Administration on Aging

Chronic Disease Self-Management Program (CDSMP) Process Evaluation

HHSP233201100492G

Final Report Appendices

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Authors:

Cynthia Woodcock, IMPAQ International
Holly Korda, Altarum Institute
Erkan Erdem, IMPAQ International
Sarah Pedersen, IMPAQ International
Michelle Kloc, Altarum Institute
Erik Tollefson, Altarum Institute

Submitted to:

Project Officer: Susan Jenkins
Office of Performance and Evaluation
Administration for Community Living
Department of Health and Human Services
330 Independence Ave SW # 4760
Washington, DC 20201

Submitted by:

Project Director: Tina Barretto
IMPAQ International, LLC
10420 Little Patuxent Parkway
Suite 300
Columbia, MD 21044
Telephone: (443) 367-0088

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APPENDIX A. CDSMP TECHNICAL ADVISORY GROUP MEMBERS

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Name	Affiliation	Bio
Teresa Brady, PhD	Senior Behavioral Scientist at the CDC - Atlanta	Dr. Brady has extensive chronic disease program knowledge and expertise in AoA/CDC partnership building.
Joshua Chodosh, MD	UCLA Associate Professor in Residence, Geriatrics	Dr. Chodosh has extensive program knowledge, with a focus on outcomes for older adults.
Candace Goehring, MN RN	Unit Manager, Aging and Disability Services, Washington State Department of Social and Health Services	Ms. Goehring has extensive chronic disease program knowledge. She has experience working with the Aging Network and has served as an implementer for AoA EBDDP grantees.
Gerry Mackenzie, MSS	Director of Community Resources, Education and Wellness in the Division of Aging and Community Services, NJ Dept. of Health and Senior Services.	Ms. Mackenzie has over 20 years experience in the management and development of state and community-based programs for older adults. She currently manages the older adult health and wellness program, senior health insurance program, Aging and Disability Resource Connection and the statewide information and assistance service. Ms. Mackenzie is the project manager for NJ's Evidence-Based Disease Prevention for Older Adults program.
Ruth Palombo, PhD	Assistant Secretary, MA Executive Office of Elder Affairs	Dr. Palombo has experience in the MA network to provide evidence-based program and ad research interests in the development of strategies to promote successful aging among older adults with chronic conditions and disabilities.
Peter Reed, PhD	Senior Director of Programs for the National Office of the Alzheimer's Association	Dr. Reed has extensive chronic disease program knowledge and has experience as a Researcher/Policy Developer and ARRA Reviewer in the field of Public Health.
Beth Richards	Arthritis Program Director, Missouri	Ms. Richards the State CDSMP Lead for the State of Missouri and has set a best practice in imitating the relationship between the Missouri Arthritis and Osteoporosis Program and State Health and Aging Departments to implement evidence-based interventions.
Carlene Russell	Iowa Healthy Links Project Director, Department of Elder Affairs	Ms. Russell has extensive chronic disease program knowledge. She has experience working with the Aging Network and has served as an Implementer for AoA EBDDP grantees.
David Sobel, MD	Regional Director of Patient Education for the Northern California Kaiser Permanente Medical Care Program	Dr. Sobel's research and teaching interests include medical self-care, patient education, preventive medicine, behavioral medicine and psychosocial factors in health. He has co-authored seven books written for the general public including Living a Healthy Life with Chronic Conditions, The Healing Brain, and Healthy Pleasures. He has been Involved in CDSMP RCT design.

Name	Affiliation	Bio
Nancy Wilson	Assistant Director for Program Development, Baylor University, Huffington Center on Aging	Ms. Wilson has extensive chronic disease program knowledge and has performed research concerning the Aging Network.

APPENDIX B. SITE VISIT GUIDE

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Chronic Disease Self-Management Program (CDSMP) Site Visit Guide

"As you know, we are employees of IMPAQ International and Altarum Institute, and we are talking with you today as part of our work with the Administration on Aging. The purpose of this discussion is to collect information about how your [state/site] is implementing the Chronic Disease Self-Management Program (CDSMP) to inform a national evaluation that is currently being designed. Although during the course of our discussion we will ask specific questions about various aspects of your program, this interview is not intended to monitor or to evaluate your program. Many of your responses will inform what questions to include in a national web-based survey that is part of this project. Your participation in this interview is voluntary and you may choose to discontinue the interview at any time, for any reason. What we learn about your efforts from this interview will be combined with input from other respondents, within your state and across five other states, and incorporated into an evaluation design report to the Administration on Aging (AoA). Your name and your role in this effort may be disclosed to our colleagues at AoA, but no specific statement or quotes will be attributed to you in the report.

Do you have any questions before we begin?"

Domain 1: CDSMP Populations, Marketing/Recruitment

Topic	Site Visit Questions
1.1 Populations Served	**1.1 Populations Served**
CDSMP Participants	1. How have the participants changed over time? 2. How do actual participants map to targeted populations? 3. What challenges have sites experienced in reaching, enrolling and keeping participants (i.e., retention)?
1.2 Marketing/Outreach	**1.2 Marketing/Outreach**
Target Populations	1. What is your catchment area? Is it urban/rural? 2. What provider groups do you target in your marketing efforts (e.g., health plans, hospitals, FQHCs, primary care physicians, health homes, pharmacies, DME suppliers)? 3. What is the message that you seek to communicate? 4. How do you segment the consumer market in your marketing and outreach efforts (e.g., by age, ethnicity, gender, chronic condition, type of health insurance (private, Medicare, Medicaid))? 5. How would you describe your target market? 6. What consumer groups do you market to directly (e.g., churches, YMCA, local AARP chapter)? What is the message that you seek to communicate? 7. What challenges have you faced in working with provider groups? Are there some groups that you would like to work with that you have not been able to? 8. What approaches have been best for attracting provider groups? 9. How do you measure whether you are reaching your target population?

Distribution Channels	1. What distribution channels do you use to disseminate program information? a) Targeted mailings: to whom, how many, response rates? b) Website: host website, target market, URL, number of hits? c) Flyers/brochures: distributed how and where? d) Telephonic marketing: to whom, how many calls/year, who conducts the calls, response rates? e) Radio or TV: which channels, type and length of ads, number of broadcasts/year? 2. For each distribution channel, which population(s) are you targeting? 3. How did you develop your dissemination approach? Was it new for this effort? Was it something that you used before? Was it preplanned or did it develop more organically? 4. Which approaches have worked best and why?
Referring Organizations	1. Have you established a formal referral network? If so, what organizations, agencies, programs, and providers are in the network? 2. Is there an informal referral network? If so, describe. 3. Do you notice a difference between consumers who self refer as compared to those that are referred by your various referral sources? (e.g., in consumer demographics, in completion rates, in participation/interest in the classes)
Marketing Organization	1. Who is responsible for developing a marketing plan for CDSMP? What is the marketing message(s), who are the target populations, and what are the distribution channels? How often is the marketing plan revised? 2. Who is responsible for implementing the marketing plan (or, in the absence of a marketing plan, carrying out marketing activities): the state grantee, host site(s), and/or implementation site(s)? 3. Who is responsible for monitoring marketing/outreach efforts? 4. Did you develop a new marketing campaign for your CDSMP program or is the marketing for CDSMP part of an existing effort?
Marketing Messages	1. What messages do you aim to communicate to providers and consumers? 2. Have you "branded" CDSMP in your state? How?
Marketing Budget	1. What was your marketing budget for CDSMP for the most recent fiscal year? 2. How were marketing funds apportioned to the state level, host site level, and implementation site level?
Marketing Research	1. Have you collected any data on how providers and/or consumers find out about CDSMP (e.g., via an enrollment form or in a follow-up survey)? If so, what are the findings? 2. Have you conducted any other marketing research? If so, what were the research questions? What did you find?
Lessons Learned	1. How do you measure whether your marketing efforts are paying off? 2. What approaches have you found to be most successful in marketing CDSMP? 3. What barriers have you encountered in marketing to specific provider and/or consumer populations? How might these barriers be overcome?

Doman 2: Site Implementation

Topic	Site Visit Questions
2.1 Budget and Financing	**2.2 Budget and Financing -** *Also see DOMAIN 5: Statewide Distribution and Delivery*
Cost Structure	1. Do you know the cost per participant? 2. How did you calculate this cost?
Program Budget	1. How does the cost CDSMP compare to other programs you administer? 2. Over the past three years, has the budget increased or decreased? Has the program had a deficit or surplus?

Grant Funding	1. What are the types of funding you have received and types of funding that you will seek to sustain the program?
Medicare Reimbursement Medicaid Reimbursement	1. Has the state been accredited by the American Diabetes Education Association to provide CDSMP for Medicare reimbursement? 2. Is CDSMP provided under Medicaid managed care in your state (i.e., through MCO capitation payments)?
Health Homes	1. Is CDSMP provided through medical/health homes in your state (e.g., Medicaid health home, ACO, FQHC)?
Fee Structure	1. What is the state's fee structure for a CDSMP workshop for the different payers, if any, that reimburse for this service?
Financial Sustainability	1. Does the state have a strategy for funding CDSMP over the long term? If so, what is it? *[Note: One of the challenges for programs like CDSMP is moving from a "grant culture" to a funding base structured around payment or reimbursement for services rendered. Probe whether the state recognizes this and is addressing it in their funding strategy.]* 2. Does your site have formal business plan for sustainability?
2.2 Fidelity to Stanford Model	**2.2 Fidelity to Stanford Model**
Trainer/Leader Fidelity and Retention	1. What supports do sites offer to leaders or trainers? 2. Are master trainers tracked or followed? 3. Who paid for the facilitator training? 4. Do your facilitators work at multiple host sites?
Fidelity Monitoring	1. "*At the agency level, fidelity refers to the how closely staff members follow the program that the developers provide. This includes consistency of delivery as intended and the time and cost of the program.*" If not, how would you define "fidelity" to the Stanford model? To what extent do you think your program operates with fidelity to the Stanford model? 2. Do you have a Quality Assurance Plan? *If so, obtain a copy*. *3. If the state's completion rates are less than 70%, probe fidelity to see if there may be an issue.* 4. Have you incorporated any changes to the Stanford model that you believe enables the program to better meets the needs of the 60+ population or increases completion rates and long-term compliance? Do you have any evidence of this? 5. Do you a process for regularly monitoring fidelity? If so, describe (e.g., protocol, frequency, metrics, responsible parties, feedback). 6. Do you have a process for continuous quality improvement? If so, describe.

Domain 3: CDSMP Eligibility, Enrollment, and Completion

Topic	Site Visit Questions
3.1 Registration and Enrollment	**3.1 Registration and Enrollment**
Process	1. Do you conduct any type of eligibility screening or administer any kind of assessment prior to enrolling a consumer (e.g., age, chronic condition, functional limitations, financial status, readiness to participate)? If so, what are the criteria for determining "readiness" or eligibility/non-eligibility? What is the basis of turning people down? Is this a documented/written process used throughout the program? *If yes, request a copy.* 2. How do consumers enroll in CDSMP? Online, in-person, mail, or by telephone? 3. Is enrollment centralized at the state level or host site level? Or do consumers enroll at the implementation site level? 4. Do people tend to enroll as individuals or as part of a couple or group (e.g., a group of friends join together)? How does this effect class participation and completion?
Workshop Structure	1. Are workshops targeted at specific population groups (e.g., age, gender, and ethnicity) or chronic conditions, or are workshops mixed groups? 2. Are workshops structured to take advantage of existing social networks? If so, how (e.g., location, group enrollments)? 3. Are the classes accessible to the target population in terms of how often classes are offered, locations of classes, etc? 4. Do your workshop sessions follow the curriculum recommended by Stanford (i.e., order of classes, number of hours, learning objectives and material covered in each class)? If not, how do your workshops differ and why do you do them differently? 5. Do you keep the ordering of the topics covered in the six CDSMP sessions fixed? That is, first day you cover Topic A, second day you cover Topic B, etc. and this ordering is constant across all host sites and implementation sites. What is the ordering of the classes? [This is supposed to be the case and gives us a sense of variability across programs or adaptations? 6. Continuity: What is the longest period of time in the last 12 months that you have gone without a workshop?
Workshop Scheduling	1. What is the class schedule for the current year? 2. Is class scheduling centralized at the state level or host site level? Or do implementation sites do their own scheduling? 3. Does the state maintain a master schedule of classes? If so, where can consumers and providers access it?
Workshop Enrollment	1. What was actual enrollment for each class offered in the past year versus available class slots? 2. In general, does demand exceed supply of class slots or can consumers generally find a class slot when they want it? 3. Do you maintain a waiting list? If so, how many people are on it and at what locations? Approximately what percent of applicants are placed on the waiting list? What is the typical waiting time to start a workshop? 4. If you have a waiting list, what efforts have you made to eliminate it? 5. If you have a waiting list or cannot accommodate someone for a particular workshop, do you ever refer consumers to other (non-CDSMP) self-management programs? If so, which programs? Is a slot usually available?
Orientation	1. Do you have orientation sessions or Class Zero? If yes, describe the curriculum, session length, and level of participation.

Registration Fees	1. Do you charge a fee to workshop participants? If so, how much? 2. If you charge a fee, do you offer a sliding fee schedule, scholarships, and/or free enrollment for individuals meeting certain criteria? What are those criteria? 3. If you charge a fee, are fees ever paid by a third party (e.g., health plan, health/medical home, FQHC, Medicaid, Medicare, health insurance)? 4. What infrastructure is in place for billing and processing receipt of fees (e.g., manual or electronic system, accept checks, cash, credit cards, part of a larger organization's billing system)?
3.2 Workshop Participation	**3.2 Workshop Participation**
Enrolled Population	1. Do you set goals for enrollment by site? If so, what are they and were they achieved (i.e., is your enrolled population representative of the population you are trying to reach)? 2. What is the prevalence of workshop participants with cognitive deficits? Have you implemented strategies aimed at better serving this population? What are those strategies? Any lessons learned? 3. Do you track re-enrollment by non-completers? If so, what do you know about these individuals? 4. Do you track re-enrollment by completers who wish to take the program again? If so, what do you know about these individuals?
Workshop Participation	1. Do you regularly examine attendance logs for problems? 2. Have you examined attendance records by enrollee characteristics (e.g., age, gender, ethnicity, chronic condition, disabilities, health insurance)? 3. Do you track milestones or achievements by participants? Which ones and why? 4. Do you offer incentives to participants to achieve specific goals or complete the program (e.g., cash, gift cards, services)? If yes, what is the incentive structure and what is the source of funding for the incentives? 5. Are there particular topics that participants seem to be most interested in?
Workshop Completion	1. Do you set goals for completion by site? If so, what are they and were they achieved? 2. Do you conduct "exit interviews" with participants (completers and non-completers) to learn about satisfaction with the program and reasons for non-completion? 3. What is your perception of non-completers versus completers (e.g., characteristics, availability of supports, barriers)? Any data to support these perceptions? 4. Have you implemented strategies to increase completion rates? If so, what?
Workshop Follow-up	1. Do you follow up with workshop participants in any way after the workshop is concluded (i.e., effectiveness evaluations, such as questionnaires 4 to 6 months following the program)? 2. Do you offer any kind of "refresher" course for individuals who have completed CDSMP? 3. Do you call participants who drop out of workshops?

Domain 4: Data Collection

Topic	Site Visit Questions
4.1 Data Collection and Program Monitoring	**4.1 Data Collection and Program Monitoring**
Data Collection Capability	1. Reporting to NCOA: Do you report the required data to NCOA on a quarterly basis? How are the data collected, aggregated, and submitted? Who is responsible for data collection, aggregation, and submission? 2. What other program data do you collect on a regular basis (e.g., purpose, users, data elements, frequency, format)? How are the data collected and who is responsible for data collection and reporting? Please share sample reports. 3. To what extent are your data collection systems electronic and centralized? What kind of software do you use? 4. What staff resources (e.g., positions, skills/expertise) are available for data collection and reporting? 5. Do you partner with a university or private research organization on data collection and reporting?
Program Monitoring	1. How and what data is used for performance monitoring? What metrics do you use? Reporting to whom? 2. How do you use data for continuous program improvement?
Assessment and Evaluation	1. Have you conducted any evaluations of CDSMP to measure the effects of CDSMP on health outcomes and costs? If so, what datasets did you use (e.g., MMIS, MDS, program data)? What was the study design? What were the findings? Are there reports available? 2. Have you followed any workshop participants beyond their workshop participation to see if there were sustained benefits of CDSMP? If so, how long? Findings? 3. How are evaluation findings being used to promote the program and ensure its sustainability?
4.2 Evaluability	**4.2 Evaluability**
Randomization	1. If asked to participate in the RCT, what process would you suggest for randomizing participants into CDSMP given the unique features and processes of your program? Randomization during a centralized registration process? Randomization using provider settings? 2. What are the chances that control group participants would enroll in another similar program? 3. How long would control group participants be willing to wait to join a CDSMP workshop? 6 months?
Leadership and Resources	1. Probe whether the state has the resources and expertise to participate in an electronic Participant Tracking System. 2. Probe whether the state has leadership and staff who recognize the importance of a RCT and have the requisite expertise and commitment to manage a RCT.

Domain 5: Statewide Distribution and Delivery System

Topic	Site Visit Questions
5.1 Program Structure/Delivery System	**5.1 Program Structure/Delivery System**
State Grantee	1. Who is the leadership? What is their authority, roles, and responsibilities? How would you rate their level of commitment to CDSMP? 2. Is there a CDSMP state-level advisory board? If so, how often does it meet? Who is on it? How are members appointed? What authority does it have?

	Responsibilities? Funding? 3. What state-level agencies partner with the state grantee on CDSMP (e.g., aging unit, department of health, Medicaid, human services department)? What is the role and responsibilities of each partner? Is there a written partnership agreement? 4. How many employees at the state level have CDSMP responsibilities? What are their positions, who do they report to, and what percent of their time do they spend on CDSMP, doing what? Is there a program coordinator? 5. Explain the organizational structure of CDSMP and the relationships/functions of the state grantee vs. host sites vs. implementation sites. 6. Is there an organizational chart for CDSMP? *(If not, sketch one with the assistance of the state grantee.)* 7. What specifically is the state grantee's role in program planning, administration, and delivery? 8. What is the role of AAAs and ADRCs in program planning, administration, and delivery? 9. Who holds the Stanford license for CDSMP? 10. To what extent is the CDSMP delivery system "institutionalized" with dedicated staff and resources at the state, host site, and implementation site levels? 11. To what extent is CDSMP delivered as a "solo" program versus a program that is part of a constellation of other programs (e.g., other evidence-based programs, other health promotion programs)? If the latter, how do you think this influences consumer participation in CDSMP as well as other programs? 12. Have you conducted an adoption evaluation to look at the settings and/or organizations that are offering a program and how successful each is?
Host Sites	1. Is there a council representing host sites? If so, how often does it meet? Who is the chairperson/ leadership? What authority does it have? Responsibilities? Funding? How are members appointed? 2. How many employees of each host site have CDSMP responsibilities? What are their positions, who do they report to, and what percent of their time do they spend on CDSMP, doing what? Is there a project coordinator and a dedicated recruiter at each host site? 3. What specifically is the role of host sites in program planning, administration, and delivery?
Implementation Sites—Facilities	1. What is the relationship of these organizations with CDSMP? Are there employees at these organizations with responsibility for managing the CDSMP workshops? If so, what percent of their time do they spend on CDSMP? Or does the organization merely provide space for the workshops? 2. Describe the facilities and equipment available to CDSMP at implementation sites. Is it adequate or is additional equipment or space needed? 3. What fees, if any, does CDSMP pay to use the various implementation sites?
Master Trainers and Leaders	1. How many Stanford-certified master trainers and T-Trainers are available in your state? How many were available to train leaders during the past year? Do any of them lead workshops as well? 2. Are the master trainers employees of an agency or organization in your state, or do they work as independent contractors? 3. Does your state or your host sites provide any additional training to master trainers beyond what is recommended by Stanford? If so, on what topics and why? 4. How many leaders did the master trainers in your state train each year over the past three years? 5. Do you ever conduct a Master Training with less than 2 Certified T-Trainers? If so,

	what difficulties are you experiencing with regard to meeting recommendations? 6. Do your master trainers facilitate one 4-day Leader training within one year of completing Master Training? How often do you have difficulty meeting this goal? What do you feel are the difficulties? Do you proactively plan to hold Leader Trainings within one year of Master Trainers completing training? 7. Do you ensure that, if training multiple Master Trainers, each facilitates a Leader? 8. Do each of your master trainers lead a full 4-day Leader training at least once every year, to remain certified? If you hire Master Trainers, do you confirm they meet these training goals (do you use the Stanford Patient Education Center's website to determine 'active' trainers?) 9. What process and curriculum do master trainers follow in training leaders? Are there documented learning objectives and competencies that must be met? 10. How consistently are you able to adhere to the recommended schedule for Leader Trainings (total of 4 days – most recommended 2 days per week for 2 weeks)? 11. How do you recruit master trainers and leaders? Do you have a recruiting strategy, goals, work plan? Who is responsible for recruiting? 12. If you hire Master Trainers, do you use the Stanford Patient Education Center's website to determine 'active' trainers? Do you use Master Trainers who have not conducted a class within the past year? 13. Do you start leader trainings with less than 12 potential Leaders or with more than 25? 14. Do you have a protocol for directly observing Leaders during sessions? 15. Do you have workshops scheduled by the Leaders complete training, so they can meet the goal facilitating within 6 months of training? If Leaders are unable to facilitate within 6 months, do you require a refresher prior to facilitating? 16. Do new Leaders co-facilitate their first workshop with an experienced, active Leader? 17. Who are the master trainers and leaders (e.g., age, gender, ethnicity, chronic conditions, disabilities, years of experience)? Are you achieving a 30% male trainer rate? Are they paid or unpaid? If paid, by whom? 18. Does your state have a central registry of master trainers and leaders? If so, who maintains it? 19. How do you assign leaders to workshops (e.g., randomly vs. try to match leaders with certain kinds of consumers)? 20. What is the attrition rate for master trainers and leaders? If you've been losing a number of them, why do you think that is and what could be done about it? 21. Have you ever experienced shortages in master trainers or leaders? Has this caused problems with staffing workshops or being able to train new leaders? 22. Have you ever had to run a workshop with only one leader (not two as required)? Do you train 3 Leaders for new areas, such that there is a back-up? 23. What do you do if a leader is sick? 24. Do you have a process for periodically evaluating master trainers and leaders? Do you track completion rates by master trainer/leader? If so, what have you found and how do you use the evaluations for program improvement? 25. Do you ask workshop participants to evaluate their leaders? If so, what has been their feedback? How do you use these evaluations for program improvement? 26. In your opinion, what are the attributes of the "best" master trainers and leaders?

Domain 6: Consumer and System-Level

Topic	Site Visit Questions
6.1 State/System Environment	**6.1 State/System Environment**
State Budget	1. Has CDSMP by affected by state budget deficits? If so, how (i.e., funding levels, staffing, number of sites)?
Political Environment	1. To what extent is the current administration supportive of CDSMP? (Democratic or Republican administration?)
Aging Network	1. What are some of the major programs of the state unit on aging? Would you consider CDSMP to be a priority program?
Medicaid Reform	1. Is your state considering any major Medicaid reform? If so, what (e.g., health homes, managed care, 1115 waiver)? 2. Are there ways in which CDSMP could benefit from Medicaid reform?
Competing Programs	1. Are there other CDSMP-type programs that could be considered competing programs? What programs? What is their catchment area? Target populations?
Comprehensiveness of services	2. Are there other CDSMP-type programs that could be considered competing programs? What programs? What is their catchment area? Target populations?
CDSMP's role in other programs	3. Are participants linked to or from other prevention/health programs (e.g., falls prevention, PEARLS)? Is CDSMP part of a larger constellation of services? If so, what else is included in the constellation? Do they think this linkage makes a difference in terms of the types of consumers they get, enrollment rates, and/or completion rates?
Complicating Factors	1. Is the effect program influenced by disease progression or other age-related declines? 2. Have problems been reported with respondent memory issues? 3. What is the respondent and site burden? 4. Are there particular outcomes of interest that are not possible to capture with current data or techniques? 5. When using proxy respondents for those for diminished cognitive ability, what are the challenges? What cultural factors or adjustments are made? How do these adjustments affect the outcomes?
6.2 Consumer Environment	**6.2 Consumer Environment**
Measures of interest to AoA	1. In addition to CDSMP-specific measures, AoA is interested in the following measures which may not directly by related CDSMP. Is your site exploring any of the following 1) Health maintenance, 2) Independence in the community, and 3) What is the effect of diminished cognitive ability on course adherence, completion and outcomes? In particular, does this program support health maintenance? Does it support helping participants remain independent in their communities?
Outcomes that CDSMP does not address	1. Are there issues that participants bring that CDSMP does not address? Does the program meeting their expectations in terms of what is advertised?
6.3 Participant Questions	**6.3 Participant Questions**

	The goal of speaking to participants is to get a sense of whether individuals are willing to be randomized, or willing to wait 6 months to take the workshop (if it would mean important research could be conducted that benefits older adults, etc). 1) Participant introductions, when did you take the class, how many times have you taken the class 2) How did you hear about the program? 3) Did you come to the class with friend(s) or family? 4) Did you have to pay for the course? 5) Was there a class zero? How do you feel about having a class zero? 6) Did you have to wait to get into the class? 7) Was the class easy/convenient to get to? 8) Was the facility and accommodation adequate? 9) Were you able to come to all the classes? If not, why? 10) What were the other participants like? 11) What did you think of your leaders? 12) Was the course content (book, charts, information) useful to you? Do you have recommendations or ideas for change? 13) Are you doing anything differently now as a result of the class? If so what? 14) Have you shared anything you learned or the course book (informally or formally) with family or friends? 15) Have/would you recommend the course to others? 16) Do your leaders follow up with you after the class? What do you think about the idea of a follow up after the class? Have you kept in touch with your leaders? 17) Are there other programs, like the CDSMP, that you have taken or are aware of? If so, what are those? 18) Do you have any thoughts about the marketing – is it adequate or do you have recommendations for improvements? 19) Is there anything else you would like to share?

APPENDIX C. SITE VISIT SUMMARY

Chronic Disease Self Management Program (CDSMP) Process Evaluation and Detailed Outcome Evaluation Design

HHSP233201100492G

Draft CDSMP Site Visit Summary

February 28, 2012

Submitted To:

Susan Jenkins, COTR
Administration on Aging, DHHS

CC:

Margo Katzper, CO
Program Support Center, DHHS

Submitted By:

Daver C. Kahvecioglu, Project Director
IMPAQ International

Site Visit Team:

Michelle Kloc, Altarum Institute
Holly Korda, Altarum Institute
Sarah Ruiz, IMPAQ International
Cynthia Woodcock, IMPAQ International

SYNTHESIS OF SITE VISIT FINDINGS

During January and February 2012, researchers from IMPAQ International and Altarum Institute conducted site visits in six states to gain an understanding of the experience of states, host[1], and implementation[2] sites in implementing the Stanford Chronic Disease Self Management Program (CDSMP) as funded by the U.S. Administration on Aging (AoA) under contract HHSP233201100492G: *CDSMP Process Evaluation and Detailed Outcome Evaluation Design*. Information obtained through the site visits will inform development of a Web-based survey of states, host, and implementation sites, and process evaluation findings, and will provide input to guide the design of a rigorous outcome evaluation under the contract.

We conducted two or three day site visits in Arkansas, California, Kansas, New York, Tennessee, and Vermont with teams of two or three individuals. Following review of National Council on Aging (NCOA) data[3] tracking implementation status and analyses of State Progress Reports[4], the team developed an interview guide, including input from AoA representatives, to address key study domains to explore onsite. Using data from the NCOA Sustainable Infrastructure and Delivery System Self-Assessment, the project team selected thirteen state grantees of interest for AoA's consideration. To obtain an understanding of the diversity of contexts in which CDSMP has been implemented, six of the thirteen states were selected to represent regional and organizational diversity, and included visits with both developmental and mature sites. Over the course of the site visits, the team spoke with eleven host sites, eight implementation sites, six groups of master trainers, ten groups of lay leaders, and seven groups of participants. This brief report highlights key site visit findings, followed by state summaries and one state comparison table[5].

Overview

CDSMP Populations, Marketing and Recruitment, Enrollment, Eligibility

Demand for CDSMP is generally weak across states. For most sites, recruiting participants is the biggest challenge, with only a few host sites reporting no difficulty. Recruitment and enrollment approaches are localized and vary considerably across sites. Sites that offer other evidence-based programs often use these programs as a source for recruitment into CDSMP or a platform for

[1] Host organizations are the organization or agency that sponsors CDSMPs offered in each state. The Host Organization is often responsible for training CDSMP Master Trainers and Lay Leaders, and for planning and monitoring the implementation of workshops. Often (but not always) the Host Organization holds the license to train and offer CDSMP. Host Organization may also serve as an Implementation Site.

[2] Implementation Sites are the physical location where CDSMP workshops are offered in the community. An Implementation Site may be identical to the Host Organization, or it may be a location (such as a community center, health care facility, church, etc.) that the Host Organization arranges to use.

[3] To facilitate the collection and reporting of the required quantitative participant data, standardized pen and pencil forms and a web-based data entry system are available to State Grantees through NCOA. Grantees must be trained and license to access the system.

[4] States grantees are required to submit standard Grantee Progress Report on a quarterly basis. Grantee Progress Reports include both quantitative and qualitative sections on program success.

[5] See Table 1 at the end of this report.

offering a constellation of evidence-based programs. We heard some participants, leaders, and trainers say that they appreciate the value of taking the course more than once and also taking other self-management courses. One trainer stated that it would be best to take the generic CDSMP first, and then take the disease-specific courses. Some sites use informal methods to screen potential participants for enrollment or accommodate individuals with a disability (i.e. cognitive or visual impairment). Two sites reported efforts to screen participants for mental health and cognitive ability to participate. Sites use a variety of approaches to recruit participants, from targeted panel management through electronic health records (EHRs), websites, presentations at senior centers, personal contacts with prospective participants, advertisements in local newspapers and newsletters, and on local radio and television. Panel management involves identifying patients in a health care practice for outreach from medical records or claims data. Use of Class Zero[6] is infrequent, given by either the host or implementation site staff. However, one state reported conducting Class Zero before about half of the workshops offered. Rarely does state-level staff deliver these presentations. Some states and some localities have given brand names to CDSMP, but the names vary.

Site Implementation and Fidelity

Workshops are provided in diverse settings including a bowling alley, restaurants, congregate meal locations, senior centers, senior housing, health centers, hospitals, and churches. Participants generally enjoy the social bonding with others in their workshops, and many continue to meet after the workshop has ended. A few enroll in CDSMP a second time. Lay leaders may receive stipends ranging up to $350 (plus mileage reimbursement) for 6 sessions. One state paid $1,500 to a host site for registering 10 participants and an additional $200 for each completer. A number of host sites have trained staff members as master trainers and lay leaders as a way to "embed" CDSMP in their organization before American Recovery and Reinvestment Act (ARRA) funding ends.

Fidelity[7] is interpreted and implemented inconsistently across state grantees, host and implementation sites, master trainers[8], and lay leaders. Whether and the extent to which sites monitor fidelity varies from grantees stating that the program is implemented with fidelity to more extensive monitoring using state-specific check lists and frequent observations of workshops. States typically determine which aspects of fidelity are important and feasible to monitor. States may have "official" and "unofficial" policies, for example, to determine the number of participants required for

[6] Class Zero, also referred to as a "pre-session" or "zero class," is a recruitment session designed to increase enrollment for CDSMP workshops. Class zero sometimes serves as mechanism to screen clients who are not serious about participating in the workshop.

[7] Stanford's Fidelity Manual can be found at http://patienteducation.stanford.edu/. Fidelity requirements include areas such as licensing, training, and how the program is monitored. The organization that holds the CDSMP license is responsible for monitoring fidelity and reporting information related to fidelity to Stanford. Every organization offering a Stanford program must have a license for the program and each license lasts for 3 years. Each licensed organization must submit a yearly report which includes the number of workshops, number of participants, number of leader trainings conducted, and the names of leaders trained with contact information.

[8] Trained leaders (T-trainers, master trainers, lay leaders) also have an obligation to monitor fidelity. Master trainers provide some oversight of CDSMP workshops, train workshop leaders, work in pairs, and serve as workshop leaders themselves. Lay Leaders are individuals who facilitate the CDSMP workshops.

workshops. Sites are implementing fidelity adaptations ranging from class sizes below Stanford requirements, lay leader workshop presentation requirements (some providing only one workshop annually), providing one-on-one follow-up visits, and use of the same buddy for all six classes rather than changing buddies every session. One master trainer described the fidelity requirements as "fuzzy," leaving some gray areas for interpretation.

We also discovered some innovative ideas about ways to incorporate CDSMP into the health care continuum such as group visits for the CDSMP participants in a given workshop. Accommodations have been made for special groups, for example using audio for blind persons. Some sites reported that it would be nice if they were made aware of any changes in the training materials before they go out and use them. One leader reported that she was surprised to see two different versions of the CDSMP book at a workshop since she was not aware of any changes Stanford made. Another person reported that the most recent fidelity manual changed some important requirements (such as the requirements to maintain trainer certification) that led to differences in interpretation of when the new manual goes into effect. Some states noted they have trained too many (or too few) master trainers. States with too many are often unable to provide sufficient workshops for the trainers to ensure their continued certification, though these states are not aggressively monitoring trainers or leaders for 'active' certification. In rural areas, meeting Stanford's requirements for leaders to maintain their certification can be a challenge. The smaller populations in rural areas means there is not a need for so many workshops in a given year. However, the reluctance of many leaders to travel long distances means that states still need to train a large cadre of leaders.

Statewide Distribution and Delivery

We noted great variation in state infrastructure and delivery networks as well as the degree to which the lead agency has decentralized responsibility for program implementation, management, and oversight. One program was rooted in a statewide hospital network involved with broader state health reform activities; others were based in state public health departments and their local networks, aging services networks including AAAs, or were comprised of loosely affiliated independent community-based organizations without formal networks. The site visit team discovered that states with longer histories of offering CDSMP tended to have more established, sustainable infrastructures[9] for CDSMP than the states with more recently established programs, many of which have found initial implementation and sustainability difficult to achieve in the current economic environment.

Sustainability after the end of ARRA funding is not guaranteed. Some developmental states say they are not sure how they will continue offering CDSMP. Some used ARRA funding to train staff from host organizations and implementation sites as leaders and see this as a way to continue offering workshops. One mature state reported they will probably downsize but are trying to find funding to sustain CDSMP. One state reported that ARRA funding will not impact their commitment or ability to provide CDSMP.

[9] Institutions are not as susceptible to fluctuations in grant and temporary funding and include organizations such as hospitals.

Data Collection and Feasibility of Outcome Evaluation

Sites need to modify enrollment procedures significantly to participate in a RCT. The sites also have to develop data collection capacity and participant tracking capability. Adequate enrollment will be a challenge in many states and localities. Enrollment numbers are likely to fall after ARRA funding ends and states limit their marketing activities. Achieving adequate enrollment for a national RCT will most likely require a major marketing campaign in evaluation sites. Sites were generally favorable towards a rigorous evaluation as they thought it was very important for sustainability (to get potential funders' buy-in). Some sites even expressed that they would prefer an evaluation of this type sooner rather later. However, sites will generally be very reluctant to deny service (required for RCT). The evaluation should not reduce the total number of people served. The agency who funds the evaluation may have to provide additional funding to encourage more participants to take the workshops than otherwise would have taken the workshops in the absence of the evaluation. Reduced social isolation/increased social networks for the older adults may be an important benefit of CDSMP and a potential program outcome to evaluate to evaluate in addition to concrete measures such as healthcare utilization and expenditures.

Goals of the Evaluation:

- One interviewee noted that if the ultimate goal is to achieve sustainable systems to provide CDSMP, then it is critical for the evaluation to consider agendas of potential funders. For example, the evaluators should learn the specific outcomes/measures potential funders (e.g., insurance companies) are interested in and should incorporate those into the design.

- The end product of this project is to design a rigorous national outcome study of the CDSMP in AoA-funded settings. Sites are not implementing "the" CDSMP as defined by the more than 100 standards[10] laid out in the Standard fidelity manual. If AoA evaluates CDSMP as it is implemented on the ground, it will be difficult to attribute the impacts to a well-defined program due to potentially important divergences from some of the CDSMP requirements. The fidelity dimension appears to need closer scrutiny. What are the few core standards out of the more than 100 standards currently listed in the manual? It is also important to consider the possibility that some of the adaptations may be effective even though they are inconsistent with the CDSMP must-do's.

[10] These standards are called "must-do's" in the manual. There are also a number of "nice-to-do's" as well.

ARKANSAS SITE VISIT SUMMARY

The research team visited the Arkansas CDSMP program, *Be Well, Live Well*, on Tuesday and Wednesday, January 17 and 18, 2012. The lead agency is the Arkansas Department of Health (ADOH). The first meeting on Day 1 was with the state coordinator and data analyst from ADOH along with the representative from the Division on Aging and Adult Services (DAAS) with responsibility for CDSMP within that agency. This team of three accompanied us on all interviews during our 2-day visit.

Our second meeting on Day 1 was convened at a senior center in Rogers, AR, in the northwest region of the state. Participants included a master trainer who was an Area Agency on Aging (AAA) employee, two lay leaders, and five participants who had recently completed a workshop together. The lay leaders were a husband-wife team—a retired educator and a retired social worker. The Rogers site was still developing, but was the most advanced of the three we visited. The senior center is owned by the city, serves an affluent retiree population (Rogers is the home of Sam Walton and Wal-Mart), and has about 1,100 people come through the door each day.

On Day 2, our first meeting was with two lay leaders, one lay leader, and six participants at a senior center in Jacksonville, AR, not far from Little Rock. One of the lay leaders was the activities director for the senior center; the other was employed by the AAA. The lay leader was an employee of the senior center. The participants had recently completed the same workshop together. We also met with two lay leaders and a lay leader at a senior center in Hot Springs, AR. Area Agencies on Aging (AAA) managed the CDSMP programs in Rogers and Jacksonville; AAI managed the CDSMP program in Hot Springs. The below table provides an overview of the interviews from the Arkansas Site Visit.

Arkansas: Overview of Visit	Arkansas: Overview of Visit - Interviews	Arkansas: Overview of Visit - Facility	Arkansas: Overview of Visit - Location
Day 1, Session 1	State Officials-Aging and Health	Department of Aging (State Grantee)	Little Rock, AR
Day 1, Session 2	Met with AAA staff person who is also a master trainer	Wellness Center (Host Site)	Rogers, AR
Day 1, Session 2	Focus Groups with lay leaders and participants	Wellness Center (Host Site)	Rogers, AR
Day 2, Session 1	Met with AAA and Wellness and Activity Center staff, one of who was a lay leader	Wellness and Activity Center (Host Site)	Jacksonville, AR
Day 2, Session 1	Focus group with participants	Wellness and Activity Center (Host Site)	Jacksonville, AR
Day 2, Session 2	Met with staff from Medical Sciences staff and Center on Aging Staff	Medical Sciences Center (Host Site)	Hot Springs, AR

1. CDSMP Populations, Marketing and Recruitment, Eligibility Screening

The state targets all adults aged 60 and older, but accepts younger people into *Be Well, Live Well*. Most participants have participated through senior centers and have been Caucasian; African Americans have been less likely to join. There are some Southeast Asian and Latino populations in the state, but few have participated in the program.

Most marketing is performed locally by host and implementation sites through newspapers, newsletters, and flyers at senior centers. There is no statewide Website that advertises *Be Well, Live Well*. The ADRC, Choices in Living, has a Website and an 800 telephone number, and staff members have access to workshop calendars for referrals. However, the state noted that they have not done as good a job as they could with this marketing channel.

Host sites promote the program to faith communities. The Hot Springs site has been especially successful with the local churches, which seek out opportunities for their members. The state promotes the program at Medicare Improvements for Patients and Providers Act (MIPPA) health fairs promoting Medicare plans and with the State Health Insurance Assistance Program (SHIP), a federally funded program that provides counseling to Medicare beneficiaries on health insurance. To date, there has been no systematic outreach to health plans or providers at either the state or local level.

2. Site Implementation

Arkansas received a Centers for Disease Control and Prevention (CDC) Empowerment grant 5 to 6 years ago for evidence-based program development. Startup under the AoA ARRA grant was delayed, with the state hiring two directors of short duration before a 0.5 FTE program coordinator was hired a year after the grant award and a 0.5 FTE data analyst 3 months later. This, in turn, delayed host site startup. Implementation and enrollment have been more challenging in rural areas due to low literacy and limited understanding of the benefits of the program, as well as a lack of transportation and sparse population density.

In addition to an eight-region network of AAAs, the state has a six-region network of Centers on Aging established by the University of Arkansas Medical Sciences (UAMS) Arkansas Aging Initiative (AAI) with tobacco settlement funds. Both the AAA and AAI regions cover the entire state and overlap with each other. Both the AAAs and AAI operate CDSMP, sometimes collaboratively. The role of the AAI Centers on Aging is education (not services); many at the state and in the AAAs feel that diverting tobacco settlement funds to AAI was not a wise use of public resources and makes for a duplicative delivery system.

Be Well, Live Well is offered free of charge in Arkansas. However, with ARRA funding about to end, local sites are considering charging for books. Some of the sites have lending libraries and only give books to participants if they complete at least four sessions. Using ARRA funding, ADOH pays each host site $300 for each completer, up to a maximum of $15,000 (50 completers). ADOH also pays

each AAA region $2,400 for lay leader trainings. The Rogers site reported stipends of $100 per 6-week workshop for lay leaders. The state requires a minimum of 8 people to start a class and a maximum of 15 per class.

The state takes an informal approach to monitoring fidelity, observing some classes and monitoring attendance forms. Maintaining the certification of master trainers and leaders is a challenge for this mostly rural state, given the low population density and travel distances for workshops and trainings. Modifications to the CDSMP protocol include allowing participants to keep the same buddy throughout the 6-week workshop if the participant is more comfortable with that arrangement (Jacksonville site) and one instance of a workshop being compressed into 3 weeks. The Hot Springs site pleaded for the ability to use *PowerPoint* instead of some of the flipcharts to save time and paper.

The state does not offer Class Zero or an orientation, nor does it track participants after the conclusion of a workshop. Strategies to sustain the program included embedding lay leaders and master trainers as paid staff of ADOH, AAAs, and AAI, and a requirement in DAAS's 4-year plan that each AAA must offer one EBP.

3. CDSMP Eligibility, Enrollment, Completion

Implementation sites and workshop leaders handle registration locally, mostly by telephone. The local sites do not perform any systematic eligibility screening. Class size and completion rates vary by class and implementation site. The state will meet its AoA enrollment and completion goals, but is finding it challenging to increase awareness of and demand for the program. The state reports 467 completers and a goal of 500. AAI's goal is 300 completers; the AAAs' goal is 200 completers. The AAA sites have higher completion rates than the AAI sites.

4. Data Collection

Data on *Be Well, Live Well* participants, enrollment, and completion are collected by workshop leaders in hard copy and submitted to the ADOH Older Adults and Communities section directly, for sites supported by ADOH. For sites supported by the Arkansas Department of Human Services DAAS, hard copy data are reviewed by the Division and forwarded to the ADOH. All hard copy data are checked and entered into an *Excel* spreadsheet by a part-time staffer who submits information to the National Council on Aging (NCOA). Only information required by Stanford is collected.

5. Statewide Distribution and Delivery

Be Well, Live Well workshops have been offered on a very limited basis by DAAS in two Arkansas counties since 2006 through AoA Empowerment grants, and by ADOH with limited funding from the CDC. ARRA funding enabled expansion of the workshops through partnership of ADOH and DAAS and their respective stakeholder networks. A statewide stakeholder coalition has formed to help

establish and support statewide implementation of CDSMP, including Medicare and state Medicaid program representatives. The state (ADOH and DAAS) has also reached out to faith-based communities, SHIP, and others.

Be Well, Live Well workshops are provided through the ADOH and DAAS using AAAs and senior centers as host sites. These sites, in turn, may reach out into the community for implementation partners, e.g., churches or retirement communities. A master trainer at one host site reported their senior center had conducted considerable outreach to local physicians, who have not been too receptive, and has attempted to recruit participants by offering other classes, such as healthy cooking sessions, at local churches in African American communities.

Overall, the state distribution and delivery infrastructure is developmental and faces continuing challenges in sustaining *Be Well, Live Well* workshops. The DAAS has been able to include, as a state policy requirement, that all AAAs offer at least one evidence-based program. This is seen as a positive step forward in sustaining CDSMP and other programs. The ADOH, prime grantee under the AoA ARRA grant, cannot sustain the program beyond ARRA funding. The current program director will be reassigned within ADOH. However, two lay leaders have been trained at ADOH and will be available as embedded staff to provide the program.

6. Feasibility of Outcome Evaluation

State ADOH and DAAS staff, workshop leaders, and participants expressed support for conducting a rigorous outcome evaluation, but funding challenges are likely to pose problems for workshop availability and presentation. Data collection will also pose challenges as the part-time state position to support data collection will be eliminated when ARRA funds expire.

Participants at all sites appeared willing to delay workshop participation to enable and evaluation. However, they emphasized the importance of informing participants at study start that they would be part of a research study. A workshop leader at one site stated that participation in research studies posed no problem, noting that the senior center has already participated successfully in several studies. This leader further stated that she would be very interested in participating in a pilot to assess the relative contribution of various fidelity elements in presenting the workshop if such a study were to be conducted.

CALIFORNIA SITE VISIT SUMMARY

The research team conducted site visits with California representatives involved with CDSMP workshops called *Healthier Living*. The interviews took place on Monday and Tuesday, February 13 and 14, 2012. The lead agency is the California Department of Aging (CDA). The first Day 1 meeting was with two CDA officials, three Public Health Department officials, and the technical assistance contractor for the state. The second Day 1 meeting was a site visit of a rural and developing CDSMP host site. The team met with an AAA director, another AAA staff member, and the local program coordinator who is also a lay leader. At this site visit, the team also met with four lay leaders and three program graduates.

The first Day 2 meeting took place with local city and county health collaborators who serve as a host site. A representative from a county school district, who adopted the program for adult education, also attended this meeting. Under this partnership, teachers who are part of the adult education program receive training as lay leaders and hold CDSMP workshops. The second Day 2 meeting was with a city healthcare district[11] that received a grant from Kaiser Permanente to implement CDSMP in their area. This meeting took place with the director of the healthcare district center and the local program coordinator who also serves as a lay leader. The third Day 2 meeting was a visit to a mature urban senior center that served as a host and implementation site. The team met with the evidence-based program coordinator who also served as a lay leader, and nine program graduates. The below table provides an overview of the interviews from the California Site Visit.

California: Overview of Visit	California: Overview of Visit - Interviews	California: Overview of Visit - Facility	California: Overview of Visit - Location
Day 1, Session 1	State officials-Aging and Public Health, Technical Assistance Contractor	Department of Aging (State Grantee)	Sacramento, CA
Day 1, Session 2	Site director and staff, program coordinator, lay leaders, program participants	Area Agency on Aging (Host Site)	Vallejo, CA
Day 2, Session 1	Los Angeles Department on Aging director and contract staff, representative from school district, technical assistance contractor program staff and CEO	Los Angeles Department of Aging (Host Site)	Los Angeles, CA

[11] Healthcare districts in California were developed in the aftermath of World War II, when American soldiers return from war with extensive medical treatment needs. At the time, California was dealing with acute hospital bed shortages and legislated was based to enact the Local Hospital District Act, later known as the Health Care District Act. It authorizes communities to form Special Districts to construct and operate hospitals and other health care facilities to meet local needs, funded through property tax assessments with acute hospital bed shortages and enacted legislation for the Local Hospital District Act, later known as the Health Care District Act.

California: Overview of Visit	California: Overview of Visit - Interviews	California: Overview of Visit - Facility	California: Overview of Visit - Location
Day 2, Session 2	Healthcare district director and CDSMP program coordinator	Health Care District (Host and Implementation Site)	Ventura County, CA
Day 2, Session 3	Evidence-based program director (lay leader), program participants	Senior Center (Implementation Site)	Downtown Los Angeles

1. CDSMP Populations, Marketing and Recruitment, Eligibility Screening

California serves an extremely diverse population, but with variation by region. AoA-funded CDSMP workshops target older adults over age 60, but encourage individuals of all ages to attend. Providing CDSMP in remote rural areas of California is much more difficult. At this point, California does not have statewide coverage, with many rural communities and regions outside of workshop coverage areas. For culturally and linguistically diverse populations, CDSMP is offered in other languages (Spanish, Chinese, Korean) when there are available lay leaders for the class. It is often difficult to recruit and train bilingual lay leaders.

Most upcoming workshops in California are advertised on the CDA Website. While the NCOA and the state technical assistance contractor, Partners in Care Foundation (PICF), provide templates for marketing and recruitment materials, most recruitment for the class occurs at the local level. Host sites reach out to their partners or constituents to participate in the class. At the AAA host site the team visited, the program coordinator reached out to individuals visiting the AAA and asked the information and referral specialist at the site to refer clients to the program. The program coordinator also reached out to AAA partners in the community (e.g. senior centers, housing) to recruit. The second host site the team visited, a city healthcare district, reached out to their plan members and individuals in the community. The final site visited, an urban senior center, recruited only from members at the center. The senior center plans to recruit from in the community in the near future, but has experienced problems recruiting individuals through their partners for other evidence-based programs currently implemented at the site.

2. Site Implementation

The site team visited three host sites during the California visit including an AAA, a Health Care District site, and a senior center. The senior center also served as an implementation site for the program, and the AAA and Health Care District held workshops at their partner sites. All sites offered CDSMP free of charge to participants. The demand was highest in the senior center and Health Care District site. The senior center sometimes had waitlists for the class, but this was largely a result of individuals who had scheduling conflicts and wanted to take the workshop later. The Health Care District recently offered a "wellness club" or incentive program for individuals who participate in more than one class. The district experienced an increase in demand as a result. The AAA host site was new to offering CDSMP and experienced challenges in starting the program due to delays

resulting from the California budget approval process, and difficulty training lay leaders. With no master trainers associated with the site, the AAA had to invest in lay leader training by bringing in two master trainers from southern California. Despite training 21 lay leaders, the AAA still experiences difficulty scheduling and offering workshops, and experienced a greater than expected drop off of lay leaders.

Funding sources mentioned throughout the state included Community Block Grants, CDC, AoA, and local host site and community resources. Sites plan to continue to offer the workshop after ARRA funding ends, but one host site reported that the pool of lay leaders has decreased significantly and there will not be funds available to conduct another lay leader training. Sustainability following ARRA funding is not assured. One host site reported that the internal funding experts would seek outside funding or grants to sustain the program. California has been able to leverage community block grants for CDSMP to provide a graduated payment scheme to sites. Sites receive decreasing levels of funding over a three-year period, with the expectation that they sustain the program when the funding ends.

3. CDSMP Eligibility, Enrollment, Completion

None of the sites visited reported any eligibility screening. Sites were encouraged to over enroll because drop out is viewed as inevitable. Class Zeros were offered inconsistently throughout California. PICF developed a Class Zero curriculum for sites to use that offers an effective "teaser" for individuals interested in enrollment. One lay leader reported that completion rates were higher for classes that resulted from a Class Zero recruitment session, as individuals had a better sense of workshop requirements and commitment. Registration usually occurs with the coordinator at the local site. Advertisements for the program generally request that local individuals be contacted.

4. Data Collection

Data packets from the workshop are all returned to a staff designee at PICF. Information required for ARRA funding is entered directly into NCOA database and the additional data elements are filed away, with the expectation that the additional data elements will be used in the future, pending new funding. Prior to receiving ARRA funding, PICF maintained a separate data system for the 2006 CDSMP grantees. Starting with 2010 funding, PICF started to enter data into the NCOA database.

5. Statewide Distribution and Delivery

The CDA is the prime grantee responsible for oversight of the CDSMP program. CDA addresses policy relating to the *Healthier Living* program and contracts program implementation and technical assistance to PICF. To distribute the ARRA funding, the state released an RFP to provide CDSMP, to which 22 applicants responded. PICF ranked the applications based on criteria that included partnering agreements and a plan for roll-out, but CDA selected the six sites that received funding.

PICF serves as the statewide technical assistance contractor, collects program data, and provides site-level technical assistance for CDSMP and other evidence-based programs. At the outset of the

grant, sites were able to select among three levels of support from PICF, from low levels of involvement to higher levels of support that might include a broader range of activities, including site-specific program consultation and support.

After ARRA funding ends, the program will be downsized. The statewide steering committee plans to meet less regularly. The CDA asked committee members which activities they would find most beneficial and prioritized those for future funding. The intent of this approach was to help ensure program sustainability after ARRA funding ends. The CDA believes that most sites will continue to offer CDSMP.

KANSAS SITE VISIT SUMMARY

The research team site visited the Kansas CDSMP program, *Kansans Optimizing Health Program* (KOHP), on Monday through Wednesday, January 9 through 11, 2012. The lead agency is the Kansas Department of Health (KDoH). Historically, the Kansas Department of Health and Environment (KDHE) led development of chronic disease management programs in the state and provides a strong leadership role for KOHP.

The first meeting on Day 1 was in Topeka with lead staff from KDoH and KDHE. That afternoon, the team traveled to Wichita and first met with a lay leader and a workshop participant who also coordinates delivery of KOHP at a senior center, followed by a meeting with seven lay leaders employed by a hospital, the AAA, local clinics, and a senior housing complex.

On Day 2, the team met with a master trainer and lay leader in Newton, followed by a meeting with three participants. That afternoon, the team went to Hutchinson for meetings with seven lay leaders and seven participants.

On Day 3, the team was back in Wichita to meet with the AAA director, a master trainer, three lay leaders, and two representatives from Wichita State University, all of whom participate in what is referred to as the KOHP community leaders group, which is taking the lead in implementing KOHP in Wichita and surrounding counties. The below table provides an overview of the interviews from the Kansas Site Visit.

Kansas: Overview of Visit	Kansas: Overview of Visit - Interviews	Kansas: Overview of Visit - Facility	Kansas: Overview of Visit - Location
Day 1, Session 1	State officials-Aging and Health	Department of Aging (State Grantee)	Topeka, KS
Day 1, Session 2	Met with two participants who now serve as a lay leader and implementation site director	Area Agency on Aging (Host Site)	Witchita, KS
Day 1, Session 3	Focus Group with lay leaders	Area Agency on Aging (Host Site)	Witchita, KS
Day 2, Session 1	Met with master trainer, lay leaders, and participants	County Recreation Center (Host Site)	Harvey County, KS
Day 2, Session 2	Met with lay leaders and program partners	Department of Aging (State Grantee)	Reno County, KS
Day 2, Session 2	Met with program participants	Department of Aging (State Grantee)	Reno County, KS
Day 2, Session 1	Met with AAA director, master trainer, lay leaders, and local program coordinators	Area Agency on Aging (Host Site)	Sedgwick County, KS

1. CDSMP Populations, Marketing and Recruitment, Eligibility Screening

The state targets all adults aged 60 and older, but serves younger people as well. One of the host sites is the Veterans Administration, which serves just veterans. There are areas in Wichita, Kansas City, and southwest Kansas with large Latino populations; the state recently trained 2 master trainers and 12 leaders to teach Tomando. Tomando participants are typically females in the "middle generation" caring for children and parents.

Most marketing is performed locally by host and implementation sites through newspapers, newsletters, and flyers distributed through senior centers, county departments on aging, and the Kansas State Research & Extension. The state hosts a KOPH Website listing upcoming workshops; prospective participants must call the local sites to register. The Kansas State Research & Extension Service's Website and the service's individual county Websites have information on KOHP, but accessibility and content varies. Lay leaders take calls from prospective participants and manage the registration process, carrying out targeted one-on-one marketing in the process.

Some community health centers are experimenting with flagging patients with chronic conditions in the patient's chart so that they can be referred to KOHP. However, there are questions about the feasibility of this approach as the clinics move to electronic health records.

2. Site Implementation

Because of a series of staff reductions and retirements in KDoA, startup under the ARRA grant was delayed. Additional staff reductions and reorganizations are anticipated for all state agencies as the budget crisis continues and the state moves to a Medicaid-managed care program and enacts health reform.

Historically, KDHE led development of chronic disease management programs (initially with a CDC grant for an arthritis program). KDHE continues to be the *de facto* lead because KDHE's staff has the most experience with these programs. AAA participation in KOHP has progressed slowly. The Kansas State Research & Extension Service trains its own lay leaders and plays a strong role in KOHP delivery through its network of county offices.

In Wichita, the KOHP community leaders group—an informal coalition that includes representation from the AAA, a local medical center, clinics, a senior housing complex, and Wichita State University (WSU)—is beginning to build momentum. In a unique arrangement, WSU provides administrative and marketing support using graduate student interns in aging studies who receive credit for assisting the program 10 hours per week, looking toward capitalizing on future research and evaluation opportunities. WSU targets provider and consumer groups to market the program and build a referral network.

Local sites may choose to charge a fee for the workshops, but most do not. The fee in Wichita count is $25. The state is considering requiring a $25 fee to cover the cost of books, but local sites do not

favor this, believing even a minimal fee would be a barrier to many participants in need of the program.

One Class Zero was offered in a housing complex in Wichita. The sites do not conduct any follow-up with participants who complete the program. There is no formal process for fidelity monitoring.

3. CDSMP Eligibility, Enrollment, Completion

Registration is handled locally (mostly by telephone) by lay leaders whose phone numbers are listed on Websites and marketing materials. There is no electronic registration system. The local sites do not perform any systematic eligibility screening.

The state has had difficulty generating demand for KOHP and filling classes, especially in rural areas. There are no waiting lists.

4. Data Collection

Data for NCOA on participants, enrollment, and completion rates are completed on paper and faxed or emailed to KDHE for data entry. In addition, the state requests that KOHP participants complete an evaluation form at the end of the workshop requesting feedback on how the participant heard about the workshop, satisfaction, and usefulness of the techniques taught. A data analyst funded through the ARRA grant periodically analyzes the data and provides reports to the state and local sites.

5. Statewide Distribution and Delivery

Responsibility for KOHP is largely decentralized, with AAAs and the Kansas State Research & Extension Service's network of county offices responsible for program development, marketing, and implementation in their respective regions. The Veterans Administration also serves as a host site.

The state has sponsored two summits to bring together community partners to brainstorm about how to build and sustain a CDSMP program. The first summit was convened in January 2011 in the Wichita area (Sedgwick, Butler, and Harvey counties). The Wichita community leaders group was an outgrowth of this summit. The second summit was in September 2011 in Johnson County.

The state has a "leader maintenance plan" that includes a listserv, quarterly Webinars, and annual meetings. The local sites reported that this assistance is very helpful. At an October 2011, annual meeting for leaders at Kansas State University, GMAMMA, an improvisational actor, used humor to communicate the importance of fidelity.

The state has requested a 6-month, no-cost extension to their ARRA grant (they have unspent funds because of their delayed startup). To help sustain the program, the state has applied for a competitive CDC grant. The state is also actively pursuing a system where master trainers and leaders are embedded (i.e., employed) in a local system that offers KOHP. Local sites are also

encouraged to raise their own funding. For example, the Department of Aging in Reno County has received three $1,000 grants from a local private senior center. The funds have been used for supplies and snacks.

NEW YORK SITE VISIT SUMMARY

The research team conducted site visits with New York representatives involved in AoA-funded CDSMP workshops. The interviews took place on Monday and Tuesday, January 23 and 24, 2012. The first meeting of Day 1 was with Quality and Technical Assistance Center (QTAC) staff to discuss state infrastructure. QTAC provides all of the technical assistance for the State of New York, including program coordination, training, and data management. The second meeting of Day 1 was a focus group with master trainers throughout the state. The final session was a site visit to a senior housing facility to conduct focus groups with lay leaders and program participants.

Day 2 started with a focus group with host and implementation site partners, including the Department for the Aging, the University of Albany's Center for Excellence in Aging and Community Wellness, a community nursing program, a retirement community, and a naturally occurring retirement community (NORC). The final Day 2 session consisted of a discussion with all officials from the public health and aging departments that have been involved with CDSMP in New York. The AoA state grantee is the New York Department of Aging, which provides high-level oversight to the program and grant management. The below table provides an overview of the interviews from the New York Site Visit.

New York: Overview of Visit	New York: Overview of Visit - Interviews	New York: Overview of Visit - Facility	New York: Overview of Visit - Location
Day 1, Session 1	Quality and Technical Assistance Center (QTAC) staff on state infrastructure	University of Albany (TA contractor)	Albany, NY
Day 1, Session 2	Focus group with master trainers	Associated with: Center for Excellence in Aging and Community Wellness and the P2 collaborative.	All over New York state
Day 1, Session 3	Focus group with lay leaders	Senior Housing Facility (Implementation Site)	Albany, NY
Day 1, Session 3	Focus group with participants	Senior Housing Facility (Implementation Site)	Albany, NY
Day 1, Session 4	Quality and Technical Assistance Center (QTAC) staff on data collection/reporting	University of Albany	Albany, NY
Day 2, Session 1	Focus group with host and implementation site partners	Department for the Aging (Host Site)	New York City, NY

New York: Overview of Visit	New York: Overview of Visit - Interviews	New York: Overview of Visit - Facility	New York: Overview of Visit - Location
Day 2, Session 1	Focus group with host and implementation site partners	Center for Excellence in Aging and Community Wellness (Implementation Site)	Implementation sites all over New York
Day 2, Session 1	Focus group with host and implementation site partners	Community Nursing Program (Implementation Site)	Albany, NY
Day 2, Session 1	Focus group with host and implementation site partners	Neighborhood NORC Program (Implementation Site)	Albany, NY
Day 2, Session 1	Focus group with host and implementation site partners	Retirement Community (Implementation Site)	Albany, NY
Day 2, Session 2	Focus group with state aging and public health staff	State Aging and State Public Health (State Grantee)	Albany, NY

1. CDSMP Populations, Marketing and Recruitment, Eligibility Screening

New York does not target any group, but serves a diverse group of participants, including 21.8 percent African Americans and 16.4 percent Latinos. New York has been able to expand from three regions covered as part of their 2006 grantee status, to six regions. Roughly 50 percent of New York counties are currently covered in these six regions that include more than half the state's population. New York provides CDSMP in a range of rural and urban settings. Master trainers conduct Class Zeros at new implementation sites. Implementation sites and lay leaders are primarily responsible for recruitment.

2. Site Implementation

Host sites serve as regional coordinators. Implementation sites in New York often perform many of the functions traditionally assumed by host sites, such as marketing and recruitment, enrollment, and sometimes monitoring workshop fidelity. New York uses six AAAs as host sites, and has hundreds of implementation sites in the state. More so than other large states, New York tends to hold only one workshop per implementation site and moves throughout the community to reach as many target populations as possible. Despite a centralized technical assistance provider, implementation at the local level is decentralized and varies tremendously.

3. CDSMP Eligibility, Enrollment, Completion

According to a 2011 significant findings and evaluation report, 3,777 participants have completed data forms for CDSMP workshops. Of those participants, 82 percent were course completers, higher than the national average. The age of participants ranges from 17 to 100, with a mean age of 70, and much younger persons resulting from health plans. Almost 70 percent of participants currently live alone. There is no eligibility screening conducted.

4. Data Collection

Data are collected by the lay leaders and are typically mailed back to the QTAC for review and data entry/management. Upon receipt, data are reviewed to ensure all fields are complete and no issues have been identified. If there is a questionable form, QTAC leadership reviews and handles it, if needed. The QTAC staff is responsible for all data collection efforts. When a workshop is scheduled, QTAC staff assembles the data packets, including copies for all participants, and send the packets to the local program coordinator. Outstanding data packets are a source of quality assurance; center staff follow-up to ensure all data packets have been returned in a timely manner.

In addition to the data collected for the NCOA database, participants also receive a participant satisfaction survey. QTAC is engaged in additional data collection efforts, including an outcome study, using instruments similar to those used by Centers for Medicare and Medicaid Services (CMS) 1,000-person pre-post study; a study with HMO organizations on healthcare expenditures compared to administrative matched sample; and a study through the Department of Public Health, the P^2 collaborative[12], where an addendum survey is collected.

5. Statewide Distribution and Delivery

QTAC supports many of the functions of a statewide distribution system by funding all training workshops for master trainers and lay leaders; providing all course materials; data collection, entry, and analysis; and providing technical assistance to sites.

Covering 50 percent of New York counties and more than half of the state population, New York is performing on par with other states in geographic coverage. QTAC ensures they have adequate master trainers and lay leaders in the six regions, though this may sometimes mean that a leader or trainer works in two regions, or across multiple counties. QTAC designed and proposed the six regions to be covered under AoA funds, based on previous relationships, known networks, population size, etc.

[12] The P^2 Collaborative of Western New York is the planning arm of the Western New York Community Health Partners Institute. They are a nonprofit initiative dedicated to improving the health of their community with eight counties of New York (Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, and Wyoming County).

TENNESSEE SITE VISIT SUMMARY

The research team conducted site visits with Tennessee representatives involved in the AoA-funded CDSMP workshops. The interviews took place on Thursday and Friday, January 19 and 20, 2012. The first meeting of Day 1 consisted of three State Commission on Aging and Disability officials. The second meeting of Day 1 was a site visit of a CDSMP host site and meeting with an AAA director, the local program coordinator, who is also master trainer. The third meeting of Day 1 was a small group session with lay leaders and a master trainer from the AAA office.

The Day 2 meeting took place with a second AAA, meeting with the AAA director, the CDSMP coordinator, and two lay leaders. The AAAs did not invite participants to our meetings, as they felt uncomfortable doing so.

The Tennessee Commission on Aging and Disability (TCAD) oversees the grant and program management of five AAAs. The AAAs have attempted to partner with the University of Tennessee Extension, which boasts a considerable number of health educators, many trained in CDSMP. However, this partnership has not worked as initially hoped due to an unexpected shortage of educators and communication and coordination problems. The below table provides an overview of the interviews from the Tennessee Site Visit.

Tennessee: Overview of Visit	Tennessee: Overview of Visit - Interviews	Tennessee: Overview of Visit - Facility	Tennessee: Overview of Visit - Location
Day 1, Session 1	Met with assistant director of commission, program coordinator, and grants manager	Aging and Disability Commission (State Grantee)	Nashville, TN
Day 1, Session 2	Met with AAA director and assistant director, local program coordinator and master trainer	Area Agency on Aging (Host Site)	Chattanooga, TN
Day 1, Session 3	Met with lay leaders, master trainer, and program coordinator	Area Agency on Aging (Host Site)	Chattanooga, TN
Day 2, Session 1	Met with AAA director, program coordinator, and lay leaders	Area Agency on Aging (Host Site)	Knoxville, TN

1. CDSMP Populations, Marketing & Recruitment, Eligibility Screening

Living Well with Chronic Conditions is the brand name for CDSMP in Tennessee. The state serves a largely rural and low income population, with some racial and ethnic diversity. The program is reportedly open to all ages, though advertising materials say "55+". AAA leaders indicate generally enrollment is 60+ and largely female. There is some increasing focus on low income and minority populations.

Marketing and recruitment is generally performed by the AAA CDSMP coordinator or the leader. For some sites hosting CDSMP, the AAA CDSMP coordinator offers to provide course and marketing materials.

The University of Tennessee Extension partnership aimed to enable classes to be held in every county in the state, but this has not performed as well as they hoped, and to date, Tennessee only has 27 implementation sites. A great deal of decentralization exists, with much variation at the AAA-regional level in implementation, recruitment, marketing, etc. Currently, little targeting of providers exists, due to difficulty accessing them. Focus is on direct participant recruitment rather than referrals.

2. Site Implementation

The five regional AAA CDSMP coordinators generally serve as the host sites. Implementation sites may be identified by these coordinators or, in some regions, by CDSMP advocates. We noted great flexibility and variation in marketing, site selection, and participant recruitment in the regions. To date, Tennessee has had 27 implementation sites. Site selection/identification is a challenge. Some AAAs reuse the same site, but indicate that they experience problems with recruitment/enrollment with subsequent sessions.

Obtaining sufficient numbers of participants is often a challenge. One leader stated that she had advertised a CDSMP at her church and had only two members show up for the class, the rest came from the community. Some leaders indicate that hospitals and rehabilitation facilities do not attract participants as well as other locations. Some AAAs offer Class Zeros more frequently than others. Southeast Tennessee Area Agency on Aging and Disability (SETAAAD), for example, will conduct a Class Zero when they have an implementation location identified--one per location. If a class date has not been set, the master trainer will take names of those interested and contact them via phone with class details.

There are no participation fees. Some AAAs do offer incentives for attendance and/or completion, such as door prizes and other small gifts. The AAAs spend $20 to $30 on snacks per meeting, emphasizing the importance of healthy meals.

We noted only the most basic monitoring of fidelity at any level. Classes may begin with less than 10 people, although they try to have at least 5. Classes do not force participants to do the buddy phone calls. For classes with small numbers of participants, the class will often be finished before the 2.5 hours.

AAAs indicate concern about scaling back once funding ends; the state and AAA CDSMP coordinators will likely be moved to other programs, but remaining part-time on CDSMP. Some of the regional AAAs are hopeful of attracting corporate sponsors and there has been some talk of TennCare reimbursements, Affordable Care Act grants, or health insurance companies' participation.

3. CDSMP Eligibility, Enrollment, Completion

Recruitment is often a challenge. Some leaders say that getting people to commit to the 6 weeks and 2.5 hour classes is hard. Recruiting men is a challenge; it does seem that having a male leader may help. Use of senior centers is good for recruitment, but there is the problem of participants wandering in and out of class and not being consistent with attendance. Consistent attendance can be a challenge for some sites. Weather may impact attendance or ability of a site to offer a class. Some leaders provide transportation if it is requested, on an as-needed basis.

There is no screening for participation. The state has provided money for incentives for completion and "nice" snacks, though some AAAs are not aware of this.

Participants contact the leader for the most part. Sometimes, the AAA staff helps with the enrollment process, and sometimes the implementation site will register participants. Phone calls are the primary means of registration/enrollment.

4. Data Collection

Tennessee only collects data required for submission to NCOA. Usually the AAA's CDSMP coordinators gather the data for their region and ensure it is completed and sent to the state lead who enters it into the database. The coordinators have the Social Assistance Management System (SAMS) database as well as the NCOA, but no other systems. There is one state-level part-time data entry person. Most of the AAAs have a full time coordinator who will transition to support other programs once AoA funding ends.

5. Statewide Distribution and Delivery

There are five regional coordinators within the AAAs for CDSMP, and one state-level program coordinator. They have five master trainers in the state, but leverage some trainers and leaders from the University of Tennessee Extension. All recruitment is done at the local (AAA) level. Generally, the AAA coordinator recruits, markets, and holds Class Zeros. There may be some marketing support provided by the implementation site or leaders. Some AAAs rely heavily on a local advocate for site identification, participant recruitment, Class Zeros etc.

The state CDSMP coordinator collects the data as received from the AAAs and ensures it is entered into the NCOA database. Tennessee recently experienced a change in the state-level program coordinator. The previous coordinator had begun to establish networks and regular communications with the AAAs. The new coordinator is still "learning the ropes" and regular communications have dropped, though she is available via phone or email to answer questions. Networking has also suffered during the transition.

The AAAs are concerned about their ability to continue to offer the same number of programs after funding ends and are each seeking other options. Each AAA seems to have its CDSMP champion

taking the initiative to try to find other funding. While not institutionalized, the presence of AAA champions and interest in seeing the program continue is promising.

VERMONT SITE VISIT SUMMARY

The research team conducted site visits with Vermont representatives involved in the AoA-funded CDSMP workshops. The interviews took place on Monday and Tuesday, January 30 and 31, 2012. During Day 1 of the site visit, the team met with officials from the Vermont Department of Health (VDH) and Department of Disability, Aging and Independent Living (DAIL), including several master trainers and one T-trainer on staff. The team also met with officials from the state health plan, Blueprint. During Day 1, the team completed a site visit at a private practice that serves as a host and implementation site. The team met with a master trainer and several lay leaders. The team also briefly observed a workshop and met with two participants.

On Day 2, the team completed a site visit to a local community hospital that serves as a host site. The team met with local coordinators of the site, who are also lay leaders and workshop participants. A second site visit took place at a local community wellness center that serves as a host and implementation site. The team also met with several master trainers and lay leaders at this site. The below table provides an overview of the interviews from the Vermont site visit.

Vermont: Overview of Visit	Vermont: Overview of Visit - Interviews	Vermont: Overview of Visit - Facility	Vermont: Overview of Visit - Location
Day 1, Session 1	Blueprint and CDSMP state infrastructure staff (led by Public Health Department with an Aging Department representative)	Public Health Department Staff (State Grantee)	Williston, VT
Day 1, Session 2	Focus Group with St Albans site staff (including hospital, AAA, Veterans Department of Health)	Medical Center - Family Medicine Practice (Host and Implementation Site)	St Albans, VT
Day 1, Session 2	Focus group with lay leaders and program participants	Medical Center - Family Medicine Practice (Host and Implementation Site)	St Albans, VT
Day 2, Session 1	Focus Group with St. Johnsbury staff (host site)	Regional Hospital (Host Site)	St. Johnsbury, VT
Day 2, Session 1	Focus group with lay leaders	Regional Hospital (Host Site)	St. Johnsbury, VT
Day 2, Session 1	Focus group with program participants	Regional Hospital (Host Site)	St. Johnsbury, VT
Day 2, Session 2	Focus group with host site staff and master trainers	Wellness Center (Host and Implementation Site)	Copley, VT

1. CDSMP Populations, Marketing & Recruitment, Eligibility Screening

CDSMP, branded *Healthier Living*, has been offered in Vermont since 2003, with workshop data available since 2004. In a recently released report from the Vermont Department of Health, 2,073 participants have completed the workshop and answered baseline questionnaires. The program coordinator believes that a *Healthier Living* workshop has been offered in nearly every county in the state. While completion rates have dropped in the last year (no one has been able to pinpoint why), the gender of participants in Vermont appear similar to the rest of the nation, with 77 percent female and an average age of 61.

All three host sites used panel management to target CDSMP participants of interest. Panel management is a technique that identifies individuals with particular characteristics (i.e., a certain chronic condition, low income, etc.) for referral to a CDSMP workshop. This technique has proven particularly effective in identifying individuals for targeted recruitment, although Vermont is in a unique position to do so because of the Blueprint for Health Care Reform, which provides a global statewide data infrastructure. One of the three host sites visited had documented and implemented a well thought out communication and marketing plan. A regional hospital host site, for example, had created a chart of stakeholder groups (i.e. public, employees, medical staff, corporate/trustees) to understand their points of view and the messages or tactics that would be most effective in reaching that stakeholder group. The same host site also developed a marketing plan through the marketing division of the hospital that includes advertising through a variety of mediums and presentations to community groups.

2. Site Implementation

The Vermont Blueprint for Health Care Reform funds the cost of the workshop, the trainings, the materials, and even a lay leader stipend, and estimates the per participant cost at $350. Vermont uses a global 1115 Medicaid waiver to fund evidence-based programs and provides reimbursement to sites for enrolling 10 participants and for each completer. Sites are not permitted to schedule a workshop with less than 10 participants enrolled. Host sites in Vermont are based around the patient-centered medical home model, with each community accessing similar hospitals, AAAs, and wellness centers.

Vermont has been able to implement CDSMP in rural settings with considerable success. When asked why this was possible, officials stated that Vermont's rural culture and community health systems are heavily relationship-based, with a history of collaboration and cooperation.

3. CDSMP Eligibility, Enrollment, Completion

There are no eligibility requirements for CDSMP, although one lay leader reported that individuals who are uncomfortable with social settings and individuals with several mental health impairments, such as schizophrenia, are not good candidates for this workshop. The lay leaders and program coordinators believe that nearly everyone could benefit from the program, no matter their chronic

condition or personality. Fidelity to the Stanford Model is a high priority. Master trainer observations of lay leaders are frequent.

4. Data Collection

The Vermont Blueprint for Health Care Reform is data-driven and captures data through electronic medical record templates, interfaces, and health information exchange; Blueprint registries; chart review; and other means. Evaluation, reporting, and analytics that address process and outcome measures, models, and knowledge are part of the Blueprint's data activities. Data analysis for the Blueprint also uses multi-payer claims, NCQA scoring, and patient experience measurement.

Data on *Healthier Living* workshops are submitted to the state's Blueprint evaluator, who conducts various population-based analyses by community health region. These data can be combined with data from other sources to provide a full picture of the workshops and their impact. The potential for in-depth analyses of CDSMP and its impact is considerable as a result. Blueprint interviewees envision scenarios where workshop participants can enter their Action Plans through a patient portal to share with their primary care practitioners. Workshop leaders at some sites actively encourage participants to share their Action Plans with their providers.

5. Statewide Distribution and Delivery

Healthier Living workshops are embedded as an integral part of the Vermont Blueprint for Health Care Reform, described as a statewide "Learning Health System." The Blueprint anchors health care delivery (including CDSMP and other wellness programs) around the state's hospitals, all of which are non-profit and together comprise a statewide network. Community Health Teams serve patient panels of approximately 20,000. Teams in each region include a care coordinator (17 statewide) for intensive care management, social workers, nutrition specialists, community health workers, Medicaid care coordinators, and a public health specialist. *Healthier Living* workshops are included as part of the Community Health Teams available to the patients in the regional panels. Each region has a local community health coalition consisting of volunteer members and a half time paid project manager who oversees the Community Health Team and a budget of $350,000, provided by insurance companies in the state. The community health coalitions decide how to allocate funds. The state's goal is to have every Vermont resident in a patient-centered medical home. Vermont also has a global Medicaid 1115 waiver, which has full flexibility across the Department of Health and Human Services and fits within the framework of the Blueprint. This robust, hospital-based infrastructure provides a solid, sustainable, statewide network for distribution and delivery of CDSMP.

Table 1: Site Visit Summary Information for All States

Site Visit Overview	Site Visit Overview
Arkansas	January 17-18, 2012. **Day 1:** Met with lead agency staff from Arkansas Department of Health (ADH) and representative from Division on Aging and Adult Services (DAAS) in the Department of Human Services; 1 master trainer, 2 lay leaders, and 5 participants at Rogers Adult Wellness Center, Rogers, AR. **Day 2**: Met with 2 lay leaders, 1 lay leader, and 6 participants at Jacksonville Senior Wellness & Activity Center, Jacksonville, AR; met with 2 lay leaders and 1 lay leader at Oaklawn Center on Aging, Hot Springs, AR.
California	February 13-14, 2012. **Day 1:** Met with State Aging Department officials and Public Health Department officials. Meeting also included technical assistance contractor for state. Visited developing rural site and met with AAA director, local program coordinator who is also lay leader. Met with 4 lay leaders and 3 participants. **Day 2:** Met with local city and county health collaborators for program who serve as host site. Met with school district that adopted training program for adult education. Visited mature urban host site (senior center) that also serves as implementation site. Met with city healthcare district. Met with local program coordinator of senior who also serves as lay leader. Met with 9 participants. Had conversations with TA contractor representatives (2 trained lay leaders) on fidelity and data collection/reporting systems.
Kansas	January 9-11, 2012. **Day 1**: In Topeka, met with staff from Kansas Department of Aging (KDoA), lead agency for AoA/ARRA grant, and Kansas Department of Health and the Environment (KDHE), lead agency for CDC CDSMP grant and historically the lead for CDSMP. In Wichita, met with a lay leader and a workshop participant who also coordinates delivery of CDSMP at a senior center; met with 7 lay leaders employed by a hospital, the AAA, local clinics, and a senior housing complex. **Day 2**: In Newton, met with a master trainer and lay leader; met with 3 participants. In Hutchinson, met with 7 lay leaders; met with 7 participants. **Day 3**: In Wichita, met with AAA director, 1 master trainer, 3 lay leaders, and 2 representatives from Wichita State University.
New York	**Day 1**: Met with statewide technical assistance contractors. Met with 5 master trainers who serve in 4 regions throughout state. Site visit at senior housing implementation site. Met with 6 lay leaders and 3 participants. **Day 2**: Met with lay leaders from 4 rural implementation sites (church, senior housing, parish nurse association/Catholic church), and spoke with 2 officials from urban host site (on-phone, representing 80 senior centers). Met with 3 state public health representatives and 3 aging state representatives. Debrief with technical assistance contractors.
Tennessee	**Day 1**: Met with Tennessee Commission on Aging and Disability (TCAD) CDSMP leadership in Nashville, including the program coordinator and grants manager. In the afternoon, met with Southeast Tennessee Area Agency on Aging and Disability (ETAAAD) in Chattanooga. Staff included the CDSMP coordinator, lay leaders, master trainers, and AAA oversight personnel. **Day 2**: Met with East Tennessee Area Agency on Aging and Disability (ETAAAD), including CDSMP coordinator and lay leaders
Vermont	**Day 1**: Met with officials from public health and aging departments, including master trainers and one T-trainer. Met with officials from state health plan. Site visit at private practice that serves as host and implementation site. Met with master trainer and several lay leaders. Briefly observed workshop and met with 2 participants. **Day 2**: Site visit to local community hospital that serves as host site. Met with local coordinators of site, who are also lay leaders. Met with 2 participants. Site visit to local community health center that serves as host and implementation site. Met with several master trainers and lay leaders.

Domain 1: CDSMP Populations, Marketing & Recruitment	Domain 1: CDSMP Populations, Marketing & Recruitment
History	**History**
Arkansas	The brand name for Arkansas' program is *Be Well, Live Well*. The lead agency is the health agency (ADOH). The state began developing evidence-based programs about 5 to 6 years ago in 2 counties when they received an AoA Empowerment grant. Start-up was delayed under the ARRA grant, although site development seemed to gain momentum in the latter half of 2011. In addition to an 8-region network of AAAs, the state has a 6-region network of Centers on Aging established by the University of Arkansas Medical Sciences (USMS) Arkansas Aging Initiative (AAI) and funded with tobacco settlement funds. Both the AAAs and AAI operate CDSMP, sometimes collaboratively. The role of the AAI Centers of Aging is education (not services); many at the state and in the AAAs feel that diverting tobacco settlement funds to set up the Centers on Aging (instead of using the funds for the AAAs) was not a wise use of public resources.
California	California is one of the original CDSMP 2006 Grantees. As a result of Stanford and their development of the CDSMP workshop and Kaiser Permanente who offer CDSMP as a plan benefit, classes have been offered in state since the 1990s.
Kansas	The brand name for Kansas' program is *Kansans Optimizing Health Program* (KOHP). KDHE initially began building a delivery system in 2005 when the state was 1 of 2 states to receive CDC funding for an arthritis program. In 2009, the state received a small "opportunity grant" from the National Association of Chronic Disease Director to investigate Medicaid and/or private insurance funding for EBPs. KDoA became involved upon receiving the AoA ARRA grant for CDSMP in 2010. The AAAs are integral to the delivery system, as is Kansas State University's Research & Extension Service, a long-standing partner that offers workshops through its county offices and trains its own leaders. Other partners include 2 hospital systems, the Veterans Administration, and Wichita State University. Because of a slow start-up with the ARRA grant, the state has requested a 6-month, no-cost extension to the grant from AoA (through September 2012).
New York	New York was a part of original CDSMP 2006 Grantees. QTAC staff member received grant in 2003 to provide CDSMP workshop.
Tennessee	This was a new effort for Tennessee, though the University of Tennessee Extension had been training leaders to conduct the program. Six different contracts were written to cover the 5 AAA's and the University of Tennessee Extension.
Vermont	Vermont has offered CDSMP since 2003. Received ARRA Grant to include collaborations with AAAs.
Population/Participant Characteristics (Race/ethnicity, SES, age, other demographics)	**Population/Participant Characteristics (Race/ethnicity, SES, age, other demographics)**
Arkansas	The state targets all adults age 60 and above.
California	California serves a diverse population but this varies by region.
Kansas	The state targets individuals aged 60 and older, but serves younger people as well. 29.6% were under age as of January 4, 2012. The local sites reported serving some minorities and a number of low-income participants, especially in rural areas. One of the host sites is the Veterans Administration, which markets the program only to VA patients, with the advantage that if a VA provider tells a veteran to attend CDSMP, typically the veteran will do so.
New York	Program reaches participants in a variety of urban and rural settings. In New York City, CDSMP is offered to diverse audiences, including African Americans, Hindu, Korean, and Latinos.
Tennessee	The program is open to all ages and race/ethnicity.

Vermont	Vermont reaches participants in a variety of urban and rural settings.
Underserved populations? Why?	**Underserved populations? Why?**
Arkansas	Most CDSMP participants come from senior centers and have been Caucasians and well educated; African Americans have been less likely to join workshops. State representatives noted that those who need it most are the less educated. There are some Southeast Asians and Latino populations, but few if any have participated. There are no tribal groups in AR.
California	More difficult to provide CDSMP in rural areas of California. At this time, CDSMP is not statewide and many rural areas are not covered. It is only possible to offer CDSMP in other languages (Tomando, Chinese, Korean speaking versions) when there are available lay leaders for the class. It is sometimes difficult to find bilingual instructors.
Kansas	There are areas in Wichita, Kansas City, and southwest Kansas with large Latino populations; the state has recently trained 2 master trainers and 12 leaders in Tomando. Tomando participants are typically females in the "middle" generation caring for children and parents.
New York	No known underserved populations.
Tennessee	There are 5 regional AAA CDSMP coordinators who generally serve as the host sites. Implementation sites may be identified by these coordinators or in some regions by CDSMP advocates. There seems to be great flexibility and variation in marketing, site selection, and participant recruitment in the regions. To date Tennessee has had 27 implementation sites. There is some increasing focus on low income and minority populations.
Vermont	Vermont has near statewide coverage, even in rural communities.
How do participants learn of classes?	**How do participants learn of classes?**
Arkansas	Most marketing is done locally by host and implementation sites through newspapers, newsletters, and flyers at senior centers. The state has a trainers' Website that includes a blog, flyers, and promotional materials that can be downloaded and used by host and implementation sites. DAAS may include information on its Website, but it is not prominent.
California	Marketing is largely localized but TA contractor provides support depending on the "package" of TA services purchased by the host site.
Kansas	Most participants learn about KOPH through flyers and brochures distributed through local host and implementation sites and newspaper/newsletter advertisements. There is no 800 number; prospective participants must call a local AAA, department on aging, or Kansas-State Research & Extension county office. Lay leaders receive these calls (they have responsibility for enrolling participants) and play an important role in convincing individuals to enroll.
New York	Classes are marketing through a variety of mechanisms, depending on the target audience. QTAC provides template materials and works with states.
Tennessee	Flyers, newsletters, Class Zero, Facebook. One of the AAAs has CDSMP information and a short video on their Website. Free radio/TV ads
Vermont	Each host site has a marketing strategy. Some learn of the program through panel management where patients receive a referral as a result of their chronic condition.
Competing programs?	**Competing programs?**

Arkansas	Diabetes Self-Management Program (DSMP): The state received CDC funding for this program and has 2 master trainers. A Matter of Balance (AMOB): Has been offered for about 2 years and is popular. Active Living Every Day (ALED): Reduced from 20 weeks to 12 weeks, but the state still had difficulty recruiting participants so the program was discontinued as of May 2011.
California	Other programs mentioned were Arthritis Tai Chi, Falls Prevention, Tomando, and locally developed program.
Kansas	Kansas Arthritis Program sponsored by the Arthritis Foundation; Diabetes Self-Management Program.
New York	Diabetes Self-Management Program; A Matter of Balance; Active Generations; Active Choices; Active Living Every Day; Health Eating Every Day; Arthritis Foundation Exercise Program
Tennessee	Varies by AAA: MOB, Arthritis Exercise, Dining with Diabetes, Tai Chi. The programs are being trained to deliver DSMP. One AAA is looking for funding through the Affordable Care Act (ACA) to deliver Care Transitions.
Vermont	Diabetes Self-Management Program; A Matter of Balance; Chronic Pain Self-Management
Marketing/Recruitment: Do you target marketing (participants, clinicians, other)? Why and how?	**Marketing/Recruitment: Do you target marketing (participants, clinicians, other)? Why and how?**
Arkansas	Two main delivery channels: AAI (6 regional Centers on Aging) and Arkansas AAAs (8 regions). Both networks have senior centers that they use as host sites. AAA/AAI service areas overlap. Most marketing is performed at the local level by host and implementation sites and leaders. There is no statewide Website advertising CDSMP to consumers. The DAAS ADRC, Choices in Living, has a Website with an 800 number and has access to CDSMP calendars for referrals, but the state noted they have not done as good a job as they could have with marketing through this vehicle. The state just printed prescription pads advertising CDSMP to distribute to providers. The state (ADOH, DAAS) promotes CDSMP to faith communities; at Medicare Improvements for Patients and Providers Act (MIPPA) health fairs promoting Medicare plans; and with the State Health Insurance Assistance Program (SHIP), a federally funded program that provides counseling to Medicare beneficiaries on health insurance. To date there has been no outreach to private health plans.
California	PICF provides varying levels of TA, which sometimes include assistance in marketing and recruitment efforts. Market and recruitment varies tremendously and is very localized. One targeted recruitment effort was in a hospital emergency room setting where repeated emergency room clients were targeted. In this small study, CDSMP was found effective in reducing repeat emergency room clients.
Kansas	Most marketing is performed locally by host and implementation sites through newspapers, newsletters, and flyers distributed through senior centers, county departments on aging, and Kansas-State Research & Extension. The state hosts a KOPH Website (http://www.kdheks.gov/arthritis/kohp.htm) that lists upcoming workshops. Prospective participants must call the local sites to register. The Kansas State Research & Extension Service's Website and the service's individual county Websites have information on KOPH, but accessibility and content varies. The Quality of Care clinics (community health centers) are experimenting with flagging patients with chronic conditions in the patient's chart so that they can be referred to KOPH.
New York	Marketing through local host or implementation sites and through health plans in some locations. Sending targeted letters to health plan participants has proven an effective method for recruitment.

Tennessee	The University of Tennessee Extension partnership aimed to enable classes to be held in every county, but this has not performed as well as they hoped and to date have only had 27 implementation sites. There is a great deal of decentralization, with much variation at the AAA-regional level in implementation, recruitment, marketing etc. Little targeting of primary care physicians, due to difficulty accessing them. Focus is direct participant recruitment.
Vermont	Marketing through local host or implementation sites and through panel management. Sending targeted letters to health plan participants has proven an effective method for recruitment.
Identify successful approaches or barriers for specific populations	**Identify successful approaches or barriers for specific populations**
Arkansas	None reported.
California	Difficult to find bilingual lay leaders in other languages. Budget crisis in California and delay in approving budget delayed program funds by 1 year. Budget is normally approved in July and was not approved until October. It was necessary to chose sites that could get started before funds were available.
Kansas	Face-to-face contact with participants and referral sources improves recruitment, as does persistence. This may make marketing and recruitment less successful for lay leaders who may have limited time and effort to devote to this.
New York	QTAC feels there is a lack of strong and effective marketing materials for the program.
Tennessee	Use of CDSMP 'advocates' is helpful in recruitment efforts. These are not necessarily the leaders, but may be an organization director, or other stakeholder interested in offering the program to his/her target population.
Vermont	For individuals who are not good candidates for CDSMP workshops, lay leaders or master trainers may go to their home for a one and one session.

Domain 2: Site Implementation	**Domain 2: Site Implementation**
Implementation challenges & opportunities	**Implementation challenges & opportunities**
Arkansas	The ARRA CDSMP grant program is a partnership involving ADOH (grantee) and DAAS. The program at first floundered under ADOH leadership, with two directors of short duration before a 0.5 FTE coordinator was hired after 1 year and a director was hired 3 months later. This delayed host site startups. Implementation and enrollment have been more challenging in rural areas due to low literacy and limited understanding of CDSMP, as well as transportation and sparse population density.
California	CDSMP is very difficult to deliver in rural areas of California. Monitoring fidelity is through class observations is inconsistent. Incoming data is monitored for fidelity but PICF does not have influence on sites reporting data outside of ARRA funding.
Kansas	Because of a number of staff reductions and retirements in KDoA and KDHE, startup under the ARRA grant was delayed. More staff changes are anticipated, especially as the state budget crisis continues and the state moves to a Medicaid-managed care program and enacts health reform. AAA participation in CDSMP has progressed slowly. Multiple-agency involvement in the program can be challenging to the program manager at the state level, with different approval processes for different agencies.

New York	Despite high expectations for some clinical or religious settings, sites have not been successful in recruitment participants. In one religious setting, a leader advocated for the workshop and only one person signed up. There is a reluctance to sign up for new programs.
Tennessee	Site selection/identification a problem. Some AAAs re-use the same site, but indicate that they experience problems with recruitment/enrollment.
Vermont	Even among sites resistant to participate, use of panel management have permitted sites to be successful in recruitment and enrollment.
Fees, scholarships?	**Fees, scholarships?**
Arkansas	There is no fee charged to participants for CDSMP. The ARRA grant pays for books and some sites have lending libraries. Sites said they may consider charging a fee to cover the cost of books when grant funds are no longer available.
California	No fees. Incentives offered at one location through wellness program, including spa certificates.
Kansas	Local sites may choose to charge a fee for the workshop, but most do not. The state is considering requiring a fee of $25 to cover the cost of the books; local sites are generally not in favor of this because they believe a fee would keep people from enrolling.
New York	No fees charged at this point. QTAC is examining whether charging for the course textbook will influence participation.
Tennessee	No fees. Some AAAs offer incentives for attendance and/or completion, such as door prizes and other small gifts. They spend $20 to 30$ on snacks per meeting, emphasizing the importance of healthy meals.
Vermont	No cost to participants
Fidelity challenges, opportunities, changes to protocol?	**Fidelity challenges, opportunities, changes to protocol?**
Arkansas	ADOH and DAAS reported that they request a minimum of 8 people and a maximum of 15 people in a class to ensure fidelity to the Stanford model. ADOH and DAAS perform some site visits to observe classes and they monitor attendance forms. Both the state and leaders said that the program is so well scripted; it is easy to follow and maintain fidelity. A challenge is maintaining the certification of master trainers and leaders, given low population density and travel distances for workshops and trainings. Changes to CDSMP protocol: One site allowed participants to keep the same buddy throughout the 6-week workshop and there was one instance of a workshop being compressed into 3 weeks. One site would like to be able to use *PowerPoint* instead of flip charts to save time and paper.
California	Lay leaders associated with health plans wanted to advertise health plans during workshop breaks (fidelity violation). New leaders paired with experience leaders to guard against problems with fidelity. Inconsistent spot checks and class observations held by TA contractor. One host site monitored fidelity by managing list of workshop leaders.
Kansas	There is no formal process for monitoring fidelity, but KDHE plans to implement a process for monitoring leaders in classes in the near future.
New York	QTAC developed a fidelity checklist that is considered a best practice. Master trainers frequently participate in observations of class to monitor fidelity. Fidelity is also monitored through the participant satisfaction survey given to all participants. If participants report information that indicates a problem with fidelity, all problems are investigated by QTAC.

Tennessee	There seems to be only the most basic monitoring of fidelity at any level. Classes may begin with less than 10 people, although they try to have at least 5. They don't force participants to do the buddy phone calls. For classes with small numbers of participants, the class will often be finished before the 2.5 hours.
Vermont	Vermont Department of Health developed their own fidelity monitoring tool and master trainers observe workshops for fidelity adherence.
Special accommodations?	**Special accommodations?**
Arkansas	Participants with dementia are handled on a case-by-case basis. One such participant didn't seem to be a good fit, but the leaders managed to accommodate her.
California	Accommodations for hearing or visual impairment.
Kansas	A lay leader read materials to a visually impaired participant.
New York	Accommodations are made for individuals with a cognitive or developmental disability. The leader may provide additional one-on-one guidance or use a "buddy system". At one workshop for younger adults with developmental disabilities, each person in the workshop had a caregiver to aid the completion of workshop action planning. Accommodations are made for visual or auditory impairments.
Tennessee	No, none specifically for older adults.
Vermont	Same accommodations as New York.
Adaptations for older adults?	**Adaptations for older adults?**
Arkansas	Small incentives (e.g., coffee mugs) have been found to help motivate participants to complete CDSMP.
California	No adaptations for older adults reported.
Kansas	No adaptations for older adults reported.
New York	Small incentives (cupcakes and graduation certificates) for older adult participants have been found to receive positive feedback.
Tennessee	No adaptations for older adults reported.
Vermont	No adaptations for older adults reported.
Demand: # classes, sufficient capacity to meet demand?	**Demand: # classes, sufficient capacity to meet demand?**
Arkansas	State is seeking to increase enrollees; would like to increase demand as enrollment is limited in some areas and with some populations.
California	Yes. There are waitlists but this is usually a result of scheduling and individuals who need to delay taking the class.
Kansas	As of January 2012, 40 CDSMP classes were scheduled for 2012 across the state.
New York	Capacity exceeds demand. There have been wait lists on very rare occasions.
Tennessee	Obtaining sufficient numbers of participants is often a challenge. One leader stated that she had advertised a CDSMP at her church and had only 2 members show up for the class, the rest came from the community. Some leaders indicate that hospitals and rehabilitation facilities do not seem to attract participants as well as other locations.
Vermont	Capacity exceeds demand. There have been wait lists on very rare occasions.

Orientation: Sessions? Who conducts orientation? Workshops? Type of lay leader? Class Zero?	Orientation: Sessions? Who conducts orientation? Workshops? Type of lay leader? Class Zero?
Arkansas	No Class Zero or formal orientation.
California	Class Zero in some areas. Special Class Zero with "teaser" where a demonstration from the workshop is held and many individuals become engaged and given a taste of the workshop dynamic.
Kansas	A Class Zero was offered in a high-rise apartment building for seniors on the recommendation of the activities director. No others have been offered.
New York	Master trainers and lay leaders reported offering Class Zeros and related recruitment sessions as frequently as possible. It was estimated that roughly 50% of individuals who attend one of these workshops enrolls in the program.
Tennessee	Some AAAs offer Class Zeros more frequently than others. Southeast Tennessee AAA, for example, will conduct a Class Zero when they have an implementation location identified, one per location. If a class date has not been set, the master trainer will take names of those interested and contact via phone with class details.
Vermont	Orientation or recruitment sessions offered infrequently.
Post-program follow-up?	**Post-program follow-up?**
Arkansas	No post follow-up, although some participants continue to get together themselves.
California	At senior centers, program graduates continue to socialize and attend other classes. Unclear whether this occurs in other sessions.
Kansas	No program follow-up.
New York	For the outcome evaluation study, participants receive follow-up self-report surveys.
Tennessee	Informal follow-up. Often in more rural areas, leaders will ”run into” participants. Participants often say they miss the class, would like to have follow-up or attend another class.
Vermont	Some program graduates share their action plan with their health care providers and continue to work on it after workshop has ended.
Financial Sustainability: Challenges, Opportunities	**Financial Sustainability: Challenges, Opportunities**
Arkansas	When the ARRA grant ends in March 2012, ADOH and DAAS hope to continue CDSMP. However, the coordinator (0.5 FTE) and data analyst (0.5 FTE) employed by ADOH will no longer be funded and will be moving on to other responsibilities or jobs.
California	Sites plan to continue to offer workshops but one host site reporting the pool of lay leaders has diminished and there will not be funds available to conduct another training. Rural areas do not have master trainers available to conduct trainings, which is a barrier to sustainability of the program.
Kansas	When the ARRA and CDC grants end, the state hopes to continue KOHP, but it is not clear how this will be done given the state’s fiscal climate. Local sites are encouraged to raise local funding. For example, the Department of Aging in Reno County has received 3-$1,000 grants from a local private senior center that has been used for supplies and snacks.

New York	QTAC will continue to provide TA after ARRA funding ends but it will be a streamlined version. For one site with a robust partner group of 180 senior centers, they will lose their CDSMP program coordinator after funding ends. There was a belief that workshops would continue but with less technical assistance.
Tennessee	Indicated concern about scaling back once funding ends. There is concern about scaling back once funding ends. The state coordinator will likely be transferred to another program. Some of the regional AAAs are hopeful of attracting corporate sponsors and there has been some talk of TennCare reimbursements as a possibility.
Vermont	Program is already sustainable.
Cost to provide	**Cost to provide**
Arkansas	$300/person based on the AoA cost calculator.
California	This information was not available.
Kansas	This information was not available.
New York	Difficult to calculate, as many staff members perform many functions.
Tennessee	This information was not available.
Vermont	Cost of program thought to be $350 per person but communities reported it was more. Sites given $1,000 for enrolling 10 participants and $200 for each completer.
Current funding, financing	**Current funding, financing**
Arkansas	Using ARRA funds, ADH pays AAI and AAA sites $300 for each completer, up to a maximum of $15,000 (50 completers). ADH also pays each AAA region $2,400 for lay leader trainings.
California	CDC, AoA, Community Block Grants, local host site, community resources, and volunteer leader time
Kansas	Current CDC grant ends June 30, 2012; the state is applying for a competitive CDC grant as a follow-on. The state hopes to receive a 6-month, no-cost extension to their ARRA grant.
New York	Sites are very rarely given funds, but QTAC provides all program coordination, training, and workshop materials.
Tennessee	AoA is only current funding source for CDSMP.
Vermont	Funded through Blueprint/1115 Medicaid Waiver
Strategies to sustain funding, ensure financial viability	**Strategies to sustain funding, ensure financial viability**
Arkansas	Host sites training paid staff as master trainers and lay leaders as a way of embedding CDSMP in their operations. DAAS's 4-year plan requires one ongoing evidence-based program (EBP) in each AAA region, thus promoting continuation of CDSMP and/or other EBPs.
California	Seek outside funding or grants. California has leveraged community block grants to provide graduated payment scheme over several years to sites, with the end goal being sustainability.

Kansas	The state is actively pursuing a system where master trainers and leaders are embedded (i.e., employed) in a local system that supports CDSMP. The state has sponsored 2 summits to bring together community partners to brainstorm about how to build and sustain a CDSMP program. The first summit was convened in January 2011 in the Wichita area (Sedgwick, Butler, Harvey counties). The second summit was in September 2011 in Johnson County. The message the state tries to communicate to prospective partners is that self-management classes help people better manage their conditions and can have a positive impact on the community health system.
New York	State officials have presented CDSMP for new Medicaid Incentives Program. Unfortunately, in the second round of consideration, CDSMP was removed from list of programs to receive Medicaid reimbursement.
Tennessee	The AAAs are looking at various options, including other grants (through ACA), TennCare reimbursement/subsidization, insurance companies etc.
Vermont	Program is already sustainable under Blueprint.

Domain 3: CDSMP Eligibility, Enrollment, Completion	**Domain 3: CDSMP Eligibility, Enrollment, Completion**
Eligibility screening? Why, How?	**Eligibility screening? Why, How?**
Arkansas	No eligibility screening reported.
California	No eligibility screening reported.
Kansas	There is no formal screening (i.e., for dementia), but the state works with leaders to help them understand that a certain level of functioning is required for participants to benefit from CDSMP.
New York	None to report. Lay leaders and master trainers felt everyone could benefit from the course.
Tennessee	No screening, no charge for participation, the state has provided money for incentives for completion and "nice" snacks, although some AAAs are not aware of this.
Vermont	None to report. Lay leaders and master trainers felt everyone could benefit from the course.
Enrollment: Challenges, Opportunities	**Enrollment: Challenges, Opportunities**
Arkansas	Enrollment has been limited among African Americans, although some host sites are reaching out via faith organizations. Enrollment has been limited in the SE Delta areas and other rural areas and among low-income, low-literacy groups (books are intimidating to these groups). Enrollment has been easiest in central Arkansas, where more residents are white and middle class, and northwest Arkansas, where there is a strong senior center and affluent retiree population.
California	Sites trained to over enroll because drop out is inevitable. Fewer drop out in the case when orientation session or Class Zero held.
Kansas	The state has had difficulty generating demand for CDSMP and filling classes, especially in rural areas. There are no waiting lists.
New York	In 2 sites, still experiencing difficulty enrolling enough participants for one workshop. In the case of one site, they had been advertising for more than 6 months, but did not have enough interested participants. If there is too much lag time between when participants express interest, they may decide against enrolling in the workshop.

Tennessee	Recruitment is often a challenge. Some leaders say that getting people to commit to the 6 weeks and 2.5 hour classes is hard. Recruiting men is a challenge; it does seem that having a male leader may help. Use of senior centers is good for recruitment, but there is the problem of participants wandering in and out of class and not attendingconsistently.
Vermont	Panel management was a successful tool in recruitment and enrollment. Targeted letters were successful in recruiting participants. Completion rates have dropped recently but health officials are unsure why.
Older adults only, mixed ages?	**Older adults only, mixed ages?**
Arkansas	The state enrolls all ages in CDSMP. Couples sometimes attend together, or one might be the caregiver for the other.
California	Mixed ages.
Kansas	Mixed ages, but mostly older adults.
New York	Age range is 17 to 100.
Tennessee	Largely over 60, some younger.
Vermont	Mixed ages. Everyone covered under Blueprint.
Registration: How? Where? Process? Supporting data system?	**Registration: How? Where? Process? Supporting data system?**
Arkansas	Registration is handled locally, either by the host site (e.g. a senior center) or by workshop leaders.
California	Register with coordinator at local site.
Kansas	Registration is typically handled at the local level by lay leaders based at senior centers, county departments on aging, and the Kansas State Extension county offices. There is no electronic registration system.
New York	Usually through local program coordinator or lay leader.
Tennessee	Participants contact the leader for the most part, sometimes the AAA staff will help with the enrollment process, and sometimes the implementation site will register participants. Phone calls are the primary means of registration/enrollment.
Vermont	Usually through local program coordinator or lay leader.
Completion: Successes & Challenges	**Completion: Successes & Challenges**
Arkansas	Class size and completion rates vary by class and implementation site. One class at a housing development in the Hot Springs area started with 11 participants and ended with 2 because many were ill and had to miss class for doctor appointments (many were couples). In contrast, classes at a senior center in northwest Arkansas are well attended with high completion rates. Transportation issues in rural areas can also be a barrier to completion.
California	Local organizations felt it was easier to market the program and obtain buy-in because there was a "deliverable" (number of completers).
Kansas	One of the host sites is a Veterans Affairs facility which refers its outpatients to the course – as they are ordered to attend, completion rates are very high. There is speculation that a physician's order or recommendation may have similar effects. Residents of senior centers, for programs hosted at their center, have inconsistent attendance during a class and over the course of the program, impacting completion and 'dosage' effects. Participants who have taken other programs may be more likely to take CDSMP.
New York	Higher completion rates for individuals who participated in a recruitment or Class Zero session.
Tennessee	Consistent attendance can be a challenge for some sites; also getting participant buy-in to the 6 sessions. Weather may impact attendance or ability of a site to offer a class.

Vermont	Higher completion rates for individuals who participated in a recruitment or Class Zero session.
Challenges providing workshop? Accommodations to meet these?	**Challenges providing workshop? Accommodations to meet these?**
Arkansas	No challenges reported.
California	Unlike states with harsh seasonal weather, California able to offer workshops year round. Demand is still low in some areas.
Kansas	Most common difficulty is site location and recruitment.
New York	Seasonal challenges to providing workshops. In winter, older adults do not want to leave their home and it can be dangerous for them to do so. Individuals reluctant to commit to activities over winter months.
Tennessee	Transportation - some leaders will provide this
Vermont	Seasonal challenges (although this appears less of an issue than seen in New York) and challenges to offering workshops in rural settings. One lay leader reported travelling 90 minutes to offer the workshop each week. Participants are often unwilling to travel this far.

Domain 4: Data Collection	**Domain 4: Data Collection**
Types of Data: What is collected, by whom, how maintained, what format?	**Types of Data: What is collected, by whom, how maintained, what format?**
Arkansas	Paper and pencil forms are completed by sites and sent to the data analyst at ADOH for review and entry into the NCOA database. ADOH does some analysis of the data, e.g., compliance with the 30/30 concept, which means that everyone in the state can access CDSMP within 30 miles and within 30 days.
California	All NCOA data is collected. Additional data elements include: information on insurance status (Medicaid, Medicare, private); Veteran status; self-management activities; and program usefulness.
Kansas	In addition to the NCOA data, the state requests that CDSMP participants complete a "KOHP Participant Feedback Form" at the conclusion of the workshop. This is a course evaluation form that requests feedback on where the participant heard about the workshop, satisfaction with the workshop, and usefulness of the techniques taught.
New York	QTAC collects and maintains all data.
Tennessee	Only NCOA data is collected. Usually the AAAs gather the data for their region, ensure it is completed, and send to the state lead who enters it into the database.
Vermont	Data is reported to analysis and collection arm of Vermont Department of Health.
Enrollment Data	**Enrollment Data**
Arkansas	Standard enrollment data is collected.
California	Standard enrollment data is collected.
Kansas	Standard enrollment data is collected.
New York	Standard enrollment data is collected.
Tennessee	Standard NCOA enrollment figures.
Vermont	Vermont will not allow the scheduling of workshops if 10 individuals are not enrolled.
Tracking participants	**Tracking participants**

Arkansas	The state does not track participants after workshop completion.
California	The state does not track participants after workshop completion.
Kansas	The state does not track participants after workshop completion.
New York	Participants are not routinely tracked, with the exception of those participating in the outcome evaluation study.
Tennessee	The state does not track participants after workshop completion.
Vermont	Sometimes participants are tracked through health plans.
Collect data other than Stanford requirements?	**Collect data other than Stanford requirements?**
Arkansas	The state does not collect any data other than that required by NCOA.
California	Additional data elements include: health insurance status, veteran status, and self-management/program usefulness scales.
Kansas	Only standard data collected.
New York	Yes, all participants asked to fill out participant satisfaction survey. Other data collection activities include an addendum survey through the public health departments in 8 rural counties, outcome evaluation study, and potential HMO study with matched administrative sample.
Tennessee	No other data is collected.
Vermont	Ability to link CDSMP data to health records. Currently doing double data entry.
Follow up on completers?	**Follow up on completers?**
Arkansas	Arkansas does not follow-up with completers.
California	California does not follow-up with completers.
Kansas	No follow-up other than the "KOHP Participant Feedback Form."
New York	For outcome evaluation study, they are following up with completers.
Tennessee	Tennessee does not follow-up with completers.
Vermont	Inconsistent follow-up with completers through health plans. If participant elects, they will discuss their action plans for the primary care physician.
Evaluation capacity, participation: Staff and systems available	**Evaluation capacity, participation: Staff and systems available**
Arkansas	ADOH depends on NCOA for most analyses. A 0.5FTE data analyst at ADOH does some data analysis and manages a password-protected Website for leaders that currently provides workshop schedules, marketing materials, and a blog.
California	Given history of involvement with program, evaluation capacity should be high if participant tracking component added to their system. At the moment, monitoring is inconsistent and data collection is not ideal with outcome evaluation study.
Kansas	NCOA forms and the "KOHP Participant Feedback Form" are completed on paper and faxed or emailed to KDHE for data entry. A data analyst at KDHE funded through the ARRA grant periodically analyzes the data and provides reports to the state and local sites via the listserv and Webinars.
New York	Staff reported they were interested but lay leaders and master trainers felt there were serious ethical implications to asking participants to wait.

Tennessee	They have the SAMS database as well as the NCOA. They have no other systems. There is one state-level part-time data entry person. Most of the AAAs have a full-time coordinator who will transition to support other programs once AoA funding ends.
Vermont	Very strong evaluation capacity.

Domain 5: State Distribution and Delivery	**Domain 5: State Distribution and Delivery**
Describe State Agency Role	**Describe State Agency Role**
Arkansas	ADOH is grantee; partners with DAAS. Leads of both agencies co-chair quarterly meetings, perform site checks of fidelity, and assist host sites with administration.
California	Largely providing oversight. Made final decision after receiving TA contractor recommendation on 6 ARRA funded sites.
Kansas	KDoA is the AoA grantee. KDHE has historically been the lead with CDSMP and has assumed a strong role under the ARRA grant.
New York	State plays an advisory role. Very strong relationship with public health department.
Tennessee	There are 5 regional coordinators within the AAAs for CDSMP. One state level program coordinator. They have 5 master trainers in the state, but leverage some trainers and leaders from the University of Tennessee Extension. The Extension claims to have educators available to train in every county in the state. All recruitment is done at the local (AAA) level. Generally the AAA coordinator recruits, markets, and holds Class Zeros. There may be some support provided by the implementation site or leaders. Some AAAs rely heavily on a local advocate for site identification, participant recruitment, Class Zeros, etc. Collects the data and enters it into the NCOA database; has some regular calls with the AAAs and master trainers.
Vermont	State involved in all program operations, providing TA to sites and monitoring fidelity.
Statewide CDSMP network? Centralized? Decentralized?	**Statewide CDSMP network? Centralized? Decentralized?**
Arkansas	Responsibility for CDSMP implementation is largely decentralized, with AAAs and AAI Centers on Aging responsible for program development, marketing, and implementation in their regions.
California	Statewide network but not statewide coverage. Some elements centralized through TA contractor.
Kansas	Responsibility for CDSMP implementation is largely decentralized, with AAAs and the Kansas State Research & Extension Service's network of county offices responsible for program development, marketing, and implementation in their respective regions.
New York	Only 50% of counties covered, but more than 50% of state residents served. TA is centralized but everything else is decentralized.
Tennessee	Decentralized, most done at the AAA level (equivalent to host sites).
Vermont	Near statewide coverage. TA is centralized but local sites have flexibility in how they implement the program, if maintaining fidelity standards.
Technical Assistance or support?	**Technical Assistance or support?**
Arkansas	The password-protected Website for leaders managed by ADOH provides marketing materials, workshop schedules, and a blog.

California	Statewide TA contractor PICF
Kansas	The state has a "leader maintenance plan" that includes a listserv, quarterly Webinars, and annual meetings. The local sites reported that this assistance is very helpful. At an October 2011, annual meeting for leaders at Kansas State University, GMAMMA, an improvisational actor, used humor to communicate the importance of fidelity to leaders. The state also shares NCOA data with the sites.
New York	QTAC provides statewide TA, with program coordination, course materials, and data collection and analysis.
Tennessee	The state AoA lead ensures the data is entered.
Vermont	Vermont Department of Health provides TA and sites also receive support from host sites, normally patient centered medical homes.
Interface with State: Successes and Challenges	**Interface with State: Successes and Challenges**
Arkansas	DAAS has been able to include in their 4-year state plan that all AAAs offer at least one EBP. The Governor's office and Medicaid are represented on the Stakeholders Partnership group. Overlapping regions and responsibilities for CDSMP on the part of the AAAs and AAI has probably not been the best use of resources. To date, there has been no involvement of the Arkansas Center for Health Improvement (a state agency headed by the state's surgeon general), which seems to be a missed opportunity.
California	CDA advertises all workshops on the Website and provides oversight
Kansas	The Kansas State Research and Extension Service provides a strong, established infrastructure at the county level, which has been helpful developing CDSMP delivery system.
New York	Strong relationship between TA contractor, Aging (DAIL, Department of Disabilities, Aging, and Independent Living), and Vermont Department of Health
Tennessee	Tennessee recently experienced a change in the state-level program coordinator. The previous coordinator had begun to establish networks and regular communications with the AAAs. The new coordinator is still "learning the ropes" and regular communications have dropped, though she is available via phone or email to answer questions. Networking has also suffered during the transition.
Vermont	Strong relationship between medical homes and health department. As a result of ARRA funding, growing relationship between aging and public health departments (mainly AAAs).
How can state agency best support your site or others?	**How can state agency best support your site or others?**
Arkansas	Insufficient information available.
California	CDA was largely providing oversight. Main source of support was TA contractor.

Kansas	It is unclear how the program will be sustained at the state level after the ARRA grant ends and if continuing CDC funding is not secured. Sustainability at the state level is also at risk given the state fiscal crisis and health reform initiatives. The local sites are trying to "embed" leaders within their agencies to continue offering CDSMP. In Wichita there is a developing partnership involving the AAA, a local medical center, senior housing developments, 2 community health centers, and Wichita State University (WSU). Using unpaid student interns, WSU has volunteered to manage program administration and marketing to providers and consumers, with the prospect of future evaluation/research opportunities. Interns are personally promoting the program to provider groups as well as potential implementation sites.
New York	State aging department is largely providing oversight. Main source of support was QTAC.
Tennessee	Funding support would be the main thing. Perhaps refresher training or other educational and skills support.
Vermont	Blueprint (state health plan) funds all sites.
Sustainability of Distribution/Delivery System	**Sustainability of Distribution/Delivery System**
Arkansas	ADOH has trained 2 lay leaders who are now embedded in the agency and will deliver CDSMP after grant funding ends. It is unclear who will manage the program at the state level after salary support ends for the program coordinator and data analyst at ADOH.
California	Extremely dependent. Delays in approving budget a large influence on program.
Kansas	KDoA, KDHE, Kansas State Research & Extension Service, Veterans Administration, 2 hospital systems, AAAs and local senior centers, and county departments on aging. In Wichita, the Wichita State University.
New York	Goal has always been sustainability, but some sites will be more successful than others.
Tennessee	The AAAs are concerned about their ability to continue to offer the same number of programs after funding ends and are each seeking other options. Each AAA seems to have its CDSMP champion taking the initiative to try and find other funding.
Vermont	Program already sustainable under current system.
How vulnerable is distribution system and CDSMP program in state/county fiscal climate?	**How vulnerable is distribution system and CDSMP program in state/county fiscal climate?**
Arkansas	Very vulnerable at state and local levels.
California	Most sites will continuing offering CDSMP after ARRA funding ends, if pool of lay leaders still exists.
Kansas	Very vulnerable, with only slightly more stability in Wichita.
New York	To be sustainable, additional funding will be needed.
Tennessee	Likely comparable to some other states.
Vermont	System is not vulnerable as it is already sustainable.
Institutionalized or dependent on a single leader, agency, temporary funding?	**Institutionalized or dependent on a single leader, agency, temporary funding?**
Arkansas	In the past year or so, CDSMP has finally gained some momentum in some areas of the state (e.g., Northwest, Hot Springs), but it is far from institutionalized.

California	CDSMP is institutionalized in some settings but not all. Institutionalization sometimes dependent on consistency of funding stream (i.e. Kaiser Permanente)
Kansas	Very vulnerable at state and local levels.
New York	Many components institutionalized but still largely dependent on actions of very few individuals.
Tennessee	While it is not institutionalized, the presence of AAA champions and interest in seeing the program continue is promising. However, lack of funding will likely diminish this.
Vermont	The program is institutionalized.

Domain 6: Feasibility of Outcome Evaluation	**Domain 6: Feasibility of Outcome Evaluation**
What data elements collected?	**What data elements collected?**
Arkansas	Insufficient information available.
California	NCOA data plus several additional elements. Additional elements unknown.
Kansas	Local sites said that they would welcome the opportunity to participate in an outcome evaluation so that they could demonstrate the effectiveness of KOHP for Kansans. Kansas was a test site for "Strong People Stay Young—Health Hearts," a research project conducted at two sites in Kansas and two sites in Arkansas by Dr. Miriam Nelson at Tufts. Twenty Kansans were enrolled and stayed with the program throughout the research period. Researchers from the aging department at WSU said they would be well suited to collaborate on an evaluation.
New York	All NCOA data and additional data elements described. Ranks in top 2 states visited for evaluation capabilities.
Tennessee	Only NCOA data is collected at this time.
Vermont	Very strong evaluation capabilities with records already linked to health plan expenditures.
Is data reliable? Why or why not? QA	**Is data reliable? Why or why not? QA**
Arkansas	Insufficient information available.
California	Data reported for California also includes Kaiser Permanente-funded workshops and any other workshop willing to submit data packets to Partners in Care Foundation. They reach out to all sites who offer CDSMP, but do not have authority over non-AoA funded workshops. TA contractor noted that she sees larger fidelity issues outside of AoA-funded workshops.
Kansas	There may be issues with incomplete data or missing data dependent on the lay leader responsible for collecting, some are more adherent to the policy than others.
New York	Insufficient information available.
Tennessee	Quality assurance performed at AAA level. It is unknown how consistent the monitoring process is between AAAs.
Vermont	Health plan data is very reliable.
What reports are generated and how are they used?	**What reports are generated and how are they used?**
Arkansas	Insufficient information available.
California	PICF generate reports to generate interest and advertise best or new practices.
Kansas	Participation and completion are monitored, but no formal reporting is done.
New York	Quarterly reports shared with aging and public health department officials who use them to influence state policy.

Tennessee	No reports generated.
Vermont	Annual reports made public. Used to influence policy makers to continue to support the program.
Is it possible to share data not reported to NCOA?	**Is it possible to share data not reported to NCOA?**
Arkansas	No additional data collected.
California	The team did not receive any data from California
Kansas	No additional data collected.
New York	The team received copies of additional data collection instruments but not the data.
Tennessee	No additional data collected.
Vermont	The team did not receive any data from Vermont.
For evaluation purposes, would states/participants/sites be willing to share data?	**For evaluation purposes, would states/participants/sites be willing to share data?**
Arkansas	Unknown.
California	At this point some sites will not share all their NCOA data that is required to protect privacy of consumers. TA contractor cannot force any site to provide data.
Kansas	Unknown.
New York	QTAC is open to discussing this further, when data requirements are known.
Tennessee	Yes
Vermont	Vermont would have very little incentive to participate. The program is already sustained.
Is it possible to turn away and track participants?	**Is it possible to turn away and track participants?**
Arkansas	Unknown.
California	In certain settings, it may be possible.
Kansas	Most leaders had concerns about doing this, mostly centering around the ethics of it.
New York	Unknown: QTAC staff said it may be possible under certain conditions. Lay leaders and master trainers raised ethical issues.
Tennessee	There was concern about the ability and ethics of doing this, but possibly less than other states.
Vermont	Vermont is not interested in an evaluation that turns away participants.

APPENDIX D. KEY INFORMANT INTERVIEW QUESTIONS

APPENDIX D. KEY INFORMANT INTERVIEW QUESTIONS

Key Informant Interviews Questions	Interview Probes
How are local sites implementing the CDSMP? For example, their organizational structure, financial resources and allocation and their fidelity to the Stanford CDSMP model? Do you expect this to change and how?	• What is the organizational structure of host sites and state? • Describe how fidelity is monitored. • What are common adaptations implemented by the sites? • What percentage of AAAs are part of CDSMP delivery system • Describe your interaction with ADRCs in the state (e.g. serve as referral source, host or implementation site, etc)
What do you perceive as the barriers and supports that affect recruitment and completion rates? Do you expect the barriers and supports to change and how?	• Which of the barriers has the greatest influence on recruitment rates? • Which of the barriers has the greatest influence on completion rates?
Other than the data reported to NCOA as part of the grant, what data, if any, does your state collect What is the state of your records systems? Do you expect the data collection efforts to change and how?	• What elements are included in the data reporting system? • Will you continue reporting to NCOA after ARRA funding has ended?
What activities do the state and local sites have to sustain the program after the end of the ARRA funding?	• How does the state and local sites use program data, including evaluations?
How would you describe your statewide distribution and delivery system? What other evidence-based self management programs are provided in your state? What aspects of your program will be sustained after ARRA funding ends? Do you expect this to change and how?	• Besides the AAAs/ADRCs, who are your top 1-5 major partners who have embedded CDSMP into their ongoing activities (i.e. offer workshops at least twice a year in multiple locations) or who have played other significant roles in helping you expand CDSMP statewide? • What are your measures of sustainability? • What program activities will continue or end (e.g. staffing, leadership, key partners, delivery infrastructure)? • In addition to the Recovery Act funding, what other funding sources are supporting the health promotion and disease prevention programs offered by your state in FY 2012? • How will staffing change? Administrators? Program coordinators? Lay leaders?
What populations does your state target and serve? Do you expect this to change and how?	• Do you foresee changes in ability to target diverse populations (i.e. rural, minority)?

APPENDIX E. CDSMP PARTICIPANTS BY AOA REGION

APPENDIX E. CDSMP PARTICIPANTS BY AOA REGION

Exhibit E.1 shows the extent to which AoA regions served the AoA target population (i.e., adults aged 60 and older). Regions III, IV, V, and IX served the greatest numbers of participants aged 60 and older. As demonstrated by Exhibit E.2, the percentage of participants 60 and older served by state grantees largely reflected the percentage of Medicare beneficiaries living in each jurisdiction. While all regions served more participants who were aged 60 and older than those under 60, there is great variation across AoA regions. For instance, Region III served the greatest proportion of participants aged 60 and older (85 percent), while Region VI served the smallest proportion (57 percent).

Exhibit E.1. CDSMP Participants by Age and AoA Region

AoA Region	Participants Under Age 60	Percent of Participants in Region Under Age 60	Participants Age 60+	Percent of Participants in Region Age 60+	Total Number of Participants in Region
Region I	1,273	25%	3,746	75%	5,019
Region II	1,917	27%	5,184	73%	7,101
Region III	1,223	15%	6,903	85%	8,126
Region IV	3,517	23%	11,717	77%	15,234
Region V	4,264	27%	11,626	73%	15,890
Region VI	2,753	43%	3,707	57%	6,460
Region VII	721	26%	2,045	74%	2,766
Region VIII	936	34%	1,839	66%	2,775
Region IX	2,801	28%	7,226	72%	10,027
Region X	2,638	40%	3,877	60%	6,515
Total	22,043	28%	57,870	72%	79,913

Note: Excludes participants with missing date of birth.
Source: NCOA data

Exhibit E.2. CDSMP Participants Age 60+ and Medicare Beneficiaries by Region

AoA Region	Participants Age 60+	Percent of Participants Age 60+	Beneficiaries Medicare Population (Age 65+)	Percent of Beneficiaries Medicare Population (Age 65+)
Region I	3,746	6%	2,316,774	5%
Region II	5,184	9%	4,799,739	11%
Region III	6,903	12%	4,636,685	11%
Region IV	11,717	20%	9,540,724	22%
Region V	11,626	20%	7,797,970	18%
Region VI	3,707	6%	4,851,767	11%
Region VII	2,045	4%	1,638,149	4%
Region VIII	1,839	3%	838,493	2%
Region IX	7,226	13%	5,916,279	13%
Region X	3,877	7%	1,762,908	4%
Total	57,870	100%	44,099,488	100%

Source: NCOA data, Medicare population statistics obtained from the AoA CDSMP Program Announcement for Cooperative Agreements.

As shown in Exhibit E.3, completion rates for participants aged 60 and older were slightly higher than for the younger population (77 percent compared to 75 percent). The differences (between under 60 and 60+) are statistically significant both in the aggregate and in all regions except in Region VIII. Exhibit E.3 also presents data on CDSMP workshops and completion rates by AoA region. Completion rates for older adults vary across region, from 72 percent in Region X to 81 percent in Region VII.

Exhibit E. 3. CDSMP Workshops and Completion Rates by Participant Age and AoA Region

AoA Region	Number of Workshops	Number of Participants Under Age 60	Number of Completers Under Age 60	Completion Rate (%) Under Age 60	Number of Participants Age 60+	Number of Completers Age 60+	Completion Rate (%) Age 60+
Region I**	562	1,273	945	74.2%	3,746	2,889	77.1%
Region II**	687	1,917	1,485	77.5%	5,184	4,172	80.5%
Region III**	645	1,223	923	75.5%	6,903	5,476	79.3%
Region IV***	1,335	3,517	2,695	76.6%	11,717	9,309	79.4%
Region V***	1,604	4,264	3,145	73.7%	11,626	8,871	76.3%
Region VI***	586	2,753	2,357	85.6%	3,707	2,828	76.2%
Region VII***	406	721	541	75.0%	2,045	1,650	80.6%
Region VIII	285	936	692	73.9%	1,839	1,378	74.9%
Region IX***	1,012	2,801	1,936	69.1%	7,226	5,275	73.0%
Region X***	627	2,638	1,711	64.9%	3,877	2,800	72.2%
Total* **	**7,749**	**22,043**	**16,430**	**74.5%**	**57,870**	**44,648**	**77.2%**

Note: Excludes participants with missing date of birth.
(*), (**), and (***) denote the 5%, 1%, and 0.1% level of significance, respectively, for the difference in completion rates between "under age 60" and "60 and older" age groups. Lower levels of significance indicate stronger test results.
Source: NCOA data

APPENDIX F. CDSMP PARTICIPANT REACH BY GRANTEE

APPENDIX F. CDSMP PARTICIPANT REACH BY GRANTEE

AoA expressed interest in the "reach" of CDSMP—that is, what proportion of the residents in a state participated in CDSMP during the ARRA grant period, and how participation varied across different population groups and across different states. Exhibit F.1 shows variations in CDSMP reach by sex, age, and race/ethnicity for each of the 45 state grantees. Values are presented by 100,000 residents. For example, Texas reached 2.7 out of every 100,000 males residing in the state, whereas Oklahoma reached 69.6 out of every 100,000 males.

Exhibit F.1. CDSMP Participant Reach by Grantee

State	Sex: Male	Sex: Female	Age: <65	Age: 65+	Ethnicity: Hispanic or Latino	Ethnicity: Not Hispanic or Latino	Race: White	Race: African American	Race: Asian	Race: American Indian	Race: Native Hawaiian/ Pacific Islander	Race: Other
Alabama	15.5	57.0	11.3	194.9	14.5	37.2	35.3	41.8	14.9	4,100.2	32.7	26.8
Alaska	32.2	89.8	34.3	327.6	40.8	42.0	55.7	81.7	10.5	251.7	40.5	42.9
Arizona	13.5	39.5	11.5	113.9	14.2	30.1	28.0	29.0	15.3	440.8	47.4	10.6
Arkansas	11.3	46.5	6.9	144.3	7.5	28.5	26.9	34.0	2.8	2,710.4	0.0	17.9
California	10.4	29.3	9.5	100.7	15.3	5.9	16.0	27.6	15.8	944.3	22.2	4.2
Colorado	6.8	26.6	10.0	69.0	18.5	15.0	14.7	7.4	44.6	1,073.0	0.0	22.5
Connecticut	11.2	39.3	5.3	129.9	20.0	24.4	25.5	30.1	4.4	6,281.1	350.1	23.7
Florida	13.2	37.5	12.4	83.4	38.3	20.4	18.3	35.7	9.5	3,603.5	40.7	32.5
Georgia	8.0	35.8	7.6	141.4	4.5	21.6	12.3	42.7	22.3	2,220.8	73.5	9.6
Hawaii	16.0	69.7	14.8	182.9	19.9	42.0	38.6	28.0	50.1	3,122.0	44.3	21.6
Idaho	33.4	125.0	37.1	344.7	47.2	68.4	75.9	20.4	26.2	4,943.8	172.6	60.8
Illinois	11.6	48.1	11.8	150.6	27.4	28.9	23.9	51.2	43.8	4,990.6	123.5	19.4
Indiana	6.2	30.0	9.3	76.7	6.9	17.6	17.2	27.6	2.9	5,097.0	42.6	12.9
Kansas	12.8	58.3	15.7	149.7	22.7	32.0	31.3	41.7	8.9	2,660.7	0.0	19.9
Kentucky	10.4	42.8	12.2	113.6	18.8	23.8	19.9	81.5	28.6	7,480.2	0.0	22.2
Louisiana	4.1	23.2	3.8	83.4	4.7	13.0	12.8	16.2	4.3	1,190.4	0.0	10.6
Maine	16.8	80.8	28.3	146.4	23.6	47.4	45.6	89.1	14.7	6,734.4	292.4	43.6
Maryland	11.1	50.5	9.6	182.6	8.7	32.1	30.1	39.5	10.3	4,951.0	63.4	12.7
Massachusetts	11.7	49.2	8.8	137.6	78.2	22.8	21.3	27.2	35.7	5,941.6	90.0	66.0
Michigan	21.1	70.8	27.2	188.0	42.6	47.9	45.0	63.8	37.8	5,663.9	76.8	41.9
Minnesota	9.4	38.7	5.7	144.9	4.0	16.1	24.7	9.1	8.4	1,837.0	92.8	9.6
Mississippi	10.2	44.1	15.3	108.3	11.0	12.1	8.9	55.4	7.8	1,037.9	421.2	9.7
Missouri	9.2	41.3	10.1	99.1	29.2	18.8	22.0	15.0	5.1	3,985.2	47.9	31.7
Nebraska	7.8	40.8	8.7	132.6	19.7	23.6	24.9	7.2	12.4	2,127.3	0.0	16.9
Nevada	8.4	27.5	6.7	95.6	8.0	20.8	19.5	29.3	9.2	1,085.4	59.3	5.1

State	Sex: Male	Sex: Female	Age: <65	Age: 65+	Ethnicity: Hispanic or Latino	Ethnicity: Not Hispanic or Latino	Race: White	Race: African American	Race: Asian	Race: American Indian	Race: Native Hawaiian/ Pacific Islander	Race: Other
New Hampshire	17.2	61.3	16.8	143.6	16.3	31.5	33.2	20.0	0.0	13,015.9	0.0	32.9
New Jersey	23.3	61.5	21.6	155.3	32.3	39.0	26.0	84.8	56.6	5,408.9	295.8	31.0
New Mexico	22.8	77.9	33.2	126.7	70.1	29.5	58.3	11.8	17.7	424.9	0.0	8.6
New York	6.9	29.0	5.3	82.1	13.6	15.2	16.3	15.0	5.5	1,945.6	11.4	14.7
North Carolina	10.2	43.5	9.2	136.9	3.6	27.0	23.8	41.1	6.2	1,273.4	30.3	8.7
Ohio	10.9	36.6	9.8	102.7	20.0	20.4	18.0	56.4	9.9	6,772.9	73.8	24.5
Oklahoma	69.6	53.9	54.6	103.2	39.5	47.3	43.3	233.8	12.3	364.6	0.0	56.4
Oregon	36.8	111.5	49.7	223.6	101.1	57.1	71.5	43.3	67.3	4,306.1	37.3	67.3
Pennsylvania	10.0	46.3	7.9	144.4	50.0	27.4	17.6	104.7	51.8	6,836.0	27.4	23.0
Puerto Rico	5.8	26.4	3.4	89.1	16.4	2.7	10.1	10.0	0.0	1,441.6	0.0	46.8
Rhode Island	23.4	69.3	22.6	186.3	63.5	40.2	39.7	63.1	6.6	5,612.4	0.0	78.2
South Carolina	11.4	49.1	9.8	135.5	11.5	27.4	14.5	61.7	16.9	2,269.0	147.8	13.4
Tennessee	6.7	30.0	7.4	82.7	4.1	17.9	17.7	22.6	13.2	4,361.3	137.3	11.9
Texas	2.7	11.7	3.2	43.1	11.0	4.6	7.5	5.7	0.5	776.2	9.2	8.1
Utah	42.1	101.9	35.2	426.9	81.5	63.8	58.6	68.3	30.7	4,236.6	1,861.2	1.7
Vermont	68.5	231.5	90.2	469.9	43.4	144.2	138.4	63.7	0.0	37,381.1	625.0	124.4
Virginia	9.7	47.0	8.5	162.9	15.5	28.6	25.6	41.1	14.1	4,800.7	33.4	23.4
Washington	16.2	47.1	20.0	113.3	79.7	24.1	21.5	19.2	22.5	1,074.4	177.9	18.0
West Virginia	14.8	39.6	17.5	69.6	18.0	26.4	22.8	131.5	8.1	10,456.8	233.6	42.1
Wisconsin	16.8	69.5	17.9	175.2	72.0	38.1	37.5	43.2	4.6	3,369.0	54.7	12.5

Source: NCOA and U.S. Census data

APPENDIX G. CLASS SIZE FIDELITY BY STATE GRANTEE

APPENDIX G. CLASS SIZE FIDELITY BY STATE GRANTEE

State	Violation of First Session Must-Do: At least 10 Participants	Violation of Any Session Must-Do: 10-16 Participants [a]	Violation of Either Must-Do
Alaska	77.1%	91.7%	91.7%
Alabama	19.8%	51.6%	52.4%
Arkansas	36.4%	68.2%	71.2%
Arizona	39.9%	73.4%	74.8%
California	47.4%	74.6%	75.9%
Colorado	53.6%	82.1%	83.3%
Connecticut	49.4%	83.1%	83.1%
Florida	13.3%	48.9%	51.6%
Georgia	43.1%	67.8%	69.0%
Hawaii	58.3%	83.3%	83.3%
Idaho	47.2%	82.4%	82.4%
Illinois	43.7%	71.6%	73.9%
Indiana	51.8%	78.9%	79.8%
Kansas	71.7%	84.1%	84.1%
Kentucky	47.2%	73.6%	73.6%
Louisiana	15.6%	51.1%	51.1%
Massachusetts	53.1%	78.4%	80.3%
Maryland	56.0%	77.7%	77.7%
Maine	64.4%	83.6%	84.9%
Michigan	52.9%	80.8%	81.0%
Minnesota	67.1%	88.6%	89.2%
Missouri	72.5%	85.8%	87.0%
Mississippi	50.7%	67.1%	68.5%
North Carolina	55.9%	76.7%	78.0%
Nebraska	58.7%	73.9%	76.1%
New Hampshire	52.7%	89.1%	89.1%
New Jersey	45.9%	71.3%	73.1%
New Mexico	58.4%	76.2%	79.2%
Nevada	43.2%	59.5%	59.5%
New York	44.4%	71.6%	72.2%
Ohio	46.9%	67.6%	68.4%
Oklahoma	33.7%	54.1%	54.1%
Oregon	61.6%	83.0%	84.4%
Pennsylvania	23.2%	51.2%	53.1%
Puerto Rico	5.6%	36.1%	36.1%
Rhode Island	36.6%	63.4%	65.9%
South Carolina	52.8%	72.9%	75.0%

State	Violation of First Session Must-Do: At least 10 Participants	Violation of Any Session Must-Do: 10-16 Participants [a]	Violation of Either Must-Do
Tennessee	49.5%	70.7%	72.7%
Texas	53.4%	74.7%	77.0%
Utah	51.2%	76.1%	77.1%
Virginia	10.7%	50.9%	51.5%
Vermont	56.0%	85.7%	85.7%
Washington	54.9%	74.9%	77.4%
Wisconsin	58.5%	81.0%	81.5%
West Virginia	57.4%	70.2%	74.5%
Total	**47.2%**	**72.5%**	**73.8%**

[a] We define compliance as having at least four workshops with 10-16 participants.

APPENDIX H. STATISTICAL TESTS FOR CHAPTER 6 EXHIBITS

APPENDIX H. STATISTICAL TESTS FOR CHAPTER 6 EXHIBITS

Table A: Difference in Percentage Points by Type of Program Oversight

Type of Program Oversight	Centralized	Decentralized
Under 60, Decentralized	-0.6%	-
Under 60, Shared	-3.0%**	-2.4%**
60+, Decentralized	-3.3%***	-
60+, Shared	-0.9%	2.4%***

(1) Participants with missing date of birth are excluded.
(2) Values show the percentage difference in completion rates between the type of program oversight in the row and the type of program oversight in the column headings.
(3) (*), (**), and (***) denote the 5%, 1%, and 0.1% level of significance, respectively, for the difference in completion rates between two types of program oversight. Lower levels of significance indicate stronger test results.
Source: NCOA data.

Table B: Difference in Percentage Points by Type of Delivery System Structure

Type of Delivery System Structure	Centralized	Decentralized
Under 60, Decentralized	0.9%	-
Under 60, Mixed	8.5%**	7.6%*
60+, Decentralized	-2.4%***	-
60+, Mixed	-2.1%	0.3%

(1) Participants with missing date of birth are excluded.
(2) Values show the percentage difference in completion rates between the type of delivery system structure in the row and the type of delivery system structure in the column headings.
(3) (*), (**), and (***) denote the 5%, 1%, and 0.1% level of significance, respectively, for the difference in completion rates between two types of delivery system structure. Lower levels of significance indicate stronger test results.
Source: NCOA data.

Table C: Difference in Percentage Points by Ethnicity

Ethnicity	Hispanic or Latino Origin	Not Hispanic or Latino
Under 60, Not Hispanic or Latino	-3.0%***	-
Under 60, Unknown	-8.0%***	-5.0%***
60 – 64, Not Hispanic or Latino	0.2%	-
60 – 64, Unknown	-6.9%***	-7.1%***
65 – 74, Not Hispanic or Latino	-1.2%	-
65 – 74, Unknown	-4.0%***	-2.8%**
75 – 84, Not Hispanic or Latino	1.9%	-
75 – 84, Unknown	-3.4%*	-5.3%***
85+, Not Hispanic or Latino	-0.9%	-
85+, Unknown	-2.9%	-2.1%

(1) Participants with missing date of birth are excluded.
(2) Values show the percentage difference in completion rates between the ethnicity in the row and the ethnicity in the column headings.
(3) (*), (**), and (***) denote the 5%, 1%, and 0.1% level of significance, respectively, for the difference in completion rates between two ethnic groups. Lower levels of significance indicate stronger test results.
Source: NCOA data

Table D: Difference in Percentage Points by Race

Age and Race	American Indian or Alaskan Native	Asian or Asian American	Black or African American	Hawaiian Native or Pacific Islander	Other / Multiracial	Unknown Race
Under 60, Asian or Asian American	3.75%	-	-	-	-	-
Under 60, Black or African American	2.72%	-1.03%	-	-	-	-
Under 60, Hawaiian Native or Pacific Islander	8.76%	5.01%	6.04%	-	-	-
Under 60, Other / Multiracial	5.72%	1.97%	3.00%	-3.04%	-	-
Under 60, Unknown Race	-2.91%	-6.86%*	-5.83%***	-11.87%*	-8.83%***	-
Under 60, White or Caucasian	0.21%	-3.54%	-2.51%*	-8.55%	-5.51%***	3.32%**
60 – 64, Asian or Asian American	1.96%	-	-	-	-	-
60 – 64, Black or African American	5.02%	3.06%	-	-	-	-
60 – 64, Hawaiian Native or Pacific Islander	22.57%***	20.60%***	17.54%***	-	-	-
60 – 64, Other / Multiracial	2.60%	0.64%	-2.42%	-19.96%***	-	-
60 – 64, Unknown Race	-0.88%	-2.85%	-5.91%*	-23.45%***	-3.49%	-
60 – 64, White or Caucasian	2.53%	0.57%	-2.49%	-20.03%***	-0.07%	3.42%
65 – 74, Asian or Asian American	7.55%	-	-	-	-	-
65 – 74, Black or African American	8.96%**	1.41%	-	-	-	-
65 – 74, Hawaiian Native or Pacific Islander	23.17%***	15.62%***	14.02%***	-	-	-
65 – 74, Other / Multiracial	9.15%*	1.59%	0.19%	-14.02%***	-	-
65 – 74, Unknown Race	4.46%	-3.08%	-4.49%**	-18.70%***	-4.68%	-
65 – 74, White or Caucasian	7.99%*	0.44%	-0.97%	-15.18%***	-1.16%	3.52%*
75 – 84, Asian or Asian American	5.36%	-	-	-	-	-
75 – 84, Black or African American	7.38%	2.02%	-	-	-	-
75 – 84, Hawaiian Native or Pacific Islander	11.73%	6.37%	4.35%	-	-	-
75 – 84, Other / Multiracial	0.44%	-4.92%	-6.94%**	-11.29%	-	-
75 – 84, Unknown Race	-4.06%	-9.42%***	-11.44%***	-15.79%*	-4.50%	-

Age and Race	American Indian or Alaskan Native	Asian or Asian American	Black or African American	Hawaiian Native or Pacific Islander	Other / Multiracial	Unknown Race
75 – 84, White or Caucasian	4.22%	-1.13%	-3.15%**	-7.50%	3.79%	8.29%***
85+, Asian or Asian American	-0.76%	-	-	-	-	-
85+, Black or African American	0.19%	0.95%	-	-	-	-
85+, Hawaiian Native or Pacific Islander	16.00%	16.76%	15.81%	-	-	-
85+, Other / Multiracial	-5.41%	-4.65%	-5.60%	-21.41%	-	-
85+, Unknown Race	-6.37%	-5.60%	-6.56%	-22.37%	-0.95%	-
85+, White or Caucasian	-5.35%	-4.89%	-5.54**	-21.35%	0.06%	1.02%

(1) Participants with missing date of birth are excluded.
(2) Values show the percentage difference in completion rates between the race in the row and the race in the column headings.
(3) (*), (**), and (***) denote the 5%, 1%, and 0.1% level of significance, respectively, for the difference in completion rates between two race groups. Lower levels of significance indicate stronger test results.
Source: NCOA data

Table E: Difference in Percentage Points by Type of Implementation Site

Type of Implementation Site	Area Agency on Aging	Faith-Based Organization	Health Care Organization	Residential Facility	Senior Center
Under 60, Faith-based organization	2.2%	-	-	-	-
Under 60, Health care organization	-7.2%***	-9.3%***	-	-	-
Under 60, Residential facility	-5.3*	-7.5%***	1.8%	-	-
Under 60, Senior center	0.1%	-2.2	7.1%***	5.3%***	-
Under 60, Other	1.7%	-0.5	8.9%***	7.0%***	1.7%
60+, Faith-based organization	1.2%	-	-	-	-
60+, Health care organization	-5.8***	-7.0%***	-	-	-
60+, Residential facility	-8.8%***	-10.0%***	-3.0%***	-	-
60+, Senior center	-2.2%	-3.4%***	3.6%***	6.7%***	-
60+, Other	-2.6*	-3.8%***	3.2%***	6.2%***	-0.4%

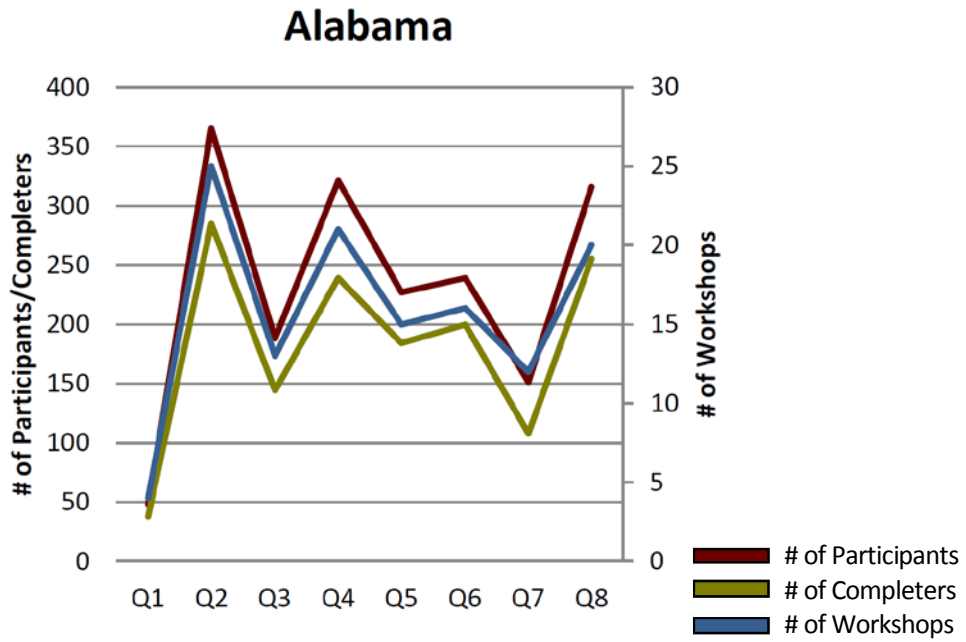
(1) Participants with missing date of birth are excluded.
(2) Values show the percentage difference in completion rates between the type of implementation site in the row and the type of implementation site in the column headings.
(3) (*), (**), and (***) denote the 5%, 1%, and 0.1% level of significance, respectively, for the difference in completion rates between two implementation site types. Lower levels of significance indicate stronger test results.
Source: NCOA data.

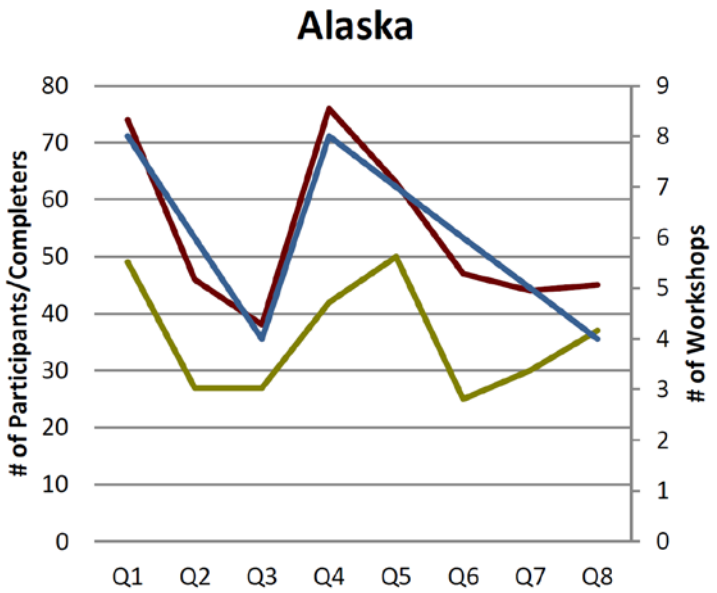
Table F: Difference in Percentage Points by Number of Reported Chronic Conditions

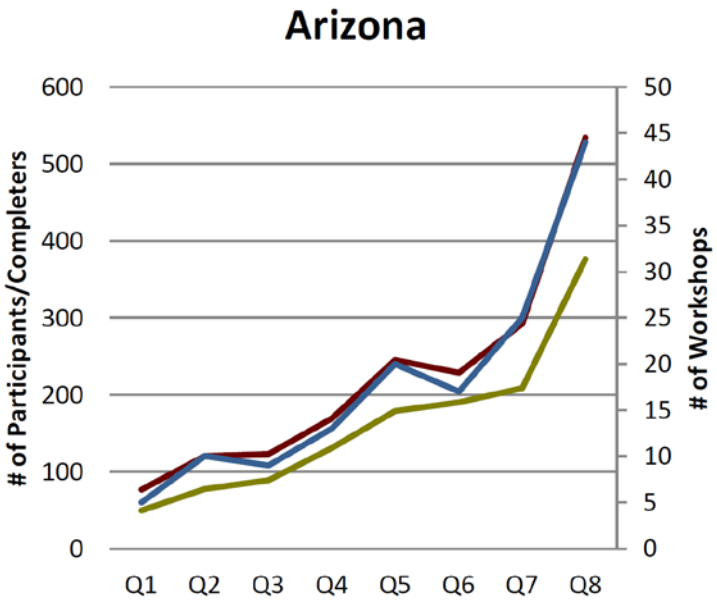
Number of Chronic Conditions	0	1	2 or 3	4 or 5
1	11.0***	-	-	-
2 or 3	11.9***	0.8	-	-
4 or 5	11.5***	0.4	-0.4	-
6 or more	9.8***	-1.3	-2.1*	-1.7

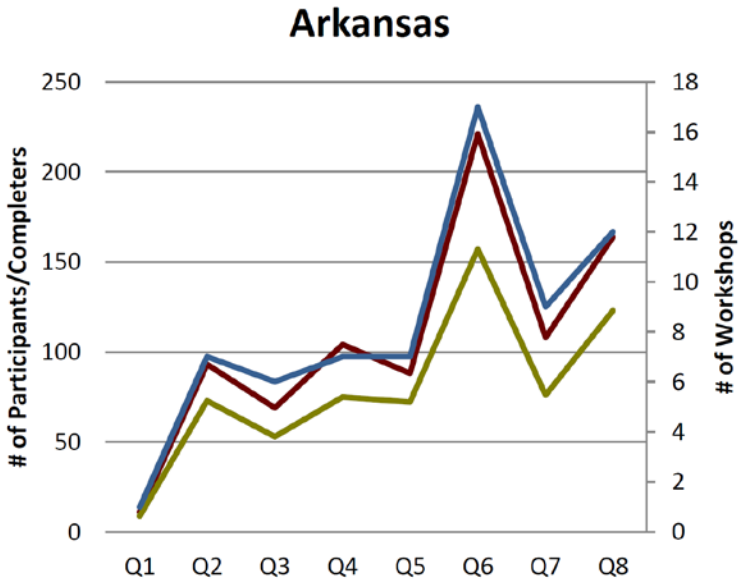
(1) Values show the percentage difference in completion rates between the number of reported chronic conditions in the row
and the number of reported chronic conditions in the column headings.
(2) (*), (**), and (***) denote the 5%, 1%, and 0.1% level of significance, respectively, for the difference in completion rates
between two chronic conditions categories. Lower levels of significance indicate stronger test results.
Source: NCOA data.

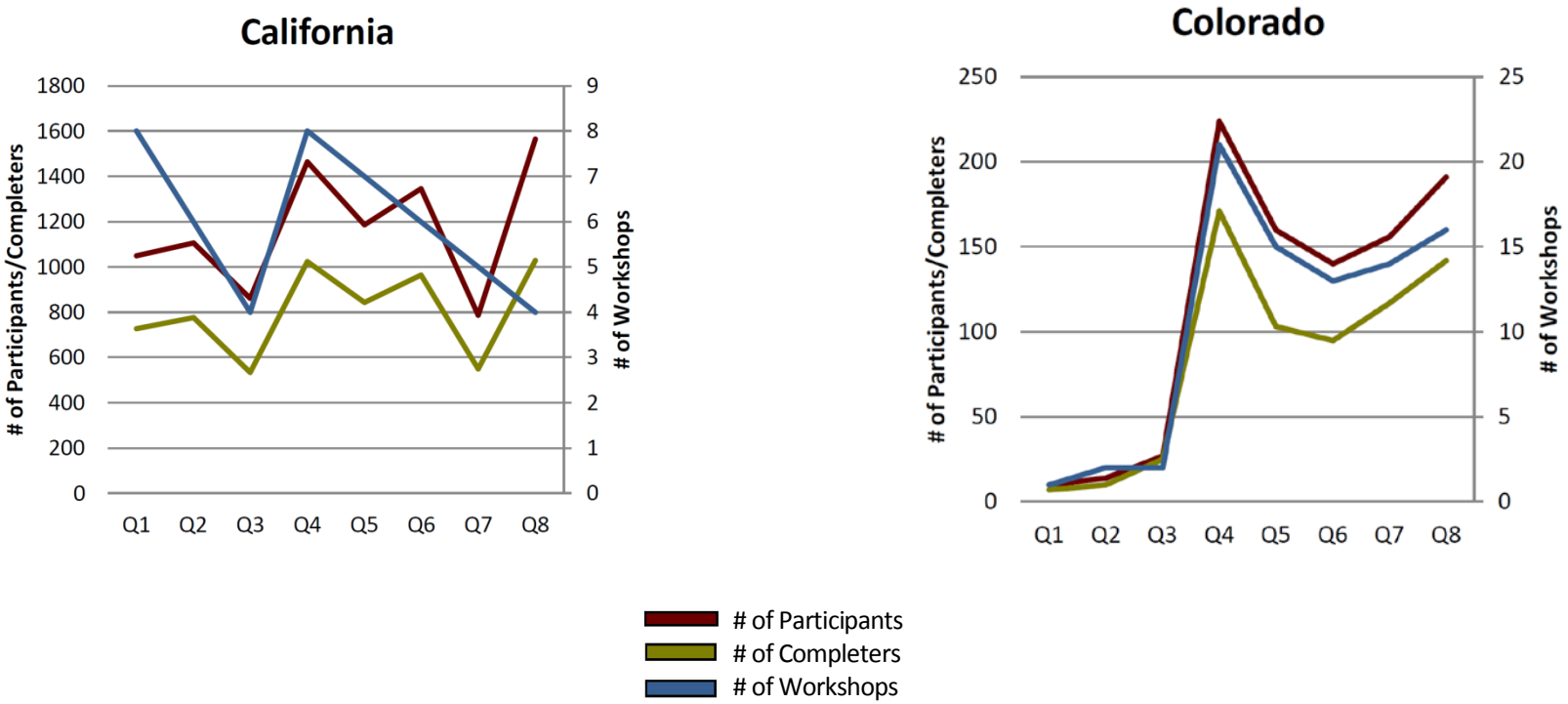
APPENDIX I. CDSMP WORKSHOPS, PARTICIPANTS, AND COMPLETERS BY QUARTER STATE GRANTEE

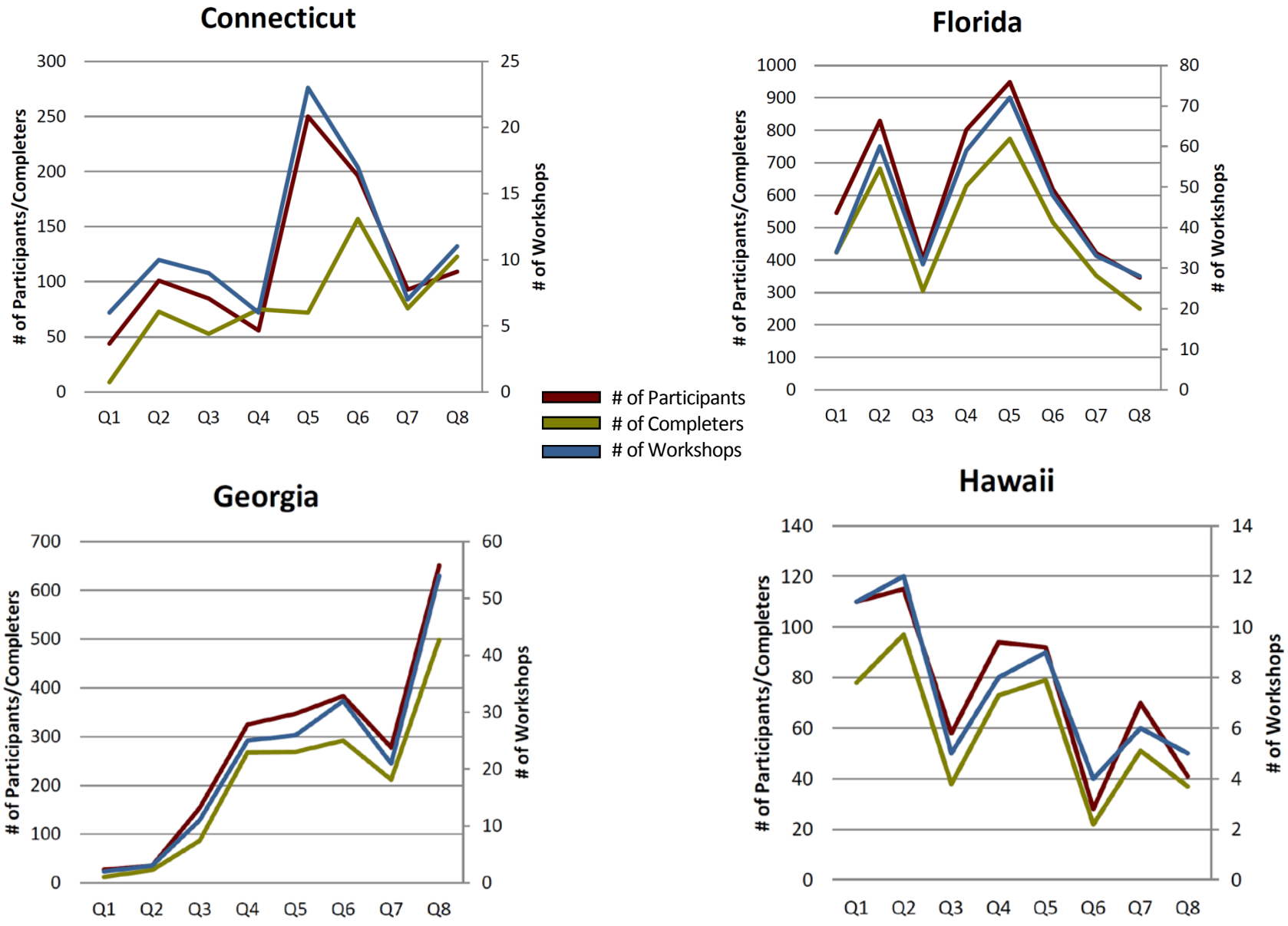

Alabama
# of Participants/Completers
# of Workshops
400
350
300
250
200
150
100
50
0
30
25
20
15
10
5
0
Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8
# of Participants
# of Completers
# of Workshops

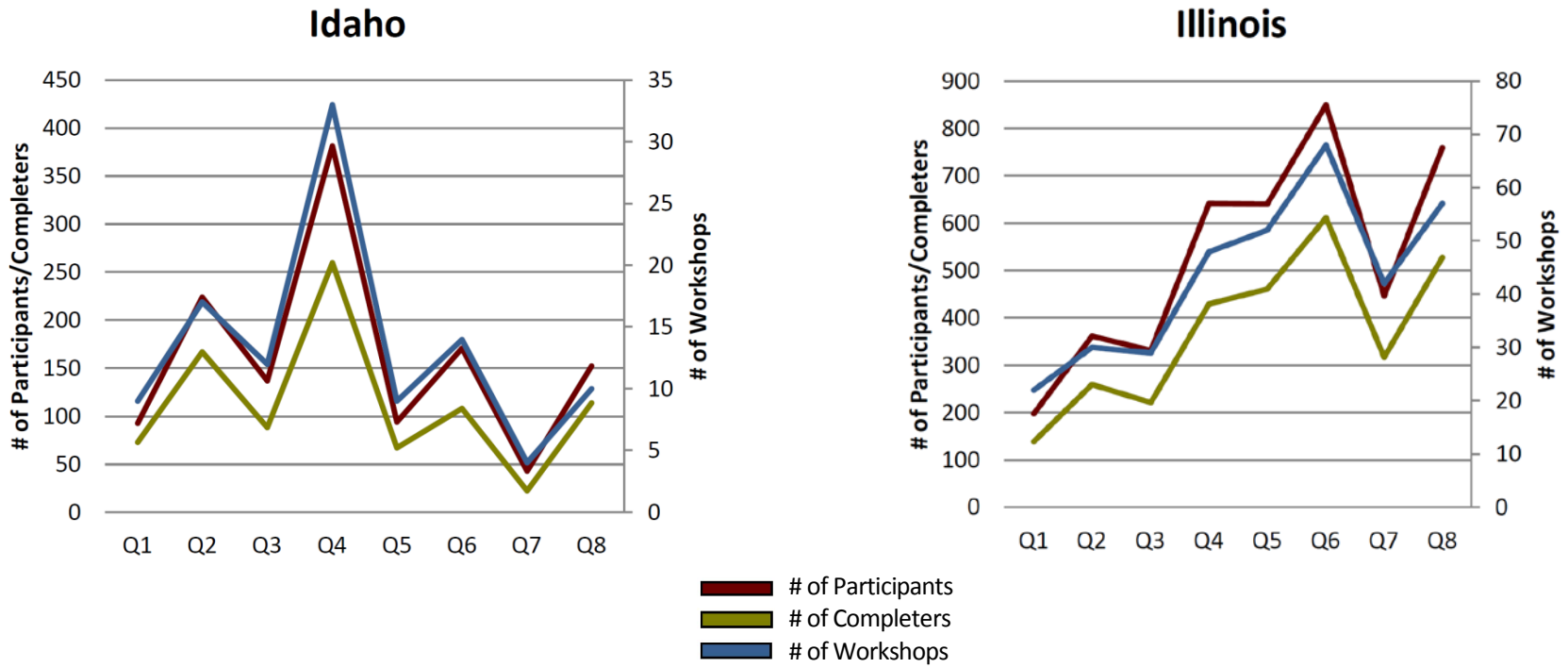

Alaska
# of Participants/Completers
# of Workshops
80
70
60
50
40
30
20
10
0
9
8
7
6
5
4
3
2
1
0
Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8

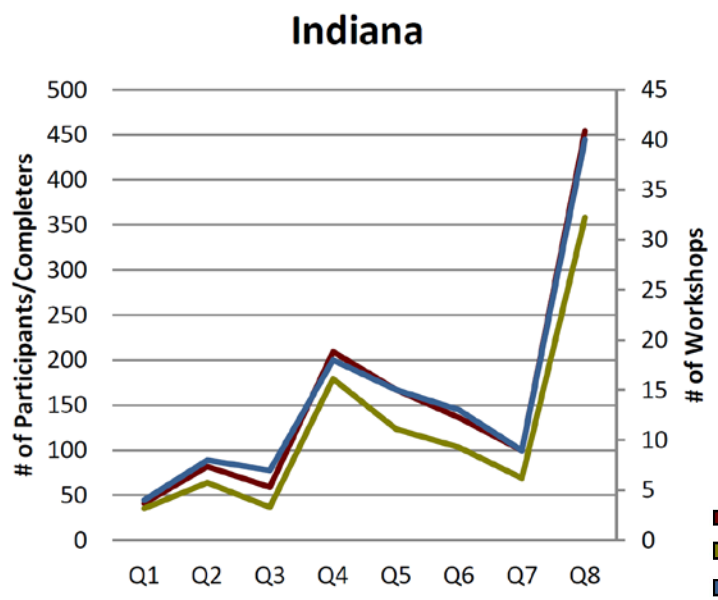

Arizona
# of Participants/Completers
# of Workshops
600
500
400
300
200
100
0
50
45
40
35
30
25
20
15
10
5
0
Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8

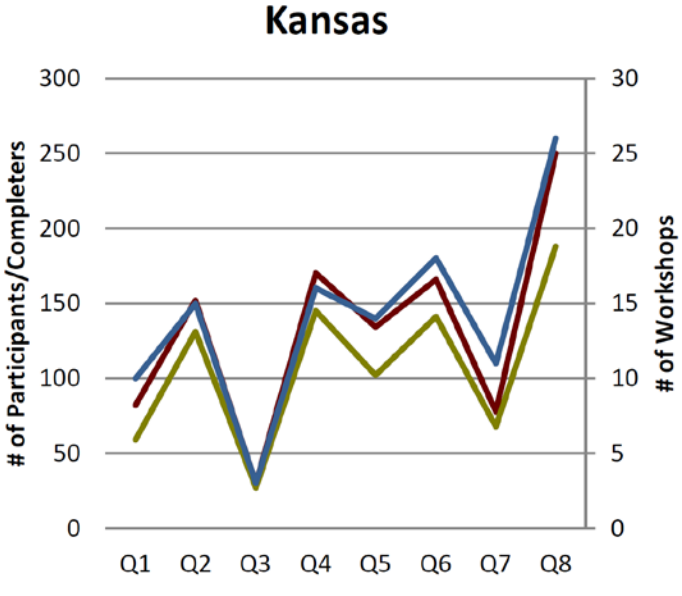

Arkansas
# of Participants/Completers
# of Workshops
250
200
150
100
50
0
18
16
14
12
10
8
6
4
2
0
Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8


California
# of Participants/Completers
# of Workshops
1800
1600
1400
1200
1000
800
600
400
200
0
9
8
7
6
5
4
3
2
1
0
Q1
Q2
Q3
Q4
Q5
Q6
Q7
Q8
Colorado
# of Participants/Completers
# of Workshops
250
200
150
100
50
0
25
20
15
10
5
0
Q1
Q2
Q3
Q4
Q5
Q6
Q7
Q8
# of Participants
# of Completers
# of Workshops

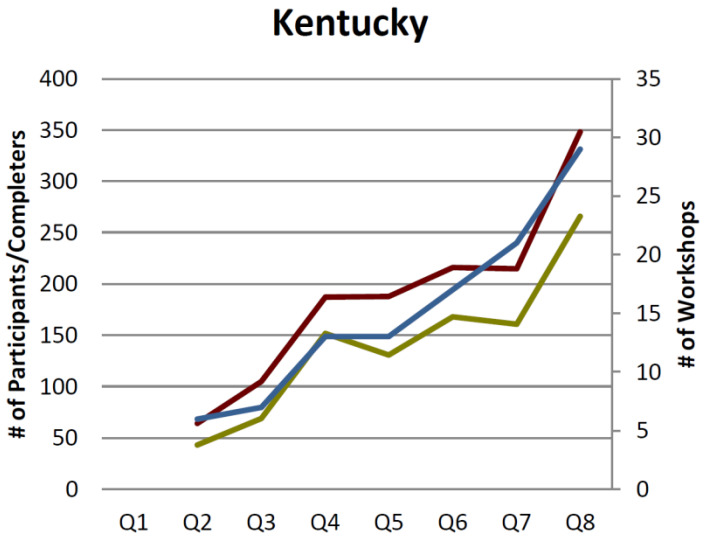

Connecticut
# of Participants/Completers
# of Workshops
300
250
200
150
100
50
0
25
20
15
10
5
0
Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8
Florida
# of Participants/Completers
# of Workshops
1000
900
800
700
600
500
400
300
200
100
0
80
70
60
50
40
30
20
10
0
Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8
# of Participants
# of Completers
# of Workshops
Georgia
# of Participants/Completers
# of Workshops
700
600
500
400
300
200
100
0
60
50
40
30
20
10
0
Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8
Hawaii
# of Participants/Completers
# of Workshops
140
120
100
80
60
40
20
0
14
12
10
8
6
4
2
0
Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8


Idaho
# of Participants/Completers
# of Workshops
450
400
350
300
250
200
150
100
50
0
35
30
25
20
15
10
5
0
Q1
Q2
Q3
Q4
Q5
Q6
Q7
Q8
Illinois
# of Participants/Completers
# of Workshops
900
800
700
600
500
400
300
200
100
0
80
70
60
50
40
30
20
10
0
Q1
Q2
Q3
Q4
Q5
Q6
Q7
Q8
# of Participants
# of Completers
# of Workshops


Indiana
# of Participants/Completers
# of Workshops
500
450
400
350
300
250
200
150
100
50
0
45
40
35
30
25
20
15
10
5
0
Q1
Q2
Q3
Q4
Q5
Q6
Q7
Q8


Kansas
# of Participants/Completers
# of Workshops
300
250
200
150
100
50
0
30
25
20
15
10
5
0
Q1
Q2
Q3
Q4
Q5
Q6
Q7
Q8


# of Participants
# of Completers
# of Workshops


Kentucky
# of Participants/Completers
# of Workshops
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350
300
250
200
150
100
50
0
35
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25
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5
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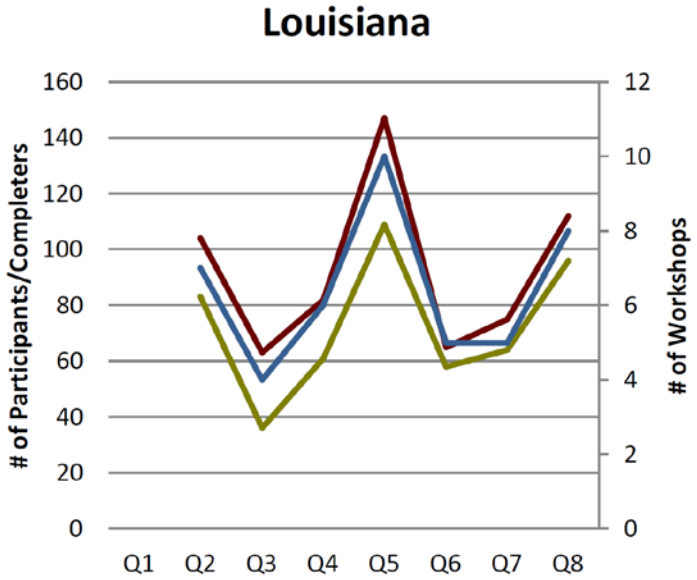
Q1
Q2
Q3
Q4
Q5
Q6
Q7
Q8


Louisiana
# of Participants/Completers
# of Workshops
160
140
120
100
80
60
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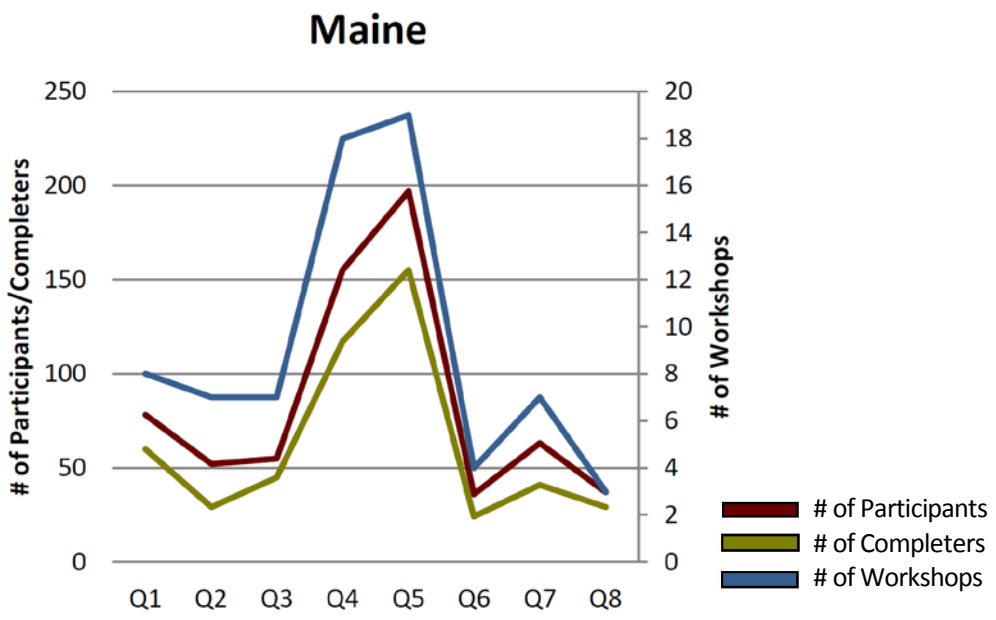
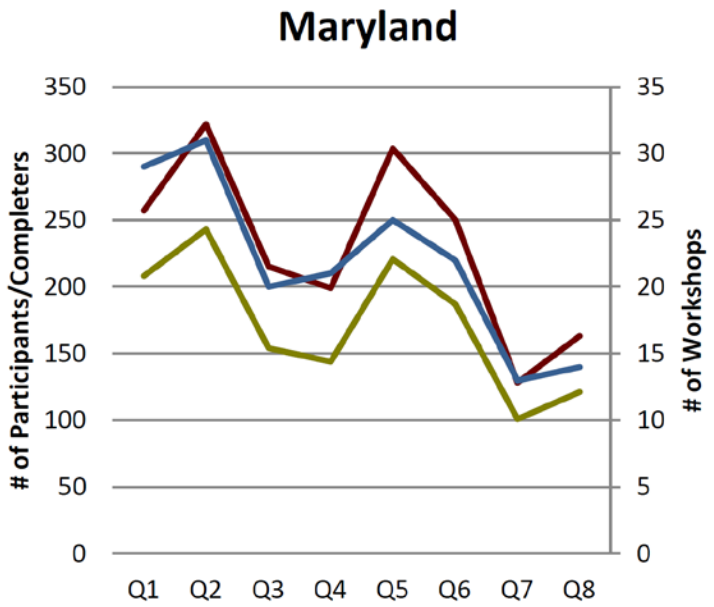
10
8
6
4
2
0
Q1
Q2
Q3
Q4
Q5
Q6
Q7
Q8


Maine
# of Participants/Completers
# of Workshops
250
200
150
100
50
0
20
18
16
14
12
10
8
6
4
2
0
Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8
# of Participants
# of Completers
# of Workshops


Maryland
# of Participants/Completers
# of Workshops
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250
200
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50
0
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25
20
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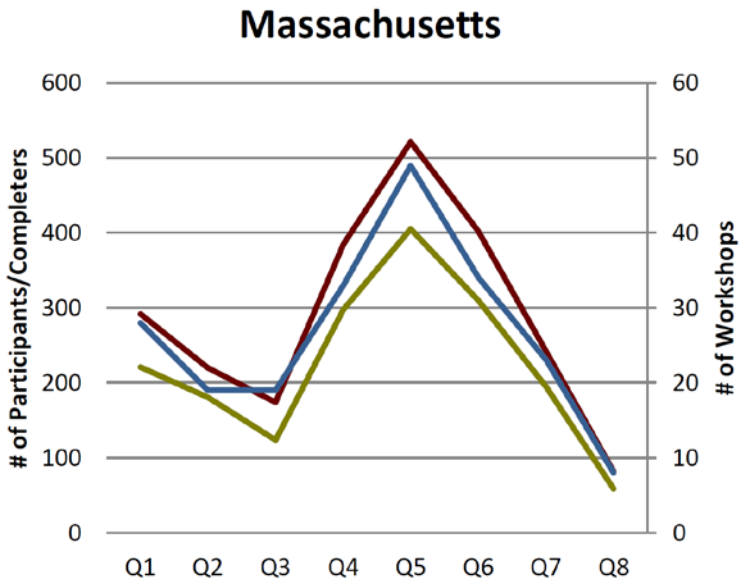
5
0
Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8


Massachusetts
# of Participants/Completers
# of Workshops
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200
100
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50
40
30
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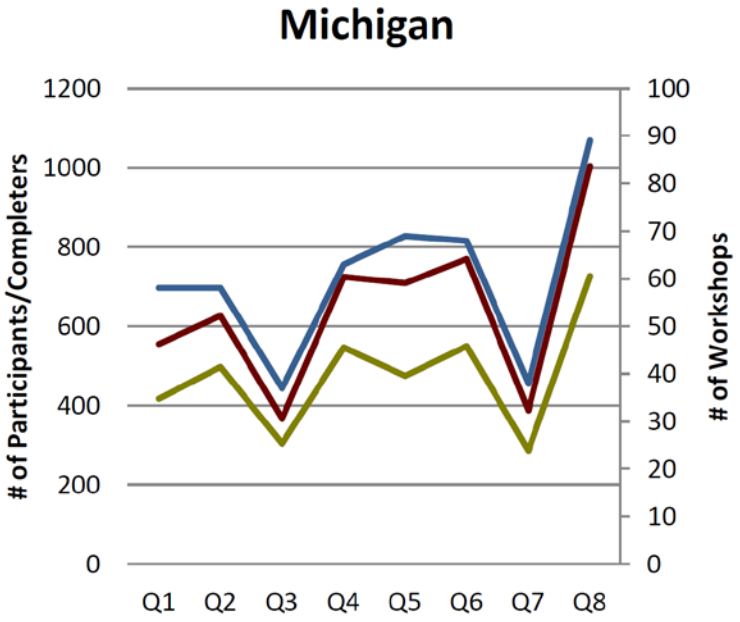
10
0
Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8


Michigan
# of Participants/Completers
# of Workshops
1200
1000
800
600
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200
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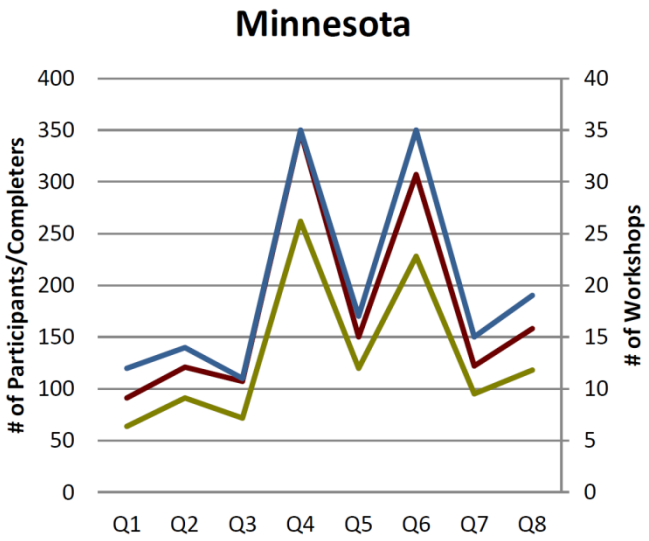
90
80
70
60
50
40
30
20
10
0
Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8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# of Participants/Completers
# of Workshops
400
350
300
250
200
150
100
50
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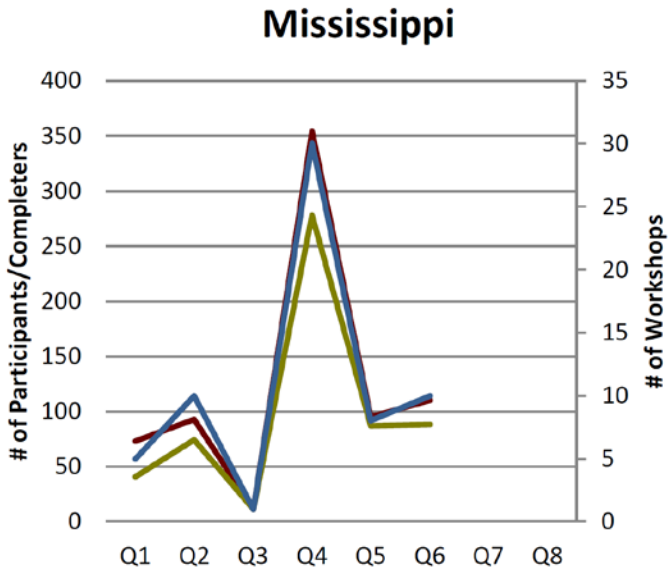
20
15
10
5
0
Q1
Q2
Q3
Q4
Q5
Q6
Q7
Q8


Mississippi
# of Participants/Completers
# of Workshops
400
350
300
250
200
150
100
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35
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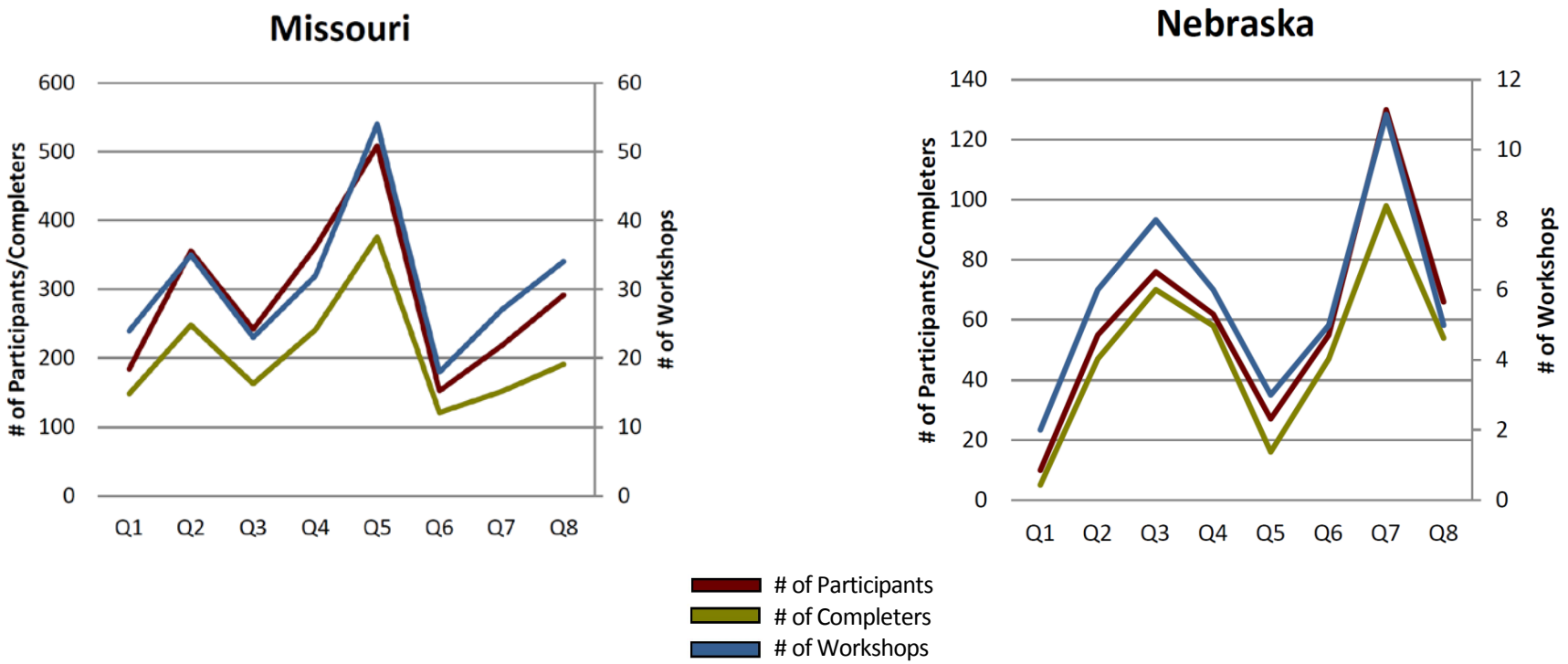
25
20
15
10
5
0
Q1
Q2
Q3
Q4
Q5
Q6
Q7
Q8


Missouri
# of Participants/Completers
# of Workshops
600
500
400
300
200
100
0
60
50
40
30
20
10
0
Q1
Q2
Q3
Q4
Q5
Q6
Q7
Q8
Nebraska
# of Participants/Completers
# of Workshops
140
120
100
80
60
40
20
0
12
10
8
6
4
2
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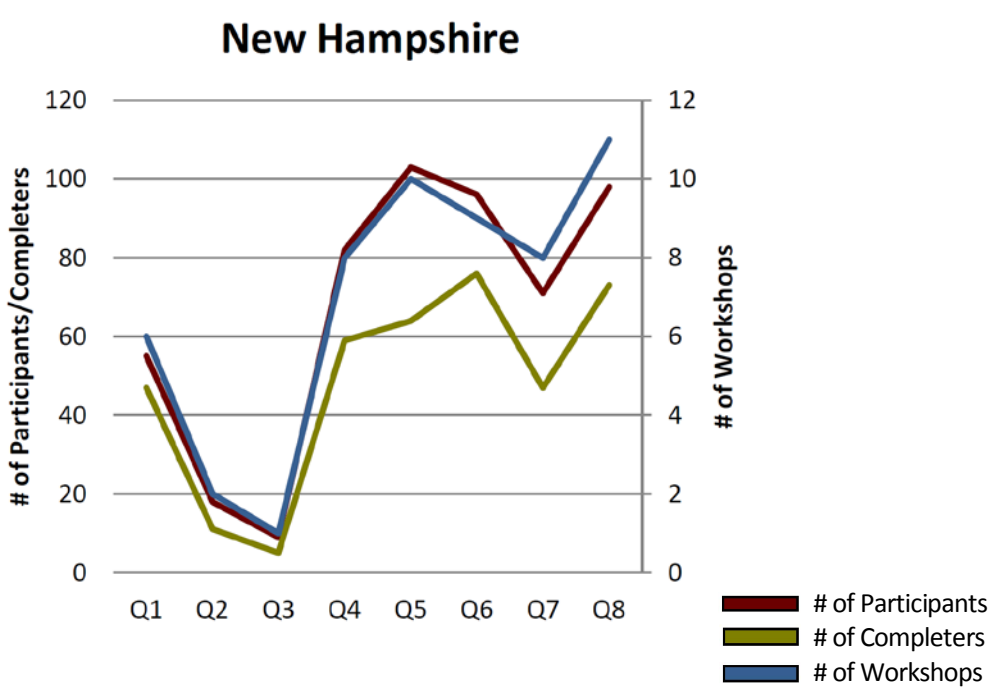
Q1
Q2
Q3
Q4
Q5
Q6
Q7
Q8
# of Participants
# of Completers
# of Workshops


New Hampshire
# of Participants/Completers
# of Workshops
120
100
80
60
40
20
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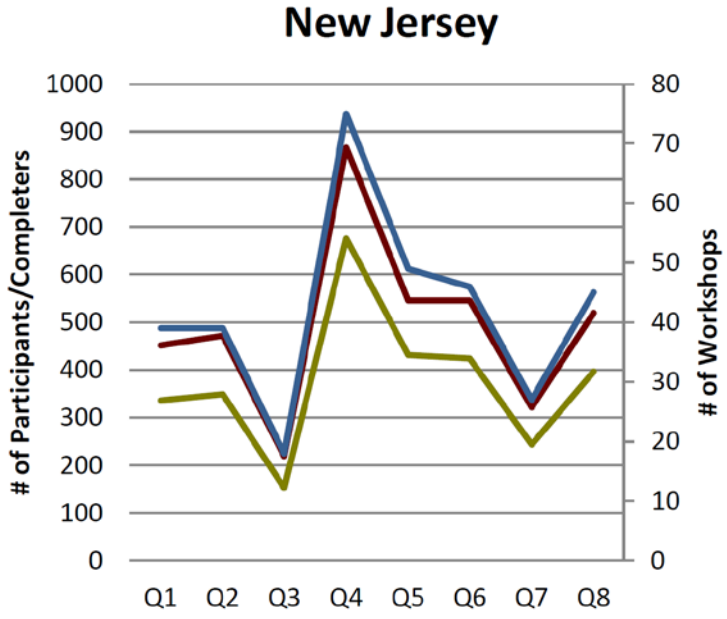
12
10
8
6
4
2
0
Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8
# of Participants
# of Completers
# of Workshops


New Jersey
# of Participants/Completers
# of Workshops
1000
900
800
700
600
500
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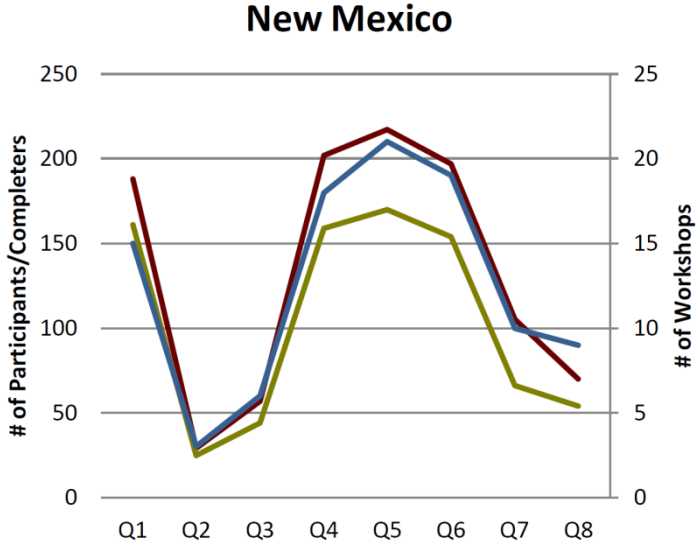
10
0
Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8


New Mexico
# of Participants/Completers
# of Workshops
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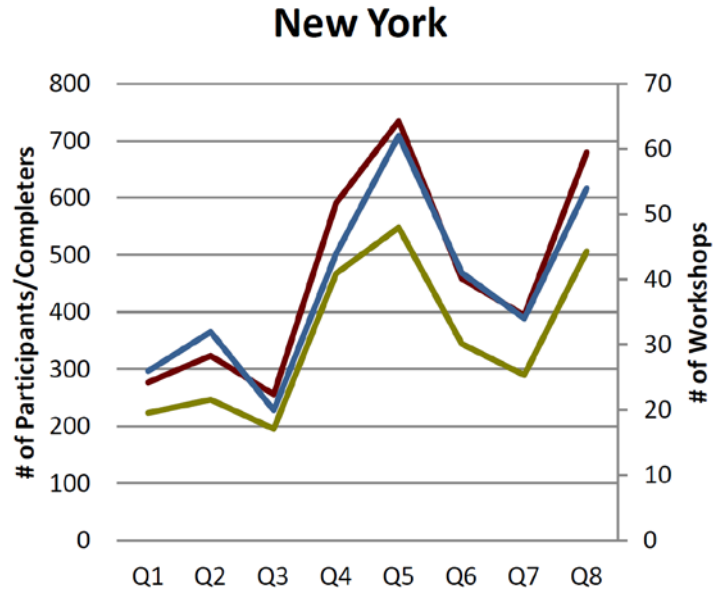
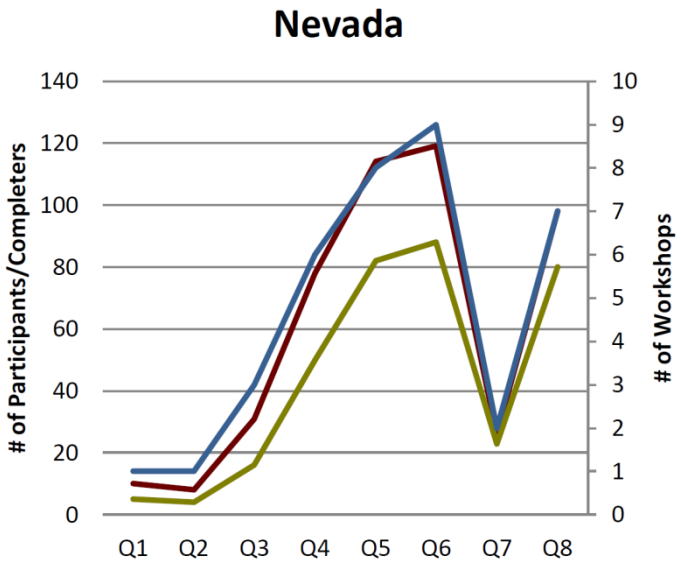
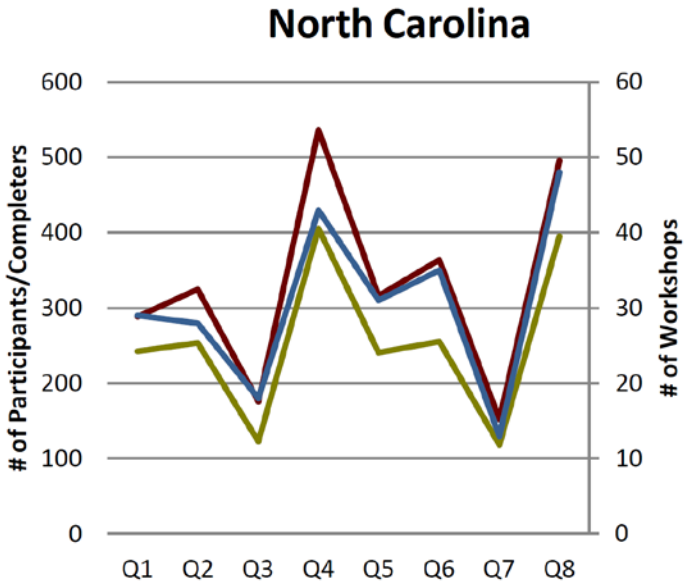
200
150
100
50
0
25
20
15
10
5
0
Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8


New York
# of Participants/Completers
# of Workshops
800
700
600
500
400
300
200
100
0
70
60
50
40
30
20
10
0
Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8


Nevada
# of Participants/Completers
# of Workshops
140
120
100
80
60
40
20
0
10
9
8
7
6
5
4
3
2
1
0
Q1
Q2
Q3
Q4
Q5
Q6
Q7
Q8


North Carolina
# of Participants/Completers
# of Workshops
600
500
400
300
200
100
0
60
50
40
30
20
10
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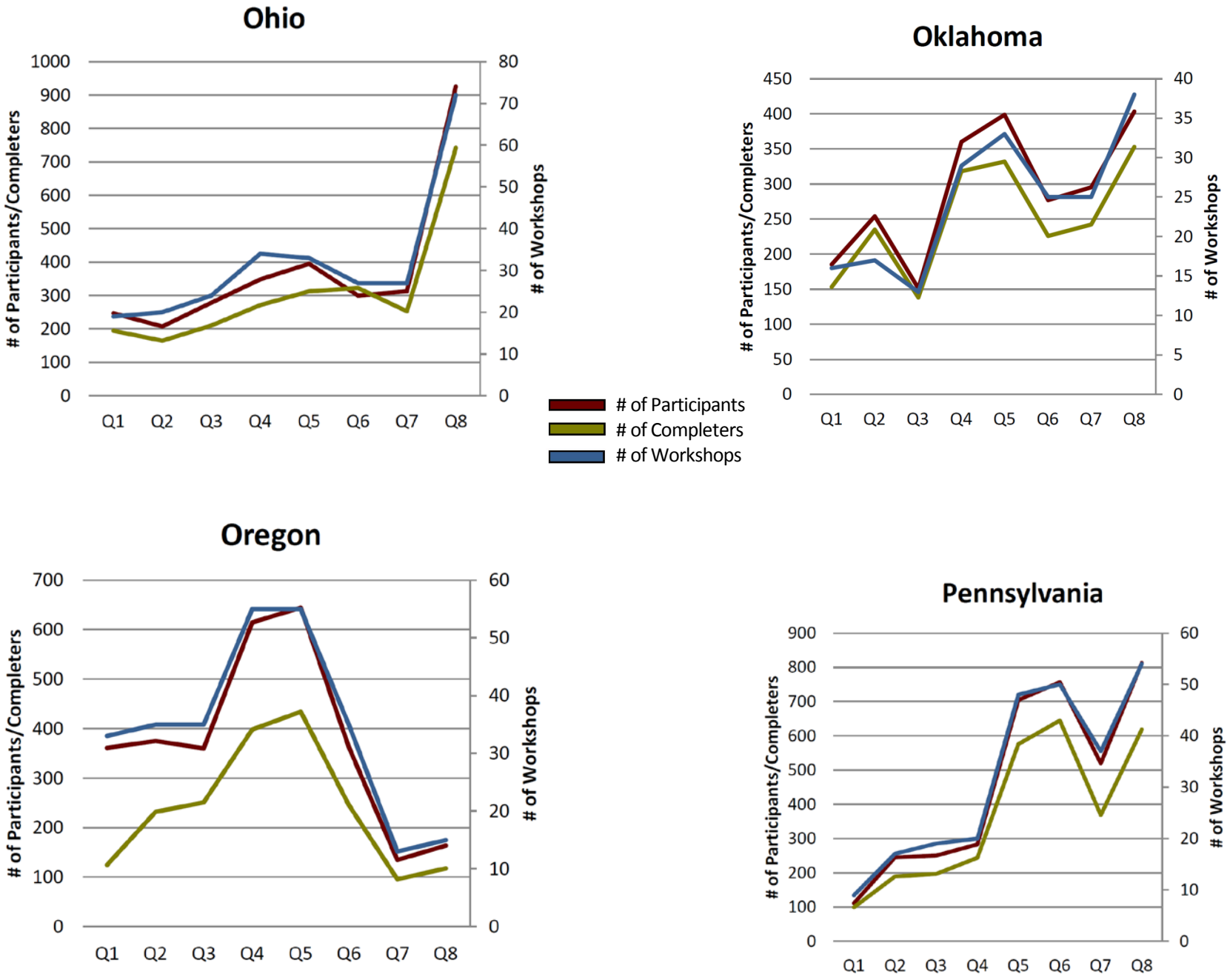
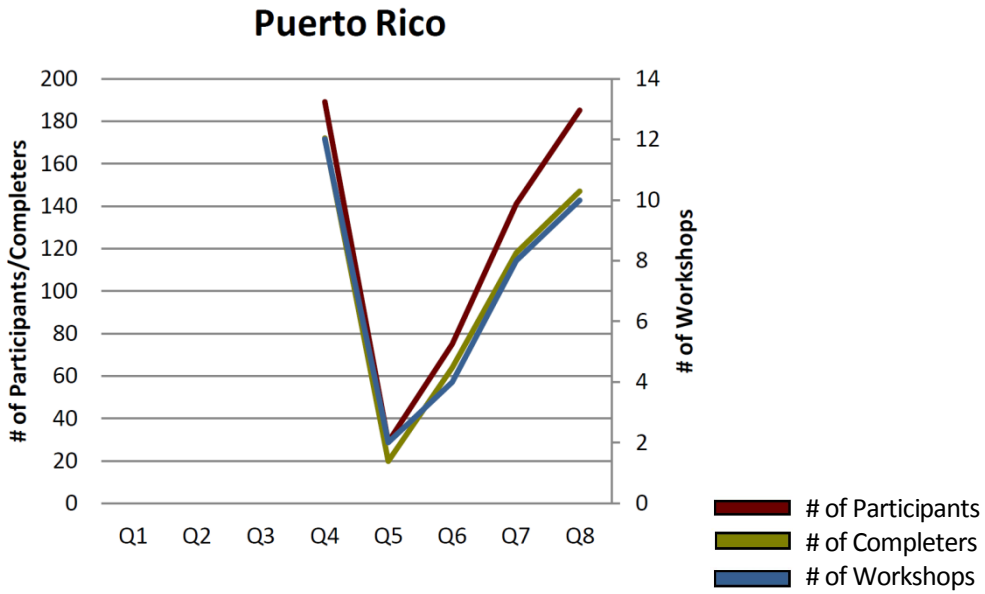
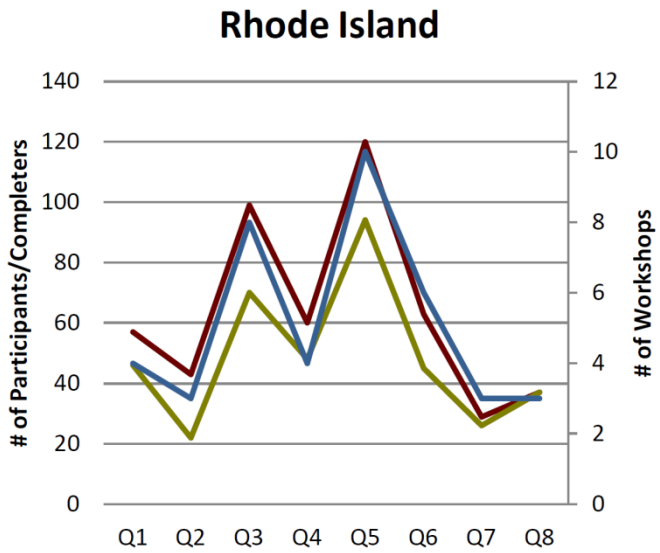
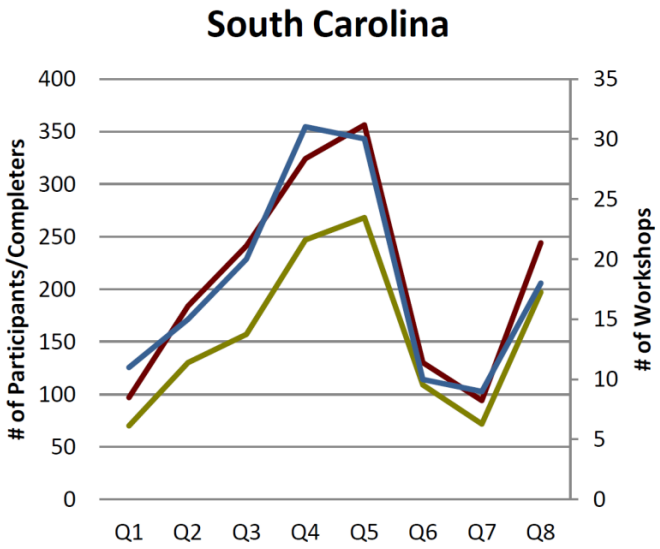
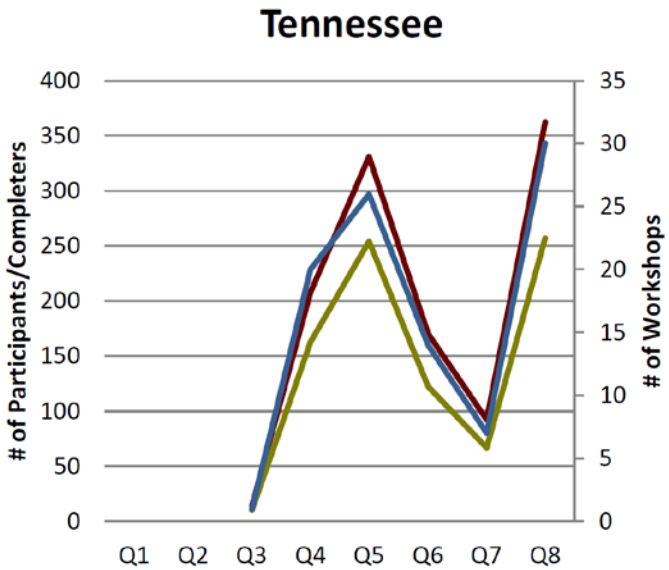
Q1
Q2
Q3
Q4
Q5
Q6
Q7
Q8

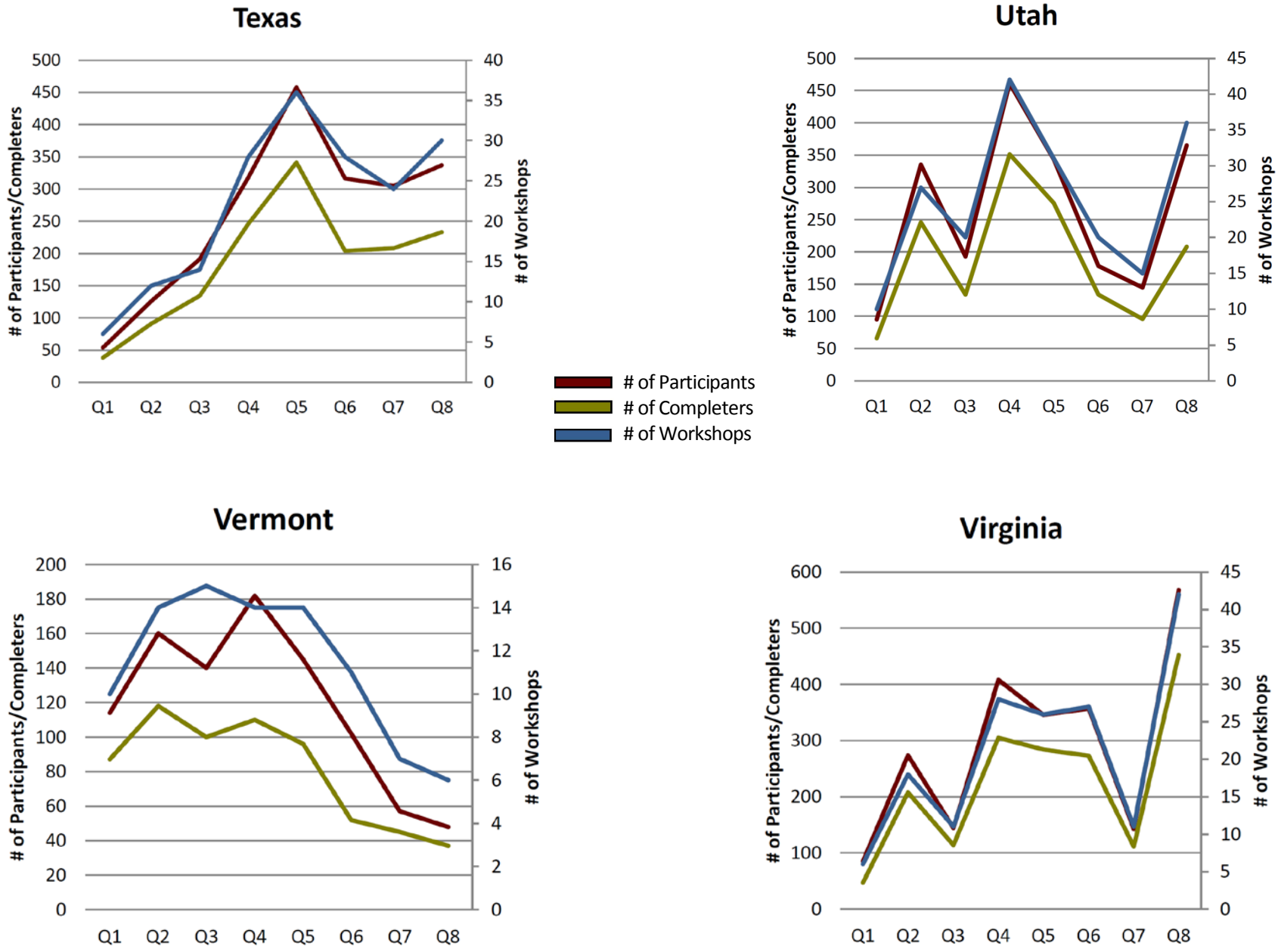

Ohio
# of Participants/Completers
# of Workshops
1000
900
800
700
600
500
400
300
200
100
0
80
70
60
50
40
30
20
10
0
Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8
Oklahoma
# of Participants/Completers
# of Workshops
450
400
350
300
250
200
150
100
50
0
40
35
30
25
20
15
10
5
0
Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8
# of Participants
# of Completers
# of Workshops
Oregon
# of Participants/Completers
# of Workshops
700
600
500
400
300
200
100
0
60
50
40
30
20
10
0
Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8
Pennsylvania
# of Participants/Completers
# of Workshops
900
800
700
600
500
400
300
200
100
0
60
50
40
30
20
10
0
Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8


Puerto Rico
# of Participants/Completers
# of Workshops
# of Participants
# of Completers
# of Workshops
Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8


Rhode Island
# of Participants/Completers
# of Workshops
Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8


South Carolina
# of Participants/Completers
# of Workshops
Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8


Tennessee
# of Participants/Completers
# of Workshops
Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8


Texas
# of Participants/Completers
# of Workshops
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450
400
350
300
250
200
150
100
50
0
40
35
30
25
20
15
10
5
0
Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8
# of Participants
# of Completers
# of Workshops
Utah
# of Participants/Completers
# of Workshops
500
450
400
350
300
250
200
150
100
50
0
45
40
35
30
25
20
15
10
5
0
Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8
Vermont
# of Participants/Completers
# of Workshops
200
180
160
140
120
100
80
60
40
20
0
16
14
12
10
8
6
4
2
0
Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8
Virginia
# of Participants/Completers
# of Workshops
600
500
400
300
200
100
0
45
40
35
30
25
20
15
10
5
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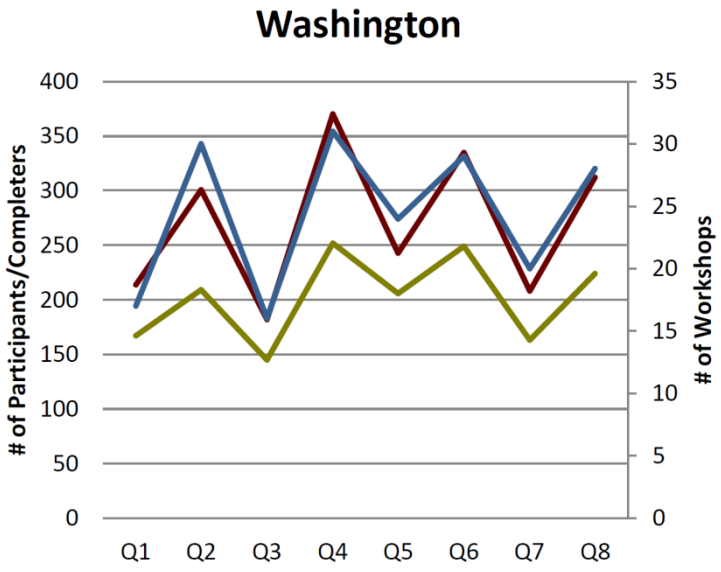
Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8


Washington
# of Participants/Completers
# of Workshops
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300
250
200
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100
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Q1
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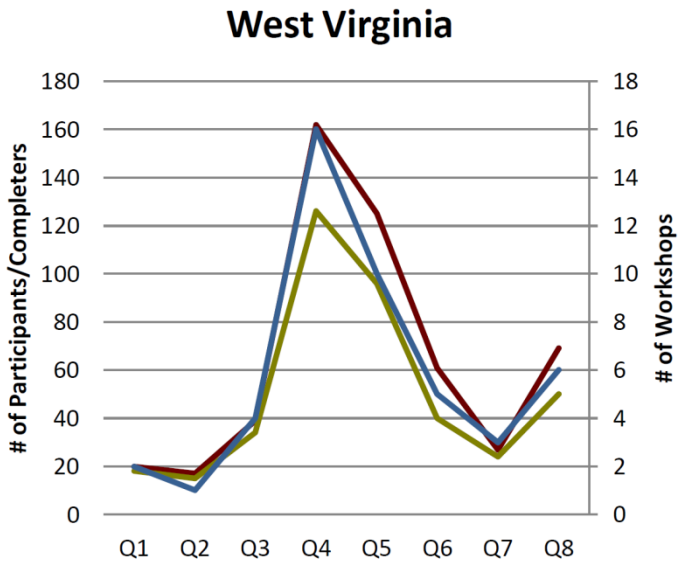
Q3
Q4
Q5
Q6
Q7
Q8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# of Participants/Completers
# of Workshops
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140
120
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80
60
40
20
0
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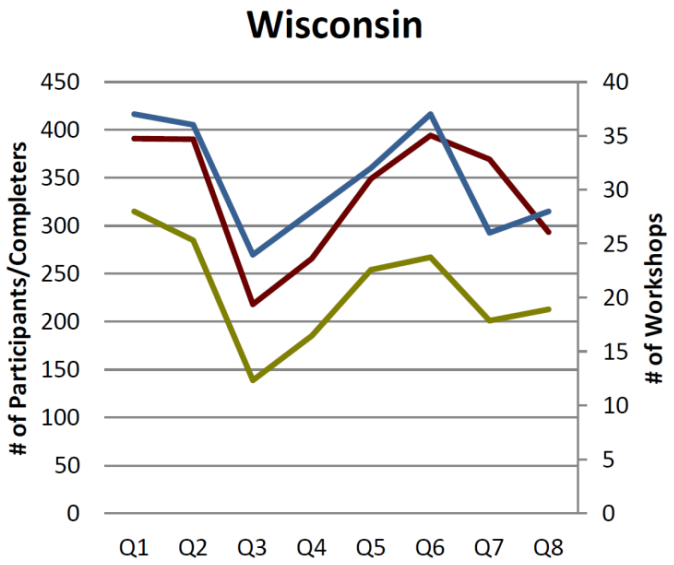
4
2
0
Q1
Q2
Q3
Q4
Q5
Q6
Q7
Q8


Wisconsin
# of Participants/Completers
# of Workshops
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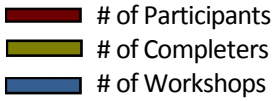
Q7
Q8


# of Participants
# of Completers
# of Workshops

APPENDIX J. LOGIT REGRESSION ANALYSIS

APPENDIX J. LOGIT REGRESSION ANALYSIS

Logistic regression is a commonly used approach in cases where the outcome (or the dependent variable) has two possible values (e.g., success vs. failure). These outcomes are coded as "0" (for failure) and "1" (for success) so that the model investigates the changes in the probability of success by changes in the observable factors (or independent variables). In this report, we investigate the probability of completion for CDSMP participants. So, if we denote the outcome variable (whether or not the participant completed the CDSMP workshop) by Y_i, and the probability that Y_i equals "1" for participant *i* by P_i, then the regression model is given by:

$$ln\left(\frac{P_i}{1-P_i}\right) = \alpha + \beta X_i + S_j + W_k + \epsilon_i \qquad (1)$$

The model includes the following control variables derived from participant characteristics as well as the attempt/interview data:

X_i contains characteristics for participant *i*, such as age and gender

S_j contains characteristics for state *j,* such as type of leadership or source of funding

W_k contains characteristics for workshop *k,* such as number of participants or location

ϵ_i is a zero mean disturbance term.

Because equation (1) does not describe a linear relationship between the independent variables and the outcome variable, exponentiation of both sides of the equation and solving for P_i converts the estimates for the coefficients (β) into *odds ratios*. An estimated odds ratio of greater (less) than one indicates an increase (decrease) in the probability that the outcome variable takes a value of one. For example, an odds ratio of 1.25 indicates that the probability that the outcome variable takes a value of one (e.g., success) is 1.25 times (or 25 percent) higher for a one-unit change in the predictor variable.

APPENDIX K. CDSMP EVALUATION EFFORTS BY STATE GRANTEE

APPENDIX K. CDSMP EVALUATION EFFORTS BY STATE GRANTEE

State	Overview	Studies	Measures & Methods	Key Findings
Alabama	Database includes intake/client enrollment form completed before each workshop. Data are collected beyond the scope of the grant. All localities send data to the Alabama Department of Social Services, which sends report to National Council on Aging (NCOA).	No studies reported.	No specific measures and methods reported.	No findings reported
Alaska	State Program Director collects, maintains CDSMP data in an ACCESS database. Data include NCOA requirements and additional information, e.g., pre-post feedback forms, age, gender, number of sick days, number of well days, attendance forms, trainer IDs, certification/re-certification dates, etc.	State Program Director is conducting evaluations including: 1) clinical outcomes study of people with diabetes (diabetes self management program under a separate grant); 2) Medicaid health center diabetes study using case-controls; and 3) separate diabetes group matching on A1C levels.	For CDSMP: Participants are pre-and post surveyed; leaders are all post-surveyed. Diabetes Outcome Study: Clinical measures collected: a) BMI; b) LDL; c) BP; d) A1C. Clinical studies focus on differences between 3-6 month and 12-month follow- up data.	Currently analyzing first group of diabetes self-management participants: 1) anecdotal evidence suggests workshop participants cost to Medicaid is 1/3 to others who did not take program; 2) seems to be cost savings in pre-post group. These findings are not final and not public.
Arizona	Arizona Living Well Institute (grantee) created data system for CDSMP that is updated on regular basis.	No studies reported.	No specific measures and methods reported.	No findings reported
Arkansas	State Department of Health grantee collects NCOA-required data from Department of Aging in Excel file, carries out basic evaluations. The state conducts some GIS mapping.	Department of Health does some analysis, e.g., compliance with the 30/30 concept (everyone in the state can access CDSMP within 30 miles and within 30 days).	Assessment reports based on: 1) fidelity; 2) leader satisfaction for CDSMP and AMOB; 3) evaluation of dropouts by non-attendees; 4) participant self-report of improved outcomes; and 5) cross-match of participants and GIS mapping of site locations/country participation.	No findings reported.
California	Partners in Care Foundation (PICF) provides technical assistance and data collection statewide under contract with the State of California. NCOA data are collected, as well as insurance status (Medicaid, Medicare, private); Veteran status; self-management activities; program usefulness. State does not track participants after completion of workshops. Data include Kaiser Permanente-funded workshops and any other workshop willing to submit data packets to PICF.	PICF monitors data from sites for fidelity but does not have influence on sites reporting data outside ARRA funding. California has a limited evaluation program at the Los Angeles Site.	Pre/post-test study using Session One data as the baseline, and following up at Session Six and a six-month follow-up.	No findings reported.

State	Overview	Studies	Measures & Methods	Key Findings
Colorado	All sites provide data through a data portal established by the Consortium for Older Adult Wellness. Pre/post evaluation data collected by local leads, in addition to NCOA data. Some counties collect excess data for funding purposes.	Some pre and post studies are conducted.	No specific measures and methods reported.	No findings reported
Connecticut	State collects additional data (other than NCOA-required data), e.g., pre-post program, level of fatigue, health, pain, mood, social activities, and diabetes measures.	Evaluation efforts have focused on evaluation of the Tai Chi program.	Pre-post workshop evaluations. The Tai Chi evaluation collected outcomes related to: 1) "Up and Go"; 2) 50- foot walk tests; 3) rise from a chair. Other data measures collected not related to the Tai Chi evaluation include: 1) the eight question new patient questionnaire for CDC funding purposes.	No findings reported.
Delaware	Department of Public Health (DPH) collects NCOA-required data; DPH recently acquired a new grant that will cover outcome research.	Pre-post data available.	No specific measures and methods reported.	No findings reported.
Florida	NCOA database exists for all site contracts; Data exist out of the system not entered into by sites outside the contract.	No studies reported.	No specific measures and method reported.	No findings reported.
Georgia	State is conducting a survey using questions from BRFSS and a nutrition class, delivered pre-post and at 6 months. Currently piloting use of evaluation data with a refining tool and a fidelity tool.	A pre-post survey is being conducted.	Questions used by BRFSS and a nutrition class are used in a survey, delivered pre-post and at 6 months.	No findings reported.

State	Overview	Studies	Measures & Methods	Key Findings
Hawaii	Department of Health has funded evaluation efforts to date. An outcome evaluation is being conducted with the University of Hawaii. For this project, additional data are collected for 3- and 6-month follow up. Data are collected on health behaviors, efficacy, health satisfaction at 3 and 6 months (since 2007). Recently, data have been collected for measures of Diabetes Self Management Program (BMI, cholesterol, glucose, A1C).	Evaluation efforts have focused on pre-post assessment of different populations in the state (e.g. Caucasian, Asian and Pacific Islanders).	The outcomes measured in the study included social and role activity limitations; communication with physicians; self-rated health; time spent engaging in stretching and strengthening exercises; self-reported physician visits; increases in time spent in aerobic exercise; ability to cope with symptoms; and self-efficacy.	The evaluation found that CDSMP can be modified to achieve behavior changes in different ethnic populations. All subgroups studied realized significant decreases in social and role activity limitations and significant increases in communication with physicians. Articles: *a)Adapting Stanford's Chronic Disease Self-Management Program to Hawaii's Multicultural Population Gerontologist; b)Cost–Benefit Estimates of an Elderly Exercise Program on Kaua'- I Hawaii Medical Journal*
Idaho	Before the ARRA grant, each participant received a pre-post questionnaire. After ARRA this changed to a pre-survey only (due to cost constraints). Workshop and leaders evaluations are collected for every workshop. Idaho contracts with Boise State University for evaluation, including collection and analysis of data collected on workshops.	Pre and post survey data existed before AARA- after AARA, this changed to a pre-survey only along with demographics and behavior. Boise State is the evaluation contractor for collecting and analyzing the data outcomes.	The LWI intervention was delivered to participants in the LWI program who completed a pre-intervention and a 6-month post-intervention survey. Findings from matched pre and post surveys were analyzed to determine changes in self-efficacy, health status, healthcare utilization and health behaviors. The study population consisted of primarily white females over the age of 65, residing in rural or frontier areas, and suffering from one or more chronic condition. Of the 298 participants, 61% reported income of less than $24,999 and 65% had a high school education or less.	Findings demonstrated significant changes in health status. Those reporting lower incomes experienced significant changes in health status; days effected by physical or mental health; and improved communication with physicians. Participants with lower incomes also reported higher utilization of physician services and the ER. Those in lower income/lower education categories also reported lower post-intervention self-management skills.
Illinois	State monitors fidelity and CDSMP implementation.	No studies reported.	No specific measures and methods reported.	No findings reported.
Indiana	State has centralized database where NCOA data are maintained. Data are submitted through a secure site. The state requires AAA sites providing CDSMP to complete a monthly Excel sheet that includes questions about the numbers of master trainers and lay leaders, completers, enrollees, master trainer and lay leader names, scheduled time of master trainer trainings, workshops, and outreach.	No studies reported.	No specific measures and methods reported.	No findings reported.

State	Overview	Studies	Measures & Methods	Key Findings
Kansas	Kansas Department on Aging manages submission of data to NCOA.	No studies reported.	No specific measures and methods reported.	No findings reported
Kentucky	Data are collected for submission to NCOA. Data are also reported to Stanford annually to maintain the license.	No studies reported.	No specific measures and methods reported.	No findings reported.
Louisiana	State has an evaluation report; the state is also looking at data elements other than those required for report to NCOA. States matches NCOA data against survey data. Some follow up is conducted by University of Louisiana-Monroe.	Study used repeated measures design.	The report focuses on results on engaging low-income and disparate populations; reports on changes in client's health behavior, health status, and reduction in client's health care utilization and health care costs; qualitative evaluation around program effectiveness in a community-based, low-income, rural, and/or African-American population, and quality improvement of the program. (Evaluation in process)	No findings reported.
Maine	Maine's Department on Aging contracts with University of Southern Maine for data entry and reporting, and relies on community partners to enter data. Pre-post surveys are conducted. Maine has developed its own data collection/ analysis tools for outcomes and evaluation, emphasizing management on the local level.	The evaluation of CDSMP focused on a pre- and post-test (6 months) of participants in the program. Four different evaluation activities have been undertaken: 1) The MaineHealth Center for Quality and Safety conducted an evaluation of CDSMP with pre test and 6 month post and looked at outcomes. 2)Jay Yoe from DHHS has conducted two QI Snapshots for state leadership - one on EnhanceWellness, which will be updated in January with the final results, and one for CDSMP that was completed this fall - both have outcomes data. 3) The work with the state employee and retiree LWBH workshop series project involves comparing participant health benefit utilization data. 4) For MOB, several papers have been submitted for publication with the outcomes of the national dissemination, and one regarding the TUG project.	One study looked at health benefit data; the outcomes for the other studies were not provided.	No findings reported- the studies mentioned are underway or in the analysis phase.

State	Overview	Studies	Measures & Methods	Key Findings
Maryland	Sites submit data required for NCOA to Maryland Department on Aging (MDoA) portal. Evaluation efforts in Maryland focus on CDSMP coordinator input and participant demographic characteristics. State has partnered with Towson State University for some evaluations.	Maryland has adopted a mixed-method study design to understand the reach and efficacy of CDSMP programs. A CDSMP evaluation was performed by Towson University in Maryland. The evaluation includes a phone interview with CDSMP coordinators across the state and an analysis of the data entered into the NCOA system plus several other questions related to participant income and language that is not in the NCOA data base but are on the participant surveys. They are looking for issues or gaps that may impede program delivery and those issues that may have made program delivery more successful. MD is also looking for any issues that may improve program outcomes and help sustain partnerships that are beneficial to the program.	Specific outcome measures are not reported; however, there is interest in findings on participation rates among different demographic groups and structural impediments to the group. Also, there is interest in collecting and reporting outcome data.	No findings reported.
Massachusetts	Evaluation efforts in Massachusetts focus on two different areas: 1) Healthy eating evaluation; there were a total 42 workshops reaching 432 participants – pre and post outcome data (weight, BMI, blood pressure) 2)CDSMP- project process evaluation The state reports that data collection is a real challenge for community programs. It is time consuming, often confusing, and very labor intensive, so the state is looking to identify essential elements to collect on an ongoing basis. Tomando is especially difficult for data collection as staff must collect data one-on-one with participants.	CDSMP- Three different evaluation exercises: 1) In-depth facilitator survey to understand challenges, barriers, continuing education needs, motivators/incentives and infrastructure needed for ARRA CDSMP; 2)Assessment of current fidelity practices and development of a fidelity and QI plan; 3) Outcome pilot evaluation (pre-post survey). The University of Massachusetts Donahue Institute conducted the main CDSMP evaluation.	The Donahue Institute disseminated CDSMP Leader and Master Trainer Survey final report on workforce diversity, motivations and challenges, fidelity, past and future capacity, and continuing education preferences. Outcome Evaluation Pilot in progress - 400 pre-workshop evaluation surveys received, beginning to receive 6-month follow-up surveys.	Preliminary findings of the outcomes evaluation pilot point to improvements in participant self-assessment of general health, levels of fatigue, pain, stress, sleep, physical activity, and communication with their physicians. In addition, small decreases in health care utilization were noted. In the area of health care utilization, completers between the ages of 65 - 74 had slightly greater decreases in health care utilization. The preliminary findings from the fidelity pilot show excellent participant satisfaction; health most common reason for drop out.

State	Overview	Studies	Measures & Methods	Key Findings
Michigan	Michigan has maintained a centralized data collection process (ACCESS database) since 2007. This uses a scannable form system and registration process that enables collection of data from both ARRA-funded and non-ARRA funded sites (all sites statewide). Data on health insurance are collected. The program receives many legislative requests for data. An in-house evaluator uses the database and other sources for comparison data. Also, the state partners with Michigan State University Geriatric Education Center for some evaluation.	The state focuses program evaluation on fidelity issues. Evaluation efforts focus on two different aspects: 1) online survey and 2) phone and face to face interviews. Michigan State University Geriatric Education Center carried out the evaluation.	Fidelity issues.	The evaluators have been trained as master trainers in CDSMP or CDSMP leaders, so they all have led one or more workshops, lending credibility to the evaluation process.
Minnesota	NCOA-required data only are collected.	No studies reported.	No specific measures and method reported..	No findings reported.
Mississippi	NCOA-required data only are collected.	No studies reported.	No specific measures and methods reported.	No findings reported.
Missouri	In 2008, Missouri established its own database including five evidence-based programs. Under the ARRA grant, the state carried out dual data entry for CDSMP, entering data for the state and also for NCOA. Missouri uses its database for GIS mapping to show availability of leaders and has cross tabulated data with BRFSS to show availability of trainers and location of persons with arthritis.	No studies reported.	No specific measures and methods reported.	No findings reported.
Nebraska	The state uses a GIS specialist to map the data and is using NCOA's Salesforce data internally and to share with partners.	Nebraska was using Stanford's questionnaire to conduct pre-post evaluations, but these were postponed due to lack of funds.	No specific measures and methods reported.	No findings reported.
Nevada	NCOA-required data only are collected.	No studies reported.	No specific measures and methods reported.	No findings reported.
New Hampshire	State has centralized database. NH developed a pre-post outcomes survey with assistance from The Dartmouth Prevention Research Center. The survey is closely aligned with that developed by Maine and Vermont. A summary report should be available in Spring 2012.	Evaluation efforts in New Hampshire have focused on pre-and post-outcomes for programs. Dartmouth University helped develop the outcome survey, and would likely be included in the evaluation.	At the time of interview, there were 60 pre-records and 40 post-records in the database. Information included on the surveys include: demographic and chronic disease information; type of insurance; medical care; ADLs, and Patient Activation Measures (PAMs).	A preliminary analysis showed higher levels of patient activation after completing the workshop. The state plans to collect data through December 2012.

State	Overview	Studies	Measures & Methods	Key Findings
New Jersey	New Jersey has a centralized database and undertakes evaluations of programs. ARRA funds were used to contract with InfoMatics at University of Medicine and Dentistry of New Jersey (UMDNJ) to develop a supplemental ACCESS database for CDSMP, to maintain information on where workshops are offered and records on peer leaders and master trainers. State receives requests for data from partners and the Commissioner of DHHS. A staff person spends 80% of time collecting and reviewing data. Office of Minority and Cultural Health maintains a separate database with demographics and non-English-speaking populations,	Evaluation efforts in New Jersey are currently performed by three providers: 1) two evaluations at UMDNJ (different divisions); and 2) one evaluation at NJ Department of Health and Human Services. The state is moving forward with three studies (aimed at different populations): 1) UMDNJ "SAVE Women and Men" related to New Jersey Cancer Education and Early Detection; enroll 90 CDSMP subjects and measure outcomes; 2) UMDNJ measuring outcomes in prisons-CDSMP has been conducted for two years; 3) Initiative at FQHC – Southern Jersey Center integration of operations with data collections.	Samples of participants range from those at risk for heart disease and stroke to a prison-based population.	Clinical outcomes are the focus of the evaluation, although specific results are not mentioned.
New Mexico	State collects and submits data related to NCOA measures, and also collects its own data for planning, and to obtain participant feedback, program reach, completion and more. The state is applying for federal funds to hire an evaluator to collect and analyze follow-up participants on data.	No studies reported.	No specific measures and methods reported.	No findings reported.
New York	QAT runs the database for workshop data. QTAC is finalizing evaluation of outcomes for CDSMP participants.	No studies reported.	No specific measures and methods reported.	No findings reported.
North Carolina	In addition to building a state database, NC has also added an evaluation component to the NC Living Health Chronic Disease Self-Management Program.	The evaluation study focuses on participants who attended the NC Living Healthy CDSMP workshop from Nov. 2009-2010. A pre- post-test survey was conducted, spaced out a year after participation in the seminar.	Four domains were explored in the questions: 1) general health; 2) physician communication; 3) symptom management; and 4) daily activities. The outcomes were divided into four different domains: 1) general health; 2) physician communication; 3) symptom management; and 4) daily activities. The NC and NY evaluations include patient activation measure and 6 domains with pre-post outcomes. The original sample size included 186; 113 participated in the survey.	Statistical trends, using ANOVA testing, were found in the four self-reported health domains. Specifically, increases in physician communication, daily activities, and symptom management were found as well as improvements in general health.

State	Overview	Studies	Measures & Methods	Key Findings
Ohio	ODA collects and submits data to NCOA; ODA also collects data in addition to NCOA requirements.	No studies reported.	No methods and measures reported.	No findings reported.
Oklahoma	In addition to collecting CDSMP data, the state also conducted a small survey to ask questions about CDSMP.	Survey addressed the following questions: 1) how participants heard about the workshops; 2) whether participants feel they are better able to deal with their conditions after taking the workshops; and 3) how participants feel they have benefited regarding enhanced abilities.	No methods and measures reported.	No findings reported.
Oregon	Oregon has produced an in-depth report evaluating CDSMP in the state-Living Well (CDSMP) Impact Report	The program evaluation takes a macro approach looking at estimates for QALYS gained and health care costs and utilization reduced because of CDSMP.	Oregon State University carried out the evaluation. The sample size included in the report is roughly 3,900 individuals. There are a number of outcome measures included in the report but they focus on QALYS and costs saved on medical care.	The report found: Savings in health care utilization would outstrip costs by $1,445 per participant in the program: 107 QALYS gained as a result.
Pennsylvania	The Department of Aging controls the inputting and reporting of data.	The University of Pittsburgh conducted a pre-post evaluation of participants, with 6 month and 12 month follow up to assess behavior changes such as levels of physical activitiy, healthy eating, and more.	No methods and measures reported.	No findings reported.
Puerto Rico	DOH is able to evaluate the leaders as well as specific workshops. DOH has an evaluator oversees data-related activities.	The evaluator will evaluate fidelity using Stanford tools; is working on an evaluation of participants that completed workshops six months ago; and conducting follow up interviews. Collected data will be analyzed and published as part of the project evaluation report	Some of the additional elements collected include information from a pre-post questionnaire that asks about physical activity, how sure participants are in managing their conditions, levels of pain, flexibility and more.	No findings reported
Rhode Island	As a health department, HEALTH describes itself as a data driven organization that collects data and uses data for decision making. In addition to data collected for NCOA the state is interested in behavior change, ROI, and ER visits.	Data are collected pre and post workshops and at 6 month follow up. Data are used for program improvement.	No methods and measures reported.	No findings reported.

State	Overview	Studies	Measures & Methods	Key Findings
South Carolina	South Carolina collects the NCOA-required data and also collects participant satisfaction data.	At one point, South Carolina was collecting outcomes data but they have since stopped those efforts citing too high a volume of paperwork. They also have data on how participants learned of the program, but it is not currently analyzed.	No methods and measures reported.	No findings reported.
Tennessee	Implementation sites are required to telephone completers at 6 months and again at 12 months to administer a short survey about whether the participant feels he/she is managing chronic conditions betters.	No Data	No methods and measures reported.	No findings reported.
Texas	Texas only collects NCOA data, though they do occasionally survey the EBP community regarding barriers to delivery and needs.	They have recently completed a pilot study at a women's prison and are hoping that they will have a dedicated site for program delivery at this facility. There was also a summit to discuss DSMP accreditation as a requirement for Medicare reimbursement. They are in process of completing the pilot required to show ability to deliver and have already identified Medicare partners (FQHCs, a nursing school and a home health organization).	No methods and measures reported.	No findings reported.
Utah	Utah has BRFSS data, arthritis program data and hospitalization data, also arthritis specific through June 2012. Two weeks after the classes, the data manager follows up with leaders about the data.	They currently use data collected for sustainability efforts and making a 'case' for Utah. They report the number of conditions they serve and a description of the population served. They are attempting to reach more organizations, but the data is helpful with internal partners as well.	No methods and measures reported.	No findings reported.
Vermont	As part of a larger state data collection effort, the state collects data on CDSMP. The state is discussing ways that action plans might be posted and shared online. Vermont collects comprehensive data as part of the Blueprint, and these data provide rich opportunities for research and evaluation.	The state conducts some analyses currently and has the ability to link CDSMP participation to outcomes in many cases.	No methods and measures reported.	No findings reported.

State	Overview	Studies	Measures & Methods	Key Findings
Virginia	Virginia collects demographic data, and is currently collecting pre/post assessment (general health, medical care, coping and symptoms) data through the end of the grant.	The state has about 4 years of pre/post data and 2 years of demographic data. They have worked to make the pre/post assessment more user-friendly to reduce the burden on data collection. While they have many years of pre/post data, it has not been analyzed since 2009.	Partnerships with health systems have led to access to clinical and utilization data. They also collect comments and feedback.	No findings reported.
Washington	Washington collects NCOA required data.	No specific studies mentioned.	No methods and measures reported.	No findings reported.
West Virginia	WV, through West Virginia University, has a number of data collection efforts and studies under way. The evaluator at West Virginia University is working with Marshall University to design a leader and participant questionnaire that will be implemented during the final quarter of the grant. The information gathered from the interviews will be summarized to highlight program outcomes, both problems and successes which will be useful to help maintain fidelity	There is an outcomes study in progress based on the Orrey model, which incorporated some questions from the BPH, as well as self-reported health, self efficacy, quality of life, communication, activities, pre-diabetes screen, pre-hypertension screen, and cholesterol levels (all self-reported). They are training leaders to distribute the outcomes survey pre-class (so far 89 completions), a 6-week satisfaction survey, and outcomes again at 3 and 6 month post program. The state is also planning a leader survey to determine activity, barriers, needs, experiences and demographics (at this point, the survey has been drafted). Also, the state is conducting telephone interviews of participants and non-participants by region, with proportional representation (CDSMP, DSMP, non-completers and completers). They aim to survey at least one participant per leader. At this point, the survey instrument is complete.	Evaluation efforts will look at a number of outcomes including: 1) participant satisfaction of participants; 2) background, experience, and satisfaction of leaders; 3) outcomes for participants including self-efficacy, self-rated health, pain, fatigue, and disability.	No findings reported.

State	Overview	Studies	Measures & Methods	Key Findings
Wisconsin	The state boasts robust evaluation efforts.	State efforts focused on program evaluation	Outcomes have largely focused on cost savings associated with the program. In addition, evaluation efforts have measured fidelity adherence, leader motivation, and retention.	Program evaluation conducted in November 2010 suggested a nearly $1.5 million savings in health care expenditures based on the same utilization indicators of emergency room and hospital days used by Stanford in their original evaluation of the program.