Employee Wellness Specialty Program Overview

Kaweah Health
MORE THAN MEDICINE. LIFE.

Kaweah Health has implemented voluntary wellness programs for a variety of conditions as part of our overall wellness initiative. Eligible conditions include:

- Diabetes
- Chronic Obstructive Pulmonary Disease (COPD)
- Certain rheumatologic conditions
- Chronic infectious disease

If you, your spouse, and/or adult dependent covered under Kaweah Health's Point of Service Plan (PSP) have been diagnosed with any of the above conditions, you/they may be eligible to participate in the Employee Wellness Specialty Program (EWSP).

Note: If covered under the High Deductible Health Plan (HDHP), copays for medications and provider visits will still apply (required by Internal Revenue Service).

Program benefits include:

- Waived/reduced copays for medications and supplies evaluated and managed by the EWSP care team
- Waived co-pays for clinic and telephone visits
- Evaluation of medications safety and effectiveness, assistance with dose adjustments, lab monitoring, and/or other necessary medication changes to improve health outcomes
- Management of refills for medications and supplies
- Provision of immunizations and basic foot exam/annual diabetes eye exam
- Education on your medications and condition
- Collaborative communication with your PCP/specialist to ensure continuity of care

Participation in this program is strictly voluntary; you may opt out of the program at any time and resume paying standard copays for your medications and supplies. In order to participate in the program, a referral must be obtained from your primary care physician (PCP) or specialist.

Participation requirements will differ based on your health condition and medication regimen (see below).

	COPD, Infectious Disease, Rheumatologic Conditions	Diabetes
Minimum Program Visits	1 in-clinic visit per year in addition to 1 telephone visit per year	1 in-clinic visit per year in addition to 1 telephone visit per year *Number of in-clinic visits per year may **vary** to help reach A1C goal in addition to telephone follow-ups as needed*
Labs	2 times per year, at minimum	
Eye Exam	1 time per year depending on medication used	Annual eye screen
Foot Exam	**N/A**	Annual foot exam
Primary Care Physician/ Specialist Visit	Must maintain established relationship with PCP in addition to routine scheduled follow up with specialist (if applicable)	

Pharmacy Information

Medication and supplies managed by the EWSP care team will be filled at the Kaweah Health Retail Pharmacy located at **202 W Willow Ave., Suite 102, Visalia, CA 93291** (just east of the Emergency Department).

Employee Wellness Specialty Program Referral Form

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Please Select Reason for Referral:

- ☐ Diabetes
- ☐ COPD
- ☐ Rheumatology
- ☐ Infectious Disease

Patient Agreement and Attestation

I, _____, agree to follow the participation requirements for the Employee Wellness Specialty Program (EWSP). If at any time, I have failed to meet the agreed upon participation requirements, I may be disenrolled from the program and forfeit all program benefits. The signature of my PCP/Specialist below constitutes initiation of a referral to this program and agreement to co-manage my medications with the EWSP care team.

_____ **(initial)** I agree to maintain my appointments as scheduled. A cancellation made less than 24 business hours prior to the appointment time will be treated as a no-show. If I have missed or canceled less than 24 business hours in advance for three (3) consecutive appointments or a total of five (5) appointments in a 12-month period, or if I do not return phone calls after three attempted outreaches, I understand I may be disenrolled from the program.

_____ **(initial)** I agree to increased follow-up visits as directed by my primary care provider, specialist(s), and/or the EWSP clinical pharmacist if my disease state goals are not met.

_____ **(initial)** I will maintain appropriate behavior with my care team and uphold the Kaweah Health behavioral standards while enrolled in the EWSP. I will not harass, demand, or threaten anyone at the clinic. Inappropriate conduct will result in immediate termination from the EWSP.

_____ **(initial)** I give consent for the EWSP team to contact other providers and pharmacies involved in my care for information regarding previous and/or ongoing treatment(s) while enrolled in the EWSP.

Patient Insurance ID#: **KDT**_____ Patient DOB: _____

Print Patient Name: _____

Patient Signature: _____ Date: _____

Note: This patient agreement will be reviewed/signed once yearly and as updated.

Physician Name: _____

Physician Signature: _____ Date: _____

Please return this signed form along with the most recent **progress note** and **labs** to:

202 W. Willow Ave, Suite 202 • Visalia, CA 93291 • Phone: (559) 624-4586 • Fax: (559)625-7661