Request for Applications
NY State Dementia Grant Program
RFA Number 0607211050
Questions and Answers

NOTE: There are four corrections to the RFA:

a. The due date for applications has been changed from December 29, 2006 to January 26, 2007 in order to provide nursing homes with an additional four weeks to prepare their applications.

b. Each funded project is required to participate in and present a paper or workshop at the Department's biennial statewide dementia conference. This is not optional.

c. Residents eligible to be sampled can be identified with a cognitive impairment screen. A medical work-up documented in the resident's medical record is not required. See questions 19 and 20.

d. The maximum indirect rate that can be charged to project budgets for non-Medicaid providers is 15%. See question 10.

WHO IS ELIGIBLE TO APPLY?

Q 1: My nursing home currently has a dementia grant from the DOH. Are we eligible to apply under this RFA?

ANSWER: Yes.

Q 2: My corporate organization has more than one nursing home. How many can apply for a grant?

ANSWER: No nursing home can be the applicant on more than one application. If the same nursing home is the applicant on more than one application, all of its applications will be rejected without review. Some corporate organizations have more than one nursing home. If there are different operating certificate numbers for those nursing homes (not PFIs), each nursing home with its own unique operating certificate number can submit an application as an applicant.

Q 3: We have six facilities under our umbrella. I don't know if they have different operating certificates. If they do, then each facility would be eligible as a lead facility?

ANSWER: Yes.

Q 4: What would be the benefit if more than one of our six nursing homes submitted an application? That is, if we submitted two to six applications.

ANSWER: We don't know. You need to decide this. But be careful. If your corporate structure is going to be supplying support to every project, you have to make sure it is not going to be overburdened. You also have to make clear to reviewers that you're not biting off more than you can chew, i.e., that your corporate structure can actually provide the support that is needed for more than one project.

Q 5: If a facility is part of a corporation and also affiliated with a medical center, and a medical center is the writer of the proposal for the facility, can the facility apply under the auspices of the medical center?

ANSWER: No. The nursing home must be the applicant regardless of who writes the application. On the face page, the words that have to go in the line for 'applicant' have to be the nursing home's name as it appears on its operating certificate. A copy of the nursing home's operating certificate should be appended to the application. The nursing home can subcontract to other organizations.

Q 6: Can one facility be both the lead nursing home for one grant application and a secondary nursing home for a second application?

ANSWER: Yes.

Q 7: Related to the Vendor Responsibility Questionnaire, if you answer yes to any of these questions, does that disqualify you? Particularly, I'm interested in the question that talks about citations from the Health Department.

ANSWER: Applicants are not disqualified for past deficiencies other than IJ or SQC. Nursing homes with an IJ or SQC in the past two years cannot be funded under this RFA. If when you apply you haven't received an IJ or SQC in the past two years, but you acquire one before we execute a contract with you, we will withdraw the award.

An IJ/SQC doesn't disqualify facilities from participating in your consortium, however. So don't avoid those folks. The lead nursing homes are the strong nursing homes. If you can include in your consortium some of the weaker nursing homes and help them learn how to operate more effectively, that's a bonus, especially if your intervention is in an area where they are really weak.

BUDGETS AND ALLOWABLE EXPENSES

Q 8: Please define fixed/movable expenses.

ANSWER: Use the definition that you use when you prepare your Residential Health Care Facility annual cost report. Ask your finance staff or accountants for this information.

Q 9: Are the consortium/indirect costs included in the annual $300,000 cap?

ANSWER: Yes.

Q 10: What is an acceptable indirect rate for the consortium partner? My organization has different indirect rates for different sponsors.

ANSWER: The maximum indirect rate for an organization that is not a Medicaid provider is 15%. This is the maximum rate that the NYS Department of Health will pay. Note that all applications must compete on cost. The financial criterion is worth 25 of 110 possible points. The lowest cost (in terms of cost per resident in the sample) application receives 25 points. Every other application receives a portion of 25 points based on the ratio of the cost of the lowest cost application to that of the application being scored. Thus it is in the applicant's best interest to minimize costs, including sub-contractors' indirect costs. See pages 19-20 of the RFA.

Q 11: Our organization has a number of entities under one administration. Part of our CFO and CEO's time is part of that Medicaid rate. And part of their time must go to other facilities they oversee. If you want to include that as part of the indirect rate, part of the administration of the overall project, that is going in not as staff time but as indirect.

ANSWER: If you are a Medicaid provider, do not include in your budget a line item for indirect expense. We will subtract it from your approved budget. Instead, break it down. Tell us exactly what those expenses are that you normally lump together as indirect. Structure it and explain it so that it's clear that these amounts are expenses that you would not incur absent the project. If these expenses appear to be expenses that you would incur even absent the project, they will be deleted from your approved budget.

All projects are subject to on-site budget reviews after the project ends. Nursing homes will have to document that facility and corporate staff time charged to the budget was for activity that was directly related to the project, would not have occurred absent the project, required them to work above and beyond their normal work week, and resulted in increased compensation. If such documentation is missing or inadequate, the funds will be recouped via a Medicaid rate-adjustment.

Non-Medicaid providers do not have to do this. But they do have to carefully review how much indirect they include in their budgets. Research and academic institutions often have federally-approved indirect rates. They may have different indirect rates for different sponsors. You are not required to pay these indirect rates. You can negotiate on this. But don't negotiate yourself out of a project. Writing a good application with a rigorous evaluation design can cost tens of thousands of dollars. Your research team will contribute a substantial amount of time to write your application. You really need to cover their costs if you get the grant. So negotiate but at the same time recognize that you have to cover their costs if they are going to write your application and conduct the evaluation.

Q 12: Did you just say that we could include in the budget the cost of writing the proposal?

Answer: No. Costs incurred prior to contract start dates are not reimbursable and cannot be included in budgets.

Q 13: Just to be clear about the budget, my understanding is that one can budget, for example, $200,000 for year one, $400,000 for year two, and $300,000 for year three, as the annual average is $300,000. Is this correct?

ANSWER: Yes. These are three-year contracts. They are capped at an average of $300,000 per year, or $900,000 for the three--year term of the project. It doesn't make any difference how many nursing homes are in the consortium.

This cap applies to every single cost incurred – the costs to administer the consortium, indirect, IRB reviews, etc. Once your budget has been approved, it cannot be increased. Projects must be completed within the approved budget.

Q 14: Regarding the budget, do you have a benchmark for how much you anticipate seeing the quality evaluation cost?

ANSWER: No.

Q 15: Would something like 10% or under be too low?

ANSWER: The standard for evaluation in the RFA is very high. The costs of the evaluation will be determined by the evaluation design and may be quite high.

Q 16: On the budget, on the 25 points, you said the lowest budget will get 25 points. Is it the lowest budget among applications that score at least 53 points?

ANSWER: Yes. The RFA explains that first all applications will be scored on technical criteria, worth 75 points. Applications that do not score at least 53 points will be eliminated without further review. Poor quality applications cannot be funded.

We've embarked on a new path starting with the last procurement. We need to see results in terms of measurable improvements in the quality of care and quality of life for residents. Reducing pressure sores, reducing falls with injury, increasing social engagement, reducing depression, reducing or treating at a higher rate the incidence of mental illness, all of these things justify this grant program.

Q 17: Do cost effective outcomes score higher than quality of life outcomes that don't have a cost effectiveness associated with them? I have an outcome measure, but it may cost a little more.

ANSWER: There are no scoring criteria that favor one over the other. However, the RFA requires that a CEA analysis be performed for your measurable resident outcomes regardless of what they are. Applications will be scored on the methodology proposed to be used.

Q 18: If you show that it's a little bit more expensive to have a better quality of life, is that held against you?

ANSWER: No. This is not a scoring criterion.

Q 19: With many grants, salary on the budget is what your salary is. You don't get a higher salary because you're going to get the grant. You mentioned that some are going to put in 10% of time that is over and above what they're normally putting in. So if a person is getting $100,000 a year, and they're putting in 10% extra time for this project, does that mean that somehow their salary is going to be $110,000?

ANSWER: We don't know. The applicant determines compensation levels for project staff and whether grant funds are used for staff compensation.

If project staff compensation is covered in the applicant's Medicaid rate, there are special considerations. Let's use the Director of Nursing Services (DNS) as an example. She is already working full time in a nursing home. One hundred percent of her salary, $100,000, is in the nursing home's Medicaid rate. If the nursing home wants her to spend a portion of her time on the project, and also wants to charge the costs associated with that time to the project, then either she works overtime and her overtime is charged to the project, or the nursing home hires a part-time DNS to cover for her when she is working on the project.

In this example, the application would state that the DNS earns $100,000 for a full 40-hour work week, she is going to spend four hours per week on the project, she will work her normal 40 hours plus four additional hours, compensation for the additional four hours will be charged to the budget, and her new salary will be $100,000 plus the additional compensation for the four hours. Page 14 of the RFA provides more information on this. For instance, if you are training your CNAs and you have to take them off the floor to train them, you can hire substitute CNAs and charge the cost to the project.

On-site budget reviews will be conducted after the grants end. The reviews will include these expenses. So you can do it, but you have to do it right. The RFA provides ways to pay staff for project-related work without using project funds to pay for expenses already reimbursed through your Medicaid rate.

Q 20: If a nurse is going to help identify residents for the study, that's not part of her normal duties. That's specifically for the study. Then she can actually get a higher salary because she participates.

ANSWER: This is the applicant's decision. See previous question and answer.

Q 21: A question on the financial criteria. Let's suppose, hypothetically, one project is doing a very small focused activity which research has shown to have a very good effect on engagement. Another facility is doing more of a culture system-wide change which also is shown to have a very good effect on resident outcomes. They have the same number of residents in their samples. One, by nature, is going to be far more expensive to execute than the other. How does the financial criterion catch that?

ANSWER: It doesn't. But in any case, it's not clear which project is more expensive.

Q 22: So there is a negative motivation to do a bigger project.

ANSWER: No. There is a negative motivation to do an expensive intervention with a small resident sample. There is also a negative motivation to do an expensive intervention, regardless of resident sample size, because it is less likely that other facilities can implement it.

SUB-CONTRACTORS

Q 23: Are there any restrictions on who I can sub-contract with?

ANSWER: No. Subcontractors can include other nursing homes, academic institutions and consultants. You will be responsible for developing subcontracts with your subcontractors, monitoring those sub-contracts and paying your sub-contractors. All grant funds are paid to the applicant who is awarded the grant. The applicant is responsible and accountable for all expenditures charged to the grant.

RESIDENT SAMPLE

Q 24: A number of residents with dementia that we work with have pre-existing psychiatric illness or have symptoms that mimic that of psychiatric patients; and/or TBI. If the resident sample we pick for the study has either of those two comorbidities, would that affect the possibility of being funded?

ANSWER: No. Projects that seek to improve quality of care and quality of life for nursing home residents with both dementia and mental illness and/or TBI are eligible to be funded.

Q 25: Regarding identification of dementia type, I have not worked in a nursing home for the past six years. Unless diagnostic criteria have changed since them, one is never certain during the life of a resident whether the dementia is of the Alzheimer's type or stroke-related. Are specific diagnoses as to the type of dementia currently required by law? Is it conventional to assign specific dementia diagnoses? Would a diagnosis "either Alzheimer's or stroke-related" be acceptable for these grants?

ANSWER: Determine what types of dementia are relevant for your project and specify them in your application. There are no types that are ineligible under this RFA.

Q 26: You mention that we have to indicate dementia type. I don't care what the dementia type is for my particular project. Is that okay?

ANSWER: It depends on what you want to do – your intervention, conceptual model, disease staging, research hypotheses, etc. If any dementia diagnosis is appropriate for your project, state this in your application and explain in detail why any dementia diagnosis is appropriate.

Q 27: From the RFA, under resident samples on page 10, what documentation in the medical record constitutes appropriate medical work-up?

ANSWER: Only residents that have or might have dementia can be in the resident sample. Other residents can participate in project, but for purposes of measuring outcomes, you are limited to residents in the sample. The RFA says that you have to specify the medical work-up – the diagnostic tests and procedures documented in the resident's record that you will use to determine whether this person has or likely has dementia. You can also use a cognitive impairment screen, because medical records in nursing homes don't always have this information. Review the current literature on cognitive screens and use one that doesn't have the biases of the Mini Mental Status Exam (MMSE). If you use only the MMSE, you will not score well on the evaluation criterion. There are several other cognitive screens. There may be publications that are going to be coming out either this month, or in the next few months, improving some of them. Choose one that reduces biases, (such as education and ethnicity), as much as possible, that has the good sensitivity and specificity, and that has cut scores that make sense for your particular project and population.

If your proposal is selected to be funded and we think you aren't using the most appropriate screen, we will discuss it with you. The RFA states that if your evaluation has weaknesses, and nevertheless your application is selected to be funded, the weaknesses must be addressed. You will be required to strengthen it in the areas where it needs strengthening, without increasing your budget. Develop your project and evaluation carefully with your research partners, and do it right the first time around. Evaluation is so important. We do not want to fund a project, especially at the level of $900,000, if we don't know that we're going to get good measurement and measurable results.

Even if we don't ask you to change your cognitive impairment screen – there are 13 months between when you submit your application and when we tell you whether you've been funded. Anything could happen during that period. A much better screen could be published. You might want to change. So come in with the best one, but be aware that a better one might come along. You might want to, or we might ask you to switch to a better one.

Q 28: What is required in the physician notes in order to have an accurate diagnosis of dementia (see page 10 of the RFA - resident samples). What is required under the 1st paragraph of page 11 -- which diagnostic tests, for which morbidities, clinical exams? What are the measurements for the disease stages?

ANSWER: You decide how you are going to identify residents that can be sampled. You decide eligibility criteria, and what medical record documentation, if any, is required. There are a number of ways to approach this. Choose the way that's best for your project and your residents.

As for disease staging, there are several approaches to this as well. It might depend on the cognitive impairment screen that you use. Determine a disease staging methodology based on your population, conceptual model, measures and cognitive impairment screen.

Q 29: What is a power analysis?

ANSWER: Power analyses help determine the minimum sample size needed to detect an effect of a given size.

Q 30: Can you recommend a good resource for determining power analyses?

ANSWER: No. It depends in part on assumptions and the parameter of interest. Your research partners will determine how to calculate power.

Q 31: Can ALP residents be counted in the resident sample if the focus is on the nursing home population?

ANSWER: Yes.

Q 32: I'm looking at two items. One is the financial criterion, which is the cost per head that's calculated, and the other is resident samples under the evaluation program of people who will be considered. Is that the same number, and should we be advising our consortium members to give us an estimate of the number of residents that we can call upon for what we want to do?

ANSWER: Yes, it is the same number. See Attachment 5 of the RFA – Budget Face Page. The RFA requires applicants to provide evidence that sufficient numbers of eligible subjects live in the participating facilities such that the sample size(s) can be attained. Applications must provide all the resident sample information listed in the RFA. First calculate required sample size based on power analyses. Then ascertain with certainty whether the facilities in your consortium can generate that number. If they can't, recruit additional facilities.

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CONSORTIA

Q 33: A project receives extra points for including more facilities. You mention adult care facilities. If we include five or more nursing homes, but no adult care facilities, are we eligible for the five points?

ANSWER: Yes.

Q 34: Is there a downside to including ACFs in the consortium?

ANSWER: No. However, carefully consider the makeup of your consortium. If there are non-nursing homes in your consortium, e.g., adult care facilities, home care agencies or assisted living programs, make sure that your project focuses on what nursing homes residents need. Don't use this money to focus on a need that is significant for non-nursing home populations but only modestly relevant to nursing home residents. That is not responsive to the RFA. Your application will be rejected without review. You can include these other populations, but make sure that the project focuses on what nursing home residents need.

Adult care facilities (ACFs) and licensed assisted living programs (ALPs) count toward the consortium points. Other kinds of providers do not.

Q 35: I am trying to identify nursing homes with whom I could have a consortium agreement. Do you think I could get some help with this at next week's meeting?

ANSWER: The Department cannot suggest nursing homes. You might consider contacting a nursing home association for assistance.

Q 36: You said that you get up to five points for a consortium of facilities. We may involve a hospice or home care agency that benefits the intervention itself. Is it more important to have the five nursing homes, versus doing the best intervention and looking at four nursing homes and a hospice or home care agency?

ANSWER: Follow the rules in the RFA. If you need a hospice but are concerned with losing consortia points, recruit five nursing homes and a hospice or home care agency.

Q 37: Please define adult care facility

ANSWER: Adult care facilities are a step below nursing homes. Originally the Department of Social Services had responsibility for licensing and surveying them. When DSS was disbanded in 1998, DOH acquired responsibility for them. There are three different kinds all of which offer residential care and services, e.g., meals, housekeeping, laundry, personal care, activities, and case management. The population in them is getting frailer and frailer. Increasingly the population in ACFs resembles lower levels of care in nursing homes.

Q 38: Are there different licenses?

ANSWER: Yes.

Q 39: And you said there are three types?

ANSWER: Yes: adult homes, enriched housing programs and residences for adults. Residences for adults were originally created to take care of adults with severe and persistent mental illnesses. Enriched housing programs are very much like apartments with services, designed for a more independent level of functioning. People live in units resembling apartments, they have their own bathrooms and kitchenettes

or kitchens. They get one congregate meal a day provided by the enriched housing program provider, and the provider is responsible for making sure there is enough food in residents' refrigerators for the other two meals. The provider is responsible for assistance with medication administration and case management. Adult homes are for the most impaired. They offer three meals a day, activities, case management and personal care.

Q 40: NORCs don't make it into any of those categories?

ANSWER: No.

Q 41: Assisted living can be involved in this?

ANSWER: Yes, licensed assisted living programs (ALPs) can participate by virtue of their underlying licensure as adult care facilities. However, entities that hold themselves out as assisted living but are not licensed adult care facilities cannot be counted for purposes of determining preference points. Make sure that the assisted living providers in your consortium are licensed as adult care facilities. Obtain the operating certificate name of the ACF that has the ALP. Go to this URL: http://www.health.state.ny.us/facilities/adult_care/. Do not click on Assisted Living. Rather, scroll down to the map of NY at the bottom of this page. Click on the county in which the ACF is located. Scroll down the list of ACFs in the county until you find the one you are looking for. If you find it, the ACF will count towards preference points regardless of whether it has an ALP. If it does have an ALP, the number of ALP beds will be listed. If the number is "0", the ACF does not have an ALP.

Q 42: But the benefit has to clearly focus on nursing home residents?

ANSWER: Yes. As the underlying licensure for all assisted living programs is either adult home or enriched housing program, ALPs can participate in the consortium and can count toward the consortium points. Just make sure that you make the case that your intervention is designed around the needs of the nursing home residents.

MEASURABLE RESIDENT OUTCOMES

Q 43: Although bullet three on page three states that objectives may address the work environment for staff, all the evaluation focus is on resident outcomes. Is a project intended to improve retention of direct care staff for residents with dementia eligible for this RFA?

ANSWER: No. However, if you can show that there is a direct relationship between retention rates of direct care staff and measurable resident outcomes, the answer is yes.

Q 44: Since we are assessing residents with dementia, satisfaction with care may require a proxy measurement. May outcome measures focus on family and staff outcomes rather than resident outcomes?

ANSWER: No. Projects that focus on other than measurable resident outcomes are not responsive to the RFA and not eligible to be funded. If you can't measure it in residents, how do you know there is any room for improvement? Determine a measurable resident outcome(s). Once that has been identified, if you think there will likely be staff, work environment or family outcomes, measure those too.

Q 45: Are the following resident outcomes acceptable: decrease in the number of residents transferred to a hospital to die; increase in number of advance directives; increase in engagement in activity programs; decrease in staff-family disputes.

ANSWER: A decrease in transfers of residents to hospitals to die, may or may not be. A decrease in such transfers isn't necessarily a marker of improvement in care and resident outcomes. Such decreases

could be produced in situations where staff does not recognize that hospitalization is appropriate for the dying resident, for example, to ensure comfort and pain control. What you need to measure is the impact on the resident. That's the primary variable(s) of interest. The process variable is of secondary interest.

An increase in the number of advanced directives is another process variable. What is the impact on the resident? If you can't measure the impact on the resident, go after something else. It's not that these process variables are not worthy outcomes to seek – they just are not the focus of this RFA.

Increased engagement in activity programs – yes, this is an appropriate resident outcome for this RFA, but you should also measure impact of increased engagement on the resident. For example, what is the impact of increased engagement and social interaction on affect, behaviors, ADLs, medications, etc.

A decrease in staff-family disputes is not a resident outcome. However, if you can build a good case that a measurable resident outcome leads to a decrease in staff-family disputes, then add incidence of staff-family disputes to your conceptual model.

Q 46: When considering measurable resident outcomes, should we focus on one particular outcome or can we include what we anticipate several positive outcomes might be? Or multiple measurable goals?

ANSWER: At least one measurable resident outcome is required. Your project can have more than one measurable resident outcome.

WHAT IS AN EVIDENCE-BASED BEST PRACTICE?

Q 47: This question is in regard to the level of documentation sufficient to provide an evidence base for a newly developed best practice. In our experience, one with an AHRQ-funded project and one performing a review of nursing best practices, criteria for evidence-based include level of evidence based on the type of study design, the extent of the effect, the type of validity examined, and the number of related publications and presentations. Given the short nature of the program, would it be acceptable to prepare an article describing evidence of effectiveness, that has not been accepted or published? Will a presentation of findings provide evidence in support of effectiveness?

ANSWER: Yes.

Q 48: Can you provide a definition for "evidence-based."

ANSWER: No. In your application, provide the research data that demonstrates that the practice works, i.e., that it actually achieves the outcomes for residents that you say that it does. If there's no research data, you probably don't have an evidence-based intervention, and you should come in under objective two.

Q 49: Regarding objectives one and two, my understanding is that objective one means there's valid literature review already on what we're doing, and objective two is something we decided to implement but there's no literature out there – it's brand new?

ANSWER: Yes. If you want to work with an objective one intervention, include in your application the data that justifies the claim that your intervention will produce the measurable resident outcomes. If you don't have that data, then you are probably thinking of an objective two project. However, a literature review is required under both objectives, as is a conceptual model that shows the relationships between input and output variables. Cite and discuss the research that justifies those relationships. You have to build a case for why the proposed intervention produces the hypothesized resident outcomes under either objective.

Q 50: In regard to the two objectives, what if there was an intervention that was a refinement of a practice currently being used. Would that count as a new evidence-based practice, even though there is existing work in that area?

ANSWER: It could be either an existing or a potential (new) evidence-based best practice. Your application will not lose points if it addresses one objective but reviewers think it should have addressed the other objective.

Q 51: Does a model have to be an empirical study, or is data from our own facility sufficient under either objective to qualify as research-based?

Answer: We assume that by "research-based" you actually mean "evidence-based." For purposes of this RFA, an evidence-based best practice is one for which there are empirical data documenting its effects. The empirical data can be collected in your facility.

INSTITUTIONAL REVIEW BOARDS (IRBs)

Q 52: I have linked with a group of seven nursing homes. They do not have an IRB. Would it be enough if my institution's IRB approved the study?

ANSWER: Yes, but only if your institution's IRB is registered with OHRP.

Q 53: We have our own IRB but it is not registered. Can we use it?

ANSWER: No. You must use a registered IRB.

Q 54: Does the IRB have to approve the study before submission of application?

ANSWER: No. The IRB does not have to approve the study before you submit your application. State in your application whether you think you need IRB approval. We will review this information and make our own determination regarding whether your project requires IRB approval. If it does, you will need to get it. Projects that require IRB approval but do not get it, cannot be funded.

The Department of Health's IRB cannot be used. Your research partners are familiar with IRBs and will have one in mind. Alternatively, go to the OHRB website. Click on your geographical area and it will list all of the IRBs that are registered in your area. The website is listed in the RFA.

We require IRB approval from the IRB for the applicant. It might be the case that the IRB requires that all of your participating facilities also get IRB approval. That is between you and your IRB. However, if your IRB requires each of the facilities participating in the project to get its own IRB approval, you will be required to submit to us documentation that those approvals were obtained.

As you design your interventions, consider structuring them as a normal quality assurance project in your facilities, if it is appropriate to do so. It might be that you will not be subject to an IRB review or you will get an expedited review. It is difficult to predict how any particular IRB will respond to a particular project if and when it is brought to their attention. They do have the final "say".

If non-nursing home personnel will have access to protected health information (PHI) for nursing home residents, there are HIPAA issues that require IRB review. The IRB will be concerned with the confidentiality of the data.

Q 55: Will we need permission from residents or health care proxies to participate in the evaluation research?

ANSWER: It depends on your project. You may need IRB review and approval.

Q 56: How do we know if we have to go to the IRB?

ANSWER: Once you know what your intervention is, discuss it with your research partners and decide whether it potentially requires IRB review. If your project potentially requires IRB review and your institution and research partners do not have a registered IRB, follow the directions in the RFA to identify an IRB that will review your project. Ask them if they charge a fee. If they do, include it in your budget.

Q 57: If we find out after the budget is submitted that we need IRB approval, would there be an extra cost that we didn't anticipate? Do IRBs charge for review and approval?

ANSWER: Some IRBs have a fee structure for organizations that are not part of the IRBs organization.

Q 58: Is there a charge (if any) by the IRB to each nursing home in the consortium?

ANSWER: We do not know the answer to this question. It might depend on the IRB.

PROJECT STAFF QUALIFICATIONS

Q 59: Does the principal research team have to be experienced and skilled specifically in medical research?

ANSWER: The research team must have the training, education, skills and experience required to design and conduct a rigorous evaluation of your intervention, with consideration given to the characteristics of the populations involved and the settings in which they live. This does not necessarily mean that *medical* research skills and experience are required.

Q 60: Can the Principal Investigator be someone within the facility or must it be somebody with a research background?

ANSWER: The Principal Investigator (PI) should have the skills, education and experience to qualify as the PI for the evaluation of your project. The PI is responsible for the design and conduct of the evaluation. The people you assign to specific positions on your project should the skills, experience, and education required for that position. This is a scoring criterion. See page 19 of the RFA, criterion five.

SUSTAINABILITY

Q 61: What are the long term commitments for a nursing home after the grant ends? What is our financial obligation, if any to prolong this program?

ANSWER: You are under no financial obligation to sustain it after the funding ends. However, pay attention to "sustain". It's a scoring criterion. We're going to look at the likelihood that you and the nursing homes participating in your project will be able to continue it after the funding ends. If it appears to us that it might end after the funding is gone, you are not going to score as many points on this criterion as you would if it's clear that you're committed to maintaining it after funding ends. It also means that we need to see how you're going to incorporate this best practice or intervention in your facility so that it becomes standard practice for your staff. One of the biggest problems we face is getting evidence-based best practices into healthcare settings such that they sustain those practices over time. Usually the researchers go in, the facility adopts the intervention, wonderful results accrue, the facility saves money because, for example, pressure sores go down. Then the researchers leave the facility and staff reverts to their former ways of doing things.

In your applications, we want to see how you're going to address this. How are you going to make sure that after funding ends, staff is still doing what you taught them to do during the project? That means you are probably going to have to introduce unit- or facility-wide change. You're going to have to get support from the top down, at every single level of your nursing homes. From perhaps the operator, board of directors, to the administrator, the DNS, housekeeping staff, charge nurses, CNAs. You're going to have to get them all to buy in and commit to doing this.

Q 62: You said we get extra points if we sustain the project after the grant is over.

ANSWER: No. See page 19 of the RFA, criterion 6. This scoring criterion addresses sustainability and is worth up to 10 points. Your application will be reviewed to ascertain the level of commitment to sustain the project after funding ends.

APPLICATION FORMAT

Q 63: The RFA states the project narrative should not exceed 25 pages. Is this single- or double-spaced?

ANSWER: It is single-spaced. You should use no smaller than font size 10.

Q 64: You said that the narrative is 25 pages, single-spaced. What about the work plan, project organization?

ANSWER: Use as many pages as you need for work plan and project organization.

OTHER QUESTIONS

Q 65: Please send me, as soon as possible, the project summaries for communication skills for direct care staff, pain assessment and management, and EDGE.

ANSWER: All available information on these projects can be downloaded from http://www.nehealth.com/Senior_Services/Alzheimer's_Services/NYS_Dementia_Grants/2003-2005_Dementia_Grant_Projects/.

Q 66: My question is about satisfying the optional deliverables in section three. Can training manuals be distributed to all 700 nursing homes in a CD instead of hard copies? Can the 30 training manuals to the DOH also be in CD form rather than hard copy?

ANSWER: No. Page 8 of the RFA says that you have to reproduce and distribute these materials to every nursing home in the state. We'll give you the mailing list, but you are responsible for all the costs associated with mailing them out. You mail out hard copy. If there's a manual, you mail out the hard copy manual. If there are transparencies, video, you mail those out. In addition, when you are assembling all this material into a professional looking package, such that you would purchase if you go to a store, put all of the hard copy documents on CD in a format that nursing homes can download and modify to fit their own particular circumstances. What works for one nursing home might not work for other nursing homes. Other nursing homes need the ability to take the materials that work in your nursing home and modify them to fit their own particular circumstances.

It's expensive to produce these kinds of training and implementation materials. But the five preference points for high quality training materials offsets the additional costs.