# TABLE OF CONTENTS

**SECTION 1: QBPC Overview** .................................................................................................................. 3
  - Introduction ........................................................................................................................................ 3
  - Background ......................................................................................................................................... 3
  - QBPC Program Overview .................................................................................................................. 4

**SECTION 2: QBPC Participation** ......................................................................................................... 5
  - Blue Cross and Blue Shield of Louisiana’s Partners ........................................................................ 5
  - Targeted Chronic Conditions .......................................................................................................... 6
  - Enrollment Criteria for QBPC Chronic Conditions ......................................................................... 7
  - Care Definitions of Chronic Conditions ........................................................................................ 8
  - Who Is Eligible to Participate in the QBPC Program? ..................................................................... 11
  - Providers Switching Business Entities ............................................................................................ 11
  - Details of Attribution ....................................................................................................................... 13

**SECTION 3: System Transformation** .................................................................................................. 17
  - Value Proposition of QBPC ............................................................................................................. 17
  - Ongoing Clinical Quality Improvement .......................................................................................... 17
  - Value Based Payment: QBPC Care Management Fees .................................................................. 18
  - Practice and Physician Quality and Efficiency Tier Adjustment Factor ........................................ 18
  - Efficiency Measures ....................................................................................................................... 22
  - Practice Transformation ................................................................................................................ 24

**SECTION 4: Roles and Requirements** ............................................................................................... 31
  - QBPC Team Member Roles and Responsibilities ........................................................................... 33
  - Integration of Blue Cross and Blue Shield of Louisiana’s Programs and Services ....................... 33
  - QBPC Continuing Medical Education Component ........................................................................ 33
  - NCQA Recognition via MDInsight Use .......................................................................................... 34
  - QBPC Training .................................................................................................................................. 35
  - Practice Onboarding ...................................................................................................................... 36

**SECTION 5: Blue Cross Quality Blue Programs** ............................................................................... 37

**SECTION 6: QBPC Contact Information** .......................................................................................... 41

**SECTION 7: Glossary of Terms** ......................................................................................................... 43

**SECTION 8: Appendix** ...................................................................................................................... 45
Introduction

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

Welcome—we are confident that this program will enhance the quality of care and health outcomes for patients and practitioners alike.

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

Please note: This manual is provided for informational purposes and is an extension of your QBPC 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 policies and procedures. Blue Cross and Blue Shield of Louisiana retains the right to add to, delete from and otherwise modify the QBPC Policy and Procedures manual as needed. The QBPC 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 (BCBSLA) 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 program was created as a direct result of this effort.

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 current episode-driven/physician care-delivery model to one that is driven by population management and features physician-led teams delivering care in order to most effectively and efficiently promote good outcomes for patients with chronic conditions.
**Healthcare System Transformation:**

**QBPC Program Overview**

**Description**

The QBPC program promotes and enhances the identification and management of prevalent chronic diseases. Blue Cross contracts with physicians and provides, free of charge, a web-based, patient-centric information tool (MDinsight) that furnishes practices with data and resources that enable proactive, efficient, high-quality care. In addition, QBPC encourages value-based (as opposed to volume-based) practice methods by equipping providers with an outcomes-based payment structure, and helps to reduce costs through carefully managed care coordination. Practices will be financially rewarded for successfully achieving their goals as outlined in this manual and in their QBPC program participation agreements. Each attribute of QBPC was designed to successfully facilitate the necessary transformation of chronic condition care.

QBPC is defined by three core elements:

1. **Population Management:** The consistent use of a patient-focused, interactive portal to aggregate clinical and claims data.

2. **Care Process Workflows and Tools:** The development and integration of standardized chronic disease management care plans, tools, resources and best practices.

3. **Learning Opportunities:** Data analysis at selected intervals to identify clinical care delivery gaps and CME needs. Practice support recommendations and CME modules have been developed to help practices achieve clinical objectives.

**The bottom line:** QBPC will result in healthier patients, more satisfied providers and cost savings for all.
SECTION 2

QBPC Participation

Blue Cross and Blue Shield of Louisiana’s Partners

To realize the QBPC program concept, Blue Cross is using the expert technology, data mining and practice enhancement capabilities of Symphony Performance Health, Inc. (SPH).

**Symphony Performance Health, Inc (SPH)** is a health information technology company that develops and hosts secure web-based platforms to improve clinician decision-making at the point of care. QBPC incorporates SPH’s MDinsight® technology to help practices identify, manage and improve the quality of care for their patients.

**MDinsight** is a cloud-based, interactive portal that utilizes analytical technology developed by SPH to help practices manage and improve the quality of care for their patients. MDinsight serves as a care coordination platform for the entire medical repository, supporting a patient-centered approach to care by:

- Providing web-based access to integrated patient data across multi-provider settings, including the hospital, primary care and specialist practices for a comprehensive view of patient care
- Providing comprehensive data aggregation from many sources, including, but not limited to, lab results, practice management schedules, EMR interfaces, registry systems, claims data and pharmacy utilization
- Identifying and highlighting care opportunities for wellness screenings and patients with chronic diseases who have gaps in care
- Performing evidence-based outcomes analysis

MDinsight organizes data from all sources to create a report dashboard featuring:

- A **Patient Care Summary** (PCS), which includes relevant medications, diagnosis and procedure history and clinical values for each clinical condition in MDinsight.
- A **Goal Progress Report** that visually shows the practice’s and physicians’ progress trend in each clinical measure over time.
- A **Patient Care Opportunity Report** that displays all process measures and clinical results outside the relevant performance range
- A **Patient List** that displays patient attribution by physician, clinical condition and patient disposition.
- A **Clinician Comparison Report**, which displays comparisons between practice locations and physicians to identify best practices and also areas where improvement is needed.

In summary, MDinsight is an invaluable analytical and organizational tool that improves quality and efficiency of patient care for all patients in the practice.
Physician Advisory Committee

In addition to our partners, BCBSLA 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 QBPC, network issues and general policies to ensure that the perspectives of participating providers are represented. The quarterly committee meetings are chaired by a BCBSLA medical director.

Targeted Chronic Conditions

The QBPC 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.

- Vascular Disease
- Diabetes
- Hypertension
- Chronic Kidney Disease

For each of these conditions, there is an MDinsight clinical suite with an associated patient registry. These registries allow for the monitoring of important indicators related to these conditions, and the identification of care opportunities with these chronically ill patients. The majority of QBPC 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.
Enrollment Criteria for Quality Blue Primary Care Chronic Conditions

Care Management Fees are paid for members with the following four chronic conditions who meet the enrollment criteria, approved by the Physician Advisory Committee on April 18, 2013, and outlined below: Vascular Disease, Diabetes, Hypertension and Chronic Kidney Disease.

Enrollment criteria for Vascular Disease:

- Enrollment is based on diagnosis of atherosclerotic occlusions of coronary arteries, aorta, lower or upper extremity arteries and carotid/cerebral arteries.
- Findings should be traceable to a radiographic or functional test, though not specifically required to be in the primary care physician’s medical record. An example would be that the diagnosis of coronary artery disease obtained from a cardiology referral as reflected in a consultation report or test report is sufficient; however, the heart catheterization film or image is not required to be in the primary care physician’s chart.

Enrollment criteria for Diabetes:

- Includes established diagnoses of diabetes mellitus type 1 and type 2 that have one or more prescribed medications for treatment of hyperglycemia.
- New diagnosis of diabetes (using American Diabetes Association’s diagnostic criteria.)
- Patients co-managed with an endocrinologist are eligible for enrollment.

Enrollment criteria for Hypertension:

- Established diagnosis of hypertension that has one or more medications for treatment of hypertension.
- New diagnosis of hypertension (using the Joint National Committee’s criteria.)

Enrollment criteria for Chronic Kidney Disease:

- Eligibility based on National Kidney Foundation Guidelines.
- Patients with three or more months of estimated Glomerular Filtration Rate (eGFR) below 60 mL/min/1.73m² or albuminuria qualify for enrollment.
- Patients on renal replacement therapy (peritoneal or hemodialysis) do not qualify for the Chronic Kidney Disease suite.
- Patients not on renal replacement therapy who are seeing a nephrologist are eligible for enrollment in the Chronic Kidney Disease suite.
- Patients entirely managed by a nephrologist and/or other specialists should be removed from the primary care physician’s attributed patient list.
Care Definitions of Chronic Conditions

VASCULAR DISEASE (AGES 18 AND OLDER)

Enrollment for QBPC includes any of the established diagnoses for Vascular Disease using ICD-10 codes. Due to the extensive variety of testing that may be performed, enrollment is based on diagnostic codes; however, these diagnoses should be supported by radiologic, angiographic or functional cardiac testing that indicates arteriosclerotic pathology.

DIABETES MELLITUS (AGES 18 AND OLDER)

Types of Diabetes Mellitus eligible for QBPC:

Type 1 or type 2 diabetes mellitus. Gestational diabetes is not considered a chronic condition until patient is diagnosed with diabetes post-partum.

Diabetes Mellitus Diagnosis Criteria:

• Fasting* venous glucose of 126 mg/dL or greater (* fasting is defined as without caloric intake for greater than eight hours). Repeat in absence of unequivocal hyperglycemia.
• Hemoglobin-A1C of 6.5 % or greater. Repeat in absence of unequivocal hyperglycemia.
• Two-hour venous glucose of 200 mg/dL or greater as part of Oral Glucose Tolerance Test (OGTT – 75 gram glucose load). Repeat in absence of unequivocal hyperglycemia.
• Patients with classic symptoms of hyperglycemia (excess urination, excess thirst, etc.) and a random glucose of 200 mg/dL or more. Repeat testing is unnecessary.

Established Diagnosis:

Patients with a diagnosis of type 1 or type 2 diabetes mellitus on one or more medications, either oral agent(s), insulin(s) or other anti-hyperglycemia medications, are eligible for QBPC enrollment. Pre-diabetes, metabolic syndrome or other pre-diabetic syndromes are not eligible for QBPC enrollment. Patients who are co-managed with an endocrinologist may be enrolled in QBPC.

HYPERTENSION (AGES 18 AND OLDER)

Measurement of blood pressure:

The auscultatory method of BP measurement with a properly calibrated and validated instrument should be used. Patients should be seated quietly for at least five minutes in a chair (rather than on an exam table), with feet on the floor and arm supported at heart level. Measurement of BP in the standing position is indicated periodically, especially in those at risk for postural hypotension. An appropriate-sized cuff (cuff bladder encircling at least 80 percent of the arm) should be used to ensure accuracy. At least two measurements should be made. Systolic blood pressure is the point at which the first of two or more sounds is heard (phase 1), and diastolic blood pressure is the point before the disappearance of sounds (phase 5). Clinicians should provide to patients, verbally and in writing, their specific BP numbers and BP goals.
Diagnosis of Hypertension eligible for QBPC:
Office:
Step 1: Take two blood pressure measurements and average the systolic blood pressure and diastolic blood pressure.
Step 2: Repeat step 1 during another visit on another day.
Step 3: Diagnosis of hypertension is supported if both (average) readings are greater than 140 / 90 mmHg.

Ambulatory Blood Pressure Monitoring:
Using a 24-hour average blood pressure monitoring device or semi-automatic device, hypertension is defined as any one of the following:
• A 24-hour average above 135/85 mmHg
• Daytime (awake) average above 140/90 mmHg
• Nighttime (asleep) average above 125/75 mmHg

Home Blood Pressure Monitoring:
Though home monitoring may be more strongly predictive with adverse outcomes, for QBPC, home blood pressure monitoring is not considered standard practice for the initial establishment of hypertension diagnosis.

Established Diagnosis of Hypertension:
Patients with a history of hypertension on one or more medications for hypertension are considered “hypertensive” for QBPC purposes regardless of blood pressure reading(s).

CHRONIC KIDNEY DISEASE (CKD) [AGES 18 AND OLDER]
Definition of Chronic Kidney Disease for QBPC enrollment:
A decline in kidney function for three or more months as determined by an estimate of the Glomerular Filtration Rate (eGFR) of less than 60 mL/min/1.73 m2 OR significant albuminuria (levels defined below) NOT on any form of renal replacement therapy including kidney transplant.

Estimation of GFR:
Several mathematical formulas are commonly used to estimate GFR when kidney function is not rapidly changing (chronic). These estimates are at times significantly different than the measured GFR. The Modification of Diet in Renal Disease (MDRD) Study equation is the most frequently used GFR estimating equation in the U.S. for the establishment of CKD. The Chronic Kidney Disease Epidemiology Collaboration (CKD-EPI) equation is more accurate than the MDRD Study equation.
The Cockcroft-Gault Equation is perhaps the most familiar estimation formula for primary care physicians and is often reported on many routine laboratory reports. This formula, however, generally overestimates creatinine clearance by 10-40% and therefore may cause a “delay” in diagnosis of impaired kidney function. Note that this continues to be the method for adjusting drug dosages for kidney function.

24-hour Creatinine Clearance (24-hour urine collection): Estimating GFR via a 24-hour, urine-collected creatinine clearance may be used as an estimation of GFR. Note that adjusting for Body Surface Area (BSA) makes this method more accurate for evaluating kidney function, and the unadjusted creatinine clearance should be used for adjusting drug dosages.

For purposes of QBPC, all of these methods may be used for evaluation of QBPC enrollment.

**Measurement of GFR:**
Measurement of eGFR is complex, cumbersome and time-consuming; therefore, this has little benefit in primary care practices. However, if a patient has had a measurement using a radioactive marker or insulin that confirms impaired GFR (less than 60 mL/min/1.73 m²), this test may be used as a criterion to enroll the patient in QBPC.

**Estimate of Albuminuria:**
Albumin-to-creatinine ratio (ACR) 30 mg/gram or greater is considered sufficient for QBPC enrollment even with a GFR greater than 60 mL/min/1.73 m², since increased mortality and progression of CKD may still occur. This test may need to be repeated if no other evidence of kidney damage is present for more than three months.

**Co-Management of CKD with Nephrologist:**
General recommendations are that patients with eGFR less than 30 mL/min/1.73 m² may be commonly referred and co-managed with a nephrologist. For QBPC purposes, these patients may remain enrolled in QBPC until the time that renal replacement therapy is initiated or renal transplant is performed. At this time, the Chronic Kidney Disease suite is no longer eligible for participation, but if the patient has other diseases being managed, such as diabetes, the patient may remain in those other suites.

Patients who have End Stage Renal Disease and are treated with dialysis/transplant are not eligible for QBPC.
Who is Eligible to Participate in the QBPC Program?

Practices

Potential participants in the QBPC program include family medicine, internal medicine, geriatric medicine and general practice physicians. Pediatricians are not eligible. 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 that exhibit a readiness to participate.

Concierge medicine practices, where the doctor or doctors in the practice have an arrangement with patients that includes enhanced care for an added fee, are not eligible to participate in QBPC. Providers that do not have and actively use an EMR will not qualify to participate.

Providers must have at least six months of experience actively using a currently installed EMR system, and install MDinsight at the practice site(s) in coordination with practice IT staff, including extraction of clinical data from the practice EMR, lab, registry or other systems for submission to SPH for processing. EMR systems must have a current Health IT Certification from the Office of the National Coordinator for Health Information Technology (ONC) in order to qualify for the program. A list of certified systems is available at: http://chpl.healthit.gov.

Providers Switching Business Entities

If a physician and/or physician practice currently participating in QBPC as part of an integrated care network (that has contracted with Blue Cross as a QBPC business entity) chooses to leave that network and participate in QBPC under a different network (that has also contracted with Blue Cross as a QBPC business entity), the physician and/or physician practice must provide a written statement on the physician’s or practice’s official letterhead to Blue Cross Clinical Partnerships.

The written statement must include a stated intention to leave the current network entity and participate in QBPC under a different network entity and a formal termination of any existing QBPC Provider Agreement.

Any physician who chooses to transfer participation in QBPC should be aware that there could be a break in Care Management Fee payments during the transfer period.

Physicians leaving one entity for another are also required to notify the current entity of this decision.

Members Included in QBPC

In order to participate in the QBPC program, Blue Cross members must be attributed to a participating physician and have a face-to-face visit with the physician in a 24-month period. Blue Cross members not seen in more than 24 months should not be attributed to a participating physician.
Attested members eligible for a monthly Care Management Fee must:

- Be diagnosed with at least one targeted chronic condition and participating in a clinical suite via MDInsight:
  - Vascular Disease
  - Diabetes
  - Hypertension
  - Chronic Kidney Disease

- Have had a claim with Blue Cross for a face-to-face visit with the physician for a service related to the targeted chronic condition or a preventive service within the required 12-month period.

Members Excluded from QBPC

The following Blue Cross members are not included in the QBPC program at this time. These patients’ data may be in MDi, but providers will not receive Care Management Fees for treating patients in these coverage groups who are linked to their practices.

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

Medicare Primary/supplemental plans

These members receive healthcare coverage through Medicare, and may also receive Blue Cross coverage through Blue Choice 65 or Blue Choice 65 Select, which are the Blue Cross series of 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)

FEP provides coverage for federal employees and annuitants. Federal employees covered through FEP who live in Louisiana can be enrolled as QBPC 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 only limited benefit coverage (vision or dental only), or they have Blue Cross as secondary health insurance coverage. These members are not eligible for QBPC, unless they have primary healthcare coverage through another QBPC-eligible Blue Cross Plan.

In addition to the above exclusions, providers will not be paid CMF for children under age 18. 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. But, providers who are participating in QBPC will be able to record all patients’ data in MDinsight, and the providers may use this resource to manage their pediatric patients’ (and other non-QBPC-attributed patients’) healthcare.

Details of Attribution

Data Collection

MDinsight normalizes structured clinical data from practices’ disparate existing systems (lab, practice management, EMR and registry systems) and analyzes it against evidence-based guidelines for process and outcome measures.

Patient Identification

MDinsight aggregates and classifies data from the records of physicians to create a comprehensive patient profile. Based upon the patient profile, physicians and patients are matched with, or “attributed to,” one another. The physician is responsible for ensuring that he/she has been correctly attributed as the patient’s physician within MDinsight. The physician is also responsible for verifying and correcting the patient’s diagnosis and participation in the chronic illness clinical suites.

In a case where two physicians select the same patient on their panels, Blue Cross and Blue Shield of Louisiana will make the ultimate decision of where the patient is assigned, taking into account available claims data and member preference. For attribution of patients who are members of a different health plan or have other healthcare coverage, the physician should contact SPH for assistance.
After each physician has reconciled his/her list of attributed members, it is the practice’s responsibility to formally sign off on all physicians and their respective attributed members. This “sign off” can be in the form of an email or scanned signature page, and will also attest that the practice will keep each physician’s attribution list current and inform Blue Cross of any physician participation changes. Blue Cross should be notified immediately (at most, within 30 days) of a physician ceasing participation in any given practice. If the practice does not notify Blue Cross in a timely manner of a physician leaving/ceasing participation in that practice, Blue Cross has the right to recoup any CMF payments made to the practice on behalf of that physician, if the payments were made after the physician left.

Patient data is then processed and compared with baseline standards for each clinical suite to identify patients with care gaps and opportunities. Refer questions about attribution to your Blue Cross practice transformation consultant.

**Data Sharing – The Practice View**

QBPC practices have the ability to see all patient demographic information and corresponding clinical data submitted by their organization on the MDinsight technology platform. They may segment reports by all patients, not just patients who are Blue Cross members.
QBPC practices also are able to see corresponding relevant Blue Cross claims data for QBPC patients.

The MDinsight tool allows for a patient’s data elements to be shared between organizations. For example, John Doe is currently attributed to Organization A; however, he may have had a low-density lipoprotein at Organization B. The low-density lipoprotein would be displayed on the Patient Care Summary for John Doe and show a data source of Organization B (Lincoln Medical Center) (Note: Both Organization A and B must be in the program).

**Data Sharing – The Blue Cross View**

Blue Cross has the ability to see patient-level data for their active members only. This is the same view the participating organization has on all of their members. Blue Cross will also be able to view and update clinical notes pertaining to their members. Clinical notes include additional information about a patient’s health that may not be reflected in the other sections of the Patient Care Summary, including, but not limited to, barriers to care, recent inpatient admits, etc.

BCBSLA is able to see aggregate data on the non-member population only, while participating organizations are able to see more.
The Value Proposition of QBPC

The QBPC population health and quality improvement program establishes a partnership between each of the stakeholders in the healthcare dynamic and benefits each of them equally.

For Practices, QBPC:

- Aligns incentives with value, compensating physicians for delivering clinical improvement via Care Management Fees in addition to traditional fee-for-service reimbursements (See Clinical Quality and Efficiency Measures diagram)
- Optimizes the existing care team, allowing the physician to focus on what s/he does best—treating the patient
- Maximizes communication of relevant information to increase comprehensiveness and efficiency of care
- Provides support and resources to minimize practice disruptions

For Members, QBPC:

- Improves the quality and efficiency of care
- Engages and empowers the patient
- Provides the support and guidance to help members set and achieve 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, QBPC:

- Reduces costs by
  - Increasing the efficiency and comprehensiveness of care
  - Incentivizing 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 learning collaborative. These collaboratives give the doctors enrolled in QBPC an opportunity to come together, share best practices and learn how they can get the most out of their participation in the program.
Blue Cross keeps participating QBPC clinical and administrative staff informed on the latest news and developments of the QBPC program via a monthly distributed e-newsletter.

If you or members of your practice would like to be added to the newsletter distribution list, email ClinicalPartnerships@bcbsla.com and include valid email addresses for recipients.

**Value-Based Payment: QBPC Care Management Fees**

Blue Cross developed the QBPC program to promote and support the necessary redesign of chronic condition healthcare. QBPC will help practitioners optimize care delivery by transitioning—transforming—chronic condition 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.

**Practice and Physician Quality and Efficiency Tier Adjustment Factor**

As has been noted, the QBPC program was designed to improve the quality of care delivered to patients with chronic illnesses and control the costs of healthcare by meeting the QBPC quality and efficiency measures (see Clinical Quality and Efficiency Measures diagram). Accordingly, practices and physicians will be rewarded based upon these measures.

Practices and physicians are ranked into three quality and efficiency tiers (Highest, Middle and Lowest) that have a corresponding reimbursement adjustment factor.* The rankings are based on clinical and efficiency outcomes of defined QBPC quality and efficiency measures.

*During the initial year of QBPC program participation, all practices and physicians will default to the middle tier, with an adjustment factor of 1. Year one of the program is equivalent to receiving payments within two payment cycles, where each cycle starts from July to December and January to June. After the practices and physicians participating in the QBPC program have passed through two payment cycles, the Care Management Fee (CMF) is evaluated for adjustment every six months based on how the participating practices and physicians perform on the clinical quality and efficiency measures established in their QBPC Program Participation Agreement.

Calculation of the adjusted CMF will be done following these steps starting in the practice’s third payment cycle of the program:

*Please refer to the diagrams on the following pages.*

1. Performance on Quality and Efficiency Measures of all QBPC program providers will be measured (see Clinical Quality and Efficiency Measures diagram).
2. The Physician Advisory Committee (PAC) will review and contribute to thresholds for each measure used for adjusting Care Management Fees. These thresholds will define how many points are awarded for each measure. (See Calculating Points Per Measure diagram for example of how points are awarded based upon performance).
3. Earned points for each measure are multiplied by the corresponding weight for each measure. Then a total score is calculated for the practice.

4. The total scores for all QBPC entities are compared and placed into one of three tiers based upon the total points obtained by each QBPC entity. The point thresholds are 0-2.99 points is the “Low Tier,” 3.00-10.49 points is the “Middle Tier,” and 10.50-15.00 is the “Top Tier.” These are designed to place approximately 20% of QBPC entities in the “Low Tier,” 50% of QBPC entities in the “Middle Tier,” and 30% of QBPC entities in the “Top Tier.” (See Example Distribution of Total Points by Practice diagram).

5. The base CMF is calculated for the practice. One base CMF is paid for members with a single targeted chronic condition. A different, higher base CMF is paid for members with two or more targeted chronic conditions.

6. The base CMF is adjusted based upon which tier the practice is in. (See Adjustments Based on Clinical and Efficiency Outcomes diagram.)

**CMF Payment Structure**

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

Providers must notify Blue Cross and Blue Shield of Louisiana Clinical Partnerships of any physicians added to their practices in order to receive payment for that physician’s attributed members.

Please see the sample of the QBPC Payment Reconciliation Report in the Appendix.

The reimbursement methodology for QBPC may vary based on unique strengths/characteristics of contracted practices. Participating practices should refer to their specific Program Agreement for details.

**CMF Adjustment:**

- The CMF is evaluated every six months to determine if an adjustment is necessary.
- Tracking of quality and efficiency scores for each clinic starts on day one of the program. CMF payments are adjusted after the first two payment cycles. 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 and July.
- For the scores set in January, providers are paid at that CMF-adjusted rate through June. For the scores set in July, providers are paid at that CMF-adjusted rate through December.
- Providers are notified of the scores every June and December.
- The scores are made available to the provider through emails/letters initially, and on the MDinsight provider portal.
SECTION 3: System Transformation

Clinical Quality and Efficiency Measures

QBPC Clinical Quality and Efficiency measures are available online. Go to [www.bcbsla.com/QBPC](http://www.bcbsla.com/QBPC) and click Program Measures. A table of the current measures will be displayed.
Example of Calculating Points Per Measure

**HTN Control Rates**

- **1 Point**
- **2 Points**
- **3 Points**

**Example Distribution of Total Points by Practice**

- **Lowest 20%**
- **Middle 50%**
- **Upper 30%**
Efficiency Measures

While we expect primary care physicians to practice high-quality, evidence-based medicine (and will reward them accordingly), today’s healthcare cost crisis demands that providers help us contain healthcare expenditures when possible. We can no longer afford to sustain a system of unnecessary utilization and high-cost healthcare. The winners of the future will successfully demonstrate high value and enact appropriate resource utilization. The QBPC efficiency measures were created to begin working toward these goals.

In Quality Blue Primary Care, value is defined as:

\[
\text{Desired clinical outcome or patient experience (Quality) / Cost of healthcare services used to achieve the outcome (Cost)}
\]

As such, we have introduced three efficiency measures to provide primary care providers with examples of the types of data that can be measured today to begin the learning process. These efficiency measures are reported for all Blue Cross-attributed members, not just those members with chronic conditions. The efficiency measures are:

1. **Low Back Pain Imaging**: A risk-adjusted measure of potentially preventable imaging for uncomplicated low back pain, taking into account the complexity of the provider’s patient population and their characteristics, including their chronic illness burden. This measure is used to assess the percentage of members with a primary diagnosis of uncomplicated low back pain who do not undergo unnecessary imaging studies (plain X-ray, magnetic resonance imaging [MRI] or computed tomography [CT] scan) within 28 days of diagnosis. Low back pain is a common problem for which patients seek treatment from primary care providers. According to the American College of Radiology, imaging studies are often not necessary to successfully treat the patients and relieve pain. Providers are asked to work with patients and educate them on when imaging studies are appropriate to avoid potentially unnecessary, costly procedures. Exclusions are built in for this efficiency measure to account for patients whose lower back pain does require an imaging study for proper diagnosis and treatment.
Specifically, this measure includes members ages 18-50. Members with the following diagnoses are excluded from this measure:

- Cancer at any point in the claims data history.
- Trauma within 12 prior months of low back pain episode.
- IV drug abuse within 12 prior months of low back pain episode.
- Neurological impairment within 12 prior months of low back pain episode.

2. **Potentially Preventable ER Visits**: Potentially preventable visits (PPV) is a population-based outcome measure. PPVs can happen because of a lack of adequate access to care or care coordination. Successful quality improvement interventions for patients with chronic conditions should reduce or eliminate the need for ER services. PPVs are defined by 3M’s© Enhanced Ambulatory Patient Groups (EAPGs). More than 75% of PPVs are associated with the EAPGs listed below. Because a PPV rate can be influenced by the patient’s chronic illness burden, any comparisons of PPV rates will be adjusted for chronic illness burden. In computing a provider’s PPV rate, the numerator is defined as the number of PPVs. The denominator of a PPV rate is identified as the number of members in the population. The PPV method uses Clinical Risk Groups (CRGs) for risk stratification for comparing actual and expected PPV rates.

**3M© EAPG Description of Top PPVs**

- 00530 - Headaches Other than Migraine
- 00531 - Migraine
- 00553 - Level I Ophthalmic Diagnoses
- 00562 - Infections of Upper Respiratory Tract
- 00564 - Level I Other Ear, Nose, Mouth, Throat & Cranial/Facial Diagnoses
- 00573 - Community Acquired Pneumonia
- 00576 - Level I Other Respiratory Diagnoses
- 00627 - Non-Bacterial Gastroenteritis, Nausea & Vomiting
- 00628 - Abdominal Pain
- 00657 - Lumbar Disc Disease
- 00673 - Cellulitis & Other Bacterial Skin Infections
- 00674 - Contusion, Open Wound & Other Trauma to Skin & Subcutaneous Tissue
- 00675 - Other Skin, Subcutaneous Tissue & Breast Disorders
- 00727 - Acute Lower Urinary Tract Infections
- 00871 - Signs, Symptoms & Other Factors Influencing Health Status

*Copyright 2013 3M©. All rights reserved.*

3. **Risk-adjusted Generic Fill Rate**: Generic fill rate is calculated using the QBPC provider’s attributed population. For the QBPC provider’s members, all pharmacy utilization (regardless of prescribing physician) is used to calculate this measure. This is a claims-based, risk-adjusted generic pharmaceutical utilization measure that compares actual generic fill rate vs. expected generic fill rate utilization of all prescribing physicians for the risk-adjusted population, taking into account patients’ chronic illness burden. For this measure, the higher the index number, the better.
Sample formula:

- Group A current generic fill rate: 92%
- Group A risk-adjusted expected generic fill rate: 90%
- Group A score: 92%/90% = 1.02
- This group is performing better than expected.

In keeping with the nature of the QBPC quality improvement effort, the combined weight of the efficiency measures is only 20% of the total measures being used to adjust Care Management Fees over time, and 80% of the measures are clinical quality measures.

There are no minimum thresholds for expected performance for any of the QBPC measures. Performance will only be compared to other primary care physicians who are participating in QBPC, so there is a level playing field.

**Practice Transformation**

Blue Cross is making a generous investment in primary care by funding the QBPC practice transformation program. It is therefore expected that each enrolled practice be an engaged and active participant.
To participate in QBPC, systems must support the transition to population management-based chronic care by committing to all of the following:

- Installation of MDInsight at the practice site(s).
  - Completion of Practice Profile and Practice Readiness Assessment.
  - Allow HIPAA-approved extraction of clinical data from the practice EMR, lab, registry or other systems by SPH for processing.
- Designation, training and orientation of a Practice Coordinator (or Practice Coordinators, depending on system size and configuration).
  - The Practice Coordinator is employed by the practice—likely a nurse practitioner (NP), a registered nurse (RN) or a medical assistant (MA).
- Training and orientation of the practice physicians and other relevant practice team members.
  - Practice representation at QBPC regional and statewide collaboratives.
- Designation, training and orientation of a Practice Champion, Physician Champion, IT/Technical Champion, CME Champion and Local MDinsight System Administrator (See descriptions in Glossary).
- Active engagement in the population management process, including:
  - Patient attribution (the identification and assignment of a patient to a physician practice panel).
  - Regularly reviewing, updating and maintaining the Patient Lists in MDinsight to keep attribution current and include patients who have had a visit within the past two years. This should be reviewed at least monthly.
  - Acceptance of high-level “care plans” reviewed in advance for management of patients who are “high-risk,” newly diagnosed and have multiple chronic conditions.
  - Regular and active participation by the Practice Coordinator in Weekly Care Coordination Calls with the Blue Cross Quality Navigator.
  - Reviewing of the MDinsight Patient Care Summaries for QBPC program members with upcoming appointments.
  - Completing a treatment plan and reviewing it with the QBPC program members at the end of each visit. This is a vital step in engaging and activating the patient.
  - Sharing the treatment plan with the Blue Cross Team via secured email or fax (whichever is preferred by the practice). The Blue Cross Nurse will coordinate follow-up with the patient after a visit to ensure the treatment plan is understood and being followed by the patient.
  - Encouraging the patient to engage with his or her Blue Cross Nurse for care coordination and education.
- Participating providers must complete the QBPC Program Provider Registry and QBPC Program Champion Registry exhibits in their contracts. (Please see contract sample in the Appendix).
- Participation by all practice physicians in the annual QBPC Overview learning module.
- Failure to comply with one or more of the above requirements can result in CMF payment suspension or termination from QBPC.
Taking a Team-Based Approach to Care

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

As such, QBPC 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 physicians focus on what they do best: diagnose and treat. Quality Navigators and Blue Cross Health Coaches will assist practices with the care coordination duties that are critically important to engaging patients and getting them to their goals, so physicians can focus on providing the best care possible.

Physician-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.

QBPC practices are recommended to initiate daily briefings as part of their core care management process.

What is a Daily Briefing?

• A quick (5-7 minute) and consistent morning “mini meeting,” when care teams at the practice, using information discussed with the Quality Navigator, review and prepare for each day’s patients and their gaps, particularly for chronic care patients
• An opportunity for physicians 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 QBPC 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 reviews the Patient Care Summaries and defines the necessary work for each QBPC patient appointment that day.

For more information about QBPC daily briefings, please refer to the QBPC Daily Briefing Guide in your QBPC Program Toolkit, in the Appendix of this manual and also in MDinsight.

QBPC Weekly Care Coordination Call

Recurring weekly (or semi-weekly) calls between the Quality Navigator and the Practice Coordinator(s) are a critical component of the QBPC workflow. The calls enable the parties to gain alignment on the issues and goals for chronic care patients with upcoming appointments and equip the practices with

SECTION 3: System Transformation
information to address those patients’ care gaps.

**Objectives of the Call:**

- To allow the Quality Navigator and Practice Coordinator to review care gaps, opportunities and critical barriers to care for Blue Cross members with chronic conditions who have appointments scheduled during the following week.
- To enable the Quality Navigator and Practice Coordinator to discuss necessary details about Blue Cross members with complex chronic conditions who require extra attention.
- To ensure regular and active collaboration between the practices and Blue Cross in managing members with chronic diseases.
- To make sure that the QBPC practices are adequately prepared for each pre-scheduled chronic care member visit.

**Process Overview:**

1. The Quality Navigator works with the designated Practice Coordinator(s) to schedule a weekly (or in some cases, depending on patient load, a semi-weekly), standing call.

   *Note: It is recommended that calls be scheduled for 30 minutes, but the actual length of the call will depend on the number of patients and issues for each practice.*

2. In advance of the scheduled call, the Practice Coordinator will look up and print out the MDInsight Patient Care Summaries for the following week’s appointments for his or her reference during the call. Each MDInsight Patient Care Summary outlines key clinical opportunity information for the Blue Cross patient with chronic diseases, in addition to clinical notes pertaining to barriers to care, recent inpatient admits and other critical details as noted by the Blue Cross care management team.

3. The call is initiated by the Quality Navigator, who leads the Practice Coordinator through reviewing chronic care patients and addressing the following:

   - Critical care gaps and opportunities to be addressed during the upcoming visit.
   - Critical barriers to care as indicated by clinical notes.
   - Recent patient hospital/ER events (if available at the time of the call, as indicated by clinical notes).
   - Patients targeted for engagement, as necessary.
   - Updates on patients discussed during the previous call, as necessary.

   *Note: Special attention is paid to members who have complex chronic conditions or require additional attention.*

4. Pursuant to the call, the Quality Navigator works with Blue Cross health coaches to ensure that chronic members are aware of and fully prepared for their scheduled appointments.

5. Before the call ends, the Quality Navigator and the Practice Coordinator confirm with one another that they are aligned and understand the patient objectives for the following week.

6. The Practice Coordinator utilizes the MDInsight Patient Care Summaries and context provided by the call to lead his or her own practice’s Daily Briefings.
For same-day or walk-in appointments, the Practice Coordinator should provide that patient’s treatment plan to the Quality Navigator for follow-up.

**Care Plans**

QBPC Care Plans outline the care to be provided to the practice’s QBPC-attributed patients. They define the set of actions the Quality Navigator and Practice Coordinator need to implement to support chronic care patients identified by the MDinsight patient population assessment and guide the ongoing evaluation and provision of care.

The Care Plans are not specific to any one chronic condition; rather, they focus on three chronic care patient types:

- High-Risk/Hospitalized Patients
- Patients with Multiple Chronic Conditions
- Newly Diagnosed Patients

*QBPC Care Plans are incorporated into the QBPC Workflows, which are found in the Appendix.*

If eligible patients do not wish to be included in QBPC, they should call Blue Cross and Blue Shield of Louisiana Customer Service at the number indicated on their membership cards. If patients contact the provider’s office to opt out of QBPC, please direct patients to Blue Cross and Blue Shield of Louisiana Customer Service.

**Clinical Workflows**

QBPC Clinical Care Coordination Workflows provide a roadmap for delivering high-quality patient care enhanced by the Quality Navigator. They are designed to enhance team collaboration, patient interactions and consultations, and streamline workflows.

Care Coordination Workflows have been developed for each of the following chronic care patient types:

- Newly diagnosed patients
- Patients with multiple chronic conditions
- High-risk/hospitalized patients
- Patients utilizing the ER

Please refer to the Appendix for samples of each Clinical Workflow. These workflows are generic, and some enrolled practices might adapt these to make customized workflows.
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 QBPC participating physicians complete a written treatment plan for each chronic care member, and that the physician 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 activated 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 impact a patient’s ability to achieve goals. The physician 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 physician and the patient will both "go in the same direction," and they empower patients.

QBPC has provided a written treatment plan template for each practice’s use and reference (see the Appendix). However, practices may utilize an existing, EMR-enabled digital treatment plan format so long as it is developed for and reviewed with each chronic patient.

At the end of each visit, it is the responsibility of the Practice Coordinator (or another office staff member) to review the treatment plan with the patient once again, ensuring that he or she understands it and has all questions answered.

The Quality Navigator may request a copy of a particular patient’s treatment plan from the Practice Coordinator. These can be shared via secure email or fax (whichever method is preferable to the practice). In consultation with the Quality Navigator, a Blue Cross health coach will follow up with the patient after the visit to ensure the treatment plan is understood and is being followed by him or her.

A sample QBPC Treatment Plan template is located in the Appendix.
Patient-Care Team Pledge (“Care Contract”)

At the onset of QBPC, the first step in establishing an ongoing partnership with the care team and the patient is the reviewing of 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 program. It is the responsibility of the Practice Coordinator to identify new patients who require a Patient-Care Team Pledge and work with the physician to review the document with the patients. 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

Participating QBPC practices gain access to the QBPC Program Toolkit 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 through the MDinsight portal:

• **Weekly Care Coordination Call Guide:** A blueprint for the Practice Coordinator to conduct effective and efficient Weekly Care Coordination Calls with the Quality Navigator.

• **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 their patient population.

• **Depression and Chronic Care Patients:** A reference tool that provides important considerations to assist practices in identifying chronically ill patients who may also be exhibiting depressive symptoms.

• **Patient Adherence:** A tip sheet to help practices overcome resistance to treatment or non-compliance in patients.

*Examples of each tool are referenced in the Appendix.*
QBPC Team Member Roles and Responsibilities

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

Implementing QBPC results in minimal disruption for the participating physicians and their staff, due in large part to Blue Cross’ investment in practice transformation resources, technology and clinical/technical support.

QBPC leverages three key care team members—the Physician, Practice Coordinator and Quality Navigator—to implement a care model that is both efficient and comprehensive.

The Physician

The QBPC program enables physicians to focus on what they do best—examining, treating and monitoring patients. QBPC physicians are responsible for:

1. Becoming QBPC trained.
2. Reviewing high-level care plans for chronic disease patient types.
3. Participating in the required learning components of the QBPC program.
4. Completing a treatment plan and reviewing it with each QBPC member at the end of his/her visit.
5. Reviewing a Patient-Care Team Pledge ("Care Contract") with each Blue Cross member.

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 team. This person is the practice-based communications hub and acts as the liaison between the Blue Cross Quality Navigator and the physicians. Practice Coordinators are responsible for:

1. Becoming QBPC trained.
2. Acting as the primary QBPC Practice contact.
3. Participating in weekly (or semi-weekly) Care Coordination Calls with the Quality Navigator to review and plan for the next week’s chronic care patient appointments.
4. Accessing and reviewing in MDinsight each chronic member’s Patient Care Summary in advance of his or her appointments.
5. Championing the Daily Briefing within the practice.
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 the patient may have.
7. Encouraging the patient to engage with a Blue Cross health coach for care coordination and education, which may include providing the patient with Blue Cross contact information.

8. Sharing the treatment plan with the Quality Navigator via secured email or fax (whichever is preferred by the practice). The 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.

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

The Quality Navigator

Blue Cross provides each practice with the services of a Quality Navigator. The Quality Navigator serves as the communication and care coordination hub for practices with Blue Cross. The Quality Navigator monitors the patient registry to identify care opportunities and coordinates relaying key information from the Blue Cross health coaches’ member calls to the Practice Coordinator in preparation for each patient visit.

The Quality Navigator is responsible for:

1. Mining patient data within MDinsight on an ongoing basis.
2. Using MDinsight and other data tools to identify care opportunities for chronically ill patients.
3. Leading phone calls on a regular schedule with the Practice Coordinator to review MDinsight Patient Care Summaries (including pertinent clinical notes) for chronically ill patients (i.e. Weekly Care Coordination Calls).
4. Working with Blue Cross health coaches to manage and/or refer patients to appropriate Blue Cross programs according to protocol.
5. Collaborating with Blue Cross health coaches and the Practice Coordinator to coordinate referrals to ancillary services as necessary.
6. Collaborating with the Practice Coordinator to schedule patient appointments as needed.
7. Being knowledgeable about strategies to promote health literacy, self-management of chronic disease, disease education and patient engagement.
8. Serving as a communications hub and general information resource for QBPC program providers.
**Required Learning Components**

**Physician Requirements:**

Every year, physicians enrolled in QBPC are required to view the QBPC Program Annual Overview module within the first 90 days of it being made available or within 90 days of enrollment in the program. This module will:

- Give a high-level overview of the QBPC program and requirements
- Discuss the QBPC program measures and thresholds used for tiering
- Focus on growth and achievement of the QBPC program in the past year
- Highlight MDi tools and technology updates

Failure to view the QBPC Program Annual Overview module within the required timeframe can result in Blue Cross suspending a physician’s Care Management Fee payments and/or suspending that physician from the QBPC program.

Enrolled physicians are also expected to participate in the annual QBPC learning collaboratives. Blue Cross hosts a series of regional collaboratives in different areas of the state, and an annual statewide collaborative. These collaboratives are an opportunity for physicians to learn best practices that help them get the most out of their participation in QBPC.

**Accessing QBPC Modules:**

- Physicians will receive an email indicating their usernames and passwords required to access the QBPC CME portal – it is important these credentials be retained for future reference.
- The QBPC CME portal is accessible via the following link: [http://www.bcbsla.com/QBPC/Pages/CME.aspx](http://www.bcbsla.com/QBPC/Pages/CME.aspx)
- The modules are available on demand for viewing and participation 24 hours per day.
- Upon successful completion of any module, the physician’s CME record on the website will display his or her completed modules.

**NCQA Recognition via MDinsight Use**

In addition to enabling targeted, coordinated management of specific patient populations, implementation and use of MDinsight may provide the practice with pre-validation points in NCQA PCMH auto credit. Practices using MDinsight may benefit from reduced documentation and have scoring associated with awarded auto credit applied to their total PCMH Survey score. Practices should check with their Blue Cross Care Transformation Consultant to see if they qualify.
QBPC Training

Blue Cross provides comprehensive QBPC training to all systems enrolled in the program. The live, two-hour Care Team Training Program is provided to practices in conjunction with technical training led by SPH. Training is conducted at the practice site. *(Note: For practices with multiple locations, one agreed-upon location is utilized.)*

**Training Objectives**

The Care Team Training Program reintroduces the QBPC program using a train-the-trainer approach to teach designated practice representatives. It provides a tutorial on the program, use of MDinsight in the context of a population management-driven workflow, educational modules, tools and communications to support the transformation initiative. The training reviews the following:

- MDinsight dashboard (gap identification and registry management)
- Roles and responsibilities/Blue Cross-practice interaction (Quality Navigator role, Practice Coordinator role, communication, briefings, patient engagement)
- Review and approval of QBPC cardiometabolic patient engagement processes for each patient type: Newly Diagnosed, Multiple Chronic Conditions and Hospitalized/High-Risk
- Clinical metrics assessment and learning and process improvement opportunities
- System-specific challenges to transformation implementation

**Training Format**

The QBPC training program is deployed on-site at practices once the MDinsight integration and attribution process is complete. Blue Cross and MDinsight representatives deliver the program. The program format is as follows:

- 1 hour (Physician(s), Practice Coordinator(s), office staff as appropriate – Program introduction, review of roles and responsibilities, tools, CQI measures. In-depth review of Practice Coordinator/Quality Navigator interaction (Weekly Care Coordination calls, utilization of MDi Patient Care Summaries, Daily Briefings).
- 40 minutes – MDinsight training/demo.

The session is designed to be hands-on and interactive in nature, and as such, active participation by practice attendees, including Q&A throughout, is anticipated. The QBPC training program video modules are available on demand and can be accessed online at [www.bcbsla.com/QBPC](http://www.bcbsla.com/QBPC).

**Expectations of the Practice**

It is expected that each QBPC practice participate in the training program, including:

- Practice physician(s)
- Designated Practice Coordinator(s)
- Other practice staff, as appropriate
Ongoing QBPC learning opportunities are made available to practice trainees after the initial training session. Practices should participate in the Regional Collaborative sessions with other participating QBPC practice stakeholders to review program updates, discuss challenges, wins, areas of opportunity and innovation and share tips/best practices.

**Practice Onboarding**

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

**Getting Started**

Once your practice has reviewed and signed the provider agreement, 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.

**ONBOARDING AGENDA**

This timeline is an at-a-glance view of the next 145 days as you are brought on board and integrated into QBPC. It takes you from signing the QBPC Provider Agreement until you begin your ongoing interaction with your Quality Navigator.

**ONBOARDING AGENDA**

This timeline is an at-a-glance view of the next 180 days as you are brought on board and integrated into QBPC. It takes you from signing the QBPC Provider Agreement until you begin your ongoing interaction with your Quality Navigator and receive follow up MDinsight consultation and training.

---

<table>
<thead>
<tr>
<th>DAY 1 (TODAY)</th>
<th>DAY 2-15</th>
<th>DAY 21-45</th>
<th>DAY 119-128</th>
<th>DAY 149-168</th>
<th>3 – 6 Months Post Go-Live</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Practice signs, completes, and returns required forms:</strong></td>
<td><strong>Documentation:</strong> Practice completes Practice Profile, Sample Data Request Template.</td>
<td><strong>Establish Connectivity:</strong> SPH begins the process of pulling the data.</td>
<td><strong>MDI Load: MDi data integration complete.</strong></td>
<td><strong>MDinsight Onsite Live Data Training:</strong> Practice starts review of patient list for attribution sign off and verifying data.*</td>
<td><strong>Follow up MDi consultation and training by SPH.</strong></td>
</tr>
<tr>
<td>QBPC Provider Agreement</td>
<td>SPH Welcome Call with practice and IT champion to review next steps for MDi software integration. Review of Practice Assessment form.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exhibits C and D</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EFT application</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SPH BAA</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice Readiness Assessment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Implementation milestone timeframes are dependent on whether data is pushed to SPH or pulled by SPH. Data push implementations take approximately 40 days longer than data pulls.**

*Date of attribution sign off determines what month practice becomes eligible for the first CMF payment**

**SPH is Symphony Performance Health Analytics - owner of MDinsight software**
Quality Blue Primary Care is one of a series of innovative healthcare quality programs developed by Blue Cross under the Quality Blue umbrella.

Quality Blue recognizes those physicians 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 physicians 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 physicians 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 and Blue Shield of Louisiana Quality Blue programs online at [http://www.bcbsla.com/Providers/Quality_Blue/Pages/default.aspx](http://www.bcbsla.com/Providers/Quality_Blue/Pages/default.aspx).

**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 Care Management programs, but QBPC helps 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 Program is a proactive, accountable, patient-centric and physician-guided team approach to care. The program consists of nurses, physicians, social workers, pharmacists, dieticians and administrative support staff that work as a team directly with the physician’s office and the physician’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 physician’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 works as an extension of the physician’s care team for patients with chronic or catastrophic conditions.

The team utilizes 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 primary care physician practices in QBPC. The Navigator monitors the patient registry to identify care opportunities and coordinates the provision of key information from Blue Cross practices.
The Navigator will also work directly with the primary care practices to assist in developing a care community for quality and cost-effective referrals.

QBPC is intended to complement day-to-day primary care practice activities, and helps 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 case and disease management programs
- Collaboration with medical directors on complex cases
- Assistance in maximizing member benefit related to utilization of network providers

**InHealth: Blue Health Services (Chronic Conditions)**

Our population health 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)**

The population health 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 ordered 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 physician relationship.

• **In Health: 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.

*NOTE: Please see the QBPC Provider Toolkit Disease Management materials, listed in the Appendix.*
Blue Cross and Blue Shield of Louisiana is here to guide you through the QBPC practice transformation process and answer questions along the way.

For information and assistance with QBPC implementation, please contact:

Quality Blue Primary Care
Phone: 1-800-376-7765
Fax: 225-298-7601
Email: clinicalpartnerships@bcbsla.com

www.bcbsla.com/QBPC
### Glossary of Terms

<table>
<thead>
<tr>
<th><strong>Blue Cross Nurse</strong></th>
<th>A Licensed Nurse employed by BCBSLA to deliver care management programs; also referred to as a Health Coach</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Care Management Fee (CMF)</strong></td>
<td>Monthly fee paid to participating QBPC physicians, which is based on the number of members with targeted chronic conditions they manage and their performance on selected efficiency and clinical quality measures</td>
</tr>
<tr>
<td><strong>Chronic Care Model</strong></td>
<td>A collaborative approach used by health systems to unify self-management support, delivery system design, decision support and clinical information systems. In combination, these elements can foster productive interactions between informed patients who take an active part in their care along with providers with resources and expertise</td>
</tr>
<tr>
<td><strong>CME Champion</strong></td>
<td>Practice-employed Quality Blue Primary Care point person responsible for ensuring PCP compliance with the required learning components of the QBPC program</td>
</tr>
<tr>
<td><strong>Daily Briefing</strong></td>
<td>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</td>
</tr>
<tr>
<td><strong>Daily Briefing Guide</strong></td>
<td>A guide to assist the Practice Coordinator in organizing the Daily Briefing with the rest of the practice’s care team</td>
</tr>
<tr>
<td><strong>IT/Technical Champion</strong></td>
<td>Practice-employed Quality Blue Primary Care program IT or technical point-person</td>
</tr>
<tr>
<td><strong>Local MDinsight System Administrator</strong></td>
<td>Practice-employed Quality Blue Primary Care program system administrator for MDinsight</td>
</tr>
<tr>
<td><strong>MDinsight</strong></td>
<td>A system that compiles and manages information on identified subsets of a patient population</td>
</tr>
<tr>
<td><strong>Patient Registry</strong></td>
<td>Cloud-based health information exchange tool developed by SPH</td>
</tr>
</tbody>
</table>
### Glossary Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician Advisory Committee (PAC)</strong></td>
<td>Committee comprised of Louisiana physicians that advises BCBSLA on its various clinical and quality programs, including QBPC, to ensure that the perspectives of participating providers are represented</td>
</tr>
<tr>
<td><strong>Physician Champion</strong></td>
<td>Practice-employed Quality Blue Primary Care program clinical point-person (may be the same as the Practice Champion)</td>
</tr>
<tr>
<td><strong>Practice Champion</strong></td>
<td>Practice-employed Quality Blue Primary Care program point-person (may be the same as the Physician Champion)</td>
</tr>
<tr>
<td><strong>Practice Coordinator</strong></td>
<td>Practice-point-person, likely an RN, NP, MA or office manager, who will have access to MDinsight and will work directly with the Quality Navigator to coordinate patient care</td>
</tr>
<tr>
<td><strong>Practice Site</strong></td>
<td>Physical location, clinic</td>
</tr>
<tr>
<td><strong>Practitioner</strong></td>
<td>Physician, provider</td>
</tr>
<tr>
<td><strong>Quality Blue Primary Care (QBPC)</strong></td>
<td>Official program name (internal and external)</td>
</tr>
<tr>
<td><strong>Quality Navigator (QN)</strong></td>
<td>BCBSLA employee appointed as Quality Blue Primary Care participating practice liaison and population management/registry champion</td>
</tr>
<tr>
<td><strong>Symphony Performance Health, Inc. (SPH)</strong></td>
<td>Health information technology firm; implementation partner</td>
</tr>
<tr>
<td><strong>System</strong></td>
<td>Term used to describe the business entity representing a group of practice sites; organized systems of care and integrated healthcare delivery systems</td>
</tr>
<tr>
<td><strong>Weekly Care Coordination Call</strong></td>
<td>Weekly call between the Quality Navigator and the Practice Coordinator, in which they review the practice’s patients who have scheduled appointments in the next week</td>
</tr>
</tbody>
</table>
APPENDIX

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

A. Sample QBPC Payment Reconciliation Report
B. Sample QBPC Payment Report
C. Listing of Patient Disease Education Materials
D. Sample QBPC Treatment Plan
E. Sample QBPC Patient-Care Team Pledge
F. QBPC Daily Briefing Guide
G. QBPC: Patient Assessment for Low Health Literacy
H. QBPC: Assessing for Cultural Competency at Your Practice
I. QBPC: The Importance of Screening for Depression in Chronic Care Patients
J. Weekly Care Coordination Call Guide for Practice Coordinators
K. Weekly Care Coordination Call Guide for Quality Navigators
L. Patient Adherence Tip Sheet
M. Newly Diagnosed Patients Workflow
N. Patients with Multiple Chronic Conditions Workflow
O. High-Risk/Hospitalized Patients Workflow
P. Patients Utilizing the ER Workflow
Q. QBPC Population Health Referral Form
## Practice XYZ Payment Reconciliation By Check Number

<table>
<thead>
<tr>
<th>Check Number</th>
<th>PCP Name</th>
<th>PCP NPI</th>
<th>Actual Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>12345678</td>
<td>Deaux, John</td>
<td>0</td>
<td>$8.33</td>
</tr>
<tr>
<td></td>
<td>Smith, Jane</td>
<td>0</td>
<td>$8.33</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td></td>
<td><strong>$16.66</strong></td>
</tr>
<tr>
<td>123456789</td>
<td>Deaux, John</td>
<td>0</td>
<td>$166.60</td>
</tr>
<tr>
<td></td>
<td>Smith, Jane</td>
<td>0</td>
<td>$216.58</td>
</tr>
<tr>
<td></td>
<td>Deaux, John</td>
<td>0</td>
<td>$1,616.02</td>
</tr>
<tr>
<td></td>
<td>Smith, Jane</td>
<td>0</td>
<td>$466.48</td>
</tr>
<tr>
<td></td>
<td>Deaux, John</td>
<td>0</td>
<td>$2,747.01</td>
</tr>
<tr>
<td></td>
<td>Brown, M.D.</td>
<td>0</td>
<td>$24.99</td>
</tr>
<tr>
<td></td>
<td>Deaux, John</td>
<td>0</td>
<td>$749.70</td>
</tr>
<tr>
<td></td>
<td>Brown, M.D.</td>
<td>0</td>
<td>$58.31</td>
</tr>
<tr>
<td></td>
<td>Deaux, John</td>
<td>0</td>
<td>$449.82</td>
</tr>
<tr>
<td></td>
<td>Brown, M.D.</td>
<td>0</td>
<td>$849.66</td>
</tr>
<tr>
<td></td>
<td>Deaux, John</td>
<td>0</td>
<td>$591.43</td>
</tr>
<tr>
<td></td>
<td>Brown, M.D.</td>
<td>0</td>
<td>$266.56</td>
</tr>
<tr>
<td></td>
<td>Deaux, John</td>
<td>0</td>
<td>$24.99</td>
</tr>
<tr>
<td></td>
<td>Brown, M.D.</td>
<td>0</td>
<td>$8.33</td>
</tr>
<tr>
<td></td>
<td>Deaux, John</td>
<td>0</td>
<td>$316.54</td>
</tr>
<tr>
<td></td>
<td>Brown, M.D.</td>
<td>0</td>
<td>$158.27</td>
</tr>
<tr>
<td></td>
<td>Deaux, John</td>
<td>0</td>
<td>$358.19</td>
</tr>
<tr>
<td></td>
<td>YOUNG, JR., HENRY</td>
<td>0</td>
<td>$199.92</td>
</tr>
<tr>
<td></td>
<td>Brown, M.D.</td>
<td>0</td>
<td>$133.28</td>
</tr>
<tr>
<td></td>
<td>Brown, M.D.</td>
<td>0</td>
<td>$2,324.07</td>
</tr>
<tr>
<td></td>
<td>Brown, M.D.</td>
<td>0</td>
<td>$1,024.59</td>
</tr>
<tr>
<td></td>
<td>Brown, M.D.</td>
<td>0</td>
<td>$16.66</td>
</tr>
<tr>
<td></td>
<td>Brown, M.D.</td>
<td>0</td>
<td>$408.17</td>
</tr>
<tr>
<td></td>
<td>Deaux, John</td>
<td>0</td>
<td>$33.32</td>
</tr>
<tr>
<td></td>
<td>Smith, Jane</td>
<td>0</td>
<td>$83.30</td>
</tr>
<tr>
<td></td>
<td>Smith, Jane</td>
<td>0</td>
<td>$8.33</td>
</tr>
<tr>
<td></td>
<td>Brown, M.D.</td>
<td>0</td>
<td>$299.88</td>
</tr>
<tr>
<td></td>
<td>Brown, M.D.</td>
<td>0</td>
<td>$124.95</td>
</tr>
<tr>
<td></td>
<td>Deaux, John</td>
<td>0</td>
<td>$258.23</td>
</tr>
<tr>
<td></td>
<td>Brown, M.D.</td>
<td>0</td>
<td>$649.74</td>
</tr>
<tr>
<td></td>
<td>Deaux, John</td>
<td>0</td>
<td>$783.02</td>
</tr>
<tr>
<td></td>
<td>Brown, M.D.</td>
<td>0</td>
<td>$208.25</td>
</tr>
<tr>
<td></td>
<td>Smith, Jane</td>
<td>0</td>
<td>$8.33</td>
</tr>
<tr>
<td></td>
<td>Smith, Jane</td>
<td>0</td>
<td>$591.43</td>
</tr>
<tr>
<td></td>
<td>Deaux, John</td>
<td>0</td>
<td>$33.32</td>
</tr>
<tr>
<td></td>
<td>Brown, M.D.</td>
<td>0</td>
<td>$383.18</td>
</tr>
<tr>
<td></td>
<td>Smith, Jane</td>
<td>0</td>
<td>$133.28</td>
</tr>
<tr>
<td></td>
<td>Brown, M.D.</td>
<td>0</td>
<td>$174.93</td>
</tr>
<tr>
<td></td>
<td>Smith, Jane</td>
<td>0</td>
<td>$2,224.11</td>
</tr>
<tr>
<td></td>
<td>Smith, Jane</td>
<td>0</td>
<td>$1,166.20</td>
</tr>
<tr>
<td></td>
<td>Deaux, John</td>
<td>0</td>
<td>$16.66</td>
</tr>
<tr>
<td></td>
<td>Deaux, John</td>
<td>0</td>
<td>$499.80</td>
</tr>
<tr>
<td></td>
<td>Deaux, John</td>
<td>0</td>
<td>$24.99</td>
</tr>
<tr>
<td></td>
<td>Brown, M.D.</td>
<td>0</td>
<td>$33.32</td>
</tr>
<tr>
<td></td>
<td>Brown, M.D.</td>
<td>0</td>
<td>$8.33</td>
</tr>
<tr>
<td></td>
<td>Deaux, John</td>
<td>0</td>
<td>$74.97</td>
</tr>
<tr>
<td></td>
<td>Brown, M.D.</td>
<td>0</td>
<td>$174.93</td>
</tr>
<tr>
<td></td>
<td>Smith, Jane</td>
<td>0</td>
<td>$508.13</td>
</tr>
<tr>
<td></td>
<td>Deaux, John</td>
<td>0</td>
<td>$91.63</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td></td>
<td><strong>$14,285.95</strong></td>
</tr>
</tbody>
</table>

| 12345678910   | Brown, M.D.   | 0       | $191.59        |
|               | Deaux, John   | 0       | $74.97         |
|               | Brown, M.D.   | 0       | $1,449.42      |
|               | Brown, M.D.   | 0       | $799.68        |
|               | Smith, Jane   | 0       | $2,215.78      |
|               | Smith, Jane   | 0       | $58.33         |
|               | Deaux, John   | 0       | $299.88        |
|               | Brown, M.D.   | 0       | $124.95        |
|               |              | 0       | $258.23        |
|               | Brown, M.D.   | 0       | $649.74        |
|               | Deaux, John   | 0       | $783.02        |
|               | Brown, M.D.   | 0       | $208.25        |
|               | Smith, Jane   | 0       | $8.33          |
|               | Smith, Jane   | 0       | $591.43        |
|               | Deaux, John   | 0       | $33.32         |
|               | Brown, M.D.   | 0       | $383.18        |
|               | Smith, Jane   | 0       | $133.28        |
|               | Brown, M.D.   | 0       | $174.93        |
|               | Smith, Jane   | 0       | $2,224.11      |
|               | Smith, Jane   | 0       | $1,166.20      |
|               | Deaux, John   | 0       | $16.66         |
|               | Deaux, John   | 0       | $499.80        |
|               | Deaux, John   | 0       | $24.99         |
|               | Brown, M.D.   | 0       | $33.32         |
|               | Brown, M.D.   | 0       | $8.33          |
|               | Deaux, John   | 0       | $74.97         |
|               | Brown, M.D.   | 0       | $174.93        |
|               | Smith, Jane   | 0       | $508.13        |
|               | Deaux, John   | 0       | $91.63         |
|               | **Total**     |         | **$13,261.36** |
# Payment Report

## Payment Register

<table>
<thead>
<tr>
<th>Business Entity</th>
<th>ABC Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment Month</td>
<td>Aug-13</td>
</tr>
<tr>
<td>Payment Amount</td>
<td>$59.85</td>
</tr>
</tbody>
</table>

## Payment Summary

<table>
<thead>
<tr>
<th>#</th>
<th>Business Entity ID</th>
<th>Business Entity</th>
<th>Payment Tax ID</th>
<th>Clinic Tax ID</th>
<th>Clinic</th>
<th>PCP Name</th>
<th>PCP NPI</th>
<th>Payment Amount</th>
<th>Clinic Total</th>
<th>Entity Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1111111111</td>
<td>ABC Clinic</td>
<td>1234567890</td>
<td>999999999999</td>
<td>123 Clinic</td>
<td>Scott, Adam</td>
<td>1111111111</td>
<td>$8.55</td>
<td>$25.65</td>
<td>$59.85</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>David, Brian</td>
<td>2222222222</td>
<td>$17.10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td>888888888870</td>
<td>456 Clinic</td>
<td>Smith, John</td>
<td>3333333333</td>
<td>$8.55</td>
<td>$34.20</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Jolie, Angelina</td>
<td>4444444444</td>
<td>$25.65</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Payment Details

<table>
<thead>
<tr>
<th>#</th>
<th>Business Entity ID</th>
<th>Business Entity</th>
<th>Payment Tax ID</th>
<th>Clinic Tax ID</th>
<th>Clinic</th>
<th>PCP Name</th>
<th>PCP NPI</th>
<th>Member Name</th>
<th>DOB</th>
<th>Gender</th>
<th>Payment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1111111111</td>
<td>ABC Clinic</td>
<td>1234567890</td>
<td>999999999999</td>
<td>123 Clinic</td>
<td>Scott, Adam</td>
<td>1111111111</td>
<td>John, Henry</td>
<td>1/1/1980</td>
<td>M</td>
<td>$8.55</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>David, Brian</td>
<td>2222222222</td>
<td>Taylor, Cathy</td>
<td>2/2/1981</td>
<td>F</td>
<td>$8.55</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td>888888888870</td>
<td>456 Clinic</td>
<td>Smith, John</td>
<td>3333333333</td>
<td>John, Butch</td>
<td>1/1/1980</td>
<td>M</td>
<td>$8.55</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Jolie, Angelina</td>
<td>4444444444</td>
<td>Taylor, Elizabeth</td>
<td>2/2/1981</td>
<td>F</td>
<td>$8.55</td>
</tr>
</tbody>
</table>
**Patient Disease Education Materials**

**Preventive Care**
Lilly For Better Health Information
To order:
Lilly for Better Health
1-800-LILLYRX (1-800-545-5979)
www.lillyforbetterhealth.com

**Diabetes**
Novo Nordisk books (4)
• Diabetes and You
• Carb Counting and Meal Planning
• Diabetes Medicines
• Your Blood Sugar Diary
To order:
Novo Nordisk
1-800-727-6500
www.novomedlink.com

**Kidney Disease**
Nutrition and Chronic Kidney Disease (Stages 1-4)
Are You Getting What You Need?
To order:
National Kidney Foundation
1-800-622-9010
http://www.kidney.org

**Cholesterol**
What You Need to Know
About High Blood Cholesterol

**Tobacco Cessation**
Clearing the Air - Quit Smoking Today
To order:
National Cancer Institute
1-800-4-CANCER (1-800-422-6237)
https://pubs.cancer.gov/ncip

**Hypertension**
• Your Guide to Lowering Your Blood Pressure with DASH
• My Blood Pressure Wallet Card

**Coronary Artery Disease**
• Atherosclerosis
• In Brief: Your Guide to a Healthy Heart
• Heart Attack Know the Symptoms. Take Action. Wallet Card

To order information on Cholesterol, Hypertension or Coronary Artery Disease:
National Heart, Lung and Blood Institute (NHLBI) Health Information Center
Phone: 301-592-8573 (representatives available 7:30 a.m. – 4 p.m. CT, Monday through Friday)
Web: http://www.nhlbi.nih.gov/health/resources
Fax: 301-592-8563
Mail: P.O. Box 30105, Bethesda, MD 20824-0105
Online catalog: http://email.nhlbihin.net (credit cards only)
Treatment Plan

Date: ____________________________  Physician: ____________________________

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: _____ °F  Weight _____ lbs  2nd BP (same appt): _____ mm Hg

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

<table>
<thead>
<tr>
<th>Medication (Rx and OTC)</th>
<th>Dose (No. of pills, injections, pumps, etc.)</th>
<th>Food</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Morning</td>
<td>Noon</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**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
In association with Blue Cross Blue Shield of Louisiana (BCBSLA), 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 BCBSLA 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 health care 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 doctors 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 doctor’s expectations, treatment goals and future plans

---

Physician

Date

Patient

Date
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 physicians 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 physicians 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.

Patient Assessment for Low Health Literacy

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

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.

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.

The Importance of Screening for Depression in Chronic Care Patients

Depression is one of the most common complications of chronic diseases. It is estimated that up to one-third of individuals with chronic illnesses experience symptoms of depression, so vigilance in assessing for depression throughout a patient’s care is critical.

Patients with depression may manifest somatic symptoms, such as:

- Headache, migraines
- Sexual dysfunction
- Appetite changes
- Menstrual-related symptoms
- Chronic pain
- Chronic medical conditions (e.g. diabetes, Parkinson’s disease, alcoholism)
- Digestive problems (e.g. diarrhea, constipation)
- Fatigue
- Sleep disturbances

In older adults, significant depressive symptoms often are associated with such common life events as medical illness, cognitive decline, bereavement and institutional placement (i.e. residential/inpatient settings).1

The most recently issued U.S. Preventive Services Task Force (USPSTF) Recommendation Statement confirms that screening for depression in primary care settings improves the accurate identification of affected individuals. In summary, the USPSTF Statement:

- Defines patient populations at increased risk for depression as those with:
  - Other psychiatric disorders, including substance misuse
  - A family history of depression
- Chronic medical diseases
- States that unemployed individuals and persons of lower socioeconomic status are also at increased risk for depression; depression affects women more often than men.

The USPSTF Statement recommends that practices with clinical staff that assist the primary care clinician by providing some direct depression care and/or coordination, case management or mental health treatment, referred to as staff-assisted depression care supports, screen for depression.1 The presence of such assures accurate diagnosis, effective treatment and follow-up.

Several easy-to-complete, formal screening tests are available. The USPSTF points out that simply asking the following two questions may be as effective as using a formal test:

- Over the past two weeks, have you felt down, depressed or hopeless?
- Over the past two weeks, have you felt little interest or pleasure in doing things?
There are also two mnemonics that may be useful for depression screening in primary care patients:

- **SALSA** (sleep disturbance, anhedonia [decreased interest in activities], low self-esteem and decreased appetite) screens for the presence of major depression; the presence of two of four symptoms every day for two or more weeks suggests the presence of depression.

- **SIG-E-CAPS** (depressed mood, must exist in addition to decreased sleep [insomnia with 2 to 4 a.m. awakening], anhedonia, feelings of guilt or worthlessness [not a major criterion], decreased energy, concentration difficulties, appetite disturbance or weight loss, psychomotor retardation/agitation and suicidal thoughts) also screens for major depression with a positive screen indicated by five of nine positive answers every day over a two-week or longer period.

Importantly, results of depression screening tools should be used to indicate the need for further evaluation—not as a basis for diagnosis. All positive tests should trigger a full diagnostic interview, using standard diagnostic criteria.

*The Family Practice Notebook depression screening tools website includes information on several formal screening tools, as well as tools used specifically in older adults:

- BATHE Technique
- Beck Depression Inventory
- Beck Depression Inventory for Primary Care
- Cornell Scale for Depression in Dementia
- Edinburgh Postnatal Depression Scale
- Geriatric Depression Scale
- Five-Item Geriatric Depression Scale
- Hamilton Depression Scale
- Children’s Depression Inventory
- Patient Health Questionnaire 2
- Patient Health Questionnaire 9
- Zung Self-Rating Depression Scale

**References**


Weekly Care Coordination Call Guide
FOR PRACTICE COORDINATORS

Call Information:
Use this guide to help you conduct efficient and effective recurring Weekly Care Coordination Calls with your Blue Cross Quality Navigator counterpart, so you can ensure that your patients are receiving the best care possible.

Quality Navigator Name: ______________________________

Recurring Call Day: Mon Tues Wed Thur Fri

Call Time: ________ AM / PM

Phone Number: (_____) _______ - _______ Email: ______________________________

Call Checklist:

1. **The day before the call, download and briefly familiarize yourself with the Patient Care Summaries for the following week’s chronic patients.**
2. **Prioritize the call.** The Quality Navigator will call you at a predetermined time. Please be available and ready for the call.
3. **Review the MDinsight Patient Care Summaries together.** The summaries are your guides to addressing the gaps in care for each chronic care patient with an upcoming appointment. The Quality Navigator will address the following:
   - Review gaps in care (“reds” and “grays”) – outdated labs, out-of-range values, etc.
   - Review key clinical notes related to barriers to care/adherence (e.g. depression, financial constraints, etc.)
   - Review key clinical notes on recent patient hospital/ER events (if available)
   - Review whether or not pre-appointment outreach has been conducted by BCBS, and if so, what the outcome was
   - Discuss patients who may require more time and assistance due to age, disability, personality or language barriers
   - Review patients targeted for engagement (if available)
4. **Limit calls to 30 minutes or less, if possible.** The Quality Navigator is aware of your time and competing priorities and will be flexible as needed.
5. **Agree to a plan of action.** Before the call ends, confirm that you understand the objectives for the QBPC patients with appointments in the coming week and have addressed any outstanding questions.
## Patient Care Summary Sample:

### Status for all measures within each clinical suite

#### Colorectal Cancer Screening
- 100% CRCS
- 90% DM 0%
- 77% HTN

#### Diabetes
- **Blood Pressure < 140/90**
  - Status: Passed
  - Value: 120/84
  - Date: 10/18/2016
- **Body Mass Index**
  - Status: Passed
  - Value: 25.59
  - Date: 10/18/2016
- **Body Mass Index < 30**
  - Status: Passed
  - Value: 25.59
  - Date: 10/18/2016
- **Diabetic Foot Exam**
  - Status: Passed
  - Value: 99212
  - Date: 06/17/2014
- **Dilated Retinal Exam**
  - Status: Passed
  - Value: 99244
  - Date: 08/23/2016
- **HbA1C < 8**
  - Status: Failed
  - Value: 8.6
  - Date: 10/18/2016
- **HbA1C < 9**
  - Status: Passed
  - Value: 8.6
  - Date: 10/18/2016
- **LDL < 100**
  - Status: Passed
  - Value: 64
  - Date: 12/08/2015
- **Statin Use or LDL < 70 (Ages 40 - 75 years)**
  - Status: Passed
  - Value: 30
  - Date: 10/18/2016
- **Urine Albumin Exam if no Albuminuria**
  - Status: Passed
  - Value: 82043
  - Date: 08/22/2016

### Hypertension
- **Blood Pressure < 140/90**
  - Status: Passed
  - Value: 120/84
  - Date: 10/18/2016
- **Blood Pressure < 150/90 (Age >= 60)**
  - Status: Passed
  - Value: 120/84
  - Date: 10/18/2016
- **Body Mass Index**
  - Status: Passed
  - Value: 25.59
  - Date: 10/18/2016
- **Body Mass Index < 25**
  - Status: Passed
  - Value: 25.59
  - Date: 10/18/2016
- **Fasting Blood Glucose < 100 or HbA1C < 5.7**
  - Status: Passed
  - Value: 8.6
  - Date: 10/18/2016
- **Fasting Blood Glucose or HbA1C Exam**
  - Status: Passed
  - Value: 8.6
  - Date: 10/18/2016
- **Serum Creatinine Exams**
  - Status: Passed
  - Value: 0.3
  - Date: 12/08/2015

### Legend
- Complete, meets criteria
- Due within 60 days
- Outcome out of range or care provided after time window ended
- Incomplete or data too old

### Status on Wellness Measures

#### Blood Pressure < 140/90
- **120/84**
  - Date: 10/18/2016
  - Note: Multiple Readings

#### BMI < 25
- **25.59**
  - Date: 10/18/2016

#### Height
- **72.00 in**
  - Date: 10/18/2016

#### Weight
- **188.00 lbs**
  - Date: 10/18/2016

#### GFR
- **102.5 ml/min/1.73 m²**
  - Date: 12/08/2015

#### Serum Creatinine
- **0.8 mg/dL**
  - Date: 12/08/2015

#### Fasting Blood Glucose
- **NO DATA**

#### Total Cholesterol
- **128 mg/dL**
  - Date: 12/08/2015

#### LDL < 70
- **64 mg/dL**
  - Date: 12/08/2015

#### HDL
- **48 mg/dL**
  - Date: 12/08/2015

#### Triglycerides
- **54 mg/dL**
  - Date: 12/08/2015
Weekly Care Coordination Call Guide
FOR QUALITY NAVIGATORS

Call Information:

Use this guide to help you lead well-planned and successful recurring Weekly Care Coordination Calls with your Practice Coordinator counterpart, so you can ensure patients are receiving the best care possible.

Practice Name: ________________________________

Recurring Call Day: Mon Tues Wed Thur Fri Call Time: _____ : _____ AM / PM

Practice Coordinator: ________________________________

Phone Number: (_____) - _______ Email: ________________________________

Physicians Represented: ________________________________

Call Checklist:

1. **The day before the call, download and familiarize yourself with the Patient Care Summaries for the following week’s chronic patients.** Take note of patients who are newly diagnosed or complex, and be sure you are briefed on any critical clinical notes.

2. **Initiate the call.** Call the Practice Coordinator at the predetermined time at the number s/he provided.

3. **Review the MDinsight Patient Care Summaries together.** The summaries are your guides to addressing the gaps in care for each chronic care patient with an upcoming appointment. Address the following:

   - Review gaps in care ("reds" and "grays") – outdated labs, out-of-range values, etc.
   - Review key clinical notes related to barriers to care/adherence (e.g. depression, financial constraints, etc.)
   - Review key clinical notes on recent patient hospital/ER events (if available)
   - Review whether or not pre-appointment outreach has been conducted by BCBS, and if so, what the outcome was
   - Discuss patients who may require more time and assistance due to age, disability, personality or language barriers
   - Review patients targeted for engagement (if available)

4. **Limit calls to 30 MINUTES OR LESS, IF POSSIBLE.** Be aware of the Practice Coordinator’s time and competing priorities and be flexible as needed.

5. **Agree to a plan of action.** Before the call ends, confirm that you are both aligned and understand the objectives for the QBPC patients with appointments in the coming week. Be sure to address any outstanding questions.
Status for all measures within each clinical suite

<table>
<thead>
<tr>
<th>Health Measure</th>
<th>Status</th>
<th>Date</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorectal Cancer Screening</td>
<td>✔️</td>
<td>12/31/2012</td>
<td>Claims - Blue Crossens</td>
</tr>
<tr>
<td>Diabetes</td>
<td>✔️</td>
<td>12/31/2012</td>
<td>Claims - Blue Crossens</td>
</tr>
<tr>
<td>Blood Pressure &lt; 140/90</td>
<td>✔️</td>
<td>10/18/2016</td>
<td>Multiple Readings</td>
</tr>
<tr>
<td>Body Mass Index</td>
<td>25.59</td>
<td>10/18/2016</td>
<td>EMR</td>
</tr>
<tr>
<td>Body Mass Index &lt; 30</td>
<td>✔️</td>
<td>10/18/2016</td>
<td>EMR</td>
</tr>
<tr>
<td>Diabetic Foot Exam</td>
<td>✔️</td>
<td>06/17/2014</td>
<td>Claims - Blue Crossens</td>
</tr>
<tr>
<td>Dilated Retinal Exam</td>
<td>✔️</td>
<td>08/23/2016</td>
<td>Claims - Blue Crossens</td>
</tr>
<tr>
<td>HbA1C &lt; 8</td>
<td>✔️</td>
<td>10/18/2016</td>
<td>EMR</td>
</tr>
<tr>
<td>HbA1C &lt; 9</td>
<td>✔️</td>
<td>10/18/2016</td>
<td>EMR</td>
</tr>
<tr>
<td>LDL &lt; 100</td>
<td>✔️</td>
<td>12/08/2015</td>
<td>EMR</td>
</tr>
<tr>
<td>Statin Use or LDL &lt; 70 (Ages 40 - 75 yrs)</td>
<td>✔️</td>
<td>10/18/2016</td>
<td>EMR</td>
</tr>
<tr>
<td>Urine Albumin Exam if no Albuminuria</td>
<td>✔️</td>
<td>12/02/2016</td>
<td>EMR</td>
</tr>
<tr>
<td>Hypertension</td>
<td>✔️</td>
<td>10/18/2016</td>
<td>Multiple Readings</td>
</tr>
<tr>
<td>Blood Pressure &lt; 140/90</td>
<td>✔️</td>
<td>10/18/2016</td>
<td>Multiple Readings</td>
</tr>
<tr>
<td>Blood Pressure &lt; 150/90 (Age &gt;= 60)</td>
<td>✔️</td>
<td>10/18/2016</td>
<td>Multiple Readings</td>
</tr>
<tr>
<td>Body Mass Index</td>
<td>25.59</td>
<td>10/18/2016</td>
<td>EMR</td>
</tr>
<tr>
<td>Body Mass Index &lt; 25</td>
<td>✔️</td>
<td>10/18/2016</td>
<td>EMR</td>
</tr>
<tr>
<td>Fasting Blood Glucose &lt; 100 or HbA1C &lt; 5.7</td>
<td>✔️</td>
<td>10/18/2016</td>
<td>EMR</td>
</tr>
<tr>
<td>Fasting Blood Glucose or HbA1C Exam</td>
<td>✔️</td>
<td>10/18/2016</td>
<td>EMR</td>
</tr>
<tr>
<td>Serum Creatinine</td>
<td>0.8</td>
<td>12/08/2015</td>
<td>EMR</td>
</tr>
</tbody>
</table>

Legend:
- Complete, meets criteria
- Due within 60 days
- Outcome out of range or care provided after time window ended
- Incomplete or data too old

Status on Wellness Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Value</th>
<th>Date</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure</td>
<td>120/84</td>
<td>10/18/2016</td>
<td>EMR</td>
</tr>
<tr>
<td>Height</td>
<td>72.00</td>
<td>10/18/2016</td>
<td>EMR</td>
</tr>
<tr>
<td>Weight</td>
<td>188.00</td>
<td>10/18/2016</td>
<td>EMR</td>
</tr>
<tr>
<td>GFR</td>
<td>102.5</td>
<td>12/08/2015</td>
<td>EMR</td>
</tr>
<tr>
<td>Serum Creatinine</td>
<td>0.8</td>
<td>12/08/2015</td>
<td>EMR</td>
</tr>
<tr>
<td>Total Cholesterol</td>
<td>126</td>
<td>12/08/2015</td>
<td>EMR</td>
</tr>
<tr>
<td>LDL</td>
<td>64</td>
<td>12/08/2015</td>
<td>EMR</td>
</tr>
<tr>
<td>HDL</td>
<td>48</td>
<td>12/08/2015</td>
<td>EMR</td>
</tr>
<tr>
<td>Triglycerides</td>
<td>54</td>
<td>12/08/2015</td>
<td>EMR</td>
</tr>
</tbody>
</table>
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.
Care Coordination Workflow
NEWLY DIAGNOSED

NOTIFICATION
ongoing/as reported
MDi indicates gap identifying newly diagnosed patient

PATIENT OFFICE VISIT
• MD reviews lab results and disease with patient; provides treatment plan & Rx
• PC conducts “Exit Interview” with patient; reviews treatment plan

REPORTING
ASAP
PC sends treatment plan to QN

COMMUNICATION
ASAP
BCBSLA nurse or CDE follows up with Care Community services as needed based on patient engagement and care goals

CDE CALL
2-3 days of notification
CDE conducts an education call with the patient

COMMUNICATION
ASAP
BCBSLA nurse refers to CDE if criteria are met

COMMUNICATION
within 1-2 days of appt.
BC nurse reviews patient visit in MDi (or in treatment plan) & conducts patient post-visit follow-up call

Review CDE Call Checklist:
• Assess patient health status
• Assess patient education needs
• Identify self-management goals
• Implement the education and behavioral intervention
• Establish personalized follow-up plan

QN = Quality Navigator
PC = Practice Coordinator
HCN = Home Care Nurse
CDE = Chronic Disease Education

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.
04/10/10 R08/15
Care Coordination Workflow
MULTIPLE CHRONIC CONDITIONS

**ASSESSMENT**
ongoing
- QN reviews data in MDi & Jiva to assess for MCC patients:
  - >1 chronic condition
  - Depression
  - Literacy concerns

**COMMUNICATION**
5-10 days pre-visit
- BC nurse conducts pre-visit call
  - Remind patient to get labs done
  - Remind patient to bring medications to visit
  - Review questions to ask MD

**PATIENT OFFICE VISIT**
- MD reviews disease with patient; provides treatment plan that addresses gaps & prescriptions
- PC conducts "Exit Interview" with patient; PC reviews treatment plan

**REPORTING**
ASAP
- PC sends treatment plan to QN

**COMMUNICATION**
ASAP
- BCBSLA nurse or CDE follows up with Care Community services as needed based on patient engagement and care goals

**CDE CALL**
2-3 days post office visit
- CDE conducts an education call with the patient

**COMMUNICATION**
ASAP
- BCBLSLA nurse refers to CDE if criteria are met

**COMMUNICATION**
ASAP
- BC nurse reviews patient visit in MDi (or in tx plan) & conducts patient follow-up call

Review CDE Call Checklist:
- Assess patient health status
- Assess patient education needs
- Identify self-management goals
- Implement education and behavioral intervention
- Establish personalized follow-up plan

QN = Quality Navigator
PC = Practice Coordinator
HCN = Home Care Nurse
CDE = Chronic Disease Education

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.
04/02/22 R08/15
NOTIFICATION within 48 hours of hospitalization
Hospitalization notification triggered in Jiva by BC UR nurse

NOTE: Hospitalization notifications are only received for patients whose authorizations of services require concurrent review

COMMUNICATION weekly
QN notifies PC of admission during Weekly Care Coordination Call

HOSPITAL DISCHARGE day of discharge
Hospital Discharge Coordinator works collaboratively with admitting physician to coordinate discharge services (e.g. home care)

• Assess patient health status
• Review treatment plan
• Review appointments/Care Community services needed
• Coordinate and authorize outpatient services

COMMUNICATION day of discharge
Hospital Discharge Coordinator calls BC UR nurse to review discharge plan and patient information and to coordinate ancillary services requiring authorization

COMMUNICATION within 1 working day of discharge
BC nurse receives post-discharge outreach call activity via Jiva alert

COMMUNICATION weekly
QN notifies PC of patient health status during weekly call through Weekly Care Coordination Report

POST-DISCHARGE VISIT 3 working days post discharge
If ordered by the physician, HCN meets with patient and family at home

POST-DISCHARGE PHONE CALL 1-2 working days post notification of discharge
BC nurse reviews discharge plan & conducts patient follow-up call

• Assess patient health status
• Assess future needs
• Address medication adherence
• Review discharge plan
• Coordinate any additional needs identified

QN = Quality Navigator
PC = Practice Coordinator
HCN = Home Care Nurse
CDE = Chronic Disease Education
UR = Utilization Review

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

04HQ1208 R08/15
**Care Coordination Workflow**

**EMERGENCY ROOM VISITS**

**NOTIFICATION**

*Monthly or ad hoc via member assessment/screening*

- ER visit notification triggered by **Monthly ER Report** to BC nurse

**NOTE:** Hospitalization notifications are received ONLY for patients who:

- Have been identified during the assessment/screening process with the BC nurse

OR

- Have 4 or more ER visits in rolling 6 months
- Have 2 or more ER visits in rolling 6 months for one or more of the following conditions:
  - Headache
  - Back symptoms
  - Acute pharyngitis
  - Dizziness and giddiness
  - Pain in joint in lower leg

**COMMUNICATION**

*Upon notification*

- BC nurse contacts patient and conducts post-ER screening

- Assess health status
- Assess understanding of discharge instructions
- Encourage physician follow-up appointment scheduling and assist with coordination if indicated
- Assess for barriers to treatment plan follow-up

**COMMUNICATION**

*Weekly*

- QN reviews ER visit utilization with PC during Weekly Care Coordination Call

- PC coordinates ancillary services

QN = Quality Navigator
PC = Practice Coordinator
HCN = Home Care Nurse

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

04HQ1211 R08/15
## Population Health Referral

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

### Patient Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name</td>
<td></td>
</tr>
<tr>
<td>Date of Birth</td>
<td></td>
</tr>
<tr>
<td>Patient Phone (Day)</td>
<td></td>
</tr>
<tr>
<td>BCBSLA ID Number</td>
<td></td>
</tr>
<tr>
<td>Evening Phone</td>
<td></td>
</tr>
<tr>
<td>Referring Physician Name</td>
<td></td>
</tr>
<tr>
<td>Referring Physician Phone</td>
<td></td>
</tr>
</tbody>
</table>

### Pertinent Clinical Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnoses</td>
<td></td>
</tr>
</tbody>
</table>

### Referral Type

<table>
<thead>
<tr>
<th>Role</th>
<th>Reason for Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Coach</td>
<td></td>
</tr>
<tr>
<td>Social Worker</td>
<td></td>
</tr>
<tr>
<td>Dietician</td>
<td></td>
</tr>
</tbody>
</table>

### Additional Information

-------------

-------------