



**Ohio Civil Money Penalty Reinvestment Program
Dementia/Alzheimer's "Rhythm of the Day®" Application**

Submitted to CMS August 16, 2019

1. Purpose and summary

Tobin & Associates, Inc. <https://tobinway.com/> is pleased to submit to the Ohio Department of Medicaid (ODM) this proposal to utilize funding from the Resident Protection Fund, made up of the state's share of the penalties (CMP) imposed on nursing facilities. This 36-month grant project proposes to offer selected Ohio nursing facilities a comprehensive holistic memory care program with center-focused interventions and proven outcomes hereafter known as Rhythm of the Day® (known nationally as Memory in Rhythm®). This project will focus on the development of a person-centered, 24-hour 7 day a week dementia/Alzheimer's care program directed to decrease behaviors and increase resident quality of life (CFR §483.15). The project will provide training and support for nursing facility personnel in communicating and dealing with residents with dementia, focused on "attaining or maintaining the highest practicable physical, mental and psychosocial well-being of each resident" (CFR §483.483.15(g)(1)), and providing educational/emotional support to families of residents in the program. Tobin & Associates will be submitting quarterly reports to ODM throughout the 36-month duration of the grant.

Rhythm of the Day® provides a parallel philosophy and practice within the ["Alzheimer's Associations Dementia Care Practice Recommendations"](#) and the ['National Partnership to Improve Dementia Care in Nursing Homes'](#).

As published by the [Alzheimer's Association](#), currently there are 5.7 million Americans living with Alzheimer's disease. By 2050 as many as 14 million Americans will have the disease. As the population ages, dementia prevalence increases. At age 65 one in ten (10%) of individuals will be affected, at 70 that number increases to one in five (20%), and by age 85 the number is a staggering one in two (50%).

Per the [CDC](#) over 50% of nursing facility residents in America have some form of dementia. Of that 50%, nursing facilities report 60% - 80% of that group having Alzheimer's. For clarification, Alzheimer's is a form of dementia, being the most prevalent in the general category of dementia.

The problem facing long term care is the numbers are ever increasing and the disease currently has few effective medical interventions. Current [dementia based medications](#) will only play a role in slowing down the timeline of disease progression in 80% of treated individuals; the remaining 20% will have no effect. Effective non-pharmacological interventions are less costly and can slow down disease process.

In recent years, nursing facilities have closed many Dementia/Alzheimer units due to the challenges of care needs presented by the resident with dementia. These challenges include wandering, agitation, aggression, sleeplessness, and various negative behavior changes. These behaviors are taxing on the staff requiring additional staffing patterns to manage the out of control behaviors. Historically, these secured units focused primarily on the physical needs of these residents. Centers added additional staffing, lacked effective behavior management, lacked effective resources, and had trouble in obtaining financial reimbursement, all of which resulted in centers closing Memory Care Units.



Rhythm of the Day© does not require additional staffing if a center has adequate staffing patterns. The program is based on efficiently implementing effective behavior interventions; thus, reducing the need for additional staffing, providing effective resources and offering ways to financially support the program.

Rhythm of the Day© engages residents in "living" rather than passive involvement in generalized nursing home activities. Both CMS and Ohio regulations direct a focus towards 'quality of life' standards for nursing facility residents. Implementing Rhythm of the Day© breathes actual "life" into that quality of life. The program has often given residents with Alzheimer's /dementia higher cognitive and physical function resulting in attaining or maintaining their highest practicable levels of functioning until the time the disease takes its final toll.

Until there is a cure for dementia/Alzheimer's, there is Rhythm of the Day©, which offers nursing facilities the expertise and tools to effectively deal with residents' dementia/Alzheimer's symptoms and needs.

Rhythm of the Day© program overview:

Rhythm of the Day©, a 24/7 comprehensive holistic memory care program, owned by miVision, LLC, with proven Interventions offers hope before the cure. The basic concept is to rhythmically guide the resident throughout the day systematically utilizing energy and calming techniques. Rhythm of the Day© takes residents through a day of living, utilizing natural bio rhythms, and their optimum mental and physical energies.

Rhythm of the Day© offers residents a quality of life not traditionally experienced in the general long-term care setting. Offering calmness and engagement throughout the day; results in enjoyment and contentment. Rhythm of the Day© utilizes resident's remaining cognitive abilities to focus on their highest practicable function without focusing on lost abilities. Rhythm of the Day© utilizes techniques of emotional memory to create a setting of peace and diffuse behaviors. Residents enhance their functionality and their psychosocial skills and simply live a better life. Rhythm of the Day© provides a 'rhythm' for staff, residents and families—simplifying and normalizing the day for everyone. Families report this program gives them their family member back.

Rhythm of the Day© has nationally published outcomes in De Witt-Hoblitt, I., Miller, M.N. and Camp, C.J. (2016) [Effects of Sustained, Coordinated Activities Programming in Long-Term Care: The Memory in Rhythm® Program](#). *Advances in Aging Research*, 5, 1-8. [\(Attachment 1\)](#).

As identified in the above-mentioned article, there are numerous predictable, measurable resident outcomes including reducing negative behaviors (i.e. agitation, wandering, sleeplessness, etc.), and decreased use of medications such as anti-psychotics, anti-anxiety medications and hypnotics. Additionally, reports show maintenance or improvement in assessment scores, reduced falls, decreased UTIs, and maintenance of functioning until the last few weeks of life. Nursing facility also experience reduced staff turnover and increased marketability.

For the purposes of this project, the outcome measurements monitored will be reduction of psychotropic medications (anti-psychotic, anti-anxiety and hypnotics), reduced UTI's, reduced falls, reduced employee turnover for memory care area and the maintenance or improvement of assessment cognitive scores



The basic philosophies utilized in Rhythm of the Day© are:

- Ebb and flow –flow of mental and physical energy
- Allowing residents their own reality
- Replaces sense of “bewilderment” and feelings of not knowing what to do next with comfortable pattern flows
- Focus on failure free activities
- 7 days a week—24/7
- Psycho-Social Approach
- Developing positive emotional memories
- Non-pharmacological approach
- Reduction of stimulation
- Alzheimer’s Time Travel
- People with Alzheimer’s/dementia can learn new things and activate brain cells
- Utilization of emotional memory
- Utilization of physical energy
- Involve residents’ families with education and support
- Dementia/Alzheimer’s is a terminal condition with associated family needs

Basic interventions used in Rhythm of the Day© are:

- Setting evaluation for optimum program effectiveness
- Staff education, staff evaluation and staff assisted problem solving
- Rhythm of the Day© (scheduled) ebb & flow program
- Based upon high & low mental & physical energy
- Montessori-Based Dementia Programming™
- Cognitive assessment tools*
- Artwork and sensory interventions
- Therapeutic olfactory, visual, auditory, taste and tactile balances
- Brain cell stimulating interventions
- Non-pharmacological interventions
- Restorative nursing
- Family member education and support

*Assessment tools are an important part of the program. The assessments will result in individualized, person centered care facilitating each residents’ highest practicable level of functioning. The assessment tool which will be utilized for the Rhythm of the Day© is Cameron Camp’s Montessori Assessment System. This assessment tool will be utilized as the primary method of evaluation for each participating resident. The assessment scoring system provides tools to develop person-centered interventions. Additionally, data will be collected and evaluated from individual resident MDS (Minimum Data Set) assessments.



Nursing Facility Solicitation for Participation

- Tobin & Associates will utilize web-based data bases for initial email contacts announcing the general availability of the program to all Ohio nursing facilities.
- Professional long-term care organizations will be contacted to assist in sharing the availability of the program to Nursing Facilities.
- Tobin & Associates will make personal contact with organizations to share the availability of the program to Ohio nursing facilities.
- Applications for participation will be available on the Tobin & Associates website for submission for consideration for participation in the program.
- Nursing facilities submitting applications will be contacted telephonically and then subsequently for an on-site visit by a trainer.
- Attached are facility intent letters in the geographic area to be served (appendix G).

Nursing Facility Requirements for Participation

- Participation is limited to 10 facilities annually, serving a maximum of 30 nursing facilities during the 3 year grant.
- Centers must have an interdisciplinary team of individuals willing to commit (as agreed in signed commitment letter) to the success of Rhythm of the Day® and its ongoing sustainability.
- Commitment (as agreed in signed commitment letter) to a full service 24/7 Rhythm of the Day program.
- Bear the expense of all staff wages for training which will all be completed on-site at nursing facility.
- Commitment (as agreed in signed commitment letter) to participate with proper preparation, customization, training, room/unit/area readiness and supply organization
- Participate in preparation and customization must include at minimum Administrator, Director of Nursing, Social Service Director and Activity Director.
- Commitment (as agreed in signed commitment letter) for ALL center staff to complete the one hour "Alzheimer's 101" training
- All management positions must complete a four-hour program training (provided at the center).
- All staff who are or will be assigned to the area of the program must complete a four-hour program training. (provided at the center).
- Commitment (as agreed in signed commitment letter) to assessment and collection of required information to evaluate facility performance.
- Facility participation will be limited to western Ohio. Geographic boundaries will be limited to Columbus and west, Toledo and south, Cincinnati and north.
- Report program data to Tobin & Associates Trainers/Consultants at a minimum of quarterly, utilizing Tobin & Associates data collection forms (which will be provided digitally to participating facilities) for the duration of the grant.



Nursing facilities will be chosen based upon their commitment to the future ongoing success and sustainability of Rhythm of the Day®. It is the intent of this project that the training and tools used in the project will become sustainable and entrenched in the participating nursing facility. Each participating facility represented by the Administrator, Director of Nursing, Social Service Director and Activity Director will be required to sign a contract/agreement (as agreed in signed commitment letter) that upon successful completion of training and assisted implementation with their facility's staff, the facility will adopt and implement Rhythm of the Day® as part of their general policy and permanent operations. In this way, the project is expected to directly impact a maximum of 30 nursing facilities across Ohio.

2. Expected Outcomes

This three-year project is expected to produce the following outcomes in approximately 30 Ohio nursing homes:

- 1) A 10% reduction in the aggregate score for MDS item N0410A (number of days the resident received antipsychotic medication during the last 7 days or since admission/entry or reentry if less than 7 days) for participating residents in participating nursing facilities, and statewide for all participating facilities.
- 2) A 15% reduction in the aggregate score for the following MDS items for participating residents in participating nursing facilities and statewide for all participating facilities:
 - a. MDS I2300 – Number of UTIs in the last 30 days
 - b. MDS J1800 - Any falls since admission/entry or prior assessment
 - c. MDS J1900 - Number of falls since admission/entry or prior assessment
- 3) A 10% reduction in the aggregate score for the following MDS items for participating residents in participating nursing facilities and statewide for all participating facilities:
 - a. MDS E0200A – Physical behavioral symptoms directed toward others
 - b. MDS E0200B – Verbal behavioral symptoms directed toward others
 - c. MDS 0200C – Other behavioral symptoms not directed toward others
- 4) A 10% reduction in memory care staff turnover in participating nursing facilities and statewide for all participating facilities.

3. Results Measurements

To establish baseline data for expected outcomes #1, #2, and #3 as specified in Section 2, Tobin & Associates will obtain quarterly MDS scores for participating residents from participating nursing facilities for the following MDS items for the first quarter preceding the start date of the project for which data is available, and will determine facility and statewide aggregate scores:

- MDS N0410A
- MDS I2300
- MDS J1800
- MDS J1900
- MDS E0200A
- MDS E0200B
- MDS 0200C



Throughout the duration of the project, quarterly scores for these MDS items will be obtained for participating residents, and aggregate scores will be compared to baseline data to determine if progress is being made toward achieving the expected outcomes specified in Section 2. The final aggregate quarterly MDS scores will be compared to baseline data to determine if the expected outcomes are achieved.

To establish baseline data for expected outcome #4 as specified in Section 2 above, Tobin & Associates will obtain quarterly memory care staffing data from participating nursing facilities for one year, and will determine facility and aggregate scores. Throughout the duration of the project, staffing data will be compared quarterly to baseline staffing data to determine if progress is being made toward achieving the expected outcomes specified in Section 2. The final aggregate staffing data will be compared to baseline data annually to determine if the expected outcomes are achieved.

4. Benefits to Nursing Home Residents

Rhythm of the Day© provides a structured day of meaningful interactions which utilize mental energies and physical energies as indicated, resulting in an improved quality of life for the resident with dementia. Nursing facility residents will benefit from decreased falls, decreased UTIs (Urinary Tract Infections), and decreased psychotropic drug use.

5. Non-Supplanting:

This project will in no way supplant the responsibilities of participating Nursing Facilities to meet existing Medicare/Medicaid regulations or other statutory and regulatory requirements. “Rhythm of the Day©” training for the Long-Term Care Industry is a specialized compliment/enhancement for care of residents with dementia needs.

6. Consumer and Other Stakeholder Involvement:

Rhythm of the Day© includes a specialized family program aimed to encourage their participation in training and support in understanding and successfully coping with their family member’s dementia. Staff education is based to enhance understanding of resident needs and develop improved resident interactions resulting in increased job satisfaction, and improved staff retention.

7. Funding

		Year 1 Months 1-12 10 Nursing Facilities	Year 2 Months 13-23 10 Nursing Facilities	Year 3 Months 24-36 10 Nursing Facilities	3 Year Total
Salaries					
Mary L Taylor, RN, LNHA, Esq. 25% of AY	Project Manager – Responsible for program - Lead Trainer & Consultant	\$30,000.00	\$30,000.00	\$30,000.00	\$90,000.00



	Rate per hour \$57.70				
Iva DeWitt-Hoblit LNHA,BA,MRE 40 hrs/week – 40% reduction of hourly rate	Primary Fulltime Dementia Trainer & Consultant Rate per hour \$36.06	\$75,000.00	\$75,000.00	\$75,000.00	\$225,000.00
Dementia Trainer	Secondary Fulltime Dementia Trainer & Consultant Rate per hour \$33.65	\$70,000.00	\$70,000.00	\$70,000.00	\$210,000.00
Administrative Assistant	Project Coordinator – data specialist – statistical analyst - 50% dedication (1040 hours annual) Rate per hour \$16.83	\$17,500.00	\$17,500.00	\$17,500.00	\$52,500.00
TOTAL SALARIES		\$192,500.00	\$192,500.00	\$192,500.00	\$577,500.00
Fringe Benefits					
Staff - 28% FY Salary/benefits/Cost of Employment		\$28,000.00	\$28,000.00	\$28,000.00	\$84,000.00
TOTAL FRINGE BENEFITS		\$28,000.00	\$28,000.00	\$28,000.00	\$84,000.00
Assessment Tool					
Montessori Assessment System (MAS)	Estimated at \$1200.00 per facility (10 Facilities)	\$12,000.00	\$12,000.00	\$12,000.00	\$36,000.00
TOTAL ASSESSMENT TOOL		\$12,000.00	\$12,000.00	\$12,000.00	\$36,000.00
License					
	Rhythm of the Day © Use License - \$1200 per facility (10 facilities)	\$12,000.00	\$12,000.00	\$12,000.00	\$36,000.00
TOTAL LICENSE		\$12,000.00	\$12,000.00	\$12,000.00	\$36,000.00
Supply Expenses					
Program Supplies for facility (see supply list)	Estimated @ \$1,000.00 per	\$10,000.00	\$10,000.00	\$10,000.00	\$30,000.00



	nursing facility (10 facilities)				
TOTAL SUPPLY EXPENSES		\$10,000.00	\$10,000.00	\$10,000.00	\$30,000.00
Facility & Administrative					
	Facility Overhead Cost such as Utilities, Rent and Internet	\$15,000.00	\$15,000.00	\$15,000.00	\$45,000.00
	Payroll Fees	\$8,850.00	\$8,850.00	\$8,850.00	\$26,550.00
TOTAL FACILITY & ADMINISTRATIVE		\$23,850.00	\$23,850.00	\$23,850.00	\$71,550.00
TOTAL FUNDING REQUESTED		\$278,350.00	\$278,350.00	\$278,350.00	\$835,050.00

8. Involved Organizations

Tobin & Associates, Inc. –
Corporate Headquarters - 8233 Howe Industrial Parkway, Canal Winchester, OH 43110

9. Contacts

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- Appendix A – Training Schedule
- Appendix B – DeWitt-Hoblitt/Miller/Camp Article
- Appendix C – Resume of Mary L. Taylor, RN, LNHA, Esq.
- Appendix D – Resume of Iva DeWitt-Hoblitt, LNHA, BA, MRE
- Appendix E – Supply List Overview
- Appendix F – Individual hours for program involvement
- Appendix G – Intent statements from facilities in service area



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Training Schedule

On site (at each participating Nursing facility)

Day 1. On Site meeting with management staff (at a minimum Administrator, Director of Nursing, Activities Director and Social Service Director)

- Explain Rhythm of the Day© program
- Discuss who is appropriate for the program and their policy for who will be included
- Receive from facility information about policies and procedures including meal times, medication schedule, staffing, space for program, tour of facility.

Day 2: Off site Preparation (Scheduled within 7 days of Day 1)

- Development of customized program.
- Developing the power point presentation.
- Develop the book used by the staff to implement the program on a daily basis
- Develop 'Quick Notes'

Day 3 On Site meeting with management staff (at a minimum Administrator, Director of Nursing, Activities Director) (Scheduled within 14 days of Day 1)

- Review the customized. Person centered program with center specifics with the management team
- Review area where program will be held
- Review tasks needed to prepare the area
- Discuss center personnel who will be implementing the program
- Identify program 'Champion'
- Identify program leader

Day 4: On-site training (scheduled within 7 days of Day 4)

- One Hour 'Dementia/Alzheimer's 101'
 - Multiple sessions to be presented to accommodate need
 - ALL interdisciplinary personnel (Housekeeping, Nursing, Therapies, Maintenance, Dietary, Management, Office personnel, and volunteers) attend
- Family Meeting/Education
 - Multiple sessions to be presented to accommodate need
 - All families of those who will be in program should be invited to the family presentation.

Day 5: Off-site preparation for training (scheduled within 7 days of Day 6)

- Finalization of full program
- Final production of book and 'Quick notes'

Day 6 and 7 On-site 4 Hour training (Scheduled within 7 days of Day 6)



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- Multiple sessions to be presented to accommodate need
- All management staff to attend
- All direct and related staff participating in the program to attend
- Supplies reviewed with staff
- Book provided with program details
- Quick Notes to be supplied to staff.

Day 8: On-Site facilitated program implementation (Scheduled within 7 days of Day 9)

Day 9: On-site Practice Day (Scheduled within 7 days of Day 10)

Day 10: On-site Visit (Scheduled within 30-40 days of Day 10)

- Assess success and problem solve 1 month after implementation.
- Schedule family meeting

Day 11: On-site Visit (Scheduled within 90-100 days of Day 10)

- Assess success and problem solve 3 months after implementation.
- Schedule family meeting

Day 12: On-site Visit (Scheduled within 120-180 days of Day 10)

- Assess success and problem solve 4-6 months after implementation.
- Schedule family meeting

Trainers/Consultants will be available for questions and problem solving via phone or video conference as requested by nursing facility.

Effects of Sustained, Coordinated Activities Programming in Long-Term Care: The Memory in Rhythm[®] Program

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Abstract

Beneficial effects of providing engaging activities to long-term care residents have been well documented. However, it is important to determine the effects of activities when providing throughout the day, especially as they related to outcomes salient to administrators. We describe the creation and pilot testing of a sustained, coordinated activities program, Memory in Rhythm[®] (MIR), which incorporated Montessori-Based Dementia Programming[™], in a skilled nursing facility (SNF). Effects of implementing MIR then were examined in memory care units in 16 aged care centers—9 SNFs and 7 assisted living residences in Ohio. For these centers, all data were collected over a period of one year before and one year after implementation of MIR. Results indicate that implementation of MIR was associated with reductions in medication use, increased census, decreased employee turnover, decreased wandering and agitation, and increased sleeping at night, eating and capacity for activities of daily living. In the SNFs, increases in RUGS case mix and use of Medicare Part B (rehabilitation services) were noted, while in assisted living implementation also was related to increased amount of time residents who were able to age in place. Implications of these findings are discussed.

Keywords

Dementia, Engagement, Medication Reduction, Agitation, Wandering, ADLs, Employee Turnover, Census, Long-Term Care, Assisted Living

1. Introduction

The effects of providing engaging activities to long-term care residents have been well documented. These in-
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clude increased positive engagement, decreased challenging behaviors, increased positive affect, decreased medication usage, etc. [1] [2]. In practice, however, provision of activities generally is sporadic, and often given a low priority. This is evidenced by routine interruptions of activities for provision of medications, rehabilitation, etc. In addition, a commonly heard complaint on long-term care units is “The residents are fine during an activity, but once it is over the problems come back.” The traditional “10 & 2” activities program, which provides a daily activity at 10 a.m. and 2 p.m., at best is passé and at worst woefully lacking. Such a simple schedule does not meet the engagement needs of most long-term care or senior living residents, much less those with significant memory loss.

This represents a view that activities provided to long-term care residents not only are a low priority, but also should be able to produce effects analogous to that of an antibiotic. Just as an antibiotic generally maintains its effects over a time frame of many hours once it enters the bloodstream, it is assumed that activities ought to maintain beneficial effects long after programming is concluded. This view ignores the role of the physical and social environments on the behavior of residents, and represents a highly mechanistic and inappropriate way of thinking regarding non-pharmacologic treatment modalities, which can be highly effective treatment regimens for persons with dementia and related disorders [1] [3]-[5].

Attempts to counter such attitudes have involved alternative approaches such as person-centered care [5]. These alternative approaches represent a different paradigm, with a different set of assumptions regarding residents and the relationship of residents to the physical and social environments of long-term care. As is often the case, attempts to change paradigms meet with resistance. Administrators of long-term care residences worry about potential unknowns involved with paradigmatic change, and are especially concerned with issues of costs associated with “novel” approaches to care delivery, making the assumption that new approaches will involve additional costs over and above current levels (It is our experience that residences with reasonable staffing patterns typically do not have to add new staffing to have excellent results, as we will discuss shortly.)

One way to help bridge this divide between paradigms, and make it easier for administrators and staff to accept change, is to view activities as a treatment. From this perspective, we may describe activities, like many drugs, as having dose-dependent effects. In addition, we might view activities in long-term care as having a short “half-life.” Fortunately, activities are much less prone to unintended negative effects and toxicity than many pharmaceuticals used in long-term care, especially when providing repeatedly over extended periods of time. Activities also can be more effective at reducing or alleviating problematic (*i.e.*, “responsive”) behaviors (e.g., repetitive behaviors; wandering; etc.) in residents than pharmaceutical treatments. In addition, we must view activities as living-everything that a resident does legitimately may be considered “activity” (e.g., activities of daily living), and thus the domain and responsibility of all persons who interact with residents is both direct and indirect [6] [7]. Viewed from this perspective, the challenge to administrators becomes one of creating procedures and infrastructure that will enable a treatment with a short half-life that is effective to be delivered frequently enough during the day to provide noticeable and sustained positive results. Now we will describe an approach to delivery of activities created within this context—the Memory in Rhythm® Program (MIR).

1.1. Creation of the MIR Program

MIR was developed by Iva De Witt-Hoblit, LNHA, MRE and Mary Neal Miller, BSN, RN. The basic program was created by De Witt-Hoblit in 1999, to assist residents in an all-Alzheimer’s skilled nursing residence of which she was administrator. Even in the infancy of the program, residents experienced reduced agitation and improved engagement in life activities. Later, Miller, who was director of nursing at the nursing residence administered by De Witt-Hoblit, added clinical and restorative nursing portions into the program. Therapeutically, this resulted in enhanced resident independence in activities of daily living, decreased urinary tract infection, and decreased weight loss. From a skilled nursing residence operations perspective,



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outcomes included enhanced RUGS case mix scores, reimbursements and revenues.

In this particular residence where De Witt-Hoblit and Miller collaborated, there was no designated dementia unit but there were many residents with memory loss issues, primarily dementia. These residents were “lost” in the crowd of other residents. They were agitated, acting out, awake at night, disturbing others, moving furniture and continually wandering. Obviously, there was a need to create interventions for these behaviors, but there also was a large gap in available services. However, Necessity is truly the mother of invention.

Given this great need in the residence, De Witt-Hoblit and Miller decided to implement an intervention program at this residence without a designated unit. Knowing this would take time to implement, they initially started a Sundowner’s Program that ran from 3 p.m.-7 p.m. The majority of the challenging behaviors of residents targeted for the program were exhibited in the afternoon, showing that this was the time residents needed the intervention most. Mimicking part of the future MIR, this program began with the high and low energy related interventions:

They were as follows:

- High energy activity such as those requiring expenditure of physical effort
- “Getting-ready-for-supper” activity
- Supper
- After supper, a light cognitive activity.

This Sundowner’s program involved eight residents with the greatest needs. The residents chosen had two or more of the following issues:

- Daily agitation
- Daily wandering
- Awake at night
- Significant memory loss/lost as what to do next
- Weight loss.

The criteria used for inclusion in the program were that residents needed to be:

- Ambulatory (walker, cane acceptable)
- Presenting with psychosocial needs that outweighed their physical needs
- Able to participate in programming 75% of the time.

One STNA (state-tested-nursing assistant) was used to implement the Sundowner’s Program. No additional staffing was added. There was not a need to add staffing, as once these residents were brought into a safe, calm and engaging environment, the rest of the staff care givers were freed up to provide care for other residents. Previously, most of the staff members were spending large amounts of their time trying to manage the behaviors of the memory loss residents, minimizing time for being with and caring for other residents.

Within a week, the agitation, wandering and sleeplessness seen in the Sundowner’s Program residents were greatly reduced. Other residents stated that they felt more comfortable to come out of their rooms. Visitors and families stated that the residence had an overall calmer ambience after the implementation of the Sundowners program. The program was run 7 days a week, until full implementation of MIR replaced the Sundowner’s Program with these residents, and including other residents with responsive/challenging behaviors.

In early 2002, the team implemented MIR into the residence. This was accomplished by setting up an “internal adult day program” within the residence. The team renovated an activity area which initially was two small rooms into a MIR program area. A wall dividing the rooms was removed and the area now included a small dining and living room area to seat 12 persons. In addition, the area included a kitchenette and a bathroom which were dedicated solely to this program.

The program ran from 10 a.m.-6 p.m. The residents came after breakfast and once their activities of daily living were complete. Seven days a week, these residents came to their “special” area, which many came to call “home.” Some thought this was their home, some that this was where they worked. They were allowed their own reality.

The following steps were critical to putting the program in place.

- Renovating the activity/program area;
- Educating families and community about the coming program;
- Comprehensive training of frontline staff in the program;
- Selection of a staff member “champion” to oversee program;
- Insisting that the champion would never be assigned to another program or position without the expressed consent of the executive director, and insisting that short staffing would never be a reason for “temporarily” reassigning the program champion.



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- Recruiting the most qualified internal caregivers to daily implement the program;
- Training all staff in the concepts of the program along with basic Alzheimer's/Dementia/Memory Loss information;
- Hands-on practice days with staff and residents;
- Rolling out the program in phases (First week—four residents; Third week—adding four more residents);
- Using the same criteria for resident selection as for the Sundowner's program.

From the beginning other interventions were utilized, including art, aroma, and pet therapy. The combination of our initial programming and these added interventions resulted in reduced agitation, reduced wandering, reduced medication usage and reduced weight loss.

1.2. Addition of Montessori-Based Dementia Programming™

In fall of 2002, in collaboration with Cameron Camp, PhD., the team added the Montessori-Based Dementia Programming™ (MBDP) component to MIR. MBDP involves activities based on the Montessori educational method, adapted for use with older adults with dementia. This approach uses techniques based on rehabilitation principles such as breaking down tasks into steps and working on one step at a time, extensive use of external aids to guide performance, emphasizing the use of abilities that are present rather than disabilities, creating materials and procedures to allow success while circumventing deficits, extensive use of materials that involve physical manipulation, and emphasizing the values of respect and dignity for all persons [1] [8] [9].

This addition enhanced the results of the already positive outcomes, as well as producing increased independence with activities of daily living, reduced medication usage, fall reduction and increased length of time a resident could remain in the program. Remarkable results included residents relearning to feed themselves, dress themselves and some regaining speech abilities. (See also [2])

1.3. “Reflections” Program

In 2003, the team implemented another MIR program (which was called “Reflections”) for residents who had higher physical needs, and who could only participate in the program 50% of the time. This group experienced an even higher outcome in enhanced ability to feed oneself and improved finger dexterity. The maximum number of residents in Reflections was 14, with one caregiver implementing the program. Activities of Daily Living (ADL) care was provided by other STNA's.

Overtime the MIR and Reflections residents were moved to live in the same section of the residence, although both internal adult day programs stayed in their same location. The team established a separate program area for the Reflections residents to experience their day. The Reflections residents took a much longer rest time in the afternoon.

The basic program of the MIR followed an ebb and flow energy pattern. The day was filled with high physical energy times, high mental energy times, low physical energy times and low mental energy times, alternating based on needs of most residents. Experience showed that most residents have the greatest success when there is at least one high physical energy activity and one high mental energy activity in the morning, a rest and relaxation after lunch, one high physical energy and one high mental energy activity in the afternoon, and a light cognitive stimulation time after supper. Examples of high physical energy activities used are dancing and balloon volleyball. Examples of low physical energy activities used are range of motion exercises and facial massages. Examples of high mental energy activities used are Montessori-based category sorting (e.g., items seen at a circus or not seen at a circus) and a Spelling Bee. Examples of low mental energy activities used are listening to soft music and watching a TV game show.

MBDP [1] [8] [9] fits nicely into MIR, creating successful restorative nursing opportunities and cognitive interventions. Montessori programming can be incorporated in all of the energy level activities, whether high or low. When utilized on a daily basis, Montessori program with MIR results in significant improvements in residents' activities of daily living, as we will demonstrate shortly.

Some very general principles of Memory in Rhythm® Program include the following:

- 1) First and foremost, consistency and regularity are of utmost importance—the program must be conducted seven days a week without fail.
- 2) Individuals with cognitive impairments should start the day at essentially the same time and the same way each day. This means choosing a rising time that is realistic 7 days a week. In addition, the initial morning routine should be very consistent (for example, breakfast time, taking their medications, oral care, bathing and or dressing). Best results include providing showers in the morning and evening, prior and after main programming.
- 3) Consistent hydration is very important and the morning routine should be followed by some sort of non-caffeinated



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beverage. Hydration should continue throughout the day every two hours during waking hours.

- 4) Following hydration the resident should be reminded to go to or be taken to the bathroom to promote urinary and bowel continence and reduce the risk of urinary tract infections.
- 5) Some time in both each morning and afternoon should include an activity that stimulates a mental and a physical activity.
- 6) Some period of the afternoon should contain a “quiet time”. This does not necessarily mean a nap (although it could). This time would be when voices are at a minimum and calmness and relaxation abounds. For the Reflections group, this time is longer and includes a nap.

2. Method

Implementation of MIR in Multiple Settings

MIR, a fully comprehensive program, began as a psychosocial program for nursing homes developing dementia units. We considered the initial implementation of MIR and “Reflections” as a pilot or “demonstration of concept” project. A key issue at this point was whether an MIR program could be implemented in other residences not administered by its creators, and if so, what results might be obtained. Since its inception, the program has expanded to meet the needs of other skilled nursing residences as well as assisted living residences.

What followed was the installation of MIR with MBDP within 9 additional skilled nursing residences and 7 assisted living residences in Ohio by the MIR creation team. For each of the 9 skilled nursing and 7 assisted living residences, the MIR team provided customized programming based on the residence’s individualized needs, size, population, geographic/cultural settings, challenges, staffing and goals. All residences had or added a separate area for a memory loss unit at the start of implementation of MIR.

3. Results

Table 1 and **Table 2** show the results of data obtained from these dementia care residences over the course of a

Table 1. Percent (%) reduction in use of medications wandering, agitation, and employee turnover before (1 year) and after (1 year) of MIR in memory units of Skilled Nursing Facilities (SNFs) and Assisted Living (AL) residences.

Center	Medication Type				Wandering	Agitation	Employee#Residents	
	Anti-Psyc	Anti-Anx	Anti-Dep	Hypnotics			Turnover	
SNF1	78	79	42	100	85	85	31	12
SNF2	75	76	40	100	85	85	31	14
SNF3	76	72	32	100	87	89	15	60
SNF4	78	73	41	100	79	86	10	12
SNF5	46	42	21	90	86	88	15	20
SNF6	56	51	32	89	75	76	15	12
SNF7	30	25	15	70	72	73	15	24
SNF8	50	48	35	95	88	90	20	10
SNF9	55	50	30	100	89	90	42	12
Average	60	57	32	94	83	85	22	
AL1	60	55	40	100	75	80	15	12
AL2	58	55	35	100	95	95	12	10
AL3	20	20	15	90	85	85	12	8
AL4	60	58	41	100	87	90	15	30
AL5	60	59	45	100	90	90	15	15
AL6	60	60	46	100	91	92	15	15



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AL7	42	65	60	100	87	90	15	15
Average	53	53	40	98	87	89	14	

Table 2. Percent (%) increase of residents showing in weight gain, residents who began sleeping at night, and census; eating (# of residents regaining ability to feed themselves), and ADLs (# of residents who regained/improved one ADL), before (1 year) and after (1 year) of MIR in memory units of Skilled Nursing Facilities (SNFs) and Assisted Living (AL) residences.

Center	Weight Gain	Sleeping	Census	Eating	ADLs	#Residents
SNF1	100	90	20	2	12	12
SNF2	100	90	20	3	7	14
SNF3	99	97	26	8	36	60
SNF4	95	95	29	2	8	12
SNF5	96	89	15	4	10	20
SNF6	81	82	15	2	2	12
SNF7	80	80	15	6	12	24
SNF8	95	92	25	1	5	10
SNF9	85	90	14	2	8	12
Average	92	89	20	3	11	
AL1	89	80	25	2	6	12
AL2	98	98	67	0	10	10
AL3	90	85	75	1	6	8
AL4	92	90	15	4	15	30
AL5	95	95	10	2	8	15
AL6	97	98	10	2	12	15
AL7	92	85	87	2	8	15
Average	93	90	41	2	9	

year after implementation of MIR in comparison with the same measures for the year previous to implementation of MIR. Much of the clinical data were collected from Skilled Nursing Facilities' (SNF) Directors of Nursing and Assisted Living (AL) Executive Directors. (Many of the ALs' Executive Directors were nurses.) Other data were collected by observation and staff interviews.

3.1. Reductions of Negative Indices

The results displayed in **Table 1** demonstrate the capacity of MIR to reduce problematic outcomes related to both residents' quality of life and to factors important to dementia care residences' administrators. Medication reductions such as anti-psychotics, anti-anxiety, anti-depressants and hypnotics shown in **Table 1** are based on an overall percentage reduction of each medication, based on monthly pharmacy tracking, before and after one year of programming. All showed reductions after implementation of MIR in all settings. This represents both a cost savings and a means of meeting demands from regulatory agencies for reducing medication usage.

Wandering and agitation reduction included tracking episodes per day by comparison before and after one year of programming. This was based on reporting from front-line staff. Finally, staff turnover was reduced in all facilities after implementation of MIR. Employee turnover was based on the percentage of turnover reduced before and after one year of programming. This makes sense from the point of view that reducing behaviors in residents such as agitation, wandering, and being awake at night would relate to reduced stress for staff members.



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3.2. Increases in Positive Indices

Table 2 illustrates improvement in a number of important areas related to dementia care. Weight gain increases were based on percentage of residents who experienced appropriate weight gain. Staff also looked at intake records of residents, verifying consistency with the reported weight gain.

Increased night sleeping was reported by night shift staff giving results. This was based on percentage of residents who began sleeping at night, rather than being up at night and sleeping during the day. Third shift staff members reported in several centers that they could tell if the program had been appropriately implemented during the day by how well the residents slept that night or not.

Census improvement represents increase based on percentage before and after one year of programming. Again, census increased in all SNFs and ALs, a finding that further validates MIR both as a means of increasing quality of life for residents as well as a viable business model for administrators.

Eating data increases represent the actual number of residents who regained the ability to feed themselves. This was observed by staff and in many SNF's tracked in restorative nursing documentation. ADL data increases represent the actual number of residents who regained/improved at least one ADL, e.g., mobility, toileting, self-care and/or finger dexterity. This was observed by staff and in many SNF's tracked in restorative nursing documentation.

3.3. Improvements in Indices Specific to SNFs

Case Mix data were collected reflecting the actual increased RUGs number for the SNF centers, before and after one year of programming. All nine SNFs showed an increase in their RUGs number, ranging from 0.22 to 0.53, with the average being 0.28. This increase positively affects overall Medicaid rate in SNFs, resulting in increased income. Long term resident case mix scores can be positively increased with restorative nursing programming, which easily is incorporated into MIR, as we have noted previously.

Data were collected for Medicare Part B rehabilitation utilization for long-term SNF residents. This represents compensation given to SNFs by the Medicare program independent of income from short-term stay residents who are to receive rehabilitation for a brief period. In the nine SNFs implementing MIR, the increased percentage of long-term stay SNF residents receiving Medicare Part B services ranged from 27% to 36%, with an average across all SNFs of 32%.

MIR implementation assists the staff in identifying the needs for therapy services. Within the MIR program, residents are able to be monitored consistently for their ADL abilities and changes, and observed changes can easily and appropriately become referral sources for therapy services. Related outcomes include increased ADL abilities and increased Part B revenue—a win-win for all, both management and the residents. As was the case with previous outcomes reported, improvements in RUGs case mix data and Medicare Part B utilization for long-term SNF residents represents changes from the previous year's outcomes compared to outcomes in the first year of MIR implementation.

3.4. Aging in Place within ALs

An important measure of the effect of implementing MIR for ALs is increasing "aging in place". This improvement number represents the average number of months per year that increased for residents to stay in the AL setting—thus "aging in place"—from before implementation of MIR to after implementation of MIR. Keeping residents within an AL enables more stability and less disruption in their lives for residents, as well as insuring a more constant source of income for ALs. Across the seven ALs, number of months of additional aging in place ranged from 2 months to 4 months, with an average of 3.2 months. This change also represents changes from the previous year's outcomes compared to outcomes in the first year of MIR implementation.

4. Conclusions

For overall ADL improvements, using a restorative nursing program within the daily MIR program had the best outcome. In many of the cases of improvement, the residents, particularly in the SNF's, were put on two restorative programs. Their programs were selected by the areas in which they needed the most improvement. Again, Montessori techniques proved to be an excellent non-pharmacological intervention in these restorative nursing programs particularly including self-care, eating and finger dexterity. When tracked as a restorative nursing program, the resident and facility both gain. The resident gains increased self-independence. SNF's have the ability, if tracked and documented appropriately; to increase their overall case mix score resulting in increased revenue.



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AL residents benefit as well from MIR combined with MBDP. For example, the resident's "aging in place" time frame (being able to live in the same location without having to move) improves. The AL residence also gains in marketability when "aging in place" data improve, another systemic motivator for maintaining the program.

MIR has been shown to have meaningful effects on measures relevant to administrators of long-term care residences and for residents as well. In so doing, MIR becomes a means of enhancing the importance of activities programming within these settings, while providing a method of enabling engaging activities to be delivered to residents throughout the day. Allowing residents to take part in a sustained program of engaging activities only will become a priority within long-term care when so doing aligns itself with systemic motivators, including income, effective marketing, and addressing stressors in the system such as responsive behaviors, especially those of importance to surveyors/inspectors (e.g. reduction of medication usage). Provision of MIR generates evidence of such an alignment, and as such may become an effective engine for culture change in long-term care environments.

"A social change of this type cannot come from the ideas or energies of individual reformers but from a slow and steady emergence of a new world in the midst of the old..."
—Maria Montessori

References

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- [2] Roberts, G., Morley, C., Walters, W., Malta, S. and Doyle, C. (2015) Caring for People with Dementia in Residential Aged Care: Successes with a Composite Person-Centered Care Model Featuring Montessori-Based Activities. *Geriatric Nursing*, **36**, 106-110. <http://dx.doi.org/10.1016/j.gerinurse.2014.11.003>
- [3] Camp, C.J., Skrajner, M.J., Lee, M.M. and Judge, K.S. (2010) Cognitive Assessment in Late Stage Dementia. In: Lichtenberg, P.A., Ed., *Handbook of Assessment in Clinical Gerontology*, 2nd Edition, John Wiley & Sons, New York, 523-547. <http://dx.doi.org/10.1016/b978-0-12-374961-1.10020-x>
- [4] Cohen-Mansfield, J. (2015) Behavioral and Psychological Symptoms of Dementia. In: Lichtenberg, P.A., Mast, B.T., et al., Eds., *APA Handbook of Clinical Geropsychology, Vol. 2: Assessment, Treatment, and Issues of Later Life, APA Handbooks in Psychology*, American Psychological Association, Washington DC, 271-317. <http://dx.doi.org/10.1037/14459-011>
- [5] Mast, B.T., Shouse, J. and Camp, C.J. (2015). Person-Centered Assessment and Intervention for People with Dementia. In: Lichtenberg, P.A., Mast, B.T., et al., Eds., *APA Handbook of Clinical Geropsychology, Vol. 2: Assessment, Treatment, and Issues of Later Life, APA Handbooks in Psychology*, American Psychological Association, Washington, DC, 319-339. <http://dx.doi.org/10.1037/14459-012>
- [6] Zgola, J.M. (1987) *Doing Things: A Guide to Programming Activities for Persons with Alzheimer's Disease and Related Disorders*. Johns Hopkins University Press, Baltimore.
- [7] Zgola J.M. (1999) *Care That Works: A Relationships Approach to Persons with Dementia*. Johns Hopkins University Press, Baltimore.
- [8] Camp, C.J. (1999) *Montessori-Based Activities for Persons with Dementia. Vol. 1*, Menorah Park Center for Senior Living, Beachwood.
- [9] Camp, C.J., Schneider, N., Orsulic-Jeras, S., Mattern, J., McGowan, A., Antenucci, V.M., Malone, M.L. and Gorzelle, G.J. (2006) *Montessori-Based Activities for Persons with Dementia. Vol. 2*, Menorah Park Center for Senior Living, Beachwood.



APPENDIX C

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marytconsult@gmail.com

Employment History

1/18 - current	Dir. of Grant/Ed. Services	Tobin & Assoc. Canal Winchester, OH
1/91-current	CEO/Owner	Taylor Consultants, Huntsville
1/17-12/18	Hospice Director	Hospice of VVRMC, Del Rio, Tx
4/13-5/16	Hospice Director	Universal HH&Hospice, Bellefontaine
8/11-4/13	DCS/Executive Director	Hospice at Methodist Eldercare, Cols.
6/09-9/11	RN- Home Health Care	Custom Staffing, Bellefontaine
12/09-07/10	CM- DOO	Amedisys Home Health, Columbus
9/04-9/09	RN-Home Health Care	American Nursing Care, Lima
11/82-7/93	Realtor	Sunset Realty, Huntsville
3/90-12/90	Consultant	LTC Consultants, Wadsworth
4/87-4/90	Surveyor	Ohio Department of Health Bowling Green & Dayton
6/86-4/87	Resident Services Director	Logan Acres, Bellefontaine
11/85-6/86	Director of Nursing	Villa Fairborne, Fairborne
7/85-11/85	ADON/Staff Development	Capitol South Care Center, Cols
5/85-7/85	Director of Nursing	Indian Lake Manor, Lakeview



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8/83-5/85	ICCU Charge Nurse	Mary Rutan Hospital, Bellefontaine
8/81-8/83	MICU Charge Nurse	Doctor's Hospital, Columbus
6/79-8/81	(various RN positions in long term/acute health care)	
6/78-6/79	(various LPN position in long term/acute health care)	
5/72-9/78	(various NA positions in long term health care)	

Education

JD, Ohio Northern University School of Law – December 1996

BS, Health Care Administration – St. Joseph's College – 1991

AD, Nursing – Columbus State College – 1979

Graduate courses in Gerontology – Miami University – 1991

1000 hour Administrator-in-training (AIT) – Logan Acres – 1991

Extensive continuing education in administration, nursing and sanitation

Licensures

Attorney-at-law (Esq) – State of Ohio

Nursing Home Administrator (LNHA) – State of Ohio

Registered Nurse (RN) – State of Ohio

Registered Sanitarian (RS) – State of Ohio (1988-2002)



APPENDIX C

Mary L. Taylor, LNHA, RN, Esq.

Taylor Consultants

Overview of Consulting Services Provided:

- HCFA (Health Care Financing Administration) consultant to evaluate the effectiveness of the OBRA survey process in Ohio, Michigan, and Georgia, 1992.
- Provided 'mock' survey services to over 70 long term care facilities in Ohio, Indiana and Michigan, 1991-1996.
- Management contract: Director of Nursing of 200 bed skilled nursing facility, 1992-1993.
- Provided post-survey management and consulting assistance in nursing facilities experiencing regulatory compliance challenges, 1992-2008.
- Organizational committee member for the Ohio State University Legal Nurse Consultant Certificate Program, 1998-1999.
- Continuing Education Seminars on various regulatory and management topics for numerous individual nursing facilities, professional groups, and national organizations, including Ohio State University, National Institute for Health and Human Services, Ohio Academy of Nursing Homes and Ohio Health Care Association, 1991-2015.
- Developed Q.A. (Quality Assurance) programs for individual facilities designed to meet unique organizational needs, 1991-2001.
- Case evaluation in over 500 cases involving nursing facility/Assisted Living/ICF-MR litigation. Expert witness in over 100 cases. 1996-current
- Management agreement: Administrator of Logan Acres, 2000-2001.
- Program Consulting Services for Long Term Care and Assisted Living facilities with MiVision 2008-2015.
- Guardian Ad Litem Logan County Court System, 2000-current.



APPENDIX D

RESUME

IVA J. DEWITT-HOBLIT, LNHA, BA, MRE

3270 North Piqua-Troy Road, Troy, Ohio 45373 • **Cell:** 937-524-1614 • **Email:** iva@woh.rr.com

EXECUTIVE SUMMARY

Extensive experience in **health care management of senior settings**, skilled nursing centers, Continuing Care Retirement Communities, including development and **marketing** of assisted living, independent living, skilled nursing and Alzheimer’s care. Expertise in **revenue/reimbursement enhancement, census building**, Medicare, consulting, operations, consumer research, market analysis, staff training, teambuilding, vision casting and geriatric life enhancement. Track record in **memory care** outcomes.

EXPERIENCE

BEACON HEALTH CARE, OHIO REGION

Administrator

Covington Care Center, Covington, Ohio

2017 – Current 2018

- Responsible for total operational management of a 106 licensed bed skilled nursing center, with skilled rehab and Memory Care specialty, 92% of short term residents rehab home
- Interim Administrator, *The Pavilion, Sidney, Ohio, December 2017 – March 2018*



COMMUNICARE, CINCINNATI, OHIO

Executive Director

Riverside Health Care Center, Dayton, Ohio

2015 – Current 2017

- Responsible for total operational management of a 180 bed skilled nursing center.
- Outcomes include exceeding 2016 Budget, overall and revenues; 2015 ODH deficiency free survey; Five Star Status Overall & Five Star Quality Measures (2016 - 2017); Turnover 23%. Oversight renovation projects





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- Member Task Force to enhance/-re-create ComuniCare’s Memory Care program “Connections”; Utilized my Rhythm of the Day®/Memory in Rhythm® Program in center; including Sundowner’s program – “Twilight” with significant outcomes, for Alzheimer’s/Dementia and mental/behavioral health

CRESTVIEW MANOR



Administrator

2013 – 2015

- Overall Operations of Long Term Care and Rehab care community.
- Improved Turnover rate 2013 to 2014 86% to 46%; Improved census by 12%, Improved Case Mix Score 2.1134 to 2.3473 highest in company; Maintain virtually no staff openings in any department; Recipient AHCA Bronze Award. Implemented Twilight Program for Memory Care and mental/behavioral health; 88% of short term residents rehab home.

MIVISION CONSULTING LLC

Chief Executive Officer,

2006 - current

- Operations/marketing consulting for senior settings, i.e., LTC, assisted living, independent living, skilled nursing and Alzheimer’s care; developed Rhythm of the Day® Memory in Rhythm® a memory care program, with exciting outcomes including reduced weight loss, agitation, wandering, and nighttime sleeplessness.
- Legal Expert Witness related to nursing centers, retirement communities, and AL.

SPRINGFIELD D MASONIC COMMUNITY, SPRINGFIELD, OHIO

Vice-President/Administrator

Springfield Masonic Community, Springfield, Ohio

2010- 2012

- Received five-star CMS rating each year 2010, 2011, 2012





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- Operation of Continuing Care Retirement Community, 144 skilled nursing beds (60 Alzheimer's; 25 Rehab; 59 Long Term Care); 108 Assisted Living
- Increased revenue and improved bottom line, from previous years.
- Recruited to enhance Skilled Nursing Rehab Unit in case mix, managed care, Medicare and niche development
- Oversight with renovation for rehab unit
- Increased average Medicare & Managed Care LOS from high 20's to about 42.
- Recruited to train Pathways staff and other OMH centers in specialty memory care implementation, specifically Rhythm of the Day[®], including skilled nursing and assisted living. (Have enhanced clinical outcomes in reduced agitation, wandering, and enhanced weight gain, sleeping patterns and assessment scores. 50% reduction anti-psychotic medications, 100% reduction in hypnotics)
- Assist President in operation of independent living apartments and villas
- Awarded Best Nursing Homes—U.S. News & World Report 2011 & 2012



HCR • MANORCARE, INC. TOLEDO, OHIO

Administrator

Heartland of Bellefontaine, Bellefontaine, Ohio

2001- 2007

- Responsible for total operational management of a 100 bed skilled nursing center.
- Recruited to enhance a census-challenged site. Census 69 upon hire, 90's by 2004; Created market niches of rehabilitation/Medicare & Alzheimer's care; Enhanced revenues from 3.7 million in 2000 to 6.8 million in 2006, including Medicare increased from 9% to 25%.
- Overall management of new therapy gym building, renovation and development
- Utilized Rhythm of the Day[®] (Created by Iva DeWitt-Hoblit & Mary Neal Miller) Program to create Alzheimer's niche in center; Outcomes include reduced agitation & wandering and enhanced weight gain in dementia population, average of at least 75% improvement; 75-100% reduction in anti-psychotic and hypnotic medications with memory loss.

Regional Manager of Market Development

HCR •ManorCare, Central Region 1; 2000-2001

- Recruited to assist seven skilled nursing centers in developing effective market strategies and to identify strengths, weaknesses and obstacles.

AdCare Health Systems, Inc. Springfield, Ohio

Senior Vice-President Market Development (1998-2001)

(Corporate Marketing Director 1994- 1998)

- Responsible for developing overall marketing strategy plans for newly developed assisted living settings, Consultant to SNF's, AL's and IL's.



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- Part of executive/management team that developed assisted living, *Hearth and Home*® including strategic market plan, market analysis, opening & fill-up, staff development, and architectural development , regulatory and operations.
- Took one year assignment of operating a 148 bed all Alzheimer’s nursing facility and six month assignment of Green Hills, a CCRC.

Administrator

Koester Pavilion, Troy, Ohio 1990-1994 (AdCare managed facility)

- Responsible for total operational management of a 150 bed skilled nursing facility.
- Recruited to orchestrate a facility “turnaround”. Lead and developed team to transform center from an understaffed (50% down), problem facility (excessive ODH deficiencies) to a viable rehabilitation care center.
- Implemented Memory Care program/Unit

Health care facilities, inc

Administrator

Wapakoneta Manor, Wapakoneta, Ohio 1987-1990

- Responsible for total operational management of a 100 bed skilled nursing facility, including day-to-day operations, resident care management, budgetary control, HR management, regulatory compliance, and physical plant maintenance.
- Recruited to implement a facility “turnaround”. Accomplishments include private pay census increased from 15-32%, census increased from 64% - 100% & ODH compliance.

Administrator-in-training

Celina Manor, Celina, Ohio and Piqua Manor, Piqua, Ohio 1986-1987

- Focused on details of total operational management, clinical, financial, employee, regulatory and physical plant.
- Assisted facility in regulatory compliance, customer satisfaction, & employee relations.

EDUCATION & CERTIFICATION



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Licensed Nursing Home Administrator

(State of Ohio)

Southern Baptist Theological Seminary

Masters of Religious Education/Social Work,

Completed internships in psychiatric social work, crisis social work (inner city), and medical social work. Selected for medical social work internship at Mount Sinai Medical Center, Miami Beach, Florida, specializing in aging and terminally ill.

LOUISIANA COLLEGE, PINEVILLE, LOUISIANA

Bachelor of Sociology/Social Work, “Cum Laude”,

“Who’s Who in American Colleges and Universities”, President of Resident Women’s Association, Resident Woman of the Year, (for Heroism), Honor Societies.

Louisiana College, Pineville, Louisiana

Two years toward B.S.N.

SKILLS & ACCOMPLISHMENTS

- Published (Vol.5 No.1 2016) of Advances in Aging Research (AAR). Effects of Sustained, Coordinated Activities Programming in Long-Term Care: The Memory in Rhythm® Program; <http://www.scirp.org/journal/AAR/>
- Copyrighted Rhythm of the Day©, trade marked Memory in Rhythm®
- Elected to OHCA (Ohio Health Care Association Board of Trustees), 1994-2002
- Governance Committee for Ohio Health Care Association, 2007-2008
- Long Term Care Trends Committee for Ohio Health Care Association, 2007-2008
- Honored by the Ohio House of Representatives for contribution to profession, 1994.
- Named “Who’s Who Worldwide”, 1991
- Marketing certification through ALFA (Assessed Living Facilities of America)
- Speaker at OALA (Ohio Assisted Living Association), WALA, OHCA & RAP
- *Iva DeWitt-Hoblit* Rose Garden established by the Celina Manor staff and residents
- Chairman Board of Trustees, Ginghamburg United Methodist Church, 2 years
- Deacon, Koinos Christian Fellowship – 2012 – current



APPENDIX D

REFERENCES

- Mike Williams, D.B.A, Retired Senior Executive, (Executive VP, AdCare Health Systems & COO, Ohio Masonic) 1321 Kensington Street, Port Charlotte, Florida 33954, Cell 941-276-0613, (Can speak to my time at Springfield Masonic & AdCare Health Systems) sewjmw@petuniassite.com
- Mary Taylor, Esq., CEO, Taylor Consultants, 937-842-6159, tconsult@columbus.rr.com
- Dr. Cameron Camp, Center for Applied Research in Dementia, Cameron@cen4ard.com; 440-829-4927
- Gary Wade, The Wade Management, Cell: 937-206-2601, gwade2342@gmail.com
- Sheila Malloris, BSN, Regional Clinical Director of Operations, 937-408-1109.
- Kathy Davidson, SpringMeade Administrator Independent Living, 937-667-1811 work; 937-877-0071 cell; kathy.davidson@springmeadeliving.com;
- Dr. Susan Berner, Medical Director, susberner@yahoo.com; 937-503-4309 cell



APPENDIX E

Supply List Overview

(\$2500 Total)

Specific supplies will be individualized based upon Nursing Facility/Resident needs.

Any 'Consumable' supplies provided initially will need to be refilled at the expense of the Nursing Facility.

General activity supplies

\$250.00 (25%)

Includes artwork supplies, papers and canvas, household items, linens, dusters, brooms, assorted wash clothes, assorted storage items, various storage bins, zip lock storage bags, song sheets, assorted games, swim noodles, assorted baskets, video games, movies, manicure sets, finger nail polish, lotions, miniatures, gardening tools, gardening hats, balls, soft balls, nerf balls, laundry baskets, CDs.

Montessori based supplies

\$250.00 (25%)

Includes kits and templates, scoops, assorted puff balls, assorted clothes pins, assorted kitchen items, assorted kitchen utensils, wooden spoons, measuring kitchen items, assorted tools, bingo chips, beauty supplies, curlers, hair clips, hair ties, purses, totes, kitchen dining items, plastic food items, cloth napkins, plates, cups, glasses, ice cube trays, tongs, tweezers, small baskets, paint supplies, paint brushes, felt, muffin tins,

Aromatherapy supplies

\$250.00 (25%)

Includes timed essential oil diffusers, essential oils, timer system, essential oil body, essential oil hand lotions, essential oil body spray, essential oil foot lotion, ice cooler, wash clothes.

Books/Resources

\$250.00 (25%)

Includes Montessori materials, Montessori-Based Activities for Persons with Dementia Vol I, Montessori-Based Activities for Persons with Dementia Vol II, "Living in the Different", by Elaine J. Klinger Sturtz.

APPENDIX F

	8233 Howe Industrial Parkway Canal Winchester, OH 43110 Ph: 888-336-7800 Fax: 614-890-2064 www.tobinsearch.com		

Individual Hours Outlook -		Annual Hours Breakdown	Annual Total	3 Year Total
	Demential/Alzheimers Grant			
Mary L. Taylor RN, LNHA, Esq.	Principal project manager responsible for program	10 Facilities	520	1560
30,000 - 25% of AY	10 Facilities Annually	5 days on-site training/Consulting/Program	296	888
\$57.70 per hour		Program Review/Revsions 2 hours/weekly	104	312
		Travel time - 3 hours daily x 3 on-site travel days (10 facillities annually)	90	270
		Data preparation 3 hours per facility x 10 facilities	30	90

APPENDIX F

Individual Hours Outlook - Nurse Manager Training Program		Annual Hours Breakdown	Annual Total	3 Year Total
	Dementia/Alzheimers Grant			
Iva DeWitt-Hoblit, LNHA, BA, MRE	Lead Trainer/Consultant	10 Facilities	2080	6240
\$36.06 per hr	10 nursing facilities annually	10 days on-site training/Consulting (10 facilities annually)	828	2484
		2 days off-site training/Consulting (10 facilities annually)	552	1656
		Travel time - 3 hours daily x 10 on- site travel days (10 facilities annually)	300	900
		Program Review/Revisions 4 hours/weekly	320	960
		Data preparation 5 hours per facility x 10 facilities	50	150

APPENDIX F

Individual Hours Outlook - Nurse Manager Training Program		Annual Hours Breakdown	Annual Total	3 Year Total
	Dementia/Alzheimers Grant			
Trainer/Consultant	Full-time Trainer/Consultant	10 Facilities	2080	6240
\$33.65/hour up to 40 hours weekly	10 nursing facilities annually	10 days on-site training/Consulting (10 facilities annually)	828	2484
		4 days off-site training/Consulting (10 facilities annually)	552	1656
		Travel time - 3 hours daily x 10 on- site travel days (10 facilities annually)	300	900
		Program Review/Revisions 8 hours/weekly	320	960
		Data preparation 8 hours per facility x 10 facilities	80	240

Individual Hours Outlook - Nurse Manager Training Program		Annual Hours Breakdown	Annual Total	3 Year Total
	Dementia/Alzheimers Grant			
Administrative Assistant	Part-time Trainer/Consultant	10 Facilities	1040	3120
\$16.82 per hr	10 nursing facilities annually		1040	3120

Accord

CARE COMMUNITY

Your Health. Your Independence. Your Choice.

June 11, 2019

In the event Tobin & Associates is awarded the grant for the Rhythm of the Day© our facility would be interested in implementing this dementia program.

Respectfully submitted,



Signature



Title

APPENDIX G



Ursuline Center of Toledo

4035 Indian Road
Toledo, Ohio 43606

419-536-3535

Fax: 419-536-3398

ursulines@toledoursulines.org

“Living in holy relationship, a contemplative presence in an ever changing world”
(Directional Statement 2014-2018)

June 12, 2019

In the event Tobin and Associates is awarded a grant for Rhythm of the Day © we are expressing interest in participating.

Thank you

Sincerely,

Rhonda Charles, LNHA
Administrator

APPENDIX G



June 11, 2019

In the event Tobin & Associates is awarded the grant for the Rhythm of the Day® our facility would be interested in implementing this dementia program.

Respectfully submitted,

Holly Gower RN
Signature

DON - Piqua Manor
Title

APPENDIX G



June 11, 2019

To Whom It May Concern:

In the event Tobin & Associates is awarded the grant for the Rhythm of the Day® our facility would be interested in implementing this dementia program.

Respectfully submitted,

A handwritten signature in black ink that reads "Deborah K. Bisel, MS, LNHA".

Deborah K. Bisel, MS, LNHA

Executive Director

Clovernook Healthcare and Rehabilitation Center

513-605-4001

DBisel@ClovernookHC.com

APPENDIX G



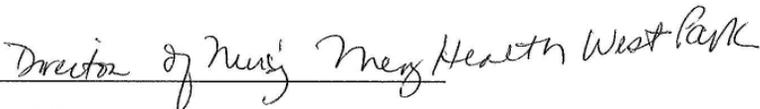
June 11, 2019

In the event Tobin & Associates is awarded the grant for the Rhythm of the Day© our facility would be interested in implementing this dementia program.

Respectfully submitted,



Signature



Title

APPENDIX G



June 11, 2019

In the event Tobin & Associates is awarded the grant for the Rhythm of the Day© our facility would be interested in implementing this dementia program.

Respectfully submitted,

Molly Brown
Signature

Administrator
Title



APPENDIX G



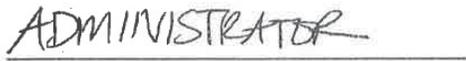
June 11, 2019

In the event Tobin & Associates is awarded the grant for the Rhythm of the Day® our facility would be interested in implementing this dementia program.

Respectfully submitted,



Signature



Title

APPENDIX G



June 11, 2019

In the event Tobin & Associates is awarded the grant for the Rhythm of the Day© our facility would be interested in implementing this dementia program.

Respectfully submitted,



Signature



Title

APPENDIX G



June 11, 2019

In the event Tobin & Associates is awarded the grant for the Rhythm of the Day© our facility would be interested in implementing this dementia program.

Respectfully submitted,

Rosemary Dennis, LNHA
Signature

Administrator
Title

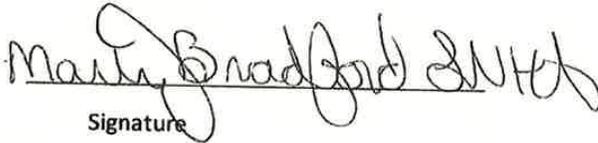
APPENDIX G



June 14, 2019

In the event Tobin & Associates is awarded the grant for the Rhythm of the Day© our facility would be interested in implementing this dementia program.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Marty Bradford". The signature is written over a horizontal line. Below the line, the word "Signature" is printed in a small, black, sans-serif font.