

# REACH II

## Resources for Enhancing Alzheimer's Caregiver Health

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### REACH II – Brief Description

REACH II (Resources for Enhancing Alzheimer's Caregiver Health) is a program for supporting caregivers of people with Alzheimer's disease and related dementias (ADRD). The program was developed as part of the [REACH](#) project, a large, multi-state randomized control study jointly funded by the National Institute of Nursing Research and the National Institute on Aging, designed to test promising interventions to enhance family caregiving for persons with dementia. REACH II addresses common stressors experienced by caregivers and provides care and self-care skills. The in-person sessions and therapeutic phone calls are delivered by a trained dementia care specialist (DCS) guided by a standardized manual. The program was [tested and found effective](#) in a multisite randomized control study of over 600 caregivers in five states. The model has since been "translated" to community settings by revising the materials and protocols to better fit the resource constraints and client needs of specific community-based organizations while remaining faithful to the core elements of the original model. Some of those adaptations are reviewed below.

### Is It a Good Fit for My Agency?

Evidence-informed community adaptations of REACH II are suitable for any community-based organization serving ADRD caregivers. The standardized DCS training and certification program takes 1.5 – 2 days to complete. A typical caseload is approximately 12 – 20 caregivers per DCS.

### Community Adaptations and Cultural Adaptability

The original REACH II multi-site study made a special effort to recruit caregivers from a variety of racial/ethnic backgrounds. The study results indicate that the program is effective for Hispanic, African American, and indigenous communities as well as for non-Hispanic White communities. There have been multiple adaptations of the program to specific community settings. For example, [REACH-TX](#) is an adaptation of REACH II for embedding the model in integrated community-based services. The REACH-TX evaluation study offered the intervention to both English and Spanish speakers. The protocol requires an initial assessment of each caregiver's support needs and tailors the intensity of each program component accordingly. This flexibility makes it possible to customize the program to varying socioeconomic and cultural contexts. It was developed and tested in Texas by a [large health system](#) in partnership with an [Area Agency on Aging](#). REACH-TX uses assessment tools and intervention materials of the original REACH II model with a reduced

number of contact hours tailored to the specific needs of each participating caregiver. It has been endorsed by the [National Council on Aging](#) and included in the [Administration for Community Living's list](#) of grantee-implemented evidence-based and evidence-informed dementia interventions. The Veterans Administration [adapted the model](#) to the needs of veterans and their families. [REACH-VA](#) is listed by the Benjamin Rose Institute on Aging as a [best practice in caregiving](#). This model has been successfully implemented in [Native American and Alaska Native communities](#). [The Rosalynn Carter Institute for Caregivers](#) (RCI), in partnership with the [Coastal Georgia Area Agency on Aging](#), adapted the REACH-VA intervention for implementation in a broader range of community settings ([RCI REACH](#)) then piloted this model in [eleven rural communities](#) in Georgia and community-based organizations in [four additional states](#) with positive outcomes. [Community REACH](#) is an adaptation developed through a partnership between the original REACH II investigators and [United HomeCare Services](#), a nonprofit organization located in Florida. The model was [tested](#) and found effective in a majority Hispanic community.

### How Does It Work?

The DCS (referred to as "caregiver coach" in some settings) uses tools developed by the original REACH II intervention to obtain information about the caregiver's environment and quality of life and conducts a standard risk assessment. Following the initial assessment, the DCS prepares an individualized profile that serves as a roadmap for the rest of the intervention. The caregiver also receives a "Caregiver's Notebook" containing resources to meet their support needs. The number of in-person sessions and follow-up phone calls and the content of the sessions are tailored to each caregiver based on the results of the risk assessment. The sessions address the caregiver's stressors and provide coping skills. A typical intervention lasts about six months; the risk assessment and intervention customization are completed during the first month.

### Program Materials

A full description of the REACH II study, including intervention materials, is available [here](#). The implementation guide for the RCI REACH adaptation can be accessed [here](#). To host a DCS training using the REACH-TX materials and protocols, organizations should contact Alan Stevens at [alan.stevens@bswhealth.org](mailto:alan.stevens@bswhealth.org). RCI offers [virtual caregiver specialist training classes](#); further detail can be obtained by contacting [info@rosalynncarter.org](mailto:info@rosalynncarter.org).

# Implementing and Financing REACH-TX

## Implementation Example and Lessons Learned: REACH-TX\*

REACH-TX was developed and originally implemented in a hospital setting. One lesson learned from the initial pilot was that the program was better suited for a community environment. The development team worked with community-based organizations to understand their need for financial and technical support to implement the program with fidelity and revised program materials based on those insights. [Texas Healthy at Home](#), a network of community-based organizations including Area Agencies on Aging and the Baylor Scott and White health system that developed the model, has been implementing the program for a decade. It is their lead intervention for the grant supporting their dementia services. Their experiences have taught them that the program works best if embedded within a CBO with strong partnerships and well-established community trust and as part of a broader portfolio of dementia support services. An ideal service provider is a trained dementia care specialist with a bachelor's degree and some experience in public health and behavioral health fields, preferably a full-time employee. The REACH-TX team has a training and technical assistance (TA) program, including DCS certification. Their on-site training takes approximately two days and costs \$5,000 plus travel expenses for the trainer—virtual trainings are not yet available. Trained CBOs have free access to electronic copies of all training materials to replicate trainings according to local needs. If needed, the REACH-TX team will support grant proposals by providing letters of commitment or acting as subcontractors for the grant. There are no additional fixed costs. The cost of services varies by the level of need of the service recipient. Service dosage is adjusted in line with the participant's level of need. If home visits are needed, mileage should be included in costs per participant.

Organizations interested in REACH-TX training and TA should contact Alan Stevens at [alan.stevens@bswhealth.org](mailto:alan.stevens@bswhealth.org).

## Potential Funding Sources

Caregiver support services are typically non-reimbursable however, there may be opportunities for reimbursement through [formal contracts with health care entities](#) to meet SDOH needs, including caregiver support services.

Community-based organizations can obtain grants to fund their REACH II and REACH-TX implementation. The Alzheimer's Disease Programs Initiative grants offered by the Administration for Community Living can be used to fund

ADRD caregiver support programs. Some community partnerships have used **Older Americans Act Title III D** funds for program implementation. *Texas Healthy at Home* has indicated that it also received funding from [United Way](#) for its implementation.

## Program Impact

The following are important program outcomes to note in this context:

REACH-TX was evaluated in a [study](#) of 1,500 ADRD caregivers. The results indicated statistically significant improvements in all five quality of life domains assessed by the program's standard measurement tools.

- ❖ Caregiver depression score decreased by 24.2%.
- ❖ Caregiver burden score decreased by 20.6%.
- ❖ Caregiver social support score increased by 10.8%.
- ❖ Caregiver self-care score increased by 2.8%.
- ❖ The problem behaviors of care recipients decreased by 15.5%.

## Expected Impact on Healthcare Costs

A [study](#) of the impact of REACH II and REACH VA on healthcare costs found that REACH II was cost-neutral, and REACH VA was associated with a 33.6% reduction in total VA costs, comparing treatment to control. A randomized control [study](#) observed 406 spouse caregivers of people with Alzheimer's disease over a 9.5-year period. The results showed that individuals with Alzheimer's whose spouses enrolled in a caregiver support program had a 28.3% reduction in the rate of nursing home placement compared to the control group. The median time to placement among the intervention group was 557 days later than the control group. According to [Genworth's Cost of Care Survey](#), the median daily cost of a nursing home stay in 2020 was \$255 for a semi-private room and \$290 for a private room. Combining the results of these two studies, the caregiver support program, by improving the quality of life of the caregiver, saved between \$142,035 and \$161,530 in healthcare costs.

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