

PROGRAM DESCRIPTIONS

Western Reserve Area Agency on Aging
Request for *Letters of Intent* to apply for 2011 and 2012 Funding

Description of Funded Programs

Each applicant is encouraged to review the program descriptions in this document before responding to the questions in the *Letter of Intent Notice*. Organizations selected to submit a complete proposal must demonstrate a capacity to successfully implement the programs as described in this document.

Category I: System of Access

This systems development initiative includes three (3) components:

- Aging and Disability Resource Centers (ADRC)
- Benefits Enrollment Centers (BEC)
- Information and Referral Assistance Programs (I&R/A)

Category II: Evidence Based Health Promotion Programs

This systems development initiative includes two (2) components:

- Chronic Disease Self Management Program (CDSMP)
- Matter of Balance (MOB)

Aging and Disability Resource Centers (ADRC)

The table below outlines the program components of an Aging and Disability Resource Center.

Program Component	Criteria/Description	Activities/ Metrics
<p>Awareness And Information</p>	<p>Public education; information on long-term support options.</p> <ul style="list-style-type: none"> • ADRCs serve as highly visible and trusted places where people can turn for the full range of long-term support options. • ADRCs actively promote public awareness of both public and private long-term support options, as well as awareness of the ADRC, including underserved and hard-to-reach populations, and consumers at risk of institutionalization. 	<p>The ADRC has proven outreach and marketing plan focused on outreach and community education that takes into consideration:</p> <ul style="list-style-type: none"> ○ culturally diverse, underserved and unserved populations, their family caregivers, individuals at risk of nursing home placement, and the professionals who serve them ○ the identification of unique needs of the different populations being served; ○ a strategy to assess the effectiveness of the outreach and marketing activities; and ○ a feedBECK loop to modify activities as needed. <p>ADRC staff have access to a comprehensive resource database which includes information about the range of long term support resources in the ADRC service area.</p> <p>- Resources included in the database conform to established Inclusion/Exclusion policies</p>

Program Component	Criteria/Description	Activities/ Metrics
<p>Assistance</p>	<p>Long-term support options counseling; benefits counseling; referral to other programs and benefits; crisis intervention; helping people to plan for their future long term needs.</p> <ul style="list-style-type: none"> • The ADRC will provide information and counseling to help people assess their potential need and eligibility for all available long-term support options, both public and private. • ADRC has the capacity to link consumers with needed support through appropriate referrals to other programs and benefits and has the ability to track client intake, needs assessment, and care plans. • ADRC has established collaborative relationships with programs that provide home and community-based services including SHIP, NFCSP, Alzheimer's Disease services, health promotion and disease prevention programs, transportation, employment, housing, adult education and others. • ADRC consistently conducts 	<ul style="list-style-type: none"> - A system is in place for updating and ensuring the accuracy of the information provided. - The database is accessible to the public via a comprehensive website and is user friendly, searchable and accessible to persons with disabilities. - The ADRC may have a single or multiple entry points within the service area. All agencies operating entry points (operating partners) have access to the same comprehensive resource database and provide consistent and uniform information. <p>ADRC actively markets to and serves private pay consumers in addition to those that require public assistance.</p> <p><u>Options Counseling</u> ADRC has the capability, either through a single operating organization or through close coordination among operating partners, to provide accurate and comprehensive long term support options counseling to any consumer who requests it.</p> <ul style="list-style-type: none"> • All ADRC entry point agencies use standard intake and screening instruments • Protocols are in place to identify consumers who will be offered options counseling. At a minimum, this will include consumers who have gone through a comprehensive assessment process. • Options counseling sessions: <ul style="list-style-type: none"> ○ are conducted by staff trained and qualified to provide objective assistance to consumers in the process of making informed decisions, as evidenced by certification requirements and/or training/cross-training practices. ○ are provided in a uniform manner to all ADRC consumers with the use of protocols or standard operating procedures; and ○ entail individualized assistance for consumers of all income levels; • ADRC can demonstrate evidence that options counseling provided enables people to make

Program Component	Criteria/Description	Activities/ Metrics
	<p>follow-up when needed to determine outcome of options counseling.</p> <ul style="list-style-type: none"> • ADRC enables people to make informed, cost-effective decisions about long term care. • ADRC has process to ensure that people are connected to the appropriate crisis intervention services. • ADRC assists individuals to plan for future long-term care needs. 	<p>informed, cost effective decisions about long-term care services.</p> <p><u>Information and Referral</u></p> <ul style="list-style-type: none"> • ADRC uses systematic processes across all entry points to provide information, referral and access to services. These services include, at a minimum: <ul style="list-style-type: none"> - Public benefits (OAA, Medicaid, Medicare including new Medicare Modernization Act benefits, state revenue programs and others) - Employment - Health promotion/disease prevention - Transportation - Crisis/Emergency services - Services for family caregivers - Residential care including assisted living <p><u>Referrals and Follow Up</u></p> <ul style="list-style-type: none"> • ADRC has the ability to track referrals made. • ADRC consistently conducts follow-up to determine outcome of options counseling. <p><u>Crisis Intervention</u></p> <ul style="list-style-type: none"> • ADRC responds to situations requiring short-term assistance to support an individual until a plan for long-term support services is in place. <p>Short-term case management is available as needed for all target populations and provided directly by ADRC (by at least one operating partner in multiple entry point system), or is contracted out.</p> <p><u>Future Long Term Support Needs Planning</u> The ADRC educates consumers regarding long term care planning</p> <p>ADRC provides futures planning directly or contractually by staff that possesses specific skills related to LTC needs planning and financial counseling.</p>
Access	Eligibility screening; assistance in gaining access to private-pay long-term support services; comprehensive assessment; programmatic eligibility	<p><u>Intake and Screening</u></p> <ul style="list-style-type: none"> • ADRC has a single, standardized entry process for accessing public and private services. In multiple entry point systems, the entry process is coordinated and

Program Component	Criteria/Description	Activities/ Metrics
	<p>determination; Medicaid financial eligibility determination that is integrated or closely coordinated with the Resource Center services; one-stop access to all public programs for community and institutional long-term support services.</p> <ul style="list-style-type: none"> • ADRC serves as the entry point to publicly funded long term care. • ADRC has in place necessary protocols and procedures to facilitate access (intake, eligibility, assessment) to public programs that is integrated or so closely coordinated that the process is seamless for consumers. • ADRC support helps to reduce the cost of long term care by delaying or preventing the need for more expensive public long term care services. 	<p>standardized so that consumers experience the same process wherever they enter the system.</p> <ul style="list-style-type: none"> • For ADRCs with multiple entry points, the entry processes are overseen by a coordinating entity. • ADRC uses uniform criteria across sites to assess risk of institutional placement in order to target support to individuals at high-risk. <p><u>Financial and Functional Eligibility Processes</u></p> <ul style="list-style-type: none"> • Financial and functional eligibility determination processes for public programs are highly coordinated. • ADRC staff conduct level of care assessments that are used for determining functional eligibility, or ADRC has a formal process in place for seamlessly referring consumers to the agency that conducts level of care assessments. <p><u>Tracking Eligibility Status</u></p> <ul style="list-style-type: none"> • ADRC is able to track individual consumers' eligibility status throughout the process of eligibility determination and redetermination. • In localities where waiting lists for public LTC programs or services exist, there is a process by which the ADRC is informed of consumers who are on the waiting list and the ADRC conducts follow-up with those individuals. • There is a process by which the ADRC is informed of consumers who are determined ineligible for public LTC programs or services and the ADRC conducts follow-up with those individuals
<p>Target Populations</p>	<p>Initially, ADRC grantees must serve the elderly and at least one target population of people with disabilities (e.g. physical; developmental/mental retardation; mental illness).</p> <p>ADRCs should move towards the goal of serving persons with disabilities of all ages and types.</p>	<ul style="list-style-type: none"> • ADRCs serve individuals with all types of disabilities, either through a single operating organization or through close coordination with operating partners. • ADRC demonstrates competencies relating to serving people of all ages and types of disabilities. • ADRC is accessible to all of the populations it serves. • The ADRC tracks the number of actual individuals served against the resident population estimate, by target population.

Program Component	Criteria/Description	Activities/ Metrics
Critical Pathways to Long Term Support	ADRCs will create formal linkages between and among the critical pathways to long-term support.	<ul style="list-style-type: none"> • ADRC has formal linkages with critical pathway providers such as hospitals, physician's offices, nursing homes that involve all three of the following components that are updated on an ongoing basis: <ol style="list-style-type: none"> (1) Providing training and education about the ADRC to Critical Pathway Providers (CPPs) (2) Establishing protocols for referrals, particularly with hospitals and LTC facilities.
Partnership & Stakeholder Involvement	<p>ADRCs must establish strong partnerships with the State Health Insurance Assistance Program (SHIP) and other programs instrumental to ADRC activities.</p> <p>Examples of other programs, Area Agencies on Aging, Centers for Independent Living, Developmental Disabilities Councils, Information and Referral/2-1-1 programs, Long-Term Care Ombudsman programs, housing agencies, transportation authorities, State Mental Health Planning Councils, One-Stop Employment Centers and other community-based organizations.</p> <p>ADRCs must meaningfully involve stakeholders, including consumers, in planning, implementation and evaluation activities.</p>	<p><u>Aging and Disability Partners</u></p> <ul style="list-style-type: none"> • There is evidence of collaboration, including formal agreements, at the state and local levels between aging and disability partners. • ADRC has protocols for information sharing and cross-training across entry point operating partners and with other critical aging and disability services partners in the community. <p><u>Stakeholders</u></p> <ul style="list-style-type: none"> • There is evidence of strong collaboration with programs and services instrumental to ADRC activities including home and community-based service providers, residential care alternatives including assisted living, institutional care providers, hospitals and other critical pathways and others. <p><u>Consumers</u></p> <ul style="list-style-type: none"> • Formal mechanisms for consumer involvement have been established.
IT/MIS	ADRCs must have management information systems including tracking client intake, needs assessment, care plans, utilization and costs.	<ul style="list-style-type: none"> • ADRC uses a management information system that can support the program functions. • ADRC can submit evidence of reports on the following: <ul style="list-style-type: none"> ○ # of contacts received YTD ○ # of unduplicated clients YTD ○ # of clients receiving options counseling and other types of assistance

Program Component	Criteria/Description	Activities/ Metrics
		<ul style="list-style-type: none"> ADRC has established an efficient process for sharing information electronically with external entities, as needed from intake to service delivery. In multiple entry point systems, all entry points use MIS that allows for electronic exchange of resource and client data across entry points and with other partners, as appropriate.
Staffing and Resources	<p>To be viable and sustainable, ADRCs must demonstrate:</p> <ul style="list-style-type: none"> Adequate staff capacity Commitment to quality Conflicts of interest among operating entities and partners have been addressed Staff training gaps are routinely identified and addressed Private and public funding opportunities are pursued 	<ul style="list-style-type: none"> ADRC has adequate capacity to assist consumers in a timely manner with long term support requests and referrals, including referrals from critical pathway providers. ADRC has an individual assigned to be the overall director/manager/coordinator of all ADRC operations. It is particularly important to have an overall coordinator or manager with sufficient authority to maintain quality processes when ADRC functions occur in more than one location or agency. ADRCs conduct annual assessment of all potential ADRC funding sources.
Quality Assurance and Quality Assurance and Evaluation Activities	<p>At a minimum, ADRCs must have performance goals and indicators related to visibility, ease of access, consumer focus, efficiency and effectiveness.</p>	<ul style="list-style-type: none"> ADRC is measuring performance related to the established indicators ADRC can demonstrate ability to develop reports summarizing issues and making recommendations for corrective action or quality improvement based on performance indicators. ADRC has used information obtained from consumer satisfaction evaluations to improve performance.

Benefits Enrollment Centers (BEC)

The table below outlines the essential program components of a Benefits Enrollment Centers (BEC).

Program Component	Criteria/Description	Activities/ Metrics
Partnership	The <i>BECs</i> are part of the WRAAA Front Door System	<ul style="list-style-type: none"> • <i>BECs</i> are WRAAA Front Door Partners and participate in collective training and marketing as appropriate. • A representative of the <i>BECs</i> participates in regular meetings for coordination of efforts and ongoing program development and improvement.
Personnel Management, Supervision, and Training	To be viable and sustainable, <i>BECs</i> must demonstrate: <ul style="list-style-type: none"> • Adequate staff, volunteer, or other worker capacity • Commitment to quality • That conflicts of interest among operating entities and partners have been addressed • That staff training gaps are routinely identified and addressed 	<ul style="list-style-type: none"> • <i>BECs</i> have adequate capacity to assist consumers in a timely manner with benefits screening, assistance with applications, and follow-up. • <i>BECs</i> have an individual assigned to be the overall director/manager/coordinator of all BAP operations. • <i>BECs</i> have a process in place for monitoring the performance of team members. • <i>BECs</i> have policies and procedures in place for orientation of new team members and ongoing training about specific benefits, use of software, and processes for effective communication with consumers.
Service Delivery and Operations	The <i>BECs</i> will provide benefits assistance services, which include screening, assistance with completing and submitting applications, and follow-up to verify submission and enrollment.	<p>The <i>BECs</i> use multiple modes for consumers to access services including in person and by phone.</p> <p>The <i>BECs</i> physical sites are well marked and clearly identifiable.</p> <p>The <i>BECs</i>' offices are located in places convenient and accessible and that ensure confidentiality.</p> <p>The <i>BECs</i> maintain regular business hours and may be open weekends and evenings with telephone services available during regular business hours with a live person and answering service after hours.</p> <p>The <i>BECs</i> respond to phone messages in a timely manner.</p> <p>The <i>BECs</i> ensure that personnel are trained in Benefits CheckUp and Ohio Benefits Bank software and are proficient using the Social Security Administration's software.</p> <p>The <i>BECs</i> ensure that personnel are knowledgeable about the primary benefits for which older adults and adults with disabilities would apply for and that they are comfortable working with consumers and answering their questions.</p> <p>The <i>BECs</i> attempt to assist consumers apply for benefits that afford the greatest financial benefits.</p>

Program Component	Criteria/Description	Activities/ Metrics
Outreach and Marketing	<p>Public education and information on available public benefits is provided.</p> <ul style="list-style-type: none"> • <i>BECs</i> serve as highly visible and trusted places where people can turn for assistance with applying for public benefits. • <i>BECs</i> actively promote public awareness of public benefits, especially to underserved, hard-to-reach populations. 	<p>The <i>BECs</i> have a procedure in place for personnel to verify and record submission of applications and enrollment in the benefits.</p> <p>The <i>BECs</i> use the Access Your Benefits brand in all outreach and marketing.</p> <p>The <i>BECs</i> have a proven outreach and marketing plan that takes into consideration:</p> <ol style="list-style-type: none"> 1. culturally diverse, underserved and un-served populations; 2. identification of unique needs of the different populations being served; 3. establishment of community relationships in the respective service areas for referrals to AYB; 4. strategies to assess the effectiveness of outreach and marketing activities; and 5. a feedback loop to modify activities as needed. <p>The <i>BECs</i> actively market the service in their respective service areas to locate the un-served populations.</p> <p>The <i>BECs</i> use a variety of marketing approaches to reach un-served populations: written materials, participation at community fairs, mailings, media, etc. that are tailored for special populations.</p> <p>The <i>BECs</i> integrate their benefits assistance work with their other departments or divisions to ensure that all targeted agency consumers have the opportunity to be screened and apply for needed benefits.</p> <p>The <i>BECs</i> have access to a comprehensive electronic database of benefits that impact older adults and adults with disabilities such as the Benefits CheckUp software for screening.</p> <p>The <i>BECs</i> have procedures in place for record keeping and assessment of the outreach and marketing activities.</p>
IT/MIS Capacity and Support	<p><i>BECs</i> have management information systems for tracking consumers receiving benefits assistance.</p>	<p>The <i>BECs</i> have adequate hardware and software for a management information system that can support the program function.</p> <p>The <i>BECs</i> have adequate software to track consumers over time to verify submission, enrollment, and the specific benefits individual consumers apply for.</p> <p>The <i>BECs</i> provide adequate training in the use of software and IT support as needed.</p> <p>The <i>BECs</i> have written policies concerning the collection, analysis, and reporting of consumer and service data and adequate monitoring of data entry.</p>

Program Component	Criteria/Description	Activities/ Metrics
		The <i>BECs</i> have formal policies regarding data security and confidentiality with staff trained in these areas.
Evaluation	<i>BECs</i> must have performance goals related to the number of targeted individuals that will submit one or more benefits applications.	<p>The <i>BECs</i> measure their performance related to the established goal.</p> <p>The <i>BECs</i> use information obtained from consumer satisfaction evaluation to improve performance.</p> <p>The <i>BECs</i> have a plan in place to monitor program quality and a process to ensure continuous program improvement through the use of the data gathered.</p>

Information and Referral Assistance Programs (I&R/A)

The table below outlines the program components of an Information and Referral Assistance Program (I&R/A). These program components are based on standards developed by the Alliance of Information and Referral Systems (AIRS). The purpose of these standards is to establish reference points that define expected practices. These standards serve as indicators of service quality and effectiveness.

Program Component	Criteria/Description	Activities/ Metrics
Assessment and Referral Provision	<p>The I&R/A service shall conduct an assessment in which the inquirer has one-to-one interaction with an I&R/A specialist. The assessment process consists of active listening and effective questioning to determine the needs of the inquirer, clarifying the need, identifying appropriate resources, selecting appropriate delivery mode(s), making referrals to organizations capable of meeting those needs, and providing enough information about each organization to help inquirers make an informed choice.</p> <p>In situations where services are unavailable, the I&R/A service shall engage in problem solving to help the inquirer identify alternative strategies</p>	<p>The I&R/A service provides barrier-free access to its services for individuals and groups who have special needs, e.g., access via applicable technology and/or communication methods for people with hearing or speech impairments; language access for inquirers who speak languages other than English; and physical access for people with disabilities if the I&R/A service assists inquirers at its facility.</p> <p>The I&R/A service ensures that staffing is structured to meet the needs of callers, i.e., that the optimum number of staff are available at the times most inquiries occur.</p> <p>The I&R/A service is expected to provide information to the community 24 hours per day, year round. The I&R/A service provides live answers during operating hours and offers live answer options via a detailed message after hours. Live answer is provided directly by its own staff or by another agency with which the I&R/A service has a formal, written agreement.</p>
Information Provision	The I&R/A service shall provide information to an inquirer in response to a direct request for such information. Information can range from a limited	<p>The I&R/A service clarifies the inquirer's initial request for information because information requests do not always accurately reflect the inquirer's actual needs and there may be an underlying or unstated problem.</p> <p>Information is accurate and pertinent to the request of</p>

Program Component	Criteria/Description	Activities/ Metrics
	<p>response (such as an organization's name, telephone number, and address) to a detailed description of community service systems (such as explaining how intake works for a particular agency), agency policies, and procedures for application. Active listening is necessary to establish a positive contact with the inquirer, understand context and provide an appropriate response.</p>	<p>the inquirer.</p> <p>The I&R/A service encourages re-contact by the inquirer if the initial information proves to be incorrect, inappropriate or insufficient to link the individual with needed services.</p> <p>The I&R/A service accurately records the nature of the inquiry, the problems/needs addressed by the inquiry if confirmed and, if applicable, the organization discussed in the course of the inquiry, for use in reports.</p>
Crisis Intervention	<p>The I&R/A service shall be prepared to assess and meet the immediate, short-term needs of inquirers who are experiencing a crisis.</p>	<p>The I&R/A service has written crisis intervention policies and procedures that provide call handling protocols for specific types of emergencies.</p> <p>If the I&R/A service does not itself provide a formal crisis intervention service, it has a prearranged agreement and documented protocol with an appropriate crisis center that does.</p> <p>The I&R/A service ensures through training and supervision that I&R/A specialists have the skills to recognize when an inquirer is experiencing a crisis, and that they determine whether the individual is in immediate danger and take steps to ensure that s/he is safe before continuing with an assessment. The specialist follows the I&R/A service's protocol for when to access 911 or other emergency rescue services.</p>
Follow Up	<p>The I&R/A service shall have a policy that addresses the conditions under which follow-up must be conducted. The policy shall mandate follow-up, when feasible, with inquirers in endangerment situations and in situations where the specialist believes that inquirers do not have the necessary capacity to follow through and resolve their problems. Additional assistance in locating or accessing services may be necessary.</p>	<p>Follow-up consists of successfully contacting the inquirer to find out if their need was met and if not, the reasons why not. Follow-up is generally conducted within one to three days of the original inquiry in cases of endangerment and within 7-14 days in other situations.</p> <p>If the inquirer has not received services or the need has not been met, the I&R/A service determines whether there is still a need and makes additional appropriate referrals. The I&R/A service also determines whether the inquirer has additional, new needs and makes appropriate referrals prior to completing the contact.</p> <p>The I&R/A service documents the follow-up results (whether service was received or there was an unmet need) for use in reports.</p> <p>Information gathered during follow-up relating to elements in the resource database is verified and used to update resource database information that may be incorrect.</p>

Program Component	Criteria/Description	Activities/ Metrics
Resource Database Management	The resource database shall contain standardized information about organizations that meet criteria for inclusion, the services provided by each organization, and the locations (sites) where those services are available. The standardized entry must contain all required data elements, where applicable (e.g., a mailing address is included if one exists). However, the specific data elements that are seen by a particular group of users (e.g., resource specialists, I&R/A specialists, the general public) may vary	I&R/A service develops and utilizes established rules for structuring, writing and indexing resource database records; and ensures that information within database records is clear, concise, consistent and relevant. Database is updated either annually or on a continuing basis throughout the year involves multiple attempts to achieve a 100% update rate within a 12-month cycle.
Cooperative Relationships	The I&R/A service shall develop cooperative working relationships to build a coordinated I&R/A system that ensures broad access to information and referral services, maximizes the utilization of existing I&R/A resources, avoids duplication of effort and encourages seamless access to community resource information. they serve.	The I&R/A service participates in ongoing cooperative program planning and development activities that take into consideration community needs, existing resources, and the activities of other I&R/A services. Each I&R/A service: Participates in efforts to identify community I&R/A needs; <ul style="list-style-type: none"> o Maintains current information about other I&R/A services and their activities; o Develops priorities for I&R/A program development; o Participates in existing cooperative I&R/A efforts; o Becomes a catalyst for new cooperative service arrangements; and o Participates in decision making that addresses community-wide I&R/A issues
Disaster Preparedness	The I&R/A service is prepared to assess and provide referrals for inquirers who are experiencing a crisis due to a disaster of natural or human origin, or who want to offer assistance and contact the I&R/A service for a means to do so. Preparation includes development of an emergency operations and business contingency plan that enables the I&R/A service to continue to provide services if its building is damaged or destroyed; and to support its	The I&R/A service shall develop, maintain, and/or use an accurate, up-to-date computerized resource database that contains information about available community resources that provide services in times of disaster. Database records shall include descriptions of the services organizations provide and the conditions under which services are available. The I&R/A service's resource database includes information about permanent local, state and federal disaster-related resources.

Program Component	Criteria/Description	Activities/ Metrics
	ability to effectively accumulate and disseminate accurate disaster-related information, provide information and referral assistance for individuals impacted by a disaster and provide community reports regarding inquirer needs and referrals	
Staff Training	The I&R/A service shall have a training policy and make training available to employees.	Training for resource staff includes an overview of the local community service delivery system.
Promotion and Outreach	The I&R/A service shall establish and maintain a program that increases public awareness of I&R/A services, their objectives, and their value to the community.	The I&R/A service has a written outreach plan that employs a systematic methodology for publicizing the agency's services to its targeted population and to other community resources (e.g., other agencies, faith-based organizations, law enforcement). The I&R/A service uses a variety of methods to publicize information and referral. The methods are tailored to meet the needs of diverse populations.
Evaluation and Quality Assurance	The I&R/A service shall have the ability to assess the quality and effectiveness of all aspects of its operation including its service delivery, resource database, reports and measures, cooperative relationships, disaster preparedness, and organizational structure. These determinations shall be made both through on-going quality assurance procedures and periodic, formal evaluations that are used to implement measurable improvements.	<p>The I&R/A service has a process in place for examining its viability as an organization, the effectiveness of its services, its appropriate involvement in the community and its overall impact on the people it serves.</p> <p>The I&R/A service provides for a regular cycle of needs assessment, program planning and service delivery; and conducts an annual evaluation of I&R/A activities (including the maintenance of its resource database).</p>

Evidence Based Health Promotion Programs (EBHPP)

The table below outlines program components that are essential for implementing an evidence based health promotion program. These program components are applicable to both the *Chronic Disease Self Management Program (CDSMP)* and the *Matter of Balance Programs (MOB)*. These program components are based on guidelines developed by the *Center for Healthy Aging* at the National Council on Aging for implementing evidence based health promotion programs by community based organizations serving older adults. These program components ensure that the program intervention reaches the targeted population and is delivered effectively.

Chronic Disease Self Management Program (CDSMP)

The Chronic Disease Self-Management Program is a workshop given two and a half hours, once a week, for six weeks, in community settings such as senior centers, churches, libraries and hospitals. People with different chronic health problems attend together. Workshops are facilitated by two trained leaders, one or both of whom are non-health professionals with a chronic diseases themselves.

Subjects covered include: 1) techniques to deal with problems such as frustration, fatigue, pain and isolation, 2) appropriate exercise for maintaining and improving strength, flexibility, and endurance, 3) appropriate use of medications, 4) communicating effectively with family, friends, and health professionals, 5) nutrition, and, 6) how to evaluate new treatments.

Matter of Balance (MOB)

A Matter of Balance (MOB) acknowledges the risk of falling but emphasizes practical coping strategies to reduce this fear. These include:

- Promoting a view of falls and fear of falling as controllable
- Setting realistic goals for increasing activity
- Changing the environment to reduce fall risk factors
- Promoting exercise to increase strength and balance.

The workshop is conducted over eight sessions, meeting weekly or twice weekly for two hours per session. Meetings are led by volunteer lay leaders called coaches. A Master Trainer is responsible for teaching the Matter of Balance curriculum to the coaches and providing them with guidance and support as they lead the Matter of Balance classes.

Program Component	Criteria/Description	Activities/ Metrics
Outreach	EBHHP reaches those most in need and at highest risk.	EBHHP identify important health issues and populations at risk: <ul style="list-style-type: none"> • Review relevant data to identify key health/ functional conditions and risk factors for older adults in the community. • Demonstrates an understanding of specific characteristics and contexts of the population at risk and of the broader community (income, education, culture, geographic location, accessibility to services)

Program Component	Criteria/Description	Activities/ Metrics
Fidelity to Evidence Based Program	EBHPP translate tested evidence based models into a program suitable for implementation in the community while maintaining fidelity (i.e. the faithful and accurate reproduction of the intervention's core elements in the design and implementation of the translated program)	EBHPP evaluate programs by conducting process and outcome evaluations. <ul style="list-style-type: none"> Outcome evaluation takes place at both the individual and community levels to assess the changes in program participants' learning, health behaviors and health status, as well as the effects of the program on community health status
Partnership	EBHPP develop partnerships that include one or more community aging service providers and community health care partners.	EBHPP develop collaborations with other organizations to increase the ability of community based agencies to design and implement evidence based programs that promote and sustain long term behavior changes with the targeted older adult populations. <p>Partnerships will enhance the community's ability to address the multi-dimensional nature of health promotion.</p>
Staff and Volunteers	EBHPP have specialized staff that are trained in the implementation of the evidence based program. <p>EBHPP have effective strategies to recruit and retain volunteers.</p>	The EBHPP recruits and retains staff and volunteers who have knowledge and training of specific health promotion and self management topics. <ul style="list-style-type: none"> Recruits and retains lay leaders, peer supporter and other volunteers