Living Well Program in Maryland:
An Evaluation Report

Prepared for the Maryland Department of Aging

Center for Productive Aging
Towson University

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The evaluation of the Living Well Program in Maryland was conducted for the State Department of Aging by the Center for Productive Aging at Towson University. The evaluation design included data collection and analysis of program participant surveys, a process evaluation, and ongoing work with the six regions over the three year duration of the program.

A total of 897 Maryland elders completed the baseline survey when they began the program. There were 728 participants who finished the program and completed the follow-up survey, 81% of the participants. Those who completed the program were more likely than the drop-outs to have an active healthcare management style and a more active coping style to manage their chronic illness. Men were more likely than women to drop out of the program before completion. Those who participated in the follow-up survey reported that they had benefited through an increase in self-confidence (43%) and improvement in health care management; both at a statistically significant levels.

The process evaluation interviews and observations revealed a range of approaches to the program implementation across the six regions. Most of the program managers at the local level were pleased with their work with the Maryland Department on Aging and impressed with the curriculum and focus of the Stamford Chronic Disease Self Management Program. There were some challenges in the recruitment of lay leaders and reaching the participation goal set by the program. Outreach efforts varied across regions but posed a challenge for most programs. The most successful partnerships were developed with other community organizations that already had large numbers of older adults affiliated with them such as retirement centers and health facilities.

“Lessons learned” included a need for more support during the planning stage in order to develop an effective set of partnerships for the program, improved strategies for retaining lay leaders, and help with planning for the sustainability of the program after funding ends.
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I. Introduction

Much attention has been given recently to the concept of self-management of chronic disease for older adults. According to the 2008 Institute of Medicine (IoM) report, Retooling for an Aging America, effective models of care will require older adults to become active participants in their own care. The Maryland Department of Aging (MDoA) has taken a step toward this proactive model of care in the “Living Well: Take Charge of Your Health” program. MDoA received funding from the Administration on Aging (AoA) to implement the program developed by Stanford University, the Chronic Disease Self Management Program (CDSMP). The Living Well program is an opportunity for the state of Maryland to take a proactive stance in the care for older adults through creating person-centered partnerships in care management.

II. Center for Productive Aging Responsibilities and Activities

Towson University’s Center for Productive Aging (CPA) entered into a Memorandum of Understanding with the Maryland Department of Aging for the purpose of conducting an evaluation of its project, “Empowering Older People to Take More Control of Their Health Through Evidence-based Prevention Programs: A Public/Private Collaboration,” funded by the U.S. Administration on Aging. The goal of the project, entitled Living Well, is to encourage older people to take charge of their health by providing an evidence-based program. The evidence-based program of focus in Maryland is the Chronic Disease Self-Management Program (CDSMP), known as the “Living Well” program in Maryland, which was implemented in six Planning Service Areas (PSA).

The evaluation of the 3 year funded project consisted of two phases. The first phase focused primarily on program participant outcomes, collecting health and other data from participants as they began the program, and again 6 months after completion of the program.
The second phase is the process evaluation (Appendix D) which focuses on fidelity and sustainability factors that relate to the long-term viability of the Living Well program.

As the program evaluator, the CPA affiliates provided ongoing feedback to the Maryland Department of Aging (MDoA) to assure grant objectives were met and the Living Well program was implemented as designed. Dr. Donna Cox, the Project Principal Investigator, was the key liaison between the evaluation team, the Maryland Department of Aging, and the Counties and regional stakeholders. She worked to establish a collaborative arrangement between the MDoA Project Director and regional site stakeholders (AAA and Aging Service Provider Organizational [ASPO] representatives), maintained communication and stayed apprised of implementation issues in the regions. Telephone and email contacts with regional coordinators, site visits (see Appendix H for site visit questions), participation in “Grantee Jurisdiction” meetings and serving on the MDoA’s Evidence-Based Advisory Board were various strategies used by CPA staff to remain informed of changes that could affect fidelity of the program and implementation overall.

In-depth interviews with key stakeholders in each region were conducted face to face and/or via telephone as part of the process evaluation. CPA staff monitored program participation, confirmed baseline data collection packets were complete, ensured sites adhered to Internal Review Board requirements and implemented the collection of information from program participants six months after program completion.

Over the course of the 3 year project, the Center provided feedback on participant outcomes to be monitored, survey items to be included in the baseline survey instrument as well as other forms used to monitor program participation and lay leader performance. The CPA was responsible for preparing and submitting the application for Internal Review Board approval of the project. Staff also identified and recommended an appropriate survey instrument to be used for collecting follow-up data as well as
implemented the survey data collection. Staff provided expertise in the development of a “Living Well” course evaluation form (Appendix C) that regional sites could choose to implement to obtain timely feedback from participants about the Living Well course.

Program participation was monitored by CPA staff using attendance sheets and periodic reports were prepared to keep MDoA and other stakeholders informed of project progress. Evaluations of lay leader performance, conducted by regional coordinators, were submitted to CPA staff and reviewed to identify potential issues that could affect fidelity of the evidence-based program. The CPA was responsible for entering and analyzing participant self-report data obtained at baseline and 6 months following completion of the course. Staff also maintained a state database for MDoA for reporting purposes (i.e., basic program participant demographics, attendance at each session conducted in a course, dates and locations of each program offered, etc.) required for inclusion in the AoA Evidence-Based Disease Prevention Grantees Central Database.

The process evaluation protocol and stakeholder interview guide were developed by Dr. Donna Wagner, who directed the process evaluation. The process evaluation was based upon a series of in-depth interviews conducted by phone of program managers and staff including master trainers and lay leaders. Dr. Cox’s work with the local stakeholders and the MDoA staff was included in the specific interviews conducted. The specific process evaluation interviews (see interview schedule in Appendix to this document) were conducted during Year II of the project. A set of follow-up interviews were conducted during Year III to determine any changes that might have occurred.

**Summary of Towson University’s Responsibilities**

During the three year project period, the Center for Productive Aging at Towson University managed the evaluation activities and supported the Maryland Department of Aging in management and
oversight activities related to evaluating the implementation process of this evidence-based peer-led wellness program. Our specific responsibilities included the following:

- Preparation of the IRB application submitted to the Towson University’s IRB and ensuring that the IRB approvals were in place and that the research adhered to these approvals;
- Monitoring of the implementation of the program to ensure fidelity to the Living Well program and (in Montgomery County) the Active for Life program;
- Developing the qualitative and quantitative evaluations measures and methods for data collection;
- Collecting data on program participants at baseline and again at six months;
- Analyzing data to explore participant characteristics, changes over time, factors in retention of program participants, and correlates.
- Conducting a process evaluation to determine if project objectives were met and provide information that will support future evidence-based programming efforts within the State of Maryland.
- Assist in the dissemination of findings and outcomes associated with the project as appropriate.

### III. Evaluation Research Design

The evaluation research design relies upon both quantitative and qualitative data collection. A baseline survey (see Appendix A) of all program participants was administered to collect information that would be used in program reports as well as in the data analysis contained in this report. At six months, a post-test survey (see Appendix B) was administered to examine changes. As per our contract with the State of Maryland, we also designed an instrument for assessing the satisfaction of the program participants after completion of the program, also in the Appendix of this report. This survey was not used by program sites. Program managers found the paperwork associated with the program to be burdensome and a new survey of participants was not viewed as helpful to the work by local site managers.
The other component of the evaluation research design was the process evaluation data collected to explore the implementation issues and lessons learned by those who were involved in the implementation of the program. Two interviews – open-ended – were conducted with site managers, trainers and others involved in the program. The first interview was conducted during the Summer of 2008, the end of the second year of work. The second interview was conducted during the Summer of 2009 to examine any changes that had occurred and ask questions about sustainability of the program. The interview schedules can be found in the Appendix D. The evaluation team used the information collected as well as notes and project meeting documents to develop the process evaluation contained in this report.

IV. Participant Data

Participant Characteristics

A total of 897 participants completed the baseline survey (Appendix A) before they began the “Living Well” program. Table I displays the individual characteristics of these participants. The average age of the group was 74 years and most (81%) were female. The majority of participants described themselves as Caucasian (81%) and 25% described themselves as Black. One-third of the participants were married, slightly more than one-third (39%) were widowed. About half of the group reported that they lived alone and a bit more than a third of the participants were living with someone else. The group was an educated group with the majority reporting some college-level education. Most had insurance (98%) and the majority of the group (71%) had income higher than $10,210 annually.
Table I: Individual Characteristics of Participants (N=897)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>24-100</td>
<td>74 (10.6)</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>18.8</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>80.7</td>
<td></td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Hispanic White</td>
<td>66.9</td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>24.5</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>6.5</td>
<td></td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>33.1</td>
<td></td>
</tr>
<tr>
<td>Widowed</td>
<td>38.8</td>
<td></td>
</tr>
<tr>
<td>Divorced</td>
<td>14.6</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>12.3</td>
<td></td>
</tr>
<tr>
<td><strong>Number of People in the Household</strong></td>
<td>1-7</td>
<td>1.7 (.92)</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some High School</td>
<td>11.0</td>
<td></td>
</tr>
<tr>
<td>High School Graduate</td>
<td>23.7</td>
<td></td>
</tr>
<tr>
<td>Some College</td>
<td>25.2</td>
<td></td>
</tr>
<tr>
<td>College Graduates</td>
<td>18.5</td>
<td></td>
</tr>
<tr>
<td>Graduate School</td>
<td>19.6</td>
<td></td>
</tr>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than $10,200/year</td>
<td>23.1</td>
<td></td>
</tr>
<tr>
<td>More than $10,200/year</td>
<td>70.7</td>
<td></td>
</tr>
<tr>
<td><strong>Insurance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has no insurance</td>
<td>2.2</td>
<td></td>
</tr>
</tbody>
</table>

Table II illustrates the health status of the participants as reported on the survey instrument. Participants rated their own health, the number of Activities of Daily Living (ADL) with which they had difficulty, and their chronic conditions. Self-perceived health was rated on a scale of 1 (poor) to 5 (excellent). The mean score for the group was 2.9 – a “good” score. ADL limitations were relatively low with an average score of 1.3. About half of the group reported they had no ADL limitations. The most commonly reported chronic illnesses were hypertension (61%), arthritis (54%), and diabetes (29%).
Table II: Health Status of Participants (n=897)

<table>
<thead>
<tr>
<th>Health Indicators</th>
<th>Range/Categories</th>
<th>Mean (SD)/Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Rated Health</td>
<td>1(poor)-5(excellent)</td>
<td>2.9 (.82)</td>
</tr>
<tr>
<td>Number of Daily Activities</td>
<td>0-6</td>
<td>1.3 (1.7)</td>
</tr>
<tr>
<td>with Difficulty</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Health Conditions</td>
<td>Has diabetes</td>
<td>29.0</td>
</tr>
<tr>
<td></td>
<td>Has hypertension</td>
<td>60.6</td>
</tr>
<tr>
<td></td>
<td>Has pulmonary disease</td>
<td>18.6</td>
</tr>
<tr>
<td></td>
<td>Has arthritis</td>
<td>53.7</td>
</tr>
<tr>
<td></td>
<td>Has heart disease</td>
<td>19.5</td>
</tr>
</tbody>
</table>

As described earlier in this document, there were five counties and one combined county service area. Table III shows the number and percentage of the entire participant population by their county. The three county areas that was a combined service included Caroline County, Kent County and Talbot County; three counties that make up the Upper Eastern Shore area. Throughout this report those counties and their participants are referred to as Upper County.

Table III. Participant Population by County

<table>
<thead>
<tr>
<th>County</th>
<th>Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baltimore County</td>
<td>228</td>
<td>25.5%</td>
</tr>
<tr>
<td>Caroline County</td>
<td>24</td>
<td>2.7%</td>
</tr>
<tr>
<td>Howard County</td>
<td>97</td>
<td>11.0%</td>
</tr>
<tr>
<td>Kent County</td>
<td>49</td>
<td>5.5%</td>
</tr>
<tr>
<td>Montgomery County</td>
<td>265</td>
<td>29.9%</td>
</tr>
<tr>
<td>Prince Georges County</td>
<td>69</td>
<td>7.7%</td>
</tr>
<tr>
<td>Talbot County</td>
<td>24</td>
<td>2.7%</td>
</tr>
<tr>
<td>Not Ascertained</td>
<td>10</td>
<td>1.1%</td>
</tr>
</tbody>
</table>
A range of health indicators and health behaviors were assessed using the baseline survey (see Appendix A). In addition to self-assessed health, chronic illnesses and the Activities of Daily Living, participants were asked to describe their health behavior related to physicians’ visits (making a list before the visit, asking questions and discussion issues), coping with their symptoms, confidence in their ability to manage symptoms and tasks that were affected by symptoms, physical activities such as walking, stretching and the like, and the frequency of health care utilization – visits to the physician, emergency room visits, and hospitalizations. Table IV displays selected health care utilization of the participants.

**Table IV: Participant Health Care Utilization**

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>MEASURE</th>
<th>NUMBER – PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Visits# During 6 months:</td>
<td>None</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>1-3</td>
<td>496</td>
</tr>
<tr>
<td></td>
<td>4-8</td>
<td>208</td>
</tr>
<tr>
<td></td>
<td>9+</td>
<td>92</td>
</tr>
<tr>
<td>Emergency Room Visit 6 months:</td>
<td>None</td>
<td>590</td>
</tr>
<tr>
<td></td>
<td>Average</td>
<td>.40</td>
</tr>
<tr>
<td>Prepare List of Questions for MD:</td>
<td>Never</td>
<td>121</td>
</tr>
<tr>
<td></td>
<td>Almost never</td>
<td>107</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
<td>241</td>
</tr>
<tr>
<td></td>
<td>Fairly often</td>
<td>96</td>
</tr>
<tr>
<td></td>
<td>Very often</td>
<td>129</td>
</tr>
<tr>
<td></td>
<td>Always</td>
<td>166</td>
</tr>
<tr>
<td>Ask Questions MD</td>
<td>Never</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td>Almost never</td>
<td>51</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
<td>174</td>
</tr>
<tr>
<td></td>
<td>Fairly often</td>
<td>172</td>
</tr>
<tr>
<td></td>
<td>Always</td>
<td>240</td>
</tr>
<tr>
<td>Talk about personal Matters</td>
<td>Never</td>
<td>92</td>
</tr>
<tr>
<td></td>
<td>Almost never</td>
<td>95</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
<td>211</td>
</tr>
<tr>
<td></td>
<td>Fairly often</td>
<td>131</td>
</tr>
<tr>
<td></td>
<td>Always</td>
<td>180</td>
</tr>
<tr>
<td>Visit Alternative HLth Professional</td>
<td>No</td>
<td>601</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>250</td>
</tr>
<tr>
<td>Visit Psychologist/Counselor</td>
<td>No</td>
<td>757</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>100</td>
</tr>
<tr>
<td>Number of overnights in hospital</td>
<td>None</td>
<td>676</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>------</td>
<td>-----</td>
</tr>
<tr>
<td>1-2 nights</td>
<td>98</td>
<td>11.0%</td>
</tr>
<tr>
<td>3+</td>
<td>13</td>
<td>1.4%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nights in long term care facility</th>
<th>None</th>
<th>785</th>
<th>87.8%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-7 nights</td>
<td>24</td>
<td>2.6%</td>
<td></td>
</tr>
<tr>
<td>8+</td>
<td>19</td>
<td>1.7%</td>
<td></td>
</tr>
</tbody>
</table>

Participants were asked to indicate how discouraged they were about their health status, how fearful they were, how frustrated they were and whether or not their health was a “worry” to them. There were 169 participants (19.5%) who reported they were never discouraged about their health; more than half (54%) reported they were discouraged a little or some of the time. More than a quarter (26%) reported they were fearful about their health, 30% reported they found their health to be a worry and 24% reported being frustrated by their health. Most participants (92%) reported a range of fatigue levels and 84% reported pain on a regular basis.

When asked about their current level of activity or exercise, 32% reported they never did stretching exercises, 22% reported never walking and 69% reported they never used exercise equipment at the beginning of their participation in the “Living Well” program.

**Profile of Participants Who Completed the Program**

Program completion was operationalized as completing at least 4 out of the 6 sessions offered. There were 728 participants (81%) who completed the program. In order to better understand the factors that influence participation in the peer-led wellness program, we compared the characteristics of those who completed the program with those who dropped out of the program. The average age of participants completing the program was 74 years and most were women (82%). A third of them were married and 39% were widowed. The average health assessment of the participants who completed the program was 2.91 on a five point scale – average rating of “good”. Nearly half (49%) reported they could manage all of the Activities of Daily Living (ADL) independently. Hypertension, arthritis and diabetes were the most commonly reported chronic illnesses for this group as they were for the “average” program participant.
The majority of those who completed the Living Well program (64.4%) reported having at least some college. However, nearly one-fourth (23.5%) reported incomes of less than $10,200 per year.

### Profile of Participants Who Dropped out of the Program

There were 162 (19%) participants who dropped out of the program (completing no more than 3 sessions). The average age of those who dropped out of the program was a bit higher than those who continued (74.6 in contrast to 74.3) in the program but the difference was not statistically significant. There were a higher percentage of men who dropped out than the percentage of men who completed the program (26% of those who dropped out were men compared with 17.3% of the completion group). More than half of this group (52%) reported that they had no difficulty with the Activities of Daily Living. Table V compares the participants who completed the program with those who dropped out of the program.

### Table V: Comparison of Participants who Completed Program with Drop-Outs

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Range/Categories</th>
<th>Completed</th>
<th>Drop-Out</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Average</td>
<td>74.3 years</td>
<td>74.6 years</td>
</tr>
<tr>
<td>Gender</td>
<td>Male</td>
<td>17%</td>
<td>26%</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>82%</td>
<td>74%</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td>Non-Hispanic White</td>
<td>67%</td>
<td>79%</td>
</tr>
<tr>
<td></td>
<td>Black</td>
<td>25%</td>
<td>24%</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>Marital Status</td>
<td>Married</td>
<td>33%</td>
<td>35%</td>
</tr>
<tr>
<td>Education</td>
<td>Some College</td>
<td>64%</td>
<td>66%</td>
</tr>
<tr>
<td>Income</td>
<td>LT $10,200/years</td>
<td>24%</td>
<td>23%</td>
</tr>
<tr>
<td>Health Assessment</td>
<td>1 (poor) to 5 (excellent)</td>
<td>2.91</td>
<td>2.78</td>
</tr>
<tr>
<td>Activities of Daily Living</td>
<td>Needs No Help With</td>
<td>50%</td>
<td>52%</td>
</tr>
</tbody>
</table>
As can be seen on the comparative table (Table V) above, the only socioeconomic difference between those who completed the program and those who dropped out is gender, with men more likely than women to drop out. There were, however, some health differences between the two groups that were statistically significant. Self-rated health, 2.91 average among those who completed the program and 2.78 among those who dropped out, was statistically significant at the .07 level. In addition, there was a statistically significant difference between the two groups in their reported incidence of arthritis with those dropping out more likely to report this condition than those who completed the program (.01 level of significant difference).

**Stated Reasons for Not Completing the Program**

The majority of participants who did not complete the program reported that they had to leave the program due to health problems (92%). The remainder of those not completing the program identified family problems (n=2), time problems (n=3), and that the program was either not needed or not helpful (n=4).

**Health Comparisons Between Drop-outs and Those who Completed Program**

As discussed in the previous section, those who completed the program and those who dropped out differed on their self-perceived health status and the presence of arthritis. In addition, those who completed the program reported more stretching exercise time than those who dropped out. Other activity levels assessed (walking or exercise equipment use) was not different between the two groups.

A new measurement was developed to assess the extent to which participants were actively managing their health care interactions with their physician. This measurement consists of variables including whether the participant prepared a list of questions for their doctor, whether they asked questions during the appointment and whether they discussed personal problems that might be related to their illness. Each of the three items had a 6 point scale ranging from 0 (never) to 5 (always). On average, participants were more likely to ask questions and discuss their concerns (3.4 out of 5 points)
than to prepare a list of questions (2.6 out of 5 points) or talk about personal problems (2.8 out of 5 points). Figure 1 illustrates the Health Care Management average scores for the program participants.

![Health Care Management: Average Score (out of 5)](image)

**Figure 1: Health Care Management Average Score (out of 5)**

- Prepare list for MD: 2.54
- Ask Questions: 3.35
- Talk about personal matters: 2.80

Figure 2 illustrates the average scores for a second new measurement – coping style – that was developed by combining five variables, each of which assessed the extent to which the respondent had developed coping mechanisms to deal with concerns about their health and/or pain or unpleasant symptoms. These included trying to feel distant, playing mental games or singing songs to keep their mind off the discomfort, practicing progressive muscle relaxation, practicing visualization or guided imagery and/or talking to self in positive ways. Response categories ranged from never (0) to always (5).
FIGURE 2: Coping Style

Average Scores:

- Feeling distant: 1.5
- Visualization: 1.3
- Mental games: 1.6
- Positive Talk: 2.3
- Relaxation: 1.3

Table VI, a comparison of health and self-care management behaviors between those who completed the program and those who dropped out illustrates the differences between these two groups on medical care utilization, physical activities, coping style and health care management. Those who completed the program had better health care management practices than those who dropped out; a statistically significant difference. In addition, drop-outs were more likely to use emergency room services. And, finally, there was a statistically significant difference between the two groups on their coping style. Those who completed the program had a more active coping style than those who dropped out.
Table VI: Health and Self-Care Management Between Completers and Drop-Outs

<table>
<thead>
<tr>
<th>Outcome Indicators</th>
<th>Categories</th>
<th>Complete</th>
<th>Drop-Outs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of visits to MD</td>
<td>Mean</td>
<td>4.16</td>
<td>4.79</td>
</tr>
<tr>
<td>Number of ER visits</td>
<td>Mean</td>
<td>.35</td>
<td>.61 *</td>
</tr>
<tr>
<td>Physical Activities:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stretching</td>
<td>Mean</td>
<td>1.40</td>
<td>1.13 **</td>
</tr>
<tr>
<td>Walking</td>
<td>“ “</td>
<td>1.65</td>
<td>1.49</td>
</tr>
<tr>
<td>Exercise Equipment</td>
<td>“ “</td>
<td>.60</td>
<td>.65</td>
</tr>
<tr>
<td>Health care management</td>
<td>0-15 range</td>
<td>8.9</td>
<td>8.2 ***</td>
</tr>
<tr>
<td>Coping Style</td>
<td>0-25 range</td>
<td>5.3</td>
<td>4.9***</td>
</tr>
</tbody>
</table>

* .016 sig.
** .015 sig.
***.05 sig.

In addition, we examined the difference between the two groups in how their chronic condition(s) affects their life and their confidence in the ability to do things in spite of chronic disease. There were no statistically significant differences between the two groups on these dimensions.

Summary of Group Differences

In examining the differences between those who completed the program and those who dropped out, we find that men were more likely to drop out than women. Those who remained in the program were more likely to have an active healthcare management style, a more active coping style and to have already been involved in some stretching exercises when they started the program.

Longitudinal Analysis

All participants were surveyed with a follow-up survey administered six months following completion of the six week course (see Appendix B). The survey repeated measures that were on the initial survey as
well as some new measures. Follow-up survey forms were sent to the 728 participants who completed the program. There were 314 completed surveys returned to us for a 43% return rate. We were interested in examining any longitudinal changes over the six month period to see how the program might have influenced health management behaviors of the participants. Our analysis focused on health indicators as well as self-care behaviors. Table VI illustrates the descriptive data for these longitudinal data.

In the self-rating of an individual’s health status, a little over half reported no change over the time we were following them with slightly more reporting an improvement than reporting a decline in their subjective health. More than one-third of the respondents (34.4%) reported that they had a decrease in their visits to their physician’s office with slightly more (35.7%) reporting an increase in physician’s visits. More than half reported that their visits to the emergency room remained the same.

About one-fifth of the respondents reported an increase in level of interference health issues presented in conducting daily activities and nearly one-third (29.6%) reported a feeling that this interference had decreased. The largest change was in the area of self-confidence with nearly half of the respondents reporting that their self-confidence had improved (43%), only 5.7% reported their self-confidence had remained the same and less than a quarter (23.6%) reported a decrease in self-confidence. Table VII illustrates selected changes over time.
Table VII. Longitudinal Analysis (n=314)

<table>
<thead>
<tr>
<th>Health Status/Care Indicators</th>
<th>Change Status</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Rated Health</td>
<td>Improved</td>
<td>20.7</td>
</tr>
<tr>
<td></td>
<td>Same</td>
<td>52.5</td>
</tr>
<tr>
<td></td>
<td>Worsened</td>
<td>18.2</td>
</tr>
<tr>
<td>Visits to physician’s office</td>
<td>Increased</td>
<td>35.7</td>
</tr>
<tr>
<td></td>
<td>Same</td>
<td>19.1</td>
</tr>
<tr>
<td></td>
<td>Decreased</td>
<td>34.4</td>
</tr>
<tr>
<td>Visits to emergency room</td>
<td>Increased</td>
<td>13.1</td>
</tr>
<tr>
<td></td>
<td>Same</td>
<td>57.6</td>
</tr>
<tr>
<td></td>
<td>Decreased</td>
<td>11.4</td>
</tr>
<tr>
<td>Feeling daily activities interfered</td>
<td>Increased</td>
<td>21.3</td>
</tr>
<tr>
<td></td>
<td>Same</td>
<td>41.1</td>
</tr>
<tr>
<td></td>
<td>Decreased</td>
<td>29.6</td>
</tr>
<tr>
<td>Self-confidence</td>
<td>Improved</td>
<td>43.0</td>
</tr>
<tr>
<td></td>
<td>Same</td>
<td>5.7</td>
</tr>
<tr>
<td></td>
<td>Decreased</td>
<td>23.6</td>
</tr>
</tbody>
</table>

In an analysis of 821 participants who participated in the Chronic Disease Self-Management Program used in the “Living Well” project, Lorig, et al (2001) found that, over a two year period of time, there was a reduction in health care utilization, improvement in the extent to which participants worried about their health and self-efficacy. Limited improvements were observed in self-perceived health measures and energy and fatigue. We examined changes over time and found no statistically significant improvements in health care utilization patterns but did find improvements in both health care management (sig. .005) and overall confidence in their ability to manage their daily lives (sig. 000).
V. Cost Analysis

Lorig, et al (2001) found that participation in the CDSMP program (implemented as “Living Well” in Maryland) resulted in cost savings as a result in reduced use of emergency room services, hospitalizations and physician visits. For our population we observed a reduction in Emergency Room visits between the baseline survey and the follow-up survey. Average use at baseline was 1.63 visits to the ER, at follow-up this had dropped to 1.51 visits. Based on an average ER visit cost of $307 (AHQR, 2005), the total estimated cost of ER visits for this group decreased from $57,528 at baseline to $54,162 at follow up.

The average physician visits increased slightly between baseline and follow-up. There was an average of 4.28 visits per participant at baseline and 4.91 at follow up. This slight increase in visits does not necessarily reflect a cost increase as a result of participation in the program, however. One of the significant changes observed for those who completed the program was a higher level of health care management behavior. Participants were more likely to report that they made a list of questions, asked questions and discussed personal matters with their physicians than when they began the program. This change might result in better health outcomes over time if they are sustained and more than offset the small increase in physicians’ visits.

VI. Process Evaluation Results

Most interviewees were administrators, managers or coordinators; two were master trainers and one was a consultant. Because of the differences between and among counties and the environment in which they are operating, each program has developed its own unique way of operating. One county coordinates its efforts with a community college (Chesapeake College) and gets support from faculty at the college in the training and recruitment of lay leaders as well as participants. The coordinator provides liaison
services between the county program and the college. Another county (Prince Georges) works with churches to support the program. All of the interviewees were actively involved in the program in their respective role in addition to other responsibilities for the county/senior center or other agency where they were employed.

KEY TOPIC AREAS

**Topic 1: Fidelity**

Maintaining the fidelity of the curriculum is of key importance when implementing an evidence-based program. The training that was provided to the program managers was effective in communicating this importance and all of the respondents were able to describe the importance of fidelity in the work and the steps they took to maintain it. The majority of respondents indicated that there were no fidelity issues. One respondent reported that one trainer was bringing in outside material and they modified her behavior; another reported they had to stop using one lay leader.

**Topic 2: Motivation for involvement in the program**

When asked why their agency became involved with the Living Well project some respondents indicated that the Program fit with other activities in which they were involved such as senior center programming and mental health services. A number of interviewees recognized a need for the program for the men and women in the area. In particular, they described those in their service areas as a population with chronic illness and many who may be isolated as a result. Others responded that it was a good fit between the agency’s mission and goals to work with people with chronic illness. One respondent stated, “We see evidence-based programming as the wave of the future and wanted to get in on the ground floor.”

Respondents were asked about their personal expectations regarding the benefits to the participants or the agency. Personal and professional expectations were interwoven. Interviewee narratives about Program experiences helped us understand the importance of the work they believed they were doing.
example, we learned that one participant who was in a wheelchair when they started the program now rides a bike daily.

Comments around “goodness of fit” included a fit between program and agency and also between the needs of the participants. Of particular importance to the professionals involved in implementing the program was the promise of an improved quality of life for those they serve. Comments that were made about this benefit of the program included: the program would “improve the quality of life of older adults” and would “enhance their feelings of self-control”, “That it would help people recognize that they could live a healthy lifestyle even though they may have one or more chronic conditions; it would help them be good self-managers.”

**Topic 3: Concerns**

Respondents expressed a number of concerns including recruitment and retention of participants and lay leaders. Reaching the numbers requested by the grant/program was difficult and the outreach effort was very intense. The recruitment of lay leaders continues to be a problem for some sites. Some interviewees linked the recruitment and retention issues to programming and the level of education of participants, indicating that the program may be more appropriate for those with higher levels of education, but not necessarily for all of the older adults in their service area. It was suggested that there be two levels of programming based on the education of participants – one for older adults with higher levels of education, one for those with less. Transportation was also cited as a problem for participants.

Concerns about the ability to train and operate sessions while maintaining the documentation and paperwork was a common theme. And finally, some indicated that there was no understanding of the program and a lack of leadership on the part of the “mentoring agency” “which gets a significant amount of the funding (25%) for doing nothing.”
**Topic Area 4: Expectations Realized?**

When respondents were asked whether or not their expectations had been realized a variety of responses were reported. For example, one interviewee stated, “My personal expectations were not realized.” And another, “…the core of living well is the assumption that individuals want to take personal responsibility for their circumstances. I’m not sure that is a safe assumption…at least in my service area”. Some indicated that time was an issue and that it was difficult to keep up with the “demands of the program”. Others were disappointed about the sustainability aspect of the program, reporting that at first there was a lot of involvement but that the next session was more difficult to get Senior Centers on board because of a [perceived] lack of interest on the part of potential participants.

Others were more positive in their responses: “Yes, my expectations were realized. We have created a partnership with a HMO and expanded our work.” “Expectations have been exceeded. I have been absolutely amazed at how invested everyone who came to these sessions were amazed at the shift that occurred during those 8 weeks.”

**Topic 5: Recruiting & Retaining Master Trainers and Lay Leaders**

Most respondents reported 3-4 master trainers, one respondent reported that there were 32 master trainers listed. The first attempts at recruiting lay leaders were somewhat easy and one respondent reported a waiting list; second attempts proved to be very difficult. One respondent stated that it was “Extraordinarily difficult to get lay leaders.” Some felt that those who were actual employees with the agency stay with the program, volunteers on the other hand, had high attrition rates. One respondent reported that none of their lay leaders ever volunteered a second time.

Some felt the reasons for this were related to money, transportation, availability of classes, and sometimes, personal reasons (injury, illness or caregiving issues). There was no money while training and that was sometimes a problem. Working with a community college worked best because the lay leaders
could become adjunct faculty and be sustained. Some agencies paid a small stipend ($100) but it was often not enough to cover gas prices or time.

**Topic 6: Participant Recruitment**

The majority of sites reported no trouble initially recruiting participants. In a few cases sites have had to cancel because of low numbers; sometimes cancellations occur not because of low numbers but because there is no lay leader. One respondent felt that there was an inverse relationship between the need for the program and the interest.

For those sites that reported good initial participation but experienced a drop later, recruitment strategies were explored. For example one respondent stated, “At first it was easy, now we have to come up with new recruitment strategies. We have used post cards which were very successful, went to fairs and did telephone follow-up.” Others indicated that “Working with a medical facility is great because they get reimbursed for screenings and we coordinate our training with these screenings.”

**Topic 7: Obtaining “buy in” to the program**

When asked about obtaining buy-in to the program some respondents reported that it had been difficult. “It’s been tough…we had the senior centers but getting health departments and others on board isn’t easy.” Those that found it more difficult reported complications due to lack of funding support from host agency and bureaucratic demands of the record-keeping and data collection and management.

Others were more successful in their efforts to implement and get other organizations on board, “We used e-mails, letters and phone calls to invite a broad base of folks to become involved. Faith-based organizations have been great.” Collaborative efforts on a large scale seemed to work. One group created an advisory board made up of County organizations.

**Topic 8: Successful partnerships**

Organizations with the most successful partnerships were reported with established organizations like a health club or retirement village, housing facilities that have space for the class and available
participants. One respondent reported that their local hospital has ongoing classes and the library hosts classes. Some reported the least successful were with those organizations that don’t already have groups of older people who could participate.

**Topic 9: Partners and the Process**

When addressing questions related to partnering and the process of implementation in general, respondents pointed to the challenges they faced. Most felt the State Department on Aging was “great” but there were barriers at the county level and with the mentoring agency, accessing the medical community was a problem and some had difficulty understanding the program from the very beginning including understanding the concept of evidence-based programs and related jargon. It was suggested that there be a manual related to the program. There is a manual and additional detailed information at the Maryland Department on Aging website for the program. However, not all of the respondents knew or remembered these resources.

Discussions about the process included successful marketing strategies that were employed. Some found success through marketing the program through physicians, word of mouth, churches. Others used media sources such as shopper circulars, newspapers and flyers. Some respondents pointed to their lay leaders as their successful marketer. Other strategies included senior television stations and the aging network.

**Topic 10: Satisfaction**

All respondents were either very satisfied or somewhat satisfied. The majority of those interviewed discussed the need for more help from Howard County and wished that they had had a more positive mentoring experience (Howard County). There were some problems reported with survey and evaluation data and the maintenance of documentation (see Topic 7 above).
**Topic 11: Advice for other AAA’s**

Do It! Get Involved…it’s astonishing.

Try to get as many partners to help it succeed.

Have Master Trainers get in touch with Stanford – they’ll tell them who the correct partners are.

Try to work with local agencies as much as possible.

Give yourself enough time to plan strategies for marketing the program, recruiting host sites and participants.

Visit the Maryland Department on Aging website to look at the blueprint.

Assess whether there is an audience looking for this type of program. Determine whether you have extra staff time.

**Topic 12: Sustainability**

Sustainability of the program over the long term was a recurring theme among interviewees. Some reported that the expectations of the program administration were “outrageous” and that was too much paperwork and record-keeping. One interviewee commented stated, “When we started we had no idea how complicated the program would actually be.”

Some respondents suggested partnering with a community college to share lay leaders and master trainers. Others felt that as long as they had the space to hold the training for no cost, they would be okay. Efforts were being made by others to identify partnerships with medical facilities/professionals and perhaps Medicare reimbursement. Some respondents reported that the program would be embedded within a hospital partner’s services and they will carry it out.
Most pointed to funding as an issues related to sustainability. Only one lay leader said she was able to continue without funding. “It’s unrealistic to think we’re going to sustain it….our agency will only offer it if it’s funded, seniors won’t buy into it unless it’s free.” Some planned to charge people for the cost of the book and CD on a sliding scale.

VII. Lessons Learned

The Living Well Program in Maryland was an exceptionally successful program in many ways. Nearly 1,000 Maryland elders participated in the program and for those who stayed with the program, there were positive benefits and improvement in participants’ self-confidence and health management behaviors. Participants had reduced emergency room use and improved their ability to effectively communicate with their physician during office visits. Anecdotally there were many personal success stories about dramatic functional improvements as a result of the Living Well Program. For some participants, the program was life altering in its effects.

For the gerontological professionals in the State of Maryland, the experience was positive as a result of the benefits that accrued to those they served. Many of the program professionals were highly motivated by their involvement in the effort to help older adults take charge of their own health and better manage their chronic disease. The six PSA’s were active in their involvement and worked diligently to overcome obstacles that they encountered during the implementation of the program. And, finally, there are lessons learned by these professionals and shared with us to help with future program implementation in the state.

- It would be helpful to provide more support to new projects at the planning stage. Program professionals involved in the past three years were very enthusiastic about the training they received from the CDSMP staff and equally enthusiastic about the promise of the peer-led program to create change in the lives of those they served. Similarly, they were positive about
the role of the MDoA staff. However, each county or PSA was somewhat on its own when it came to developing the partnerships necessary to start a successful program. Implementation at the local level is the most complicated part of any new community program. Implementation is also very time-consuming. New projects would benefit from more intensive support and help in the implementation of the program and, in particular, in planning the steps that are necessary to get a program up and running with the correct mix of partners and people. *This could be accomplished by creating a mentorship program between a new service area team and an experienced team that was designed specifically to address planning issues.*

- The consultation model that was developed between Howard County and the PSAs was not viewed as a positive one by most professionals involved. *A new mentorship model should focus on implementation at a community level with adequate lead time and with specific expectations negotiated between each PSA and the MDoA.*

- Additional resources are necessary if the paperwork and documentation is to be maintained appropriately. In an evidence-based program, this aspect of the program can provide valuable information to the program managers on an ongoing basis if it is maintained in a timely fashion. We believe that a more proactive role can be played by the MDoA in this regard if additional resources were available. Specific steps that would help local PSAs implement a program would include (1) an identified resource person who is available as an “consultant” to each new agency as they plan for their future; (2) an interactive website or listserve that would allow professionals at the local level to consult with one another; and, or (3) more support and assistance with the collection of data including reviews of data as it was collected, reminders and recognition of the sites who do a good job of submitting their data and reports.

- The problems associated with lay leaders require some attention as the program goes forward. Too many sites reported high drop-out rates of the lay leaders. Since these leaders are an integral
component of the program itself, it would be worthwhile to convene a small group of managers, trainers and lay leaders to discuss and devise strategies that would improve the retention of these critical actors in the program.

- A very high percentage of participants (81%) completed the program – a positive indicator of not only the quality of the program and its relevance to older adults but to the quality of the managers and trainers involved. However, there were data suggesting that men were more likely than women to drop out of the program and that the drop-outs were more likely to have arthritis and somewhat lower levels of self-assessed health at baseline. As the program goes forward, it would be a good strategy to reach out to the participants who have lower self-assessed health and who are men to encourage their continued participation in an effort to retain them in the program.

- Completing the program was associated with improved confidence in one’s ability to manage their disease and improved health care management behavior. Both of these improvements have important implications for both the quality of life of the participants and health care utilization. We found a drop in emergency room use among those who completed the program which has cost-savings implications. As the program goes forward it is likely, based on other research using this program, that additional benefits to both older adults and the health care system could be forthcoming.
APPENDIX A

ID #__________________________________________

“Living Well... Take Charge of your Health” Survey

Class Location:________________________________________________

Date of First Class:_____________________________________________

Lay Leader:___________________________________________________

Lay Leader:___________________________________________________

Name: _________________________________________________

Address:______________________________________Zipcode:________

Telephone: __________________ Email: __________________________

Date of Birth:_____________ Sex: ☐ Female ☐ Male

The following information may help the state save money.

I have the following insurance type? (Please check all that apply)

Medicare________

Medicaid________

Other________

None________

Does your income exceed? (Please check which one applies to you)

$10,210 ☐ Yes ☐ No
Ethnic Origin (check ☐ only one)
☐ White (Alone)- Non-Hispanic ☐ Black or African American (Alone)
☐ White (Alone)- Hispanic ☐ Native Hawaiian or Other Pacific Islander (Alone)
☐ American Indian/Alaskan Native (Alone) ☐ Mixed ethnicity
☐ Asian (Alone) ☐ Other:______________________

Marital Status: (check ☐ only one)
☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Highest Grade Level: (check ☐ only one)
☐ Less than high school ☐ Some high school ☐ High school graduate
☐ Some college or vocational school ☐ College graduate ☐ Graduate school or beyond

Please indicate how many people live in your household, including yourself?
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 or more

Do you speak a different language other than English at home?
☐ Yes ☐ No

Please indicate below which chronic condition(s) you have:
☐ Diabetes ☐ High blood pressure ☐ Asthma ☐ Heart disease ☐ Cancer ☐ Arthritis

☐ Emphysema or Chronic Obstructive Pulmonary Disease

☐ Other lung disease: __________________________________________________________

☐ Specify other chronic condition _____________________________________________

In the past six months how many times did you visit a physician? ________
In the past six months how many times have you been hospitalized? ________
In the past six months how many times have you been to the emergency room? _______

GENERAL HEALTH

1. In general, would you say your health is: (check ☐ only one)

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor
### SYMPTOMS

How much time during the past 2 weeks...

<table>
<thead>
<tr>
<th></th>
<th>None of the time</th>
<th>A Little of the time</th>
<th>Some of the time</th>
<th>A good bit of the time</th>
<th>Most of the time</th>
<th>All of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Were you discouraged by your health problems?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Were you fearful about your future health?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. Was your health a worry in your life?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Were you frustrated by your health problems?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. Did you have enough energy to do the things you wanted to do?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

6. We are interested in learning whether or not you are affected by fatigue. Please circle the number below that describes your fatigue in the past 2 weeks:

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>No fatigue</td>
<td>Severe fatigue</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. We are interested in learning whether or not you are affected by pain. Please circle the number below that describes your pain in the past 2 weeks.

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>No pain</td>
<td>Severe pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### PHYSICAL ACTIVITIES

During the past week, even if it was not a typical week, how much total time (for the entire week) did you spend on each of the following? (Please circle one number for each question.)

<table>
<thead>
<tr>
<th></th>
<th>none</th>
<th>less than 30 min/wk</th>
<th>30-60 min/wk</th>
<th>1-3 hrs per week</th>
<th>more than 3 hr/wk</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Stretching or strengthening exercises (range of motion, using weights, etc.)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. Walking for exercise</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. Aerobic exercise equipment (stairmaster, skiing, healthrider, treadmill)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
When you are feeling down in the dumps, feeling pain or having other unpleasant symptoms, how often do you (Please circle one number for each question):

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Almost never</th>
<th>Sometimes</th>
<th>Fairly often</th>
<th>Very often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Try to feel distant from the discomfort and pretend that it is not part of your body</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Play mental games or sing songs to keep your mind off the discomfort</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. Practice progressive muscle relaxation</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Practice visualization or guided imagery, such as picturing yourself somewhere else</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. Talk to yourself in positive ways</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

**PHYSICAL ACTIVITIES**

Please check (☐) the one best answer for your abilities.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Without ANY difficulty</th>
<th>With SOME difficulty</th>
<th>With MUCH difficulty</th>
<th>UNABLE to do</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Dress yourself, including tying shoe laces and doing buttons</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2. Get in and out of bed</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3. Lift a full cup or glass to your mouth</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4. Walk outdoors on flat ground</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5. Wash and dry your entire body</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6. Bend down to pick up clothing from the floor</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
The following items ask about how much your illness(es) and/or its treatment interfere with your life. Please circle the one number that best describes your current life situation.

How much does your illness(es) and/or its treatment interfere with:

1. Your feeling of being healthy
   Not very much > 1…………2……..3……..4……..5……..6……..7 < Very much

2. The things you eat and drink
   Not very much > 1…………2……..3……..4……..5……..6……..7 < Very much

3. Your work, including job, house work, chores, or errand
   Not very much > 1…………2……..3……..4……..5……..6……..7 < Very much

4. Playing sports, gardening, or other physical recreation or hobbies
   Not very much > 1…………2……..3……..4……..5……..6……..7 < Very much

5. Your financial situation
   Not very much > 1…………2……..3……..4……..5……..6……..7 < Very much

6. Social activities with your friends, neighbors, or groups
   Not very much > 1…………2……..3……..4……..5……..6……..7 < Very much

7. Your involvement in community or civic activities
   Not very much > 1…………2……..3……..4……..5……..6……..7 < Very much
For each of the following questions, please circle the number that corresponds with your confidence that you can do the tasks regularly at the present time.

**How confident are you that you can…**

1. Keep the fatigue caused by your disease from interfering with the things you want to do?  
   [1-10] not at all confident  
2. Keep the physical discomfort or pain of your disease from interfering with the things you want to do?  
   [1-10] not at all confident  
3. Keep the emotional distress caused by your disease from interfering with the things you want to do?  
   [1-10] not at all confident  
4. Keep any other symptoms or health problems you have from interfering with the things you want to do?  
   [1-10] not at all confident  
5. Do the different tasks and activities needed to manage your health condition so as to reduce your need to see a doctor?  
   [1-10] not at all confident  
6. Do the things other than just taking medication to reduce how much your illness affects your everyday life?  
   [1-10] not at all confident

**DAILY ACTIVITIES**

During the *past 2 weeks*, how much….

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Slightly</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Almost totally</th>
</tr>
</thead>
</table>
| 1. Has your health interfered with your normal social activities with family, friends, neighbors or groups?  
   [0]  
| 2. Has your health interfered with your errands and shopping?  
   [0]  

36
1. When you **visit your doctor**, how often do you do the following (please circle one number for each question).

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Almost never</th>
<th>Sometimes</th>
<th>Fairly often</th>
<th>Very often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>b.</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>c.</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

1. **In the past 6 months**, how many times did you visit a physician?  
   *Do NOT include visits while in the hospital or to a hospital emergency room.*

   Did you include any visits to a chiropractor, acupuncturist, podiatrist, or other alternative health provider in the number above?  
   [ ] Yes  [ ] No

   If yes, how many visits did you include in the number above?  
   __________visits

   Did you include any visits to a psychiatrist, psychologist, family counselor, social worker, or other mental health provider in the number above?  
   [ ] Yes  [ ] No

   If yes, how many visits did you include in the number above?  
   __________visits

2. **In the past 6 months**, how many times did you go to a hospital emergency room?  

3. **In the past 6 months**, how many TIMES were you hospitalized for one night or longer?  

4. How many total NIGHTS did you spend in the hospital in the past 6 months?  
   (do NOT include nights in a skilled nursing facility, convalescent hospital or other minimum care facility)

5. How many total NIGHTS did you spend in a skilled facility, convalescent Hospital, or other minimum care facility in the past 6 months?
APPENDIX B

“Living Well… Take Charge of your Health” Survey

Please complete the following information.

Home Address Zip code:________________________

Date of Birth:_____________ Gender: □ Female □ Male

The following information may help the state save money.

I have the following insurance type? (Please check all that apply)

Medicare_____ Medicaid_________ Other___________ None___________

Does your annual income exceed?

$10,210 □ Yes □ No

Today, how many people live in your household (including yourself)?

In general, would you say your health is: (check only one)

□ Excellent □ Very good □ Good □ Fair □ Poor
2. Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days, was your physical health not good?

_____________ DAYS

3. Now thinking about your mental health, which includes stress, depression and problems with emotions, for many days during the past 30 days, was your mental health not good?

_____________ DAYS

4. During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work or recreation?

_____________ DAYS

5. In the past 6 months, how many times did you visit a physician?

_____________ TIMES

6. In the past 6 months, how many times did you go to a hospital emergency room?

_____________ TIMES

7. In the past 6 months, how many times were you hospitalized for one night or longer?

_____________ TIMES
7.a. How many total NIGHTS did you spend in the hospital in the past 6 months?

____________ NIGHTS

7b. Were any of these hospitalizations at a skilled nursing facility, convalescent hospital or other minimum care facility?

☐ Yes

☐ No

8. We are interested in learning whether or not you are affected by pain. Please circle the number below that describes your pain in the past 2 weeks.
9. We are interested in learning whether or not you are affected by fatigue. Please circle the number below that describes your fatigue level in the past 2 weeks.

![Fatigue Level Scale]

10. During the past month, other than your job or housework activities, did you participate in any physical activity or exercises such as running, calisthenics, golf, gardening, or walking for exercise?

- [ ] Yes
- [ ] No

11. How many days in the past week were you physically active for at least 30 minutes (it does not have to be all at one time)? Things like brisk walking, bicycling, vacuuming, gardening, or anything else that causes you to breathe faster.

__________ DAYS
12. During the past 4 weeks, how much has your health interfered with: (please check one answer for each question)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Not at all</th>
<th>Slightly</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Almost totally</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your normal social activities with family, friends, neighbors or groups</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your hobbies or recreational activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your household chores</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your errands and shopping</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

13. Please check the box below that tells us how sure you are that you can do the following activities: (please check one answer for each question)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Not sure at all</th>
<th>Not very sure</th>
<th>Somewhat sure</th>
<th>Absolutely sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>You can find a way to get up if you fall</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>You can find a way to reduce falls</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>You can protect yourself if you fall</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>You can increase your physical strength</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>You can become more steady on your feet</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

14. In the past month, how many times have you fallen? (By fall, we mean when a person unintentionally comes to rest on the ground or another level.)

______________ TIMES

15. How many of these falls caused an injury? (By injury, we mean the fall caused you to limit your regular activities for at least a day or go to see a doctor.)

______________ TIMES
16. **Please answer the following questions as they apply to you:** *(please circle your answer)*

- Do you have pains, tightness or pressure in your chest during physical activity (walking, climbing stairs, household chores, similar activities?)
  - Yes
  - No

- Do you currently experience dizziness or lightheadedness?
  - Yes
  - No

- Have you ever been told you have high blood pressure?
  - Yes
  - No

- Do you have pain, stiffness or swelling that limits or prevents you from doing what you want or need to do?
  - Yes
  - No

- Have you fallen in the past year, or do you feel unsteady or use a cane or walker while standing or walking?
  - Yes
  - No

- Is there a health reason not mentioned why you would be concerned about starting an exercise program?
  - Yes
  - No

17. **When you visit your doctor, how often do you do the following:** *(please check one answer for each question)*

<table>
<thead>
<tr>
<th>Activity</th>
<th>Not at all</th>
<th>Slightly</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Almost totally</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepare a list of questions for your doctor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ask questions about the things you want to know and things you don’t understand about your treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discuss any personal problems that may be related to your illness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
18. **How confident you are in doing certain activities.** For each of the following questions, please circle the number that corresponds to your confidence that you can do the tasks regularly at the present time.

How confident do you feel that you can keep the fatigue caused by your disease from interfering with the things you want to do?

[1 2 3 4 5 6 7 8 9 10] totally confident

How confident do you feel that you can keep the physical discomfort or pain of your disease from interfering with the things you want to do?

[1 2 3 4 5 6 7 8 9 10] totally confident

How confident do you feel that you can keep the emotional distress caused by your disease from interfering with the things you want to do?

[1 2 3 4 5 6 7 8 9 10] totally confident

How confident do you feel that you can keep any other symptoms or health problems you have from interfering with the things you want to do?

[1 2 3 4 5 6 7 8 9 10] totally confident

How confident do you feel that you can do the different tasks and activities needed to manage your health condition so as to reduce your need to see a doctor?

[1 2 3 4 5 6 7 8 9 10] totally confident
How confident do you feel that you can do things other than just taking medication to reduce how much your illness affects your everyday life?

not at all 1 2 3 4 5 6 7 8 9 10 totally confident

Please help us improve the ways we identify and serve future participants.

19. How did you hear about this program?

20. What was the most important reason you took this course?

21. Would you recommend the course to other individuals with medical conditions?

___Definitely yes

___Yes with some suggestions (please list below)

________________________________________________________________________
________________________________________________________________________

___Definitely no (please list reasons below)

________________________________________________________________________
________________________________________________________________________
Course Evaluation

Congratulations on having completed the Living Well With Chronic Disease Course. We hope this course has helped you to make improvements in your health and benefit your chronic conditions.

Please take a few minutes to answer our questions about the course so we can make improvements for future participants.

Date____/____/____

Name of Living Well Course Location ___________________________________

Names of Lay Leaders: 1. ____________________2.________________________

Using a scale from 1 to 4, where 1=”Strongly Disagree” and 4=”Strongly Agree,” please CIRCLE the number indicating the degree to which you agree or disagree with the following statements.

Strongly Disagree ----- Strongly Agree

1. The content of the Living Well course was as advertised and presented in overview at the opening meeting. 1 2 3 4

2. The lay leaders of my course presented topics that increased my knowledge about my health. 1 2 3 4

3. The lay leaders were helpful to me and sensitive to my needs. 1 2 3 4

4. The lay leaders were organized. 1 2 3 4

5. The class meeting times were convenient for me. 1 2 3 4
6. The class location was convenient for me.  
7. I found the textbook to be useful.  
8. I found the relaxation tape to be useful.  
9. As a result of attending this course, I feel better able to manage my condition(s)  

10. Would you recommend the course to other individuals with chronic diseases?  
    ___ Definitely yes  
    ___ Yes with some suggestions (please list below)  
    ___________________________________________________________  
    ___________________________________________________________  
    ___ Definitely no (please list reasons below)  
    ___________________________________________________________  

11. What did you like the MOST about the course?  
12. What did you like LEAST about the course?  

   Please write down any other suggestions or comments you have here.  

   Thank you for your contributions of time and talent!
APPENDIX D

“Living Well” Process Evaluation

Approach:

Telephone Surveys with 2 to 3 informants in each of the six regions. These informants should include the region’s Program coordinator as well as 1-2 additional informants who partnered with the region and is designated by the Program coordinator to be knowledgeable about the implementation of Living Well in the region (e.g., aging services provider organization (ASPO) representative, local health department representative, health service provider representative, faith-based organization representative, etc.).

Survey Questions for Telephone Survey with Program Coordinator

Informant Role in the Living Well Project

1. Describe your role in the “Living Well” project that has been implemented in your county/region.
   Probe for exact responsibilities for the work…make a list and ask if it isn’t mentioned:
   • Did you recruit and hire staff to assist with implementation of program? Which staff? Did you coordinate the schedule for Living Well classes?
   • Did you coordinate lay leader training?
   • Were you involved in recruiting lay leaders?
   • Were you involved in recruiting participants and marketing the program to older adults in the community? If so, in what way?
   • Did you have direct supervisory responsibility for either professional staff or lay leaders?

2. In what way does this role “fit” within your general duties within the agency?

3. Were you involved in the project from the time it began? If not, when did you become involved in the project? Describe the circumstances under which you became involved after the project had gotten underway.

Implementation of the Living Well Project

4. In your opinion, what were the key reasons your agency decided to become involved in the “Living Well” project?

5. What were your personal expectations about the project and the potential benefits to older adults in your community? To your agency?

6. What were your concerns about the project when you first became involved?
7. Now that the project has been underway for two years and experience has accumulated with the Living Well project, would you say that:

(a) …your personal expectations about the project’s benefits were realized? Explain.

(b) …your concerns about the project were unfounded? Explain.

8. How many Master Trainers do you have available to your county/region?

9. How easy was it to get lay leaders to volunteer for the project?

10. How many lay leaders do you have currently involved in the project? How many have been involved since the project began?

11. How easy was it to get the lay leaders to continue working with the project over time? Have any incentives been instituted to keep lay leaders involved with the project?

Sustaining the Project

12. Describe the process your agency used to get “buy-in” within your county/region?

13. What partnerships have been established within the county/region to help promote the program? Who was responsible for establishing these partnerships? Which partnerships do you see as being most successful? Which have been least successful?

14. How easy was it to get sufficient numbers of older persons to participate in courses?

15. What strategies have been used to market the Living Well course to older people in your county/region? Which have been most successful?

16. What strategies have been used to sustain the program in your county/region?

17. Have you encountered any issues in maintaining fidelity with Chronic Disease Self-Management Program? How did you resolve those issues? What “checks” have you put in place to assure fidelity is maintained?

General satisfaction with the project

18. Thinking about the project over time, would you say that there was anything that the following involved parties could have done to make the process more effective?

   o State Department on Aging?
   o Agency Director?
   o Support Staff of the Agency in which the program was housed?
   o Others (specify)?
19. In general, how satisfied with the program are you at this stage in its development?
   Very       Somewhat       Neutral       Unsatisfied       Very Unsatisfied

20. What could have been changed to increase your satisfaction with the way in which this project has been implemented?

21. In general, what do you think was the most difficult part of implementing the project? What would have made it easier?

22. Would you say that the roles were clearly defined for the State Unit on Aging? the Area Agency on Aging? Respective partners in the project? Describe your opinions on each.

23. If someone were to call you from another State Area Agency about starting the “Living Well” Program, what would be your advice?

24. What are your primary concerns for the future of the program?

25. What are your expectations for the future of the program?

Do you have anything else you would like to add?

Survey Questions for Telephone Survey with Other Informants

Informant Role in the Living Well Project

1. Describe your role in the “Living Well” project that has been implemented in your community. (Probe for exact responsibilities for the work…make a list and ask if it isn’t mentioned:
   • Did you recruit and hire staff to assist with implementation of program? Which staff? Did you coordinate the schedule for Living Well classes?
   • Did you coordinate lay leader training?
   • Were you involved in recruiting lay leaders?
   • Were you involved in recruiting participants and marketing the program to older adults in the community? If so, in what way?
   • Did you have direct supervisory responsibility for either professional staff or lay leaders?)

2. In what way does this role “fit” within your general duties in the organization?

3. Were you involved in the project from the time it began? If not, when did you become involved in the project? Describe the circumstances under which you became involved in the project?

Implementation of the Living Well Project

4. In your opinion, what were the key reasons your organization decided to become involved in the “Living Well” project?

5. What were your personal expectations about the project and the potential benefits to older adults in your community? To your agency?

6. What were your concerns about the project at the beginning?
7. Now that the project has been underway for two years and experience has accumulated with Living Well project, would you say that:

(a) …your personal expectations about the project’s benefits were realized? Explain.

(b) …your concerns about the project were unfounded? Explain.

General satisfaction with the project

8. Thinking about the project over time, would you say that there was anything that the following involved parties could have done to make the process more effective?

   o State Department on Aging?
   o Agency Director?
   o Support Staff of the Agency in which the program was housed?
   o Others (specify)?

9. In general, how satisfied with the program are you at this stage in its development?

   Very       Somewhat       Neutral       Unsatisfied       Very Unsatisfied

10. What could have been changed to increase your satisfaction with the way in which this project has been implemented?

11. In general, what do you think was the most difficult part of implementing the project? What would have made it easier?

12. Would you say that the roles related to the project were clearly defined for the State Unit on Aging? the Area Agency on Aging? Respective partners in the project? Describe your opinions on each.

13. If someone were to call you from another organization which is interested in starting the “Living Well “ Program, what would be your advice?

14. What are your primary concerns for the future of the program?

15. What are your expectations for the future of the program?

Do you have anything else you would like to add?
I understand that as a participant in the “Living Well” program, I will be asked to provide information to help the Maryland Department of Aging (MDoA) determine how well the program is meeting the needs of those who participate. I have been informed that any information that I provide will be recorded but will be kept confidential. A code number will be applied to the information I provide and any information that can be linked to my identity will be kept in a secure location at the Center for Productive Aging, Towson University. Only authorized staff will have access to these files. After completing the program, in approximately 6 months, I understand that a staff person from this project will be contacting me to ask for my participation in a follow-up survey to help MDoA determine how well the “Living Well” program has helped me to manage my medical conditions.

I understand that my participation in these surveys will provide valuable information to MDoA to better serve those who participate in the “Living Well” Program. Any information collected will remain anonymous and will be reported in group form only.
I understand that there is no personal risk involved with providing information to program staff, that my participation is voluntary, and that I am free to withdraw my consent and discontinue participation in this information collection at any time. A decision to not participate in the collection of information will not affect the services available to me from MDoA.

If I have any questions or problems that arise in connection with my participation in this information collection, I should contact Mr. Joseph V. Gennusa, MDoA Nutrition & Health Program Manager, at 410-767-1090 or Dr. Patricia Alt, Chairperson of the Institutional Review Board for the Protection of Human Participants at Towson University at (410) 704-2236.

_____________________________________________________
(Date)  
(Signature of Participant)

_____________________________________________________
(Date)  
(Signature of Witness)
APPENDIX F

IRB

PLEASE SUBMIT THE ORIGINAL AND ONE (1) COPY OF THE APPLICATION FORM AND ALL ACCOMPANYING MATERIALS TO:

Office of University Research Services
Towson University
8000 York Road
Towson, MD 21252
(410) 704-2236
(410) 704-4494 (Fax)

APPLICATION FOR APPROVAL OF RESEARCH INVOLVING
THE USE OF HUMAN PARTICIPANTS

Please type or print legibly. This form must be completed by the Principal Investigator/Researcher for any research project that involves human participants. Please submit:

1) the completed application;

2) the informed consent form(s) or cover letter

3) all materials, including instruments, to be used;

4) copies of any fliers, advertisements, or announcements that will be used to solicit participants.

1. Principal Investigator: Donna M. Cox

Principal Investigator

Signature: ____________________________________________
Title of Research: Evaluation for the Maryland Department of Aging “Living Well” Program

Period of Research (start and end dates) Start __December 2006__ End __July 31 2009 (data collection to begin March 2007 when programming starts)

Institution & Department: Maryland Department of Aging and Center for Productive Aging, Towson University

Address to which approval should be sent: Department of Health Science, BU 141

Applicant's Phone: 4-4214 Applicant's E-mail Address: dcox@towson.edu

Co-Investigator(s): Donna Wagner, Director, Center for Productive Aging

2. If you are a student please provide the following: N/A

3. Has this research project been previously considered by the IRB?
   Yes ________ No X Last approval date: __________________

4. If the research is funded, indicate the source:
   External Agency Name: Maryland Department of Aging________________

5. Check if the following is true: (Be sure that you check all appropriate responses)
   Does the research involve:
   minors prisoners pregnant women
   the use of educational tests (cognitive, diagnostic, aptitude, or achievement)
   X survey or interview instrument
   ____ procedures in which the anonymity** of the participant will be insured
   X the participants being fully informed of the research project
   X voluntary participation by all participants
information which would place the participant at risk of criminal or civil liability if it became known outside the research

information that could affect the participant's employability, financial standing or reputation

information which deals with sensitive aspects of the participant's own behavior, such as illegal conduct, drug use, sexual behavior, or use of alcohol.

interviewing or surveying only elected or appointed public officials or candidates for public office

observation of public behavior

the collection or study of existing data, documents, records or specimens

6. What is the objective of the study?  (Be clear and concise. Do not use jargon)

Data collection is for the purpose of evaluating client health outcomes and self-reported ability to manage chronic conditions, based on participation in a nationally recognized evidence-based chronic disease self-management program. (See Attachment 1 for brief description of the Stanford

The program is open to all interested older adults, 60 years and older who have at least one chronic condition. Each county will work with its community partners to inform the public about the program as well as when and where these workshops will be held.

9. Do you believe that your research should be considered:  exempt

or for expedited review XX under research category number 

***"Anonymous" refers to a study designed so as not to allow the investigator or anyone else to determine the identity of individual participants from the collected data.
"Confidential" refers to a study designed so that, even if participants are identifiable to the investigator, their identity will not be revealed to anyone else.

10. What are the risks to the human participant (physiological, psychological)** Low

11. How will confidentiality of the participants be maintained? (Is the study anonymous? Who will know the identity of the participants? If pre- and post-test, how will participants be identified?)

When the baseline questionnaire is completed (see Attachment 2), a unique participant ID number will be applied. The completed questionnaire with facesheet that includes the participant’s contact information will be delivered to the Center for Productive Aging for data entry purposes when the 6 week session has ended. The facesheet will be removed by Center staff and secured in a locked file cabinet. A database using participant ID numbers will be developed to keep track of when a 6 month follow-up must be conducted.

12. Is there any information with regard to protocol or intention that will not be disclosed to the participant on the informed consent form? If so, what is it, and why will it not be disclosed?

   No

13. What debriefing information will be given to the participants following their participation? If any information was withheld from the participants, it must be disclosed at the debriefing.

   N/A

14. Specify the participant characteristics required (age, gender, etc.) and the number of participants. (Be specific)

   It is estimated by the MDoA that approximately the educational program will attract approximately 850–900 participants in each of the 3 year of the funded grant, a total of 2500–2700 participants.

15. How will the data be recorded and stored? (Be specific). **PLEASE NOTE:** All original data must be kept for a minimum of three years. Data of student researchers must be kept in a secure place in the faculty sponsor’s office.

   Data will be entered into a SPSS program for analysis.
**"At Risk."** A participant is considered to be at risk if the possibility of physical, psychological, sociological, or other types of harm may be the consequence of an activity which goes beyond the application of established and accepted methods necessary to meet the needs of the participant, or which increases the ordinary risks of daily life, including the recognized risks inherent in a chosen occupation or field of service.
APPENDIX G

Maryland Department of Aging Project

Suggested Questions for Site Visit

• Since _____, how many classes have been conducted? [What was the goal?]

• How many people have participated in classes to date? Does this number meet projected goals for participation?

• What percentage of people have “dropped out” of the classes? What are some of the reasons given for discontinuing the class?

• What recruiting strategies have been used? Which would you say have been most helpful?

• How many lay leaders have you trained?

• What type of feedback have you received from the lay leaders?

• How many Master trainers have you trained?

• What type of feedback have you received from the Master trainers?

• Describe the organizational partnerships in which you are involved in conducting the Living Well program.

• In what ways have these partnerships been positive? What have you learned from your involvement with these partners?

• Overall, how would you describe participants’ reaction to the program?

• To date, what “lessons learned” would you pass on to others involved in this project?