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## **Evaluation of the Jewish Community Housing for the Elderly Memory Support Initiative**

Joan Hyde

*University of Massachusetts Boston*, [joan.hyde@umb.edu](mailto:joan.hyde@umb.edu)

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# **Evaluation of the Jewish Community Housing for the Elderly Memory Support Initiative**

**Joan Hyde, PhD  
Gerontology Institute  
January, 2014**

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**Jewish Community Housing for the Elderly**

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This report was created by researchers in the Gerontology Institute, within the John W. McCormack School of Policy & Global Studies at the University of Massachusetts Boston, under contract with Jewish Community Housing for the Elderly (JCHE), and in fulfillment of the evaluation requirement of a LeadingAge Innovations Award.

It is a result of collaboration between the researchers and members of the Memory Support Initiative Team at JCHE. In particular we want to recognize the work of Caren Silverlieb, Vice President for Program Development, for providing leadership to this project. We submit this report to LeadingAge in the hopes that it will inform the efforts of senior housing providers who wish to strengthen their ability to serve residents with cognitive impairment.

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## **Evaluation of Jewish Community Housing for the Elderly's Memory Support Initiative**

### ***Background***

Jewish Community Housing for the Elderly (JCHE) is a large, multi-campus organization that houses and serves 1,500 residents (80 market rate and 1,420 low income). The average age is 80 years old, with one-third of residents 85 and older. Three quarters of the residents are not native English speakers. Through HUD and other funding, JCHE offers a range of supports to these residents, including translators, interpreters and staff with language and cultural competence, meals, transportation and, through their Service Coordinators, facilitation of resident access to government benefits, home care and other services.

According to the Alzheimer's Association's 2012 special report "People with Alzheimer's Disease and Other Dementias Who Live Alone" there are 800,000 Americans with cognitive impairment living on their own in community settings. Extrapolating from these national estimates, JCHE estimates that approximately 255 of their residents have some level of cognitive impairment. More generally, it is clear that cognitive impairment is prevalent in market rate and subsidized independent senior housing properties throughout the United States. These cognitively impaired individuals, at JCHE and elsewhere, may also be struggling with limited resources and language barriers. They face great difficulty in managing many aspects of day to day life, like transportation to doctors' visits, shopping, getting along with neighbors, and accessing needed support services and government benefits. Without staff that is prepared to assist these cognitively impaired residents to overcome barriers and access services, many individuals may be needlessly institutionalized.

### ***Goals of the JCHE Memory Support Initiative***

In keeping with its commitment to expanding the ability of seniors to age in place in subsidized housing settings, LeadingAge funded the first step of JCHE's "Memory Support Initiative," a pilot project designed to explore how best to prepare senior housing providers to serve their cognitively impaired residents.

JCHE's stated goals for this project were to:

- Increase Resident Services Coordinators' knowledge and skills
- Educate staff in every department to work more comfortably and effectively with residents with memory impairment
- Improve the experience of residents with memory impairment and their families

The project was funded for one year (February 1, 2013 through January 31, 2014) by LeadingAge in their first round of Innovation Awards. Upon learning of receipt of the award, JCHE created a formal "Memory Support Team." This seven-person team consisted of the Director of Strategic Planning and Partnerships, one Executive Director, one Resident Services Administrator, three incumbent Resident Service Coordinators, and, once hired, a Service Coordinator who would serve as the Memory Support Specialist.

After considering many options, the team recommended two specific approaches which they hypothesized would be most likely to improve their organizational capacity to support residents with cognitive impairment. These are:

1. Providing education for the majority of JCHE employees in “Habilitation Therapy”, an educational program developed and offered by the Alzheimer’s Association of Massachusetts and New Hampshire.
2. Hiring a Service Coordinator to serve as a system wide “Memory Support Specialist” at their largest (Brighton) campus, as well as designating one Service Coordinator at each of their other sites to fulfill this role.

### ***Description of the Evaluation Component***

#### **Goals of the Evaluation**

While ultimately JCHE hopes to be able to obtain funding to study the effectiveness of these interventions in extending length of stay in independent senior housing and in reducing unnecessary hospitalizations, the goals of this evaluation are to:

1. document the steps and resources needed to implement the initiative
2. measure the extent to which staff competence increased due to the training
3. identify changes to organizational capacity and resident services
4. make recommendations for future action, both internally to JCHE and more generally to independent senior housing providers throughout the United States and internationally.

Further, this evaluation is designed to inform a guidebook JCHE and the Alzheimer’s Association are developing for use by other senior housing providers who wish to consider enhancing their capacity to serve residents with cognitive impairment.

#### **Evaluation Methods**

1. **Baseline Data Collection:** To better understand the organization’s pre-intervention services and supports for the target population, the researcher reviewed JCHE materials and conducted five in-depth interviews with key staff prior to the start of the project
2. **Evaluation of the Habilitation Training:**
  - a. Measure and report on the level of effort required to effectuate the training
  - b. Analyze the results of pre- and post-tests that were administered to all trainees
  - c. Collect trainee satisfaction data, using a pencil and paper survey. This was administered during staff meetings at each site about a month after all training had been completed and captured both satisfaction and indicators of the utility of the training.
3. *Resident Referral* and *Intervention* reports were developed for this pilot project. These were collected and analyzed in order to identify reasons for referral to a Memory Support Service Coordinator, and to determine the types of services and interventions referred residents received.
4. Focused interviews of a purposive sample of key staff were completed at the end of the pilot phase of the project (December 2013 and January 2014).

The project received approval from the University of Massachusetts Institutional Review Board for the protection of Human Subjects. Pre and Post Tests and the written surveys were anonymous. Focused interview subjects each gave consent to be interviewed.

## ***Description of the Memory Support Initiative Training***

JCHE engaged the Alzheimer’s Association, Massachusetts/ New Hampshire Chapter to train the Memory Support Team in the “Habilitation Training” program. This particular training was selected as the one most likely to improve services to residents with cognitive impairment. The Habilitation program was developed by this Alzheimer’s Association Chapter and has been in use for over twenty years. The Alzheimer’s Association’s description of their program can be found in the sidebar to the right.

The members of the Memory Support Team attended the one day Train-the-Trainer Program and were provided with the materials, such as slides, interactive exercises, and props, needed to offer the training to other JCHE staff.

The initial intention had been to modify the standard training to better meet the needs of housing providers, but due to the illness of the key Alzheimer’s Association contact, the JCHE Memory Support Team members received the standard Train-the-Trainer curriculum and materials. The Memory Support team made modest changes to the training, including omitting one of the modules (6.B. Personal Care), and modifying some aspects of others.

This modified, 12-hour training program was then offered by JCHE trainers to all Resident Service Coordinators, members of the maintenance department and members of the administrative staff who interact with residents on a constant basis.. Staff from most other departments were invited to attend a more basic seven hour training that was comprised of Modules 1A&B, 2A&B, 3, 4A&B, and 8A&B.

### **Designated Memory Support Service Coordinators**

A related component of the intervention was implemented simultaneously when JCHE’s application for an additional Service Coordinator was approved by HUD as the LeadingAge project was beginning. This position was designed to serve those with cognitive impairment. In recruiting for this position JCHE chose a person who was qualified to work with the large Russian speaking resident population living in the buildings on the Brighton campus.

To serve the cognitively impaired residents in the other buildings one of other members of the Memory Support Team, typically a Service Coordinator who had attended the “Train the Trainer” session, was designated to be the Memory Support Specialist for the building in which she works.

## THE HABILITATION TRAINING CURRICULUM

The newly revised curriculum is a train the trainer model created to prepare attendees, already familiar with Alzheimer's and dementia care, to train direct care staff in a wide array of care settings. The 7 hour training teaches attendees the 13 hour curriculum in best Habilitation Therapy practices. Modules include a PowerPoint presentation, discussion activities, lecture, and demonstration, role-play and group work.

### **Module Topics:**

1. Understanding Alzheimer's and Dementia (parts A & B)
2. Habilitation Therapy (parts A & B)
3. Knowing and Understanding the Individual
4. Communication Skills: We Need to Know the Language (parts A & B)
5. Does the Physical Environment Make a Difference?
6. Our Approach to Personal Care (parts A & B)
7. Activity and Purposeful Engagement
8. Behavior as Communication: Understanding and Responding
9. Understanding and Working with Families

Further, all Service Coordinators who were so designated, as well as several other key individuals, were given the opportunity to attend monthly group sessions with the co-developer of the Habilitation Training and the Alzheimer's Association's Vice President for Clinical Services, Dr. Paul Raia. These sessions are designed to provide a forum for the most challenging cases, and to further refine the capabilities of these specialists and other key staff.

Organizationally, the introduction of these Memory Support Specialists, both the new employee and those designated from among the existing Service Coordinators, created a small shift in operational procedures. Most notable was the initiation of a specialized form created for referrals to these individuals (See Appendix 1).

### ***Study Findings***

The study findings draw on multiple methods, including quantitative, qualitative and observational data, as described above. The findings are organized into three categories:

(1) The Habilitation Training; (2) Organizational Changes and the Role of the Memory Support Specialists; and (3) Other findings. Each section also provides specific information regarding the challenges and level of effort required for implementation, in the hopes that such detailed descriptions may be useful to this report's readers and all those who wish to build on and replicate this project.

#### **1. Habilitation Training**

##### ***Training Implementation***

Key staff at JCHE were aware of the Alzheimer's Association of MA/NH's innovative training, and favored its use for this project, and of the fact that this training had been developed with nursing home and assisted living personnel in mind. The original intention was to work with the Alzheimer's Association to modify the training prior to implementation for this project.

However, as the co-developer of the training, Alzheimer's Association Vice President Paul Raia was unexpectedly unavailable due to protracted health problems, it was decided to go ahead with the existing "Train the Trainer" program and adapt it as needed internally. Other housing providers who choose to use existing trainings are likely to encounter similar issues, as most dementia trainings were developed for family caregivers or personal care workers in nursing and assisted living settings.

Of the eight staff and one student intern who attended the "Train the Trainer" training offered by the Alzheimer's Association, seven ultimately became trainers, and one of those left before the end of the training, so that the bulk of the training was done by six individuals.

The Memory Support Team had initially expected that they would be able to provide at least some parts of the training to all 105 JCHE staff, it soon became clear that this was an unrealistic goal for the short duration of the pilot project. Due to scheduling difficulties, most food service employees, and overnight emergency personnel, did not receive training during the pilot period.

Just over 50 hours of training was offered, with each module being scheduled multiple times at multiple locations over a four month period (July through October). This was intended to enable staff members to attend the sessions that best matched their schedules. Of the 84 staff who were invited to participate in the training, 74 attended at least two sessions. (See Table 1).



### *Learning as Measured by Pre- Post-Test Scores*

The Alzheimer's Association had developed a test to gauge the learning levels of trainees, who are more typically personal care workers (home health aides and certified nursing assistants). This multiple choice test was comprised of ten questions for each module. While the test was not designed for this very different trainee population, JCHE utilized it as a pre- post-test. Of the 74 staff members who attended trainings, 68 completed pre- and post-tests for at least some of the modules they attended (See Table 2).

Modules that showed the greatest overall improvement between pre- and post-test were *The Brain and Alzheimer's*, *Overview of Habilitation Principals and Behavior and Communication*. However, given the basic level of the questions, most of the respondents obtained scores of nine or ten out of ten on the pre-test for most modules, leaving little room for improved scores, even if the trainee had increased his understanding considerably. This accounts for the small variation between the pre- and post-test scores overall. More interesting is an analysis of the outliers.

For example, the average pretest score for Module 1 was 8.5 and the post-test score was 9.1, a 7% improvement (i.e. on average less than one more correct answer at post-test than at pre-test). However, the 61% of trainees with the top scores had little or no room for improvement. Looking at the four trainees with the lowest pre-test scores, who presumably had the most potential to improve their scores, these only averaged a two point improvement, from an average of 4.75 to 6.75, with two trainees actually having lower post test scores. Further exploration is needed to determine why some of the lowest achieving trainees failed to improved, while others did considerably better at post-test.

### *Satisfaction with the Training and Descriptions of Its Utility*

Satisfaction questionnaires filled out by half (N=37) of the 74 attendees (Table 3) revealed considerable enthusiasm about the benefit of the training. Even those who had the most prior training and experience voiced such opinions as “my patience and tolerance level when asked the same repetitive question is far, far higher” and “the training changed my attitude. My responses are more helpful. . . . I have more tools to redirect. . . . [my goal is to] make them FEEL better.”

Their five favorite modules were: *Understanding Alzheimer's and Dementia*; *Behavior and Communication*; *Communication Skills*; *Activities and Purposeful Engagement*; and *Working with Families*. As might be expected, the module people felt was least valuable was *Approaches to Personal Care*, despite the fact that this module had been modified to make it more relevant to housing providers.

Overall the respondents were enthusiastic about the value of the trainings. They offered such comments as:

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“At the front desk, I use all skills learned from the training”  
“I found better ways to address the tenant who asks repetitive questions”  
“I am less likely to ask for people to try to remember something”  
“To explain communication/behavior issues to residents”  
“To discuss individual resident issues and how to deal with them with staff, maintenance in particular”  
“My awareness and patience and tolerance level when asked the same repetitive question is far, far higher”  
“Finding different approach to dealing with people with dementia”  
“It has helped me better identify those with dementia”  
“Improved and using better ways to talk with the tenants showing early signs of dementia”  
“I have been working with a family who isn't knowledgeable about the progression of dementia and it is easier to talk to them”  
“Enhanced positive emotions of the individual”  
“I have looked at behavior in a different way and achieved a different level of understanding”  
“Also helpful in explaining things to families”  
“I feel more professional in my job”  
“Happy affect”  
“Been more aware of situation”  
“Look from more theoretical point of view”  
“Been more aware and observe residents behavior more”  
“The way I approach people”  
“Lighting decisions”  
“Approaching various people affected by dementia”  
“I gave someone with dementia a clerical job - it was like giving her a million dollars!”  
“Understanding why some residents act the way they do”

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Similar themes arose during the more in depth focused interviews:

“People are looking more, communicating when they see something ‘odd.’”  
“Eyes are opened; it’s bringing more insight to us.”  
“I’ve seen many positive interactions by staff at all levels.”  
“Definitely worked for the maintenance guys. . . .Feeling how heavy a healthy brain was compared to a brain affected by Alzheimer’s.”  
“Now I understand that it is part of the disease. I need to behave like I never told her before.”  
“It helped to know what is going on in her brain.”  
“Now I wouldn’t say I just told you this. Instead give a compliment or something to help her to have a positive emotional experience.”

Those with considerable background and experience emphasized how it gave them a deeper understanding of the need to generate positive emotions. For example: “What happened to me is, well you tend, when someone comes in 8 times asking the same question, well, I’m always polite, but it’s tiring. My attitude changed. My responses are more helpful, I have more tools. I can help them to leave feeling better than when they came in.”

Another theme was the ability of staff that had been through the training to be better at explaining situations to families, other staff, volunteers and particularly the residents’ neighbors and friend. For example, when a resident lost her ticket for a trip “I gave the staff the words ‘come to my office, I’ll get you another ticket.’”

Those with less prior experience had similar responses: “If someone was lost we’d bring them back [to their apartment]. Now we bring them back AND we tell someone.” “The biology helped . . . the resident doesn’t have control, she’s not doing it purposely.” “Props really helped. Feeling the difference between the weight of a healthy brain and the brain of someone affected by Alzheimer’s.” “Role playing was good. How to react if someone was angry. Not to startle someone. Stay at eye level.”

Several of the informants noted that the cross department training was very helpful. “It was good to hear from maintenance. It was multidisciplinary, interactive.” And “when I noticed an issue in the dining room it’s easier for me to discuss with them [the wait staff]. They give more clues, more specifics, not just ‘he’s annoying.’ One resident came through the line six or seven times. The wait staff themselves came up with a solution: they give the resident a small portion, so when he comes back they can give him more without having to charge for a second meal.”

A respondent gave an example of how the training improved one resident’s outcome. Prior to the training she had failed the test required to allow unsupervised access to the gym. “We took her key away. She was very angry.” Following the Habilitation training, the Memory Support Specialist “did an intervention with the resident and her family.” They helped her recognize that she could still use the gym when someone was there to offer support, and with the family’s encouragement “she went away happy.”

Because JCHE has an unusually rich array of available services and cutting edge programs, informants tended to focus on how this program enhanced the effectiveness of other JCHE initiatives. For example, JCHE has instituted a falls prevention program. They have added information on how cognitive impairment may lead to falls in their training. In addition, when they have had to restrict someone who is a fall risk due to dementia from using the gym unsupervised, they had the tools to work with the resident and her family to make this change more understandable and acceptable.

Several interviewees saw the training as being particularly helpful to those who were less familiar with dementia. For example “Every year our tenants must be recertified that they are eligible. The compliance officer saw one lady who always used to have all her financial paperwork in good order. This year she didn’t have anything ready, everything was a mess. I talked to the person, verified the changes, and then talked to her son. He said he would take her to the doctor, that he would help her with check writing. . .”

### *Suggestions for Improving the Training*

Test scores, the paper and pencil survey and qualitative interviews all suggest five potential areas for improvement of the training program:

- a. Follow up with staff who got less out of the training: A small numbers of trainees, whose test scores were low at retest, did not learn as much as might have been expected. The reasons for this are not clear, but may include language barriers, or lack of motivation. One informant who had attended the training reported that residents sometimes get lost coming to her office. “I tell them ‘calm down, don’t worry, be happy, you will get better. . . . I don’t pay a lot of attention to their dementia. It’s not my responsibility. It is my responsibility to [describes job tasks].” This suggests that there was little follow up on those with poor scores, and there is no formal mechanism in place to assess the extent to which individual staff members have benefited from the training.
- b. Select trainers with more experience or provide support to novice trainers: Trainee satisfaction surveys and analysis of focused interview data point to some variation in the skill level of these trainers, with some offering more compelling sessions than others. “Some trainers were better than others.” “They could make it more interesting.”
- c. Customize training to prior educational and experience level of the trainees. Test scores, interviews and the paper and pencil survey results all suggest that the training for the more experienced trainees should be adapted to better meet their level of knowledge and sophistication: “I learned this in grad school.”
- d. Gear the training more explicitly toward the needs of housing providers: “some of the topics were geared toward nursing homes. I think we did a pretty good job adapting, but they should be rewritten for housing.”
- e. Shorten training and make it more convenient. Staff also suggested that they would prefer that the training be shortened, that it be held in more locations, and that each module be offered more times, spread over more months.

These suggestions are combined with the data gathered about the initiative as a whole and are used in the recommendations section below.

### Implementation of a Referral System and other Organizational Changes

#### *Description of System*

Jewish Community Housing for the Elderly is unique in the availability of a comprehensive range of services offered to its residents. These include fitness, wellness, and computer spaces and programs, two different homecare programs that are affiliated with JCHE, on site dining and home delivered meals and convenience stores, transportation services, Adult Day Health, and several enrichment activities, such as the “Generations Together” initiative.

Approximately 60% of the residents receive in home services. Residents are assisted in accessing these, and other services such as Medicaid benefits, physical and mental health services, and food stamps, by the Resident Service Coordinators.

Prior to the initiation of this project, there were fourteen full and part time Service Coordinators. Much of the funding for these positions is provided by HUD, and is supplemented by grants and JCHE’s considerable private fundraising efforts. Due to this high level of service, the length of stay

averages 12.7 years. However, there was no formal system for specifically addressing the needs of people with dementia.

Recruiting a Dementia Specialist for this Service Coordinator position was much more difficult than anticipated. This was particularly true in this case, as the most pressing need was for a Russian speaker who had the cultural knowledge to assist older Russian immigrants with cognitive impairment. Members of the memory support team contacted numerous schools (Boston University, Boston College, Simmons University, University of Massachusetts/Boston), agencies (Alzheimer's Association, Jewish Family and Children's Services, Jewish Vocational Service), and membership organizations (Massachusetts Assisted Living Facilities Association, National Association of Social Workers, Russian-Jewish Foundation, Massachusetts Gerontology Association) to try to find the right person. After a lengthy search, a suitable candidate was hired but left after two months. The second Dementia Specialist served during the last three months of the pilot, and has reportedly been successful in this role.

With heightened awareness and the formalization of a referral system, informants suggested that residents were more likely to be noticed and given services. "I like the fact that there is a specific form and one designated person responsible for dementia cases."

Staff overall were pleased with this new system. "It has changed the work flow. Marina [the new, designated Memory Support Specialist] has taken on the more difficult cases. She explains well what is going on with the person, good at communicating when she makes a referral. Marina is very positive, kind and professional without her own need to go above tenants and coworkers."

An important component of the project has been the monthly meetings with Dr. Raia at the Alzheimer's Association. Several of the interviewees discussed their more complex cases, and expressed their appreciation for these opportunities to find ways to serve their more difficult residents, or to get support in helping a resident transition to a higher level of care.

#### *Analysis of referral and service records*

Prior to the implementation of this initiative, there was an informal referral system, whereby staff who noticed a resident who seemed to need services may tell a Service Coordinator of the issue, send an email, fill out an incident report, or leave a note for him/her. A standard referral form was developed for this project, as much for use in the evaluation as to facilitate referrals for those residents who showed signs of cognitive impairment. The informal system continued to operate in parallel with the formal referrals. Once the formal referral system was put into place, toward the end of the pilot project period, thirteen referrals were made using the form developed by JCHE in conjunction with the project evaluation team.

When a resident was referred to one of the Memory Support Specialists, she would contact that person and invite him to drop by her office. If the resident was not able or willing to come to the office, she might meet them at his or her apartment or at another location in the building.

Prior to this project, many people with cognitive impairment were not being referred for services. "It used to be, if someone was lost, being nice, maintenance would bring him back [to his apartment]. Now they'd follow up, bring him back AND tell someone." It appears that the combination of a

formal referral process, a designated “specialist” and the encouragement of the training led to an increase in the numbers of people with cognitive impairment being referred for services.

As stated, a total of thirteen formal referrals were made using this system. The most common reasons for referral were “getting lost/wandering.” Based on the qualitative interviews it seems that simply needing help with way-finding might not have been a common reason for referral, while wandering in a way that was potentially dangerous or intrusive to neighbors would trigger a referral. Behavioral/psychological issues, such as delusional ideas, depression, anxiety, and paranoia were the second most common reason for referral to one of the Memory Support Service Coordinators. Those with psychiatric symptoms were clearly more challenging for the staff. Assisting a resident with simple confusion and memory issues was relatively straightforward for this sophisticated team and did not necessarily trigger a referral, as can be seen by the fact that only one instance of “asking repetitive questions” was listed as a reason on the referral form.

<b>Reason for Referral (N=13)*</b>	
Getting Lost/ Wandering/ Not oriented to place	9
Paranoid ideation, hallucinations, delusions	6
Not oriented to time or person	5
Going into other people’s apartments	4
Tearful, depressed, having anxiety	3
Family/caregiver concern	2
Verbal aggression	1
Poor personal hygiene	1
Asking repetitive questions	1
*Multiple reasons may be given for referral	

Some of the reasons staff did not make referrals for residents who appeared to be having cognitive difficulties included not wanting to embarrass them, and “the family takes care of them . . . they already have a live in aide.”

*Services Provided to Cognitively Impaired Residents during the Pilot Project*

Many residents with cognitive impairment received redirection, assistance or encouragement without being formally referred to the program. Even those residents who were referred for formal services were not told that they were part of a special program. A data collection form was developed to track the interventions of staff (See Appendix 2). Specific interventions included contact and involvement of the family (N=7), referral to a health care or service provider (N=7). These included two to their primary care physicians, three to a psychiatrist, two to receive home care services, and one to receive medical alert and safe return bracelets. One was enrolled in the on-site Adult Day Health.

***Other Study Findings***

To obtain in depth perspectives on the project’s overall effectiveness, the researcher conducted focused individual interviews with a purposive sample of eight key staff who were involved in the program. These staff represented three of the four JCHE sites, and a range of departments, including administration, finance, maintenance, fitness/wellness, members of the MST, and regular Service Coordinators. Many of their insights were incorporated into the findings about the Habilitation Training and the Memory Support Resident Services. This section focuses on additional issues and insights raised by the informants, and is organized by theme.



### Neighbors, Families and Cultural Issues

Over half of the residents are Russian immigrants, while nearly a quarter have emigrated from Asia. They, their fellow residents, and often their families, are unfamiliar with our concept of a physiological etiology for dementia. This, added to a cultural disinclination to discuss private issues and a distrust of government and public agencies, adds an additional layer of reluctance to the common difficulties people experience when faced with the changes brought about by Alzheimer's and related disorders.

Because of this, residents who were referred to and received services from a Memory Support Service Coordinator were not told that they were receiving specialized services. Nor did the Memory Support Team choose to invite families or tenants to trainings or in any other way advertise the initiative. "More than half of our population is Russian speaking. They won't come to ANY program." "In Russia people fear being put in a mental institution." "No family [from either the culturally Russian or Asian communities] would come to a session. They wouldn't want anyone to know their parent has Alzheimer's."

However, now that the project has been successful for staff at all levels, several of the informants advocated for resident training sessions: "I think it would be really important for the tenants to be trained. They're not very tolerant...[when we provided them with suggestions for interacting with their cognitively impaired neighbors] they have been kinder. It would have to be much abbreviated. Just the basics in one or two sessions."

### When Should Residents Move Out?

Despite the fact that more than half of all residents receive in-home services, and many get support from families, who continue to serve as caregivers, the informants saw many gaps in services that could make the difference between a resident who does not need nursing care being able to stay in the community vs. moving to a nursing home. "One person was progressing to the point where we thought she might need to move. Now she was referred to Adult Day Health and evening homecare."

Wandering and other unsafe behaviors were also a concern. Interviewees suggested that technology might be used to monitor resident whereabouts, allowing them freedom while enhancing safety.

Several informants questioned whether as many people with cognitive impairment could age in place in less service rich buildings: "The idea of this building is different from anywhere else. The whole model is unique. . . . Yes it [the Memory Support Initiative] could be replicated – if you had the whole model."

Informants also raised questions about how far a senior housing "landlord" could and should go in supporting residents to age in place. "I'm realizing there are constraints. Behaviors that have an impact, that impinge on the community. They are always ready to go above and beyond. Is it still safe?"

One interviewee asked "Can we do a Mini-Mental Status Exam [the standard 10 question quiz used in many settings to gauge someone's level of cognitive function]." While another asked "what are the implications if we think someone is very [cognitively] impaired?" and "What about dementia AND mental health problems?"

Several of the Service Coordinators saw the need for even more continuity of services. For example, some residents participate in the Adult Day Health (ADH) Program and also receive evening home care services. But there is a gap in the afternoon between the two, during which the residents may wander in the building or be unsure what to do. One recommended that the ADH program be extended until late afternoon or even into the evening.

## ***Conclusions and Recommendations***

### **Limitations of the Evaluation**

As participation in the written survey and the focused interview was largely voluntary, it is likely that those who were less interested in or enthusiastic about the initiative did not offer their views. Also, given level of effort and time needed to fully implement a program like this, the number of cases collected was small and possibly not representative of those residents who will be referred in future months. Further, those participating in the final focused interviews had only observed a few months of a fully operating program and had had little time to reflect on the efficacy of the program and the opportunities for improvement and next steps. Several informants expressed the expectation that this report will assist them as their reflection and planning goes forward in the coming year.

### **Recommendations for Consideration Internally by JCHE**

As JCHE incorporates this program into their ongoing operations they may choose to do the following:

1. Continue to provide staff education in dementia
  - a. Offer “refresher” courses to existing staff, perhaps annually
  - b. Work with the Alzheimer’s Association to further adapt the training for use in senior housing
  - c. Offer the training to dining staff, site reps and other key staff who were not able to attend the trainings during the pilot period
  - d. Offer the modified version of the Habilitation Training to all new staff
  - e. Address the needs of staff who don’t improve their scores on the post test, and offer those individuals additional training.
2. Expand Services:
  - a. Improve I&R capability to include more knowledge of services specific to people with dementia, such as neurologists and geriatric psychiatrists
  - b. Build on existing links to outside service providers, including providing such providers with Habilitation or similar training
  - c. Expand ADH hours and capabilities
3. Offer dementia sensitivity training to residents and families. This will have to be handled carefully due to the continued stigma among the tenant population. One informant envisioned a flyer saying something like: “Come learn how to be part of a caring community: Tips for helping your neighbor with memory impairment.”
4. Advocate for more Medicaid-funded services for low income seniors with cognitive impairment.
5. Consider the potential for technology as one mechanism to allow residents with cognitive impairment to age in place.
6. Seek funding for continuation of the Memory Support Initiative and for research on cost savings, increased length of stay and other potential benefits of this program.



### Recommendations for Consideration by other Senior Housing Providers

1. Work with their Alzheimer's Association Chapter to identify a suitable training program and work with them on an ongoing basis to ensure staff support for the most complex resident situations.
2. Provide all staff with basic training about dementia, including understanding changes in the brain, expected behaviors, and interactive tools for teaching how to foster positive emotion. Based on feedback from the trainees at JCHE, this training should be geared toward the needs of housing providers rather than hands on caregivers, should be shorter than the 12 hour training piloted here, and should, if possible, be given at each location and on multiple days, allowing staff to work the training more easily into their work schedules.
3. Use a brief post-test or otherwise gauge the trainees increased understanding of key training topics.
4. Provide similar, though shorter, sensitivity trainings for residents, volunteers and resident families.
5. Assess current internal and external services available for residents with cognitive impairment, and develop a plan for adding/improving such services
6. Consider the potential for technology
7. Designate one or more staff (depending on numbers of residents served) who have more in-depth expertise in working with this population and develop a referral system so that staff who have other job duties or less expertise know who to turn to when they see a resident who needs help.

### Conclusions

This appears to be a valuable program that is worth continuing, replicating and expanding. JCHE has made significant progress in a short time to institute both the training and specialist referral models. Further refinement is likely to produce even more robust results in both staff capability and resident services. More research is needed to determine the efficacy of the program in extending length of stay in senior housing and reducing unnecessary hospitalization and institutionalization.

# Table 1

## Staff Training Attendance by Module

	For Staff Invited to attend Modules 1, 2, 3, 4 & 8								
	Module 1	Module 2	Module 3	Module 4	Module 5	Module 6	Module 7	Module 8	Module 9
Invited	33	33	33	33				33	
Attended	27	27	28	28				25	
Percent	82%	82%	85%	85%				76%	

	For Staff Invited to attend Modules 1, 2, 3, 4, 5 & 8								
Invited	5	5	5	5	5			5	
Attended	5	5	4	4	3			4	
Percent	100%	100%	80%	80%	60%			80%	

	For Staff Invited to attend Modules 1-9								
Invited	45	45	45	45	45	45	45	45	45
Attended	40	40	42	42	26	26	31	33	31
Percent	89%	89%	93%	93%	58%	58%	69%	73%	69%

Total Invited	83	83	83	83	50	45	45	83	45
Total Attended	72	72	74	74	29	26	31	62	31
Percent	87%	87%	89%	89%	58%	58%	69%	75%	69%

## Table 2

### Pre- and Post-Test Results

### Habilitation Training

### (N=68)

Module 1 Section A		Module 1 Section B		Module 2		Module 3		Module 4 Section A		Module 4 Section B		Module 5		Module 6 Section A		Module 7		Module 8 Section A		Module 8 Section B		Module 9		
Pre-Test	Post-Test	Pre-Test	Post-Test	Pre-Test	Post-Test	Pre-Test	Post-Test	Pre-Test	Post-Test	Pre-Test	Post-Test	Pre-Test	Post-Test	Pre-Test	Post-Test	Pre-Test	Post-Test	Pre-Test	Post-Test	Pre-Test	Post-Test	Pre-Test	Post-Test	
8	8	10	10	10	10	9	10	9	10	9	10	10	10	9	10	6	9	9	10	10	10	10	10	
10	10	10	10	10	10	7	8	10	10	7	10	10	10	5	9	10	10	9	9	10	10	9	10	
7	7	7	10	8	10	10	10	9	10	9	10	7	10	10	10	8	10	9	8	9	8	9	10	
5	4	3	4	7	10	10	10	10	10	10	10	8	8	8	9	9	10	10	10	10	10	10	10	
9	10	6	10	8	10	10	10	9	10	9	10	9	10	8	9	10	9	10	9	10	9	10	7	
9	9	10	10	6	8	10	10	9	10	10	10	9	10	9	10	10	10	6	5	1	5	10	10	
9	10	8	10	8	9	10	10	10	10	10	10	9	10	10	10	10	10	7	8	9	9	10	10	
10	9	9	10	8	10	10	10	10	10	4	5	9	10	10	10	10	10	10	10	10	10	10	10	
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8	9	10	9	9	10	10	10	9	9	10	10	10	10	10	10	8	9	10	10	10	10	7	9	
7	10	9	10	8	9	10	10	5	7	10	10	6	6	9	9	6	8	9	10	10	10	10	10	
9	9	5	10	10	10	10	10	10	10	10	10	8	9	9	9	9	9	9	10	9	10	10	10	
10	10	8	10	10	10	9	10	10	10	10	10	8	10	10	10	9	9	5	6	9	10	10	9	
10	10	8	10	10	10	8	6	10	10	10	10	9	9	8	9	9	9	7	9	10	10	8	8	
7	7	6	7	10	10	10	10	9	9	10	10	9	10	6	10	9	9	8	10	10	10	9	10	
9	9	8	10	10	10	10	10	9	10	10	10	8	9	9	10	8	9	10	10	10	10	10	9	
6	9	5	7	8	10	10	10	10	10	10	10	9	9	10	10	10	6	10	10	9	9	10	10	
4	8	2	5	7	9	9	9	10	10	10	10	8	9	9	10	8	9	9	10	9	10	10	10	
4	6	5	7	7	8	10	10	10	10	9	10	8	9	8	9	10	10	7	10	10	10	10	10	
10	10	10	10	7	10	9	6	9	10	9	10	10	10	9	9	10	10	10	10	10	10	9	10	
9	9	8	9	7	9	10	10	8	9	10	10	9	9	9	8	10	10	10	10	10	10	10	10	
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7	10	10	10	6	8	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	8	7	10	10
9	9	10	10	6	10	9	10	10	10	10	10	9	10	9	10	9	10	9	9	7	9			
7	8	10	10	8	9	10	10	10	10	8	10	10	10	10	10			10	10	8	10			
8	9	4	10	8	9	9	10	9	10	10	10	10	10	10	10			10	10	8	8			
9	9	6	10	8	10	10	10	10	10	10	10	10	10	10	10			6	9	10	10			
8	8	8	10	7	8	9	10	10	10	9	6				8	10		6	6	10	10			
10	9	9	10	10	10	10	10	10	10	5	10							5	8	10	10			
10	10	9	10	10	10	7	10	10	10	5	7							4	4	10	10			
9	10	10	10	9	10	10	10	8	8	10	10							8	9	1	4			
9	9	6	5	8	10	10	10	10	10	10	10							10	10	10	10			
10	10	5	10	10	10	9	10	10	10	10	10							10	10	8	9			
10	10	10	10	8	8	5	7	9	10	10	10							8	10	10	10			
9	10	10	10	7	9	9	9	8	9	10	10							6	7	10	9			
9	9	7	10	9	10	10	10	10	10	10	10							10	10	10	10			
10	10	7	10	10	10	10	10	10	10	10	10							10	8	9	10			
8	10	6	10	9	9	10	10	10	10	10	10							10	10	10	10			
9	9	8	8	9	10	10	10	10	10	10	10							10	10	7	7			
10	10	4	10	6	10	10	10	10	10	10	10							10	10	10	10			
9	10	7	8	10	10	10	10	10	10	10	10							9	10	9	10			
9	8	8	10	7	10	10	10	9	10	10	10							10	10	9	9			
8	9	7	10	7	10	10	10	10	10	10	10							6	10	10	10			
9	9	8	10	8	10	10	10	10	10	10	10							6	10	9	9			
8	9	7	10	4	4	10	9	10	10	10	10							9	10	10	10			
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8	10	9	10	9	9	10	10	10	10	10	10							10	10	10	10			
7	10	8	9	5	10	10	10	10	10	9	9							7	7	10	10			
9	9	10	10	10	9	10	10	10	10	10	10							9	10	10	10			
9	9	6	10	7	10	10	10	10	10	6	8							9	9	9	9			
8	9	8	10	9	9	10	10	10	9	8	10							9	8					
10	10	6	8	8	8	10	10	10	10	10	10							9	10					
9	10	8	10	6	9	5	6	9	10	7	7							7	9					
9	10	4	4	8	10	10	10	10	10	9	10							10	10					
9	9	8	9	3	6	10	10	9	10	10	10							10	9					
10	9	10	10	8	8	9	9	9	9	10	10													
8	9	4	10	7	8	10	10	10	10	10	10													
8	10	7	9	6	8	10	10	10	10	10	10													
9	8	7	10	10	10	10	10	6	4	10	10													
7	5	7	10	10	10	10	10	8	9	7	10													
8	9	10	9	10	10	10	10	9	10	10	10													
8	10			10	9	9	10	10	10	9	10													
10	10			5	7	10	10	10	9	9	9													
8	8			9	10	10	10	10	10	10	10													
10	10			8	10	10	10	10	10															
7	10			7	10	10	10	10	10															
7	9					10	10	10	10															
						5	7	10	10															
								10	10															
								10	10															
								9	10															
<b>67</b>	<b>67</b>	<b>61</b>	<b>61</b>	<b>66</b>	<b>66</b>	<b>68</b>	<b>68</b>	<b>71</b>	<b>71</b>	<b>64</b>	<b>64</b>	<b>27</b>	<b>27</b>	<b>28</b>	<b>28</b>	<b>24</b>	<b>24</b>	<b>55</b>	<b>55</b>	<b>50</b>	<b>50</b>	<b>23</b>	<b>23</b>	
8.5	9.1	7.5	9.2	8.1	9.3	9.5	9.6	9.5	9.7	9.2	9.6	9.0	9.4	8.9	9.6	9.0	9.5	8.5	9.2	9.1	9.4	9.5	9.7	

## Table 3

### Paper and Pencil Survey Results (N=37)

#### Training Evaluation Survey

	Golda (N=12)	Brighton (N=11)	Shillman (N=6)	Coleman (N=8)
Attended train the trainer	1	5	1	1
Led one or more modules	1	2	0	1
Attended one or more modules	9	10	5	8
Did not attend any modules	3	1	0	0

#### Value of the Modules

Most		Least	
1. Understanding Alz & Dementia	20	6. Approach to Personal Care	6
8. Behavior and Communication	9	2. Habilitation Therapy Overview	3
4. Communication Skills	7	3. Knowing and Understanding the Individual	4
7. Activities & Purposeful Engagement	5	1. Introduction to Alz & Dementia	2
9. Working with Families	5	9. Working with Families	2
2. Habilitation Therapy Overview	4	4. Communication Skills	1
3. Knowing & Understanding the Individual	4	5. The Physical Environment	1
5. The Physical Environment	2		
6. Personal Care	1		

Many people declined to answer "least valuable" or wrote "they were all good"

# Appendix 1

## Memory Support Initiative – Referral Form

Resident Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Building/Apartment Number: \_\_\_\_\_  
 Telephone Number: \_\_\_\_\_  
 Referral Made By: \_\_\_\_\_ Title: \_\_\_\_\_  
 Referral Received By: \_\_\_\_\_

Check appropriate behavior

	Getting lost/wandering		Not oriented to time
	Going into other people’s apartments		Not oriented to place
	Dressing differently		Family/caregiver concern
	Seeing things		Asking repetitive questions
	Hearing things		Constantly returning meal
	Bill paying/writing checks incorrectly		Losing things and accusing others of taking them
	Forgetting to turn off water, stove, other appliances		Not taking part in activities when they previously were active
	Not recognizing children, spouse or friends		Not having proper hygiene (specify)
	Having behavior issues ___ Verbally aggressive ___ Annoying neighbors		Other : _____

Additional Notes:

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## Appendix 2

# Memory Support Initiative - Data Collection Form

Resident Name: \_\_\_\_\_ Date: \_\_\_\_\_

Building/Apartment Number: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Check appropriate type of intervention

	Referral to family Who: _____
	Referral to provider <input type="checkbox"/> GCM <input type="checkbox"/> Neurologist <input type="checkbox"/> PCP <input type="checkbox"/> ASAP or Home Care agency <input type="checkbox"/> Other: _____
	Redirect MSI participant
	Spoke with current provider <input type="checkbox"/> GCM <input type="checkbox"/> Neurologist <input type="checkbox"/> PCP <input type="checkbox"/> ASAP or Home Care agency <input type="checkbox"/> Other: _____
	Utilized skills from MSI training
	Brief, in the moment training for staff/volunteer that is interacting with the MSI Topic covered: _____
	List skills we are looking to track: _____ _____ _____

Additional Notes:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_