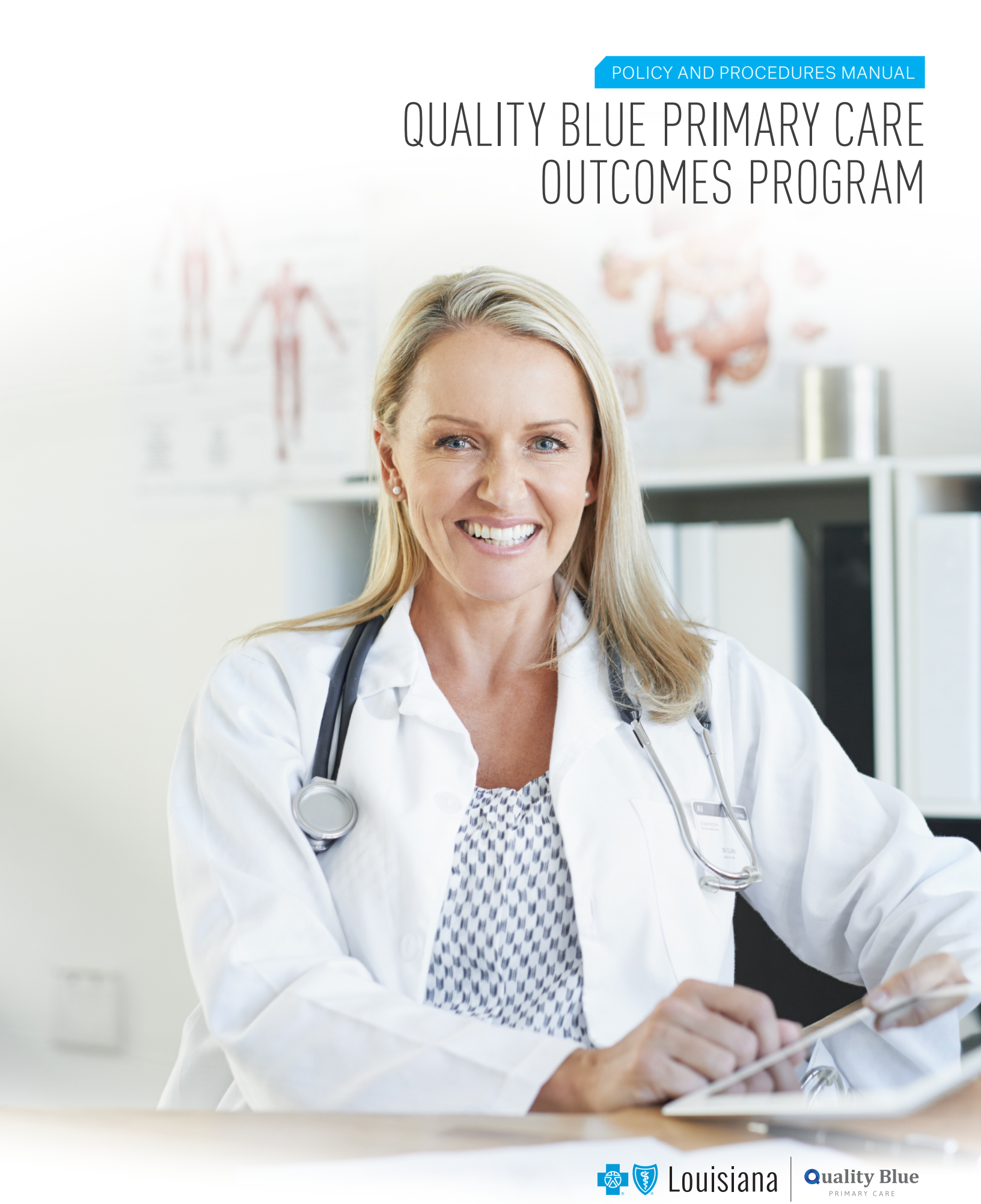
POLICY AND PROCEDURES MANUAL

QUALITY BLUE PRIMARY CARE OUTCOMES PROGRAM



Louisiana | Quality Blue PRIMARY CARE

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SECTION 1 *QBPC Overview*

Introduction

Thank you for taking the time to explore the Quality Blue Primary Care Outcomes Program Policies and Procedures Manual (QBPC Program Manual). This resource will provide you with a comprehensive understanding of the Quality Blue Primary Care Outcomes 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 providers alike.

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 Program Manual at our sole discretion. The QBPC Program 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 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.

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

QBPC Program Overview

Stronger Than

Your patients are stronger than any diagnosis. And through the strong partnerships Blue Cross is building with healthcare providers around the state, we have a real opportunity to improve Louisiana's historically poor health outcomes and hold the line on costs. We stand strong with you, ready to support your patients on their journey toward optimal health.

Description

The QBPC Outcomes program promotes and enhances the identification and management of prevalent chronic diseases. Blue Cross contracts with primary care practices/entities 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:** Integrating a health information exchange tool in practices facilitates population management by aggregating clinical and claims data.
2. **Care Coordination Tools and Support:** The development and integration of standardized workflows, tools, resources and best practices.
3. **Process Improvement:** Identification of gaps in care and processes to improve closure. This includes collaborative action planning between the practice care team and Blue Cross in addition to participation in learning collaboratives and webinars.

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

QBPC Expansion to Include Blue Advantage (BA)

To streamline the programs that our providers participate in and provide a space where they can manage all their patients, both commercial and Medicare Advantage, Blue Cross added its Blue Advantage plan to the QBPC Outcomes program effective Jan. 1, 2020. Amendments to existing QBPC Program Agreements have been provided.

Adding Blue Advantage to the QBPC Outcomes program will:

- Align with Medicare Advantage STARs goals and objectives
- Focus Blue Cross plan performance on HEDIS
- Provide optimal clinical benefit for Blue Cross members

The Value Proposition of QBPC

QBPC is a patient-centric population health and quality improvement program designed to transform our primary care provider network from an episode-driven, provider care delivery model to a team-based care delivery model.

The 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 providers for delivering clinical improvement via Care Management Fees in addition to traditional fee-for-service reimbursements
- Optimizes the existing care team, allowing providers to focus on what they do best—treating patients
- 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
- Increases engagement and empowerment
- Provides the support and guidance to achieve health goals
- Creates a proactive, collaborative patient/provider relationship, in which both parties are a team responsible for the patient's health
- Encourages members to see a QBPC provider by possibly reducing the office visit copay

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

Blue Cross and Blue Shield of Louisiana's Partners

Azara Healthcare

To realize the QBPC program concept, Blue Cross is using the expert technology, data mining and practice enhancement capabilities of Azara Healthcare.

Azara Healthcare is a health information technology company that develops and hosts secure web-based platforms to improve provider decision-making at the point of care. The QBPC Outcomes program incorporates Azara Healthcare'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. This portal 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 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 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 provider, clinical condition and patient disposition
- A **Clinician Comparison Report**, which displays comparisons between practice locations and providers 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, Blue Cross has organized a Physician Advisory Committee (PAC), comprised of approximately 12 - 20 primary care physicians 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 Blue Cross medical director.

Provider and Member Eligibility

Practices/Providers

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

Nurse practitioners (NP) and physician assistants (PA) must meet the following criteria to participate:

- Credentialled with Blue Cross as a PCP, and
- Have a collaborative agreement with a supervising physician that is participating in QBPC, and
- If the supervising physician and NP/PA are both affiliated with an ACO in the Quality Blue Value Partnerships program, they must both be affiliated with the same ACO.

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

All eligible providers under the practice's TIN will be included for participation. Participating providers will be indicated with a Blue Q in our online provider directory. NOTE: The Blue Q indicator may be removed from providers who are in tier 1 for three consecutive tiering cycles.

Providers who 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 Azara Healthcare 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**.

Practice Participation Changes

If a practice chooses to leave their current participating group or network (that has contracted with Blue Cross as a QBPC business entity), the practice or the contracted entity must provide a written statement with a stated intention to leave the current participating group or network and the effective date of termination.

Upon receipt of such notification, the termed practice's:

- Access to MDInsight will be terminated,
- Listing in QBPC Program Provider directory will be removed
- Eligibility for any reimbursement related to the QBPC Program will be terminated.

If a practice chooses to transfer participation in QBPC to another participating group or network an interruption in Care Management Fee payments can occur. In addition, attribution can be affected. Please see sub-section Blue Cross Attribution Hierarchy in MDInsight further on for details.

The practice leaving one group or network for another is also required to notify the current group or network of this decision.

Commercial Members Included in QBPC

In order to participate in the QBPC Outcomes program, Blue Cross members must be attributed via Blue Cross' Attribution Hierarchy to a participating Primary Care Provider (PCP). Blue Cross out-of-state members (Blue Card) must be attributed via Blue Cross' claims-based attribution only to a participating PCP. Details of attribution are in the following section.

Blue Advantage Members Included in QBPC

In order to participate in the QBPC Outcomes program, Blue Advantage members must be attributed via Blue Cross' Attribution Hierarchy (with the exception of the claims-based step) to a participating PCP.

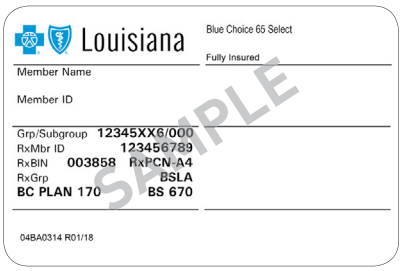
Members Excluded from QBPC

Members of the following programs are not included in the QBPC Outcomes program at this time. These patients' data may be in MDInsight, 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 a member's network.

Traditional Medicare primary/supplemental plans

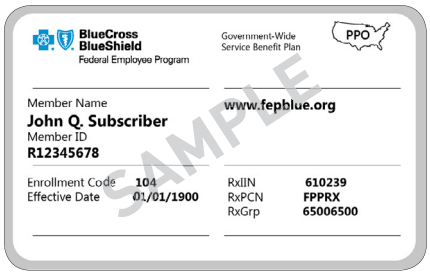
These members receive healthcare coverage through Medicare and may also receive Blue Cross coverage through Blue Choice 65 or Blue Choice 65 Select, which are the Blue Cross series of Medicare supplement plans. If a member receives Medicare, then Medicare is considered the member's primary form of healthcare coverage, not Blue Cross.



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

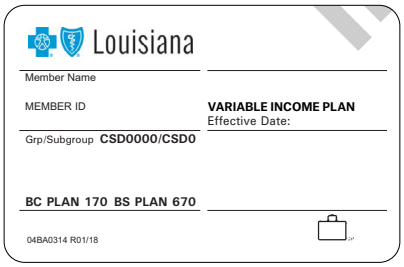
(in-state members are included)

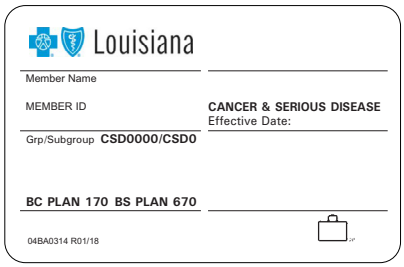
FEP provides coverage for federal employees and annuitants. Federal employees covered through FEP who live in Louisiana can be enrolled as QBPC members, but those who are out-of-state residents receiving services through Louisiana's FEP network are not eligible.



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.





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

Blue Cross Attribution and Assignment in MDinsight

Blue Cross and Blue Shield of Louisiana Attribution Hierarchy

Blue Cross members shall be attributed to primary care providers using the following hierarchy. The process below specifically defines attribution.

1. **Member Selected:** All members selecting a primary care provider through insurance product design will be attributed to their selected primary care provider. (This step does not apply to Blue Cross out-of-state members – Blue Card.)

    a. This includes, but is not limited to, members on the Blue Connect, Community Blue, Precision Blue, HMO Louisiana, Blue Advantage plans.

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

2. **Claims-Based:** Unattributed members will be attributed using the most recent 12 months' claims data as follows (this step does not apply to Blue Advantage members):

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

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

    c. In cases where two or more primary care providers have an equal number of E/M services, a tie-breaking logic will be applied.

        - This includes reviewing an additional 12 months, most recent visit and most allowable.

3. **Automatic Assignment:** All remaining unattributed members who are required to select a primary care provider by insurance product design will be automatically attributed to a primary care provider based on geographical area. (This step does not apply to Blue Cross out-of-state members – Blue Card.)

This process results in "Attributed Members."

Patient Identification/Assignment in MDinsight

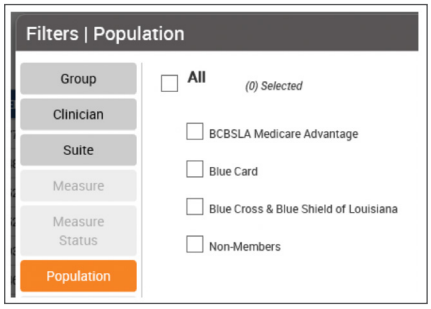
Azara Healthcare uses Blue Cross attribution to match members with QBPC primary care providers in MDinsight. The primary care provider or practice is responsible for ensuring that patient status (active, inactive, expired) is documented in the EHR and/or sent to Azara Healthcare correctly. The primary care provider or practice is also responsible for verifying and correcting all member data in the EHR, including but not limited to:

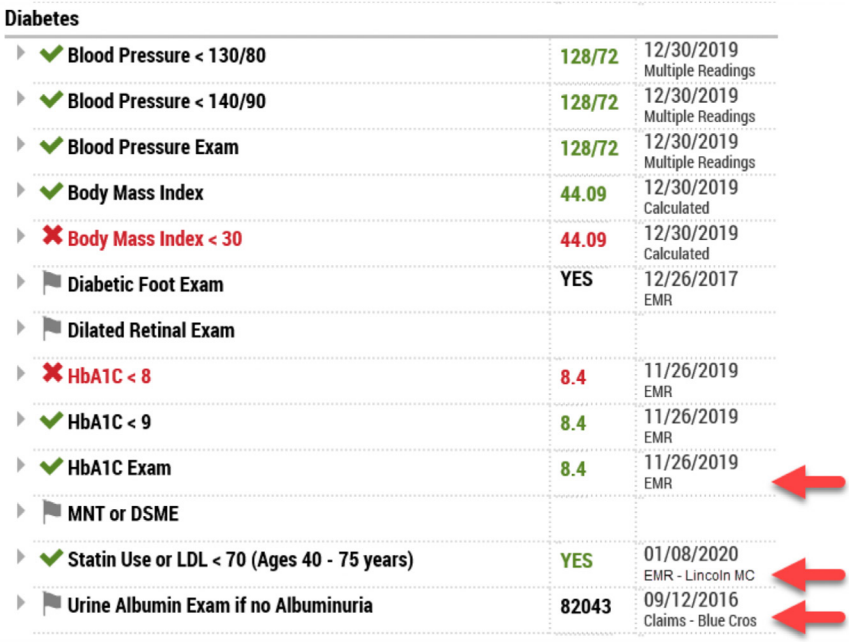
- Demographics
- Diagnoses (active problem lists and problems addressed during encounters)
- Immunizations
- Laboratory results
- Medications (all active medications, including OTC and supplements) and date of last review
- Insurer
- Procedures (diagnostic and screening procedures)
- Tobacco use status and date of last review
- Visit dates and appointment schedule
- Vital signs

Refer questions about Blue Cross attribution to your Blue Cross Care Transformation Consultant. Questions about attribution of patients who are members of a different health plan or have other healthcare coverage should be referred to Azara Healthcare.

Data Sharing – The Practice View

MDinsight aggregates data from multiple sources to create a longitudinal patient record. The MDinsight record for a patient may include clinical data from more than one provider. MDinsight users at the provider level can access all patient records for which the provider is sending EHR data to Azara Healthcare. Blue Cross users can only access records for patients with active Blue Cross, out-of-state (Blue Card), Blue Advantage, or Healthy Blue coverage. Population filter settings are available in MDinsight to limit patient lists to specific payors. *See images below.*





Targeted Chronic Conditions

The QBPC Outcomes 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.

- Ischemic 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.

Diagnosing Guidelines for QBPC Chronic Conditions

Care Management Fees are paid for members with the following four chronic conditions approved by the Physician Advisory Committee on April 18, 2013, and outlined below:

ISCHEMIC VASCULAR DISEASE (IVD):

- Any diagnosis for atherosclerotic occlusions of coronary arteries, aorta, lower or upper extremity arteries, and carotid/cerebral arteries (including vascular ectasia) using ICD 10 codes.
- Findings should be traceable to a radiographic or functional test, though not specifically required to be in the primary care provider'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 provider's chart.

DIABETES (DM):

- Any established diagnosis of diabetes mellitus type 1 or type 2. Gestational diabetes is not considered a chronic condition until patient is diagnosed with diabetes post-partum.
- New diagnosis of diabetes (using American Diabetes Association's diagnostic criteria.)
- Pre- diabetes, metabolic syndrome (including insulin resistance), or other pre-diabetic syndromes are not considered a diagnosis for DM in QBPC.

HYPERTENSION (HTN):

- Any established diagnosis of hypertension.
- New diagnosis of hypertension (using the Joint National Committee's criteria.)
- 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. Please refer to the QBPC Program website for the Home BP Reading Policy for established diagnosis.

CHRONIC KIDNEY DISEASE (CKD):

- New diagnosis of chronic kidney disease (using the National Kidney Foundation Guidelines.)
- Patients on renal replacement therapy (peritoneal or hemodialysis), ESRD, Stage 5 Kidney Disease, or history of kidney transplant should be coded appropriately. These diagnoses will be excluded from CKD in QBPC.
- For QBPC purposes, patients who are co-managed with a nephrologist are included until the time that renal replacement therapy is initiated, or renal transplant is performed. At that point, the patient is no longer included in CKD for QBPC.
- Patients with three or more months of estimated Glomerular Filtration Rate (eGFR) below 60 mL/min/1.73m2 or significant albuminuria (levels defined below) qualify for CKD.

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 providers 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.

Any of these methods may be used as diagnosing guidelines for CKD in QBPC.

Measurement of GFR:

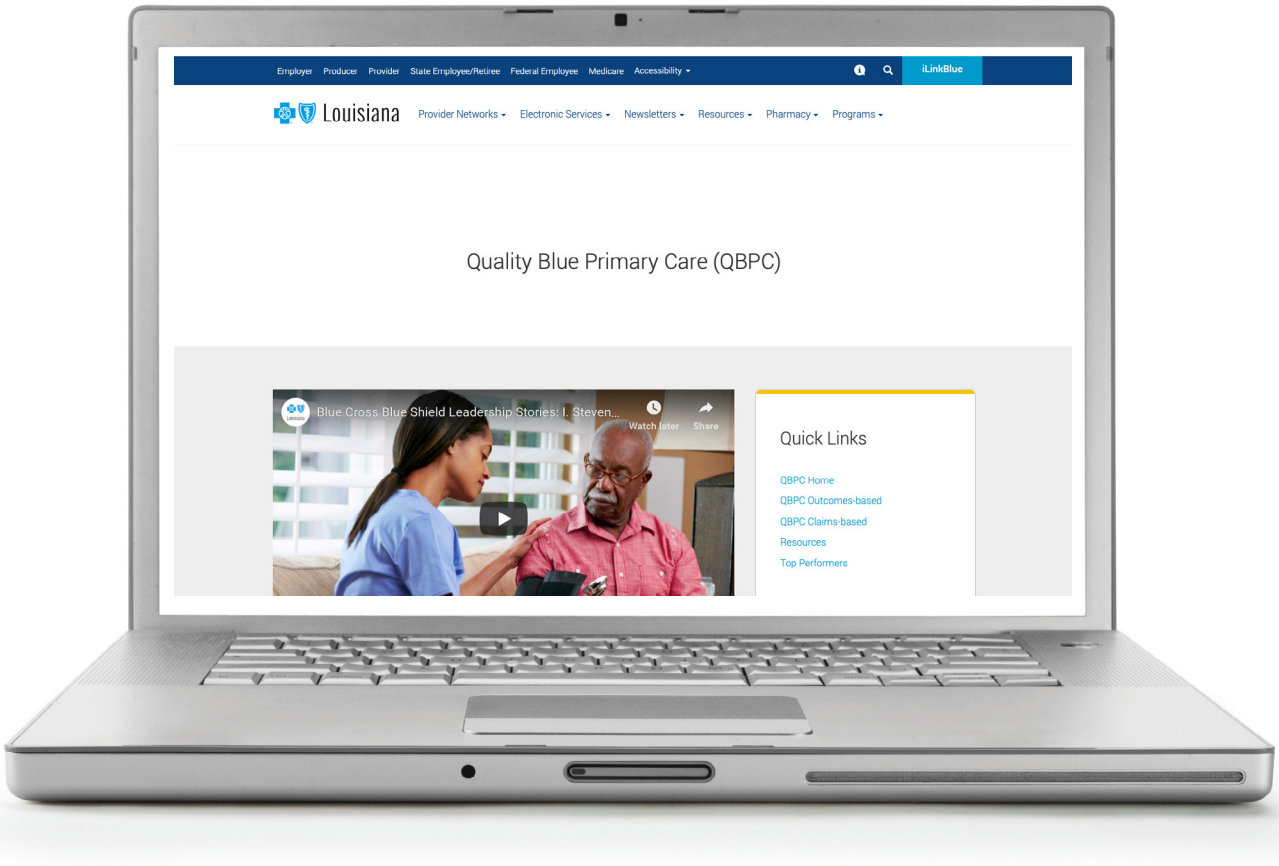
Measurement of GFR is complex, cumbersome and time-consuming; therefore, this has little benefit in primary care practices. However, if a patient has had a measurement using a radioactive marker of insulin that confirms impaired GFR (less than 60 mL/min/1.73 m2), this test may be used as diagnosing guidelines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

Estimation of Albuminuria:

Albumin-to-creatinine ratio (ACR) 30 mg/gram or greater is considered sufficient for CKD diagnosis in QBPC 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.

Clinical Quality and Population Measures

QBPC Clinical Quality and Population Measures are available online for both Commercial and Blue Advantage Members. Go to **www.bcbsla.com/QBPC** and click **Program Measures**. A table of the current measures will be displayed.



Value-Based Payment: QBPC Care Management Fees

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 Clinical Quality and Population Measures. Accordingly, primary care providers will be rewarded based upon these measures.

A Care Management Fee is a performance-based payment paid to the participating provider in addition to existing Fee For Service (FFS) payments for attributed Blue Cross, Blue Card and Blue Advantage members.

The Care Management Fee is paid per attributed member per month who have had an eligible PCP visit (CPT codes 99201-99499) within the last 12 months with the attributed practice.

Every month, participating practices will receive a QBPC Value-Based Payment Report for Commercial Blue Cross members via secure FTP in order to reconcile payments. This report will include the check number, practice TIN and participating providers, in addition to many other provider and patient level details. Payment details for Blue Advantage members can be accessed using the Blue Advantage portal.

In order to begin receiving the Care Management Fee, the QBPC Program Training must be completed. Providers must also notify Clinical Partnerships of any primary care providers added to their practices in order to receive payment for that provider's attributed members. Please refer to Section 4: QBPC Requirements, Roles and Responsibilities for more information regarding Care Management Fee initiation and provider modifications.

Care Management Fee Adjustment

Patient Risk Category

The Care Management Fee will be adjusted according to the patient risk category as detailed in your QBPC Program Participation Agreement.

Thresholds and Tiering

The Care Management Fee is also adjusted based on the Clinical Quality and Population Measure Tier.

Every year the performance of all QBPC program practices will be evaluated on defined Clinical Quality and Population Measures in order to set thresholds. The Physician Advisory Committee will review and contribute to the thresholds. These thresholds are used to rank practices into one of five tiers (1 being the lowest and 5 being the highest). Each Clinical Quality Suite and Population Measure has a set of thresholds with corresponding point values. Points for each suite and measure are tallied to determine tier placement. Please refer to the Program Measures document located at **www.bcbsla.com/QBPC** for details.

Practices are notified of thresholds prior to the upcoming tiering cycle and notified of their tier every June and December. The Care Management Fee is then adjusted based on the tier placement. For the tier set in June (Spring Tiering), providers are paid at that Care Management Fee-adjusted rate for July through December. For the tier set in December (Fall Tiering), providers are paid at that Care Management Fee-adjusted rate for January through June.

Each Clinical Quality suite and Population measure has a corresponding weight and associated point value for thresholds. Earned points for each Clinical Quality suite and Population measure are totaled. The total score is then used to place the QBPC entity into one of five tiers.

If the practice also participates in the Blue Advantage network, then commercial and Blue Advantage total scores will be combined into one final tier with Blue Advantage members being weighted at 150% when compared to commercial members.

If an entity is in tier 1 for three consecutive tiering cycles, Blue Cross reserves the right to remove the Blue Q indicator for the contracted entity's providers in the online directory. Any copay reduction that is applied when a member visits a QBPC provider is not available, nor applied, for a provider whose Blue Q indicator has been removed. Entities will be notified of the change in status.

Please refer to your program participation agreement for your practice's payment methodology and rates. For additional details, please contact your Care Transformation Consultant.

SECTION 4 QBPC Requirements, Roles and Responsibilities

Practice Transformation

Blue Cross is making a generous investment in primary care by funding the QBPC Outcomes Program. We expect that each enrolled practice be an engaged and active participant.

To participate in QBPC, practices 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 Azara Healthcare's Practice Profile.*
  - *Allowing HIPAA-approved extraction of clinical data from the practice EMR, lab, registry or other systems by Azara Healthcare for processing.*
- Designation, training and orientation of a Practice Coordinator (or Practice Coordinators, depending on entity size and configuration).
  - *The Practice Coordinator is employed by the practice—typically a nurse practitioner (NP), a registered nurse (RN) or a medical assistant (MA).*
- Training and orientation of the practice providers and other relevant practice team members.
  - *Practice representation at QBPC regional and statewide collaboratives.*
- Designation, training and orientation of a Practice Champion, Provider Champion, IT/Technical Champion, FTP Site Champion and Local System Administrator (See descriptions in Glossary).
- Active engagement in the population management process, including:
  - *Patient Panel Assignment: Assignment of patient to a primary care provider in the EMR.*
  - *Regularly reviewing, updating EMR patient assignments to a primary care provider and inactivating patients in the EMR data that are no longer being seen or have not been seen in the past two years by the practice.*
  - *Review of clinical workflows in advance for management of patients who have chronic conditions, have been hospitalized, or visited the emergency room.*
  - *Regular and active participation by the Practice Coordinator in Weekly Care Coordination Communications 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 the patient.*
  - *Sharing the treatment plan with the Blue Cross Team upon request by the Quality Navigator via secured email or fax (whichever is preferred by the practice). When necessary a Blue Cross Health Coach will contact patients post 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 Health Coach for care coordination, health coaching, case management and education.*

- Completion of the QBPC Program Provider Registry and QBPC Program Champion Registry exhibits in their Program Participation Agreement.
- Provider and staff participation in learning collaboratives and webinars.
- Completion by each practice location of the Annual Quality Blue Practice Transformation Assessment to help inform performance improvement activities.
- Participation in performance improvement activities in collaboration with their QBPC Care Transformation and Health Care Value Consultants.

Failure to comply with one or more of the above requirements can result in Care Management Fee 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, provider 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 providers focus on what they do best: diagnose and treat. Blue Cross 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 providers can focus on providing the best care possible.

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

QBPC Weekly Care Coordination Communication

Weekly communication between the Blue Cross Quality Navigator and the Practice Coordinator(s) is a critical component of the QBPC Workflow. This communication enables the parties to gain alignment on the issues and goals for chronic care patients and equip the practices with information to address those patients' care gaps.

Objectives of the Care Coordination Communication:

- 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.
- To enable the Quality Navigator and Practice Coordinator to discuss necessary details about Blue Cross members with complex chronic conditions who require extra attention – expanded care coordination.
- 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 or are informed of any barriers or updates communicated to/by an identified member during the Blue Cross Health Coach's calls.

Care Coordination Process Overview:

1. The Blue Cross Quality Navigator works with the designated Practice Coordinator(s) to schedule a weekly method of communication (email or call). The actual length of the call will depend on the number of patients and issues for each practice.
2. Prior to the weekly communication, it is highly recommended the Practice Coordinator print out the MDinsight Patient Care Summaries for the following week's appointments for his or her reference. 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 method of communication is initiated by the Blue Cross Quality Navigator, who leads the Practice Coordinator through reviewing chronic care patients and addressing the following:
    - Critical care gaps and opportunities.
    - Critical barriers to care as indicated by clinical notes.
    - Recent patient hospital/ER events (if available as indicated by clinical notes).
    - Patients targeted for engagement, as necessary.
    - Updates on patients discussed during the previous communication, as necessary.
4. After receiving feedback from the Practice Coordinator, the Blue Cross Quality Navigator works with the Blue Cross Health Coach to determine if the member needs a post-visit call outreach.
5. The Blue Cross Quality Navigator and the Practice Coordinator confirm with one another that they are aligned and understand the patient objectives.
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.

Gaining Alignment on Patient Care Opportunities with Daily Briefings or Huddles

Care team coordination is critical to achieving care transformation. By hosting daily briefings or huddles, 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 or huddles as part of their core care management process.

What is a Daily Briefing or Huddle?

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

Blue Cross recommends that the QBPC Practice Coordinator act as a daily briefing or huddle 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, please refer to the QBPC Daily Briefing Guide in the Appendix of this manual.

Care Management Referrals

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

Below are example reasons a patient may benefit from Blue Cross Care Management Programs:

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

Clinical Workflows

QBPC Care Coordination Workflows provide a roadmap for delivering high-quality patient care enhanced by the Blue Cross Quality Navigator. They are designed to enhance team collaboration, patient interactions and consultations, and streamline processes. These Workflows also have an accompanying action plan that defines a set of actions from care team members to ensure alignment, improvement and engagement.

The Care Coordination Workflows are not specific to any one chronic condition; rather, they focus on the following:

- Chronic Conditions
- Hospitalizations
- Emergency Room Visits

Please refer to the Appendix for samples of each Clinical Workflow and Action Plan. These are generic, and we encourage enrolled practices to adapt these to make customized workflows.

Treatment Plans

Aligning the patient and care team toward the same health goals is paramount in achieving effective chronic disease management. Therefore, we require that all QBPC providers complete a treatment plan for each chronic care member, and that the provider and/or the Practice Coordinator (or designated person at the practice) review it with the patient at an end-of-visit "exit interview."

The goal of the treatment plan is to help patients understand their disease(s) and become 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, consider cultural, economic, physical, mental and social barriers that may affect a patient's ability to achieve goals. The provider and the patient should discuss long- and short-term goals and the steps needed to reach them. Jointly considered treatment goals increase the probability that the provider and the patient will both "go in the same direction," and they empower patients.

QBPC has provided a written treatment plan template for reference (see 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.

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

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 reviewing a Patient-Care Team Pledge. This pledge symbolizes the commitment of both parties to be actively engaged and proactive participants in improving chronic disease management. 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 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 in the Appendix of this manual or through the MDinsight portal:

- **Weekly Care Coordination Guide:** A blueprint for the Practice Coordinator to conduct effective and efficient Weekly Care Coordination with the Blue Cross 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.
- **Patient Adherence:** A tip sheet to help practices overcome resistance to treatment or non-compliance in patients.

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 providers, practice staff, Blue Cross and patients to maximize practice efficiency and improve outcomes.

Implementing QBPC results in minimal disruption for the participating providers 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 Provider, Practice Coordinator and Blue Cross Quality Navigator—to implement a care model that is both efficient and comprehensive.

The Provider

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

1. Becoming QBPC trained.
2. Establishing care plans for chronic disease patient types.
3. Participating in performance improvement activities of the QBPC program.
4. Completing a treatment plan and reviewing it with each QBPC member at the end of each visit.

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 providers. Practice Coordinators are responsible for:

1. Becoming QBPC trained.
2. Acting as the primary QBPC Practice contact.
3. Participating in weekly Care Coordination with the Blue Cross Quality Navigator.
4. Accessing and reviewing in MDinsight each chronic member's Patient Care Summary in advance of 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 the treatment plan and gets answers to any questions.
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 Blue Cross Quality Navigator via secured email or fax (whichever is preferred by the practice). The Blue Cross Quality Navigator shares this information with Blue Cross health coaches, who follow up with the patient after a visit to ensure the patient understands and follows the treatment plan.

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

The Blue Cross Quality Navigator

Blue Cross provides each practice with the services of a Quality Navigator. The Blue Cross Quality Navigator serves as the communication and care coordination hub for practices with Blue Cross. The Blue Cross Quality Navigator 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 Blue Cross 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 weekly care coordination with the Practice Coordinator to review patient care gaps, opportunities, barriers to care, or patients in need of expanded care coordination.
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 providers.

FTP Site Champion

In addition to the above three key care team members, the QBPC Program requires a File Transfer Protocol (FTP) Site Champion at the practice. The FTP Site Champion will be responsible for downloading program reports from a secure FTP site, which will include, but is not limited to, Value-based Payment Reports and Performance Trend Reports. The FTP Site Champion will receive an email when reports are available for download then distributes these actionable reports to necessary staff members.

Practice Onboarding and Training

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.

Blue Cross provides comprehensive QBPC training to all practices enrolled in the program using a train-the-trainer approach. (Note: For practices with multiple locations, one agreed-upon location is utilized.) This in-person training is provided to practices in conjunction with an MDinsight Live Data training led by Azara Healthcare. Training is designed to be hands-on and interactive in nature, and as such, active participation by practice attendees, including Q&A throughout, is encouraged.

Getting Started

Once your practice has reviewed and signed the QBPC Program Participation 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.

MDinsight Live Data Training (led by Azara Healthcare)

The MDinsight Live Data Training is a one-hour training and demo of the population health tool that includes gap identification and registry management. This training is for all Program Champions in addition to providers and practice staff as appropriate. Blue Cross and Azara Healthcare representatives deliver the training.

QBPC Program Training

The QBPC program training is a one-hour training for all Program Champions, providers and practice staff as appropriate. The training includes the following:

- Program overview with Clinical Quality Suites and Population Measures
- Use of MDinsight in the context of a population management-driven workflow
- Tools/reports to support the transformation to a patient-centric model of care
- QBPC Team Roles and Responsibilities
- Care Coordination Process
- Evidence-based practices and recommendations for successful implementation of the QBPC program

Care Management Fee Initiation

To qualify for the first Care Management Fee payment, you must complete QBPC Program Training.

EHR Data Expectations

The practice is responsible for informing Blue Cross and Azara Healthcare of any server change, server upgrade, EMR software change, or other modifications that would cause changes to clinical data Azara Healthcare receives. You must notify Blue Cross and Azara Healthcare as soon as the practice is aware of the upcoming change.

Provider Modifications

The practice is responsible for notifying Clinical Partnerships or their assigned Care Transformation Consultant of any provider modifications that include adding, terming or updating providers in the program. These modifications should be submitted by the practice via a modification form within 30 days. For adding or updating providers, credentialing must be complete with the correct TIN affiliation. Failure to notify Clinical Partnerships or their assigned Care Transformation Consultant of these modifications can affect care management fees. Please contact Clinical Partnerships for a modification form template.

Ongoing Learning Opportunities

For added learning opportunities, Blue Cross hosts a series of collaboratives around the state. These collaboratives give practice staff and primary care providers 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. Practices will be notified if continuing education hours are available.

Blue Cross also keeps participating QBPC practices and providers informed on the latest news and developments of the QBPC program via a quarterly distributed e-newsletter and occasional webinars.

Data Use Agreement

As a reminder, QBPC contracted entities are responsible for adhering to the restrictions and conditions outlined in the Data Use Agreement of the QBPC Agreement. Data Blue Cross provides to the QBPC contracted entity can only be used and disclosed to conduct healthcare operations that fall within the first or second paragraph of the definition of healthcare operations at 45 CFR Part 164.501, which may include the evaluation of the performance of physicians and other providers/suppliers, conducting quality assessment and improvement activities, and conducting population-based activities to improve the health of its virtually aligned QBPC Program Members. Entities cannot use or disclose data for any purpose other than as permitted in the Data Use Agreement or in such a manner that violates the Privacy Rule, 45 C.F.R. Part 164, Subpart E.

QBPC contracted entities are responsible for adopting and using appropriate administrative, physical and technical safeguards to preserve the integrity and confidentiality of the data and to prevent its use or disclosure, other than as permitted by Section 2 of the Data Use Agreement, as otherwise permitted in writing by Blue Cross, or as required by law.

QBPC contracted entities are responsible for requiring any agent or vendor, that has been permitted by the Data Use Agreement to use the data, to agree by written contract to comply with the same restrictions and conditions of the Data Use Agreement.

QBPC contracted entities are responsible for reporting to Blue Cross' Privacy Office at (225) 298-1751 or the Compliance and Ethics Hotline at l-800-973-7077 any use or disclosure of the data that is not permitted by the Data Use Agreement no later than 15 days after the QBPC contracted entity learns of such non-permitted use or disclosure. The report will at least:

1. Identify the nature of the non-permitted use or disclosure;
2. Identify the data content used or disclosed;
3. Identify who made the non-permitted use or disclosure and who received the non-permitted disclosure;
4. Identify the corrective action taken or that will be taken to prevent further non-permitted uses or disclosures;
5. Identify what has or will be done to mitigate any deleterious effect of the non-permitted use or disclosure; and
6. Provide such other reasonably requested information, including a written report

For more information, please consult your QBPC Agreement or you may contact your Blue Cross Care Transformation Consultant.

SECTION 5 *Other Blue Cross Programs*

Quality Blue

Quality Blue is a series of innovative healthcare quality improvement programs that allow network providers opportunities to earn recognition, additional payments and other incentives.

In keeping with its mission, Blue Cross has taken a leadership role in developing programs that reward doctors for quality improvements that get better health results for patients while making healthcare more affordable.

Quality Blue programs recognize those providers who are working in partnership with Blue Cross to transform healthcare systems and improve the way care is delivered to Blue Cross members – their patients – to help them achieve better health outcomes.

See a listing of all Blue Cross and Blue Shield of Louisiana Quality Blue programs online at **https://providers.bcbsla.com/blue-cross-programs**.

Care Management Programs

Your patients are stronger than any disease or diagnosis. Blue Cross' clinical team stands with you, ready to support your patients on their journey to optimal health. We have more than 200 clinical professionals, including doctors, nurses, pharmacists, dietitians and social workers. We also offer many long-standing, results-driven programs to support your patient relationships and help our mutual customers - your patients, our members, achieve their health and wellness goals.

These programs include:

- Case Management
- Disease Management
- Rare Condition Management in partnership with Accordant, an independent health management company
- Preventative and Wellness Services
- Behavioral Health Management in partnership with New Directions, an independent behavioral health management company
- Utilization Review
- Pharmacy

Help your patients be stronger than their diagnosis. There is no out-of-pocket cost to a patient to work with a Blue Cross health coach. Patients can learn more about our available programs and clinical staff at www.bcbsla.com/Stronger.

Referrals can be made using the following methods:

- Practice referral by calling 1-800-317-2299 Monday - Friday, 8 a.m. until 5 p.m. (except office holidays)
- Population Health Referral form (see appendix) faxed to 225-298-3184 from practice
- Prescription pad referral provided to patient (contact your Care Transformation Consultant or Quality Navigator for more detail)
- Patient self-referral by calling 1-800-821-2749 Monday - Friday, 8 a.m. until 5 p.m. (except office holidays)

Patients who are already in a Blue Cross Care Management Program and do not wish to continue participating can call the number above to opt out.

Case Management

Transplant Care Management: We work with patients who have had organ/tissue transplants to educate them on risks, promote safety, manage comorbidities and offer support throughout their care experience. This program helps improve transplant outcomes, lower the risk for hospitalizations and readmission, and lower overall costs associated with the transplant.

Oncology Management: We support patients who are in active cancer treatment to help them manage treatment side effects and symptoms, assess access to care and coordinate services. We also offer education on Louisiana Physician Orders for Scope of Treatment (LaPOST) and other life care-planning legal documents.

High Utilizers/High Cost: Blue Cross encourages all of its customers to have a primary care doctor who handles most of their health needs when they are sick or injured. We particularly emphasize this for patients who have a lot of healthcare needs. The overall goal is to help these patients with care coordination and lower their risks of admissions and readmissions.

- **Discharge Outreach**
  Nurses engage select patients at high risk of readmission within 48-72 hours of discharge to assess their needs, make sure they are taking any medication as directed, coordinate care and help them lower their risks of complications and/or readmissions.
- **ER Outreach**
  Our health coaches work with your patients who go to the ER often to connect them with primary care doctors who can handle most of their health needs when they are sick or injured. We want to help your patients access care in the right setting outside of office visits with you and save on their out-of-pocket costs so they get the most value out of their health plan benefits.

Healthy Blue Beginnings: All pregnant women have access to educational information and resources through Text 4 Baby, a program that helps moms-to-be improve pregnancy and birth outcomes. We work with pregnant patients who are at risk for premature births to educate them on their conditions and the risks involved, promote safety and support optimal health for mother and baby. This helps improve pregnancy/birth outcomes, reduce NICU stays and lower overall costs associated with pre-term births and pregnancy complications.

Tobacco Cessation: Nurses help patients who are trying to quit smoking or using tobacco to work through the stages of this change, set and meet goals and stick to quitting. Nurses also connect these patients with primary care doctors, community resources and other support services.

Disease Management

Blue Cross health coaches are here to help your patients stay on top of their long-term health needs.

These programs aim to improve the physical and psychosocial well-being of patients through cost-effective, personalized solutions. Your patients are stronger than any diagnosis, and we will empower them to reach their best health.

Blue Cross Disease Management programs are here to support your patients who have any of the following health conditions:

- Asthma
- Chronic Kidney Disease (also part of Quality Blue Primary Care)
- Chronic Obstructive Pulmonary Disease
- Congestive Heart Failure
- Coronary Artery Disease/Hypertension (also part of Quality Blue Primary Care)
- Diabetes (also part of Quality Blue Primary Care)
- End Stage Renal Disease
- Pre-diabetes/Metabolic Syndrome

NOTE: Blue Cross is constantly assessing the market and may add Disease Management programs for other conditions as appropriate.

Rare Condition Management

Blue Cross offers the My Health, My Way program in partnership with Accordant*, an independent health management company, to support patients who have any of 17 rare conditions with health coaching, follow-up and education.

My Health, My Way supports patients who have any of the following 17 rare chronic conditions:

- ALS (Amyotrophic Lateral Sclerosis)
- CIDP (Chronic Inflammatory Demyelinating Polyradiculoneuropathy)
- Crohn's Disease
- Ulcerative Colitis
- CF (Cystic Fibrosis)
- Dermatomyositis
- Gaucher Disease
- Hemophilia
- MS (Multiple Sclerosis)
- MG (Myasthenia Gravis)
- PD (Parkinson's Disease)
- Polymyositis
- RA (Rheumatoid Arthritis)
- Scleroderma
- Epilepsy (Seizures)
- Sickle Cell Disease
- SLE or Lupus (Systemic Lupus Erythematosus)

*Accordant is an independent health management company that provides rare disease management services for Blue Cross and Blue Shield of Louisiana and its subsidiaries.

Preventive and Wellness Services

We stand with your patients in their moments of illness and their moments of wellness. Your Blue Cross patients may be eligible for prevention benefits related to obesity, cardiovascular disease and diabetes. Preventive services that might be covered by your patients' health plans include health coaching on diet and exercise, BMI screenings and behavioral counseling to address underlying causes of obesity.

Whether your patients are eligible for this benefit depends on their Blue Cross health plans and coverage. Your patients can find out if they are eligible by calling Blue Cross Customer Service at the number on their member ID cards. If you have staff who provide these types of services, Blue Cross can provide you with a list of procedure codes covered under these benefits for your eligible patients.

Behavioral Health Management

Your patients have access to behavioral health services to keep them healthy and strong. New Directions* is Blue Cross and Blue Shield of Louisiana's behavioral health vendor for most of our members, providing utilization management, case management, substance use management, autism resource management and various provider network support services.

Your patients can reach New Directions by calling their hotline, which is listed on the back of the patient's ID card. The hotline is open Monday-Friday 8 a.m. until 5 p.m. (except office holidays). You can call New Directions' Primary Care Provider Helpline at 1-877-206-4865 Monday-Friday 8 a.m. until 5 p.m. (except holidays) to refer patients for managed behavioral health services.

*New Directions Behavioral Health is an independent company that provides behavioral healthcare services for Blue Cross and Blue Shield of Louisiana and its subsidiaries.

Utilization Review

The Blue Cross Utilization Review program is designed to make sure our mutual customers - your patients, our members - receive safe, high-quality, cost-effective care.

Our clinical staff conduct prior authorization, concurrent review and retrospective review for inpatient and outpatient services. Staff clinicians determine the medical necessity and appropriateness of the services requested, using established, evidence-based guidelines.

These services protect your patients' health and well-being and help rein in costs by making sure they get the care they need in the right setting.

Our medical directors and staff work with Blue Cross' Fraud Investigations Unit and others to review patients' services against specific medical policy criteria and to make sure healthcare services are being used appropriately.

Pharmacy

Blue Cross' $0 Drug Copay Program offers $0 copay (with deductible waived) for certain drugs used to treat certain chronic conditions. Members do not have to meet a deductible before getting program drugs for $0. Drugs in the $0 Drug Copay Program are regularly recommended to treat asthma, chronic obstructive pulmonary disease (COPD), coronary heart disease, diabetes, heart failure and other common chronic conditions. The $0 Drug Copay Program is available for copay-based pharmacy benefits offered through Blue Cross or HMO Louisiana, Inc. The program is not available for coinsurance-only pharmacy benefits.

To find out if your patient is eligible for this program, please have him or her call our Care Management staff at 1-800-317-2299.

***The $0 Drug Copay Program is available for most members who pay copays for prescription drugs** (it is not available for coinsurance-only pharmacy benefits).*

Visit **www.bcbsla.com/CoveredDrugs** to see our covered drug list.

SECTION 6 *QBPC Program Contact Information*

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 further information and assistance please contact:

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

or visit **www.bcbsla.com/QBPC**

SECTION 7 *Glossary of Terms*

Blue Cross Health Coach	A licensed nurse, dietitian or social worker employed by Blue Cross to deliver Care Management programs
Blue Cross Quality Navigator (QN)	Blue Cross employee appointed as Quality Blue Primary Care participating practice liaison and population management/registry champion
Care Management Fee (CMF)	Monthly fee paid to participating QBPC providers, which is based on the number of members with targeted chronic conditions they manage and their performance on selected program measures
Daily Briefing	A daily (5-7 minute) morning "mini meeting" when care teams at the practice review and prepare for that day's chronic care patients and their gaps
FTP Site Champion	Practice-employed QBPC Program technical point-person who is responsible for downloading the reports from the secure FTP site and distributing them among practice staff as necessary
IT/Technical Champion	Practice-employed Quality Blue Primary Care program IT or technical point-person
Local System Administrator	Practice-employed Quality Blue Primary Care program system administrator for MDinsight
MDinsight	Cloud-based health information exchange tool developed by Azara Healthcare
Patient Registry	A system that compiles and manages information on identified subsets of a patient population
Payment Cycle	A period of six months, from January to June or July to December, in which monthly CMF payments are received
Physician Advisory Committee (PAC)	Committee comprised of Louisiana physicians that advises Blue Cross on its various clinical and quality programs, including QBPC, to ensure that the perspectives of participating providers are represented

Provider Champion	Practice-employed Quality Blue Primary Care program clinical point-person (may be the same as the Practice Champion)
Practice Champion	Practice-employed Quality Blue Primary Care program point-person (may be the same as the Physician Champion)
Practice Coordinator	Practice point-person, likely an RN, NP, MA or office manager, who will have access to MDinsight and will work directly with the Blue Cross Quality Navigator to coordinate patient care
Practice Site	Physical location, clinic
Provider	Physician, nurse practitioner and/or physician assistant
Quality Blue Primary Care (QBPC)	Official program name (internal and external)
Azara Healthcare	Health information technology firm; implementation partner
Weekly Care Coordination Communication	Weekly call or email between the Blue Cross Quality Navigator and the Practice Coordinator, in which they review patient care gaps, opportunities, barriers to care, or patients in need of expanded care coordination

APPENDIX

The Appendix contains all Quality Blue Primary Care documents referenced throughout the Policies and Procedures Manual.

A. Treatment Plan Template

B. Patient-Care Team Pledge

C. Daily Briefing Guide

D. Health Literacy Assessment

E. Assessing for Cultural Competency at Your Practice

F. Weekly Care Coordination Guide for Practice Coordinators

G. Patient Adherence Tip Sheet

H. Care Coordination Workflow – Chronic Conditions

I. Care Coordination Workflow - Hospitalizations

J. Care Coordination Workflow – Emergency Room Visits

K. Care Coordination Action Plan

L. Population Health Referral Form

Treatment Plan

Louisiana | Quality Blue PRIMARY CARE

Date: _____ Provider: _____

Patient Name: _____ Insurance ID #: _____

Caregiver Name/phone (if applicable): _____

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

Diagnosi/es: _____

Long-Term Goal(s): _____

_____

Current Appointment:

Reason for visit: _____

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

_____

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

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

_____

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

Care Services:

Referrals: _____

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

_____

Lab Tests Ordered (type & date scheduled): _____

Next Steps:

Patient-Provider Agreed Upon Short-term Goals: _____

_____

Date of Next Appointment: _____

_____ _____

Patient Signature *Provider Signature*

Patient-Care Team Pledge

Louisiana | Quality Blue PRIMARY CARE

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

In order to fulfill this partnership, we will:

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

In return, we trust you to:

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

_____ _____

Provider *Date*

_____ _____

Patient *Date*

QBPC Daily Briefing Guide

Louisiana | Quality Blue PRIMARY CARE

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

What is a Daily Briefing?

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

How to Conduct Daily Briefings:

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

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

Patient Assessment for Low Health Literacy

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

Health Literacy Checklist: *(Check if Present)*

Behaviors

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

Responses to Written Information

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

Responses to Questions About Medications

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

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

Assessing for Cultural Competency at Your Practice

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

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

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

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

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

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

Consider the following in your care setting:

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

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

Weekly Care Coordination Guide

FOR PRACTICE COORDINATORS

Call Information:

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

Blue Cross Quality Navigator Name: _____

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

Phone Number: ( ) - Email: _____

Care Coordination Checklist:

1. **The day before the call, or after you receive the email correspondence, download and briefly familiarize yourself with the Patient Care Summaries or utilize your EMR to capture information about the previous week's chronic patients.**
2. **Pre-Visit Prep: Review the MDinsight Patient Care Summaries and care coordination report from QN.** These resources are your guides to addressing the gaps in care, barriers, interventions, etc. The Blue Cross Quality Navigator will address the following:

   - ☐ Review previous 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, post-appointment, or follow up 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)

3. **Prioritize the call or email correspondence.** The Blue Cross Quality Navigator will call or email you at a predetermined time. Please be available or able to respond timely.
4. **The Blue Cross 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, or during exchange of information, confirm that you understand the objectives for the QBPC patients with appointments and have addressed any outstanding questions.

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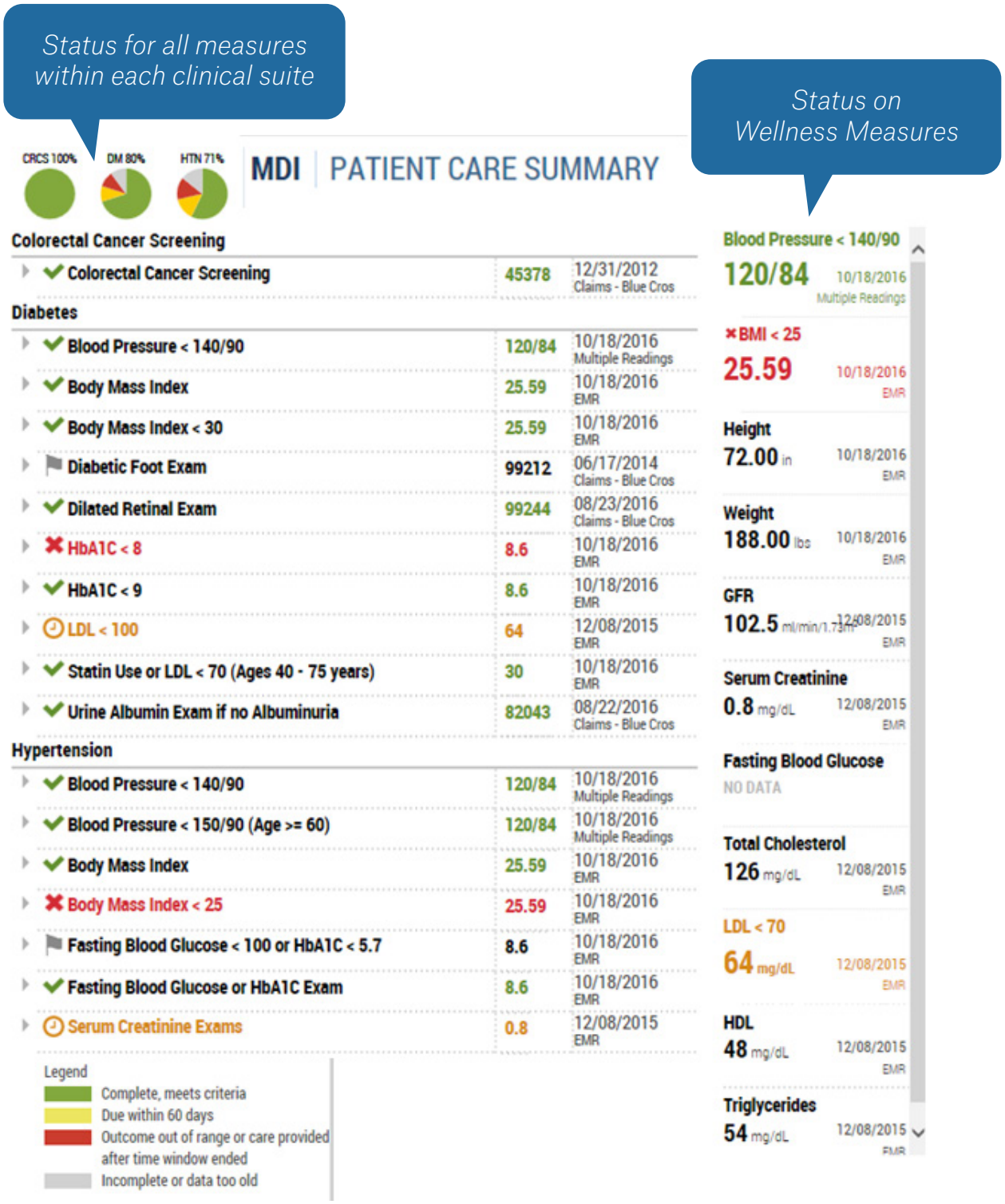
Patient Care Summary Sample:



Patient Adherence

TIP SHEET TO OVERCOME RESISTANCE OR NON-COMPLIANCE

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

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

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

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

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

1. **Respect and honor the resistance**

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

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

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

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

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

3. **Establish mutual goals**

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

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

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

Care Coordination Workflow

CHRONIC CONDITIONS

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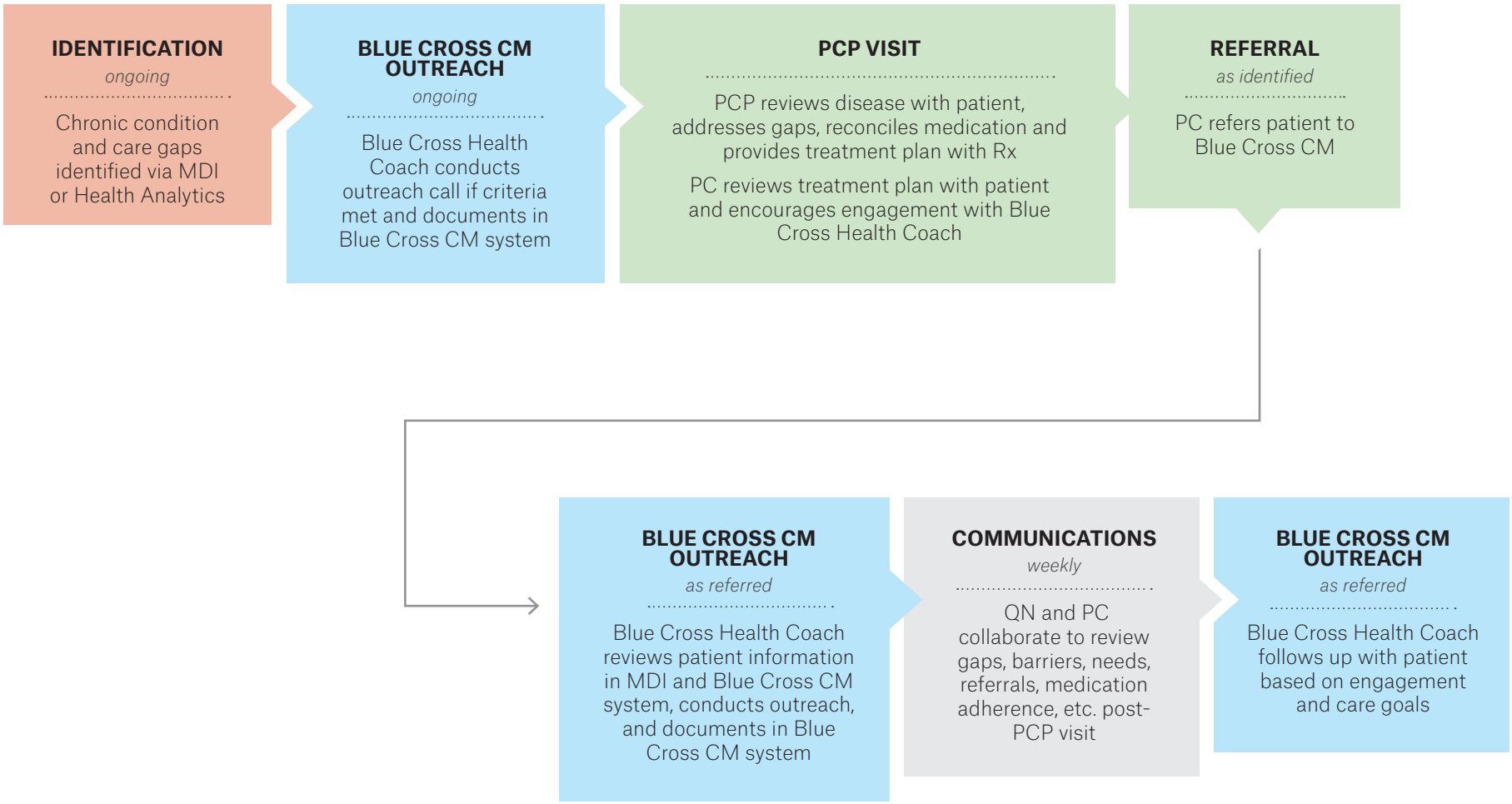

QN = Blue Cross Quality Navigator
PC = Practice Coordinator
CM - Care Management
MDI - MDinsight

Care Coordination Workflow

HOSPITALIZATIONS

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NOTIFICATION

Hospitalization notification received within 48 hrs. and added to Blue Cross CM system

Blue Cross Health Coach receives notification via Blue Cross CM system within 1 working day of discharge

BLUE CROSS CM OUTREACH

2-3 working days post notification of discharge

Blue Cross Health Coach reviews discharge plan, conducts post-discharge call assessment, provides support, education, referral to ancillary services, etc. as needed and documents in Blue Cross CM system

COMMUNICATION

weekly

QN notifies PC of admissions/discharges during Weekly Care Coordination Communication

PCP VISIT

within 7 days of discharge

PC schedules PCP visit

PCP reviews discharge summary, addresses any new diagnoses, reconciles medication, red flag teach backs, etc.

REFERRAL

as identified

PC refers patient to Blue Cross CM if necessary (dietitian services, social services, health coaching, etc.)

QN = Blue Cross Quality Navigator
PC = Practice Coordinator
CM - Care Management

Care Coordination Workflow

EMERGENCY ROOM VISITS

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NOTIFICATION
ongoing/as reported

ER Visit notification received and added to Blue Cross CM system

Blue Cross Health Coach notified of ER visit via Blue Cross CM system

BLUE CROSS CM OUTREACH
upon notification

Blue Cross Health Coach contacts patient and conducts post-ER assessment, provides support, education, or referrals to ancillary services, etc. as needed and documents in Blue Cross CM system

COMMUNICATION
weekly

QN notifies PC of ER visit during Weekly Care Coordination Communication

PCP VISIT
as identified

PC schedules PCP visit

PCP reviews discharge summary, reconciles medication, addresses any new diagnoses, red flag teach backs, etc.

REFERRAL
as identified

PC refers patient to Blue Cross CM if necessary (dietitian services, social services, health coaching, etc.)

NOTE: Notifications are received ONLY for patients who:

- Have been identified during the assessment/screening process with the Blue Cross Health Coach

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

QN = Blue Cross Quality Navigator
PC = Practice Coordinator
CM - Care Management

Care Coordination Action Plan

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BLUE CROSS CARE MANAGEMENT	PRACTICE	PATIENT

The Blue Cross Health Coach:
• Conducts patient outreach and assesses/provides:
  • Patient health status, health literacy and barriers
  • Discharge plan/treatment plan
  • Depression screening
  • Patient self-management/caregiver support
  • Medication adherence
  • Disease education
  • PCP appointment
  • Referral to ancillary services
• Enrolls/engages patient in Blue Cross Care Management Program as identified
 	
The Quality Navigator:
• Assesses patient care gaps and disease trajectory in MDinsight and Blue Cross' care management systems to include Blue Cross Health Coach outreach assessment
• Communicates admission/discharges, care gaps, barriers/needs, medication adherence, etc. weekly to practice coordinator
• Notifies practice coordinator if referrals to additional ancillary services are recommended (pharmacy or dietitian services, PT/respiratory therapy, rehab, home health services, DME, behavioral health, etc.)
	• Ensures processes in place to routinely follow chronic conditions and other healthcare needs
	• Ensures discharged patients are scheduled for follow-up visit within seven days to address care gaps/barriers/needs identified
	• Performs Comprehensive Medication Review/Reconciliation and Red Flag Teach Backs
	• Collaborates with Quality Navigator weekly to review care gaps, admissions/discharges, patient barriers/needs, medication adherence, etc.
	• Holds daily briefing/huddle to align care team
	• Completes a treatment plan and reviews with patient at the end of visit
	• Refers patient to Blue Cross Care Management as identified
	• Encourages patient to actively engage with Blue Cross Health Coach
		• Actively engages with Blue Cross Health Coach
		• Understands where to appropriately seek care (PCP vs. ER)
		• Understands treatment plan
		• Understands all medications within regimen, when and how to take them appropriately
		• Engages and becomes an active participant in his or her own healthcare

Louisiana

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Population Health Referral

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

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

Patient Information

Patient Name _____

Date of Birth _____ Patient Phone (Day) _____

BCBSLA ID Number _____ Evening Phone _____

Referring Physician Name _____ Referring Physician Phone _____

Pertinent Clinical Information

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

_____

_____

Referral Type

☐ **Health Coach**

Reason for Referral

_____

_____

☐ **Social Worker**

Reason for Referral

_____

_____

☐ **Dietician**

Reason for Referral:

_____

_____

Additional Information

_____

_____