



Picking up the pace of change: Scaling services for a changing caregiver profile

Evaluation of the California Caregiver Resource Centers' service delivery and system change

Reporting Period: July 2021-June 2022

Submitted by the Family Caregiving Institute, November 1, 2022

UC DAVIS
HEALTH

BETTY IRENE MOORE
SCHOOL OF NURSING

Family Caregiving Institute



Evaluation Team

Investigators:

Heather M. Young, PhD, RN, FAAN | Co-Principal Investigator

Janice Bell, MN, MPH, PhD, FAAN | Co-Principal Investigator

Jennifer Mongoven, MPH | Co-Investigator

Study team:

Benjamin Link, BS

Jessica Famula, MS, CCRP

Robin Whitney, PhD, RN

Orly Tonkikh, PhD, RN

Acknowledgements

This work is a collective effort with many dedicated individuals sharing a vision and contributing their time, energy, and effort to serve the caregivers of California. The evaluation team worked closely with the Family Caregiver Alliance (FCA) team (represented by Christina Irving and Kathleen Kelly) and the Quality Process (QP) team (represented by Brad Silen) throughout the evaluation design, data collection, and data verification process. We appreciate the leadership and commitment of the eleven CRC directors and the dedicated staff who participated in the implementation while delivering high quality services.

Table of Contents

Executive summary	1
California Caregiver Resource Centers (CCRCs) July 2021 – June 2022 Dashboard	2
I. INTRODUCTION	6
California CRC Services	7
Figure I-a: Site Catchment.....	7
Table I-a: Overview of the 11 California Caregiver Resource Centers	7
Table I-b: Core Services.....	9
Program Goals of 2019-2022 expansion	9
Timeline for CRC expansion	10
Evaluation of Program Expansion.....	10
Evaluation Design and Methods	10
Table I-c: Evaluation Data Sources	10
II. POPULATION SERVED	14
Caregiver Sociodemographic Characteristics	14
Figure II-a: Age: Caregiver and Care Recipient.....	14
Figure II-b: Gender: Caregiver and Care Recipient.....	14
Figure II-c: Sexual Identity: Caregiver and Care Recipient.....	14
Table II-a: Caregiver Sociodemographic Characteristics.....	15
Figure II-d: Racial & Ethnic Identity: Caregiver and Care Recipient	15
Table II-b: Caregiver Sociodemographic Characteristics.....	16
Table II-c: Care Recipient Sociodemographic Characteristics.....	17
Care Recipient Sociodemographic Characteristics	17
Figure II-e: Caregiver Relationship to Care Recipient	17
Table II-d: Care Recipient Health Needs	18
Care Recipient Health Needs.....	18
Figure II-f: Care Recipient Primary Diagnosis	18
Figure II-g: Care Recipient Health Service Use	18
Table II-e: Characteristics of Caregiving.....	19
Characteristics of Caregiving	19
Table II-f: Assistance with Activities	20
Assistance with Activities	20
Table II-g: Assistance with Medical/Nursing Tasks	21

Medical/Nursing Tasks	21
Figure II-h: Tasks Performed by Caregivers who Reported Performing Medical/Nursing Tasks	21
Behavior Problems Checklist	22
Table II-h: Care Recipient Memory and Behavior-Related Problems Checklist...	22
Table II-i.1: Caregiver Health and Caregiving Outcomes	23
Caregiver Health and Caregiving Outcomes.....	23
Table II-i.2: Caregiver Health and Caregiving Outcomes	24
Figure II-i: Caregiver Health Service Use in the Last 6 Months	24
III. SERVICES PROVIDED.....	25
CRC Case Status Summary	25
Table III-a: Case Status Summary – All California CRCs Combined.....	25
Intake	26
Table III-b: Caregiver Activity Summary – All California CRCs Combined	26
Assessment	26
Reassessment.....	26
Family Consultation	26
Support Groups	27
Individual Counseling.....	27
Service Grant Vouchers.....	27
Table III-c: Service Grant Voucher Totals - All California CRCs Combined.....	28
Outreach and Education	29
Figure III-a: Statewide Classes Offered.....	29
Outreach.....	29
Table III-d: Outreach and Education Terms.....	30
Table III-e: Social Media Use	31
Table III-f: Fairs, Meetings, Public Information or Outreach	32
Table III-g: Education Activities by Site	32
Education Activities.....	32
Statewide Activities.....	32
Media.....	33
Table III-h: Media Channels Used to Promote Services Fiscal Year	33
Referral Source.....	33
Figure III-b: Referral Source FY 2020-2021 vs FY 2021-2022	34
IV. CAREGIVER EXPERIENCE	35

Caregiver Satisfaction with Services	35
Satisfaction Survey	35
Table IV-a: Satisfaction Surveys: Impact of Services Between FYs 2020-2021 and 2021-2022	35
Table IV-b: Satisfaction Surveys: Comparison Between General Category Means of FYs 2020-2021 and 2021-2022	36
Caregiver Comments About Services	37
Table IV-c: Caregiver Feedback about Services	37
Caregiver feedback about the online platform	39
Table IV-d: Satisfaction Surveys: Caregiver Engagement with Online Services & CareNav™ of FYs 2020-2021 and 2021-2022	39
Figure IV-a: Satisfaction with CareNav™	39
Figure IV-b: Reasons for not Using CareNav™	39
V. IMPLEMENTATION PROCESS: CRC STAFF EXPERIENCES WITH CARENAV™	
40	
CRC Staff Interviews and Survey.....	40
Table V-a: Demographic characteristics of the interview and survey participants.....	40
Implementation process progress	40
CareNav™ utilization	41
Table V-b: CareNav™ design components and current functionality	41
Data harmonization and quality assessment	41
Outreach.....	42
Diversity, equity, and inclusion.....	43
Table V-c: Translation of CRC resources	43
Table V-d: Examples of current and future approaches to support diversity, equity, and inclusion (DEI)	44
Early outcomes	45
Table V-e: Readiness survey	45
CRC staff and leadership.....	45
Staff and leadership knowledge and beliefs, self-efficacy, and readiness for change	45
Figure V-a: Readiness Survey.....	45
Comparisons across sites, roles and hiring dates.....	46
Comparison to pre-CareNav™ training (2020)	46
Figure V-b: Baseline and two-years after comparison of knowledge and beliefs, self-efficacy, and readiness for change	46

Client outcomes 47

Site-level outcomes 48

System outcomes 49

Overarching interview themes..... 50

Developmental phases of implementation 50

 Table V-f: Developmental Phases of Implementation..... 52

Being Part of System 52

 Figure V-c: Tension: Being Part of a System vs. Autonomy 53

IMPACT..... 55

RECOMMENDATIONS..... 56

REFERENCES..... 57

APPENDIX..... 58

The photos included in this report cannot be copied or reused for other purposes.

EXECUTIVE SUMMARY

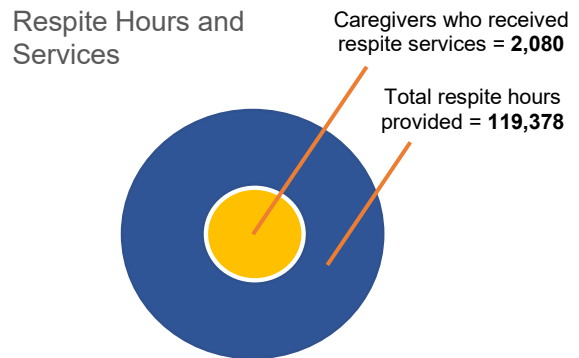
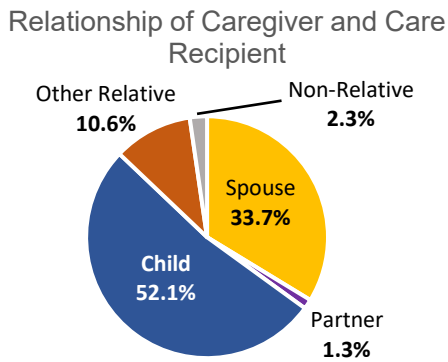
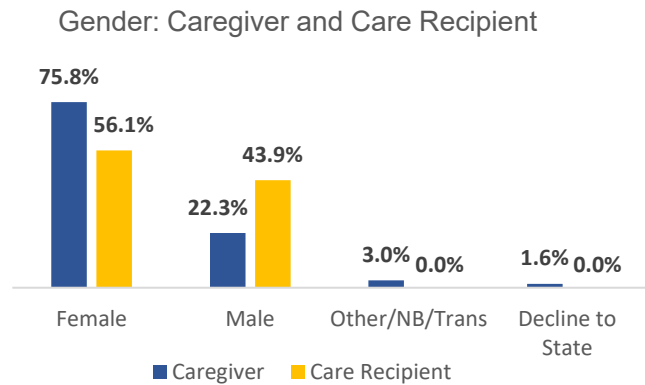
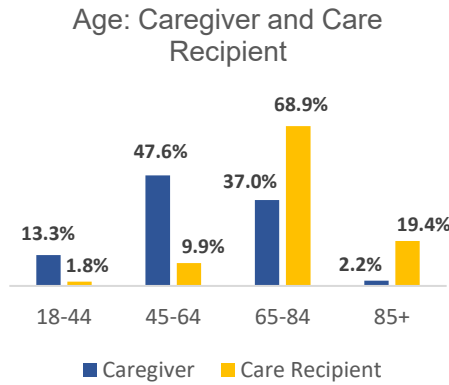
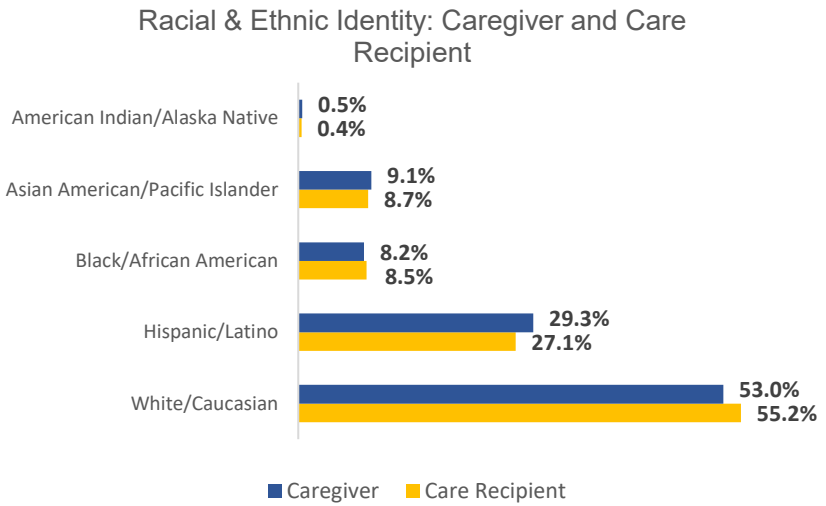
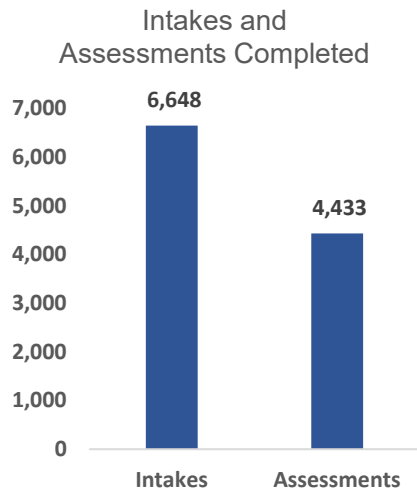
In 2019, the California Department of Health Care Services awarded the eleven nonprofit Caregiver Resource Centers (CRCs) \$30 million for the *Picking Up the Pace of Change: Scaling Services for a Changing Caregiver Profile* project. The aim was to “expand and improve family caregiver services and enhance CRC information technology services” between 2019 and 2022. Early in Fiscal Year 2021, the CRCs accomplished full deployment of CareNav™, an online system that includes data collection using a uniform caregiver assessment, a record of CRC services provided, consumer information, care plans, CRC forms, and secure communications. During FY 2021-2022, CRCs advanced to using data from CareNav™ to inform decision making in program and outreach. Over the past year, the CRC Directors focused on the following overall goals for this project:

1. Monitor and optimize data quality in CareNav™, including harmonizing data definitions and reporting
2. Increase CRC staff technical capacity and technology acquisition to scale services
3. Promote uniform quality practice and availability of core CRC services statewide
4. Increase number of family caregivers served with one or more CRC services

Across all CRCs, 14,670 unduplicated family caregivers received services from professional staff in FY 2021-2022. Of those 14,670 caregivers, 4,302 were first-time (new) CRC clients who went through intake on to full assessment and intensive services. Of all 6,648 caregivers who participated in intake screening, 4,433 (67%) completed at least one assessment. The CRCs provided one or more services such as family consultation, counseling, education, or vouchered services (counseling, legal, respite, supplemental) to 6,897 family caregivers. The total number of open cases (the sum of new and ongoing cases in the CareNav™ record) in FY 2021-2022 totaled 10,887 across the CRC system. Importantly, these counts underestimate the actual open caseload because they do not include family caregivers who entered before CareNav™ deployment. In FY 2021-2022, the CRCs provided family consultations (133,666 instances), reassessments (3,326), “in-house” counseling (174 caregivers), and vouchered services (counseling: 267 caregivers; legal: 165 caregivers; respite 2,080 caregivers; supplemental: 344 caregivers) as well as 9,884 outreach activities.

The CRCs serve diverse caregivers across the adult lifespan. Of the 4,433 caregivers who completed assessments, most were ages 45-64 years (47.6%) or 65-84 years (37.0%), and identified as female (75.8%), heterosexual (90.4%), and as married or partnered (67.9%). The CRCs serve a racially and ethnically diverse population, including white non-Hispanic (53.0%), Hispanic/Latino (29.3%), Asian American/Pacific Islander (9.1%), Black non-Hispanic (8.2%), and Native American/Alaska Native (0.5%) caregivers.

California Caregiver Resource Centers (CCRCs) July 2021 – June 2022 Dashboard | n = 4,433



Outreach and Education Activities

Outreach = 9,884
 Direct referrals, general public information/awareness activities, provider awareness.

Education = 1,039
 Programs designed to help caregivers learn new skills or educate providers about the needs of family caregivers and available resources.

Caregiver Supports

Family Consultation = 133,666 consultations

Support Groups = 1,054 clients

Individual Counseling Services = 441 clients

Legal and Financial Consultation = 165 clients

Supplemental Service Vouchers = 344 clients

Those served by the CRCs provide complex and intense care, with 90.5% providing a high level of care (based on weekly care hours and number of ADL and IADL supports). Most (82%) assisted with at least one medical/nursing task, with 40.3% reporting that performing these tasks is difficult. Caregivers devote a great deal of time to their role, with 76.2% spending more than 40 hours per week caregiving. Despite these heavy demands, 70.6% received no paid help. Caregivers experienced health issues themselves, with only about one-quarter reporting being in excellent health (6.0%) or very good health (19.5%). Nearly one third (32.2%) reported worsening of health over the past year. Caregivers reported mental health concerns, with more than half experiencing strain (59.8%), 21.2% reporting moderate to severe depressive symptoms, 32.7% reporting sleep disturbances, and 22.8% experiencing significant loneliness. On a positive note, nearly half of caregivers report being satisfied with the spiritual support they receive (43.5%). Many caregivers made employment modifications as a result of caregiving responsibilities, with 7.1% reducing work hours, 5.2% quitting their current job, 3.4% taking early retirement, and 3.3% declining a promotion.

Taken together, findings from the evaluation point to impact as follows:

CRCs serve caregivers who are providing complex, intense, and time-consuming care. Caregivers are often the primary or only caregiver in the situation and commonly have little family or paid support. They are paying the price with their own mental health, experiencing strain, worsening physical health and symptoms of depression and loneliness. The population served is in high need of services and supports. At the same time, this raises the question of how to bolster outreach to caregivers at lower risk, likely greater in number but not currently being served, who might benefit from CRC support and resources earlier in the caregiving trajectory.

Caregivers are highly satisfied with CRC services. Caregivers identify an array of benefits from their engagement with the CRCs, including tangible supports such as respite and legal assistance and emotional supports that improve confidence and capacity to care and reduce isolation. The CRCs have increased service and support during a time of significant need related to the pandemic, providing a lifeline to caregivers.

CareNav™ implementation is advancing. Sites are benefiting from real-time accurate caregiver data and are using data for decision-making regarding programs, outreach, and equity.

The CRCs are functioning as a system. The sites have a shared commitment to supporting California's caregivers and are functioning as a collaborative network, sharing ideas and resources to improve equity, inclusion, and quality.

Fiscal Year 2022 was the third year of the augmentation cycle for the CRCs. In three years, the CRCs:

- Adopted and mastered a variety of communication technologies

- Implemented a client-facing, interactive record platform to provide curated content to individual caregivers and real time data at the site level
- Participated in extensive retraining of staff on change management, how to use communication and client record technologies, retrained on service model definitions and practice issues, telehealth consults and service delivery, and increased use of social media
- Enhanced staff development in areas of diversity and clinical practice
- Expanded referral sources so that 60% of referrals come from social services or health care services
- Established statewide internal CRC committees on policy, clinical supervision, community education and staff education
- Worked with the Evaluation Team at UC Davis to submit information and data for annual reports and participated in process evaluation
- Responded to state and local requests for assistance during COVID-19
- Reorganized internally to respond to staff and caregiver service needs during the pandemic
- More than doubled all service numbers by Year 2 of the augmentation

RECOMMENDATIONS

The CRCs have expanded services and are using CareNav™ data in important ways to inform decisions and strategy. The Caregiver Resource programs could expand upon the following efforts:

- At the CRC site level:
 - Continue to review and address data quality and streamline work processes
 - Use CareNav™ data to improve program quality and responsiveness and refine outreach efforts to reach sub-populations that have yet to benefit from the CRC services and supports
- Across all CRC sites, expand public outreach and information to increase awareness and support caregivers to use CareNav™ as a resource
- At the CRC system level:
 - Refine decision support to identify and target caregivers dealing with the most complexity and most challenging situations, so that CRC staff can be alerted more readily to prioritize these caregivers for services and more frequent reassessment
 - Collaborate to develop strategies to address priority health issues for caregivers, such as loneliness and sleep deprivation
 - Identify opportunities for collaboration that leverage strengths across the system, for example, sharing bilingual staff across regions.
 - Prioritize efforts to enhance equity and inclusion, identifying potential strategies
- At the state level (California Department on Aging):
 - Consider enhanced funding to enable further service expansion

- Prioritize funding for increasing diversity, equity, and inclusion with investments in linguistic and cultural refinements of resources and supports already available in the CRC system
- Use data on caregivers and services to inform implementation of the California Master Plan on Aging and other statewide planning efforts.
- Collaborate with CRCs to advance caregiving service standards and quality



I. INTRODUCTION

Since 1984, California has been a leader in recognizing the vital role that caregivers play in the health and well-being of older Californians and those living with disability. The California Caregiver Resource Center (CRC) system was launched in 1984 by the Comprehensive Act for Families and Caregivers of Brain-Impaired Adults to support caregivers and care recipients. In 2019, California reasserted its leadership in the technological era by investing in a state-wide caregiver resource network supported by an on-line platform, CareNav™. The California Department of Health Care Services awarded the 11 nonprofit CRCs an additional \$30 million for the *Picking Up the Pace of Change: Scaling Services for a Changing Caregiver Profile* project to “expand and improve family caregiver services and enhance CRC information technology services.” The expansion of services and deployment of CareNav™ was funded to occur over 3 years (2019-2022). CareNav™ is a proprietary software platform developed with private funding by Family Caregiver Alliance with multiple use cases across sectors and populations. More information can be found on www.caregiver.org.

This investment by the State of California recognizes the high prevalence of caregiving in the U.S. and the vital role that caregivers (unpaid family members or friends) play as members of the health care team. About one in five Americans provides care to a family member¹. The complexity and intensity of caregiving for older adults and persons with disabilities is increasing, as the population ages and more individuals are living longer with challenges in physical, cognitive, and mental health. Caregivers enable family members and friends to live with chronic conditions in their environments of choice, assist with navigating acute health crises and hospitalizations, and provide comfort and support at the end of life. Over half of all family caregivers provide complex care including medical/nursing tasks previously performed in inpatient settings, delivering most of the care after discharge from hospitals². State level data reveals that in California, 4.7 million family caregivers assist individuals over the age of 18; of these caregivers, over half (56%) are employed while providing care. These individuals provide an estimated \$63 billion worth of unpaid care each year in California³. Caregivers remain relatively invisible in the health care system, to their employers and in their communities, yet they bear the brunt of delivering most of the long-term care for the aging population.

The implementation of CareNav™ and training required for start-up activities was carried out by Family Caregiver Alliance (FCA). Activities included implementing CareNav™ throughout the state, training CRCs to use the platform, and conducting educational activities for CRCs on quality improvement, change management and use of technologies. In addition to the expansion activities, two other statewide projects were included in the augmentation, an evaluation of the implementation and program activities, and statewide outreach and marketing of the CRC system. FCA conducted a call for proposals and awarded the evaluation to UC Davis Family Caregiving Institute, Betty Irene Moore School of Nursing with oversight by Family Caregiver Alliance and awarded the statewide marketing of the CRC system to Finest City Entertainment with oversight by Southern Caregiver Resource Center.

California CRC Services

Together, the 11 CRCs serve as a point of entry to services available for caregiving families in every county of California, with each site responsible for a catchment area of 1 to 13 counties (see [Figure I-a](#) and site-specific descriptions below in [Table I-a](#)). While each center tailors its services to its geographic area, all CRCs have core programs that provide uniform caregiver assessment, information, education, and support for caregivers. The CRCs provide services across income categories and the original enabling legislation included middle-income families who are often overlooked and targeted by few services. The CRCs are united by shared values emphasizing choice, collaboration, innovation, quality, participation, respect, and diversity. [Table I-b](#) summarizes Core Services of the California CRCs. The state website provides on-line access to all CRCs (<https://www.caregivercalifornia.org/>)

Figure I-a: Site Catchment



Table I-a: Overview of the 11 California Caregiver Resource Centers

Caregiver Resource Center	Counties Served	County RUCA Categorization (n)*	Population of Catchment Area	Geographic coverage (square miles)	Notes
Bay Area	San Francisco, San Mateo, Santa Clara, Alameda, Contra Costa, Marin	Metropolitan (4) Micropolitan (1) Small Town (1)	6,628,802	3,760	Serves diverse population, urban and suburban, original site for CareNav™, resources in Spanish, Chinese, Tagalog and Vietnamese
Coast	San Luis Obispo, Santa Barbara, Ventura	Micropolitan (2) Small Town (1)	1,574,257	7,876	Hosted within a hospital/rehabilitation system, does not offer legal services; resources in English and Spanish.
Del Mar	Monterey, Santa Cruz, San Benito	Metropolitan (1) Micropolitan (2)	767,748	5,114	Suburban and rural setting, fewer community resources. Serves significant Latino population, delivers Caregiver University education series, provides services in English and Spanish

Caregiver Resource Center	Counties Served	County RUCA Categorization (n)*	Population of Catchment Area	Geographic coverage (square miles)	Notes
Del Oro	Alpine, Amador, Calaveras, Colusa, El Dorado, Nevada, Placer, Sacramento, San Joaquin, Sierra, Sutter, Yolo, Yuba	Metropolitan (7) Micropolitan (2) Small Town (3) Rural (2)	3,439,752	13,133	Large catchment area across urban and rural counties, diverse need and community resources
Inland	Riverside, San Bernardino, Inyo, Mono	Metropolitan (1) Micropolitan (1) Small Town (2)	4,592,757	40,512	Programs include caregiver supports/resources, supports to seniors living alone and PEARLS (in home treatment for depression), CBT for Late Life Depression Program, and resources in Spanish and Chinese. Racially and ethnically diverse, large county with complex array of services and supports, hosted by USC Leonard Davis School of Gerontology; provides resources in several languages.
Los Angeles	Los Angeles	Metropolitan (1)	10,081,570	4,058	Racially and ethnically diverse, large county with complex array of services and supports, hosted by USC Leonard Davis School of Gerontology; provides resources in several languages.
Orange	Orange	Metropolitan (1)	3,168,044	793	Racially and ethnically diverse, Vietnamese and Spanish Speaking staff, high housing costs
Passages	Butte, Glenn, Lassen, Modoc, Plumas, Shasta, Siskiyou, Tehama, Trinity	Micropolitan (5) Small Town (3) Rural (1)	611,470	30,167	Programs include family caregiver support, information and access to community services, care management, ombudsman program, Medicare counseling; provides material in Spanish and Hmong.
Redwood	Del Norte, Humboldt, Mendocino, Lake, Sonoma, Napa, Solano	Metropolitan (1) Micropolitan (4) Small Town (2)	1,396,078	12,480	Housed within a Community Action Agency; provides material in Spanish, Tagalog, and Vietnamese.
Southern	San Diego, Imperial	Metropolitan (1) Micropolitan (1)	3,496,774	8,384	Large Latino and migrant community, Delivering REACH for Spanish speaking families, resources available in Spanish. Serves as contractor for statewide CRC media/marketing campaign
Valley	Fresno, Kern, Kings, Madera, Mariposa, Merced, Stanislaus, Tuolumne	Micropolitan (3) Small Town (4) Rural (1)	3,526,225	29,536	Programs include caregiver supports/resources, Medicare counseling, adult day programs, ombudsman programs; provides material in Spanish.

*Population and geographic data were drawn from U.S. Census Bureau tables by rolling up county level statistics.

*County RUCA codes range from 1 (least rural) to 10 (most rural) and are categorized as Metropolitan (1-3), Micropolitan (4-6), Small Town (7-9), Rural (10). See technical appendix for further detail.

Table I-b: Core Services

CRC Core Service	Description
Specialized Information	Advice and assistance on caregiving issues including stress, diagnoses, and community resources
Uniform Caregiver Assessment	Standardized intake and assessment tools to help define and explore issues, options, and information needs, to determine interventions and services for caregivers, and to provide key data for evaluation and program design
Family Consultation & Care Planning	Individual sessions and telephone consultations with trained staff to assess needs of both the person receiving care and their families, and to explore courses of action and care options for caregivers
Respite Care	Financial assistance for brief substitute care in the form of in-home support, adult day care services, short-term or weekend care, and transportation to assist families caring at home
Short-term Counseling	Family, individual and group sessions with licensed counselors to offer emotional support and help caregivers cope with the strain of the caregiving role
Support Groups	Meetings in a supportive atmosphere where caregivers share experiences and exchange ideas to ease the stress of caregiving
Professional Training	Individually tailored workshops on long-term care, health management, public policy issues, and legal/financial issues
Legal & Financial Consultation	Personal consultations with experienced attorneys regarding powers of attorney, estate and financial planning, conservatorships, community property laws and other complex matters
Education	Special workshops on topics such as diagnosis, treatment, long-term care planning and stress management to help caregivers cope with day-to-day concerns

Program Goals of 2019-2022 expansion

The goals of the *Picking Up the Pace of Change: Scaling Services for a Changing Caregiver Profile* project are to: A) Increase service delivery; B) deploy a statewide record of caregiver assessments and services; C) increase use of technologies to extend services; and D) promote quality practice and standardization of core services.

Timeline for CRC expansion

The 2021-2022 fiscal year is the third year of the *Picking Up the Pace of Change: Scaling Services for a Changing Caregiver Profile* project that includes staff training, technology installation, service evaluation and service delivery evaluation.

Planned Activities for Year 3 (FY 2021-2022) included:

- Continue service delivery; make adjustments to service model based on evaluation
- Conduct evaluation of process and service delivery model and outcomes; produce report; circulate key findings

Evaluation of Program Expansion

This third annual report (for FY 2021-2022) summarizes both the process of implementation and progress on Year 3 goals, results of aggregated data across the California CRCs regarding population served, services provided, and CRC client and staff satisfaction.

Evaluation Design and Methods

The evaluation plan was developed by UC Davis researchers at the Betty Irene Moore School of Nursing in the Family Caregiving Institute in collaboration with FCA and with input from the directors of all the California CRCs. The evaluation plan and measures were approved by the UC Davis Institutional Review Board. The evaluation includes multiple data sources and methods. [Table I-c](#) summarizes all the data sources for this report and for ongoing evaluation.

Table I-c: Evaluation Data Sources

<p>CareNav™: Intake and assessment data from July 2021 – June 2022 for analysis.</p>
<p>Outreach and Public Information Activities: CRC reports of public information and outreach activities conducted from July 2021 – June 2022. This includes activities such as: direct referrals, general public information, community education/public awareness (e.g., health fairs), provider awareness).</p>
<p>Education Activities: CRC reports of education activities conducted from July 2021 – June 2022. This includes programs designed to help caregivers learn new skills or educate providers about the needs of family caregivers and available resources.</p>
<p>Media: CRC reports of media placement (e.g., ads, PSAs) or media appearances with potential reach reported based on circulation numbers or impressions (e.g., bus ads).</p>
<p>Caregiver Satisfaction Surveys: Quarterly surveys of caregivers who have enrolled in CareNav™ or have received services from the CRC sites.</p>
<p>Qualitative Data: Focus groups, individual interviews and comments collected on surveys.</p>
<p>CRC Staff readiness survey: Anonymous survey of CRC staff conducted in Spring 2022 assessing knowledge about CareNav™, and preparation and confidence regarding the implementation process.</p>

Throughout this reporting period, all CRC sites contributed CareNav™ data. The evaluation team prepared quarterly and annual reports using data collected in CareNav™ and survey data collected from caregivers served by all sites. The evaluation team engaged directly with staff at the CRC sites to validate the data, establish shared definitions for data fields, harmonize data sources, and assure the quality, accuracy, and integrity of the data. In this report, the terms “caregiver” and “client” are used interchangeably.

Data Extracted from CareNav™ Technology Platform

CareNav™ is a technology platform that enables comprehensive and standardized caregiver assessment, a common data set across the eleven California CRCs, and access to online caregiver resources. This software was developed by Quality Process (QP), FCA’s technology partner, and deployed across the CRC sites to reduce the variability in their existing data collection tools and software used to collect and aggregate their data about the caregivers they served and the programs they administered. Members of the QP, FCA and UC Davis evaluation teams met weekly to review reports generated by the evaluation team using data extracted from CareNav™. Through this process, UC Davis analysis protocols and algorithms were refined to assure concordance with reports generated from CareNav™ and data filters were defined for the evaluation. Twice during the year, the QP, FCA and UC Davis evaluation teams met with staff at each individual CRC site. During these meetings, site-specific reports generated by the evaluation team were shared, and the group discussed and investigated any issues where the reports did not match site records or expectations. Unexpected values, outliers, missing values, and issues with data entry were identified, investigated, and resolved. In some cases, the QP team was able to implement system-level solutions to address problems identified across multiple sites. In other cases, the sites corrected individual entries as warranted. Taken together, these meetings were highly beneficial to harmonizing data for the evaluation; understanding site-specific challenges related to staffing and CareNav™ implementation; identifying needs for future CRC training; and identifying problem variables in CareNav™ that need further refinement by the QP developers to support consistent data collection across the sites. We will continue to host these productive meetings on an ongoing basis.

For the evaluation analysis, data were extracted from the CareNav™ platform for cases, activities, and service grants during the reporting period (July 1, 2021 – June 30, 2022) and transferred from Excel to Stata statistical software (version 16; College Station, TX) for analysis. Dates and times in all evaluation data sets were converted to Pacific Standard Time and data were limited to CRC clients in CareNav™ eligible for California DHCS funding, with the exception of the analysis of intakes which included all CRC clients regardless of funding eligibility because this eligibility is not always known at the time of intake assessment. A small number of case records and activities previously retired/deleted or missing caregiver county of residence was removed from the analysis set.

The evaluation results include summary statistics (counts, mean, standard deviation, percentage) for the total of all cases combined across sites, as well as for each

individual site. A case status summary was compiled including counts of total cases and by type (new cases, and ongoing cases with/without activity during FY 2021-2022 looking back within a two-year window). Intakes, assessments, reassessments were tallied by mode of service delivery (i.e., online-internet or email; telephone; in-person-CRC office, caregiver's home or community location; and telehealth). Caregiver characteristics—including sociodemographic, health, and caregiving variables—are presented for the subset of caregivers who proceeded from intake to assessment, since these cases had the most comprehensive data and least amount of missing data. The breakdown for each variable is presented as a complete case analysis (i.e., focusing on non-missing data). Reported percentages reflect the total number excluding missing values for each variable. Missing data was minimal and is discussed further in the Technical Appendix, along with methodological details about the measures used for caregiver health (e.g., UCLA Loneliness Scale, PHQ-9), and caregiver sociodemographic characteristics.

Outreach, Public Information and Education Activities

The evaluation team designed a data collection tool for sites to report their activities in the areas of outreach, public information, and education. Sites provided information on a quarterly basis, detailing the activity, medium, audience, and number of participants. These data were summarized using descriptive statistics.

Caregiver Satisfaction Surveys

The evaluation team designed a caregiver satisfaction survey in collaboration with FCA to assess satisfaction with services, confidence in caregiving, knowledge, caregiver stress, and experiences with the online platform and technology. The surveys included items rated on a five-point scale, where 5 represents the most positive response. The survey also invited comments from caregivers in an open-ended format. All caregivers who encountered the CRCs were invited to complete a satisfaction survey. Requests for participation were sent out each quarter by the sites and data were submitted to the Evaluation team for descriptive analysis.

Qualitative Data— Focus groups and individual interviews

The evaluation team conducted group interviews with leaders and staff at each site separately, for a total of 22 focus groups, and conducted 2 individual interviews with key informants from the implementation team. All current leaders and staff of the 11 CRCs were eligible to participate in these focus groups. The interviews elicited perspectives on the CareNav™ implementation and expansion of services, including COVID-19 pandemic effects, outreach approaches and perspectives on diversity, equity, and inclusion of the CRCs. The interviews were conducted and audio-recorded over Zoom in March and April 2022. Recordings were transcribed, audited, then imported into the Dedoose qualitative data analysis software. Qualitative descriptive methods were used to analyze the transcripts. Three members of the research team reviewed the transcripts and developed initial codes and definitions. Two team members coded the transcripts, then met regularly with the third member to discuss coding decisions, refine code definitions, reach consensus about the coding, and identify themes, sub-themes,

and relationships among ideas. The team maintained an audit trail of codes and refinements.

Readiness survey

All staff from the 11 CRCs were invited to complete anonymous on-line demographic and readiness surveys between March and May 2022. Demographic data were collected using a separate link, to support the anonymity of participants and included gender, age, and ethnicity. The 11-item readiness survey assessed preparation and confidence regarding the implementation process and self-efficacy using a 5-point scale (1 represents the most negative and 5 the most positive response). The survey also assessed knowledge about CareNav™, support of caregivers to get online and to use CareNav™, and perceptions about ongoing training and support. Open-ended questions identified benefits and concerns about CareNav™, and suggestions for improvement.

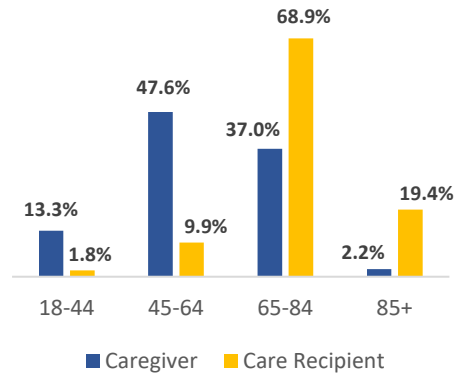
Quantitative data were analyzed using descriptive statistics. Quantitative analyses were performed using the SPSS statistical package (version 27; IBM Corporation). We used one way ANOVA (with Bonferroni adjustment for multiple comparisons 0.05/15 comparisons) to explore differences in scores across sites, roles and hiring date. Open-ended responses to the survey were imported into Dedoose, coded, and analyzed using qualitative descriptive methods. We created a subsample of longitudinal data for those respondents who also completed a baseline readiness survey in 2020 (presented in Y1 annual report). We compared baseline scores with current scores using the Wilcoxon signed rank test.

II. POPULATION SERVED

Caregiver Sociodemographic Characteristics

Across the 11 CRCs in FY 2021-2022, there were a total of 4,433 caregivers with assessment data. Most caregivers were in the 45-64yr age range (47.6%) followed by the 65-84yr (37.0%) age range (Figure II-a) and identified as female (75.8%) (Figure II-b), heterosexual (90.4%) (Figure II-c), and married/partnered (67.9%). The population is diverse, including caregivers who are White non-Hispanic (53.0%), Hispanic/Latino (29.3%), Asian American/Pacific Islander (9.1%), Black non-Hispanic (8.2%), and American Indian/Alaska Native (0.5) (Figure II-d). Detailed sociodemographic data may be found in Table II-a with additional details about income, employment changes, and insurance available in Table II-b.

Figure II-a: Age: Caregiver and Care Recipient



CRC caregivers had fairly high levels of education, with 30.9% reporting a college degree and 16.2% reporting a graduate degree. Most caregivers (96%) reported that they were the care recipient’s primary caregiver, and a small percentage reported having additional caregiving responsibilities, including providing care to a child (7.3%), disabled child (1.1%), disabled adult (3.2%), or other caregiving responsibility (3.6%). Over a third of caregivers reported being retired (36.1%), with 28.0% working full-time and 12.3% working part time. Nearly one in five caregivers were unemployed.

Figure II-b: Gender: Caregiver and Care Recipient

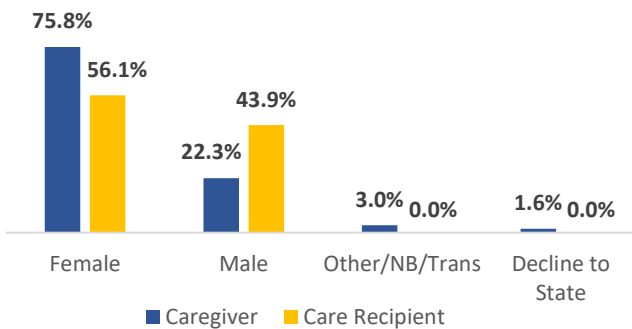


Figure II-c: Sexual Identity: Caregiver and Care Recipient

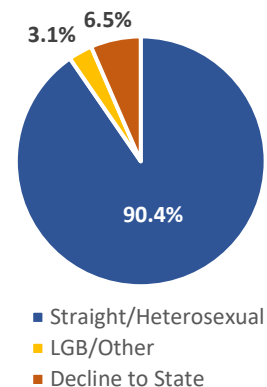


Figure II-d: Racial & Ethnic Identity: Caregiver and Care Recipient

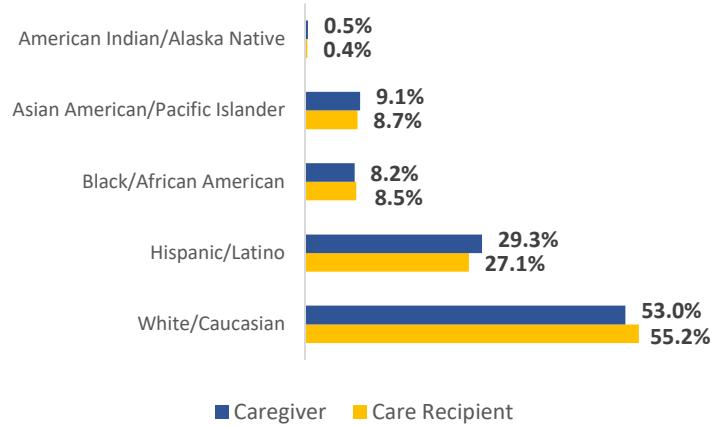


Table II-a: Caregiver Sociodemographic Characteristics

<i>n</i> = 4,433	%
Primary Language	
English	90.0
Spanish	8.3
Other	1.7
Highest Level of Education	
Some High School	3.7
High School Graduate	12.9
Some College	26.6
College Graduate	30.9
Post Graduate Degree	16.2
Decline to State	9.7
Marital Status	
Married/Partnered	67.9
Single	18.6
Widowed	3.1
Divorced/Separated	10.4
Employment Status	
Full time	28.0
Part time	12.3
Retired	36.1
Unemployed	18.8
Leave of absence	1.8
Decline to state/ Undefined	2.9
Caregiver Lives Alone	8.5
Caregiver Lives in Rural Area	12.8
Identifies as Primary Caregiver	96
Other Caregiving Responsibilities	
Care for a child	7.3
Care for a child with disability	1.1
Care for an adult with disability	3.2
Other	3.6

*Among completed assessments

*Deduplicated by caregiver; percentages may not add to 100 due to rounding

CRC participants reflect multicultural groups with a substantial proportion living below the federal poverty level

Most caregivers (70.5%) reported that caregiving did not have an impact on their employment status. However, some caregivers reported caregiving-related employment changes, such as decreasing hours (7.1%), retiring early (3.4%), or quitting (5.2%).

Among caregivers who reported household income ($n = 817$), a majority (73.5%) reported earning less than \$70,000 annually, with a substantial number (14.1%) earning below \$13,200. Similarly, 14.9% reported earnings below the Federal Poverty Level.

Well over half of caregivers reported Medicare coverage (58.2%), with about a quarter (24.5%) reporting Medicaid/Medi-Cal coverage, and around 5% being uninsured.



Table II-b: Caregiver Sociodemographic Characteristics

$n = 4,433$	%
Household Income	
Under \$13,200	14.1
\$13,200-20k	8.9
20k-30k	12.6
30k-40k	11.6
40k-55k	15.1
55k-70k	11.1
70K-80K	5.1
80k-95k	5.4
95-110K	7.2
110-120K	3.5
120k-135K	5.3
Employment Change Due to Caregiving	
No Change	70.5
Began Working	0.5
Quit Job	5.2
Changed Jobs	1.1
Decreased Hours	7.1
Increased Hours	1.2
Early Retirement	3.4
Laid Off	1.3
Declined a Promotion	3.3
Family Leave	0.5
Other Change	6.3
Income below FPL	16.7
Insurance Type	
Medicare	58.2
Medicaid/ Medi-Cal	24.5
VA Insurance	3.7
Uninsured	5.0
Other/Self-Pay	5.7

*Among completed assessments

*Deduplicated by caregiver; percentages may not add to 100 due to rounding

Care Recipient Sociodemographic Characteristics

A majority of CRC care recipients were in the 65-84 yr. age range (68.9%) followed by the 85+yr. (19.4%) age range. Just over half of care recipients identified as female (56.1%). Most care recipients were non-Hispanic White (55.2%), followed by Hispanic/Latino (27.1%), Asian American/Pacific Islander (8.7%), non-Hispanic Black (8.5%), and American Indian/Alaska Native (0.4%). Around half of care recipients were married or partnered (52.0%), with nearly a third being widowed (29.9%). Over half of care recipients were being cared for by an adult child (52.1%), and around one-third were cared for by a spouse (33.7%). Less frequently, care recipients were cared for by another relative (10.6%) or non-relative (2.3%) (Figure II-e). A majority (85.4%) receive Medicare, with around one-quarter (25.9%) receiving Medicaid/ Medi-Cal. Detailed care recipient sociodemographic characteristics are available in Table II-c.

Figure II-e: Caregiver Relationship to Care Recipient

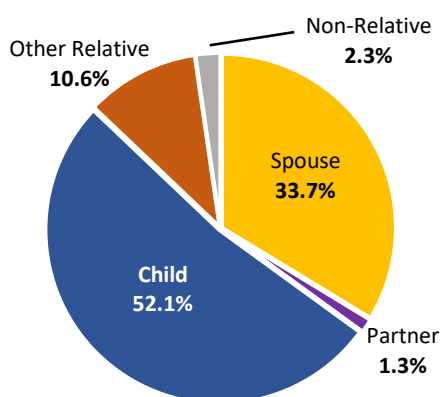


Table II-c: Care Recipient Sociodemographic Characteristics

<i>n</i> = 4,433	%
Care Recipient Age (yrs.)	
18-44	1.8
45-64	9.9
65-84	68.9
85+	19.4
Care Recipient Gender Identity	
Male	43.9
Female	56.1
Care Recipient Race/Ethnicity	
American Indian/ Alaska Native	0.4
Asian/Pacific Islander	8.7
Black/AA	8.5
Hispanic/Latino	27.1
White	55.2
Care Recipient Marital Status	
Married or domestic partner	52.0
Single	8.1
Widowed	29.9
Separated or divorced	10.1
Lives in Rural Area	
No	91.3
Yes	8.7
Care Recipient Lives Alone	10.9
Care Recipient is a Veteran	25.0
Care Recipient Medicaid Eligible	25.0
Insurance Type	
Employer Insurance	1.6
Medicare	85.4
Medicaid/ Medi-Cal	25.9
VA Insurance	5.3
Uninsured	1.1
Other/Self-Pay	2.2
Long Term Care Insurance	8.0
Income Below FPL	23.5

*Among completed assessments

*Deduplicated by caregiver; percentages may not add to 100 due to rounding

Care Recipient Health Needs

Detailed care recipient health needs are reported in Table II-d. Among care recipients, a majority required care primarily due to Alzheimer’s Disease or related dementias (69.8%), followed by stroke (11.0%), “other” conditions (7.5%), Parkinson’s Disease (6.7%), cancer (2.7%), and brain injury (2.3%) (Figure II-f). Care recipients had a mean of 3.4 comorbid chronic conditions, with 40.5% having 4 or more. For most care recipients (89.0%), caregivers reported that their medical condition was worsening.

Table II-d: Care Recipient Health Needs

<i>n</i> = 4,433	%
Number of Comorbid Chronic Conditions	
Mean 3.4, SD 1.9	
0	2.3
1	8.6
2	23.5
3	25.1
4 or More	40.5
Medical Condition is Worsening	89.0
Experiences Memory Loss	92.0
Can Be Left Alone	
Always	6.9
Several Hours	27.7
<1 Hour	21.5
Never	43.9
Wanders	15.8
Documents in Place	
Advanced Healthcare Directive	79.0
Financial Durable POA	2.2
Healthcare Durable POA	79.0
Conservatorship/Guardianship	1.1
Living Will	78.9
POLST/DNR	3.2
Unsure of documents in place	12.6

Figure II-f: Care Recipient Primary Diagnosis

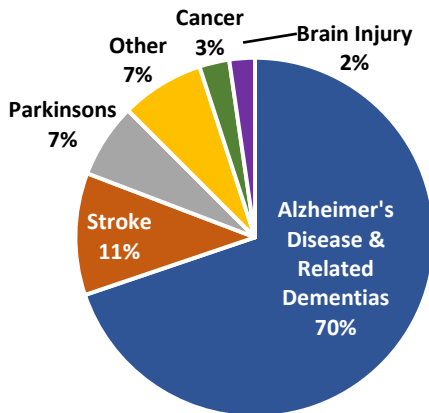
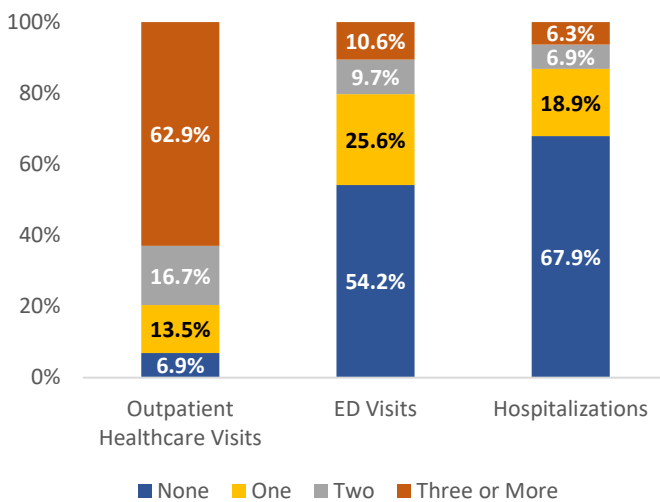


Figure II-g: Care Recipient Health Service Use



Almost all care recipients experience some degree of memory loss (92.0%), and around two-thirds require near constant care, only able to be left alone for <1hr (21.5%) or not at all (43.9%). Around 16% of care recipients also exhibit wandering behaviors. Not surprisingly, care recipients have fairly high levels of health service use. In the past 6 months, around 63% required 3 or more outpatient healthcare visits, nearly half had one or more ED visits (45.9%), and

nearly one-third had at least one inpatient hospitalization (32.1%) (Figure II-g).

Most care recipients had at least some healthcare documents in place, most commonly, advanced directives (79.0%), durable power of attorney for healthcare (79.0%), and living wills (78.9%). However, only a small percentage reported having a trust (8.3%), POLST/DNR (3.2%), durable power of attorney for finances (2.2%), or conservatorships (1.1%) in place.

Characteristics of Caregiving

Caregiving characteristics, reported in Table II-e, describe the care recipient's healthcare needs and the nature of care provided by the caregiver. Nearly one-third of care recipients had been cared for for greater than 5 years (31.2%), with a quarter (25.2%) between 2-5 years, and 43.6% 2 years or less.

Caregivers served by the CRCs are highly engaged in caregiving activities, with 76.2% spending more than 40 hours per week on caregiving activities and 82% performing medical/nursing tasks. In fact, 90.5% of CRC caregivers provide what would be considered high intensity caregiving, as determined by AARP's Care Intensity Index (based on assistance with activities and weekly hours of care). Nearly 80% of caregivers perceived that they receive either no help or less than they need from family and friends. Despite their high burden of care responsibilities, most caregivers receive very little assistance, with 70.6% receiving zero hours of paid help and 47.1% receiving zero hours unpaid help on a weekly basis.

“The help I get usually takes me by surprise that these services are available and gives me such a relief it's unbelievable. I worked all my life and quit to take care of my wife. I did not [know] people helped like this and especially on this scale.” – CRC caregiver

Table II-e: Characteristics of Caregiving

n = 4,433	%
Duration of Caregiving	
<2 Years	43.6
2-5 Years	25.2
>5 Years	31.2
Performs Medical/Nursing Tasks	
	82.1
Level of Care (AARP)	
1-3	9.4
4	21.0
5	69.5
Care Intensity (AARP)	
Low intensity	3.1
Medium intensity	6.4
High intensity	90.5
Caregiving Hours Per Week	
0-10	6.6
11-20	6.4
21-39	10.8
40+	76.2
Paid Help Hours Per Week	
0	70.6
1-10	12.3
11-20	6.7
21-30	3.6
31-40	2.9
>40	4.5
Perceived Help from Family and Friends	
No help	27.7
Less than needed	52.0
Amount needed	18.6
Don't need	1.7
Unpaid Help Hours Per Week	
0	47.1
1-10	31.1
11-20	7.9
21-30	3.9
31-40	2.6
>40	7.3

*Among completed assessments

*Deduplicated by caregiver; percentages may not add to 100 due to rounding

Assistance with Activities

Caregivers were asked about which of fifteen different daily activities they assisted care recipients with and how often they needed assistance (needs no help, a little help, help most of the time, or help all of the time). [Table II-f](#) reports the percentage of care recipients that needed at least some help on each of these activities. Caregivers assisted with a median of 13 different activities. Most care recipients required at least some help with all fifteen activities assessed. The highest percentages requiring assistance were for transportation (96.8%), shopping (97.3%), housekeeping (96.4%), preparing meals (95.8%), and managing money (95.4%). Activities with the least assistance required included eating (58.3%), toileting (68.6%), transferring (70.5), and managing incontinence (71.0%).



CRCs serve caregivers who are providing complex, intense, and time-consuming care. Caregivers are often the primary or only caregiver in the situation and commonly have little family or paid support.

Table II-f: Assistance with Activities

<i>n</i> = 4,433	%
Total Number of Assisted Activities (Mean, 11.7)	
0	0.2
1	1.1
2	3.5
3	1.4
4	1.8
5	2.3
6	2.5
7	3.3
8	3.6
9	4.5
10	5.4
11	6.5
12	7.8
13	9.9
14	14.4
15	31.9
Assistance with Activities	
Bathing/Showering	84.0
Dressing	79.5
Grooming	76.2
Eating	58.3
Incontinence	71.0
Toileting	68.6
Transferring	70.5
Mobility	78.1
Preparing Meals	95.8
Managing Money/Finances	95.4
Housekeeping	96.4
Managing Medications	93.3
Shopping	97.3
Using Telephone	79.6
Transportation	96.8

*Among completed assessments

*Deduplicated by caregiver; percentages may not add to 100 due to rounding

Medical/Nursing Tasks

The 82% of CRC caregivers who reported performing medical/nursing tasks ($n = 3,396$) assisted with a median of 2 tasks (Table II-g). The most commonly reported tasks were organizing medications (95.9%), administering oral medications (81.9%), managing durable medical equipment (53.7%), and managing meters and monitors (53.1%). The least commonly reported tasks included managing other medical devices/equipment (17.3%), administering injections (26.6%), and “other” tasks (27.7%) (Figure II-h). A sizeable minority (40.3%) of caregivers who assisted with medical/nursing tasks agreed or strongly agreed that they found this difficult, although nearly two-thirds (65.4%) agreed or strongly agreed that they felt prepared to perform the tasks.

Caregivers provide significant support for care recipients in accomplishing ADLs, IADLs, and medical/nursing tasks.

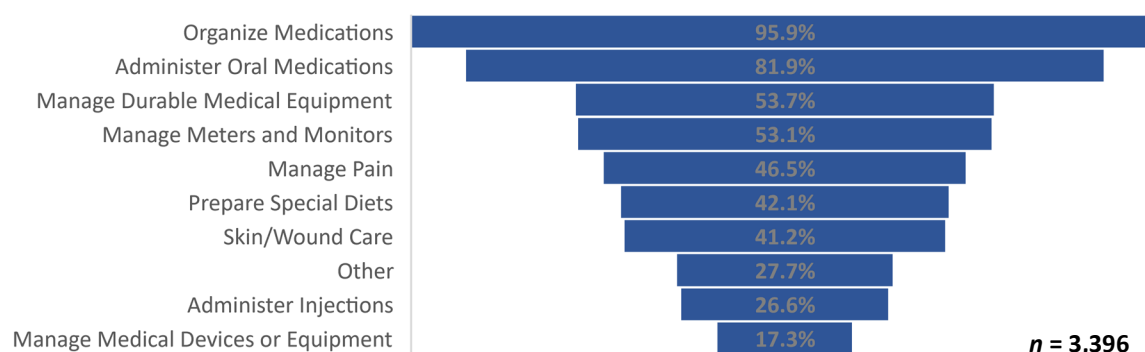
Table II-g: Assistance with Medical/Nursing Tasks

$n = 3,396$	%
Total number of Tasks (Mean 2.7)	
0	1.0
1-3	42.1
4-6	39.7
7-9	16.7
10+	0.4
Finds Medical/Nursing Tasks Difficult	
Strongly Disagree	18.3
Somewhat Disagree	18.9
Neutral	22.6
Somewhat Agree	29.4
Strongly Agree	10.9
Feels Prepared for Medical/Nursing Tasks	
Strongly Disagree	4.3
Somewhat Disagree	9.9
Neutral	20.4
Somewhat Agree	36.7
Strongly Agree	28.7

* Among individuals who reported performing medical/nursing tasks

*Deduplicated by caregiver; percentages may not add to 100 due to rounding

Figure II-h: Tasks Performed by Caregivers who Reported Performing Medical/Nursing Tasks



Behavior Problems Checklist

Caregivers who reported that the care recipient exhibited problems with memory or confusion-related behaviors ($n = 3,532$) completed a memory and behavior problems checklist, reporting on whether each of 15 behaviors occurred and the degree to which the behavior bothered them (Table II-h).



Table II-h: Care Recipient Memory and Behavior-Related Problems Checklist

$n = 3,532$	Has Occurred in the Past Week	If Yes, how much has this bothered or upset you?		
		Yes (%)	Extremely (%)	Moderately (%)
Problems With:				
Asking the same question over and over	67.1	16.6	49.0	34.4
Trouble remembering recent events	76.2	15.0	42.9	42.1
Trouble remembering significant past events	5.0	13.0	39.1	47.9
Losing or misplacing things	56.3	18.3	40.9	40.8
Forgetting what day it is	69.3	13.8	32.6	53.6
Starting, but not finishing things	48.2	13.5	42.3	44.1
Difficulty concentrating on a task	56.9	15.0	39.9	45.1
Destroying property	6.7	11.6	13.7	74.7
Doing things that embarrass you	17.0	14.1	34.5	51.4
Waking you or others up at night	5.0	21.0	39.3	39.7
Talking loudly and rapidly	13.1	13.4	24.0	62.7
Engaging in behavior that is potentially dangerous to self or others	2.7	20.1	28.6	51.4
Threats to hurt others	4.9	10.1	12.5	77.5
Aggressive to others verbally	19.8	21.2	35.4	43.4
Arguing, irritability/complaining	7.2	22.7	45.4	31.9

*Includes those who responded “yes” to the care recipient experiencing problems with memory or confusion

*Deduplicated by caregiver; percentages may not add to 100 due to rounding

The most commonly observed behaviors included trouble remembering recent events (76.2%), forgetting what day it is (69.3%), and asking questions over and over (67.1%). For these commonly reported behaviors, 13.8-16.6% of caregivers reported feeling “extremely” bothered and 6.3-8.8% wanted help addressing them.

Some less commonly occurring behaviors appear to create more stress for caregivers who experience them. For example, only 5% reported problems with the care recipient waking others at night, but among those who did, 21% reported feeling “extremely” bothered by this behavior and 38.9% wanted help addressing this behavior. Similarly, 2.7% reported that the care recipient was dangerous to self or others, 20.1% were extremely bothered by this and 14.3% wanted help.

Caregiver Health and Caregiving Outcomes

The stress of caregiving can impact the health and wellbeing of caregivers themselves. Only around one-quarter of caregivers reported being in excellent (6.0%) or very good (19.6%) health, with nearly one-third (32.2%) reporting that their health is worse than it was 6 months ago. Most (55%) of caregivers reported at least one medical condition; of these, the most prevalent were sleep disturbances (32.7%), depression (31.6%), and chronic pain (22.9%). Nearly a quarter (23.1%) reported having 3 or more medical conditions.

More than half of caregivers (59.8%) experience high caregiving strain, as measured by the Zarit Burden Interview Screening. About a third of caregivers (36.7%) are somewhat or very dissatisfied with the amount of support received from family and friends. Around one in

Table II-i.1: Caregiver Health and Caregiving Outcomes

n = 4,433	%
Self-Reported Health Status	
Excellent	6.0
Very Good	19.6
Good	41.1
Fair	26.0
Poor	7.3
Current Health Compared to 6 Months Ago	
Better	9.5
Same	58.3
Worse	32.2
PHQ-9 (Depressive Symptoms)	
None	37.6
Minimal/mild	41.2
Moderate	13.3
Moderate/severe	5.5
Severe	2.4
UCLA-3 Loneliness Scale	
Not lonely	77.2
Lonely	22.8
Zarit Burden Interview	
<8 (low strain)	40.2
8+ (high strain)	59.8
Satisfaction with Support-Family & Friends	
Very satisfied	33.7
Neutral	29.4
Somewhat dissatisfied	22.7
Very dissatisfied	14.2
Satisfaction with Support-Spiritual	
Very satisfied	43.5
Neutral	42.2
Somewhat dissatisfied	9.8
Very dissatisfied	4.6

*Among completed assessments

*Deduplicated by caregiver; percentages may not add to 100 due to rounding

five caregivers experience moderate to severe depressive symptoms (21.2%), and significant loneliness (22.8%). On a positive note, nearly half of caregivers (43.5%) report being very satisfied with the spiritual support they receive (Tables II-i.1 & II-i.2).

Nearly one-third of caregivers reported having 3 or more outpatient healthcare visits, around 12% had one or more emergency room visits, and 5% had one or more inpatient hospitalization within the past 6 months (Figure II-i). Rates of health service use among CRC caregivers are roughly comparable to population rates age 45 years and older.⁴ Most caregivers had completed advanced healthcare directives (69.9%), Healthcare Durable Power of Attorney (69.9%) and Living Wills (69.8%)

Figure II-i: Caregiver Health Service Use in the Last 6 Months

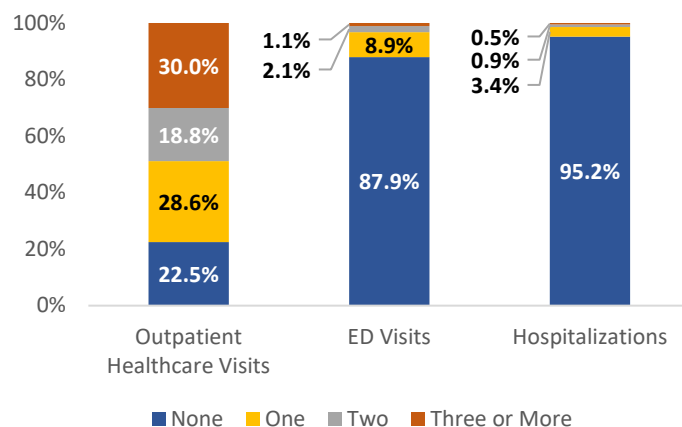


Table II-i.2: Caregiver Health and Caregiving Outcomes

n = 4,433	%
Medical Conditions	
Anxiety	44.2
Arthritis	24.0
Cancer	4.2
Cardiovascular Disease	10.0
Depression	31.6
Diabetes	11.5
Gastrointestinal	9.6
Chronic Pain	22.9
HIV AIDS	0.1
Kidney Disease	1.8
Liver Disease	1.3
Other Health Condition	58.1
Parkinson's Disease	0.5
Respiratory Condition	6.6
Sleep Disorder	32.7
Stroke	1.4
Number of Medical Conditions	
0	44.4
1	17.1
2	14.9
3 or more	23.5
Documents in Place	
Advanced Healthcare Directive	69.9
Financial Durable Power of Attorney	1.3
Healthcare Durable Power of Attorney	69.9
Living Will	69.8
Trust	14.4
POLST/DNR	1.6

*Among completed assessments

*Deduplicated by caregiver; percentages may not add to 100 due to rounding

III. SERVICES PROVIDED

CRC Case Status Summary

In FY 2021-2022, the 11 CRCs together provided services for 14,670 unduplicated family caregivers. They conducted 6,648 conducted intakes and opened 4,302 “new cases” (site mean: 391), defined as conducting a full assessment (i.e., risk assessment questions on intake indicate a need for more intensive services and the caregiver is interested in participating in this next level of engagement). In each quarter, the sites also followed an average of 7,360 “ongoing cases” (site mean: 669), defined as caregivers having an assessment in the past two years; of these, 47% received one or more services each quarter (e.g., family consultation, reassessment, counseling, vouchered services) throughout FY 2021-2022.

Table III-a: Case Status Summary – All California CRCs Combined

	FY 2021-2022
New Cases	4,302
Ongoing Cases with Activity	6,897
Ongoing Cases no Activity	9,883
Total Open Cases	10,887

CRCs provided more services to California caregivers in FY 2021-2022 than in the previous year.

* Definitions - refer to Appendix A: Glossary

* Inclusion Criteria – refer to Appendix B: Technical Specifications

* Case Status Counts – refer to Appendix B: Technical Specifications.

“Open cases” (i.e., the sum of new and ongoing unique cases) in FY 2021-2022 totaled 10,887 for all CRCs (site mean: 990) (Table III-a). Importantly, these counts **underestimate** the actual CRC open caseload because they do not include caregivers seen by CRCs prior to CareNav™ implementation during the past two years. In the next annual report (2022 -2023), for the first time, all sites will have complete data in CareNav™ for two years or more.



Intake

The 11 CRCs conducted a total of 6,648 initial intakes or caregiver screenings in FY 2021-2022 (site mean: 604), an increase of 9% over intakes conducted in FY 2020-2021 (Table III-b). Of these, approximately 39% were initiated by the caregivers using the CareNav™ portal. Not all intake screenings move to full assessment; for instance, a case may be completed at intake if staff are able to make a referral or provide advice during the screening and the caregiver does not desire further support.

Table III-b: Caregiver Activity Summary – All California CRCs Combined

	FY 2021-2022	FY 2020-2021
Intake, <i>n</i>	6,648	6,126
Assessment, <i>n</i>	4,433	4,299
Reassessment, <i>n</i>	3,326	2,856
Family Consultation, <i>n</i>	133,666	126,312
Support Group, <i>unique caregivers</i>	1,054	920
Individual Counseling, in house <i>unique caregivers</i>	174	119
Individual Counseling, vouchered <i>unique caregivers</i>	267	--

* Definitions - refer to Appendix A: Glossary

* Inclusion Criteria – refer to Appendix B: Technical Specifications

* Unreported Delivery Mode – refer to Appendix B: Technical Specifications

Assessment

Of the caregivers completing intakes, 4,433 (67%) moved forward to full assessment (site mean: 403), reflecting an increase (9%) over the number of assessments conducted in the last fiscal year. Most caregivers had one assessment completed this fiscal year. Full assessment occurs when the risk assessment questions on intake indicate a need for more intensive services and the caregiver is interested in participating in this next level of engagement.

Reassessment

Together the sites conducted 3,326 reassessments (site mean: 302), an increase of 16% over the previous fiscal year, following up with caregivers who had a full initial assessment, typically within six months.

Family Consultation

In total, the CRCs completed 133,666 family consultations (site mean: 12,151), with each caregiver on average having between 2 to 17 encounters. Thus, 7,354 more family consultations (6%) were performed this fiscal year than last.

Support Groups

1,054 unique caregivers participated in professionally led support groups across all 11 sites (site mean: 96). This is a 15% increase from last year's total of 920 unique caregivers. These services are facilitated by licensed social workers and do not include peer-lead support groups.

Individual Counseling

Seven CRCs (Bay Area, Coast, Del Mar, Inland, Orange, Southern and Valley) provided "in-house" counseling sessions for 174 unique caregivers (site mean: 16) and eight (Bay Area, Coast, Del Mar, Del Oro, Los Angeles, Passages, Redwood, Valley) offered individual counseling vouchers to 267 unique caregivers in the community (site mean: 24). Overall, 441 unique caregivers were offered individual counseling sessions by all eleven CRCs through either "in-house" services or grant vouchers.

Variability in the reported activities by site has several possible explanations: 1) differences in overall site volume and caregivers eligible for CDA funding; 2) geographic distribution of resources within the state and CRC catchment areas, leading to some services being offered "in house" rather than by referral; and 3) differences in site-specific workflow or understanding of definitions for entry into CareNav™.



“Everyone has been very helpful. I have been shocked and happy that people care and want to help me and my family. Thank you for the respite grant and therapy.” – CRC Caregiver

Service Grant Vouchers

The CRCs provide vouchers for specific services to eligible caregivers (Table III-c). In FY 2021-2022, 716 vouchered transactions for counseling services totaling 1,344 hours (\$134,938) were provided to 267 unique caregivers; 169 vouchered transactions for legal services totaling 196 hours (\$24,695) were provided to 165 unique caregivers; 6,801 vouchered transactions were provided for respite care totaling 119,378 hours (\$3,223,778) to 2,080 unique caregivers; and 531 vouchered transactions for supplemental grants (\$130,765) were provided by five CRCs to 344 caregivers, typically for durable medical equipment or groceries.

In FY 2021-2022, total CRC spending for vouchered legal services increased by 53% but decreased for respite services (-6%) and supplemental grants (-29%). During the COVID-19 pandemic, staffing shortages freed up funds that the CRCs redeployed for additional respite and supplemental grants to caregivers. Accordingly, these declines reflect a return to prior spending patterns.

Table III-c: Service Grant Voucher Totals - All California CRCs Combined

	FY 2021-2022	FY 2020-2021
Counseling		
Transactions	716	714
Unique Caregivers	267	--
Hours	1,344	1,379
Amount	\$134,938	\$131,451
Legal Consultation		
Transactions	169	147
Unique Caregivers	165	--
Hours	196	141
Amount	\$24,695	\$16,140
Respite		
Transactions	6,801	6,513
Unique Caregivers	2,080	--
Hours	119,378	139,340
Amount	\$3,223,778	\$3,426,469
Supplemental Grants		
Transactions	531	1,492
Unique Caregivers	344	--
Amount	\$130,765	\$183,039

* Definitions - refer to Appendix A: Glossary

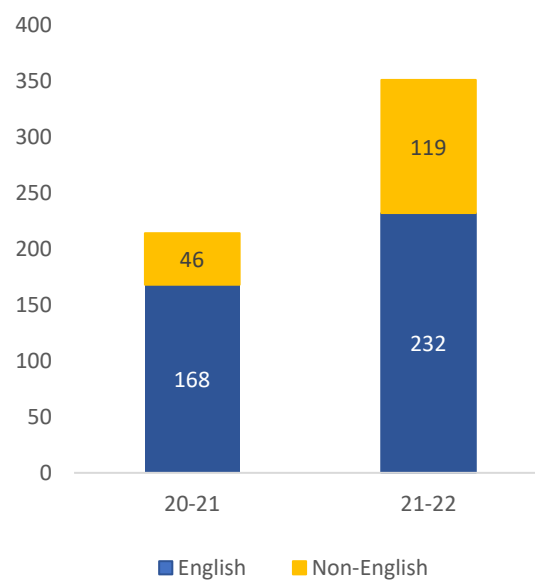
* Unique caregiver counts are not available for FY 2020 - 2021 due to issues with data completeness in CareNav™

CRCs spent \$3,223,778 (or 22% of their collective budget) on respite services in this fiscal year, exceeding the 10% threshold specified in the contract

Outreach and Education

In FY 2021-2022, the 11 CRCs and State CRC conducted 9,884 outreach activities and 1,039 education activities. There was an increase in reported public information and outreach activities (including social media posts) and presentations or meetings with stakeholders. The number of reported education activities decreased this fiscal year, but there was a noteworthy increase of more than double the number of statewide activities offered in a language other than English compared to FY 2020-2021 (Figure III-a). This section includes state-wide activities conducted by an outside organization (“State CRC”). Definitions related to outreach and education activities can be found in Table III-d.

Figure III-a: Statewide Classes Offered



Outreach

Outreach activities (as defined in Table III-d) are reported in Table III-e and Table III-f. Use of social media (Table III-e) was the most frequent mode of outreach. Together, the 11 CRCs and State CRC conducted an additional 4,170 outreach activities (Table III-f) reported as: meetings or presentations ($n=1,976$), health fairs ($n=1,430$) and public information or outreach ($n=764$). Overall, sites continued to conduct most activities virtually with targeted outreach to reach diverse and underserved populations.

The population served is in high need of services and supports. At the same time, this raises the question of how to bolster outreach to caregivers at lower risk, likely greater in number but not currently being served, who might benefit from CRC support and resources earlier in the caregiving trajectory.

Table III-d: Outreach and Education Terms

Term	Definition
Diverse or Underserved Audiences (D or U)	Communities or individuals “at a higher risk for health disparities by virtue of their race or ethnicity, socioeconomic status, geography, gender, age, disability status, or other risk factors associated with sex and gender” ⁵ . Sites included activities for specific populations (e.g., Hmong Health Alliance, Asian Community Health Center) as well as those that include a D or U audience.
Education	Education/training sessions for members of the community. These sessions are open to the community and are not limited to CRC clients.
Health or Resource Fairs	Health, senior or resource fairs conducted in person or virtually.
Meetings Presentations	In-person or virtual meetings to members of the public (potential clients), community groups and/or providers with the goal of generating awareness of CRC services.
Public Information Sharing Outreach	Outreach with the purpose of building name recognition, community building, and encouraging use of / referral to services through email blasts, newsletters, social media posts, etc.

Social Media

Social media is utilized extensively by sites as part of CRC outreach campaigns (Table III-e). Almost all sites ($n = 10$) and the State CRC use Facebook, and 83% use three or more social media platforms to promote their services. The CRC sites and State CRC together reported 5,714 social media outreach activities in FY 2021-2022, with over 86,000 ($n = 86,048$) “subscribers” (also referred to as “followers”, “friends” or “contacts”) across five platforms. The number of subscribers varies substantially by site. The Bay Area CRC has a significant national following, which is reflected in their subscriber numbers ($n = 55,856$). The remaining sites who used social media noted a range of subscribers from 385 to 10,188.

Facebook is the most frequently used social media platform by CRCs with 2,496 posts reported across sites in FY 2021-2022. This is followed by Instagram ($n = 1,248$) and Twitter ($n = 1,042$); LinkedIn ($n = 633$) and YouTube ($n = 230$) are used less frequently. The number of people with potential exposure through social media is substantial. Examining Facebook alone, potential views of social media posts about CRC services ranged from 23,184 to 4,207,692 in FY 2021-2022.

“Estoy muy agradecido por los servicios que he [recibido] gracias.” – CRC Caregiver

Table III-e: Social Media Use

Site	Followers/ Posts					Posts
	Facebook	Twitter	Instagram	YouTube	LinkedIn	Other
Bay Area	22,622/ 186	8,856/ 349		22,300/ 23	2,078/ 57	
Coast						
Del Mar	1,613/ 248		191/ 87	1/ 3	95/ 68	
Del Oro	1,782/ 294	353/ 161	480/ 85	96/ 7	185/ 31	
Inland	2,881/ 347	144/ 105	278/ 183	32/ 21	246/ 41	
LA	896/ 221	598/ 193	347/ 111	172/ 57		
Orange	6,580/ 93		2,725/ 91	355/ 76	528/ 87	
Passages	385/ 155					37
Redwood	168/ 138		583/ 120			28
Southern	1,970/ 397	463/ 2	1,729/ 365	345/ 30	153/ 0	
Valley	1,311/ 241	36/ 55	367/ 125		457/ 184	
State CRC	439/ 176	224/ 177	683/ 81	104/ 13	197/ 165	
Total	40,647/ 2,496	10,674/ 1,042	7,383/ 1,248	23,405/ 230	3,939/ 633	65

Fairs, Meetings and Public Information or Outreach

Health and Resource Fairs: All CRCs reported participation in health or resource fairs. Southern CRC classifies and records all in-person, informational outreach as a “health fair” and they are unable to distinguish traditional “health fairs” and, for instance, tabling at a public library, in their tracking system. In FY 2021-2022, Southern reported 1,335 health fairs that reached 60,103 individuals. The remaining ten sites reported 95 activities (site mean = 9.5) that reached 18,392 people. Approximately half of the health fairs that Southern CRC reported were conducted virtually ($n = 658$). The other sites reported nearly 90% of health fairs conducted virtually.

Meetings/Presentations: Eighty-seven percent of the meetings/presentations were conducted virtually and over 70% were designed to reach diverse or underserved populations.

Public Information or Outreach: All sites reported some type of monthly communication to their contact lists. Sites reported public information or outreach activities such as monthly newsletters, periodic emails blasts and one-time notices regarding new services that targeted consumers, community members and providers (Table III-f).

Table III-f: Fairs, Meetings, Public Information or Outreach

Site	Health or Resource Fair		Meetings / Presentations		Public Information/ Outreach		Totals	
	# Events	Exposure	# Events	# Reached	# of Distributions	# Contacts	# Events	# Reached
Bay Area	3	900	90	1,605	74	284,405	167	286,910
Coast	8	1,150	54	1,078	18	9,193	80	11,421
Del Mar	0	0	35	587	24	51,574	59	52,161
Del Oro	8	1,111	24	300	14	50,160	46	51,571
Inland	16	1,305	307	9,256	30	53,370	353	63,931
Los Angeles	0	0	173	345	84	280,740	257	281,085
Orange	36	8,365	166	18,206	148	408,318	350	434,889
Passages	5	136	27	360	81	663,437	113	663,933
Redwood	9	3,250	183	1,625	70	113,974	262	118,849
Southern	1,335	60,103	888	16,749	89	5,830	2,312	82,682
Valley	10	2,175	26	319	4	14,532	40	17,026
State CRC			3	1,221	128	458,480	131	459,701
% D or U	98.7%		71.8%					
% Virtual	88.7%		87.1%					
Total	1,430	78,495	1,976	51,651	764	2,394,013	4,170	2,524,159

Education Activities

Together, the CRCs reach a large audience with their education activities. In this fiscal year, the CRCs conducted 1,039 education activities statewide that were attended by over 26,542 people (Table III-g). Ninety-six percent of the activities were conducted virtually. The number of activities conducted by site varied from 2 to 456 with an average of 94 across the 11 CRCs.

Statewide Activities

The CRCs partner on a shared calendar featuring on-line education activities that are accessible to caregivers from throughout California. In addition to site-level education activities, a total of 351 classes were offered FY 2021-2022, a 60% increase from FY 2020-2021. Of those classes, a third were offered in a language other than English.

Table III-g: Education Activities by Site

Site	Total Activities	Total # of Participants
Bay Area	54	1,019
Coast	2	7
Del Mar	48	554
Del Oro	58	1,207
Inland	228	1,701
LA	45	3,389
Orange	49	833
Passages	24	507
Redwood	17	169
Southern	456	16,749
Valley	58	407
Total	1,039	26,542

Media

Sites use a variety of media channels to promote caregiver services, including media appearances; print, radio and television, and internet ads; outdoor advertisements (e.g., ads on benches, billboard), and public service announcements. The number of channels used by site ranges from 1 to 7 (Table III-h).

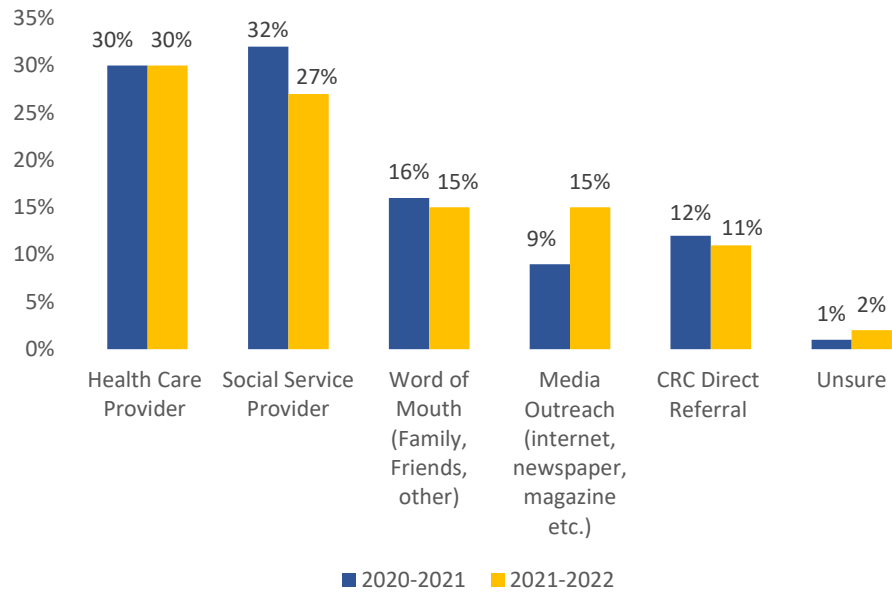
Table III-h: Media Channels Used to Promote Services | Fiscal Year

Site	Print ad	Radio ad	Television ad	Internet ad	Outdoor	Media Appearance	PSA
Bay Area			✓	✓			✓
Coast		✓					
Del Mar	✓			✓	✓		
Del Oro				✓		✓	
Inland		✓					
LA	✓					✓	
Orange	✓	✓	✓		✓	✓	✓
Passages	✓	✓	✓				✓
Redwood			✓			✓	
Southern	✓	✓	✓	✓	✓	✓	
Valley	✓	✓	✓	✓	✓	✓	✓
State CRC				✓			
Total	6	6	6	6	4	6	4

Referral Source

As part of the intake, caregivers are asked by care consultants how they heard about CRC services (Figure III-b). Health care providers are the leading source of referrals (30%), followed by social service providers (27%), word of mouth from family and friends (15%), media outreach (15%), and direct referrals from the CRCs. Compared to the last fiscal year, there was an uptick in the percentage of caregivers learning about CRC services from media outreach (9% to 15%), driven by internet sources.

CRCs expanded referral sources so that 60% of referrals came from social services or health care services.

Figure III-b: Referral Source FY 2020-2021 vs FY 2021-2022

IV. CAREGIVER EXPERIENCE

Caregiver Satisfaction with Services

Satisfaction Survey

Satisfaction surveys were sent to all caregivers who had contact with the CRCs on a quarterly basis. For the year, 2,624 caregivers provided their feedback on services received. Caregivers are still highly satisfied with their experiences with the CRCs, with 78.6% reporting they are extremely satisfied and 13.5% somewhat satisfied (Table IV-a). The vast majority would recommend the CRC to others, with 83.7% definitely and 10.1% likely to recommend. As can be seen in Table IV-a, results from this year are very similar to last year.

Table IV-i: Satisfaction Surveys: Impact of Services Between FYs 2020-2021 and 2021-2022

Overall Satisfaction Score (%)			Recommend CRC to Friend or Family Member Score (%)		
	2021-2022	2020-2021		2021-2022	2020-2021
Response Options	<i>n</i> = 2,624	<i>n</i> = 2,869	Response Options	<i>n</i> = 2,624	<i>n</i> = 2,869
Strongly Satisfied	78.6	81.7	Will Definitely Recommend	83.7	84.2
Somewhat Satisfied	13.5	10.7	Probably Will Recommend	10.1	10.3
Neutral	4.2	3.5	Neutral	3.7	3.5
Dissatisfied	1.6	1.6	Will Probably Not Recommend	1.3	1.0
Extremely Dissatisfied	2.2	2.6	Will Definitely Not Recommend	1.1	0.9

*Percentages may not add to 100 due to rounding.

The survey explored the impact the services had on the lives of the caregivers. Table IV-b captures the impact and highlights mean score changes from the previous year to this one. Scores range from 1 (Strongly Disagree) to 5 (Strongly Agree) with scores closer to 5 indicating a more positive impact in a particular domain. Generally, scores remained relatively unchanged from last FY to this year. Caregivers on average strongly agreed that services left them feeling more confident (4.15); better able to manage care (4.17); more knowledgeable and aware of community resources (4.30); and with better understanding of the related diseases, disabilities, and issues (4.06). They also broadly agreed that they are taking better care of their physical and emotional health (3.98) and feel less stressed about caregiving (3.83).

Table IV-j: Satisfaction Surveys: Comparison Between General Category Means of FYs 2020-2021 and 2021-2022

Question Categories	FY 2021-2022 <i>n</i> = 2,624	FY 2020-2021 <i>n</i> = 2,869	Change in Mean
Overall Satisfaction	4.64	4.67	-0.03
Would Recommend	4.75	4.76	-0.01
More Confident as a Caregiver	4.15	4.17	-0.03
Better Able to Manage Care	4.17	4.19	-0.01
More Knowledge and Awareness	4.30	4.29	0.01
Understand the Disease/Disability/Problem Better	4.06	4.08	-0.02
Taking Better Care of Self	3.98	4.03	-0.05
Less Stressed	3.83	3.91	-0.08



Caregivers are highly satisfied with CRC services. Caregivers identify an array of benefits from their engagement with the CRCs, including tangible supports such as respite and legal assistance and emotional supports that improve confidence and capacity to care and reduce isolation.

Caregiver Comments About Services

Caregivers provided 336 comments about services received or pending. Most comments (256) describe how resources helped and the impact of the services on caregiver experiences. The remaining 67 comments reflect challenges or future suggestions. Some comments address contract agencies or external providers. Eight comments were provided in Spanish. The comments about the most-cited services are summarized in [Table IV-c](#).

Table IV-c: Caregiver Feedback about Services

Service type	Caregivers impacts Examples	Exemplar quotes
Assessments	Caregiver and care recipient benefits: Identifying needs, encouragement, support	CRC is really great about finding out the needs of not only the recipient but the caregiver, encouragement and support
Respite grant	Caregiver benefits: Break, rest, time away, detach from caregiving responsibilities, personal time, relief; reduced toll, financial strain, physical and emotional stress; being a better caregiver Care recipient benefits: improved mental health, joy	I cannot believe the [...] change in my husband after he started going to Daycation. I think he had been suffering from an ever-increasing depression. All he wanted to do was sleep all day. He re-engaged with life wanting to try doing things around the house and got his sense of humor back. For me, I thought I would get a lot done while he was gone during the day, but I found that if I sat down, I fell asleep. I didn't know how exhausted I was or what a toll the daily care had taken on me. I also didn't know how much I had been holding inside until the case worker asked me how I was doing and I couldn't speak without crying and couldn't stop crying. I'd forgotten that part of our situation is about me. I'd lost myself in his complicated changes. Thank you from the bottom of my heart on behalf of both of us. It truly changed our world.
Training/ Education	Benefits: Knowledge to deal with mental problems, awareness of resources, enlightening, ongoing support	Care workshop was great. I appreciate the contacts & resources I've been made aware of for when I will need them.
Support groups	Caregiver benefits: Focus on own health, ability to keep up with own health, meaningful experience, peer support and counseling, connection to resources, organization and making plan, comfort Challenges: being sad from listening to other experiences	I am at the point in my caring where my person is in a skilled nursing facility. The caregiving does not stop. It changes, and it still takes a lot of work. I am very grateful that you have support group for caregivers with placed care receivers. It helps us to connect with others and share experiences and advice. It validates what we are going through and helps us to see situations from different points of view. The moderator is very helpful, listens, and provides guidance.

Service type	Caregivers impacts Examples	Exemplar quotes
Overall CRC Experience	<p>Caregiver benefits: <i>Knowledge and resource:</i> Addressed concerns and questions, advice on behaviors, access to assistance; feel not alone, understood; Understand how to handle care recipient’s disease, end of life care, having a plan; <i>Caregivers’ well-being:</i> Reduced stress, improved well-being and self-care, personal identity; positive thinking; confidence, hope, encouragement; Financial support</p> <p>Challenges: Didn't get the proper help, feel forgotten, the support isn't needed, the stress hasn't been eliminated</p>	<p>The family consultant is such a valuable resource you provide. Helping us to connect to different resources, helping us to remember we as caregivers shouldn't forget to take care of our mental, emotional, and physical well-being. I am grateful they can help us to organize and make a plan to help ourselves to be there for our care receivers.</p>
Counseling	<p>Benefits: Learn tools to strengthen relationship with care recipient and better engage in self-care, understand caregiving and future actions</p>	<p>Cognitive Behavioral counseling helped me to better understand my frustrations as a caregiver, my reactions and how better to deal with circumstances</p>

“I want to send a heartfelt thank you for your help during my husband's long illness. I'm grateful for people like yourself and programs like the CRC. You listened to me when I did not have the energy and strength to keep helping my loving husband. You provided much-needed help through educational programs. My counseling sessions were healing and provided the knowledge that the situations I'm going through are normal. Most importantly, I learned that I need to have compassion for myself. Thank you.” – CRC Caregiver

Caregiver feedback about the online platform

On the satisfaction survey, we also collected information about caregiver experiences with the online platform and the reasons given for not engaging with the online platform. [Table IV-d](#) indicates that most caregivers were offered online services (81%), an increase over last year; similarly, a quarter of caregiver respondents (25%) indicated having used the CareNav™ system this year, reflecting an increase from last year (19%).

Table IV-d: Satisfaction Surveys: Caregiver Engagement with Online Services & CareNav™ of FYs 2020-2021 and 2021-2022

Response Categories	Were Offered Option for Online Services (%)		Used CareNav™ (%)	
	FY 2021-2022 n = 2,624	FY 2020-2021 n = 2,869	FY 2021-2022 n = 2,624	FY 2020-2021 n = 2,869
Yes	80.5	76.2	24.6	18.9
No	9.0	12	64.2	70.7
I Don't Know	10.4	11.7	11.2	10.4

*Percentages may not add to 100 due to rounding.

[Figure IV-a](#) shows that the majority of caregivers who did use CareNav™ were extremely satisfied (51%) or somewhat satisfied (33%), with an increase in caregivers scoring extremely or somewhat satisfied from last FY (59%) to this FY (81%). Those who did not use CareNav™ were asked about the reasons for not engaging with the online program. As observed in [Figure IV-b](#), the largest barrier to use was awareness about the program (31.4%), followed by the impression that the caregiver did not need this (18.4%). Access to internet (5.1%), lack of technology experience (13.7%) and finding the platform too confusing (3.3%) were less frequently identified as barriers. Percentages did not change significantly between the two years.

Figure IV-a: Satisfaction with CareNav™

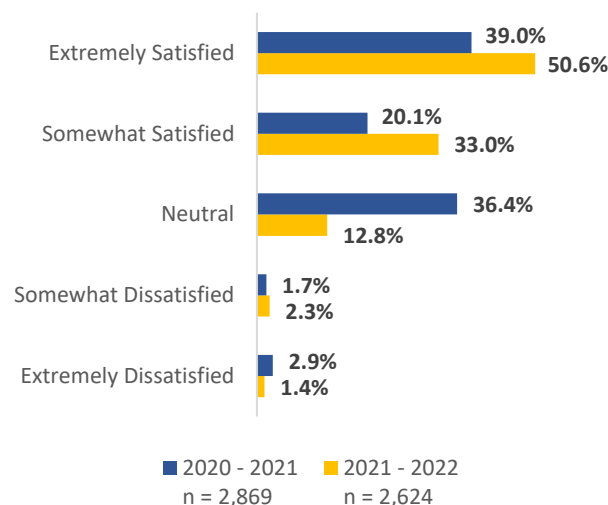
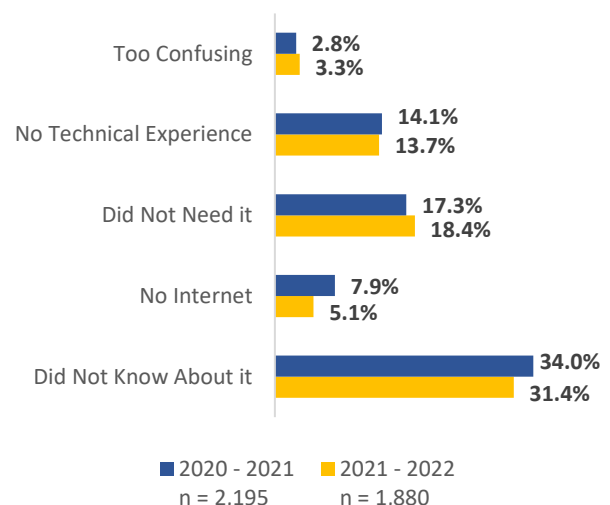


Figure IV-b: Reasons for not Using CareNav™



V. IMPLEMENTATION PROCESS: CRC STAFF EXPERIENCES WITH CARENAV™

CRC Staff Interviews and Survey

CRC staff Interviews. Across sites, 80 CRC staff members (43 family consultants/ social workers, 10 administrative support and 27 leaders i.e., directors, clinical directors, managers) participated in 22 focus groups with between 2 and 15 participants per site. In addition, two individual interviews were conducted with key implementation team informants.

CRC staff Survey. Between 4 and 24 staff from each site participated in the online survey, totaling 114 respondents (39 administrators, 75 clinical support staff members). Of the respondents, 107 (93.9%) provided complete readiness survey responses, 73 (63.5%) contributed demographic data, and 103 (89.6%) commented on at least one open-ended question. A subsample of 29 (11 administrators, 18 clinical support staff members) participants (59.2% of the eligible participants) from eight sites also completed 2020 surveys, enabling longitudinal comparisons. [Table V-a](#) summarizes demographic characteristics of the interview and readiness survey participants.

Implementation process progress

This fiscal year was the first year that all CRCs contributed a full data set from CareNav™, entering all their client data for activities (e.g., intakes, assessments, reassessments, training) and service grants. The CRCs continued to make progress on cultural and procedural changes for operational integration. Participants in both focus group interviews and in the online survey provided rich information about progress. In this section, we summarize how the sites are using CareNav™; their outreach and expansion of services; diversity, equity, and inclusion efforts; early outcomes; and close with overarching themes.

Table V-a: Demographic characteristics of the interview and survey participants

Participant characteristics	Interviews (n = 82)	Readiness survey (n = 73)*
	%	%
Age		
25 or under	9.8	8.2
26-35	36.6	39.7
36-45	13.4	20.5
46-55	14.6	9.6
56-65	13.4	16.4
Over 65	4.9	5.4
Decline to answer	7.3	
Gender		
Female	73.2	80.8
Male	19.5	15.1
Other	1.2	--
Decline to answer	6.1	4.1
Racial identity†		
African American or Black	4.9	4.1
Asian	14.6	13.7
Hispanic/Latino	41.5	39.7
Native American	2.4	1.4
White or Caucasian	36.6	43.8
Other	1.2	--
Decline to answer	6.1	6.8
Missing		1.4

*Of 114 survey respondents, 41 participants opted not to provide demographic data.

†Percentages may not add to 100 due to multiple racial identities

CareNav™ utilization

During FY 2021-2022, all CRCs were fully operational, using basic level CareNav™ functions and contributing data to the state-wide record. Several sites have attained advanced capabilities in using the platform for site and system-level decision making. The sites highlighted three CareNav™ features (standardized assessment, reports, and client portal) that were variably used to support CRCs' workflow, provide services, and manage sites. [Table V-b](#) summarizes CareNav™ features and their utilization.

Table V-b: CareNav™ design components and current functionality

		CareNav™ Features		
Functionality Domains	Functionalities	Standardized Assessment	Report Generation	Client Portal
Client-Level Functionalities	Client records	Data collection Service history	Client utilization Use of online resources	Self-administration of intake and assessment
	Case management and decision support	Access to client records for all staff on the team	Aggregate client information, units of service	Messaging clients, assigning resources
	Real-time client interaction, services provision	Generating tailored resources	Client engagement, units of service	Continuous access to tailored resources, communication
Consultant, Site, and System-Level Functionalities	Caseload management to support efficiency	Navigation features (search, sort, filter)	Family consultant caseload	Caseload management to support efficiency
	Outreach and Diversity, Equity and Inclusion (DEI) support	Ease of access for diverse clients	Penetration into target populations Services for target populations	Convenient access services Introduces potential clients to CRCs
	State-level planning	Aggregate summary of client needs	Populations served Service provision	

Data harmonization and quality assessment

There were two major issues in implementation of a standardized assessment: mapping previous data to the appropriate fields in CareNav™ and coming to consensus on variable definitions, reconciling diverse interpretations of specific data points. Those hosted within larger health systems faced greater challenges in data harmonization with CareNav™ associated with technical and regulatory issues.

Several threats to data quality occurred. First, consultants and administrators held diverse beliefs about data accuracy and quality leading to different practices in collection and entry. Data collection and entry practices range from consultants using

the standardized assessment and completing fields in a systematic way, to consultants using the standardized assessment as a general guide for conversation, then entering their interpretation of the client's narrative as data later. Data integrity is further threatened as staff interpret the meaning of data fields differently and subsequently record with that bias. These issues are compounded when staff conduct the interviews in languages other than English (the only language currently supported by CareNav™), then translate and enter data. Complex concepts, such as spirituality or loneliness, carry different cultural meanings and are subject to linguistic inaccuracy. The evaluation team conducted extensive analysis to identify data discrepancies and then worked very closely with sites throughout the implementation process providing rapid-cycle feedback to sites when data discrepancies were noted. The evaluation team also brought the issues to the CRC directors and clinical directors for discussion and consensus building.

Outreach

Outreach and expansion of services were major goals of the state investment in the CRC system. Participants shared commitment to expanding collaborations with diverse community organizations and were generally focused on reaching diverse communities. Sites grappled with the appropriate structures and processes to perform outreach and serve additional clients. The COVID-19 pandemic had a dampening effect on outreach across most sites, limiting in-person connections. The pandemic also affected staffing levels and priorities both at the CRCs and in community agencies. Many sites pivoted to online outreach and the capacity of the CRC websites continue to evolve. Finally, leaders at a few sites recognized the importance of evaluation, comparing data about who is served to regional characteristics.

Overall, community partnerships were seen as the most effective outreach approach, generating referrals from health systems or community agencies. Some sites have successfully incorporated flyers in patient discharge packets at local hospitals. A rural site has generated engagement by mailed advertisements of statewide CRC virtual events, expanding access to education in their region. Several respondents cited system-wide web-based advertising and outreach as highly effective. Social media outreach is gaining traction among younger caregivers. Plans for outreach included emphasizing diverse communities in each region and tailoring the approaches in culturally congruent ways. Many look forward to greater opportunities for in-person contact at community cultural and health events, as historically this method was valued by the community and effective for engaging potential clients. Several sites are examining the capacity of their staff to meet the needs of newly engaged clients, both in terms of volume and in terms of linguistic and cultural congruence. Several sites discussed the potential to share bilingual staff across CRCs for outreach to particular communities, such as the Korean- or Vietnamese-speaking communities. With this strategy, sites would have greater capacity to serve the diverse clients in their regions. Leaders recognized the importance of aligning and readying staff for additional clients engaged through outreach, building internal capacity in concert with outreach efforts. Finally, most sites identify ongoing evaluation as crucial to optimize resource deployment.

Diversity, equity, and inclusion

Based on the findings of last annual report (FY 2020-2021) regarding the diversity of clients served and the variable penetration into racial/ethnic communities in each region, we explored perspectives on CRC efforts to promote diversity, equity, and inclusion (DEI). Depending on the CRC location, staff identified different types of diversity, including race/ethnicity, language, culture, geography (rural vs. urban), economic status, gender, and generation. Staff shared a general belief in DEI as a broad concept addressing inclusion of traditionally underserved people. Some were reflective of the role of personal biases that impinge on DEI efforts and recognize the importance of open-mindedness, adaptability, flexibility, and dedication to lifelong learning. Several sites emphasized their success in outreach to specific communities and all reflected on the importance of family care navigators/consultants as providing a “space to be heard.”

The most common DEI challenge identified by sites was the linguistic diversity of their regional population and the issues associated with having staff available who speak the client’s preferred language. Differences in educational attainment (literacy and proficiency levels) affect access to online and printed materials. [Table V-c](#) summarizes current availability of resources in various languages.

Table V-c: Translation of CRC resources

	All Languages	English	Spanish	Chinese	Vietnamese	Tagalog
Fact Sheets/In-depths	312	95	59	65	49	40
Tip Sheets/Quick reads	50	28	6	7	6	3
Videos	93	49	22	17	5	
Webinars	20	19	1			
Audio	2	1			1	

Different communities also exhibit different levels of technological literacy. Beyond language, several CRC leaders and staff recognized the importance of a broader cultural adaptation approach for specific communities, for example, Tribal communities, Hmong, Latino, LGBTQ+, rural to assure congruence of programming with client needs. Particular issues raised included trust, stigma, and generational differences. Furthermore, financial strain is both a stressor for many clients and a barrier to accessing technology.

Several leaders cited the dearth of evidence about the best approaches to serve certain underrepresented communities and shared the hope that evaluation of their efforts will contribute to this important knowledge base. Cultural and linguistic translation of the assessment and educational materials was emphasized repeatedly by staff and leadership across sites. [Table V-d](#) summarizes current and future approaches to support DEI.

Table V-d: Examples of current and future approaches to support diversity, equity, and inclusion (DEI)

Theme	Current approaches to support DEI	Future directions to support DEI
System-level and site-level	<p>Matching staff demographics with regional population</p> <p>Language capacity to improve access</p>	<p>Hiring bilingual staff</p> <p>More staff time to educate clients to use technology</p> <p>Sharing/pooling the resource of the staff members who speak specific language</p>
Translation	<p>Using external translation service when needed</p>	<p>Translate assessment and more materials</p>
CareNav™ and website	<p>Using CareNav™ data to assess how the site serves their population and to inform county funders</p> <p>Analysis of use patterns on website with redesign to improve equity</p>	<p>Standardized assessment: linguistic and cultural adaptation</p> <p>Using data to learn about clients and improve inclusivity</p> <p>Client dashboard: adaptation and redesign to be accessible in different languages</p> <p>Americans with Disability Act compliance, accommodating hearing or visual impairments</p> <p>Website: Improving navigation across languages</p>
Access to CareNav™	<p>Staff at some sites take on the role of providing tech support and education</p>	<p>Providing clients with devices (e.g., tablet) with tech support</p>
State level resources	<p>CRC shared calendar of statewide linguistically diverse services</p> <p>e-newsletter to target stigmatized topics</p> <p>Programs open to the public in California</p>	<p>Combining statewide CRC resources will allow development of programs addressing small/niche populations</p>
DEI training	<p>Dedicated, mandatory staff DEI training</p>	<p>Funding for DEI training</p> <p>Competency-based training</p>
Community organization partnerships	<p>Participation in community leader coalitions, boards, agencies focused on specific populations</p> <p>Engaging community heroes to gain entree</p> <p>CRCs presence in the community and building trust</p>	<p>Funding to engage community "heroes"</p>
Tailored messages/ services	<p>Advertising in various languages</p> <p>Culturally sensitive/competent/adapted messages focusing on community specific experiences</p> <p>Paper and digital newsletter, fact sheets with audio to extend accessibility</p> <p>Culturally tailored support groups</p> <p>Variety of service options for respite</p>	<p>Hybrid model of services provision considering groups who are less likely to use online resources</p> <p>Translating the materials and including more graphics to increase inclusivity</p> <p>Funding for research on adapting caregiver programs to minority populations</p>

Early outcomes

CRC staff and leadership

Early outcomes of CareNav™ implementation and expansion of services were assessed in two ways, using an online survey and asking open-ended questions during focused interviews. We present the results of the online survey first, summarizing staff and leadership perceptions of the changes.

Staff and leadership knowledge and beliefs, self-efficacy, and readiness for change

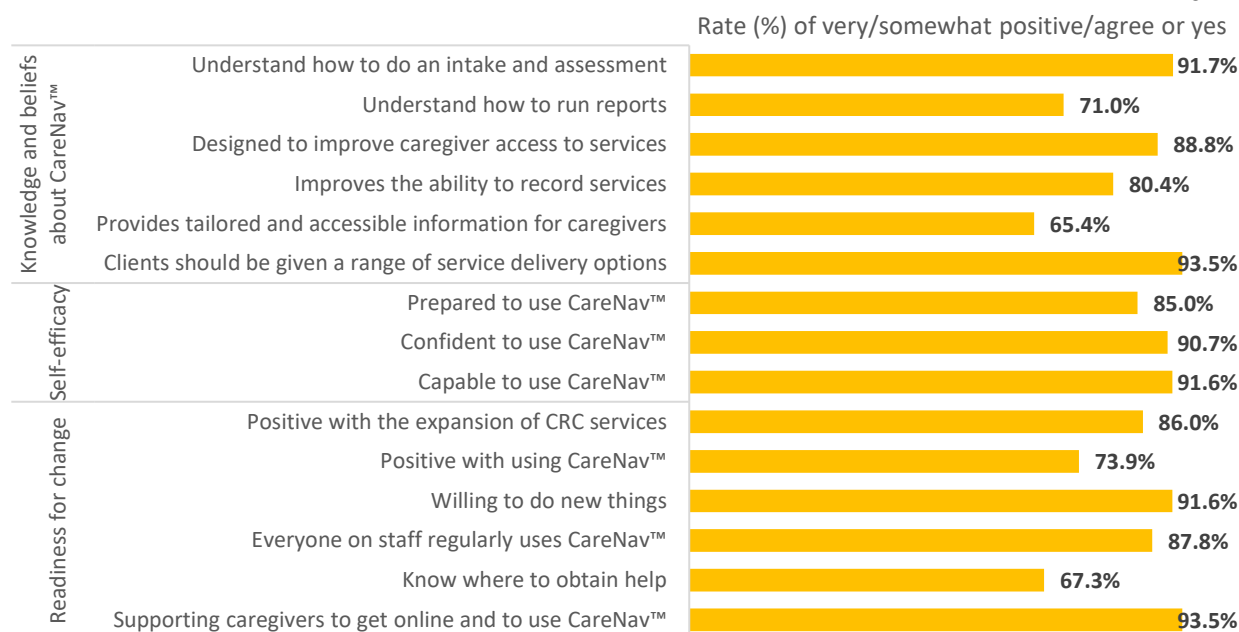
Overall, participants had very positive attitudes toward the implementation of CareNav™ (Figure V-a), with a total readiness score of 4.3 (SD 0.5) on a scale of 1 to 5 where 5 is the most positive. Average responses to all items were in the positive range (Table V-e).

Table V-e: Readiness survey

<i>n</i> = 107	
Item	Mean
Knowledge and beliefs about CareNav™	
CareNav™ improves the ability to record services	4.3
CareNav™ provides tailored and accessible information for caregivers	3.8
Clients should be given a range of service delivery options to ensure they select one that works best for them	4.7
Self-efficacy	
Prepared to use CareNav™	4.1
Confident to use CareNav™	4.5
Capable to use CareNav™	4.5
Readiness for change	
Positive with the expansion of CRC services	4.4
Positive with using CareNav™	3.9
Willing to do new things	4.4
Everyone on staff regularly uses CareNav™	4.4
Know where to obtain help	3.7

Figure V-a: Readiness Survey

n = 107



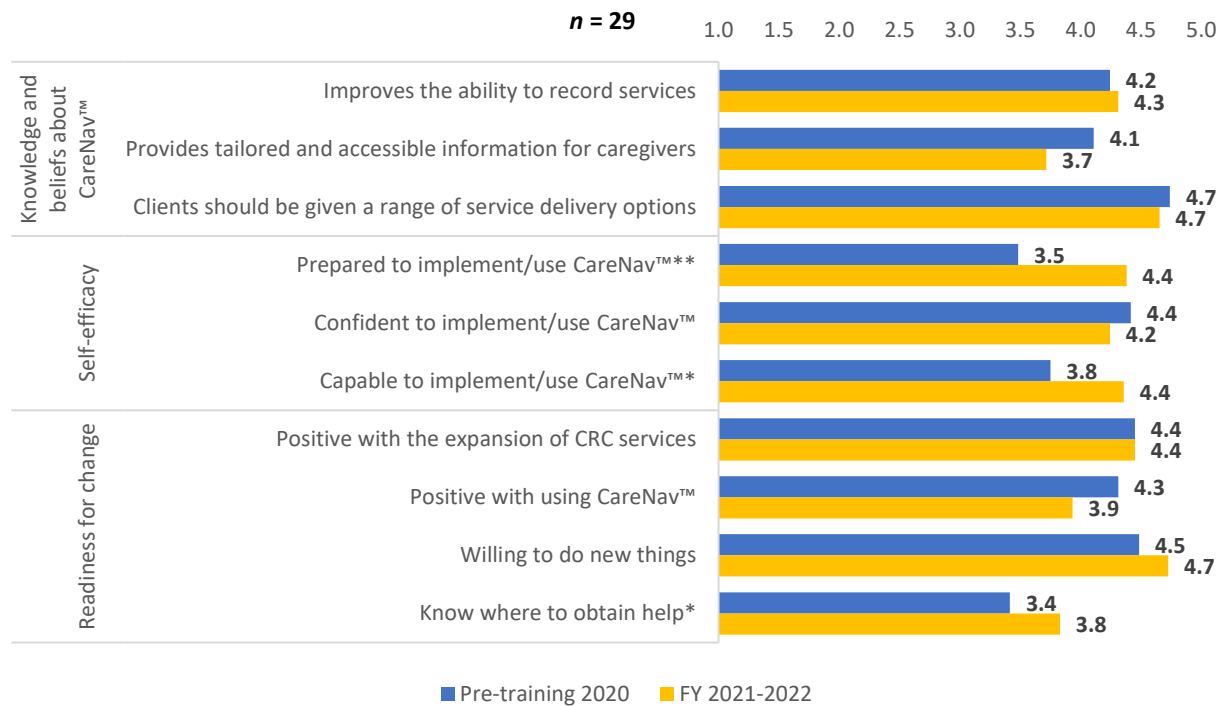
Comparisons across sites, roles and hiring dates

This analysis showed that while their scores will still in the positive range, one site had significantly lower scores for overall score and three specific items: CareNav™ improves the ability to record client services, prepared to use CareNav™, and positive about using CareNav™. Comparing the scores across roles showed a slightly lower score for regular use of CareNav™ among participants with administrative roles (mean = 4.0, SD 1.2 for administrative roles vs. mean = 4.6, SD 0.8 for clinical support, $p = .004$). In three sites, 50% or fewer participants indicated that they understood how to run reports. No significant differences were found between participants hired before 2020 and those hired in 2020 or after (or between those hired before July 2020 vs. others).

Comparison to pre-CareNav™ training (2020)

We compared scores for participants who participated in the 2020 pre-training survey and the current survey. Results showed stable high scores of knowledge and beliefs about CareNav™ and readiness for change (Figure V-b). The proportion of participants who reported that they understand how to complete an intake and assessment in CareNav™ increased from 47.8% to 100%. Both in pretraining (2020) and in the current survey, staff believed that the system would improve caregiver access to services (100% of participants pretraining and 92.3% of participants in 2022). Wilcoxon signed rank test showed significant increases in several items: staff and leadership self-efficacy and in knowledge about where to obtain help.

Figure V-b: Baseline and two-years after comparison of knowledge and beliefs, self-efficacy, and readiness for change



Wilcoxon signed rank test significance: * $P < .05$; ** $P < .01$

Client outcomes

Sites noted a significant increase in client needs and fragility during the COVID-19 pandemic, indicated by higher risk scores on standardized assessments of strain, depression, and loneliness, as well as the information they shared during consultations. Caregivers reported feeling more overwhelmed due to increased caregiving responsibilities while working from home, limited availability of healthcare facilities and respite, and fewer breaks from caregiving responsibilities. Many experienced economic strain and had more changes in their living situation, with an increased prevalence of multigenerational households. Consultants noted that there were fewer available community services, particularly respite care, and changed access to food and other services. These shortages were worse in rural and under-resourced areas.

The most reported impact of CareNav™ on serving clients was the ability to provide more resources for more people in a faster and more convenient way for clients. The standardized assessment provides more comprehensive information, helpful in identifying potential resources and tailoring recommendations for clients. The assessment also offers longitudinal information helpful to monitoring trends in the caregiving situation and enriching the conversation with clients as consultants can reflect on the trends. Many staff noted improved client-provider relationships because CareNav™ allows a transparent means to provide services, accessible to both staff and client, shifting to a more collaborative relationship. The virtual messaging tools enable timely and consistent communication. Staff reported that having standardized assessment enabled better identification of need, and funding allowed expanded access to services such as respite. Web-based statewide resources provide more options to clients than a small regional program can offer, providing more opportunities for caregivers to attend educational and support group resources, from any site. Several sites offered virtual support groups that enabled caregivers to meet at a convenient time without having to worry about finding coverage for the person in their care.

Some staff expressed concern about the digital divide disproportionately affecting certain client populations because of cost, internet access or technological literacy. Both clients and staff missed having in person connections during the pandemic, and some clients were unable or unwilling to join virtual support groups. A few staff perceive the inability to make home visits as precluding precise and comprehensive evaluation of both caregiver and care recipient needs, including safety. Finally, staff recognize that full client engagement will require further tools and education to prepare clients to use the CareNav™ platform.

Staff reported positive client feedback about using CareNav™, including that it saves time and improves quality of life. Specifically, clients appreciate having a centralized resource that records precise identification of both care recipient and caregiver needs, coupled with tailored resources. They appreciate seeing the questions, being able to upload forms, as well as the security and privacy of the site. For some clients, learning how to use CareNav™ opened the door to using other technologies, developing tech literacy and confidence. Consultants also noted the power of asking certain questions

that help caregivers to evaluate their situation and change behavior (for example, drinking alcohol).

“...I did a follow up three months later, and she [one of the clients] said she was glad that I asked that question because it made her look at herself and reevaluate her [...] couple of glasses of wine every night and change those habits.”

Overall, staff report that CareNav™ has improved their ability to identify and respond to client needs and has changed the way they engage with clients.

“...that [the results of the assessment] gives you room to have a conversation [...]. No wonder you're feeling so overwhelmed. Look at, this is what you just told us. We're not guessing you're overwhelmed. You just told us you were overwhelmed, right, by answering these questions in that way. So, having the questions you ask in CareNav™, sort of be the structure for that, the clinical interview, [...], but taking that information and using it for developing the care plan [...]. You said you don't have your financial [...] documents in order, so [...] perhaps that should be on your care plan, right? Is that something that you can commit to do? [...] you're feeling overwhelmed and isolated, perhaps one of our support groups might work, right? [...] what we ask in the assessment tells you, sort of, informs the conversation with the client.”

Implementation of CareNav™ was timely as the COVID-19 pandemic disrupted office work and in-person engagements. By deploying this system, consultants were able to increase services during the pandemic when they were most needed and while many services for caregivers were closing. In the coming years, over the next phases of the pandemic, staff indicate that the CRC sites and system will grapple with the ideal balance between online and in-person client engagement and will identify activities that benefit from in-person contact.

Site-level outcomes

Participants identified several site-level structures, processes, and outcomes impacted by the implementation process. Several sites reported reorganizing staff, refining roles to accommodate the new workflow, and improving team collaboration. One site reported operational efficiencies created by the CareNav™ system, enabling them to assign entry level staff to the intake process, reserving masters-level consultants for the standardized assessment. Several reported that the assessment saves time, particularly when clients self-administer at least a portion of the assessment. Virtual visits save both staff time and transportation costs for staff and clients. Real-time data entry also saves and eliminates paper waste, as well as filing and storage costs.

The implementation process provided an opportunity to reflect on and revise workflow at the sites, resulting in streamlining core processes such as timing for assessment and reassessment and processes for making service referrals. Site leaders cite administrative efficiencies and improved ability to serve clients, particularly for those

servicing large geographic areas. They also appreciate the ability to monitor the quality of service more systematically and consistently and assess employee productivity. Both the reports generated within CareNav™ and the quarterly summaries provided by the UC Davis evaluation team provide new information for sites to better understand the population they are serving and to guide decision making regarding outreach, service provision and advocacy needs.

The additional state-level funding investment, coupled with CareNav™ deployment, enabled CRC sites to provide more services to more clients. They were able to expand services and increase their visibility, reaching those they have not served before. Reports have elucidated service gaps and populations in the region who remain underserved by the CRC sites, contributing to more targeted future plans.

System outcomes

The most commonly discussed system outcome was the statewide identity across the sites that has created various opportunities for current and future partnership. The sites appreciate having a shared identity created by the “reunion” after many years of decentralized operation. Almost all participants are motivated by a shared vision and mission and feel a sense of community afforded by being part of a state-wide system with a common identity. Several express pride in being part of a system that is a model for the nation and has a goal to support all caregivers in California. Site leaders recognize the power of working together and using their collective data to better serve clients and to substantiate the needs and requests for funding from various sources including government and non-governmental organizations.

CRC leaders also identify system-level outcomes that benefit clients directly. They recognize the potential of shared services, staff, and resources to foster greater inclusion across race/ethnicity and language groups. This has particular impact for service to smaller populations who are geographically dispersed. The state-wide shared calendar of virtual events is the prime example of wide dissemination of valuable resources across the entire state. Some sites have also noted the ease of transfer for clients relocating from one region to another.

“...the whole CRC, coming together after all these years, communicating, I think that us sharing information and also promoting the educational presentations, that's been wonderful. I think all of us coming together. And we have people from all over the state learning from, and participating in these presentations or conferences, you know, not just within our area. So we're learning from each other. Not just as staff, as CRCs, but also our caregivers.”

The CRC leaders have formed a learning community with one another, sharing best practices and knowledge to improve the quality of their programming and operations. Directors and clinical directors have developed system-wide clinical policies and engaged in cross-site marketing efforts. Several statewide meetings are occurring that build collective momentum, including directors, clinical directors, supervisors, and

education coordinators. The statewide education committee enriches site-level effectiveness as well as creating shared resources.

“Since we’ve gone forward with CareNav™, our entire Caregiver Resource Center system has really gone through a massive enhancement. And I think a lot of it is the work that the directors and the staff have done. So we’re getting together on a regular basis. We’re meeting. We are developing, you know, policies with the clinical side, the staff, they’re getting together and they’re coming up with policies. We’ve created a marketing campaign. Through Zoom, we’re now sharing education events statewide and collecting data statewide. So again, CareNav™ is critical tool. But I think the driving force behind everything has been this kind of movement of the Caregiver Resource Centers coming back together, working with lobbyists, legislators, leveraging money to come in and support our efforts.”

Overarching interview themes

Developmental phases of implementation

In interviews exploring the overarching design, the goal of creating a state-wide database and service management system carried a number of important assumptions, including standardizing the assessment, major workflows around services and referrals, and agreeing to shared metrics for success. During the early part of the project, the design team engaged in deep learning at each site to understand the local conditions and to map the technology implementation path. The overall approach to initial deployment was to optimize the common elements and to minimize customization. The philosophy of designing and scaling CareNav™ necessitated balancing the unique data collection and integration needs of each site, with the goal of creating a state-level decision support and resource provision system to expand services for California caregivers. Thoughtful decisions have been made regarding the extent of site-level flexibility that the system can support for each CareNav™ feature without compromising uniformity. Valuing site-level customization while at the same time maintaining the scope and flow of the assessment, reports, and resources created flexible design solutions, according to the priorities and pace of each site and requiring dedicated training.

Similar considerations were at play with regards to CareNav™ functionality. The sites valued long-term case-management which required integrating historic records into CareNav™ for better access. Therefore, several site-level harmonization workflows were developed to address site needs and requirements, according to the available resources. Some functionalities, such as finance management support, were not envisioned as part of CareNav™, rather as having an interface with CareNav™, and thus have been deemphasized from the outset, despite the expectations of a few administrators for a full-service platform.

While all CRC sites are now using CareNav™ for daily operations, individual sites represent different dynamic stages of operational integration of CareNav™, outreach approaches and expansion of services, and diversity, equity, and inclusion efforts. Developmental phases are shaped by the baseline systems in place at each site, their unique local conditions and relationships, and when they went live with the program. With the complexity of CRC operations, from client engagement to outreach to creating business efficiencies, it is not surprising that sites manifest variable patterns of implementation phases across CareNav™ and services expansion dimensions.

“Learning a new system. It just requires [...] time and patience and flexibility. And one thing came up [...] about CareNav™ in particular. [...] there's a lot of functionality built into it. We can do a lot of things with CareNav™. And so right now we're doing, maybe we're only using a certain percentage of all of the tools that are built into it, and really learning how.”

Table V-f summarizes the implementation phases across CareNav™ functionality, CareNav™ features, outreach, and diversity, equity, and inclusion. Sites were categorized as early phase when they focused on technical aspects of implementation and actions that include basic data collection and documentation, using pre-defined report templates, a passive approach to guiding clients to self-administer, relying on historical referral sources, and viewing diversity, equity, and inclusion at a task vs. strategic level. Sites were categorized as more advanced when they presented a more strategic and outcome-oriented focus. Advanced-phase sites use data for client service, site level improvements, and for informing state-wide strategy, creating reports to guide quality improvement, using data to understand community need and gaps in service and to inform outreach, and thinking more deeply about the meaning of diversity, equity, and inclusion, applying a strategic lens to this vital work. As can be seen in Table V-f, sites are in different phases of implementation depending on the dimension, with one site operating at an advanced level across all and one site at an early level across all dimensions. To date, the greatest progress across all sites is in using CareNav™ and opening a client portal, with moderate progress in using standardized assessment and creating reports. Using data to create strategy for outreach and to optimize diversity, equity and inclusion has begun, with room for growth in these areas.

Leaders are committed to moving forward based on these lessons learned in crafting the future hybrid model of CRC service delivery, building on the successes of both the in-person and online aspects of the programs. They recognize that moving some assessments and services online saves care consultant time and enables the CRCs to serve a larger client base. Another area of planned emphasis is on redesigning the CareNav™ dashboard and improving the user interface to encourage self-administration and self-service (e.g., self-scheduling), saving time for clients and consultants.

Table V-f: Developmental Phases of Implementation

Phases	Dimension Number and Title										
	1	2	3	4	5	6					
	CareNav™ Functionality	CareNav™ Feature: Standardized Assessment	CareNav™ Feature: Report Generation	CareNav™ Feature: Client Portal	Outreach Approach	Diversity, Equity, Inclusion					
Early Phase	Client-level: data collection and documentation	Asynchronous and selected fields; dedicated tech staff entering paper data	Predefined templates	Passive approach	Historical relationships and referral	Translation of materials, focus on specific local ethnic groups					
Moderate to Advanced Phase	Client level: case management and decision support; consultant, site- and system-level: caseload management	Synchronous, comprehensive data collection; staff or clients enter data in real time	Flexible reports run by sites as needed, according to sites' design; use reports for decision support	Active approach: staff encourage and support clients to use client Portal	Using data to guide and evaluate selective outreach	Broad definition of diversity (race/ ethnicity, geography, LGBTQ, income) or data driven					
Dimension Number	Sites										
	1	2	3	4	5	6	7	8	9	10	11
1											
2											
3											
4											
5											
6											

Being Part of System

During interviews, a major theme related to the developmental phase was how each site weighed the benefits of incorporation into the CCRC system alongside the benefits of autonomy as an individual CRC (see [Figure V-c](#)). For some sites, CareNav™ implementation involved a shift in service philosophy, in addition to implementing new technology. For example, this shift triggered a tension between a professional philosophy valuing open-ended interviewing vs. standardization of the intake and assessment processes, an important feature of incorporation into a larger system with a

uniform database. While most sites appreciate that standardized assessment enables the site to match caregivers with complex needs with their most skilled staff, some sites are concerned about losing professional staff who resist conducting standardized assessments. One site described their historic approach of exploring the topics identified by the client, without doing any standardized screening such as for depression, using a reactive approach to building the assessment, rather than a proactive approach. Some participants expressed concern about losing the opportunity to build client rapport when using a standardized assessment rather than relying on a conversation and professional judgement.

"...When you're serving someone, you don't want to seem like you're just checking off, [...] what about this? What about that? [...] I know what that feels like, and I don't like it."

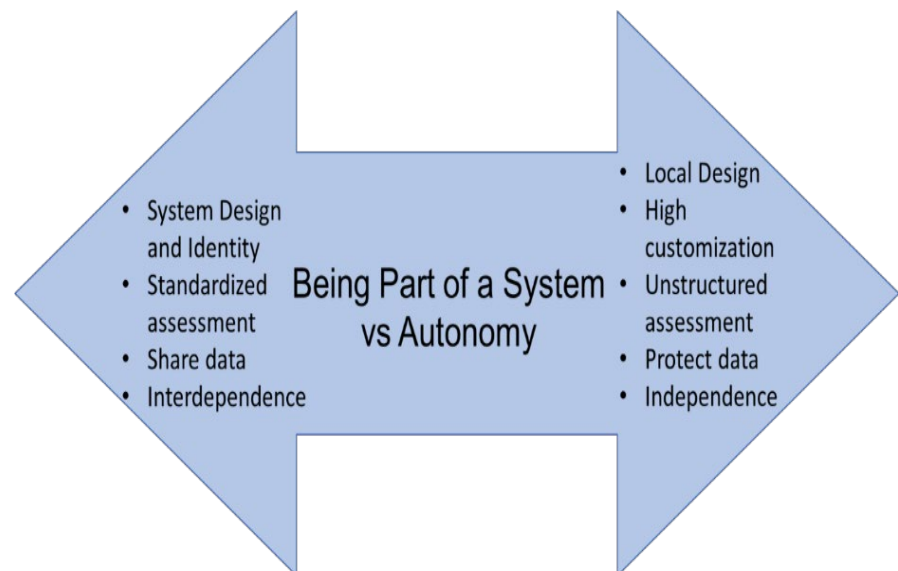
Most of the tension around being a system centered on standardized assessment, coupled with the ability to customize reports to meet local needs. This tension was most acute when a site had a previous data management system in place, requiring adaptation and harmonization.

"All these counties are trying to figure out their office on a standardized assessment, so that you can hand people off and not have to revisit a lot of these questions, and I just think that that's a good thing. I just think that it takes time to implement, and then it takes time to practice it. And do it in a way that kind of meets, I mean, in our, and this is our perspective, obviously, in a way that is humanistic."

Another area of tension related to the extent to which sites are proactive in reaching the population of the region vs. being more reactive and relying on established referral sources. As a system with a commitment to expand services, advanced sites are using data to identify unmet needs in the region and designing strategies to connect with underserved communities and to tailor programs to meet cultural and

linguistic requirements, coupled with collaborating with one another to leverage resources across regions. Having a shared identity and mission, sharing data and collaborating are critical elements to actualize the potential of a system of delivery for California's caregivers.

Figure V-c: Tension: Being Part of a System vs. Autonomy



Implementation of CareNav™ occurred during a unique time in history, with rapid advances in technology in all sectors of society, changing expectations by caregivers as younger generations assume this role, as well as a global pandemic. In many ways, these forces accelerated and aided the implementation process. In other ways, these collective changes deepened the divide between those who are accepting and embracing change and those who prefer to retain the status quo. Going forward, the California CRCs will grapple with important questions about being a system, advancing technological capacity for clients and staff, and solving vital equity issues to get services and supports to all caregivers in need.

IMPACT

The successful implementation of CareNav™ across California has generated enthusiasm for future systemwide efforts with a vision to expand collaboration and reach. Leaders envision bolstering statewide structures to support CRCs workflow, for example, developing a statewide outreach team of dedicated staff to support outreach efforts and expand services. The COVID-19 pandemic accelerated implementation and demonstrated benefits of virtual assessment and service delivery, illuminating operational and staffing efficiencies. Finally, CRC leaders and staff share a commitment to developing a systemwide approach to support linguistic and cultural diversity so that their services and support can reach all communities equitably.

Taken together, findings from the evaluation point to impact as follows:

CRCs serve caregivers who are providing complex, intense, and time-consuming care. Caregivers are often the primary or only caregiver in the situation and commonly have little family or paid support. They are paying the price with their own mental health, experiencing strain, worsening physical health and symptoms of depression and loneliness. The population served is in high need of services and supports. At the same time, this raises the question of how to bolster outreach to caregivers at lower risk, likely greater in number but not currently being served, who might benefit from CRC support and resources earlier in the caregiving trajectory.

Caregivers are highly satisfied with CRC services. Caregivers identify an array of benefits from their engagement with the CRCs, including tangible supports such as respite and legal assistance and emotional supports that improve confidence and capacity to care and reduce isolation. The CRCs have increased service and support during a time of significant need related to the pandemic, providing a lifeline to caregivers.

CareNav™ implementation is advancing. Sites are benefiting from real-time accurate caregiver data and are using data for decision-making regarding programs, outreach, and equity.

The CRCs are functioning as a system. The sites have a shared commitment to supporting California's caregivers and are functioning as a collaborative network, sharing ideas and resources to improve equity, inclusion, and quality.

Fiscal Year 2022 was the third year of the augmentation cycle for the CRCs. In three years, the CRCs:

- Adopted and mastered a variety of communication technologies
- Implemented a client-facing, interactive record platform to provide curated content to individual caregivers and real time data at the site level

- Participated in extensive retraining of staff on change management, how to use communication and client record technologies, retrained on service model definitions and practice issues, telehealth consults and service delivery, and increased use of social media
- Enhanced staff development in areas of diversity and clinical practice
- Expanded referral sources so that 60% of referrals come from social services or health care services
- Established statewide internal CRC committees on policy, clinical supervision, community education and staff education
- Worked with the Evaluation Team at UC Davis to submit information and data for annual reports and participated in process evaluation
- Responded to state and local requests for assistance during COVID-19
- Reorganized to respond to staff and caregiver needs during the pandemic
- More than doubled all service numbers by Year 2 of the augmentation

RECOMMENDATIONS

The CRCs have expanded services and are using CareNav™ data in important ways to inform decisions and strategy. The Caregiver Resource programs could expand upon the following efforts:

- At the CRC site level:
 - Review and address data quality and streamline work processes
 - Use CareNav™ data to improve program quality and responsiveness and refine outreach efforts to reach sub-populations that have yet to benefit from the CRC services and supports
- Across all CRC sites, expand public outreach and information to increase awareness and support caregivers to use CareNav™ as a resource
- At the CRC system level:
 - Refine decision support to identify and target caregivers dealing with the most complexity and most challenging situations, so that CRC staff can be alerted more readily to prioritize these caregivers for services and more frequent reassessment
 - Collaborate to develop strategies to address priority health issues for caregivers, such as loneliness and sleep deprivation
 - Identify opportunities for collaboration that leverage strengths across the system, for example, sharing bilingual staff across regions
 - Prioritize equity and inclusion, identifying potential strategies
- At the state level (California Department on Aging):
 - Consider enhanced funding to enable further service expansion
 - Prioritize funding for increasing diversity, equity, and inclusion with investments in linguistic and cultural refinements of resources and supports already available in the CRC system
 - Use data on caregivers and services to inform implementation of the California Master Plan on Aging and other statewide planning efforts.
 - Collaborate with CRCs to advance caregiving service standards and quality

REFERENCES

1. National Alliance for Caregiving and AARP (2020). Caregiving in the US: 2020. Washington DC: NAC and AARP. <https://www.caregiving.org/caregiving-in-the-us-2020/>
2. Reinhard, SC, Young, HM, Levine, C, Kelly, K, Choula, R, and Accius, J. (2019). Home Alone Revisited: Family Caregivers Providing Complex Care. Washington DC: AARP. <https://www.aarp.org/content/dam/aarp/ppi/2019/04/home-alone-revisited-family-caregivers-providing-complex-care.pdf>
3. Reinhard, S, Feinberg, LF, Houser, A, Choula, R, and Evans, M. (2019). Valuing the Invaluable 2019 Update: Charting a Path Forward. Washington DC: AARP. <https://www.aarp.org/ppi/info-2015/valuing-the-invaluable-2015-update.html>
4. National Center for Health Statistics. (2019). National Health Interview Survey, Tables of Summary Health Statistics. <https://www.cdc.gov/nchs/nhis/shs/tables.htm>
5. Health Resources & Services Administration. (2020). Vulnerable Populations. In Health Workforce Glossary. <https://bhw.hrsa.gov/glossary>
6. National Alliance for Caregiving and AARP. (2016). Caregiving in the U.S. 2015 Appendix B: Detailed Methodology. Washington, DC: NAC and AARP. <https://www.caregiving.org/wp-content/uploads/2020/05/CGV016-Main-Report-Appendix-B-Detailed-Methodology-5.21.15.pdf>
7. U.S. Census Bureau. *American Community Survey 1-year estimates: Census Reporter Profile page for California* (2019). Washington DC: US Census Bureau. <http://censusreporter.org/profiles/04000US06-California>
8. Villarroel MA and Terlizzi EP. (2019). Symptoms of depression among adults: United States, 2019. NCHS Data Brief, no 379. Hyattsville, MD: National Center for Health Statistics. 2020. <https://www.cdc.gov/nchs/products/databriefs/db379.htm>
9. Bédard, M., Molloy, DW, Squire, L, Dubois, S, Lever, JA, & O'Donnell, M (2001). The Zarit Burden Interview: a new short version and screening version. *The Gerontologist*, 41(5):652-657

APPENDIX

A. Glossary

B. Technical specifications

C. Appendix tables

1. Table C1: Case Status Summary by Quarter and CRC - Fiscal Year 2021 – 2022
2. Table C2: Caregiver Activity Summary by Quarter and CRC - Fiscal Year 2020 – 2021
3. Table C3: Service Grant Vouchers by Quarter and CRC - Fiscal Year 2020 - 2021

A. Glossary

Table Appendix A.1.: Glossary of Terms

Terms	Definitions
Caregiver Education/ Training	Individually tailored workshops on long-term care, patient management, public policy issues, and legal/financial issues.
CareNav™	A secure, interactive electronic social care record for family caregivers.
CRC Core Services	See Table I-b in the body of the report.
Family Consultation	Individual sessions and telephone consultations with trained staff to assess needs of both the individuals who are incapacitated and their families, and to explore courses of action and care options for caregivers to implement.
Individual Counseling	Family, individual and group sessions with licensed counselors to offer emotional support and help caregivers cope with the strain of the caregiving role. This activity may take place with counselors within the CRC or by service grant vouchers for use with counselors outside the CRC.
Intake and Assessment	Standardized intake and assessment tools to help define and explore issues, options and best package of information, to determine interventions and services for caregivers, and to provide key data for evaluation and program design.
Legal Consultation	Personal consultations with experienced attorneys regarding powers of attorney, estate and financial planning, conservatorships, community property laws and other complex matters; accessed with service grant voucher.
New Case	Date of first CRC assessment is within reporting period.
Ongoing Case with activity	Activity within reporting period; date of first CRC assessment within two years before reporting period.
Ongoing Case without activity	No activity within reporting period; date of first CRC assessment within two years before reporting period.
Psycho-education	Group workshops and classes in which participants to learn new skills to apply to cope with stress and burden in their personal lives and, with practice, to use these skills consistently enough to cause changes in their lives.
Reassessment	Includes a subset of the assessment questions, designed for follow-up approximately six months after assessment.

Terms	Definitions
Respite	Financial assistance for brief substitute care in the form of in-home support, adult day care services, short-term or weekend care, and transportation to assist families caring at home for an adult with a disabling condition.
Reporting Period	Fiscal Year 2019-2020 (7/1/2019-6/30/2021) Fiscal Year 2020-2021 (7/1/2020-6/30/2021) Quarter 1: 7/1/2021-9/30/2021 Quarter 2: 10/1/2021-12/31/2021 Quarter 3: 1/1/2022-3/31/2022 Quarter 4: 4/1/2022-6/30/2022
Supplemental Grant	Supplemental Grant: service grant voucher for supportive tangible items most commonly durable medical equipment or groceries.
Support Group	On-line or in-person caregiver support groups.
Total Open Cases	The unduplicated count of caregivers who have had their first assessment: <ul style="list-style-type: none"> • During one of this fiscal year's quarters. • Within the past two years of any of this fiscal year's quarters

B. Technical Specifications

Inclusion Criteria

Cases were included in the evaluation analysis if:

- County is not missing / null
- Case is not deleted / retired
- Caregiver funding eligibility includes DHCS. Note this filter was not applied to intake assessment because funding eligibility is not always known at that time.

Activities were included in the evaluation analysis if:

- Activity is not deleted
- Activity duration is greater than zero (durationHours>0)
- Activity date falls within reporting period

Counts of caregivers, service activities (other than intake assessments) and grant vouchers distributed are limited to caregivers eligible for DHCS funding; therefore, these counts do not reflect the entirety of the CRC caseloads and services provided. CRCs provide additional services funded by county contracts, foundations, business partners and donations.

Case Status Counts

All totals reported in [Table III-a: Case Status Summary – All California CRCs Combined](#) represent unduplicated counts of caregivers who have had an assessment within the two years before each respective quarter. A caregiver is no longer an ongoing case in later quarters of the same fiscal year if those quarters lie outside of the two-year window of the most recent assessment. A given caregivers can be categorized as a new case, an ongoing case with activity, and ongoing case without activity at various points across quarters. The same caregiver can be counted in up to four categories but is always counted as an open case. Thus, the pool of caregivers remains fixed at 10,887 total open cases for this year. Please see Table B1 for example cases of how counts are conducted.

Table B1: Caregiver Case Status Journey Examples

Quarter	Caregiver 1	Caregiver 2	Caregiver 3	Caregiver 4
Most recent assessment within previous two years?	No	Yes	No	Yes
Q1	First Assessment	No Activity	No Activity	No Activity
Q2	Activity	No Activity	No Activity	No Activity
Q3	Activity	No Activity	No Activity	No Activity
Q4	No Activity	Activity	First Assessment	No Activity
FY Case Summary	<ul style="list-style-type: none"> • New Case • Ongoing Case with Activity • Ongoing Case without Activity • Open Case 	<ul style="list-style-type: none"> • Ongoing Case with Activity • Ongoing Case without Activity • Open Case 	<ul style="list-style-type: none"> • New Case • Open Case 	<ul style="list-style-type: none"> • Ongoing Case without Activity • Open Case

Delivery Mode

Delivery modes (i.e., telephone, CRC office visits, online, video/telehealth, etc.) for intakes, assessments, and reassessments are not presented in this annual report. We identified data quality issues related to how this is currently recorded in CareNav™. Specifically, we found that the “online” status of caregivers who initiate or complete forms through the online CareNav™ portal appear to be overwritten when clinicians modify or submit any elements of these forms. Thus, there is no current way to delineate the true distribution of delivery modes. In ongoing efforts, QP, UC Davis and FCA are collaborating to address this issue and to clarify classification priorities given that some forms are completed after engagement through multiple delivery modes.

Service Grant Voucher Totals

Service grant voucher totals reflect entries into CareNav™ by CRC staff; they are not official summaries derived from the CRC accounting systems. As such, there may be minor discrepancies between the totals presented in this report and those reported by the CRCs for other purposes.

Case Tallies

The ongoing and open cases tallies may be incomplete in this fiscal year based on the individual CRC timing of complete CareNav™ adoption. These tallies rely on ascertainment of assessment in the prior two years. Not all CRCs have complete data during this two-year period; therefore, the tallies underestimate the true caseload. The denominators for the analysis of caregiver and care recipient characteristics derived from assessments and the count of assessments in the activity tables are similar, but do not match exactly. This is because the case analysis was conducted with data extracted from CareNav™ at a slightly earlier date than the analysis of assessment counts.

Although the reporting periods are the same, the later extraction includes a small number of assessments entered by the CRCs after the initial reporting deadline.

Missing Data

The analysis of caregiver and caregiver sociodemographic characteristics, caregiver health, caregiving variables (hours, medical/nursing tasks etc.,) focused on complete case analysis (i.e., observations with non-missing data) for caregivers who had an assessment in the current fiscal year ($n = 4,299$). Overall, missing data appears to be minimal (less than 10% for any given variable). To improve data quality and reporting, the UC Davis evaluation team is working with Quality Process and FCA to develop algorithms that accurately report the prevalence of missing data for future reports for each variable in CareNav™ by CRC and by activity (i.e., intake, assessment or reassessment).

Measures

Zarit Burden Interview Screening

Caregiver strain was assessed using the 4-item screening version of the Zarit Burden Interview, which assesses caregiver strain by asking how frequently the caregiver experiences the following feelings: 1) that because of the time you spend with your relative that you don't have enough time for yourself; 2) stressed between caring for your relative and trying to meet other responsibilities (work/family); 3) strained when you are around your relative; and 4) uncertain about what to do about your relative. Caregivers respond to each item as 0 (never), 1 (rarely), 2 (sometimes), 3 (quite frequently), or 4 (nearly always), with total scores ranging from 0-16 and higher scores indicating higher levels of strain. We categorized caregivers as experiencing substantial strain if they scored 8 or above.

Bédard, M., Molloy, D. W., Squire, L., Dubois, S., Lever, J. A., & O'Donnell, M. (2001). The Zarit Burden Interview: a new short version and screening version. *The Gerontologist*, 41(5), 652-657.

Patient Health Questionnaire-9 (PHQ-9)

The Patient Health Questionnaire-9 (PHQ-9) is a 9-item questionnaire that assesses depressive symptoms, including: 1) little interest or pleasure in doing things; 2) feeling down, depressed, or hopeless; 3) trouble falling or staying asleep, or sleeping too much; 4) feeling tired or having little energy; 5) poor appetite or overeating; 6) feeling bad about yourself-- or that you are a failure or have let your family down; 7) trouble concentrating on things, such as reading the newspaper or watching television; 8) moving or speaking so slowly that other people could have noticed? Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual?; and 9) thoughts that you would be better off dead or hurting yourself in some way.

Caregivers report how often they have been bothered by the nine symptoms over the past two weeks, rating each item as 0 (not at all), 1 (several days), 2 (more than half the days), or 3 (nearly every day). Scores are summed, with possible scores ranging from 0-27 and higher scores indicating greater symptom burden. We categorized caregivers

into one of five levels based on their total PHQ-9 scores: none (0-2); minimal/mild (3-9); moderate (10-14); moderate/severe (15-19); or severe (20-27).

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: validity of a brief depression severity measure. *Journal of General Internal Medicine*, 16(9), 606-613.

UCLA-3 Loneliness Scale

Loneliness was assessed using the UCLA-3 Loneliness Scale. The UCLA-3 asks three questions about how often the caregiver has felt that they 1) lack companionship, 2) feel left out, and 3) feel isolated from others. The caregiver responds to each item on a scale from 1 (hardly ever) to 3 (often). Responses to the three questions are summed, with total scores ranging from 3-9 points. Caregivers with scores of 6 and above are categorized as experiencing loneliness.

Russell, D. W. (1996). UCLA Loneliness Scale (Version 3): Reliability, validity, and factor structure. *Journal of Personality Assessment*, 66(1), 20-40.

AARP Care Index

Level of care and care intensity were calculated using a formula developed by AARP, based on points assigned for the number of activities of daily living (ADLs) and instrumental activities of daily living (IADLs) assisted with, and weekly hours spent on caregiving.

In CareNav™, caregivers were asked about a total of fifteen different activities and how much help the care recipient needed with each. For the purposes of calculating the level of care and care intensity, we selected the 6 activities that aligned most with the ADLs and 7 activities that aligned best with the IADLs assessed in the AARP survey. See tables B2 and B3 below for ADLs and IADLs in AARP and equivalent activities in CareNav™. Caregivers were considered as assisting with an ADL or IADL if they reported that the care recipient needed at least a little help with the activity.

Table B2. Activity of Daily Living (ADL) Variables in AARP and equivalent activity variables in CareNav™

AARP	CareNav™
Getting in/out of bed/chair	Transferring
Getting Dressed	Dressing
Getting to and from toilet	Using Toilet
Bathing or showering	Bathing/showering
Dealing with Incontinence/Diapers	Incontinence
Feeding	Eating

Table B3. Instrumental Activity of Daily Living (IADL) Variables in AARP and equivalent activity variables in CareNav™

AARP	CareNav™
Finances	Managing Finances
Grocery or other Shopping	Shopping
Housework	Household chores
Preparing Meals	Preparing meals
Transportation	Transportation
Giving Medications (asks about this in the same list but doesn't tally as ADL)	Taking medications
Arranging Services, such as nurses, aides, etc.	Using Telephone

Points were then assigned based on the number of ADLs and IADLs performed consistent with the points assigned for the AARP level of care index variable (see Table B4).

Table B4. Level of Care Formula Points Assigned for Types of Care (ADLs and IADLs) Provided

ADL and IADL Totals	Points Assigned
0 ADLs; 1 IADL	1 point
0 ADLs; 2+ IADLs	2 points
1 ADL + any number of IADLs	3 points
2+ ADLs + any number of IADLs	4 points

Weekly caregiving hours were also categorized slightly differently between the two datasets. Table B5 shows the equivalent categories between AARP and CareNav™, as well as the points assigned for the level of care and care intensity calculations.

Table B5: Weekly Hours Spent on Caregiving in AARP and CareNav™ and points assigned for level of care/care intensity calculation

AARP	CareNav™	Points Assigned
0-8hrs	1-<10 + 0	1 point
9-20	11-<20	2 points
21-40	20-<30 + <40	3 points
41+	>40	4 points

Level of care and care intensity were calculated based on total scores for both types of care provided and weekly caregiving hours (see Table B6).

Table B6: Formula for calculating level of care and care intensity variables

Total Points (weekly caregiving hours + types of care provided)	Level of Care	Care Intensity
2-3 points	Level 1	Low Intensity
4 points	Level 2	
5 points	Level 3	Medium Intensity
6-7 points	Level 4	High Intensity
8 points	Level 5	

Caregiving in the U.S. 2015 Appendix B: Detailed Methodology (2016). Retrieved from Washington, D. C.: <https://www.caregiving.org/wp-content/uploads/2015/05/CGV016-Main-Report-Appendix-B-Detailed-Methodology-5.21.15.pdf>

Racial and Ethnic Identity Categories

For consistency, we use the following category labels through the report: White non-Hispanic, Hispanic/Latino, Asian American/Pacific Islander, Black non-Hispanic, and multi-racial/other racial identity. These categories closely match those collected in CareNav™ and were mapped to categories used in other data sources in the report (e.g., state and national datasets, US Census files) with only minor modifications.

C. Appendix Tables

Table C1: Case Status Summary by Quarter and CRC - Fiscal Year 2021 - 2022

Quarter 1	Total	Mean	Bay Area	Coast	Del Mar	Del Oro	Inland	LA	Orange	Passages	Redwood	Southern	Valley
New Cases	1,259	114	115	46	47	126	102	191	89	53	89	241	160
Ongoing Cases with Activity	3,159	287	262	150	152	471	338	565	207	99	200	363	352
Ongoing Case no Activity	3,426	311	561	348	122	616	140	317	344	81	151	454	292
Active Cases	7,844	713	938	544	321	1,213	580	1,073	640	233	440	1,058	804
Quarter 2	Total	Mean	Bay Area	Coast	Del Mar	Del Oro	Inland	LA	Orange	Passages	Redwood	Southern	Valley
New Cases	899	82	109	50	26	116	95	84	71	23	63	156	106
Ongoing Cases with Activity	3,548	323	266	136	161	469	420	637	325	105	204	402	423
Ongoing Case no Activity	3,753	341	571	350	127	614	112	352	262	127	213	656	369
Active Cases	8,200	745	946	536	314	1,199	627	1,073	658	255	480	1,214	898
Quarter 3	Total	Mean	Bay Area	Coast	Del Mar	Del Oro	Inland	LA	Orange	Passages	Redwood	Southern	Valley
New Cases	1,140	104	132	75	31	128	86	125	81	33	106	221	122
Ongoing Cases with Activity	3,386	308	238	137	157	337	419	574	312	133	221	485	373
Ongoing Case no Activity	4,222	384	605	351	138	671	179	399	288	122	244	729	496
Active Cases	8,748	795	975	563	326	1,136	684	1,098	681	288	571	1,435	991
Quarter 4	Total	Mean	Bay Area	Coast	Del Mar	Del Oro	Inland	LA	Orange	Passages	Redwood	Southern	Valley
New Cases	1,004	91	106	66	48	97	83	98	82	30	102	160	132
Ongoing Cases with Activity	3,676	334	280	140	111	416	432	592	341	165	263	544	392
Ongoing Case no Activity	4,269	388	583	330	161	524	200	361	259	123	287	891	550
Active Cases	8,949	813	969	536	320	1,037	715	1,051	682	318	652	1,595	1,074

Fiscal Year	Total	Mean	Bay Area	Coast	Del Mar	Del Oro	Inland	LA	Orange	Passages	Redwood	Southern	Valley
New Cases	4,302	391	462	237	152	467	366	498	323	139	360	778	520
Ongoing Cases with Activity	6,897	627	617	321	289	977	661	1,014	560	250	442	989	777
Ongoing Case no Activity	9,883	898	1,179	669	378	1,457	761	1,282	792	289	609	1,435	1,032
Active Cases	10,887	990	1,285	735	426	1,554	844	1,380	874	319	711	1,595	1,164

*Ongoing and Open Case Tallies may be incomplete based on CRC timing of CareNav™ adoption

* Definitions - refer to Appendix A: Glossary

* Inclusion Criteria – refer to Appendix C: Technical Specifications

* Activity reporting dates by quarter: Q1 = 7/1/2021-9/30/2021; Q2 = 10/1/2021 - 12/31/2021; Q3 = 1/1/2022-3/31/2022; Q4 = 4/1/2022-6/30/2022

* All totals represent deduplicated counts. Caregivers could occupy the new cases, ongoing cases with activity, and ongoing cases without activity categories at various points across quarters. Therefore, the same caregiver can be counted in up to four categories, including total open cases, but the pool of caregivers remains fixed at 10,887 total open cases for the year.

* Data extraction dates: 08/01/2022 – 08/10/2022

Table C2: CRC Caregiver Activity Summary by Quarter and CRC - Fiscal Year 2021-2022

Intake	Total	Mean	Bay Area	Coast	Del Mar	Del Oro	Inland	LA	Orange	Passages	Redwood	Southern	Valley
Quarter 1	1,878	171	291	94	45	140	155	298	144	62	107	354	188
Quarter 2	1,323	120	230	85	27	126	109	160	116	24	83	222	141
Quarter 3	1,813	165	342	127	29	145	141	176	128	52	158	335	180
Quarter 4	1,634	149	361	106	50	104	122	114	141	45	156	278	157
Fiscal Year	6,648	604	1,224	412	151	515	527	748	529	183	504	1,189	666
Assessment	Total	Mean	Bay Area	Coast	Del Mar	Del Oro	Inland	LA	Orange	Passages	Redwood	Southern	Valley
Quarter 1	1,284	117	117	50	48	135	102	192	91	54	92	241	162
Quarter 2	928	84	110	53	26	132	95	84	72	24	65	156	111
Quarter 3	1,178	107	137	77	33	144	86	128	84	33	109	223	124
Quarter 4	1,043	95	110	66	48	124	83	99	87	31	103	160	132
Fiscal Year	4,433	403	474	246	155	535	366	503	334	142	369	780	529
Reassessment	Total	Mean	Bay Area	Coast	Del Mar	Del Oro	Inland	LA	Orange	Passages	Redwood	Southern	Valley
Quarter 1	834	76	44	54	15	214	89	72	52	64	56	91	83
Quarter 2	792	72	51	33	21	176	94	75	93	47	48	67	87
Quarter 3	875	80	39	28	25	149	79	96	105	78	50	87	139
Quarter 4	825	75	44	23	13	181	87	97	95	52	62	79	92
Fiscal Year	3,326	302	178	138	74	720	349	340	345	241	216	324	401
Family Consultation	Total	Mean	Bay Area	Coast	Del Mar	Del Oro	Inland	LA	Orange	Passages	Redwood	Southern	Valley
Quarter 1	33,864	3,079	1,557	670	1,200	2,522	6,036	7,774	2,548	453	2,756	5,968	2,380
Quarter 2	32,859	2,987	1,398	697	974	2,768	6,277	8,448	3,198	367	2,171	4,185	2,376
Quarter 3	34,593	3,145	1,209	872	1,113	1,847	5,829	10,106	3,093	532	2,404	5,104	2,484
Quarter 4	32,350	2,945	1,233	860	924	1,979	6,611	8,453	2,668	691	1,938	4,383	2,610
Fiscal Year	133,666	12,151	5,397	3,099	4,211	9,116	24,753	34,781	11,507	2,043	9,269	19,640	9,850

Support Group (Unique Caregivers)	Total	Mean	Bay Area	Coast	Del Mar	Del Oro	Inland	LA	Orange	Passage	Redwood	Southern	Valley
Quarter 1	529	48	43	21	30	13	79	127	41	41	52	71	11
Quarter 2	549	50	64	24	32	10	74	108	41	44	69	65	18
Quarter 3	553	50	48	34	30	14	80	117	46	41	68	65	10
Quarter 4	538	49	56	28	30	13	83	95	52	37	68	73	3
Fiscal Year	1,054	96	104	62	49	20	142	212	95	77	144	118	31
Individual Counseling (Unique Caregivers)	Total	Mean	Bay Area	Coast	Del Mar	Del Oro	Inland	LA	Orange	Passage	Redwood	Southern	Valley
Q1, in house	60	5	1	19	0	0	24	0	1	0	0	15	0
Q1, vouchered service	86	8	31	23	0	13	0	0	0	11	1	0	7
Q2, in house	62	6	2	17	0	0	32	0	0	0	0	11	0
Q2, vouchered service	119	11	45	29	0	27	0	0	0	11	1	0	6
Q3, in house	64	6	1	27	1	0	24	0	0	0	0	10	1
Q3, vouchered service	156	14	49	47	1	22	0	20	0	8	3	0	6
Q4, in house	71	6	0	23	2	0	30	0	8	0	0	8	0
Q4, vouchered service	131	12	40	37	2	11	0	25	0	7	3	0	6
Total, in house	174	16	2	53	2	0	72	0	9	0	0	35	1
Total, vouchered service	267	24	92	63	2	34	0	29	0	20	4	0	23
Total, all	441	40	94	116	4	34	72	29	9	20	4	35	24

*Unique caregiver count totals do not reflect the sum of all unique caregivers across quarters – this would result in duplicate counting. The Fiscal Year and total counts are deduplicated for the entire year whereas each quarter count is deduplicated by that specific quarter. This means that the same caregiver can appear across multiple quarter counts but will only be counted once for the annual total.

*Definitions - refer to Appendix A: Glossary

*Inclusion Criteria – refer to Appendix C: Technical Specifications

* Activity reporting dates by quarter: Q1 = 7/1/2021-9/30/2021; Q2 = 10/1/2021 - 12/31/2021; Q3 = 1/1/2022-3/31/2022; Q4 = 4/1/2022-6/30/2022

* Data extraction dates: 08/01/2022 – 09/15/2022

Table C3: Service Grant Vouchers by Quarter and CRC - Fiscal Year 2021 - 2022

Quarter 1	Legal Consultation				Respite				Supplemental		
	Transactions	Clients	Hours	Amount	Transaction	Clients	Hours	Amount	Transaction	Clients	Amount
Bay Area	7	7	11	\$1,575	43	29	1,426	\$31,100	19	14	\$2,962
Coast	0	0	0	\$0	128	64	1,618	\$52,262	0	0	\$0
Del Mar	9	9	9	\$950	19	17	571	\$12,671	0	0	\$0
Del Oro	1	1	2	\$200	51	37	765	\$21,711	0	0	\$0
Inland	0	0	0	\$0	38	31	1,606	\$28,828	5	3	\$528
LA	0	0	0	\$0	6	5	286	\$7,835	1	1	\$46
Orange	0	0	0	\$0	143	63	2,065	\$54,786	42	22	\$13,504
Passages	0	0	0	\$0	56	40	679	\$20,464	0	0	\$0
Redwood	2	2	2	\$190	101	66	7,474	\$215,232	0	0	\$0
Southern	5	5	5	\$525	107	73	2,002	\$48,246	0	0	\$0
Valley	2	2	2	\$350	404	260	5,795	\$141,805	0	0	\$0
Total	26	26	31	\$3,790	1,096	685	24,287	\$634,938	67	40	\$17,039
Quarter 2	Transactions	Clients	Hours	Amount	Transaction	Clients	Hours	Amount	Transaction	Clients	Amount
Bay Area	1	1	1	\$120	50	33	1,598	\$35,458	0	0	\$0
Coast	0	0	0	\$0	175	89	1,921	\$61,277	0	0	\$0
Del Mar	5	5	5	\$500	69	38	2,158	\$52,612	0	0	\$0
Del Oro	13	13	23	\$2,270	157	84	3,168	\$99,732	0	0	\$0
Inland	0	0	0	\$0	71	50	2,252	\$38,312	5	5	\$1,121
LA	0	0	0	\$0	31	25	380	\$10,721	35	17	\$2,076
Orange	0	0	0	\$0	322	112	3,932	\$113,555	28	23	\$10,630
Passages	1	1	1	\$175	143	56	1,476	\$44,403	0	0	\$0
Redwood	6	6	6	\$570	190	83	4,828	\$131,402	0	0	\$0
Southern	8	8	8	\$870	176	93	2,611	\$65,580	0	0	\$0
Valley	1	1	1	\$150	345	220	4,708	\$108,376	1	1	\$360
Total	35	35	44	\$4,655	1,729	883	29,031	\$761,427	69	46	\$14,187

	Legal Consultation				Respite				Supplemental		
Quarter 3	Transactions	Clients	Hours	Amount	Transaction	Clients	Hours	Amount	Transaction	Clients	Amount
Bay Area	15	15	22	\$3,450	47	33	1,809	\$38,334	2	2	\$208
Coast	0	0	0	\$0	196	102	2,217	\$70,335	0	0	\$0
Del Mar	4	4	4	\$450	92	53	3,182	\$74,445	0	0	\$0
Del Oro	5	5	9	\$900	288	133	4,701	\$154,270	0	0	\$0
Inland	0	0	0	\$0	53	40	1,644	\$29,551	4	4	\$1,101
LA	2	2	2	\$200	102	68	3,090	\$84,679	90	48	\$10,397
Orange	2	2	2	\$500	403	124	4,088	\$118,019	20	19	\$10,811
Passages	5	5	5	\$875	106	49	1,209	\$36,373	0	0	\$0
Redwood	8	8	8	\$760	159	65	1,945	\$82,932	0	0	\$0
Southern	9	9	9	\$985	59	39	601	\$15,339	0	0	\$0
Valley	5	5	5	\$875	401	248	5,746	\$130,752	1	1	\$432
Total	55	55	66	\$8,995	1,906	954	30,231	\$835,030	117	74	\$22,949
Quarter 4	Transactions	Clients	Hours	Amount	Transaction	Clients	Hours	Amount	Transaction	Clients	Amount
Bay Area	10	10	13	\$1,875	36	23	911	\$28,791	6	4	\$994
Coast	0	0	0	\$0	226	121	3,146	\$101,583	0	0	\$0
Del Mar	9	9	9	\$1,050	109	53	4,313	\$100,278	0	0	\$0
Del Oro	0	0	0	\$0	240	113	3,105	\$97,178	0	0	\$0
Inland	0	0	0	\$0	50	34	2,449	\$39,267	143	137	\$40,782
LA	8	8	8	\$800	220	106	7,299	\$199,051	102	53	\$12,213
Orange	2	2	2	\$500	509	156	5,653	\$185,790	27	25	\$22,601
Passages	5	5	5	\$875	144	71	1,998	\$61,667	0	0	\$0
Redwood	6	6	6	\$570	90	41	251	\$9,200	0	0	\$0
Southern	9	9	9	\$885	80	48	1,064	\$30,773	0	0	\$0
Valley	4	4	4	\$700	366	252	5,641	\$138,802	0	0	\$0
Total	53	53	56	\$7,255	2,070	1,018	35,829	\$992,383	278	219	\$76,589

Fiscal Year	Legal Consultation				Respite				Supplemental		
	Transactions	Clients	Hours	Amount	Transaction	Clients	Hours	Amount	Transaction	Clients	Amount
Bay Area	33	32	45	\$7,020	176	88	5,744	\$133,682	27	20	\$4,164
Coast	0	0	0	\$0	725	206	8,902	\$285,458	0	0	\$0
Del Mar	27	27	27	\$2,950	289	98	10,224	\$240,007	0	0	\$0
Del Oro	19	18	34	\$3,370	736	229	11,738	\$372,891	0	0	\$0
Inland	0	0	0	\$0	212	102	7,951	\$135,958	157	140	\$43,532
LA	10	10	10	\$1,000	359	157	11,054	\$302,286	228	106	\$24,731
Orange	4	4	4	\$1,000	1,377	278	15,738	\$472,150	117	76	\$57,545
Passages	11	11	11	\$1,925	449	106	5,361	\$162,907	0	0	\$0
Redwood	22	22	22	\$2,090	540	142	14,497	\$438,766	0	0	\$0
Southern	31	29	31	\$3,265	422	174	6,278	\$159,939	0	0	\$0
Valley	12	12	12	\$2,075	1,516	500	21,890	\$519,735	2	2	\$792
Total	169	165	196	\$24,695	6,801	2,080	119,378	\$3,223,778	531	344	\$130,765

*Definitions - refer to Appendix A: Glossary

* Activity reporting dates by quarter: Q1 = 7/1/2021-9/30/2021; Q2 = 10/1/2021 - 12/31/2021; Q3 = 1/1/2022-3/31/2022; Q4 = 4/1/2022-6/30/2022

* Data extraction dates: 08/01/2022 – 09/15/2022