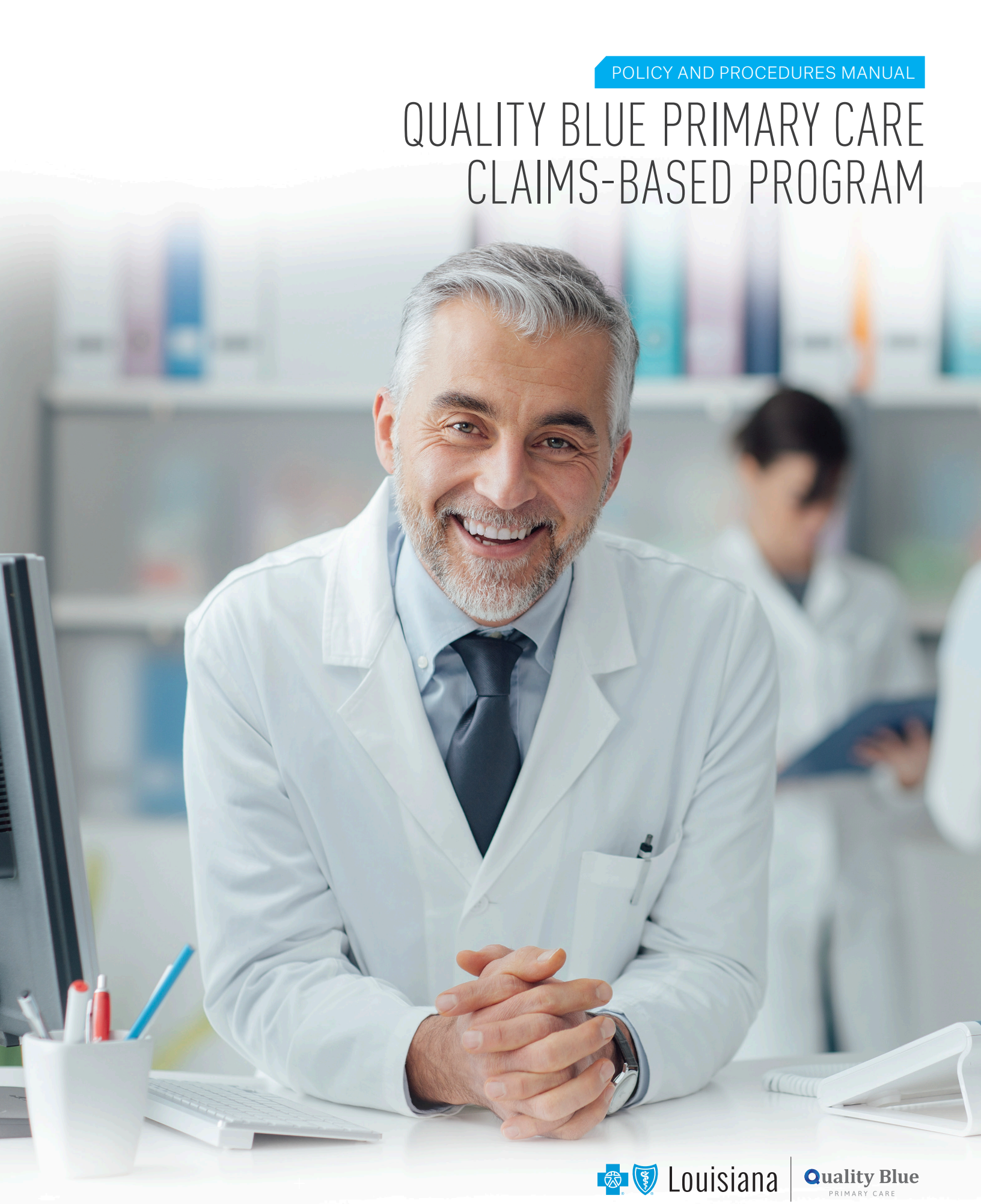
POLICY AND PROCEDURES MANUAL

QUALITY BLUE PRIMARY CARE CLAIMS-BASED PROGRAM



Louisiana | Quality Blue PRIMARY CARE

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SECTION 1 *QBPC Overview*

Introduction

Thank you for taking the time to explore the Quality Blue Primary Care (QBPC) Claims-based Program Policy and Procedures manual. This resource will provide you with a comprehensive understanding of the QBPC Claims-based Program. In it, you will find all the information you need to incorporate the QBPC Claims-based Program into your professional environment.

We are confident that this program will enhance the quality of care and health outcomes for patients and providers alike.

If you have questions about the information in this manual, please call program staff at 1-800-376-7765.

Please note: This manual is provided for informational purposes and is an extension of your QBPC Claims-based Program Participation Agreement. Every effort has been made to print accurate, current information. Errors or omissions, if any, are inadvertent. This manual is intended to set forth in detail QBPC Claims-based Program policies and procedures. Blue Cross and Blue Shield of Louisiana retains the right to add to, delete from and otherwise modify the QBPC Claims-based Program Policy and Procedures manual as needed. The QBPC Claims-based Program Policy and Procedures manual is proprietary and confidential, and may constitute trade secrets of Blue Cross..

Background

Blue Cross and Blue Shield of Louisiana's Commitment to Quality Care

Since 1934, Blue Cross and Blue Shield of Louisiana (Blue Cross) has been committed to providing our members with access to quality, affordable healthcare. Doing so is our mission, our passion and our joy, and we constantly seek ways to improve the quality and affordability of healthcare being delivered to our members. The QBPC programs were created as a direct result of this effort. Both are aimed at improving the health of patients, boosting satisfaction of the providers, and increasing cost savings for all:

- Quality Blue Primary Care Outcomes-based Program (QBPC)
- Quality Blue Primary Care Claims-based Program (QBPC-CB)

Both options promote and enhance the identification and management of prevalent chronic diseases. Blue Cross contracts with providers and furnishes data and resources that enable proactive, efficient, high-quality care. In addition, these programs encourage value-based (as opposed to volume-based) practice methods by equipping providers with a performance-based payment structure, and help to reduce costs through population health and enhanced communication between Blue Cross and the practice.

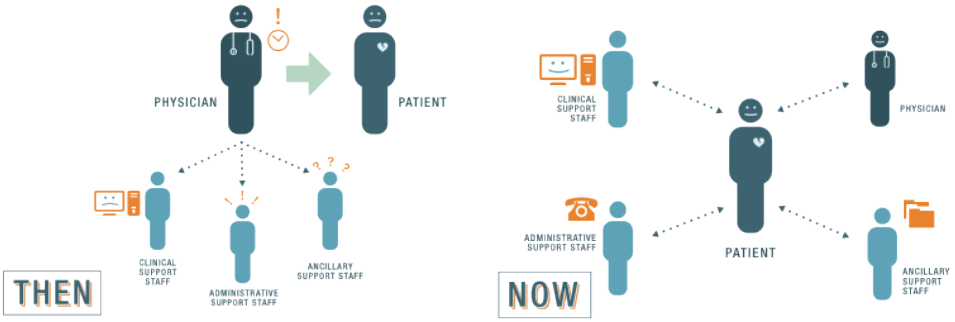
The Status Quo—Clinically and Economically Unacceptable

From both an economic and quality-of-life perspective, chronic illness has an immense negative impact on our nation and our state. More than 145 million people—almost half of all Americans—live with a chronic condition. These diseases account for 75% of overall healthcare costs, and as the prevalence of chronic conditions such as diabetes and hypertension continues to rise, so do the costs

associated with them. In Louisiana, the annual economic burden associated with chronic illness, in terms of treatment expenditures and lost productivity, exceeds $22 billion.

Recognizing the need to reverse this alarming and unsustainable trend, Blue Cross has taken a lead role in assessing the chronic care model that has until now been the standard. Exhaustive study and consideration have led to one conclusion: Healthcare must evolve from the episode-driven, provider care delivery model to one that is driven by population management and features provider- led teams delivering care in order to most effectively and efficiently promote good outcomes for patients with chronic conditions.

Healthcare System Transformation:



Physician Advisory Committee:

Blue Cross has organized a Physician Advisory Committee (PAC), comprised of approximately 12-20 network primary care physicians, including many of those who are enrolled in QBPC. The PAC is organized to provide feedback and input on clinical and quality programs, including the QBPC programs, network issues and general policies, to ensure that the perspectives of participating providers are represented. The quarterly committee meetings are chaired by a Blue Cross medical director.

QBPC Claims-based Program

Description

Practices participating in the QBPC Claims-based Program will be financially rewarded for successfully achieving their goals as outlined in this manual and in their QBPC Claims-based Program Participation Agreements. Each attribute of the QBPC Claims-based Program was designed to successfully facilitate the necessary transformation of patient care to a population health-based approach.

The QBPC Claims-based Program is defined by three core elements:

1. **Population Management:** The consistent use of patient-focused, Blue Cross-provided reports and information on gaps in care and under/over/inappropriate utilization of services.
2. **Care Coordination Tools:** The development and integration of tools, resources and best practices.
3. **Process Improvement:** Identify gaps in care and processes to improve closure. This includes collaborative action planning between the practice care team and Blue Cross.

SECTION 2 *QBPC Claims-based Program Participation*

Targeted Chronic Conditions

The QBPC Claims-based Program currently focuses on the below prevalent and costly chronic conditions. These conditions are targeted because they represent significant opportunities to improve patient outcomes and reduce costs.

- Diabetes
- Hypertension

Blue Cross provides the practice with member attribution and performance reports. These reports identify patients with one or more of the targeted chronic conditions and allows for the monitoring of important indicators related to these conditions. The majority of QBPC Claims-based Program Care Management Fees (CMF) that are paid to practices are based on meeting the quality measurements for health improvements linked to these selected chronic conditions.

Who Is Eligible to Participate in the QBPC Claims-based Program?

Practices

Potential participants in the QBPC Claims-based Program include family medicine, internal medicine, geriatric medicine and general practice physicians , as well as physician assistants and nurse practitioners who have a primary care designation with Blue Cross. Pediatricians and providers credentialed as hospitalists are not eligible at this time. Participation is limited to targeted practices treating adequate numbers of Blue Cross and Blue Shield of Louisiana/HMO Louisiana, Inc. members with chronic conditions and exhibiting a readiness to participate.

Concierge medicine practices, where the provider(s) in the practice have an arrangement with patients that includes enhanced care for an added fee, are not eligible to participate in the QBPC Claims-based Program.

Members Included in the QBPC Claims-based Program

Attributed members eligible for a monthly Care Management Fee must:

1. Be at least 18 years or older
2. Be diagnosed with at least one targeted chronic condition and identified on the Blue Cross-provided patient registry as having:
   - Diabetes and/or
   - Hypertension
3. Have had a claim with Blue Cross for a PCP visit with a participating provider within the required 12-month period.

NOTE: If eligible patients do not wish to be included in the QBPC Claims-based Program, they should call Blue Cross Customer Service at the number on their membership cards. If patients contact the provider's office to opt out of the QBPC Claims-based Program, please direct patients to Blue Cross Customer Service. Patients with questions or concerns about how their data is shared as part of this program may contact the Blue Cross Information Governance Office at 225-298-1751.

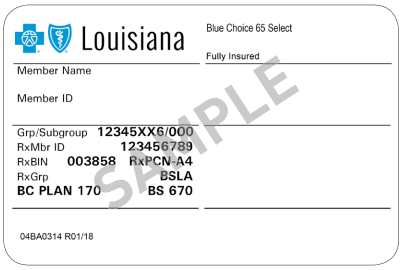
Members Excluded from QBPC Claims-based Program

The following Blue Cross members are not included in the QBPC Claims-based Program at this time.

Please refer to the card samples for each group to know how to identify which network Blue Cross members belong to.

Medicare plans

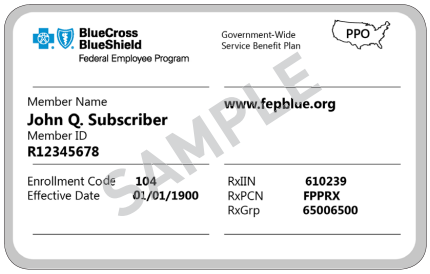
These members receive primary healthcare coverage through Medicare, and may also receive Blue Cross coverage through Medicare Advantage or Medicare Supplement plans. If a member receives Medicare, then Medicare is considered the member's primary form of healthcare coverage, not Blue Cross.



Out-of-state members of the Federal Employee Program (FEP)

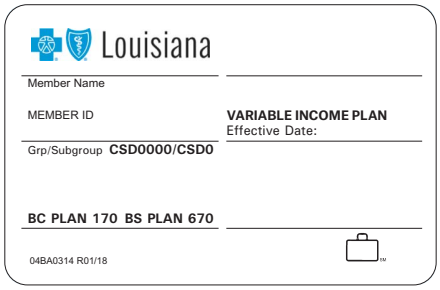
(in-state members are included)

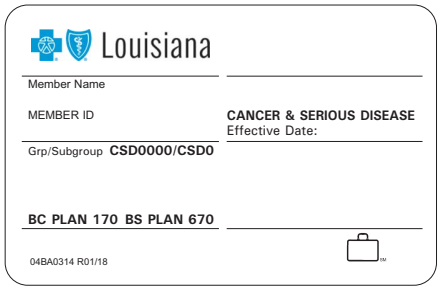
FEP provides coverage for federal employees and annuitants. Federal employees covered through FEP who live in Louisiana can be enrolled as QBPC Claims-based Program members, but those who are out-of-state residents receiving services through Louisiana's FEP network are not eligible.



Limited benefits or secondary coverage (VIP/CSD)

Some members have limited benefit coverage (vision or dental only), or they have Blue Cross as secondary health insurance coverage. These members are not eligible for the QBPC Claims-based Program, unless they have primary healthcare coverage through another QBPC Claims-based Program-eligible Blue Cross plan





In addition to the above exclusions, some members may be covered by multiple insurance policies. Members who have a Blue Cross policy that is not the primary payer/carrier are excluded..

BlueCard (out-of-state Blue plan members)

Members covered by out-of-state Blue Cross and Blue Shield plans are not included. The BlueCard Program links independent Blue Cross and Blue Shield (BCBS) plans across the country and abroad, and allows BCBS participating providers in every state to submit claims for members who are enrolled through another Blue plan to their local BCBS plans. The two main identifiers on cards for BlueCard members are the alpha prefix (three-character element at the front of the member's ID number that identifies the account to which that member belongs) and the suitcase logo.

Attribution Process

Members will be attributed to QBPC Claims-based Program providers according to the following hierarchy:

1. **Member Selected:** All members selecting a primary care provider through insurance product design will be attributed to their selected primary care provider.

    a. Members can voluntarily select a PCP when not required.

2. **Claims-Based:** Unattributed members will be attributed using the most recent 12 months' claims data as follows:

    a. The member is first assigned to the provider group (determined by Blue Cross) with the most Evaluation and Management (E/M) services (CPT codes 99201-99499) billed as an office visit for that member. A minimum of one E/M service is required.

    b. The member is attributed to the primary care provider with the most E/M services (CPT codes 99201-99499) billed as an office visit for that member.

    c. In cases where two or more primary care providers have an equal number of E/M services, a tie-breaking logic will be applied. This includes reviewing an additional 12 months, most recent visit and most allowable.

3. **Automatic Assignment:** All remaining unattributed members who are required to select a primary care provider by insurance product design will be automatically attributed to a primary care provider based on geographical area.

This process results in "Attributed Members."

The Value Proposition of the QBPC Claims-based Program

The QBPC Claims-based Program establishes a partnership among each of the stakeholders in the healthcare dynamic and benefits each of them equally.

For Practices, the QBPC Claims-based Program:.

- Aligns incentives with value, compensating providers for delivering clinical improvement via Care Management Fees in addition to traditional fee-for-service reimbursements
- Maximizes communication of relevant information to increase comprehensiveness and efficiency of care
- Provides support and resources to minimize practice disruptions

For Members, the QBPC Claims-based Program:

- Improves the quality and efficiency of care
- Engages and empowers the patient
- Provides the support and guidance to help members set and achieve their health goals
- Creates a proactive, collaborative patient/provider relationship, in which both parties are a team responsible for the patient's health

For the state of healthcare, the QBPC Claims-based Program:

- Reduces costs by
  - Increasing the efficiency and comprehensiveness of care
  - Incenting the subsequent improved outcomes of healthier patients, who need fewer and less-intensive treatments
- Allows the implementation of a value-based benefit design
- Applies to a range of practice types/settings

Learning Opportunities

For added learning opportunities, Blue Cross hosts a series of regional collaboratives around the state, along with an annual statewide collaborative. These collaboratives give the providers enrolled in both QBPC programs an opportunity to come together, share best practices and learn how they can get the most out of their participation in QBPC.

Blue Cross keeps enrolled QBPC clinical and administrative staff informed about the latest news and developments via a quarterly distributed e-newsletter.

Value-Based Payment: QBPC Claims-based Program Care Management Fees

Blue Cross developed the QBPC Claims-based Program to promote and support the necessary redesign of chronic-condition healthcare. The QBPC Claims-based Program will help providers optimize care delivery by transitioning patient care from a model that is reactive and in which providers are disconnected to a model that is proactive and in which providers are interconnected. Doing so will result in healthier patients, more satisfied providers and cost savings for all.

Quality and Efficiency Tier Adjustment Factor

As has been noted, the QBPC Claims-based Program was designed to improve the quality of care delivered to patients and control the costs of healthcare by meeting the QBPC Claims-based Program quality and efficiency measures (see www.bcbsla.com/QBPCClaims). Accordingly, providers will be rewarded based upon these measures.

Practices are ranked into five tiers that have a corresponding reimbursement adjustment factor.* The rankings are based on performance of defined QBPC Claims-based Program quality and efficiency measures. See the program website for details.

> **During the initial year of QBPC Claims-based Program participation, all practices will default to the base payment with an adjustment factor of 1. Year one of the program is equivalent to receiving payments for a minimum of nine months.*
>
> *After the practices participating in the QBPC Claims-based Program have nine payment months, the Care Management Fee (CMF) is evaluated for adjustment annually based on how the participating practices perform on the clinical quality and efficiency measures established in their QBPC Claims-based Program Participation Agreement.*

NCQA Health Plan Rating Methodology

NCQA Health Plan Rating Methodology will be applied to the QBPC Claims-based Program Scoring Process.

NCQA Overall Rating

- The overall rating is the weighted average of a plan's Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measure ratings, plus accreditation standards (if plan is NCQA accredited), rounded to the nearest half point.
- Performance includes three subcategories (also scored 0–5 in half points):

- Prevention and Treatment.
  - Process measures (such as screenings) are given a weight of 1.
  - Outcome and intermediate outcome measures like HbA1c or blood pressure control and childhood immunizations are given a weight of 3.
- Consumer Satisfaction
  - Patient experience (CAHPS) measures receive a weight of 1.5.
- The overall rating is based on performance on dozens of measures of care and is calculated on a 0–5 (5 is highest) scale in half points.

NCQA Measure and Composite Ratings

- Measure ratings are calculated as whole numbers on a 1–5 scale.
- (Sub) Composite Rating = Σ (measure rating * measure weight) / Σ weights

NCQA Final Rating

- A plan that is in the top decile of plans - 5
- A plan that is in the top third of plans, but not in the top 10 - 4
- A plan in the middle-third of all plans - 3
- A plan that is in the bottom-third of plans, but not in the bottom 10 percent - 2
- A plan that is in the bottom 10 percent of plans - 1

Percentile	Points
0 - 10th	1
> 10th – 33.33rd	2
> 33.33rd – 66.67th	3
> 66.67th - 90th	4
> 90th – 100th	5

QBPC Claims-based Program Scoring and Tiering

Individual measures will be scored and weighted. Measures are scored using National Quality Compass Percentile Measure Cut points. Chronic measures (hypertension, diabetes) are weighted at 2, and all other measures are 1.

Calculation of the adjusted Care Management Fee will be done following the steps below, starting in the practice's second year of the program.

All measures will use the following formula for scoring:

STEP ONE

- The National All Lines of Business 10th, 33.33rd, 66.67th and 90th percentiles of the measure will be used for the ratings.
- Measure ratings are calculated as whole numbers on a 1-5 scale.

Percentile	Points
0 - 10th	1
> 10th – 33.33rd	2
> 33.33rd – 66.67th	3
> 66.67th - 90th	4
> 90th – 100th	5

STEP TWO

- Each measure is assigned a weight and multiplied by the number of points earned in Step 1.
- (Sub) Composite Rating = Σ (measure rating * measure weight) / Σ weights

Category	CA Measures	Weights
Overutilization	Low-Back Pain Imaging Studies Acute Bronchitis-Antibiotic Prescription	1 1
Hypertension	High Blood Pressure Screening	2
Diabetes	Eye Exam LDL Screening Nephropathy HbA1c Screening	2 2 2 2
Preventive	Breast Cancer Screening Cervical Cancer Screening	1 1

STEP THREE

- Determine final scoring denominator.
- If the measure denominator is 0, the measure will receive a weight of zero.

Category	CA Measures	Weights	Measure Denominator
Overutilization	Low-Back Pain Imaging Studies Acute Bronchitis-Antibiotic Prescription	1 1	5 5
Hypertension	High Blood Pressure Screening	2	10
Diabetes	Eye Exam LDL Screening Nephropathy HbA1c Screening	2 2 2 2	10 10 10 10
Preventive	Breast Cancer Screening Cervical Cancer Screening	1 1	5 5
Final Denominator			**70**

STEP FOUR

- Each clinic's final score is percentile ranked
- Scores falling into the ranges below will fall into the corresponding tier

Percentile	Points
0 - 10th	1
> 10th – 33.33rd	2
> 33.33rd – 66.67th	3
> 66.67th - 90th	4
> 90th – 100th	5

NOTE: Blue Cross reserves the right to change the tiering methodology. QBPC Claims-based Program providers will be notified of any changes made.

Care Management Fee (CMF) Payment Structure

The adjusted CMF is divided by 12 (per-member per-year CMF/12 months) and paid monthly. Going forward, the CMF is calculated on the first of the month and paid each month for services provided in the previous month.

CMF Adjustment

- The CMF is evaluated annually in November to determine if an adjustment is necessary.
- Tracking of quality and efficiency scores for each clinic starts on day one of the program. All entities included in tiering must have a minimum of nine payment months prior to being tiered.
- The PAC reviews and contributes to tiering point thresholds in January.
- Providers are notified of their scores and CMF payment tiers in December to be applied to the upcoming January through December payments.
- Blue Cross makes the scores and tiering information available to providers through emails and letters.

QBPC Claims-based Program Measures

NOTE: Details about individual measures are available upon request

Diabetes Measures	• Eye Exam • LDL-C Screening • Nephropathy Screening or Monitoring • HbA1C Tested
Hypertension Measures	• Blood Pressure Screening
Overutilization Measures	• Low-Back Pain • Acute Bronchitis
Preventive Measures	• Breast Cancer Screening • Cervical Cancer Screening

Practice Transformation

To participate in the QBPC Claims-based Program, practices must support the transition to population management-based chronic care by committing to all of the following:

- Designation, training and orientation of a Practice Coordinator.
  - *The Practice Coordinator is employed by the practice— typically a nurse practitioner (NP), a registered nurse (RN) or a medical assistant (MA).*
- Training and orientation of the practice providers and other relevant practice team members.
  - *Practice representation at QBPC regional and statewide collaboratives.*
- Designation, training and orientation of a Practice Champion, Provider Champion and FTP Site Champion (See descriptions in Glossary).
- Active engagement in the population management process, including:
  - *Regular and active participation by the Practice Coordinator, Provider Champion and/or Practice Champion in quarterly discussion with Blue Cross.*
  - *Reviewing of the monthly Performance/Gap Reports.*
  - *Completing a treatment plan and reviewing it with the QBPC Claims-based Program members at the end of each visit. This is a vital step in engaging the patient.*
  - *Sharing the treatment plan with the Blue Cross Team via secured email or fax (whichever is preferred by the practice) upon request by the Blue Cross Quality Navigator. Blue Cross health coaches (nurses, dietitians and/or social workers) will coordinate follow-up with those high-risk patients after a visit to ensure the treatment plan is understood and being followed, barriers to care are addressed and any additional needs are provided as appropriate.*
  - *Encouraging the patient to engage with his or her Blue Cross health coach for care coordination and education.*
- The practice must complete the QBPC Claims-based Program Provider Registry and the QBPC Claims-based Program Champion Registry exhibits in their contracts.
- Failure to comply with one or more of the above requirements can result in CMF payment suspension or termination from the QBPC Claims-based Program.

Taking a Team-Based Approach to Care

Our goal is to transform the Blue Cross network from an episode-driven, provider care-delivery model to a population management-driven, team-care delivery model.

As such, the QBPC Claims-based Program places a high value on team-based care that focuses on the goals and priorities of patients and their families.

Blue Cross has invested in tools and resources to help providers focus on what they do best: diagnosing and treating their patients. Blue Cross Quality Navigators and Blue Cross health coaches will assist practices with care-coordination duties that are critically important to engaging patients and getting them to their goals, so providers can focus on providing the best care possible.

Provider-led teams who work collaboratively with each other, the patient and the extended care community to accomplish shared goals can achieve efficient, high-quality, cost-effective care for our growing patient population.

Gaining Alignment on Patient Care Opportunities with Daily Briefings

Care team coordination is critical to achieving care transformation. By hosting daily briefings, practices gain alignment on the issues and goals for each day's chronic care patients and are equipped with information to close those patients' care gaps.

Blue Cross recommends that QBPC Claims-based Program practices initiate daily briefings as part of their core care management process.

What Is a Daily Briefing?

- A quick (5-7 minutes) and consistent morning "mini meeting," when care teams at the practice review and prepare for each day's patients and their gaps, particularly for chronic care patients
- An opportunity for providers and practice staff to align on each day's goals
- An easily implementable strategy for improved practice efficiency and communication

It is recommended that the Practice Coordinator act as a daily briefing champion. This person will be responsible for leading the meetings and aligning all care team members to each day's objectives. The Practice Coordinator defines the necessary work for each QBPC Claims-based Program patient appointment that day.

For more information about daily briefings, please refer to the QBPC Daily Briefing Guide in the Appendix.

QBPC Claims-based Program Quarterly Meetings

Recurring quarterly meetings, either by web-based conference call or in person that include the Blue Cross Quality Navigator, Blue Cross Care Transformation Consultant and the practice team, are a critical component of the QBPC Claims-based Program workflow. The meeting enables the parties to check in, align activities around patient engagement and gap closure and conduct action planning to close gaps.

Care Management Referrals

Blue Cross has its own in-house clinical team of more than 200 doctors, nurses, pharmacists, dietitians, social workers and wellness consultants, who support our members in their moments of illness and moments of wellness. At any time, practices can refer Blue Cross members to our Care Management Programs. Blue Cross members can also refer themselves. Please refer to Section 5: Other Blue Cross Programs for more detail.

Below are example criteria to use when considering a referral:

- Newly diagnosed chronic condition
- Elevated A1c or uncontrolled BP
- Medication adherence issues or barriers
- Patient readiness to change
- Dietitian counseling
- Mental or behavioral health needs
- High risk or high acuity

Treatment Plans

Alignment of the patient and his or her care team in their goals is paramount in achieving effective chronic disease management. Therefore, it is required that all participating providers complete a treatment plan for each chronic care member, and that the provider and/or the Practice Coordinator (or designated person at the practice) review it with the patient at an end-of-visit "exit interview."

The goal of the treatment plan is to help patients understand their disease(s) and become active in managing their own care. Because patients' needs change over time, the treatment plan provides them with an up-to-date blueprint of their optimal care path and ensures that the provider and patient are working toward the same goals.

A treatment plan provides a summary of the patient's:

- Health status
- Recent visit
- Medications (including when and how to take them)
- Necessary referrals/ancillary services required
- Goals
- Next appointment date

Each patient's treatment plan is different and should reflect how the patient lives. When developing the treatment plan, it's important to consider cultural, economic, physical, mental and social barriers that may affect a patient's ability to achieve goals. The provider and the patient should discuss long and short-term goals and the steps needed to reach them. Jointly considered treatment goals increase the probability that the provider and the patient will both go in the same direction, and they empower patients.

Provided in this manual is a written treatment plan template for each practice's use and reference (see the Appendix). However, practices may use an existing, electronically enabled digital treatment plan format so long as it is developed for and reviewed with each chronic patient.

The Blue Cross Quality Navigator may request a copy of a particular patient's treatment plan from the Practice Coordinator. These can be shared via secure fax or email (whichever method is preferable to the practice). In consultation with the Blue Cross Quality Navigator, a Blue Cross health coach will follow up with the patient after the visit to ensure the treatment plan is understood, is being followed, barriers to care are addressed and any additional needs are provided as appropriate.

Patient-Care Team Pledge ("Care Contract")

At the onset of both QBPC programs, the first step in establishing an ongoing partnership with the care team and the patient is reviewing the QBPC Patient-Care Team Pledge. This document symbolizes the commitment of both parties to be actively engaged and proactive participants in improving chronic disease management through the QBPC programs. Having patients sign the pledge is recommended, but verbal commitments are acceptable if that is more convenient for the practice.

A sample Patient-Care Team Pledge template is located in the Appendix.

Care Coordination Tools

Practices participating in the QBPC programs have access to multiple tools and guides to support population health management and care coordination. Each tool has been created to support practices in their efforts to manage chronic patient care, standardize workflow processes and educate and engage patients effectively.

Practice Coordinators may access the following tools in the Appendix:

- **Daily Briefing Guide:** An organizational resource for the Practice Coordinator that demonstrates how to conduct and optimize daily briefings.
- **Patient-Care Team Pledge:** Reinforces the commitment of both the patient and the care team to take an active role in the management of the patient's chronic disease(s).
- **Treatment Plan Template:** Provides a summary of the patient's health status and establishes goals for improving the management of care.
- **Health Literacy Assessment:** A checklist to help the practice gauge the level of the patient's health knowledge and ability to manage chronic disease(s).
- **Assessing for Cultural Competency:** A reference tool used to evaluate the practice's sensitivity to the cultural characteristics of the patient population.
- **Patient Adherence:** A tip sheet to help practices overcome resistance to treatment or non-compliance in patients.

QBPC Claims-based Program Team Member Roles and Responsibilities

The QBPC Claims-based Program was developed with the understanding that the cornerstone of effective chronic disease management is collaborative, team-based care. The program is designed to foster productive interactions among providers, practice staff, Blue Cross and patients to maximize practice efficiency and improve outcomes.

Implementing the QBPC Claims-based Program results in minimal disruption for the participating providers and their staff, due in large part to Blue Cross' investment in practice transformation resources and clinical support.

The QBPC Claims-based Program leverages three key care team members—the provider, Practice Coordinator and Blue Cross Quality Navigator—to implement a care model that is both efficient and comprehensive.

The Provider

The QBPC Claims-based Program enables providers to focus on what they do best-examining, treating and monitoring patients. The QBPC Claims-based Program providers are responsible for:

1. Becoming QBPC Claims-based Program trained.
2. Completing a treatment plan and reviewing it with each QBPC Claims-based Program attributed patient at the end of his/her visit.
3. Participating in performance improvement activities of the QBPC Claims-based Program.

The Practice Coordinator

Meanwhile, to ensure a collaborative and productive system of care, the practice must designate a Practice Coordinator (typically an individual already employed by the practice). The Practice Coordinator is a vital component of the QBPC Claims-based Program team. This person is the practice-based communications hub and acts as the liaison between the Blue Cross Quality Navigator and the providers. Practice Coordinators are responsible for::

1. Becoming QBPC Claims-based Program trained.
2. Acting as the primary QBPC Claims-based Program practice contact.
3. Participating in quarterly meetings with the Blue Cross team to review opportunities to improve processes and coordination efforts, and conduct action plans for the next quarterly meeting.
4. Reviewing necessary reports provided by Blue Cross.
5. Acting as the daily briefing champion.
6. Ensuring that dedicated staff members conduct an "exit interview" for each Blue Cross chronic patient appointment to ensure that the patient understands his or her treatment plan and gets answers to any questions.

7. Encouraging the patient to engage with a Blue Cross health coach for clinical support and education, which may include providing the patient with Blue Cross contact information.
8. Sharing the treatment plan with the Blue Cross Quality Navigator when requested via secured fax or email. The Blue Cross Quality Navigator shares this information with Blue Cross health coaches, who follow up with the patient after a visit to ensure the patient understands and follows the treatment plan, barriers to care are addressed and any additional needs are provided as appropriate.

Together, this team of champions ensures that the patient-centric, enhanced-communication model of chronic-condition healthcare promoted by the QBPC Claims-based Program runs smoothly.

The Blue Cross Quality Navigator

Blue Cross provides each practice with the services of a Blue Cross Quality Navigator. The Blue Cross Quality Navigator serves as the communication and care coordination hub for practices with Blue Cross.

The Blue Cross Quality Navigator is responsible for:

1. Mining Blue Cross patient data for identified high-risk members for opportunities to intervene and increase patient engagement.
2. Fielding calls/referrals from the practice related to high-risk members needing care coordination.
3. Working with the practice to refer attributed patients to appropriate Blue Cross programs and services, according to protocol.
4. Collaborating with Blue Cross health coaches and the Practice Coordinator to coordinate referrals to ancillary services as necessary.
5. Being knowledgeable about strategies to promote health literacy, self-management of chronic disease, disease education and patient engagement.
6. Serving as a communications hub and general information resource for clinical and care coordination questions.

FTP Site Champion

In addition to the above three key care team members, the QBPC Claims-based Program requires an FTP Site Champion at the practice. This champion will be responsible for downloading reports from a secure File Transfer Protocol (sFTP) site, which will include, but is not limited to, payment reconciliation reports, performance/gap reports and attribution reports. The FTP Site Champion will receive an email when reports are available for download and, once downloaded, will distribute these actionable reports to necessary staff members.

Practice Onboarding and Training

Our goal is to make your transition to the QBPC Claims-based Program as seamless as possible. Our team provides step-by-step assistance along the way, ensuring that your practice gets off on the right foot.

Blue Cross provides comprehensive QBPC Claims-based Program training to all practices enrolled in the program. Training is provided to practices by the Blue Cross Care Transformation Consultant upon full execution of the QBPC Claims-based Program Provider Agreement and attribution of patients to the practice.

Getting Started

Once your practice has reviewed and signed the Provider Agreement and patients have been attributed to your practice, the onboarding process will commence. We'll gather information from you, introduce you to key contacts and train you and your practice staff on the program particulars.

Training Objectives

The training program introduces the QBPC Claims-based Program using a train-the-trainer approach to teach designated practice representatives. It includes an overview of the QBPC Claims-based Program practice reports and best practices for use by the practice in the context of population health management. The training reviews the following:

- QBPC Claims-based Program reports (ex. performance/gap and attribution reports)
- Roles and responsibilities/Blue Cross-practice interaction (Blue Cross Quality Navigator role, Practice Coordinator role, communication, briefings, patient engagement)
- Referral process and care coordination processes
- Clinical Quality and Efficiency Measures
- Practice-specific challenges to transformation implementation
- Action-planning process used to increase gap closure, patient engagement and efficiency of practice processes to promote population health

Training Format

The training format is as follows:

- One hour– QBPC Claims-based Program introduction, review of roles and responsibilities, reports, clinical quality and efficiency measures, program resources and support available.
- 15 minutes --In-depth review of Practice Coordinator / Blue Cross Quality Navigator and Blue Cross program and service referral process.

Attendance of the QBPC Claims-based Program Practice Champion, Provider Champion, Practice Coordinator and FTP Site Champion is required at the training. It is recommended that involved practice providers and office staff attend the training as well, to ensure the practice care team is successful.

Ongoing learning opportunities are made available to practice trainees after the initial training session. Practices should participate in the QBPC regional collaboratives with other participating QBPC practice stakeholders to review program updates and discuss challenges, wins or areas of opportunity and innovation. This is also an opportunity for staff from enrolled practices to share tips and best practices.

SECTION 5 *Blue Cross Quality Blue Programs*

The QBPC Claims-based Program is one of a series of innovative healthcare quality programs developed by Blue Cross under the Quality Blue umbrella.

Quality Blue recognizes those providers who are working with Blue Cross to improve the way care is delivered and improve the overall value of healthcare for our members—your patients. Our programs enable providers to demonstrate a model of care that is thorough and puts patients in control of their healthcare, as evidenced in a commitment to performing comprehensive patient assessments and continual reassessments, educating patients and sharing decision-making with patients.

Quality Blue programs enable providers to provide comprehensive primary care that facilitates partnerships among individual patients (and family members) and the patients' extended care communities. See a listing of all Blue Cross Quality Blue programs online under the provider portal at **www.bcbsla.com**.

Care Management Support Programs

Blue Cross health coaches work directly with patients to follow up between visits and provide them with assistance and support to manage their chronic conditions. Many patients with chronic conditions already participate with Blue Cross' integrated Population Health Care Management programs, but QBPC programs help providers and Blue Cross identify additional patients who may benefit from these resources.

Integration of Blue Cross' Programs and Services

The Blue Cross Population Health Care Management programs offer a proactive, accountable, patient-centric and provider-guided team approach to care. The program consists of nurses, physicians, social workers, pharmacists, dieticians and administrative support staff who work as a team directly with the provider's office and the provider's care network to support the patients, acting as advocates to help them make decisions or resolve any issues that interfere with complying with the provider's plan of care. This direct interaction with patients helps them comply with recommended treatment, address barriers, prepare for visits, understand treatment options and improve participation in care and accountability.

Blue Cross health professionals work with patients on self-care, and help them set and achieve health goals in accordance with the provider's treatment plan. This approach is designed to slow the progress of the patients' diseases and minimize related health problems. The Blue Cross staff work as an extension of the provider's care team for patients with chronic or catastrophic conditions.

The team uses multiple tools for risk identification and to assess a patient's future "trajectory" into higher levels of care or failed outpatient management. This integrated program also addresses areas such as treatment to therapeutic levels, psychosocial, cognitive and financial concerns.

The Blue Cross Quality Navigator serves as the communication and care coordination hub for practices in our QBPC programs. The Blue Cross Quality Navigator monitors the practice's patient population and coordinates the provision of key information from Blue Cross to the practices.

The Blue Cross Quality Navigator will also work directly with enrolled practices to assist in developing a care community for quality and cost-effective referrals.

QBPC programs are intended to complement day-to-day practice activities and help identify interventions and care support needed for individual patients to connect them with services and resources to manage their conditions and meet their health goals.

InHealth: Blue Review

Blue Cross health coaches review requests for services and assist with transitions of care to ensure members receive quality, cost-effective healthcare. Utilization review includes prior authorization, concurrent and retrospective review of inpatient and outpatient service requests to determine medical policy coverage status, medical necessity and clinical appropriateness of the services and level of care.

Blue Review also offers:

- Promotion and facilitation of optimal outcomes
- Assistance in the development of timely transitions of care
- Monitoring for quality of care, including over- and under-utilization
- Identification of potential network enhancement
- Evaluation for referral to Blue Cross Population Health Case and Disease Management programs
- Collaboration with medical directors on complex cases
- Assistance in maximizing member benefit related to visits with in-network providers

InHealth: Blue Health Services (Chronic Conditions)

Our Population Health Care Management programs assist members with chronic conditions such as heart failure, diabetes, chronic kidney disease, asthma, COPD and coronary heart disease (CHD) who are not conforming to evidence-based care recommendations, to understand their conditions and what is needed to improve them. Our team of nurses and support staff works with members to improve their health by self-managing their conditions and changing unhealthy behaviors.

InHealth: Blue Touch (Complex or Non-Chronic Conditions)

Blue Cross' Population Health Care Management program is a comprehensive, whole-person model that assists members with complex or non-chronic conditions by addressing potential barriers to good health outcomes from multiple areas including clinical, functional, cognitive, environmental, support system, psychosocial and financial. Based on an individual's needs, we may help to coordinate services, provide information regarding disease processes and community-based resources and help to set positive healthcare goals and coach the member to help reach these goals.

InHealth: Blue Script Program

The Blue Script program focuses on getting our members to improve their adherence with prescribed medications for hypertension, diabetes, cholesterol and asthma/COPD. All members enrolled in one of the Blue Cross clinical programs are screened for non-adherence. Nurse calls to these members who are found to be non-adherent will focus on overcoming barriers to medication adherence.

InHealth: Blue Aware Program

Blue Aware targets members who frequently go to the ER. Members meeting criteria for the program receive education and may be assessed to determine if the member has unique needs that are not being met, such as access-to-care issues, an unstable medical condition or lack of an established provider relationship.

InHealth: Blue Transitions Program

The Blue Transitions program is a telephonic outreach program focusing on transitioning patients successfully from the acute-care setting to other levels of care, including home. Our nurses assist the member with the transition to home, focusing on the goal of reducing readmissions, complications and medical costs, as well as addressing safety and compliance issues.

Lifestyle Modification, Such as Smoking Cessation Support

All members in a program are assessed for tobacco use. For those members ready to quit smoking or using tobacco products, interventions are incorporated into their plans of care. Our nurses are trained in behavioral modification and coaching techniques that have been shown to be successful for smoking cessation. Referrals are also made to community resources for support in their efforts to quit smoking.

SECTION 6 *QBPC Claims-based Program Contact Information*

Blue Cross and Blue Shield of Louisiana is here to guide you through the QBPC Claims-based Program practice transformation process and answer questions along the way.

For information and assistance with the QBPC Claims-based Program implementation, please contact:

Quality Blue Primary Care

Phone: **1-800-376-7765**
Fax: **(225) 298-7601**
Email: **clinicalpartnerships@bcbsla.com**

SECTION 7 *Glossary of Terms*

Blue Cross Health Coach	A licensed nurse, dietitian or social worker employed by Blue Cross to deliver care management programs
Blue Cross Quality Navigator (QN)	Blue Cross employee appointed as the participating practice liaison and population management/registry champion
Care Management Fee (CMF)	Monthly fee paid to participating QBPC Claims-based Program providers, which is based on the number of members with targeted chronic conditions they manage and their performance on selected efficiency and clinical quality measures
Daily Briefing	A daily (5-7 minute) morning "mini meeting" when care teams at the practice review and prepare for that day's chronic care patients and their gaps
FTP Site Champion	Practice-employed QBPC Claims-based Program technical point-person responsible for downloading the reports from the secure FTP site and distributing them among practice staff as necessary
Physician Advisory Committee (PAC)	Committee comprised of Louisiana physicians that advises Blue Cross on its various clinical and quality programs, including QBPC Claims-based Program, to ensure that the perspectives of participating providers are represented
Practice Champion	Practice-employed QBPC Claims-based Program point-person (may be the same as the Provider Champion)
Practice Coordinator	Practice point-person, likely an RN, NP, MA or office manager, who will work directly with the Blue Cross Quality Navigator to coordinate patient care
Practice(s)	Entity or clinic(s) participating in the QBPC Claims-based program
Provider	Physician, nurse practitioner, and/or physician assistant
Provider Champion	Practice-employed QBPC Claims-based Program clinical point-person (may be the same as the Practice Champion)
Quality Blue Primary Care Claims-based Program	Official program name

APPENDIX

The Appendix contains all Quality Blue Primary Care documents referenced throughout the Policy and Procedures manual.

A. Treatment Plan Template

B. Patient-Care Team Pledge

C. Daily Briefing Guide

D. Health Literacy Assessment

E. Assessing for Cultural Competency at Your Practice

F. Patient Adherence Tip Sheet

G. Population Health Referral Form

Treatment Plan

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Date: _____ Provider: _____

Patient Name: _____ Insurance ID #: _____

Caregiver Name/phone (if applicable): _____

Phone *(home)*: _____ Phone *(mobile)*: _____

Diagnosi/es: _____

Long-Term Goal(s): _____

_____

Current Appointment:

Reason for visit: _____

Change(s) in health or factors affecting health since last visit: _____

_____

BP: ____ mm Hg Pulse: ____ bpm Temp: ____ 0F Weight ____ lbs 2nd BP *(same appt)*: ____ mm Hg

Any abnormalities on review of systems/exam/labs: _____

_____

Medication (Rx and OTC)	**Dose (No. of pills, injections, pumps, etc.)**				**Food**	
	Morning	*Noon*	*Evening*	*Before Bed*	*With*	*Without*

Care Services:

Referrals: _____

Ancillary Care (e.g. home health, CDE, medical equipment): _____

_____

Lab Tests Ordered (type & date scheduled): _____

Next Steps:

Patient-Provider Agreed Upon Short-term Goals: _____

_____

Date of Next Appointment: _____

_____ _____

Patient Signature *Provider Signature*

Patient-Care Team Pledge

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In association with Blue Cross Blue Shield of Louisiana, we at _____ have a primary goal of providing you with the best possible care. A trusting partnership among an engaged patient, the patient's care team and Blue Cross is essential to achieve this goal.

In order to fulfill this partnership, we will:

- Respect you as an individual by:
  - Keeping your medical information and records private
  - Explaining tests and their results and diseases/conditions and their treatments
  - Listening to your questions and concerns to assist you in making decisions and setting goals
- Provide safe and qualified care by:
  - Providing you with a multidisciplinary care team to meet all of your healthcare needs
  - Individualizing your medical care to meet your needs
  - Providing clear instructions on how to take medications and use other therapies
  - Sending you to trusted experts, when needed
  - Ending every visit with clear instructions on expectations, treatment goals, medications and how to take them, and future plans
- Ensure continuity over time

In return, we trust you to:

- Participate as an engaged, activated member of the care team
- Take charge of your health
  - Educate yourself about wellness, preventing disease and making healthy choices
  - Be honest and thorough about your history, symptoms and any changes in your health
  - Tell us when you see other providers and what medications they have prescribed
- Be proactive:
  - Take all of your medicine and follow your treatment plan as prescribed, or tell us if you cannot do so
  - Respect us as partners in your care
  - Keep your appointments as scheduled, or let us know if you need to cancel
- Communicate with us
  - Ask questions, share feelings, be part of your care team
  - Call your care team first with all problems, unless it is a medical emergency
  - Provide us with feedback to improve our services
  - Let us know after every visit if you understand your provider's expectations, treatment goals and future plans

_____ _____

Provider *Date*

_____ _____

Patient *Date*

QBPC Daily Briefing Guide

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Care team coordination is critical to achieving care transformation. By hosting Daily Briefings, your practice can gain alignment on the issues and goals for each day's chronic care patients and be equipped with information to close those patients' gaps. Daily Briefings will improve practice efficiency by increasing communication and proactively identifying potential issues.

What is a Daily Briefing?

- A quick and consistent morning "mini meeting" when care teams review and prepare for that day's chronic care patients and their gaps
- An opportunity for providers and their practice staff to align on each day's goals
- An easily implementable strategy for improved practice efficiency and communication

How to Conduct Daily Briefings:

1. **Establish the QBPC Practice Coordinator as a Daily Briefing champion.** S/he will lead the meetings and align all care team members to each day's objectives.
2. **Settle on a time to meet consistently.** It's important that the "briefing time" becomes a part of everyone's daily routine, so agree on a time to meet that will work for everyone, before morning appointments commence.
3. **Limit Daily Briefings to seven minutes or less, and make it a standing meeting.** This keeps the meeting focused and prevents team members from becoming long-winded.
4. **Hold the Daily Briefing in a private, central location.** Remember to choose a location where protected health information can be confidentially discussed, if needed.
5. **Reflect on the previous day's appointments.** Discuss what worked well and what problems persist. How can you work differently today?
6. **Review the Care Coordination Report.** This is your guide to addressing the gaps your chronic care patients are facing. Review patients one by one, defining necessary work for each. Consider the following:
    - Do any of the patients require more time and assistance due to age, disability, personality, health literacy, cultural differences or language barriers? Who can help?
    - Review potential scheduling conflicts related to patient acuity.
    - Are lab results, test results and notes from other providers ready in the patient's chart?
7. **Agree to a plan of action.** Before you break to take on the day, ensure each team member understands his/her objectives for the day.

Resource: Huddles: Improve Office Efficiency in Mere Minutes
(Family Practice Management 6/07) www.aafp.org/fpm/20070600/27hudd.html

Patient Assessment for Low Health Literacy

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Assess for low or limited health literacy with this easy-to-complete checklist. Patients who respond positively to **any** of the behaviors and/or responses below may be at risk for low health literacy. Although a patient may not exhibit any of the below behaviors or responses, it's important to be vigilant in assessing gaps in understanding and communication throughout a patient's care.

Health Literacy Checklist: *(Check if Present)*

Behaviors

- ☐ Incomplete or inaccurately completed patient forms
- ☐ Frequently missed appointments
- ☐ Noncompliance with disease management plan, therapies
- ☐ Lack of follow-through with lab tests, imaging tests or referrals to specialists
- ☐ Lack of expected change in lab tests or physiological parameters in patients who state they are taking their medications as prescribed

Responses to Written Information

- ☐ "I don't have my glasses. I'll read this when I get home" or simply, "I'll read this later"
- ☐ "I forgot my glasses. Would you read this to me?"
- ☐ "I'd like to take this home to discuss with my [spouse/children/other]"

Responses to Questions About Medications

- ☐ Unable to name medications
- ☐ Unable to describe purpose of medications
- ☐ Unable to explain timing of medication administration

Adapted from Weiss BD. Removing Barriers to Better, Safer Care. Health Literacy and Patient Safety: Help Patients Understand. Manual for Clinicians. 2nd ed. Chicago, IL: American Medical Association Foundation and American Medical Association; May 2007. http://www.ama-assn.org/ama1/pub/upload/mm/367/healthlitclinicians.pdf.

Assessing for Cultural Competency at Your Practice

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The United States has been experiencing a growth in racial and ethnic communities, each of which embraces its own cultural customs and traits. The patient and healthcare provider bring unique learned patterns of language and culture to the healthcare experience. These customs, traits and languages, as well as other aspects of culture, may influence:

- Patients' health, healing and wellness belief systems
- Patients' perceptions of illness, disease and their causes
- Behaviors of patients who are seeking healthcare
- Patients' attitudes toward healthcare providers

The "changing face" of America challenges healthcare providers. The importance of meeting these challenges of diverse cultures is perhaps best reflected in the trend for future generations. Within 50 years, nearly one-half of the U.S. population will be from cultures other than white, non-Hispanic.

Cultural competency, defined as "the ability of an individual to understand the social, linguistic, moral, intellectual and behavioral characteristics of a community or population, and translate this understanding systematically to enhance the effectiveness of healthcare delivery to diverse populations," is a critical aspect of the delivery of quality healthcare. To attain cultural competency, a practice or system must deliver healthcare services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients.

This checklist ***(on back)*** allows for assessment of cultural competency in your practice.* A check (or absence of a check) may reaffirm commitment to cultural competency and/or assist in identifying areas for improvement.

*Adapted in part from Sutton M. Improving patient care: cultural competence. Fam Pract Manag. 2000;7(9):58-60.

Consider the following in your care setting:

- ☐ Pictures, posters, artwork and other decor in the office reflect the cultures and ethnic backgrounds of patients
- ☐ Magazines, brochures and other printed materials in waiting room are of interest to and reflect the different cultures of individuals and families in the practice/system
- ☐ Printed information distributed to patients takes into account the average literacy levels of individuals and families receiving care
- ☐ Have bilingual-bicultural staff and/or personnel and volunteers skilled or certified in the provision of medical interpretation available during visits, on calls, and generally for any communication with patient
- ☐ Recognize that limitations in English proficiency are in no way a reflection of a patient's level of intellectual functioning
- ☐ All notices and communiqués to patients and families are written in their language of origin
- ☐ Recognize that it may be necessary to use alternatives to written communications for some individuals and families; verbal communication may be preferred
- ☐ Do not impose values that may conflict or be inconsistent with those of other cultures or ethnic groups
- ☐ Recognize and accept that different cultures define family differently
- ☐ Accept and respect that male-female roles may vary significantly among different cultures and ethnic groups (e.g. family member who makes major decisions for the family)
- ☐ Recognize that age and life-cycle factors must be considered in interactions with individuals and families (e.g. high value placed on the decision of elders, the role of eldest male or female in families, or roles and expectation of children within the family)
- ☐ Recognize that the meaning or value of medical treatment and health education may vary greatly among cultures
- ☐ Recognize that religion and other beliefs may influence how individuals and families respond to illnesses, disease and death
- ☐ Recognize that perception of health, wellness and preventive health services has different meanings to different cultural or ethnic groups
- ☐ Seek information from individuals, families or other key community informants that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse groups
- ☐ Seek information on acceptable behaviors, courtesies, customs and expectations that are unique to the culturally and ethnically diverse groups
- ☐ Keep up-to-date on the major health concerns and issues for ethnically and racially diverse patient populations
- ☐ Be aware of socioeconomic and environmental risk factors that contribute to the major health problems of culturally, ethnically and racially diverse patient populations
- ☐ Keep up-to-date on the most current and proven practices, treatments and interventions for major health problems among ethnically and racially diverse patient populations
- ☐ Maintain continuity of cultural appropriateness across the care team

*Adapted in part from Sutton M. Improving patient care: cultural competence. Fam Pract Manag. 2000;7(9):58-60.

Patient Adherence

TIP SHEET TO OVERCOME RESISTANCE OR NON-COMPLIANCE

With all members of the care team working together, everyone is better prepared to help patients stick to their care plans, meet their health goals and overcome any obstacles they experience in getting the proper treatment.

However, the patient is an autonomous decision maker for his/her own health, and changing patients' attitudes and convincing them to adopt new, healthier behaviors is a long and ongoing process that can take months or years to be successful.

Providers can unintentionally create resistance or non-compliance with patients in the way they handle patients' expressions of their problems and/or feelings. Some things that can cause this are:

- Bringing up anxiety-provoking or threatening realizations
- Discussing attitudes or problems with a patient who isn't ready to face them
- Stating things in ways that arouse negative psychological factors in a patient, or the characteristics of the person stating these things (e.g. demeanor, tone, stance)

The following are some tips that can help practices better engage with non-compliant patients and resolve any issues that are impeding care.

1. **Respect and honor the resistance**

   Instead of countering or arguing about whatever the patient is resisting, be empathetic and move to a position of understanding. This will make the patient more willing to consider the desired alternative or share information.

   For example, instead of saying, "You need to keep your appointment with me every three months!" say, "I know it must be difficult to keep your appointments with your busy schedule."

2. **Don't move too fast.**

   Resistance is the gap between where the patient is and where you think s/he should be. Patients are in their world, not your world, when it comes to what is needed to solve problems. The bigger the gap, the greater the resistance. Patients often feel resistant when they hear explanations they aren't ready to accept, are confronted too soon about a medical problem or feel like they are being pushed too soon to complete their treatments and reach their health goals. Think about what the smallest step would be that moves the patient in the right direction to start solving his/her problems, and begin there. Patients will be less resistant if given small, manageable goals.

   For example, instead of saying, "You need to lose 50 pounds," advise the patient to try losing 10 pounds between this visit and his next visit in three months.

3. **Establish mutual goals**

   Patients will have much less resistance when you are both working toward the same thing. The most fundamental thing a provider can do is ask (not tell!) the patient what his/her goals are, then align treatment goals accordingly.

4. **Discover emotionally compelling reasons to change, and emphasize those**

   People do not change their attitudes and behaviors based on logic. They change when they have emotionally compelling reasons to do so. Work with your patients to discover and clarify the emotional reasons they want to make changes. Use high-level empathetic statements that label and bring out the emotions attached to issues. As you do so, patients will give cues that make clear which emotions are most important to them. Going forward, you can gently remind patients of these emotional drivers to encourage them to stick to their care plans.

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Population Health Referral

POPULATION HEALTH FAX: 225-298-3184 **POPULATION HEALTH PHONE: 1-800-317-2299**

NOTE: ***DO NOT use this form for urgent or emergent referrals. Upon receipt of the referral form, a Population Health nurse will reach out to the patient within 3-5 business days.***

Patient Information

Patient Name _____

Date of Birth _____ Patient Phone (Day) _____

BCBSLA ID Number _____ Evening Phone _____

Referring Physician Name _____ Referring Physician Phone _____

Pertinent Clinical Information

Diagnoses, treatment plan, labs/test results, vital signs, discharge summary, etc.

_____

_____

Referral Type

☐ **Health Coach**

Reason for Referral

_____

_____

☐ **Social Worker**

Reason for Referral

_____

_____

☐ **Dietician**

Reason for Referral:

_____

_____

Additional Information

_____

_____