Georgia BRI Care Consultation
Grant #90AEO349
Translation Guide

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Section I: Project Background

- Background on Evidence-Based Project

  The Georgia Department of Aging Services (GDAS) and Georgia Area Agencies on Aging (AAA) identified three significant problems in the current system of care for Georgia families living with Alzheimer’s Disease or Related Dementias (ADRD).

  1. The first is the growing service waiting lists for underserved clients. The Georgia AAAs had seen dramatic budget cuts during the past years while the number of requests for services had increased. With fewer dollars for services and more people living with ADRDs, their caregivers remained on waiting lists or received only a portion of needed services.

  2. Secondly, while ADRD caregivers suffer the highest levels of caregiver strain and report significant unmet service needs, they also have lower rates of utilization of formal services compared to caregivers of non-dementia patients.

  3. Lastly, the absence of evidence-based program models and interventions that offer an accessible and supportive framework for personal planning and problem solving for people living with ADRD and their caregivers. While the majority of interventions were developed to serve primarily caregivers, a limited number targeted people living with ADRD and their caregivers together.

- Briefly describe what motivated your choice of this particular intervention for meeting a need in the identified community

  The evidenced-based program BRI (Benjamin Rose Institute) Care Consultation was selected to address the aforementioned problems. The intervention has evidence of a high level of efficiency. For example, one Care Consultant is able to manage a caseload of 75 to 150 underserved clients, or clients selected from a waiting list, at a very reasonable annual cost per family. The telephonic/e-mail service eliminates the travel expense incurred with traditional case management. The Care Consultant at the implementing agency makes the initial telephone contact followed by subsequent contacts per the evidence-based protocol. The strategy of the Care Consultant initiating contacts, instead of the client(s), is advantageous in overcoming a family’s reluctance to seek services. The intervention also allows clients to contact the Care Consultant as well. Another consideration is that BRI Care Consultation is designed to provide highly
individualized support for both the caregiver and/or care receiver to achieve their chosen caregiving goals through a series of simplified action steps. The intervention offers personal access to a “friend”, the Care Consultant, who is also a highly knowledgeable professional about ADRD and community services. In addition, the Care Consultation Information System (CCIS) allows Care Consultants to manage caseload information with greater efficiency, document assessments/reassessments and action steps, locate and send educational resources, and follow-up with clients. Lastly, even though BRI Care Consultation has proven to be a feasible and effective intervention in a wide range of agencies, it was not previously tested within Area Agencies on Aging and with particular emphasis on rural Georgia counties.

- **Discuss the goals of the evidence-based project**

The goal of this project was to implement an innovative telephone-based program for persons living with ADRD and their caregivers in three AAA regions in Georgia and evaluate its effectiveness, including the potential value as a platform to support early intervention and treatment initiatives. The specific objectives were: 1) Install and operate BRI Care Consultation with fidelity and evaluate its impact on ADRD patients, caregivers and the service delivery system. 2) Document and analyze the process of implementation within each AAA and the Georgia Aging Network, 3) Adapt the program as necessary in response to ongoing evaluation, 4) Assure long-term maintenance and continued development of the program in Georgia, and 5) Support the adoption and implementation of the intervention by others.

BRI Care Consultation is an intervention for adults with a chronic physical or mental health condition or disability and a primary caregiver (family member or friend) who assists the adult with daily activities, tasks, and health-related discussions. The intervention links and coordinates health care, community, and family services for clients (both the care receiver and the primary caregiver), organizes family and friends in assisting in care tasks, and provides emotional support.

Trained Care Consultants (nurses, social workers, and others with at least a bachelor’s degree in a human services field) deliver the intervention by phone as well as by mail and email. They establish an ongoing relationship with clients and offer personalized coaching while following a standardized protocol focused on helping to find solutions to priority problems of both adults with chronic health problems and primary caregivers. If the adult is too impaired to participate in care and/or care-related decisions, the Care Consultant works exclusively with the primary caregiver. Similarly, adults who do not have a caregiver are the sole focus of the program.
BRI Care Consultation uses an electronic computerized Care Consultation Information System (CCIS) to guide the delivery of the intervention. BRI Care Consultation is a coaching model driven by consumer choice, with Care Consultants helping find solutions to concerns that are the priorities of caregivers and care receivers. BRI Care Consultation follows a set, standardized protocol that requires at least a minimum of one to two contacts between Care Consultants and consumers per month; more frequent contacts occur as needed. The protocol also requires Care Consultants to discuss with caregivers and care receivers a broad-range of medical and non-medical issues. However, the specific content of assistance is tailored to consumers’ preferences and needs. BRI Care Consultation gives equal attention to preferences and needs of the caregiver and the care receiver rather than focusing on one or the other member of the caregiving dyad. BRI Care Consultation has three main components: 1) initial assessment, 2) action plan, and 3) ongoing monitoring and support.

BRI Care Consultation is an evidence-based program model developed through a series of research projects that began in 1997. The research projects primarily involved older adults with dementia and their family caregivers, although it has also been tested with older adults with depression and multiple chronic health conditions. Dr. David Bass and his MBRI team, in collaboration with a number of community agencies, developed and tested BRI Care Consultation in nine prior and/or current investigations (Bass et al., 2003; Clark et al., 2004, 2005; Bass et al., 2012; Bass et al., 2013, Bass et al, 2014, Judge et al., 2011). BRI Care Consultation received the 2002 ‘Healthcare and Aging’ award from the American Society on Aging, is a recommended evidence-based program by the Rosalynn Carter Caregiving Institute (2007) and the U.S. Administration on Aging (2008), and has been approved by the Administration for Community Living to be listed on their Aging and Disability Evidence-Bases Programs and Practices (ADEPP). Improved outcomes of this EBP include: reduced hospital and ER use, improved emotional and physical health; increased satisfaction with primary healthcare; and decreased depression (Bass et al., 2003; Clark et al., 2004, 2005).

- **Summary of intervention components:**

The intervention consists of three components delivered concurrently. First, clients participate in an initial assessment administered by phone. The assessment addresses several domains, with questions for both the adult with chronic health problems (e.g., arranging services, insurance benefits, depression, financial concerns, medications, personal care and home safety, social isolation) and the caregiver (e.g., capacity to provide care, emotional and physical health strain, sleep). Next, to address unmet needs,
the Care Consultant and clients create an action plan with specific and time-sensitive tasks for the adult with health problems (e.g., ask physician about medication side effects) and caregiver (e.g., install grab bars in bathroom). Action steps may also be created for the Care Consultant, other family members, or service providers. The third component is maintenance and support. Care Consultants maintain a relationship with clients through regular phone contact, clients are reassessed in all domains at least once between month 5 and 12 and then annually for the duration of enrollment in the program, and new action steps are formulated as needed throughout the period of enrollment. Care Consultants use a Web-based reporting system called the Care Consultation Information System (CCIS) to track all client information, assessments, action plans, completed tasks, and ongoing contacts.

- **Describe the Partners**

  i. **Identify the translation evaluator for the project and their general responsibilities**

  **Grantee:** The Rosalynn Carter Institute for Caregiving (RCI), at Georgia Southwestern State University, 800 Georgia Southwestern State University Drive, Americus, Georgia 31719.

  **Principal Investigator:** Leisa Easom, PhD, RN, RCI Executive Director

  **Project Manager:** Cynthia Holloway, RN, RCI BRI Care Consultation Program Manager

  **General Responsibilities:** Complete contracts with all consultants and partnering agencies. Convene Steering Committee consisting of partner agencies, Care Consultants and project leadership team. Hold orientation meeting for implementation teams and project partners. Assess agency and staff readiness to adopt the intervention. Develop implementation plan and time line to guide installation and initial implementation of the program. Attend biweekly teleconferences with the implementation team. Participate in scheduled fidelity reviews and support webinars. Operate a hotline for AAA staff and Care Consultants.

  **Research Evaluator and Implementation Partner:** The Benjamin Rose Institute on Aging, 11890 Fairhill Road, Cleveland, OH 44120

  **Dr. David M. Bass:** Senior Vice President for Research & Education

  **Branka Primetica, MSW, BRI Care Consultation Program Manager & Senior Research**
Analyst II

General Responsibilities: Permit the use of training manuals, assessment and evaluation tools, program delivery forms, educational materials, and any copyrighted materials required for the implementation of the Georgia BRI Care Consultation Project. Installation of the Care Consultation Information System (CCIS) at each AAA site. Provide intensive, on-site training to Care Consultants. Provide consultation required for successful project adoption implementation and evaluation. Participation in the project Steering Committee. Conduct scheduled fidelity reviews and support webinars. Operate a hotline for AAA staff and Care Consultants. Complete project data analysis for final ACL reports and assist in writing of reports and journal articles.

Dr. Bass and Ms. Primetica served as the primary consultant in implementing and evaluating the Georgia BRI Care Consultation Project. Ms. Primetica provided technical assistance and ongoing consultation during the three-year grant period. In the startup phase, the first six months after the grant was awarded, Dr. Bass and Ms. Primetica supervised the installation of the Care Consultation Information System (CCIS) at each site, provided troubleshooting assistance for data integration issues, and providing intensive, on-site training to Care Consultants and site supervisors. In the second six months, Ms. Primetica and the RCI Program Manager continued with refresher trainings and fidelity reviews with Care Consultants through scheduled conference calls and webinars. Dr. Bass and Ms. Primetica conducted data analysis and served as consultants in planning sustainability and expansion of the program statewide. They also collaborated with the RCI team in BRI Care Consultation presentations and publications.

ii. Area Agency on Aging Partner Agencies

The Georgia Area Agencies on Aging (AAAs) are a network of nonprofit agencies created by Congress to be one-stop shops with information about programs, services and housing options. AAAs were mandated 35 years ago through the federal Older Americans Act to create home and community-based services that maximize the independence and dignity of older adults. Georgia’s AAAs work in collaboration with the Georgia Department of Aging Services (GDAS) as well as other state and local service providers. Georgia AAA’s do not provide home care services directly, but work with a network of service providers in Georgia including senior centers and home health agencies. They also work in collaboration with the Georgia Department of Aging Services (GDAS) as well as other state and local service providers, such as faith based
organizations, Georgia Care-Nets, and other aging service non-profits to become Georgia’s “aging network. BRI Care Consultation was implemented in three Georgia AAA regions, serving 40 counties from September 1, 2010 through August 31, 2013.

1. Atlanta Regional Commission AAA (ARC)
   40 Courtland Street, NE
   Atlanta, Georgia  30303
   Community based service agency (decentralized region)
   10 urban counties: Cherokee, Clayton, Cobb, DeKalb, Douglas, Fayette, Fulton, Gwinnett, Henry and Rockdale, as well as the City of Atlanta.
   Total Population (2010 census): 4,135,943

2. Heart of Georgia Altamaha AAA (HOG)
   331 W. Parker Street
   Baxley, Georgia 31513
   Community based service agency
   17 rural counties: Appling, Bleckley, Candler, Dodge, Emanuel, Evans, Jeff Davis, Johnson, Laurens, Montgomery, Tattnall, Toombs, Treutlen, Wayne, Wheeler, and Wilcox
   Total population (2010 census): 303,199

3. Legacy Link, Inc. AAA (LL)
   4080 Mundy Mill Road
   Oakwood, Georgia  30566
   Community based service agency
   13 rural counties: Banks, Dawson, Forsyth, Franklin, Habersham, Hall, Hart, Lumpkin, Rabun, Stephens, Towns, Union, and White
   Total population (2010 census): 617,646

• **Describe the overall translation and what was changed from the original intervention.**

BRI Care Consultation translation at three Georgia AAAs involved original and modified implementation activities. The overall translation included a joint, intensive initial training with Program Managers and Care Consultants from all three AAAs followed by support calls and webinars for refresher trainings and fidelity reviews. In addition, since the implementation involved multiple AAAs, Care Consultants from each AAA
participated in consultation and refreshers from one another via e-mail along with the RCI Project Manager and, at times, the BRI Care Consultation Program Manager. Consultations included CCIS documentation, fidelity to the three intervention components, and clinical questions related to caregiving for persons with Alzheimer’s Disease and Related Conditions (ADRC). A significant change was the use of the Care Consultation Information System (CCIS) in Microsoft Access database form whereas in the original intervention, Excel was used for case record documentation. As Care Consultants utilized the Access-based CCIS, they provided a great deal of feedback for ease of documentation in the CCIS. Examples include necessary fields for enrollment, simplicity of triggered assessment/reassessment domain and action step documentation, as well as new reports to aid in caseload management, effective supervision and fidelity monitoring. Recommendations to CCIS changes were ultimately used to create the current web-based CCIS. The CCIS also included a basic set of educational resources built into the CCIS; Care Consultants were able to add specific ADRD-related and non-ADRD-related resources to send to clients. Another change that occurred after the initial launch of BRI Care Consultation was the realization that written consent from clients was a barrier to enrollment and led to the decision to obtain verbal consent, which resulted in increased enrollment. Lastly, a change proven effective with enrollment was the activity to review client waiting lists for home and community-based services.

Section II: Reach

- Describe the intended audience for the intervention

  The number of Georgia adults aged 60 and older is expected to increase 65.8% between 2010 and 2030, one of the fastest growing populations in the United States (GDAS, 2014). Currently, 120,000 Georgians live with Alzheimer’s disease and are cared for by an estimated 495,000 caregivers (GDPH, 2013). By the year 2025, nearly 160,000 Georgians will be living with some form of dementia (GDPH, 2013). With this in mind, the intended audience for this intervention is Georgia families living with Alzheimer’s Disease or Related Dementias.

- Define the selection criteria for participants

  The following criteria was used as a guideline for enrollment: Caregiver reports that either a) a physician has diagnosed the care receiver with dementia (formal confirmation of diagnosis not required), or b) the care receiver or caregiver reports that the care
receiver has memory impairment, or a health problem that is affecting his/her memory. In addition, the care receiver is living in the community with or without the support of a family member.

- **Discuss the recruitment strategies used**

Recruiting participants into a new program presents a challenge for most service organizations. However, this was not anticipated for this project, as it was estimated that there would be a sufficient number of clients to meet the goal of a 75-100 client caseload at each site, for a total of 225-300 active clients, and 450 over the course of the three-year project period (150 per year). Clients came from three sources: 1) existing client waiting lists of those living with ADRD and their caregivers, 2) clients already participating in a service who were identified as “underserved,” 3) new clients contacting the agencies for the first time who were either ineligible for other services or would be placed on waiting lists for services. During the planning phase of this implementation, a review of the combined wait lists of ADRD clients in the AAAs was approximately 415. Agency staff also estimated that approximately 20% (N=488) of the 2441 current clients were currently “underserved” and could benefit from the addition of BRI Care Consultation. Finally, the three AAAs in this project received a combined total of more than 6,000 new calls for service each month, of which a minimum of 20% (N=1200) are ADRD-related. The combined total of these three client sources was approximately 2,100. Based on the prior experience of the BRI Care Consultation developer, it was anticipated that at least one quarter of eligible clients offered the service would ultimately enroll, or approximately 526 clients.

Although, an adequate number of clients was available through the AAA internal sources, there was also an external marketing strategy developed and implemented. Program information was posted on the three AAA websites, brochures were developed, and community program informational presentations were presented at senior centers, churches, hospitals, and other community organizations.

Care Consultants record referral sources in the CCIS, which populates to a report. Internal agency referrals accounted for 70% of enrollees, with the remaining 30% from community marketing activities.

- **Discuss the enrollment process and enrollment numbers**

The BRI and RCI Program Managers worked with agency directors to assess the intake and referral process at each implementation site. HOG and LL obtained calls for services
through the Gateway staff located at each region’s central office. ARC has a
decentralized region with Gateway staff located within each county office as well as the
ARC regional office. A BRI Care Consultation educational orientation meeting was
conducted for Gateway staff at each site. The content included program service outline,
enrollment criteria, introduction script, and enrollment flow chart. This meeting provided
valuable feedback from Gateway and Care Consultant staff on the most efficient means
to streamline the enrollment process. For example, Gateway staff used a brief
standardized script to explain the program and refer to the Care Consultant for additional
program information, and informed consent. Using an expanded standardized script and
informed consent, the Care Consultant completed the enrollment process and documented
key pieces of information in the CCIS.

Total Enrollment for Each Site:

- Atlanta Regional Commission: 225 families
- Heart of Georgia Area Agency on Aging: 141 families
- Legacy Link: 227 families

- **Provide completion and drop-out rates for the intervention**

<table>
<thead>
<tr>
<th>Agency</th>
<th>Total Enrollment</th>
<th># of Completers</th>
<th>% Completers</th>
<th># of Non-Completers</th>
<th>% of Non-Completers</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARC</td>
<td>225</td>
<td>148</td>
<td>66%</td>
<td>77</td>
<td>34%</td>
</tr>
<tr>
<td>HOG</td>
<td>141</td>
<td>112</td>
<td>79%</td>
<td>29</td>
<td>21%</td>
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<tr>
<td>LL</td>
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<td>70</td>
<td>31%</td>
</tr>
<tr>
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<td>HOG</td>
<td>LL</td>
<td></td>
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<tr>
<td>---------------------------------</td>
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<td>-----</td>
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<td>Total</td>
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<td>29</td>
<td>70</td>
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</tr>
</tbody>
</table>

The ARC and LL Care Consultant reported that a number of clients disenrolled, or clients who stopped accepting calls (UTC), when they realized that their participation in the program was not going to advance them on the wait list for in-home services. To remedy this confusion, during the enrollment process, Care Consultants stressed that BRI Care Consultation is a program that would assist participants in finding alternatives to meeting their needs while on the waiting list for in-home services. The HOG Care Consultant reported that her lower attrition rate was probably due to the extreme isolation that many of her clients experience. She was a listening “friend” to most of her clients. The Georgia BRI Care Consultation attrition, on average, is slightly higher compared to other BRI Care Consultation implementations, which vary from 15-25%, after one year of being enrolled in the program.

- **Discuss any challenges that occurred and how they were addressed**

  **Challenge #1:**

  *Challenge:* As a grant provision of the Georgia Southwestern State University IRB, a signed written consent was a requirement. This was a barrier to enrollment for two reasons: 1) the written consent required a reading level of a Master’s degree or above to comprehend, and 2) it was not the policy of AAA to require a signed written consent for services.

  *Response:* A revised verbal consent was submitted to the IRB and approved.
Lesson Learned: For real world translation of a research project, all client forms need to undergo a thorough review for universal readability.

Challenge #2:

Challenge: In June 2011, ARC and RCI staff identified a marked reduction in referrals from the ARC Gateway staff. A reevaluation of referral data was conducted for barriers to BRI Care Consultation referrals and the following challenges were identified:

- ARC Gateway staff averaged 3,500 calls per month for service requests
- Each Gateway staff member takes an average of 16 calls per day
- BRI Care Consultation is one of 73 initiatives offered by ARC
- ARC is a large building with little personal contact between Care Consultants and Gateway staff
- ARC intake staff is not centralized in the 10 county region as in the other two BRI Care Consultation sites.

Response: The ARC Care Consultant conducted an internal marketing campaign that included providing Gateway staff with a colorful desk ornament as a constant visual reminder of the program, sending e-mail updates with enrollment numbers, and sending thank you e-mails for each referral.

Lesson Learned: This challenge provided an invaluable experience for future program start-ups. An evaluation of internal marketing needs to be conducted and a marketing plan set in place based on an agency’s organizational structure.

Challenge #3:

Challenge: After pulling clients from waiting lists, HOG experienced a marked reduction in Gateway referrals in Spring 2012. The RCI Program Manager noted that the HOG Care Consultant was largely depending on her co-workers to market the program secondary to conducting other AAA business in the community.

Response: In collaboration with the Care Consultant, the RCI Program Manager developed an external marketing plan to be executed for the remainder of the enrollment phase of the project.
Lesson Learned: Although Georgia AAAs had extensive waiting lists, it was essential to have an external marketing plan in place and ready to execute.

Section III: Adoption

- Describe site selection including identified geographic areas, criteria for selection, and site development plan

The RCI in consultation with the Georgia Division of Aging Services sent an invitation to all twelve Area Agencies on Aging across the state of Georgia. This invitation offered a brief explanation of the project and requested any AAA interested in participating to contact RCI. Six of the twelve agencies expressed interest. These six responded to five questions:

1. How many families who are coping with Alzheimer’s or a Related Dementias (ADRD) do you currently serve?

2. How many are on your wait list for other services?

3. What services/programs are available to your ADRD clients and their caregivers in your region?

4. Please attach a copy of your organizational chart.

5. Please provide contact information for the person who will be working with us on the grant proposal should you be selected.

Based upon a review of the responses and in consultation with GDAS, three sites were selected:

1. Atlanta Regional Commission AAA (ARC)
   40 Courtland Street, NE
   Atlanta, Georgia 30303
   Community based service agency (decentralized region)
   10 urban counties: Cherokee, Clayton, Cobb, DeKalb, Douglas, Fayette, Fulton, Gwinnett, Henry and Rockdale, as well as the City of Atlanta.
   Total Population (2010 census): 4,135,943

2. Heart of Georgia Altamaha AAA (HOG)
   331 W. Parker Street
• Discuss staffing needs and interview process

According to the National Implementation Research Network (NIRN), best practices in hiring interventionists includes having them demonstrate their skills by participating in a behavioral vignette during the interview process. In addition to the Care Consultant Job Description provided by BRI, the RCI recommended that the role-play model of interview be used during the Care Consultant hiring process. The AAAs sites have a policy of staffing new programs with existing employees. Hence, the RCI was not invited to participate in the BRI Care Consultation selection process.

Care Consultant: Care Consultants are knowledgeable professionals, who can implement the BRI Care Consultation program by maintaining the evidence-based components. This involves 1) Initial Assessment; 2) working with persons with chronic health conditions and their caregivers to develop an Action Plan; and 3) maintain and support clients through an ongoing contact protocol to establish a long-term relationship, including a Reassessment of needs.

Requirements for candidates for the Care Consultant position includes:

- A Bachelors or advanced degree in social work, nursing, or related field
- Excellent clinical skills in assessment, coaching, and problem solving strategies.

Baxley, Georgia 31513
Community based service agency
17 rural counties: Appling, Bleckley, Candler, Dodge, Emanuel, Evans, Jeff Davis, Johnson, Laurens, Montgomery, Tattnall, Toombs, Treutlen, Wayne, Wheeler, and Wilcox
Total population (2010 census): 303,199

3. Legacy Link, Inc. AAA (LL)
4080 Mundy Mill Road
Oakwood, Georgia 30566
Community based service agency
13 rural counties: Banks, Dawson, Forsyth, Franklin, Habersham, Hall, Hart, Lumpkin, Rabun, Stephens, Towns, Union, and White
Total population (2010 census): 617,646
- Ability to partner with clients in developing and enhancing their skills as caregivers
- Skilled at evaluating the need for community services and making appropriate referrals
- Organizational skills and time management with minimal supervision
- Significant knowledge of or experience with ADRD and family caregiving.
- Proven track record in thorough and accurate record keeping and documentation
- Skilled at engaging and establishing rapport and maintaining an ongoing relationship with clients over the telephone

A Care Consultant’s caseload may vary depending on the urgency and complexity of issues faced by clients. On average, a full-time Care Consultant can maintain a caseload of 75 to 125 clients. This assumes initial enrollment is spread over several months, since the first few months of using BRI Care Consultation requires more frequent communication with clients.

BRI Care Consultant Job Description included as “Attachment A”

AAA Internal Supervision: The AAA site supervisors had three main functions related to effectively delivery of BRI Care Consultation.

1. Administrative function:
   - Promoting the standardized implementation of BRI Care Consultation as outlined in the manual.
   - Coordinate and integrate BRI Care Consultation with other programs and operational policies within the parent organization
   - Conduct periodic fidelity reviews of client records using the CCIS reporting tools.
   - Oversee the quality of delivery of BRI Care Consultation by reviewing the client satisfaction surveys

2. Educational function:
   - Enhance the skills and knowledge of the Care Consultant
o Assist with finding solutions and resolving difficult client situations
o Present ideas on resources in the community that may benefit clients
o Discusses ways to maintain a positive ongoing relationship between the Care Consultant and clients, including reactions, responses, and outcomes of Action Steps

3. Support function:
o Address issues of job-related stress, and job satisfaction of Care Consultants
o Assist with any problems of concerns related to the use of the CCIS and the lack of face-to-face interaction with families

- **Describe orientation, training and mentorship of interventionists/staff**

  **BRI Care Consultation Orientation:**

  The original research investigators, Dr. David Bass and Ms. Branka Primetica, provided orientation. Orientation included a history and conceptual basis of BRI Care Consultation, outcomes from the scientific research studies, key feature of the program, and protocol components of the program. The orientation was followed by a demonstration and in-depth training of the Care Consultation Information System (CCIS).

  Following best practices as stated by the National Implementation Research Network, all Supervisors and Care Consultants from the three agencies were trained as Care Consultants, though only the Care Consultants would provide clients service provision. Dr. Bass and Ms. Primetica conducted a 2-day training. Each trainee received the copyrighted BRI Care Consultation manual, a copy of the training PowerPoint and two case study Vignettes for practice role-play. Training components included program description, client descriptions, and history of research, outcome benefits, and key features types of assistance, comparison to case management, program operations, and detailed instruction on the evidence-based components of the program. Ms. Primetica provided a detailed demonstration of the development of clients’ services, from referral, enrollment to Assessment, Action Step development, and Reassessment in the CCIS. The training concludes with trainee hands-on practice using a training version of the
CCIS with supervision provided by the trainers. Additional webinar training was scheduled at a later date on the reporting and survey features of the CCIS.

- **Discuss any challenges that occurred and how they were addressed**

**Challenge #1**

*Challenge*: Exiting AAA Staff had a lack of dementia care knowledge. AAAs typically use existing staff to implement new program interventions. An evaluation of the selected Care Consultants training and experience with ADRD revealed that they required training specific to serving this population to be effective Care Consultants.

*Solution*: Prior to initiating services, the RCI Program Manager conducted an informal survey of the Care Consultants experience and education in the needs of families living with ADRD. A two and one half day intensive training in ADRD was conducted which included an overview of ADRD, ADRD behaviors and problem solving techniques, ADRD best practices in communications, and a practical application through intervention role-playing.

With the awareness that families coping with dementia face unique challenges in their caregiving experience, in 2011 the Georgia Division on Aging Services partnered with the RCI to provide 23 educational webinars to ensure the dementia capability of all Georgia AAA staff. These webinars were made possible by funding from the Alzheimer’s Disease Supportive Services Program of the Administration on Community Living.

*Lesson Learned*: Hiring interventionists who had strong experience with Alzheimer’s and dementia who are able to empathize with the caregiving family and quickly establish a relationship is recommended. New and contracted Care Consultants within the Georgia Aging Network may not be aware of the availability of these educational webinar tools. Information on availability and how to access is now made available to each new intervention site.

**Challenge #2**

*Challenge*: The first HOG Care Consultant resigned after six months of service. In an exit interview, she stated that she felt uncomfortable problem solving with the clients with care receiver behavior challenges. She stated, “That she did not like telling people what to do”.
Solution: After a review of the Assessment and Action Step development to ensure that, the Care Consultant did not have any misunderstandings of the process, the RCI Program Manager and Care Consultant agreed that this model of service was not the right fit for her.

Lesson Learned: This staff turnover may have been avoided using role-play during the interview and hiring process.

- Discuss any innovations that would be valuable for the aging network

Branka Primetica revised the BRI Care Consultation Manual to include new sections that align with the new web-based CCIS. The copyrighted Admin, Supervisor, Quality Assurance Manual was developed and added to the manual.

Internal Supervision Requirements included as “Attachment B”

Section IV: Implementation

- Describe the implementation approach

The Rosalynn Carter Institute employs the National Implementation Research Network (NIRN) model of implementation.

The implementation stages of the NIRN model list the critical activities that occur during the planning and execution of implementation of an evidence based intervention. Although these stages often overlap with earlier and later stages, each stage requires attention and fulfillment for successful implementation. The stages are Exploration and Adoption, Installation, Initial Implementation, and Full Implementation.

The Exploration stage was realized prior to the development of the grant proposal. Adoption took place once the sites were selected and provided with orientation training within the first six months of grant funding. During the next two and a half years, the Installation and Initial Implementation stages were completed. Sites that opted to continue with the program after the funding ended were considered as Full Implementation.

Beyond these stages of implementation, the NIRN model also emphasized the importance of employing best practices in the application of “implementation drivers.” Implementation Drivers constitute the infrastructure for implementation because they are the processes required to implement, sustain, and improve identified, effective
interventions. The implementation drivers are advantage points in a system to influence staff competency (staff selection, training, and coaching), to guide appropriate leadership approaches (adaptive and technical), and to create enabling organization and systems conditions (systems intervention, facilitative administration, and decision support data systems).

As part of the training and technical assistance offered to each implementation site, the RCI and BRI staff introduced and modeled these strategies in the implementation of BRI Care Consultation at each of the three AAAs.

- **Describe the approach for monitoring fidelity to the planned intervention, including across sites and staff.**

  There was a twofold approach to monitoring fidelity and ongoing Care Consultant support, 1) multi-site support webinars, 2) individual site visits.

  1. In the first three months of service provision, Branka Primetica in collaboration with RCI Program Manager, Cindy Holloway, conducted weekly support webinars that included Care Consultants from the three sites. During these webinars, the team would discuss any issues pertaining to serving the clients, and view CCIS generated fidelity reports. Ms. Primetica used “Go-To-Meeting” computer platform to open and display the CCIS for continued training. This approach accelerated the Care Consultants learning curve by gaining experience from one another as well as the BRI and RCI staff. Between calls, Care Consultants were instructed to copy everyone when sending an e-mail to discuss a clinical, documentation, or technical issue. BRI and/or RCI would reply to all, which again, assisted the Care Consultants in gaining additional experience in this model of service. In month 4 through month 9, the webinars was conducted every other week, then monthly thereafter.

  2. The RCI Program Manager conducted monthly site visits to review a selected number of cases and assist Care Consultant and site supervisor with reports review. During these visits a variety of issues were discussed, such as marketing and sustainability, Monthly across-site supervisor calls were conducted to problem solve any issues that arose that would pose a barrier to full implementation.

- **Discuss any challenges that occurred and how they were addressed**

  *Challenge:* In September 2011, the Heart of Georgia Care Consultant submitted her resignation, and a replacement Care Consultant was hired prior to the turnover. To
facilitate a smooth transition the Agency and RCI Program Managers addressed the following questions:

- How do we facilitate a smooth client transition to the new Care Consultant without negatively affecting the quality and fidelity of program services?
- How will the transition impact families’ confidence in program services?
- How do we proceed with training the new Care Consultant?
- How will this transition impact the referral and enrollment numbers?

Response: A plan was developed to provide the smoothest transition possible for the enrolled families. The site issued a press release and sent each family a letter introducing with a photo of the new Care Consultant. The last telephone contact made by the outgoing consultant included the incoming Care Consultant as another form of introduction. The BRI Program Manager trained the incoming Care Consultant via Go-To-Meeting format in two sessions. The RCI Program Manager provided an on-site Basic Alzheimer’s disease training. The plan proved to be successful as evidenced by a low disenrollment rate after the transition.

Lesson Learned: Have a staff transition protocol developed and ready to implement when staff turnover occurs.

- Discuss any innovations that would be valuable for the aging network

In Winter 2015, the Benjamin Rose Institute on Aging invested in the development of a web-based Care Consultation Information System (CCIS) to replace the Access-based software. There are numerous advantages to this upgrade that benefited this project: 24/7 access to the CCIS from any location; improved accessing and processing speed; improved design, improved user layout, and functions. This upgrade was completed without compromising the fidelity of the evidence-based protocol.

Section V: Effectiveness

- Define the intended impact of the intervention

For the Georgia implementation, the intervention was designed to impact clients with ADRD, their caregivers, and the service delivery system. It was hypothesized that negative outcomes, including various measures of Caregiver Strain, Depression, and
Social Isolation would have overall reductions from enrollment to 12-months post enrollment. Positive outcomes representing Needs Met and Caregiver Confidence in Caregiving were expected to have overall increases from enrollment to 12-months post enrollment. It also was expected that there would be significantly greater reductions in negative outcomes, and increases in positive outcomes, for caregivers who were more vulnerable, meaning caring for more cognitively or behaviorally impaired care receivers.

- **Describe the data collection process and the measures used. (Include the AoA-specified data on participants and recommended measures for all evidence-based grant projects as well as any other measures.)**

Caregiver Interviews were conducted by RCI staff. Care Consultants obtained verbal consent from caregivers for program enrollment as well as participation in interviews. Shortly after enrollment/consent, Care Consultants electronically sent caregiver and care receiver contact information to RCI staff who then administered the T1 Interview (baseline) via phone. T2 Interviews were administered 12-months post-baseline. Interview measures included met needs, depression, social isolation, and strain outcomes. The analysis section displays results that test for baseline to 12-month changes in five caregiver outcome measures: 1) Depression, 2) Caregiving Confidence, 3) Social Isolation, 4) Health Strain, and 5) Needs Met, including Total Needs Met and eight categories of Needs. The total sample was for this analysis was 439.

Each of the five outcomes were constructed based on responses from caregivers to structured questions included in the baseline and 12-month follow-up interviews. These outcomes were used in the original studies that tested the efficacy of BRI Care Consultation, had good structural validity and reliability with the study sample of caregivers, and have been included in published articles. The measure of Depression was the 11-item Center for Epidemiological Studies Scale (Kohout et al., 1993). Caregiving Confidence, Social Isolation, Health Strain, and Needs Met were scales developed by the Benjamin Rose Institute on Aging (Bass et al., 2003; Clark et al., 2004; Bass et al., 2004). Caregiving Confidence (i.e., felt uncertain how to best care for him/her, felt unsure whether he/she was getting proper care), Social Isolation (i.e., participated less in organized activities, visited less often with family/friends), and Health Strain (i.e., under more stress, strain, pressure; physical health was worse) were sums of four, five, and eight individual questions, respectively, with each items using a Likert Scale response set. Needs Met was based on responses of caregivers to 39 items representing Total Needs Met as well as eight Needs Met subscales (i.e., informal help, dementia diagnosis,
daily tasks, respite, legal/financial, support, service access, and living arrangements). Each of the 39 items used a simple “yes/no” response set.

- **Discuss data analysis and results**

  The Benjamin Rose Institute on Aging conducted the analysis using repeated-measures ANOVA to test for change in outcomes from enrollment (i.e., baseline) to 12-months post-enrollment (change in outcomes was calculated by comparing caregivers’ responses to questions in the first interview with responses to the same questions in the second interview). The repeated measures ANOVA also tested interaction effects representing whether the changes in outcomes significantly differed depending on: whether the care receiver had: 1) high vs. low levels of difficulty with cognitive impairment, and 2) high vs. low frequency of behavior problems. In addition, significant interaction effects were further clarified using paired sample t-tests.

  The analysis used an “intent-to-treat” approach in order to account for sample bias due to attrition from the program before completing the 12 months and refusals to complete the 12-month follow-up interviews. For caregivers who did not complete the 12-month follow-up interview, the intent-to-treat approach cared forward responses from the baseline interview to the follow-up interview. The result is “no change” in answers, which does not inflate differences in outcomes due to attrition.

  The following five tables display bar chart results for changes in caregiver outcomes including: 1) Depression, 2) Caregiving Confidence, 3) Social Isolation, 4) Health Strain, and 5) Needs Met, including eight types of needs. The sample was 439 caregivers.
Caregiver Symptoms of Depression – Change from Baseline to 12 Months

- Total Sample: No statistically significant change from baseline to 12 months. Baseline levels maintained.
- Caregivers of Persons with High Behavior Problems: A statistically significant decrease in symptoms of depression from baseline to 12 months.

Table 1. Baseline to 12-Month Change in Depression

<table>
<thead>
<tr>
<th>% Change</th>
<th>Total Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>2%</td>
<td></td>
</tr>
<tr>
<td>4%</td>
<td></td>
</tr>
<tr>
<td>6%</td>
<td></td>
</tr>
<tr>
<td>8%</td>
<td>5.4%, NS</td>
</tr>
</tbody>
</table>

Subsample High Baseline Problem Behaviors*

-9.0% (p=.02)
Caregiver Confidence in Caregiving – Change from Baseline to 12 Months

Table 2. Baseline to 12-Month Change in Caregiving Confidence

<table>
<thead>
<tr>
<th>% Change</th>
<th>Total Sample</th>
<th>Subsample High Baseline Problem Behaviors*</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Total Sample: A statistically significant increase in caregiver confidence from baseline to 12 months.
- Caregivers of Persons with High Behavior Problems: An additional statistically significant increase in caregiver confidence from baseline to 12 months.
Caregiver Social Isolation – Change from Baseline to 12 Months

- Total Sample: No statistically significant change from baseline to 12 months. Baseline levels maintained.
- Caregivers of Persons with High Behavior Problems: A statistically significant decrease in symptoms of depression from baseline to 12 months.
- Caregivers of Persons with High Cognitive Impairment: A statistically significant decrease in symptoms of depression from baseline to 12 months.
Caregiver Emotional and Physical Health Strain – Change from Baseline

Table 4. Baseline to 12-Month Change in Health Strain

- Total Sample: No statistically significant change from baseline to 12 months. Baseline levels maintained.
- Caregivers of Persons with High Behavior Problems: A statistically significant decrease in emotional and physical health strain from baseline to 12 months.
Needs Met – Change from Baseline

Overall, results showed reductions in negative caregiving outcomes (Depression, Social Isolation, and Health Strain) and increases in positive outcomes (Caregiving Confidence and Needs Met) from enrollment to 12-months post-enrollment. For some outcomes, beneficial changes were significantly greater for caregivers assisting a relative who had more cognitive impairment and/or problem behaviors.

- **Discuss how these results compare with the original intervention**

Results from the Georgia implementation of BRI Care Consultation are in-line with outcomes from the original intervention. For example, in the Cleveland Managed Care Demonstration, at 12-month follow-up, caregivers in the intervention group had fewer reported symptoms of depression than those in the comparison group ($p < .05$; 21.0% fewer symptoms of depression). In another study, caregivers from the intervention group had a significantly greater decrease in perceived unmet needs than those in the comparison group (45.7% vs. 27.6%; $p = .01$). In addition, among caregivers assisting a more cognitively impaired patient with dementia, those in the intervention group had a
significantly greater decrease in perceived unmet needs than those in the comparison group (54.2% vs. 24.6%; p < .001). From baseline to 12-month follow-up, caregivers in the intervention group had a significantly greater decrease in perceived unmet needs than those in the comparison group (35.4% vs. 21.9%; p < .001).

- Discuss any challenges that occurred and how they were addressed

There were several challenges, also outlined in great detail in other parts of this report, related to service delivery, enrollment/attrition, and staffing. The Care Consultants that were selected to lead the project initially had minimal experience with serving a dementia population. Additional dementia training was provided to remedy this challenge. Furthermore, Care Consultants at a couple AAAs had the responsibility of multiple roles within the agency, which limited their availability to document and adhere to the evidence-based protocols and fidelity to the model. Additional refreshers and fidelity review trainings, along with discussions with management to provide additional supervision, helped to temporarily alleviate this issue, although it still remained to be a challenge. In terms of enrollment and attrition, obtaining written consent, receiving intra-organizational referrals, external program marketing, and attrition were challenging throughout program delivery. These challenges were addressed by changing written consent to verbal consent; increasing program awareness within agencies; developing innovative external marketing strategies; and reviewing disenrollment strategies with Care Consultants.

- Discuss any innovations that would be valuable for the aging network

- A major innovation of BRI Care Consultation in the Georgia AAAs was that it was an effective and efficient supplement and, in some cases, a substitute for traditional, in-person case management. Other minor innovations aided in feasibility and acceptability of program implementation: 1) Reduced number of required contacts for selected sights, 2) Additional dementia training and education, 3) Increased fidelity monitoring, refresher trainings, and site visits, 4) Referrals from waiting lists, 5) Allowing an in-person visit for one site, 6) Updates to the CCIS, including reporting features, and 7) Web-based CCIS development by BRI and implementation at all current and future licensed sites.

Section VI: Maintenance

- Describe sustainability of project and plan for embedding into state long term services and supports
Due to challenges that the Georgia Department of Aging Services faced at the time that this grant was awarded, GDAS was exploring effective and cost efficient alternatives to traditional case management services for the Georgia aging population. This created an atmosphere of support in the form of program champions at all levels of the Georgia Aging Services AAA implementation sites. Discussions on sustaining this model of service began very early on in the project.

On June 20, 2013, the RCI BRI Care Consultation team met with GDAS. The goal of the meeting was to review previous BRI Care Consultation project outcomes, preliminary Georgia BRI Care Consultation project outcomes and preliminary cost analysis comparisons to traditional case management. Based on the data presented by the RCI team and reports from grant site directors, GDAS announced a policy change which resulted in the addition of BRI Care Consultation to the Georgia Area Agency on Aging’s’ approved evidence based menu of services. In addition, this policy change identified BRI Care Consultation not only for families living with ADRD, but all families expressing needs. Currently, there are six Georgia AAAs licensed and trained in BRI Care Consultation. The remaining six AAAs are receiving a BRI Care Consultation program orientation with the goal of making referrals to the licensed agencies or adopting the program in 2016.

- **Describe funding sources for the project**

  Current funding sources for the Georgia statewide expansion are monies provided through the Older Americans Act for evidence-based caregiver interventions. In 2016, AAAs will offer BRI Care Consultation as a fee for service to families who do not meet the financial qualification for no-cost services.

- **Discuss any challenges that occurred and how they were addressed**

  *Challenge:* Full time Care Consultants were employed for the Georgia BRI Care Consultation three-year grant project. To test the ability of AAA staff person to split their time between a partial BRI Care Consultation caseload and other responsibilities, ARC, RCI and BRI piloted a program in Henry and DeKalb counties.

  *Solution:* The Henry county supervisor was not able to realign the Care Consultants job assignments to provide her with dedicated time to serve her clients. The DeKalb county supervisor was able to make provisions for a dedicated block of time to work with her clients.
Lesson Learned: The staff found it challenging to divide their time between a traditional case management model of service and the BRI Care Consultation empowerment model. In addition, it was discovered that efficiency and effectiveness was compromised when the Care Consultant did not have a dedicated block of time to serve their clients.

- Discuss any innovations that would be valuable for the aging network

Going forward the best practices for BRI Care Consultation staff is a Care Consultant with dedicated time allocated to program service delivery.

Section VII: Budget and Cost Analysis

- Provide report on budget

The Rosalynn Carter Institute for Caregiving was awarded $1,209,180 to fund the three year project. The total expended on direct services was $1,171,462 and $41,970 spent on administrative services.

- Describe and present cost analysis

All sites initiated client services on March 1, 2011. New client enrollment cutoff date was set for July 31, 2012 to ensure that clients enrolled in July 2012 would receive a full 12 months of service before the end of the grant period. We will report on the client service period from August 1, 2011 through July 31, 2012. This reporting period was selected to reflect peak enrollment numbers in each AAA site. The cost analysis demonstrates inputs (costs) and outputs (hours of direct and in-direct client services) for the reporting period.

Expected Inputs

- RCI Inputs:
  - Salary and fringe benefits/RCI Program Manager
  - Travel expenses to attend steering committee meetings, orientation, initial training and agency site visits/mileage, lodging, and meal per diem
  - Overhead, computer, and consumable supplies
  - Teleconferencing fees

- AAA Implementation Site Inputs:
  - Salaries, fringe benefits
Overhead, computer
- Long distance phone charges
- Program brochures

**BRI Inputs:**
- Contracted Services

**Expected Outputs:**

It was expected that the three AAA sites would enroll 150 caregiver/care receiver dyads per site for a total of 450 clients receiving the program services for 12 months over the three year grant period.

- Atlanta Regional Commission AAA enrolled 226 (goal exceeded by 76 clients)
- Heart of Georgia Altamaha AAA enrolled 227 (goal exceeded by 77 clients)
- Legacy Link, Inc. AAA enrolled 142 (goal not met by 8 clients)

Total three site enrollment: 595 clients (goal exceeded by 145 clients)

This cost discussion will examine the salary and fringe benefits for site managers, Care Consultants, and administrative support staff as well as agency indirect cost. Further program cost considerations is the BRI Care Consultation copyrighted licensing agreement for program and training materials.

The site cost data was collected using the CCIS generated reporting features. With each client contact, the Care Consultant is prompted by the CCIS to enter Direct client service time in the Contact Log using a start and stop clock. The In-Direct service time, such as documentation or information research on behalf of the client is a manual entry. This time usage data populates to the Direct and Indirect Time Report. For the purpose of this report, the average direct and indirect time and the program expenditures was used to calculate the average daily and annual cost of service per family.

- Atlanta Regional Commission Annual Cost per Family Served: $435.15
- Heart of Georgia at Altamaha Annual Cost per Family Served: $437.25
- Legacy Link, Inc. Annual Cost per Family Served: $232.33
The Atlanta Regional Commission reported that the annual cost of serving a client with traditional case management using the same budget line items as used in the Georgia BRI Care Consultation cost analysis is $1,454.40 a year. BRI Care Consultation can provide a proven evidence-based service for caregiving families at a savings of $1,019.25 per year over traditional case management.

Table 1:

<table>
<thead>
<tr>
<th>Atlanta Regional Commission (ARC) August 1, 2011 through July 31, 2012</th>
<th>Number of Units of Service in Hours</th>
<th>Number of Clients served during this time period</th>
<th>Average Cost per Client per Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Consultant Salary plus Fringe 40.13/hour</td>
<td>709 hours x 40.13/hr. = $28,452.17</td>
<td>117</td>
<td>$243.18</td>
</tr>
<tr>
<td>Site Supervisor Salary plus Fringe 73.62/hour</td>
<td>104 hours x 73.62/hr. = $7,656.48</td>
<td>117</td>
<td>$65.44</td>
</tr>
<tr>
<td>Agency Indirect (office space, equipment, phone charges) 41% of Salaries</td>
<td>$28,452.17 + $7,656.28 = $36,108.45</td>
<td>$14,804.46 divided by 117 = $123.45</td>
<td>$126.53</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total Annual Cost Per Client</td>
<td>$435.15/year or $1.19/day</td>
</tr>
<tr>
<td>ARC Service Hours For Reporting Period</td>
<td>Units</td>
<td>Total</td>
<td>Mean minutes per contact</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-------</td>
<td>-------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>Indirect Time</td>
<td>minutes</td>
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<td>8.2</td>
</tr>
<tr>
<td>Direct Time</td>
<td>minutes</td>
<td>19,991</td>
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</tr>
<tr>
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<td></td>
</tr>
<tr>
<td>Mean Days Enrolled</td>
<td></td>
<td>324.8</td>
<td></td>
</tr>
</tbody>
</table>
Table 3:

<table>
<thead>
<tr>
<th>Heart of Georgia at Altamaha (HOG)</th>
<th>Number of Units of Service in Hours</th>
<th>Number of Clients served during this time period</th>
<th>Average Cost per Client per Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 1, 2011 through July 31, 2012</td>
<td>868 hours x 22.26/hr. = $19,321.68</td>
<td>88 $19,321.68 divided by 88 = $219.56</td>
<td>$219.56</td>
</tr>
<tr>
<td>Site Supervisor Salary plus Fringe</td>
<td>182 hours x 58.64/hr. = $10,672.48</td>
<td>88 $10,672.48 divided by 88 = $121.28</td>
<td>$121.28</td>
</tr>
<tr>
<td>Agency Indirect (office space, equipment, phone charges) 42% of salaries</td>
<td>$19,321.68 + $879.60 = $20,201.28 42% = $8,484.53</td>
<td>$8,484.53 divided by 88 = $96.41</td>
<td>$96.41</td>
</tr>
</tbody>
</table>

Total Annual Cost Per Client $437.25/year or $1.20/day

Table 4:

<table>
<thead>
<tr>
<th>HOG Service Hours For Reporting Period</th>
<th>Unit</th>
<th>Total</th>
<th>Mean minutes per contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indirect Time</td>
<td>minutes</td>
<td>36,837</td>
<td>14.9</td>
</tr>
<tr>
<td>Direct Time</td>
<td>minutes</td>
<td>15,215</td>
<td>6.1</td>
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<tr>
<td>Total Time</td>
<td>minutes</td>
<td>52,052</td>
<td>21.0</td>
</tr>
<tr>
<td>Number of Contacts</td>
<td></td>
<td>2,479</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of Units of Service in Hours</td>
<td>Number of Clients served during this time period</td>
<td>Average Cost per Client per Year</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-------------------------------------</td>
<td>-----------------------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td><strong>Care Consultant Salary</strong></td>
<td>343 hours x 19.27/hr. = $6,609.61</td>
<td>125</td>
<td>$52.88</td>
</tr>
<tr>
<td><strong>plus Fringe 19.27/hour</strong></td>
<td></td>
<td>$6,609.61 divided by 125 = $52.88</td>
<td></td>
</tr>
<tr>
<td><strong>Care Consultant Assistant</strong></td>
<td>343 hours x 17.73/hr. = $6,081.39</td>
<td>125</td>
<td>$48.65</td>
</tr>
<tr>
<td><strong>Salary plus Fringe 17.73/hour</strong></td>
<td></td>
<td>$6,081.39 divided by 125 = $48.65</td>
<td></td>
</tr>
<tr>
<td><strong>Site Supervisor Salary</strong></td>
<td>208 hours x 46.57/hr. = $9,686.56</td>
<td>125</td>
<td>$77.49</td>
</tr>
<tr>
<td><strong>plus Fringe 46.57/hour</strong></td>
<td></td>
<td>$9,686.56 divided by 125 = $77.49</td>
<td></td>
</tr>
<tr>
<td><em><em>Other</em> (phone charges, equipment, supplies charges for analysis period)</em>*</td>
<td>$6,651</td>
<td>$6,651 divided by 125 = $53.21</td>
<td>$53.21</td>
</tr>
<tr>
<td><strong>Total Annual Cost Per Client</strong></td>
<td></td>
<td></td>
<td><strong>$232.33/year or $.64/day</strong></td>
</tr>
</tbody>
</table>

*LL corporate structure does not support indirect charges
Table 6:

<table>
<thead>
<tr>
<th>LL Service Hours For Reporting Period</th>
<th>Units</th>
<th>Total</th>
<th>Mean minutes per contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indirect Time</td>
<td>minutes</td>
<td>10,045</td>
<td>6.3</td>
</tr>
<tr>
<td>Direct Time</td>
<td>minutes</td>
<td>10,507</td>
<td>6.6</td>
</tr>
<tr>
<td>Total Time</td>
<td>minutes</td>
<td>20,551</td>
<td>12.8</td>
</tr>
<tr>
<td>Number of Contacts</td>
<td></td>
<td>1,604</td>
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</tr>
<tr>
<td>Mean Days Enrolled</td>
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<td>353.2</td>
<td></td>
</tr>
</tbody>
</table>

An additional consideration for agencies to factor into program start-up and sustainability is the cost of the BRI Care Consultation program licensing. In the Winter 2015, the Benjamin Rose Institute on Aging invested in the development of a web-based Care Consultation Information System (CCIS) to replace the Access-based software. This upgrade was completed without compromising the fidelity of the evidence-based protocol and provides the agency with a safe and easy access for Care Consultants to work from home. Two of the six Georgia AAAs are implementing the program with contracted Care Consultants working out of a home office. This further reduces the cost of client services by eliminating the cost of fringe benefits and overhead.

BRI Care Consultation Web-Based Program & Training Materials Agreement included as “Attachment C”

BRI Care Consultation Information System Web-based Hosting Agreement included as “Attachment D”

Georgia BRI Care Consultation Cost Analysis Report Grant# 90AE0349/01 included as “Attachment E”

- **Section VIII: Conclusion**

  The Georgia BRI Care Consultation was a successful translation of BRI Care Consultation. The success of this translation can be linked to several factors:

  - An interactive partnership between the Rosalynn Carter Institute and the researcher and developers, specifically, Dr. David Bass and Branka Primetica with the Benjamin Rose Institute on Aging. The quality the BRI Care Consultation program and their support cannot be overstated. They provided
invaluable experience, technical assistance and support in all phases of the project. They have also provided consultation and support in moving the project for the three site Georgia BRI Care Consultation to the statewide BRI Care Consultation adoption.

- The ongoing partnership with the Georgia Department of Aging in supporting the project with an eye on sustaining from the initial planning to the adoption of BRI Care Consultation statewide.

- The commitment of the AAAs selected for this project, Atlanta Regional Commission, Heart of Georgia at Altamaha, and Legacy Link. In each site, there were program champions, from agency directors, site supervisors and Care Consultants who understood the value of a committed team dedicated to highest level of evidence-based implementation.

- The purveyor capabilities of the Rosalynn Carter Institute for Caregiving. The RCI staff’s knowledge of implementation science greatly facilitated the success of this program.

Section IX: References


Section X: Appendices

A. Care Consultant Job Description
B. Internal Supervision Requirements
C. BRI Care Consultation Web-Based Program & Training Materials Agreement
D. BRI Care Consultation Information System Web-based Hosting Agreement
E. Georgia BRI Care Consultation Cost Analysis Report Grant #90AE0349/01