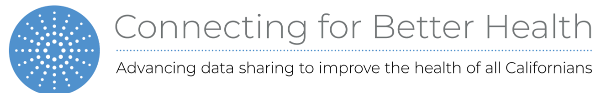


Sonoma Medically Tailored Meal (MTM) Referrals User Story - Norma Garcia

- Age: 55
- Health Concerns: Uncontrolled Type 2 Diabetes, uncontrolled Hypertension, back and other joint pain
- Social Needs: Speaks only Spanish, lacks transportation, lacks access to grocery stores
- Location: Sonoma County
- Occupation: Janitor/house cleaner
- Insurance: Medi-Cal Plan
- Pronouns: She/her

About Norma:

- Travels every 6 months to Mexico
- Resides with her children when in California
- Lives in a suburban area

Norma's Challenges and Goals:

- Relies on her children for transportation
- Monolingual Spanish speaker
- No easy access to a grocery store (lives in a suburban area and has to take a bus, walk, or get a ride)
- Has intermittent medication adherence; prefers a natural approach to disease management
- Wants to be able to walk, spend time with her family
- Would like to be free of pain
- Doesn't want to be a burden on her family
- Does not have time to participate in nutrition education classes

Norma's Pain Points

- When traveling to Mexico, Norma misses regular appointments.
- Does not take medication regularly.
- With limited access to grocery stores, Norma buys mostly non-perishable items that will last longer instead of more fruits and vegetables.
- Reliance on an interpreter who speaks Spanish means that Norma can only access care at specific times and in certain settings.

- Is not able to answer her phone during the day and misses calls from providers
- May not be available to receive meals due to her work schedule

Norma's Typical Routine & Interactions

- Norma visits her primary care provider every other month to get blood tests and blood pressure checks
- Norma visited the ER twice in the last year due to her uncontrolled diabetes
- Works 8-4pm M-F and some evenings
- Gets home at 5:30pm and likes to cook and eat meals with her family

What Norma Wants from the CA Health and Social Care System

- I want healthy food so I can manage my diabetes at home, so I don't have to go to the hospital
- I want to get my routine care close to home with providers who understand my needs and culture
- I want culturally-relevant services and support for my preference for natural approaches
- I want a trusted person I can go to to access resources/services
- I want healthy food access
- I want educational materials

Sonoma Medically Tailored Meal (MTM) Referrals Use Case Scene Breakdown

- Use Case 1: PCP visit at FQHC and MTM referral
- Use Case 2: Authorization of MTM Services
  - Scene 2A: Referral Received and Reviewed by MTM Organization
  - Scene 2B: Request for Authorization sent to MCP
- Use Case 3: Initial MTM Services Delivered and Extension of MTM Services
  - Scene 3A: Intake and Service Delivery
  - Scene 3B: Extension of MTM Services

Assumptions:

- Norma is enrolled in Medi-Cal and has been assigned to a Managed Care Plan.
- Norma is initially diagnosed with Diabetes and Hypertension.
- Norma and her family have a stove and refrigerator and basic cooking knowledge.
- The Regional Referral Platform ingests the referral information using the interface protocol that the FQHC has established through their EHR.
- The Regional Referral Platform has a pre-established connection to the MTM Service Organization to enable outbound electronic send without manual intervention.
- MTM Service Organization Case Management Platform automatically ingests the Referral form and the assumption is that they will be using the built-in APEX functionality or API

Use Case 1: PCP visit at FQHC and MTM referral

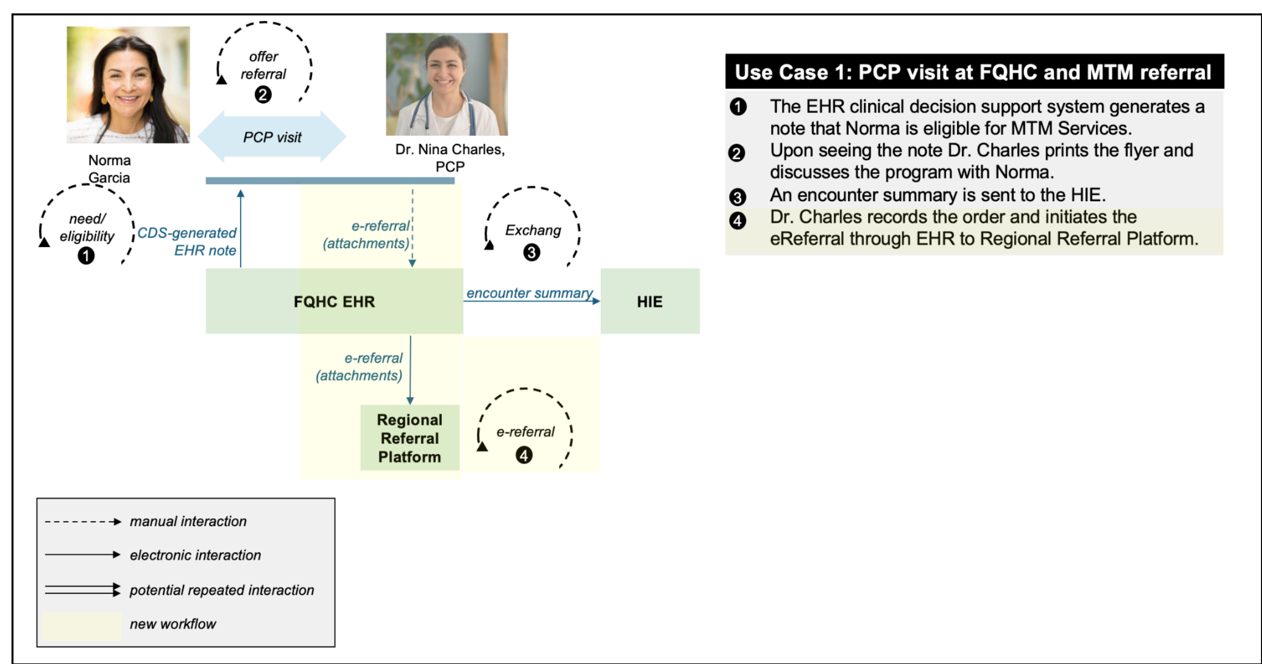
- **Norma** comes in for her follow up for Diabetes care
- **Norma** is already part of Team SOL
- **Norma's** last A1C was > 9 (it was tested in the last 90 days)
- **Current Workflow**:
  - When Norma's PCP, **Dr. Nina Charles** opens the progress note, she sees a note that Norma qualifies for MTM and, upon review of the chart, agrees with the recommendation for her to receive Medically Tailored Meals
  - This happens through a rule in the EHR which automatically creates a note in Norma's record that she qualifies for MTM
    - See below new criteria as of 7/1

Condition	Criteria
Heart Failure	NYHA class 2-4 functional status
Chronic Kidney disease/End stage Renal Disease	Stage 3b,4 or 5 CKD
Asthma/COPD other pulmonary conditions	Asthma: severe persistent; COPD stage 3-4; non-obstructive pulmonary disease of severe or very severe levels
Liver Disease	Cirrhosis or liver failure or any level of Wilson's disease or hemochromatosis
Cancer, Stroke	Karnofsky Performance Status (KPS) of 40-50
Cardiovascular Disorders and hypertension	3 independent BP within past month of > 180/100 on medication
Diabetes	Glycohemoglobin level within the last 3 months > 9
Elevated lead Levels (children)	Lead levels>20 mcg/dl
High Cholesterol/dyslipidemia	Any one of the following in the past 2 months: Total Cholesterol >300, Triglycerides > 1000, LDL>200
HIV infection	Diagnosis of AIDS with CD4<100 and BMI<20
Fatty liver (hepatic steatosis)	MASH, MASH with scarring, or cirrhosis

Malnutrition	BMI<17
Obesity	BMI>40
Stroke	KPS of 40-50
Gastrointestinal Disorders	With anemia or other nutritional micronutrient deficiency
Gestational diabetes or pregnancy with diabetes	Any severity level
High risk perinatal	Pre-pregnancy BMI>30, if has other condition+pregnancy also qualifies*
Chronic or disabling mental/behavioral health disorders	GAF scale less than 50, plus any other condition above, regardless of severity
Other conditions	Require individual Medical Director evaluation and review, to ensure nutritionally sensitive/amenable to MTM intervention

- **Dr. Charles** prints flyer in Spanish for **Norma** describing the benefits of MTM for managing diabetes
    - PCP obtaining consent from a patient to send information to MTM organization is not necessary when MTM organization is a HIPAA covered entity.
- **Dr. Charles** enters “referred for MTM” in the clinical note in the EHR and signs and saves the note
- **Current Workflow:**
    - **Dr. Charles’** EHR sends the encounter note to HIE
- **Current Workflow:**
    - Dr. Charles selects “MTM Referral” which faxes the MTM Referral Form (filled with the data from within the EHR) to the MTM organization via secure fax.
        - Note: In the current workflow, no order is created and several manual steps are needed which is different from all other Order/Referral workflows. The desire is to bring MTM referrals into the same workflow as other referrals that create an order and send a referral via the EHR eReferral protocol.
- **New Proposed Workflow:**
    - **Dr Charles** enters an Order/Referral for MTM into the EHR (using the eReferral module in her EHR which creates an order)
        - There is a checkbox on the Order/Referral for MTM that Dr. Charles selects saying that she has reviewed Norma’s diagnoses and is approving that a standard menu is appropriate. Referral can’t be closed unless this checkbox is checked.

- Once the order is signed it automatically generates a document with the following information: (this is based on the Ceres Referral Authorization Form (RAF))
    - Patient Information
        - First name, last name
        - Cell phone (Petaluma will provide Primary Phone)
        - Home phone (Petaluma will provide Primary phone)
        - Date of Birth
        - Medi-Cal Subscriber ID
        - Preferred language
    - Clinical / Physical Information
        - Height/Weight
        - Allergies
        - Medications
    - Diagnoses Information
        - If A1C include most recent
        - Most recent eGFR, if on file (Petaluma will provide last GFR, if on file)
        - Diagnosis(es)
        - The phrase "The Physician has reviewed the client's diagnoses and medications and approves the client to receive the standard menu."
    - Other Comorbidities - Other medical conditions not listed in Diagnosis(es) above.
    - Referrer Information
        - Provider's affiliation/org
        - Provider's Name
        - Provider's credential
        - Provider's Phone (Petaluma will include the health center phone number)
        - Provider's email (Petaluma will include general health center email)
    - Preferred:
        - Patient email
        - County or city of residence (address would be even better!)
        - Number of Emergency Department visits
        - Number of Hospitalizations
- The completed referral document (containing the above information) is sent to the Regional Referral Platform via the EHR's eReferral workflow where an order is created in the EHR.
    - Assumption: The Regional Referral Platform ingests the referral information using the interface protocol that the FQHC has established through their EHR. (In the case of EPIC, it is an electronic Referral)



Use Case 1: PCP visit at FQHC and MTM referral

Steps for Use Case 1:

1. The EHR clinical decision support system generates a note that Norma is eligible for MTM Services.
2. Upon seeing the note Dr. Charles prints the flyers and discusses the program with Norma.
3. An encounter summary is sent to the HIE.
4. Dr. Charles records the order and initiates the eReferral through EHR to the Regional Referral Platform.

Use Case 2: Authorization of MTM Services

Scene 2A: Referral Received and Reviewed by MTM Organization

New Proposed Workflow:

- The Regional Referral Platform creates a new inquiry for Norma and, upon gathering the name of the organization she is being referred to for MTM from the referral information received, it automatically sends this referral information outbound to the MTM Organization
    - Assumption: The Regional Referral Platform has a pre-established connection to the MTM Service Organization to enable outbound electronic send without manual intervention. (in this case Ceres which has the Apex interface configured via Salesforce).
- MTM Client Referral Coordinator, **Abby Johnson**, receives referral
    - **New Proposed Workflow**:
        - MTM Service Organization Case Management Platform automatically ingests the

Referral form

- In this case Ceres uses Salesforce and the assumption is that they will be using the built-in APEX functionality or Salesforce API

- Referral form automatically populates a new inquiry for Norma in the Case management system.

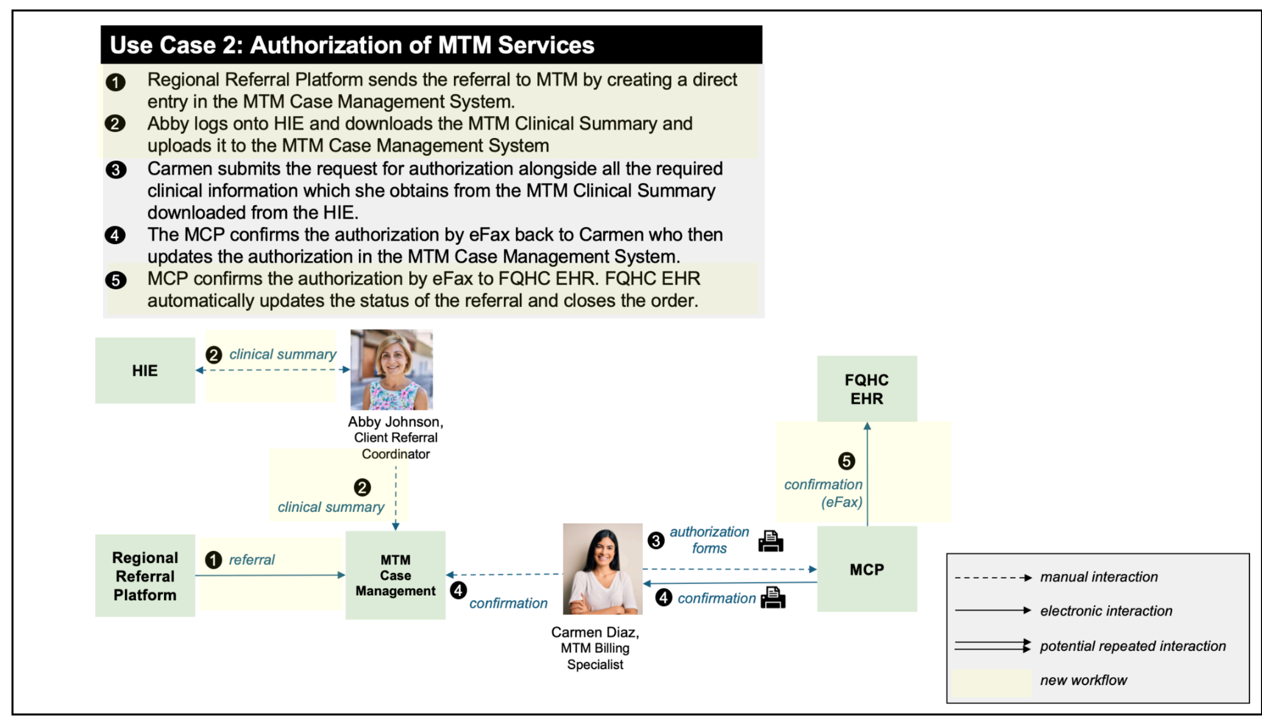
- **New Proposed Workflow**:
    - MTM Service Provider logs onto HIE, navigates to **Norma's** client page and downloads the MTM Clinical Data Summary.
        - This form includes the minimum data necessary to conduct an MTM referral, authorization and intake and ensures that no additional information is disclosed beyond what is necessary.
    - She uploads the form to Norma's record in the Case Management system where it is parsed into discrete fields into the Case Management System
- **Abby** reviews the information sent by FQHC as well as the clinical information from the HIE to determine if the client meets the requirements.
    - If not, she will follow up with the provider to get more information. (ie. CKD stage)

Scene 2B: Request for Authorization sent to MCP

- **Carmen Diaz,** the MTM Billing Specialist, runs a report from within her Case Management system that includes information from Norma's record necessary to complete the Treatment Authorization Request form on the Managed Care Plan's portal.
    - Billing specialist filters report by:
        - Client Status = Active or Scheduled Start Date
        - Insurance Status
        - TAR Status
        - Diagnoses 1 & 2 fields
        - Meal program not equal to Meals for Health or GusNIP
    - Data fields from the Case Management System that are included on the form:
        - Client Start date
        - Menu type
        - Servings
        - Dependent recipient (eliminates billable serving)
        - Caregiver recipient (eliminates billable serving)
- Carmen then logs into the Managed Care Plan's provider portal to verify that Norma is enrolled in Medi-Cal and to make sure she isn't already authorized for a meal service at another organization.
- Carmen completes the MCPs Community Supports Authorization form and Treatment Authorization Request (TAR) form and submits them, along with the MTM Clinical Data Summary Form (that Abby, the client referral coordinator, uploaded into the Case Management system) via the MCPs portal.
- Each day **Carmen** checks the MCP portal for the status of the TAR
    - There is a report she runs daily that will print a list of the clients that the MTM

organization is waiting on authorization response for.

- After 5 days, the MCP has approved services for **Norma** and sends an approval fax to the MTM Service Organization and the FQHC
- **New Proposed Workflow**:
    - The MCP sends a notification of approval via eFax to the FQHC which automatically processes the inbound fax so that the information received closes the open order within the EHR.



Use Case 2: Authorization of MTM Services

Steps for Use Case 2

1. Regional Referral Platform sends the referral to MTM by creating a direct entry in the MTM Case Management System.
2. Abby logs onto HIE and downloads the MTM Clinical Summary and uploads it to the MTM Case Management System.
3. Carmen submits the request for authorization alongside all the required clinical information which she obtains from the MTM Clinical Summary downloaded from the HIE.
4. The MCP confirms the authorization by eFAx back to Carmen who then updates the authorization in the MTM Case Management System.
5. MCP confirms the authorization by eFax to FQHC EHR. FQHC EHR automatically updates the status of the referral and close the order.

Use Case 3: Initial MTM Services Delivered and Extension of MTM Services

Scene 3A: Intake and Service Delivery

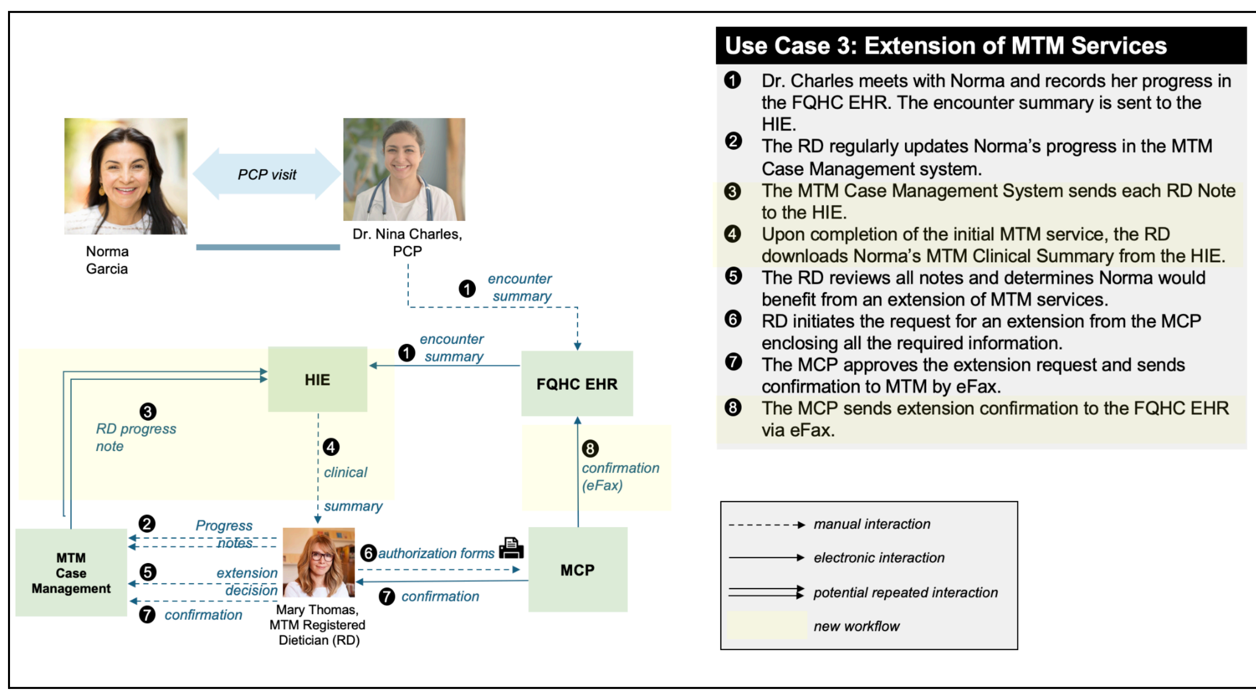
- **New Proposed Workflow**: Prior to making the call to Norma for a full intake, **Silvia Castillo**, MTM Client Care Coordinator, pulls up the Intake Questionnaire which is pre-filled with information from the MTM Clinical Data Summary which was brought in from the HIE in an earlier step.
  - She then reviews the form to verify that Norma has a DX that qualifies her for the services and make sure she has one other condition such as that she is homebound or food insecure or active Medi-Cal or at risk for malnutrition or can't shop or cook
- Silvia calls Norma and:
  - Confirms Norma isn't receiving services from other MTM providers.
  - Confirms Norma's Demographics data
  - Screens to see if Norma is eligible for CalFresh
- Norma's intake screening placed her on a prioritized list for Registered Dietician (RD) outreach;
- The RD**, Mary Thomas,** reaches out to conduct her initial assessment 2 weeks before Nornma's first meal delivery.
- **New Proposed Workflow**: Prior to performing the Initial Assessment, the RD logs into the HIE portal where she reviews Norma's current medications, past medical history, confirmation of DX, etc.
- The RD keys this information into the nutrition record in the MTM Case Management system (nutrition care object)
- **New Proposed Workflow**:
  - The Intake information is automatically sent to the HIE

Scene 3B: Extension of MTM Services

- All throughout the meal delivery, the RD is following up with Norma to monitor her progress.
- **New Proposed Workflow**:
  - Each time the RD charts a progress note in the Case Management system, it is automatically sent to the HIE
- After missing several SOL clinic appointments, and at the urging of the RD, Norma attends her next scheduled visit to the FQHC. **Dr. Nina Charles**, the PCP at the SOL clinic tests her A1C and finds it has come down from 9 to 8.5. She also confirms with Norma that she successfully completed the clinic's Diabetes education course.
- **New Proposed Workflow**;
  - Dr. Charles logs into the HIE to review the RD's notes and see the types of progress being made with the MTM services.
- Dr. Charles makes a note of Norma's progress in her EHR and then signs and saves the note.
- **Current workflow**:
  - **Dr. Charles'** EHR sends the encounter note to HIE

- After Norma's 10th week of meal delivery, the RD makes a note in the MTM Case Management system about Norma's progress so far. She notes that Norma:
    - Was able to start her weekly walking plan
    - Has been consuming 100% of Ceres meals (2 meals per day)
    - Reports eating more vegetables
    - Demonstrated understanding of which foods contain carbs
    - Established next set of goals to
        - Increase activity
        - Additional education about healthy eating, and which foods contain carbs
        - Cooking and sticking to the meal plan more days a week'

- Seeing that Norma has been making progress but has not yet attained her goal of an A1C of 7, the RD decides to request an extension for MTM services for Norma from the MCP.
- New Proposed Workflow: she logs into the HIE in order to obtain information from Norma's PCP at the FQHC where she is being seen for her Diabetes condition.
    - Within the HIE portal, she sees Norma's most recent A1C values as well as the note from the PCP saying that Norma successfully completed a Diabetes education course.
    - She downloads the most recent note from the PCP so she can attach that, along with her own progress summary, to the MCP MTM extension request.
- The RD logs into the MCPs Provider Portal and enters a request for extension of MTM services. The request includes: interventions to date, improvements, and explanation of how additional time would lead to full dietary agency/autonomy where Norma was not able to achieve this in the initial TAR period.



Steps for Use Case 3

1. Dr. Charles meets with Norma and records her progress in the FQHC EHR. The encounter summary is sent to the HIE.
2. The RD regularly updates Norma’s progress in the MTM Case Management System.
3. The MTM Case Management System sends each RD Note to the HIE.
4. Upon completion of the initial MTM service, the RD downloads Norma’s MTM Clinical Summary from the HIE.
5. The RD reviews all notes and determines Norma would benefit from an extension of MTM services.
6. RD initiates the request for an extension from the MCP enclosing all the required information.
7. The MCP approves the extension request and sends confirmation to MTM by eFax.
8. The MCP sends extension confirmation to the FQHC EHR via eFax.

Personas referenced in this document:

Name	Photo	Human Actor	Business Actor	System Actor
Norma Garcia		Patient		
Dr. Nina Charles		PCP at FQHC	FQHC	FQHC EHR
Rita Micheals		Referral Coordinator at FQHC	FQHC	FQHC EHR
Abby Johnson		MTM Client Referral Coordinator	MTM Community Supports Organization	Food Provider Case Management System
Carmen Diaz		MTM Billing Specialist	MTM Community Supports Organization	Food Provider Case Management System
Silvia Castillo		MTM Client Care Coordinator	MTM Community Supports Organization	Food Provider Case Management System

Name	Photo	Human Actor	Business Actor	System Actor
Mary Thomas		MTM Registered Dietician	MTM Community Supports Organization	Food Provider Case Management System