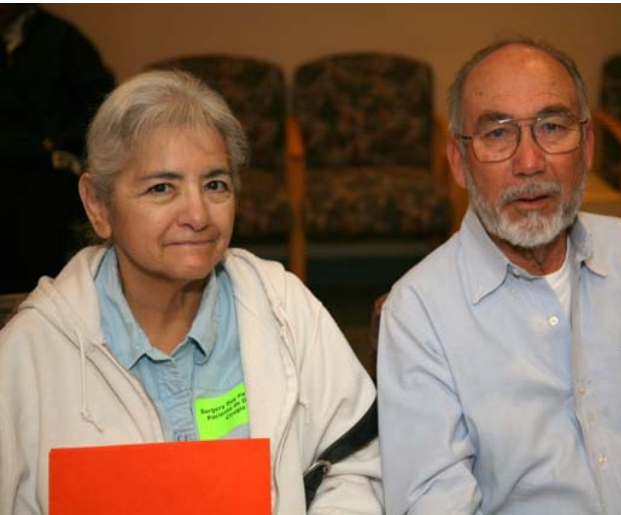




SAN DIEGO COUNTY
MEDICAL SOCIETY
FOUNDATION



PROJECT ACCESS





SAN DIEGO COUNTY
MEDICAL SOCIETY
FOUNDATION



PROJECT ACCESS

Project Access San Diego (PASD)

Referral Manager Training

Project Access San Diego (PASD)

- Increases access to health care for the medically underserved by linking low-income, uninsured San Diegans with free health care services
- Patients will be screened for eligibility by Case Managers with CMO oversight to ensure that patients are medically appropriate
- Provides enabling services such as transportation and translation
- Provides access to the full continuum of care through arrangements with hospitals, ancillary service providers, etc
- Patients receive a \$1,000 annual (calendar year) pharmacy benefit. Patients must follow PASD pharmacy guidelines.



Participate in PASD



- Select patients from your clinic that need specialty care or outpatient surgery to enroll in PASD
- Patients will be initially enrolled for six months
- Fax referral form, **COMPLETED** enrollment application, medical records and proof of residency and income
- Patients will be case managed and returned to their medical home for regular care



Choosing a Patient for PASD



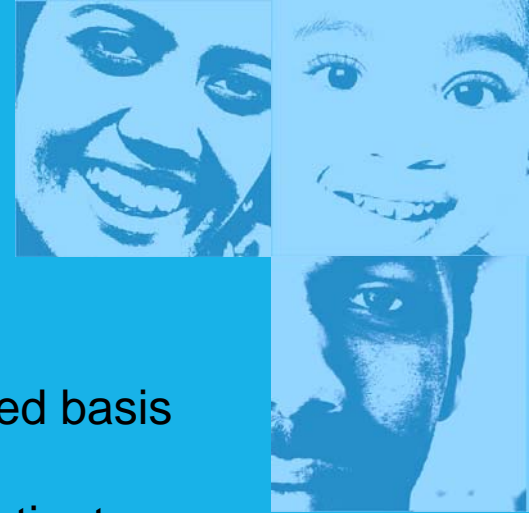
- Someone who needs something of limited scope/duration
 - Examples:
 - Needs one specialist consultation to help determine a diagnosis or to provide a treatment recommendation to the primary physician, OR
 - Needs a single test, e.g. an MRI or CT scan
 - Needs a minor surgery (e.g., gallbladder removal, biopsy, hernia repair)
- NOT appropriate:
 - Examples:
 - Known cancer patient
 - Chronic pain patient for ongoing care (single consult with one follow up ok)
 - End stage disease of any type for ongoing care (single consult for treatment plan OK)

PASD Eligibility Requirements

- PASD referral guidelines must be satisfied
- Patient must earn less than 350% of the Federal Poverty Level
- Patient must be a resident of San Diego County
- Patient must not have any health insurance or Workers' Compensation coverage
- Patient must be ineligible for any publicly sponsored programs including CMS, Medi-Cal or Medicare
- Patient must agree to follow PASD Rights and Responsibilities



PASD Referral Process



- All referrals are handled on a first come first served basis
- Clinics will be notified when PASD is recruiting patients, also referred to as “Open Enrollment Period (OEP)”
- Clinics will be provided with a status update for each patient submitted during OEP
- Clinics will be notified when OEP is closed

PASD Referral Guidelines



The referral guidelines are available on the San Diego County Medical Society Foundation's Website at www.sdcmsf.org. Please review them with the referring physician **PRIOR** to submission to ensure that guidelines have been met.

SAMPLE REFERRAL GUIDELINE

CHOLECYSTECTOMY: Criteria for Referral:

History (any one of 3)

- **History of Jaundice**
- **Two or more documented episodes of abdominal colic or severe RUQ pain**
- **The presence of nausea/vomiting, chills and fever, leukocytosis (if evidence of infection, consider immediate hospitalization outside the purview of PASD)**

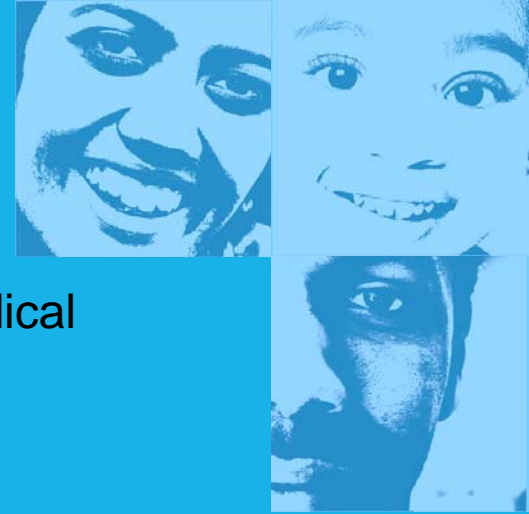
AND

Diagnostic Tests

- **Ultrasound or CT scan documents presence of gallstones**




PASD Patient Referral Form



The referral form is available on the San Diego County Medical Society Foundation's Website at www.sdcmsf.org.

Patient Referral Form to be completed by referring physician or referral manager

		Project Access San Diego Patient Referral Form	
<i>Referring clinic: Once completed, please fax to (858) 560-0179 with the Patient Enrollment Form and pertinent medical records attached.</i>			
Patient Information			
Name		DOB	
Gender		Preferred Language	
Phone		Other Phone	
Address			
City, State, Zip			
Diagnosis (include both description and ICD-9 code):			
Specialty Service(s) and Procedure(s) Requested (include CPT code):			
Level of Urgency (Applications will be reviewed within this time period): Non-Routine (3-5 days) Routine (2-3 weeks)			
Primary Care Information			
Provider Name			
Referral Coordinator Name			
Clinic Name			
Address			
City, State, Zip			
Office Phone		Office Fax	
Provider Signature		Date	
Direct Phone Number for Specialist to Contact Physician			
Attached:			
<input type="checkbox"/> Problem List <input type="checkbox"/> Medical History <input type="checkbox"/> Labs <input type="checkbox"/> Radio. Report <input type="checkbox"/> Consults			
<input type="checkbox"/> Progress Note			
<input type="checkbox"/> Other			


Include both the ICD-9 Code, CPT Code & Description



PASD Patient Enrollment Form (Page 1)



The Patient Enrollment form is available on the San Diego County Medical Society Foundation's Website at www.sdcmf.org

		Project Access San Diego Patient Enrollment Form Patient: Please return this form to your primary care clinic. Project Access San Diego (PASD) will contact you after we have received this completed form.		
Patient Information				
First Name:		Last Name:		
<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number:	Date of Birth:	Married? <input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No
Phone Number:		Other Phone Number:		
Address:		City, State, Zip:		
Preferred Language:		Race/Ethnicity:		
Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No		Disabled: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you live in San Diego County? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Please provide a copy of one of the following (check one):				
<input type="checkbox"/> CA Driver's License <input type="checkbox"/> CA State Identification <input type="checkbox"/> Utility Bill <input type="checkbox"/> Rental Agreement <input type="checkbox"/> School Registration <input type="checkbox"/> Statement from shelter, service agency, or person you are living with <input type="checkbox"/> Federal Tax Return				
Education Completed: <input type="checkbox"/> Less than High School <input type="checkbox"/> GED <input type="checkbox"/> High School Diploma <input type="checkbox"/> College or higher				
Religion: <input type="checkbox"/> Catholic <input type="checkbox"/> Christian <input type="checkbox"/> Jewish <input type="checkbox"/> Muslim <input type="checkbox"/> None <input type="checkbox"/> Other:				
Medical Benefit Information				
Do you have MediCal? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No				
CMS? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Have you applied for MediCal? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No				
CMS? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Please explain (ie, waiting for a response): Include copies of any Notices of Action you have received.				
Do you currently have private health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Enrollment form to be completed by patient

Patient must provide proof of residency

Patient must include any notices of action



PASD Patient Enrollment Form (Page 2)



Financial Information	
What is your monthly household income? \$ / per month <i>List all sources of income. Please provide documentation.</i> Example: Monthly Amount: \$300 Source: Unemployment benefits	
Monthly Amount:	Source:
Monthly Amount:	Source:
Monthly Amount:	Source:
Please list everyone who lives in your home full-time:	
Name:	Relationship: Date of Birth:
Name:	Relationship: Date of Birth:
Name:	Relationship: Date of Birth:
Name:	Relationship: Date of Birth:
Name:	Relationship: Date of Birth:
Are you currently employed? <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Student <input type="checkbox"/> Unemployed <input type="checkbox"/> Seasonal <input type="checkbox"/> Disabled If employed, please provide copies of pay stubs.	
If you are currently unemployed and without other types of income, please explain how your basic needs are met:	
Any additional information about your financial situation you would like Project Access to know:	
Emergency Contacts	
1. First Name:	Last Name:
Phone Number:	Relationship:
2. First Name:	Last Name:
Phone Number:	Relationship:

Patient must provide proof of income



PASD Patient Enrollment Form (Page 3)



Patient must sign the application and agree to the following conditions

You agree that you will:

- Not schedule appointments with any doctor, clinic, or hospital other than the ones to which you have been referred.
- Follow your treatment plan- for example, get prescribed medications and take them as directed.
- Promptly supply any information that may be requested by the program.
- Allow all information regarding your participation in this program to be shared with other individuals, organizations, and agencies at the discretion of Project Access San Diego (PASD).
- Immediately contact PASD if your income changes or if you become covered by MediCal, Medicare, CMS, VA benefits, disability, employer-sponsored or any other type of health insurance.
- Apply for MediCal or other assistance programs at PASD request.
- Go to an emergency room if you have an emergency, as PASD is an outpatient, nonemergency program. Emergency room visits, however, are not covered by PASD.
- Be disenrolled from the program if we find that you have intentionally misrepresented information regarding finances and/or enrollment in medical assistance programs.

You understand that:

- Your eligibility is for 6 months.
- You must show up on time for all appointments.
- If you miss an appointment, you will be dropped from the program and will not be eligible for re-enrollment.
- You must notify PASD at least one week in advance of an appointment if you need transportation and/or translation.

You certify that:

- You live in San Diego County.
- The information you have given is accurate and complete to the best of your knowledge.
- Your household income is below 350% of the Federal Poverty Level (\$3,034/month for a family of one; \$6,184/month for a family of four)

By signing below, you confirm that you understand and agree to the above conditions.

Patient Signature

Date

Patients who miss an appointment will be dropped from the program & will be ineligible to reapply

Applications without signatures will be considered incomplete and will not be processed

IMPORTANT: You must include:

- Proof of residency
- Proof of income

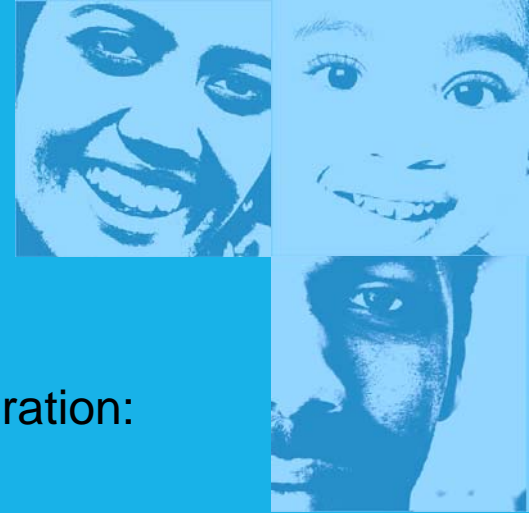
Your application will not be processed without these documents.

Please return this form to your primary care clinic.

Project Access San Diego (PASD) will contact you after we have received this completed form.



PASD Application Packet Checklist



The following items must be submitted to PASD for consideration:

- Complete Patient Referral Fax Cover Sheet (1 page)
- Complete and signed patient enrollment form (3 total pages)
- Proof of residency
- Proof of income
- PASD referral form completed and signed by the referring physician
- Patient medical records

INCOMPLETE SUBMISSIONS WILL NOT BE CONSIDERED. PLEASE ENSURE THAT THE REFERRAL GUIDELINES HAVE BEEN SATISFIED.



PROJECT ACCESS

PASD Steps & Communication



- Patient Referral Application is received on a secure, dedicated fax line at PASD
- “Letter of Action” (LOA) will be sent to the clinic as a source of communication.
- *PASD Case Manager* reviews application and supporting documents for completeness.
- *PASD Case Manager* will prepare and prioritize patient records for meeting with the PASD Chief Medical Officer to review for medical appropriateness, as needed.
- *PASD Case Manager* will contact the patient after completing the procedures for intake. **Do not distribute PASD phone numbers to patients.**
THREE ATTEMPTS will be made (one phone call per business day) to contact the patient at the contact telephone numbers listed on the application. If the patient does not return the phone call within **THREE BUSINESS DAYS** from the first phone call attempt, the patient is not appropriate for PASD and will not be enrolled in the program.
- *PASD Case Manager* will schedule first appointment and will remind patient. Patient is responsible for scheduling following appointments.



Saturday Surgery Days



- Referrals for Saturday Surgery Days will still be accepted.
- The exact same application packet is required as for other PASD patients
 - Patient Enrollment Form
 - Patient Referral Form
 - Proof of residency
 - Proof of income
 - Patient medical records
- Applications will only be accepted during specified OEPs
- Each Surgery Day will have various specialty surgeries, but all will include:
 - GI Procedures
 - General Surgeries (hernia repairs, choleystectomies, etc)
- Future dates for 2009/2010
 - August 22
 - December 5
 - Mid-March



Question and Answer Period



What questions do you have?



PASD Contact Information



All forms and referral guidelines can be found at the San Diego County Medical Society Foundation's website

WWW.SDCMSF.COM

Project Access San Diego

Barbara Rodriguez, Patient Care Manager

T: 858.300.2785

F: 858.560.0179

E: brodriguez@sdcms.org

Brenda Salcedo, Patient Care Manager

T: 858.565.8161

F: 858.560.0179

E: bsalcedo@sdcms.org

Saturday Surgery Days

Alisha Mann, Program Manager

T: 858.565.8156

F: 858.560.0179

E: amann@sdcms.org



PROJECT ACCESS



SAN DIEGO COUNTY
MEDICAL SOCIETY
FOUNDATION



PROJECT ACCESS

