The BRIGHTEN Program: Implementation and Evaluation of a Program to Bridge Resources of an Interdisciplinary Geriatric Health Team via Electronic Networking

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Purpose: To demonstrate the feasibility of the BRIGHTEN Program (Bridging Resources of an Interdisciplinary Geriatric Health Team via Electronic Networking), an interdisciplinary team intervention for assessing and treating older adults for depression in outpatient primary and specialty medical clinics. The BRIGHTEN team collaborates “virtually” to review patient assessment results, develop a treatment plan, and refer to appropriate team members for follow-up care.  

Design and Methods: Older adults in 9 academic medical center clinics and 2 community-based clinics completed screening forms for symptoms of depression and anxiety. Those with positive screens engaged in comprehensive assessment with the BRIGHTEN Program Coordinator; the BRIGHTEN virtual team provided treatment recommendations based on the results of assessment. A collaborative treatment plan was developed with each participant, who was then connected to appropriate services.  

Results: Two thousand four hundred twenty-two older adults were screened in participating clinics over a 40-month period. Eight hundred fifty-nine older adults screened positive, and 150 elected to enroll in BRIGHTEN. From baseline to 6 months, significant improvements were found in depression symptoms (Geriatric Depression Scale, p < .01) and general mental health (SF-12 Mental Component, p < .01).  

Implications: The BRIGHTEN Program demonstrated that an interdisciplinary virtual...
Nearly 30% of older adults report depressive symptoms at primary care visits (Alexopoulos et al., 2000). Unfortunately, physicians rarely have the training or time to adequately assess and treat mental health problems (Simon, Goldberg, Tiemens, & Ustun, 1999). Bartels (2003) found that many mental health problems in older adults go undetected by primary care providers, and primary care clinics rarely employ mental health providers to address this issue (U.S. Department of Health and Human Services, 1999). Recognizing this need, the Surgeon General issued a report identifying primary care as a pivotal point of care for older adult mental health (U.S. Surgeon General, 1999).

Models of Integrated Care

Models of collaborative depression intervention have demonstrated that widespread screening and intervention for depression among older adults through primary care can be effective in treating mental health problems. In the IMPACT study, participants assigned to the collaborative intervention (primary care physician [PCP], psychiatrist, and nurse or psychologist depression care manager) reported a reduction in the severity of their depression as compared with those receiving usual care at 12, 18, and 24 months postintervention (Hunkeler et al., 2006). Similarly, Gallo and colleagues (2007) found through the PROSPECT study that primary care patients treated for depression with integrated care (PCP, nurse, psychologist, and social worker) had a lower mortality rate than those without such intervention.

In the PRISM-E study (Krahn et al., 2006), integrated care (colocated mental health and substance abuse providers in primary care) was linked to greater reductions in depressive symptom severity, greater satisfaction with care, and less mental health care stigma after intervention than those in usual care (Chen et al., 2006; Krahn et al., 2006). Integrated care was also associated with greater communication between primary care clinicians and mental health specialists.

In each of these projects, teams operated collaboratively in a single setting. Although this may be ideal, not all health care settings have this luxury. The Bridging Resources of an Interdisciplinary Geriatric Health Team via Electronic Networking (BRIGHTEN) Program integrates the primary care collaboration concepts for geriatric mental health from IMPACT, PROSPECT, and PRISM-E with the virtual team communication process developed in the Virtual Integrated Practice (VIP) project (Rothschild & Lapidos, 2003) to bring together resources of a disparately located interdisciplinary team using technology. VIP developed communication protocols via email, phone, and fax to maximize collaborative care for primary care providers with community providers they commonly shared patients with. Employing a VIP-based electronic communication protocol, BRIGHTEN allows a unique team of geriatric specialty professionals to make treatment recommendations and collaborate in ongoing treatment for older adults without the challenges of in-person meetings.

Because older adults often have a variety of health issues that interact with symptoms of depression, the BRIGHTEN team goes beyond those who typically treat mental health problems. The virtual team includes psychology, social work, psychiatry, physical therapy, occupational therapy, dietetics, chaplain, and pharmacy. Physicians whose patients are screened into BRIGHTEN are also integral team members, as they often know the patients best at time of enrollment. Each of these disciplines contributes a unique perspective on healing for older adults with depression and anxiety. This paper presents the BRIGHTEN model and discusses evaluation of the program through the Reach, Efficacy, Adoption, Implementation, Maintenance (RE-AIM) framework.

The core components of the BRIGHTEN intervention are screening, assessment, virtual team communication, participant-centered treatment plan development, and connection to recommended evidence-based services. Although the evidence-based services (e.g., psychotherapy) may be effective alone, many older adults do not have access to them, and even when available, most do not get them (Bartels, 2002). It is hypothesized that the BRIGHTEN components are what serve to identify older adults with depression through screening in primary care, overcome the stigma of mental health treatment with the use of an interdisciplinary team approach that uses technology to maximize efficiency and collaborative care, and engage the older adult in multilevel treatment that meets the older adult’s multiple needs. Services
received are tailored to the individual’s needs; thus, there is a highly variable level of service provided. Future effectiveness studies will examine which components account for the greatest amount of variance in outcomes and whether or not there is a dose-response relationship for individual interventions.

**Methods**

**Target Population**

BRIGHTEN participants were screened in nine primary and specialty medical clinics. As other physicians learned of the service and requested referrals to the program, these “outside” referrals were grouped as one site. Inclusion criteria for participants included age (65+ in first 3 years; funder required change to 60+ in Year 4 of the program) and English or Spanish language proficiency. Exclusion criteria included cognitive impairment that precluded independent consent to participation via consent teach-back (National Quality Forum, 2003, 2005) and active psychosis or psychotic disorder.

**Recruitment.**—BRIGHTEN posters, brochures, and screening forms were displayed in partner clinic waiting rooms and exam rooms for patients and family members to self-screen. Some clinics allowed screening forms to be placed on charts of all older adults to be completed by nursing staff or the physician. Clinic medical staff was encouraged to refer depressed patients who had not completed screening forms. The Program Coordinator (PC, a geriatric social worker) collected screening forms from clinics twice weekly.

**Screening.**—The screening form included the Patient Health Questionnaire-2 (PHQ-2; Spitzer, Kroenke & Williams 1999), a validated brief measure of depressive symptoms with sensitivity of 83% and specificity of 92% for major depression (Kroenke, Spitzer, & Williams, 2003). For ease of responding for older adults and to maximize sensitivity, the response format was changed from a Likert scale to Yes/No. Given the prevalence of anxiety disorders in late life (Byers, Yaffe, Covinsky, Friedman, & Bruce, 2010), a third item about anxiety was added to the early screening forms: “During the past two weeks, have you been bothered by feeling worried or nervous?” Screening was later modified to our current use of the standard response format PHQ-4 (Kroenke, Spitzer, Williams, & Löwe, 2009). Individuals who screened positive (a “yes” response to one or more of the three items) and provided contact information were contacted by the PC to schedule an in-person assessment.

**Assessment.**—Participants signed an informed consent form that included permission for the virtual team and any health care providers the participant sees as a part of their BRIGHTEN participation to communicate openly about the participant’s health. The PC then administered the following measures in interview format: demographics; Geriatric Depression Scale (GDS-15; Yesavage et al., 1982); Medical Outcomes Study, Short Form-12 (SF-12; Hays, Sherbourne, & Mazel, 1995); and the Rush Interdisciplinary Needs Assessment (RINA). The RINA was developed by the BRIGHTEN team to broadly assess functional status. Items include personal and family medical history, medication list, falls history, recent losses, living arrangements, assistive device use, independence in activities of daily living, and the degree to which each of these impacts daily functioning.

**Team Communication.**—Results of the formal measures and a de-identified narrative report of the interview were distributed by the PC via secured email to the interdisciplinary team. Each team member responded to the full team with recommendations from their discipline’s perspective within 2 weeks and often commented on the recommendations of other team members. These recommendations were focused on mental health symptoms and on general health issues that may be contributing to or resulting from mental health issues. Recommendations ranged from general (e.g., “physical therapy evaluation and treatment to address mobility deficits”) to very specific (e.g., “16–20 sessions of interpersonal psychotherapy to minimize interpersonal disputes with adult children”), depending on the individual participant’s needs and the specificity of information they were able to provide in the evaluation. Team discussion often included (a) questions to other team members about available treatment and/or resources (e.g., “Occupational Therapy, is there a low-cost simulation car driving evaluation available in her community?” or “Primary Care, how adherent has he been with medications? Might this be an issue with antidepressants? Perhaps this should be a focus of behavioral intervention?”), (b) suggested
cortreatment (e.g., “psychologist and chaplain could meet with her together to explore spiritual struggle and how it relates to her depressive symptoms”), or (c) building on each other’s recommendations (e.g., “agree with recommendation for Chronic Disease Self-Management (CDSM) class—rehab just started a CDSM class for stroke survivors; the specificity would be ideal given limited stroke awareness”).

The PC then compiled all treatment recommendations and reviewed them with the participant. The PC and participant worked collaboratively to develop an individualized treatment plan and link the participant to appropriate services. The PC then contacted the participant within 2 weeks to assure connection to services. Additional case management was provided as needed; utilization of service ranged from 1 to 12 phone calls, with a mode of one call to the participant.

Treatment.—The screening, assessment, team recommendations, and connection to appropriate services are considered to be the core of the BRIGHTEN intervention. Individual treatment services included but were not limited to physical therapy, occupational therapy, nutritional intervention, psychotherapy, psychiatric medication management, neuropsychological testing and compensatory strategy development, chaplain consultation, and referral for care management (e.g., linkages to services and community resources, such as exercise and support groups, Medicare benefits checks, and transportation and housing services). The PC also followed up with the participant via phone to maximize adherence to the agreed upon treatment plan. Frequency of follow-up was tailored to the needs of the individual participant; some needed multiple calls to facilitate connection to services, although higher functioning participants were able to access recommended services more independently.

Ongoing Evaluation.—Participants complete the GDS-15 and the SF-12 every 3 months for the duration of participation.

An example of an interdisciplinary approach to a BRIGHTEN participant and its outcomes:

Mrs. P is a 62-year-old, married, African American woman with severe anxiety, persistent nightmares, and mild depression, describing her situation as “hopeless” following a minor stroke. Mrs. P had multiple emergency room visits due to anxiety. She was linked to a grandparents-raising-grandchildren group, chronic disease self-management group for stroke survivors, occupational therapy to improve household functioning, and individual psychotherapy for anxiety. Group involvement allowed her to improve communication with her husband and health care providers regarding her needs. Her nightmares of ten years abated in one month of psychotherapy, and symptoms of both depression and anxiety decreased by 50% within three months. She has not been to the emergency room since beginning psychotherapy.

Program Evaluation

Reach, Efficacy, Adoption, Implementation, Maintenance

The BRIGHTEN program was evaluated using the RE-AIM framework (Glasgow, McKay, Piette, & Reynolds, 2001). RE-AIM has been used to plan health promotion programs, evaluate success, and improve chances of programs working in real-world situations. The model addresses Reach, Efficacy, Adoption, Implementation, and Maintenance; this paper focuses on the reach and outcomes of the program to date. Although the RE-AIM model is typically used to evaluate interventions that have a significant evidence base, we have found it helpful in clarifying the utility of the BRIGHTEN program.

Data presented here reflect participants enrolled from August 1, 2006, through December 1, 2009. The first 3 years of the program (2005—2008) were conducted in academic medical center clinics and expanded into a federally qualified health center and one large Cook County primary care clinic in 2008.

Reach

Prior to the beginning of the BRIGHTEN Program, there was no consistent screening for mental

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Table 1. Demographics

<table>
<thead>
<tr>
<th></th>
<th>All clinics (n = 150) %/M (SD)</th>
<th>6-month follow-up (n = 76) %/M (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>80.7</td>
<td>81.6</td>
</tr>
<tr>
<td>Married</td>
<td>30.7</td>
<td>28.9</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>32.0</td>
<td>27.6</td>
</tr>
<tr>
<td>African</td>
<td>46.0</td>
<td>46.1</td>
</tr>
<tr>
<td>American</td>
<td>20.7</td>
<td>25.0</td>
</tr>
<tr>
<td>Hispanic</td>
<td>1.4</td>
<td>1.3</td>
</tr>
<tr>
<td>Other</td>
<td>1.4</td>
<td>1.3</td>
</tr>
<tr>
<td>Age</td>
<td>71.9 (7.3)</td>
<td>71.4 (7.2)</td>
</tr>
<tr>
<td>12+ Years</td>
<td>54.0</td>
<td>53.9</td>
</tr>
</tbody>
</table>

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Note: *N* = number of participants; *M* = mean; *SD* = standard deviation; *η²* = effect size.
health needs or protocol for referral to treatment in any of our partner clinics. Furthermore, geriatric specialty mental health service availability was extremely limited in the university clinics and not available at all in community clinics. The PC along with geriatric psychology and social work fellows provided specialty case management and psychotherapy services that are not otherwise available in any of our partner health facilities outside of BRIGHTEN. BRIGHTEN team members also consulted with primary care providers to coordinate care and recommend interventions. Thus, BRIGHTEN increased access to mental health services for older adults by increasing screening, providing consistent protocols, and availability of geriatric specialty services.

Table 1 provides a description of the sample at time on enrollment in BRIGHTEN (n = 150) and 6 months later (n = 76). At baseline, participants were predominantly women, not married, African American, and had at least 12 years of education (54%). This sample is reflective of the broader population of older adults on the west side of Chicago where participating clinics are located. At 6 months, the sample maintained similar demographics characteristics.

The target population of the program was older adults with symptoms of depression or anxiety. A total of 150 participants were enrolled in BRIGHTEN during this time period. Of the 2,422 collected screening forms, 43% of the population (1,053) provided complete screening and contact information, allowing BRIGHTEN staff to contact them (see Figure 1). Of those who left the screening form blank, but requested follow-up with study personnel, 17 were enrolled into the study. Of the 1,053 providing contact information, 61% (643 older adults) screened positive by responding with a “yes” to one or more of the items on the screening form. When contacted, however, only 192 (18%) endorsed ongoing depressive and/or anxious symptoms (many reported that they were no longer symptomatic) and were thus appropriate for BRIGHTEN assessment. Of these, 131 (68% of true positives) enrolled in the program. Of those who screened negative, but requested follow-up communication with program personnel, two were found to show depressive symptoms that were not captured in the screening and were enrolled in the program.

Prevalence rates for community-dwelling older adult depressive symptoms range from 15% to 30% (Montgomery et al., 2001) and 14% with symptoms of anxiety (Cohen, Magai, Yaffee, & Walcott-Brown, 2006). Given underreporting of these symptoms by the general population and specifically minority older adults, we expected a slightly smaller proportion of older adults to screen into BRIGHTEN despite our screening instrument modification to maximize sensitivity. Our 61% positive screen rate indicates poor specificity, however, which is the primary reason for change to the PHQ-4 as a screener (Kroenke et al., 2009). Thus, PCs contacted those who screened positive by telephone to further assess for symptoms of depression and anxiety. This yielded a sample consistent with prevalence rates among those who provided contact information (18%). The large number of incomplete screening forms is of concern; however, it remains unclear whether they were incomplete due to lack of desire to report symptoms, lack of understanding of the screening form, incomplete instruction from those administering the screening forms in the clinic, or other reasons. Further investigation of this pattern is warranted.

### Effectiveness

Program outcomes were examined at participant, team, and clinic levels. Participant level goals were to decrease symptoms of depression as measured by the GDS-15 and improve general mental and physical health among participants as measured by the SF-12. Data presented in Table 2 include scores on measures administered at baseline and 6 months after enrollment. Average baseline depression scores were in the clinical range (M = 7.6; scores > 5 are suggestive of depression). From baseline to 6 months, the average change in score on the GDS was −2.64, demonstrating

<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline M (SD)</th>
<th>6-month M (SD)</th>
<th>p Value</th>
<th>( \eta^2 )</th>
</tr>
</thead>
<tbody>
<tr>
<td>GDS (N = 76)</td>
<td>7.62 (3.82)</td>
<td>4.97 (3.64)</td>
<td>&lt;.001</td>
<td>.39</td>
</tr>
<tr>
<td>SF-12 MCS (N = 73)</td>
<td>37.69 (10.31)</td>
<td>42.96 (10.66)</td>
<td>&lt;.001</td>
<td>.19</td>
</tr>
<tr>
<td>SF-12 PCS (N = 73)</td>
<td>42.06 (12.76)</td>
<td>40.44 (12.18)</td>
<td>.16</td>
<td>.03</td>
</tr>
</tbody>
</table>

Note: GDS = Geriatric Depression Scale; SF-12 MCS = Short Form-12 Mental Component Score; PCS = Physical Component Score.
significant decrease in symptoms of depression and reducing average scores into the nonclinical range (see Table 2). Although no absolute cut-points have been published for the SF-12 components, average change scores on the SF-12 Mental Component Score were +5.26, demonstrating significant improvement in symptoms of mental distress. This is particularly interesting, given the average 0.5 point decrease in scores on the SF-12 Physical Component Score, suggesting that mental health improved despite physical health remaining relatively stable overtime. A subset of our participants (n = 13) completed different versions of the SF-12 at baseline (Version 1) and follow-up (Version 2). Results of similar analysis on the smaller sample of participants who were administered the same version at baseline and follow-up (n = 60) resulted in substantially similar results.

Team level goals were to build a cohesive, interdisciplinary virtual team with members who provided strong evidence-based treatment recommendations and were able to have open constructive discussions about older adult participants. Team assessment indicated that not only were these goals met but team members also reported learning from each other’s recommendations, which enhanced their work with BRIGHTEN and non-BRIGHTEN patients (Emery, Millheiser, Garcia, Marquine, & Golden, 2011). Team members reported that virtual communication was far easier and more effective than they had anticipated upon engagement in the team process. Furthermore, email communication maximized efficiency of team participation, with an average of 10–15 min spent on team communication per week, which included 1–2 new patients per week. Some telephone consultations with the chaplain required up to 30 min.

Component analysis of which team members’ contributions or services were directly responsible for creating patient level outcomes, and potential dose–response, is in progress. It is possible that not all current team members are required for adequate outcomes. Furthermore, it is likely that replication with other populations may require different team members. For example, if older adults with more significant cognitive impairment were included in the program, a neuropsychologist or speech pathologist may be an appropriate addition.

Clinic level goals were to create a seamless integration of the screening process into existing clinic protocols and engage clinic staff in both screening and treatment of participants. These proved to be the most challenging goals to achieve. Success was highly dependent upon individual provider investment in mental health services and the addition of new tools in their protocol as well as relationship with BRIGHTEN staff. Clinics with staff members who were very interested in mental health and/or aging, were able to engage other staff in consistent screening, and had the strongest relationships with BRIGHTEN Program staff were the most successful in screening and enrollment. Physicians were the most difficult to engage; although participation increased after having a patient enroll in the program and receive helpful treatment, participation of physicians in office screening remained relatively low.

As the program was expanded from the university clinics into community clinics, a diverse board of older adults was convened and consulted on BRIGHTEN protocols, including screening instruments and brochures. Materials were altered based on feedback, including minimizing the words “depression” and “anger,” which were found to be more off-putting than “stress” and “frustration.” The virtual team met in person monthly for 1 year, then quarterly to address recruitment, team communication, and participant outcomes.

Adoption

Based on previous experience in integrating new clinical services in medical settings through the VIP project (Rothschild & Lapidos, 2003), BRIGHTEN investigators took great care to assure that each participating clinic was ready to engage in a new service. The nine clinics represented family, geriatric, and internal medicine, cardiology, neurosurgery, and physical medicine/rehabilitation. The clinics were selected based on the number of older adult patients in the clinic, practitioner engagement, and the base rates of depression within the clinic population (e.g., higher rates of depression in older adults with cardiac and chronic illness).

A “site champion” clinic staff member was designated within each clinic who demonstrated investment in BRIGHTEN success as well as willingness to commit time and effort to aide in planning and implementation. BRIGHTEN program adoption was managed largely by the PC. Serving as the key promotional and operations link for the project, the coordinator’s frequent presence in the clinics supported and motivated them to refer older adults to BRIGHTEN.

Participant Level Adoption.—Service utilization tracking began in 2009; thus, data are incomplete.
Based on available data, the most frequently recommended services were psychotherapy (98%), nutrition (72%), and chaplain (70%). Other services were also recommended regularly: occupational therapy (65%), medical follow-up (41%), psychiatry (39%), physical therapy (37%), neuropsychological testing (22%), benefits check-up (20%), housing services (17%), and substance abuse services (11%). Analysis of service utilization along with links between specific service utilization and outcomes will be completed when a larger data set is available.

**Implementation**

Training for the implementation of BRIGHTEN was conducted by the principal investigators and the PC. Training sessions for each clinic provided education about depression and anxiety in older adults, described the process of working as a virtual team, discussed each staff member’s role in BRIGHTEN, identified expectations for clinics to coordinate with the team, and determined which staff in each clinic would be responsible for project promotion, data safeguarding, and liaison with the PC. Although the link between this training and patient level outcomes is unclear, we were able to see increases in engagement of clinic staff following each training, as evidenced by increased screening consistency.

The PC visited clinics at least weekly to collect screening forms, assess and assure implementation consistency, provide support and problem solving to clinic staff regarding BRIGHTEN protocols, and maintain professional relationships with staff. Follow-up meetings with investigators and clinic staff were conducted as needed to maximize fidelity to screening protocols.

**Maintenance**

In most sites, once BRIGHTEN was integrated into clinic protocols, PC contact and support was sufficient for program maintenance. However, staff changes in some clinics created insurmountable barriers to program maintenance.

Following the first 3 years of BRIGHTEN development in university clinics, a second wave of the program expanded into community clinics as well as adding on a geriatric mental health fellowship training program. Furthermore, with the success of the program expansion and program outcomes, the National Institute of Health funded a randomized controlled trial of the BRIGHTEN program (BRIGHTEN Heart) for minority older adults with cardiometabolic syndrome.

Models are currently being developed for program maintenance following the termination of grant support that includes billable services and creative partnerships with medical clinics and
health insurance organizations as well as training partnerships with area mental health graduate programs.

Discussion

The BRIGHTEN Program’s interdisciplinary approach is highly promising in treating older adult depression and general mental health through primary and specialty care clinics.

Innovation

The virtual team provides the older adult with unique and comprehensive treatment recommendations that utilize team member resources effectively and efficiently. This team approach serves to decrease stigma around mental health for older adults and physicians; primary care physicians reported that their patients found it more palatable to go to a “program” rather than a psychiatrist in the same primary care clinic or outside mental health referral. The experience of having a full team of professionals to consult with and ongoing geriatric care management provided a level of care most consumers of primary care services never receive (Bartels, 2002).

This team approach may have also contributed to the strong minority enrollment, which has historically been difficult to engage in mental health treatment and research (Stahl & Vasquez, 2004). Because older adults generally, and African American and Hispanic older adults specifically, are more likely to report somatic complaints (Wetherell et al., 2010), they may find a broad team-based intervention more inviting than an exclusively mental health team. Furthermore, minority underserved participants reported feeling comfortable knowing that they had a full team of providers to count on for their treatment, even if they had never met those providers; feeling connected to a team of people who they felt cared about them was a very new experience for many BRIGHTEN participants. Further investigation into minority engagement is warranted.

Challenges

The process of implementing the BRIGHTEN program in participating clinics was carefully planned with the needs and considerations of both clinics and older adults in mind. Still there were barriers to successful implementation. First, although some clinics were highly invested in the program and chose to designate staff to aid implementation, other clinics were less prepared to devote time or resources to it. This had significant implications for fidelity to the protocol and the magnitude of screening completed. Clinic staff indicated that the primary barrier to protocol fidelity was limited time for screening, which is a common concern in primary care clinics. Additional barriers included limited investment by staff in assessment of mental health issues and staff fears of being unable to manage mental health issues once identified, despite resources and training provided. These barriers were not related to participant outcomes but did limit the number of older adults screened in some clinics, thus limiting access to services. Building relationships with physicians, nurses, medical technicians, and administrative staff was crucial for maximizing effective participation in recruitment efforts.

There were also participant-level challenges to implementation. Stigma remains a significant barrier to seeking mental health services for the general population and even more so for older adults. Unfortunately, provider reticence to discussing mental health issues serves to exacerbate this among potential consumers. Though concerns about cost of treatment were minimized when services were paid for by grant funding, cost will remain a sustainability barrier for many older adults without insurance when grant funding is no longer available for such services. Trainees providing services to those without insurance may overcome this barrier.

Practice Applications

Most primary and specialty care clinics do not have access to a full team of professionals to address the mental health needs of their older adult patients, much less colocated services. The BRIGHTEN Program is an innovative solution to this problem. The PC works directly with the clinics, but virtual team members do not need to be even geographically located in the same area as the patient or the practice. Provider resources are used very efficiently, allowing for many patients to receive recommendations with minimal commitment from virtual team members and clinic staff. Detailed analysis of program cost and potential overall cost savings are currently being conducted. With guidance from program developers, the BRIGHTEN Program could be replicated and implemented in primary or specialty care clinics.
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able to go to a "program" rather than a psychiatric mental health referral. The experience of having a full team of professionals to consult with and reported that their patients found it more palatable among potential consumers. Though concerns mental health issues serves to exacerbate this problem. The PC works directly with the clin- and retention of minority elders participating in research: Examples on telehealth (e.g., Mohr et al., 2010) may also stretch the options for provision of services virtually to underserved areas as well.

The BRIGHTEN model has the potential to be very successful in a variety of settings and with a variety of virtual team members. For example, adults with severe mental illness are a vastly underserved population with regard to both mental and physical health care (Parks, Svendsen, Singer, & Foti, 2006). A BRIGHTEN program that included vocational rehabilitation providers, home health, community outreach, and other members on the virtual team could be implemented in a community health clinic. Similarly, a BRIGHTEN model focusing on those with a specific illness could prove to be highly effective integrating specialty providers (e.g., diabetes educator, wound care specialist, nutritionist, chef, and exercise physiologist for a diabetes-focused program).

In the context of growing need for collaborative care, as our older adult population grows and health care reform demands it, BRIGHTEN may be a creative solution to managing the care of older adults with complex health needs.

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