I. Background on Evidence-Based Project

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

In 2008, the Michigan Office of Services to the Aging (OSA), the state unit on aging, responded to the Alzheimer’s Disease Support Services Program (ADSSP) call for proposals that specified the use of evidence-based programs. After a careful review of all the programs, OSA chose the Savvy Caregiver Program (SCP) for several reasons: first, it embodies a person-centered approach to dementia care, which was an emerging initiative in the aging network at the time. SCP’s unique focus on the caregiver dyad and the impact of changing roles illuminated a potential source of pain and conflict for both caregivers and persons with dementia, which makes it more than an educational program. The program, designed and tested in rural areas of Minnesota, Alaska, and Colorado, addressed the geographic factors of the majority of Michigan’s dementia caregivers. The six-week program delivered in a group format is familiar to Michigan’s aging network as Michigan has been successful with evidence-based “disease-prevention, health-promotion” programs, e.g., Stanford patient education programs. Another feature that appealed to OSA was that SCP does not require its trainers to be clinicians, case managers, or other designations. As it has no credential criteria, a variety of agency or service provider staff can provide the program (e.g., nurses, social workers, dementia agency staff, or community members); this allows staff flexibility among community partners, a strength at this time of severe budget constraints. Finally, the group format provided by one staff person meant that costs to provide the program seemed within the reach of project partners, increasing its likelihood of sustained implementation beyond the grant period.

Discuss the goals of the evidence-based project

The project’s goal was to successfully replicate the SCP under “real world” conditions to provide an effective, time-efficient caregiver intervention in rural regions to persons caring for a family member with dementia living at home, using the Area Agencies on Aging (AAAs) and their community partners. In the proposal, OSA, using Alzheimer’s Association projections,
estimated 57,000 dementia caregivers in the five regions and 14,000 dementia caregivers living in the most populous county of each region. The project’s goal was to serve about 1,100 caregivers, using a “train the trainer” model. The project benefited from the participation of Carey W. Sherman, PhD, a co-developer of SCP.

Each AAA developed a regional plan and budget, setting their own goals for participants and programs. Due to trainer turnover and budget adjustments, the project was approved for No Cost Extensions through September 2013. Based on data received for the final report, the project held 200 programs in 39 counties serving 1,690 participants with an 80% completion rate.

Michigan’s aging network had not previously benefited directly from the Administration on Aging’s Alzheimer’s Disease funding program. Previous Alzheimer’s disease grants to Michigan were implemented by the mental health system; thus, this project was the first opportunity for AAAs to develop dementia caregiver capacity in the aging network. Being successful in reaching the target audience and demonstrating positive outcomes was important on many levels.

Provide an overview of the original intervention that includes: brief description and summary of intervention components

The Savvy Caregiver Program (SCP) is an evidence-based psycho-educational intervention for family caregivers of relatives with Alzheimer’s and other dementias (AD). Recognizing the substantial toll that dementia caregiving can take on caregivers’ physical and mental health, the SCP intervention is designed to enhance the knowledge, skills and attitudes of the family caregiver. Empowered with information and strategies, SCP aims to improve the quality of life of caregivers in multiple domains, including caregiver burden, self-care, depressive symptoms, social support and problem situations.

The SCP takes a unique perspective on caregiver training. Modeled on the Minnesota Family Workshop (MFW), the psycho-education approach is grounded in Folkman and Lazarus’ (1984) stress and coping theory framework. SCP emphasizes that family members have undergone (and continue to undergo) a process of role change and acquisition.

While family members generally become caregivers based on their existing relationship with the person with dementia (PWD), SCP asserts that family members who become caregivers assume a role for which they are, typically, unprepared and untrained. The complex role of
“savvy” caregiving requires specific knowledge of dementia diseases, skills to adapt one’s environment and routine to accommodate the needs and disease stage of the PWD, and flexible, strategic attitudes, or ‘stance’ in order to be performed successfully. Moreover, the progressive and degenerative nature of AD requires that caregivers continually adjust and modify the level of support and structure provided to the PWD.

According to SCP, the goal of caregiving is to create *contented involvement* for the PWD. Therefore, the objective of SCP is to coach caregivers to use a strategic, informed, and skillful approach to their caregiving work in order to minimize distress and enhance reward in care dyad and family interactions. Similarly, caregiver self-care is emphasized as fundamental to protecting the long-term health of the caregiver and for sustaining an effective and meaningful care relationship.

SCP is delivered in six two-hour sessions. The SCP trainer manual contains a detailed explanation of the content, including session flow, and agenda pacing for each session. While not a strictly scripted protocol, it provides content and the underlying rationale for each session’s focus so that trainers can fully grasp and reflect the program’s conceptual and training objectives. The psycho-educational format utilizes adult learning principles and requires trainers to be well versed in the content and principles. Each session incorporates a mini-lecture as well as participant involvement in exercises, discussion, and videos. Caregivers are encouraged to read the SCP Caregiver Manual at home and practice caregiving strategies discussed in the group sessions. In addition to not requiring professional credentials for the trainers, the program can be provided in a variety of settings, e.g., community centers, adult day services, office buildings, or agencies. These factors increase its portability to the target audience.

Trainers rely on the SCP Trainer Manual, which provides specific and clearly organized curriculum. The six sessions include: 1) introduction to Alzheimer’s Disease and other types of dementia; 2) caregiver self-care; 3) the anchors of enjoyable (contented) involvement; 4) understanding levels of thinking and performance; 5) decision-making skills and 6) strengthening the family (social ties) as a resource for caregiving. Each session carries some the previous sessions’ content forward for review and integration in practice. One of the unique program components is a series of video recordings of persons at various stages of dementia. This enables caregivers to view the disease progression as expressed by PWDs who perform the same tasks. This content is often a significant turning point for SCP participants, as it
complements lecture information and other tools to encourage participants to apply in their individual situations.

Describe the Partners: Identify the translation evaluator for the project and their general responsibilities and identify the partners, including their role in the project and a brief description of each partner agency.

The project’s research consultant/translation evaluator was Carey W. Sherman, PhD, Institute for Social Research, University of Michigan. Prior to this project, Dr. Sherman worked with Michigan’s aging network on dementia caregiving projects. She conducts ongoing research focused on family dynamics of caregiving, caregiver intervention development and evaluation, and the consequences of social relations on health and well-being. As an original co-developer of SCP, she was an ideal choice for this role. Dr. Sherman brought her deep understanding of the structure and content of SCP, as well as her skills as a researcher in dementia caregiving. Dr. Sherman’s contributions began with the proposal and included the review and selection of participant measures and scales. She drew on the scales used in the SCP random controlled trial to construct the pre- and post-surveys and participant evaluation forms. Over the course of the project, Sherman conducted the de-identified data analysis.

In addition, Dr. Sherman planned and conducted the training events to train the trainers. She designed a two-day agenda, in collaboration with project staff and personally trained the project trainers. As the steps of the fidelity management system were developed, she played a key role as fidelity consultant, sharing knowledge, skills, and assessments with project staff, trainers, and community partners. Dr. Sherman reviewed and contributed to most of the project reports and participated on Administration on Community Living/Administration on Aging (ACL/AoA) project teleconferences and meetings, as available. Dr. Sherman occupied a unique role; she is a SCP co-developer who became intimately involved in the translation and implementation of SCP.

The project had five primary agency partners: AAAs 4, 6, 9, 10, and 11. OSA contracted with the AAAs for the implementation of the program. Each AAA is in a rural part of Michigan, with three (AAAs 9, 10, and 11) in northern Michigan and the Upper Peninsula. While AAAs 4 and 6 each serve three counties, the northern AAAs serve more than ten counties each, with few population centers, and a growing number and percent of older adults. Increasingly, northern
Michigan has an expanding aging population due, in part, to the trend of people retiring to their summer homes and those returning from employment downstate at retirement or for family needs. The AAAs were familiar with the difficulties of rural areas, where services are either scarce or in some cases, limited. Adult day services, in particular, have difficulties in rural areas, where obtaining sufficient participants to survive is a challenge due to distance.

Each AAA selected their community partners. Region 4 selected a county council on aging. As a three-county region, this provided convenient coverage of two counties. Regions 6, 10, and 11 contracted with local Alzheimer’s Association offices. Over the course of the project, these regions expanded their training teams to include staff of aging services, e.g., councils on aging, or other agencies, such as community mental health. Region 9 selected county councils on aging and senior centers as their community partners.

Another project partner was the Michigan Commission on Services to the Aging. The Commission is composed of 15 individuals appointed to three-year terms by Michigan’s Governor. The Commission reviews and approves the annual implementation plans of the AAAs and OSA’s contracts and sub-grants. At the project’s start, several commissioners had experience caring for a family member with dementia; the project resonated with their personal experience. In addition to approving grants to project partners, the Commission created a panel of members who reviewed applicants for Master Trainers and then issued certificates to Master Trainers, certifying them for two years. The Commission panel was a key component in the project sustainability process.

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

SCP was delivered with a high level of fidelity to the original model. Dr. Sherman provided a strong start with her training agenda. In the two-day training, she reviewed the content, organization and pacing, as well as the background and rationale for each session, discussing the content’s value and providing training tips. The training ran 14-16 hours, allowing for ample opportunities for training participants to engage in role-play, sample the SCP exercises and discuss SCP and project implementation requirements. As discussed in detail below, the project implementation content focused on using the ADSSP required RE-AIM framework: Reach, Effectiveness, Adoption, Implementation and Maintenance. While it was
OSA’s responsibility for using the framework, AAAs and trainers needed to know how RE-AIM goals and objectives were measured through program data.

In order to provide timely and systematic information to all SCP trainers involved in the implementation, the Michigan project followed up every Train the Trainer workshop with regularly scheduled project calls. These calls would allow trainers to ask questions about the SCP content or pacing, as well as discuss implementation issues or challenges. The phone meetings enabled project partners to share their successes as well as their strategies for overcoming implementation barriers and to encourage consistency with the SCP model.

OSA decided that one of the first elements of fidelity was to ensure the program was provided to the target audience. The project defined participant eligibility based on both SCP and ADSSP requirements. SCP, as originally developed, included family members who might be considered secondary caregivers. All ADSSP funded projects, however, focus on primary caregivers. For the project’s purposes, secondary caregivers, such as adult children, were considered “on deck” to become primary caregivers when they were actively involved in supporting one or both parents in caregiving. Many adult children were, in fact, primary caregivers for both parents, for various reasons, and distinguishing among several adult children as to who was primary was not congruent with the project’s goals. In a many situations, multiple family members attended the program. The project developed a clear eligibility definition, discussed below. The focus on eligibility was based on the presumption that maximum benefits will accrue to the target population and “who is in the room” is the first step of fidelity. Social caregivers, e.g. neighbors and church friends, and paid professionals were ineligible because they are not primary caregivers, nor are the SCP target audience. Per ADSSP requirements, family members with a PWD in a care facility were also ineligible. Real life situations and family dynamics are complex and many trainers used the project telephone meetings to discuss and clarify participant requirements.

SCP suggests that groups consist of 6-12 participants and the project set that as the ideal group size. In very rural areas, however, Dr. Sherman allowed groups of four participants, as long as the participants represented a minimum of three PWDs. Fewer than four participants meant re-scheduling the program. In addition, the program did not allow guests/observers out of respect for the participants’ privacy. The only exception was a Master Trainer or new trainer who needed to observe for fidelity and learning purposes.
Program modifications were minimal and always reviewed by Dr. Sherman. Her expertise on SCP was valuable as trainers proposed small modifications to the program. Not all modifications suggested by trainers were approved, but others deemed consistent with SCP and the learning experience were adopted. For example, one trainer made a “feelings quadrant” handout for each participant to take home, along with small sticky notes. The trainer still used the large diagram in class, but the handout reinforced the exercise’s aim by making it a “take home” exercise. Dr. Sherman endorsed this and shared it with other trainers. Another trainer shifted one exercise from the end of a session to the start of the next session, when participants seemed more attentive.

The project’s dedication to consistency, on-going training, and trainer meetings, plus a shared commitment to fidelity gradually merged into a coherent fidelity management process that involved various partners, both internal and external, all with a shared commitment to a high quality program. As a “translational research” project, with the goal of replicating the original research findings, Michigan’s implementation emphasized fidelity to SCP, and consistency across trainers and regions. As was often stated at training and project conference calls, this project wanted every caregiver to be able to attend SCP anywhere in the state, assured that they were getting the same proven content and high quality training approach. The importance of consistency increased as family members around the state attended programs individually. Sometimes, a spouse would attend first and later, the daughter. In other cases, a son of a PWD attended in a different region from his sister. Family members need to receive the same clear, consistent content, skills, and knowledge, regardless of time or location. Family caregivers have sufficient opportunities for differing opinions, without including the program’s content.

II. Reach

Describe the intended audience for the intervention.

The project’s intended audience was family caregivers of persons with dementia who were living at home. In the proposal, OSA estimated the number of dementia caregivers in these regions to be between 14,000 and 57,000. These estimates include all categories of caregivers, some of whom would not be eligible for SCP as well as some who were unlikely to attend a six-session program. In the proposal, each AAA set a participant goal. In year one, the overall goal was 365 participants; Region 4, 60; Region 6, 75; Region 9, 70; Region 10, 60; and Region 11,
Successive years had goals of 400 participants and more, totaling over 1,000 caregivers. In actuality, the project, over five years, served 1,690 caregivers, with 80% of participants attending four or more sessions.

The level of reach can be estimated using generally accepted assumptions about caregivers. First, families, not institutions, currently provide nearly 80% of long-term care in this country (Family Caregiver Alliance, Policy Brief, 2007). Using 80% of the dementia caregivers as active engaged in caregiving tasks for someone living at home, reduces the estimated population by 20%, from 57,000 to 45,600. Most family caregivers are women, according to the Family Caregiver Alliance and AARP’s Caregiving Resource Center. They estimate between 66-80% of caregivers are women. Group formats also tend to be more attractive to women. While women were not a specific target, they represented nearly 80% of the attendees. The potential number became 31,920. Then there are individual factors, such as the realization that one is a caregiver and one is willing to attend a multi-session intervention. This is a harder number to estimate, but if the potential served was reduced by 10%, it would be 28,728. The number served, 1,690, is about 5% of the estimated target group, without considering individual factors, such as illness, weather, nursing facility or assisted living placements.

**Define the selection criteria for participants.**

OSA established clear selection criteria for participants. Spouses and persons living with the PWD were deemed eligible and primary. Adult children who were either active, primary caregivers for a parent or who assisted a parent with caregiving were also eligible. Other family members who were active caregivers for a PWD were eligible. In complex situations, of which there were many, trainers applied the criteria of relationship and responsibility. Family members are connected by relationship and bear the burden of responsibility for the well-being of the PWD. One issue was long distance caregiving. Since Michigan borders three states (Ohio, Indiana and Wisconsin) with Illinois an hour away from Region 4, if either member of the caregiver dyad lived in Michigan, the caregiver was eligible. However, if the PWD lived in Texas, the Michigan family member was not eligible.

The following is a list of those ineligible, per ADSSP and SCP requirements.
family members of persons with dementia (PWD) who are in a care facility, e.g., nursing home, adult foster care home (AFC), assisted living, or similar setting with paid staff to assist residents;

- family members of PWD who died;
- professionals; volunteers; in-home aides; AFC providers; assisted living staff; nursing home staff; and certified nurse assistants (CNA);
- church groups; church “families;” ministers; social friends;
- persons diagnosed with dementia;
- persons wanting to know more; neighbors of person with dementia; people who knew people with dementia;
- persons running caregiver support groups; persons who want to start a caregiver support group; and
- persons with a relative with dementia living in another state, unless contiguous with Michigan (see exception above).

The enrollment/registration process used by the AAAs needed to identify the target population and to provide referrals and resources to those who did not qualify. No one was simply turned away. Trainers referred people to the Alzheimer’s Association for assistance, programs, and other resources. While trainers were often hesitant to turn possible participants away, especially when recruitment was difficult, program effectiveness was obtained by providing the target group with the tested, proven intervention. Over the five years of the evidence-based Michigan implementation project, trainers allowed fewer than 20 ineligible participants (1%), demonstrating remarkable adherence to the established eligibility criteria.

Discuss the recruitment strategies used.

The aging network in Michigan, and AAAs, in particular, are not accustomed to “recruiting” clients. In accordance with the Older Americans Act, aging services are targeted to those who are at risk, specifically older adults with social or economic concerns. Offering a program without age, income, or assessment criteria was a new experience. As a result of this, recruitment strategies evolved over time, with the first shift occurring during the first project year. Project partners found that their original recruitment assumptions were false. First, there were not large numbers of caregivers of PWDs already being served by aging services. Outreach
efforts to service providers were quickly exhausted. Next, publicizing the program without program details and options also failed. Program publicity needs to be clear as to time, date, location, and provide multiple options, as well as registration/information contacts. A brochure could not state, “Classes start in fall, call for more information.” AAAs were ultimately required to develop and publicize several months of programs in advance and provide specific dates, locations, times, and registration information on all written and online program materials.

AAAs used their websites for reaching caregivers and OSA asked AAA to submit their schedules for posting on the OSA website, so the class schedule was available to all. Project staff decided to use the project’s title, “Creating Confident Caregivers,” for all programs provided by the ADSSP project. This distinguished the ADSSP project from other offerings. Later, the CCC designation provided the project with a clear and uniform brand name and identified the project across diverse regions of the state. OSA received calls from potential participants asking for the Creating Confident Caregiver program, not just “a caregiver program” or “dementia training.”

Brochures were an early form of program publicity and are useful and highly portable. They were distributed at meetings, left in waiting rooms, posted on bulletin boards, and updated as needed. AAA trainers carried brochures and program flyers in their cars. Sharing brochures with community aging services, such as meal sites and adult day services, was a common method.

Some AAAs turned to other media. In Region 10, the AAA trainer appeared on a local television show, while a Region 9 AAA trainer was a guest on a radio talk show. Such media appearances provided trainers with invaluable opportunities to talk about the program and answer questions. Some AAAs used community newspapers, both paid and free advertising options. Many shoppers’ guides and other weeklies listed programs, as did community events listings in local newspapers. The project asked people how they heard about the program on the demographic/pre-survey form. See the chart below for 2012 data.
<table>
<thead>
<tr>
<th>How Hear CCC</th>
<th>Responses</th>
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<tbody>
<tr>
<td>Friend*</td>
<td>154</td>
</tr>
<tr>
<td>Family Member*</td>
<td>143</td>
</tr>
<tr>
<td>Newsletter/Flyer</td>
<td>195</td>
</tr>
<tr>
<td>Support Group*</td>
<td>71</td>
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<tr>
<td>Service Provider*</td>
<td>149</td>
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<td>6 - Alz Assn</td>
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<td>6 - Blank</td>
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<td>6 - Church</td>
<td>5</td>
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<tr>
<td>6 - COA</td>
<td>22</td>
</tr>
<tr>
<td>6 - Internet</td>
<td>10</td>
</tr>
<tr>
<td>6 - Newspaper</td>
<td>63</td>
</tr>
<tr>
<td>6 - Other</td>
<td>16</td>
</tr>
<tr>
<td>6 - Person Identified*</td>
<td>11</td>
</tr>
<tr>
<td>6 - Phone</td>
<td>5</td>
</tr>
<tr>
<td>6 - Radio</td>
<td>7</td>
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<tr>
<td>6 - Sr Ctr</td>
<td>4</td>
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<tr>
<td>6 - VA</td>
<td>0</td>
</tr>
<tr>
<td>6 - Work</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>867</td>
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</tbody>
</table>

The real surprise came from categories marked with *, which account for 528 of 867 responses and constitute “word of mouth.” This is 81% of the 2012 responses provided by participants. Word of mouth cannot be bought, but is highly prized as the most desirable, effective form of information dissemination. Word of mouth referrals come from people with shared circumstances or needs, who are satisfied with the program, and personally endorse it to others. In several instances across the state, support group members advised new group members to take the CCC program and come back when done, so all members would know the program. Not surprisingly, “friend and family member” are the highest referral sources. The program, provided with quality, consistency, and compassion, earned the best form of publicity: personal referral.

Recruiting caregivers for an intervention is a complex interaction. First, the people engaged in caregiving must identify themselves as a caregiver, and not just a good spouse. Then there is the “teachable moment” when a person realizes that more information is needed. The “teachable moment” occurs when a situation evokes doubt or anxiety and the person recognizes his/her limitations. This can happen at any time and publicity about specific programs need to be continual; the person who ignored the flyer last month is registering for the program next month.
Discuss the enrollment process and enrollment numbers.

AAAs were responsible for handling the enrollment responsibility. The project did not provide registration forms or specify an enrollment process to AAA staff. OSA’s requirement was that participants registered in advance, received the pre-survey prior to the first session, and met the eligibility criteria. Each region was able to develop and implement their own registration process, while meeting those requirements. This varied across regions and agencies. Some agencies relied on administrative staff to handle registration, while some trainers personally contacted participants in advance to confirm attendance. There were no specifications about this aspect and each AAA developed their own process.

Following registration, AAAs sent participants a pre-survey in the mail to complete and bring to the first session. Many participants left the form at home, so AAAs discussed methods of gathering the forms. One AAA increased their pre-survey return rate at the first session by printing neon labels that read: “Bring this to the first session” and affixed a label on each pre-survey.

In 2009, the return rate for pre-surveys was low. In that first year, brochures did not list program dates, so recruitment was slow and trainers were new to gathering the pre-surveys. Submitting a completed pre-survey was not a pre-requisite for attending, so some trainers were relaxed about collecting them. Dr. Sherman coached the trainers on methods to increase pre-survey collection and stressed the importance of the demographic data for ADSSP reporting. Gradually, trainers became skilled in asking for pre-surveys and came to the sessions with additional copies for those who left them home. Overall, trainers gathered and submitted 1,463 pre-surveys of 1,690 participants on the roster, obtaining a return rate 86.5%.

Provide completion and drop-out rates for the intervention (Note: Completers are defined as those who attended two-thirds or more of the total intervention sessions.)

Alzheimer’s Disease Support Services Programs (ADSSP) projects must gather and report participant demographic data. Thirty-nine trainers provided 200 six-week programs in 39 rural counties serving 1,690 participants. Sign-in sheets recorded participant attendance for each session and were used to determine “completers,” those attending four or more sessions. Project staff also used attendance sheets for post-survey eligibility, which was defined as completing a pre-survey and attendance at three or more sessions.
Based on the attendance sheets, 1,690 individuals attended at least one session and 1,351 participants (80%) attended four or more sessions. Trainers followed up with participants after any missed sessions and determined their intention to return. If the participant indicated no intention of returning, trainers encouraged the participant to attend another program in the future. The two most common reasons for dropping-out were illness in the dyad or placement of the PWD in a facility.

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

ADSSP programs presented Michigan’s aging network with new participant eligibility and funding requirements. The shift from Medicaid/ Older Americans Act programs and the specific funding and reporting requirements of ADSSP required clarification and OSA created individual budget forms for the AAAs to help track spending requirements. Recruitment was a continual topic and provided AAAs with opportunities to be innovative.

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

AAAs were able to develop their own recruitment methods, but OSA required a consistent use of the project logo and brochure format. Articles, brochures, ads, and other media products were required to follow similar designs and formats, establishing the program identity in the public’s mind. Families are scattered and the goal was to identify the program clearly.

OSA developed ADSSP budget/Financial Status Reports in a combined format, with the built-in ability to track expenditures. Each AAA received an individualized spreadsheet for reporting, which had key formulas for direct services and other costs. The ADSSP spreadsheet eventually proved useful as a financial tracking form.

**III. Adoption**

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

OSA’s project proposal identified rural caregivers as the target population. The five regions selected for this project represent over half of Michigan’s counties and most of the State’s rural areas. The participating regions include three in northern Michigan and two in southern Michigan. See map below.
• Region 4 is composed of three counties in the southwest corner of the state;
• Region 6 is a three county area in south-central Michigan. While it includes Lansing, the state capital, the surrounding areas are a mix of rural and suburbs.
• Region 9 is 12 counties in northeast Michigan. A large, rural region, the number of older residents has grown as people retire to their summer homes;
• Region 10 is 10 counties in northwest Michigan and is also a retirement destination.
• Region 11 is the Upper Peninsula (UP), 15 counties, stretching across northern Michigan. Region 11 has a high percentage of older adults and rural areas that qualify as “frontier.”
There was no site competition for this project. OSA contacted the AAA directors in the five most rural regions about their interest and willingness to be part of the project’s proposal. There were several required tasks for inclusion, such as the development of a multi-year project budget, designation of AAA staff as regional project leader, and participation in training and program meetings. All five regional directors agreed, and all five regions remained active in the project for the five project years.
Discuss staffing needs and interview process

OSA provided two part-time staff persons as the project team: the project director and later, a data coordinator. As part of the “real world” implementation strategy, other than Dr. Sherman, specific project staff persons were not hired. Initially, data management was done by a part-time administrative staff, but as program data expanded, an OSA staff person with data management skills assumed all data responsibilities and became an integral part of the project team. Dr. Sherman had an annual contract for consultation, evaluation oversight, and training.

Each participating AAA director selected a staff person as the regional project administrator; this internal selection was made without OSA input. AAA project administrators were the points of contact for program oversight, training, and eventually, program document submission. Three of the five AAA project administrators are still in place, demonstrating continuity of the program. OSA encouraged the AAAs to select the Alzheimer’s Association as a partner agency; however, the AAAs made the final choice. They also decided the number and location of the regional trainers. The project’s intent was to use and empower existing resources and staff, rather than create new project positions that might not be underwritten following the grant period. AAAs selected all the project’s trainers. AAAs were able to send as many staff persons to the training as they wished, as their budget covered the trainers’ expenses for the two-day train-the-trainer (TTT) events. AAAs received a simple registration form with event information and no one selected by an AAA was turned away from attending the TTT. While most attendees were either social workers or nurses, there was no requirement for either profession.

The project took a risk in not establishing trainer prerequisites. In a “real world” implementation, available staff often provide programs and most staff have multiple duties, even those designated as a trainer. The mix of trainers and their skills created a variety that enriched the project, and using existing resources proved successful.

Describe orientation, training and mentorship of interventionists/staff

The development of a fidelity management model is based on training, oversight, and support. Over the course of the project, there were 10 formal “train-the-trainer” workshops, held in locations accessible to all participating regions. As the project matured, the project added refresher training workshops, and later, “by invitation” learning sessions. Registration was
required for these events and AAAs received the registration forms. The project also provided an array of informal supports: regularly scheduled project program phone meetings; responsive e-mail communication, and regional phone consultations. The objectives for these informal supports was to provide guidance and support to trainers who could, in turn, be a source of project monitoring in their respective regions. While trainers were strongly encouraged to participate in these fidelity-focused program calls, they were not required. These were one-hour conference calls with an agenda sent out in advance. Some calls were held for AAA trainers only; others were open to all trainers, depending on the agenda. Dr. Sherman participated on nearly all calls. The face-to-face workshops in concert with the regular email and phone communications proved to be critical to the development and maintenance of a solid, informed and collaborative cadre of SCP trainers in the regions.

Train the Trainer: Each train-the-trainer (TTT) event was a two-day program planned by project staff and Dr. Sherman. The project held two TTT events each project year, one in northern Michigan, one in central Michigan. Dr. Sherman was responsible for training participants in the SCP content and Ms. Steiner described the project's implementation and reporting requirements. As noted above, registration for training was limited to the partner agencies without individual prerequisites; however, the project used a “closed registration” process: registration forms were sent only to the project AAAs and registrations needed to be submitted by the AAAs. By submitting the registrations, AAAs approved the participants’ attendance. A minimum of six participants was required for a TTT.

The TTT agenda included project overview, review and discussion of each SCP session, strategies for group facilitation, and information on the RE-AIM framework and ADSSP requirements for data collection and reporting. The sessions were set up similar to the SCP classes: participants signed in each day, received their manual and other materials, and the room was set up in a circle or U-shape.

As a SCP developer, Dr. Sherman possesses a unique understanding of the SCP framework. As the trainer, she trained the staff participants, and discussed each session in turn, covering the mini-lectures, linking content to the exercises, while offering tips to maximize effectiveness and understanding.

The program implementation portion of the training addressed the project overview, the RE-AIM framework, data collection, and reporting requirements. RE-AIM guided each aspect
of the implementation. Specifically the “Reach” component requires AAAs to seek participants from the general community and beyond their normal service population. Project staff encouraged AAAs to use a variety of sites and program hosts to reach rural caregivers of all ages. The project coded 15 different locations, from churches to the community room of a tribal casino. RE-AIM incorporates program measurement to demonstrate effectiveness, which led to the data collection requirement. Trainers needed to understand the role of data and project documentation.

**Refresher Sessions**: As the project matured, it was noted that some trainers provided a few SCP programs a year, maybe only once or twice a year. Providing the program and maintaining contact with other trainers supported consistency and skill development. While the informal program calls were useful resources, they could not replicate the open discussion of a face-to-face meeting. The project developed a one-day refresher session, offered to all trainers, regardless of experience, to refresh and reinforce the SCP program content, sharpen trainers’ skills and develop camaraderie among the trainers. These in-person programs addressed project topics beyond the trainer manual, explored challenges and provided some fun learning opportunities. Dr. Sherman addressed topics raised in the program calls or other project communication, for example, participant engagement. Trainers shared techniques, discussed situations and methods. SCP encourages a “coaching” approach and the refresher workshops allowed Dr. Sherman to emphasize the value of assuming the “coaching” stance as leaders of SCP. These refresher events always received very positive evaluation scores from trainers.

**Learning Sessions**: Later in the project, another format provided support and further engaged experienced trainers. These events were “by invitation only” so were small groups of trainers and staff. These sessions provided the trainers with supplemental learning opportunities. The one-day workshop agenda included project updates, such as preliminary analyses of participant outcome measures by Dr. Sherman, but also other faculty discussing topics such as outreach to Latino caregivers by Dr. Velez-Ortiz, Michigan State University, SCP by Dr. Ken Hepburn, and professional development sessions by an OSA staff who is a certified life coach. Judith Heidebrink, MD, University of Michigan Health System, presented on the diverse types of dementia and presenting symptoms at one learning session. These events received very high evaluations from attendees.
Program Phone Meetings (Project Fidelity Calls): One of the integral informal support methods used in this implementation was the Program Phone Meetings. OSA would schedule and coordinate teleconference meetings for the newly trained trainers following the TTT events. Ms. Steiner and Dr. Sherman were present to discuss content, answer questions, and review implementation goals and strategies. This activity was especially valuable in the first two years of the project, as the number of new trainers increased rapidly and there were few, if any, Master Trainers to provide guidance at the regional level. The teleconference meetings had a standard agenda: project overview and regional reports; a fidelity topic, questions and answers (Q & A) and “brag and steal.” This format allowed trainers to interact with each other as well as project staff. Dr. Sherman’s fidelity topic was a mini-lecture on an issue, and was often selected based on questions from trainers. These calls were one hour long and conducted using a toll-free call-in system provided by OSA. This was an effective tool for discussing implementation and process issues, but attendance was not required and gradually, attendance dropped. As Master Trainers were certified, they continued to join these calls, but also were able to serve the same role within their regions, meeting with their training teams and addressing questions.

Informal “as needed” assistance: Throughout the course of the project, trainers were encouraged to send e-mails or contact the project director with specific questions or concerns. Over the first two years, most trainers took advantage of the ability to discuss situations or pose questions with the project director, by either e-mail or phone. These conversations often included Dr. Sherman, especially if there was a fidelity concern. The topics were often about a complex issue or situation, the answers were not self-evident, and through these discussions, many project guidelines emerged. The process of working through the problem engaged the trainer’s intellect and project investment. Decisions or guidelines from these unscheduled meetings were shared with all trainers. Sorting out complex situations with trainers reinforced the project’s direction and consistency.

Upon occasion, an AAA or project staff would identify an issue that was specific to a region. OSA would schedule a regional assistance call with Dr. Sherman participating. These calls were rare, but useful.
Discuss any challenges that occurred and how they were addressed

As previously noted, the project did not stipulate any prerequisites for the AAAs or other partners regarding who could serve as program trainers. As long as staff members were prepared to provide the SCP with fidelity, the CCC project trained all who attended. This produced many excellent trainers who might have been overlooked, but also included a few staff who were not well suited to the project. Trainer turnover was a challenge in some, but not all, regions. Two regions retained their original training team throughout the project, while three regions suffered from trainer turnover.

Trainer turnover is an inevitable and natural aspect of real-world community based project implementation. Staff change jobs, face their own or family health issues or move to other parts of the state or country. In a single year, one region lost three excellent trainers who had been active and engaged. This region suddenly had no trainers at all. As newly hired and existing staff persons were designated to become trainers, a time lag reduced the project’s momentum and in many ways, the AAA started the project from scratch a second time. The project provided the TTT workshop to help bring the AAA back to capacity and mentored the new AAA project administrator.

SCP occupies a unique niche in caregiver programs. It is psycho-educational and unscripted, but carefully designed to support caregivers in role and skill acquisition. The two most familiar programs present in the aging network are caregiver support groups and the EB health promotion programs. Distinguishing the differences between these two formats and SCP was always a challenge, especially if trainers were experienced in one or both of these similar programs. TTT sessions included discussions of these distinctions. The project team and a group of senior trainers developed a list of characteristics of support groups versus SCP so that new SCP trainers could recognize the differences.

A few trainers with extensive experience in leading support groups struggled with the shift away from a problem-oriented focus to a solution-oriented discussion. A sizeable number of trainers also provided EB health promotion programs; while those formats are six-weeks, two-hour sessions, they are scripted and have other implementation requirements that are not part of SCP. Adhering to the SCP format - as well as the intended training modality - of the EB intervention is a critical aspect of program fidelity. As a result, this issue of establishing and
maintaining a psycho-educational training focus has been a major topic at all staff training sessions and on project-wide conference calls, throughout the project.

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

A primary innovation of the CCC implementation was the use of program teleconferences, often referred to as fidelity calls, to support trainers, and reinforce, and augment training and consistent performance. In adopting an evidence-based program, clear and consistent guidelines are necessary. OSA project staff coordinated, managed and shared information and updates with trainers. Trainers shared regional activities and updates, raised questions and sometimes provided a “best practice” technique and information. Another adoption innovation was the development and implementation of a formalized “Master Trainer” certification process. This title was intended originally to designate all SCP trainers and became a title that indicated a level of mastery and leadership; it was awarded to a small group of exceptional trainers. While the certification process engaged trainers to develop skills and leadership, it also contributed to implementation and maintenance, since Master Trainers (MT) were capable of providing program monitoring in their regions.

The project team established a path to become a MT as an indication of exceptional skill and program knowledge. Project staff clarified that not all trainers were expected to become MT, but contracts with the AAAs stated that each region was to have at least one MT by the end of the project. The AAAs accomplished that, with each of the five regions having at least two MTs and at least one at each AAA. The certification process involved project staff, OSA staff, and external reviewers familiar with the project. The Michigan Commission on Services to the Aging granted the certification, only after approval from previous review panels. When this process was described to Dr. Hepburn, he expressed his approval of a clear system, involving a variety of reviewers with effective results.

IV. Implementation

*Describe the implementation approach*

The project’s implementation framework is based on “train the trainer” (TTT). The project trained the trainers who in turn provided the program and MTs were able to monitor
regional programs and trainers. Considerable latitude was allotted to AAAs. They selected the partner agencies, the trainers, the program schedule, host sites, arranged for respite care for participants, and handled project recruitment, registration, and publicity. They provided manuals and handouts for trainers to distribute to participants. The project’s focus was on the provision of the program and timely receipt of program documentation and local program scheduling. AAAs have great experience in monitoring and program oversight and they could decide how much they wanted to control day-to-day operations and/or delegate to partner agencies.

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

Fidelity to the EB program is at the cornerstone of any community-based implementation. Moreover, program monitoring for Michigan’s CCC projects was done in a manner that was labor and cost-effective, manageable in rural areas for a dispersed training cadre and ultimately sustainable for “real world” implementation. Project staff used extensive in-person training, regularly scheduled and as-needed project conference calls and provided additional refresher and learning workshops to review and reinforce SCP goals and objectives. Indeed, every interaction between project staff and trainers were viewed as an opportunity to evaluate, review and revisit fidelity issues.

Any fidelity concerns or performance issues detected or known by project staff were shared directly and discreetly with the AAA staff. It was not the project staff’s role to interfere in any contractual arrangements made by the AAA, but since the AAA was OSA’s contract agency for the project, program performance issues were properly directed to the AAA for handling.

Discuss any challenges that occurred and how they were addressed

The initial challenge for the implementation phase was recruitment for both participants and trainers. The ADSSP participant criteria are broader than many eligibility criteria for Older Americans Act funded programs. Being able to serve people with resources under age 60 and who met caregiver criteria was a shift in perspective for local agencies. However, as noted above, AAAs and community partners became effective in publicizing the program over the course of the project. Additionally, as participants’ referred others to the program, recruitment
issues abated. The project used consistent marketing tools to present a clear program message to the target audience. While AAAs and trainers often raised recruitment as an issue, it was open to innovative approaches; trainers shared their successes on program calls.

Discuss any innovations that would be valuable for the aging network

In 2012 when Title III D program and funding changes occurred, OSA added the CCC program to the list of approved evidence-based programs. Preliminary analysis of the project data indicated health and well-being benefits for caregivers, making the program fundable under this title. Later, AoA followed suit. OSA’s intent was to build sustainability for dementia programs with proven results.

In 2012, the ADSSP project staff collaborated with the OSA staff administering a Health Resources Services Administration (HRSA) grant to train personal care aides, under the Affordable Care Act. The curriculum was required to include sessions on dementia care and OSA wanted the consistent and person-centered approach of SCP. With AoA approval for this modification, Drs. Sherman and Hepburn, SCP developers, reviewed and approved two sessions of differing lengths based on SCP. Dr. Sherman provided training to a group of SCP Master Trainers, who either provided or supervised these modules in four regions.

Later in 2012, project staff collaborated with OSA staff to identify relevant content for Aging and Disability Resource Collaborations (ADRC) Options Counselors on dementia care. The collaboration produced a three hour training provided by SCP Master Trainers to about 35 Options Counselors on the basic concepts of SCP.

V. Effectiveness

Define the intended impact of the intervention.

SCP is an evidence-based psycho-educational program with proven effectiveness for dementia caregivers. SCP is designed for groups of family caregivers and implemented at the community level. The SCP curriculum aims to increase caregiver knowledge of the disease’s impact and trajectory, and enhance caregivers’ skills and perspective/attitude. While knowledge and skills are useful, a caregiver’s perception about caregiving is associated with the caregiver’s experience of caregiving. The ability to handle difficult situations is often rooted in the
caregiver’s sense of confidence and competence in their ability to manage. Hence, the importance of “creating confident caregivers:” caregivers who develop confidence are more likely to be effective and experience less stress.

The intended outcome of Michigan’s CCC/SCP implementation was to replicate the outcomes found in the original randomized control trial (RCT) of SCP, such as increasing caregiver knowledge, competence, and reducing caregivers’ distress. The project’s specific target population was rural caregivers of PWD living in the community. The goal was to reach a significant number of rural caregivers of persons with dementia living at home and measure their distress at two times: prior to the intervention and at least six months post intervention. Of 1,690 participants, 796 participants attended three or more sessions and returned both surveys.

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

Participants received the pre-survey prior to the program and trainers collected the forms at the first session. Participants were encouraged to complete the pre-surveys, but were not required. All participants who completed pre-surveys were given unique identifier codes. Trainers were encouraged to obtain demographic data from all participants for ADSSP and OSA reporting purposes. In all, 1,463 participants (88% of attendees) provided pre-surveys or demographic sheets.

Trainers collected the pre-surveys and sent them to OSA project staff for entry into the database. The post-survey forms, which were identical to the pre-surveys, were mailed from OSA six months post-intervention. Post-surveys were sent to participants who had submitted a pre-survey and attended at least three of the six sessions, as reported on the attendance log. The post-survey linked to the pre-survey by an unique identifier. A pre-paid self-addressed business reply envelope was included with the post-survey, along with a cover memo thanking the participant for completing the form. There were no incentives provided to participants for returning the surveys. After a few weeks, if no post-survey was received, a second mailing of the post-survey went out to those who had not returned the post-survey. The overall return rate was 78%, a very good return rate for a mail survey with no incentives.
The survey measures used by CCC were based on the original SCP randomized control trial (RCT) instruments. Demographic information (e.g., age, gender, region, relationship to PWD and ethnicity/race) was collected along with estimated length of caregiving, whether the participant lived with the PWD, and whether the PWD had a diagnosis. The pre and post-surveys included measures of caregiver depressive symptomology (Center for Epidemiologic Studies-Depression, CES-D, Radloff, 1997) and select subscales and items to measure stress and effectiveness from participants (Pearlin, et al., 1990). Drs. Sherman and Hepburn consulted and decided to use the Revised Scale for Caregiving Self-Efficacy (Steffen, et al, 1999) in the pre and post-surveys. This measure was deemed more appropriate for measuring effectiveness of SCP. It measures perceived self-efficacy for caregiving tasks: obtaining respite, responding to disruptive behaviors and controlling upsetting thoughts. Using many measures from the original RCT program allowed for meaningful comparison of this implementation with the original program findings.

CCC/SCP Participant Demographics

The following demographic characteristics were gathered and reported to AoA.

Of 1,690 participants, 1,641 provided demographic information (97%).

Age:

- 675 (41%) of the caregiver participants were under the age of 60
- Of 821 adult children, 524 (64%) of adult children reported being under age 60

Gender:

- Females represented 1,304 (79%) of the participants.
- This is at the high end of the estimates of women caregivers (Women and Caregiving Fact Sheet, Family Caregiver Alliance, May 2003).
- 83% of the participants under age 60 were females
- 77% of those over age 60 were females

Geography:

- Participants were predominantly rural (63%) which is expected.
- 65% of those age 60 and above lived in rural areas.
Relationship:

- Adult children represented 50% of the participants.
- The next highest category was spouse, with 617 participants (38%).
- The third highest was “other relative” with 119 (7%).

Ethnicity and Race:

- The population served was primarily non-Hispanic or Latino (96%).
- The majority of participants identified as White, non-Hispanic (79%).
- The next highest group was Black or African-Americans (15%).

Veterans:

- About 9% of the participants indicated they were veterans.

Discuss data analysis and results.

The project found significant improvements on measures of caregiver well-being, self-care, attitude, and skills. These findings replicate, and in some cases, extend original SCP RCT results. The project’s findings align with the core objectives of SCP and suggest sustained benefits for the caregivers who participated in the CCC/SCP intervention programs provided in Michigan. The findings support that a high level of fidelity was maintained in the provision of SCP content.

Caregiver well-being often suffers due to the relational losses and demands of long-term care. Similarly, self-care, while encouraged in the program, is difficult for caregivers to justify or do. SCP trains caregivers to be better able to identify the remaining strengths of the PWD and accommodate their environment and routines to support those strengths. Moreover, SCP encourages caregivers to adapt their expectations of the PWD and shift expectations of the necessary tasks. It was very encouraging that project findings indicate that participants were able to adjust expectations, see their situation as different, and focus on life lessons learned as a result of caregiving, even six months post-intervention. These findings, discussed below, demonstrate the program’s fidelity and overall effectiveness.

Analyses were based on a de-identified dataset using paired sample t-tests. The sample included 796 caregivers (78% of eligible participants) who completed both pre and post-surveys and attended at least three sessions. Despite statistical significance, changes (in means) were
often small. Nonetheless, given disease progression and that post-intervention data were collected a full six months post-intervention, it is encouraging to document participants’ reported gains in caregiver well-being, skills, and attitude. An overview of the significant findings are presented here.

- **Well-Being:** Overall, participants indicated significantly increased life satisfaction, significantly lower indications of depression on the CES-D and lower feelings of “overload”
  
  - Dementia, with a progressive trajectory of deficits, creates new challenges for caregivers over time. Trainers reported many caregivers presenting with signs of self-neglect, fatigue, and stress at the first session. At session six, the visible presentation of participants had improved, leading many trainers to take class photos to share with participants, as visible proof of increased self-confidence and well-being.

- **Self-Care:** Participants reported via post surveys increased exercise and significantly more time alone.
  
  - These findings are promising because exercise is known to promote physical well-being, with stress-reducing benefits for many. Although isolation can be an adverse effect of caregiving, caregivers reporting having time alone is often desirable, especially in dementia care situations requiring constant supervision. In SCP, caregivers are encouraged to take time to care for themselves and/or relax during their daily routines and many of the self-care activities cited by participants are individual: reading, taking a walk, doing a hobby, etc.

- **Skills:** Participants had significantly increased scores on their perceived ability “to be firm in directing the PWD’s behavior, to focus on doing the things that must be done and letting other tasks slide, and finding ways to keep your person busy.”
  
  - Moreover, results from subscales of the Caregiver Self-Efficacy Scale reflect that caregivers reported they were significantly more able to respond calmly and appropriately in response to repeated, disruptive or upsetting questioning.

- **Attitudes:** Participants in SCP are encouraged to understand and accept the inevitable changes that develop as the disease progresses. Caregivers’ attitude shift is understood to enable them to better manage the demands and losses, and respond more appropriately to
the PWD. Caregivers in the CCC/SCP reported significantly increased ability to “reduce expectations” and reported lowered efforts to “try to make sense of the illness.”

- At the same time, participants reported significant increases in their ability to “think about life lessons you have learned by caregiving.” Caregivers also reported, via the Steffen measure, that they felt significantly more confident in their ability to control negative thoughts regarding caregiving challenges, losses, and worries about the future. Recognizing the level of impairment, being able to sort out priority tasks, and being confident to manage the essential tasks are all part of the program.

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

The OSA CCC/SCP findings are based on 796-paired surveys, 78% of the eligible participants. The data collection spread over five years, 200 programs, thirty-nine trainers, and 43 counties. As reported above, OSA data found caregivers reported greater life satisfaction and fewer symptoms of depression, while lowering expectations and engaging in self-care. In the original RCT, Hepburn and colleagues (2007) reported that the experimental group of caregivers receiving SCP reported a significantly greater sense of mastery and were less distressed than the control group. The 2007 study, which had a dropout rate of 50%, was based on 52 participants in three states (MS, AK, and CO). In the original RCT, mastery was measured by combining several items, some of which were not used in this project. The RCT used a 10-item anxiety scale (Spielberger, Gorusch and Lushene, 1983), the 10-item Bradburn Affect Scale (Bradburn, 1969), as well as the 22-item Zarit Caregiver Burden Scale (Zarit, 1985). The RCT also measured levels of activities of daily living and instrumental activities of daily living (ADL/IADL) (Lawton and Brody, 1969) and disruptive behaviors (Teri, 1997). Hepburn and colleagues developed an overall distress score, based on a composite of the 12 scales used in their questionnaire (Hepburn et al., 2005).

**Program Evaluations:** In September 2012, the project analyzed the program evaluations of 899 participants in the SCP. The form, completed at the final session, asked participants about the site, the use of materials/handouts, the trainer, relevance of the content, and concluded
with: “Overall, Creating Confident Caregivers (Savvy Caregiver) Program is: Poor—Fair—Good-- Very Good-- Excellent.”

Each item had five scaled responses, with “5” as the highest score. Across all trainers and all items, e.g., trainer skills, relevance, materials, site, and overall program, the averages for the project were 4.69 to 4.98. Below is the graph for the overall program item. The regional differences are tenths of a point, demonstrating high consistency and performance across the sites, and there are no scores below 4.6.

![Graph of CCC Evaluations Overall Program](image)

**Trainer engagement:** One unexpected, but note-worthy, finding was the level of engagement by trainers, demonstrated in anecdotes provided to project staff. As trainers grasped the concepts of psycho-education and became skilled in coaching participants, they witnessed visible improvements in participants’ appearance and their abilities to handle difficult situations. For the many trainers able to make this shift, they accrued rewards and satisfaction from the program. Even trainers who found the program’s requirements demanding became strong adherents after witnessing participants’ changes over the course of six weeks.

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

One challenge was that the project failed to anticipate the size and scope of data collected. By end of Year Two, the demand for maintaining accurate, timely data entry and management had exceed staff abilities. An OSA staff with expertise in data management joined the project staff to monitor data quality, data entry, and provide data oversight. With this addition, the project’s database became a highly organized and reliable source of information.
On occasion, there were challenges convincing trainers of the critical role data collection held for the project. AAAs are very familiar with program data reporting and as a group, were consistent and organized in data collection and submission. Some trainers failed to understand the importance of collecting and submitting documents.

Discuss any innovations that would be valuable for the aging network

OSA did not develop any innovations in the data collection, analyses, or reporting aspect of the project.

VI. Maintenance

Describe sustainability of project and plan for embedding into state long term services and supports.

OSA’s initial plans for continuing the program developed during the project’s implementation. AAAs not in this project expressed interest in having this program in their regions; over a three-year timeframe, OSA applied for and received ADSSP funds to develop and expand SCP to all 16 AAAs in the state. Creating statewide capacity to deliver the program was the first step in sustaining it.

The next step was to design and use a distinctive project logo. In late 2009, OSA developed a logo for the Creating Confident Caregivers® program. In early 2012, the Michigan Attorney General’s Office on behalf of OSA applied for trademark registration to the U. S. Patent and Trademark Office and in early 2013, the logo and name were registered. The logo and the distinctive brochure style identify this program in the public’s mind and is part of program consistency. Since caregivers come from all parts of the state and families live in different regions, it is important that all receive the same content. The logo and brochures identify the program, regardless of location.

OSA has discussed developing a service definition for CCC for several years. Project and AAA staff had expressed a desire to have a service definition that would allow the AAAs to fund and monitor the program provision. AAAs contract for services with other agencies and rely on OSA’s service standards to describe the services to provide and as a performance measurement tool. Some AAA staff indicated they could use the service definition to ensure that
SCP was provided, separate from traditional support groups. OSA is reviewing the long-term impact of a service definition.

OSA requested a Medicaid service code, necessary for billing under the Medicaid Home and Community Based Services Waiver for Elderly and Disabled, known as MI Choice, for Medicaid participants who could benefit from SCP. Staff changes and other factors combined to delay this action, which is still pending.

As family caregivers gained information about person-centered dementia care through this project, agencies recognized the benefit of personal care aides (PCA) having the same perspective and knowledge. In fact, a SCP participant asked in-home aides about their dementia training and reported to the AAA that the caregivers who attended CCC “had more dementia training than the aides.” The opportunity to develop a congruent pilot dementia module for PCAs presented itself as grant #T82HP21496, funded by the Division of Nursing, U.S. Dept. of Health and Human Services, Health Resources and Services Administration, a Personal and Home Care Aide State Training (PHCAST) Demonstration project, administered by OSA. As part of the PHCAST project to train aides and with AoA’s approval, OSA and Dr. Sherman developed pilot dementia programs (3.5 hours and 7 hours) for personal care aides, tested in four sites, using CCC trainers as leaders. As a result of this collaboration, OSA applied for, but regrettably did not receive, a dementia-capable human services grant in 2013. However, OSA and the AAAs are still interested in providing SCP congruent training to a wider audience.

Describe funding sources for project in the future

ADSSP programs meet the funding requirements under Title III-E, the National Family Caregiver Support Program. OSA shared this information with AAAs early in the project. At this point, some AAAs are using III-E for partial program funding. In 2012, AoA mandated that Title III-D funds must be used on evidence-based programs. A preliminary review of the project’s data indicated that CCC/SCP had a positive impact on health and well-being. OSA sent the AAAs a letter allowing them to use Title III-D funds to support or supplant existing funding for CCC/SCP. This decision signaled OSA’s support and a few AAAs shifted funding to SCP. With both of these funding options available, most of the AAAs have indicated plans to use one or both for maintenance of the program.

In August 2013, Dr. Hepburn came to Michigan to give a presentation and meet with OSA managers about the future of the program. Dr. Hepburn indicated his support for the
continuation of the CCC/SCP program and stipulated that the program should be provided without cost to participants. The AAAs are allowed to request payment for all or some of the respite care required, but not for the program.

It is anticipated that a Medicaid service code will be received to allow Medicaid beneficiaries and their caregivers to participate, as appropriate, in the SCP.

Discuss any challenges that occurred and how they were addressed

CCC/SCP delivered proven outcome measures and positive impact on caregivers, more than six months post-intervention. These facts have made the program attractive and sustainable. Drs. Sherman and Hepburn agree that the program’s value rests in two factors: Dr. Hepburn asks that SCP is provided at no cost to caregivers and Dr. Sherman supports the fidelity management that produced quantifiable success.

Discuss any innovations that would be valuable for the aging network

As discussed above, the development and registration of a project logo is innovative. OSA registered the logo and project title, Creating Confident Caregivers®, with the U.S. Patent and Trademark Office to create a distinct identity for the program’s consistency and quality. As the first evidence-based dementia caregiver program provided by AAAs under the ADSSP, SCP extended the scope of AAAs to new populations and triggered new partnerships. Under the Title III-E, National Family Caregiver Support Program of the Older Americans Act, AAAs fund caregiver support groups, education sessions, caregiver fairs and other resources. These offerings are typically open to the public, without registration or eligibility requirements. This project provided a time-limited intervention for a target population, with expected attendance at six consecutive sessions.

The logo also served as part of quality management. The project supported trainers in providing an unscripted psycho-educational program by providing on-going training and support. While SCP materials are available outside the ADSSP project, trainers in the project received skill development and program support, additional resources including discussions with both Dr. Sherman and Dr. Hepburn, developers of SCP. Therefore, OSA sought to distinguish the trainers and their agencies through the logo.
The logo also created a recognizable “product” across the state, which assisted family members in finding a local program. Aging services are often a “patchwork quilt,” especially in the public’s mind. Services are often identified with the provider agency, rather than the funding source or the aging network. For example, older adults at congregate meal sites often think the host agency provides the meals, and it is not unusual for people to not know about AAAs. OSA wanted to create a clear service product that would be understood by the public.

As the project and the trainers developed expertise in providing the multi-faceted intervention, the CCC designation created statewide recognition of an evidence-based program and promised uniform content and consistency, regardless of time or locale. Those given rights to the logo and mark were required to use the registered mark on media, as well as a similar brochure format, creating a distinct identity for the program.

OSA is also interested in developing training modules based on SCP for other audiences. The goal is to introduce the person-centered dementia content into the aging network and community caregivers.

VII. Budget and Cost Analysis

Provide report on budget

The CCC total project budget was $1,123,708; $743,492 was federal ADSSP funds and the remaining amount was in-kind contributions. Each project partner was required to provide the appropriate match amount for the federal funds received, so the project’s match, as budgeted, was $389,216. Of the federal funds, $590,252 were originally contracted to AAAs and community partners for program implementation. This budget was intended for three years and supported the project for five years. For just the five AAAs over the five years, their total expenditures were $914,655 and their direct services expenditures were $425,510. Eighty percent of the federal funds were designated for program implementation and 81% of the total budget was spent by community partners to provide the program.

Describe and present cost analysis

As part of the final report, OSA did a separate cost analysis report. There are several factors for consideration in determining program costs. First, the project’s target audience was
rural caregivers and rural services often include transportation or travel costs. In the northern regions, trainers drove two or more hours in some instances to provide the program in remote areas. There are two methods for accounting these travel time and expenses: either as part of the trainer cost (direct service) or as part of the match. However, AAAs varied their accounting and allocation of these costs. The next issue is caregiver incentives. Usually caregiver incentives referred to items such as snacks, beverages, and project branded tote bags for program materials. In some rural areas, participants received gas cards as a transportation incentive for attending. AAAs determined the value of the cards, based on the program’s location. Since gas prices soared above $4/gallon during the project, this was an important incentive. Finally, a few programs served small groups; with many fixed program costs, e.g., trainer, space, and travel, small groups increased the cost per participant.

For the overall cost analysis, the project developed the following chart. On the chart, “Total spent*” refers to both federal and match funds and includes direct services, administration, and other expenses. The Direct Services is the amount reported spent on service costs, e.g., trainers, materials, respite, caregiver incentives, and cost of training the trainers.

**Table 1: Costs analysis across the project**

<table>
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<th>CCC Costs 2008-2013</th>
<th>Total spent*</th>
<th>Dir. Serv.</th>
<th># progs</th>
<th># prog/Dir. Serv.</th>
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<td>$914,655</td>
<td>$425,510</td>
<td>198</td>
<td>$2,149.04</td>
</tr>
</tbody>
</table>

| Ave. per ppt.        | $546         | $254       | 1675 participants |
| Year 3 average       | $256         |            |                   |
| Ave. per prog.       | $4,619       | $2,149     | 198 programs      |
| Year 3 average       | $2,221       |            |                   |

Year Three of the project is used as the base year. Year One was not a full implementation year, Year Two had trainer turnover and Year Three was the most stable. It also
had the highest match level: 45%, so the analysis used federal funds for direct services only. The amount of federal funds in the regional awards varied among AAAs, but the match requirement was fixed. The chart for Year Three is Table 2.

For Year Three, the average program cost in rural areas was $2,221/program and an average cost of $256/participant. This is based on direct services expenditures: trainer costs, manuals and materials, caregiver incentives, trainer travel, and participant respite care. There are many ancillary expenses, such as meeting space, brochures, coordination with partner agencies, and data submission. However, many of these costs were part of the local match and varied a great deal.

As noted on the bottom of Table 1, the cost per program and per participant over five years is nearly identical to the cost analysis of one year, demonstrating high consistency for the estimated costs. Direct Services: the amount of federal funds reported by the AAA expended on program delivery and direct services, e.g., trainer costs, manuals, respite, etc. For more information, please review the CCC cost analysis report, submitted separately.

**Creating Confident Caregivers: Year 3 Costs**

**Direct Services Expenditures**

**Table 2**

<table>
<thead>
<tr>
<th>AAA</th>
<th>Direct Services Amount</th>
<th>Direct Services/number of programs</th>
<th>Direct Services/number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAA 4</td>
<td>$21,541</td>
<td>$2693</td>
<td>$303</td>
</tr>
<tr>
<td>AAA 6</td>
<td>$15,984</td>
<td>$2664</td>
<td>$246</td>
</tr>
<tr>
<td>AAA 9</td>
<td>$25,786</td>
<td>$2149</td>
<td>$258</td>
</tr>
<tr>
<td>AAA 10</td>
<td>$12,343</td>
<td>$1543</td>
<td>$220</td>
</tr>
<tr>
<td>AAA 11</td>
<td>$30,821</td>
<td>$2055</td>
<td>$253</td>
</tr>
<tr>
<td>Totals</td>
<td>$106,475</td>
<td>$2221-Ave./program</td>
<td>$256 Ave./participant</td>
</tr>
</tbody>
</table>
VIII. Conclusion

*Summarize lessons learned and identify any translational issues.*

Michigan is one of three states funded under the ADSSP evidence-based program to provide the Savvy Caregiver Program and the only state to implement the program entirely through AAAs. Michigan combined local AAA control with project oversight and support to demonstrate the aging network’s ability to have a significant positive impact on informal caregivers of persons with dementia living at home in rural Michigan.

Successful replication of an evidence-based program requires a high level of oversight, either by the licensing authority, e.g., Stanford for patient education programs, or the project’s authorized grantee, e.g., OSA. SCP materials are available through the program developers and organizations have acquired the materials needed to provide the program. However, in addition to materials, the project provided participants with ongoing training, support, and regular opportunities to discuss fidelity with one of the program’s developers. The results were impressive.

OSA’s success was the result of the aging network’s abilities. AAAs have a wealth of program management and oversight experience. The staff members of Michigan’s aging service network are recognized for their dedication and commitment to serving older adults. OSA credits the AAAs and the aging services staff for their persistence, dedication, and ability to meet all challenges. Throughout the project, AAA directors and staff have championed the project, with enthusiasm and credibility. As stated many times to AAA directors, this project’s success rests with the AAAs and their providers.

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

This was Michigan’s aging network first ADSSP project. While the federal Alzheimer’s funding has been available since 1990, it is important to note that this is the first such funding award for Michigan’s aging network. ADSSP has unique funding requirements, definitions, and performance/data measures. AAAs are familiar with the Older Americans Act (OAA) funding requirements and the Medicaid Home and Community Based Services Waiver programs for Elderly and Disabled. Understanding and meeting the fiscal and program requirements of ADSSP was an initial challenge, but questions were resolved by phone meetings with program staff, fiscal officers, and/or administrators to clarify funding limits or other concerns.
In going forward, OSA was asked to address the OAA section about AAAs providing direct services. Given that all participating AAAs had trainers on staff, it was necessary to allow AAAs to request and receive a waiver. With each Annual Implementation Plan, the AAAs can request a waiver for this program.

From the outset, OSA had assumed that Alzheimer’s Association staff would be effective community partners for this project, since the Michigan chapters gave their support to the proposal. Logistics and priorities, however, sometimes failed to mesh. AAAs were reluctant to contract with the Alzheimer chapter if the office and staff were not within the AAA’s region. Chapters, as part of a national organization, must meet internal goals, forcing staff changes or reassignments. These situations, like trainer turnover, are part of the implementation challenges faced by this project.

Evidence-based programs present unique challenges in replication. Trainers are required to provide the content with consistency. An unscripted program like SCP requires trainers to use both conceptual and group leadership skills. As one MT shared, trainers are helping people to become savvy caregivers, by coaching and challenging them to see things differently. Some trainers grasped these essential elements, while others could not make the shift. A combination of factors created “blind spots” for some trainers. For some, the considerable training and additional coaching could not overcome their preference for providing program material in unauthorized or idiosyncratic ways. The strength of the project was that AAAs would replace trainers with performance concerns rather than retain them. This is a difficult choice for an agency, but it served the program participants well.

Discuss any innovations that would be valuable for the aging network

Recruitment issues extended beyond participants; it often included trainers. While AAAs typically looked to senior centers or councils on aging staff for trainers, some found excellent trainers in unexpected places. One future trainer attended the program as a caregiver for her mother. Later, she contacted the trainer about providing the program. Her training skills were enhanced by her use of the program in her family and she quickly became a MT. Following a program presentation to the AAA board by the AAA MT, a board member inquired about becoming a trainer. She is on her way to becoming MT. These trainers bought their personal
skills and community credibility to the program. The AAAs’ vision had expanded to include them, to everyone’s benefit.
IX. References


