National Council on Aging

ISSUE BRIEF

Evidence-Based Health Promotion Programs for Older Adults

Key Factors and Strategies Contributing to Program Sustainability

Background

Older adults are disproportionately affected by long-term (chronic) health conditions such as arthritis, diabetes, heart disease, and disabilities that result from injuries such as falls. Consider:

- 91% of older adults have at least one chronic health condition.[1]
- 77% of older adults have at least two chronic health conditions.[5]
- More than one-third of older adults fall each year, with the financial impact of falls expected to reach nearly $55 billion by 2020.[2]
- One in four older adults experience behavioral health issues such as depression and anxiety, as well as medication and substance misuse.[3]

These health challenges result in high economic and health care costs[4] and call attention to the critical role that evidence-based health promotion programs play in helping older adults adopt healthy self-management behaviors, increase well-being, and reduce health service utilization. Despite the positive program outcomes, however, states and local partners often find it difficult to sustain these programs after the initial grant period due to limited resources in a challenging economic environment. Policymakers and funders are increasingly concerned with allocating scarce resources effectively and efficiently. This brief serves to provide a framework for program sustainability. While many of the examples are based on the experiences of state units on aging and public health departments, the overarching themes are certainly applicable to community-based organizations.

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1 Anderson G. Chronic Care: Making the Case for Ongoing Care. Princeton, NJ: Robert Wood Johnson Foundation, 2010.

2 Administration on Aging (AoA) Falls Prevention Programs Fact Sheet. 2011. Available at *www.ncoa.org/improve-health/center-for-healthy-aging/content-library/AoA-Falls-Program-Overview.pdf.*

3 Lessons Learned on Sustainability of Older Adult Community Behavioral Health Services. Available at *www.ncoa.org/improve-health/center-for-healthy-aging/content-library/lessons-learned-on.html.*

4 *http://www.ahrq.gov/research/ria19/expendria.htm and http://content.healthaffairs.org/content/20/2/9.short*

5 Rabin, B., Brownson, R., Haire-Joshu, D., Kreuter, M., & Weaver, N. (2008). A Glossary for Dissemination and Implementation Research in Health. Journal of Public Health Management and Practice, 14(2), 117-123.

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Sustainability Framework

The goal of sustainability is to integrate and embed evidence-based health promotion programs within organizations, as well as health and long-term services and supports systems. Sustainability ensures that evidence-based health promotion programs are easily accessible and available to individuals beyond the time after external support from a donor agency ends.[5,6] An ongoing and interactive process, planning for sustainability must be integrated into the program implementation process from the beginning. A sustainability plan focuses on the management and acquisition of resources, both fiscal and in-kind, to maintain and expand programming.[7] Refer to the RE-AIM

Partnerships	• Engage key stakeholders • Set common priorities and goals • Create a sustainability committee • Secure resource contributions from diverse partners
Infrastructure & Delivery System	• Designate a program champion • Engage executive leadership support • Plan for sufficient staffing and training • Develop a centralized or coordinated logistical process
Financing	• Diversify funding streams • Incorporate objectives, strategies, and action steps into a business plan • Demonstrate value and demand
Marketing	• Utilize testimonials • Build the network by tailoring messaging • Build a roster of community champions • Use a broad range of media and outlets
Quality Assurance	• Focus on continuous quality improvement • Monitor program fidelity • Determine specific and measurable performance indicators • Conduct ongoing evaluation
Policy Action	• Raise and maintain awareness • Build credibility • Educate the public and policymakers • Champion organizational policies and processes • Cultivate community ownership

[6] Scheirer, M.A. (2005). Is sustainability possible? A review and commentary on empirical studies of program sustainability. American Journal of Evaluation, 26(3), 320-347.

[7] AoA/NCOA Quality Assurance Planning Template: *http://www.ncoa.org/assets/files/pdf/QA-Planning-Template.pdf*

framework[8] to learn how sustainability/maintenance is integral to the planning process. The following factors and strategies should be considered when planning for sustainability:[5,9,10,11]

Partnerships

A strong state-level aging and public health partnership can provide effective leadership and project management. These partners should collaboratively identify and document a state vision for evidence-based programming and develop strategies for an integrated system to support programming in their state plans. State partners can build strategic partnerships with the public and private sector to expand program reach and embed evidence-based programs into health and long-term services and supports systems.

Partnerships can increase program awareness through shared messaging and facilitate the integration of health promotion programming into referral and service delivery systems. Effective partnerships can be established with agencies that have successfully embedded evidence-based programs within their systems, have multiple implementation sites throughout the state, and/or can reach targeted underserved populations. Visit the National Council on Aging's (NCOA) Center for Healthy Aging website[12] at *www.ncoa.org/CHA* to learn more about an array of evidence-based programs for older adults.

Engage key stakeholders, early and often, to support evidence-based health promotion programming as part of health and long-term services. Stakeholders help champion program benefits, conduct outreach to diverse communities, and mobilize demand and support for programs. Identify external and internal stakeholders who can provide a unique perspective and expertise to achieving program sustainability. External stakeholders may include community leaders, community based organizations, faith-based organizations, parks and recreation, volunteer groups such as RSVP, physician groups, hospitals, health care providers, advisory boards, community-based organizations, and Medicaid coalitions. Internal stakeholders include decision-makers within the organization such as key leadership and board members. Encourage stakeholders to educate at multiple levels and reinforce program impact, including collecting and sharing participant testimonials and outcome data.

Potential Partners

- Senior centers
- Aging and Disability Resource Centers (ADRCs)
- Faith-based organizations
- Senior housing
- Federally Qualified Health Centers (FQHC)/Rural Health Centers (RHC)
- Patient-Centered Medical Homes (PCMHs)
- Accountable care organizations (ACOs)
- Health plans
- Veterans Administration
- State Medicaid agencies
- State mental and behavioral health departments
- Department of Corrections
- Philanthropic and charitable organizations
- Corporations and employers
- Tribal entities
- Volunteer programs such as RSVP
- Tobacco cessation programs

[8] NCOA RE-AIM Framework (Reach, Effectiveness, Adoption, Implementation, and Maintenance). Available at *www.ncoa.org/improve-health/center-for-healthy-aging/content library/re-aim-for-program-planning.html.*

[9] Evashwick, C., & Ory, M. (2003). Organizational characteristics of successful innovative health care programs sustained over time. Family Community Health, 26(3), 177-193.

[10] Shediac-Rizkallah, M.C., & Bone, L.R. (1998). Planning for the sustainability of community-based health programs: Conceptual frameworks and future directions for research, practice and policy. Health Education Research, 13(1), 87-108.

[11] Missouri Arthritis and Osteoporosis Program (2012). Missouri's sustainability toolkit: Self-management education programs for people with chronic conditions. Columbia, MO.

[12] National Council on Aging (NCOA) Center for Health Aging (CHA) Intro to Health Promotion Programs. Available at *www.ncoa.org/improve-health/center-for-healthy-aging/online-training-modules/series-1-intro-to-health.html.*

Set common priorities and goals to support program sustainability over the long-term. Establish consistent communication on progress, monitoring, and evaluation. Develop a formal agreement that details the roles and responsibilities of each partner, as well as measurements to monitor progress toward goals. Recognizing partnership efforts and accomplishments is also important.

Create a sustainability committee by recruiting stakeholders with diverse expertise, such as program champions, marketers, evaluators, program experts, researchers, and community leaders, to advise and make recommendations toward program sustainability.

Common Priorities

The **University of Medicine and Dentistry of New Jersey** School of Nursing is embedding education on CDSMP and evidence-based programs in the curriculum at all nursing degree levels.

Delaware embeds the Diabetes Self-Management Program (DSMP) into their health system through strategic partnerships with the Healthier Sussex Task Force, a Federally Qualified Health Center, the Centers for Disease Control and Prevention, and the Department of Corrections. Leveraging these partnerships has strengthened the delivery and referral system throughout the state, while effectively marketing and recruiting targeted populations.

The **Wisconsin Institute for Healthy Aging** (WIHA) is the state's home for evidence-based prevention programs. It develops partnerships with public and private organizations within the state to disseminate programs and further research efforts. WIHA also convenes an Evidence-Based Prevention Program (EBPP) Coordinating Committee to ensure program continuity and fidelity. Committee members represent diverse state partners, including Area Agencies on Aging, the Department of Health Services, the University of Wisconsin, county and tribal aging offices, and heath care agencies and providers.

Secure resource contributions from diverse partners so resources and expertise can be maximized. Examples include sharing program staffing, facilities, equipment, marketing materials, technical expertise, printing costs, participant transportation, programming fees, in-kind support, workshop space, and website assistance.

Infrastructure & Delivery System

Begin by engaging both public health and aging/disability networks at the state and local level. Multiple factors work together to create a robust infrastructure and a well-coordinated delivery system, ensuring that evidence-based health promotion programs are available and accessible to as many people as possible. For instance, likelihood for sustainability increases with accessible workshop space and sufficient workforce capacity to meet workshop need in targeted delivery areas. It also increases when programs are integrated within an organization's current processes and policies, with staff and other stakeholders perceiving programming benefits for themselves and participants. Systems and procedures also should be in place for efficient communication, data collection, and monitoring. A well-coordinated and integrated service and delivery system creates a pipeline for participant referrals and also provides the opportunity to embed programs into delivery system partners, known as "turnkey" partners, such as health care organizations, community health clinics, county public health agencies, managed care organizations, tobacco cessation programs, Medicaid, Aging and Disability Resource Centers (ADRCs), State Health Insurance Assistance Programs (SHIPs), and the Senior Community Service Employment Program (SCSEP).

Identify a program champion(s), a key person(s) who is responsible for implementing the program. The champion has influence on, or control over, daily program operations and decision making, along with access to executive leadership. A champion advocates for program needs and secures resources for program sustainability. The program champion is often responsible for coordinating the program, gaining buy-in within the organization, and embedding it into an organization's operations. A linking agent is a champion who is external to the organization and can help in diffusing a program to multiple agencies.

Engage executive leadership support to increase the likelihood that programs become institutionalized into existing organizational policies and procedures. Institutionalization ensures that the programs are not "stand-alone" offerings and are protected if the program champion departs. Leadership support helps attract internal resources (fiscal management, program evaluation, personnel) and external resources (funding, partnerships, and development support).

Plan for sufficient staffing and training so that an optimal workforce will match the number of needed workshops. A well-trained pool of trainers, instructors, community health workers, and health care providers located in targeted delivery areas needs to be available to refer and deliver programs with fidelity. Refresher courses should be offered to correct drift, as well as continued education on related topics to retain staff and instructor interest. Volunteers can also be engaged to augment available personnel resources and workload. Retention efforts include recognizing the time and dedication of staff, instructors, and volunteers.

Develop a centralized or coordinated logistical process for recruitment, referral, enrollment, monitoring, and marketing. This promotes efficiencies and cost reduction, as well as ensures that potential participants have consistent and easy access to programs. Strategies include using a statewide workshop calendar, online registration, an information-sharing listserv to support trainers/leaders, a referral registry, and Aging and Disability Resource Center (ADRC) coordination to offer a menu of evidence-based health promotion programs. Coordinate or integrate program delivery with existing programs through state Medicaid waivers or referral systems such as patient-centered medical homes (PCMHs) and accountable care organizations (ACOs).

Financing

Identify consistent clients or funding streams and explore which payers might come to the table. Business and financial planning is essential to support the delivery and infrastructure required to ensure high-quality implementation, continuous quality improvement, and program sustainability. It is important to engage in active financial planning from the beginning—to develop specific, itemized financial strategies, performance targets, and an implementation plan.

Centralized Processes

Michigan Partners on the PATH (MI PATH), a partnership between the state aging and health units, the academic community, private partners, and local aging and public health networks, is responsible for coordinating, implementing, and expanding CDSMP throughout the state. Geocoding by county is used to identify and evaluate service gaps, including mapping out where there is population need, where current workshops are located, and where there are workforce gaps.

North Carolina posts a state map and workshop list by region to make it easy for people to locate workshops close to their residence. Program forms, marketing materials, and participant materials are also centrally located online in an easy to download and edit format.

Maine's Healthy Choices webpage is designed for professionals, consumers, and volunteers. The webpage located on the website of Maine DHHS's Office of Aging and Disability Services (OADS) contains information on evidence-based programs and an interactive calendar where program partners can post programs and volunteer training opportunities.

Massachusetts' Healthy Living Center of Excellence website is a "one-stop shop" on evidence-based programs. The centralized website offers program coordination, a workshop calendar, leader portal, on-going training and technical assistance.

New York, Wisconsin, and Vermont have centralized processes for program implementation and **New York** also has a centralized data management system.

Diversify funding streams to ensure that programs are viable over the long term. Many states voice concern that Title IIID funds are insufficient to adequately support implementation of evidence-based programs and that sustainability remains challenging.[13,14] Additional funding sources include state Medicaid agencies and health care

[13] NCOA (2012) Title IIID Funding State Survey.

[14] (2012) American Recovery and Reinvestment Act (ARRA) States Self-Assessment Report.

organizations, which can strengthen the referral pipeline and provide financial reimbursements. At a local level, support from foundations, hospital community benefit programs, and civic groups are viable sources of program funding. See "Financial Sustainability for Evidence-Based Program: Strategies and Potential Sources of Financing" to learn more about potential funding sources and strategies.[15]

The Affordable Care Act (ACA) and related health reform initiatives create new opportunities for program funding through Medicaid and Medicare reimbursements. Partnerships with ACOs, Patient Centered Medical Homes (PCMHs), or other Medicare and Medicaid providers can promote cross-referral to programs as well as reimbursement for program participation.

Incorporate objectives, strategies, and action steps into a business plan to obtain and maintain resources. An accounting and financial system needs to be in place to document program costs and demonstrate the capacity to fund programs over the long-term. Program costs include program fees (e.g., licensing, training, facility, and material fees), marketing costs, travel/ancillary expenses, and data collection/evaluation expenses. Business planning will help project operating costs for an evidence-based program system and establish an annual operating budget. The business plan also should provide for regularly monitored operational performance through monthly financial statements. Have an overall plan for resource sustainability, such as including evidence-based health promotion programs as a budget line item or embedding the programs into an existing menu of self-management programs.[16] View the online learning module "Creating a Business Plan for Evidence-based Health Promotion Programs" to learn how to write a business plan.[17]

Demonstrate value and demand so that the need for sustainable funding is clear. Funders and partners need to see that evidence-based health promotion programs not only align with their mission and goals, but also produce significant health outcomes. Potential participants need to understand how they benefit from completing these programs.

Diversify Funding Streams

With the Affordable Care Act (ACA), movement towards patient-centered managed care versus a fee-for-service medical model will create opportunity for new funding and partnerships. Currently, 18 states are partnering on ACA initiatives related to evidence-based programs, including **Illinois** (Bridge Model and Care Transitions Intervention); and **Ohio** (SAGE Project).

In **Delaware**, the two largest Medicaid Managed Care Organizations (MCOs), in which 90% of Medicaid members with diabetes are enrolled, are referring their members to DSMP workshops. MCOs are paying for books and CDs for members and providing healthy food for all participants. Workshops are targeted to zip codes with large numbers of members with diabetes. A special emphasis is placed on those members with A1C's (quarterly blood sugar readings) of nine or greater. One MCO provides a cash incentive if all sessions are attended.

Elders Services of Merrimack Valley, an Area Agency on Aging in **Massachusetts**, receives Centers for Medicare and Medicaid Services (CMS) reimbursement for Care Transition enrollees for evidence-based interventions.

The **Vermont Blueprint for Health** is a statewide public-private initiative to transform care deliver, improve health outcomes, and enable everyone in the state to receive seamless, well-coordinated care, including access to evidence-based self-management programs in the community. Funded by a Medicaid Global Commitment to Health 1115 waiver, its key innovation is having Community Health Teams work with primary care providers to assess patients' needs and coordinate community-based support services.

[15] Gordon, G., & Galloway, T. Financial sustainability for evidence-based program: Potential sources of financing. Available at *www.ncoa.org/chamodules/documents/FinancialSustainability.pdf.*

[16] University of Kansas Community Tool Box. Work Group for Community Health and Development. Available at *http://ctb.ku.edu.*

[17] NCOA. Creating a Business Plan for Evidence-based Health Promotion Programs. Available at *www.ncoa.org/improve-health/center-for-healthy-aging/online-training-modules/module-9.html.*

Marketing

Create tailored value propositions for effective marketing to secure new resources, build stakeholder support, increase program demand, and recruit program participants. Well-developed messages are targeted, personalized, concise, and use clear consumer-centered language. Consistent messaging on how evidence-based health promotion programs promote better health, better care, and lower costs and empower participants toward self-management should be delivered across all communication channels. Marketing should be tailored to engage and compel action from multiple audiences of participants, partners, and funders. Strategies include using a broad range of communication methods and channels, leveraging partnerships to maximize marketing efforts, integrating programs into larger public health campaigns, and delivering ongoing communication of program impact. Establish a monitoring and evaluation process to ensure continued effectiveness. Many states use statewide branding for evidence-based health promotion programs to deliver consistent and concise messaging. Dedicate expert staff to marketing efforts, either internally or externally, through partnerships.

Utilize testimonials from participants on how evidence-based health promotion programs impact their lives. Testimonials can attract new participants, especially in underserved and diverse communities. Communicate program "fit" and benefits to diverse groups, including stakeholders, potential funders, internal staff, participants, and communities.

Build the network by tailoring messaging to resonate with a potential partner's own goals and values. Think broadly about the assets that potential partners can provide to widen message reach, such as marketing, in-kind support, and community linkages. Market program benefits to communities and organizations. Use data from studies that demonstrate program effectiveness and health care utilization reduction to attract partnerships with health care groups, hospitals, and health plans.

Use a broad range of media and outlets to garner publicity, engage interest, and generate conversation around health promotion and prevention. Use media outlets and nontraditional communication channels that resonate with targeted communities, such as print media, social media, word-of-mouth referral, trusted community partners, tapping into venues such as shopping centers, pharmacy outlets, churches/temples, libraries, community centers, and YMCAs. Use video, human interest stories, testimonials, op-eds, public service announcements, conferences, journals, community events, and health fairs to share evidence and program outcomes.

Build a roster of community champions who can communicate how evidence-based health promotion programs are related to better health and healthy communities. Use them to increase awareness and serve as supporters for resources and increased delivery throughout the community. A roster should include stakeholders from diverse expert groups, including participants, state leaders, community leaders, researchers, trainers and instructors, and health care providers.

Engage Interest

North Carolina, **New Jersey**, and other states offer a CDSMP session "zero" to demonstrate what the program is like to potential participants. Potential funders and partners also can be invited to attend this demonstration session.

Quality Assurance

Quality assurance (QA) provides evidence that all components of program implementation are working as intended. QA incorporates ongoing data systems, processes, and procedures to describe, measure, and evaluate program delivery to ensure that participants receive effective, quality services and that program goals are being met.[18] A continuous data-driven process for team decision-making and problem-solving, QA systems also provide credibility with funders and stakeholders that evidence-based health promotion programs are worthwhile investments. View the "QA: Assuring Program Quality" module to learn more about developing a QA program and how to use the RE-AIM framework as a guide for specifying quality assurance performance indicators.[19]

[18] Administration on Aging (AoA) Recommendations for Grantee Quality Assurance Programs. Available at *www.ncoa.org/improve-health/center-for-healthy-aging/content-library/AoA_Quality_Assurance_Expectations-9-16-w-text-boxes.pdf.*

[19] NCOA. QA: Assuring Program Quality" Training Module. Available at *www.ncoa.org/improve-health/center-for-healthy-aging/online-training-modules/qa-assuring-program-quality.html.*

Continuous Quality Improvement

New York's Center for Excellence in Aging & Community Wellness (CEACW) seeks to facilitate and establish both initial and ongoing capacity for communities throughout the state to deliver sustainable evidence-based models of health promotion and disease prevention through its Quality and Technical Assistance Center (QTAC). The QTAC is responsible for master trainer and peer leader training and certification, in addition to managing quality related data collection and reporting to funders. The QTAC also trains regional/local program staff on quality assurance/quality improvement techniques, fidelity monitoring, data collection protocols, and business planning for sustainability.

States should develop QA plans to ensure effective programs and efficient delivery and distribution systems. An effective QA plan addresses both continuous quality improvement and program fidelity. Use the AoA/NCOA "Quality Assurance Planning Template"[20] to determine how to effectively integrate QA into sustainability and implementation planning. A comprehensive QA plan includes the following components:[21]

- Specification of designated roles, responsibilities, and timelines for QA activities.
- Team orientation about the QA plan and system, including program coordinators, host sites, and partners.
- Performance indicators, including measures of participant reach, organizational capacity, and program delivery; identification of performance indicators should be developed with input from key stakeholders.
- Mechanisms for periodic team review of fidelity monitoring efforts and assessments of overall performance indicators.
- Standardized protocols for making corrective actions when necessary and checking whether such actions are effective.

Focus on continuous quality improvement (CQI). Having a quality assurance plan allows organizations to monitor outcomes and demonstrate results. CQI is a cyclical process that includes planning, monitoring, evaluating, and making as-needed corrective changes. Planning involves setting performance objectives and mechanisms to monitor program delivery and grant goals. Monitoring involves obtaining on-going partner and participant input and collecting program data to inform decision-making. Evaluation involves team analysis of what is/is not working and problem-solving. Finally, as-needed corrective changes are made with the aim of improving overall performance and enhancing participant satisfaction. CQI reviews should be conducted on a regular basis.

Monitor program fidelity to assess the extent to which an evidence-based program is delivered consistently by all personnel across sites and according to the program's intent and design. This is known as adherence and is the central focus of program implementation. Use debriefings and establish a protocol for fidelity checks. Maintaining fidelity to a program's intended design and protocols also ensures that collected data is reliable and valid for evaluation.

Determine specific and measurable performance indicators to evaluate if the program is operating successfully. Indicators should be tailored to a program's goals and objectives, while also being mindful of what is feasible within organizational contexts and functioning. Indicators should be developed and prioritized with input from key stakeholders. Performance indicators include monitoring components of the program distribution and delivery system, such as program management, participant enrollment, partnerships, organizational infrastructure and capacity building, resource and program coordination, and program outcomes. Specific examples include monitoring class size and completion rates, the number and types of partnerships that are involved in promoting program activities, and leader performance.

[20] AoA/NCOA Quality Assurance Planning Template. Available at *www.ncoa.org/assets/files/pdf/QA-Planning-Template.pdf.*

[21] Administration on Aging (AoA) Recommendations for Grantee Quality Assurance Programs. Available at *www.ncoa.org/improve-health/center-for-healthy-aging/content-library/AoA_Quality_Assurance_Expectations-9-16-w-text-boxes.pdf.*

Statewide Evaluation and Reporting

In **Vermont**, the Blueprint for Health incorporates statewide evaluation and reporting through a centralized electronic data system to allow for highly structured and flexible reporting. This evaluation system uses diverse data sources and databases, such as a central clinical registry and a multi-payers claims database, as well as structured qualitative assessments, to measure performance indicators and fuel continuous quality improvement of the health care system. Current outcome data reports show reductions in hospital admissions, emergency department visits, and associated costs.

Conduct ongoing evaluation to assess long-term health outcomes, program effectiveness, program planning, and cost effectiveness. Through the systematic collection and analysis of data, evaluation helps drive continuous quality improvement. It is a useful tool to inform decision-making in improving delivery process and programming quality, and gain resource support. Evaluation tools include interviewing key participants and stakeholders, generating goal attainment reports, administering surveys, and utilizing community mapping.

Policy

Embed programs into existing state and federal initiatives. Program sustainability also depends on supportive local, state, and national policies. Specific to this topic, policies are rules and regulations aimed at achieving defined goals of improving health, as well as specifying funding streams. Evidence-based health promotion programs can be integrated into existing policies that address related health issues and concepts, such as self-management principles. State units on aging and health are ideal agencies to lead and coordinate with community organizations in the collection and sharing of data to help inform policy development. Policy action occurs on multiple levels to achieve desired outcomes and sustain change.

Raise and Maintain Awareness

The National Falls Free© Coalition of falls prevention experts includes 72 national organizations, professional associations and federal agencies that are working toward the progress of one or more of the strategies in the Falls Free© National Action Plan. Members are engaged in disseminating evidence-based falls prevention programs, advocating for funding and educating older adults about how they can reduce their fall risk.

Raise and maintain awareness within lead agencies, partnerships, community health agencies, stakeholders, and policymakers. Presenting current research and outcome evidence will keep evidence-based health promotion programs visible and empower older adults, adults with disabilities, and their family members to mobilize and request continued programming.

Build credibility by articulating how evidence-based programs align with local, state, and national goals and are part of the solution to achieving better care, better health, and lower costs. Strategies include making data available, providing evidence and fact finding in a scientific way, and conducting research on policy and its effect on individuals and communities. Provide leadership and share best-practices with like-minded organizations on local, state, and national levels.

Educate the public and policymakers on the impact that evidence-based health promotion programs have on participant health and health care utilization. Invite policymakers to attend workshops in the community to gain first-hand experience with the programs. Encourage participants to educate policymakers on the impact the workshops had on their health and quality of life. Provide legislators with information on current health data, program outcome evidence, and health care savings specific to their constituent communities. Share data outcomes with influential organizations such as the National Committee on Quality Assurance (NCQA) and the Joint Commission on Patient Safety.

The Importance of Education

The South Carolina Healthy Aging Policy Platform Initiative (Project HAPPI) was an 18-month collaborative effort guided by state-level partners and the academic community to introduce broad-based policy measures that would lead to statewide access and use of evidence-based prevention programs for older adults. The purpose was to inform legislators and other decision makers of the need to prioritize prevention programs in the state through a formal, written policy platform.

Champion organizational policies and processes that support program sustainability. Foster an internal organizational culture that is committed to delivering and sustaining evidence-based health promotion programs and promotes a self-management and person-centered approach to health and aging.

Cultivate community ownership through a participant advisory council that represents a trusted voice to their peers, targeted populations, and communities. The advisory council can help recruit participants, instructors, and volunteers, as well as assist in navigating community barriers.

Resources

Sustainability

- *Community Tool Box* from the University of Kansas. This extensive website provides practical resources for sustainability. Available at: *http://ctb.ku.edu/en/dothework/tools_tk_16.aspx*
- Illinois ResourceNet. *Sustainability: Your Program Beyond Now* explains sustainability planning and the financial, community, and organizational aspects for it. Available at: *www.ncoa.org/chamodules/documents/IL_WebinarSlides.pdf*
- The Missouri Arthritis and Osteoporosis Program (2012) offers Missouri's *Sustainability Toolkit: Self-Management Education Programs for People with Chronic Conditions.* Available at: *www.ncoa.org/improve-health/center-for-healthy-aging/content-library/missouris-sustainability.html*
- NCOA's Center for Healthy Aging offers a number of resources specific to sustainability and quality assurance. Available at: *www.ncoa.org/improve-health/center-for-healthy-aging/sustainability.html*

Partnerships

- Community-Based Care Transitions Program (CCTP) provides a partner list and program summaries. Available at: *http://innovations.cms.gov/initiatives/Partnership-for-Patients/CCTP/partners.html*
- *Older Americans Behavioral Health: Issue Brief Series* (SAMSHA/AoA/NCOA) provides examples of partnerships for addressing behavioral health issues among older adults. *www.ncoa.org/improve-health/center-for-healthy-aging/content-library/issue-brief-1-aging-and.html*

Infrastructure & Delivery System

- An NCOA webinar describes how New Jersey developed the infrastructure for Chronic Disease Self-Management Program (CDSMP) program sustainability. Available at: *www.ncoa.org/improve-health/center-for-healthy-aging/content-library/Grantee-Webinar_February-2012.pdf*

Financing

- Gordon, G., & Galloway, T. offer *Financial Sustainability for Evidence-Based Programs: Potential Sources of Financing.* Available at: *www.ncoa.org/chamodules/documents/FinancialSustainability.pdf*

Working with Medicaid

- Learn how Iowa, North Carolina, and Washington developed relationships with their state Medicaid offices by accessing the webinar *Working With Your State Medicaid Office: How to Build a Relationship for Referrals to Self-Management and Other Evidence-Based Programs.* Available at: *www.ncoa.org/improve-health/center-for-healthy-aging/content-library/working-with-your-state.html*
- A tip sheet on *Working with State Medicaid Agencies* provides strategies on partnering with Medicaid. Available at: *www.ncoa.org/improve-health/center-for-healthy-aging/content-library/NCOA-AoA-Flyer-StateMed_Final.pdf*

- A presentation on the *Role of State Medicaid Agencies in Evidence-Based Prevention Program Delivery and Distribution Systems* is available at: *http://www.nasuad.org/documentation/hcbs2011/Presentations/M4RegencyC.pdf*

Marketing

- Oregon's Living Well with Chronic Conditions marketing campaign includes resources and strategies that the state uses to deliver consistent self-management principles and programming benefits to participants, providers, and partners throughout the state. The toolkit is available at: *http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/LivingWell/Pages/LivingWellMarketingToolkit.aspx*
- Health marketing involves offering programs that are relevant to participant needs, determining realistic program pricing, delivering programs at convenient locations, and actively promoting the programs to partners, funders, and potential participants. Visit the CDC Health Marketing website to learn more about health communication and social marketing at: *www.cdc.gov/healthcommunication/index.html*

Selected State Websites

- Maine's Healthy Choices: *http://www.maine.gov/dhhs/oads/aging/healthy-choices/*
- MaineHealth Partnership for Healthy Aging: *http://www.mainehealth.org/pfha*
- Massachusetts' Healthy Living Center of Excellence: *http://www.healthyliving4me.org/coalition.html*
- Michigan Partners on the PATH (MI PATH): *http://mihealthyprograms.org/mipath.aspx*
- New York's Center for Excellence in Aging & Community Wellness (CEACW), Quality and Technical Assistance Center (QTAC): *http://ceacw.org/the-quality-and-technical-assistance-center/*
- North Carolina's Living Healthy Initiative: *http://www.ncdhhs.gov/aging/livinghealthy/livinghealthy.htm*
- South Carolina Healthy Aging Policy Platform Initiative (ProjectHAPPI): *http://www.scdhec.gov/health/chcdp/healthyaging/*
- Vermont Blueprint for Health: *http://hcr.vermont.gov/blueprint*
- Virginia: *http://www.vdh.state.va.us/LHD/peninsula/chronicdiseasemanagement.htm*
- Washington's Living Well with Chronic Conditions: *http://livingwell.doh.wa.gov/*
- Wisconsin Institute for Healthy Aging (WIHA): *http://wihealthyaging.org/*

Quality Assurance

- *Recommendations for Grantee Quality Assurance Programs* provides guidance on how to develop a quality assurance plan using the RE-AIM framework. Available at: *http://www.ncoa.org/improve-health/center-for-healthy-aging/content-library/AoA_Quality_Assurance_Expectations-9-16-w-text-boxes.pdf*
- AoA/NCOA *Quality Assurance Planning Template* provides indicators and action steps to guide quality assurance planning. Available at: *http://www.ncoa.org/assets/files/pdf/QA-Planning-Template.pdf*
- NCOA online training module, *QA: Assuring Program Quality.* Available at: *www.ncoa.org/improve-health/center-for-healthy-aging/online-training-modules/qa-assuring-program-quality.html*
- NCOA online training module, *Assuring Program Quality: Maintenance.* Available at: *www.ncoa.org/improve-health/center-for-healthy-aging/online-training-modules/module-5-assuring-program.html*

Policy Action

- *Advocacy: Education in Action* shares states' efforts in advocacy and policy changes that contribute to the dissemination and sustainability of evidence-based health promotion programs for older adults. Available at: *http://www.ncoa.org/improve-health/center-for-healthy-aging/content-library/NCOA-Advocacy-is-Education.pdf*

Evidence-based Health Promotion Programs

- NCOA Center for Health Aging "Intro to Health Promotion Programs" webinar series. Available at: *www.ncoa.org/improve-health/center-for-healthy-aging/online-training-modules/series-1-intro-to-health.html*
- Learn about the five components of RE-AIM—Reach, Effectiveness, Adoption, Implementation, Maintenance—and their applicability to evidence-based programming at: *www.ncoa.org/improve-health/center-for-healthy-aging/content-library/re-aim-for-program-planning.html*

About NCOA

The National Council on Aging is a nonprofit service and advocacy organization headquartered in Washington, DC. NCOA is a national voice for millions of older adults—especially those who are vulnerable and disadvantaged—and the community organizations that serve them. It brings together nonprofit organizations, businesses, and government to develop creative solutions that improve the lives of all older adults. NCOA works with thousands of organizations across the country to help seniors find jobs and benefits, improve their health, live independently, and remain active in their communities. For more information, please visit: *www.ncoa.org, www.facebook.com/NCOAging, www.twitter.com/NCOAging.*