Implementation of the REACH model of dementia caregiver support in American Indian and Alaska Native communities

Jennifer Martindale-Adams, Ed.D.¹ Tina Tah, MBA, BSN, RN,² Bruce Finke, MD,³ Cynthia LaCounte,⁴ Barbara J. Higgins, MA,⁵ Linda O. Nichols, Ph.D.⁶

¹Department of Preventive Medicine, University of Tennessee Health Science Center and Co-Director Caregiver Center, Veterans Affairs Medical Center Memphis, Memphis, USA

²Division of Nursing Services, Office of Clinical and Preventive Services, Indian Health Service, Rockville, USA

³Nashville Area Indian Health Service and Learning and Diffusion Group, CMS Innovation Center, Nashville, USA

⁴Office for American Indian, Alaska Natives and Native Hawaiian Programs, Administration for Community Living, Administration on Aging, Washington, USA

⁵Department of Preventive Medicine, University of Tennessee Health Science Center, Memphis, USA

⁶Caregiver Center, Veterans Affairs Medical Center Memphis and Departments of Preventive Medicine and Internal Medicine, University of Tennessee Health Science Center, 1030 Jefferson Avenue (11h), Memphis, TN 38104, USA

Correspondence to: L Nichols
linda.nichols@va.gov

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Abstract

The Resources for Enhancing Alzheimer's Caregivers Health in the VA (REACH VA) dementia caregiving intervention has been implemented in the VA, in community agencies, and internationally. As identified in the 2013 and 2015 National Plan to Address Alzheimer's Disease, REACH is being made available to American Indian and Alaska Native communities. Implementation activities are carried out by local Public Health Nursing programs operated by Indian Health Service and Tribal Health programs, and Administration for Community Living/Administration on Aging funded Tribal Aging program staff already working in each community. The implementation is described using the Fixsen and Blasé implementation process model. Cultural, community, health system, and tribe-specific adaptations occur during the six implementation stages of exploration and adoption, program installation, initial implementation, full operation, innovation, and sustainability. Adaptations are made by local staff delivering the program. Implementation challenges in serving AI/AN dementia caregivers include the need to adapt the program to fit the unique communities and the cultural perceptions of dementia and caregiving. Lessons learned highlight the importance of using a clinically successful intervention, the need for support and buy-in from leadership and staff, the fit of the intervention into ongoing routines and practices, the critical role of modifications based on caregiver, staff, and organization needs and feedback, the need for a simple and easily learned intervention, and the critical importance of community receptivity to the services offered.

Keywords

Caregiving-informal, Dementia, Organizational and institutional issues

Dementia caregivers are at risk of negative psychological and physical effects, more so than caregivers of other adults [1–7]. American Indian/Alaska Native (AI/AN) dementia caregivers also report psychological and physical health challenges [8–10]. The National Plan to Address Alzheimer's Disease, which is required by the National Alzheimer's Project Act (NAPA) [11], proposed an implementation of the Department of Veterans Affairs REACH VA dementia

Implications

Practice: To implement an intervention successfully, even if staff and organizations are engaged, the community must recognize and identify the problem as a concern.

Policy: Sharing of successful caregiving programs across federal and local agencies is an efficient and effective way to serve caregivers, reduce start-up time, and maximize resources, but programs should be targeted to address local community and cultural factors by the individuals implementing the programs.

Research: Future research conducted in partnership with Tribes and local communities is needed to evaluate ways to increase community awareness of dementia and caregiving and different models of providing support to AI/AN caregivers.

caregiving intervention [12] with AI/AN caregivers. The project involves collaboration among Public Health Nursing (PHN) programs operated by Indian Health Service (IHS) and Tribal Health programs, the Administration for Community Living/Administration on Aging's (ACL/AoA) Native American Caregiver Support programs, the Department of Veterans Affairs Caregiver Support Program, and the University of Tennessee Health Science Center (UTHSC).

Two factors suggested that a focus on dementia and dementia caregiving intervention was needed. Although likely under recognized and under diagnosed, dementia is a significant problem in American Indian and Alaska Native communities [13, 14]. IHS mortality data indicate that AI/AN death rates from Alzheimer's disease are approximately half that reported for All US Races but follow a similar pattern of increase over the past 20 years [15]. Recent IHS workload statistics representing only a subset of IHS beneficiaries show nearly 17,000 unduplicated patients with dementia between 2007 and 2013 [16]. These data almost certainly represent underestimates of the true prevalence of AI/AN dementia. High rates of diabetes, cardiovascular disease, and traumatic

brain injury also suggest a large population risk for dementia [15].

While American Indians and Alaska Natives with Alzheimer's disease and related dementia can receive diagnostic and therapeutic services through IHS, Tribal, and Urban Indian Health programs, caregiver assistance relies on the general support framework of ACL/AoA's Native American Caregiver Support Program (NACSP) without a focus on the specific and complex challenges of caring for individuals with dementia. Although AI/AN caregivers share similarities with other caregivers, cultural practices also influence AI/AN caregiving, and there are differences and similarities across Tribes. The high prevalence of family caregiving, with 16 to 17% of adults serving as caregivers [17, 18], could be related to the lack of resources in rural and reservation settings and to cultural emphases on familial interdependence [19]. In general, research suggests that AI/AN caregivers rely on Tribal and community relationships and shared caregiving [8, 17, 20, 21].

The intervention, Resources for Enhancing Alzheimer's Caregivers Health in Tribal Communities (REACH into Indian Country), teaches caregivers behavioral skills (problem solving, stress management, mood management) to manage ongoing and evolving care recipient behavioral problems and behaviors relating to their own physical and emotional health. The intervention goal is to improve caregiver depression, burden, self-care, and social support and management of patient problem behaviors and safety. REACH has been implemented with stressed and burdened caregivers and with caregivers coping with varying challenges and levels of disease [22]. Implementing REACH into AI/AN Tribal organizations and communities provides an opportunity to examine its fit and utility and to determine the optimal design and requirements for adaptation and spread. Adoption of REACH for AI/AN caregivers supports the work of IHS and ACL/AoA around their person-centered goals for improving care for and lives of American Indians and Alaska Natives with dementia and their families [11, 23].

History of the REACH Program

REACH is based on the 2001 to 2004 multi-site National Institute on Aging/National Institute of Nursing Research (NIA/NINR) randomized controlled trial Resources for Enhancing Alzheimer's Caregivers Health (REACH II) [22]. 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 (1995 to 2001) [24].

A clinical translation of REACH II in 27 sites in the VA, known as Resources for Enhancing All Caregivers' Health in VA (REACH VA), occurred 2007 through 2009 [25]. After passage of Public Law 111-163, which funded services for caregivers of seriously wounded post 9/11 veterans, caregiver services

became a part of VA care. With VA's commitment to older veterans, REACH VA became a VA clinical program for dementia and spinal cord injury/disease (SCI/D) caregivers in 2011, funded by the Caregiver Support Program, which is part of Care Management and Social Work, one of the Veterans Health Administration's (VHA) Patient Care Services. REACH VA was very similar to the REACH II intervention with 12 in-person and/or telephone sessions and five telephone support group meetings.

In June 2012, a modified REACH intervention was developed for VHA based on staff and caregiver comments [12]. The modified intervention has four core sessions during 2 to 3 months, targeting the critical skills of problem solving and mood management. Additional sessions can be added based on caregiver need, desires, goal attainment, and clinician judgment. A maintenance phase where caregivers can reach out to program staff follows the active phase. A Caregiver Notebook based on research, clinical practice, and caregiver experience and written at a fifth grade reading level is provided to each caregiver. Each chapter focuses on practical strategies to address either patient behavior challenges, such as bathing, wandering, and repeated questions, or caregiver stress and coping topics, such as asking for help, grief, and communicating with health care providers. In 2016, REACH VA was expanded to include post-traumatic stress disorder, multiple sclerosis, and amyotrophic lateral sclerosis caregivers.

Just as for REACH II [22, 26] and the REACH VA translation [25], four session REACH model caregivers experience significant decreases in burden, depression, anxiety, caregiving frustrations, and stress symptoms (feeling overwhelmed, feeling like crying, being frustrated as a result of caregiving, being lonely). For patient care, caregivers report 1.2 fewer troubling patient behaviors and a decrease in safety concerns, both of which are significant findings. Concomitant with these findings, caregivers report a significant decrease of 1.6 h per day on duty [12].

In addition to the 962 VA staff trained, the model has also been implemented outside the VA system. Community agencies, including state and local Units on Aging, social service agencies, Alzheimer's Associations, and academic medical centers, have received training from VA or UTHSC to deliver the intervention. Agencies that have been trained are in Arkansas, Georgia, Illinois, Kentucky, Massachusetts, Minnesota, Oklahoma, and Vietnam.

Staff training is by live webinars where staff view slides and interact with the Caregiver Center Coordinator. In VA, clinical staff, predominantly psychologists, social workers, and nurses, are trained and certified by the Memphis Caregiver Center to deliver the intervention. In community, agency staff deliver the intervention. After training, a consultation call is held to answer questions and to discuss barriers or facilitators in how the program will be implemented by the individual REACH Coach in the community setting. Finally, a live telephone role play is held for

certification where the Caregiver Center Coordinator is able to interact with the REACH Coach and a mock caregiver who role play problem solving and mood management. A staff manual with protocols, guidelines, scripts, and talking points is provided to staff.

A major strength of the REACH intervention as it has been implemented both in the VA and the community is its targeting to the specific needs of the caregiving dyad and use of local staff to deliver the intervention. This enables the REACH Coaches to function as local experts to adjust delivery of the intervention to increase cultural appropriateness. This is particularly important given the unique culture and practices of each Tribe. REACH Coaches must recognize and be aware of local culture and nuances to incorporate them in the intervention. For example, one REACH Coach who came from another tribe reported on her efforts to better understand caregivers' and elders' rituals and traditions in the community she served before could effectively deliver the intervention.

METHODS

Any caregiving dyad from a federal or Tribal health care program serving one of the 546 federally recognized Tribes, an Urban Indian Health program, or awardees of the ACL/AoA Native American Caregiver Support Program (NACSP) is eligible. All implementation activities are carried out by local staff already working in the community. To describe the implementation of REACH into Tribal communities, the implementation process model developed by Fixsen and Blasé and their colleagues [27, 28] was used. This theoretical framework has previously been used to describe implementation of REACH in the VA system [12]. The model has six stages [28]: exploration and adoption, program installation, initial implementation, full operation, innovation, and sustainability. The model provides a structured way to present both formative evaluation information (progress monitoring of implementation) and summative evaluation information (findings and recommendations to decide future directions).

Evaluation information included changes in professional behavior, changes in organizational structures that support professional behavior, and changes in relationships to consumers and stakeholders [27]. Data and documents examined included reports to the Foundation, numbers of individuals trained and certified, and numbers of communities participating. Staff and leadership information included comments from twice monthly calls among agency partners discussing progress and obstacles, training evaluation forms, comments from certification calls and technical assistance calls with agency staff in the field who were preparing to implement the program, and presentations by Program Coaches at regional and national meetings.

RESULTS

Exploration and adoption—In the Fixsen and Blasé model, during exploration, the organization determines if

the new evidence-based practice is needed, assesses the potential match between the organization and the practice, and determines whether or not the practice can be implemented. The 2013 National Plan to Address Alzheimer's Disease, required by the National Alzheimer's Project Act (NAPA), mandated that lessons learned through VA caregiver support strategies, specifying REACH VA, should be shared with state, tribal, and local governments [23]. In 2013, exploration of REACH into Indian Country began when IHS and the VA Caregiver Support Program and its Memphis VA Caregiver Center began to train IHS and Tribal public health nurses in the modified four session REACH VA intervention to work with caregivers of AI/AN veterans. As one Public Health Nurse said, "The REACH program was a method to help the caregiver to deal with complex problems in a structured way. Our caregivers changed from viewing the issues with their loved ones as huge problems into thinking proactively by addressing small parts of the issues. The book helped them to break things down into a doable level. The program in our experience was very user friendly. I really, really liked the notebook. It was well organized; the patients were very receptive to it."

With positive feedback from public health nurses and the caregivers of veterans came requests to provide the program to non-veteran caregivers. A partnership of IHS, primarily the Division of Nursing Services, the Administration on Community Living (ACL) through the Administration on Aging's Native American Caregiver Support Services Program, and the University of Tennessee Health Science Center (UTHSC), was formed to implement REACH for caregivers of persons with dementia regardless of veteran status. UTHSC was involved as the VA Caregiver Center did not have capacity to train non-VA staff. Staff included public health nurses and community health representatives (Tribal and IHS) and Tribal aging network (senior center) staff funded through Title VI of the Older Americans Act (ACL/AoA). During this phase, administrative support has been critical. IHS and ACL/AoA leadership were enthusiastic about the implementation of REACH, and staff in both HHS agencies have served critical liaison roles in the development of the project.

Program installation—During program installation, the organization begins to modify and install infrastructure. This infrastructure will likely include funding for staff training and for implementation. In addition, patient referral processes and networks must be developed, and initial data on the intervention process and outcomes are gathered. With funding for 3 years from the private Rx Foundation, the process of tailoring the intervention for AI/AN caregivers begun in February 2015. REACH VA materials, with permission from the VA, were modified. Photographs for the Caregiver Notebook and REACH Coach manual now reflect only AI/AN diversity and not the broader diversity of the VA.

As for any program offered for implementation in AI/AN communities, Tribal organizations have control over whether the program is accepted and how it is implemented. For example, in the VA, extensive data are collected on each caregiver to evaluate caregiver outcomes, including a risk assessment that is used by the REACH Coach to tailor the intervention to the specific concerns of the caregiving dyad. For REACH into Indian Country, in accordance with Tribal requests for privacy, no personally identifiable information is collected. The risk assessment is still used by the REACH Coach, but no information, including demographics, is collected on caregivers for evaluation. REACH Coaches are asked to provide information on their delivery of the program, including topics discussed, to determine fidelity.

In focusing attention on the needs of individuals with dementia and their families, the intervention was expected to increase awareness of Alzheimer's disease and related dementias in the communities and bolster other initiatives aimed at improving recognition, diagnosis, and management. One of the concerns from staff was how to identify caregivers because memory concerns may not be brought to the attention of the healthcare system. In addition, although primary care providers may be aware of memory concerns, public health nurses who are serving as Coaches may not be. This continues to be a concern for Coaches. Community practitioners who are serving as REACH Coaches have presented talks on Alzheimer's and dementia symptoms to help caregivers recognize that dementia symptoms are not normal aging.

Despite the number of adults serving as caregivers [17, 18], family members do not necessarily see themselves being caregivers. In addition, while some individuals caring for a family member may report similar types of burden as other caregivers [9], others report low levels of burden [21] or conceptualize burden as having too much to do in other responsibilities outside the home to be a good caregiver [29]. REACH Coaches have helped caregivers articulate their concerns and problems to be able to say that they are, in fact, providing care and may need assistance.

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, any change or proposed change in practice causes difficulties, including fear of change [27]. At this point, many new practices are abandoned because of inertia or a determination that implementing a new practice is not worth the difficulties inherent in change [27].

Many interventions and programs are not culturally adapted after development [30]. As REACH has been implemented, staff needs and suggestions have reframed the program. This cultural targeting recognizes and reinforces community values, beliefs, and behaviors and builds on them to provide context and meaning to the health message [31] of support for the caregiver. One of the primary benefits was strengthening

the ability of staff to deliver the program and, thus, of participants to embrace and act on the strategies developed [32]. For example, staff training was designed to be carried out using webinar technology. Although this model is still being used, states and Tribes have requested large, in-person trainings followed by on-site certifications. These face-to-face trainings allow staff to interact with the Caregiver Center Coordinator in a more personal way and to interact and share with each other about strategies to deliver the program. Watching certifying role plays provides additional examples of both concerns that may occur and how other staff may handle these concerns. While funding did not originally include face-to-face trainings, they have proved so valuable that the Caregiver Center and the partnering agencies are finding ways to provide them. Another example of a change that benefited staff and their ability to engage caregivers is in language. REACH had always been called an intervention when it was developed as part of research and in its implementation in the VA system. However, IHS, Tribal, and ACL/AoA staff were uncomfortable with that term because it is commonly used in the context of an alcohol or drug intervention. At their suggestion, the REACH intervention became the REACH program and REACH Interventionists became REACH Coaches, a change that has now gone back to the VA. In their view, their role was not to intervene but rather to coach the caregiver in learning skills and managing concerns. This term aptly describes the REACH relationship, which has always been conceived of as collaborative and facilitative, rather than prescriptive. For there to be success, the caregiver's wants, needs, preferences, and desires must be paramount.

The collaborative aspect, where the caregiver is in control of what occurs, has helped IHS, AoA/ACL, and Tribal clinical and aging services staff in their implementation of the program. Although AI/AN caregivers share similarities with other caregivers, cultural practices also influence AI/AN caregiving and there are differences and similarities across Tribes. A respect for elders and family caregiving [8, 17, 20, 21] has been clear as REACH Coaches and caregivers problem solve and brainstorm solutions to the caregiver's concerns. For one Coach and caregiver, a solution to family and tribal buy-in involved publically identifying the caregiver's older brother, a Tribal elder, as a caregiver involved in REACH. This designation provided validation and credibility for the program and the sister's participation. In a problem solving session with another caregiver, family and community expectation was that the youngest daughter would serve as the caregiver and receive the mother's house after her death. However, despite the caregiver agreeing with this expectation, she could not manage alone and needed to determine how to ask for help without feeling she was not handling her responsibility.

Full operation—In a fully operational program, staff are comfortable in their roles and the organization supports the intervention. As of February 2017, REACH has been implemented in 47 Tribal

communities in Arizona, Kansas, Michigan, Minnesota, Mississippi, Montana, New Mexico, Oklahoma, and Wisconsin. The initial process of implementation is slow and dependent on agency leadership support, publicity about the program, and word of mouth.

Staff are taking increasing ownership, and several strategies have been implemented to increase participation by staff and by caregivers. For staff, the IHS Clinical Support Center made it possible for training to be accredited for nursing continuing education credits. The two federal agencies, IHS and ACL/AoA, have shared face-to-face training venues and costs to increase opportunities for training.

Training participants are asked to list at least one thing from the training they would incorporate into their practice. They are also asked to include any potential barriers they foresee in making practice changes. Their responses, both changes and barriers, are both similar and different from those identified by REACH coaches in the VA and in other communities. Similar to other REACH implementers, staff report enthusiasm for teaching skill building techniques, such as problem solving and mood management, delving into the Caregiver Notebook, and helping caregivers with strategies for self-care. They believe that the program will help them be more in tune with their caregivers. They report caregivers' satisfaction with the program. Just as staff anywhere, they worry about whether caregivers will want to participate, their own time constraints, coding issues, and documentation. Many coaches value in-person over telephone contact. Added to usual time constraints, on larger reservations, time and distance to the home may make conducting the intervention time-prohibitive. In addition, in these frontier settings, telephone service and Internet connections may be less reliable, precluding intervention delivery by technology. As can be the case for other minority populations, caregiver education level may necessitate making changes in the materials or format.

REACH Coaches work to fit the program into traditional values and beliefs of AI/AN caregivers and their families [8]. For example, the signal breath is a stress management strategy used in the program. One of the Coaches added burning sage to the calming breathing at the request of a caregiver. To conform to the value of respect for elders, some caregivers declined to participate in the program until the elder with dementia gave permission. For some elders and caregivers, this permission is not always forthcoming. Elders with dementia for whom English is a second language have had difficulty understanding what the REACH program is, and why their caregivers should participate. Although it has not been articulated as such, there is a balance that must be struck between respect for the elder's opinion and a caregiver's need for assistance, especially when the elder does not want the caregiver to participate. For some rural locales with limited services, there are few options for the caregiver to have

a private meeting about caregiving, e.g., by telephone or computer conferencing, or while the elder participates in a program such as day care.

In response to requests for additional information and post-training guidance, the Caregiver Center holds Audio Chats on a monthly basis to discuss implementation of the program. Audio Chats participants have identified the need for a refresher course to help participants gain a better understanding of how to get into the community and suggested implementing a volunteer Marketing/Strategy Committee to help with publicizing the program to local caregivers. Committee members are REACH Coaches and have been responsible for coordinating REACH training sessions. Each member directly supervises staff from multiple tribes, giving them access to information on REACH implementation in diverse communities. Initial feedback from staff indicates that caregivers do not see the benefit of enrolling in a program that does not provide direct service (e.g., respite, home care, transportation). Another challenge faced by REACH staff is frequent encounter of caregivers coping with a loved one's memory-related problems without the benefit of a formal dementia diagnosis. Increasing diagnosis is an IHS goal, but in the absence of a dementia diagnosis, presenting REACH as a program for dementia caregivers becomes challenging and decreases the likelihood of caregiver participation.

The Marketing/Strategy Committee initially identified two areas of focus. The first is to assist REACH Coaches in recruitment using strategies and language that will resonate with AI/AN dementia caregivers. For example, a REACH Coach participated in a local radio program providing information on Alzheimer's and dementia and highlighted REACH as a community resource available for family caregivers. Coaches have requested a publicity brochure for distribution throughout the community. The Marketing/Strategy committee is working on developing a brochure template that can be customized to a community. This brochure could be used to encourage primary care providers to make referrals of caregivers who are in need of help, encourage IHS, Tribal, and AoA/ACL staff to become Coaches, and encourage local agencies and services that support elders or family caregivers to include REACH in their programming. However, for other areas without well-frequented community gathering places, other ways to publicize, such as radio and television PSAs and social media, may be a better strategy to reach caregivers.

The second area of focus is to make the training sessions more user-friendly. For example, during training, the Committee suggested less emphasis on program structure and more emphasis on how REACH helps caregivers. In addition, training has been modified in response to suggestions captured on post-training evaluation surveys and Audio Chats. More detailed instructions are now included on the use of the risk assessment, a key tool used in assessing caregiver areas of risk that helps tailor the program to the care dyad's needs. More training time was allotted to review stress

management techniques, and electronic handouts will be made available to all participants in future training sessions. A brief video of certified REACH staff sharing their experience in training and the benefits of the program will be used during the training introduction to increase the level of comfort and acceptance of new trainees.

The partnering agencies are supporting REACH through developing needed clinical infrastructure such as billing and workload codes. System infrastructure, especially around payment, is critical in encouraging provider interactions with caregivers. Medicare Current Procedural Terminology (CPT) codes allow providers to be paid to communicate with caregivers about a beneficiary's care. However, services caregivers need may not be reimbursable, such as comprehensive assessment [33]. IHS is addressing these issues by developing coding guidelines to insure that nurses receive workload credit for REACH and can document in the electronic health record. In addition, REACH implementation has been added to staff performance evaluations and instituted as a quality improvement project.

Innovation and sustainability—These two phases of implementation have not yet occurred, although plans have been discussed for sustainability. During the innovation phase, after the evidence-based program has first been implemented with strict fidelity, agencies and practitioners can refine and expand to continue to fit the program to the organization's needs. The changes that are being made in REACH are not yet to the level of innovation. In the sustainability phase, the program is institutionalized and survives and remains effective. Ongoing discussions are being held among the agencies as to how REACH can be incorporated into existing training programs and initiatives to continue.

DISCUSSION

The evidence-based REACH intervention has been shown to improve dementia caregivers' emotional and physical well-being and their management of their loved one's difficult behaviors. This implementation of REACH involved the collaboration of federal agencies, through the National Alzheimer's Plan, to make the intervention available to American Indian/Native Alaska caregivers. However, the decision to adopt REACH remains in the hands of the local Tribal communities' clinical and aging services programs. The implementation focus has been on intervention fit and utility in Tribal communities and on the optimal design and requirements for adaptation and spread. Implementation relies on the existing staffing and organizational infrastructure in clinical services (public health nursing) and in aging services (Title VI funded senior center and Native American Caregiving Program staff). The federal agencies involved (IHS and ACL/AoA) have provided a critical liaison role, linking the Memphis Caregiver Center to clinical and aging services staff. The Rx Foundation has

provided funding and required regular, data-driven reporting on the implementation process.

Lessons learned are similar to, but expand on, those from the implementation of REACH into the VA system [12]. Similar lessons include the importance of using a clinically successful intervention, the need for support and buy-in from both leadership and staff, the fit of the intervention into ongoing routines and practices of staff and organizations, and the critical role of modifications based on caregiver, staff, and organization needs. Modifications are especially important when different cultural groups are involved [34]. One ongoing topic of discussion for the Caregiver Center and REACH coaches is how modification to fit AI/AN caregiving should occur. To date, most cultural adaptations have been through the staff member delivering the program. As the cultural and community experts, and with the collaborative nature of REACH's skills building components, staff have been able to incorporate traditional beliefs and practices into the evidence-based strategies.

An additional lesson is that a proposed program needs to be simple and easily learned. Although skills and nuances come from continued use of the program, the REACH program is designed to be "grab and go" for staff with scripts, talking points, and guidelines to help structure interactions, and a Caregiver Notebook that provides clinically relevant strategies to supplement the knowledge base of staff. A final, and perhaps most important, lesson is that introduction of REACH services has highlighted the need to strengthen the approach to recognition of memory problems, timely diagnosis, and assessment of function, resources, and needs of the individual with dementia and the caregiver. Without awareness by staff, caregivers, and the community, the perceived need for the program is lowered and case-finding becomes problematic.

These lessons learned are important for any program being implemented at large scale, especially in diverse communities. For example, the REACH program is in the beginning stages of implementation into Vietnam and the community concerns about leadership and staff buy-in and infrastructure are very similar. The issues of recognition and diagnosis of memory problems are also presenting challenges. The initial cultural adaptation is through the use of local Vietnamese staff delivering the intervention to families they are already serving.

In the next year, the federal agencies' support for this initiative will require attention to sustainability and continued spread after the end of the initial funding period. Much of the implementation process model we have discussed focuses on the placement and fit of a practice into an organization and the readiness of practitioners and organizations. For example, core implementation components that are facilitators or barriers to successful implementation include staff selection, training, consultation and coaching, staff and program evaluation, and facilitative administrative supports [27]. The practitioners, REACH Coaches, have been trained and certified and have identified codes and

developed templates to explore documenting REACH in the electronic health record. Organizationally, REACH implementation has been added to staff performance evaluations and instituted as a quality improvement project.

Although these are important and critical, implementing new programs also depends on community readiness [27]. With under-recognition and under-diagnosis of dementia, staff do not have a ready base of caregivers to serve. Using Community Readiness Model categorizations [27, 35], REACH Coaches report community readiness at the two lowest levels—no awareness (just the way it is) or denial (some recognition of the problem but it is confined to a small group). The Marketing/Strategy Committee has suggested reframing dementia and caregiving to a less clinical presentation of confusion, wandering, problems with bathing, eating or dressing, and difficulty following simple instructions. With this approach, they hope to encourage caregivers to ask agencies for the program. In examining what works in school reform, Felner and colleagues [36] stated “The community both defines the problem to be solved and tests the adequacy of the answer.” This is no less true for any implementation. The most critical challenge to the successful implementation of REACH into Tribal communities is the recognition by communities and caregivers of cognitive decline and what it means to families.

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Compliance with ethical standards

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Human rights: The University of Tennessee Health Science Center was the institutional review board of record. The project was judged to be exempt and in accord with 45 CFR 46.116(d), informed consent was waived. The application was determined by IRB to comply with proper consideration for the rights and welfare of human subjects and the regulatory requirements for the protection of human subjects. The implementation of the REACH program reported in this manuscript was performed in accordance with the ethical standards as laid down in the 1964 Declaration of Helsinki and its later amendments or comparable ethical standards, in that the health, well-being and rights of individuals participating in the intervention were promoted and safeguarded.

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