Be Well Enrollment

Welcome to the Condition Management Program

What is Condition Management?

The 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
- Ongoing preventive care 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 main 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;
- Is ready to make a time investment of at least three months;
- 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;

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- Will contact the Condition Manager 24 hours in advance if an appointment needs to be rescheduled; and
- Will notify the Condition Manager if he/she decides to unenroll.

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; in person or over the phone
- 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

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By completing and signing this form, I am requesting to participate in the Be Well 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

Instructions for Enrollment

Is your primary care provider at the Shaw Family Health Center? If so, fill our section A and fax the form to **706.913.1269.** 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 **706.913.1269**. You may also scan and email this form to the Shaw Family Health Center at SFHC@PremiseHealth.com You will be contacted to schedule an appointment.

If you would prefer the health center staff request this information from your primary care provider, please complete the page labeled, Authorization to Use or Disclose Protected Health Information, and fax it to **706.913.1269**.

SECTION A:

Patient: ______________________________ **DOB:** ___/___/___

Name 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:

All patients	Weight_________ Height__________ BMI_________ Date: ___/___/___
Asthma	☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent ☐ Well Controlled ☐ Not Well Controlled ☐ Poorly Controlled
COPD	☐ Well Controlled ☐ Not Well Controlled ☐ Poorly Controlled
Hypertension	BP: _______/_____ Date: ___/___/___ Total Cholesterol (fasting): _________HDL: _____ LDL: ___________ TGL: ___________ Date: ___/___/___
Diabetes	Blood Pressure: _____/_____ Date: ___/___/___ HbA1C ____________Date: ___/__/___ Fasting Glucose: _______ Date: ___/__/___ Total Col(fasting): _________HDL: _____ LDL: ___________ TGL: _________Date: ___/___/___ Eye Exam: ☐ Normal Diabetic Finding: ☐ Mild ☐Moderate ☐Severe Date: _____/___/___ Foot Exam: ☐ Normal Diabetic Finding: ☐ Mild ☐Moderate ☐Severe Date: _____/___/___
Dyslipidemia	Total Cholesterol (fasting): _________HDL: _____ LDL: ___________ TGL: ___________ Date: ___/___/___

Name of Primary Care Provider: ____________________________________

Signature of Primary Care Provider: ________________________________ **Date**: ____________________