



SCHOOL OF PUBLIC HEALTH

UNITED WAY OF TARRANT COUNTY

Healthy Aging and Independent Living Initiative

Annual Evaluation Report

July 1, 2010 – June 30, 2011



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Executive Summary

HEALTHY AGING AND INDEPENDENT LIVING INITIATIVE

2013 BOLD Goal:

5% (10,850) more older adults with chronic disease will be living at home.

For the 10,850 served, there will be:

- A **20% reduction** in hospital admissions 6 months after completion
- A **10% reduction** in Emergency Room visits 6 months after completion

HAIL Strategies

Respite care

Allows caregivers regular opportunities to relax and take care of themselves, which lowers the risk of care recipients being placed in nursing homes.

Education and Counseling

Like Resources for Enhancing Alzheimer's Caregiver Health (REACH II), an evidence-based program, can help caregivers reduce stress and depression, and improve their capacity for self-care. Of the 2,000 served, **80%** will still be living at home after 6 months

Stanford Chronic Disease Self-Management Program

This evidence-based program teaches those with chronic health problems, like diabetes, how to deal with pain and isolation; use proper medications, exercise and nutrition; and communicate clearly with family and health professionals.

Diabetes Screening and Intervention

Identifies at-risk individuals and helps them spend fewer nights in the hospital, with fewer visits to the emergency room.

Clients Served/Targets/Percent of Target

Strategy	Agency	Year 1 Target	Actual (%)
Caregiver Respite	Easter Seals	242	180 (74%)
Caregiver Education and Counseling (REACH II)	Alzheimer's Association	417	381* (91%)
Disease Management Education (Stanford)	Senior Citizen Services	500	314 (63%) (495 Enrolled)
Diabetes Screening	Senior Citizen Services	2,000	2,040 (104%)
Nutrition Screening Counseling	Meals on Wheels	3000 500	3,204 (107%) 513 (103%)

*This includes 164 clients served through the Area Agency on Aging's Community Living Program

Demographics

	Caregiver Respite (%)	Caregiver Education/ Counseling (REACH II) (%)	Diabetes Self-Management (Stanford) (%)	Diabetes Education/ Counseling (%)
<u>Race/Ethnicity</u>				
American Ind.	0%	<1%	2%	<1%
Asian	0%	1%	2%	0%
Black	25%	20%	18%	12%
Hispanic	12%	15%	16%	8%
White	63%	63%	58%	80%
Not Reported	0%	<1%	3%	<1%
<u>Gender</u>				
Male	46%	23%	24%	33%
Female	54%	75%	76%	67%
Not Reported	0%	2%	0%	0%
<u>Median Age</u>	80	62.5	70	79

Key Findings Year-to date:

- All services were implemented as proposed by the agencies. Although enrollments were slow to start they have significantly increased in the last two quarters.
- Alzheimer’s caregiver families who received Education and Counseling and/or Respite services achieved the goal of 80% of Alzheimer’s clients remaining in the community. However, 12 persons were deceased before the end of the program which may indicate that services were provided to “end stage” Alzheimer’s clients, rather than the “mid-stage” target population.
- Caregiver counseling and education services achieved a total of 20,457 days in which the Alzheimer’s patient remained in the community.

- It is estimated that this results in a \$2.72 million reallocation from institutional to community settings.
- Respite care- Data from DFW Hospital Council data was inadequate to assess days and dollars at the time of this report.
- Clients receiving Diabetes and Nutrition Education and Counseling were at moderate risk of hospitalizations or emergency room visits, a total of 39 in the pre-service period. Of these clients only 11 had reached 6 months after their start of service. Inpatient admissions for these clients increased from 1 to 2. However emergency room visits decreased from 23 to 10 in the post service period. Numbers are too small for conclusions at this time but are encouraging.
- Clients participating in the Senior Citizen Services Diabetes Self-Management Workshops are at relatively low risk of diabetes related hospitalizations or emergency room visits (total of 11) in the 6 month pre-service period. Of these only 3 have reached 6 month after start of services.
- Focus group findings showed very positive receipt of services by clients.

Successes:

- Implementation of all services in Tarrant County funded by the HAIL initiative.
- The Alzheimer’s Association has been invited by the Rosalynn Carter Institute to present the REACH II program at the RCI National Summit Capital Training in October 2011.
- Senior Citizens Services and Don Smith made a presentation to the Texas Conference on Aging regarding implementation of best practices programs.

Areas of Concern:

- The startup period prior to enrollment of clients in most services was greater than anticipated. This resulted in lower than expected enrollments in the first two quarters.
- The proportion of Hispanic, Asian, and male clients served by agencies was low.
- Completion rate of Diabetes Self-Management Workshops was lower than anticipated.
- Interaction between agencies to optimize client receipt of appropriate services can be improved.
- Alzheimer’s patients whose families received services were at a later “stage” of the disease than anticipated.

Continuous Improvement Efforts and Plans moving forward:

- Increase outreach activities for all services to meet 2011-2012 increased targets.
- Expand the number of service agencies to compare effectiveness of different approaches to diabetes self-management and Alzheimer’s caregivers’ education and support.
- As numbers of clients who reach 6 months after start of diabetes education and self management services increase, more information will be available for analysis of reductions in hospitalizations and emergency room visits.
- Meals on Wheels has recently purchased and implemented software developed by the American Association of Diabetes Educators to track achievement of client behavior goals.

Comments for Further Exploration:


- Explore the use of nutrition risk and diabetes assessment data to determine short term, and intermediate outcomes in Stanford Chronic Disease Self-Management Program and Diabetes Screening Intervention.

- Due to the low risk of hospitalization Identified for the Senior Citizen Services’ Diabetes Education population an alternative outcome measure should be explored.
- Have Alzheimer’s Association and Easter Seals conduct and report a telephone contact with caregiver families 6 months after service ends to determine if the Alzheimer client continues to live in the community.

Recommendations:

- Continue to increase outreach to Hispanic, African-American, Asian, male and other under-served populations among all agencies.
- Increase referrals/intakes to respite services for Alzheimer’s caregiver families as appropriate.
- Utilize outreach funds to increase numbers served and target Hispanic and Asian communities.
- Increase outreach to male population for diabetes education and self management. For example through more workshops at the Veteran Administration sites.
- Utilize incentives to increase completion of Diabetes Self Management Workshops.
- Enhance assessment and intake process to target “mid-stage” Alzheimer’s patient families for caregiver education and respite.
- Revise reporting procedures to maximize capture of data for diabetes self management clients.
- Improve interaction among service agencies to optimize client receipt of appropriate services.
- Explore strategies to provide transition of Alzheimer’s families from the United Way funded respite services as service limits are reached.
- Clarify what will constitute achievement of Bold Goal.

Live Well: Healthy Aging and Independent Living Initiative

On target for bold goal	Health Strategies	Targets Reached	Results Achieved
	Caregiver Respite for Alzheimer’s families	B-	A-
	Diabetes & Nutrition Screening	A	A
	Caregiver Education and Counseling (REACH II)	A-	A-
	Diabetes Self-Management Training (Stanford)	B	Pre-service hospitalizations and ER visits to date not adequate for determination

Healthy Aging and Independent Living Year 1 Evaluation Report July 1, 2010 – June 30, 2011

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Figure 1: Clients Served/Targets/Percent of Target

Strategy	Agency	Year 1 Target	Actual (%)
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Clients Served:

Figure 1 shows the cumulative number of clients who began receiving services from the period July 1, 2010 through June 30, 2011. The Alzheimer's Caregiver Respite service program has started services to 180 Alzheimer families out of an annual target of 242. This represents 74% of the annual target. The Alzheimer's Caregiver Education and Support program, in the first year, started service to 217 Alzheimer's families and 164 families were served by the Community Living Program (CLP) out of a total annual target of 417. This represents 91% of the target.

The Diabetes Self Management, in the first year, has screened 2,040 persons for diabetes out of a target of 2,000 for the first year. This represents 102% of the first year target. Regarding participants in the disease management education workshops, they have enrolled 314 persons out of a target of 500 for the first year. This represents 63% of the first year target. However a total of 495 clients enrolled in the workshops. The rate of completions has stayed consistent throughout the first year.

During this period the Diabetes Education and Counseling program screened 3,204 clients for diabetes and nutritional risk out of a target of 3,000 clients. Thus they have achieved 107% of their first year target. Regarding service enrollment in the diabetes and nutrition education program 513 clients started receiving services out of a target of 500 for the first year. This represents 103% of the first year target.

Table 1: Demographics

	Caregiver Respite (%)	Caregiver Education/ Counseling (REACH II) (%)	Diabetes Self-Management (Stanford)	Diabetes Education/ Counseling (%)
<u>Race/Ethnicity</u>				
American Ind.	0%	<1%	2%	<1%
Asian	0%	1%	2%	0%
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Not Reported	0%	2%	0%	0%
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Demographics

Table 1 above summarizes the percentage of clients served by each agency by Race/Ethnicity, Gender, and Age. Very few American Indians or Asians were served by any of the agencies. Hispanics served were also proportionately low (8-16% compared to 26.7% in Tarrant County overall), especially for the Diabetes Education and Counseling services (8%). It should be noted that a limitation of the service is that is only available to clients receiving Meals on Wheels home delivered meals. Males were also under-represented (23-44%, compared to the County total 50%). Although caregiver roles often are taken by women the diabetes

related services actually had low rates of male participation. Median age ranged from 62.5 years for Caregiver Respite services to 80 years for the Caregiver Education and Support Services. The Diabetes Self-management workshop participants were significantly younger (median age 70), than the Diabetes Education and Counseling clients (median age 79), who are receiving home delivered meals. The workshop participants were able to come to various sites for 2.5 hours per session.

Outcomes:

Alzheimer’s Strategies

As shown in Table 2 the goals of 80% of the clients remaining without nursing home placements was met for families who completed the HAIL program in Year 1. Only families for whom services had ended were included in this analysis. Families whose Alzheimer’s member was deceased while receiving services were excluded from this analysis. Nineteen of the Alzheimer members of families receiving Caregiver Education and Support services died and thus services to families ended. The comparable number of Alzheimer’s patients in families receiving Respite Services who dies was twelve.

Table 2: Alzheimer's Families Outcomes

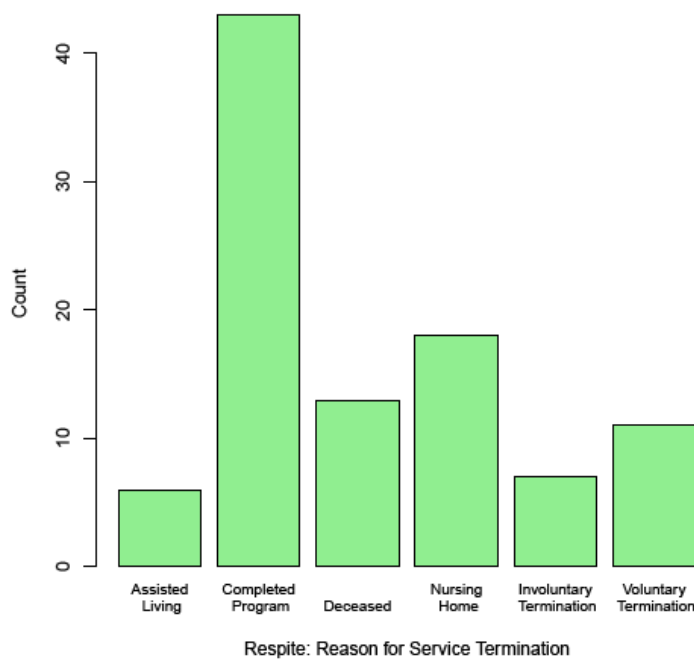
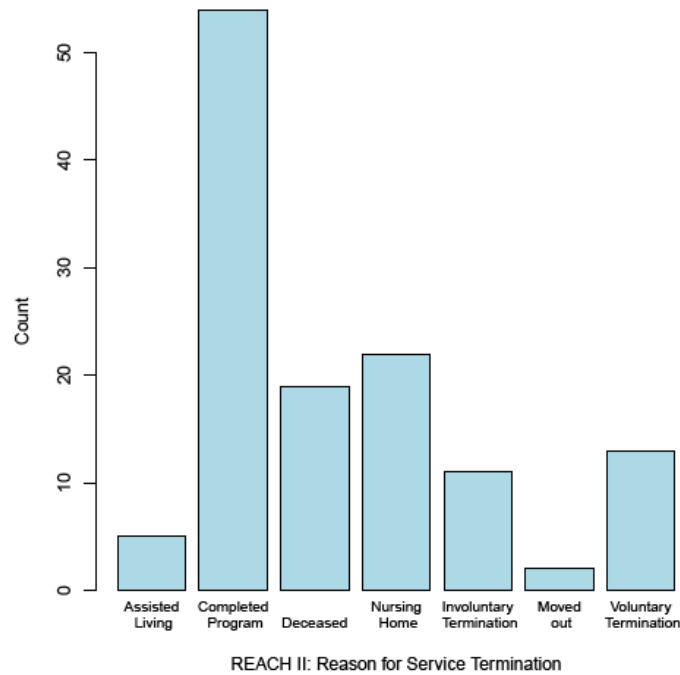
Agency	% Goal At Home/Community	Actual % At Home/Community
Caregiver Respite	80%	(48) 79%
Caregiver Education/Counseling (REACH II)	80%	(58) 81%

Reasons for Service Termination

As shown in Figure 2 below, the primary reason that Caregiver Education and Counseling and Caregiver Respite recipients left these programs was due to completion of their period of eligibility (43 clients). Five clients were placed in assisted living and still remain in the community. Only 20% of the Alzheimer clients in these families were placed in a nursing home while receiving their respective services. Of clients and families receiving Caregiver Education/Counseling (REACH II) services, 53 remained at home and 5 were place in

assisted living. It should be noted that some caregiver families received both services. As data is acquired on more client families separate analysis will be conducted for these families to assess how receipt of both services effects families' ability to keep their Alzheimer members at home. Due to the number of clients who died while receiving services, it appears that the service population for these two programs were at a late stage of disease.

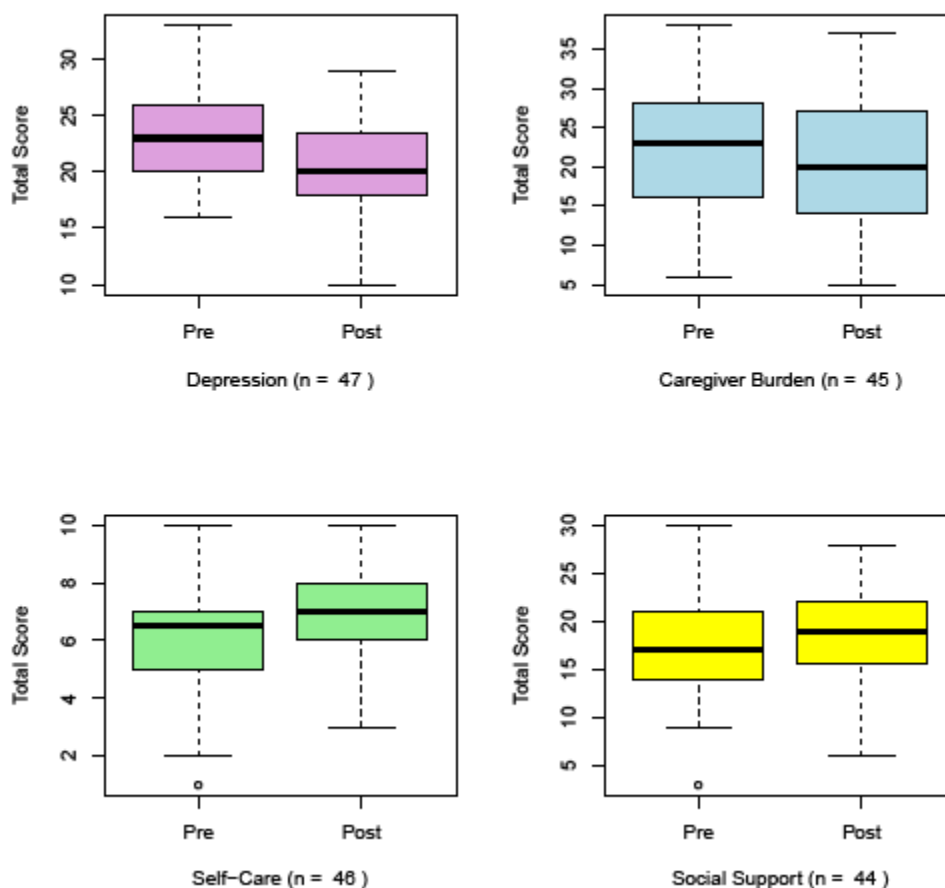
Figure 2: Reasons for Service Termination



Benefits for Alzheimer’s Caregivers

A questionnaire developed at Scott & White Clinic by Dr. Alan Stevens was administered to the caregivers of Alzheimer’s patients who received the Caregiver Education and Counseling (REACH II) services at the beginning of services, and was repeated at the time when services were completed. Four domains were measured; depression, caregiver burden, self-care, and social support. As shown in Figure 3, the median scores improved for all of the domains. Depression score and caregiver burden were reduced and self-care and social support increased. These improvements contribute to the caregiver’s ability to continue caring for their Alzheimer’s family member at home.

Figure 3: Pre and Post Service Domain Scores For Caregivers Receiving Education and Support



Cost Analysis

For Alzheimer’s families receiving the Caregiver Education and Support services who had completed services or whose Alzheimer’s family member died during service the Evaluation Team calculated the number of days

the family member was able to stay at home while receiving these services. These families achieved 20,457 days of keeping their Alzheimer's patient in the community. This resulted in over \$2.72 million of reallocation from institutional care to the community setting, (see Appendix).

Respite care data from DFW Hospital Council data was inadequate to assess days and dollars of reallocation at the time of this report. The Evaluation Team will continue to monitor these outcome measures and include analysis in future reports.

Outcomes for Diabetes Strategies

Clients receiving Diabetes and Nutrition Education and Counseling were at only moderate risk of hospitalizations or emergency room visits, (a total of 39 diabetes related admissions or visits in the pre-service period were found). Of these clients only 11 had reached 6 months after their start of service. Inpatient admissions for these 11 clients increased from 1 to 2. However emergency room visits decreased from 23 to 10 in their post service period. Numbers are too small for conclusions at this time but are encouraging. The Evaluation Team will continue to monitor these outcomes and included analysis in future reports. (See Appendix).

Clients participating in the Senior Citizen Services Diabetes Self-Management Workshops are at relatively low risk of diabetes-related hospitalizations or emergency room visits (total of 11) in the 6 month pre-service period. Of these only 3 clients have reached 6 months after start of services with no hospitalizations or ER visits. The Evaluation Team will continue to monitor these outcomes and included analysis in future reports.

Narrative Reports Summary:

Implementation Status

REACH II (Alzheimer's Association) –

The Alzheimer's Association Caregiver Education and Counseling REACH II staff were hired and received training from Dr. Alan Stevens of Scott & White Center for Applied Health Research who developed the program. The REACH staff continued to make presentations in the community to maximize exposure of the REACH program. Collaboration with partner agencies continues in order to further improve program implementation. Also staff supported two caregiver focus groups. Changes in ADL/IADLs have benefitted the respite protocol. A professionally printed caregiver notebook in Spanish is being planned based on a former program in Pittsburgh, PA. The bilingual REACH intern will re-work the material being facilitated in Spanish.

Respite (Easter Seals North Texas (ESNT))

A program coordinator was hired as well as respite care providers. All providers received extensive training in home care assistance. Signed agreements with partner vendors were received. Recruitment highlights for the Fourth Quarter include listing respite provider positions at eleven area organizations and colleges in addition to six Hispanic churches and two Vietnamese churches. ESNT recruitment and training coordinator continued

to distribute flyers regarding Respite provider positions in the community including in shops and restaurants. Recruitment is ongoing due to staff turn-over and increasing numbers of client families.

Nutrition Education (Meals on Wheels)

A Registered Dietician was hired to coordinate intake and nutrition education services. She served until December 2010.

Meals on Wheels then hired a certified Diabetes educator (RD/CDE) to provide education regarding insulin, oral diabetes medication, meter training, problem-solving, risk reduction, nutrition and physical activity with clients with diabetes. Clients with increased risk of developing diabetes learned about risk factors that specifically applied to them and symptoms of hyperglycemia to watch for and discuss with their physicians. All clients received education in home on improving choices of activity, food, and fluid intake to benefit their health. Additional education and reinforcement continued by follow-up phone calls by dietetic interns.

Stanford Chronic Disease Self-Management Workshops (Senior Citizens Services)

Thirty-one lay leaders were trained, four are bilingual in Spanish.

During the Fourth quarter, twelve six-session workshops were started and nine were completed in Tarrant County. This included twenty participants, seventeen of whom completed the program from the VA clinic. Four workshops were started in late June to be completed in the First Quarter of the Year II of the HAIL initiative. Workshops were held throughout Tarrant County in different locations.

Workshops were conducted in Spanish at three locations during the lay leader training in May 2011. Additional lay leader training is scheduled for August and December 2011.

There are five new lay leaders from the VA and three of them will be leading in Dallas area pending an agreement.

Milestones

Caregiver Education and Counseling, REACH II (Alzheimer's Association)

HAIL REACH II cumulative enrollment for Year 1 was 217 reaching the target goal of 217 caregivers in one year. An addition 165 families were served through the Area Agency on Aging's community Living Program. Hiring an additional bilingual intern resulted in the enrollment of 20 new Hispanic caregivers as well as the development of Spanish materials to distribute to each caregiver hence a renewed focus on making REACH II accessible to Spanish-speaking caregivers. Dr. Alan Stevens recommended the HAIL REACH II project to the Rosalynn Carter Institute to share the results of the first year's outcomes. The Institute took note of the unique partnership between United Way, Alzheimer's Association, and Easter Seals. As a result of the decision, an invitation was extended to the REACH II partners to participate in the 2011 RCI National Summit Capital and Training Institute in October 2011.

Respite (Easter Seals North Texas (ESNT))

Implementation was started in the first quarter. However referrals were slow which resulted in lower volume than anticipated. The year-to-date number of HAIL clients is 120. Additional 60 client families were served by AOA's Community Living Program.

Nutrition Education (Meals on Wheels)

Students from Texas Christian University (TCU) were trained each semester to deliver the nutrition education and counseling. Program staff and the TCU nutrition professor, Dr. Lyn Dart, conducted the training and supervised the students.

During the 4th Quarter, the number of follow-up phone calls increased significantly as interns were employed specifically to respond in May and June 2011. It was established that it was critical to conduct the follow-up phone call soon after the initial assessment visit. It was ascertained that for clients deemed at increased risk for developing diabetes based on the Diabetes Detection Initiative assessment tool, or those who have already been diagnosed with diabetes, a follow-up visit by the RD educator is necessary while others will receive phone calls. In regard to follow-up RD visit, it was determined that the visits should ideally occur 2-3 months after the initial visit especially since research revealed the average length of time a client receives MOW service is six months.

In order to more fully measure the effectiveness of the MOW nutrition education session, administrators approved the purchase of client-tracking software for the new MOW HAIL initiative starting July 2011. The software as developed, by the American Association of Diabetes Educators, will allow project personnel to track client achievement of behavior goals as well as the topics of education provided to program participants. During the period of April 16 to June 30, 146 appointments were made, 200 clients were seen, 520 phone calls were completed, 502 additional phone calls were attempted.

Clients continue to offer positive feedback regarding success in making behavior changes in diet, diabetes self-management, and/or physical activity during their telephone follow up calls. A highly positive outcome from the collaboration between HAIL Nutrition Education and Counseling project and TCU Dietetic interns is the submission of a manuscript for publication in the Academic Exchange Quarterly (AEQ) describing the service learning project. The authors included MOW HAIL staff, TCU nutrition faculty and two of the UNTHSC Evaluation team. Another positive outcome has been the invitation of MOW HAIL project personnel to speak to state and local organizations regarding collaborative efforts.

Chronic Disease Self-Management Workshops, Stanford (Senior Citizens Services)

A total of 2040 diabetic risk assessment tools were completed. A presentation was made at the Texas Conference on Aging of 2011 in San Antonio by Don Smith, Matthew Smith (Texas A&M), and Jeffrey Kaufman, Department of Aging and Disability Services (DADS) on implementation of evidence-based practices. The 4th Quarter Report included the testimonial of a workshop participant who became a lay leader after experiencing success in his own diabetes self-management.

The Star-Telegram featured a press release regarding six-session workshop graduate volunteering to lead Diabetes Self-Management Workshops.

Methods to increase six-session work shop completion rates are being explored to achieve targets of Bold Goal.

Challenges

Caregiver Education and Counseling, REACH II (Alzheimer's Association)

Two REACH II counselors were hired and trained for the program model. Later one counselor resigned additional staff were hired. Challenges were experienced in maintaining consistent service delivery due to training of new staff.

REACH II program staff met with Dr. Stevens and Don Smith in June 2011 to discuss to program fidelity issues. In particular, concern was expressed regarding caregivers whose loved ones passed away prior to the completion of the 6-month REACH program. Dr. Stevens made the recommendation that relevant parts of the Quality of Life questionnaire should be completed and renamed bereavement battery for those whose family members died. This has led to improved data capture of services delivered by mainly including the depression and self-care sections. This modification will impact the data that is reported to the UNTHSC Evaluation team.

Respite (Easter Seals North Texas (ESNT))

As previously mentioned the number of referrals was low in the first two quarters of the program. Although the number of referrals increased during the Fourth quarter, the program administrative assistant tendered resignation and it was determined that due to budgetary concerns, the position would be not filled. Two providers resigned without prior notice.

Nutrition Education (Meals on Wheels)

None reported.

Stanford Chronic Disease Self-Management Workshops (Senior Citizens Services)

Two workshops did not achieve required enrollment to proceed. At Harris HEB Hospital a class during the fall would be better attended. A delayed workshop obtained improved participation by change in location and started with 11 persons enrolled. Another class with seven enrolled (one below the acceptable enrollment of eight persons) graduated six participants.

Adjustments to Implementation Plan

Caregiver Education and Counseling, REACH II (Alzheimer's Association)

As the REACH program has been implemented, it has been established that each dementia care specialist can successfully manage 50 active caregivers and the intern will enroll and maintain 25 Hispanic caregivers during the fall and spring.

Four key areas have been identified as contributing factors to decline of Alzheimer's patients. Greater emphasis will be placed on informing the caregivers during home visits and additional informational handouts will be placed in the caregiver notebooks to equip caregivers by increasing their knowledge and ability to prevent decline of their loved ones.

Respite (Easter Seals North Texas (ESNT))

ESNT plans to pursue partner vendor contracts with two agencies that specialize in outreach to the Hispanic and Vietnamese communities.

Nutrition Education (Meals on Wheels)

Information collected from clients through home visits or follow up telephone calls regarding behavior change will be analyzed by utilizing software developed by the American Association of Diabetes Educators, which was purchased to track client behavioral changes.

Stanford Chronic Disease Self-Management Workshops (Senior Citizens Services)

A lay leader quarterly update training held at Resource Connection presented program goals for the upcoming year, and provided program updates and curriculum changes to the Stanford model. Lay leaders were given the opportunity to sign in their Retired Senior Volunteer Program to allow for improved volunteer opportunities and acquire volunteer liability insurance. The staff at SCS began using a 'Zero Session' before the first workshop session of workshops to allow potential participants to learn more about the program and understand the commitment involved.

Evaluator Comments

The agencies have responded to issues identified in the interim reports making appropriate program revisions. These include expanding outreach efforts generally, and specifically outreach to the Hispanic community. Meals on Wheels and Senior Citizen Services have committed to use of client tracking software to improve this aspect of their programs. The Alzheimer's Association and Easter Seals have added needed staff to increase their capacity to serve the targeted number of clients. Program delivery revisions have been made to "fine tune" the services as experience with the programs increased. This is evidenced by the Alzheimer's Association meeting on program fidelity with Dr. Stevens. Data enhancements and increases in home visits by Meals on Wheels, and the addition of workshops delivered in Spanish by Senior Citizens Services are examples of this "fine tuning."

In Year 2 of the initiative more emphasis will be placed on outcomes. Thus increased evaluation data capture on clients, especially behavior changes, will be helpful. Monitoring of outreach to Hispanic community members is still warranted. The risk level of Alzheimer's clients continues to need monitoring since a significant number of these clients were deceased before completion of their services.

Respite and REACH Focus Groups

Qualitative evaluation of the Respite and Caregiver Education and Counseling REACH II services was conducted at the completion of Year One utilizing caregiver clients' focus groups. This provided formative evaluation of the program to help identify strengths and weaknesses and to improve implementation of the program in Year Two. Focus groups are particularly effective in gathering data among participants who have a shared experience because they allow for interaction among participants who may elaborate on ideas which are mentioned (Patton, 2002). Three 90-minute focus groups were conducted, one with recipients of both Respite and REACH II services (7 participants), one for recipients of REACH II only (6 participants) and one with recipient of Respite only (7 participants). All participants were recruited by the Alzheimer's Association and the Easter Seals. Focus groups were moderated by a faculty member of the *HAIL* evaluation team and detailed notes were taken by other team members. Focus group protocol, consent forms, and script design were approved by the University of North Texas Health Science Center Institutional Review Board prior to implementation.

Focus group scripts were developed based upon standard focus group methodology for formative evaluations (Patton, 1997). Content of the questions addressed to the caregivers focused on their personal experience as they provide care to their loved ones, including: 1) reasons that caregivers choose to care for their loved ones, 2) support received by caregivers to assist them in their duties from others, 3) caregivers ability to manage their own needs, 4) services received by caregivers before REACH II, 5) description of how REACH II assisted and unburdened them, 6) activities that Respite, or REACH II services allow care givers to engage in to feel healthier, 7) suggestions to improve the delivery of services, 8) description of how REACH II program helped in coping with memory and behavior issues and improved communications, 9) caregivers and the patients satisfaction with the care provided by the respite care provider, 10) caregivers perceived benefits of receiving both Respite and REACH II services, 11) reasons that receiving both services assist in the care of the loved one, and aid in improved health of the caregiver.

Findings

Findings from the three focus group sessions provided insight about Respite and REACH service recipients on dealing with caregiver responsibilities and challenges, and addressed complexities faced by caregivers. The majority of focus group participants commented that their loved one would not be happy in a nursing home and would much rather stay at home. Most addressed lack of support from other family members and friends adding to their burden and responsibilities: “Our sons have jobs, they cannot help me at all”. The majority of caregivers are challenged by not meeting their own responsibilities and needs: “I cannot ever leave my mother at home alone; she feels threatened if left”. Participants stated that often their needs must come second and every participant mentioned having experienced great distress by the burden of being a caregiver: “I had to quit my job to take care of my (mom, wife, husband)”.

All participants agreed that the services they received were conducive to improve their health and well-being: “When my husband was diagnosed, the doctor sent us home and I was in shock; I would not have survived without the REACH counselor’s help”. Another mentioned that: “I can not leave my husband unattended; I am 82 and if it was not for respite care I could not keep him at home”, several participants said that they were physically and mentally exhausted: “Just the daily chores wore me out; I can not even take a nap; I appreciate the respite so I can take the few hours and ...”. Most agreed that they needed the REACH II services to learn coping mechanisms and need Respite to have help with the care of their loved one and time to tend to their own needs. There were many comments to affirm the competent role that REACH II counselors were playing to assist them, as well as the respite providers being a good fit in meeting the needs of the patients.

The focus group participants in all three sessions found the agencies to be accommodating, caring and willing to do what is possible to meet their needs.

Diabetes Screening and Nutrition Education Services Focus Groups

Qualitative evaluation of the Diabetes Screening and Nutrition Education Services program was conducted at the completion of Year One using TCU nutrition student, (who had conducted the phone calls) focus groups. This provided formative evaluation of the program to help identify strengths and weaknesses and to improve implementation of the program in Year Two. Focus groups are particularly effective in gathering data among

participants who have a shared experience because they allow for interaction between participants who may elaborate on ideas which are mentioned (Patton, 2002). Three 90-minute focus groups were conducted with total of 23 dietetics students at the completion of the fall 2010 and spring 2011 semesters.

Content of the questions addressed to the TCU nutrition students focused on their personal experience with the clients during the nutrition education and consultations sessions, including (1) client receptivity to receiving nutrition education, (2) examples of clients changing eating behaviors due to intervention, (3) client challenges in changing eating behaviors, (4) best approaches and practices for engaging clients in discussing nutrition topics, (5) student challenges in delivering nutrition intervention, (6) suggestions for improving effectiveness of the intervention, and (7) what the student gained from this service-learning experience that enhanced their learning and professional practice skills in dietetics.

Findings

Findings from focus group sessions provided insight about Diabetes Education and Counseling services outcomes and addressed solutions for program improvements. The six themes discussed at the focus group meetings are included in Table 1, along with content descriptions, reported frequency of each theme mentioned by students, and primary outcomes based on student experience. Themes were derived from the questions and incorporated similarities of responses.

Client Receptivity: Focus group participants stated that there was a wide range of client receptivity to receiving nutrition education. One participant added that a client wanted “some one to talk to” and it helps to “ask the client how they are doing, this could hence turn disinterest into interest”. One positive example of behavior change was stated that a client wanted to practice their nutrition skills by reading to the student the food labels. A few students noted that a client could not remember who the students were, confusing them with other health care professional. Another student added that for some clients it is not inattention but hearing loss. Some clients were enthusiastic about making dietary changes, while others asserted that change would be unimportant or unnecessary, saying “I have lived all right this long without changing”. Some students were concerned that some clients did not understand basic concepts of nutrition, but one student added that in this case she would “suggest specific foods” to the client. One participant recalled that a wife wanted to help her husband with his cholesterol.

Client Successes and Challenges: As a result of nutrition intervention services, many clients reported they were able to make positive changes in their dietary practices and had successfully met their self-identified behavior goals – including a commitment to decrease calorie intake and a reduction in carbohydrates, lower sodium intake, and an increase in fruits and vegetable consumption.

There were several reasons mentioned by the clients as barriers to changing eating habits. Some stated they consumed whatever foods and beverages that were made available to them by family members or caregivers; others cited difficulty in being able to access fresh and more healthful foods due to transportation and disability challenges. Some students gave examples of barriers to healthy eating: “I cannot afford healthier food.” Another client said that her doctor did not want her to make many changes when he was adjusting her medication.

Best Approaches: The majority of students agreed that most clients were extremely appreciative of the personal attention they received from home visits and phone consultations and knowing that someone cared about their well being. Students mentioned that home visits provided greater insight about the clients and their environment, and provided more flexibility with time allotted for assessing and intervention. Clients also seemed comfortable being consulted in their home setting and more receptive to nutrition education sessions. The students found different levels of interest and diverse needs in the clients they consulted. Most often, clients were eager to talk about their personal lives and interests. Typically, clients wanted to talk about their health problems, their families, or earlier life events. As a result, students learned to facilitate consultations that provided time for clients' personal interest conversations and time for nutrition education and intervention discussions. It was also noted that some clients benefited from a review of previous consult sessions and had to be reminded of the topics which were covered. This strategy was especially important for those clients with impaired memory ability, and helped to reinforce prior concepts and build on new knowledge.

Student Challenges: The majority of the clients contacted by the student were elderly and frequently exhibited hearing and memory disabilities. As a result, students' agreed that phone consultations were less effective overall than the home visits. Students reported that trying to adjust to hearing difficulties during phone consults made it difficult for them to deliver nutrition education, and believed it compromised the level of intervention effectiveness for the client. Moreover, being able to deliver important health messages and convey compassion in counseling clients was difficult for students to achieve over the phone. Also, with follow up consults, some clients had difficulty recalling prior sessions or comprehending the information provided. Students again noted that these issues were not as pronounced with the home visits compared to phone consultations. Students also indicated that often the clients were not able to take their phone calls or had limited time for the consultation, resulting in delayed delivery of the intervention. Self-reported behavior change was another concern for the students and the reliability of information shared by the client was difficult to determine during a phone consultation; whereas, the home visit allowed students to better assess the client's health status.

Improving Effectiveness: Students provided insight about implementing measures and changing procedures for improving the effectiveness of the program. Although students agreed that face-to-face interactions with the client can be more effective than phone consults, they also acknowledged that this would be more labor-intensive, a higher cost solution, and not as effective for reaching a greater number of clients. Thus, improving phone consultation strategies and procedures would provide a solution in addressing students' challenges and benefit the program in subsequent years. The students indicated that scheduling an appointment for the telephone consult might improve the rate of timely intervention delivery; and for those clients who showed impaired levels of dementia or other cognitive disabilities, to make sure to include family members and/or caregivers are present during consultation. Also, providing students with more in-depth training and access to client information prior to consultations would improve students' communication and delivery skills for effective phone sessions. Students remarked that it is important to ascertain the client's level of nutrition knowledge to deliver adequate education. Thus, being able to review detailed documentation from prior consultations by other students or the Dietitian would provide insight about client progress and their key

interests/concerns, and help students in developing effective strategies for improving client's health outcomes.

Lessons Learned: Students stated that being able to participate in the Nutrition Education Services service-learning project enhanced their knowledge and professional application skills in dietetics. Students appreciated the experience because of the exposure to health care in a home setting vs. an institutional or clinical setting and the personal interaction with the clients was an important component. They learned how to communicate and relate more effectively to elderly clients on a one-to-one basis and became more confident in their practice skills. The students remarked that this was an especially valuable experience given the increased need for nutrition intervention to reduce health complications and hospitalizations in this growing demographic. Students also indicated they learned to be more flexible and to accommodate the individual needs of each client and their ability to make changes in eating behaviors. It was understood by the students that changing health behavior is a process that takes time and effective intervention approaches must take that into consideration.

Table 1. Student Focus Groups Themes and Descriptions

Theme	Description	Frequency*	Primary Findings
Client Receptivity	Receptivity to receiving nutrition education.	15	Wide range of client receptivity.
Client Successes, Challenges	Successes in changing eating behaviors.	17	Commitments to making positive changes.
	Challenges in changing eating behaviors.	17	Inability to access recommended foods for dietary changes.
Best Approaches	Engaging clients in discussing nutrition topics.	18	Clients more receptive to home visits and nutrition intervention.
Student Challenges	Challenges in delivering nutrition intervention.	17	Adapting to clients' hearing disability or level of dementia. Delay in delivery of intervention due to client's conflicting schedule. Facilitating session to accommodate clients' desire to talk about personal interests.
Improving Effectiveness	Students' suggestions for improving intervention.	20	Revise phone consultation procedures. Increase number of follow up home visits. More in-depth training for students.
Lessons Learned	What the student gained from this experience.	23	Exposure to clients in a home environment. Enhanced practice and communication skills for elderly adults.
*Frequency includes number of student responses (N=23)			

Continuous Improvement Efforts and Plans moving forward:

- Increase outreach activities for all services to meet 2011-2012 increased targets.
- Expand the number of service agencies to compare effectiveness of different approaches to diabetes self management and Alzheimer's caregivers education and support.
- As numbers of clients who reach 6 months after start of diabetes education and self management services increase more information will be available for analysis of reductions in hospitalizations and emergency room visits.
- Meals on Wheels has recently purchased and implemented software developed by the American Association of Diabetes Educators to track achievement of client behavior goals.

Comments for Further Exploration:

- Explore the use of nutrition risk and diabetes assessment data to determine short term, and intermediate outcomes in Stanford Chronic Disease Self-Management Program and Diabetes Screening Intervention.
- Due to the low risk of hospitalization Identified for the Senior Citizen Services' Diabetes Education population an alternative outcome measure should be explored.
- Have Alzheimer's Association and Easter Seals conduct and report a telephone contact with caregiver families 6 months after service ends to determine if the Alzheimer client continues to live in the community.

Recommendations:

- Continue to increase outreach to Hispanic, African-American, Asian, male and other under-served populations among all agencies.
- Increase referrals/intakes to respite services for Alzheimer caregiver families as appropriate.
- Utilize outreach funds to increase numbers served and target Hispanic and Asian communities.
- Increase outreach to male population for diabetes education and self management. For example through more workshops at the Veteran Administration sites.
- Utilize incentives to increase completion of Diabetes Self Management Workshops.
- Enhance assessment and intake process to target "mid-stage" Alzheimer's patient families for caregiver education and respite.
- Revise reporting procedures to maximize capture of data for diabetes self management clients.
- Improve interaction between service agencies to optimize client receipt of appropriate services.
- Explore strategies to provide transition of Alzheimer's families from the United Way funded respite services as service limits are reached.
- Clarify what will constitute achievement of Bold Goal.

Appendix A:

Technical Notes

Evaluation Activities

The HAIL Evaluation Team completed Year 1 evaluation activities including quantitative data collection through the service agencies and the Dallas Fort Worth Hospital Council Foundation. The Evaluation Team designed a common database template for all service agencies which included client demographics, risk assessment scores, services received, start and end of service dates, reasons for terminating services and post-service assessment scores. Each quarter this data was uploaded to the Dallas Fort Worth Hospital Council Foundation for matching with inpatient and emergency room services received by the client. The de-identified data was then sent to the UNT Health Science Center team members for analysis and interpretation. The Principal Investigators reported the evaluation progress to the Healthy Aging and Independent Living Initiative Committee regarding progress of each of the service agencies at the end of each quarter of the project year. Additionally, year-to-date information on demographics, pre-service assessment scores, completions of service, and reasons for service termination was presented.

The evaluation team conducted three focus groups of Alzheimer’s family caregivers, one each for those receiving either Caregiver Education and Counseling services or Respite services and one of caregivers receiving both services. Additionally, two of the Senior Citizens Services workshop (Stanford) sessions were attended by Evaluation staff and an observation worksheet was completed for each session. The summary analysis of these focus groups and observations are presented at the end of this report.

The evaluation team conducted three focus groups with TCU Nutrition students who had conducted the Nutrition Education via telephone calls. A total of 23 students participated in the three focus groups. Groups were moderated by a faculty member of the *HAIL* evaluation team and detailed notes were taken by other team members. Focus group protocol, consent forms, and script design was approved by the University of North Texas Health Science Center Institutional Review Board prior to implementation.

Findings from the quantitative data analysis and summaries of the service agency narrative reports are presented as follows.

Actual Clients Served and Demographics

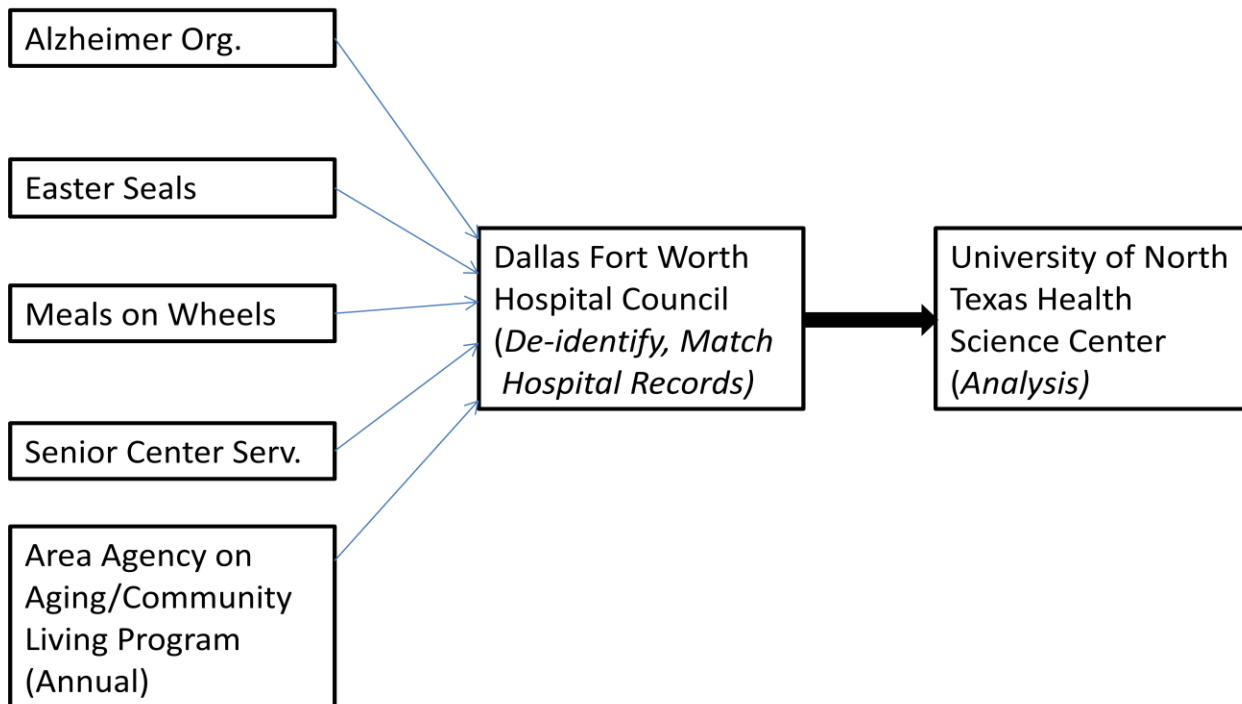
Figure 1, Targets and Actual Clients Served, and Table 1, Demographics, are based on data submitted directly to the evaluator and include all clients served by the agencies.

Outcomes Analysis

Personal Health Information is protected by the Health Insurance Portability and Accountability Act (HIPAA) and requires the consent of the patient/client for organizations to share such information with each other. To comply with the HIPAA statute clients were requested to sign a HIPAA release of information form when they

began services with each of the provider agencies. Most clients did sign the release (1288 or 94%). Data for these clients which included demographics, start and end dates, reasons for service termination, quarterly service hours, and pre- post service assessment scores. Each quarter this data was uploaded to the Dallas Fort Worth Hospital Council for matching to inpatient admissions and emergency room visits. The data was then de-identified and uploaded to a web portal accessible to the UNTHSC evaluators for analysis per a data use agreement. This data flow process was reviewed and approved by the UNTHSC Institutional Review Board for the protection of human subjects. It is shown in the diagram below.

HAIL Quantitative Quarterly Data Flow



Each quarter and at the end of the first year of the HAIL initiative this data was downloaded by the UNTHSC evaluators and several analyses were conducted.

Caregiver Education and Counseling Program and Respite Services

To assess progress toward the goal of keeping 80% of Alzheimer’s family members in the community, the evaluators determined which client families had either terminated or completed their allowed period of service on the programs. From this analysis, the families whose Alzheimer’s member died during this period were excluded. Then, the proportion of those family members who stayed in the home or in assisted living was calculated from this subset. The results are shown in Table 2.

Using this subset of families who had completed or terminated services for both the Caregiver Education and Support, and Respite services the distribution of reasons for terminating services was calculated and shown in Figure 2.

Diabetes and Nutrition Education Counseling and Stanford Chronic Disease Self-Management Workshops

Matched client program information with hospital admissions and emergency room visits was downloaded from the DFWHC web portal by the UNTHSC evaluators. For each client the periods of 6 months pre-start of service and 6 post-start of service was determined, and number of admissions and ER visits for each client was extracted. Using these files, the Board Certified Geriatrician determined which diagnosis codes were diabetes-related and those records where the primary, secondary, or tertiary diagnoses were diabetes related were extracted. Only the first 3 quarters of the initiative were examined since there is a 3 month lag from the date of service to the DFWHC receipt of the records. From this set of records, the first three diagnosis codes were examined to determine if this was a diabetes related admission or visit (For example, admissions/visits for cancers, fractures, orthopedic conditions, surgeries and others were removed). This final set of records was then analyzed separately for the pre- and post- service start dates.

Cost Reallocation Analysis

At the end of the first year of the HAIL initiative only the Caregiver Education and Counseling program had adequate data to look at the cost experience. Data from the clients who had completed or terminated services or who were deceased was examined. The start of service date was subtracted from the end of service date to determine how many days each such Alzheimer's patients had remained in the home or community while receiving this service and these were totaled. Average cost per nursing home day was obtained from the Own Your Future/ Texas Long-Term Care Partnership website ([www://ownyourfuturetexas.org](http://ownyourfuturetexas.org)) for the Dallas Area in 2008. This average rate was extrapolated to 2011 using the Consumer Price Index for Medical Care from the Bureau of Labor Statistics (<http://bls.gov/cpi.htm>). Days remaining in the home or community multiplied by this average nursing home daily rate was calculated to estimate the cost reallocation from institutional to community settings.