Premise Health

Welcome to the Be Well Condition Management Program

What is Be Well Condition Management?

The Be Well Condition Management Program is designed to improve the health of persons with specific chronic conditions. This is an opt-in program in which you agree to participate. A primary care model is followed where you will remain with the same Condition Manager throughout the process.

The sessions will cover:

- Specifics of the condition,
- Possible complications,
- Modifiable risk factors,
- Guidance on self-care skills,
- Education on medications as needed,
- Related healthy eating and physical activity recommendations, and
- Ongoing preventive Condition needs.

The Condition Manager:

- Is specially trained in the management of chronic conditions;
- Will work with you on a 1:1 basis, following Evidence-Based Medicine Guidelines;
- Will schedule the frequency of visits determined by your condition and your availability;
- Will provide you with the knowledge, skills, and motivation to effectively manage your condition;
- Will help you to formulate stepwise goals to help you reach your healthcare goal;
- Will assist with identifying your challenges and strategies to address them;
- Keeps all conversations private and confidential.;
- Is punctual and responsive; and
- Will be your guide along the way in the journey to better health.

The Participant:

- Will strive to communicate openly with the Condition Manager;
- Will be punctual, responsive, and prepared for sessions;
- Will be open and honest about information that is relevant to his/her condition;
- Will ask questions to make certain that he/she understands explanations and instructions that are given;
- Will strive to make the changes and follow the suggestions offered: you may be encouraged to make some changes to your lifestyle, daily routines, medication adherence, eating habits, and physical activity to improve your health;
- Will contact the Condition Manager 24 hours in advance if an appointment needs to be rescheduled;
- Will notify the Condition Manager if he/she decides to unenroll;
- Will participate in 2 virtual Be Well Condition Management phone visits yearly; and
- If active in the Be Well Condition Management Program for Diabetes, participant will ensure that 2 HbA1C test results are submitted to the Condition Manager yearly.

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Other information:

How will my health care provider be included?

- If you use the Shaw Family Health Center as your primary Care practice, your Condition Manager will work with your provider to establish a coordinated plan of care. If you would like to maintain your relationship with your community provider, we will work with them upon your consent. Condition Management does not change the treatment plan of your provider but rather complements the plan, providing you with information and understanding of your condition to be as healthy as possible.

Will my employer have access to my information?

- No: this program, as with the Health Center, is provided by Premise Health. Your employer contracts with Premise Health to provide the services confidentially. No personal information or identifiable data about you will be shared with your employer. The Notice of Privacy Practices that you received upon registering at the Health Center applies. You will be asked to sign an Authorization for Use and Disclosure of Protected Health Information to authorize specific disclosure of your protected health information.

Are there additional benefits when I enroll in this program?

- You have free, unlimited access to your Be Well Team
- Flexibility in appointments
- Some of your medication and supplies are free just for participating and being compliant with the program.
- Assurance that your health can improve, and you will have a better quality of life.

By completing and signing this form, I am requesting to participate in the Be Well Condition Management Program offered through the Shaw Medical Plan. I understand my participation is voluntary and I will only be able to qualify for the free medication and supplies associated with this program if I remain compliant with the information requested and my participation.

_____ _____

Signature of Participant Date

_____

Contact number:

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Instructions for Enrollment

Is your primary care provider at the Shaw Family Health Center? If so, fill out section A and fax the form to 706.609.3397 or email to shawreferral@premisehealth.com. You will be contacted to schedule an appointment.

If your primary care provider is in the community (not at the Shaw Family Health Center) submit all the information in sections A and B, along with your primary care provider's signature, by fax to 706.609.3397 or email to shawreferral@premisehealth.com

To remain compliant and to continue to offer zero-cost medications, participants in the Be Well program for Diabetes must supply a diabetes diagnosis and an A1C of 6.5 or greater at the time of diagnosis. Prediabetes does not qualify.

SECTION A:

Patient: _____ DOB: ___/___/___

Name of Primary Care Provider: _____

For Members Enrolling for Diabetes
HbA1C at Diagnosis: _____

Signature of Primary Care Provider: _____

Phone: _____

Please circle the condition(s) you are enrolling for:

Asthma COPD Hypertension (High Blood Pressure)

Diabetes Dyslipidemia (High Lipid Levels)

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SECTION B

Be Well Condition Management Program Assessment Form

Name: _____ Date of Birth: _____

Contact Number: _____

Vital Signs – All members	**Date:** _____ **BP**: _____ **Weight:** _____ **Height:** _____ **BMI:** _____
Hypertension	Complete the Vital Signs section above.
Diabetes* and /or Dyslipidemia (High Cholesterol)	**HbA1C:** Date: _____ Result: _____ **Lipid Panel:** Date: _____ Total Chol: _____ TGL: _____ LDL: _____ HDL: _____ **Eye Exam:** Date: _____ Normal: ☐YES ☐NO Diabetic Retinopathy Finding: ☐Mild ☐Moderate ☐Severe **Foot Exam:** Date: _____ Diabetic Altered Sensation Finding: ☐Mild ☐Moderate ☐Severe
Asthma	☐Completely Controlled ☐Somewhat Controlled ☐Not Controlled at all ☐ Intermittent ☐Mild Persistent ☐Moderate Persistent ☐Severe Persistent
COPD	☐Completely Controlled ☐Somewhat Controlled ☐Not Controlled at all ☐ Intermittent ☐Mild Persistent ☐Moderate Persistent ☐Severe Persistent

*** Enrollees must supply a diabetes diagnosis of Diabetes and an HbA1C of 6.5 or greater. Prediabetes does not qualify.**

Name of Primary Care Provider: _____

Signature of Primary Care Provider: _____ Date: _____

Please present this form in person at the Shaw Family Health Center, **OR** Mail to Shaw Family Health Center, 2659 Abutment Road, Dalton, GA 30721, **OR** Fax to: 706-609-3397, **OR** email to shawreferral@Premisehealth.com.

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Incentive Program Employee Notice and Authorization

Your employer has contracted with Premise Health Employer Solutions, LLC, along with its professional affiliates ("Premise Health") to provide certain health and/or wellness services in connection with your employer's voluntary incentive program.

If applicable, by participating in the Incentive Program, you consent to the collection of a blood specimen and/or bodily fluids. You understand and acknowledge that the collection of blood through a needle or fingerstick may cause pain, a bruise or, rarely, an infection. You also consent to the collection of additional biometrics (height, weight, blood pressure, waist circumference, and perhaps other measurements, as per the design of the program), health history, physical exam, health coaching and other services based on your employer's incentive program. You understand that a biometric screening and other screenings are not meant to replace the Condition of a medical professional and that Premise Health may recommend that you seek additional medical Condition based on the screening.

If applicable, by participating in the incentive program, you may be asked to complete a voluntary health risk assessment ("HRA") that presents a series of questions about your health-related activities and behaviors and whether you had or have certain medical conditions (e.g., cancer, diabetes, or heart disease).

If applicable, by participating in the Flu vaccination program, you may be asked to answer a series of questions about certain medical conditions.

Protection of Your Health Information: Premise Health agrees to abide by all applicable laws and regulations governing the privacy and security of your personal health information. To the extent, the information is subject to the Health Insurance Portability and Accountability Act and its implementing regulations ("HIPAA"), Premise Health will abide by HIPAA and maintain the privacy and security of your Protected Health Information ("PHI") in accordance with its Notice of Privacy Practices ("Notice"), which Premise Health has provided to you. This Notice is also available at Health Center and on the Premise Health website. You may also request a copy of this Notice from Premise Health at any time.

Authorization: I understand that my participation in the incentive program is strictly voluntary, but in order to determine my eligibility for health and/or wellness incentives, the administrator(s) of the health and wellness program must receive a record of my participation. By signing below, I authorize Premise Health to disclose information regarding my participation in the program with the administrator(s) of the program. If the incentive program includes by design a review of my results (e.g., measurement, test or blood specimen results) so that I can be provided recommendations in furtherance of my health, I authorize Premise Health to disclose my results to my employer, Premise Client or any third party who has contracted with my employer to review and analyze those results in connection with the program.

I understand that this information may be disclosed through electronic means. I also understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Effective Date: This consent and authorization will expire five (5) years from the date of signature.

Right to Revoke Authorization to Release PHI: I understand that I may revoke this authorization at any time by submitting notice of my revocation in writing to the Health Center, or to Premise Health, Compliance Department, 5500 Maryland Way, Suite 120, Brentwood, TN 37027. I understand that my revocation of this authorization does not affect any actions taken prior to receipt of my revocation. I further understand that my revocation of this authorization may impact my ability to participate in the incentive program and/or receive the incentives.

Signature and Copy: I have read and understand this form in its entirety and voluntarily authorize the consent to treat and uses and disclosures of the information described above. I acknowledge that the person executing this form is the person participating in or receiving services, or such participant's legal representative who is authorized to act on such person's behalf to sign this form. I further acknowledge I am at least 18 years old. I understand that I have the right to receive a copy of this authorization upon request.

Participant First Name:_____ Last Name:_____

Date of Birth:_____

Participant or Legal Representative Signature:_____

Date: _____

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Consent for treatment and Acknowledgement of the Notice of Privacy Practices

Consent for treatment

I consent to all necessary and reasonable medical examinations, laboratory and diagnostic testing and treatment by Premise Health. I voluntarily request the provider to explain the nature, risks, and purpose of a medical examination, testing, and treatment, including possible alternatives if I do not consent to treatment. I understand that I can change my mind about treatment. If I have any questions about my examination, testing, or treatment, Premise Health and the provider will not proceed, unless it is an emergency, until such questions have been answered so that I am fully informed.

I acknowledge that it is important to give all relevant medical information to Premise Health and my provider and to the extent that additional examinations, testing, or treatment are needed and recommended, it may be necessary for me to read and sign additional consents.

I am aware that no guarantee is made concerning a final medical result, outcome, or cure.

To better serve patients, Premise Health offers some health Condition services with combinations of asynchronous, interactive video communications, telephone, and/or by the electronic transmission of information. This may assist in the evaluation, diagnosis, management and treatment of certain health conditions. This process is referred to as “telemedicine” or “telehealth.” In a telehealth encounter, you may be evaluated and treated by a health Condition provider from a distant location. Since this may be different than the traditional evaluation, it is important that you read, understand, and agree to the following:

- At my option, Premise Health may provide some services via telehealth. Telehealth offers convenient, timely access to healthcare services but is not always a substitute for face-to-face consultations. I understand that, as with any technology, telehealth has limitations. Though unlikely, it is possible some information may be lost due to technical failures. Ultimately, my healthcare addressing my condition(s). I understand the appropriate use of telehealth is a decision that can only be made by my provider.

- I understand that I can withdraw my permission at any time and that I do not have to answer questions that I consider to be inappropriate or am unwilling to have heard by other medical professionals in the room with the provider. Nonetheless, I am aware healthcare confidentiality standards apply to telehealth sessions just as they would to any other healthcare encounter. While any communications may be recorded, and may be added to my medical records, these recordings and records remain confidential. Premise Health's electronic communications portal encrypts all data transmissions and authenticates all users prior to accessing any healthcare data. I recognize that despite these security measures, data compromises remain possible, though unlikely.

- By executing this consent, I authorize this electronic transmission of information. I understand that if I do not choose to participate in a telehealth session, no action will be taken against me that will cause a delay in my Condition and that I may still pursue face-to-face consultation. I also authorize the information from a telehealth encounter to be forwarded to my primary Condition provider if my primary Condition provider is different from the telehealth provider. I MAY DECLINE TO AUTHORIZE FORWARDING TO MY PRIMARY CONDITION PROVIDER IF NOT A PREMISE HEALTH PROVIDER.

I have read this Consent for Treatment or have had it read to me, and it has been explained to my satisfaction. I understand that this Consent for Treatment is valid from the date that I sign it until the physician-patient relationship is terminated; a new health care representative is appointed; or I revoke consent. I understand that any proposed invasive diagnostic or treatment procedure will require separate informed consent.

"Premise Health" means Premise Health Employer Solutions, LLC along with its affiliated entities and professional organizations, including its professional, technical, and administrative staff providing services as part of the Premise Health clinic.

Acknowledgement of Notice of Privacy Practices:

I have received the Premise Health Notice of Privacy Practices either today or at a past visit and acknowledge that I can receive a copy at my request or from the Premise Health website (www.premisehealth.com).

By signing below, I consent to treatment by Premise Health, including any treatment I choose to receive via telemedicine, and I acknowledge receipt of the Premise Health Notice of Privacy Practices:

_____ _____

Patient/Personal Representative Signature Date

_____ _____

Patient/Participant Name (please print) Date of Birth

_____

Relationship of Personal Representative (parent/legal guardian)

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Patient did not sign or refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency prevented us from obtaining acknowledgement

_____ Other (Please describe:_____)