The Older Americans Act Title IIDD and the Evidence-Based Program Requirement

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OAA Title III-D: The Evidence-Based Program Requirement

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Title III-D in the Legislation

• 2012: Congress changed Appropriation Bill language
  • Funding amount for Title III Part D section 361 of the Older Americans Act for Disease Prevention and Health Promotion may only be used for programs and activities which have been demonstrated through rigorous evaluation to be evidence-based and effective.

• 2016 OAA re-authorization added “evidence-based” into Title III-D itself, affirming the language in the appropriations bills
Phasing in the Evidence-Based Program Requirement

- First phase
  - 2012—Sept 30, 2016
  - Three tiers of programs

- Second phase
  - Oct 1, 2016 and on
  - Only highest-level (tier 3) programs

- Wanted to help states meet the evidence-based program requirements, without abruptly ending programs taking place
Three-Tiers of Evidence-Based (2012-FY2016)

**Minimal Criteria (Tier 1)**

Demonstrated through evaluation to be effective for improving the health and wellbeing or reducing disease, disability and/or injury among older adults; and

Ready for translation, implementation and/or broad dissemination by community-based organizations using appropriately credentialed practitioners.

**Intermediate Criteria (Tier 2)**

All of the Minimal Criteria, PLUS:

Published in a peer-review journal; and

Proven effective with older adult population, using some form of a control condition (e.g. pre-post study, case control design, etc.); and

Some basis in translation for implementation by community level organization.

**Highest-Level Criteria (Tier 3)**

All of the Intermediate Criteria, PLUS:

Proven effective with older adult population, using Experimental or Quasi-Experimental Design; and

Fully translated in one or more community site(s); and

Includes developed dissemination products that are available to the public.
ACL Definition of Evidence-Based, Oct 1, 2016

AKA “highest-level only”

• Demonstrated through evaluation to be effective for improving the health and wellbeing or reducing disease, disability and/or injury among older adults; and
• Proven effective with older adult population, using Experimental or Quasi-Experimental Design; and
• Research results published in a peer-review journal; and
• Fully translated in one or more community site(s); and
• Includes developed dissemination products that are available to the public.
State Responsibility

• States are to ensure that Title III-D funds are spent only on evidence-based programs for older adults

• **SUAs have discretion on how they implement this requirement**
  – SUAs can choose to be more restrictive than ACL’s criteria
  – However, SUAs cannot be less restrictive than ACL’s criteria
Examples of Evidence-Based Programs

• Common program types include:
  – Class-based physical activity programs
  – Falls prevention programs (classes or one-on-one)
  – Self-management programs
  – One-on-one health interventions within the home
What Makes Something a “Program”?

• Different than stand-alone materials or resources (even if they are based on scientific evidence)
• Must be studied itself—as a program.
• Should have resources for the leader/organization to guide implementation and dissemination materials for program participants
Why is there an EBP Requirement?

- Proving the value of OAA investments to Congress
- Opportunity where AAAs can provide something payers want
ACL Perspective

• Recognize the significant challenge with this requirement
• Dedicated to helping states and AAAs implement appropriate programs
• Grateful for the resources from our non-governmental partners
Lessons Learned—Best Practices

Strong state leadership to the aging network and the public Health promotion staff identified and made available

• TA provided to AAAs
• Conference calls held regularly
• Centralized websites with workshop locators
• State-wide branding/marketing materials available
Lessons Learned—Best Practices, cont.

Consider the Hub Model

• A State, AAA, or network of AAAs serves as a hub.
• The hub holds the licenses, orders materials and supplies in bulk, provides marketing services and provides trainers and facilitators
• Reduces costs and increases efficiencies
Lessons Learned—Best Practices, cont.

Leverage existing infrastructure, such as prior and current discretionary grants from AoA/ACL:

- Evidence-based Disease & Disability Prevention Program (2003-2012)
- ARRA grants (2010-2012)
- PPHF Falls Prevention grants (2014, 2015)
Lessons Learned—Best Practices, cont.

Don’t build from scratch

• See who you can buy services from within your state/PSA
• Partner with nonprofits already doing this work, braid funding
• Leverage existing resources
  – Contract with other organizations to provide your workshops
  – May be less expensive than paying for your staff or volunteers to be trained
Maryland’s Experience: Translating Federal Requirements into State Programs

MARYLAND DEPARTMENT OF AGING

Larry Hogan, Governor    Boyd K. Rutherford, Lt. Governor    Rona Kramer, Secretary
Successful Implementation Steps

✓ Provide timely translation of federal requirements
✓ Consider option for AAAs to request additional evidence-based programs for IID funding
✓ Create or gather existing training and reporting materials
✓ Track and share activities, best practices
Timely Translation FY2012: Tiered Levels

- Lowest, Moderate, Highest
- Permitted all levels
- Shared AoA guidance and training documents
- Added Title III-D EB requirements to Annual HP Monitoring Report
Title III-D Monitoring Report

(REMINDER: COMPLETE A SEPARATE PAGE FOR EACH TITLE III-D PROGRAM)

Program #: Name of Program: __________________________
Amount of Title III-D funding: ____________________________
(Total figure for all programs combined must equal total Title III-D allocation)

Category of Evidence Level: (check one)  ○ Minimal ○ Intermediate ○ Highest

Place a check mark on applicable checklist based on the Evidence Level for this Program to indicate the documentation on file. Documentation must be on file at AAA and available for review.

Required Materials for Minimal Evidence Level:
- Copies of the key peer-reviewed journal articles or guidelines and/or consensus statements based on scientific evidence from the National Institute of Medicine, Food and Drug Administration or other similar institution.
- Explanation of the program, including agenda of event(s), contracts for service(s), and etc which fully detail the service(s) provided.
- Schedule of program delivery for the current Federal fiscal year.
- Copies of licenses or other necessary certifications for all practitioners.

Required Materials for Intermediate Evidence Level:
- Copies of the key peer-reviewed journal articles or guidelines and/or consensus statements based on scientific evidence from the National Institute of Medicine, Food and Drug Administration or other similar institution.
- Explanation of the program, including agenda of event(s), contracts for service(s), and etc which fully detail the service(s) provided.
- Schedule of program delivery for the current Federal fiscal year.
- Copies of licenses or other necessary certifications for all practitioners.
- Copies of or full resource listing for the evidence base supporting the program or service implementation with the adult population
- Copies of outcome studies, including results, for this program

Required Materials for Highest Evidence Level:
- The Program appears on the list of Tier III Evidence-Based programs provide in APD-12-04.
- Schedule of program delivery for the current Federal fiscal year.
- Copies of licenses or other necessary certifications for all practitioners.
Timely Translation FY2015: Highest Only

- Monitoring focus on documentation

- Shared federal compendiums and encouraged regular use of ACL website for updates
Timely Translation FY2015: Highest Only

- Annual HP Monitoring Report Title III-D requirements updated

- Established “Consideration of Highest Level” Request Process
Title III-D Expenditure Areas

- CDSME 47%
- Falls Prevention 27%
- Physical Fitness/Arthritis 22%
- Nutrition/Caregiver (<1%)
- Medication Management (4%)
# Statewide Landscape of Title III-D Programs

<table>
<thead>
<tr>
<th></th>
<th>CDSME</th>
<th>Falls Prevention</th>
<th>Fitness - Arthritis</th>
<th>Healthy Eating or Hypertension</th>
<th>Caregiver or Mental Health</th>
<th>Medication Management</th>
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**RED** boxes indicate EB programs which currently receive no IIID funding.
<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>FOCUS AREA</th>
<th>PROVEN OUTCOMES</th>
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<tbody>
<tr>
<td><strong>HEALTHY EATING FOR SUCCESSFUL LIVING</strong></td>
<td>EATING HEALTHFULLY AND PHYSICAL ACTIVITY</td>
<td>IMPROVED EATING HABITS</td>
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<td><strong>HOMEMEDS</strong></td>
<td>ADDRESS MEDICATION-RELATED PROBLEMS AND ERRORS</td>
<td>PREVENTS FALLS</td>
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<td><strong>ENHANCE FITNESS</strong></td>
<td>FUNCTIONAL FITNESS &amp; WELLBEING</td>
<td>IMPROVED SOCIAL FUNCTION</td>
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<tr>
<td><strong>STEPPING ON</strong></td>
<td>FALLS (Falls → inactivity and isolation)</td>
<td>BEHAVIORAL CHANGE</td>
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<td><strong>PEARLS</strong></td>
<td>REDUCES SYMPTOMS OF DEPRESSION AND &amp; IMPROVES QUALITY OF LIFE</td>
<td>&gt;50% REDUCTION IN DEPRESSION SYMPTOMS</td>
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*Sample of Key Outcomes.*
## CDSME Example: Connecting to The Accountable Care Act

<table>
<thead>
<tr>
<th>Triple Aim Goal</th>
<th>Outcome Measure</th>
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<tbody>
<tr>
<td><strong>Better Care</strong></td>
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<tr>
<td>Medication Compliance</td>
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<tr>
<td>Health Literacy</td>
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<td><strong>Better Outcomes</strong></td>
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<td>Self-assessed Health</td>
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<td>PHQ Depression</td>
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<td>Quality of Life</td>
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<td>Unhealthy Physical Days</td>
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<tr>
<td>Unhealthy Mental Days</td>
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<td><strong>Lower Health Care Costs</strong></td>
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<tr>
<td>% w/ ED Visits in the Past 6 Months</td>
<td>↓ REDUCED</td>
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</table>
Translate **Fidelity**; Select Outcomes

- ✓ Credentialing at all levels
- ✓ Mentoring/supervision
- ✓ Adherence to curriculum
- ✓ Program Updates
- ✓ Continuing education
  - Refreshers
Translate **Fidelity**; Select Outcomes

- Follow instructional format
- (workshop, individual, etc)
- Licensing fees

**2016 CDSME Fidelity Manual**
- Fidelity Before Workshop
- Fidelity During Workshop
- Fidelity After Workshop
- Sample contracts
- Sample fidelity forms
- Job descriptions
GOAL for Evidence Based Studies: “Community Translation”

**Grant Funding**
- Workforce
- Data
- Partners
- Training, Capacity Building
- Business Plan

**Outcomes**
- Healthy behaviors, blood value changes.
- Expenditures: National Studies (estimated and actual)

**Sustainability**
- Hospitals, Insurance, Medicaid, Medicare billing/payments
- AAAs partner to provide services
Maryland’s Successful Practices

✓ Living Well Center of Excellence
✓ Gather Outcomes (database)
✓ Regional Coordinators or Hubs
✓ Quarterly Webinars (FY2016 Focus: “Alternative” Evidence Based Programs)
Maryland’s Successful Practices

- Older Marylanders Walk a Million Miles
- In-person Trainings, as Feasible
- Highlight Low-Cost, Low Resource Programs
QUESTIONS AND DISCUSSION