

SERVICE SPECIFIC ON-SITE REVIEW
Evidence Based Education Programs (EBPs)

I. Service Capacity

- A. Indicate any of the following EBP workshops your organization may offer and provide a # of trained facilitators. If your EBP is not listed here, enter EBP information below this chart

<input type="checkbox"/>	Arthritis Self-Management Program (English and Spanish) # of trained facilitators- Licensing Entity-	<input type="checkbox"/>	Healthy Eating for Successful Living # of trained facilitators- Licensing Entity-
<input type="checkbox"/>	Better Choices, Better Health # of trained facilitators- Licensing Entity-	<input type="checkbox"/>	Healthy Ideas (identifying depression empowering activities for seniors) # of trained facilitators- Licensing Entity-
<input type="checkbox"/>	Cancer: Thriving and Surviving Program # of trained facilitators- Licensing Entity-	<input type="checkbox"/>	Living La Vida Dulce (Spanish Diabetes Self-Management Program) # of trained facilitators- Licensing Entity-
<input type="checkbox"/>	Chronic Disease Self-Management Program (CDSMP) # of trained facilitators- Licensing Entity-	<input type="checkbox"/>	Matter of Balance (Falls Prevention) # of trained facilitators- Licensing Entity-
<input type="checkbox"/>	Chronic Pain Self-Management Program # of trained facilitators- Licensing Entity-	<input type="checkbox"/>	Positive Self-Management Program (HIV/AIDS) # of trained facilitators- Licensing Entity-
<input type="checkbox"/>	Cuidando Con Respeto (Spanish Savvy Caregiver Program) # of trained facilitators- Licensing Entity-	<input type="checkbox"/>	Powerful Tools for Caregivers # of trained facilitators- Licensing Entity-
<input type="checkbox"/>	Diabetes Self-Management Program # of trained facilitators- Licensing Entity-	<input type="checkbox"/>	Savvy Caregiver # of trained facilitators- Licensing Entity-
<input type="checkbox"/>	Enhance Wellness # of trained facilitators- Licensing Entity-	<input type="checkbox"/>	Tai Chi for Healthy Aging # of trained facilitators- Licensing Entity-
<input type="checkbox"/>	Fit for Your Life # of trained facilitators- Licensing Entity-	<input type="checkbox"/>	Tomando Control de su Salud (Spanish CDSMP) # of trained facilitators- Licensing Entity-

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If applicable, list other EBP workshops offered:

B. Provide host locations for all workshops offered.

C. Describe Evidence Based Programs that may be available to be provided via telehealth (including telephone and live video) to support consumers and provide options for participants that may benefit from class due to extenuating circumstances (if applicable). *

**Modality may only be offered if EBP model supports it also being evidenced based. Telephone and live video must be an approved modality for the specific EBP workshop.*

D. Do you offer one-to-one personalized trainings with a trained coach? If so, specify capacity in which EBP content area?

Also, specify the # of trained coaches for each EBP content area and location of offering.

II. General Policies and Procedures

A. Describe the process for providing the Healthy Living Center of Excellence (HLCE) or the Self-Management Resource Center (SMRC) all required information when offering a workshop. Specifically, what information is provided, at what stage of the workshop is the information provided, and who is designated to communicate with the HLCE/SMRC.

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- B. If applicable, describe the process for arranging one-to-one personalized trainings with a trained coach.
- C. Describe your policy for notifying the ASAP when a consumer is absent from one of the sessions and for communicating when there is a possible barrier that affects completion of the workshop (for example, access to transportation, request for telehealth accommodation*).
**Modality may only be offered if EBP model supports it also being evidenced based. Telephone and live video must be an approved modality for the specific EBP workshop.*
- D. If there is no capacity for translation, describe your procedure for serving consumers who speak a language other than English, or have specific hearing or visual needs.

III. Staff Qualifications

- A. Describe how you ensure that all your EBP facilitators/coaches have been trained and certified by the Healthy Living Center of Excellence (HLCE) or by the Self-Management Resource Center (SMRC).

Attach a Certificate of good standing from the HLCE or SMRC for each of your facilitators.

- B. Describe how you ensure that Certificates remain current, in good standing.

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IV. Training and In-Service Education

- A. Describe how you ensure that fidelity observation is completed for newly trained facilitators.

- B. Describe how you ensure that facilitators complete two hours of continuing education annually either by attending a one- day conference or participating in monthly (recorded) webinars provided by the HLCE or SMRC.

V. Supervision

- A. Describe the procedures for supervision, including frequency, documentation, and credentials/qualifications of supervisors.

VI. Proposed Rate Structure for Evidence Based Education Programs (EBPs)

- A. If rate structure(s) differ for EBPs, please describe in detail and list below.

Provider employee who completed this form:

Name: _____

Date: _____

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Please note the documents and records which will be required for the Consumer files and/or Employee files to be reviewed at the time of On-Site Evaluation

EMPLOYEE Record Review						
ASAP(s) Name & Monitor(s):						
Provider:				Date:		
Employee Name:						
Start Date:						
Termination Date (if applicable)						
Number of Reference Checks						
CORI Check						
OIG Checks: Time of Hire/ Monthly						
Job Description(s)						
Initial Training & Certification by HLCE/SMRC						
Fidelity observation for newly trained facilitator by a master trainer or other leader trained to observe						
Certificate in Good Standing:						
Annual Two Hours Continuing Education (Dates, Conference, Webinar):						
Annual Performance Appraisal Date:						
Comments:						

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Please note the documents and records which will be required for the Consumer files and/or Employee files to be reviewed at the time of On-Site Evaluation

CONSUMER Record Review						
ASAP(s) Name & Monitor(s):						
Provider:				Date:		
Consumer Name:						
ASAP Authorization:						
ASAP Authorization for Telehealth (If applicable):						
ID Information: Name; Address; Phone; DOB:						
Emergency Contact(s) & Phone:						
Functional Status or Limitations:						
Name of Current CM/RN:						
Service Start Date:						
Termination Date (If applicable):						
EBP: Specify Program Name Sessions Attended (individual workshop dates)						
EBP: One-to-One Personalized Training Dates:						
ASAP Authorization	Name, Address, Phone, DOB	Emergency Contact(s) Name & Phone	Current CM/RN & Phone	Date of Referral	Date of Termination	
Note: Shaded data elements are only required in the Consumer file if provider is not on Service Delivery Manager (Provider Direct). Otherwise, the agency demonstrator will be asked to illustrate "on screen."						
Name & Position of Agency Demonstrator:						

ADMINISTRATIVE OVERVIEW
SERVICE SPECIFIC ATTACHMENT
Evidence-Based Education Programs (EBPs)