WHOLE PERSON CARE

STAFF GUIDE

Office of System Integration

and

Transformation

COUNTY OF SANTA CLARA
Health System

December 5, 2019

Table of Contents

1. Introduction to Whole Person Care
2. Goals of Whole Person Care
3. Guiding Principles
4. Transformational Changes
5. T2020
6. Embrace the Change
7. Whole Person Care Implementation
8. Whole Person Care Enrollment
9. Community Worker Screening
10. Care Coordination
11. Care Transitions
12. Outreach and Engagement
13. Whole Person Care Reverse Enrollment
14. Whole Person Care Disenrollment
15. Whole Person Care Reports
16. Whole Person Care Support
17. Appendix (A-B-C-D-E)
18. Appendix 1

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 services are 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 state also reimburses for "outreach and engagement" for non-enrolled but eligible patients.

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. These patients often experience Serious Mental Illness (SMI), a Substance Abuse problem, and/or are homeless. The specific criteria for WPC eligible status is:

- 18 years old and above
- Medi-Cal insurance (Restricted MediCal excluded)
- HUMS score 7 or greater* (Appendix A) **OR**
    - 2 high risk factors as listed below:
        - Homeless over the last 12 months
        - In custody over the last 12 months
        - Mental Health Diagnosis
        - Substance Use Diagnosis
        - 2 Chronic Health Conditions
- Dementia as primary diagnosis is excluded

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. 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. 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. Embrace the Change:

- All staff have an opportunity to be part of the transformation.
- Work with your manager and co-workers to create the move to “Whole Person Care” through ensuring care is coordinated and the Whole Person is addressed in the treatment goals.
- Ask to be a Care Coordinator for the WPC patients you serve.

7. 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. 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. The data warehouse was further developed to identify WPC patients and HealthLink (HL) was expanded to support WPC enrollment and care coordination services.

Some of the benefits include:

- Identification of the Care Team including the WPC Care Coordinator
- Alert System of Emergency Services and Hospitalization.
- Identification of WPC Enrollment Status.
- Consistent use of “Patient Outreach Encounter” for non-billable activities.
- Care Plan documented and viewed in Snapshot.
- Social Determinants of Health Wheel which documents areas that are high risk
- Enhance the documentation capacity by para-professional staff.
- Knowledge of services that are being received outside the VMC system.
- Ability for external partners to view relevant aspects of the patient’s VMC medical chart to facilitate coordinated patient care.

8. Whole Person Care Enrollment: (Appendix B)

Patients eligible for WPC services will be identified in HealthLink in the header. (See Section 13 -Reverse Enrollment for patients who are not identified but appear to meet the criteria). The WPC status can also be added to a column of the schedule of a staff person and can be identified in a WPC report/registry in HL.

The WPC statuses include:

- Eligible
- Enrolled (Care Coordinator assigned or pending)
- WPC graduated
- Disenrolled

- **The Enrollment process begins with a staff identifying a patient's WPC status.**

1. Review patient's WPC status for possible enrollment. If patient has a WPC status, they are eligible to be enrolled or re-enrolled. The only exception is if their Medi-Cal is not current. Patients who have been disenrolled or graduated can be re-enrolled.

2. Review patient chart and health assessment.

- Review chart, Staying Health Assessment (SHA) or any other current assessment in chart, complexity score and other relevant information to assist you in understanding the patient.
  - View Synopsis Tab/Screening Tools for SHA and other completed screening tools.

3. If the patient is eligible for enrollment:
   - The identified Care Coordinator should be the staff doing the enrollment **OR**
   - A clinic workflow should be designed to assign a Care Coordinator to the patient.
   - "Care Coordinator Pending" status is for patients who sign the authorization form, but a Care Coordinator has not yet been assigned.
   - Only assign another staff as Care Coordinator with the staff's consent.

3. The Enrollment Script for the Care Coordinator 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.
- 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 work as a team with others to set goals and achieve improved health

B. Have patient sign the authorization form

- Provide a copy of the signed authorization form to the patient.

- Provide patient with the WPC Patient Information Flyer and WPC Card with completed contact information. (Appendix C)
- Document the date the authorization was signed in the WPC enrollment tab. (Appendix B)
- Place the original signed authorization in the clinic area for Medical Records scanning.

C. HealthLink Documentation:

- Update WPC enrollment status and add date the authorization was signed, enrollment site and program length in Patient Outreach Encounter (Appendix B).
- Add self to the Care Team as the "Whole Person Care Coordinator"

D. Complete a screening/assessment (required within 60 days of enrollment) and identify goals.

- There are screening/assessment tools in Healthlink:
  - Community Worker Screening
  - Staying Healthy Assessment (SHA)
  - Nurse's Care Management Assessment
  - MSW Assessment
- Program length and goals should be derived from an assessment or screening and a discussion with the patient:
  - 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 E).
    - Program Choices (Appendix E)
      - 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)
    - The estimated end date of the program is entered (Appendix B)
      - If patient needs a longer or shorter length program, change the program length when clinically appropriate and document change and reason.
  - Goals can be the "action items" that need to occur and not necessarily the final achievement of the desired outcome. Document goals in the Patient Outreach Encounter/goal section. (Appendix B)
    - *<u>Example</u>: the overall goal may be to lose weight but the action items to achieve this may be the goals listed:*
      - *Identify a support program to assist with weight loss*
      - *Refer to an exercise program to increase activity*.
      - *Assist in locating low cost fruits and vegetables*.

        - *Refer to a dietician*
    - Keeping goals as the action items will allow more patients to graduate who receive WPC services without necessarily achieving the long-term goal.
- Set up future encounters for a minimum of once a month service activity. (Track Patient Outreach in the "Call Initiation" section (Appendix B)
- Be available to facilitate care coordination services for the patient.
- Document all ongoing care coordination interventions and attempts in the Patient Outreach Encounter (Appendix B).

    - **WPC Service Interventions are listed in HealthLink in the Patient Outreach Note. It is important to <u>check all the interventions</u> that you provide. (See Appendix B)**
        - **Benefit Assistance:** Employment, Food, Housing, Legal
        - **Care Coordination**: Care Coordination; Communication with Participants and Providers; Referrals to Other Healthcare Services; Referrals to Social/Community Support; Transportation Coordination' Preventative Healthcare
        - **Education**: Education; Goal Setting/Care Plan; Group Services; Life Skill Coaching; Medication Counseling; Self-Care Training
        - **Support:** ADL and IADL in Home Support; Adult Care Support; Advocacy; Child Care Support; Elder Care Support; Emotional Support; Transportation Assistance; Family Support; Home/Community Visit; Language Assistance; Medical/Medication Support Services; Peer Support; Peer Counseling
        - **Other:** Unable to Contact Patient; No Interventions Performed.

9. Community Worker Screening

A. The Community Worker may complete a screening to assist in understanding the patient's needs and identifying goals for WPC coordination. (Appendix B)

- The Community Worker Screening tool is in the Care Management tab of the Patient Outreach Encounter in HealthLink.
- The dot phrase: ".screening" will allow the completed screening to populate the note.

10. Care Coordination

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 meeting with patient
- Phone call 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
    - Messaging with patient regarding patient goals, concerns, referrals (not appointment communication)
- Communication with another staff person about the patient
    - Consultation or information with the billable provider
    - Corresponding with other staff in the health system about the patient

Responsibility of the Care Coordinator:

1. **Engage the patient (and family/caregiver) in Whole Person Care participation.**
    - *Meet patient, enroll in WPC and provide contact information*
    - *Identify length of service (short-term, mid-term, long-term)*

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), Biopsychosocial Assessment (Social Work).*
    - *Ensure there is an updated assessment within 60 days of enrollment either by updating the SHA or doing a new assessment*
    - *Review Social Determinants of Health Wheel (HealthLink/Healthy Planet-Nov. 2018)*

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 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. **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*
    - *Assist patient in utilizing "MyHealth Online" if appropriate*

6. **Follow up with patient (at least once a month) to ensure their needs are being meet and monitor the progress made toward their goals.**
    - *Set regular meetings (in person/phone) and monitor progress to facilitate WPC graduation.*
    - *Take advantage of patient's regular 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 in the Patient Outreach Encounter.*

11. Care Transitions

Care Transitions refers to the transition of care from one setting, provider or staff to another. It is essential that all transitions occur with a “warm hand off” which may include a telephone call, email or face-to-face with the transitional party and, if possible, the patient. The initiation of a warm hand off starts with the staff person who will be initiating the referral/transition and it is that staff person who is responsible for the patient until the transition is confirmed.

Whole Person Care services may include a transition of care coordinators for a variety of reasons. For example, a patient leaving the hospital may initially be enrolled in the hospital and upon discharge may receive WPC services by the team at Valley Specialty; once the patient is stable post-hospitalization and follow up care has been provided by the specialist, the care coordination services may be most appropriate in the Primary Care setting. This would require a transition of the Care Coordinator:

- The Care Coordinator who initiated enrollment or transition must ensure that any transition of care of the patient is completed
- The existing Care Coordinator must ensure this process:
    - Communicate (email, in-basket, telephone or face-to-face) with the transitional party to facilitate an introduction, information and a warm hand off
    - Include patient in the warm hand off as much as possible
    - Check health record to ensure all documentation regarding transition has been completed
    - Close your coordination services when you have confirmed that the new Care Coordinator is assigned and active with the patient.
- The new Care Coordinator will:
    - Add self as the WPC Care Coordinator to the care team
    - Change Enrollment Site to new location for Care Coordination services.

12. Outreach and Engagement

Outreach and Engagement is listed as an intervention on the WPC template. (See Appendix B).
Please use this selection when you have outreached to a WPC eligible patient to facilitate enrollment and/or referrals and the patient does not enroll.
Examples of this may include:

- Outreach to “eligible” patients on the telephone informing them about their eligibility for the program and services offered.
- Outreach to “eligible” patients in the clinic/community regarding WPC enrollment and services offers and patient declines
- Following up with “eligible” patients
- Providing “eligible” patients with referrals and resources

13. Whole Person Care Reverse Enrollment:

At times, staff will identify patients who could benefit from WPC services but are not listed as eligible in HL. A process has been developed to facilitate enrollment for this group of patients. (See Appendix D)

- Identify the patient who you would like to enroll
- Only submit the form if patient has MediCal (restricted MediCal is an exclusion)
- Only submit the Reverse Enrollment form if patient has signed the WPC authorization
- Review the patient to determine eligibility:
    - Does patient have a HUMS of 7 or above OR
    - One risk area as identified on the form
- Send form to the email address on the form
- Receive a response (enrolled/not eligible) within 5 business days
- The day of enrollment will be the day the patient signed the authorization
- There may be some delay in the HL WPC status showing up in HL.
- One the status is there, change the status to WPC Care Coordinator assigned and add yourself as the care coordinator.

14. Whole Person Care Disenrollment:

- Care Coordinators can disenroll a patient in HL.
    - WPC status can be changed for disenrollment and a reason will be selected:
        - Graduated (Program completed; goals achieved)
        - Patient Declined (patient no longer wants to receive services)
        - No longer Medi-Cal eligible: (Care Coordinator finds out the patient no longer has MediCal). The expectation would be that the Care Coordinator would assist patient with re-enrolling.
        - Unable to Contact (3 attempts and letter)
            - Patient has been out of contact for 2 months AND
            - Minimally 3 phone call attempts and letter over two months AND
            - Frequent chart review to determine if patient has been in the system when the “no contact” began AND
            - Coordinate and/or message Providers in chart to support locating patient
            - All attempts and chart review have been documented in a Patient Outreach Encounter.
        - Moved (patient has moved out of the county)
        - Deceased
    - HL Disenrollment documentation may be completed inside the Patient Outreach Note encounter under the Care Management Tab. (Appendix B)

15. Whole Person Care Reports

- WPC Reports are available in the HL Library
    - Search in the Library for WPC
    - Find the report: WPC My Current Care Team Patients
    - Star this report as a Favorite
    - Use this report to track your enrolled patients and your outreach

16. Whole Person Care Support:

WPC Enrollment and Care Coordination Services is being guided by the Office of System Integration and Transformation. The OSIT team is in the Administrative Office (AOB) of the Santa Clara Valley Health and Hospital System. The OSIT team is here to help. We are a group of Senior Managers, Clinicians and Business Intelligence Data Professionals.

If you have any questions, comments or suggestions, please contact:
Whole Person Care: 408-885-7713

If you are having HealthLink related issues, please submit a Help Desk ticket: HHSISHELPDESK@hhs.sccgov.org. The request will be forward to the Healthy Planet team who is providing the WPC technical support.

Appendix A

Scoring of High Utilizers of Multiple Systems (HUMS)

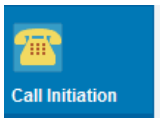
Event Type/Number of Points	Example	Points
Inpatient Stay-1 point per day	5 day stay in defined timeframe*	=5
ED or EPS admission-3 per event	3 ED/EPS event in defined timeframe*	=9
Acute psych care facility	2 day stay in defined timeframe*	=2
Urgent/express care 1 point per event	5 urgent care events in defined timeframe*	=5
TOTAL SCORE		17

*Timeframe is the previous 12 months

Authorization must be signed to be fully enrolled in the WPC program

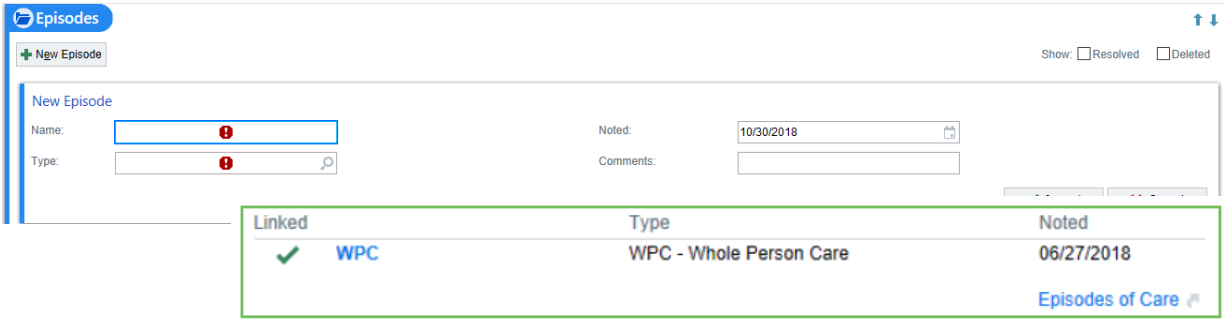
Document a Patient Outreach Encounter: Open a **Patient Outreach Encounter**. All your non-billable services should be documented using the Patient Outreach Encounter: No longer use "Telephone" or "Documentation". From the main toolbar open the Encounter and select the type as Patient Outreach.

In the open Patient Outreach Encounter- The encounter opens into the **Call Initiation Activity.**



Open **Call Initiation Activity**. Complete the following sections:

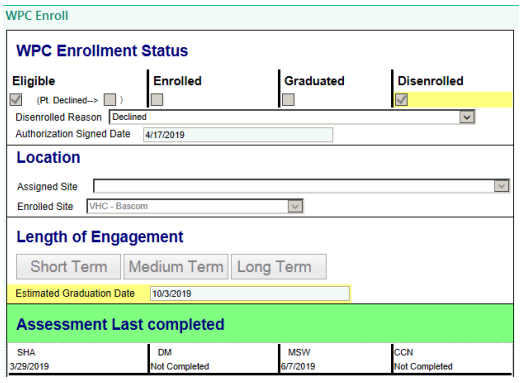
- **Episode:** Create a new Episode: Name-WPC; Type-WPC. This only needs to be created once as part of the initial enrollment process.



- **Reason for Documentation:** Enter a main purpose for this encounter.
  - **Contacts:** PHONE CONTACT ONLY document: *Type*: *Relationship* and *Phone*.
- **Care Team**: Assign yourself to the Care Team as the Whole Person Care Coordinator.
- **Track Patient Outreach**: Record information about the current contact and information to track the next contact.

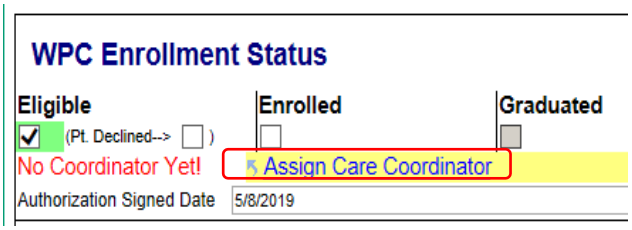
Open the **Care Management Activity** and complete the following sections:

ENROLLING PATIENTS IN WPC: Access the **WPC Enroll** (WPC Enrollment Status) form.

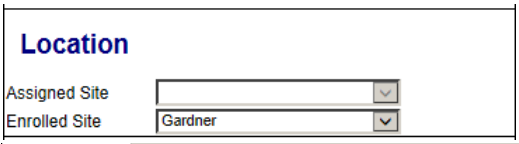


- From the Patient Header
- From an open Patient Outreach Encounter
  (Epic Button-> Patient Care -> Encounter -> New…)

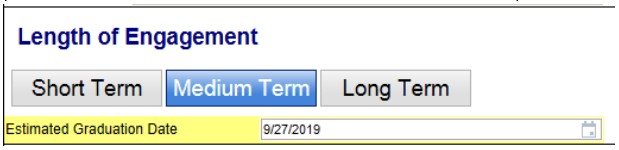
WPC Enrollment Status:



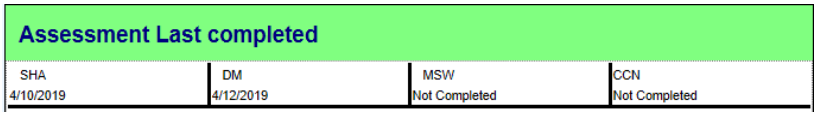
- Choose the "Enrolled" checkbox. The background turns green when selected.
- Add yourself to the Care Team as the "Whole Person Care Coordinator". Use the hyperlink. Once assigned the red message will go away.
- Enter the "Authorization Signed Date".



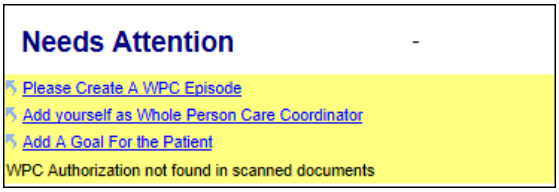
- Pick an enrollment site in the "Enrolled Site" field.



- Select the "Length of Engagement": Short, Medium, Long.
- Enter the "Estimated Graduation Date".

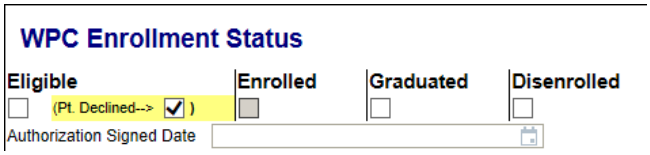


The information on the "Assessment Last Completed": dates for SHA; DM; MSW; CCN.

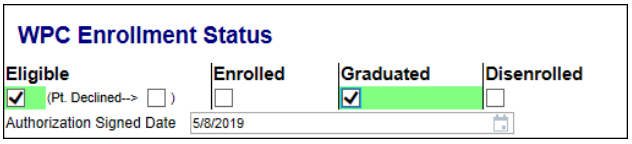


NOTE: Items highlighted in yellow needs your attention. Once they are completed, they will no longer appear in yellow.

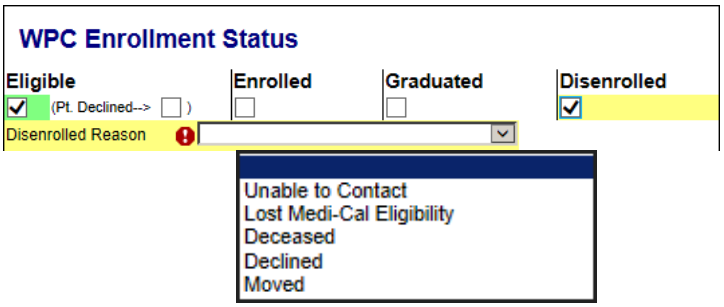
ELIGIBLE, RE-ENROLLED, GRADUATED, AND DISENROLLED WPC PATIENTS:



The patient has declined involvement in the WPC. Select the checkbox next to "Eligible" to document the patient has declined.

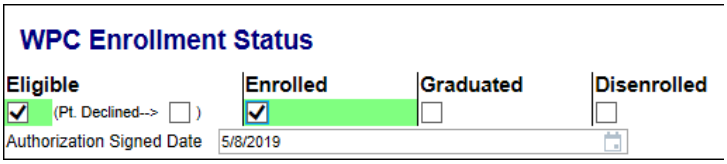


Click on the "Graduated" checkbox for the graduated patient.



Click on the "Disenrolled" checkbox to disenroll a patient.

This will cause a "Disenrolled Reason" to appear. Select a reason through the drop-down menu.



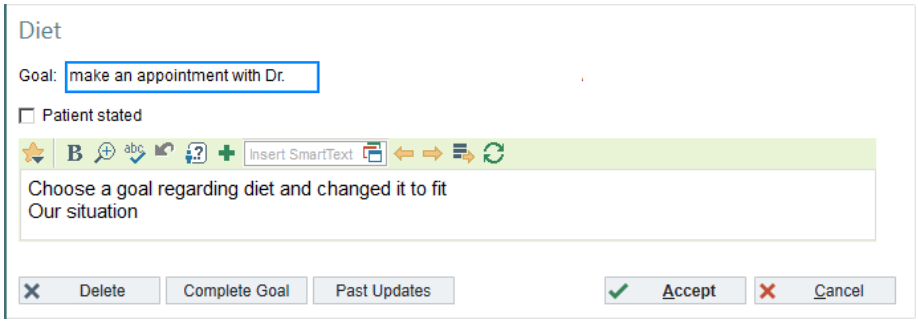
To re-enroll a patient simply click the "Enrolled"
button again.

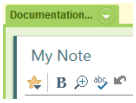
- **Interventions:**
  - Select all the interventions that apply for the encounter.
  - For patients that are not enrolled, but you are providing outreach services, please select the interventions under: Outreach and Engagement.

WPC Interventions Performed (Select all that apply)

Outreach and Engagement *Do not use for enrolled patients*			
Telephone: Patient Needs to Sign Authorization	☐	Considering But Declined at This Time	☐
Not Interested	☐		
Benefit Assistance			
Employment Assistance	☐	Housing Assistance	☐
Food Assistance	☐	Legal Assistance	☐
Care Coordination			
Care Coordination	☐	Referrals to Social / Community Support	☐
Communication with Participants and Providers	☐	Transportation Coordination	☐
Referrals to Other Healthcare Services	☐	Preventative Healthcare	☐
Advance Care Planning	☐		
Education			
Education	☐	Life Skill Coaching	☐
Goal Setting / Care Plan	☐	Medication Counseling	☐
Group Services	☐	Self-Care Training	☐
Support			
ADL and IADL in home support	☐	Family Support	☐
Adult Care Support	☐	Home/Community Visit	☐
Advocacy	☐	Language Assistance	☐
Assessment	☐	Medical / Medication Support Services	☐
Child Care Support	☐	Peer Support	☐
Elder Care Support	☐	Peer Counseling	☐
Emotional Support	☐	Transportation Assistance	☐
Unable to Contact Patient	☐	No Intervention Performed	☐

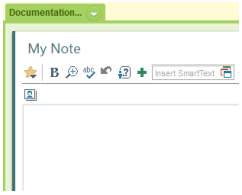
- **Patient Goals**: Add a goal. If you could not find an appropriate option, choose Free text and edit the Goal. Complete documentation of a goal: this services as your care plan.





Note: Document a free text note with any other relevant information from the encounter.

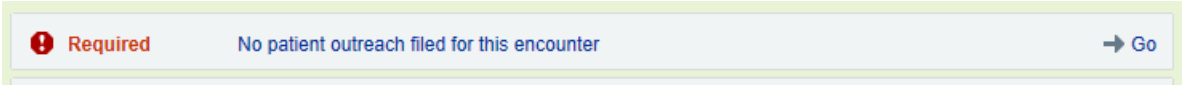
In the **Documentation Activity** sidebar: a note is required to sign/close an encounter.



- There are a few dot phrases that can be helpful to complete the note without rewriting information entered in the Patient goals.

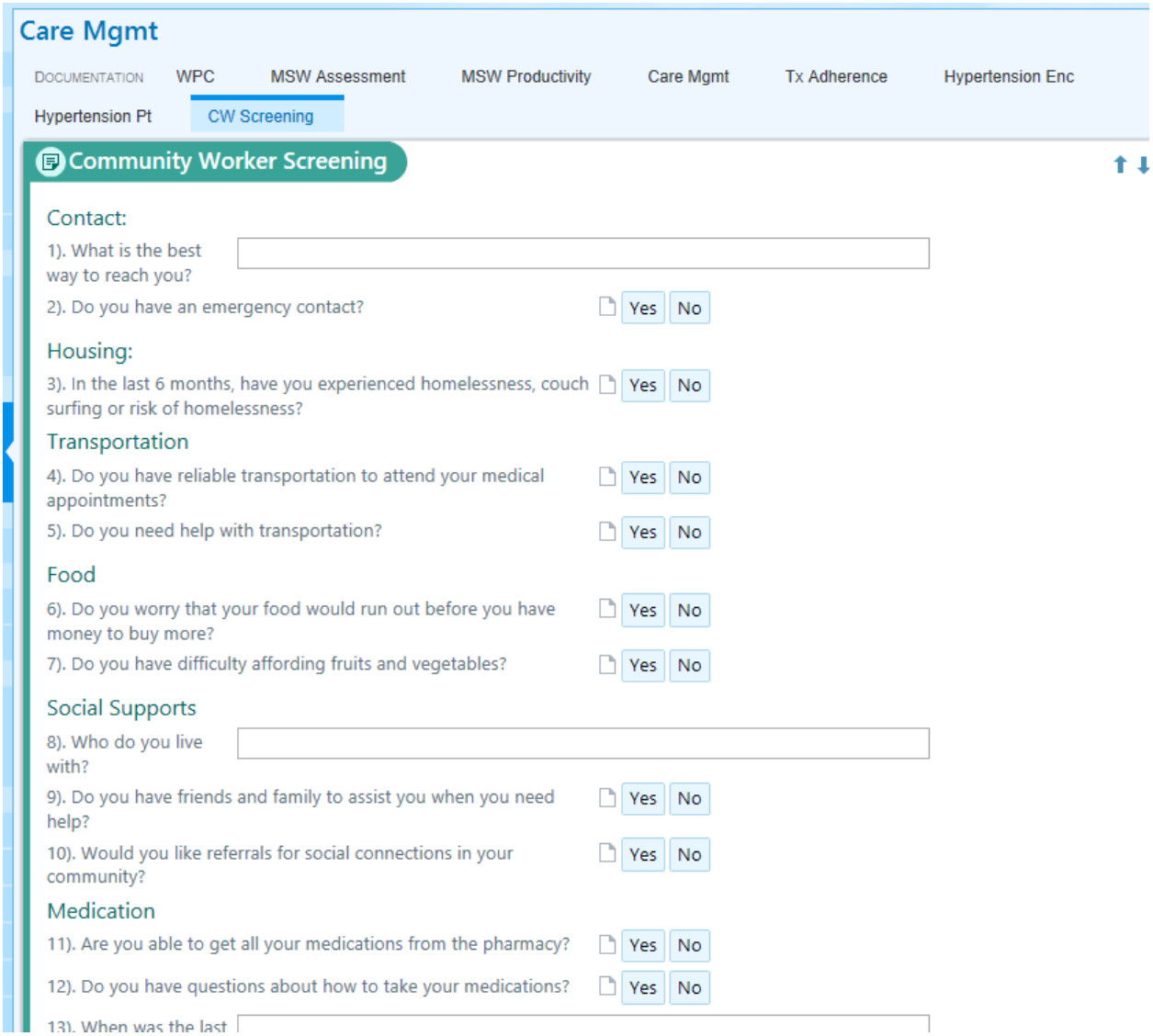
  .GOALS
  .GOALSADDRESSED
  .WPC
  .MSW (will bring the MSW assessment into the note and allow others to view it.

Click on the **Sign Encounter** button when the encounter is finished. You should return to the previous activity.



- If required information is missing from the encounter the system will indicate and a hyperlink to jump to the missing area.

Community Worker Screening: This screening can be found in the Care Management tab. The dot phrase: ". cwscreening "
will paste the completed screening tool into the note.



Whole Person Care
Patient Information

COUNTY OF SANTA CLARA
Health System

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.

COUNTY OF SANTA CLARA
Health System

REVERSE ENROLLMENT

Appendix D

Patients may be eligible for Whole Person Care based on a Reverse Enrollment process.

Please provide the following information by reviewing the chart and/or a discussion with the patient. Have patient sign the WPC Authorization form prior to submitting this form.

Patient must have MediCal (some exclusions). Patients may have a HUMS score of 7 or above OR at least one risk area as identified below.

Only Submit Form if Patient Signed WPC Authorization. Date Signed:_____

Patient Name: _____DOB_____

Medical Record Number _____OR Social Security Number_____

INSURANCE: **MediCal:** yes____no____unsure____

Which Plan: VHP____Blue Cross____Santa Clara Family Health____Restricted____Unknown____

Other_____

CIN_____ (if known)

UTILIZATION: Emergency Services (last 12 months): # of ED or EPS Visits _____

Urgent Care Services (last 12 months): # of Urgent Care Services: _____

Inpatient Hospital Days (last 12 months): # of Days: _____

HEALTH CONCERNS: Does patient have at least two serious health conditions: Yes____ No____

List Conditions: _____

Does Patient have a Behavioral Health Diagnosis: Yes_____No_____

Substance Use _____ Mental Health_____

SOCIAL DETERMINANTS OF HEALTH:

Is patient currently Homeless or at risk for Homelessness: Yes_____No_____Unsure_____

Has patient been in Custody over the last 12 months: Yes_____No_____Unsure_____

Staff Name_____Date: _____

Email_____

SUBMIT: VMC: Email to HHS_OSIT_BI@HHS.SCCGOV.ORG (use SCCSecure)

Please allow 5 business days for processing and the response will be via email.

Whole Person Care - Levels of Care & Coordination Services Appendix E

8/16/2018

Short Term Care Coordination

Evidence-Based Model Description	Goals	Suggested Patient Population	Types of Services	Average Length of Time
Coodination for medium to high-risk individuals needing short-term assistance.	Address needs of patients at significant risk for avoidable complicantion 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 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	**1-3 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 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	**4-9 months**

Whole Person Care - Levels of Care Coordination & Services

8/16/2018

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 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	**12-18 months**

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.	Willingness and need; those graduating from nursing homes transitions; can be a concurrent set of services with short, mid or long term care coordination; ends when individual no longer needs the services	Life Skills Coaching – Self-Care Training or Socialization Skills Group Services & Education Emotional Support Peer Support & Mentoring Benefits Assistance Employment Assistance Housing Assistance Food Assistance Transportation Assistance – coaching or transportaing patients to medical, behavioral health or social services appointments	**3-42 months**

Enrollment WPC – workflow variable inputs VMC

Appendix 1

Patient WPC Eligible

WHERE?

Touch point by Individual at VMC: ED, EPS, IP, BH, Clinic, BAP

Enroll?

yes

no

Sign Consent

Utilizing Services?

yes

no

Responding to Outreach?

yes

no

Engaged in WPC coordination?

yes

no

Goals met?

Yes

no

Are there other areas to set goals or to support?

Case Conference and next steps outline

Graduate

Disenroll per 90 day policy

WPC staff

Outreach / Engagment

Yes

Date, Site enrolled, Care Coordinator assigned, Level of care; Assessment and Goals

Care Provider

Standard care

Key documentation – Points for reporting

Outreach Date and Outcome

Enrollment?

Yes

no

Complete patient outreach, change status; add intervention under "outreach and engagement"

Signed consent to medical scanning

Enrollment date= date signed

Pt outreach ; enrollment site, status, identify case coordinator

Site and care team documentation

Assessment and Goals

Clear goals based on patient need and measurable outcomes; SHA; next follow up

Follow up patient outreach

Document outreach attempts and outcomes; include care coordination if unable to reach yet completed coordination with other providers

Graduate, disenroll, patient outreach care coordinator role and change status

Include interventions and outcomes; provide details on status change; next steps