

APPENDIX D: SITE INTERVIEW SUMMARY

TABLE OF CONTENTS

Illinois Telephone Interview Response Summary	1
1. Program Structure	1
A. Program Organization	1
B. Program Personnel	2
C. Program Workshop Facilitators	2
D. CDSMP in the Larger Context of State Services	3
E. Financial Structure	3
F. Sustainability	4
G. Program Services – Workshops	4
H. Program Services – Integration	4
2. Participant Profile – Population Served	5
3. Program Processes	5
A. Marketing/Outreach	5
B. Intake Process	6
4. Data Management Systems and Data Availability	6
A. Tracking and Outcomes	6
B. Collection Process	6
C. Data Storage	6
D. Quality Control	6
5. Evaluate Activities	6
6. Experiential Wisdom/Lessons Learned	7
A. Grant Progress (Question 1)	7
B. Program Facilitators (Question 2)	8
C. Program Challenges/Barriers (Question 3)	8
D. Program Promising Practices (Question 4)	8
Michigan Telephone Interview Response Summary	9
1. Program Structure	9
A. Program Organization	9
B. Program Personnel	10
C. Program Workshop Facilitators	10
D. CDSMP in the Larger Context of State Services	11

E. Financial Structure	11
F. Sustainability	13
G. Program Services – Workshops	13
H. Program Services – Integration	13
2. Participant Profile – Population Served	14
3. Program Processes	14
A. Marketing/Outreach	14
B. Intake Process	15
4. Data Management Systems and Data Availability	15
A. Tracking and Outcomes	15
B. Collection Process	16
C. Data Storage	16
D. Quality Control	16
5. Evaluate Activities	16
6. Experiential Wisdom/Lessons Learned	18
A. Grant Progress	18
B. Program Facilitators	18
C. Program Challenges/Barriers	19
D. Program Promising Practices	19
North Carolina Telephone Interview Response Summary	21
1. Program Structure	21
A. Program Organization	21
B. Program Personnel	22
C. Program Workshop Facilitators	22
D. CDSMP in the Larger Context of State Services	23
E. Financial Structure	23
F. Sustainability	24
G. Program Services – Workshops	24
H. Program Services – Integration	25
2. Participant Profile – Population Served	25
3. Program Processes	25
A. Marketing/Outreach	25
B. Intake Process	26

4. Data Management Systems and Data Availability	26
A. Tracking and Outcomes	26
B. Collection Process	26
C. Data Storage	26
D. Quality Control	26
5. Evaluative Activities	27
6. Experiential Wisdom/Lessons Learned	28
A. Grant Progress	28
B. Program Facilitators	28
C. Program Challenges/Barriers	28
D. Program Promising Practices	29

ILLINOIS TELEPHONE INTERVIEW RESPONSE SUMMARY

The research team conducted two telephone interviews with Illinois respondents. The first interview took place on Monday, March 07, 2011. Respondents were Rhonda Clancy, State Lead, Division of Chronic Disease Prevention and Control in the Department of Public Health (DPH) and Janice Cichowlas, State Partner, Illinois Department of Aging (DOA). The second interview took place on Tuesday, March 08, 2011 with Dana Bright, Master Trainer (MT), Rush University. Following is a summary of the responses from the two Illinois telephone interviews.

1. Program Structure

A. Program Organization

The Illinois Department of Public Health (DPH) was awarded an American Recovery and Reinvestment Act (ARRA) grant to fund the Chronic Disease and Self-Management Program (CDSMP). The Illinois DPH works in partnership with the Department on Aging (DOA) on the CDSMP. The DPH has contracted with 10 of the 13 Area Agencies on Aging (AAA) in the State to coordinate the CDSMP locally. The funds are channeled through the DPH to local AAAs, who, in turn, may subcontract to other organizations such as the White Crane Wellness Center, University of Illinois, the Affordable Assisted Living Coalition, and Rush University, to conduct trainings and/or host workshops.

The organizations and responsibilities of the host sites vary. Some of the AAAs are host sites and hold programs in their facilities; other AAAs coordinate the workshops but hold them in other sites in their service area. Rush University is on the coordinating end; they are the project managers for the state working very closely with the DOA. In the city of Chicago, the AAA is housed under the city government. Age Option (AAA) is the non-profit serving the suburbs of Chicago. Rush is the subcontractor to both of these AAAs with the responsibility of program implementation, but the roles that each of those AAAs have taken is different. In the city, a lot of the work has been given to Rush and White Crane Wellness Center. These two subcontractors go back and forth serving as the coordinator for the host site. Each organization has master trainers (MTs) who facilitate the training. Rush covers more of central Cook County and White Crane covers more of the Northwest. The city AAA is playing a hands-off role, but they are supportive. In the suburbs, AAAs coordinate the program and have their own MTs and leaders. Rush is involved in the implementation; they are equipped to provide training, but they also conduct workshops. They are one of the coordinating organizations for the city and for other organizations that want to adopt the program. Workshops are held in a variety of locations (e.g., churches, senior centers, libraries).

Respondents stated that, in general, the structure of the CDSMP works well to facilitate successful program operations; the State has the capacity to be successful. However, it also has been challenging due to the fact that the AAAs already have the responsibility for coordinating many other programs, so adding the CDSMP is an extra burden. The structure of the program

works better in some AAAs than in others. In metro areas with large AAAs, there are a lot of employees to spread across programs. However, in rural areas there are fewer employees that serve larger geographical areas—even if the number of target participants is similar to urban employees—they are more limited in terms of implementing the program due to their location. From the perspective of the subcontractor, (i.e., Rush), the structure of the program has been challenging in terms of the way decisions were made. The respondent reported that Rush has not received an adequate amount of support from the AAAs; there is much better support from Age Option (suburban Chicago AAA). For example, Age Option (also serving as the ADRC) has an 800 number that may be used for planning purposes as well as recruiting program participants. It is important to let consumers know that they can go locally, but there should be a statewide 800 number for people to call. Strengthening coordination at the State-level might be a solution to this problem.

B. Program Personnel

The DPH has a program manager funded 50 percent through the ARRA grant; in reality, this person devotes more than 50 percent time to the CDSMP. In addition, the DPH division chief, fiscal staff, and disability programs staff assist as needed. The DOA has designated three staff members to provide program assistance as needed, but their funding is in-kind; none of their salary is paid directly from the grant.

According to the subcontractor respondent, the relationship between the MTs and the State-level administrative staff is open and collaborative. They have worked together for a long time so they are able to have difficult but constructive conversations. They do not always agree because they come from different perspectives, but the relationship is give and take. Recently, they have been considering options that other states have used to strengthen the line of communication between the MTs and the leaders to increase leader buy-in and the retention rate.

Key leaders of the Illinois CDSMP include the Age Options Director of Evidence-Based programs. She is a program champion and strong advocate for the program; she is often invited to present the program at conferences. There is also strong support from Rush University in terms of program leadership and a champion for the medical community. Finally, the DPH State Office Coordinator is viewed as a key leader in the program.

C. Program Workshop Facilitators

There are approximately 10 – 15 MTs in Illinois, including both Diabetes and CDSMP MTs. The number of class leaders is a moving target although Cook County maintains a database with this information. In general, MTs are professionals who are working in the health or social service sectors and providing CDSMP training as part of their paid positions. This may also apply to class leaders who have jobs in agencies that coordinate classes. Some MTs may be paid directly through an AAA grant. Other MTs and leaders work as volunteers. In Cook County, sometimes Age Options will provide a stipend to the host site, or White Crane might reimburse for mileage.

Because Rush is a contracted agency, the funds that they receive support administrative staff (and MTs), so in that sense they are being paid by their own sub-grant.

The need to train leaders comes up often. This was described as manageable in Northern Illinois where efforts are greatest because of Chicago, and the AAAs in the northern part of the state are large and have been able to engage more MTs; however, it has been more difficult in the west, central, and southern parts of the State which are more rural and spread out. The demand is greatest and trainings are easiest to organize in Northern Illinois. There is demand in the South, but there it is more difficult to organize. Sustained commitment of the leaders was described as difficult, so trainings are held frequently.

All respondents noted that they do not have enough administrative staff. There are not enough designated personnel in DOA or in DPH. Illinois continues to receive grants to implement programs, but a tight budget restricts the hiring of new staff, so the current staff are over-extended. The subcontractor noted that Rush needs one full-time staff dedicated to coordinating the CDSMP. The State grantees reported that they are currently training to replace -- rather than add -- leaders. For example, in Northern Illinois where the capacity is large, there is only a sub-pool of leaders who are active and ready and willing to conduct trainings. They recently contacted the active trainers to talk about how to get non-active trainers more involved. Administrative staff experiences a very low turn-over rate in both the DPH and DOA.

D. CDSMP in the Larger Context of State Services

The primary stakeholders are the DPH, DOA, and the AAAs. The DOH applied for the grant in 2006, so they got the CDSMP ball rolling for the state. The funds go directly from DPH to AAAs. The DOA is a key partner who provides technical assistance and support. The DOA played an active role in coordinating the training programs; at the beginning of the program, there were only three AAAs involved, now there are ten. DOA also helped to develop a sustainability planning webinar and created a planning sheet for the AAAs. They incorporated the CDSMP into the ADRC transitions grant and other programs. The subcontractor, Rush University, is trying to work more closely with State Medicaid partners, health care partners, and the Aging Network (Public Health).

E. Financial Structure

Major funding sources have not changed over time in Illinois. The Title III-D funding is new, but is allocated directly to the AAAs, and not all of them use the funds for CDSMP. Illinois does not target Medicaid participants, although it is written into the AAA workplans to recruit Medicaid beneficiaries. The Illinois Family Services has connected them with "Your Healthcare Plus," with whom they partner for referrals. This is primarily a Medicaid population.

Funding for the Illinois CDSMP comes from the ARRA funding. State contributions play a small role in funding CDSMPs in Illinois, and the state does not use other grant money as a major

source for the CDSMPs. The state does, however, receive various types of in-kind support, though information on where this funding comes from was not available to the research team. Federal funding for CDSMPs was given for the period of March 31, 2010 to March 31, 2012.

F. Sustainability

Illinois does not monitor for sustainability although they do monitor the program for fidelity. The local AAAs and sub-grantees have sustainability plans that they are required to complete.

G. Program Services – Workshops

A workshop participant is someone who has attended one of six program sessions; a completer is a participant who attends four of the six workshops. There is no charge for the CDSMP workshops. Approximately 72 percent of participants complete the program. According to the Illinois State-level respondents, the reasons that participants drop out of workshops include 1) illness, which is understandable given that this is a chronic disease population, 2) inclement weather, and 3) they do not really understand that the program is a full six weeks, not a drop-in series of classes.

In Cook County, the participant retention rate is 65 – 70 percent with the primary reasons for dropping out attributed to 1) health related issues (either participant, or family), 2) transportation barriers, 3) participants' schedules/travel, and 4) probably to a lesser degree, those who feel that the workshop just isn't what they were looking for. There is no charge for attendance, although the materials that are on loan during the workshops can be purchased. The cost of the program is not estimated.

The participants have to register for the workshops, but there is no eligibility screening; everyone who registers can attend. When participants call to register, they are given detailed information about the program that allows them to self-screen (i.e., the program is not for them). Respondents feel that this process results in better participant retention. Illinois administers the required National Council on Aging (NOCA) participant survey to all enrollees; it contains demographic and chronic condition information. In addition, Illinois has added a couple of their own items to the survey such as depression. There are no online CDSMP programs in Illinois but respondents stated that they would entertain this option if there was funding for it.

H. Program Services – Integration

The Your Healthcare Plus AAA program does not provide funding, but they receive Title III-D funding which is a health prevention program, and they may require their subcontractors to incorporate a CDSMP. There are also two or three AAAs that have received Title IV funding that also may require CDSMP training or coordination.

2. Participant Profile – Population Served

The Illinois CDSMP reaches statewide; their goal was to go statewide, and they believe that they have achieved that goal. In the Cook County, the catchment area is urban and suburban. Some participants may travel from rural areas, but in Cook County, it is primarily urban and suburban. The target population is persons with chronic conditions; however, there is a mandate in DOA to target people 60+. Recently, there has been more of a push for targeting people age 45 to 60 with chronic conditions.

The average age of Cook County participants is mid-70s with the majority being Caucasian, one-third African Americans and Asian Americans, and a low percentage of Hispanics. Similar to other states, women make up the majority of participants (75 percent) as well as the majority of MTs and leaders. The respondents did not have any knowledge of the proportion of participants who are Medicare, Medicaid, or Managed Care.

3. Program Processes

A. Marketing/Outreach

Each AAA and each host site is responsible for marketing in their geographic area. AAAs use all available marketing materials, including all printed materials on NCOA website. Some of the strategies the sites use are as follows:

- Marketing in the community and outreach through presentations;
- TV/Radio/Newspaper/Newsletter drops;
- Use of a “program champion” in their community;
- Asking former participants to lead a community presentation;
- Recruiting at site-level (much more common, but the are trying to build referral networks); and
- Using the state “tobacco quit line” to refer participants to CDSMP.

Approximately 750 participants applied for the workshops in the first year of the grant period. There is no online CDSMP due to funding limitation, although other CDSMPs, funded through other sources, may have one. AAAs in larger areas had to put participants on waiting lists. Filling classes can be very easy or extremely difficult, depending on the dates and the season in which the workshops are held. Getting participants to stay committed is also a challenge. It is a very difficult program to sell via a flyer, and therefore requires face-to-face recruitment to fully express the benefits of the program.

Illinois respondents reported trying “everything but the kitchen sink” to market the program. They rely on word of mouth and community and church presentations. Participants are sometimes referred from local health plans or targeted in retirement communities.

B. Intake Process

There is no application process; rather, participants simply register for a given workshop. Participants in Cook County are not charged a fee for the workshop, and are loaned program materials. Participants can choose to purchase these materials at the end of the session.

4. Data Management Systems and Data Availability

A. Tracking and Outcomes

All participants are required to fill out an enrollment form/participant survey that obtains demographic information including gender, ethnic background, and geographic region. Family and informal caregiver information is not tracked on current forms. The data evaluation team is a subcontractor from the University of Illinois at Chicago. They do not collect outcome data since it was not a requirement for ARRA funding. Illinois is having a difficult time meeting their quota of participants.

B. Collection Process

The enrollment forms are completed at the first session of the workshop via paper and pencil. The forms are collected and sent to the evaluation team, who enters the data for each participant into the NCOA database.

C. Data Storage

Collected information is reflected in national database (NCOA). Implementation sites keep copies of paper forms. Since 2006, NCOA has used an organization in Seattle to warehouse the national database.

D. Quality Control

The State does not conduct quality checks, but they do make sure the leaders follow the specific program instructions (fidelity).

5. Evaluate Activities

As of the most recent funding from ARRA, there is a short evaluation form that is administered to participants at the last workshop session. The evaluation collects information on the quality of the leaders (how they did, if they worked together), as well as participant satisfaction.

During this current grant period, there is some frustration with the data that the State would like to collect versus what AoA requires and therefore funds. There is a lot more data that the

State grantees and local hosts would like to collect, but limited resources and capacity prohibit collecting it. For instance, the State would like to measure how to effectively recruit and retain leaders, and how to effectively market to potential participants. In addition, they would like to assess participant outcomes. Grantees acknowledged that there is some truth to the argument that the CDSMP is an evidence-based program, and therefore, its effectiveness has already been assessed. However, Illinois would still like to test the program data at the local- and state-level. Grantees also mentioned that in the healthcare arena, utilization is very important for program support and should be assessed.

Private funding allowed Illinois to conduct a two-year program evaluation in three geographic areas of the State that included a baseline and four-month follow-up data collection. This study evaluated efficacy, utilization, and the effectiveness of leaders, coordinators, and directors of different agencies. The evaluation focused somewhat on outcomes, but more so on the reach of the program and the maintenance of it. This was a separate initiative funded by AoA, and was completed recently by the State evaluation team.

Information from the program evaluation, including that of the privately-funded evaluation, is not shared directly with program participants. Data provided by the privately-funded evaluation were shared in professional and academic audiences, and the State is in the process of drafting professional papers based on these data. The information is also shared with AoA per grant requirements.

Illinois is working on a monitoring tool to be used at a national-level. An MT has been tasked with checking in on leaders, which involves attending workshops and filling out a yes/no evaluation form based on their observations. That information is sent to the State evaluation team, but because the data collected at this time are at a minimal level, any findings would be statistically insignificant.

6. Experiential Wisdom/Lessons Learned

A. Grant Progress (Question 1)

Representatives from State- and local-levels believed that the program is currently delayed. It is believed that the current funding from ARRA brought with it higher target numbers for the states compared to past cycles of funding. Some of the larger sites were said to have hit roadblocks, and it was harder to get the program started and to regroup after a problem than was originally anticipated. Various regions are taking different strategies to combat these issues. In fact, a recent conference call discussed the program delay and that strengthening of networks may be a way to tap into other structures for participant outreach. That said, grantees are confident that the State is capable of meeting its program goals.

B. Program Facilitators (Question 2)

“Funding, funding, funding” was indicated to be both the greatest facilitator and inhibitor to program success. Federal organizational staff were praised for program support. They stated that NCOA staff serve as great supporters to the State in their programming efforts. AoA has also been extremely important in helping to solve problems by offering advice, resources, and lessons from other states. The Illinois State-level respondents reported that the NCOA and AoA staff could be considered additional Illinois CDSMP staff. One respondent indicated that she hoped federal-level supporters continue to assist throughout the program, as the CDSMP in the State has become dependent on them for assistance.

C. Program Challenges/Barriers (Question 3)

Aside from funding barriers, it is problematic in rural areas to recruit the minimum number of participants in order to hold a class. The respondents indicated that in order to organize and hold a workshop, at least ten enrollees are needed; however, it is extremely difficult to recruit this many participants in rural areas. Fewer than ten participants make it not worthwhile for MTs to travel such great distances for six classes.

The State-level respondents did not report any general program concerns, although they questioned whether or not they would be given more direction from AoA for Title III-D dollars, such as stipulating that the funds must be spent on evidence-based programs.

D. Program Promising Practices (Question 4)

The State-level respondents reported the following key practices as impacting the success of their CDSMP:

- *Integrating transitional care models.* Illinois has worked with a patient-centered medical home to integrate it into a pilot initiative. In addition, Rush University is a leader in transitional care models, and is working to integrate the CDSMP into models that link hospital patients with the CDSMP when they are discharged.
- *Creating a sustainability plan.* Illinois created a unique sustainability plan, for which they were asked to participate in a national call to report on the process that they used for developing the plan. Guided by webinars presented by the University of Illinois, all CDSMP AAAs and subgrantees/subcontractors were asked to develop sustainability plans. The UIL webinars presented information on how to develop sustainability on three levels: financial, organizational, and community. The Illinois DOA committed to assisting with sustainability training, and each AAA put individual plans together that were subsequently submitted to AoA.

Illinois State-level respondents reported that they have worked to adopt the best practices of other states when they began their CDSMP, such as working to partner and network with other organizations, and gaining referrals from the State’s Tobacco Quit Line.

MICHIGAN TELEPHONE INTERVIEW RESPONSE SUMMARY

The research team conducted two telephone interviews with Michigan respondents. The first interview took place on Wednesday, March 2, 2011. Respondents included Judith Lyles, Manager, Other Chronic Diseases Unit, Diabetes & Other Chronic Diseases Section of the Michigan Department of Community Health (DCH), and AnnMarie Hodges, Workshop Leader and Data Manager. The second interview took place on Thursday, March 3, 2011 with Sherri King, Health & Wellness Specialist, the Chronic Disease Division of the Michigan Office of Services to the Aging (OSA). Following is a summary of the responses from the two Michigan telephone interviews.

1. Program Structure

A. Program Organization

In 2001, the Michigan State University Extension (MSUE) trained 25 Master Trainers (MT) with a T-trainer from Stanford University (a T-trainer is an individual trained by Stanford with qualifications to train MTs). In 2003-2004, the Area Agency on Aging (AAA) of Western Michigan received a grant from AoA to train additional MTs. Through this grant, they worked with two or three emergency departments to request that they refer patients to the program when there was a chronic non-life threatening condition. That grant went through 2006, and in 2007 the Office of Services to the Aging was awarded another AoA grant to expand CDSMPs to more AAAs. At this point, three agencies came together in 2005 to form a partnership in support of the Michigan Chronic Disease Self-Management Program (CDSMP). These agencies include the Michigan Department of Community Health, Office of Services to the Aging, West Michigan AAA, and Michigan State University Extension. DCH supported the first “train the trainer” session when they brought T-trainers to Michigan to train workshop leaders. The three original agencies brought others with them (a total of eight at the time) to collaborate and coordinate to get the implementation of the program off the ground. They formed the “Michigan Partners on the PATH (Personal Action Toward Health)”, which is now composed of 25 licensed agencies, including OSA and the Department of Mental Health. OSA has a delivery system through the AAAs, and DCH works with people and conducts trainings.

Currently, the Office of Services to the Aging oversees 16 AAAs. Each of the 16 AAAs received a portion of money to conduct CDSMP trainings and to create new workshop sites. The percentage of money that was allocated per AAA depended on the anticipated percentage of workshop completers. Every AAA received at least \$50,000 to start the CDSMP in their region. The AAAs work with agencies in their regions to see who is interested in marketing and recruiting for CDSMP. DCH conducts trainings and the Michigan Partners on the PATH have representatives from various areas in the State to help with marketing. They also partner with the Michigan State University Extension, who has been coordinating the program since 2001. Respondents believe that the system of funding going from OSA through the AAAs is an outstanding structure to facilitate successful program operations. All AAAs have the Title III-D

dollars for health and wellness, and the CDSMP is a program they for which they can use that funding.

All of the AAAs are host sites, but they also recruit other organizations such as senior centers, churches, hospitals, medical clinics, and home health agencies to host workshops. Regardless of the host, the AAAs coordinate the workshops. In some cases, a host site like a hospital may indicate that they want to coordinate the workshop so the AAA will be there only to provide technical assistance. Other times, a host site like a senior center will allow the AAA to use the facility but will not actively participate in the organization, recruitment, or leadership of a workshop.

B. Program Personnel

Designated administrative program personnel at the State-level are minimal. The Office of Services to the Aging has one employee who is a full-time health and wellness coordinator. She manages the CDSMP as well as the nutrition program for the OSA. The Department of Community Health has two full-time staff dedicated to the CDSMP, although they both work on other initiatives as well. The Department of Community Health also employs two part-time staff, funded by the Arthritis Foundation, who help to administer the program. None of the program personnel are funded by the CDSMP, per se. The respective agencies (e.g., OSA, DCH) have received grants to implement the program but employees are funded through the budgets of the OSA and DCH, respectively.

C. Program Workshop Facilitators

Throughout the State, there are approximately 100 Master Trainers, and anywhere from 300 – 700 leaders (one respondent cited 700; the other 300-400). MTs and workshop leaders are volunteers, although some conduct this work as part of their regular employment. The mental health leaders are paid, but the public health and OSA leaders are volunteers or get paid as part of their jobs. Some trainers receive a stipend for teaching a training session. There is very low turnover in AAA staff. Currently there are plenty of leaders to meet the demand, but as more clinics get interested in referring patients, they may need to train more leaders.

It is very easy to train leaders in Michigan. They have two T-trainers and over 100 MTs (as stated above). Agencies such as the Kidney and Arthritis Foundations conduct leader trainings using their own finances, but when the OSA receives a grant, they reserve some funds for training in areas of the State that need more leaders. If there is an area that is underserved, the State can recruit and train more leaders in that area; generally the AAAs set up the actual training.

There is very low turnover in any of the AAA staff, and it was reported that there are currently enough personnel to meet the demand; however, the program is starting to grow, so more staff may be needed in the future. There are currently no vacancies; however if there were, the program would not have the means to recruit new staff due to a hiring freeze in Michigan.

D. CDSMP in the Larger Context of State Services

The primary organizational stakeholders of this program are the AAAs, Councils on Aging, home health agencies and also more local agencies such as senior centers and fitness centers. Respondents report that OSA and DCH have open communication and interaction with all of these levels. These groups contribute to the success of the program by helping with marketing, and identifying champions for the program to recruit leaders and participants. They have been assisted by the Michigan State University Extension, who is connected to the medical school and can “get in the door” at hospitals and residency programs with the program. The arthritis and diabetes foundations have their own funding streams, so the OSA works with them to share trainers or other resources. They share resources as much as they can with the other statewide agencies.

E. Financial Structure

Following is the program's budget for the current and past fiscal years including one-third of the Older American's Act (OAA) Title III-D funding, not including local expenditures:

3/31/2010-3/30/2011:	\$653,239.50
3/31/2011-3/30/2012:	\$653,239.50

The budgets have remained relatively stable over the two years. On March 30, 2012 Michigan will be left with the Title III-D funding as the main source of the budget unless (or until) the AoA provides more funding (competitive or non-competitive). Program spending is delayed in Michigan because federal grant dollars must be approved and allocated by the State legislature before they can be used by the department or agency for which they are intended. The legislature is slow to let go of funds, so this causes a delay in the State Units on Aging making funding available to AAAs.

Michigan has concerns regarding the availability of future funding. All State budgets seem to be in disastrous shape, so even if prevention/self management is a top priority, there seems to be no funding for it. Also, from the perspective of the State Units on Aging respondent, it appears that much of the Health Care Reform Act prevention monies go to the Centers for Disease Control and thus end up at that State Public Health Departments rather than some going to the State Units on Aging. Michigan has a poor track record of sharing between departments when it is not required.

Approximately 10 percent of the CDSMP budget funds administration of the programs (data entry, technical assistance, development of marketing materials, marketing, record-keeping) and 90 percent goes to conducting workshops and trainings. Ninety percent of the program's funding is from grants. ARRA (stimulus dollars) covers Stanford CDSMP programs only. All 16 AAAs received these funds but they are tied to the number of expected program completers

from March 31, 2010 to March 30, 2012. State funding was also tied to expected number of completers.

Currently, no direct state funds are used in this effort. It is anticipated that they will begin using State Medicaid waiver dollars to fund programs that serve waiver clients. Waiver dollars will be a sustainability strategy, as the Evidence-Based Disease and Disability Prevention (EBDDP) programs will become a qualified waiver service and continue to be eligible for payment. Currently, all AAAs may use their Title III-D dollars to support the local EBDDP programs. Michigan is working toward a percentage requirement for this funding that would secure at least a portion for the EBDDP work. Title III-D funding appears to be a sustainable source and accounts for 10 percent of the annual EBDDP budget.

Other sources of support include local dollars and both in-kind and monetary contributions to help support AAA programs. Funding also comes from the Centers for Disease Control, Arthritis Control program. There are no client cost-sharing plans or fees to participate in the program.

Major funding sources have changed over time. Michigan has always had the Title III-D program (health prevention dollars from the Older Americans Act), but in 2007 the federal dollars that they received gave them a needed boost to train more MTs and lay leaders, and to identify program champions. Program champions are the people outside of the funded agencies who act as program advocates; respondents described them as the key to lower costs. Champions are recruited from senior centers and churches (e.g., pastors as champions for faith-based programs). They try to get people involved who can promote the program and even become leaders.

In 2007, Michigan received the first grant that empowered older adults to take charge of their health. There were 15 – 20 different evidence-based disease and disability programs, and each grantee had to work with at least one CDSMP and two other programs in the State.

The cost of the program per participant is about \$300 in urban areas and about \$150 – 200 in rural areas. NCOA has a cost calculator that takes into consideration cost of space, snacks, material, instructor, and administration costs. It does not include the cost of training leaders. Low-income participants are targeted for the program. The ARRA grant was specifically designed to target low income and minority populations. It was reported that participants in the Michigan CDSMP are at or below 185 percent of the poverty level. This estimate is based on the fact that many of their participants also participate in the food security programs, which stipulates that a recipient be at 135-185 percent of poverty.

Michigan does not track insurance, so they do not know the percent of participants who are Medicaid beneficiaries; however, they are pursuing Medicaid waiver approval. They feel that it is very likely that approval will be obtained, since Michigan has several AAAs that have high proportions of consumers who are Medicaid beneficiaries and/or waiver participants.

Anecdotally, the Michigan respondents feel that the program has been cost effective in terms of health care utilization. Based on informal comments provided at the end of the program, participants say that they feel more empowered. However, statistical data are not supported nor analyzed to support this claim. Michigan is planning a study on health care utilization.

F. Sustainability

The Michigan CDSMP has established program monitoring practices to determine the sustainability of the program. MTs who conduct training sessions are required to monitor the leaders whom they train. They sit in on classes and call leaders to inquire about how the leaders think that their classes are going. Through this monitoring process, the MT determines if additional training is needed. Further, the OSA has a consultant to analyze the data so that they can assess the number of workshop completers for each leader as a way to target leaders who may need additional help.

G. Program Services – Workshops

A workshop participant is an enrollee who attends at least one session, whereas a completer is defined as a participant who completes at least four of the six sessions. The retention rate is high with approximately 76 percent of all enrollees completing the program. Although these data are not collected, leaders report anecdotally that the primary reasons for participants to drop out of the program are 1) having problems or an illness (since this is a chronic disease population, this is expected), 2) starting a class, but traveling south for the winter (snow birds), 3) picking and choosing the classes based on the topic that will be presented at a given workshop, or 4) misunderstanding the program. Respondents also mentioned that participants may not like the program or the leader of the workshop, though they suspect this is a negligible number. There is no eligibility screening; all potential participants are eligible to enroll. Participants are not charged for participation in the program, and there is no online CDSMP in Michigan.

H. Program Services – Integration

Many of the evidence-based programs are out of the OSA, so there is a considerable amount of integration. For example, they have integrated the CDSMP with the Aging and Disability Resource Center (ADRC), Person Centered Planning (PCP), Veterans Administration (VA), the Medicare Improvements for Patients and Providers Act program (educating Medicare beneficiaries on prevention benefits), and the Senior Farmers' Market Nutrition program. OSA is also currently working on integrating the CDSMP with the State Medicaid waiver program. They have also integrated with the disability community, such as the Centers for Independent Living (CIL), to recruit leaders and participants. Respondents stated that they have tried to integrate into every level possible. The number one goal in the State is to improve the quality of life of older adults through health and wellness, so the CDSMP is at the top of the pyramid.

The program does not formally share resources with other programs/organizations. They do share outreach efforts, and they share the National Adaptation Programmes of Action (NAPA) database to obtain demographic data.

2. Participant Profile – Population Served

The average age range of participants in Michigan CDSMP workshops is between 68 – 71 years. The ethnic composition is similar to that of the State with 12 - 14 percent Hispanic and five to six percent Arab. There are also high percentages of Russians and Asians in the program, but these numbers do not match the State profile. Typical of such programs, there are many more females (over 80 percent) than male participants.

It was estimated that approximately 10 percent of the participants are Managed Care enrollees, but respondents could not provide information about the proportions of Medicaid and Medicare participants. There is an optional checkbox on the enrollment form for insurance, but since these data are not reported to the National Council on Aging (NCOA), these data are not monitored or analyzed..

3. Program Processes

Michigan respondents provided great detail about CDSMP marketing and recruitment strategies, as follows.

A. Marketing/Outreach

Recruitment “varies tremendously” and could include any of the follow vehicles:

- A community center, where the leaders came from a state university and recruit on their end;
- Brochures, branding, and advertisement in newspapers;
- Advertisement in the church bulletin, especially if the workshops are to be held in those locations;
- Outreach to health care providers where they will share materials and process with partners (this is currently being piloted in the State);
- A website where people can review locations and dates for what will be offered in their area in the coming months;
- Cross-referral of people from tri-county office on aging or physician health plans (they come to a regional meeting and they will be told about all upcoming meetings); and
- A provider will sometimes provide materials to a patient.

Overall, there is still a need to reach a critical mass of programs and regions to develop a strong cross-referral system. Michigan has developed a new “leader kit” so the leaders know how to market their program and understand why information is collected from them. It is the responsibility of the licensed agency to follow fidelity trends in their workshops.

Sometimes those who are enrolling or recruiting make errors and there is large drop off at a second session because people don’t understand the type of program in which they enrolled. Respondents indicated that they wish to focus more on targeting specific populations for participation. Staffing is a barrier to reaching target populations on a couple of different levels. With more staff, the State could gather partners and help them understand better ways to market and recruit for different populations. Limited funding, however, restricts multiple meetings per year. Respondents believe that Michigan is very successful at both effectively convening partners and gathering data given adequate resources. To target specific populations, respondents felt the State would need to be more concentrated on that and have sessions on just that issue to develop strategies, and do follow-ups to discuss best practices.

At the local level, the AAA solicits participants by “Identifying champions.” They look for leaders in senior centers or religious institutions that can promote the program and become leaders themselves. Generally, recruiters work to connect with physician office staff and ask them talk to patients about the program. In some areas there is good media coverage through radio spots or advertisements on cable TV. Small newspapers will place announcements and workshop sites will post fliers about the program.

In addition, DCH created brochures that are available, ready-made, to host agencies, and have online brochure templates that can be customized for a given population. For example, when recruiting areas that comprise largely African American participants, brochures have pictures and diseases that are ethnic specific. For Native Americans, brochures adapt cultural appropriate practices such as the dream catcher and a talking stick.

B. Intake Process

There are no eligibility requirements for participation. Participants enroll at their own discretion.

4. Data Management Systems and Data Availability

A. Tracking and Outcomes

Data is collected at the first workshop session, though participants may join at the second session and fill out enrollment forms then. At the last session, participants fill out an evaluation form, discussed further in Section 5. There are two points of data collection, and there is attendance taken and matched. The NAPAs database is useful in identifying program areas. It is possible to organize by service provider, AAA, or county.

B. Collection Process

An Access database is used and the State retains hard copies for a minimum of a year. Michigan enters information into the database to report to NCOA by participant and sends the information through a secure system to the evaluator to analyze the data. They have an idea about drop out of leaders but do not collect this information. Workshops are limited to 16 people, so there is a potential it would fill up quickly. Locally, there may be a small cohort of people who need to wait but this is not the norm.

C. Data Storage

DCH only keeps the data long enough to enter them into the NCOA database; data are then deleted. The NCOA database has no identifiers. As part of data review for all projects, the department checks that all fields are filled in. They have not had a lot of missing data so far.

D. Quality Control

Respondents indicated that they would like to do more quality control of data than they do currently. They are careful to avoid collecting identifying information about participants, but indicate it may be feasible for national evaluation to collect identifying information of participants.

5. Evaluate Activities

Michigan Partners on the PATH distribute program evaluation forms to workshop participants, to be completed during the final session of class. This form includes information desired by the ARRA grantees, as well as information required by the CDC for a Department of Community Health grant. All sites signed a letter of agreement stating they would participate in data collection; consequently, all sites that are in contact with OSA and DCH deploy and submit participant surveys. The evaluation form does not ask explicitly about satisfaction with the program, but does employ questions that are used to indicate participant satisfaction, such as:

- Would you recommend this workshop to your family and friends?
- What did you like BEST about the workshop?
- What did you like LEAST about the workshop?

One indicator used to evaluate MTs is the retention rate. The assessment includes both the retention of participants, used to indicate the success/effectiveness of individual MTs, as well as the retention of MTs by Area Agencies on Aging. There is a self-assessment that they have provided to their partners as well—and several are using it—but it is not standard practice. The State grantees indicated that this is something developing on many levels and should be addressed.

Health outcomes are not monitored as part of the evaluation process. Instead, participants are asked at the final session whether they will use the tools they learned in the workshop, and which tools they are currently using. The DCH very intentionally avoided collecting identifying information about the participants, as it would cause extra burden on leaders to collect consent forms.

Findings from the workshop surveys are not shared or made available to program participants, but are available to partners, should a request be made. These findings can be reported by county, agency, etc. but are usually reported statewide to give an overall picture of CDSMP in the State. There are plans, however, to submit a report at the end of the first grant year (March 2011); after the report is complete, it will be posted to the State website and distributed among the aging network and the AAA contacts.

Overall, the State does not engage in self-evaluation activities. State grantees indicated that self-evaluation was not a top priority at this point given resources and capacity, though they do track whether or not they are meeting program goals, such as number of people served and number of classes taught. The State Arthritis Program, however, has a consulting firm that is conducting a CDC-funded national evaluation, and the CDSMP is evaluated in that program.

Future plans for self-evaluation include partnering with academic institutions and healthcare providers in the State. A geriatric center contract with the Michigan State University School of Medicine has been conducive to evaluation; they have surveyed lay leaders and master trainers online, and are currently following up with one-on-one phone interviews. The goal of this data collection is to determine areas of improvement for implementing CDSMP. The State is also working with the Medical Advantage Group, which comprises 800 physician offices across the State. The DPH and OSA are working with them to introduce self-management programs, and the physicians are interested in looking at healthcare utilization evaluation. Obtaining aggregate information about participants from this group would allow them to get around human subject restrictions because the documents will not have any identifiers. If possible, one respondent would like to collect data through a pre-post test with the programs to see how much participants knew before and after the program. Some advocates would like to do biometric measures of blood pressure and cholesterol to see if behavior changes affect those measures.

Representatives from the grantee organizations indicated that there are many dimensions that they would like to study. At the community level, they communicated that asking questions to get at what participants feel would be helpful for improving not just the quality of the workshop, but also the program process in terms of marketing and recruitment. Additionally, the State grantee organization stated that it would be interested in determining how well integrated CDSMP is into the aging network and local public health organizations. The Michigan State grantees get feedback from partners and steering committees on programming, but nothing specific to PATH or from the participants themselves.

Though representatives from the State agencies stated they would like to collect information on health outcomes and changes in participant behavior, they also mentioned that the CDSMP is considered to be an evidence-based project, and therefore don't believe it is as interesting to study questions that have already been studied, than it is to look at questions such as program structure or recruitment.

In particular, State grantees were hesitant to consider health care utilization a good measure of program success for two reasons:

1. For patients managing chronic conditions, such as diabetes, the workshop may give them methods to manage the disease and reduce complications. However, that does not suggest that they should go to the doctor less. The healthcare utilization indicator would not capture prevention of additional doctors' visits, such as the prevention of an amputation.
2. It's possible that patients, now more aware of the care needed for their condition and the steps needed to self-manage, will at first see the doctor more often; patients who were under utilizing health care may now have consistent check-ups as part of their self management program. Health care utilization, then, would not capture the improvement in the management of care.

6. Experiential Wisdom/Lessons Learned

A. Grant Progress

The grantee organization considers their project on track, though they would like to be farther along in terms of actual numbers. They believe that the groundwork was laid when the partnership was created during the first year of the grant, and that they will reach their goals by the end of Year Two. The State grantees are believers in the program itself, and are working to convince AAAs to use only evidence-based programming.

B. Program Facilitators

The biggest facilitator to the current success of the program is the partnership that was created to get the program off the ground. The DPH and OSA believe that the coalition of partners, and the nature of that partnership—one based on non-competitive, cross-referral relationships—were critical to the program.

Another facilitator to the success of CDSMP in Michigan has been the Access database that is available to all partners. The State grantee organizations stated that the database has been a communication mechanism. By allowing partners to see what others are doing, they are engaged and feel part of a statewide initiative. The AAAs in the State are willing to embrace the programs and use it as their own.

Lastly, without Federal funding, the current CDSMP program would not be possible. State grantees believe that the AAAs will continue to use the program, but funding will be necessary from a state- or federal-level.

C. Program Challenges/Barriers

Respondents stated that when the program first started, barriers were in communicating with potential participants. The DPH and OSA felt that people were not signing up for the workshops because they did not know what it was, and the organizations could not adequately communicate the benefits of such a program. However, the State grantees indicated that the problem was rectified easily by mere word of mouth after people had taken the program.

Currently, legislation tends to become a barrier because federal monies must be approved by the State legislature. In the first year of the grant, the ARRA funding was given on March 30, 2010, but the State legislature did not approve its distribution until June 16, 2010. The newly-elected governor also poses a challenge—the State organizations believe that, while the last governor was a champion of CDSMP, the new governor supports the program but doesn't yet have it as a top priority. It was mentioned that the political climate might facilitate community-based programs, and in time necessitate them, as people will not be able to get their needs met from other sources.

Also, barriers exist between the partner organizations, due to different goals and procedures. This also includes partners who are more interested in the skill set and what the program could offer, rather than the process of the program itself. For example, organizations are interested in reimbursement options. Consequently, these organizations may be willing to take the program out of the public health setting, whereas DPH believes that the community-based and low-tech aspects of the program are essential to its effectiveness and success. Pulling it out of the community, then, may increase the likelihood that the program be corrupted or deteriorated in some way.

D. Program Promising Practices

Michigan respondents reported several promising practices, based on what has been unique and successful in the State:

- *Forming and solidifying a coalition among partners and stakeholders.* Michigan State grantees believe this was crucial to the continued communication. In addition, it was mentioned that bringing people together for information sessions and trainings were helpful.
- *Compiling a central database based on enrollment forms.* Though grantees were not clear on how this would be transferred to states that already have a CDSMP in place, it was recommended as a definite facilitator to success.
- *System analysis and community analysis by host sites.* The OSA stated that they required the partnering AAAs in the State to complete a system analysis and community

analysis, before the workshops were scheduled. The AAAs were asked to look for potential partners before beginning, and create coalitions to integrate themselves with other organizations that aren't exclusive to older adults. The AAAs also surveyed their region (using root cause analysis and strategic planning) to understand what the older population looked like in the region and how the CDSMP could be successfully rolled out. This also brought a lot of partners and agencies on board with the concept—before they said, “here’s the training,” they started with, “here’s what we see and hope to accomplish.”

NORTH CAROLINA TELEPHONE INTERVIEW RESPONSE SUMMARY

The research team conducted two telephone interviews with North Carolina respondents. The first interview took place on Thursday, March 3, 2011. The respondent was Linda Miller, Centralina Area Agency on Aging (AAA) Aging Specialist, Regional CDSMP Coordinator, Master Trainer (MT). The second interview took place on Tuesday, March 8, 2011 with Audrey Edminsten, State Lead, Division of Aging and Adult Services (DAAS), Sarah Kennedy, NC DAAS project evaluator, Sharon Rhyne, State partner at the Division of Public Health (DPH), and Oby Nwankwo, NC DAAS. Following is a summary of the responses from the two North Carolina telephone interviews.

1. Program Structure

A. Program Organization

The North Carolina State grantee is the DAAS, where the Project Director and Evaluator are housed. One DAAS employee sits in the office of the partner agency, the DPH, and acts as a liaison between the two agencies. Both agencies contribute a CDSMP Project Manager. CDSMP funding is distributed through the State Department of Health and Human Services (DHHS) through DAAS, who then funnels monies to all 17 North Carolina AAAs. North Carolina has a memorandum of agreement (MOA) between DAAS and DPH on how to spend the CDSMP funds. The MOA also includes the University of North Carolina (UNC) Institute on Aging.

The DAAS AAA funding provides for a regional coordinator and money to implement the CDSMP. There are 100 counties in North Carolina and 17 AAAs, so one AAA covers between three and ten counties. The AAAs do not contract out with host locations; they partner. The AAAs serve as the program coordinators in their regions; they train leaders and participants at the host sites (e.g., senior centers). The regional AAAs coordinate the licenses, activities, and provide a Master Trainer (MT). The AAAs also provide materials and supplies, as well as maintain the database, track leaders, and engage in recruitment activities (more for leaders, but they also train on how to recruit participants).

Some AAA coordinators may also act as MTs and/or leaders, though it is neither required nor expected. Prior to American Recovery and Reinvestment Act (ARRA) funding, six or seven AAAs coordinated the CDSMP but when all 17 AAAs received ARRA funds, the AAAs were required by grant stipulations to set up the CDSMP infrastructure, including designating a regional coordinator. Host sites may be an AAA or other regional location.

All respondents noted that the program structure works well toward facilitating successful program operations. At the regional AAA level, there is one central ordering system where they track all of the leaders, assess program fidelity, and conduct marketing. Eighty-three CDSMP workshops were conducted in the State last year, 29 of which took place in the region served by the Centralina AAA.

B. Program Personnel

According to respondents, key State-level personnel are a tight group who have a strong partnership with the diabetes branch. There is also a State-level advisory group that is key to program operations (although not program personnel, per se). The relationship with the 17 regional coordinators is formalized; otherwise the relationships are considered partnerships.

The Centralina AAA has two designated program staff, but they are not full-time. The coordinator is 45 – 50 percent time on CDSMP, and the assistant to the coordinator is about 60 – 70 percent time on CDSMP. Centralina is the only AAA in which the coordinator has an assistant; AAAs had to designate a regional coordinator for CDSMP (aka “Living Healthy”), not an assistant. However, because Centralina is so big, and they have other grants to help cover the salary of the assistant, they have hired one. The assistant handles database tracking including program fidelity and teaches once a year.

As noted in the previous section, CDSMP funding primarily comes from the ARRA, as designated in the federal stimulus bill. North Carolina is currently about halfway through the ARRA grant cycle. They also have an AoA-sponsored Evidence-Based Prevention Program grant, the Health, Prevention, and Wellness Program, and Title III-D, Older Americans Act funds. The CDSMP is also supplemented with State funding through Programs & Support.

The relationship between various levels of agency staff works well in North Carolina. There is a State-level coordinator who conducts training for the local AAAs and engages in outreach activities (consumers make contact at the State level who provides local contact numbers). The State-level grantee builds the infrastructure and maintains it by providing technical assistance. The State has monthly conference calls with all regional AAA coordinators. They recently held a State retreat although they hold regional retreats as well.

C. Program Workshop Facilitators

North Carolina has 46 MTs, one T-trainer (an individual trained by Stanford with qualifications to train MTs) with two additional T-trainers completing certification, 87 lay leaders for diabetes self-management programs (DSMP), and 300 lay leaders for CDSMP. The T-trainers are paid if they conduct master trainings. Paying T-trainers and MTs is allowed by the State, but it is up to each AAA whether or not they want to use their resources in this way. Some MTs and leaders are volunteers who may be given stipends and/or are reimbursed for expenses (e.g., transportation); other MT and leaders lead trainings and workshops as part of their agency positions. The CDSMP has been operating in North Carolina for several years, so the leader trainings are beginning to slow. For the nine counties served by the Centralina AAA, there are currently four MTs and approximately 46 leaders.

The biggest problem in terms of staff turnover is with CDSMP regional coordinators. Respondents voiced concern over the increased workload on regional coordinators due to the addition of the CDSMP program on top of their other job responsibilities. At the State level, in

the past year, there was only one position that turned over (the evaluator). At the regional level, one of 17 regional coordinator positions turned over. However, as you move down the chain, there are more staff turnovers with MTs and lay leaders. At this point, respondents do not consider it a “huge terrible issue”, but stated that it’s tough to lose trained leaders. To address this issue, the State is expanding their reach by working more with Medicaid and faith-based organizations to recruit potential leaders.

D. CDSMP in the Larger Context of State Services

At the State level, DAAS and DPH are the two primary organizational stakeholders in the CDSMP. One employee sits in the DPH, but is a paid employee of DAAS. This employee sits in the cancer branch of the DPH, and serves as a liaison between the two divisions to give each other access to division networks. For instance, the DAAS can now tap into cancer contacts at DPH, and the DPH can now connect with the AAAs under the DAAS. The diabetes branch of the DPH was active even before the first CDSMP funds came into the State through the DAAS; for example they implemented older programs like “Men for Men”, and some prison CDSMPs. The commitment to the CDSMP was alive in the State prior to the first DAAS grant award.

At the regional level, over the past year, hospitals have become interested in the CDSMP, likely because they will no longer be reimbursed for readmissions that occur within 30 days. So, they are looking for tools to share with their patients to keep them from coming back to the hospital. Other regional stakeholders include the YMCA system which is very large in North Carolina, faith-based communities, senior centers, providers (nutrition for seniors, home meal delivery, clinics), as well as other components of the Aging Network that have been integral for the program to grow.

E. Financial Structure

North Carolina currently has a two-year ARRA grant to implement the CDSMP. The project budget, by year is: Project Year 1 budget: \$473,683; Project Year 2 budget: \$532,888 (PY2 starts April 1, 2011). Previously, North Carolina had an AoA grant to implement the CDSMP. Once the ARRA grant has ended, North Carolina will use AoA Title III-D funding (approximately \$200,000) to continue to implement the program, and respondents were hopeful that other partners would help supply materials, locations, etc.

The rate of budget spending is currently on target; however, North Carolina has concerns regarding the availability of funding going forward. After the ARRA grant terminates, the total funding to support the CDSMP will drop drastically. Although they have an infrastructure and strong cadre of trainers, funds for staffing and materials will be reduced, resulting in a reduction in implementation and reach (especially in rural, low income areas). The breakdown of expenditures between program infrastructure and services is approximately 50 percent infrastructure, and 50 percent direct services.

The major sources of this program's income are as follows:

- ARRA CDSMP grant March 2009-April 2012 (\$1.06 million).
- AoA Sustaining Evidence-Based Health Promotion Programs, May 2010-June 2011 (approximately \$1000).
- The DPH diabetes and cancer branches: (approximately \$10,000/year).

Federal funds include the AoA Title III-D awards, of which 35 percent must be allocated to support evidence-based health promotion programs. Approximately \$50,000 is spent statewide to support CDSMP. State/federal funds total approximately \$600,000 annually. Other sources of support include donations, in-kind support, income from partners such as the Chronic Care Network (Medicaid agency), and faith-based groups who may purchase books, a license, or host a site. There is no client cost-sharing or program participation fees.

Major CDSMP funding sources have changed over time in North Carolina. Originally, they were funded by an AoA grant to implement the CDSMP, now the program is supported with an ARRA grant and supplemented with Title III-D and an AoA grant for Sustaining Evidence-based Programs that is nearly completed. In addition, they have other stakeholders besides DAAS and DPH such as the Chronic Care Network through the North Carolina Medicaid Network, who have provided funding for training and licenses.

The respondents did not know the income level of CDSMP participants or whether or not they are Medicaid beneficiaries. However, they are working with Medicaid Partners, and the Chronic Care Networks, who are very interested in becoming more involved in the program with a focus on the Medicaid population.

F. Sustainability

North Carolina monitors for program fidelity, but not for sustainability. They understand that it is a best practice, but since it is not a requirement of AoA, they do not do it.

G. Program Services – Workshops

North Carolina follows the AoA mandate and defines a workshop participant as a participant who attends one of the six sessions; a completer is a participant who completes four of the six sessions. There is no eligibility screening for participants; any one of any age can participate. The coordinator (or MT or leader) presents a brief screening to potential enrollees to be sure that they understand what the program is about and to determine that either they have a chronic condition or they care for someone with a chronic condition. It is more of a self-screening rather than an eligibility screening. The respondents noted that they want people to know up front the specifics of the class so that they can decide, prior to enrollment, if the program is for them. This is to inform the participant of the time commitment, but also to ensure that participants do not drop out because they were not in the right place. For instance,

in a recent class coordinated through the Centralina AAA, of the sixteen participants who started the workshop, only nine attended four of the six sessions. Although all sixteen were considered participants because they attended at least one class, only nine could be counted toward ARRA goals. Overall, there is a 77 percent state-wide workshop retention rate, although the Centralina AAA has a higher regional rate of 82-85 percent. The primary reasons for dropping out of a workshop are: 1) timeframe and commitment – participants realize that the program was not what they expected; and 2) illness, which is understandable given that the program targets a chronic disease population. A fee is not charged to participants of the workshop, and there is no on-line CDSMP in North Carolina.

H. Program Services – Integration

The level of integration of CDSMP into other programs varies across the State. The CDSMP isn't as integrated with other grants and programs as the CDSMP grantees would like, so they have convened a meeting to talk about integrating the CDSMP with other grants. State grantees and partners will discuss the possibility of combining efforts at the regional-level by integrating other funding opportunities and developing a consistent marketing strategy. It is their intent to embed the CDSMP in other programs and they feel that they have done this with the DSMP. The State has found that CDSMP participants want to move from one self-management program to another, an experience reflected in self-management literature. For example, a participant may start with a general CDSMP and then move to a DSMP. The CDSMP grantees push this philosophy at the regional-level, in order to cross-reference other programs available in the region. In addition, there is a state-level task force on sustaining evidence-based programs that focuses on program integration.

2. Participant Profile – Population Served

The catchment area for the Centralina AAA is both rural and urban. There are nine counties surrounding Charlotte, and the outlying counties are rural. The Outer Bank, a rural region, has been struggling with program implementation. Because AAAs coordinate the CDSMP program, the target population is over 60. The current average age is 68, the majority of participants are white, and similar to other states, there is a gender bias toward women participants (82 percent) and leaders (96 percent; 44 of the 46 MTs). The respondents did not know the proportion of Medicare, Medicaid, or Managed Care.

3. Program Processes

A. Marketing/Outreach

There were a total of 29 workshops across the Centralina AAA region last year and 83 total in the State. Recruitment took place at various centers, particularly those frequented by older adults. For example, in the region served by the Centralina AAA, recruitment was conducted at places such as libraries, retirement communities, and doctor's offices. Currently, 95 percent of

Centralina's efforts are recruitment but they are working to transition to a referral system. The Centralina AAA is enhancing their regional marketing by talking with faith-based organizations, such as the YMCA, and providers of older adult programs, such as home meal delivery.

B. Intake Process

When participants call to register for a class, they are each read a brief script that explains the purpose, structure, and length of the program. Participants are informed that the program involves six weekly classes and are asked to make the commitment to all six if they decide to enroll. The brief description of the program helps to increase workshop completion rates. There is generally no waiting list, but there have been instances where a waiting list has been created in regions where the program was popular. For this reason, respondents felt that a waiting period of six months for a national evaluation is feasible. Their overall program goal is to integrate and embed the program in both State and regional policies. They hope to reach out to members of the aging network, senior centers, and other organizations in their network.

4. Data Management Systems and Data Availability

A. Tracking and Outcomes

Participants are tracked for attendance, and trainers are tracked for fidelity. Participant information is recorded for anyone who attends at least one class.

B. Collection Process

The standardized National Council on Aging (NOCA) form is used to collect contact and demographic information (e.g., age, DOB, income, race, type and number of chronic conditions, zip code) from all enrollees in all workshops, and is administered during the first class. The only additional data that are collected from participants is their session attendance.

C. Data Storage

Records are maintained for a certain period, and each site is required to backup their data. AAAs send to the State, enrollment figures and attendance records with a cover sheet that contains the number of participant completions and the number of workshops held. The State maintains these data to track their status in meeting program goals. The State, therefore, has information at the agency- and leader-level, but not at the participant-level, such as participant demographics.

D. Quality Control

There is no quality control system currently in place in North Carolina.

5. Evaluative Activities

State-level respondents stated that they make sure AoA requirements are monitored such as number of workshops held and completion rates. No evaluations or surveys have been conducted to assess health outcomes or changes in healthcare utilization. In addition, State grantees have discussed evaluating program processes and efficiency, but they have not yet begun this effort.

North Carolina at the State-level is currently administering a follow-up survey of participants one year after they completed the CDSMP, asking them about their health and asking them to fill out the same type of questionnaire they took at the end. They are interested in whether participants continue to use the tools obtained via CDSMP.

The Centralina AAA administers a satisfaction surveys at the end of the final workshop session. The survey utilizes a five-point scale ranging from Poor to Excellent to collect administrative information such as time and/or day of the workshop, location, fee, and overall workshop satisfaction; participants' perceptions of the abilities and skills of the workshop leaders (e.g., leader organization, communication, preparedness, respectful and non-judgmental); anticipated use of skills learned in the workshop; and, whether or not they would recommend the workshop to a friend. The surveys are anonymous and do not collect specific participant data, nor do they track client outcomes. The Centralina AAA compiles anecdotal comments from participants to include in their newsletter.

Findings from the follow-up survey have not yet been made available to program participants, because the data are still being compiled. Summary data will be made available to participants when the analysis is complete. The Centralina AAA updates leaders and program partners and collaborators; they also plan to post the annual report, once complete, to their website.

All North Carolina respondents discussed the desire to assess the reasons for participant dropout as well as completion. In addition, state-level respondents also indicated that they would like to evaluate the effect that small and large groups have on completion rates and satisfaction.

The state-level respondents believe they are meeting their goals by reaching the target numbers required by AoA when the grant was awarded. The target number of workshops for the first year was 94 workshops, and the State held 83 workshops. The target rate of participant workshop completion was 75 percent; the State exceeds this target by reaching 77 percent completion rate.

6. Experiential Wisdom/Lessons Learned

A. Grant Progress

The State grantees and local host believe that the progress of the grant is on track, even progressing better than the goals set by AoA. It was mentioned that some programs may struggle more in rural areas, but for suburban and urban areas, the only limitation is funding for staff, workshops, and other materials.

One respondent noted that the program will achieve its outcomes, based on both the professional literature and anecdotal evidence. Anecdotally, she saw people changing behaviors and stay connected to others from the class—even the “harshes of people” opened up by the end of the program and bought-into the skills. It was compared to Alcoholics Anonymous—one is converted by the end of the program.

B. Program Facilitators

“It’s all about networking and coordinating.” All respondents interviewed expressed that the program success is facilitated by the strong network of AAAs in the State, as well as the partners who have bought into the program and refer clients. Outreach areas that were mentioned in terms of continued network improvement was that of Veteran Affairs, chronic disease groups, and Medicaid; the program hopes to create a stronger network by incorporating these groups as partners and program champions.

C. Program Challenges/Barriers

The grant recipients expressed two primary barriers that impede program success in North Carolina.

The first challenge is filling seats in the program. It was expressed that the marketing and outreach was particularly difficult, and that selling the program to get people to agree and attend meant contacting 70-80 people to fill twelve seats. It is for this reason that North Carolina is placing an emphasis on growing the referral network, so that others outside of the CDSMP can speak to its success and benefits. Lay leader turnover was also expressed as a challenge; in the nine counties surrounding Charlotte, four to five percent of leaders lose eligibility every year because they have not been active.

In addition to filling the seats, another challenge is encouraging participants to complete the workshop sessions. Transportation is especially problematic in the rural areas where public transportation is not available or not accessible. This makes it difficult to keep participants in the program to completion.

D. Program Promising Practices

North Carolina offers several promising practices. North Carolina's continuing partnerships, policies concerning evidence-based programs, and the online roadmap for all evidence-based programs provide other states and CDMSPs opportunities to learn from the State:

- a. *Continued Partnership.* North Carolina established a Healthy Aging coalition prior to the onset of the AoA-funded CDSMP, and there was an agreement in place between DAAS, DPH, and their academic partners. The UNC-Chapel Hill's Institute on Aging assisted in developing the coalition, evaluating the program, and setting a strong foundation for program fidelity. Although they are no longer contracted with the DPH and DAAS, UNC still serves in a consulting role and is available should the program administrators need additional support.
- b. *Embedding Evidence-based Programs into Policy.* North Carolina has taken the step (described as "bold" by one respondent) to formalize and necessitate the presence of evidence-based programs, such as CDSMP, across the State. When the State received the Title III-D funding, North Carolina required that 35 percent of the funding must go to evidence-based programs. This was done at a time when people may not have heard of or understood the benefits of such a program. It "changed the way people were doing business," so that programs offered to older adults were more than for entertainment value. In addition, the State has written evidence-based programs into the goals and objectives of the North Carolina State Aging Plan, and the DPH has put into policy that they will offer evidence-based programming. Embedding it into State and regional policies has greatly impacted the success of the program.
- c. *Roadmap to Healthy Aging.* The agreement with DAAS, DPH, and UNC also facilitated working on a roadmap prior to the start of the ARRA/AoA-funded CDSMP in North Carolina. It is online as a wiki format, which allows providers, AAAs, and other partners, as well as potential participants, to go online and look at the statistics for their county. It also provides information about evidence-based programs in the State with tools for how to set them up. They are currently adding onto the DPH evidence-based programs. One can go into any one county and see where there is a T-trainer, MT, or lay leader and learn about them, and to see the current classes available. It was described as "alluring", in that it allows people to connect across counties and see how others are running the program. The State grantees can contact people in each county to update the wiki for classes available, fees, etc.