

# RCI REACH

Resources for Enhancing Alzheimer's Caregiver Health

## Implementation Guide

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## ADSSP Grantee

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ROSALYNN CARTER INSTITUTE FOR CAREGIVING

# REACH Implementation Guide

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## Introduction: RCI REACH

Resources to Enhance Alzheimer's Caregiver Health (REACH) (Burgio et al., 2003) began in 1995, as a variety of multicomponent interventions implemented at six sites designed to enhance family caregiving for Alzheimer's disease and related disorders. This first study examined the feasibility of using multiple different intervention approaches. The interventions were based on diverse theoretical frameworks, all of which are consistent with basic health-stress models. The goals of the health-stress model are to recognize the stressor, change the stressor, and/or change the caregivers' response to the stressor. Results of this first study emphasized the need for further research focusing on a tailored approach which assessed the risk or needs of the caregiver.

### **Randomized Control Trial**

The follow-up study, REACH II, was a randomized, controlled trial sponsored by the National Institute on Aging and the National Institute on Nursing Research (Belle et al., 2006). and the project was implemented with caregivers of loved ones with dementia. This multi-component intervention assessed the risk of the caregiver and based upon the results of this assessment, provided tailored, caregiver specific education, support, and enhancement of stress management skills. Delivery of this six month intervention occurred through one on one sessions including a combination of face to face visits and telephone conversations. When viewed as a group, REACH II findings indicated that caregivers demonstrated improvement in caregiver burden, depression, and management of difficult behaviors, social support and self-care.

### **Translation to Community Agency**

In 2008, the Rosalynn Carter Institute for Caregiving was awarded funding through the Alzheimer's Disease Support Services Program to implement this evidence based program within a community agency. The goals of this project included serving family caregivers of loved ones with dementia and developing a model of the clinical trial protocol that could be delivered by staff of a community agency with similar positive outcomes for those served. This demonstration project titled GA REACH served 85 caregivers and achieved statistically significant outcomes in the reduction of caregiver stress and burden, caregiver depression, and caregiver health. In 2010 the Rosalynn Carter Institute was awarded a second ADSSP grant

to replicate the program through the Coastal Georgia Regional Commission Area Agency on Aging. Within eight months of initiating services, data analysis revealed outcomes similar to those of the first translation project. With the intention of offering this translation to agencies around the nation, GA REACH was then renamed RCI REACH and was listed on the menu of evidence based caregiver support programs offered through the national RCI Training Center for Excellence.

This guide is intended to serve as a tool for agencies and organizations in selecting and implementing RCI REACH successfully. This implementation guide addresses guidelines that drive the successful implementation of the intervention, not the actual protocols and activities needed in the delivery of the services. For more detailed information on actual service delivery refer to *RCI's Training Center for Excellence* ([http://www.rosalyncarter.org/training\\_center/](http://www.rosalyncarter.org/training_center/)).

## Exploration: Is this the right intervention for your agency?

### Does RCI REACH “FIT” Your Agency?

#### Does it fit your TARGET POPULATION?

RCI REACH was developed to meet the unique needs of family members caring for someone with Alzheimer’s or a related dementia. There have been successful replications of the intervention serving rural caregivers, urban caregivers, and caregivers of veterans with dementia.

Materials used in RCI REACH have been translated into Spanish in order to serve Hispanic caregivers and will be available in the Spring of 2016. However, there are no other translations available at this time.

Not all caregivers are at the same risk of developing physical and/or emotional health problems. Preventive interventions are most effective when they are appropriately matched to their target population’s level of risk. The Institute of Medicine defines three broad types of prevention interventions (Levels of Risk, Levels of Intervention).

- **Universal preventive interventions** take the broadest approach for caregivers who may not demonstrate caregiver burden or depression;
- **Selective preventive interventions** address caregivers who are experiencing levels of stress and are in need of assistance to manage their caregiver responsibilities;
- **Indicated preventive interventions** target caregivers who are approaching burn out or experiencing health issues related to long term stress.

RCI REACH is considered a selective intervention because it is individualized and delivered one-on-one to the family caregiver. RCI REACH provides a comprehensive assessment, a tailored care plan based on the assessment followed by 12 one-on-one sessions delivered face to face and by telephone. These sessions

serve to empower the caregiver with skills in stress management, mood management, problem solving, and self-care. Working with the caregivers to develop strategies for improved management of dementia related behaviors is a major component of the intervention.

RCI REACH is best suited for agencies with access to a substantial number of family caregivers for loved ones with dementia experiencing stress, depression, and a sense of feeling overwhelmed. Often agencies who have been offering universal level caregiver supports, such as caregiver workshops and support groups, feel a need for a more intense intervention for caregivers who request additional, individualized support. RCI REACH would fulfill this need.

<b>Does it fit THE NEEDS OF YOUR CONSUMERS?</b>
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RCI REACH addresses five areas of concern for the family caregivers:

- **Safety concerns:** evaluate and address safety alerts related to care recipient behaviors or hazards within the home.
- **Social Isolation:** an optional component of the intervention is to provide monthly telephone support groups. If not utilized, caregivers are provided with a comprehensive list of available support groups and are regularly encouraged to participate.
- **Managing Problem behaviors:** caregivers are taught problem solving techniques and provided with a guide with proven strategies to address common care recipient and caregiver challenges.
- **Improving emotional wellbeing:** caregivers are taught and encouraged to engage in a number of stress reduction activities, assertive communication techniques, mood management tools, and a plan to increase pleasant events for themselves and their care recipients.
- **Focus on caregiver self-care:** Education on the potential impact of caregiving on their health and regular review of their health care needs and maintenance activities are encouraged.

### **Literacy levels**

RCI REACH provides a Dealing with Dementia Guide to each participating caregiver. This guide provides information and strategies for managing potential problems for both the care recipient and caregiver. It is written on a fifth grade reading level and serves as a reference manual for the caregiver even after they have completed their participation in the program.



## **Empowerment for caregivers**

RCI REACH is considered an empowering program in that it coaches the family caregivers in the development of skills that will continue to serve and support them after they have completed their participation in the program.

Specifically, they are trained and encouraged to use:

- seven stress management techniques
- a nine-step problem solving model
- skills to enhance communication with their care recipient, care team members and medical professionals
- links to available resources.

## **Convenience**

The sessions are scheduled and delivered with the convenience of the caregiver in mind. Caregiver coaches should be prepared to work non-traditional hours as there are caregivers who can only meet with their coach in the evenings or weekends. The majority of the sessions are delivered face-to-face. Usually the caregiver will welcome the coach into their home, but there are circumstances in which a different location is a better choice. RCI REACH Caregiver Coaches must be amenable to change and be flexible.

## **Teaches skills and strategies**

All sessions are delivered to individuals in a one-on-one format to address their specific challenges and to help alleviate the isolation family caregivers experience. These sessions help:

- Increase the caregiver's awareness of how their responsibilities are impacting their physical and emotional well-being.
- Increase their understanding of the condition of their care recipient, how it affects them as their caregivers and how to prepare as the disease progresses.
- Guide the caregiver through the process of identifying their support network including family, friends and their community and enlisting/accepting their assistance.
- Demonstrate the importance of stress management and mood management, providing specific tools and techniques to build expertise in each area.

- Increase their understanding of the basis of dementia behaviors and the effectiveness of their response.
- Build confidence in their self-efficacy to provide quality and loving caregiving for the long term.

### **RCI REACH Provides Education and Information**

Caregivers have access to a great deal of information regarding dementia. They receive written materials from many sources. However, caregivers report having someone explain to them in person while answering their specific questions leads to a much better understanding of how to cope with their situation. RCI REACH Caregiver Coaches deliver a broad education and then pinpoint specific education needs for the caregiver.

Information provided during the sessions regarding available resources and enrollment procedures can also lead to increased utilization of appropriate services by the caregiver and care recipient. The multiple session format offers the RCI REACH Caregiver Coach the opportunity to monitor how effectively the caregiver acts upon identified resources and provide structured support as they learn to seek and accept assistance.

### **Follow up**

With twelve contacts made over six months, the RCI REACH Caregiver Coach is able to provide reminders and encouragement to the caregivers to practice the strategies and techniques that will improve their caregiving experience. Each session begins with and ends with a review of accomplishments and planned activities. Potential barriers to successful use of the newly learned strategies are identified and addressed by both the caregiver and the caregiver coach to improve chances for success.

### **RCI REACH Outcome Data**

As you will see in the chart below, RCI REACH has significantly impacted the caregiver's experience in positive ways: reduction in caregiver depression and burden, improvement in caregiver health, less frustration with dementia behaviors, and increased self-efficacy or confidence in the caregivers ability to provide care and obtain respite.

The p value listed in the right hand column indicates the level at which you can be confident that it was the intervention rather than some other influences that made the difference in that measure. A p value of .05 or less is the standard for statistical significance.

<b>Outcome</b>	<b>Pre Scores Mean</b>	<b>Post Scores Mean</b>	<b>p value</b>
Depression	12.17	6.83	.000
Burden	20.71	13.42	.000
Physical Health	2.74	2.95	.051
Reaction to Behavioral Problems	1.86	1.03	.000
Self-Efficacy for Obtaining Respite	46.15	60.78	.000
Overall Self-Efficacy	60.32	74.19	.000

Table shows data analysis from Coastal Georgia REACH project 2010-2014

<b>Does it fit the ABILITIES OF YOUR STAFF?</b>
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### **Administrative Support**

In most agencies, administrative duties supporting the intervention include fielding inquiries from potential clients, conducting an initial eligibility screen, and referring interested clients to the caregiver coach for further screening. However, some agencies also provide administrative support in collecting and entering data (referrals, enrollees, service delivery, and other program procedures) and assisting caregiver coaches with scheduling and coordinating sessions.

Does your administrative staff:

- Have a team mentality?
- Demonstrate enthusiasm about new services offered to the clients served by your agency?
- Accept new responsibilities willingly?

### **Data Management**

Data management tools such as excel spreadsheets are included in the training provided by RCI. A webinar on data collection and management is also provided following the training provided to the caregiver coaches and support team. Managing the data collected throughout the process of the intervention includes ensuring uniformity of data collection, accuracy of data entry, and appropriate analysis and application of data trends.

Does your agency have someone currently responsible for data management or will the program manager be responsible for this component? If the caregiver coach

will be responsible for collecting, entering, and managing the data, who is responsible to ensure thorough collection, accurate entry and careful and confidential management of the data?

Does that person on your staff:

- Understand how to use data to identify trends and opportunities for process improvement?
- Have technology/software expertise that will enable them to move between data collection to data analysis and reporting?

### **RCI REACH RCI REACH Caregiver Coach**

As far as the community and the clients are concerned, the caregiver coach you select IS the intervention. Their communication and coaching skills will determine the effectiveness of the program for your clients.

The RCI REACH Caregiver Coach should:

- Have a high level of expertise in handling the challenges of caregiving for someone with Alzheimer's disease or other form of dementia.
- Be able to conduct a thorough interview and individualized session with sensitivity.
- Understand the context in which the client provides care to a family member.
- Speak the language of the caregiver. Be familiar with cultural stigma and norms.
- Know the main types of dementia diagnoses, along with the corresponding prognoses and expected progression.
- Be committed to the importance of maintaining fidelity to protocol.

After years of training and certifying RCI REACH Caregiver Coaches, RCI has determined that extensive understanding of the special challenges of caring for someone with dementia is a MANDATORY requirement for this position.

For best outcomes, the Coach should have at least one year of experience in at least one of the following:

- Working directly with care recipients in a dementia care unit.
- Providing counseling, case management, other types of support to dementia caregivers.
- Personal experience as the primary caregiver of a person with dementia.
- Lived in the home with a dementia care recipient, even though they were not the primary caregiver.

## **Program Manager**

The person who provides supervision to the RCI REACH Caregiver Coaches should expect to spend at least 15% of their time during the first six months of the intervention. A supervision plan should be developed, put in writing and shared with each interventionist. This plan should include the expectation of attending the team meetings and a schedule of individual supervision meetings.

Their duties will include:

- Monitor and motivate the marketing and recruitment activities.
- Conduct team meetings (at least bi-weekly).
- Review referral and session tracker spreadsheets weekly.
- Randomly check client folders to ensure fidelity and thorough documentation.
- Work with team to identify trends and monitor process improvement opportunities.

The program manager should:

- Have a relationship with community partners who may refer clients for service.
- Have a high level of expertise in handling the challenges of caregiving for someone with Alzheimer's disease or other form of dementia.
- Have knowledge of available resources to meet the needs of clients expressed during the team meetings.
- Understand how to use data reports and analysis to evaluate the process, caregiver coach performance, and outcome measures.
- Practice a "coaching" approach to supervision.

## **Telephone Group Leader**

Not all agencies choose to include that Telephone Support group sessions in the intervention. Data indicates that attendance of the telephone support groups tends to be low (often only 1 or 2 caregivers phone in). However, those caregivers who do participate rate this component of the program as "very helpful". If it is not provided, there should be a comprehensive and current list of available caregiver supports both locally and nationally provided to all participating caregivers. One agency found the caregivers in the program more readily attended these community based support groups than the ones provided with the program. Reasons stated include: more opportunities, a variety of locations and times to participate and more participants involved for interaction and learning.

If your agency intends to include the telephone support group component, the telephone support group leader is responsible for the enrollment and scheduling of caregivers (who are currently active in the program), 5-6 caregivers per group, in a telephone support group over the course of the program.

Whether your agency is providing this component or referring to other sources for support groups, the Caregiver Coaches should strongly encourage participation at every session throughout the program. Peer support is a powerful source of encouragement, validation, and reduced isolation.

<b>Does RCI REACH fit your agency's SERVICE DELIVERY CULTURE?</b>
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RCI REACH was originally provided to caregivers in their homes, or another location convenient for the caregiver. More than 50% of the caregivers were referred by community agencies, medical professionals, or other caregivers. In the community translations, the sessions have been delivered primarily in the home of the caregiver. In deciding if this program is a good fit for your agency, you should determine now how you will deliver the intervention.

**In-Home delivery Pros:**

- Eliminates the barriers of transportation needs and time constraints for the caregivers.
- RCI REACH Caregiver Coaches gain helpful insights from observing the home environment and interactions between the caregiver and care recipient.
- Caregivers may feel more relaxed and open when in their home environment.

**In-home delivery cons:**

- Can be costly in terms of Caregiver Coach time and travel expenses.
- The presence of the care recipient in the home during the assessment and sessions can be a challenge for the Caregiver Coaches. Providing respite when possible or having the family make arrangements for a companion to be there during this time is helpful.
- It is not unusual for caregivers to forget the appointment and not be available leading to lost time and frustration for the RCI REACH Caregiver Coach.
- Depending on how far spread the clients are geographically, home visits may reduce the number of clients the Caregiver Coach can reasonably carry on their caseload.
- Some caregivers seem to place a greater value on sessions held in a professional setting.

- Some caregivers prefer an alternative location such as a nearby restaurant or library. The priority should be the convenience and comfort of the caregiver, as long as the safety of the caregiver coach is not at risk.

<p><b>Does RCI REACH fit your BUDGET?</b></p>
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Budget considerations should include:

- Cost of qualified RCI REACH Caregiver Coaches
- Cost of training (\$5,000 plus travel expenses for one Master Trainer; annual license renewal: \$1,500 – costs may change, contact RCI for current fees)
- Cost of delivery of face to face sessions.
- Cost of program supervision, administrative support, and data management.
- Cost of equipment, office space, etc.
- Cost of marketing the intervention, marketing to diverse communities may cost more for personalized materials and translation of documents, as well as time spent networking with agencies that serve these communities.

Delivery in rural settings can prove to be challenging in terms of client recruitment and retention and costly in terms of travel expenses and limited caseloads. However, strategies that ameliorated these challenges were employed at the sites and included:

- In rural areas, word of mouth and personal testimony is the best recruitment strategy. Knowing that it will take time for people who receive the service to share their endorsement helps the agency better plan for staffing needs.
- In our experience, RCI REACH Caregiver Coaches were assigned cases by their location so that visits could be combined to reduce mileage costs. This was not always possible due to caregiver availability or session cancellations, but as a rule this strategy improved cost effectiveness.
- RCI REACH Caregiver Coaches made reminder calls prior to the visits to reduce “no one at home” visits. It was found that the calls the day before **and** just prior to leaving for a visit were needed.
- In some cases, the caregiver and care recipient were transported to the adult day care center where the care recipient was served as a day care client while the caregiver attended a session.

## Readiness Assessment:

What is in place and what is needed to implement this intervention?

**A**lthough consideration of readiness is part of the decision making in selecting this intervention for implementation, a more in-depth assessment must be performed in preparation for actual service delivery.

### **Assessing Readiness: MARKETING AND RECRUITMENT**

- Access to clients
  - In-house or partner agencies should be polled to determine how potential clients will be identified, contacted, and enrolled.
  - A projected number of clients eligible for and interested in the project should be determined.
  - Service delivery – what parameters will you set to determine the face-to-face/telephone delivery ratio.
  - What policies are in place for the delivery format you have chosen?
- Do you have a history of success with receiving referrals from other agencies in your community?
- How will you alert your community that this new service is going to be available?
- What are the opportunities for free publicity through the local paper, television stations or radio stations?
- What marketing campaigns have been successful in the past and how may they be utilized for this program?



- If you already have an active outreach staff, what materials and training will they need and what venues will they pursue to begin marketing this service? What costs are associated with these materials?
- Develop all printed marketing materials now for a media blitz to be conducted immediately upon implementation. Arrange to speak at community meetings, participate in health fairs and other community events. Marketing and outreach activities may need to continue throughout the program in order to maintain optimal caseload flow.

### **Assessing Readiness: STAFFING**

- Have the education/skills been clearly outlined for the hiring/assigning of staff to this particular project?
- What is the time line for hiring/assigning the staff for administrative support, data management, service delivery, and program supervision as explained previously?
- Has sufficient time been built into the time line for training and mentoring of staff for this program?
- Will the referrals be in place soon after the training is completed?

### **Assessing Readiness: TECHNOLOGY**

Different implementation sites have used different methods to collect, store and analyze the data from the program.

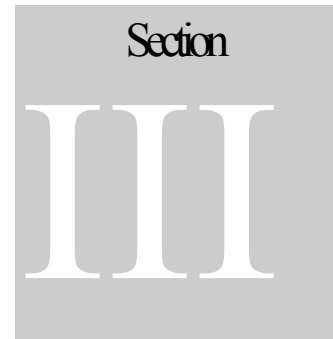
Options include:

- Pencil and paper to complete forms in the field, entering the data in an excel spreadsheet or other software once in the office.
- Tablets and software such as ACCESS and Sharepoint in the field, directly entering responses into the forms as the assessment is conducted.
- Program management data such as interventionist time logs, referral tracking and session tracking spreadsheets are in excel format and can be maintained on the computer and shared via encrypted email with password protection.
- If data will be used in statistical analysis, it will need to be exported from Excel or ACCESS into the statistical analysis software you are using. RCI uses SPSS for analysis.

Questions to consider:

- Will your RCI REACH Caregiver Coaches complete documentation with pen and paper or are there laptops or tablets available for data entry in the field?

- Data storage:
  - What type of software is needed for easy data entry by staff involved in data entry?
  - How can duplicate entry of information be avoided?
  - What type of software is used for reporting purposes?
  - How will the files be maintained with confidentiality yet be readily accessed by all staff involved in data entry and analysis?
  - Do you have a shared drive that can contain password protected files? If not, how will you ensure everyone is working from the most recent spreadsheet?
  - Do you have encryption capabilities for emailing confidential files?



## PRE-Implementation

**O**nce it is decided RCI REACH is a fit for your agency and you have fulfilled the readiness checklist, you will focus on pre-implementation activities for launching this program. The steps involved in the pre-implementation stage lay the foundation for the ultimate success of the program. Remember success in evidence based implementation means delivering the services with fidelity to the original research intervention which results in achieving similar positive outcomes for those served.

### **Create Implementation Team**

An Implementation Team provides the internal capacity within an organization to support systems change and effective implementation of a program.

Implementation Team members have special expertise regarding programs, implementation practice, improvement cycles, and organization and system change methods. They are accountable for making it happen; for assuring that effective interventions and effective implementation methods are in use to produce intended outcomes.

Team members should bring differing perspectives on how the intervention plays out within the agency. It should include those directly involved in the delivery of the service as well as staff members who support the delivery and who provide the referrals and adjunct services to the clients enrolled.

**The implementation team should include (at a minimum):**

- The agency decision maker who can approve any changes needed in policies, procedures, and/or funding allocations.
- Program Manager
- RCI REACH Caregiver Coach(es)
- Supervisor of the agency intake staff (source of referrals to the program)
- Data manager or person(s) responsible for data entry and reporting.
- Any external stake holders who may support the program through substantial referrals or funding.

Although there is much to be said for keeping working groups small, in this case it is important to include representatives from each group of staff and all community partners who will be involved in the project.

<b>MAP THE PROCESS</b>
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A process map is a tool to visually illustrate how RCI REACH work flows within your agency. The exercise of creating the process map facilitates communication across your agency, serves as a planning tool and will be useful in the supervision of the program.

Set aside at least one hour, preferably two for a brain storming session with the full implementation team, your full staff and, when appropriate, partner agencies to create the step by step map illustrating how clients would be referred, screened for eligibility, enrolled, served, and evaluated.

Identify each action step and decision made from the first contact with the client through the evaluation of outcome data and client satisfaction. The key phrases for this exercise:

- And then what?
- Who is responsible for that?

You can expect the process map will need revisions along the way but this exercise serves two important purposes.

- It forces the team to identify in detail the procedural flow (with documentation along the way) and the responsibilities of everyone involved in the project.
- It gives those involved a very clear picture of how they will be supporting the success of the new program. (See Attachment A) for an example of a process map.

### **DESIGN THE CLIENT RECRUITMENT CAMPAIGN**

Unless you know you have access to the number of clients needed to maintain full caseloads for your counselors, you will need to market this program to new clients. These steps will begin that work for your agency.

- Develop the “elevator speech”. Everyone on your team should have a three to four sentence explanation of what the program is and how it benefits the caregiver. This is referred to as the “elevator speech” because you should be able to give it in the span of an elevator ride. This speech should be tailored to your regional culture. Some areas may need a more academic sound, others may need a grassroots, “git ‘er done” tone. This is why it should be developed during the process mapping with the entire team. If they helped create it, they will be more likely to remember and use it. Practice the elevator speech until it can be comfortably delivered in any setting.
- Develop recruitment/marketing strategies, recruitment materials and role play recruitment.
- Determine where recruitment will take place. Do not let “business as usual” be the mantra here. Challenge the team to think creatively about where potential clients can be reached and what means is most effective in your area.
- Presentations to the staff of agencies that will be making referrals is necessary. Paint a vivid picture of who is appropriate to refer and exactly how they will benefit. It has been noted that the more clearly referral agencies can understand how the program works and who it serves, the more readily they will refer their clients.

Client recruitment among persons of color needs to include marketing materials that reflect their race/ethnicity and understanding of their cultural priorities.

## DATA COLLECTION AND MANAGEMENT

Established parameters and procedures for data collection must be in place before any other work is begun for project. Careful planning will help avoid crossing the fine line between ensuring the collection of data important to the success of your project and creating undue burden for staff.

Remember that data is used in evidence-based implementation to:

- justify adaptations for site specific process improvement
- identify possible fidelity issues
- measure impact on clients served
- compare outcomes to the original clinical trials
- support continuation of the program to potential funding sources.

Staff members with a history of attention to detail and accuracy in record keeping should be selected for the data entry and management of the data spreadsheets. The program manager or the data manager should be responsible for regularly checking files that have been selected randomly for accuracy of data entry.

Spreadsheets may be maintained in Excel, Access, SharePoint, or any other software your agency uses for this purpose. If you intend to conduct statistical analysis on your outcomes measures, you will need to employ a program that imports/exports easily with the analysis software that will be used. SPSS is a program often used by implementation sites for data analysis. Beta test the collection system with potential users to improve the tool; be certain to create a tool that can readily export information when needed; be able to cross tabulate different populations and demographics.

Training and discussions on all areas of the program are needed prior to implementation and on an ongoing basis to assure that criteria for data collection were operationalized; i.e., that all staff were interpreting and recording data in the same manner.

The data manager should be able to provide the Implementation Team with a “dash board” of data points which can be used as a snapshot of the program’s effectiveness and results.

### **Recruitment and Enrollment Data (Referral Tracking Spreadsheet)**

- Track how each referral is obtained. You may want to note the specifics such as church, grocery store, word of mouth, web site etc. This will help you know which method of recruitment is working best.

- Document individual who expressed an interest in the program whether enrolled or not in the Referral Tracking Spreadsheet by their name, contact information, how they heard about the program, agency referred by, their ongoing status in relationship to enrollment (not eligible, not interested, referred, screened, active, completed, discharged) and a column for notes pertaining to that client. If the client was eligible but refused to participate, their reason for refusal should also be documented in a column on this sheet.

The Referral Tracking spreadsheet is maintained by the intake staff or administrative assistant. It is reviewed prior to and during all team meetings to gauge the number of referrals available for enrollment, the effectiveness of outreach efforts in stimulating inquiries about the program, and to ensure potential clients are not lost in the process.

RCI experienced having clients on the referral list for a long time often resulted in the caregiver losing interest in participating. However, restricting outreach efforts to maintain a limited number of referrals waiting may result in caregiver coach caseloads falling below productive and cost effective levels. The program manager will regularly monitor the list and learn with experience the range that serves best for your agency.

### **Session Tracking Spreadsheet**

The session tracking spreadsheet is an excel document that provides a snapshot of progress through the RCI REACH program with each caregiver.

**The Session Tracking Spreadsheet is reviewed at all team meetings and is used:**

- to ensure the intervention is delivered within the protocol timeline
- to identify clients who are at risk of attrition or noncompliant
- to identify clients who should be closed due to noncompliance
- to determine counselor availability for next enrollees
- to alert for program evaluation survey to be conducted.

This spreadsheet includes **only the clients who have been enrolled. Enrollment is defined as any client who has received the first session.** It is maintained by the RCI REACH Caregiver Coach or administrative assistant. The spreadsheet is often shared via email therefore clients are identified by client ID only.

### **Outcome Measures Spreadsheet**

The Outcome Measures Spreadsheet contains the pre-intervention and post intervention responses to the assessment that indicate the impact of the intervention

on the caregiver. Accuracy of data entry should be checked regularly by a member of the management team so that needed corrections are caught in a timely fashion.

The data entered into the spreadsheet is used to analyze how effective the program is in achieving outcomes similar to the original study. Closely monitoring the changes in caregiver burden, depression, and satisfaction with support will inform the team of possible fidelity issues or how well the intervention does fit with the population served.

If all other process indicators show the intervention has been delivered with fidelity to the original study and the RCI REACH Caregiver Coach has conducted the assessment and intervention according to protocol but the outcome measures are not in line with expectations, it may mean the intervention is not successful with your caregiver demographics.

<b>Process Indicators</b>
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It is not prudent to wait until the outcome data is secured to determine the success of the project in achieving its goals. Process indicators can provide interim feedback on individual steps of the process map created in the early stages of pre-implementation.

Some process indicators are:

- Number and locations of marketing activities
- Number of referrals received from partner agencies and from outreach efforts
- Percentage of eligible referrals that enrolled
- Reasons eligible enrollees did not enroll
- Timeline of service delivery
- Client participation and completion
- RCI REACH Caregiver Coach challenges and lessons learned from service delivery
- Attrition rates and reasons
- Ad hoc contacts
- Number of clients completing within prescribed timeline

<b>Opportunities For Feedback</b>
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Communication up and down the chain of command is essential for successful implementation. The staff conducting outreach, taking inquiry calls, processing eligibility, the caregiver coaches delivering the sessions and the management staff conducting caregiver satisfaction surveys will have extremely valuable insights into the nuts and bolts of process improvement.



Establish opportunities for feedback, indicating who, when and how feedback will be gathered and the process for response. For agencies working with RCI Technical assistance, there are 12 consultation calls held within the first year of the implementation. These consultation calls include reporting the number of enrollees, active clients, completed clients, outreach activities, and a discussion around operational and/or client issues.

Early in implementation, these technical assistance calls may need to be supplemented with meetings at the agency level with various members of the implementation team. It is also encouraged to set aside some time at each staff meeting to discuss the project, giving all staff opportunities to learn more about what the program offers and to ask questions to ensure appropriate referrals.

## **STAFFING**

### **Program Manager:**

- Experience and understanding of the rigor required to implement an evidence-based intervention
- Advanced understanding of the specific intervention and the research behind it
- Commitment to ensure fidelity to the original intervention
- Time commitment
  - Participate in RCI REACH training
  - Meet weekly (first six months to a year) and then bi-weekly with care coaches to discuss progress, solve administrative problems, provide support and guidance with outreach/recruitment, support in implementation of RCI REACH with fidelity
  - Available for one on one support as needed
  - Coaching model of supervision which includes regular observation, positive reinforcement and constructive course correction of staff
  - As new caregiver coaches are hired and trained, providing time with an experienced caregiver coach as their mentor can prove very helpful in the learning process.

### **RCI REACH Caregiver Coach**

- Full time dedicated RCI REACH Caregiver Coaches

Pros: focused on promoting and delivering the intervention.

Cons: staff hired specifically for and dedicated to the program can lead to high cost per client, especially if lulls in enrollment causes down time for

the caregiver coach or they are routinely included in activities outside the work of the program.

- Part-time shared RCI REACH Caregiver Coaches

Pros: having multiple staff trained and certified to provide the intervention can:

- Increase the “RCI REACH community” within the agency which increases awareness and acceptance by the full team.
- Provides immediate back up coaches should there be staff turnover.
- If the coach has other responsibilities that are not as intense as serving dementia caregivers, it can alleviate the stress associated with full time service provision.

Cons: RCI REACH Caregiver Coach attention is shared with competing projects; time paid for by this program may be actually used on other programs; more coaches to serve the same number of clients means more people to train and supervise.

- Contracted “free lance caregiver coaches” - Pay per service

Pros: payment only for services rendered, may be able to negotiate a competitive rate; keeps costs down when referrals lag.

Cons: provider may hold multiple contracts which will compete for time availability, fees could be prohibitive depending on how competitive the job market is in your area.

- Stipend contracted: set monthly rate based on deliverables.

Pros: a fixed monthly income may attract premium talented RCI REACH Caregiver Coaches.

Cons: if enrollments lag, cost per client becomes prohibitive; incentive to meet enrollment and completion goals is not as effective as pay per service.

#### Requirements for RCI REACH Caregiver Coaches

First-hand experience of the challenges faced by dementia caregivers is a critical requirement for this position. Successful Caregiver Coaches have come from a variety of backgrounds including activity director from dementia units, nurses, and people who were themselves family caregivers of a loved one with dementia.

Skill set needed include:

- Listening/communicating/interpersonal skills
  - Must be able to establish rapport quickly.
  - Must be mature enough to feel comfortable directing elderly participants.
- Investigative /Intuitive
  - Probes beyond superficial answers.
  - Picks up on cues about what is causing concerns.
  - Reads between the lines of what is being said to gain deeper understanding.
- Tactful/sensitive
  - Be directive without offending.
  - Understand cultural differences: racial; educational; financial

### **Telephone Support Group Leader**

Sites that choose to include the Telephone Support Group component of the program will need to assign the group leader responsibilities. The Group Leader is responsible for the enrollment and scheduling of caregivers, 5-6 caregivers/group, in a telephone support group over the course of the program. The Group Leader conducts a total of 5 telephone support group sessions, all of which are topic focused and scripted in regard to general information for the topic to be discussed. These calls are in addition to the three RCI REACH Caregiver Coach telephone sessions.

Support Group Leader should have:

- Good leadership skills, including team building, professional development and quality assurance.
- Strong background in working with caregivers of people with Alzheimer's or related dementia.
- Knowledge of group dynamics and psycho-educational instruction.

### **Data Manager**

Managing spreadsheets for the data collected in the intervention can be the work of the Program Manager or Administrative Support staff. Since statistical analysis is not required (but encouraged) from implementation sites, calculating the mean score for all participants pre and post intervention for key outcomes should not pose a challenge. Someone with an aptitude for math and accuracy should be able to provide the data reports needed to identify the successes and challenges of the program.

Basic skills should include:

- Experience in creating and utilizing spreadsheets.
- Ability to calculate group means for comparison.
- Ability to generate charts and reports to be shared with the implementation team.

### **Orientation For All Staff**

Providing an orientation presentation to the entire staff ensures everyone has the same information regarding the program and helps generate ownership or buy-in by staff members who otherwise would not be included. The orientation should include:

- Background information on the program and its effectiveness in serving caregivers.
- How the program fits into current agency operations.
- Roles and responsibilities of the staff.

### **Training In The Intervention**

Following hiring, each RCI REACH Caregiver Coach and Group Leader complete a multi-component training process.

The training and certification process for the RCI REACH Caregiver Coach requires

- Pre-training required reading list
- One day of interactive classroom instruction
- Demonstration of skills through Skype session in which the caregiver coach role plays delivery of a session with a “mock” caregiver (played by the Master Trainer). This role play is observed and scored RCI Training Center staff to determine their readiness to deliver the intervention in the field. Caregiver Coaches who do not achieve the required score are given feedback and the opportunity to practice and try again. If they do not achieve the necessary score the second time, the RCI and the agency leadership will discuss possible solutions to move the program forward.
- If the support group component is to be provided at your agency, the support group leader will attend the training with the Caregiver Coaches. A demonstration of skills will be conducted via telephone following the

training in which the group leader will deliver a session while being observed by the Master Trainer.



## Implementation

**I**n this chapter we will discuss the tools and strategies useful in the implementation activities around the delivery of the intervention.

### **Intake**

Agency frontline staff who are responsible for client inquiries will need regular reminders of the availability of the program. Most intake staff have many program options available to clients according to their eligibility criteria. Expecting them to immediately include a new program in that list is not realistic. Strategies for reminding them of the new program have included:

- Provide a one page summary listing the eligibility criteria and the agreed upon language to be used in promoting the program to potential clients. Printing on brightly colored paper and asking staff to keep it on their desks will be helpful as a reminder.
- Creative reminders to have on their desks like magnets, postcards, a sign on their wall, etc.
- Discuss the program at every staff meeting, providing data regarding number of clients referred through the intake desk.
- Consider a contest with a small reward for the intake staff member who provides the most referrals in a certain time frame.
- Potential participants may already be known to the agency, may be referred by another agency or may respond to brochures and other outreach mechanisms. They may make the initial contact by phone, mail, email or in

person. You should record the referral source and method of contact in your records. The main purpose of tracking the many aspects of implementing the intervention is to learn as much as possible about how to most effectively offer the service.

- A candid approach to potential clients should be neither defensive nor overly eager. Rather, being open to questions and concerns may be most effective. The description of the program should include the eligibility criteria so that the listener will know whether he or she qualifies or if the person on whose behalf the inquiry is made will qualify. In all cases the option to receive usual care if the person decides not to participate in the program should be made clear.

#### **Initial Contact With RCI Reach Caregiver Coach**

- When there is no prior relationship between the caregiver and the RCI REACH Caregiver Coach, the initial contact sets the stage for the engagement of the participant. The RCI REACH Caregiver Coach should convey the idea that the intention of the program is to be supportive and be sure that the potential participant understands what is being offered.
- The RCI REACH Caregiver Coach should explain that participation involves a collaboration in which they will be actively participating in learning.
- The RCI REACH Caregiver Coach should respond to e-mail or telephone inquiries with an offer to send written informational materials. An offer should be made to discuss the program further in person if after reviewing the information the caregiver is interested and appears to be eligible for the program. An important aspect of this intervention is the supportive relationship with the Caregiver Coach so the ability to engage face to face is essential.

#### **Eligibility**

Some eligibility and exclusion criteria will be specific to the agency providing the program. Such criteria may include geographic, language, and/or condition of the care recipient or caregiver.

General criteria for enrollment for the program are:

1. Caregiver is a co-resident or responsible for daily meal preparation for an individual with Alzheimer's disease or related dementia.
2. Caregiver verbally expresses that the care recipient has memory problems.

3. Caregiver provides a minimum of 4 hours of care per day.
4. Caregiver rates themselves as having stress at a level of 5 or greater on a scale of 1 to 10. The stress level rating is a verbal rating, not a formal scale.
5. Caregiver is not expecting to place the care recipient in a facility over the next six months.
6. Caregiver will be available to participate for a full six months.

Most implementation sites found it beneficial for the RCI REACH Caregiver Coach to complete the screening and “sell” the program to potential clients. Once a client is identified as a caregiver of someone with dementia, they are immediately referred to the Coach for further screening. The relationship between the RCI REACH Caregiver Coach and client will actually begin during this process and may help ease the client’s anxiety about enrolling in a program with someone who will come into their home (if that delivery model is chosen).

**During eligibility screening:**

- Explain the purpose of the intervention
- Ask the screening questions (“RCI REACH Eligibility Screening Form”)
- Describe the process of the intervention: There are twelve sessions conducted over six months. The RCI REACH Caregiver Coach meets face-to-face with the caregiver for up to nine sessions (in their home or a location of their choice), approximately 1 ½ hours each. In addition, there are up to three telephone sessions of approximately ½ hour each. During the sessions the caregiver will receive information on dementia and resources as well as training in strategies and techniques for managing stress and dementia behaviors.

<b>Enrollment</b>
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Agencies could consider a client enrolled once they are determined to be eligible, have agreed to participate in the program and have attended the first session. However, it has proven to be best practice to delay declaring a client to be “enrolled” until there has been a face-to-face contact between the RCI REACH Caregiver Coach and the client. If the client appears to be a good candidate for the program and agrees to participate, they should be told so but not guaranteed enrollment at that point. Situations that have been found by Caregiver Coaches that would nullify enrollment include:

- The person who agreed to participate may not actually be the primary caregiver.



- The care recipient may be too progressed in the disease or have additional health complications that may not allow the caregiver to complete a six month program.
- The caregiver may exhibit mental health issues that would preclude their ability to successfully complete the program. Note that many caregivers are dealing with depression. Mental health issues that could impact their ability to effectively participate would be untreated bipolar disorder or schizophrenia.
- In rare occasions a Caregiver Coach has felt unsafe at the home of a potential client. It is important to respect the instincts of the coach. If the caregiver cannot meet outside the home and the troubling situation cannot be resolved, then the caregiver should not be enrolled.

If the caregiver is determined to be appropriate for enrollment during this initial contact, the RCI REACH Caregiver Coach would then proceed with the consent form and assessment.

### **Assessment**

A detailed caregiver assessment is essential. The purpose of the initial assessment is to gather information about the caregiver and care recipient that will increase understanding of their current situation and challenges. Through completion of the assessment, the Caregiver Coach will learn about the caregiving environment, and problems that require immediate or subsequent attention. **Severe** depression, for example may require a referral to other services before the caregiver enrolls in the program. The initial assessment also provides the baseline data against which post intervention data can be compared. These comparisons will indicate the effectiveness of the program and may highlight opportunities for improvement or adaptation.

It is important to gather pre and post data on the outcomes measures that are most important to your agency in serving caregivers. Measuring depression, burden, self-care and health are critical outcome components needed to compare results to the original study.

In order to be helpful to the caregiver, the RCI REACH Caregiver Coach should know whether the person with dementia is in the early, middle or late stage. This can be determined by using the Global Deterioration Scale (GDS). The stage of the illness is a sensitive issue for many caregivers. Discussion of the meaning of the symptoms during the initial assessment should be handled carefully, with the caregiver's perspective in mind. It is possible that the RCI REACH Caregiver Coach will have met the person with dementia previously and so will have firsthand information. The person with dementia should not be present at the initial assessment. However, if that is not possible, using the provided flash cards to

secure responses to sensitive questions will help free the caregiver to answer honestly by pointing to their chosen response and spare the care recipient negative feelings about their answers. If the care recipient must be present and the questions of the assessment cause increased agitation, the assessment should be set aside and arrangements made so that it can be completed privately at the next session.

## **Sessions**

As explained earlier, a total of twelve contacts by the RCI REACH Caregiver Coach with each caregiver is expected, but the type of contact could vary. Sessions 1 through 4 are delivered at one week intervals. The remaining sessions are held within two week intervals. If adhering to the 9 face to face/3 telephone session protocol, sessions 7, 9, and 11 are provided by phone. See Attachment B for an overview of the session content and delivery timeline.

As a “real life” adaptation that has been tested and supported by data, the caregiver and the Caregiver Coach could choose to substitute up to four of the face to face visits for telephone visits. This adaptation differed from the original REACH II intervention which allowed up to two by phone visits that could be substituted for face to face visits. These decisions are based on the needs and convenience of the caregiver but should be supported by the Caregiver Coach only if they feel there will be no value loss by making the substitutions.

Some RCI REACH Caregiver Coaches have found scheduling all future visits during the first session can be helpful. Identifying dates and times that would work for the caregiver and could be offered as alternatives to the others is a good first step in coordinating these sessions. For instance, Tuesday mornings may be a good time for a caregiver as a rule.

Fidelity checklists must be completed after each session and reviewed regularly by the program manager. The program manager will also randomly select files to review the assessment and session notes to ensure appropriate completion.

## **Telephone Support Groups**

The original clinical trial included five telephone support group sessions delivered in addition to the face-to-face and telephone sessions. However, translations since the original protocol was developed have varied in their adherence to that protocol. The original RCI REACH translation at RCI included the telephone support groups delivered by a contracted provider with extensive experience working with dementia patients and their caregivers. The following paragraphs share our experience.

Five to six caregivers would be enrolled in each support group and times were selected based on the availability of the participants. Each session consisted of

the group leader providing 20 to 30 minutes of information on a specified topic followed by 30 to 40 minutes of open discussion by the group. Analysis of the program evaluation data indicated that though caregivers reported the telephone support groups to be very helpful, this component received the lowest score of any other part of the intervention. It was determined that those caregivers who attended regularly received great benefit but many of the caregivers elected not to participate.

During the second translation of RCI REACH, the Caregiver Coaches delivered the Telephone Support Sessions themselves, enrolling five to six of the clients with whom they were working. After ongoing disappointing attendance the agency requested permission to discontinue the telephone support group sessions. The time spent by agency staff to provide this component was not reaping meaningful participation by the clients. It was not unusual to have only one client call in for the session which defeated the purpose of the call, to increase social support for REACH participants.

After actively seeking ways to increase participation, the agency chose to allow the interventionists to use their time in providing the one-on-one sessions and discontinued the telephone support sessions.

However, the RCI Program manager requested the coaches research alternative opportunities for their clients to participate in peer support activities, in person, by telephone and via the internet. They prepared a list of those opportunities with the necessary contact information and encouraged their clients to participate.

The caregiver coaches asked at each visit if the client had attended a support group type activity since the last visit and record that information on their fidelity checklist. In the months following the discontinuation of the RCI REACH telephone support group sessions, it appeared the caregivers were much more interested in attending these other sources for support groups. Reasons stated by the caregivers included:

- There was more flexibility of times available.
- There were more caregivers at those events, since they were open to the entire community and had been in existence longer.
- The clients enjoyed hearing from new professionals in the field rather than just more meetings with the RCI REACH interventionist.

Moving forward with agencies seeking to implement RCI REACH, the information and training to provide this component of the intervention can be provided based on agency's choice to implement or not.

### **The Follow-Up Assessment**

During the final session, the second assessment is conducted with the caregiver. The comparison between the baseline assessment and this final assessment will provide data needed to evaluate the effectiveness of the intervention with the population served and hopefully support the value of continuation and/or expansion of the program. Positive outcome data can be extremely helpful in sustaining programs and providing rationale for seeking new funding streams for caregiver support programs.

### **Placement Protocol**

Most caregivers do not want to place their loved one in a nursing home. However, it is not clinically sound, nor do the data substantiate evidence for the RCI REACH Caregiver Coach to focus his or her treatment efforts directly towards avoiding nursing home placement. Indeed, there are circumstances that may call for placement for the wellbeing of both the care recipient and the caregiver.

Often caregivers remain heavily involved in care even after their loved one is placed in a facility. Based on the desire of the caregiver and the judgment of the caregiver coach, sessions may continue after placement.

If the caregiver is no longer providing a meaningful level of care or they choose to discontinue participation in the program due to placement, the date of placement is noted on the Change of Status Form, and a modified post-assessment protocol is implemented. The Training class addresses this protocol.

### **Bereavement Protocol**

Alzheimer's is a terminal disease. That means that the person with dementia will ultimately die from the effects of the disease unless he or she dies earlier from some other cause. In the event of the death of the care recipient, the date of death is noted on the Change of Status Form.

A modified protocol (discussed during the training class) is implemented in which the counselor is available for two sessions after the death of the person with dementia. RCI REACH Caregiver Coaches can provide emotional and practical support for caregivers throughout the grieving process.

### **Tools For Supervision And Fidelity Assurance:**

#### **Session Tracking Spreadsheet**

The Session Tracking Spreadsheet is an excel document that provides a snapshot of the progress through the RCI REACH Program with each

caregiver. The Caregiver Coach completes the Session Tracking Spreadsheet after each session held with the caregiver.

The supervisor reviews the spreadsheet regularly to monitor:

- Timely delivery of each session: are there valid reasons listed for each client whose sessions are not being delivered according to the protocol timeline?
- Outcome measure assessment and client satisfaction surveys: are they being conducted according to the established time line?
- What is the attrition rate? The average attrition rate for programs is between 20% and 30%.
- Are all referrals being monitored to ensure no potential client is lost through the process?

### **File Checklist**

The File Checklist is a very low tech tool but serves an important purpose to ensure all documentation is provided within each case file. A checklist should be included at the front of each folder and checked off as each document is added. Supervisors should also use this checklist and personally check off each item when they conduct random folder audits. The Checklist includes the dates of completion for each component of the intervention.

### **Monitoring Session Delivery**

The Fidelity Checklists (See an example in attachment C) are a self-reporting tool for RCI REACH Caregiver Coaches to complete after each session. It is important the RCI REACH Caregiver Coaches know this is not a punitive tool but one that will help alert the implementation team of protocol activities that are not easily managed in this setting. If RCI REACH Caregiver Coaches are having problems completing a protocol activity regularly, this should be discussed with the team. Perhaps an adaption is in order that should be discussed with the full implementation team and with the RCI Master Trainer.

### **Regular Team Meetings**

Each team meeting is an opportunity to review operational or procedural changes. More importantly it is a time for RCI REACH Caregiver Coaches to debrief from their experiences in the field and seek advice and support from the team. During these discussions, supervisors have a window into the conversations and challenges the coaches have with the clients. Sometimes, deviations from protocol will be revealed, giving the supervisor a chance to guide the staff back on course. Despite

the difficulty in carving out the time for these meetings weekly or biweekly, they are critical to the success of the project.

## Evaluation

**B**ecause evidence based programs have been proven to be effective through very rigorous analysis, people may question the need for further evaluation when it is implemented in the field. After all, they may reason, isn't that the point of using evidence based programs? However, ongoing evaluation is a critical tool to be used to ensure successful implementation with fidelity (process evaluation) and achieving positive outcomes for the client served similar to those achieved by the original study (outcome evaluation).

### **Process Evaluation**

- Exposes possible problem areas early so they can be corrected before they impact the ultimate success of the project.
- Monitors fidelity to protocol to identify possible drift from protocol.
- Identifies and justifies adaptations to protocol needed to better serve the clients of the agency.
- Can reveal why an agency does not achieve the expected outcomes from their implementation efforts. Process evaluation data may help determine if there were errors in implementation or if the intervention was not suitable for the population served.

### **Outcome Evaluation**

- Indicates how well the agency was able to replicate the outcomes of the original study within their agency and with their clients.
- Provides tangible evidence of effectiveness of the services provided to the community.

- May help justify ongoing funding and resources for the continuation of the project.

Most of the tools used for the evaluation of the project have already been discussed as components of implementation, data management, and supervision. Process and outcome evaluation is often the responsibility of the site program manager and the data manager.

<p><b>Tools For Process Evaluation</b></p>
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- **Client Referral Spreadsheet**
  - Why: Monitor rate of referrals / enrollees; Monitor effectiveness of marketing strategies; Monitor number of eligible clients who did not agree to participate and their reasons for refusal; Provide status of waiting list and possible need for increased marketing activities.
  - How: An excel spreadsheet that is password protected and is updated with each new inquiry into the program and with each referral processed on to the Caregiver Coach.
  - Who:
    - May be maintained in a shared folder with multiple referral staff members updating
    - May be updated from referral sheets completed with each inquiry by one assigned staff member on a daily basis or weekly.
- **Session Tracking Spreadsheet** (described in section III page23)
  - Why: Provides a snapshot of caseloads and timeline for delivery of sessions, indicates attrition rates, and highlights clients at risk of attrition. Ensures that clients are not “lost” in the process since this sheet is reviewed at all team meetings and by the supervisor on a regular basis.
  - How: An excel spreadsheet that is password protected and updated on a daily, weekly or bi-weekly basis.
  - Who: Can be maintained by the RCI REACH Caregiver Coach(s). If more than one RCI REACH Caregiver Coach, it may be a good idea to one person responsible for a single spreadsheet updated with



the information coming from the multiple RCI REACH Caregiver Coaches.

- Caregiver Coach Time Log
  - Why: identifies issues with time management or training needs of coaches; supports cost analysis.
  - How: coaches enter in their time utilization in each category in 15 minute increments on an excel spreadsheet. This can be daily or weekly.
  - Who: coaches maintain the spreadsheet and submit to their supervisor on an agreed upon schedule.

<b>Tools For Outcome Evaluation:</b>
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- **Analysis of Outcome Data**
  - Why: indicates the effectiveness of the program in delivering desired outcomes, positive data can be utilized in securing funding for program maintenance.
  - How: data from pre and post assessments are entered into the outcome measure spreadsheet. Statistical analysis may be conducted using software such as SPSS or a simple comparison of group means pre and post can indicate if expected improvements have been realized.
  - Who: Data manager or person charged with the management of this spreadsheet.
- **Analysis of Program Evaluations**
  - Why: to secure feedback from program participants on their satisfaction with the intervention as a whole, with each component of the intervention, and their suggestions for improvement of the intervention; positive feedback can be used in marketing activities and publications.
  - How: Within two weeks following the completion of the intervention, each participant is contacted via telephone and asked specific questions regarding aspects of the program. The responses from the surveys are entered into a spreadsheet by someone other than the RCI REACH Caregiver Coach.

- Who: conducted by a third party, either the program supervisor or a trained staff member. This should not be accomplished by the caregiver coach.

Some key factors you should keep in mind during your evaluation are:

- Ease or difficulty of implementing the intervention at the program site.
- Acceptance and perceived value of the intervention by the Caregiver Coaches and other support staff.
- Perceived value of the RCI REACH program by caregivers who completed the program.
- Cost of the intervention and likelihood of reimbursement or funding to cover the cost going forward.
- What marketing efforts to introduce the program worked and didn't work.

## **RECRUITMENT AND OUTREACH**

Some ways that were found most useful in marketing the program to obtain referrals were:

- Placing articles in local newspapers, these can be announcements of the implementation start date, regular columns offering caregiver advice with a “plug” for the program at the end, or any other events that could prove newsworthy. Small town newspapers are generally very open to submitted articles and people tend to read these papers cover to cover.
- Presenting at local community service group meetings and health fairs
- Attending local support groups.
- Providing a program at senior centers on caregiving tips or stress management techniques.
- Partnering with local Aging and Disability Resource Centers.
- Developing relationships with doctors and pharmacists while distributing flyers at their business.
- Having an agreement with medical clinics or doctors to make referrals that includes follow-up communications.
- Placing flyers about the program at any business in your community etc. grocery stores, churches, health departments, senior centers

Keeping track of outreach and where referrals were generated will contribute to the success of the program in knowing which marketing efforts worked best.



## Maintenance & Sustainability

**M**aintenance and sustainability in evidence based interventions not only refers to the financial support needed to continue the program in your agency, but also maintaining and sustaining fidelity to the protocol to continue to achieve the expected positive outcomes. Both issues will be addressed in this chapter.

### **Maintaining and Sustaining Fidelity**

The importance of fidelity to the original protocols of the intervention has been stressed throughout this manual. With time, coaches and supervisors may be replaced and the protocols can be easily altered as they are “handed down” to new staff. Avoiding drift becomes even more important, requiring dedication to the training and manuals provided at the onset of the project and conscientious adherence to the supervisory plan.

New coaches and supervisors should be encouraged to go through the training before reviewing the work of their predecessor so that the correct delivery will be upper most in their minds.

Continuing the activities necessary for ongoing evaluation will also ensure ongoing fidelity.

Specifically these activities include:

- Weekly or bi-weekly team meetings with the coaches, their supervisor, and the person(s) responsible for maintaining the spreadsheets.
- Supervisory reviews of fidelity check lists and documentation in randomly selected client files.
- Regularly scheduled individual meetings with each Coach.

## **Maintaining and Sustaining Financial Supports**

Planning for ongoing funding of the intervention should begin in the planning phase. Where and how the program is embedded within your agency can be very important in determining ongoing sustainability. Your agency's decision to provide the services with in-house staff or contract with outside provider agencies will impact how sustainable it may be.

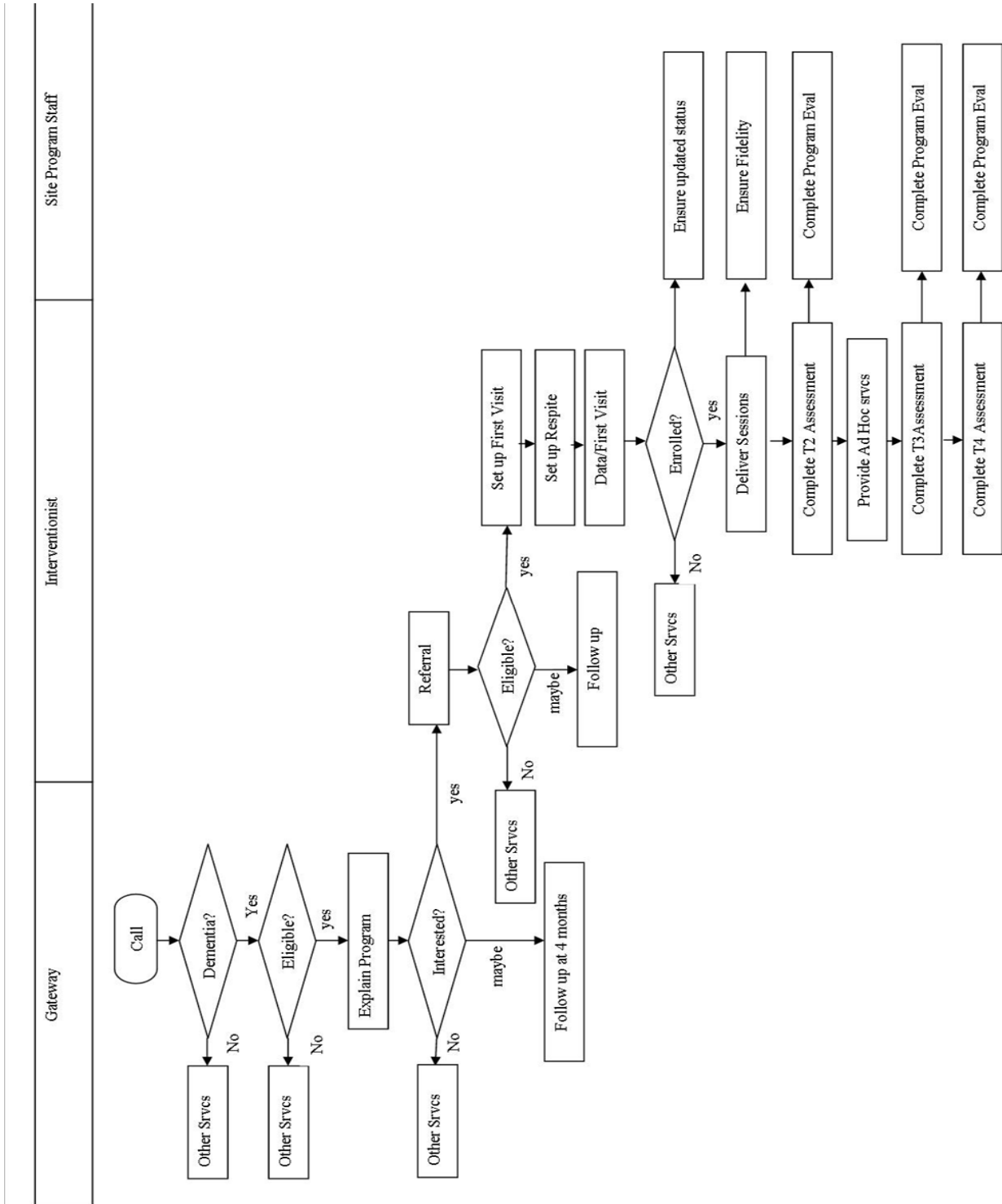
Recently funds available through the Older American's Act have been identified as supports to family caregivers. Title IIID can be used for evidence based caregiver support services.

Title III-E, the National Family Caregiver Support Program and the Older Americans Act, as amended, addresses the need to acknowledge and encourage the role caregivers play in the country's home and community-based services system.

The following are services available under Title III - E:  
Counseling Support Groups, Respite, Supplemental Services (home modifications, assistive technologies, emergency response systems, and incontinence supplies)

Family Care Assistance and Family Care Information. Much of the work of this intervention could fall within these funded activities.

# Attachment A Process Map



## Attachment B

### RCI REACH Session Overview

Session	Week	Scheduled Type				
Data Collection		Face to Face	Brief Introduction	Consent Form	T1 Assessment	
1	1	Face to Face	Introduce Intervention	Notebook	Introduce Support Groups	CG Story (Meaning)
2	2	Face to Face	Dementia Education	Safety materials	Health Guide	Effects of Stress
3	3	Face to Face	Target Behavior 1	Problem Solving	Signal Breath	Prepare for music
4	4-5	Face to Face	Review health and safety	Rate and review TB1 and SMT	Introduce Power of Music	
5	6-7	Face to Face	Review TB1 and SMT	Introduce TB2		
6	8-9	Face to Face	Review TB 1 & 2 and SMT	Introduce Stretching	Introduce Guided Imagery	
7	11	Phone	REVIEW			
8	13-14	Face to Face	Review TB 1 & 2 and SMT	Introduce TB3	Introduce Pleasant Events	
9	16	Phone	REVIEW			
10	17-18	Face to Face	Review TB 1 & 2 & 3 and SMT	Introduce Mood Management		
11	20	Phone	REVIEW			
12	21-22	Face to Face	Review accomplishments	Review Worksheet	Conduct T2 Assessment	Remind of evaluations

**TB Target Behavior Strategies**

**SMT = Stress Management Techniques**

 Education	 Review	 Stress and Mood Management	 Problem Solving
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### Structure of Each Session:

- Brief explanation of today's session
- Review of stress management techniques and target behavior strategies
- Modify for improvements as needed
- Initiate new topics when appropriate
- Closure: Review, Acknowledge and Encourage
- Set up next meeting
- After session: Fidelity Checklist and Client progress notes.