Nutrition and Aging Resource Center

# SixtyPLUS: How Meals-on-Wheels Redefines Population Health

Appendix Documents

# Table of Contents

# Appendix A: Home Care Frailty Scale

Home Care Frailty Scale—LifeCare Alliance

| Item | Response | Response |
|---|---|---|
| **Function (last 3 days)** | | |
| Housework | ☐ No issue | ☐ Requires extensive help (1) |
| Meals | ☐ No issue | ☐ Requires some help (1) OR<br>☐ Requires extensive help (2) |
| Phone use | ☐ No issue | ☐ Requires help (1) |
| Personal hygiene | ☐ No issue | ☐ Requires help (1) |
| Walking | ☐ No issue | ☐ Requires physical help (1) |
| Transfers | ☐ No issue | ☐ Requires extensive help (1) |
| Toilet use | ☐ No issue | ☐ Requires help (1) |
| **Movement** | | |
| Climbing stairs in last 3 days | ☐ No issue | ☐ Requires help (1) |
| Physical activity hours | ☐ 2+ hours in 3 days | ☐ <2hrs in 3 days (1) |
| Fell in last 90 days | ☐ No | ☐ Yes (1) |
| Dizzy in last 90 days | ☐ No | ☐ Yes (1) |
| **Cognition & Comm.** | | |
| Decision-making in last 90 days | ☐ No issue | ☐ Requires help (1) |
| Medication mgmt. | ☐ No issue | ☐ Requires extensive help (1) |
| Financial mgmt. | ☐ No issue | ☐ Requires help (1) |
| Dementia (not Alzheimer's) | ☐ No | ☐ Yes (1) |
| Understands others | ☐ Yes | ☐ No (1) |
| **Social** | | |
| Decline in social activities in 90 days | ☐ No | ☐ Yes (2) |
| Reduced social interactions in the last 3 days | ☐ No | ☐ Yes (1) |
| Withdrawal from activities of interest in the last 2 days | ☐ No | ☐ Yes (1) |
| **Nutritional status (in last 90 days)** | | |
| Weight loss (unintentional) | ☐ No | ☐ Yes (1) |
| Loss of appetite | ☐ No | ☐ Yes (1) |
| Decrease in food eaten (unintentional) | ☐ No | ☐ Yes (1) |
| **Clinical symptoms and diagnoses** | | |
| Bowel incontinence – last 3 days | ☐ No | ☐ Occasional (1) |
| Urinary tract infection -last 30 days | ☐ No | ☐ Yes (1) |
| Renal failure - current | ☐ No | ☐ Yes (1) |
| Pneumonia - current | ☐ No | ☐ Yes (1) |
| Congestive heart failure - current | ☐ No | ☐ Yes (1) |
| Emphysema - current | ☐ No | ☐ Yes (1) |
| | | **TOTAL SCORE:** _____/30 maximum |

Comments:

This project was supported, in part by grant number 90INNU0016, from the Administration for Community Living, U.S. Department of Health and Human Services, Washington, D.C. 20201. Grantees undertaking projects with government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official ACL policy.

Home Care Frailty Scale drawn from: Morris, J. N., Howard, E. P., & Steel, K. R. (2016). Development of the interRAI Home Care Frailty Scale. *BMC Geriatrics, 16*(1), 188. https://doi.org/10.1186/s12877-016-0364-5

# Appendix B:  Frailty Scale Training

# Frailty Scale Training

## LifeCare Alliance

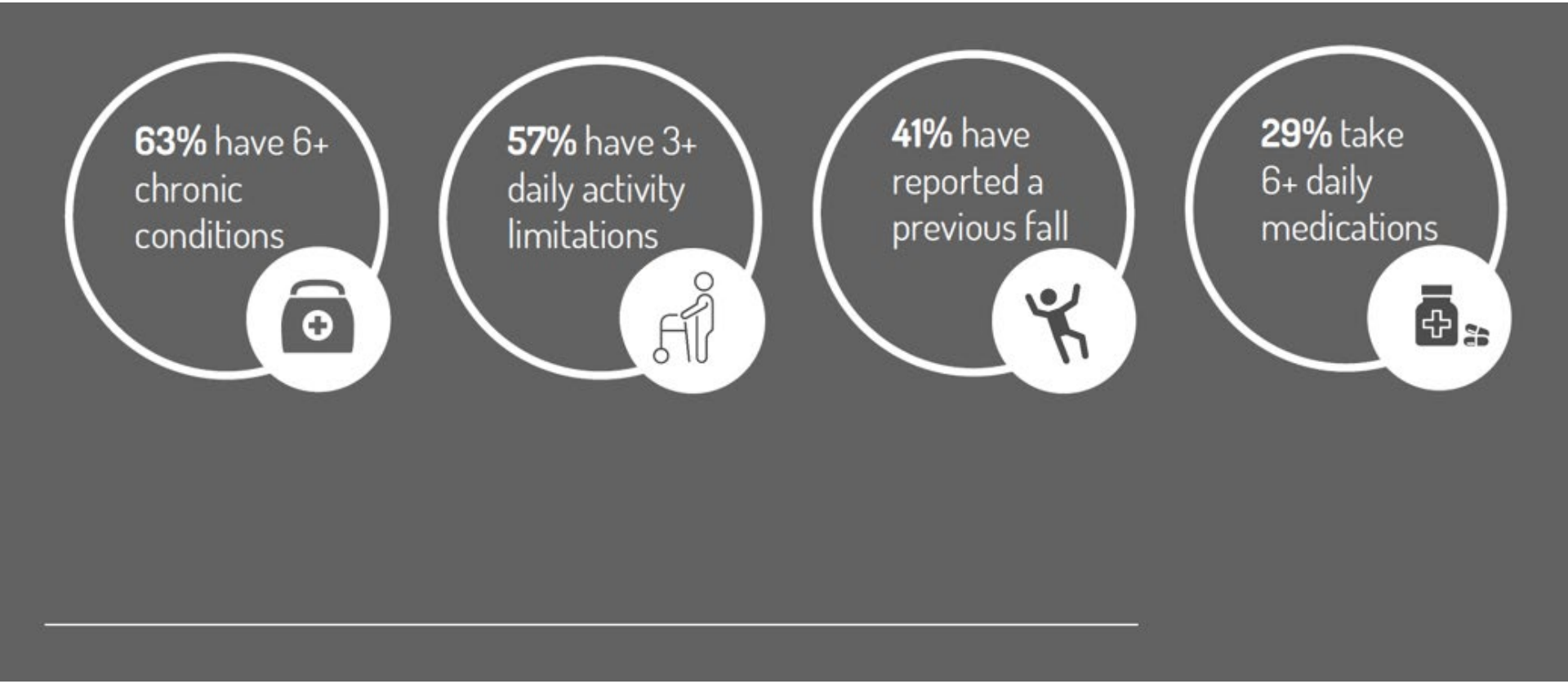
This project was supported, in part by grant number 90INNU0016, from the Administration for Community Living, U.S. Department of Health and Human Services, Washington, D.C. 20201. Grantees undertaking projects with government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official ACL policy.

# What we will cover…

- General characteristics of clients
- Review of Frailty Scale items
- Q&A

# Health characteristics of clients (national estimates)

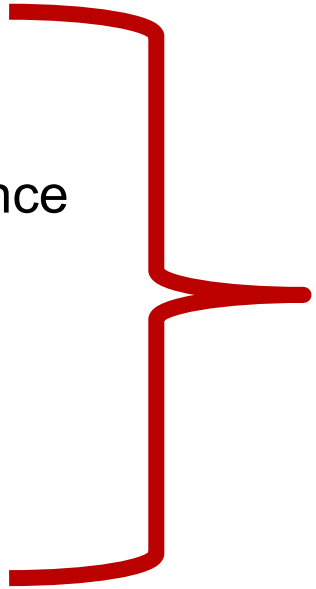
- Home- and community-based services (HCBS) or Long term supports and services (LTSS)



# The Frailty Scale—What is it?

- Two components: Score of frailty (out of 30 points) and your impression of frailty (from 1 to 7)

- Frailty: A relative state of weakness with expected gradual decline in multiple ***functional and health domains***
  - Function
  - Movement
  - Cognitive performance
  - Communication
  - Social engagement
  - Nutritional issues
  - Clinical symptoms and diagnoses



These domains are all assessed through the Frailty Scale

# The Frailty Scale—Review of Function items

- Function items

# The Frailty Scale
# Review of Function items 1

- Item 1: Housework

| Housework | ☐ No issue | ☐ Requires extensive help (1) |
|---|---|---|

Scoring tip:

| Housework | Requires extensive help = help needed with more than 50% of household tasks such as cleaning, laundry, vacuuming, and dishes |
|---|---|

# The Frailty Scale
# Review of Function items 2

- Item 2: Meals

| Meals | ☐ No issue | ☐ Requires some help (1) OR<br>☐ Requires extensive help (2) |
|---|---|---|

## Scoring tip:

| Meals | Requires some help = help needed with less than 50% of meal tasks (i.e. client can prepare cereal and use microwave but requires assistance with complex meal preparation.)<br><br>Requires extensive help = help needed with more than 50% of meal tasks such as retrieving food, beverage prep, using stove, using oven, using microwave. |
|---|---|

# The Frailty Scale
# Review of Function items 3

- Item 3: Phone use

| Phone use | ☐ No issue | ☐ Requires help (1) |
|---|---|---|

Scoring tip:

| Phone use | Requires help = help needed with any part of basic phone use (e.g. dialing) |
|---|---|

# The Frailty Scale
# Review of Function items 4

- Item 4: Personal hygiene

| Personal hygiene | ☐ No issue | ☐ Requires help (1) |
|---|---|---|

Scoring tip:

| Personal hygiene | Requires help = help needed with ANY part of hand washing, grooming, face washing, oral care, etc. |
|---|---|

# The Frailty Scale
# Review of Function items 5

- Item 5: Walking

| Walking | ☐ No issue | ☐ Requires physical help (1) |
|---|---|---|

Scoring tip:

| Walking | Requires physical help = hands-on assistance is required for safe walking. Mark as “No issue” if a client uses a cane or walker but does not require hands-on help. If using a wheelchair, mark “Requires physical help” and place note in the comments section |
|---|---|

# The Frailty Scale
# Review of Function items 6

- Item 6: Transfers

| Transfers | ☐ No issue | ☐ Requires extensive help (1) |
|---|---|---|

Scoring tip:

| Transfers | Requires extensive help = hands-on help for helping a client move off a piece of furniture/equipment (such as a bed, couch, or wheelchair) |
|---|---|

# The Frailty Scale
# Review of Function items 7

- Item 7: Toilet use

| Toilet use | ☐ No issue | ☐ Requires help (1) |
|---|---|---|

Scoring tip:

| Toilet use | Requires help = hands-on help OR supervision/cueing during toileting. This does NOT include help getting on/off the toilet |
|---|---|

# Movement Items

- Movement items

# The Frailty Scale
# Review of Movement items 8

- Item 8: Climbing stairs

| Climbing stairs in last 3 days | ☐ No issue | ☐ Requires help (1) |
|---|---|---|

Scoring tip:

| Climbing stairs | Requires help = any hands-on help OR supervision assistance needed to ensure safety with climbing stairs |
|---|---|

# The Frailty Scale
# Review of Movement items 9

- Item 9: Physical activity

| | | |
|---|---|---|
| **Physical activity hours** | ☐ **2+ hours in 3 days** | ☐ **<2hrs in 3 days (1)** |

Scoring tip:

| | |
|---|---|
| **Physical activity hrs** | **<2 hrs in 3 days = less than two hours of movement (walking outside or purposefully walking in home for exercise)** |

# The Frailty Scale
# Review of Movement items 10

- Item 10: Fall history

| Fell in last 90 days | ☐ No | ☐ Yes (1) |
|---|---|---|

Scoring tip:

| Fell in last 90 days | Yes = report or indicator of a fall |
|---|---|

# The Frailty Scale
# Review of Movement items 11

- Item 11: Dizziness

| Dizzy in last 90 days | ☐ No | ☐ Yes (1) |
|---|---|---|

Scoring tip:

| Dizzy in last 90 days | Yes = report or indicator of dizziness |
|---|---|

# Cognition and Communication Items

- Cognition and Communication Items

# The Frailty Scale
# Review of Cognition items 12

- Item 12: Decision-making

| Decision-making in last 90 days | ☐ No issue | ☐ Requires help (1) |
|---|---|---|

Scoring tip:

| Decision-making | Requires help = help with basic decisions such as choosing items of clothing, knowing when to eat meals, asking for help with tasks when necessary, knowing when it's necessary to use cane/walker, knowing when and how to use a calendar to plan the week |
|---|---|

# The Frailty Scale
# Review of Cognition items 13

- Item 13: Medication management

| Medication mgmt. | ☐ No issue | ☐ Requires extensive help (1) |
|---|---|---|

Scoring tip:

| Med mgmt. | Requires extensive help = help with filling and removing pill box or verbal reminders to take medication. The use of a pill box alone does NOT indicate “extensive help” |
|---|---|

# The Frailty Scale
# Review of Cognition items 14

- Item 14: Financial management

| Financial mgmt. | ☐ No issue | ☐ Requires help (1) |
|---|---|---|

Scoring tip:

| Financial mgmt. | Requires help = any help with bill paying, writing checks, counting money |
|---|---|

# The Frailty Scale
# Review of Cognition items 15

- Item 15: Dementia

| | | |
|---|---|---|
| **Dementia (not Alzheimer's)** | **☐ No** | **☐ Yes (1)** |

Scoring tip:

| | |
|---|---|
| **Dementia** | **Yes = indicators from client, family, or chart that client has symptoms consistent with dementia** |

# The Frailty Scale
# Review of Cognition items 16

- Item 16: Comprehension

| | | |
|---|---|---|
| **Understands others** | ☐ **Yes** | ☐ **No (1)** |

Scoring tip:

| | |
|---|---|
| **Understands others** | **No = requires repetition of instructions, does not appear to comprehend conversation, slower processing** |

# Social Engagement Items

- Social engagement Items

# The Frailty Scale
# Review of Social Engagement items 17

- Item 17: Social activities

| | | |
|---|---|---|
| **Decline in social activities in 90 days** | **☐ No** | **☐ Yes (2)** |

Scoring tip:

| | |
|---|---|
| **Decline in social activities in last 90 days** | **Yes = as indicated by client or caregiver** |

# The Frailty Scale
# Review of Social Engagement items 18

- Item 18: Social interaction

| | | |
|---|---|---|
| **Reduced social interactions in the last 3 days** | ☐ **No** | ☐ **Yes (1)** |

Scoring tip:

| | |
|---|---|
| **Reduced social interaction in last 3 days** | **Yes = decreased interaction with others in last three days** |

# The Frailty Scale
# Review of Social Engagement items 19

- Item 19: Activities of interest

| | | |
|---|---|---|
| **Withdrawal from activities of interest in the last 2 days** | **☐ No** | **☐ Yes (1)** |

Scoring tip:

| | |
|---|---|
| **Withdrawal from activities of interest** | **Yes = decline in hobbies that may/may not include socializing with others (reading, crosswords, jigsaw puzzles, knitting)** |

# Nutritional Issues Items

- Nutritional issues Items

# The Frailty Scale
# Review of Nutritional Issues items 20

- Item 20: Weight loss

| Weight loss (unintentional) | ☐ No | ☐ Yes (1) |
|---|---|---|

Scoring tip:

| Weight loss | Yes = unintentional weight loss in last 90 days |
|---|---|

# The Frailty Scale
# Review of Nutritional Issues items 21

- Item 21: Appetite

| Loss of appetite | ☐ No | ☐ Yes (1) |
|---|---|---|

Scoring tip:

| Loss of appetite | Yes = in last 90 days |
|---|---|

# The Frailty Scale
# Review of Nutritional Issues items 22

- Item 22: Food intake

| | | |
|---|---|---|
| **Decrease in food eaten (unintentional)** | **☐ No** | **☐ Yes (1)** |

Scoring tip:

| | |
|---|---|
| **Decrease in food eaten** | **Yes = unintentional decrease in food consumption in last 90 days.** |

# Clinical Symptoms and Diagnoses

- Clinical symptoms and diagnoses

# The Frailty Scale
# Review of Clinical Symptoms items 23

- Item 23: Bowel incontinence

| | | |
|---|---|---|
| **Bowel incontinence – last 3 days** | ☐ **No** | ☐ **Occasional (1)** |

Scoring tip:

| | |
|---|---|
| **Bowel incontinence-last 3 days** | **Occasional = report of 1 or more incontinent episodes in last 3 days** |

# The Frailty Scale
# Review of Clinical Symptoms items 24

- Item 24: Urinary tract infection

| | | |
|---|---|---|
| **Urinary tract infection, last 90 days** | **☐ No** | **☐ Yes (1)** |

Scoring tip:

| | |
|---|---|
| **UTI – last 90 days** | **Yes = report of UTI in last 90 days** |

# The Frailty Scale
# Review of Clinical Symptoms items 25

- Item 25: Renal failure

| Renal failure - current | ☐ No | ☐ Yes (1) |
|---|---|---|

Scoring tip:

| Renal failure | Yes = report of present renal failure |
|---|---|

# The Frailty Scale
# Review of Clinical Symptoms items 26

- Item 26: Pneumonia

| Pneumonia - current | ☐ No | ☐ Yes (1) |
|---|---|---|

Scoring tip:

| Pneumonia | Yes = report of present pneumonia |
|---|---|

# The Frailty Scale
# Review of Clinical Symptoms items 27

- Item 27: Congestive heart failure

| | | |
|---|---|---|
| **Congestive heart failure - current** | ☐ **No** | ☐ **Yes (1)** |

Scoring tip:

| | |
|---|---|
| **Congestive heart failure** | **Yes = report of present congestive heart failure** |

# The Frailty Scale
# Review of Clinical Symptoms items 28

- Item 28: Emphysema

| | | |
|---|---|---|
| **Emphysema - current** | ☐ **No** | ☐ **Yes (1)** |

Scoring tip:

| | |
|---|---|
| **Emphysema** | **Yes = report of present emphysema** |

# The Frailty Scale—Final score

_____ out of 30

# Questions?

# Q&A?

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# Appendix C & D: Relevant Articles

# Relevant Articles

**Appendix C** – Article: Development of the interRAI home care frailty scale published in *BMC Geriatrics* on November 21, 2016.

**Summary:** The concept of frailty, a relative state of weakness reflecting multiple functional and health domains, continues to receive attention within the geriatrics field. It offers a summary of key personal characteristics, providing perspective on an individual's life course. The interRAI Home Care Frailty Scale is based on a strong conceptual foundation and in the analysis, performed as expected. Given the use of the interRAI Home Care Assessment System in multiple, diverse countries, the Home Care Frailty Scale will have wide applicability to support program planning and policy decision-making impacting home care clients and their formal and informal caregivers throughout the world. Read the full article here.

**Appendix D** – Article: Implementing a Community-Based Initiative to Improve Nutritional Intake among Home-Delivered Meal Recipients published in *Public Health Nutrition and Health Aging* on February 23, 2022.

**Summary:** Home-delivered meal (HDM) recipients are a highly vulnerable group of older adults at risk for malnutrition and subsequent health decline. To help HDM recipients increase their nutritional intake, HDM agencies may provide expanded meal options that allow older adults to have greater autonomy over their meal selection; however, the extent to which recipients are able to select nutritious meals that are responsive to their health complexities is unknown. This study examined the nutritional content of meals selected by HDM recipients enrolled in an expanded menu plan through a large HDM agency. Data were drawn from a retrospective chart review of 130 HDM recipients who had the option of selecting their own HDM meals and frequency of meal delivery. Findings indicate that older adults who selected their own meals chose meals that were significantly lower in protein, potassium, fat, and calories. The lack of these nutrients suggests that older adults enrolled in expanded menu plans should be referred to registered dietitian nutritionists who can provide skilled guidance in meal selection. To address this need, we also describe and provide preliminary data representing a referral program designed to connect HDM recipients to dietetic services with the goal of optimizing older adult nutrition and health-related outcomes. Read the full article here.

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# Appendix E: Frontiers HDM Frailty Implementation

Published Article available for download.

# Strategies for Implementing the Home Care Frailty Scale with Home-Delivered Meal Clients

**Lisa A. Juckett[1*], Haley V. Oliver[1], Govind Hariharan[2], Leah E. Bunck[3], Andrea L. Devier[3]**

[1]Occupational Therapy Division, School of Health and Rehabilitation Sciences, College of Medicine, The Ohio State University, Columbus, Ohio, United States
[2]Coles College of Business, Kennesaw State University, Kennesaw, Georgia, United States
[3]Lifecare Alliance, Columbus, Ohio, United States

***Correspondence:**
Lisa A. Juckett
lisa.juckett@osumc.edu

**Keywords**: Evidence-based practice; home- and community-based care and services; evaluation; nutrition implementation science

## Abstract

**Introduction:** Frailty is a complex condition that is highly associated with health decline and the loss of independence. Home-delivered meal programs are designed to provide older adults with health and nutritional support that can attenuate the risk of frailty. However, home-delivered meal agencies do not routinely assess frailty using standardized instruments, leading to uncertainty over the longitudinal impact of home-delivered meals on frailty levels. Considering this knowledge gap, this study aimed to facilitate home-delivered meal staff's implementation of a standardized frailty instrument with meal clients as part of routine programming. This article (a) describes the use of Implementation Mapping principles to develop strategies supporting frailty instrument implementation in one home-delivered meal agency and (b) examines the degree to which a combination of strategies influenced the feasibility of frailty instrument use by home-delivered meal staff at multiple time points.

**Methods and Materials**: This retrospective observational study evaluated staff's implementation of the interRAI Home Care Frailty Scale (HCFS) with newly enrolled home-delivered meal clients at baseline-, 3-months, and 6-months. The process of implementing the HCFS was supported by five implementation strategies that were developed based on tenets of Implementation Mapping. Rates of implementation and reasons clients were lost to 3- and 6-month follow-up were evaluated using descriptive analyses.

**Results**. Staff implemented the HCFS with 94.8% ($n$ = 561) of eligible home-delivered meal clients at baseline. Of those clients with baseline HCFS data, staff implemented the follow-up HCFS with 43% of clients ($n$ = 241) at 3-months and 19.4% of clients ($n$ = 109) at 6-months. Insufficient client tracking and documentation procedures complicated staff's ability to complete the HCFS at follow-up time points.

**Discussion**. While the HCFS assesses important frailty domains that are relevant to home-delivered meal clients, its longitudinal implementation was complicated by several agency-level factors that limited the extent to which the HCFS could by feasibly implemented over multiple time points. Future empirical studies are needed to design and test theoretically derived implementation strategies to support frailty instrument use in the home- and community-based service setting.

**Keywords**: Evidence-based practice; home- and community-based care and services; evaluation; nutrition and feeding issues; D&I/implementation science/pragmatic trials

## Introduction

Home-delivered meal programs provide community-dwelling older adults with health and nutritional support that help optimize wellness and reduce the need for more advanced healthcare services (1,2). Programming often targets older adults who are unable to safely and independently perform routine mealtime activities (e.g., shopping, meal preparation), who live alone and below the poverty line, and experience fair-to-poor health (3,4). In a recent nationwide sample, 76% of home-delivered meal clients had at least one activity of daily living (ADL) impairment, 74% had five or more reported health conditions, and 33% experienced difficulty affording food items on a routine basis (5).

The aforementioned characteristics of home-delivered meal clients also place them at elevated risk for frailty – a complex condition associated with age-related declines in physiological health (6–8). Frailty-related health declines drastically minimize older adults' ability to tolerate health stressors (e.g., acute illness), leading to poorer health outcomes and individual healthcare costs that can total over $30,000 annually (9,10). Although various health professionals (e.g., physicians, nurse practitioners) can address frailty and its associated risk factors (11), the assessment of frailty can be time- and resource-intensive (12,13), particularly with older adults, such as home-delivered meal clients, who present with complex needs and chronic comorbidities (3,14). Given that over 70% of home-delivered meal clients experience frailty (15), innovative approaches are needed to regularly assess and monitor the frailty levels of older adults enrolled in home-delivered meal programs.

Frailty has previously been assessed in the home-delivered meal setting by means of secondary data analyses (e.g., chart review) (15) but has yet to be examined longitudinally through the use of standardized frailty instruments administered directly to clients. The implementation, also referred to as "uptake" or "use," of such instruments by home-delivered meal staff has the potential to provide home-delivered meal agencies with metrics representing clients' improvement or maintenance of frailty levels – metrics that are necessary for demonstrating the valuable impact of these meal programs overtime (16,17).

Despite the high prevalence of frailty and the importance of monitoring frailty levels, there is little guidance for how home-delivered meal staff members can effectively implement instruments that validly and reliably assess frailty, particularly when those instruments are implemented at multiple time points (e.g., baseline, 3-month, and/or 6-month follow-up). Accordingly, the purpose of this paper is to (a) describe the use of Implementation Mapping (18) principles to develop strategies supporting frailty instrument implementation in one home-delivered meal agency and (b) examine the degree to which a combination of strategies influenced the feasibility of frailty instrument use by home-delivered meal staff at multiple time points. Insights from agency staff and leadership also illuminate challenges and opportunities for implementing frailty instruments within the home-delivered meal context. This work underscores practical considerations for how home-delivered meal providers may assess frailty and continuously monitor health status changes among a highly vulnerable group of community-dwelling older adults.

## Materials and Methods

### Study Design

To evaluate our implementation strategies, we used a retrospective observational design and examined home-delivered meal staff's implementation the interRAI Home Care Frailty Scale (HCFS; Morris et al., 2016) at baseline (program enrollment), 3-months, and 6-months.

### Setting

The agency partner for this study was a not-for-profit organization that provided home-delivered meals and nutritional support services to older adults, age 60 and over, in the five surrounding counties of Columbus, Ohio. With a staff of over 200 full- and part-time individuals, our partner agency employed a diverse group of staff members representing the fields of social work, nursing, community health, and dietetics, as examples.

### Frailty Instrument Description

The HCFS is a 30-point scale developed from a secondary analysis of client-level interRAI Home Care data (Morris et al., 2016). HCFS items cover the following five domains: *function*, *movement*, *cognition and communication*, *social interaction*, and *nutrition*, with higher HCFS scores indicating greater levels of frailty. Agency staff members and leaders, in collaboration with our research team, selected to implement the HCFS given its perceived ease of use by clinical and non-clinical staff, implementability via telephone (a requirement per state COVID-19 restrictions on in-home visits), and evidence of acceptable internal consistency and criterion-related validity (see Morris et al., 2016, Table 2). Unlike the agency's standard in-take assessment that was implemented with clients upon enrollment and every 12-months thereafter, staff implemented the HCFS at 3-month and 6-month follow-up points for the purposes of the present study.

### Implementation Mapping

Implementation Mapping is a systematic, theory- and evidence-informed process designed to guide the development of *implementation strategies* – or the approaches used to support the uptake of high-quality interventions, assessments, programs, or practices (18,20). It consists of a series of tasks that culminate in implementation strategy deployment and the evaluation of implementation outcomes (e.g., feasibility, adoption, fidelity) (21). The manner in which these tasks were applied to HCFS implementation is described below and expand upon prior methods used to develop implementation strategies in the community-based setting (22). All Implementation Mapping tasks (Figure 1) were co-led by agency partners (assistant director of nutrition programs, a case manager, and three administrators) in collaboration with our research team.

[Insert Figure 1]

**Task 1. Conduct a needs assessment.** Our needs assessment was conducted in two phases. Phase 1 involved 1-on-1 interviews and focus groups with home-delivered meal staff as well as personal care assistants, homemakers, nurses, and dietitians employed by our partner agency. Interview and focus group guides were structured to evaluate the factors (i.e., determinants or barriers and facilitators) influencing evidence-based practice implementation in the context of home- and community-based services more broadly. Qualitative data underwent directed content analysis to identify key determinants of evidence implementation, and complete methodological details are reported elsewhere (23). In Phase 2, we held three, one-hour meetings with agency leadership and staff to understand current workflow procedures and how those procedures may be altered as a result of implementing the HCFS with home-delivered meal clients.

**Task 2. Identify implementation determinants, outcomes, and performance objectives.** Through our needs assessment, we identified that determinants at the agency-level – rather than policy-level, staff-level, or client-level – served as major determinants of HCFS implementation. In recognition of these determinants, home-delivered meal program directors, assessment staff, and the research team established the target outcomes (21) and performance objectives that needed to be achieved in order for HCFS implementation to be successful. Establishing target outcomes and performance objectives also informed the research team's selection of data sources available within the agency that were needed for our outcome evaluation.

**Task 3. Choose guiding theory; select implementation strategies.** The identification of determinants (Task 2) was informed by the Consolidated Framework for Implementation Research (CFIR) – a meta-theoretical framework of constructs representing the dynamic context within which organizations may implement new practices (24). Thus, the CFIR also guided the research team's selection of HCFS implementation strategies that were vetted and confirmed by agency partners. Strategies were drawn from the Expert Recommendations for Implementing Change (ERIC) taxonomy (Powell et al., 2015) using the CFIR-ERIC matching tool (Powell et al., 2015; Waltz et al., 2019). Whereas the CFIR provides uniform nomenclature to define implementation barriers and facilitators, the ERIC taxonomy is a compilation of over 70 implementation strategies hypothesized to promote the uptake of evidence-based practices into routine care. The CFIR-to-ERIC matching tool uses expert opinion data to generate a rank-ordered list of specific strategies to support evidence -based practice implementation.

**Task 4. Design and deploy implementation strategies and materials.** Our team began designing our implementation strategies and materials over the course of 5-months prior to HCFS implementation. Strategy development was led primarily by the agency's assistant director of nutrition programs as well as our research team. All strategies were designed and operationalized according to recommendations by Proctor et al. (2013). These recommendations include: clearly identifying the individuals involved in providing (actors) and receiving each strategy (action targets), describing how the strategy is delivered (action), and establishing the strategy's main goal (outcome), justification (rationale), and frequency (temporality, dosage).

**Task 5. Evaluate implementation outcomes.** To evaluate HFCS implementation outcomes, data were collected retrospectively from our agency's custom HCFS documentation website from the 12-month time period of June 1, 2020 – May 31, 2021, as per chart audit recommendations for implementation studies (Prusaczyk et al., 2018). HCFS data were examined monthly by the research team to determine rates of HCFS implementation for individual clients at baseline, 3-months, and 6-months. Rates were established by calculating the proportion of clients who had documentation of the HCFS being completed compared to the total number of clients eligible for the HCFS. Documented reasons why staff were unable to complete the HCFS with clients were also analyzed descriptively. All associated research activities were approved by the Institutional Review Board at The Ohio State University (#2020E1238).

## Results

### Results from Task 1: Conduct a needs assessment

Our needs assessment found three key, agency-level determinants influencing the implementation of evidence-based practices in the home-delivered meal setting. These determinants, as defined by the CFIR (24), were: (1) networks and communications, (2) available resources, and (3) compatibility (23). *Networks and communications* referred to the nature and quality of how HCFS data were documented and shared within the agency; *available resources* included the time, staff, and equipment needed to implement the HCFS; and *compatibility* referred to the perceived "fit" of the

HCFS with the agency's existing workflow and values. Our meetings with agency leadership and staff also allowed our team to gather robust understanding of standard in-take assessment procedures and the extent to which these procedures would be altered by implementing the HCFS at multiple time points. Figure 2 compares staff's processes of implementing both the standard in-take assessment and the HCFS.

[Insert Figure 2]

**Results from Task 2: Identify implementation determinants, outcomes, and performance objectives**

Determinants of implementation were identified through the completed needs assessment (see above). Consensus from agency leadership and staff indicated their primary outcome of interest was staff's *feasibility* of implementing the HCFS longitudinally. For the present study, feasibility was defined as the utility or suitability of an evidence-based innovation for everyday use, which can be measured through the collection and analysis of administrative or health record data (21,27). Lastly, agency partners identified the following, single performance objective for staff: To implement the HCFS with 100% of home-delivered meal clients – funded through Title-IIIC – at baseline as well as 3-months and 6-months after program enrollment, for all clients still enrolled in a meal plan.

**Results from Task 3: Choose guiding theory and select implementation strategies**

Identified determinants from the CFIR, recommendations from the CFIR-ERIC matching tool, and input from agency leadership and staff facilitated our selection of *five* implementation strategies to address the determinants of networks and communications, available resources, and compatibility. These included (a) conduct ongoing training, (b) identify and prepare a HCFS champion, (c) complete pilot testing, (d) change record systems, and (e) perform chart audits and provide feedback.

**Results from Task 4: Design and deploy implementation strategies and materials**

The five implementation strategies designed and deployed by our team are described below and specified in (Table 1):

**Conduct ongoing training**. When developing the structure for HCFS staff training, our team purchased the HCFS training manual ($65) (28), which contained instructions for how to administer and interpret each of the 29 HCFS items. We then converted the training manual into a presentation format that was delivered to home-delivered meal staff members during an initial training session. Initial training consisted of an in-depth review of all HCFS items, examples of how to score the HCFS, demonstration of how to document the HCFS (see "Change record systems" description below) and a question-and-answer session. Five months after initial training, a 1-hour follow-up "booster" training session was held. Training materials were updated with additional examples of how to administer and interpret client responses to individual HCFS items. Staff were also provided a "cheat sheet" document for interpretation and scoring of item responses.

**Identify and prepare a HCFS champion**. The agency's assistant director of nutrition programs held the role of HCFS champion. In addition to their leadership within the agency, the champion had extensive knowledge of agency workflow and oversaw assessment procedures completed by staff. In this role, the HCFS champion received advanced training in administering and interpreting the HCFS, facilitated our research team's receipt of monthly HCFS data files for auditing and analysis, and maintained a tracking log of clients to indicate when each baseline HCFS was completed as well as anticipated dates for 3-month and 6-month HCFS collection. Each month, the HCFS champion emailed staff the updated tracking log and also sent weekly emails containing a list of clients due to

have their HCFS completed. Staff were responsible for administering the HCFS within a 14-day window of clients' estimated 3- or 6-month HCFS follow-up date. Moreover, the champion held biweekly phone calls with our research team to discuss concerns with HCFS implementation and to clarify discrepancies in staff's interpretation of individual HCFS items.

**Complete pilot testing**. After initial HCFS training, home-delivered meal staff ($n$ = 7) pilot tested the HCFS with a minimum of 10 clients over a 30-day period. Piloting the HCFS allowed for home-delivered meal staff and leadership to gain comfort with its administration and allowed our research team to clarify any challenges with HCFS interpretation prior to formally rolling out the HCFS with all home-delivered meal clients. Results from pilot testing also informed how our research team structured "booster" training sessions with staff, such as by including specific examples of how to interpret/score responses to each HCFS item.

**Change record systems**. As part of our agency's routine operating procedures, all standard in-take assessments were completed by staff and entered into the agency's main EHR system. Building HCFS items into the main EHR required involvement from programmers external to the agency, thus complicating the extent to which staff could feasibly document the HCFS electronically. As a solution to this documentation issue, the agency's information technology (IT) department developed their own HCFS website that allowed staff to document HCFS data electronically but separately from the agency's EHR system. Staff accessed the HCFS website to enter the following data: (a) client ID, (b) date HCFS was attempted, (c) HCFS completion [yes/no], (d) reason if HCFS was *not* completed [unable to reach client after three attempts, client unenrolled from services, client deceased, client on hold, etc.], (e) responses to all 29 HCFS items, (f) date follow-up HCFS was expected, and (g) name of staff member completing the HCFS.

**Perform chart audits and provide feedback**. The HCFS champion shared monthly data sets with our research team who monitored the extent to which staff completed the HCFS at baseline, 3-month, and 6-month time periods. Implementation rates were reported to agency leadership during each monthly team call. When rates of implementation fell below 60-70%, the HCFS champion provided additional reminders to staff via email and encouraged staff to share any challenges they experienced relative to HCFS use or scoring. Further details on this audit-and-feedback approach and our four additional implementation strategies are described in Table 1.

[Insert Table 1]

**Results from Task 5: Evaluate implementation outcomes**

**Feasibility of implementation**. Analyses from our retrospective chart review indicated that rates of implementation were highest in June 2020 (94.6%) and lowest in May 2021 (57.1%) (Figure 3). Staff completed the HCFS with 94.8% of eligible clients at the baseline timepoint. Of those who completed the HCFS at baseline, however, staff were only able to obtain HCFS data from 43% of clients at 3-months and 19.4% of clients at 6-months.

[Insert Figure 3]

**At baseline, the most common reason staff were unable to complete the HCFS was attributed to clients ($n$ = 13) being "on hold" as they were recently hospitalized or admitted to a care facility (e.g., rehabilitation**

**facility), had a family member who could temporarily provide nutritional support, or were in the process of relocating. At 3-month and 6-month follow-up, clients having "unenrolled" from their meal plan was the most frequently *documented* reason staff could not complete the HCFS (*n* = 77 at 3-months; *n* = 24 at 6-months) (Figure 4). Overwhelmingly, however, staff did not or were not able to document the reasons clients were lost to follow-up. The reason for missed follow-up was *not* documented for 53.8% of clients at 3-months and 83.9% of clients at 6-months.**

## Discussion

This study examined one home-delivered meal agency's process of implementing the HCFS – an instrument for measuring the frailty levels of home-delivered meal clients at multiple time points. Although our strategies to support HCFS use by home-delivered meal staff were systematically developed using principles from Implementation Mapping (18,22), our strategies did not lead to the feasible collection of HCFS data from clients overtime. Though staff demonstrated a high rate of HCFS implementation at baseline (94.8%), our findings also indicated that follow-up HCFS data were not collected from as high as 84% of home-delivered meal clients for reasons such as staff being unable to contact clients, clients having meal deliveries placed on temporary "holds," or clients becoming unenrolled from services. Insights provided by our agency partners, described below, shed light on the complex challenges associated with HCFS implementation and opportunities for improvement given the importance of monitoring the frailty levels of home-delivered meal clients over time. Specifically, these insights draw attention to the intricate details that may have been overlooked when our agency and research team members were designing strategies to support HCFS implementation. Consistent with our guiding framework, insights are organized by constructs from the CFIR (24).

### Agency Insights: HCFS Implementation Challenges

**Networks and communications.** Perhaps the most significant agency-level factor influencing HCFS implementation was the manner in which it was documented and how HCFS data were communicated across the agency. Given that modifications within the main EHR system could not be made directly by the agency, its IT department built a custom website – accessible only to agency staff – for HCFS documentation. Though this solution was initially a viable option to support HCFS use, it ultimately posed challenges for our team over the course of our study period. For instance, as indicated in Figure 2, both the in-take assessment and HCFS evaluated areas related to functional status and nutrition. These areas of overlap were duplicative and interrupted the flow of staff's assessment procedures, especially as staff were required to access two different documentation systems to complete all in-take and baseline HCFS items. This interruption also hindered staff's natural course of conversation in the first encounter during which staff could build rapport with clients. Further, staff found substantial difficulty in tracking which clients needed to be contacted for their 3-month and 6-month HCFS. Although the HCFS champion's tracking log and reminder emails helped alert staff when they needed to contact clients for follow-up, these reminders did not indicate if clients were still actively receiving meals, nor did they list client phone numbers. Accordingly,

staff were expected to log into their EHR system account, verify that the client had an active meal plan, and obtain the client's phone number, increasing the total amount of time staff were expected to dedicate to HCFS follow-up activities.

**Available resources**. Our agency's lack of integrated documentation systems also limited the extent to which HCFS data could be entered longitudinally for individual clients. To accommodate for this barrier, the research team had one dedicated member who was responsible for merging baseline, 3-month, and 6-month HCFS data together for individual clients, but this was not a sustainable solution for tracking client frailty levels. An additional, though minor, barrier to HCFS implementation was staff's lack of access to dual-monitor computers during standard in-take assessments. After completing in-take assessments in the EHR system, staff immediately transitioned to implementing the baseline HCFS with clients. However, given the challenge of logging out of the EHR system, opening a web browser, and accessing the custom HCFS website on the same computer, staff often completed the HCFS on a paper form and entered client responses – at a later time – through the HCFS website. The timing of data entry, though, was occasionally delayed given staff's other demands and work responsibilities.

**Compatibility**. The concept and format of the HCFS were initially perceived to be compatible by our agency's administrative leaders. Despite these perceptions, leaders later expressed their concern that the information collected via the HCFS was being underutilized internally. Once HCFS implementation began, agency staff and leaders quickly learned of the additional needs of clients (e.g., mobility needs, social interaction needs) that were not necessarily being met by meal delivery alone. Our agency partners expressed their discomfort with assessing but not *addressing* these needs that were revealed as a result of implementing the HCFS longitudinally.

## Agency Insights: Opportunities to Advance HCFS Implementation

**Advancing networks and communications**. Given that documentation was arguably the primary barrier to HCFS implementation, integrating the 29 HCFS items directly into the agency's main EHR system could have likely streamlined documentation, particularly during the baseline period where staff completed both the in-take assessment and HCFS. Going forward, centralizing this information in one location has the opportunity to decrease staff burden, improve assessment workflow, and enhance staff's interaction with clients (29). The return to in-person baseline assessments, pending statewide adjustments to COVID-19 restrictions, may also facilitate more streamlined assessments of frailty as staff can leverage their professional judgment and observational skills to determine the extent to which frailty domains (e.g., mobility, ADLs) are impaired (30,31).

**Advancing available resources**. Notably, staff who implemented the HCFS were partially compensated through a demonstration project grant which reduced the agency's expenditures towards implementation activities. As these funds were temporary, alternative strategies are needed to support staff's future ability to implement the HCFS feasibly and more consistently. Integrating HCFS items into the agency's main EHR system is a first step towards minimizing assessment and documentation burden on staff. Though, while customized changes to EHR systems have shown promise for improving the quality of staff documentation behaviors (32), these system-level changes may need to be augmented by additional sources of support to promote assessment implementation (33). One additional option for this support is through clinical alerts which have served as effective reminders for staff who are involved in client documentation activities (34,35). These alerts may take the forms of e-mails, electronic "flags" directly within client charts, and/or pop-up notices within the EHR. Such alert systems can also be configured to deliver text message reminders to staff if documentation is not completed for clients on a specified date (36). While these alert systems have led to

improvements in documentation, there is also the threat of "alert fatigue" which may negatively impact staff job performance and satisfaction (37). Thus, use of these alerts, how often they are triggered and under what circumstances should be thoughtfully considered in collaboration with staff and leaders involved in documentation procedures (38).

**Advancing HCFS compatibility**. Implementation of the HCFS revealed frailty-related needs (e.g., fall risk factors, mental health concerns) that staff did not feel fully equipped to address. Although home-delivered meal providers can serve as "gatekeepers" to other community-based services and supports for older adults (39), our agency's staff were not sufficiently aware of recommendations and local resources that could be shared with clients who indicated specific frailty needs. Cataloging these resources for staff, prior to the study period, may have facilitated their ability to make recommendations or referrals to other health and nutrition services, thereby improving the "fit" of the HCFS with the mission of our partner agency to maximize older adult health and well-being (14,40).

## Limitations

Although this study makes unique contributions to the understudied home-delivered meal context, it is not without limitations. First, our application of Implementation Mapping principles could have been strengthened by selecting a behavioral change theory to guide predictions about staff's HCFS use. While strategy selection was informed by the CFIR (24) – comprehensive implementation framework – frameworks are not explanatory in nature and can rarely help predict relationships among theoretical constructs. Secondly, our implementation strategy named "complete pilot testing" is not a discrete strategy as defined in the ERIC taxonomy (25) but was a strategy that was recommended by our agency partners prior to staff's use of the HCFS. We also recognize that our strategies only targeted agency-level implementation determinants whereas policy-level, staff-level, and client-level determinants may have also played an influential role in our implementation efforts. Third, given that this was a natural, observational study, we did not conduct an *a priori* power analysis but rather collected data retrospectively from clients over a 12-month time frame, as recommended for studies of implementation that include chart review methodology (26). Lastly, though we specified our five implementation strategies (Table 1), more robust details were needed to understand the mechanisms that promoted – or hindered – HCFS implementation. In addition to our own future work, we encourage other teams to consider routinely tracking their implementation activities to obtain thorough information on the types of implementation activities completed, their purpose, their duration, and the individuals involved (41).

## Conclusion

Home-delivered meal agencies are essential for providing health and nutrition services to a population of older adults at great risk for frailty-related health decline. Frailty instruments, such as the Home Care Frailty Scale (19), can serve as tools to help home-delivered meal staff assess and monitor the frailty levels of their clients. However, prior to adopting such instruments, home-delivered meal providers are encouraged to comprehensively evaluate and address barriers that pertain to the longitudinal electronic documentation of frailty data, the staff and resources needed to implement frailty instruments consistently, and the extent to which instruments "fit" within agency workflow and values.

## Conflict of Interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

## Author Contributions

LAJ conceptualized this study, led study activities, and led manuscript development. HVO completed data management and preliminary data analysis activities. GH assisted with developing the study design and approach to data analysis. LEB and AD completed project management activities and provided agency insights, as described in the Discussion section. All authors contributed to manuscript development and approved the final submitted version.

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**Data Availability Statement**

Data collected and analyzed for this manuscript are not publicly available as to comply with our partner agency's data sharing policies; however, materials used to deploy our implementation strategies with staff are available upon request made to the corresponding author.

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573 Table 1. Specification of strategies to promote HCFS implementation.

| **Specification Criteria** | **Implementation strategies** | | | | |
|---|---|---|---|---|---|
| | Conduct ongoing training | Identify and prepare a HCFS champion | Complete pilot testing | Change record systems | Perform chart audits and provide feedback |
| Actor | Research team | Research team | Research team | Research team, HCFS champion, IT department | Research team |
| Action | Conduct initial and follow-up training sessions | Prepare internal staff member to serve as on-site HCFS resource and liaison to research team | Conduct HCFS with HDM clients prior to full HCFS roll-out | Develop a web-based portal to increase ease of HCFS documentation | Review rates of HCFS adoption |
| Action target | HDM assessment staff | Assistant director of nutrition programs | HDM assessment staff | IT department; documentation systems | HDM assessors |
| Dose | 1-hour in-person training; 1-hour online training | 2-hour review of administration and documentation of HCFS | 1-month pilot of staffing administering the HCFS with HDM clients | Development of the 30-item web-based HCFS | Monthly chart review of completed HCFS |
| Temporality | Initial in-depth training in Jan 2020; follow-up training in June 2020; as needed emails and phone calls | Bi-weekly phone calls with research team; monthly phone calls with research team and assessors | 7 HDM assessors completed up to 10 HCFS with clients | Initial development of web-based HCFS; modifications to web-based HCFS made after pilot testing was complete (Jan 2020) | Every month for the first 3-months of implementation |
| Outcome | HCFS feasibility | HCFS feasibility | HCFS feasibility | HCFS feasibility | HCFS feasibility |
| Justification | CFIR-ERIC matching tool; agency input | CFIR-ERIC matching tool; agency input | CFIR-ERIC matching tool; agency input | CFIR-ERIC matching tool; agency input | CFIR-ERIC matching tool; agency input |

574 *Note*. Table adapted from Proctor et al.'s recommendations for specifying implementation strategies (20). HCFS = Home Care Frailty Scale; HDM = home-delivered
575 meal; IT = information technology. CFIR = Consolidated Framework for Implementation Research; ERIC = Expert Recommendations for Implementing Change.

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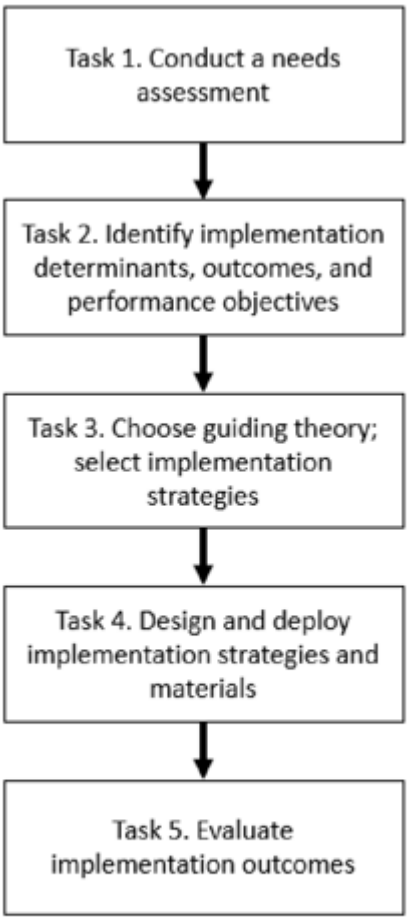


Figure 1. Implementation Mapping steps informed by Fernandez et al. (18).

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| | Standard in-take assessment | Home Care Frailty Scale (HCFS) |
|---|---|---|
| Initial assessment process | Staff completes in-take assessment via telephone with new clients at HDM enrollment | Staff completes HCFS with new client via telephone after in-take assessment completion |
| Areas assessed | Socio-demographics<br>Health history<br>Functional status<br>Malnutrition risk | Functional status<br>Mobility<br>Cognition/Comm.<br>Social interaction<br>Nutritional status |
| Documentation procedures | Documented in main EHR system | Documented in custom, HCFS website |
| Time to administer | 30-45 minutes | 15-20 minutes |
| Follow-up schedule | 12-months | 3-months<br>6-months |

Figure 2. Comparison of standard in-take assessment with HCFS at baseline, 3-months, and 6-months; HDM = home-delivered meals; EHR = electronic health record

582

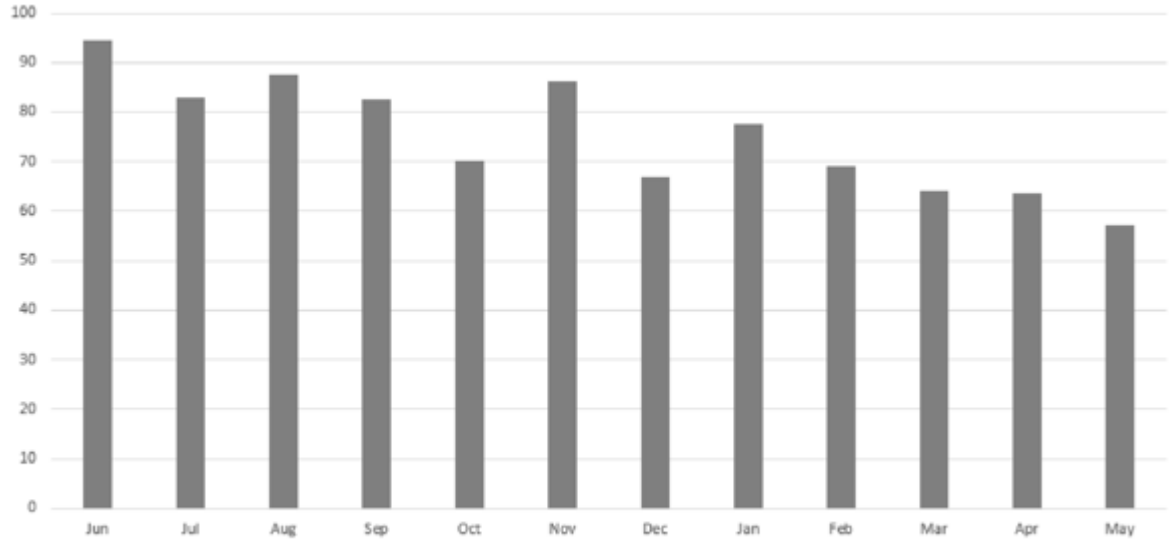


Figure 3. Monthly rates (%) of Home Care Frailty Scale implementation (June 2020 – May 2021)

583
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586 This project was supported, in part by grant number 90INNU0016, from the Administration for
587 Community Living, U.S. Department of Health and Human Services, Washington, D.C. 20201.
588 Grantees undertaking projects with government sponsorship are encouraged to express freely their
589 findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official
590 ACL policy.

# Appendix F: Yard Sign (Partner and Volunteer)


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# Appendix G: SixtyPLUS Magnet

**If you are 60 years of age or older and need home-delivered meals or diabetes management, call:**

LIFECARE ALLIANCE
Nourishing The Human Spirit.

# 614-278-3130

**www.lifecarealliance.org/referral**

ACL
Administration for Community Living

This project was supported, in part by grant number 90INNU0016, from the Administration for Community Living, U.S. Department of Health and Human Services, Washington, D.C. 20201. Grantees undertaking projects with government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official ACL policy.

# Appendix H: Partner Presentation

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# Overview of Organization

**Mission Statement**

LifeCare Alliance leads our community in identifying and delivering health and nutrition services to meet the community's changing needs.

**About Us**

- Located in Columbus, Ohio, LifeCare Alliance was founded in 1898 and currently provides a wide array of services, including home-delivered meals, congregate dining centers, diabetes counseling, homemaker services, and wellness centers.
- LifeCare Alliance delivers hot meals 365 days a year through its home-delivered meal congregate meals programs to over 8,000 consumers annually.
- LifeCare Alliance nutrition programs services five Ohio counties: four rural; one urban/suburban- Champaign, Franklin, Madison, Marion, and Logan
- LifeCare Alliance also has several “social entrepreneurship” ventures, including LA Catering, Corporate Wellness, and Adult Immunizations.

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# LifeCare in Marion County

- 225 Clients served in 2020 to Date
- 149 Clients currently being served through home delivered meals
- 26,541 meals delivered in 2019
- 21,609 in 2020 through July 31
- 10% of clients are 90 years or older
- 58% live alone
- 20% live with their spouse
- 90% of clients are in Marion proper
- Over 50% have diabetes

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# How did we get here?

- In 2018, noticed more referrals from EMS services and started researching community paramedicine.
- Starting offering in home diabetes counseling and online referral system.
- Looked for ways to continue partnerships, grow reach, and collect data on interventions.
- Awarded an Innovations in Nutrition Programs and Services grant through Administration of Community Living
- Only 1 of 7 group awarded this grant, and only one in the Midwest region
- Allows us to expand services to rural areas

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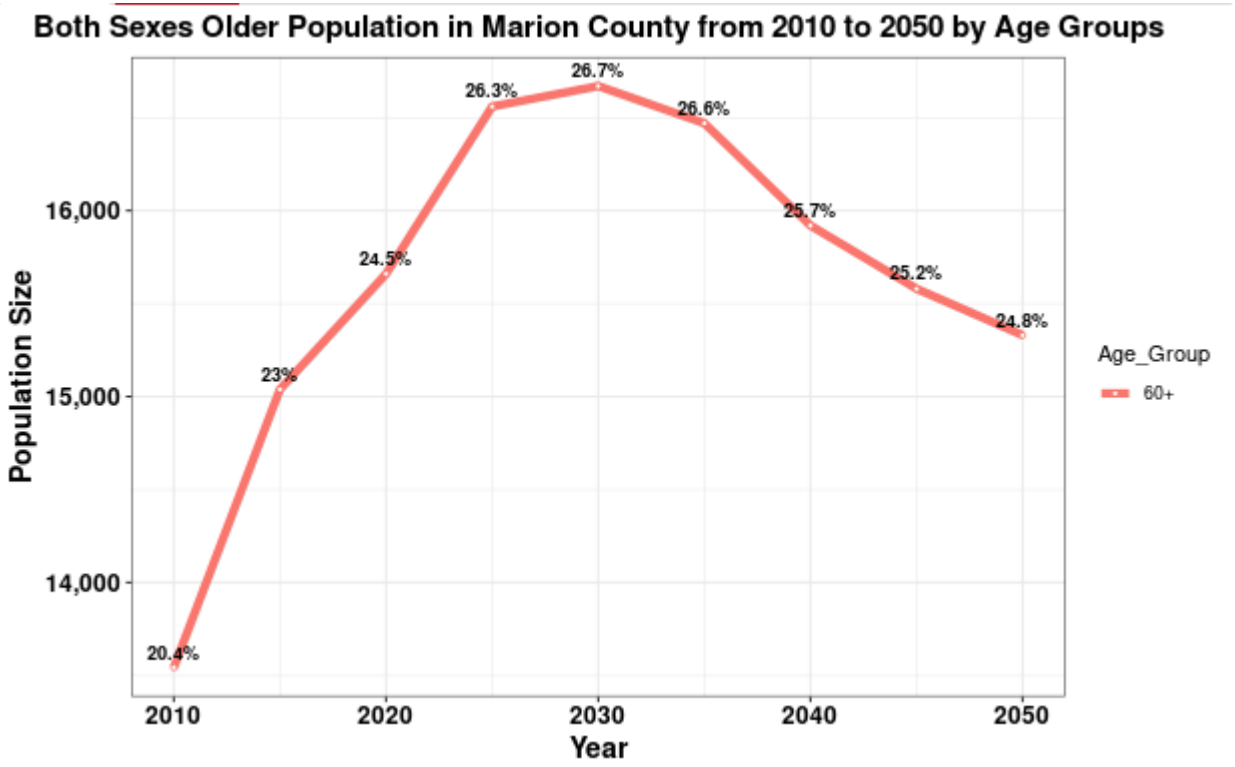
# Marion County “Silver Tsunami”




Mehri, N., Cummins, P. A., Nelson, I. M., Wilson, T. L., and Kunkel, S. (2019). *Ohio Population Interactive Data Center*, Scripps Gerontology Center, Miami University, Oxford, OH. www.ohio-population.org.

LIFECARE ALLIANCE
Nourishing The Human Spirit.

# SixtyPLUS is Born!

**What is it?**

SixtyPLUS bridges the gap between the healthcare and community-based service systems, to ensure the safety and wellbeing of seniors.

Together, we can position our community to meet the growing demand of seniors.

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Nourishing The Human Spirit.

# SixtyPLUS: a New Program!

**How It Works**

- Through strategic partnerships with first responders, medical professionals, discharge planners, etc., LifeCare Alliance intervenes to provide non-emergency assistance in the home, reducing seniors' reliance on excessive emergency resources.
- A few basic helps in the home — such as meals, wellness checks, or diabetes management — can help seniors to remain safe, independent, and in their own homes, where they want to be!
- Partners will securely share relevant data with LifeCare Alliance to identify senior needs and, over time, measure improvements in both service delivery and client outcomes.

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# Meet Ronald

- 75 year old male, lives alone, family lives in Maryland
- Diabetes, COPD, High Blood Pressure
- Loves his 2 Chihuahuas and the Price is Right

- Calls 9-1-1 every other week because blood sugar spikes. Forget to check blood sugar regularly.

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# SixtyPLUS: A New Program!!

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# Let's Help Ronald

- We all want Ronald to improve/maintain his health

LifeCare Interventions:

- In home (or phone) assessment of needs; additional referral made as needed
- Offer him weekly frozen meals, selected with our dietitians to work with his diabetes
- Offer in home diabetes counseling at no cost to him
- Client reports falls in shower- shower chair provided through LifeCare
- Bring pet food to his dogs every other week
- Weekly wellness check- report on blood sugar testing
  - Report back to Fire Department if client out of compliance

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# You Refer, We Deliver- Literally

- Meal delivery can start immediately next day (Monday-Friday)
- Daily or weekly wellness check catered to the request of the partner
  - Client to check blood pressure
  - Client to check A1C
  - Client to get out of bed before Meals-on-Wheels delivered
  - Did the client eat breakfast?

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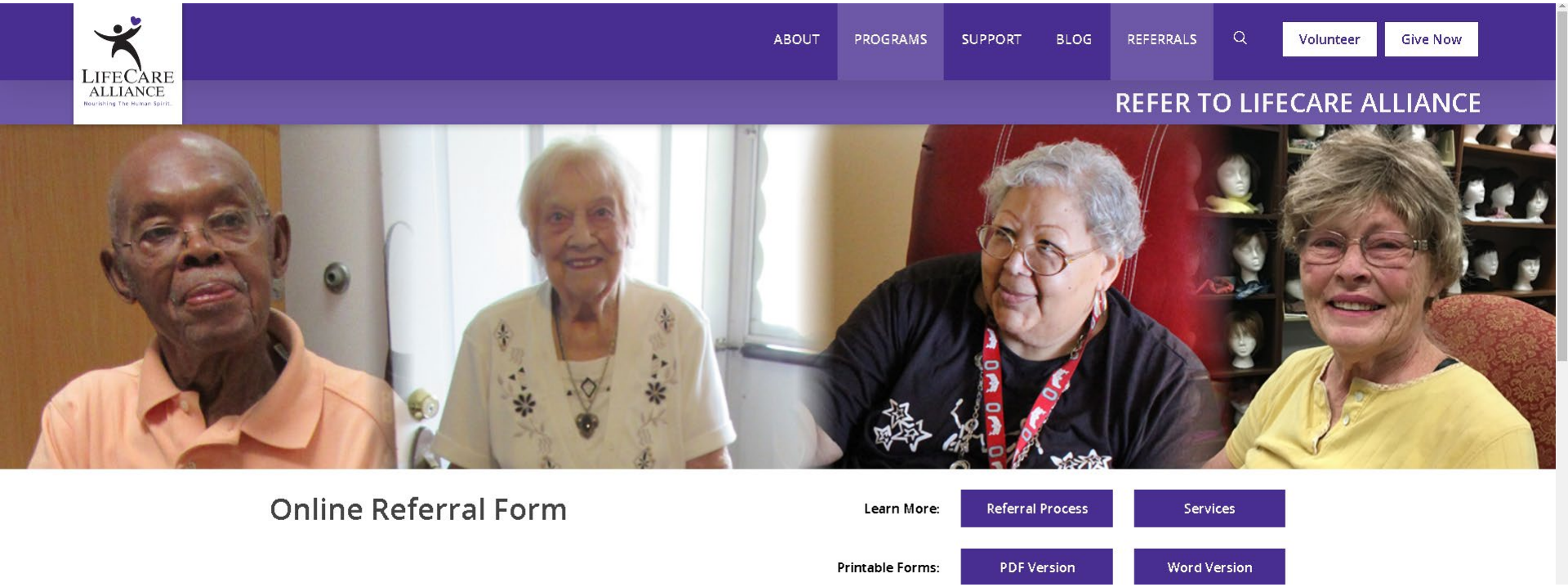
# One Stop Easy Referral Portal

- https://www.lifecarealliance.org/referral/



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# SixtyPLUS

**What's In It For You?**

- Become a part of a growing central Ohio network of community partners who are paving the way nationally for a long-term solution to meet an increasing demand for senior care.
- By measuring and evaluating service delivery and client outcomes, the project sets central Ohio apart as a leader.
- When you partner with LifeCare Alliance, we provide:
  - Collaborative analysis of local data to verify the project's success
  - Targeted marketing materials to distribute to senior patients
  - Shared media and press releases to highlight the innovative partnership

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# Partners

Current Partnerships:

- Fire Departments:
  - Jackson Township
  - Norwich Township
  - Prairie Township
  - Truro Township
- Researcher from The Ohio State University
- Administration for Community Living
- Local Area Agency on Aging
- Meals-on-Wheels of America

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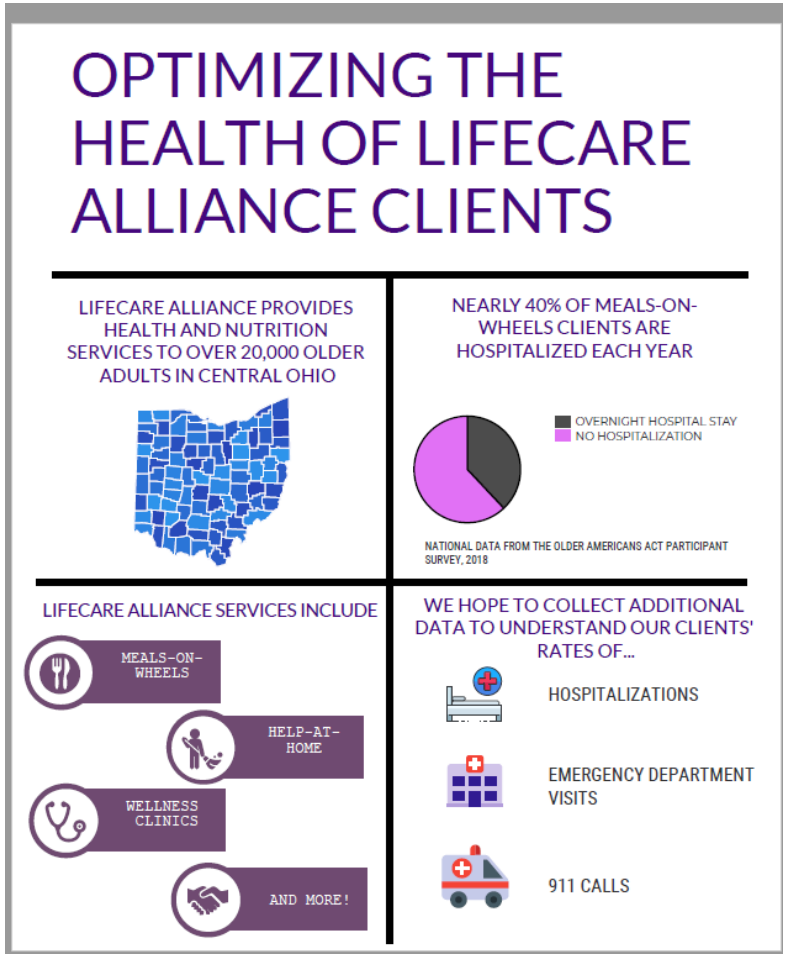
# Importance of Data Collection




- Can always make referrals
- MOU/BAA
- Enhanced partnership
- Frailty Scale to support our findings

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# Thank You!

Contact:

Fannisha Page

Client and Community Liaison

614-437-2881

Fpage@lifecarealliance.org

LIFECARE ALLIANCE
Nourishing The Human Spirit.

# Questions and Next Steps

This project was supported, in part by grant number 90INNU0016, from the Administration for Community Living, U.S. Department of Health and Human Services, Washington, D.C. 20201. Grantees undertaking projects with government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official ACL policy.

# Appendix I: Partner Meeting Questions

# Partner Meeting Questions

**Assessment of Partnership so far?**

**What/any has been beneficial for your department?**

**Has info sharing (BAA) been useful? Being utilized?**

**Have the referrals made resulted in any noticeable difference?**

**How many runs per year?**

**Is staff aware of partnership?**

**-of available services (MOWs vs nutrition counseling)/**

**-of how to refer?**

**-do they connect importance of good nutrition to fall reduction?**

**Are we capturing "frequent flyers"? (what metric designates that? How often?)**

**How can we capture this info?**

**Is there any way to follow-up with 60+ callers who call 911?**

**Is this an area you need help addressing?**

**Any benefit for you to review list of LCA clients in your county? Any known to you?**

**Would you like any follow-up from us after a referral is received?**

**Any other info/data you might want from us? How often?**

**What is currently limiting referring to LCA? Barriers?**

**Would a regular presence/contact be helpful? (or maybe presentations, bulletins, etc?)**

**What would you like to see from us in next 8 months?**

**Would you like to continue partnership?**

**Are you considering a paramedicine position for your department in future? (Factors to be considered?)**

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# Appendix J: Functional Home Assessment

**Functional Home Assessment** **Date_____**

**Name:** _____ DOB: _____ Age: _____ Veteran? _____

Address: _____ Phone: _____

Referred by: _____ Reason: _____

House/Condo/Apt/Complex Rent/Own___months/years Drives Y/N Rural/urban/suburban

Occupants of home_____

Services Utilized_____

Concerns of client/other_____

**Physical Function**

Health Hx/Disability_____

Ht_____ Wt_____ Vision_____ Hearing_____

R/L dominant Cognition_____

Pain issues_____

Adaptive Equipment Utilized_____

Endurance/Activity Tolerance_____

Fall Hx/Balance issues_____

TUG score_____ or Functional Reach score_____

Grip strength: R_____ L_____

UE function_____ LE function_____

Mobility/Transfers/Stairs_____

ADLs_____

IADL concerns_____

Meal prep/nutritional barriers_____

**Home Environment**

Parking lot/street parking/driveway/garage_____ Most used entrance_____

Auto doors/security doors/elevator Entrance/door: Width_____Threshold_____

Steps/ramp_____ Handrail_____

Additional entrance/exterior notes_____

_____

Mailbox house/curb/lobby_____ refuse_____

**Bathroom** 1st/2nd floor door_____ threshold_____

Toilet round/elongated Ht_____ grab bars_____

Step-in Shower/Tub step ht_____ ext ht_____ int ht_____ lip edge_____ bottom width_____

Grab bars_____Flooring_____

Tub material_____ Wall material_____

Shower head/hand-held/slide bar Sliding door/Curtain R/L entry Faucets knobs/lever

Sink vanity/wall-mount/pedestal Ht_____ W_____D_____ Knob/lever Lighting_____

Layout/accessibility/additional notes: _____

_____

B**edroom** 1st/2nd floor Door_____ Lighting_____

Bed size_____ Ht_____ W_____ Closet access_____ Phone_____

**Kitchen**_____

_____

**Living Room**_____

**Basement**_____

**Laundry**_____

Noted fall hazards_____

Phones_____ Smoke detector_____ CO2 detector_____

**Additional Notes**

_____
_____
_____
_____
_____

**Recommendations/Action Taken**

_____
_____
_____
_____

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# Appendix K: SixtyPLUS Project Columbus

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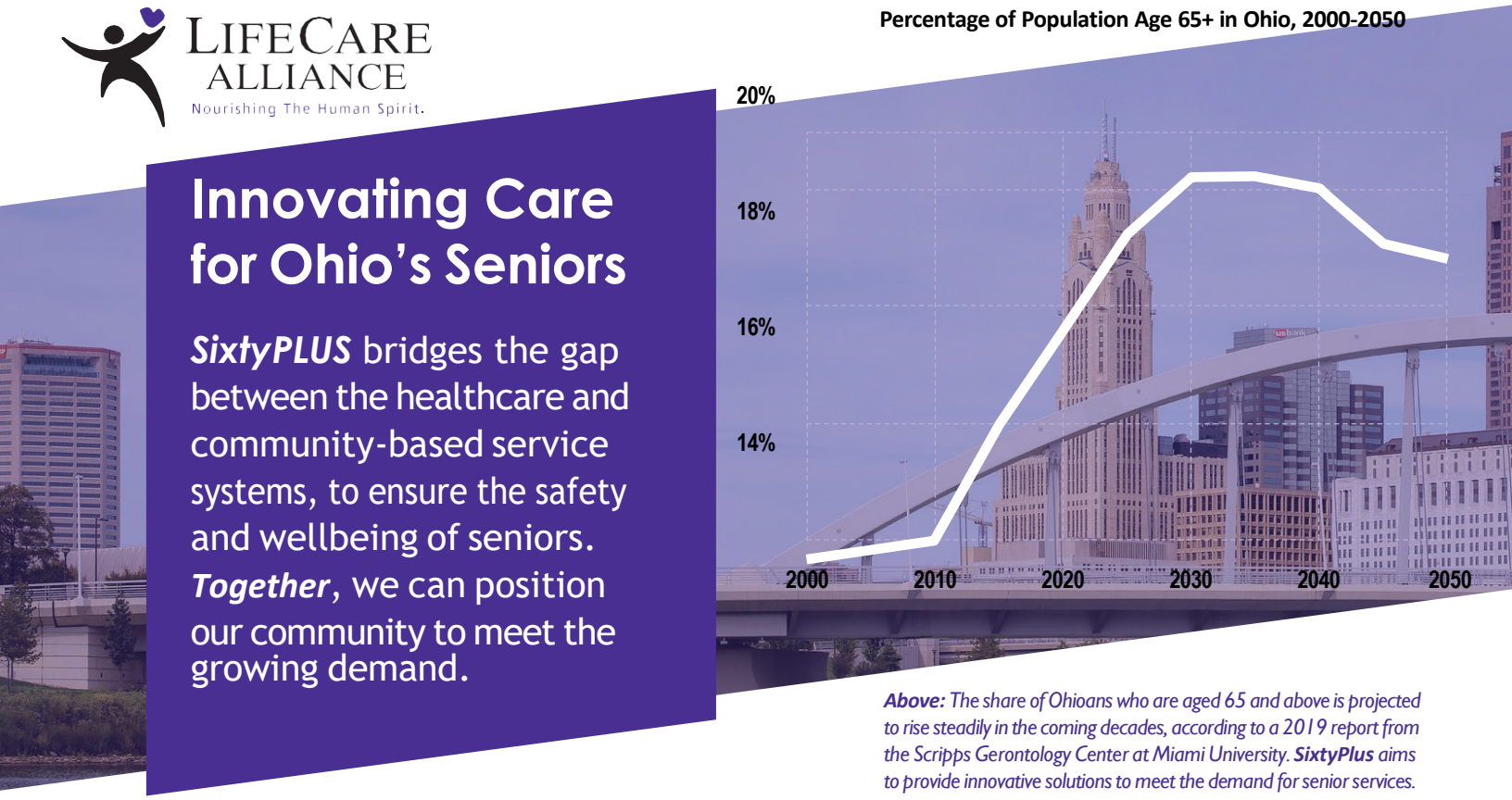
# Innovating Care for Ohio's Seniors

***SixtyPLUS*** bridges the gap between the healthcare and community-based service systems, to ensure the safety and wellbeing of seniors. ***Together***, we can position our community to meet the growing demand.




***Above:*** *The share of Ohioans who are aged 65 and above is projected to rise steadily in the coming decades, according to a 2019 report from the Scripps Gerontology Center at Miami University.* ***SixtyPlus*** *aims to provide innovative solutions to meet the demand for senior services.*

## *SixtyPLUS: A National Model for Success*

### How It Works

Through strategic partnerships with first responders, medical professionals, discharge planners, etc., LifeCare Alliance intervenes to provide non-emergency assistance in the home, reducing seniors' reliance on excessive emergency resources.

A few basic helps in the home — such as meals, home repairs, or chronic disease management — can help seniors to remain safe, independent, and in their own homes, where they want to be!

Partners will securely share relevant data with LifeCare Alliance to identify senior needs and, over time, measure improvements in both service delivery and client outcomes.

### What's In It For You?

Become a part of a growing central Ohio network of community partners who are paving the way nationally for a long-term solution to meet an increasing demand for senior care. By measuring and evaluating service delivery and client outcomes, the project sets central Ohio apart as a leader. When you partner with LifeCare Alliance, we provide:

- Collaborative analysis of local data to verify the project's success
- Targeted marketing materials to distribute to senior patients
- Shared media and press releases to highlight the innovative partnership

### A United Front

Distressed senior calls 911 for non-emergency help.

Public safety agencies respond, assessing need.

Senior referred to LifeCare Alliance for services.

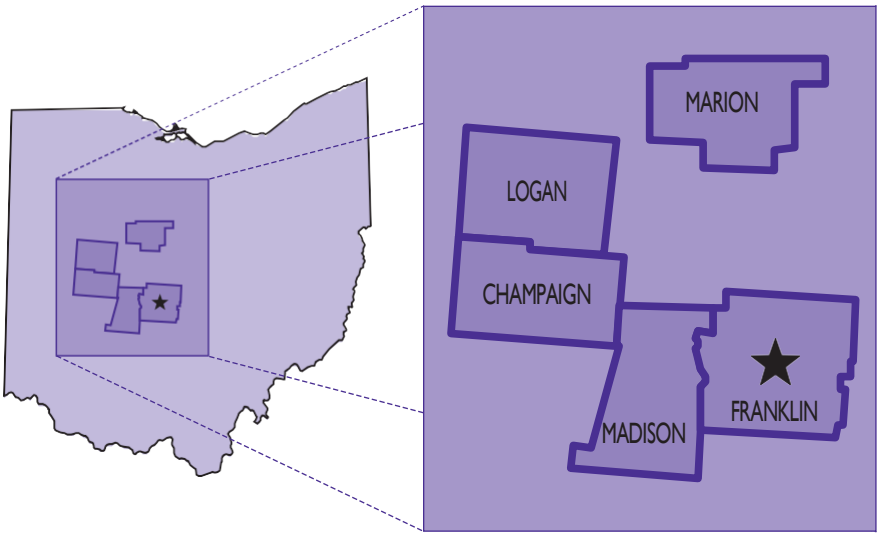
Long-term case management established.

### Contact

To get started, contact:

Fannisha Page
Community and Client Liaison
614-437-2881
fpage@lifecarealliance.org

# *SixtyPLUS*: About This Project




***Above:*** *LifeCare Alliance serves seniors and people with medical challenges or disabilities in five central Ohio counties — Franklin, Madison, Marion, Champaign, and Logan.*

## How Is This Program Possible?

LifeCare Alliance is one of seven nonprofits chosen from a nationwide pool of applicants to study the effectiveness of services offered to seniors in American communities.

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Administration for Community Living

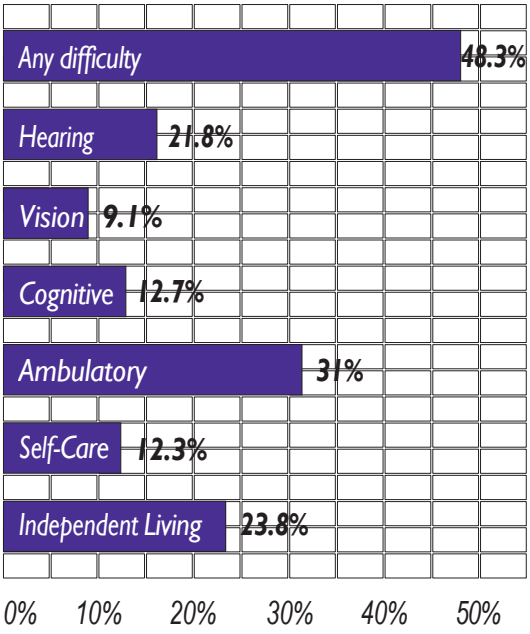
Through this study, called ***SixtyPLUS*** and funded by the Administration for Community Living, LifeCare Alliance will help create a national model to address the needs of the nation's growing senior population. We will implement unique and innovative partnerships with fire departments, hospital systems, and healthcare providers while collecting accurate data that represent the true impact of our services.

Together, we can "bridge the gap" between the healthcare system and the community-based service system for the betterment of our seniors.

## The Need

More than 48 percent of Ohioans aged 75 years and older live with a "functional difficulty," according to 2015 data from the U.S. Census Bureau. As Ohio's senior population continues to grow, communities will need to address the unique challenges faced by their older-adult residents.

***% of Adults Age 75+ with Functional Difficulties, by Type, 2015***




*Source: U.S. Census Bureau. 2013-2017 American Community Survey (ACS) 5-Year Summary File. Integrated Public Use Microdata Sample, National Historical Geographic Information Systems (IPUMS NHGIS), www.nhgis.org. Compiled by Scripps Gerontology Center at Miami University.*

Formed in 1898, LifeCare Alliance provides a comprehensive array of health and nutrition services to older adults and individuals living with a medical challenge or disability in central Ohio—keeping them safe, independent, and in their own homes, where they want to be! LifeCare Alliance operates a national model for its programs, leading in volunteer engagement, effective mergers, and social entrepreneurship. A not-for-profit organization, the Agency's mission is to lead the community in identifying and delivering health and nutrition services to meet the community's changing needs.

Meals-on-Wheels—Franklin, Madison, Marion, Champaign, and Logan Counties
Senior Dining Centers | Wellness Centers | Help-at-Home | Visiting Nurses
The Columbus Cancer Clinic | Project OpenHand-Columbus | Groceries-to-Go
IMPACT Safety | Central Ohio Diabetes Association | Senior PetCare | L.A. Catering
L.A. Wellness Works | Travel Vaccines and Immunizations | Meals-for-Kids | Carrie's Café

LIFECARE ALLIANCE
Nourishing The Human Spirit.

1699 West Mound Street
Columbus, OH 43223
614-278-3130
info@lifecarealliance.org
www.lifecarealliance.org

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# Appendix L: Business Associate Agreement

## BUSINESS ASSOCIATE AGREEMENT

**THIS BUSINESS ASSOCIATE AGREEMENT** ("Agreement") between **FILL HERE** ("Business Associate") and **ORGANIZATION** ("Covered Entity") is to allow the parties to comply with the provisions of 45 C.F.R. Parts 160 and 164 ("Privacy Rule") and Parts 160, 162, and 164 ("Security Rule") of the federal Code of Regulations dealing with confidentiality and security of health or health-related information, as well as the requirements of the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 (the "HITECH Act"), and any regulations issued by the United States Department of Health and Human Services ("DHHS").

### SECTION 1. DEFINITIONS

Terms used but not otherwise defined in this Agreement shall have the same meaning as used in the Health Information Portability and Accountability Act of 1996, as amended, and all regulations promulgated thereunder by the United States Department of Health and Human Services ("HIPAA").

1.1. "Protected Health Information" or "PHI" shall have the same meaning as the term "protected health information" in 45 C.F.R. 160.103, limited to information created or received by Business Associate from or on behalf of Covered Entity.

1.2. "Individual" shall have the same meaning as the term "individual" in 45 C.F.R. 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. 164.502(g).

1.3. "Required By Law" shall have the same meaning as the term "required by law" in 45 C.F.R. 164.103.

1.4. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his/her designee.

### SECTIONS 2. PERMITTED USES AND DISCLOSURES OF PHI

2.1. Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity as specified, provided that such use or disclosure would not violate the Privacy Rule or HITECH Act if done by Covered Entity.

2.2. Business Associate may use Protected Health Information it creates or receives from Covered Entity for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate.

2.3. Business Associate may disclose such Protected Health Information as necessary for Business Associate's proper management and administration or to carry out Business Associate's legal responsibilities only if:

a. The disclosure is required by law; or

b. Business Associate obtains reasonable assurance from any person or organization to which Business Associate will disclose such PHI that the person or organization will:

i. Hold such PHI in confidence and use or further disclose it only for the purpose for which Business Associate disclosed it to the person or organization or as required by law; and
ii. Promptly notify Business Associate (who will in turn promptly notify Covered Entity) of any instance of which the person or organization becomes aware in which the confidentiality of such PHI was breached.

2.4. Business Associate's use, disclosure or request of PHI shall utilize a Limited Data Set if practicable. Otherwise, Business Associate will make reasonable efforts to use, disclose, and to request of a Covered Entity only the minimum amount of PHI reasonably necessary to accomplish the intended purpose. However, Business Associate will not be obligated to comply with this minimum necessary limitation with respect to any use or disclosure that is excepted from the minimum necessary limitation as specified in 45 C. F. R. 164.502(b)(2).

2.5. Business Associate may de-identify and use any and all Protected Health Information created or received by Covered Entity under this Agreement, provided that the de-identification conforms to the requirements of the Privacy Rule. Such resulting de-identified information shall not be subject to the terms of this Agreement.

2.6. Business Associate may use Protected Health Information to report violations of law to appropriate federal and state authorities, consistent with 42 C. F. R. 164.502(j)(1).

**SECTIONS 3. OBLIGATIONS AND ACTIVTIES OF BUSINESS ASSOCIATE**

3.1. Business Associate agrees to not use or disclose Protected Health Information other than as permitted or required by this Agreement or any other agreement with Covered Entity or as Required by Law.

3.2. Business Associate agrees to establish and maintain appropriate administrative, technical, and physical safeguards that reasonably protect the confidentiality of PHI from any intentional or unintentional use or disclosure in violation of the Privacy Rule.

3.3. Business Associate agrees to establish and maintain appropriate administrative, technical, and physical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that Business Associate creates, receives, maintains, or transmits on Covered Entity's behalf as required by the Security Rule and the HITECH Act. Business Associate will also develop and implement policies and procedures to meet the Security Rule documentation requirements as required by the HITECH Act.

3.4. Business Associate agrees to promptly report to Covered Entity any security incident or unauthorized use or disclosure of the Protected Health Information of which it becomes aware. For purposes of this agreement, a "security incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of PHI or interference with Business Associate's system operations in Business Associate's information systems. This does not include routine, unsuccessful attempts that occur on a daily basis, including but not limited to pings on Business Associate's firewall, port scans, attempts to log on to Business Associate's system to enter a database with an

invalid password or username, or unsuccessful attempts to penetrate computer networks or servers maintained by the Business Associate.

3.5. Business Associate will report, following discovering and without unreasonable delay, any "Breach" of "Unsecured Protected Health Information" as these terms are defined by the HITECH Act and any implementing regulations. Business Associate will cooperate with Covered Entity in investigating the Breach and in meeting Covered Entity's obligations under the HITECH Act and any implementing regulations. Any such report will:

a. Include the identification (if known) of each individual whose Unsecured PHI has been, or is reasonably believed by Business Associate to have been, accessed, acquired, or disclosed during such Breach;
b. Identify the nature of the non-permitted access, use or disclosure, including the date of the Breach and the date of discovery of the Breach;
c. Identify the PHI accessed, used or disclosed as part of the Breach;
d. Identify who made the non-permitted access, use or disclosure and who received the non-permitted disclosure;
e. Identify what corrective action Business Associate took or will take to prevent further non-permitted access, use or disclosures: and
f. Identify what Business Associate did or will do to mitigate any deleterious effect of the non-permitted access, use or disclosure.

3.6. Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from or created or received by Business Associate on behalf of Covered Entity agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.

3.7. Within 15 days following Covered Entity's request, Business Associate will make available to Covered Entity or, at Covered Entity's request, an Individual (or the individual's personal representative) any PHI about the Individual that is in Business Associate's custody or control, so the Covered Entity may meet its access obligations under 45 C. F. R. 164.524 and, where applicable, the HITECH Act.

3.8. Business Associate will, upon receipt of notice from Covered Entity, promptly amend or permit Covered Entity access to amend any portion of the PHI which Business Associate created for or received from Covered Entity, so that Covered Entity may meet its amendment obligations under 45 C. F. R. 164.526.

3.9. Business Associate agrees to make its internal practices, policies and procedures, books and records pertaining to its use and disclosure of Protected Health Information, available to the U.S. Department of Health and Human Services to determine compliance with HIPAA or this Agreement.

3.10. Business Associate agrees to document and record disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to meet its disclosure accounting obligations under 45 C. F. R. 164.528.

a. Business Associate will make the disclosure information available to Covered Entity within 15 days following Covered Entity's request for such disclosure information to comply with an individual's request for disclosure accounting.
b. Where Business Associate is contacted directly by an individual based on information provided to the individual by Covered Entity, and where so required by the HITECH Act and/or any accompanying regulations, Business Associate will make such disclosure information available directly to the individual.
c. Except for repetitive disclosures of PHI as specified below, Business Associate will record for each accountable disclosure: (i) the disclosure date, (ii) the name and (if known) address of the person of entity to which Business Associate made the disclosure; (iii) a brief description of the PHI disclosed; and (iv) a brief statement of the purpose of the disclosure. Business Associate will provide any additional information to the extent required by the HITECH Act and any accompanying regulations.
d. For repetitive accountable disclosures of PHI that Business Associate makes for a single purpose to the same person or entity (including Covered Entity), Business Associate will record (i) the disclosure information specified in Section 3.9(a) above for the first of the repetitive disclosures; (ii) the frequency, periodicity, or number or number of the repetitive accountable disclosures; and (iii) the date of the last of the repetitive accountable disclosures.
e. Unless otherwise provided under the HITECH Act, Business Associate will maintain the disclosure information for 6 years following the date of the accountable disclosure to which the disclosure information relates.

## SECTIONS 4. OBLIGATIONS OF COVERED ENTITY

4.1. Covered Entity shall be responsible for using appropriate administrative, physical and technical safeguards to maintain and ensure the confidentiality, privacy, and security of Protected Health Information transmitted to Business Associate pursuant to this Agreement in accordance with the standards and requirements of the Privacy and Security Rules, until such Protected Health Information is received by Business Associate.

4.2. Covered Entity shall notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 C. F. R. 164.520, to the extent that such limitation(s) may affect Business Associate's use or disclosure of Protected Health Information.

4.3. Covered Entity will obtain any authorizations necessary for the use or disclosure of Protected Health Information so that Business Associate can perform its obligations under this Agreement and/or the underlying services agreement.

4.4. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose Protected Health Information, to the extent that such changes may affect Business Associate's use or disclosure of Protected Health Information.

4.5. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 C. F. R. 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.

4.6. Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity, except as such use or disclosure by Business Associate is otherwise allowed under the Agreement for data aggregation and/or management and administrative activities of Business Associate.

**SECTIONS 5. TERM AND TERMINATION**

5.1. **Term.** The term of this Agreement shall be effective as of the date this Agreement is signed by both parties, and shall terminate when all of the Protective Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section.

5.2. **Termination for Cause**. Upon Covered Entity's knowledge of a material breach of this Agreement by Business Associate that is directly related to the impermissible use or disclosure of Protected Health Information, Covered Entity shall either:

5.2.1 Provide an opportunity for Business Associate to cure the breach or end the violation; provided that the Covered Entity may terminate this Agreement and any underlying services agreement if Business Associate does not cure the breach or end the violation within a reasonable period of time; or

5.2.2 Immediately terminate this Agreement and any underlying services agreement if a cure is not possible.

5.3. **Effect of Termination.**

5.3.1 Except as provided in Section 5.3.2, upon termination of this Agreement for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall also apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

5.3.2 In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon providing such notice that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected

Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintain such Protected Health Information.

5.3.3 The respective rights and obligations of Business Associate under this Sections 5.3 shall survive the termination of this Agreement.

**SECTIONS 6. MISCELLANEOUS**

6.1. **Amendment**. Upon the effective date of any final regulation or amendment to final regulations promulgated by the U.S. Department of Health and Human Services with respect to PHI, the Security or Privacy Rule, or the HITECH Act, the parties agree this Agreement shall be automatically amended as appropriate such that the obligations they impose on the parties remain in compliance with the most current regulations; provided, however, that if Business Associate provides written notice to Covered Entity that is unable to comply with the amended last, then either party may terminate this Agreement and any underlying services agreement upon thirty (30) days written notice to the other.

6.2. **Interpretation**. Any ambiguity in this Agreement shall be resolved to permit the parties to comply with HIPAA.

6.3. **Certain Provisions Not Effective in Certain Circumstances.** The provisions of this Agreement relating to the HIPAA Security Rule shall not apply to Business Associate if Business Associate does not receive any Electronic PHI from or on behalf of Covered Entity.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed as of the Effective Date set forth in Section 5.1

| | |
|---|---|
| _____ | _____ |
| _____ | _____ |
| Printed Name | Printed Name |
| _____ | _____ |
| Printed Title | Printed Title |
| _____ | _____ |
| Date | Date |

This project was supported, in part by grant number 90INNU0016, from the Administration for Community Living, U.S. Department of Health and Human Services, Washington, D.C. 20201. Grantees undertaking projects with government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official ACL policy.

# Appendix M: Patient Referral Form

# LifeCare Alliance · Patient Referral Form

1699 W. Mound St · Columbus, OH 43223
Phone: 614-278-3141 · Fax: 614-278-3143 · Email: referral@lifecarealliance.org

- **Referring Agencies**: Please complete sections A, B and C of this form.
- **Physician's Offices:** Please complete sections D and E of this form.

## A. Referring Agency

**Today's Date:**

**Agency Representative Making Referral:**

**Phone Number:** **Email Address:**

1. **As the Referring Agency representative, I have communicated the service basics and referral process for the identified LifeCare Alliance services checked on this form to the below patient.** ☐ Yes ☐ No
2. **The patient referenced on this form agrees to proceed with the assessment process for the identified service(s).** ☐ Yes ☐ No

**If you answered no to either #1 or #2 above, provide background information so that we may proceed with initiating service:**

## B. PATIENT INFORMATION

**Patient Name:**

**DOB:**

**Phone Number:**

**Street Address:**

**City, State:**

**Zip:**

**Emergency Contact:**

**Emergency Contact Relationship:**

**Emergency Contact Phone:**

**Primary Insurance:**

**Member ID #:**

**Group #:**



Client ID# _____ LifeCare Alliance RD's Name (if applicable)_____

# LifeCare Alliance · Patient Referral Form

1699 W. Mound St · Columbus, OH 43223
Phone: 614-278-3141 · Fax: 614-278-3143 · Email: referral@lifecarealliance.org

**Secondary Insurance:**

**Member ID #:**

**Group #:**

**Patient's Physician:**

**Physician's Fax:**

**Physician's Phone:**

**Veteran** ☐ Yes ☐ No If yes, please include a copy of patient's DD214 with completed referral form, if possible.

**Franklin County Senior Options Recipient** ☐ Yes ☐ No If yes, provide case manager's name: _____ Services being received, if applicable:

**PASSPORT/MyCare Ohio Recipient** ☐ Yes ☐ No If yes, provide case manager's name: _____ Services being received, if applicable:

**This person receives home-delivered meals already.** ☐ Yes ☐ No **If yes, what is the meal provider?**

## C. SERVICES BEING REQUESTED (check all that apply)



Client ID# _____ LifeCare Alliance RD's Name (if applicable)_____

# LifeCare Alliance · Patient Referral Form

1699 W. Mound St · Columbus, OH 43223
Phone: 614-278-3141 · Fax: 614-278-3143 · Email: referral@lifecarealliance.org

***Diabetic or Nutritional Counseling***

- ☐ **Medical Nutrition Therapy (MNT)**
- ☐ **Diabetes Self-Management Training (DSMT)**

***Supportive In-Home Services***

- ☐ **Home-Delivered Meals*+ –** Daily Hot
- ☐ **Home-Delivered Meals*+ –** Weekly frozen
- ☐ **Safety/Wellness Check Only (no meal needed)**
  - **Frequency:** ☐ **Daily** ☐ **Weekly** ☐ **Other** _____
  - **Verifying:** ☐ **Blood pressure** ☐**Blood sugar**
    ☐ **Weight** ☐ **Other** _____
  - **Report to referring agency when**
- ☐ **Meal Preparation**
- ☐ **Home Repair Assistance**

***Other Service* – please provide as much detail as possible, explaining service(s) requested:**

***Please pick only one.**

**+Meal customers must be home to receive the delivery and must sign/initial delivery receipt.**

## D. PATIENT MEDICAL HISTORY

**ICD DIAGNOSIS CODE(S):**

***Complete the below for Diabetic or Nutritional Counseling only***

**MOST RECENT A1C RESULTS:**

**DATE OF A1C TEST:**

**LABS:**
☐ **Labs Enclosed** ☐ **No Current Labs**

**MEDICATIONS:**
☐ **RX List Enclosed** ☐ **No RX List**

## E. REFERRING PHYSICIAN *(To be completed by physician's office)*

**Practice Name:**

**Phone #:**

**Fax #:**



Client ID# _____ LifeCare Alliance RD's Name (if applicable)_____

# LifeCare Alliance · Patient Referral Form

1699 W. Mound St · Columbus, OH 43223
Phone: 614-278-3141 · Fax: 614-278-3143 · Email: referral@lifecarealliance.org

| |
|---|
| **Street Address:**<br><br>**City, State:**<br><br>**Zip:** |
| **PCP/Referring Physician Name *(please print):***<br><br>**NPI #:**<br><br>**Medicare #:** |
| **PCP/Referring Physician Signature:**<br><br>**Date Signed:** |

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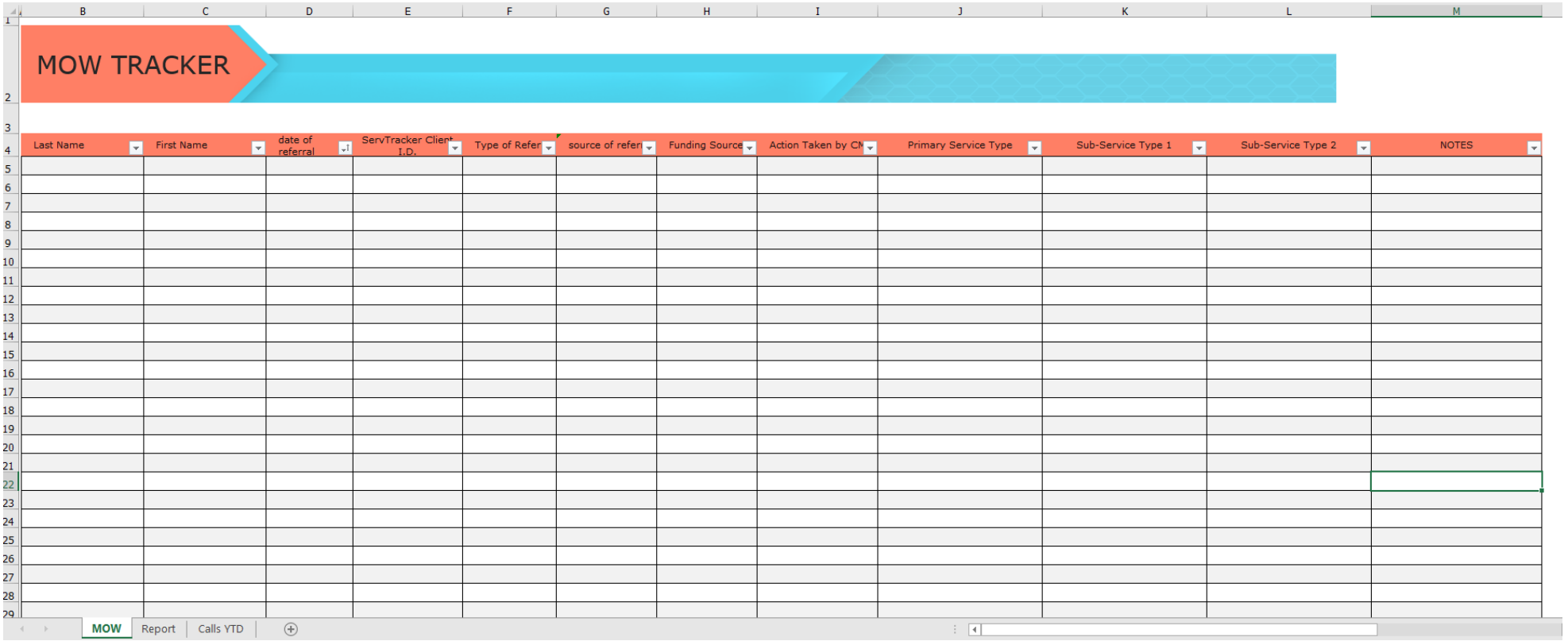
Client ID# _____ LifeCare Alliance RD's Name (if applicable)_____

# Appendix N: Registered Dietitian Call Tracker

SixtyPLUS: Registered Dietitian Call Tracker




MOW Tracker Tab: Used for entering client names, dates, and services received from a Registered Dietitian

Columns include: Last Name, First Name, Date of Referral, Client ID, Type of Referral, Source of Referral, Funding Source, Action Taken by Case Manager, Primary Service Type, Sub-Service Type 1, Sub-Service Type 2, Notes

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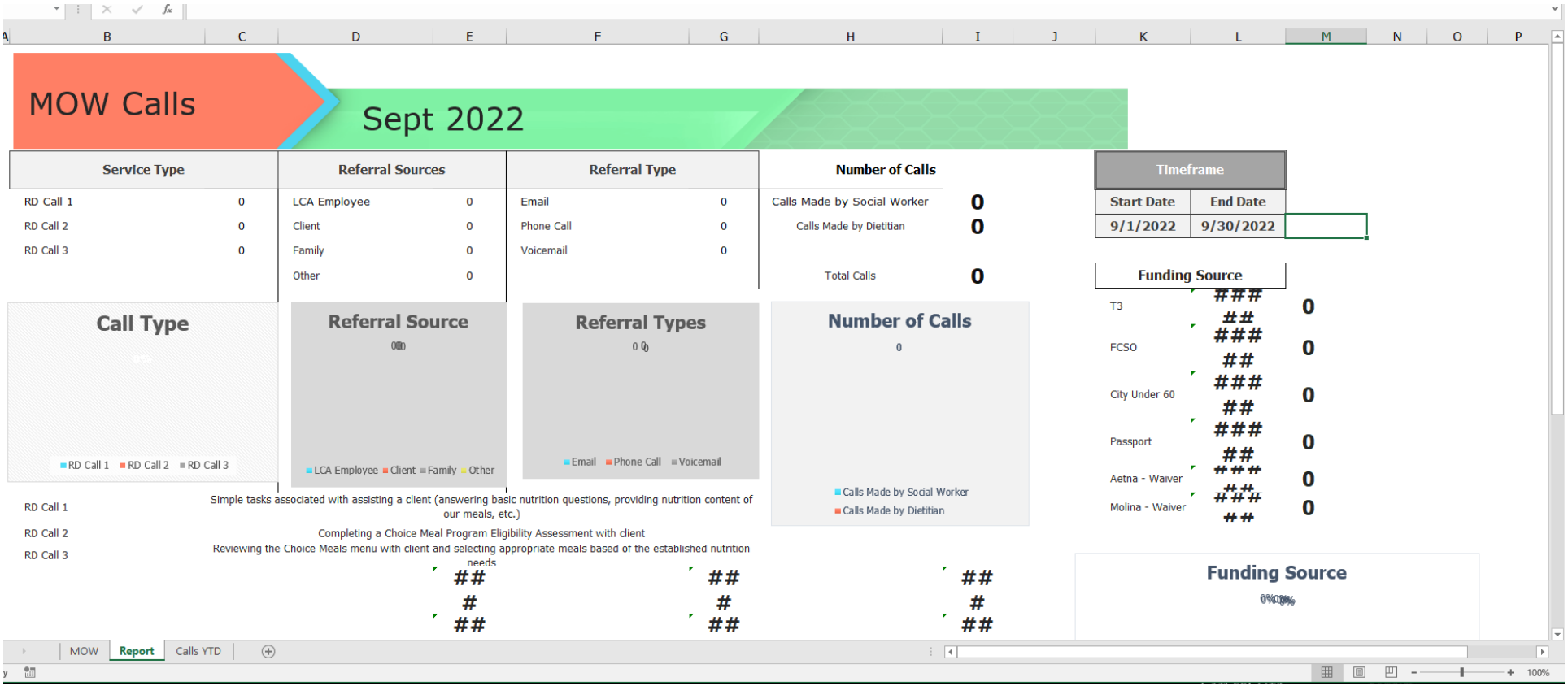
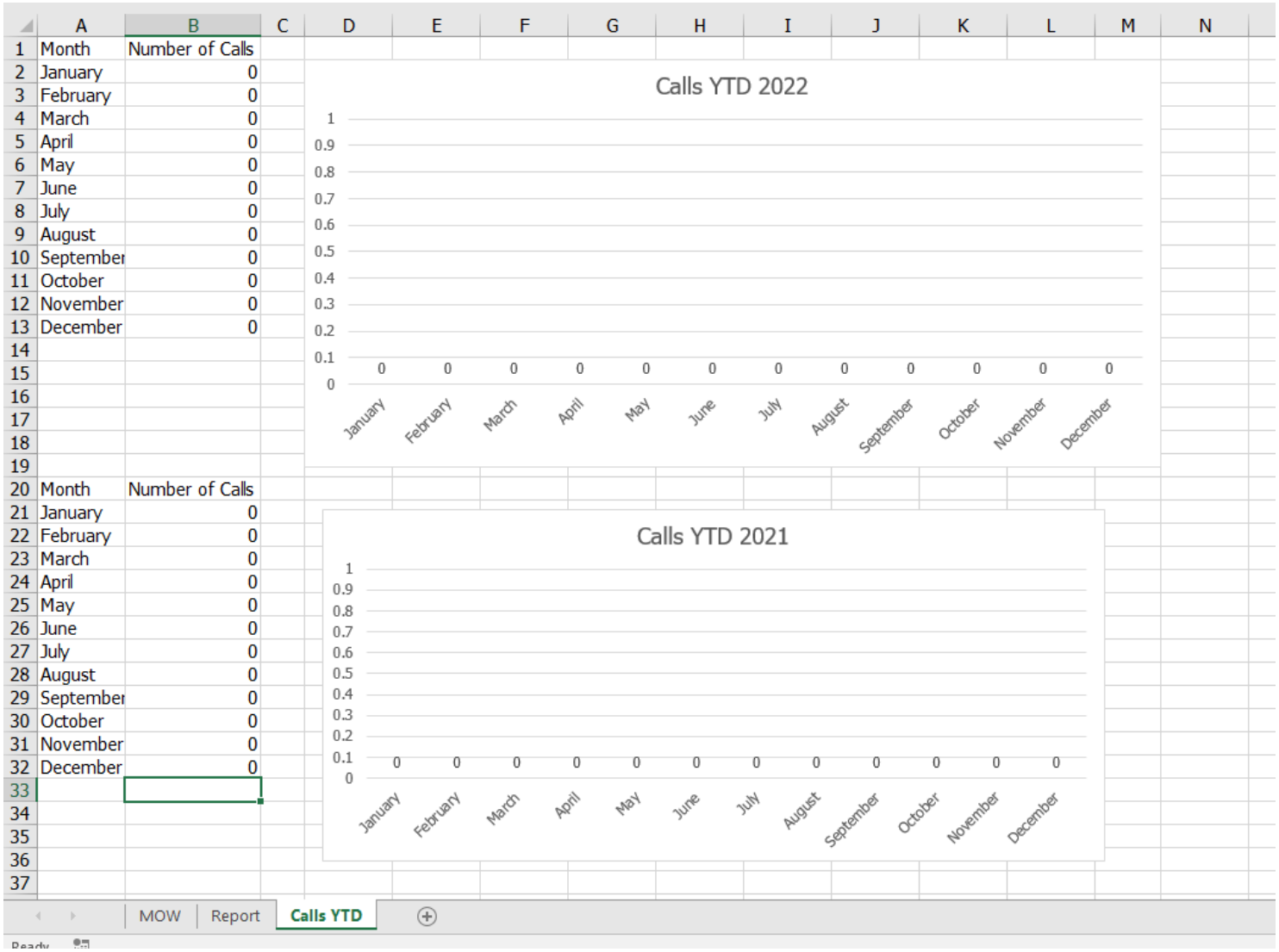



Report Tab: Used to compile client services from MOW tab into a comprehensive report




| Month | Number of Calls |
|---|---|
| January | 0 |
| February | 0 |
| March | 0 |
| April | 0 |
| May | 0 |
| June | 0 |
| July | 0 |
| August | 0 |
| September | 0 |
| October | 0 |
| November | 0 |
| December | 0 |

| Month | Number of Calls |
|---|---|
| January | 0 |
| February | 0 |
| March | 0 |
| April | 0 |
| May | 0 |
| June | 0 |
| July | 0 |
| August | 0 |
| September | 0 |
| October | 0 |
| November | 0 |
| December | 0 |

Calls YTD Tab: Used to track number of calls over a 12-month period (2022 vs. 2021)