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Advanced Community-Clinical Teams

September 19, 2024 | 2:00-3:30 p.m. ET

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A Few Reminders

- ✓ Please introduce yourself and your organization in the chat
- ✓ Recording and slides will be shared following this session of the Health Equity Learning Collaborative
- ✓ Please keep yourself muted unless you have a question. We will have time for questions, but feel free to raise your hand at any time.
- ✓ A live transcript of the meeting is available. To turn on closed captioning, click on the upward arrow next to Live Transcript and select “Captions.” The Captions option may also be available under the icon labeled “More.”

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Agenda

1. Welcome and Introductions
2. Documentation Requirements
3. Case Study Discussion
4. Next Steps

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Documentation Elements

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CHI / PIN Key Documentation Elements

Documentation Elements	
• Patient Name • Date of service • Start time for service • Stop time for service • Total time for this encounter • HRSN / Navigation Need addressed	• Impact of the HRSN / Navigation Need • Plan of care element addressed • Intervention • Outcome of the intervention • Next steps if any • Sign and date the note • Close the note

Food Insecurity

- Does this sample note meet the expected requirements:
- “I met with Ms. Mary at 2pm and spent 2 hours addressing her housing insecurity.”
- Total time spent = 2 hours

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Sample Food Insecurity Physician Documentation

- **Patient Name: Monica Sprewell**

HRSN:
- Problem List updated in EMR
- Food Insecurity
- Diagnosis Code: Z59.41

Clinical Implications of HRSN:
- Patient has a diabetes diagnosis. Patient unable to adhere to prescribed low carbohydrate, low—fat diet due to food insecurity. Failure to adhere to prescribed diet changes will lead to disease complications.

Clinical Goal:
- Improve HgbA1c, reduce incidence of complications related to diabetes

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Food Insecurity Intervention Documentation

Community Health Integration intervention:

- Date: Thursday September 5, 2024
- Time: Start time: 10:15am – 12:22pm

Problem:

Patient has food insecurity. Reports that she often has only one meal per day. She only receives $50 per month in food stamps. Met with the patient on September 5th. Conducted an interview to determine current access to food sources, SNAP benefits, and assistance in the home to provide supports. In-home assessment findings reveal the following supports:

- Consumer is blind
- Lives alone
- Receives personal care aide services for 8 hours per day
- Receives $50 in SNAP benefits per month

- Patient reports that she does not have money to purchase food and has limited ability to purchase and prepare food due to blindness. Patient is eligible for expanded personal care aide services.

Sample CHI Plan

After completing the assessment, I informed the patient that we would pursue the following options to secure consistent food supports:

- Emergency food bank distribution
- Apply for an increase in SNAP benefits
- Apply for home-delivered meals
- Process application for expanded personal care aide services to assist with meal preparation
- Refer to the American Resources for the Blind for diabetes

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Sample CHI Services Rendered

- Application obtained for Capitol Area Food Bank. Requested home-delivered meals.
- Visited the Mission Foodbank on Bladensburg Road, NE to determine the process to obtain food distribution, process to apply for access, distribution times, and frequency of distribution.

- Coordinated with the care manager to determine the status of the EPD waiver application to expand PCA hours.

- Met with the Personal Care Aide to determine assistance given to ensure patient is receiving prepared food.

- Obtained one distribution for food from Bread for the City. Will follow-up to ensure patient has routine access to food biweekly until a permanent resolution is obtained for food insecurity.

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Transportation Insecurity Sample

- **Patient Name: Michael Smith**

- HRSN:
- Problem List updated in EMR
- Transportation Insecurity
- Diagnosis Code: Z59.82

Clinical Implications of HRSN:
- Patient has a history of end-stage-renal disease (ESRD). The patient has missed multiple scheduled dialysis sessions which resulted in emergency dialysis in the emergency department. The patient reports that the Medicaid transportation frequently comes late and causes him to miss the scheduled dialysis time.

Clinical Goal:
- Improve adherence to dialysis schedule to maintain homeostasis and reduce risk of complications related to lack of adherence to scheduled dialysis.

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Transportation Insecurity Documentation

Community Health Integration intervention:

- Date: Thursday September 5, 2024
- Time: Start time: 14:22 – 16:00
-

Problem:
The consumer has a history of transportation insecurity and end-stage renal disease. Failure to adhere to the scheduled dialysis schedule will result in worsening health outcomes. Patient lives alone and has limited family support. Dialysis is scheduled three (3) days per week via a graft in the left arm. The consumer has multiple missed dialysis sessions. The consumer reports that the Medicaid transportation service often comes to pick him up late. When the transportation is late, he refuses to go. This refusal to accept the late Medicaid transport results in missed dialysis. When questioned about what actions are taken when the scheduled dialysis is missed, the consumer reports that he will call 911 if he misses 2 dialysis sessions. The consumer reports that the EMS Medics will take him to the hospital for emergency dialysis when he misses two or more scheduled outpatient dialysis sessions.

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Transportation CHI Plan

Plan:

- Contact the Medicaid Transportation Provider to address the issue with dialysis transportation
- Discuss plan to address transportation with Dialysis Center
- Review the revised transportation plan with the consumer

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CHI Intervention for Transportation Insecurity

- I contacted the assigned transportation provider to determine if there are challenges with the dialysis transportation schedule. The transportation provider reports that the consumer is required to wait for the wheelchair van at the curb. The transportation provider reports that the consumer is often not at the curb when they arrive, and the transportation provider is not contracted to go to the door to assist patients that require transportation. The transportation provider reports that the primary barrier is the patient not coming to the curb for pickup at the scheduled time.

- After speaking with the transportation provider, I contacted the consumer. The consumer confirms that he has difficulty getting to the corner to receive transportation. The consumer reports that it is difficult for him to get ready in the morning. He. Has difficulty completing ADLs which delays him getting to the corner on time for transportation pickups. The consumer has a 9am pickup time. He reports that he would benefit from an afternoon pickup because it would provide him more time to get ready.

- Based on the consumer request for an afternoon dialysis schedule, I contacted the dialysis center and requested a change in the dialysis chair time. The dialysis center reports that they have an afternoon chair time that starts at 1pm.

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CHI Intervention Outcome

- I contacted the consumer, and he agreed to change from a morning dialysis chair time to the 1pm dialysis chair time. The consumer thanked me for coordinating the change in the dialysis chair. I confirmed that I would contact the transportation provider to change the pickup time for the 1pm dialysis time.

- I contacted the transportation provider and informed them that the dialysis chair time has been changed to 1pm. I explained that the consumer has difficulty getting to the corner on time to meet the transportation with a morning schedule. The afternoon schedule will give the consumer more time to get ready and to the curb to receive the scheduled transportation. The transportation provider confirmed the time change and contacted the consumer to review the afternoon pickup and drop off time and afternoon transportation procedure.

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Documentation Resources

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General Documentation sample narrative:

- The identified HRSNs have a direct impact on the health outcomes. The HRSNs must be addressed or there is increased likelihood of worsening health outcomes. CHI/PIN services are indicated to address the identified HRSNs to reduce the negative impact on the expected health outcomes. Failure to address each HRSN will result in less-than-optimal health outcomes.

- CHI/PIN services will include the following key steps:
- Assessment of the HRSNs
- Develop of person—centered plan with defined goals to address each identified need
- Targeted interventions to address each identified HRSN
- Assessment of the impact of each HRSN intervention
- Ongoing emotional support to facilitate behavior change to ensure proper maintenance of the root causes of the development of HRSNs that lead to worsening health outcomes.

- CHI/PIN services will be provided each calendar month according to the person-centered plan. Each intervention and encounter will be documented with an assessment of the impact of each intervention to achieve the goals in the clinical treatment plan.

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General Indications for CHI

Maintaining a healthy lifestyle requires a person to eat a healthy balanced diet and to exercise regularly. Persons with food insecurity often have limited access to key aspects of a balanced diet to include fresh fruits and vegetables, whole grains, healthy sources of protein, and minimally processed foods. In fact, persons with food insecurity and persons that reside in food deserts often have access to high processed foods with high sodium content. A diet that consists of high-processed, high-sodium foods will lead to worsening health outcomes over time. Food insecurity is a critical element in improving health outcomes by ensuring that the person has access to the recommended dietary choices that align with the recommended treatment plan.

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Diabetes Narrative Bank

Diabetes: Consumer with food insecurity has reduced capacity to obtain the required food that adheres with a low carbohydrate, low fat diet. Failure to adhere to the recommended dietary restrictions will lead to poor management of diabetes. Poor diabetes management leads to an increase in the HgbA1C and the potential for complications related to diabetes.

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Prediabetes Narrative Bank

Prediabetes: Prediabetes is a condition that if not properly managed will lead to diabetes. The key self-management activities for prediabetes are to enact behavior change concepts to reduce the risk of diabetes. The key self-management activities include eating a low-carbohydrate, low-fat diet, increasing exercise, and lose weight. Food insecurity limits the person's ability to adhere to the recommended diet. Interventions are needed to address food insecurity in order to facilitate the consumer with adhering to the dietary changes required to reduce the risk of diabetes. Failure to address the consumer's access to the required dietary changes has an increased likelihood of causing worsening health outcomes.

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COPD Narrative Bank

COPD: Chronic Obstructive Pulmonary Disease is a chronic lung disease that causes air flow limitation and breathing-related symptoms. According to the American Lung Association, breathing requires more energy for people living with COPD. The muscles required for breathing require 10 times more calories than someone without COPD. Persons with COPD should eat a balanced diet that is low in carbohydrates. Food insecurity limits the person's ability to eat a balanced diet that is low in carbohydrates. The consumption of inadequate calories or foods that are high in carbohydrates with low nutritional value can cause worsening COPD related symptoms. Food insecurity should be addressed in order to reduce the potential for health complications related to COPD.

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Heart Disease Narrative Bank

Heart Disease: Optimal health outcomes related to heart disease requires a person to eat a healthy balanced low-sodium diet and to exercise. Failure to adhere to a balanced, low-sodium diet will lead to worsening health outcomes related to heart disease. Food insecurity will limit the persons access to foods that make up a balanced, low-sodium diet. It is imperative to address food insecurity to ensure that the consumer has access to a balanced diet that includes fresh fruits and vegetables, whole grains, healthy sources of proteins and minimally processed foods.

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Obesity/Obesity-Related Condition Narrative Bank

Obesity: Food insecurity is a major risk factor for obesity and obesity-related conditions. Persons with food insecurity often resort to eating foods that are high in carbohydrates, low in nutritional content, and high in sodium. The consumption of foods with limited nutritional value is caused because of the lack of access to foods that make up a balanced diet. Food insecurity interventions are required to assist the consumer in obtaining the recommended dietary items that align with a balanced diet to include fresh fruits and vegetables, low-carbohydrate foods, and minimally processed foods. Food insecurity must be addressed to secure the food required to adhere to the recommended diet for the management of obesity and obesity-related conditions.

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HRSN Sample Interventions

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Domain: Food Insecurity

2-week health plan meal benefit	VA Meal Benefit
Medically Tailored Meal (MTM) benefit	Medicaid Waiver Meal Benefit
Food Is Medicine Intervention (MTM + Nutrition Counseling)	Personal Care aide/Homemaker
Mechanically Altered Meals (i.e., Pureed Meals, Pureed Meals with Thickened liquids, etc.)	Assisted Living Facility
Nutrition Supplements (Ensure, Boost, Glucerna)	Tube Feeding
SNAP	Mental Health Group Home
WIC	ID/DD Group Home
Home Delivered Meals -- Hot	Veteran Group Home
Home Delivered Meals -- Frozen/Chilled	Shelf-Stable meals
Food Bank	Adult Day Health Program (ADHP)
Church donations	Older Americans Act Nutrition Svc
Congregate meals	Mental Health Day Program
Low-barrier shelter	ID/DD Day Program
Instacart/Instacart EBT	Amazon Prime/Amazon Prime SNAP
FCC Lifeline Cell Phone Program	FCC Affordable Connectivity Program

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Domain: Housing Insecurity

Low-barrier Shelter	Assisted Living Facility
Family shelter	Section 8 Voucher
Domestic violence shelter	HUD 811/202 housing
Rapid Rehousing	Medicaid Waiver housing voucher
Housing First	Money Follows the Person
Veteran HUD/VASH	VA home modification benefit
Short-term Housing voucher	Medicaid waiver home modification benefit
Accessible Housing program	CDBG Home weatherization program
Single Room Occupancy (SRO) program	CDBG heating assistance
Group home	Mental Health Group Home
Transitional Housing	ID/DD Group Home
Supportive Housing program	Veteran Group Home
FCC Lifeline Cell Phone Program	FCC Affordable Connectivity Program

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Domain: Transportation Insecurity

Uber/Lyft voucher	**Instacart/Instacart EBT**
Accessible transportation voucher / Paratransit	Amazon Prime
Health plan transportation program	Amazon Prime SNAP
FCC Lifeline Cell Phone Program	FCC Affordable Connectivity Program

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Domain: Health/Medication Access

340B pharmacy program	**Walmart $4 prescription program**
Pharmaceutical Company Pharmacy Assistance program/RxAssist	Target $4 prescription program
Health plan Prior Authorization process	FQHC/RHC medical visit sliding scale
Part D subsidy: State Health Insurance Program	Free clinic
Pharmaceutical rep samples	Mental Health Group Home
Medication voucher	ID/DD Group Home
Veteran Group Home	FCC Lifeline Cell Phone Program
FCC Affordable Connectivity Program	Home-Delivered Meds/Pill Packs

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Domain: Interpersonal Violence

Adult Protective Services referral	**Sexual Assault complaint filed with police department**
Adult exploitation referral	Domestic Violence Shelter/Housing Program
Child Protective Services referral	Sex Trafficking referral
Criminal complaint filed with police department	FCC Lifeline Cell Phone Program
FCC Affordable Connectivity Program	Victim of Crime Support Fund

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Domain: Assistance with ADLs/IADLs (contributes to housing insecurity)

Medicaid waiver	**VA Caregiver support program (Program of Comprehensive Assistance for Family – PCAFC)**
Medicaid State Plan Benefit	Centers for Independent Living
Home health benefit	Older Americans Act/Area Agency on Aging
Personal Care Aide Benefit	Mental Health Group Home
Veteran Directed Care benefit	ID/DD Group Home
VA Aide and Attendant program	Veteran Group Home
FCC Lifeline Cell Phone Program	Subacute Rehab
FCC Affordable Connectivity Program	Home Health Therapy Benefit (PT/OT/Speech Therapy)
Instacart/Instacart EBT	Amazon Prime/Amazon Prime SNAP

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Documentation Case Studies

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Case Study: Housing Insecurity

Scenario

- Ms. Mary lives in HUD-Supported Housing. She have failed two of the last inspections and is at risk of eviction.
- Ms. Mary reports difficulty maintaining her unit because she has bad arthritis and it is painful to walk or stand. She has withdrawn from social interaction and reports that she cannot cook or clean her apartment.

Create a Note

1. Patient Name
2. Date of service
3. Start time for service
4. Stop time for service
5. Total time for this encounter
6. HRSN / Navigation Need addressed
7. Impact of the HRSN / Navigation Need
8. Plan of care element addressed
9. Intervention
10. Outcome of the intervention
11. Next steps if any
12. Sign and date the note
13. Close the note

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Case Study: Access to Health Services

Scenario

- Mr. Tim lives in his adult son. The son works 12 hour shifts at Walmart and has a second job as a bartender. The son has limited capacity serve as the caregiver. Mr. Tim often misses doctors appointments, he has not been to the dentist and reports a toothache, and he does not regularly get his medication filled.
- Mr. Tim cannot drive and depends on his son for assistance.

Create a Note

1. Patient Name
2. Date of service
3. Start time for service
4. Stop time for service
5. Total time for this encounter
6. HRSN / Navigation Need addressed
7. Impact of the HRSN / Navigation Need
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Case Study: PIN-PS

Scenario

- Ms. Brie. Ms. Brie is a transgender female with a history of bipolar disease, HIV, and Opioid Use Disorder. Ms. Brie lives in an apartment alone. Ms. Brie reports that she has a history of childhood trauma and turns to drugs when she gets lonely and depressed. Ms. Brie is not taking her medicine regularly is behind on rent, and does not have any food in her apartment.

Create a Note

1. Patient Name
2. Date of service
3. Start time for service
4. Stop time for service
5. Total time for this encounter
6. HRSN / Navigation Need addressed
7. Impact of the HRSN / Navigation Need
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Open Discussion

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LET'S CHAT

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Next Steps

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Reminder

- **October HELC Sessions**
  - **<u>October 3</u>** @ 2:00-3:30 p.m. ET, HELC ECHO Session for **EMERGING Community Clinical Teams**
  - **<u>October 17</u>** @ 2:00-3:30 p.m. ET, HELC ECHO Session for **ADVANCED Community Clinical Teams**

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Upcoming Session Topics

Emerging Community-Clinical Team Topics	Advanced Community-Clinical Teams Topics
~~✓ Landscape analysis~~	~~✓ TeamSTEPPS framework~~
~~✓ Case Study Discussion~~	✓ Theory of Change: Alternative Payment Models (APMs)
✓ Determining return on investment	✓ Using APMs to advance health equity
✓ Value Proposition	✓ Sustainability through multi-payer alignment
✓ Contracting 101	✓ Payment incentives to reduce health disparities
✓ Billing and Coding 101	✓ Expanding target populations
✓ IT systems	✓ Blending and braiding services
✓ Quality	✓ IT Systems
	✓ Quality

- **Deciding which track to join?** If you have partnerships in place and already have one or more contracts with health systems or plans, join the **ADVANCED** Community-Clinical Team calls.
- If you are still working to establish partnerships, the **EMERGING** sessions may be best. You and/or your team members are welcome to join both sessions each month.
- Questions? Email acampbell@partnership2asc.org.

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Learning Collaborative Resources

- HELC ECHO Sessions Recordings & Resources: https://www.partnership2asc.org/healthequity/helc-resources/
- Partnership CHI/PIN Implementation Resources and Events: https://www.partnership2asc.org/implementation-resources/
- Freedmen's Health Consulting Implementation Resources: https://communityintegration.info

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More Information About the HELC

- Overview: www.partnership2asc.org/heathequity/
- FAQ: www.partnership2asc.org/FAQ
- Example: https://www.partnership2asc.org/healthequity/example-participating-market/
- Health Plan Outcomes: https://www.partnership2asc.org/healthequity/healthplanoutcomes/
- CHI Implementation: https://www.partnership2asc.org/healthequity/chiimplementation/

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Thank you!

Tim McNeill, RN, MPH

tmcneill@freedmenshealth.com

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Next Steps

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Reminder

Next Session for the EMERGING Community-Clinical Teams is July 18th from 2 to 3:30 EST

Starting in August:

- Emerging Community-Clinical Teams – 1st Thursday
- Advanced Community Clinical Teams - 3rd Thursday

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Learning Collaborative Resources

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- Partnership CHI/PIN Implementation Resources and Events: https://www.partnership2asc.org/implementation-resources/

- Freedmen's Health Consulting Implementation Resources: https://communityintegration.info

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Thank you!

Tim McNeill, RN, MPH

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