WPC COMMUNITY CLINICS:

STAFF GUIDE

Office of System Integration and Transformation

Santa Clara Valley
Health and Hospital System

October, 2018

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1. Introduction to Whole Person Care:

Whole Person Care (WPC) is a pilot project funded through the Centers for Medicare and Medicaid Services (CMS) to provide funding for transforming and improving the quality of care, access and efficiency of health care services for Medi-Cal members.

The overarching goal of WPC is to provide patient-centered care that will address the entire spectrum of needs a patient may have. Through a collaborative and coordinated assessment, planning and treatment process, patients will receive improved care as well as assistance with both their health needs and the barriers that affect their health.

WPC is a benefit of the patient's Medi-Cal health plan at no additional cost. Patients eligible for WPC must have active Medi-Cal. There are a few Medi-Cal programs that are excluded from WPC eligibility. (Restricted Medi-Cal is an exclusion).

WPC participation is billed to the State. We are reimbursed for a patient's enrollment. We are also reimbursed monthly if the patient receives a minimum of one service activity each month. At times, the more "service interventions" (Section10 - Checklist) documented, the greater the reimbursement rate will be from the State. Only "non-billable" services are eligible for service activity for WPC. Therefore, doctors' visits, lab tests, and therapy visits are not counted as service activity. An intervention from a nurse, outreach worker and pharmacist are examples of staff who provide non-billable service activity.

The target population of WPC services are the High Utilizers of Multiple Systems (HUMS). These patients often utilize Emergency Services and are not engaged in Primary Care Services nor follow up with Specialty Care. Additionally, patients with Serious Mental Illness (SMI), a Substance Abuse diagnosis, or are Homeless are our high-risk patients. The specific criteria for WPC eligible status is:

- 18-64 years old
- Medi-Cal insurance (Restricted Medi-Cal is excluded)
- HUMS score 7 or greater* (Appendix A) and/or
- High Risk (as defined by diagnosis and/or housing status)

2. Goals of Whole Person Care:

- Improve the health, wellness and satisfaction of the patient.
- Create a welcoming, patient-centered care environment.
- Reduce avoidable Emergency Service utilization.
- Increase consistent primary care utilization.
- Increase the patient's ability to navigate the health system.
- Create coordinated healthcare teams to support patient care.

3. WPC Guiding Principles:

- Meet the patient "where they are".
- Develop a patient-centered collaborative partnership with the patient and family.
- Remain sensitive to the individual patient's culture, preferences, needs and values.
- Facilitate patient's self-determination and self-management through advocacy, shared and informed decision making and health education.
- Use a comprehensive, holistic and compassionate approach to care delivery that integrates a patient's medical, behavioral, social, psychological, functional and other needs.
- Foster safe and manageable navigation through the healthcare system to enhance the patient's timely access to services and the achievement of successful outcomes.
- Utilize a team approach to healthcare to support the patient.

4. Transformational Changes:

- This is a health system and all parts of the system (roles) are integral to the patient's care.
- Team work allows for shared accountability and treatment planning that includes representation from a variety of disciplines and agencies to support the "Whole Person."
- All our individual roles will expand to ensure that care is coordinated by looking at the "whole person" as an element of the assessment, treatment planning as well as all aspects of customer service.

5. Transformation 2020 (T2020):

Whole Person Care is a part of the “Transformation 2020” planning that is occurring in our Valley Medical Center (VMC) system. Some of the projects include:

- The Navigation Center
- The Sobering Center
- Peer Respite
- Intensive Clinical Team
- SBIRT (Screening, Brief Intervention and Referral to Treatment)
- Medication Assisted Treatment in the Emergency Department and Primary Care
- Nursing Home Transitions and Diversions
- Medical and Psychiatric Skilled Nursing Placements
- Medical Respite (expanded)

Our system is building opportunities to provide patients with prevention, early intervention, transitional and coordinated care to serve the patient in the location and service level that best matches their needs.

6. Whole Person Care Implementation:

WPC implementation began with developing a plan for data integration throughout our enterprise. This includes our health system, criminal justice, behavioral health and social service system and community partners. A data warehouse was developed so that our system would be able to collect data, but more importantly, provide data to both our internal and external partners that would support their work with patients.

7. Whole Person Care Enrollment:

Patients eligible for WPC services will be identified and uploaded into the WPC Database. Reverse Enrollees (patients identified as potentially eligible for WPC services) are referred to WPC administration for approval.

Whole Person Care Reverse Enrollment:

At times, staff will identify patients who could benefit from WPC services. A process has been developed to facilitate enrollment for this group of patients.

- Review the criteria for WPC and assess that the criteria may match the profile of the patient:
  - 18-64 years old
  - Medi-Cal insured (**restricted Medi-Cal is an exclusion to WPC**)
  - HUMS score 7 or greater* (Appendix A) and/or
  - High Risk (as defined by diagnosis and/or housing status)
- Patient has signed WPC authorization and your agency's consent form.
  - Enter the information in the Reverse Enrollment form (Reverse Enrollment Tab)
- Office of System Integration and Transformation (OSIT) Data Team processes requests weekly.
- Reverse Enrollments with identified as approved or not approved in the WPC Database-Reverse Enrollment Tab.
- Proceed with WPC services after approval of WPC eligibility confirmation.
- **Please note that you may not bill for WPC services until the patient has been approved**.

**For clinics not using the WPC Access Database, the list of eligible WPC candidates could be sent to the OSIT team using email id HHS_OSIT_BI@hhs.sccgov.org.*

Enrolling WPC eligible patients:

1. Review patient chart and/or health assessment.

- Review the Health Risk Assessment or Staying Health Assessment (SHA) or any other current assessments in chart.
  - Based upon your WPC workflow, assign the patient to a coordinator/navigator or complex case manager.

If the patient is not identified on the WPC eligible patient list and appears to meet WPC criteria complete the Reverse Enrollment information utilizing the Reverse Enrollment Tab in the WPC Database (See previous page).

2. The Enrollment Process for the Care Coordinator/Navigator or Complex Case Manager includes:

A. Introduce WPC as a program under their Medi-Cal insurance plan

- Inform the patient that the program is free.
- Explain that the program is designed to help patients improve their health.
- Matches the patient with a Care Coordinator/Navigator.
- Helps the patient connect to the services that they need.
- Provides referrals to services including transportation, support groups, food and more.
- Assists the patient in navigating the health system.
- Minimize the use of the emergency services and facilitates the use of Primary Care and Urgent Care services (when needed).
- Patient and the Care Coordinator/Navigator and Complex Case Manager will work as a team with others to set goals and achieve improved health

B. Have patient sign the authorization and your agency's consent forms

- Provide a copy of the authorization and consent forms to the patient and upload a copy to OSIT via the SFTP folder.
- Document signature date of consent and authorization forms in the Patients Details/Care Coordination tab
- Provide patient with the WPC Patient Information Flyer and WPC Card with completed contact information if available. (Appendix C)
- Based upon the patient's needs and goals, clarify the plan and next steps with the patient.

C. Discuss length of program and patient goals.

- Program length should be dependent on a variety of factors,

including patient complexity, barriers, chronicity and acuity of medical conditions and support system. This may be a discussion with the patient and the team. (Appendix D)

- Patient may be triaged into the following bundles:
- Short Term: Up to 3 months
- Medium Term: Up to 9 months
- Long Term: 10 months or longer
- Rehabilitation Services (assigned based on interventions-no time limit)

- Document WPC enrollment status, program length and service(s) assignment in Patients Details/Care Coordination TabIe (Appendix B).
- Conduct assessment & relevant screenings or review assessment (s) on record and establish goals. Document goals in Care Plan tab (Appendix B)
- Set up future encounters based upon the risk level identified by the team
- Be available to facilitate care coordination services for/with the patient.

8. Care Coordination/Navigation

Care Coordination Defined:
Facilitating communication and coordination with the patient and between members of the health care team in order to minimize fragmentation in the services.

Care Coordinator Activities:

- Face-to-face (In-home or site-based) meeting with patient
- Phone or text messaging with patient
  - "Check in" phone call to review patient's goals and progress
  - Message to the patient (if patient requested and voicemail with patient's name for HIPPA protection) regarding patient information (appointment reminders do not count)
- MyHealth Online Messaging with patient if requested by patient
  - Messaging with patient regarding patient goals, concerns, referrals (not appointment communication)
- Face-to-face meeting with another staff person about the patient
  - Consultation or information with the billable provider

Responsibility of the Care Coordinator/Navigator:

1. Engage the patient (and family/caregiver) in Whole Person Care participation.

- *Meet patient, enroll in WPC and provide contact information*
- *Conduct HRA, SHA and Screenings*
- *Assess*

2. Identify barriers that affect the patient's ability to adhere to treatments or maintain their health.

- *Review assessments in health record. For example: Staying Health Assessment (SHA) or Health Risk Assessment), Biopsychosocial Assessment (Social Work).*

3. Ask the patient to identify goals that he or she would like to achieve through WPC services.

- *Ensure patient understands the goals, their role in achieving the goals and support their efficacy in the process.*
- *Identify to the patient how the Care Coordinator/Navigator will support the patient and the process*

4. Identify and communicate with the appropriate team of health care professionals to address the patient's needs.

- *Refer to needed providers/staff and resources to support the patient's healthcare needs*
- *Follow up with referrals, either through reviewing the chart, electronic communication, phone or face-to-face to support a seamless process*

5. If patient is registered for MyHealth online, educate the patient to improve the patient's ability to use the health system.

- *Provide patient with information on the Valley Health Plan Advice Line (if appropriate), Valley Connections and other Call Centers to support their ability to manage their health and make same day appointments.*
- *Provide patient with instructions on when to use Urgent Care services and the Emergency Department along with contact information*
- *Provide patient with your clinics contact and emergency information*

6. Follow up with patient (at least once a month) if the patient is low risk or bi-weekly if the patient is high risk to ensure their needs are being meet and monitor the progress made toward their goals.

- *Set regular meetings (in person/phone) and monitor progress.*
- *Take advantage of patient's regular medical visits to check in with patient and provide WPC services.*
- *Services initiated by a non-billable provider other than the Care Coordinator can count if documented appropriately.*

7. *Licensed clinical staff (for example RNs, LCSWs) are responsible for developing and integrating the social needs of the patient into the patients care plan. Licensed staff are responsible for managing the clinical/health needs of the patient and ensuring that the social needs are addressed. The care plan should include integrated interventions that include the patient's goals, clinical and social interventions and specific timelines for the interventions to be met.*

WPC Service Interventions

- **Goal Setting/Care Plan**
- **Care Coordination**
- **Language Services/Assistance**
- **Referrals to Social/Community Support**
- **Referrals to Other Healthcare Services**
- **Referral to Medical/Medication Support Services**
- **Medication Reconciliation**
- **Transportation Coordination**
- **Peer Counseling**
- **Employment Assistance**
- **Providing Access to food**
- **Childcare Assistance**
- **Legal Resources**
- **Life Skills Coaching**
- **Group Services**
- **Home/Community Visit**
- **Health Education**
- **Counseling**
- **Education**
- **Life Skills Development**
- **Mentoring**
- **Assessment**
- **Self-Care Training**
- **Socialization**
- **Group Services**
- **Emotional Support**
- **Peer Support**
- **Benefit Assistance (employment, housing, social security, food)**
- **Transportation Assistance**
- **Family Support**
- **Advocacy**

7. Responsibility of the Complex Case Manager (Clinician RN/LCSW/Other):

1. Develop and monitor the care plan to ensure that goals are met.
2. Develop, document and monitor the patient's clinical goals, interventions and outcomes.
3. Participate in patient huddles and triage processes.
4. Ensure WPC database documentation is completed depending upon your clinic's workflow.

11. Whole Person Care Disenrollment: (See Disenrollment Policy)

- Manual Disenrollment should occur in the WPC Access Database.
  - WPC status can be manually changed to the following disenrollment status:
    - Graduated (Program completed, goals achieved)
    - Patient Declined
    - Patient Moved
    - Unable to Contact Patient
    - Other

12. Whole Person Care Community Clinics Contact Information:

If you have any questions, comments or suggestions, please contact:

Dr. Relda Robertson-Beckley, Quality Transformation Manager @Relda.Beckley@hhs.sccgov.org

Sally Lawrence, MFT, Senior Health Care Program Manager@Sally.Lawrence@hhs.sccgov.org

Navdeep Mehta, Business Information Technical Consultant @ Mehta, Navdeep@hhs.sccgov.org

APPENDIX A

Scoring of High Utilizers of Multiple Systems (HUMS)

Event Type/Number of Points	Example	Points
Inpatient Stay-1 point per day	5 day stay in defined timeframe*	=5
ED or EPS admission	3 ED/EPS event in defined timeframe*	=3
Acute psych care facility	2 day stay in defined timeframe*	=2
Urgent/express care 1 point per event	5 urgent care events in defined timeframe*	=5
TOTAL SCORE		17

*Timeframe is the previous 12 months

APPENDIX B

Access Database User Guide


Better Health for All
WHOLE PERSON CARE
CLIENT ENROLLEES
ACCESS DATABASE
SANTA CLARA
VALLEY
HEALTH & HOSPITAL SYSTEM

OBJECTIVE

The objective of this document is to provide information regarding functionality of Access Database related to Whole Person Care Client Enrollment, Utilization and PDSA reporting.

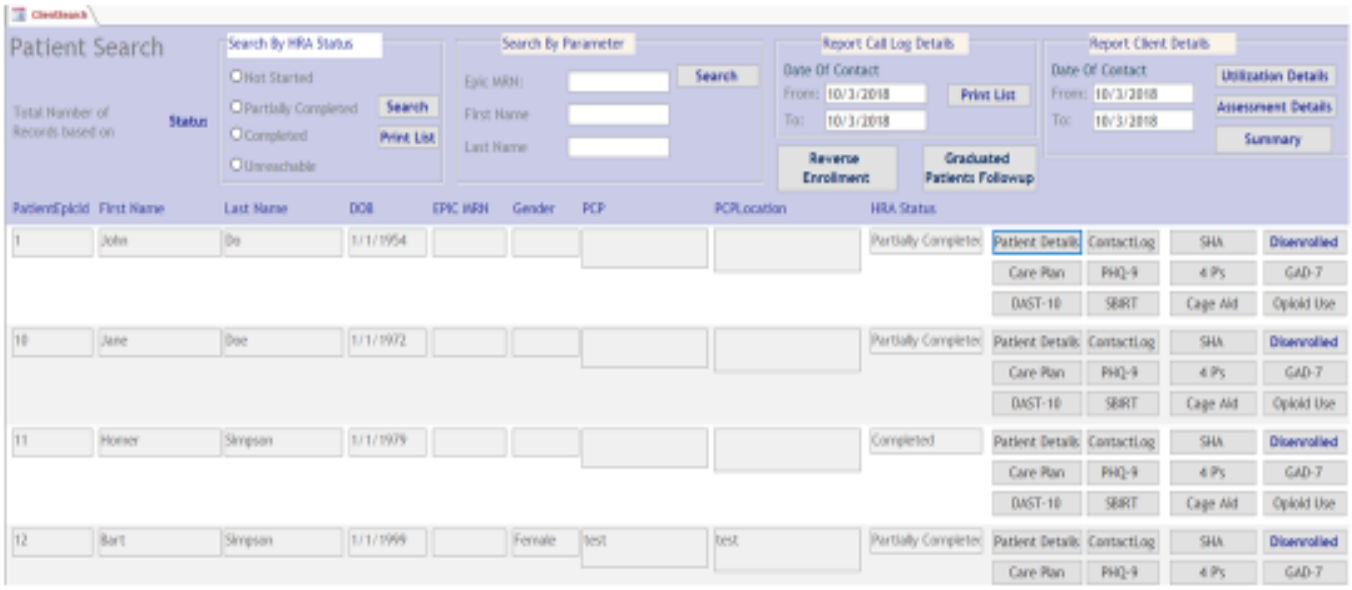
The Access database is replicated as a separate instance to share with Partner agencies like Gardner, Root, Peninsula, AACI, Mayview, Indian Health, School Health, Planned Parenthood Clinics using secured SFTP site.

Data from different Clinic sites will be aggregated, summarized for Sate reporting and Invoicing.

WPC ENROLLEES DATABASE

Santa Clara Valley Health & Hospital System

PATIENT SEARCH SCREEN



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WPC ENROLLEES DATABASE

Santa Clara Valley Health & Hospital System

PATIENT DETAILS

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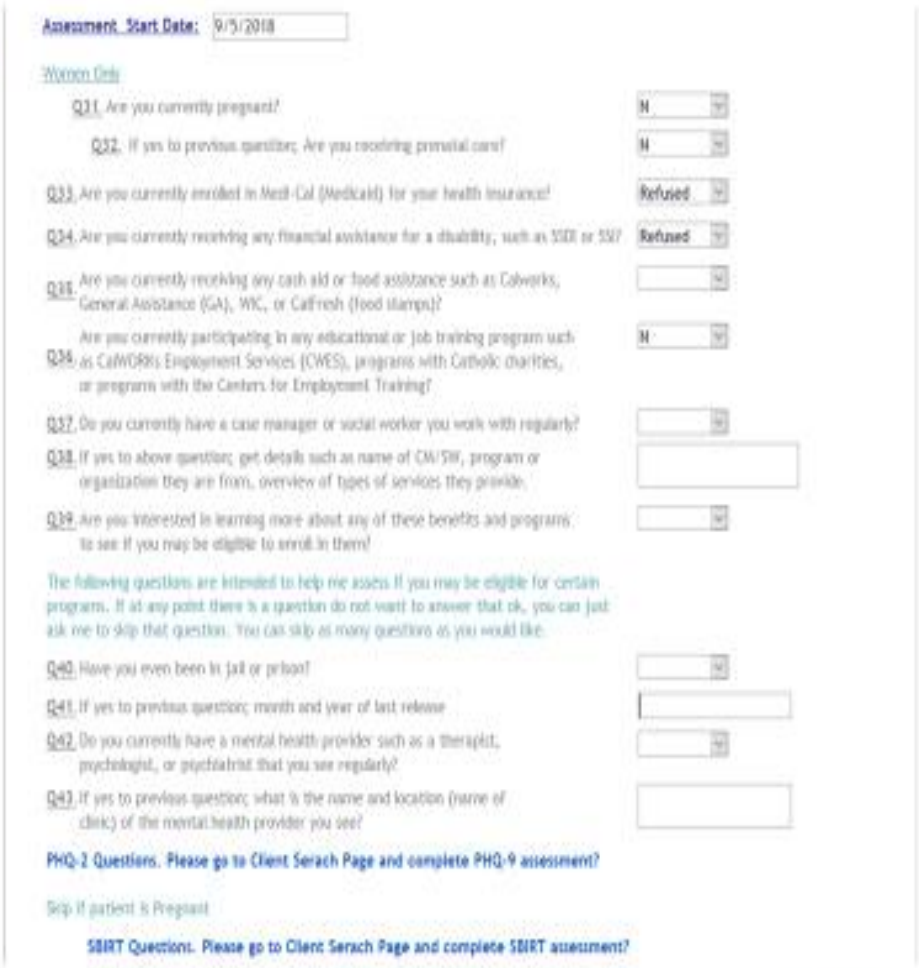
WPC ENROLLEES DATABASE

Santa Clara Valley Health & Hospital System

HRA



Assessment Start Date: 9/5/2018

Women Only

Q31. Are you currently pregnant? N

Q32. If yes to previous question; Are you receiving prenatal care? N

Q33. Are you currently enrolled in Medi-Cal (Medicaid) for your health insurance? Refused

Q34. Are you currently receiving any financial assistance for a disability, such as SSDI or SSI? Refused

Q35. Are you currently receiving any cash aid or food assistance such as Calworks, General Assistance (GA), WIC, or CalFresh (food stamps)?

Q36. Are you currently participating in any educational or job training program such as CalWORKs Employment Services (CWES), programs with Catholic charities, or programs with the Centers for Employment Training? N

Q37. Do you currently have a case manager or social worker you work with regularly?

Q38. If yes to above question; get details such as name of CM/SW, program or organization they are from, overview of types of services they provide.

Q39. Are you interested in learning more about any of these benefits and programs to see if you may be eligible to enroll in them?

The following questions are intended to help me assess if you may be eligible for certain programs. If at any point there is a question do not want to answer that ok, you can just ask me to skip that question. You can skip as many questions as you would like.

Q40. Have you ever been in jail or prison?

Q41. If yes to previous question; month and year of last release

Q42. Do you currently have a mental health provider such as a therapist, psychologist, or psychiatrist that you see regularly?

Q43. If yes to previous question; what is the name and location (name of clinic) of the mental health provider you see?

PHQ-2 Questions. Please go to Client Serach Page and complete PHQ-9 assessment?

Skip if patient is Pregnant

SBIRT Questions. Please go to Client Serach Page and complete SBIRT assessment?

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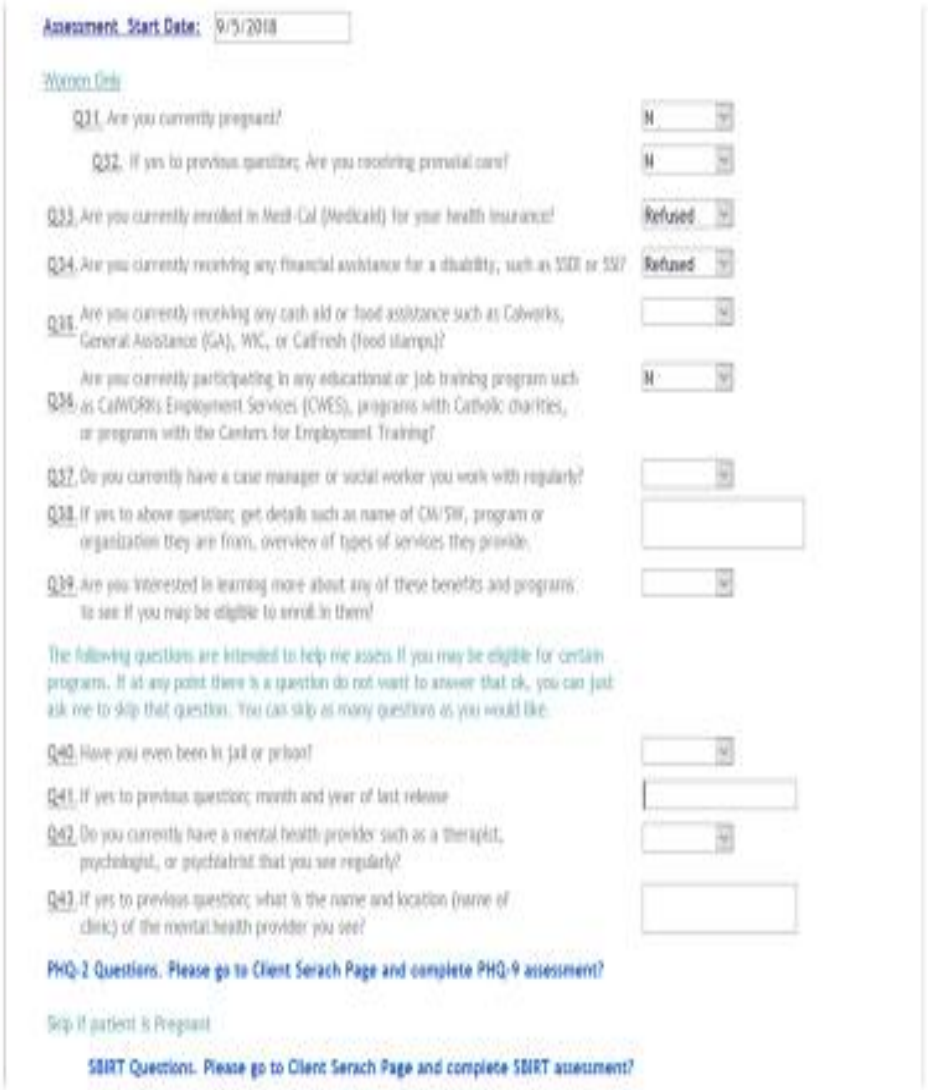
WPC ENROLLEES DATABASE

Santa Clara Valley Health & Hospital System

HRA



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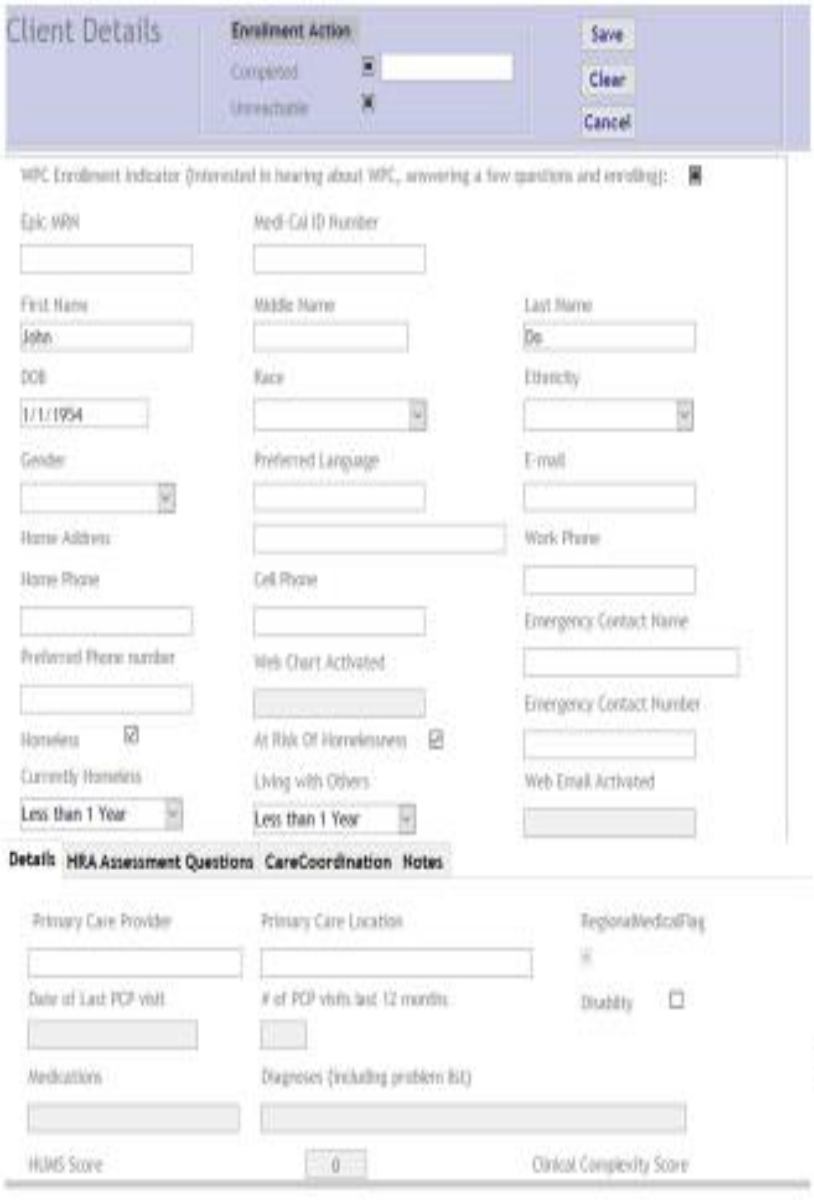
WPC ENROLLEES DATABASE

Santa Clara Valley Health & Hospital System

PATIENT DETAILS



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Care Coordination Values:

Enrolled in Care Coordination	Yes	Program	
Enrolled in Complex Case Management	Yes	Care Coordinator	
Care Plan Status	Complete	RN Complex CM	
Type of Care Coordination Bundle	MT	Location	

Rehab ☑ Patient Sucessfully Engaged: ☐ Patient Sucessfully Enrolled: ☑ Patient Screened ☐

Navigation Contact Completed: ☑ Type Of Contact: Date Of Contact: 9/12/2018

Number of Engagement Attempts (Not Enrolled): 0 Type Of Engagement Attempts (Not Enrolled): Assessment Completed in 30 Days: ☐

Services Provided:

Service Date	Service Provider	Service Location	Services Provided	Comments
9/12/2018	test	test	Transportation Resour	
9/13/2018	test2	test2	test2	
9/20/2018	test3	test3	test3	
9/28/2018	test4	test4	test4	
9/30/2018	test5	test5	test5	

Referrals:

Date	Referral Type	Followup Date	Services Provided By
	tesdt		
9/6/2018	food		
9/6/2018	test		

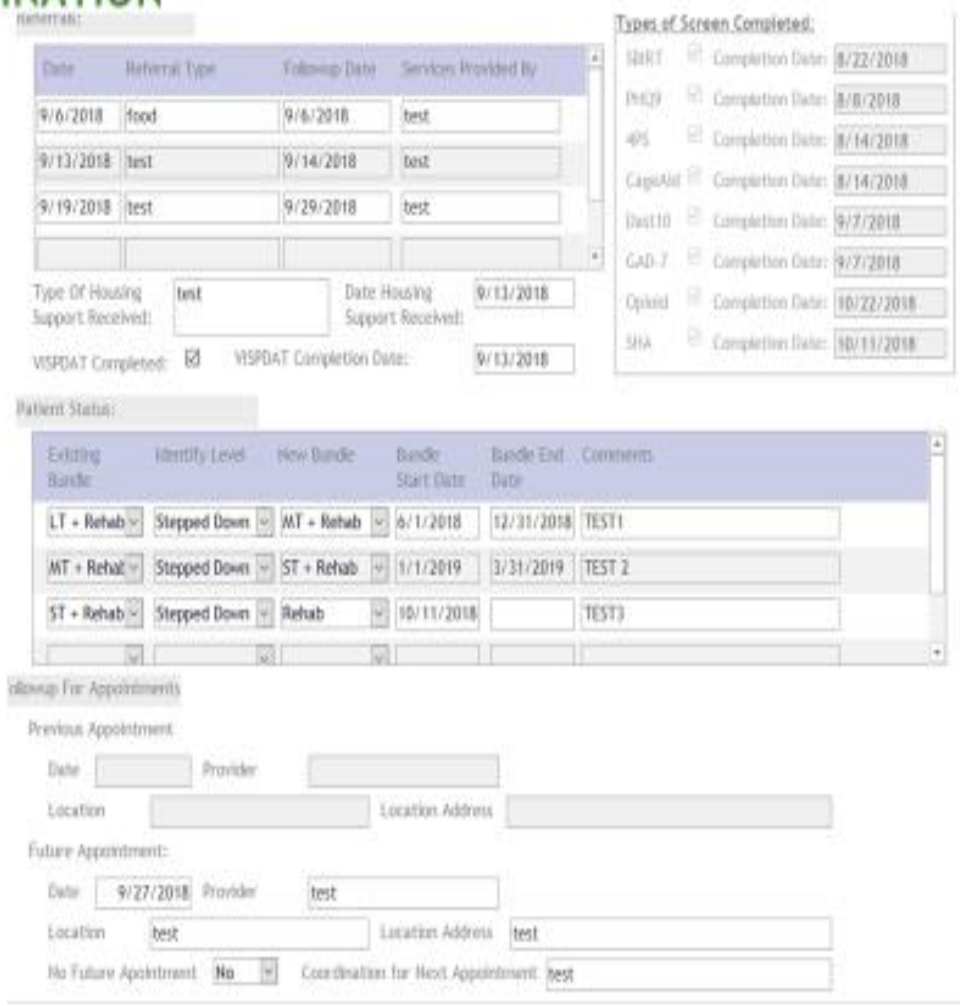
Types of Screen Completed:

SBIRT	☐	Completion Date:	
PHQ9	☐	Completion Date:	
4PS	☐	Completion Date:	
CageAid	☑	Completion Date:	9/5/2018
Dast10	☐	Completion Date:	
GAD-7	☐	Completion Date:	
Opioid	▣	Completion Date:	

WPC ENROLLEES DATABASE

Santa Clara Valley Health & Hospital System

CARE COORDINATION



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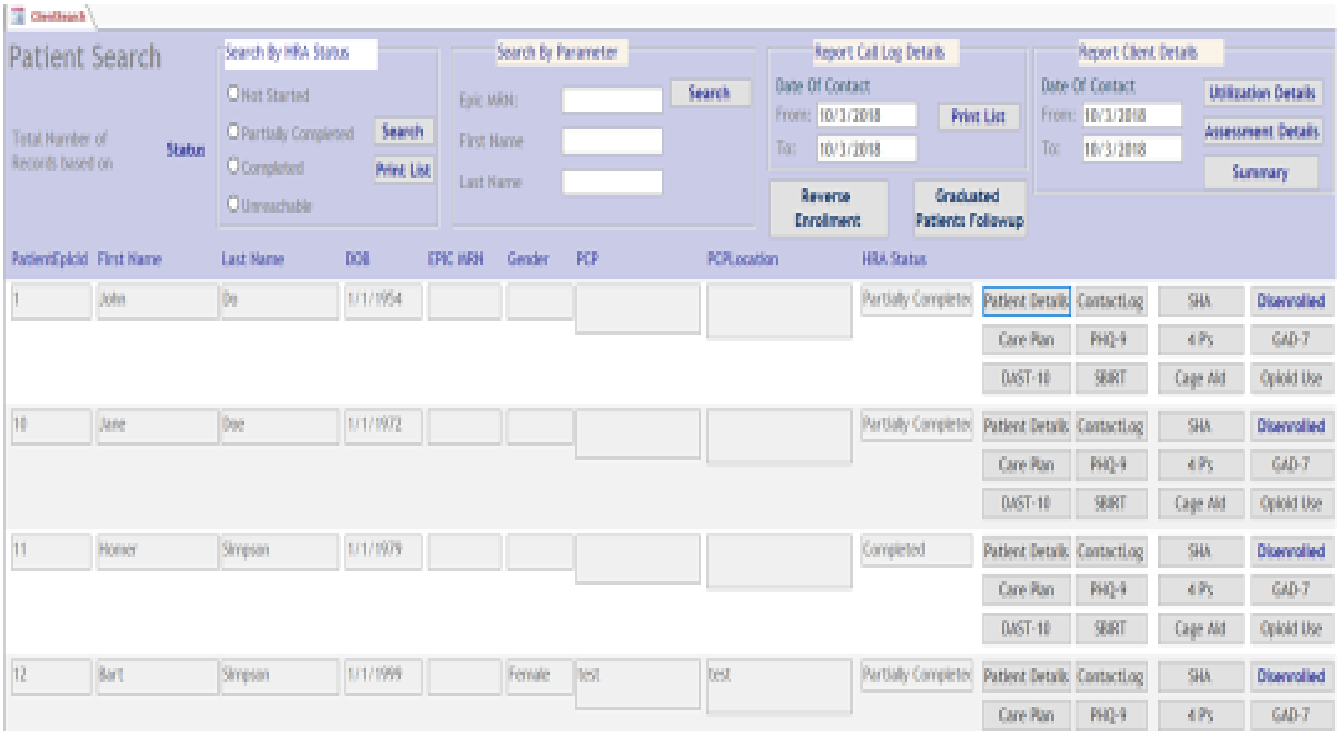
WPC ENROLLEES DATABASE

Santa Clara Valley Health & Hospital System

PATIENT SEARCH SCREEN



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WPC ENROLLEES DATABASE

Santa Clara Valley Health & Hospital System

PATIENT REVERSE ENROLLMENT

ClientSearch | PatientsList_ReverseEnrollment

PatientsList_ReverseEnrollment

PatientEpicID	VMC MRN	Medi-Cal Number	SSN	First Name	Middle Name	Last Name	DOB	Gender	HomePhone
TBD		123456789A	123456789	BOB		TEST	1/1/1950	Male	5100000000

Home Address	Requested Date	Requested By	WPC Eligible	Reason for Ineligibility
123 Main Street			No	Not eligible Aid Code

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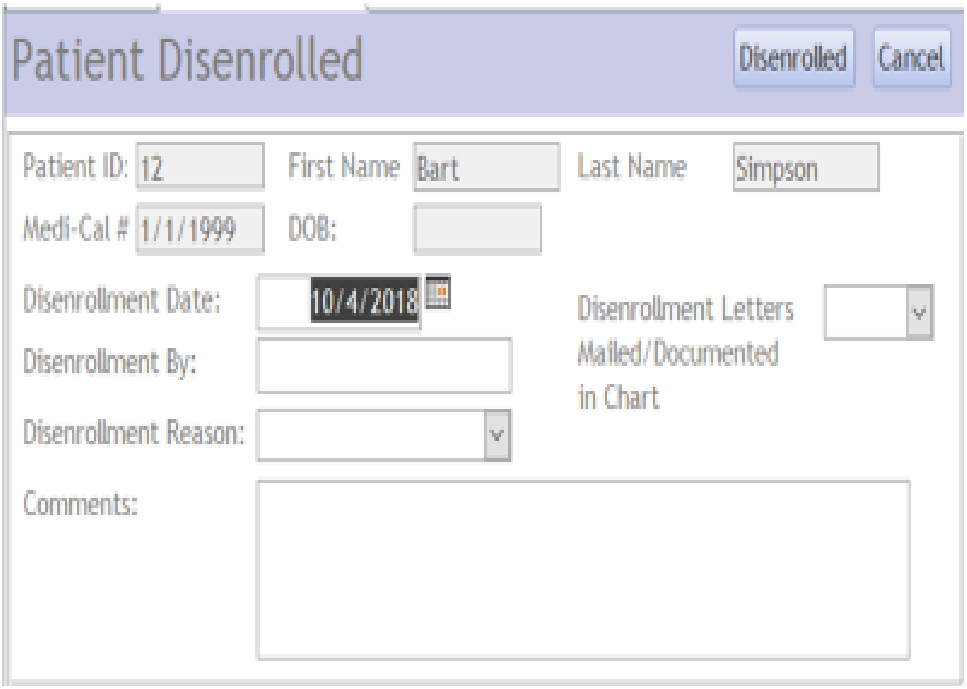
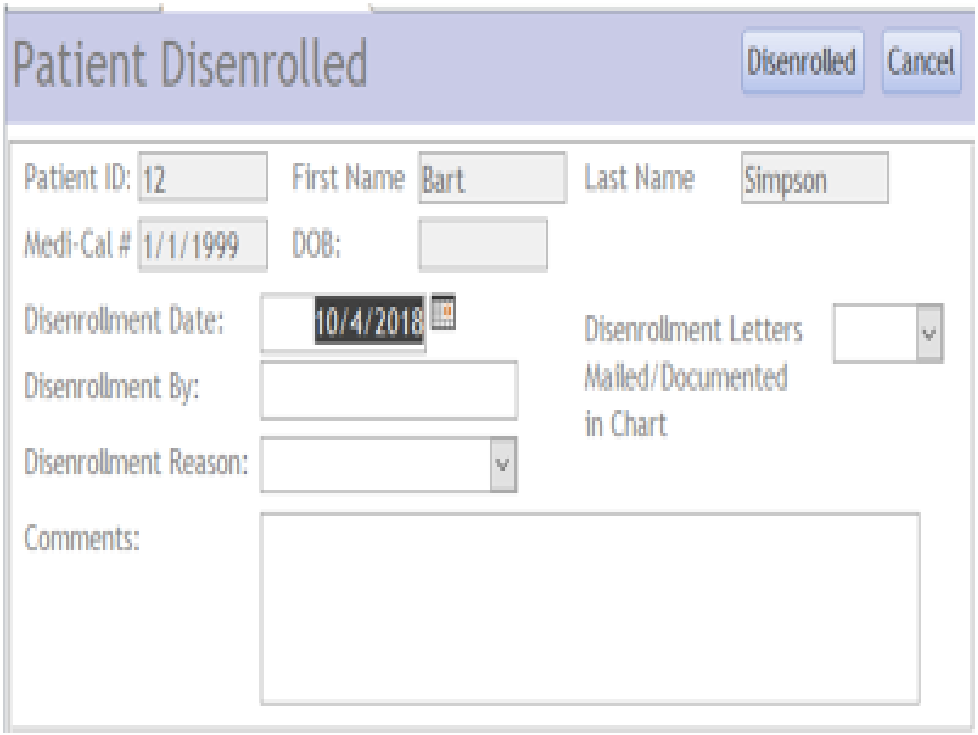
PATIENT DISENROLLED



PATIENT DISENROLLED



WPC ENROLLEES DATABASE

Santa Clara Valley Health & Hospital System

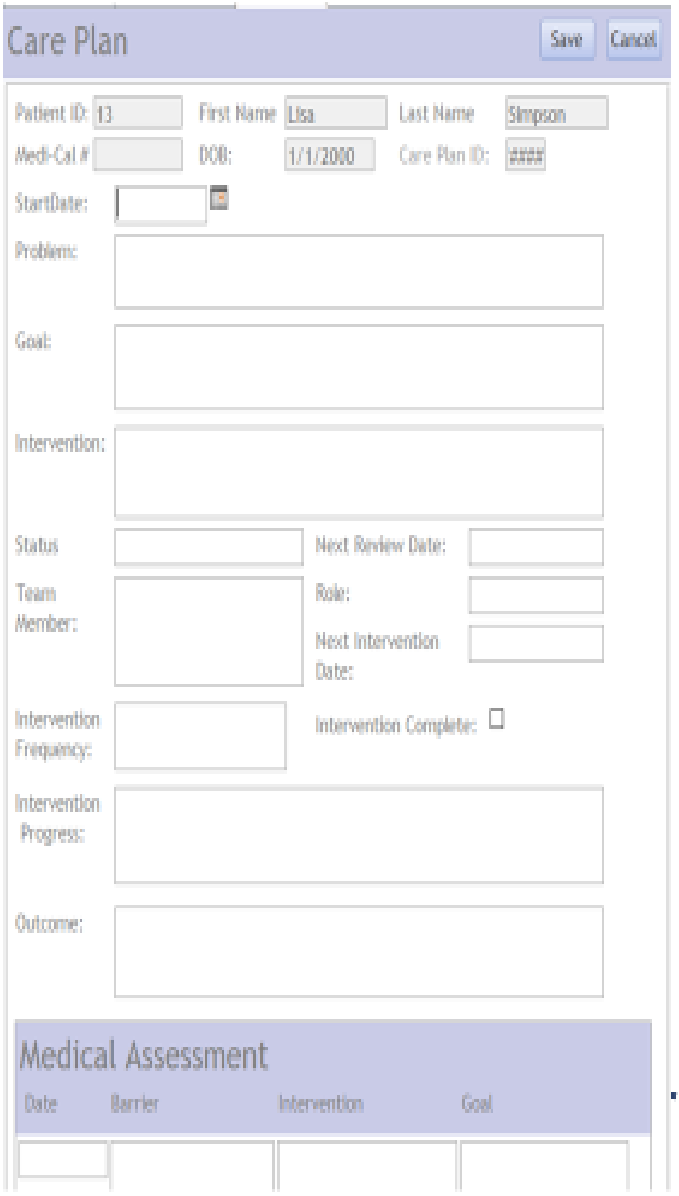
CARE PLAN

Health for All

WPC ENROLLEES DATABASE

Santa Clara Valley Health & Hospital System

CARE PLAN



· Health for All

Appendix C

Whole Person Care Patient Information

Welcome to Whole Person Care! We are happy that you have enrolled and look forward to serving you.

Whole Person Care is a free program to help you get the best healthcare possible. The plan is to improve your health by focusing on the many things that affect your health.

At times, the healthcare system may be confusing and you may need support in getting resources that could improve your health. Whole Person Care can help! With Whole Person Care you will be working in a team with your primary care physician, care coordinator and others to get past the obstacles that impact your health.

What does Whole Person Care do for me?

- Helps you improve your health and well-being.
- Matches you with a care coordinator
- Helps you find and connect to services.
- Helps you find what you need in the healthcare system.
- Helps you find transportation and support groups.
- Assists with applying for CalFresh and other programs.

What is my role?

- Set goals with your care coordinator and work toward getting to those goals.
- If you can, use MyHealth Online to send messages your care coordinator and providers.
- Use the phone numbers given to you by your care coordinator.
- Go to your primary care physician or urgent care clinic if you need to see a doctor right away when ***you are not having*** a medical emergency.

- Improve how you use healthcare system.
- Let us know how we can help.

Whole Person Care connects you to someone who can help. You will see your primary care physician and care team more often and go to the hospital less. With Whole Person Care you can have a better healthcare experience and improve your health.

If you have questions, please contact your care coordinator.

Whole Person Care - Levels of Care & Coordination Services - APPENDIX D

Revised 9/11/2018

Short Term Care Coordination

Evidence-Based Model Description	Goals	Suggested Patient Population	Types of Services	Average Length of Time
Coordination for medium to high-risk individuals needing short-term assistance.	Address needs of patients at significant risk for avoidable complication or readmission by coordinating proactive transition services.	Post-discharge from inpatient stay and/or at risk for readmission within 30 days; lack of social supports; at risk for non-adherence to medications	Goal Setting/Care Plan Case Management Communication with Participants & Providers Assessment Counseling Family Support Advocacy Language Services Support Coordination Patient Navigation Referrals to Social and Community Supports Referrals to Other Healthcare Services Medical/Medication Support Services Transportation Support Coordination Health Education Peer Counseling Home/Community Visit	**Up to 3 months**

Medium Term Care Coordination

Evidence-Based Model Description	Goals	Suggested Patient Population	Types of Services	Average Length of Time
Time-limited coordination grounded in stages of change and motivational enhancement.	Provide intensive assessment and care coordination to stabilize complex cases, address health-related needs, recovery barriers and wellness for transition to independence or long-term coordination.	High HUMS score; multiple diagnoses and utilization of services; in crisis; at risk for homelessness or homeless; involved in criminal justice system; graduating from high intensity nursing home transitions care coordination	Case Management Communication with Participants & Providers Assessment Counseling Family Support Advocacy Language Services Support Coordination Patient Navigation Referrals to Social and Community Supports Referrals to Other Healthcare Services Medical/Medication Support Services Transportation Support Coordination Health Education Peer Counseling Home/Community Visit	**Up to 9 months**

Whole Person Care - Levels of Care Coordination & Services

Revised 8/22/2018

Long Term Care Coordination

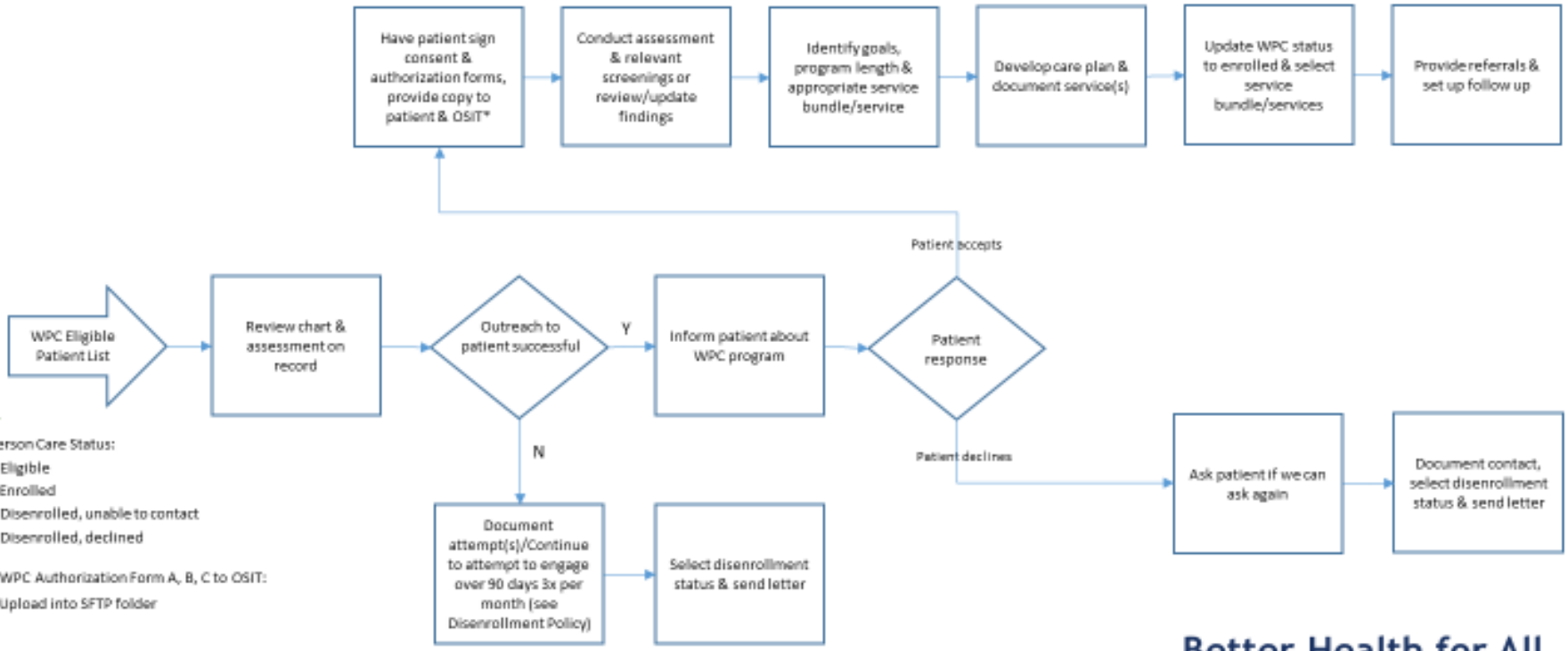
Evidence-Based Model Description	Goals	Suggested Patient Population	Types of Services	Average Length of Time
Coordination without time limits for individuals with high needs likely to persist over time.	Intensive coordination for those unlikely to maintain health/recovery and maximal independence in the absence of ongoing intensive services.	Mental health disorder; multiple hospitalizations in EPS/ED/BAP; co-occurring substance abuse or medical disorder; without treatment, at risk for deteriorating function in community	Case Management Communication with Participants & Providers Assessment Counseling Family Support Advocacy Language Services Support Coordination Patient Navigation Referrals to Social and Community Supports Referrals to Other Healthcare Services Medical/Medication Support Services Transportation Support Coordination Health Education Peer Counseling Home/Community Visit	**10 months or longer**

Rehabilitation Services

Evidence-Based Model Description	Goals	Suggested Patient Population	Types of Services	Average Length of Time
Health promotion and stabilizing services, focusing on prevention and engagement.	Ongoing services focusing on rehabilitation, using peer support via coaching, education, mentoring, and life skills development including employment, health navigation, housing assistance and activities of daily living training.	Patients from all program are eligible: either concurrently or post-graduation	Life Skills Coaching – Self-Care Training or Socialization Skills Group Services & Education Emotional Support Peer Support & Mentoring Assessment Counseling Family Support Advocacy Benefits Assistance Employment Assistance Housing Assistance Food Assistance Transportation Assistance – coaching or transporting patients to medical, behavioral health or social services appointments	**No time limit**

WPC WORK FLOW PROCESS-APPENDIX E

Santa Clara Valley Health & Hospital System



Notes:

Whole Person Care Status:

- Eligible
- Enrolled
- Disenrolled, unable to contact
- Disenrolled, declined

*Provide WPC Authorization Form A, B, C to OSIT:

- Upload into SFTP folder

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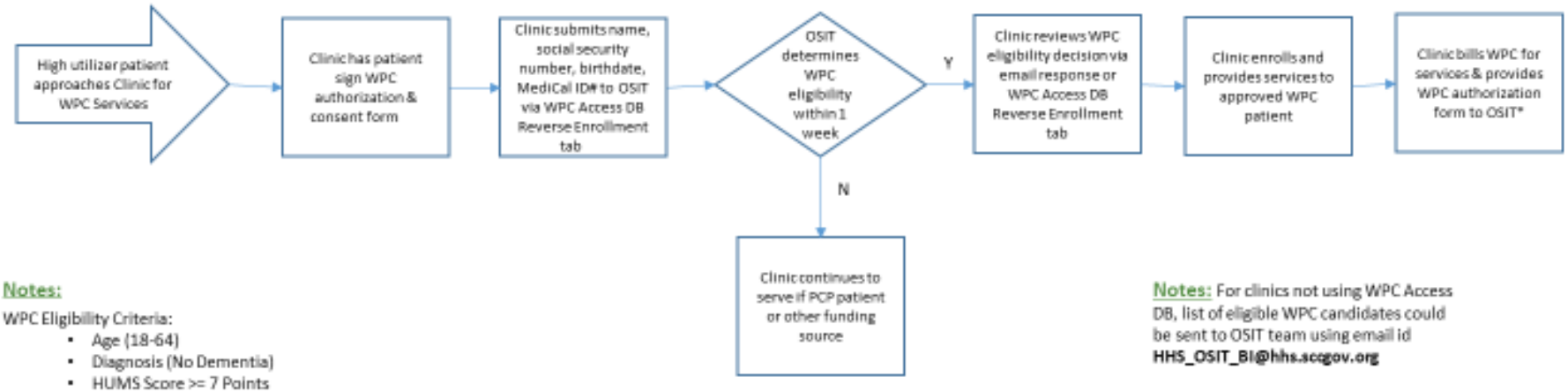
Revised 10/12/18

WPC WORK FLOW PROCESS FOR REVERSE ENROLLMENT
APPENDIX F

Santa Clara Valley Health & Hospital System



Notes:

WPC Eligibility Criteria:

- Age (18-64)
- Diagnosis (No Dementia)
- HUMS Score >= 7 Points
- Valley Health Plan MCMC

Manually for Enrollment

If the Patient meets the base criteria, the person can be send to the OSIT BI team as much basic demographics populated as possible from the operating environment. Post the information being received, additional enrollment information may be gathered by OSIT BI. OSIT team will validate, approve and then the person will be enrolled in WPC. The person will be reported to the state as being enrolled in WPC in the next enrollment cycle.

*Provide WPC Authorization Form A, B, C to OSIT:

- Upload into SFTP folder

Notes: For clinics not using WPC Access DB, list of eligible WPC candidates could be sent to OSIT team using email id **HHS_OSIT_BI@hhs.sccgov.org**

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Revised 10/12/18

Transportation to Medical Appointments-Appendix G
Santa Clara Family Health Plan Members
(including VHP MCMC)

Ambulatory Patients

1. Allow 3 business days for coordination of transportation to medical appointments
2. Contact SCFHP at 1-800-260-2055
3. At the prompts, press #8 for provider then #5 for other
4. Provide date and time of the appointment, type of appointment, patient name, physician name, address of clinic and address of pickup
5. At time of coordination of appointment, taxi phone number will be provided to coordinate the pickup only.
6. After the appointment, the provided taxi number needs to be called for curbside pickup.

*If SCFHP provided taxi phone number is not used, the patient will be charged for the taxi service.
*Taxi service is curbside arrangement only.
*Limit of 1 companion only to accompany patient to the appointment.

Wheelchair bound Patients

1. Allow 5 business days for coordination of transportation to appointments
2. Physician or medical staff must complete a Physician Certification Statement (PSC) form available on the SCFHP health plan website (https://www.scfhp.com/transportation-physician-certification-statement)
3. Fax to SCFHP Utilization Management at 1-408-874-1957
4. Once PSC form approved, SCFHP will provide the vendor phone number to coordinate pick up only
5. After the appointment, the vendor phone number needs to be called for pickup

*Medical appointments include physician visits, behavioral health appointments, physical therapy, labs, x-rays, pharmacy, dental, methadone etc.
*If any appointment is rescheduled or cancelled, contact SCFHP.

Appendix H

Disenrollment Policies and Procedures: (Contractors: WPC Enrollment)

I. Change in WPC patient status regarding the following:

1. WPC Patients Mailed Enrollment Letter.
2. Patient included on contractor list for engagement/enrollment into WPC.
3. Patient could not be contacted to confirm or consent to WPC enrollment and services.

II. Criteria for WPC Disenrollment:

1. Attempted but failed patient contact over a period of 90 days
2. Attempted contact is defined as:

3 attempted contacts per month over 90 days to include:

a. At least 1 mail contact/per month to current and emergency address listed and/or emergency contact information identified
b. At least 2 attempted Phone/text contacts to identified phone contacts per month
c. Or at least 2 attempted home visits or face-to-face visits per month

III. Procedure to Disenroll Patient:

a. Send and file final disenrollment letter to patient noting that the patient has been dis-enrolled from WPC. Including agency contact information if the patient is interested in reenrollment for WPC services.
b. Update patient disenrollment information on WPC monthly report and WPC Excel file and in Healthlink (if agency has access) noting date of dis-enrollment letter mailed. Attach a copy of the patient's letter in the patients file.
c. If the patient contacts your agency regarding re-enrolling into WPC, update patient enrollment information on WPC monthly report and WPC Excel file (of agency has access) and in Healthlink (if agency has access) noting date of re-enrollment, consent to participate in WPC and update patient contact information.