



EVIDENCE-BASED
PRACTICES

KIT

Knowledge Informing Transformation

Guide to EBPs

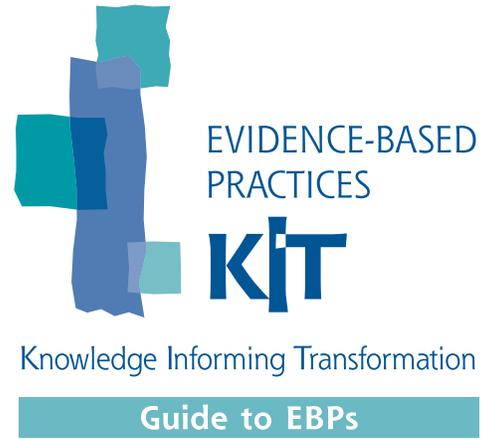
Leadership Guide

For Mental Health,
Aging, and General
Medical Health Authorities

The Treatment of Depression in Older Adults



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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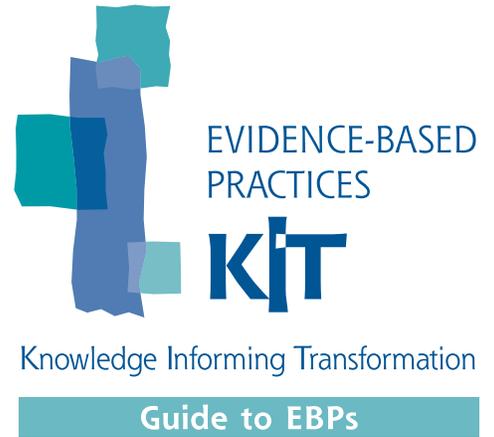
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Leadership Guide For Mental Health, Aging, and General Medical Health Authorities

This workbook describes a step-by-step approach to providing effective support for implementing evidence-based practices (EBPs) for depression in older adults.

Treatment of Depression in Older Adults

This KIT is part of a series of Evidence-Based Practices KITs created by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

This booklet is part of The Treatment of Depression in Older Adults Evidence-based Practices KIT, which includes 10 booklets:

**How to Use the Treatment of Depression in Older Adults
Evidence-Based Practices KIT**

Depression and Older Adults: Key Issues

**Selecting Evidence-Based Practices for Treatment
of Depression in Older Adults**

Evidence-Based Practices Implementation Guides:

**Older Adult, Family, and Caregiver Guide
on Depression**

**Practitioners' Guide for Working with Older Adults
with Depression**

Guide for Agency Administrators and Program Leaders

**Leadership Guide for Mental Health, Aging,
and General Medical Health Authorities**

Evaluating Your Program

The Evidence

Using Multimedia to Introduce Your EBP



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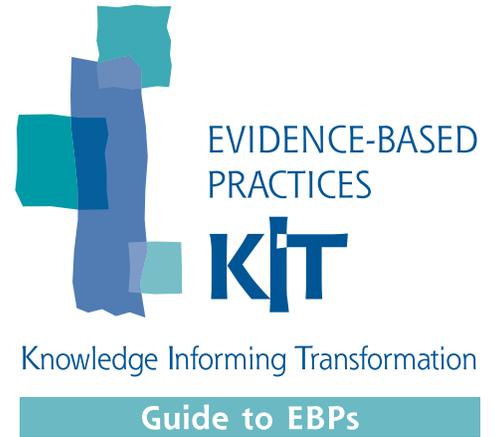
Knowledge Informing Transformation

Guide to EBPs

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The Treatment of Depression in Older Adults



Leadership Guide for Mental Health, Aging, and General Medical Health Authorities

The *Leadership Guide for Mental Health, Aging, and General Medical Health Authorities* describes a step-by-step approach to providing effective support for implementing evidence-based practices (EBPs) for depression in older adults.

Successfully implementing EBPs for older adults with depression requires the leadership and involvement of mental health, aging, and general medical health authorities. This booklet discusses why you should be involved in implementation and the types of activities that you are likely to undertake.

This KIT presents mental health, aging, and general medical health authorities with a unique opportunity to improve clinical services for older adults with depression. Research about service systems has evolved to a point where it can identify a cluster of practices that demonstrate a consistent, positive impact on the lives of older adults. EBPs for treating depression in older adults include psychotherapy interventions, antidepressant medications, outreach services, and collaborative and integrated mental and physical health care.



Why You Should Care About EBPs for Older Adults with Depression

Over the last several years, EBPs have become part of the vocabulary of mental health, aging, and general medical health authorities. They have been part of the physical health care community for many years and are the gold standard for selecting which medical services should be delivered. These practices are important because they can improve the health and functioning of your constituents.

The role of administrators of mental health, aging, and general medical health authorities is central to disseminating and implementing EBPs. Specific examples of this role include the following:

- Setting or implementing broad policy for providers;
- Developing consensus among stakeholders regarding priorities;
- Supporting the development of infrastructure;
- Allocating financial and other resources; and
- Acting as the primary change agent for incorporating EBPs into services for older adults and their families or caregivers.

Recognition of older adults with depression as a target population

Mental health authorities traditionally have not recognized older adults as a priority population. Despite the rising numbers of older adults (by 2030, 20 percent of the population will be older than 65), and the high prevalence of depression in the population (estimates range from 5 to 25 percent), older adults are rarely treated in traditional community mental health centers (3 to 4 percent of total treatment population). Demand for services for older adults typically has been low. However, changes in the size and needs of this population will change this demand in the near future.

Older adults with depression rarely seek treatment in traditional mental health settings because of a variety of barriers, including ageism, stigma, and transportation or financial needs. Instead, those older adults who do seek treatment for mental health problems are most likely to do so through their general medical practitioners or through social service practitioners supported by physical health or aging services authorities.

Accessing mental health care through these nontraditional settings requires new collaborations across and between mental health, aging, and general medical health service systems to adequately design and provide care for older adults.

Impact of depression

According to the World Health Organization (2001), depression is among the top causes of worldwide disability. Depression in older adults is associated with decreased levels of functioning, worsened health status, and reduced quality of life.

Depression in older adults can lead to disability and poor health outcomes, including increasing the likelihood of mortality from common medical conditions. For example, depression increases the likelihood of mortality in people with cancer and in those who have experienced a heart attack.

Older adults with depression also are more disabled than older adults without depression. They tend to recover more slowly from physical illnesses, such as stroke or hip fractures, thus increasing health care costs. Depression is a leading risk factor for suicide in older adults (Pearson & Brown, 2000). Treating depression may help prevent suicide in older adults.

Cost of depression

Depression is an expensive health problem. Health care costs for older adults with depression are approximately 50 percent higher than for those without depression (Unützer et al., 1997). Older adults with depression are more likely to be admitted to a hospital or a nursing home, visit their physician, and visit an emergency room, and they are more often prescribed multiple medications.

Effective depression treatment can be provided to older adults at a modest cost. For example, Katon et al., (2005) found that integrated and collaborative treatment of depression in the primary care setting produces positive clinical outcomes and increases total health care costs by less than \$150 per older adult per year.

The potential cost savings for treating depression in older adults may be best appreciated by taking a long-term perspective. For example, Unützer et al. (2008) found that 1 year of integrated and collaborative treatment using the Improving Mood, Promoting Access to Collaborative Treatment (IMPACT) model of care cost approximately \$520 per patient. Over a 4-year period, older adults with depression who received IMPACT services had lower average costs for all of their health care. Even when the cost of IMPACT care was included, total health care costs were approximately \$3,360 less than costs for older adults who received traditional care.

Offsets in overall health care costs have also been shown in a study that evaluated psychiatric consultation services for older adults who were hospitalized with a hip fracture. Psychiatric consultation services resulted in fewer days of hospitalization and a significant reduction in overall yearly health care costs. Cost savings were greater than the costs of providing psychiatric treatment (Mossey, Knott, & Craik, 1990).

Why provide EBPs for older adults with depression?

Providing EBPs for depression is an effective way to reduce the symptoms of depression, improve overall functioning and health outcomes, and ensure that older adults receive effective types of care. Prioritizing the implementation of EBPs also is a cost-effective response to the need to maximize the impact of limited resources in a fiscally challenging environment.

Several effective treatments are available to treat depression in older adults. For a description of EBPs, see *Selecting Evidence-Based Practices for Treatment of Depression in Older Adults* in this KIT.



EBPs for Depression in Older Adults

- Psychotherapy interventions
- Cognitive behavioral therapy
- Behavioral therapy
- Problem-solving treatment
- Interpersonal psychotherapy
- Reminiscence therapy
- Cognitive bibliotherapy
- Antidepressant medications
- Multidisciplinary geriatric mental health outreach services
- Collaborative and integrated mental and physical health care

Despite the importance of providing effective care, many EBPs for treating depression are unavailable to older people. This problem has been highlighted in several reports, including those by the U.S. Surgeon General (U.S. Department of Health and Human Services, 1999, 2001), the New Freedom Commission on Mental Health (2003), and the Institute of Medicine (2001, 2006).

Building Momentum for Change

Leadership support will signal to your constituents that you are committed to implementing EBPs and that you view the task as a priority. Leading the implementation involves marketing EBPs, supporting the next tier of leadership in this effort, and collaborating with other agencies. At the same time, your support may be crucial for developing effective financial reimbursements and removing barriers to implementation.

Important considerations for building momentum to implement EBPs include the following:

- Developing a clear implementation message;
- Placing EBP implementation within the context of national implementation efforts;
- Understanding agency and provider roles;
- Assessing organizational readiness; and
- Defining roles and responsibilities.

Developing a clear implementation message

Presenting a clear rationale for implementing EBPs is critical to successful implementation. This rationale should provide a framework for you to promote the implementation of EBPs by providers, while also facilitating discussions with payors.

EBP implementation also can help to drive a quality and accountability agenda. EBPs for older adults with depression may be needed as part of a mandate or as a solution to a particular problem.

Key questions that you should be prepared to answer as they relate to your agency or department include the following:

- Why focus on older adults?
- Why focus on depression?
- What is not working in the current system that will be addressed by introducing EBPs for older adults with depression?
- What amount of time, staff, finances, and resources will be required to move implementation forward and sustain the EBP?

The booklet in this KIT titled *Depression and Older Adults: Key Issues* provides information that will help you develop your responses to these questions.

In overview, some important facts are as follows:

- Older adults are a rapidly growing part of the American population.
- Depression is one of the most common mental health problems in older adults.
- Untreated depression in older adults is associated with disability, poor functioning, high health care costs, high mortality, and an increased rate of suicide.
- EBPs can reduce the symptoms of depression in 60 to 80 percent of older adults.
- Older adults rarely receive effective treatment for depression.
- Most health and social service organizations lack practitioners with appropriate training in geriatric care, and most practitioners are not trained to provide EBPs for depression.
- Effective types of treatment can be provided at modest cost.

Placing EBP implementation within the context of national implementation efforts

Although EBPs have become an integral part of the new direction of health care systems, administrators of mental health, aging, and general medical health services differ in their focus.

- Mental health authorities focus on addressing the dysfunction associated with mental disorders.
- Aging service authorities prioritize a range of services that allow older adults to function in the community for as long as possible. They also address residential long-term care when it is necessary.
- General medical health and public health authorities focus on ensuring good health and providing adequate and appropriate health care.

National implementation efforts that target EBPs for people with mental disorders have been supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Administration on Aging of the U.S. Department of Health and Human Services.

SAMHSA has developed implementation resource KITs on Illness Management and Recovery, Supported Employment, Family Psychoeducation, Assertive Community Treatment, Integrated Treatment For Co-Occurring Disorders (substance use and mental illness), and Medication Treatment, Evaluation, and Management.

In addition to this KIT on the Treatment of Depression in Older Adults, SAMHSA is supporting the development of several new KITs. These include Consumer-Operated Services, Permanent Supportive Housing, Interventions for Disruptive Behavior Disorders, and Mental Health Promotion and Prevention of Mental Illness.



Recently, the Administration on Aging awarded grants to 24 states to support effective programs and practices for practitioners caring for older adults. These grants support programs in disease prevention, chronic disease self-management, fall prevention, nutrition, medication management and depression. AoA and SAMHSA are continuing to collaborate on a variety of efforts to identify and promote the use of evidence-based practices suitable for broad dissemination within AoA's aging network.

While Healthy IDEAS is not an EBP (i.e., a practice that has been tested and proved to be effective in at least two randomized controlled trials—see *Selecting Evidence-Based Practices for Treatment of Depression in Older Adults*) in this KIT, it includes components that may help some older adults with depression.

Understanding agency and provider roles

While the impetus for implementing EBPs for older adults with depression may originate in one agency, it is important that you understand and define the roles of other relevant agencies. Other agencies may already have services planned or underway for older adults with depression. This may create opportunities for collaboration. Similarly, you can share the responsibility for moving forward with EBP implementation with local service organizations or provider systems.

An important initial activity is convening relevant state, tribal, or other organizational representatives to identify the *current array* of services available for older adults across agencies and to explore areas of mutual support and interest in advancing EBPs for older adults. At a minimum, meetings should include representatives from mental health, aging, and general medical health agencies. Other important participants may include adult protective services, substance abuse, or public health

organizations. Budget and Medicaid or Medicare agencies, provider organizations, and older adults and their family members or caregivers should be included in initial or subsequent meetings.

The purpose of these initial meetings is to help you identify what resources exist and to define the potential roles of key agencies. These forums will provide the opportunity to assess the organizational readiness and capacity to proceed with implementation and build consensus among stakeholders.

Assessing organizational readiness

Assessing organizational readiness at the health or aging authority level will help you evaluate existing supports for implementation. Administrative backing is necessary but not sufficient to begin EBP implementation.

You should assess your readiness for EBP implementation for the following:

- Policy direction specifically for older adults;
- Resource availability (at the state, tribal, local or provider levels);
- Competing priorities; and
- Timing.

Identifying a fit with an existing policy direction, such as a legislative mandate, will help you establish the need for implementation. This alignment could be the basis for developing resources for the project and can provide initial options for creating or diverting resources for the initiative. Even if various factors seem aligned, the issue of timing can be critical. You should take into account impending legislative sessions, a change in administrations, and promotion or retirement of key leaders and supporters.

Defining roles and responsibilities

While roles of different organizations may be defined at a policy level, it is critical to define roles and responsibilities of the staff that will implement the EBP. Depending on the organizational configuration, discussions should occur to build internal support among key administrators.

If multiple agencies are involved, you should address the following areas before implementation begins:

- Roles in terms of leadership;
- Team composition and structure;
- Decisionmaking at different levels;
- Resources available;
- Potential opportunities for blended funding or jointly provided services; and
- Mechanisms to resolve problems and barriers.

EBP implementation efforts often require that you assign new responsibilities that may change the scope and role of staff resources. Such changes often encounter early resistance. However, establishing internal consensus and cohesion using established evidence of effective implementation in other settings may help you overcome these obstacles.

Steps You Can Take

- Establish a strong, clear rationale for implementation.
- Ensure that senior administrators support implementation.
- Coordinate planning efforts among mental health, aging, and general medical health authorities.
- Build consensus among stakeholders.
- Ensure that resources are available or obtainable.
- Consider innovative approaches to blended financing or collaborative service models.
- Define the roles and responsibilities of team players.



Initiating Implementation Activities

Several actions can help you begin to implement EBPs for older adults with depression. Your chances of achieving successful implementation will be improved by taking these actions:

- Supporting EBPs;
- Building stakeholder consensus;
- Developing financing options;
- Promoting demonstration projects;
- Collaborating with stakeholders;
- Supporting training and implementation;
- Ensuring cultural competence; and
- Evaluating implementation and measuring and demonstrating outcomes.

Supporting EBPs

Your role is to champion EBPs. The purpose of championing is to send a signal that the initiative is a priority for leadership of the mental health, aging, or general medical health authority. This involves a variety of activities including sponsoring meetings and conferences, problem-solving collaboratively, and taking advantage of opportunities to deliver your message promoting the value and importance of EBPs.

You may need to be a champion at two levels:

- General support for EBPs for older adults and
- Support for a specific EBP for older adults with depression.

The resources provided in this KIT will support you in these activities.

Building stakeholder consensus

Leadership involves building consensus across diverse stakeholder groups. An initial stage of building consensus is ensuring that the correct stakeholders participate in planning activities. Stakeholders could include the following:

- Agency administrators;
- Program leaders;
- Practitioners;
- Older adults;
- Family members;
- Caregivers;
- Community members; and
- Other important partners.

You must balance your rationale for moving forward with a plan for making the change. Building consensus also involves addressing the concerns and objections that different constituencies have related to EBP implementation.

Suggested steps for engaging key stakeholders in the process include the following:

- **Conduct a meeting or conference that focuses on sharing information and increasing awareness of EBPs for older adults with depression.**

Invite key stakeholders. National and state experts on mental health and aging, successful implementers of EBPs, and older adults who have benefited from the proposed interventions are possible presenters.

The purpose of the meeting is to do the following:

- Increase awareness;
- Establish the rationale for EBP implementation; and
- Set the stage for implementation.

- **Conduct a meeting with providers and older adults to discuss what it would take to move forward with implementation.** The purpose of this meeting is to address objections and barriers to EBP implementation.

Through this process, you may begin to identify enthusiasts and innovators who might serve as the first wave of providers interested in implementing EBPs.

- **Conduct a meeting with mental health, aging, and general medical health authorities; agency administrators; and health care payors to review administrative and financing policies** to decide on the following:
 - How to address barriers and issues;
 - Whether to proceed with EBP implementation at this time; and
 - How to build adequate and appropriate support and ensure sustainability.

Identifying financing options

Funding EBPs for older adults with depression is likely to occur through one of several methods:

- Using existing mechanisms of reimbursement or resource allocation;
- Reallocating or reassigning existing funds or resources; and
- Identifying new funds or resources.

The extent of initial EBP implementation will depend on available resources or the mandate requiring EBP implementation (for example, a lawsuit, legislation, or a grant requirement), or both.

Using existing mechanisms of reimbursement or resource allocation

The implementation initiative may occur within an existing service delivery system through currently available mechanisms of reimbursement. A range of options for funding may exist, including fee-for-service, capitated, or other formula-based funding (for example, based on population and other need indicators). Alternatively, practitioners who are salaried through dedicated funding (for example, through the Older Americans Act) may incorporate EBPs into the array of services that they provide.

Reallocating existing funding or resources

Other opportunities for funding EBP implementation include reallocating or reassigning existing program dollars to achieve new goals. For example, as new programs are implemented to move older adults from nursing homes to community settings or to prevent nursing home admissions, programs can be implemented that focus on supporting older adults in the community.

These programs can explicitly address critical risk factors associated with institution-based care. As depression is a risk factor for long-term care institutionalization, EBPs that include screening and treating depression can be included in these services. This also is true for programs that receive funding related to wellness in aging.

Identifying new funds or resources

Seeking new funds or grants also provides a potential resource for EBP implementation. New funding may be sought by advocating for new budgetary allocations of funds under a new initiative. Alternatively, federal or foundation grants may be identified that target a particular population or medical condition for initial implementation of EBPs.



A common challenge associated with seeking new grant funding (beyond the competitive nature of winning a grant) pertains to the issue of sustainability. Due to the very common occurrence of programs failing and disappearing once grant funding goes away, granting agencies routinely require evidence of your capacity to sustain a program beyond the term of the grant.

This requirement should be carefully considered and taken seriously. The failure to sustain a successful program is harmful to the mission and morale of practitioners, and can undermine the confidence and long-term welfare of older adults and their families or caregivers.

Other considerations

A fundamental distinction is necessary between the resources needed for direct service provision and resources needed for training. Depending on the flexibility that exists within the funding mechanisms, the cost of training and the down-time when providers are not offering services that result in billable hours can be subsumed in a capitated or a formula-based allocation system.

In a fee-for-service system, funding the training component can pose a problem. For example, the service itself may be billable for Medicaid reimbursement but the training component may not. You may need to use different sources to fund the various components. Medicaid may reimburse the cost of the service, and federal community mental health funds might pay for the training component.

Older adults will have different types of insurance coverage. Some of these insurance plans will cover the EBP, while others will not. You must estimate the proportion of the potential older adult population that has insurance that covers the EBP. You must also identify other resources or mechanisms for providing the EBP to older adults who do not have insurance.

You may need to revise rules for reimbursement that are driven by service definitions and criteria; this may require interagency meetings on the federal, state, and local levels. Some actions that may help you secure financing for EBPs include the following:

- Clearly define the EBP being considered;
- Identify components of the EBP that may be reimbursed through existing mechanisms, such as Medicare, Medicaid, or other health care funders;
- Describe qualifications of practitioners;
- Describe the intensity and duration of the service; and
- Present cost effectiveness data, if available.

You will increase the likelihood of EBP uptake by clearly articulating and defining these sources and providing mechanisms and codes for billing. To facilitate EBP implementation, one state identified the current procedural terminology (CPT) and Health Insurance Portability and Accountability Act (HIPAA) codes that were to be used. Such specificity reduces providers' burden. The reimbursement rate established for the intervention also can facilitate implementation.

As demographic changes occur (described in *Depression and Older Adults: Key Issues* in this KIT), funding for older adult programs is likely to grow. If savings or benefits from implementation efforts can be obtained and documented, these data can become a powerful argument for ongoing implementation.

Promoting demonstration projects

In any process that adopts innovation, not everybody comes on board at the same time. A small group of enthusiasts will begin implementing the practice, followed by the remaining majority. Supporting demonstration projects with enthusiasts is one way to begin EBP implementation.

Usually, state, tribal, or health care system administrators can implement innovations through demonstration grants or projects in a few organizations because of resource availability, the strength of the leadership, and the culture of those settings.

Within a state, tribe, or health care system, a viable approach is initiating demonstration projects with a select group of providers who will act as a learning community and do the following:

- Work out the kinks related to EBP implementation;
- Develop a group of provider experts who can advise the next generation of implementers; and
- Showcase successful implementation efforts while making the case for additional resources.

A key aspect of selecting this group is to choose providers most likely to succeed. This group should be interested, willing providers rather than a group that is required or mandated to implement the practice. The failure of this initial group can often thwart later efforts to disseminate the EBP.

Some options for selecting this initial group are as follows:

- Developing a competitive process through a Request for Application (RFA) process;
- Self-selecting providers or provider organizations; or
- Developing a contractual understanding with providers.

You can support the efforts of these providers through these initiatives:

- Establishing funds for obtaining training and technical assistance;
- Requiring mechanisms to monitor fidelity of EBP implementation;
- Ensuring that implementation efforts document successful outcomes;
- Providing resources and support for evaluation; and
- Providing opportunities for showcasing these efforts and recognizing them as leaders.

The division of labor between the aging or health authority and provider organizations must be clearly defined. For example, in some implementation efforts, the expectation is that the provider organizations will be responsible for obtaining training and technical assistance; in others, these may be provided by the aging or health authority.

In this initial phase, you can establish a collaborative forum among the organizations to share experiences, learn from one another, and provide mutual support.



Collaborating with stakeholders

Increasingly, there is recognition that the problems being addressed by multiple agencies are interrelated. Depression may be the cause or consequence of poor health; poor health may be the cause or consequence of depression. No single agency has a monopoly on older adults with depression. Collaboration across the spectrum of agencies that serve older adults is needed.

Collaboration among key stakeholder groups can help shape your decision to move forward with implementation. Once you decide to initiate implementation, stakeholder collaboration can vary in intensity. These relationships are shaped by the degree of formality, the roles of the various collaborative entities, and the types of exchanges that occur through these relationships.

In the varying degrees of formality, the range could include an informal arrangement where stakeholders participate as part of a decisionmaking or advisory group, memoranda of agreement, or contractual agreements.

Different stakeholders can have different roles. Older adults and their family members or caregivers should be part of any evaluation and quality management component. Staff of different agencies could have specified, differentiated functions.

At a minimum, information is part of the exchange that occurs in a collaborative effort. Depending on the specific initiative, data and technology can be shared between agencies. In some situations, staff from one agency can be assigned to work with staff at another agency (for example, a mental health agency staff person being assigned to a primary care or aging service setting). Collaborative exchanges also can include pooling resources and doing joint contracts with providers or developing joint purchasing arrangements.

Supporting training and implementation

You can address training needs for implementing your EBP by importing national experts related to a particular EBP. While this may help in the initial phases, the lack of a training infrastructure may be a barrier to sustained implementation.

Different states and health care systems have developed a range of approaches to address this issue, but most of them involve some arrangement with institutions of higher learning. For example, Ohio has developed coordinating centers of excellence at different universities, each of which is responsible for the dissemination, technical assistance, and implementation support for a particular EBP. Other states such as Hawaii, Maryland, and New Hampshire have developed other forms of affiliations with universities to support EBP implementation.

An important fact from the initial generations of EBP implementation is that training by itself is necessary but not sufficient. Ongoing consultation and implementation support is critical.

Factors that facilitate the training and implementation process include the following:

- Monthly calls among practitioners implementing the EBP;
- The ability to consult experts; and
- Trainers and staff who can provide feedback on fidelity to the model.

Ensuring cultural competence

Most EBPs have not been validated across different racial or ethnic minority groups. This can result in skepticism about the evidence that is part of your rationale for promoting EBPs. Potential differences in the effectiveness of the interventions may exist across racial or ethnic minority groups, as they may differ in help-seeking behavior and approaches to accessing and using care.

You can adopt different approaches to addressing this lack in the knowledge base. You can monitor to determine if differential groups have different outcomes. This then becomes the basis for introducing adaptations. You also can work collaboratively with diverse leaders and professionals to make necessary adaptations, and then monitor outcomes to test whether the adaptations have produced the desired outcomes.

Mental health, aging, and general medical health authorities can help develop a more culturally competent mental health system. Examples of how this can be done include the following:

- Designate staff with the responsibility for improving and monitoring cultural competence;
- Create a strategic plan to incorporate cultural competence into the mental health, aging, and general medical health service systems;
- Establish an advisory committee that includes representatives from all the major racial, ethnic, and cultural groups you serve;
- Address barriers to care (including cultural, linguistic, geographic, or economic barriers);
- Promote staffing that reflects the composition of the community you serve;
- Promote regular organizational self-assessments of cultural competence;
- Collect and analyze data to examine disparities in services;
- Designate specific resources for cultural competence training; and
- Include cultural competence in quality assurance and quality improvement activities.



Evaluating implementation

Evaluating EBPs can help you convince skeptics of the value of the intervention. Data collected in implementing the EBP may be powerful in persuading payors and purchasers to invest in the specific interventions being promoted.

Monitoring outcomes in the implementation process can help you assess whether the intervention is working for an older adult. If the desired outcomes are not produced, two explanations are possible: either the intervention is not being appropriately administered or, if fidelity criteria are met, the intervention itself is inappropriate for the particular older adult. You can modify the treatment plan once these needs can be determined.

Information about collecting and using process and outcome measures is included in *Evaluating Your Program* in this KIT.

Steps You Can Take

- Support and encourage implementation of EBPs for older adults with depression.
- Build consensus among stakeholders and collaborate with other departments and agencies.
- Develop a plan for financing the implementation and delivery of the EBP.
- Sponsor a small number of demonstration projects that can serve as models for other organizations.
- Develop a training infrastructure to support training and implementation activities.
- Monitor outcomes to ensure that services are appropriate for members of racial and ethnic minority groups. Consult with people who have expertise in aging and minority services.
- Periodically request reports and updates of progress and address problems and barriers that are identified.

Expanding and Sustaining Implementation Activities

Results from initial implementation efforts and demonstration projects will shape the decision to expand and sustain the EBP.

As the intervention becomes integrated into the array of services available across your state, tribe, or health care delivery system, you should consider the intervention as part of business as usual rather than a service that has its own independent implementation bureaucracy. The intervention must be incorporated into your contracts, information systems data elements, and quality management efforts.

As you approach this phase, it is critical that you use the expertise and knowledge acquired by the first wave of providers to not only be part of the technical assistance and implementation support effort, but also to act as cheerleaders who provide encouragement and testimony to the next generation of implementers. Expect that the new wave of implementers may not have as high a level of enthusiasm or interest as your first wave of providers. In all likelihood, they will require a greater extent of training, technical assistance, and implementation support than the first wave.

Steps You Can Take

- Incorporate evidence-based treatment for depression into your contracts, information system data elements, and quality management efforts.
- Use existing expertise and knowledge to support ongoing implementation efforts.



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