REACH VA: Moving from Translation to System Implementation

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Abstract

Purpose of the Study: Resources for Enhancing All Caregivers Health in the Department of Veterans Affairs (REACH VA) has been implemented in the VA system as a national program for caregivers.

Design and Methods: We describe the trajectory of REACH VA from national randomized clinical trial through translation to national implementation. The implementation is examined through the six stages of the Fixsen and Blase implementation process model: exploration and adoption, program installation, initial implementation, full operation, innovation, and sustainability. Different drivers that move the implementation process forward are important at each stage, including staff selection, staff training, consultation and coaching, staff evaluation, administrative support, program evaluation/fidelity, and systems interventions.

Results: Caregivers in the REACH VA 4 session intervention currently implemented in the VA had similar outcomes to longer REACH interventions, including Resources for Enhancing Alzheimer’s Caregivers Health (REACH II). Caregivers experienced significant decreases in burden, depression, anxiety, number of troubling patient behaviors reported, caregiving frustrations, stress symptoms (feeling overwhelmed, feeling like crying, being frustrated as a result of caregiving, being lonely), and general stress. Effect sizes (Cohen’s d) for these significant variables were between small and medium ranging from .24 to .46.

Implications: The implementation of REACH VA provides a road map for implementation of other behavioral interventions in health care delivery settings. Lessons learned include the importance of implementing a proven, needed intervention, support from both leadership and clinical staff, willingness to respond to staff and organization needs and modify the intervention while preserving its integrity, and fitting the intervention into ongoing routines and practices.

Key Words: Caregiving-informal, Dementia, Organizational and institutional issues

Although the process of health care delivery in the United States is one of constant innovation and adoption of new interventions or technology, actual change comes slowly. Within a large health care system, implementation of new interventions is difficult. Challenges and obstacles to implementation occur at multiple levels. The purpose of this article is to discuss the implementation of a behavioral intervention for dementia caregivers, Resources for Enhancing All Caregivers Health in the VA (REACH VA), into the Department of Veterans Affairs (VA) Veterans Healthcare Administration (VHA).
In 2013, 15 million U.S. caregivers provided 17.7 billion hours of care yearly to people with Alzheimer disease, at a value of almost $220.2 billion (Alzheimer’s Association, 2014). In fiscal year 2012 (October 1, 2011 to September 30, 2012), the VHA healthcare system had 138,090 patients with dementia; total VA costs for these patients was $3,145,801,740, with cost per patient of $22,781. In 2010, a change in law and regulations allowed the VA to provide care for caregivers in addition to veterans. Because family caregivers provide the majority of care to these patients, the VA has developed multiple initiatives to facilitate clinicians working with caregivers. REACH VA is one of the caregiver centered programs implemented during this change.

REACH VA was developed to provide family caregivers with disease specific knowledge and appropriate skill training to increase their efficiency in care of their family member. The administrative challenge for implementation is one shared by many large health care systems. Clinicians were challenged with increasing caseloads, and adopting and documenting performance measures. The largest challenge was persuading clinicians to add yet another clinical intervention to their repertoire. In this environment, convincing front line clinicians of the long term benefit of yet another intervention, even though that intervention will improve clinical efficiency and interaction, is a hard sell.

Our goal in implementing REACH in the VA system was inclusion of the REACH intervention in the skill set and practice of clinicians. However, to make this happen, both formal (e.g., reimbursement, workload credit) and informal (e.g., seeing caregivers as a focus for VA care, rather than only ancillary to veteran care) changes in VA culture were necessary to encourage the system and clinicians to routinely and seamlessly support caregivers. These larger changes were part of the mission of the national Caregiver Support Program (CSP), of which the Memphis VA Caregiver Center was a part.

The REACH Intervention—History, Theory, and Essential Components

The REACH intervention (Belle et al., 2006; Nichols, Martindale-Adams, Burns, Graney, & Zuber, 2011) is designed to help caregivers manage patient behavioral concerns and their own stress. REACH provides education, support, and skills building that can intervene at any point to stop the stress-health process (Figure 1) (Cohen, Kessler, & Gordon, 1995; Lazarus & Launier, 1978). It is structured through a protocol that specifies activities to occur at each session to ensure that the main caregiving risk areas (information on the disease and its course, safety for the care recipient, caregiver health and emotional well-being, social support, and management of patient problem behaviors) are covered. It is targeted to meet the needs of the caregiving dyad as are the most effective caregiving interventions (Goy, Kansagara, & Freeman, 2010). It helps the caregiver focus on what needs to be done in the short and long term, without being overwhelmed by the many challenges of dementia care.

Targeting is through a Risk Priority Assessment that identifies caregiving risk areas. The interventionist teaches core components that have been shown to be the building blocks of successful caregiver interventions (Belle et al., 2006; Gottman, Gottman, & Atkins, 2011; Schulz et al., 2003) including problem solving, mood management/cognitive restructuring, stress management (e.g., signal breath, stretching, guided imagery, pleasant events), and communication. An important component of the intervention is practical personalized strategies for caregiving problems or patient behaviors identified by the risk assessment. For REACH VA interventions, a Caregiver Notebook with 30 behavioral management topics and 18 caregiver stress and coping topics provides these strategies.

The genesis of REACH VA was the 2001–2004 multisite National Institute on Aging/National Institute of Nursing Research (NIA/NINR) randomized controlled trial Resources for Enhancing Alzheimer’s Caregivers Health (REACH II) (Belle et al., 2006). See Table 1 for information on the REACH evolution. The REACH II intervention was based on the most promising intervention components identified in six feasibility studies from the NIA/NINR REACH I multi-site research program (Gitlin et al., 2003). Each caregiver received 12 individual sessions in home and by telephone plus five telephone support groups of 5 or 6 caregivers with a trained group leader in a conference call format. For REACH II, intervention caregivers showed significant improvement in a quality-of-life indicator comprising measures of caregiver depression, burden, self-care, and social support and care recipient problem behaviors.

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**Figure 1.** The stress-health process model and REACH intervention components. REACH = Resources for Enhancing All Caregivers Health.
Belle et al., 2006, decreased caregiver frustrations (Elliott, Burgio, & DeCoster, 2010), and gained one extra hour per day not spent in caregiving tasks compared to control caregivers (Nichols et al., 2008).

### The REACH VA Implementation Process

Multiple theoretical models can be used to examine implementation. The theoretical framework of Fixsen, Blasé and their colleagues has been used by the Rosalyn Carter Institute on Caregiving to examine their caregiving programs (Fixsen, Blasé, Naoom, & Wallace, 2009; Fixsen, Naoom, Blasé, Friedman, & Wallace, 2005). In 2009, this theoretical framework was used to begin to examine the implementation of REACH VA. The implementation process model has six stages (Fixsen et al., 2009): exploration and adoption, program installation, initial implementation, full operation, innovation, and sustainability. The model conceptualizes drivers that move the implementation process forward, including staff selection, staff training, consultation and coaching, staff evaluation, administrative support, program evaluation/fidelity, and systems interventions. Different implementation drivers may have heightened importance at each stage of the implementation process.

### Exploration and Adoption

The purpose of exploration is to determine if the new evidence-based practice is needed, assess the potential match between the organization and the practice, and determine whether or not the practice can be implemented.

In 2007–2009, VHA Patient Care Services initiated The Pilot Program for Caregiver Assistance in response to Public Law 109–461, the Veterans Benefits, Health Care, and Information Technology Act of 2006 that required VHA to evaluate “feasibility and advisability” of approaches to improve and expand services that provide assistance to caregivers. Its purpose was to provide supportive services to caregivers of aging or disabled veterans, especially in situations where options are limited, for example, geographic isolation.

### Table 1. REACH Interventions, REACH I to REACH VA

<table>
<thead>
<tr>
<th>Name</th>
<th>Dates</th>
<th># Sessions</th>
<th>Sites</th>
<th># Caregivers</th>
<th>Caregiver race/ethnicity</th>
<th>References cited</th>
</tr>
</thead>
<tbody>
<tr>
<td>REACH I (six feasibility trials)</td>
<td>September 1995–August 2001</td>
<td>varied</td>
<td>Birmingham; Boston; Memphis; Miami; Palo Alto; Philadelphia</td>
<td>1,224</td>
<td>Caucasian; African American; Latino</td>
<td>Gitlin et al., 2003</td>
</tr>
<tr>
<td>REACH II RCT</td>
<td>September 2001–August 2004</td>
<td>12 individual, 5 telephone support groups</td>
<td>Birmingham; Memphis; Miami; Palo Alto; Philadelphia</td>
<td>642</td>
<td>Caucasian; African American; Latino</td>
<td>Belle et al., 2006; Nichols et al., 2008</td>
</tr>
<tr>
<td>REACH VA clinical translation</td>
<td>September 2007–August 2009</td>
<td>12 individual, 5 telephone support groups</td>
<td>27 VA sites</td>
<td>127</td>
<td>Caucasian; African American; Latino; Asian/Pacific Islander; Native American</td>
<td>Nichols et al., 2011</td>
</tr>
<tr>
<td>REACH VA program phase 1</td>
<td>January 2011–June 2012</td>
<td>12 individual, 5 telephone support groups</td>
<td>10 VA sites</td>
<td>36</td>
<td>Caucasian; African American; Asian/Pacific Islander</td>
<td></td>
</tr>
<tr>
<td>REACH VA program phase 2</td>
<td>Began June 2012</td>
<td>4 individual, telephone support groups optional</td>
<td>27 VA sites</td>
<td>374 enrolled; 125 analyzed; enrollment ongoing</td>
<td>Caucasian; African American; Latino; Asian/Pacific Islander</td>
<td></td>
</tr>
</tbody>
</table>

Note: REACH I and II = Resources for Enhancing Alzheimer’s Caregivers Health II; REACH VA = Resources for Enhancing All Caregivers Health in the VA; RCT = randomized clinical trial.

*This does not include REACH intervention versions from other institutions (e.g., Burgio et al., 2009; Stevens, Smith, Trickett, & McGhee, 2012).

*See innovation section for analysis selection criteria.
One of ten programs funded was a clinical translation of the dementia intervention for REACH II, the REACH VA clinical translation (Nichols et al., 2011). Staff at the VA Medical Center at Memphis translated the REACH II research materials for clinical care use (intervention manuals, scripts, certification procedures, and evaluation materials), developed comprehensive caregiver materials for each topic, developed training materials, trained and coached clinical staff, and collected data from caregivers and staff for evaluation. The intervention was 12 individual sessions plus five telephone support groups. Clinical staff from 24 Home Based Primary Care (HBPC) programs in 29 cities and 15 states identified stressed caregivers of veterans with dementia from their panels who met the same eligibility criteria as REACH II and delivered the in-home intervention. Many of the interventionists were mental health professionals newly integrated into HBPC (Karlin & Karel, 2014).

Training and coaching implementation drivers were important during this period. At the onset of implementation, training sessions were archived online to provide on-demand and just in time training. Technical assistance calls were regularly scheduled. This initial plan was not successful and had to be changed. We discovered the following important facts about the clinicians: (a) they did not want to be trained by archived training sessions; (b) a coaching model was preferred and more effective than a training model; and (c) clinicians were reluctant to ask questions in a group call for fear of embarrassing themselves. Thus, we changed from a training model to a coaching model with customized training provided as it was needed.

In the REACH VA clinical translation, from baseline to six months, caregivers reported significantly decreased burden, depression, impact of depression on daily life, caregiving frustrations, and number of troubling dementia-related patient behaviors (Nichols et al., 2011).

Program Installation
During program installation, the organization begins to function differently and install structural supports. This infrastructure will likely include funding for staff training and for implementation. In addition, patient referral processes and networks must be developed, and data on the intervention process and outcomes are gathered.

After success of the Caregiver Pilot programs, Congress mandated that VA begin to provide services to caregivers of veterans with the passage of Public Law 111–163 Caregivers and Veterans Omnibus Health Services Act of 2010. The law focused on the needs of seriously wounded post 9/11 Iraq and Afghanistan veterans who require intensive care from a family caregiver.

However, VA committed to developing services for caregivers of veterans of all eras because of their high stress and burden. For caregivers of veterans (not dementia specific), 65% are in a high burden and 68% are in a high stress caregiving situation, and 40% provide care with a high degree of physical strain (NAC, 2010). Caregivers of veterans also provide care for a long period of time. Almost three quarters report that caregiving or the veteran’s condition places a strain on their marriage, 88% report increased stress or anxiety, and 77% have sleep deprivation (NAC, 2010).

Although it addressed the needs of only dementia caregivers, the REACH VA Program Phase 1 was a good fit for inclusion as an official program in the VHA National Caregiver Support Program Office because it had been pilot tested as a clinical translation in the VA system. REACH VA was implemented as a national training program through the establishment of the Memphis VA Medical Center Caregiver Center in February 2011. For implementation, because the Center did not have direct supervisory control, there was a compensatory shift from control drivers of implementation (staff selection and development) to support drivers such as increased coaching and consultation (Fixsen et al., 2005).

Initial Implementation
During initial implementation, changes in the overall practice environment occur. Skill levels, organizational capacity, and organizational culture require education, practice, and time. In addition, the organization and its practitioners struggle with many difficulties inherent in making changes, including fear of change and inertia. At this critical point in the implementation process, many new practices are abandoned, because the power of the status quo is strong. Decision leaders may also question whether the gain of implementing a new practice is worth the pain.

The REACH VA Program Phase 1 was a faithful replication of the two previous REACH interventions. It consisted of 12 individual sessions, primarily in the home, and five telephone support groups during six months. There were a number of challenges to successful implementation. From February 2011 to May 2012, REACH VA trained 30 sites and 124 staff and certified 85 staff in the 12 session model. Staff at the individual VA Medical Centers identified caregivers and patients in their clinical panels who fit the REACH II criteria for enrollment. The Memphis Caregiver Center collected staff evaluations for difficulties, successes, and suggestions for improvement. Most suggestions and requests from staff were aimed towards modification of the intervention to meet their clinical needs and time constraints. They wanted to make changes to fit their needs, facility needs, and caregiver needs. There is a tenuous balance in trying to be flexible in encouraging adoption of an intervention but also maintaining the fidelity of the intervention to ensure that the intervention has the potential to lead to expected clinical outcomes.

We discovered in the course of program evaluation that it was hard for clinicians to deliver 12 in-home sessions for caregivers. This limited the number of families who were exposed to and benefitted from the program. However, as
a caregiver pilot program and as a CSP program, REACH VA was exposed to a wide variety of VHA leaders in geriatrics, home care, health services research, mental health, and social work. Although the actual enrollment was small in the clinical translation and the Program Phase 1, these leaders saw and believed in REACH VA’s possibility of success.

In addition, there was strong external support to see the program succeed. As the first national clinical translation of a behavioral intervention for dementia caregivers, REACH VA received national attention. REACH VA was selected as one of the Senate Special Committee on Aging exemplary geriatrics projects to be used to inform aging policy. REACH VA was selected for the 2008 Rosalynn Carter Leadership in Caregiving Award, which recognizes leadership in implementing innovative partnerships between community agencies and caregiving researchers that bridge the gap between science and practice to move caregiver support programs to widespread use in the community more quickly and efficiently. On January 4, 2011, the National Alzheimer’s Project Act (NAPA) was signed into law. The National Plan to Address Alzheimer’s Disease mandated that lessons learned through VA caregiver support strategies, specifying REACH VA, should be shared with other federal agencies. This has continued through each update of the Plan (HHS, 2013).

**Full Operation**

Fully operational programs work. Referrals are made, staff carry out the evidence-based practice with skill, and the organization supports the intervention.

The Memphis Caregiver Center took into consideration all of the concerns and comments from VA staff. The goal was to modify REACH VA to provide the flexibility needed by staff while preserving the critical skills needed to empower caregivers. Components that have been shown to be successful in caregiving interventions were retained, including education, support, and practical skills building, including problem solving, communication strategies, cognitive restructuring, and stress reduction (Belle et al., 2006; Gottman, et al., 2011; Schulz et al., 2003).

In June 2012, a modified REACH intervention, REACH VA Program Phase 2 was rolled out to the VHA system based on staff and caregiver comments. Staff identified stressed and burdened caregivers of patients from their panels based on their clinical judgment. The modified intervention has four core sessions during two to three months, with the option for additional sessions based on caregiver need, desires, goal attainment, and clinician judgment. Caregivers receive a review/closure component to discuss accomplishments and encouragement to continue the skills they have learned before being released to the maintenance phase. If clinical problems arise, in the maintenance phase additional problems/stress issues can be addressed with the caregiver. The intervention can be offered in the home, in facility or clinic, or by telephone or telehealth modalities. The Caregiver Notebook from the REACH VA translation, which includes 48 behavior and coping topics, continues to be an important source of strategies for action. The telephone support groups can now be a complementary or standalone intervention. Sites can implement both individual sessions and telephone support groups, individual sessions only, or telephone support groups only. The support groups have been formatted to include several different options.

The modified intervention is still based on a Risk Priority Assessment that targets the main caregiving risk areas and incorporates the core evidence-based components of the original REACH model. There was precedent to shorten the intervention because two reduced session versions of the REACH protocol, less than seven sessions, have been tested by REACH II investigators in different populations with similar results to REACH II and REACH VA (Burgio et al., 2009; Stevens, Smith, Trickett, & McGhee, 2012).

Since roll-out of the four session model, the Memphis Caregiver Center has provided training, certification, and coaching to 151 VA sites in providing the intervention, a 500% increase, with 444 staff trained and 265 certified. Data from a Return on Investment evaluation of REACH VA training conducted by the VA’s Employee Education System, showed about 68% of those trained are certified within three months with others taking six months or longer due to job constraints.

During the move to full operation of the four session model, several implementation drivers were critical: training, consultation and coaching, administrative support, and system innovations. The Caregiver Center included more role-playing, feedback, and examples to help staff better understand the intervention and their role. Certifying interventionists by videoconferencing has been extremely useful because it allows immediate feedback as interventionists role-play the intervention. From REACH I through REACH VA Program Phase 2, interventionists range from a variety of disciplines including social workers, psychologists, nurses, and other social and behavioral scientists, and at a variety of levels from bachelor to graduate degrees.

Administration on all levels must buy into the intervention. It is not enough for top level leadership, in our case, Congress or VHA, to be supportive of the program, although this certainly helps. Local facility and clinic leadership and local clinicians must all be onboard. Timing of implementation is critical. When the clinicians were ready, a facility administration might have other priorities and when leadership was ready, clinicians might not be ready. Securing coordination became part of site readiness preparation—to encourage discussion between clinicians and administration before training and certification.

Another important factor for implementation success was workload capture. The only care the VA previously provided was Veteran care, so there has been no administrative support for how to structure care and workload and obtain facility reimbursement. The Congressionally mandated part
of caregiver support for caregivers of seriously injured post 9/11 veterans who were receiving stipends had separate rules and regulations that did not necessarily apply to caregivers who were receiving REACH VA services or other non-mandated services. However, workload credit was extremely important in determining whether the program would and could be implemented at a site. The Caregiver Center became a clearinghouse for informal guidance to sites on coding caregiver services for reimbursement.

Innovation

At the innovation stage of implementation, there are opportunities to refine and expand the evidence-based program to learn more about the program itself and the conditions under which it can be used with fidelity. As programs are implemented, it is advisable to implement with strict fidelity first before innovations are attempted. However, at some point, innovations may sufficiently change the program so that additional outcome studies are needed to confirm the continued benefits of the revised program (Fixsen et al., 2009).

This was the case for the REACH VA Program, Phase 2. The intervention had been reduced from twelve to four sessions, telephone support groups were optional, complementary, or standalone, and the mode of delivery could be face to face or by telephone or telehealth. Although the new shorter intervention had strong staff support, it was unclear if it would produce the same outcomes as the original intervention. Therefore, an evaluation of the shorter intervention was undertaken to determine if caregiver outcomes were comparable to those of the original intervention.

At time of analysis, 374 caregivers were enrolled in REACH VA Program Phase 2 (Figure 2). To be included in the analysis, participants had to have been in the individual sessions only, have at least one session, and have completed follow-up data collection. Follow-ups that could be unduly affected by known factors (participants whose care recipient had died or had been placed in a long term care facility or participants whose follow-up was too far from end of intervention) were not included in analysis.

Outcomes are presented for 125 caregivers from REACH VA Program Phase 2. Of these 125 caregivers, 76.8% had four sessions with review/closure included in the 4th session or five sessions with the 5th session as a review/closure only session. Data on caregiver outcomes are collected by the site interventionist as part of the initial intervention risk assessment and by Caregiver Center staff by telephone at the end of the active phase of the intervention. The Caregiver Center also collects caregiver satisfaction with the intervention.

Outcomes include caregiver burden, as measured by the 4-item Zarit Burden Interview (Bédard et al., 2001; Zarit, Reever, & Bach-Peterson, 1980). Items are scored from never (0) to nearly always (4), and higher total scores indicate greater burden. Cronbach’s alpha for the 4-item scale is 0.78. The 4-item Patient Health Questionnaire (Kroenke, Spitzer, Williams & Lowe, 2009) assessed caregiver depression and anxiety on a scale from not at all (0) to nearly every day (3), with higher total scores indicating greater symptoms. Cronbach’s alpha for the 4-item scale is 0.85. Two items assessed caregiver frustrations (e.g., feel like yelling at or hitting patient) (Burgio et al., 2009). These items are scored from never (0) to often (2). Higher scores indicate greater frustrations.

Caregivers were also asked about stress symptoms including feeling overwhelmed, feeling like crying, being frustrated as a result of caregiving, feeling cut off from family and friends, and feeling lonely. Caregivers were asked if they experienced these symptoms often, sometimes, or never. On a 10-point scale, with 10 representing extremely stressed, caregivers were asked to rate their general stress.

Caregiver health was scored from poor (0) to excellent (4), using one question from the Medical Outcomes Study Short-Form 36 (Ware et al., 1995). This question has been shown to be comparable to multiple item health scales (DeSalvo et al., 2006). Caregiver level of stress during the past month was assessed with five questions (e.g., felt overwhelmed, been frustrated); each scored from never (0) to often (2). Measures of vigilance from the Caregiver Vigilance Scale (Mahoney et al., 2003) included the time that the caregiver spent performing tasks for the veteran and the overall time spent “on duty” per day. Cronbach’s alpha for the 4-item scale is 0.66. Twenty-five problem behaviors linked to caregiver notebook topics were assessed as occurring (1) or not (0) during the past month. For each behavior present, the caregiver was asked about bother or concern.

Data analysis used paired t-tests or McNemar-Bowker tests, as appropriate, to compare baseline and post-intervention follow-up scores. Each outcome measure was treated as independent of the others. P values less than or equal to .05 were considered statistically significant. For

![Figure 2. REACH VA program phase 2 flow diagram. REACH VA = Resources for Enhancing All Caregivers Health in the VA.](image-url)
Caregivers appreciated the direct assistance they received but it was also important that there was acknowledgement and emotional support. One caregiver articulated this directly: “Knowing that I was being included and that they [VA] cared whether I was around. It wasn’t just all him [care recipient].” Other saw themselves and the VA as partners. “In the long run you think you can handle everything yourself, but you find out you can’t…. They can’t change it for you. You still have to go through it. It’s good to help us if we’re going down the wrong path on what we’re doing.”

Sustainability

Post implementation, small and large changes in the organization will occur. Implementation leaders must work to ensure that the intervention survives and remains effective without losing its essential components. Several emerging trends will likely define REACH VA in the future. The Caregiver Center continues to train staff at new sites but also provides re-training for sites where certified staff have left. In addition to re-training staff at these sites, new marketing must take place to highlight the benefits of the intervention and assistance must be provided in placing the intervention in the appropriate context in the clinical setting. REACH VA has become a popular intervention for trainees to deliver. They are provided with specialized training and skills and consultation that their site may not be able to offer, and the site is able to provide the intervention to stressed caregivers.

A second trend is the expansion of the program to other diagnoses. REACH VA Spinal Cord Injury/Disorders (SCI/D) is being pilot tested at five sites. REACH VA is being expanded for caregivers of individuals with multiple sclerosis and post traumatic stress disorder. Each will have its own Caregiver Notebook and Risk Priority Inventory that highlights the needs of caregivers of individuals with the targeted condition. The REACH VA model is standardized and structured, but it is shaped by parameters of the clinical condition and draws upon best practices in managing that condition. For example, although both dementia and SCI/D have sections on safety, they focus on different aspects, even when the topics are the same. Dementia safety issues include smoking, leaving the patient alone, driving, gun safety, fire safety, and falls. SCI/D safety issues include smoking, fire safety, wheelchairs, gun safety, driving, aging changes, traveling/transfers, and emergency situations and planning. Dementia fire safety targets the patient’s inability to recognize danger; SCI/D fire safety targets ways to escape from the home for a patient in a wheelchair.

REACH VA is also being expanded into different modalities. Because VA staff and caregivers have varying needs, clinicians are providing the intervention face-to-face in the facility and with iPads linking the caregiver in the home and the clinician in the facility. The intervention is being tested as a component in the VA’s version of outpatient medical home. Requests are being made to expand to other settings such as adult day health-care or medical foster care.
Finally, REACH VA is also expanding in the Federal Government, in partnerships through NAPA. REACH VA is currently being pilot tested with several Tribal Nations sites through the Indian Health Service and the Administration for Community Living and Administration on Aging.

Lessons Learned—Replication and Applicability for Other Agencies

The implementation of REACH VA provides a road map for implementation for other interventions and organizations. Demographic trends and national budgetary constraints suggest that strategies to support caregivers will be increasingly important for agencies that work with older people (Wolff & Kasper, 2006). The REACH intervention has proven to be simple to use and robust in its results. Neither decreasing the number of sessions nor changing the method of delivery from primarily face-to-face to primarily by telephone has negatively impacted outcomes. Staff from many different disciplines and levels of training have used it successfully.

One frequent criticism is that the VA is unique and programs implemented in this setting cannot be implemented as easily elsewhere. However, for a behavioral intervention
for dementia and other caregivers, this is not the case. The REACH VA model has been implemented in communities across the country and agencies including Area Agencies on Aging and Alzheimer’s Associations by us and by the Rosalyn Carter Institute on Caregiving (in the 12 session model [Easom, Alston, & Coleman, 2013]). The REACH intervention is a focused way to interact with caregivers and can be part of a clinical or social service staff member’s toolkit to be used with stressed and burdened caregivers. In many ways, the VA’s size, number of facilities, and large catchment areas add a complexity that smaller agencies would not have. Training, certification, and caregiver interactions would be on-site or more likely to be local, rather than national or regional.

There are several lessons learned that are applicable for the VA and for other agencies implementing REACH VA. First, a clinically successful intervention is key. Second, support from leadership and from clinical staff is critical; this support has likely been the most important factor in the success of implementation. Third, listening to staff and organization needs, modifying the intervention, and testing it in its new form can make the difference between implementation and abandonment. Fourth, fitting the intervention into staff’s and the organization’s ongoing routines and practices helps ensure sustainability. Finally, for an organization, budget savings or budget neutrality can determine whether the intervention will continue. The National Institute on Aging has recently provided funding to investigate patient and caregiver healthcare costs for REACH II and REACH VA Clinical Translation. If there are positive findings, organizations may be more likely to invest in behavioral interventions for caregivers.

REACH VA continues to evolve and grow and fit itself into the VA system. Staff have increasingly full schedules with the post 9/11 influx of veterans using VA services. The intervention fits into clinical practice. It provides a structured way for staff and caregivers to interact that is focused and sparing of staff time while providing information, skills, and support targeted to caregiver and care recipient’s needs. As one caregiver said: “I think whoever makes the decisions should make it mandatory for caregivers.” However, our model is one of persuasion. Full implementation of an evidence-based program often requires 2–4 years (Fixsen et al., 2009), and we are committed to incremental gains in the program because the benefits of the intervention are clear. When asked about her experiences with the program, one caregiver replied: “The interventionist helped me accept it [dementia]. They saved my life every time they came.”

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