IMPACT
Improving Mood – Promoting Access to Collaborative Treatment for Late-Life Depression

Funded by
John A. Hartford Foundation,
California HealthCare Foundation,
Robert Wood Johnson Foundation,
Hogg Foundation
What is Depression?

Depression is NOT...

- Having
  - a ‘bad day’,
  - a ‘bad attitude’,
  - or ‘normal sadness’
  - Part of ‘normal aging’
Major Depression

Common: 5-10% in primary care

Pervasive depressed mood / sadness and loss of interest/pleasure...

Plus: lack of energy, Fatigue, poor sleep and appetite, physical slowing or agitation, poor concentration, physical symptoms (aches and pains), thoughts of guilt, irritability and thoughts of suicide

If untreated, depression can last for years.

Often complicated by: chronic medical disorders, chronic pain, anxiety, cognitive impairment, grief/bereavement, substance abuse
In late-life, depression is rarely the only health problem.
Depression is expensive:
Annual Health Costs in 1995 $

Unützer et al, JAMA, 1997
Depression is deadly
Older adults have the highest rate of suicide.

U.S. SUICIDE RATES BY AGE, GENDER, AND RACIAL GROUP

Source: National Institute of Mental Health
Data: Centers for Disease Control And Prevention, National Center For Health Statistics
Depression CAN be treated, BUT...

- Only **half** of depressed older adults are ‘recognized’

- Older men, African Americans and Latinos have particularly low rates of depression treatment

- **Fewer than 10%** seek care from a mental health specialist. Most prefer treatment by their primary care physician

- Only **one in five** older adults treated for depression in primary care improve
## One-Year Service Use by Depressed Adults

<table>
<thead>
<tr>
<th>AGE GROUP</th>
<th>18-64 (N = 1,382)</th>
<th>65+ (N = 113)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Mental Health (MH)</td>
<td>4%</td>
<td>3%</td>
</tr>
<tr>
<td>ER visit for MH</td>
<td>4%</td>
<td>1%</td>
</tr>
<tr>
<td>Outpatient Mental Health</td>
<td>25%</td>
<td>8%</td>
</tr>
<tr>
<td>Primary care visit addressing Mental Health Needs</td>
<td>45%</td>
<td>49%</td>
</tr>
</tbody>
</table>

Barriers to Effective Depression Care

Knowledge and Attitudes
- “I didn’t know what hit me …”
- Stigma of mental illness: “I am not crazy”
- “Isn’t depression just a part of ‘normal aging’?”
- “Of course I am depressed. Wouldn't you be?” The ‘fallacy of good reasons’

Challenges in Primary Care
- Limited time and competing priorities:
- Limited follow-up -> early treatment dropout
- Staying on ineffective treatments for too long
  “I thought this was as good as I was going to get”
- Limited access to mental health experts
1998 - 2003

1,801 depressed older adults in primary care

18 primary care clinics - 8 health care organizations in 5 states

- Diverse health care systems (FFS, HMO, VA)
- 450 primary care providers
- Urban and semi-rural settings
- Capitated and fee-for-service

Funded by
John A. Hartford Foundation; California HealthCare Foundation; Robert Wood Johnson Foundation; Hogg Foundation
IMPACT Study Team

None of us is as smart as all of us.

Study coordinating center

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PST-PC experts: Patricia Arean, Mark Hegel

Study sites

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Study Advisory Board

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Kenneth Wells,
Cathy Sherbourne,
Lisa Rubenstein,
Howard Goldman

PST-PC experts: Patricia Arean, Mark Hegel
IMPACT Study Methods

**Design**
Randomized control trial. 1,801 depressed older adults with major depression and/or dysthymia randomly assigned to IMPACT or Care as Usual.

**Usual Care**
Primary care or referral to specialty mental health as available.

**IMPACT Care**
Collaborative/stepped care disease management program for depression in primary care offered for up to 12 months.

**Analyses**
Independent assessments of health outcomes and costs for 24 months. Intent to treat analyses.

Unützer et al, Med Care 2001; 39(8):785-99
# IMPACT Study Participants

<table>
<thead>
<tr>
<th>Category</th>
<th>N = 1,801*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>65 %</td>
</tr>
<tr>
<td>Mean age (SD)</td>
<td>71.2 (7.5)</td>
</tr>
<tr>
<td>Non-white</td>
<td>23 %</td>
</tr>
<tr>
<td>African American</td>
<td>12 %</td>
</tr>
<tr>
<td>Latino</td>
<td>8 %</td>
</tr>
<tr>
<td>All others</td>
<td>3 %</td>
</tr>
<tr>
<td>Major depression + dysthymia</td>
<td>53 %</td>
</tr>
<tr>
<td>Cognitive impairment at screening</td>
<td>35 %</td>
</tr>
<tr>
<td>Mean chronic medical diseases (out of 10)</td>
<td>3.2</td>
</tr>
<tr>
<td>Antidepressant use in 3 months prior to study</td>
<td>42 %</td>
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</tbody>
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* No significant baseline differences between intervention and usual care.
IMPACT TEAM Care Model

Effective Collaboration

Prepared, Pro-active Practice Team

Practice Support

Informed, Activated Patient
Collaborative Care

Patient

Chooses treatment in consultation with provider(s):
- Antidepressants and/or brief psychotherapy

Primary care provider (PCP)

Refers; prescribes antidepressant medications

+ Depression Care Manager
+ Consulting Psychiatrist

Unützer et al, Med Care 2001; 39(8):785-99
Evidence-based ‘team care’ for depression

<table>
<thead>
<tr>
<th>TWO PROCESSES</th>
<th>TWO NEW ‘TEAM MEMBERS’ Supporting the Primary Care Provider (PCP)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Care Manager</td>
</tr>
<tr>
<td>1. Systematic diagnosis and outcomes tracking</td>
<td>- Patient education / self management support</td>
</tr>
<tr>
<td></td>
<td>- Close follow-up to make sure pts don’t ‘fall through the cracks’</td>
</tr>
<tr>
<td>2. Stepped Care</td>
<td>- Support anti-depressant Rx by PCP</td>
</tr>
<tr>
<td>a) Change treatment according to evidence-based algorithm if patient is not improving</td>
<td>- Brief counseling (behavioral activation, PST-PC, CBT, IPT)</td>
</tr>
<tr>
<td>b) Relapse prevention once patient is improved</td>
<td>- Facilitate treatment change / referral to mental health</td>
</tr>
<tr>
<td></td>
<td>- Relapse prevention</td>
</tr>
</tbody>
</table>

Consulting Psychiatrist

Supporting the Primary Care Provider (PCP)

- Consultation focused on patients not improving as expected
- Recommendations for additional treatment / referral according to evidence-based guidelines
Stepped Care

Systematic outcomes tracking
- Patient Health Questionnaire (PHQ-9)

Adjust treatment based on clinical outcomes

Insufficient response
Change treatment
- According to evidence-based algorithm
- In consultation with team psychiatrist
**Evidence-Based Depression Care Management**

**Identify and track depressed patients**
- Case finding (screening, referral) -> confirm diagnosis
- Proactive follow-up & tracking (PHQ-9)
  - Change treatment if patient not improving
  - Relapse prevention plan for patients in remission

**Enhance patient self-management**
- Education
- Brief Therapy: Behavioral Activation / Problem Solving

**Support additional treatment**
- Primary Care (Antidepressant Medications)
- Specialty Mental Health Care / Psychotherapy

**Mental health consultation for difficult cases**
- Caseload supervision / consultation for care managers
- Psychiatry consultation for treatment nonresponders
Improved Satisfaction with Depression Care

(\% Excellent, Very Good)

Unützer et al, JAMA 2002; 288:2836-2845
IMPACT: Doubles the Effectiveness of Usual Care for Depression

Mean HSCL-20 Depression Severity Score

Follow-up (Months)

Baseline  3  6  12

Usual Care

Intervention

P=.553

P<.0001

P<.0001

P<.0001

Unutzer, et al. JAMA 2002; 288:2836-2845

Unutzer, et al. JAMA 2002; 288:2836-2845
Findings Robust Across Diverse Health Care Organizations

TREATMENT RESPONSE
50% or greater improvement in depression at 12 months

Usual Care
IMPACT

Participating Organizations

Unutzer, et al. JAGS 2003; 51:505-514
Better Physical Function

PCS-12

Usual Care

IMPACT

P=0.35

P<0.01

P<0.01

Baseline 3 mos 6 mos 12 mos

Effects persist even 1 year after the program ends

IMPACT in Diabetes

116 more Depression-Free Days over 2 Years

Katon et al, Diabetes Care; 2006
IMPACT in Diabetes
Lower Health Care Costs

Usual Care

$18,932

IMPACT

$18,035

Katon et al, Diabetes Care; 2006
IMPACT Summary

- Less depression
  (IMPACT doubles effectiveness of usual care)
- Less physical pain
- Better functioning
- Higher quality of life
- Greater patient and provider satisfaction
- More cost-effective

“I got my life back”

Photo credit: J. Lott, Seattle Times
Resources for Implementation

Supported by a grant from the John A. Hartford Foundation.

IMPACT Dissemination
http://impact-uw.org
IMPACT Training
In Person and on the Web

Trained over 1600 providers

IMPACT Web-based Learning

What is IMPACT
IMPACT is an evidence-based model of care that helps primary care physicians and mental health providers collaborate effectively to treat depression. It was developed by a group of national experts with support from the John A. Hartford Foundation and the California Healthcare Foundation. Across all 8 participating organizations, IMPACT doubled the effectiveness of usual care for depression. Based on this strong performance, IMPACT was recommended as a model treatment program by the President’s New Freedom Commission on Mental Health and a growing number of health care organizations in the United States and Canada have adapted the program to care for a wide range of patients.

How to Use this Training Program
Each module in this training program includes an audio-annotated PowerPoint presentation, a case study illustrating the key points of the module, a link to the relevant section of the IMPACT treatment manual and a quiz. Some modules also include video that demonstrates concepts and skills discussed in the PowerPoint presentation. We suggest that you view the PowerPoint presentation first, next, review the case study, view the related video and then review the related sections of the IMPACT treatment manual. Finally, take the quiz.

Continuing Nursing Credit Available
To receive continuing education credit, please go to the “Sign Up For CNE” and follow the instructions. The last slide icon indicates available CNE credits for that particular module.

The Instructors
- Jürgen Unutzer, MD, MPH
  University of Washington
- Rita Haverkamp, RN, MSN
  Kaiser Permanente
- Mark Hegel, PhD
  Dartmouth
- Wayne Katon, MD
  University of Washington
- Elizabeth Lin, MD, PhD
  Group Health

The IMPACT Implementation Center conducts a variety of in-person training meetings each year at locations around the country. We offer both public training meetings and trainings that are designed for a specific organization. See below for a listing of upcoming training meetings. If none of these meet your needs, please contact the Implementation Center to discuss options and alternatives.

Upcoming Presentations and Training Events:

<table>
<thead>
<tr>
<th>Date(s)</th>
<th>Location</th>
<th>Organization / Type of Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 20-21, 2007</td>
<td>Seattle, WA</td>
<td>University of Washington / IMPACT training conference</td>
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<tr>
<td>May 25, 2007</td>
<td>San Diego, CA</td>
<td>California Older Adults Systems of Care Conference / 2 hour presentation re: implementing IMPACT in California</td>
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Past Presentations and Training Events:

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<tr>
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<th>Location</th>
<th>Organization / Type of Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 14-15, 2007</td>
<td>Santa Fe, NM</td>
<td>Sangre de Cristo Community Health Partnership / 2 day IMPACT training</td>
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<tr>
<td>March 27-29, 2007</td>
<td>Las Vegas, NV</td>
<td>National Council for Community Behavioral Healthcare Conference / 1.5 day IMPACT workshop</td>
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Participating Organizations

States shown in blue on the map below have individuals or organizations implementing IMPACT or key components of the program. Moving your mouse over a state will tell you the total number for each state.