Disease Prevention and Health Promotion Services (OAA Title IIID) Webinar

Moderator: Laura Lawrence

April 5, 2012

2:00 p.m. Eastern Time

Coordinator: Welcome and thank you all for standing by. At this time all participants are in a listen-only mode. During the question-and-answer session, please press star 1 on your touch-tone phone. Today's conference is being recorded. If you have any objections, you may disconnect at this time. Now I will turn the meeting over to Ms. Laura Lawrence. Ma'am, you may begin.

Laura Lawrence: Thank you (Amy) so thanks everybody for joining us for this Disease Prevention and Health Promotion Services Older Americans Act Title III-D Webinar. We affectionately call it the "dip hips OD Webinar" and we have over 260 people so hello people, we're glad you're here.

Just a little bit of housekeeping so before I introduce our speakers as (Amy) just mentioned but some of you are just coming in now, all participants are in listen-only mode so you can talk to yourself and we will not hear you.

However, we welcome your questions throughout the course of the Webinar. There's two ways that you can ask your question. Through the Web using the chat function in WebEx, you can enter your questions now or whenever you

have them and we will sort through them and answer them as best as we can once we get to the Q&A session.

In addition after the short presentations we will also offer you a chance to ask your questions through the audio line, you know, when the time comes (Amy)'s going to remind us of the instructions of how to queue-up for the questions.

Now if there's any questions that you ask that we can't answer during the course of this Webinar, well that means you've stumped us and we owe you a prize but don't worry, we're going to follow-up and make sure that we do get you the answers.

Now if you think of any questions after the Webinar maybe tonight when you're sleeping, you can also e-mail them so here's the e-mail address: Danielle.nelson@aoa.hhs.gov. The first name is D-A-N-I-E-L-L-E dot Nelson at aoa.hhs.gov. If you didn't write it down now, don't worry. The e-mail address is also included in the last PowerPoint slide.

Okay, as (Amy) also mentioned we are recording this Webinar so we'll post the recording, the slides and a transcript on the AoA Title III Website as soon as possible so maybe by the end of next week.

Let's get into the speakers because our time is so short today. I'm not going to be reading full bios for today's speakers but I'm pleased to introduce today's four presenters briefly and then they'll get right into the meat of the Webinar and pass it on to each one, you know, without me getting in the middle of them.

So first we'll hear from Edwin Walker with the Deputy Assistant Secretary for Program Operations at AoA and he's going to give a brief background on Title III-D and catch us up to where we are now and the big changes that have occurred.

Danielle Nelson, Aging Services Program Specialist in the Office of Home and Community-Based Services will be our second speaker and she'll be highlighting those new requirements and guidance.

Third we'll hear from Nina Keller who is Assistant Director and Director of Planning and Program Development at the Area Agency on Aging District 7 incorporated in Ohio and she's going to share with us an oral health program funded with Title III-D that meets the AoA's evidenced-based definition minimal criteria. Cheryl Evans-Pryor will be our fourth and final speaker.

She is the Mental Health and Aging Specialist, Aging Resources of Central Iowa. She's going to be speaking about behavioral health programs that are being implemented that meet AoA's evidence-based definitions, specifically at the highest-level criteria, okay, so four speakers and I pass it on now to our first, Edwin Walker.

Edwin Walker: Thanks, Laura. Hi, it's great to be on the call today on this Webinar today. I was asked to give a brief and I stress background about the III-D program and many of you may know that it was established in 1987 and has always focused on trying to meet the goals of the Older Americans Act and keeping older people independent through keeping them healthy.

And priority has always been in the program focused on serving those in medically-underserved areas and those who are in the greatest economic need. It's a formula grant meaning that we give money to all states and then they

allocate the money to area agencies and to medically-underserved areas in the state.

The funding has been fairly consistent which I guess is positive but it's been flat for quite awhile and it's been around $21 million nationwide which is why once it gets down to the area agency and provider level it's often very, very small.

And I know that and actually the Administration on Aging applauds the efforts of the Aging Network because you guys have been incredibly creative through the years with this money and have used it to leverage other resources in the community and we're just so proud of your accomplishments.

The appropriations that we've received out of the $21 million for the last 11 or so years have had a provision that required a particular set-aside for activities regarding medication management, screening and education and we've included that in our grant awards to states and you guys have been doing that as well.

This year that provision was removed from the appropriations and it was replaced with a new requirement that we put out in frequently-asked questions and in our Web but basically it indicates that the amounts appropriated may be used for - that we give to the states - have to be used only for disease prevention and health promotion programs and activities which have been demonstrated through rigorous evaluation to be evidence-based and effective.

And we certainly recognize that this is a major change in that it has occurred in the middle of a program year. We believe it's a significant change and so we have really attempted to provide as much training, technical assistance,

information, frequently-asked questions to assist you in making this change in the middle of the year.

We think it's significant as well however that prior to this new evidence-based requirement being put into the appropriations law that 33 states were already using or well on their way to using some type of evidence-based program with their III-D funding.

What we've done is developed an evidence-based definitions for the program and Danielle's going to cover that in more detail but we've developed as you've heard three tiers to our definition to help maintain flexibility, to allow for innovation and to be inclusive of the vast spectrum of evidence-based health and wellness programs that exist.

Since this change, questions have really been pouring in from our regional offices to our central office to (Nashua) and to (Inforay) and most recently at the ASA conference. Every health-related workshop that we were a part of, we received questions about III-D.

So here at AoA there's been a team that's been put together consisting of our headquarters staff and central and regional office staff to strategize about how to make this new evidence-based change as easy yet as straightforward as possible for the Network so that we can all comply with the law but mitigate program disruption while providing a structure path for the future of our investments in health promotion and disease prevention that are clearly evidence-based.

We really hope that every state, every area agency and every provider that leaves today's Webinar will have their questions answer and clarified or at least know how to follow-up with us to continue to get your questions

answered so we're really excited about the opportunity to interact with you today and so now I'd like to turn it over to Danielle so that she can begin to go through the guidance that we've developed.

Danielle Nelson: Wonderful, thank you, Edwin. As Edwin mentioned, the Aging Network has been moving towards evidence-based disease prevention and health promotion programs for the past several years. The evidence-based change to Title III-D due to the FY 2012 Congressional appropriations can be viewed which I'm sure most of you have viewed them on this Title III-D Webpage.

This Webpage that you see listed here on this slide will be updated regularly to reflect the additional guidance as it comes up so this Webinar is a good example. As Laura said, it will be posted on this III-D Webpage next week along with additional program examples that meet evidence-based criteria.

So on our next slide, let's take a look tier-by-tier at AoA's three-tiered definition of evidence-based interventions so this slide we're looking at is the minimal criteria for the first tier.

Looking at the first bullet here, the program is demonstrated through evaluation to be effective for improving the health and well-being or reducing the disease, disability and/or injury among older adults.

And the program must also meet the second bullet, be ready for translation, implementation and/or broad dissemination by community-based organizations using appropriately-credentialed practitioners. So here's the gist:

As long as your program fits both of these two minimal criteria bullets for evidence-based interventions, it is an appropriate use of your Title III-D

funds. We at AoA do not require prior approval or documentation of your evidence-based programs.

However, it might be a good idea for you to retain documentation for your own record of the evidence behind your program. The form of documentation would really depend on the program you decide to use.

So for an example, a III-D program like a health screening, this could be blood pressure, cancer, diabetes, etcetera, that documentation could include a copy of the performing practitioner's credentials whether that person is a certified nursing assistant, an LPN or other.

So moving on to the second tier which is called the intermediate criteria for AoA's evidence-based definition, the first bullet here out of the three says, the program should be published in a peer-reviewed journal.

The second is that it should be proven effective with older adult populations using some form of controlled condition so this could be a pre-post study, a case-controlled design, etcetera.

And just for slight clarification here, pre-post study means that you compare the effects of an intervention on older adult participants in the program. This would be by examining the difference in that pre-test you gave them to the post-test you give them after the intervention.

A well-known case-controlled study that you may be familiar with was the one that linked tobacco and smoking and lung cancer by showing the association between the two.

And so the third tier in the intermediate criteria states that the program has some basis in translation for implementation by a community-level organization. Looking back at that second criteria here, we've had a lot of questions around pre-post study and case control.

Let's go to the next slide where I have two graphics. I know I'm a very visual learner so I think these graphics might help to better explain the difference between the pre-post study which is the first or top graphic and a case-controlled design which is the bottom graphic.

The top graphic is an example of a pre-post study, so that first box at the top is your target population, that would be older adults, and then you move down and you select from that population, let's say you're looking at diabetes.

So then you would group your older adults into two groups, the one receiving your program or your intervention, and one that doesn't so business as usual, and then you're going to give both groups a pre-test as well as a post-test and compare them. Now to the bottom graphic which is an example of a case-controlled design.

This graphic starts on the right-hand side with a study population, which is divided by cases and controls. This could be for example let's use diabetes again, this could be older adults with diabetes which would be the cases and then older adults without diabetes, that would be your control. Both groups would receive your disease prevention health promotion intervention.

And for the older adults with diabetes, the cases as you move to the left, the reason you would have an unexposed outcome group is typically due to those clients either opting-out or maybe you opted them out for any number of reasons. Maybe non-compliance or they were a really difficult client that you

just had to opt-out. I hope that's was helpful in better understanding the evidence-based definition criteria in terms of study designs used.

And moving on to the next slide, now take a look at our final or third tier, the highest-level criteria of AoA's three-tiered evidence-based definition. The first of these three bullets states the program has to have undergone some experimental or quasi-experimental design.

The second bullet, the program should have a level at which full translation has occurred in a community site and if you find this a little confusing the way it's worded - just take out level at which and read it as full translation has occurred in a community site.

So what this is talking about is the whole science-to-service idea, so it means a program has been translated from a peer-reviewed journal - that's the science piece, into service - so the program in other words, the program has hit the ground and been implemented in a community site. That might be within your AAA (Area Agency on Aging).

So the third and final bullet here for the highest-level criteria is the level at which dissemination products have been developed and are available to the public, so in order to meet this highest-level criteria your program must meet each bullet within this slide here - the third tier - as well as the other two tiers we just touched on.

It's helpful to think of the AoA evidence-based definition as a bit of a checklist, so you start at the bottom, the minimal criteria, and you check-off each bullet of the graduated set of three criteria and then your program moves further towards meeting the highest level.

If you've looked on the III-D Website you've probably seen that that highest-level criteria is very program example top-heavy. There's a lot of examples and the reason for that is if you look at the third bullet number 3 here, the dissemination products are available to the public.

So there's a URL we can link to for that program where you can find product dissemination and replicate the program. That's the reason that it's very top-heavy in terms of programs here.

So this next slide I wanted to kind of explain that highest-level tier that talks about experimental designs because a lot of people want to know, what does that mean. An experimental design you see here is the same as a randomized controlled trial or RCT as it's commonly referred to.

Participants are randomly allocated into an experimental group or a control group followed over time for the variable or outcomes of interest that you're looking at, so looking at this graphic, let's use the example of chronic disease self-management or CDSMP which I'm sure many of you are familiar with.

So CDSMP when they went through the research or the experimental design, they looked at 1000-plus people with heart disease, lung disease, stroke or arthritis and these people participated in an RCT so the variables or changes that were monitored in this RCT were health status, healthcare utilization and self-management behaviors.

So the study outcome was that the subject who took part in the CDSMP program when compared to that population that did not, demonstrated improvement in exercise, communication with their physicians, self-reported general health and then they also spent fewer days in the hospital, so that's an example of an experimental design in action.

So I'm almost done here. This slide we're looking at now is an example of the programs that meet highest-level criteria on AoA's Title III-D Webpage. The list of evidence-based disease prevention health promotion programs on our III-D Webpage is not exhaustive nor is it meant to be exclusive.

Because it is very time-intensive to research and place programs in the appropriate tier, we at AoA have developed a new and simplified process for potential programs to become listed on this Webpage.

Any program administrators who are interested in having their programs listed or anyone for example on this call interested in checking on a program, please contact me and I will get back to you and as Laura said my e-mail address will be on the last slide of this PowerPoint which will be archived and that is danielle.nelson@aoa.hhs.gov.

So moving on, I wanted to quickly just mention that our HHS sister agency SAMHSA known as the Substance Abuse Mental Health Services Administration has a national registry of evidence-based programs and practices also known as NREPP.

We understand that reading a peer-review journal is not sufficient for readiness or replication of an evidence-based program, so this registry created in 1992 houses over 230-plus evidence-based programs which are reviewed by independent reviewers and it lists descriptive info, readiness, costs, etcetera.

Currently there are 49 interventions for older adults. SAMHSA classifies older adults as 55 and older. You can click the boxes here that you see on this

slide to find interventions specifically by race or ethnicity, geographic location, etcetera.

And so between the Title III-D Webpage and this NREPP webpage, these are two helpful ways for you to find evidence-based programs for your community. On this slide here you see that there are eight older-adult programs currently listed in SAMHSA's NREP database.

And these eight programs on the screen are all acceptable uses of Title III-D funding and they're also linked on our AoA III-D page under program examples. These eight programs have specific components for caregivers as well as behavioral health.

And I'm sure many of you are familiar with these programs, if not implementing them, as we're going to actually have a presenter here shortly briefly talk about implementing one of these behavioral health programs in their community.

And so some of you on this Webinar are probably thinking, this is great information but we don't have money currently in III-D to implement a highest-level evidence-based program.

In order to stretch the limited funding that you have, as you know and we know partnerships are very key. Partnerships both broaden the reach and bring different expertise to the table.

Some communities and some of you out there have either obtained donated services or found volunteers, while others have created partnerships among all the AAAs in their state to leverage funding and create a statewide highest-level criteria program. You know best what would work for your community.

So with your strategic health promotion partnerships in your community, it's important to clarify the win-win as well as the roles and responsibilities of your potential partners. If you're able to demonstrate the program's utility as it relates to your partner's strategic goals, they're more likely to get onboard.

My last slide here I just wanted to highlight some diverse partnerships. We know that getting an evidence-based health promotion program at the highest level started as well as keeping it going is really no small feat, so here are just a few suggestions that have come up from your other AAAs and state units.

One of the suggestions is universities. This is a great resource both for student volunteers and research expertise; so looking at schools of nursing, occupational therapy, physical therapy, medicine, psychology, social work, etcetera, these programs have students that either have to go out and get hours whether it's for a practicum, and internship or a rotation.

This is the potential for real win-win situation. Last week I learned about two partnerships between AAAs and universities that disseminate A Matter of Balance which is a highest-level criteria program, using college students to deliver the class within the communities. The two universities were A.T. Still University and Texas A&M School of Rural Public Health.

One of the major pros is that the school of nursing with no Title III-D funding provides the printed participant manuals, the DVDs, markers, easels, TVs and the student trainers even provide their own transportation and gas and so this is really important because these communities are spread out in very rural areas and so this is a big deal.

Next one we're looking at is faith based partners and this could include training parishioners between their congregations, program recruitment, embedding health promotion program into church ministry and so on and so forth.

Another one is healthcare. As you well know, this is a great referral source as well as an established network of providers whether that's case management departments, patient-centered medical homes, primary care or specialty services, physician hospital organizations, insurers.

I know a lot of you have partnerships with pharmacies or geriatric physicians. Another one that many of us are already working with is the Disability Network. You know this can really broadened the understanding of how we deliver programs to persons with a range of ability levels.

One that we might not have thought of are corporations. A lot of corporations are starting workplace wellness programs, this is a way for employers to market or to improve the health of its employees.

I recently met with one Aging Service Network provider that uses this program to generate additional money for their III-D funding. And lastly, federal and state opportunities could include partnering with a local federally-qualified health center.

Their focus is prevention and wellness so it's great to use that to your advantage and also engaging community health workers is important. This can help with sharing funding, quality control and even program sustainability.

So now I pass things along to our first of two community programs we want to highlight, the first of which is a program that meets AoA's definition of evidence-based health promotion at the minimal criteria.

And this is an innovative program that's going on at the Area Agency on Aging District 7. Nina I'd like to pass things over to you.

Nina Keller: Okay, thank you Danielle and I want to thank you all for the opportunity to share this program with you today. We're actually celebrating our 11 years in partnership with the Ohio State University in Columbus, Ohio and I just want to give you a quick background about the program.

In the year 2000 there were a number of articles written in the Columbus Dispatch about the poor oral health in the southern part of Ohio and Dr. Mohammad who you see there on the screen actually contacted our triple-A and said we would like to do something with you to start addressing the issues around oral healthcare in your particular region.

And so we were in conversation with them over just a few weeks and decided that the best way to establish a partnership was to become a part of their student rotation and he had done this program at another school where he had been and so we ended-up signing sort of a multi-year contract with them to be a part of their senior student rotation.

If we go to the next slide there's some basic things about how the program works. Their senior-year dental students are given our program as a part of their opportunity to get out and about and what they do is they setup a yearly schedule and we have about 20 visits a year and they average twice per month in a variety of settings within our district.

Some of them are senior centers or (congret mill) sites, housing complexes. The students are traveling anywhere from an hour and a half to two hours one-way to come to the program to the site so it does take some dedication on their part.

All the publicity about the program, the appointment scheduling are provided either by our staff at the Area Agency on Aging but more often by the host agency so it also is a good partnership with our community focal points that we've established in our counties.

We do have them fill-out the participants who come do fill-out an information form so we have all the (nasses) data and we can do all of our reporting on the state level.

We'll go to the next slide. This is a picture of just one of the sites that's here at the University of Rio Grande. A lot of times when people think that it is a mobile dental program, they think of a big van pulling up and the folks going in. That is not how they setup this program.

They actually have a van that they bring but all of their equipment is inside and they will actually setup the clinic on-site and in this photo you can actually see the different students working. They do extractions. They do fillings. They do denture realignment and they also will do clean and check for individuals.

As a part of the information that they provide to us, we do have a medication review that happens so that the students and Dr. Mohammad are very well aware of what medications they're on so they will not potentially interfere with, you know, with the procedure that they're receiving that day.

So say if somebody is on Coumadin which is a blood thinner, they really do not want to be doing an extraction that day and they will work with the person so that they'll reschedule them and they'll know how to work with their medication.

Because we are in contact with a school, they do the program 10 months out of the year and so they're not here like in June and July. This is another site that is setup at a local senior center. The folks that we have coming many times have Medicare and no other type of insurance.

If they do happen to have Medicaid, then we do refer them to our local dental clinics that are run by our community action agencies that are connected and with the federally-qualified health centers and that has worked very well for us. As you can see sometimes they're using high-tech equipment.

Sometimes they're using low-tech equipment which you can see you have the lady with a flashlight. When we have done a number of client testimonials and the school has also done some video work that they have used to share this program and the results, state and national conferences and the program has also been given an award from the American Dental Association which is the next slide.

And he's also received some notoriety within Ohio with several organizations giving awards because it's seen as a cutting-edge program. He has used the program also to write a textbook for dental students about working with geriatrics and it's been very successful as well.

Are there any - I will tell you - we provide around $60,000 of our Title III funding and they match it at probably 40 to $45,000 a year.

Laura Lawrence: Okay, Cheryl?

Cheryl Evans-Pryor: Good afternoon. I want to talk today, share with you what Iowa's doing for two of our evidence-based practices for depression care management and the first slide is we're going to talk about the pearls program which is a patient care management that focuses on minor depression and dysthymia which is a chronic low-grade depression over a period of two years.

At the in-home treatment, eight sessions over 19 weeks and the caveat to this particular model is that it requires psychiatric consultations in order to remain and have fidelity to that particular model and it is in the national registry of evidence-based practices.

How we developed our partnership with the Iowa Coalition on Mental Health and Aging, they decided in 2007 they wanted to endorse the adoption of these practices and so we had some startup funds through a HRSA grant and at the University of Iowa and the next slide will talk to us about (unintelligible) we use the state aging program services fund to support the administration pieces such as that I conduct.

And we use county funding at a contracted rate with our partners in this particular program which is through the local mental health center and that senior outreach counseling team does in-home psychiatric consultation and provision of services and so my role there as an organizational leader and in establishing our partnership.

So those folks have a contracted rate in which they provide the services and they also have regular consultation with a psychiatrist and that's part of that model.

And in addition to that then we have the healthy ideas through Baylor College of Medicine and we utilize the state service funds which comes from the state general fund for again for my role as a trainer and a program champion and then the implementation piece is the state elderly waiver or Medicare dollars for our case managers to implement the program.

This particular program is designed to work with the case management staff who are already seeing clients in their homes so it's a natural fit for that particular model and it works quite well.

And then for the units of service that they provide then are through that elderly waiver and our partnership again is with the folks at Baylor and the care for elderly staff who are national trainers and in the next slide we talked about how we've piloted the healthy ideas model with our case management staff and we completed that in 2011.

Those folks are homebound, have functional limitations and are quite frail and both myself and my colleague in-house, we conduct intrastate training of the triple-As and after Baylor has decided that they are ready for implementation so it's kind of a two-part process.

And then our intent is to have some systemized assessment and outcomes and establish a norm base over time for and then we can look at the variables within our state as they're applicable and provide technical assistance statewide, we're all on the same page so to speak.

And then the final slide talks about our universal protocols that we're going to utilize providing continuity of care and address all of the dynamics and implementation issues that may be privy to that particular area or region and

the variances there and then consultation will be provided to those triple-As that adopt the models that they choose to utilize.

And then the part that's rather exciting is that there can be some cost-sharing among the triple-As for training in that we want to remain flexible to get folks to, you know, adopt and be excited about these evidence-based practices as they are very effective and once the models are adopted, staff become quite excited about the results that they're seeing with older adults. Now I'd like to turn it back to Laura.

Laura Lawrence: Okay, thanks, Cheryl. Appreciate that. Okay, so we've heard from our four speakers and now we know you have a lot of questions. We are up to 404 of you out there so we've got to have a lot of questions. Some have already been submitted so (Amy), tell us what we're supposed to do now.

Coordinator: Certainly. If you would like to ask a question at this time, please press star 1. To withdraw a request, that's star 2. Once again to ask a question, please press star 1. One moment.

Laura Lawrence: And so while we are waiting for you to queue-up in the audio question line, I want to go ahead and take a question that's come in through chat so this question is will the three tiers within AoA's evidence-based definition be in place next year or will the highest-level criteria be the only acceptable level.

So the answer is that while the goal for everyone to move towards highest-level criteria, programs meeting the minimal or intermediate criteria will meet and continue to meet evidence-based requirements.

Our three-tiered definition of evidence-based health promotion is not going to change any time in the near future including the acceptability of for example

minimal and intermediate-criteria programs. That's the answer to this question and (Amy) do we have our first audio question ready?

Coordinator: We do. Our first question comes from (Kelsey Crittle). Your line is open. Ma'am, your line is open.

(Kelsey Crittle): I'm sorry, I didn't have a question. I'm sorry. I pressed the wrong button.

Coordinator: Okay. Our next question comes from I believe the name is (Lee). Your line is open.

(Leland King): It's (Leland King).

Coordinator: Yes, sir, your line is open.

(Leland King): Actually my questions was answered but I'm just wondering if the Web pages that we've seen can be downloaded at some point.

Cheryl Evans-Pryor: Well, you mean the information - these slides - from this Webinar?

(Leland King): Yes.

Cheryl Evans-Pryor: Yes. They are going to be posted on the III-D Website which is this first link that you see on the resources slide that's up there right now.

(Leland King): Okay, yes.

Cheryl Evans-Pryor: Yes, and you'll be able to go there and you can read or print to your heart's content.

(Leland King): And as long as I'm here, let me make sure I understand. I think you said that basically our health promotion programs have to meet the minimal requirements but you want us to move toward the higher levels.

Cheryl Evans-Pryor: Yes, that's exactly correct.

(Leland King): Okay. Okay, great. Thank you.

Laura Lawrence: You're welcome.

Coordinator: Our next question comes from (Sabrina Ramos). Your line is open.

(Sabrina Ramos): Hi. I guess I wanted a little clarification on what the expectation was because in the beginning you explained the different criteria and you used the diagram to show what control groups were and things like that. Are we expected to develop our own evidence-based programs using things that we've already been doing? That's the first part of it.

And if so, are we supposed to be using the III-D funding towards that research and development of those programs because it does take quite a bit of work to get the evidence and to get the data and to run those groups.

And then the second part is are you I think somebody else said this also but are you saying we can implement programs that falls in the first two criteria but you are putting emphasis on the higher-level programs.

Is that your preference or does it really not matter, I mean, because we've got, you know, it also it depends on staff, the staff that you're using to go out and facilitate the resources that you have in your organization.

I mean, we're in New York City and we're lucky we've gotten other grants. We have a lot of people trained in CDSMP but, you know, we want to facilitate and implement other programs as part of our whole program design has been to train people in the community to do this.

And sometimes the higher-level criteria programs are not as accessible in a number of different areas from everything starting with skill level and capacity, individual and organizational capacity all the way up to, you know, purchasing resources and books and materials.

Greg Case: Thanks, (Sabrina), this is Greg Case. Those are good questions and I hope I'll be able to cover them all.

(Sabrina Ramos): Okay.

Greg Case: First of all we have no expectation that anybody try and develop evidence.

(Sabrina Ramos): Okay.

Greg Case: We're not asking you to be a science agency. We are not asking you to make the investments that are required in order to do the research in the randomized-control trial of your own studies.

What Danielle was trying to show was the process through which some of this has been done. Certainly if you take enhanced fitness for example, that's a program that's started in the senior center and they found funding and they produce the evidence but our intent is simply to help the Aging Network use III-D dollars in a way that meets one of our three criteria...

(Sabrina Ramos): Okay.

Greg Case: ...intermediate or that maximum criteria. The reason that we talk about moving toward maximum is because so much evidence that those particular practices are very effective in reducing hospitalization, cutting down on emergency room visits, saving dollars to the medical care system that we think that's great.

We also recognize that to get there given the limited amount of III-D dollars you've really got to do partnerships and other kinds of things and that's why Danielle kind of spoke about that for a little bit but right now and in the foreseeable future if you're able to meet minimal criteria, we're very happy with your doing that. Thank you.

Laura Lawrence: Sorry for that empty space. I feel like I'm on the radio. Is there anyone else queued-up for...

Coordinator: Yes.

Laura Lawrence: ...okay.

Coordinator: Yes, we have a question from (Doug May). Your line is open.

(Doug May): Yes, thank you. We have subcontracted to a variety of providers who are giving some really good services and for example this yoga tai-chi exercise but they're not doing pre and post-testing. We were wondering if we could substitute Title III-D funds while we're making the transition with other providers or other programming with Title III-D. That way we would not be defunding those programs that are in place in the community.

Edwin Walker: (Doug), this is Edwin Walker. We've had that question for other programs as well that where they weren't quite sure that what they had been funding under III-D would fit the criteria even at the minimal level.

If you want to continue to provide that activity and use III-D dollars for that, that would be fine. It's just that this restriction is a change in the law that authorizes the use of Title III-D so for III-D expenditures you have to have an evidence-based activity.

(Doug May): Very good. Thank you.

Laura Lawrence: (Amy), the next question?

Coordinator: Our next question comes from (Angie Malone). Your line is open.

(Angie Malone): Hi, yes, I guess it's a follow-up on what we were just taking about with the exercise classes and these types of things and I'm wondering if you have something that's being led by a certified teach or somebody who does have the credentials if that can qualify under the first tier, given the evidence that regular exercise, you know, is good for everybody.

Danielle Nelson: This is Danielle Nelson. As long as you are meeting that first level of minimal criteria and we're going to go back to that slide as I'm answering this and the answer is as long as you're using an appropriately-credentialed practitioner and it's being implemented in a community setting and there is evaluation evidence to prove that it's effective, by all means that program would be appropriate.

(Angie Malone): So I would just need to add-in the evaluation piece of it?

Danielle Nelson: Well for example as long as it was demonstrated through evaluation to be effective or yes there was already evaluation done and you have that evidence, that's great. If not you would just need some evidence to prove that it is effective for improving the health of the overall population you're serving.

And then just keep some sort of documentation for your own records in terms of who that appropriately-credential practitioner is that's performing it.

Edwin Walker: I would check with your credentialed practitioner. Chances are the program that they've brought to you is something that has been evaluated in the past. Certainly I know in my past days of working in housing settings there were many programs for exercise that had been evaluated but hadn't met all of the rigors of a full randomized-control trial.

So check with your practitioner and see if in fact he or she is using something that's gone through an evaluation process.

(Angie Malone): Okay, thank you.

Laura Lawrence: Okay, here's one that's come in through the Web. If a triple-A has staff facilitating a CDSMP workshop, can the staff time be billed to Title III-D and the answer is yes so chronic disease self-management programs say the one that Stanford has developed, that is a Tier 3 program and so yes, you can use your Title III-D funds for that.

So thanks (Beverly Dunlap) for answering that, I mean, for asking that. (Amy), what do we have coming up on the queue?

Coordinator: Our next question comes from (Brenda Wilmoth). Your line is open.

(Brenda Wilmoth): Hello. Our agency is 100% rural service area for we're in a very rural county. Our Title III-D dollars are $1502 for the year. I've checked, I'd like to have an instructor trained for tai-chi. The cost for that for travel and lodging are going to be over $300. Can we bill that to III-D?

Greg Case: The costs are going to be how much?

(Brenda Wilmoth): It's going to be around $330 for lodging and travel. That doesn't include meals.

Greg Case: And that's to bring in your certified practitioner?

(Brenda Wilmoth): That's to get a person trained through the arthritis foundation tai-chi program. They're only offering it in two areas of our state and one's two-and-a-half hours away and one's four hours away.

Greg Case: And then by paying those costs, it is the cost of your service; is that correct?

(Brenda Wilmoth): It's the cost to train the trainer.

Greg Case: Which will be part of your overall service so the answer would be yes, if that's part of the total cost.

(Brenda Wilmoth): Okay.

Edwin Walker: That $330 will allow you to provide an evidence-based program and gosh, you've got a whole 1200 bucks left.

Laura Lawrence: Wow, how about that?

(Brenda Wilmoth): Okay, I'll tell you. Let me just tell you. For me this is frustrating because you're asking for a lot of bang for $1500. I think it's just really unrealistic. If we lived in a city where we had access to a lot of these resources would be one thing but we're run 100% rural. That's just my two cents.

Edwin Walker: We understand that and we also understand as I indicated that Congress changed the law which is why we have been and AoA has been investing in making the implementation of the law practical, pragmatic and to mitigate disruptions in service and with an ear towards understanding situations just like yours.

Greg Case: And you're doing a great job. Your idea is innovative and creative and with the rest of that money if you can, you know, do blood pressure screenings with a nurse or other kinds of programs like that, use volunteer times, you know, I think you can get a lot of bang for a very small amount of money and we realize that when it comes to rural areas, by the time III-D trickles down to you it's really peanuts.

Edwin Walker: And that's why we're doing this Webinar as well to sort of help you work through the frustration and to give you the answers that you're struggling with so thank you for asking.

Laura Lawrence: Okay, let's see. I'm going to take one from the Web and then we'll go back to the queued-up questions so this one is for Cheryl. I'm hoping your still on the line.

Cheryl Evans-Pryor: I am.

Laura Lawrence: Okay, it's from (Jennifer Meade). This is her question. Cheryl, it sounds like you're using state, county and Medicare funds to support pearls and healthy

ideas. Are the triple-As also using their III-D funds to support these programs? Cheryl?

Cheryl Evans-Pryor: Well, in answer to that currently we are using our III-D funds for health promotion activities such as matter of balance, chronic disease, self-manage it, better choices, better health for diabetes, things of that nature.

Because we are able to utilize this braided funding from the state and the county funding then through the HRSA through the Iowa Geriatric Education Center, we currently are not but we will be and I think the point is is that it's not that we don't need the money to do that. It's just that we've been able to braid the funding together in a different way.

Laura Lawrence: Okay, thank you Cheryl for that. Okay (Amy), who do we have queued-up now?

Coordinator: Our next question comes from I believe the first name is (Beth). Your line is open.

(Beth): Yes, some of my questions have been answered but we were trying to understand what translation means as far as implementing programs and also concern with rural areas that we have many rural areas here too with very limited funding and it is so challenging that again if we can get one program there, we're doing well.

Danielle Nelson: And this is Danielle Nelson and that's a great question about the translation piece but what it's really talking about is that whole science-to-service piece. You know, that translation from the science piece into the community where it hits the ground and gets running.

So translation means to move things out of the research lab and into the community to be implemented as a program, turning the research into practice. Does that answer - do you understand - the concept of that? Am I making it clear enough because it is quite confusing.

Greg Case: Let me just add to it a little bit. If you had a university that had done randomized-control trials or on a particular health promotion or disease-prevention activity but had not had an opportunity to test it at the community level and they came to you, you would be able to get involved in translational activity with that project and that would be a great partnership and work well.

(Beth): So the problem is I have a rural area. There's no university. There's nothing out there. They have a yoga class. They have a certified yoga teacher. I have printed in peer-review journal articles indicating that wellness improves after yoga classes. Is that going to meet the minimum criteria for this rural area. There's no hospital. There's no university. They're frontier.

Danielle Nelson: This is Danielle Nelson. My contact information is on the next slide here that we're going to - if you haven't written it down, please do - if you would like me to take a look at the specific program I'd be happy to work with you to make sure it does meet that minimal criteria if you're still unsure and we can work together on that.

And again we do understand that this is a small amount of money. We do encourage partnerships. We understand that in a rural area if you do not have a community college or a local university, there are other partnerships and again you know your community best and who those great partnerships could be to help get braided funding and additional funding to meet as we said the peanuts that come down to you for this funding.

Greg Case: Let me just answer your specific question about yoga. Yoga is a practice that has been evaluated. If you have a certified yoga teacher in your area willing to volunteer their time and come in or at a small cost to you, yes, that would be great. That would be very creative way to use Title III-D funding with your older participants.

(Beth): Thank you. That's what I thought, was it evidence public evidence-based public or a journal article, that would be enough information?

Greg Case: Yes - that would be enough information.

(Beth): Great. Thank you.

Coordinator: The next question comes from (Erin). Your line is open.

(Erin): Hi. My question is regarding the Tier 1 Bullet 1 on the evaluation tool we use. Is there a tool already out there that we can use or do you have any standards on the way we can measure effectiveness?

Danielle Nelson: That's actually a great question and we're right now working with our resource center as well as some other federal partners to come up with some resources for you because I know this has come up in the past couple of weeks and we understand that most areas are not going to be able to do the research to evaluate these programs.

But those of you that want additional guidance, we are currently working on that and we will have that updating III-D Webpage with this additional guidance as it comes available so there are some resources out there and we're compiling them right now so it better speaks to our network, so stay tuned.

Laura Lawrence: Okay. Is there anyone else in queue?

Coordinator: Yes, ma'am. Our next question comes from I believe the name is (Janet). Your line is open. The name is either (Janna) or (Janet). Your line is open.

Laura Lawrence: Did you mean (Lietta)?

Coordinator: No, I have the slide tagged as a (Janna) or (Janet) but your line is open if you want to go ahead and ask your question.

(Lietta): Oh, okay, thank you. The question that I had has been coming up from our network regarding under Tier 1 originally there had been some information on the AoA site talking about preventative screens and some of our rural areas have been using III-D dollars for health fairs so basically bone density or osteoporosis screening, some lipid disorder screening and diabetes screening.

And I was wondering if you could talk to that and whether or not that would continue to meet the minimum criteria and someone alluded to blood pressures being taken by nurses would be fine, if you could address that please? Thank you.

Danielle Nelson: Yes, this is a great question and we do have an FAQ on the III-D Webpage that directly addresses this in writing if you'd like to refer to that but the answer is that III-D funding is not appropriate for health fairs; however, that being said it is appropriate for activities such as health screenings that occur at health fairs.

That could be diabetes, blood pressure and others that meet the minimal criteria, so for example you're using an appropriately-credentialed practitioner to perform those health screenings as a health fair.

And for other activities you might be doing at your health fairs that don't meet the evidence-based criteria, we encourage you to use other funding whether it's for example Title III-B, administration funds, partnerships and so there are some examples on the III-D Website under FAQs suggesting some partnerships and ways to leverage other funding for services that would not be appropriate now for the evidence-based Title III-D program so thank you for your question.

Laura Lawrence: Okay, it looks like we have just a couple of minutes left. Could we take one more, (Amy)?

Coordinator: Certainly. Our next question I believe the name is (Melissa). Your line is open

(Melissa): Hello. Can you hear me?

Laura Lawrence: Yes.

(Melissa): Hi. I'm not sure. I just sort of tagged along with what you were just talking about but we wanted to do a fall prevention activity in the fall tied-up with the national event and we're trying to work with a lot of local senior centers, PTEs, hospitals, paramedics, all the people that get involved in falls.

And we want to know kind of how we can use - we're going to be promoting our matter of balance classes in those areas when we have the events going on that week - is that an okay use of the money?

Edwin Walker: Yes, it's a very good use of the money to use a matter of balance with people who have been trained to present matter of balance. That's great news.

(Melissa): So we can use them if we use them in activities just talking about matter of balance but any of the other things that we had like we're trying to get perhaps some people who are willing to come in and do assessments from the medical community, perhaps some people who would do vision checks, that kind of thing. We have pharmacy who are going to do medication presentation.

Edwin Walker: Okay, well let me elaborate a little bit on my answer. I thought you were going to implement matter of balance with a certified practitioner.

(Melissa): No. We already have those programs going. We will certainly give out the information that those are going on and the locations and the...

((Crosstalk))

Edwin Walker: ...promoting matter of balance could not be done with III-D dollars; however, some of the other things you mentioned after that that are screenings, this is sort of like the answer to Danielle's question - to the question that Danielle answered - just previously.

(Melissa): Right.

Edwin Walker: By doing screenings with certified practitioners, those pieces of this activity can certainly be paid for by III-D. Sort of straight educational program that sometimes occurs at these kinds of events, you can use III-B dollars to do that or certainly those organizations can volunteer their services at your event and get that kind of outreach and marketing for their own organizations.

But you would have to be actually doing - you could use - you say you implement matter of balance. You could certainly use III-D dollars for that.

(Melissa): Okay. Thank you.

Danielle Nelson: This is Danielle. I wanted to say there are a lot of questions. I know our time together here is up and we have a lot of questions that have come in and I know that I'm sure many of you will follow-up and e-mail me.

We are going to be doing another Webinar eventually to help give additional guidance so please stay tuned and we will of course put it through the same mode of communication we did this Webinar to make sure it reaches each of you and so thank you for your questions and I'm going to pass it over to Laura.

Laura Lawrence: Okay. I want to thank our speakers very much. We appreciate the time that you gave us Edwin, Danielle, Nina and Cheryl. Thank you very much and then (Amy), you kept us going so we appreciate that as well and those are good questions all of you have asked and I see that we have a lot more also that have been sent to us through the Web base.

So as Danielle said, this isn't the end of it so we are going to have another Webinar probably just for Q&As but if you haven't yet, if you'll look at the screen that's up there right now and that is the information so you can e-mail Danielle but if you're already submitted your question, you know, you don't need to do that again.

Now if you have any suggestions for future Webinar topics or if you have stories about your community's evidence-based disease prevention and health promotion work, we want to hear from you.

Not just questions but also we'd appreciate some good news, some down-to-earth community stories of how we have helped - you have helped - older adults. Thank you very much for joining us.

Coordinator: Thank you for your participation. You may disconnect at this time.

END