VALLEY HEALTH PARTNERS

Enabling Services Referral Resource

Care Manager (Adult IM/FM/Street Medicine)

Complex Care Coordination (Risk scores 6-8)

High Utilization (Admissions, Readmissions, or ED visits)

Care Navigation (Complex patients accessing multiple providers and services)

Proactive outreach,
Post-discharge disease management for patients admitted with:
- COPD
- CHF
- Pneumonia
- Sepsis
- CABG
- HgA1c >8
- CKD/ESRD

Need for self-management education

Non-compliance with medications, treatment plan, or appropriate follow-up
Caregiver Stress

Street Medicine
- Respite Program
- Support individuals experiencing homelessness within local agencies and in the community
- Clinical support as needed in the field

Care Manager (OB High Risk)

Patient is classified as High Risk by OB or during referred Maternal Fetal Medicine (MFM) consult. Patient to follow MFM plan of care.

Assists patient to facilitate completion of provider treatment plan through close coordination between patient and treatment team.

Collaborates with providers in High-Risk Clinics on Tuesdays and Thursdays

Patient Education:
- Glucometer teaching
- Blood Pressure cuff instructions
- Insulin management
- Facilitating and reminding patients of appointments
- Facilitate scheduling of tests, imaging, and specialty referrals
- Connecting to other Enabling Services team members as needed (SW, BHS, MAC)

Facilitate interventions of patients that will be entering Diabetes In Pregnancy Program (DIPP) and Connections Clinic

Use outreach techniques to facilitate care outside network, if needed

Collaborate with social services
OB High Risk care management episodes are completed upon patient delivery

Postpartum follow up shall follow typical transition of care

Care Manager (Pediatrics)

Complex case management for the medically complex child, with routine follow-ups at determined ratios to maintain health

Care coordination for patients with multiple specialists or needs

Transition for pediatric to adult practice for both the complex and non-complex needs population

Parent noncompliance with prescribe medical plan for child

Coordination of autism care with Behavioral Health and Social Work team

DME and LOMN needed for patients

Early Intervention

Lead program management and follow up

Care Manager (Diabetes Management)

Run and identify patients on “DM Met Report” in EPIC (Patient whose A1C = or > 8 or has not had an A1C in the last 12 months)

Follow the Diabetic PVP Workflow to address BPA/Health Maintenance, including Direct Scheduling

Complete Med Rec or place a referral to Clinical Pharmacist for a Comprehensive Medication Reconciliation (based on discretion of the Care Manager)

Assist patient during PCP visit (patients with multiple missed appointments, unable to obtain medication, uninsured, patients without a working phone, non-compliant with bloodwork, non-compliant with checking blood sugars)

Provide supportive on-going education and care coordination

Care Manager (GYN)

Follow up for Post Operative patients
Care and management of patients with diagnosis of Pregnancy of unknown location or missed AB

Colposcopy/Pathology follow ups
Assistance and care management for cancer diagnosis prior to seeing GYN Oncology

Guidance and education for Teen Pregnancy

Follow up for abnormal uterine bleeding

Follow up for sexually transmitted diseases

Behavioral Health

Consultations to evaluate for appropriate level of care options

Collaboration with providers about the BH aspect of patient care

Comprehensive Psychiatric Evaluations for internal Psychiatry referrals

Connection to long-term mental health treatment

Short-term model of therapy (prior to discharge or linkage to community provider for long term)

Typical diagnosis treated:
- Depression
- Anxiety
- Grief
- Adjustment Disorder
- Other Short-term concerns

Video Visits & Phone Visits available

Transition of Care Associate

- Medical Assistants and Nurses
- Follows VHP Transition of Care Policy
- and Procedure
- Completes Transition of Care outreach call for Hospital and ER follow ups within 1-2 business days of discharge for VHP attributed patients and schedules PCP appts within 0-14 days
- Places referrals to VHP Enabling Services as needed
- Care Coordination with RN Care Managers

Clinical Pharmacist

Perform comprehensive medication reviews to optimize medications and help reach intended goals of therapy

Evaluate medication regimen for:
- Dosing errors
- Drug-drug / drug-disease interactions
- Duplicate therapy
- Inappropriate therapy
- Medication omissions
- Appropriate vaccinations

- Determine adherence issues and provide recommendations to improve compliance
- Evaluate lab results pertaining to medications
- Provide medication education through teach-back including indication, appropriate administration, common side effects
- Provide device teaching
  - Insulin / GLP-1 injection
  - Inhaler technique
- Provide drug information to providers as requested

Financial Counselors

Available for Walk-In Hours Monday through Friday 8-5PM to assist patients with Sliding Fee Scale Application, Medicaid Application, and more

Assists patients with:
- SFS Application
- Medicaid Application
- Pennie
- SNAP
- SSI/SSD
- Medication Affordability Concerns
- Breath Hope (free Nebulizers)
- VHP specific medical bills

Referral process:
- Walk in at VHP CHWC
- Schedule an appointment be calling RCC at (610) 969 4200
- At practice, PSR provides SFS application, cover letter, and checklist

For Patients in need of medication assistance, appropriate referrals are:
- Uninsured
- Medicare A&B (part D depending upon pharmaceutical provider)
- Patients in the “Donut hole” with Medicare Advantage plan

For Patients in need of medication assistance, inappropriate referrals are:
- Patients with Medicaid or private insurance
- Medication coverage determination requested by provider (FCs are unable to independently select a medication that may be covered by patient’s insurance)

Social Work

Social determinant of health intake assessment.

Can assist with the following:
- Domestic violence
- Housing barriers
- Transportation barriers
- Utility Assistance
- Food Insecurity Assistance (Food Bank information, WIC)
- Provide resources/information to patients/caregivers on ALFs and SNF
- Apply and navigate for waiver services

***Refer to Financial Counselors for Insurance/Financial questions and concerns:**

- Financial Concerns
- SNAP
- Lack of income
- Medication Affordability Concerns

Community Outreach Liaison (Pediatrics)

Identifies social needs for Newborn Patients/Caregivers

Reviews what services patients can expect within the practice (well visits, ill visits, and other services)

Reviews Baby Store incentive and how they can accumulate points by showing up to visits – and extra points by taking classes – they will then go over all classes offered – i.e.: car seat safety (they receive a free car seat after this class), crib safety (they receive a free play pin after this class) etc.

Identify lack of insurance and/or financial barriers to connect with Financial Counselors

Veteran Health Program

- Addresses the unique circumstances of men & women who have performed military service
- Addresses Veteran care as it relates to the Dept of Veterans’ Affairs/Dept. of Defense benefits/Community Health Care
- Navigation and Coordination of Care & Benefits
- Guidance and Care Planning
- Access to an Accredited Veteran Service Officer
- Gap Services for Veterans/immediate family
  - Veterans “Circle of Trust” community referral partners
  - Free service to Veterans and immediate family

Community Health Worker

Educate, advocate, and encourage individuals regarding healthcare services and other community health needs

Provide assistance with paperwork regarding financial barriers and insurance application process

Collaborates with community partners to promote the health of the population

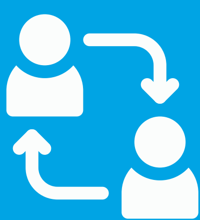
Provides culturally and linguistically appropriate health education

Link individuals/families to healthcare system, financial services, transportation services

Provide informal supportive counseling and encourage communication among patients, family members, health care provider

Perform community outreach and building partnership with local agencies and groups

Home Visits as identified by CHW through CHW referrals (COVID precautions in place)



How to refer to Enabling Services in Epic:

- **Enabling Services EPIC referral: REF638 - AMB REF VHP ENABLING SERVICES**
- **Behavioral Health EPIC referral: REF729 - AMB REF VHP EMBEDDED BEHAVIORAL HEALTH SERVICES**
- **One referral is to be entered per discipline per patient. Specific reason/details should be added as to why the patient was referred for the service.**