OFFICE OF GRANTS MANAGEMENT

Empowering Older Adults and Adults with Disabilities through CDSME Programs Grants

Date Received: 6/11/2012 Application: GRANT 11157418 ID: HHS-2012-AOA-CS-1211

Applicant: South Carolina Lieutenant Governor's Office on Aging City: Columbia State: SC

Screened By: Heather Wiley

APPLICATION SCREENING CRITERIA	**Yes**	**No**
In order for an application to be reviewed, it must meet the following screening requirements:		
1. Applications must be submitted electronically via http://www.grants.gov by 11:59 p.m., Eastern Time, **June 11, 2012**.	X	
2. The application must contain an abstract of no more than 300 words that specifies the evidence-based chronic disease self-management education programs the applicant plans to offer under this funding opportunity.	X	
3. The Project Narrative section of the application must be **double-spaced**, on 8 ½" x 11" plain white paper with **1" margins** on both sides, and a **font size of not less than 11**.	X	
4. **The Project Narrative must not exceed 20 pages**. NOTE: The Project Work Plan, Project Map, Letters of Commitment/ Support, documentation of other evidence-based education programs, and Vitae of key project personnel **are not counted** as part of the Project Narrative for purposes of the 20-page limit.	X	
5. The applicant must be a State Unit on Aging or a State Public Health Department.	X	
6. The application must include a letter of commitment from the co-lead State Unit on Aging or a State Public Health Department or an explanation for its absence.	X	
7. The application must include a letter of support from the State's Governor or an explanation for its absence.	X	

Comments:

APPLICANT SCREENING: PASSED X **FAILED**

Type of CDSME(S) Proposed:
Stanford programs: X CDSMP ☐ Spanish CDSMP/ Tomando X DSMP ☐ Spanish DSMP
X Arthritis Self-Management Program (ASMP) ☐ Spanish ASMP ☐ HIV ☐ Chronic Pain
☐ Online CDSMP ☐ Online DSMP ☐ Online Arthritis
Other program (list name):

OMB Number: 4040-0004
Expiration Date: 03/31/2012

Application for Federal Assistance SF-424

* 1. Type of Submission:
- [ ] Preapplication
- [x] Application
- [ ] Changed/Corrected Application

* 2. Type of Application:
- [x] New
- [ ] Continuation
- [ ] Revision

* If Revision, select appropriate letter(s):

* Other (Specify):

* 3. Date Received: 06/11/2012

4. Applicant Identifier:

5a. Federal Entity Identifier: Administration on Aging

5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name: South Carolina Lieutenant Governor's Office on Aging

* b. Employer/Taxpayer Identification Number (EIN/TIN): 1-576000286-BJ

* c. Organizational DUNS: 6208012950000

d. Address:

* Street1: 1301 Gervais Street
Street2: Suite 350
* City: Columbia
County/Parish: Richland
* State: SC: South Carolina
Province:
* Country: USA: UNITED STATES
* Zip / Postal Code: 29201-3378

e. Organizational Unit:

Department Name: Office on Aging

Division Name: Division of Aging Services

f. Name and contact information of person to be contacted on matters involving this application:

Prefix: Mrs.
* First Name: Denise
Middle Name: Wiles
* Last Name: Rivers
Suffix:

Title: Deputy Director

Organizational Affiliation:

* Telephone Number: 803-734-9939
Fax Number: 803-734-9887

* Email: riversd@aging.sc.gov

Application for Federal Assistance SF-424

*** 9. Type of Applicant 1: Select Applicant Type:**

A: State Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

Administration on Aging

11. Catalog of Federal Domestic Assistance Number:

93.048

CFDA Title:

Special Programs for the Aging_Title IV_and Title II_Discretionary Projects

*** 12. Funding Opportunity Number:**

HHS-2012-AOA-CS-1211

* Title:

Empowering Older Adults and Adults with Disabilities through Chronic Disease Self-Management Education Programs

13. Competition Identification Number:

Title:

14. Areas Affected by Project (Cities, Counties, States, etc.):

Project is statewide.docx | Add Attachment | Delete Attachment | View Attachment

*** 15. Descriptive Title of Applicant's Project:**

Statewide expansion and enhancement of EBP's in South Carolina

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant: 6th
b. Program/Project: SC-all

Attach an additional list of Program/Project Congressional Districts if needed.

Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date: 09/01/2012
* b. End Date: 08/31/2015

18. Estimated Funding ($):

* a. Federal	1,724,949.00
* b. Applicant	0.00
* c. State	0.00
* d. Local	0.00
* e. Other	0.00
* f. Program Income	0.00
* g. TOTAL	1,724,949.00

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

☐ a. This application was made available to the State under the Executive Order 12372 Process for review on .

☐ b. Program is subject to E.O. 12372 but has not been selected by the State for review.

☒ c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes," provide explanation in attachment.)**

☐ Yes ☒ No

If "Yes", provide explanation and attach

Add Attachment | Delete Attachment | View Attachment

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)**

☒ ** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix: Mr.
* First Name: Anthony
Middle Name:
* Last Name: Kester
Suffix:

* Title: Director

* Telephone Number: 803-734-9910
Fax Number: 803-734-9887

* Email: kester@aging.sc.gov

* Signature of Authorized Representative: Denise Rivers
* Date Signed: 06/11/2012

BUDGET INFORMATION - Non-Construction Programs

OMB Number: 4040-0006
Expiration Date: 06/30/2014

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. Empowering Older Adults and Adults with Disabilities through Chronic Disease Self-Management Education Programs	93.734/93.048	$	$	$ 1,724,949.00	$	$ 1,724,949.00
2.						
3.						
4.						
5. Totals		$	$	$ 1,724,949.00	$	$ 1,724,949.00

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Prescribed by OMB (Circular A -102) Page 1

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY (1)	(2)	(3)	(4)	Total (5)
	Empowering Older Adults and Adults with Disabilities through Chronic Disease Self-Management Education Programs				
a. Personnel	$ 109,434.00	$	$	$	$ 109,434.00
b. Fringe Benefits	10,329.00				10,329.00
c. Travel	7,800.00				7,800.00
d. Equipment	0.00				
e. Supplies	60,780.00				60,780.00
f. Contractual	1,509,126.00				1,509,126.00
g. Construction	0.00				
h. Other	21,000.00				21,000.00
i. Total Direct Charges (sum of 6a-6h)	1,718,469.00				$ 1,718,469.00
j. Indirect Charges	6,480.00				$ 6,480.00
k. TOTALS (sum of 6i and 6j)	$ 1,724,949.00	$	$	$	$ 1,724,949.00
7. Program Income	$ 0.00	$	$	$	$

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SECTION C - NON-FEDERAL RESOURCES				
(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e)TOTALS
8.	$	$	$	$
9.				
10.				
11.				
12. TOTAL (sum of lines 8-11)	$	$	$	$

SECTION D - FORECASTED CASH NEEDS					
	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$	$	$	$	$
14. Non-Federal	$				
15. TOTAL (sum of lines 13 and 14)	$	$	$	$	$

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT				
(a) Grant Program	FUTURE FUNDING PERIODS (YEARS)			
	(b)First	(c) Second	(d) Third	(e) Fourth
16.	$	$	$	$
17.				
18.				
19.				
20. TOTAL (sum of lines 16 - 19)	$	$	$	$

SECTION F - OTHER BUDGET INFORMATION	
21. Direct Charges:	22. Indirect Charges: 14.48% of salary and fringe for FTE
23. Remarks:	

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OMB Number: 4040-0007
Expiration Date: 06/30/2014

ASSURANCES - NON-CONSTRUCTION PROGRAMS

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

NOTE: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C.§§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U. S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee- 3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally-assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.

* SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	* TITLE
Denise Rivers	Director
* APPLICANT ORGANIZATION	* DATE SUBMITTED
South Carolina Lieutenant Governor's Office on Aging	06/11/2012

Standard Form 424B (Rev. 7-97) Back

Budget Narrative/Justification — YEAR ONE (1)

Object Class Category	Federal Funds	Non-Federal Cash	Non-Federal In-Kind	TOTAL	Justification
Personnel	$36,478	$0	$0	$36,478	Project Manager (Crystal Strong) = 25% FTE @ $45,913/yr = $11,478 Project Coordinator (vacant) = 100% PT @ $20/hr x 25hr/wk x50wks = $25,000/yr **Total** **$36,478**
Fringe Benefits	$3,443	$0	$0	$3,443	30% of Salary for Project Manager @ $45,913= $3,443
Travel	$2,600	$0	$0	$2,600	Statewide and National meeting **Out of State Travel $1,600** **Event Location**: National Meeting, WashingtonDC Mode of Travel: Air: $667 Registration: $250 Lodging: @ $175 per night : $525 Per Diem: Days (3) @ $36 per day: $ 108 Misc Travel (i.e. taxi, shuttle): $50 **In State Travel $1,000** Use of personnel auto for statewide meeting and monitoring 2000 miles @ $.50 each **Total** **$2,600**
Equipment	$0	$0	$0	$0	No equipment requested

Object Class Category	Federal Funds	Non-Federal Cash	Non-Federal In-Kind	TOTAL	Justification
Supplies	$20,260	$0	$0	$20,260	Printing costs for promotional materials and manuals $2,000 Multi- Program State license - additional sites $3,000 Training Materials (help books/CDs/binders) $15,260 **Total** **$20,260**
Contractual	$503,042	$0	$0	$503,042	**USC -** Evaluation and statistical analysis of data $29,459 **DHEC – Project Co-Lead and Staff-**provides planning, management, and oversight/responsible for assuring reporting per grant requirements/coordinates team meetings $209,333 **Ten (10) AAA/ADRCs** – To provide implementation and expansion of CDSMP/DSMP and ASMP $224,350 Marketing – Develop and implement marketing plan $25,000 Training – To train/cross-train/ update Master Trainers $12,500 Ambassador Fees – Ambassador speaker fee for outreach $2,400 **Total** **$503,042**
Other	$7,000	$0	$0	$7,000	Admin Cost (rent=$4,800 utilities=$1,700 phone=$240, copier=$260) **Total** **$7,000**
Indirect Charges	$2,160	$0	$0	$2,160	14.48% of salary plus fringe = $1,662

Object Class Category	Federal Funds	Non-Federal Cash	Non-Federal In-Kind	TOTAL	Justification
TOTAL Year 1	**$574,983**	$0	$0	$574,983	

Budget Narrative/Justification — YEAR TWO (2)

Object Class Category	Federal Funds	Non-Federal Cash	Non-Federal In-Kind	TOTAL	Justification
Personnel	$36,478	$0	$0	$36,478	Project Manager (Crystal Strong) = 25% FTE @ $45,913/yr = $11,478 Project Coordinator (vacant) = 100% PT @ $20/hr x 25hr/wk x50wks = $25,000/yr **Total** **$36,478**
Fringe Benefits	$3,443	$0	$0	$3,443	30% of Salary for Project Manager
Travel	$2,600	$0	$0	$2,600	Statewide and National meeting **Out of State Travel $1,600** **Event Location**: National Meeting, WashingtonDC Mode of Travel: Air: $667 Registration: $250 Lodging: @ $175 per night : $525 Per Diem: Days (3) @ $36 per day: $ 108 Misc Travel (i.e. taxi, shuttle): $50 **In State Travel $1,000** Use of personnel auto for statewide meeting and monitoring 2000 miles @ $.50 each **Total** **$2,600**
Equipment	$0	$0	$0	$0	No equipment requested

Object Class Category	Federal Funds	Non-Federal Cash	Non-Federal In-Kind	TOTAL	Justification
Supplies	$20,260	$0	$0	$20,260	Printing costs for promotional materials and manuals $2,000 Multi- Program State license - additional sites $3,000 Training Materials (help books/CDs/binders) $15,260 **Total** **$20,260**
Contractual	$503,042	$0	$0	$503,042	**USC -** Evaluation and statistical analysis of data $29,459 **DHEC – Project Co-Lead and Staff-**provides planning, management, and oversight/responsible for assuring reporting per grant requirements/coordinates team meetings $209,333 **Ten (10) AAA/ADRCs** – To provide implementation and expansion of CDSMP/DSMP and ASMP $224,350 Marketing – Develop new marketing materials $15,000 Training – To train/cross-train/ update Master Trainers and leaders cross-train for both ASMP and DSMP $22,500 Ambassador Fees – Ambassador speaker fee for outreach $2,400 **Total** **$503,042**
Other	$7,000	$0	$0	$7,000	Admin Cost (rent=$4,800 utilities=$1,700 phone=$240, copier=$260) **Total** **$7,000**
Indirect Charges	$2,160	$0	$0	$2,160	14.48% of salary plus fringe $1,662

Object Class Category	Federal Funds	Non-Federal Cash	Non-Federal In-Kind	TOTAL	Justification
TOTAL Year 2	**$574,983**	$0	$0	$574,983	

Budget Narrative/Justification — YEAR THREE (3)

Object Class Category	Federal Funds	Non-Federal Cash	Non-Federal In-Kind	TOTAL	Justification
Personnel	$36,478	$0	$0	$36,478	Project Manager (Crystal Strong) = 25% FTE @ $45,913/yr = $11,478 Project Coordinator (vacant) = 100% PT @ $20/hr x 25hr/wk x50wks = $25,000/yr **Total** **$36,478**
Fringe Benefits	$3,443	$0	$0	$3,443	30% of Salary for Project Manager
Travel	$2,600	$0	$0	$2,600	Statewide and National meeting **Out of State Travel $1,600** **Event Location**: National Meeting, WashingtonDC Mode of Travel: Air: $667 Registration: $250 Lodging: @ $175 per night : $525 Per Diem: Days (3) @ $36 per day: $ 108 Misc Travel (i.e. taxi, shuttle): $50 **In State Travel $1,000** Use of personnel auto for statewide meeting and monitoring 2000 miles @ $.50 each **Total** **$2,600**
Equipment	$0	$0	$0	$0	No equipment requested

Object Class Category	Federal Funds	Non-Federal Cash	Non-Federal In-Kind	TOTAL	Justification
Supplies	$20,260	$0	$0	$20,260	Printing costs for promotional materials and manuals $2,000 Multi- Program State license - additional sites $3,000 Training Materials (help books/CDs/binders) $15,260 **Total** **$20,260**
Contractual	$503,042	$0	$0	$503,042	**USC -** Evaluation and statistical analysis of data $29,459 **DHEC – Project Co-Lead and Staff-**provides planning, management, and oversight/responsible for assuring reporting per grant requirements/coordinates team meetings $209,333 **Ten (10) AAA/ADRCs** – To provide implementation and expansion of CDSMP/DSMP and ASMP $224,350 Marketing – Develop new marketing materials (i.e. Radio and newspaper ads) $15,000 Training – To train/cross-train/ update Master Trainers and leaders cross-train for both ASMP and DSMP $22,500 Ambassador Fees – Ambassador speaker fee for outreach $2,400 **Total** **$503,042**
Other	$7,000	$0	$0	$7,000	Admin Cost (rent=$4,800 utilities=$1,700 phone=$240, copier=$260) **Total** **$7,000**

Object Class Category	Federal Funds	Non-Federal Cash	Non-Federal In-Kind	TOTAL	Justification
Indirect Charges	$2,160	$0	$0	$2,160	14.48% of salary plus fringe = $1,662
TOTAL Year 3	**$574,983**	$0	$0	$574,983	

Budget Narrative File(s)

*** Mandatory Budget Narrative Filename:** Budget Narrative.docx

Add Mandatory Budget Narrative | Delete Mandatory Budget Narrative | View Mandatory Budget Narrative

To add more Budget Narrative attachments, please use the attachment buttons below.

Add Optional Budget Narrative | Delete Optional Budget Narrative | View Optional Budget Narrative

CERTIFICATION REGARDING LOBBYING

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,00 0 and not more than $100,000 for each such failure.

Statement for Loan Guarantees and Loan Insurance

The undersigned states, to the best of his or her knowledge and belief, that:

If any funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this commitment providing for the United States to insure or guarantee a loan, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. Submission of this statement is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required statement shall be subjec t to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

* APPLICANT'S ORGANIZATION

South Carolina Lieutenant Governor's Office on Aging

* PRINTED NAME AND TITLE OF AUTHORIZED REPRESENTATIVE

Prefix: Mr. * First Name: Anthony Middle Name:

* Last Name: Kester Suffix:

* Title: Director

* SIGNATURE: Denise Rivers * DATE: 06/11/2012

OMB Number: 4040-0010
Expiration Date: 08/31/2011

Project/Performance Site Location(s)

Project/Performance Site Primary Location ☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: Lt. Governor's Office on Aging

DUNS Number: 6208012950000

* Street1: 1301 Gervais Street

Street2: Suite 350

* City: Columbia County: Richland

* State: SC: South Carolina

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 29201-3378 * Project/ Performance Site Congressional District: SC-all

Project/Performance Site Location 1 ☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name:

DUNS Number:

* Street1:

Street2:

* City: County:

* State:

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: * Project/ Performance Site Congressional District:

Additional Location(s) Add Attachment Delete Attachment View Attachment

Close Form

Project Narrative File(s)

*** Mandatory Project Narrative File Filename:** FINAL NARRATIVE.doc

Add Mandatory Project Narrative File | Delete Mandatory Project Narrative File | View Mandatory Project Narrative File

To add more Project Narrative File attachments, please use the attachment buttons below.

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South Carolina Project Narrative PPHF-2012

i. Summary/Abstract: This initiative is a collaboration of the Lt. Governor's Office on Aging (LGOA), the South Carolina Department of Health and Environmental Control (DHEC), and the University of South Carolina (USC) School of Public Health and a statewide network of partners, including regional Aging and Public Health teams, the State Medicaid Agency, disability organizations, health care systems, faith-based organizations, and the Catawba Indian Nation. Project Goals are to: 1) significantly increase access to and use of chronic disease self-management education (CDSME) programs to improve the quality of life of older adults and adults with disabilities; and 2) provide a statewide integrated, sustainable service system for CDSME programs. The Overall Approach is to develop and strengthen partnerships to facilitate the spread of CDSME programs: the Chronic Disease Self-Management Program (CDSMP), the Arthritis Self-Management Program (ASMP), and the Diabetes Self-Management Program (DSMP). The Target Population is persons 60 and older with chronic health conditions, especially rural, low income, underserved and minority populations who are disproportionately affected. Project Objectives are to: 1) implement CDSMP and ASMP in un-served geographic regions; 2) expand the number of counties offering workshops at least twice a year and increase the number of people reached; 3) implement DSMP in Year 2; 4) ensure that low income, rural, African American, and Native American older adults have access to CDSME programs; 5) integrate programs with existing health care systems; and 6) enhance centralized, coordinated processes for implementation and evaluation. Primary Outcomes are: 1) CDSME programs will be available in all 46 counties; 2) at least 5,250 older adults and adults with disabilities will complete a CDSME workshop; 3) programs will be embedded in sustainable systems; and 4) a centralized coordinated process to easily access programs will be provided. Expected Products are: written implementation, marketing, evaluation, quality assurance, and sustainability plans and processes; data collection surveys; and marketing materials.

ii. Problem Statement: South Carolina (SC) ranks near the top of the nation in the prevalence of chronic diseases, which are the leading causes of death and disability. Older adults are disproportionately affected by these diseases, which diminish both the quality and years of life and place an enormous

burden on the individual, the family, and the health care system. One of every five older adults in SC has Diabetes, which often leads to serious medical complications and untimely death. Twenty-five percent have some form of Cardiovascular Disease (CVD), which includes heart disease and stroke; and SC is among a cluster of southeastern states referred to as the "stroke belt." Adults 65+ with CVD have a death rate nearly 10 times higher than the 45-64 year-old age group. Chronic Lung Diseases are the 4th leading cause of hospitalization and death among older adults. Arthritis, the leading cause of disability, affects more than half of older adults in SC and limits activity for 21% of them. Only 11% of older adults with arthritis report that they have attended a class to help with arthritis symptoms (BRFSS).

Ninety-five percent of adults 65+ in SC report at least two chronic health conditions, and 50% report three or more (BRFSS). People with co-occurring chronic diseases are more likely to report poor health and experience pain, activity limitation, and decreased function which impede effective management of their conditions. They are also at greater risk of poor health outcomes and premature death. The impact of chronic diseases is compounded by the fact that one third of older adults in SC have less than a high school education, and 13% live in poverty, factors that negatively influence health. Furthermore, 32% reside in rural areas where health care access is limited due to issues such as lack of transportation, an inadequate number of programs and services, and geographic isolation. There is ample evidence that prevention measures, such as CDSME programs, are effective in addressing chronic diseases. Research studies on the Stanford model have consistently demonstrated health benefits. While these programs and other prevention approaches are urgently needed to address the growing prevalence and impact of chronic diseases, they are not uniformly available and are underused because the benefits of prevention are often not recognized or valued.

Since 2005, the LGOA, the designated state unit on aging (SUA) and DHEC, the state public health department (SPH), have provided joint leadership to develop a statewide infrastructure to disseminate evidence-based interventions, including CDSME programs. The University of SC (USC) School of Public Health, the third prong of the Leadership Team, has provided expertise on evaluation and quality assurance, including development of a fidelity manual and training of fidelity monitors. Through their

collaborative efforts, the three agencies have received a number of competitive federal and national EBPP grant awards (see description of awards - attachment B). These initiatives have provided valuable knowledge and experience that prepare us to successfully carry out this initiative.

In October 2006, when SC received its first award from AoA to implement CDSMP, there was only one aging service provider in the state that offered the program. In 2007, the program was rolled out in three regions. Since then, workshops have been offered in all regions and consistently in seven regions. Numerous partnerships have been formed to support EBPPs, including, the SC Partnership for Healthy Aging (PHA) coalition with a broad-base of stakeholders who provide guidance, support, and advocacy for EBPPs. In 2009, the Healthy Aging Policy Taskforce (HAPPI) was formed as the policy arm of the SC PHA to develop state-level policies that support EBPPs. The impact has been enhanced collaboration among state organizations, such as the SC Department of Health and Human Services (DHHS - the state Medicaid agency) and heightened awareness among decision makers.

At the regional level, Aging and Public Health teams have been formed in seven areas as the primary means of implementing programs. The teams have worked together to expand the number of leaders, sites, workshops, and people reached and to develop a diverse group of partners, including libraries, hospitals, churches, community centers, and health care organizations.

To support local efforts and increase the reach of the programs, the State Leadership Team has developed partnerships with health care systems, such as the Community Long Term Care and Managed Care Divisions of the SC DHHS and the SC Primary Health Care Association (SCPHCA), the organization to oversee local federally qualified health centers (FQHCs). The ultimate goal is to systematically incorporate CDSME programs into the patient's medical visit and plan of care. Additionally, we are engaging other health care systems, chronic disease programs, faith-based and community organizations, and disability partners to serve as delivery and referral partners to further the reach of the programs. Inter-organizational collaboration has led to a steady increase in the geographic spread of the program and the number of workshop sites and participants. During the Recovery Act

project period (03/31/10-03/30/12), 2,064 people were reached with 1,556 completers in 33 of the state's 46 counties, with 19 counties offering workshops at least twice a year on a regular basis (attachment C).

While great strides have been made, the gap between the need for and the availability of CDSME programs is extensive. Ideally, CDSME programs would be offered to all older adults and adults with disabilities in every community in SC, regardless of race, ethnicity, residence, or income.

Challenges - South Carolina is a poor, rural state with limited resources. The economic downturn has made the situation worse, causing major cutbacks in funding and staffing for the government and private sector. As a result, resources that were already stretched have become even more scarce; and organizations have had to make tough decisions about what to keep and what to let go. In this unstable environment, it is difficult to secure the level of commitment necessary for implementing CDSME programs and sustaining them financially. A second challenge is finding successful approaches to reach older adults and interest them in signing up for workshops, especially in rural areas where self-management approaches may be unfamiliar and not considered a high priority. For this reason, it is important to have programs in settings that are familiar and trusted, so that older adults will be more likely to take advantage of the programs. Additionally, marketing strategies and messages that are effective and culturally appropriate need to be identified and applied.

iii. Goals and Objectives: (see attachment D) Long Range Goals: 1) reduce the burden and impact of chronic diseases in SC; 2) improve the quality of life of older adults and adults with disabilities in SC; and 3) achieve health equity among disparately affected populations. Project (three-year) Goal 1- Increase access to and use of CDSME programs: CDSMP, ASMP, and DSMP. During the three-year project, we plan to, reach 7,000 people with 5,250 completers, compared to our Recovery Act numbers (03/31/10-03/30/12) of 2,064 reach and1,556 completers, or 3.39 x more people reached and 3.37 x more completers. Benchmarks for each budget year are: 1,933 people/1,450 completers by the end of the first year; 2,480 people/1,860 completers by the end of Year 2; and 2,587 people/1,940 completers in Year 3. The completer rate will be at least 75%, which is consistent with the Recovery Act rate.

Objective: 1.1 - By August 31, 2015, implement CDSMP and ASMP in three un-served geographic regions: Area Agency on Aging/Aging and Disability Resource Centers (AAA/ADRC) Regions II (Upper Savannah), III (Catawba), and VI (Santee Lynches). Leaders from the three regions will be trained in August-September, with workshops beginning in mid-October 2012 in at least one county in each of the three regions. In January 2013, each region will expand into new counties and increase the number of workshops; a schedule of workshops will be planned in advance for each quarter, with incremental growth. By the end of Year 1, at least one workshop will have been offered in the majority of counties. At the beginning of Year 2, key leaders from each area will be cross-trained in ASMP. By the end of Year 2, workshops will be offered at least twice a year in 50% or more of the counties. By the end of Year 3, workshops will be held at least twice a year in the majority of counties; and at least one county in each region will consistently offer four or more workshops a year, with a completer of at least 75%.

Objective 1.2 - By August 31, 2015, increase the number of counties in expansion regions with CDSME workshops held at least twice a year and the number of people reached. In 7 of the 10 AAA/ADRC regions (hereafter referred to as expansion regions), Aging and Public Health teams have developed partnerships for CDSMP and ASMP; however, only two of these regions offer workshops at least twice a year in every county (see attachment C). We will continue to expand CDSMP and ASMP, while further increasing the reach by introducing DSMP in Year 2 (see Objective 1.3*)* to provide regions with program options that will help achieve expansion and provide choices for older adults. The geographic spread will be increased to all 33 expansion counties, with workshops offered at least twice a year. The number of people served in each region will also be increased by offering more workshops.

Objective 1.3 - By August 31, 2015, implement DSMP in at least five of the seven expansion regions and develop at least one large health care systems partner to embed the program in its organization. In Year 2, we will roll out DSMP; and by the end of Year 3, it will be offered regularly (two or more times a year) in at least one county in five regions, while sustaining CDSMP and ASMP. We will collaborate with the DHEC Diabetes Program to help identify an appropriate health care systems partner with potential to embed the program in its organization.

Objective 1.4 - By August 31, 2015, ensure that low income, rural, African American, and Native American older adults have access to CDSME programs.

Project Goal 2 - Strengthen and expand integrated, statewide systems to support, embed, and sustain CDSME programs. *Objective 2.1 - By August 31, 2015, integrate and embed programs with existing systems, e.g., aging, disability, faith-based, chronic disease programs, and health care.* To develop a sustainable infrastructure, it is important to embed programs into existing systems. We have many delivery, referral, and support partners that are described below and in Attachment E.

Objective 2.2 - By August 31, 2015, enhance and formalize coordinated state and regional processes for implementation and evaluation. We have developed a number of coordinated state and regional processes, e.g., fidelity/quality assurance, data systems/reporting, leader training, marketing, and sustainability strategies. We have also worked with state agencies to develop policies that support EBPPs to provide a greater long-term impact; however, we are still in the early stages of implementation. We need centralized, coordinated processes at the state and regional level, including referral, intake, and marketing. This project will provide the resources to further the work to develop a truly coordinated system with a "no wrong door" and easy access for all.

iv. Proposed Project: We propose to implement the Stanford CDSMP, ASMP, and Diabetes Self-Management Program (DSMP, Year 2) to improve the health and quality of life of older adults and adults with disabilities with chronic health conditions, targeting populations disparately affected by chronic diseases, i.e., low income, rural, African Americans, and Native Americans.

Addressing the Challenges: To achieve financial sustainability, we plan to develop and strengthen partnerships with large delivery and support systems that can embed CDSME programs in their organizational operations, such as the Dorn Veterans Administration, the SC Department of Alcohol and Other Drug Services (DAODAS), Medicaid Managed Care Organizations (MCOs), Medical Homes, Care Transitions, Medicare Advantage Plans, Money Follows the Person Initiative, and the Veteran Directed Home and Community Based Services program. Health Care organizations are undergoing a transformation in service delivery to reduce costs, improve health outcomes, and provide a holistic,

integrative approach with the patient at the center of care. These changes provide a ripe opportunity for CDSME programs to be introduced as an integral and potentially reimbursable service; and we are on the cusp of integrating them with these transformative initiatives. Furthermore, we are coordinating with partners, such as the AAA/ADRCs, the Partnership for Healthy Aging coalition, the HAPPI Task Force, and the Silver Haired Legislature, to advocate for policies and funding to support evidence-based physical activity and CDSME programs. We are taking every opportunity to inform legislators and decision makers that CDSME programs are a good investment with many benefits, such as improved quality of life of older adults and potentially a lessened financial burden on the state. This project will make it possible to take the next steps to advocate for a holistic approach to health that incorporates self-management as an integral component and to explore the feasibility of CDSME programs as a health plan benefit.

To address the challenge of recruiting sufficient participants to fill scheduled workshops, we will continue to navigate and strengthen referral partnerships with health systems (see above) because we know that doctors and other health care providers reach many older adults and influence their choices. To assist our partners with promoting the programs, we have developed and disseminated a marketing "toolkit" with a variety of promotional strategies and materials. We have also discussed marketing challenges, successes, and "best practices" during grantee calls. While these efforts have been helpful, additional measures and resources are needed. Through this initiative, we plan to secure the expertise of a marketing or communications consultant to assess our current practices and resources and to assist our State Team with the development of a comprehensive multi-faceted marketing plan and campaign. We will also centralize media efforts and focus them strategically where workshops are available but not being filled. We intend to create high visibility of CDSME programs, while assuring that strategies reach minority and underserved populations and messages are culturally appropriate. We will continue to provide workshops in settings that are trusted and accessible, such as COA's, senior centers, churches, and community health centers. We will also develop approaches to increase recognition of workshop sites as wellness centers, so that older adults know where to go to receive a CDSME program.

Strengthening the Evidence-Based Services System: A variety of approaches will be used to achieve the project goals; however, integration of CDSME programs and processes with ARDCs will be crucial to the success of the project and will be a cross-cutting focus. To significantly increase access to and use of CDSME programs (Goal 1), a four-fold approach described below will be employed.

1) Implement CDSMP and ASMP in three un-served geographic areas to provide statewide coverage (Objective 1.1) - Each region will form an implementation team with representation from COAs, Public Health, and AAA/ADRCs. The State Leadership Team will provide training, oversight, technical assistance, and guidance to help each region develop and implement a detailed roll-out plan that takes into consideration their unique geographic and cultural makeup, available resources, and potential partners. Each region will be expected to build a diverse group of partners with various roles, e.g., conducting workshops, embedding programs in organizational operations, hosting workshops, promoting the programs, and referring older adults and adults with disabilities to workshops. In Region III, a partnership with the Catawba Indian Nation will be introduced by the DHEC state office. The State Team will also facilitate partnerships with FQHCs, CLTC (the Medicaid waiver program), Care Transitions, Select Health, and other health care systems/initiatives to help regions achieve their goals. Workshops will be held in a variety of accessible locations. However, to build awareness of the program and to accommodate referral partners, each region will be expected to identify primary sites in more populated areas to offer workshops on a regular basis.

2) Increase the number of counties with workshops held at least twice a year and increase the number of people reached (Objective 1.2) - We will assist the seven expansion regions (see attachment C) in developing a specific plan to spread the programs geographically and to increase the reach. First, existing partnerships, leaders, trainers, and implementation sites will be mapped. Next, a timeline and approaches to expand to new counties and to increase the reach in existing counties will be established. A variety of marketing methods will be used to recruit participants (see pages 7-8). We will continue to facilitate integration with ADRCs and to foster relationships with Medicaid and FQHCs.

In addition to providing support to the regions to increase access to and use of CDSME programs, we will continue to recruit and nurture new large-system multi-site delivery partners to make programs widespread throughout the state. Key delivery-system partners are discussed below on pages 11-12.

3) Implement DSMP in all 7 expansion regions, and develop a health care systems partnership to embed the program in its organization (Objective 1.3) - In Year 2, each region will complete a "readiness" assessment to determine their capacity for implementing DSMP, along with a plan and timeline for introducing it, based on their assessment results. Trainers will be cross-trained and will then train leaders. The State Team will provide ongoing technical assistance to help regions develop and maintain the capacity to offer all three programs. During Year 2, at least one health care system delivery partner that can potentially embed DSMP in its organization will be identified, ideally one that is already accredited to provide Diabetes Self-Management Training (DSMT). The Diabetes Program will be instrumental in leveraging partners and Medicare and/or Medicaid reimbursement will be explored.

4) Ensure that underserved population groups are served (Objective 1.4) - We will continue the current approach of employing Aging and Public Health Regional teams to implement programs since it has been successful in reaching underserved, vulnerable population groups. We will also continue to develop and nurture partnerships with organizations that serve the target populations. To reach Native Americans, we will partner with the Catawba Indian Nation and formalize an agreement as we move forward.

To achieve Goal 2, "strengthen and expand integrated, sustainable statewide systems to support, embed, and sustain CDSME programs," we will employ the six components described below.

1) Provide state-level Aging and Public Health leadership - LGOA, (the SUA) will be the lead agency; and DHEC (the SPH department) Healthy Aging Program will be the co-lead, working in full collaboration during the grant application and throughout all phases of the project. Since 2005, LGOA and DHEC have been at the forefront of leadership in SC to increase access to CDSME programs among older adults with chronic diseases (see pages 2-4 and attachment B). In 2011, a Memorandum of Agreement (MOA) was signed by both agencies to formalize their commitment.

The relationship between LGOA and DHEC is longstanding, and this initiative will further solidify their firm commitment to strengthen and expand an integrated, sustainable infrastructure for CDSME programs in SC. Crystal Strong, LGOA, and Cora Plass, DHEC, who have worked together on previous projects, will co-lead this initiative and keep the evidence-based agenda as a central focus of Aging and Public Health. Ms. Strong, in coordination with Denise Rivers, the Deputy Director of Aging of LGOA, will assure that EBPPs, including CDME programs, are a priority in the State Aging Plan; and Ms. Plass will assure that CDSME programs are included in the State Coordinated Chronic Disease Plan.

Staffing, resources, and responsibilities will be shared between the agencies, with Aging and Public Health teams working together in leadership roles at both the state and regional level to achieve the goals of this project. At the state level, a System Developer position to build partnerships and infrastructure will be split-funded by LGOA and DHEC, and a Data Entry Specialist/Project Assistant will be located at DHEC but will be accountable to both agencies. While not funded by this grant, the Arthritis Program Coordinator will serve as a member of the project team. Within the Public Health Regions, activities of this project will be integrated with chronic disease program efforts. The Public Health commitment to work in full cooperation with LGOA is evidenced by the Letters of Support in Attachment F.

The University of SC (USC) School of Public Health, the third agency represented on the State Leadership Team, will conduct evaluation and quality assurance and ensure that continuous quality improvement is a focus throughout the project. The team will provide a coordinated approach to project management, performance monitoring, and quality assurance. Quarterly meetings will be held to monitor performance, determine strategies to meet objectives, and plan for future activities. Quarterly milestones will be defined, reviewed, and "checked off" during the meetings to monitor progress; findings will be reported in the interim and annual reports. The team will provide guidance, oversight, and technical assistance to partners to help achieve the reach goals and provide programs with fidelity to the original design. Monthly conference calls/webinars and semi-annual meetings will be held with regional Aging and Public Health teams to provide networking, support, technical assistance, and continued learning

opportunities. Regular meetings and conference calls will also be established with delivery and support system partners to monitor progress and to help them fulfill their commitments.

2) Effective partnerships to embed CDSME programs into statewide health and long-term services and support systems - Existing and proposed delivery-system partners - For a sustainable statewide infrastructure, a diverse network of multi-site delivery systems and support partners is needed. Over the course of our CDSME program projects, we have worked with a variety of delivery system partners, including senior and wellness centers, the Parish Nurse Network, residential care facilities, the AME Zion Church, senior housing, libraries, SC Department of Mental Health, and adult day care centers. We have learned a great deal, sometimes through trial and error, about how to assess the "readiness" of a partner and also about what technical assistance, support, and resources are needed for the programs to be sustainable. As a result of these lessons, we are wiser and more strategic in initiating partnerships that will be effective, sustainable, and provide the most impact.

For this project, we will work with some former delivery system partners and a number of new ones, such as designated Medical Homes, to substantially increase access to and use of the CDSME programs. In determining appropriate partners, we will evaluate factors, such as the geographic area served, potential reach, population served (disability, aging, minorities, etc.), available resources for implementing the program, degree to which the organizational structure can support and sustain it, and commitment from senior leadership. We will assist all partners with developing a process for embedding the interventions toward long-term sustainability.

Partnerships with organizations that can reach low income, minority, and rural populations are essential to reduce the impact of chronic diseases and to achieve health equity. Our key delivery partners described below will increase access to the target population of older adults and adults with disabilities who are disproportionately affected by chronic diseases: 1) SC Faith Community Nurses Association (SCFCNA) parish nurse network; 2) the Catawba Indian Tribe in York County with 2,600 tribal members, the majority of whom have one or more chronic diseases; 3) the Dorn Veterans Administration Medical Center (Dorn VA) and its seven outpatient clinics; 4) Palmetto Primary Care Physicians, a

designated Medical Home with 28 primary care physician practices serving seven counties; 5) South Carolina Department of Alcohol and Other Drug Abuse Substances (DAODAS), the state agency that provides treatment for alcohol and other drug substances abuse through its statewide network; 6) SC DHEC, STD/HIV/AIDS Division and its Medicaid and Ryan White providers; and 7) Healthy Columbia, the state's "Organizing for Health" project, a grassroots population-based initiative to improve the health of the 45,000 residents in the 29203 zip code in Columbia, where there is a large African American population, high poverty level, and some of worst health measures nationally. Partner commitments are evidenced by Letters of Support in attachment F.

Aging Network and local Health Department involvement - Our largest, longstanding delivery system partner is the statewide Aging Network of AAA/ADRCs, COAs, and other Aging Service Providers (ASP), in coordination with Public Health Regions and a diverse network of local partners. The roles of each organization vary from region to region; however, all seven regions that offer CDSME programs work as a coordinated team, with Aging and Public Health represented. This approach has been successful in increasing accessibility to the programs, especially among rural, older African American adults. ADRC information and referral staff and caregiver advocates have started providing information about the benefits of EBPPS to older adults and adults with disabilities and helping them enroll in workshops. During this project, we plan to strengthen each ADRCs role as a regional call-in center, while retaining the COAs ability to enroll people, with "no wrong door" to access services.

We will continue to develop new delivery system partners, especially with health care systems, such as Medical Homes and hospitals, to increase access to and use of the programs. The University of SC School of Medicine, the SC Department of Health and Human Services, and the SC Hospital Association, will leverage relationships with health care systems (see Letters of Support). Within a year, we project that we will have commitments from several Medical Homes to offer CDSMP and possibly some hospitals, as well. We are also in discussion with the South Carolina Cancer Coalition to determine the potential for Cancer Centers to become delivery systems. As we strengthen and expand existing

partnerships and forge new ones, we will assure a coordinated, integrated delivery system, with easy access for recruitment, intake, and enrollment at the state, region, and local level.

Support Partners - In addition to delivery-system partners, support partners provide a variety of roles, such as outreach to specific population groups, referrals, promotional activities, quality assurance, advocacy, advisory, policy making, financial support or reimbursement. Key support partnerships that will be nurtured through this project include: (see attachment E for more information.)

Existing Support Partners	
USC School of Public Health	Leadership; Evaluator; Quality assurance
Partnership for Healthy Aging Coalition	Advisory
HAPPI Task Force	Advocacy and policy making
SC Primary Health Care Association (SCPHCA)	Linkage to FQHCs as referral network
SC Department of Health and Human Services (SCDHHS) Managed Care Division	Linkage to Medicaid Managed Care organizations
SC DHHS Community Long Term Care (CLTC)	Area offices to serve as referral network
Select Health (Medicaid Managed Care)	Referral network and possibly delivery partner
Silver-Haired Legislature	Advocacy for older adults
DHEC Chronic Disease Programs and Regions	Integrate CDSME with program activities
SC Hospital Association	Linkage to Care Transitions and hospitals
New and Proposed Support Partners	
Consortium for Southeastern Hypertension Control	Linkage to Medicaid Medical Homes
USC School of Medicine, Interagency Office of Disability and Health	Outreach to adults with disabilities
USC School of Medicine, Department of Family and Preventive Medicine	Linkage to Medical Homes, Medicaid, and other health care systems
Medicare Advantage Plans	Referral Network and possible reimbursement
VAMC for Veteran Directed Home and Community-Based Services Program	Referral network

3) Delivery infrastructure/capacity to provide the programs throughout the state- During the Recovery Act grant, we reached 2,064 people, with 1,556 completers or 75%. For this project, we plan to make significant gains through the strategic partnerships described above. The project reach goal is 7,000 with 5,250 completers or 75%. By working with all 10 AAA/ADRCs, we plan to increase the number of counties offering workshops at least twice a year from 19 to 40 counties, or more than twice the number currently served. During the ARRA project, 48 Host Organizations and 206 implementation sites were represented. As regional teams have been formed, some of the smaller former Host Organizations are now operating under the AAA/ADRC Host Organizations. As we move forward, we plan to work with

fewer but larger Host Organizations to make a bigger impact, while increasing the number of implementation sites. We have intentionally limited Master Trainers to 10 to assure quality trainings, with each person providing multiple trainings a year. There are 135 active CDSMP Leaders and 33 active ASMP Leaders. We will continue to increase the leader pool to accommodate new delivery partners, while retaining existing leaders (attachment C).

4) Centralized or coordinated processes for recruitment, intake, referral, and marketing - We plan to contract with a marketing specialist to help the team develop a campaign with appropriate messages to reach the target audience. Radio and newspaper ads, press releases, and public affairs interviews will be placed by the state offices and coordinated with regional partners. Also at the state level, a mailing list of individuals who "signed up" at health fairs, presentations, and other events will be maintained, and post cards/emails will be sent to notify them of upcoming workshops. An existing toll-free, state information line will be marketed, while also providing ADRC toll-free lines as regional call-in centers for information, referral and enrollment in CDSME programs. County-level processes will also be maintained because older adults, especially those in rural areas, might feel more comfortable contacting the COA. Multi-points of contact will assure easy access. An online data base will be maintained with a schedule of workshops, so that participants can enroll at the state, region, or local level. All forms, reporting processes, quality assurance measures, and marketing materials will be posted on line, while also making hard copies available for our partners. Technology resources from DHEC and LGOA will be leveraged. At the local level, word of mouth messages, including use of Ambassadors, will continue to be employed because this approach has proven effective. With guidance from the marketing expert, we plan to develop bulletin inserts, short announcements from the pulpit, and a call to action because churches reach and influence older adults.

5) Quality assurance program and ongoing data systems and procedures - The USC School of Public Health will plan and conduct evaluation and quality assurance activities for this project (see pages 18-19 below). The State Team will meet quarterly to monitor progress and to determine if the project is on target or if adjustments need to be made to achieve the desired outcomes. Semi-annual management

reports documenting progress toward the work plan objectives will be provided. There will be 100% compliance with the timeline and content of all required data collection and reporting.

6) Business planning and sustainability - We have developed a variety of approaches to sustain CDSME programs. First of all, we are working to embed the programs in a variety of delivery and referral systems as described above, including health care systems, such as Medical Homes, FQHCs, and the VA. Next, LGOA and DHEC have top-level support and commitment to work collaboratively to expand EBPPs. That commitment has made it possible to work together across the two agencies, sharing resources and integrating activities. Public Health Chronic Disease Programs have incorporated CDSMP activities in their work plans (see attachment E), with the Healthy Aging and Arthritis Programs at the forefront; more recently cross-cutting efforts have been established with the Diabetes Program. Since the inception of the CDSMP rollout, activities have been aligned with the DHEC Healthy Aging and Arthritis Programs. Staff and resources have been shared to improve efficiency and provide a greater impact. Opportunities for sustainability are being sought by working toward linkages with a variety of funding sources that can support CDSME programs, such as the Veteran Directed Home and Community-Based Services, Money Follows the Person, and Community Transformation mini-grants.

The SC PHA coalition and its policy arm, the HAPPI Task Force, comprised of decision makers and leaders who support expansion of EBPPs, bring public attention to the cause and advocate for a prevention focus and funding in SC. We have engaged the State Medicaid Agency and Medicaid Managed Care Organizations, such as Select Health, as referral networks and plan to explore the potential of compensation for their members to attend workshops. Furthermore, support has been enlisted from the Silver-Haired Legislature to advocate for legislation and funding to expand EBPPs to improve the health of older adults. The AoA Title III-D change in policy has furthered the understanding of the AAA/ADRC Directors about the importance of EBPPs and increased their commitment to embed programs in aging services and sustain them. The funds are being used to support CDSME and other evidence-based programs, and we are working toward making CDSMP a key program in every county. We recently developed a relationship with Palmetto Primary Care Physicians, a Medical Home, and we are working

with several partner organizations to facilitate linkages to other Medical Homes. The SC Hospital Association is helping us work toward inclusion of CDSME programs in Care Transitions.

While we have achieved many successes, there is still a lot of work that must be done to provide financially sustainable programs. This opportunity will allow us to strengthen partnerships with existing health care partners, while also fostering new relationships. We plan to engage primary care practice Medical Homes, Care Transitions, Hospital specialty areas, such as Cancer or Diabetes Centers, and health plans, such as Medicaid Managed Care, Medicare Advantage Plans, and Blue Cross/Blue Shield, to financially support and sustain the programs. We will also continue to develop partnerships with faith-based organizations, since the church plays an important role in the lives of older adults and influences their choices. In Year 2-3, as we implement the Diabetes Program, we will work toward Medicare reimbursement.

v. Target Population - We will target older adults 60+ and adults with disabilities, especially minorities, low income individuals, rural residents, African Americans (the state's largest minority population), and Native Americans. These groups are likely to have chronic diseases and to experience diminished quality of life, have disabilities and an early death due to their health conditions.

vi. Anticipated Outcomes: System Outcomes - 1) increase in the number of multi-site delivery system partners; 2) embed programs in organizational operations and sustain financially; 3) integrate programs in referral, delivery and/or reimbursement processes of health care systems; 4) develop and implement sustainability plan; 5) coordinate and centralize processes for information, referral, enrollment, and marketing; 6) formalize written processes for program implementation at state and regional levels; 7) market 800# call-in line; 8) integrate programs in ADRCs; 9) develop and implement state health communication plan; 10) embed and financially support DSMP in at least one health care system; and 11) 100% compliance with AoA data collection and reporting requirements. Program Delivery Outcomes - 1) reach at least 7,000 older adults and adults with disabilities/5250 completers; 2) offer at least 2 workshops per year in 40 counties; 3) increase the number of workshops at least three-fold; 4) provide fidelity monitoring in all 10 ADRC regions; 5) meet at least 85% of fidelity monitoring elements; 6)

increase the number of Host and implementation sites; 7) have a sufficient pool of leaders for statewide reach; and 8) geographically place at least 12 Master Trainers to cover leader trainings. Participant Outcomes - 1) High degree of participant satisfaction with workshop leaders, content, and delivery; 2) majority of participants are older adults and adults with disabilities, 3) underserved populations are represented at percentages equal to or higher than the state rate, and 4) completion rate is at least 75%.

vii. Project Management: (vitaes - attachment G) LGOA, DHEC, and USC will work together as the project **Leadership Team** to jointly plan and manage the project. The Leadership Team will provide guidance, direction, and oversight to the project partners through all phases of the project to assure that the objectives and outcomes are achieved. The team will be responsible for planning and conducting training for partners to instill the knowledge, skills, and competency needed to successfully carry out their roles. **Organizational Oversight:** 1) **Denise Rivers, LMSW,** Deputy Director of the Division of Aging Services at LGOA and manager of federal wellness funds, will assure fiscal accountability to AoA and LGOA and keep CDSME at the forefront of discussions that involve health care change, such as Care Transitions. She will provide leadership and promote cooperation with the intent of this application among ADRC Directors. 2) **Project Lead (25%): Crystal Strong, BSN**, Program Manager for the Nutrition/Health and Wellness Promotion Programs at LGOA, will provide leadership, management, project oversight, and contractual compliance. She will serve as the primary communicator with AoA and will be responsible for preparing and submitting required reports. 3) **Project Co-Lead (25%): Cora Plass, MSW**, Director of the Healthy Aging Program at DHEC and Program Manager for the SC Arthritis Program, will assume equal responsibility with Ms. Strong for leadership, management, oversight, and grant reporting. Ms. Plass will share staff and resources within her area and promote coordination with other chronic disease programs and public health initiatives. 4) **Project Evaluator (15%): Katherine Leith, PhD, MPH, MSW,** Research Associate at the USC School of Public Health, will plan and conduct evaluation and quality assurance activities, including fidelity monitoring oversight and training.

The **Core Team** is comprised of the Leadership Team members and other key staff at the State level: 1) **Project Coordinator (25 hours/week):** This new position will be housed at LGOA to coordinate day-to-day activities for the project and to serve as the Aging Network point of contact for technical assistance and coordination of trainings; 2) **Arthritis Program Coordinator: Patricia Williams, MPH,** DHEC, while not funded by this grant, will contribute to the efforts of this project through an integrated approach with the DHEC Arthritis Program. She will provide technical assistance for program implementation, and she will work in collaboration with the Project Coordinator to coordinate leader trainings; 3) **Systems Developer (10 hours/week): Julie Lumpkin, MPH,** who resides at DHEC will be split-funded. She will be responsible for developing and nurturing new delivery and referral systems partnerships and working with partners to help them move toward integrated, sustainable service systems. She will document state-level processes to guide implementation and navigate relationships between health systems and regional partners; 4) **Health Communications Coordinator:** This position will be funded by DHEC to promote CDSME programs; activities will be fully integrated with this project; and 5) **Data Entry Specialist/Project Assistant (40 hours/week):** This position will be housed at DHEC to provide data entry, maintain workshop and training schedules on the website and provide support to project staff.

Regional Project Leads and Teams will be formed with representatives from the ADRCs, local ASPs, Regional Health Departments, and other key partners to provide a coordinated regional approach. Each region will determine a structure that best utilizes available resources to make the greatest impact. In some areas, the ADRC will be the lead, while in other areas COAs, Regional Health Departments, or other partners will take the lead. Regardless of the lead agency, all regions will provide a coordinated, integrated approach with "no wrong door" to access CDSME programs.

viii. <u>Quality Assurance</u>: An organizational capacity evaluation will ascertain the degree to which project efforts achieve anticipated outcomes, including: 1) who is involved – the diversity and array of people and organizations; 2) how partners are involved – whether participation is active and ongoing; and 3) what the scope of the process is – does it focus on multiple issues and address taking action. Quarterly team meetings will be held to assess and establish satisfactory progress toward goals and to determine

when and, if so, how changes should be made to address challenges and barriers. Data will be collected to flush out progress toward the project activities; barriers and opportunities that affect progress; and individual, organizational, and systems characteristics that affect progress. The outcomes evaluation will incorporate three main components: 1) Qualitative Data Collection - collaborative and cooperative relationships will be assessed on four levels: a) between regional project team members at the local sites; b) between the regional partners and the state team; c) between project team members and partnering organizations; and d) across program sites in the regions; 2) Quantitative Data Collection –surveys will be completed by CDSME program leaders and by partners to assess participation in workshops. Workshop participation and attendance, as well as demographics and satisfaction of participants, will be captured. On a programmatic level, progress toward outcomes will be assessed by defining, reviewing, and "checking off" progress through quarterly team meetings and through interaction with partners at several points during the project; 3) Fidelity and Quality Improvement - quality assurance activities will be a shared responsibility, and all project staff and partners will receive training on this component. Fidelity data will be captured through a variety of methods using existing surveys, e.g., workshop observation visits, leader self-monitoring assessments, trainer monitoring, and feedback from leaders/trainers/fidelity monitors. The state Fidelity Manual will be maintained and used to guide the fidelity process that is in place. Quality assurance activities will include evaluative updates, fidelity and quality improvement trainings, and monthly conference calls with regional partners. Corrective action will be brought to the attention of Fidelity Monitors, the Regional Team and/or the state Leadership Team, depending on the severity of the issue, to determine the appropriate course of action. Challenges and "lessons learned," both positive and negative, will be discussed during calls and team meetings, and this process will be used to continually make the project more successful. Lessons learned will be documented and shared.

ix. Organizational Capacity: (attachment H) As the designated SUA under the Older Americans Act (OAA), LGOA is the leader for aging issues for older persons in SC. The mission of LGOA is to enhance quality of life for older adults through advocacy, planning, and resource development. LGOA provides

leadership and oversight for the 10 regional AAA/ADRCs and awards them federal and state funding to contract with local providers for services. The Aging Network delivers programs and services to more than 28,000 older adults and adults with disabilities in all 46 counties. Other funding and resources support services to an additional 25,000 individuals. LGOA has many partnerships that can be leveraged for this initiative, such a longstanding relationship with the SC Hospital Association to facilitate a linkage with Care Transitions. LGOA is involved in important transformative health care efforts, such as Money Follows the Person, and the Veteran Directed Home and Community Based Services program, which provide opportunities for integration with this project.

DHEC, the state public health agency, is charged with promoting and protecting the health of the public and the environment and is organized into service areas. As the largest organizational unit in DHEC, the Health Services area is dedicated to providing culturally competent services to address public health issues through prevention with overarching goals of increasing the quality and years of healthy life and achieving health equity. It has more than 2,219 employees and 8 public health regions with multiple health departments that serve all 46 counties of the state. The Bureau of Community Health and Chronic Disease Prevention (BCH/CDP), a unit within Health Services, has 9 divisions and offices working in a coordinated approach to address chronic diseases. The Healthy Aging section resides in the BCH/CDP Bureau and works to reduce the impact of chronic diseases. Since 2006, DHEC's Healthy Aging section has partnered with LGOA to provide leadership for EBPPs. In 2008, DHEC was one of 12 states to receive a CDC award expand EBPPs for arthritis by embedding them in delivery systems.

USC School of Public Health, the third prong of the state leadership team has a long-standing relationship with LGOA and DHEC and has been the evaluator for several EBPP initiatives. USC brings expertise in program planning, policy and research, and evaluation and houses one of 33 Prevention and Research Centers in the country for conducting community-based prevention research and translating it into practice.

Attachment G

VITAES OF PROJECT STATE LEVEL PERSONNEL

Denise Rivers, MSW, CIRS, General Oversight Manager (riversd@aging.sc.gov, 803-734-9939), serves as the Deputy Director of Aging Services for the Lt. Governor's Office on Aging. She supervises and manages programs and staff for Older American Act programs and federal grants. She has been involved with Public Health for nearly 30 years and has served as Program Manager for the Lt. Governor's Office on Aging, Program Director for the SC Services Information System, Counseling Services, and Social Services. Denise is a member of several Public Health boards and committees including: Aging and Disability Resource Center Advisory Board and Developmental Disabilities and Information Technology Sub-Committee. She has a Bachelor of Arts in Child Development and Psychology from the University of South Carolina (1980); and a Master of Social Work from the University of South Carolina (1983). She is a Licensed Master Social Worker.

Crystal Strong BSN, Project Lead (cstrong@aging.sc.gov, 803-734-9889) is the Nutrition/Health and Wellness Program Manager for the Lt. Governor's Office on Aging since 2007. She works closely with the Administration on Aging, and the South Carolina Department of Social Services. She provides provide leadership and guidance to the AAAs for implementation of the Chronic Disease Self-Management Program and served as the lead for the Recovery Act Chronic Disease Self-Management Program grant. Crystal has been with the LGOA since 2000 when she served in the State Health Insurance Assistance Program as the Program Coordinator. Her experience includes monitoring and evaluating the senior nutrition program with the Aging network, presenting information on health and wellness related topics, educating seniors and disabled population about health prevention/promotion and insurance options, and educating the community about outreach programs through door-to-door community outreach, health fairs, and community events. Crystal has a Bachelor of Science in Nursing from South Carolina State University, 1995.

Cora Plass, MSW, Project Co-Lead (plasscf@dhec.sc.gov, 803-898-0349), is the Director, Healthy Aging Program, Bureau of Community Health and Chronic Disease Prevention, SC DHEC. She serves as the agency's focal point for aging and provides leadership for older adult initiatives. She is the Healthy Aging and Arthritis state contact for the National Association of Chronic Disease Directors. She is a member of the Bureau Management Team and Health Services Central Office Management Team and serves as Program Manager for the SC Arthritis Program, providing oversight, leadership, and grant management. She has written and managed a number of grants for arthritis and healthy aging and served as the Co-lead for the Administration on Aging evidence-based projects, including the Recovery Act grant. From April 1999 - September 2004, she served as Director of Home and Community-Based Services for the Bureau of Home Health Services. Prior to that, she provided social work consultation for Home Health for nine years. She has worked in public heath for twenty years. She is a member of the National Association of Social Workers and is an Academy Certified Social Worker. Education and Licensure - MSW, University of South Carolina, 1986; BA, Duquesne University, Pittsburgh, PA, 1975. Licensed Independent Social Worker, Advanced Practice and Clinical Practice; Academy Certified Social Worker.

Katherine Leith, PhD, MSW, Project Evaluator (khleith0@mailbox.sc.edu, 803-777-0317), is a Research Associate at the University of South Carolina Center for Health Services and Policy Research. Her research interests include aging, policy, and evidence-based programming. She currently functions as project evaluator for various evidence-based practice projects, such as "Empowering Older People to Take More Control of Their Health Through Evidence-Based Prevention Programs (*Living Well South Carolina*)". Dr. Leith is a member of the Measures of Success workgroup, the USC PRC Healthy Aging Research Network, and is an expert panel member of the Special Interest Panel on Depression in Older Adults and of the Special Interest Panel on Emotional Health in Older Adults. Dr. Leith has been teaching at USC since Fall 2004. Licensed Master Social Worker; Certificate in Gerontolgy; MPH-Health Administration; PhD-Health Services and Policy Management.

Julie Lumpkin, M.S.P.H., System Developer (lumpkijl@dhec.sc.gov), 803-898-0762, Healthy Aging Program, Bureau of Community Health and Chronic Disease Prevention, SC DHEC. Ms. Lumpkin will continue to serve as the public health point of contact with region partners funded by previous AoA and ARRA evidence-based grant programs, in coordination with the LGOA Nutrition/ Health and Wellness Program Manager and DHEC's Healthy Aging staff. She is responsible for establishing systemic partnerships to expand evidence-based prevention programs for people with arthritis and chronic health conditions. This includes developing linkages and processes within partner systems for an integrated approach to program implementation. During her public health career, she has served as program manager, planner, public information director, and market researcher. From 1996-2002, she was DHEC Women's Health Program Manager (Assistant Mgr. 1996-98), and in 1998 was appointed S.C. Women's Health Coordinator, US DHHS Reg. IV Office of Women's Health. From 1999-2002, she served as co-PI, S.C. Arthritis Prevention and Control Program, with Ms. Plass. Her research for her thesis, *Physical and Mental Health Status of Front-Line Workers in Anti-Violence Agencies in South Carolina (2005),* received awards from Delta Omega and the USC School of Public Health, 2005, and the USC School of Medicine, 2007.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Indian Health Service
Nashville Area Office
711 Stewarts Ferry Pike
Nashville, TN 37214-2634

May 29, 2012

Denise W. Rivers
Deputy Director of Aging Services
Lt. Governor's Office on Aging
1301 Gervais Street, Suite 200
Columbia, SC 29201

Dear Ms. Rivers:

As the Diabetes Coordinator with the Indian Health Services based at the Catawba Indian Nation in York County, S.C., I welcome the opportunity to submit this letter of support to the Lieutenant Governor's Office on Aging (LGOA), in partnership with the South Carolina Department of Environmental Control (DHEC), for the US Administration on Aging application, "Empowering Older Adults and Adults with Disabilities through Chronic Disease Self-Management Education Programs."

As we enjoy partnering with other state health efforts such as the Eat Smart Move More South Carolina Coalition, Eat Smart Move more York County, and the DHEC Diabetes and Obesity Programs, I was happy to be approached about implementing the Chronic Disease Self-Management Program (CDSMP) for the Catawba Indian Nation. The only federally qualified tribe in South Carolina, the Catawba Indian Nation is located in York County, South Carolina, near Charlotte and Rock Hill. The Catawba Tribe comprises 2600 number of people, the majority who live with chronic health conditions such as diabetes (44% over age 55), asthma, arthritis and hypertension.

The Catawba Service Unit (Health Clinic) works collaboratively with the Tribe in sponsoring and organizing health programs, and we are excited about adding CDSMP. We value this program because it addresses chronic diseases broadly, so that regardless of which health condition someone has, he or she can benefit. Furthermore, we recognize that many people, especially those in their middle and later years of life, have more than one chronic health condition, and they are at the highest risk of having poor health outcomes. Therefore, this program is an ideal place for us to start. We also look forward to making the Arthritis Self-Management Program available and in the second year of your grant, discussing implementation of the Stanford Diabetes Self-Management Program.

Dawn Osborn, the Senior Center Director, is excited about offering the program to the Seniors who eat lunch every day at the center. Ms. Osborn is interested in being trained as a Leader, along with 5-10 more possible clinic staff and volunteers. Besides the Senior population, we have mid-life adults who could benefit from techniques and skills in stress reduction, relaxation, and problem-solving to improve their health. We will discuss offering another CDSMP series in the evening for our working adults to attend.

By July 2012, we will host LGOA and DHEC staff here at the Catawba reservation so they can make a presentation to potential Leaders and participants. We will also plan our partnership agreement in more detail then or in subsequent communications. Once again, we very much appreciate the opportunity to partner with you and DHEC to bring positive health benefits of CDSMP to our tribal population.

Sincerely,

Lisa Martin, M.A., R.D., C.D.E.
Diabetes Coordinator/Nutritionist/Certified Diabetes Educator
Indian Health Services, Catawba Service Unit

May 31, 2012

Denise Rivers, LMSW, CIRS
Deputy Director
Lt. Governor's Office on Aging
1301 Gervais Street, Suite 350
Columbia, SC 29201

Dear Ms. Rivers and Ms. Plass:

As Director of Community Outreach for AARP and liaison to our 25 Chapters, I am writing to show support for your application, "Empowering Older Adults and Adults with Disabilities through Chronic Disease Self-Management Education Programs." Many older adults in South Carolina suffer needlessly from arthritis and other chronic diseases, resulting in years of poor health, loss of independence, and disability.

The goal of AARP is to enhance the quality of life for older adults by leading positive social change and providing members information, advocacy, and service. AARP has a history of working in partnership with DHEC on preventive initiatives. We are represented on the Arthritis Advisory Council, the Healthy Aging Partnership coalition, and the S.C. Healthy Aging Policy Platform Initiative (HAPPI). Through these efforts, we have made the evidence-based prevention programs more visible to legislators and decision-makers and more widely available to older adults throughout the state.

We will continue to offer our services to support your program activities in policy, advisory, and promotional roles. AARP-SC will publicize and disseminate information about evidence-based programs, using our various channels of communication such as our website, the AARP Bulletin and other publications, and communications with our 25 Chapters, who can champion the cause of physical activity and self-management programs in their service areas.

We are excited about this ongoing partnership and are committed to working in full cooperation with DHEC to promote long and healthy lives for older adults in South Carolina.

Sincerely,

Doris Gleason

Doris Gleason
Director of Community Outreach

Catawba Area Agency on Aging

PO Box 4618 • Rock Hill, SC 29732 • 803.329.9670 • 800.662.8330 • www.Catawba-Aging.com

June 4, 2012

Denise W. Rivers
Deputy Director
Lt. Governor's Office on Aging
1301 Gervais Street, Suite 350
Columbia, SC 29201

Dear Ms. Rivers and Ms. Plass:

We are pleased to partner with the Lt. Governor's Office on Aging and the SC Department of Health and Environmental Control's (DHEC) Healthy Aging Program and to provide support for your application, "Empowering Older Adults and Adults with Disabilities through Chronic Disease Self-Management Education Programs."

We understand the importance of this initiative in providing support to our Aging Network and other partners to expand the Stanford chronic disease self-management education programs in South Carolina. The Aging Disability Resource Centers are an ideal location to facilitate expansion of these programs, and I will serve as the lead for our region to assure that programs are made available in our three counties.

We will coordinate with the Aging Service Providers in all counties and with our local health departments to train staff and volunteers to offer the programs. One county already has leaders trained and are ready to start holding workshops. We plan to recruit and train more Leaders late summer or early fall, so that the first round of workshops can be scheduled before the holidays. We will also build partnerships with community organizations, churches, and health care providers and systems in our area to provide workshops and embed the programs in their organizations.

In our Catawba ADRC, we will assure that all staff are knowledgeable about the programs and provide information about them when people call or come into the center for assistance. In particular, we will train our Information and Referral staff to refer individuals to local workshops. We will also assure that the reporting requirements are met and that paperwork is submitted in a timely manner to the state office to report to the Administration on Aging. Fidelity will also be emphasized, and we will follow the state protocol so that we have quality programs with good results. We will work together in our region so that older and disabled adults can easily enroll in the programs and access them in their communities.

During the three-year grant period, we will work diligently to expand the number of people reached and the number of workshops, providing access in all three counties. Once we are providing CDSMP workshops regularly, we would like to offer the Arthritis and Diabetes Programs, as well.

Our thanks again for this exciting opportunity to join in partnership to deliver health programs that can make a genuine difference in the lives of our clients.

Sincerely,

Barbara Robinson

Barbara Robinson
Executive Director
Catawba Area Agency on Aging

CENTRAL MIDLANDS
Council of Governments

June 4, 2012

Denise W. Rivers, LMSW, CIRS
Deputy Director
Lt. Governor's Office on Aging
1301 Gervais Street, Suite 350
Columbia, SC 29201

Dear Ms. Rivers:

We are pleased to join in partnership with the Lt. Governor's Office on Aging(LGOA) and the SC Department of Health and Environmental Control's (DHEC) Healthy Aging Program and support your application, "Empowering Older Adults and Adults with Disabilities through Chronic Disease Self-Management Education Programs."

As we are faced with a growing number of older and disabled adults and the Aging Network undergoes a transition to prepare for the baby-boomer generation, we recognize the importance of evidence-based chronic disease self-management education (CDSME) programs to improve quality of life and health outcomes. With this recognition, we are pleased to have the opportunity to expand the existing CDSMP program and offer new ones in the Midlands region. The Stanford Chronic Disease Self-Management Program and the Arthritis Self-Management Program are already being offered regularly in downtown Columbia, with Arthritis Exercise programs in Richland, Newberry and Fairfield counties. CDSMP is also being offered in Lexington County. The programs are very popular in these areas. This opportunity will make it possible to expand the programs to outlying areas within Richland County, while maintaining the gains we have made in Lexington, Newberry and Fairfield counties. With some start-up funding, we feel certain that the LGOA and DHEC can build partnerships to sustain the programs to improve the quality of life of older adults.

Our thanks again for this exciting opportunity to join in partnership to deliver evidence-based health programs that can make a genuine difference in the lives of our seniors and adults with disabilities.

Sincerely,

Sharon Seago, MPA, CIRS-A
Director of the Area Agency on Aging/ADRC
Central Midlands Council of Governments

Lowcountry Council of Governments

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Office at Point South: I-95 Exit 33 at US Hwy. 17

Lowcountry Regional Development Corporation • Lowcountry Workforce Investment Area
Lowcountry Economic Development District • Lowcountry Regional HOME Consortium
Lowcountry Aging & Disability Resource Center / Area Agency on Aging

June 4, 2012

Denise W. Rivers, LMSW, CIRS
Deputy Director
Lt. Governor's Office on Aging
1301 Gervais Street, Suite 350
Columbia, SC 29201

Dear Ms. Rivers:

I am writing on behalf of the Lowcountry Area Agency on Aging/ADRC. We look forward to our continued partnership with the SC Lieutenant Governor's Office on Aging and the S.C. Department of Health and Environmental Control's (SC DHEC) Healthy Aging Program and support your application entitled *Empowering Older Adults and Adults with Disabilities through Chronic Disease Self-Management Education Programs*, funded by the Administration on Aging.

We firmly believe in the overall mission of the effort, to develop, offer and sustain evidence-based programs that help older adults maintain their health and independence in their homes and communities, such as CDSMP and Arthritis and Diabetes Self Help programs. As in previous years, we are ready and willing to contribute actively to the implementation of evidence based programs.

The partnership between our agency and DHEC Public Health Region 7 and 8 has brought together a team that has made a tremendous impact through the CDSME programs offered in our four county service area. To date, most of the counties have been very active with program offerings. We are looking forward to increasing the reach numbers across all four counties.

The team has made progress in embedding the CDSME programs, as well. Several of our counties have a Public Health partnership that has taken on the program's logistics: handling program registration calls, finding site locations and scheduling classes, supporting volunteer leaders, etc. We are also working with the Federally Qualified Health Centers and look forward to the opportunity to strengthen this relationship and embed the programs in this and other health care systems. We plan to expand the

program to all counties on a regular basis and continue to offer workshops at new sites and serve more people.

We will continue to offer the Chronic Disease Self-Management Program and the Arthritis Self-Management Program in our agency, at a rate of at least one workshop per county per quarter. In addition, we are eager to have current leaders cross-trained in the Diabetes Self-Management Program. We will also continue to work with you on fine-tuning marketing and recruitment strategies.

Carlon Mitchell with the Health Department Regions 7 and 8 will serve as the lead to coordinate efforts for our region. We will assure that CDSME programs, as well as other evidence-based programs, are incorporated in daily activities of the center and that all staff understand the benefits of the programs and know when workshops or classes are scheduled, so that they can refer interested individuals to the programs. We will also coordinate with our Aging Service Providers to enlist their support in offering programs, so that there is "no wrong door" for the older adult or adult with disabilities who lives in our area of the state.

As we have in the past, we will encourage and support agency staff and community volunteers to enlist in leader training workshops. We will also identify suitable persons from currently trained and active Leaders who will become fidelity monitors for the region and will work with new Leaders to help them become successful. We currently have one Master Trainer in our region and will recommend other suitable Fidelity Monitors for the Master Trainer course.

Again, we are fully invested in this effort, as we believe that it has made and will continue to make a significant improvement in the health of older South Carolinians. We express our sincere appreciation for the ongoing opportunity to work with you and to join in your efforts to make a genuine difference in the lives of our seniors.

Sincerely,

Marvile Thompson
Aging Unit Director
Lowcountry ADRC

Lower Savannah
Council of Governments

P.O. Box 850, Aiken, S.C. 29802
Tel. (803) 649-7981 Fax (803) 649-2248
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June 4, 2012

Denise W. Rivers, LMSW, CIRS
Deputy Director
Lt. Governor's Office on Aging
1301 Gervais Street, Suite 350
Columbia, SC 29201

Dear Ms. Rivers:

I am writing on behalf of the Lower Savannah Area Agency on Aging/ADTRC. We look forward to our continued partnership with the SC Lieutenant Governor's Office on Aging and the S.C. Department of Health and Environmental Control's (SC DHEC) Healthy Aging Program and wholeheartedly support your application entitled *Empowering Older Adults and Adults with Disabilities through Chronic Disease Self-Management Education Programs,* funded by the Administration on Aging.

We firmly believe in the overall mission of the effort, to develop, offer and sustain evidence-based programs that help older adults maintain their health and independence in their homes and communities, such as CDSMP and Arthritis and Diabetes Self Help programs. As in previous years, we are ready and willing to contribute actively to the implementation of evidence based programs.

The partnership between our agency and DHEC Public Health Region 5 has brought together a team that has made a tremendous impact through the CDSME programs offered in our six county service area. To date, half of the counties have been very active with program offerings; and the remaining three are now poised to show an increase in program offerings as well. We are looking forward to increasing the reach numbers across all six-counties.

The team has made progress in embedding the CDSME programs, as well. One of our counties has a Human Service partnership that has taken on the program's logistics: handling program registration calls, finding site locations and scheduling classes, supporting volunteer leaders, etc. Another has an agency that has adopted the program and has been instrumental in identifying leaders, scheduling classes, etc. We are also working with the Federally Qualified Health Centers and the Medicaid Community Long Term Care area office and look forward to the opportunity to strengthen these relationships and embed the programs in these and other health care systems. We plan to expand the program to all counties on a regular basis and continue to offer workshops at new sites and serve more people.

We will continue to offer the Chronic Disease Self-Management Program and the Arthritis Self-Management Program in our agency, at a rate of at least three classes during the year. In addition, we are eager to have current leaders cross-trained in the Diabetes Self-Management

Program. We will also continue to work with you on fine-tuning marketing and recruitment strategies.

Our Aging, Disability and Transportation Resource Center is willing to continue co-leading the classes with our Regional DHEC, as leader. We will assure that CDSME programs, as well as other evidence-based programs, are incorporated in daily activities of the center and that all staff understand the benefits of the programs and know when workshops or classes are scheduled, so that they can refer interested individuals to the programs.

As we have in the past, we will encourage and support agency staff and community volunteers to enlist in leader training workshops. We will also identify suitable persons from currently trained and active Leaders who will become fidelity monitors for the region and will work with new Leaders to help them become successful. We currently have one Master Trainer in our region and will recommend other suitable Fidelity Monitors for the Master Trainer course.

Again, we are fully supported of this effort, as we believe that it has made and will continue to make a significant improvement in the health of older South Carolinians. We express out sincere appreciation for the ongoing opportunity to work with you and to join in your efforts to make a genuine difference in the lives of our seniors.

Sincerely,

Connie H. Shade

Connie H. Shade
Executive Director

June 7, 2012

PALMETTO
PRIMARY CARE
PHYSICIANS

Denise W. Rivers
Deputy Director of Aging Services
Lt. Governor's Office on Aging
1301 Gervais Street, Suite 200
Columbia, SC 29201

Dear Ms. Rivers and Ms. Plass:

On behalf of Palmetto Primary Care Physicians, I am pleased to write this letter in support the Lt. Governor's Office on Aging, in partnership with the SC Department of Health and Environmental Control application to the U.S. Administration on Aging (AoA), "Empowering Older Adults and Adults with Disabilities through Chronic Disease Self-Management Education Programs." Our mission is to facilitate healthier lives in the communities we serve. We are a designated Medical Home in Charleston with 28 primary care practices located in a seven-county area.

We appreciate your staff coming to present information about the evidence-based chronic disease self-management education programs that are being offered and your application to increase the reach of these programs in South Carolina. Palmetto Primary Care Physicians work diligently to offer the best in quality healthcare, providing a whole-centered approach to help our patients achieve improved health outcomes. We provide care to approximately 300,000 individuals (276,083 adults), many of whom have chronic diseases; and we believe that the Stanford Chronic Disease Self-Management Program (CDSMP) will greatly benefit these patients and improve their quality of life.

We would like to train our staff to offer CDSMP and plan to embed it as a core component of medical care patients receive from our physician practices. We look forward to talking with you this summer to develop a specific rollout plan and timeline for training staff and implementing the program. This model and the other Stanford chronic disease self-management programs hold great promise to improve health status and health outcomes for our patients.

Thank you for the opportunity to support your program activities and to join in partnership to deliver health programs that can make a genuine difference in the lives of our patients.

Yours truly,

Ron Piecone
Chief Executive Officer
Palmetto Primary Care Physicans

2550 Elms Center Road • North Charleston, SC 29406 • (843) 572-7727 • Fax (843) 569-5872
www.palmettoprimarycare.com

June 6, 2012

Denise W. Rivers, LMSW, CIRS
Deputy Director
Lt. Governor's Office on Aging
1301 Gervais Street, Suite 350
Columbia, SC 29201

Dear Ms. Rivers:

We are pleased to join in partnership with the Lt. Governor's Office on Aging and the SC Department of Health and Environmental Control's (DHEC) Healthy Aging Program and support your application, *"Empowering Older Adults and Adults with Disabilities through Chronic Disease Self-Management Education Programs,"* funded by the US Administration on Aging.

Chronic disease are is a significant problem for our region, and a growing problem as our population ages, as older adults are more likely to have one or more chronic conditions. This is an even greater concern for our area, because the prevalence rate is high and the area is mostly rural, with a large number of African Americans, who are disproportionately affected by chronic diseases. We understand the importance of offering quality prevention programs and are pleased to have this opportunity to work in cooperation with our County Councils on Aging and other Aging Service Providers, the local health department, and other community and faith-based partners to make a difference through chronic disease self-management education (CDSME) programs, such as the Stanford Chronic Disease Self-Management Program (CDSMP). We also look forward to building partnerships with health care systems, such as the Federally Qualified Health Centers and to working with those systems and other partners to provide s sustainable program infrastructure. This opportunity will make it possible to generate programs and build capacity in sites within our four county- area where these programs are not yet being offered on a regular basis to improve the quality of life of older and disabled adults.

We will assist in the coordination of the CDSMP in our region with our partners. This will hopefully assure the success of this endeavor. Our Aging Disability and Resource Center (ADRC) will provide a regional centralized location to offer information to older adults about the benefits of CDSME programs and refer them to the lead organization to get them enrolled in local workshops. We will assist in the coordination with our partners in the region to provide a coordinated approach, so that an older/disabled adult can receive information at the county or region level for a "no wrong door" approach. Our staff, especially the Information and Referral Specialists is willing to provide information about the programs to older adults and individuals with disabilities whom they serve. It is our belief that all counties will work in coordination with the health department to integrate these programs with other chronic disease activities, such as Arthritis and Diabetes.

Our thanks again for this exciting opportunity to join in partnership to deliver evidence-based health programs that can make a genuine difference in the lives of our seniors and adults with disabilities.

Sincerely,

Shawn Keith
Aging Unit Director
Santee-Lynches Council of Governments/ADRC

SOUTH CAROLINA
PRIMARY HEALTH CARE
ASSOCIATION

"Access to Quality Health Care for All South Carolina"

June 6, 2012

Ms. Cora Plass, MSW, Director
SC DHEC Office of Healthy Aging
1751 Calhoun St.
Columbia, SC 29201

Dear Ms. Plass:

On behalf of the South Carolina Primary Health Care Association (SCPHCA), I am pleased to support the application being submitted by the Lt. Governor's Office on Aging, in partnership with the South Carolina Department of Health and Environmental Control (DHEC) Healthy Aging Program, for "Empowering Older Adults and Adults with Disabilities through Chronic Disease Self-Management Education Programs." The SCPHCA is committed to improving access to quality care for the medically vulnerable in South Carolina, and as such, is fully supportive of this initiative.

The SCPHCA is the membership organization that represents all of South Carolina's community health centers, which are an integral part of the primary health care system in our state. In 2011, the 19 community health centers provided quality, affordable, and community-based preventive and primary health care services to over 325,000 patients through 120 service sites. Community Health Centers provide high quality comprehensive primary health to patients, while reducing inappropriate emergency room use, overall health care costs, racial and ethnic health disparities, and other barriers to care.

The SCPHCA is pleased to be working in partnership with you to bridge the gap between community and clinical services by incorporating information about the benefits of chronic disease self-management interventions into clinical services at the point of care. We will continue to facilitate linkages between local Federally Qualified Health Centers (FQHC) and regional aging and health department teams for the purpose of enrolling health center patients into local Stanford Chronic Disease Self-Management and the Arthritis Self-Management workshops. When available, we will also evaluate how the Stanford Diabetes Self-Management Program might be implemented by Community Health Centers. The goal of these efforts is to significantly increase the number of patients who receive self-management education programs to improve their health outcomes.

We look forward to a continued working relationship with you and DHEC as we strive to assure access quality health care for all in South Carolina.

Sincerely,

L J Woodard

Lathran Woodard
Chief Executive Officer

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Select Health
of South Carolina, Inc.
An AmeriHealth Mercy Company

South Carolina Healthy Connection

May 31, 2012

Denise Rivers, LMSW
Deputy Director
Lt. Governor's Office on Aging
1301 Gervais Street, Suite 350
Columbia, SC 29201

Dear Ms. Rivers and Ms. Plass:

On behalf of the Integrated Case Management/Maternal and Child Health Division of Select Health of South Carolina, I am pleased to write this letter in support for your application to the U.S. Administration on Aging (AoA), "Empowering Older Adults and Adults with Disabilities through Chronic Disease Self-Management Education Programs."

Select Health of South Carolina is a managed care organization with 226,000 members enrolled in its First Choice Medicaid health plan. As a result of our joint meeting, February 2012, Select Health is an avid referral and support partner for the Stanford Chronic Disease Self-Management Program and the Arthritis Self-Management Program, both of which are already being provided in South Carolina. Our 19 nurse case managers have started to promote and refer our members to program workshops throughout the state. We are excited both by the potential health improvement to our members and the added potential benefits of lower health care costs. We will also work with you to develop policies and procedures for referrals and to evaluate effects on our members' health outcomes.

We are coordinating with Kimberley Wilson, the Select Health Outreach and Education Coordinator, who was recently trained as a Leader for the Stanford CDSMP. Ms. Wilson is assisting in publicizing these programs and enlisting the involvement of our Provider Network. She is using a "Care Gap" List to identify providers with high numbers of patients with chronic conditions. Providers will be approached to promote and refer First Choice Members into Select Health-sponsored CDSMP workshops. As Ms. Wilson finds successful approaches to work with our providers, we hope to train a number of other staff within Select Health to implement CDSMP for our members who have chronic diseases.

As we work together to navigate a process that fits our member needs, we want to make chronic disease self-management education programs widely available to our members. In the second year of your project, we are also interested in working with you to make the Stanford Diabetes Self-Management Program available to our members with diabetes. Together, we want to determine the best approaches for embedding these programs in our organization so that they are routinely available to all of our members with chronic diseases.

I am delighted to offer my support to facilitate the spread of CDSMP and other chronic disease self-management education programs in South Carolina and wish you the best of luck with your application.

Sincerely,

Angela M. Glyder, R.N.
Director, Integrated Case Management/ Maternal Child Health Division
Select Health of South Carolina

D H E C

PROMOTE PROTECT PROSPER

June 4, 2012

Denise W. Rivers
Deputy Director of Aging Services
Lt. Governor's Office on Aging
1301 Gervais Street, Suite 200
Columbia, SC 29201

Dear Ms. Rivers:

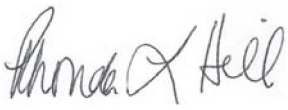
On behalf of the Diabetes Prevention and Control Division, South Carolina Department of Health and Environmental Control (DHEC), I am pleased to write this letter of support to the Lieutenant Governor's Office on Aging, (LGOA), in partnership with the DHEC Healthy Aging Program, for the funding opportunity, "Empowering Older Adults and Adults with Disabilities through Chronic Disease Self-Management Education Programs," with the U.S. Administration on Aging (AoA).

Diabetes is an extremely serious health issue in South Carolina, affecting one in 10 of all adults and one in five of those 65 and older. The DHEC Diabetes and Arthritis Programs are collaborating to provide programs dedicated to preventing and reducing the effects of diabetes, arthritis and other co-morbidities and will coordinate these efforts with this AoA initiative. In the 2012-2013 CDC Diabetes continuation application, we agreed to partner with the Arthritis Program to build partnerships to expand the Stanford Chronic Disease Self-Management Program (CDSMP) to underserved geographic areas, and we have designated funding to support this objective. Arthritis is one of the most common chronic conditions affecting 55% of older adults, more than half of whom have diabetes. Self-management interventions are important prevention strategies to address these conditions, as well as other chronic diseases.

We will integrate our current activities with this initiative to provide a coordinated approach at the state level. Additionally, during the second year, when the Diabetes Self-Management Program (DSMP) is introduced, we will help identify additional partners to provide DSMP, including working together to identify one or more health systems that could potentially bill Medicare for Diabetes Self-Management Training (DSMT). The Stanford DSMP offers great potential for billing as it should be lower cost for organizations to implement, and it has been proven to produce good outcomes. As we work together on DSMP, we will also continue to support and promote CDSMP, since there are so many older adults who have more than one chronic health condition.

We are enthusiastic about this opportunity to work with the Lt. Governor's Office and the DHEC Healthy Aging and Arthritis Programs to make the chronic disease self-management education program more accessible to people with diabetes and other chronic health conditions, and to improve health status and quality of life for South Carolinians. We look forward to working together in the coming year, and we will commit the necessary resources to achieve the goals that we have mutually established.

Sincerely,



Rhonda L. Hill, PhD, MCHES
Director
DHEC Diabetes Prevention and Control Program

Trident Area Agency on Aging

Assistance, Advocacy, Answers on Aging

June 5, 2012

Denise W. Rivers, LMSW, CIRS
Deputy Director of Aging Services
Lt. Governor's Office on Aging
1301 Gervais Street, Suite 350
Columbia, SC 29201

Dear Ms. Rivers and Ms. Plass:

On behalf of the Trident Area Agency on Aging/Aging Disability and Resource Center, I am pleased to write this letter of support for your application for the Administration on Aging (AoA) application, *"Empowering Older Adults and Adults with Disabilities through Chronic Disease Self-Management Education Programs."*

I understand that the aim of this effort is to expand availability of chronic disease self-management education (CDSME) programs and to help ensure that they are embedded in health and long-term services systems. This application will provide an opportunity to continue to expand the program distribution and delivery systems, developed under the previous AoA Evidence-Based Disease and Disability Prevention Program and Recovery Act CDSMP grants.

Trident Region Area Agency on Aging (AAA) will assist in the grant-related activities and act as a liaison between the state office and region for fiscal matters. The Region Project Lead will be Ms. Carlon Mitchell, R.N., who has served as DHEC Arthritis Program Region Coordinator for the Public Health Regions 7 and 8. Her coverage area includes the AAA three-county area of Charleston, Berkeley and Dorchester. Ms. Mitchell is a CDSMP Master Trainer and has extensive experience providing Leader Trainings and workshops, as well as building partnerships in the coastal area. Ms. Mitchell and I have worked together on previous grants and are looking forward to this opportunity to build more capacity for CDSME programs in our area of the state. Ms. Mitchell has excellent working relationships with the services providers and with other community, health, and faith-based partners in the Trident area, so she is a natural fit for this role.

We are committed to coordinating CDSME program activities with our Aging Disability and Resource Center (ADRC). We will work together to assure a seamless approach in our region, with "no wrong door" to enter CDSME and other evidence-based prevention programs. We will assure that all ADRC employees and volunteers are knowledgeable about the CDSME programs and take opportunities to connect older and disabled adults to local workshops.

We will work diligently to build partnerships and offer workshops at a variety of sites to reach older and disabled adults, especially those who are disproportionately affected by chronic diseases. Partnership endeavors will include local churches, community centers senior centers, residential and assisted living communities. These partners may call upon coordination support from the Aging and Health Department Region Teams. We also look forward to working with the Federally Qualified Health Care Centers and

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Community Long Term Care (Medicaid Waiver Program). This opportunity will allow us to strengthen these relationships for a coordinated and systematic approach in our region.

Ms. Mitchell and local partners will continue to provide data to meet the grant requirements and assure that we have quality programs. We will continue to emphasize fidelity and provide local support to our program lay leaders to build their self-confidence and facilitation skills.

On behalf of the Trident Area Agency on Aging, we are grateful to have this opportunity. We appreciate the opportunity to make CDSME programs accessible throughout our region, so that our older and disabled adults have quality programs to improve their quality of life.

Sincerely,

Stephanie M. Blunt

Stephanie M. Blunt
Executive Director

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UPPER SAVANNAH

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June 4, 2012

Denise W. Rivers, LMSW, CIRS
Deputy Director
Lt. Governor's Office on Aging
1301 Gervais Street, Suite 350
Columbia, SC 29201

Dear Ms. Rivers:

We are pleased to join in partnership with the Lt. Governor's Office on Aging and the SC Department of Health and Environmental Control's (DHEC) Healthy Aging Program and support your application, *Empowering Older Adults and Adults with Disabilities through Chronic Disease Self-Management Education Programs,* funded by the U. S. Administration on Aging.

We find the goals of your application, especially to significantly increase the number of older and/or adults with disabilities that have chronic conditions who complete evidence-based CDSME programs, fit well with our mission. We plan to start with the Chronic Disease Self-Management Program and then cross train leaders to offer the Arthritis Self-Management Program and the Diabetes Self-Management Program. The Stanford programs fit well with our agency's commitment to fostering client empowerment and encouraging self-management of their conditions. With your support, we are confident that we can leverage resources in this area to create an integrated, sustainable service system to improve the quality of life of older adults and adults with disabilities.

The AAA will take the lead to find partners to assist with this project. Our plan is to train staff and volunteers from our region, gradually spreading CDSMP to all counties and expanding to include the Arthritis and Diabetes Self-Management Programs. We will work with local aging providers, health departments and, faith-based, support and advocacy organizations to recruit Leaders to attend the 4-day Leader Training.

This project will be coordinated with service providers in our area, and within our ADRC. We will work together to provide an integrated approach so that older adults and adults with disabilities in the Upper Savannah region can easily access and enroll in the programs in their communities.

Once the original Leaders offer courses, we plan to train others to expand the program and reach more people. From the Leader pool, we will identify individuals to become Trainers, which will provide a sustainable program, embedded in within the aging network.

Our thanks again for this exciting opportunity to join in partnership to deliver health programs that can make a genuine difference in the lives of our seniors and adults with disabilities.

Sincerely,

Vanessa Wideman
Aging Unit Director

UNIVERSITY OF SOUTH CAROLINA

June 6, 2012

DEPARTMENT OF FAMILY AND
PREVENTIVE MEDICINE
SCHOOL OF MEDICINE

Denise Rivers
Deputy Director of Aging Services
Lt. Governor's Office on Aging
1301 Gervais Street, Suite 350
Columbia, SC 29201

Dear Ms. Rivers and Ms. Plass:

As Associate Professor with the University of South Carolina School of Medicine and medical consultant to the South Carolina Medicaid program, I am writing to express support of the S.C. Lieutenant Governor's Office on Aging's (LGOA) application, in partnership with the S.C. Department of Health and Environmental Control, "Empowering Older Adults and Adults with Disabilities through Chronic Disease Self-Management Education Programs," offered by the U.S. Administration on Aging (AOA).

As a clinician and medical consultant, I have a long-time, personal knowledge of the serious impact of chronic diseases on the people of South Carolina. Daily, I see the high cost of lost quality of life among my patients; the high cost of treatment; and the inability of my patients to pay for this care or for insurance to cover recommended medical treatment. Due to my various roles with the USC School of Medicine and the SC Department of Health and Human Services, I am in a unique position to see the continuum of care for patients and to understand the benefits of prevention approaches. I am highly committed to doing my part to reduce the impact of chronic disease, to improve patient care, and to identify funding sources within the health care system to reduce the overall health burden and cost of care in South Carolina.

One of the initiatives in which I am greatly involved is the establishment of the medical home model using patient-centered care in physician practices. Adopting the medical home concept provides incentives for consistent payment through medical reimbursement plans and better health outcomes in patients, which in turn drives health care costs down. For example, a small test run by the major insurance provider BlueCross BlueShield of South Carolina was remarkably successful. Hospital admissions for 150 patients with chronic illnesses enrolled in the program were reduced by 27%, and emergency room visits by 41% compared to the previous year. Due to that success, Blue Cross is now involving eight physician practices in the Midlands which treat 3,000 patients with chronic conditions who will receive patient-centered medical home care.

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I am very supportive of this project aims to further embed and expand chronic disease self-management educations programs, such as the Stanford Model, in South Carolina. The programs are compatible with the patient-centered medical home concept. I will assist your agencies in providing linkages with medical home practices and medical insurance plans to increase awareness of the Stanford programs and their benefits and in discussing how the programs can be incorporated into medical practices and health care systems. Some practices might want to train their own staff as leaders and others might want to serve as a referral system with potential of reimbursement for the service.

Thank you for this opportunity to work toward our mutually shared goals of reducing the burden and impact of chronic diseases in South Carolina. I look forward to meeting with you to discuss possible linkages and next steps.

Sincerely,

Tan J. Platt, M.D.
Associate Professor of Clinical Family and Preventive Medicine
Department of Family and Preventive Medicine
University of South Carolina School of Medicine

DEPARTMENT OF VETERANS AFFAIRS
Medical Center
6439 Garners Ferry Road
Columbia, South Carolina 29209

May 31, 2012

Denise W. Rivers LMSW, CIRS
Deputy Director
Lt. Governor's Office on Aging
1301 Gervais Street, Suite 350
Columbia, SC 29201

Dear Ms. Rivers and Ms. Plass:

We are pleased to join in partnership with the Lt. Governor's Office on Aging and the S.C. Department of Health and Environmental Control's (DHEC) Healthy Aging and Arthritis Program to support your application, "Empowering Older Adults and Adults with Disabilities through Chronic Disease Self-Management Education Programs."

The aims of chronic disease self-management education programs fit very well with the transformation in health care that the Veterans Administration is undergoing nationally and here in South Carolina. The Stanford programs provide a model of care consistent with our national commitment to provide a holistic and integrative approach to care. The high burden of chronic disease among veterans is a driving force behind these efforts. This partnership will help our clinicians build a therapeutic partnership with patients to empower them to make positive lifestyle changes and fully participate in their medical plan of care, so that they can live healthy and fulfilling lives.

The Stanford Chronic Disease Self-Management Program will be launched at the Dorn VA in Columbia this summer. Our plan is to train staff and volunteers from our in-patient facility and seven outpatient clinics to become Leaders for CDSMP. We are also extending an invitation the VAs in Charleston and Augusta. We will work with clinical staff, veteran's advocacy/ support organizations, and volunteer services to recruit appropriate Leaders to attend the 4-day Leader Training. The Leaders, in turn, will offer courses to veterans with chronic health conditions as an integral component of their medical plan of care. To start, we plan to train 18-20 Leaders. Once the original Leaders offer courses, we plan to train others to expand the program and reach more veterans. From the Leader pool, we will identify individuals to become Trainers, which will provide a sustainable program, embedded in our system. We believe that this project will have significant impact. Once we have built capacity for this program, we are also interested in the other self-management programs that will be available.

Our thanks again for this exciting opportunity to support your program activities and to join in partnership to deliver health programs that can make a genuine difference in our veterans' lives.

Sincerely,

Ruth W. Mustard, RN, MSN
Associate Director Patient Care/Nursing Services

Vantage POINT

Taking The Higher Ground For Mature Adults

June 4, 2012

Denise W. Rivers, LMSW, CIRS
Deputy Director, Lt. Governor's Office on Aging
1301 Gervais Street, Suite 350
Columbia, SC 29201

Dear Ms. Rivers:

We are excited to let you know that we look forward to continuing our partnership with the Lt. Governor's Office on Aging and the S.C. Department of Health and Environmental Control's (DHEC) Healthy Aging Program in support of the application titled *Empowering Older Adults and Adults with Disabilities through Chronic Disease Self-Management Education Programs,* funded by the U. S. Administration on Aging.

We understand that the goal of this effort is to help ensure that evidence-based self-management education programs are embedded into the health and long-term services systems. Based on our past work with you, we are satisfied that this effort is helping to preserve and expand prevention programs that we have developed together in past years, with support from previous grants. We are fully committed to incorporate the evidence-based efforts within the various areas of our Aging Disability and Resource Center, such as Information and Referral and Family Caregiver Support Programs. We will assure that all staff are aware of the evidence-based programs being offered in our area so that we have a seamless approach. We will also continue to support the efforts of the Aging Service Providers that have taken the lead on this effort in the Pee Dee region and will make every effort to connect with health systems, such as Care Transitions, which is being applied for in our area.

In our region of six counties, we have two region leads working across three counties each; one is Darlington County Council on Aging (CoA) and the other is Senior Citizens Association of Florence County. Our leads will continue to work with the CoA's, health departments, and other to hold Chronic Disease Self-Management Education workshops and to expand the program to all counties in the region. We will continue to monitor our active Leaders to ensure fidelity and to build partnerships to encourage additional staff and community residents to become trained as new Leaders and recommend those with the potential to become Master Trainers. We strongly believe in the value of this effort and are committed to its continued success. We are also looking forward to adding the Diabetes Self-Management Program, as we have many older adults with diabetes in our area.

We want to thank you for being given this opportunity and we are determined that, by continuing to partner with you on this effort, together we will make a positive, lasting impact on the health and well-being of older South Carolinians.

Sincerely,
Sheila Welch
Sheila Welch
Aging Unit Director, Vantage Point M.S.

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A division of CareSouth Carolina

WACCAMAW REGIONAL
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June 4, 2012

Denise W. Rivers, LMSW, CIRS
Deputy Director
Lt. Governor's Office on Aging
1301 Gervais Street, Suite 350
Columbia, SC 29201

Dear Ms. Rivers:

It is with pleasure that we write this letter of support to continue our partnership with the Lt. Governor's Office on Aging and the South Carolina Department of Health and Environmental Control's (DHEC) Healthy Aging Program for the Administration on Aging application, "Empowering Older Adults and Adults with Disabilities through Chronic Disease Self-Management Education Programs."

Due to funding under the South Carolina Recovery Act CDSMP grant, we are currently holding workshops in all three of our counties. Our rural region has a high prevalence of chronic diseases, a large African American population, and many older adults who have low income levels and less than a high school education. We are pleased to have this new opportunity to expand the number of people reached and workshops held with CDSMP, Arthritis and Diabetes Self-Management Programs.

As with the Recovery Act grant, the lead for this project will be Ms. Angela Weaver with the Georgetown County Bureau of Aging Services. Through her dedication and belief in the benefits of self-management, we have had many successes in building partnerships and offering workshops at a variety sites. These include local churches, community centers, Councils on Aging, senior centers, residential and assisted living communities, as well as non-traditional partners (i.e., local correctional institution). We are also working with the Federally Qualified Health Care Centers and Community Long Term Care and are in discussion about incorporating this program in our Care Transitions application. This opportunity will allow us to strengthen these relationships for a coordinated and systematic approach in our region.

Ms. Weaver is coordinating with our regional Aging and Disability Resource Center and we are exploring how to strengthen those ties and assure that all ADRC staff and volunteers are knowledgeable about the CDSME programs and take every opportunity to connect older adults and adults with disabilities to local workshops. Recognizing that these programs can significantly contribute to the health and wellbeing of these individuals, we will work to assure a coordinated, seamless approach in our region to enter evidence-based prevention programs.

Ms. Weaver and local partners will continue to make site visits, provide feedback and data and increase our pool of fidelity monitors to assure that we have quality programs. We will also continue to provide local support to our leaders to help them feel confident in their ability and their skill level.

We are grateful for this opportunity will provide full support throughout the grant to make these quality programs accessible to older adults and adults with disabilities throughout our region so that they can live healthier and longer lives in their own communities.

Sincerely,

Kimberly Harmon

Kimberly Harmon
Aging Unit Director

ACRONYMS

Administration on Aging	AoA
Aging Disability and Resource Center	ADRC
American Recovery and Reinvestment Act	ARRA
Area Agency on Aging	AAA
Arthritis Self-Management Program	ASMP
Center for Health Services Policy and Research	CHSPR
Centers for Disease Control and Prevention	CDC
Chronic Disease Self-Management Education	CDSME
Chronic Disease Self-Management Program	CDSMP
Community Long-Term Care	CLTC
County Councils on Aging	COAs
Department of Health and Human Services	DHHS
Diabetes Self-Management Program	DSMP
Diabetes Self-Management Training	DSMT
Dorn Veterans Administration Medical Center	Dorn VA
Evidence-Based Prevention Programs	EBPPs
Federally Qualified Health Centers	FQHCs
Healthy Aging Policy Task Force	HAPPI
Helping Our Precious Elderly	H.O.P.E
Lt. Governor's Office on Aging	LGOA
Managed Care	MC

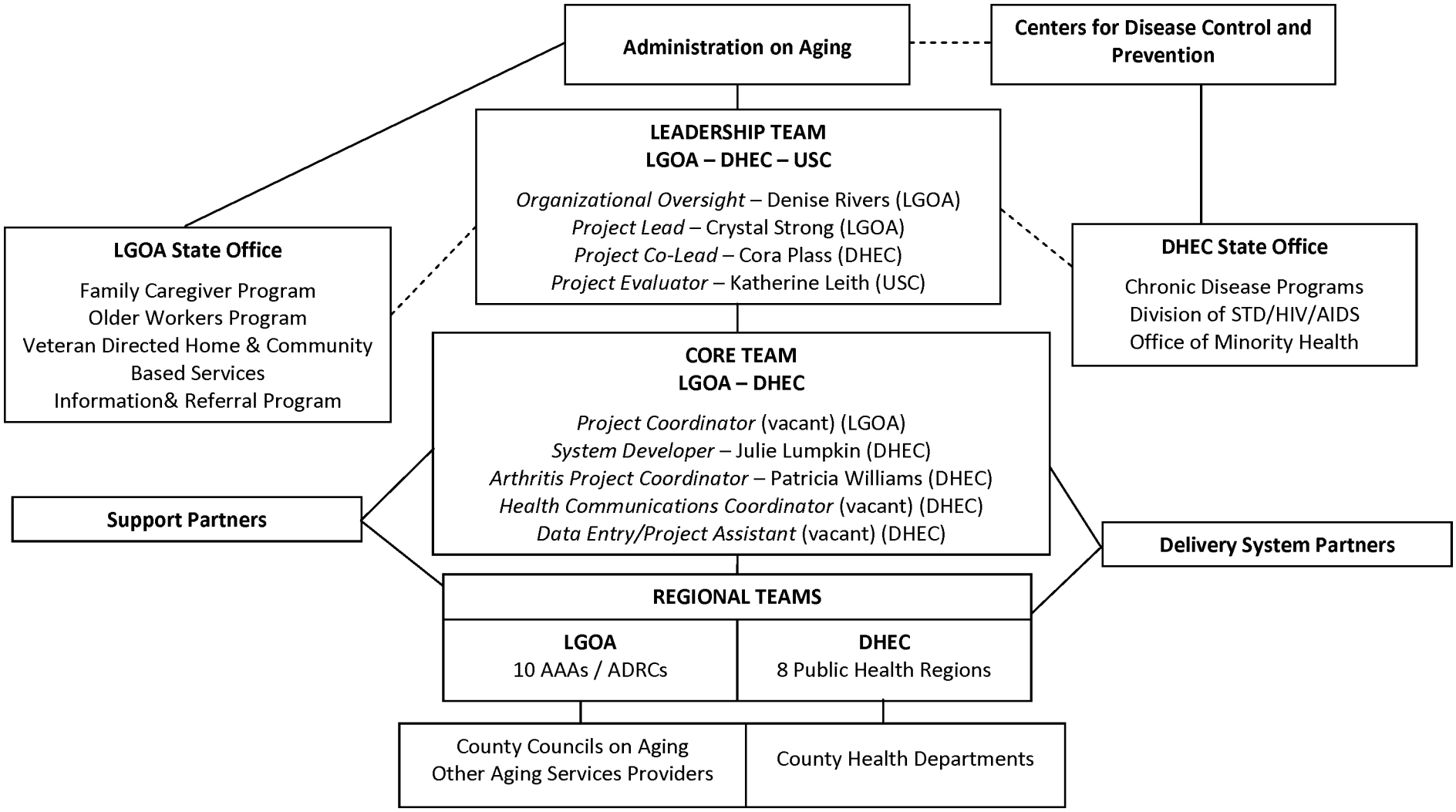
Medicaid Managed Care Organizations	MMCO
Memorandum of Agreement	MOA
National Association of Chronic Disease Directors	NACDD
SC Department of Alcohol and Other Drug Abuse Services	DAODAS
SC Faith community Nurses Association	SCFCNA
South Carolina Department of Health and Environmental Control	DHEC
South Carolina Department of Mental Health	DMH
South Carolina Partnership for Healthy Aging	SCPHA
State Public Health Department	SPHD
State Unit on Aging	SUA
University of South Carolina	USC

EVIDENCE-BASED PREVENTION PROGRAM GRANT AWARDS

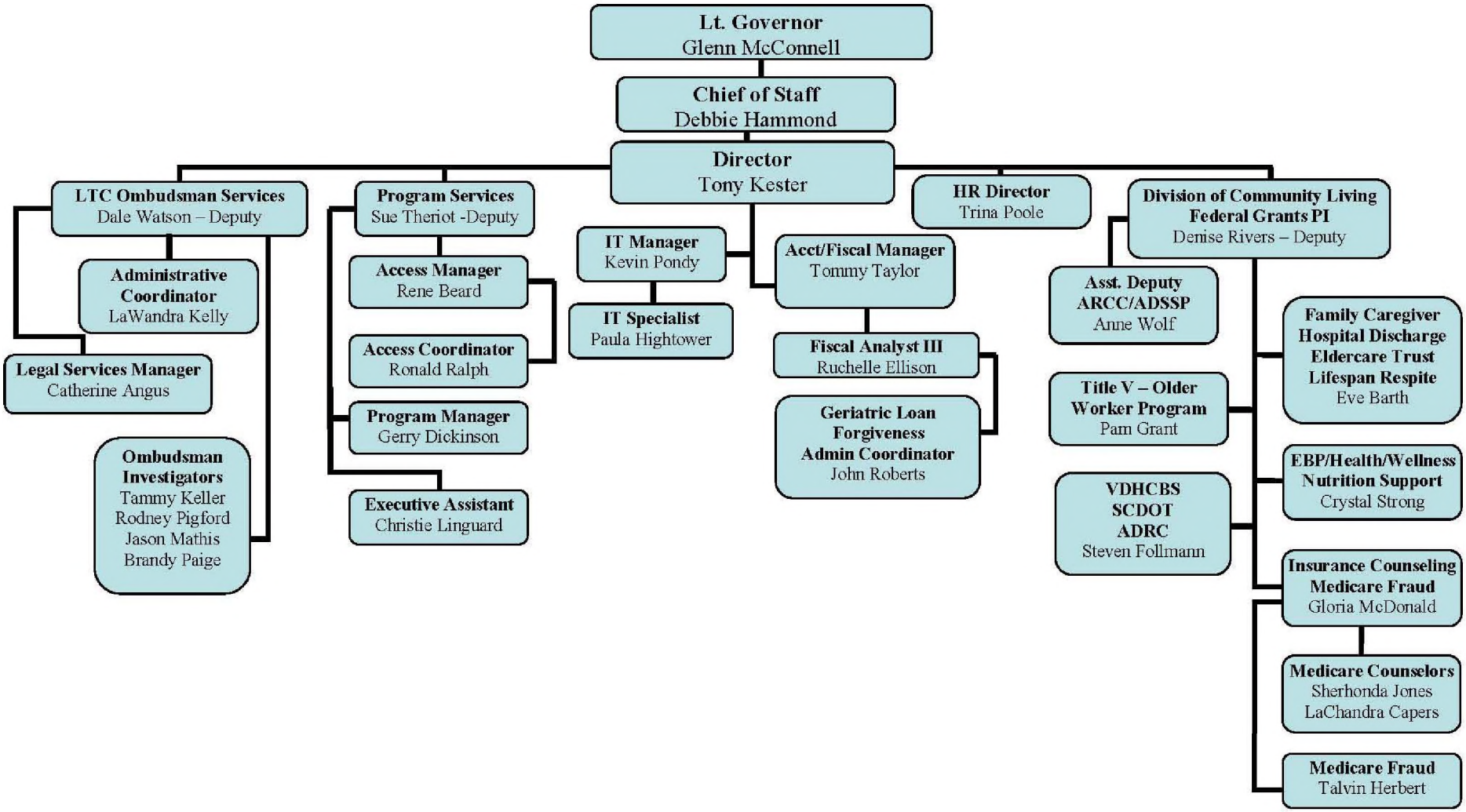
Grant Title or Project	Sponsors	Timeframes	Description
State-based Examples of Network Innovation, Opportunity and Replication (SENIOR) Grant	NACDD with support of CDC	January 2005-December 2005	Expanded the People with Arthritis Can Exercise (PACE) program in rural areas of SC.
Evidence-Based Disability and Disease Prevention for Elders: Translating Research into Community Programs Workshop	Agency for Healthcare Quality and Research (AHRQ)	February 2006	Received a scholarship to send state representatives to a national conference on evidence-based programs.
Evidence-Based Learning Network	AHRQ, AoA, and CDC	June 2006	One of six states awarded a scholarship to participate in a year-long learning network.
State-based Examples of Network Innovation, Opportunity and Replication (SENIOR) Grant	NACDD with support of CDC	July 2006-June 2007	Provided an opportunity for the state team to begin implementing EBIs.
Empowering Older People to Take More Control of their Health through Evidence-Based Programs	AoA	October 2006-July 2009	Delivered EBPPs to older adults through the AAAs in 3 areas of the state.
AoA EBPP Supplemental Grant for Empowering Older People to Take More Control of their Health through Evidence-Based Programs	AoA	Aug 2009-July 2010	Continuation of the original grant for another year, with a focus on recruitment and retention of leaders.
Centers for Disease Control and Prevention (CDC), State Public Health Approaches to Arthritis	CDC	June 2009-June 2012	Exponential expansion of EBBPs for adults with arthritis
Opportunity Grants for Healthy Aging	NACDD	August 2009-Jan 2011	Developed a policy platform and advocacy toolkit for expanding physical activity and chronic disease self-management EBPPs for older adults.
AoA Supplemental Grant Empowering Older People to Take More Control of their Health through Evidence-Based Programs	AoA	June 2010 - May 2011	Expansion of CDC.
American Recovery and Reinvestment Act Communities Putting Prevention to Work	AoA, in collaboration with CDC	March 2010 - March 2012	Expansion of CDSMP in original 3 regions of the state; implementation of CDSMP in 3 new regions; implementation of ASMP.

Attachment H

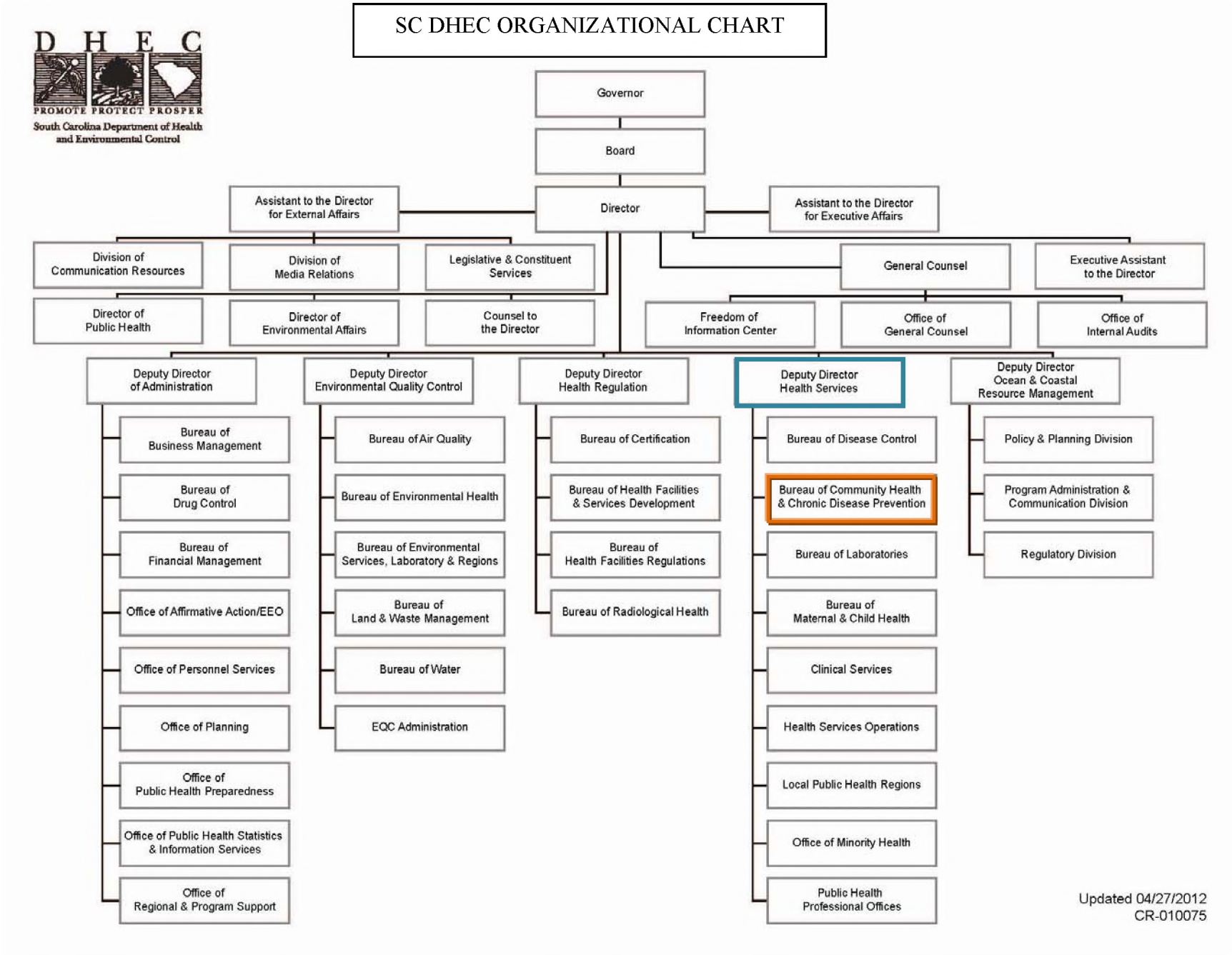
Chronic Disease Self-Management Education Programs
Project Organization Chart



Lieutenant Governor's Office on Aging

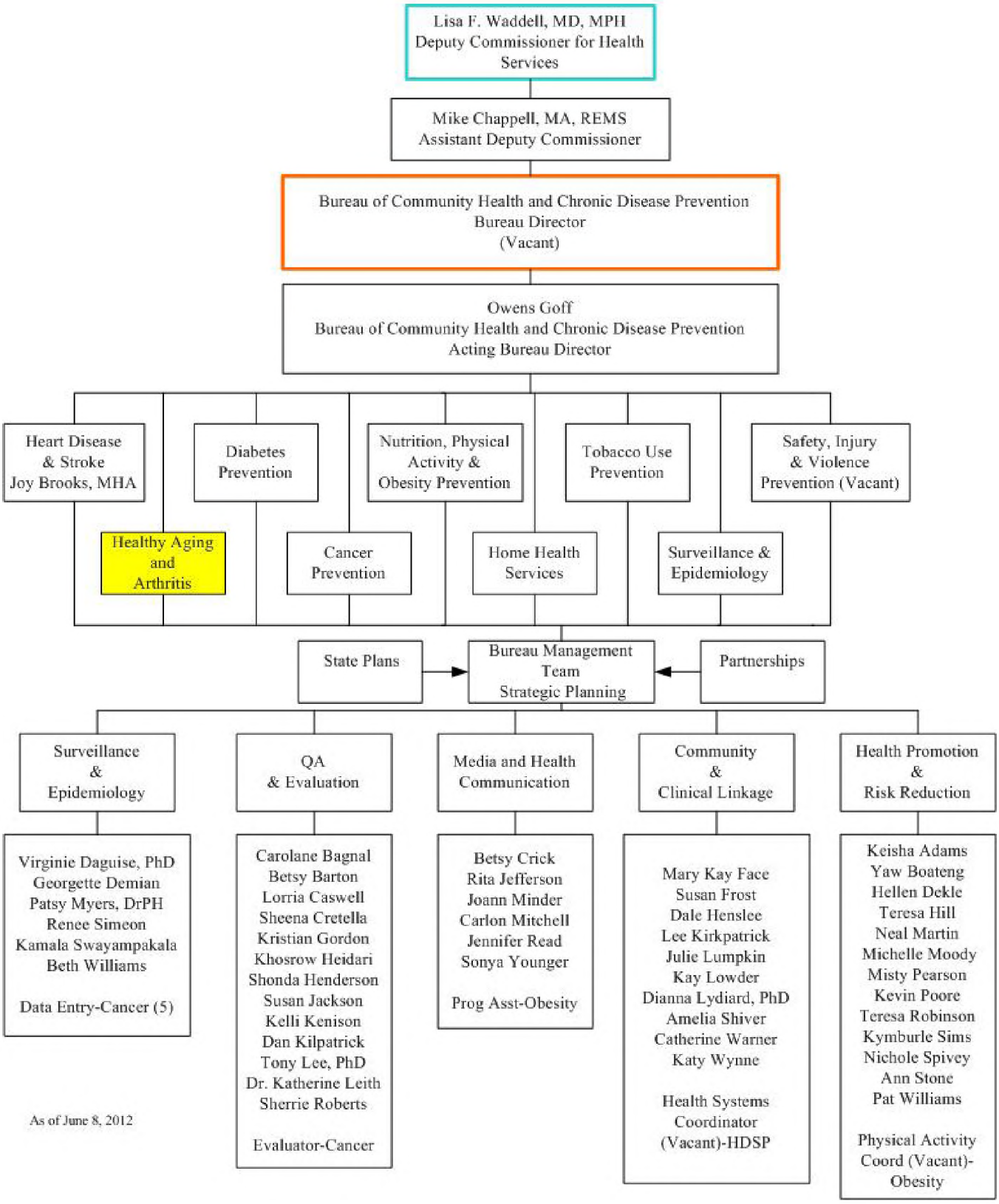


Attachment H



Attachment H

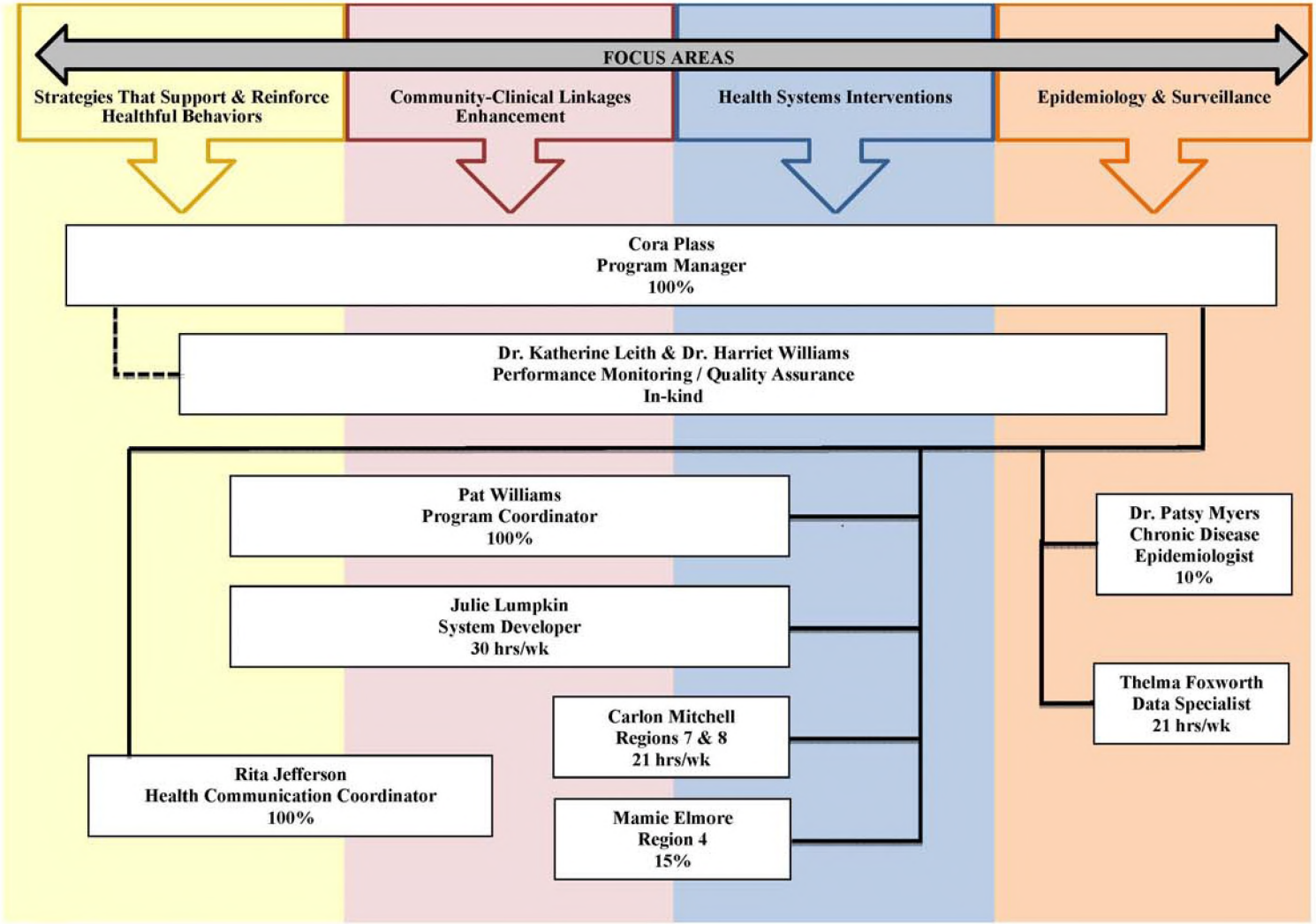
SC DHEC
BUREAU OF COMMUNITY HEALTH & CHRONIC DISEASE PREVENTION
Functional Organizational Chart



As of June 8, 2012

Attachment H

SC DHEC Healthy Aging and Arthritis Programs



D H E C

PROMOTE PROTECT PROSPER

June 4, 2012

Denise W. Rivers
Deputy Director of Aging Services
Lt. Governor's Office on Aging
1301 Gervais Street, Suite 200
Columbia, SC 29201

Dear Denise and Crystal:

As Director of the Healthy Aging Program of the S.C. Department of Health and Environmental Control (DHEC), I am pleased to submit this letter of commitment to work alongside the Lt. Governor's Office on Aging to apply for and co-lead the U.S. Administration on Aging (AoA), "Empowering Older Adults and Adults with Disabilities through Chronic Disease Self-Management Education Programs" initiative. This is a welcome opportunity to strengthen our longstanding partnership and to continue to provide joint leadership for expanding chronic disease self-management education (CDSME) programs.

Chronic diseases are one of the most common and serious public health problems facing our nation. Most older adults in South Carolina have one or more chronic diseases, which can cause loss of independence, disability, and untimely death. Fortunately, prevention efforts, such as the Stanford CDSME programs, can reduce the impact of these diseases and improve the quality of life of older adults. While great strides have been made to build an infrastructure for the Chronic Disease Self-Management Program (CDSMP) and more recently the Arthritis Self-Management Program (ASMP), continued funding is needed to fully integrate the programs with health care systems, such as the Dorn Veterans Administration, Care Transitions, Medical Homes, Medicaid and Medicare managed care organizations, Federally Qualified Health Care Centers, and other entities. Our partnerships with these health care systems are at various stages, and we are pleased with our progress. This funding will allow us the opportunity to continue to develop and strengthen existing partnerships and add new ones to fully embed and sustain CDSME programs in organizational operations. Our ultimate goals are to improve the quality of life of older and disabled adults and to provide access to all, regardless of race, ethnicity, or residence; programs need to be available in every community in South Carolina in locations that are accessible and culturally appropriate to the population served.

As the project co-lead with LGOA, I will work alongside you to provide leadership and oversight throughout all phases of the project. I will supervise DHEC project staff, and work collaboratively with internal and external partners to achieve the project goals and objectives. As Program Manager for the Arthritis Program, I will assure an integrative approach with Arthritis to build a sustainable, statewide infrastructure for evidence-based prevention interventions, including chronic disease self-management education programs. Our Arthritis program staff will work in full cooperation with this initiative to expand CDSMP and ASMP. I will also facilitate relationships with other chronic disease programs, such as Diabetes, Heart and Stroke, Tobacco, and Cancer and the STD/HIV/AIDS Division to expand CDSMP. In year two, our Diabetes Program will help develop partnerships for DSMP and work with us to explore the feasibility Medicare reimbursement. I will assure that our state chronic disease plan includes information about healthy aging and CDSME programs.

DHEC is also committed to continue to work in collaboration with LGOA to develop new partnerships to substantially expand the reach of the CDSME programs. In particular, we are pleased to have worked together to secure new partnerships with the Dorn Veterans Hospital, the SC Department of Alcohol and Other Drug Abuse Services, and the Catawba Indian Tribe. We are in discussion with other organizations that hold promise and are excited about transforming our culture in South Carolina to one that values and utilizes prevention approaches.

Our history of collaboration has proven that by combining our expertise, experience, knowledge, and resources, we can accomplish much more than we can alone. In addition our partners who implement the programs, we are proud to have developed a statewide base of support through the South Carolina Partnership for Healthy Aging coalition formed in 2007 and the Healthy Aging Policy Platform Initiative (HAPPI) Task Force formed in 2009 to establish policies that support expansion of evidence-based chronic disease self-management and physical activity programs.

Once again, we appreciate the opportunity to work with you to build on the many outreach efforts and successes that we have achieved to provide for lasting change toward a healthy South Carolina.

Sincerely,

Cora Plass, LISW, ACSW
Director of Healthy Aging
Arthritis Program Manager

UNIVERSITY OF SOUTH CAROLINA

CENTER FOR HEALTH SERVICES AND POLICY RESEARCH
ARNOLD SCHOOL OF PUBLIC HEALTH

June 8, 2012

Denise W. Rivers, LMSW, CIRS
Deputy Director
Lt. Governor's Office on Aging
1301 Gervais Street, Suite 350
Columbia, SC 29201

Dear Denise:

I am pleased to support your proposal entitled **Empowering Older Adults and Adults with Disabilities Through Chronic Disease Self-Management Education Programs.** I fully endorse the project as an important step toward furthering both the science and the research base of evidence-based programming.

As you know, I am member of the Prevention Research Center Healthy Aging Research Network, and as such, I have been involved in evidence-based research from both the research and practice perspectives. I am also the lead of South Carolina's Administration on Aging (AoA) initiative for evidence-based programs. I am proud to work in full cooperation with LGOA and DHEC as a member of the state team to provide leadership for planning, implementing, evaluating, and expanding chronic disease self-management education programs to improve the health status of older adults in South Carolina.

I will continue to provide evaluation oversight and performance monitoring to track attendance data, participant demographic information, participant satisfaction, and progress toward outcomes for the chronic disease self-management education workshops. The evaluation design also includes an assessment of fidelity, in recognition of the importance of delivering evidence-based interventions as originally designed to ensure their effectiveness.

As we continue to integrate the various ongoing efforts toward embedding and sustaining chronic disease self-management education programs more systemically across the state, I will continue to share all findings with LGOA and DHEC and provide updates and other related information from the AoA project and from ongoing HAN efforts to the state team. I also agree to participate actively in other, related activities that support this project, including serving on the DHEC performance monitoring team and representing healthy aging on the bureau functional team for quality assurance/improvement and evaluation.

I wholeheartedly support your efforts and wish you success in your proposal. I look forward to working with you in the future.

Sincerely,

Katherine H. Leith, Ph.D., LMSW
Center for Health Services and Policy Research

D H E C

PROMOTE PROTECT PROSPER

June 3, 2012

Denise W. Rivers
Deputy Director of Aging Services
Lt. Governor's Office on Aging
1301 Gervais Street, Suite 200
Columbia, SC 29201

Dear Ms. Rivers:

I am pleased to write this letter in support on behalf of Public Health Services and the eight Public Health regions for your application to the U.S. Administration on Aging (AoA), Empowering Older Adults and Adults with Disabilities through Chronic Disease Self-Management Education Programs. This funding opportunity will allow the SC Department of Environmental Health and Control to continue our longstanding partnership with the Lt. Governor's Office on Aging (LGOA) to build a statewide sustainable infrastructure for chronic disease self-management programs to improve the health of South Carolinians.

In South Carolina, chronic diseases make up seven of the top ten leading causes of death. Because South Carolina is a rural state with limited resources, many people lack access to prevention programs, such as the Chronic Disease Self-Management Program (CDSMP) proven to be effective in managing chronic conditions. Since 2005, the DHEC Healthy Aging and Arthritis Programs have worked with the LGOA to build partnerships to provide a distribution system for CDSME programs. We are proud of the gains that have been made during this time to reduce the impact of chronic diseases in our state and to provide access to rural, vulnerable, and minority populations.

As the Assistant Deputy Commissioner for Public Health Services, I oversee all eight Public Health Regions in South Carolina, which cover 46 counties. Each region is comprised of County Health Departments staffed with health professionals, such as nurses, health educators, and social workers.
Long experienced in working with faith-based and community partners, region staff have expertise and resources to support the goals of the self-management program grant and to reach diverse populations by integrating this opportunity with other chronic disease activities.

Under the new Coordinated Chronic Disease Prevention and Public Health program, central office and region staff are developing new approaches to integrating self-management interventions into existing chronic disease prevention efforts. Using our ongoing collaboration with the Lt. Governor's Office on Aging, our Public Health Regions will continue to provide regional coordination to add new partners to deliver CDSMP through this funding. Under the previous AoA and ARRA funding, Regions 2, 4, 5, 6, 7 and 8 have been the designated regions for CDSMP delivery and expansion. Through this opportunity, these and our other regions will

offer support by providing Trainers, promoting local programs, building local partnerships, and working in teams with state Aging Network partners.

In closing, I offer support on behalf of our Central Office and the eight Public Health Regions. The Region partners are committed to playing an instrumental role in achieving the goals of this grant.

Sincerely,

Michael Chappell, MA, REHS
Assistant Deputy Commissioner
Public Health Services

D H E C

PROMOTE PROTECT PROSPER

Catherine B. Templeton, Director

Promoting and protecting the health of the public and the environment

May 31, 2012

Denise W. Rivers, LMSW, CIRS
Deputy Director
Lt. Governor's Office on Aging
1301 Gervais Street, Suite 350
Columbia, SC 29201

Dear Ms. Rivers:

On behalf of the Bureau of Community Health and Chronic Disease Prevention (BCHCDP) at the South Carolina Department of Health and Environmental Control, we are committed to working in full support with you as we jointly apply for the U.S. Administration on Aging (AoA) initiative, "Empowering Older Adults and Adults with Disabilities through Chronic Disease Self-Management Education Programs."

The DHEC Healthy Aging Program resides in the BCHCDP. Ms. Plass, who is the Director of Healthy Aging, will continue to work with you and Ms. Strong as the co-lead. She has worked very hard to integrate the Stanford model with chronic disease programs to improve quality of life for older and disabled adults who have one or more chronic health conditions. We are more than happy to have this opportunity to work with you again to further expand chronic disease self-management education programs in South Carolina programs and embed them in health care systems and other organizations. This application is critical to enabling our state to continue this all-important work.

Internally, the DHEC Healthy Aging Program has successfully facilitated the coordination of shared activities across chronic disease programs in the BCHCDP to reduce the burden and impact of chronic diseases. This is exemplified in the specific goals and activities that are included in the categorical program work plans, including the Diabetes, Cancer, Obesity (Eat Smart, Move More Coalition), Tobacco (Tobacco Quitline), and Heart Disease/ Stroke Prevention and Control Programs.

The Coordinated Chronic Disease Grant Program (CCDP) funded by the Centers for Disease Control to help states provide an integrated public health approach to address chronic diseases provides a new opportunity to create an organizational structure that fosters collaboration and efficient use of resources across program lines. The Chronic Disease Self-Management Program, in particular, is important to this integrated approach, since it addresses chronic diseases broadly, such as arthritis, diabetes, hypertension, and heart disease. We also support the Stanford disease specific programs, such as the Arthritis Self-Management Program, which fits with our Arthritis Program goals; and we are looking forward to working with you to build capacity for the Diabetes Self-Management Program in the second year of the grant, since South Carolina has a high prevalence of diabetes. Our state has a large African American population that is disproportionately affected by chronic diseases, and having these programs available, especially in rural areas will help us to eliminate disparities and achieve health equity, with quality prevention programs accessible statewide to improve quality of life of older adults and disabled persons.

In South Carolina, state government and health care systems are undergoing transformation. These changes provide challenges, yet also great opportunities to make connections that will lead to long-term partnerships and enduring change. We are proud to be in a leadership role to bring attention to the importance of prevention and to assure that chronic disease self-management education is an important element of prevention efforts here in South Carolina.

Sincerely,

L. Owens Goff, Jr., Acting Director
Bureau of Community Health and Chronic Disease Prevention
DHEC - Health Services

D H E C
PROMOTE PROTECT PROSPER
Catherine B. Templeton, Director
Promoting and protecting the health of the public and the environment

June 1, 2012

Denise W. Rivers
Deputy Director of Aging Services
Lt. Governor's Office on Aging
1301 Gervais Street, Suite 200
Columbia, SC 29201

Dear Ms. Rivers:

As Director of the STD/HIV/AIDS Division of the S.C. Department of Health and Environmental Control (DHEC), I am pleased to submit this letter in support of the Lieutenant Governor's Office on Aging's application to the U.S. Administration on Aging (AoA), "Empowering Older Adults and Adults with Disabilities through Chronic Disease Self-Management Education Programs." Among my staff, Tony Price, HIV Prevention Program Manager, and Noreen O'Donnell, Ryan White and HOPWA Program Manager, are fully in support of engaging our partners to provide the Chronic Disease Self-Management Program (CDSMP) to HIV client populations.

CDC and DHEC epidemiologists are reporting a rising number of midlife persons with HIV in South Carolina, now experiencing older adult health issues, in addition to their main condition. **In 2010 the mean age of living cases was 44, compared to age 39 in 2000, and age 33 in 1990. As the population ages, we anticipate seeing more cases of arthritis and other chronic diseases in HIV clinics.** We see much potential in using CDSMP to relieve aging health issues among persons with HIV, while providing them an effective next-step intervention.

We are currently planning a joint CDSMP Leader Training for August 2012 for DHEC Social Workers and counselors from the Department of Alcohol and Drug Abuse Services (DAODAS). About 20 total are expected to attend. This is an excellent linkage with other CDSMP outreach DAODAS is discussing with your office and DHEC. Other shared activities are:

- Facilitating Ryan White and Prevention partners as delivery partners
- Publicizing/ promoting the availability of CDSMP leader trainings and workshops to Prevention and Ryan White Partners by available in-person and electronic means
- Recruiting partners to refer clients to CDSMP workshops

I believe this partnership holds great promise for PWHIV who have emerging health needs. We wholeheartedly support the Lt. Governor's Office on Aging's application for funding as we jointly seek ways to empower them to build self-efficacy in their personal health management.

Sincerely,

Janet Tapp

Janet W. Tapp, MPH
Director, DHEC Division of STD/HIV/AIDS

healthy
COLUMBIA

June 6, 2012

Denise W. Rivers
Deputy Director of Aging Services
S. C. Lieutenant Governor's Office on Aging
1301 Gervais Street, Suite 200
Columbia, SC 29201

Dear Ms. Rivers and Ms. Plass:

As Campaign Director for Healthy Columbia, I am pleased to write in support of the Lt. Governor's Office on Aging and the S. C. Department of Health and Environmental Control's (DHEC) joint Administration on Aging (AoA) application, "Empowering Older Adults and Adults with Disabilities through Chronic Disease Self-Management Education Programs." We endorse the program goals of expanding self-management interventions, promoting health equity, and reaching out to diverse populations.

After engaging the 29203 community in determining health needs, Healthy Columbia is focused on equipping people with the skills, tools, and support to make long-lasting, sustained individual and community health behavior change. A partnership with your agencies on the state level and in the Midlands area will enable us to expand the resources available to the 29203 residents. Zip code 29203 covers a large geographic area out North Main Street, much including the 45,000 residents of the resurgent Eau Claire Community. Neighborhoods fall within and outside the City of Columbia boundaries.

When studied by measures of income, crime rates, health status, and health access, 29203 is one of the worst areas to live in the nation, statistically speaking. Healthy Columbia identified particular health hot spots of high rates of chronic disease, emergency room use, limited health care access, and the medically uninsured. Using a community organizing model, Healthy Columbia's goals are to improve health outcomes, reduce costs, and increase access to care. Public schools, over 50 churches, community centers, small businesses, and influential neighborhood associations provide excellent infrastructure to support these goals.

We believe the AoA funding opportunity to expand evidence-based, self-management programs holds promise of a proven means of better health to the 29203 residents. In partnership with your agencies, we agree to discuss and develop an implementation plan for self-management programs by late July. Involving our neighborhood and community leaders, we will work with you to develop a roll-out plan, with an aim to set participant workshops by Fall 2012.

We are excited about the great potential this partnership offers, as we see many possibilities for building self-efficacy and teaching ways to make lasting health change.

Sincerely yours,

Terri Jowers, Campaign Director
Healthy Columbia
1301 Taylor Street Suite 10A
Columbia, South Carolina 29203

State of South Carolina
Office of the Governor

NIKKI R. HALEY
GOVERNOR

1205 PENDLETON STREET
COLUMBIA 29201

June 6, 2012

Ms. Michele Boutaugh
U.S. Department of Health and Human Services
Administration on Aging
Washington, DC 20201

Dear Ms. Boutaugh,

I am writing to endorse the application of the South Carolina Lieutenant Governor's Office on Aging (LGOA), in partnership with the South Carolina Department of Health and Environmental Control (DHEC), for "Empowering Older Adults and Adults with Disabilities through Chronic Disease Self-Management Education Programs" through the U.S. Department of Health and Human Services, Administration on Aging (AoA).

Since 2006, the LGOA and DHEC have collaborated on and received funding for several grants to expand evidence-based chronic disease prevention programs from AoA and the Centers for Disease Control and Prevention (CDC). Our state has some of the highest rates of chronic disease in the nation, and older adults are disproportionately affected. These low-cost effective programs are necessary to help older adults and persons with disabilities remain in their own homes in community settings and to prevent hospitalizations and nursing home placement.

Through the leadership of the LGOA and DHEC, chronic disease self-management education workshops have been offered in all areas of the state, and the Stanford Chronic Disease Self-Management Program has grown significantly. Our goal is to continue CDSMP and offer additional programs, such as Diabetes Self-Management and Arthritis Self-Management, on a regular basis, in every county, so that they are accessible to adults everywhere who need them.

To continue the significant progress that has been made by the LGOA and DHEC and their partners, additional funding is needed. The two agencies are committed to continue working together in a leadership role to substantially expand and embed evidence-based education programs throughout the aging network. They have developed a statewide system of partners, and this opportunity will provide resources to strengthen those partnerships and develop new ones for a greater impact.

This funding opportunity will help our state "take the programs to the next level," making them widely accessible statewide and increasing the use of programs through centralized promotional activities. Aging and Disability Resource Centers (ADRCs) will provide regional linkages to workshops, assisting with outreach to targeted seniors and adults with disabilities and providing support for local provider efforts. Health services systems, such as the South Carolina Primary Health Care Association and the state's Medicaid office, will serve as referral networks to facilitate individuals enrolling in workshops in their areas.

I am fully in support of continued collaboration between the LGOA and DHEC and applaud their efforts to continue to provide evidence-based, prevention-focused programming in South Carolina.

My very best,

Nikki R. Haley

NRH/es

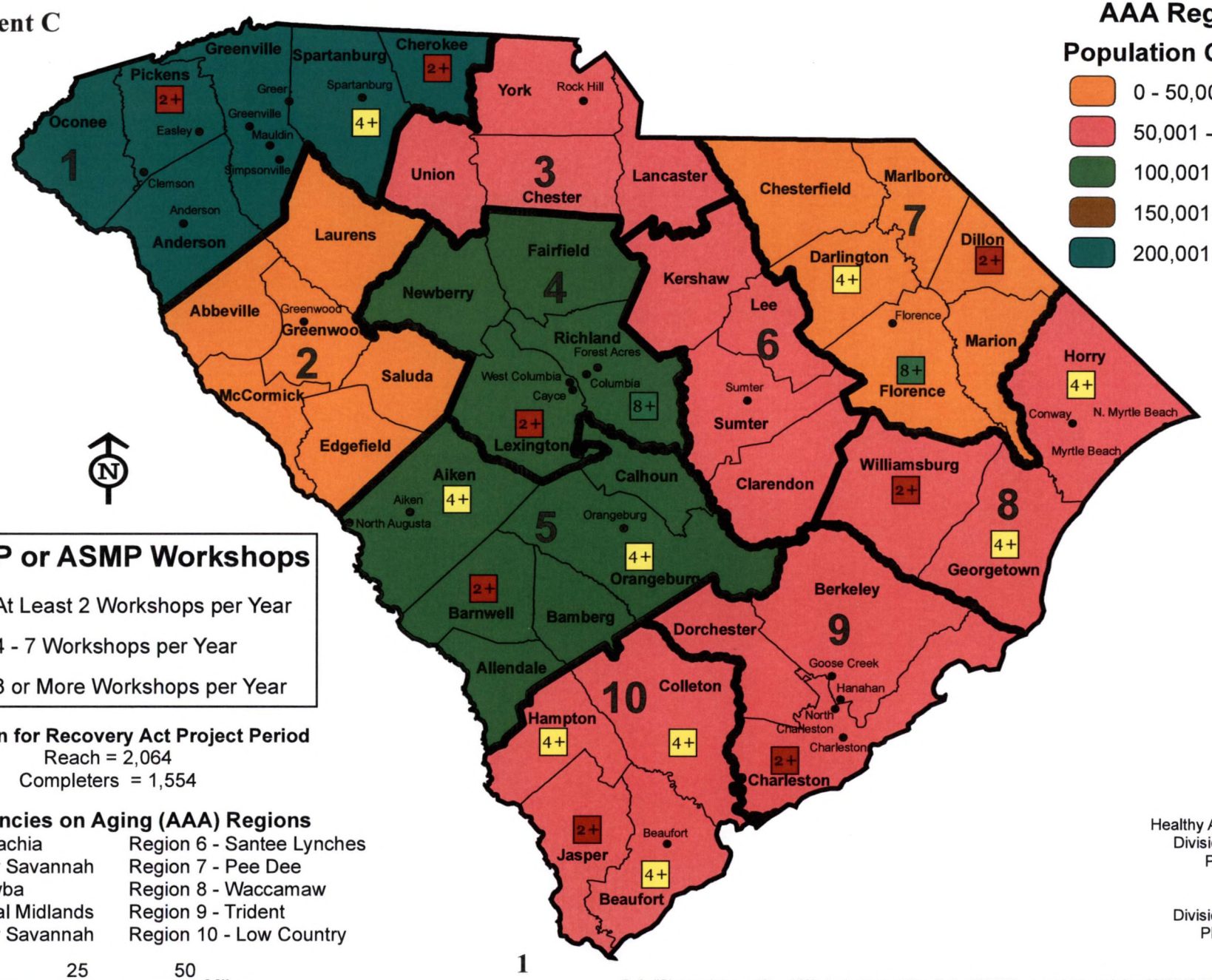
D H E C

PROMOTE PROTECT PROSPER

South Carolina Department of Health and Environmental Control

Project Map for CDSMP and ASMP in South Carolina
Workshops Offered on a Regular Basis
March 31, 2010 - March 30, 2012

Attachment C



CDSMP or ASMP Workshops

- 2+ At Least 2 Workshops per Year
- 4+ 4 - 7 Workshops per Year
- 8+ 8 or More Workshops per Year

Population for Recovery Act Project Period
Reach = 2,064
Completers = 1,554

Area Agencies on Aging (AAA) Regions

Region 1 - Appalachia
Region 2 - Upper Savannah
Region 3 - Catawba
Region 4 - Central Midlands
Region 5 - Lower Savannah
Region 6 - Santee Lynches
Region 7 - Pee Dee
Region 8 - Waccamaw
Region 9 - Trident
Region 10 - Low Country

0 25 50 Miles

Data Source:
Healthy Aging, SC DHEC;
Division of Informatics,
PHSIS, SC DHEC

Map Source:
Division of Informatics,
PHSIS, SC DHEC,
June 2012 (JFA)

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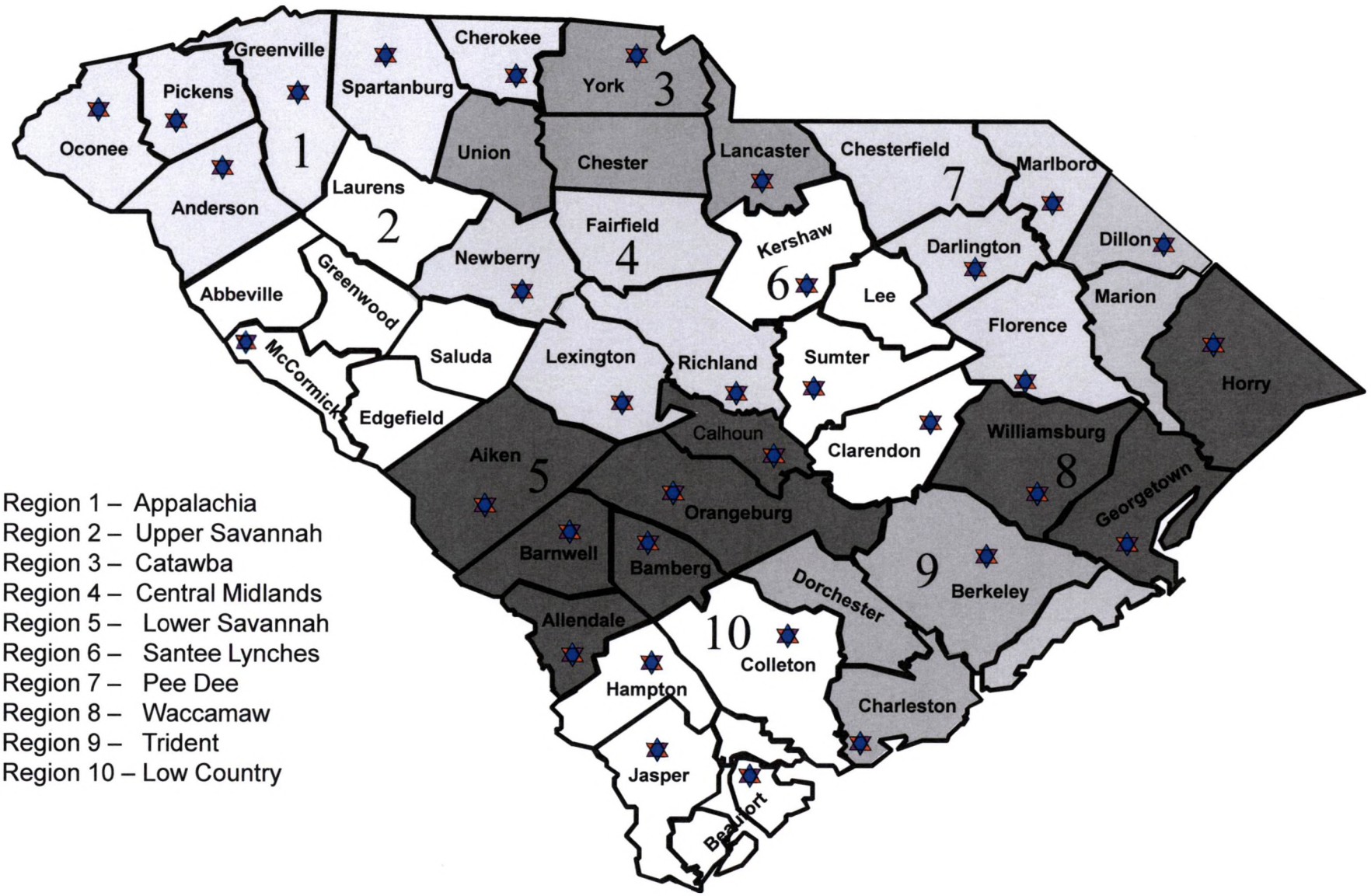
Attachment C

Project Map for CDSMP and ASMP in South Carolina

Counties That Offered at Least One Workshop during Recovery Act Project

March 31, 2010 – March 30, 2012



Region 1 – Appalachia
Region 2 – Upper Savannah
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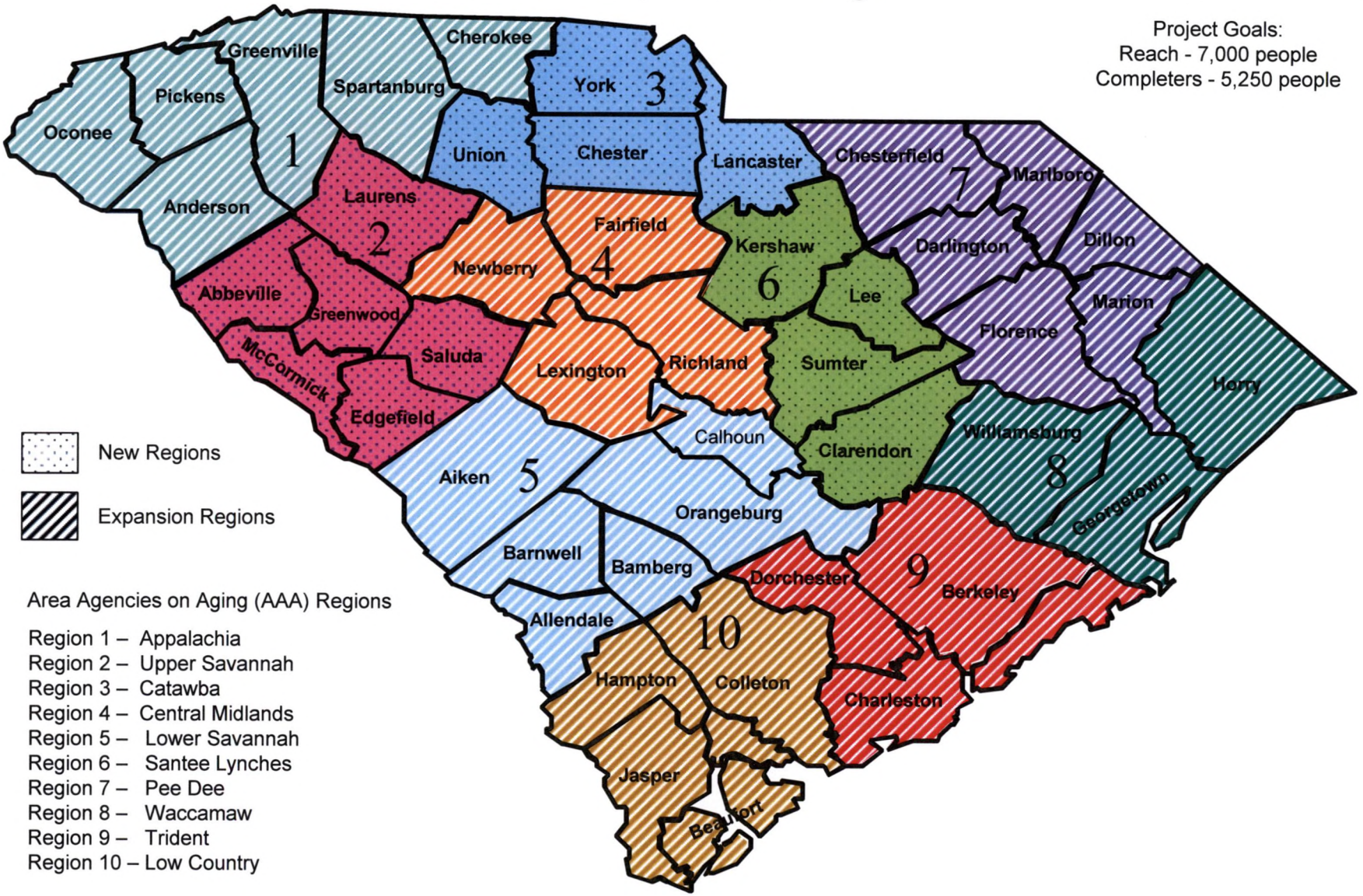
Region 7 – Pee Dee
Region 8 – Waccamaw
Region 9 – Trident
Region 10 – Low Country

Attachment C

Proposed Project Areas and Population Reach

New and Expansion Regions



Area Agencies on Aging (AAA) Regions

Region 1 – Appalachia
Region 2 – Upper Savannah
Region 3 – Catawba
Region 4 – Central Midlands
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Region 6 – Santee Lynches
Region 7 – Pee Dee
Region 8 – Waccamaw
Region 9 – Trident
Region 10 – Low Country

Attachment C

Chronic Disease in the 60 and Over and Disabled Populations							
Area Agencies on Aging Regions	**Population 60 and Over**	**Percent of Population 60 and Older**	**Prevalence of Chronic Disease in 60+ Pop.***	**Population 60 and Over with Chronic Diseases***	**Population of Disabled Adults**	**Prevalence of Chronic Disease in Disabled Pop. (all ages)**	**Population of Disabled Adults with Chronic Diseases***
AAA - Region I (Anderson, Cherokee, Greenville, Oconee, Pickens and Spartanburg)	230,600	20%	96.1	221,504	250,766	89.4	224,240
AAA - Region II (Abbeville, Edgefield, Greenwood, Laurens, McCormick and Saluda)	48,110	22%	93.9	45,171	46,502	97.9	45,544
AAA - Region III (Chester, Lancaster, York and Union)	68,640	19%	95.5	65,542	69,528	94.1	65,406
AAA - Region IV (Fairfield, Lexington, Newberry, Richland)	117,330	17%	94.3	110,589	141,313	95.6	135,049
AAA - Region V (Aiken, Allendale, Bamberg, Barnwell, Calhoun and Orangeburg)	68,240	22%	96.4	65,779	60,788	93.9	57,100
AAA - Region VI (Clarendon, Kershaw, Lee and Sumter)	44,680	20%	92.1	41,147	34,946	97.5	34,087
AAA - Region VII (Chesterfield, Darlington, Dillon, Florence, Marion, and Marlboro)	68,830	20%	95.7	65,861	70,897	90.8	64,370
AAA - Region VIII (Georgetown, Horry, and Williamsburg)	90,250	25%	95.4	86,127	75,323	91.0	68,517
AAA - Region IX (Berkeley, Charleston, and Dorchester)	113,580	17%	94.4	107,211	112,333	95.1	106,789

Attachment C

Chronic Disease in the 60 and Over and Disabled Populations							
Area Agencies on Aging Regions	**Population 60 and Over**	**Percent of Population 60 and Older**	**Prevalence of Chronic Disease in 60+ Pop.***	**Population 60 and Over with Chronic Diseases***	**Population of Disabled Adults**	**Prevalence of Chronic Disease in Disabled Pop. (all ages)**	**Population of Disabled Adults with Chronic Diseases***
AAA - Region X (Beaufort, Colleton, Hampton, and Jasper)	62,170	25%	92.8	57,722	43,817	88.7	38,861
South Carolina	912,430	20%	95.0	867,027	906,213	92.5	837,974
Data Source: SC BRFSS 2010							
*Chronic Diseases included Diabetes, Heart Disease, Stroke, Asthma, Arthritis, Cancer, Hypertension, High Cholesterol							

Prevalence of Chronic Diseases in South Carolina	
	South Carolina 60+ population
Asthma, current or former	13.0
Heart Disease(MI or CHD)	16.8
Stroke	9.3
Hypertension	62.6
High Cholesterol	62.2
Diabetes	21.0
Arthritis	58.8
Cancer	23.3
More than one of the above conditions	95.0
Data Source: SC BRFSS 2010	

Primary Partners
September 1, 2012- August 31, 2013

This chart provides a listing of our Delivery System Partners, in order of appearance in the narrative, then Support Partners, DHEC Support Partners, and New and Proposed Support Partners, in alphabetical order.

DELIVERY SYSTEM PARTNERS (in order in narrative)				
Partner Name	**Established Partner**	**New Partner**	**Partner Role**	**Impact**
1. Lead Delivery Partner: Statewide Aging Network - Area Agencies on Aging (AAAs), County Offices on Aging (COAs), Aging Service Providers (ASPs)	X		The largest and longest-standing partner, the State Aging Network, in collaboration with LGOA and DHEC, fully participates in building a sustainable infrastructure for EBPPs, through previous AoA and ARRA grants. Under this AoA renewal, the network will continue the effort to expand, embed and sustain EBI programs in their delivery systems, particularly outreaching to ethnic minorities, the disabled, and low-income, rural populations. The Network will support Aging-Health Department Region Teams to continue providing technical assistance and coordination to diverse local CDSME partners. The ADRC role will establish a regional call-in center for CDSME programs, while retaining the County Council on Aging's ability to enroll people, with "no wrong door" services.	Impact: System serves ~51,000 in 46 County Councils on Aging. Collaboration at state and local levels; continued expansion of EBIs in 10 AAA regions; programs embedded in aging delivery system; strengthened ADRC role. Programs available to underserved older adults of varying income levels and race/ethnicity and to individuals with disabilities. New AoA federal policy requires Title III-D federal wellness funds to be used for EBIs.
2. SC Faith Community Nurses Association (SCFCNA; aka Parish Nurse Network)	X		SCFCNA represents the parish nurse ministries in the state. It will leverage existing partnerships and support, promote, and provide CDSME programs by engaging region and local parish ministries. One SCFCNA member heads the Health Coaches Team for the Healthy Columbia 29203 Campaign.	Impact: Make CDSME programs available through ongoing collaboration with the faith-based community. Adoption of programs as integral health ministry service in churches. Increased reach to people in rural and underserved areas.
3. Catawba Tribe (Catawba Indian Nation), York County, SC		X	The Catawba Service Unit (Health Clinic) will work collaboratively with the Catawba Tribe's Senior Center Director, other clinic staff and volunteers to launch CDSMP for the Catawba Tribe. The Tribe comprises 2,600 people, many who live with chronic health conditions, such as diabetes, asthma, arthritis and hypertension. The plan is to work first with Seniors during the day, and later, with working adults in the evenings.	Impact: Tribe places high value on CDSMP and recognizes its many benefits; will serve as strong advocate. The Service Unit already enjoys partnerships with DHEC and the Eat Smart Move More Coalition. Provides another avenue for promoting and embedding CDSME programs like Diabetes Self-Management in health initiatives.

Partner Name	Established Partner	New Partner	Partner Role	Impact
4. WJB Dorn Veteran's Administration Hospital		X	Through the Nursing and Preventive Health Offices, the Dorn VA will implement CDSMP for VA patients affected by multiple chronic conditions. Participation from Charleston and Augusta VA's will be encouraged, with intent to embed program through staff training and VA supported offerings.	Impact: Life-changing outreach to veterans who can especially benefit from CDSMP, which reinforces personal accountability under patient-centered care model. Outreach to Viet Nam vets, as well as those from wars in Afghanistan and Iraq.
5. Palmetto Primary Care Physicians, Charleston, SC		X	On forefront of patient-centered model, PPCP is a designated Medical Home with 28 primary care physician practices, serving 7 counties and providing care to 300,000 individuals. Will develop referral stream and train staff to promote, launch and embed CDSMP in or through physician practices, with goal of improving health outcomes and reducing health care cost.	Impact: Because of influence as leader in patient-centered medical home model, will not only provide CDSME programs effectively to patients, but will serve as role model for other health care providers to develop same. Potential to link with state-based agencies and hospitals adopting medical model and to inspire creation of more Accountable Care Organizations statewide (ACOs).
6. SC Alcohol & Other Drug Abuse Services (DAODAS)		X	With a mission to prevent or reduce the impact of substance use and addictions, DAODAS coordinates at the state and county level to provide direct intervention and/or treatment services to over 50,000 residents each year. DAODAS' Treatment Services will first implement CDSMP in the Women's Residential Services Program, where long-term clients are housed and out-patients receive day treatment. DAODAS counselors and DHEC HIV social workers will be trained in CDSMP in August, through the CDC Arthritis grant, which will be integrated with AoA efforts.	Impact: CDSME programs are well-suited to a DAODAS partnership, as clients receiving services for alcohol and drug abuse are often affected by chronic conditions that impede their recovery and wellness goals. CDSMP hold potential in clients to shorten recovery processes and lead to longer-lasting, healthier outcomes. Once launched, CDSMP may be expanded to other treatment and prevention programs.
7. Healthy Columbia Campaign, Organizing for Health SC		X	Through collaboration with Palmetto Health, Blue Cross-Blue Shield, Select Health - First Choice, USC School of Medicine, DHHS, and DHEC, Healthy Columbia is organizing communities and neighborhoods, is building infrastructure to establish an Accountable Care Community (ACC) to cooperate with Accountable Care Organizations – patient-centered medical home providers - to serve residents of 29203 zip code, one of worst in the nation for health conditions, access, outcomes, costs in largely African American population.	Impact: Community Organizers, Health coaches, and volunteers will present choices to community and neighborhood leaders of CDSME programs in three selected communities of 29203 zip code, with goal to start one in fall 2012 and/or spring 2013 and gradually add one or two more.

Partner Name	Established Partner	New Partner	Partner Role	Impact
8. SC Hospital Association (SCHA) and SC Hospital Research and Education Foundation (SCHREF)	X		The SCHA assists its 88 member-hospitals with addressing health care needs and transforming health care. LGOA and SCHA are partnering in Care Transitions. Four ADRC's work with their local hospitals on Care Transitions, incorporating CDSME programs into their work plans. Other linkages with the state Quality Improvement Organization, hospital wellness programs, disease education and management, and community outreach efforts will occur. Member, SC Arthritis Advisory Council; Partnership for Healthy Aging.	Impact: If several hospitals take lead to adopt CDSME programs, then others will follow. Potential to reach thousands who receive services from hospitals and their partners, with long-term benefit of significant impact on chronic disease rates by improving health outcomes and reduce the burden of chronic diseases. With quickly transforming health care, opportunities to embed CDSMPs in health care systems will increase in effort to provide an integrative approach to health care.
SUPPORT PARTNERS (in alphabetical order after lead partner)				
9. Lead Support Partner: University of South Carolina Arnold School of Public Health	X		USC provides leadership for evidence-based research, performance monitoring, and evaluation. Staff serves on state aging team to expand EBPPs and on DHEC Community Health and Chronic Disease Bureau functional team for quality assurance and evaluation.	Impact: Continuous quality improvement in provision of EBPPs with fidelity to programs as designed to ensure their effectiveness in order to improve the health status of older adults and impact chronic disease outcomes.
10. AARP	X		Advocates for home and community-based services, including CDSME programs; publicizes Arthritis programs through the AARP-SC Chapters. Participant, Arthritis Advisory Council, Healthy Aging Policy Platform Initiative (HAPPI).	Impact: Continues to build awareness and support for CDSME programs within its membership, assisting with recognition of need to establish EBPPs as standard in health interventions.
11. Partnership for Healthy Aging Coalition (PHA)	X		Advisory partners act as statewide network to support the LGOA older South Carolinian and DHEC Healthy Aging and Arthritis Program goals.	Impact: A statewide system to support, expand, and sustain EBPPs and encourage their use as a health care standard for self-management and personal accountability for individual health care.
12. SC Budget & Control Board, Prevention Partners (PP)	X		Through employee insurance program, PP provides wellness information and programs to state employees, including awareness of EBPPs and CDSME programs.	Impact: Increased awareness of and participation in EBPPs among state employees. Encourages healthier state employee work force.
13. SC Department of Health and Human Services (DHHS), Community Long Term Care (CLTC)	X		Through case management system, DHHS will leverage referral partnerships with State Medicaid Plans and CLTC waiver program. Participant, Healthy Aging Policy Platform Initiative (HAPPI).	Impact: More dialogue with State Medicaid agency re potential coverage for CDSME programs long-term. Establish a referral stream to expand program reach. Collaboration with insurance providers and medical systems to establish Accountable Care Organizations.

Partner Name	Established Partner	New Partner	Partner Role	Impact
14. SC Department Health and Human Services (DHHS) Managed Care and Medical Services Division	X		Mission of serving SC populations eligible for Medicaid motivates division support for programs that have a significant impact on health status and best use of health care dollars. As partners, we leverage relationships with managed care health plans to serve as large referral networks for CDSME programs.	Impact: With our growing older adult population and the rise in chronic diseases, chronic disease self-management education (CDSME) programs are needed to maintain quality of life and prevent and delay disability.
15. SC Healthy Aging Policy Platform Initiative (HAPPI) Task Force.	X		The HAPPI Task Force is a collaborative endeavor of state agency partners guided by LGOA, DHEC, and the USC Arnold School of Public Health. Established in 2009 to pave the way for healthy aging, it is the policy work-group for the S.C. Arthritis Advisory Council and the S.C. Partnership for Healthy Aging. Its principal goal was to develop a formal, written policy platform and advocacy toolkit for expanding physical activity and chronic disease self-management EBPPs for older adults in SC.	Impact: LGOA, DHEC and its partners now use the policy platform created through HAPPI to guide CDSME program development and expansion. It has provided a platform for stating positions and values related to older adults' welfare in SC, which is frequently drawn upon when citing project goals. It strengthens current efforts and leverages partnerships, holding the potential for far-reaching systemic change toward the goal of keeping older adults healthy.
16. SC Library Association		X	As organization that represents libraries which serve as backbone institutions in large and small communities, SCLA promotes and supports the provision of CDSME programs in its local library community rooms.	Impact: The provision of space to convene CDSME programs is highly significant, especially in communities where the library offers one of the few locations to meet. People are comfortable in libraries as one of the truly public institutions available to all ages and ethnicities.
17. SC Primary Health Care Association (SCPHCA)	X		SCPHCA links Federally Qualified Health Centers (FQHCs) to Aging and Health Department Region Teams which collaborate as EBPP referral system. Facilitates SC Arthritis Program relationship with local health centers. Member, SC Arthritis Advisory Council, SC Partnership for Healthy Aging (SCPHA).	Impact: Increased collaboration at state level across health departments, community health centers, and aging network to expand CDSME program reach in under-served areas to vulnerable adults with arthritis and co-morbid conditions.
18. Select Health of SC		X	Through their Integrated Case Management Department, Select Health, the largest Medicaid managed care organization, will actively refer their First Choice Members to CDSME programs and promote and publicize EBPPs through their media outlets.	Impact: Increased referrals to members of the 226,000 First Choice Member network; increased awareness among members to request CDSME programs, due to their effectiveness in self-management of chronic health conditions.

Partner Name	Established Partner	New Partner	Partner Role	Impact
19. Silver-Haired Legislature	X		A unicameral body in the SC House of Representatives, the Silver Haired Legislature's purpose is to identify concerns and solutions for problems of the aging population and to make recommendations to the Governor, General Assembly, and various departments and agencies on aging. Participant, Healthy Aging Policy Platform Initiative (HAPPI).	Impact: Carries ongoing commitment to advocate for access to evidence-based physical activity and self-management programs in South Carolina so that older adults can remain independent in their own homes. Will continue to raise attention of legislative leaders and the Governor to designate funding to support EBPPs as low-cost and effective approaches to address chronic diseases.
SC DHEC SUPPORT PARTNERS				
20. Co-Lead with LGOA: DHEC Healthy Aging and Arthritis Prevention and Control Program	X		Based in the SC Department of Health and Environmental Control (DHEC), Community Health and Chronic Disease Bureau, the Healthy Aging and Arthritis Program is dedicated to reducing the impact of arthritis and other chronic conditions. As such, it advocates for healthy aging by supporting programs and policies that assist people in living longer, with higher quality of life, at home. A key partner with the LGOA since 1996, it has collaborated closely to advance joint missions. It provides leadership, support, training and technical assistance to partners to implement and sustain EBPPs in all ten state regions. Expansion of CDSME programs is a top priority.	Impact: Significant inroads have been made in building partnerships to expand program delivery and provide a statewide network of support for partners. With us, the Aging Network now provides exercise and self-management programs in all ten aging regions. Countless experiences and written testimonials have shown that these quality, low-cost programs have and will improve the quality of life for many older adults in SC. CDSME programs in particular will build the self-confidence and skills necessary to help participants learn how to manage the difficult symptoms that result from living with physical, mental and psychosocial conditions that often interact together.
21. DHEC Bureau of Disease Control, Division of STD/HIV/AIDS		X	With Prevention staff oversight, the HIV/AIDS Prevention Program will use Prevention, Ryan White Care Act, and Medicare Part B partners to implement CDSMP in local facilities to provide people with HIV (PWHIV) a next –step program to manage their health and aging conditions.	Impact: Through local partners, CDSMPs will become embedded in quality health providers for PWHIV. PWHIV will manage aging health conditions better. CareSouth Carolina examplifies multi-agency linkages as AAA, Community Health Center, HIV/AIDS provider, and potential transition care provider.
22. DHEC Cancer Prevention & Control, WISEWOMAN		X	Women screened through the WISEWOMAN program found to have a chronic health condition will be informed of local CDSME programs and their benefits. DHEC co-lead will meet with SC Cancer Alliance to discuss ways to promote CDSME programs to people at cancer risk and to cancer survivors.	Impact: CDSME programs will provide women with cancer skills to manage their health more holistically as they recover from cancer treatment and return to a more balanced life. CDSME programs will restore confidence and self-efficacy after women experience the challenges of being a cancer survivor, or will help in coping with fear of a cancer diagnosis.

Partner Name	Established Partner	New Partner	Partner Role	Impact
23. DHEC Chronic Disease Epidemiology and Evaluation	X		The burden of Arthritis, including arthritis and mental health, will be included in other chronic disease reports and in the Coordinated Chronic Disease State Plan.	Impact: Greater knowledge of inter-relatedness of arthritis with other chronic health conditions. Data show importance of tracking leading cause of disability and relationship with leading causes of death.
24. DHEC Coordinated Chronic Disease Program and Coalition		X	Through involvement in the Chronic Disease Coordinated State Plan, the Healthy Aging and Arthritis Program will support Coalition goals of integrating chronic disease programs to improve service delivery, develop holistic interventions, and reduce health care cost. Healthy Aging will assure inclusion of CDSME programs in Chronic Disease State Plan.	Impact: Increased cross-referrals from other chronic disease programs, such as diabetes, cancer, heart disease and stroke, obesity, and tobacco prevention. Increased embedment of CDSME programs into disease-specific interventions will address chronic disease more holistically.
25. DHEC Diabetes Prevention and Control Program	X		The Diabetes Program is committed to increasing the number of people with diabetes and number of counties served who receive CDSME programs. Health Communication will promote CDSME programs, and relevant topics will be presented at its annual conference.	Impact: Diabetes funding has been identified to support training for diabetes partners to become Leaders and offer CDSME programs, targeting people with diabetes. CDSME programs offer potential to reach many people with diabetes who otherwise would not be served.
26. DHEC Heart Disease and Stroke Prevention and Control Program		X	Heart Disease staff have connected Healthy Aging with the Consortium for Southeastern Hypertension Control (COSEHC). Its purpose is to reduce cardiovascular morbidity and mortality through education and outreach.	Impact: COSEHC will arrange meetings with affiliated physician practices to determine the potential for incorporating CDSME programs into the quality improvement process and offering courses for patients as part of their medical plan of care.
27. DHEC Obesity Prevention – Eat Smart Move More (ESMM) Coalition	X		A major initiative of the Obesity Program, the ESMM Coalition is comprised of over 500 members. It supports healthy eating and active living in SC. ESMM promotes CDSME programs through its communication channels, including its e-newsletter, website, and member Chapters. It supports legislation and infrastructure development to promote adult active living. Participant, Healthy Aging Policy Platform Initiative (HAPPI).	Impact: ESMM's advocacy role will help further the cause of making prevention a priority and increasing access to EBPPs to improve the quality of life for South Carolinians. Awareness of the importance of CDSME programs and an integrated approach to active living among older adults will increase. Policy and environmental changes will lead to increased options to stay physically active and access healthy foods.
28. DHEC Office of Minority Health	X		The Office of Minority Health serves as Agency support to program areas to work effectively with African-American organizations, faith-based partners, or community organizing programs (e.g. Healthy Columbia Campaign).	Impact: Lends credibility to aging and public health programs by facilitating access to minority populations. Increased effectiveness of partnerships with faith-based organizations, neighborhood associations, and targeted initiatives. Increased CDSME program participation.

Partner Name	Established Partner	New Partner	Partner Role	Impact
29. DHEC Public Health (PH) Regions	X		PH Regions partner with Aging Network to expand CDSME programs through AoA and ARRA grants. Provides coordination in Regions 4, 7, and 8. Strengthens and expands partnerships; provides technical assistance to partners. Integrates healthy aging and arthritis activities with other chronic diseases.	Impact: Regions will become more effective with infusion of AoA funds to expand and embed CDSME programs. Increased collaboration between Aging and Health Department at local level. Healthy Aging and Arthritis integrate more with other chronic disease activities.
30. DHEC Tobacco Quitline	X		The Quitline has agreed to include arthritis as one of the chronic diseases tracked when people call for help. When an individual reports having arthritis or another chronic disease, the Quitline counselor will be trained to provide information about CDSME programs and where classes can be accessed locally. Culturally appropriate information about CDSME programs will be included with the other educational materials that smokers receive when they call the Quitline.	Impact: The Quitline counseling and outreach activities will reach another segment of the population at high risk for chronic disease due to using tobacco and related products. A referral into a CDSME program could be life-altering for many South Carolinians, not only in helping to quit smoking or chewing tobacco, but in preventing chronic conditions.
NEW and PROPOSED SUPPORT PARTNERS (in alphabetical order)				
31. Consortium for Southeastern Hypertension Control (COSEHC)		X	COSEHC key player in facilitating linkages with Medicaid Medical Homes that serve people who would benefit greatly from CDSME programs.	Impact: Further reinforces the medical home model and compatibility of CDSME Programs for people with hypertension and co-morbidities.
32. Medicare Advantage Plans		X	Medicare Advantage Plans could serve as another large referral network, with development of provider reimbursement.	Impact: Potential to use large networks to promote and deliver CDSME programs, with added incentive of reimbursement to providers.
33. Money Follows the Person, MDS 3.0 Section Q and Dual Eligibles		X	Money Follows the Person will collaborate with LGOA and the State Medicaid agency to identify participants to refer into CDSME programs. ADRCs will assist in referral to CDSME programs in their respective areas of state.	Impact: An increased number of appropriate candidates will be referred to CDSME programs and will benefit from health improvements. Will support more widespread acceptance and adoption of these programs.
34. Sun City-Hilton Head (HH)		X	Arthritis Foundation Walk With Ease Program (WWE) will be launched Fall 2012 in Sun City HH. WWE will be made available to 200 employees, residents in 8,000 homes, in 60 neighborhoods, in effort to engage inactive or less active adults.	Impact: Once taste success of WWE, using support of Sun City staff and considerable resources, there is good potential to add CDSME programs, which will be explored at appropriate time.

Partner Name	Established Partner	New Partner	Partner Role	Impact
35. USC School of Medicine, Interagency Office on Disability and Health (IODH)		X	IODH will partner with the LGOA and DHEC Healthy Aging and Arthritis Program to identify service gaps and develop strategies to make CDSME programs available to people with disabilities.	Impact: CDSME programs will be promoted and embedded into the disability service sector to conduct more outreach. More people with disabilities will benefit from health education, physical activity, group support, helping them to lead more active and fulfilling lives.
36. USC School of Medicine, Department of Family and Preventive Medicine		X	The Department of Family and Preventive Medicine is a key player in linking with the State Medicaid agency and insurance providers to facilitate linkages with medical homes and other health care systems. Staff dedicated to improving health outcomes and reducing cost of care.	Impact: Strong and numerous connections of this department, acting in forefront of development of patient-centered medical homes, will establish more Accountable Care Organizations. This activity is cutting-edge and will lead to new ways of providing more effective health care, improving health status, reducing chronic disease and health care burden. Could be extremely significant in time.
37. Veteran Directed Home and Community Based Services (VDHCBS)		X	Two VA Medical Centers are partnering with LGOA and local ADRC's to refer a majority of vets and their caregivers into CDSME programs. VAMC's are agreeable to referring veterans to local programs.	Impact: If continued funding from the VA is available, the VDHCBS program will be established as statewide program within the next year. With this occurrence, opportunity for referrals into CDSME programs increases significantly.
Lieutenant Governor's Office on Aging 06/11/12				

Appalachian
Council of Governments

Providing Quality Services To Local Governments Since 1965

June 7, 2012

Denise Rivers
Deputy Director
Lt. Governor's Office on Aging
1301 Gervais Street, Suite 350
Columbia, SC 29201

Dear Ms. Rivers:

It is with pleasure that we look forward to the continuation of our partnership with the Lt. Governor's Office on Aging and the S.C. Department of Health and Environmental Control's (DHEC) Healthy Aging Program. On behalf of the Appalachian Area Agency on Aging, I am writing this letter in support of your application titled *Empowering Older Adults and Adults with Disabilities through Chronic Disease Self-Management Education Programs* funded by the U. S. Administration on Aging (AOA).

Over the past six years, our area has been a grantee of Administration on Aging and Recovery Act project. We are so pleased to have the Chronic Disease Self-Management Program (CDSMP) in our area and are just beginning to introduce the Arthritis Self-Management Program. We want to continue to grow these programs so that workshops are available in every county of our region. We are also interested in implementing the Diabetes Self-Management Program. As in previous years, we will provide our firm commitment to work with the Aging Service Providers in this area to bring these quality programs to older and disabled adults to improve their health and quality of life. We will also continue to encourage and support agency staff and community volunteers to enlist in leader training workshops.

We express our sincere appreciation for the ongoing opportunity to work with you and to join in your effort to make a difference in the lives of older and disabled persons in the Appalachian Region.

Sincerely,

Beverly W. Allen, Director
Appalachian AAA

P.O.Box 6668 . Greenville, SC 29606

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South Carolina Department of Health & Human Services

Anthony E. Keck, Director
Nikki R. Haley, Governor

June 5, 2012

Denise Rivers
Deputy Director
Lt. Governor's Office on Aging
1301 Gervais Street, Suite 350
Columbia, SC 29201

Dear Ms. Rivers:

On behalf of the Office of Managed Care and Medical Services of the South Carolina Department of Health and Human Services (SCDHHS), I am pleased to offer our support for the Lieutenant Governor's Office on Aging (LGOA) and the South Carolina Department of Health and Environmental Control's (DHEC) joint application, "Empowering Older Adults and Adults with Disabilities through Chronic Disease Self-Management Education Programs."

Based on the ranking of six chronic conditions, South Carolina's current health ranking is 46th in the nation. We support a continued partnership with the LGOA and DHEC's Healthy Aging and Arthritis Programs to help achieve our shared goal of improving health status in our state. Since our mission is to serve the population eligible for Medicaid, we are interested in supporting programs that will have a significant impact on this population's health status and best utilize our health care dollars.

With our growing older adult population and the rise in chronic diseases, chronic disease self-management education programs are needed to maintain quality of life and prevent/delay disability. Our Managed Care Division is collaborating with LGOA and DHEC to leverage relationships with managed care health plans to serve as large referral networks for the prevention program offerings.

We are excited about the additional potential this funding can provide to increase our partnership efforts. We know that when our state agencies work together we can provide more effective and efficient services to improve the health of our citizens. Thank you for this opportunity for continued collaboration to improve health status of our South Carolinians.

Sincerely,

Melanie "BZ" Giese
Deputy Director

Office of Managed Care and Medical Services
P.O. Box 8206 • Columbia, South Carolina 29202-8206
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DHEC

PROMOTE PROTECT PROSPER

May 29, 2012

Denise W. Rivers
Lt. Governor's Office on Aging
Deputy Director of Aging Services
1301 Gervais Street, Suite 200
Columbia, SC 29201

Dear Ms. Rivers:

On behalf of the S.C. Department of Health and Environmental Control (DHEC) Health Services, I am pleased to write this letter of commitment to continue our partnership with the S.C. Lieutenant Governor's Office on Aging (LGOA) through the funding opportunity "Empowering Older Adults and Adults with Disabilities through Chronic Disease Self-Management Education Programs" of the U.S. Administration on Aging.

DHEC and LGOA have a long history of collaboration, culminating in a number of grant awards for evidence-based initiatives. Since 2006, LGOA and DHEC have provided joint leadership to improve quality of life of older adults and disabled persons in South Carolina through evidence-based prevention efforts. DHEC has successfully collaborated with LGOA and the Aging Network to build an infrastructure for providing evidence-based prevention programs, such as the Stanford Chronic Disease Self-Management Program (CDSMP) and the Arthritis Self-Management Program (ASMP). Over the course of the various projects from 2006 to the present, self-management workshops have been offered in all ten of the Area Agencies on Aging; and seven areas offer workshops regularly. Statewide accessibility to self-management education programs is critical to reduce the considerable burden and impact of chronic diseases in our state and to achieve health equity.

The Health Services Deputy area is the largest within DHEC, with 2,219 employees, 8 public health regions that serve all 46 counties of the state, 5 central office bureaus, and 6 professional offices. We are fully committed to working with LGOA and our many other partners to assure the success of this initiative. Cora Plass, Director of the Healthy Aging Program and Manager of the Arthritis Program, will serve as the Co-Lead. Ms. Plass will continue to assist in integrating efforts throughout Health Services, including coordinating with other Chronic Disease Programs, the STD/HIV/AIDS Division, and the eight Public Health Regions.

This funding will strengthen our relationship with public health and aging working in unison throughout the state to deploy the programs. Our integrative approach will create more efficient utilization of valuable state resources and will help build public/private partnerships that can embed and sustain the programs.

We welcome this opportunity to join with LGOA to continue to provide leadership in the delivery of chronic disease self-management education programs in South Carolina to reduce the burden and the impact of chronic diseases in our state and to help older adults have more years of quality life.

Sincerely,

Lisa Waddell, M.D., M.P.H.
Deputy Director
Health Services

South Carolina Department of Health & Human Services

Anthony E. Keck, Director
Nikki R. Haley, Governor

June 11, 2012

Denise W. Rivers, LMSW, CIRS
Deputy Director
Lieutenant Governor's Office on Aging
1301 Gervais Street, Suite 350
Columbia, South Carolina 29201

Dear Ms. Rivers:

I am pleased to support your application for "Empowering Older Adults and Adults with Disabilities through Chronic Disease Self-Management Education Programs."

The South Carolina Department of Health and Human Services (SCDHHS) is the state Medicaid agency and operates home and community-based waiver programs as an alternative to nursing facility care. SCDHHS has a long-standing partnership with the Lieutenant Governor's Office on Aging (LGOA) and the South Carolina Department of Health and Environmental Control (DHEC) Healthy Aging Program. We are pleased to continue working collaboratively with your agency to increase access to and use of chronic disease self-management education programs by frail, older adults and their caregivers who are served by Medicaid waiver programs.

As a result of our work together on the Healthy Aging Policy Platform Initiative (HAPPI) Task Force, we have developed state-level policies and procedures for referring waiver consumers and family caregivers to Evidence Based Programs, including the Stanford Chronic Disease Self-Management program, Arthritis Self-Help and Exercise Programs and the Diabetes Self-Management Program. We are now implementing the policy by facilitating relationships between local SCDHHS nurses and waiver case managers and Aging/Public Health Region Teams. The case managers will identify persons awaiting services, family caregivers and consumers who can benefit from a referral to local Evidence Based Programs. In time, we intend to see routine and systematic implementation and documentation of referrals. The taskforce will also be a valuable resource in our Dual Eligible Demonstration, which will integrate primary care, long term care and behavioral health services.

I appreciate this opportunity to work together toward the goal of keeping older South Carolinians healthy, independent, and in their own homes.

Sincerely,

Samuel T. Waldrep, MA, LMSW
Deputy Director

Office of Long Term Care and Behavioral Health
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June 5, 2012

Denise W. Rivers
Deputy Director of Aging Services
S. C. Lieutenant Governor's Office on Aging
1301 Gervais Street, Suite 200
Columbia, SC 29201

Dear Ms. Rivers and Ms. Plass:

As senior vice-president for quality and patient safety with the South Carolina Hospital Association (SCHA), I am pleased to support the S.C. Lieutenant Governor's Office on Aging's (LGOA) application, in partnership with the S. C. Department of Health and Environmental Control, for "Empowering Older Adults and Adults with Disabilities through Chronic Disease Self-Management Education Programs," funded by the U.S. Administration on Aging (AoA).

Chronic diseases are serious health problems in South Carolina, causing diminished quality of life, disability and early death for many. With the rapid growth of retirees and the aging population, the number of people living with chronic conditions in South Carolina will dramatically increase, placing an enormous burden on our hospitals and other health care systems. The Stanford chronic disease self-management education (CDSME) programs are proven to be effective for preventing and managing chronic conditions and helping older adults remain independent at home.

Now numbering some 88 member-hospitals, the SCHA was established to assist hospitals in addressing the healthcare needs of South Carolinians through advocacy, education, networking and regulatory assistance. The SCHA takes pride in being at the forefront of advancing initiatives in our hospitals that transform health care in our state.

We are pleased to partner with you to facilitate linkages between the hospitals and the Stanford programs to improve the health status and health outcomes and to reduce the impact of chronic diseases in South Carolina. We are involved in coordinating Care Transition applications with member hospitals and their partners and have already discussed the potential for inclusion of the CDSME programs in these applications. We will facilitate linkages to continue to discuss the Stanford model, as the benefits of CDSME programs are apparent.

We will also help to make other linkages, such as with our state's Quality Improvement Organization, hospital wellness programs, disease education and management, and community outreach efforts. With the quickly transforming nature of health care, there are many opportunities for embedding CDSME programs in health care systems to provide an integrative approach to health care.

We value and appreciate the work that the LGOA and DHEC are doing to build partnerships to increase access to CDSME programs for people with chronic conditions and embed them in health care systems. As always, we are enthusiastic about working together to improve the health of South Carolinians.

Sincerely,

Rick Foster, MD
Senior Vice-President, Quality and Patient Safety

COSEHC
YEAR 2012

The Consortium for Southeastern Hypertension Control

P.O. Box 5097, Winston-Salem, NC 27113-5097 · Tele: 800-COSEHC-1/Fax: (336) 716-6644
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Debra R. Simmons, RN, MS
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June 1, 2012

Denise Rivers, LMSW, CIRS
Deputy Director
Lt. Governor's Office on Aging
1301 Gervais Street, Suite 350
Columbia, SC 29201

Dear Ms. Rivers and Ms. Plass:

As Executive Director of the Consortium for Southeastern Hypertension Control (COSEHC), I am writing to show support for your application, "Empowering Older Adults and Adults with Disabilities through Chronic Disease Self-Management Education Programs." Many older adults in South Carolina suffer needlessly from hypertension and other chronic diseases, resulting in years of poor health and loss of independence. Therefore, we are pleased to have this opportunity to work with you to improve the quality of life of older adults with chronic diseases and learn from the DHEC Heart and Stroke Program about the Stanford Chronic Disease Self-Management Program, which is a good model for our partner physician practices to embrace.

COSEHC is a nonprofit (501c3) organization created in 1992 to improve the disproportionate hypertension-related morbidity and mortality throughout the region. The southeastern region, with the largest ethnic minority component, has the highest prevalence of hypertension and hypertension-related complications. From the initial six charter members, COSEHC has grown to include a wide variety of members, connecting academic physicians, primary care clinicians, public health officials, allied health personnel and health care consumers. Your work to expand and embed evidenced programs for chronic disease self-management in South Carolina aligns well with COSEHC's promotion of scientifically based research and educational activities for the reduction of hypertension and other cardiovascular diseases.

We will offer our services to support your program activities by providing linkages to the physician practices with which we are working to improve cardiovascular disease health outcomes. We believe that the Stanford model will fit well in the medical home environment to support the treatment plan, improve health outcomes, and provide for a holistic approach to health. We have already received a very favorable response from the Palmetto Primary Care Physicians, a group of twenty-five practices in the Charleston area; and will have the opportunity to introduce you to our other affiliated primary care practices.

We look forward to the potential of this partnership and will work in cooperation with the Lieutenant Governor's Office on Aging and the SC Department of Health and Environmental Control to promote long and healthy lives for older adults in South Carolina.

Sincerely,

Debra Simmons, MS
Executive Director

"Eradicating vascular disease in all people"

May 30, 2012

Denise Rivers, LMSW, CIRS
Deputy Director
Lt. Governor's Office on Aging
1301 Gervais Street, Suite 350
Columbia, SC 29201

Dear Ms. Rivers and Ms. Plass:

The South Carolina Faith Community Nurses Association (SCFCNA) is pleased to write this letter in support of the application "Empowering Older Adults and Adults with Disabilities through Chronic Disease Self-Management Education Programs" being submitted to the U. S. Administration on Aging.

Through our work with faith congregations, our nurses have directly experienced the impact of chronic diseases on people in South Carolina. We welcome this opportunity to partner with you to expand evidence-based chronic disease self-management education programs for older and disabled adults with ongoing health conditions through the South Carolina community nurse network.

As an association that has recently applied for its nonprofit 501(c)3 status, the SCFCNA has organized the faith community nursing networks across the state to better serve its congregational nurses and individual health ministries. Our state association includes congregational nurse networks that serve multiple churches, as well as individual faith-based ministries that serve a particular faith community. Many of our networks are connected with universities, hospitals and community healthcare systems, serving hundreds of faith communities across all areas of the state.

We will help expand efforts within areas currently served by health ministries and will also leverage partnerships with health ministry networks to increase access in unreached areas. We will educate members about the benefits, promote Leader Trainings among nurses/health ministers, and provide opportunities for sharing "best practices" to get the programs underway, successfully adopt them, and sustain them. We will also promote programs through one-on-one contacts, website postings, emails, bulletin inserts, flyers and posters in network sites.

Once again, I am delighted for the opportunity to bring the SCFCNA and the DHEC Arthritis Program together to promote quality programs for people with arthritis and to reduce the burden of chronic disease.

Sincerely,

Renatta Loquist

Renatta Loquist, RN, MN, FAAN
Chair, South Carolina Faith Community Nurses Association

Attachment D

YEAR 1

Project Work Plan and Time Line

September 1, 2012 – August 31, 2013

Long Range Goals: Goal 1 - Reduce the burden and impact of chronic diseases in SC; Goal 2 - Improve the quality of life of older and disabled adults in SC; Goal 3 - Achieve health equity among disparately affected populations.

Project Goals: Goal 1- Increase access to and use of CDSME programs: CDSMP, ASMP, and DSMP;
Goal 2-Strengthen and expand integrated, sustainable statewide systems to support and embed CDSME programs.

Measurable Outcomes:

Systems Outcomes - 1) increase in the number of multi-site delivery system partners; 2) programs embedded in organizational operations and financially sustained; 3) programs integrated in referral, delivery and/or reimbursement processes of health care systems; 4) sustainability plan developed and implemented; 5) centralized, coordinated, processes for information, referral, enrollment, and marketing; 6) written, formalized processes for program implementation; 7) programs integrated in ADRCs; 8) health communication plan developed and implemented; 9) DSMP embedded in at least one health care system; 10) 100% compliance with AoA data collection and reporting requirements; 11) CDSME programs included in Aging and Chronic Disease State Plans.

Program Delivery Outcomes - 1) reach at least 7,000 older/disabled adults/5250 completers; 2) at least 2 workshops per year offered in all 46 counties; 3) increase the number of workshops at least three fold; 4) fidelity monitoring provided in all 10 AAA regions; 5) at least 85% of fidelity monitoring elements met; 6) increase in number of Host organizations and implementation sites; 7) sufficient pool of leaders to serve every county; 8) at least 12 Master Trainers geographically placed to cover the need for Leader Trainings.

Participant Outcomes - 1) high degree of participant satisfaction with workshop leaders, content, and delivery; 2) the majority of participants are older/disabled adults, 3) underserved populations are represented at percentages equal to or higher than the state rate, 4) completion rate of 75%.

Major Objectives	Key Tasks	Lead Person	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
Objective 1.1 - By August 31, 2015, implement CDSMP and ASMP in three un-served geographic regions: Area Agency on Aging (AAA) Regions II (Upper Savannah), III (Catawba), and VI (Santee Lynches).	**1.1a. Provide leadership, technical assistance, and training to regions.**													
	-Hold kick-off meeting/training with regions to introduce project.	Strong, Plass, Core Team	X											
	-Assist regions with developing implementation plan, timeline, communication flow, and potential key partners.	Strong, Plass, Core Team	X	X										
	-Schedule and conduct monthly conference calls/webinars with regions for training, TA, networking, sharing challenges/success.	Strong, Plass		X	X	X	X	X	X	X	X	X	X	X
	-Provide ongoing technical assistance (phone calls, site visits, emails).	Project Coordinator Arthritis Coordinator		X	X	X	X	X	X	X	X	X	X	X
	1.1b. Assist New Regions with developing partnerships.													
	-Provide training and TA to regions regarding partnership development: types of partners/roles/approaches/commitments, etc.	System Developer	X	X	X	X	X	X	X	X	X	X	X	X

Attachment D

Major Objectives	Key Tasks	Lead Person	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
(continued) Objective 1.1 - By August 31, 2015, implement CDSMP and ASMP in three un-served geographic regions: Area Agency on Aging (AAA) Regions II (Upper Savannah), III (Catawba), and VI (Santee Lynches).	-Provide "partnership materials" for making presentations to partners.	Health Communication Coordinator	X			X			X			X		
	-Facilitate linkages with other delivery systems partners to provide a coordinated approach.	Strong, Plass	X	X	X									
	-Introduce Catawba region lead to Catawba Indian Nation.	Plass, System Developer	X	X										
	-Provide guidance for integration with ADRCs.	Rivers, Strong	X	X	X									
	-Facilitate linkages with support systems partners to provide referrals.	Strong, Plass, System Developer		X	X	X	X	X	X	X	X	X	X	X
	1.1c. Assist regions with conducting promotional efforts.													
	-Provide education on marketing approaches that have proven successful at kick-off meeting and via webinars/conference calls.	Health Communications Coordinator	X	X	X	X	X	X	X	X	X	X	X	X
	-Distribute "toolkit" of promotional materials to regions.	Health Communications Coordinator	X	X	X	X	X	X	X	X	X	X	X	X
	-Provide template and guidance for regions to plan and develop localized marketing strategies.	Health Communications Coordinator	X	X	X									
	-Coordinate with local media to announce new programs in each area.	Health Communications Coordinator, Region Lead	X	X	X									
	-Provide regular radio/newspaper media coverage (ads, PSAs, releases, community calendars, public affairs interviews).	Health Communications Coordinator, Region Teams				X	X	X	X	X	X	X	X	X
	-Include discussion of marketing approaches on conference calls and provide TA.	Health Communications Coordinator	X	X	X	X	X	X	X	X	X	X	X	X
	1.1d. Schedule and coordinate leader trainings in conjunction with regions.													
	-Plan initial centralized leader training: set date, schedule site, order materials, secure trainers.	Project Coordinator Arthritis Coordinator	X											

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Major Objectives	Key Tasks	Lead Person	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
(continued) Objective 1.1 - By August 31, 2015, implement CDSMP and ASMP in three un-served geographic regions: Area Agency on Aging (AAA) Regions II (Upper Savannah), III (Catawba), and VI (Santee Lynches).	-Announce training to partners via email (attach flyer/application).	Project Coordinator	X											
	-Collect applications.	Project Assistant	X											
	-Hold leader training.	Master Trainers Project & Arthritis Coordinators, Region Teams	X											
	-Collect roster of attendees and evaluations from training.	Project Coordinator		X										
	-Enter training data in spreadsheets.	Data Entry Specialist		X										
	-Analyze data, produce reports, and share findings.	Leith					X			X			X	
	-Plan/hold additional leader trainings to expand the number of leaders and the number of workshops in each region.	Project & Arthritis Coordinator			X		X	X	X	X	X	X		
	1.1e. Implement CDSMP in New Regions.													
	-Establish quarterly reach objectives for the year.	Leadership Team Region Leads	X	X										
	-Provide oversight to assure that regions conduct workshops.	Strong, Plass		X	X	X	X	X	X	X	X	X	X	X
	-Provide ongoing support and nurturance to assure success.	Core Team	X	X	X	X	X	X	X	X	X	X	X	X
	-Provide feedback to regions about progress toward objectives.	Leadership Team			X			X		X		X		
	-Problem solve to overcome challenges and barriers.	Core Team Region Teams	X	X	X	X	X	X	X	X	X	X	X	X
	1.1f. Collect Data from CDSMP workshops in New Regions.													
	-Obtain schedule of workshops from regions.	Project Coordinator		X			X			X		X		
	-Collect data from leaders once workshops are completed.	Data Entry Specialist		X	X	X	X	X	X	X	X	X	X	X
	-Enter data in spreadsheets and national data base.	Data Entry Specialist		X	X	X	X	X	X	X	X	X	X	X
	-Analyze data, produce reports, and share findings.	Leith			X		X			X			X	
	1.1g. Conduct evaluation and quality assurance activities.													
	-Hold State Leadership and Core Team meetings quarterly to monitor progress of new regions and associated outcomes.	Plass, Strong	X			X			X			X		
	-Establish quarterly milestones for Year 1 to assess progress of regions re: partnership development and program implementation.	Leadership Team Region Leads	X	X										
	-Educate region teams on CQI and fidelity protocols.	Leith, Core Team	X	X										
	-Coordinate with fidelity monitors/Master Trainers to monitor leaders in new regions.	Strong, Plass		X	X		X							
	-Collect initial fidelity monitoring surveys from monitors.	Leith			X		X							
	-Enter and analyze data .	Leith			X									
	-Provide feedback to regions.	Leith			X									
	-Produce fidelity reports.	Leith					X					X		

Attachment D

Major Objectives	Key Tasks	Lead Person	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
(continued) Objective 1.1 - By August 31, 2015, implement CDSMP and ASMP in three un-served geographic regions: Area Agency on Aging (AAA) Regions II (Upper Savannah), III (Catawba), and VI (Santee Lynches).	-Train fidelity monitors in new regions.	Leith						X						
	-Continue to provide evaluation and oversight for fidelity monitoring.	Leith & Leadership Team												
	-Provide qualitative data collection.	Leith					X	X	X	X	X	X		
	1.1h. Train Master Trainers.													
	-Assess the need for additional Trainers.	Core Team			X	X	X	X						
	-Coordinate with Stanford to arrange for Master Trainings if needed.	Strong, Project Coordinator, Region Leads							X	X	X	X		
Objective 1.2 - By August 31, 2015, increase the number of counties in expansion regions with CDSME workshops at least twice a year and the number of people reached. (all 33 counties to be served)	**1.2a. Continue to provide leadership, technical assistance, and training.**													
	-Hold kick-off meeting/training with regions to prepare for expansion efforts.	Strong, Plass, Core Team	X	X										
	-Establish baseline numbers and reach objectives for each region.	Leadership Team, Region Leads	X	X										
	-Map existing partnerships, leaders, trainers, and implementation sites.	System Developer	X	X										
	-Assist regions in developing approaches and timeline to increase the reach and geographic spread of the programs.	Core Team			X	X	X	X	X	X	X	X	X	X
	- Continue to hold monthly conference calls/webinars for networking, sharing, problems solving, and increasing knowledge base.	Strong, Plass												
	-Provide ongoing support and technical assistance (phone calls, site visits, email).	Core Team	X	X	X	X	X	X	X	X	X	X	X	X
	1.2b. Assist regions in developing partnerships.													
	-Continue to partner with the SCPHCA to facilitate region linkages with FQHCs in their areas as a referral source.	Plass, System Developer	X	X	X		X	X	X	X	X	X	X	X
	-Continue to partner with DHHS to facilitate region linkages with area CLTC offices as referral partners.	Plass, System Developer	X	X	X		X	X	X	X	X	X	X	X
	-Continue to provide guidance and oversight for integrating ADRCs.	Rivers, Strong, Plass	X	X	X	X	X	X	X	X	X	X	X	X
	-Link region partners to large multi-site delivery-system partners in their respective regions to promote a coordinated approach to program implementation.	Leadership Team, System Developer					X	X	X	X	X	X	X	X
	-Facilitate linkages to support partners to increase access to and use of programs.	Leadership Team, System Developer	X	X	X	X	X	X	X	X	X	X	X	X

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Major Objectives	Key Tasks	Lead Person	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
(continued) Objective 1.2 - By August 31, 2015, increase the number of counties in expansion regions with CDSME workshops at least twice a year and the number of people reached. (all 33 counties to be served)	-Facilitate linkages to health care systems in local areas.	Leadership Team, System Developer	X	X	X	X	X	X	X	X	X	X	X	X
	-Provide continuing education on partnership development through conference calls/webinars.	Leadership Team, System Developer	X	X	X	X	X	X	X	X	X	X	X	X
	-Help problem solve challenges and brain storm solutions.	Core Team	X	X	X	X	X	X	X	X	X	X	X	X
	1.2c. Assist regions with enhancing promotional efforts.													
	-Provide centralized approach for media: (newspaper/radio) ads, PSAs, interviews.	Strong, Plass, Health Communications Coordinator	X	X	X	X	X	X	X	X	X	X	X	X
	-Include discussion of marketing approaches on conference calls.	Health Communications Coordinator	X	X	X	X	X	X	X	X	X	X	X	X
	-Assist regions in developing "best practices" strategies based on previous successes.	Health Communications Coordinator, Core Team	X	X	X	X	X	X	X	X	X	X	X	X
	-Encourage regions to train and use Ambassadors and provide guidance for the process.	Health Communications Coordinator, Core Team	X	X	X		X	X	X	X	X	X		
	-Coordinate with ADRCs to help promote programs.	Rivers, Strong, Project Coordinator	X	X	X	X	X	X	X	X	X	X	X	X
	-Utilize multi-faceted approaches to promote programs.	Health Communications Coordinator, Region Teams	X	X	X	X	X	X	X	X	X	X	X	X
	1.2d. Coordinate leader trainings with regions.													
	-Help regions promote training and recruit leaders.	Project Coordinator Arthritis Coordinator System Developer	X	X	X		X	X	X	X	X	X		
	-Schedule ASMP online training with Stanford and coordinate with regions.	Arthritis Coordinator, Project Coordinator	X	X	X					X	X			
	-Collect roster of attendees and evaluations from leader trainings (ASMP and CDSMP).	Data Entry Specialist	X	X	X	X	X	X	X	X	X	X	X	X

Attachment D

Major Objectives	Key Tasks	Lead Person	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
(continued) Objective 1.2 - By August 31, 2015, increase the number of counties in expansion regions with CDSME workshops at least twice a year and the number of people reached. (all 33 counties to be served)	-Enter training data in spreadsheets.	Data Entry Specialist	X	X	X	X	X	X	X	X	X	X	X	X
	-Analyze data, produce reports, and share findings.	Leith			X		X				X		X	
	1.2e. Expand CDSMP and ASMP in Expansion Regions													
	-Establish baseline and quarterly reach objectives.	Leadership Team, Region Leads	X	X										
	-Post workshop schedules.	Data Entry Specialist, Region Leads	X			X			X			X		
	-Assist with approaches to expand geographic spread in Year 1; help regions to be strategic in decision making (data driven decisions).	Leadership Team	X	X	X		X	X	X	X	X	X		
	-Provide oversight for program implementation.	Leadership Team	X	X	X	X	X	X	X	X	X	X	X	X
	-Provide ongoing support and nurturance.	Core Team	X	X	X	X	X	X	X	X	X	X	X	X
	-Help problem solve to overcome challenges and barriers.	Core Team	X	X	X	X	X	X	X	X	X	X	X	X
	-Provide feedback to regions about their progress toward objectives.	Leadership Team			X	X	X	X	X	X	X	X	X	X
	1.2f. Collect data from CDSMP workshops.													
	-Obtain schedule of workshops for quarter from regions.	Project Coordinator	X			X			X			X		
	-Collect data from leaders once workshops are completed.	Data Entry Specialist	X	X	X	X	X	X	X	X	X	X	X	X
	-Enter data in spreadsheets and national data base.	Data Entry Specialist	X	X	X	X	X	X	X	X	X	X	X	X
	-Analyze data, produce reports, and share findings.	Leith			X		X			X			X	
	1.2g. Conduct evaluation and quality assurance activities.													
	-Hold State Core and Leadership Team meetings quarterly to monitor progress and make adjustments as needed.	Plass, Strong, Core Team	X			X			X			X		
	-Establish baseline measures and milestones to assess progress of regions re: partnership development and program implementation.	Plass, Strong	X	X	X									
	-Continue to provide planning and oversight for fidelity monitoring activities**.**	Leith, Leadership Team	X	X	X	X	X	X	X	X	X	X	X	X
	-Collect fidelity monitoring surveys from regions.	Leith	X	X	X	X	X	X	X	X	X	X	X	X
	-Produce fidelity reports.	Leith					X					X		
	-Train additional fidelity monitors.	Leith			X					X				
	-Provide qualitative data collection activities.	Leith					X	X	X	X	X	X	X	X
	1.2h. Train Master Trainers.													
	-Assess need to train additional Trainers.	Core Team	X	X	X				X	X	X			
	-Coordinate with Stanford to arrange for Master Training.	Strong, Project Coordinator, Regions	X	X	X				X	X	X			
	-Recruit appropriate Leader Trainers from aging and public health regions to attend; schedule trainings upon completion.	Strong, Project Coordinator, Regions			X	X	X	X	X	X	X	X	X	X

Attachment D

Major Objectives	Key Tasks	Lead Person	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
Objective 1.3. - By August 31, 2015, implement DSMP in at least five of the seven expansion regions and develop at least one large health care systems partner to embed the program in its organization.	See Year 2 Work Plan.													
Objective 1.4 - By August 31, 2015, ensure that low income, rural, African American, and Native American older adults have access to CDSME programs.	**1.4a. Continue to implement programs through AAA Regions.**													
	-Foster Aging/Public Health teams to reach underserved population groups.	Core Team	X	X	X	X	X	X	X	X	X	X	X	X
	-Continue to employ COAs as implementation sites to reach vulnerable elderly.	Region Leads and Teams	X	X	X	X	X	X	X	X	X	X	X	X
	-Continue to provide workshops at a variety of sites, e.g., churches, low-income housing, FQHCs and community health centers, etc.	Region Leads and Teams	X	X	X	X	X	X	X	X	X	X	X	X
	1.4b. Develop and nurture relationships with other organizations that serve target population.													
	-Partner with faith-based organizations that reach African Americans.	Core Team	X	X	X	X	X	X	X	X	X	X	X	X
	-Partner with Catawba Indian Nation.	Plass, System Developer	X	X	X	X	X	X	X	X	X	X	X	X
	-Assess partnerships periodically to assure that minorities are represented and engaged.	Core Team, Evaluator			X			X		X		X		
	-Monitor data and make adjustments if needed to reach target population.	System Developer, Evaluator				X			X		X		X	
	-Enlist help of Region Teams and other partners to provide more workshops in rural areas.	Leadership Team, Core Team	X	X	X	X	X	X	X	X	X	X	X	X
	-Develop and employ strategies and messages that are appropriate (seek assistance of marketing expert).	Health Communications Coordinator	X	X	X	X	X	X	X	X	X	X	X	X

Attachment D

Major Objectives	Key Tasks	Lead Person	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
Objective 2.1 - By August 31, 2015, integrate and embed programs with existing systems, e.g., aging, disability, faith-based, chronic disease programs.	**2.1a. Provide joint Aging and Public Health leadership to facilitate an integrated sustainable delivery system**													
	-Convene quarterly Leadership Team meetings to develop strategies for integrating with health care and other systems and programs.	Strong, Plass	X			X			X			X		
	-Coordinate meetings with systems partners across agency – Aging and Public Health.	Strong, Plass, System Developer	X	X	X	X	X	X	X	X	X	X	X	X
	-Convene SCPHA and HAPPI Task Force meetings.	Strong, Plass			X						X			
	-Develop a detailed sustainability plan.	Leadership Team	X	X	X	X								
	-Coordinate with Aging and Public Health to assure that CDSME programs are incorporated in State Aging and Public Health plans.	Rivers, Strong, Plass	X	X										
	-Monitor and evaluate partners' progress and degree of movement toward adopting the programs.	Leadership and Core Team	X			X			X			X		
.	**2.1b. Develop effective multi-site delivery system partners.**													
	-Maintain and strengthen existing relationships.	Core Team, Regions	X	X	X	X	X	X	X	X	X	X	X	X
	-Provide TA to partners to help them move toward embedding programs in their organizations and maintaining financial sustainability.	Plass, Strong, System Developer	X	X	X	X	X	X	X	X	X	X	X	X
	-Schedule meetings with established partners (Dorn VA, Palmetto Primary Care, DAODAS, etc.) to assess progress toward reach goals and sustainability.	System Developer, Strong, Plass	X	X	X	X	X	X	X	X	X	X	X	X
	- Assess "readiness" of potential new partners.	System Developer	X	X	X	X	X	X	X	X	X	X	X	X
	-Continue to identify and engage new multi-site partners to discuss potential of implementing programs, especially large health systems, such as Medical Homes.	System Developer, Strong, Plass	X	X	X	X	X	X	X	X	X	X	X	X
	-Provide information about embedding programs in organizations from the beginning of the relationship.	System Developer, Strong, Plass	X	X	X	X	X	X	X	X	X	X	X	X
	2.1c. Develop effective support partners.													
	-Facilitate linkages with chronic disease programs and other public health partners and initiatives.	Plass	X	X	X	X	X	X	X	X	X	X	X	X
	-Facilitate linkages with Aging programs and initiatives, such as the Veteran Directed Home and Community Based Services.	Rivers	X	X	X	X	X	X	X	X	X	X	X	X
	-Collaborate with health systems/health plans to serve as referral networks and explore potential for reimbursement, funding for services.	Strong, Plass, System Developer	X	X	X	X	X	X	X	X	X	X	X	X
	-Schedule meetings with newly established support partners to explore potential roles, linkages, and next steps for working together.	System Developer	X	X	X	X								

Attachment D

Major Objectives	Key Tasks	Lead Person	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
(continued) Objective 2.1 - By August 31, 2015, integrate and embed programs with existing systems, e.g., aging, disability, faith-based, chronic disease programs.	**2.1d. Embed programs in the Aging Network.**													
	-Continue to provide leadership and guidance to Aging/Public Health region teams and promote continued collaboration.	Leadership Team, Core Team	X	X	X	X	X	X	X	X	X	X	X	X
	-Provide leadership and guidance to help expansion regions develop sustainability plans for their areas.	Strong, Plass, System Developer	X	X	X	X	X	X	X	X	X	X	X	X
	-Share successful region models and processes among regions.	Leadership Team, Core Team	X	X	X	X	X	X	X	X	X	X	X	X
	-Place CDSME programs on the agenda at monthly LGOA/AAA meetings; share challenges and successes; assess progress related to integrating CDSME programs with ADRCs, and provide TA to assist with moving toward integration.	Rivers	X	X	X	X	X	X	X	X	X	X	X	X
Objective 2.2 - By August 31, 2015, enhance and formalize coordinated state and region processes for implementation and evaluation.	**2.2a. Provide joint DHEC/LGOA leadership for a coordinated processes at state, region, and local levels.**													
	-Schedule Leadership and Core Team meetings to set timeline and priorities for working together to accomplish integration and other project objectives and outcomes.	Strong, Plass	X	X	X									
	-Fill vacant positions.	Rivers, Strong, Plass	X	X	X									
	-Share staffing and resources across agency.	Rivers, Plass	X	X	X	X	X	X	X	X	X	X	X	X
	-Continue to integrate efforts with Arthritis Program.	Plass	X	X	X	X	X	X	X	X	X	X	X	X
	-Hold monthly conference calls with Aging and Public Health represented at State and Region Level.	Plass, Strong	X	X	X	X	X	X	X	X	X	X	X	X
	-Enlist technical support to help develop automated processes for sharing information with partners for a coordinated approach.	Strong, Plass, System Developer	X	X	X	X	X	X	X	X	X	X	X	X
	-Post workshop schedules so that region, state, and local level staff/partners can access the information.	Data Entry Specialist, Project Coordinator	X			X			X			X		
	2.2b. Develop and implement centralized, coordinated intake, and referral, and marketing													
	-Contract with a marketing specialist to help team develop a state plan and campaign .	Health Communications Coordinator	X	X	X									
	- Create state and region call-in lines, with local call-in maintained for a “no wrong door” approach.	System Developer, Core Team			X	X	X	X	X					
	-Publicize call-in lines.	Health Communications Coordinator					X	X	X	X	X	X	X	X
	-Develop and provide radio and newspaper ads, releases, and public affairs interviews to promote programs.	Health Communications Coordinator, Region Teams	X	X	X	X	X	X	X	X	X	X	X	X

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Major Objectives	Key Tasks	Lead Person	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
(continued) Objective 2.2 By August 31, 2015, enhance and formalize coordinated state and region processes for implementation and evaluation.	-Develop and maintain mail-out lists/emails to promote workshops.	Data Entry Specialist					X	X	X	X	X	X	X	X
	-With guidance from a marketing expert, develop and employ a variety of strategies to promote programs and fill workshops.	Core Team, Health Communications Coordinator	X	X	X	X	X	X	X	X	X	X	X	X
	-Develop a state marketing plan.	Media Expert, Leadership Team					X	X	X	X	X	X	X	X
	2.2c. Maintain a centralized and coordinated evaluation process.													
	-Review, revise as needed, and maintain fidelity monitoring surveys and processes that are centralized to assure fidelity to the program design.	Leith	X	X	X	X	X	X	X	X	X	X	X	X
	-Continue to reinforce fidelity and provide TA to partners relative to fidelity issues.	Leith, Core Team	X	X	X	X	X	X	X	X	X	X	X	X
	-Continue to assess organizational capacity, the level of commitment from partners, and who the partners are to assure representation of target populations.	Leith Leadership Team	X	X	X			X	X	X	X	X		
	-Hold quarterly team meetings to monitor progress, "check-off" milestones toward objectives and outcomes, and determine if changes need to be made.	Leith Leadership Team	X			X			X			X		
	-Establish milestones for each project objective for Year 1.	Leadership Team	X	X										
	-Maintain quantitative data collection from paper and/or online surveys to document participation in workshops.	Leith Data Entry Specialist	X	X	X	X	X	X	X	X	X	X	X	X
	- Conduct qualitative data collection on collaborative and cooperative relationships at all levels and across organizations.	Leith	X	X	X		X	X	X	X	X			
	-Provide reports on evaluation findings and project progress to AoA and share results with partners.	Leadership Team					X					X	X	

Attachment D

YEAR 2
Project Work Plan and Time Line
September 1, 2013 – August 31, 2014

Long Range Goals: Goal 1 - Reduce the burden and impact of chronic diseases in SC; Goal 2 - Improve the quality of life of older and disabled adults in SC; Goal 3 - Achieve health equity among disparately affected populations.

Project Goals: Goal 1- Increase access to and use of CDSME programs: CDSMP, ASMP, and DSMP;
Goal 2 - Strengthen and expand integrated, sustainable statewide systems to support and embed CDSME programs.

Measurable Outcomes:
Systems Outcomes - 1) increase in the number of multi-site delivery system partners; 2) programs embedded in organizational operations and financially sustained; 3) programs integrated in referral, delivery and/or reimbursement processes of health care systems; 4) sustainability plan developed and implemented; 5) centralized, coordinated, processes for information, referral, enrollment, and marketing; 6) written, formalized processes for program implementation; 7) programs integrated in ADRCs; 8) health communication plan developed and implemented; 9) DSMP embedded in at least one health care system; 10) 100% compliance with AoA data collection and reporting requirements; 11) CDSME programs included in Aging and Chronic Disease State Plans.

Program Delivery Outcomes - 1) reach at least 7,000 older/disabled adults/5250 completers; 2) at least 2 workshops per year offered in all 46 counties; 3) increase the number of workshops at least three fold; 4) fidelity monitoring provided in all 10 AAA regions; 5) at least 85% of fidelity monitoring elements met; 6) increase in number of Host organizations and implementation sites; 7) sufficient pool of leaders to serve every county; 8) at least 12 Master Trainers geographically placed to cover the need for Leader Trainings.

Participant Outcomes - 1) high degree of participant satisfaction with workshop leaders, content, and delivery; 2) the majority of participants are older/disabled adults, 3) underserved populations are represented at percentages equal to or higher than the state rate, 4) completion rate of 75%.

Major Objectives	Key Tasks	Lead Person	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
Objective 1.1 - By August 31, 2015, implement CDSMP and ASMP in three un-served geographic regions: Area Agency on Aging (AAA) Regions II (Upper Savannah), III (Catawba), and VI (Santee Lynches).	**1.1a. Provide leadership, technical assistance, and training to regions.**													
	-Hold annual grantee meeting/training with regions to increase knowledge base and plan for Year 2.	Strong, Plass, Core Team	X											
	-Assist regions with developing implementation plan, timeline, communication flow, and potential key partners.	Strong, Plass, Core Team	X	X										
	-Schedule and conduct monthly conference calls/webinars with regions for training, TA, networking, sharing challenges/success.	Strong, Plass		X	X	X	X	X	X	X	X	X	X	X
	-Provide ongoing technical assistance (phone calls, site visits, emails).	Project Coordinator Arthritis Coordinator		X	X	X	X	X	X	X	X	X	X	X

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Major Objectives	Key Tasks	Lead Person	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
(continued) Objective 1.1 - By August 31, 2015, implement CDSMP and ASMP in three un-served geographic regions: Area Agency on Aging (AAA) Regions II (Upper Savannah), III (Catawba), and VI (Santee Lynches).	**1.1b. Assist New Regions with expanding partnerships.**													
	-Provide TA and additional training to regions regarding partnership development: types of partners/roles/approaches/commitments, etc.	System Developer	X	X	X	X	X	X	X	X	X	X	X	X
	-Provide supply of "partnership materials," including new materials for making presentations to partners.	Health Communication Coordinator	X			X			X			X		
	-Facilitate linkages with other delivery systems partners to provide a coordinated approach.	Strong, Plass	X	X	X	X	X	X	X	X	X	X	X	X
	-Facilitate ongoing coordination between the Catawba region team and the Catawba Indian Nation.	Plass, System Developer	X	X										
	-Monitor progress with regions linkages to ADRCs and help strengthen ADRC role as a call-in center and referral network.	Project Coordinator	X	X	X	X	X	X	X	X	X	X	X	X
	-Facilitate linkages with support systems partners to provide referrals.	Strong, Plass, System Developer		X	X	X	X	X	X	X	X	X	X	X
	1.1c. Assist regions with conducting promotional efforts.													
	-Provide continuing education on marketing approaches that have proven successful at kick-off meeting and via webinars/conference calls.	Health Communications Coordinator	X	X	X	X	X	X	X	X	X	X	X	X
	-Distribute new "toolkit" of promotional materials and refill supplies to assure regions have needed products to promote programs.	Health Communications Coordinator, Project Assistant	X	X	X	X	X	X	X	X	X	X	X	X
	-Provide template and guidance for regions to plan and develop localized marketing strategies for Year 2.	Health Communications Coordinator	X	X	X									
	-Coordinate with local media to promote introduction of ASMP in each area in Year 2.	Health Communications Coordinator, Region Lead		X	X	X	X	X						
	-Provide regular radio/newspaper media coverage (ads, PSAs, releases, community calendars, public affairs interviews).	Health Communications Coordinator, Region Teams	X	X	X	X	X	X	X	X	X	X	X	X
	-Include discussion of marketing approaches on conference calls and provide TA.	Health	X	X	X	X	X	X	X	X	X	X	X	X

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(continued) Objective 1.1 - By August 31, 2015, implement CDSMP and ASMP in three un-served geographic regions: Area Agency on Aging (AAA) Regions II (Upper Savannah), III (Catawba), and VI (Santee Lynches).		Communications Coordinator												
	1.1d. Schedule and coordinate leader trainings in conjunction with regions.													
	-Provide a coordinated approach to leader trainings: set dates, schedule sites, order materials, secure trainers.	Project Coordinator Arthritis Coordinator, Region Partners	X	X	X		X	X	X	X	X	X		X
	-Announce training to partners via email (attach flyer/application).	Project Coordinator	X	X	X		X	X	X	X	X	X		X
	-Collect applications.	Region Partners	X	X	X		X	X	X	X	X	X		X
	-Hold leader trainings.	Master Trainers, Region Teams	X											
	-Collect roster of attendees and evaluations from training.	Data Entry Specialist	X	X	X		X	X	X	X	X	X		X
	-Enter training data in spreadsheets.	Data Entry Specialist		X										
	-Analyze data, produce reports, and share findings.	Leith					X			X			X	
	1.1e. Expand reach and geographic spread of CDSMP in New Regions.													
	-Establish quarterly reach objectives for Year 2.	Leadership Team Region Leads	X	X										
	-Provide oversight to assure that regions conduct workshops.	Strong, Plass		X	X	X	X	X	X	X	X	X	X	X
	-Provide ongoing support and nurturance to assure success.	Core Team	X	X	X	X	X	X	X	X	X	X	X	X
	-Provide feedback to regions about progress toward objectives.	Leadership Team			X			X		X		X		
	-Problem solve to overcome challenges and barriers.	Core Team Region Teams	X	X	X	X	X	X	X	X	X	X	X	X
	1.1f. Implement ASMP.													
	-Assess regions' capacity to introduce a new program.	Leadership Team	X											
	-Schedule cross-training for leaders to offer ASMP.	Arthritis Program Coordinator, Project Coordinator		X							X			
	-Collect certificates; document attendance; enter in spreadsheets.	Data Entry Specialist			X						X			
	1.1g. Collect Data from CDSMP workshops in New Regions.													
	-Obtain schedule of workshops from regions.	Project Coordinator		X			X			X		X		
	-Collect data from leaders once workshops are completed.	Data Entry		X	X	X	X	X	X	X	X	X	X	X

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Major Objectives	Key Tasks	Lead Person	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
(continued) Objective 1.1 - By August 31, 2015, implement CDSMP and ASMP in three un-served geographic regions: Area Agency on Aging (AAA) Regions II (Upper Savannah), III (Catawba), and VI (Santee Lynches).		Specialist												
	-Enter data in spreadsheets and national data base.	Data Entry Specialist		X	X	X	X	X	X	X	X	X	X	X
	-Analyze data, produce reports, and share findings.	Leith			X		X			X			X	
	1.1h. Conduct evaluation and quality assurance activities.													
	-Hold State Leadership and Core Team meetings quarterly to monitor progress of new regions and associated outcomes.	Plass, Strong	X			X			X			X		
	-Establish quarterly milestones for Year 2 to assess progress of regions re: partnership development and program implementation.	Leadership Team, Region Leads	X	X										
	-Reinforce fidelity protocols, monitor compliance, provide ongoing education regarding fidelity.	Leith, Core Team	X	X	X		X	X	X	X	X	X		
	-Coordinate with fidelity monitors/Master Trainers to monitor leaders.	Region Teams	X	X	X	X	X	X	X	X	X	X	X	X
	-Collect fidelity monitoring surveys from monitors.	Leith	X	X	X	X	X	X	X	X	X	X	X	X
	-Enter and analyze data.	Leith			X			X			X			
	-Provide feedback to regions.	Leith			X				X			X		
	-Produce fidelity reports.	Leith						X						
	-Train additional fidelity monitors in new regions.	Leith	X						X					
	-Continue to provide evaluation and oversight for fidelity monitoring.	Leith, Leadership Team	X	X	X	X	X	X	X	X	X	X	X	X
	-Provide qualitative data collection.	Leith					X	X	X	X	X	X		
	1.1i. Train Master Trainers.													
	-Assess the need for additional Trainers.	Core Team	X	X	X	X								
	-Coordinate with Stanford to arrange for Master Trainings if needed.	Strong, Project Coordinator, Region Leads				X	X	X	X	X	X	X		
Objective 1.2 - By August 31, 2015, increase the number of counties in expansion regions with CDSME workshops at least twice a year and the number of people reached.	**1.2a. Continue to provide leadership, technical assistance, and training.**													
	-Hold annual grantee meeting/training with regions to prepare for expansion efforts.	Strong, Plass, Core Team	X	X										
	-Establish reach objectives for each region for Year 2.	Leadership Team, Region Leads	X	X										
	-Map progress with developing partnerships, leaders, trainers, and implementation sites.	System Developer	X	X										
	-Assist regions in developing approaches and timeline to increase the reach and geographic spread of the programs.	Core Team			X	X	X	X	X	X	X	X	X	X

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Major Objectives	Key Tasks	Lead Person	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
(continued) Objective 1.2 - By August 31, 2015, increase the number of counties in expansion regions with CDSME workshops at least twice a year and the number of people reached. (all 33 counties to be served)	- Continue to hold monthly conference calls/webinars for networking, sharing, problems solving, and increasing knowledge base.	Strong, Plass	X	X	X	X	X	X	X	X	X	X	X	X
	-Provide ongoing support and technical assistance (phone calls, site visits, email).	Core Team	X	X	X	X	X	X	X	X	X	X	X	X
	1.2b. Assist regions in strengthening and expanding partnerships.													
	-Continue to partner with the SCPHCA to facilitate region linkages with FQHCs in their areas as a referral source	Plass, System Developer	X	X	X		X	X	X	X	X	X	X	X
	-Continue to partner with DHHS to facilitate region linkages with area CLTC offices as referral partners.	Plass, System Developer	X	X	X		X	X	X	X	X	X	X	X
	-Continue to provide oversight for integration with ADRCs.	Rivers, Strong, Plass	X	X	X	X	X	X	X	X	X	X	X	X
	-Link region partners to large multi-site delivery-system partners in their respective regions to promote a coordinated approach to program implementation.	Leadership Team, System Developer	X	X	X	X	X	X	X	X	X	X	X	X
	-Facilitate linkages to support partners to increase access to and use of programs.	Leadership Team, System Developer	X	X	X	X	X	X	X	X	X	X	X	X
	-Facilitate linkages to health care systems in local areas.	Leadership Team, System Developer	X	X	X	X	X	X	X	X	X	X	X	X
	-Share partnership successes, challenges and reinforce strategies that have proven successful during conference calls/webinars.	Leadership Team, System Developer	X	X	X	X	X	X	X	X	X	X	X	X
	-Help problem solve challenges and brain storm solutions.	Core Team	X	X	X	X	X	X	X	X	X	X	X	X
	1.2c. Assist regions with enhancing promotional efforts.													
	-Provide centralized approach for media: (newspaper/radio) ads, PSAs, interviews.	Strong, Plass, Health Communications Coordinator	X	X	X	X	X	X	X	X	X	X	X	X
	-Include discussion of marketing approaches on conference calls.	Health Communications Coordinator	X	X	X	X	X	X	X	X	X	X	X	X
	-Assist regions in developing “best practices” strategies based on previous successes.	Health Communications Coordinator, Core Team	X	X	X	X	X	X	X	X	X	X	X	X

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(continued) Objective 1.2 - By August 31, 2015, increase the number of counties in expansion regions with CDSME workshops at least twice a year and the number of people reached. (all 33 counties to be served)	-Reinforce use of regions Ambassadors and monitor progress with this approach.	Health Communications Coordinator, Core Team	X	X	X		X	X	X	X	X	X		
	-Coordinate with ADRCs to help promote programs.	Rivers, Strong, Project Coordinator	X	X	X	X	X	X	X	X	X	X	X	X
	-Utilize multi-faceted approaches to promote programs.	Health Communications Coordinator, Region Teams	X	X	X	X	X	X	X	X	X	X	X	X
	1.2d. Coordinate leader trainings with regions.													
	-Help regions promote training and recruit leaders.	Project Coordinator Arthritis Coordinator System Developer	X	X	X		X	X	X	X	X	X		
	-Schedule ASMP online training with Stanford and coordinate with regions.	Arthritis Coordinator, Project Coordinator	X	X	X					X	X			
	-Collect roster of attendees and evaluations from leader trainings (ASMP and CDSMP).	Data Entry Specialist	X	X	X	X	X	X	X	X	X	X	X	X
	-Enter training data in spreadsheets.	Data Entry Specialist	X	X	X	X	X	X	X	X	X	X	X	X
	-Analyze data, produce reports, and share findings.	Leith			X		X			X			X	
	1.2e. Sustain and expand CDSMP and ASMP in Expansion Regions.													
	-Establish baseline and quarterly reach objectives.	Leadership Team, Region Leads	X	X										
	-Post workshop schedules.	Data Entry Specialist, Region Leads	X			X			X			X		
	-Assist with approaches to expand geographic spread in Year 1; help regions to be strategic in decision making (data driven decisions).	Leadership Team	X	X	X		X	X	X	X	X	X		
	-Provide oversight for program implementation.	Leadership Team	X	X	X	X	X	X	X	X	X	X	X	X
	-Provide ongoing support and nurturance.	Core Team	X	X	X	X	X	X	X	X	X	X	X	X
	-Help problem solve to overcome challenges and barriers.	Core Team	X	X	X	X	X	X	X	X	X	X	X	X

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(continued) Objective 1.2 - By August 31, 2015, increase the number of counties in expansion regions with CDSME workshops at least twice a year and the number of people reached. (all 33 counties to be served)	-Provide feedback to regions about their progress toward objectives.	Leadership Team			X	X	X	X	X	X	X	X	X	X
	1.2f. Collect data from CDSMP workshops.													
	-Obtain schedule of workshops for quarter from regions.	Project Coordinator	X			X			X			X		
	-Collect data from leaders once workshops are completed.	Data Entry Specialist	X	X	X	X	X	X	X	X	X	X	X	X
	-Enter data in spreadsheets and national data base.	Data Entry Specialist	X	X	X	X	X	X	X	X	X	X	X	X
	-Analyze data, produce reports, and share findings.	Leith			X		X			X			X	
	1.2g. Conduct evaluation and quality assurance activities.													
	-Hold State Core and Leadership Team meetings quarterly to monitor progress and make adjustments as needed.	Plass, Strong, Core Team	X			X			X			X		
	-Establish milestones to assess progress of regions re: partnership development and program implementation in Year 2.	Plass, Strong, Leith, Region Leads	X	X	X									
	-Continue to provide planning and oversight for fidelity monitoring activities.	Leith, Leadership Team	X	X	X	X	X	X	X	X	X	X	X	X
	-Collect fidelity monitoring surveys from regions.	Leith	X	X	X	X	X	X	X	X	X	X	X	X
	-Produce fidelity reports.	Leith					X					X		
	-Train additional fidelity monitors.	Leith												
	-Provide qualitative data collection activities.	Leith	X	X	X				X	X	X	X		
	1.2h. Train Master Trainers.													
	-Assess need to train additional Trainers.	Core Team	X	X	X				X	X	X			
	-Coordinate with Stanford to arrange for Master Training.	Strong, Project Coordinator, Region Leads	X	X	X				X	X	X			
	-Collect certificates of completion from attendees and enter data in spreadsheets.	Data Entry Specialist	X	X	X				X	X	X			

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Major Objectives	Key Tasks	Lead Person	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
Objective 1.3 - By August 31, 2015, implement DSMP in at least five of the seven expansion regions and develop at least one large health care systems partner to embed the program in its organization.	**1.3a. Develop DSMP implementation plan for expansion regions.**													
	-Provide "readiness" assessment to determine capacity of regions to implement DSMP.	Leith, Strong, Plass	X											
	-Assist regions in developing a rollout plan and timeline to add DSMP, while sustaining CDSMP and ASMP.	Strong, Plass, Core Team	X	X	X									
	-Coordinate with regions and Stanford to cross train CDSMP Master Trainers in DSMP.	Strong, Project Coordinator	X	X										
	-Schedule and hold DSMP Leader Training.	Project Coordinator, Master Trainers			X									
	-Schedule/hold workshops for DSMP.	Region Teams			X	X	X	X	X	X	X	X	X	X
	-Collect data from workshops.	Data Entry Specialist			X	X	X	X	X	X	X	X	X	X
	-Enter data in spreadsheets.	Data Entry Specialist			X	X	X	X	X	X	X	X	X	X
	-Analyze and provide reports on data.	Leith						X				X		
	1.3b. Identify health system with potential to embed DSMP.													
	-Coordinate with DHEC Diabetes Director to discuss potential health systems partner.	Strong, Plass	X	X										
	-Schedule meeting with potential partner to discuss DSMP and determine next steps.	Strong, Plass, Diabetes Program Director		X	X									
	-Continue to meet and collaborate with partner to explore possibilities and develop a plan and timeline.	Strong, Plass, System Developer				X	X	X	X	X	X	X	X	X
	-Begin to implement plan.	Strong, Plass, System Developer										X	X	X
	-Review implementation steps and adjust as needed for success.	Strong, Plass, System Developer										X	X	X

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Major Objectives	Key Tasks	Lead Person	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
Objective 1.4 - By August 31, 2015, ensure that low income, rural, African American, and Native American older adults have access to CDSME program.	**1.4a. Continue to implement programs through AAA Regions.**													
	-Foster Aging/Public Health teams to reach underserved population groups.	Core Team	X	X	X	X	X	X	X	X	X	X	X	X
	-Continue to employ COAs as implementation sites to reach vulnerable elderly.	Region Leads & Teams	X	X	X	X	X	X	X	X	X	X	X	X
	-Continue to provide workshops at a variety of sites, e.g., churches, low-income housing, FQHCs and community health centers, etc.	Region Leads & Teams	X	X	X	X	X	X	X	X	X	X	X	X
	1.4b. Develop and nurture relationships with other organizations that serve target population.													
	-Strengthen and expand partnerships with faith-based organizations that reach African Americans.	Core Team	X	X	X	X	X	X	X	X	X	X	X	X
	-Assess progress with Catawba Indian Nation and identify strategies to expand reach and embed programs.	System Developer, Project Coordinator, Region Lead	X	X	X	X	X	X	X	X	X	X	X	X
	-Assess potential for introducing DSMP to Catawba Indian Nation.	System Developer, Project Coordinator	X	X	X									
	-Assess partnerships periodically to assure that minorities are represented and engaged.	Core Team, Evaluator			X			X		X		X		
	-Monitor data and make adjustments if needed to reach target population.	System Developer, Evaluator				X			X		X		X	
	-Enlist help of Region Teams and other partners to provide more workshops in rural areas.	Leadership Team, Core Team	X	X	X	X	X	X	X	X	X	X	X	X
	- Employ strategies and messages that are appropriate, using "lessons learned" and recommendations of marketing expert.	Health Communications Coordinator	X	X	X	X	X	X	X	X	X	X	X	X
Objective 2.1 - By August 31, 2015, integrate and embed programs with existing systems, e.g., aging, disability, faith-based, chronic disease programs.	**2.1a. Provide joint Aging and Public Health leadership to facilitate an integrated sustainable delivery system.**													
	-Convene quarterly Leadership Team meetings to strengthen strategies for integrating with health care and other systems and programs.	Strong, Plass	X			X			X			X		
	-Coordinate meetings with systems partners– Aging and Public Health both to participate.	Strong, Plass, System Developer	X	X	X	X	X	X	X	X	X	X	X	X
	-Convene SCPHA and HAPPI Task Force meetings.	Strong, Plass			X						X			
	-Set priorities for implementing detailed sustainability plan and assess progress with moving toward a sustainability.	Leadership Team	X	X	X				X	X	X			
	-Continue to integrate CDSME programs with Aging and Public Health priorities for an integrated approac	Rivers, Strong, Plass	X	X	X	X	X	X	X	X	X	X	X	X

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Major Objectives	Key Tasks	Lead Person	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
(continued) Objective 2.1 - By August 31, 2015, integrate and embed programs with existing systems, e.g., aging, disability, faith-based, chronic disease programs.	-Monitor and evaluate partners' progress and degree of movement toward adopting the programs.	Leadership & Core Team	X			X			X			X		
	2.1b. Develop effective multi-site delivery system partners.													
	-Maintain and strengthen existing relationships.	Core Team, Regions	X	X	X	X	X	X	X	X	X	X	X	X
	-Provide TA to partners to help them move toward embedding programs in their organizations and maintaining financial sustainability.	Plass, Strong, System Developer	X	X	X	X	X	X	X	X	X	X	X	X
	-Schedule meetings with established partners (Dorn VA, Palmetto Primary Care, DAODAS, etc.) to assess progress toward reach goals and sustainability.	System Developer, Strong, Plass	X	X	X	X	X	X	X	X	X	X	X	X
	- Assess "readiness" of potential new partners.	System Developer	X	X	X	X	X	X	X	X	X	X	X	X
	-Continue to identify and engage new multi-site partners to discuss potential of implementing programs, especially large health systems, such as Medical Homes.	System Developer, Strong, Plass	X	X	X	X	X	X	X	X	X	X	X	X
	-Provide information about embedding programs in organizations from the beginning of the relationships.	System Developer, Strong, Plass	X	X	X	X	X	X	X	X	X	X	X	X
	-Assist partners in planning for sustainability and developing processes and practices that will lead to sustainability.	System Developer, Strong, Plass	X	X	X	X	X	X	X	X	X	X	X	X
	2.1c. Strengthen and expand effective support partners.													
	-Facilitate linkages with chronic disease programs and other public health partners and initiatives.	Plass	X	X	X	X	X	X	X	X	X	X	X	X
	-Facilitate linkages with Aging programs and initiatives, such as the Veteran Directed Home and Community Based Services.	Rivers	X	X	X	X	X	X	X	X	X	X	X	X
	-Collaborate with health systems/health plans to serve as referral networks and explore potential for reimbursement or funding for services.	Strong, Plass, System Developer	X	X	X	X	X	X	X	X	X	X	X	X
	-Schedule meetings with potential new support partners to explore roles, linkages, and next steps for working together.	System Developer	X	X	X	X	X	X	X	X	X	X	X	X
	2.1d. Embed programs in the Aging Network.													
	-Continue to provide leadership and guidance to Aging/Public Health region teams and promote continued collaboration.	Leadership Team, Core Team	X	X	X	X	X	X	X	X	X	X	X	X
	-Provide leadership and guidance to help expansion regions develop sustainability plans for their areas.	Strong, Plass, System Developer	X	X	X	X	X	X	X	X	X	X	X	X

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(continued) Objective 2.1 - By August 31, 2015, integrate and embed programs with existing systems, e.g., aging, disability, faith-based, chronic disease programs.	-Share successful region models and processes between regions.	State and region teams	X	X	X	X	X	X	X	X	X	X	X	X
	-Continue to place CDSME programs on the agenda at monthly LGOA/AAA meetings; share challenges and successes; assess progress related to integrating CDSME programs with ADRCs, and provide TA to assist with moving toward integration.	Rivers	X	X	X	X	X	X	X	X	X	X	X	X
Objective 2.2 - By August 31, 2015, enhance and formalize coordinated state and region processes for implementation and evaluation.	**2.2a. Provide joint DHEC/LGOA leadership for coordinated processes at state, region, and local levels.**													
	-Schedule Leadership and Core Team meetings to set timeline and priorities for Year 2 to accomplish integration and other project objectives and outcomes.	Strong, Plass	X	X	X									
	-Share staffing and resources across agency.	Rivers, Plass	X	X	X	X	X	X	X	X	X	X	X	X
	-Continue to integrate efforts with Arthritis Program.	Plass	X	X	X	X	X	X	X	X	X	X	X	X
	-Hold monthly conference calls with Aging and Public Health represented at State and Region Level.	Plass, Strong	X	X	X	X	X	X	X	X	X	X	X	X
	-Continue to develop new and improved automated processes for sharing information with partners for a coordinated approach.	Strong, Plass, System Developer	X	X	X	X	X	X	X	X	X	X	X	X
	-Post workshop schedules on website so that region, state, and local level staff/partners can access the information.	Project Coordinator, Health Communications Coordinator	X			X			X			X		
	2.2b. Develop and implement centralized, coordinated intake, and referral, and marketing.													
	-Contract with a marketing specialist for Phase 2 of a marketing campaign.	Strong, Plass, Health Communications Coordinator	X	X	X									
	- Monitor degree to which state and region call-in lines are used and helpful.	Leith, System Developer			X	X	X	X	X					
	-Identify strategies to enhance state, region, and local level coordination during Year 2.	Leadership Team	X	X	X	X								

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Major Objectives	Key Tasks	Lead Person	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
(continued) Objective 2.2- By August 31, 2015, enhance and formalize coordinated state and region processes for implementation and evaluation.	-Continue to publicize call-in lines.	Health Communications Coordinator	X	X	X	X	X	X	X	X	X	X	X	X
	-Develop and provide radio and newspaper ads, releases, and public affairs interviews to promote programs.	Health Communications Coordinator, Region Teams	X	X	X	X	X	X	X	X	X	X	X	X
	-Develop and maintain mail-out lists/emails to promote workshops.	Data Entry Specialist	X	X	X	X	X	X	X	X	X	X	X	X
	-With guidance from the marketing expert, enhance approaches to create high visibility of the program.	Core Team, Health Communications Coordinator	X	X	X	X	X	X	X	X	X	X	X	X
	-Distribute the marketing plan to partners and review with them to increase their marketing success.	Marketing expert, Health Communications Coordinator, Plass	X	X	X	X	X							
	2.2c. Maintain a centralized and coordinated evaluation process.													
	-Review, revise as needed, and maintain fidelity monitoring surveys and processes that are centralized to assure fidelity to the program design.	Leith	X	X	X	X	X	X	X	X	X	X	X	X
	-Develop fidelity leader self-monitoring forms for DSMP.	Leith	X	X	X	X								
	-Continue to reinforce fidelity and provide TA to partners relative to fidelity issues.	Leith, Core Team	X	X	X	X	X	X	X	X	X	X	X	X
	-Continue to assess organizational capacity, level of commitment from partners, and progress toward outcomes .	Leith Leadership Team	X	X	X			X	X	X	X	X		
	-Hold quarterly team meetings to monitor progress, "check-off" milestones toward objectives and outcomes and determine if changes need to be made.	Leith Leadership Team	X			X			X			X		
	-Establish milestones for each project objective for Year 2.	Leadership Team	X	X										
	-Maintain quantitative data collection from paper and/or online surveys to document participation in workshops.	Leith Data Entry Specialist	X	X	X	X	X	X	X	X	X	X	X	X
	- Conduct qualitative data collection on collaborative and cooperative relationships at all levels and across organizations.	Leith	X	X	X		X	X	X	X	X			
	-Provide reports on evaluation findings and project progress to AoA and share results with partners.	Leadership Team					X					X	X	

Attachment D

YEAR 3
Project Work Plan and Time Line
September 1, 2014 - August 31, 2015

Long Range Goals: Goal 1 - Reduce the burden and impact of chronic diseases in SC; Goal 2 - Improve the quality of life of older and disabled adults in SC; Goal 3 - Achieve health equity among disparately affected populations.

Project Goals: Goal 1- Increase access to and use of CDSME programs: CDSMP, ASMP, and DSMP;
Goal 2 - Strengthen and expand integrated, sustainable statewide systems to support and embed CDSME programs.

Measurable Outcomes:

Systems Outcomes - 1) increase in the number of multi-site delivery system partners; 2) programs embedded in organizational operations and financially sustained; 3) programs integrated in referral, delivery and/or reimbursement processes of health care systems; 4) sustainability plan developed and implemented; 5) centralized, coordinated, processes for information, referral, enrollment, and marketing; 6) written, formalized processes for program implementation; 7) programs integrated in ADRCs; 8) health communication plan developed and implemented; 9) DSMP embedded in at least one health care system; 10) 100% compliance with AoA data collection and reporting requirements; 11) CDSME programs included in Aging and Chronic Disease State Plans

Program Delivery Outcomes- 1) reach at least 7,000 older/disabled adults/5,250 completers; 2) at least 2 workshops per year offered in all 46 counties; 3) increase the number of workshops at least three fold; 4) fidelity monitoring provided in all 10 AAA regions; 5) at least 85% of fidelity monitoring elements met; 6) increase in number of Host organizations and implementation sites; 7) sufficient pool of leaders to serve every county; 8) at least 12 Master Trainers geographically placed to cover the need for Leader Trainings.

Participant Outcomes - 1) high degree of participant satisfaction with workshop leaders, content, and delivery; 2) the majority of participants are older/disabled adults, 3) underserved populations are represented at percentages equal to or higher than the state rate, 4) completion rate of 75%.

Major Objectives	Key Tasks	Lead Person	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
Objective 1.1 - By August 31, 2015, implement CDSMP and ASMP in three un-served geographic regions: Area Agency on Aging (AAA) Regions II (Upper Savannah), III (Catawba), and VI (Santee Lynches).	**1.1a. Provide leadership, technical assistance, and training to regions.**													
	-Hold annual grantee meeting/training with regions to provide continuing education to enhance knowledge and skills.	Strong, Plass, Core Team	X											
	-Assist regions with developing a plan to achieve the objectives in Year 3 and a sustainable program model.	Strong, Plass, Core Team	X	X										
	-Schedule and conduct monthly conference calls/webinars with regions for training, TA, networking, sharing challenges/success.	Strong, Plass		X	X	X	X	X	X	X	X	X	X	X
	-Provide ongoing technical assistance (phone calls, site visits, emails.	Project Coordinator Arthritis Coordinator		X	X	X	X	X	X	X	X	X	X	X
	1.1b. Assist New Regions with expanding partnerships.													
	-Provide TA to assist with partnership development and sustainability.	Core Team, System Developer	X	X	X	X	X	X	X	X	X	X	X	X

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Major Objectives	Key Tasks	Lead Person	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
(continued) Objective 1.1 - By August 31, 2015, implement CDSMP and ASMP in three un-served geographic regions: Area Agency on Aging (AAA) Regions II (Upper Savannah), III (Catawba), and VI (Santee Lynches).	-Continue to supply partnership materials centrally to support regions delivery of programs.	Health Communications Coordinator	X			X			X			X		
	-Continue to facilitate linkages with other delivery systems partners for an integrated sustainable approach.	Strong, Plass,	X	X	X	X	X	X	X	X	X	X	X	X
	-Facilitate continued collaboration with the Catawba region team and the Catawba Indian Nation.	Plass, System Developer	X	X	X	X	X	X	X	X	X	X	X	X
	-Continue to monitor progress with regions linkages to ADRCs as a call-in center and referral network and develop approaches to provide an ongoing commitment to CDSME programs.	Strong, Project Coordinator	X	X	X	X	X	X	X	X	X	X	X	X
	-Facilitate linkages with support systems partners to provide referrals.	Strong, Plass, System Developer		X	X	X	X	X	X	X	X	X	X	X
	1.1c. Assist regions with conducting promotional efforts.													
	-Continue to provide education and TA on marketing approaches that have proven successful to help increase knowledge base.	Health Communications Coordinator	X	X	X	X	X	X	X	X	X	X	X	X
	-Continue to distribute promotional materials and refill supplies to assure regions have needed products and materials to promote programs.	Health Communications Coordinator, Project Assistant	X	X	X	X	X	X	X	X	X	X	X	X
	-Provide guidance for regions to develop localized marketing strategies that are consistent with the state plan.	Health Communications Coordinator	X	X	X									
	-Coordinate with local media to highlight at least one success or accomplishment in each area.	Health Communications Coordinator, Region Lead		X	X	X	X	X						
	-Provide regular radio/newspaper media coverage (ads, PSAs, releases, community calendars, public affairs interviews) to inform the public and decision makers about the importance and growth of CDSME programs and the availability of workshops.	Health Communications Coordinator, Region Teams	X	X	X	X	X	X	X	X	X	X	X	X
	-Include discussion of marketing approaches on conference calls and provide TA related to multi-faceted approaches.	Health Communications Coordinator	X	X	X	X	X	X	X	X	X	X	X	X
	1.1d. Schedule and coordinate CDSMP leader trainings in conjunction with regions.													
	-Provide a coordinated approach to leader trainings: set dates, schedule sites, order materials, secure trainers.	Project Coordinator Arthritis Coordinator, Region Partners	X	X	X		X	X	X	X	X	X		X
	-Announce training to partners via email list serve.	Project Coordinator	X	X	X		X	X	X	X	X	X		X

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Major Objectives	Key Tasks	Lead Person	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
(continued) Objective 1.1 - By August 31, 2015, implement CDSMP and ASMP in three un-served geographic regions: Area Agency on Aging (AAA) Regions II (Upper Savannah), III (Catawba), and VI (Santee Lynches).	-Collect applications.	Region Partners	X	X	X		X	X	X	X	X	X		X
	-Plan and hold leader trainings.	Master Trainers Region Teams	X	X	X		X	X	X	X	X	X		X
	-Collect roster of attendees and evaluations from training.	Data Entry Specialist	X	X	X		X	X	X	X	X	X		X
	-Enter training data in spreadsheets.	Data Entry Specialist	X	X	X		X	X	X	X	X	X	X	X
	-Analyze data, produce reports, and share findings.	Leith	X	X	X				X	X	X	X		
	1.1e. Expand reach and geographic spread of CDSMP in New Regions.													
	-Establish quarterly reach objectives for Year 3.	Leadership Team Region Leads	X	X										
	-Provide oversight to assure that regions conduct workshops.	Strong, Plass		X	X	X	X	X	X	X	X	X	X	X
	-Provide ongoing support and nurturance to assure success.	Core Team	X	X	X	X	X	X	X	X	X	X	X	X
	-Provide feedback to regions about progress toward objectives.	Leadership Team			X			X		X		X		
	-Help regions problem solve to overcome challenges and barriers.	Core Team Region Teams	X	X	X	X	X	X	X	X	X	X	X	X
	1.1f. Continue to implement and expand ASMP.													
	-Assess regions' capacity for maintaining and expanding ASMP.	Leadership Team	X											
	-Schedule cross-trainings for more leaders to offer ASMP.	Arthritis Program Coordinator, Project Coordinator	X	X	X						X			
	-Collect certificates; document attendance; enter in spreadsheets.	Data Entry Specialist			X						X			
	1.1g. Collect Data from CDSMP workshops in New Regions.													
	-Obtain schedule of workshops from regions.	Project Coordinator		X			X			X		X		
	-Collect data from leaders once workshops are completed.	Data Entry Specialist		X	X	X	X	X	X	X	X	X	X	X
	-Enter data in spreadsheets and national data base.	Data Entry Specialist		X	X	X	X	X	X	X	X	X	X	X
	-Analyze data, produce reports, and share findings.	Leith			X		X			X			X	
	1.1h. Conduct evaluation and quality assurance activities.													
	-Hold State Leadership and Core Team meetings quarterly to monitor progress of new regions and associated outcomes.	Plass, Strong	X			X			X			X		
	-Establish quarterly milestones for Year 3 to assess progress of regions re: partnership development and program implementation.	Leadership Team Region Leads	X	X										
	-Reinforce fidelity protocols, monitor compliance, provide ongoing education regarding fidelity.	Leith, Core Team	X	X	X		X	X	X	X	X	X		

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Major Objectives	Key Tasks	Lead Person	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
(continued) Objective 1.1 - By August 31, 2015, implement CDSMP and ASMP in three un-served geographic regions: Area Agency on Aging (AAA) Regions II (Upper Savannah), III (Catawba), and VI (Santee Lynches).	-Coordinate with fidelity monitors/Master Trainers to monitor leaders.	Region Teams	X	X	X	X	X	X	X	X	X	X	X	X
	-Collect fidelity monitoring surveys from monitors.	Leith	X	X	X	X	X	X	X	X	X	X	X	X
	-Enter and analyze data.	Leith			X			X			X			
	-Provide feedback to regions.	Leith			X				X			X		
	-Produce fidelity reports.	Leith						X						
	-Train additional fidelity monitors in new regions as needed.	Leith	X						X					
	-Continue to provide evaluation and oversight for fidelity monitoring.	Leith & Leadership Team	X	X	X	X	X	X	X	X	X	X	X	X
	-Provide qualitative data collection.	Leith					X	X	X	X	X	X		
	1.1i. Train Master Trainers.													
	-Assess the need for additional Trainers.	Core Team	X	X	X	X								
	-Coordinate with Stanford to arrange for Master Trainings if needed.	Strong, Project Coordinator, Region Leads				X	X	X	X	X	X	X		
Objective 1.2 - By August 31, 2015, increase the number of counties in expansion regions with CDSME workshops at least twice a year and the number of people reached. (all 33 counties to be served)	**1.2a. Continue to provide leadership, technical assistance, and training.**													
	-Hold annual grantee meeting/training with regions to plan last year and increase knowledge base of developing a sustainable, integrated system for CDSME programs.	Strong, Plass, Core Team	X	X										
	-Establish reach objectives for each region for Year 3, including a localized sustainability plan that fits with the state plan.	Leadership Team, Region Leads	X	X										
	-Monitor progress, and share challenges, and successes related to developing partnerships, sustaining leaders/partners/trainers and embedding the program for a sustainable model.	System Developer	X	X	X	X	X	X	X	X	X	X	X	X
	-Assist regions in developing approaches and a timeline to increase the reach and geographic spread of the programs.	Core Team			X	X	X	X	X	X	X	X	X	X
	- Continue to hold monthly conference calls/webinars for networking, sharing, problems solving, and increasing knowledge base.	Strong, Plass	X	X	X	X	X	X	X	X	X	X	X	X
	-Provide ongoing support and technical assistance (phone calls, site visits, email).	Core Team	X	X	X	X	X	X	X	X	X	X	X	X
	1.2b. Assist regions in strengthening and expanding partnerships.													
	-Continue to partner with the SCPHCA to facilitate region linkages with FQHCs in their areas as a referral source.	Plass, System Developer	X	X	X		X	X	X	X	X	X	X	X
	-Continue to partner with DHHS to facilitate region linkages with area CLTC offices as referral partners.	Plass, System Developer	X	X	X		X	X	X	X	X	X	X	X
	-Continue to provide guidance and oversight for integration with ADRCs.	Rivers, Strong, Plass	X	X	X	X	X	X	X	X	X	X	X	X

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Major Objectives	Key Tasks	Lead Person	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
(continued) Objective 1.2 - By August 31, 2015, increase the number of counties in expansion regions with CDSME workshops at least twice a year and the number of people reached. (all 33 counties to be served)	-Link region partners to large multi-site delivery-system partners in their respective regions to promote a coordinated approach to program implementation.	Leadership Team, System Developer	X	X	X	X	X	X	X	X	X	X	X	X
	-Facilitate linkages to support partners to increase access to and use of programs.	Leadership Team, System Developer	X	X	X	X	X	X	X	X	X	X	X	X
	-Facilitate linkages to health care systems in local areas.	Leadership Team, System Developer	X	X	X	X	X	X	X	X	X	X	X	X
	-Continue to share partnership successes, challenges and reinforce strategies that have proven successful during conference calls/webinars.	Leadership Team, System Developer	X	X	X	X	X	X	X	X	X	X	X	X
	-Help problem solve challenges and brain storm solutions.	Core Team	X	X	X	X	X	X	X	X	X	X	X	X
	1.2c. Assist regions with enhancing promotional efforts.													
	-Provide centralized approach for media: (newspaper/radio) ads, PSAs, interviews.	Strong, Plass, Health Communications Coordinator	X	X	X	X	X	X	X	X	X	X	X	X
	-Include discussion of marketing approaches on conference calls.	Health Communications Coordinator	X	X	X	X	X	X	X	X	X	X	X	X
	-Assist regions in developing "best practices" strategies based on previous successes.	Health Communications Coordinator, Core Team	X	X	X	X	X	X	X	X	X	X	X	X
	-Continue to utilize ambassadors to support promotional activities, especially in rural areas and build a volunteer base to have "voices" everywhere to promote the programs.	Health Communications Coordinator, Core Team	X	X	X		X	X	X	X	X	X		
	-Continue to assess barriers and successes of collaboration with ADRC and strengthen relationships.	Rivers, Strong, Project Coordinator	X	X	X	X	X	X	X	X	X	X	X	X
	-Utilize multi-faceted approaches to promote programs often and widely and leverage wide base of partners to promote programs.	Health Communications Coordinator, Region Teams	X	X	X	X	X	X	X	X	X	X	X	X
	1.2d. Coordinate leader trainings with regions.													
	-Help regions promote trainings and recruit leaders for CDSMP.	Project Coordinator Arthritis Coordinator System Developer	X	X	X		X	X	X	X	X	X		
	-Continue to schedule ASMP leader trainings training with Stanford and coordinate with regions.	Arthritis Coordinator, Project Coordinator	X	X	X					X	X			
	-Collect roster of attendees and evaluations from leader trainings (ASMP and CDSMP).	Data Entry Specialist	X	X	X	X	X	X	X	X	X	X	X	X

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Major Objectives	Key Tasks	Lead Person	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
(continued) Objective 1.2 - By August 31, 2015, increase the number of counties in expansion regions with CDSME workshops at least twice a year and the number of people reached. (all 33 counties to be served)	-Enter training data in spreadsheets.	Data Entry Specialist	X	X	X	X	X	X	X	X	X	X	X	X
	-Analyze data, produce reports, and share findings.	Leith			X		X						X	
	1.2e. Sustain and expand CDSMP and ASMP in Expansion Regions.													
	-Establish baseline and quarterly reach objectives for Year 3.	Leadership Team, Region Leads	X	X										
	-Post workshop schedules.	Data Entry Specialist, Region Leads	X			X			X			X		
	-Assist with approaches to expand and maintain geographic spread in Year 3; help regions to be strategic in decision making (data driven decisions).	Leadership Team	X	X	X		X	X	X	X	X	X		
	-Provide oversight for program implementation.	Leadership Team	X	X	X	X	X	X	X	X	X	X	X	X
	-Provide ongoing support and nurturance.	Core Team	X	X	X	X	X	X	X	X	X	X	X	X
	-Help problem solve to overcome challenges and barriers.	Core Team	X	X	X	X	X	X	X	X	X	X	X	X
	-Provide feedback to regions about their progress toward objectives.	Leadership Team			X	X	X	X	X	X	X	X	X	X
	1.2f. Collect data from CDSMP workshops.													
	-Obtain schedule of workshops for quarter from regions.	Project Coordinator	X			X			X			X		
	-Collect data from leaders once workshops are completed.	Data Entry Specialist	X	X	X	X	X	X	X	X	X	X	X	X
	-Enter data in spreadsheets and national data base.	Data Entry Specialist	X	X	X	X	X	X	X	X	X	X	X	X
	-Analyze data, produce reports, and share findings.	Leith			X		X			X			X	
	1.2g. Conduct evaluation and quality assurance activities.													
	-Hold State Core and Leadership Team meetings quarterly to monitor progress and make adjustments as needed.	Plass, Strong, Core Team	X			X			X			X		
	-Establish milestones to assess progress of regions re: partnership development and program implementation in Year 3.	Plass, Strong, Leith, Region Leads	X	X	X									
	-Continue to provide planning and oversight for fidelity monitoring activities**.**	Leith, Leadership Team	X	X	X	X	X	X	X	X	X	X	X	X
	-Collect fidelity monitoring surveys from regions..	Leith	X	X	X	X	X	X	X	X	X	X	X	X
	-Produce fidelity reports.	Leith					X					X		
	-Train additional fidelity monitors.			X						X				
	-Provide qualitative data collection activities.	Leith	X	X	X				X	X	X	X		
	1.2h. Train Master Trainers.													
	-Assess need to train additional Trainers.	Core Team	X	X	X				X	X	X			
	-Coordinate with Stanford to arrange for Master Training.	Strong, Project Coordinator, Region Leads	X	X	X				X	X	X			

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Major Objectives	Key Tasks	Lead Person	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
(continued) Objective 1.2 - By August 31, 2015, increase the number of counties in expansion regions with CDSME workshops at least twice a year and the number of people reached. (all 33 counties to be served).	-Collect certificates of completion from attendees and enter data in spreadsheets.	Data Entry Specialist	X	X	X				X	X	X			
Objective 1.3. - By August 31, 2015, implement DSMP in at least five of the sever expansion regions and develop at least one large health care systems partner to embed the program in its organization.	**1.3a. Develop expansion plan for DSMP.**													
	-Assist regions in developing an expansion plan and timeline for DSMP, while sustaining CDSMP and ASMP.	Strong, Plass, Core Team	X	X	X									
	-Coordinate with regions and Stanford to cross train CDSMP Master Trainers in DSMP.	Strong, Project Coordinator	X	X										
	-Schedule and hold DSMP Leader Trainings.	Project Coordinator, Master Trainers	X	X			X		X	X	X			
	-Schedule/hold workshops for DSMP.	Region Teams	X	X	X	X	X	X	X	X	X	X	X	X
	-Collect data from workshops.	Data Entry Specialist			X	X	X	X	X	X	X	X	X	X
	-Enter data in spreadsheets.	Data Entry Specialist			X	X	X	X	X	X	X	X	X	X
	-Analyze and provide reports on data.	Leith						X				X		
	1.3b. Continue to partner with at least one large health system to explore embedding DSMP.													
	-Meet with partner on regular basis to implement DSMP successfully.	Strong, Leith, System Developer		X	X	X	X	X	X	X	X	X	X	X
	-Identify steps for billing as Medicare or Medicaid service: beneficiary requirements, accreditation, and recognition	Diabetes Program Director, Strong, and Plass			X	X	X	X						
	-Identify and problem solve challenges together with partner.	Strong, Plass, Diabetes Director				X	X	X	X	X	X	X	X	X
	-Develop a step-by-step process for navigating the requirements.	Strong, Plass					X	X	X	X	X	X	X	X
	-Implement steps for reimbursement as sustainability measure.	Strong, Plass, Diabetes								X	X	X	X	X

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Major Objectives	Key Tasks	Lead Person	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
Objective 1. 4 By August 31, 2015, ensure that low income, rural, African American, and Native American older adults have access to CDSME programs.	**1.4a. Continue to implement programs through AAA Regions.**													
	-Foster Aging/Public Health teams to reach underserved population groups.	Core Team	X	X	X	X	X	X	X	X	X	X	X	X
	-Continue to employ COAs as implementation sites to reach vulnerable elderly.	Region Leads and Teams	X	X	X	X	X	X	X	X	X	X	X	X
	-Strengthen and expand relationships with implementation sites, e.g., churches, low-income housing, FQHCs, and community health centers, etc.	Region Leads and Teams	X	X	X	X	X	X	X	X	X	X	X	X
	1.1b. Develop and nurture relationships with other organizations that serve target population.													
	-Nurture and develop at least one large delivery partner that reaches African Americans.	Core Team	X	X	X	X	X	X	X	X	X	X	X	X
	-Continue to partner with Catawba Indian Nation and identify strategies to embed and sustain the programs and offer multiple self-management options, e.g., CDSMP, ASME, DSMP.	System Developer, Project Coordinator, Region Lead	X	X	X	X	X	X	X	X	X	X	X	X
	-Assess partnerships periodically to assure that minorities are represented and engaged.	Core Team, Evaluator			X			X		X		X		
	-Monitor data and make adjustments if needed to reach target population.	System Developer, Evaluator				X			X		X		X	
	-Enlist help of Region Teams and other partners to provide more workshops in rural areas.	Leadership Team, Core Team	X	X	X	X	X	X	X	X	X	X	X	X
	- Employ strategies and messages that are culturally appropriate, using "lessons learned" and recommendations of marketing expert.	Health Communications Coordinator	X	X	X	X	X	X	X	X	X	X	X	X
Objective 2.1 - By August 31, 2015, integrate and embed programs with existing systems, e.g., aging, disability, faith-based, chronic disease programs.	**2.1a. Provide joint Aging and Public Health leadership to facilitate an integrated sustainable delivery system.**													
	-Convene quarterly Leadership Team meetings to strengthen strategies for integrating with health care and other systems and programs.	Strong, Plass	X			X			X			X		
	-Coordinate meetings with systems partners: Aging and Public Health both to participate.	Strong, Plass, System Developer	X	X	X	X	X	X	X	X	X	X	X	X
	-Convene SCPHA and HAPPI Task Force meetings.	Strong, Plass			X						X			
	-Assess degree to which sustainability plan is being implemented, and employ multiple strategies to achieve an integrated, sustainable services system with "no wrong door."	Leadership Team	X	X	X	X	X	X	X	X	X	X	X	X
	-Continue to integrate CDSME programs with Aging and Public Health priorities for an integrated approach.	Rivers, Strong, Plass	X	X	X	X	X	X	X	X	X	X	X	X

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Major Objectives	Key Tasks	Lead Person	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
(continued) Objective 2.1 - By August 31, 2015, integrate and embed programs with existing systems, e.g., aging, disability, faith-based, chronic disease programs.	-Monitor and evaluate partners' progress and degree of movement toward adopting and sustaining the programs.	Leadership and Core Team	X	X	X			X	X	X	X	X		
	2.1b. Develop effective multi-site delivery system partners.													
	-Maintain and strengthen existing relationships/partnerships.	Core Team, Regions	X	X	X	X	X	X	X	X	X	X	X	X
	-Provide TA to partners to help partners move toward embedding programs in their organizations and maintaining financial sustainability.	Plass, Strong, System Developer	X	X	X	X	X	X	X	X	X	X	X	X
	-Schedule regular meetings with all established partners (Dorn VA, Palmetto Primary Care, DAODAS, etc.) to assess progress toward reach goals and sustainability.	System Developer, Strong, Plass	X	X	X	X	X	X	X	X	X	X	X	X
	- Assess "readiness" of potential new partners.	System Developer	X	X	X	X	X	X	X	X	X	X	X	X
	-Continue to identify and engage new multi-site partners to discuss potential of implementing programs, especially large health systems, such as Medical Homes.	System Developer, Strong, Plass	X	X	X	X	X	X	X	X	X	X	X	X
	-Provide information about embedding programs in organizations from the beginning of the relationships.	System Developer, Strong, Plass	X	X	X	X	X	X	X	X	X	X	X	X
	-Assist partners in strengthening processes and practices that will lead to sustainability.	System Developer, Strong, Plass	X	X	X	X	X	X	X	X	X	X	X	X
	2.1c. Strengthen and expand effective support partners													
	-Strengthen and expand partnerships with chronic disease programs and other public health partners and initiatives for an integrated approach that support sustainable CDSME programs.	Plass	X	X	X	X	X	X	X	X	X	X	X	X
	-Strengthen and expand linkages with Aging programs and initiatives, such as the Veteran Directed Home and Community Based Services.	Rivers	X	X	X	X	X	X	X	X	X	X	X	X
	-Collaborate with health systems/health plans to serve as referral networks and explore potential for reimbursement or funding for services	Strong, Plass, System Developer	X	X	X	X	X	X	X	X	X	X	X	X
	-Schedule meetings with potential new support partners to explore roles, linkages, and next steps for working together	System Developer	X	X	X	X	X	X	X	X	X			
	2.1d. Embed and sustain programs within the Aging Network.													
	-Continue to provide leadership and guidance to Aging/Public Health region teams and promote continued collaboration.	Leadership Team, Core Team	X	X	X	X	X	X	X	X	X	X	X	X
	-Provide leadership and guidance to help all Aging partners to implement sustainability plans.	Strong, Plass, System Developer	X	X	X	X	X	X	X	X	X	X	X	X

Attachment D

Major Objectives	Key Tasks	Lead Person	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
(continued) Objective 2.1 - By August 31, 2015, integrate and embed programs with existing systems, e.g., aging, disability, faith-based, chronic disease programs.	-Share successful region models and processes between regions	State and region teams	X	X	X	X	X	X	X	X	X	X	X	X
	-Continue to place CDSME programs on the agenda at monthly LGOA/AAA meetings; share challenges and successes, and work with AAAs to champion programs and advocate for them in their designated areas.	Rivers	X	X	X	X	X	X	X	X	X	X	X	X
Objective 2.2 By August 31, 2015, enhance and formalize coordinated state and region processes for implementation and evaluation.	**2.2a. Provide joint DHEC/LGOA leadership for a coordinated processes at state, region, and local levels**													
	-Schedule Leadership and Core Team meetings to set timeline and priorities for Year 3 to accomplish integration and other project objectives and outcomes.	Strong, Plass	X	X	X									
	-Share staffing and resources across agency.	Rivers, Plass	X	X	X	X	X	X	X	X	X	X	X	X
	-Continue to integrate efforts with Arthritis Program.	Plass	X	X	X	X	X	X	X	X	X	X	X	X
	-Hold monthly conference calls with Aging and Public Health represented at State and Region Level.	Plass, Strong	X	X	X	X	X	X	X	X	X	X	X	X
	-Continue to develop new and improved automated processes for sharing information with partners for a seamless approach at the local, region, and state level.	Strong, Plass, System Developer	X	X	X	X	X	X	X	X	X	X	X	X
	-Continue to post workshop schedules on website so that region, state, and local level staff/partners can access the information.	Project Coordinator, Health Communications Coordinator	X			X			X			X		
	-Explore option for social networking media to heighten visibility and recruit participants to workshops.	Health Communications Coordinator	X	X	X									
	2.2b. Develop and implement centralized, coordinated intake, and referral, and marketing													
	-Contract with a marketing specialist for Phase 3 of the marketing campaign and approaches to sustain marketing efforts and programs.	Strong, Plass, Health Communications Coordinator	X	X	X									
	- Capture, document, and promote success stories of integration with ADRCs.	Leith, Core Team						X	X	X	X	X	X	
	-Identify strategies to further strengthen and sustain state, region, and local level collaboration and integration.	Leadership Team	X	X	X	X								
	-Continue to publicize call-in lines and other centralized, coordinated	Core Team, Regions	X	X	X	X	X	X	X	X	X	X	X	X

Attachment D

Major Objectives	Key Tasks	Lead Person	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
(continued) Objective 2.2 By August 31, 2015, enhance and formalize coordinated state and region processes for implementation and evaluation.	methods of promoting programs.													
	-Develop and provide radio and newspaper ads, releases, and public affairs interviews to continue to promote programs.	Health Communications Coordinator, Region Teams	X	X	X	X	X	X	X	X	X	X	X	X
	-Maintain and expand mail-out lists/emails to promote workshops.	Data Entry Specialist	X	X	X	X	X	X	X	X	X	X	X	X
	-With guidance from the marketing expert, enhance approaches to create high visibility of the program.	Core Team, Health Communications Coordinator	X	X	X	X	X	X	X	X	X	X	X	X
	2.2c. Maintain a centralized and coordinated evaluation process													
	-Review, revise as needed, and maintain fidelity monitoring surveys and processes that are centralized to assure fidelity to the program design	Leith	X	X	X	X	X	X	X	X	X	X	X	X
	-Develop fidelity leader self-monitoring forms for DSMP	Leith	X	X	X	X								
	-Continue to reinforce fidelity and provide TA to partners relative to fidelity issues	Leith, Core Team	X	X	X	X	X	X	X	X	X	X	X	X
	-Assess progression of partnerships, e.g., whether there has been progress and the degree to which there is true collaboration and cooperation and the extent to which integration is demonstrated.	Leith Leadership Team	X	X	X			X	X	X	X	X		
	-Hold quarterly team meetings to monitor progress, "check-off" milestones toward objectives and outcomes and determine if changes need to be made	Leith Leadership Team	X			X			X			X		
	-Establish milestones for each project objective for Year 3 to achieve project objectives and outcomes.	Leadership Team	X	X										
	-Maintain quantitative data collection from paper and/or online surveys to document participation in workshops	Leith Data Entry Specialist	X	X	X	X	X	X	X	X	X	X	X	X
	- Conduct qualitative data collection on collaborative and cooperative relationships at all levels and across organizations	Leith	X	X	X		X	X	X	X	X			
	-Hold final year meeting with Core Team and partners to share and document successes and challenges/barriers.	Leadership Team									X	X	X	
	-Prepare and submit final report for AoA and final evaluation report.	Leadership Team											X	X
	-Share findings with partners and decision makers.	Leadership Team												X

Project is statewide