State Planning and Organization for Stanford Chronic Disease Self-Management Program

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States have used several models to successfully foster implementation of Stanford Chronic Disease Self-Management Program (CDSMP) and other evidence-based prevention programs. State agencies determine the optimal organization of the program(s) in their state through early consultation between the core state partners: the State Unit on Aging and the State Public Health Agency, designating one of the agencies as the lead state agency. Each core partner agency provides substantial mutual effort, cooperation, and substantive contributions. The core partners confer with the State Medicaid Agency and other state agencies to develop significant roles for these partners. In many states, the core partners bring additional public and private sector partners into planning the operational model.

State partners identify short term and long term programmatic and policy goals and objectives, consider the primary streams of work, and the options for designating responsibility and accountability. The primary considerations include capacity, readiness, authority, assets, knowledge, interest and prior success in program development and implementation in efforts similar to the requirements of the CDSMP.

State planning for implementation includes the areas of work identified below. The work is presented in the RE-AIM framework that has been found valuable to state agencies in thinking through and organizing local and statewide program implementation. RE-AIM is an evolving framework designed to inform program decision-making by focusing on Reach, Effectiveness, Adoption, Implementation, and Maintenance. States have added Partnerships and Planning to this framework. See “RE-AIM for Program Planning: Overview and Applications” http://www.healthyagingprograms.org/resources/IssueBrief_ReAim_Final.pdf.

PARTNERSHIPS

Actions in Early Planning

- Develop partnerships with private and public sector organizations and stakeholder groups necessary for successful implementation and sustainability of CDSMP. State, regional and local partnerships benefit from collaboration among different sectors and types of organizations that help expand the reach of CDSMP.
- Coordinate or integrate delivery of new CDSMP projects with existing ones and other community-based prevention programs for older adults.
- Establish an active collaborative partnership between the aging and public health networks:
- Develop a formal MOU agreement at State level for collaborative evidence-based prevention programming activities between public health and aging service network (ASN) partners;
- Develop a shared vision statement for the MOU endorsed by each organization;
- Reflect quality improvement monitoring process for Lead Local Organizations and Implementation Sites in the MOU.
- Coordinate with tribal entities.

**Actions in Start-Up**

- Coordinate partnerships to optimize program reach and delivery:
  - Leverage statewide systems that provide community-based services and supports to older adults to help them maintain health and independence in the community;
  - Encourage partnerships to endorse the state goal statement that defines near term and long term plans and outcomes;
  - Establish structured communication process between partners and schedule partner meetings.
- Develop system to monitor performance of partners for quality assurance.

**PLANNING**

**Actions in Early Planning**

- Secure, document and use diverse stakeholders’ input for a State CDSMP plan.
- Identify system outcomes, program delivery outcomes and participant outcomes in collaboration with state partners and Lead Local Organizations.
- Develop a plan for the distribution system to deliver CDSMP in designated sub-state area(s), and later distribution of CDSMP and other evidence-based prevention programs for older adults statewide.
- Develop plans to embed CDSMP structure and systems into statewide systems that provide community-based services and supports to older adults to help them maintain their health and independence in the community.
- Identify roles, responsibilities and individuals for leadership, management, development and support of partnerships, operationalizing plans, monitoring, reporting and communicating.
Actions in Start-Up

- Rapidly make grant awards getting funds to Lead Local Organizations to insure early and continued workshop offerings.
- Manage state, regional and/or local CDSMP licenses with Stanford University.
- Connect communities with CDSMP tools and resources.
- Identify strategy to include CDSMP as key programmatic areas in state strategic or long-term plan.

**REACH**

Actions in Early Planning

- Identify the various CDSMP target populations at high risk based on age, health and social characteristics.
- Establish specific goals for numbers and types of participants to be reached in the State through participating communities.

Actions in Start-Up

- Lead and coordinate program that can reach and retain older adults in CDSMP who have, or are at high risk of having, the specific diseases or disabilities that are the focus of the diabetes or arthritis programs. (Undertaken by Lead Local Organizations)
- Develop proactive recruitment strategies tailored to reach different segments of the targeted populations giving special attention to serving low-income, minority and limited English speaking seniors;
  - Develop state, regional and local marketing campaigns to engage older adults in CDSMP workshops.
- Assure that the maximum number of older adults with chronic conditions participate in CDSMP.

**ADOPTION**

Actions in Early Planning by State Partnership (or designee)

- Identify and select community(ies) that can best administer CDSMP locally.
- Recruit, fund, provide technical assistance and support a Lead Local Organization (area agency on aging, local public health office, or tribe or tribal entity) in each community that oversees and coordinates local efforts.
Actions in Start-Up by State Partnership (or designee)

- Provide strong leadership.
- Manage training and engagement of Master Trainers.

Action in Early Planning by Lead Local Organizations

- Connect with potential Implementation Sites serving diverse populations; recruit Sites.

Actions in Start-Up by Lead Local Organizations

- Fund, guide, assist, support and monitor program Implementation Sites offering the workshops.
- Mobilize broad-based public-private partnerships to support local implementation of CDSMP.
- Manage essential oversight functions.
- Coordinate regional technical assistance (in collaboration with State).
- Manage training and engagement of Master Trainers (with State) and training of Lay Leaders.

IMPLEMENTATION

Actions in Early Planning

- Plan to train implementation site leadership, staff and volunteers in CDSMP implementation.
- Plan for trained Lay Leaders to teach workshops.
- Plan for making required tools, facilities, materials and other resources available.
- Plan for required data collection.

Actions in Start-Up

- Execute plans noted above.
- Work with AoA and its technical assistance partners to refine quality assurance systems, to facilitate attention to fidelity and continuous program improvement.
- Develop a quality assurance program as a component of the delivery system that ensures CDSMP is delivered with fidelity and achieves results.
- Establish data collection and reporting system.
- Conduct program monitoring activities that will allow for continuous quality improvement at both the state and community level.
- Establish efficiency and cost management procedures.
EFFECTIVENESS

Actions in Early Planning

- Work with partners and stakeholders to identify evaluation needs and how results of evaluation activities will contribute to program quality and sustainability.
- Consider inclusion of program level, partner level and State level outcomes and documentation in the evaluation plan.
- Enlist appropriate research and evaluation expertise to assist with planning and managing evaluation.
- Ensure that budget includes adequate support for the evaluation plan.

Actions in Start-Up

- Work with AoA and its technical assistance partners to refine outcome indicators and formative evaluation methods.
- Establish program evaluation plan:
  - Describe plan for ensuring quality data collection and processing at Lead Local Organization and Implementation Sites;
  - Describe plan for data analysis, including level of expertise required for appropriate analyses.
  - Include plan to manage timely completion, review and transfer of data;
  - Include assessment of workshop completion rates and other indicators of participant satisfaction and engagement.
- Ensure timely, high quality, comprehensive data collection, processing and reporting for required measures.

MAINTENANCE and SUSTAINABILITY

Action in Early Planning

- Embed CDSMP structure and systems into statewide systems that provide community-based services and supports to older adults to help them maintain their health and independence in the community.

Actions in Early Operations

- Develop plans to maintain and sustain CDSMP in areas where implemented.
- Plan for state partnerships to continue to promote CDSMP.
- Develop a long-term financing plan to diversify funding sources.
- Secure organizational commitments for resource contributions from diverse partners.
• Plan for ongoing communication of CDSMP Program impacts.

**STATE CDSMP DELIVERY MODELS**

Each State needs to develop and manage a system for allocating tasks, accountabilities and funds among its partners. Based upon our work in 27 States, NCOA’s Center for Healthy Aging has identified three generic models for successfully disseminating CDSMP and other evidence-based prevention programs. We have labeled these models: Centralized, Decentralized and Contracted. These models are offered to help partners discuss and plan how to organize for long-term success. In actual practice, States will adapt a generic model to suit their specific assets and needs. The following diagrams represent the models; key organizational units, features, tasks and accountabilities are noted.
CENTRALIZED MODEL

State Unit on Aging and State Public Health Agency form the core Aging & Health Partnership that sets goals, plans and drives the implementation of CDSMP across parts or all of the state. This state partnership is the engine that develops and maintains the distribution and delivery systems to foster program implementation and expansion. The state Aging & Health Partnership recruits the State Medicaid Agency to be a major partner. The partnership (or lead entity) secures and manages a CDSMP statewide license. The core partnership recruits and sustains additional statewide public and private partners and fosters regional and local partnerships for program operation, marketing and referrals, funding, links with health care, etc. The state partnership recruits and funds Lead Local (or regional) Organizations that oversee and coordinate the program; they recruit and fund Implementation Sites that conduct workshops.

As the model indicates there are several potential Lead Local Organizations and many potential Implementation Sites. Among the initial 27 state systems, Lead Local Organizations included organizations such as area agencies on aging, local health departments, health care organizations or associations.

Implementation Sites conduct CDSMP workshops. Examples of sites include: community human service organizations, community aging service providers, senior centers, group meal sites, faith-based organizations, private and public clinics, Federally Qualified Health Centers, community centers, Senior Community Service Employment Program sites, Senior Corps and other volunteer program sites, residential sites, recreation sites, and many others.
Decentralized Model

State Aging & Health Partnership / Lead Agency
- Goals
- Administration
- Funding
- Operations
- Quality Assurance (QA)
- Monitoring, Program Assessment & Reporting

Program Advisory Council
(State Partners, Local Lead Organization Coordinators)
- Marketing
- Program Assessment Committee

Partner Organization
- Training Management

Master Trainer Network

Local Lead Organization
Example: AAA partners Public Health & Others
- CDSMP License
- Advisory Group
- Regional Delivery & Implementation
- Local Capacity
- Training
- Implementation Sites
- QA
- Program Assessment, Data & Reporting

Local Lead Organization
Example: Public Health Office partners with AAA & Others
- CDSMP License
- Advisory Group
- Regional Delivery & Implementation
- Local Capacity
- Training
- Implementation Sites
- QA
- Program Assessment, Data & Reporting

Local Lead Organization
Examples: Community Organizations, Tribes, or Health Care partner with AAAs and PH
- CDSMP License
- Advisory Group
- Regional Delivery & Implementation
- Local Capacity
- Training
- Implementation Sites
- QA
- Program Assessment, Data & Reporting

Regional Orgs
Master Trainers train Lay Leaders

Referral Organizations

Implementation Sites: Marketing, Workshops, Reporting
Examples: Human Services organizations, Community Aging Service Providers, Senior Centers, Meal Sites,
Faith-based, Clinics (private & public), Health Centers, Community Centers,
SCSEP, Residential sites, Recreation sites, Volunteer Programs, Others
DECENTRALIZED MODEL

The State Unit on Aging and the State Public Health Agency form the core State Aging & Health Partnership that sets goals, plans at a high level and causes the implementation of CDSMP across parts or all of the state. The State Aging & Health Partnership recruits the State Medicaid Agency to be a major partner. The state partnership recruits and funds Lead Local (or Regional) Organizations. In this model, the state partnership designates the Lead Local Organizations as the engines that develop and maintain distribution and delivery systems to foster program implementation and expansion. The state partnership may develop and offer systems to support this work. The Local Lead Organizations secure and manage CDSMP licenses for their geographic areas. The Local Lead Organizations recruit and sustain additional public and private partners and foster for program operation, marketing and referrals, funding, links with health care, etc. Local Lead Organizations recruit and fund Implementation Sites that conduct workshops.

In the initial 27 states, there have been a number of Lead Local Organizations and a wide variety of Implementation Sites. Local Lead Organizations have included organizations such as area agencies on aging, local health departments, health care organizations or associations.

Implementation Sites conduct CDSMP workshops. Examples of sites include: community human service organizations, community aging service providers, senior centers, group meal sites, faith-based organizations, private and public clinics, Federally Qualified Health Centers, community centers, Senior Community Service Employment Program sites, Senior Corps and other volunteer program sites, residential sites, recreation sites, and many others.
**Contracted Model**

- **State Aging & Health Partnership / Lead Agency**
  - Goals
  - Sub-grant / Contract State Operations
  - Partnership Development
  - Report Submission

- **Non-profit Contract Organization - State Program Operations**
  - Distribution & Delivery System; Planned Expansion
  - Funding
  - Partner Recruitment
  - Administrative Processes
  - Technical Assistance
  - Marketing
  - Quality Assurance
  - State / Region CDSMP Licenses
  - Master Trainer Training
  - Program Assessment, Data Analysis & Reporting

- **State / Regional Partners**
  - Lead Local Organizations & Recruiting Implementation Sites
  - Marketing
  - Funding

- **Lead Local Organizations**
  - Example: AAAs
    - Recruiting Implementation Sites
    - Marketing
    - QA & Reporting
  - Example: Public Health
    - Recruiting Implementation Sites
    - Marketing
    - QA & Reporting

- **State Advisory Committee**
  - Advising all areas
  - Resource Mobilization

- **Lead Local Organizations**
  - Example: Community Organization, Tribe, Health Care
    - Recruiting Implementation Sites
    - Marketing
    - QA & Reporting

- **Implementation Sites**
  - Market, Conduct Workshops, Report
  - Examples: Community Human Service organizations, Community Aging Service Providers, Senior Centers, Meal Sites, Faith-based, Clinics (private & public), Health Centers, Community Centers, Social Service Agencies, SCSEP, Residential sites, Recreation sites, Volunteer Programs, Others

NCOA Center for Healthy Aging
CONTRACTED MODEL

The State Unit on Aging and State Public Health Agency form the core State Aging & Health Partnership that sets goals and plans at a high level and causes implementation of CDSMP across parts or all of the state. The State Aging & Health Partnership recruits the State Medicaid Agency to be a major partner. The state partnership identifies and contracts with entity outside state government to create the larger partnership to plan in detail and carry out the implementation. This contract entity, generally a non-profit organization with statewide experience in older adult service or health care, is the engine that develops and maintains the distribution and delivery systems to foster program implementation and expansion. The contract organization secures and manages CDSMP statewide or regional licenses. The organization recruits and sustains additional statewide public and private partners and fosters regional and local partnerships for program operation, marketing and referrals, funding, links with health care, etc. The contracted organization identifies Lead Local (or Regional) Organizations, however, the state partnership / agencies may directly contract /grant funds to the Lead Local Organizations. The Lead Local Organizations recruit and fund Implementation Sites that conduct the workshops.

In the initial 27 states, there have been a number of Lead Local Organizations and a variety of potential Implementation Sites. Lead Local Organizations have included organizations such as area agencies on aging, local health departments, health care organizations or associations.

Implementation Sites conduct CDSMP workshops. Examples of sites include: community human service organizations, community aging service providers, senior centers, group meal sites, faith-based organizations, private and public clinics, Federally Qualified Health Centers, community centers, social service agencies, Senior Community Service Employment Program sites, Senior Corps and other volunteer program sites, residential sites, recreation sites, and many others.