United Way of Tarrant County
Healthy Aging and Independent Living Initiative
Evaluation Report
Program Year Three Annual Report
July 1, 2012 – June 30, 2013

Community Research Center for Senior Health
Scott & White Healthcare
Texas A&M School of Rural Public Health

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Executive Summary

In response to the United Way of Tarrant County’s 2020 Bold Goal, the Healthy Aging and Independent Living (HAIL) initiative delineated specific strategies to address known health risks in Tarrant County. The United Way has partnered with key community-based service organizations to provide health interventions that address the immediate needs of individuals at risk of poor health outcomes as well as health promotion activities that engage adults in self-management techniques and healthy behaviors that are associated with better health and, long term, with lower healthcare costs (e.g., fewer hospitalizations, less need for nursing home care). This report summarizes the activities of the six organizations who have been commissioned to provide the 10 health interventions. This Annual Report covers project activities occurring from July 2012 through June 2013. This means that the participant enrollment numbers are complete, but a significant amount of output and outcome data associated with Year 3 enrollment has not yet occurred (i.e., participants have been enrolled and are currently receiving services from the funded organizations). A Year 3 Final Report will be prepared in early 2014 and will include a summary of all output and outcome data associated with Year 3 funding.

Data reported in tables address specific outputs and outcomes delineated in the HAIL logic model. Additionally, we report on variables that are critical to the implementation of the health interventions by each of the organizations (Table 2: Intervention Activities Thought to Influence Measures of Success). Data from these tables as well as information abstracted from the monthly reports provided by each organization has also been synthesized and is summarized below. We have analyzed outcome data in two ways. First, we have used summary statistics to provide information on the mean, or average, scores on each of the designated outcome variables for each of the health intervention programs. We provide the mean score at baseline and following delivery of the intervention. In most cases, the follow up mean score was collected six months after the baseline score. This commonly used summary statistic provides an indicator of how the intervention impacted the group of participants. In a second set of analyses, we provide information on the actual number of clients served by the interventions who demonstrated positive change on the outcome variables of interest to the United Way. Results of these analyses assist in determining the number of lives positively impacted by the interventions (i.e., lives that count towards the Bold Goal of 30,000 individuals being impacted by HAIL). Please see Section V for more detailed information on the health outcomes.

2645 Additional People Served

Overall Goal was to enroll at least an additional 1,250 people in HAIL Programs in Year 3

73%

of HAIL clients that have completed the service programs and have completed a follow up assessment demonstrated improvements in health status or other key outcome measures
<table>
<thead>
<tr>
<th>Strategy</th>
<th>Organization(s)</th>
<th>Targets</th>
<th>Year 3 Total To Date</th>
<th>% of Annual Target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health Literacy</strong></td>
<td>University of North Texas Health Science Center</td>
<td>50 librarians trained</td>
<td>51</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>125 organizational representatives trained</td>
<td>199</td>
<td>159%</td>
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<tr>
<td></td>
<td></td>
<td>85 percent of library staff trained will demonstrate improved capacity to engage patrons in accessing, obtaining and understanding health information/resources</td>
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<tr>
<td><strong>Alzheimer’s Caregiver Health</strong></td>
<td>Alzheimer’s Association &amp; Easter Seals</td>
<td>500 Alzheimer’s caregivers will receive evidence-based caregiver education or respite services</td>
<td>476</td>
<td>95%</td>
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<tr>
<td></td>
<td></td>
<td>80% of caregivers whose loved ones are a high risk for nursing home placement that receive services will still be living in the community after 6 months</td>
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<td></td>
<td></td>
<td>50% of caregivers whose loved ones are a high risk for nursing home placement that receive services will demonstrate a reduction in stress and depression and increased capacity for self-care</td>
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</tr>
<tr>
<td><strong>Falls Prevention</strong></td>
<td>Senior Citizen Services</td>
<td>450 persons will participate in an 8-week workshop to learn how to overcome fear of falling and to work on balance and strength to reduce falls</td>
<td>529</td>
<td>118%</td>
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<tr>
<td></td>
<td></td>
<td>75% graduates will improve their confidence in falls management</td>
<td></td>
<td></td>
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<tr>
<td><strong>Chronic Disease Self-Management</strong></td>
<td>Senior Citizen Services</td>
<td>2,000 individuals will be screened for diabetes and nutritional risk</td>
<td>1934</td>
<td>129%</td>
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<tr>
<td></td>
<td></td>
<td>525 consumers complete at least 4 of 6 evidence-based Stanford Chronic Disease Self-Management (CDSMP) classes</td>
<td>296</td>
<td>75%</td>
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<tr>
<td></td>
<td></td>
<td>50% of those completing SCDSM classes will demonstrate improved health status and capacity for self-care</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>75% of graduates will report greater confidence in dealing with health issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strategy</td>
<td>Organization(s)</td>
<td>Targets</td>
<td>Year 3 Total To Date</td>
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<td>---------------------------------------------------</td>
<td>-----------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>----------------------</td>
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</tr>
<tr>
<td>Medication Management*</td>
<td>Meals On Wheels &amp; Senior Citizen Services</td>
<td>1,980 persons will be enrolled in the HomeMeds program</td>
<td>1875</td>
<td>95%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>95% of participants taking potentially harmful medications will have a review conducted by a pharmacist within 30 days</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Community Health Navigation*</td>
<td>Meals On Wheels</td>
<td>225 persons will be enrolled in the patient activation/CHN project</td>
<td>241</td>
<td>107%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>50% of participants receiving health navigation services will report greater confidence in dealing with their health issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes Screening/ Counseling &amp; Education</td>
<td>Meals On Wheels &amp; North Texas Area Community Health Center</td>
<td>3,000 persons will be screened for diabetes and high nutritional risk</td>
<td>3573</td>
<td>119%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1,750 persons will receive individualized evidence-based diabetes and/or nutrition counseling</td>
<td>1651</td>
<td>94%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>50% of those receiving counseling services will demonstrate improved health status and capacity for self-care</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>80% of participants serviced will improve HgA1c by 10% (North Texas Area Community Health Center patients only)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Of note- The medication management, fall prevention and community health navigation strategies were funded in September 2012. The health literacy strategy was funded in December 2012. Therefore, these programs have a shortened funding year (September 2012 – June 2013 and December 2012-June 2013) and data will reflect as such throughout this report.

Due to time requirements for training and recertification of all CDSMP staff and volunteers in the new CDSMP curriculum, all BCBH targets have been adjusted to represent the amount of time available for workshops, 75%, and are presented as such in the table.

Forthcoming. Outcome data are still being collected and will be reported to United Way in March 2014. Preliminary outcome data on a small subset of clients are reported in Appendix A of this Annual Report.

NEW Expansion grant in Year 3 (July 2012 – June 2013) of HAIL. Goal was expansion from five to eight projects.
Health Literacy

University of North Texas Health Science Center
The Health Literacy staff made a lot of progress during the 4\textsuperscript{th} quarter to meet their goals for Year 3. Four clinical organizations were approached. There were six “Building the Bridge to Health” librarian trainings. A total of 51 library staff from public libraries, a community college library, two area medical center libraries, and a hospital organization were trained. Additionally, 199 organizational representatives and 15 community-based organizations were trained on the program.

The symposium, Health Literacy in Tarrant County Adults: A Systems Approach took place on Thursday, June 6\textsuperscript{th}, 2013. Dr. Laurie Martin, MPH, ScD, a nationally-recognized expert on health literacy from the RAND Corporation gave the keynote address. A total of 156 attendees participated representing over 39 partner organizations. Feedback from attendees was positive.

Alzheimer’s Caregiver Health

Alzheimer’s Association
The Alzheimer’s Association achieved 88\% of their enrollment goal for Year 3 with 313 caregivers enrolled in the REACH II program. To date, 75\% of caregivers have received three therapeutic sessions within four months of enrollment. Caregivers receive an average of 2.31 face-to-face therapeutic sessions and Alzheimer’s Association staff initiated an average of 3.25 therapeutic sessions by phone.

On average, caregivers self-reported an improvement in General Health after receiving the intervention and reported fewer episodes of hospitalization than in the months before enrolling in REACH II. Only 6.1\% of clients with Alzheimer’s disease (CRs) were placed into nursing homes between the beginning and ending of the REACH II intervention (Goal is less than 20\%). To date, 80 follow up interviews have been collected with the 93 caregivers who have completed the REACH II intervention. Of those 80, 73 reported positive change on at least one of the outcome variables.

Easter Seals
Easter Seals staff essentially made their annual goal of providing in-home respites services, serving 163 individuals with dementia (99\% of their goal). A majority of caregivers strongly agree that the services provided by Easter Seals contributed to their loved one being able to stay at home (84\%) and that caregivers were able to ensure their own needs were met as a result of the respite services (80\%).

Fifty-nine of the 163 enrolled clients have completed the program and only 7.4\% have been placed in a nursing home to date (Goal is less than 20\%), which is the primary outcome for this service that targets individuals at high risk of nursing home placement. Follow up interview data is currently available on 30 of the family caregivers of the clients at high risk of nursing home placement and few changes are noted in these self-report outcome variables, which is not unexpected given the focus on this service, respite, which is intended to support the community living of the CR.
**Falls Prevention**

**Senior Citizen Services**

Senior Citizen Services AMOB staff exceeded their goal for the number of individuals who participated in workshops to overcome their fear of falling and to increase balance and strength to reduce falls, serving 529 individuals (118% of their annual goal). AMOB has exceeded annual output goals for the current grant year, with an 87% graduation rate. This graduation rate exceeds the national rate of 79% recorded on a national AMOB online data entry system for 68 AMOB projects. Additionally, 89% of course were led by volunteers.

Of the 459 clients who completed the program, follow up data is available at the graduation point for 371. In general, clients receiving AMOB did not report improvements on the EQ-5D, but the group means did show an improvement from baseline to follow up on the General Health Measure. Fewer hospitalizations were also reported at follow up compared to baseline. Of the 371 clients reporting data at graduation, 215 self-reported a positive change in at least one of the outcome variables. Many fewer client interviews (57) are available for the six-month follow up assessment with only 27 of the 57 reporting positive change on an outcome measure. SCS staff continue to focus on six month follow up surveys to improve the response rate.

Additionally, Senior Citizen Services have just implemented their new Access-based data management system. This will allow SCS to collect and track data for clients served in all of their programs in one data system. Data from Year 3 has been imported into the system and all HAIL data will be entered into the system in Year 4. *This represents an enduring systems change for Senior Citizen Services.*

**Chronic Disease Self-Management**

**Senior Citizen Services**

Senior Citizen Services staff screened 1934 individuals for diabetes and nutritional risk, exceeding their adjusted target of 1500 (129% of the goal). Despite offering 19 courses in quarter 4 (158% of the quarterly target), SCS only met 75% of its adjusted annual goal for completers. Most courses are led by lay volunteers. The course completion rate to date is at 67% for participants. The finding that the large number of screenings did not produce the expected enrollment into the self-management course is in need of additional review.

Of the 491 clients served with the Better Choices, Better Health intervention, 296 completed the program and 236 reported follow up data at program graduation. One hundred and nine of the 236 clients reported positive change on the two outcome measures collected at this time point (Health Status and Confidence). The complete set of outcome measures is collected at the six month assessment point; however, only 69 client interviewers are available at this time. Forty-nine of the 69 clients show positive change on at least one outcome measure at six months. Summary data of the outcome measures do not show a clear pattern of change from baseline to six month follow up, but this may be due to the low number of six month follow up interviewers that are available.
Additionally, Senior Citizen Services have just implemented their new Access-based data management system. This will allow SCS to collect and track data for clients served in all of their programs in one data system. Data from Year 3 has been imported into the system and all HAIL data will be entered into the system in Year 4. This represents an enduring systems change for Senior Citizen Services.

**Medication Management**

**Meals On Wheels**
Meals On Wheels staff ended the year enrolling 123% of the quarter 4 target for a total of 1529 individuals for medication management, 102% of the annual target. Meals On Wheels found that 52% of clients had medication alerts. To date, a total of 1491 alerts were identified in clients who received the HomeMeds program. The program is continuing to run smoothly as 100% of alerts were resolved within 30 days and 100% of participants found to be taking harmful medicines were advised to discontinue use. Due to the shortened funding year for this program, six month outcome data were not yet collected at the time data were pulled for this report. Six month follow up data are currently being collected and will be included in the Year 3 Final Report.

**Senior Citizen Services**
Senior Citizen Services staff served 346 individuals into their medication management program, 72% of the annual target, despite enrolling 103% of the quarter 4 target. Of clients who received a medication review, 60% were found to have alerts and 94% were resolved within 30 days.

Only a small number (36) of the 320 clients who completed the program were available for six month follow up interviews. Of those, 23 reported positive change on at least one of the outcome variables.

Additionally, Senior Citizen Services have just implemented their new Access-based data management system. This will allow SCS to collect and track data for clients served in all of their programs in one data system. Data from Year 3 has been imported into the system and all HAIL data will be entered into the system in Year 4. This represents an enduring systems change for Senior Citizen Services.

**Community Health Navigation**

**Meals On Wheels**
Meals On Wheels staff did not enroll new individuals for the patient activation program in quarter 4 due to how the program was designed and structured. Requirements of the program resulted in all clients being enrolled earlier in the funding year. The program ended the year meeting 107% of their annual enrollment target. Participants received an average of 10.7 therapeutic contacts with their community health navigators.

One hundred twenty-seven of the 241 clients served have completed the program at this time. Remarkably, follow up data is available on 123 clients with 100 of those clients self-reporting a positive
change on at least one of the outcome variables. Summary statistics (i.e., means) of outcome variables collected at baseline and follow up show a consistent positive trend with clients, on average, reporting an increase in quality of life and general health and a decrease in hospital care.

**Diabetes Screening, Counseling & Education**

**Meals On Wheels**
Meals On Wheels staff screened 119% (3573) of their annual target for individuals for diabetes and high nutritional risk. The annual target was exceeded for the number of individuals who received diabetes and/or nutrition counseling (1252 clients/100% of the annual target). Additionally, 3245 (216% of the annual target) follow up calls were made to clients receiving counseling. Sixty-five percent of clients who received counseling set a goal. Of those clients who set a goal and reported on goal attainment, 85% reported any level of attainment and 53% met their goal all of the time.

Of the 1252 clients served by this program, 389 have completed the program to date. Six-month follow up client interview data are available for 365 clients. Two hundred fifty-six (or 70%) of those surveyed at six months report positive outcomes on at least one outcome variable. These positive findings do not, however, translate into clear differences in the mean values of the EQ-5D and General Health measures, which are relatively stable across the two time points. A reduction in hospital stays was reported by clients at six months.

Of note, MOW review of the draft reported provided to programs indicated a discrepancy between the data tracked by MOW staff and the data provided to the Evaluation Team. MOW staff and the Evaluation Team are working together to address this discrepancy to ensure accurate data for the Year 3 Final Report.

**North Texas Area Community Health Center**
North Texas Area Community Health Center staff met 80% of their annual target of 500 for number of individuals enrolled in the DiabetesSalud! Intervention. DiabetesSalud! staff referred 92% of their clients for dilated eye exams within three months of enrollment and 31 clients successfully received a dilated eye exam within three months. However, 98% of clients received at least one completed eye exam. Referrals to dental exams show similar trends with 97% of clients receiving a referral and 10 were successfully completed within three months of enrollment. However, 97% did receive at least one completed dental exam.

Of the 399 clients served by this program, an initial set of follow up data is available for 20 clients. Of the 20 clients with follow up data, 19 show at least one positive change. Outcome measures are collected later on in the intervention; however, only four clients have data. Three of the four clients show positive change on at least one outcome measure at the later follow up point.
Activities and Recommendations of the Evaluation Team

The Scott & White Evaluation Team has worked closely with sites to ensure a valid and reliable exchange of data. At this time, we are receiving client-level data (i.e., individual data on each of the outcome variables) from all sites. We have also worked with the sites to construct brief case study reports to reflect the personal stories of those who are being served by HAIL projects. This was requested by the Evaluation Team’s local advisors, and we are supportive of this request. The final case studies will be submitted to the UW by the end of September, 2013.

Dr. Stevens will be making an invited presentation at the Meals On Wheels Association of America Annual Conference in Boston on August 28. He will be presenting an overview of his evaluation experience with Tarrant County MOW and the HAIL Initiative.

Data provided in this report is viewed as preliminary since programs are still collecting outcome data on many of their Year 3 clients. The Evaluation Team highly recommends that any decisions regarding the future direction of the HAIL Initiative or future funding of specific programs be put on hold until the Year 3 Final Report that will be provided in March 2014.

Dashboard

Each year, the HAIL Initiative as a whole is assigned a “traffic light” value to indicate whether or not it appears to be headed in the right direction. Additionally, each strategy is assigned a grade to assess performance on the following measures:

1. **Reach**: How well did HAIL reach their target populations?
2. **Participant Impact**: Who is better off? What is the impact of the United Way investment on participants?
3. **Collective Impact**: To what extent has the United Way and HAIL partners engaged the community to ensure success and sustainability?
4. **System Change**: Are we seeing system or culture change? Are they starting to do things differently to effectively address underlying problems?
## Is the HAIL Initiative on Target?

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Organization</th>
<th>Project Status Based on Available Data</th>
<th>Reach</th>
<th>Participant Impact</th>
<th>Collective Impact</th>
<th>System Change</th>
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<td>Health Literacy</td>
<td>University of North Texas Health Science Center</td>
<td>🟢</td>
<td>A</td>
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<td>B</td>
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<tr>
<td>Alzheimer’s Caregiver Health</td>
<td>Alzheimer’s Association</td>
<td>🟢</td>
<td>B</td>
<td>A</td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td></td>
<td>Easter Seals</td>
<td>🟢</td>
<td>A</td>
<td>A</td>
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<td>B</td>
</tr>
<tr>
<td>Falls Prevention</td>
<td>Senior Citizen Services</td>
<td>🟢</td>
<td>A</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Chronic Disease Self-Management</td>
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<td>🟢</td>
<td>C</td>
<td>C+</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Medication Management</td>
<td>Meals On Wheels</td>
<td>🟢</td>
<td>A</td>
<td>🟡</td>
<td>🟢</td>
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<td>A</td>
<td>A</td>
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<tr>
<td>Diabetes Screening/Counseling &amp; Education</td>
<td>Meals On Wheels</td>
<td>🟢</td>
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<td>A</td>
<td>A</td>
<td>A</td>
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<tr>
<td></td>
<td>North Texas Area Community Health Center</td>
<td>🟢</td>
<td>B-</td>
<td>🟢</td>
<td>B</td>
<td>🟢</td>
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</tbody>
</table>

The lack of outcome data prohibits an assignment of grade at this time.

**NOTE:** Participant Impact grades are based on outcome data that are available at this time. Grades reported in the Final Report are subject to change.
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<td>Diabetes Screening/Counseling &amp; Education</td>
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</table>
I. Background

The United Way of Tarrant County has identified a three-armed initiative in its 2020 strategic plan to improve the financial, educational, and health-related aspects of its community. The 2020 Bold Goal for Health states that 30,000 adults over age 35 who have chronic disabling conditions will be healthy at home.

In light of this 2020 Bold Goal, the United Way of Tarrant County delineated specific strategies to address known health risks in Tarrant County. The United Way has partnered with key community-based service organizations to provide health interventions that address the immediate needs of individuals at risk of poor health outcomes as well as health promotion activities that engage adults in self-management techniques and healthy behaviors that are associated with better health and, long term, with lower healthcare costs (e.g., fewer hospitalizations, less need for nursing home care). Ten health interventions make up the United Way’s Healthy Aging and Independent Living (HAIL) initiative. These 10 evidence-based or evidence-informed interventions are serving adults coping with heart disease, stroke, respiratory disease, diabetes (including pre-diabetic conditions), depression, Alzheimer’s, and physical and mental impairments due to chronic conditions. In many cases, family caregivers of adults with chronic illness are also benefiting from the interventions.

This report summarizes the activities of the six organizations who have been commissioned to provide the 10 health interventions, and is limited to the data available for the 12 months of Year 3 of the HAIL initiative at the time the report was developed. A Final Report will include all of the data from Year 3 participants. Information is presented in text, table and graph formats. Tables provide data on specific outputs and outcomes established by United Way of Tarrant County. Accompanying text is presented to summarize significant accomplishments of the partner organizations and provides insight into the health interventions and the impact of interventions on the citizens of Tarrant County.

II. Outputs from Year 3

Identifying and serving those with the most urgent health-related needs are essential tasks to achieving the 2020 Bold Goal. Thus, the United Way has worked with partner organizations to set yearly goals for the number of individuals served by the health interventions. This has been defined as “output targets”. Specific data on the progress towards output targets for Year 3 are presented in Table 1.
<table>
<thead>
<tr>
<th>Strategy</th>
<th>Organization</th>
<th>Output Targets</th>
<th>Quarter 4 Total</th>
<th>% of Quarter Target</th>
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<td>25</td>
<td>100%</td>
<td>51</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3% of library circulation statistics are health-related</td>
<td>NA</td>
<td>100%</td>
<td>3</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 chief medical officer meetings (clinical organizations)</td>
<td>2</td>
<td>100%</td>
<td>4</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>125 organizational representatives trained</td>
<td>NA</td>
<td></td>
<td>199</td>
<td>159%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>15 community-based organizations trained (libraries and other)</td>
<td>NA</td>
<td></td>
<td>15</td>
<td>100%</td>
</tr>
<tr>
<td>Alzheimer’s Caregiver Health</td>
<td>Alzheimer’s Association</td>
<td>357 Alzheimer’s caregivers will be enrolled in the evidence-based caregiver intervention, REACH II</td>
<td>74</td>
<td>82%</td>
<td>313</td>
<td>88%</td>
</tr>
<tr>
<td></td>
<td>Easter Seals</td>
<td>164 persons with dementia who are at risk of nursing home placement and their family caregivers will be provided in-home respite services (6 hours/week for 6 months)</td>
<td>40</td>
<td>98%</td>
<td>163</td>
<td>99%</td>
</tr>
<tr>
<td>Falls Prevention*</td>
<td>Senior Citizen Services</td>
<td>450 persons will participate in an 8-week workshop to learn how to overcome fear of falling and to work on balance and strength to reduce falls</td>
<td>144</td>
<td>107%</td>
<td>529</td>
<td>118%</td>
</tr>
<tr>
<td>Chronic Disease Self-Management</td>
<td>Senior Citizen Services</td>
<td>2,000 individuals will be screened for diabetes and nutritional risk</td>
<td>383</td>
<td>102%</td>
<td>1934</td>
<td>129%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>525 consumers complete at least 4 of 6 evidence-based Stanford Chronic Disease Self-Management (CDSMP) classes</td>
<td>112</td>
<td>113%</td>
<td>296</td>
<td>75%</td>
</tr>
<tr>
<td>Strategy</td>
<td>Organization</td>
<td>Output Targets</td>
<td>Quarter 4 Total</td>
<td>% of Quarter Target</td>
<td>Year 3 Total To Date</td>
<td>% of Annual Target</td>
</tr>
<tr>
<td>----------</td>
<td>--------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>-----------------</td>
<td>---------------------</td>
<td>----------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Medication Management*</td>
<td>Meals On Wheels</td>
<td>1,500 persons will be enrolled in the HomeMeds program</td>
<td>653</td>
<td>123%</td>
<td>1529</td>
<td>102%</td>
</tr>
<tr>
<td></td>
<td>Senior Citizen Services</td>
<td>480 persons will be enrolled in the HomeMeds program</td>
<td>148</td>
<td>103%</td>
<td>346</td>
<td>72%</td>
</tr>
<tr>
<td>Community Health Navigation*</td>
<td>Meals On Wheels</td>
<td>225 persons will be enrolled in the patient activation/CHN project</td>
<td>-</td>
<td>-</td>
<td>241</td>
<td>107%</td>
</tr>
<tr>
<td>Diabetes Screening/ Counseling &amp; Education</td>
<td>Meals On Wheels</td>
<td>3,000 persons will be screened for diabetes and high nutritional risk</td>
<td>855</td>
<td>114%</td>
<td>3573</td>
<td>119%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1,250 persons will receive individualized evidence-based diabetes and/or nutrition counseling</td>
<td>320</td>
<td>107%</td>
<td>1252*</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1,500 follow-up phone calls to persons who receive individualized counseling</td>
<td>565</td>
<td>151%</td>
<td>3245</td>
<td>216%</td>
</tr>
<tr>
<td></td>
<td>North Texas Area Community Health Center</td>
<td>500 persons will be enrolled in the evidence-based DiabetesSalud! Intervention (United Way supports the first 3 visits of the 12-month intervention)</td>
<td>90</td>
<td>72%</td>
<td>399</td>
<td>80%</td>
</tr>
</tbody>
</table>

Of note- The medication management, fall prevention and community health navigation strategies were funded in September 2012. The health literacy strategy was funded in December 2012. Therefore, these programs have a shortened funding year (September 2012 – June 2013 and December 2012–June 2013) and data will reflect as such throughout this report.

* Due to time requirements for training and recertification of all CDSMP staff and volunteers in the new CDSMP curriculum, all BCBH targets have been adjusted to represent the amount of time available for workshops, 75%, and are presented as such in the table.

* MOW review of the draft reported provided to programs indicated a discrepancy between the data tracked by MOW staff and the data provided to the Evaluation Team. MOW staff and the Evaluation Team are working together to address this discrepancy to ensure accurate data for the Year 3 Final Report.
III. Indicators of Service Provision to Target Populations

The 10 health interventions impact the clients served in different ways. Some interventions target the immediate needs of the individual or caring family (e.g., respite services), while others provide the individuals with skills that can be used over the course of the person’s chronic illness (e.g., diabetes counseling). In Table 2, we report on characteristics of each of the health interventions. These data are intended to demonstrate the organization’s ability to deliver the essential elements of the health intervention(s) it has been commissioned to deliver. *When applicable, actual performance targets are compared to expected performance for “targets”. Because targets were not always defined, these data points are frequently missing in the table below.* These variables provide insight into the immediate impact that the health intervention is having on persons served. These variables also provide insight into the mechanisms of action that are thought to drive the desired outcomes of the intervention. In other words, positive findings on these immediate measures are thought to be necessary in order to find positive findings on the outcome measures that are assessed at the end of the service period or target end point (frequently six months after enrollment).

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Organization</th>
<th>Annual Performance Target</th>
<th>Quarter 4 Total</th>
<th>% of Quarter Target</th>
<th>Year 3 Total To Date</th>
<th>% of Annual Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Literacy</td>
<td>University of North Texas Health</td>
<td>#/% of librarians with 75% increased knowledge (from pre- to post-test)</td>
<td>-</td>
<td>-</td>
<td>22 (50%)</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Science Center</td>
<td>#/% of symposium attendees with 75% increased knowledge (from pre- to post-test)</td>
<td>-</td>
<td>-</td>
<td>74 (64%)</td>
<td>-</td>
</tr>
<tr>
<td>Alzheimer’s Caregiver</td>
<td>Alzheimer’s Association</td>
<td>#/% of caregivers that received 3 individualized therapeutic sessions within 4 months of enrollment among those with a 3rd visit</td>
<td>8/100%</td>
<td>-</td>
<td>91/75%</td>
<td>-</td>
</tr>
<tr>
<td>Health</td>
<td></td>
<td>Mean and range of face-to-face therapeutic sessions</td>
<td>1.46 (0-5)</td>
<td>-</td>
<td>2.31 (0-8)</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mean and range of therapeutic sessions by phone</td>
<td>AA Initiated:</td>
<td>-</td>
<td>AA Initiated:</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1.32 (0-5)</td>
<td>-</td>
<td>3.25 (0-11)</td>
<td>-</td>
</tr>
<tr>
<td>Strategy</td>
<td>Organization</td>
<td>Annual Performance Target</td>
<td>Quarter 4 Total</td>
<td>% of Quarter Target</td>
<td>Year 3 Total To Date</td>
<td>% of Annual Target</td>
</tr>
<tr>
<td>----------------------------------</td>
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<td>------------------------------------------------------------------------------------------</td>
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<td>---------------------</td>
<td>---------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>% of caregivers that receive <em>A Caregiver’s Notebook</em> and family profile</td>
<td>100%</td>
<td>-</td>
<td>100%</td>
<td>-</td>
</tr>
<tr>
<td>Easter Seals</td>
<td></td>
<td>#/% of caregivers reporting <strong>strong agreement</strong> that services contributed to them/their loved one being able to stay at home</td>
<td>16/84%</td>
<td>-</td>
<td>58/84%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>#/% of caregivers reporting <strong>strong agreement</strong> that respite services allowed them to ensure their own needs were met</td>
<td>16/84%</td>
<td>-</td>
<td>55/80%</td>
<td>-</td>
</tr>
<tr>
<td>Falls Prevention</td>
<td>Senior Citizen Services</td>
<td># of courses offered (8 classes/course)</td>
<td>17</td>
<td>106%</td>
<td>45</td>
<td>92%</td>
</tr>
<tr>
<td></td>
<td></td>
<td># of lay volunteers trained</td>
<td>8</td>
<td>-</td>
<td>33</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>#/% courses led by lay volunteer</td>
<td>16/94%</td>
<td>-</td>
<td>40/89%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Completion rate</td>
<td>84%</td>
<td>-</td>
<td>87%</td>
<td>-</td>
</tr>
<tr>
<td>Chronic Disease Self-Management</td>
<td>Senior Citizen Services</td>
<td>% maintaining /achieving self-management goals</td>
<td>-</td>
<td>-</td>
<td>65/13%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td># of courses offered (6 classes/course)</td>
<td>19</td>
<td>158%</td>
<td>45</td>
<td>70%</td>
</tr>
<tr>
<td></td>
<td></td>
<td># of lay volunteers trained</td>
<td>7</td>
<td>-</td>
<td>28</td>
<td>85%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>#/% courses led by lay volunteer</td>
<td>14/74%</td>
<td>-</td>
<td>41/89%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Completion rate</td>
<td>45%</td>
<td>-</td>
<td>67%</td>
<td>-</td>
</tr>
<tr>
<td>Medication Management</td>
<td>Meals On Wheels</td>
<td>#/% of clients with medication alerts</td>
<td>283/43%</td>
<td>-</td>
<td>753/52%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td># of medication alerts</td>
<td>534</td>
<td>-</td>
<td>1491</td>
<td>-</td>
</tr>
<tr>
<td>Strategy</td>
<td>Organization</td>
<td>Annual Performance Target</td>
<td>Quarter 4 Total</td>
<td>% of Quarter Target</td>
<td>Year 3 Total To Date</td>
<td>% of Annual Target</td>
</tr>
<tr>
<td>----------</td>
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<td>---------------------------</td>
<td>----------------</td>
<td>---------------------</td>
<td>---------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>% of medication alerts resolved within 30 days</td>
<td>100%</td>
<td>-</td>
<td>100%</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of participants found to be taking harmful medicines advised to discontinue use</td>
<td>99%</td>
<td>-</td>
<td>100%</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Senior Citizen Services</td>
<td>% of medication alerts resolved within 30 days</td>
<td>85%</td>
<td>-</td>
<td>94%</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>#/% of clients with medication alerts</td>
<td>78/53%</td>
<td>-</td>
<td>207/60%</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#/% of participants found to be taking harmful medicines advised to discontinue use</td>
<td>99%</td>
<td>-</td>
<td>100%</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Health Navigation</td>
<td>Mean number of therapeutic contacts with participants</td>
<td>-</td>
<td>-</td>
<td>10.7</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Meals On Wheels</td>
<td>#/% of scheduled contacts achieved</td>
<td>Data will be provided in Final Report.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes Screening/ Counseling &amp; Education</td>
<td>#/% of clients that received the individualized evidence-based diabetes and nutritional counseling who set a goal</td>
<td>209/65%</td>
<td>-</td>
<td>815/65%</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>#/% of clients meeting their goal all of the time</td>
<td>16/39%</td>
<td>-</td>
<td>257/53%</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#/% of clients that reported a level of goal attainment</td>
<td>34/83%</td>
<td>-</td>
<td>413/85%</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meals On Wheels</td>
<td>#/% of referrals to dilated eye exam within 3 months of enrollment</td>
<td>82/91%</td>
<td>-</td>
<td>366/92%</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>North Texas Area Community Health Center</td>
<td># of successful referrals for dilated eye exam w/in 3 months of enrollment</td>
<td>8</td>
<td>-</td>
<td>31</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Strategy</td>
<td>Organization</td>
<td>Annual Performance Target</td>
<td>Quarter 4 Total</td>
<td>% of Quarter Target</td>
<td>Year 3 Total To Date</td>
<td>% of Annual Target</td>
</tr>
<tr>
<td>----------</td>
<td>--------------</td>
<td>----------------------------</td>
<td>-----------------</td>
<td>---------------------</td>
<td>---------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>#/% of patients with at least one completed dilated eye exam</td>
<td></td>
<td>89/99%</td>
<td>-</td>
<td>390/98%</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>#/% of referrals to dental exam within 3 months of enrollment</td>
<td></td>
<td>89/99%</td>
<td>-</td>
<td>389/97%</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td># of successful referrals to dental exam w/in 3 months of enrollment</td>
<td></td>
<td>7</td>
<td>-</td>
<td>10</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>#/% of patients with at least one completed dental exam</td>
<td></td>
<td>88/98%</td>
<td>-</td>
<td>389/97%</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>% of patients that received 4 scheduled visits (sessions 1-5) within 6 months of enrollment</td>
<td></td>
<td>0</td>
<td>-</td>
<td>0</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>
IV. Demographic Characteristics of Clients Served by Partner Organizations

The following graphs provide demographic characteristics for each of the HAIL partner organizations. They show the variation in the clients served in each program.

**Mean Age**

![Mean Age Chart]

**Sex**

![Sex Chart]
V. United Way of Tarrant County HAIL Initiative Outcome Targets

Each of the HAIL initiative interventions is associated with a desired set of outcomes with some outcomes specifically chosen to reflect the unique focus of the interventions. Importantly, the HAIL initiative has also mandated several assessment tools to be used in each project, creating a common set of outcome measures across the interventions. Assessment tools are used to document the beginning or baseline status of individuals served and again at specific follow up assessment points to document the impact of the health interventions. The follow-up assessment occurring at six months after baseline is the outcome point of greatest interest to the United Way; however, health programs that have a short duration often collect data immediately after intervention activities (e.g., Better Choices, Better Health). We have included data from these outcome points when appropriate.

We have analyzed outcome data in two ways. First, we have used summary statistics to provide information on the mean, or average, scores on each of the designated outcome variables for each of the health intervention programs. We provide the mean score at baseline and following delivery of the intervention. In most cases, the follow up mean score was collected 6 months after the baseline score. This commonly used summary statistic provides an indicator of how the intervention impacted the group of participants. In a second set of analyses, we provide information on the actual number of
clients served by the interventions who demonstrated positive change on the outcome variables of interest to the United Way. Results of these analyses assist in determining the number of lives positively impacted by the interventions (i.e., lives that count towards the Bold Goal of 30,000 individuals being impacted by HAIL). Please see Appendix A for a detailed report on all outcome variables.

Summary Statistics of Outcome Measures by Health Intervention

Summary statistics on key outcome variables follow. In each case, we describe the variable and present outcomes for all programs on a sign figure. Please note that only a partial amount of outcome data has been collected at this time since many individuals being served by the sites have not yet finished all of the plan intervention treatments.
The EQ-5D is a brief, standardized, generic measure of health outcomes that provides a profile of patient function and a global health state rating. EQ-5D includes single item measures of five health dimensions: mobility, self-care, usual activities, pain/discomfort, and anxiety/depression. Each item has three possible response options that allows patients to rate their current state with respect to each of the five domains on an ordinal scale (no problems/some or moderate problems/extreme problems). Together, these five domains represent a unique health state from which an index score is calculated. The index score ranges from -0.11 to 1.00, higher scores indicate better health.

Additionally, the EQ-5D includes a visual analog scale (VAS) score. This score is rated on a scale of 0 to 100, higher scores indicate better health.

*This data is preliminary and is subject to change on the Year 3 Final Report.*
2008 NHIS Questionnaire- Health Status and Functional Limitations

Health status is measured by the self-rated general health expressed on a five point scale: “excellent”, “very good”, “good”, “fair”, and “poor”, higher scores indicate better health.

*This data is preliminary and is subject to change on the Year 3 Final Report.
Access to health care utilization is measured by four questions that assess utilization in the past six months: any hospital stays, number of hospital stays, number of nights in the hospital, and number of emergency room visits.

*This data is preliminary and is subject to change on the Year 3 Final Report.

**Preliminary Findings on Aggregate Change from Baseline to Follow Up on NHIS Hospitalized Overnight Measure**

(Year 3 Quarter 1 - Quarter 4 Data, %)

<table>
<thead>
<tr>
<th>Program</th>
<th>Baseline</th>
<th>Follow Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA-REACH II</td>
<td>9</td>
<td>6.3</td>
</tr>
<tr>
<td>ES-Caregiver Respite</td>
<td>15</td>
<td>7.7</td>
</tr>
<tr>
<td>SCS-AMOB</td>
<td>39.3</td>
<td>13.1</td>
</tr>
<tr>
<td>SCS-BCBH</td>
<td>16.4</td>
<td>14.3</td>
</tr>
<tr>
<td>MOW-HomeMeds</td>
<td>34.1</td>
<td>34.1</td>
</tr>
<tr>
<td>MOW-Diabetes Counseling</td>
<td>34.1</td>
<td>12.9</td>
</tr>
<tr>
<td>NTACH-DiabetesSaud</td>
<td>0</td>
<td>9</td>
</tr>
</tbody>
</table>
Living Arrangement Status 6 Month after Enrollment

A critical outcome variable for the interventions within the Alzheimer’s Caregiver Health strategy (REACH II and Respite Care) is the status of the care recipient at the end of six months of service. The goal set by UW is that 80% of the CRs, all of whom are judged to be at risk of nursing home placement, remain in community living at the end of six months of intervention services.

**Alzheimer’s Association REACH II Client Outcomes**
(N=313)

**Easter Seals Respite Care Client Outcomes**
(N=163)
Frequency Count of the Number of Clients with Documented Positive Changes on at least One Outcome Variable

In the next figure, we provide information on the actual number of clients served by the interventions who demonstrated positive change on the outcome variables of interest to the United Way. A positive change was determined to have occurred when the difference in scores (follow up score compared to baseline score) is larger than +0.5 standard deviation (SD). Standard deviation shows the amount of variation from the average for a set of data. Technically, a half of a standard deviation would be equal to 50% of the average difference from the mean in the set of data. This criteria was used for the EQ-5D Health State VAS, EQ-5D Health State Index, Health Competence, and program specific measures. 0.5 SD is commonly used as an indicator of improvement for a minimally important change in health-related measurements and in clinical settings.

We have also included information on the number of clients enrolled and the number of clients with follow up data for each program. Only clients for whom sites were able to collect the follow up assessment data are included. We expect sites to increase the number of clients with follow up data by the end of 2013 and those data will be reflected in the Year 3 Final Report to UW.
Preliminary Findings on Number of Clients Served with Documented Positive Changes on at least One Outcome Variable
VI. Critical Analysis and Summary of Year 3 Annual Report Data by Partner Organizations

**Health Literacy**

**University of North Texas Health Science Center**

The Health Literacy staff made a lot of progress during the 4th quarter to meet their goals for Year 3. Four clinical organizations were approached. There were six “Building the Bridge to Health” librarian trainings. A total of 51 library staff from public libraries, a community college library, two area medical center libraries, and a hospital organization were trained. Additionally, 199 organizational representatives and 15 community-based organizations were trained on the program.

The recruitment approach needed to be adjusted for library trainings. Additionally, alternative means of providing continuing education credit are being explored due to the unexpected closure of Not Typical Library Partners (NTLP). An additional community component and modifications to the existing library trainings will be explored to accommodate for different community partners. Meeting with clinical organizations was difficult. To overcome this obstacle, marketing and referral materials were developed. Health Literacy staff also met with each of the other HAIL partners to discuss each program in depth. Scheduling conflicts resulted in lower librarian attendance at trainings. Meetings were then set up with the head reference librarian and library director to explain the initiative and set a training date. This proved to be successful for the rest of the libraries. The symposium, Health Literacy in Tarrant County Adults: A Systems Approach took place on Thursday, June 6th, 2013. Dr. Laurie Martin, MPH, ScD, a nationally-recognized expert on health literacy from the RAND Corporation gave the keynote address. A total of 156 attendees participated representing over 39 partner organizations. Feedback from attendees was positive.

An abstract, “Enhancing health literacy in adults with chronic disease: A systems approach”, was submitted and accepted for oral presentation at the 141st American Public Health Association Annual Meeting, November 2 – November 6, 2013.

**Alzheimer’s Caregiver Health**

**Alzheimer’s Association**

The Alzheimer’s Association achieved 88% of their enrollment goal for Year 3 with 313 caregivers enrolled in the REACH II program. To date, 75% of caregivers have received three therapeutic sessions within four months of enrollment. Caregivers receive an average of 2.31 face-to-face therapeutic sessions and Alzheimer’s Association staff initiated an average of 3.25 therapeutic sessions by phone.

On average, caregivers self-reported an improvement in General Health after receiving the intervention and reported fewer episodes of hospitalization than in the months before enrolling in REACH II. Only 6.1% of clients with Alzheimer’s disease (CRs) were placed into nursing homes between the beginning and ending of the REACH II intervention (Goal is less than 20%). To date, 80 follow up interviews have
been collected with the 93 caregivers who have completed the REACH II intervention. Of those 80, 73 reported positive change on at least one of the outcome variables.

One dementia care specialist transferred to another position within the chapter in May. A new dementia care specialist was hired and started in mid-June. This transition period negatively impacted enrollments as case levels per dementia care specialist increased in order to deliver services to existing clients.

During this quarter, Alzheimer’s Association staff focused on identifying methods to improve the number of follow up data obtained by clients.

**Easter Seals**

Easter Seals staff essentially made their annual goal of providing in-home respite services, serving 163 individuals with dementia (99% of their goal). A majority of caregivers strongly agree that the services provided by Easter Seals contributed to their loved one being able to stay at home (84%) and that caregivers were able to ensure their own needs were met as a result of the respite services (80%).

Fifty-nine of the 163 enrolled clients have completed the program and only 7.4% have been placed in a nursing home to date (Goal is less than 20%), which is the primary outcome for this service that targets individuals at high risk of nursing home placement. Follow up interview data is currently available on 30 of the family caregivers of the clients at high risk of nursing home placement and few changes are noted in these self-report outcome variables, which is not unexpected given the focus on this service, respite, which is intended to support the community living of the CR.

The Personal Support Services (PSS) Director attended the James L. West Alzheimer’s Center Anniversary Celebration in May. During the celebration, attendees were given the opportunity to participate in the Center’s new Virtual Dementia Tour. This tour provides a simulation of the sensory experiences of people with dementia. Arrangements were made for the tour to be provided at Easter Seals North Texas for two days in July 2013 so all the PSS providers had the opportunity to experience this valuable teaching tool.

The Personal Support Services program experienced a significant number of resignations of direct care providers in May and June. A corresponding number of qualified applicants have not been received making staffing challenging. However, the hiring process began in June for a potential new bilingual English/Spanish provider. This individual has experience working with people with Alzheimer’s and other dementias.

**Falls Prevention**

**Senior Citizen Services**

Senior Citizen Services AMOB staff exceeded their goal for the number of individuals who participated in workshops to overcome their fear of falling and to increase balance and strength to reduce falls, serving 529 individuals (118% of their annual goal). AMOB has exceeded annual output goals for the current
grant year, with an 87% graduation rate. This graduation rate exceeds the national rate of 79% recorded on a national AMOB online data entry system for 68 AMOB projects. Additionally, 89% of course were led by volunteers.

Of the 459 clients who completed the program, follow up data is available at the graduation point for 371. In general, clients receiving AMOB did not report improvements on the EQ-5D, but the group means did show an improvement from baseline to follow up on the General Health Measure. Fewer hospitalizations were also reported at follow up compared to baseline. Of the 371 clients reporting data at graduation, 215 self-reported a positive change in at least one of the outcome variables. Many fewer client interviews (57) are available for the six-month follow up assessment with only 27 of the 57 reporting positive change on an outcome measure. SCS staff continue to focus on 6 month follow up surveys to improve the response rate.

Senior Citizen Services staff have tried to reach out to additional referral sources and in different areas, with great success. AMOB received referrals from balance screenings conducted by Physical Therapy students from UNT Health Science Center School of Physical Therapy at senior centers. Free balance, vision and medication screenings provided by professionals at SCS senior centers result in AMOB referrals and address the multifactorial nature of fall risk. AMOB continues to receive an average of 10 physician referrals per month from North Texas Specialty Physicians group. Progress is being made in locating and starting classes in challenged areas. In June, two classes completed in the Stop Six area with completion rates of over 90%. Alternative locations to gyms for classes are being considered through the help of Silver and Fit health program leadership (an Aetna senior fitness program). This resulted in 17 completed classes at 16 unique locations in quarter 4, including five senior housing communities, three faith-based locations, four senior centers, and four Texas Health Resources hospitals. A diversity of class locations helps AMOB reach new senior groups and identify new coaches. Eight coaches were added to the AMOB team, including seven faith-based nurses and one physical therapist.

During the quarter 4, AMOB staff met with the Safe Communities Task Force to discuss training encouraging primary care physicians to incorporate falls screenings into their standard practice and to identify new partnership opportunities. This training will be presented by UNTHSC faculty.

Additionally, Senior Citizen Services have just implemented their new Access-based data management system. This will allow SCS to collect and track data for clients served in all of their programs in one data system. Data from Year 3 has been imported into the system and all HAIL data will be entered into the system in Year 4. This represents an enduring systems change for Senior Citizen Services.

**Chronic Disease Self-Management**

**Senior Citizen Services**

Senior Citizen Services staff screened 1934 individuals for diabetes and nutritional risk, exceeding their adjusted target of 1500 (129% of the goal). Despite offering 19 courses in quarter 4 (158% of the quarterly target), SCS only met 75% of its adjusted annual goal for completers. Most courses are led by lay volunteers. The course completion rate to date is at 67% for participants. The finding that the large
number of screenings did not produce the expected enrollment into the self-management course is in need of additional review.

Of the 491 clients served with the Better Choices, Better Health intervention, 296 completed the program and 236 reported follow up data at program graduation. One hundred and nine of the 236 clients reported positive change on the two outcome measures collected at this time point (Health Status and Confidence). The complete set of outcome measures is collected at the 6 month assessment point; however, only 69 client interviewers are available at this time. Forty-nine of the 69 clients show positive change on at least one outcome measure at six months. Summary data of the outcome measures do not show a clear pattern of change from baseline to six month follow up, but this may be due to the low number of six month follow up interviewers that are available.

Participants continue to provide positive feedback on the impact and quality of the program through the six month follow-up survey. A follow-up mailing, calls by volunteers and staff, as well as incentives for completing the six month follow up survey have increased the response rate, the response rate for all six month follow-up surveys for workshops completing in June-December 2012 increased to 55%.

The program sponsor agreement has been updated and will be used as a screening tool when conducting site visits and scheduling all workshops. Emphasis will be made on the importance of director involvement and at least one information session will be conducted by staff. These efforts will allow staff to assess facility management involvement and get to know the participants before the workshops start to create rapport and improve enrollment and graduation rates. This approach was implemented by the Program Coordinator at four sites in April and results were positive for facility management involvement and participant enrollment.

The Better Choices, Better Health program has reached out into the community to increase awareness of the program. Staff presented at the first Senior Synergy Expo, an event sponsored by Tarrant County judge Glen Whitley. The Better Choices, Better Health program is now represented at the Healthy Tarrant County Collaboration Group and the Texas Harris Southwest Community Council. Texas Health Resources has also expressed interest in partnering with Better Choices, Better Health for the delivery of the Chronic Disease Self-Management program in Tarrant County.

Additionally, Senior Citizen Services have just implemented their new Access-based data management system. This will allow SCS to collect and track data for clients served in all of their programs in one data system. Data from Year 3 has been imported into the system and all HAIL data will be entered into the system in Year 4. This represents an enduring systems change for Senior Citizen Services.

**Medication Management**

**Meals On Wheels**

Meals On Wheels staff ended the year enrolling 123% of the quarter 4 target for a total of 1529 individuals for medication management, 102% of the annual target. Meals On Wheels found that 52% of clients had medication alerts. To date, a total of 1491 alerts were identified in clients who received the
HomeMeds program. The program is continuing to run smoothly as 100% of alerts were resolved within 30 days and 100% of participants found to be taking harmful medicines were advised to discontinue use. Due to the shortened funding year for this program, 6 month outcome data were not yet collected at the time data were pulled for this report. Six month follow up data are currently being collected and will be included in the Year 3 Final Report.

**Senior Citizen Services**

Senior Citizen Services staff served 346 individuals into their medication management program, 72% of the annual target, despite enrolling 103% of the quarter 4 target. Of clients who received a medication review, 60% were found to have alerts and 94% were resolved within 30 days.

Only a small number (36) of the 320 clients who completed the program were available for 6 month follow up interviews. Of those, 23 reported positive change on at least one of the outcome variables.

In addition to senior living centers, efforts were increased in quarter three towards in-home assessments, depending on client’s preference. During quarter four, eight medication reviews were completed in client’s homes. In exploring how to best administer the HomeMeds program, and with the encouragement of HomeMeds program developers at Partners in Care Foundation, the program has considered offering medication reviews to individuals who are reporting falls, confusion, dizziness or lightheadedness even if they are taking fewer than three medications. This would increase the potential number of participants in the program and improve the participant’s health.

Outreach to other community partners has been successful. HomeMeds staff have made several new contacts including an Emergency Preparedness Educator with Tarrant County Public Health who was interested in partnering to ensure seniors have a plan to get the medications they need in case of a disaster. They agreed to coordinate and have TCPH staff accompany HomeMeds staff to schedule senior center sites in which there is a large interest in medication reviews. Educators will sit down individually with seniors and help them fill out an emergency preparedness kit. While at the Arlington Eunice Senior Center Health Fair, this Care Coordinator was approached by the City of Arlington Wellness Program Coordinator who was interested in having medication reviews done with city staff. This will also increase the potential number of clients served through this program. Additionally, the director at Fair Oaks senior center was trained in HomeMeds to assist with reaching their residents, and the senior center director from Arlington, New York, is assisting the program by translating marketing material and letters to better serve the Spanish-speaking community.

The program was also presented at the Senior Synergy Expo, an event sponsored by Tarrant County judge Glen Whitley.

HomeMeds staff are continually trying to collaborate with other SCS programs. BCBH and AMOB volunteer leaders and coaches have now started to refer to HomeMeds medication management program at the completion of their workshops.
Additionally, Senior Citizen Services have just implemented their new Access-based data management system. This will allow SCS to collect and track data for clients served in all of their programs in one data system. Data from Year 3 has been imported into the system and all HAIL data will be entered into the system in Year 4. *This represents an enduring systems change for Senior Citizen Services.*

**Community Health Navigation**

**Meals On Wheels**

Meals On Wheels staff did not enroll new individuals for the patient activation program in quarter 4 due to how the program was designed and structured. Requirements of the program resulted in all clients being enrolled earlier in the funding year. The program ended the year meeting 107% of their annual enrollment target. Participants received an average of 10.7 therapeutic contacts with their community health navigators.

One hundred twenty-seven of the 241 clients served have completed the program at this time. Remarkably, follow up data is available on 123 clients with 100 of those clients self-reporting a positive change on at least one of the outcome variables. Summary statistics (i.e., means) of outcome variables collected at baseline and follow up show a consistent positive trend with clients, on average, reporting an increase in quality of life and general health and a decrease in hospital care.

The Community Health Navigator monthly meetings have been very beneficial and focused on different topics each month such as various types of fat, how to identify them, how the body reacts, and how to discuss with the clients; CHF and use of the level appropriate CFA resources; and CHN input as to the program success, lessons learned, and data collection. Information is presented to demonstrate how the knowledge can be used to assist clients in terms of their level of activation and highlight the multiple resources available through the PAM website.

There have been over 50 people interested in being CHNs for the next funding year. Many highly professional and now mostly retired individuals are interested in giving back to their community.

**Diabetes Screening/Counseling & Education**

**Meals On Wheels**

Meals On Wheels staff screened 119% (3573) of their annual target for individuals for diabetes and high nutritional risk. The annual target was exceeded for the number of individuals who received diabetes and/or nutrition counseling (1252 clients/100% of the annual target). Additionally, 3245 (216% of the annual target) follow up calls were made to clients receiving counseling. Sixty-five percent of clients who received counseling set a goal. Of those clients who set a goal, 85% reported any level of goal attainment and 53% met their goal all of the time.

Of the 1252 clients served by this program, 389 have completed the program to date. Six-month follow up client interview data are available for 365 clients. Two hundred fifty-six (or 70%) of those surveyed at six months report positive outcomes on at least one outcome variable. These positive findings do not,
however, translate into clear differences in the mean values of the EQ-5D and General Health measures, which are relatively stable across the two time points. A reduction in hospital stays was reported by clients at six months.

One of the RD/LDs resigned in April and the position was not filled until the end of May. Keeping up with the required number of new clients had been a challenge for the remaining RDs during this time. Despite this staffing change, staff were still able to exceed their annual enrollment goals.

**North Texas Area Community Health Center**

North Texas Area Community Health Center staff met 80% of their annual target of 500 for number of individuals enrolled in the DiabetesSalud! Intervention. DiabetesSalud! staff referred 92% of their clients for dilated eye exams within three months of enrollment and 31 clients successfully received a dilated eye exam within three months. However, 98% of clients received at least one completed eye exam. Referrals to dental exams show similar trends with 97% of clients receiving a referral and 10 were successfully completed within three months of enrollment. However, 97% did receive at least one completed dental exam.

Of the 399 clients served by this program, an initial set of follow up data is available for 20 clients. Of the 20 clients with follow up data, 19 show at least one positive change. Outcome measures are collected later on in the intervention; however, only four clients have data. Three of the four clients show positive change on at least one outcome measure at the later follow up point. After quarter 3, the evaluation team talked with the DiabetesSalud! Program and suggested asking the assessments earlier in the intervention timeline in order to obtain additional follow up data. This change took some time and in part resulted in the low number of follow up data available. For the first set of follow up (N=20), the average length to follow up was 144.60 days, standard deviation=57.93, range (49-283); Days to Follow up 2 (N=4): average length to follow up was 223.75, standard deviation=20.27, range (203-244). These processes have been refined and additional follow up data is expected for the Year 3 Final Report and in Year 4.

There continues to be a challenge in appointment adherence and many no-shows and cancellations. This is negatively impacting the collection of follow up client self-report data and prohibiting a clear discussion of findings from this project. Staff are aware of the issues and additional resources are being explored that can assist to provide incentives for participants.

**VII. Activities and Recommendations of the Evaluation Team**

The Scott & White Evaluation Team has worked closely with sites to ensure a valid and reliable exchange of data. At this time, we are receiving client-level data (i.e., individual data on each of the outcome variables) from all sites. We have also worked with the sites to construct brief case study reports to reflect the personal stories of those who are being served by HAIL projects. This was requested by the
Evaluation Team’s local advisors, and we are supportive of this request. The final case studies will be submitted to the UW by the end of September, 2013.

Collecting client-level data from each of the HAIL sites allowed us to provide comparative analysis of program results to date. The results of this analysis are included in the outcome graph in Appendix A. The graphs demonstrate the total number of individuals served by the HAIL projects (i.e., Outputs), the total number of individuals who completed the six month program, the total number of clients who had any follow up data, and the total number of clients who had any six month follow up data. For those HAIL projects that collect data at multiple time points, there will be a difference in the number of clients who have any follow up and any six month follow up data. For HAIL projects that only have one follow up time point, these two figures will be the same. The graphs also show the total number of clients who show at least one positive impact as outlined in the HAIL Bold Goal statement (e.g., increased confidence in self-management skills, improved quality of life, reduced ER visits). Finally, the graphs then outline the number of clients who showed a positive change within each of the outcomes. These graphs provide the data necessary to determine the number of individuals that can be counted towards the Bold Goal of 30K individuals receiving a positive impact from the HAIL initiative. These figures can also be seen in the graph in section V above. As shown in the variability of the graphs, the analysis is dependent on the availability of follow up data on clients served. Each of the HAIL projects has initiated new methods to increase the number of clients who complete the intervention and answer the follow up assessments. These numbers will increase as the final outcome data is being collected which will be presented in the Year 3 Final Report.

Dr. Stevens will be making an invited presentation at the Meals On Wheels Association of America Annual Conference in Boston on August 28. He will be presenting an overview of his evaluation experience with Tarrant County MOW and the HAIL Initiative.
Appendix A

Summary of Outcome Data by Organization and Intervention

Description of Cross Site Outcome Measures

**EQ-5D**
The EQ-5D is a brief, standardized, generic measure of health outcomes that provides a profile of patient function and a global health state rating. EQ-5D includes single item measures of five health dimensions: mobility, self-care, usual activities, pain/discomfort, and anxiety/depression. Each item has three possible response options that allows patients to rate their current state with respect to each of the five domains on an ordinal scale (no problems/some or moderate problems/extreme problems). Together, these five domains represent a unique health state from which an index score is calculated. The index score ranges from -0.11 to 1.00, higher scores indicate better health.

Additionally, the EQ-5D includes a visual analog scale (VAS) score. This score is rated on a scale of 0 to 100, higher scores indicate better health.

**2008 NHIS Questionnaire- Health Status and Functional Limitations**
Health status is measured by the self-rated general health expressed on a five point scale: “excellent”, “very good”, “good”, “fair”, and “poor”, higher scores indicate better health.

**Perceived Competence Scale for Health**
Perceived competence scale for health is measured by how confident participants feel in managing their own health problems. These measures include participant’s ability to manage own health, to handle health problems, to do routine health care, to meet challenge of own health. The composite measure ranges from 4 to 28, higher scores indicate greater competence.

**2011 NHIS Questionnaire-Family Access to Health Care & Utilization**
Access to health care utilization is measured by four questions that assess utilization in the past six months: any hospital stays, number of hospital stays, number of nights in the hospital, and number of emergency room visits.

Description of Program-Specific Outcome Measures

**REACH II Risk Assessment Measure**
The RAM is a 16-item assessment that is used to identify the areas of greatest need for the caregiver. This information is used to guide the development of a family profile and the therapeutic sessions of the intervention. It ranges from 0 to 38; higher scores indicate a higher risk caregiver.
REACH II Quality of Life
The Quality of Life consists of five domains: depression, caregiver burden, social support, self-care, and care recipient problem behaviors. The five assessments used include: CES-D depression scale, Zarit Caregiver Burden Interview, REACH II Social Support and Self-Care Composites, and questions from the Revised Memory Behavior Problem Checklist. The CES-D is a 10-item assessment that ranges from 0 to 30; higher scores indicate greater depressive symptoms. The Zarit Caregiver Burden Interview is a 12-item assessment that ranges from 0 to 44; higher scores indicate greater burden. The REACH II Social Support Composite is a 10-item assessment that ranges from 0 to 34; higher scores indicate increased levels of social support. The REACH II Self-Care Composite is a 15-item assessment that ranges from 0 to 15; higher scores indicate greater attention given to one’s health and well-being. There are three questions assessing domains of the Revised Memory Behavior Problem Checklist which ranges from 0 to 3, higher scores indicate greater attention given to one’s health and well-being.

Falls Efficacy Scale
The Falls Efficacy Scale is a 10-item assessment that measures the client’s perceived confidence in completing a number of common activities (i.e., take a bath or shower, prepare meals not requiring carrying heavy or hot objects). A higher score indicates less confidence.

Matter of Balance Survey- Falls Efficacy Scale Modified
The Falls Efficacy Scale Modified is a 5-item assessment that measures the client’s perceived ability to manage falls. A higher score indicates a greater perceived ability to control falls.

Matter of Balance Survey- PACE Modified Activity Scale
The PACE Modified Activity Scale uses one question, a higher score indicates a higher level of exercise.

Morisky’s Measure of Medication Taking Behavior/Self-Efficacy in Medication Adherence
The Morisky Medication Adherence Questionnaire is an 8-item assessment that measures the client’s adherence to a medication regimen. A higher score indicates less medication adherence.

Patient Activation Measure
The Patient Activation Measure is a 13-item assessment that measures the knowledge, skills and confidence essential to managing one’s own health and healthcare. A higher score indicates a higher level of activation.

Diabetes Knowledge Assessment
The Diabetes Knowledge Assessment includes 11 items that measures the client’s knowledge about their diabetes. The score ranges from 0 to 11, higher scores indicate greater client knowledge.

Diabetes Quality of Life
The Diabetes Quality of Life assesses dissatisfaction with diabetes management, how diabetes has affected quality of life and concerns regarding care and diabetes. It is a 22-item assessment ranging from 22-110, higher scores indicate less dissatisfaction.
### Table 1: Criteria Used to Determine Positive Change in Outcome Measures

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Measures Used</th>
<th>Criteria for positive change from baseline to 6 month follow-up/graduation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cross-Site</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utilization</td>
<td>NHIS: Times Overnight Hospital Stay</td>
<td>Decrease in number of times overnight hospital stay</td>
</tr>
<tr>
<td></td>
<td>NHIS:ER visits</td>
<td>Change from ‘Yes’ to ‘No’</td>
</tr>
<tr>
<td>Health Status</td>
<td>NHIS: General Health</td>
<td>A higher self-reported health level</td>
</tr>
<tr>
<td></td>
<td>EQ-5D Health State VAS</td>
<td>Larger change than +0.5 standard deviation (SD) of baseline score</td>
</tr>
<tr>
<td>Quality of Life</td>
<td>EQ-5D Health State Index</td>
<td>Larger change than +0.5 standard deviation (SD) of baseline score</td>
</tr>
<tr>
<td>Confidence, Efficacy, Activation, Goal Setting</td>
<td>Health Competence</td>
<td>Larger change than +0.5 standard deviation (SD) of baseline score</td>
</tr>
<tr>
<td>Program-Specific</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AA- REACH II</td>
<td>REACH II Quality of Life</td>
<td>Larger changes than +0.5 standard deviation (SD) of baseline scores</td>
</tr>
<tr>
<td></td>
<td>• Burden</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Depression</td>
<td></td>
</tr>
<tr>
<td>ES- Caregiver Respite</td>
<td>REACH II Quality of Life</td>
<td>Larger changes than +0.5 standard deviation (SD) of baseline scores</td>
</tr>
<tr>
<td></td>
<td>• Burden</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(only if CG is not AA client)</td>
<td></td>
</tr>
<tr>
<td>SCS-AMOB</td>
<td>Falls Efficacy Scale (Modified)</td>
<td>Larger change than +0.5 standard deviation (SD) of baseline score</td>
</tr>
<tr>
<td>SCS-BCBH</td>
<td>Goal Attainment</td>
<td>Self-managed goal met 100%/all of the time at 6 month follow up</td>
</tr>
<tr>
<td>MOW-HomeMeds</td>
<td>Morisky’s Medication Adherence Score</td>
<td>Larger change than +0.5 standard deviation (SD) of baseline score</td>
</tr>
<tr>
<td>SCS-HomeMeds</td>
<td>Morisky’s Medication Adherence Score</td>
<td>Larger change than +0.5 standard deviation (SD) of baseline score</td>
</tr>
<tr>
<td>MOW-PAM</td>
<td>Patient Activation Measure</td>
<td>Larger change than +0.5 standard deviation (SD) of baseline score</td>
</tr>
<tr>
<td>MOW-Diabetes Counseling</td>
<td>Goal Attainment</td>
<td>Self-managed goal met 100%/all of the time at 6 month follow up</td>
</tr>
<tr>
<td>NTACHC-Diabetes Salud!</td>
<td>• Diabetes Quality of Life</td>
<td>Larger changes than +0.5 standard deviation (SD) of baseline scores</td>
</tr>
<tr>
<td></td>
<td>• Diabetes Knowledge Assessment</td>
<td></td>
</tr>
</tbody>
</table>
A positive change occurs when the difference in scores (follow up score compared to baseline score) is larger than +0.5 standard deviation (SD) compared to the baseline score. Standard deviation shows the amount of variation from the average for a set of data. Technically, a half of a standard deviation would be equal to 50% of average difference from the mean in the set of data. This criteria was used for the EQ-5D Health State VAS, EQ-5D Health State Index, Health Competence, and program specific measures. 0.5 SD is commonly used as an indicator of improvement for a minimally important change in health-related measurements and in clinical settings.

**Outcome Measures by Strategy and Organization**

**Health Literacy**

Due to changes in the Health Literacy program over the course of Year 3, there are no outcome measures to report. Outcome data will be collected and tracked in Year 4.

**Alzheimer’s Caregiver Health: REACH II for Dementia Caregivers**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Individual</th>
<th>Baseline Mean (N)</th>
<th>6 Month Follow Up Mean (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health Status (EQ-5D)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health State VAS</td>
<td>CG</td>
<td>72.23 (N=301)</td>
<td>77.99 (N=79)</td>
</tr>
<tr>
<td><strong>2008 NHIS: Family Health Status &amp; Limitations</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Health</td>
<td>CG</td>
<td>2.99 (N=302)</td>
<td>3.31 (N=80)</td>
</tr>
<tr>
<td><strong>Health Competence (Perceived Competence Scale for Health)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalized Overnight Hospital Stay (N, %)</td>
<td>CG</td>
<td>27/9.0% (N=299)</td>
<td>5/6.3% (N=80)</td>
</tr>
<tr>
<td>Times Overnight Hospital Stay (N, %)</td>
<td>CG</td>
<td>1.38 (N=26)</td>
<td>1.20 (N=5)</td>
</tr>
<tr>
<td>Nights in Hospital (N, %)</td>
<td>CG</td>
<td>5.42 (N=26)</td>
<td>1.40 (N=5)</td>
</tr>
<tr>
<td>ER Visits (N, %)</td>
<td></td>
<td>64/21.4% (N=299)</td>
<td>5/6.3% (N=80)</td>
</tr>
<tr>
<td><strong>Risk Assessment Measure (range: 0-38)</strong></td>
<td>CG</td>
<td>15.11 (N=313)</td>
<td>^</td>
</tr>
</tbody>
</table>

Table 2: Baseline and 6 Month Follow Up Data on Clients Served by Alzheimer’s Association
Table 2: Baseline and 6 Month Follow Up Data on Clients Served by Alzheimer’s Association

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Individual</th>
<th>Baseline Mean (N)</th>
<th>6 Month Follow Up Mean (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>REACH II Quality of Life Measure</td>
<td>CG</td>
<td>Depression: 9.78 (N=275)</td>
<td>Depression: 7.55 (N=73)</td>
</tr>
<tr>
<td>(ranges: Depression: 0-30; Burden: 0-44; Soc. Support: 0-34; Self-Care: 0-15; Prob. Behaviors: 0-3)</td>
<td></td>
<td>Burden: 18.09 (N=275)</td>
<td>Burden: 15.78 (N=72)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Self-Care: 5.56 (N=275)</td>
<td>Self-Care: 5.78 (N=72)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prob. Behaviors: 0.71 (N=274)</td>
<td>Prob. Behaviors: 0.66 (N=70)</td>
</tr>
</tbody>
</table>

† This project does not complete the EQ-5D Health State Index assessment.

^ Risk assessment Measure only completed at baseline.

Alzheimer’s Association REACH II Outcomes:
Number of Clients at 6 Months
## Alzheimer’s Caregiver Health: Caregiver Respite

### Table 3: Baseline and 6 Month Follow Up Data on Clients Served by Easter Seals

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Individual</th>
<th>Baseline Mean (N)</th>
<th>6 Month Follow Up Mean (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health Status (EQ-5D)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health State Index</td>
<td>CR*</td>
<td>0.47 (N=27)</td>
<td>0.44 (N=27)</td>
</tr>
<tr>
<td>Health State VAS</td>
<td></td>
<td>53.56 (N=116)</td>
<td>58.06 (N=30)</td>
</tr>
<tr>
<td>Health State Index</td>
<td>CG (only if not AA Client)</td>
<td>0.70 (N=3)</td>
<td>0.72 (N=7)</td>
</tr>
<tr>
<td>Health State VAS</td>
<td></td>
<td>69.29 (N=7)</td>
<td>75.00 (N=7)</td>
</tr>
<tr>
<td><strong>2008 NHIS: Family Health Status &amp; Limitations</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Health</td>
<td>CR*</td>
<td>2.55 (N=116)</td>
<td>2.47 (N=30)</td>
</tr>
<tr>
<td>General Health</td>
<td>CG (only if not AA client)</td>
<td>3.29 (N=7)</td>
<td>3.43 (N=7)</td>
</tr>
<tr>
<td><strong>Health Competence (Perceived Competence Scale for Health)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Competence (Perceived Competence Scale for Health)</td>
<td>CR*</td>
<td>8.86 (N=117)</td>
<td>5.63 (N=30)</td>
</tr>
<tr>
<td></td>
<td>CG (only if not AA client)</td>
<td>24.57 (N=7)</td>
<td>24.29 (N=7)</td>
</tr>
<tr>
<td><strong>2011 NHIS: Family Access to Health Care &amp; Utilization</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalized Overnight (N, %)</td>
<td>CR*</td>
<td>46/39.3% (N=117)</td>
<td>7/23.3% (N=30)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.50 (N=46)</td>
<td>1.86 (N=7)</td>
</tr>
<tr>
<td>Nights in Hospital</td>
<td></td>
<td>7.28 (N=46)</td>
<td>6.43 (N=7)</td>
</tr>
<tr>
<td>ER Visits (N, %)</td>
<td></td>
<td>39/33.3% (N=117)</td>
<td>9/30.0% (N=30)</td>
</tr>
<tr>
<td>Hospitalized Overnight (N, %)</td>
<td></td>
<td>1/0.14% (N=7)</td>
<td>1/0.14% (N=7)</td>
</tr>
<tr>
<td></td>
<td>CG (only if not AA client)</td>
<td>0.14 (N=1)</td>
<td>0.14 (N=1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0.28 (N=1)</td>
<td>0.14 (N=1)</td>
</tr>
<tr>
<td>ER Visits (N, %)</td>
<td></td>
<td></td>
<td>1/0.14% (N=7)</td>
</tr>
<tr>
<td>Zarit Caregiver Burden Interview (range: 0-44)</td>
<td>CG (only if not AA Client)</td>
<td>34.14 (N=7)</td>
<td>30.14 (N=7)</td>
</tr>
</tbody>
</table>

*Proxy report completed by caregiver (CG) for care recipient with dementia (CR)
Assessment data will not give an accurate picture of the health improvement of the client. The Easter Seals’ clients are individuals with Alzheimer’s disease or dementia and we do not expect to see improvements in their health as a result of their caregiver receiving respite care.

Falls Prevention: A Matter of Balance

Table 4: Baseline, Graduation, and 6 Month Follow Up Data on Clients Served by Senior Citizen Services

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Individual</th>
<th>Baseline Mean (N)</th>
<th>Graduation Follow Up Mean (N)</th>
<th>6 Month Follow Up Mean (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Status (EQ-5D)</td>
<td>Health State Index Client</td>
<td>0.82 (N=390)</td>
<td>0.84 (N=243)</td>
<td>0.74 (N=23)</td>
</tr>
<tr>
<td></td>
<td>Health State VAS Client</td>
<td>77.15 (N=413)</td>
<td>79.86 (N=250)</td>
<td>76.66 (N=29)</td>
</tr>
<tr>
<td>2011 NHIS: Family Access to Health Care &amp; Utilization</td>
<td>Hospitalized Overnight (N, %) Client</td>
<td>52/15.0% (N=346)</td>
<td>26/11.0% (N=237)</td>
<td>2/7.7% (N=26)</td>
</tr>
<tr>
<td></td>
<td>Times Overnight Hospital Stay</td>
<td>0.28 (N=326)</td>
<td>0.18 (N=222)</td>
<td>0.18 (N=22)</td>
</tr>
</tbody>
</table>
Table 4: Baseline, Graduation, and 6 Month Follow Up Data on Clients Served by Senior Citizen Services

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Individual</th>
<th>Baseline Mean (N)</th>
<th>Graduation Follow Up Mean (N)</th>
<th>6 Month Follow Up Mean (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nights in Hospital</td>
<td></td>
<td>0.67 (N=322)</td>
<td>0.51 (N=218)</td>
<td>.52 (N=23)</td>
</tr>
<tr>
<td>ER Visits (N, %)</td>
<td></td>
<td>87/26.2% (N=332)</td>
<td>39/17.8% (N=219)</td>
<td>3/12.5% (N=24)</td>
</tr>
<tr>
<td>Falls Efficacy Scale</td>
<td>Client</td>
<td>20.1 (N=437)</td>
<td>17.35 (N=256)</td>
<td>20.12 (N=20)</td>
</tr>
<tr>
<td>Falls Efficacy Scale Modified</td>
<td>Client</td>
<td>2.72 (N=501)</td>
<td>3.17 (N=371)</td>
<td>3.05 (N=57)</td>
</tr>
<tr>
<td>Matter of Balance Survey</td>
<td></td>
<td>4.54 (N=501)</td>
<td>5.10 (N=371)</td>
<td>5.12 (N=57)</td>
</tr>
</tbody>
</table>

*This project does not complete the Perceived Competence Scale for Health assessment.*

---

Senior Citizen Services A Matter of Balance Outcomes: Number of Clients at Graduation

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Number of Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients Served</td>
<td>529</td>
</tr>
<tr>
<td>Completed Program To Date</td>
<td>459</td>
</tr>
<tr>
<td>Clients With Any Follow Up To Date</td>
<td>371</td>
</tr>
<tr>
<td>Clients Showing Any Positive Change</td>
<td>215</td>
</tr>
<tr>
<td>Utilization</td>
<td></td>
</tr>
<tr>
<td>Health Status</td>
<td>80</td>
</tr>
<tr>
<td>Quality of Life</td>
<td>18</td>
</tr>
<tr>
<td>Falls Efficacy Scale</td>
<td>153</td>
</tr>
</tbody>
</table>
Chronic Disease Self-Management: Better Choices, Better Health

Table 5: Baseline, Graduation, and 6 Month Follow Up Data on Clients Served by Senior Citizen Services

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Individual</th>
<th>Baseline Mean (N)</th>
<th>Graduation Follow Up Mean (N)</th>
<th>6 Month Follow Up Mean (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Status (EQ-5D)</td>
<td>Health State Index</td>
<td>0.76 (N=370)</td>
<td>NA</td>
<td>0.73 (N=62)</td>
</tr>
<tr>
<td></td>
<td>Health State VAS</td>
<td>71.93 (N=416)</td>
<td>NA</td>
<td>72.81 (N=67)</td>
</tr>
<tr>
<td>2008 NHIS: Family Health Status &amp; Limitations</td>
<td>General Health</td>
<td>3.03 (N=437)</td>
<td>3.24 (N=171)</td>
<td>2.90 (N=68)</td>
</tr>
<tr>
<td>Health Competence (Perceived Competence Scale for Health)</td>
<td>Client</td>
<td>21.63 (N=434)</td>
<td>25.01 (N=236)</td>
<td>23.85 (N=67)</td>
</tr>
<tr>
<td>2011 NHIS: Family Access to Health Care &amp; Utilization</td>
<td>Hospitalized Overnight (N, %)</td>
<td>46/13.0% (N=353)</td>
<td>NA</td>
<td>5/7.2% (N=69)</td>
</tr>
<tr>
<td></td>
<td>Times Overnight Hospital Stay</td>
<td>2.26 (N=42)</td>
<td>N/A</td>
<td>1.6 (N=5)</td>
</tr>
<tr>
<td></td>
<td>Nights in Hospital</td>
<td>5.66 (N=41)</td>
<td>N/A</td>
<td>3.4 (N=5)</td>
</tr>
</tbody>
</table>
Table 5: Baseline, Graduation, and 6 Month Follow Up Data on Clients Served by Senior Citizen Services

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Individual</th>
<th>Baseline Mean (N)</th>
<th>Graduation Follow Up Mean (N)</th>
<th>6 Month Follow Up Mean (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ER Visits (N, %)</td>
<td></td>
<td>89/23.4% (N=381)</td>
<td>N/A</td>
<td>12/18.2% (N=66)</td>
</tr>
<tr>
<td>Goal attainment (N/%, Met goal 100% of the time)</td>
<td>Client</td>
<td>^</td>
<td>^</td>
<td>5/7.2%</td>
</tr>
</tbody>
</table>

^ Goal Attainment set at Graduation and measured at 6 Month Follow Up

Senior Citizen Services Better Choices, Better Health Outcomes: Number of Clients at Graduation

<table>
<thead>
<tr>
<th>Clients Served</th>
<th>Clients Completed Program To Date</th>
<th>Clients With Any Follow Up To Date</th>
<th>Clients Showing Any Positive Change</th>
<th>Health Status</th>
<th>Confidence, Efficacy, Activation, Goal Setting</th>
<th>Cross-Site Outcomes at Graduation</th>
</tr>
</thead>
<tbody>
<tr>
<td>491</td>
<td>296</td>
<td>236</td>
<td>109</td>
<td>50</td>
<td>90</td>
<td></td>
</tr>
</tbody>
</table>
Medication Management: HomeMeds

Table 6: Baseline and 6 Month Follow Up Data on Clients Served by Meals On Wheels

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Individual</th>
<th>Baseline Mean (N)</th>
<th>6 Month Follow Up Mean (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morisky’s Measure of Medication Taking Behavior/Self-Efficacy in Medication Adherence</td>
<td>Client</td>
<td>2.06 (N=319)</td>
<td>#</td>
</tr>
</tbody>
</table>

*This project does not complete the EQ-5D, 2008 NHIS: Family Health Status & Limitations, Perceived Competence Scale for Health, and 2011 NHIS: Family Access to Health Care & Utilization assessments, they are completed annually by Meals On Wheels Case Manager. Data collected close to the 6 Month Morisky date will be included in Final Report.

# Morisky’s Measure of Medication Adherence collected starting January 2013; 6 Month data not collected until July 2013. Data will be provided in the Year 3 Final Report.
Morisky’s Measure of Medication Adherence collected starting January 2013; 6 Month data not collected until July 2013. Data will be provided in Year 3 Final Report.

Medication Management: HomeMeds

Table 7: Baseline and 6 Month Follow Up Data on Clients Served by Senior Citizen Services

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Individual</th>
<th>Baseline Mean (N)</th>
<th>6 Month Follow Up Mean (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health Status (EQ-5D)</strong></td>
<td>Client</td>
<td>0.76 (N=242)</td>
<td>0.71 (N=31)</td>
</tr>
<tr>
<td></td>
<td>Health State Index</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Health State VAS</td>
<td>71.71 (N=290)</td>
<td>69.27 (N=33)</td>
</tr>
<tr>
<td><strong>2008 NHIS: Family Health Status &amp; Limitations</strong></td>
<td>Client</td>
<td>3.03 (N=296)</td>
<td>3.06 (N=35)</td>
</tr>
<tr>
<td></td>
<td>General Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2011 NHIS: Family Access to Health Care &amp; Utilization</strong></td>
<td>Client</td>
<td>47/16.4% (N=287)</td>
<td>5/14.3% (N=35)</td>
</tr>
<tr>
<td></td>
<td>Hospitalized Overnight (N, %)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Times Overnight Hospital Stay</td>
<td>1.53 (N=43)</td>
<td>1.2 (N=5)</td>
</tr>
<tr>
<td></td>
<td>Nights in Hospital</td>
<td>5.90 (N=41)</td>
<td>2.4 (N=5)</td>
</tr>
<tr>
<td></td>
<td>ER Visits (N, %)</td>
<td>49/18.1% (N=270)</td>
<td>3/9.1% (N=33)</td>
</tr>
<tr>
<td>Morisky’s Measure of Medication Taking Behavior/Self-Efficacy in Medication Adherence</td>
<td>Client</td>
<td>1.66 (N=300)</td>
<td>1.67 (N=36)</td>
</tr>
</tbody>
</table>

* This project does not complete the Perceived Competence Scale for Health assessment.
### Community Health Navigation: Patient Activation Model

#### Table 8: Baseline and 6 Month Follow Up Data on Clients Served by Meals On Wheels

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Individual</th>
<th>Baseline Mean (N)</th>
<th>6 Month Follow Up Mean (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Status (EQ-5D)</td>
<td>Health State Index</td>
<td>Client</td>
<td>0.51 (N=189)</td>
</tr>
<tr>
<td></td>
<td>Health State VAS</td>
<td>Client</td>
<td>55.80 (N=186)</td>
</tr>
<tr>
<td>2008 NHIS: Family Health Status &amp; Limitations</td>
<td>General Health</td>
<td>Client</td>
<td>2.32 (N=192)</td>
</tr>
<tr>
<td>Health Competence (Perceived Competence Scale for Health)</td>
<td></td>
<td>Client</td>
<td>18.50 (N=185)</td>
</tr>
<tr>
<td>2011 NHIS: Family Access to Health Care &amp; Utilization</td>
<td>Hospitalized Overnight (N, %)</td>
<td>Client</td>
<td>77/34.1% (N=226)</td>
</tr>
<tr>
<td></td>
<td>Times Overnight Hospital Stay</td>
<td></td>
<td>1.62 (N=66)</td>
</tr>
<tr>
<td></td>
<td>Nights in Hospital</td>
<td></td>
<td>8.08 (N=62)</td>
</tr>
<tr>
<td></td>
<td>ER Visits (N, %)</td>
<td></td>
<td>79/35.6% (N=222)</td>
</tr>
</tbody>
</table>
Table 8: Baseline and 6 Month Follow Up Data on Clients Served by Meals On Wheels

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Individual</th>
<th>Baseline Mean (N)</th>
<th>6 Month Follow Up Mean (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Activation Measure</td>
<td>Client</td>
<td>54.40 (N=193)</td>
<td>59.66 (N=123)</td>
</tr>
</tbody>
</table>

Meals On Wheels Patient Activation Model Outcomes: Number of Clients at 6 Months

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients Served</td>
<td>241</td>
</tr>
<tr>
<td>Clients Completed Program To Date</td>
<td>127</td>
</tr>
<tr>
<td>Clients With Any Follow Up To Date</td>
<td>123</td>
</tr>
<tr>
<td>Clients with Any 6M Follow Up To Date</td>
<td>123</td>
</tr>
<tr>
<td>Clients Showing Any Positive Change</td>
<td>100</td>
</tr>
<tr>
<td>Utilization</td>
<td>21</td>
</tr>
<tr>
<td>Health Status</td>
<td>48</td>
</tr>
<tr>
<td>Quality of Life</td>
<td>30</td>
</tr>
<tr>
<td>Confidence, Efficacy, Activation, Goal Setting</td>
<td>34</td>
</tr>
<tr>
<td>Patient Activation Measure</td>
<td>48</td>
</tr>
</tbody>
</table>

Cross-Site Outcomes at 6 Months

Program-Specific Outcome at 6 Months
## Diabetes Screening/Counseling & Education: Diabetes Counseling

### Table 9: Baseline and 6 Month Follow Up Data on Clients Served by Meals on Wheels

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Individual</th>
<th>Baseline Mean (N)</th>
<th>6 Month Follow Up Mean (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health Status (EQ-5D)</strong></td>
<td>Health State Index</td>
<td>0.61 (N=1135)</td>
<td>0.62 (N=230)</td>
</tr>
<tr>
<td></td>
<td>Health State VAS</td>
<td>67.78 (N=927)</td>
<td>60.44 (N=209)</td>
</tr>
<tr>
<td><strong>2008 NHIS: Family Health Status &amp; Limitations</strong></td>
<td>General Health</td>
<td>2.64 (N=1063)</td>
<td>2.66 (N=224)</td>
</tr>
<tr>
<td><strong>Health Competence (Perceived Competence Scale for Health)</strong></td>
<td>Client</td>
<td>21.82 (N=848)</td>
<td>21.32 (N=196)</td>
</tr>
<tr>
<td><strong>2011 NHIS: Family Access to Health Care &amp; Utilization</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospitalized Overnight (N, %)</td>
<td>435/34.1% (N=1251)</td>
<td>47/12.9% (N=365)</td>
</tr>
<tr>
<td></td>
<td>Times Overnight Hospital Stay</td>
<td>1.58 (N=423)</td>
<td>1.30 (N=46)</td>
</tr>
<tr>
<td></td>
<td>Nights in Hospital</td>
<td>9.71 (N=407)</td>
<td>6.65 (N=46)</td>
</tr>
<tr>
<td></td>
<td>ER Visits (N, %)</td>
<td>470/37.6% (N=1251)</td>
<td>47/12.9% (N=365)</td>
</tr>
<tr>
<td><strong>DADS (Determine) Nutrition Risk Screening Tool</strong></td>
<td>Client</td>
<td>7.97 (N=1251)</td>
<td>^</td>
</tr>
</tbody>
</table>

^ Assessment completed annually by Meals On Wheels Case Manager

---

### Meals On Wheels Diabetes Counseling Model Outcomes:

**Number of Clients at 6 Months**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients Served</td>
<td>1252</td>
</tr>
<tr>
<td>Clients Completed Program To Date</td>
<td>389</td>
</tr>
<tr>
<td>Clients With Any Follow Up To Date</td>
<td>365</td>
</tr>
<tr>
<td>Clients with any 6M Follow Up To Date</td>
<td>365</td>
</tr>
<tr>
<td>Clients Showing Any Positive Change</td>
<td>256</td>
</tr>
<tr>
<td>Utilization</td>
<td>112</td>
</tr>
<tr>
<td>Health Status</td>
<td>68</td>
</tr>
<tr>
<td>Quality of Life</td>
<td>43</td>
</tr>
<tr>
<td>Confidence, Efficacy, Activation, Goal Setting</td>
<td>21</td>
</tr>
<tr>
<td>Goal Setting</td>
<td>152</td>
</tr>
</tbody>
</table>

Cross-Site Outcomes at 6 Months

Program-Specific Outcome at 6 Months
**Diabetes Screening/Counseling & Education: DiabetesSalud!**

### Table 10: Baseline and Follow Up Data on Clients Served by North Texas Area Community Health Center

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Individual</th>
<th>Baseline Mean (N)</th>
<th>1&lt;sup&gt;st&lt;/sup&gt; Follow Up Mean (N)*</th>
<th>2&lt;sup&gt;nd&lt;/sup&gt; Follow Up Mean (N)*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health Status (EQ-5D)</strong></td>
<td>Client</td>
<td>0.82 (N=396)</td>
<td>0.85 (N=19)</td>
<td>0.90 (N=3)</td>
</tr>
<tr>
<td>Health State Index</td>
<td>Health</td>
<td>52.80 (N=394)</td>
<td>80.56 (N=18)</td>
<td>60.00 (N=3)</td>
</tr>
<tr>
<td>VAS</td>
<td>Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2008 NHIS: Family Health Status &amp; Limitations</strong></td>
<td>General</td>
<td>2.65 (N=394)</td>
<td>3.22 (N=18)</td>
<td>3.00 (N=4)</td>
</tr>
<tr>
<td>Health</td>
<td>Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2011 NHIS: Family Access to Health Care &amp; Utilization</strong></td>
<td>Hospitalized Overnight (N, %)</td>
<td>34/9.0% (N=378)</td>
<td>0/0% (N=19)</td>
<td>0/0% (N=3)</td>
</tr>
<tr>
<td>Times Overnight Hospital Stay</td>
<td>Client</td>
<td>2.86 (N=29)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Nights in Hospital</td>
<td>Client</td>
<td>3.37 (N=27)</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>ER Visits (N, %)</td>
<td>Client</td>
<td>64/16.9% (N=378)</td>
<td>1/100% (N=1)</td>
<td>1/50% (N=2)</td>
</tr>
<tr>
<td><strong>Diabetes Knowledge Assessment (range: 0-11)</strong></td>
<td>Client</td>
<td>8.31 (N=398)</td>
<td>9.35 (N=20)</td>
<td>10.67 (N=3)</td>
</tr>
<tr>
<td><strong>Diabetes Quality of Life Measure (range: 22-110)</strong></td>
<td>Client</td>
<td>90.63 (N=390)</td>
<td>91.80 (N=33)</td>
<td>91.50 (N=4)</td>
</tr>
</tbody>
</table>

* Due to delays in clients returning for follow up appointments, follow up data is categorized by rounds of follow up. For the first set of follow up (N=20), the average length to follow up was 144.60 days, standard deviation=57.93, range (49-283); Days to Follow up 2 (N=4): average length to follow up was 223.75, standard deviation=20.27, range (203-244).
### North Texas Area Community Health Center DiabetesSalud!
#### Outcomes: Number of Clients at 1st Follow Up

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients Served</td>
<td>399</td>
</tr>
<tr>
<td>Clients Completed Program To Date</td>
<td>399</td>
</tr>
<tr>
<td>Clients With Any Follow Up To Date</td>
<td>20</td>
</tr>
<tr>
<td>Clients Showing Any Positive Change</td>
<td>19</td>
</tr>
<tr>
<td>Health Status</td>
<td>13</td>
</tr>
<tr>
<td>Quality of Life</td>
<td>18</td>
</tr>
<tr>
<td>Confidence, Efficacy, Activation, Goal Setting</td>
<td>7</td>
</tr>
<tr>
<td>Diabetes Quality of Life and Knowledge Assessment</td>
<td>12</td>
</tr>
</tbody>
</table>

### Cross-Site Outcomes at 1st Follow Up

#### North Texas Area Community Health Center DiabetesSalud!
#### Outcomes: Number of Clients at 2nd Follow Up

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients Served</td>
<td>399</td>
</tr>
<tr>
<td>Clients Completed Program To Date</td>
<td>399</td>
</tr>
<tr>
<td>Clients With Any 6M Follow Up To Date</td>
<td>4</td>
</tr>
<tr>
<td>Clients Showing Any Positive Change</td>
<td>3</td>
</tr>
<tr>
<td>Health Status</td>
<td>3</td>
</tr>
<tr>
<td>Confidence, Efficacy, Activation, Goal Setting</td>
<td>2</td>
</tr>
<tr>
<td>Diabetes Quality of Life and Knowledge Assessment</td>
<td>2</td>
</tr>
</tbody>
</table>

### Cross-Site Outcomes at 2nd Follow Up