Caring for Adults and Caregivers at Home (COACH)

EXECUTIVE SUMMARY

As the United States faces an aging population, the number of individuals and families affected by dementia will continue to grow significantly. Nearly seven million Americans aged 65 and older are diagnosed with dementia, and this figure is expected to triple to nearly 14 million by 2060.[1]

Substantial societal cost is associated with caring for individuals diagnosed with dementia, including increased utilization of health care and financial burdens for caregivers. The total costs associated with caring for individuals with dementia ranged from $159 billion to $215 billion nationwide, including informal care.[2]

In fiscal year (FY) 2022, the Department of Veterans Affairs (VA) provides health care and other services to nearly 300,000 with dementia. Additionally, research has identified traumatic brain injury (TBI) and posttraumatic stress disorder (PTSD) as risk factors for developing dementia.[1] The prevalence of dementia among service members and Veterans is expected to increase because of the growing rate of TBI and PTSD diagnoses.[1]

Dementia degrades an individual's memory and other cognitive functions, lessening the ability for those affected to function independently.[3] Most Americans living with dementia receive care from family members and friends.[4] In 2015, there were roughly 15 million individuals caring for someone with dementia; these caregivers provided approximately 18.1 billion hours of unpaid care.[5]

The impact of caregiving is complex and varies between individuals. Many studies have found increased levels of psychological distress and lower subjective well-being and physical health associated with caregiving.[4] According to a meta-analysis conducted by *Chien et al.,* caregiver support groups have been proved to reduce depressive and angry feelings, bolster caregivers' skills, maintain favorable health behavior and quality of life, and increase social support and satisfaction for caregivers.[6]

Furthermore, many individuals and families affected by dementia have a strong preference to keep the affected loved one living at home. However, the progressive frailty, caregiver strain, and significant behavioral challenges often result in the individual being moved to a long-term care facility.[7]

To address the needs of Veterans diagnosed with dementia and their caregivers, the Durham VA Medical Center established the Caring for Older Adults and Caregivers at Home (COACH) program. This program focuses on home-based dementia care that assists Veterans with moderate to severe dementia living at home with a caregiver and within 50 miles of the Durham VA Medical Center (VAMC), Greenville Health Care Center, or Morehead City Community Based Outpatient Center.

The program provides support; education on dementia, progression, and behavioral management; referrals and assistance with resources; and recommendations to address safety in the home, delays in nursing home placement, and alleviation of caregiver burden. The COACH program respects the wishes of the caregiver to keep a loved one living at home for as long as possible. The program focuses on

fulfilling this goal while improving the quality of life of both the Veteran and the caregiver.

Who Can Use This Rural Promising Practice?

Social workers and registered nurses with the support of an interdisciplinary team that includes a geriatrician, psychiatrist, and pharmacist with experience in geriatrics and dementia care can adopt this program. The program can be used by VAMCs that have compassionate and experienced staff in the field of dementia care.

Findings suggest that ongoing caregiver support helps caregivers better cope and deal with loved ones who have dementia. Knowing they have someone to talk to about specific caregiving challenges and feeling supported during the overwhelming task of providing care 24 hours a day reduces caregivers' feelings of isolation and increases their access to critical resources.

Needs Addressed

Caring for Veterans with dementia at home is a difficult task that often results in Veterans being placed in costly long-term care facilities. Many individuals with dementia experience problematic behavioral symptoms, including disturbed emotions, mood, perceptions, thoughts, motor skills, and altered personality traits, which weaken their ability to access needed services because the challenges they face leaving their home environment.

More specifically, outpatient clinic assessments to obtain additional assistance are often inadequate because of the travel involved, emotional stress, and confusion the Veteran may experience. Another challenge individuals living with dementia face is having trouble adhering to drug treatment protocols, increasing the risk for drug ineffectiveness, adverse drug effects, overdosage, underdosage, and negative drug interactions. Behavioral symptoms experienced by individuals living with dementia provide a significant challenge for caregivers and can be a primary predictor of nursing home placement.[7] Faced with these challenges, many caregivers often experience loneliness and stress.

IMPLEMENTATION

The COACH program is an innovative care coordination model that provides home-based support to Veterans with dementia and their caregivers. The COACH program supports patient-centric care by assigning an interdisciplinary team to assess the needs of the Veteran and caregiver, develop a comprehensive treatment plan, and monitor the Veteran's overall well-being. The COACH program offers the following services:

- Home visits by a licensed clinical social worker and registered nurse
- Education on dementia care, progression, and behavioral management
- Medication review and home safety review
- Ongoing monitoring of the Veteran's function or health
- Referrals for other services to support the Veteran and the caregiver
- Caregiver support and education

To enroll in the COACH program, the Veteran must meet the following criteria:

- Be enrolled in the VA health care system
- Be at least 65 years old
- Have a cognitive impairment
- Have a home-based caregiver
- Not be institutionalized or prepared to be institutionalized
- Live within a 50-mile radius of the VAMC or from any other COACH program headquarters
- Not receive services from another home-based program (e.g., home-based primary care)

Overview of COACH Program

The COACH program provides Veterans and their caregivers with home-based support from a social worker and registered nurse. An interdisciplinary team, including a program coordinator, geriatrician, geriatric psychiatrist, and geriatric pharmacist, provides support to the social worker and registered nurse with oversight of the program and the development of the treatment plan.

Once a Veteran and their caregiver are screened and found to be eligible for the COACH program, the social

worker and registered nurse conduct a home assessment. After the initial assessment, the social worker, registered nurse, or both conduct follow-ups via telephone calls and home visits at one month, three months, and six months. The frequency of visits and follow-up may vary based on the needs of the Veteran and caregiver.

After the first year, telephone follow-ups occur at least every three months, and additional home visits occur bi-annually and after hospitalization or a change in condition. Between the scheduled follow-ups, Veterans and caregivers can also contact the social worker and registered nurse if challenges or questions arise.

The COACH Process

The social worker and registered nurse perform a comprehensive medical and psychosocial assessment, including a home safety evaluation; assessments of patients' behaviors, cognitive, and functional abilities; medication review; caregiver stress and family resources; and caregiver's health literacy; and they develop a plan to improve caregiver support. The interdisciplinary team meets weekly to develop treatment plans and collaborate with each Veteran's existing care team.

Implementing the COACH model requires five steps intended to assess needs, develop a treatment plan, provide needed support and resources, and engage in follow-up activities. The process is depicted in Figure 1.

Figure 1. Five-Step Process for Implementing COACH

1. Consult from Primary Care Provider and Social Worker

The first step in the process is for a primary care provider and social worker to identify Veterans who may benefit from the COACH program. In early implementation phases, the social worker can use data within VISTA to identify and reach out to providers about potential participants. As the program becomes more established and provider awareness increases, participants can be referred to the COACH program through their primary care provider or other clinicians throughout the system.

During the initial screening, the team explains the program, determines a) whether the Veteran and caregiver welcome the support, and b) if the Veteran meets criteria for the COACH program. Then, services are offered to the caregiver and an in-home assessment is scheduled with their permission.

2. In-home Assessment by Registered Nurse and Social Work

During the initial home visit, the team evaluates the patient's cognition, functioning level, and behaviors.

They also evaluate the caregiver's needs, knowledge of dementia, and stress level and burden; screen for depression; and evaluate coping skills. The team reviews medication safety and compliance. Starting with the initial home visit, the team begins to establish a trusting relationship with the caregiver by offering support and validation. Trust is important to the success of the program as it fosters ongoing communication and promotes the adoption and considerations of the team's recommendations.

One of the main components of the COACH program is addressing home safety concerns for both the Veteran and the caregiver. All participants receive a home safety evaluation. During the first visit (lasting approximately two to two-and-a-half hours), both the social worker and registered nurse evaluate the needs of the Veteran and caregiver. If the social worker and registered nurse feel there are safety concerns for themselves, the team members might provide follow-up with the Veteran and caregiver over the phone.

While the initial assessment is designed to create a safe environment, the COACH team may continue to make recommendations to maintain a safe environment for Veterans and educate caregivers with basic home

modifications and placement of assistive devices (e.g., removing rugs, increasing light, reducing clutter). Many improvements to the home can be performed at zero to minimum cost. VA has several resources and programs available to assist Veterans and their caregivers with home safety improvements (e.g., ramps, durable medical equipment, ID bracelets, life alerts, grab bars, hand-held showers).

The major focus of subsequent visits is to provide personalized education in multiple areas, addressing each Veteran's particular needs related to disease progression, behavioral management, safety, resources, and long-term care planning.

3. Care Plan Developed by Interdisciplinary Team

After the initial home visit, the social worker and registered nurse present all COACH Veteran cases at a weekly interdisciplinary team meeting (lasting two and a half hours). The interdisciplinary team formulates or updates a plan composed of 1) interventions for implementation by the social worker and registered nurse, and 2) recommendations for primary care providers, who continue to provide general medical care to the Veteran.

The team makes recommendations to address poor medication compliance, medication burden, and therapeutic response. Plans and recommendations are communicated to the Veteran's primary care provider through notes within the electronic medical record with primary care providers designated as the additional signer of the notes.

Veterans and their caregivers are supported in the implementation of the treatment plan through close communication involving ongoing iterative modifications to the treatment plan to address the evolving needs of Veterans and their caregivers.

4. Plan Implemented by Registered Nurse, Social Worker, and Primary Care Provider

The team implements the plan, which includes interventions across four categories 1) medical issues, 2) challenging behaviors, 3) safety concerns, and 4) caregiver burden/stress (see Figure 2). The interventions are based on the needs of the Veteran and caregiver and are intended to improve their quality of life.

Figure 2. Types of Interventions

Category	Interventions
Medical Issues	• Delirium assessment • Anticholinergic burden reduction • Sleep hygiene plans • Strategies to manage activities of daily living • Vision and hearing assistive devices to increase sensory stimulation • Palliative care and advance directives
Challenging Behaviors	Evidenced-Based Practices: • Communication skills training • Education on reminiscence therapy • Validation therapy • Music • Activities • Environment modification • Geriatric psychiatry consults
Safety Concerns	• Driving evaluation referrals • Securing gun access • Strategies to reduce wandering • Fall-prevention strategies • Supervised medication intake • Durable medical equipment orders and assistive devices • Home modification plans to install night lights or door chimes, lock toxic products, and remove clutter • Fire-prevention strategies
Caregiver Burden/Stress	• Counseling • Stress management • Coping skills • Respite options (e.g., adult day care, home and inpatient respite) • Mental health referrals • Support groups • Realistic expectations • Education on resources • Long-term care planning

5. Ongoing Follow-Up via Phone and Home Visit

The social worker and registered nurse will continue to execute the plan on an ongoing basis. Follow-up is performed through telephone calls and routine in-home visits. Additionally, the social worker and registered nurse continue to provide education and

resources that may be beneficial to the Veteran and caregiver.

One additional resource offered by the COACH program is a monthly dementia caregiver support group open to all dementia caregivers regardless of their eligibility to be enrolled in the COACH program. Education about dementia, disease progression, and behavioral management is also part of an ongoing educational process with caregivers and their families.

The team trains caregivers to use appropriate communication techniques and evidence-based approaches such as validation, reassurance, redirection, and reminiscence as alternative or complementary to pharmacological interventions.

PROMISING RESULTS

Since its inception in 2010, the COACH program has improved the lives of Veterans with dementia and their caregivers. In the last ten years, the program has served nearly 1,200 Veterans. Each year, COACH enrolls roughly 100 new Veterans each year. The COACH program has demonstrated the following results:

- Improved quality of life for Veterans with dementia;
- Decreased health care costs resulting from delays in long-term care facility placement;
- Reduced burden on caregiver, from caregiver support groups and education, as reflected in the Zarit burden questionnaire;
- Increased access to dementia-related services;
- Addressed safety hazards at home; and
- Identified and improved Veterans Equitable Resource Allocation (VERA) related to Veterans' needs, supporting the ability for the program to be sustainable.

The COACH program demonstrates each of the criteria necessary to be a Promising Practice:

Improved Access: The COACH program improves access to unique specialty care for dementia patients by providing services to Veterans in their home setting. The interdisciplinary team works collaboratively to address the needs of Veterans, including geriatric psychiatry, physical therapy, and occupational therapy. The social worker and registered nurse are also able to educate the caregiver in

OFFICE OF RURAL HEALTH RURAL PROMISING PRACTICE CRITERIA:

Improved Access: A demonstrated, measurable improvement(s) in access to care and/or services. Examples include reduction in distance traveled to care, reduction in wait times, improved care coordination and reduction in missed appointments.

Demonstration of Need and Evidence of Impact: Qualitative or quantitative indicators that the proposed RPP fulfills a need or addresses a significant gap in care for rural Veterans. This can include a formal needs assessment, a literature review that demonstrates need, or positive outcomes based on evaluation conducted during the innovation pilot and/or replication period (e.g., clinical impact, enhanced enrollment, improved care coordination, etc.).

Customer Satisfaction: Increased patient, provider, partner or caregiver satisfaction.

Potential for Sustainability: Improvement in health system performance by 1) optimizing the cost of care or services delivery, 2) improving or at least maintaining outcomes of current interventions, 3) proposing a clear sustainment strategy for participating facilities, VISNs or Program Offices to eventually assume all costs and provide all resources for the proposed intervention.

Operational Feasibility: Program demonstrates scalability in that implementation is feasible and known facilitators of success can be effectively shared across implementation sites. Evidence of support from VISN and facility leadership is strongly encouraged.

Strong Partnerships and/or Working Relationships: Inclusion of VA and/or non-VA partners to maximize relevance of the intervention and the likelihood of its eventual widespread adoption.

accessing VA resources and benefits, including Homemaker and Home Health Aide (H/HHA), NI-respite, Contract Adult Day Health Care, inpatient and home respite, and aid and attendance benefits.

Evidence of Clinical Impact: The overall impact of the program is the ability to provide care coordination to Veterans with dementia and support services for their caregivers. The program has met and exceeded the ten national dementia care standards: staging of dementia; cognitive, functional, and behavioral assessments; depression; behavioral management; counseling on safety issues; driving; advance care planning; caregiver education; and support. The COACH program has demonstrated the ability to reduce caregiver burden, improve dementia care at home, delay long-term care facility placement, and improve Veteran safety.[8]

Customer Satisfaction: The program receives ongoing positive feedback from providers and caregivers. Caregivers have expressed high levels of satisfaction with the program related to quality and staff courtesy. It has demonstrated ability to improve dementia care at home, delay long-term care facility placement,[6] reduce caregiver burden, and improve safety at home.[5] COACH exceeds all national dementia performance measures.[9]

Return on Investment: At the Durham VAMC, the COACH program converted more than 50% of the Veterans enrolled in the program to a higher resource allocation category because of their complexity in care. By increasing VERA allocations, the program increased funding to support the COACH program.

Operational Feasibility: The Durham VAMC implemented the COACH program with support of primary care providers and facility leadership. During the first years of the COACH program, the team developed strong policies as well as procedures as well as critical partnerships that ensured the program's success.

Strong Partnerships and/or Working Relationship: The program serves as a valuable resource to primary care providers and other clinicians in managing Veterans with dementia. The COACH program partnered with recreational therapy programs to offer simultaneous therapy groups for Veterans with dementia while their caregivers attend a support group. The COACH program also partnered with community centers to use their facilities for monthly caregiver support groups.

Adoption Considerations

Keys to adoption of the COACH program include:

- Communication and messaging related to the program's purpose,
- Leadership and resourcing support,
- Strong VA and non-VA coordination, and
- Data collection and analysis.

Communication and Messaging: Making the program known to obtain referrals can be accomplished by educating health care providers and leaders in the early stages of the implementation process. It is important to make ongoing presentations using visual support, including PowerPoint presentations, brochures, posters, and flyers to disseminate and promote the program.

Leadership and Resourcing: Delays in program implementation can be prevented if recruitment and hiring processes start as soon as possible. This requires the buy-in and support of leadership to staff the program appropriately. Staffing ratios may vary depending on population complexity and geographical dispersion. Appropriate administrative support and staffing is important to avoid staff fatigue associated with caring for an intensive and challenging population.

The pilot site recommended a caseload of 90 patients per one full-time employee (FTE) social worker and one FTE registered nurse. The interdisciplinary teams can remain fairly fixed as long as their workload allows for routine review of all COACH participants at least monthly.

Getting resources in place such as a car, laptop computers, and cellphones are very important, and the process to acquire them needs to start as soon as possible. The Durham COACH program secured necessary resources through grants from the VA Central Office and the Office of Rural Health.

Having a part-time program support assistant is valuable for data collection, management, administrative tasks, and scheduling. Currently, the Durham COACH program has one full-time program support assistant for two sites and eight staff members.

Strong VA and Non-VA Coordination: Developing strong partnerships with providers, VA programs, and community programs is critical to the success of the COACH program. The program is effective because it works to integrate its services with a network of VA and community resources, such as VA contracted home care services, the VA prosthetics department, and adult day care centers.

Data Collection and Analysis: Collecting data to demonstrate the effectiveness of the program provides critical information to aid in making the program sustainable and informs continuous improvement. Data may include active panel size, nursing home placement, length of stay in nursing homes and hospitals, caregiver satisfaction, ZARIT (caregiver burden) scores and ABIDS (Agitated Behaviors in Dementia Scale) over time, and a change in VERA after enrollment.

Conducting a cost comparison between a similar population and program participants would improve evaluations of the COACH program. Data collected for a comparison study may include nursing home days and hospitalizations.

CONCLUSION AND NEXT STEPS

The COACH program provides an innovative care coordination model that supports Veterans with dementia, as well as their caregivers, and allows VA providers to meet the needs of rural Veterans by improving access to additional services and resources.

Addressing Veterans' needs within their home environment reduces behavioral symptoms that may be exacerbated as a result of a clinic visit (e.g., agitation and confusion) and increases home safety while providing needed support to their caregivers.

The Durham VAMC continues to support the COACH program, recognizing the importance of providing care coordination to address the evolving needs of Veterans living with dementia and their caregivers.

The Durham COACH program continues to expand its program both in enrollment and in resources by advertising the program and improving the resources provided to Veterans and their caregivers, including piloting the use of iPads to increase Veterans' cognitive stimulation.

Overall, the COACH program may help VA care for a growing population of Veterans. A more complete cost/benefit analysis is being conducted to understand the financial feasibility of expanding this program nationally. Initial results from this pilot program, however, suggest that the COACH program increases quality of and access to care for Veterans living with dementia and their caregivers.

AVAILABLE RESOURCES

The pilot program administrators of this Rural Promising Practice created several resources to aid in its replication at other sites of care; these are available upon request:

- Program instruments (MOCA, ABIDS, ZARIT, and Mini-COG)
- Home safety evaluation
- COACH program policies and procedures
- Program handbook

Resources are available at:
www.ruralhealth.va.gov/providers/promising_practices.asp

Support for Caregivers: http://www.caregiver.va.gov/

SUBJECT MATTER EXPERT

Judith Davagnino, MSW, LCSW, Durham VAMC
Judith.Davagnino@va.gov

TO LEARN MORE:

The Rural Promising Practices initiative is overseen by the U.S. Department of Veterans Affairs (VA) Office of Rural Health (ORH) as part of its targeted, solution-driven approach to improving care for the nearly 3 million Veterans living in rural communities who rely on VA for health care. As VA's lead advocate for rural Veterans, ORH works to see that America's Veterans thrive in rural communities. To accomplish this, ORH leverages its resources to increase rural Veterans' access to care and services. To discuss implementing a Rural Promising Practice at your facility or to learn more, visit www.ruralhealth.va.gov or email rural.health.inquiry@va.gov.

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