CAC UNIVERSITY of INDIANAPOLIS

CENTER FOR AGING & COMMUNITY

April 20, 2018

Vincent Davis
State Survey Agency Director
665 Mainstream Drive, 2nd Floor
Nashville, TN 37243

Dear Mr. Davis,

The University of Indianapolis, a private higher education institution located in Indiana, has reviewed the general information presented in Nursing Home Civil Monetary Penalty Quality Improvement (CMPQI) Program Implementation Funding Opportunity RFA # 34305-22318 and is pleased to submit this proposal. The specific unit of the University that will be doing the work of the project is the Center for Aging & Community (CAC). As one of Indiana's leading centers for aging studies, CAC collaborates, educates, and conducts research in order to be a catalyst for change that leads to a world in which all people age with dignity and optimal health.

CAC submits the attached two-year proposal for $495,548 in CMP funding to develop a statewide system of Regional Healthcare Quality Improvement Collaboratives that bring together Tennessee nursing facilities for quality improvement. CAC has created, implemented, and refined this innovative quality improvement approach over the last four years in Indiana and in doing so has demonstrated skill and expertise in designing, implementing, and evaluating projects; in developing collaborations and partnerships among key stakeholders; and in committing to a system-wide approach to quality improvement that leads to transformational change. Specifically for this proposal, the following products and services will be provided:

- Coordination of all project activities by the CAC Project Team including all logistics necessary to recruit participants and facilitate successful Regional Collaboratives.
- Recruitment and hiring of a Tennessee-based Subject Matter Expert to provide onsite technical assistance to Regional Collaboratives.
- Technical assistance through centralized education, group webinars, and individual conference calls designed to prepare regional leadership to create, manage and sustain their Collaboratives.
- Tools and resources in the form of toolkits, meeting agendas, templates and other resources to use for regional trainings and initiatives; onsite consultation; on-site assistance with regional meetings and activities; and “on-call” coaching as needed.
- In addition to gathering and analyzing basic demographic, attendance and certification information, CAC will evaluate the project through a combination of quantitative and qualitative data collection techniques to ensure formative data can be used to make adjustments to the program as it progresses, and summative data can inform the overall results.
- An Advisory Group composed of representatives from state agencies, provider organizations, provider systems, professional organizations, quality improvement organizations, consumer

organizations, and content experts will be recruited to assure coordination of quality educational efforts across the state.
- Reports with current evaluation progress and results will be prepared for the Tennessee Department of Health quarterly. A final report will be prepared at the conclusion of the project.

Through this pioneering program in Indiana, CAC was able to achieve significant results for resident health outcomes, building function and staff satisfaction, and cost savings for the state's long term care network. We anticipate similar results could be achieved in Tennessee. A sampling of results (additional outcomes in the proposal) include:

- Reduction of antipsychotic medications by 43%.
- Reduction of rates of falls by 30%.
- Reduction of hospitalizations by 38%.
- Reduction of rates of UTIs by an average of 43% across five Collaborative (24-57% reductions).
- Reduction CNA turnover by 16% (during a time of typically higher turnover).
- Savings of more than $1,438,058 were identified.

CAC is committed to providing products and services subject to the terms and conditions set forth in the RFP including, but not limited to, the State's *Sample Grant Contract - GR*. The proposed Tennessee Regional Healthcare Quality Improvement Collaboratives Initiative will provide an array of tools, education and training designed to help Regional Collaboratives measurably improve the quality of care in nursing homes in Tennessee.

The principal contact for the RFP is Ellen Burton. Her contact information is as follows:

Ellen Burton, MPH
Senior Project Director
University of Indianapolis
Center for Aging & Community
1400 East Hanna Avenue
Indianapolis, IN 46227
317-791-5940
burtones@uindy.edu

In closing, we are confident that the University's leadership and expertise in long term care quality improvement will make a significant difference in the lives of Tennessee citizens residing in long term care facilities.

Sincerely,

Ellen W. Miller, PhD
Executive Director
Center for Aging & Community
University of Indianapolis

REQUEST

Date of Application: 04 / 20 / 2018
MM / DD / YYYY

PART I: Background Information

Name of the Organization: University of Indianapolis

Address Line 1: 1400 E. Hanna Ave.

Address Line 2: Center for Aging & Community

City, County, State, Zip Code: Indianapolis, IN 46227-3630

Tax Identification Number: 35-0868107

CMS Certification Number, if applicable: ☐☐ – ☐☐☐☐ (Not Applicable)

Medicaid Provider Number, if applicable: ☐☐ – ☐☐☐☐ (Not Applicable)

Name of the Project Leader: Ellen Burton, MPH

Address: 1400 E. Hanna Ave., Center for Aging & Community

City, County, State, Zip Code: Indianapolis, IN 46227

Internet E-mail Address: burtones@uindy.edu

Telephone Number: 3 1 7 – 7 9 1 – 5 9 4 0

Mobile Number: 3 1 7 – 7 9 1 – 5 9 4 0

Have other funding sources been applied for and/or granted for this proposal? ☐ Yes ☑ No

Authorized Officials of Organization:

Michael Holstein
Michael Holstein (Apr 5, 2018)

Michael P. Holstein
VP, CFO, and Treasurer

Andrea Newsom
Andrea Newsom (Apr 6, 2018)

Andrea Brandes Newsom
VP and General Counsel

Part II: Applicable to Certified Nursing Home Applicants

Name of the Facility: _(Not Applicable)

Part III: Project Category

Please place an "X" by the project category for which you are seeking CMP funding.

- [x] Direct Improvement to Quality of Care
- [ ] Resident or Family Councils
- [x] Culture Change/Quality of Life
- [ ] Consumer Information
- [ ] Transition Preparation
- [x] Training
- [ ] Resident Transition due to Facility Closure or Downsizing
- [ ] Other: Please specify _____

Part IV: Funding Category

Please specify the amount and place an "X" by the funding category.

Amount Requested: $__495,548.00_____

- [ ] $2,500 or less
- [ ] $2,501 – $5,000
- [ ] $5,001 – $10,000
- [ ] $10,001 – $25,000
- [ ] $25,001 – $50,000
- [x] Over $50,000

Part V: Proposed Period of Support

From: 10 (MM) / 01 (DD) / 2018 (YYYY) (e.g. 06/01/2010) **To:** 09 (MM) / 30 (DD) / 2020 (YYYY) (e.g. 12/01/2010)

GENERAL ASSURANCES

Assurance is hereby provided that:

1. This program will be administered in accordance with all applicable statutes, regulations, program plans and applications:
   a. The laws of the State of Tennessee;
   b. Title VI of the federal Civil Rights Act of 1964;
   c. The Equal Employment Opportunity Act and the regulations issued there under by the federal government;
   d. The Americans with Disabilities Act of 1990 and the regulations issued there under by the federal government;
   e. The condition that the submitted application was independently arrived at, without collusion, under penalty of perjury; and,
   f. The condition that no amount shall be paid directly or indirectly to an employee or official of the State of Tennessee as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to the Agency in connection with any grant resulting from this application.
2. Each agency receiving funds under any grant resulting from this application shall use these funds only to supplement, and not to supplant federal, state and local funds that, in the absence of such funds would otherwise be spent for activities under this section.
3. The grantee will file financial reports and claims for reimbursement in accordance with procedures prescribed by the State of Tennessee Department of Health.
4. Grantees awarded grants resulting from this application process will evaluate its program periodically to assess its progress toward achieving its goals and objectives and use its evaluation results to refine, improve and strengthen its program and to refine its goals and objectives as appropriate.
5. If applicable, the program will take place in a safe and easily accessible facility.

CERTIFICATION/SIGNATURE

I, THE UNDERSIGNED, CERTIFY that the information contained in the application is complete and accurate to the best of my knowledge; that the necessary assurances of compliance with applicable state/federal statutes, rules and regulations will be met; and, that the indicated agency designated in this application is authorized to administer this grant.

I FURTHER CERTIFY that the assurances listed above have been satisfied and that all facts, figures and representation in this application are correct to the best of my knowledge.

Michael Holstein
Michael Holstein (Apr 5, 2018)

Signature of Authorized Official

Andrea Newsom
Andrea Newsom (Apr 6, 2018)

Signature of Authorized Official

Part VII: Expected Outcomes

Abstract

National initiatives have recently focused on improving quality of care in nursing homes with special emphasis on reducing hospitalizations and the use of antipsychotic medications. Many states, including Tennessee, have struggled with these quality indicators compared to the national benchmarks and are working to implement state-level initiatives to improve quality of care.

To address this need, the University of Indianapolis Center for Aging & Community (CAC) proposes creating regional healthcare quality improvement collaboratives for five regions in the state of Tennessee. Based on a successful similar project in Indiana, the *Tennessee Regional Healthcare Quality Improvement Collaboratives Initiative* will facilitate greater learning and implementation of the Centers for Medicare and Medicaid Services' (CMS) Quality Assurance Performance Improvement (QAPI) model in individual long term care (LTC) facilities throughout the state and ultimately improve quality of care for LTC residents in Tennessee.

Collaboratives will recruit regional member LTC facilities, facilitate development of facility QAPI plans, and facilitate two group process improvement projects (PIPs). An Advisory Group will be formed and, together with a Tennessee-based Subject Matter Expert, will provide the necessary connections to the LTC network in Tennessee. CAC will provide the overall support, structure, and technical assistance needed to create and sustain these Collaboratives. CAC will complete a multilevel evaluation of the project, led by Sharon Baggett, PhD, Associate Professor of Aging Studies, employing a combination of qualitative and quantitative measures to track Collaborative development and progress toward goals.

CAC is uniquely qualified to provide these services due to the knowledge gained during the initial implementation of this project in Indiana. Outcomes in Indiana included the reduction of several key indicators including urinary tract infections (57%), use of antipsychotic medications (43%), CNA turnover (16%), falls (30%), hospitalizations (38%), and pneumonia (16%). In addition, more than $1,438,058 in savings were identified. CAC anticipates similar outcomes for Tennessee.

Statement of Need

By 2030, the number of Tennessee seniors aged 65 and older is expected to increase to 1.7 million - 22% of Tennessee's total population.[1] It is projected that Tennessee's oldest old population (85 and older), will increase by 68%, with growth in 12 counties projected to increase by over 100%.[1] This anticipated growth in the aging population will lead to a higher demand for LTC services and increased costs.[1]

[1] Mattson, S., & Bergfeld, T. (2017, April). Senior Long-Term Care in Tennessee: Trends and Options. Retrieved February 14, 2018, from http://www.comptroller.tn.gov/repository/RE/aging.pdf

In 2016, Tennessee ranked 43rd in overall health for seniors[1] and 37th for nursing home quality of care.[2] Tennessee ranks significantly lower in several quality measures compared to the national benchmarks. Areas for improvement include: LTC residents who had a pressure ulcer (state average of 6.99% vs. national average of 4.57%), rates of residents with a urinary tract infection (8.505% TN vs. 5.02% US), use of antipsychotic medication for residents without an indicated diagnosis (20.5% TN vs. 11.7% US), rates of falls with major injury (3.60% TN vs. 1.96% US), and rates of residents whose depression or anxiety increased (3.80% TN vs. 2.54% US).[3]

These challenges highlight the need for a statewide initiative that addresses quality of care, improved health outcomes, and resident quality of life while simultaneously decreasing overall costs. Providing LTC facilities across the state with quality improvement strategies, support in their QI efforts, and a structure to create sustainable change will have significant positive impact on the LTC system in Tennessee.

Program Description

To address the statewide need for LTC quality improvement in Tennessee and per conversations with Qsource (Tennessee's CMS contracted Quality Improvement Organization), CAC proposes the development of an initial five regional healthcare quality improvement collaboratives, across the state. Each Collaborative's leadership team will spearhead efforts to engage LTC facilities and other stakeholders to collectively analyze quality metrics, discuss common challenges, and build on the facilities' existing QAPI programs to complete two Process Improvement Projects (PIPs) that would have immediate positive impact on quality of care in the region. CAC will coordinate, organize, and manage the project in three phases: Planning, Collaborative Start Up, and Collaborative Implementation/Evaluation. As the overall project manager, CAC will create and support the infrastructure needed to develop, implement, and evaluate the Collaboratives.

Phase I - Planning (Year 1 Q 1-2)

Phase I will consist of planning, infrastructure development, and network communications necessary to create successful Collaboratives. Project accomplishments and outcomes for this phase include:

1. Identification of key stakeholders, establishment, and at least one meeting of a TN Regional Collaboratives Advisory Group.
2. Development and dissemination of a Request for Applications (RFA) from organizations that will lead the Collaboratives.

[2] America's Health Rankings 2017 Senior Report. (n.d.). Retrieved February 15, 2018, from https://www.americashealthrankings.org/learn/reports/2017-senior-report/state-summaries-tennessee

[3] National Healthcare Quality and Disparities Reports. (n.d.). Retrieved February 14, 2018, from https://nhqrnet.ahrq.gov/inhqrdr/National/benchmark/summary/All_Measures/All_Topics

3. Solicitation of Letters of Interest prior to the due date of the RFA that will allow CAC to gauge level and geographic distribution of interest.
4. Receipt & review of applications, selection of winning proposals, and formal awarding of five Collaborative sub-grants to the selected lead organizations in each of five regions.

Prior experience has shown that requesting applications from interested parties (rather than recruiting and awarding directly) better ensures dedication to the end goals of the project, stronger nursing facility participation, better health outcomes throughout the process, and project sustainability. Applicants will provide the geographic boundaries of their region and will be encouraged to develop relationships with LTC facilities and other regional stakeholders as part of the application process. Letters of commitment from potential member nursing homes will be encouraged to streamline the Collaborative Start Up Process.

Phase II - Collaborative Start Up (Year 1 Q 3-4)

Phase II will begin once Collaborative awards are made and is the key development phase for building each of the Collaboratives where CAC will work closely with Collaborative leaders to recruit members, build group cohesion, develop Collaborative goals, and prepare for implementation. Key activities, deliverables, and outcomes in this Phase include:

1. A kick off meeting with all Collaborative Leadership Teams and the CAC Project Team (includes the Tennessee Resource Subject Matter Expert).
2. Provision of technical assistance to Collaborative leaders for recruitment, membership building, and individual Collaborative kick off meetings through monthly conference calls and webinars.
3. Provision of technical assistance to Collaborative leaders for regional needs assessment and asset mapping.
4. Convening the TN Regional Collaboratives Advisory Group at least once.
5. Receipt of quarterly reports from Collaboratives, oversight & technical assistance provision.
6. Development and submission of regional work plans by individual Collaboratives.
7. Review and approval of regional work plans by CAC
8. Disbursement of Collaborative grant funds for costs associated with start-up and PIP1.

During Phase II - Regional Collaborative Start Up, each region will build their Collaborative, work with members to raise all to the same level of QAPI integration into building function, and outline a work plan for the remainder of the grant period. All five Collaborative leadership teams (one from each region) will attend a two-day kick off meeting led by CAC. This meeting will include discussion of the overall initiative, an introduction of how to manage the QAPI process as a Collaborative, strategies for member recruitment and engagement, discussion of common challenges, and best practices discovered during the implementation of this project in Indiana. Collaborative lead organizations will be given significant tools to guide and support the

management of their Collaboratives, including critical pathways for projects and a toolkit for Collaborative implementation.

After the kick off meeting, CAC will continue to provide detailed technical assistance (webinars, TA conference calls, additional resources) to the Collaborative leaders as they continue to build their Collaborative and establish their Collaborative work plan. Members of the Project Team will attend Regional Collaborative meetings at least quarterly to assist in group building, planning, and needs assessment efforts.

Phase III - Regional Collaborative Implementation (Year 2)
In the second year of the project, Collaboratives will implement two PIPs as a group, each requiring about six months of active Collaborative time. The first of these projects for each Collaborative will focus on a topic related to healthcare associated infection (HAI). In addition to ensuring this project addresses some of the most pressing needs of Tennessee, experience shows that narrowing the scope of possible projects when Collaborative members are first learning to work as a group helps to focus the Collaborative and streamline the process, leading to a more positive initial experience and better member retention. Key activities, deliverables, and outcomes of this Phase include:

1. Ongoing provision of technical assistance to Regional Collaborative leadership.
2. Receipt of quarterly reports from the Collaboratives to aid in oversight and technical assistance provision.
3. Planning, development, and implementation of QAPI PIP #1 (HAI focused).
4. Improved HAI related health outcomes for Collaborative participants.
5. Convening Midpoint Meeting for Collaborative Leadership.
6. Convening the TN Regional Collaboratives Advisory Group at least twice in this period.
7. Planning, development, and implementation of QAPI PIP #2 (focus determined by the Collaborative).
8. Improved health outcomes/quality of life/staff satisfaction for Collaborative participants (as determined by PIPs).
9. Convening a Project Close Out meeting with Regional Collaborative Leadership.

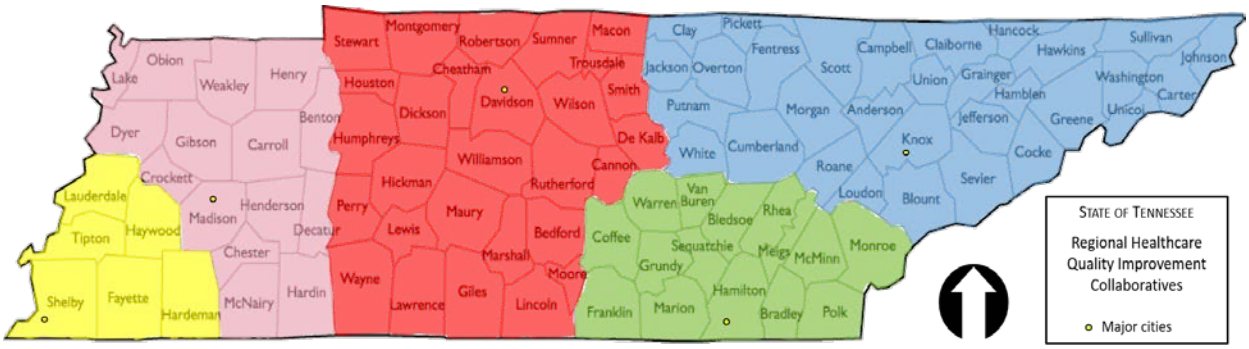
Phase III is the longest of the project as it encompasses the development and implementation of two QAPI PIPs by each Collaborative, where QI is most directly seen. Experience tells us that while project development and implementation can be overlapped, groups need roughly six months for each project to be completed. During this phase, emphasis will be placed on the process for identifying areas of interest/need and for developing a strong QAPI project. Collaboratives will develop and track both process and outcome measures. In addition, lead organizations will learn how to tell the story of the data for maximum impact on myriad audiences. Technical assistance for leadership teams will be provided in train-the-trainer manner, increasing the dissemination and sustainability of best practices throughout the Collaborative.

Collaboratives will be required to submit close out reports for each PIP (with the final portion of funding disbursed upon receipt of Close-Out Report #1). CAC will use these reports to further develop the existing toolkit and provide guidance for all Collaboratives. These toolkit developments will be available to Collaboratives wishing to address a topic already covered by another Collaborative, decreasing effort and increasing project outcomes. A **sample** timeline (Table 1) and sample Collaborative map (Figure 1) is included below.

Table 1. Proposed Regional Healthcare Quality Improvement Collaboratives Timeline

Year 1												Year 2											
Q1			Q2			Q3			Q4			Q1			Q2			Q3			Q4		
1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12
Phase I - Planning																							
						Phase II – Collaborative Start Up																	
												Phase III – Implementation											
												QAPI Project 1					QAPI Project 2						
																						Final Reporting	

Figure 1. **Sample** Regional Collaboratives Map



Part VIII: Results Measurement

Overall, this project has two main goals:

1. Establish successful, sustainable Regional Collaboratives that support QAPI efforts in LTC facilities.
2. Improve LTC quality indicators and measures for both quality of care and quality of life.

To ensure the project achieves both of these goals, evaluation will focus on four areas:

1. Determining the feasibility of Regional Collaboratives as a means to encourage quality improvement;
   a. Assessing the effectiveness of the technical assistance provided by CAC;
2. Assessing participation of Regional Collaborative nursing homes in the QAPI model;

3. Determining the impact of various QAPI projects on LTC quality metrics and/or resident health outcomes; and
4. Determining the impact of various QAPI projects on LTC costs

Both quantitative and qualitative data collection techniques will be used to ensure that formative data can be used to make program adjustments and that summative data can inform the overall results. The table below outlines the specific evaluation activities that will occur, which goal is addressed (process or outcome), and what questions are answered in evaluating the success of each goal. This design allows CAC to involve multiple stakeholders as data providers, resulting in a well-rounded evaluation that produces immediately usable results on the effectiveness of CAC's ongoing efforts to establish and support Collaboratives, and final results that measure the overarching goal of impact on quality of care.

The specific data collection procedures will be based on experience from prior implementation of this project, but devised and implemented by CAC to match the individual needs of the project. This flexibility allows additional evaluation topics to be explored as they emerge. Previous experience ensures CAC evaluation design includes appropriate measures, reasonable data collection plans, and strategic follow up methods. We anticipate working closely with the State of Tennessee throughout the project period to ensure that specific evaluation needs are assessed and the best plan is devised to meet expectations and deliver a high quality result.

Collaboratives will be encouraged to leverage existing data collection and reporting processes to inform their outcome evaluation to promote ongoing quality monitoring and improvement after the project's conclusion. Reports with current evaluation progress and results will be prepared periodically. A final report will be prepared at the conclusion of the initiative. All electronic records will be stored on a password-protected computer and all paper records will be stored in a locked file cabinet in a locked office at CAC. Only the members of the CAC project team will have access to these records. This is outlined in Table 2 below (page 12).

Part IX: Benefits to NF Residents

We anticipate that the Regional Healthcare Collaboratives for Quality Improvement project could provide significant benefits to LTC residents across the state of Tennessee. This project has the ability to address all of the areas of concern detailed in the Request for Applications. During project implementation in Indiana, the following outcomes for LTC residents were achieved by at least one of the seven Indiana Collaboratives:

- Reduction of antipsychotic medications by 43%
- Reduction of rates of falls by 30%
- Reduction of hospitalizations by 38%
- Reduction of rates of UTIs by an average of 43% across five Collaboratives
- Reduction of rates of pneumonia by 16%

Table 2. Regional Collaborative Evaluation Matrix

Goal 1: Establish successful, sustainable Regional Collaboratives that support QAPI efforts in long term care health facilities (Process Evaluation)				
• Who are the collaborative members? • What topics were addressed through QAPI projects? • How did Collaboratives utilize technical assistance?		• How did Collaboratives respond to technical assistance? • Were Collaboratives successfully managed? • Were the QAPI project process changes adopted and sustained across the collaborative?		
Related Project Activity	**Short Term Outcome (Immediate)**	**Intermediate Outcome (6-12 months)**	**Long Term Outcome (12-18 months)**	**Measured How?**
Form and conduct Regional Collaboratives	Connect organizations and stakeholders in region	Strong Collaboratives with effective governance, structure, & communication	Collaborative projects across the region	Collaborative reports (Monthly) QAPI project plans
Train Regional Collaboratives, provide technical assistance	Increase knowledge of collaborative leadership of coalition building, QAPI process.	Increase collaborative implementation of best practices in coalition building and QAPI process improvement	Successfully implemented QAPI projects	Technical assistance evaluation – electronic and paper survey QAPI project plans and reports
Complete Infection Prevention QAPI project	Implement process improvements	Increase facility implementation of best practices (policies and procedures) in infection prevention through ongoing process improvement.	Changes identified by project are sustained and process improvement is ongoing	Knowledge and Practices Questionnaire
Complete second QAPI project	Implement process improvements	Increase facility implementation of best practices (policies and procedures) in selected topic area	Changes identified by project are sustained and process improvement is ongoing	Knowledge and Practices Questionnaire

Goal 2: Improve specific long term care quality indicators (Outcome Evaluation)				
• Has the desired improvement in quality of care for patients/residents been realized? • What is the financial impact of the quality improvement process?				
Related Project Activity	**Short Term Outcome (Immediate)**	**Intermediate Outcome (6-12 months)**	**Long Term Outcome (12-18 months)**	**Measured How?**
Complete Infection Prevention QAPI project	Implement process improvements Improvements in the chosen primary metric (i.e. UTIs, hang hygiene, etc.) Identification of related cost savings.	Increase facility implementation of best practices (policies and procedures) in infection prevention through ongoing process improvement.	Improvement in HAI related metrics. Ongoing cost savings	Knowledge and Practices Questionnaire (as above) QAPI Project data (Quarterly)
Complete second QAPI project	Implement process improvements Improvements in the chosen primary metric (i.e. falls, staffing, etc.) Identification of related cost savings.	Increase facility implementation of best practices (policies and procedures) in selected topic area.	Improved MDS and QAPI indicators related to topic area of second projects. Ongoing cost savings	Knowledge and Practices Questionnaire (as above) QAPI Project data (Quarterly)

Part IX: Benefits to NF Residents (continued from page 11)

Additionally, the following benefits were seen for LTC collaborative members:

- Reduction CNA turnover by 16% (during a time of typically higher turnover).
- More than $1,438,058 in savings identified.
- Members overwhelmingly reported (98%) using skills learned in the Collaborative to update and improve their QAPI plans.

Based on best practices developed and lessons learned from three years of implementing this project in Indiana, we believe similar impacts could be seen in Tennessee. Extrapolated to the publicly available quality measures for the state of Tennessee, impacts could be as large as:

- Decreasing UTIs statewide by at least 43%, from 8.51 to 4.85 (below national average);
- Decreasing the use of antipsychotics statewide by at least 43%, from 20.5 to 11.69;
- Decreasing falls by at least 30%, from 3.60 to 2.52.

Without specific Tennessee data to extrapolate, we are confident, based on previous experience in Indiana, that Tennessee could also see meaningful reductions in rates of pneumonia and rehospitalizations or other quality measures chosen by the Collaboratives, as well as significant cost savings.

Part X: Consumer/Stakeholder involvement

All members of the Tennessee LTC community will be directly involved in the development and implementation of this project. Facility staff will participate in monthly Collaborative meetings to learn best practices and improve QAPI skills. All information will be presented in a way that ensures ease of dissemination throughout the building. Facility staff will be encouraged to consult residents/families for suggestions on areas for improvement, possible process changes, and priorities for efforts.

The statewide LTC network will be engaged through the Regional Healthcare Quality Improvement Collaboratives Advisory Group. CAC and Tennessee Department of Health will work collaboratively to lead and invite stakeholders to this group. Potential members include the head of LTC surveyors; the state Quality Improvement Organization, Qsource (see letter of support), the state nursing home associations; key state health associations (i.e., APIC, Tennessee Alzheimer's Association); corporate representatives; universities that can bring subject matter expertise and data analysis support; and any other stakeholders who can contribute to the success of the project.

Part XI: Funding

See Excel Spreadsheets in Attachment 2. Narrative information below

Salaries: Year 1: **$80,321** Year 2: **$82,732** **Two Year Total: $163,053**

Funds will be used to support the efforts of several key members of the CAC project team. These roles for the **entire term of the project** are detailed below.

1. **Ellen Miller,** PT, PhD, (0.01 FTE), UIndy Associate Provost and the Executive Director of CAC, will serve as an advisor to the project.
2. **Ellen Burton,** MPH, (0.10 FTE), Senior Project Director, will provide overall management of the project and determine project outcomes.
3. **Project Director,** TBD, (0.50 FTE) will provide overall management and oversee daily operations for the project.
4. **Kayleigh Adrian,** MA, (0.40 FTE), Project Coordinator, will handle daily management and organization of the project.
5. **Amy Magan,** BA, (0.05 FTE), Communications Manager, will manage and oversee all communication and reports.

6. **Amy Marack,** MPA**,** (0.05 FTE), Business Manager, will manage and oversee accounts payable and receivable; track expenses, administer regional collaborative grants; and provide requested budget reports.
7. **Lidia Dubicki**, MA, (0.10 5FTE), Project Director, will oversee data collection efforts and serve as the Evaluation Project Director.
8. **Sharon Baggett**, PhD, (0.10 FTE), faculty in the UIndy College of Health Sciences, will serve as the Lead Evaluator for the project.

Fringe Benefits: Year 1: **$20,884** Year 2: **$21,732** **Two Year Total: $42,394**
Fringe benefits will be paid at a rate of 26% of allocated salaries.

Professional Fee (Consultant)/ Grant & Award:
Year 1: **$91,600** Year 2: **$141,600** **Two Year Total: $233,200**
TN Resource Subject Matter Expert To ensure strong connection with the LTC network in Tennessee, CAC will hire a Tennessee-based 0.50 FTE who will serve as the Tennessee Resource Subject Matter Expert. This consultant will assist with the selection process and establishment of the Regional Collaboratives, provide on-and off-site consultation and training, and will connect the Project Team to key stakeholders and local resources. Initial conversations to embed this individual within a Tennessee-based organization have been positive.

Collaborative Grants Grants in the amount of $30,000 will be awarded to the five Regional Collaboratives for the planning and implementation phases. A total of $150,000 will be awarded.

Travel/Conference & Meetings:
Year 1: **$8,832** Year 2: **$11,864** **Two Year Total: $20,696**
The onsite TN Coordinator may be required to travel locally to the Collaborative meetings. The UIndy team and up to ten Collaborative leaders (two from each) will travel to Nashville for three meetings (kick-off, mid-point meeting, and end-point). Includes mileage at $0.545 per mile, hotel rooms at $120 per night, Per diem at $32 per day, and Room Rental/AV at $250 per day.

Program Expenses Year 1: **$3,444** Year 2: **$1,944** **Two Year Total: $5,388**
Program and meeting expenses include office supplies, miscellaneous meeting supplies such as nametags, table tents, etc., plus the fees for online discussion boards provided by PowerSchool Learning and teleconferencing expenses. Toolkits will be printed to provide a blueprint and reference manual for the Collaboratives and to promote sustainability and dissemination.

Indirect Cost: Year 1: **$15,181** Year 2: **$15,636** **Two Year Total: $30,817**
Indirect costs are normally calculated at 45.3% of salaries and benefits. Due to the cap on indirects they are calculated as 15% of salaries and benfits.

Annual CMP Fund Requests:
Year 1: $220,262 Year 2: $275,286 TOTAL REQUEST (2 YR PERIOD): $495,548

Inkind Expenses: Year 1: **$30,665** Year 2: **$31,585** **Two Year Total: $62,250**
UIndy's indirect rate is 45.3% of salaries and benefits. Given the indirect rate cap of 15%, UIndy will provide 30.3% of its indirect rate as in-kind support for the project.

Part XII: Involved Organizations
Organizations receiving funding under this agreement include:

University of Indianapolis
Center for Aging & Community
Overall project management, coordination, and evaluation
Contact: Ellen Burton
Senior Project Director
1400 East Hanna Avenue
Indianapolis, IN 46227
(317) 791-5940
burtones@uindy.edu

Tennessee Resources Subject Matter Expert
Connection to and communication with the Tennessee LTC network Contact: TBD

Regional Collaborative Leadership Organizations (5)
Leadership of individual Collaboratives - membership development, meeting management, data analysis, reporting to CAC. Will be required to name fiscal agent for the project. Contact: TBD

Copies of subcontracts shall be available upon request to CMS and the State of Tennessee.

Biosketches
KAYLEIGH K. ADRIAN, MS serves as project Coordinator for the CAC. She brings a Master of Science in Gerontology program and five years of experience in the aging network. Prior to her role with the CAC, Ms. Allen serves as a social services manager in long-term care and as memory care facilitator at an assisted living facility where she oversaw the development and implementation of programming for both early stage and mid stage dementia “neighborhoods.”

SHARON BAGGETT, PHD has been a consultant in research and evaluation since 1993 and has led more than 50 projects in the public and private sectors at the local, regional, and national level. She has authored a book on residential care for the elderly, a book chapter on long-term care, two articles in refereed journals, 15 proprietary publications, and made more than 30 national and regional conference presentations.

ELLEN S. BURTON, MPH serves as the Senior Project Director for the Center for Aging & Community. In this role, she works with CAC faculty and staff and local, state and national aging services organizations to provide consulting services, project management and evaluation that promotes the health and wellbeing of older adults. Prior to her role at CAC, Burton managed

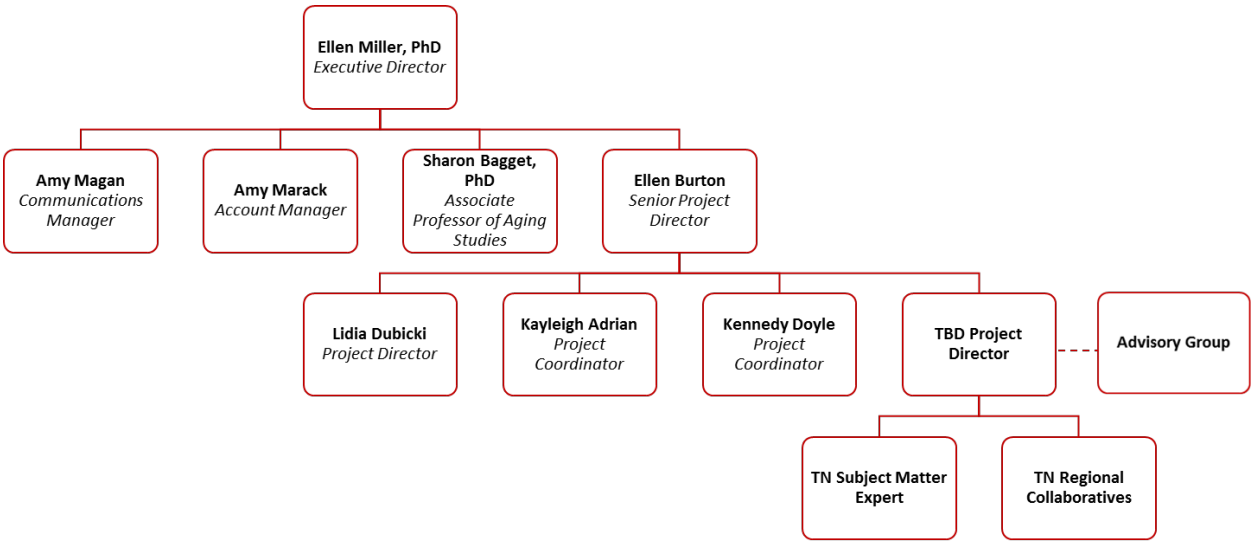
collaboration in education, research and administrative operations for the health science schools of Indiana University and served as a grant director for the Indiana FSSA Division of Aging.

LIDIA DUBICKI, MS as the primary Project Coordinator for CAC's Pressure Ulcer Initiative, Chronic Disease Self-Management Program, Home Modifications Project and Healthcare Associated Infection Initiative. Since 2012, she has been an integral part of the OPTIMISTIC project for long-term care quality, for which she serves as the Project Director. She designed and managed an integrated relational database for healthcare quality initiative data collection. She has also coordinated and executed over 50 regional trainings, 20 webinars and six CAC continuing education events.

AMY M. MAGAN is responsible for publication of e-newsletters, the Center's social media presence and works with University Communications on media opportunities. She also provides communications management to the University's College of Health Sciences. Prior to joining UIndy, she was a freelance writer and worked in health care and pharmaceutical communications.

AMY MCFADDEN MARACK, MPA spent four years as Deputy Controller for the City of Indianapolis. During her 10 years at the State of Indiana, she served as Procurement Director at the Department of Administration, coordinated Budget Committee meetings at the State Budget Agency, and calculated tax liabilities for businesses at the Department of Commerce.

ELLEN W. MILLER, PT, Ph.D. has been at the University of Indianapolis since 1990 and has worked with the Center for Aging & Community (CAC) since its inception in 2001. She was named executive director in 2005 and awarded the DeHaan Chair in Gerontology in 2007. As the executive director, Dr. Miller has led CAC to a prominent role in gerontology education and training. Under her direction, CAC has partnered with local, state and national aging network and government organizations to conduct work that enhances quality of life for older adults.



Qsource

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49 Music Square West
Ste. 402
Nashville, TN 37203

124 West Capitol Ave.
Ste. 900
Little Rock, AR 72201

9000 Wessex Place
Ste. 204
Louisville, KY 40222

911 E. 86th St.
Ste. 202
Indianapolis, IN 46240

920 Main Street
Ste. 801
Kansas City, MO 64105

April 16, 2018

ATTN: Grant Review Committee

RE: Tennessee Regional Healthcare Quality Improvement Collaboratives

Qsource is pleased to partner with the University of Indianapolis Center for Aging and Community (CAC) team in the development of five regional healthcare quality improvement collaboratives across the state of Tennessee.

Qsource, the Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for Alabama, Indiana, Kentucky, Mississippi and Tennessee focuses on three aims: better patient care, better population health and lower health care costs through improvement. As part of current Centers for Medicare & Medicaid Services (CMS) initiatives, our goal is to facilitate quality improvement efforts within our state and support nursing home staff in quality improvement projects and evaluate the impact of these efforts on care quality.

Our specific role in this project will be to: (1) Participate in CAC's Regional Collaborative Advisory Group, to make sure we are synergistic rather than duplicative in our efforts and believe the Regional Collaboratives can support the work of the QIO Statewide Collaborative (mutual recruitment, common goals, etc.); (2) Participate in the collaborative meetings as much as possible; (3) Provide provision of regional data on quality measures for the TN's nursing homes who have agreed to participate in CAC/Qsource Regional Collaboratives validated by a signed participation agreement.

We believe this partnership will provide Qsource additional resources for buildings in Tennessee without additional strain for the QIO or the nursing facilities. We, therefore, enthusiastically support the proposed work and look forward to partnering with this team to make this a successful project.

Sincerely,

Dawn FitzGerald, MS, MBA
Chief Executive Officer

ATTACHMENT 2

GRANT BUDGET

(BUDGET PAGE 1)

University of Indianapolis RFA # 34305-22318

APPLICABLE PERIOD: The grant budget line-item amounts below shall be applicable only to expense incurred during the period beginning October 1, 2018, and ending September 30, 2020.

POLICY 03 Object Line-item Reference	EXPENSE OBJECT LINE-ITEM CATEGORY [1] (detail schedule(s) attached as applicable)	GRANT CONTRACT YEAR 1	GRANT CONTRACT YEAR 2	TOTAL PROJECT
1	Salaries[2]	$80,321.00	$ 82,732.00	$163,053.00
2	Benefits & Taxes	$ 20,884.00	$ 21,510.00	$42,394.00
4, 15	Professional Fee/ Grant & Award [2]	$91,600.00	$ 141,600.00	$233,200.00
5	Supplies	$ 1,344.00	$ 1,344.00	$2,688.00
6	Telephone	$ 600.00	$ 600.00	$1,200.00
7	Postage & Shipping	$0.00	$0.00	$0.00
8	Occupancy	$0.00	$0.00	$0.00
9	Equipment Rental & Maintenance	$0.00	$0.00	$0.00
10	Printing & Publications	$ 1,500.00	$ -	$1,500.00
11, 12	Travel/ Conferences & Meetings[2]	$ 8,832.00	$ 11,864.00	$20,696.00
13	Interest [2]	$0.00	$0.00	$0.00
14	Insurance	$0.00	$0.00	$0.00
16	Specific Assistance To Individuals[2]	$0.00	$0.00	$0.00
17	Depreciation [2]	$0.00	$0.00	$0.00
18	Other Non-Personnel [2]	$0.00	$0.00	$0.00
20	Capital Purchase [2]	$0.00	$0.00	$0.00
22	Indirect Cost (% and method)	$ 15,181.00	$ 15,636.00	$30,817.00
23	**TOTAL BUDGET REQUESTED**	**$220,262.00**	**$275,286.00**	**$495,548.00**
24	In-Kind Expense	$ 30,665.00	$ 31,585.00	$62,250.00
25	**GRAND TOTAL**	$250,927.00	$306,871.00	$557,798.00

[1] Each expense object line-item shall be defined by the Department of Finance and Administration Policy 03, Uniform Reporting Requirements and Cost Allocation Plans for Subrecipients of Federal and State Grant Monies, Appendix A. (posted on the Internet at: https://www.tn.gov/assets/entities/finance/attachments/policy3.pdf).

[2] Applicable detail follows this page if line-item is funded.

ATTACHMENT 2 (continued)

GRANT BUDGET LINE-ITEM DETAIL

(BUDGET PAGE 2)

SALARIES		AMOUNT YEAR 1	AMOUNT YEAR 2	AMOUNT TOTAL
Executive Director - Administrative	0.01 FTE	$ 1,517.00	$ 1,563.00	$ 3,080.00
Senior Project Director - Direct	0.10 FTE	$ 8,417.00	$ 8,670.00	$ 17,087.00
Project Director - Direct	0.50 FTE	$ 30,000.00	$ 30,900.00	$ 60,900.00
Project Coordinator - Direct	0.40 FTE	$ 17,994.00	$ 18,534.00	$ 36,528.00
Communications Manager - Administrative	0.05 FTE	$ 3,503.00	$ 3,608.00	$ 7,111.00
Business Manager - Administrative	0.05 FTE	$ 3,189.00	$ 3,285.00	$ 6,474.00
Evaluation Project Director - Direct	0.10 FTE	$ 6,180.00	$ 6,365.00	$ 12,545.00
Evaluation Faculty Lead - Direct	0.10 FTE	$ 9,521.00	$ 9,807.00	$ 19,328.00
ROUNDED TOTAL		$ 80,321.00	$ 82,732.00	$ 163,053.00
Benefits @ 26% of Salary Breakdown: FICA: 7.6% Health 10% Life 0.5% Retirement 6.8% Workers Comp 0.7% Long Term Disability 0.2% Unemployment 0.2%		$ 20,884.00	$ 21,510.00	$ 42,394.00

PROFESSIONAL FEE/ GRANT & AWARD			AMOUNT YEAR 1	AMOUNT YEAR 2	AMOUNT TOTAL
Program Consultant in TN	0.50 FTE		$ 41,600.00	$ 41,600.00	$ 83,200.00
Grants to Regional Collaborative Projects	$30,000 each	5 Collaboratives	$ 50,000.00	$ 100,000.00	$ 150,000.00
ROUNDED TOTAL			$ 91,600.00	$ 141,600.00	$ 233,200.00

TRAVEL/ CONFERENCES & MEETINGS/Supplies	AMOUNT YEAR 1	AMOUNT YEAR 2	AMOUNT TOTAL
Hotel Rooms for staff & attendees @ $120 per night * 57 nights	$ 3,480.00	$ 3,360.00	$ 6,840.00
Per Diem for Trainers & Project Coordinator @ $32 per day * 57 days	$ 928.00	$ 896.00	$ 1,824.00
Mileage ($0.545 per mile * 20,242 miles)	$ 3,924.00	$ 7,108.00	$ 11,032.00
Room Rental & AV ($250 per day * 4 days)	$ 500.00	$ 500.00	$ 1,000.00
ROUNDED TOTAL	$ 8,832.00	$ 11,864.00	$ 20,696.00

PROGRAM EXPENSES	AMOUNT YEAR 1	AMOUNT YEAR 2	AMOUNT TOTAL
ToolKits (100 copies @ $15 each)	$ 1,500.00	$ -	$ 1,500.00
Program & Meeting Expenses (supplies, etc. @ $100 per month)	$ 1,200.00	$ 1,200.00	$ 2,400.00
Discussion Boards - Power School Learning	$ 144.00	$ 144.00	$ 288.00
GoToWebinar Conference Calls ($50 per month)	$ 600.00	$ 600.00	$ 1,200.00
ROUNDED TOTAL	$ 3,444.00	$ 1,944.00	$ 5,388.00

Indirects @ 15.0% of Salaries & Benefits Per Federal guidelines, the calculation of the indirect rate includes general administration and general expenses (excluding student related activities); operation and maintenance of the physical plant and depreciation; library expenses; and departmental administration expenses.	$ 15,181.00	$ 15,636.00	$ 30,817.00

In-Kind Expense:	$ 30,665.00	$ 31,585.00	$ 62,250.00

UIndy's indirect rate is 45.3% of salaries and benefits. Given the indirect rate cap of 15%, UIndy will provide 30.3% of its indirect rate as in-kind support for the project. Per Federal guidelines, the calculation of the indirect rate includes general administration and general expenses (excluding student related activities); operation and maintenance of the physical plant and depreciation; library expenses; and departmental administration expenses.

Total Request:	**$ 220,262.00**	**$ 275,286.00**	**$ 495,548.00**
Total w. in-kind:	$ 250,927.00	$ 306,871.00	$ 557,798.00