Medical University of South Carolina
CONSENT TO BE A RESEARCH SUBJECT

TITLE OF RESEARCH:

Palliative care telehealth delivered Program of SUPPORT-D Intervention for persons with Alzheimer's Disease and caregivers Phase 2

Person with Alzheimer's Disease or Mild Cognitive Impairment Consent

Principal Investigator: Diana Layne, PhD

NCT#05501119

Concise Summary

You are being asked to volunteer for a research study. Research studies are voluntary, and you do not have to participate. The purpose of this research study is to help us better understand if a Program of SUPPORT Intervention may be helpful to persons diagnosed with Alzheimer's or a Mild Cognitive Impairment (MCI) and their caregivers. The 6-week SUPPRT-D program provides educational information for both the Caregiver and Person with Alzheimer's or MCI to assist with planning as the disease progresses.

If you agree to volunteer for this study, you, or you and your Caregiver, will both be asked to complete some questionnaires, you or you and your caregiver, will be sent written information and will review it bi-weekly for 6 weeks with a nurse over telehealth. There will be 5 telehealth visits over 8 weeks, each visit will be about 45-60 minutes.

There may be no direct benefit to you by participating in this research. Potential risks from participating in this research study include loss of confidentiality and privacy. It is possible that some of the questions asked could be emotionally upsetting. You can refuse to answer any questions. If you are interested in learning more about this study, please continue to read below.

A. PURPOSE OF THE RESEARCH

Please read this consent form carefully and take your time making your decision. As your study doctor or study staff discusses this consent form with you, please ask him/her to explain any words or information that you do not clearly understand. You are being asked to participate in this study because you are over the age of 18 and have been diagnosed with Alzheimer's or Mild Cognitive Impairment (MCI). This study hopes to learn more about how a useful a Program of SUPPORT might be for Caregivers and their loved ones with a recent Alzheimer's or MCI diagnosis. The program provides information on the disease progression, safety concerns and future care and planning. This study is sponsored by South Carolina Translational Research at the Medical University of South Carolina. The investigator in charge of this study at MUSC is Dr. Diana Layne. Approximately 60 people (30 pairs of people with Alzheimer's/MCI and their caregivers) will take part in this study.

B. PROCEDURES

To be eligible to participate in this study, you must be:

1. *18 years old or older*
2. *Diagnosis of Alzheimer's Disease or suspected Alzheimer's disease or Mild Cognitive Impairment*
3. *Able to read and speak English (written materials in English)*

If you agree to be in this study, the following will happen:

1. **Visit 1:** After the Informed Consent is complete you will be asked to complete questionnaires and provide personal information about yourself. This will include demographic information, questionnaires about your Alzheimer's Disease knowledge, Stress level, anxiety, depression, sleep, fatigue, and overall physical functioning. These questionnaires can be completed in person, over the phone, via telehealth, or electronically (About 45-60 minutes). After this visit you and your loved one will be sent informational materials (and a Tablet, if needed for use during the project).
2. **Visit 2:** After the materials are received, you will meet with the research staff (within 1-2 weeks of enrollment) for an orientation to using the technology (and Tablet if applicable) you will use for future meetings with the nurse. (45-60 minutes) You will be asked to review written materials (parts 1 and 2) for the nurse meeting (within the next 2 weeks).
4. **Visit 3:** At week 3 of the study, you will meet with the Nurse via telehealth for an in-depth review of parts 1- 2 of the materials (60 minutes) and you will be asked to review parts 3 and 4 for the next nurse meeting which will take places within 3 weeks.
5. **Visit 4:** Within 3 weeks of Visit 3 you will meet again with the Nurse for in depth review of parts 3-4 of the materials. The meeting will take place via telehealth and be about 60 minutes.
6. Final **Visit 5 (Week 8):** Within 2 weeks of the last Visit 4 you will be asked to complete the same surveys from Visit 1: about your Alzheimer's Disease knowledge, stress level, anxiety, depression, sleep, fatigue and overall physical functioning. These questionnaires can be completed in person, over the phone, via telehealth, or electronically (About 45-60 minutes). If you used a Tablet provided by MUSC you will return it.
7. **Post-intervention interviews:** 10 pairs of enrolled participants that agree to be interviewed will be chosen at random to complete a post-study interview. The interview will be audio-recorded and last about 45-60 minutes. During the interview, we will ask you and your loved one for feedback on your experience during the study. The interviews can be conducted in person, through a video conference or over the phone. Only the audio portion of the interview will be recorded regardless of where it is completed.

C. DURATION

Participation in the study will be 5 visits over a period of 8 weeks.

D. RISKS AND DISCOMFORTS

There is a risk of a loss of confidentiality of your personal information as a result of participation in this study.

Loss of privacy: There is a risk of loss of privacy from participation in this study. Your privacy is very important to us, and we will make every effort to protect it. However, your information will be coded to help protect your identity.

All research records gathered from your medical record, from questionnaires, and from the interview will have any information that could directly identify you will be removed.

Emotional distress: Some of the questions in the surveys may be upsetting or make you feel uncomfortable. You can always refuse to answer a question. You may find some of the information on disease progression and symptoms distressing.

Physical fatigue: Completing the questionnaires and Nurse meetings may be tiring for some participants. You will be given ample time to complete the questionnaires and you may take breaks throughout the process.

E. MEDICAL RECORDS AND/OR CERTIFICATE OF CONFIDENTIALITY

Information about your study participation will not be in your medical record. This means that neither your research participation nor any of your research results will be included in any MUSC medical record.

F. BENEFITS

There will be no direct benefit to you from participating in this study. However, it is hoped that the information gained from the study will help in the treatment of future patients with similar conditions will help the researcher learn more about providing helpful information and how to best help caregivers and people diagnosed with Alzheimer's or Mild Cognitive Impairment plan for the future. We hope you and your loved one may find some of the information provided useful.

G. COSTS

If you use your own device for meetings and surveys, normal cellular and data usage rates will apply to your mobile device charges. You may incur costs related to study participation as a result of downloading and using the MS Teams app for study visits.

H. PAYMENT TO PARTICIPANTS

In return for your time and effort, you and your loved one will be paid for participation in this study.

You and your loved one will receive up to $100 in total as a pair in $25 increments over four time periods (enrollment/baseline data collection, study visit 1, study visit 2, and post intervention visit) with pairs participating in key informant interviews receiving an additional $25 as a pair. Payment is in the form of gift cards. If you are participating without a Caregiver, the payment is the same as described.

Payments that you receive from MUSC for participating in a research study are considered taxable income per IRS regulations. Payment types may include, but are not limited to checks, cash, gift certificates/cards, personal property, and other items of value. If the total amount of payment you receive from MUSC reaches or exceeds $600.00 in a calendar year, you will be issued a Form 1099.

I. ALTERNATIVES

Your alternative is to not participate in this study.

J. DATA SHARING

Information about you (including your identifiable private information) may have all of your identifiers removed and used for future research studies or distributed to other researchers for future research without additional informed consent from you or your legally authorized representative.

K. DISCLOSURE OF RESULTS

The researchers will share overall results of in scientific presentation and publications. Your individual results will not be disclosed.

L. AUTHORIZATION TO USE AND DISCLOSE (RELEASE) MEDICAL INFORMATION

As part of this research study the research team will keep records of your participation in this study.

The health information MUSC may use or disclose (release) for this research study includes information in your medical record, results of physical exams, medical history, lab tests or certain health information indicating or relating to your condition.

Your study doctor and his/her research team will use and disclose (release) your health information to conduct this study. The health information listed above may be used by and/or disclosed (released) to the following, as applicable:

- The sponsor of the study including its agents such as data repositories or contract research organizations monitoring the study;
- Other institutions and investigators participating in the study;
- Data Safety Monitoring Boards;
- Accrediting agencies;
- Clinical staff not involved in the study who may become involved if it is relevant;

- Parents of minor children if less than 16 years old. Parents of children 16 years old or older require authorization from the child; or
- Health insurer or payer in order to secure payment for covered treatment;
- Federal and state agencies and MUSC committees having authority over the study such as:

    - The Institutional Review Board (IRB) overseeing this study; Committees with quality improvement responsibilities; Office of Human Research Protections; Food and Drug Administration; National Institutes of Health or Other governmental offices, such as a public health agency or as required by law.

Those persons whom receive your health information may not be required by Federal privacy laws (such as the Privacy Rule) to protect it and may share your information with others without your permission, if permitted by laws governing them. You do not have to sign this consent form. If you choose not to sign, it will not affect your treatment, payment or enrollment in any health plan or affect your eligibility for benefits. However, you will not be allowed to be a participant in this research study.

You will be given a copy of this consent form. Your authorization will expire at the conclusion of this study or, if you are participating in a study designed for the development of a drug or device, your authorization will remain in effect until the drug or device is approved by the FDA or until the company's application to study the drug/device is withdrawn. You have the right to withdraw your agreement at any time. You can do this by giving written notice to your study doctor. If you withdraw your agreement, you will not be allowed to continue participation in this research study. However, the information that has already been collected will still be used and released as described above. You have the right to review your health information that is created during your participation in this study. After the study is completed, you may request this information.

Your health information will be used or disclosed when required by law. Your health information may be shared with a public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury or disability and for conducting public health surveillance, investigations or interventions. No publication or public presentation about the research study will reveal your identity without another signed authorization from you.

If you have questions or concerns about this Authorization or your privacy rights, please contact MUSC's Privacy Officer at (843) 792-8740.

Regulations require that you be given a copy of the MUSC Notice of Privacy Practices (NPP) describing the practices of MUSC regarding your health information. One can be found at the end of this form.

M. EMPLOYEE PARTICIPATION

Your participation or discontinuance will not constitute an element of your job performance or evaluation, nor will it be a part of your personnel record at this Institution.

N. FUTURE CONTACT
The researcher in charge of this study might like to contact you in the future about other research opportunities. Please initial by your choice below for paper consents, or scroll down to the bottom of the screen and select your choice electronically:

____Yes, I agree to be contacted

____No, I do not agree to be contacted

Results of this research will be used for the purposes described in this study. This information may be published, but you will not be identified. Information that is obtained concerning this research that can be identified with you will remain confidential to the extent possible within State and Federal law. The investigators associated with this study, the sponsor, and the MUSC Institutional Review Board for Human Research will have access to identifying information. All records in South Carolina are subject to subpoena by a court of law.

In the event that you are injured as a result of participation in this study, you should immediately go to the emergency room of the Medical University Hospital, or in case of an emergency go to the nearest hospital and tell the physician on call that you are in a research study. They will call your study doctor who will make arrangements for your treatment. If the study sponsor does not pay for your treatment, the Medical University Hospital and the physicians who render treatment to your child will bill your insurance company. If your insurance company denies coverage or insurance is not available, you will be responsible for payment for all services rendered to your child.

Your participation in this study is voluntary. You may refuse to take part in or stop taking part in this study at any time. You should call the investigator in charge of this study if you decide to do this. Your decision not to take part in the study will not affect your current or future medical care or any benefits to which you are entitled.

The investigators and/or the sponsor may stop your participation in this study at any time if they decide it is in your best interest. They may also do this if you do not follow the investigator's instructions.

Volunteers Statement

I have been given a chance to ask questions about this research study. These questions have been answered to my satisfaction. If I have any more questions about my participation in this study or study related injury, I may contact **Dr. Diana Layne at (843) 792-6825.** I may contact the Medical University of SC Patient and Family Care Liaison (843) 792-5555 concerning medical treatment.

If I have any questions, problems, or concerns, desire further information or wish to offer input about my rights as a research subject in this study, I may contact the Medical University of SC Institutional

Review Board for Human Research IRB Manager or the Office of Research Integrity Director at (843) 792-4148. This includes any questions about my rights as a research subject in this study.

I agree to participate in this study. I have been given a copy of this form for my own records.

If you wish to participate, please sign below for paper consents or scroll to the bottom of the screen to provide an electronic signature.

_____ _____
Signature of Person Obtaining Consent Date *Printed Name of Participant

_____

Signature of Participant Date

_____
Signature of Participant's Personal Representative (if applicable) Date

_____
Printed Name of Personal Representative (if applicable)

Relationship: ___ Spouse ___ Parent ___Next of Kin ___Legal Guardian* ____ DPOA for Healthcare*

**(If you are the health care agent or guardian, please provide proof of your authority to act on behalf of the patient)*

MUSC Medical University of South Carolina

NOTICE OF PRIVACY PRACTICES

MUSC Organized Health Care Arrangement (OHCA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESSS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

UNDERSTANDING YOUR PROTECTED HEALTH INFORMATION (PHI)
The Medical University of South Carolina and its affiliates (including but not limited to the Medical University Hospital Authority, MUSC Physicians, MUSC Physicians Primary Care, MUSC Health Partners, MUSC Health Alliance, MUSC Strategic Ventures, LLC, and MUSC Strategic Ventures (MSV) Health, Inc.) participate in a clinically integrated health care setting. As a result of this clinical integration, these organizations function as an Organized Health Care Arrangement (OHCA) as defined by the Health Insurance Portability and Accountability Act (HIPAA). For purposes of this notice, the members of the MUSC OHCA are collectively referred to in this document as "MUSC." **We collect, receive, or share this information about your past, present or future health condition to provide health care to you, to receive payment for this health care, or to operate the hospital and/or clinics.**

OUR PLEDGE REGARDING YOUR HEALTH INFORMATION
MUSC is committed to protecting the privacy of health information we create and obtain about you. This Notice tells you about the ways in which we may use and disclose health information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of your health information. We are required by law to: (i) make sure your health information is protected; (ii) give you this Notice describing our legal duties and privacy practices with respect to your health information; and (iii) follow the terms of the Notice that is currently in effect.

HOW WE MAY USE AND RELEASE YOUR PROTECTED HEALTH INFORMATION (PHI) –

A. The following uses do NOT require your authorization, except where required by SC law:
1. For treatment. Your PHI may be discussed by caregivers to determine your plan of care. For example, the physicians, nurses, medical students and other health care personnel may share PHI in order to coordinate the services you may need.
2. To obtain payment. We may use and disclose PHI to obtain payment for our services from you, an insurance company or a third party. For example, we may use the information to send a claim to your insurance company.
3. For health care operations. We may use and disclose PHI for hospital and/or clinic operations. For example, we may use the information to review our treatment and services and to evaluate the performance of our staff in caring for you.
4. Business Associates. Your medical information could be disclosed to people or companies outside our Health System who provide services. These companies typically are required to sign special confidentiality agreements before accessing your information. They are also subject to fines by the federal government if they use/disclosure your information in a way that is not allowed by law.
5. For public health activities. We report to public health authorities, as required by law, information regarding births, deaths, various diseases, reactions to medications and medical products.
6. Victims of abuse, neglect, domestic violence. Your PHI may be released, as required by law, to the South Carolina Department of Social Services when cases of abuse and neglect are suspected.
7. Health oversight activities. We will release information for federal or state audits, civil, administrative or criminal investigations, inspections, licensure or disciplinary actions, as required by law.
8. Judicial and administrative proceedings. Your PHI may be released in response to a subpoena or court order.
9. Law enforcement or national security purposes. Your PHI may be released as part of an investigation by law enforcement or for continuum of care when in the custody of law enforcement.
10. Military and Veterans. If you are a member of the U.S. or foreign armed forces, we may release your medical information as required by military command authorities.
11. Uses and disclosures about patients who have died. We may provide medical information to coroners, medical examiners and funeral directors so they may carry out their duties.
12. For purposes of organ donation. As required by law, we will notify organ procurement organizations to assist them in organ, eye or tissue donation and transplants.
13. Research. We may use and disclosure your medical information for research purposes. Most research projects are subject to Institutional Review Board (IRB) approval. The law allows some research to be done using your medical information without requiring your written approval.
14. To avoid harm. In order to avoid a serious threat to the health or safety of a person or the public, we may release limited information to law enforcement personnel or persons able to prevent or lessen such harm.
15. For workers compensation purposes. We may release your PHI to comply with workers compensation laws.
16. Marketing. We may send you information on the latest treatment, support groups, reunions, and other resources affecting your health.
17. Fundraising activities. We may use your PHI to communicate with you to raise funds to support health care services and educational programs we provide to the community. You have the right to opt out of receiving fundraising communications with each solicitation.
18. Appointment reminders and health-related benefits and services. We may contact you with a reminder that you have an appointment.
19. Disaster Relief Efforts. We may disclose your medical information to an entity assisting in disaster relief efforts so that your family can be notified about your condition.
Note: incidental uses and disclosures of PHI sometimes occur and are not considered to be a violation of your rights. Incidental uses or disclosures are by-products of otherwise permitted uses or disclosures which are limited in nature and cannot be reasonably prevented.

B. You may object to the following uses of PHI:
1. Inpatient hospital directories. Unless you tell us not to, we may include your name, location, general condition and religious affiliation in our patient directory so your family, friends and clergy can visit you and know how you are doing.

2. Information shared with family, friends or others. Unless you tell us not to, we may release your PHI to a family member, friend, or other person involved with your care or the payment for your care.
3. Health plan. You have the right to request that we not disclose certain PHI to your health plan for health services or items when you pay for those services or items in full.

C. Your prior written authorization is required (to release your PHI) in the following situations:
You may revoke your authorization by submitting a written notice to the privacy contact identified below. If we have a written authorization to release your PHI, it may occur before we receive your revocation.
1. Any uses or disclosures beyond treatment, payment or healthcare operations and not specified in parts A & B above.
2. Mental Health Records unless permitted under an exception in section A.
3. Substance Use Disorder Treatment records unless permitted under an exception in section A.
4. Any circumstance where we seek to sell your information.

WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

Although your health record is the physical property of MUSC, the information belongs to you, and you have the following rights with respect to your PHI:
A. The Right to Request Limits on How We Use and Release Your PHI. You have the right to ask that we limit how we use and release your PHI. We will consider your request, but we are not always legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. Your request must be in writing and state (1) the information you want to limit; (2) whether you want to limit our use, disclosure or both; (3) to whom you want the limits to apply, for example, disclosures to your spouse; and (4) an expiration date**.**
B. The Right to Choose How We Communicate PHI with You. You have the right to request that we communicate with you about PHI and/or appointment reminders in a certain way or at a certain location (for example, sending information to your work address rather than your home address). You must make your request in writing and specify how and where you wish to be contacted. We will accommodate reasonable requests.
C. The Right to See and Get Copies of Your PHI. You have the right to inspect and/or receive a copy (an electronic or paper copy) of your medical and billing records or any other of our records used to make decisions about your care. You must submit your request in writing. If you request a copy of this information, we may charge a cost-based fee. MUSC will act on a request for access or provide a copy usually within 30 days of receipt of the request. We may deny your request in limited circumstances. If you are denied access to your records, you may request that the denial be reviewed by a licensed health care professional. Additionally, we may use and disclose information through our secure patient portal which may allow you to view and communicate with certain health care providers in a secure manner. For more information see our https://mychart.musc.edu/mychart/
D. The Right to Get a List of Instances of When and to Whom We Have Disclosed Your PHI. This list may not include uses such as those made for treatment, payment, or health care operations, directly to you, to your family, or in our facility directory as described above in this Notice of Privacy Practices. This list also may not include uses for which a signed authorization has been received or disclosures made more than six years prior to the date of your request.
E. The Right to Amend Your PHI. If you believe there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we amend the existing information or add the missing information. You must provide the request and your reason for the request in writing. We may deny your request in writing if the PHI is correct and complete or if it originated in another facility's record. Notification will be provided within 60 days.
F. The Right to Receive a Paper or Electronic Copy of This Notice: You may ask us to give you a copy of this Notice at any time. For the above requests (and to receive forms) please contact: Health Information Services (Medical Records), Attention: Release of Information / 169 Ashley Avenue / MSC 349 / Charleston, SC 29425. The phone number is (843) 792-3881.
G. The Right to Revoke an Authorization. If you choose to sign an authorization to release your PHI, you can later revoke that authorization in writing. This revocation will stop any future release of your health information except as allowed or required by law.
H. The Right to be Notified of a Breach. If there is a breach of your unsecured PHI, we will notify you of the breach in writing.

HEALTH INFORMATION EXCHANGES

MUSC, along with other health care providers, belongs to health information exchanges. These information exchanges are used in the diagnosis and treatment of patients. As a member of these exchanges, MUSC shares certain patient health information with other health care providers. Should you require treatment at another location that is a part of one of these exchanges, that provider may gather historical health information to assist with your treatment. You have the option of saying that this cannot be done. If you choose not to take part in these alliances, please contact the MUSC Privacy Office at 792-4037.

HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think your privacy rights may have been violated, or you disagree with a decision we made about access to your PHI, you may file a complaint with the office listed in the next section of this Notice. **Please be assured that you will not be penalized and there will be no retaliation for voicing a concern or filing a complaint. We are committed to the delivery of quality health care in a confidential and private environment.**

PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you have any questions about this Notice or any complaints about our privacy practices please call the Privacy Officer (843) 792-4037, the Privacy Hotline (800) 296-0269, or contact in writing: HIPAA Privacy Officer / 169 Ashley Avenue / MSC 332 / Charleston SC 29425. You also may send a written complaint to the U.S. Dept. of Health and Human Services, Office for Civil Rights. The address will be provided at your request or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

CHANGES TO THIS NOTICE

We reserve the right to change the terms of this Notice at any time. The changes will apply to all existing PHI we have about you.. This Notice will always contain the effective date and may be reviewed at http://academicdepartments.musc.edu/musc/about/compliance/privacy.html

EFFECTIVE DATE OF THIS NOTICE

This Notice went into effect on April 14, 2003 and was last revised on August 2018.