VANDERBILT UNIVERSITY MEDICAL CENTER

Division of General Internal Medicine and Public Health

October 31, 2019

Mr. Vincent Davis
State Survey Agency Director
665 Mainstream Drive, 2nd Floor
Nashville, TN 37243

RE: RFA 34305-23419 Civil Monetary Penalty (CMP) Reinvestment Program Funding Opportunity

Dear Mr. Davis,

Vanderbilt University Medical Center (VUMC) and the Nashville Veterans Administration Hospital (VA) at the Tennessee Valley Healthcare System (TVHS) in collaboration with American Health Communities is honored to submit our proposal: "**Empowering Nursing Homes to Accomplish Nuanced Communication Expertise and Goals of Care Discussions in TN Long Term Care Facilities"** (The **ENHANCE** Goals of Care Discussions in TN Long Term Care (LTC) Facilities) Project.

The purpose of this project is to enduringly impact ways in which effective Goals of Care (GOC) conversations and communications could occur though skilled and trained nursing home teams. By 2030, nearly half of Americans over age eighty-five will reside and die in a nursing home, due to advanced dementia and chronic serious advanced illnesses. Expert consensus is emerging on improving quality and reducing costs for complex patients with a range of diagnoses, in all settings, through care coordination, transition management, and timely documented conversations that match individualized treatment to goals.

The VA is an emerging leader (https://www.ethics.va.gov/goalsofcaretraining/team.asp) in the effort through their U.S. Department of Veterans Affairs National Center for Ethics in Health Care Goals of Care. Our team aims to create, embed and disseminate tailored training specific to nursing homes to help facility clinicians and teams improve their communication skills to conduct goals of care conversations with residents and families based on elicited values and personal preferences, which in turn would help direct their medical care.

In summary, our proposal aims to impact the culture of nursing homes across the state by empowering a cadre of nursing home teams to facilitate and embed resident and family-centered care into their daily care plans hence directly impact experience of care and maintain the intrinsic dignity of the resident. Were we fortunate and privileged enough to be the recipient of this award, as Principal Investigator, I will assume responsibility for the timely and accurate reporting of the budget and oversee all aspects of the project planning, coordination and implementation, analysis, and dissemination. The funds requested are in the amount of $633,200 over three years. We look forward to the review of our proposal. Thank you for your kind consideration and time.

Warmest regards,

S. Misra

Sumi K Misra, MD, MPH, FAAHPM
Associate Professor of Medicine, Vanderbilt University Medical Center,
Associate Director for Education and Evaluation, Geriatric Research Education Clinical Center (GRECC)
Chief, Palliative Medicine, Nashville Veterans Administration Medical Center
ph: (615) 873-8170; fax: (615)873-8170; email: Sumathi.misra@vumc.org

REQUEST

Date of Application: 10 (MM) / 31 (DD) / 2019 (YYYY)

PART I: Background Information

Name of the Organization: Vanderbilt University Medical Center

Address Line 1: Office of Sponsored Programs

Address Line 2: 3319 West End Avenue, STE 970

City, County, State, Zip Code: Nashville, Davidson, TN, 37203-6856

Tax Identification Number: 35-2528741

CMS Certification Number, if applicable: ☐☐ – ☐☐☐☐

Medicaid Provider Number, if applicable: ☐☐ – ☐☐☐☐

Name of the Project Leader: Sumathi Misra MD, MPH

Address: 2525 West End Avenue, STE 450

City, County, State, Zip Code: Nashville, Davidson, TN, 37203-1775

Internet E-mail Address: sumathi.misra@vumc.org

Telephone Number: 615 – 936 – 1010

Mobile Number: 615 – 887 – 8620

Have other funding sources been applied for and/or granted for this proposal? ☐ Yes ☑ No

If yes, please explain/identify sources and amount.

PART II: Applicable to Certified Nursing Home Applicants

Name of the Facility: N/A

Address Line 1: _____

Address Line 2: _____

City, County, State, Zip Code: _____

Telephone Number: ☐☐☐ – ☐☐☐ – ☐☐☐☐

CMS Certification Number: ☐☐ – ☐☐☐☐

Medicaid Provider Number: ☐☐ – ☐☐☐☐

Date of Last Recertification Survey: ____ /____ /_____
MM DD YYYY

Highest Scope and Severity Determination: (A – L) _____

Date of Last Complaint Survey: ____ /____ /_____
MM DD YYYY

Highest Scope and Severity Determination: (A – L) _____

Currently Enrolled in the Special Focus Facility (SFF) Initiative? ☐ Yes ☐ No

Previously Designated as a Special Focus Facility? ☐ Yes ☐ No

Participating in a Systems Improvement Agreement? ☐ Yes ☐ No

Administrator's Name: _____

Owner of the Nursing Home: _____

CEO Telephone Number: ☐☐☐ – ☐☐☐ – ☐☐☐☐

CEO Email Address: _____

Name of the Management Company: N/A

Chain Affiliation (please specify) Name and Address of Parent Organization: N/A

Outstanding Civil Money Penalty? ☐ Yes ☐ No

Nursing Home Compare Star Rating: _____ (can be 1, 2, 3, 4 or 5 stars)

Date of Nursing Home Compare Rating: ____ /____ /_____
MM DD YYYY

Is the Nursing Home in Bankruptcy or Receivership? ☐ Yes ☐ No

If an organization is represented by various partners and stakeholders, please attach a list of the stakeholders in the appendix.

NOTE: The entity or nursing home which requests CMP funding is accountable and responsible for all CMP funds entrusted to it. If a change in ownership occurs after CMP funds are granted or during the course of the project completion, the project leader shall notify CMS and the State Agency within five calendar days. The new ownership shall be disclosed as well as information regarding how the project shall be completed. A written letter regarding the change in ownership and its impact on the CMP Grant application award shall be sent to CMS and the State Agency.

Part III: Project Category

Please place an "X" by the project category for which you are seeking CMP funding.

- ☐ Direct Improvement to Quality of Care
- ☐ Resident or Family Councils
- ☒ Culture Change/Quality of Life
- ☐ Consumer Information
- ☐ Transition Preparation

[X] Training

[ ] Resident Transition due to Facility Closure or Downsizing

[ ] Other: Please specify _____

_____

Part IV: Funding Category

Please specify the amount and place an "X" by the funding category.

Amount Requested: $ 633,200

[ ]	$2,500 or less	[ ]	$10,001 – $25,000
[ ]	$2,501 – $5,000	[ ]	$25,001 – $50,000
[ ]	$5,001 – $10,000	[X]	Over $50,000

Part V: Proposed Period of Support

From: 04 (MM) / 01 (DD) / 2020 (YYYY) (e.g. 06/01/2010) **To:** 03 (MM) / 31 (DD) / 2023 (YYYY) (e.g. 12/01/2010)

D. Clinton Brown, MBA, CRA
Director, Office of Sponsored Programs

10/31/2019
Date

Part VI: Purpose and Summary

PROJECT TITLE

Include a cover letter to the State Agency Director with the application. The cover letter should introduce your organization, explain the purpose of the project and contain a summary of your proposal. The letter should include the amount of funding that you are requesting, the population it will serve, and the need it will help solve. Make a concerted effort to bring your project to life in the cover letter and actively engage the reader.

ATTACHMENT 2
GRANT BUDGET
(BUDGET PAGE 1)

APPLICABLE PERIOD: The grant budget line-item amounts below shall be applicable only to expense incurred during the period beginning 04/01/2020, and ending 03/31/2023.

POLICY 03 Object Line-item Reference	EXPENSE OBJECT LINE-ITEM CATEGORY [1] (detail schedule(s) attached as applicable)	YEAR 1 04/01/2020-03/31/2021 GRANT CONTRACT	YEAR 2 04/01/2021-03/31/2022 GRANT CONTRACT	YEAR 3 04/01/2022-03/31/2023 GRANT CONTRACT	TOTAL PROJECT
1	Salaries[2]	$105,400.00	$106,600.00	$107,900.00	$319,900.00
2	Benefits & Taxes	$22,100.00	$22,500.00	$22,800.00	$67,400.00
5	Supplies	$1,500.00	$1,500.00	$0.00	$3,000.00
10	Printing & Publications	$4,500.00	$4,500.00	$0.00	$9,000.00
11,12	Travel/ Conferences & Meetings [2]	$17,000.00	$34,400.00	$34,400.00	$85,800.00
18	Other Non- Personnel [2]	$2,600.00	$1,600.00	$1,600.00	$5,800.00
22	Indirect Cost (29% TDC) (rounded to the nearest 100th)	$44,400.00	$49,600.00	$48,300.00	$142,300.00
25	**GRAND TOTAL**	$197,500.00	$220,700.00	$215,000.00	$633,200.00

1	**Salaries**	
	Dr. Sumathi Misra, PI, 18% effort is to assume responsibility for the timely and accurate reporting of the budget and oversee all aspects of the project planning, coordination training, implementation, analysis and dissemination.	
	Dr. Mohana Karlekar, Co-Investigator, 2% effort to provide content expertise for training materials as well as serve as a trainer , coach for the in person and web based remote training sessions and will contribute towards team engagement and debriefing at the facilities.	
	Dr. Ralf Habermann, Co-Investigator, 2% effort to provide content for training materials, develop risk stratification tools at facilities and engage with facility leadership and staff for program planning, recruitment and implementation of the project	
	Ms. Avantika Shah, Project Evaluation Specialist, 10% effort to conduct data collection and analysis for outcomes measurement, conduct chart abstracts, and provide additional assistance to study team as needed.	
	Project Coordinator (TBN) –100% effort to coordinate facility training, collate and distribute training materials, disseminate best practices, complete regulatory documentation for site IRB, and conduct follow up interviews with patient families and staff	
2	**Benefits & Taxes (Total $67,400) -** Fringe benefits for the personnel are requested based on institutional rates.	
5	**Supplies** - We request $3000 for training supplies such as binders, binder tabs for 350 training manuals for nursing home faculty and staff for reference and other training supplies as needed for the training sessions.	
10	**Printing & Publications**- We request $9000 total for printing and copying costs for training materials which will be inserted in the training binders for nursing home faculty and staff to use.	
11, 12	**Travel/Conferences & Meetings**– We are requesting $85,800 total over three years for 4-person training team to travel to participating sites for a cumulative 1.5 day (one 8-hr day & one 4-hr day) face to face training sessions & refresher trainings at all 18 facilities. Costs include overnight lodging where applicable, mileage, meals, parking & incidentals. Principal Investigator and Program Coordinator will additionally conduct a face to face pre-training visit in each of the 18 facilities.	
18	**Other Non-Personnel** – We request $5,800 total for CEU set-up costs for course development, CEU credits, and Website training module development for nurses to gain credit for attending training	
22	**Indirect Costs -** Our current indirect cost rate with State of TN projects is at 29%.	

ATTACHMENT 2 (continued)
GRANT BUDGET
(Budget Page 2)

GRANT BUDGET LINE-ITEM DETAIL - YEAR 1

SALARIES										AMOUNT
Sumathi Misra	0.18	x	192300	x	1	+				$34,614.00
Mohana Karlekar	0.02	x	192300	x	1	+				$3,846.00
Ralf Habermann	0.02	x	192300	x	1	+				$3,846.00
Avantika Shah	0.10	x	58050	x	1	+				$5,805.00
TBN- Project Coordinator	1.00	x	57267	x	1	+				$57,267.00
ROUNDED TOTAL										$105,400.00

TRAVEL	AMOUNT
Travel costs including lodging, mileage, parking, meals, & incidentals (12 trips/36 nights)	$ 16,968.00
ROUNDED TOTAL	$17,000.00

OTHER NON-PERSONNEL	AMOUNT
CEU Administrative Fees, CEU Credits & Website Training Module	$ 2,600.00
ROUNDED TOTAL	$2,600.00

GRANT BUDGET LINE-ITEM DETAIL - YEAR 2

SALARIES										AMOUNT
Sumathi Misra	0.18	x	192300	x	1	+				$34,614.00
Mohana Karlekar	0.02	x	192300	x	1	+				$3,846.00
Ralf Habermann	0.02	x	192300	x	1	+				$3,846.00
Avantika Shah	0.10	x	59210	x	1	+				$5,921.00
TBN- Project Coordinator	1.00	x	58412	x	1	+				$58,412.00
ROUNDED TOTAL										$106,600.00

TRAVEL	AMOUNT
Travel costs including lodging, mileage, parking, meals, & incidentals (18 trips/60 nights)	$34,370.00
ROUNDED TOTAL	$34,400.00

OTHER NON-PERSONNEL	AMOUNT
CEU Administrative Fees, CEU Credits & Website Training Module	$1,600.00
ROUNDED TOTAL	$1,600.00

GRANT BUDGET LINE-ITEM DETAIL - YEAR 3

SALARIES										AMOUNT
Sumathi Misra	0.18	x	192300	x	1	+				$34,614.00
Mohana Karlekar	0.02	x	192300	x	1	+				$3,846.00
Ralf Habermann	0.02	x	192300	x	1	+				$3,846.00
Avantika Shah	0.10	x	60390	x	1	+				$6,039.00
TBN- Project Coordinator	1.00	x	59581	x	1	+				$59,581.00
ROUNDED TOTAL										$107,900.00

TRAVEL	AMOUNT
Travel costs including lodging, mileage, parking, meals, & incidentals (18 trips/60 nights)	$34,370.00
ROUNDED TOTAL	$34,400.00

OTHER NON-PERSONNEL	AMOUNT
CEU Administrative Fees, CEU Credits & Website Training Module	$1,600.00
ROUNDED TOTAL	$1,600.00

Job descriptions for Key Personnel

Sumathi Misra, MD, MPH PI is Associate Professor of Medicine Vanderbilt University Medical Center (VUMC). She assumes overall responsibility for all aspects of the project planning, coordination, implementation, analysis, dissemination and the timely and accurate reporting of the budget. She has authored over 25 peer reviewed publications and is a national expert in the area of communication and care coordination in the seriously ill and the elderly.

Ralf Habermann MD Co-PI is Assistant Professor of Medicine and board-certified geriatrician and internist at VUMC and has been medical director of several nursing homes in Tennessee over the past 20 years. His extensive expertise in clinical care and medical direction in nursing homes over past 22 years brings his deep knowledge of nursing home regulations and polices which will be utilized in the role of content expert as well as development of risk stratification tools and in engaging facility stakeholders and interactions with facility leadership and staff recruitment.

Sandra Simmons Ph.D. is a Professor of Medicine in the Division of Geriatrics at Vanderbilt University Medical Center. She leads the Vanderbilt Center for Quality Aging (www.VanderbiltCQA.org) and is Deputy Assistant Director of Research at the VA, GRECC. Her extensive expertise in quality improvement in nursing home care over the past 20 years will be utilized in the role of content expert and in engaging facility stakeholders and interactions with facility leadership and staff recruitment and training.

Mohana Karlekar MD is the Medical Director of the palliative care program at VUMC. Her area of expertise is the intersection of palliative care and geriatrics and has presented nationally on this topic. She will be a content expert for training development as well as an experienced coach for the training sessions and will contribute towards team engagement and debriefing at the facilities in person and in web-based interactions and refresher trainings.

Program coordinator (TBN): will be responsible for all aspects of the project as outlined in the detailed budget. They will be critical to organizing training sessions, data management and timing of collection, maintenance of educations programs and resources including the web-based platform.

Roles of Overall Project team during implementation:

Project Team Roles **Misra, Habermann, Karlekar, Simmons**	**GOC Trainers Roles** **VA team: In kind contribution** **Karlekar, Habermann, Misra**	**Facility Team Roles**
Overall project design Working with each nursing home leadership team to design a system to integrate the GOC process into the existing culture of the nursing home Recruitment of nursing homes and facilitators Liaising with all and consultants Outcomes and evaluations	Leading initial 8 hr. and 4 hr. face to face refresher GOC training Leading the 4-hr. web-based refresher sessions Leading the quarterly web based Coaching sessions	Successfully participating in initial and refresher GOC training Conduct GOC in the risk stratified patients as identified in collaboration with LTC Documentation of GOC, integrated care plans and POLST and ACP.

Biographical Sketches for Key Personnel

Sumathi Misra MD, MPH - Academic Appointments: Associate Professor of Medicine Vanderbilt University Medical Center. Chief of Palliative Medicine at the Veterans Administration (VA) Hospital. She is the Associate Director for the Geriatric Research Education and Research center (GRECC). Board certified in Medicine, Geriatrics and Hospice and Palliative care. Founded the clinical and educational programs at Vanderbilt and the VA in palliative care. Over 20 years in practice Certified Medical Director in Nursing homes and is the recipient of the prestigious AMDA Pfizer nursing home.

Grant funding: over 7 Million in federal funding for creation of local palliative care training and educational and clinical programs for aging Veterans and in Long-term care and geriatrics.

*Monroe T **Misra S** et al Pain "Reports and pain medication treatment in Nursing home residents with and without Dementia", Geriatrics and Gerontology International 2013.*

*Munroe, T, **Misra S**, Habermann R et al.Title: Specific Physician Orders Improve Pain Detection and Pain Reports in Nursing Home Residents: Preliminary Data .Pain Management Nursing PMN-D-14-00085R1 June 2015.*

Ralf Habermann MD - Academic Appointments: Assistant Professor of Medicine, VIMC. Currently the chief medical officer (CMO) for The American Health Communities Senior Living Umbrella, Medical Director of the Geriatric Patient Aligned Care Teams (Geri-PACT) at the Nashville VA. Director of Acute care for the Elderly at VUMC 2001-2018.

Reducing Antipsychotic Medication Use in Nursing Homes: A Qualitative Study of Nursing Staff Perceptions. Simmons SF, Habermann R, etal Gerontologist. 2018 Jul 13;58(4):e239-e250. doi: 10.1093/geront/gnx083.

Prevalence of constipation symptoms in fecally incontinent nursing home residents.
Schnelle JF, Habermann R, J Am Geriatr Soc. 2009 Apr;57(4):647-52. doi: 10.1111/j.1532-5415.2009.

Sandra Simmons Ph.D. - Academic Appointments: Professor of Medicine in the Division of Geriatrics at VUMC. She leads the Vanderbilt Center for Quality Aging (www.VanderbiltCQA.org) ; Deputy Assistant Director of Research at the VA, GRECC. Received numerous grants to examine issues in gerontology from the National Institutes of Health and Aging, Agency for Healthcare Research & Quality, and the National Alzheimer's Association, Research foci include clinical interventions to improve quality of care and quality of life for older adults in a variety of care settings including long term care and dementia care, especially related to staffing issues in the long-term care setting.

Determining Nurse Aide Staffing Requirements to Provide Care Based on Resident Workload: A Discrete Event Simulation Model. Schnelle JF, et al. J Am Med Dir Assoc. 2016

Comparison Between Quality of Care Provided by Trained Feeding Assistants and Certified Nursing Assistants During Between-Meal Supplementation in Long-Term Care Settings.
Hollingsworth EK, et al. J Appl Gerontol. 2018.

Mohana Karlekar MD - Academic appointments: Assistant Professor of Medicine, VUMC Director, Palliative Care, Associate Director of Clinical Palliative Fellowship UMC Director, Palliative Care training program. She is currently the chair of the state palliative care task. She is currently the chair of the state palliative care task.

Facility Placement as a Barrier to Hospice for Older Adult Patients Discharged From a Palliative Care Unit.Shinall MC, Wilson JE, Karlekar M, Ely EW.Am J Hosp Palliat Care. 2018 Jul 31:1049909118791149. doi: 10.1177/1049909118791149

GENERAL ASSURANCES

Assurance is hereby provided that:

1. This program will be administered in accordance with all applicable statutes, regulations, program plans and applications:
   a. The laws of the State of Tennessee;
   b. Title VI of the federal Civil Rights Act of 1964;
   c. The Equal Employment Opportunity Act and the regulations issued there under by the federal government;
   d. The Americans with Disabilities Act of 1990 and the regulations issued there under by the federal government;
   e. The condition that the submitted application was independently arrived at, without collusion, under penalty of perjury; and,
   f. The condition that no amount shall be paid directly or indirectly to an employee or official of the State of Tennessee as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to the Agency in connection with any grant resulting from this application.
2. Each agency receiving funds under any grant resulting from this application shall use these funds only to supplement, and not to supplant federal, state and local funds that, in the absence of such funds would otherwise be spent for activities under this section.
3. The grantee will file financial reports and claims for reimbursement in accordance with procedures prescribed by the State of Tennessee Department of Health.
4. Grantees awarded grants resulting from this application process will evaluate its program periodically to assess its progress toward achieving its goals and objectives and use its evaluation results to refine, improve and strengthen its program and to refine its goals and objectives as appropriate.
5. If applicable, the program will take place in a safe and easily accessible facility.

CERTIFICATION/SIGNATURE

I, THE UNDERSIGNED, CERTIFY that the information contained in the application is complete and accurate to the best of my knowledge; that the necessary assurances of compliance with applicable state/federal statutes, rules and regulations will be met; and, that the indicated agency designated in this application is authorized to administer this grant.

I FURTHER CERTIFY that the assurances listed above have been satisfied and that all facts, figures and representation in this application are correct to the best of my knowledge.

10/31/2019

Signature of Applicant Agency Administrator — Date Signed (Month/Day/Year)

Project Title: The ENHANCE Goals of Care discussions in TN LTC Facilities Project: **E**mpowering **N**ursing **H**omes **t**o **A**ccomplish **N**uanced **C**ommunication **E**xpertise **and Goals of Care Discussions in TN Long Term Care Facilities**

Project abstract: The **goal** of this project is to enhance and impact effective Goals of Care (GOC) conversations and communications that occur through skilled and trained nursing home teams. **The project via the proposed interventions would directly impact the quality of life of the residents, morale of the staff and delivery of the right care at the right time for the right residents, based on their preferences.** Our proposal aims to impact the culture of participating facilities across the state by empowering a cadre of nursing home teams to facilitate and embed resident and family centered care into their daily care plans. Our project will tailor, embed and disseminate tailored Goals of Care communication interactive modules specific to the needs of staff and residents in nursing homes in Tennessee. This directly impacts the experience of care and maintains the intrinsic dignity of the resident. In order to meet our goal of significant recruitment efforts in medically underserved and rural counties, we will focus on the 15 most distressed rural counties in Tennessee (Lake, Lauderdale, Hardeman, McNairy, Perry, Jackson, Clay, Grundy, Van Buren, Bledsoe, Fentress, Morgan, Scott, Hancock and Cocke). Dr Misra the PI, with her training as a board-certified geriatrician and palliative care physician who leads key aging related program at the Veterans Affairs and Vanderbilt University Medical Center, is uniquely poised to lead this project. As director of Education and Evaluation, GRECC, she is well qualified to assume responsibility of the design, content and evaluation of the project.

Method: We aim to target a rural and urban mix of 18 distressed facilities and up to 360 facility staff over a period of three years. We will coach GOC Facilitators identified by the LTC (in collaboration with Nursing home key stakeholders including the Family councils and providers). The identified facilities will initially receive an 8-hour face to face training with a team of experts with training materials. Following this, they will receive a 4-hour face to face refresher course and a second web-based 4-hour refresher course. They will also have quarterly "mentoring and coaching" sessions be webinars.12 of the 28 TN faculties under the American Health communities Senior Living Umbrella will be participating in this project. 50% of these will be in medically underserved, rural or distressed counties. We will additionally recruit six VA contracted facilities in TN. We will identify an overlap of these facilities with F552 and F553 to provide an intervention and impact where we know it may prove the most beneficial. The VA is an emerging leader in creating a systemized approach to having goals of care conversations in the effort through their U.S. Department of Veterans Affairs National Center for Ethics in Health Care Goals of care.
https://www.ethics.va.gov/goalsofcaretraining/team.asp.
This approach will subsequently inform best practices and help in the development of further tailored approaches that can be disseminated statewide and nationally and impact measured in subsequent initiatives**.**

Measurement and Evaluation: we will create collaboratively developed mechanisms with the facilities (including chart reviews) that incorporates quality metrics to ensure implementation of timely GOC conversations by trained and competent skilled staff. The PI, program coordinator, evaluation specialist will be accountable for the evaluation.

I. Primary outcomes measured:

1) Increase in the number of residents with goals of care (GOC) centered Plans of Care (POC's) demonstrated by documented GOC conversations in the medical record
2) Increase in number of accurately and meaningfully completed Advance Care Plans (ACP) and Physician Orders for Life Sustaining Treatment (POLST) forms
3) LTC Staff satisfaction with the GOC training process through a 5-question survey instrument
4) Resident and Family satisfaction of the GOC implementation process by 5 question survey.

II. Secondary outcomes

1) Measures of re-hospitalization rates and the impact of such hospitalization events on patients (procedures, life prolonging interventions, surgeries etc.) and families.
2) Documentation of patient functioning and goals, symptoms, and adjustment in care goals during their LTC stay.
3) Impact on transition to Hospice and length of stay in hospice.

Benefits: Focused GOC conversations occurring in nursing homes by trained staff could enhance the care of the residents in their facilities This project will impact the key areas of LTC staffing, quality measures, honoring residents rights and goals .It will empower clinicians and teams to enhance their communication skills, communicate and document interactions with residents and families based on elicited values and personal preferences, impacting overall satisfaction of resident centered medical care plans.

Statement of Need: The U.S. population is aging as the baby boomer generation reaches senior citizen status. Projections indicate that the number of frail elderly will triple to quadruple in the next 30 years By 2030, nearly half of Americans over age eighty-five will reside and die in a nursing home, due to advanced dementia and chronic serious advanced illnesses. Studies of nursing home residents, families, and staff endorse care focused on comfort and personal dignity, as well as continuity of care delivery by compassionate staff. Because substantial numbers of Americans view life in a nursing home as "totally unacceptable," [1] attempts at correcting this situation is important and relevant as many nursing home residents die in that setting, and providing excellent end-of–life care is important. Expert consensus is emerging on improving quality and reducing costs for complex patients with a range of diagnoses, in all settings, through care coordination, transition management, and timely documented conversations that match individualized treatment to goals. [2,3] Delivery of care customized to the needs of nursing home residents—those with dementia as well as other progressive conditions—is a potentially solvable problem through staff training and modification of existing processes of approaching appropriate access to high-quality communication and goals based care in nursing homes. Aligning nursing home care with personalized goals centered care can create a win- win situation for both parties and aligns well with strategic priorities for the facilities as well as state and federal agencies, and most importantly, for the resident. The growing acceptance of the culture-change movement centered on elder-directed goals in nursing homes is promising evidence of the goodness-of-fit of basic care principles in the long-term care setting. Recent studies [5, 6] suggest that quality of care—even survival—is better in nursing home residents who receive care grounded in good goals of care conversations .

Barriers to implementation and plans to address them. Contingency plan to address the issues below will be grounded in clear communication between Project teams, facility leadership and administrators with a focus on improved meaningful outcome measures and ongoing collaborative brainstorming for creative solutions.

Table 1: Potential Barriers to program implementation and approaches to minimize them

	Barrier	*Measures to potentially overcome the barrier*
1	*Inadequate staff knowledge in conducting conversations*	*Intervention will provide skills and techniques to conduct these conversations in a train the trainer model with enduring resources provided to facility as well as refresher training, ongoing personal and web-based support to reinforce the initial face to face training*
2	*Lack of embedded protocols that encourage timely conversations*	*Available tools (12-point risk scale, dementia mortality risk scale etc. will be discussed with individual facility leadership to decide which tool may be most applicable)*
3	*Integration of the process into the regular workflow of the clinicians and staff*	*The risk stratification tool-based list will be made available to the clinicians to alert them as to the need for a GOC discussion and documentation.* *Potential for integration into the LTC electronic medical record if that's an available option*

4	*Staff turnover*	*Intervention will provide skills and techniques to conduct these conversations in a train the trainer model with enduring resources provided to facility as well as refresher training and web-based support to reinforce the initial face to face training. With 15-20 LTC team members trained at each facility, the model can be sustained. We will additionally embed enduring physical on site and web-based resources available for new staff, including pairing them with a trained staff member.*
5	*Perceived financial disincentives and potentially perceived lack of reimbursement for specialized conversations that could be time intensive*	*Education and outcomes will demonstrate the value of these conversations and if the skill is taught diligently and skills practiced frequently with mentorship, the increased competency in having these conversations will be evident and efficient.*
6	*Misconceptions about discussing anything that is perceived as "not cure",*	*Education and skill training in conducting these discussions will allow for true goals of care that are embedded in hope as well as reality. This provision of a new toolkit for communication" will mitigate the concern of "not cure"*
7	*Paucity of comfort and skills in having these conversations in institutions without the institution being burdened by it*	*Intervention will provide skills and techniques to conduct these conversations in a train the trainer model with enduring resources provided to facility as well as refresher training and web-based support to reinforce the initial face to face training. Provision the new toolkit for communication" will remove the burden from the facility to develop such processes.*

Program description

Project implementation: The project intervention is meant to empower and create an enduring legacy in the nursing facilities that are intended to get incorporated into the day to day fabric of the work and be self-sustaining rather than be a burden and "one more thing to check off". **Recruitment is** divided into three parts: 1) Recruitment of Nursing Homes; 2) Recruitment of residents and 3) Recruitment of GOC Facilitators at the Nursing facilities.

Recruitment of Nursing Homes: We plan to enroll 18 Facilities in TN, majority of which will be underserved, distressed or rural facilities. 12 of the 28 TN facilities under the American Health communities Senior Living Umbrella and 6 VA contracted facilities will be participating in this project. We will identify an overlap of these facilities with F552 and F553 to provide an intervention and impact where we know it may prove the most beneficial.

Table 2: Facility Recruitment Schedule

Year 1 (2020)	Year 2 (2021)	Year 3 (2022)	Total
Facilities 1-6	Facilities 1-6 + Additional Facilities 7-12	Facilities 1-12 + Additional Facilities 13-18	18 Facilities

Resident recruitment: It is helpful to develop a risk stratification model where the sickest patients are identified and prioritized**.** Eligibility criteria for screening and inclusion will include 1) Residents with serious or life limiting illnesses such as those with advanced dementia, metastatic cancer, advanced cardiac, pulmonary, renal disease, 2) those with acute symptom needs and complicated family dynamics. 3) recognizing patients without completed advance directives and those with multiple recent hospitalizations This approach completed by personnel in the nursing home environment such as the MDS Coordinator or Admissions Nurse, could help identify those in greatest need for goals of care conversations

Recruitment of GOC Facilitators: Integrating staff and volunteers as a nursing home GOC facilitation team is an innovative and effective approach that may provide the necessary support to assimilate and sustain and

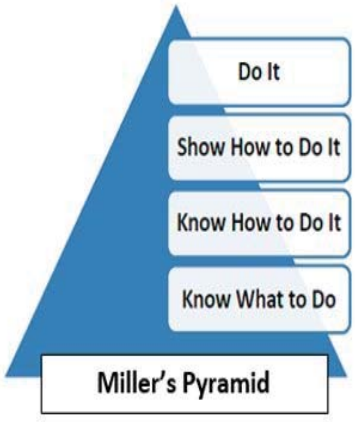
integrate the GOC program into nursing home culture. This model emphasizes a culture of partnership between staff, volunteers and families that allows for a team approach towards co-creating a culture of health and wellness for nursing home residents (CMS: Person and Family Engagement (PFE) Strategy, 2016).
A team of up to 20 members affiliated with each nursing home (selected staff members, SW, Nursing, care plan manager, all available medical providers including MD's and NP's, at least 2 community volunteers which may include active family members) will be trained as GOC Facilitators.

Table 3: Key factors in successful recruitment of facilitators

1	Identification of Staff members to be trained	Staff that would be most effective in this model are: Social worker (SW), RN care plan manager, all available medical providers including MD's and NP's, at least 2 community volunteers which may include active family members Each Facility will have up to 20 personnel trained. A combine up to 120 new staff can be trained in each of the three years for a total of 360 trained staff, who in turn ca be trainers for the facility, to address issues of turnover and attrition.
2.	Type of targeted staff training	All trainees will receive the same training as it is a highly adaptable and inclusive of the group identified to be most impactful for this type of intervention. Training will include one 8-hour face to face session, a 4-hour face to face refresher training and a 4-hour web-based refresher as well. ongoing quarterly webinars for problem solving and support will be provided. The project team will work with the facilities as they integrate the process into the routine workflow of the facility.
2	Type of recruitment effort	An initial visit by the PI and the program coordinator will occur to have face to face discussions with facility stakeholders including leadership team (DON, Facility administrator, medical director) to: 1) Identify trainees. 2) To get assurance form the stakeholders that time, space and resources will be provided for trainees to undergo the training

Training of Goals of Care Facilitators:

This coaching-based approach will be based on the adult learning theory and Millers Pyramid, which essentially builds on a learner's skills based on face to face experiential learning.



The Goals of Care (GOC) interactive Facilitator Coaching sessions	Total 8 hours
1. Introduction and Course Agenda	6.Aligning with resident values
2. Small group assignments	7.Discussing Medical plans and treatments
3. Delivering serious news	8.. Discuss life sustaining treatments
4. Reframing: We're in a different place now	9. Documenting POLST and advance care plans (ACP)
5. Mapping the Future	10. Adjourn

Approximately 120 new individual trainees (up to 20 per nursing home) will be trained in an 8-hour face to face annually as GOC Facilitators annually for three years for a total of 360 facilitators. We will additionally create a web-based platform that will have all the materials and resources available for module based independent instruction. CEU's will be offered through Vanderbilt for eligible trainees.

All training is competency-based. Each facility receives GOC facilitator training is comprised of

1) An 8-hour face to face interactive training.
2) A half-day in person refresher training
3) Webinar based 4-hour interactive GOC refresher training
4) quarterly interactive trouble shooting and coaching session.

This methodology allows for ongoing maintenance of training despite staff turnover as well as an opportunity to discuss challenging cases and scenarios that facilities are encountering.

Table 4: Timeline and interventions at facilities for recruitment

Facility Number	Year 1	Year 2	Year 3
Facility 1-6	**90-120 trained face to face onsite (15-up to 20 in each facility at each session)**	**One annual onsite 4 hr. face to face** refresher + One annual interactive module-based remote refresher course with live web-based training + Quarterly webinars for specific problem solving and coaching	One annual interactive module-based remote refresher course with live web-based training. + Quarterly webinars for specific problem solving and coaching
Facility 7-12		**90-120 trained face to face onsite (up to 20 in each facility at each session)** + One annual interactive module-based remote refresher course with live web-based training + Quarterly webinars for specific problem solving and coaching	**One annual onsite 4 hr. face to face refresher** One annual interactive module-based remote refresher course with live web-based training. Quarterly webinars for specific problem solving and coaching
Facility 13-18			**90-120 trained face to face onsite (up to 20 in each facility at each session)** + One annual interactive module-based remote refresher course with live web-based training + Quarterly webinars for specific problem solving and coaching
Travel schedule of teams to Facilities for face to face training	PI +coordinator overnight trip to six facility (#1 to #6 to meet stakeholders and finalize training and recruitment + PI +coordinator + 2 trainers overnight for an 8-hour face to face training at six facilities #1-#6	PI +coordinator overnight trip to six facility (#7-1#12) to meet stakeholders and finalize training and recruitment + PI +coordinator + 2 trainers overnight for an 8-hour face to face training at six facilities #7-#12 + PI+ Coordinator+ 2 trainers to 1 onsite half day refresher training for year 1 training sites at six facilities #1-#6	PI +coordinator overnight trip to six facility (#13-#18) to meet stakeholders and finalize training and recruitment + PI +coordinator + 2 trainers overnight for an 8-hourface to face training at six facilities #13-#18 + PI+ Coordinator+ 2 trainers to 1 onsite half day refresher training for year 1 training sites at six facilities #7-#112

Project teams Prior experience with similar projects: The Project PI, Co-PI's and training teams have extensive experience in curriculum development for communication skills and in dissemination of these skills. They have been part of a TN state sponsored statewide initiative to conduct GOC in the community hospitals, and Dr. Misra has received significant federal funding for communication in the seriously ill. The training is based on the well defined "House of healing "model of communication in serious advanced illness as shown below.

The House Model below by Bhang et al demonstrates the basic tenets of GOC communication skills.

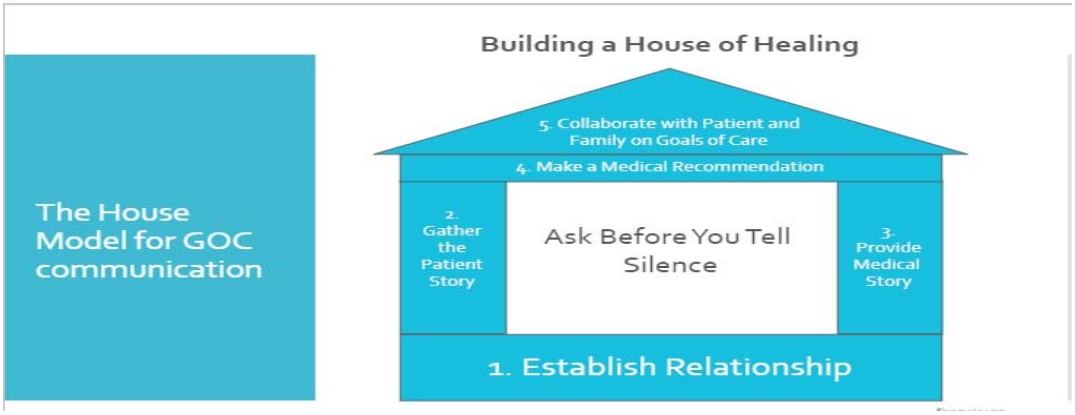


Table 5: Timeline for implementation benchmarks, deliverables, and measurements

Planned Task	1-6 MTH	6-12 MTH	12-18 MTH	YR 2	YR 3	POST PROJECT
Strategic Planning Consultation and Site Visit(s) to Examine Best Practices						
Identify Facilities from pool of 28 LTC's in Tennessee						
Obtain Baseline data at selected facilities for operations data						
Development of Risk Stratification Criteria for GOC conversations						
Onsite GOC Training						
Refresher GOC Training						
Wed Based Debriefing and training						
Development of Outcome measures collection tools						
Data Collection						
Evaluations						
Dissemination of Best practices						
Assess resource needs and gap analysis						
Web based platform development						

Measures the project will use to evaluate success: Creation of collaboratively developed mechanisms with the facilities (including chart reviews) that incorporates quality metrics to ensure timely GOC conversations. The PI, data analyst and the GRECC team will be accountable for the evaluation. We will measure both primary and secondary outcomes as mentioned prior under the abstract section of the grant in detail, however to highlight, again: **Primary outcomes measured**: Increase in the number of residents with goals of care (GOC) centered Plans of Care (POC's), Advance Care Plans (ACP) and Physician Orders for Life Sustaining

Treatment (POLST) forms, LTC Staff satisfaction and resident and Family satisfaction of the GOC implementation process.

Results Measurements and evaluation outcomes: Measurement for this project will take place on five levels as delineated below in Table 6.

Table 6: Measurement and Evaluation Outcomes

Frequency & Demographics	Qualitative	Quantitative	Pre-Post	Project Fidelity Monitoring
Number of GOC conversations held	Evaluation of GOC conversations prior to program and every 6 months after implementation.	% of residents re-hospitalized (re-admissions)	Knowledge of GOC, POLST, ACP	Content
Presence and location of GOC in care plans, number of POLST forms completed	Integration of GOC conversations in nursing home admission process (within first 100 days)	Hospitalization deaths Utilization of Hospice benefit	Perceived value and usability of the face to face coaching	Pedagogy
Identified resident surrogates	Satisfaction with GOC conversations (resident/healthcare agent/representative)	Satisfaction with GOC conversations (resident/healthcare agent/representative)	Feedback by stakeholders	Implementation

Benefits to NH: The project and proposed interventions would directly impact the quality of life of the residents, morale of the staff and anticipated right care at the right time for the right patients based on their preferences**.**

How project will directly benefit/enhance well-being of **NH residents**

1) Increased occurrence and documentation of GOC discussions
2) Better alignment of GOC with advance care directives and plans
3) Increased and accurate number of completed POLST forms
4) Better alignment of wishes with actual care plan-transitions in treating place
5) Improved end of life care-increased utilization of hospice services

How project will **impact staff**:

1. 1.New knowledge will be learnt and disseminated over an extended period.
2. Facilities and teams will be empowered with trained facilitators in their own facilities can then adopt a "Train-the-Trainer" approach to local facility dissemination,
3. It could improve collaboration between residents and facility staff and impact morale and workforce retention

Consumer/Stakeholder Involvement; The NH community;

1.The family councils and direct care staff will be involved in the initial development of the risk stratification criteria as well will be invited to be part of the GOC training sessions. The staff and teams will be the link (1) to engage patients/families in identifying residents for GOC conversations;(2) to help encourage and set up the

GOC meetings after identification; (3) assist with completion of advance care directives (POST) (4) Be an ongoing supportive to residents and families as they navigate the medical care based on personal choices. 2.The governing body of Nursing home (1) will identify the staff and protect their time for training and embedding the GOC into their usual practice. (2) collaboratively create developed mechanism that incorporates quality metrics to ensure timely GOC conversations (3) assist in creating risk stratification tools for the GOC interventions.

Financial feasibility and sustainability: Please see attached detailed budget sheet. We request a sum of $633,200 over the three-year period. The six VA consultants and Dr Simmons, a co-PI are Federal employees and they will be cumulatively devoting over 5% each of their time annually to this project without direct compensation from this budget.

Involved organizations and Partnerships: This project leverages several crucial partnerships with the following agencies:

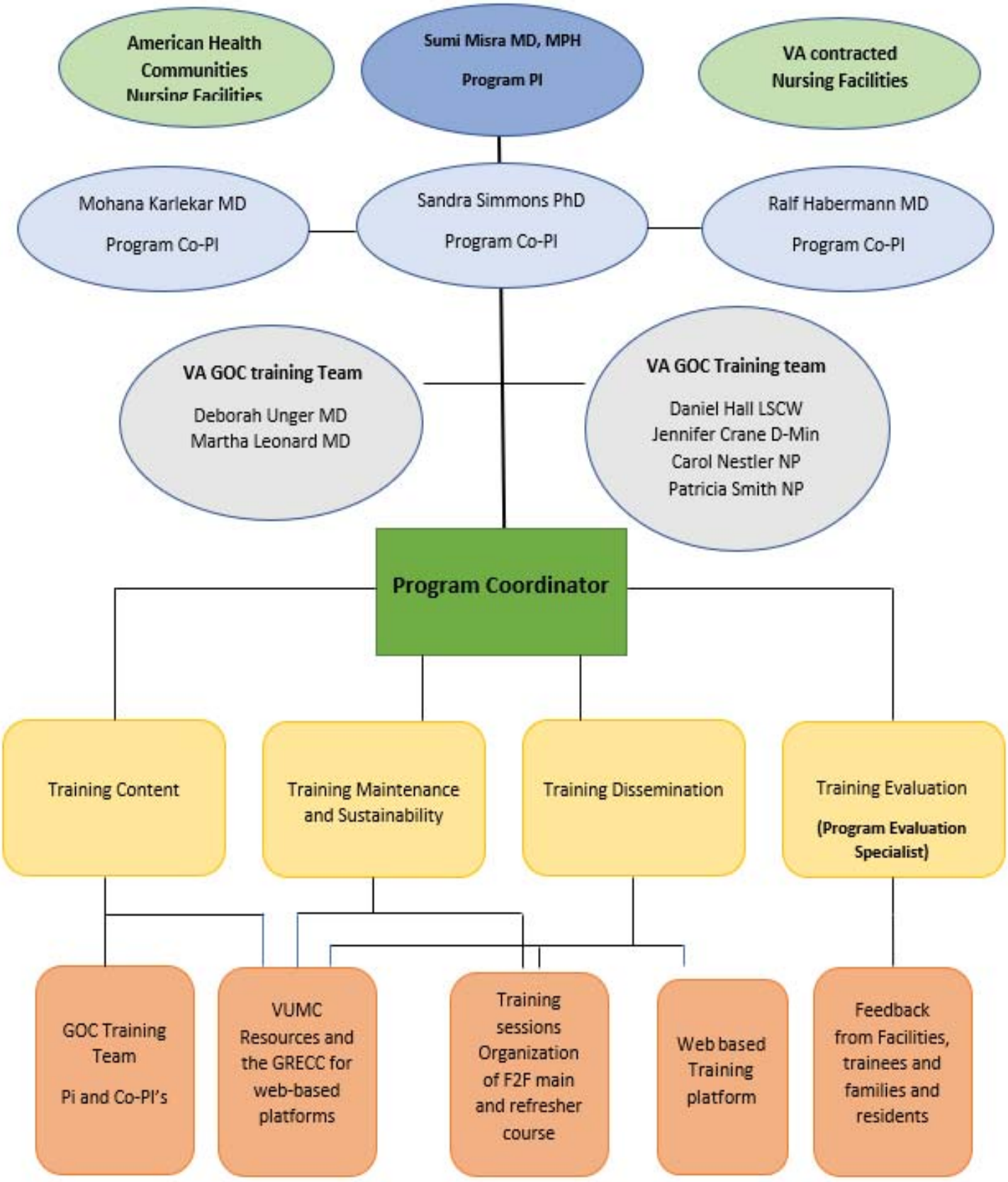
1. **VUMC** *(Address: 3319 West End Avenue, STE 970; Nashville, TN 37203, Contact: Mr. D. Clinton Brown, email: sponsoredprograms@vumc.org, and phone#: 615-870-6070)* will be the site for database maintenance and analysis. VUMC has a full array of computer support technology and resource support. It will support the project team with administrative tasks, space, IRB related support, and creation and dissemination of project related materials, including development and maintenance of the web-based platform.

2. **The VA and Geriatric Research, Education and Clinical Center (GRECC) at the Nashville VA** *(Address: 1310 24th Ave. S; Nashville, TN 37212, Contact: Ms. Jeannie Helton, email: Jeannie.Helton@va.gov, and phone#: 615-873-8004).* Dr. Misra is the Associate director for Education and Evaluation of this Center funded by the Department of Veterans Affairs, which provides a foundation for research in geriatrics with a focus on prevention, geropharmacology, pharmacoepidemiology/economics, and quality improvement/patient safety. Center faculty has 65 grants with annual funding exceeding $30 million (total all-year funding exceeding $130 million).

3. **The American Health Communities Senior Living Umbrella** (see letter of support)

Innovation and replicability: Training facilities repetitively through multiple modalities in a thoughtfully phased manner allows for enduring learning and infusion into the culture of a healthcare environment. The three-year multiple modality approach innovatively avoids the “one and done” approach to education and training. It fundamentally allows for durable and lasting change in the culture despite challenges of staff turnover. Funding will be used to develop personalized curricular materials as well provide training and a tool kit to facilities to sustain the interventions long after the project period ends. The GOC related materials will be readily available on a web-based platform that can be accessed by anyone with internet access and easily incorporated into the routine NH staff training without significant additional overhead costs and will have all the necessary tools to reproduce this project: both educational content and details of how to operationalize the project in new environments.

Organizational Chart for the ENHANCE Goals of Care in LTC Project



AMERICAN
HEALTH COMMUNITIES
SENIOR LIVING • REHABILITATION

October 25th, 2019

RE: Drs. Sumi Misra, and Ralf Habermann's proposal, "Empowering Nursing Homes to Accomplish Nuanced Communication Expertise and Goals of Care Discussions in TN LTC Facilities
(The ENHANCE Goals of Care discussions in TN LTC Facilities Project)

ATTN: Grant Review Committee

American Health Communities is pleased to partner with the Veterans Administration Medical Center and its affiliate Vanderbilt University Medical Center.

We are a large healthcare system of 28 facilities in the State of Tennessee and one in Huntsville, Alabama. A significant number of our facilities are in rural counties and overall, we serve a mix of Long term and skilled care patients. As part of our current Center for Medicare and Medicaid Services (CMS) initiatives, we are committed to facilitate quality improvement efforts geared towards improving communication and improving quality of care at the bedside with timely interactions with patients, their surrogates and key stakeholders in their care.

Our specific role in this project will be to 1) Assist in the recruitment of nursing homes throughout the state of Tennessee to participate in this training effort; 2) Collaborate with the teams in identifying staff and team members within our nursing home community to participate in the training effort; 3) Provide deidentified information that is respectful of the residents rights and privacy for primary and secondary outcomes as a result of the interventions proposed by the project team over the three year period.

We believe the proposed project and its dissemination of trained facilitators with expertise in communication skills geared towards the ability to conduct effective goals of care discussions will benefit a substantial portion of nursing home residents throughout the state. Moreover, this effort closely aligns with our quality improvement efforts to engage and support our residents and their families and empower them in the care of their loved one's disease trajectories as they navigate various parts of the health care system. We therefore, enthusiastically support the proposed project and look forward to partnering with the project team to make this a successful demonstration project that could have nationwide and certainly statewide positive implications.

Sincerely,

Nina Monroe, R

Nina Monroe, R.N.

Vice President of Quality and Clinical Operations

201 Jordan Road, Suite 200 • Franklin, TN 37067 • P: 615.905.5200

RFA 34305-23419 CMP Reinvestment
Program Application Checklist

Applicants Name: Vanderbilt University Medical Center, Sumathi K. Misra, MD, MPH

Page(s) #:	Required Element:	PASS	FAIL
1	Cover letter is included and addressed to: Vincent Davis, State Survey Agency Director 665 Mainstream Drive, 2nd Floor Nashville, TN 37243		
1	Cover letter is signed by facility administrator if nursing home or signed by project administrator if other.		
2-5	CMS Fillable Application (**Attachment 1**) is included and is signed by an individual who can legally sign a contract with the State of Tennessee. **Please sign anywhere on the application.**		
2-5	All applicable blanks are completed in CMS application including Tax Identification number, and if applicable, Medicare/Medicaid numbers.		
6-7	Submitted the completed Excel budget spreadsheet and budget details page (**Attachment 2**) for the project, along with a narrative expalnation of the costs.		
8	Job descriptions for key personnel are included (one page limit).		
9	Biographical sketches/Curriculum Vitae for currently employed key personnel are included (one page limit).		
19	Project organizational chart is included and significant collaborators are identified.		
11	Project Title information is included per CMS application.		
11	Required Abstract information is included per CMS application.		
12	Statement of Need information is included per CMS application, and addresses possible problems and contingency plan.		
13-16	Project Description information is included per CMS application and includes **projected outcomes, the timeline, deliverables, benchmarks, and dates**.		
17	Results Measurements information is included per CMS application and identifies what data will be measured, how and when it will be measured, and who will measure it.		
17-18	Description of how the nursing home community and governing body will assist and provide support for the project which is included per CMS application.		
18	Identification and list of all organizations and subcontractors that will receive funds from this grant are included per CMS application (specific nursing homes, hospitals, local community agencies, etc.). If no other organizations or subcontractors receive funds, please include a note.		

	Letters of commitment/agreement from all organizations and subcontractors that will receive funds from this grant or are serving as partners are included per Request for Application.		
	General Assurances form is included and signed per Request for Application.		

Primary Evaluator Signature and Date: