REQUEST

Date of Application: 04 / 26 / 2016
MM / DD / YYYY

PART I: Background Information

Name of the Organization: Florida Atlantic University

Address Line 1: 777 Glades Road

Address Line 2:

City, County, State, Zip Code: Boca Raton, Palm Beach County, Florida, 33431-0991

Tax Identification Number: 65-0385507

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

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

Name of the Project Leader: Ruth M. Tappen, Ed.D., R.N., F.A.A.N.

Address: 777 Glades Road, Bldg. NU-84, Rm. 307

City, County, State, Zip Code: Boca Raton, Palm Beach County, Florida, 33431-0991

Internet E-mail Address: rtappen@fau.edu

Telephone Number: 561 – 297 – 3188

Mobile Number: 954 – 647 – 1449

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: Not Applicable.

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: _____

Chain Affiliation (please specify) Name and Address of Parent Organization: _____

_____

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.

- [X] Direct Improvement to Quality of Care
- [ ] Resident or Family Councils
- [X] Culture Change/Quality of Life
- [ ] Consumer Information
- [X] Transition Preparation

☐ 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: $ 509,226

☐ $2,500 or less	☐ $10,001 – $25,000
☐ $2,501 – $5,000	☐ $25,001 – $50,000
☐ $5,001 – $10,000	☒ Over $50,000

Part V: Proposed Period of Support

From: 07 (MM) / 01 (DD) / 2016 (YYYY) (e.g. 06/01/2010) **To:** 06 (MM) / 30 (DD) / 2018 (YYYY) (e.g. 12/01/2010)

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.

Part VI: Cover Letter, Purpose and Summary

FLORIDA ATLANTIC UNIVERSITY

CHRISTINE E. LYNN COLLEGE OF NURSING
Committed to Nurturing the Wholeness of Person & Environment through Caring
Christine E. Lynn Eminent Scholar

April 26, 2016

Stephanie M. Davis, M.S., R.D.
Chief, LTC Certification & Enforcement Branch, Centers for Medicare & Medicaid Services
Sam Nunn Atlanta Federal Center
61 Forsyth Street, S.W., Suite 4T20, Atlanta, GA 30303-8909

Dear Ms. Davis,

We are submitting this application, *Dissemination of Resident and Family Decision Guide, Go to the Hospital or Stay Here? in CMS Region IV*, to CMS and the eight states of CMS Atlanta Region IV, Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee to support Region IV-wide dissemination of the family and resident Decision Guide, *Go to the Hospital or Stay Here?* and an accompanying staff training program. In our data from INTERACT™ studies, NH staff consistently ascribed 15-18% of potentially preventable hospitalizations to resident or family insistence on transfer. With support from PCORI, we designed this Guide based on interviews with a diverse sample of 271 NH residents, family members, staff and providers. It has been enthusiastically received by residents, families and NHs.

The proposed project would be led by Dr. Ruth Tappen, Professor and Eminent Scholar at the College of Nursing, Florida Atlantic University. She is a widely published and funded researcher and expert in dementia care and care transitions. As Principal Investigator of the original PCORI study, she led the research team through the conduct of the interviews, development of the Guide and analysis of the outcomes. Florida Atlantic University is a public university with a highly diverse student body and a commitment to serving the public, particularly the older population. Dr. David Wolf joined the original PCORI study in the last phase, bringing his NH administrator experience and expertise in long-term care administration to the team. He is on the faculty of Barry University, a private institution in North Miami, Florida.

To be effective, the Guide has to be put into the hands of NH residents and their families before an acute change in condition occurs and a hospitalization decision has to be made. This proposed two year project would enable us to disseminate the Guide to every NH resident and family member in the eight states of Region IV and to train NH staff in the effective use of the Guide. We are requesting your consideration of our application with a proposed budget of $509,226 that would be divided across the eight states involved in the project.

Warmest regards,

Ruth M. Tappen

Ruth M. Tappen, Ed.D., R.N., F.A.A.N.
Professor and Christine E. Lynn Eminent Scholar, C.E. Lynn College of Nursing, Florida Atlantic University
David G. Wolf, Ph.D.
Associate Professor - Health Services Administration, School of Professional and Career Education, Barry University

Part VII: Expected Outcomes

Project Abstract

The cost of hospitalizing a NH resident, both in terms of risk to the resident and cost to the health care system, are well-documented. Quality improvement (QI) programs such as INTERACT™ and Evercare™ have been developed to reduce the number of potentially preventable hospitalizations (PPHs) of NH residents that occur. However, these QI programs do not fully address one of the most intractable reasons for PPHs, resident and family insistence on hospitalization (Lamb, Tappen, Diaz, Herndon, & Ouslander, 2011). The Decision Guide, *Go to the Hospital or Stay Here?* (referred to as the "Guide") for residents and their families provides information on treatment that can be provided in the NH, risks and benefits of hospitalization vs. treatment in the NH and information about advance care planning. The Guide is intended to *prepare* residents and their families should an acute change in condition occur or the resident is actively dying. Developed with input from residents, families and providers, the Guide has been enthusiastically received by residents, their families and NHs.

Resident and family insistence on hospitalization contributes significantly to the incidence of PPHs and may put the resident at increased risk related to hospitalization. The Guide is designed to help residents and their family members engage in informed discussions with their providers when the need for such a decision arises. The purpose of this proposed project is to widely disseminate the Guide and smaller Trifold version to every NH in the eight states, Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee, in CMS Region IV.

In Phase I, we propose to edit the Guide and smaller Trifold version to conform to CMS standards, prepare training videos to explain the purpose of the Guide and demonstrate its use, create an electronic version that can be shown to residents on a television or tablet and pilot these materials in six NHs, two from each state, in Georgia, South Carolina and Tennessee, before dissemination in Phase II. In Phase II, a complete package of Guides, Trifolds and training materials will be sent to every Medicare-certified NH in the eight states of Region IV. Two to three workshops (the geographic spread of Florida and North Carolina will require three) will be held in each state to prepare NHs and their staff to use the Guide effectively.

Evaluation of the project will include periodic feedback from our Stakeholder Advisory Committee that will include representatives from each state, NH residents, families and administrators; number of NHs receiving the package of materials and reports of their distribution in the NHs; number of attendees at the workshops and their evaluation of their usefulness; and NH reports of the effect of the Guide on resident and family response to change in resident condition and the question of hospitalization and statewide readmission rates.

Statement of Need

The many risks of hospitalizing a NH resident are well-documented: increased risk of falls, increased confusion, delirium, nosocomial infection, pressure ulcers and so forth (Binder et al., 2003; Creditor, 1993; Friedman, Mendelson, Bingham, & McCann, 2008; Leff et al., 2005; Thomas & Brennan, 2000; Ouslander & Maslow, 2012). It has also been well-documented that a substantial proportion of these hospitalizations are potentially preventable (Saliba et al., 2000; Ouslander et al., 2010; Grabowski, O'Malley, & Barhydt, 2007). Federal initiatives have created considerable motivation to reduce these potentially preventable hospitalization (PPHs) which increase risk and place an additional burden on an already stressed health care system (Ouslander

& Maslow, 2012). Quality Improvement Programs such as INTERACT™ (http://interact.fau.edu) and Evercare™ (Boutwell et al., 2009) have been developed to assist staff to identify early warning signs of a change in the resident's condition; best practices for assessing this change; communicating more effectively with medical providers and across settings; and strengthening advance care planning. These combined efforts have raised staff awareness of PPHs and shifted physician and provider thinking about hospital transfer.

One source of PPHs that had remained virtually unremarked, however, was family and resident insistence on transfer. Considered one of the most intractable factors contributing to PPHs (Tappen et al, 2014), once a resident or family member does insist on transfer, providers generally acquiesce despite evidence that it is not necessary.

The CMS *Guide to Preventing Readmission among Racially and Ethnically Diverse Medicare Beneficiaries* (Betancourt et al, 2015) urges strengthening patient and family engagement in care, particularly engaging families in care transitions. Noting that NHs care for a vulnerable and increasingly diverse population, the CMS Equity Plan (2015) also calls for increasing the ability of the healthcare workforce to provide culturally and linguistically sensitive care in NHs.

Development and use of the resident and family Decision Guide, *Go to the Hospital or Stay Here?* addresses these goals in several ways. Development of the Guide was based upon input from a diverse sample of 271 residents, families and providers who were 22% African American, 28% Afro-Caribbean, 12% Hispanic, 34% European American and 4% Other or Mixed Race/Ethnicity. Sensitivities and concerns expressed by individuals from each group were integrated into the narrative of the Guide, acknowledging both individual and ethnic/cultural differences in preferences. Actual NH residents, families and staff are pictured in the accompanying photographs, reflecting a diverse population. The Guide has been translated into the top 5 languages other than English spoken in the United States: Spanish, French, Chinese, Tagalog (Filipino), and Haitian Creole. It has also been audio recorded for those with low vision. Although it is written at a 6th grade reading level, for those with a very low literacy level (such as older immigrant populations and/or residents in highly disadvantaged locales), we also propose to prepare a patient video that can be uploaded from an electronic file onto a tablet or shown on closed circuit television. All of the materials edited or created in this project will be available in downloadable electronic versions as well as print.

Prior Work. To better understand the reasons behind resident and family insistence on hospital transfer, we conducted interviews of 271 residents, family members, and providers from 19 South Florida NHs in a study titled, *Involving Nursing Home Residents and Their Families in Hospital Transfer Decisions* supported by the Patient Centered Outcomes Research Institute (PCORI). Most residents told us they had not thought about the possibility of returning to the hospital until we asked them about it. Half of the family members also had not thought about it before. From qualitative analyses of these interviews, we learned that *most residents and family members were unaware of the risks of hospitalization or the extent of treatment that can be provided in NHs. Many also said they did not know that they had a right to participate in the decision and were unfamiliar with much of the terminology related to advance care planning.* We also learned that they take different approaches to making such a decision and are affected by previous experience in the hospital and nursing home but that level of education, ethnic group and religion were not as influential as might have been expected. The composition of the Guide reflects these lessons learned. Our prior experience with the INTERACT™ program and results of this study guided development of the decision guide [http://www.decisionguide.org]. A

smaller Trifold version was also created. Audio versions are also available. All can be downloaded and printed without charge.

The Guide was evaluated by a sample of residents, families, and providers who were in the study and a stakeholder Advisory Committee and edited based on their suggestions. It was also used by a sample of 96 residents and family members who highly rated its usefulness. Of the 96 residents and families who were given the Guide 93% rated it somewhat or very helpful. Only 4% said it was not helpful, the other 3% were neutral. Eighty-five percent told us they reviewed it a second or third time after we had reviewed it with them. We also found that their knowledge of the risks of hospitalization and of treatment a NH can provide increased, as did their preference to remain in the NH should a change in condition occur. The purpose of this proposed project is to widely disseminate this Guide, bringing it to every NH in the 8 states of CMS Region IV Atlanta.

Program Description

To make optimal decisions concerning hospitalization or treatment in the NH, residents and family members need to understand the risks and benefits of hospitalization, the resident's prognosis, and treatment that can be provided in the NH. To accomplish this goal for Region IV, we propose a two phase project, *Dissemination of Resident and Family Guide Go to the Hospital or Stay Here? in CMS Region IV*. In Phase I, we will further edit and refine the Guide to conform to CMS specifications, develop a video-based staff training program that will explain the purpose of the Guide and demonstrate its use through vignettes, and pilot these materials in three states prior to distribution across Region IV. In Phase II, we will 1) produce a package of the above materials and ship a sufficient number to reach every resident and family member in every Medicare-certified NH in each of the eight states, and 2) hold two or three (for Florida and North Carolina) training meetings in each of these eight states to introduce the Guide and its purpose across Region IV. All of this work will be guided by input from our Stakeholder Advisory Committee and from CMS. A timeline of the Activities, Benchmarks, and Deliverables for Phase I and II follows (see Table 1).

Part VIII: Results Measurement

We will evaluate both the *processes* (activities) and *results* (products and outcomes) of the project. The processes or activities (editing the Guide, preparing training videos, sending complete packages to every NH in the 8 states of Region IV and holding 18 Workshops) are listed in Table 1: Project Timeline with the dates by which each deliverable should be complete. In addition, we will *maintain records* on the results of all of our team meetings, monthly Advisory Committee meetings and evaluative comments from our stakeholders. Table 2 lists project objectives, evidence of achievement and how the data will be collected, analyzed and reported.

The *results* or outcomes of the project include the *products* developed (the videos, PowerPoint presentations for the Workshops, edited Guides and Trifolds) and the *outcomes* of Guide implementation. A mixed-methods approach employing both qualitative and quantitative data will be used to measure the outcomes (see Table 2).

The results or outcomes of this proposed project include the products developed and the effects on resident and/or family insistence on hospital transfer (see Table 2). The products to be developed include:

- Edited Guide and Trifold

- Resident/Patient Video that contains content of the Guide
- Staff Training Video including vignettes demonstrating use of the Guide
- PowerPoint presentation for the Workshops

The effect on hospital transfers will be measured using a Quality Improvement (QI) Review tool to be completed on every hospital transfer that occurs within a 3 month Guide implementation window. For purposes of comparison, we will also ask participating NHs to complete the QI tool on every transfer that occurs in the 30 day period *prior* to introducing use of the Guide and 30 days *following* the 3 month evaluation period in order to calculate 30 day re-admission rates for the implementation period. Survey items were selected from the detailed measures used in the NIH-funded INTERACT™ study but are reduced to those needed to describe participating NHs, document use of the Guide and evaluate effect on hospital transfer:

Participating NH Survey

Nursing Home Characteristics:

- Individual to be contacted
- Number and type of licensed beds
- Resident type and census
- Profit or Not-for-profit status
- Tenure of Administrative staff
- Nursing staff turnover and hours per resident day
- EMR in use
- Number of hospitals used for transfers
- Availability of hospice care/consultation

Specific Nursing Home Capabilities:

- Primary care clinician availability
- Diagnostic testing services
- Consultations
- Social and psychology services
- Therapies on site
- Nursing services and interventions
- Pharmacy services

Quality Improvement Review: Resident/Patient Transfers

- Data and Evaluation Phase (prior to distribution, 3 month guide implementation, or 30 days post)
- Guide format used (full size Guide, Trifold or Electronic)
- Resident characteristics
- Reasons for hospital transfer
- Actions taken prior to transfer, including advance directives
- Use of Guide
- Result of transfer (admission, returned to NH, etc.)
- Look-back: Could transfer have been prevented? How?

To keep within application page limits the data to be collected are listed here instead of the actual survey form. We will use Qualtrics-based forms which are similar to the familiar Survey Monkey forms to conduct the surveys.

The surveys are designed to be easy to complete online. The forms and their use will be reviewed by the Florida Atlantic University Committee for the Protection of Human Subjects prior to use. Given the individual attention they will receive and their recognition as pilot sites, we anticipate that the pilot NHs will respond to our request for a completed survey and QI tools. However, we recognize that, despite efforts to make the surveys easy to complete, some NHs receiving the mailed packages of materials will not complete them. The results will therefore provide an indication of the potential effect of Guide use on hospital transfers but not the full magnitude of impact across Region IV. To increase participation, we will use reminder emails and telephone calls to individual NHs to encourage them to complete the forms.

Finally, quarterly progress reports, a final report and 6 months post-project report will be submitted to the funding agency.

Part IX: Benefits to Nursing Home (NH) Residents

NH staff consistently ascribe 15-18% of potentially preventable hospitalization (PPHs), to resident and/or family insistence on transfer (Lamb, Tappen, Diaz, Herndon, & Ouslander, 2011). These transfers carry potentially high risk of falls, skin breakdown, nosocomial infection or delirium for the resident. Thus, reduction of PPHs benefits the resident as well as reducing cost to the system. The purpose of the Decision Guide is to inform residents and their families of treatment that can be safely provided in the NH, the risks and benefits of hospitalization and provide information about advance care planning. Those who have received the Guide will be better prepared to make an informed decision should an acute change in condition occur.

Part X: Consumer/Stakeholder Involvement

In the development of this proposal, we consulted with Ms. Stephanie Davis, Long Term Care Certification and Enforcement Branch, CMS in Atlanta, representatives of the 8 states in Region IV via teleconference as well as representatives of NHs in Florida and Ms. Taylor from The Carolinas Center for Medical Excellence (CCME) (see below). In implementation of the project, we will ask CMS Region IV and each state to name a representative to our Project Advisory Committee and invite a long-term care resident, short-term resident (or previous resident), family members of both a long-term and a short-term resident and a NH administrator, NH Director of Nursing or Director of Social Services to serve on this 15 member Stakeholder Advisory Committee. The Advisory Committee will meet telephonically once a month to review project progress and all materials produced.

Ms. Taylor, our proposed consultant for this project, is an advanced practice nurse, who has been a care Improvement Specialist V for the Carolinas Center for Medical Excellence QIO since 2009. In this position, she assists with development of project methodologies, data collection tools and protocols, maintains relationships with providers and makes site visits, among other responsibilities. Prior to her current position, she was a project manager and nurse educator for two Agency for Healthcare Research and Quality (AHRQ) supported projects involving 23 NHs in Georgia.

Ms. Taylor has consulted with more than 20 QIOs, served on expert panels for CMS and AHRQ, developed educational materials for NH staff and published 15 articles in peer-reviewed journals. Her role on this project is described in the budget justification.

Table 1: Timeline

Phase I	Activities	Benchmark	Deliverables	Completion Date
Preparation & Pilot	A. Project start-up	Project team complete	Team member list	Aug. 1, 2016
	B. Edit Guide and Trifold	CMS and Advisory Committee edits incorporated	Revised Guide and Trifold	Sept. 1, 2016
	C. Prepare staff training and patient videos	Script written and reviewed Videos recorded	Project Advisory Committee and CMS approval of scripts Completed video set on DVD	Oct. 1, 2016
	D. Prepare evaluation forms		See Table 2	Nov. 1, 2016
	E. Pilot entire package: Revised Guide, Trifold, videos and evaluation forms	Two NHs in Georgia, South Carolina and Tennessee receive and test videos, Guide, and evaluation forms	Pilot results reported	Feb. 1, 2017
	F. Review results of pilot, modify as indicated	Pilot NHs, Advisory Committee and Project Team review	Revised package, list of changes made	March 1, 2017
Phase II				
Dissemination Throughout Region IV	A. Distribute Guide and Trifold: • Update list of all NHs in Region IV • Collate materials • Package and mail • Follow up with email	Every Medicare-certified NH in all 8 states (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina and Tennessee) receives appropriate number of Guides, Trifolds, and the Training Program Email to confirm receipt and query use	Mail sample package to CMS program officer and designated state offices Report receipt and use	June 1, 2017
	B. Hold statewide training workshops: • Announce meeting schedule • Open registration • Prepare presentations • Hold two meetings in each state	Eighteen training sessions scheduled, two per state, except three in Florida and North Carolina	Training program registration, PowerPoints, rosters and attendee evaluations	Feb. 1, 2018
	C. Evaluation	See Table 2 for details		June 30, 2018
Reports	Report to CMS Region IV and State Agencies	Quarterly, Final and 6 month Post project reports delivered on time		Dec. 30, 2018

Table 2 Project Evaluation

Project Objective & Sub-objectives	Data Collection	Evidence of Achievement	Data Analysis & Reporting
1. Organize project team a. Orient research team b. Convene Stakeholder Advisory Committee	• Certifications submitted • Meeting minutes • Emailed agreements from each member	• CITI Training (IRB) • Team orientation meetings • Confirmation of agreement to serve	• Documents in electronic folders
2. Revise Guide & Trifold a. Consult with CMS regarding edits b. Consult with Stakeholder Advisory Committee c. Edit as advised	• Document edits requested and changes made	• Edited Guide and Trifold	• Edited Guide and Trifold including translated versions
3. Create training program a. Write scripts and record b. Prepare training manual c. Prepare workshop PowerPoints d. Obtain feedback e. Revise	• Written scripts • Recorded videos • Written manual • PowerPoint presentation • Feedback noted • Revisions completed	• Completed scripts • Completed videos and accompanying manual • Complete workshop PowerPoints • Review and revisions completed	Scripts, videos, manual, and PowerPoints revised in response to stakeholder feedback
4. Develop outcomes data collection forms a. NH Survey b. QI Review Tool	• Review by research team and stakeholders • Review with pilot NHs • Approved by IRB	• Data Collection form address both extent of Guide use and Guide effectiveness	• Data Collection forms easy to use, generate needed data • IRB approval notice
5. Pilot implementation in 6 NHs in 3 Region IV states a. Provide materials and guidance to participating NHs b. Collect pre-implementation and post-implementation data	• Extent of pilot NHs' Guide use • Collect pre and post data on effectiveness	• All 6 NHs provide the Guide or Trifold to every resident and family member • Use of the Guide reduces insistence on hospitalization	• Extent of use of Guide and Trifold • Statistical comparison of pre and post implementation resident and family insistence on hospitalization

6. Modify as indicated by pilot results a. Obtain feedback from all participating pilot sites b. Review with stakeholders and revise as indicated	• All pilot sites surveyed • Stakeholders' review of results	• Feedback obtained • Revisions made	• Revised training program, data collection forms
7. Distribute Guide, Trifold and Training Program to all certified NHs in all 8 states a. Prepare packages and mail b. Follow-up on use via email, telephone	• Email or telephone survey of all NHs to determine distribution and use of the Guide and Trifold	• All Medicare-certified NHs in the eight states have received the packages and implemented use of Guide and/or Trifold	• Percent of NHs reporting use of Guide and/or Trifold and reported percent of residents receiving Guide or Trifold
8. Conduct statewide trainings a. Prepare program b. Present at 18 selected locations c. Evaluate outcomes in participating NHs	• Attendee evaluation of training program • Reported Guide use • Reported hospitalizations related to resident and family insistence	• Training found useful by attendees • Guide used in participating NHs • Guide impact on hospitalization decisions	• Average ratings of program by attendees in excellent range • Statistical comparison of pre and post implementation resident and family insistence on hospital transfer
9. Evaluate project effect on family and resident response to PPHs	• Nursing home survey • Quality improvement review: Resident/patient transfer • Statewide readmission rates	• NHs and NHs receiving packages of materials will be sent survey for the NH and QI tool for each transferred resident • Obtain and compare statewide readmission rates for implementation period and previous year.	• Proportion of evaluations completed as proposed • Results of QI reviews
10. Report to funding agency a. Quarterly progress reports b. Final and 6 month post project reports	• Completed reports	• On-time submission	• Acknowledgement by funding agency

Tappen, R.; Florida Atlantic University

Dissemination of Resident and Family Decision Guide, *Go to the Hospital or Stay Here?* in CMS Region IV

PI Name: Ruth Tappen													
Sponsor: CMS													
Project Title: Dissemination of Resident and Family Decision Guide, Go to the Hospital or Stay Here? in CMS Region IV													
Project Period: 7/1/2016 - 6/31/2018													
							Cost for Individual States						
				Year # 1	**Year # 2**		**Alabama**	**Florida**	**Georgia**	**Kentucky**	**Mississippi**	**North Carolina**	**South Carolina**	**Tennessee**
				8/1/2016 7/31/2017	**8/1/2017 7/31/2018**	**Cumulative Total**								
PERSONNEL/SALARIES:														
A. Key Personnel														
Name	**Title / Project Role**	**% Effort**	**Cal. Mnths**											
Ruth Tappen	Principal Investigator	20%		$26,543	$26,543	$53,086	$6,636	$6,636	$6,636	$6,636	$6,636	$6,636	$6,636	$6,636
				$0	$0	$0								
	Total Fringe Benefits @		31.0%	$8,228	$8,228	$16,457	$2,057	$2,057	$2,057	$2,057	$2,057	$2,057	$2,057	$2,057
			Sub-Total	$34,771	$34,771	$69,543	$8,693	$8,693	$8,693	$8,693	$8,693	$8,693	$8,693	$8,693
B. Other Key Personnel														
Name	**Title / Project Role**	**% Effort**	**Cal. Mnths**											
Danielle Neimark	Coordinator	20%		$ 7,200	$ 7,200	$ 14,400	$1,800	$1,800	$1,800	$1,800	$1,800	$1,800	$1,800	$1,800
	Total Fringe Benefits @		34.0%	2,448	2,448	4,896	$612	$612	$612	$612	$612	$612	$612	$612
				$ 9,648	$ 9,648	$ 19,296	$2,412	$2,412	$2,412	$2,412	$2,412	$2,412	$2,412	$2,412
Students														
Name	**Title**	**% Effort**												
TBA	Research Assistant	50%		$ 18,792	$ 18,792	$ 37,584	$ 4,698	$ 4,698	$ 4,698	$ 4,698	$ 4,698	$ 4,698	$ 4,698	$ 4,698
				$ -	$ -	$ -								
		Fringe	3%	$ 564	$ 564	$ 1,128	$ 141	$ 141	$ 141	$ 141	$ 141	$ 141	$ 141	$ 141
				$ 19,356	$ 19,356	$ 38,712	$ 4,839	$ 4,839	$ 4,839	$ 4,839	$ 4,839	$ 4,839	$ 4,839	$ 4,839
		Total Personnel		$ 63,775	$ 63,775	$ 127,550	15,944	15,944	15,944	15,944	15,944	15,944	15,944	15,944
C. Consultant														
Jo Taylor, North Carolina: 75 hours per year @ $100/hour				$ 7,500	$ 7,500	$ 15,000								
				$ 7,500	$ 7,500	$ 15,000	1,875	1,875	1,875	1,875	1,875	1,875	1,875	1,875
D. Travel														
Year 1: 6 trips @ $1,000/trip; Year 2: 18 trips @ $1,000/trip				$ 6,000	$ 18,000	$ 24,000								
				$ 6,000	$ 18,000	$ 24,000	$ 3,000	$ 3,000	$ 3,000	$ 3,000	$ 3,000	$ 3,000	$ 3,000	$ 3,000
E. Participant/Trainee Support Costs														
None						$ -								
				0	0	-								
F. Other Direct Costs														
Workshop expenses				$ -	$ 36,000	$ 36,000	4,500	4,500	4,500	4,500	4,500	4,500	4,500	4,500
Translation				$ 3,000	$ 3,000	$ 6,000	750	750	750	750	750	750	750	750
Refreshments for meetings				$ 4,000	$ 4,000	$ 8,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Med Pass: printing & shipping Guides, etc.				$ 150,870	$ -	$ 150,870	18,859	18,859	18,859	18,859	18,859	18,859	18,859	18,859
Videographer				$ 15,000	$ -	$ 15,000	1,875	1,875	1,875	1,875	1,875	1,875	1,875	1,875
Graphic Design				$ 1,000	$ 1,000	$ 2,000	250	250	250	250	250	250	250	250
Website Updates and Maintenance				$ 500	$ 500	$ 1,000	125	125	125	125	125	125	125	125
G. Subcontract		**% Effort**												
Barry University: Dr. David Wolf		20%		$ 30,662	$ 46,850	$ 77,512	9,689	9689	9689	9689	9689	9689	9689	9689
Travel Year 1: 6 trips @ $1,000/trip; Year 2: 18 trips @ $1,000/trip														
		Total Other Direct Costs		$ 205,032	$ 91,350	$ 296,382	$ 37,048	$ 37,048	$ 37,048	$ 37,048	$ 37,048	$ 37,048	$ 37,048	$ 37,048
H. Direct Costs														
		Total Direct Costs (A thru G)		$ 282,307	$ 180,625	$ 462,932	$ 57,867	$ 57,867	$ 57,867	$ 57,867	$ 57,867	$ 57,867	$ 57,867	$ 57,867
I. Indirect Costs (10%)			**Indirect Costs**	$ 28,231	$ 18,063	$ 46,293	$ 5,787	$ 5,787	$ 5,787	$ 5,787	$ 5,787	$ 5,787	$ 5,787	$ 5,787
		TOTAL COSTS		$ 310,538	$ 198,688	$ 509,226	$ 63,653	$ 63,653	$ 63,653	$ 63,653	$ 63,653	$ 63,653	$ 63,653	$ 63,653

Part XI: Funding

Budget Justification

Ruth M. Tappen, Ed.D., R.N., F.A.A.N. is the Christine E. Lynn Eminent Scholar and Professor, College of Nursing, Florida Atlantic University. Her expertise is in geriatrics, particularly dementia care and care transitions. She has directed a number of federally funded projects including her position as MPI of the NIH-funded INTERACT™ study and published over 80 articles and 5 textbooks on related topics. Dr. Tappen will be responsible for overall project direction and management, budget, evaluation and reporting results.

Danielle Neimark, B.S., Administrative Assistant, Florida Atlantic University, will coordinate project activities, maintain project records, input evaluative data and prepare project reports.

Research Assistant, TBA. A full-time (20 hours per week) research assistant will provide support to Drs. Tappen and Wolf and assist with collection of the evaluative data.

David G. Wolf, Ph.D., is an Associate Professor in the School of Professional and Career Education at Barry University. He brings his experience as a NH owner and administrator and member of the INTERACT™ team to this project. Dr. Wolf will work closely with Dr. Tappen managing the project, organizing the workshops and collecting and interpreting evaluative data. *The amount shown includes travel to pilot NHs in Year 1 and to conduct workshops in Year 2 as well as 20% effort for Dr. Wolf and 10% indirect costs.*

Jo Taylor, R.N., M.P.H. is a Quality Specialist for the Carolinas Center for Medical Excellence (CCME) and has been a consultant to more than 20 QIOs. She brings her experience working with NHs to improve the quality of the care they provide, including use of the INTERACT™ program. Following her September 2016 retirement from her position with CCME, Ms. Taylor will consult with us on the development of the videos and training workshops and coordinating the pilot of these materials at NHs in South Carolina and Tennessee.

Amanda Burns, FAU videographer, will direct a team of experienced videographers to record and edit the staff training video and patient video. This is an experienced team that has produced high quality, professional quality, instructional videos.

Workshop materials, equipment, refreshments, sites and incidentals. Funds are requested for workshop venues, projection equipment, coffee breaks and materials for 18 workshops: 3 each in North Carolina and Florida, 2 each in Alabama, Georgia, Kentucky, Mississippi, Tennessee and South Carolina.

Travel. In the first year, travel to two pilot sites in each of three states (Georgia, Tennessee, South Carolina) is planned. In the second year, travel to two to three workshop sites in each of the eight states is budgeted for mileage and/or airfare and lodging for two trainers per workshop.

Production and mailing packages to NHs. A package will be mailed to every Medicare-certified NH in Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina and Tennessee. The package will include the training video, uploadable patient video, cover letter explaining the project, implementation assistant, list of additional languages available, sufficient number of full Guides and smaller Trifolds for each resident and an additional supply of Spanish versions or other languages sent to NH that request them.

Translation, graphic design and website updates will be needed once the Guide and Trifolds have been edited. The amounts requested reflect cost of these modifications. Downloadable versions of the training videos and Guide will be available on the website at no cost to the user.

Part XII: Involved Organizations

Primary Contractor/Project Lead:
Ruth M. Tappen, Ed.D., R.N., F.A.A.N.
Christine E. Lynn College of Nursing
Florida Atlantic University
777 Glades Rd., Bldg. NU-84, Rm. 307
Boca Raton, FL 33431-0991
561-297-3188
rtappen@fau.edu

Institutional Representative:
Miriam Campo
Director, Sponsored Programs
Division of Research
Florida Atlantic University
777 Glades Road, Bldg. AD-10, Rm. 210A
Boca Raton, FL 33431-0991
561.297.02312
campom@fau.edu

Sub-Contractor/Subcontract Lead:
David G. Wolf, Ph.D.
School of Professional and Career Education
Barry University
11300 NE 2nd Avenue
Miami Shores, FL 33161-6695
484-678-1128 Cell
dwolf@barry.edu

Institutional Representative:
Sandra Mancuso
Director, Grant and Sponsored Programs
Barry University
11300 NE 2nd Ave
Miami Shores, FL 33161
305-899-3072
SMancuso@barry.edu

References

Betancourt, J. R., Tan-McGrory, A., & Kenst, K. S. (2015). *Guide to Preventing Readmissions among Racially and Ethnically Diverse Medicare Beneficiaries*. Baltimore, Maryland: Centers for Medicare & Medicaid Services, Office of Minority Health. Retrieved from https://www.cms.gov

Binder, E., Kruse, R., Sherman, A., Madsen, R., Zweig, S., D'Agostino, R., & Mehr, D.R. (2003). Predictors of short-term functional decline in survivors of nursing home acquired lower-respiratory tract infection. *Journals of Gerontology. Series A, Biological Sciences and Medical Sciences, 58,* M60-M67.

Boutwell, A., Griffin, F., Hwu, S., & Shannon, D. (2009). Effective interventions to reduce rehospitalizations: A compendium of 15 promising interventions. Cambridge, MA: Institute for Healthcare Improvement.

Centers for Medicare & Medicaid Services, Office of Minority Health (2015). The CMS equity plan for improving quality in Medicare. Retrieved from https://www.cms.gov

Creditor, M.C. (1993). Hazards of hospitalization of the elderly. *Annals of Internal Medicine, 118,* 219-223.

Friedman, S.M., Mendelson, D.A., Bingham, K.W., & McCann, R.M. (2008). Hazards of hospitalization: Residence prior to admission predicts outcomes. *The Gerontologist, 48,* 537-541.

Grabowski, D.C., O'Malley, A.J., & Barhydt, N.R. (2007). The costs and potential savings associated with nursing home hospitalizations. *Health Affairs, 26,* 1753-1761.

Lamb, G., Tappen, R., Diaz, S., Herndon, L., & Ouslander, J.G. (2011). Avoidability of hospital transfers of nursing home residents: Perspectives of frontline staff. *Journal of the American Geriatrics Society, 59,* 1665-1672. doi:10.1111/j.1532-5415.2011.03556.x

Leff, B., Burton, L., Mader, S.L., Naughton, B., Burl, J., Inouye, S.K.,…Burton, J.R. (2005). Hospital at home: Feasibility and outcomes of a program to provide hospital-level care at home for acutely ill older patients. *Annals of Internal Medicine, 143,* 798-808.

Maslow, K., & Ouslander, J. G. (2012). Measurement of potentially preventable hospitalizations. *White Paper prepared for the Long Term Quality Alliance*.

Ouslander, J.G., Lamb, G., Perloe, M., Givens, J.H., Kluge, L., Rutland, T.,…Saliba, D. (2010). Potentially avoidable hospitalizations of nursing home residents: Frequency, causes, and costs. *Journal of the American Geriatrics Society, 58,* 627-635. doi:10.1111/j.1532-5415.2010.02768.x

Ouslander, J. G., & Maslow, K. (2012). Geriatrics and the Triple Aim: Defining Preventable Hospitalizations in the Long-Term Care Population. *Journal of the American Geriatrics Society, 60*(12), 2313-2318.

Saliba, D., Kington, R., Buchanan, J., Bell, R., Wang, M., Lee, M.,…Rubenstein, L. (2000). Appropriateness of the decision to transfer nursing facility residents to the hospital. *Journal of the American Geriatrics Society, 48,*154-163.

Tappen, R. M., Worch, S. M., Elkins, D., Hain, D. J., Moffa, C. M., & Sullivan, G. (2014). Remaining in the Nursing Home Versus Transfer to Acute Care: Resident, Family, and Staff Preferences. *Journal of Gerontological Nursing, 40*(10), 48-57.

Thomas, E.J., & Brennan, T.A. (2000). Incidence and types of preventable adverse events in elderly patients: Population based review of medical records. *BMJ, 320,* 741-744.

BIOSKETCH

Name: *Tappen, Ruth M.* **Project Role: Principal Investigator**

POST-SECONDARY EDUCATION/TRAINING/FELLOWSHIPS

INSTITUTION AND LOCATION	DEGREE	COMPLETED	FIELD OF STUDY
Wagner College, Staten Island, NY	B.S.	1966	Nursing
Teachers College, Columbia University, NY	M.Ed.	1974	Nursing Education & Community Health
Teachers College, Columbia University, NY	Ed.D.	1980	Nursing Education & Curriculum and Instruction
College of Nursing, University of Arizona, Tucson, AZ		1991	Postdoctoral fellow

EMPLOYMENT HISTORY

INSTITUTION AND LOCATION	TITLE	DATES
Pascack Valley Hospital, Westwood, NJ	Staff Nurse	1966-1968
Vassar Brothers Hospital, Poughkeepsie, NY	Staff Nurse	1968-1971
Mt. Saint Mary College, Newburgh, NY	Instructor, Assistant Professor	1974-1978
Cedars of Lebanon Health Care Center, Miami, FL	Patient Education Coordinator	1979-1980
University of Miami, Miami, FL	Gerontology Nursing Curriculum Coordinator; Community Health Graduate Program Director	1981-1985
University of Miami, Miami, FL	Professor & Director, Ph.D. in Nursing Program	1987-1990
University of Miami, Miami, FL	Interim Dean, School of Nursing	1988-1989
Miami Area Geriatric Education Center; Miami, FL	Executive Board, Secondary appt, Dept. of Psychiatry.	1990-1991
Miami VAMC Geriatric Research & Education Center (GRECC), Miami, FL	Investigator	1992-1995
Florida Atlantic University, Boca Raton, FL	Acting Vice President for Research	1999-2001
Louis & Anne Green Memory & Wellness Center, Boca Raton, Florida	Director, Memory Disorder Center	2000-2007
Florida Atlantic University, College of Nursing, Boca Raton, Florida	Christine E. Lynn Eminent Scholar and Professor	1995-present

HONORS/ AFFILIATIONS (MEMBERSHIP OR LEADERSHIP POSITIONS)

1966 Magna Cum Laude, Wagner College.
1972-1974 U.S. Public Health Nurse Traineeship for Graduate Study in Nursing.
1983 Designated American Nurses Foundation Scholar (ANF research grant recipient).
1984 Sigma Theta Tau, Nursing Honor Society.
1986 Leadership Award for Outstanding Public Health Nursing Leadership from Florida State Department of Health and Rehabilitative Services, Public Health Section.
1991 Institutional National Research Service Award. University of Arizona, College of Nursing. Instruments for Clinical Nursing Research: Measurement of Communication in Alzheimer's Disease.
1993 South Florida Nursing Research Society Research Recognition Award
1994 Fellow, American Academy of Nursing.
2010 Geriatric Research Award: SNRS John Harford Association

SELECTED PEER-REVIEWED PUBLICATIONS (Selected from over 85 publications)

Tappen, R. M. (January 2016). They know me here: Patients' perspectives on their nursing home experience. *Online Journal of Issues in Nursing.*

Ouslander, J. G., Naharci, I., Engstrom, G., Shutes, J., Wolf, D. G., Alpert, G., Rojido, C., Tappen, R. & Newman, D. (2016). Lessons learned from root cause analyses of transfers of skilled nursing facility (SNF) patients to acute hospitals: Transfers rated as preventable vs non-preventable by SNF staff. *Journal of the American Medical Directors Association.*

Naharci, I., Engstrom, G., Tappen, R. M., & Ouslander, J. G. (2016). Frailty in four ethnic groups in south Florida. *Journal of the American Geriatrics Society, 64*(3), 656-657.

Ouslander, J. G., Naharci, I., Engstrom, G., Shutes, J., Wolf, D. G., Alpert, G., Rojido, C., Tappen, R. M. & Newman, D. (2016). Root cause analyses of transfers of skilled nursing facility patients to acute hospitals: Lessons learned for reducing unnecessary hospitalizations. *Journal of the American Medical Directors Association*. (Online ahead of print).

Vieira, E. R., Tappen, R., Engstrom, G., & da Costa, B. R. (2015). Rates and factors associated with falls in older European Americans, Afro-Caribbeans, African-Americans, and Hispanics. *Clinical Interventions in Aging, 10,* 1705-1710.

Bonner, A., Tappen, R., Herndon, L., & Ouslander, J. (2015). The INTERACT Institute: Observations on dissemination of the INTERACT Quality Improvement Program using certified INTERACT trainers. *The Gerontologist, 55*(6), 1050-1057.

Tappen, R. M., Worch, S. M., Elkins, D., Hain, D. J., Moffa, C. M., & Sullivan, G. (2014). Remaining in the nursing home versus transfer to acute care: resident, family, and staff preferences. Journal of Gerontological Nursing, 40(10), 48-57.

Bensadon, B., Rojido, M., Wolf, D., Shutes, J., Tappen, R. M., & Ouslander, J. (2014). Barriers & approaches to implementing the INTERACT quality improvement program. *Journal of the American Geriatrics Society, 62*, S135-S135.

McLeod Dyess, S. M., Tappen, R. M., & Hennekens, C. H. (2014). Increasing rates of advance care planning through interdisciplinary collaboration. *The American Journal of Medicine, 127*(12), 1142-1143.

CURRENT/COMPLETED PROJECTS

SPONSOR & PROJECT TITLE	RESPONSIBILITIES	DATES
PCORI, Eugene Washington Engagement Award *Engaging Stakeholders in Implementation of Decision Aids. Sub-contract with University of Massachusetts*	Co-Principal Investigator	9/1/15-12/31/15
PCORI. Eugene Washington Engagement Award: *Involving Nursing Home Residents and Their Families in Hospital Transfer Decisions: Dissemination.*	Principal Investigator	9/1/15-12/31/15
PCORI. *Involving Nursing Home Residents and Families in Hospital Transfer Decisions*.	Principal Investigator	10/31/12-6/30/15
NIH, NINR. *Implementation of Interventions to Reduce Hospitalizations of Nursing Homes Residents.*	Principal Investigator (MPI)	04/20/12-02/29/17
MAGEC. *Prevention of Falls in Older Person.* VAMC Miami, FL	Investigator	07/01/10-06/30/15
Healthy Aging Research Initiative (HARI): *Interdisciplinary Research to Improve the Quality of Life and Quality of Care for Aging Americans*	Co-Director	07/01/10-06/30/16

BIOSKETCH

Name: Wolf, David **Project Role: Project Coordinator**

POST-SECONDARY EDUCATION/TRAINING/FELLOWSHIPS

INSTITUTION AND LOCATION	DEGREE	COMPLETED	FIELD OF STUDY
Villanova University, Villanova, PA	BSBA	05/1983	Administrative Science
Cabrini College, Radnor, PA	MSOL	12/2007	Organizational Leadership
Eastern University, St. Davids, PA	Ph.D.	05/2012	Organizational Leadership

EMPLOYMENT HISTORY

INSTITUTION AND LOCATION	TITLE	DATES
Barry University, Miami Shores, FL	Assoc. Professor – Health Services Administration	12/2014 – Pres
College of Medicine – Florida Atlantic University	Affiliate Assistant Professor	2/2013 – Pres
INTERACT™ Training, Education And Management	CEO	2/2013-12/2014
Rosemont College, Rosemont, PA	Adjunct Professor	9/2011-12/2014
Linwood Care Center, Linwood, NJ	Licensed Administrator	5/2012 –2/2013
Access Consulting Services, L.L.C., Delray, FL	CEO, President	12/2007-5/2012
Brandywine Senior Care, Exton, PA	President, Skilled Nursing Division	11/2002-12/2007

HONORS/ AFFILIATIONS (MEMBERSHIP OR LEADERSHIP POSITIONS)

Fellow – American College of Health Care Administrators
Member – Florida Health Care Association/American Health Care Association
Member – Academy of Management
Member – American Society of Training and Development
ACHCA-Vice-Chair – Long Term Care Mentoring Committee (2011 to present)
Award Winner and Presenter, International Leadership Association, Boston, 2010
ACHCA "Distinguished Administrator of the Year" Award, 1996
Certified Instructor - 2011 – Leadership Challenge Workshop using the Leadership Practices Inventory

PEER-REVIEWED PUBLICATIONS

Ouslander, J. G., Naharci, I., Engstrom, G., Shutes, J., Wolf, D. G., Alpert, G.,... & Newman, D. (2016). Lessons Learned From Root Cause Analyses of Transfers of Skilled Nursing Facility (SNF) Patients to Acute Hospitals: Transfers Rated as Preventable Versus Non-preventable by SNF Staff. *Journal of the American Medical Directors Association.*

Ouslander, J. G., Naharci, I., Engstrom, G., Shutes, J., Wolf, D. G., Alpert, G., Rojido, C., Tappen, R. M. & Newman, D. (2016). Root cause analyses of transfers of skilled nursing facility patients to acute hospitals: Lessons learned for reducing unnecessary hospitalizations. *JAMDA.*

CURRENT/COMPLETED PROJECTS

SPONSOR & PROJECT TITLE	RESPONSIBILITIES	DATES
PCORI. Eugene Washington Engagement Award: *Involving Nursing Home Residents and Their Families in Hospital Transfer Decisions: Dissemination*	Project Coordinator	9/1/15-12/31/15
NIH/NINR. Implementation Interventions to Reduce Hospitalization of Nursing Home Residents (INTERACT™)	Research Associate	2/2013-12/31/2014