ABSTRACT

THE DEVELOPMENT OF A VIABLE BUSINESS PLAN: IMPLEMENTATION OF THE GERIATRIC RESOURCE NURSE MODEL AND ACUTE CARE UNIT FOR THE ELDERLY IN A COMMUNITY-BASED HOSPITAL

By

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The aging population coupled with the complexity of the older adult patient has presented a significant challenge for the healthcare industry. The literature has shown that the elderly are the major consumers of healthcare expenditures in the United States. Caring for this population in the realm of healthcare reform will require new strategies to improve the health status of the older adult patient. The objective of this study was to complete a comprehensive literature review of geriatric care models and create a business plan applying the Nurses Improving Care for Healthsystem Elders (NICHE) program.

NICHE is a national nurse-driven geriatric program that provides the necessary resources and tools to assist healthcare organizations in enacting system-level changes, which will impact the care of the older adult patient.

THE DEVELOPMENT OF A VIABLE BUSINESS PLAN: IMPLEMENTATION OF THE GERIATRIC RESOURCE NURSE MODEL AND ACUTE CARE UNIT FOR THE ELDERLY IN A COMMUNITY-BASED HOSPITAL

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

FIGURE Page

LIST OF ABBREVIATIONS

ACA	Affordable Care Act
ACE	Acute Care for Elders
ADL	Activities of Daily Living
ALOS	Average Length of Stay
APN	Advanced Practice Nurse
CAUTI	Catheter associated urinary tract infection
CDPH	California Department of Public Health
CEO	Chief Executive Officer
CMS	Centers of Medicare and Medicaid
CNO	Chief Nursing Officer
CNS	Certified Nurse Specialist
COG	Chief Officer's Group
COO	Chief Operating Officer
CHNA	Community Health Needs Assessment
CINAHL	Cumulative Index to Nursing and Allied Health Literature
FY	Fiscal Year
GIAP	Geriatric Institutional Assessment Profile
GRN	Geriatric Resource Nurse
HR	Human Resources
IDS	Integrated Delivery System
IOM	Institute of Medicine

IRS	Internal Revenue Service
LTP	Leadership Training Program
NICHE	Nurses Improving Care for Healthsystem Elders
NRC	National Research Corporation
ODPHP	Office of Disease Prevention and Health Promotion
OSHPD	Office of Statewide Health Planning and Development
PDE	Patient day equivalents
PMO	Project Management Office
PRF	Project Request Form
PPACA	Patient Protection and Affordable Care Act
RN	Registered Nurse
SPA	Service Planning Area
SWOT	Strengths, Weaknesses, Opportunities, and Threats
US	United States

CHAPTER 1

BACKGROUND AND SIGNIFICANCE

Today's healthcare industry is faced with an ageing population. Increasing life expectancy and the retirement of the baby boomer generation are contributing to the steady increase in the number of adults aged 65 and older (Institute of Medicine [IOM], 2008). For purposes of this paper, adults aged 65 and older will be referred to as the older adult. Studies have predicted that by 2030, 1 in 5 residents of the United States will reach the older adult population (Steele, 2010). In 2008, the IOM's report, *Retooling for an Aging America: Building the Health Care Workforce,* predicted "between 2005 and 2030 the number of older adults will almost double, from 37 million to over 70 million, accounting for an increase from 12 percent of the U.S. population to almost 20 percent" (p. 1). Further, Centers of Medicare and Medicaid (CMS), predict that national health spending will reach $4.6 trillion and comprise one-fifth of the gross national product (GDP) by 2020 (2010). The older adult patient within the U.S. population is the major consumer of healthcare spending and represents the core business of hospitals (Fox et al., 2013).

Although, the older adult represents approximately 13% of the population today, they have much higher rates of hospitalization than any other age group. In the United States, the older adult accounts for 37% of hospital discharges and 43% of inpatient hospital days (Hall, DeFrances, Williams, Golosinskiy, & Schwartzman, 2010). In a

statistical brief from the Agency on Healthcare Research and Quality (2010), Wier, Pfuntner, and Steiner reported, "there were more than 14 million hospital stays among adults ages 65 years and older. These hospitalizations accounted for more than one-third of all U.S. community hospital stays and about 14 percent ($157.7 billion) of total hospital costs" (p. 2). The escalating costs of caring for the older adults can be attributed to higher acuity, longer length of stays, complications, and adverse outcomes (Steele, 2010).

Advancing medical science and biomedical innovations have contributed to a longer life expectancy and it is projected that 134 million people will have one or more chronic conditions by 2020 contributing to an increase in healthcare spending (IOM, 2008). According to the IOM (2008), 3 out of every 4 older adults have at least one chronic medical condition and one out of every five Medicare beneficiaries has five or more chronic conditions that requires complex care management. The ageing population and the exorbitant cost of caring for the older adult patient create many challenges for the healthcare industry. The hospitalized older adult patient is highly vulnerable and at risk for hospital-acquired complications due to the presence of these chronic conditions and multiple other variables (Wendel, Durso, Cayea, Arbaje, & Tanner, 2010). Physical frailty and cognitive impairments, such as dementia and/or delirium further complicate the care management of the older adult patient (Steele, 2010).

In order to meet the challenges of the aging population, it is undeniably beneficial for healthcare organizations to look at geriatric models of care that will improve the quality of life and health outcomes for the older adult patient. The aim of this paper is to (1) present a critical analysis of the literature with focus on geriatric care models and (2)

to present a business plan implementing the Geriatric Resource Nurse (GRN) model and Acute Care Unit for the Elderly (ACE) in a community-based hospital applying the Nurses Improving Care for Healthsystem Elders (NICHE) program.

Search Methods

A literature search was conducted to obtain research reports on Nurses Improving Care for the Health-system Elders (NICHE), Geriatric Resource Nurse (GRN), and Acute Care for Elders (ACE) models. Three search engines were used: Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medline, and PubMed. The literature research was conducted using the following keywords: ACE unit, acute care unit for the elders, ACE model, GRN model, geriatric resource nurse, geriatric nursing models of care, geriatric nursing care, NICHE, nurses improving the care for the health-system elder, NICHE business model, and business case for chronic care.

Literature Review

Due to the increasing numbers of hospitalized older adults and the risks for additional complications, there is an urgency to look at new models to support the care management of this complex group of patients. The older adult patient poses many challenges for the healthcare system, which include higher risk for complications, hospital-related infections, and impairment in their functional status, including an increase in mortality due to hospitalization (Kleinpell, Fletcher, & Jennings, 2013). Additionally, the normal aging process coupled with multiple chronic conditions creates the multifaceted situation that healthcare providers are faced with today (Krall et al., 2012). Changes that occur in the older adult can include impairments with vision and hearing, bone density changes, musculoskeletal weakness, malnutrition, reduced

sensations, cognitive impairment, and frailty (Buurman et al., 2011). Nursing models specialized in the care of the older adult can address these distinct needs, optimizing the care and promoting healing of the older adult patient. According to Steele (2010), "traditional hospital design and models of care focus purely on treatment of disease, rather than on the distinct needs of the older patient" (p. 332). The current hospital setting is not adequately designed to meet the needs of the older adult patient. Environmental designs, flooring, lighting, noise, and staffing models contribute to a poor environment for healing (Steele, 2010). Further, poor coordination of care, such as polypharmacy, use of psychotropic medications, sleep disturbances, and poor mobility may cause worsening conditions and functional decline (Conley et al., 2012). The many factors mentioned may result in deconditioning, immobility, risk of falls, and delirium (St. Pierre & Twibell, 2012). These expensive chronic conditions and complications coupled with the various dynamics mentioned leads to higher utilization of resources and escalating healthcare spending.

Early recognition and specialized treatment of the older adult patient can contribute to better health status and improved patient outcomes. Multiple studies have been conducted on the benefits of acute care nursing models of practice. The NICHE program and two nursing models known as Acute Care for Elders (ACE) model and the Geriatric Resource Nurse (GRN) model have shown to be effective in improving the care of the geriatric patient (Conley et al., 2012). These models were created to have a positive impact on the care of the older adult, preventing complications and decreasing factors that contribute to worsening conditions (Capezuti et al., 2012). All three models use evidence-based, age-sensitive nursing strategies to address the care of the older adult

in the hospital setting (Boltz et al., 2008). Steele (2010) acknowledged, "geriatric patient outcomes reflect deeply on the nursing care that is provided to older patients" (p. 338). Further, Wild, Nelson, Szczepura, and Kydd (2012) stated "modern nursing care of the elderly should be about mobilisation not bedcare; it should be about regaining and maintaining skills and abilities, not acceptance of less than the older individual's maximum functional level. Underlying such dynamic nursing care of the old is comfort and support" (p. 12).

The first model is the NICHE program, which represents Nurses Improving the Care of the Healthsystem Elder. This program was developed in 1992 by the Hartford Institute for Geriatric Nursing at New York University (St. Pierre & Twibell, 2012). The NICHE program supports the nursing practice environment by assisting the hospital to accomplish systematic change and help embed evidence-based geriatric knowledge within the organization (Capezuti et al., 2012). The program is designed to provide extensive resources and tools to educate, stimulate, and transform the nurse competence in geriatric care (Boltz et al., 2013). The NICHE program consists of eight core components as it framework: guiding principles, leadership, organizational structures, physical environment, patient and family centered approaches, ageing-sensitive practices, geriatric staff competence, and interdisciplinary processes (Capezuti et al., 2012). The guiding principles focus on these vital concepts: evidence-based geriatric knowledge, patient-family centered care, healthy-productive practice environment, and multidimensional metrics of quality (Capezuti, Bub, Bricoli, & Boltz, 2013).

The NICHE nursing resource program supports two nursing care models, known as the Geriatric Resource Nurse (GRN) model and the Acute Care for Elders (ACE)

model. Both of these models can be implemented together or separately depending on the preference of the organization. Hospital organizations most frequently implement the GRN model of care (Capezuti, Bub, & Boltz, 2013). Implementation of the GRN model is accomplished through participating in the NICHE program. Although NICHE supports the ACE unit, the model can be implemented independent of the NICHE program (Steele, 2010).

The GRN model was originated in the 1980s at Beth Israel Hospital in Boston. The model was further developed and tested at Yale New Haven Hospital (Steele, 2010). The GRN model is based on the premise that the bedside nurse is best positioned to have the greatest influence on the care of the older adult patient (Capezuti, Bub, & Boltz, 2013). Through the NICHE program, the nursing staff is educated through a comprehensive training program and become certified GRN nurses. The education of nurses throughout the organization promotes the implementation of evidenced-based practices and improves the outcomes of the geriatric patient (Steele, 2010). In addition, the NICHE program has developed an institutional assessment tool known as the Geriatric Institutional Assessment Profile (GIAP). The tool is a 131 item self-report survey to assess: knowledge about geriatric practice, perceived quality of geriatric practice, knowledge of geriatric syndromes, and knowledge in the appropriate use of treatments in the care of the geriatric patient (Capezuti, Bub, & Boltz, 2013). The organization can use the survey to target their strategies for improvement and benchmark against other organizations that participate in the NICHE program (Capezuti, Bub, & Boltz, 2013). Research studies on the impact of the NICHE program have shown a significant impact and positive outcomes related to the GRN model. The studies

demonstrated that hospitals who have implemented the program have improved outcomes and improved nursing knowledge in the areas of incontinence, use of restraints, sleep disturbances, family support, delirium, urinary tract infections, mobility loss, fall-related injuries, pain management, and frailty (Capezuti et al., 2012). Overall, the NICHE program has been the most successful in hospital membership and its contribution to the care of the geriatric patient.

The third model of care is known as Acute Care for the Elderly (ACE) unit. This model of care was developed in 1995 at the University of Cleveland (Steele, 2010). The ACE model focuses on creating an acute care unit that addresses the specialized training that meets the needs of the older adult from admission to discharge (Barnes et al., 2012). This specially designed unit employs dedicated staff that has been trained in geriatric care, patient and family-centered care, and interdisciplinary discharge planning (Barnes et al. 2012). The environment of the unit is specifically designed to meet the physical and psychosocial needs of the older adult; including the unit's floor plan, single occupancy rooms, lighting, flooring, artwork, and unit routines (Ahmed, Taylor, McDaniel, & Dyer, 2012). Additionally, common areas for dining, socializing, and outdoor activities are created to promote independence and increase function in activities of daily living (Steele, 2010). The ACE model integrates the interdisciplinary team including a physician, nursing, physical therapy, occupational therapy, dietician, pharmacist, case manager, and social worker into the delivery of patient-centered care (Ahmed & Pearce, 2010). Interdisciplinary rounding, focused assessments, and discharge planning are all centered on the goal of maintaining the patient's prior level of functioning and preventing or reducing hospital acquired complications (Barnes et al., 2012). Detailed assessment

tools and interventions are utilized to prevent falls, skin breakdown, cognitive & functional decline, constipation, immobility, delirium, and use of indwelling urinary catheters and restraints (Steele, 2010). Research studies have shown that positive results and trends for geriatric patients participating in the ACE model of care such as improvement in activities of daily living (ADL), decreased length of stay, less likely discharged to a nursing home, less likely to be physically restrained, and depression was recognized and treated early (Ahmed & Pearce, 2010). Overall, the multiple studies have indicated that the ACE model of care improves outcomes and the general health status of an extremely frail and vulnerable population (Ahmed et al., 2012).

Business Plan

The Nurses Improving Care for the Healthsystem Elders (NICHE) program is the strategy that a local community-based hospital has chosen to improve the care of the older adult. According to Capezuti, Briccoli, and Boltz (2013), the purpose of becoming a NICHE designated facility is to "enact system-level change that targets the unique needs of the older adults and embeds evidenced-based geriatric knowledge into practice" (p. 1387). To meet the vision that all older adults will receive geriatric sensitive and exemplary care, a business plan was established to ensure successful organizational outcomes and financial sustainability into the future.

A core leadership team was created to participate in the NICHE leadership-training program (LTP). Participants within the hospital were selected based upon the role and influence that will be required to implement NICHE within the organization. The leadership team consists of the Administrative Director of Medical-Surgical services, Administrative Director of Post-Acute services, Director of Performance Excellence,

Assistant Clinical Director of Education, and a gerontological clinical nurse specialist. The participants of the steering committee engaged in a 6-week LTP to plan and prepare for implementation of the GRN model of care applying the NICHE program. Considering alignment with the NICHE principles, the core team reviewed the organization's mission statement, strategic plan, and other health system programs evaluating the opportunity for shared resources and alignment with strategic goals (NICHE, n.d.). In preparation of the business plan, a detailed analysis of both internal and external factors was conducted. The analysis included an assessment of the organizational environment, evaluation of the competitors, and an assessment of the consumer desires and market needs (Hillestad & Berkowitz, 2013). The initial step was to develop a shared vision for improved geriatric care. Aligning with the organization's vision of "Patients First" the core team each submitted a personal vision statement. Through careful consideration of each vision statement including the chief operating officer and chief nursing officer, the following vision statement was established:

To provide evidence-based geriatric care utilizing excellence in nursing practice and relationship-based care that will promote the highest function of the older adult through all transitions while being cared for with the utmost respect, dignity, and compassion (Lama, McKnight, Merkle, Necke, & Place, personal communication, October 15, 2014).

The core team partnering with NICHE through the LTP completed an internal assessment analyzing both quantitative data and qualitative information to formulate an accurate assessment of the organizations current state (Zuckerman, 2012). Both internal and external factors were evaluated to evaluate any actual or potential influences that

could impact the implementation of the NICHE program within the organization. Initially, an analysis of the strengths, weaknesses, opportunities, and threats (SWOT) was completed to review the organizational assets and barriers relative to the implementation of geriatric initiatives (Lama, McKnight, Merkle, Necke, & Place, personal communication, October 15, 2014). See Table 1.

TABLE 1. SWOT Analysis

Strengths

- Hospital Vision: Patient's First
- Integrated Delivery System
- Integrated Delivery System (IDS) offers all services across the continuum
- Executive and organizational support
- Electronic Record
- Nursing Model: Relationship-based care
- Nursing Culture: the professional practice of the RN is empowered & respected
- Shared Governance Model
- Oversight over nursing sensitive outcomes through our Performance Excellence department
- Support of Lean Methodology
- Strong professional relationship between medical and nursing staff
- 2014 America's 100 Best Hospitals by Healthgrades
- Top designated Stroke Center in Los Angeles
- Los Angeles County Stemi-Receiving Center
- National Research Corporation (NRC) Picker Annual Path Excellence Award 2010 through 2013

Weaknesses

- Core team member's project capacity
- Allocated funding for staff education
- Allocated funding for a geriatric advanced practice nurse (APN)
- Lack of specialized training nurses and physicians in care of the older adult
- No formal nursing plan for utilization of the APN within the organization
- Lack of Geriatricians
- Lack of a comprehensive palliative care program
- No standard assessment tool utilized for the older adult
- Discharge planning process – disconnect in transitions throughout continuum
- Interdisciplinary rounds are exclusive of the physicians
- No Gero-psychiatrist

Opportunities

- Partnership with the IDS physicians group
- Optimize the electronic medical record
- Partnership with payer groups
- Partnership with the strategic plan in palliative care
- Partnership with the IDS Marketing department
- Partnership with local School of Nursing

Threats

- The rate of increase of the older adult
- Changing financial landscape
- Changing landscape of payer system
- Fragmented care and practice amongst physicians and different payer systems

Company Description

The community-based hospital is a non-profit healthcare organization and is part of a regional integrated delivery system (IDS). The first hospital of the IDS, it was founded in 1959 by volunteers who went door-to-door with coffee cans to raise money to build a local hospital (Biel, 2013). The hospital is in Service Planning Area 7 (SPA 7), which is located in the southeast portion of Los Angeles County (Biel, 2013). According to the California Department of Public Health (CDPH), "a Service Planning Area, or SPA, is a specific geographic region within Los Angeles County" (n.d.). The county of Los Angeles has been divided into eight geographic areas due to the county's size at 4,300 square miles (CDPH, n.d.). SPA 7 is determined by hospital discharge data acquired through the Office of Statewide Health Planning and Development (OSHPD). Approximately 73% hospital discharges of this community based hospital come from the nine cities noted in Table 2. The hospital's secondary service area includes additional cities in the San Gabriel Valley and North Orange County and can be seen below in Table 3 and Table 4 (Biel, 2013). The primary service area map can be seen in Figure 1 noted below.

TABLE 2. Primary Service Area Cities

City	**Zip code**
Hacienda Heights	91745
La Habra	90631
La Habra Heights	90631
La Mirada	90638
Montebello	90640
Norwalk	90650
Pico Rivera	90660
Santa Fe Springs	90670
Whittier	90601-90606

TABLE 3. Secondary Service Area Cities--West

City	Zip code
Bell	90201
Bellflower	90706
Downey	90240-90242
Los Angeles	90022
Los Angeles	90040
South Gate	90280

TABLE 4. Secondary Service Area Cities—East

City	Zip code
Chino Hills	91709
Diamond Bar	91765
La Puente	91744
La Puente	91746
Rowland Heights	91748
Walnut	91789
West Covina	91792

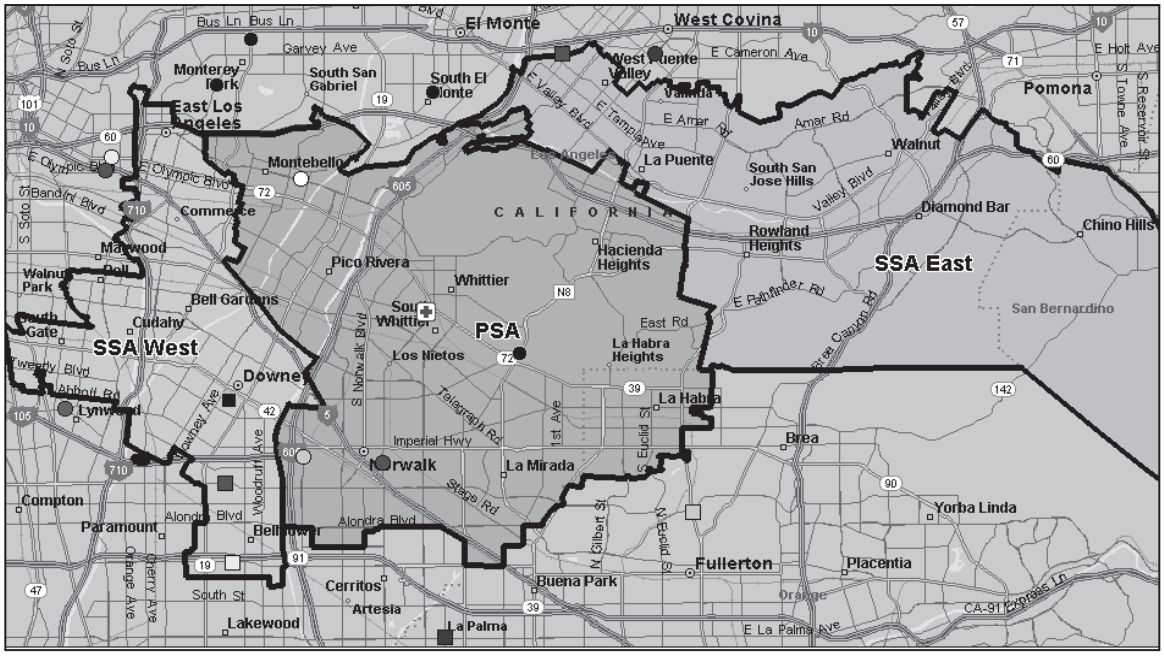

FIGURE 1. Service area map.

In 2013, the hospital conducted and published their triennial Community Health Needs Assessment (CHNA). California Senate Bill 697 (SB 697) and the federal Patient Protection and Affordable Care Act (PPACA) mandate the CHNA. In exchange for their tax-exempt status, private not-for-profit hospitals in California are required to conduct a community needs assessment every 3 years; develop a community benefit plan in consultation with the community; and annually submit a copy of its plan to Office of Statewide Health Planning and Development (OSHPD; 2013).

Within the 2013 CHNA, the population demographics for the service area were noted at 606,484. The service area's total population increased by 1.2% from the years 2000 to 2010. According to the report, this was a slower rate of growth than experienced statewide (Biel, 2013). Further statistics found that children and youth (ages 0-17) make up 25.7% of the population; ages 18-39 comprise 31.4% and 30.8% of the population are 40-64. The older adult comprises 12.1% of the population. According to internal data reports, for fiscal year 2012–2013, 56% of total discharges (excluding maternal/child) were age 65 and older with 16% age 85 and older (Necke, personal communication, 2014). Examining race and ethnicity, the Hispanic or Latino make up the largest population at 67.7%; White/Caucasians comprise 18.8% of the population; the Asian population comprise 10.4%, and African Americans, Native Americans, Hawaiians, and other races combined total 3.1% of the population (Biel, 2013). Considering language, Spanish is the primary language of the SPA in 48% of the homes. Forty-one percent of the residents speak English and 8.5% speak an Asian language within the home (Biel, 2013).

The social determinants of the primary service area provide the hospital with significant data and statistics that is fundamental to the implementation of the NICHE program within the organization. Understanding the social determinants will aid the organization in identifying systems to create social and physical environments that promote good health in the older adult patient (Office of Disease Prevention and Health Promotion [ODPHP], n.d.). The hospital's CHNA reported that 10% of the population is at poverty level and 30% of residents are at 200% of the Federal Poverty Level. In SPA 7, the city of Montebello has the highest percentage of seniors living in poverty at 13.1% and the city of Whittier has the lowest rate of seniors in poverty at 4.9%. The unemployment rate in the area is 10.2%. The residents of the primary service area owner occupy 62.3% of the housing units with approximately one-third of the residents are renter occupied. Lastly, the social determinant of median household income ranges from $50,881 in Montebello to $121,380 in La Habra Heights (Biel, 2013).

Key factors in health promotion for the older adult is access to healthcare. The data within the CHNA showed that 79.3% of the total population has health insurance. For the adult population within the service area, multiple barriers to accessing care may include: cost of care, lack of a medical home, language barrier, and lack of transportation. Statistics showed that residents of SPA 7 delayed care 9.3% of the time and 6.3% delayed obtaining prescription medications (Biel, 2013). Further, 38.5% of the older adult within the service area gave themselves a fair or poor health status rating. These rates are greater than Los Angeles County at 32.5% and 27.6% for the state of California (Biel, 2013). With focus on the older adult population, the Alzheimer's disease mortality within the service area is 26.1 per 100,000 persons. The city of La

Habra has the highest rate of death from Alzheimer's disease at 41.3 per 100,000 persons, and La Mirada has the lowest rate of death at 20.0 per 100,000 persons. SPA 7 has a high rate of death due to heart disease with Whittier at 192.9 per 100,000 persons has the highest rate of death. The city of Hacienda Heights located in the secondary service area has the lowest rate of death from heart disease at 140.1 per 100,000 persons. All communities within the service area do not meet the Healthy People 2020 objective for heart disease death rate at 100.8 per 100,000 persons (Biel, 2013). In reviewing the data for rate of death by stroke, the service area has a lower rate of 35.9 per 100,000 persons than found in the state of California at 37.8. The city of Whittier has the highest rates (44.2) of death due to stroke and Montebello has the lowest rate (27.5). The Healthy People 2020 rate for stroke deaths is 33.8 per 100,000 persons. The cities of Whittier, 90604 and 90606, La Mirada, Montebello, Norwalk, Santa Fe Springs, and Hacienda Heights all meet this objective (Biel, 2013).

Through strategic planning and the completion of the CHNA, the hospital has identified three priority health areas noted below:

1) Health Access to ensure basic and preventative care access for the uninsured and underinsured via: effective use of health insurance enrollment resources; promotion of free and low-cost health-related resources and services; and collaborative efforts to meet community needs. 2) Healthy Living to deliver health promotion and prevention programs that: enhance health-related knowledge and behavior; support policies and environmental changes, which promote healthy eating and active living with emphasis on making the healthy choice the easy choice. 3) Health Management to improve community health

through efforts seeking to: enhance health-related knowledge related to prevention and management of chronic diseases; increase awareness of the importance of various prevention strategies (i.e. immunizations and screenings); and promote available community resources. (Biel, 2013, p. 1)

CHAPTER 2

FEASIBILITY ANALYSIS

The health care industry is faced with providing the best possible care for their patients and the community. The duty of how to deliver quality care is at the forefront of healthcare leaders across the nation. The recent passage and implementation of the PPACA has spearheaded the largest health care reform in decades. Although controversy and massive public opinion surround this law, healthcare reform has pushed the healthcare industry into a critical time of strategic planning. In 2001, the IOM of the National Academies' report, *Crossing the Quality Chasm,* defined quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (p. 44). The IOM further stated that quality healthcare should be safe, effective, patient-centered, timely, efficient, equitable, and effective (IOM, 2001). The PPACA, health care reform, IOM reports, and national quality organizations are all calling for large scale and broad-sweeping changes in our healthcare systems. This type of transformation will require physicians, payers, nurses, and healthcare administration leaders to strategically approach the delivery of quality care.

In addition to the strain of healthcare reform, other factors, such as the aging population, increasing life expectancy, and the complexity of multiple chronic conditions pose substantial challenges for the delivery of quality healthcare (IOM, 2008). Many other factors confront healthcare organizations, patient outcomes, comparative data, and

competitive forces, all of which drive the organization to produce evidenced-based effective care. Innovations and new strategies must be designed to address these challenges and to set forth a course of action that will advance our nation's readiness to care for an aging population. The 2008 IOM report, *Retooling for an Aging America: Building the Health Care Workforce,* proposes the following three-pronged approach to improve the capability of the health care system to care for older Americans:

> 1) Enhance the competence of all individuals in the delivery of geriatric care
>
> 2) Increase the recruitment and retention of geriatric specialists and caregivers
>
> 3) Redesign models of care and broaden provider and patient roles to achieve greater flexibility. (p.2)

Shifting an organizational culture from long standing practices to new innovative approaches can be challenging. The feasibility of implementing the GRN model of care applying the NICHE program will be evaluated to provide an objective and complete assessment of the strengths and weaknesses of the proposed business case.

Mission, Vision, and Values

Considering the vision created for improving the care of the geriatric patient within the hospital setting, it is important to assess the organizational readiness for the implementation of the NICHE program. An important phase is to evaluate the geriatric vision of care and how it will be integrated within the organization's mission and strategic plan. Fundamental to an organization is the philosophy or the written statement that reflects the mission, vision and values. The mission statement is a wide-ranging, universal statement of the organization's reason for existence (Sullivan & Decker, 2009). According to Roussel and Swansburg (2009), the basic tools of strategic planning are the

"statements of mission or purpose, vision and values, philosophy or beliefs" (p. 9). The mission statement and vision of the organization are as follows (PIH, n.d.):

> Mission
>
> We provide high-quality healthcare, without discrimination, and contribute to the health and well being of our communities in an ethical, safe and fiscally prudent manner, in recognition of our charitable purpose.
>
> Vision
>
> Patients First
>
> Values
>
> Patients First, Respect & Compassion, Responsiveness, Integrity, Collaboration & Innovation, and Stewardship. (Our Mission, n.d.)

Given the mission and vision of the organization, the established geriatric vision for the NICHE program was set forth by the team members with a strong background in nursing and geriatric care. The stakeholders were carefully selected to establish the vision and create a broad basis of support for the NICHE program. In addition, the core team members possess a strong commitment to improving the care of the older adult patient within their scope of practice (Bond, Rodenhausen, Spragens, & Yellig, 2013). Hence, the NICHE vision was created and designed to align with the organization's vision of Patient's First and is supported by the Chief Executive Officer (CEO), Chief Operating Officer (COO), and Chief Nursing Officer (CNO).

The capacity for the hospital's workforce and leadership team to adopt a change initiative in the care of the older adult patient will be the most substantial challenge.

Understanding the significance of readiness for change, the NICHE core team established a NICHE steering committee with support from senior management, which provides the backing and collaboration needed to implement the goals and objectives of the project. The steering committee was designed with key stakeholders and early adopters that will influence others and contribute to creating systematic change within the initiative (Bond, et al. 2013). The NICHE steering committee includes specific team members, such as, the NICHE coordinator, administrators, physicians, nursing directors, quality analyst, nursing educator, and multiple interdisciplinary team members who will have an impact on the change project. Lastly, the organization has a strong project management department built into the organizational structure. The core team has submitted a project request, which was presented to the Chief Officer's Group (COG) for approval and assignment of a project manager. This crucial step demonstrates the acknowledgment needed by the Board of Directors and Chief administrators.

The NICHE core team and steering committee are the integral members in securing resources and moving the project forward. In the early phases of building support for the project, the core team has developed formal presentations to promote awareness and facilitate discussions on the topic of improving geriatric care and the NICHE program (Bond, et al., 2013). The presentations are vital components of the action plan developed by the NICHE core team. An action plan provides the needed structure to ensure continuous information is communicated to administration, staff, and ensure timelines are being met (Bond, et al., 2013). The first step in developing the goals within the action plan was to establish baseline data to capture the opportunity for improvements and outline the gaps that exist within the organization. Completing an

internal assessment of the hospital provided the team with information and helped establish where to focus time and efforts in improving the care of the older adult patient (Bond, et al., 2013). Considering the vision created and the SWOT analysis, targeted baseline data illustrated the impact and accelerating demands the geriatric population places upon the health care system (IOM, 2008). The fiscal year (FY) data in total admissions for the older adult patient within the organization is noted below (Lama, McKnight, Merkle, Necke, & Place, personal communication, October 15, 2014):

> FY 2012--2013, 56% of total discharges (excluding maternal/child patients) were age 65 and older; with 16% age 85 and older
>
> FY 2013-- 2014, 54% of total discharge (excluding maternal/child patients) were age 65 and older; with 15% age 85 and older.

Additional areas for measurement examined total admissions, patient day equivalents (PDE), average length of stay (ALOS), average cost, average net collections for the population age 65 years and older and age 75 years and older. This data will be further scrutinized by the location of the patient within the hospital setting. Additionally, the baseline data included quality data and avoidable hospital events. The core team will stratify data and analyze for trends, costs, and utilization in the areas of: falls, pressure ulcers, restraint usage, catheter associated urinary tract infections (CAUTIS), medication errors, readmissions less than 30 days, and patient transfers from medical/surgical units to the Intensive Care Unit (Capezuti, Bub, & Boltz, 2013). Another key area of focus for data analysis is to consider the patient satisfaction survey results, and nursing, physician, and staff satisfaction. The organization utilizes a national organization to collect, analyze, and benchmark the patient satisfaction survey results. The NICHE core team

will develop a basic staff satisfaction survey to use in collecting data specific to measure the satisfaction of both nursing and physicians during and post implementation of the program. Currently, the organization does not utilize a formal staff satisfaction survey. Previously mentioned, the NICHE program has developed an institutional assessment tool known as the Geriatric Institutional Assessment Profile (GIAP). This organizational assessment tool will identify the frontline staff's knowledge about geriatric practice, syndromes, and knowledge in the care of the geriatric patient (Capezuti, Bub, & Boltz, 2013). The NICHE core team will use the survey to target their strategies for improvement and benchmark against other organizations that participate in the NICHE program (Capezuti, Bub, Boltz, & 2013). The survey will be conducted to obtain baseline numbers and will be utilized post implementation of key initiatives to measure the effectiveness of the program. Another area of focus for the organization is the impact the advanced geriatric education will have on the nursing profession and practice within the organization. The specific baseline data will include: total number of registered nurses (RNs), total number of advance practice nurses (APNs), total number of geriatric certifications, and nursing turnover rates. The cumulative baseline data will determine at the nursing unit level or line of service the priorities for the team and help in selecting the pilot unit to implement the plan to improve geriatric care (Capezuti, Bub, & Boltz, 2013).

The internal assessment included reviewing and determining if the organization's aligns itself with it's mission, vision, and values and does it have the organizational structure to support the implementation of the NICHE program (Zuckerman, 2012). Overall, the mission, vision, and values can be seen in the data, outcomes, and successes of the healthcare system. The organization has had tremendous growth and has

successfully become an integrated delivery system (IDS) in the last few years. The hospital has earned the distinction of Healthgrades® America's 100 Best Hospitals for 2014 and Healthgrades® Distinguished Hospital Award for Clinical Excellence™ for the last four years in a row. Further, U.S. News & World Report ranked the hospital as one of the Best Regional Hospitals and most recently, the Hospital and Health Networks presented the organization with The Most Wired award for their innovations in Information Technology (PIH, n.d.). The organization's achievements and strong reputation within the community demonstrates that the organization embodies a professional environment guided by a strong and visionary leadership who advocate and support the pursuit of excellence in delivery of quality healthcare.

Establishing the baseline data and reviewing the readiness for organizational change, the NICHE core team established long-term goals within the action plan. The specific goals of the plan will be utilized to drive the implementation of the program and evaluate key milestones. Seven long-range goals were identified to guide the vision and priorities and design a two-year implementation plan. The long-range goals of the program's action plan are noted in table five. Outlined in table six, the specific goals and priorities are defined. The NICHE core team is utilizing this plan to develop detailed working documents, which outline the specific tasks necessary to implement each specific goal. A detailed action plan is listed in Table 5 and Table 6.

TABLE 5. Long-Term Goals

Goal #	Long-Term Goal	Responsible Party
1	The healthcare organization will have a NICHE core team in place by January, 2015	NICHE Coordinator, NICHE Core Team, CNO
2	The healthcare organization will have a NICHE steering team in place within 6 months (June, 1015) of completing the Leadership Training Program (LTP)	NICHE Coordinator, NICHE Core Team, CNO
3	The healthcare organization will implement GIAP within 3 months (March, 2015) of LTP training	NICHE Coordinator, NICHE Core Team, Educator, Analyst Statistician
4	The healthcare organization's NICHE core team will determine clinical outcomes to measure impact of implementation of geriatric best practices within 6 months of completing the LTP	NICHE Coordinator, NICHE Core Team
5	The healthcare organization will have GRNs in one medical unit and one post-acute care within 18 months of completing the LTP	NICHE Coordinator, NICHE Steering Committee, Certified Nurse Specialist (CNS)
6	The healthcare organization will have GRNs on a second medical unit and within 24 months of completing the LTP	NICHE Coordinator, NICHE Steering Committee, CNS
7	The healthcare organization will consider the opening of an Acute Care Unit for the Elderly in FY 15-16	NICHE Coordinator, NICHE Steering Committee, CNO, CNS
8	PIH Health will present at the NICHE Conference 2017	NICHE Coordinator, NICHE Steering Committee, CNS

TABLE 6. Specific Goals and Priorities

Goal #	Activity	Target Date	Responsible Party/ Department	Measureable Outcomes
1	Add additional members to NICHE Core team	1/2015	NICHE Coordinator, NICHE Core Team, CNO	Core Team in place, members aware and ready to participate; addition of a Geriatric CNS
1	Submit Project Request Form (PRF) to PMO	11/2014	NICHE Coordinator, NICHE Core Team, CNO	PRF will be submitted to the PMO department, requesting a project manager
1	Obtain funding for the NICHE program	6/2015	NICHE Coordinator, NICHE Core Team, CNO	A budget plan will be created by 1/2015; funding in place for GIAP and pilot unit/program; Materials and supplies are in place
1	Hire a NICHE Coordinator	FY 15-16	NICHE Coordinator, NICHE Core Team, CNO	Coordinator hired and in place. Leadership support of role and process of NICHE implementation. Develop yearly self-assessment plan for NICHE.
2	Include other disciplines in the NICHE Team	6/2015	NICHE Coordinator, NICHE Core Team, CNO	Steering Committee in place, members aware and ready to participate. Promotion of NICHE at leadership and point of service level
3	Administer GIAP with goal of 80% response rate	3/2015	NICHE Coordinator, NICHE Core Team, Educator, Analyst Statistician	Plan to educate Nursing Executive Council, Nursing Leadership Council & Nursing Professional Practice Council completed. Plan to roll out to staff completed. Plan to interpret results after 1-month administration. Identify process to address needs and get information to staff, shared governance and/or leadership teams.
4	Identify Clinical Outcomes	1/2015	NICHE Coordinator, NICHE Core Team	NICHE Dashboard created outlining clinical outcomes currently measured and identification of (2) clinical outcomes currently not measured

TABLE 6. Specific Goals and Priorities

Goal #	Activity	Target Date	Responsible Party/ Department	Measureable Outcomes
5	Develop NICHE curriculum	6/2015	NICHE Coordinator, NICHE Core Team, Educator	Process for education and identification of educators are in place. Timeline and development of courses. Development of measurement of staff satisfaction and improvement in knowledge.
5	Determine one medical pilot unit and one post-acute care unit	1/2015	NICHE Coordinator, NICHE Core Team, CNO	Using Targeting Priorities & Shared Vision worksheets, (1) medical unit and (1) post-acute care unit will be selected with leadership support of role and process of NICHE implementation
5	Recruit RNs to participate in GRN roles	6-9/ 2015	NICHE Coordinator, NICHE Steering Committee, Human Resources (HR)	Recognition of staff in place, incentives available (GRN on name badge, pins)
6	Determine second pilot unit	1/2016	NICHE Coordinator, NICHE Steering Committee, CNO	Using Targeting Priorities and Shared Vision worksheets, second medical unit will be selected with leadership support of role and process of NICHE implementation
6	Recruit RNs to participate in GRN roles	1/ 2016	NICHE Coordinator, NICHE Steering Committee, HR	Recognition of staff in place, incentives available (GRN on name badge, pins).
7	Determine unit space within hospital for ACE unit	1/2016	NICHE Coordinator, NICHE Steering Committee, CNO	Acute Unit selected and hospital facilities department aware and ready to participate in re-model.

TABLE 6. Specific Goals and Priorities

Goal #	Activity	Target Date	Responsible Party/ Department	Measureable Outcomes
7	Submit Project Request Form (PRF) to Project Management Office (PMO)	2/2016	NICHE Coordinator, NICHE Core Team, CNO	PRF will be submitted to the PMO department, requesting a project manager
7	Develop unit re-model plans	3/2016	NICHE Coordinator, NICHE Steering Committee	Detailed remodel plan established and approved by the PMO, facilities department, and steering committee.
7	Develop budget, staffing, and education plan for ACE Unit	6/2016	NICHE Coordinator, NICHE Steering Committee, CNE	Using Allocating Human & Material Resources worksheet, a budget, staffing, and education plan will be created with leadership support of NICHE implementation in an ACE unit
8	Present at 2017 NICHE conference	6/2016	NICHE Coordinator, NICHE Steering Committee, CNE	Identification of an evidence-based innovative project that had a positive outcome and experience for the hospitalized older adult

CHAPTER 3

REGULATORY ANALYSIS

The inescapable forces reshaping healthcare in the United States have brought new demands upon nonprofit healthcare organizations. Hospitals are confronted with intensified competition, increased regulations, managed care, value-based purchasing, and justification of tax exemption status. With the phasing in of health care reform, the industry is faced with the challenge of how to deliver and meet the demand of care for millions of Americans who will gain access to healthcare. Further, because of the growing number of elderly, as well as the aging of the older adult population, healthcare organizations must make every effort to create a safe, cost-effective, and high-quality healthcare delivery system if they are to meet the demands and satisfy the regulators, competitors, and communities they serve.

Disparity in quality outcomes and the exorbitance in healthcare spending were the driving forces for the creation of the PPACA, often called the Affordable Care Act (ACA) for short. When the ACA became law in March 2010, it contained the most significant change in health care reform and represented the largest implementation of regulations in recent history. The new regulations are intended to expand access to affordable quality healthcare, control future costs, and improve the overall functioning of the healthcare delivery system (Showalter, 2012). The primary laws of the ACA are to: 1) ensure that all Americans have a government approved insurance or pay a penalty; 2) create a federal system to subsidize the required health insurance; 3) implement extensive

requirements for the healthcare industry; 4) mandate widespread regulatory standards regarding medical and clinical practice (Manchikanti, et al., 2011). The ACA is made of ten titles and many provisions with an implementation timeline from 2010 through 2018 (PPACA, 2010). The healthcare reform law contains 2,407 pages and is expected to produce an enormous amount of regulations (Manchikanti, et al., 2011). Several provisions in the beginning of the timeline line have already been implemented. One section of the law's aim is to incentivize or penalize hospitals for the quality of care provided. According to Kavanagh, et al (2012), "the PPACA became law and directed CMS to initiate a value based purchasing system to financially incentivize healthcare quality and lower societal healthcare costs" (p. 385). For purpose of this discussion, focus will be on Title III-Improving the quality and efficiency of healthcare; Subtitle A-Transforming the Health Care Delivery System; Part I – Linking payment to quality outcomes under the Medicare Program; Section 3001; Hospital Value-Based Purchasing Program. This section of the law addresses value-based purchasing and this portion of the healthcare reform became effective October 2013. Execution of the law and gathering of historical data went into effect as of October 2011 (PPACA, 2010).

Value-based purchasing is a payment model in which healthcare providers are paid or rewarded for efficient healthcare, which they are accountable for both cost and quality of care (IHA, 2006). Fundamentally, would the average American reach in their pocket and pay for the service provided. According to the Integrated Healthcare Association (2006), value-based purchasing has one goal: "to create a business case for quality improvement through a compelling set of incentives that would drive breakthrough improvements in the quality and experience of healthcare" (p. 1). This new

methodology of awarding and penalizing hospitals has initiated sweeping changes within healthcare organizations and systems. Value-based purchasing has resulted in transparency and public reporting of clinical outcomes, standardization of performance measurement, payment innovation, and informed consumer decision-making (NBCH, 2011).

In the era of healthcare reform, the ACA has enacted additional requirements, which healthcare organizations must meet in order to satisfy the regulations found in section 501(c)(3) of the U.S. Internal Revenue Code (IRS, 2014). This section of the code applies to not-for-profit or charitable organizations. Not-for-profit hospitals are organized under this section of the Internal Revenue Service (IRS) tax code and are exempt from federal, state, and property taxes. Further, the exemption status allows for hospitals to have the benefit of tax-exempt bond financing and a tax-deductible status for gifts and contributions (Barton, 2010). The passing of the ACA added the following additional requirements for hospitals to maintain tax-exempt status: 1) conduct a community health needs assessment (CHNA) at least once every three years; 2) implement strategies to meet the health needs identified in the targeted populations found within the CHNA; 3) establish and publish a charity care policy; 4) develop a emergency services non-discrimination policy; 5) implement a financial plan that limits the amounts charged for care to indigent patients; 6) limit aggressive collection activities without first assessing the patient's financial ability (Barton, 2010). In addition to the new standards, the ACA has added more stringent reporting requirements. Hospitals will be audited every three years for compliance with the CHNA and are required to submit financial statements with a summary of the how the organization is meeting the needs of the

community. Lastly, tax-exempt hospitals must file Form 990 annually with the Internal Revenue Service (IRS). This requirement provides information on the organization's mission, programs, finances, and documents the organizations activities and policies as required by the federal law (Barton, 2010).

In order for hospitals to remain competitive and in compliance with the many regulations, new strategies and collaboration amongst all stakeholders is crucial. In future years, CMS will continue to enforce regulatory policies in the pursuit of greater value and quality. The business decision of implementing the NICHE program is one of the many strategies a local community-based hospital has chosen to improve the care of older adult. Enacting system-wide change that targets the fastest growing population is critical to improving the quality of care for the older adult patient. Transforming the care of the geriatric population leads to improved outcomes, reduction of costs, and meets the regulatory requirements outlined within the ACA.

APPENDICES

APPENDIX A

PROJECTIONS

		2015					
	0	1	2	3	4	5	6
	Sales %	100%	100%	100%	100%	100%	100%
Income							
Sales		900,000.00	900,000.00	900,000.00	900,000.00	900,000.00	900,000.00
COGS							
COGS		328,500.00	328,500.00	328,500.00	328,500.00	328,500.00	328,500.00
Expenses							
Director fees		9,522.00	9,522.00	9,522.00	9,522.00	9,522.00	9,522.00
Laundry		5,780.00	5,780.00	5,780.00	5,780.00	5,780.00	5,780.00
Other supplies		8,222.00	8,222.00	8,222.00	8,222.00	8,222.00	8,222.00
Marketing		1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00
Wages & Benefits		116,666.67	116,666.67	116,666.67	116,666.67	116,666.67	116,666.67
Business/Travel		850.00	850.00	850.00	850.00	850.00	850.00
Dues/Subscrip.		433.00	433.00	433.00	433.00	433.00	433.00
Debt Servicing		4,891.54	4,891.54	4,891.54	4,891.54	4,891.54	4,891.54
Total Expenses		147,365.20	147,365.20	147,365.20	147,365.20	147,365.20	147,365.20
Income Before Taxes		**424,134.80**	**424,134.80**	**424,134.80**	**424,134.80**	**424,134.80**	**424,134.80**
Taxes Due		169,653.92	169,653.92	169,653.92	169,653.92	169,653.92	169,653.92
Cash Out	133,750.00	645,519.12	645,519.12	645,519.12	645,519.12	645,519.12	645,519.12
Cash In	400,000.00	900,000.00	900,000.00	900,000.00	900,000.00	900,000.00	900,000.00
Cash On Hand	266,250.00	520,730.88	775,211.76	1,029,692.63	1,284,173.51	1,538,654.39	1,793,135.27

	2015					
	7	8	9	10	11	12
	100%	100%	100%	100%	100%	100%
Income						
Sales	900,000.00	900,000.00	900,000.00	900,000.00	900,000.00	900,000.00
COGS						
COGS	328,500.00	328,500.00	328,500.00	328,500.00	328,500.00	328,500.00
Expenses						
Director fees	9,522.00	9,522.00	9,522.00	9,522.00	9,522.00	9,522.00
Laundry	5,780.00	5,780.00	5,780.00	5,780.00	5,780.00	5,780.00
Other supplies	8,222.00	8,222.00	8,222.00	8,222.00	8,222.00	8,222.00
Marketing	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00
Wages & Benefits	116,666.67	116,666.67	116,666.67	116,666.67	116,666.67	116,666.67
Business/Travel	850.00	850.00	850.00	850.00	850.00	850.00
Dues/Subscrip.	433.00	433.00	433.00	433.00	433.00	433.00
Debt Servicing	4,891.54	4,891.54	4,891.54	4,891.54	4,891.54	4,891.54
Total Expenses	147,365.20	147,365.20	147,365.20	147,365.20	147,365.20	147,365.20
Income Before Taxes	**424,134.80**	**424,134.80**	**424,134.80**	**424,134.80**	**424,134.80**	**424,134.80**
Taxes Due	169,653.92	169,653.92	169,653.92	169,653.92	169,653.92	169,653.92
Cash Out	645,519.12	645,519.12	645,519.12	645,519.12	645,519.12	645,519.12
Cash In	900,000.00	900,000.00	900,000.00	900,000.00	900,000.00	900,000.00
Cash On Hand	2,047,616.14	2,302,097.02	2,556,577.90	2,811,058.78	3,065,539.66	3,320,020.53

Year 1 Pre-tax Income **5,089,617.56**

		2015					
		1	2	3	4	5	6
Loan Principal Balance	250,000.00	246,462.63	242,906.10	239,330.30	235,735.14	232,120.50	228,486.28
Principal Payment		3,537.37	3,556.53	3,575.80	3,595.16	3,614.64	3,634.22
Interest Payment		1,354.17	1,335.01	1,315.74	1,296.37	1,276.90	1,257.32
Total Loan Payment		4,891.54	4,891.54	4,891.54	4,891.54	4,891.54	4,891.54

	7	8	9	10	11	12
Loan Principal Balance	224,832.38	221,158.68	217,465.09	213,751.49	210,017.77	206,263.83
Principal Payment	3,653.90	3,673.70	3,693.59	3,713.60	3,733.72	3,753.94
Interest Payment	1,237.63	1,217.84	1,197.94	1,177.94	1,157.82	1,137.60
Total Loan Payment	4,891.54	4,891.54	4,891.54	4,891.54	4,891.54	4,891.54

	2016					
	1	2	3	4	5	6
	100%	100%	100%	100%	100%	100%
Income						
Sales	900,000.00	900,000.00	900,000.00	900,000.00	900,000.00	900,000.00
COGS						
COGS	328,500.00	328,500.00	328,500.00	328,500.00	328,500.00	328,500.00
Expenses						
Director fees	9,522.00	9,522.00	9,522.00	9,522.00	9,522.00	9,522.00
Laundry	5,780.00	5,780.00	5,780.00	5,780.00	5,780.00	5,780.00
Other supplies	8,222.00	8,222.00	8,222.00	8,222.00	8,222.00	8,222.00
Marketing	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00
Wages & Benefits	120,833.33	120,833.33	120,833.33	120,833.33	120,833.33	120,833.33
Business/Travel	850.00	850.00	850.00	850.00	850.00	850.00
Dues/Subscrip.	433.00	433.00	433.00	433.00	433.00	433.00
Debt Servicing	4,891.54	4,891.54	4,891.54	4,891.54	4,891.54	4,891.54
Total Expenses	151,531.87	151,531.87	151,531.87	151,531.87	151,531.87	151,531.87
Income Before Taxes	**419,968.13**	**419,968.13**	**419,968.13**	**419,968.13**	**419,968.13**	**419,968.13**
Taxes Due	167,987.25	167,987.25	167,987.25	167,987.25	167,987.25	167,987.25
Cash Out	648,019.12	648,019.12	648,019.12	648,019.12	648,019.12	648,019.12
Cash In	900,000.00	900,000.00	900,000.00	900,000.00	900,000.00	900,000.00
Cash On Hand	3,572,001.41	3,823,982.29	4,075,963.17	4,327,944.04	4,579,924.92	4,831,905.80

	2016					
	7	8	9	10	11	12
	100%	100%	100%	100%	100%	100%
Income						
Sales	900,000.00	900,000.00	900,000.00	900,000.00	900,000.00	900,000.00
COGS						
COGS	328,500.00	328,500.00	328,500.00	328,500.00	328,500.00	328,500.00
Expenses						
Director fees	9,522.00	9,522.00	9,522.00	9,522.00	9,522.00	9,522.00
Laundry	5,780.00	5,780.00	5,780.00	5,780.00	5,780.00	5,780.00
Other supplies	8,222.00	8,222.00	8,222.00	8,222.00	8,222.00	8,222.00
Marketing	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00
Wages & Benefits	120,833.33	120,833.33	120,833.33	120,833.33	120,833.33	120,833.33
Business/Travel	850.00	850.00	850.00	850.00	850.00	850.00
Dues/Subscrip.	433.00	433.00	433.00	433.00	433.00	433.00
Debt Servicing	4,891.54	4,891.54	4,891.54	4,891.54	4,891.54	4,891.54
Total Expenses	151,531.87	151,531.87	151,531.87	151,531.87	151,531.87	151,531.87
Income Before Taxes	**419,968.13**	**419,968.13**	**419,968.13**	**419,968.13**	**419,968.13**	**419,968.13**
Taxes Due	167,987.25	167,987.25	167,987.25	167,987.25	167,987.25	167,987.25
Cash Out	648,019.12	648,019.12	648,019.12	648,019.12	648,019.12	648,019.12
Cash In	900,000.00	900,000.00	900,000.00	900,000.00	900,000.00	900,000.00
Cash On Hand	5,083,886.68	5,335,867.56	5,587,848.43	5,839,829.31	6,091,810.19	6,343,791.07
				Year 2 Pre-tax Income		**5,039,617.56**

		2016					
		1	2	3	4	5	6
Loan Principal Balance	250,000.00	202,489.56	198,694.84	194,879.56	191,043.63	187,186.91	183,309.30
Principal Payment		3,774.27	3,794.72	3,815.27	3,835.94	3,856.72	3,877.61
Interest Payment		1,117.26	1,096.82	1,076.26	1,055.60	1,034.82	1,013.93
Total Loan Payment		4,891.54	4,891.54	4,891.54	4,891.54	4,891.54	4,891.54

	7	8	9	10	11	12
Loan Principal Balance	179,410.69	175,490.96	171,550.00	167,587.69	163,603.92	159,598.57
Principal Payment	3,898.61	3,919.73	3,940.96	3,962.31	3,983.77	4,005.35
Interest Payment	992.93	971.81	950.58	929.23	907.77	886.19
Total Loan Payment	4,891.54	4,891.54	4,891.54	4,891.54	4,891.54	4,891.54

	2017					
	1	2	3	4	5	6
	100%	100%	100%	100%	100%	100%
Income						
Sales	900,000.00	900,000.00	900,000.00	900,000.00	900,000.00	900,000.00
COGS						
COGS	328,500.00	328,500.00	328,500.00	328,500.00	328,500.00	328,500.00
Expenses						
Director fees	9,522.00	9,522.00	9,522.00	9,522.00	9,522.00	9,522.00
Laundry	5,780.00	5,780.00	5,780.00	5,780.00	5,780.00	5,780.00
Other supplies	8,222.00	8,222.00	8,222.00	8,222.00	8,222.00	8,222.00
Marketing	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00
Wages & Benefits	125,000.00	125,000.00	125,000.00	125,000.00	125,000.00	125,000.00
Business/Travel	850.00	850.00	850.00	850.00	850.00	850.00
Dues/Subscrip.	433.00	433.00	433.00	433.00	433.00	433.00
Debt Servicing	4,891.54	4,891.54	4,891.54	4,891.54	4,891.54	4,891.54
Total Expenses	155,698.54	155,698.54	155,698.54	155,698.54	155,698.54	155,698.54
Income Before Taxes	**415,801.46**	**415,801.46**	**415,801.46**	**415,801.46**	**415,801.46**	**415,801.46**
Taxes Due	166,320.59	166,320.59	166,320.59	166,320.59	166,320.59	166,320.59
Cash Out	650,519.12	650,519.12	650,519.12	650,519.12	650,519.12	650,519.12
Cash In	900,000.00	900,000.00	900,000.00	900,000.00	900,000.00	900,000.00
Cash On Hand	6,593,271.94	6,842,752.82	7,092,233.70	7,341,714.58	7,591,195.46	7,840,676.33

	2017						
	7	8	9	10	11	12	**Total**
	100%	100%	100%	100%	100%	100%	
Income							
Sales	900,000.00	900,000.00	900,000.00	900,000.00	900,000.00	900,000.00	**32,400,000.00**
COGS							
COGS	328,500.00	328,500.00	328,500.00	328,500.00	328,500.00	328,500.00	**11,826,000.00**
Expenses							
Director fees	9,522.00	9,522.00	9,522.00	9,522.00	9,522.00	9,522.00	
Laundry	5,780.00	5,780.00	5,780.00	5,780.00	5,780.00	5,780.00	
Other supplies	8,222.00	8,222.00	8,222.00	8,222.00	8,222.00	8,222.00	
Marketing	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	
Wages & Benefits	125,000.00	125,000.00	125,000.00	125,000.00	125,000.00	125,000.00	
Business/Travel	850.00	850.00	850.00	850.00	850.00	850.00	
Dues/Subscrip.	433.00	433.00	433.00	433.00	433.00	433.00	
Debt Servicing	4,891.54	4,891.54	4,891.54	4,891.54	4,891.54	4,891.54	
Total Expenses	155,698.54	155,698.54	155,698.54	155,698.54	155,698.54	155,698.54	**5,455,147.33**
Income Before Taxes	**415,801.46**	**415,801.46**	**415,801.46**	**415,801.46**	**415,801.46**	**415,801.46**	**15,118,852.67**
Taxes Due	166,320.59	166,320.59	166,320.59	166,320.59	166,320.59	166,320.59	
Cash Out	650,519.12	650,519.12	650,519.12	650,519.12	650,519.12	650,519.12	
Cash In	900,000.00	900,000.00	900,000.00	900,000.00	900,000.00	900,000.00	
Cash On Hand	8,090,157.21	8,339,638.09	8,589,118.97	8,838,599.84	9,088,080.72	9,337,561.60	
				Year 3 Pre-tax Income			**4,989,617.56**

		2017					
		1	2	3	4	5	6
Loan Principal Balance	250,000.00	155,571.53	151,522.67	147,451.88	143,359.04	139,244.03	135,106.73
Principal Payment		4,027.04	4,048.86	4,070.79	4,092.84	4,115.01	4,137.30
Interest Payment		864.49	842.68	820.75	798.70	776.53	754.24
Total Loan Payment		4,891.54	4,891.54	4,891.54	4,891.54	4,891.54	4,891.54

	7	8	9	10	11	12
Loan Principal Balance	130,947.02	126,764.78	122,559.89	118,332.22	114,081.65	109,808.05
Principal Payment	4,159.71	4,182.24	4,204.89	4,227.67	4,250.57	4,273.59
Interest Payment	731.83	709.30	686.64	663.87	640.97	617.94
Total Loan Payment	4,891.54	4,891.54	4,891.54	4,891.54	4,891.54	4,891.54

APPENDIX B

YEAR 1 BALANCE SHEET

NICHE (GRN & ACE Model)
Balance Sheet

Unaudited

		2015
ASSETS		
CURRENT		
Cash	$	3,320,021
Accounts Receivable		-
Deposits and Prepaid Expenses		-
Inventory		-
		3,320,021
PROPERTY, PLANT, & EQUIPMENT		50,000
INVESTMENTS		-
		3,370,021
LIABILITIES		
CURRENT LIABILITIES		
Line of Credit	$	-
Accounts Payable and Accrued Liabilities		-
Long-term debt - current portion		46,665
Income Tax Payable		-
		46,665
LONG-TERM DEBT		159,599
		206,264
SHAREHOLDER'S EQUITY		
CONTRIBUTED CAPITAL		150,000
RETAINED EARNINGS (DEFICIT)		3,013,757
		3,163,757
		3,370,021

APPENDIX C

YEAR 1 INCOME STATEMENT

NICHE (GRN & ACE Model)
Statement of Income and Retained Earnings
For The Year Ended

UNAUDITED

	2015
REVENUE	$ 10,800,000
COST OF SALES	
Opening Inventory	-
Purchases	3,942,000
	3,942,000
Closing Inventory	-
	3,942,000
GROSS PROFIT	6,858,000
OPERATING EXPENSES	1,768,382
INCOME FROM OPERATIONS	5,089,618
OTHER INCOME (EXPENSES)	
Loss on disposal of property, plant and equipment	-
Gain on sale of investment	-
Miscellaneous	(40,014)
	(40,014)
NET INCOME BEFORE TAXES	5,049,604
INCOME TAX EXPENSE	2,035,847
NET INCOME	3,013,757
(DEFICIT) - Beginning of Year	-
DIVIDENDS	-
RETAINED EARNINGS (DEFICIT) - End of Year	$ 3,013,757

APPENDIX D

YEAR 1 STATEMENT OF CASH FLOWS

NICHE (GRN & ACE Model)
Statement of Cash Flow
For the Year Ended

UNAUDITED

	2015
CASH FLOWS FROM OPERATING ACTIVITES	
Net income for the year	$ 3,013,757
Adjustment for:	
Amortization	-
Loss on disposal of property, plant and equipment	-
Gain on disposal of investment	-
Cash derived from operations	3,013,757
Decrease (increase) in working capital items	
Accounts receivable	-
Deposits and prepaid expenses	-
Inventory	-
Accounts payable and accrued liabilities	-
Long-term debt - current portion	-
Income tax payable	-
Cash flows from operating activities	3,013,757
CASH FLOWS FROM INVESTING ACTIVITIES	
Acquisition of property, plant and equipment	(50,000)
Proceeds from disposal of property, plant and equipment	-
Proceeds from disposal of investment	-
Dividends	-
Cash flows from investing activities	(50,000)
CASH FLOWS FROM FINANCING ACTIVITIES	
Advances from (repayments to) shareholder	150,000
Acquisition of (repayment of) long-term debt	206,264
	356,264
NET INCREASE (DECREASE) IN CASH RESOURCES	3,320,021
CASH (DEFICIENCY) RESOURCES - Beginning of Year	-
CASH RESOURCES (DEFICIENCY) - End of Year	$ 3,320,021

APPENDIX E

VALUATION

Valuation

Venture Capital Valuation Method	
Terminal Net Income	$209,550.00
Terminal Value	$2,305,050.00
Estimated PV of Company	$428,588.16
Shares to Issue to Investor	0
Share Price	#DIV/0!

DCF Valuation Method

DCF NPV $13,045,418.89

Year	Income From Operations	PV of Cash Flow	Residual
0	-$133,750.00	-$133,750.00	
1	$5,089,617.56	$3,635,441.11	
2	$5,039,617.56	$2,571,233.45	
3	$4,989,617.56	$1,818,373.74	
			$5,154,120.59

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