

Transforming the Workforce to Provide Better Chronic Care: The Role of Local Care Coordinators at CareFirst

Mary Takach and Rachel Yalowich
National Academy for State Health Policy

Susan Reinhard
AARP Public Policy Institute

This is the sixth in a series of case studies exploring the evolving role of nurses in new delivery system models designed to better meet the needs of consumers with complex health conditions. Each case study provides policy recommendations and showcases the work of a nurse in a new initiative. This study looks at how locally-based registered nurses, shared among many primary care practices, are working to improve chronic care within CareFirst's Patient-Centered Medical Home (PCMH) Program. It also provides readers with an opportunity to see how the policy decisions that created this initiative influence practice through a "Day in the Life" of the local care coordinator beginning on page 2.

Primary care in the United States is still dominated by small- to medium-sized primary care practices,¹ which have limited staff and financial resources to adopt advanced delivery system models such as the patient-centered medical home (PCMH).² The PCMH model emphasizes providing high quality, comprehensive, coordinated, and patient-centered care.³ Many PCMH initiatives find that shared community-based teams may be an effective strategy to help resource-limited small- and medium-size practices coordinate care for their patients.⁴

In 2011, CareFirst, a commercial insurer serving Maryland, northern Virginia, and the District of Columbia, launched

its PCMH program with the goal of improving health outcomes while also controlling costs.

The CareFirst PCMH program currently includes over 4,000 primary care providers—many in solo or small practices—and approximately 1.1 million commercially insured patients. In 2012, a three-year Health Care Innovation Award from the Center for Medicare and Medicaid Innovation, allowed CareFirst to expand its PCMH program to 25,000 Medicare patients in Maryland.⁵

A key component of the PCMH program is care coordination. The program uses more than 200 community-based local care coordinators (LCCs) to support primary care providers by offering care coordination, care planning, and patient education to chronically ill CareFirst patients. LCCs are experienced registered nurses who “have the background and education to think critically and make clinical decisions to help improve the health outcomes of CareFirst patients,” according to Jennifer Baldwin, Senior Vice President of CareFirst's PCMH program.

Each LCC is assigned to work with panels of 5 to 15 providers. LCCs identify patients for care coordination based on referrals from these providers and from CareFirst's hospital transition coordinators and case managers. Additionally, LCCs can utilize CareFirst's electronic data portal to identify high-cost and high-risk patients.

Once a patient is identified and consents to participate, the LCC works with the provider to develop a care plan that incorporates both the provider and patient's health care goals. LCCs aim to engage patients in care coordination for approximately six months, developing a relationship with the patient through in-person visits and frequent telephone communication. LCCs help patients manage their chronic conditions through referrals to services, such as behavioral health and home assessments, and connect them with resources to better self-manage their conditions.

Approximately 80 percent of CareFirst's provider network currently participates in its PCMH program. This high participation rate is largely a result of provider peer-to-peer outreach about the program's benefits. Providers engage each other within their panels to work collectively to improve care for their combined patient populations. CareFirst regularly reports data on a number of metrics, including cost, quality, and utilization. PCMH program consultants and regional care coordinators help

providers utilize these data to better manage the health of their patients and address gaps in care.

If a panel performs well on these metrics, it is eligible to receive financial incentives. Since performance on these metrics is based on all patients on the panel, providers are motivated to collaborate with the LCCs to help improve health outcomes and control costs for their chronically ill patients. Providers also earn additional fees for each care plan they activate and maintain.

After three years of operation, CareFirst reported that its PCMH program's overall cost of care was \$267 million less than projected and participating providers improved their quality scores by over 9 percent from year one to year two of the program.⁶ Most recently, after the program's third year, CareFirst continued to report cost savings compared to projected cost of care. It also reported improvements in utilization metrics, including 8.1 percent fewer hospital readmissions.⁷

A Day in the Life of Local Care Coordinator Michele Brown in the CareFirst Patient-Centered Medical Home Program

Designing a successful PCMH program involves policy decisions that create new provider and patient expectations, incentives, and infrastructure to support patient-centered care. An integral feature of the CareFirst PCMH program is the development of a care coordination infrastructure at the central, regional, and local level.

Much of the work at the local level is done by registered nurses, such as Michele Brown, who serve as local care coordinators (LCC). Supported by a regional care coordinator and a central data system, Michele is charged with identifying and then actively engaging high-need, high-cost patients by linking patients with their primary care provider and community-based services. Michele's performance as an LCC is measured by the number, type, and quality of patient and provider interactions.

Preparing for the Day

Each morning, Michele attends a daily huddle convened by Georgette Moderacki, RN, a CareFirst regional care coordinator, with 17 other LCCs based in Georgette's region. This region spans 52 practices that serve as PCMHs for 27,600 members.

...continued on page 3

A Day in the Life...

(continued from page 2)

The LCCs live in the communities where they work. According to Jennifer Baldwin, CareFirst Senior Vice President of PCMH, “hiring from the local community is very important. You can’t underestimate the importance of relationships being built on common ground.”

Michele usually attends this huddle from her home. Today, during the daily huddle convened over videoconference, Georgette introduces staff from the central office to discuss goals for “activating” and “closing” care plans. The LCCs, in collaboration with the primary care provider and patient, are responsible for writing the care plan. The care plan is also reviewed through a quality review process to ensure it meets PCMH standards.

Typically during the 20-minute huddle, the LCCs also receive information about resources available to help support their work. Today, the discussion focused on how to improve the use of CareFirst’s intensive care management resources for high-risk patients being discharged from hospitals.

In addition, Georgette frequently describes new reports and data being added to “Searchlight”—a section of the electronic data portal. Today, she describes a data report that identifies the top reasons patients are being admitted to the hospital. One panel of providers, for example, was having a significant amount of behavioral health-related hospitalizations. As a result, a behavioral health coordinator was designated to work specifically with this panel’s patients.

...continued on page 5

Lessons Learned and Remaining Challenges at CareFirst’s PCMH Program

CareFirst offers the following recommendations for developing the local care coordinator role in a PCMH initiative.

Lessons Learned

- ***Base care coordinators in their communities.*** Initially, LCCs were hired independent of where they lived within CareFirst’s service areas. CareFirst now hires LCCs to work within the region where they live. Basing LCCs directly in the communities allows ready access to practices and meetings. Additionally, it increases their understanding of the unique needs of the patients they serve, the community culture, and local resources.
- ***Strike a balance between telephone and in-person communication.*** Providers and program leadership credit the in-person communication between LCCs and patients during maintenance visits at provider’s offices as the key to success of care coordination. This face-to-face time helps build relationships with patients and reinforce the role of LCCs as part of patient care teams.
- ***Measure LCCs’ performance.*** Starting in 2012, CareFirst introduced tiered performance incentives for LCCs. These incentives are based on the size of their active caseloads and maintenance of weekly communication with patients. CareFirst desired to acknowledge LCC’s commitment to working often irregular and long hours in order to meet the needs and availability of their patients.
- ***Establish robust data systems.*** CareFirst’s Portal is a robust data system that contains information about each CareFirst patient, including prior claims utilization and diagnoses,

which LCCs can use when looking for patients that would be good candidates for care coordination. LCCs utilize the portal to track the status of their patients actively receiving care coordination. Additionally, the portal contains a reporting system, SearchLight, containing over 75 different reports that help LCCs manage their patients and understand gaps in care as well as opportunities to improve outcomes.

the program without overburdening patients or providers.

- **Integrate community resources into PCMH program.** There are many untapped or underutilized resources, including social services and health department services, which could be integrated into the CareFirst PCMH program to further assist in meeting the comprehensive needs of chronically ill patients.

Overcoming Remaining Challenges

- **Engage consumers in their care.** CareFirst plans to develop ways to increase patients’ empowerment in their health care. CareFirst wants to provide patients more opportunities to provide input on their care plans and on the future development of

Role of Policy

CareFirst has implemented many policies that have shaped the development of the PCMH program and its use of RNs to serve as LCCs. The table below highlights these policies and notes persisting challenges facing local care coordinators.

**Table 1
Local Care Coordinator (LCC) Role—Policy Facilitators and Challenges**

	Facilitators	Challenges
Model	Community-based LCCs provide care coordination services in-person and on the phone, including care planning and education, to chronically ill CareFirst commercial and Medicare patients; patients can be referred to LCC by providers or CareFirst hospital transition coordinator; patients can also be identified by LCC through CareFirst’s portal; LCC caseload is approximately 50 patients.	Largely telephonic communication between patients and LCC; referral programs for patients are contracted to various external vendors (e.g., behavioral health services, home-based assessments), which can be confusing for patients; only patients with care coordination benefits and the chronically ill are eligible for this service within PCMH program; insurance-based care coordinators may result in providers working with more than one care coordinator.
Education & Qualifications	RN licensed in Maryland, Virginia, or the District of Columbia; 7–10 years of experience, must be self-motivated, organized, and have strong communication skills.	Limited educational opportunities for care coordination training generally in nursing curricula.
Training & Resource Supports	Monthly educational forum, daily huddle with LCCs and regional care coordinator in each region, and biweekly meetings with regional care coordinator; initial training for new LCCs includes 4 weeks of shadowing LCCs in the field and learning about the program.	Care coordination is fairly new; teaching resources as well as sufficient research and evidenced-based practices are minimal.

Table 1 (continued)

	Facilitators	Challenges
Physician/Staff Acceptance	Approximately 80 percent of providers in CareFirst's network currently participate; a local physician champion recruits other providers; providers realize that LCC is an added benefit and also receive financial incentives for participating.	At first, providers, many of whom operate solo practices, felt like they didn't have time to participate; some providers find it hard to integrate LCCs into their practice operation.
Financing & Payment	CareFirst contracts with another organization, Healthways, to employ LCCs to work exclusively for CareFirst's PCMH program. CareFirst pays Healthways as part of the PCMH program's operating budget. As part of participating in the program and working with LCCs, providers receive significant incentive payments. Additionally, LCCs are eligible to receive performance incentives.	Patients receive an Explanation of Benefits from CareFirst although no out-of-pocket money is due, since it is a covered benefit. The LCC's name is on the Explanation of Benefits as the provider, which may be new to the member. It is important that patients see the value from their individual LCC.
Access to Data	CareFirst portal provides electronic claims-based records of each CareFirst patient and robust data reports through a patient portal. Quarterly meetings of LCCs, the region's program consultant, regional care coordinator, and providers review the providers' performance data.	Some providers do not have electronic medical records (EMR). Some that have them do not provide LCCs with access, making it challenging for LCCs to retrieve information on patients. However, all providers and LCCs have access to the full CareFirst-provided claims-based member health record (with consent).
Consumer Input in Model Development	Patient satisfaction surveys are sent to all CareFirst members quarterly.	Limited consumer input on model development.

A Day in the Life...

(continued from page 3)

Identifying High-Risk Patients

After the huddle, Michele springs into action. She has 57 active patients and 3 “in development.” Through claims data, patients are given an “illness burden score” that identifies them for care coordination services. In addition, providers also generate referrals. A large part of Michele’s job is identifying and then engaging these patients through regular communication and encounters.

At the initiation of care coordination, the LCC meets face-to-face with each patient at his or her primary care provider’s office. The LCC then meets with the patient about once every three months thereafter. In addition LCCs communicate by phone at least once a week with each patient. All of these encounters are documented within the care plan, which is accessed through the data portal. Additionally, the care plan is updated at each provider visit to reflect patient progress, health status, and updated goals.

...continued on next page

A Day in the Life...

(continued from page 5)

Communicating with Her Patients

Most of Michele's patients are blue-collar workers and their families between 42 and 69 years of age. She makes several calls before heading out in the morning. She phones a primary care provider to discuss switching her patient's prescriptions to lower-cost brands and requests that the provider waive co-pays for one patient who is struggling to make ends meet.

Michele receives a morning text from one of her longer-term patients, Joe, who provides her with his morning weight and blood glucose. Joe, who prior to being enrolled in the PCMH program was hospitalized six times in the previous year for complications related to congestive heart failure and diabetes, has been successfully treated at home with no hospitalizations in over a year. She replies with an encouraging text.

Meanwhile Michele receives an email from a hospital transition coordinator to discuss a patient's pending discharge. CareFirst has embedded transition coordinators in area hospitals to alert providers of hospital admissions, do "intakes" and also plan for hospital discharges. She phones the transition coordinator to discuss the need for daily home care and they discuss the need for reconciling the discharge medications with the patient's previous medication regimen.

Michele then logs into the electronic data portal to check if one of her patients filled a new blood pressure medication after a recent visit to his primary care provider—and he did. She phones the patient to see if he began the prescription and if he is having any side effects. Michele explains, "a lot of my job is monitoring and education."

She heads out the door and drives to meet a new patient at Dr. Goldman's office. Dr. Goldman is a solo provider—one of many in CareFirst's PCMH network. CareFirst primary care providers are charged with banding with their peers to form a panel, which usually consists of between 5 and 15 providers and 3,000–5,000 CareFirst patients. Dr. Goldman shares a panel with nine other primary care providers. Together, they collectively work to improve cost, quality, and satisfaction outcomes for their combined patient populations. If successful, their panel qualifies for performance payments paid as increases on fees for most primary care services.

Engaging with CareFirst Providers

Michele has worked as a LCC at CareFirst since 2011. It hasn't always been easy to get providers to actively collaborate and refer patients to her, but this has changed. Peer-to-peer outreach has proven to be a successful strategy to engage CareFirst providers in participating in the PCMH program. Because of the mix of financial incentives and the new resources, collaborating with CareFirst providers is getting easier. "They are coming to me and saying, 'I have a patient that would be very good for the program,' because they are seeing the results," says Michele.

...continued on next page

A Day in the Life...

(continued from page 6)

She walks into the office and settles into office space provided to her by Dr. Goldman. “It’s critical that patients and the staff see the LCCs as part of the office,” said Michele. Solo providers like Dr. Goldman typically do not have a registered nurse on staff and having Michele in the office several days a week to care for his chronically ill populations has been welcomed. Michele meets with Dr. Goldman and they discuss several CareFirst patients, including a new patient referral. He leaves to bring the new patient into the exam room and introduces Michele as part of his team. The three briefly discuss goals and then the physician leaves and Michele begins her assessment.

Michele does a patient intake assessment and begins by interviewing the patient and taking her history. The patient is 52 years old, a person with long-term diabetes. She has recently quit smoking and is interested in learning how to count carbohydrates and switch to an insulin pump. Michele explains that her role is to help coordinate among the patient’s many doctors and communicate with them through weekly updates—and the patient appears visibly relieved. Michele makes future plans to connect her with a diabetic educator and an endocrinologist as well as a home monitoring program where she can send daily blood glucoses to Michele. They arrange a time to meet next.

Measuring Performance

Michele heads out the door and makes one more stop at the office of Dr. Schendel, another primary care provider in the panel. Dr. Schendel is the designated “provider representative” or physician champion for Michele’s panel. As the champion, he is responsible for convening the panel quarterly, reviewing data, and discussing issues. Dr. Schendel describes having an LCC to take care of his complex patients as “a relief.” Dr. Schendel remarks, “we all get a benefit that none of us can afford.” Although he has worked with other insurance-based care managers, what makes this program different is the face-to-face time and communication among the provider, the LCC, and the patient.

CareFirst “provider representatives” work closely with the regional care coordinators, like Georgette, and program consultants to discuss issues within the panel, such as performance data trends. Today, Georgette and Diana Mantel, the CareFirst program consultant for this region, join Michele in a meeting with Dr. Schendel to review panel trends. Together they discuss patients that have had readmissions and how resources, including home monitoring programs, might be better utilized.

After the meeting, she leaves for home to begin writing the care plan for her new patient, and have dinner before she begins evening office hours. She offers telephone times between 6–9 PM several nights a week as part of her strategy to connect with her working patients. Michele remarks, “The holistic part of patient care is what makes an RN ideal for this job. We need to assimilate information from multiple providers and settings and develop a care plan and a course of treatment. Nurses are good at taking individual pieces and putting them together, while meeting the needs and desires for a patient.”

Endnotes

¹ Thomas Bodenheimer and Hoangmai H. Pham, Primary Care: Current Problems and Proposed Solutions, *Health Affairs* 29, no.5 (2010):799-805.

² Diane R. Rittenhouse, Small and Medium-Size Physician Practices Use Few Patient-Centered Medical Home Processes, *Health Affairs* 30, no. 8 (2011):1575-1584.

³ Agency for Healthcare Research and Quality, “Defining the PCMH.” Accessed on August 10, 2014, at <http://pcmh.ahrq.gov/page/defining-pcmh>.

⁴ Mary Takach and Jason Buxbaum, Care Management for Medicaid Enrollees Through Community Health Teams, 2013. Available at http://www.commonwealthfund.org/~media/files/publications/fund-report/2013/may/1690_takach_care_mgmt_medicaid_enrollees_community_hlt_teams_520.pdf.

⁵ Centers for Medicare and Medicaid Services, “Health Care Innovation Awards Round One Project Profiles - CareFirst,” page 6. Available at <http://innovation.cms.gov/Files/x/HCIA-Project-Profiles.pdf>.

⁶ CareFirst, “CareFirst BlueCross BlueShield’s Patient-Centered Medical Home Program: An Overview.” Available at <https://member.carefirst.com/carefirst-resources/pdf/pcmh-program-overview.pdf>.

⁷ CareFirst, “Patient-Centered Medical Home Program Shows Promising Quality Trends and Continued Savings on Expected Costs,” [press release] July 10, 2014. Available at <https://member.carefirst.com/individuals/news/media-news/2014/patient-centered-medical-home-year-3-results.page>.

Spotlight 16, November 2014

AARP Public Policy Institute,
601 E Street NW, Washington, DC 20049
www.aarp.org/ppi
202-434-3840, ppi@aarp.org
© 2014, AARP.
Reprinting with permission only.

About This Series

Transforming the Workforce to Provide Better Chronic Care: The Role of Registered Nurses

*Susan Reinhard, AARP Public Policy Institute;
Mary Takach and Rachel Yalowich, National Academy for State Health Policy*

This series explores the evolution of primary care systems to better meet the needs of consumers with complex health conditions. It demonstrates that changes in the workforce are required to empower consumers to better manage their health.

The series is a collaboration of the National Academy for State Health Policy and the AARP Public Policy Institute. We recognize that it takes a team of skilled professionals to deliver improved chronic care. In this series, we focus on how registered nurses—who make up the largest segment of the health care workforce—are being deployed in ambulatory delivery systems to take on new roles. Future series will focus on other members of the health care team.

We selected six initiatives that offer replicable policy strategies to develop, implement, and sustain patient-centered approaches to care. Each case study highlights one of these initiatives and provides policy recommendations and an “on-the-ground” look at the work of its nurses.

We conducted site visits to:

- **Rhode Island’s Chronic Care Sustainability Initiative:** a multipayer medical home initiative that supports an embedded nurse care manager in each primary care practice.
- **North Carolina’s Pregnancy Medical Home Program:** a medical home program for high-risk pregnant Medicaid beneficiaries where obstetric nurse coordinators oversee program operation and quality improvement.
- **Minnesota’s Health Care Homes:** a multipayer medical home initiative where nurses play a crucial role ensuring that primary care practices meet state standards.
- **Hennepin Health (MN):** an accountable care organization where a behavioral health nurse care coordinator orchestrates care among primary care, behavioral health, and social service agencies.
- **Yamhill (OR) Community Care Organization’s Community HUB:** an accountable care organization where a nurse leads a program to improve care for super-utilizer patients.
- **CareFirst’s (MD) Patient-Centered Medical Home Program:** a commercial medical home program using nurse care coordinators to help consumers better manage their chronic conditions. CareFirst is also piloting this program with Medicare consumers through an Affordable Care Act “Health Care Innovation Award.”

These six initiatives offer replicable opportunities and lessons for other states and/or payers that are developing or considering patient-centered models of primary care delivery. All of these initiatives support consumer navigation of complex care systems, understanding of illnesses, and learning self-management skills.

Additionally, all of these initiatives have policies in place that facilitate roles where nurses are supporting practices to be more responsive to consumer needs. The final paper of this series will synthesize lessons learned across all cases studies and offer recommendations for states, policy makers, and educators.

For more information please visit our websites: <http://www.aarp.org/transformingtheworkforce> or <http://www.NASHP.org>.