State Innovation Model Grant (SIM-Grant)

Stakeholder Meeting

Update on Community Links Portal

Monday, September 29, 2014
2:00PM - 3:30PM

One Ashburton Place
Video Conference Room, 10th Floor
Boston, MA
**Agenda**

**Project Context**
- Current EOEA sub-projects under SIM-Grant
- SIMS – Senior Information Management System

**What is Community Links Portal (CLP)?**
- Vision: Bridging the gap & changing perspectives
- Patient information visible on portal
- Administration & Consent

**CLP Demonstration**

**Implementation & Challenges**
- Pilot Group
- Matching Patients to Consumers
- Standardization & Promotion

**Lessons Learned (so far...)**

**Current Project Status**

**Questions?**
Four (4) EOEA projects under SIM-Grant

- **AGD – AFC/GAFC Determination Streamline**
- **Section-Q Reporter**
- **Community Links Portal**
  - Professionals
  - Caregivers

Diagram:
- Community Links Portal: Professionals
- Community Links Portal: Caregivers
- SIMS: Senior Information Management System
- SAMS: Provider Direct
- Service Hub
- Connector
- Secure User Portal
- System-to-system exchange
- ADRC Referrals
  - 11 ILCs
- ASAPs/AAAs
  - 27 orgs
- Direct-service Providers
  - ASAP contractors; 300 orgs
- AFC & GAFC Providers
  - 220 orgs
- Section Q notifications
  - 450 Nursing Facilities
- EOEA’s HCBS system-of-record for state Home Care Program & Frail Elder Waiver

**ASAPs/AAAs**
- 27 orgs

**Direct-service Providers**
- ASAP contractors; 300 orgs

**Funding**
- SIM Grant
- Section Q notifications
- 450 Nursing Facilities
- AFC & GAFC Providers
  - 220 orgs

**Community Links Portal**
- Professionals
- Formerly: Caregiver Connect
- Service Hub
- ADRC Referrals
  - 11 ILCs
- ASAP contractors
  - 300 orgs

**EOEA**
- HCBS system-of-record for state Home Care Program & Frail Elder Waiver
- EOEAs
-Dispatcher
- ASAP contractors; 300 orgs
- Community Links Portal
- Formerly: Caregiver Connect
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**FY2015 Capstone Initiative**
SIMS (Senior Information Management System)

- Statewide consumer database
- Administered centrally
  - Standardized data
- Managed locally by ASAPs

<table>
<thead>
<tr>
<th>27</th>
<th>Aging Services Access Points (ASAPs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2,900</td>
<td>SIMS users: Case Managers, RNs (5,500 total active users)</td>
</tr>
<tr>
<td>42,000</td>
<td>Active Home Care consumers</td>
</tr>
</tbody>
</table>
What is the Community Links Portal?

Vision: Bridging the gap & changing perspectives

• HCOs have limited knowledge of ASAP system & function

• Value of ASAP comprehensive data source

• CLP was ASAP group initiative (Mass Home Care)

Patient Information Visible on Portal

• Based on regular Home Visits (180 days or less)

• Consumer information, including informal supports

• Service Plan

• Clinical information: self-reported meds, ADLs & IADLs

• High-quality documentation, with interdisciplinary case review at ASAP
What is the Community Links Portal?

Administration & Consent

- ASAPs – easy data update to make patient info (in)visible
- Light support burden
  - Easy for ASAP to add org
  - User management is delegated to Health Care Organization
- CM gathers consent, updates record to make it visible in CLP
- New standardized protocol: Informed consent forms updated for all home-care
CLP Demonstration
Community Links Portal: Screenshot #1

Community Links Portal

Enter your Community Links Portal username and password.

User name: james.example@health-pro
Password: %

Log in  Forgot Password

Screenshots of the Community Links Portal

• Left-hand: full frame view of the portal (7 total)
• Right-hand side: same screen, cropped & zoomed to better show content of interest
Community Links Portal - Xample Healthcare, Inc.

Abate, Sam
119 Westwood Road, Peabody, 01960
(45) 950-4785
DOB: 10/30/1926 (87)

Current Services
- Personal Emergency Response Sys (Monthly) - 1 unit (Unit Type = Month) monthly
- Homemaker - 8.00 units (Unit Type = 15 Minutes) weekly (Fri: 8:00)
- HDM Meal Lunch Weekday Hot - 3.00 units (Unit Type = Meal) weekly (Mon: 1:00 Wed: 1:00 Fri: 1:00)

Assessment Date: 9/10/2014

Comments
Cm conducted an annual home visit with ckt and dil on 3/10/14. Ckt was appropriately dressed and groomed and her home was neat and clean. All necessary paperwork was signed and completed. Public benefits were discussed. Ckt’s fuel assistance application was sent in by SIL. She stated that while they did not receive an approval letter it appears as though they were approved as she has a $1000 credit on her gas bill. CM called fuel assistance and spoke to a representative who stated that the application was received but has not been processed yet. CM relayed this information to Sandi and suggested that she contact the Gas Company in regards to the credit.

Ckt denies any recent falls or hospitalizations. Ckt reports that her appetite is good and she sleeps well. Ckt’s last visit with her PCP, Dr. Ford, was at the end of the summer and has another scheduled for some time in January. Sandi reported that the elder will be going back to her former PCP Dr. Behrens. Dr. Ford has given Sandi his contact information. Ckt is not medically dependent.

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Clt currently receives 12 units of home making provided by Independence. Clt stated that she does not feel comfortable with the homemaker that is currently providing service for her. The clt and clt requested a new worker, named Alex, who can provide service for the clt on the same day and time, Weds mornings. Clt also receives 4 units of cab rides monthly provided by Yellow Cab, as well as a PERS, 1 unit monthly, provided by Lifeline which is now paid for by Mass Health. Clt denies the need from additional services at this time. CSP remains appropriate. Next home visit will be 6/14.

<table>
<thead>
<tr>
<th>Memory Loss Screen Score</th>
<th>0, 1, or 2 possible impairment</th>
<th>3, 4, or 5 suggests no impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicate the date of the Memory Loss Screen</td>
<td>03/10/2014</td>
<td></td>
</tr>
<tr>
<td>Indicate the score of the Memory Loss Screen</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Indicate the reason for the Memory Loss Screen</td>
<td>Annual</td>
<td></td>
</tr>
</tbody>
</table>

**Physical Findings**

<table>
<thead>
<tr>
<th>Estimated Height</th>
<th>59 inches</th>
</tr>
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<tbody>
<tr>
<td>Estimated Weight</td>
<td>142 lbs.</td>
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**Pain**

- Frequency with which client complains or shows evidence of pain: Pain daily
- Intensity of pain: Moderate
- From client's point of view, pain intensity disrupts usual activities: Yes
- Character of pain: Localized - single site
- From the client's point of view, medications adequately control pain: No pain control pain

**Responsibility / Advanced Directives**

- Client has a legal guardian: Yes
- Legal Guardian's Name: Paul Abate

**Visits in Last 90 Days or Since Last Assessment**

- Number of times ADMITTED TO HOSPITAL with an overnight stay: 1
### Self-Reported Medications

**PERFORMANCE CODE - MANAGING MEDICATIONS**
Medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments)

**DIFFICULTY CODE - MANAGING MEDICATIONS**
Medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments)

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<thead>
<tr>
<th>Name</th>
<th>Dosage</th>
<th>Form (Route of Administration)</th>
<th>Frequency</th>
<th>Taken as needed (PRN)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calcium</td>
<td>600 Milligram (mg)</td>
<td>by mouth (PO)</td>
<td>(BID) twice daily (every 12 hours)</td>
<td>No</td>
<td>supplement</td>
</tr>
<tr>
<td>Bayer</td>
<td>81 Milligram (mg)</td>
<td>by mouth (PO)</td>
<td>(PRN) as necessary</td>
<td>No</td>
<td>pain, blood thinner</td>
</tr>
<tr>
<td>Fosamax</td>
<td>70 Milligram (mg)</td>
<td>by mouth (PO)</td>
<td>(QD or HS) once daily</td>
<td>No</td>
<td>osteoporosis</td>
</tr>
<tr>
<td>Acetomenaphen</td>
<td>325 Milligram (mg)</td>
<td>by mouth (PO)</td>
<td>(PRN) as necessary</td>
<td>No</td>
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Mood and Behavior Patterns

A FEELING OF SADNESS OR BEING DEPRESSED—that life is not worth living, that nothing matters, that he or she is of no use to anyone or would rather be dead.

PERSISTENT ANGER WITH SELF OR OTHERS—e.g., easily annoyed, anger at care received.

EXPRESSIONS OF WHAT APPEAR TO BE UNREALISTIC FEARS—e.g., fear of being abandoned, left alone, being with others.

REPETITIVE HEALTH COMPLAINTS—e.g., persistently seeks medical attention, obsessive concern with body functions.

REPETITIVE ANXIOUS COMPLAINTS, CONCERNS—e.g., persistently seeks reassurance regarding schedules, meals, laundry, clothing, relationship issues.

SAD, PAINFUL, WORRIED FACIAL EXPRESSIONS—e.g., furrowed brows.

RECURRENT

Informal Support Services

Primary Helper
Lives with client
Relationship to client
If needed, willingness (with ability) to increase help with advice or emotional support
If needed, willingness (with ability) to increase help with ADL care

Home Environment - Living Space Hazards

Heating or cooling problems
Flooring or carpeting problems

Internal Support Services

Primary Helper
Lives with client
Relationship to client
If needed, willingness (with ability) to increase help with advice or emotional support
If needed, willingness (with ability) to increase help with ADL care

Home Environment - Living Space Hazards

Heating or cooling problems
Flooring or carpeting problems

Informal Support Services

Primary Helper
Lives with client
Relationship to client
If needed, willingness (with ability) to increase help with advice or emotional support
If needed, willingness (with ability) to increase help with ADL care
Community Links Portal: Screenshot #6

IADL (Instrumental Activities of Daily Living)

- Performance Code, difficulty, who helps, device needed, type of device or mode (when indicated)
- Meal preparation
  - Done with help all of the time, Some difficulty
- Housework, Ordinary
  - Needs assistance most of the time, Great difficulty
- Housework, Heavy
  - Does with maximum help
- Manage finances
  - Needs assistance sometimes, Some difficulty
- Telephone use
  - Independent, No difficulty
- Shopping
  - Done with help all of the time, Great difficulty
- Transportation use
  - Done with help all of the time, Great difficulty

ADL (Activity of Daily Living)

- Performance, difficulty, who helps, device needed, type of assistance / device / appliances / medical equipment
- Mobility in bed
  - Independent
- Transfer in/out of bed/chair
  - INDEPENDENT - but experiences difficulty
- Locomotion in home
  - Uses device
  - Locomotion outside of home
  - Limited assistance
Community Links Portal: Screenshot #7

Home Evaluation 9/14/2014

During most recent visit, Care Manager noted that railing on stairs from first to second floor is in need of repair. One of the banisters appears to have loosened from the banister. CM asked consumer if she would be agreeable to having this fixed, and she said she has been needed for some time. CM will approach supervisor for increase in service plan to pay for home repair services and update record once repair is scheduled.

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Laura Teckman (CM)
North Shore Elder Services, Inc.

Risk Evaluation 9/14/2014

Care Manager Update
Recent phone call with consumer about a service issue became a discussion regarding her fear of falls. She has indicated in the past several assessments that she prefers not to venture outside due to this perceived risk. She explained that she was recently invited by a neighbor for lunch and declined because of this. Various options to address this were discussed, as it has become apparent that her level of socialization has decreased in recent years. She feels that her quad cane is adequate for getting around outside, but going anywhere by herself doesn’t feel safe. She doesn’t feel that asking her elderly neighbor to walk her over is appropriate, and her daughter-in-law is frequently unavailable during the day. She was asked if the PERS button gave her a sense of security, and she replied that she wouldn’t want to bother those nice people who manage the service. She was assured that this is their main function. She was also told that she should not venture out if she was not comfortable with the idea. Eventually she decided that she would have her neighbor over for lunch next week and discuss the issue.

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Laura Teckman (CM)
North Shore Elder Services, Inc.
Implementation & Challenges

ASAP initiates contact -> Signed Organizational Agreement -> Submits to EOEA

Pilot Group

• 10 signed organizational agreements
• Varied group of HCO types & plans for usage
• Implementation pace dictated by partners (with EOEA’s encouragement)

Matching Patients and Consumers

• Challenge #1 – no quick and easy method
• ASAPs can initiate process with database reports
• Small starter group / Initial larger batch / ongoing process

Standardization & Promotion

• Evolving “Quick Start” implementation
• ASAPs must see benefit outweighing effort (project lead, gathering consent..)
• Existing relationships key
Lessons Learned (so far...)

- CLP – Health Care Organization Types:
  - Standard Physician’s Practice
  - Community Health Centers
  - Large Providers with Multiple Sites
  - Hospitals

- CLP – Different Applications:
  - “Standard” Use – Physician’s Office
  - CCTP Tool (Boston Senior Home Care)
  - New Program Initiative (Elder Services of Worcester)

- Feedback
  - Recognized as high value information
  - HCOs love up to date service data!
  - Dedham Medical Associates:
    - CLP part of routine roster reviews (standard operations) with MDs, SWs
    - Nursing Managers use CLP information to supplement phone contact with ASAP
Current Project Status

10 Signed Partnerships (ASAP – HCO)
Questions?

Thanks!

Contacts

EOEA Project Leads:

Jim Ospenson
James.Ospenson@state.ma.us

Andy Grigorov
Andy.Grigorov@state.ma.us