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Healthy IDEAS: Implementation of a Depression Program Through Community-Based Case Management

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Purpose: Healthy IDEAS (HIDEAS; IDEAS stands for Identifying Depression, Empowering Activities for Seniors) is an evidence-based depression program addressing commonly recognized barriers to mental health care for older adults. The purpose of this study was to describe the implementation of HIDEAS and assess its feasibility. ***Design and Methods:*** Three community agencies implemented the program with 94 eligible older adults who were identified from 348 screened older adults. We assessed program implementation by using the Core Implementation Component framework, using a client-tracking database, written survey of case managers, focus-group interview with coaches, and agency and project progress reports. ***Results:*** We identified several challenges: clients' reluctance to acknowledge depressive symptoms and difficulty in engaging in behavioral changes; differences among case managers' mental health knowledge, skills, and ''buy-in'' and difficulty managing limited time; and differences in agency culture that foster in-agency supervision. ***Implications:*** Successful adoption and sustainability of HIDEAS are more likely when essential elements of the Core Implementation Component framework are addressed to bring about behavioral changes at all treatment-implementation levels—clients, practitioners, and organizations.

Key Words: Case management, Community-based services, Elder depression, Mental health intervention

Untreated depression is a major public health concern, associated with impaired physical, mental, and social functioning (U.S. Department of Health and Human Services [DHHS], 1999), as well as increased use of health services (Rowan, Davidson, Campbell, Dobrez, & MacLean, 2002). Concerns are even greater for older adults, especially minority and low-income elders, who are underserved for mental health needs (Alvidrez, Areán, & Stewart, 2004; Ojeda & McGuire, 2006). Clinical trials have shown that mental health interventions are effective in treating depressive symptoms in older adults (Bartels et al., 2002; Cole & Dendukuri, 2004; Roy-Byrne et al., 2003). However,

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these interventions have not been widely adopted in community agency settings because of a number of challenges.

In a comprehensive review of the current literature, Ell (2006) identified barriers to depression care for older adults at all levels of treatment delivery—patients, providers, and organizational systems. At the patient level, older adults' lack of knowledge about mental illness and the stigma associated with mental health care impede them from seeking mental health services. At the provider level, health care providers' lack of knowledge about late-life depression often results in their failure to recognize it. Ell's review also suggests that insufficient training in depression care may cause providers' reluctance to assess and treat mental health problems. This shortage of providers with expertise in geriatric mental health care leads to delayed recognition and detection of mental illness among the elderly population. Additionally, organizational cultural differences among medical, mental health, and social-service provider systems (Kilbourne et al., 2004) and lack of coordination among them (Bartels et al., 2002) hinder depression care for older adults. Successful efforts to translate clinical evidence and improve the quality and delivery of mental health care for older adults will likely have to address these barriers.

Healthy IDEAS (HIDEAS; IDEAS stands for Identifying Depression, Empowering Activities for Seniors), a demonstration project of the Administration on Aging Evidence-Based Disease Prevention Program, is a community-based depression program delivered through community agencies that offer a range of services for older adults. It targets the underserved low-income, chronically ill older adults in the community and addresses commonly recognized barriers to mental health care: detecting depression; helping clients understand depression as treatable; assisting them to gain knowledge and skills to self-manage it; and linking primary care, mental health care, and social-service providers. HIDEAS uses a unique approach in delivering depression care in that the entire intervention is delivered, not by mental health professionals employed solely to perform the intervention, but by case managers in existing social-service agencies who may or may not have a prior mental health background. It is designed so that all components of the intervention are embedded into the ongoing assessment and care plan routine of community case-management programs.

Our purpose in this article is to report a formal evaluation of the HIDEAS implementation by using the Core Implementation Component (CIC) framework proposed by Fixsen, Naoom, Blase, Friedman, and Wallace (2005). The CIC framework, developed from a synthesis of implementation research literature published in the past 35 years, consists of six of "the most essential and indispensable components" (p. 24) of evidence-based program implementation: (a) staff selection, (b) preservice and inservice training, (c) ongoing consultation and coaching, (d) staff and program evaluation, (e) facilitative administrative support, and (f) system interventions. Systems intervention involves strategies in working with external systems to ensure program sustainability through the securing of financial, organizational, and human resources. Although plans for sustainability were part of the last phase of the HIDEAS demonstration, insufficient time and resources prevented collection of formal data on this component. Therefore, this article reports the essential elements and evaluation of the first five CIC framework components of HIDEAS. Table 1 shows a description of the CIC framework.

HIDEAS Program Overview

HIDEAS is an evidence-based program translated and adapted from approaches tested in two randomized controlled trials treating depression in older adults, namely, IMPACT (Unützer et al., 2002) and PEARLS (Ciechanowski et al., 2004). It was implemented by a community–academic partnership and delivered through case-management programs at three social-service agencies (two nonprofit and one county). Each agency directed all its employed case managers to implement HIDEAS during routine duties. Table 2 shows characteristics of agencies and their case-management staff surveyed in this study. Faculty affiliated with Baylor College of Medicine and the Houston Center for Quality of Care & Utilization Studies provided training, coaching, consultation, and program evaluation. HIDEAS participants included ethnically and socioeconomically diverse community-dwelling older adults at high risk for depressive symptoms. Table 3 summarizes participants' characteristics.

A detailed overview of the program and evaluation findings of successful client-level outcomes, including reductions in depressive symptoms and pain and improvements in clients' self-management skills, is available elsewhere (Quijano et al., 2007). Briefly, HIDEAS consists of four components: (a) screening and assessment, (b) education, (c) referral and linkage, and (d) behavioral activation. All existing and new clients enrolled in case-management programs of participating agencies at the time of recruitment (June 2004 to December 2005) were asked to participate. Participant inclusion criteria were being at least 60 years of age, having the cognitive ability to participate and communicate verbally, and scoring 6 points or more on the 15-item Geriatric Depression Scale (GDS-15; Sheikh & Yesavage, 1986).

During the demonstration project, case managers approached 348 clients, screened them by using a two-item depression-screen question from the Primary Care Evaluation of Mental Disorders (Kroenke, Spitzer, & Williams, 2003), and assessed them for depression by using the GDS-15. Eligible clients (GDS-15 $\geq$ 6) and their family members received education on depression and printed materials. Case managers assisted clients to communicate with a medical or mental health provider to receive appropriate treatment. Behavioral activation included written tools and focused on increasing positive reinforcement in the clients' environment by helping them understand the link between mood and actions and engage in fulfilling activities (pleasant

Table 1. Core Implementation Components and Evaluation Strategies

Core Implementation Component	Data Source	Elements Assessed
Staff selection		
Identifying and recruiting qualifying practitioners and organizations. Qualifications go beyond academic background or experiences and include certain personal characteristics and organizational culture, such as willingness to learn new approaches.	Project progress reports Case-manager survey Coach focus group	Organizational prerequisites Case-manager characteristics, education, experiences, professional scope
Preservice and inservice training		
An essential step for successful delivery of interventions in which necessary background information and the key components and rationale of the new program are introduced to the practitioners, and interactive learning opportunities are given to practice new skills and techniques.	Agency reports Case-manager survey Coach focus group	Adequacy and helpfulness of training and manuals
Ongoing consultation and coaching		
A critical process in which the skills introduced in training are learned and reinforced on the job for adaptation with the help of consultation and coaching.	Case-manager survey Coach focus group	Adequacy and helpfulness of coaching
Staff and program evaluation		
Program fidelity assessed for its context, compliance, and competence. *Context* refers to prerequisites for program operation, such as staffing, service–agency settings, and prior training. *Compliance* and *competence* concern how faithfully practitioners deliver the new program as prescribed and how skillfully they do so, respectively.	Agency reports Tracking records Coach focus group Case-manager survey	Context: Organizational setting, scope, resources Compliance: Delivery of intervention components as prescribed Competence: Ease or difficulty with implementation
Facilitative administrative support		
Providing leadership by making informed decisions, supporting the implementation process, and maintaining a focus on program outcomes.	Case-manager survey Coach focus group data Agency reports	Adequacy of program leadership and facilitation

events or simple accomplishments). HIDEAS components were incorporated into the routine case-management procedures and schedule of each participating agency and delivered in 10 steps through face-to-face visits in the clients' homes and telephone contacts. Table 4 summarizes the guidelines, actions, tools, and resources used within each component.

Methods

Evaluation Strategies

We documented and evaluated HIDEAS program implementation by using multiple methods involving data collection from case managers, agency leadership, and trainers or coaches.

Client-Tracking Data.—We used tracking data to document delivery of the intervention. Using a written tracking tool, case managers recorded contacts and steps for each client. We then had recorded contacts entered into a database to monitor and evaluate fidelity. Figure 1 summarizes the tracking records, illustrating delivery steps and rates as well as reasons for nondelivery at each step.

Case-Manager Survey.—Of 12 case managers, 10 completed an anonymous written survey at their agency and mailed them to a designated evaluator (2 had departed from agency employment). We then entered all data in an SPSS database for analysis. The survey questionnaire asked case managers to rate six areas of program implementation: program leadership and facilitation, organizational context, professional scope, effectiveness, client's experience, and ease or difficulty of implementation (Table 5). It also included several open-ended questions asking case managers to list benefits and challenges that they and clients experienced. In general, responses were short and specific. We had the written responses to these entered in the database verbatim and had them transferred to a spreadsheet for content analysis by using the analytic strategy proposed by Stockdale (2002). Although Stockdale's strategy was originally proposed for the analysis of focus group data, we found that the strategy was also useful in the content analysis of case managers' responses. First, we entered the questions and responses in separate columns of the spreadsheet and sorted them by the questions. We reviewed the responses and coded them for themes. We created a column for each code identified, resulting in multiple codes for some responses. We reviewed codes and identified themes for four areas: benefits for case managers, challenges for case managers, benefits for clients, and challenges for clients.

Focus Group.—Using a semistructured interview schedule, an independent evaluator not on the coaching

Table 2. Characteristics of Participating Agency and Case-Management Staff

Agency	Agency Description	Case-Management Staff Surveyed
Agency A	Nonprofit, multiservice agency Founded 1893 200 full-time employees Case management: United Way-funded program Eligibility: 60+ years, all incomes Serves 272 clients annually	Supervisor: Licensed master-level social worker Case managers ($n = 4$) Education: 4 BSW Average years working as a case manager: 10.1 years (range = 1.5–30 years) Average years working with older adults: 7.8 years (range = 5–10 years) Average caseload: 39 cases (range = 35–45 cases)
Agency B	Nonprofit multiservice agency Founded 1943 257 full-time employees Case management: Provided through agency's program for seniors Eligibility: 65+ years, living alone, all incomes Serves 105 clients annually	Supervisor: Licensed master-level social worker Case managers ($n = 3$) Education: 3 MSW (turnover in two positions) Average years working as a case manager: 3.5 years (range = 0.5–9 years) Average years working with older adults: 2.8 years (range: 2.5 to 3 years) Average caseload: 33 cases (range = 25–37 cases)
Agency C	County agency 420 full-time employees (human services for all ages, settings) Case management Provided through assistance programs regarding financial needs or financial representation Eligibility: 60+ years, country residents, meet income criteria Serves 1,630 clients annually	Supervisor: Licensed master-level social worker Case managers ($n = 3$) Education: 3 MSW Average years working as a case manager: 2.6 years (range = 2.4–2.8 years) Average years working with older adults: 3.1 years (range = 2.6–4 years) Average caseload: 38 cases (range = 11–70 cases)

team conducted 1-hour focus-group interviews with all coaches ($N = 6$). This information was tape recorded and transcribed verbatim by a research assistant. Another independent evaluator then reviewed and transferred the transcript to a spreadsheet for analysis, using the same analytic strategy (Stockdale, 2002) used in analyzing the responses of the case managers' survey just described. Themes identified in the focus group were analyzed for three areas: coaches' experiences with coaching process, assessment of staff and agency readiness, and intervention protocol.

Meeting Notes and Program Reports.—We reviewed meeting notes and program progress reports, including those required by the funding source (Administration on Aging), to document implementation activities, including training and agency quality-improvement activities. Table 1 summarizes how we used these data to assess each CIC of the HIDEAS implementation.

The evaluation protocol of HIDEAS was reviewed and approved as an exempt project by Baylor College of Medicine and the University of Maryland, Baltimore Institutional Review Boards.

HIDEAS Core Implementation Components and Evaluation Results

CIC 1: Staff Selection

Because HIDEAS was designed to be delivered through existing case-management services in the community, the selection of agencies to implement HIDEAS was crucial, resulting in "automatic" determination of individuals who would be delivering the intervention. On the basis of a previous 9-month pilot of the program, we developed the following criteria to identify agencies with adequate capacity to implement it: (a) comprehensiveness and adequacy of the case-management program, (b) ability to use standardized screening and assessment tools, (c) capacity for linking to primary health care and mental health providers, (d) adequacy of staffing for agency caseload, and (e) commitment to addressing depression in clients by adding an intervention. The project lead and demonstration coordinator conducted lengthy meetings with program leaders of seven different agencies serving diverse populations. Ultimately, four of these agencies satisfied the readiness and capacity criteria; and three of these agreed to adopt the program during the demonstration.

Twelve case managers delivered the intervention during the project period. Case managers' racial or ethnic background was diverse, with three Caucasian, five African American, two Hispanic, one Asian American, and one biracial manager, reflecting the clientele each agency was serving. All had either a master's degree ($n = 7$) or bachelor's degree ($n = 5$) in social work, with a mean of 5.8 years' experience in case management ($SD = 8.8$, range = 6 months to 30 years), and six managers reported some experience providing mental health services. Mean years of working with older adults was 4.8 ($SD = 2.9$, range = 2.5–10 years). Average active caseload per worker was 37 cases ($SD = 15$, range = 11–70 cases; see Table 2).

Although survey results (Table 5) indicated that case managers in general positively assessed their role in the program (80%) and most agreed that HIDEAS was within the scope of the agency (70%), coaches observed variations in the skill level of workers, as well as

differences in agency culture that seemed to facilitate or impede the worker–agency partnership in implementation. In the focus group, coaches reported that agencies with ongoing and open communication between case managers and their supervisor seemed to be adaptive to the challenges of integrating a new program in the existing case management. At the same time, they sensed skepticism about mental health interventions in a few case managers and spoke of the challenge of gaining their ''buy-in.''

CIC 2: Preservice and Inservice Training

HIDEAS case managers needed to understand the rationale for program components, as well as acquire new skills for successful program delivery. To support staff training, agency supervisors and case managers received a detailed program manual and 12 hours' interactive training over 2 days before implementation. Training was conducted by academic mental health professionals and included demonstration of skills and opportunities for practice through role plays. To ensure adequacy of training, we sought feedback from participants after each training session and addressed their concerns during subsequent sessions. Whenever participating agencies hired new case managers, they were individually trained, following standardized training guidelines. Updates and booster training sessions were given to all providers during project implementation (two sessions, each a month apart after initial training; and three additional sessions quarterly afterward) to prevent ''drift'' in skills and address questions or barriers that staff encountered.

In written reports, agency supervisors noted that the program manual and training session were adequate and helpful. Case managers agreed that training was adequate (100%) and the manual helpful (80%; see Table 5). In the focus group, coaches echoed that preservice training was sufficient but recommended that further emphasis on motivational interviewing would enhance case managers' ability to deliver the intervention, especially the behavioral activation component, gain client buy-in, and reduce resistance.

CIC 3: Ongoing Coaching

In HIDEAS implementation, a psychologist or social worker from the academic partner provided coaching to ensure fidelity of intervention delivery and address individual needs for further training. Coaches and case managers met twice a month for the first 3 months and then once a month for up to 6 months for ongoing coaching. Although the coaching model was integral for program implementation, limitations existed around how much coaches could monitor and supervise case managers. To create a sustainable and practicable approach to maintaining intervention fidelity, coaches worked to transition the fidelity-monitoring and support role to agency supervisors once an individual case manager demonstrated adequate understanding and skill in performing the intervention.

Table 3. Characteristics of Healthy IDEAS Clients

	Screened ($N = 348$)		Eligible ($N = 94$)	
Characteristic	*n*	%	*n*	%
Age (years)				
60–64	52	14.9	23	24.5
65–74	104	29.9	35	37.2
75–84	132	37.9	25	26.6
85+	60	17.2	11	11.7
Gender				
Male	84	24.1	20	21.3
Female	264	75.9	74	78.7
Ethnicity				
Caucasian	93	26.7	32	34.0
African American	151	43.4	19	20.2
Hispanic	98	28.2	41	43.6
Other	6	1.7	2	2.1
Marital status				
Married	54	15.6	22	23.4
Widowed	185	53.3	38	40.4
Divorced or separated	67	19.3	23	24.5
Never married	41	11.8	11	11.7
Education				
≤6 years	77	23.6	21	23.3
7–12 years	179	54.9	45	50.0
13+ years	70	21.5	24	26.7
Monthly income ($)				
0–775	174	53.4	40	45.5
776–1,499	139	42.6	44	50.0
1,500+	13	4.0	4	4.6
Living situation				
Alone	232	66.9	61	64.9
With others	115	33.1	33	35.1
Primary language				
English	275	79.0	58	61.7
Spanish	71	20.4	35	37.2
Other	2	0.6	1	1.1
Self-rated health				
Poor or fair	246	72.6	80	87.0
Good or very good	85	25.1	12	13.0
Excellent	8	2.4	0	0.0

Note: For the age of screened clients, $M = 75.9$, $SD = 9.5$; for eligible clients, $M = 72.5$, $SD = 9.4$. IDEAS = Identifying Depression, Empowering Activities for Seniors.

Most case managers (90%; see Table 5) agreed that coaching was adequate and helpful. Coaches reported that coaching was effective for developing case managers' skills and knowledge, as well as building confidence. They saw their role as a clinical consultant or resource for case managers, providing encouragement and guidance during implementation. Although coaching was effective overall, coaches did find that effectiveness was influenced by case managers' attitudes toward mental health interventions and that negative attitudes made coaching more challenging. Coaches used both individual and group coaching approaches; they found the former beneficial for establishing trust with case managers and the latter beneficial for mutual

learning and supportive process. Of particular importance for effective group coaching was open and ongoing communications between agency supervisors and case managers.

CIC 4: Staff and Program Evaluation

Context.—HIDEAS carefully selected implementing agencies to ensure the context for success. Each community agency had a well-established case-management program directly supervised by a master's-level social worker who welcomed partnering with academic and mental health partners. All agency supervisors agreed to embed HIDEAS steps in the existing case-management routine and to train all case managers to implement the program.

When surveyed (Table 5), most case managers saw HIDEAS within the scope of their agency (70%), and they had enough resources to implement it (80%). They expressed skepticism regarding the time required: more than half (60%) thought it unrealistic as part of their case-management duties. The results of focus-group interviews indicated that although, in general, coaches observed staff receptiveness to the new program, they also recognized challenges related to time, especially among case managers with a heavy caseload.

Compliance and Competency.—We used ongoing coaching and a written tracking tool to monitor how faithfully and skillfully each component was delivered (see Frank, Coviak, Healy, Belza, & Casado, 2008, for a description of monitoring strategies used to deliver HIDEAS). Results of tracking records showed that the delivery rate of each intervention component was 86.2% for education, 56.3% for referral and linkage, and 44.7% for behavioral activation (Figure 1). Lower delivery rates and a higher frequency of missing documentation on the delivery, especially of the referral–linkage and behavioral activation components, were notable and reflected in challenges reported by case managers with these two components. When asked about ease or difficulty with intervention components (Table 5), most case managers found screening and education easy (90%), whereas only a half (50%) and less than one third (30%) found referral and linkage and behavioral activation components easy, respectively.

In response to open-ended survey questions, case managers listed challenges in helping clients engage in behavioral activation activities. Challenges were both attitudinal and technical. At the attitudinal level, case managers noted clients' lack of motivation and buy-in. At the technical level, some clients had difficulty identifying activity goals and following through with them. The interview with coaches further accentuated challenges with behavioral activation that some case managers encountered. They observed that some case managers were skeptical of the effectiveness of behavioral activation, possibly affecting their engagement in implementation. At the technical level, they observed that some case managers had difficulty engaging in the client-directed approach involved in behavioral activation, in which clients select their own activities.

The most reported reason for nondelivery was clients' refusal to take further action about their depressive symptoms (Figure 1), a major challenge repeatedly reported by case managers and consistent with other depression-treatment studies (Bruce, Wells, Miranda, Lewis, & Gonzalez, 2002; Wetherell & Unützer, 2003). In written survey responses, several case managers noted a particular challenge related to negative perceptions about mental illness in clients, especially African Americans, making it difficult to engage them in the intervention. Helping clients choose and follow through behavioral activation activities was also deemed a major challenge. Such difficulty among case managers implementing behavioral activation was also observed by coaches. Coaches also reported that some case managers had difficulty with differences in the helping process between behavioral activation and traditional case management (the former emphasizing a client self-help approach and the latter tending to be task focused and more worker directed).

The HIDEAS model places additional time demands on case managers, and many repeatedly reported this to be a challenge. Survey results indicated that case mangers spent, on average, 3.6 hours per client (SD = 2.5 hours) to deliver entire HIDEAS steps (Table 5). As noted, 6 of 10 case managers found the time required for HIDEAS, including added documentation, to be unrealistic as part of their case-management duties. Coaches observed this in a few case managers who saw behavioral activation as an addition to their regular duties. Although accurately measuring the exact time needed to deliver all HIDEAS components is difficult, reported time varied widely, ranging from 0.5 to 7 hours. This additional time, however, seems relatively reasonable, given that delivery of HIDEAS components was spread out over 10 or fewer steps over 3 months, and the fact that some contacts could be by telephone. Although time was a considerable challenge for many, survey results indicate that most case managers agreed that HIDEAS was easily implemented in other similar case-management programs (70%) and that mental health intervention should be part of case management (90%).

CIC 5: Facilitative Administrative Support

HIDEAS was implemented through a community–academic partnership, with overall administrative coordination by Care for Elders, a partnership of public, private, and nonprofit organizations focused on elder-care issues in Houston, Texas. Care for Elders coordinated key activities: (a) facilitating training and coaching for all three agencies, (b) conducting monthly meetings of community agencies and academic partners, and (c) identifying additional resources to support program implementation.

In the survey (Table 5), case managers gave high marks to the lead and facilitation provided, with most agreeing about the adequacy and helpfulness of training (100%), training manuals (80%), coaching (80%), and overall program facilitation (90%).

Table 4. Healthy IDEAS Overview of Steps

Component	Timing Guideline	Actions	Tools and Resources
Step 1: Screening and assessment of depressive symptoms	Incorporate as part of an initial client assessment or a client reassessment In-person contact	1. Ask two yes–no questions to determine whether new or continuing clients may be experiencing depressive symptoms. 2. Ask further questions of clients who respond positively to determine severity of clients' depressive symptoms.	Two-item question screen for depression (PRIME-MD) GDS-15 Suicide risk protocol (if indicated)
Step 2: Education on depressive symptoms	Can be combined with Step 1 In-person contact	1. Review depressive symptoms with older adult and family members or caregiver (with permission). 2. Help older adults understand what they can do to improve depressive symptoms (self-care) and how family can help. 3. Explain what good depression care is.	Written-materials: Handouts and brochures *Depression: Don't Let the Blues Hang Around* *Information for Families and Friends About Depression*
Step 3: Referral, linkage to treatment	Refer and link clients with GDS-15 score $\geq$6; can be combined with Steps 1 or 2 In-person or telephone contacts	1. Help clients obtain appropriate medical treatment through interaction with primary care provider or mental health professional. 2. Address and overcome barriers where possible.	Pamphlet to help older adults communicate information to physician: *Talking to Your Doctor About Depression* Inventory of local mental health resources to facilitate referrals Follow-up communication to primary care provider
Step 4 (BA): Understanding of BA	Begin within 2 weeks of completing Step 2 for clients with GDS-15 score $\geq$6 In-person contact	1. Help clients understand the connection between behavior and mood.	Client-personalized forms: *Record Daily Activities and Rate Mood*
Step 5 (BA): Setting goals by reviewing activities	Within 2 weeks of completing Step 4 (or combine with Step 4) In-person contact	1. Identify pleasant events and meaningful activities; identify activities and steps to promote well-being. 2. Coach client and family through changing behaviors, taking action to improve symptoms and achieve goals.	Client personalized forms: *Identify Pleasant Events and Meaningful Activities* *Identify Activities with Steps You Can Take to Help You Feel Better* *List of Possible Activities*
Step 6 (BA): Reinforce client	Contact within 1 week of completing Step 5 In-person or telephone contacts	1. Review depressive symptoms and condition. 2. Review progress on all goals and accomplishments. 3. Support client for progress made.	Tools for reinforcing progress on goals: *Activity Planning and Tracking Form* *Consider Why Engaging in Activity is Difficult*
Step 7 (BA): Maintain contact	Complete contact within 2 weeks of Step 6 In-person or telephone contacts	1. Review depressive symptoms and condition. 2. Review progress on all goals and accomplishments. 3. Support client for progress made.	Tools for reinforcing progress on goals: *Activity Planning and Tracking Form* *Consider Why Engaging in Activity is Difficult*
Step 8 (BA): Continue to maintain contact	Complete contact within 2 weeks of Step 7 In-person or telephone contacts	1. Review depressive symptoms and condition. 2. Review progress on all goals and accomplishments. 3. Support client for progress made.	Tools for reinforcing progress on goals: *Activity Planning and Tracking Form* *Consider Why Engaging in Activity is Difficult*
Step 9: Reassessment	Within 2 weeks of Step 8 (usually 90 days from Step 1) In-person contacts	1. Re-administer the Geriatric Depression Scale. 2. Review accomplishments of goals. Encourage client to maintain gains and seek to attain new goals. 3. Review with supervisor and pursue additional professional input for clients with GDS scores above 6 who have not been treated.	GDS-15 Use Step 5 tools for new goals.

(Table 4 continues on next page)

Table 4. (*Continued*)

Component	Timing Guideline	Actions	Tools and Resources
Step 10: Follow-up	Within 3 months of Step 9 In-person contacts	1. Re-administer the GDS-15. 2. Review accomplishments of goals. Encourage client to maintain gains and seek to attain new goals. 3. Review with supervisor and pursue additional professional input for clients with GDS scores above 6.	GDS-15 Use Step 5 tools for new goals.

Note: IDEAS = Identifying Depression, Empowering Activities for Seniors; BA = behavioral activation; GDS-15 = 15-item Geriatric Depression Scale; PRIME-MD = Primary Care Evaluation of Mental Disorders.

Coaches in the interview also agreed that coaching was effective in assisting case managers to gain knowledge and skills, as well as develop self-efficacy and confidence in mental health intervention.

Discussion

Use of the CIC framework to examine the implementation of HIDEAS has illuminated key issues and challenges for agencies seeking to successfully replicate this evidence-based depression intervention within case-management programs. As demonstrated in this study, assessing both organizational and individual worker readiness and capacity to implement an evidence-based intervention is critical. Although all case managers trained to deliver the intervention were assessed as being generally competent in skills to deliver HIDEAS components, variability was documented in worker effectiveness in addressing barriers to completing all program components, especially among clients who needed encouragement and follow-through to complete the intervention. Furthermore, some agency supervisors were more effective than others in helping workers address attitudinal and technical barriers to successfully conducting the intervention. As commonly noted in the literature on organizational change, agencies seeking to implement evidence-based programs have to carefully identify internal advocates and champions who recognize the value and ''essential ingredients'' of the intervention.

Our findings also underscore the importance of training and ongoing consultation support involving mental health expertise beyond what is available through participating agencies. Because so-called external partners with a mental health background have limitations as to how much they can monitor the everyday business of agency staff, training and coaching have to include agency supervisors to encourage and prepare them for within-agency supervision and monitoring of program implementation.

Because the aim of HIDEAS is client self-management of depression, it is imperative that case managers understand and appreciate the value of a helping process that encourages building client self-efficacy to identify goals and take action. From our evaluation with case managers and coaches, however, it was apparent that some case managers struggled with the client-directed selection of goals and activities of behavioral activation and took a more directive approach (setting goals and activities for clients) in a manner used when services are being ordered to meet an instrumental case-management need. Thus, the importance of helping workers support client action around goals that have meaning to them should be addressed during preservice and inservice training, as well as during ongoing consultation and coaching. On the basis of lessons learned from this study, the HIDEAS team produced a set of training tools, including a training DVD, facilitators' guide, and improved program manual, to enable new agencies and front-line providers to replicate the program (see www.careforelders.org).

Key lessons regarding improvements to intervention documentation and reduction of associated time burden were also identified. The documentation required during the demonstration was independent of other case-management record keeping and, as evident in Figure 1, some case managers did not use the ''extra'' written tool to document implementation steps for each client. Streamlining documentation requirements and integrating tracking activities into routine case-management record keeping have been recommended for future program implementation.

Even with a strong community–academic partnership, comprehensive information, and linkages to available mental health resources in the community, case managers still faced difficulties obtaining professional mental health care for some clients, especially non-English-speaking clients without insurance. Although HIDEAS can be a feasible extension to the existing health and mental health care continuum, efforts must be made to enhance and secure adequate mental health resources in the community that are affordable and accessible to older adults.

Clearly, a major challenge in HIDEAS implementation was overcoming case managers' discomfort and lack of buy-in with behavioral activation. In the survey, we found that many were uncertain about the effectiveness of behavioral activation and found it difficult. This component required new skills and was the major change in role for many case managers. It is interesting to note, however, that although most case managers found the implementation of behavioral activation difficult, most also agreed that HIDEAS could be easily implemented in similar case-management programs.

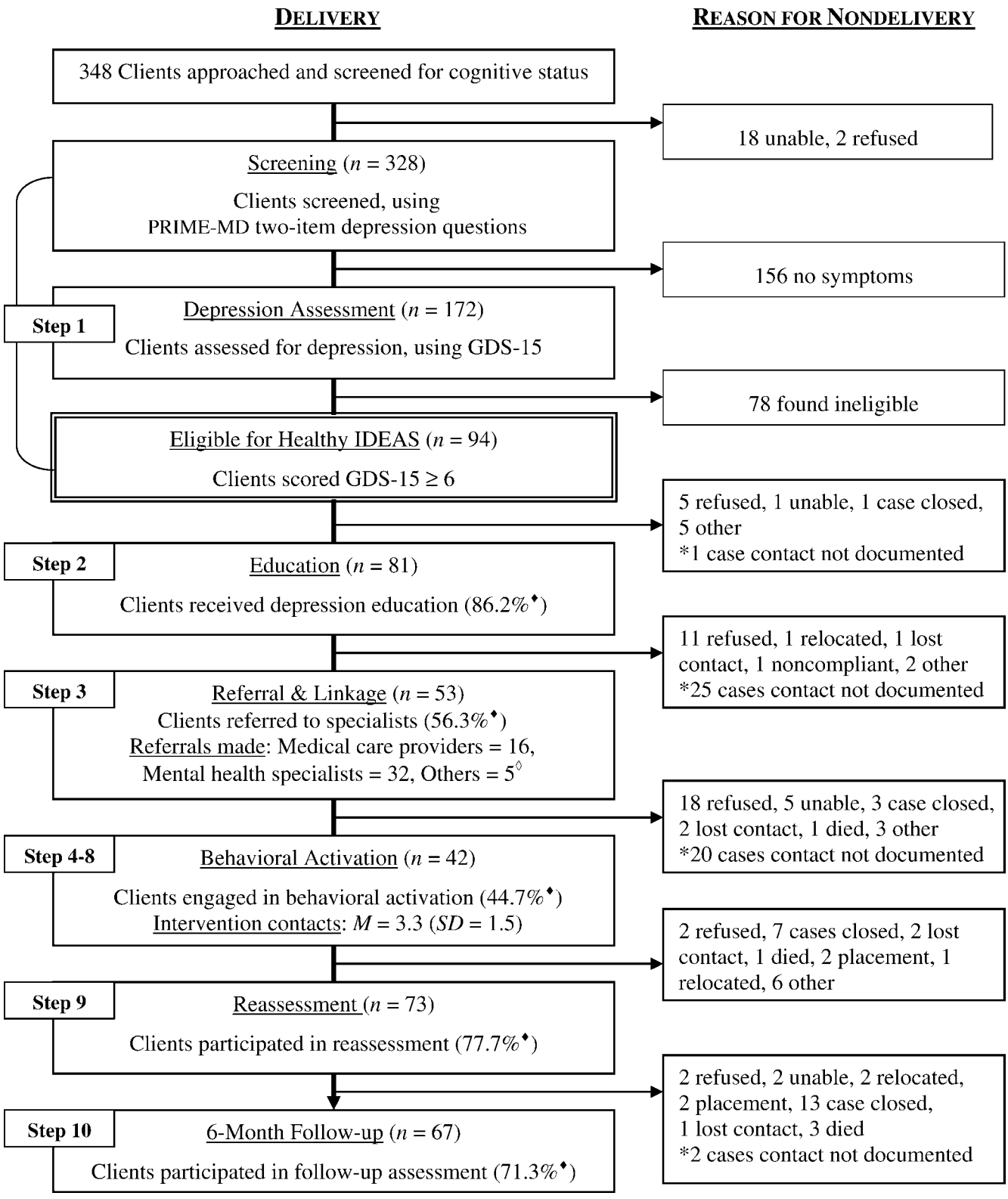

Figure 1. Flowchart of intervention components and delivery rates. The asterisks indicate that client contacts related to the intervention were not documented by case managers; closed diamonds indicate that the delivery percentage was based on 94 clients found eligible for Healthy IDEAS (IDEAS = Identifying Depression, Empowering Activities for Seniors); the open diamond, others, includes referrals to Adult Protective Services and a substance abuse counselor.

Table 5. Case Managers' Survey Questions and Results

Questions	% Agree	% Neutral	% Disagree
Program leadership and facilitation			
Training for the Healthy IDEAS program adequately prepared me to do the intervention.	100	0	0
The training manual was helpful in understanding and implementing the intervention.	80	20	0
My coach helped me to learn and implement the Healthy IDEAS intervention steps.	90	10	0
Questions and concerns about the Healthy IDEAS program were addressed adequately.	90	10	0
Organizational context			
The Healthy IDEAS intervention is within the scope of my agency.	70	20	10
Agency resources supporting the Healthy IDEAS project were adequate.	80	10	10
Healthy IDEAS could easily be implemented in similar case management programs.	70	20	10
The time required for the Healthy IDEAS intervention was realistic as part of my case-management duties.	30	10	60
Professional scope			
Helping clients manage their depression is a part of my professional scope of work.	90	0	10
I feel comfortable providing the Healthy IDEAS intervention.	90	10	0
The Healthy IDEAS intervention fits in my role at the agency.	80	0	20
Mental health interventions should be a part of case management.	90	10	0
Effectiveness			
The GDS worked well to identify clients with depressive symptoms.	80	20	0
Education helped to raise my clients' awareness of and understanding about depression.	70	30	0
Referring and linking my clients to other providers helped me to address my clients' mental health needs.	80	10	10
The behavioral activation steps helped reduce my clients' depressive symptoms.	40	60	0
Overall, the Healthy IDEAS intervention helped clients manage their depression.	50	40	10
Client's experience			
Overall, my clients were pleased that depression screening and assistance with depression were offered as part of case management.	40	40	20
As the result of the depression education, my clients were able to do the following:			
Identify depressive symptoms.	70	20	10
Understand ways to cope, prevent, and get help for depression.	80	10	10
My clients followed through with the recommended referrals for depression treatment.	50	10	40
My clients were able to make behavior change(s) to manage depression.	40	30	30
	% Easy	% Routine	% Difficult
Implementation ease and difficulty			
In general, how easy or difficult was it to do the following:			
Administer the GDS?	90	10	0
Provide education about depression?	90	10	0
Refer or link clients to health and mental health providers?	50	20	30
Carry out the behavioral activation steps?	30	0	70
Do follow-ups?	30	30	40

Note: For case managers' survey questions and results, N = 10. All questions used a 5-point Likert scale (1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, and 5 = strongly agree; or 1 = very difficult, 2 = somewhat difficult, 3 = routine, 4 = somewhat easy, and 5 = very easy). IDEAS = Identifying Depression, Empowering Activities for Seniors; GDS-15 = 15-item Geriatric Depression Scale. For the column headings, note that Agree, Disagree, Easy, and Difficult each include two possible answers (strongly agree and agree, strongly disagree and disagree, very or somewhat easy, and very or somewhat difficult). The questionnaire also asked the following question: On average, how much time was required to complete the entire Healthy IDEAS intervention with a client who had a positive GDS score? The range was 0.5–7.0 hours (M = 3.6, SD = 2.5).

Although, from data we have, we cannot draw a conclusion about the capacity of each case manager to deliver behavioral activation, our study suggests that paying careful attention to the potential of individual providers, both in agency selection at the beginning and in within-agency staff selection, may be crucial for successful implementation of the program.

Other barriers in implementing HIDEAS were consistent with those in the literature—negative attitudes and skepticism toward mental health care

and reluctance to acknowledge or address depression among older adults (Ell, 2006). Although those who chose to participate saw improvement in their depressive symptoms (see Quijano et al., 2007), case managers repeatedly noted clients' refusals and reluctance to engage in the intervention, especially African Americans. It is possible that this reluctance might have contributed to the visibly low prevalence of depressive symptoms found among our African American clients, compared with our Caucasian and Hispanic clients (13% of African Americans scored $\geq$6 on the GDS-15, vs 34% and 42% for Caucasians and Hispanics, respectively). Given the persistent findings of negative attitudes toward mental health care (DHHS, 1999), multicultural approaches to delivering the intervention are needed in program training. For example, clients unwilling to acknowledge depression might be willing to do something to help feelings of pain. Perhaps religious advisors can be enlisted to support a client's taking action to feel better. Helping older adults recognize their ability to take action to feel better is necessary for successful implementation of the intervention.

The essence and challenge of implementation are bringing about behavioral changes in consumers, practitioners, and organizations (Fixsen et al., 2005), and our study identified several such challenges. Despite challenges, the outcome study has demonstrated that HIDEAS is an effective evidence-based psychosocial intervention for depression in older adults (Quijano et al., 2007); and in written survey responses, case managers also reported that HIDEAS helped clients increase their knowledge of mental health issues and gain skills to self-manage depression. We believe that HIDEAS is a model for dissemination of effective evidence-based psychosocial interventions for depression and could be successfully adopted and sustained when essential elements of the CIC are addressed to bring about behavioral changes at all implementation levels.

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