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Introduction

ABOUT THE CAMDEN COALITION OF HEALTH CARE PROVIDERS
The Camden Coalition of Healthcare Providers (Camden Coalition) is a citywide coalition of hospitals, primary care providers, and community representatives committed to elevating the health of patients facing the most complex medical and social challenges. The Coalition is a non-profit organization in Camden, New Jersey, working in the community to improve health and reduce costs. The Coalition innovates and tests health care delivery models to improve patient outcomes and reduce the cost of care using data driven, human-centered practices. Drawing on clinical team experiences with patients, Coalition staff also work to transform health care costs and delivery at the policy level. With over a decade of experience working with vulnerable populations in the city, the Coalition shares learnings with other communities across the nation to help implement and scale the Coalition's philosophies and methods.

INTRODUCTION
In Camden, New Jersey, hospital costs reach more than $108 million every year for its nearly 78,000 residents. Thirty percent of these costs come from just 1 percent of patients. Many of these patients either habitually frequent the emergency rooms (ERs) and hospital inpatient wards for easily treatable conditions or seek care for advanced conditions that could have been prevented if diagnosed and treated earlier.

This pattern is not unique to Camden but common across the country, and it comes with high costs for patients, families, and communities. With growing recognition of this pattern comes an increasing interest in understanding those patients who heavily rely on the emergency rooms and hospital inpatient wards. For these patients, ‘care planning’—the process of identifying their needs, as well as prioritizing, creating and activating a plan to help them become medically and socially stable—is enormously complex work. It is work that we in the emerging field of population health are only beginning to understand.

At the Camden Coalition, care planning historically was completed through a time-intensive, artisanal approach lacking the documentation and methodology required to advance this work with reliability, efficiency, and scale. To progress, the Camden Coalition needed to adopt many of the practices used in the business world—practices such as defining and measuring goals, developing and consistently using tools and processes, and continually assessing progress and making corrections—to tackle complicated operational problems of patient care management. Understanding this need, the Camden Coalition spent the last two years applying business best practices, qualitative methods, and human-centered design approaches to the Camden Coalition's work to define and develop a care planning system for its patient population. This toolkit documents the Camden Coalition's processes and lessons learned in developing its care planning system.

ABOUT THIS TOOLKIT
This toolkit is the culmination of years of working on the frontlines of healthcare delivery with the most complex and vulnerable patients in Camden, New Jersey. Rooted in the principles of harm-reduction, motivational interviewing, and trauma-informed care, the Camden Coalition developed a robust care plan...
system for medically and socially vulnerable patients with frequent hospitalizations. This tool distills key learnings to help care providers create similar systems tailored to their own target population.

The purpose of this toolkit is to help organizations create rigorous and effective care planning systems that expand patient access to the healthcare system, empower patients to become their own advocates, and improve patient health outcomes. In the work that the Camden Coalition undertook to understand and standardize care planning, we focused on our care management activities and the needs of complex patients. This process can also apply to organizations with different services and populations. Aligned with the Coalition's core value of being open source, the primary objective of this toolkit is to share with other sites what the Camden Coalition has learned since its inception of complex care planning.

This toolkit includes 5 modules:

**Module 1: Understanding the Role of Care Planning within Your Organization**
- What is care planning?
- Understanding the current and desired state of care planning

**Module 2: Designing Your Care Planning Framework**
- Defining domains of care
- Understanding and defining patient drivers and interventions

**Module 3: Identifying and Defining Resources in Your Community**
- Assessing and documenting available resources
- Developing protocols

**Module 4: Disseminating and Maintaining Resources**
- Developing an online resource to share and maintain resources
- Training staff, partners and patients to use web-based resources

**Module 5: Creating a Care Plan with a Patient**
- Conducting a needs-assessment
- Resources for creating and executing a mutually-agreed upon care plan

**HOW TO USE THIS TOOLKIT**

The primary audience for this toolkit are organizations looking to design a care planning system. While each module is can be used independently, reading the full toolkit is recommended in order to gain a comprehensive understanding of the process used by the Camden Coalition.

It is important to note that care planning is local, specific, and tailored to the needs of the population being served and the resources available in a particular area. The process by which the Camden Coalition developed a care planning system, however, can be replicated and scaled. The Coalition's key lessons, processes, and tools are described below and artifacts are offered as example where available. It is not recommended, however, to take these documents and use them directly without tailoring to the needs of the
population being served. Additionally, it is worth noting that these are living processes and tools that adapt and evolve as the resources available and needs of the population evolve.

The development of the Camden Coalition's Care Planning system is presented at the beginning of each module in the toolkit as an illustrative case study. After the case study, the essential learnings and components of our process that are transferable to other sites are described.
Module 1

**CAMDEN COALITION CASE STUDY: THE INCEPTION OF THE CARE PLANNING STANDARDIZATION PROCESS**

The Camden Coalition created the Planning & Performance Improvement (P&PI) department to integrate process tracking and analyses, qualitative methods, and human-centered design approaches into the Coalition’s work. These tools, often found in business best practices, would help to improve how the organization functioned internally and externally.

Standardizing care planning was one of the P&PI department’s first projects. The project began with interviews with care team members to understand both the current and desired state of care planning at the organization. The interviews, conducted by P&PI, provided an opportunity to hear directly from leadership and care providers to inform decisions around how to develop a care planning system.

Over a two week period, the P&PI team conducted a series of hour-long semi-structured interviews with a wide variety of members on the Coalition care teams including clinical leadership, nurse managers, licensed practical nurses, community health workers and health coaches. Some interviews were conducted one-on-one and some were conducted as focus groups. Extensive notes were taken during the interviews. These notes were reviewed and synthesized into themes once all interviews were completed.

Interviewees referenced a variety of challenges in the current care planning system. Care team members highlighted that there was ‘no structure and no protocol’ or system for care planning. This resulted in challenges in knowing what work to prioritize with patients, what activities to implement, and what success would look like.

Interviewees expressed a desire for standardized tools and processes to help guide and monitor the care planning process. Specifically interviewees asked for:

- Tools to capture, assign, and monitor care plan activities
- Protocols on how care planning activities are implemented
- Structure for transferring knowledge at handoffs between care team members
- Education materials for the team and patients
- Standard ‘leave behind’ tools for patients

These themes were presented back to interviewees and clinical leadership to check for resonance with experience. The themes served as the basis of the design for the Camden Coalition’s care planning system and the presentation of the themes served as a kick off to initiate the second phase of the project: designing the care planning frame for the organization.
Understanding the Role of Care Planning Within Your Organization

WHAT IS CARE PLANNING?
Individuals with frequent hospitalizations are complex and their health care needs are significant; they may have multiple chronic conditions, take several medications to manage these conditions, experience repeated hospital stays and emergency department visits. Individuals with this level of complexity must regularly navigate a fragmented health and social service delivery systems not designed to meet their needs and often resulting in inappropriate and ineffective care.

As a result of this complexity, care management and coordination interventions are complex. It can be challenging to prioritize where to begin, define fidelity in implementation, track progress, and measure success. Care planning is a process that involves asking and learning about patient needs, helping patients define their priorities, identifying available resources to address their needs, developing a plan, and tracking progress towards achieving these priorities. A care planning system is a set of tools and processes to standardize and facilitate these steps to minimize the complexity.

UNDERSTANDING THE CURRENT AND DESIRED STATE OF CARE PLANNING WITHIN YOUR ORGANIZATION
This module draws on lessons from the Camden Coalition, to describe processes to identify and understand the emerging need within the organization that a care planning system can help address.

Purpose
Key informant interviews are a powerful tool to gather information as they provide an opportunity to talk directly with individuals who can provide insight into the problem being addressed. Interviewing helps to identify emerging need within the organization and build momentum to design a system to address this need.

Outcomes
Interviews with team members will:

• Identify and prioritize current challenges with care planning
• Generate potential solutions to address these challenges
• Ensure buy-in to initiate a care planning process

Process
1. Identify individuals to interview

It is important to select stakeholders who have informed perspectives on care planning within the organization. The number of interviews conducted and individuals interviewed will depend on the size and structure of the care team. In general, select a range of individuals who represent all roles within
the clinical team, including those who provide direct patient care, are responsible for management and oversight; and set vision and direction.

2. Select interview questions

Semi-structured interviews center around an interview guide provide a focus and help ensure the same areas of information are collected across interviewee. Specifically, focusing a set of open ended interview questions around care planning will elicit an understanding of the care planning context in the organization. Customize the questions below to come to a final interview questionnaire.

*Suggested Questions*

- How would you define care planning?
- How would you describe our current care planning process?
- What works well about our current care planning process?
- What important barriers or challenges are you facing in care planning for our patients?
  - in defining and prioritizing activities with patients
  - in tracking activities
  - in transferring knowledge between care providers
- What steps do you think we could take to move toward stronger care planning?

3. Schedule interviews

Interviews are best conducted face-to-face if possible. Suggested length of time for the interview is 30-45 minutes.

Contact interviewees by phone or email ahead of time to introduce the purpose of the interview, schedule a time and place to meet, and answer any questions interviewees may have. Inform the interviewee that their daily experience is all the preparation they will need for the interview. The interviewer should decide whether or not to share interview questions in advance.

4. Conduct Interviews

*Prior to the interview:*

Interviewer should allow some time for quiet preparation and reflection to review the interview questions. Gather necessary supplies for the interview: interview questionnaire, a paper and pen or computer to take notes.

*During the interview:*

Re-introduce the purpose of the interview. To encourage interviewees to speak freely, assure them that what they share is confidential and they will not be identified with any information that is shared. If it is a group discussion, ask that the identities of the participants and information shared by the group stay within the group.

The purpose of the interview is to elicit the interviewee's perspective; listen deeply to the interviewee with an open mind and neutral attitude. It is important to take notes reporting on what the interviewee states or does, resist the urge at this stage to interpret what the interviewee is saying. The interviewer's perspective on the topic should be invisible, otherwise it could influence
what the interviewee shares. The interviewer should listen and encourage interviewees to elaborate without expressing approval, disapproval, judgement or bias. Use the interview questionnaire as a guide; feel free to deviate as necessary and ask questions that arise spontaneously.

At the end of the interview:
Thank the interviewee for their time and leave time to answer any questions the interviewee may have.

After the interview:
Immediately after the interview take time to finalize notes and capture key thoughts. In the days following take time to reflect on the key insights that were gained during the interview.

5. Synthesize and share the interview data

Once all interviews have been completed, the process of reviewing, theming and synthesizing the notes begins. This process, outlined below, helps make sense of the interviews, transforming a series of interview notes to understanding, interpretation, and explanation in the form of themes. Form a team of collaborators to work through this process.

Reading & Extracting

Read and re-read all interview notes to identify key points and useful information. There is no set formula for this process, it involves sifting through the interview notes and taking note of different ideas and responses that were heard throughout the interviews. Pull out key points in the form of
words or phrases used by the interviewee, rephrased points or facts. Record each key point on a separate sticky note. Take note of all the different ideas that were heard in the interviews.

**Theming**

Visually arrange key point sticky notes to identify patterns across interviews. To do this, read the first key point and place it on a clear wall to start a cluster. Review the second key point - if it is similar in meaning to the first place it in proximity, otherwise place it apart and start a new theme. Repeat this pattern until all key points are on the wall. Discuss and regroup as necessary so all similar key points are clustered in proximity to each other.

**Summarizing**

Review and discuss the clusters of information. Talk about why each grouping is important and what it means. Label the cluster with a word or theme that it represents. Articulate the insights that emerged from the themes in one or two simple statements.

**Sharing**

Develop a PowerPoint or document that brings together the key insight statements. Present this information to individuals who were not involved in the process. Give them context, describe the insight, and get their reactions. Ask them, “Do these insights resonate with what you are experiencing?” “What insights, if any, surprised you?” The insights from this process will inform the care planning framework and system moving forward.
CAMDEN COALITION CASE STUDY: DEFINING THE COALITION’S CARE DOMAINS

The interview themes confirmed that there was both an emerging need and desire for standard tools and structures for care planning within the Camden Coalition. It was clear that clinical team members were spending a large portion of their time ‘re-inventing the wheel’ with each patient when there were many aspects of care planning common across patients that could be standardized as such a more systemized approach was needed.

To begin the process of defining and developing standard structures and tools for care planning, the clinical leadership met to determine the core areas of work where clinical staff excelled and aspirational areas where the team wanted to improve. All activities and work that clinical teams currently did or would like to do for or on behalf of patients were listed. As patterns and themes emerged, the list of activities was further refined to similar groupings which were then reviewed by frontline clinical and other organizational staff.

The following fourteen core areas of work were identified as the Camden Coalition's domains of care, including a domain of “Patient-Specific Wildcard” to capture new and emergent activities that did not fit into existing domains of care.

- Addiction
- Advocacy and Activism
- Benefits and Entitlements
- Education and Employment Connection
- Family, Personal, Peer Support
- Food and Nutrition Support
- Health Maintenance, Management, and Promotion
- Housing and Environment
- Identification Support
- Legal Assistance
- Medication and Medical Supplies
- Mental Health Support
- Provider Relationship Building
- Transportation Support

After initial domains were identified, a core team of Coalition staff held weekly work sessions for an extended period of time to define patient drivers and needs that would lead a care team member to work within a particular domain and strategic action steps that could be implemented to address the patient needs (Appendix 1-Example Camden Coalition Domain Overview Document-Food and Nutrition).
Designing Your Care Planning Framework

This module draws on lessons from the Camden Coalition to describe the steps in defining a care planning framework, including: (1) identifying and defining the domains of care, (2) the needs of the patient population served, and (3) strategic action steps that can be implemented to address these needs.

IDENTIFYING YOUR ORGANIZATION'S DOMAINS OF CARE

Purpose

Given the complexity of individuals with frequent hospitalizations and the plethora of activities that may be required to address their health and social service needs, it can be difficult to know or identify core areas of work and activities. This can result in ambiguity and varying quality in implementation for patients. An initial step in providing clarity is identifying the organization’s “domains of care” or the core areas of work.

Outcomes

Identifying the organization’s domains of care will:

- Provide clarity on the core elements of the organization's care model
- Provides focus to develop specific protocols

Process

1. **Form a brainstorming team**
   
   Assemble a small team of collaborators (2-4) who have in-depth knowledge of the population served and the services offered. Mix stakeholders to include both leadership and direct service delivery staff. Choose a facilitator to guide the group through this process.

2. **Brainstorm Pre-Work**
   
   Prior to the brainstorm, ask the team to reflect on and informally interview others to gather a list of activities done with or on behalf of the patient population. Ask the team to come to the brainstorm with their pre-work and remind them to not bring cell phones, computers, and other possible distractions. Secure a space with plenty of wall space and conducive to brainstorming.

3. **Brainstorm a list of activities**
   
   Ask a team member to describe one activity they work on with or on behalf of the patients in the intervention. The facilitator will record the activity on a sticky note. Repeat with the next team member. Continue going around the room naming activities until there are no more activities to be named. Think broadly of all activities.

4. **Visually arrange activities in an orderly way**
   
   After creating an exhaustive list of activities the facilitator will lead the group through a clustering activity to visually group activities according to similarity. The facilitator will ask one person to describe and then place one of the activity sticky notes on the wall. The facilitator will then ask collaborators to place similar items in proximity to the first activity note to form a cluster. When
there is a dis-similar activity, start a new cluster. Repeat this pattern until all activity notes are a part of a cluster on the wall.

Pause, read the wall, reflect and regroup activities as necessary so all similar activities are clustered in proximity to each other.

5. **Label Domains of Care**

Next review and discuss the clusters of activities as a group. These groupings are the organization’s initial domains of care. Talk about why each grouping of activities is important and what it means. The clusters of activities may group around types of areas of need for the patient, such as legal support or food and nutrition. Select a word or phrase that summarizes the grouping and label the clusters with that word or phrase. Once this is completed stop for the day. Take a picture and share with the collaborators. Ask the collaborators to reflect on the groupings for a couple days and determine the following: are these the right groupings? What is missing? What is in the wrong place? What is mis-labeled? Re-convene as a group to discuss reflections, add activities, regroup and re-label activities as necessary until the group arrives at a final draft of the domains of care.

6. **Share groupings with stakeholders not involved in the brainstorming process**

Develop a document that summarizes the domains of care. Present this information to individuals who were not involved in the process. Provide context, describe the domains, and get reactions. Ask
stakeholders: “Do these domains resonate with what you are experiencing?” “What domains, if any, seem to be missing?” Reconcile the insight from stakeholders to finalize the domains of care.

DEFINING DOMAINS, PATIENT DRIVERS AND INTERVENTIONS

Purpose
Many activities involved in care planning for individuals with frequent hospitalizations can be broken down into components: domains, patient drivers, and interventions. Developing a roadmap of these components to guide care teams turns complexity and ambiguity into steps that can be routinized, taught, and implemented with fidelity.

Outcomes
Defining the organization’s domains of care, patient drivers, and interventions will:

- Provide a framework for care planning within the organization
- Identify and document resources and interventions available to address patient needs
- Empower team members to make decisions independently
- Increase efficiency and fidelity in implementing interventions

Process
1. Form a core design team
   
   Assemble a broad set of stakeholders with complementary competencies and experiences to co-create the care planning framework. It is important that this core team reflect the diverse players that the system will serve: clinical leadership, direct care delivery staff, and operations/management staff. Choose a facilitator(s) to guide the group through the design process. Ideally facilitator(s) will not be involved in direct care delivery to provide an outside perspective. It is important that the core team make developing the care planning framework a priority.

2. Establish supporting infrastructure
   
   As initial business, the core team will establish their supporting infrastructure for developing the care planning system prototype, including:

   - Recurring worksessions: schedule a series of weekly work sessions
   - Creative space: reserve a space for the work sessions that helps the team focus with minimal distractions; set ground rules that team members provide full attention during work sessions.
   - Timeline: Develop a tight timeline with milestones that propels the team to develop and quickly refine early prototypes. Define milestones by domain completion and map milestones to work sessions. Aim to complete 2-3 domains at a time over a series of 3 worksessions. A sample timeline is below:
     - Work Session 1: Initiate Domain 1&2
     - Work Session 2: Review Domain 1&2
     - Work Session 3: Finalize Domain 1&2; Initiate Domain 3&4
3. Hold a Kick Off Meeting

Prior to the first work session, hold a kick off meeting with the design team to signify that this phase of the project has begun and ensure everyone has a common understanding of the project goals. The facilitator will share everything that has been learned so far and then describe the purpose of the team which is to define and codify the care planning framework for the organization including domains, patient drivers, and interventions.

- Domain Definition: A concise overview describing the purpose and objective of the domain. For example:

  * Housing and Environment Support: Assess patient’s living conditions and work to address immediate issues with safety and/or stability. Connect patient to resources that improve safety and/or long-term housing stability. Approach patient with unconditional positive regard.

- Patient Driving Diagnosis: A description of needs, problems, motivations and desires from a patient’s perspective that would indicate a care provider would work within a particular domain, for example:

  * Housing and Environment Support:
    - Patient does not have housing
    - Patient cannot afford current housing
    - Patient lacks clothing, furniture, or utensils
    - Patient housing has safety and/or environmental issues
    - Patient cannot afford utility bills

- Intervention: Description of interventions that can be implemented to address a particular driving diagnosis, for example:

  * Patient does not have housing
    - Connect patient to housing funding sources
    - Connect patient to emergency or interim housing
    - Connect patient to permanent housing options
    - Connect patient to advocacy and human services organizations
  
  * Patient cannot afford current housing
    - Connect patient to rent/mortgage assistance programs
    - Connect patient to financial counseling organizations
    - Connect patient to supplemental income programs

As a later step, resources available to complete each intervention and protocols on implementing the intervention will be developed (Module 3).

4. Design, Define and Iterate
In the recurring work sessions the core team will work domain by domain to develop overview documents that define the patient drivers and intervention frameworks for each domain; the process is described below.

Prior to Work session 1: Team members will reflect on and interview care providers in the organization around the domain(s) that are the focus of the session. In particular ask team members to reflect on:

- Patients whom you have worked with in the particular domain
- What these patients said or did to lead you to identify that domain as an area of need
- What actions you took or resources you leveraged to address the patient’s needs

Team members will take notes on reflections and come prepared to share.

Work Session 1: The purpose of work session 1 is to synthesize team members experiences and observations on a particular domain into patient drivers and interventions. To begin the facilitator will create an empathy map\(^1\) similar to the one below for the first domain.

The facilitator will ask team members to share their reflections and observations in the form of needs and action:

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• **NEEDS:** What did your patients say or do to lead you to identify the _____ domain as an area of need?
  - **SAY:** What are some quotes and defining words your patient said?
  - **DO:** What actions or behaviors did you notice?
  - **THINK:** What did the patient’s words or actions lead you to believe they might be thinking?
  - **FEEL:** What did your patient’s words or actions lead you to believe they might be feeling?
• **ACTION:** What actions did you take or resources did you leverage to address your patient’s needs?

The facilitator will capture observations on sticky notes and place them on the insight to action map. Continue to share and compare experiences until an exhaustive list of insights and actions for the domain are mapped. Once complete, move on to the next domain.

**After Work Session 1:** The facilitator(s) will use the hour immediately after the session to capture what was learned. Use the clustering method described in Module 2 visually arrange needs by similarity and define them with a “Patient Driving Diagnosis” label and to group actions by similarity and define them with an “Intervention” label. Look across the patient drivers and interventions to identify the overarching theme to develop the domain definition (Appendix 1-Example Camden Coalition Domain Overview Document-Food and Nutrition). Prior to Work Session 2 prepare a domain overview document for each domain covered in Work Session 1. The domain document will identify the domain definition and map patient drivers and interventions covered in the domain.
WORK SESSION 2: The purpose of work session 2 is to review and provide feedback on the domain overview document for all domains completed in work session 1. Facilitator(s) will distribute domain overview documents for all domains completed in the prior work session. Provide time for the team to read and review the domains. After reading, discuss each domain as a group and capture feedback. Discuss the domain definition, patient drivers and interventions. Identify drivers or interventions that are missing, mis-represented, or conceptually in the wrong domain. Try to avoid using this time to wordsmith. Come to consensus before moving onto the next domain.

AFTER WORK SESSION 2: Facilitator(s) will incorporate changes and edits based on the work session into the domain overview documents and circulate for review. Provide a deadline prior to the next work session for additional feedback. This is the time to provide wordsmith edits. Facilitator(s) will resolve and incorporate feedback prior to the next work session.

WORK SESSION 3: The purpose of this work session is to review, approve and finalize the updated domain overview documents. The facilitator(s) will distribute the updated domain overview documents. Provide time for the team to read and review the domains. Discuss as a group and make any final modifications. Once completed, initiate the next round of domains following the same process described above. Please note, these are living documents that will evolve as patient needs and available resources evolve.

REPEAT: Continue to repeat the process above until all domains are documented.
Module 3

CAMDEN COALITION CASE STUDY: IDENTIFYING AND DEFINING RESOURCES USED BY THE COALITION CARE TEAM

The P&PI department hired a former Americorp Health Coach to coordinate the care planning project. Health Coaches at the Camden Coalition are recent college graduates who are interested in healthcare, and work on the care teams collaborating closely with clinical staff to provide care coordination for patients. After the service year, health coaches gain a strong understanding of our organization, clinical workflows, patients, and community resources.

The care planning project coordinator investigated and verified the available resources to address patient needs within each domain of care through interviews with clinical staff, online research, attendance at community meetings, and phone calling to ensure identification and documentation of all resources in the community. Protocols outlining the process of helping patients to access and use resources for each care domain were drafted and reviewed by appropriate staff members. This process took approximately eight months for the care planning project coordinator who worked full-time on the project.

Identifying and Defining Resources in Your Community

This module describes the process for identifying available resources within the team and community, and developing protocols to standardize care delivery.

Purpose

Identifying resources and writing step-by-step protocols on how to access a resource or provide a particular service creates a standardized approach to care delivery. Establishing these standards improves productivity, efficiency, and effectiveness.

Outcomes

Codifying resources and processes in the form of protocols:

- Standardizes processes across care providers
- Enhances efficiency and ability to delegate tasks to other staff
- Ensures best practices remain with patient when care providers leave
- Creates a robust collection of resources that can be shared with external partners

Process

1. Select personnel to lead the work

The ideal individual is someone who is familiar with your organization's work, has clinical experience, and is interested in process improvement. This individual will need skills in project management and
research as well as an ability to work with clinical staff to understand their workflows and the needs of the patient population.

2. Identify resources available to complete each intervention

Conduct a multifaceted search of available resources within the team or community to address all patient drivers and interventions within a particular domain. Identify clinical staff within the organization who are knowledgeable about the resources in a particular domain. Gather information from these domain experts through surveys, focus groups, or personal interview. Identify additional resources through online research and attendance at community meetings. Collate resources identified into the domain overview document. Identify one domain expert to review the resources, confirm that the correct resources are included and identify any additional resources that may be missing. Gather feedback through track-changes in a Word document or in-person review.

Repeat this process for each subsequent domain until all domains have a comprehensive list of resources mapped to interventions (Appendix 1-Example Camden Coalition Domain Overview Document-Food and Nutrition).

3. Draft preliminary protocol

For each resource within each domain, document the detailed steps necessary to complete the activity. Create a template that can be applied to every resource, standardizing where and how information is stored so that staff can quickly find the information they need (Appendix 2-Example Protocol in the Food and Nutrition Domain: Accompany Pt in Obtaining NJ SNAP).

To complete the protocol for a particular resource, conduct online research to gather all details; imagine every step in the referral or coordination process:

- What should a care provider know about a particular resource before beginning the process?
- What are the eligibility requirements?
- What information and documents are needed to determine eligibility?
- What are the steps to apply for a particular service or resource?
- What is the contact information, services offered, and hours of operation?
- What are the logistics of traveling to and enrolling in a program?

4. Verify protocol elements

After drafting the protocol, contact the resource to verify the protocol is correct, as organizations may change services and requirements more frequently than they update their websites. Create a standard script for verifying information to increase efficiency and consistency in validation. An example phone script for a food resource is below:

“Hi, my name is ______ and I’m calling from ______. We do case management for patients here in _________. We are trying to compile a list of food pantry locations in _____ to help our patients who may have difficulty accessing proper nutrition, which is critical to improving their health.”
• Do you mind if we ask couple questions about your food pantry services?
• What type of food is available?
• What identification/documentation is required to access the services?
• What is the location of the service?
• What are your hours of operation?
• Is this the right phone number to call in case of questions?"

5. Repeat steps 3 and 4 until protocols are drafted for all resources within a particular domain

6. Review protocol content with domain experts

Review the domain protocols with the identified clinical staff who are most knowledgeable of the resources in that particular domain. This ensures that the knowledge from their experience working with patients and accessing resources is aligned with the information the resource has provided. Ask domain experts to provide feedback on protocol content. Tailor the feedback format to the domain experts’ availability and preference. Feedback can be gathered through focus groups, one-on one meetings, or through email using the “track changes” feature in Microsoft Word.
7. Finalize protocol

To finalize protocols, identify an individual outside of the care planning project to copy-edit. Copy-edit the protocols in batches to look for consistency across. Create a checklist of items to check while reviewing. This will streamline the task, increase efficiency and standardize the process. Include the following in the checklist:

Check for:

- uniform formatting
- clear language
- spelling/grammar errors, including consistent punctuation
- complete and consistently listed contact information for resources
- hyperlink accuracy

8. Repeat steps 6 and 7 until all protocols for a particular domains are reviewed and finalized. Repeat the process for all domains.
Module 4

CAMDEN COALITION CASE STUDY: DEVELOPING AN ONLINE PLATFORM TO SHARE AND DISSEMINATE CARE PLANNING RESOURCES

Because of the vast amount of information in the Camden Coalition’s care planning resource library, the clinical staff needed a portable way to access and share this information. Putting the information online allowed for user-friendly access not only by care coordination staff, but also by providers, patients, and the patient’s support systems. Additionally, online resources could easily be updated and disseminated to reflect the most current information.

The Camden Coalition’s original online platform was Google Drive—a free, flexible structure that provided customizable web-based access to the care planning resources. Early release of the information in a lean platform allowed Coalition staff to evaluate the care plan domains and protocols in practice and evaluate elements necessary for an online platform.

In order to share these modules more widely with providers, community partners, and patients, the Camden Coalition determined that they needed a robust online platform that would easily facilitate the sharing and editing of the protocols. The Camden Coalition evaluated vendors for ease of use, cost effectiveness, and open-source philosophy. Several vendors were interviewed, quotes were solicited for the scope of work, and demos and trials were pursued to select the most appropriate platform for the organization.

After reviewing and testing several vendors, the Camden Coalition selected Aunt Bertha, a public benefit organization with an online platform that connects people to services. Identifying a vendor took longer than anticipated. However, the Coalition was ultimately able to identify a vendor that was compatible with Coalition philosophies and willing to customize their product to move with the Camden Coalition intervention. Aunt Bertha worked with the Camden Coalition to co-design a care planning resource library and workflow system that aligned with the Coalition’s care planning process. Aunt Bertha interviewed Coalition clinical staff to understand their needs and develop a product to address those needs. The Coalition and Aunt Bertha met weekly to review the prototype, validate site functionality and flow, and conduct usability testing with clinical staff. The soft launch of the online care planning system was released in February 2016 internally to Coalition staff. The Coalition and Aunt Bertha are in ongoing partnership to enhance and evolve the system to meet the needs of the Camden Coalition clinical team and the community.

Disseminating and Maintaining Resources

This module defines the essentials of developing a care planning resource library to maintain and disseminate codified care planning materials. A care planning resource library is a centralized place to store and share the catalog of available resources and protocols.
Purpose
Due to the vast amount of information in the care planning system, the care planning resource library needs to live in a portable, user-friendly, easy to access and share platform. Additionally, the platform needs to be easily edited and updated to reflect and disseminate the most current information.

Outcomes
Establishing a portable, online care planning resource library will:

- Allow staff to easily access and share information
- Provide a mechanism to easily edit and update information
- Provide a structure for version control to ensure only the most up to date information is being used

Process
1. Assess needs for an online care planning resource library

Factors to consider when determining the need for an online system include:

- amount of information in the resource library
- how and where staff will access information in the resource library
- how frequently resources change, and updating requirements
- time and resources available to dedicate to an online resource library

2. Develop and test a prototype for web-based access

As an early prototype, place the care planning resources in a free, easy-to-edit online platform such as Google Drive or Github. These platforms are free, flexible, easy to use and accessible through mobile devices. They allow for an early launch of the library to test workflow and get feedback from staff. Enlist internal staff as well as outside partners to validate and beta-test the care planning modules as well as evaluate the effectiveness and usability of the prototype platform.

Consider the following survey questions as a tool to assess care planning modules and online platform:

- How often do you use the care planning modules? (more than once a day, daily, a few times a week, once a week, less than once a week, never).
- What device do you use most often to access the care planning modules? (laptop, iPad, phone, other device).
- Where are you located when you access the care planning modules, select all that apply: (office, home visits, hospital, community, while driving, etc.)
- Please rate the ease of navigation of the care planning modules (very easy, easy, somewhat difficult, difficult).
- Please rate the use of protocols in connecting clients to resources (very easy, easy, somewhat difficult, difficult).
- What do you like about the care planning resource library?
3. Evaluate and decide if a fee-based vendor is necessary

After developing and testing the early prototype for web-based access, decide if a fee-based vendor is necessary to host the care planning resources. Weigh the costs and benefits: an online vendor will provide a more robust, easy to use platform that is shareable and scalable, however, it will be more expensive than a free system and identifying and working with a vendor may present unanticipated challenges.

4. Identify, evaluate and select a vendor

If a more robust online system is desired, look for a vendor to host and maintain the care planning resource library. This will involve testing the early web-based platform and analyzing feedback from staff to identify essential features. Identify, research and talk with a series of potential technical partners. Use demo’s and trial periods to assess potential vendors. Select criteria to evaluate potential vendors. Criteria to consider are web-based, mobile enabled, ability to customize, ease of access, app functionality, security features, usability, cost, and aesthetics. In addition to these features, evaluate potential partners on their values and guiding principles. Selecting a partner with aligned values may lead to more flexibility in customization.
Module 5

CAMDEN COALITION CASE STUDY: CREATING A CARE PLAN WITH A PATIENT

After the patient is enrolled in the Camden Coalition's care intervention, a social worker or nurse will conduct an intake with validated survey questions that solicit patient needs within our 14 care planning domains. These surveys include the Centers for Disease Control and Prevention’s Healthy Days Measure, The Suicide Behaviors Questionnaire-Revised (SBQ-R) Suicide Screen, The Patient Health Questionnaire for Depression and Anxiety (PHQ-4), and the National Institute on Drug Abuse (NIDA) Substance Abuse Screen (Appendix 3- Camden Coalition Enrollment Intake Paperwork).

The Camden Coalition works with “high-utilizer” patients who are frequently hospitalized for complications related to multiple chronic illnesses. Our patients therefore indicate needs in several domains of care at enrollment. It can be overwhelming or not feasible to address each domain immediately, and we therefore use a backwards planning activity—a process where the patient identifies health goals and we work backwards to create a plan to reach those goals—to help patients prioritize multiple social or health conditions. The Camden Coalition uses backwards planning cards and board to assist patients in mapping their health and social priorities. The backwards planning activity involves Domain Cards, which lists the fourteen care planning domains on the front and activities within those domains on the back. The language on these domain cards was modified from its original state in the care planning resource library so that it was more accessible to patients. Staff cut out the cards and read through each one with the patient, using the activities listed on the back as conversation prompts, to determine which domains that patient is most interested in addressing. The patient indicates the prioritization of that domain by placing the card on the backwards planning Board, which is divided into the following categories: “Need to work on-Right now”; “Need to work on-Later”; and “Don’t need to work on.” (Appendix 4-Backwards Planning Board and Appendix 5-Backwards Planning Card Deck).

The information obtained in the needs-assessment and the patient's identified health priorities is incorporated into a care plan that contains strategic next action steps and a timeline for completing those steps. Resources related to the patient’s needs are identified in care planning resource library and noted in the care plan. The care plan is stored in a secure, online platform that all staff have access to and that can be easily updated at weekly care planning meetings.

Patients are enrolled in the Camden Coalition’s intervention for sixty to ninety days, and clinical staff meet once a week with the patient to move the care plan forward. Clinical teams also meet without the patient to update the care plan and discuss emergent issues with other team members for advice.
While there are no predetermined criteria that determine if a patient is ready for graduation, Coalition staff assess if the patient can navigate the healthcare system and effectively advocate for themselves. Camden Coalition staff also determine if the patient has met their health goals that emerged from the backwards planning process and if they are connected to resources in the community that can further help and support them in problem-solving through emergent health issues. The essentials of Patient Graduation have been codified by the Camden Coalition staff in webinar on Adobe Connect.

Once the readiness of graduation is mutually agreed on by the staff and the patient, Camden Coalition staff conduct a warm hand off with the primary care provider, who can regularly check-in with the patient to ensure that they are continuing to manage their chronic conditions. Camden Coalition staff have culminated details of the primary care handoff in the Handoff to Primary Care module on Adobe Connect.

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3 “Handoff to Primary Care,” Camden Coalition of Healthcare Providers, https://cchp.adobeconnect.com/p3y9e1e2tn/?launcher=false&fcsContent=true&pbMode=normal
Creating a Care Plan with a Patient

After understanding and systematizing care planning for your organization, you can apply what you have learned to creating and delivering a care plan for a patient. This process helps staff rank competing priorities in care planning and allows patients to identify the health goals they would like address.

The case study illustrated above describes the Camden Coalition’s process for creating and delivering a care plan. The Camden Coalition honed in on this process through learned experience and years of providing health care on the frontlines of Camden, New Jersey. While each organization, region or population may have unique circumstances, we hope our learnings can provide guidelines to help you develop your own care planning process. If your organization would like more information about the Camden Coalition’s care planning process, or assistance in developing your care management program, please visit the Healthcare Hotspotting website (http://hotspotting.camdenhealth.org/).
Epilogue

This toolkit is built on the lessons learned from the Camden Coalition’s process of understanding and systematizing care planning. It provides a framework for other organizations to understand their emerging needs and to create a care planning system customized to their organization and patient population. After reading this toolkit, organizations should be able to:

- Understand the need for care planning within the organization
- Define the core areas of work within the organization
- Design a care planning framework
- Identify and document available resources available to address patient needs
- Disseminate and maintain a robust collection of resources

LOOK AHEAD

Care planning is a living process which requires intentional change. Continue to look ahead towards new opportunities to improve the resource library and share resources with other communities conducting similar work.

We encourage you to apply these modules and bring enhanced scale, efficiency and capacity to care planning at your organization.
References

The Camden Coalition’s work in developing a care planning resource library and system was informed by the following resources that use best practices in qualitative research and human centered design:


Appendix 1

Example Camden Coalition Domain Overview Document-Food and Nutrition
**Domain: Food and Nutrition (FN)**

**Objective:** Assist patient to gain immediate access to food, and connect patient to a sustainable support to receive long term access to food. Communicate and teach concepts related to healthy food choices. Approach patient with unconditional positive regard.

<table>
<thead>
<tr>
<th>Patient Driving Diagnosis</th>
<th>Intervention</th>
<th>Description</th>
<th>Type of Resource</th>
<th>Documents Required</th>
<th>Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pt. Lacks Access to Food</strong></td>
<td><strong>FN1: Connect Patient to Immediate Food Source</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>FN1.1</td>
<td>Connect Pt to Cathedral Kitchen</td>
<td>Provides hot meals: entrée, side dishes, bread, dessert and beverage, and space to eat/take out. 1514 Federal Street, Camden, NJ 08105 (856) 964-6771</td>
<td>Soup Kitchen</td>
<td>None</td>
<td>Mon-Fri: 4-5 PM (Dinner) Sat: 12-1 PM (Lunch)</td>
</tr>
<tr>
<td>FN1.2</td>
<td>Connect Pt to New Visions Homeless Day Shelter</td>
<td>Homeless Day Shelter. Provides both soup kitchen food and food bags for end of the month emergencies. 523 Steven Street, Camden, NJ 08102 (856) 963-0857</td>
<td>Soup Kitchen &amp; Pantry</td>
<td>For Emergency Food Bag Only, ID, Proof of Camden County Residency, SNAP</td>
<td>Pantry Mon-Fri: 8:30-3:30. Kitchen Mon-Fri 9:30-10:15 breakfast &amp; 12:30-1:15 lunch. Emergency Food Bag after 15th of the month 10AM-12PM</td>
</tr>
<tr>
<td>FN1.3</td>
<td>Enroll Pt. in Cathedral of Immaculate Conception Food Program</td>
<td>The parish of the Cathedral of the Immaculate Conception, the Mother Church of the Diocese of Camden provides free food as soup kitchen. On the corner of Broadway and Federal street. Sandwiches and Soup given out through the window. Also provides food baskets. Enrollment Required. 642 Market Street, Camden, NJ 08102 (856) 964-1580</td>
<td>Soup Kitchen</td>
<td>Only for food basket – SNAP card and ID</td>
<td>Mon- Fri 10AM-12PM Food Baskets on 3rd Tues of the month</td>
</tr>
<tr>
<td>FN1.4</td>
<td>Connect Pt. to St. Paul’s Episcopal Church</td>
<td>Provides food pantry service as well as breakfast and dinner soup kitchen. Known around the area as the ‘pancake house.’ 422 Market Street, Camden, NJ 08102 (856) 365 – 2664</td>
<td>Soup Kitchen &amp; Pantry</td>
<td>For Food pantry: ID. Nothing required for Soup Kitchen</td>
<td>Pantry Fri 8AM – 11AM (start lining up at 7AM) Kitchen Sun breakfast 8:30AM-10AM, supper 7PM – 9PM</td>
</tr>
<tr>
<td>FN1.5</td>
<td>Connect Pt. to Parkside U.M. Church</td>
<td>United Methodist Church runs soup kitchen and pantry. 1420 Kaighn Avenue, Camden, NJ 08103 (856)541-3153</td>
<td>Soup Kitchen &amp; Pantry</td>
<td>ID, Proof of Camden County Residence</td>
<td>Mon 5PM – 7PM &amp; Wed 11AM – 12PM</td>
</tr>
<tr>
<td>FN1.6</td>
<td>Connect Pt. to Neighborhood Center</td>
<td>Different food every week. Call ahead for emergency food. 278 Kaighn Avenue, Camden, NJ 08103 (856) 365-5295</td>
<td>Soup Kitchen &amp; Pantry</td>
<td>ID &amp; Proof of Camden County Residency</td>
<td>Mon-Fri 1:30 – 3PM Serve lunch from 12 - 1pm (Mon-Sat) Sun: lunch from 1-2 pm Tues, Thurs give out pantry food between 1PM – 2PM</td>
</tr>
<tr>
<td>FN1.7</td>
<td>Enroll Pt. into St. Joseph’s Pro Cathedral Food Program</td>
<td>St. Joseph’s Pro Cathedral provides food pantry service for residents within certain zip codes. Provides non-perishables foods. Enrollment Required. 2907 Federal Street, Camden, NJ 08105 (856) 964-1269</td>
<td>Pantry</td>
<td>Picture ID, Proof of Address (08105,08109,08110), Proof of Income, and Proof of Family Size</td>
<td>Every Tue 9AM – 12PM &amp; 1PM – 3PM Every Thurs. 9AM – 12PM</td>
</tr>
<tr>
<td>FN1.8</td>
<td>Connect Pt to Antioch Baptist Church</td>
<td>Normal food pantry, but also provides Four $5 vouchers (per season) for use at Farmer’s Market while in season only for seniors (60+). Apply in person. 690 Ferry Avenue, Camden, NJ 08104 (856) 966-1765</td>
<td>Pantry</td>
<td>3rd Tue 11AM - 1PM</td>
<td></td>
</tr>
<tr>
<td>FN1.9</td>
<td>Connect Pt. to Ferry Avenue U.M. Church</td>
<td>Food pantry service with non-perishables and fresh food available depending on the week. 768 Ferry Avenue, Camden, NJ 08104 (856) 541-0449</td>
<td>Pantry</td>
<td>ID with Address (first time no ID is ok), not limited to people in the city</td>
<td>Every Tue 2:30pm - 3:30pm (sometimes until 4pm)</td>
</tr>
<tr>
<td>FN1.10</td>
<td>Connect Pt. to Hope Community Outreach Services, Inc.</td>
<td>Human services rights organization with food pantry service. 1299 Morton Street, Camden, NJ 08104 (609) 932-4600</td>
<td>Pantry</td>
<td>Proof of Income, Proof of Address</td>
<td>2nd or 3rd Sat 12 PM – 3 PM</td>
</tr>
<tr>
<td>FN1.11</td>
<td>Connect Pt. to Koinonia Family Life, Inc.</td>
<td>Human services rights organization with food pantry service. 1658 Mt. Ephraim Avenue, Camden, NJ 08104 (856)757-4899</td>
<td>Pantry</td>
<td>Enrollment required, proof of address, income, photo ID, documents to</td>
<td>3rd Sat 9 AM - 11:30AM Last 2 weeks Monday - Thurs 10 AM -12PM for emergencies</td>
</tr>
</tbody>
</table>
| FN1.12 | Connect Pt. to Mt. Calvary Baptist Church | Food pantry service with non-perishables and fresh food available depending on the day. Friday eligibility limited to North Camden residents. First time can come without ID.  
1198 Penn Street, Camden, NJ 08102  
(856) 614-1991 | Pantry | verify # of children | Every Tues 11:30AM – 2PM (philabundance produce)  
Friday 12PM-1PM (only North Camden) |
| FN1.13 | Connect Pt. to New Life Ministries | Food pantry service with non-perishables.  
1721 Haddon Avenue, Camden, NJ 08103  
(856) 541-5433 | Pantry | Medical card for children / report cards, proof of address if not on ID | 3rd Fri 4PM – 5PM (till food runs out) |
| FN1.14 | Connect Pt. to 27th Street Revival Center | Food pantry service with non-perishables.  
130 N. 27th Street, Camden, NJ 08105  
(856) 963-6115 | Pantry | ID required | 3rd Sat 9:30AM – 1PM (or when food runs out) |
| FN1.15 | Enroll Pt. in Senior Citizens United Community Services food pantry | Food pantry service for Seniors (60+) only with non-perishables. Enrollment required. Call in ahead of time to do intake by phone. Can pick up food without proof of income for emergency only once per year.  
537 Nicholson Road, Camden, NJ 08106  
(856)456-1121 | Pantry | If on food shelf, proof of income is required. 90 people max (if full, go on waitlist) | 3rd Tue, Wed & Thur 10:00am - 2:00pm |

| FN2: Enroll Pt in Sustainable Food Access Program | Processing Time |
| FN2.1 | Accompany Pt. in obtaining NJ SNAP | EBT card replenished monthly with funds exclusively for food. Must apply at board of social services or online. Need to make below 185% of poverty line unless elderly or disabled.  
600 Market St. Camden, NJ 08102-1255  
(856) 255 – 8800  
Mon-Fri: 8:30am-4:30pm 3rd Thurs: 8:30am-6pm | Food Stamps | Proof of Income: Paystub, Award Letter.  
Proof of Address. Social Security Card | 2-3 weeks |
| FN2.2 | Accompany Pt in obtaining WIC | Federal grant program designed to aid low-income, nutritionally at risk pregnant and/or breastfeeding women, infants, and children up to their 5th birthday. Must reapply every 6-12 months.  
Suite 410, 2600 Mt. Ephraim Ave. Camden, NJ 08104  
(856) 225 – 5050  
Mon-Fri: 8AM to 4:30PM Wed: 8AM to 6:30PM | Food Vouchers | Proof of Identity  
Proof of Address  
Proof of Income  
Social Security Card | 1 month |
| FN2.3 | Connect Pt to Meals on Wheels | Dietitian approved meals delivered to home. Hosted by SCUCS. Must be over 60, and homebound. Assessment over phone, and medical assessment form faxed to physician to be filled out. Phone: (856) 456 – 1121 x 444 | Delivered Meals | Physician contact info. Age, date, address, social situation, chronic medical conditions & disability status | 3-4 weeks |
| FN2.4 | Connect Pt to MANNA | A week’s supply of cooked meals delivered once a week. Must have MANNA referral forms completed and signed by medical provider. Specifically designed for medical malnutrition. Eligibility includes surgery recovery, abnormal lab values, and recent weight loss. Must reapply every 6 months. 2323 Ranstead St. Philadelphia, PA 19103 Phone: (215) 496 – 2662 x 117 Fax: (215) 496 – 9102 Attn: Client Services | Delivered Meals | Completed referral form | 2-3 weeks |

<table>
<thead>
<tr>
<th>Patient Driving Diagnosis</th>
<th>Intervention</th>
<th>Description</th>
<th>Documents Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pt. Struggles in Making Healthy Food Choices</td>
<td><strong>FN3: Teach and Motivate Pt Around Healthy Food Choices</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FN3.1</td>
<td>Communicate and teach concepts about healthy food choice tailored to Pt.’s chronic diseases and medication</td>
<td>LPN/RN teach patients about avoiding sugary/fatty/salty food depending on chronic disease. Also refer to verified online sources as needed.</td>
<td>None</td>
</tr>
<tr>
<td>FN3.2</td>
<td>Motivate Pt. to make healthy food choices</td>
<td>Use Motivational interviewing to motivate pt. to make healthy food choices. May require multiple MI sessions.</td>
<td>None</td>
</tr>
<tr>
<td>FN3.3</td>
<td>Communicate and inform patient about Healthy Corner Store Network in Camden.</td>
<td>Campbell’s Healthy Communities initiative formed partnerships with Corner stores in Camden to sponsor them in providing healthy groceries and cooking classes. Map of all these sponsored stores can be found here.</td>
<td>None</td>
</tr>
</tbody>
</table>

<p>| FN4: Connect Pt. With Dietician | | | |
| FN4.1 | Connect Pt. to Virtua Dietitian | One-on-one meeting with dietitian at Virtua Family Health Center. Create a nutrition plan that works with patient’s normal routine. Prefers patients who have attended Virtua DSME, and those with recent blood work done. | Medicare, Charity Care or private insurance with nutritionist. Does NOT accept United Signed Prescription for DSME or dietitian. | Appointments only available on Tuesdays and Wednesdays |</p>
<table>
<thead>
<tr>
<th>FN4.2</th>
<th>Connect Pt. to Cooper Medical Nutrition Therapy</th>
<th>One-on-one meeting with dietitian at Cooper. Require insurance covered by Cooper. Medicare covers 2 hours of Medical Nutrition Therapy every year. Suite 240 B, 1210 Brace Rd. Cherry Hill, NJ 08034 (856) 321 – 0112</th>
<th>Medicare or private insurance with nutritionist coverage, Can be flexible about no insurance</th>
<th>Signed Prescription for DSME. Lab report (a1c &amp; lipids)</th>
<th>Appointments available Mon-Fri 9AM – 5PM</th>
</tr>
</thead>
<tbody>
<tr>
<td>FN4.3</td>
<td>Connect Pt to Camcare Dietitian</td>
<td>One-on-one meeting with dietitian at Camcare. Requires that patient is a registered with CamCare. 817 Federal Street. Camden, NJ 08103 (856) 583 – 2466</td>
<td>Medicare or private insurance with nutritionist coverage</td>
<td>Signed Prescription for DSME.</td>
<td></td>
</tr>
<tr>
<td><strong>FN5. Enroll Patient in Educational Nutrition Classes</strong></td>
<td><strong>Insurance Required</strong></td>
<td><strong>Documents Required</strong></td>
<td><strong>Schedule</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FN5.1</td>
<td>Enroll Pt. in Camden Coalition DSME Class</td>
<td>Diabetes self-management education class. Morning, evenings &amp; weekends available. Both Spanish and English. Suite 102, 1892 River Rd. Camden, NJ 08105 (Spanish) 522 State St. Camden, NJ 08102 (Spanish) 2950B Yorkship Square. Camden, NJ 08104 (English) For DSME: (856) 365 – 9520</td>
<td>N/A</td>
<td>Insurance Card, Signed Prescription for DSME. Lab report (a1c &amp; lipids)</td>
<td>Tue 9AM-12PM (Spa.) Fri 9AM-12PM (Eng.) Tue 4PM – 6:30PM (Eng.)</td>
</tr>
<tr>
<td>FN5.2</td>
<td>Enroll Pt. in Virtua DSME</td>
<td>Diabetes self-management education class. Must be diabetic and Virtua patient. First Wed of the month. English only. 9AM-2PM. Accept Charity Care. Does not work with UNITED insurance. 2nd Fl. 1000 Atlantic Ave. Camden, NJ 08014 For DSME: (856) 291 – 8661 Also Call: 1-888 – 847 – 8823</td>
<td>Insurance Accepted by Virtua, Charity Care. No UNITED</td>
<td>Insurance Card, Signed Prescription for DSME. Lab report (a1c &amp; lipids)</td>
<td>1st Wed 9:30AM – 2:00PM Lunch included</td>
</tr>
<tr>
<td>FN5.3</td>
<td>Enroll Pt. in Osborn ABC Diabetes Education</td>
<td>Diabetes education course for Pt with Diabetes. 1601 Haddon Ave. Camden, NJ 08103 (Osborn) 1 Brace Road. Cherry Hill, NJ 08034 (Lourdes Care) For DSME: 1-877-267-9220</td>
<td>Insurance accepted by Our Lady of Lourdes</td>
<td>Insurance Card, Signed Prescription for DSME. Lab</td>
<td>Fri mornings at Osborn Sat. morning and weeknight</td>
</tr>
</tbody>
</table>
Also Call: 1-877-533-4222

| FN5.4 | Enroll Pt. in CAMcare Gateway DSME Visits | Group visits dependent on Pt’s chronic disease. Inquire beforehand about which chronic disease is relevant for pt. Must have insurance accepted by Cooper. Morning & afternoon visits available. 817 Federal Street. Camden, NJ 08103 For DSME: (856) 541 – 4611 | Insurance accepted by CAMcare | Insurance card, Signed Prescription for DSME. Lab report (a1c & lipids) | evening at Lourdes Care |

### Treatment Plan

<table>
<thead>
<tr>
<th>Patient Driving Diagnosis</th>
<th>Intervention</th>
<th>Description</th>
<th>Insurance Required</th>
<th>Documents Required</th>
<th>Processing Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pt Unable to Cook Available Food</td>
<td><strong>FN6: Connect Pt with Home Health Aid Service that Includes Cooking Service</strong></td>
<td>Refer to Health MMP Domain: HP7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>FN7: Connect Pt. to a Family Caregiver Who Can Cook For Patient</strong></td>
<td>Refer to Family and Personal Support Domain: FP1</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
Appendix 2

Example Protocol in the Food and Nutrition Domain:
Accompany Pt in Obtaining NJ SNAP
# Protocol- FN2.2: Accompany Pt in obtaining NJ SNAP

## STEP 1. Note the following before beginning

- New Jersey Supplemental Nutrition Assistance Program (SNAP), also known as Food Stamps, is the nutrition assistance program to help low-income individuals and families buy groceries.
- New Jersey is notorious for its slow processing time for SNAP applications (3rd worst in US), and new bills are in the process of being reviewed to bring the processing time down to one week.
- NJ SNAP is the easiest of all entitlements to be qualified for, and could be seen as the first step in becoming more familiar with state-funded social programs.
- Being eligible and applying for NJ SNAP can expedite application process for various other programs, such as LIHEAP, OEO, Weatherization, Lifeline (Obamaphone), PAAD, etc.
- With New Jersey's SNAP Standard Utility Allowance, a patient can receive higher NJ SNAP amount if he/she pays for his/her own utility bills. For a brief overview, refer to the [NJ SNAP Utility poster](#).
- For a brief overview, refer to the [NJ SNAP Poster](#) (English, Spanish).

## STEP 2. Assess patient’s eligibility to see if income requirements are met

<table>
<thead>
<tr>
<th>People in Household</th>
<th>Gross Monthly Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$1800</td>
</tr>
<tr>
<td>2</td>
<td>$2426</td>
</tr>
<tr>
<td>3</td>
<td>$3051</td>
</tr>
<tr>
<td>4</td>
<td>$3677</td>
</tr>
<tr>
<td>5</td>
<td>$4303</td>
</tr>
<tr>
<td>6</td>
<td>$4929</td>
</tr>
<tr>
<td>7</td>
<td>$5555</td>
</tr>
<tr>
<td>Each Additional Member</td>
<td>+$626</td>
</tr>
</tbody>
</table>

- Eligibility depends on income, household size, and current resources.
- In most cases, board of social services **DO NOT** count resources unless income is tied to the resource.
- Maximum level for eligible income is 185% of the Federal Poverty Level.
- Refer to the [income eligibility guideline chart](#) for more details.

## STEP 3. Assess and gather necessary documentation with patient

- Patient needs to have at least one item from each category and more if applicable:
  - **Proof of Identity**
    - Birth Certificate
    - Old Food Stamp ID
Refer to the NJ SNAP Application Checklist for overview of all required documents. (English, Spanish)

- Work Photo ID
- Driver’s License
- School ID
  - Proof of Address
    - Current rent receipt
    - Current lease
    - Current mortgage statement and/or tax bill
  - Proof of Income
    - Copy of award letter for pension
    - Letter from provider or private disability
  - Evidence of Resources
    - Bank Statement
  - Evidence of Expense
    - Rent receipt
    - Utility bills
    - Phone bill
    - Mortgage statement
    - Medical bills

4a. **Apply Online**: Accompany the patient in navigating NJ SNAP application portal

- Creating a new account online is only possible if the patient does not have an existing account under his/her social security number
- In order to retrieve an old password or account id, patient must know his/her previous email address, previous phone numbers, and accurate answers to the security questions
- Some patients without phone are automatically given phone numbers: (000) 000 – 0000 OR (999) 9999 as their phone numbers
- After three failed attempts to log in, patient’s online account will be locked out for an extended period of time
- Patient does not have to finish all the questions in one session. If he/she need more time, you can save the information and come back later

OR

4b. **Apply in Person**: Accompany the patient to the board of social services to apply for NJ SNAP

   Camden County Board of Social Services
   Aletha. R Wright Administration Bld., 600 Market Street
   Camden, NJ 08102-1255
   Phone: (856) 225 - 8800
   Mon-Fri 8:30am to 4:30pm

- Even if the patient does not have all of the documents listed above, the social services representative can help acquire the missing ones
- In person applications recommended over online applications
### 4c. Apply by Mail/Fax:

Accompany the patient in filling out the paper application form ([English](#), [Spanish](#)) and send it in by mail or fax.

Camden County Board of Social Services
Aletha. R Wright Administration Bld.,
600 Market Street
Camden, NJ 08102-1255
Fax: (856) 225 - 7797

**OR**

- **DO NOT** fill out the ‘office use only’ grey section
- Documentation providing proof of eligibility is **NOT** required at the time of application

### 5. Wait for follow up

- Processing time is generally 3 to 4 weeks
- After being processed, the applicant will receive letter in the mail asking for photocopies of documentation providing proof of eligibility.
- After the patient sends the letter back with the photocopies, the patient will receive the Families First Electronic Benefits Card in the mail if approved.
Appendix 3

Camden Coalition Enrollment Intake Paperwork
Client Name:_____________________________________________________________

DOB: ___________________ Hospital Discharge Date:___________________

**INSURANCE INFORMATION**

Primary Insurance Type:

- □ Medicare
- □ Medicaid-United
- □ Medicaid-Amerigroup
- □ Medicaid-Horizon
- □ Medicaid-Other
- □ Private
- □ None
- □ Other

Primary Insurance ID#: ____________________________________________

Secondary Insurance Type:

- □ Medicare
- □ Medicaid-United
- □ Medicaid-Amerigroup
- □ Medicaid-Horizon
- □ Medicaid-Other
- □ Private
- □ None
- □ Other

Secondary Insurance ID#: ____________________________________________

Pharmacy Name: ______________________________________________________

**MEDICAL/HEALTH NEEDS**

*Would you say that in general your health is:

- □ Excellent
- □ Very Good
- □ Good
- □ Fair
- □ Poor

*Now thinking about your physical health, which includes physical illness & injury, for how many days during the past 30 days was your physical health not good?

# of days ___________
MENTAL HEALTH/SUBSTANCE ABUSE CONDITIONS (PHQ-4 and NIDA Substance Abuse Screen)

Over the last 2 weeks, how often have you been bothered by the following problems?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not At All</th>
<th>Several Days</th>
<th>More than half of the days</th>
<th>Nearly Every Day</th>
<th>Prefer not to say</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling nervous, anxious, or on edge</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not being able to stop or control worrying</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Little interest or pleasure in doing things</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling down, depressed, or hopeless</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Now thinking about your mental health, which includes stress, depression, and emotional problems, for how many days during the past 30 days was your mental health not good?  

# of days __________

In the past year, how many times have you used any of the following?

<table>
<thead>
<tr>
<th>Substance</th>
<th>Never</th>
<th>Once or twice</th>
<th>Monthly</th>
<th>Weekly</th>
<th>Daily or Almost Daily</th>
<th>Prefer not to say</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol (Men &gt; 5 drinks/day, Women &gt; 4 drinks/day)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobacco products (cigarettes, cigars, chew, etc)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recreational drugs (marijuana, cocaine, heroin, etc)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription drugs (for reasons other than prescribed)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments:
SBQ-R SUICIDE SCREEN

Have you ever thought about or attempted to kill yourself (check ONE answer only)?

□ Never  □ It was just a brief passing thought  □ I have had a plan at least once to kill myself but did not try to do it  □ I have had a plan at least once to kill myself and really wanted to die  □ I have attempted to kill myself but did not want to die  □ I have attempted to kill myself and really hoped to die

How often have you thought about killing yourself in the past year (check ONE answer only)?

□ Never  □ Rarely (1 time)  □ Sometimes (2 times)  □ Often (3-4 times)  □ Very often (5 or more times)

Have you ever told someone that you were going to commit suicide, or that you might do it (check ONE answer only)?

□ No  □ Yes at one time but did not really want to die  □ Yes at one time and really wanted to die  □ Yes more than once but did not want to do it  □ Yes more than once but really wanted to do it

How likely is it that you will attempt suicide someday (check ONE answer only)?

□ Never  □ No chance at all  □ Rather unlikely  □ Unlikely  □ Likely  □ Rather Likely  □ Very Likely

FOOD AND NUTRITION

Do you follow a special diet?

□ Yes  □ No  □ Not Sure  □ Prefer Not to Say

In the past three months, have you gained or lost more than 10 pounds without trying?

□ Yes  □ No  □ Not Sure  □ Prefer Not to Say

Do you have trouble affording food on a regular basis?

□ Yes  □ No  □ Not Sure  □ Prefer Not to Say

Based on the following statements which answers do you agree with?

In the last year I worried that we would run out of food before we had the money to buy more:

□ Often True  □ Sometimes True  □ Never True  □ Not Sure/Prefer Not to Say
In the last year we ran out of the food we bought and we did not have money to buy more:

- [ ] Often True
- [ ] Sometimes True
- [ ] Never True
- [ ] Not Sure/Prefer Not to Say

**FAMILY, PERSONAL, & PEER SUPPORT**

*During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?*

# of days ___________

*Are you LIMITED in any way in any activities because of any impairment or health problem?*

- [ ] Yes
- [ ] No
- [ ] Not Sure
- [ ] Prefer Not to Say

**IF NO, UNSURE, or REFUSED, skip to Housing and Environment**

*What is the MAJOR impairment or health problem that limits your activities? (CHECK ONLY ONE)*

- [ ] Arthritis/rheumatism
- [ ] Back or neck problem
- [ ] Cancer
- [ ] Depression/anxiety/emotional problem
- [ ] Diabetes
- [ ] Eye/vision injury
- [ ] Fractures, bone/joint injury
- [ ] Hearing problem
- [ ] Heart problem
- [ ] Hypertension (High Blood Pressure)
- [ ] Lung/breathing problem
- [ ] Stroke
- [ ] Walking problem
- [ ] Other Impairment/Problem _______________
- [ ] Not Sure
- [ ] Prefer Not to Say

*For HOW LONG have your activities been limited because of your major impairment or problem?*

- [ ] Days
- [ ] Weeks
- [ ] Months
- [ ] Years
- [ ] Not Sure
- [ ] Prefer Not to Say

____    ____    ____    ____

*Do you need the help of other people with your PERSONAL CARE needs, such as eating, bathing, dressing, or getting around the house?*

- [ ] Yes
- [ ] No
- [ ] Not Sure
- [ ] Prefer Not to Say
*Do you need the help of other people in handling your ROUTINE needs, such as household chores, doing necessary business, shopping, or getting around for other purposes?*

☐ Yes  ☐ No  ☐ Not Sure  ☐ Prefer Not to Say

**Are you receiving any of the following support services? (Check All That Apply)**

☐ Visiting nurse  ☐ Social worker
☐ Home health aid  ☐ Adult daycare
☐ Speech therapy  ☐ Home delivered meals
☐ Physical therapy  ☐ Other: ____________________________
☐ Occupational therapy  ☐ None of the above services
☐ Prefer not to say

*If any of the above are checked, please list agency/provider for each:*

__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

**What is Your Religious Preference?:**

☐ Agnostic  ☐ Mormon
☐ Apostolic  ☐ Muslim
☐ Atheist  ☐ Non-denominational Christian
☐ Baptist  ☐ Presbyterian
☐ Buddhist  ☐ Pentecostal
☐ Catholic  ☐ Roman Catholic
☐ Christian Scientist  ☐ Sikh
☐ Episcopal  ☐ Spiritual, but not religious
☐ Hindu  ☐ Zoroastrian
☐ Jehovah’s Witness  ☐ Prefer not to say
☐ Jewish  ☐ None
☐ Lutheran  ☐ Other: ____________________________
☐ Methodist

*Comments*
HOUSING & ENVIRONMENT

Where are you living right now?
- House/Apartment/Room
- Streets/abandoned home
- With friend/relative
- Other: _________________________
- Prefer not to say
- Shelter/boarding home
- Other: _________________________

Do you plan on moving out of Camden?
- Yes
- No
- Not Sure
- Prefer not to say

When do you plan on moving out of Camden? _________________________________

Comments:

EDUCATION & EMPLOYMENT; BENEFITS & ENTITLEMENTS

Do you have a source of income and/or entitlements?
- Yes
- No
- Prefer Not to Say

What is your source of income? (Check All That Apply)
- Work, “on the books” (earned income)
- Pension/Retirement
- Work, “off the books” (under the table income)
- Sex Work/Trade
- Social Security Disability Insurance (SSDI/SSA)
- Drug Trade
- SNAP/Food Stamps
- Recycling/Scraping
- Unemployment
- Panhandling
- Plasma Center
- Veteran’s Administration (VA) Benefits
- No Income
- Other: _________________________
LEGAL

Do you have a Power of Attorney?

Yes ☐ No ☐ Not Sure ☐ Prefer Not to Say ☐

Do you have any current charges (or a trial) pending?

Yes ☐ No ☐ Not Sure ☐ Prefer Not to Say ☐

Are you on probation/parole?

Yes ☐ No ☐ Not Sure ☐ Prefer Not to Say ☐

Do you have any felony convictions?

Yes ☐ No ☐ Not Sure ☐ Prefer Not to Say ☐

IDENTIFICATION

Do you have a state identification card (license, non-driver’s ID, etc)?

Yes ☐ No ☐ Not Sure ☐ Prefer Not to Say ☐

Do you have a Social Security card?

Yes ☐ No ☐ Not Sure ☐ Prefer Not to Say ☐

Do you have a Birth Certificate or Passport?

Yes ☐ No ☐ Not Sure ☐ Prefer Not to Say ☐

Where were you born? __________________________________________________________________________

Page 7 of 10
TRANSPORTATION

How do you get around, including getting to your medical appointments? (Check All That Apply)

□ I drive a car.    □ I walk, ride a bike, or ride a scooter.
□ My friends or family drive me.    □ I cannot get around easily.
□ I take public transportation or a taxi.    □ I take medical transportation (i.e. Logisticare)
□ Prefer not to say
□ Other: __________________________

Comments:

MEDICATION & MEDICAL SUPPLIES

CURRENT DURABLE MEDICAL EQUIPMENT: check all that apply

□ Apnea Monitor    □ Nebulizer
□ Bath bench/shower chair    □ Oxygen
□ Bedside commode    □ Peak flow
□ Blood pressure equipment    □ Scales
□ Cane    □ Trach supplies
□ CPAP/biPAP    □ Walker
□ Feeding pump    □ Wheelchair
□ Glucometer    □ None
□ Grab bars    □ Other: __________________________
□ Hospital bed

DURABLE MEDICAL EQUIPMENT NEEDED: check all that apply

□ Apnea Monitor    □ Nebulizer
□ Bath bench/shower chair    □ Oxygen
□ Bedside commode    □ Peak flow
□ Blood pressure equipment    □ Scales
□ Cane    □ Trach supplies
□ CPAP/biPAP    □ Walker
□ Feeding pump    □ Wheelchair
□ Glucometer    □ None
□ Grab bars    □ Other: __________________________
□ Hospital bed
PAIN NEEDS:

Are you currently taking any medications for pain management (e.g. Percocet, Oxycontin, Vicodin, etc)?

- □ Yes
- □ No
- □ Not Sure
- □ Prefer not to say

Are you currently seeing a pain specialist for treatment?

- □ Yes
- □ No
- □ Not Sure
- □ Prefer not to say

*If yes, specify provider: _______________________________________________________

How bad is your pain? (circle a face)

[Image of smiley faces from 0 to 10]

- 0: No Symptoms
- 1-3: Mild Symptoms
- 4-6: Moderate Symptoms
- 7-10: Severe Symptoms

Where is your pain? __________________________________________________________

Comments:
MEDICATIONS:

Are you allergic to any medications?

☐ Yes  ☐ No  ☐ Not Sure  ☐ Prefer Not to Say

If yes, specify medications:
_____________________________________________________________________________________

Current Medications:

**Use med rec sheet attached to complete med reconciliation**

*Please make sure that the med reconciliation form is complete and now complete the CPCQ Questionnaire*
Appendix 4

Backwards Planning Board
<table>
<thead>
<tr>
<th>NEED TO WORK ON</th>
<th>RIGHT NOW</th>
<th>LATER</th>
</tr>
</thead>
<tbody>
<tr>
<td>DON'T NEED TO WORK ON</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 5

Backwards Planning Card Deck
| Get a job and/or go back to work | Have spending money  
(Education & Employment)  
• Get an education  
• Work hard at a job I like |
|---------------------------------|--------------------------------------------------|
| Have medical equipment & medication  
(Medication & Equipment Support) | Find medications that work for me  
• Get medical equipment that will help me manage my conditions |
| Legal issues  
(Legal Assistance) | Stay out of jail  
• Get help with a legal issue I am facing  
• Get a lawyer |
| Talk to someone about my mental health | • To feel better about myself  
• To have more energy and motivation  
• Have fun and not worry all the time |
|---------------------------------------|--------------------------------------------------------------------------------|
| Have transportation                   | • Find ways to get to and from medical appointments  
• Not have to rely on others to get places |
|---------------------------------------|------------------------------------------------------------------------------------------------|
| Have a better living situation        | • Have a safe place to live  
• Make improvements to where I stay  
• Find housing I qualify for |
| (Mental Health Support)               | (Transportation Support)                                                                 |
| (Transportation Support)              | (Housing Support)  |
| (Housing Support)                     | |
| Have a better relationship with my doctors & nurses | • Feel at ease in my health care providers office  
• Feel comfortable telling my provider when I don’t understand something they say |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(Provider Relationship)</td>
<td></td>
</tr>
</tbody>
</table>
| Learn more about _______ (COPD, Diabetes, etc...) | • Better control my pain  
• Learn more about managing my health on a day-to-day basis  
• Be physically fit |
| (Health Management)                            |                                                                                  |
| See if I qualify for insurance and other government programs | • Apply for assistance  
• Apply for health insurance  
• Figure out if I qualify for additional income |
| (Benefits & Entitlements)                      |                                                                                  |
| Help people in my community (Advocacy & Activism) | • Get involved with/organize a local interest group  
• Let people know about issues happening in our community  
• Use my story to raise awareness |
|------------------------------|------------------------------------------------------------------------------------------------|
| Identification (ID Support) | • Get a photo ID  
• Get a driver’s license  
• Get a social security card  
• Get a birth certificate  
• Get proof of income |
| Have support (Family, Personal, & Peer Support) | • Socialize with friends and family  
• Find a good friend  
• Feel like my life matters to someone else |
| Talk to someone about my drug or alcohol use | • Learn more about how a drug or alcohol I use affects my chronic condition  
• Find someone I can talk to about my alcohol or drug use |
|---------------------------------------------|------------------------------------------------------------------------------------------------------------------|
| Food & Nutrition                            | • Get access to healthy food  
• Eat better  
• Learn how to cook healthy food |