State Units on Aging Survey of Title III-D Evidence-Based Program Delivery and Review Process

Summary Report / February 2024

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I. Executive Summary

The National Council on Aging (NCOA) conducted an online survey of State Unit on Aging (SUA) Older Americans Act (OAA) Title III-D health promotion and disease prevention program leads from March through May 2023, followed by one-on-one phone interviews with six leads in August 2023.

The goals of this survey were to understand:

- Evidence-based programs currently being delivered by states
- Root causes of changes in volume of evidence-based programs
- Gaps in evidence-based programming
- Strategic use of funding sources to support evidence-based programs
- Approach toward the remote delivery of evidence-based programs
- Obstacles faced in delivering evidence-based programs
- Technical assistance priorities and experience to date
- Intent to further support states' delivery of evidence-based programs.

This report summarizes findings from 41 states and territories and offers insights and recommendations for technical assistance to SUAs. Where applicable, comparisons are made to a similar survey conducted in 2017 in which 31 states responded.

A key focus of the survey was on the use of remote programs, which in this context refers to the use of technology for the provision of support and education to older adults, including virtual versions of workshops that have traditionally been delivered in person.

> **Flexible policies and funding that support the delivery of affordable, evidence-based programs that meet the needs of the intended population and are offered in multiple formats appear to be critical strategies for ensuring program success.**

I. Executive Summary

Most (97%) states acknowledged the pandemic for declines in participation in evidence-based programs, though another 45% also cited the cost of training and certification and challenges with delivering remote programs.

While many states experienced some difficulty in pivoting to more remote programming during the pandemic, most states were very confident that participation in evidence-based programs will return to pre-pandemic levels, as many are already seeing some growth, albeit slow. Flexible policies and funding that support the delivery of affordable, evidence-based programs that meet the needs of the intended population and are offered in multiple formats appear to be critical strategies for ensuring program success.

Program Scope and Changes

A total of 69 unique evidence-based programs were being implemented in the network as identified by SUA leads from 37 states, three territories, and the District of Columbia, with most of the programs being offered in multiple states/territories. The most common programs were **A Matter of Balance** (83% of respondents), **Chronic Disease Self-Management Program** (76%), **Tai Chi for Arthritis and Falls Prevention** (66%), and the **Diabetes Self-Management Program** (61%). Compared to a similar survey conducted of SUAs in 2017, there is a greater diversity of programs, with new ones emerging on the scene (e.g. **Powerful Tools for Caregivers, Bingocize**). A smaller percentage of states were delivering Chronic Disease Self-Management Education Programs in 2023 compared to 2017 (76% vs 93%). Slightly fewer are delivering Tai Chi compared to 2017 (66% vs 84%), while programs like **A Matter of Balance** and **Walk With Ease** remain popular.

Programmatic Gaps

Some notable program gaps were identified in the areas of alcohol and substance use disorder programs (64%), Tribal-specific programs (61%), and programs addressing mental health concerns (61%). However, SUA leads expressed unfamiliarity with some currently ACL-approved behavioral health evidence-based programs, such as **Screening, Brief Intervention and Referral to Treatment (SBIRT)** for substance use disorders, and **HealthyIDEAS** for depression management.

The most common gaps in populations served included those living in rural communities, individuals with dementia, LGBTQ+ older adults, adults under 60 with disabilities, and veterans. SUA leads described having difficulty locating data on LGBTQ+ communities in their state, which makes planning and outreach a challenge. Some SUA leads pointed to specific cultural gaps in delivering programs to Tribal communities and Spanish speakers, citing challenges with understanding appropriate cultural adaptations to program curricula and recruiting Spanish-speaking leaders.

Respondents expressed significant interest in identifying affordable, low-resource programs that do not require a facilitator to lessen the administrative and cost burden of evidence-based program delivery. Lower costs and greater flexibility would allow states to reach additional communities (including rural older adults, working older adults, caregivers, and people with disabilities). Examples of programs provided that achieved this well were Powerful Tools for Caregivers and the Walk With Ease self-directed program. Leads also reported that older adults are gravitating toward programs whose format has less of a traditional classroom style (e.g., Tai Chi, Walk With Ease, Bingocize). Longer programs are less attractive because it is more difficult to find leaders and participants.

I. Executive Summary

Staffing and Capacity

A primary need and top challenge for states: recruiting and training leaders. According to phone interviews, Older Americans Act Title III-D funds were reportedly insufficient to cover dedicated staff or incentivize facilitators. Limited staff (82% of states) and obtaining sufficient instructors/leaders (77%) were cited among the top reasons for facing difficulty in delivering remote programs during and post-pandemic.

Phone interviews expanded on this theme, sharing that many area agencies on aging (AAAs) do not have specific staff members dedicated to these programs, and funding is often insufficient to support a full-time staff member and still provide services. State leads reported that Title III-D funds can only be used to provide the services, not cover administrative costs, which has been challenging for some AAAs. Another factor contributing to a shortage of facilitators is the cost of training new leaders; maintaining licenses for certain programs is also highlighted as a barrier. For these and other reasons, several state leads described having to reduce the number of leader trainings offered for their programs.

States reported a high turnover of trained facilitators, exacerbating this shortage. In addition, when the demand or availability of evidence-based programs wanes in certain counties, community-based organizations run the risk of losing passionate facilitators who see there is little work for them. The compensation rate offered is not competitive, and there has been a decline in the volunteer base, especially among older volunteers, since the pandemic. AAAs often rely on volunteers, who are older adults themselves, as well as senior center staff who have multiple responsibilities.

One state lead noted the challenges of getting participants and facilitators to commit to longer programs. A strategy noted by one state is testing out requiring leaders to sign a contract agreement to deliver a set number of workshops before paying for their training. Most states are looking for additional strategies to recruit and retain leaders and their volunteer base.

Remote Program Delivery

Most SUAs (88%) allowed AAAs to use Older Americans Act Title III-D funds for remotely delivered programs. However, only half (51%) of SUAs actively facilitated partnerships among AAAs to aid in the delivery of these programs. Approximately 83% are continuing with remote programs, and most want to offer multiple formats.

The most notable identified challenges of remote delivery were:

- Difficulty with broadband and internet access (85%)
- Limited staff (82%)
- Insufficient instructors/leaders (77%)

The broadband limitation was most evident for rural states; however, several SUA leads noted in phone interviews that their state was making strides to expand connectivity.

Despite the challenges, most SUA leads felt that it was likely (53%) or very likely (30%) that remote programs would remain a part of the overall strategy. While some SUAs were able to pivot to remote delivery with ease, others found the process very challenging. Most, however, fell somewhere in the middle of the two extremes. Low tech literacy by staff in rural areas and by potential participants also contributed to difficulties with remote program delivery.

I. Executive Summary

Aside from the staffing challenges already noted, factors that are unique to evidence-based programs contribute to the ability of states to deliver them remotely. Limitations in offering classes and training were partly due to funding constraints, forcing states to be more selective with their program selections. For example, leaders were said to be hesitant to deliver Tai Chi remotely because they need to observe participants to ensure they are performing safely and correctly. There is wide appeal for delivering each of the Walk With Ease (WWE) formats. Older adults enjoy the social and engaging aspect of the in-person WWE program, while staff and older adults alike enjoy the flexibility, affordability, and convenience of delivering the self-directed versions.

Powerful Tools for Caregivers, according to one phone interview, was a success, attracting many caregivers who would not otherwise have attended in person, and was easy to coordinate remotely. Other programs are more complex, such as Stepping On, which was described by a lead as well-received by participants, but one that comes with a higher cost and administrative burden. Time spent with a program's reporting requirements can make staff less inclined to deliver it, which may be a notable implementation barrier. For example, CAPABLE was described by one lead as a quality program, but one that came with a high administrative burden and reporting requirements, and was being pulled from offerings, as reported by one SUA lead during a phone interview.

Although 82% of states report "limited staff to provide technical support," only 44% permitted the use of Title III-D funds for technology support/IT staff. It is unclear if this was due to funding restrictions, uncertainty around what qualifies as an allowable use of Title III-D funds, or another reason.

Partnerships and Sustainability

States recognize the value of partnerships, community care hubs, and want to leverage these further, with many already creatively working with partners. In particular, 51% of SUA leads mentioned their SUA was involved in facilitating partnerships among AAAs for remote program delivery.

When asked about additional support, 73% of respondents highlighted sustainability strategies as a key area (compared to 83% in 2017). The desire for infrastructure support for delivering statewide remote programs (e.g., promotion of online workshops, tech support, technology platforms, funding) was reported by many states (69%). Strategies for improving participation included developing partnerships and collaborations, using workgroups and meetings to share best practices, and regularly introducing new and interesting programs.

Familiarity with Older Americans Act Title III-D Criteria

Less overall familiarity with ACL's Title III-D criteria for evidence-based programs was reported in 2023 compared to 2017. Close to 70% of state respondents were very familiar with ACL's criteria for evidence-based programs and had applied the criteria, while another 17% were familiar and working toward applying the criteria. In contrast, 77% of participants in 2017 were very familiar with ACL's criteria and had applied them, while 13% were familiar and were working towards applying the criteria.

I. Executive Summary

During phone interviews, SUA leads expressed challenges applying criteria for evidence-based programs, particularly ensuring program fidelity and finding programs that had undergone rigorous studies published in peer-reviewed journals. All phone interviewees said they lacked the resources for a formal review process when AAAs submit programs for review that are not already on their list of approved programs. Several leads expressed a desire for less stringent requirements for experimental or quasi-experimental studies to approve a wider variety of programs that could help meet programmatic gaps and the needs of underserved communities.

States that are single units (i.e., those that serve their entire state's aging services rather than partnering with local AAAs), under-resourced, and rural also seek greater support and more flexibility in program implementation. This may include getting additional assistance with meeting reporting requirements, application of Title III-D criteria, and appropriate use of funds.

Technical Assistance

Nearly two-thirds (63%) of state leads sought technical assistance from evidence-based program developers/administrators (48%), their ACL Regional Administrator (41%), and the NCOA's National Chronic Disease Self-Management Education and/or Falls Prevention Resource Centers (41%).

Some SUAs provided technical assistance to AAAs, often in the form of phone calls and email messages, group meetings, and sharing of best practices. Respondents were interested in additional support for many topics, including support for recruitment and training (75%), sustainability strategies (73%), and establishing partnerships (70%).

Specifically, states operating as single units are looking for more collaboration and support. They emphasized the need for a more user-friendly and comprehensive evidence-based program database that includes details such as program costs, training costs, and remote options. To fill programming gaps, they would also like assistance with identifying low-resource evidence-based programs, including those that do not require a facilitator.

States note that they would benefit from the following:

- Guidance on understanding and applying the Older Americans Act Title III-D evidence-based program criteria.
- Appropriate use of Title III-D funds.
- Education and resources on approved programs that fill programming gaps, such as areas related to behavioral health and reaching Hispanic/Latino and other underserved populations.
- Resources, tools, and webinars in other targeted areas, such as culturally adapting programs, reaching rural communities, and recruiting/retaining leaders.
- Forums in which best practices and strategies can be exchanged.

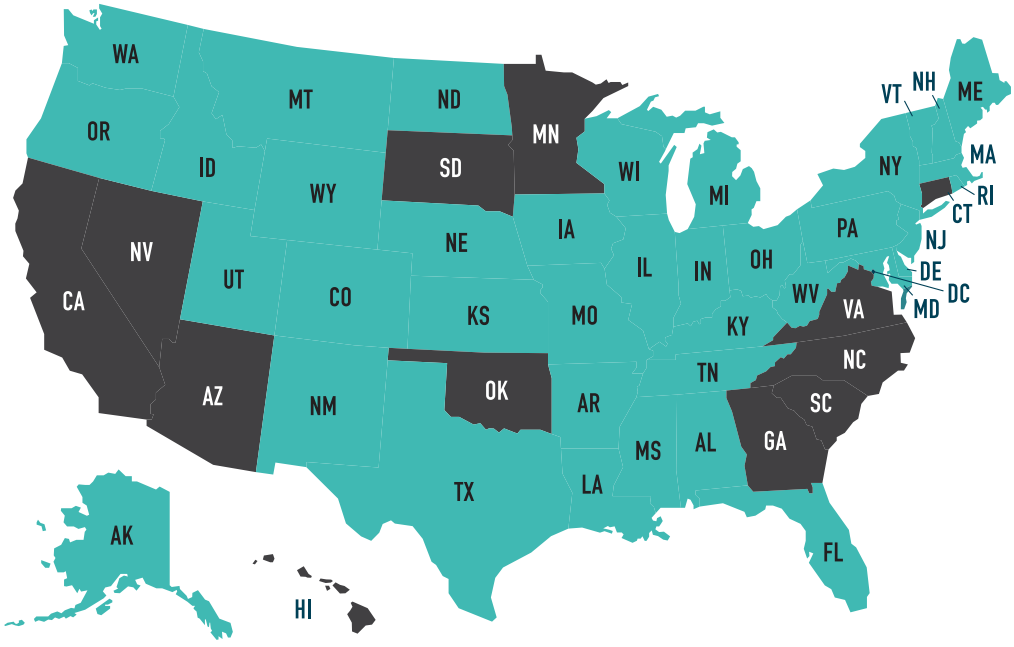
II. Survey Methodology

A. Online Survey

The National Council on Aging invited the State Unit on Aging (SUA) Older Americans Act Title III-D leads to complete an online survey between March 23 and May 24, 2023. A total of 41 state responses were received, including three territories and the District of Columbia. Five states provided duplicate responses that were combined or averaged, as appropriate.

States and Territories Represented in this Survey:

Alabama
Alaska
American Samoa
Arkansas
Colorado
Delaware
District of Columbia
Florida
Guam
Idaho
Illinois
Indiana
Iowa
Kansas
Kentucky
Louisiana
Maine
Massachusetts
Michigan
Mississippi
Missouri
Montana
Nebraska
New Hampshire
New Jersey
New Mexico
New York
North Dakota
Northern Mariana Islands
Ohio
Oregon
Pennsylvania
Rhode Island
Tennessee
Texas
Utah
Vermont
Washington
West Virginia
Wisconsin
Wyoming



B. Phone Interviews

NCOA staff conducted six telephone interviews with state Title III-D leads in August 2023. With ACL input, states with varying success related to evidence-based program delivery and other factors (e.g., confidence of returning to pre-pandemic levels and challenges experienced during the pandemic) were identified for the interviews. Individual responses are confidential and are primarily reported in aggregate in this report.

III. Findings

To keep the list of evidence-based program options on the online survey manageable, NCOA provided a pre-set picklist of the most popular programs based off the most common program listed in the 2017 survey. The most common programs reported in NCOA's national databases, formerly known as the National Falls Prevention Database and National CDSME Database, were also included in the picklist. In addition to selecting the programs currently delivered in their state, SUA leads were also asked to write in any other programs not on the picklist, such as those officially on the ACL-approved list, as well as any others state support with Title III-D funding.

A total of 69 unique programs are being implemented by states using Title III-D funds. Of these, 46 came from the picklist provided by NCOA to survey participants, while the remaining 23 were written in independently as part of an "Other" option. Included in the "Other" category was a mix of programs that were ACL-approved and others not officially on the list.

A. Popular Programs

The most commonly offered programs were: A Matter of Balance (83%), Chronic Disease Self-Management Program (76%), Tai Chi for Arthritis and Falls Prevention (66%), and Diabetes Self-Management Program (61%).

Table 1. Number and percentage of states offering listed NCOA programs (n=41)

Program	n	%
A Matter of Balance	34	83%
Chronic Disease Self-Management Program (CDSMP)	31	76%
Tai Chi for Arthritis and Falls Prevention	27	66%
Diabetes Self-Management Program (DSMP)	25	61%
Bingocize	24	59%
Powerful Tools for Caregivers	22	54%
Walk With Ease (in-person)	22	54%
Chronic Pain Self-Management Program (CPSMP)	19	46%
Arthritis Foundation Exercise Program	17	42%
EnhanceFitness	16	39%
Tai Ji Quan: Moving for Better Balance	15	37%
National Diabetes Prevention Program (NDPP)	14	34%
Stay Active and Independent for Life	14	34%
Stepping On	14	34%
PEARLS	13	32%
Walk With Ease (self-directed)	12	29%
Active Living Every Day	11	27%
Stress-Busting Program for Family Caregivers	11	27%
Tomando Control de su Salud (Spanish CDSMP)	11	27%
Healthy IDEAS	10	24%
Savvy Caregiver	10	24%

III. Findings

Program	n	%
HomeMeds	9	22%
CAPABLE	8	20%
Mind Over Matter	8	20%
Programa de Manejo Personal de la Diabetes (Spanish DSMP)	7	17%
Cancer: Thriving and Surviving	6	15%
Fit & Strong!	5	12%
Tool Kit for Active Living with Diabetes	5	12%
Better Choices, Better Health	4	10%
Diabetes Empowerment and Education Program (DEEP)	4	10%
EnhanceWellness	4	10%
FallsTalk	4	10%
Programa de Manejo Personal de Dolor (Spanish CPSMP)	4	10%
Resources for Enhancing Alzheimer's Caregiver Health I and II	4	10%
Tool Kit for Active Living with Chronic Pain	4	10%
Workplace Chronic Disease Self-Management (wCDSMP)	4	10%
YMCA Moving for Better Balance	4	10%
Arthritis Foundation Aquatic Program	3	7%
Positive Self-Management Program	3	7%
The Otago Exercise Program	3	7%
Tool kit for Active living with Chronic Conditions	3	7%
Tai Chi Prime	2	5%
GeriFit Strength Training	2	6%
Care Transitions Intervention	2	6%
Healthy Moves for Aging Well	2	6%
T-CARE	2	6%
Active Living Every Day	1	2%
Building Better Caregivers	1	2%
Eat Smart, Move More, Weigh Less	1	2%
FallScape	1	2%
Health Coaches for Hypertension Control	1	2%
Healthy Steps for Older Adults	1	2%
Healthy Steps in Motion	1	2%
On The Move	1	2%
Screening, Brief Intervention, and Referral to Treatment (SBIRT)	1	2%
Stay Safe Stay Active	1	2%
Wellness Recovery Action Plan (WRAP)	1	2%
Wellness Initiative for Senior Education (WISE)	1	<1%

III. Findings

B. Non ACL-Approved Programs

A total of 11 other programs were identified by states that are not officially on the ACL-approved list.

- The most common was the Aging Mastery Program (12%) among all 41 reporting states.
- Others included Trualta, Stressbusters for Professionals, and Yoga for Arthritis. A full list is shown in Table 2.

Table 2. Programs written in by SUA leads that are not ACL-approved (n=11). Percent is out of total 41 participating states reporting.

Program	n	%
Aging Mastery Program	5	12%
Trualta	2	5%
Living a Healthy Lifestyle (English)	1	<1%
Living Well in the Community	1	<1%
Stay Strong, Stay Healthy	1	<1%
Stressbusters for Professionals	1	<1%
T-Exercise Select	1	<1%
Training of Trainers	1	<1%
Wisdom Warriors/Care Transitions Bridge Model	1	<1%
Working Well With a Disability	1	<1%
Yoga for Arthritis	1	<1%

Many of the popular programs identified in the 2017 survey remained popular in 2023. This is shown in the table below, which compares the top 10 programs from each year. Notably:

- Self-management programs (e.g. CDSMP, DSMP, CPSMP) remained popular in both time periods, but less so in 2023.
- Walk with Ease remained equally popular in both periods, with slightly over half of SUA leads reporting they were delivering the program in both periods (54% in 2017; 55% in 2023).
- Falls prevention programs, such as A Matter of Balance, increased to 83% in 2023 compared to 2017, while Tai Chi for Arthritis and Falls Prevention dropped in 2023 to 66%.
- Bingocize was a new mention for 2023 and was highly popular, reported by 59% of SUA leads.
- Powerful Tools for Caregivers (reported by 54% of SUA leads) and Arthritis Foundation Exercise Program were not included in the official program list in 2017. However, both were popular entries in the ‘other’ programs list in 2017 (19% and 13%, respectively).

III. Findings

Table 3. Comparison of the top 10 ACL-approved programs in 2023 (n=41) and 2017 (n=31)

2023			2017		
Program	**n**	**%**	**Program**	**n**	**%**
A Matter of Balance	34	83%	Chronic Disease Self-Management Program (CDSMP)	29	94%
Chronic Disease Self-Management Program (CDSMP)	31	76%	Tai Chi	26	84%
Tai Chi for Arthritis	27	66%	A Matter of Balance	24	77%
Diabetes Self-Management Program (DSMP)	25	61%	Diabetes Self-Management Program (DSMP)	23	74%
Bingocize	24	59%	Walk With Ease (group)	17	55%
Powerful Tools for Caregivers	22	54%	Tomando Control de su Salud (Spanish CDSMP)	15	48%
Walk With Ease (in-person)	22	54%	Enhance Fitness	11	36%
Chronic Pain Self-Management Program (CPSMP)	19	46%	Chronic Pain Self- Management Program (CPSMP)	11	36%
Arthritis Foundation Exercise Program	17	42%	HomeMeds	11	36%
EnhanceFitness	16	39%	Healthy IDEAS	11	36%

C. Populations Reached and Gaps

Of the nine population categories presented in the survey, SUA leads indicated they most often reached older adults (age 60+), as expected. Approximately 88% of SUAs were reaching rural communities through their EBPs, followed by racial/ethnic minorities (85%). People under 60 with a disability, LGBTQ+, and people with dementia were the least commonly served groups, but more than half of states still served these groups.

Table 4. Populations served by participating SUAs (n=41)

Population Served	N	%
Consumers age 60+	41	100%
Rural communities	36	88%
Racial/ethnic minorities	35	85%
Persons with Limited English Proficiency	32	78%
Caregivers, of any age	28	68%
Veterans, Veteran's spouses, and widows	26	63%
Persons under age 60 with a disability	23	56%
LGBTQ+	23	56%
Persons with dementia	22	54%

Large increases were also seen for some populations, notably:

- People with dementia (36% of states in 2017 vs. 54% in 2023)
- LGBTQ+ individuals (36% in 2017 vs. 56% in 2023)
- Caregivers, of any age (48% in 2017 vs. 68% in 2023)
- People with Limited English Proficiency (55% in 2017 vs. 78% in 2023)

In open-ended responses, one SUA lead identified urban communities and low income as additional served groups. Phone interviews added that it was difficult to find demographic information on the LGBTQ+ population in their state, making it challenging to properly recruit and reach this community for programming. Others expressed difficulty in making appropriate adaptations for programs to ensure their cultural relevance and that further guidance on this is needed.

D. Programming Areas Currently Not Met

In 2017, relatively few programming gaps were identified. The most common gap identified in 2017 was diabetes, but this was only highlighted by three SUAs.

Many more program gaps were identified in 2023. Among 36 SUAs responding in 2023, alcohol and substance abuse programs (64%), tribal-specific programs (61%), and mental health programs (61%) were the most common program gaps. Only four SUAs (11%) identified no program gaps at all.

Table 5. Programming areas currently not met by SUAs in 2023 (n=36)

Programming Area	N	%
Alcohol and substance abuse programs	23	64%
Tribal specific programs	22	61%
Mental health programs	22	61%
Culturally specific programs	19	53%
Non-English language	16	44%
Caregiver programs	5	14%
There are no gaps in program areas	4	11%
Diabetes	3	8%

One respondent identified medication management as an additional programming area that was not currently met, despite the availability of programs, such as HomeMeds. Another highlighted that mental health and substance use disorder programs were offered through their sister agency.

Phone interviews corroborated this finding. Participants from phone interviews identified the need for programs focusing on resiliency and mental health and substance use. Some noted the lack of familiarity with programs and resources to get behavioral health programs off the ground.

One reported being only somewhat familiar with ACL-approved mental and behavioral evidence-based programs like Screening, Brief Intervention and Referral to Treatment (SBIRT), while another was unsure whether HealthyIDEAS requires licensed social workers or case managers for delivery.

Some SUA leads pointed to specific cultural gaps in serving tribal communities and Spanish speakers. Even when materials were available in Spanish, they could not recruit Spanish-speaking leaders.

IV. Familiarity of SUA with ACL's Criteria for Evidence-Based Programs

Most states were familiar or very familiar with ACL's criteria for evidence-based programs (95%) and had applied criteria (68%) or were taking steps to do so (17%).

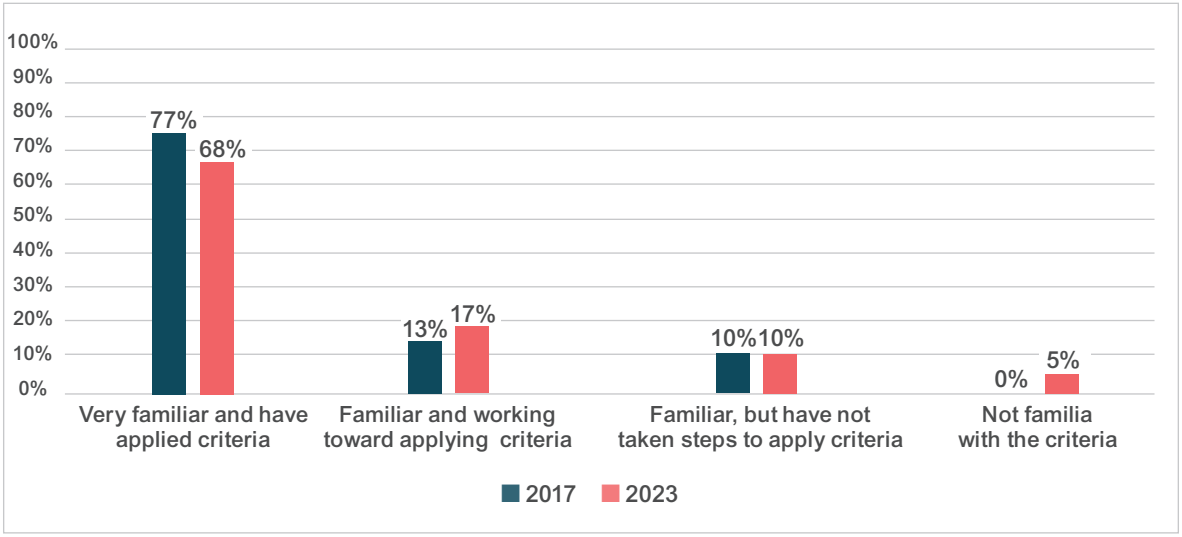
Table 6. Familiarity with ACL's evidence-based program criteria in 2023 (n=41)

Familiarity	N	%
Very familiar and have applied criteria	28	68%
Familiar with and working toward applying criteria	7	17%
Familiar, but have not taken steps to apply criteria	4	10%
Not familiar with the criteria	2	5%

Less familiarity with ACL's criteria for evidence-based programs was reported in 2023 compared to 2017. Close to 70% were very familiar with ACL's criteria for evidence-based programs and had applied criteria, while another 17% were familiar and working towards applying the criteria. In contrast, 77% of participants in 2017 were very familiar with ACL's criteria and had applied them, while 13% were familiar and were working towards applying the criteria.

Exact interpretations of 'familiar with' and 'working toward applying' criteria are likely to vary between SUAs. However, in general, the term refers to SUAs practicing a combination of approaches to step them toward ACL requirements, such as educating AAAs about the qualifying criteria for a given program to be eligible or revising their set of approved programs to include only those meeting the criteria.

Figure 1. SUAs Familiarity With and Application of III-D Criteria in 2017 (n=31) vs 2023 (n=41)



IV. Familiarity of SUA with ACL's Criteria for Evidence-Based Programs

Discussions with the six SUA leads from phone interviews provided additional context around the challenges of applying criteria for evidence-based programs. SUA leads noted difficulty with ensuring fidelity to program design and finding programs that have undergone rigorous studies and have been published in peer-reviewed journals.

All interviewees said they lacked the resources for a formal review process. Typically, agencies refer to the available Evidence-Based Program Registry found on the NCOA website. If there are questions or doubts, they reach out to the program lead/administrator for clarification.

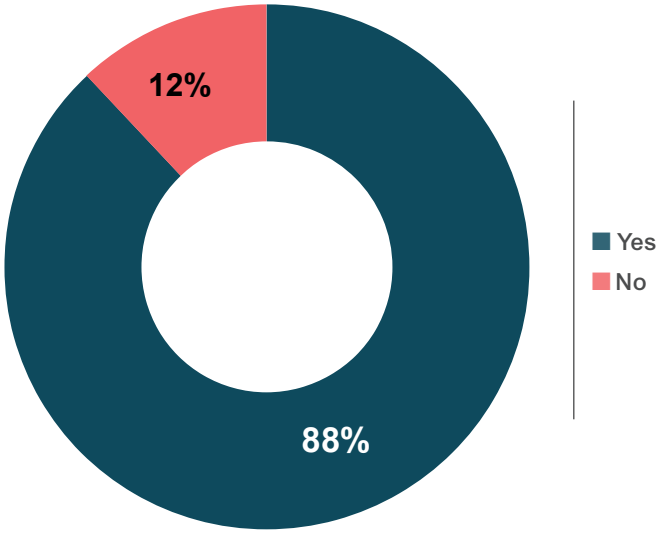
A few SUAs noted that they invite AAAs to submit any evidence they have to support their proposed program. A similar number stated that AAAs seldom propose programs outside 'the list', referring to the searchable Evidence-Based Program Registry on NCOA's website. When programs are not on that list, SUA leads felt they were ill-equipped to decipher the eligibility of programs against the criteria when they were in the gray area. They erred on the side of caution by not approving programs lacking clear evidence.

When they did review the evidence, one spoke of using resources available at the state library, including medical journals, to validate the programs and to check if a program is peer-reviewed. Several SUA Leads expressed a desire for less stringent requirements for quasi-experimental studies. Leads further stated interest in and willingness to approve a wider variety of programs, such as those that could address specific regional needs (e.g., home modifications to address unique environmental conditions) or to make a program culturally relevant.

V. Remote Evidence-Based Programming

Most SUAs (88%) have allowed AAAs to use OAA funds for delivering remote programs during and post-pandemic, such as those delivered through videoconference, phone calls, self-directed at home, or some combination of these formats. Only 12% of respondents had not permitted this.

Figure 2. Percent of SUAs Allowing AAAs to Use OAA Funds for Delivering Remote Services (n=41)



A. Older American Act Title III-D Funds Permitted by SUA

Among 36 respondents, tools and materials were the most often reported costs associated with the delivery of remote programs (97%). Expenses for technology, marketing, recruitment, and registration were high as well, with 78% of SUAs reporting they used funds for these purposes.

Table 7. Associated costs that the SUA has permitted the use of Title III-D Funds for, from the list provided by NCOA (n=36)

Associated Costs	n	%
Tools, materials	35	97%
Technology (e.g. Zoom licenses, equipment)	28	78%
Marketing, Recruitment	28	78%
Registration	28	78%
Data collection	25	69%
Technology support/IT staff	16	44%

V. Remote Evidence-Based Programming

Six participants identified additional related costs, which were related to the program site (25%) and training coaches and master trainers (25%).

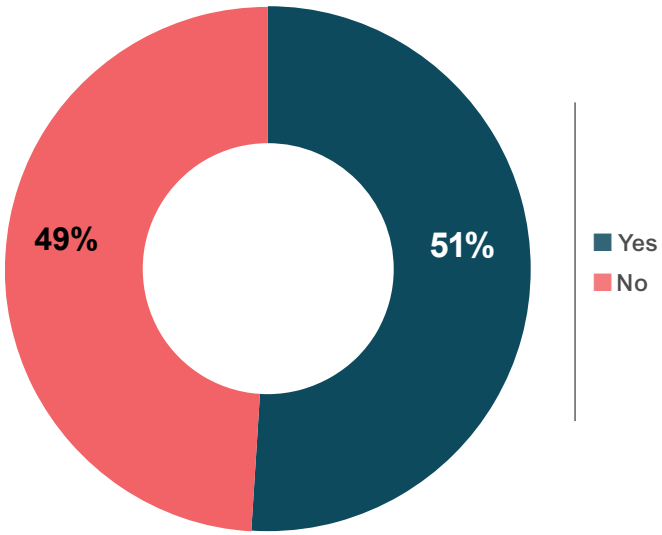
Table 8. Associated costs SUA leads identified in their 'other' responses (n=12)

Other Associated Costs	n	%
Securing and renting a program site, plus related costs	3	25%
Training coaches and master trainers	3	25%
Travel	2	17%
Direct service	1	8%
Staff time	1	8%
Master trainers and education for master trainers	1	8%
Program supplies and program licenses	1	8%

B. SUA Involvement in Remote Programming

SUAs were split in their involvement facilitating partnerships with AAAs for remote programs, with about half (51%) reporting they had a hand in supporting the AAAs with some aspect of remote evidence-based program delivery.

Figure 3. Percent of SUAs Facilitating Partnerships to Support Remote Evidence-Based Programs (n=41)



SUAs provided support to AAAs in three main areas: partnerships, the provision of information, and support, as summarized below.

V. Remote Evidence-Based Programming

Partnerships

- Partnered with the Department of Health and Governor's office to offer remote programs for those in quarantine.
- Worked in conjunction with one specific evidence-based program to ensure it could be successfully implemented remotely.
- Worked closely with the entity contracted to deliver evidence-based programs.
- Met monthly with community partners to discuss effective ways to partner with agencies.
- Generally encouraged partnerships.

Provided Information

- Created a document that gave AAAs access to information on resources, available remote programs, and information on assisting older adults.
- Provided details about what other states were doing.
- Brought examples of evidence-based programs to the network.
- Worked to develop and provide revised marketing materials for remote delivery.
- Created a newsletter with details about COVID-19 as well as a remote health promotion program. Followed up with a memorandum informing/reminding AAAs that Title III funding could be used for leader training for remote and in-person classes.
- Hosted statewide and regionally focused webinars to provide guidance and promote resource sharing.
- Acted as a conduit among AAAs, sharing best practices.

Support

- Allowed flexibility whenever possible.
- Co-facilitated monthly statewide collaborative meetings.
- Provided support, education, guidance, clarification and/or technical support.
- Coordinated remote delivery statewide with facilitators in various locations.

C. SUA Stance on the Remote Delivery of Evidence-Based Programs

Most of the 35 states (83%) are continuing to permit or are seeking to expand remote programs. Only three states have ended remote programs (9%), and two only permitted the programs during the pandemic (6%).

V. Remote Evidence-Based Programming

Table 9. SUA Stance on Remote Delivery of Evidence-Based Programs (n=40)

Response	n	%
State is continuing to permit, is planning to permit and/or seeking to expand remote evidence-based programs post-pandemic	29	73%
State has ended or significantly reduced remote evidence-based programs at this time	3	8%
State permitted remote delivery of evidence-based programs only during the critical pandemic period	2	5%
Hybrid programs that include in-person and virtual components	2	5%
The state never permitted the broad delivery of remote evidence-based programs	1	3%
The SUA is not involved in the delivery of remote programs, but AAAs can decide for themselves whether to use the programs	1	3%
State permits the programs in cases where the program developer has approved a virtual or hybrid delivery option	1	3%
Funds through Major Disaster Declaration are used for Title III-B, as a significant cut from local funds	1	3%

D. Significant Challenges to Delivery of Remote Evidence-based Programs

Among 38 respondents, the difficulty with broadband or internet access (85%) was most significant. However, staff-related challenges were common as well, including limited staff for technical support (82%), issues with getting sufficient instructors/leaders (77%), and rebuilding the leader and volunteer base (74%).

V. Remote Evidence-Based Programming

Table 10. Areas that Present Significant Challenges to the Delivery of Remote Evidence-Based Programs (n=39)

Identified Challenges	n	%
Difficulty with participants' or organizations' broadband or Internet access	33	85%
Limited staff to provide technical support for participants and leaders with technology or software	32	82%
Getting instructors/leaders to lead online workshops	30	77%
Rebuilding leader and volunteer base	29	74%
Recruiting participants in rural areas	29	74%
Recruiting participants/lack of demand for remote evidence-based programs in general	26	67%
Lack of participant engagement and comfort on camera	17	44%
Collecting data from participants digitally, online or by phone	16	41%
Allocating funds for technology and equipment to support remote classes	15	39%
Following fidelity guidelines for programs in remote format	12	31%
Currently NOT delivering remote evidence-based programs	5	13%

On open-ended responses, three SUAs identified the following challenges attributed to AAA/ service providers:

- Limited internet access in rural areas
- Difficulty training older adults to use technology
- Limited staffing
- Program start-up time would be significant

One respondent also highlighted a planned or in progress approach: "Expanding access to programs through improved hybrid and/or remote delivery; targeting older adults (working or retired), adults with disabilities (especially low/no vision, hearing loss, developmental disabilities, etc.) and caregivers, many of whom prefer remote delivery programs."

Phone interviews shed further light on these challenges that relate to three main categories:

1) Rurality
2) Facilitator/training demands
3) Program-specific strengths and limitations

V. Remote Evidence-Based Programming

Rurality

- Limited organizational capacity in rural areas
- Limited broadband, though several have state-led initiatives to improve connectivity (One SUA is partnering with a technical provider to help set up platforms for remote programs.)
- Low tech literacy by staff in rural areas and by potential participants

Staffing and Training Demands

- Many AAAs don't have specific staff members dedicated to these programs.
- Funding is often insufficient to support a full-time staff member and still provide services.
- Funds can only be used to provide the services, not for administrative purposes, which has been tricky for some AAAs.
- The pay rate offered is not competitive, and there has been a decline in the volunteer base, especially among older volunteers, since the pandemic.
- The cost of training new instructors and maintaining licenses for certain programs is highlighted as a barrier.
- Difficulty of training facilitators remotely for certain programs is another challenge.
- High turnover of trained facilitators; high impact of losing passionate individuals on the availability of EBPs in certain counties is a concern.
- There are limitations in offering classes and training due to funding constraints; they have to be more selective.
- There has been a reduction in the number of trainings offered for each of their programs.
- AAAs often rely on volunteers, who are older adults themselves, and senior center staff members who have multiple responsibilities.
- One state is testing out requiring facilitators to sign a contractual agreement to deliver X number of workshops before paying for their training.

Program Specific Strengths and Limitations

- Hesitancy of leaders to deliver Tai Chi remotely because they need to observe participants to ensure they are performing correctly
- Even split and wide appeal to Walk With Ease (WWE)— in-person/group-led vs self-directed
- High costs but well-received—Stepping On (Challenges with administrative time and reporting requirements for this program.)
- Preference for in-person programs, except for Powerful Tools for Caregivers, which has seen success remotely
- Capable – high administrative burden and reporting requirements.
- One state noted the challenges of getting participants and facilitators to commit to longer courses.

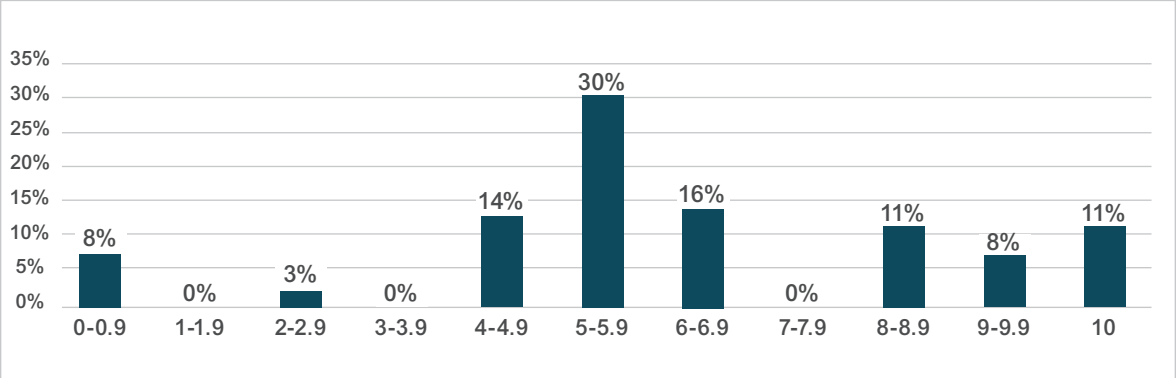
V. Remote Evidence-Based Programming

E. Challenges AAAs Face to Pivot to Alternate Delivery Arrangements During Pandemic

SUA leads were asked to rate the difficulty and challenge their AAAs faced in pivoting to alternate delivery formats during the pandemic, such as launching more remote programs and establishing socially distant policies for their trainings and workshops.

- Responses to this question (n=37) ranged from a challenge rating of 0.4 to 10 (where 1 represented Not at All Challenging and 10 represented Extremely Challenging).
- The responses had a mean of 6.07 (SE: 0.423) and a median of 5.5.
- The distribution of responses (see graph below) shows that many participants were clustered around moderate levels of difficulty. However, some participants found the pivoting process relatively easy, while others found it extremely challenging instead.

Figure 4. Level of Difficulty in Pivoting to Alternate Delivery Arrangements (n=37)



VI. Technical Assistance Practices

Over 60% of 41 SUAs sought technical assistance in the past year related to evidence-based programs and/or Older Americans Act Title III-D. Fewer states reported seeking technical assistance in 2023 compared to 2017 (90%).

Figure 5. Percent of SUA Leads Seeking Technical Assistance in the Past Year (n=41)

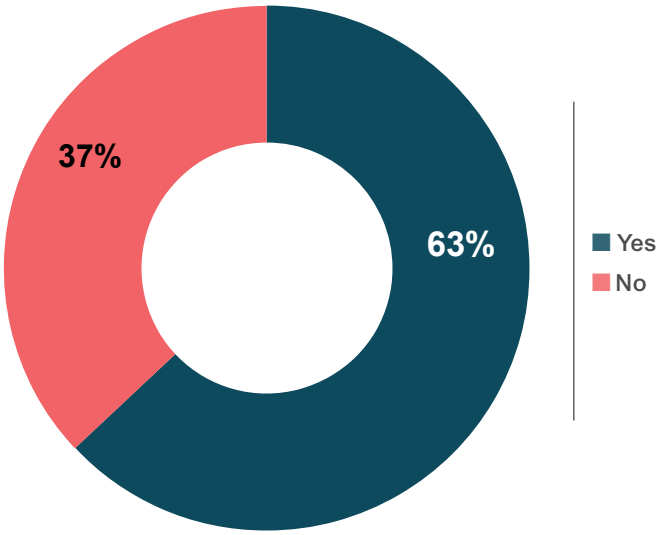
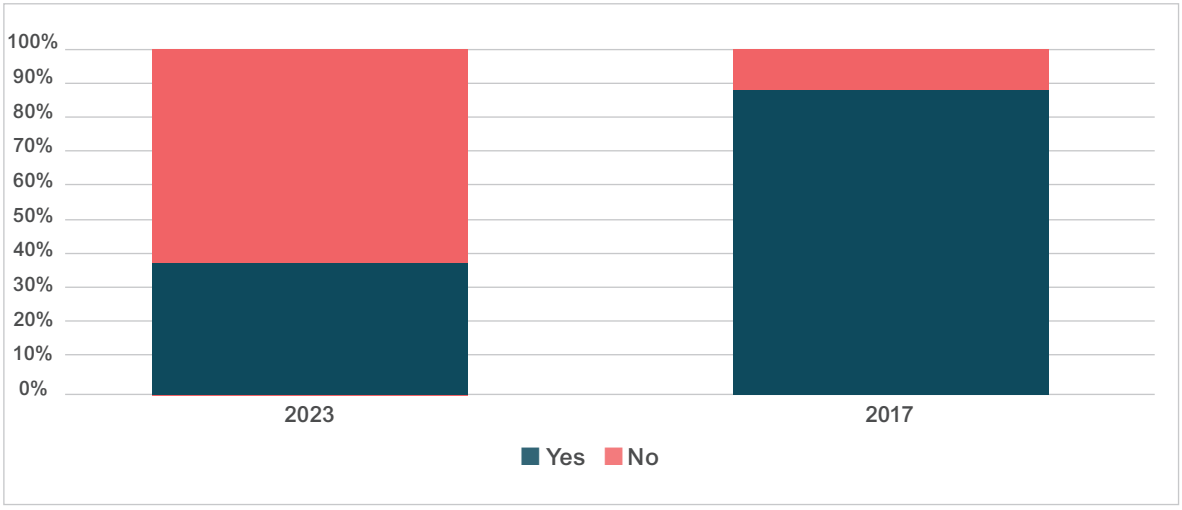


Figure 6. Percent of SUA Leads Seeking Technical Assistance in 2023 (n=41) vs 2017 (n= 31)



VI. Technical Assistance Practices

A. Sources of Technical Assistance

Among 27 SUA leads, about half (48%) sought technical assistance from evidence-based program developers/administrators, followed by ACL Regional Administrators (41%), and NCOA's National CDSME and/or Falls Prevention Resource Centers (41%).

Evidence-based program developers/administrators, ACL, and national aging organizations were popular sources of technical support in both 2017 and 2023, with 2023 participants relying more heavily on ACL regional offices compared to the central office.

Table 11. Sources of Technical Assistance in 2023 (n=27) and 2017 (n=28)

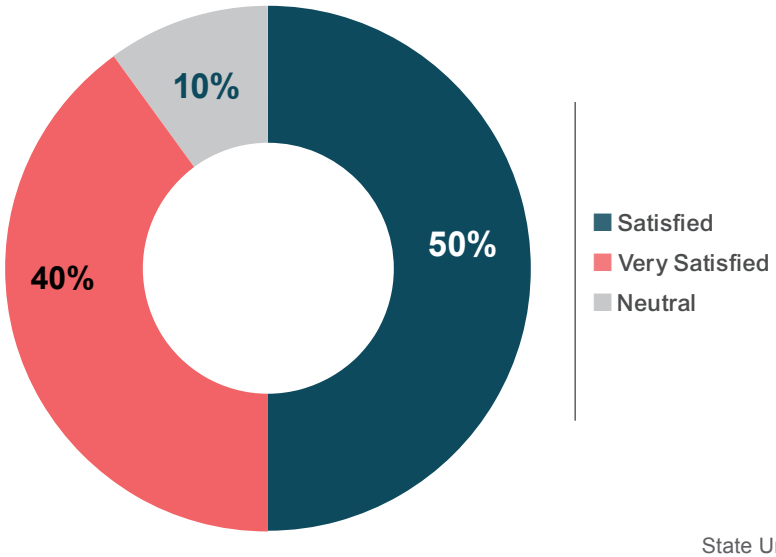
	2023	2017
Evidence-Based Program Developers/Administrators	48%	32%
ACL Regional Administrator/Office	41%	64%
National Aging Organizations (including NCOA and National CDSME Centers)	41%	25%
ACL Central Office	19%	39%
Other Officials/Departments in your State Government	15%	21%
Academia	15%	11%
Health Care Partners	11%	11%
Other	0%	11%

One participant mentioned seeking technical assistance via ACL FAQs and the Nutrition and Aging Resource Center, while another sought assistance from CDSME Master Trainers.

B. Satisfaction with NCOA's Technical Assistance

Among 10 participants seeking technical assistance from NCOA, most participants were satisfied (50%) or very satisfied (40%), with none reporting that they were dissatisfied.

Figure 7. Satisfaction with NCOA's Technical Assistance (n=10)



VI. Technical Assistance Practices

Examples of technical assistance sought/received through NCOA:

- Connecting with another SUA EBP professional who had successfully worked through barriers
- Sought TA on the submission of reporting data for the 2019-2023 ACL CDSME grant
- Two SUAs accessed the NCOA website for assistance concerning education/resources on the evidence-based programs

C. Technical Assistance Provided to AAAs by SUAs

Twenty-nine SUA leads reported providing technical assistance to their AAAs or local partners. Some highlighted multiple examples, and others just a single approach.

- Approaches like phone calls, Zoom calls, and emails were often used to provide support (n=7), with some SUAs also providing group meetings (n=3).
- SUAs frequently provided information about available programs when needed (n=9) and used outreach processes to promote new programs to SUAs (n=5).
- Sharing of best practices was common (n=4), as was program and budget oversight (n=4). SUAs also provided guidance in a variety of specific areas, including data entry/data collection (n=4) and getting funding for non pre-approved programs (n=2).

The information below summarizes the responses provided (n=1, unless otherwise specified).

Support

- Technical assistance phone calls, Zoom meetings, and emails as needed (n=7)
- Training (n=6)
- Program and budget oversight (n=4)
- Conducted meetings with trainers or coordinators (n=1) or for groups (n=3)
- Provided guidance for:
  - Data entry/data collection or monitoring (n=5)
  - Getting funding for programs that meet ACL's requirements but are not pre-approved (n=2)
  - Allowable costs
  - Fidelity
  - How Title III-D funds can be used
  - Particular AAA questions/scenarios
  - Policy
  - Rules and regulations regarding programs and reporting
- Connection with developers/administrators of evidence-based programs (n=2)
- Assisted in facilitating partnerships
- Clarified requirements

VI. Technical Assistance Practices

Information

- Provided lists of and details about available programs, including where to find programs, manuals, and online information (often upon request) (n=9)
- Program outreach, including informing AAAs about new programs and showing them new ways to find programs (n=5)
- Sharing of best practices (n=4)
- Guidance on allowable costs and process for getting programs approved for funding if they meet ACL requirements
- Identify and share evidence-based programs and best practices

D. Desired Technical Assistance

Among 40 SUA leads, 75% expressed interest in receiving support for recruitment and training, 73% for sustainability strategies, and 70% for establishing partnerships. In contrast, relatively fewer SUAs needed support with centralized data management and reporting (35%), understanding payment models (33%), or quality assurance and fidelity (30%).

Table 12. Areas Where Additional Support from ACL or Other Organizations Would be Helpful (n=40)

Areas for Additional Support	n	%
Recruitment and training of evidence-based programs	30	75%
Sustainability strategies	29	73%
Establishing partnerships with healthcare providers	28	70%
Creating network hubs for referrals and contracting	27	68%
Delivery of remote evidence-based programs	27	68%
Providing the infrastructure for delivering statewide remote programs (e.g. promotion of online workshops, tech support, technology platforms, funding)	27	68%
Instructors	25	63%
Identifying whether programs meet the definition of evidence-based under Older Americans Act III-D	22	55%
Centralized data management and reporting	14	35%
Understanding payment models	13	33%
Quality assurance and fidelity	12	30%

VI. Technical Assistance Practices

Only one 'other' response was provided for this question. In it, the SUA lead talked about ACL needing to provide official allowable use of funds for Title III-D. The respondent also mentioned that there should be more opportunities to support SUAs as the provider of evidence-based programs.

Sustainability strategies were popular in 2023 and 2017 (73% and 83%, respectively), as were establishing partnerships with health care providers (70% and 77%, respectively). However, recruitment and training for evidence-based programs was the most requested area in 2023 (75%), which was not featured in the 2017 list.

In phone interviews, SUA leads expressed a desire for:

- More collaboration and support for smaller, single-unit, and under-resourced states to help with the administrative burden and stringent reporting requirements imposed by program developers
- An exportable spreadsheet of EBPs that includes costs
- Up-to-date and relevant information on various programs
- A more user-friendly and comprehensive database that includes details such as program costs, training costs, and whether remote options are available
- A resource that lists different technologies or apps that could be used by the AAAs to reduce administrative burden and streamline processes like intake form
- Strategies to promote the idea that these programs are a form of economic and community development, helping residents stay in their communities and contribute to the local economy

VII. Perceived Reasons for Program Decline

Of 33 participants, 97% cited the pandemic as one of the major reasons for the decline in evidence-based program participation over the past five years.

Table 13. Perceived Reasons for Decline in Evidence-Based Program Participation Over the Past Five Years (n=33)

Reasons for Decline	n	%
COVID-19	32	97%
Cost of training/certification for programs meeting evidence-based program criteria	15	46%
Challenges with delivering remote evidence-based programs	15	46%
Lack of demand for evidence-based programs	5	15%

Nine participants provided responses in the 'other' box concerning reasons for a decline in program participation. Three of these stated N/A or that their program participation has not declined. Responses for the remaining six participants included the following reasons for the decline, principally centered around limitations due to staffing shortages:

- Difficulty sourcing leaders/instructors for the classes
- Lack of consistency in leaders/facilitators
- The cost of staffing
- The balance of staff time between Title III-D programs and other duties (n=2).
- Turnover and considerable time needed to train and re-certify new leaders (n=2)
- Training new leads, which is cost-prohibitive unless no-cost trainings are offered
- Layoffs and retirement due to COVID, plus decreases in volunteers leading to a smaller network than needed

VIII. Perceived Future Outlook

Among 40 SUA leads, 90% were at least somewhat confident that participation in evidence-based programs would return to pre-pandemic levels. Only four participants (10%) were not so confident or not at all confident.

Table 14. Level of Confidence That Participation Will Return to Pre-Pandemic Levels (n=40)

Level of Confidence	n	%
Extremely Confident	2	5%
Very Confident	13	33%
Somewhat Confident	21	53%
Not So Confident	3	8%
Not at All Confident	1	3%

Most of the 40 SUAs were at least somewhat confident that program participation would increase (93%). Only three participants (8%) were not so or not at all confident of this increase.

Table 15. Confidence that Participation in Evidence-Based Programs Will Grow in the Year Ahead (n=40)

Level of Confidence	n	%
Extremely Confident	2	5%
Very Confident	16	40%
Somewhat Confident	19	48%
Not So Confident	2	5%
Not at All Confident	1	3%

Most of the 40 SUA leads felt it was likely (53%) or very likely (30%) that remote programs would remain a part of the overall strategy to improve participants in EBPs. Only two of them (5%) felt that this was unlikely.

Likelihood of Integrating Remote Programming into States' Overall Strategy

Table 16. Likelihood of Integrating Remote Programming into State's Overall Strategy (n=40)

Level of Confidence	n	%
Very Likely	12	30%
Likely	21	53%
Neither Likely Nor Unlikely	5	13%
Unlikely	2	5%
Very Unlikely	0	0%

State leads described several notable strategies to improve participation in evidence-based programs based on (1) partnerships, (2) technology support, (3) program variety and cross-training, and (4) other approaches (n=25).

VIII. Perceived Future Outlook

Partnerships

Collaborative strategies were particularly common, including (n=1 for responses, unless stated otherwise):

- Forming partnerships and collaborations (n=7) with state and local government agencies (n=2), senior living communities (n=2), local universities, and other community organizations
- Connecting with local groups and using workgroup/quarterly calls (n=2) to promote collaboration, sharing of best practices, and brainstorming
- Getting buy-in from senior centers
- Establishing a falls prevention coalition
- Monthly meetings with AAA wellness coordinators
- Providing information at libraries, particularly those that are already providing private locations for telehealth appointments

Technology Support

The use of technology was important as well, such as:

- Offering virtual classes (n=3), hosting preliminary virtual meet and greets, promoting programs through websites and social media (n=2), using video presentations to reach more seniors, and text reminders
- Expanding broadband
- Using websites (n=2) and social media to promote programs
- Established and enhanced state-operated websites, plus online recruitment and registration processes
- Providing assistance with technology and devices

Program Variety & Cross-Training

The programs themselves were also relevant, including:

- Regularly adding new programs that participants are excited about (n=2)
- Some participants used cross-training of staff, partly because doing so meant that programs had a familiar leader (n=2)
- Combines fun and exciting culturally relevant exercise programs with nutritional/healthy living information as part of CDSMP
- Requires AAA to have at least one Self-Management Resource Center (SMRC) workshop per year plus one Healthy Steps for Older Adults (HSOA) or Healthy Steps in Motion (HSIM) per year. Then they can focus on other programs that their community needs.

VIII. Perceived Future Outlook

Other Approaches

- A multi-modal approach that includes in-person, virtual, and telephonic workshops
- Cross-training staff to lead evidence-based programs, including meal site managers and RD. This way there is already a relationship of trust (n=2)
- Engaging in person-centered dialogues with Care Transitions participants about programs that could help them specifically
- Having a staff member at the AAA dedicated to evidence-based programs.
- Obtaining additional funding
- Offering stipends, incentives, and opportunities to increase recruitment of coaches, master trainers, etc.
- Outreach and promotion of the available evidence-based programs
- Requiring individual AAAs to have a different outreach outcome for their community, such as LGBTQ+, veterans, low income, or minorities
- Working to rebuild lost capacity

IX. Additional Program Data Collected

States reported collecting the following additional programmatic data for the Older Americans Act Title III-D, beyond what ACL requires (unduplicated persons served) (n=15).

Health Data

- Patient Health Questionnaire (PHQ)-9
- Pre & post health and fitness assessments
- Participant health conditions
- Nutrition information
- Social isolation

Demographics

- Ethnicity
- Race
- Other demographic

Workshop Data

- Attendance logs
- Program satisfaction
- Program-specific, grantee-related information

Trainer Information

- Details on master trainers and leaders

Partner Agencies

- Details on partner agencies

Area Plans

- Outside reimbursement
- The contractor
- Expected number of participants
- Remote delivery
- Total units of service and expenditures for EB activities

IV. Resources

National Chronic Disease Self-Management Resource Center: This ACL-funded resource center raises awareness about the impact of chronic conditions on older adults and supports the dissemination of evidence-based health promotion programs across the nation.

National Falls Prevention Resource Center: This ACL-funded resource center increases public awareness about the risk of falls and supports the implementation and dissemination of evidence-based falls prevention programs and strategies across the nation.

These centers provide information on a range of topics related to evidence-based programs, including:

- Basics about Evidence-based Programs
- Capacity building
- Cross Promoting Programs Across the Continuum of Care
- Data collection and database management
- Fidelity
- Marketing and Recruitment
- Outreach to underserved populations
- Partnerships
- Recruiting and Supporting Volunteer Leaders
- Remote Delivery
- Resource development
- Review Process
- Sustainability
- Technical assistance
- Using Technology for Program Delivery

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Find ACL-Approved Evidence Based Programs

www.ncoa.org/evidence-based-programs

To learn more about evidence-based programs approved for funding through Older Americans Act Title III-D, use NCOA's search tool and identify specific programs through the use of a filter based on program topic area, format, type, and length. You can also find and download a spreadsheet of approved programs, arranged in alphabetical order.

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