DATA TRENDS, PUBLICATIONS, AND IMPLICATIONS FROM THE NATIONAL CDSME AND FALLS PREVENTION DATABASES

Chelsea Gilchrist, Thomas Eagen, & Angelica Herrera-Venson | June 17, 2019
Our Vision

A just and caring society in which each of us, as we age, lives with dignity, purpose, and security

Our Mission

Improve the lives of millions of older adults, especially those who are struggling
NCOA’s Center for Healthy Aging

- Goal: Increase the quality and years of healthy life for older adults and adults with disabilities

- Two national resource centers funded by the Administration for Community Living
  - Chronic Disease Self-Management Education (CDSME)
  - Falls Prevention

- Other key areas: behavioral health, physical activity, immunizations, oral health
Administration for Community Living
Falls Prevention & CDSME Grantees

Funding
• CDSME: American Recovery and Reinvestment Act (2010-2011) and ACA Prevention and Public Health Fund (2012-Present)
• Falls Prevention: ACA Prevention and Public Health Fund (2014-Present)

Grant Goals
• Significantly increase the number of older adults and adults with disabilities at risk of falls who participate in evidence-based community programs to reduce falls and falls risks.
• Build partnerships and/or secure contracts with the health care sector and identify innovative funding arrangements that can support these evidence-based falls prevention programs while embedding the programs into an integrated, sustainable, evidence-based prevention program network.
Administration for Community Living Falls Prevention & CDSME Grantees

- Grantees must collect required program and participant data
  - Data collection forms are approved by Office of Management and Budget
  - Includes data on host and program implementation site, leaders/instructors, attendance log

- Participant self-reported data
  - Falls Prevention: Pre- and post-program surveys
  - CDSME: Pre-program survey and one post-program question
Technical Assistance Activities

- One-on-One Support
  - Tailored technical assistance based on your needs

- Networking & Peer Learning
  - Work groups
  - Learning Collaboratives
  - Listservs for professionals

- Online Tools and Resources
  - Ongoing webinars
  - Best practices from organizations across the country

- National Databases
  - Data collection & management
  - CDSME & falls prevention
National Falls Prevention Database By the Numbers

- 27 States
- 733 Host Orgs
- 4,048 Impl. Sites
- 7,315 Workshops
- 92,974 Participants
Falls Prevention Programs

- A Matter of Balance
- CAPABLE
- EnhanceFitness
- FallScape
- Fit & Strong
- Otago Exercise Program
- Tai Chi for Arthritis
- Stepping On
- Stay Active and Independent for Life
- Stay Safe, Stay Active
- Tai Ji Quan: Moving for Better Balance
- YMCA Moving for Better Balance

Not an exhaustive list.
Distribution of Falls Prevention Programs in the Database

Program Distribution

- MOB - 53.8%
- Stepping On - 15.5%
- Tai Chi for Arthritis - 12.5%
- Tai Ji Quan - 8.8%
- EnhanceFitness - 6.7%
- SAIL - 1.9%
- FallScape - 0.3%
- Otago - 0.3%
- Stay Safe Stay Active - 0.2%
Workshop Languages

- Braille
- Cambodian
- Chinese
- English
- Hmong
- Korean
- Navajo
- Portuguese
- Spanish
- Vietnamese
Participant Distribution by State in the Database
Participants by Age Categories

<table>
<thead>
<tr>
<th>Age Category</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 60</td>
<td>2000</td>
</tr>
<tr>
<td>60-70</td>
<td>12000</td>
</tr>
<tr>
<td>71-80</td>
<td>30000</td>
</tr>
<tr>
<td>81+</td>
<td>20000</td>
</tr>
</tbody>
</table>
## Participant Characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Age</td>
<td>76 years</td>
</tr>
<tr>
<td>Disability</td>
<td>37%</td>
</tr>
<tr>
<td>Female</td>
<td>81%</td>
</tr>
<tr>
<td>Two or More Falls Past 3 Months</td>
<td>7,411 participants</td>
</tr>
<tr>
<td>Hispanic Ethnicity</td>
<td>6%</td>
</tr>
<tr>
<td>Two or More Chronic Conditions</td>
<td>30,964 participants</td>
</tr>
<tr>
<td>Race</td>
<td></td>
</tr>
<tr>
<td>African-American (8%)</td>
<td></td>
</tr>
<tr>
<td>American Indian/Alaska Native (2%)</td>
<td></td>
</tr>
<tr>
<td>Asian (3%)</td>
<td></td>
</tr>
<tr>
<td>White (86%)</td>
<td></td>
</tr>
<tr>
<td>Multiracial (1%)</td>
<td></td>
</tr>
<tr>
<td>In Poor or Fair Health</td>
<td>17%</td>
</tr>
<tr>
<td>Education</td>
<td></td>
</tr>
<tr>
<td>High School or less (33%)</td>
<td></td>
</tr>
<tr>
<td>Some College (30%)</td>
<td></td>
</tr>
<tr>
<td>College Graduate (37%)</td>
<td></td>
</tr>
<tr>
<td>Programme Reduced Fear of Falling:</td>
<td>89%</td>
</tr>
<tr>
<td>Lives Alone</td>
<td>48%</td>
</tr>
<tr>
<td>Fearful of Falling Before Attending Program:</td>
<td>50%</td>
</tr>
</tbody>
</table>
Health and Fall-Related Variables

• Self-reported health
• Chronic health conditions
• Limitations due to disability
• Healthcare referral
• Fear of falling
• Social engagement limitation due to concern about falling
• Falls self-efficacy
• Falls and injuries from falls, in past 3 months and following program completion
• Actions taken to reduce falls risk (post-test only)

Not an exhaustive list.
Optional and New Data Fields

Optional Data Fields

- Income (Less than $1,000 - $4,000 or more)
- Caregiver status
- Zip code
- Type of health insurance (E.g., Medicare, Humana)
- Referral source—Facebook ad
- Have you taken this falls prevention program before?
- Have you taken a falls prevention program before? If yes, please indicate program name.
- Timed Up and Go Test
- Chair Stand Test

New Data Fields

- Location of fall
- Hospitalization
- Physical activity level
Program Outcomes

On average, there was a statistically significant ($p < .001$) improvement in self-reported general health following program participation.
On average, there was a statistically significant ($p < .001$) improvement in self-reported fear of falling following program participation.
On average, there was a statistically significant ($p < .001$) improvement in self-reported ability to reduce falls following program participation.
### Program Outcomes

#### More comfortable talking to health care provider

<table>
<thead>
<tr>
<th></th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7a</td>
<td>19295 (46%)</td>
<td>21421 (51%)</td>
<td>1051 (2%)</td>
<td>202 (1%)</td>
<td>5205 (11%)</td>
</tr>
</tbody>
</table>

#### More comfortable talking to family and friends about falling

<table>
<thead>
<tr>
<th></th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7b</td>
<td>18184 (43%)</td>
<td>22289 (53%)</td>
<td>1640 (4%)</td>
<td>320 (1%)</td>
<td>4831 (10%)</td>
</tr>
</tbody>
</table>

#### More comfortable increasing activity

<table>
<thead>
<tr>
<th></th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7c</td>
<td>21113 (50%)</td>
<td>20394 (48%)</td>
<td>897 (2%)</td>
<td>186 (0%)</td>
<td>4674 (10%)</td>
</tr>
</tbody>
</table>

#### Plan to continue exercising

<table>
<thead>
<tr>
<th></th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7d</td>
<td>24324 (65%)</td>
<td>12927 (34%)</td>
<td>198 (1%)</td>
<td>168 (0%)</td>
<td>9647 (20%)</td>
</tr>
</tbody>
</table>
Program Outcomes

Feel more satisfied with life

- / Post Q7e

<table>
<thead>
<tr>
<th>Response</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>18914</td>
<td>46%</td>
</tr>
<tr>
<td>Agree</td>
<td>21196</td>
<td>51%</td>
</tr>
<tr>
<td>Disagree</td>
<td>1041</td>
<td>3%</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>200</td>
<td>0%</td>
</tr>
<tr>
<td>N/A</td>
<td>5913</td>
<td>13%</td>
</tr>
</tbody>
</table>

Would recommend program to friend or relative

- / Post Q7f

<table>
<thead>
<tr>
<th>Response</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>32362</td>
<td>75%</td>
</tr>
<tr>
<td>Agree</td>
<td>10182</td>
<td>24%</td>
</tr>
<tr>
<td>Disagree</td>
<td>193</td>
<td>0%</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>378</td>
<td>1%</td>
</tr>
<tr>
<td>N/A</td>
<td>4142</td>
<td>9%</td>
</tr>
</tbody>
</table>
Research from the National Falls Prevention Database: Program Dissemination in Rural Areas

Smith et al. (2018) examined national program delivery in rural areas.
- 12.7% of program participants lived in a non-metro adjacent area.
- 5.5% of program participants lived in a non-metro non-adjacent area.

Primary implementation sites included:
- Senior centers (26%)
- Residential facilities (20%)
- Health care organizations (13%)
- Faith-based organizations (9%)

Workshop attendance/retention was consistent across rurality (~70%).

Eagen et al. (2019) compared participation in two falls programs in individuals with and without long-term disabilities (LTD).

- Significantly higher attendance and rates of completion among those with LTD
- Significant change in falls risk factors among both groups.
  - Greater rate of change observed in LTD group.

Leveraging Your Data
Florida
Falls Prevention Programs
Save Money and Lives

Since 2014 more than 7014 older adults and adults with disabilities have participated in Falls Prevention programs.

Evidence-Based Falls Prevention Programs target older adults and adults with disabilities who are at risk.
82% over age 60
29% are disabled
46% live alone
29% have more than one chronic condition

Top three chronic conditions in Florida are Arthritis, Heart Disease, and Diabetes.

Benefits to older adults in FL
Health Care Dollar Savings
$3,347,462 saved through falls prevention programs for older Floridians

14% reduction in the number of falls
43% improved balance
50% improved ability to reduce falls
71% exercised at home
8% had medications reviewed
22% made changes to home to reduce falls risk

To learn more, visit www.ncoa.org/fallsprevention
Managing Chronic Conditions

Living Well with Chronic Conditions is a 2-part, 3-day workshop evidence-based intervention proven to improve well-being and decrease health care utilization through self-management in people with diabetes. The programs are delivered by trained leaders and are available in both English and Spanish.

<table>
<thead>
<tr>
<th>Living Well with Chronic Conditions Outcomes</th>
<th>2016 &amp; 2017</th>
<th>2018-2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living Well participants</td>
<td>1,307</td>
<td>1,307</td>
</tr>
<tr>
<td>Cost savings per participant</td>
<td>$714</td>
<td>$714</td>
</tr>
<tr>
<td>Hospitalization and ED visits per person in the first year post-intervention</td>
<td>$933,196</td>
<td>$933,196</td>
</tr>
<tr>
<td>Over the caring biennium, with the addition of the requested state budget appropriation:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated increase in program participants: 10% (n=2,118) over the biennium</td>
<td>$1,096</td>
<td>$1,096</td>
</tr>
<tr>
<td>Total Emergency Department &amp; Hospital Charges That Could Be Avoided = $1,725,840 in the first year post-intervention</td>
<td>$261,460</td>
<td>$261,460</td>
</tr>
<tr>
<td>Total Charges Avoided</td>
<td>$3,224,050</td>
<td>$3,224,050</td>
</tr>
</tbody>
</table>

Costs & Prevalence of Chronic Conditions in Wisconsin

85% of older adults have at least one chronic condition. Approximately 1 in 5 (274) people with chronic conditions are hospitalized each year in Wisconsin.

37,157 People went to an emergency department (ED) due to a fall in 2014
$3,076 Average charge per ED visit due to a fall
$114,293,055 ED charges due to falls in 2014

Costs & Prevalence of Falls in Wisconsin

17,234 People were hospitalized due to a fall in 2014
$34,854 Average charge per hospitalization due to a fall
$600,667,061 Hospital charges due to falls in 2014

Preventing Falls

Stepping On is a 7-week once-a-week evidence-based intervention proven to decrease the incidence of falls in older people. In addition to practicing balance and strength exercises, participants learn about the role vision, medication, and footwear can play in falls. They also learn strategies for avoiding or eliminating fall hazards to better navigate inside and outside the home.

Stepping On Outcomes

- 31% reduction in falls for people who complete Stepping On

4,384 Stepping On participants
1,096 would have fallen
340 falls avoided
$261,460 ED Charges Avoided
$3,224,050 Total Charges Avoided

Over the caring biennium (using the same assumptions as above), with the addition of the requested state budget appropriation:

- Estimated increase in program participants: 10% (n=4,682) over the biennium
- Total Emergency Department & Hospital Charges That Could Be Avoided = $3,546,228 in the first year post-intervention
- Hospital charges = $3,250,640 in hospital charges
In 2016 and 2017, 4,384 people took a Stepping On workshop in Wisconsin. We know that 1 in 4 people age 65 or older fall every year so we could expect that 1,096 people would have fallen. By participating in Stepping On, 31% of those falls were avoided (340 falls). If we assume that only half (170) of those people who avoided a fall would have needed medical care and, of those, half (85) visited the emergency department (ED) while the other half (85) were hospitalized, we have avoided $261,460 in ED charges (based on an average charge of $3,076) and $2,962,590 in hospital charges (based on an average charge of $34,854).

Over the coming biennium (using the same assumptions as above), with the addition of the requested state budget appropriation:

Estimated increase in program participants: 10% (to 4,822)
Falls avoided: 374

Total Emergency Department & Hospital Charges That Could Be Avoided = $3,546,228 in the first year post-intervention
$287,379 in ED charges + $3,258,849 in hospital charges

Wisconsin Institute for Healthy Aging: “Healthy Living, Healthy Aging By the Numbers”
Rush University Medical Center: Customized Value Proposition for Health Plans
Data from OMB-Approved Fields

• **Behavior Change**
  - Home safety modifications
  - Talked to a family member or friend about how I can reduce my risk of falling
  - Talked to a health care provider about how I can reduce my risk of falling
  - Had vision checked
  - Had medications reviewed by a health care provider or pharmacist
  - Participated in another fall prevention program in my community

• **Location of Fall**

• **Social Engagement**

• **Physical Activity Level**

• **Satisfaction from Program**
  - Feel more satisfied with life
  - Would recommend program to friend

• **Program Effectiveness**
Leverage Optional Data Fields

Target Special Populations

• Income (Less than $1,000 - $4,000 or more)
• Caregiver status
• Zip code
• Chronic conditions

Track Participants Across Programs

• Have you taken this falls prevention program before?
• Have you taken a falls prevention program before? If yes, please indicate program name.
Chronic Disease Self-Management (CDSME) Program Database
Self-Management Resource Center (formerly Stanford) Chronic Disease Self-Management Programs

- Chronic Disease Self-Management Program
- Tomando Control de Su Salud
- Cancer: Thriving and Surviving
- Chronic Pain Self-Management
- Diabetes Self-Management
- Programa de Manejo Personal de su Salud
- Positive Self-Management Program for HIV
- Better Choices, Better Health® online
- ToolKit for Acive Living with Chronic Conditions (self-directed)
- Workplace Chronic Disease Self-Management Program

Not an exhaustive list.
Additional Programs in National CDSME Database

- Active Living Every Day
- Camine Con Gusto (in person)
- EnhanceFitness
- EnhanceWellness
- HomeMeds
- Health Coaches for Hypertension Control
- Living Well in the Community
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Program to Encourage Active, Rewarding Lives (PEARLS)
- Walk With Ease (in-person)
- Walk With Ease (self-directed)
- Wellness Recovery Action Plan (WRAP)
CDSME Program – By the Numbers

- 391,597 Program Participants
- 35,996 Workshops
- 247 Database Users
- 71 Active Networks

Figure 1. National CDSME Database Program Reach and Usage (3/1/2010 – 5/31/2019)
National Chronic Disease Self-Management Education Resource Center: Program Highlights and Charts

Explore this quarterly update of data housed in the National Chronic Disease Self-Management Education Database. It includes national data on the number of participants, workshops, trends, and stats from 2010 to present.

Download Document

Number of Participants

The # of grantees and grantee target goals for enrollment varies by year, which contribute to variation in yearly totals.

Figure 3. Total Number of Participants Enrolled By Calendar Year (1/1/2010 to 12/31/2018)
Workshops Delivered In Past 12 Months
Change in Programming

• Just five years ago (2013), the Chronic Disease Self-Management Program (CDSMP) accounted for 72% of programs reported by organizations to the National CDSME Database.

• In 2018, that proportion has dropped substantially to 42%.

• Every year, more organizations are adding an array of evidence-based programs to improve physical activity, better manage depression symptoms, or manage medication to address the multiple health concerns and offer variety to older adults.

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDSMP, n</td>
<td>33369</td>
<td>9917</td>
</tr>
<tr>
<td>CDSMP, %</td>
<td>71.5%</td>
<td>41.6%</td>
</tr>
<tr>
<td>Total</td>
<td>46683</td>
<td>23818</td>
</tr>
</tbody>
</table>

Figure 6. Change in Programming Over the Years (CDSMP vs Other Programs), between 2013 and 2018
Completion Rates

<table>
<thead>
<tr>
<th>Program Type</th>
<th>Completion Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>All SMRC Programs Combined</td>
<td>74%</td>
</tr>
<tr>
<td>Programa de Manejo Personal de la Diabetes</td>
<td>80%</td>
</tr>
<tr>
<td>Tomando Control de su Salud (Spanish CDSMP)</td>
<td>77%</td>
</tr>
<tr>
<td>Positive Self-Management Program</td>
<td>76%</td>
</tr>
<tr>
<td>Cancer: Thriving and Surviving</td>
<td>75%</td>
</tr>
<tr>
<td>Diabetes Self-Management Program (DSMP)</td>
<td>75%</td>
</tr>
<tr>
<td>Arthritis Self-Management Program (ASMP)</td>
<td>75%</td>
</tr>
<tr>
<td>Chronic Pain Self-Management Program...</td>
<td>73%</td>
</tr>
<tr>
<td>Chronic Disease Self-Management Program...</td>
<td>74%</td>
</tr>
<tr>
<td>Better Choices, Better Health</td>
<td>51%</td>
</tr>
</tbody>
</table>

Figure 8. Completion Rates for All SMRC CDSME Program Types, 3/1/2010 to 1/29/2019; n=383,473
## Program Participant Demographics

<table>
<thead>
<tr>
<th></th>
<th>CDSME</th>
<th>General Older Adult Population</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Average Age:</strong></td>
<td>65 years</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>Female:</strong></td>
<td>76%</td>
<td>56%</td>
</tr>
<tr>
<td><strong>Race/Ethnicity:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>White (70%)</td>
<td>White (77%)</td>
</tr>
<tr>
<td></td>
<td>African-American (24%)</td>
<td>African-American (9%)</td>
</tr>
<tr>
<td></td>
<td>Hispanic (15%)</td>
<td>Hispanic (8%)</td>
</tr>
<tr>
<td></td>
<td>Asian (4%)</td>
<td>Asian (4%)</td>
</tr>
<tr>
<td></td>
<td>Native Hawaiian/Pacific Islander (.8%)</td>
<td>Native Hawaiian/Pacific Islander (.1%)</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td>56% have some college or higher</td>
<td>30%</td>
</tr>
<tr>
<td><strong>Caregiver</strong></td>
<td>25%</td>
<td>19%</td>
</tr>
<tr>
<td><strong>In Poor or Fair Health</strong></td>
<td>30%</td>
<td>22%</td>
</tr>
<tr>
<td><strong>Disability</strong></td>
<td>31%</td>
<td>35%</td>
</tr>
<tr>
<td><strong>Two or More Chronic Conditions:</strong></td>
<td>59%</td>
<td>70%</td>
</tr>
<tr>
<td><strong>Top Chronic Health Conditions:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hypertension (41%)</td>
<td>Hypertension (58%)</td>
</tr>
<tr>
<td></td>
<td>Hyperlipidemia (33%)</td>
<td>Hyperlipidemia (48%)</td>
</tr>
<tr>
<td></td>
<td>Arthritis/Rheumatic disease (36%)</td>
<td>Arthritis (31%)</td>
</tr>
<tr>
<td></td>
<td>Diabetes (36%)</td>
<td>Ischemic heart disease (29%)</td>
</tr>
<tr>
<td></td>
<td>Heart disease (13%)</td>
<td>Diabetes (27%)</td>
</tr>
<tr>
<td></td>
<td>Anxiety/Depression (21%)</td>
<td></td>
</tr>
<tr>
<td><strong>Lives Alone:</strong></td>
<td>40%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Referred by physician</strong></td>
<td>14%</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>Confidence managing chronic condition after workshop</strong></td>
<td>8 of 10</td>
<td>n/a</td>
</tr>
</tbody>
</table>

Figure 9. National CDSME Program Participant Demographics Compared to General Older Adult Population; n=383,433 (Rev. 1/3/2019)
Chronic Health Conditions

Figure 10. Most common chronic health conditions among participants enrolled in the National CDSME Database (n=383,473)
Most Common Languages

arabic  asl  chinese  english  gujarati  hindi
korean  navajo  portuguese  russian  somali
spanish  tongan  vietnamese
Confidence Managing Chronic Condition
(upon completion of program)

Figure 13. Percent distribution of participants’ post-program completion rating on their confidence in managing their chronic health conditions (n=12,528), (1/30/2018 to 1/29/2019)
# Most Common Implementation Site Types by Race/Ethnicity

<table>
<thead>
<tr>
<th></th>
<th>Hispanic</th>
<th>Black/African-American</th>
<th>Asian American</th>
<th>American Indian</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care organizations</td>
<td>31.7</td>
<td>16.6</td>
<td>20.3</td>
<td>22.8</td>
<td>23.7</td>
</tr>
<tr>
<td>Senior centers</td>
<td>18.3</td>
<td>21.9</td>
<td>24.1</td>
<td>16.9</td>
<td>21.7</td>
</tr>
<tr>
<td>Faith-based organizations</td>
<td>7.8</td>
<td>12.3</td>
<td>3.7</td>
<td>5.1</td>
<td>6.6</td>
</tr>
<tr>
<td>Residential facility</td>
<td>11.5</td>
<td>18.6</td>
<td>18.6</td>
<td>14.5</td>
<td>17.7</td>
</tr>
<tr>
<td>Other</td>
<td>10.3</td>
<td>11.6</td>
<td>7.7</td>
<td>16.4</td>
<td>10.8</td>
</tr>
<tr>
<td>Tribal center</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>7.1</td>
<td>--</td>
</tr>
</tbody>
</table>

Figure 16. Location of most common implementation site (venue) for all workshops by race and ethnicity (n=356,427)
Program Leaders Activity Across SMRC Programs (n=28,666 workshops)

- CPSMP programs have the highest average number of workshops per leader.

<table>
<thead>
<tr>
<th>Program</th>
<th>Average # of Workshops Delivered by Program Leaders</th>
<th>No. of Workshops</th>
<th>SD</th>
<th>Total # of Leaders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Pain Self-Management Program (CPSMP)</td>
<td>9.9</td>
<td>889</td>
<td>12.4</td>
<td>531</td>
</tr>
<tr>
<td>Cancer: Thriving and Surviving</td>
<td>8.9</td>
<td>101</td>
<td>10.3</td>
<td>69</td>
</tr>
<tr>
<td>Diabetes Self-Management Program (DSMP)</td>
<td>8.4</td>
<td>5677</td>
<td>10.5</td>
<td>2793</td>
</tr>
<tr>
<td>Programa de Manejo Personal de la Diabetes (Spanish CDSMP)</td>
<td>7.7</td>
<td>479</td>
<td>7.6</td>
<td>279</td>
</tr>
<tr>
<td>Tomando Control de su Salud (Spanish CDSMP)</td>
<td>7.4</td>
<td>1956</td>
<td>9.4</td>
<td>888</td>
</tr>
<tr>
<td>Chronic Disease Self-Management Program (CDSMP)</td>
<td>6.4</td>
<td>20453</td>
<td>8.6</td>
<td>9508</td>
</tr>
<tr>
<td>TOTAL</td>
<td>6.9</td>
<td>28666</td>
<td>9.1</td>
<td>4560</td>
</tr>
</tbody>
</table>
## Average # of Workshops Delivered by Program Leaders – *by Employment Status*

<table>
<thead>
<tr>
<th>Employment Type</th>
<th>Average # of Workshops Delivered by Program Leaders</th>
<th># of Workshops</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment Type Not Stated</td>
<td>6.55</td>
<td>18204</td>
</tr>
<tr>
<td>Staff</td>
<td>8.44</td>
<td>7390</td>
</tr>
<tr>
<td>Volunteer</td>
<td>5.94</td>
<td>3961</td>
</tr>
</tbody>
</table>

Figure 19. Average No. of Workshops Delivered by Program Leaders (n=29,555)

**Tip Sheet: Strategies to Improve Leader Retention for Chronic Disease Self-Management Education**

New Data Fields & Optional Items

• Possible New Additions/Changes to Future CDSME Data Collection Tools
• Self-rated Health (pre & post)
• Confidence in Managing Chronic Conditions (pre & post)
• Expanded questions on disability

Optional Items

Improving the lives of 10 million older adults by 2020
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Research from National CDSME Database- 2018 - 2019

Rural Reach of CDSME Programs

Chronic Pain Self-Management Program
• PAPER: *In Preparation*

Diabetes Programs – Hispanic/Latino participation
• PAPER SUBMITTED: Mendez-Luck, C., Participation of Latinos in the Diabetes Self-Management Program & Programa de Manejo Personal de la Diabetes, Innovations on Aging
• PRESENTATION: Herrera-Venson, A.P. et al, Participation of Latinos in the Diabetes Self-Management Program & Programa de Manejo Personal de la Diabetes, GSA, 2018
Research from National CDSME Database- 2018 - 2019

Disability x Chronic Diseases
• **POSTER:** Influence of Disability and Disease on Chronic Disease Self-Management Education (CDSME) Program Attendance. Smith, M.L et al, 2017, APHA.

Caregiving Trends
• **POSTER:** Caregiver Participation in Chronic Disease Self-Management Education Programs: Findings from a National Study. Smith, M.L. GSA, 2018.

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• Angelica Herrera-Venson  
  angelica.herrera-venson@ncoa.org
References

• University of Massachusetts / Leading analysis of Health Retirement Survey (2014)
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