west Tennessee, we added Consolidated Medical Group to our program, and expanded our contract with The Jackson Clinic; in middle Tennessee, we added Heritage Medical Group, St. Thomas Medical Partners and Premier Medical Group; and in east Tennessee, we added Memorial Health Partners and Rural Health Consortium, as well as expanded our contract with Summit Medical Group.

As a result of the newly contracted PCMH practices and legacy expansions, the BlueCross PCMH program has grown to 30 PCMH groups consisting of approximately 1,200 providers and 225,000 members.

The benefits of primary care transition help ensure:

- Appropriate care setting and forms of delivery
- Increased access to care
- Effective medication reconciliation
- Appropriateness of treatment
- Enhanced chronic condition management
- Referrals to high-value medical and behavioral health care providers
- Reduced readmissions

Primary Care Transformation

Primary Care Transformation seeks to create an aligned model for multi-payer Patient Centered Medical Homes (PCMHs) and Health Homes for TennCare participants with serious and persistent mental illness, as well as a shared care-coordination tool that includes hospital and emergency department admission, discharge and transfer alerts for attributed providers.

This initiative will build on the existing PCMH efforts of providers and payers to create a robust PCMH program that features alignment across payers on critical elements and develop Health Homes to improve integrated and value-based behavioral and primary care services for people with Severe and Persistent Mental Illness (SPMI). In addition, this initiative is designed to reward those PCMH practices and Health Homes who administer superior value-based care to our TennCare members.

PCMH 2015: A Year in Review

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Successful implementation of a new care management tool has allowed the PCMH program to have a more deliberate focus on our patients’ health while reducing utilization.

The advantages of primary care transition help ensure:

- Appropriate care setting and forms of delivery
- Increased access to care
- Effective medication reconciliation
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Looking Ahead

BlueCross will implement each initiative of the Tennessee Health Care Innovation Initiative in different phases. The Episodes of Care initiative is already in operation with the successful implementation of waves 1 and 2, with waves 3 and 4 to be added in 2016. Performance periods for waves 3 and 4 will begin Jan. 1, 2017. BlueCross qualifying Health Homes will be identified based on a set of objective criteria with an expected launch date of July 1, 2016, and BlueCross will aim to initiate the Primary Care Transformation with identified PCMH pilot practices by Jan. 1, 2017, and expanding thereafter.

Role of the Provider Performance Consultant (PPC)

BlueCross requires all PCMH practices to achieve a minimum of National Committee for Quality Assurance (NCQA) Level 1 PCMH Recognition by the end of Year 1, with a minimum of achieving the next level by end of Year 3. The ultimate goal is for each of our PCMH practice sites to become an NCQA level 3 Patient Centered Medical Home—the highest level of recognition.

BlueCross assigns Provider Performance Consultant (PPCs) to regions across the state to assist practices seeking to achieve recognition. These PPCs facilitate, support and guide these practice sites toward obtaining and maintaining NCQA recognition by setting up monthly workgroup meetings, facilitating NCQA discussions and providing templates and examples.
Cervical Cancer Screening:

What is the quality measure?

This quality measure focuses on cervical cancer screenings for your female patients 21 to 64 years of age based on the clinical practice guidelines below:

- Women 21 to 29 years of age: Cervical cytology (Pap) test every three years.
- Women 30 to 64 years of age: Cervical cytology test (Pap) every three years OR every five years if they have co-testing – Cervical cytology (Pap) with Human Papillomavirus (HPV) tests.

What can you do to improve this quality measure?

You play an essential role in developing and ensuring member trust by offering high-quality care. You can help us maintain a high level of quality care by:

1. Educating women about the importance of cervical cancer screenings every three to five years.
2. Explaining why screenings need to continue even though your patient decided to stop having children or after getting the HPV vaccine.
3. Coding accurately. Always file a claim for the Pap procedure even if it's part of a routine exam.

Sample Codes:

**Cervical Cytology HCPCS:** G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091

**Cervical Cytology CPT®:** 88141-88143, 88147-88148, 88150, 88152-88154, 88164-88167, 88174-88175

**HPV Test:** 87620-87622

COPD Pharmacotherapy Management

What is the quality measure?

The quality measure focuses on your COPD patients ages 40 and older who have been in the hospital or had an ER visit for a COPD exacerbation. Your patients should receive a prescription for the following upon discharge (D/C):

- Corticosteroid
- Bronchodilator

What can you do to improve this quality measure?

1. Develop a shared treatment plan with your patients.
2. Assess your patients' understanding of their medications.
3. Explore possible reasons for your patients' medication non-compliance, i.e. cost, denial, depression, substance abuse.
4. Enlist your patients' support network.
5. Work with the hospital discharge planner.
6. Offer your patients educational handouts on COPD treatment from multiple sources, including American Lung Association (ALA).

Sample Diagnoses: Emphysema, Chronic Obstructive Asthma, Chronic Obstructive Bronchitis

HEDIS® Measure Education
NCQA PCMH Recognition Training

NCQA Recognition Programs hold monthly customer education sessions for each program. All current and potential customers are invited to attend audio (telephone) conference workshops or WebEx training sessions that combine audio and Internet-accessible video presentations. No reservations are required. Follow this link for course information: ncqa.org/Programs/Recognition/RelevanttoAllRecognition/RecognitionTraining.aspx

April 2016

Diabetes Recognition Program (DRP) Standards
- April 5 | 2:00-3:00 p.m. – ET | Telephone

Heart Stroke Recognition Program (HSRP) Standards
- April 6 | 2:00-3:00 p.m. – ET | Telephone

Patient Centered Medical Home & Patient Centered Specialty Practices (Getting On Board—Learn It)
- April 6 | 10:00-11:00 a.m. – ET | WebEx & Telephone

Use of the Web-based Data Collection Tool (DCT) for Diabetes or Heart Stroke Programs
- April 7 | 2:00-3:30 p.m. – ET | WebEx & Telephone

Patient Centered Medical Home & Patient Centered Specialty Practices (Getting On Board—Earn It)
- April 7 | 10:00-11:00 a.m. – ET | WebEx & Telephone

Patient Centered Medical Home & Patient Centered Specialty Practices (Getting On Board—Keep It)
- April 8 | 3:00-3:45 p.m. – ET | WebEx & Telephone

Patient Centered Specialty Practice (PCSP 2013) Standards Live Q&A Session
- April 12 | 3:00-3:30 p.m. – ET | WebEx & Telephone

Patient Centered Medical Home (PCMH 2014) Standards Live Q&A Session
- April 13 | 2:00-3:00 p.m. – ET | WebEx & Telephone

Renewing and Converting to (PCMH 2014) Live Q&A Session
- April 19 | 3:00-4:00 p.m. – ET | WebEx & Telephone

Patient Centered Medical Home & Patient Centered Specialty Practices (Getting On Board—Learn It)
- April 20 | 10:00-11:00 a.m. – ET | WebEx & Telephone

May 2016

Diabetes Recognition Program (DRP) Standards
- May 3 | 2:00-3:00 p.m. – ET | Telephone

Heart Stroke Recognition Program (HSRP) Standards
- May 4 | 2:00-3:00 p.m. – ET | Telephone

Patient Centered Medical Home & Patient Centered Specialty Practices (Getting On Board—Learn It)
- May 4 | 10:00-11:00 a.m. – ET | WebEx & Telephone

Use of the Web-based Data Collection Tool (DCT) for Diabetes or Heart Stroke Programs
- May 5 | 2:00-3:30 p.m. – ET | WebEx & Telephone

Patient Centered Medical Home & Patient Centered Specialty Practices (Getting On Board—Earn It)
- May 5 | 10:00-11:00 a.m. – ET | WebEx & Telephone

Patient Centered Medical Home & Patient Centered Specialty Practices (Getting On Board—Keep It)
- May 6 | 3:00-3:45 a.m. – ET | WebEx & Telephone

Patient Centered Specialty Practice (PCSP 2013) Standards Live Q&A Session
- May 10 | 3:00-3:30 p.m. – ET | WebEx & Telephone

Patient Centered Medical Home (PCMH 2014) Standards Live Q&A Session
- May 11 | 2:00-3:00 p.m. – ET | WebEx & Telephone

Renewing and Converting to (PCMH 2014) Live Q&A Session
- May 17 | 3:00-4:00 p.m. – ET | WebEx & Telephone

Patient Centered Medical Home & Patient Centered Specialty Practices (Getting On Board—Learn It)
- May 18 | 10:00-11:00 a.m. – ET | WebEx & Telephone

Mark Your Calendars

Patient-Centered Medical Home Annual Meeting
- Hilton Nashville Downtown
- 121 4th Avenue South
- Thursday, Aug. 25 – Nashville, TN 37201
- Friday, Aug. 26, 2016

Please visit www.ncqa.org for the most up-to-date training schedule.

Telephone number for all events: 1-866-505-4013 | Participant Code: 7023159766#
(You must enter the # symbol after the code.) WebEx Internet URL: ncqaevents.webex.com/meet/RecognitionEducation#sthash.TZKWLgfM.dpuf. Enter your name and email address at this link to join the WebEx.

Additional details will be forthcoming.
Celebrating 37 Years of Service

Whether enjoying her free time on the golf course or working as a Provider Performance Consultant for BlueCross, patience is the name of the game for Kay Newcomb.

Kay started her career at BlueCross in claims processing. From there, she moved on to processing provider complaints for BlueCross’s corporate attorney and was one of the first BlueCross employees to spearhead electronic claims submission. Now in her 37th year of service with BlueCross, Kay has settled into a vital role in the PCMH program.

As a Provider Performance Consultant for middle Tennessee, Kay helps providers navigate the often confusing, yet mandatory, process of NCQA accreditation. Working hand-in-hand with practices seeking to join or remain members of BlueCross’s PCMH program, Kay is the primary resource for NCQA requirements and best practices.

While helping practices achieve required NCQA accreditation, Kay never loses sight of the ultimate goal of the PCMH practice model—enhanced patient care.

“The NCQA accreditation process can be overwhelming and requires a tremendous amount of cooperation within a practice,” says Kay. “The process takes a lot of patience, and I serve as the Middle TN resource for our practices and provide key steps that can help ensure our practices achieve NCQA recognition. It is truly fulfilling to see our practices hard work pay off by adopting new processes to provide patient centered care. Patient centered medical homes are the foundation for a health care system that gives more value by achieving the ‘Triple Aim’ of better quality, experience and cost.”

When she isn’t working with BlueCross PCMH practices, Kay can be found spending time with her family, on the links perfecting her golf swing or cheering on Nashville-native professional golfer Brandt Snedeker.

West Tennessee Practice Spotlight
Prime Care Medical Center

Prime Care Medical Center in Selmer, Tennessee, has employed teamwork and collaboration to drive improvements in continuation of care and quality scores in key areas of patient care.

Working hand-in-hand with the information technology staff at the practice, providers and care coordinators at Prime Care have taken great strides to provide comprehensive care for patients. From process development to ensuring timely follow up and appointment scheduling, Prime Care has gone above and beyond to revolutionize care practices to put patients first.

One of the most successful tactics developed by Prime Care has been the creation of quality checklists for each patient that visits the facility. Based on each patient’s age, gender, chronic health conditions and HEDIS measures, each checklist offers providers a comprehensive picture of a patient’s health — indicating care gaps to close and opportunities to further coordinate care.

“The level of care coordination we have achieved has resulted in more seamless care experiences and more effective preventive and acute medical care for our patients,” explains Tammy Moore, RN, care coordinator at Prime Care. “These accomplishments are the products of cooperation and collaboration at all levels of our practice. From physicians to administrative and clerical roles, each member of our practice understands the importance of care quality and transition, and we work each day to improve in order to better serve our community.”

Prime Care by the Numbers

The work done by providers and staff at Prime Care Medical Center has shown numerous benefits, including:

- A reduction of more than 40 percent in admits/1000
- Approximately a 30 percent reduction in overall risk score
- An 80 percent reduction in 30-day readmissions
- More than 40 percent improvement in patient care quality scores
- More than 80 percent improvement in preventive patient screenings
- More than 300 percent improvement in cardiovascular quality scores

Helpful NCQA Hints

NCQA Recognition Redesign Q&A

If you want to stay up to date and in the know for the NCQA Recognition Redesign, we recommend you check out and follow blog.ncqa.org for detailed Q&A. This site will advise you on how the recognition and application process is changing as well as update you on the core requirements coming in 2017.

Corporate Submission

The corporate/multi-site survey is a time-saving option for larger networks. While each individual practice will still need to submit an individual survey to receive recognition, a multi-site survey can streamline the survey process. There are 17 eligible elements for organizations to identify for review in the Corporate Survey Tool. All multi-site organizations must be able to respond to at least 12 elements in their Corporate Survey Tool. All remaining elements must be completed at the practice-site level.

Did you know?

All multi-site practice recognitions share the first recognized site’s three-year end date. For example, if the first site has a recognition period of Dec. 18, 2015, to Dec. 18, 2018, all sites submitted within the three-year period have same end date (Dec. 18, 2018). Each site’s start date is based on the date when the site survey decision is completed (this may not be a full three-year period).
Welcome, New Employees!

Julie Scott, RN, MSN has joined BlueCross as the middle Tennessee PCMH Team Lead. In this role, Julie will assist Nancy Muldowney with operational oversight of BlueCross’ PCMH Care Coordinators. Julie’s main roles may include, but are not limited to, the following: problem-solving, rounding on all middle Tennessee PCMH Care Coordinators, conducting training, assisting Nancy with interviews for vacant PCMH care coordinator positions, orientation and onboarding of new PCMH care coordinators, ensuring clinical competencies for PCMH care coordinators, assisting with the establishment of educational classes for the monthly PCMH care coordinator staff meetings and reinforcement of established workflows and troubleshooting issues within respective PCMH practices.

Julie has been an adult oncology nurse since 2008. Most recently, Julie worked at Vanderbilt University Medical Center as a manager within the Vanderbilt-Ingram Cancer Center. In this role, Julie provided oversight for eight research staff members for breast cancer clinical trials and was responsible for the start-up process, opening and oversight of these clinical trials.

Laura Buchanan started her new role as the BlueCross PCMH Care Coordinator at Medical Care, Elizabethton, on Jan. 4, 2016. Laura Buchanan has come to us from Mountain States Medical Group, where she worked as a Care Coordinator. She has now transitioned to the role of BlueCross Care Coordinator for Medical Care in which she will be instrumental in helping decrease utilization and close gaps in care.

Teresa Ramsey accepted the role as the BlueCross Care Coordinator at Holston Medical Group (HMG), Kingsport, on Feb. 15, 2016. She has already been working within HMG, and is very familiar with the BlueCross PCMH Program. She will be a great asset to both HMG and the BlueCross PCMH team.

Please welcome these new employees to our team!

Visit Us Online!

We are proud to announce that a PCMH page has been added to the provider section of the BlueCross BlueShield of Tennessee website. The PCMH page provides valuable information about program objectives and current practice locations, as well as access to newsletters and other educational pieces.

Visit the web page today at http://www.bcbst.com/providers/quality-initiatives/patient-centered-medical.page

The Power of Care Coordination

The people behind the processes are what make care coordination so successful — and even possible. While patient-centered care principles are intended and successful at improving health service delivery for individual patients, the personal touches surrounding care delivery are what make a true difference.

At Prime Care Medical, Renae White is one of these care coordinators making a difference. Every morning, she checks provider schedules of three practices in Adamsville, Henderson, and Selmer, Tennessee, to identify BlueCross members visiting the locations, as well as opportunities to close care gaps for these members. Providers notify Renae once the gaps are closed, and she ensures appropriate follow up.

Perhaps the most important aspect of Renae’s position, however, is the patient outreach she performs. On a regular basis, she calls members and initiates follow up care or opens up the doors for vital preventive treatment or education.

In the case of one patient, Renae’s persistence not only led a member to seek out care, but helped her overcome an extremely painful health condition.

“This particular patient had been struggling with an extremely painful mouth infection for months,” explains Renae. “She turned to homeopathic remedies, which weren’t really working, following limited success with clinical care. Despite her initial apprehension, I was able to convince her to visit a specialist, who not only diagnosed the condition, but cured it and restored our member’s quality of life.”

This story is just one example of how Renae and her fellow care coordinators across the state deliver meaningful change for patients of PCMH practices.

“The relationships I establish with patients make all the difference to me,” adds Renae. “Seeing our patients enjoy improved health as a result of our work makes all the difference.”