



Replication Report

Healthy IDEAS

(Identifying Depression, Empowering Activities for Seniors)

An evidence-based depression program



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Healthy IDEAS was initially developed by Baylor College of Medicine's Huffington Center on Aging as part of the Model Programs Project sponsored by the National Council on Aging (NCOA) and funded by the John A. Hartford Foundation. An extensive demonstration was subsequently funded by the U.S. Administration on Aging to further enhance and evaluate the program. Baylor College of Medicine and the Michael E. DeBakey Veterans Affairs Medical Center Houston Center for Quality Care and Utilization Studies conducted the evaluation of Healthy IDEAS for the Administration on Aging.



Care for Elders provided management and staff support for the development and local implementation of Healthy IDEAS during its demonstration phase. Care for Elders is a Houston-based partnership of more than 80 organizations committed to increasing access to services, improving quality of care and enhancing the quality of life for older adults. Care for Elders and Baylor College of Medicine now manage the dissemination of Healthy IDEAS to potential adopters.

Healthy IDEAS Partners:

- Baylor College of Medicine-Huffington Center on Aging
- Michael E. DeBakey Veterans Affairs Medical Center Houston Center for Quality Care and Utilization Studies
- Harris County Area Agency on Aging
- Aging Network Social Service Providers
 - Sheltering Arms Senior Services
 - Catholic Charities Services to the Alone and Frail Elderly Program
 - Harris County Social Services
- Community Health Care & Mental Health Care Providers

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I. Introduction

Depression: A Serious Problem for Older Adults

Major depression can be highly disabling. Beyond its symptomatic sadness, inactivity, cognitive deficits, and attention problems, it often accompanies other serious, age-associated medical conditions such as heart disease, stroke, cancer, and diabetes. And like these other diseases, it robs older adults of their quality of life by reducing physical, mental, and social functioning and increasing healthcare costs. Depression is also responsible for thousands of preventable deaths. It complicates recovery from illnesses and injuries such as cardiovascular disease and hip fracture and is a precursor to suicide. In fact, older adults commit suicide at a higher rate than any other age group.

By 2020, depression is expected to be the second most common cause of disability and death in established market economies like the United States (Murray and Lopez, 1996). Although chronic clinical depression affects only one to four percent of all community dwelling older adults, an estimated 15 to 30 percent of U.S. adults aged 65+ experience depressive symptoms on any given day. In this group, severe depressive symptoms appear more commonly among women than men, but by age 85, they occur equally in both groups—22.5 percent in men, 23 percent in women (FIFARS, 2000). Prevalence rates are similar between African-American and White older adults (Bazargan and Hamm-Baugh, 1995), and may be higher among less acculturated Hispanics (González, Haan, and Hinton, 2001).

In addition to physical illness and disability, other major risk factors for depression among older adults include cognitive impairment, declining functional status, social network losses, low social support, and negative life events (Bruce, 2002; Mojtabai and Olfson, 2004).

Choosing Healthy IDEAS

Evidence shows that structured depression prevention and intervention models, if applied with fidelity, can decrease the risk or delay the onset of depression and reduce the suffering it causes (DHHS, 2000). Of particular interest, especially in today's climate of overstretched budgets and limitations on mental health care insurance benefits, are disease self-management programs. These programs are designed to prevent further disease progression and decline in functioning by teaching people how to effectively manage their illness, thereby improving quality of life and reducing the need for more costly medical services (Hollon et al, 2002).

Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors) is an evidence-based program designed to detect depression and reduce the severity of depressive symptoms among community-dwelling older adults. This model program was developed as a *depression self-management program* through a Houston academic-community partnership led by interdisciplinary faculty at Baylor College of Medicine. Support came from the National Council on Aging and the John A. Hartford Foundation. An extensive demonstration was subsequently funded by the U.S. Administration on Aging to further enhance and evaluate Healthy IDEAS (and other evidence-based health promotion and disease prevention programs).

Consistent with the collaborative care approach, which has been shown effective in improving depression outcomes (Eli, 2006), Healthy IDEAS is embedded into the ongoing assessment and care plan routine of community case management programs. It emphasizes the active role of elders with depressive symptoms in learning about how to partner with providers and make changes to feel better.

The four evidence-based components of Healthy IDEAS are “packaged” together to overcome client, provider, and system barriers to effective depression care to older adults. The program components are:

- Screening and assessment of depressive symptoms;
- Education for older adults and family caregivers about depression and self-care;
- Referral and linkage to healthcare and mental health professionals; and
- Behavioral activation (BA)

All four components were translated and adapted from the approaches and evidence developed in the Program to Encourage Active, Rewarding Lives for Seniors (PEARLS), and Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) programs, and designed for delivery by case managers who may or may not have professional degrees. Program lessons and content from a national guide and a federal toolkit on aging and mental health also informed program design and resources (SAMHSA, 2003; SAMHSA and NCOA, 2003).

A Strong Base of Evidence, Strong Benefits

Healthy IDEAS is built on *evidence-based* practices and models. These are scientifically tested interventions that have demonstrated their ability to improve outcomes for older adults. Using them allows community providers to offer higher quality care and services to people in need, including at-risk older adults who otherwise would not receive treatment.

Evidence-based health promotion is a process of planning, implementing, and evaluating community-based programs adapted from tested models or interventions. Evidence-based programs are already proven to work, thus increasing the likelihood of achieving successful outcomes, and third-party payers often prefer their use. Ultimately, this may make it easier to market the program and engage valuable partners. Also, the methodology needed to implement a program is already in place, reducing the time and resources necessary to start it. Finally, evidence-based programs can help evaluate a program and 1) determine whether goals are achieved and 2) if adaptations are necessary to sustain the program over time. For additional information on evidence-based health programming, please see the Center for Healthy Aging’s Issue Brief “Using the Evidence Base to Promote Healthy Aging,” Number 1 Revised, Spring 2006, at: www.healthyagingprograms.org/content.asp?sectionid=15andElementID=97.

The primary evidence base for Healthy IDEAS is from PEARLS (Ciechnowski et al, 2004), and Project IMPACT (Unützer et al, 2002), which includes two randomized controlled trials on the treatment of depression in older adults. Project IMPACT demonstrated that screening, education, problem-solving therapy, activation, and pharmacotherapy for depression—when delivered by trained professionals—were

effective for older adults in primary care with comparable efficacy for minority populations, namely African Americans and Latinos (Aréan et al, 2005). The PEARLS project demonstrated that trained social-work case managers could use a similar treatment approach in the home environment and effectively treat medically ill, low-income, mostly home-bound older adults with dysthymia (chronic low-grade depression) and minor depression (Ciechanowski et al, 2004).

Adapting Healthy IDEAS

Unlike PEARLS and IMPACT, the Healthy IDEAS model does not introduce a separate case manager focused exclusively on a client's depression. Rather, it embeds the four program components into regular case management duties. Instead of scheduling weekly, in-person individual sessions with clients, case managers complete the tasks as part of regular phone calls or home visits. This reduces the transportation and added personnel costs associated with utilization of a separate case manager. This adaptation is possible because helping clients manage their own depression can be done by nonprofessionals using valid tools (Whooley et al, 1997, Sheikh and Yesavage, 1986, Williams et al, 2002). Additionally, Healthy IDEAS uses telephone calls for some intervention steps, which differs from PEARLS but is consistent with other depression intervention evidence.

Although Healthy IDEAS case managers use problem-solving skills in working with clients, they specifically use behavioral activation (BA) approaches to help clients improve mood. BA is a brief, straightforward approach for reducing depressive symptoms by helping older adults set and achieve goals that produce positive mood outcomes—pleasure and feelings of accomplishment—and decrease negative mood outcomes—feeling sad, tired, or lonely (Hopko et al, 2003, Ciechanowski, et al, 2004, Jacobson et al, 2001). For example, older, depressed adults who face physical or cognitive limitations may select simple, structured activities such as filling a birdfeeder or calling a friend. Behavioral activation goals may also involve addressing problems such as cleaning out home clutter or pursuing needed healthcare.

PEARLS used a psychiatrist for weekly or bi-weekly supervision and to provide patient-specific management recommendations (medication issues, etc.). The Healthy IDEAS model incorporates the expertise of licensed mental health providers in a manner more in keeping with the resources of a community agency. Licensed psychiatrists and psychologists conduct staff training and are available for problem solving as requested by agency supervisors or case managers. However, clients needing further evaluation or treatment are linked to their primary care physician or other mental health providers. This allows agencies implementing Healthy IDEAS to include clients with all levels of depressive symptoms.

A Multi-Disciplinary Partnership

An academic-community partnership involving professionals of various disciplines and cultural backgrounds has guided the development, implementation, and evaluation of the Healthy IDEAS model. Partners have a shared commitment to reaching older adults who might not be identified as having depressive symptoms or are not likely to receive treatment without significant community support and collaboration.

The Healthy IDEAS model was implemented through the collaborative efforts and leadership of the following organizations:

- Care for Elders, a private-public partnership of more than 80 organizations, provided management and staff support for the overall demonstration of Healthy IDEAS, including the distribution of funds through Sheltering Arms Senior Services, the program's fiscal agent. Care for Elders focuses on expanding the availability of critical services to vulnerable, high-risk older adults through creating provider networks and integrating new programs into existing service delivery systems.
- Three community agencies, including two nonprofit agencies (Sheltering Arms Senior Services and Catholic Charities Services to Alone and Frail Elders) and one county social service agency (Harris County Social Services) modified their case management programs and developed their staffs' capacity to implement this depression intervention. The three agencies serve diverse populations, including Spanish and English-speaking older adults who reside throughout the geographic area and in general live on a very limited income.
- Baylor College of Medicine and Houston Center for Quality Care and Utilization Studies utilized faculty members in psychiatry, psychology, and social work to conduct training, help evaluate program outcomes, and serve as coaches to support agency supervisors and case managers.
- The Harris County Area Agency on Aging, (AAA), helped identify agencies serving diverse populations at risk of depression and disseminated program information to other potential providers locally and throughout the State.
- Community mental health service providers helped with in-home evaluation and treatment.

The Many Benefits of Healthy IDEAS

Healthy IDEAS partners combined resources and skills to improve client outcomes and produced many benefits to the community agencies and academic organizations as well. Among the benefits reported by participating organizations and their staff members were:

- Expanded capacity within agencies to assess the mental health needs of clients;
- Refined approaches to communicating with medical and mental health care providers;
- Creation of new partnerships among community agencies and mental health care providers;
- Increased staff knowledge and confidence in helping clients with depression;
- Enhanced skills of case managers to help clients address problems; and
- Strengthened ability of agencies to attract funding by reporting positive outcomes from a proven program.

Academic partners also derived benefits from their roles in evaluation and training. These benefits included:

- Rich experience in implementation of evidence-based programs in real-world, community settings outside of the traditional medical environment; and
- Strengthened understanding of the needs of diverse populations, which informed future mental health research and training of professionals.

Benefits for participating older adults included:

- Increased ability to recognize depressive symptoms;
- Improvement of depressive symptoms;
- Decreased levels of self-reported pain; and
- Increased knowledge about how to get help for depression and how to reduce depressive symptoms by increasing activities.

II. Planning and Partners

In deciding whether to adopt Healthy IDEAS, it is important to understand the prevalence of depression among older adults in your community and/or among your agency clients. There are a variety of ways to do so. Your local and/or state health or mental health department can be a good starting point for gathering information to use in your planning efforts. You and your partners should review any relevant epidemiological data and other available local data on community-residing older adults to identify key health issues, rates of functional disabilities, or risk factors that could be addressed through health promotion programs.

If data regarding the prevalence of depression in older adults in your specific community does not exist, there are a few other strategies to consider. The easiest is to use prevalence of depressive symptoms for the age group you are targeting and doing an estimate of individuals with depression (e.g., 20 percent of the estimated population over 65). Community needs assessments identify those most at risk for under-diagnosed and untreated depression. Generally, these are ethnically diverse and low income older adults, as well as recent immigrants trying to cope with both stress and loss simultaneously. During a pilot phase of this project, one community agency added the two depression screening questions to their telephone intake tool and determined how many new clients of those contacting their agency might be at risk for depressive symptoms. Conducting telephone interviews or focus groups with healthcare providers and social service agencies may identify populations underserved for depression.

Once the health issues are identified and the target population defined, it is important to locate available mental health and medical treatment services, as well as gaps. Your search may also turn up additional partners and existing collaborations that can be leveraged in your work. To be most effective, be sure to include agencies or groups who serve or represent older adults, as well as some older adults themselves in your planning activities. In the work of Healthy IDEAS, this was particularly important, ensuring that the educational materials and language used with different groups was culturally relevant.

Getting Started

Contacting agencies to assess their capacity and willingness to participate in your program is the first step toward joining with them in either an informal collaboration or a more formal partnership. If you convene key providers serving these at-risk populations, you might encourage them to use the two screening questions for a two-week period to help them assess the prevalence of depression among their clients. Or you might look at estimates of the number of elders in their caseloads using population figures as described above. Alternatively, through those agencies that collect health or medication information, you may be able to identify how many clients have been prescribed antidepressants using a list of these medications to estimate clients with depression in current caseloads and then recognize this is an underestimate of those with symptoms.

Key resources needed for this work are trained staff, available supervisors, and/or community consultants with mental health expertise. Healthy IDEAS is a skills-based depression intervention. It requires resources to train current agency staff and supervisors initially and then provide ongoing follow-up training, especially during the

first year. Outside trainers can assist supervisors with training new staff. Agencies also need to have relationships with community medical and mental health care resources to do further assessment and treatment of persons with severe difficulties. As part of establishing a suicide protocol, agencies will also need to identify crisis support resources.

Partnerships

Useful partners to implement Healthy IDEAS include:

- Academic institution(s) or other community professionals with mental health expertise to help with training and ongoing consultation around both services and outcome assessment activities;
- Mental health professionals who are available for outside referral when needed and who can act as consultants to staff;
- Your AAA, which as a supporter of evidence-based programs for older adults can help identify appropriate agencies for the intervention; and
- Community social service or aging services agencies selected as Healthy IDEAS demonstration sites.

As your partnership or group forms, it is important to come to a consensus on clear goals and objectives. In general, it may be helpful to access resources on effective partnerships to learn more about building and maintaining these important relationships. Working with existing agencies with a similar mission and values creates a common bond that helps to foster partnerships. Clarifying the benefits of working together to achieve a common goal is basic and critical. Sharing expertise among agencies reduces the need for each partner to hire separate consultants or specialists. Clearly identifying your partners' roles, experience, and expertise avoids overlap and competition and fosters smoother linkages. Finally, having a staff champion at the supervisory level makes the program intervention easier to incorporate at the staff level.

A variety of resources are available to help you organize and sustain effective partnerships that will promote this work. We refer you to the Center for Healthy Aging Web site www.healthyagingprograms.org for a listing of resources, including: *Partnering to Promote Healthy Aging: Creative Best Practice Community Partnerships* which may be found at: <http://www.healthyagingprograms.com/resources/HPartnerships.pdf>.

III. Adoption – Settings

Among the suitable settings for this intervention are community-based aging agencies with ongoing service delivery in the home environment via case managers or comparable social service staff members. Appropriate agencies are those that serve older adults at risk for depression, including older adults with chronic illness, immigrants to the U.S., and socially isolated elders. In addition to community-based agencies, other settings can include congregate housing settings with social services, such as assisted living residences.

Any adopting agency needs to demonstrate readiness and capacity to deliver the intervention as designed. This means it must have a comprehensive case management program, as well as the following:

- An ability to use standardized screening and assessment tools;
- A capability for linking to primary healthcare and mental health providers;
- Adequate staffing; and
- The willingness to change.

Agencies must have existing assessment and follow-up procedures around identified client needs and should express a willingness to improve the quality of care for persons with depression.

Adopting agencies also need personnel capable of establishing ongoing, problem-solving relationships with older adults who may have many problems, both medical and non-medical, and may be socially isolated. Agencies need to have established procedures for linking older adults to other healthcare providers and maintaining contact in person and by telephone.

Having agencies complete an assessment of their readiness to adopt Healthy IDEAS can help determine which resources would be needed that do not already exist, especially with regard to training expertise and mental health services. In order to help determine an agency's capacity for implementing an evidenced-based program such as Healthy IDEAS, you can use the Assessment of Readiness: Self-Assessing Readiness for Implementing Evidence-based Depression Program Tool. (See Appendix VIII under Additional Tools.)

Key Partners

There are a variety of partners that can help you get Healthy IDEAS off the ground. A strong, aging service provider in your community can help identify potential settings. Local Area Agencies on Aging can help connect you to appropriate providers as well. Partnering with an academic institution can decrease training costs, as these institutions are often seeking sites where their staff and students can get access to older adults and gain clinical experience. And developing a partnership with health and mental health care agencies can allow for a flow of easy referrals for the medical and mental health care services clients may require.

IV. Reach – Outreach – Recruiting Participants

Identifying Your Target Population

Healthy IDEAS is a relevant model for all older adults in a community and is specifically intended to reach an ethnically and socio-economically diverse population who are at high risk for depressive symptoms. Materials for Healthy IDEAS are available in both English and Spanish.

Common psychosocial risk factors for older adults with depression include death of a spouse or loved one, co-morbid conditions, disability, loss of functioning, and social isolation. The design of the program for older adults (60+) requires the participant's ability to understand and communicate verbally, the cognitive skills to participate, and current enrollment in a long-term supportive services program.

Through the Administration on Aging's demonstration period, three case management agencies screened more than 350 older adults (clients and some caregivers) and the characteristics of the 27 percent who screened positive for depressive symptoms were:

- Mean age of 72.5 with over 40 percent 75 years and older
- 80 percent female
- 66 percent racial/ethnic minority (predominantly Hispanic and African-American)
- 65 percent living alone
- Mean of 3.6 other major health conditions (diabetes, heart disease, etc.)
- Mean income of \$846.00 per month

As these selected social and demographic characteristics illustrate, routinely screening clients who are receiving case management can identify an underserved population with significant needs beyond depression.

Barriers to Participation

Some older adults are not willing to consider mental health treatment because of bad past experiences, cultural beliefs, denial of the problem, or the stigma of mental illness. Other barriers to treatment include lack of resources. For example, in some places, there are an inadequate number of mental health practitioners willing to work with older adults (especially non-English speaking and non-American citizen older adults). There may also be a lack of insurance coverage; the cost of medications may be prohibitive; and transportation may be unavailable (Ell, 2006). Fortunately, case managers can reach older adults in their homes and through training and ongoing support help clients overcome many of the usual treatment barriers.

Recruitment

The key to recruiting Healthy IDEAS participants is to target older adults who are at highest risk for depression. Although an agency could choose to do outreach to the public or accept referrals from healthcare settings or other agencies, the demonstration model of Healthy IDEAS required older adults and family caregivers to be existing clients of the agency conducting the intervention. In fact, the Healthy IDEAS intervention was not designed as a stand alone mental health care service but as an expansion of case management services. All existing clients were screened at the time of

reassessment to stagger the entry of cases into the program. Today, as new clients require services, they are screened as their cases are opened. Optimally, all clients should be re-screened at least annually and after any significant change in status.

Evidence-based health promotion programs such as Healthy IDEAS are designed to help participants make informed decisions about their health and support appropriate behavior change. Change interventions are especially useful in addressing lifestyle modification for chronic disease self-management. We have found that the Stages of Change model offers a sophisticated way of better understanding participant readiness to make change, of appreciating barriers to change, and of helping older adults anticipate relapses. The design of Healthy IDEAS allows clients at different 'stages' to find help for their depressive symptoms by requiring case managers to do screening and follow-up over time, as needed, and engage clients in the intervention.

The Stages of Change model, developed by Prochaska and DiClemente (Prochaska et al, 1992) argues that for most persons a change in behavior occurs slowly. Regardless of age, all individuals go through several stages when making a life-altering change. They begin by being uninterested, unaware, or unwilling to make a change (**precontemplation**), and then progress to considering whether a change might be warranted (**contemplation**), and finally move on to deciding and preparing to make an actual change (**preparation stage**). Ultimately, the individual takes genuine, determined action, and over time, he or she attempts to maintain the new behavior (**action stage**). Relapses are almost inevitable and become part of the process of working toward life-long change (**maintenance stage**).

Effective recruitment and retention strategies take into consideration the stage of the potential participants, as each stage requires very different approaches to engage the client in working on his/her depressive symptoms. We suggest you learn more about the Stages of Change model and how it can be used to enhance your recruitment and retention of participants.

V. Implementation

Healthy IDEAS: The Basics

Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors) is a community-based program designed to detect and reduce the severity of depressive symptoms among older adults with chronic health conditions and functional limitations. The presence and severity of depressive symptoms determines the scope and duration of the intervention.

There are four main program components of Healthy IDEAS:

- Screening and assessment of depressive symptoms;
- Education about depression and self-care for clients and family caregivers;
- Referral and linkage to medical and mental health care professionals; and
- Behavioral activation.

All clients undergo screening for depressive symptoms and receive education about the disorder, effective treatment, and self-care. Each component has evaluation/monitoring tools and educational materials. The program manual provides specific protocols, detailed scripts for case managers to use in preparing to talk with their clients, and forms for the client and agency. (See Section VIII for these resources.) Typically, the program involves two or three face-to-face visits and five or more telephone contacts, which can be combined with other agency visits or calls.

1. Screening and Assessment of Symptom Severity

Agency case managers or other outreach workers screen both new and ongoing clients for depressive symptoms. They administer a two-question depression screening (Whooley et al, 1997) at the initial assessment interview with a new client or during a follow-up interview with an existing client. This screening interaction is scripted and incorporated into the established assessment and follow-up record-keeping system of the agency. Providers also ask older adult caregivers who reside with the client to respond to the two-question screening.

If the client answers yes to one or both of the screening questions, then providers ask the older client and/or older caregiver to complete the Geriatric Depression Scale (GDS) fifteen-item short form (to assess the severity of the depressive symptoms. As appropriate, the provider uses cards with the response categories printed in large type in the client's preferred language or reads the questions.

2. Education about Depression and Treatment

In order to expand awareness of the symptoms of depression and increase understanding of ways to prevent and treat it, all older adults receive some printed information about self-care strategies and local treatment resources. Interested clients or family members may also view videos about late-life depression. At this initial stage, case managers also provide family members residing in the home with the information and encourage them (with the elder's consent) to participate in the individual's self-management program.

3. Referral and Linkage to Treatment for Depressive Symptoms

Clients with moderate or severe depression are encouraged to seek medical attention, especially if they are taking medication that is not fully effective. In addition to discussing medication usage with clients, the case managers offer other depression treatment options for consideration. If clients are uncomfortable or unable to discuss his/her depressive symptoms with a physician, their case manager helps them to communicate with the doctor and shares screening results by letter or fax if clients consent.

Healthy IDEAS strives to improve linkages and communication among social, medical, and mental health care services. The Houston team reviewed the list of aging and mental health care service providers maintained by the local mental health association and augmented the resources used by the participating social service agencies. This work resulted in an inventory of mental health services for agency staff that helped them link older adults to mental health care providers.

4. Behavioral Activation Intervention

This phase of the program actively engages older adults with reducing their depressive symptoms if they have the desire to do so. After the initial assessment and education visit, the behavioral activation intervention typically involves one or two face-to-face visits and three or more telephone contacts related to depression self-care over a period of three to six months. The presence and severity of depressive symptoms determine the scope and duration of the program for each client. The needs of the older person with depressive symptoms, his/her ability to participate in the intervention, and changes in symptom severity over time determine the number of contacts. If at any time a client's symptoms become severe, the intervention then refocuses to help the client obtain treatment.

Building on carefully established rapport, case managers help clients understand the connection between behavior and mood. Using a problem-solving approach and knowledge of a client's overall abilities and needs, case managers help clients select goals that add some pleasurable or satisfying activities back into their lives, and identify the steps and other support needed to achieve the client's chosen goal(s). In some instances, a client may choose taking steps to obtain further evaluation and treatment for depressive symptoms as the first "activity goal." Other goals may involve taking action to avoid negative experiences such as problematic interactions with a family member or resuming an "old activity" such as social contact with lost friends.

It is important to allow clients to choose their own goals in order to increase self-efficacy. Case managers may use a tool (see Section VIII for a Checklist of Potential Activities) to help clients who have difficulty identifying a purposeful activity goal. Through follow-up telephone and in-person support, case managers monitor progress toward goals, help clients adjust goals as needed, and reinforce positive behavior. Activities in behavioral activation vary and may change over time—depending on what clients find important—to help alleviate a depressed mood (as assessed with repeat administration of the Geriatric Depression Scale).

Measuring Impact

Healthy IDEAS identifies and addresses depressive symptoms and offers depression treatment options. Depression is itself a medical condition, but it also affects the health outcomes of other medical illnesses. The concept of “activation” has been identified as a mechanism for helping to improve functioning and decrease avoidance of tasks/activities that may be important or convey benefits. Healthy IDEAS measures the following health outcomes:

- **Client Satisfaction and Change in Knowledge and Skills.** This is determined by a client satisfaction questionnaire and a pre- and post-comparison of the client’s knowledge about managing depressive symptoms.
- **Health Status and Function.** As noted above, this is measured by a 15-item Geriatric Depression Scale and a self-report of health status, pain, activities of daily living (ADLs), instrumental activities of daily living (IADLs), and pre- and post-changes in symptoms.

Healthy IDEAS has specific, measurable program goals and objectives to reduce the severity of depressive symptoms in older clients of community agencies through:

1. Improving recognition and understanding of depression among older adults and their families;
2. Assuring that the program is appropriate for, and highly satisfying to, culturally diverse clients and caregivers;
3. Improving the knowledge and skills of community aging service providers/ case managers regarding recognition and treatment of depression;
4. Strengthening the working relationships among older adults and providers of social, medical, and mental health care services; and
5. Reducing barriers to successful treatment of depressive symptoms.

We measured these goals and objectives by collecting client level outcome data as well as conducting surveys of clients, participating case managers, and agency administrators. Below, we summarize our evaluation approach and findings.

Keys to Program Fidelity

Evidence-based programs are grounded in research. Specific core components or constellations of components make up the essence of the programs. In order to assure the health outcomes ascribed to any given program, these core components must be maintained in your implementation. This is termed “maintaining fidelity” to the model. In order to implement a program in your community and better match the program to your target population, you may wish to alter some of the program’s characteristics. Before making changes, however, be sure you understand what adjustments can be made without affecting the intervention’s core components, and hence its outcomes.

Key components of fidelity for Healthy IDEAS include: 1) routinely asking questions regarding depression in the way they were designed to be asked, and 2) implementing the components of the intervention so that clients pursue actions that will address their depressive symptoms. In order to assist with program implementation, we developed a

program manual detailing the timing, activities, and content for each component. In order to ensure fidelity to the process, the research team also created a tracking tool that specified the activities and corresponding time interval to be used by case managers to track and record the progress of each participant.

Staff needs to complete training with the components of the intervention before implementation can begin. It is important to focus on the skills needed to do the intervention rather than specific steps. The relationship between client and case manager/agency worker is key to establishing rapport. Failure to complete the core elements of the intervention will negatively affect its outcomes.

Since agencies have established policies and procedures, Healthy IDEAS' timeframes can be modified to fit with agency protocols. This allows conducting assessments and re-assessments of depressive symptoms to occur during routine-care plan assessment/reassessment intervals. Written forms and tools may also need to be adapted to a given population's language or culture. Many clients are unable to do written homework or self-monitoring forms, so case managers may need to offer help.

In our experience, it's best when agencies maintain an ongoing relationship with their clients for six (6) months or longer in order ensure sufficient time to do the intervention and to evaluate its effectiveness.

Intensive Training and Preparation

Community agencies adapting the program should use the Healthy IDEAS program manual and related training materials (see Section VIII) to ensure that its providers are adequately trained. The program manual includes an overview of the project and detailed "scripts," descriptions, and guidelines for each intervention component. Training resources include educational videos and handouts on depression as well as case studies and models of completed forms. Additionally, we have developed a training video with case examples that illustrate the clinical skills needed to do the intervention. This video is part of the Healthy IDEAS training curriculum for agencies seeking to adopt the program (www.careforelders/healthyideas) and is available as part of the program implementation package, available through Healthy IDEAS or NCOA (www.healthyagingprograms.org).

In Houston, we gave the program manual to all agency administrators and case managers and used it in the training sessions. All case managers and their supervisors received two, six-hour days of training before the beginning of the project. Our academic partners had mental health expertise and facilitated the training sessions using lectures, role plays, and demonstrations. In addition, updates and booster training sessions were given to all of the providers during the project's implementation in order to prevent "drift" in providers' skills as well as address any questions or barriers that the providers had encountered in implementing the intervention.

Mental health professionals from academic or healthcare partners provided depression training for agency workers and also served as "coaches" to enable supervisors and workers to acquire the skills needed for this evidence-based intervention. Clinically qualified agency supervisors or program directors were also trained to serve as

“coaches” and trainers for ongoing sustainable programs. Volunteers were not used in this intervention, given the extent of the training and skills required.

In Houston, we trained all case management staff at participating agencies to implement the intervention. Master’s level social work staff grasped the practice skills more quickly than other staff. We did not recruit case managers individually, as the intervention was embedded into the routine service delivery for all staff. Interest in helping older adults address their depression was an asset. This motivated staff members to accept the changes required by Healthy IDEAS training more readily.

Getting Supervisors On Board

Since our intervention was embedded in the agency’s routine service delivery, we trained agency supervisors or case management program managers to do the intervention and then provide ongoing supervision to their staff. For your program, outside consultants can be an alternative resource to supervisors, acting as coaches for the staff implementing the Healthy IDEAS intervention. Another alternative is to train supervisors as coaches and use a specialized mental health consultant, such as a behavioral psychologist or psychiatrist, for queries, consultation, and ongoing group staff training. Given the important role they play in helping embed the program into agency procedures and forms, agency supervisors are important program champions. In addition to helping train and supervise staff, these supervisors can also be key leaders in working with other community providers to address barriers to depression treatment as well as reviewing outcome data to maintain program effectiveness.

VI. Maintenance

As an embedded intervention, no special recruitment efforts are required to maintain the program. At our agencies in Houston, all case management clients are routinely screened for depression. As new clients apply for agency services, they are automatically screened using the two-question depression assessment, as well as during their annual re-evaluation. As an adopting agency, you can choose to do the screening every 90 days at care-plan review or less frequently, if this fits your client population.

Effective collaborative efforts are sustained over time if they are beneficial to all parties. It is helpful to keep informed about local mental health resources to which you can refer clients for specialized treatment. Ongoing training and case review sessions give added support to staff and supervisors. Conducting these sessions with multiple agencies can create efficiencies and enhance helpful collaborations and support for work throughout the community. Partnering with mental health professionals from academic institutions or healthcare agencies to provide depression training for clinically qualified agency supervisors or program directors to serve as “coaches” and trainers can also support ongoing sustainable programs.

Since no additional staff is required to maintain Healthy IDEAS over time, specific fundraising may not be necessary if formal training linkages exist for the agency. The only ongoing costs relate to ongoing training and consultation needs. New staff members need to be trained to do the intervention. Ongoing training to support current staff efforts can also be beneficial.

VII. Effectiveness, Performance Measures, and Other Outcomes

When implementing Healthy IDEAS at your agency, it is necessary to include performance measures and examine outcomes at several different levels: individual client, program, and agency. Collecting information at each of these levels will enable you to answer important questions such as whether older clients received benefits from participating, whether individual workers are able to deliver the program as designed, and whether the agency is reaching the clients at highest risk of depression and finding adequate community services to help them address their depressive symptoms. You can use outcome data to pursue resources to support the program or support your staff with further training. Staff can also use some findings to help clients recognize progress in addressing their depression.

Evaluation

The Healthy IDEAS partners selected some basic process and outcome measures and worked to embed the data collection within routine agency forms and procedures as much as possible. A full description and report of the evaluation plan and outcomes is published in the peer-reviewed literature (Quijano et al, 2007). The key areas for client outcome measurement were consistent with the depression projects that constituted the evidence base for Healthy IDEAS (i.e., IMPACT, PEARLS): levels of depressive symptoms, quality of life, level of physical and social activity, knowledge of depression self-management, and use of medical and mental health services. An agency staff member (other than the case manager) or volunteer also conducted telephone client satisfaction surveys asking how satisfied the clients were with the services they received and to what extent the intervention helped them in dealing with their depression.

Incorporating some process evaluation measures addresses key “agency level” program evaluation questions including:

- Is the program being implemented as designed?
- What difficulties/barriers are staff members experiencing?
- Are all staff performing at an appropriate skill level?
- What is the overall rate of client participation in and completion of the program?

Process evaluation of Healthy IDEAS included examining key elements of fidelity and whether Healthy IDEAS was successfully integrated into the agency’s ongoing case management program. As discussed in Section V: Implementation, case managers used tracking forms to record client contacts and progress through the intervention components as well as to document reasons for nonparticipation. In regularly scheduled meetings, coaches/supervisors and agency workers reviewed the progress of participants on the tracking forms. Staff also documented client progress in their client records.

Case management tracking forms or some mechanism to generate reports from client files are needed to answer questions related to client participation rates as well as overall success in improving rates of depression treatment. Finally, in Houston, case managers were surveyed about their views concerning the overall intervention as well

as their confidence in conducting each component. We found that case managers who value addressing depression as part of their service delivery and are confident in their ability to deliver the intervention within their daily practice are more likely to be effective in helping clients change their behavior to address depressive symptoms.

Outcomes: What We Found

A full-scale evaluation of the Healthy IDEAS program involved looking at pre- and post-intervention outcomes for a total of 361 clients (thirteen were caregivers) served through three different case management programs, two in nonprofit agencies and one in a public county agency. The results of evaluation of the Healthy IDEAS program demonstrate that training case managers to deliver an evidence-based practice in real-world conditions reaches the target population and significantly reduces depressive symptoms. Noteworthy client outcomes include:

- Approximately one in four (27 percent) of all clients screened for depression reported significant depressive symptoms on the Geriatric Depression Scale (GDS).
- For Healthy IDEAS eligible clients, there were statistically significant improvements in mean GDS scores at six months (9.0 vs. 5.5), with scores above 6 indicative of mild depressive symptoms and 10 or above indicating moderate to severe depressive symptoms.
- A statistically significant percentage of clients reported a reduced level of pain, with more clients reporting no pain or milder pain than when they began the program.
- Significant improvements were also noted from baseline to six months in the percentage of clients who could make an appointment to get help with depression, identify symptoms of depression, and know what to do if their depression worsened (self-management self-efficacy).
- A higher percentage of clients at six months (56.6 percent) reported little or no interference of their physical or emotional health with their social activities, compared with baseline (26.4 percent).
- Of those who completed a six month survey, almost all (95 percent) reported receiving help with their depression and all of them were satisfied with the services they received.

Overall, groups of underserved Houston, Harris County, seniors who would not otherwise have received needed mental health services have been helped. The program reached the intended, often overlooked population of frail, high-risk, and diverse older adults. Older individuals with lower socioeconomic status who belong to an ethnic minority and lack knowledge about care for depression are not likely to access treatment for depression. Healthy IDEAS participants experienced a reduction in depression severity and pain. Their knowledge increased about how to get help for depression and how to reduce depressive symptoms through increasing activities.

Agency and Staff Outcomes

We successfully trained agency staff to provide and deliver an evidence-based intervention for depression to older adults who were in their caseloads. Case managers demonstrated their ability to identify depression in the target population and carry out the intervention. Findings from the surveys of case managers and coaches show that staff increased their knowledge about depression and experienced greater confidence in their ability to help with the condition.

Agencies who participated in the demonstration project have integrated Healthy IDEAS into their ongoing case management service delivery. They view Healthy IDEAS as an effective depression management program and an important educational approach to lessening the stigma of mental illness for their clients.

Healthy IDEAS represents a successful community-academic partnership that developed evaluation expertise and provided mental health training to supervisors and case managers and fostered linkages to treatment resources. As a result, an evidence-based depression intervention reached a large number of diverse, at-risk older adults.

Performance Measures

Integrating objective measures into the daily practice and data-collection procedures of community agencies that serve older adults lends greater credence to work conducted in nonacademic settings. It also supports the expansion of evidence-based mental health services to this population.

Performance measures for Healthy IDEAS need to address client and staff level performance in key areas and require examining progress over time. To evaluate client progress, case managers should do periodic follow-ups with participants using structured measures to assess the following:

Severity of depressive symptoms: We used the Geriatric Depression Scale, 15 items (Sheikh and Yesavage, 1986) in English and Spanish (Velasquez, 1998); however, there are other valid depression assessment tools that can be used.

Quality of life: Depression affects many dimensions of life, so we advise using items that address bodily pain, general health perception, and social function. We chose three items from the Medical Outcomes Study Short Form-36 for use in our program (Ware and Sherbourne, 1992).

Medical and mental health utilization: Part of the intervention addressed helping clients obtain further medical and/or mental health treatment. We chose and recommend four items from the Depression PORT II study to assess use of medical and mental health services during the previous three months, including:

- Whether the client has had contact with a medical provider;
- Whether the client discussed depression with a medical provider;
- Whether the client was given a prescription for antidepressant medication;
- and

- Whether the client had contact with a mental health professional (Ritter, et al, 2001).

Level of social and physical activity: Given the focus of behavioral activation, we also recommend asking questions from The Community Healthy Activities Model Program for Seniors (CHAMPS) questionnaire, a self-report measure of frequency and duration of physical activity (Stewart et al, 2001). In our intervention, modifications were made to assess overall level of social and physical activity using five-point Likert scales with values ranging from “not at all active” to “very active.”

Knowledge about and satisfaction with depression self-management: From our experience, we recommend asking at least one question about whether clients know what to do if depressive symptoms worsen, along with some questions about satisfaction at the end of the intervention. This provides valuable feedback concerning participants’ understanding and use of the Healthy IDEAS self-management skills. The questions used during the AoA demonstrations, for example, were not easily understood by all clients, although they included relevant content (Cretin et al, 2004).

Staff performance: As discussed in the keys to fidelity, staff need to demonstrate adequate skills for conducting the intervention as well as delivering program components according to the correct time schedule. Therefore, we recommend using a tracking tool or system that both supports a case manager’s success and enables a supervisor to ensure fidelity to the process and monitor caseload size, etc. Some method of observing a case manager’s interactions or discussing how a given worker does the intervention is necessary to confirm a worker’s skills after training.

VIII. Appendices: References, Tools and Resources

References

The references cited in this report are listed below. Articles include background on older adult depression as well as descriptions of the original research evidence for Healthy IDEAS.

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Tools

Some of the tools listed below will be available on the web site of the Center for Healthy Aging (www.healthyagingprograms.org) or the Healthy IDEAS program Web site (www.careforelders/healthyideas) Agencies that pursue program replication will receive the following copyrighted manuals and training DVD as well as additional tools:

Healthy IDEAS Program Manual: The program manual includes an overview of the evidence for the program as well as detailed information for each program component: protocols for in-person and telephone sessions, recommended language for worker-client interactions, sample forms for educating and supporting client activation, and tools for tracking client progress and outcomes.

Healthy IDEAS Client Handouts: Educational handouts and forms to support the client's participation in the intervention.

Healthy IDEAS Training DVD and Facilitators Guide: An 80 minute training DVD has been produced to provide important content regarding the Healthy IDEAS intervention, including a review of the key skills required to do the program with clients having different degrees of depressive symptoms. The training manual includes background materials on depression and the intervention as well as guidelines and suggestions for training staff to conduct the intervention with fidelity to the program model.

Other Tools

Planning and Partnering

1. Letter to agency director
2. Agency capacity questionnaire including agreement

Adoption

1. Readiness: National Council on Aging form for Self-Assessing Readiness for Implementing Evidence-based Depression Program

Implementation

1. Program Manual (described above)
2. Client Handouts (described above)
3. Sample Assessment Forms
4. Sample Reporting Forms
5. Training DVD and Facilitator Guide (described above)
6. Agendas for Initial Staff Training

Maintenance

1. Client Tracking Form: Used by each case manager to record client contacts and produce summary reports of clients served, screened, linked to mental health services, engaged in behavioral activation
2. Agendas for Staff “Booster” Training

Effectiveness and Performance Measures (Evaluation Tools)

1. Baseline and follow-up measures assessing individual outcomes (English and Spanish): depressive symptoms, quality of life, services and medication services use, level of activity, knowledge and self-efficacy
2. Organizational:
Staff skill assessment (assessing fidelity)
3. Programmatic:
Client satisfaction survey
4. Staff Survey about Intervention

Planning and Partnering Tools

1. Letter to agency director

A letter was initially sent to agency directors regarding level of effort and time requirements required to include Healthy IDEAS as part of their agency’s case management program. It included the following paragraphs:

As part of the Healthy IDEAS project team, your agency representative will be asked to participate on the Healthy IDEAS Advisory Committee, which will meet once or twice a year. Training will be provided to your case management staff and their supervisors to ensure their expertise and comfort in delivering the Healthy IDEAS program to their clients. It is anticipated that this staff training will require two, four hour sessions, and a third follow up “booster” training to address any issues or concerns that have emerged while the intervention was being delivered. Ongoing data collection and documentation will be integrated into your current documentation time frames and standardized to reduce staff burden.

Healthy IDEAS requires implementation of a prescribed intervention that consists of eight client sessions conducted over a 90-day period. Some of the sessions require an in home face-to-face visit while others can be done by telephone. The visits can and should be combined with routine case management service delivery. Follow up telephone contact after completion of the 90-day period is optimal to encourage continued client use of the intervention and to reduce the likelihood of depression reoccurrence. In addition, it is our hope that the SAFE program will embed Healthy IDEAS into their routine practice and continue to offer this depression self-management program to clients beyond the demonstration grant period.

2. Agency capacity questionnaire and agreement to participate as follows:

LETTER OF AGREEMENT

Name of Organization:

Address:

Date Founded:

Name of Participating Program/Department:

Liaison for this project:

Phone Number

E-Mail:

Clients served in 2005 by program:

2005 Demographics of clients:

___ % Hispanic ___ % White ___ % Other (Unknown)

___ % age 65–79 ___ % age 80+

Our organization is willing to: (participate in all of the following)

_____ Improve our care for older people with depression

_____ Strengthen partnerships with health and mental health professionals

_____ Designate 2 or more staff members who currently do in-person assessments of older clients and provide individual case management services and assistance over time

_____ Commit to attending required training sessions in Houston

_____ Conduct the program intervention as designed

_____ Confer monthly with a coach/consultant

_____ Collect and submit necessary data and statistics

_____ Participate in interviews about the implementation process

_____ Coordinate with other sites chosen

_____ Be a spokesman for the intervention in publications or media

_____ Contribute to presentations on the demonstration project

PLEASE PROVIDE 2-4 sentences under each topic/question:

1. Describe interest and ability to adopt, manage and sustain the demonstration project. Answer the question: Why are you willing to participate and what are your potential plans to maintain the intervention beyond the demonstration?
2. Briefly describe the staff and the agency support, including facilities, which will be available for the project.
3. Describe plans for identifying clients to be screened and to participate in the depression intervention.

4. Identify the proposed neighborhoods and/or zip codes where you expect to conduct the demonstration project.
5. Briefly list existing agency programs that will interface with the demonstration project.
6. Describe linkages with the healthcare and mental health sectors, that is, what providers do you currently interact with (if anyone) to address the needs of older adults with depression?

This agreement is effective on the date completed and signed by: Sheltering Arms Senior Services, the fiscal agent for Healthy IDEAS and AGENCY.

Signature Date

Signature Date

Printed name and title

Printed name and title

Adoption Tools

Readiness: NCOA Form for Self-Assessing Readiness for Implementing Evidence-based Depression Program modified for Healthy IDEAS



Self-Assessing Readiness for Implementing Healthy IDEAS: Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors): Evidence-Based Disease Self-Management for Depression

This tool is to assist a community aging service provider and other partnering organizations in determining their readiness to implement one or more components of the evidence-based prevention program, Healthy IDEAS. The answers to these questions will help you understand what additional commitments, capabilities, or resources you might need to progress with plans to implement this proven program.

1. Do you have an established program of Case Management or another one-on-one social service program with the following features?
 - Comprehensive focus on needs of older adults including attention to client's functioning and well being on multiple dimensions: environmental, medical, financial, social, etc.;
 - Established system for documentation of assessment, care plan, monitoring, and follow-up contacts; and
 - Feasibility of having at least two-three in-person contacts and five to six telephone contacts with client over the course of 3 to 6 months.
2. Are you able to have one-on-one contact in the home or other confidential setting with older adults at risk for depressive symptoms, e.g., chronic health conditions, functional disability, or social isolation?
3. Can you incorporate standardized screening and assessment questions for depression into your work with clients?
4. Are you willing/able to modify your record-keeping and documentation system to incorporate key process and outcome tracking requirements?
5. Can you make an organizational commitment to improve the quality of care for persons with depression?
6. Can you establish or strengthen strong linkages with one or more primary healthcare providers and mental health providers?
7. Can your agency workers play a role in coordinating care plans with health and mental health providers including attention to medications?
8. Can you help clients address barriers to receiving depression treatment including finances, transportation, cultural barriers or other access barriers?
9. Do you have adequate staffing to ensure "coverage" of case management clients and support for staff to implement an intervention requiring new skills and additional time?

10. Can you identify clinical partners with mental health and aging expertise to assist with the training and support of staff to implement the program?

11. Will you support a program supervisor and staff members to be trained in the skills necessary to deliver the model program and maintain fidelity to the model?

This tool was developed with support from by the John A. Hartford Foundation of New York.