Evidence-Based Program Application Form
STAGE 2: Program Implementation

STAGE 2: BY INVITATION ONLY

Stage 1: Research and Outcomes
Stage 2: Program Implementation – *BY INVITATION ONLY*

This stage will require information about the program implementation, training, dissemination materials, supports available, and other elements essential for successful implementation.

The purpose of the Evidence-Based Program Review Process is to identify new community-based programs that meet the criteria established by the Administration for Community Living/Administration on Aging (ACL/AoA) for evidence-based programs funded through the Older Americans Act (OAA) Title III-D. Please carefully read the Title III-D criteria and operationalizing recommendations in Appendix A.

Your application and all attached materials will not be made public and will kept strictly confidential.

STAGE 2 APPLICATION, SECTION I: PROGRAM NAME AND CONTACT INFORMATION

Name of Program:
Name of Primary Contact:
Position/Title:
Organization/Institution:
Phone Number:
Email:
Street Address:
City, State, Zip:

STAGE 2 APPLICATION, SECTION II: PROGRAM IMPLEMENTATION

Description of program components and delivery approach (Maximum of 500 words)
Describe the program components, instructor(s)/leader(s), and how this program is delivered to the target audience in the intended settings.

Please list up to three primary goals of the program (Maximum of 250 words)

Please tell us about what types of organizations (e.g., senior centers, fitness centers, faith-based organizations, health care facilities) are delivering your program (Maximum of 250 words)

Who delivers the intervention? (Check all that apply)

- ☐ Case manager
- ☐ Licensed social worker
- ☐ Health care professional (e.g., nurse, physical therapist, occupational therapist)
- ☐ Community health worker
- ☐ Certified fitness instructor
- ☐ Lay leader (e.g., volunteer, peer)
- ☐ Student
- ☐ Other – write in: _____

Program Reach (Maximum 500 words)
Please describe the following:

- The number of participants who have taken part in the program
- The percent of participants who started the program at the first or second encounter and went on to complete the program (e.g., 70 % of participants completed 4 of 6 sessions, or participants completed 7 of 10 sessions on average)
- Marketing and recruitment approaches.

Your response should address Review Criterion #4: Fully translated in one or more community site(s)

How can the program be adapted for local context (per 4c of the operationalizing criteria)?

Has the program been adapted to serve people with: (Check all that apply)

- ☐ Low vision
- ☐ Hearing loss
- ☐ Dementia
- ☐ People who speak languages other than English
- ☐ Racial/ethnic minorities
- ☐ People with disabilities
- ☐ Other –please specify the population for whom the adaptation was made- write in: _____
- ☐ N/A

Demographic of Participants (check all that apply)

- ☐ Adults (18-64 years old)
- ☐ Older Adults (65+)
- ☐ People with Alzheimer's Disease/dementia
- ☐ People with alcohol and other substance misuse disorders
- ☐ People with cardiovascular disease/hypertension
- ☐ People with chronic kidney disease
- ☐ People with chronic lung disease
- ☐ People with chronic pain
- ☐ People with diabetes
- ☐ People with disabilities
- ☐ People at risk for falls
- ☐ People with medication management concerns
- ☐ People with mental health concerns such as depression
- ☐ People with multiple chronic conditions
- ☐ People with nutrition concerns
- ☐ People with oral health concerns
- ☐ People who smoke
- ☐ Caregivers
- ☐ People living in poverty
- ☐ People of color
- ☐ People who speak languages other than English
- ☐ People who identify as LGBTQ
- ☐ Other (write-in): _____

Cost (Maximum of 500 words)

Please describe the costs of implementing the program, including resources required (e.g., meeting space 3x/week, administrative requirements such as evaluation, securing guest speakers). Include any licensure, certification and/or training costs. The content available for download here includes an example of program costs.

Do you have a tool to help organizations budget for your program?

- ☐ Yes
- ☐ No

Has your program been translated into other languages?

- ☐ Yes -please specify the language(s): _____
- ☐ No

STAGE 2 APPLICATION, SECTION II: DISSEMINATION, QUALITY ASSURANCE, AND TECHNICAL ASSISTANCE

Readiness for dissemination (Maximum of 750 words):
Provide a description and, where available, attach copies of or links to the following materials to demonstrate the program is ready for dissemination by other organizations. These materials will only be shared with the Review Council; members have agreed to respect any copyright and keep materials confidential. Acceptable materials include:

- Licensing and/or administration process.
- Program materials, manuals and/or curriculum, and their availability.
- Availability of necessary leader/trainer training and ongoing technical assistance.
- Description of any modifications made to manuals following any dissemination studies.
- Links to handouts, videos, and other program and marketing materials. If you are unable to provide a link to materials you would like to share, please contact NCOA to ship us the materials.
- Reports to funders or other non-peer-reviewed reports/articles.
- Tools for ongoing outcome tracking and quality assurance.

Your response should address Review Criterion #5: Program includes developed dissemination products that are available to the public

Attach all relevant program materials related to dissemination, quality assurance, and technical assistance (PDF files only)

Training and Fidelity (Maximum of 750 words)
Please describe the following:

- The instructor/leader qualifications and training requirements.
- Address any need for ongoing training or retraining/certification.
- Availability and accessibility of training and training materials to adopting organizations (note any websites or contact information to access training materials).
- How is fidelity monitoring accomplished? Explain all fidelity training, systems, and tools (attach, if available).
- Listing of implementation tools, and how each has performed in the field

Tell us what types of technical assistance/support are available to organizations and individuals who adopt and/or implement the program (Maximum 250 words)

What system and/or tools are used (recommended or required) to document organizations replicating the program, number of program sites, participants (served, demographics, outcomes), and trainers/leaders? (Maximum 250 words)

What is your process for updating your program to keep it current? (Maximum 250 words)

Is there anything else you would like to tell us about your program? (Maximum 250 words)

Appendix A

U.S. Administration on Aging Title III-D Highest-Level Criteria for Disease Prevention and Health Promotion Evidence-Based Programs and Operationalizing Recommendations

The table below includes the five Title III-D evidence-based program criteria; ALL FIVE MUST BE MET FOR YOUR PROGRAM TO BE APPROVED AS BEING EVIDENCE-BASED. Under each criterion are clarifying recommendations to help you determine if your program meets the criterion.

Criteria 1: Demonstrated through evaluation to be effective for improving the health and well-being or reducing disease, disability and/or injury among older adults
1a. Intervention targets at least one primary behavioral, psychosocial, physical and/or physiological outcome(s) relevant to improving the health and well-being, or reducing disease, disability or injury among older adults (age 60+) and/or adults with disabilities. *<u>Relevant</u> depends on what intervention is being studied, e.g. for physical activity, may include strength or function; for depression, includes depressive symptoms.* Changes to knowledge or attitudes is not sufficient.
1b. Meaningful improvement is demonstrated in at least one relevant primary outcome at least 6 months following the end of the intervention. "Meaningful improvement" is indicated by effect size or other clinically or statistically significant change in outcome using a valid and reliable measure. *"Clinically significant change" may be demonstrated using effect sizes, comparison to an established intervention (e.g., a new falls prevention intervention delivered using lay leaders provides similar positive health outcomes and is more cost effective than a well-established falls prevention intervention delivered by physical therapists), or a public health criterion (e.g. exercising 150 minutes or more per week per recommended CDC physical activity guidelines).*
1c. Outcomes are reported as effect sizes or provide data to be able to calculate effect sizes *(e.g. mean, SD, N).*
1d. Study provides eligibility criteria and descriptive statistics (demographics, representativeness) on study participants to describe the study population (at least half of which are older adults or adults with disabilities). * **We recommend that descriptive statistics include age; gender; education or income; other chronic conditions; disease severity; recruitment source/setting; enrollment rate.* *While not a minimum threshold, ACL supports the development of evidence-based programs that a) are broadly applicable and b) reduce or at a minimum do not exacerbate health disparities experienced by underserved populations (e.g. tribal communities, people who speak languages other than English) and fill gaps in health areas (e.g. oral health, nutrition, hypertension).*
1e. Evidence is provided for the safety and tolerability of the intervention as indicated by: (a) minimal/no adverse events directly associated with intervention delivery; and (b) dropout rate is reported for the intervention group and is comparable (or better) than the study's control group or for similar interventions with similar populations.

Criteria #2: Proven effective with older adult population*, using Experimental or Quasi-Experimental Design** **Title III-D criteria specifically addresses older adults; however, programs submitted through this review process may address older adults and/or adults with disabilities.* ***Experimental designs use random assignment and a control group. Quasi-experimental designs do not use random assignment. See appropriate designs from the US Preventive Services Task Force here on page 74 of the article (page 31 of the PDF).*
2a. Intervention is evaluated using an appropriate *experimental* or *quasi-experimental* design that includes an appropriate control group. *An "appropriate control group" is one in which the intervention (treatment) and control (comparison) groups are equivalent OR statistically controls for confounding differences between groups if such differences are identified. Furthermore, allocation to the intervention and control group is conducted using a standard/systematic process that minimizes bias (randomization could be utilized, but is not required).* *Pilot studies are acceptable if the study meets other criteria.*
2b. The sample size provides sufficient power to determine an effect.
2c. If more than one study is published, there are consistent trends in study findings (direction and magnitude).
2d. Information is provided on the implementation of the intervention during the study (e.g., planned and actual frequency, intensity and duration; participation rates).
2e. Methods are reported in sufficient detail for replication and are appropriate given study design.
Criteria #3. Research results published in a peer-review journal.
3a. The published study article(s) has gone through a journal's independent, external peer-review.
3b. Journal has a published Impact Factor or other published measure of quality.
3c. Journal is indexed in a national scientific indexing database such as PubMed or Web of Science.
Criteria #4: Fully translated in one or more community site(s)**
4a. The program has been delivered with fidelity and achieved positive outcomes in at least one community site that was not part of the original research study.
4b. The program developer and/or replication sites can be contacted to learn about program implementation and maintenance.
4c. The program's forms can be adapted for local context using *appropriate* standards (e.g. changes to program setting, population or modality) without removing or significantly altering core functions. *Appropriate standards include RTIP and HHS/ACF.* Forms are "modes of delivery, who delivers, materials/tools, dose, frequency/intensity" that can be tailored to local literacy, language, culture and learning styles. Core functions are "the intended purpose or goals of the intervention" that are done across delivery settings and populations.

Criteria #5. Developed dissemination products that are available to the public.
5a: The program training is standardized and available on a regular basis so sites that adopt the program can be trained within 6 months of selecting the program.
5b: There is a reliable way to contact the program developer or national office to obtain training, manuals, and dissemination materials; to discuss implementation; and to receive timely technical assistance regarding implementation on an ongoing basis.
5c: Supports and guidelines for implementing the program are readily available, including implementation manual, quality assurance/fidelity guidelines, data collection protocol, anticipated costs for implementing the program, and overall technical assistance.
5d: Supports for implementing the program are updated on a regular basis.