VIRTUAL 2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

# Using an Electronic Health Record to Support Non-Medical Case Management Processes, Assessments, and Program Graduation, 16174


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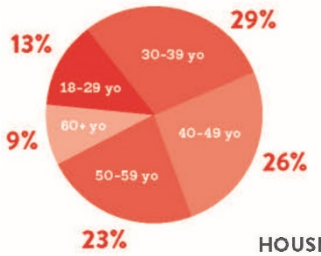
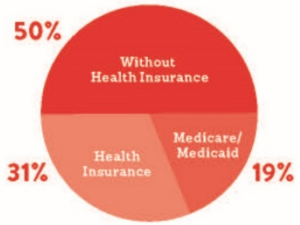
# Prism Health North Texas by the Numbers

## Patient Profile

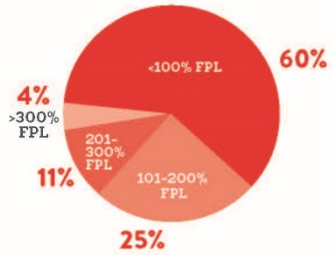
AGE (HIV ONLY)




INSURANCE STATUS




HOUSEHOLD INCOME




## Personalized HIV Primary Care

**2,574** PATIENTS

**85%** UNDETECTABLE VIRAL LOAD

**17** CLINICAL RESEARCH STUDIES WITH **164** PARTICIPANTS

**561** PATIENTS IN BEHAVIORAL HEALTHCARE

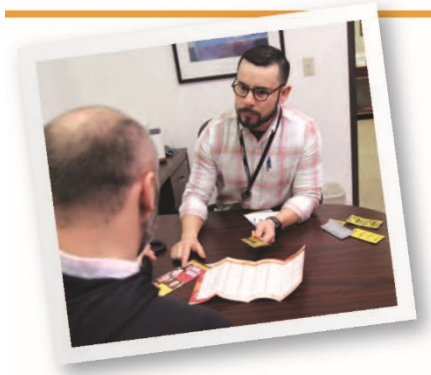
### Unique Interventions

**361** FORMERLY INCARCERATED INDIVIDUALS CONNECTED TO CARE

**228** EMERGENCY HOUSING NIGHTS PROVIDED

**501** EMPOWERMENT EVENT ATTENDEES

## HIV Prevention



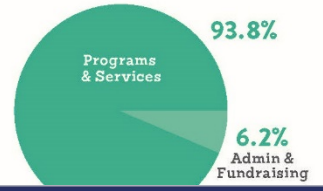
**405,481** CONDOM/PREVENTION KITS DISTRIBUTED

**129** PREVENTION COUNSELING PARTICIPANTS

**3,903** HIV TESTS

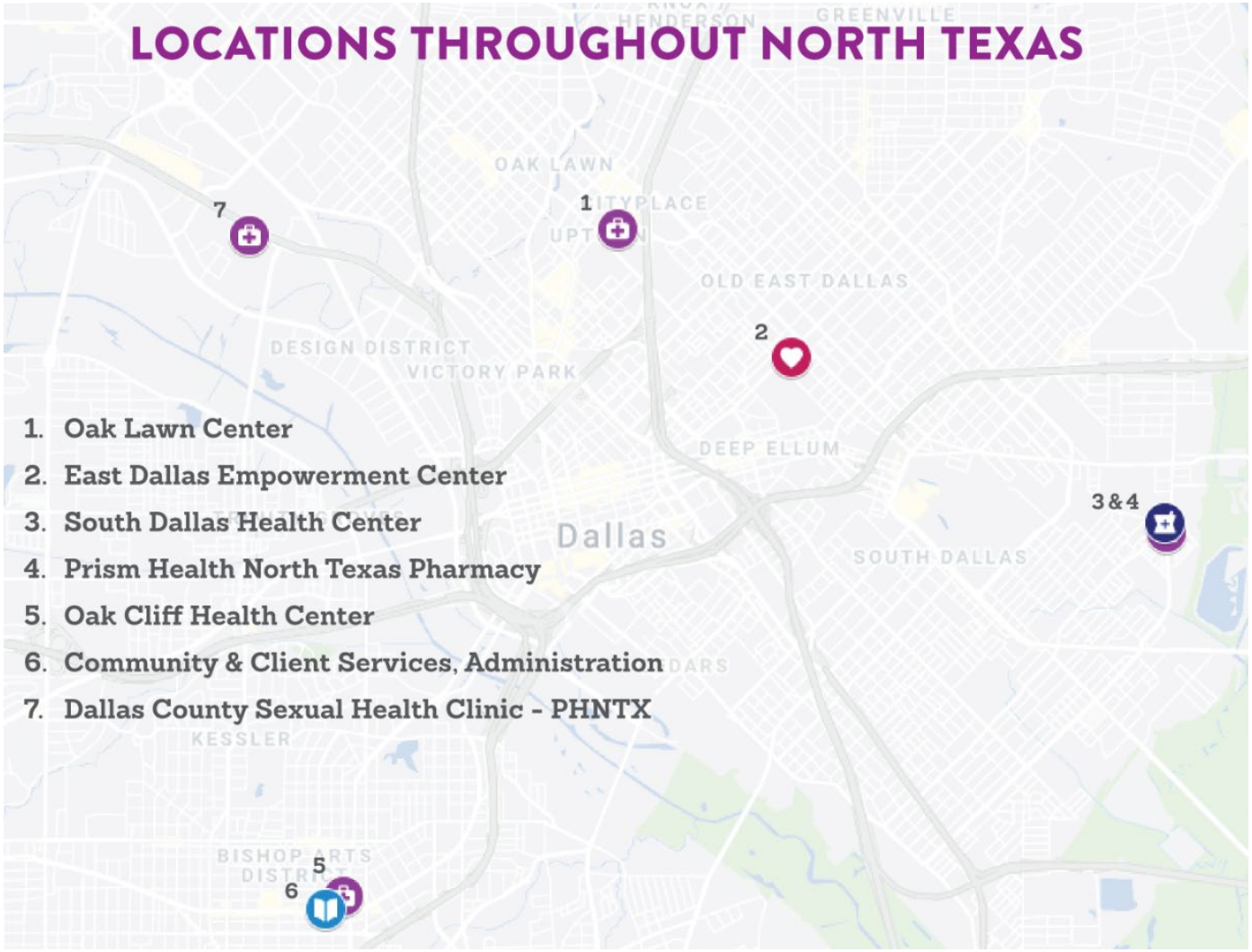
**164** PEOPLE ON PrEP (PRE-EXPOSURE PROPHYLAXIS)

OPERATING EXPENSES



# North Texas Locations

VIRTUAL 2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

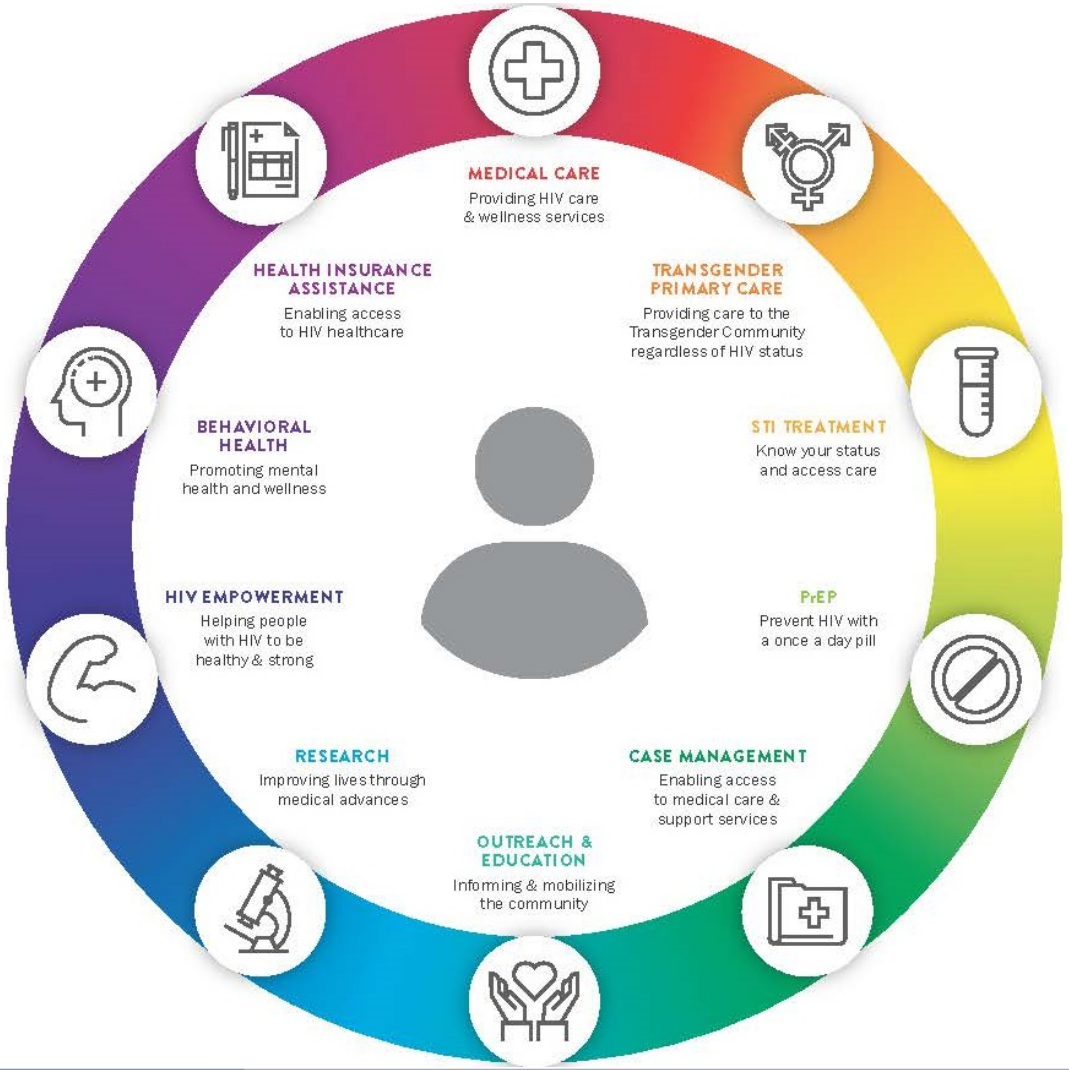



PrismHealth NORTH TEXAS

AETC AIDS Education & Training Center Program South Central

# Prism Health North Texas

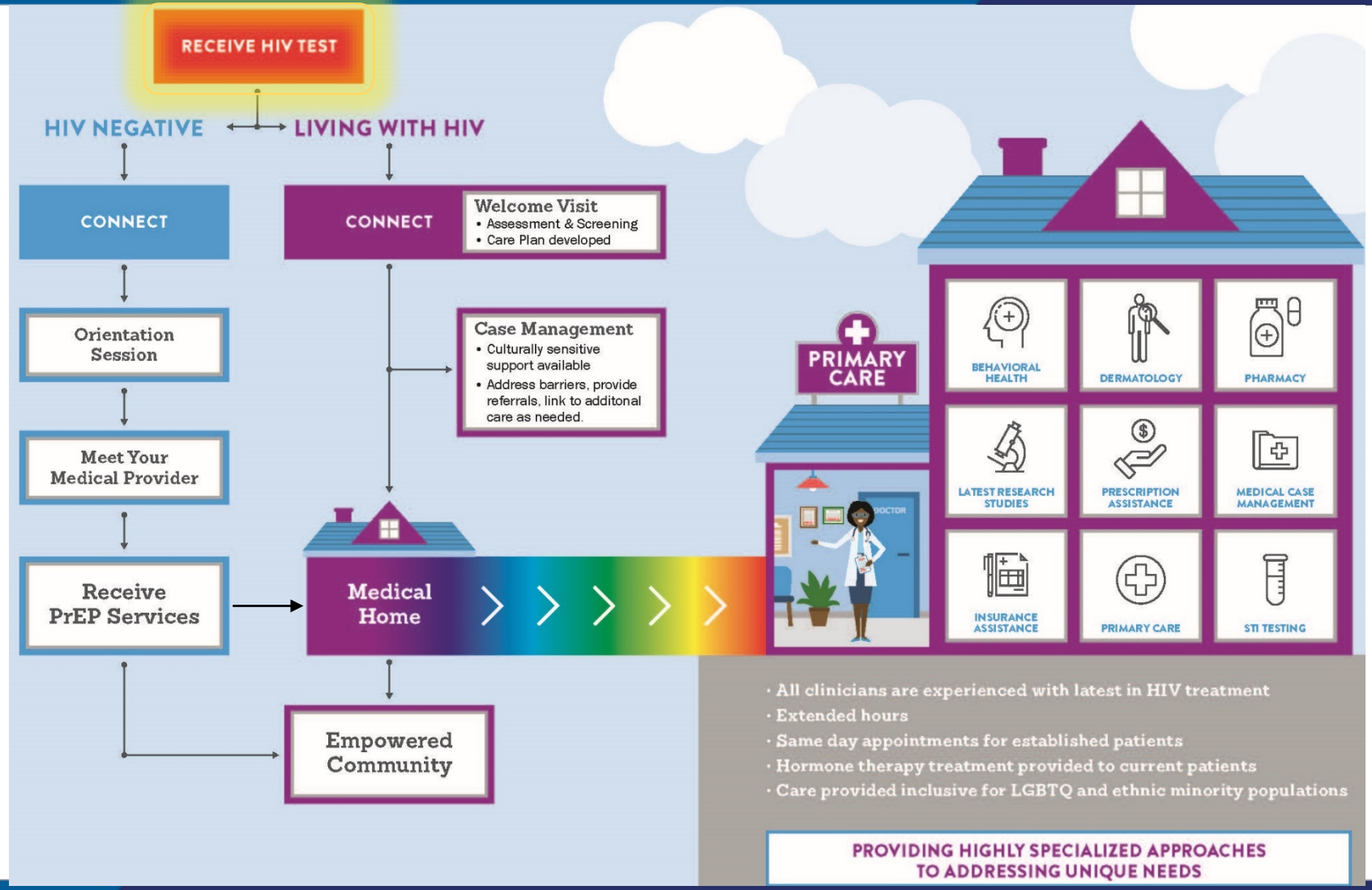





Advancing the Health of North Texas through education, research, prevention, and personalized integrated HIV care.

# Integrated Care and HIV Medical Home





# Learning Objectives



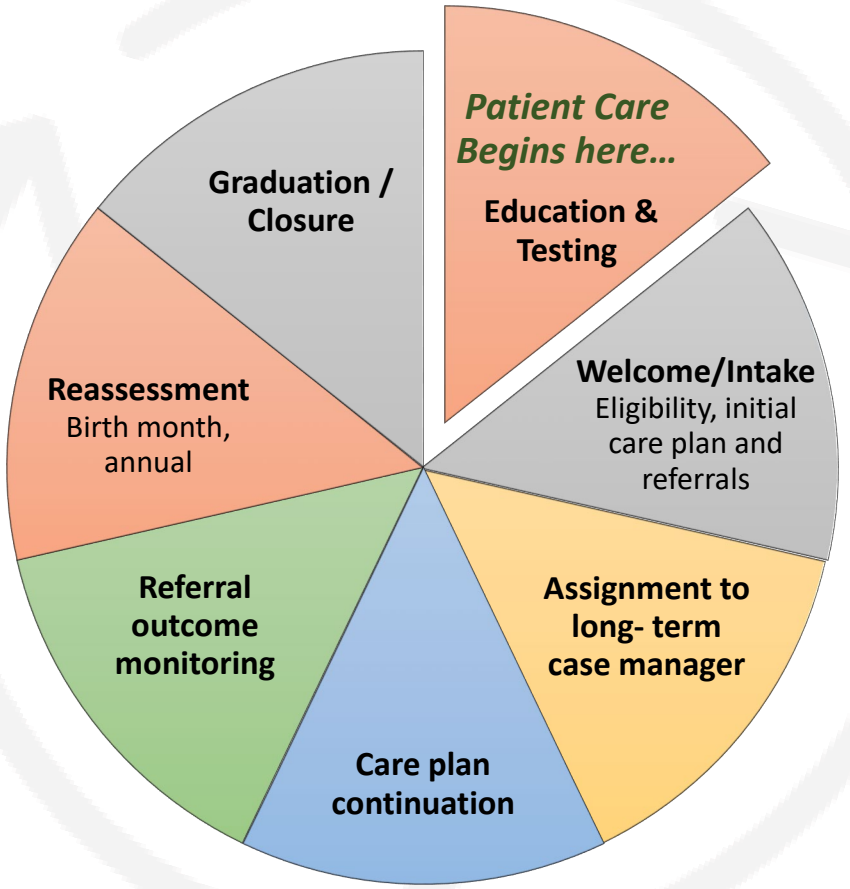
1. Outline the implementation phases of non-medical case management (N-MCM) workflow processes to document reportable and non-reportable activities
2. Detail case management assessments embedded within an electronic health record (EHR) system to determine assessment outcomes and the needed interventions to support patient care
3. Provide details on creating a care plan model to identify patient needs, action items, patient goals to decrease acuity and determine program graduation

# PHNTX Care Engagement Process



- The PHNTX N-MCM program aligns key activities with Texas Department of State Health Services standards of care:
  - Initial assessment of service needs
  - Development of a comprehensive, individualized care plan
  - Coordination of services required to implement the plan
  - Patient monitoring to assess the efficacy of the plan
  - Periodic re-evaluation and adaptation of the plan as needed over the patient's enrollment in N-MCM services

**PHNTX NMCM care engagement process**



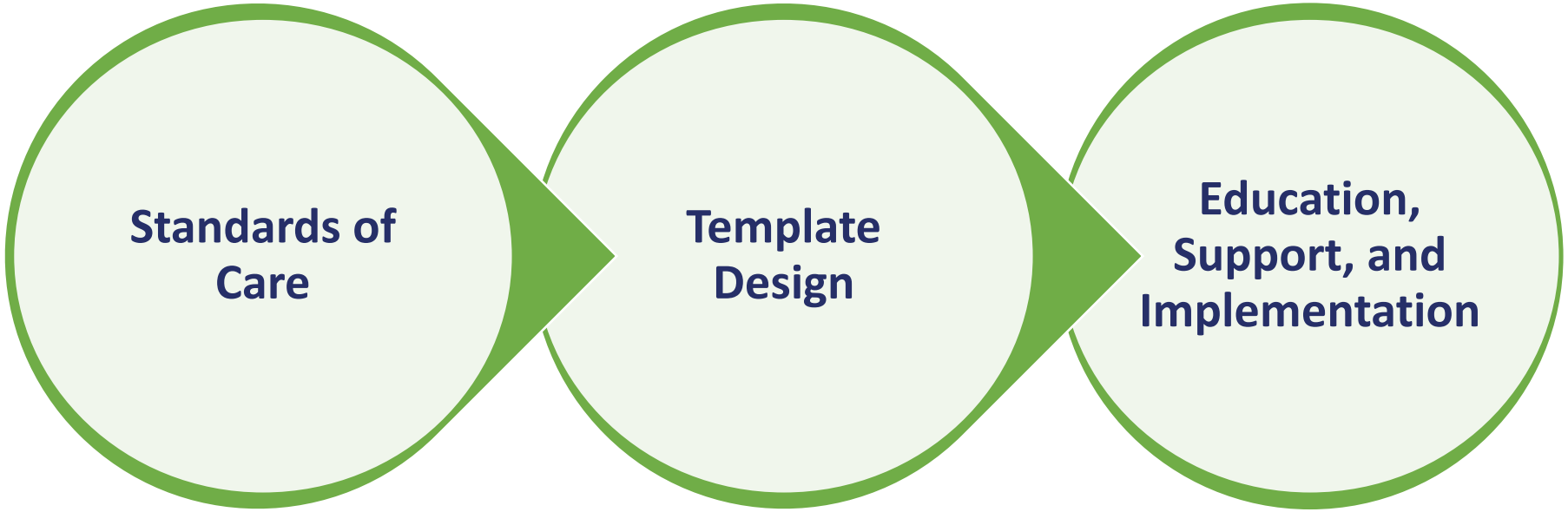
# Program Indicators and Documentation Structure in EHR



| | |
|---|---|
| Initial assessment of service needs | Encounter Note, Encounter Log, Needs Assessment (System Acuity Measurement Scale) |
| Development of a comprehensive, individualized care plan | Encounter Note, Encounter Log, Needs Assessment, Care Plan, Referral/Intervention Monitoring |
| Continuous patient monitoring to assess efficacy of the care plan | Encounter Note, Encounter Log, Needs Assessment, Care Plan, Referral/Intervention Monitoring |
| Re-evaluation of care plan at least every six months with adaptations as needed | Encounter Note, Encounter Log, Needs Assessment, Care Plan, Referral/Intervention Monitoring |
| Ongoing assessment of patient's and key family members' needs and personal support systems | Encounter Note, Encounter Log, Needs Assessment, Care Plan, Referral/Intervention Monitoring |
| Case closure / graduation assessment | Case Closure / Graduation Assessment Form |

# Learning Objective 1

Outline the implementation phases of N-MCM workflow processes to document reportable and non-reportable activities.



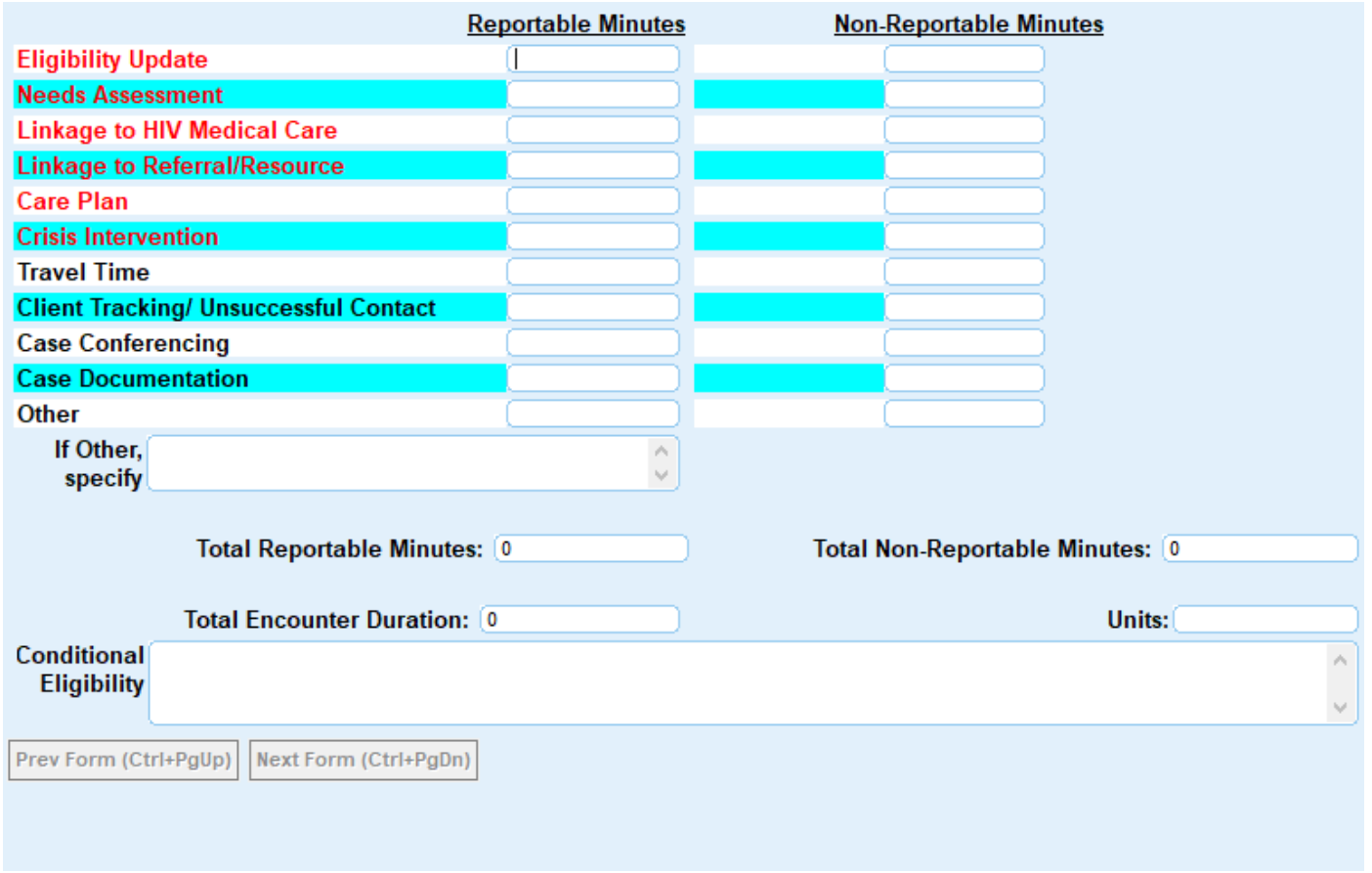
# Education, Support, and Implementation

- Education
  - Internally developed N-MCM workflow electronic health record user guide with frequent updates to reinforce current standards
- Support
  - Beta testing: one-on-one and small N-MCM group practice sessions
- Implementation
  - Go Live for entire department
  - On demand/immediate on-site assistance

# Encounter Log Template Design (Time Allocation)



- **Goal:** capture total encounter time N-MCM spends to assess a patient's needs to facilitate access to services.
- **Key template features**
  - Key assessment areas
  - Reportable, non-reportable data points
  - Holding an incomplete log
  - Signing a completed log
  - Appending a completed log with Supervisory approval
  - Emergency assistance / conditional eligibility



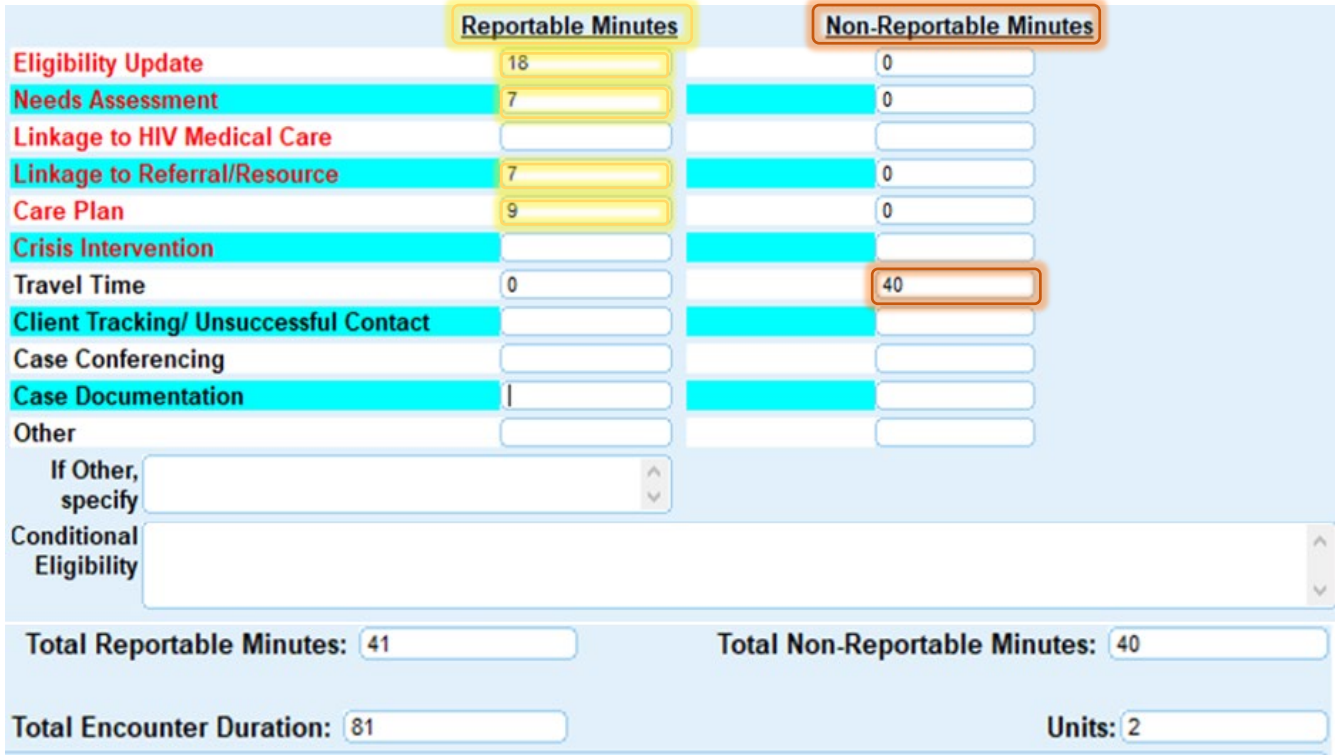
# Encounter Log Documentation



## Case Scenario

A case manager travels to a patient's homeless encampment (20 minutes one way). During the encounter, the case manager reviews and updates the patient's Ryan White eligibility documents (18 minutes), assesses the patient's needs (7 minutes), reviews the care plan (9 minutes), prepares documents to fax to service providers (7 minutes).

**Visual representation of an encounter log documentation**



| | Reportable Minutes | Non-Reportable Minutes |
|---|---|---|
| Eligibility Update | 18 | 0 |
| Needs Assessment | 7 | 0 |
| Linkage to HIV Medical Care | | |
| Linkage to Referral/Resource | 7 | 0 |
| Care Plan | 9 | 0 |
| Crisis Intervention | | |
| Travel Time | 0 | 40 |
| Client Tracking/ Unsuccessful Contact | | |
| Case Conferencing | | |
| Case Documentation | | |
| Other | | |

If Other, specify:

Conditional Eligibility:

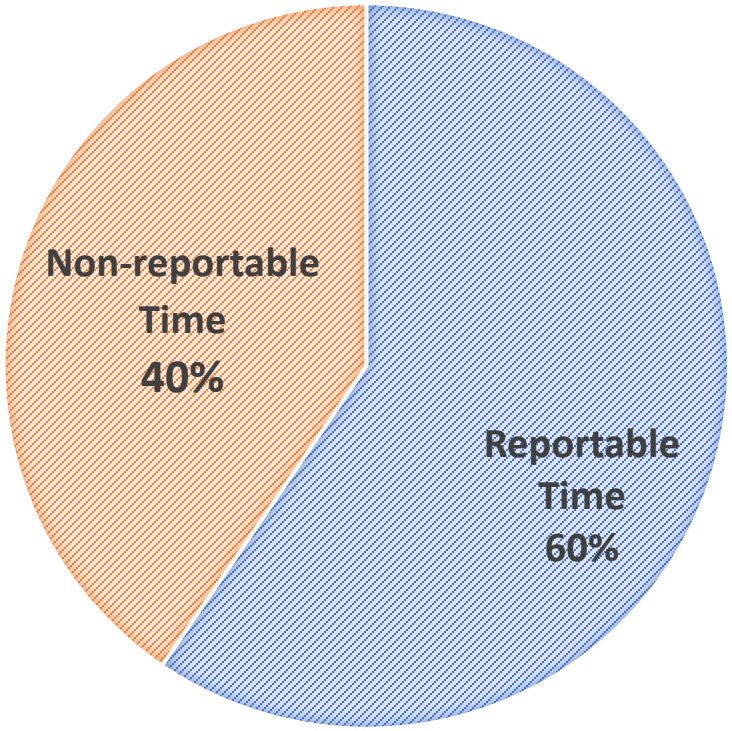
Total Reportable Minutes: 41 Total Non-Reportable Minutes: 40

Total Encounter Duration: 81 Units: 2

# Encounter Log Data Uses



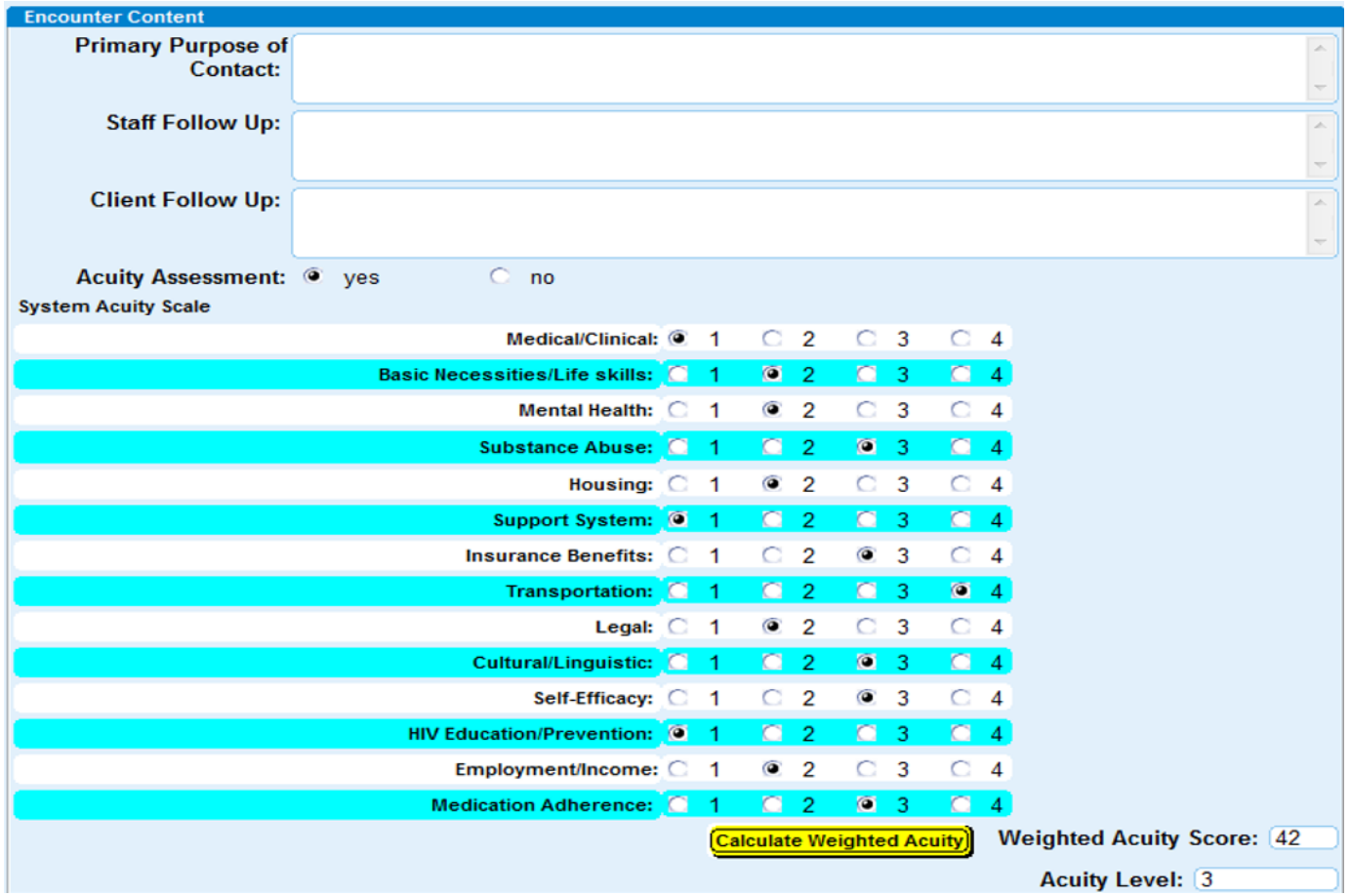
## Reportable vs Non-reportable Time (n=2,202)




- Averages
  - 42 minutes encounter duration
  - <3 days to complete documentation
  - 7 encounters per client
- Top Reportable Activities
  - 60% of efforts are reportable to RW
  - Assessments
  - Linkage to referrals/ resources
  - Care plan
  - Eligibility updates
- Top Non-reportable Activities
  - 40% of efforts are not reportable to RW
  - Case documentation
  - Case tracking
  - Travel time

# Encounter Note Template (Contact Purpose and Acuity)

- **Goal:** To capture case management session details to support encounter log (time)
- **Template Features**
  - Primary purpose of contact
  - N-MCM required follow-up
  - Patient required follow-up
  - Acuity Assessment (used to assist in assessing case management need)



# N-MCM Documentation Structure in the EHR



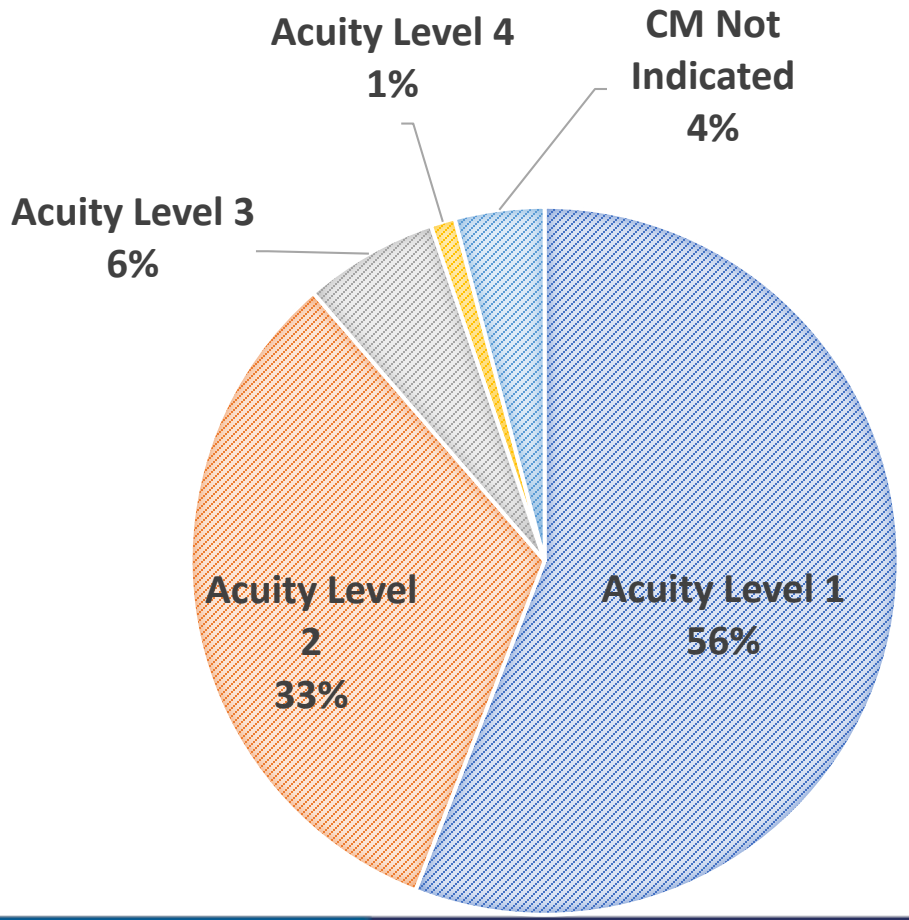
- Acuity Scale – Used to determine the level of case management need across 14 life areas (Systems Acuity Measurement Scale)
  - Systematic approach – ensures standardized assessments across all case management teams
  - Calls the case manager's attention to the areas of unmet need
  - Provides a clear set of objectives to work towards to meet the patient's needs
  - Outlines guidance for frequency of contact, based on need

- Medical / clinical
- Basic necessities / life skills
- Mental health / psychosocial
- Substance use
- Housing / living situation
- Support system
- Insurance benefits
- Transportation
- HIV-related legal
- Cultural / linguistic
- Self-efficacy
- HIV education / prevention
- Employment / income
- Medication adherence

# Encounter Note Data Uses



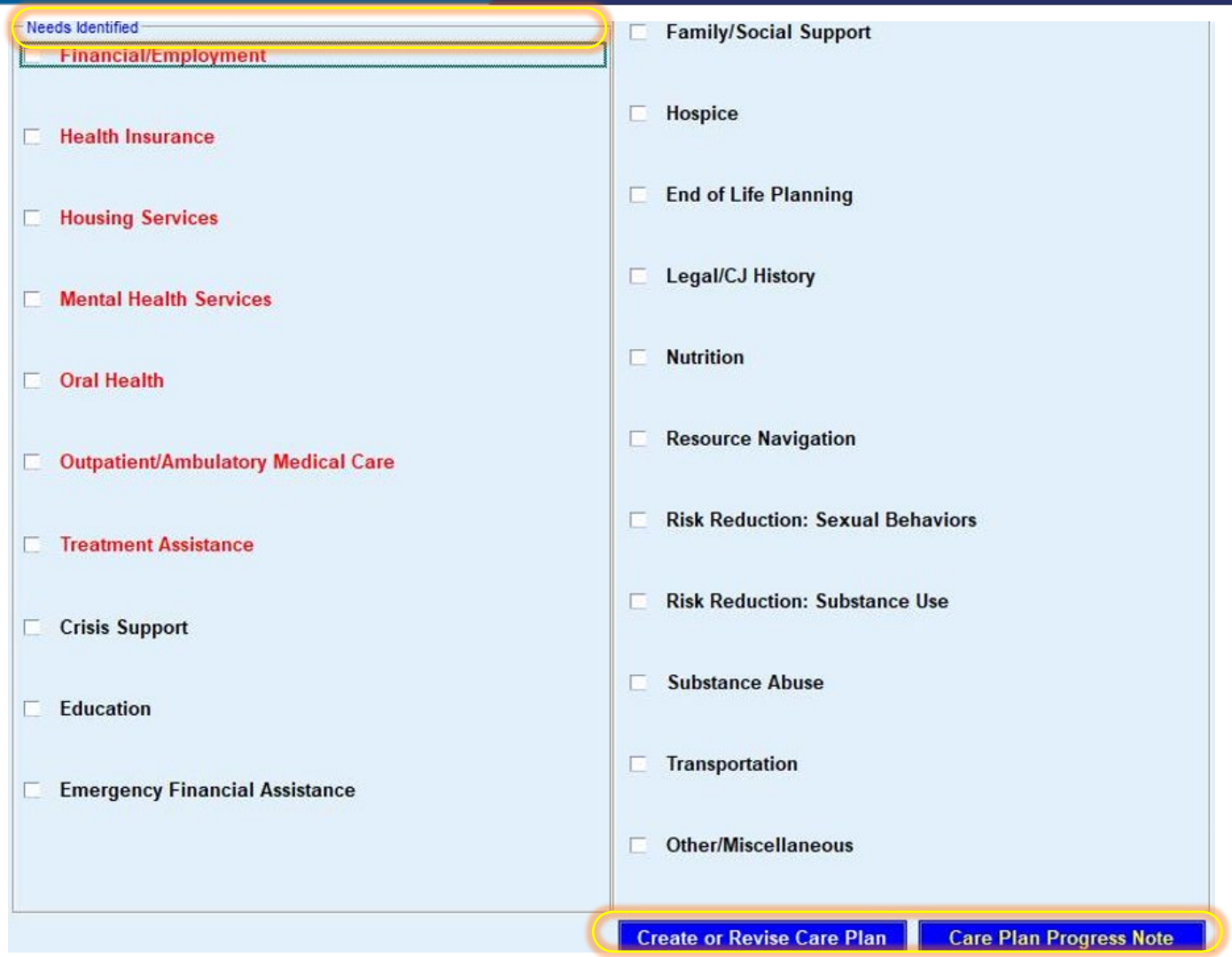
## Acuity Level of N-MCM Patients (n=538)




- Identifies non-HIV related support needs
- Informs caseload distribution
- Contact standards
  - Level 0: Case Management Not Indicated
  - Level 1: CM initiated contact bi-annually
  - Level 2: CM initiated contact quarterly
  - Level 3: CM initiated contact monthly
  - Level 4: CM initiated contact every two weeks minimum
- Graduation is indicated when an acuity level of 1 or CM not indicated is achieved and the patient is able to navigate the health system and has achieved a level of self sufficiency.

# Encounter Note Template (Identified Needs)

- Template Features
  - Additional assessment areas
  - N-MCM creates a care plan to address the identified needs on the encounter notes
  - N-MCM launches care plan from a needs assessment page



# Uses Beyond Encounter Documentation



- Supports integrated team-based approach to serve patients
- Facilitates structured data reporting
  - Monthly service utilization reporting to administrative agency (ARIES Importing)
  - Internal ad hoc reports for supervisors
  - Provider reports for performance monitoring
- Automates
  - Calculations (acuity, time, unit conversion)
  - Reminders to sign documents (provider document dashboard)
  - Creation and follow - up of patient-centered care plans
- Supports compliance monitoring

# Learning Objective 2

- Objective 2: Detail case management assessments tools embedded within an electronic health record system to determine assessment outcomes and the necessary interventions to support patient care.

# Embedded N-MCM Assessments



- Screening/assessment tools yields a positive or negative response
- Positive screening results allow N-MCM and the patient to decide on the next priority

| System Acuity Measurement Scale | Substance Abuse and Mental Illness Symptoms Screening (SAMISS) | Behavioral Risk Assessment |
|---|---|---|
| • 14 needs assessment categories to identify unmet needs | • 16 questionnaire/ tool to screen for mental health and substance abuse conditions | • Identifies behaviors which increase HIV exposure risk to patients and persons with whom they engage in such behaviors |
| • Offer case management services to patient<br>• Assigns a N-MCM level (1-4) to each patient | • **If negative** – intervention is not required<br>• **If positive** – referral is offered<br>  • Patient is already in program<br>  • Patient declined referral | • **If negative** – intervention is not required<br>• **If positive –** referral is offered<br>  • Patient is already in program<br>  • Patient declined referral |

System Acuity Measurement (SAM ) Scale Acuity was developed by Washington State Department of Health

# Determining Appropriate Interventions



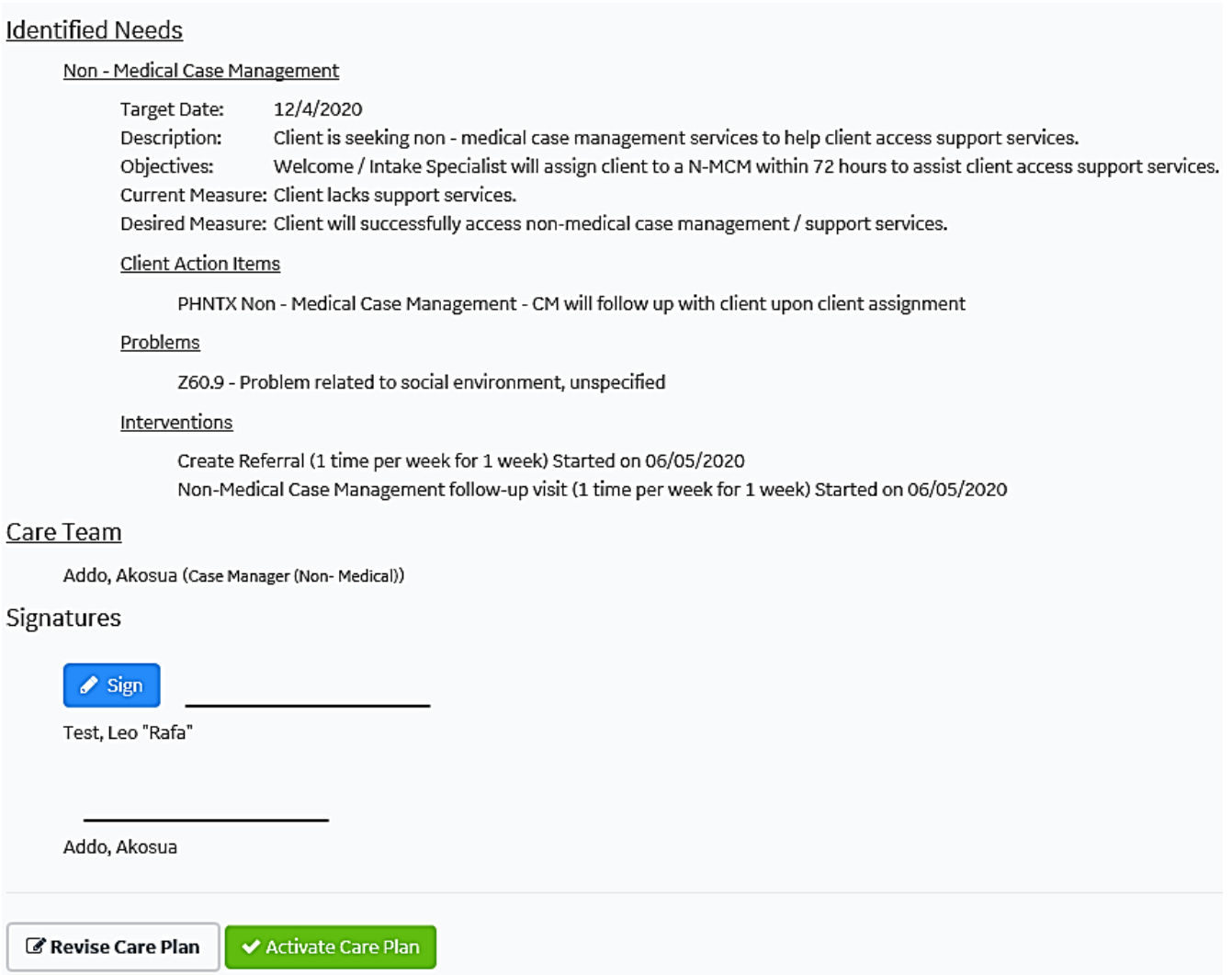
- Case managers
  - Work with patients to identify the most appropriate intervention to support patients.
  - Advocate and help facilitate access to care with service providers
    - Outpatient medical care
    - Behavioral health
    - Health insurance assistance
    - Empowerment events
    - Prevention services
    - Substance abuse/misuse treatment (Outpatient / in patient treatment)
    - And other necessary services

# Learning Objective 3

- Provide details on creating a care plan model to identify patient needs, action items, patient goals to decrease acuity and determine program graduation

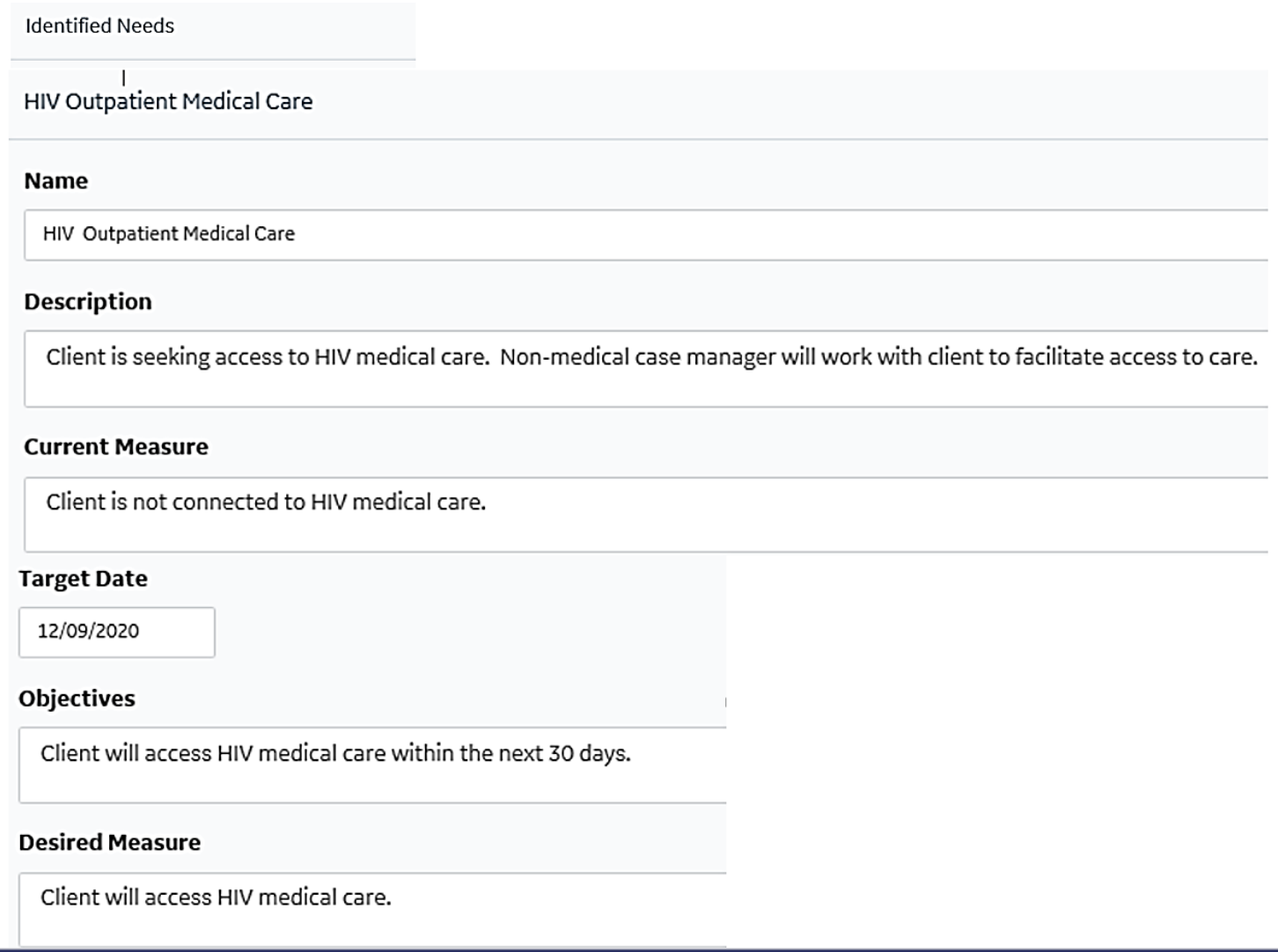
# Care Planning Components (Case Management)

- N-MCM work with patients to identify the following :
  - Problem statement/need
  - Goal(s)
  - Intervention (tasks, referrals, service delivery)
  - Responsible party for the activity
  - Timeframe for completion
  - Client acknowledgment



# Care Planning Process (HIV Medical Care)

- Layout of care plan to facilitate access to HIV medical care
  - Sets expectation for non-medical case manager and the patient.
  - Case manager works with service providers to ensure patient get services within 30 days



# Patient Centered Care Plan



## Th patient action list outlines patient responsibilities

- [ ] Parkland: Amelia Court Clinic - follow up with service provider
- [ ] PHNTX: Oak Cliff - follow up with service provider
- [ ] Parkland: Bluitt-Flowers COPC - follow up with service provider
- [ ] Veterans Affairs Medical Center - follow up with service provider
- [ ] Parkland: DeHaro-Saldivar COPC - follow up with service provider
- [ ] PHNTX: Oak Lawn ahealth Center - follow up with service provider
- [ ] Parkland: Southeast Dallas COPC - follow up with service provider
- [ ] Your Health Clinic (North rural) - follow up with service provider
- [ ] HSNT (North rural) - follow up with service provider
- [ ] PHNTX: South Dallas - follow up with service provider
- [ ] Parkland: SDHC Women's COPC - follow up with service provider
- [ ] SHRT (East rural) - follow up with service provider

## The intervention and referrals list outlines N-MCM responsibilities

| | Category | Start Date |
|---|---|---|
| ✖ | Create Referral | 06/09/2020 |
| ✖ | Non-Medical Case Management follo | 06/09/2020 |

| Frequency | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 1 | to | 1 | x per | week | for | 1 | week(s) |
| 1 | to | 1 | x per | month | for | 2 | month(s) |

# N-MCM Status Monitoring



- Longitudinal view of patient's N-MCM acuity levels
  - Displays areas of unmet and met needs
  - Supports program graduation or continuation based on identified needs

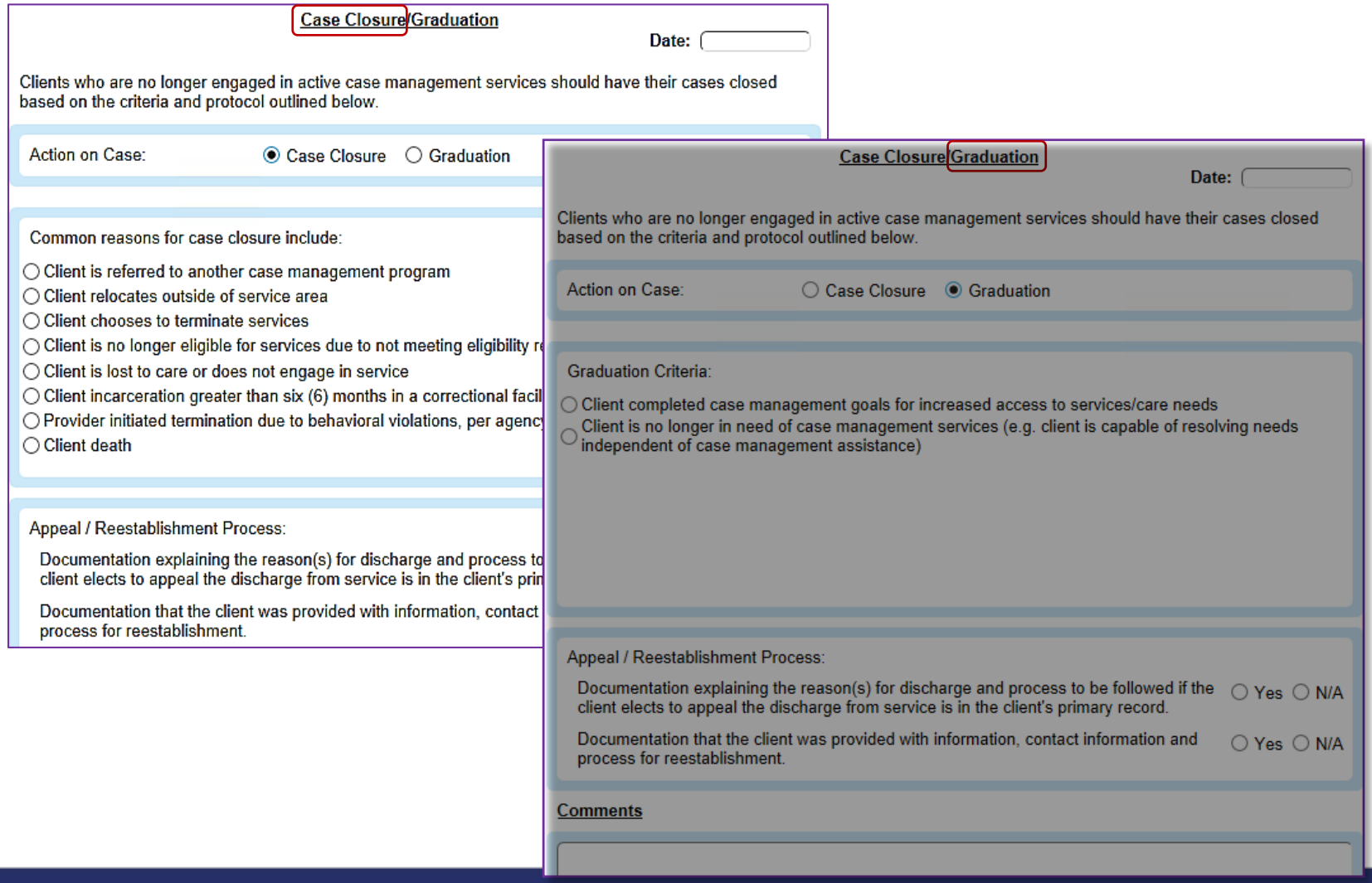
Vie C&CS Acuity R To

| | 05/08/2019 | 05/07/2019 | 05/06/2019 | 01/31/2019 | 03/12/2018 | 01/19/2018 | 10/15/2017 | 03/24/2016 | 03/22/2016 |
|---|---|---|---|---|---|---|---|---|---|
| MEDCLIN | 1 | 1 | 1 | 1 | 2 | 2 | 3 | 2 | 4 |
| BASICNEC | 1 | 1 | 1 | 1 | 3 | 3 | 4 | 2 | 4 |
| MENTHLTH | 1 | 1 | 1 | 2 | 3 | 2 | 3 | 3 | 4 |
| SUBSABUSE | 1 | 1 | 1 | 3 | 3 | 3 | 4 | 2 | 4 |
| ACU_HO | 1 | 1 | 1 | 1 | 3 | 3 | 3 | 2 | 4 |
| SUPSYSTM | 1 | 1 | 1 | 1 | 3 | 3 | 4 | 2 | 4 |
| INSBEN | 1 | 1 | 1 | 1 | 1 | 2 | 3 | 3 | 4 |
| ACU_TR | 1 | 1 | 1 | 1 | 4 | 3 | 4 | 2 | 4 |
| LEGAL | 1 | 1 | 1 | 1 | 3 | 2 | 3 | 1 | 4 |
| CULTLING | 1 | 1 | 1 | 1 | 4 | 2 | 4 | 2 | 4 |
| SELFEFFICAC | 1 | 1 | 1 | 1 | 4 | 3 | 3 | 1 | 4 |
| HIVEDPREV | 1 | 1 | 1 | 1 | 4 | 2 | 4 | 2 | 4 |
| EMPLINCOME | 1 | 1 | 1 | 1 | 4 | 3 | 3 | 2 | |
| MEDADHERE | 1 | 1 | 1 | 1 | 4 | 2 | 4 | 1 | 4 |
| WGTDSCORE | 14 | 14 | 14 | 25 | 63 | 49 | 73 | 37 | 88 |
| ACUITYFINAL | CM Not I... | CM Not I... | CM Not I... | 1 | 4 | 3 | 4 | 3 | 4 |

# Case Closure, Graduation, and Reengagement



- Identifies reason for N-MCM status change to graduation or closure
  - Case closure is for patients who are lost to care and are not reachable
  - Graduation is for patients who achieve self sufficiency and are able to navigate the health system to access
- Outlines documentation requirement for appeal and reestablishment process



Case Closure/Graduation

Date:

Clients who are no longer engaged in active case management services should have their cases closed based on the criteria and protocol outlined below.

Action on Case: ◉ Case Closure ○ Graduation

Common reasons for case closure include:

- ○ Client is referred to another case management program
- ○ Client relocates outside of service area
- ○ Client chooses to terminate services
- ○ Client is no longer eligible for services due to not meeting eligibility r
- ○ Client is lost to care or does not engage in service
- ○ Client incarceration greater than six (6) months in a correctional facil
- ○ Provider initiated termination due to behavioral violations, per agency
- ○ Client death

Appeal / Reestablishment Process:

Documentation explaining the reason(s) for discharge and process to client elects to appeal the discharge from service is in the client's prin

Documentation that the client was provided with information, contact process for reestablishment.

Case Closure/Graduation

Date:

Clients who are no longer engaged in active case management services should have their cases closed based on the criteria and protocol outlined below.

Action on Case: ○ Case Closure ◉ Graduation

Graduation Criteria:

- ○ Client completed case management goals for increased access to services/care needs
- ○ Client is no longer in need of case management services (e.g. client is capable of resolving needs independent of case management assistance)

Appeal / Reestablishment Process:

Documentation explaining the reason(s) for discharge and process to be followed if the client elects to appeal the discharge from service is in the client's primary record. ○ Yes ○ N/A

Documentation that the client was provided with information, contact information and process for reestablishment. ○ Yes ○ N/A

Comments

# COVID 19- Managing Patient Care



- Priorities and program adjustments due to COVID-19 pandemic:
  - Incorporated telehealth case management appointments
  - Increased telephone patient assistance
  - Provided state approved emergency applications to support patients
  - Increased use of patient portal to allow patients to submit eligibility documents
  - Expanded use of HIPAA complaint SMS platform to allow for secured messaging and document sharing between non-medical case managers and patients

# Acknowledgement and Thank You



Our sincere gratitude to the following individuals for their contribution in the early stages of building templates in the EHR and for their continued support:

Akosua Addo

Katie Mulosia

Leonardo Zea

Martha Guerrero

Nicole Chisolm

William Tebbs

The entire N-MCM team

# Questions/Comments/Feedback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