Specific Aims:

Currently over 31,000 assisted living (AL) settings nationwide serve almost 750,000 older adults. Nearly 40% of residents in ALs require assistance with three or more activities of daily living (ADLs) and the majority need help with meal preparation and medication management. They have multiple chronic conditions and an average length of stay of two years. Residents in ALs are sedentary and experience functional decline beyond what is expected from disease progression. This decline is multifactorial and due to resident, caregiver and setting related factors. Caregiving staff tend to limit residents activities as they fear residents might fall and/or they might be reprimanded for not getting care tasks done quickly. Limited physical activity increases residents’ risk for falls, pain, pressure ulcers and hospitalizations and decreases quality of life.

To prevent functional decline we developed a four-step theory-based approach, Function Focused Care for AL (FFC-AL), which was implemented by a Research Nurse Facilitator. In randomized controlled trials we demonstrated that residents maintained or improved function, increased physical activity and were less likely to be transferred to the hospital. Direct care workers exposed to FFC-AL showed improved knowledge and beliefs about function focused care and provided more function focused care to residents.

Disseminating and implementing evidence-based care approaches such as FFC-AL across any health care system occurs slowly and is challenging. To facilitate dissemination and implementation of FFC-AL we pilot tested an approach in which we trained setting-based champions and worked with them monthly for 12 months to integrate our four-step FFC-AL intervention. At 12 months there were changes in AL environments, policies and service plan formats to facilitate function and physical activity, and the number of residents transferred to acute care settings for non-fall associated events decreased. In both studies only the setting champions worked with us and 20% of the settings did not participate in any of the FFC-AL activities. We did not consider if function focused care was disseminated to direct care workers within settings; what impact FFC-AL had on residents in terms of function and physical activity; goals were not developed by a stakeholder team (staff, residents and families); and we did not evaluate the processes associated with implementation of FFC-AL or differences between settings that were early, late or non-adopters. To overcome these weaknesses we propose a randomized controlled dissemination and implementation trial including 96 AL settings testing our revised FFC-AL intervention, FFC-AL-EIT. FFC-AL-EIT is guided by the Evidence Integration Triangle (EIT) model. The EIT combines a participatory implementation process that includes all stakeholders, uses practical progress measures and incorporates key components of an effective intervention. The Reach, Effectiveness, Adoption, Implementation and Setting (RE-AIM) model will be used to evaluate successful translation based on: Reach to the intended target; Efficacy of the intervention; Adoption by staff and settings; Implementation consistency, costs and adaptations; and Maintenance of in settings over time. The aims include:

**Aim 1: To test the implementation of FFC-AL-EIT.** Research question: Do settings exposed to FFC-AL-EIT demonstrate evidence of implementation over an 18 month period based on Reach, Effectiveness, Adoption, Implementation, and Maintenance (RE-AIM) criteria? For Reach: Descriptions of settings volunteering/number invited; number of direct care workers and residents exposed. For Effectiveness: Resident Level Outcomes: Hypothesis 1: Residents in FFC-AL-EIT settings will maintain or improve function and physical activity and have fewer falls and transfers compared to residents in settings exposed to Function Focused Care-Education Only (FFC-EO) at 4 and 12 months post implementation of the intervention. Setting Level Outcomes: Hypothesis 2: FFC-AL-EIT settings will demonstrate improvements in environments and policies supporting function focused care and service plans will reflect a greater number of function focused care activities at 4 and 12 months post-implementation when compared to FFC-EO settings. For Adoption: Evidence of changes in settings and comparisons between early, late and non-adopters. For Implementation: Delivery, receipt and enactment of intervention activities and setting based adjustments. For Maintenance: Hypothesis 3: Settings exposed to FFC-AL-EIT will maintain or improve environments, policies and service plans that support function focused care at 18 months post implementation of FFC-AL-EIT compared to FFC-EO settings.

**Aim 2: Evaluation of the feasibility, utility and cost of FFC-AL-EIT.** Using descriptive and qualitative data captured during the intervention and focus groups 12 months post implementation of FFC-AL-EIT, we will evaluate the EIT strategy and our participatory implementation process with stakeholders and direct care workers. We will determine the costs of the implementation process using an activity-based costing method.

Currently there are no established methods to successfully disseminate and implement effective care approaches into assisted living settings. This study will add new information about ways in which to reach and engage staff within settings, identify barriers and challenges and assure that care approaches are maintained over time. This approach will then become a model for dissemination and implementation of evidence based interventions in AL and other long-term care settings.