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New York State
Department of Health
Division of Quality and Surveillance for Nursing Homes and ICFs/MR

Request for Applications

On-Time Quality Improvement for Long Term Care

KEY DATES

RFA Release Date: August 1, 2007

Live Webcast (Applicant Conference): August 8, 2007

Questions Due: August 17, 2007

RFA Updates Posted: August 29, 2007

Applications Due: Continuously accepted after September 4, 2007 until all funds available for this program have been awarded or until October 15, 2007, whichever comes first.

DOH Contact Name & Address: Beth Dichter, Ph. D., Director
Bureau of Professional Credentialing
Division of Quality and Surveillance
for Nursing Homes and ICFs/MR
161 Delaware Avenue
Delmar, NY 12054

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I. Purpose of RFA

The Division of Quality and Surveillance (DQS) announced the "War on the Sore" in DAL #06-22, November 30, 2006. Since the release of this DAL, DQS has worked closely with nursing homes, provider associations, researchers and the federal government to identify evidence-based quality improvement models that produce sustainable decreases in prevalence and incidence of pressure ulcers among nursing home residents. One such evidence-based model is "On-Time Quality Improvement for Long Term Care", developed by Dr. Susan Horn and colleagues at the Institute of Clinical Outcomes Research[1] and additional colleagues at Health Management Strategies[2], with financial support from the federal Agency for Healthcare Research and Quality (AHRQ) and the California Health Care Foundation. It has been implemented, tested and refined in 30+ nursing homes across the nation. This approach to nursing home acquired pressure ulcer prevention has produced an average decrease of 33% in prevalence rates in the nursing homes that implemented the model.

The On-Time model integrates clinical guidelines and clinical information into each nursing home's daily routines and processes for assessment, care planning, care delivery, communication and reassessment using health information technology (HIT). The On-Time model streamlines CNA documentation and focuses their documentation on critical data. Using health information technology, CNAs spend *less* time documenting (redundancies are eliminated), but they document more information in a standardized way and it is more accurate, meaningful, and useful to them in their daily assignments. New work is integrated into daily routines rather than added on to them. The model facilitates timely information flow that informs weekly monitoring of resident status and on-going care planning. The communication mechanisms used in the On-Time model are effective and efficient and provide staff with current and accurate information on the resident on a weekly or more frequent basis.

It is anticipated that about $600,000 will be allocated to this initiative although this is subject to change. At this level of funding, up to 12 nursing homes that commit to implementing the model for all of their chronic or long stay beds will be selected to participate. Awards from the Department of Health are capped at $49,999 and are intended primarily to partially subsidize the costs of the required health information technology that must be purchased to implement the On-Time model. The Department will execute a two-year grant contract with each nursing home awarded funds under this initiative. (A sample grant contract is available upon request to profcred@health.state.ny.us.)

The federal Agency for Healthcare Research and Quality is partnering with the NY State Department of Health, the Institute for Clinical Outcomes Research and Health Management Strategies to provide the selected nursing homes with additional resources and consultation to effectively implement the model.

Participating nursing homes whose costs to implement the On-Time model exceed $49,999 will cover costs in excess of $49,999 with their own funds.

II. Who May Apply

Eligibility is limited to nursing homes licensed under Article 28 of New York's Public Health Law with pressure ulcer rates for high risk residents that average 10% or more in the most recent two quarters for which the required data are available, as measured by NYS Department of Health for posting on its website on the Nursing Home Profile page (http://nursinghomes.nyhealth.gov/). Nursing homes are eligible if they have current health information system (HIT) for CNA documentation or if they do not. Discussions related to HIT will be part of the application and

[1] Institute for Clinical Outcomes Research, 699 East South Temple, Suite 100, Salt Lake City, Utah 84102.

[2] Health Management Strategies, 6109 Tasajillo Trail Austin, TX 78739.

implementation planning process.

Nursing homes awarded funds under this RFA may also apply for and receive funds under any other pressure ulcer reduction RFA issued by the Department of Health. However, a nursing home that receives an award under this RFA to implement the On-Time model must propose a different project in its application for funds under any other pressure ulcer reduction RFA issued by the Department of Health.

I. On-Time Quality Improvement for Long Term Care

A. Overview

The On-Time approach re-engineers the nursing home's workflow processes around pressure ulcer prevention and integrates health information technology into those processes with the result that:

1. Daily documentation for CNAs is more efficient, accurate and comprehensive but less time-consuming;

2. Reports based on CNA documentation: (1) are generated by HIT in a timely fashion (i.e., no more than seven days after the documentation is completed); (2) provide useful information to staff, including risk status and a much broader picture of each specific resident's status on a number of outcomes related to pressure ulcers in the past week and over time; and (3) reduce the amount of time spent compiling information for care team meetings and outside agency reporting.

3. Communication mechanisms among staff are efficient and effective: specific staff (e.g., dietician, nurse, or social worker) get weekly information on resident status changes and trends in outcomes related to pressure ulcer risk. This ensures that assessment, reassessment, care plans and care delivery are current, consistent and match the resident.

The model requires the following:

1. A project management team that includes Director of Nursing (DON) or Director of Nursing Services (DNS), staff development and medical records;

2. Multi-disciplinary clinical teams that include CNAs, nurses, social workers and dietician;

3. Replacement of the typical disparate CNA paper documentation process with standardized data elements, consolidated documentation forms and electronic data capture using health information technology (HIT);

4. Use of "on time" data and weekly feedback reports that: (a) identify residents at highest risk for pressure ulcers, (b) show trends in multiple outcomes for these residents over time, and (c) help staff monitor the effectiveness of care in a timely fashion;

5. Integration of these reports into daily work flow and care planning;

6. Regularly scheduled opportunities for members of the multi-disciplinary teams to review trended resident information (e.g., weight loss) and communicate with each other; and

7. Networking with other nursing homes to solve common issues that arise as the nursing homes implement the model.

In sum, more efficient and accurate CNA information is captured on each shift as the CNAs document the care they provide in handheld electronic data capture devices. At the end of each shift, the CNAs download the data to a website maintained by the nursing home's clinical software vendor. The software vendor analyzes the data according to On-Time protocols and produces weekly (or more frequent) reports specific to each resident, unit, and the nursing home as a whole. The reports are made available to nursing home staff through the same website. Privacy protections are in place to ensure that unauthorized individuals are not able to access or view the reports.

These standard weekly reports on each resident are effective tools for clinical teams focused on preventing pressure ulcers: they monitor changes in nutrition, incontinence and behaviors. In general, certain elements of the On-Time model are the same for all nursing homes; other elements can be customized to suit individual nursing homes. Additional outcomes can be added to the reports if the nursing home wishes to track them. Customizing the reports to each individual facility's goals and needs will be accomplished in the first quarter of the project.

B. What Clinical Guidelines Are Used?

The clinical guidelines used include AHRQ pressure ulcer prevention and treatment guidelines[3] and AMDA guidelines for nursing homes[4]. In addition to these commonly referenced guidelines, refinements from current literature are included such as triggers for considering nutritional supplements.

C. What Consultation and Education Will Be Provided?

Nursing homes selected to participate in this initiative will agree to implement the On-Time model as described in this RFA. The federal Agency for Healthcare Research and Quality has retained the developers of the On-Time model, the ICOR/HMS team led by Dr. Susan Horn and Ms. Siobhan Sharkey, to provide education, training and technical assistance to nursing homes selected to participate in this initiative. These services will be provided both onsite and through telephone conference calls and other communication mechanisms. Nursing homes will incur minimal costs for these services, which include the following:

1. Initial orientation for facility-based project management teams including:

    - Information on project purpose, scope, benefits, overall timeline, example documentation forms, and reports with explanations of use; and

    - Overview of pressure ulcer prevention best practices.

2. Technical assistance to the nursing homes' software vendors to develop or adapt an electronic decision support system that:

    - uses the documentation electronically captured by CNAs from standardized clinical documentation forms and downloaded to the vendor's website;

    - stores this information in a database and analyzes it; and

    - supports feedback to facilities in weekly reports that meet On-Time specifications.

3. Workflow redesign and pre-implementation planning facilitation resulting in:

[3] Pressure Ulcer Guideline Panel. Pressure Ulcers in Adults: Prediction and Prevention. Guideline Report number 3, Agency for Health Care Policy and Research, Rockville, Maryland , AHCPR Publication 93-0013.
[4] Clinical Practice Guideline: Pressure Ulcers. While these guidelines are currently under revision, they are expected to be finalized and posted on the AMDA website (http://www.amda.com/tools/cpg/pressureulcer.cfm) by November, 2007.

- Streamlined CNA documentation within each facility;
- Documentation consolidated to a small number of forms;
- Redundant documentation eliminated; and
- Standardized set of CNA documentation elements embedded into redesigned facility form.

4. Focused discussions with the multi-disciplinary clinical team on each report, including overview of how it is used in care planning and examples of how to incorporate these On-Time reports into weekly practices of multi-disciplinary clinical team members.

5. Strategies for implementing the redesigned CNA documentation and using the clinical reports.

1. On-going implementation support, including:

   - Facilitating integration of clinical protocols into clinical decision-making and fine tuning best practices; and

   - Targeting specific education to one or more staff members when completeness reports indicate that their documentation in some clinical assessment area is inadequate.

2. Monitoring outcomes and auditing processes of care, e.g., forms and instructions about how to collect the data needed to track impact on the nursing home as a whole in such areas as pressure ulcer incidence rates, staff job satisfaction and workflow measures.

D. Multi-Disciplinary Teams

The multi-disciplinary teams include CNAs, charge and staff nurses, MDS and wound care nurses, dietary, social services, staff development, and restorative care staff. By involving front-line staff in the redesign of workflow and implementation processes, the On-Time approach aims to strengthen collaborative relationships and improve communication and access to information across disciplines. These implementation teams will champion the workflow redesign and provide daily leadership throughout the implementation process.

E. CNA Documentation

CNA daily documentation is redesigned. While a new CNA documentation form is used, it replaces the multiple log books and worksheets that often lead to wasted time and increased chance for error.

Standardized data elements and consolidated forms increase efficiencies of documentation and facilitate electronic data capture and reporting by the CNAs. Then, weekly reports (see Section F below) generated for the unit's nurses and CNAs provide ongoing, longitudinal information for use in resident care planning; problems can be identified early and interventions promptly instituted. For example, residents with poor nutritional intake and urinary and bowel incontinence are at high risk for developing pressure ulcers. Prompt intervention can prevent the development of pressure ulcers in such residents.

The consultants will review each facility's existing CNA documentation forms and documentation used by the wound care team. They will compare each facility's existing documentation to On-Time forms and will identify, in collaboration with the facility implementation team, data elements to be incorporated into redesigned CNA documentation forms and process. The consultants and facility team members will work together to finalize a new daily documentation form for CNA staff

(e.g., daily flow sheets). The data required for quality reporting, best practices, and state regulatory purposes will be incorporated into the reformatted documentation.

F. Weekly On-Time Reports

CNA documentation is captured at the point of documentation (there is no extra data entry) using the health information technology (HIT) of the applicant's choice. There are five weekly On-Time reports created using the CNA data: a completeness report for the CNA documentation; nutrition report; behaviors report; a "triggers" report that identifies residents at high risk for pressure ulcer formation; and a priority report that provides an overall summary. Each report displays resident specific information for each unit. Sample reports are shown in Attachment 7 to this RFA.

The staff that typically use these reports are DON or DNS, Assistant DON or DNS, MDS nurse, Unit Manager, Charge Nurse, Dietician, Wound Nurse, staff development, social services and CNAs. The reports are used in existing meetings, i.e., Weight Loss Committee and Skin Team, as well as in new processes like 5-minute stand-up meetings between dietician and CNAs. These are examples only and can be customized according to each nursing home's goals and objectives:

1. CNA Documentation Completeness and Consistency Report - This report is used to monitor CNA form completeness and consistency by nursing station.

2. Nutrition Report – This report is used to identify and monitor residents with decreased meal intake and/or weight loss, both of which are indicators for high risk of pressure ulcer development based on the guidelines. The weekly meal intake for the past four weeks is trended for each resident. Weight changes for the past 30, 90 and 180 days are calculated. This report helps staff answer the question, How many residents trigger for high risk (decreased meal intake of 2 meals @ =<50% at least one time during report week AND weight loss for report week)? Medium risk (decreased meal intake OR weight loss)?

3. Behavior Report - This report is used to summarize resident behavior trends by nursing unit and behaviors by resident by nursing station. This report helps nursing and social services staff identify changes in resident behaviors, understand patterns across shifts, and summarize information for MDS reporting.

4. Trigger Summary Report – High Risk for Pressure Ulcer Development - This report is used to monitor the number of pressure ulcer triggers by resident. It enables staff to compare the current week to the previous week.

5. Priority Report - This report is used to identify and monitor priority residents, i.e., residents with changes from previous week including decreased meal intake and weight loss, change in behaviors, increased bladder incontinence, new pressure ulcer or worsened ulcer. It also monitors residents with red or open areas.

G. Health Information Technology (HIT)

This section describes the functional requirements or system features of health information technology that nursing homes funded under this RFA need to comply with requirements of this RFA. Each nursing home will decide for itself the vendors that it will contract with to provide the software and hardware. It is anticipated that nursing homes will first contact their current vendors to discuss the functional requirements of this RFA to ascertain whether the vendor currently has the required system features or can make the features available to meet those requirements. This section of the RFA is designed to help facilitate those discussions. Information on two

vendors who currently meet requirements for the On-Time program is provided at the end of this section.

The grants from the Department of Health that are awarded to nursing homes under this RFA are capped at $49,999 and are intended to cover at least in part the costs of the required health information technology (HIT). Nursing homes will use their own funds to cover any HIT costs in excess of this amount. The HIT will have two components: (1) electronic data entry devices used by CNAs to document the daily care that they deliver; and (2) standard reports (based on CNA documentation) per the On-Time specifications.

CNAs will use the devices to document daily care. The devices must support transmission of CNA documentation to a database on a website maintained by the nursing home's software vendor. The vendor then processes and analyzes that data, produces the reports as per On-Time specifications, and posts them on the same website so that the nursing home can immediately access and print them out. Examples of the five basic reports are appended to this RFA.

If the applicant's CNAs already use electronic data-capturing technology and the nursing home wishes to use it in the On-Time project, the nursing home and the vendor should discuss feasibility, costs and timeline to develop or adapt the applicant's current HIT to meet On-Time standardized report specifications within the required timeframes, provided below.

Writing the software required to produce these reports often requires intensive review by the vendor programming team and follow-up discussion of report specifications with original programmers of the On-Time reports; therefore nursing homes that wish to work with their current software vendors should immediately initiate discussions with them on whether they have the capacity to produce such reports within the timeframes required for participation in this initiative.

The required five On-Time reports can be found in Attachment 7. The column headings for each report are in Attachment 8. Both should be shared with the applicant's vendor. Vendors will need to see the five reports and column headings before they can discuss whether they can produce them within the required timeframes. Vendors will be required to produce the CNA Documentation Completeness/Consistency, Nutrition and Priority Reports within three months of signing a sub-contract with the nursing home to do so, and the Behavior and Trigger Summary Reports within six months of signing a sub-contract with the nursing home.

These reports are the **primary deliverables** in **both** the contracts between the Department and nursing homes and the sub-contracts between the nursing homes and their software vendors. The contracts between the Department of Health and the nursing homes will require the reports to be produced as per On-Time specifications before the nursing home can request reimbursement for vendor fees from the Department. The sub-contracts between nursing homes and their vendors will contain a similar provision: the nursing home will not pay the vendor until the reports are produced as per On-Time specifications.

Vendors have reported an estimated cost of $40,000 - $60,000 to write and debug the programs required to produce the On-Time reports. If several nursing homes contract with the same vendor, economies of scale are possible. Nursing homes should be able to negotiate a price that decreases as the number of nursing homes contracting with the vendor increases. Applicants should be aware that after installation and implementation of all On-Time HIT, vendors will charge on-going fees to produce the reports.

Two conference calls have been scheduled to enable potential software vendors to discuss On-Time report specifications with the consultants so that the vendors can ascertain whether they have the capability to program the reports. Applicants are strongly encouraged to ask their vendors to participate in one of these calls. Vendors will register for one of the calls by e-mail to

Sandy Hudak at slhudak@earthlink.net. Ms. Hudak will reply by e-mail with the call-in number and conferee code. Dates and times for the two conference calls are:

Monday, August 13, 2007, 2 - 3 PM EST **or** Tuesday, August 14, 2007, 10 – 11 AM EST
If the applicant's CNAs are documenting on paper and do not already use a computer program to document daily care, or if the applicant's vendor does not have the capacity to modify data entry screens or produce the reports per On-Time specifications, other vendors that are known to have this capacity can be contracted by the nursing home. These are discussed below.

Applicants could consider a low-cost device that many nursing homes implementing the On-Time approach have used: digital pen technology available from Digital Pen Systems. It is a customizable HIT solution to transfer data from paper to a centralized web-based database. It uses handwriting recognition and check box processing to manage documentation workflow with accurate capture of handwritten information in a digital format for processing. The digitized form and digital pen capture resident clinical data without changing clinical workflow and processes. At the end of each shift, the CNA downloads the data from the digital pen to a database maintained on a secure Digital Pen System website. The number of digital pens that must be purchased equals the number of CNAs on the day shift plus a few extra ones to replace those that are lost or damaged. The On-Time reports are available to nursing homes that have implemented this model via a secure connection on the Internet. For information about Digital Pen Systems contact Jason Soulier, President Digital Pen Systems at (801) 824-0697 or email jason.soulier@digitalpensystems.com.

Optimus EMR also has the capacity to provide reports that meet On-Time specifications. Optimus EMR provides a complete electronic medical record solution including but not limited to electronic documentation of nursing and multidisciplinary notes and assessments, MDS documentation, physician order entry, and results reporting. In January 2007, Optimus EMR made available the CNA Module that can be purchased separately from the complete electronic medical record package. The CNA Module provides an option for CNA staff to use handheld devices or wall-mounted kiosks for electronic data entry of daily documentation. All On-Time reports are included in the CNA Module. For information about the Optimus EMR or Optimus CNA Module contact Tim Quarberg, Vice President of Sales & Marketing at (952) 545-0440 or email tquarberg@optimusemr.com.

Nursing homes applying for funds under this RFA should reach a tentative decision regarding the vendor(s) they wish to contract with for the hardware and software required to be used under this RFA. They should obtain a firm cost from the vendor(s) and build a project budget, to be submitted as part of their application for funds, based on this cost. Applications will not compete on cost, and in any case grant awards will not exceed $49,999 regardless of the applicant's total budgeted cost for the two-year project.

Applications will be reviewed and scored as described in Section VI D. For those that score 10 or more points on the technical criteria, and thus are eligible for an award, the consultants will facilitate further discussions between the nursing home and the vendor(s) it identifies in its application. The goal of these discussions will be to understand the vendor's actual capability to program and produce the reports within the required timeframes at a cost that the nursing home is willing to pay. After this discussion, the nursing home will decide whether to sub-contract with the vendor identified in its application or another vendor.

Impact of On-Time Technology on the Nursing Home's Current Technology

It is anticipated that many nursing homes will want to understand how the On-Time model, including automation of CNA documentation, interfaces with their MDS software and/or EQUIP. Unless the applicant's MDS software is being used by CNAs to capture daily documentation, there is no role in the short term and no impact on MDS software. There is, however, an impact on MDS data quality. Implementing the On-Time model improves the completeness and

accuracy of CNA documentation, provides summarized information accessible via the web, and therefore results in more accurate MDS data. In the longer term, the applicant may decide to explore integrating the automated CNA documentation into the MDS software, but this is not within the scope of this RFA.

III. Work Plan and Project Timeframes

A December 1, 2007 start date is anticipated. All nursing homes selected to participate in this initiative will follow the same basic work plan over the course of the two-year project.

TASK	DETAILS	QUARTER				
		Q1	Q2	Q3–Q4	Q5-Q6	Q7-Q8
Nursing homes develop work plans and establish teams.	Each nursing home adapts the general work plan included in the RFA to its own situation, with the recognition that timeframes for conference calls and onsite reviews with the consultants must be coordinated with other participating facilities and the consultants own schedules. Each nursing home establishes its project management team and multi-disciplinary teams.	X				
Vendor develops software required to produce weekly reports as per On-Time specifications.	Via conference calls, consultants work with nursing homes and their vendors re: development of software needed to produce reports.	X	X			
CNA documentation review.	Via weekly conference calls, consultants review with each nursing home its current documentation forms for CNA and wound care team. Together, they will compare existing documentation to On-Time forms, and identify differences in data elements and information flow.	X	X			
Develop standardized CNA documentation.	Via weekly conference calls, consultants work with facility project management team to assess work flow, develop and pilot test initial documentation form; gather feedback from staff on workflow and pilot test; and modify accordingly.	X	X			

Review and confirm workflow redesign	Via weekly conference calls, consultants work with facility project management team to confirm process for new CNA documentation; review reports and develop initial plan to use in daily practice.	X	X			
Develop facility roll-out plan for new CNA documentation process and reports; coordinate with HIT vendor for installation & training.	Via monthly conference calls, consultants provide on-going support and problem-solving for site-specific implementation.		X	X		
Consultants convene a day-long meeting with participating nursing home staff as a group in a central NY location. The meeting may be held at one of the participating nursing homes.	Participating nursing home staff meet each other and the consultants. Nursing homes share with each other their plans on use of weekly reports and how to incorporate reports into weekly care planning processes, etc.		X			
Weekly On-Time reports integrated into daily workflow.	Via bi-monthly conference calls with sub-groups of nursing homes, consultants provide on-going support and problem-solving for site-specific implementation.		X	X		
Nursing home collaboration and sharing.	The consultants will convene monthly conference calls in which all NHs participate as a group. Agendas will include: analyze current processes (CNA and clinical team documentation – nurses, wound care team, MDS nurses, and dieticians); review reports and discuss strategies to integrate into care planning activities; share learning; review implementation status; provide feedback; discuss areas for streamlining and/or improving.		X	X	X	X
Progress review.	Conference calls with consultants scheduled as needed but no less frequently than once a month.			X	X	X
On-site review.	The consultants will provide onsite review and support toward the end of the fourth quarter or the beginning of the fifth quarter.			X	X	

Consultants convene a day-long meeting with participating nursing home staff as a group in a central NY location. The meeting may be held at one of the participating nursing homes.	The purpose of this meeting is to enable participating nursing homes to share their experiences, progress, barriers and solutions, and next steps with each other. Next steps could include, for example, pressure ulcer healing, expansion of the On-Time approach to other resident outcomes, and moving into an electronic medical records environment.					X

V. Budget Information and Requirements

The Department of Health grants, capped at $49,999, are intended primarily to subsidize HIT hardware and software costs for CNA pressure sore documentation and weekly report programming and production. In addition, participating nursing homes are expected to cover the costs of sending three to five staff to the two all-day meetings in a central NY location in Q2-3 and Q7-8. These costs should be itemized in the application budget as they are required expenditures of grant funds. All consultant fees are the responsibility of the federal Agency for Healthcare Research and Quality.

Nursing homes funded under this RFA are expected to cover all additional costs with their own funds. Payment of approved budgeted expenditures will be through voucher, i.e., nursing homes will be reimbursed after they submit documentation of expenditures in accordance with their approved budgets and contractual requirements concerning production of the On-Time reports as per On-Time specifications.

VI. Timeframes for Procurement

A. Live Interactive Applicant Webcast

In lieu of an applicant conference, there will be a live interactive webcast on August 8, 2007 from 1:30 to 3:30 EST. The webcast agenda includes:

- Members of the team that developed and implemented the On-Time Quality Improvement for Long Term Care model (Dr. Susan Horn, Siobhan Sharkey, Sandra Hudak and Dr. William Spector), will describe the model and why it is so effective in helping nursing homes prevent pressure ulcers. This is the team of consultants that will work with nursing homes selected to participate in this initiative to implement the model;

- Management staff at two nursing homes that have implemented the model (Country Villa Health Services in California and National Church Residences in Ohio) will discuss why they selected On-Time and their experiences with the model.

- A video in which all levels of staff in nursing homes that have implemented the On-Time approach talk about their experiences with the model;

- Several questions and answers segments during which New York State nursing home staff can direct questions about the initiative to Drs. Horn and Spector, Ms. Sharkey, Ms. Hudak, and the staff from Country Villa Health Services and National Church Residences.

- A presentation from Dr. Elizabeth Dichter, New York State Department of Health, on the RFA.

- A question and answer period during which nursing homes can direct their questions on the RFA to Dr. Dichter.

Nursing homes are urged to participate in this live interactive webcast but must register to do so. Interested nursing homes are encouraged to allow multiple staff to participate, e.g., the administrator, director of nursing services, CNAs, dietician, social worker, etc. Vendors may also participate, although they should be aware that separate conference calls have been scheduled to meet their specific needs for information.

Those wishing to participate in the webcast must register by e-mail to garyw@dfmc.org, or through www.delmarvafoundation.org/events/AHRQ/webCast/. There is no deadline to register for the webcast.

Two CEU credits are available for nursing home administrators who participate in the webcast.

B. Software Vendor Conference Calls

Two conference calls have been scheduled to enable potential software vendors to discuss On-Time report specifications with the consultants so that the vendors can ascertain whether they have the capability to program the reports. Applicants are strongly encouraged to ask their vendors to participate in one of these calls. Vendors must register for one of the calls by e-mail to Sandy Hudak at slhudak@earthlink.net. Ms. Hudak will reply by e-mail with the call-in number and conferee code. Dates and times for the two conference calls are:

Monday, August 13, 2007, 2:00 – 3:00 PM EST
Tuesday, August 14, 2007, 10:00 – 11:00 AM EST

C. Questions and Answers

All questions posed during the live webcast or e-mailed to the Department of Health (profcred@health.state.ny.us) by close of business on August 17, 2007 will be compiled into a questions and answers document and posted on the Department's website (www.health.state.ny.us). *Questions will not be accepted via telephone. Telephone callers will be requested to e-mail their questions to the above address.*

D. Application Process

Applications will be reviewed and scored on a "first come, first served" basis after September 4, 2007 until all funds allocated to this initiative have been awarded or October 15, 2007, whichever comes first. Seven copies of the application, one of which should be an original and marked as such, should be sent to the following address:

Beth Dichter, Director
Bureau of Professional Credentialing
Division of Quality and Surveillance for
Nursing Homes and ICFs/MR
NYS Department of Health
161 Delaware Avenue
Delmar, NY 12054

As they arrive, applications will be stamped with the date and time of arrival at the above address. Multiple applications delivered simultaneously by a carrier will all be stamped with the same date and time.

Applications will be eliminated without review if they:

- Are submitted by an entity that is not a nursing home licensed under Article 28 of NYS Public Health Law; and/or

- Do not have pressure ulcer rates for high risk residents that average 10% or more for the most recent two quarters for which the data are available, as measured by NYS Department of Health for posting on its website on the Nursing Home Profile page; and/or

- Do not include a Face Page (Attachment 1) with signatures of the Administrator of Record, the Director of Nursing Services,and the Dietician; and/or

- Do not include a completed and signed Administrator's Attestation (Attachment 5); and/or

- Are received after all the funds available for this initiative have been awarded or October 15, 2007, whichever comes first.

Additionally, the Department reserves the right to eliminate applications submitted by nursing homes that have incurred immediate jeopardy or substandard quality of care designations in the past 24 months, if, in the Department's sole opinion, the nursing home is not likely to be able to implement this initiative successfully within the timeframes specified in the workplan. This means that such nursing homes will not be automatically eliminated but will be subject to additional review to ascertain their readiness to implement the On-Time model.

Applications that are not eliminated based on the above factors will be reviewed in the order in which they are received, and scored. *Applications will not compete on cost.* Those that score fewer than 10 points on the technical criteria are not eligible to be funded and will be eliminated. Those that score 10 or higher on the technical criteria, which are worth a total of 35 points, are eligible to be funded if funds are available or potentially available. For such applications, the consultants will facilitate further discussions between the nursing home and the vendor(s) it identifies in its application. The goal of these discussions will be to understand the vendor's actual capability to program and produce On-Time reports within the required timeframes at a cost that the nursing home is willing to pay. After this discussion, the nursing home will decide whether to sub-contract with the vendor identified in its application or another vendor.

Nursing homes that choose to seek another vendor are expected to identify another vendor within 21 calendar days of the date of the discussion between the consultants, the nursing home and the vendor(s) identified in the application. This is necessary in order to have the same contractual start date, or start dates that are fairly close together, for all participating nursing homes. Start dates that are the same or near each other are necessary in order to enable all participating nursing homes to implement the same work plan and achieve work plan milestones according to the same timeframes. Department of Health staff and the consultants will be available to help nursing homes identify other vendors should they wish to select one other than the vendor identified in their applications. It is recognized that requested budgets may, at the Department's discretion, change as a result of these discussions. However, in no case will the final approved budget exceed $49,999.

The Department will end the application review and scoring process upon its determination that all funds available for this initiative have been awarded.

It is possible that at some point during the review process, more applications will be scored and eligible for awards than can be funded. In this case, such applications will be ordered by submission date and time, by score, by average pressure ulcer rate. This means that the earliest submitted application with the highest score and highest pressure ulcer rate will be funded before applications with latter submission dates and time, lower scores and lower pressure ulcer rates.

E. Application Requirements

Applications should be typed, single-sided and paginated. The font size should be clearly readable. Note that applications do ***not*** include project narratives and work plans because those selected to be funded will implement the intervention described in this RFA according to the work plan provided in this RFA. Applicants should use the following outline:

- **Face Page**. The form in Attachment 1 must be used. It may be reproduced or re-typed with a different font as long as all text is identical to and in the same order as the original. It may not be altered in any other way.

- **Operating Certificate(s).** Include a clear, legible copy of the applicant's Operating Certificate.

- **Table of Contents**. Use the Table of Contents in Attachment 2.

- **Applicant Survey.** Complete Attachment 3. This information will ***not*** be used to score applications. It will be used to enable the consultants to "preview" applicants' experience with health information technology and how they currently manage residents at high risk of pressure ulcers.

- **Application Review Criteria**. Complete Attachment 4. The information provided in this document will be used to score applications.

- **Administrator's Attestation**. Complete Attachment 5. This is the administrator's agreement to implement On-Time Quality Improvement for Long Term Care as described in this RFA. The grant contract between the nursing home and the Department of Health will include this and the five On-Time reports as the primary deliverables. The administrator will also attest to the accuracy and truthfulness of the Application Review Criteria responses (Attachment 4) submitted with the application.

- **Proposed Project Management Team.** Identify the staff and their positions in the nursing home, who will be appointed to the project management team and who will be accountable for implementing On-Time Quality Improvement for Long Term Care as described in this RFA.

- **Project Organization, Staffing and Management**. A project organization chart should be included that shows how various staff and teams will manage the project, e.g., the relationships between the AOR, department heads (including nursing, dietary, social work, physical therapy, etc.), wound nurse if there is one, project management team and the multi-disciplinary teams that will need to be established to implement the On-Time model for all chronic care or long stay beds. Note that On-Time can be implemented in phases over the course of the two-year project. However, it must be implemented for all long stay beds by month 10 of the 24-month project.

- **Letter(s) of Participation from Vendor(s).** Include a letter from each software/hardware vendor that states that the vendor will produce the required reports as per On-Time specifications within the required timeframes and the cost to the nursing home to do so. The letter should also describe the data entry devices for CNAs if the nursing home has not already purchased them, and the number and cost of the devices to be purchased.

- **Budget.** Use Attachment 6. Prepare a budget for each year of the two-year contract and a summary budget for the two-year period as a whole. Budgets should identify all costs that

the applicant will incur to implement the project, not just those to be reimbursed by the Department. NOTE: Applications will *not* compete on cost.

- **Budget Narrative.** Each budget should be accompanied by a budget narrative. The budget narrative should address expenses in the same order that they appear in the budget itself. All items should be as specific and detailed as possible, and explained or justified. If possible, hardware costs should be differentiated from software costs. The portion of each budget line covered by the Department of Health grant and the portion covered from the applicant's own funds should be identified. NOTE: Applications will *not* compete on cost.

F. Application Review Criteria

Application review criteria are listed in Attachment 4. The ten technical criteria are worth 35 points. Applicants must score 10 or more points to be eligible to funded. Applications will not compete on cost.

VII. Administrative Requirements

A. Issuing Agency

This RFA is issued by the NYS Department of Health, Division of Quality and Surveillance for Nursing Homes and ICFs/MR. The Department is responsible for the requirements specified herein and for the evaluation of all applications.

Prospective applicants should note that all clarifications and exceptions, including those relating to the terms and conditions of the contract, are to be raised prior to the submission of an application.

This RFA has been posted on the Department of Health's public website at: http://www.nyhealth.gov/funding/. Questions and answers, as well as any updates and/or modifications, also will be posted on the Department of Health's website.

Submission of a letter of interest is not a requirement for submitting an application.

B. Reserved Rights

The Department of Health reserves the right to:

1. Reject any or all applications received in response to this RFA.

2. Award more than one contract resulting from this RFA.

3. Waive or modify minor irregularities in applications received after prior notification to the applicant.

4. Adjust or correct cost figures with the concurrence of the applicant if errors exist and can be documented to the satisfaction of DOH and the State Comptroller.

5. Negotiate with applicants responding to this RFA within the requirements to serve the best interests of the State.

6. Modify or eliminate mandatory and/or eligibility requirements unmet by all applicants or met by fewer than 12 applicants.

7. If the Department of Health is unsuccessful in negotiating a contract with the selected applicant within an acceptable time frame, the Department of Health may begin contract negotiations with the next qualified applicant(s) in order to serve and realize the best interests of the State.

8. The Department of Health reserves the right to award grants based on geographic or regional considerations to serve the best interests of the state.

C. Term of Contract

Any contract resulting from this RFA will be effective only upon approval by the New York State Office of the Comptroller.

It is expected that contracts resulting from this RFA will have the following time period: December 1, 2007 – November 30, 2009.

D. Payment and Reporting Requirements for Grant Awardees

The State (NYS Department of Health) may, at its discretion, make an advance payment to not for profit grant contractors in an amount not to exceed 10% percent.

The grant contractor will be required to submit quarterly invoices and required reports of expenditures to the State's designated payment office:

Bureau of Professional Credentialing
NYS Department of Health
161 Delaware Avenue
Delmar, NY 12054-1393

Payment of such invoices by the State (NYS Department of Health) shall be made in accordance with Article XI-A of the New York State Finance Law. Contractor will be reimbursed for actual expenses incurred as allowed in the Contract Budget and Workplan.

The grant contractor will be required to submit quarterly and annual programmatic and financial reports according to a format that will be supplied by the Department of Health.

All payment and reporting requirements will be detailed in Appendix C of the final grant contract.

E. General Specifications

1. By signing the "Application Form" each applicant attests to its express authority to sign on behalf of the applicant.

1. Contractor will possess, at no cost to the State, all qualifications, licenses and permits to engage in the required business as may be required within the jurisdiction where the work specified is to be performed. Workers to be employed in the performance of this contract will possess the qualifications, training, licenses and permits as may be required within such jurisdiction.

2. Submission of an application indicates the applicant’s acceptance of all conditions and terms contained in this RFA. If this applicant does not accept a certain condition or term, this must be clearly noted in a cover letter to the application.

3. An applicant may be disqualified from receiving awards if such applicant or any subsidiary, affiliate, partner, officer, agent or principal thereof, or anyone in its employ, has previously failed to perform satisfactorily in connection with public bidding or contracts.

4. Provisions Upon Default

   a. The services to be performed by the Applicant shall be at all times subject to the direction and control of the Department as to all matters arising in connection with or relating to the contract resulting from this RFA.

   b. In the event that the Applicant, through any cause, fails to perform any of the terms, covenants or promises of any contract resulting from this RFA, the Department acting for and on behalf of the State, shall thereupon have the right to terminate the contract by giving notice in writing of the fact and date of such termination to the Applicant.

   c. If, in the judgement of the Department of Health, the Applicant acts in such a way which is likely to or does impair or prejudice the interests of the State, the Department acting on behalf of the State, shall thereupon have the right to terminate any contract resulting from this RFA by giving notice in writing of the fact and date of such termination to the Contractor. In such case the Contractor shall receive equitable compensation for such services as shall, in the judgement of the State Comptroller, have been satisfactorily performed by the Contractor up to the date of the termination of this agreement, which such compensation shall not exceed the total cost incurred for the work which the Contractor was engaged in at the time of such termination, subject to audit by the State Comptroller.

D. Appendices

The following will be incorporated as appendices into any contract(s) resulting from this Request for Application.

APPENDIX A - Standard Clauses for All New York State Contracts

APPENDIX A-1 Agency Specific Clauses

APPENDIX A-2 Program Specific Clauses <*if applicable*>

APPENDIX B - Budget

APPENDIX C - Payment and Reporting Schedule

APPENDIX D - Workplan

APPENDIX H - Federal Health Insurance Portability and Accountability Act (HIPAA) Business Associate Agreement <*if applicable*>

APPENDIX E - Unless the CONTRACTOR is a political sub-division of New York State, the CONTRACTOR shall provide proof, completed by the CONTRACTOR's insurance carrier

and/or the Workers' Compensation Board, of coverage for:

Workers' Compensation, for which one of the following is incorporated into this contract as **Appendix E-1**:

- **WC/DB-100**, Affidavit For New York Entities And Any Out-Of-State Entities With No Employees, That New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage Is Not Required; OR

- **WC/DB -101**, Affidavit That An OUT-OF STATE OR FOREIGN EMPLOYER Working In New York State Does Not Require Specific New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage; OR

- **C-105.2** -- Certificate of Workers' Compensation Insurance. PLEASE NOTE: The State Insurance Fund provides its own version of this form, the **U-26.3**; OR

- **SI-12** -- Certificate of Workers' Compensation Self-Insurance, OR **GSI-105.2** -- Certificate of Participation in Workers' Compensation Group Self-Insurance

Disability Benefits coverage, for which one of the following is incorporated into this contract as **Appendix E-2**:

- **WC/DB-100**, Affidavit For New York Entities And Any Out-Of-State Entities With No Employees, That New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage Is Not Required; OR

- **WC/DB -101**, Affidavit That An OUT-OF STATE OR FOREIGN EMPLOYER Working In New York State Does Not Require Specific New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage; OR

- **DB-120.1** -- Certificate of Disability Benefits Insurance OR the **DB-820/829** Certificate/Cancellation of Insurance; OR

- **DB-155** -- Certificate of Disability Benefits Self-Insurance

NOTE: Do not include the Workers' Compensation and Disability Benefits forms with your application. These documents will be requested as a part of the contracting process should you receive an award.

ATTACHMENT ONE

FACE PAGE
NEW YORK STATE DEPARTMENT OF HEALTH
ON-TIME QUALITY IMPROVEMENT FOR LONG TERM CARE
RFA 0704271204

Name of Applicant (Must be identical to Operating Certificate name, including D/B/A if on Operating Certificate):

_____

Operating Certificate Number: |__|__|__|__|__|__|__|_N_| PFI: |__|__|__|__|

NYS Charities Registration Number (if not for profit): _____

Federal Employer Identification Number: _____

Address (Must be identical to address on Operating Certificate): _____

_____ _____

Contact Person: _____ Title:_____

Phone:_____ Fax:_____ E-mail: _____

Name of Project Director: _____
****

Institutional Endorsement: This application has the full support and endorsement of the applicant's Administrator of Record, Director of Nursing Services/Director of Nursing, and Dietician.

AOR: _____
(Print Name)

Signature: _____ Date: _____

****

DNS/DON: _____
(Print Name)

Signature: _____ Date: _____

****

Dietician: _____
(Print Name)

Signature: _____ Date: _____

ATTACHMENT TWO
TABLE OF CONTENTS

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Budget……

Budget Narrative……..

ATTACHMENT THREE
APPLICANT SURVEY

The information that applicants provide in this survey will ***not*** be used to score applications and will have ***no*** impact on whether the application is selected to be funded.

A. Self-Assessment of Key Processes Related to Pressure Ulcer Prevention & Healing

Please complete a separate Part A survey for each chronic care unit in your nursing home. The Unit Manager or Unit Charge Nurse should complete the survey.

UNIT:_____ NAME OF PERSON COMPLETING PART A: _____

1. How would you rate your unit on each of the following processes related to Pressure Ulcer Risk?

	Needs improvement	Fair	Adequate	Good	Excellent	Not Applicable
a. Comprehensive skin assessment on admission for all residents						
a. Skin assessment x 4 Consecutive weeks following admission for all residents						
b. Skin assessments Monthly and quarterly for all residents						
c. Identify residents at pressure ulcer risk and provide prompt intervention						
d. Daily skin assessment for residents at high risk						

2. How would you rate your unit on each of the following processes related to Nutritional Risk?

	Needs improve-ment	Fair	Adequate	Good	Excellent	Not Applicable
a. Weekly assessment for nutritional risk for all residents						
b. Dietary consult within 7 days of high risk determination						
c. Weekly weights for residents at high risk						
d. Plan to ensure adequate hydration						
e. Compliance monitoring of nutritional risk protocols						
f. Identification of residents at nutrition risk and provide prompt intervention						

3. How would you rate your unit on each of the following processes related to Repositioning?

	Needs improvement	Fair	Adequate	Good	Excellent	Not Applicable
a. Repositioning every two hours						
B. Changing position—"off loading" hourly for those sitting or in bed/recliner with head at 30 degree angle						

4. How would you rate your unit on each of the following processes related to Incontinence?

	Needs improvement	Fair	Adequate	Good	Excellent	Not Applicable
Staff compliance with incontinence management protocol						
Compliance monitoring of incontinence management protocols						
Identification of incontinence risk for low risk residents						

5. How would you rate your unit on each of the following processes related to Wound Care?

	Needs improvement	Fair	Adequate	Good	Excellent	Not Applicable
Consistent nurse or team of nurses assess the resident's wound						
Clear accountability for prevention and management of pressure ulcers						
Weekly compliance monitoring of prevention & treatment of pressure ulcers						

6. How would you rate CNA involvement in the following care processes?

	Needs improvement	Fair	Adequate	Good	Excellent	Not Applicable
CNA involvement on interventions for residents at risk for pressure ulcer development						
CNA involvement on interventions for residents with significant decrease meal intake						
CNA involvement on interventions for residents with significant weight loss						
CNA involvement on interventions for residents with increase or change in urinary incontinence						

A. Overview of Your Facility's Current Information Technology (IT) Systems and Your Plans for Future IT Purchases

Please complete Part B only once for your entire nursing home.

The first column lists common documentation activities that lend themselves to IT. For any IT product that you have either purchased or are considering purchasing for the activity, please enter vendor or product name and contact information for the IT. Then please circle yes or no, as appropriate, to indicate whether you have already purchased the IT or are considering or planning to purchase it. If you do not use a computer to document any of the information and are not considering using a computer, please leave the spaces blank.

Software Purpose	**Vendor/Product Name**	**Vendor Contact Name and Phone Number**	**Have You Purchased This IT? (circle one)**	**Currently Considering Purchase? (circle one)**
Nursing note or assessment documentation			Yes / No	Yes / No
CNA daily documentation			Yes / No	Yes / No
Dietician note documentation			Yes / No	Yes / No
MDS data entry and submission			Yes / No	Yes / No
Billing			Yes / No	Yes / No
Physician order entry			Yes / No	Yes / No
Reporting and analysis using MDS data (e.g., EQUIP)			Yes / No	Yes / No
Other – i)			Yes / No	Yes / No
Other – ii)			Yes / No	Yes / No

ATTACHMENT FOUR
APPLICATION REVIEW CRITERIA

Name of nursing home as it appears on Operating Certificate:

_____

Number of long term or chronic stay beds: _____

Number of short stay or sub-acute beds: _____

Total number of beds on Operating Certificate:_____

NOTE: The number of short stay and long term beds should equal the number of beds on the nursing home's Operating Certificate.

Review Criterion	Response
1. Administrator: Number of months in current position in this facility. (0 or 3 points)	
2. DON/DNS: Number of years in current position in this facility: (0 or 3 points)	
3. Percent of all full time CNAs whose tenure in the nursing home as CNA is three years or more. (0 – 3 points) Calculation: # full time CNAs three years or more on August 1, 2007 = (a) ____ # CNA full time positions on August 1, 2007 = (b) ____ % full-time CNAs with tenure three years or more = (a) / (b) = _____	
4. How many hours per week is a Registered Dietician at the facility? (0 – 3 points)	
5. Do you have a dedicated position for staff educator who has no other role? (0 or 3 points)	|__| Yes If Yes, name_____ |__| No
6. How many hours per week are budgeted for staff educator, excluding hours for employee health and infection control. (0 – 3 points)	
7. Do you have CNA team leads? Note: CNA team lead is a dedicated position that serves as mentor and leader to CNA peers. This position may or may not have a team assignment. (0 or 3 points)	|__| Yes |__| No
8. Experience with QI. Please append the following to the application: (0 – 5 points) i) Written policies and procedures for QI Committee; provide the names of the staff who are members of the QI committee and for each one specify the role, discipline, and term on the committee; describe how QI committee members are selected and how long they serve; describe how QI projects are identified and selected; describe how often the Committee meets and who determines the agenda. ii) Describe a recent QI project and the changes in resident outcomes that occurred; describe how a successful QI project has resulted in changes to every day routine work; iii) Describe a recent QI project that was not successful and why it was not successful; What were the barriers and how did you address them? What did you learn to inform future QI efforts?	Attach documents to application.

Review Criterion	Response
10. Wound Management (0 – 6 points) i) Please select one of the following that best describes wound management at your facility: |___| One person does all the wound assessments, wound measurements, and wound treatment plans facility-wide. |___| For nursing units: there is one person who does all the unit's wound assessments, wound measurements, and wound treatment plans. |___| Nurses covering the unit are responsible for wound assessments, wound measurements, and wound treatment plan reviews that are due during their shift. Multiple nurses are involved. ii) Do you have a dedicated wound team at your facility? If no, skip iii and iv. |___| Yes |___| No iii) Who participates on the Wound Team? Check all that apply. |___| Dietary |___| Rehab team member(s): PT, OT |___| DON/DNS and/or Assistant DON/DNS |___| Unit manager and/or Primary RN iv) How often does the Wound Team conduct wound rounds? Select one. |___| Ad hoc |___| Weekly |___| Monthly	
1. Use of data. (0 – 3 points) Check all that apply: |___| EQUIP data used in reports for care planning. |___| Reports other than MDS or EQUIP, e.g., reports produced by vendors such as Optimus or Medicus, are used for care planning. Please describe:_____ |___| My InnerView reports (quality benchmarking or satisfaction reports) used in monthly QI meeting and action plans developed to improve. Please include example action plan based on My Innerview report.	

ATTACHMENT FIVE
ADMINISTRATOR'S ATTESTATION

I have thoroughly read the RFA and understand the requirements of the On-Time Quality Improvement for Long Term Care model. If my application is selected to be funded, I agree to implement the model as described in the RFA according to the timeframes provided in the RFA work plan. I agree to implement the model for all long stay or chronic care beds in my facility.

I attest to the accuracy and truthfulness of the responses to the application review criteria (Attachment Four of the RFA) for my facility.

_____
Print Name of Administrator of Record

_____
Signature of Administrator of Record Date

ATTACHMENT SIX
BUDGET

Year number or summary budget: |__| 1 |__| 2 |__| Total for both years

Category 1: Staff

- Grant related travel expenses only.
- See Category 6 for travel expenses related to sub-contracts.

Item	**Budgeted Amount**
_____	_____
_____	_____
_____	_____
_____	_____
Subtotal	_____

Category 2: Travel

- Grant related travel expenses only.
- See Category 6 for travel expenses related to sub-contracts.

Item	**Budgeted Amount**
_____	_____
_____	_____
_____	_____
_____	_____
Subtotal	_____

Category 3: Supplies

- Medical or non-medical supplies used as part of the grant project.
- See Category 6 for supply expenses related to sub-contracts.

Item	**Budgeted Amount**
_____	_____
_____	_____
_____	_____
_____	_____
Subtotal	_____

Category 4: Fixed and/or Moveable Capital Expense

- See Category 6 for equipment expenses related to sub-contracts.

Item	**Budgeted Amount**
_____	_____
_____	_____
_____	_____
_____	_____
Subtotal	_____

ATTACHMENT SIX, CONT'D.
BUDGET

Year number or summary budget: |__| 1 |__| 2 |__| Total for both years

Category 6: Contracts

- Includes contracts with hardware and software vendors
- List each individual and/or organization separately.

Individual or Organization	**Budgeted Amount**
_____	_____
_____	_____
_____	_____
Subtotal	_____

Total _____

ATTACHMENT 7

Sample On-Time Reports

NUTRITION REPORT

High Risk (Decreased Meal Intake AND Weight Loss)

Resident Name	Resident Id	Decreased Intake	Avg Meal Intake % wk 07/10/06	Avg Meal Intake % wk 07/17/06	Avg Meal Intake wk % 07/24/06	Avg Meal Intake % wk 07/31/06	Weight Change lbs	History Resolved Pressure Ulcer	Most Recent Ulcer Assess Date	# PUs
Sample Resident 1	0000000	07/31/2006	73	51	61	52	-2.3		-	-
Sample Resident 2	1111111	07/31/2006	0	7	33	36	-6.2		07/19/2006	1

Medium Risk (Decreased Meal Intake OR Weight Loss)

Resident Name	Resident Id	Decreased Intake	Avg Meal Intake % wk 07/10/06	Avg Meal Intake % wk 07/17/06	Avg Meal Intake wk % 07/24/06	Avg Meal Intake % wk 07/31/06	Weight Change lbs	History Resolved Pressure Ulcer	Most Recent Ulcer Assess Date	# PUs
	[redacted]	07/31/2006	32	34	40	42	-		-	-
	[redacted]	07/31/2006	76	76	-	71	-		-	-
	[redacted]	08/02/2006	49	36	44	54	-		-	-
	[redacted]	08/01/2006	74	78	-	64	-		-	-
	[redacted]	07/31/2006	56	23	43	43	-		-	-
	[redacted]	07/31/2006	41	23	28	47	-		-	-
	[redacted]	08/04/2006	73	71	71	62	-		-	-

Weight Summary

Resident Name	Resident Id	Weight 180 Days Prior	Weight 90 Days Prior	Weight For Week 07/10/06	Weight For Week 07/17/06	Weight For Week 07/24/06	Weight For Week 07/31/06	Weight Change lbs	Date 5-10% Wt Loss <=30 Days	Date >10% Wt Loss <=180 Days
	[redacted]	-	-	139	-	139	140	1	-	-
	[redacted]	-	-	-	-	-	-	-	-	-
	[redacted]	-	-	159	159	-	-	0	-	-
	[redacted]	-	-	-	-	-	-	-	-	-

PRIORITY REPORT

Name	Resident Id	Decreased Meal + weight loss	Weight loss >= 5% last 30 days	Incontinence Increase	Behaviors >= 3	Worsening Ulcer	New Ulcer	Open Area
Resident Name					3*			
Resident Name				X				X
Resident Name				X	4*			
Resident Name				X				
Resident Name				X	X			
Resident Name				X		X		
Resident Name								X
Resident Name				X		X	X	X

Residents with Red Areas

Name	Resident Id	Red Area
Resident Name	0001119	X
Resident Name	0038900	X
Resident Name	0082800	X
Resident Name	0001117	X
Resident Name	0047100	X

PRESSURE ULCER TRIGGER SUMMARY REPORT

Number of residents and the percentage of the unit within each trigger by week

Pressure Ulcer Triggers	Week 1	Week 2	Week 3	Week 4
	2006-07-10	2006-07-17	2006-07-24	2006-07-31
Wt Loss 5-10% in <= 30 Days	-	-	-	-
Wt Loss > 10% in <=180 Days	-	-	-	-
2 Meals <=50% in 1 Day	6 (18%)	8 (23%)	8 (23%)	8 (22%)
Weekly Meal Intake Average <50%	4 (12%)	7 (20%)	5 (14%)	4 (11%)
Daily Urine Incont	10 (30%)	16 (47%)	13 (38%)	15 (41%)
>3 Days Bowel Incont	13 (39%)	18 (52%)	12 (35%)	15 (41%)
Urinary Catheter	10 (30%)	16 (47%)	8 (23%)	12 (33%)
History of Resolved Ulcer	-	-	-	-
Current Pressure Ulcer	-	-	-	-

Pressure Ulcer Trigger Summary by Resident for Current Week

Name	Resident ID	Wt Loss 5-10% in <=30 Days	Wt Loss >10% in <=180 Days	2 Meals <=50% in 1 Day	Weekly Meal Intake Average <50%	Daily Urine Incont	>3 Days Bowel Incont	Catheter	Hx of Resolved Ulcer	Current Pressure Ulcer	# of Triggers Last Week	# of Triggers This Week
Resident						X	X	X			2	3
Resident				X			X	X			5	3
Resident						X	X	X			0	3
Resident						X	X	X			2	3
Resident				X			X	X			0	3
Resident				X	X			X			3	3
Resident						X	X				1	2
Resident				X				X			1	2
Resident							X	X			3	2

BEHAVIOR REPORT

Number of Residents with Behaviors by Shift: Unit Snapshot

Shift	Frequent Crying	Yell / Scream	Kicking / Hitting	Pinch / Scratch / Spit	Biting	Wander	Abusive Lang	Threat Behav	Resist Care	Repit Verbal	Repit Movement	Sexually Inapprop
D	2 (6%)	4 (13%)	1 (3%)	0 (0%)	0 (0%)	4 (13%)	2 (6%)	2 (6%)	2 (6%)	4 (13%)	2 (6%)	0 (0%)
E	1 (3%)	4 (13%)	1 (3%)	0 (0%)	0 (0%)	4 (13%)	2 (6%)	1 (3%)	5 (17%)	5 (17%)	1 (3%)	0 (0%)
N	3 (10%)	3 (10%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (3%)	0 (0%)	3 (10%)	3 (10%)	2 (6%)	0 (0%)
ALL	5 (17%)	5 (17%)	1 (3%)	0 (0%)	0 (0%)	5 (17%)	2 (6%)	2 (6%)	6 (20%)	5 (17%)	3 (10%)	0 (0%)

Behaviors by Resident

Name	Resident Id	Shift	Frequent Crying	Yell / Scream	Kicking / Hitting	Pinch / Scratch / Spit	Biting	Wander	Abusive Lang	Threat Behav	Resist Care	Repit Verbal	Repit Movement	Sexually Inapprop	Total # of Behaviors
Resident 1		D	0	0	0	0	0	0	0	0	0	1	1	0	2
		E	0	0	0	0	0	0	0	0	0	3	3	0	6
		N	0	0	0	0	0	0	0	0	0	0	0	0	0
Resident 2		D	0	1	0	0	0	0	0	0	1	1	0	0	3
		E	1	0	0	0	0	0	0	0	3	3	0	0	7
		N	3	1	0	0	0	0	0	0	3	1	1	0	9
Resident 3		D	0	6	0	0	0	0	5	0	0	0	0	0	11
		E	0	5	0	0	0	0	4	0	0	0	0	0	9
		N	0	7	0	0	0	0	6	0	0	0	0	0	13
Resident 4		D	0	1	1	0	0	2	0	1	1	1	0	0	7
		E	0	1	1	0	0	4	0	2	1	2	0	0	11
		N	0	0	0	0	0	0	0	0	0	0	0	0	0

ATTACHMENT 8

On-Time Report Definitions

Nutrition Report

Decrease Meal Intake	The date of the first decrease in meal intake of 50% or greater for two meal in one day..
Average Meal Intake % Week	Displays average meal intake (breakfast, lunch, dinner) for the week; displays previous four weeks
Last Diet Consult Date	The date of the most recent dietary consultation
Weight Change Lbs	The change in weight (lbs) from the previous (most recent) weight to the current weight (Current Weight- Previous Weight).
Most Recent Ulcer Assess Date	Displays the date of last pressure ulcer report.
# PUs	Displays total number of pressure ulcers, as documented on Pressure Ulcer Tracking.

Weight Summary

Weight 180 Days Prior	The weight of the resident approximately 180 days prior to this week's current weight.
Weight 90 Days Prior	The weight of the resident approximately 90 days prior to this week's current weight.
Weight Change lbs	The change in weight from the previous weight to the current weight (Current Weight- Previous Weight).
Date 5-10% Wt Loss <=30 Days	Displays the date when a resident has a weight loss of 5-10% within 30 days.
Date >10% Wt Loss <=180 Days	Displays the date when a resident has a weight loss greater than 10% within 180 days.

Priority Report

Decreased Meal + Wt Loss:	Decreased meal intake AND wt loss (all high risk residents from Nutrition Report)
Weight Loss >= 5% or more weight loss in last 30 days:	Residents who have weight loss of >=5% in the last 30 days
Incontinence Increase:	Increase in # times incontinent by 3 or more shifts from previous week.
Behaviors >=3:	Display if three or more different behaviors for the current report. An asterisk displays next to the number If a resident has a change in behaviors by 2 or more from the previous report week.
Worsening Ulcer:	From PU Tracking sheet - outcome status of existing PU = worsened
New Ulcer:	From PU Tracking sheet - new ulcer
Open areas:	Collected from Skin Observation section of CNA form. An 'x' will display if 'open area' checked at least once during report week. This does not include 'skin tear' documentation.
Residents with Red Areas:	Residents with red areas display in alphabetical order at bottom of report. Red areas collected from Skin Observation section of CNA form. An 'X' will display if red area checked at least once during report week.

Trigger Summary Report

Pressure Ulcer Triggers	
Wt Loss 5-10% in <= 30 Days	Resident has a weight loss of 5-10% within 30 days.
Wt Loss > 10% in <=180 Days	Resident has a weight loss greater than 10% within 180 days.
2 Meals <=50% in 1 Day	Resident has taken < 50% of two meals in one day
Weekly Meal Intake Average <50%	Meal intake for resident averaged < 50% for the week
Daily Urine Incont	Residents has been incontinent of urine at least once / shift during the report week
>3 Days Bowel Incont	Residents has been incontinent of bowels more than 3 days during the report week
Catheter	Resident has a urinary catheter
History of Resolved Ulcer	Resident has documented history of resolved pressure ulcer, capture from PU Tracking sheet
Current Pressure Ulcer	Resident has a documented pressure ulcer during the report week

Behavior Report

The behavior report consists of two views:

1) Number of residents with behaviors by shift: displays behaviors and total # number of residents and % residents by nursing unit exhibiting behaviors for each shift.

Shift	Frequent Crying	Yell/ Scream	Kicking/ Hitting	Pinch/ Scratch/ Spit	Biting	Wander	Abusive Lang	Threat Behav	Resist Care	Repit Verbal	Repit Movement	Sexually Inapprop
D	2 (5%)	2 (5%)	0 (0%)	1 (2%)	0 (0%)	1 (2%)	5 (14%)	0 (0%)	3 (8%)	1 (2%)	0 (0%)	0 (0%)
E	2 (5%)	2 (5%)	0 (0%)	1 (2%)	0 (0%)	0 (0%)	5 (14%)	1 (2%)	2 (5%)	1 (2%)	0 (0%)	0 (0%)
N	0 (0%)	1 (2%)	1 (2%)	1 (2%)	0 (0%)	1 (2%)	2 (5%)	0 (0%)	3 (8%)	0 (0%)	0 (0%)	0 (0%)
ALL	3 (8%)	2 (5%)	1 (2%)	1 (2%)	0 (0%)	1 (2%)	5 (14%)	1 (2%)	4 (11%)	1 (2%)	0 (0%)	0 (0%)

2) Resident behaviors by shift: displays list of residents exhibiting one or more behavior; displays # times that behavior exhibited on each shift.

- Frequent crying
- Repetitive verbalization
- Repetitive movement
- Yelling/screaming
- Kicking/hitting
- Pinching/ scratching/ spitting
- Biting
- Wandering
- Abusive language
- Sexually inappropriate
- Threatening behavior
- Resistant to care

COMPLETENESS REPORT

I. Documentation Completeness: All Shifts

Documentation Item	7/10/06	7/17/06	7/24/06	7/31/06
Meal Intake	90.2	84.9	83.7	88.3
Bowels	65.8	61.9	63.3	72.7
Bladder	60.1	63.1	60.4	70.3
Behaviors	72.0	74.8	76.5	81.7

II. Summary for Week of 7/31

Total Residents	30
# residents missing >=75% nutritional intake data	0
# residents missing >=75% of bowel data	0
# residents missing >=75% of bladder data	0
# residents missing >=75% of behavior data	0

III. Documentation Completeness: Night Shift

Documentation Item	7/10/06	7/17/06	7/24/06	7/31/06
Bowels	39.7	41.6	45.2	62.9
Bladder	40.6	58.0	46.5	68.1
Behaviors	46.0	69.0	65.0	77.6

IV. Documentation Completeness: Day Shift

Documentation Item	7/10/06	7/17/06	7/24/06	7/31/06
Breakfast	88.8	84.1	82.0	85.2
Lunch	92.0	86.9	82.9	85.2
Bowels	87.5	76.3	73.3	75.7
Bladder	68.3	62.9	61.3	67.1
Behaviors	87.9	83.3	82.9	81.0

V. Documentation Completeness: Evening Shift

Documentation Item	7/10/06	7/17/06	7/24/06	7/31/06
Dinner	89.7	83.7	86.2	94.3
Bowels	70.1	67.8	71.4	79.5
Bladder	71.4	68.6	73.3	75.7
Behaviors	82.1	72.2	81.6	86.7