Generating Care Management Referrals

Overview

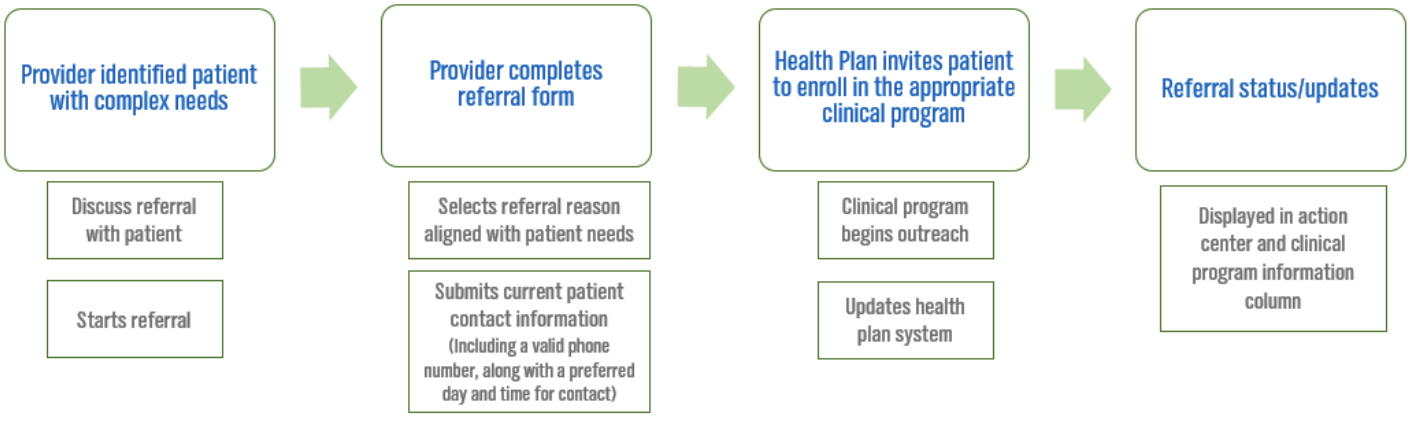
Patients with complex medical conditions who may be in the need of a care intervention are good candidates for referral to Anthem Blue Cross and Blue Shield (Anthem) clinical programs. This quick reference tool outlines how to generate a care management referral from the Population Management section of your program's reporting application. The reporting application provides a secure process for submitting patient information to the Anthem clinical programs for collaboration. To learn more about how to identify patients who can benefit from Care Management, refer to the Care Plan Handbook.

Provider Role

Providers must discuss the referral with their patients in order to support engagement in clinical programs and to avoid patient confusion. A patient is more likely to engage with an Anthem Care Manager when a provider has recommended their participation in a care management program. Providers should advise that through the patient's health plan, and at no additional cost, they may have access to a trained professional health consultant to help them achieve their health care goals.

- Explain to your patient that once the referral is submitted they will receive a call from their health plan.

How Referral Automation Works



Anthem

What Your Patient Can Expect

Patients should expect a contact from their health plan to provide support for meeting their health goals such as:

- What to expect during and after a hospital stay
- Assistance with navigating the health system
- Access to educational information from medical professionals like dietitians, social workers or pharmacists
- Support for managing a serious or complex condition
- Answers to family questions and referrals or recommendations to other programs provided at no additional cost

What the Provider Can Expect

- Providers can expect easy access to referral status for their patients
- View results of referrals via status and outcome
- Request care management nurse contact via note section in referral form
- View list of referrals sent and received in the last 12 months
- View detailed care management activities by clicking "View Patient Details"

Note: *If a status shows 'Unable to Reach' a provider should follow up with the patient to encourage participation.*

After consulting with your patient, you will need the following information on hand to complete the submission.

Patient Information	Your program's reporting application will auto populate patient demographic fields, including the phone number on record. The provider will need to input additional patient contact information
Submitter Contact Information	Name, contact phone number and email address
Reason for Referral	Request reason: Is this an urgent referral? How did you identify the patient? Referral discussed with patient?
Clinical Information	Date of patient's most recent visit. Is patient newly diagnosed with any conditions? Patient's most recent BP reading and date, PAM score, PHQ2 or PHQ9 score, if available
Other Notes to Support Referral	Relevant notes to assist with patient engagement, care management and care planning

Read the Referral Automation User Guide found in Quick Links/Resources section of your program's reporting application for additional guidance on submitting a referral to Anthem clinical programs.