State Unit on Aging Survey of Evidence-Based Program Delivery and Review Process: Summary Report

June 26, 2017

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Survey Goals and Purpose

This survey was conducted online via Survey Monkey and targeted State Units on Aging (SUA) Older Americans Act (OAA) Title III-D coordinators. The survey was open from March 18, 2017 to April 26, 2017. Thirty-one Title III-D coordinators responded to the survey.

The key goals of the survey were to gather information to help the aging network and National Council on Aging, Center for Healthy Aging to better understand the scope of evidence-based program (EBP) delivery and funding across the U.S.

The survey was also intended to identify key technical assistance needs and gaps in resources, and determine the effect of ACL's Title III-D Older Americans Act criteria change on program offerings within states. The 19 questions in the survey focused on a range of topics associated with evidence-based programming, including programs that states currently offer and the ones that they are interested in, along with the needs, priorities, and challenges they are experiencing with EBP delivery and funding.

Definitions

Respondent = Title III-D Coordinator responding to the survey on behalf of their state
Aging Network = organizations or agencies devoted to providing health and social services to older adults
SUA = State Unit on Aging
AAA = Area Agency on Aging

This document describes the survey and the methods used, in addition to a summary of key findings.

Methods

Responses to questions are presented in tabular form and graphics, as well as written summaries highlighting trends and key findings.

In the summaries of quantitative data, responses are often given as frequency of responses, and percentages rounded to either zero or one decimal place depending on the context. These percentages represent the total percent of respondents who answered a single part of the question. For several questions, respondents could select multiple answer options. Thus, the total number of responses may exceed 31.

In questions that use a rating scale of 1 to 4 (e.g., not at all important, not very important, somewhat important, and very important), numbers were assigned to each response, with the highest number representing the most positive outcome. For example, 'not at all important' would be assigned a 1 and 'very important' would be assigned a 4. This data allows for the calculation of a weighted average, which offers a single number that can be used to compare responses to the different topics.

Qualitative Analysis and Summary

Numerous questions were entirely open-ended, soliciting qualitative responses, while others allowed for qualitative comments to be provided when available answer options did not apply. For some questions, the responses given were often lengthy and often only parts of a given responses were pertinent to the question. In many cases, a single respondent could provide information regarding various emerging themes.

Analysis of open-ended questions focused on identifying and summarizing key themes that related to the question at hand. As a result, this summary does not show the responses from respondents word-for-word. Instead, any information that is provided is summarized and may only include part of a participant's response.

Additionally, qualitative responses were excluded from analysis and summary if they did not answer the question at hand. For example, some respondents used qualitative sections to state that the topic did not apply to them or to discuss an unrelated topic. Omitting these responses allows for more effective analysis overall and a better indication of the trends that were present.

Nevertheless, every effort has been made to ensure the representations of statements from respondents are accurate.

General Summary of Results

Evidence-Based Program Offerings, Reach and Languages
State Unit on Aging Title III-D coordinators identified 58 unique programs, including 27 from the list provided in the survey. The most popular evidence-based programs were Chronic Disease Self-Management Program (CDSMP) (93.5%), Tai Chi (83.8%), A Matter of Balance (MOB) (77.4%) and Diabetes Self-Management Program (DSMP) (74.2%). Many other programs identified are being delivered in just one or two states. About half of respondents (n=16) also mentioned 33 other programs in the open field;

however, it is unclear which of those listed have been reviewed by states to determine if they fit ACL's evidence-based review criteria.

All respondents reported that their programs reached consumers aged 60+, and over half (55%, n=17) of states reported reaching people with disabilities under age 60 with EBPs. Additionally, more than 75% of respondents indicated that rural communities and racial/ethnic minorities were reached. They were least likely to be reaching LGBTQ older adults or persons with dementia through their programs, each reported by 36% of respondents.

Only 4 of the 26 states responding to the language question reported delivering programs in English only. The remaining respondents offered programs in multiple languages, with one having as many as 9 different language options. The most common languages were Spanish (46.2%), Chinese (15.3%), and Korean (11.5%), although there were many others offered by single states.

Funding
According to respondents, the most common source of funding was the Older American's Act Title III-D, with close to 95% of respondents identifying this as a funding source. The next most common sources were grants/private funds (40%) and state general revenue (34%).

Health Concerns
A wide range of health-related concerns were identified by respondents, many of which were related to chronic disease. For example, 80.6% of respondents identified diabetes as being a primary health-related concern, followed by falls (77.4%). Almost half (48.4%) of SUA representatives felt that arthritis and hypertension were important areas of concern.

Program Gaps
Over half (58.1%) of respondents noted that the current programs being offered met their health priority areas. Another 29% felt that their existing menu of programs only partially met their needs, while another 12.9% felt that gaps still existed. The identified gaps varied considerably, but the most commonly mentioned were programs targeting diabetes, linguistically and culturally specific programs, and fall prevention programs.

Respondents also highlighted challenges associated with programming. While some programs met needs in certain regions, those programs were not fully scaled to the state level, leaving gaps in some parts of the state. Other gaps were attributed to the lack of trainers available to deliver a given program.

When asked about how programs met the needs of 1) older adults, 2) their state's health priority areas, and 3) their language needs, SUA representatives were most likely to report that their current programming fully meets the needs of their older adult population (59.1%). Again, slightly over half (53.1%) felt their programs addressed their health priority areas. However, results were less encouraging for language availability, with only 34% reporting that programs met their language needs.

SUA representatives were most interested in learning more about the Chronic Pain Self-Management Program, the Diabetes Empowerment Education Program, and HomeMeds. However, the number of responses for that question was small (n=17) and many additional programs were identified. Three individuals reported interest in each of those programs.

The top issues affecting states' abilities to expand fundable evidence-based programs in their states were program costs and availability of trainers, possibly associated with low populated areas and limited transportation funds.

Capacity to Review Evidence-Based Programs
The vast majority (77.4%) of SUA representatives were very familiar with and have applied ACL's evidence-based criteria. However, most respondents felt that their resources were limited for evaluating a program by ACL standards. Most felt that they had a moderate (38.7%) or a modest/scant (32.3%) amount of resources to evaluate whether a program met the new ACL EBP requirements. Relatively few respondents felt that they had ample resources (9.7%).

The most common process was described by 11 states, which required that AAA or partners declare the programs they sought to implement in their Area Plans. At times, it was the sole decision of the SUA III-D coordinator, though most often it wasn't clear who made this final decision. Eight SUAs provide a pre-approved list to AAAs from which they can select programs to implement. States employed a range of other activities to provide AAAs with the tools and opportunities to introduce new programs. If a program was not on this list, one state offered a waiver process that allowed AAAs to submit that program for review as long as they can point to specific evidence, such as quasi-experimental study design, peer-reviewed publications, effectiveness in older

adults, and presence of dissemination materials. Some states issued RFPs and grants. To aid with the review process, one SUA developed a Title III-D Workgroup consisting of a Title III-D specialist, while another state created a Title III-D assessment tool worksheet that AAAs must complete.

ACL's Aging and Disability Evidence-Based Programs and Practices (ADEPP) (93.5%) and NCOA evidence-based program list (87.1%) were the most popular resources used by SUA's III-D coordinators for determining whether evidence-based programs met ACL's newest criteria. The next most popular resource was the National Registry of Evidence-Based Programs and Practices (NREPP) at the Substance Abuse and Mental Health Services Administration (48.4%).

## *Technical Assistance Needs*

Most respondents (90.3%) had sought some form of technical assistance, with the most popular sources of this assistance being the ACL Regional Office (64.3%) or the ACL Central Office (32.1%). However, 39.3% turned to evidence-based program developers for assistance in technical assistance related to specific programs.

The majority of SUA representatives (93.5%) were in communication with AAAs, with 86.7% communicating with them at least on a quarterly basis. Frequency of communication varied across respondents, with the most common patterns being either monthly (35.5%) or quarterly (22.6%). Additionally, respondents were generally confident about their ability to provide information to AAAs, with 35.5% saying that they were 'very confident' and the remaining 58.1% saying that they were moderately confident.

Respondents felt that extra support would be beneficial in all areas provided as options, suggesting a strong interest in learning as much as possible. Of the topics highlighted, the most significant ones were sustainability strategies (83%), establishing partnerships (76.7%), and creating network hubs (63.3%). In qualitative responses, respondents also highlighted the importance of providing technical support for programs for rural areas, as well as support for effective communication and processes that make programs easier to find and identify.

Survey Questions and Responses

OAA Title III-D program coordinators from the following 31 states responded to the survey:
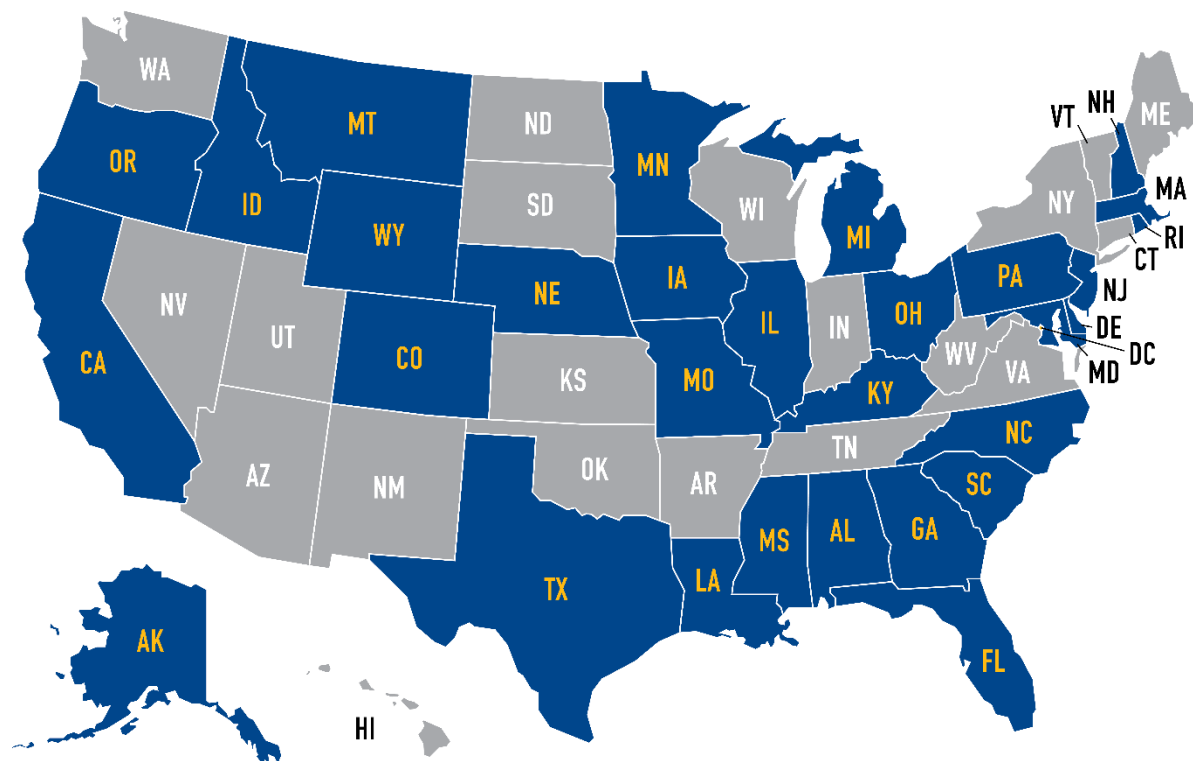
Question 1: Which of the following evidence-based programs are offered in your state by Area Agencies on Aging (AAAs), either directly or through contracted organizations? Please note programs offered via various funding sources, not just Title III-D. (Check all that apply) **(n=31)**

- A total of **58 unique programs** were identified by SUA Title III-D coordinators, 25 derived from the pre-set list provided in the survey.
- The most popular programs were **Chronic Disease Self-Management Program (93.5%)**, **Tai Chi (83.8%)**, **A Matter of Balance (77.4%),** and **Diabetes Self-Management Program (74.2%)**, all of which were offered in upwards of 70% of states.
- About half of respondents (n=16) also mentioned 33 other programs in the open/other field, which are shown in the second table.

Program	Responses	Percent of Respondents
Chronic Disease Self-Management Program (CDSMP)	29	93.5
Tai Chi	26	83.8
A Matter of Balance	24	77.4
Diabetes Self-Management Program (DSMP)	23	74.2
Walk With Ease (Group)	17	54.8
Tomando Control de su Salud	15	48.4
EnhanceFitness	11	35.5
Chronic Pain Self-Management Program	11	35.5
HomeMeds	11	35.5
Healthy IDEAS	11	35.5
Stepping On	10	32.3
Program to Encourage Active, Rewarding Lives (PEARLS)	10	32.3
Stay Active and Independent for Life (SAIL)	8	31.9
Programa de Manejo Personal de la Diabetes	7	22.6
Active Living Every Day	6	19.4
Otago	6	19.4
EnhanceWellness	5	16.1
Better Choices, Better Health (online CDSMP)	5	16.1
Fit and Strong!	5	16.1
FallScape/FallsTalk	3	9.6
Healthy Steps for Older Adults	3	9.6
Positive Self-Management Program for HIV	2	6.5
Wellness Initiative for Senior Education (WISE)	2	6.5
Screening, Brief Intervention and Referral to Treatment (SBIRT)	2	6.5
Better Choices, Better Health-Diabetes (online DSMP)	1	3.3

An additional 33 programs were mentioned under 'Other programs.' The most common programs in this selection were **Powerful Tools for Caregivers, Arthritis Foundation Exercise Program (AFEP),** and the **National Diabetes Prevention Program (NDPP)**. However, the majority of programs listed (27 out of the 33) were being delivered in single states.

Program	Responses	Percent of Total "Other Programs'
Powerful Tools for Caregivers	6	18.8%
National Diabetes Prevention Program (NDPP)	6	10.3%
Arthritis Foundation Exercise Program (AFEP)	5	12.8%
Arthritis Foundation Aquatics Exercise Program	3	7.7%
Care Transitions Intervention (CTI)	3	7.7%
Diabetes Empowerment and Education Program (DEEP)	3	7.7%
Savvy Caregiver	3	7.7%
Stress-Busting Program for Family Caregivers	3	7.7%
Resources for Enhancing Alzheimer's Caregiver Health I or II	2	5.1%
Balance and Fall Prevention Program	1	2.6%
Bone Builders	1	2.6%
Cardio Rehab Phase III	1	2.6%
Care Consultations	1	2.6%
Coleman Care Transitions	1	2.6%
Complete Health Improvement	1	2.6%
Creating Confident Caregivers (modified Savvy Caregivers)	1	2.6%
Dakim Brain Fitness	1	2.6%
Geri-Fit	1	2.6%
Healthy Heart, Healthy Family	1	2.6%
Healthy Moves for Aging Well	1	2.6%
Heart360	1	2.6%
Medication Management – BeMedSmart	1	2.6%
Move Today	1	2.6%
Move with Balance	1	2.6%
N'Balance	1	2.6%
Project Healthy Bones	1	2.6%
SeniorFit	1	2.6%
SeniorReach	1	2.6%
STAR-C	1	2.6%
Strong Seniors	1	2.6%
Strong Women	1	2.6%
Timeslips	1	2.6%
Zumba & Zumba Gold	1	2.6%

Question 2: To the best of your knowledge, from which of the following sources are evidence-based programs in your state funded? (Check all that apply) **(n=31)**

- By far, the most common source of funding was **OAA Title III-D** (n=31, 100%)
- The next two most common responses were **grant/private funds** (n=14, 45.2%) and **state general revenue** (n=12, 38.7 %).
- On the other end of the spectrum, the following three options were not identified by any respondent as funding sources: **Medicare or Medicare Advantage**, **Department of Veterans Affairs** and **employer (e.g.,** employee assistance program, pension fund).
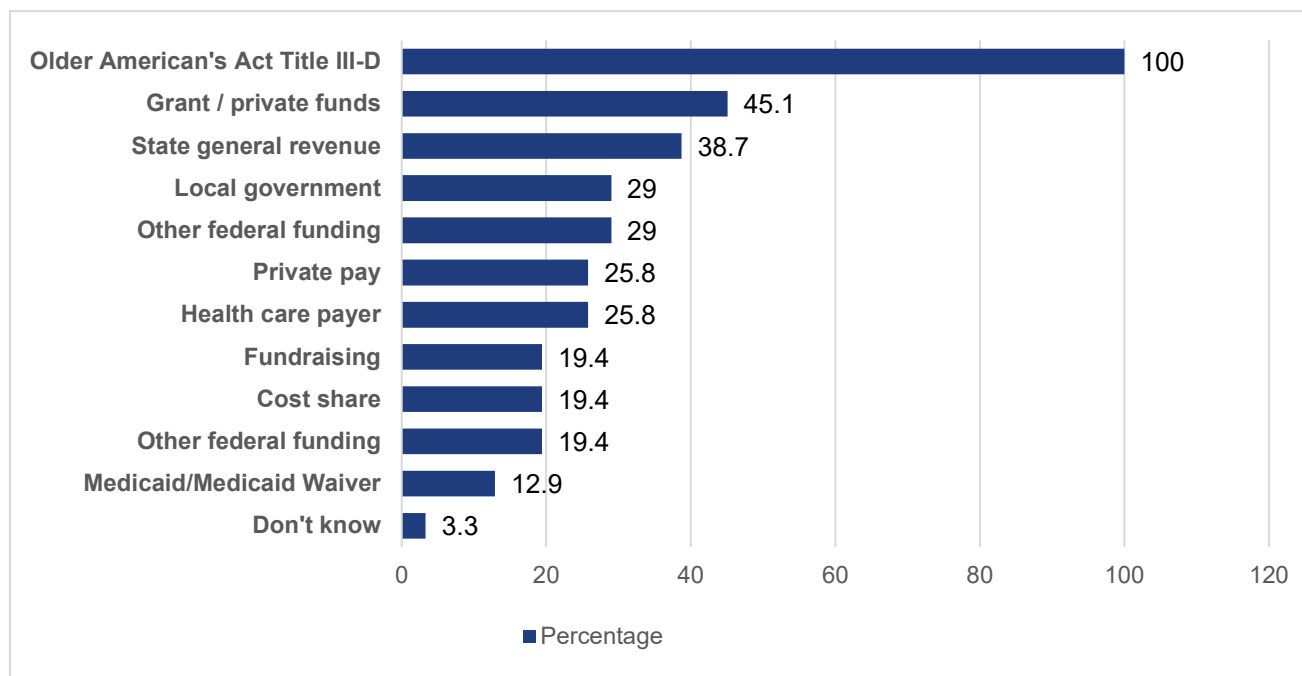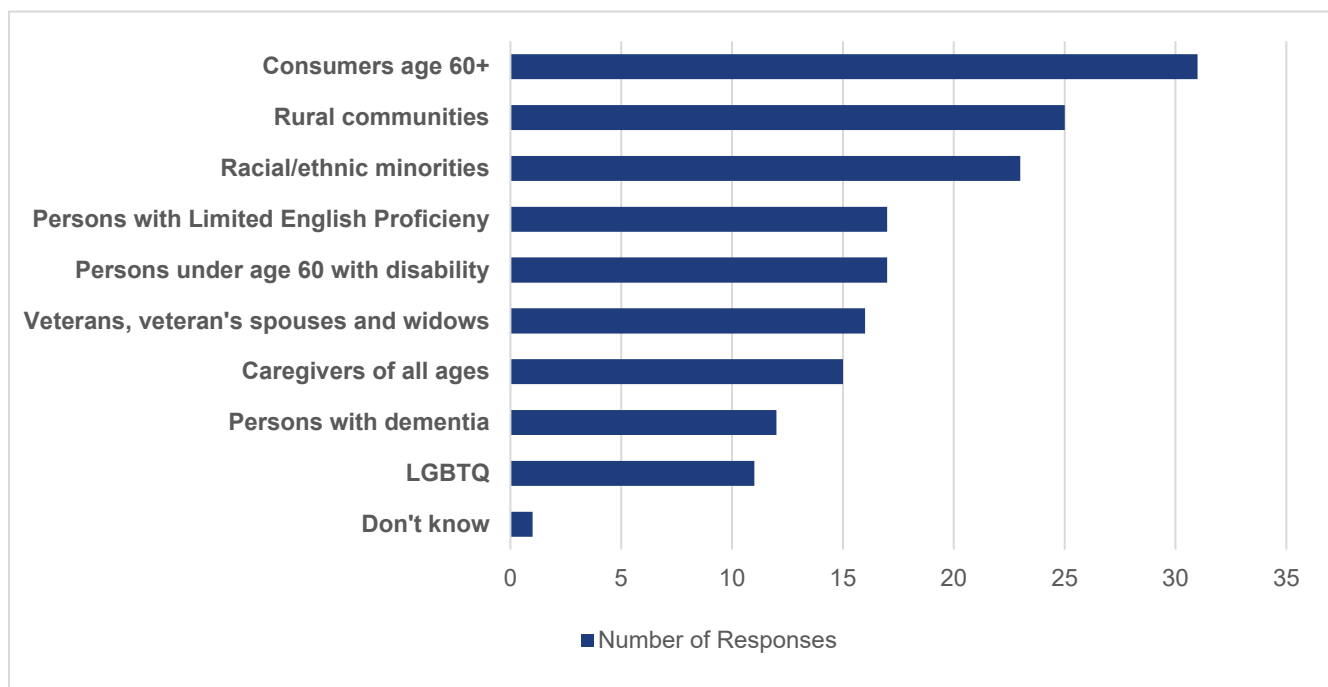

Other responses to this question included:

- Partnerships with local organizations, including healthcare organizations (n=4).
- Fee for service (n=1)
- MD Senior Citizens Activity Center Operating Fund Sponsorships (n=1)

Question 3: Which of the following populations are reached by evidence-based programs in your state? (Check all that apply) **(n=31)**

- All respondents reported that **consumers 60+** were reached by programs in their state, and about 75% of respondents felt that **rural communities** and **racial/ethnic minorities** were reached as well.
- Over half, 55% (n=17) of states reported reaching people with disabilities under age 60 with EBPs. In addition, 52% (n=16) of states indicated that Veterans as well as spouses and widows of Veterans are reached with EBPs.
- Of the populations highlighted, **LGBTQ** older adults and **persons with dementia** are those reached to the least extent compared with other population groups. However, over one-third (36%, n=11) of states are actively providing EBPs to these populations.
- Additionally, one participant noted that they do not ask about Limited English Proficiency (LEP) or LGBTQ status, but all are welcome to join the programs.

Question 4: What are the primary health-related concerns in your state (e.g., diabetes, hypertension, arthritis, falls, etc.)? **(n=31)**

- Most respondents provided a large number of responses to this question, often listing five or more areas of concern.
- The most common health-related concerns highlighted were **diabetes** (n=25, 80.6%), **falls** (n=24, 77.4%), **arthritis** (n=15, 48.4%) and **hypertension** (n=15, 48.4%).
- In contrast, many other concerns were only identified by one or two states, such as isolation, substance abuse, traumatic brain injury and smoking.

Health-Related Concerns	Number of Responses	Percent
Diabetes	25	80.6%
Falls	24	77.4%
Arthritis	15	48.4%
Hypertension	15	48.4%
Heart disease	9	29.0%
Chronic disease	7	22.6%
Affordable food/nutrition	5	16.1%
Cancer	4	12.9%
Mental health	4	12.9%
Obesity	4	12.9%
Alzheimer's disease (and related disorders)	3	9.6%
COPD (Chronic Obstructive Pulmonary Disease)	3	9.6%
Chronic pain	3	9.6%
Caregiver stress and burden	2	6.5%
Physical inactivity	2	6.5%
Cerebrovascular disease	1	3.3%
General health care	1	3.3%
Isolation	1	3.3%
Language barriers	1	3.3%
Osteoporosis	1	3.3%
Poly-pharmacy	1	3.3%
Respiratory disease	1	3.3%
Smoking	1	3.3%
Social determinates of health	1	3.3%
Stroke	1	3.3%
Substance abuse	1	3.3%
Traumatic brain injuries	1	3.3%

Question 5: Do the evidence-based programs you currently offer address the concerns you listed in #4 above, or are there programming gaps? **(n=31)**

- General responses to this question fell into the following three categories:
  - ○ Most respondents (n=18, 58.1%) said that the programs were **sufficient**.
  - ○ A smaller group (n=9, 29.0%) felt their programs addressed their primary concerns, but some **gaps still existed**. The remaining respondents (n=4, 12.9%) felt that programming **did not address** their primary concerns.
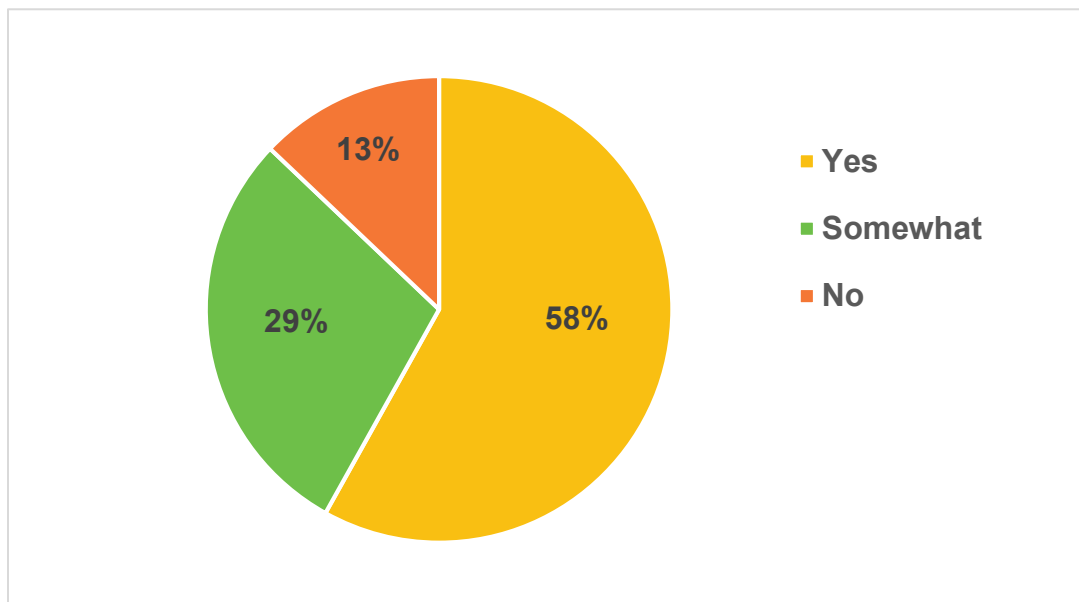
- The following table highlights the key areas that respondents mentioned as needing improvement.
- State representatives cited gaps in the area of **diabetes** (n=3), others lacked **culturally and linguistically appropriate programs** (n=2), and others felt they did not have enough **caregiver focused programs** (n=2).

Programming Gap	Number of Responses
Diabetes	3
Limited English Proficient /Culturally specific programs	2
Caregivers	2
Tribal	1
Oral health	1
Physical activity	1
Chronic pain	1
Drug abuse	1
Younger people with disabilities	1
Falls	1

Programming Gap	Number of Responses
Obesity	1
Arthritis	1
Smoking	1
Hypertension	1

The need for more culturally and linguistically appropriate programs was important for several states. Respondents highlighted other programming challenges. While some programs met needs in certain regions, those programs were not fully scaled to the state level, leaving gaps in some parts of the state. Some gaps were attributed to the lack of trainers available to deliver a given program. For another state, a gap became evident after some physical activity programs were pulled for lacking the evidence base.

Specific comments included:

- Gaps in PSAs were due to funding;
- Some gaps persist, as not all programs are statewide;
- Want to plan other programs as well;
- Some physical activity programs were removed because they were not "evidence-based";
- Need more culturally-specific or culturally-adapted programs for tribal populations, younger people with disabilities, and different cultural/language population;
- Our AAAs currently do not offer caregiver-focused evidence-based programs and DSMP in Spanish is new;
- There are not enough leaders to lead the Chronic Pain Self-Management workshops;
- We are working on adding more programs and service provision statewide;
- Currently finding a smoking cessation EBP proven effective for seniors; and
- We are developing an enhanced EB exercise program, Health Steps in Motion, to better meet older adults falls prevention needs.

Question 6: If applicable, to what extent does the present list of programs on NCOA's website meet the OAA Title III-D criteria reflect your population's needs in terms of age, language availability, and health priority areas (e.g. diabetes, falls)? **(n=31)**

- Most respondents felt that the programs either fully met their needs (59.4%) or somewhat met their needs (31.3%) related to the delivery of programs targeting older adults. Age also received the highest rating average of 3.54 of 4 points.
- In contrast, there was less support for language availability. Most respondents (n=14) felt that the programs only 'somewhat met their needs' (43.8%), 'marginally met their needs' (15.6%), or 'did not meet their needs (3.1%). Language availability received the lowest rating of 2.87, as shown in the chart below.

	Does not meet our needs		Marginally meets our needs		Somewhat meets our needs		Fully meets our needs		N/A		Rating Average
	n	%	*n*	%	*n*	%	*n*	%	*n*	%	
Age	0	0%	2	6.3%	10	31.3%	**19**	**59.4%**	1	3.1%	3.54
Health priority areas	0	0%	2	6.3%	11	34.1%	**17**	**53.1%**	1	3.1%	3.43
Language availability	1	3.1%	5	15.6%	**14**	**43.8%**	9	28.1%	2	6.3%	2.87

Question 7: In what languages, other than English, do you provide evidence-based programs? (please list) **(n=26)**

- Only 4 of the 26 respondents delivered programs only in English.
- The most popular language was **Spanish** (n=12, 46.2%), followed by **Chinese** (n=4, 15.3%) and **Korean** (n=3, 11.5%).
- The remaining languages were represented infrequently, generally -only one respondent identifying use of them. This pattern is partly connected to the fact that one participant offered programs in 9 languages and a few others offered programs in three or more languages.
- Some respondents stated that the languages offered were only for some programs, while other respondents offered no indication to how many programs the language options pertained.
- A respondent declared that they were leaving the answer blank because there are two official languages in their state.
- A respondent noted that interpreters were provided as needed.
- Some of the leaders work with Stanford directly to get translations for CDSME.

- Specific languages in which programs were needed were mentioned by one state representative. Those languages were Russian, Vietnamese and Somali.
- The Office of Refugees, for one state, received permission from Stanford Patient Education to teach the CDSMP course in multiple languages.

| Language	Number of Responses	Percentage
Spanish	12	46.2%
Chinese	4	15.3%
Korean	3	11.5%
Hmong	2	7.7%
Afghani	1	3.8%
American Sign Language	1	3.8%
Arabic	1	3.8%
"Asian languages"	1	3.8%
Cambodian	1	3.8%
Chamorro (Guam, N Mariana Islands)	1	3.8%
Iñupiat (Alaskan Native)	1	3.8%
Japanese	1	3.8%
Karin (Armenian dialect)	1	3.8%
Low vision adaptations	1	3.8%
Lao	1	3.8%
Napali	1	3.8%
Portuguese	1	3.8%
Samoan	1	3.8%
Tagalong	1	3.8%
Various American Indian Tribal Languages	1	3.8%
Vietnamese	1	3.8%

Question 8: Please list the names of programs that you would like to learn more about, review as an evidence-based program, implement for the first time, or expand in your state (e.g. "learn more about HomeMeds", "expand EnhanceFitness in my state" "review N'Balance as a qualified evidence-based program"). **(n=17)**

- Many of the state representatives mentioned different programs, with the most common being **Chronic Pain Self-Management Program** (n=3), **DEEP** (n=3), and **Home Meds** (n=3)
- In some cases, respondents did not know which specific program they were interested in, but instead mentioned the program's focus, such as desiring a walking program.
- Additionally, there were two other responses that didn't mention specific programs or types of program. Mainly, one was interested in any researched adaptations. Another respondent noted that their interests in new programs were limited by funding and that they were eager to learn how to maximize funding dollars.
- A respondent expressed interest in regionally-developed EB or evidence-informed (EI) programs that would complement or support the current menu of options in the State (e.g., DSMP, CDSMP, MOB) and serve as a "next step"" for program respondents.
- There was interest in learning more about evidence-based dementia capability for the aging network from one state representative.
- For one state representative, their desire to launch a program was hindered by competition with Silver Sneakers. While they had, some YMCAs working through the arthritis grant offering EnhanceFitness, the program has been hard to get off the ground since it competes with Silver Sneakers for which YMCAs receive reimbursement.
- Another respondent felt knowledgeable about most existing and recognized programs, but wanted to learn more about new and emerging programs, as well as access published research adaptations of existing programs.

Program or Program Type To Learn More About	Number of Responses
Chronic Pain Self-Management Program	3
Diabetes Empowerment Education Program (DEEP)	3
Home Meds	3
Cancer: Thriving and Surviving	2
EnhanceFitness	2
Matter of Balance	2
Powerful Tools for Caregivers	2
SAIL	2
"Diabetes management"	1
Eat Smart, Live Strong	1
Fit and Strong!	1
Healthy IDEAS	1
Healthy Steps in Motion	1
Programa de Manejo Personal de la Diabetes	1
Otago	1
"Other online or self-directed programs"	1
PEARLS	1
Powerful Tools for Caregivers	1
Regionally-developed EB or EI programs	1
Stay Safe, Stay Active	1
Tai Chi /	1
Tai Ji Quan: Moving for Better Balance	1
"Walking program"	1

Question 9: How familiar are you with ACL's criteria for evidence-based programs? **(n=31)**

- The vast majority (n=24, 77.4%) were very familiar and have applied the criteria.
- Beyond this group, 4 respondents (12.9%) stated that they were working toward applying the criteria and another 3 (9.7%) had not yet begun to take steps.
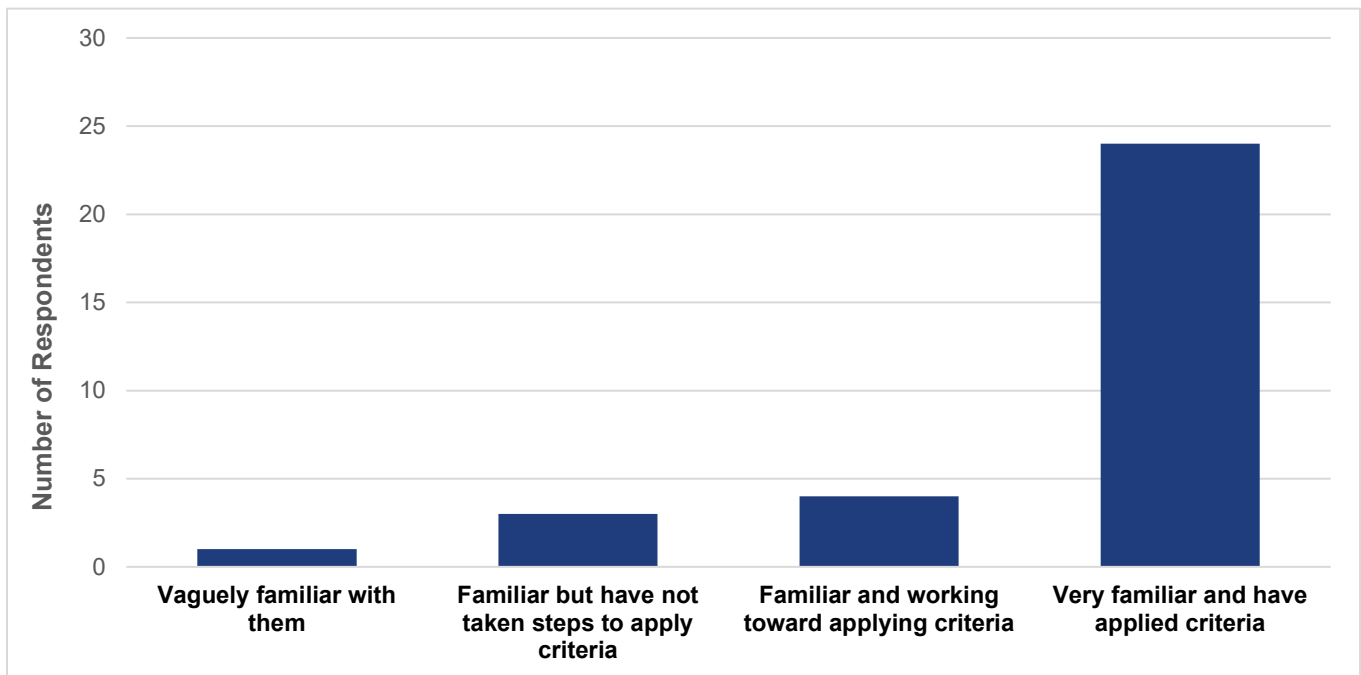
Question 10: How are decisions made as to which evidence-based programs are allowed to receive Title III-D funding in your state? Is there a review process? If so, how does it work? **(n=31)**

- The most common process was described by 11 states. They required that AAAs or partners indicate which programs they sought to implement by identifying them in their area plans. This list is informed by a number of resources, including a comparison to programs recognized by the CDC, ACL, SAMHSA, HHS, or programs selected based on public health reports, data and priorities established by the state, program sustainability potential, NCOA's list, and the Evidence Based Leadership Council website.

- Eight SUAs provide a pre-approved list to AAAs from which they select the programs they wish to implement. A range of resources are used to generate this list, including an internal log of recognized programs, or any others they can identify through CDC, ACL's webpage, ADEPP, SAMSHA, NCOA's list, or conversations with ACL staff. Some did not specify what source they used to determine if a program met the requirements.

  - Of these states, 2 issue an RFP and invite specific pre-approved programs to be proposed.
  - One state has a waiver process that allows AAAs to submit a program for review that is not already on the pre-approved list, so long as they can point to specific evidence, such as quasi-experimental study design, peer-reviewed publications, effectiveness in older adults, and has dissemination materials.

- Another state has a grant review process in place; however, they have only had a few applicants. The applicant selects the evidence-based program, and implements that program if they are funded, assuming the program meets ACL criteria.

- One state requires that the AAA have someone on staff or on contract certified in the program in order for that program to be approved by the SUA for III-D funding.

- Another state has a Title III-D assessment tool worksheet that AAAs must complete, which SUA then reviews and approves.

- One state developed a Title III-D Workgroup consisting of a Title III-D specialist to refine the process.

- There were a few other general responses that only those evidence-based programs that met ACL criteria were approved at the state level, though no specifics were given about how evidence was reviewed.
- Two state representatives shared that they had limited capacity and resources to evaluate new programs, with one adding that they did not have a review system in place as it was not needed.
- Lastly, one state representative noted that their SUA's greatest struggle was not deciding which programs proposed by the AAAs would be funded. Rather, the issue was educating them about the concept of evidence-based programs to avoid regular requests for such items as smoke alarms or pedometers.

Question 11: How would you describe the adequacy of resources (e.g. fiscal, personnel) in your state to evaluate whether a program meets the new ACL Evidence-Based Program requirements? **(n=31)**

- Relatively few respondents felt that they had ample resources (n=3, 9.7%)
- In contrast, most felt that they had a moderate (n=12, 38.7%) or a modest/scant (n=10, 32.3%) amount of resources.
- States reporting a range of resources:
  - Do not have resources (n=6)
  - Modest or scant resources (n=11)
  - Moderate resources (n=11)
  - Ample resources (n=3)
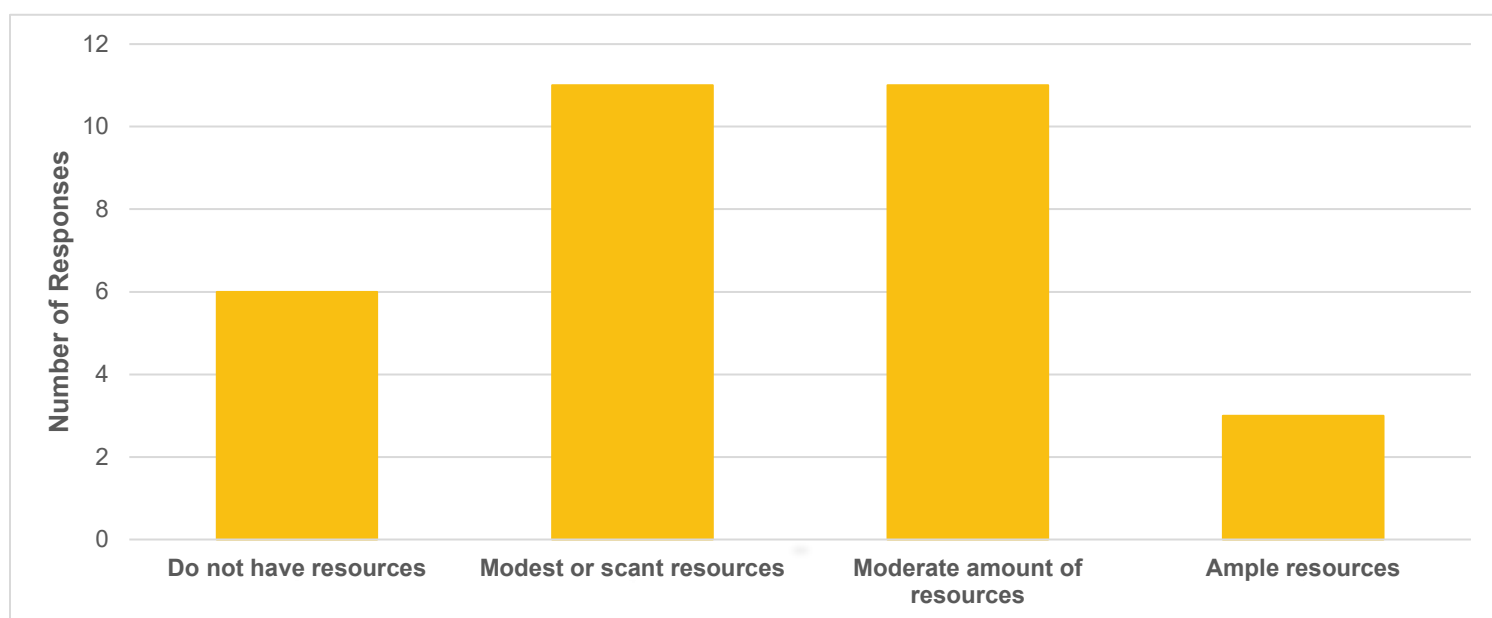
Question 12: What resources do you rely on to identify evidence-based programs suitable for your state? (Check all that apply) **(n=31)**

- **ACL's Aging and Disability Evidence-Based Programs and Practices (ADEPP)** (n=29, 93.5%) and **NCOA** (n=27, 87.1%) were the popular resources used by SUAs for determining whether evidence-based programs meet ACL's newest criteria.
- The next most popular resource was The National Registry of Evidence-based Programs and Practices (NREPP) at The Substance Abuse and Mental Health Services Administration (n=15, 48.4%).
- In the 'other' section, respondents listed information from the CDC, other HHS departments, an OAA EBP checklist, and other partners in the aging network.

Resources	Number of Responses	Percentage
ACL, Aging and Disability Evidence-Based Programs and Practices (ADEPP) listing	29	93.5%
NCOA, Highest Tier Evidence-based Health Promotion/Disease	27	87.1%
The Substance Abuse and Mental Health Services Administration (SAMHSA), The National Registry of Evidence-based Programs and Practices (NREPP)	15	48.4%
Evidence-Based Leadership Council, Recommended Programs	13	41.9%
Program websites	10	32.3%
Scientific literature	10	32.3%
Experience from other state/AAA directors who have implemented that program	5	16.1%
Evidence-based program developer	4	12.9%
Other (please specify)	4	12.9%

The qualitative responses given under 'other' are given in the table below. Some provided multiple sources.

Other Resources	Number of Responses
CDC and its compendium	2
Any HHS operating division	1
Older Americans Act Title III-D Evidence-Based Program Assessment Checklist	1
Partners in the aging network	1
NCOA's list, though it was noted that it was unclear how up-to-date the list was, and the logic of its organization was unclear	1

Question 13: In terms of expanding the options for fundable evidence-based programs in your state, what are the top priorities? **(n=31)**

- With the exception of availability in **non-English languages**, all of the priorities received a rating average of more than 3.0, indicating that respondents viewed them as at least 'somewhat important'.
- The two most significant areas were **program costs** and **availability of trainers**. For these areas, 80.6% (n=25) of respondents viewed them as being 'very important'.
- Additionally, **impact on specific outcomes** and **program length** were also topics that more than half of the respondents considered to be 'very important'.

|	Not at all important		Not very important		Somewhat important		Very important		Rating Average
	n	%	n	%	n	%	n	%	
Program costs (e.g. licensing, materials)	0	0%	0	0%	6	19.4%	**25**	**80.6%**	3.80
Availability of trainers that meet leader qualifications	0	0%	0	0%	6	19.4%	**25**	**80.6%**	3.80
Program length and staff time/cost	0	0%	0	0%	12	38.7%	**19**	**61.3%**	3.61
Impact on specific outcomes of highest need in your state (e.g. depression, reduced # of falls)	0	0%	1	3.2%	11	35.5%	**19**	**61.3%**	3.58
Delivery approach (e.g. face-to-face, online, self-directed)	0	0%	3	9.7%	11	35.5%	**16**	**51.6%**	3.43
Cost savings per participant resulting from improved outcomes & other program benefits	0	0%	0	0.0%	**19**	**61.3%**	12	38.7%	3.38
Flexibility of curriculum to make cultural adaptations	0	0%	3	9.7%	**21**	**67.7%**	7	22.6%	3.12
Availability of program in non-English languages	0	0%	7	22.6%	**19**	**61.3%**	5	16.1%	2.93

Question 14: Aside from those listed above, what other factors are considered in determining funding priorities for evidence-based programs? **(n=13)**

- As this was an open-ended question, the answers varied considerably. However, the table below shows the general trends.
- The most common concerns were related to funding (n=6) and ensuring that the programs were appealing to the population (n=4).
- A respondent raised the importance of addressing rural communities and the costs of training certified program leaders. In a related comment, it was noted that in rural areas, having programs that don't require a minimum number of participants is important. In addition, rural communities benefit from programs with web-based training, such as Walk With Ease. Otherwise, AAAs may have to wait several months or a year until the next training is available.

| Factors	Number of Responses
Funding, program costs and budget	6
Appeal to population	4
Ease of offering training and time involved	2
Sustainability	2
Ability to maintain fidelity	1
Administration	1
Cost of travel for training	1
Flexibility	1
Number of leaders needed	1
Partners	1
Programs that can use volunteers vs health care professionals	1
Promotion, outreach and marketing	1
Retention	1
Transportation	1
Programs not already offered/overall scope of programs offered	1
Programs with online training	1
Programs offered in the home	1

Question 15: Have you sought technical assistance (TA) related to evidence-based programs and Title III-D? **(n=31)**

- The majority of respondents had sought TA for programs and Title III-D (n=28, 90.3%)
- The remaining 9.7% (n=3) respondents had not sought assistance.
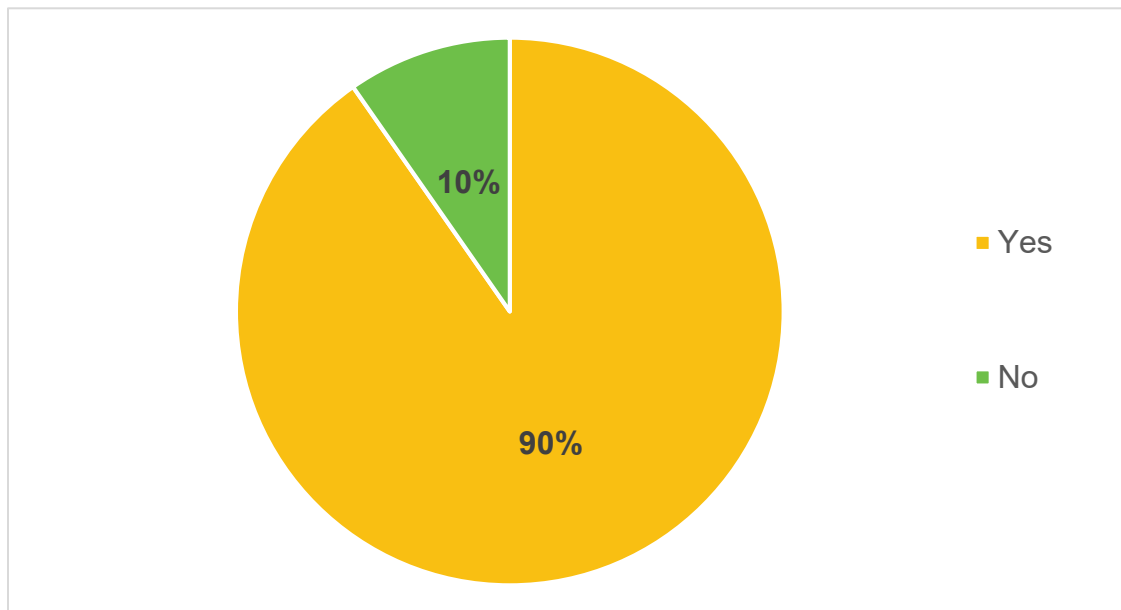
Question 16: If yes, where have you sought TA from? (Check all that apply) **(n=28)**

- ACL was the most common place respondents sought support from, with 64.3% of respondents (n=18) looking to the **ACL Regional Office** and 9 respondents favoring the **ACL Central Office** 32.1% (n=9).
- About 39.3% (n=11) communicated with **evidence-based program developers**.
- Other sources of TA support were less common, with the least likely being academics (n=3, 10.7%) and healthcare partners (n=3, 10.7%).
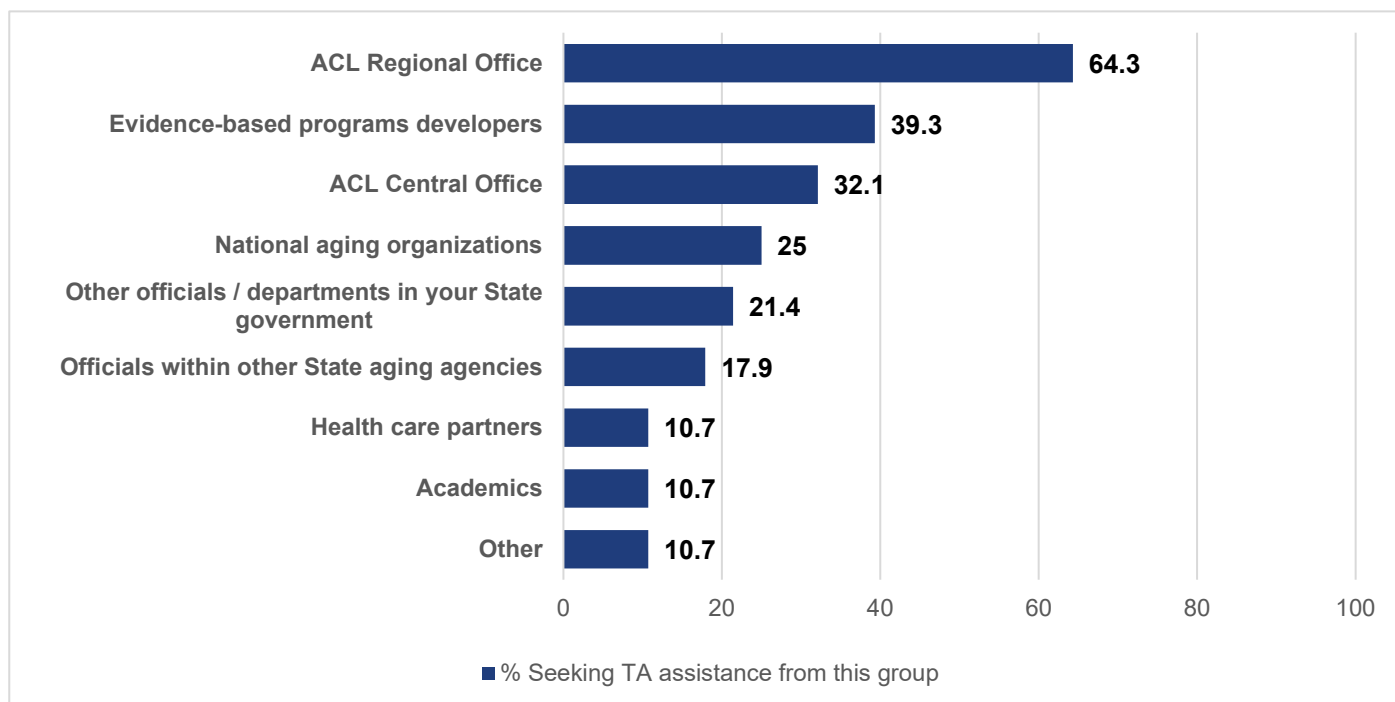
Question 17: Approximately how often are you in communication with AAAs in your state in an effort to support their delivery of evidence-based disease prevention and health promotion programs? **(n=30)**

- The majority of respondents (n=29, 93.5%) are in communication with AAAs.
- Frequency of communication varied across respondents, with the most common patterns being either **monthly** (n=11, 35.5%) or **quarterly** (n=7, 22.6%).
- In contrast, only 12.9% (n=4) of respondents communicated **bi-annually** and the remaining 22.6% (n=7) communicated **weekly**.
- As such, the majority of respondents communicated **at least quarterly** with AAAs (n=26, 86.7%).

Question 18: How confident do you feel in providing substantive, current, and accurate information to AAAs to support their efforts in delivering evidence-based programs to their constituents/consumers? **(n=30)**

- The majority of respondents (n=18, 58.1%) were '**moderately confident**' about providing substantive, current and accurate information to AAAs.
- Only one person indicated they were 'not very confident'.
- The remaining respondents (n=11, 35.5%) were '**very confident**'.
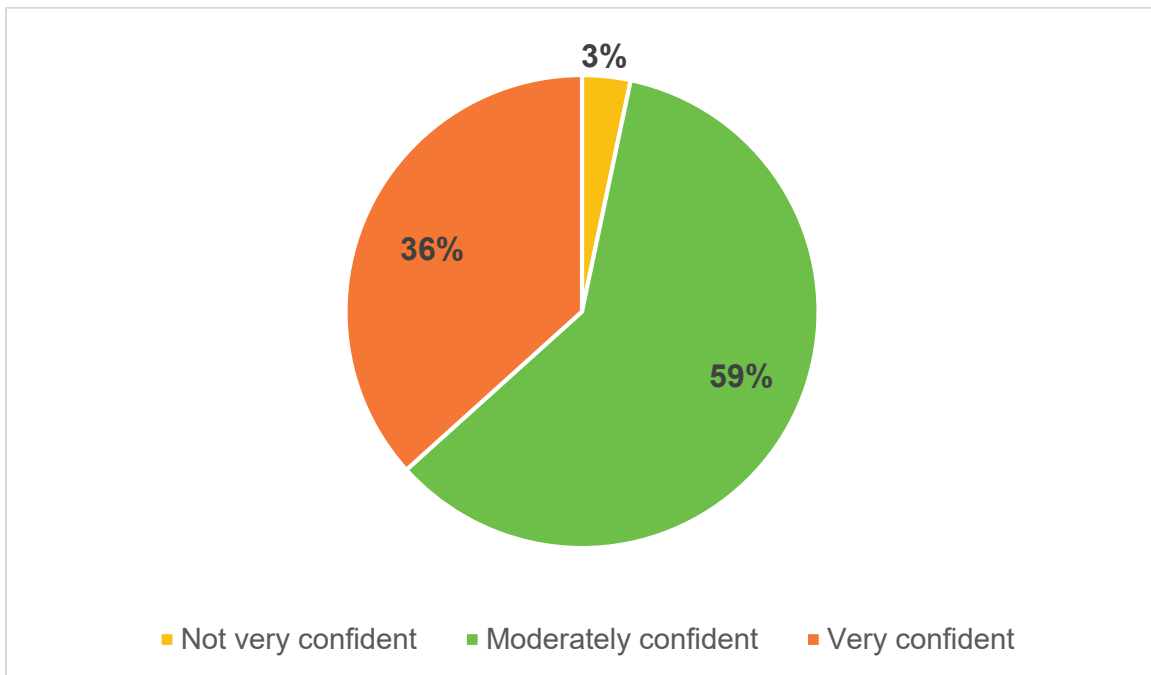
Question 19: On what subjects would additional technical support from ACL or other organizations such as NCOA be helpful to you as you guide AAAs in expanding the impact and reach of evidence-based programs? (Check all that apply) **(n=30)**

- All seven topics addressed in this question received responses from 45% or more respondents.
- The most popular topics were **sustainability strategies** (83.3%, n=25), **establishing partnerships** (76.7%, n=23) and **creating network hubs** (63.3%, n=19).
- In contrast, the least popular was centralized data management/reporting systems (46.7%, n=14).
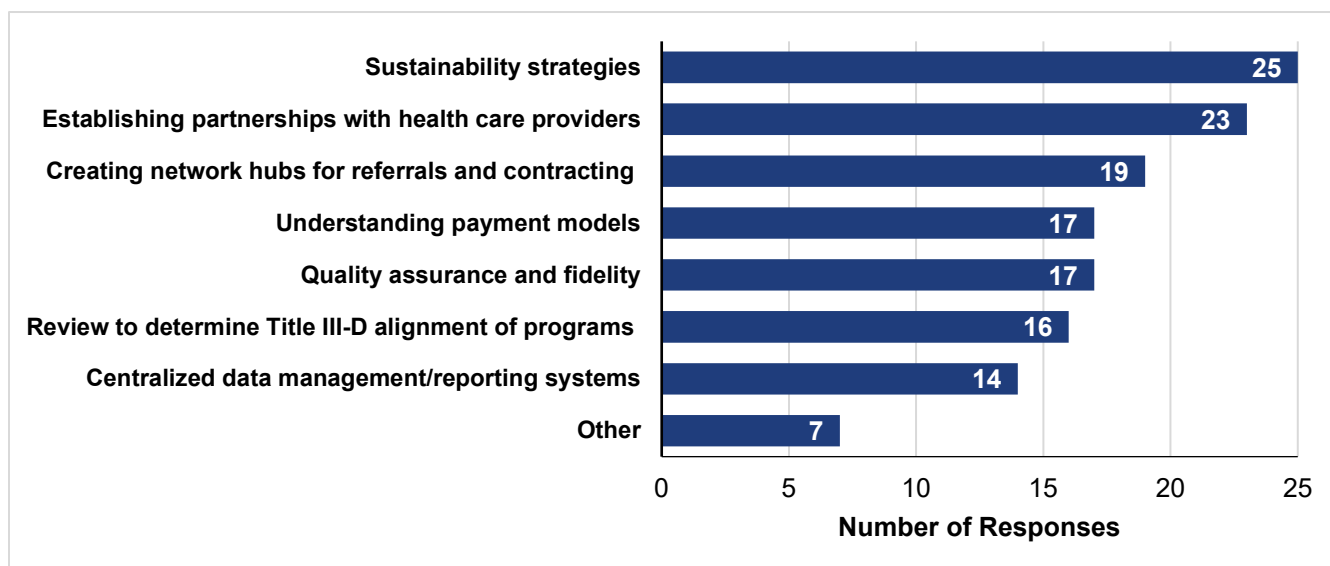
As part of those responses, 7 respondents (23.3%) stated 'other' and wrote in responses. Two of these were not relevant and were excluded, while the remaining 5 responses were as follows:

- Affordable and accessible **programs for rural frontier**
- Identifying new/emerging **program options for rural areas**
- '**One stop shop'** for all approved evidence-based programs
- More **EB physical activity programs**
- **Effective communication with healthcare providers, insurers, and integrated care professionals**, particularly through people in the business talking to AAAs.