1. **What is the amount of the licensing fee that Johns Hopkins will charge to the national lead organization?**

   The amount of the licensing fee that Johns Hopkins charges to the national lead organization will be negotiated as part of the contracting process. Johns Hopkins will take into account the organization’s tax status (i.e. for-profit vs. nonprofit) and its overall financial resources when negotiating the fee. This fee is intended to cover Johns Hopkins’ costs of monitoring program fidelity and supporting local sites, including training. Johns Hopkins does not make any profit from charging this fee.

2. **How will the licensing fees charged to the sites work? How soon will the national lead organization be able to collect fees, and will it collect fees for new sites only or also for existing sites? What factors has Johns Hopkins considered when setting these rates to date, and how frequently have the rates changed?**

   The national lead organization will assume the ability to collect licensing fees as soon as the contract between Johns Hopkins and the national lead organization is finalized; this will include fees charged to new sites that join the program after that date, as well as relicensing fees charged to existing sites that renew their participation after that date. Please note that some existing sites will not be due for re-licensing for several years. The national lead organization will retain the entirety of the licensing fees unless the contract between the national lead organization and Johns Hopkins states otherwise. The licensing fee has both increased and decreased over time, and the timing of the fee in relation to the execution and renewal of the professional services agreement between Johns Hopkins and the sites has also varied. It will be up to the national lead organization to set the license fee and renewal process, and Johns Hopkins is open to recommendations in the RFP proposals.

3. **How many sites have started implementation or terminated participation over the last few years? What were the reasons for termination?**

   There has been a steady increase in the number of sites beginning their first implementation year over the last several years, with eight new sites starting in 2020 and 13 new sites starting in 2021. The number of new sites has surpassed the number of sites terminating participation (two in 2020 and five in 2021). Stated reasons for termination included the ending of grant funding to the site and insufficient staff capacity at the site.
4. **How many sites does the existing Johns Hopkins CAPABLE staffing support, and how many staff currently support scaling efforts?**

Johns Hopkins currently has five staff—with hours equal to 1.7 FTE—who support the administration of the CAPABLE program at more than 40 existing sites as well as scaling efforts. The exact staffing is: Director of Implementation and Evaluation 2 days/week; Clinician Training Specialist 2.5 days/week; Director of Strategic Partnerships 2 days/week; Administrative Associate 1 day/week; Tech Support 1 day/week. Staff report working more than their designated hours many weeks, based on the number of potential and active sites, need for support during training and implementation, legislative and advocacy work.

5. **What is the typical level of effort and time required to transition a site from expressing initial interest to signing an agreement, and what typical level of effort is required to sustain sites once they have started implementing the program? How much support do sites typically need to secure funding? How many philanthropic organizations have been involved in funding sites?**

There is no ‘typical’ level of time and effort to transition, start-up or sustain a CAPABLE site – it is highly variable, depending on the site sophistication and experience with similar programs. It may take the program manager 5-8 hours/week or more, in some cases (up to 20 hours/week). Sites generally receive initial guidance (e.g., one hour telephone call with a Johns Hopkins team member) and then they pursue funding options on their own. Again, time and effort are variable. Johns Hopkins is aware of at least three distinct philanthropic organizations supporting sites, but there may be additional ones.

6. **What will the ongoing role of Johns Hopkins be? Will current CAPABLE staff continue to support the program? If so, how will that affect the amount of Rita and Alex Hillman Foundation grant funding potentially available to the national lead organization?**

Current CAPABLE staff will be available during a transition period to provide technical assistance and support to the national lead organization, and the Rita and Alex Hillman Foundation grant will continue to support their salaries during that time. The exact length of the transition period will be negotiated between Johns Hopkins and the national lead organization. After the transition period, Johns Hopkins will no longer dedicate those staff to support the CAPABLE program (some may remain employed by Johns Hopkins to support other work, but their salaries will no longer be supported by the Rita and Alex Hillman Foundation grant). At this time, if the lead organization is nonprofit, the Hillman funds would be available to cover salaries and other costs through the funding period. The national lead organization may choose to offer part-time or full-time employment to existing CAPABLE staff following the transition period.

Dr. Sarah Szanton will continue to serve in an oversight, consultative, and advisory capacity on an ongoing basis. She will require and review regular status and progress reports from the national lead organization and will provide direction and advice as needed. Johns Hopkins will also continue to oversee the five CAPABLE research sites.
7. **What is the reason for the 10% limit on indirect costs and the 25% limit on personnel benefits in the budget?**

The 10% limit on indirect costs is a requirement of the Rita and Alex Hillman Foundation grant. It does not apply to for-profit organizations that are not eligible for the grant. Non-profit organizations that are eligible for the grant may budget more than 10% indirect costs for their total budget; however, the total costs to which they apply pass-through funding from the Rita and Alex Hillman Foundation grant (a subset of the total budget) may not include more than 10% indirect costs. As a point of clarification: the 25% limit on personnel benefits that was included in the example budget table was an error; there is no such requirement. This note was inadvertently included in the budget table example, and organizations may include personnel benefits that exceed 25% of total personnel costs.

8. **Are there restrictions on the use of Rita and Alex Hillman Foundation grant funds (e.g. salary caps, travel and conference costs, etc.)?**

There are no up-front restrictions on these uses; however, if the selected national lead organization is eligible for pass-through funding, the Rita and Alex Hillman Foundation may require its own approval process for the use of funds prior to disbursal.

9. **Will eligibility for pass-through funding from the Rita and Alex Hillman Foundation grant differ if more than one nonprofit organization partners to submit a proposal, or if a nonprofit partners with a for-profit organization?**

If multiple non-profits partner to serve as the national lead organization, they will each be eligible to potentially receive pass-through funding from the Rita and Alex Hillman Foundation grant. However, the total amount of funding provided to Johns Hopkins through the grant is already set (an amount sufficient to sustain the current staffing model for two years); the number of organizations that partner to serve as the national lead organization will not affect this amount.

If a non-profit and for-profit organization partner to serve as the national lead organization, the non-profit will be eligible to potentially receive pass-through funding from the grant, but the for-profit organization will not. In this event, the non-profit will be required to keep documentation to clearly demonstrate that the Rita and Alex Hillman Foundation funding is used only for costs incurred by the non-profit entity and not by its for-profit partner.

10. **Is there a recommended range for the budget amount to include in the proposal? Will the national lead organization need to seek additional philanthropic funding to cover its costs?**

The budget amount that applicants include in their proposals will depend on their plans for staffing and resourcing the program and the amount of revenue they anticipate dedicating to it. The RFP provides the current Johns Hopkins staffing levels as a reference point, but the national lead organization will likely need to employ additional
staff in order to successfully scale the program. There are a variety of revenue sources that applicants may propose in their funding plan—including but not limited to Rita and Alex Hillman Foundation grant funding (for eligible non-profits), additional philanthropic funding, licensing fees charged to sites, shared savings payments negotiated with value-based care organizations, and reimbursement negotiated with health plans.

11. How open is Johns Hopkins to changes to the CAPABLE Model?
The current CAPABLE model is evidence-based and grounded by more than a decade of research. Johns Hopkins prioritizes model fidelity to ensure consistency in the quality of care and enable valid evaluations of the CAPABLE model. While Johns Hopkins is open to discussions of potential changes to the model, any significant changes (e.g. changing the number or type of staff who work with the older adult) will require advance review and approval by Johns Hopkins.

12. Does Johns Hopkins conduct trainings and share materials with participating sites virtually, or in-person/ hard copy? Does Johns Hopkins use a learning management system (LMS), and if so, will the national lead organization have access to that system?
All trainings are online/virtual. There is a Johns Hopkins system for tracking module completion by each clinician, and for tracking results on the post-course assessment for each clinician. The Johns Hopkins LMS was not designed to support growth in the program and would therefore not be an appropriate LMS for moving forward. The national lead organization would need to develop or purchase their own LMS or use an existing system that they have.

13. Which entity currently pays for the cost of materials and labor for the handy worker services? Is there a limit on the amount to be spent on those services?
Each individual site includes the handy worker costs in their budget. There is not a limit; however, the average cost of handy worker wages and supplies is about $1,300.00 per older adult. Larger home modifications such as putting a new roof on the home or a new boiler or wheelchair ramp ($5,000 or greater) are not considered part of CAPABLE.

14. What costs are included in the cost per older adult incurred by participating sites? Is this amount an average or an upper limit?
The historical average of the program costs over the past decade has been approximately $3,000 and is inclusive of all program costs, training, salaries, etc. Current estimates are that average costs per participant are closer to $4,000-$4,500. The licensed CAPABLE site is responsible for arranging logistics with the handy worker, including locating, hiring, training, and covering contract costs.

15. What scaling targets would be acceptable to Johns Hopkins?
Ultimately, Johns Hopkins aims to have CAPABLE available in every state or region of the U.S. Applicants should include achievable, short-term goals that show progress toward this aim in their proposal.
16. What scaling milestones has Johns Hopkins already met? What organizations has Johns Hopkins partnered with in this effort?
CAPABLE was tested in Baltimore, MD in research trials. Over the past decade, the program has grown from this original site to more than 40 sites in 21 states. Johns Hopkins has partnered with health systems and other health care settings, community-based organizations, housing agencies, government agencies, research entities, health plans/insurers, and accountable care organizations and other value-based care organizations. The map of current CAPABLE sites is available here.

17. Will Johns Hopkins transfer the ownership and costs of hosting the Research Electronic Data Capture (REDCap) system to the national lead organization?
REDCap is a web-based application developed by Vanderbilt University to capture data for clinical research and create databases and projects. It is Health Insurance Portability and Accountability Act (HIPAA)–compliant. REDCap stores its data and all system and project information in various relational database tables (i.e. utilizing foreign keys and indexes) within a single MySQL database, which is an open source RDBMS (relational database management system). The national organization will need to purchase REDCap, and the usual cost is about $2,000.

18. What is the typical FTE staffing of participating sites?
One full-time OT and 0.75 FTE RN can usually see up to 100 participants over a year. Sites also have a program manager (part-time, hours will vary). The handy worker is engaged as needed to meet the scheduling needs of participants.

19. Are sites able to bill Medicare for any activities conducted under the CAPABLE model?
CAPABLE is not a covered benefit under traditional Medicare; therefore, Medicare may NOT be billed. Medicare Advantage plans may apply to CMS to be able to offer CAPABLE as a supplemental benefit.

20. What are the “short white boards” referred to under task 2 in the statement of work?
The short white boards are animated white boards that address basic CAPABLE principles and clinical/operational issues such as what to do if a clinician encounters bed bugs, participant resistance, etc.

21. What is the definition of ‘clinical’ in the following qualification: “proven competency and capacity to administer an interdisciplinary, clinical program”?
In the context of this qualification, “clinical” refers to a program that explicitly aims to improve the health or function of patients or participants. The intervention used by the program to achieve those aims does not need to be a reimbursable medical service, nor does it need to utilize licensed medical professionals. However, the program’s primary mission should be related to health outcomes or function.
22. What training exists now within the CAPABLE model for OTs, RNs, handy workers, and program managers?
   Please refer to the Statement of Work section of the RFP for a detailed description of the training that the Johns Hopkins CAPABLE team currently provides to participating sites, for which the national lead organization will assume responsibility. The amount of training provided to program managers varies depending on previous experience running similar programs.

23. If the national lead organization modifies or creates new CAPABLE materials or other products, would the national lead organization own the intellectual property? CAPABLE © intellectual property is and will continue to be owned by JHU with all rights reserved.

24. What data does Johns Hopkins have on savings generated by CAPABLE compared to savings generated by other interventions?
   Studies to date have primarily examined clinical and cost outcomes with CAPABLE program implementation compared to 'usual care'. In some cases, studies have included descriptions of other models as well as CAPABLE; however, to our knowledge, head-to-head comparisons have not been reported.