OLDER AMERICANS BEHAVIORAL HEALTH

Issue Brief 7: Using the RE-AIM Implementation Framework to Improve Behavioral Health

Introduction

The Substance Abuse and Mental Health Services Administration (SAMHSA) and Administration on Aging (AoA) recognize the value of strong partnerships for addressing behavioral health issues among older adults. This Issue Brief is part of a larger collaboration between SAMHSA and AoA to support the planning and coordination of aging and behavioral health services for older adults in states and communities. Through this collaboration, SAMHSA and AoA have developed Issue Briefs and archived Webinars in the areas of suicide, anxiety, depression, and alcohol and prescription drug use and misuse among older adults, and are partnering to get these resources into the hands of aging and behavioral health professionals.

This Issue Brief is designed to:

- Foster the adoption of evidence-based behavioral health programs and promising practices by state and local service system leaders.
- Recognize essential elements of behavioral health practices that support sustainability of services.

RE-AIM Framework

The RE-AIM framework offers a model for planning, executing, and evaluating efforts to implement population-level changes in the health and well-being of older adults. RE-AIM stands for *Reach, Effectiveness, Adoption, Implementation, and Maintenance*. It can be used by state or local leaders to understand the prevalence of behavioral health problems. Furthermore, RE-AIM can assist program leaders in selecting, implementing, and assessing effective prevention and early intervention programs and practices.

The goal of RE-AIM is to encourage stakeholders to identify essential elements that improve the implementation and sustainability of programs and practices.[1] Paying attention to the RE-AIM elements increases the likelihood of improving the health of the entire population. In a recent survey of aging service leaders, 85–90% said that RE-AIM is useful to community leaders, providers, evaluators, and policymakers for planning, implementation, and evaluation of prevention, self-management, and other programs.[2]

The RE-AIM model is described at **http://www.re-aim.org/index.html**. This Issue Brief applies the model to older adult behavioral health issues and programs.

Organizations that successfully implement evidence-based practices are attentive to and perform well in the five RE-AIM elements. The five elements can be strengthened when they are preceded by a focus on Planning and Partnerships. This enhanced model is referred to as (P)RE-AIM and has been particularly useful in collaborative work among the National Council on Aging (NCOA), AoA, and many state and local organizations.[3]

RE-AIM

Administration on Aging

Substance Abuse and Mental Health Services Administration
SAMHSA
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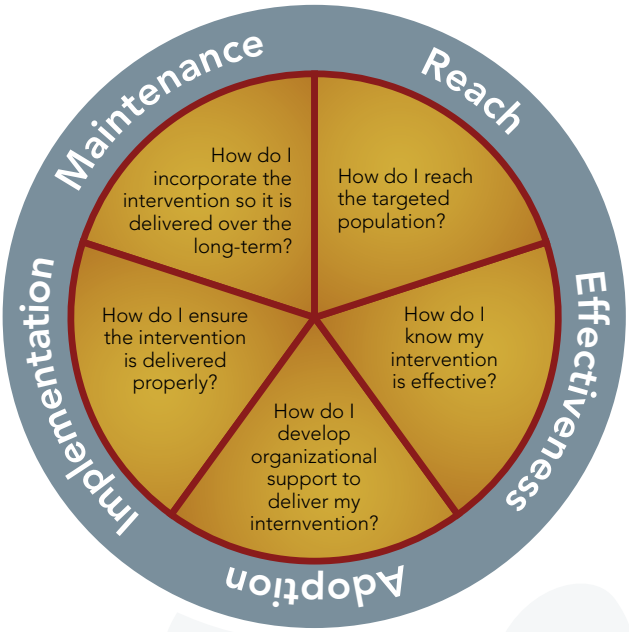
RE-AIM Elements



Planning and Partnerships calls for convening stakeholders, setting population-level behavioral health change goals, and selecting prevention and early intervention practices for implementation. *How do I find partners and plan?*

- Convene leaders to gain common understanding of issues and resources (see Resources section for *State Older Adult Behavioral Health Profiles*).
- Establish a collaborative building on successful prevention efforts.
- Designate a lead organization.
- Recruit organizational partners to reach large numbers of older adults and link participants to other services.
- Establish service objectives and outcomes, an operational structure, and implementation and communication plans.

Reach refers to the ability of the practice to engage the targeted population—including identifying the total number of older adults in the program, the proportion of older adults participating from the targeted population, and the representativeness of the target population among those willing to participate in a prevention and early intervention practice. *How do I reach the targeted population with the practice?*[4]

- Define the numbers and characteristics of clients from partner organizations and potential partners and identify outreach strategies.
- Identify, recruit, and retain clients who can benefit from the practice.
- Embed *universal* prevention education and pre-screening within partner organizations.

Effectiveness is defined as the impact of a prevention and early intervention practice on important health outcomes in real-world settings. *How do I know my practice is effective?*

- Identify evaluation needs and develop a plan.
- Define reporting requirements and process and analyze data.

Measuring effectiveness helps identify opportunities for improvement. Measurement methods from original studies are often used so that local results can be compared with those from the original studies.

Effectiveness includes measures of:

- *Impact* or change in health status and health behaviors (e.g., risky use of medication and alcohol);
- Symptom severity (e.g., depressive symptoms) or illness remission; psychosocial functioning and quality of life; and
- Costs associated with delivering the practice and related outcomes.

Adoption by target organizations refers to the total number of settings and staff members that implement the practice, the proportion of potential settings and staff members who are involved in implementation from the target organizations, and the representativeness of settings and staff (of all target organizations) who are willing to implement the prevention and early intervention practice. *How do I develop organizational support to deliver the program or practice?*

- Recruit a range of organizations suitable for implementing part or all of the practice.
- Manage training and interface with national program disseminators and trainers.

Implementation includes consistent delivery of the prevention and early intervention practice. At the aging or behavioral health service-setting levels, implementation refers to the organizational and staff fidelity to various elements of the practice's protocol. At the individual level, implementation refers to the use of the practice strategies by the client population. *How do I ensure the practice is delivered properly?*

- Develop practice infrastructure with lead regional organizations (e.g., an Area Agency on Aging [AAA], mental health service system, a prevention network, a health system) and with local program sites (e.g., community service agencies, mental health centers, clinics, hospital emergency departments).
- Schedule, promote, and conduct the practice.
- Design and implement quality assurance processes, including those that ensure fidelity.

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RE-AIM Elements, continued

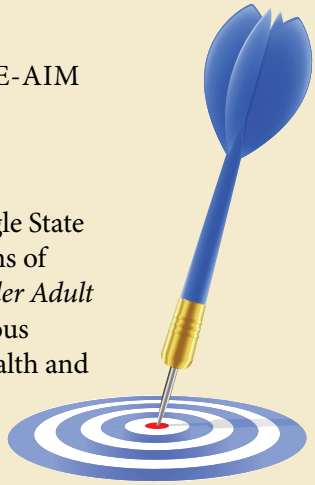
Maintenance and sustainability considers the extent to which a practice becomes institutionalized. At the client level, maintenance is the long-term effects of a practice on outcomes after 6 or more months. *How do I incorporate the practice so that it is delivered over the long term?*

- Embed practices in organizations and service systems.
- Carry out plans to finance and sustain practices after initial grants.
- Establish a process for continuous quality improvement.[5]

RE-AIM Scenarios to Improve Behavioral Health

The following hypothetical scenarios illustrate how states and communities can use the RE-AIM framework to improve older adult behavioral health.

State Initiative to Reduce Depression and Prevent Its Recurrence



In this hypothetical scenario, the State Unit on Aging, the State Mental Health Authority, the Single State Agency for Substance Abuse Services, and Medicaid agree to look into behavioral health problems of older adults in their state. The agency representatives review state data, especially their State's *Older Adult Behavioral Health Profile* (see Resources section). State agencies identify that depression is a serious problem. Working with university faculty, they explore the impact of untreated depression on health and health care costs and determine they want to know the rates of clinically significant depression among older adults served by Medicaid, aging services, and community mental health centers.

The agencies agree that older adults served in agency-funded programs will be screened for depression annually using valid screening tools. In some agencies, valid depression screens are added to intake and annual reassessment forms; in other agencies, valid questions are substituted for questions that are less suitable. With data from the first year, state agencies learn that among 100,000 older participants in the programs, 25% (25,000 older adults) have clinically significant symptoms of depression.

The state partners set a population-level goal of decreasing depression symptoms by 50% among 25% of older program participants with symptoms (6,250 older adults) each year. State agencies ensure that all sites conducting screening can offer effective depression care or provide successful referrals to such care. The state identifies several effective depression care management practices, including Improving Mood—Promoting Access to Collaborative Treatment (IMPACT)[6] and Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT)[7] models of integrated primary and behavioral health care; Program to Encourage Active, Rewarding Lives for Seniors (PEARLS);[8] Healthy IDEAS;[9] Cognitive Behavioral Therapy for Late-Life Depression;[10] problem-solving therapy; interpersonal therapy;[11] and antidepressant therapy with scheduled outcome monitoring and follow-up.[11, 12]

State partners collaborate with providers to develop implementation plans using the RE-AIM framework to establish service objectives to achieve the goal of reducing depressive symptoms among 6,250 older adults. Plans are set to screen 100,000 older adults each year which is expected to identify 25,000 older adults with clinically significant depression symptoms who will be offered depression care. Assuming that 50% agree to participate in care and that the effective practices selected are effective in decreasing depressive symptoms in 50% of participants, the state and local leaders can expect to meet their population goal—providing a 50% or greater decrease in depressive symptoms per year for 6,250 older adults.

RE-AIM Scenarios to Improve Behavioral Health, continued

Local Prevention Initiative

An AAA forms a collaborative with the local healthy aging coalition, the aging and mental health coalition, the prevention network, and a university hospital to prevent risky use of alcohol and psychoactive medications among older adults. Concern rose among community leaders from national and local reports of increased emergency department use.

The leaders agree to *adopt* and *implement* the older adult prevention practice identified in the *Older Americans Behavioral Health, Issue Brief 3: Screening and Preventive Brief Interventions for Alcohol and Psychoactive Medication Misuse/Abuse*. This practice is an application of the evidence-based Screening, Brief Intervention, and Referral to Treatment (SBIRT) model.[13] The leaders set a goal of reducing risky use of alcohol and/or psychoactive medications among a targeted population of 2,225 older adults.

To *reach* this number of older adults, the leaders recruit numerous partners among aging and behavioral health service providers, hospitals, health systems, and primary care practices to offer universal pre-screening to older adults using their services. The lead agency arranges for a 2-day staff training of partner organizations to conduct screening and brief interventions. Partner organizations incorporate this practice into current services. Based on research findings, the leaders set the following objectives and outcomes:

- **Pre-screening**—2,000 older adults per year (estimated 90% of targeted population);
- **Screening**—600 older adults per year (estimated 30% of those pre-screened will have positive scores and will receive a full screening);
- **Brief Intervention**—125 older adults per year (estimated 25% of those completing full screens will have positive scores indicating the need for a brief intervention—however, not all will agree to participate); and
- **Participant outcomes**—Up to 40% of older adults receiving one brief intervention session (20–30 minutes) will reduce their risky drinking and/or risky use of psychoactive medications. Some older adults will need more time and additional sessions.

The lead agency, in consultation with the program researchers, develops and implements the monitoring system to ensure *implementation* fidelity and continuous quality improvement and effectiveness. The leaders initiate *maintenance* and financial sustainability planning from the start.

Lessons Learned from the Field

Key Actions for State and Local Service Planners

- Set a population behavioral health goal to prevent or reduce specific behavioral health problems.
- Establish a collaborative of organizations to design an initiative to implement effective programs or practices to reach the goal.
- Identify financing opportunities in current programs and in health care reform to launch the initiative.

Key Actions for Aging and Behavioral Health Care Service Providers

- Use the RE-AIM framework to select and implement programs and practices.
- Use RE-AIM to reach targeted populations, measure effectiveness, assess adoption, implement with fidelity, and to maintain practices by embedding them within organizational systems with stable financing.

Resources

- ***RE-AIM website.*** http://www.re-aim.org/index.html
- ***RE-AIM for Program Planning: Overview and Applications* (2007).** This Issue Brief by B. Belza, D.J. Toobert, and R.E. Glasgow introduces the RE-AIM framework. http://www.ncoa.org/improve-health/center-for-healthy-aging/content-library/re-aim-for-program-planning.html
- **Series 1: Introduction to Health Promotion Programs.** This online training module from NCOA uses the RE-AIM framework and includes five additional self-paced modules that introduce the basics of evidence-based health promotion programs for older adults. http://www.ncoa.org/improve-health/center-for-healthy-aging/online-training-modules
- **State Older Adult Behavioral Health Profiles titled "Policy Academy State Profiles" (2012)** include state-level data on older adults, suicide, substance abuse and treatment, medication misuse and abuse, co-occurring disorders, and mental health measures. Profiles were prepared by the SAMHSA/AoA Older Adult Behavioral Heath Technical Assistance Center and provided to state agency directors. http://www.aoa.gov/AoARoot/AoA_Programs/HPW/Behavioral/index.aspx
- **NIATx Process Improvement Model** offers behavioral health care settings methods and tools to improve access and retention in treatment, especially for substance abuse. The model consists of Four Aims for effective ways to plan, institute, and measure improvements; Five Principles critical to fostering change based on factors examined through research; Promising Practices; and a Learning Collaborative. http://www.niatx.net/Content/ContentPage.aspx?NID=8
- ***Lessons Learned on Sustainability of Older Adult Community Behavioral Health Services* (2012).** SAMHSA and NCOA developed this guide. http://www.ncoa.org/improve-health/center-for-healthy-aging/content-library/lessons-learned-on.html
- ***Older Americans Behavioral Health, Issue Brief 6: Depression and Anxiety: Screening and Interventions.*** http://www.aoa.gov/AoARoot/AoA_Programs/HPW/Behavioral/index.aspx
- **Treatment of Depression in Older Adults Evidence-Based Practices (EBP) KIT (2011).** SAMHSA's Center for Mental Health Services developed this kit containing information about an array of evidence-based practices. http://store.samhsa.gov/product/Treatment-of-Depression-in-Older-Adults-Evidence-Based-Practices-EBP-KIT/SMA11-4631CD-DVD

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