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THE CARE SPAN

North Dakota Assistance Program For Dementia Caregivers Lowered Utilization, Produced Savings, And Increased Empowerment

ABSTRACT **North Dakota's state-funded Dementia Care Services Program provides individualized assistance to caregivers of persons with dementia. Caregivers can contact program representatives at any time and may continue to contact them throughout the years they are caring for the person with dementia. During the program's first forty-two months of operation (January 2010 to June 2013), care consultants assisted 1,750 caregivers, primarily family members, of 951 persons with dementia. In survey responses and other self-reported data, the unpaid caregivers credited the assistance program with helping them feel more empowered, consider their charges less likely to be placed in long-term care, and use less potentially avoidable medical services such as hospitalizations and 911 calls. The program's estimated potential savings were $39.2 million from delayed long-term care placement and $0.8 million from reduced use of medical services, and its two-year costs were $1.2 million. The program's success with its rural service population, for which travel tends to be difficult and resources limited, provides a model for others to adapt. It also encourages further research on impacts of individualized support programs on persons with dementia and their caregivers.**

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An estimated 5.2 million American adults had Alzheimer's disease in 2013, and five million of them were over age sixty-five. This number is expected to grow as the general US population over age sixty-five increases.[1] In 2010 the Census Bureau reported 97,477 people over age sixty-five in North Dakota—14.5 percent of the state's population.[2] In that same year the Alzheimer's Association estimated that 18,000 North Dakota residents ages sixty-five and older were living with Alzheimer's disease, representing 18.5 percent of the state's population in that age category. A 25 percent increase in the number of persons with dementia in North Dakota is expected by the year 2025.[2,3]

The highly rural nature of North Dakota creates a unique challenge in health care service delivery. One-third of the state's population lives in small (population 2,500–9,999) or isolated rural areas (population less than 2,500).[4] Disproportionately, 44.5 percent of the population ages sixty-five and older live in small or isolated rural areas.[2,4] Caregivers and persons with dementia who live in such areas have reduced access to health care services because of limited availability and greater travel times and distances. Insufficient health care services are available for persons with dementia (which includes Alzheimer's disease) in rural areas of the state. North Dakota possesses fewer than ten adult day care service providers. Also, many caregivers

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have moved away from North Dakota's rural areas, creating large distances between them and their charges with dementia.

Background

THE NATIONWIDE COSTS OF DEMENTIA In 2013 the direct costs of caring for persons with dementia nationwide were estimated at $203 billion, including $142 billion in costs to Medicare and Medicaid. Total spending for health care, long-term care, and hospice for persons with dementia are projected to increase to $1.2 trillion by 2050 (in 2013 dollars). This dramatic rise includes a 500 percent increase in combined Medicare and Medicaid spending.[1]

Nationwide surveys have shown that 92.6 percent of unpaid caregivers receive some level of professional support but that 67.4 percent need more support than they are receiving.[5] In 2012, 15.4 million family and friends provided 17.5 billion hours of unpaid care to persons with dementia—care valued at $216.4 billion.[1] Further, nearly 15 percent of caregivers were long-distance caregivers, living an hour or more away from their loved ones. Out-of-pocket expenses for long-distance caregivers were nearly twice as high as those incurred by local caregivers.

More than 60 percent of dementia caregivers rate the emotional stress of caregiving as high or very high; more than one-third report symptoms of depression.[6] Twenty-four percent of caregivers have had clinically significant levels of anxiety symptoms. They have a four times higher risk of depression than noncaregivers and have been found to have a sixfold increased risk of developing dementia themselves. Dementia caregivers incurred $9.1 billion in health care costs of their own in 2012.[1]

HOW SUPPORT SERVICES CAN HELP Studies have shown that intervention with different services over time to meet caregivers' needs results in their improved well-being and the decreased premature placement of persons with dementia in long-term care.[7–9] In 2006 Mary Mittelman and colleagues reported on care consultations tailored to the caregiver's situation provided at regular time intervals.[10] They followed these caregivers for up to eleven years and found that the intervention resulted in improved family support and delayed long-term care placement.

In the Mittelman model, caregiver support services consisted of four components: two individual counseling sessions tailored to each caregiver's specific situation; four family counseling sessions with the primary caregiver and selected family members; participation in a weekly support group; and telephone counseling as needed. The first two components were provided within four months of starting the intervention. Counselors also supplied resource information and referrals to caregivers. Each caregiver received all of the components during the study and was given support for an unlimited period of time. Counselors also interviewed caregivers face to face, completing questionnaires when the caregivers enrolled and at regular intervals afterward. The impact of these caregiver support services on caregiver depression, caregivers' appraisals of the person with dementia's behavior problems, and delayed nursing home placement was shown to be long lasting and both clinically and statistically significant.[11]

The purpose of this article is to show how a state-funded dementia caregiver support program, employing an evidence-based model modified to reflect local resources and access to care, is making a positive impact on caregivers and reducing potentially avoidable health care costs.

North Dakota's Dementia Care Services Program

The Dementia Care Services Program in North Dakota has been in operation since January 2010 and is funded by the North Dakota Department of Human Services, Aging Services Division, and administered by the Alzheimer's Association of Minnesota–North Dakota. The program is publicized through education classes (available locally to paid and unpaid caregivers and covering topics such as disease basics, communication, and end of life), social service agencies, health care providers, the Fargo Veterans Affairs Medical Center and its community-based outreach clinics, senior centers, the media, and word of mouth. The program's services provide emotional support, education about dementia-related issues, and referrals to other agencies to persons with dementia and their caregivers. The program's main goals are to increase empowerment of the caregiver, delay premature nursing home placement, and reduce the use of acute health services by the person with dementia.

Empowerment has been defined as the ability to control or participate in one's life and environment, or as a process that provides the tools, resources, and environment to build, develop, and increase the ability of others to set and reach goals.[12,13] A study of home health workers in 2011 further defined the work of empowerment as increasing knowledge of the disease and availability of health care resources, engaging caregivers in planning and decision-making, reassuring caregivers about their ability to give care, advocating for families' wishes, providing resources for home care, and encouraging caregivers to seek other sources of support and to

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care for themselves.[14]

The North Dakota Dementia Care Services Program is modeled after the caregiver support program designed by Mittelman and colleagues.[10] Its intake model is a scaled-down version of the Mittelman model. Both models focus on long-term planning (such as establishment of power of attorney and health care directives), disease education, and linking caregivers and patients to resources. The models take into account existing support networks and attempt to expand or deepen relationships with family, friends, and community resources. Both models offer emotional support and allow a safe place for caregivers and families to express emotions surrounding grief, loss, and relationship changes.

Exhibit 1 highlights the differences between the Mittelman and North Dakota models and the reasons why the North Dakota model was modified. Unlike the Mittelman model, where a diagnosis must be confirmed, the North Dakota program enrolls caregivers who provide care to a person with a suspected or confirmed diagnosis of dementia and does not limit the number of consultations that caregivers can receive. There is also no limit to the amount of time they can work with the program. The North Dakota program encourages caregivers to complete the care plan action steps—a guide provided to the caregivers to help them address the key problem (s) discussed in the consultation—within three care consultations, usually within six months of initial contact. Compared to the Mittelman model, the North Dakota program allows fewer care consultations but within a longer period of time, so that more family members may be included, to support the team model of care and to address time and travel constraints in rural areas.

Given the particular needs of North Dakotans, including the limited availability of services and problems associated with isolation, the state's Dementia Care Services Program method for constructing a care plan over the course of an unlimited number of sessions offers greater flexibility than the Mittelman model in addressing the individual needs of caregivers within a rural state. For example, in-person care consultations may be desired, but phone calls are more practical than asking a caregiver to travel 300 miles. In rural areas, services such as housekeeping may not be available, and there may not be assisted living nearby, so the North Dakota program may help the caregiver in making informal arrangements for services with a neighbor.

PROGRAM SERVICES The North Dakota Dementia Care Services Program provides service to eight regions in the state with two project staff members providing supervision and oversight to five regional care consultants. All program staff have backgrounds in human services (master's degree in social work or equivalent) and receive orientation in service delivery.

The Alzheimer's Association monitors the program's work from a clinical perspective, similar to the monitoring done in the Mittelman model, and schedules periodic visits with each care consultant and supervisor to ensure quality and best practices. The program implements improvements as needed. Monitoring and outcome evaluation is conducted by an external university-based agency.

CONTACT AND CONSULTATION Caregivers can

EXHIBIT 1

Key Modifications Of The Mittelman Dementia Caregiver Support Services Model To The North Dakota Dementia Care Services Program (DCSP)

Aspects of Mittelman model	Aspects of DCSP model	Reasons for modifications
Research study	State-funded program	Different funding streams
Caregivers randomly assigned as cases and controls	All caregivers received same services	Funder request to reach entire population
Subjects were recruited	Any subject who contacted DCSP was accepted	Funder request to reach entire population
Required Alzheimer's or dementia diagnosis	No diagnosis required	Diagnoses difficult to obtain in many rural areas
Two individual sessions, four family sessions, all in-person	A target goal of three in-person individual or family sessions	Adjusted to the needs of the caregiver(s); challenges to rural/isolated client travel
Phone consultations beyond in-person sessions as needed	Phone consultations readily available for all purposes	Challenges to rural/isolated client travel
Assessments at regular intervals	Assessments at every contact	Funder request for evaluation purposes
Consultations stopped at four months	Consultations continue as needed	Funder request to provide continued service
Weekly support group required	Support group available, not required	Challenges to rural/isolated client travel
All have a master's degree in clinical social work, counseling, psychology, etc.	Majority have master's degrees; preferred, not required	Challenges locating credentialed individuals in rural/isolated areas

SOURCES Information from the DCSP supervisors and Mittelman M, et al. Improving caregiver well-being delays nursing home placement of patients with Alzheimer's disease (Note 10 in text).

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contact the program through several options: using the 24/7 Information Helpline, attending an educational presentation about dementia, or requesting a formal care consultation. All entry points involve initial contact with trained, professional staff of the Alzheimer's Association of Minnesota–North Dakota. Care consultants offer two levels of consultation based on the assessment of the complexity of the need. Level 1 care consultations focus on one specific need, while level 2 consultations address multiple needs. Care consultations are provided both in person and by telephone. The mode of service delivery is determined by caregivers' preferences and the complexity of the concerns. Every effort is made to provide care consultation in person. Follow-up care consultations enable the caregiver and care consultant to assess the success of the care plan, to determine whether further approaches are needed, and to discuss any new concerns. Care plans are developed collaboratively between the caregiver and the care consultant.

The care consultations consist of an intake process modeled after that of Mittelman and colleagues,[10] identifying issues, concerns, and resources; developing care plans and referrals; and providing education and follow-up. The care consultants do not use a specific formula of interventions; rather, they tailor each care consultation to the current needs of the caregiver and the person with dementia. During the care consultation, care consultants gather detailed information about the caregiver and the person with dementia, listening closely to understand the caregiver's perception about how the disease affects his or her work and daily living. They also assess the caregiver's situation, to gain insight about the coping strategies used to manage the circumstances and complications of caring for a person with dementia. The care consultants provide information about the disease and emotional support, and they work with caregivers to determine the best combination of community services (social, legal, religious) to help manage their situations. There is no formal discharge from the North Dakota Dementia Care Services Program, and a caregiver can return for additional care plans at any time.

OUTCOMES TO MEASURE Key outcomes to measure, related to the program's goals, are reduction in potentially avoidable health care use and costs, delay in long-term care placement leading to potential cost savings, and improved behavioral health and empowerment of the caregiver.

Study Data And Methods

DATA COLLECTION From January 2010 to June 2013 data were collected for the evaluation and assessment of the North Dakota Dementia Care Services Program. These data included demographics of 951 persons with dementia, 1,750 caregivers, and services provided by the program during 2,985 contacts with caregivers. Further data collected from caregivers after multiple visits included a survey of 101 caregivers regarding self-reported empowerment, 372 caregivers' estimates of likelihood to place the person with dementia in long-term care, and 867 caregivers' estimates of health care use. The program did not randomly select caregivers for services; nor was there a control group, as any caregiver who wished to participate was allowed to do so. All data from caregivers with multiple visits constituted a convenience sample of those who reported information.

ASSESSING SERVICES Specific services by the North Dakota Dementia Care Services Program that were measured included whether the contact was through a call by the caregiver to the information helpline or a care consultation. Care consultations were classified as in person or by phone, initial or follow-up, and action level 1 (focus on one specific need) or action level 2 (focus on multiple needs). Other program services included the care consultant providing a resource or a referral to the caregiver. There was no set time limit to complete services; nor was there a limit on the number of services or specific services that had to be provided.

Caregivers who worked with the North Dakota Dementia Care Services Program were either paid (such as health care professionals) or unpaid (such as family members or friends). Both paid and unpaid caregivers received care consultations, resources, and referrals. However, paid caregivers usually received only level 1 consultations, and those were typically over the phone. Paid caregivers' needs were usually about management of behavioral symptoms such as communication and care techniques to assist in reduction of potentially harmful or distressing behavior. Commonly one follow-up call was made to paid caregivers. Because paid caregivers often do not provide information on the health care use or long-term care placement of specific persons with dementia, they were not included in those analyses.

Nearly 300 unpaid caregivers who had multiple contacts with the North Dakota Dementia Care Services Program were asked during care consultations between April 2012 to June 2013 if they would fill out a survey and mail it back to the program office. Of those, 101 caregivers voluntarily completed the survey. The survey contained eight questions eliciting caregivers' views on how the program helped them as caregivers and with the care of the person with dementia.

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These were measured on a five-point Likert scale (1, strongly disagree, to 5, strongly agree). Average scores of the caregivers' responses for each question were estimated.

Unpaid caregivers were asked during contact with the information helpline or at a care consultation to assess how likely they were to place the person with dementia in long-term care. There were 372 people with dementia whose caregivers reported likelihood at first contact with the program, then they reported again at each time they had further contact. The first report of likelihood and the most recent report that was two weeks or more after the first report (the report furthest in time from the first report) were used to estimate change in likelihood during the forty-two-month study period. Likelihood was rated using a scale of 1 (not at all likely to place in long-term care) to 6 (already placed in long-term care). The development of this method using likelihood to estimate time and its reliability is described in detail by Marilyn Klug and colleagues.[15] Each possible difference in likelihood ratings was translated into a change in time to place in long-term care (for example, changing from 5 [as soon as possible] to 4 [very soon] delays placement by an estimated two years). Delays in placement were estimated for 106 persons with dementia. The potential cost savings for each day delayed was estimated using the median cost of the long-term care facility nearest the caregiver within North Dakota.

UTILIZATION AND COSTS Unpaid caregivers were asked to report usage of hospital (days hospitalized), ambulance (number of ambulance uses), emergency department (number of trips to the emergency department), and 911 (number of calls) by the person with dementia during the past three months. During the first three months of working with the North Dakota Dementia Care Services Program, 867 caregivers reported utilization by the person with dementia; 283 did so at four to six months, 189 at seven to nine months, 133 at ten to twelve months, 106 at thirteen to fifteen months, and 70 at sixteen to eighteen months. The rates of usage for the five time periods beginning at four to six months over the eighteen-month period were compared to the first three-month time period, which often reflected utilization before working with the North Dakota Dementia Care Services Program. Differences in rates over time or between the three-month periods were tested for significance using the normal approximations to the binomial for differences in proportions.

Estimated cost savings were calculated using cost estimates of $1,977 per day in a hospital,[16] $617 per urban ambulance use,[17] $927 per rural ambulance use,[17] $568 per emergency department visit,[18] and $82 per 911 call.[19] The change in event rates was multiplied by the number of people and cost per event to estimate cost savings. This method is described in detail by Klug and colleagues[20] and is compared to the feasibility of other methods, including how these rates are associated with estimated cost savings.

LIMITATIONS There are limitations in the design of the North Dakota Dementia Care Services Program that reduce the generalizability of the outcomes. The data were not obtained at regular intervals; nor were all data and data sources, such as medical records, always available. Systematic evaluation and standard cost-savings models were not applicable. Results were based on caregivers' self-reports, affected by their own timing and needs. Second, the program was designed to provide services to all caregivers in need. Without a control group or randomized selection of caregivers, there is no way to prove that the positive outcomes from this population are unique to them.

Third, the program was designed to provide services unique to each caregiver's needs at any time, which precludes any use of specific interventions at structured time intervals. Fourth, the population of North Dakota is not racially diverse (90 percent is white), and approximately half of the population resides in rural areas. Although the principle of tailoring the program model and services to local population characteristics may be broadly generalizable, the present outcomes might not be.

Study Results

There were 2,985 contacts made with 1,750 caregivers during this forty-two-month time frame; 1,641 (55 percent) were care consultations between the care consultant and the caregiver, and 1,344 (45 percent) were information helpline calls from the caregiver. Of the care consultations, 657 (40 percent) were in person and 564 (34 percent) were follow-up. Two-thirds of all care consultations (1,092, 67 percent) were action level 1 (focusing on one need) and 549 (33 percent) were action level 2 (focusing on many needs). From the 2,985 contacts, 471 referrals were made to other agencies, and 1,170 resources about dementia were provided.

Of the 1,750 caregivers, 1,273 (73 percent) were female, the average age was 61.2 years (range: 20–96), and 1,418 (81 percent) were white. There were 836 caregivers (48 percent) living in rural areas, and the average travel distance for the 558 caregivers who traveled to reach the person with dementia was 293 miles (standard deviation: 496 miles; median: 84 miles). More than one-fourth of caregivers par-

$40 million

Saved

Estimated savings from unpaid caregivers' use of the program totaled just over $40 million over 42 months; the program's current two-year cost is $1.2 million.

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ticipating in the North Dakota Dementia Care Services Program (460, 26 percent) had to travel fifteen or more miles to reach the person with dementia. Caregivers tended to be family members, with 349 (20 percent) being a spouse and 759 (43 percent) being a child of the person with dementia. Paid caregivers accounted for 222 (13 percent) of all caregivers and often worked with multiple persons with dementia. There were 826 (47 percent) caregivers who had multiple contacts with the program (average: two contacts per caregiver; maximum number: twenty-seven). The average time working with the program was six months, and the maximum time was the full duration of the study period, forty-two months.

Of the 951 people with dementia, 515 (54 percent) were female, and the average age was seventy-nine years (reported range: 30–100). The majority (684, 72 percent) continued to live at home, with 210 (22 percent) living alone and 479 (50 percent) living in rural areas. There were 707 persons with dementia (74 percent) who had a formal diagnosis of Alzheimer's or dementia, and fifty-six of them were reported as young onset (younger than age sixty-five). Comorbidities (any disease reported other than Alzheimer's or dementia) were self-reported in 369 persons with dementia (39 percent). Only 265 (28 percent) had the stage of their dementia self-reported, with 67 (7 percent) in early stage, 170 (18 percent) in middle stage, and 28 (3 percent) in late stage.

Exhibit 2 shows unpaid caregivers' average scores for eight questions regarding their empowerment after working with the North Dakota Dementia Care Services Program. All respondents had multiple visits with the program and were primarily female (80 percent), white (96 percent), family members (85 percent), and from urban areas (54 percent). The majority did not have to travel to see the person with dementia (64 percent). The persons with dementia they reported on were usually living at home (81 percent), had a diagnosis of Alzheimer's or dementia (93 percent), and had a comorbid condition (84 percent). All responses were measured at a single point in time. Most statements produced an average score higher than 4 out of a possible 5 (Exhibit 2).

The responses of the unpaid caregivers who provided multiple estimates of the likelihood of their charges' being placed in long-term care indicated reduced likelihood for 106 of 372 persons with dementia (28 percent) after their caregivers began working with the North Dakota Dementia Care Services Program. As previously noted, likelihood of placement was estimated on a scale of 1 (not at all likely) to 6 (already placed). A decrease of one point in likelihood was given for sixty-nine people with dementia (for example, 4 to 3), eighteen people dropped two points, ten dropped three points, three dropped four points, and six dropped five points. These likelihood changes translated to potential delays in placement and saved an estimated 179,580 number of days in long-term care (average: 7.7 years per person with dementia), which translated in-

EXHIBIT 2

Empowerment Scores Of Unpaid Caregivers With Multiple North Dakota Dementia Care Services (DCSP) Program Contacts, From Survey Conducted April 2012 To June 2013

Statement	Number responding	Mean score	SD
The care consultation helped me improve my knowledge of dementia	97	4.320	0.785
This program made me feel better equipped to manage this disease	97	4.237	0.814
The program helped me improve my general health	79	3.418	0.841
The care consultation program helped me feel less stressed	95	4.042	0.798
This program helped me improve my knowledge about dementia-related resources and supports	93	4.441	0.616
This program helped me have better access to dementia care information	95	4.495	0.599
This program helped me improve my knowledge about dementia-related resources	97	4.392	0.638
The care consultation program helped me access health care	86	3.895	0.868

SOURCE Authors' analysis of data from the DCSP survey. **NOTES** Mean is from a five-point Likert scale from 1 (strongly disagree) to 5 (strongly agree). SD is standard deviation.

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to $39.2 million in potential cost savings during the forty-two-month period.

Exhibit 3 shows the utilization rates of persons with dementia for hospitalization, ambulance, emergency department, and 911 as reported by the caregiver for three-month periods. For the five time periods beginning with the fourth month, utilization rates decreased significantly from the first three-month interval for all measures and all times. Some of the highest decreases in rates relative to the first three months were in the sixteen-to-eighteen-month time period. Using median costs for these potentially avoidable health care services, the total estimated savings was $833,516 ($731,743 for hospital, $43,645 for ambulance, $51,658 for emergency department, and $6,470 for 911).

EXHIBIT 3

Changes In Potentially Avoidable Health Care Utilization Rates In North Dakota After Unpaid Caregivers Began Working With The Dementia Care Services Program (DCSP)

Months with DCSP	Number of persons with dementia	Rate of events per person	Change in rate
HOSPITAL STAYS			
1–3	867	0.754	Ref
4–6	283	0.272	0.482****
7–9	189	0.328	0.426****
10–12	133	0.241	0.514****
13–15	106	0.406	0.349****
16–18	70	0.071	0.683****
AMBULANCE USES			
1–3	860	0.108	Ref
4–6	281	0.046	0.062****
7–9	187	0.027	0.081****
10–12	131	0.038	0.070***
13–15	105	0.038	0.070**
16–18	68	0.000	0.108***
EMERGENCY DEPARTMENT VISITS			
1–3	867	0.210	Ref
4–6	283	0.117	0.093****
7–9	189	0.079	0.131****
10–12	133	0.105	0.105***
13–15	106	0.094	0.116***
16–18	70	0.014	0.196****
911 CALLS			
1–3	867	0.141	Ref
4–6	283	0.046	0.095****
7–9	189	0.053	0.088****
10–12	133	0.030	0.111****
13–15	106	0.038	0.103***
16–18	70	0.000	0.141****

SOURCE Authors' analysis of data from the Dementia Care Services Program. **NOTE** Data were reported by the caregiver regarding the use of health care services for a person or persons with dementia during the past three months. **$p < 0.05$ ***$p < 0.01$ ****$p < 0.001$

Discussion

As the population ages and the incidence and prevalence of Alzheimer's and dementia increases, unpaid caregivers for persons with dementia will become increasingly important because the need for care will not be entirely met by additional professionals.[21] There is considerable variability in the competency and confidence of unpaid caregivers in providing care to persons with dementia. Additionally, the expectations about taking on the responsibility of caregiving and the impact on the relationship of the caregiver to the person being cared for will differ.[5,22]

The course of dementia is variable. To meet the growing demands for care of those with dementia, it will be necessary to design more programs with sufficient services that are flexible enough to efficiently meet specific needs with the right care at the right time to support both caregivers and persons with dementia.

The potential of North Dakota Dementia Care Services Program to achieve the program's primary goals—increasing unpaid caregivers' competence and confidence—is amply demonstrated by their survey responses (Exhibit 2). Likewise, our findings indicate that program participation can accomplish the additional goals of prolonging care at home and reducing the use of potentially avoidable medical services, resulting in significant savings even after program costs are accounted for.

There were 106 persons with dementia whose caregivers indicated that they were less likely to place the person in long-term care after working with the program, resulting in potential future savings of more than $39 million. Health care utilization cost savings have continued past six months and then increased by eighteen months (totaling $833,516 in savings). Further, this decrease in utilization rates is consistent whether or not the caregiver needs extensive assistance (Appendix Exhibit 1A).[23] The current cost of the program is $1.2 million over two years. Total estimated savings from unpaid caregivers (long-term care avoidance; less use of hospital, emergency department, ambulance, and 911) were estimated at just over $40 million over forty-two months, or nearly $23 million every two years.

Conclusion

A lack of structured interventions with specific time constraints makes generalization of our results and comparison of our methods to other dementia caregiver support programs difficult. However, the flexibility within the North Dakota Dementia Care Services Program's defined structure allowed adjustment at the individual level when addressing common, difficult situations. The program's success within this rural popula-

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tion, where travel is difficult and resources are limited, serves as a model for others to adapt and continue to research. The program works by empowering families and connecting them to community resources that benefit them emotionally and may benefit families and the state in terms of cost related to health care use. Further understanding of the outcomes of programs directed at meeting the needs of these families in rural and urban settings may result in cost savings that can be redirected to enhance services for persons with dementia and their caregivers, or to meet other health care needs. ■

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23 To access the Appendix, click on the Appendix link in the box to the right of the article online.

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