

1. DATE ISSUED MM/DD/YYYY 08/26/2014  
 2. CFDA NO. 93.734  
 3. ASSISTANCE TYPE PROJECT\_GRANT

Department of Health and Human Services

Administration For Community Living

AOA - PPHF-2012 CDSMP

One Massachusetts Avenue NW  
 Washington, DC 20001

NOTICE OF AWARD

AUTHORIZATION (Legislation/Regulations)  
 Sec4002 ACA (PPHF)

1a. SUPERSEDES AWARD NOTICE dated  
 except that any additions or restrictions previously imposed remain  
 in effect unless specifically rescinded

4. GRANT NO. 90CS0048-03-00  
 Formerly  
 5. ACTION TYPE Non-Competing Continuation

6. PROJECT PERIOD MM/DD/YYYY  
 From 09/01/2012 Through 08/31/2015

7. BUDGET PERIOD MM/DD/YYYY  
 From 09/01/2014 Through 08/31/2015

8. TITLE OF PROJECT (OR PROGRAM) Missouri Department of Health and Senior Services Empowering Older Adults and Adults with Disabilities

9a. GRANTEE NAME AND ADDRESS  
 Missouri Dept. of Health and Senior Services/DSS&R  
 PO BOX 570  
 920 WILDWOOD DR  
 Jefferson City, MO 65102-0570

9b. GRANTEE PROJECT DIRECTOR  
 Belinda Heimericks  
 PO BOX 570 920 Wildwood Drive  
 Jefferson City, MO 65102-0570  
 Phone: 573-522-2800

10a. GRANTEE AUTHORIZING OFFICIAL  
 Mr. Bret Fischer  
 920 Wildwood Dr  
 Division of Administration  
 Jefferson City, MO 65102-0570  
 Phone: 5737516014

10b. FEDERAL PROJECT OFFICER  
 Ms. Theresa Arney  
 One Massachusetts Ave.  
 Administration for Community Living  
 Washington, DC 20201-1401  
 Phone: 202 357-3515

ALL AMOUNTS ARE SHOWN IN USD

11. APPROVED BUDGET (Excludes Direct Assistance)

I Financial Assistance from the Federal Awarding Agency Only		<b>I</b>
II Total project costs including grant funds and all other financial participation		
a. Salaries and Wages .....	15,845.00	
b. Fringe Benefits .....	7,764.00	
c. Total Personnel Costs .....	23,609.00	
d. Equipment .....	0.00	
e. Supplies .....	99.00	
f. Travel .....	715.00	
g. Construction .....	0.00	
h. Other .....	593.00	
i. Contractual .....	199,451.00	
j. TOTAL DIRECT COSTS	224,467.00	
k. INDIRECT COSTS	4,533.00	
l. TOTAL APPROVED BUDGET	229,000.00	
m. Federal Share	229,000.00	
n. Non-Federal Share	0.00	

12. AWARD COMPUTATION

a. Amount of Federal Financial Assistance (from item 11m)	229,000.00
b. Less Unobligated Balance From Prior Budget Periods	0.00
c. Less Cumulative Prior Award(s) This Budget Period	0.00
d. AMOUNT OF FINANCIAL ASSISTANCE THIS ACTION	229,000.00
13. Total Federal Funds Awarded to Date for Project Period	739,000.00

14. RECOMMENDED FUTURE SUPPORT  
 (Subject to the availability of funds and satisfactory progress of the project):

YEAR	TOTAL DIRECT COSTS	YEAR	TOTAL DIRECT COSTS
a. 4		d. 7	
b. 5		e. 8	
c. 6		f. 9	

15. PROGRAM INCOME SHALL BE USED IN ACCORD WITH ONE OF THE FOLLOWING ALTERNATIVES:  
 a. DEDUCTION  
 b. ADDITIONAL COSTS  
 c. MATCHING  
 d. OTHER RESEARCH (Add / Deduct Option)  
 e. OTHER (See REMARKS)

**b**

16. THIS AWARD IS BASED ON AN APPLICATION SUBMITTED TO, AND AS APPROVED BY, THE FEDERAL AWARING AGENCY ON THE ABOVE TITLED PROJECT AND IS SUBJECT TO THE TERMS AND CONDITIONS INCORPORATED EITHER DIRECTLY OR BY REFERENCE IN THE FOLLOWING:

- a. The grant program legislation.
  - b. The grant program regulations.
  - c. This award notice including terms and conditions, if any, noted below under REMARKS.
  - d. Federal administrative requirements, cost principles and audit requirements applicable to this grant.
- In the event there are conflicting or otherwise inconsistent policies applicable to the grant, the above order of precedence shall prevail. Acceptance of the grant terms and conditions is acknowledged by the grantee when funds are drawn or otherwise obtained from the grant payment system.

REMARKS (Other Terms and Conditions Attached -  Yes  No)

GRANTS MANAGEMENT OFFICER: Rimas T Liogys, Director, OGM

17. OBJ CLASS 41.45	18a. VENDOR CODE	18b. EIN	19. DUNS 878092600	20. CONG. DIST. 04
FY-ACCOUNT NO.	DOCUMENT NO.	ADMINISTRATIVE CODE	AMT ACTION FIN ASST	APPROPRIATION
21. a. 4-29966R0	b. 90CS004803	c. ACLAOA	d. \$229,000.00	e. 7540142
22. a.	b.	c.	d.	e.
23. a.	b.	c.	d.	e.

PAGE 2 of 2	DATE ISSUED 08/26/2014
GRANT NO. 90CS0048-03-00	

---

## STANDARD TERMS

1. Grantees are hereby given notice that the 48 CFR section 3.908, implementing section 828, entitled “Pilot Program for Enhancement of Contractor Whistleblower Protections,” of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2013 (Pub. L. 112-239, enacted January 2, 2013), applies to this award. The effective date is for all grants and contracts issued on or after July 1, 2013, through January 1, 2017.
2. All grantees are expected to recognize any same-sex marriage legally entered into in a U.S. jurisdiction that recognizes their marriage, including one of the 50 states, the District of Columbia, or a U.S. territory, or in a foreign country so long as that marriage would also be recognized by a U.S. jurisdiction. This applies regardless of whether or not the couple resides in a jurisdiction that recognizes same-sex marriage. However, this does not apply to registered domestic partnerships, civil unions or similar formal relationships recognized under the law of the jurisdiction of celebration as something other than a marriage. Accordingly, recipients must review and revise, as needed, any policies and procedures which interpret or apply Federal statutory or regulatory references to such terms as “marriage,” “spouse,” “family,” “household member” or similar references to familial relationships to reflect inclusion of same-sex spouse and marriages. Any similar familial terminology references in HHS statutes, regulations, or policy transmittals will be interpreted to include same-sex spouses and marriages legally entered into as described herein.

## STAFF CONTACTS

1. Please direct any questions related to the negotiation of this award and/or interpreting the fiscal or administrative requirements, policies, or provisions, to the Grants Management Specialist, **Sean Lewis (202) 357-3445 or [Sean.Lewis@acl.hhs.gov](mailto:Sean.Lewis@acl.hhs.gov)**. If you have questions related to the program requirements, or if you require additional technical assistance, please contact the Program Officer listed in section 10b., of the Notice of Award.

## SPECIAL CONDITIONS - GrantSolutions Registration

1. ACL discretionary grantees are required to use GrantSolutions (GS) for their end to end grants management services (tracking and receiving various award actions, submitting financial and progress reports, general correspondence, requests etc.). The grantee authorizing official identified in box 10a., and grantee project director identified in box 9b., must ensure they are registered with GS and have the appropriate role assigned to them by their organization. Please follow the GS grantee account registration information located at the following URL: <https://www.grantsolutions.gov/support/registration.html>. If you are unable to register or have questions associated with registration, contact your Grants Management Specialist (GMS).

# AWARD ATTACHMENTS

Missouri Dept. of Health and Senior  
Services/DSS&R

---

90CS0048-03-00

1. Attendance Log
2. Semi-Annual Performance Report Directions and Sample Template
3. CDSME Sustainability Tool
4. Participant Information Survey
5. Workshop Info Cover Sheet
6. Attachment P Organization Data Form

## Attendance Log

**Instructions to the Group Leaders:** Please clearly print the Workshop Information and the Participant Names below. Write participants' names as they appear on their *Participant Information Surveys*.

Mark each session that the participant attends like this:

Implementation Site Name: \_\_\_\_\_

Start Date (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_ End Date (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_

**Table 1: CDSMP Participant Attendance Log**

Participant Name	Session Number						
	1	2	3	4	5	6	7 <i>(PSMP Only)</i>
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							
16.							
17.							
18.							
19.							
20.							

## **Prevention and Public Health Fund Chronic Disease Self-Management Education Semi-Annual Performance Report Directions and Sample Template**

### **Purpose of Semi-Annual Reports:**

Briefly describe major or significant activities related to grantee goals, including key steps towards achieving target numbers of individuals that complete an approved Chronic Disease Self-Management Education Program, and in the development of an integrated, sustainable, evidence-based CDSME delivery system.

### **Directions:**

- Use the format outlined in the “*Guidelines for Preparing Performance Reports for Discretionary Grants Supported by the U.S. Administration for Community Living*” ([http://www.ncoa.org/improve-health/center-for-healthy-aging/content-library/PPR-Instructions\\_ACL\\_OMB\\_FINAL\\_expires\\_12-31-15.pdf](http://www.ncoa.org/improve-health/center-for-healthy-aging/content-library/PPR-Instructions_ACL_OMB_FINAL_expires_12-31-15.pdf)):
  - Double-space with 1-inch margins
  - Use a font size of 12, preferably Times New Roman.
  - Organize your report by the following headers: Title Page, Activities and Accomplishments, and Appendix.
  - Under the Activities and Accomplishments section, list the four questions included on the template, followed by your response.
- Please be thorough about any major or significant activities, but provide succinct information, using either a bulleted-list format or short sentences to convey your responses. We suggest that you limit your report to no more than 10-15 pages.
- Only include information that pertains to the specified period, not cumulative to date.
- See below for bulleted examples of what you may want to consider including under each question in the Activities and Accomplishments section.
- Include a quantitative report of your up-to-date participant and completer data from the CDSME National Database as Appendix A of the report. To download a pre-populated report, navigate to the Additional Reports tab (State Reports section) and select the appropriate reporting period under the Grantee Progress Reports header at the bottom of the page.
- Include a copy of each project product as additional Appendices and identify each by capital letters in sequence (i.e. Appendix B, C, etc.).
- If you have any questions, please contact your AoA Project Officer.
- Send your completed report within 30 days after each six-month reporting period to your AoA Project Officer and copy the following: Sean Lewis at [sean.lewis@aoa.hhs.gov](mailto:sean.lewis@aoa.hhs.gov); [grants.office@aoa.hhs.gov](mailto:grants.office@aoa.hhs.gov); and NCOA to the attention of Binod Suwal at [binod.suwal@ncoa.org](mailto:binod.suwal@ncoa.org).

### **Activities and Accomplishments Examples:**

1. What did you accomplish during this reporting period and how did these accomplishments help you reach your stated project goal(s) and objective(s)? Please note any significant project partners and their role in project activities.

*Please describe any relevant activities that occurred during this period related to the following:*

**Program Management and Statewide Leadership:** (describe partnership-building activities between public health, aging, or other state agencies or local partners; statewide coalition building or other new management/ leadership structures; new staff and their roles and responsibilities, etc.). For example:

- Hired project manager who will be responsible for [key roles, e.g. state-wide coordination of training and data entry].
- Established statewide Healthy Aging Coalition [or steering committee or other key planning/ advisory group] with x number of agencies. Held kickoff meeting on [date].

**Partnership Development:** (describe activities to build effective partnerships to embed CDSME programs into statewide health and long-term services and supports systems; note significant partners and their roles). For example:

- Established memorandum of understanding with x organization that has agreed to embed the CDSMP and offer it on a quarterly basis through its 12 sites.

**Statewide Infrastructure Development:** (describe how you are expanding delivery infrastructure/capacity to provide programs throughout your targeted geographic area including workforce development/ recruitment/ training or retention activities and new host organizations and implementation sites). For example:

- Obtained multi-site license from Stanford for the CDSMP and DSMP.
- Conducted master training in [location] on [dates] using Stanford T-trainers. X individuals completed the training.

**Centralized or Coordinated Logistical Processes for Recruitment, Referral, Enrollment, and Marketing:** (describe any new, innovative strategies to make it easier for potential participants to learn about and access programs and to improve overall program efficiencies). For example:

- Established process for clients (from ADRC, Medicaid, Tobacco quit line, SHIP, other agencies) to be referred to CDSMEs.
- In collaboration with CDC-funded state health department arthritis program, established state Healthy Aging website and marketing campaign which includes CDSME and other evidence-based program information and a workshop calendar.

**Business Planning and Financial Sustainability:** (describe any policy changes, planning activities, external funding received, or other activities related to helping to sustain your CDSME programs beyond the grant period). For example:

- Convened a Sustainability Task Force with x key stakeholders to develop a sustainability plan.
- X partner completed a business plan for implementing the DSMP with a Medicare provider.
- Received x amount of funding from (name of foundation, corporation, etc.)
- Completed NCOA cost calculator and determined average workshop cost to be X\$.
- Established CDSME as a covered service under the state's Medicaid waiver.

**Quality Assurance/Fidelity:** (include activities related to monitoring whether the CDSMEs are being implemented appropriately and grant objectives are being met). For example:

- Identified performance indicators and developed a quality assurance/ fidelity monitoring plan.
- Completed the following fidelity monitoring/ quality assurance activities during this period included: (e.g. five master trainers conducted 10 workshop site visits).

2. What, if any, challenges did you face during this reporting period and what actions did you take to address these challenges? Please note in your response changes, if any, to your project goal(s), objective(s), or activities that were made as a result of challenges faced.

*Describe key challenges related to partnerships, infrastructure and delivery system, coordinated processes, financial sustainability, and program fidelity/quality assurance and describe how you tried to address each challenge.*

For example:

- Had to cancel one workshop due to insufficient registration. Rescheduled the workshop at a different time and successfully filled the class.
- High rate of non-completers in one workshop. Called drop outs and discovered primary reason for dropouts was health problems.

3. How have the activities conducted during this project period helped you to achieve the measurable outcomes identified in your project proposal?

*Describe how your activities have helped you address your proposed outcomes such as the CDSME programs implemented, target number of completers, targeted populations (low-income, minority, rural, disabled, Native American, etc.), and geographic area covered.*

4. What was produced during the reporting period and how have these products been disseminated? Products may include articles, issue briefs, fact sheets, newsletters, survey instruments, sponsored conferences and workshops, websites, audiovisuals, and other informational resources.

*Possible resources to share include:*

- New print materials, e.g. business or quality assurance plans, how-to manuals, tip sheets, promotional materials
- Electronic, e.g. web addresses of new websites; listservs for leaders/ trainers
- Presentations at conferences (e.g. copies of PowerPoints)
- Reports (e.g. summaries of workshop satisfaction or outcome data)

**Prevention and Public Health Fund  
Chronic Disease Self-Management Education Grant  
Semi-Annual Performance Report for the State of XXXXXXX**

**Title Page**

**1. Grant Award Number:**

**2. Project Title:**

**3. Grantee Agency Name:**

**Address:**

**4. Project Director/Principle Investigator Name:**

**Telephone #:**

**Email:**

**5. Report Author Name(s):**

**6. Total Project Period:**

**7. Reporting Period:**

**8. Date of Report:**

**9. ACL Program Officer:**

**10. ACL Grants Management Specialist:**

**Prevention and Public Health Fund  
Chronic Disease Self-Management Education Grant  
Semi-Annual Performance Report for the State of XXXXXXX**

**Activities and Accomplishments**

1. What did you accomplish during this reporting period and how did these accomplishments help you reach your stated project goal(s) and objective(s)? Please note any significant project partners and their role in project activities.
2. What, if any, challenges did you face during this reporting period and what actions did you take to address these challenges? Please note in your response changes, if any, to your project goal(s), objective(s), or activities that were made as a result of challenges faced.
3. How have the activities conducted during this project period helped you to achieve the measurable outcomes identified in your project proposal?
4. What was produced during the reporting period and how have these products been disseminated? Products may include articles, issue briefs, fact sheets, newsletters, survey instruments, sponsored conferences and workshops, websites, audiovisuals, and other informational resources.



## CHRONIC DISEASE SELF-MANAGEMENT EDUCATION INTEGRATED SERVICES DELIVERY SYSTEM ASSESSMENT TOOL

We designed this tool to help you evaluate your progress in building a sustainable infrastructure for Chronic Disease Self-Management Education (CDSME) Programs and other evidence-based programs. The assessment covers six key elements of an integrated services delivery system: 1. leadership, 2. delivery infrastructure, 3. partnerships, 4. centralized and coordinated logistical processes, 5. business planning and financial sustainability, and 6. quality assurance and fidelity. We think the tool can help to determine where you might invest resources to build a stronger system.

Please remember to answer the survey questions from the perspective of your overall state—not areas within your state. While we understand that there will be some variation within states, and that some localities may have individual capacity, this tool is meant to ascertain the sustainability of the infrastructure and delivery system at the state-level. Please feel free to use the “additional comments” space following each element to provide further information about any areas you feel are unclear.

We ask that both of your state’s co-leads (state unit on aging and state health department) complete ONE tool together, with input from other partners as time allows.

For questions about the assessment, please contact Emily Dessem at [emily.dessem@ncoa.org](mailto:emily.dessem@ncoa.org) or 202-479-6627.

### Contact Information

Name of Primary Person Submitting the Survey

Agency Name

Email Address

Type of CDSME programs offered (Select all that apply)

- Chronic Disease Self-Management Program (CDSMP)
- Tomando Control de su Salud (Spanish CDSMP)
- Arthritis Self-Management Program (English)
- Arthritis Self-Management Program (Spanish)
- Chronic Pain Self-Management Program (CPSMP)
- Diabetes Self-Management Program (English)
- Diabetes Self-Management Program (Spanish)
- Positive Self-Management Program (HIV/AIDS)
- Better Choices, Better Health (Online CDSMP)
- Better Choices, Better Health for Diabetes (Online Diabetes)
- Better Choices, Better Health for Arthritis (Online Arthritis)
- Other: \_\_\_\_\_

## ELEMENT 1: LEADERSHIP

Effective leadership and project management includes a strong state unit on aging and state health department partnership, an integrated state vision, documented plan and mutually agreed-upon goals.

Please indicate which of the following is true in your state: (Select all that apply)

- Our state unit on aging and state health department have worked together to identify and target underserved geographic areas.
- Our state health department and unit on aging have an integrated and documented vision for evidence- based programming.
- Strategies to support CDSME or other evidence-based programming are included in our state unit on aging state plan.
- Strategies to support CDSME or other evidence-based programming are included in our state health department state plan.
- Strategies to support CDSME or other evidence-based programming are included in in another management body's state plan.
- There is a management structure (e.g. steering group, coalition, partner team etc.) including public health and aging that provides overall direction and leadership for CDSME in the state.
- Our state unit on aging and state health department have a signed agreement documenting responsibilities related to CDSME.
- None of the above.

How often do your state unit on aging and state health department meet?

- Weekly
- Monthly
- Quarterly
- Semi-annually
- Annually
- Other, please describe: \_\_\_\_\_

Do you have any existing organizational charts or other graphics that describe your state's structure for managing and delivering the CDSME program(s)?

- Yes.
- No.

Please select the key bodies that are involved in managing or directing CDSME activities at the state level:

- State unit on aging
- State health department
- State advisory council or other management team
- State coalition
- Foundation/ other oversight agency
- Other management body, please describe: \_\_\_\_\_

Which agencies are responsible for the following key functions?  
(Select all that apply for each agency)

	State unit on aging	State health department	Local Agencies	Other management body
Develops plan for expanding CDSME	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Convenes state advisory council/ other management structure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Holds CDSME license	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coordinates master trainings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Develops and/or coordinates marketing/ promotional activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manages website	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coordinates workshop calendar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Responsible for NCOA data entry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conducts fidelity and performance monitoring activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coordinates evaluation studies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recruits major partners/ host sites	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seeks funding support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provides technical support to trainers, leaders, sites	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Designates Agency staff to work on CDSME	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recruits and trains T-trainers/MTs/Lay leaders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please indicate the extent to which the following statement is true in your state: Our state currently has a strong leadership and project management team including public health and aging that will continue to lead CDSME efforts after AoA funding ends.

- To a large extent
- To a moderate extent
- To a small extent
- To a very small extent
- Not at all

Any additional comments:

## ELEMENT 2: DELIVERY INFRASTRUCTURE

To make certain that evidence-based programs are as “accessible as prescription medications” requires ensuring a delivery infrastructure with an adequate workforce that can support the number of workshops needed to ensure that programs can be delivered statewide to the targeted populations.

Which of the following elements are currently part of your CDSME delivery system?

(Select all that apply)

- An appropriate number of active CDSME master trainers to meet the needs for leader training.
- An adequate number of lay leaders to provide CDSME workshops across the state.
- A mechanism or system to track CDSME master trainers or leaders statewide.
- Ongoing communications, support, and other retention strategies for CDSME master trainers or leaders that are implemented across the state.
- Appropriate Stanford licensing to cover all implementation sites and planned number of workshops and trainings.
- A delivery structure in place that is capable of delivering CDSME programs throughout the state.
- None of the above.

How many active CDSME T trainers do you have in your state?

How many active CDSME master trainers do you have in your state?

How many active CDSME lay leaders do you have in your state?

What percentage of your state's counties would you estimate currently have enough sites and leaders to provide CDSME workshops at least twice a year?

- 100%
- 75-99%
- 50-74%
- 25-49%
- Less than 24%
- Don't know/unsure

What approximate percentage of your state's population is included in the counties where you are able to offer CDSME workshops at least twice a year?

- 100%
- 75-99%
- 50-74%
- 25-49%
- Less than 24%
- Don't know/unsure

Any additional comments:

### ELEMENT 3: PARTNERSHIPS

To ensure that programs are as available as possible and are sustained over time requires establishing effective partnerships with agencies that have effectively embedded CDSME and/or other evidence-based programs within their systems (i.e., the organization has incorporated CDSME into their ongoing operations), have multiple implementation sites throughout the state and/or can reach the targeted audiences.

Please indicate which of the following is true in your state:

(Select all that apply)

- We collaborate with agencies already reaching targeted underserved populations.
- Our partnerships include agencies with host sites with multiple implementation sites and/or capacity to scaling up statewide.
- We are effectively coordinating and integrating with existing CDSME and other community-based evidence-based prevention programs.
- We are coordinating with chronic care management programs and demonstrations being sponsored by physician groups and hospitals.
- We have signed agreements documenting responsibilities with all of our major partners.
- None of the above.

What percentage of your Area Agencies on Aging (AAAs) are part of your CDSME delivery system?

How do you interact with the Aging and Disability Resource Centers (ADRCs) in your state?

(Select all that apply)

- They serve as CDSME host sites.
- They serve as CDSME referral sites.
- They serve as CDSME implementation sites.
- They have integrated CDSME into their Options Counseling program.
- They have integrated CDSME into their Care Transitions program.
- We do not have ADRCs in our state.
- Other, please describe: \_\_\_\_\_

Besides the AAAs/ADRCs, who are your other major partners who have embedded CDSMEs into their ongoing activities or who have played other significant roles in helping you expand CDSMEs statewide?

(Select all that apply)

	Embedded program	Provides statewide delivery system	Referral Source	Funding source	License holder
Advocacy/support groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Agencies that reach rural populations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Area health education centers (AHECs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assisted Living Facilities/Continuing Care Retirement Communities (CCRCs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Centers for Independent Living (CILs)(or other groups working with people with disabilities)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Civic groups (e.g. Rotary Club, women’s group, Kiwanis, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cooperative extension centers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Corporations /for-profit groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Department of corrections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ethnic/minority agencies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Faith-based organizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Federally Qualified Health Centers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foundations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Groups working with people with disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health insurers/health plans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospitals/ health care systems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental/behavioral health care providers/clinics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Native American tribal organizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Primary care practice/local health organizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality Improvement Organizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retiree groups/ groups for adults 55+	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Senior Community Service Employment Program (SCSEP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Senior housing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse Prevention/Treatment facilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
University/academic institutions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Veteran’s Administration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worksite programs/employee benefits programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
YMCA’s and Recreation Centers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Are there other organizations in your state that hold a CDSME license who were not funded through your current AoA grant?

- Yes
- No

Please list the agencies and describe how they have been integrated within your system (e.g. do they share workshop data with you?):

Which of the following sources provide referrals to your evidence-based health program system? (Select all that apply)

- Aging and Disability Resource Centers (ADRCs)
- Tobacco cessation programs/quit lines
- State Health Insurance Assistance Program (SHIP)
- State Health Insurance Exchange
- Health care systems (including physicians, HMOs and Retiree Benefits Plans)
- Local public health agencies
- Cross-referrals from other evidence-based programs
- Medicaid
- Medicaid Waiver
- Medicaid Managed Care
- Medicaid Dual Eligible Plans
- Other, please specify:

Please indicate the extent to which the following statement is true in your state: We have at least two major partners/ host organizations (outside of AAAs/ADRCs) that have embedded the CDSME into their delivery system and are offering the workshops in multiple implementation sites throughout the state.

- To a large extent
- To a moderate extent
- To a small extent
- To a very small extent
- Not at all

Any additional comments:

#### **ELEMENT 4: CENTRALIZED & COORDINATED PROCESSES**

Centralized and coordinated logistical processes need to be in place for optimal efficiency, to decrease costs and to ensure that potential participants hear about and enroll in the program as easily as possible and receive consistent service.

Which of the following are currently in place for CDSME in your state?

(Select all that apply)

- A statewide brand name for your evidence-based initiatives.
- A statewide brand name for your CDSME programs.
- An ongoing public relations plan with multiple promotional strategies.
- Standardized CDSME marketing materials
- A formal process for using former participants or other ambassadors to promote the program.
- A statewide website for CDSME.
- A statewide workshop calendar for CDSME.
- A statewide toll-free number for CDSME.
- A single or coordinated referral mechanism.
- At least one major partner using an electronic medical record referral system.
- Online registration for CDSME.
- A statewide mechanism for tracking wait time or a waitlist.
- A consistent or coordinated intake, enrollment and registration process.
- Ongoing activities to educate potential advocates and decision makers about CDSME in your state.
- Agency bulletin boards for CDSME.
- Mass mailings for CDSME.
- Bulk or coordinated ordering of CDSME materials for the state.
- Regular in-service or update training around CDSME.
- A listserv or other information sharing tool for CDSME personnel and stakeholders.
- Coordinated data reporting and entry procedures.
- None of the above.

Please share the statewide brand name for CDSME (if applicable):

Please share the web address for your CDSME website (if applicable):

Please share the web address for your Workshop calendar (if applicable):

Please share your states toll free number (if applicable):

Please describe if/how are referrals tracked/is there reporting back to referring organization when participants enroll?

Do you track the number of T-trainers, master trainers and leaders and their training and workshop activity?

- Yes
- No

Who does this tracking and how?

In addition to CDSME, do you cross-promote or use your CDSME distribution system to deliver any other evidence-based health promotion and disease prevention programs?

(Select all that apply)

- A Matter of Balance
- Active Living Every Day
- Fit and Strong!
- EnhanceWellness
- EnhanceFitness
- Program to Encourage Active Rewarding Lives (PEARLS)
- Healthy IDEAS
- Arthritis Foundation Walk with Ease Program
- Arthritis Foundation Exercise Program
- Arthritis Foundation Tai Chi Program
- Other:

Please indicate the extent to which the following statement is true in your state: We have a coordinated, state-wide process for program marketing, referral, and recruitment, including a plan for using multiple, ongoing, promotional activities.

- To a large extent
- To a moderate extent
- To a small extent
- To a very small extent
- Not at all

Any additional comments:

#### **ELEMENT 5: BUSINESS PLANNING AND FINANCIAL SUSTAINABILITY**

To maintain their evidence-based programs, states must have a business infrastructure including an accounting/

financial system to document program expenses and have a demonstrated capacity to fund programs after the grant period.

Which of the following are currently in place in your state?

(Select all that apply)

- A CDSME business plan (i.e., a management tool to guide planning for financial sustainability and to assist in seeking support from other organizations)
- A CDSME sustainability plan (i.e., plan that focuses on the management and acquisition of fiscal and in-kind resources to expand and sustain programming).
- A requirement that community partners complete a CDSME business or sustainability plan.
- Calculated and accurate operating costs for CDSME.
- An established per participant cost for CDSME.
- An established rate for programs using costs and local market information.
- An established annual operating budget for CDSME.
- Break-even analysis (calculation of how many workshops and participants you need to break even with income and expenses).
- Cash flow management system established (includes accounts receivable and payable systems to track and manage revenue and payment of expenses).
- Regularly monitored operational performance through monthly financial statements and accounts receivable reports.
- Partnerships with healthcare organizations to provide CDSME.
- Use of a consumer survey or needs assessment in business planning.
- None of the above.

What are your calculated operating costs for CDSME (if applicable):

What is your established per participant cost for CDSME (if applicable):

What is your established "sell" rate at which you can provide programs using costs and local market information (if applicable):

What is your established annual operating budget for CDSME (if applicable):

Are any of your sites currently charging a fee for participation in a CDSME program?

- No
- Yes. Please share the range of fees: \_\_\_\_\_

Which of the following additional sources of funding (besides the CDSME grant funds) is your state using to support the evidence-based program system?

(Select all that apply)

- Older Americans Act, Title IIID.
- Older American Act – Other.
- Affordable Care Act Initiatives.
- Medicare - DSMT.
- Medicare
- Medicaid Waiver.
- Medicaid Managed Care.
- Medicaid State Plan (Long-term Services and Supports).
- Medicaid Dual Eligible Plan.
- Foundation support or other non-ACL grants.
- Health plan.
- Fee for service.
- Accountable Care Organization.
- Care Transitions
- CDC – Arthritis.
- CDC – Diabetes.
- CDC – Heart Disease.
- CDC – Coordinated Chronic Disease.
- CDC – Injury Prevention.
- CDC – Communities Putting Prevention to Work.
- CDC – Other.
- CMS Innovation Funds.
- National Association of Chronic Disease Directors (NACDD).
- None of the above.
- Other, please specify:

Please identify your Medicaid waiver:

Please describe your other CDC funding:

Please identify your other Older Americans Act funding:

In which ways has your state been able to collaborate with Medicaid for evidence-based programs?

(Select all that apply)

- We are partnering on Affordable Care Act Initiatives related to evidence-based programs.
- We have reimbursement for program participation through a Medicaid waiver plan.
- We have reimbursement for program participation through the state Medicaid plan.
- We are working on reimbursement but have not yet received reimbursement for program participation.
- We have a good working knowledge about how our state Medicaid system works.
- None of the above.
- Other, please specify: \_\_\_\_\_

Please describe how you are partnering on Affordable Care Act Initiatives related to evidence-based programs:

Please indicate the extent to which the following statement is true in your state: We have an effective business or sustainability plan and processes in place to fund CDSME after the grant period.

- To a large extent
- To a moderate extent
- To a small extent
- To a very small extent
- Not at all

What are you doing that seems to be most effective in helping you sustain the CDSME activities in your state (e.g. policies, sustainability planning activities, financial sustainability efforts, plans for applying for grants, etc.)?

Any additional comments:

## **ELEMENT 6: QUALITY ASSURANCE & FIDELITY TO INTERVENTIONS**

To ensure effective, quality programs and efficient delivery and distribution systems, states should develop quality assurance (QA) plans and have ongoing data systems and procedures in place that address: 1) Continuous Quality Improvement (CQI) and 2) Program Fidelity. CQI is a cyclical process that includes setting performance objectives, monitoring, evaluating what is or is not working and problem-solving, and making corrective changes as needed. Program Fidelity is one aspect of quality assurance that focuses on monitoring the extent to which an evidence-based program is delivered consistently by all personnel across sites, according to program developers' intent and design.

How would you describe your state's current approach to fidelity?

- Our state program has implemented its fidelity monitoring plan.
- Our state program has a fidelity monitoring plan, which we have not yet implemented.
- Fidelity monitoring activities are taking place in some sites, without state-wide coordination or leadership.
- We have begun developing a state-wide fidelity monitoring plan, but we don't currently have one.
- We do not have a fidelity monitoring plan, state-wide nor site-specific.

Which of the following are part of your state's fidelity system and processes?

(Select all that apply)

- The Stanford Implementation/Fidelity Manual is used throughout the state.
- Fidelity standards are disseminated throughout the state.
- Standard fidelity check list forms have been developed for each week of the workshop and are used for all fidelity checks.
- A system of regional mentors is in place to facilitate fidelity monitoring, coaching, and technical assistance.
- Training webinars are held for fidelity monitors.
- Fidelity checks are conducted for new leaders during their first workshop.
- New leaders are required to conduct a workshop within 4-6 months of training.
- Leaders sign an MOU agreeing to follow fidelity manual/fidelity protocols.
- Quarterly observation is conducted from a Master Trainer or trained fidelity monitor.
- Leaders are observed once per year.
- Annual master trainer reviews are held.
- On-site technical assistance visits are conducted with leaders.
- Workshop data is tracked to monitor potential fidelity issues.
- Leader evaluation forms are used to monitor fidelity.
- Enhanced leader training on fidelity process and tools is provided.
- Monthly, quarterly, or semi-annual reports on fidelity monitoring process and outcomes are collected.
- An online database is used to monitor quality, reach and effectiveness.
- Fidelity reporting is collected by an outside contractor.
- A fidelity group meets regularly to address fidelity issues.
- Fidelity monitoring tools are posted on the statewide CDSME website.
- New leaders are paired with experienced leaders to increase program fidelity.
- None of the above.

Which of the following are part of your state's quality assurance/quality improvement system and processes?

(Select all that apply)

- A written quality assurance plan that addresses both CQI and fidelity monitoring.
- Identification of performance indicators developed with input from key partners and other stakeholders.
- Ongoing processes for leadership to review fidelity monitoring and performance indicators.
- Specification of designated roles, responsibilities and timelines for fidelity monitoring and other quality assurance activities.
- Orientation of the team (program coordinators, host sites and partners) about the quality assurance plan and system.
- A system for feedback to involved personnel and stakeholders.
- A system for making corrective changes as needed with the aim of improving overall performance and enhancing participant satisfaction.
- A system for using metrics and data to continuously improve quality and system performance.
- None of the above.

Please indicate the extent to which the following statement is true in your state: We have a quality assurance plan and ongoing mechanisms in place to monitor fidelity and to ensure continuous quality improvement.

- To a large extent
- To a moderate extent
- To a small extent

- To a very small extent
- Not at all

Are you conducting evaluation work or planning to do so?

- Yes
- No

Please describe your evaluation work:

Any additional comments:

## Participant Information Survey

**Instructions:** Please use a pen to answer the questions on both sides of this form. Please print clearly. Mark your choice within the box, like this:

Your Name (or other way to identify you): \_\_\_\_\_

1. What is your date of birth?   /   /       
Month Day Year

2. What is your ZIP code?

3. What is your sex?

Female  Male

4. Are you of Hispanic, Latino, or Spanish origin?

Yes  No  Unknown

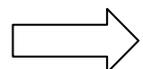
5. What is your race? (Mark all that apply.)

- American Indian or Alaska Native
- Asian
- Black or African-American
- Native Hawaiian or Other Pacific Islander
- White

6. Has a health care provider ever told you that you have any of the following chronic conditions? (Please mark all that apply.)

- |   |   |
|---|---|
| <input type="checkbox"/> Alzheimer's or Related Dementia                              | <input type="checkbox"/> High Cholesterol                   |
| <input type="checkbox"/> Arthritis/Rheumatic Disease                                  | <input type="checkbox"/> Hypertension (High Blood Pressure) |
| <input type="checkbox"/> Breathing/Lung Disease (Asthma, Emphysema, Bronchitis, etc.) | <input type="checkbox"/> Multiple Sclerosis                 |
| <input type="checkbox"/> Cancer or Cancer Survivor                                    | <input type="checkbox"/> Osteoporosis (Low Bone Density)    |
| <input type="checkbox"/> Chronic Pain   | <input type="checkbox"/> Stroke                             |
| <input type="checkbox"/> Depression or Anxiety Disorders                              | <input type="checkbox"/> Other Chronic Condition:           |
| <input type="checkbox"/> Diabetes   | _____   |
| <input type="checkbox"/> Heart Disease  | <input type="checkbox"/> None (No Chronic Conditions)       |

Please turn over



Your Name (or other way to identify you): \_\_\_\_\_

7. During the past year did you provide regular care or assistance to a friend or family member who has a long-term health problem or disability?

Yes     No

8. Are you limited in any way in any activities because of physical, mental, or emotional problems?

Yes     No

9. Today, how many people live in your household (including yourself)?

(Number of people)

10. What is the highest grade or year of school you completed?

- Some elementary, middle, or high school
- High school graduate or GED
- Some college or technical school
- College 4 years or more

# Your Program Name

---

## Workshop Information Cover Sheet

---

**Instructions to the Group Leaders: Please provide the requested details about this Workshop. Please print clearly. Use this as a cover sheet for the completed data collection forms to return to the Survey Coordinator.**

1. Site Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
County: \_\_\_\_\_

2. Name of organization licensed to offer program: \_\_\_\_\_

3. Workshop Leaders' Names (please provide full first and last names). If we may contact you with questions about these forms, please provide your daytime phone number as well.

\_\_\_\_\_      \_\_\_\_\_       Staff  Volunteer Ph: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
First Name      Last Name

\_\_\_\_\_      \_\_\_\_\_       Staff  Volunteer Ph: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
First Name      Last Name

4. Workshop Start Date (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
End Date (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_\_

5. Did you offer a "Session 0" with this workshop? (Session 0 is an optional pre-workshop session. Not all workshops offer a Session 0.)

- Yes
- No
- Don't know

6. What type of workshop is this? (Mark only one.)

- Chronic Disease Self-Management Program (CDSMP)
- Tomando Control de su Salud (Spanish CDSMP)
- Diabetes Self-Management Program (DSMP)
- Tomando Control de su Diabetes (Spanish DSMP)
- Arthritis Self-Management Program (ASMP)
- Programa de Manejo Personal de la Artritis (Spanish ASMP)
- Positive Self-Management for HIV
- Chronic Pain Self-Management Program
- Other, list name: \_\_\_\_\_

---

## **Workshop Information Cover Sheet—continued**

---

7. Please check which language you used when leading this workshop:

- English  Spanish  Arabic  Bengali  Chinese  Dutch  French  German  
 Greek  Hindi  Italian  Japanese  Korean  Khmer  Norwegian  Punjabi  
 Russian  Somali  Swedish  Tagalog  Tamil  Turkish  Vietnamese  Other: \_\_\_\_\_

8. Number of participants *enrolled* (attending at least 1 session\*): \_\_\_\_\_

9. Number of participants who *completed at least 4 sessions*\*: \_\_\_\_\_

\* Excluding "Session 0"

10. Number of *Participant Information Surveys* included in the returned packet: \_\_\_\_\_

If the number of forms is fewer than the number of participants noted in #8 above, please provide a brief explanation (e.g., illness, refusal, loss or destruction of forms, etc.):

\_\_\_\_\_

11. If you charged the participants a fee to attend this workshop, please indicate the amount:

\_\_\_\_\_

### **Forms Checklist Examples**

#### ***Sample instructions if Group Leaders will return all forms at one time:***

Please return the following forms to the Survey Coordinator (contact information below) within one week after the final session:

- This *Workshop Information Cover Sheet*
- Attendance Log*
- All completed *Participant Information Surveys*

#### ***Sample instructions if Group Leaders will return forms as they are completed:***

- After the first session, complete items 1-7 of this form. Make a copy.
- Return this copy along with the completed *Participant Information Surveys* to the Survey Coordinator (contact information below) within one week of workshop completion.
- Keep the original of this form. At the conclusion of the workshop, complete items 8-10 of the original of this form and send with the *Attendance Log* to the Survey Coordinator (contact information below) within one week after the final session.

[Survey Coordinator Contact Info]











