October 29, 2015

Coordinator: Welcome and thank you for standing by. At this time all participants will be on a listen-only mode for the duration of today's conference. This call is being recorded. If you have any objections, you may disconnect at this time. I would now like to turn the call over to Mr. Casey Dicocco. Sir, you may begin.

Casey Dicocco: Thank you and welcome, everyone so I think everyone should be on now and welcome to the Webinar today. Of course we're going to be talking about Title III-D and the evidence-based program requirements of that.

My name is Casey Dicocco. I am the ACL point of contact on Title III-D and I work in the Office of Nutrition and Health Promotion Programs at the Administration on Aging. Today you're going to hear from me and also from some of your colleagues in a state AAA and a state unit on aging.

So just starting with a couple housekeeping items, we have questions you can submit through the WebEx through the chat function and we will be compiling those throughout the presentation and then at the end of the presentation we'll have a question-and-answer section where we'll go back throughout and myself and some of my colleagues at ACL and the state and AAA folks can respond to your questions then.

Also the slides and recording will be available on the Title III-D Website following this presentation. The agenda for today—first I'm going to be talking a bit about the Title III-D requirements, what they are now, and what needs to be happening by October 1st, 2016.

Then we will be turning it over to our colleagues in the state and AAA and so you're going to be hearing from the Georgia State Unit on Aging and a AAA

in North Carolina called Centralina and I think you're really going to enjoy those presentations. Then it's going to come back to me and my colleagues at ACL.

And then I'm going to talk a bit about some of the main lessons that we've heard and then some national resources that are available and then we're going to turn it over to questions and discussions and so again feel free to please send those in throughout the presentation in the chat box and we'll be working to compile those.

So first we're going to talk about the Title III-D evidence-based program requirements so as many of you know there is an evidence-based program requirement in Title III-D following a 2012 change to our appropriations language, the ACL's appropriations language.

And in that appropriation it said that funds in the Older Americans Act Title III-D need to be used on programs which have been demonstrated through rigorous evaluation to be evidence-based and effective.

And so when that language was introduced ACL developed guidance to help states comply and that guidance has consisted of two different definitions to what an evidence-based program is and it's kind of we developed these in order to help move the network in an iterative way towards using only the highest-level of evidence-based programs and we're going to talk about those two different definitions a little bit right now.

So the current or tiered definition is the one that many of you are probably familiar with. We developed a definition of a three-tiered and told the network that you can be using programs that meet any of these tiers from now until the end of FY '16, sorry, so September 30th, 2016.

And we also know that many states have already moved their networks to using only highest level so if you're not sure you should be checking with your state so these are the actual three tiers of the current or tiered definition. I'm not going to go into these but you probably have seen them before and they can all be accessed on the Title III-D Website.

So the future or highest-level only definition has no tiers but it is equivalent to the Tier 3 or highest level of the tiered definition and so we know that a number of the network states are already using this definition and all states must be using this definition by October 1st, 2016.

And so the highest-level only definition consists of five points on five criteria and the main points on them are that the evidence-based program in question needs to have been shown to be effective among older adults. It needs to be shown to be effective with a controlled research design.

The research also needs to be published in a peer review journal. It has to have actually been translated in the real world before so actually implemented in a community setting and it needs to include dissemination products for implementation.

And so the other way that sites can meet the evidence-based requirement that's separate from the ACL definition is to use Title III-D funds on programs that have been deemed evidence-based by an HHS agency so ACL is an agency of the Department of Health and Human Services and the Department of Health and Human Services has 11 agencies.

And a number of them have compiled registries of evidence-based programs and in order to maintain continuity across our department, we allow Title III-

D funds to be spent on programs that are considered evidence-based by other agencies within the Health and Human Services.

And so later in this presentation in the resources section we're going to highlight a couple of those registries that can be useful for you if you're looking for programs so I just said a lot in words and I wanted to kind of offer a visual as well.

So this is a visual flow chart that is outlining the tiered definition in ways that you can be meeting the evidence-based program requirements now up until the end of FY '16 so you're either using a tiered program or using a program that is considered evidence-based by HHS.

And then this is a flow chart for using the highest level only evidence-based programs so either me (using a) definition or it's (Phil) using a program considered evidence-based by another agency within HHS.

So this slide is in response to a question that we get a fair amount about differentiation between a program and an evidence-based material resource so a an evidence-based program is different than a standalone material in that it has an implementation evidence base so I put a little example together here.

On the left if you look a university created a face facts booklet based on the best scientific evidence and then that university is marketing that resource and a senior center wants to buy these booklets so that even though they're scientific evidence it is not a highest-level evidence-based program because there's not dissemination materials or evidence on actually using the booklet.

If you look on the right, a university creates a safe sex booklet based on the best evidence and creates the curriculum and the leader manual for using the booklet to teach a class of seniors so there they're really developed a program.

And then in the box below that the university pilots the program in a few senior centers with an intervention group and a control group, the positive outcomes of the pilot study are published in a peer youth journal so there they've really developed the evidence base so hopefully that is clear but that would be a highest-level evidence-based program.

And so this slide in the same vein is just some common characteristics of evidence-based programs so programs should have resources for the leader or organization to guide the implementation and dissemination materials so if you look at the photos here, you see on the left that looks like a class with probably a trained leader there who is following a curriculum.

If you look in the middle there's some pretty clear dissemination materials that the individual is using to work with that older adult and on the right is probably also a that is a leader or a peer leader, someone who's doing an activity with a group of older adults that is based on a curriculum and it looks like we're still getting questions about the slides being available after the presentation and yes, they will be.

We'll put the slides and the audio on the Title III-D Webpage and so the evidence-based definition offers a pretty broad range of what can be considered but we know some common program types that are out there include class-based physical activity, fall prevention programs that many of you are probably familiar with and self-management programs of course.

And also we know a handful of one-on-one health interventions that's in the home that folks are using evidence-based - that are evidence-based programs - folks are using such as Otago or the (parole) program.

And so this is another visual that is just kind of showing where we are and where we are moving with this evidence-based program requirement so we know, you know, that many states do not yet require highest level only but hopefully the states have plans in place to do so and are working on that.

And then we know a number of states also already require the highest level only and of course all states must be doing this by a year from now October 1st, 2016 or less than a year to do it so at this point I'm actually going to be turning it over to my colleagues at the state and AAA level so I think we'll really be able to hear from them some of the good lessons they've learned in really taking this guidance and running with it.

So first we're going to hear from the Georgia Department of or the Georgia Division of Aging Services which is in their Department of Human Services and we're going to hear a presentation from Megan Stadnisky who is the Evidence-Based Aging Services Coordinator and Gwenyth Johnson who's the Livable Communities Section Manager so Gwenyth and Megan, I will be turning it over to you now.

Megan Stadnisky: Okay, oh you did, good job, okay, so this is Megan Stadnisky, thanks so much for having us do this and kind of show you our journey through evidence-based programs just for the past five years that we've been working with them statewide and to share with you our experiences shifting III-D funding all the way to the top tier as Casey mentioned.

So we'll go over our history of bringing evidence-based programs here and our menu of services across the Older Americans Act and then what we kind of see as our five steps to shifting to the highest tier and then some suggestions for folks who may not have had some of the opportunities that we've had just using III-D dollars.

So here's our little timeline. It all started back with the American Recovery and Reinvestment Act communities putting prevention to work grants where we were able to bring chronic disease self-management program, one program to the state and focus on that.

We were really focused on five areas so we were looking at five of our regions and doing it very systematically and small but all 12 of our area agencies on aging really wanted to be involved with this.

So through a master trainer training, we were able to get at least two people trained in all of our 12 AAAs in Georgia so we were able to go - you can't see my air quotes - statewide with all 12 of our AAAs in 2011. Then we received we've been doing a lot of this through grant funding obviously these four grants that we're talking about.

So in 2011 we received a systems integration grant which one of the components was doing some health and wellness evidence-based programs and that for us was the matter of balance program and then the tai chi for health programs that was formerly called the arthritis tai chi program.

And then through the CDSMP grant that we received in 2012 - both of these are three-year grants - we were able to expand even further our implementation of the chronic disease self-management program, introduce the diabetes self-management program as well as some (unintelligible).

And then we have a large Korean-speaking population in Georgia and so we were able to actually translate those 2012 lay leader manual the CDSMP lay leader manual into Korean so that is available if any of you out there have Korean-speaking residents, you can contact Stanford to do that.

We did have for our requirements for SCSMP which started in 2010 that any of our master trainers had to implement their first two workshops as Stanford requires that then every year after they are required to implement a lay leader training so every 365 days these pairs should be doing lay leader training.

And we require that for the diabetes self-management program (unintelligible) all of the evidence-based programs that we have (asked) and then our lay leaders or our coaches if (they're a) matter of balance are also required to implement one workshop every six months so at least two a year which may be a little bit more than required by the originators of the program.

But we do this to make sure that our leaders and training individuals maintain familiarity with the program and then also we are getting a program into the hands of our fellow Georgians. Finally we were awarded the Falls Grant and so we were able to expand matter of balance and then introduce Otago which helped us to meet new partners or make new partners.

That's with physical therapist associations here in Georgia and the tai chi for health program has been so popular that it is going on its own and we are committed at the state level to make sure that we coordinate a training at least once a year so more individuals can become trained as instructors and we can expand that program as far as it will go and for that individuals are paying for registration for the training in covering those costs 100%.

So that's helping us to sustain that program so here is our menu of evidence-based programs which include III-E, III-D and then some other purveyance through our hospital transitions initiative across the state where area agencies on aging either through help from the division of aging services or on their own independently became trained in the Coleman model or the care transitions intervention and then the bridge model to do hospital transitions and then as I mentioned here are a listing of Title III-D programs and...

Gwenyth Johnson: And this is Gwenyth. We have also started working with our university partners across the state to make sure that we're moving in an evidence-based direction for our nutrition programs as well so exploring evidence-based nutrition education.

Megan Stadnisky: Okay, and in anticipation of these changes, we have systematically shifted the use of these funds towards evidence-based programs and so we early on tried to seek-out these grants to help us bring these programs or get the foundation laid for these programs as early as possible.

So that we, you know, if we were able to receive a grant, we offered post trainings or master trainer trainings to everyone and made them available to anyone across our state and anyone in our partner agencies, public health sister state-level agencies so that we could spread them not just through our aging network but through other networks as well.

Okay, which brings us to the five steps that we kind of took that enabled us to shift to this highest tier and that's choosing the right evidence-based programs, building the infrastructure for those programs, writing policy to support that, doing some business planning which has been a really interesting venture for us and then working through our resistance to teams.

We know that this was not an easy thing for our partner agencies to do but we wanted to make sure that we set the stage for them at the state level to support them as they shifted to the program so how do you choose the right evidence-based program?

For us we wanted to be able to expand rapidly so we did look at the lay led train the trainer program so that we could to this pyramid team and build-out as quickly as possible but also that they were peer leaders so we were not having to pay a lot of money for credentialed individuals or individuals with certification that we would not be able to afford or sustain that infrastructure.

And then honestly we looked at what grantors were funding, if there were programs that fellow state agencies had already receive funding like the chronic disease self-management program. Those were the ones that we were looking to write into grants. Whoops, I don't know what the -- okay, that was weird. Yikes. Sorry.

((Crosstalk))

Casey Dicocco: It looks like there's a little trouble here with the slides. Let me try and make you the presenter again here.

Megan Stadnisky: Okay, thanks.

Casey Dicocco: If not, I can just forward them for you but...

Megan Stadnisky: Okay, so for the choosing the right programs and then also we looked for what was being funded and we had shifted in that direction. We also worked with public health - our state public health partners - and they helped us understand

hey, we have a lot of individuals - older individuals - with diabetes. Let's look at the diabetes self-management program.

We have a lot of people falling in this region of your state. Why don't we focus Otago and recruiting physical therapists in this area of the state so that we can do it fast and good with these programs and probably reach more individuals who'd be interested in it because they're suffering from the conditions that we're trying to help them with so we did that.

And all of this was done in partnership with our area agencies on aging and they brought in their partners as well and so after choosing that and being awarded the grants we jumped right into building the infrastructure for these programs and we did them systematically and it wasn't all (Heller at 7) programs at once.

We started with one and figured-out how our network would handle it and we built it from there and to make implementation as easy as possible for our statewide partners and to maximize the money that we were investing into these programs, the Division of Aging Services was able to hold the license, any licensure that was needed we were able to purchase that from the state level and cover all of our partners.

So that each partner was not having to do that on their own. We also purchased supplies in bulk from the state level so that they only had to ship it to one location and then during meetings or as our state employees were going-out to visit our partners in the field, they would actually transport the material. I don't know if I would fully recommend that but...

Gwenyth Johnson:It does take-up a lot of space in your office so that that can be a concern.

Megan Stadnisky: ...yes, but it was a good excuse to get out into the field and make sure that we were seeing face to face with individuals which brings us to meetings and buy-ins.

We hold at least annually a face-to-face meeting and brainstorming session where we invite all of our area agency on aging wellness coordinators, all of their partners that they can invite, community-based agencies, county-based agencies, public health partners at hospitals, anybody that we can invite to these meetings, we bring them together.

So that we can have a participant-driven meeting where we talk about barriers and we brainstorm and we problem solve and make sure that we at the state understand what is happening in the field and how we can make it easier for them.

And we do this for all levels so that we know what we can do at the state level to support our partners in the field, what they can be doing to work on issues to better support their county-based agencies and so forth.

And as I mentioned when funding permitted we held trainings for at least two representatives from each of our partner organizations so that they would have a partner and be able to sustain programs like the chronic disease self-management program at the local level.

And then partner sets, I know that our Centralina folks are going to be talking about partnerships and how important they are and making sure that we're looking outside of our traditional aging services partners and we're looking at for-profit organizations and corporations and agencies who want to help support community efforts and community, sorry, public health efforts.

And as we're looking at those partnerships non-traditional and traditional, we spent some time looking at what those organizations need, what are their (objectives) and goals for their programs and how can we make the programs that our network provides more attractive to them?

We recently attended the college of physicians' conference here in Georgia and provided a one-page flyer that talked about evidence-based programs, provided the single ADRC number, talked about the opportunity for referrals and community supports for their patients and are really working to start that referral system for our state.

We also look at hospital transitions and working with our AAA partners and other partners kind of bundling these evidence-based programs into those hospital transition packages, working with our QIO, with health departments, making sure that our 1-800 number's in everybody's hands but also with a list of the opportunities for referral that there are.

As we work towards managed care organizations and we have not yet been completely touched by managed care but we're preparing for that, we're looking at what the outcomes are for each of the managed care organizations that could potentially come into Georgia and preparing how can we prepare the network to meet the needs of that managed care organization as well as the bundled payment systems?

To get our network ready we really had to take a hard look at our policy so we wrote the policy in 2012 to reflect the changes to Title III-D. We recommended that shift towards the top tier and at the same time we're bringing trainings into the state to support the movement to that top tier.

We have a commitment particularly in my section that every quarter we will look at our policies and we will look at them based on our conversations with the AAAs, what we've observed through our programs where the barriers are to success as we're trying to implement these programs and expand our reach.

We've looked at our fee for service policy and worked to strengthen that to provide better guidance but also to open-up the possibilities while still holding our partners to the letter of the law. We've looked at the wellness requirements for senior centers.

Our site counsels now have to have a wellness goal for each senior center and so within that we're able to focus on some of these same topics that we have evidence-based programs to support which has been a good way to help implement that and bring awareness not only to the staff of the aging networks but to the senior participants as well.

We're also looking at policies to support our AAAs working in partnership with one another across AAA boundaries. If one AAA is able to provide an evidence-based program on a larger basis than another one, then maybe they can work together and so really working with the policy to support those kinds of needs.

Along with those changes we with the systems integration grant spent some time working on business planning and we took this very seriously. We brought-in a consultant and worked with them to develop a year-long training which resulted in a business plan as an end product. Each AAA that participated in that and 10 of our 12 participated in this training.

Each AAA decided which programs they offered already or which programs they were being trained to offer they were going to write their business plan

around so it was very focused. They worked through what are the concerns for business planning, working with a consultant for many of them and each AAA then produced that business plan.

One of our AAAs the coastal region AAA actually approached a hospital who had not been fined for readmissions and talked with them about the benefits of a hospital transition program to prevent that type of fining.

To continue what was done at the systems integration grant in business planning, through our fault prevention grant we are actually working with four area agencies on aging and this is our shameless plug. They will be available as consulting agencies to assist other AAAs across the country to establish solid sustainable processes with evidence-based programs.

They're actually continuing with the contractor that we initially worked with with our system integration grants. They are going to have a full package together of what they have done to successfully embed evidence-based programs within their regions and how they are making them sustainable so you all will have more information on that.

Please reach out to us if you are interested and then also we really look at continue the discussion with our partner agencies about the possibilities for sustaining the program whether it be fee for service or sliding scales, reaching-out to community organizations to promote sponsorship, looking at becoming accredited for the diabetes self-management program, also looking at Otago and engaging new partners like the Physical Therapy Association of Georgia to get PTs involved in helping us keep people from falling.

And then from some of our meetings we know that we are in need of statewide marketing and ensuring that that starts at our level at the state so that

we can have our brand out there and that the same messages happening in one part of our state and happening in another part of our state and we can have this uniform statewide method.

Has this been easy? Of course not. It's in the evolving process and it's a lot of change and so some of the if you look at our little cons list over here, these are some of the things that we hear regularly about shifting this small little amount of money to the evidence-based programs.

And so I think in the past much of this money had gone to support ongoing programs at our senior centers and that doesn't really happen when you're using evidence, you know, when this money goes to support short-term intervention evidence-based programs.

There's not a lot of money in III-D. I think it comes out to be about just about $1000 per county for the entire year and $1000 doesn't support a ton of different workshops and going from being a little bit more flexible to something more rigid and defined is difficult.

So we appreciate that and we wholeheartedly understand that it's difficult which is why we have done all that we can to get out of their way from our level or make it as easy as possible to have these programs available so what can you do? What do you do to use this funding source in a more prescriptive way?

We purchase programs or we invest in programs that we know are effective and can actually use this foundation of amazing individuals to sell these programs to new and non-traditional residents in our state so that we are touching more individuals than we possibly could just looking at our senior centers or in a narrow just narrowly-defined population.

You can pool this money. We have AAAs who are brilliant partners with one another and they will pool their money to have a training or host a training in a centralized location and invite people from multiple regions or even across the state to this training so that it reduced the overall cost for one AAA.

You can serve more individuals through these short-term programs and introduce them to a self-management technique so that they can carry that on through their lives and we know that our older adults often times are kind of the matriarchs and the patriarchs of their family and what they learn it trickles down to the rest of the community.

So you are affecting a greater change than just having an ongoing class at one location and wherever you go across the state now, your fellow neighbors, your neighbors have the same access to similar services that are proven to improve health outcomes and again we have a unified statewide menu that all of our Georgians can access so I know that we were heavily grant-funded and that was a huge way that we were able to get this process started. However, III-D is a good bit of money.

And if you take that money and are able to get your partners together, I know they're not minions but they're cute and - minions are cute - anyway you get your partners together and come-up with one program that you think that your partners are interested in getting together with and have them pool their money and use federal, state and local money as seed money to get these programs - these evidence-based programs - up and running in your communities.

To start with though you all have to have that same goal and make sure that you are unified in what you all are trying to accomplish, use that money to get

you started and keep going with your partners and charge for programs to funnel money back in to support programs to help individuals who truly are not able to pay for the whole cost of the workshop.

However, with that and I'll leave you with this, I would just caution not to assume that an individual cannot afford something. Don't put that in their mouths because you can always ask and go from there so always be thinking about that sustainability piece.

Casey Dicocco: Okay, thank you very much Megan and Gwenyth, that was really great. It was really beneficial to hear from you guys so thanks for sharing your experience at the state level so next we're going to hear from our colleagues at the AAA level so we're going to be hearing from Centralina which is in North Carolina.

Speaking to everyone today is going to be Linda Miller who is the aging program director in the Centralina AAA and Annette Demeny who is the EPHP coordinator for the Centralina AAA and Linda I'm going to hand over to you the presentation to you.

Annette Demeny: Thanks Casey, actually I'm going to start it over. This is Annette Demeny and like Casey said I'm the coordinator for the HTDP program and I'm going to get started and talk to you mainly about our region first and then I'll turn it over to Linda and let her talk more on the funding side and the coordination.

So Centralina is the second-largest area agency on again in North Carolina. There's a total of 16 served and we serve nine countries surrounding the Charlotte region and Charlotte's in the Mecklenburg County as you can see that.

We also serve a wide demographic range that's rural and urban areas so we have a lot of reach to both, you know, all the way from Archdale down to Anson County which is very rural area so we have a widespread range there.

We also are housed in a RPO which is a regional planning organization which provides transportation, planning, mapping and GIS support so that's a great benefit to us especially with data support and things like that for our programs.

We also serve as a regional evidence-based program for or a hub, a site or a hub for training and that's really for the central and western part of the state and then the eastern part of the state I think has some of their master trainings there but we are in mainly the central and the western part and we deliver most of the evidence-based health programs in North Carolina.

All right, this slide here really focuses on the five core evidence-based programs that we have in-house that we focus on mainly and you can see the big core of them is the Stanford model which is the chronic disease self-management program.

The diabetes self-management program, the (Tomando) which is the Danish version of the CDSMP and then the (manejo) which is the diabetes this Danish of the DSMP and then we also have a matter of balance program and that's offered in the English and the Spanish versions.

And I didn't include this but we also support powerful tools for caregivers and I did not include that but we do offer that and we have master trainers here at Centralina and we offer that in our region as well. Just some numbers for FY '15. We had a total of 105 workshops and I did not include I think we had a couple of powerful tools for caregivers.

I think we had two or three workshops that I did not include that but either way it's 105 workshops and you can see 47 of those were matter of balance, the matter of balance program and then 58 of those was the CDSME which really encompasses all of those the Stanford models there.

Okay, here's a real quick overview of just a matter of balance. As you can see we had a total of 680 total participants in this FY '15 year. We have four trained master trainers in our region and 67 trained leaders. This past year we've conducted two matter of balance coach trainings and then we also did a master training here at Centralina which we have done now for three years.

We are the hub for the southeastern states for master training so we have that in June every year so the main health who oversees the matter of balance programs typically have master trainings in Arizona, in Maine and now North Carolina here at Centralina we're the hub for the southeastern states and real proud of that.

And here's an overview of the CDSME which like I said encompasses all of these programs. We have 621 total participants. We have seven master trainers, 123 lay leaders.

We conducted (solve) lay leader certified trainings this past year and then we also teamed-up with Georgia Division of Aging Services and offered a master training for the (Tomando) program and had three states represented and also Puerto Rico so that was a fun training there.

All right and this is a quick snapshot of just who we serve. As you can see our top three diagnoses that's reported in our programs are hypertension, diabetes and arthritis was not a surprise to us, 6.5 of the attendees had multiple

diagnoses and you see the attendees female is 79%, 21% male so we're really trying to work more on that.

I've seen a little bit of a change in that and seen more males come to especially the matter of balance programs and the diabetes programs so hopefully we'll have a shift in that and get more males into the program and then you see our completion rate is at 73%. All right, I'm going to go ahead and turn this over to Linda Miller.

Linda Miller: Good afternoon, everybody. I'm glad you're all here. Just going to move into even over the years why we think we'll be successful and we've been successful. Annette threw a lot of numbers and to some of you they might seem small and to some they might seem big but, you know, it took a lot of years of building this program up and a lot of patience to get there.

And I hope that during our presentation you really see some common themes between a little bit from what Casey said and more so from what Megan and Gwenyth said because common themes are good.

We're hoping that those are things that are going to stick in your mind and say well those are really good things and hopefully those are some things we need to be successful or I see those through both programs.

So for the Older Americans Act the III-D funds (support), what we did years ago and we're very fortunate, much more fortunate than the people in Georgia after Megan gave me that of about $1000 a county, we're much more fortunate than that in our region in that we get a nice chunk of money in that early on.

Of course we gave all our money out to what we call our community services providers. We don't do a lot of direct services in-house in the North Carolina AAA format. A lot of it is subcontracted out to the individual counties maybe and they do that.

But when the III-D money started to change about four-five years ago, we began keeping a combination of some of the funds in-house to be able to absorb those foundation costs that were going to be required such as purchasing a license or training leaders and paying for a coordinator's salary as opposed to giving it all up because we knew that if you didn't have that foundation, you weren't going to be able to increase capacity.

And then what we did is we give some of the funds awarded-out to our subcontractors in the region to assist them with expansion and sustainability. We also early on designated what we believed yes, probably because of some grants that we go that we were going to call these our core evidence-based health programs.

Yes people, you know, there's a long, long list like Casey was saying but we wanted to say that, you know, given our choice we were going to offer these core programs with this III-D money and those were the ones that we wanted to grow and develop. Didn't mean that they can't do other things.

It's just that the bulk of the money was going to be used to develop these core workshops so we monitor the workshops in the nine counties for program fidelity and for allowable expenses and what we did is a few years ago we put-out a proposal process to the people in the region who think that they have the capacity to deliver an evidence-based program from our core list post.

And they submit maybe it's a senior center and they said well we think that we're going to do three matter of balances this year. We think we can do two chronic disease self-management and maybe one diabetes and that's their proposal and we maybe get I don't know Annette what, 15 or more proposals?

Annette Demeny: Yes.

Linda Miller: Yes, probably about that but everybody writes it according to what they think their capacity is and we do the training of the leaders under our license and maintain them and maintain the fidelity and keep an eye on them but then they tell us when they're teaching classes. We get the materials and supplies out to them. We get everything they need.

We get the marketing material out because it's all consistent. We maybe put their information for to RSVP for the class but it's a very deliberate, a very consistent message and then upon receiving all of the required paperwork, the pre and post-tests, the sign-in, everything that we need then we reimburse them $600 per class and we release them a check for $600.

But again it had to have been a successful proposal that they wrote that we approved and we don't always approve everything that they wrote and that's how we began to also disseminate I think wider and get some buy-in from some of the (congadyne) sites, the senior centers, some faith-based communities, some other non-profits, some of the departments of social services do them and that's how we felt we were able to spread that.

And as we said we started-out really slow, you know, we had some of the first people trained way back in '07 with a grant and maybe did, you know, two or three classes that year and then added something each year and then in '12

began to do the (Tomando) and then we just started the diabetes Spanish program.

It takes a long time so more about that again building that infrastructure or that hub like Gwenyth and Megan said or we like to believe that we're an evidence-based health program regional center. We maintain the licensing. We maintain and select all the master trainers. They don't have to be Centralina staff.

The only reason that I think we're able to have so many master trainers is we've got some phenomenal partnerships particularly because we've got no one here bilingual but all of the Spanish programs have been maintained because we have some wonderful partners and then again like Megan and Gwenyth said, the bulk purchase of materials and supplies really does save money. It's not pretty in our office but it saves a lot of money.

We also for the matter of balance for instance the participants get a handbook. Well, we started printing that on our own with all of our, you know, just as it is and we were able to get that down to like barely $5 a book when we ordered three-four, you know, a few thousand of them so that's a way that we've been able to even do some of that and really save some money.

As I mentioned before, we have a focused outreach and marketing with a very consistent message, you know, we don't recreate the wheel. We don't want to. NCLA has been a wonderful resource with a lot of their marketing materials if we could use it, CDC, you know, ACL, everybody's done that.

We may tweak thing a little but we use a lot that's out there but we want everybody using the same posters, brochures, we want everybody delivering the same message and we want to make sure that we're giving credit since we

supply all the materials, all the marketing and so forth but we really felt that we were able to stretch our funds a lot more.

We're also talking to as the years - this year - we're talking to some of the other AAAs about ways we can better partner too because they're also seeing that lack of capacity and sort of hitting a wall with growth and the ability to make their money stretch.

So and again we're also able to conduct fidelity from here, to visit on all of our workshops and leaders and also make sure that we I think we wrote in about '10 - 2010 or '11 - we wrote our own centralized policies and procedures. You know, people were struggling.

They, you know, a lot of the senior centers would get the money but they didn't know oh okay, so we don't want anybody to buy food for the last couple of years so you say that but you still have to write it into policies and procedures.

Or with putting maximums on certain other things or what they could spend the money on or we had to reiterate that people had to train, you know, minimum once every 12 months but the policies and procedures were also a big help.

I think that was mentioned a couple times that it's really important to designate a full-time coordinator to conduct all those logistics, the full-time tasks of administrative like keeping everybody in line as well. Those of you that work with a lot of volunteers, even if they're professional volunteers know that it takes a lot of time and a lot of customer service and patience.

But we have the centralized database for all the workshops taught in the nine-county areas, participants, leaders, you know, if we have a leader we know so that we know what leaders are due to teach, if they're lasting, if they need to teach and all sorts of other data collection, you know, we do other training.

You know, fidelity just isn't an annual visit to a class. We feel fidelity is such things as an annual training retreat. We get all the leaders together once a year. It's a newsletter giving them hints about what they need to do or what's happening or what we've noticed.

It's surveys to make sure their needs are getting met or surveying the host agency sites to see if, you know, was it easy to setup a matter of balance class? Did everything go well but those are things that we feel that we try to do fidelity all year around.

We can get in centralized referral especially through the state. Our state has a quit hotline but they're also trained to ask for do you need help to get to a chronic disease self-management class so those types of things will come here.

As Annette said we try to have all of the leader and master training done here and we also feel that that centralized coordination is a marketable product. We have had health departments that say well we want to get trained in the chronic disease and we say well that's great if, you know, you can get trained here at Centralina and we want to have our own license and do our own thing.

That's great but why build something when you can buy it so we have also made a little bit of money off of offering our coordination and some of our benefits to other people who want to get a program started-up so that's helped a little bit too.

Don't buy, you know, I mean, don't build it yourself, buy it. Partners in Collaboration has been wonderful. I probably don't have to tell anybody that but we really make sure that everybody has some skin in the game. There's something you can bring.

Even if you're a small non-profit and you want to get onboard but I can give you a leader and I'll pay that leader and pay their gas when they go to train for you even though you hold the license so everybody contributes something. We use an agency and a leader memorandum of agreement.

We have an evidence-based health program committee or coalition. We call it an advisory board actually so I don't have either one of those right, provide a lot of partnership feedback and data when they need it. We also use a lot of people as champions to help us promote and market out in the region. Those types of things are really important.

We want to make sure everyone gets credit. We're not in this to, you know, all by ourselves or to, you know, we may take the lead but we really want to make sure everyone gets credit. We really also network with everyone and to not reinvent the wheel, not at all.

And we also I wish I, you know, had money for every time somebody calls and says well how much will this program really cost and, you know, what's it really going to be to run? We have all that stuff ready so we don't have to throw it together.

We really want to do a really good analysis for people to say well this is what this costs and this is how much time we put in on a class and that's how you do a really good cost analysis.

So you know what it costs per person or per leader when you're training them truly to cover your costs and make sure you cover your staff time as well when somebody asks how much these programs cost or whether they're cost down and that kind of leads into then don't undervalue yourself. Make sure that you get your costs covered.

Effective leadership has also been something that I think has helped us greatly. We think that Georgia, you know, we were writing notes and taking notes when you guys were talking, we've been doing this for years but they said some cool things that we hadn't thought of and we're going to call them right out but your state unit on aging in my mind has been one of our biggest advocates and has been huge here in North Carolina.

We call them constantly. I'm sure they're sick of talking to us but use your state unit if you're a AAA. I see a lot of AAAs up there on the attendee board. Use your AAA, I mean, your unit on again. They're great. Again Annette is sort of seen as the expert in our nine countries when you designate a coordinator, she is that go-to person.

You know, they have to have that persistence to get classes booked and get, you know, and be patient with volunteers, that passion about these programs, be really flexible to hit the ground running and creative to get these things working and running and that vision to be able to, you know, get all this stuff into practice.

But, you know, once we really in those early years we weren't able to set that up but once we setup a position like that, we really saw things grow at a rapid pace. Of course your champions should be leaders for you, that advisory

council's helping us a lot. We also are trying to go for the diabetes self-management and become a Medicare agency.

And then get the DSMP certified through the AADE the American Association of Diabetes Educators so that we can get the workshop reimbursed through Medicare and it is a long road but we're being patient and that advisory council is also something that you have to do for that AADE application so that's coming-in really, really handy.

Our master trainers and key trainers are just invaluable and again if you can't lead, if your leaders if it's not for them, would help to find people that identify well then what can you do?

Continuing with that, we from Day 1 have done pre and post-measures, of course matter of balance has sort of come with that built into it and we've really appreciated that but we've continued to do that with all of our CDSME programs.

Right now we're involved in the CMS Centers for Medicare and Medicaid Services (west stat) study in which we're pre and post they're measuring six months later to see if these classes are effective, if they're reducing some sort of they're looking more at a cost analysis and that's been a real interesting year.

It'll be a year. We're closing next month or the month after. Early on we also purchased a license for something call it by Insignia called a patient activation measure. It's just a quick 13-question survey and looks at somebody.

We'll give it before the class started and then with follow-up six months to see where you are and how you're motivated in your healthcare regime for change

so I understand my - an example might be - I understand my medication regime and I am ready and able to change it. I'm in Stage, you know, 4, I'm far along or I don't understand it.

I'm really not self-motivated. I don't know where to go from there so we were seeing if there were numbers and that would be moved after if they took the class so we're really actually having the university help us to analyze that now and we're hoping to have some really good numbers with that.

So leadership is just that, you know, measuring anything because data is going to measure the effectiveness of your program but again as a selling point to new partners and sponsors when they see that cost savings or who you're saving, it's not just about demographics. They want to see those cost savings.

We also suggest and I think that Georgia said this in that you take that time to write a business plan. Our state helped us write one at least a template and then everybody took it and started to put their own Oracle data in so that was a huge help but it gives you that blueprint to move forward.

We're really moving also the needle on charging organizations for our services, more private pay workshops, charging more for leader training and particularly for people out of our region and looking more at foundations and grants as ways to enhance our III-D money and increase the sustainability.

We're looking more at some global or systemic partners or that some insurance companies, some of the hospitals. We talked about the DSMP as a Medicare reimbursable service.

We worked with Georgia and we're working with the main health with the MOB to become not only a site but to, you know, see us if one of your staff

would be interested in key training or lead training to being that income in and have those types of things to train master trainers.

And of course, you know, we do a lot of resource and call others on our, you know, call other people to see what they're doing. There's the new evidence-based leadership council, NCOA, ACL, they've all been huge resources for us and just be patient. There's our contact information and Annette anything I missed? I know Casey has questions.

Annette Demeny: I don't think so. I think you did a great job (then).

Casey Dicocco: Yes, thank you guys. Thanks Linda and Annette. That was really excellent and we've got a lot of great questions coming-in. I have a few more slides to go through and then I will go back and go through these questions and hopefully we'll have time to get to them all and if not, we can follow-up individually with folks.

But thank you guys again so I'm just really quickly going to go through kind of some of the themes from both of those presentations and kind of core lessons that we are hoping folks are getting so, you know, I think we heard in both presentations how important leadership from the top can be and really having that buy-in from committed leaders.

And I think, you know, one of the ways to get that buy-in is really highlighting how evidence-based programs align with the mission and using available data to make that case and to link the mission (unintelligible), sorry, there, a little slide administration so as Linda just said state leadership is really important.

It's great if the state has a health promotion person identified whether or not that's their full-time position or it's part of some facilities but it's nice for the network to have someone to contact and hopefully that state person can write a TA to AAAs or if not they can link AAAs to one another which is a really important resource.

And in that vein we definitely recommend holding conference calls on evidence-based programs within the states. Specialized Websites, that's great if the state has the infrastructure to do that but that's also, you know, may not be doable for many folks.

So the hub model is one of the key themes we're hoping comes across in these presentations. As we've seen with both of the presentations, these folks have a great model or did a really great job utilizing a hub model and kind of leveraging a small amount of resources to be able to build a pretty systematic approach.

Also a theme with obviously leveraging infrastructure of prior grants, you know, obviously the reach of these grants varies depending on the funding streams but there's also there's the grants that you as an organization may have received but also the grants that your neighbors or other AAAs in the state may have received and, you know, be aware of that and there may be a way to take advantage of that.

And in that same vein, you know, one of the key concepts is don't build from scratch as Linda said very well, you know, see who you can buy services from and partner with other organizations to create funding. It's really all about leveraging those existing resources.

And now we're going to talk briefly about some of the resources that are available nationally and then we're going to go to question. I see a few questions still coming-in so two resources that are really kind of comprehensive soup to nuts evidence-based programs in the community setting resources.

So the first is this Website from some folks in Texas rather who put together this really nice site that really offers comprehensive guides to evidence-based programs and community settings and then the second link on there is from the National Council on Again NCOA who has put together some really great guides also for understanding, implementing and also business case resources.

So these are resources if you're really looking to build from scratch or you're just kind of troubleshooting a particular problem but they're pretty comprehensive. Linda mentioned the evidence-based leadership council or the EBLC for short.

They've just redone their Website and they have a number of notable programs that they've been doing in the network for a long time and can be very valuable for folks and this 101 fact sheet is just a one-pager on evidence-based programs that can be useful for folks who you're trying to introduce the concept to.

So this link in the middle of the page here links to PDFs that contains a list of evidence-based programs that ACL and NCOA put together in 2012 and 2013 to aid the network in finding and implementing evidence-based programs so everything on this list meets the highest-level criteria but we stress that programs do not have to be on this list in order to meet the highest-level criteria.

The list also is not particularly updated now with broad updates. There's more just minor updates to program costs and links and that sort of thing so that's important for states to keep in mind if they're utilizing this as a resource.

These are the federal registries so in the beginning of the presentation I spoke about how if you are using a program that has been deemed evidence-based by another agency within Health and Human Services, then you can use Title III-D funds and so these are three great registries of such programs.

The first is from SAMHSA and it's a pretty robust registry. It's got about 350 programs in there and they're filterable and searchable. They're probably not all relevant to older adults but there's certainly ways to look at the filters I think and see which ones are.

The compendium of falls intervention, many of you may be familiar with that but that is a great resource and obviously very germane to our network and that last link on there comes from the National Institutes of Health and it's a cancer control and prevention intervention registry but it's got a lot of great, you know, physical activity, nutrition, smoking cessation, interventions on there and filterable by older adults.

So if you're looking to learn about some new programs that could be a great place to start. ACL also has our own registry of evidence-based programs on our Website.

It's called ADEP and there's 11 programs on there and we put this together as a way to share with the network and other interested parties some evidence-based programs that are relevant to our stakeholders and so we have not had the capacity to review a great deal of programs but there are some very comprehensive reviews on there.

So if you're looking to learn about some programs, that's a good place to go and again we want to stress that a program does not have to be on this list in order to meet the highest-level evidence-based requirements. This is just one place to find them.

And some past presentations from ACL and our partners at NCOA or other Webinars that are available here and they're available on the Title III-D Website and this presentation will be put on there as well.

Okay, now we are going to get into the Q&A section and so I am just going to be going through and looking at some of the questions and sending the questions out to the group, the bulk of the group of presenters and the folks I have here with me so let's start with one that I saw that was pretty directed to ACL.

And that was - here we go, from (Joanna) - if five points of the future definition of an evidence-based program is met, does the program have to be approved by ACL in order to use in the highest-level only and so that's a great question and one that we have gotten before so the answer is no.

The Older Americans Act puts the responsibility and ability to come-up with the guidance to states and so we know states are using multiple different ways of looking at the programs that they are going to consider eligible for the highest level and that's something that I've definitely seen as a need since I've been here.

And so we are looking to develop some resources to help states who don't already have a system in place for assessing whether something is program or not and they don't feel that they have that capacity. We're looking at kind of

guides or ways to ease that process for states and so stay tuned on that certainly.

And this is a question that I'm going to put out to the group that has anyone from (Mindy) has anyone approached MCOs and contracted with them to help move towards building a private business alliance?

Laura Lawrence: Okay, I don't know if anyone else will answer that but I'll take a stab. This is Laura Lawrence and I'm the Director of the Office of Nutrition and Health Promotion Programs and so Title III-D falls in my office and I've just been tinkled pink that I was able to hire Casey to handle this portfolio.

Excellent question. As you all probably know, ACL has taken very much interest in how we can connect with healthcare entities and show them the importance of our program in helping the individuals that they serve on the healthcare more of the clinical side and how we can partner together and how they can pay for our program.

And so yes, we do have some examples of networks throughout the U.S. that are made-up of some of our AAAs, direct service providers, etcetera, that do have contracts with healthcare entities and specifically I don't know if you're familiar with it but we're now in our second cohort of a learning collaborative to learn business skills for doing exactly that.

And I think between the two groups we have maybe 20-21 networks across the U.S. and they have entered into so I'm guessing numbers something along the 15 to 17 contracts so far and we are working on how we can share all that they've learned in terms of doing this with everyone in the network so again that's an ongoing project and you'll be hearing more about it so I hope that touches on some of that question.

Casey Dicocco: Thank you, Laura and I have a question for Georgia and it may be repeating a bit of your presentation but the question from (Jennifer) and they ask Georgia, does the state require AAAs to implement the menu of programs you shared or are these options the AAAs can choose from and/or other as other evidence-based program?

Megan Stadnisky: Our AAAs they can choose whichever one is right for them. These were just the programs that we were able to bring through grant funding and we're able to help folks get up and started.

There's one AAA who was not finding success offering the chronic disease self-management program at all but as soon as they offered the diabetes self-management program their program kind of flew and went - it was the right-sized - or the right-sized program for them with the DSMP so I hope that answers the question.

Gwenyth Johnson: And I found it interesting that that particular area is one of the diabetes hotspots for Georgia which we were able to look at and so some targeting with our public health departments.

Megan Stadnisky: So we would allow our AAAs - allow our AAAs - we encourage our AAAs to do whatever is going to help their area and their region. These were just programs that we were able to bring through grants.

Gwenyth Johnson: Most of our state is covered by most of the programs however.

Megan Stadnisky: Yes.

Casey Dicocco: Great, also this is a question who was the funder of the systems innovation grant?

Megan Stadnisky: That was an ACL grant.

Casey Dicocco: Georgia and North Carolina, this is a question for both of you. Do you have any tips for supporting Spanish language programs especially if you don't have a coordinator who is bilingual?

Laura Lawrence: Partner, partner, partner.

Megan Stadnisky: Yes, community partnerships are key to us for any language venture that we go into.

Gwenyth Johnson:And I think that Linda mentioned having your champions and finding your champions. We are very new to (Tomando) control. Actually our partnership with Centralina in getting master trainers together is our first venture into truly finished culturally-competent programs - Spanish-speaking culturally competent programs - and the 10 folks that we had trained, they have teamed-up they are all teams and they are huge champions within their communities to bring this program there.

Linda Miller: And this is Linda and Annette in Charlotte. They're right. All of our (Tomando) and the (manejo) the diabetes for Spanish master trainers, none of them work here.

                    What we've had to do we do have staff in the regional planning organization our council of government that are bilingual that help us if needed with interpretation but a couple of the (Tomando) master trainers one is a senior

center director of a multicultural international senior center and she's bilingual.

She has been a blessing because we defer most of the issues or she'll do some of our interpreting of hard copy materials if we need it or to change things on the Website or different things, she's done all that for us and she'll call a leader if we have a problem or an issue but she has just been our best champion but again they're right.

You know, we couldn't do it with them. The partnership has just been amazing.

Annette Demeny: Right, and with the diabetes with the (manejo)s we're like we were saying on the slides, you know, we've very new at that. We just trained two master trainers who are nurses in our Carolina healthcare system here in North Carolina so that's going to give us a really great way of, you know, getting into the healthcare system, not only getting referrals but also, you know, getting leaders trained as well for that program.

So partnership is key especially in those bilingual situations and those programs. As a matter of fact today we have a program - a (Tomando) program - going on at a senior center that there's no bilingual people there and that work there and so one of our master trainers who's really, you know, taken them under her wing to try to get this program going in that senior center.

Casey Dicocco: Great, thank you and one of the earlier questions we got was is there going to be a central place for all highest-level evidence-based programs and that, no, the point of the guidance is to kind of provide the criteria that can help folks find and recognize evidence-based programs but there's not going to be a

central place where we say these are all the evidence-based programs out there.

And especially considering the other HHS agencies, component of the definition. There's, you know, a fair amount of resources that you can look to to look for evidence-based programs.

We have a question about Title III-D funds being used for participants under 60 years of age and the service units to be accounted for.

Older Americans Act resources are for folks 60 and over and that remains the case. You know, if there's infrastructure that the network has built with grants and with their work and they're serving individuals under 60, you know, that could take place but that would not be reported in terms of units served.

Laura Lawrence: Yes, and this is Laura. If I could just add one more thing Casey, is that okay?

Casey Dicocco: Yes, shoot.

Laura Lawrence: You really if you're going to be serving individuals 60 and older and under in your programs, just make sure you have a good cost accounting system. You know, if you have paid for the master trainers using III-D, that's fine but then if you're holding the class whatever the variable costs are, get past the classes, you know, age 50, well just be able to have a method for separating that.

Casey Dicocco: Thank you and related to costs actually we got a question from (Juliette). How does bulk ordering help reduce costs? Wouldn't the supplies then have to be shipped to far-reaching areas of the state?

Megan Stadnisky: I can handle that. It's really if you purchase 1000 books from Bull Publishing for your chronic disease self-management program and then have multiple places to ship that to directly from Bull, it would be astronomical.

So what we do is we purchase that 1000 books, we have them send them right to Atlanta to our Division of Aging Services and then as our staff go out to do monitoring or mentoring at the various AAAs, we actually load vehicles and drive them to them and we get to see people face-to-face and have another connection but we also get to deliver the materials.

Gwenyth Johnson: We really work with every section within the division to make sure that these books get out so we're not spending additional money so if someone from our Medicaid waiver program is going to one region of the state, we'd load their cars with books and send them off.

If we're going to a meeting around a partnership with Wick Farmers Market, we load the car and send them off so we really try to utilize every person who's leaving the state office to go anywhere in the state to get those books out.

Linda Miller: And we have a very large state geographically speaking so as much trouble as it is, it really does save so much money. You can get more books or more whatever you're looking for.

Casey Dicocco: Great, thank you. We got a question from someone, couldn't find ADEP on the acl.gov Website. It should be linked from the Title III-D page and if you're having trouble, my contact info's on the screen now. You can just send me a note and I can send you the link to ADEP.

We also got a question about whether you can combine multiple highest-tier evidence-based programs—that is not going to be an evidence-based program at that point probably, unless it's been studied and it's kind of some sort of program with multiple components to it. But in general no, you cannot be combining multiple evidence-based programs.

Kristie Kulinski: Casey, this is Kristie. I'm sorry to interrupt but I just wanted to say that's not just saying you can't implement multiple evidence-based programs through your III-D infrastructure. That's saying you can't take into portions of multiple evidence-based programs to complete your own unique evidence-based program. It would no longer be considered an evidence-based program.

Casey Dicocco: Great, thank you. Still getting a bunch of great questions and we're probably not going to have enough time to get to all these questions so we will try and hold a list of who sent the questions and get back to you one on one but definitely thank you for all these great questions.

So go to a question from someone for I guess Georgia, who holds the statewide license for the proprietary programs, the state or the AAA state association?

Megan Stadnisky: The Division of Aging Services does.\

Casey Dicocco: Okay, I guess with only a few minutes left I'd probably like to turn it back over to you guys if you have any comments or main questions or comments you'd like to bring-up to the group in our last few minutes?

Laura Lawrence: I guess my only thing is be strategic and use your partners, partner, partner, partner, and see what they want to do because if you have their buy-in, you can take it wherever you want to take it.

Linda Miller: And my comment would be if you've got an idea about a way to do something and you don't know if it's possible, just get in touch with your regional ACL folks. They have been so helpful to us along the way.

Casey Dicocco: Absolutely. We cannot reiterate that enough. We rely on them a great deal and we know the states and AAAs rely on them a great deal so the regional ACL staff are really a crucial partner in this whole process.

                  So again apologies to those folks whose questions we didn't get to directly answer but we will get back to you individually. There's some really great questions in here and you have my contact info on the page there.

Laura Lawrence: Yes, and Casey if some of the questions don't seem to be universal that we think a lot of you all would be interested in, we do have a frequently-asked questions part of the Title III-D Webpage and for some of these questions that are simply excellent - well, I mean, they're all excellent questions - but some that are universal we'll make sure to add those to our FAQs.

Casey Dicocco: Yes, absolutely and just kind of in that theme, you know, we're always looking to hear what interesting successes are going on in the states and AAAs so if you have, you know, some great advice to answer any of the questions we may have heard, please contact your regional representative at ACL who would be great conduits because they really need to know what is going on in the regions they work with so closely.

                  So thank you all for being with us today and thank you again so much to our presenters. You did a great job and the slides and the audio of this will be available on the Title III-D Website. Thank you all and have a great afternoon.

Coordinator: Thank you for participating in today's conference. That does conclude this

call. Please disconnect your line.

END