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The IMPACT Treatment Program

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These articles describe the IMPACT program, the roles of various healthcare professionals in IMPACT, and the process of implementing IMPACT in the primary care clinics participating in the randomized trial.

1. Hegel MT, Imming J, Cyr-Provost M, Hitchcock-Noel P, Arean P, Unützer J. **Role of allied behavioral health professionals in a collaborative stepped care treatment model for depression in primary care: project IMPACT.** *Fam Syst Health.* 2002;20:265-77.

   Describes a new collaborative stepped care treatment model for depression in primary care that was recently tested in Project IMPACT, a multi-site, randomized, controlled study with older adults. The authors present in particular detail the role of the central figure in this model, the Depression Clinical Specialist, a behavioral health professional (a psychologist or psychiatric nurse) trained to coordinate the delivery of a flexible, multicomponent intervention that includes antidepressant medications and brief psychotherapy. The training program for these specialists is described and two patient case studies demonstrating the stepped care model in practice are presented. Finally, the authors discuss the issues involved in implementing this model and review recent changes in training and reimbursement practices for behavioral health professionals, suggesting the viability of the model for the future. (PsycINFO Database Record (c) 2010 APA, all rights reserved)

2. Saur CD, Harpole LH, Steffens DC, Fulcher CD, Porterfield Y, Haverkamp R, et al. **Treating depression in primary care: an innovative role for mental health nurses.** *J Am Psychiatr Nurses Assoc.* 2002;8:159-67.

   Late-life depression is common in primary care. However, because of barriers such as stigma and the assumption that depression in older adults is a normal part of aging, it is often underrecognized and undertreated. Further, most primary care providers do not have the time or resources to provide adequate follow-up depression care. By integrating a depression clinical specialist into the primary care setting, many of these barriers to effective treatment can be addressed. In this paper, a collaborative, stepped care treatment program with registered nurses practicing as depression clinical specialists is described. Additionally, three case reports illustrate the model. This intervention program offers a unique opportunity for mental health nurses to practice collaboratively in the primary care setting and to provide much needed care to an underserved population.(J Am Psychiatr Nurses Assoc [2002]. 8, 159-67.)

3. Harpole LH, Stechuchak KM, Saur CD, Steffens DC, Unützer J, Oddone E. **Implementing a disease management intervention for depression in primary care: a random work sampling study.** *Gen Hosp Psychiatry.* 2003;25(4):238-45.

We describe the daily work activities of 13 Depression Clinical Specialists (DCSs) at 7 national sites who served as care managers in an effective multisite randomized trial of a disease management model for depression in primary care. DCSs carried portable random-reminder beepers for a total of 147 consecutive workdays and recorded 4,030 work activities. Patient care activity comprised the largest percentage of the workday, 49.4% (95% confidence interval [CI], 42.0 to 56.7%), followed by research-related activity, 18.3 % (95% CI, 14.7 to 21.9%), administrative work, 17.9% (95% CI, 12.2 to 23.7%), personal time, 9.4% (95% CI, 5.4 to 13.4%), and time in transit, 5.1% (95% CI, 2.8 to 7.4%). The DCSs delivered 19.2% (95% CI, 14.4 to 24.1%) of direct patient care by telephone. The DCSs spent a significant portion of the day alone 48.7% (95% CI, 43.3 to 54.1%), followed by time spent with patients, 37.5% (95% CI, 31.6 to 43.3%). Less than 10% (7.8%) (95% CI, 5.1 to 10.6%) of their time was spent with local study staff. Less than 4% of their time was spent with other health care providers. Our results demonstrate that the DCSs' time was primarily devoted to clinical care, a significant portion of which was delivered by telephone. They functioned independently, making efficient use of the limited amount of time that they interacted with other health care providers. This information will be helpful to those who may wish to implement this disease management strategy.

4. Oishi SM, Shoai R, Katon W, Callahan C, Unutzer J, Arean P, et al. **Impacting late life depression: integrating a depression intervention into primary care.** *Psychiatr Q.* 2003;74(1):75-89.

groups and semi-structured individual interviews with all Depression Clinical Specialists (DCSs) working with Project IMPACT (Improving Mood: Promoting Access to Collaborative Treatment), a study testing a collaborative care intervention for late life depression, to examine integration of the intervention model into primary care. DCSs described key intervention components, including supervision from a psychiatrist and a liaison primary care provider, weekly team meetings, computerized patient tracking, and outcomes assessment tools as effective in supporting patient care. DCSs discussed details of protocols, training, environmental set-up, and interpersonal factors that seemed to facilitate integration. DCSs also identified research-related factors that may need to be preserved in the real world. Basic elements of the IMPACT model seem to support integration of late life depression care into primary care. Research-related components may need modification for dissemination.

5. Haverkamp R, Arean P, Hegel MT, Unutzer J. **Problem-solving treatment for complicated depression in late life: a case study in primary care.** *Perspect Psychiatr Care.* 2004;40(2):45-52.

TOPIC: Treatment of depression in primary care. PURPOSE: To describe the application of problem-solving treatment for a person with complicated depression.

SOURCES: Specific treatment details from audiotaped therapy sessions; published literature. CONCLUSION: This case demonstrates how an older person benefited from problem-solving treatment.