

Home Health Aid Heat Illness Training Adaptation Action and Evaluation Plan

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This adaptation plan is entirely fictional. The plan is based on a case study presented in the video series [“Evaluating Health Adaptation for a Changing Climate.”](#)

This example plan is intended to be a resource for those who are developing community climate and health adaptation action plans.

PART 1. Description of Adaptation Action

Brief summary of adaptation action

In 3–5 sentences, what is the rationale for the action? Who will help make it happen? What are the main adaptation activities? What is it intending to achieve?

In recent years, extreme heat events in Heatsville County have led to an increase in heat-related hospitalizations, 60% of which are adults with low incomes aged 65 and older. Those who are hospitalized are often residents with low incomes who lack reliable access to air conditioning during the hot months. The Heatsville County Health Department’s Extreme Heat Public Health Work Group, consisting of clinicians and non-profit partners, will work with local stakeholders (including home health aides, Medicare and Medicaid representatives, community groups, and hospital partners) to create and add a new module to an existing online training for home health aides (HHAs) whose clients primarily include low income and older adults. The purpose of the module is to increase HHA’s knowledge and skills on how to better protect clients, especially clients in high-risk neighborhoods, during extreme heat events.

Identification of stakeholders and partners needed for overall action

Who are the stakeholders that will be engaged? Have communities directly affected by climate change been involved in the development of the adaptation action? How was this achieved and what role will they play? How will you engage the listed stakeholders over time? List organizations and individuals, along with expected role and level of involvement.

Stakeholder Engagement Summary Table

Stakeholder name or group	Stakeholder category	Interest of perspective	Role in adaptation action
Individuals or groups who have an interest in the adaptation	<i>Typically fall into 1 of 3 categories: 1) Directly affected by the program or policy, 2) Help implement the program, or 3) Make decisions about the program: they are the most invested and affected by the evaluation findings</i>	<i>What is their perspective of the adaptation action? For example, are they interested in the cost, are they interested in the effectiveness, or are they a critic?</i>	<i>What role will the listed individual or group play in developing or implementing this action plan?</i>
County Extreme Heat and Public Health Working Group (government)	Make decisions	Effectiveness	Primary project manager; Content expertise for curriculum development
Home healthcare organizations (public and private)	Directly affected	Interest in how it can improve their work and relationships with clients	Participate in training
Recipients of home health care (general population)	Directly affected	Interest in how it can improve their health outcomes	Provide input and data

Stakeholder name or group	Stakeholder category	Interest of perspective	Role in adaptation action
Medicare and Medicaid representatives (government)	Help implement	Effectiveness	Content expertise for curriculum development; provide incentives for behavior change and project participation (e.g., extra HHA visits, support energy vouchers)
Hospital partners (public and private)	Help implement	Effectiveness—reduced hospitalizations	Provide data
Heatsville’s Office of Aging (government)	Help implement	Effectiveness	Provide input and data
County leadership (government)	Make decisions	Cost and effectiveness for decision-making	Use pilot results to make funding decisions

Climate hazard addressed

What climate hazard(s) will be addressed?

Extreme heat

Challenge addressed and supporting evidence

What local need, problem, challenge will this adaptation or intervention address? Will this adaptation address exposure to climate threats, sensitivity, and/or adaptive capacity? (See resources for definition.) What is the rationale for selecting this adaptation (evidence-based, results from stakeholder engagement, etc.)? What evidence and local-scale data were used to select on this adaptation action? This could be the Climate Impact Compendium (please be specific), peer reviewed literature, or feedback from partner organizations.

In recent years, extreme heat events in Heatsville County have led to an increase in heat-related hospitalizations, 60% of which are for adults with low incomes aged 65 and older. Those who are hospitalized often lack reliable access to air conditioning during the hot months. Extreme heat kills more county residents than any other extreme weather event and leads to an average of 600 heat-related hospitalizations, 10 heat-stroke deaths, and 350 deaths from natural causes exacerbated by extreme heat.

Data analyses from the county’s Climate Impact Compendium project an increase of up to seven heat waves per year (up from two per year currently) and a doubling of the number of days above 90 degrees by 2050. Heatsville County is home to approximately 100,000 people aged 65 and older, 16% of whom live in neighborhoods with low incomes.

HHAs have routine access to 40% of the county’s elderly population, 8% of whom have low incomes. The county extreme heat and public health workgroup conducted a needs assessment last year that concluded that many HHAs are not providing their clients with adequate support for protection during extreme heat events. The assessment revealed that many HHAs lack proper knowledge and skills.

Specific populations of focus and locations that will be included

Who will ultimately benefit from this action? What is the geographic boundary for the action? How was the population selected? What data or community supported this decision?

All HHA organizations in the county will have access to the training module, and therefore, all HHA clients have the potential to benefit from this action. However, this action will benefit older adults in neighborhoods with low incomes the most. We will specifically work to promote the training in partnership with state-funded home-care agencies that work in priority neighborhoods with low incomes. Priority neighborhoods were selected based on a recent heat vulnerability assessment that included a social vulnerability index based on census data and recent local hospitalization data.

Context

What is the context for the adaptation? As described in *Planting the Seeds* (CDC, 2021), context could include the people involved, their values and beliefs, cultural and historical circumstances, and ways that power and privilege are brought to bear. What contextual factors may affect its implementation or effectiveness?

- People aged 65 or older are more susceptible to heat-related health illness. Older adults have more difficulty adjusting to sudden temperature changes than younger people. This may happen because of certain medicines they take or chronic illnesses that affect their ability to regulate body temperature.
- Heat-exacerbated mortality is higher in neighborhoods that are home to a greater proportion of communities of color, reflecting the impacts of structural racism at the neighborhood level. Communities of color may be more exposed to extreme heat if located in an urban heat island, where an area of the county is warmer than surrounding areas due to the lack of trees, more traffic, and more concrete and asphalt.
- Heat-exacerbated mortality is also higher in communities with a greater proportion of people with household incomes below the federal poverty line. Because of lower adaptive capacity, vulnerability increases for those living in communities with low incomes and those who live alone or lack social support. Communities with lower average incomes tend to have a greater number of people without access to air conditioning or who can't afford to pay for it during hot months.
- HHA organizations in the project's priority neighborhoods are primarily funded through Medicare or Medicaid and tend to be lower resourced than the primarily privately run HHA organizations in other, wealthier parts of the county.

Stage of development

How long has the program, project, or action been in place? Is it in the planning or implementation stage?

A needs assessment was conducted in 2021. We are currently in the planning phase (i.e., securing partnerships and preparing the curriculum) and will begin implementation in 2023. We already have the

necessary leadership approval for implementation and evaluation, and county leadership is interested in the results.

Social determinants of health

What were the social determinants of health that influenced the selection and development of the action?

Three of the seven vital conditions¹ influenced the selection and development of this action:

- Socio-economic status/economic security (meaningful work and wealth)
- Social inclusion/social support (belonging and civic muscle)
- Housing (humane housing)

Resources and inputs

What resources are available to support the action (e.g., personnel, money, space, time, partnerships, and technology)?

The HHA training is a project within a larger Cool County program funded by the county. BRACE funds will also support this project by funding temporary project staff members. The county workgroup has five core staff members and will include at least five additional partners to support this project.

Theory of change and logic model

What is the theory of change that underlies this adaptation action? In general, a theory of change describes how and why a desired change is expected to happen as a result of the actions taken. It makes the underlying rationale explicit, and it fills in what can sometimes be the missing middle between what a program does (i.e., activities) and how this leads to goals being achieved. It can be helpful to think of this as an “outcomes pathway.” First consider the long-term goals, work back from these to identify all the outcomes that logically must be in place, and then consider how these relate to one another causally for the goals to occur. The same information is also illustrated in a program logic model. See resources below for guidance on how to develop a logic model.

Need: There are high rates of heat-related illness and hospitalizations among older adults with low incomes in Heatsville County. HHAs that work with this population have not been trained in how to identify and reduce extreme heat risk among their clients.

Hypothesis: If HHAs are trained in heat-related illness (including symptoms and best practices to prevent and respond to extreme heat risks), they will be better prepared to conduct risk assessments, identify symptoms of heat-related illness in their clients, and implement heat-related illness prevention measures, such as taking cool showers, wearing loose-fitting clothes, and creating an extreme heat-care plan. If HHAs identify symptoms of heat-related illness in their clients and if they help their clients

¹ <https://www.communitycommons.org/collections/Seven-Vital-Conditions-for-Health-and-Well-Being>

implement heat-related illness prevention measures, there will be a reduction of heat-related illness, and therefore heat-related hospitalizations, among HHA clients. Ultimately, Heatsville County will see a decrease in heat-related hospitalizations among the elderly because of this training.

County X's Home Health Aids (HHA) Heat Illness Training Logic Model						
Inputs	Activities (A)	Outputs (O)	Outcomes			Impact (I)
			Short term (ST)	Medium term (MT)	Long term (LT)	
Funding Implementing partners Training curriculum Training platform Heat related protocols at HHA agencies	A1. Train HHAs on how to identify and respond to heat-related threats A2. Promote the training to HHA organizations, focusing on those in priority, low-income neighborhoods	O1. At least 80% of HHAs that work in priority, low-income neighborhoods are trained	ST1. HHAs increase knowledge on heat related illness ¹ ST2. HHAs learn best practices to help assess, educate, and reduce extreme heat risks for their clients ¹	MT1. HHAs identify symptoms of heat related illness in their clients ² MT2. HHAs help their clients implement heat related illness prevention measures ³	LT1. Reduced heat illness effects on clients ⁴ LT2. Reduced heat illness of clients LT3. HHA training programs across the county adopt the module as a core HHA training	I1. Decrease in heat related hospitalizations among older adults
Assumptions: ¹ The training provides HHAs with new information. ² Aides are with clients while they're experiencing heat-related illness symptoms. ³ Clients are receptive to aides' suggestions for symptomatic control and treatment. ⁴ HHAs respond to identified symptoms.						

Outcomes to be achieved, including health equity

What is the intended outcome, i.e., the goals and objectives that will be achieved? What do the program designers ultimately want to change as a result of the activities (long-term outcomes)? What occurs between the activities and the point at which the ultimate outcomes are realized (short-term and intermediate outcomes)? Are they individual, systems, or health outcomes? What outcomes related to reducing health disparities are expected? When will these outcomes be achieved?

See the logic model above. The outcomes in the logic model are individual-level (ST1–2, MT1–2), systems-level (LT3) and health outcomes (LT1–2, I1).

This project is currently focused on HHAs that work with clients with low incomes in communities that have a historically higher rate of heat-related hospitalizations among people 65 and older. Focusing on these communities will reduce health disparities among the elderly in these communities.

Below are target objectives (O) that align with our accountable outcomes (outcomes we will evaluate and for which we are accountable to our stakeholders):

- O1. By 2024 (after the training), training post-test scores will average at least 70%.

O2. By 2024, there will be at least a 20% average increase in pre- to post-test scores (ST1, ST2).

O3. By 2026, there will be a decrease in heat-related hospitalizations among older adults in Heatsville County (I1).

Methods and activities

How will the adaptation be implemented? What needs to occur in terms of activities, tasks, processes, and procedures to achieve the intended outcomes? Is there a logical chronological order to those? What is the timeline?

The pilot project will take place over the course of the 5-year BRACE award.

Year 1 is the planning phase and includes finalizing HHA organization partners that will participate, hiring staff members (including an evaluator), conducting participatory development of the extreme heat module curriculum, integrating the module with the existing online training, collaborating with partners to promote the training among HHA staffs.

The training will be launched in year 2 and follow-up training will occur in years 3 and 4.

Year 5 is the data analysis and reporting phase.

Evaluation is an integral part of this adaptation action; therefore, evaluation will be considered throughout the entire project (see more in Part 3).

Anticipated challenges

What might act as barriers to implementing the planned activities or achieving the expected outcomes? What can be done to minimize the effects of

Potential Challenge	Potential Solution
Low training participation rate	Incentivize training participation or make it required for employment
Little to no behavior change among HHAs (knowledge does not translate into action.)	Work with HHA agencies to establish HHA heat-illness related protocols
Clients unable or unwilling to use information to reduce heat-related illness risk	Work with partners (HHA organizations, Medicare/Medicaid representatives, community organizations) to incorporate culturally competent communication strategies for HHAs to use with clients; work with community partners to provide additional support to clients (e.g., donation of resources, transportation)

PART 2. Communications

This section refers to communications activities that are part of the adaptation action, not dissemination of findings after the action has been implemented.

Communications objectives

What is the goal of the communication strategy? What do you hope to accomplish by the end of the project in terms of communications?

The goal of the communications strategy is that HHAs in priority communities are aware of, participate in, and learn from the training.

Communications activities

What are the planned communication activities for this adaptation action? How will you communicate your proposed adaptation to your stakeholders and/or focus audience? Who is the audience that will be reached? What is the timeline? What materials will be used?

Activities:

- Work with HHAs to gather feedback to inform communication strategies
- Diversify communication delivery through a variety of channels
- Conduct a usability assessment of the online training website and update based on results

These activities will take place during planning and preparation in year one. Communication strategies and activities may be modified year to year based on lessons learned during prior years' implementation and project monitoring.

PART 3: Evaluation

Stakeholder engagement

Primary stakeholders are those who have the ability and authority to use evaluation findings to alter the course of the action being evaluated. Secondary stakeholders are those affected in some manner by the action and, therefore, are likely to be affected by any changes made because of the findings. Tertiary stakeholders are those who might have a general interest in the results. Which types of stakeholders will be engaged in the evaluation? How will they be involved throughout? What are key stakeholders' needs and perspectives in terms of the evaluation focus and results?

Evaluation Stakeholder Engagement Summary Table

Stakeholder name or group	Stakeholder category (primary, secondary, or tertiary)	Interest or perspective in the evaluation	Role in evaluation	Other considerations: cultural, logistical, historical, or other factors that need to be considered to facilitate meaningful engagement
County Extreme Heat and Public Health Working Group (government)	Primary	Interested in the effectiveness of the training and recommendations for improvement	Provide strategic direction, oversight, and resources	Will ensure continuity by asking for term agreements when members join
Home healthcare organizations (public and private)	Secondary	Interested in HHA perception of the training and the improvements to client relations and health	Provide planning input; provide data; participate in participatory interpretation of data	Highly trusted by members of the population
Medicare and Medicaid representatives (government)	Secondary	Interested in the effectiveness of the training and the extent to which their incentives for participation worked	Provide planning input; Participate in participatory interpretation of data	-
Hospital partners (public and private)	Secondary	Interested in the effectiveness of the training to prevent heat-related hospitalizations	Provide data; participate in participatory interpretation of data	Very knowledgeable of the community's health needs
Coolsville county	Tertiary	A neighboring county interested in the results of the evaluation for their own population	Provide data for the outcome evaluation's comparison group	Will work with county representatives to select comparison HHA organizations
County leadership (government)	Tertiary	Interested in the effectiveness of the training and the extent to which it can/should be scoped	Review results and recommendations	Not very trusted by members of the population

Cultural competence

How have diverse stakeholders who reflect those who may be affected by the evaluation's findings been incorporated or consulted? How will the program account for the influence of context and culture in

Example BRACE Adaptation and Evaluation Plan

your evaluation design, implementation, and reporting? For practical suggestions, see CDC's Practical Strategies for Culturally Competent Evaluation (resource below).

Stakeholders (i.e., home healthcare organizations, Medicare and Medicaid, senior centers) that represent older adults in communities with low incomes will be represented in the project working group. The current working group has already worked with community partners to implement the needs assessment and will continue to consult and collaborate with partners to design the training module and promote the training. We will facilitate a participatory data interpretation session to ensure diverse perspectives are incorporated in the interpretation of the evaluation data.

Evaluation purpose*

In 3–5 sentences, what is the overall purpose of evaluating this adaptation? How will you use the evaluation findings? Common uses include gaining insights to help develop the adaptation (formative evaluation); implementation assessment, accountability, continuous program improvement (process evaluation); and establishing the effectiveness (outcome evaluation). An evaluation can have multiple purposes.

The evaluation will yield evidence about whether the training is effective in increasing awareness, knowledge, and motivation and changing behavior among HHAs in terms of identifying and reducing heat risk among their clients. The evaluation will also identify areas of improvement in the training design and implementation.

Evaluation questions*

What 3–5 questions will the program be able to answer during or after the implementation of the adaptation? Some example evaluation questions are as follows: Was the activity implemented as planned? Did outcomes occur and at an acceptable level for the population overall and for specific groups? Were the changes in outcomes due to activities as opposed to something else? What factors prevented or facilitated the activities in the focus from being implemented as planned? Were certain moderating factors responsible? What factors prevented (more) progress on the outcomes in the focus? What was the cost for implementing the activities? What was the cost-benefit or cost-effectiveness of the outcomes that were achieved? Do the questions align with the Good Evaluation Questions Checklist (see resources)?

Evaluation Questions (EQs):

1. To what extent did HHAs increase their knowledge on how to protect clients during extreme heat events? (outcome)
2. To what extent did the training contribute to a decrease in heat-related illness among HHA clients? (outcome)
3. How can we improve the training to make it as effective as possible? (process)

Evaluation design*

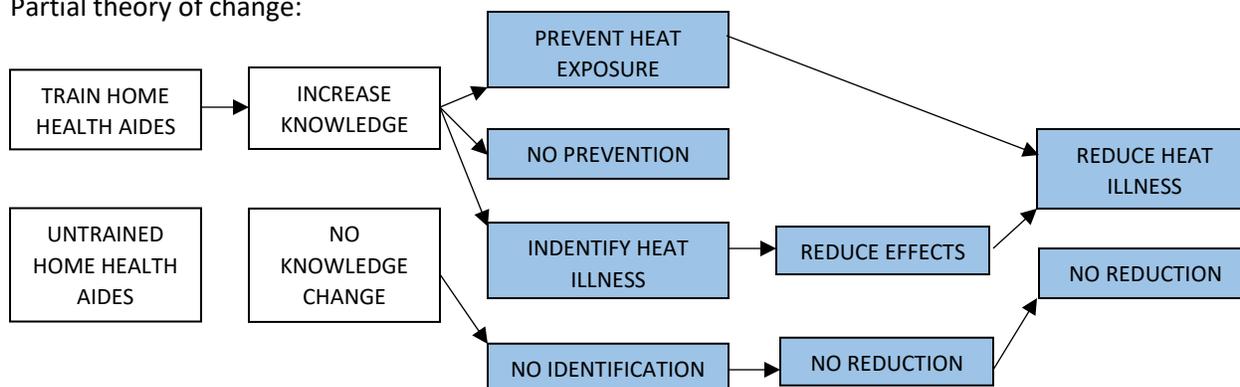
What is the evaluation design? What is the rationale for using this design? Common designs are as follows: non-experimental (no comparison or control group, e.g., case study or post-only test); quasi-experimental (use of a comparison group, but no random assignment, e.g., pre-/post-test with comparison group, interrupted time series, or regression discontinuity); experimental (random assignment to an experimental or control group, e.g., randomized controlled trial). Some factors to consider in selecting the most appropriate design include these: With what level of rigor must decisions about “causal attribution” be made? How much money and skill are available to devote to implementing the evaluation? Are there naturally occurring control or comparison groups? If not, will selection of these be very costly or disruptive to the programs being studied?

Three designs will be incorporated in this evaluation (one for each evaluation question):

Question	Design Approach
1. To what extent did HHAs increase their knowledge on how to protect clients during extreme heat events?	This approach uses a non-experimental pre-/post-test design using matched survey data.
2. To what extent did the training contribute to a decrease in heat-related illness among HHA clients?	<p>This approach uses a quasi-experimental cohort design (see figure below). This design was selected because of the following reasons:</p> <ul style="list-style-type: none"> • There is already a broader cohort study the county health department has planned for the training course with which the module will integrate (which reduces initial logistics costs). • Coolsville County, a neighboring county that is also experiencing a similar increase in heat-related illness and hospitalizations, is interested in the results of the pilot project and is willing to support the evaluation by providing a comparison group. • The cohort design allows flexibility to consider the seasonal nature of heat exposure and the swift predictable onset of heat illness during the heat season.
3. How can we improve the training to make it as effective as possible?	This approach uses a non-experimental descriptive design. This design was selected because of the descriptive nature of the evaluation question.

Example BRACE Adaptation and Evaluation Plan

Partial theory of change:



This flow chart explains part of the theory of change in training home health aides to reduce heat illness. Training of home health aides leads to an increase in knowledge which could prevent heat exposure or identify heat illness among patients. This increased knowledge facilitates patients to take steps that should reduce the effects of extreme heat and eventually heat illness. With untrained home health aides, there is no knowledge change, and no reduction in heat illness.

Health equity

How will the evaluation assess the degree to which the adaptation promotes health equity or reduces climate related health disparities? Will the evaluation assess differential reach, experiences, or outcomes among populations most vulnerable to climate change sensitive threats?

The population of focus of the program consists of those most vulnerable to extreme heat in Heatsville County. The evaluation will help us to understand the extent to which the training decreases heat-related illness among elderly people with low-incomes.

Outcomes to be measured

What individual, systems, or health outcomes will be measured in the evaluation? Will there be a certain threshold to be reached for the adaptation action to be considered successful? What is the follow-up period for measuring these outcomes?

We will measure the following outcomes (which correspond to the targeted objectives described on page 6):

- Increase in HHA knowledge on how to protect clients during extreme heat events (individual)
- Decrease in heat-related hospitalizations among HHA clients (health)

The adaptation action will be considered successful if the following conditions are met:

- Overall average post-test scores are at least 70% (O1) AND there is at least a 20% increase in test scores after the training (O2).
- There is a decrease in heat-related hospitalizations among HHA clients in Heatsville (treatment group) AND rates of heat-related hospitalizations are lower for HHA clients in Heatsville (treatment) compared to HHA clients in Coolsville (comparison) (O3).

Data and data collection methods*

What are the methods to be used for the evaluation? How will the program collect data? What is the source of the data and how recent is it? Will there be a sample? Will new data collection instruments be developed? How will the team test instruments for readability, reliability, validity, and cultural responsiveness? How will the team determine the quality and utility of existing data? What will be the data source?

Evaluation question	Data collection method (e.g., surveys, interviews, medical chart abstraction)	Source and latency of data (e.g., the recency of the data)	Frequency of data collection	Party responsible for collection	Due date
1. To what extent did HHAs increase their knowledge on how to protect clients during extreme heat events?	Surveys	HHAs will complete the survey before, during, and after implementation. ¹	Annually	County's workgroup will provide the survey. Each HHA organization will be responsible for data collection among their staff.	Quarter 1 the year following the training
2. To what extent did the training contribute to a decrease in heat-related illness among HHA clients?	Surveys HHA patient data	Client self-reports HHAs (admin data) County hospitals ²	The program will collect data from 3 years prior to the training (retrospective surveys for client self-reports) and 3 years after the initial training.	County workgroup	Year 5
3. How can we improve the training to make it as effective as possible?	Surveys	HHAs	Annually	The county's workgroup will provide the survey. Each HHA organization will be responsible for data collection among their staff.	Quarter 1 the year following the training

¹ A sample of at least 100 HHAs that work in neighborhoods with low incomes will be surveyed. This sample size was calculated based on a 95% confidence level and a 5% margin of error. We will identify an incentive for completing the survey to mitigate a low response rate.

² Hospital data is less complete than had been previously believed, so we will mainly use two data sources for health outcome indicators: self-report data and observations.

Indicators and standards*

What measurable and observable elements (indicators) can serve as markers of the program’s performance? Are there specific standards that will be used to determine whether the program has been successful? That is, to what standards will the implementation team and stakeholders compare the evaluation findings? Alternatively, what process will the team engage in to understand and interpret performance on this indicator?

Evaluation question	Indicators	Standards (what constitutes success“?)
1. To what extent did HHAs increase their knowledge on how to protect clients during extreme heat events?	Combined average post-test score 20% improvement between post-test and pre-test scores	At least 70% Overall average increase in scores
2. To what extent did the training contribute to a decrease in heat-related hospitalizations among HHA clients?	a) HHA client heat-related hospitalization rates by treatment and comparison groups, before the training and after the heat season (numerator = total # of qualifying HHA clients who have gone to the hospital at least once for heat, denominator = total qualifying HHA clients in the county) b) Heat-related hospitalization rates for the county’s older population with low incomes by treatment and comparison groups before the training and after the heat season (numerator = heat-related hospitalization rate among the county’s population of people aged >=65 years with low incomes; denominator = heat-related hospitalization rate among all the county’s >=65 population)	Rates of heat-related hospitalizations are lower for the treatment group compared to the comparison group
3. How can we improve the training to make it as effective as possible?	HHA feedback on the training content and design (e.g., extent to which training held participants’ interest, extent to which the content was easy to understand, extent to which the training portal was easy to navigate)	NA

Analysis plans

What method(s) will the team use to analyze the data (e.g., descriptive statistics, inferential statistics, and qualitative analyses such as content analysis and thematic analysis)? Who will be involved in drawing, interpreting, and justifying conclusions? Does this group include program participants or others affected by the program? What are the plans to involve them in this process?

Outcome evaluation analysis:

1. To what extent did HHAs increase their knowledge on how to protect clients during extreme heat events?

- a. Outcome variables:
 - i. post-test scores—descriptive statistics
 - ii. change in pretest and posttest scores—inferential statistics (paired t-test)
2. To what extent did the training contribute to a decrease in heat-related hospitalizations among HHA clients?

- b. Outcome variables:
 - i. Heat-related hospitalizations at baseline and over time (incidence rate)
 - ii. Difference in heat-related hospitalization rate change between the treatment and comparison group—inferential statistics (regression analysis)

To control for temperature, we will normalize metrics by declared National Weather Service heat alert days, which are at the county scale and already take local climate norms into account.

Process evaluation analysis:

3. How can we improve the training to make it as effective as possible?
 - Descriptive statistics
 - Qualitative thematic analysis

Evaluation (outcome and process) interpretation:

We will facilitate a two-hour participatory data interpretation session with the workgroup that includes representatives from various stakeholders. Uninterpreted results for each evaluation question will be presented and participants will discuss the meaning of the results and develop and justify conclusions.

Plans to use process or implementation evaluation results*

What will be learned from the process evaluation? How will those be used to inform the process evaluation?

We will use the process evaluation results to make quality improvements to the design and implementation of the training. We will also use information about program implementation to track progress and report to our partners.

Plans for use dissemination*

How will the evaluation findings be used? How does the timeline for reporting findings and potential recommendations align with key events? Who is responsible for creating and monitoring an action plan to guide the implementation of evaluation? How will the program disseminate findings from the evaluation? What methods (e.g., in-person meetings, emails, written reports, newsletter article, presentations) will be used? Who is best suited to deliver the information (e.g., evaluator, program manager, coalition leader)?

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Audience for evaluation findings	Evaluation information of interest	Purpose of communicating to this audience (e.g., they make decisions about evaluation design/activities, they have requested to be updated, they will be presenting the finding elsewhere)	Potential dissemination formats (e.g., infographics, formal presentation, conference, manuscript)	Month and year of planned dissemination	Person(s) responsible for dissemination
Home healthcare organizations	HHA perspective of the training	They are core implementation partners and can promote the training to their staff.	Presentation; one-pager	August 2026	County workgroup
County leadership	Effectiveness	They will make decisions about the future of the module.	Formal presentation	August 2026	County workgroup
Adaptation community	Effectiveness	They may use this information to make decisions in their own communities.	Manuscript	TBD (possibly by January 2027)	County workgroup

PART 4. Project Management

This section is divided into two parts to help planners conceptualize management for the adaptation action and the evaluation separately, because distinct planning and project management are often needed.

A. Adaptation Action

Needed resources

Considering the resources available that you listed in Part 1, what additional resources will be needed in the way of additional funding mechanisms, equipment, human capital (expertise, skills, etc.), and organizational capital (processes, policies, or other agency-level facilitators) to implement the adaptation?

No additional resources will be needed.

Team roster, identifying roles and responsibilities

Who will be doing which tasks? What are the specific roles and responsibilities? Consider developing a RACI matrix. This involves delineating four key responsibilities (responsible, accountable, consulted, and informed). See resources below.

Individual	Role in Project	Responsibilities
Jackson A.	Project lead	<ul style="list-style-type: none"> Coordinates working group and facilitates meetings Liaises with county leadership
Mary B.	Curriculum lead	<ul style="list-style-type: none"> Leads the development of the module curriculum
Brian C.	Administrator	<ul style="list-style-type: none"> Manages the budget, contracts, etc.
Karen D.	Medicare representative	<ul style="list-style-type: none"> Represents Medicare and Medicare recipients
Jordan E.	Medicaid representative	<ul style="list-style-type: none"> Represents Medicaid and Medicaid recipients
Amy F.	Partnership and Community Liaison	<ul style="list-style-type: none"> Coordinates with partners

Timeline with milestones and deadlines

What are the project start and end months, as well as major milestones within the project period? Timelines serve as a useful tool to track activities and shifting schedules. There are several types of timelines (e.g., milestone, yearly/monthly basic progress, Gantt chart) that may be suitable for your teams' activities. See resources below.

- Year 1 (2022): Planning
 - Finalize partnerships (April 2022)
 - Conduct participatory development of the extreme heat module curriculum (May–July 2022)
 - Integrate the module with existing online training (August 2022)

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- Collaborate with implementing partners to promote the training among the HHA staff (ongoing)
- Years 2–4 (2023–2025): Implementation
 - Train HHAs. Promotion for the training will occur in late-spring/early-summer, prior to the onset of the historically hottest part of the year.
 - Adjust communication strategies/activities as necessary.
- Year 5 (2026): Evaluation and reporting (see timeline in next section)

B. Evaluation

Needed resources

Considering the resources available that you listed in Part 1, what additional resources will be needed in the way of additional funding mechanisms, equipment, human capital (expertise, skills, etc.), and organizational capital (processes, policies, or other agency-level facilitators) to implement the evaluation?

- Incentives for survey participation

Team roster, identifying roles and responsibilities

Who will be doing which tasks? What are the specific roles and responsibilities? Consider developing a RACI matrix. This involves delineating four key responsibilities (responsible, accountable, consulted, and informed).

Individual	Role in Evaluation	Responsibilities
Jackson A.	Project lead	<ul style="list-style-type: none">● Hire an evaluator● Provide evaluator with access to staff and data
TBD	Evaluation lead	<ul style="list-style-type: none">● Oversee the design and implementation of the evaluation

Timeline with milestones and deadlines

What are the project start and end months, as well as major milestones within the project period? Timelines serve as a useful tool to track activities and shifting schedules. There are several types of timelines (milestone, yearly/monthly basic progress, Gantt chart) that may be suitable for your teams' activities. See resources below.

- Year 1 (2022): Evaluation planning
 - Hire an evaluator and begin evaluation and data collection planning, include collecting baseline data (June 2022)
- Years 2–4 (2023–2025): Data collection
 - Data collection
- Year 5 (2026): Analysis and reporting

Example BRACE Adaptation and Evaluation Plan

- Data analysis
- Reporting/dissemination of findings
 - Presentation to HHAs and other local stakeholders (Fall)
 - Presentation to county leadership (Fall)
 - Prepare manuscript for peer-reviewed publication (ongoing)