





The Porchlight Project: A Pilot Study to Adapt the Senior Companion Program to Enhance Memory Care Services and Supports

Gerontology & Geriatric Medicine
Volume 7: 1–11
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DOI: 10.1177/23337214211017651
journals.sagepub.com/home/ggm


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Abstract

Older adult volunteer programs present an important opportunity to provide low cost, community-based support to families living with Alzheimer's disease and Alzheimer's disease related dementias (AD/ADRD). In this mixed methods pilot study, volunteers ($n = 15$) from the Minnesota Senior Companion Program received training in AD/ADRD and palliative care, with the objective of providing more "dementia capable" support to people living with memory loss and their family caregivers. Volunteers applied their skills by engaging clients in a series of guided conversations over 3 months of dementia capable visits. Despite enrollment challenges, volunteers, clients, and caregivers reported that the intervention was appropriate and useful to improve understanding of memory loss and enhance volunteer-client communication. Results of the pilot study were used to refine the Porchlight Project for a future statewide evaluation.

Keywords

Alzheimer's/Dementia, caregiving and management, volunteering, community, palliative care

Manuscript received: February 2, 2021; **final revision received:** April 14, 2021; **accepted:** April 20, 2021.

Introduction

The public health implications of Alzheimer's disease and Alzheimer's disease-related dementias (hereafter referred to as ADRD) are significant. In 2021, the cost of formal health and long-term care services for people living with ADRD is projected to be \$355 billion; family and friends contribute an additional \$257 billion in unpaid care (Alzheimer's Association, 2021). The health care system does not consistently coordinate long-term services and supports (LTSS) for people with dementia and their family caregivers (Borson & Chodosh, 2014). Therefore, there is a need to identify alternative, community-based approaches to the coordination and delivery of LTSS for ADRD. Among the strategies that have received consideration is the use of volunteer/lay persons to engage families living with ADRD and connect them with LTSS, a potentially scalable and cost-effective approach to bridge the gaps in ADRD care (Fields, Roark, et al., 2021; Samus et al., 2019).

The Senior Companion Program (SCP), funded by Corporation for National and Community Service with

supplemental state and local support, trains volunteers aged 55 years and older to provide friendly visiting services to older adult clients with the goal of alleviating loneliness. Volunteers help clients maintain independent living by assisting with daily activities, such as grocery shopping and transportation to medical appointments, while often simultaneously providing respite to family caregivers (Butler, 2006; Corporation for National & Community Service, 2020). Participation in the SCP has been shown to benefit volunteers by reducing social isolation, improving quality of life, providing purpose and meaning, and enhancing understanding of aging (Butler, 2006; Hood et al., 2018). Similarly, clients have

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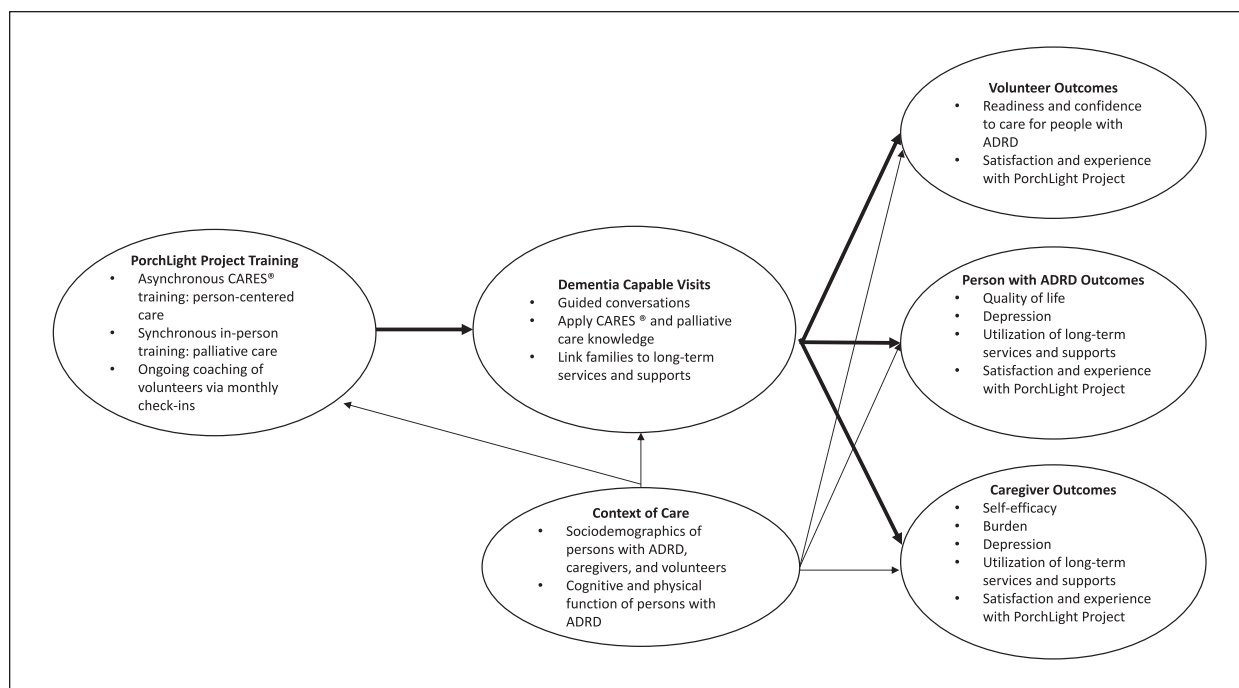


Figure 1. PorchLight Project conceptual model.

reported short-term improvements in their wellbeing, including physical and mental health, functional status, and life satisfaction (Rabiner et al., 2004).

Although national data are unavailable, some state SCPs track the number of clients with ADRD and/or cognitive impairment; for example, one SCP in Texas noted that 35% of their clients receiving respite care had documented cognitive impairment and/or ADRD (Fields, Roark, et al., 2021). To our knowledge, only one study has assessed the effects of a dementia-focused adaptation of an SCP. The Senior Companion Program Plus trained African American volunteers in Texas to provide culturally-tailored psychoeducation to family caregivers of older adults with ADRD (Fields et al., 2020; Fields, Xu, et al., 2021). Volunteers ($n=23$) reported improved understanding of ADRD and overall satisfaction with the training (Fields et al., 2020). Caregivers ($n=16$) also experienced improvements in feelings of social support and well-being (Fields, Xu, et al., 2021). Despite the considerable number of SCP clients with ADRD, most SCPs do not yet provide comprehensive education and training on best practices for engaging older adults with ADRD.

To date, no study has examined the feasibility of a dementia-focused training to increase the readiness of SCP volunteers to engage clients with ADRD. In the Porchlight Project, we developed and pilot tested a training program for SCP volunteers to increase their ADRD knowledge and enhance their communication skills to help clients and their families live with memory loss. Volunteers engaged clients and their caregivers over the course of 3 months to provide dementia-focused support in the context of their usual visits. This study aimed to:

(1) examine the feasibility, acceptability, and utility of the Porchlight Project for volunteers, with a secondary focus on how the enhanced training was received by clients and family caregivers, and (2) refine the delivery and implementation of the project for a future statewide evaluation.

Methods

Conceptualization

The conceptual model guiding the PorchLight Project (Figure 1) was based on our prior experience designing and evaluating caregiver interventions (Gaugler et al., 2015; Gaugler, Reese, et al., 2016) and existing models of health service utilization and dementia caregiver well-being. The PorchLight Project training prepares volunteers to conduct dementia capable visits using a guided conversation approach and best practices in ADRD and palliative care (Britt et al., 2019; Ferrell et al., 2018; Rollnick, 2008). Directed by the Andersen Behavioral model, we framed social relationships between volunteers and clients (enriched by dementia capable visits) as an enabling resource that may help identify and meet clients' care needs (Andersen, 1995). The Stress Process Model (Pearlin et al., 1990) was used to select important context of care variables and identify caregiver role strains that may be alleviated by dementia capable visits. We adapted our conceptual model via regular meetings with our community partner, Lutheran Social Service of Minnesota (LSS-MN), to refine intervention components, identify potential outcomes, and clarify postulated relationships between the two. We

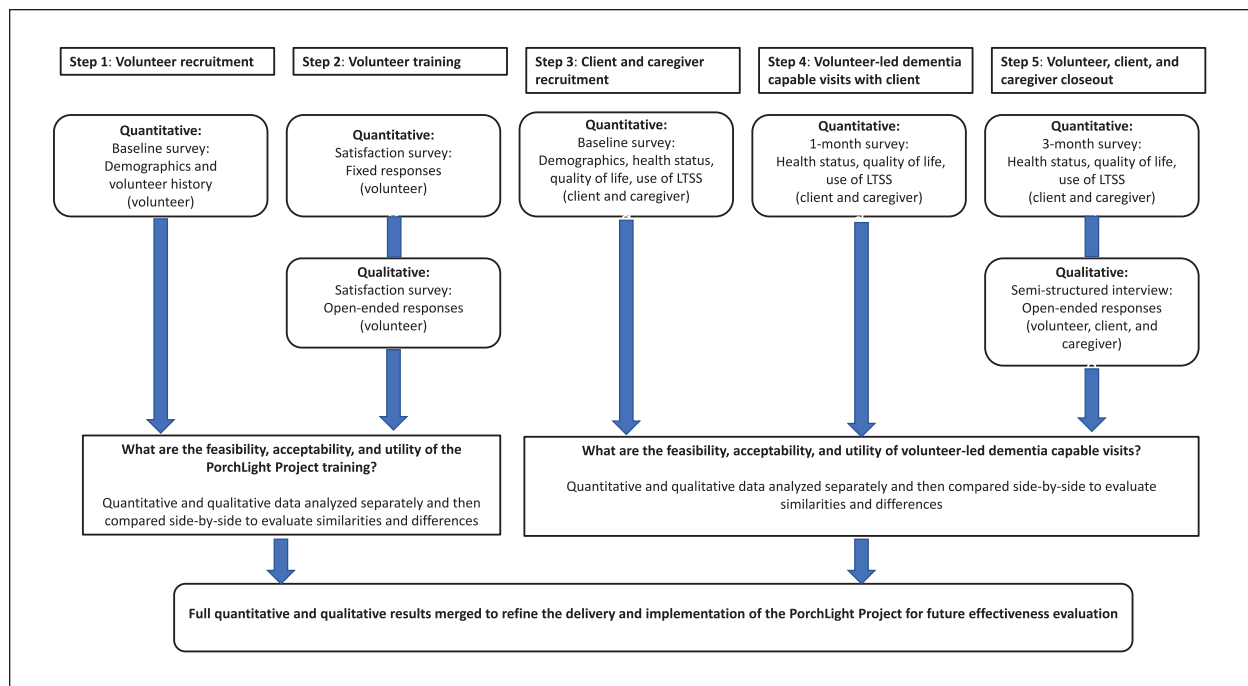


Figure 2. PorchLight Project mixed.

hypothesized that the PorchLight Project will improve volunteer understanding of dementia and readiness to care for clients with memory loss and, secondarily, positively influence the satisfaction of clients and their family caregivers with the SCP.

Study Design

The Porchlight Project (IRB STUDY00004176) was a single-arm pilot study that enrolled volunteers between April 2019 and April 2020 to participate in comprehensive training and 3 months of dementia capable visits with one or more clients and caregivers. Participants were located in two regions of Minnesota, one urban and one rural. We used a parallel convergent mixed methods design to collect, independently analyze the quantitative and qualitative data, and interpret the feasibility, acceptability, and utility of the PorchLight Project (Creswell & Clark, 2017) (Figure 2).

Participants

LSS-MN administers Minnesota's SCP. In 2018, 339 SC volunteers served more than 1,520 clients and families in 78 of Minnesota's 87 counties. Volunteers typically served for 15 to 40 hours per week and received an hourly stipend of \$3.00 and reimbursement for travel and meal expenses (Butler, 2006; Corporation for National & Community Service, 2020).

LSS-MN's regional program coordinators (RPCs) introduced the PorchLight Project to volunteers during SCP meetings and via telephone. They then collected forms from interested volunteers and granted the

University team permission to contact them. Enrolled volunteers were encouraged to discuss the study with their peers and directed questions and concerns to the University and LSS-MN teams. Enrolled volunteers assisted RPCs in recruiting clients and caregivers by distributing flyers and permission to contact forms during their usual visits; RPCs and lead volunteers followed up via telephone as needed.

Volunteers were required to complete all Porchlight Project training components. Clients were required to be ≥ 55 years of age and meet one of the following criteria: (a) client or caregiver was concerned about the client's memory, (b) client had a physician diagnosis of ADRD, or (c) client or caregiver scored ≥ 2 on the AD8, an 8-item validated screening interview that was administered only if prior inclusion criteria were not met (Galvin et al., 2005). Family caregivers were required to be ≥ 21 years of age and provide care to an eligible client at least in part due to their cognitive impairment. Volunteers who did not serve potentially eligible clients at baseline were nonetheless enrolled and trained so that they could be matched with eligible clients and caregivers as the study progressed.

The University team obtained written informed consent from volunteers, caregivers, and clients who scored ≥ 14.5 on the UCSD Brief Assessment of Capacity to Consent (Jeste et al., 2007). As the intervention was determined to be no greater than minimal risk, for clients who scored < 14.5 the team obtained oral assent as well as written consent from their caregiver and/or legally authorized representative (LAR). If the assenting client did not have a caregiver or LAR, they were not invited to participate. All caregivers were also provided

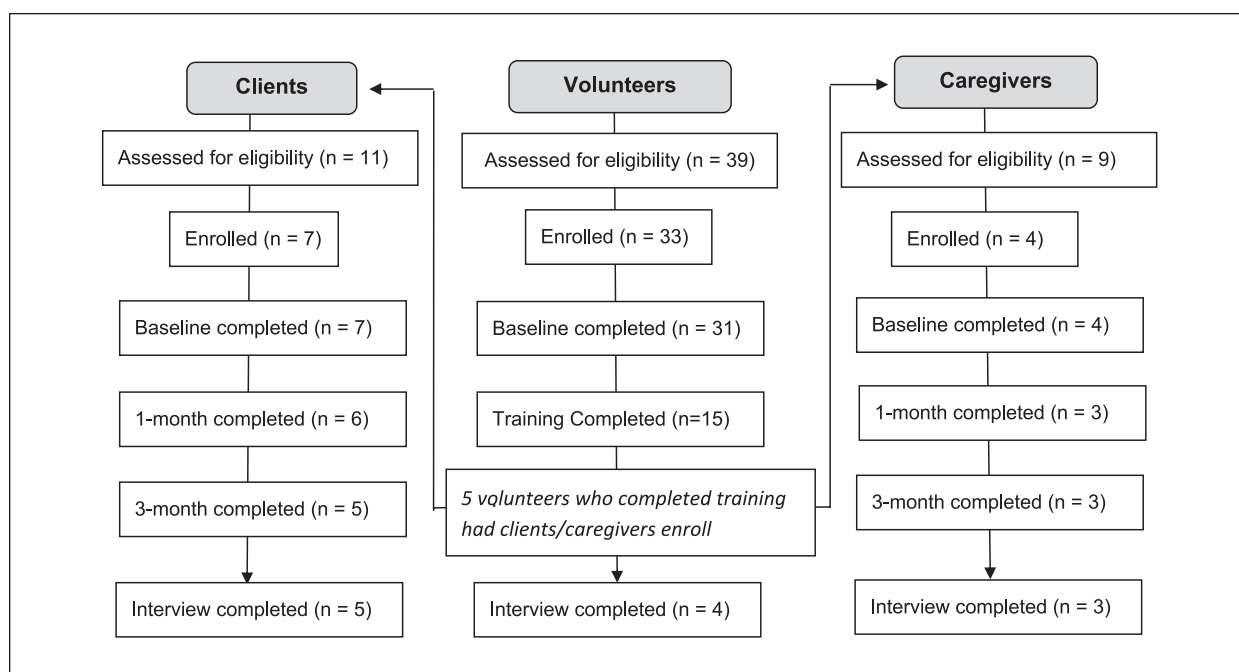


Figure 3. Enrollment and disposition of participants in the PorchLight Project.

the option to enroll in the study with the client (i.e., participate in data collection including surveys and interviews). Clients and caregivers who enrolled together were treated as dyads. All clients continued to receive companionship from their volunteers regardless of study participation.

We aimed to recruit 20 volunteers and a total of 25 clients and caregivers at the outset of the study. Due to the COVID-19 pandemic and other challenges to recruiting, the study focused primarily on volunteer recruitment, enrollment, and training. Thirty-three volunteers consented to participate (Figure 3). In response to recruitment challenges, we refined our approaches to identifying clients with memory loss and communicating study processes and goals. Client and caregiver recruitment improved in early 2020 but was terminated to comply with the COVID-19 physical distancing recommendations, resulting in the enrollment of only seven clients and four caregivers. In-person volunteer training was also terminated early (15 of 33 completed training). During follow-up, one client passed away, one client did not receive the full intervention due to an extended hospitalization, and one caregiver was lost to follow-up.

Intervention

Enrolled volunteers were asked to complete online CARES® Dementia Care Specialist modules, in-person training, and monthly check-ins. They applied their training while visiting clients with memory loss over 3 months. The training and subsequent client visits were offered on a rolling basis. Volunteers did not alter their

existing relationships with clients and only engaged caregivers during visits if it was their usual practice.

CARES® training. The CARES® modules are designed to provide education and tools to help professionals and families provide person-centered, effective care across the spectrum of ADRD. The CARES® Approach is based on the following principles: C – Connect with the Person, A – Assess Behavior, R – Respond Appropriately, E – Evaluate What Works, and S – Share with Others. The asynchronous, self-paced program includes textual, audio, and visual resources, passive and active learning modes, and opportunities for interactive feedback. The feasibility and utility of CARES® for diverse groups of learners have been previously demonstrated (Gaugler, Hobday, et al., 2016; Hobday et al., 2010, 2017). LSS-MN selected three modules as most relevant to volunteer training needs: Dementia Basics, Dementia-Related Behavior, and Dementia Care for Families. Volunteers who were unable to complete the training independently online were offered a tablet or group training option ($n = 5$). A 20-item assessment was used to check CARES® knowledge acquisition; volunteers were able to revisit modules and retake the assessment as needed to achieve a passing score ($\geq 80\%$).

In-person training. The in-person training was adapted from elements of existing, evidence-based palliative care interventions for older persons (Britt et al., 2019; Ferrell et al., 2018; Rollnick, 2008) and provided volunteers an overview of: (1) the study background and aims, (2) National Consensus Clinical Practice Guidelines for Quality Palliative Care, (3) the guided conversation

approach, and (4) community-based LTSS. Guided conversations were designed to elicit client preferences for physical, family, social, cultural, financial/legal, and spiritual care. Volunteers were given a booklet of conversation prompts that included both memory-specific and general health questions (Supplemental Appendix Table 1) as well as space for post-visit reflection. Facilitators from the University team with experience in gerontology and clinical psychology trained volunteers to use and adapt the prompts to help their clients discuss their memory concerns holistically. Volunteers were encouraged to incorporate elements of the CARES® Approach. A particular emphasis was placed on identifying each client's strengths and needs and suggesting appropriate community-based LTSS.

Monthly check-ins. The University and LSS-MN teams conducted monthly group check-ins with volunteers to review client cases (e.g., discuss challenges and solutions), provide ongoing education and resources, and ensure volunteers were regularly engaged with their clients. Check-ins were delivered in-person or via secure telephone conference. As monthly check-ins were embedded in existing SCP meetings and were not mandatory, the University team also called volunteers individually each month to provide support and answer questions. These fidelity checks were used to ensure that volunteers were implementing the Porchlight Project as designed. In-person check-ins were discontinued due to COVID-19, though the team continued calling volunteers individually for the duration of the study.

Data Collection Procedures

Prior to training, volunteers received an online or mailed baseline survey. Variables included sociodemographic characteristics, health status (5-point scale ranging from poor to excellent), experience caring for someone with memory loss (yes/no), and LSS-MN volunteer experience (i.e., years, number of clients, hours per week). Following training, volunteers were asked to complete an anonymous satisfaction survey (Supplemental Appendix Table 2). Volunteers received a small gift for training completion. For volunteers with enrolled clients and caregivers, a semi-structured telephone interview was conducted after 3 months of delivering dementia capable visits to assess their overall experience (mean duration 27 minutes [$SD \pm 9$]). Interviews elicited information about the utility of training, content of dementia capable visits and guided conversations, and acceptability of time and effort required to participate in the project. Interviews were audio recorded and transcribed by a third party service.

Following enrollment, clients and caregivers received baseline surveys that included well-established, validated measures. Follow-up surveys were administered after 1 and 3 months of receiving dementia capable visits. In-person, online, telephone, and mailed options

were provided. Client baseline variables included sociodemographic characteristics, living arrangement, presence of memory concerns (yes/no), memory-related diagnoses, and dependence on assistance for basic and instrumental activities of daily living (ADLs) (Katz et al., 1963; Lawton & Brody, 1969). Baseline and follow-up surveys included the Geriatric Depression Scale (GDS) (Sheikh & Yesavage, 1986); the Quality of Life in Alzheimer's Disease (QOL-AD) (Logsdon et al., 2002); and 15 items assessing use of community-based LTSS. Follow-up surveys also included a 15-item checklist developed by the University team to assess satisfaction with the Porchlight Project (Supplemental Appendix Table 3).

Caregiver baseline variables included sociodemographic characteristics and relationship to the client. Caregiver survey measures administered at baseline and follow-up included an assessment of caregiver self-efficacy (Fortinsky et al., 2002), the Zarit Burden Interview (Zarit et al., 1980), the Center for Epidemiologic Studies Depression Scale (CES-D) (Radloff, 2016), and 15 items assessing client use of community-based LTSS. Follow-up surveys also included a 17-item checklist to assess satisfaction with the Porchlight Project. Finally, client and caregiver semi-structured telephone interviews were conducted after 3 months of dementia capable visits (mean duration 11 minutes [$SD \pm 4$]). Interviews elicited information about the content and value of volunteer visits, effect of visits on dementia care, and facilitators and barriers to engaging with the SCP. They were audio recorded and transcribed as detailed above. Clients and caregivers received \$25 following the completion of each survey and interview.

Data Analysis

We described baseline characteristics of the study population using means for continuous variables and frequencies for categorical variables. We summarized volunteer responses for quantitative statements on the post-training evaluation. Additionally, we summarized client and caregiver responses from the PorchLight Project satisfaction checklists at 1 and 3 months.

The first and third authors coded all qualitative data, including open-ended responses from the volunteer training evaluation ($n=12$) and 3-month volunteer ($n=4$), client ($n=5$), and caregiver ($n=3$) semi-structured interviews. We conducted thematic analysis (Braun & Clarke, 2006) to describe the experiences of volunteers, clients, and caregivers in the PorchLight Project. Using an inductive approach, we first reviewed all data to develop themes and generate a list of preliminary codes. We refined the coding scheme through discussion and consensus. All evaluation responses and interviews were then double-coded in Nvivo, and we reviewed and discussed our coding to resolve disagreements.

Table 1. Volunteer Baseline Characteristics ($n=31$).

Volunteer characteristic	Frequency (%) or mean (SD)
Age, mean (SD)	69.7 (7.4)
Female, n (%)	25 (80.6)
Region, n (%)	
Urban	20 (64.5)
Rural	11 (35.5)
Race/ethnicity, n (%)	
White, Non-Hispanic	28 (90.3)
White, Hispanic	1 (3.2)
American Indian/Alaska Native	1 (3.2)
Two or more races	1 (3.2)
Bachelor's degree or higher, n (%)	10 (32.3)
Currently married, n (%)	14 (45.2)
Difficulty paying for basic needs, n (%)	
Not at all difficult	18 (58.1)
A little difficult	10 (32.2)
Difficult or very difficult	3 (9.7)
Currently working (part- or full-time), n (%)	3 (9.7)
Health status, n (%)	
Poor	0 (0)
Fair	5 (16.1)
Good	15 (48.4)
Very good or excellent	11 (35.5)
Years as volunteer, mean (SD)	4.2 (4.0)
Experience caring for someone with memory loss, n (%)	20 (66.7)

Note. One survey was missing response for experience caring for someone with memory loss; only those with responses are included in % reported.

Quantitative and qualitative results were integrated by comparing data from volunteer, client, and caregiver surveys to qualitative themes from the training evaluation survey and semi-structured interviews to determine whether the Porchlight Project intervention was perceived as feasible, acceptable, and useful to participants and to identify areas for improvement.

Results

Descriptive baseline data on volunteers, clients and caregivers are included in Tables 1 and 2, respectively. The mean age of volunteers was 69.7 (SD \pm 7.4) years. The majority were female (80%), non-Hispanic white (90.3%), lived in the urban study region (65%), and had experience caring for someone with memory loss (66.7%). On average volunteers had served with the SCP for 4.2 (SD \pm 4) years. The mean age of clients with memory loss was 83.4 (SD \pm 4.7) years. The majority were female (71.4%) and had been diagnosed with AD/DRD (71.4%). The caregivers' mean age was 60 (SD \pm 5.1) years. All caregivers were female, non-Hispanic white, and caring for a parent. The mean caregiver depression score was 5.8 (SD \pm 5.1) (score range 0–60) and the mean caregiver burden score was 20.5 (SD \pm 18.9) (score range 0–88). All clients and caregivers lived in the urban study region.

Although volunteer enrollment was successful (33 of 39 volunteers who expressed interest in the project consented to participate), there were barriers to volunteers

Table 2. Client ($n=7$) and Caregiver ($n=4$) Baseline Characteristics.

Client characteristics	
Client characteristic	Frequency (%) or mean (SD)
Age, mean (SD)	83.4 (4.7)
Female, n (%)	5 (71.4)
Region, n (%)	
Urban	7 (100%)
Rural	0
White, Non-Hispanic, n (%)	7 (100)
Bachelor's degree or higher, n (%)	0 (0)
Currently married, n (%)	2 (28.6)
Currently working, n (%)	0 (0)
Living arrangement, n (%)	
Alone	2 (28.6)
With spouse	3 (42.9)
With family member	2 (28.6)
Type of memory loss	
Vascular dementia, diagnosed	2 (28.6)
Dementia unspecified, diagnosed	2 (28.6)
Cognitive impairment post-stroke, diagnosed	1 (14.3)
Undiagnosed memory concerns	2 (28.6)
Quality of life-AD score, mean (SD)	34.9 (8.7)
Depression, mean (SD)	4.0 (3.9)
Activities of daily living dependencies, mean (SD)	2.0 (1.6)
of daily living dependencies, mean (SD)	5.9 (2.0)
Caregiver characteristics	
Caregiver characteristic	Frequency (%) or mean (SD)
Age, mean (SD)	60.0 (5.1)
Female, n (%)	4 (100)
Region, n (%)	
Urban	4 (100%)
Rural	0
White, Non-Hispanic, n (%)	4 (100)
Bachelor's degree or higher, n (%)	1 (25)
Currently married, n (%)	3 (75)
Currently working, n (%)	3 (75)
Child of client, n (%)	4 (100)

completing all training elements. Barriers included challenges accessing a computer and internet for the CARES[®] training and, for volunteers in the rural region, distance from in-person training and check-ins. We also identified a limited pool of existing SCP clients who reported having memory loss. Due to these challenges, only five volunteers were able to apply their training during dementia capable visits with seven total clients. Volunteers completed the full guided conversation booklet, requiring at least six visits over 3 months, with four of the seven enrolled clients. Two clients did not receive the full intervention due to ill health and a third lost regular contact with their volunteer. Despite these challenges, 23 of 33 consented volunteers (70%) were retained for the duration of the study as evidenced by participation in monthly check-ins.

On the post-training volunteer satisfaction survey, 13 statements regarding the acceptability and utility of CARES[®] received a mean score of ≥ 4 (agree) on a

scale from 1 (strongly disagree) to 5 (strongly agree) (Supplemental Appendix Table 2). All volunteers agreed that CARES[®] provided new ideas for interacting with people with memory loss and gave them a better understanding of changes in thinking associated with dementia. An additional 13 statements regarding acceptability and utility of the in-person training received a mean score of ≥ 3.8 . Scores suggested that the in-person training provided volunteers a better understanding of the components of palliative care, gave them tools to start emotionally difficult conversations, and would help them better communicate with clients with memory loss.

On the 1- and 3-month surveys, clients expressed satisfaction with the SCP generally and memory support components of the Porchlight Project specifically. At 3 months, 100% of enrolled clients reported that their volunteer talked about issues that were important to them, 80% stated that they discussed their health concerns, and 60% that they discussed their memory concerns (Supplemental Appendix Table 3). Fewer clients reported that their volunteer helped connect them with community-based LTSS (Supplemental Appendix Table 4), including enrolling them in a program in the community (40%) or teaching them about services to help them in their home (40%).

Qualitative results

Feasibility, acceptability, and utility of volunteer training. In open-ended responses on the post-training volunteer satisfaction survey, the repetitiveness of the CARES[®] training modules was discussed by six volunteers, in both positive and negative ways. Volunteers found the online training to be lengthy but helpful in reinforcing important concepts of ADRD care (e.g., approaching clients from the front and using their names). Four volunteers also reported technological difficulties accessing CARES[®] or working through the embedded interactive features. We offered these volunteers pre-loaded tablets with step-by-step instructions or the option to meet with the LSS-MN team to work through CARES[®] in-person.

Regarding the in-person training, volunteers reacted positively to opportunities provided for peer interaction and feedback, including round table discussions and time to share past experiences with clients or family members with ADRD. One volunteer described the humanistic approach emphasized in the training:

“Knowing this is not about ‘training’ - this is dealing with the lives of real people, we are working with people who especially need assistance - going beyond the training onto the personal approach, the community.”

Analysis of semi-structured interviews with four volunteers after 3 months of dementia capable visits identified

one theme related to use of training during client encounters.

Understanding client needs. All four volunteers reported that the Porchlight Project training and intervention improved their ability to engage clients with memory loss. They noted that the Porchlight Project helped them maintain patience, redirect the conversation when a client was “stuck,” and to structure outings that were appropriate for their client’s abilities and needs. As one volunteer summarized:

“I think it showed me a whole new side of compassion for everybody, and it also showed me how to better deal with this and have the patience. And if they got stuck on one subject, the— this really showed me how to get them onto another source of mind-thinking, so they weren’t just stuck on that one thing. So that was really important for me to learn that.”

Volunteers also reported that the training helped facilitate conversations with clients’ family members and in their volunteer roles outside of the SCP. Volunteers praised the project and stated that they knew several people who would benefit from such training or wished the training were offered to all older adults. As one volunteer said of her client’s family:

“I honestly think everyone like in your forties and fifties should take this so they understand about their parents and their relatives and stuff, but it really did open my eyes. I really learned a lot, and I thought I knew, but I didn’t.”

Feasibility, acceptability, and utility of client and caregiver intervention. Initially, our intent was to examine the feasibility and utility of the PorchLight Project among clients and caregivers. Revised and streamlined enrollment procedures were gaining traction in early 2020 when recruitment was halted due to the COVID-19 pandemic; thus, we present our findings for caregivers and clients as preliminary. Qualitative analysis of semi-structured interviews with five clients and three caregivers identified three themes.

Acceptance of aging and memory loss. Clients generally did not distinguish between the SCP and the Porchlight Project, suggesting that volunteers successfully blended memory support into the existing structure of their client visits. Guided conversations were structured in a way that allowed for, but did not force, discussion of memory loss and other difficult conversations related to aging. Four clients discussed the project’s benefits when discussing their memory, health, and well-being holistically.

“[The project has] given me more enjoyment to be who I am. Well, I always try to strive to do the best I can do, and I realize that [memory loss] is going to advance, it’s going

to change a lot. I think the female companionship. . . let me see things in a different way."

"I think it opens up a lot of the things that some people don't want to talk about. I mean, I don't want to talk about the end-of-life things . . . But it opens up the conversation for that type of thing."

Caregiver respite and peace of mind. All caregivers described minimal involvement in volunteer-client visits apart from coordination and scheduling. One caregiver used volunteer visits as dedicated respite time ("I didn't sit in on their time together very often because I had other obligations") while others felt it was important to allow their relative autonomy with their volunteer. Nonetheless, two caregivers discussed that the SCP gave them peace of mind in knowing their relative had social and emotional support:

"It's nice to know that there's someone out there that can relate to my mom, extend my mom friendship."

"It gives her a certain day that she can decide to get some things done, that she isn't being told what to do. . . she can make some of those choices herself and spend that quality time with her companion."

Trust in volunteer referrals. Most clients and caregivers did not recall specific community-based LTSS that were introduced by their volunteer, suggesting that new LTSS reported on client and caregiver surveys were not necessarily the result of volunteer recommendations. However, two clients reported that their volunteer connected them with specific services. One client and their caregiver both mentioned the benefits of a recommended food delivery program:

"Well, it gives me satisfaction. . . if she needs something to eat or something, she can simply just pull it out of the refrigerator. . . The quality of eating really makes a difference."

The client's volunteer confirmed the referral and explained that she also connected the client to a Medicaid waiver program to cover the costs of home healthcare supplies (e.g., shower chair, medical alert system). This example suggests that volunteers can be trusted referral sources for clients and caregivers for health-related needs.

Discussion

The Porchlight Project is one of the first to build on an existing SCP to provide community-based support to older adults with memory loss and their family caregivers. We designed and tested a training program that provided SCP volunteers with psychoeducation in ADRD and skills to help their clients discuss their memory

concerns and care needs holistically. The pilot study demonstrated that the training was acceptable and useful to volunteers and that despite recruitment challenges, dementia capable visits were valuable to clients with memory loss and their caregivers. We used results and lessons learned from the study to refine the intervention for a potential statewide implementation and effectiveness evaluation.

Our study focused on training volunteers to effectively engage clients with ADRD and, secondarily, on client and caregiver satisfaction with dementia capable visits. Similar to findings from a memory support adaptation of a Texas-based SCP (Fields et al., 2020; Fields, Xu, et al., 2021), our mixed methods results showed that training positively influenced volunteer knowledge and skills in ADRD. The PorchLight Project training helped volunteers understand the perspective and thinking of clients with ADRD, enhanced their communication, and gave them tools to engage in emotionally difficult conversations. We also found that volunteer support may directly benefit clients with ADRD including facilitating their acceptance of memory loss, although our small sample makes any inferences tenuous. The PorchLight Project training was designed for SCP volunteers serving clients throughout Minnesota, while the Texas study evaluated a culturally-informed training that specifically targeted SCP volunteers who support African American caregivers (Fields et al., 2020; Fields, Xu, et al., 2021). Although the majority of our study sample was non-Hispanic white, the success of the Texas program suggests that future iterations of the PorchLight Project could be supplemented with culturally-tailored trainings developed in collaboration with local community-based organizations.

The literature on peer- and lay-led community health interventions demonstrates improvements in interventionists' and older adults' quality of life, self-efficacy, and self-care (Ramis et al., 2015; Webel et al., 2010). Benefits have been attributed to shared culture, language, knowledge, or health conditions among individuals delivering and receiving the intervention. Several studies explore the experiences of volunteers who serve older adults with memory loss and their family caregivers but few evaluate volunteer training programs. In the United Kingdom, volunteer "befriender" programs aim to reduce loneliness and improve quality of life among older adults with dementia (Greenwood et al., 2016). In one study, befrienders identified relationship-building as the key to successful client interactions and discussed the many, often emotionally-charged, roles they played in their client relationships ranging from caregiver to confidante (Greenwood et al., 2016). Similarly, volunteers in our study reported the importance of trust and comfort when discussing difficult topics such as memory loss and end-of-life wishes. Such insider knowledge plays a crucial role in peer-led interventions because it improves receptiveness to emotional and informational support (Andrews et al., 2004). SCP clients in our study

described how their volunteers helped them openly discuss aging and memory loss, and their family caregivers expressed gratitude that the volunteers helped meet the social and emotional needs of their care recipients.

Studies of Norwegian volunteer programs for older adults with dementia and family caregivers suggest that the programs help clients and caregivers via improved social and emotional support, management of everyday challenges, and coping skills (Halvorsrud et al., 2019; Malmedal et al., 2020; Söderhamn et al., 2012). However, volunteers in one study expressed a desire for more dementia-specific training and opportunities to receive support from their volunteer peers (Malmedal et al., 2020). The in-person training and check-in components of the PorchLight Project were designed to provide volunteers time to reflect on their client experiences and receive feedback from the University and LSS-MN teams as well as their peers. Volunteers were eager to provide examples of challenges and successes during the in-person sessions, and their peers provided them valuable and realistic advice based on their own experiences caring for clients with memory loss.

In another Texas study, volunteers in a community-based weekly activity program for older adults living with memory loss discussed how the program increased their confidence working with people with dementia and enhanced their understanding of dementia and family caregiver needs (Han & Brown, 2020). However, it is unclear whether these benefits were the result of volunteer training or participation in a program that required them to interact with people living with dementia.

Finally, a study in the Caribbean evaluated the effects of a 6-week, nurse-led dementia training program offered to respite volunteers (Wilesmith & Major, 2020). Volunteers reported increased knowledge and confidence in topics such as communication, person-centered care, symptoms of dementia, and safeguarding of vulnerable adults. The PorchLight Project trained volunteers in a similar curriculum, also offering them the tools to apply their new knowledge using the guided conversation approach during client visits. Though our findings regarding acceptability and utility of the PorchLight Project among clients and caregivers are preliminary, they indicate that dementia training programs may not only improve volunteer knowledge and confidence but also benefit clients and caregivers receiving volunteer services.

Our study did have several limitations. As noted earlier, initial recruitment challenges as well as the COVID-19 pandemic severely curtailed our enrollment of clients and caregivers, leading us to focus our pilot primarily on preparing volunteers to provide dementia capable visits. Volunteer recruitment was successful ($n=33$), and the largest barrier to training completion was early termination related to the pandemic. Most volunteers and all clients and caregivers who completed the intervention were located in the urban study region. Volunteer

training was delivered earlier in the urban region due to a larger base of interested volunteers in close geographic proximity. All urban volunteers received the in-person training in one location, whereas we offered several trainings in the rural region to maximize convenience to volunteers. Due to slower training progress in the rural region, we did not enroll any rural clients or caregivers.

Interviews were only conducted with volunteers who had clients enrolled in the study. It is unlikely that we reached saturation in our qualitative analysis due to the small sample size. Instead, the interviews provide preliminary insights into how a dementia-focused training program may enhance the readiness of SCP volunteers to provide social and emotional support to clients with memory loss. Further, follow-up surveys were not administered to volunteers at 3 months. Though we cannot draw conclusions about long-term effects of the PorchLight Project on volunteers, training evaluation ($n=12$) and limited interview ($n=4$) data suggest the training holds the potential to improve volunteer competence in working with older adults with memory loss.

Conclusion

PorchLight Project participants indicated the training and intervention were acceptable and useful. Lessons learned regarding the program's feasibility helped us refine it for a possible statewide implementation and effectiveness evaluation. For the statewide evaluation, the training (i.e., CARES[®], in-person training, and monthly check-ins) and intervention would be integrated into regular LSS-MN program operations rather than offered as a University research study. Using a cluster-randomized design, LSS-MN would deliver the PorchLight Project training to all volunteers in intervention regions and incorporate key outcome measures in their existing surveys administered biannually to volunteers, clients, and caregivers. Traditional research methods used in the pilot project, including enrolling participants through the University and asking volunteers to document their visits and guided conversations, would be omitted as these steps present potential barriers to participation and more widespread implementation of the Porchlight Project. Rather, volunteers would be asked to use their new dementia and palliative care knowledge to inform visits with *all* clients and caregivers who may benefit. By integrating training and data collection into the day-to-day operations of LSS-MN, we aim to evaluate a more pragmatic dementia care intervention (Mitchell et al., 2020) that LSS-MN can continue to offer Minnesota communities for years to come.

If the planned statewide evaluation successfully improves volunteer competency in dementia care and client and caregiver health outcomes (e.g., client quality of life and loneliness, caregiver burden), the PorchLight Project may serve as a model of innovation for SCPs and other volunteer programs serving older adults with

memory loss. The CARES® Dementia Care Specialist modules are accessible online (HealthCare Interactive, 2021) and existing volunteer program staff could be trained to deliver in-person training and monthly check-ins. Offering all training components requires an investment of financial resources and staff and volunteer time. However, given the high prevalence of ADRD among older adults, the potential payoff in volunteer, client, and caregiver satisfaction and well-being is great. The long-term goal of the PorchLight Project is to help incorporate dementia education and skill development into routine training of volunteers serving families living with memory loss across the U.S.

Acknowledgments

The authors thank John Hobday, CEO of HealthCare Interactive, the organization that developed the CARES® modules. We appreciate the dedication of the Lutheran Social Service of Minnesota senior management and program coordinators. Finally, we thank the senior companion volunteers, persons with memory loss and their families for generously sharing their time and experiences with us.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This work was supported by a grant from the National Institutes of Health (NIA/NIH R61 AG061903). Dr. Nkimbeng is supported by the Robert L. Kane Endowed Chair at the University of Minnesota School of Public Health.

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Supplemental Material

Supplemental material for this article is available online.

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