Other IMPACT Study Findings
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These articles include factors influencing depression severity, treatment and effectiveness of IMPACT in various subgroups of patients as well as patient and physician satisfaction with IMPACT.


This purpose of this paper is to discuss the effectiveness of psychotherapy for treating depression in older, primary care patients. This paper highlights the feasibility of implementing psychotherapy in primary care settings, patient preference for psychotherapy, and the utility of primary care versions of therapy in treating depression in older adults. The discussion is supported with examples from three ongoing research projects, specifically the San Francisco General Hospital Depression in Late Life Study, the Hartford Foundation/California Healthcare Foundation IMPACT study, and the NIMH PROSPECT study. The findings presented here support the value of offering psychotherapy as a treatment alternative in primary care medicine.


OBJECTIVES: To examine rates and predictors of lifetime and recent depression treatment in a sample of 1,801 depressed older primary care patients DESIGN: Cross sectional survey data collected from 1999 to 2001 as part of a treatment effectiveness trial. SETTING: Eighteen primary care clinics belonging to eight organizations in five states. PARTICIPANTS: One thousand eight hundred one clinic users aged 60 and older who met diagnostic criteria for major depression or dysthymia. MEASUREMENTS: Lifetime depression treatment was defined as ever having received a prescription medication, counseling, or psychotherapy for depression. Potentially effective recent depression treatment was defined as 2 or more months of antidepressant medications or four or more sessions of counseling or psychotherapy for depression in the past 3 months. RESULTS: The mean age +/- standard deviation was 71.2 +/- 7.5; 65% of subjects were women. Twenty-three percent of the sample came from ethnic minority groups (12% were African American, 8% were Latino, and 3% belonged to other ethnic minorities). The median household income was $23,000. Most study participants (83%) reported depressive symptoms for 2 or more years, and most (71%) reported two or more prior depressive episodes. About 65% reported any lifetime depression treatment,
and 46% reported some depression treatment in the past 3 months, although only 29% reported potentially effective recent depression treatment. Most of the treatment provided consisted of antidepressant medications, with newer antidepressants such as selective serotonin reuptake inhibitors constituting the majority (78%) of antidepressants used. Most participants indicated a preference for counseling or psychotherapy over antidepressant medications, but only 8% had received such treatment in the past 3 months, and only 1% reported four or more sessions of counseling. Men, African Americans, Latinos, those without two or more prior episodes of depression, and those who preferred counseling to antidepressant medications reported significantly lower rates of depression care. CONCLUSION: The findings suggest that there is considerable opportunity to improve care for older adults with depression. Particular efforts should be focused on improving access to depression care for older men, African Americans, Latinos, and patients who prefer treatments other than antidepressants.


Although hypothyroidism is purportedly an important cause of depression, prior studies have involved small samples of young people and produced conflicting results. We examined the yield of thyroid-stimulating hormone (TSH) testing in a large group of elderly patients with major depression or dysthymic disorder. The study sample comprised 883 outpatients aged 60 years or older from 18 primary care sites enrolled in the intervention arm of a clinical trial of depression management. Thyroid function was assessed by a single TSH value. Depressive diagnoses were confirmed with the Structured Clinical Interview for DSM-IV (SCID) and depression severity was assessed with the HSCL-20, a modified depression scale of the Hopkins Symptom Checklist. TSH results were available for 725 (82.1%) participants. Although 32 (4.4%) of those tested had TSH > 5 mIU/L, the vast majority (27/32) had marginally elevated results (5.1-9.4 mIU/L). Only five patients (0.7%) had TSH levels > 10 mIU/L. Patients with elevated TSH did not differ from those with TSH < or = 5 mIU/L in the severity or symptom pattern of depression as measured by the baseline HSCL-20 score (P = .37) or SCID score (P = .44). These findings should caution physicians against acceptance of borderline TSH values as the primary cause of a patient's clinical depression.


PURPOSE Our objective was to examine the relative association of depression severity and chronicity, other comorbid psychiatric conditions, and coexisting medical illnesses with multiple domains of health status among primary care patients with clinical depression. METHODS We collected cross-sectional data as part of a treatment effectiveness trial that was conducted in 8 diverse health care organizations. Patients aged 60 years and older (N = 1,801) who met diagnostic criteria for major depression or dysthymia participated in a baseline survey. A
survey instrument included questions on sociodemographic characteristics, depression severity and chronicity, neuroticism, and the presence of 11 common chronic medical illnesses, as well as questions screening for panic disorder and posttraumatic stress disorder. Measures of 4 general health indicators (physical and mental component scales of the SF-12, Sheehan Disability Index, and global quality of life) were included. We conducted separate mixed-effect regression linear models predicting each of the 4 general health indicators. RESULTS Depression severity was significantly associated with all 4 indicators of general health after controlling for sociodemographic differences, other psychological dysfunction, and the presence of 11 chronic medical conditions. Although study participants had an average of 3.8 chronic medical illnesses, depression severity made larger independent contributions to 3 of the 4 general health indicators (mental functional status, disability, and quality of life) than the medical comorbidities. CONCLUSIONS Recognition and treatment of depression has the potential to improve functioning and quality of life in spite of the presence of other medical comorbidities.


OBJECTIVE: Although estrogens are thought to have a beneficial effect on menopausal symptoms, the role of estrogen in the etiology and treatment of depression in older women remains unclear. The authors examined the relationship between hormone therapy (HT) use and depressive symptom severity. METHODS: Authors report the findings from a cross-sectional analysis of baseline data from the Improving Mood: Promoting Access to Collaborative Treatment (IMPACT) Study, using data from 1,160 women age 60 years and older. RESULTS: Women who were taking HT were likely to be younger, White, married, and to have had at least some college education. They were also more likely to report good or better health and to have taken antidepressant medications in the past 3 months. Although HT use was associated with more severe depressive symptoms in the unadjusted analysis, it was not associated with depression severity in adjusted analyses. Although there was a trend for a differential effect of college education with HT use on depression scores, no significant interaction was found between HT and race. CONCLUSION: There was no evidence to suggest that women HT users differ from non-HT users in depressive symptom severity.


OBJECTIVE: This study describes physicians' satisfaction with care for patients with depression before and after the implementation of a primary care-based collaborative care program. METHOD: Project Improving Mood, Promoting Access to Collaborative Treatment for late-life depression (IMPACT) is a multisite, randomized controlled trial comparing a primary care-based collaborative disease management program for late-life depression with care as usual. A total of 450
primary care physicians at 18 participating clinics participated in a satisfaction survey before and 12 months after IMPACT initiation. The preintervention survey focused on physicians' satisfaction with current mental health resources and ability to provide depression care. The postintervention survey repeated these and added questions about physician's experience with the IMPACT collaborative care model. RESULTS: Before intervention, about half (54%) of the participating physicians were satisfied with resources to treat patients with depression. After intervention, more than 90% reported the intervention as helpful in treating patients with depression and 82% felt that the intervention improved patients' clinical outcomes. Participating physicians identified proactive patient follow-up and patient education as the most helpful components of the IMPACT model. CONCLUSIONS: Physicians perceived a substantial need for improving depression treatment in primary care. They were very satisfied with the IMPACT collaborative care model for treating depressed older adults and felt that similar care management models would also be helpful for treating other chronic medical illnesses.


PURPOSE: To describe the patterns of physical symptoms in older adults and to examine the validity of symptoms in predicting hospitalization and mortality. SUBJECTS AND METHODS: Adults aged 60 years and older (N=3498) who completed screening for self-reported symptoms at routine primary care visits. Self-reported symptoms were collected using an abbreviated PRIME-MD screening instrument. Clinical characteristics, hospitalization, and mortality in the year following screening were measured using data taken from a comprehensive electronic medical record. RESULTS: The mean patient age was 69 years, 69% were women, and 56% were African-American. A majority (51%) of respondents characterized their health as fair or poor. The most commonly reported symptoms were musculoskeletal pain (65%), fatigue (55%), back pain (45%), shortness of breath (41%), and difficulty sleeping (38%). A summary score of physical symptoms (range 0-12) was a significant independent predictor of future hospitalization and death even when controlling for clinical characteristics, chronic medical conditions, self-rated health, and affective symptoms. Disease-specific symptoms were more common among patients diagnosed with the specific condition but there was also a substantial background prevalence of these symptoms. CONCLUSION: Physical symptoms are highly prevalent in older primary care patients and predict hospitalization and mortality at one year. Future work is needed to determine how to target symptoms as a potential mechanism to reduce health care use and mortality.


PURPOSE: For depressed older primary care patients, this study aimed to examine (a) characteristics associated with depression treatment preferences; (b) predictors
of receiving preferred treatment; and (c) whether receiving preferred treatment predicted satisfaction and depression outcomes. DESIGN AND METHODS: Data are from 1,602 depressed older primary care patients who participated in a multisite, randomized clinical trial comparing usual care to collaborative care, which offered medication and counseling for up to 12 months. Baseline assessment included demographics, depression, health information, prior depression treatment, potential barriers, and treatment preferences (medication, counseling). At 12 months, services received, satisfaction, and depression outcomes were assessed. RESULTS: More patients preferred counseling (57%) than medication (43%). Previous experience with a treatment type was the strongest predictor of preference. In addition, medication preference was predicted by male gender and diagnosis of major depression (vs dysthymia). The collaborative care model greatly improved access to preferred treatment, especially for counseling (74% vs 33% in usual care). Receipt of preferred treatment did not predict satisfaction or depression outcomes; these outcomes were most strongly impacted by treatment condition. IMPLICATIONS: Many depressed older primary care patients desire counseling, which is infrequently available in usual primary care. Discussion of treatment preferences should include an assessment of prior treatment experiences. A collaborative care model that increases collaboration between primary care and mental health professionals can increase access to preferred treatment. If preferred treatment is not available, collaborative care still results in good satisfaction and depression outcomes.


OBJECTIVES: The objectives of this study were to examine gender differences in recruitment, depression presentation, and depression treatment history in a large effectiveness trial; and to use qualitative data to generate hypotheses about reasons for observed gender differences. METHODS: Data from IMPACT, a multisite trial of a disease management program for late-life depression in primary care were used to examine gender differences quantitatively. Qualitative interviews were conducted with 30 key informants from IMPACT (referring physicians, depression care managers, and study recruiters) to learn more about challenges in recruiting and treating depressed older men and then analyzed thematically. RESULTS: Compared with older women, older men were significantly less likely to be referred to IMPACT, to endorse core depressive symptoms, and to have received prior depression treatment. Gender differences in prior depression treatment persisted after adjustment for covariates. Qualitative themes identified as important contributors to gender disparities included 1) how men experience and express their depression, 2) traditional masculine values, and 3) the stigma of chronic mental illness. CONCLUSION: This study provides further evidence of the gender gap in depression care, identifies possible contributing factors, and suggests avenues for future research.

**OBJECTIVE:** The purpose of this study is to examine the incidence and clinical predictors of symptom deterioration in depressed elderly patients who have responded to treatment in primary care. **METHOD:** A cohort study of 901 older adults from 18 primary care clinics in five states who met Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) criteria for major depression and/or dysthymia at baseline interview, had participated in a trial of collaborative care for depression compared to usual care, and had improved to the point of no longer meeting criteria for major depression at 12 months were observed for one year (18 and 24 months) after enrolling in the original study. **RESULTS:** A total of 40% of patients met criteria for significant depressive symptom deterioration over the 12- to 24-month observational period. Among usual-care patients, higher initial severity of depression and a higher number of residual DSM-IV depressive symptoms at 12 months were significant predictors of symptom deterioration. No variables predicted symptom deterioration in intervention patients. **CONCLUSIONS:** There is a high rate of symptom deterioration among elderly patients in primary care who are treated for depression. Efforts to improve long-term outcomes of older patients with major depression and/or dysthymia should focus on providing more intensive treatment and follow up for patients with residual depressive symptoms.


**OBJECTIVE:** Older adults with low incomes rarely use mental health care, and untreated depression is a serious problem in this population. This study examined whether a collaborative care model for depression in primary care would increase use of depression treatment and treatment outcomes for low-income elderly adults as well as for higher-income older adults. **METHODS:** A multisite randomized clinical trial that included 1,801 adults aged 60 years and older who were diagnosed as having depression compared collaborative care for depression with treatment as usual in primary care. Participants were divided into groups by income definitions on the basis of criteria used by the U.S. Census Bureau and the U.S. Department of Housing and Urban Development (HUD). A total of 315 participants (18%) were living below the poverty level by the U.S. Census criteria, 261 (15%) were living below 30% of the area median income (AMI) (HUD criteria) but above poverty, 438 (24%) were living between 30% and 50% of the AMI, 327 (18%) were living between 50% and 80% of the AMI, and 460 (26%) were not poor. The income groups were compared on service use, satisfaction, depression severity, and physical health at baseline and at three, six, and 12 months after being randomly assigned to collaborative care or usual care. **RESULTS:** The benefits for low-income older adults were similar to those for middle- and higher-income older adults. At 12 months, intervention patients in all economic brackets had significantly greater rates of depression care for both antidepressant medication and psychotherapy, greater satisfaction, lower depression severity, and less health-related functional
impairment than usual care participants. CONCLUSIONS: Lower-income older adults can experience benefits from collaborative management of depression in primary care similar to those of higher-income older adults, although they may require up to a year to reap physical health benefits.


BACKGROUND: Recent models integrating depression care management into primary care have demonstrated improved clinical outcomes and patient satisfaction. To date, none have examined psychiatric-mental health clinical nurse specialists (PCNSs) as providers in primary care. OBJECTIVES: To describe patient perception of and satisfaction with care provided by PCNSs, to compare patients with high versus lower levels of satisfaction and clinical outcomes, and to explore patient preference for future depression treatment and willingness to copay for PCNS services. STUDY DESIGN: A postintervention survey after a 12-month late-life depression care program delivered by a PCNS in primary care. Participants were 105 adults age 60 or older with major depression and/or dysthymia. RESULTS: A majority of patients perceived PCNS care as excellent, were highly satisfied with the relationship with the PCNS, would seek future treatment with the PCNS, preferred the primary care physician’s office for mental health care, and reported improved clinical and functional outcomes. CONCLUSIONS: PCNS services are well received by patients in the primary care setting. PCNSs are uniquely qualified to help patients achieve significant clinical improvement in collaboration with their primary care providers.


OBJECTIVE: To ascertain the effects of baseline pain on depression outcomes in a collaborative care treatment trial of depression for older adults. METHODS: A secondary data analysis of 1,801 depressed older adults in the Improving Mood: Providing Access to Collaborative Treatment trial, comparing groups with no/low and high baseline pain using two pain interference variables. The primary outcome was a 50% reduction in depression score at 12 months. Analyses were performed separately for usual care and intervention groups, then examined for interactions. RESULTS: In the treatment-as-usual group, there was no significant association of baseline pain status with depression outcomes. In the intervention group, higher pain interference was significantly associated with worse depression response: 48.9% of those with no/low pain interference achieved a depression response, compared with 37.4% of those with high pain (chi² = 12.27, df = 1, p = 0.001). Arthritis pain interference showed a similar association (chi² = 4.04, df = 1, p = 0.044). Controlling for sociodemographic and baseline characteristics did not diminish this association. A significant interaction effect on depression response was found between pain interference and the intervention, suggesting that higher pain differentially impairs depression response in collaborative care compared to usual care. CONCLUSION: A collaborative care intervention was significantly more
successful in older adults with less pain. Pain may be an important barrier to improvement of depression and attending to pain might produce better depression outcomes.


OBJECTIVE: To describe the course of suicide ideation (SI) in primary-care based late-life depression treatment, identify predictors of SI, characterize the dynamic relationship between depression and SI, and test the hypothesis that collaborative care decreases the likelihood of reporting SI by decreasing the severity of depressive symptoms. METHODS: This was a secondary analysis of a randomized controlled trial comparing collaborative care to usual care for late-life depression. Participants were 1,801 adults age 60 and older from eight diverse primary-care systems. Depression was measured using the Hopkins Symptoms Checklist (HSCL-20). SI was operationalized using one item from the HSCL-20. Predictors of incident SI were identified by a series of univariate analyses followed by multiple logistic regression. A mediator analysis was conducted to test the hypothesis that the effect of collaborative care on SI can be ascribed to the intervention's effect on depressive symptoms. RESULTS: The prevalence of SI was 14% (N = 253); the cumulative incidence over 24 months was 21% (385). The likelihood that SI emerged after baseline was highly dependent on change in depression (odds ratio: 5.38, 95% confidence interval: 3.93-7.36, df = 81, t = 10.66, p <0.0001). As hypothesized, the effect of collaborative care on SI was mediated by the treatment's effect on depression. CONCLUSION: SI is not uncommon in depressed older adults being treated in primary care. The likelihood that depressed older adults will report SI is strongly determined by the course of their depression symptoms. Providers should monitor SI throughout the course of depression treatment.


PURPOSE: We compared a primary-care-based psychotherapy, that is, problem-solving therapy for primary care (PST-PC), to community-based psychotherapy in treating late-life major depression and dysthymia. DESIGN AND METHODS: The data here are from the IMPACT study, which compared collaborative care within a primary care clinic to care as usual in the treatment of 1,801 primary care patients, 60 years of age or older, with major depression or dysthymia. This study is a secondary data analysis (n = 433) of participants who received either PST-PC (by means of collaborative care) or community-based psychotherapy (by means of usual care). RESULTS: Older adults who received PST-PC had more depression-free days at both 12 and between 12 and 24 months (beta = 47.5, p <.001; beta = 47.0, p <.001), and they had fewer depressive symptoms and better functioning at 12 months (beta(dep) = -0.36, p < .001; beta(func) = -0.94, p < .001), than those who received community-based psychotherapy. We found no differences at 24 months.
IMPLICATIONS: Results suggest that PST-PC as delivered in primary care settings is an effective method for treating late-life depression.


STUDY OBJECTIVES: Insomnia and depressive disorders are significant health problems in the elderly. Persistent insomnia is a risk factor for the development of new-onset and recurrent major depressive disorder (MDD). Less clear is whether persistent insomnia may perpetuate MDD and/or dysthymia. The present longitudinal study examines the relationship of insomnia to the continuation of depression in the context of an intervention study in elderly subjects. DESIGN: Data were drawn from Project IMPACT, a multisite intervention study, which enrolled 1801 elderly patients with MDD and/or dysthymia. In the current study, subjects were assigned to an insomnia-status group (Persistent, Intermediate, and No Insomnia) based on insomnia scores at both baseline and 3-month time points. Logistic regressions were conducted to determine whether Persistent Insomnia was prospectively associated with increased risk of remaining depressed and/or achieving a less than 50% clinical improvement at 6 and at 12 months compared with the No Insomnia reference group. The Intermediate Insomnia group was compared with the other 2 groups to determine whether a dose-response relationship existed between insomnia type and subsequent depression. SETTING: Eighteen primary clinics in 5 states. PARTICIPANTS: Older adults (60+) with depression. MEASUREMENTS AND RESULTS: Overall, patients with persistent insomnia were 1.8 to 3.5 times more likely to remain depressed, compared with patients with no insomnia. The findings were more robust in patients receiving usual care for depression than in patients receiving enhanced care. Findings were also more robust in subjects who had MDD as opposed to those with dysthymia alone. CONCLUSIONS: These findings suggest that, in addition to being a risk factor for a depressive episode, persistent insomnia may serve to perpetuate the illness in some elderly patients and especially in those receiving standard care for depression in primary care settings. Enhanced depression care may partially mitigate the perpetuating effects of insomnia on depression.


BACKGROUND: Depression occurs in 5-10% of older adults and there are nearly 6 million informal caregivers aged 65 or older. Prior research has focused on vulnerability to psychological distress in caregivers. Research has not addressed the caregiving burden of depressed elderly patients or how that burden affects depression treatment outcomes. AIMS: To describe the self-reported caregiving burden in a large, representative cohort of depressed elderly patients and compare depression treatment outcomes between caregivers and non-caregivers. METHODS: Univariate and multiple regression analyses were performed comparing 24-month depression outcomes (measured as depression free days) in those providing care at
any time over the 24-month trial to those who never reported a caregiving burden. RESULTS: At 3, 6, 12, 18, and 24 months, nearly 10% of cohabitating elderly depressed patients provided care for basic activities such as bathing or dressing while nearly 20% reported providing care for other activities such as making phone calls or taking medication. Over 24 months, after adjusting for marital status, intervention status, and number of medical comorbidities, those reporting any caregiving burden had over 30 more days with depression compared to those with no caregiving burden. The IMPACT collaborative care model did not modify the effect of caregiving on depression outcomes. CONCLUSION: Caregiving is common in depressed older adults and appears to affect response to depression treatment. In the future, interventions for depressed older adults should consider and specifically address caregiving activities in addition to specific depression treatment.


OBJECTIVE: To determine whether a subset of depressive symptoms could be identified to facilitate diagnosis of depression in older adults in primary care. METHOD: Secondary analysis was conducted on 898 participants aged 60 years or older with major depressive disorder and/or dysthymic disorder (according to DSM-IV criteria) who participated in the Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) study, a multisite, randomized trial of collaborative care for depression (recruitment from July 1999 to August 2001). Linear regression was used to identify a core subset of depressive symptoms associated with decreased social, physical, and mental functioning. The sensitivity and specificity, adjusting for selection bias, were evaluated for these symptoms. The sensitivity and specificity of a second subset of 4 depressive symptoms previously validated in a midlife sample was also evaluated. RESULTS: Psychomotor changes, fatigue, and suicidal ideation were associated with decreased functioning and served as the core set of symptoms. Adjusting for selection bias, the sensitivity of these 3 symptoms was 0.012 and specificity 0.994. The sensitivity of the 4 symptoms previously validated in a midlife sample was 0.019 and specificity was 0.997. CONCLUSION: We identified 3 depression symptoms that were highly specific for major depressive disorder in older adults. However, these symptoms and a previously identified subset were too insensitive for accurate diagnosis. Therefore, we recommend a full assessment of DSM-IV depression criteria for accurate diagnosis.


BACKGROUND: Depression is common among older cancer patients, but little is known about the optimal approach to caring for this population. This analysis evaluates the effectiveness of the Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) program, a stepped care management program for depression in primary care patients who had an ICD-9 cancer diagnosis. METHODS: Two hundred fifteen cancer patients were identified from the 1,801
participants in the parent study. Subjects were 60 years or older with major depression (18%), dysthmic disorder (33%), or both (49%), recruited from 18 primary care clinics belonging to 8 health-care organizations in 5 states. Patients were randomly assigned to the IMPACT intervention (n = 112) or usual care (n = 103). Intervention patients had access for up to 12 months to a depression care manager who was supervised by a psychiatrist and a primary care provider and who offered education, care management, support of antidepressant management, and brief, structured psychosocial interventions including behavioral activation and problem-solving treatment. RESULTS: At 6 and 12 months, 55% and 39% of intervention patients had a 50% or greater reduction in depressive symptoms (SCL-20) from baseline compared to 34% and 20% of usual care participants (P = 0.003 and P = 0.029). Intervention patients also experienced greater remission rates (P = 0.031), more depression-free days (P < 0.001), less functional impairment (P = 0.011), and greater quality of life (P = 0.039) at 12 months than usual care participants. CONCLUSIONS: The IMPACT collaborative care program appears to be feasible and effective for depression among older cancer patients in diverse primary care settings.


OBJECTIVE: Chronic medical problems might amplify suicide risk in later life. Feelings of happiness may reduce this risk. We tested the hypothesis that happiness attenuates the association between number of self-reported chronic diseases and suicidal distress. METHODS: A sample of 1,801 depressed, primary care patients, 60 years of age or older, entering a clinical trial, were assessed for the presence of positive emotion, suicidal distress and self-reported chronic medical problems. RESULTS: Chronic medical problems are associated with suicide ideation and, as hypothesized, happiness attenuates the relationship between self-reported diseases and suicidal distress. CONCLUSIONS: Decreased risk for distressing thoughts of suicide in the context of medical illness is predicted by the presence of positive emotions. Our results suggest that treatments designed to help older primary care patients identify sources of joy and enhance happiness might decrease suicide risk.


OBJECTIVES: To compare the clinical outcomes of young-old patients (aged 60-74 years) and old-old patients (aged 75 years and older) who received collaborative care management for depression. DESIGN: Multisite randomized clinical trial. SETTING: Eighteen primary care clinics from eight healthcare organizations. PARTICIPANTS: Nine hundred six patients (N = 606 young-old; N = 300 old-old) with major depression and/or dysthymia who were randomized to receive collaborative care in the Improving Mood: Promoting Access to Collaborative Treatment trial. INTERVENTION: Patients had access for 12 months to a depression clinical specialist who coordinated depression care with their primary care physician.
MEASUREMENTS: Young-old and old-old patients were compared on process of
care and outcome variables. Process of care was determined by the type of
treatment and level of care received. Clinical outcomes included Symptom Checklist
(SCL)-20 depression scores, treatment response (defined as a >or=50% decrease in
the SCL-20 score from baseline), and complete remission (defined as a SCL-20 score
<0.5) at 3-, 6-, 12-, 18-, and 24-month follow-up. RESULTS: The process of care
variables did not significantly differ between the two age groups. Young-old
patients had similar treatment responses at initial follow-up (3 months) but were
significantly more likely to respond to treatment and meet complete remission
criteria than old-old patients at 6-, 12-, 18-, and 24-months. CONCLUSIONS: Young-
old and old-old patients who receive collaborative depression care have a similar
initial clinical response, but old-old patients may have a lower rate of long-term
treatment response and complete remission in the long run.

22. Apesoa-Varano EC, Hinton L, Barker JC, Unützer J. Clinician approaches and

OBJECTIVE: The aim of this study is to explore primary care physicians' (PCPs) and
depression care managers’ (DCMs) approaches to diagnosing and treating
depression in older men. The authors focus on older men because studies have
shown that they are undertreated compared with women and younger groups. The
authors contribute to previous research by identifying facilitators of care for older
men from the perspective of clinicians. METHODS: Participants in this study were
part of the Improving Mood-Promoting Access to Collaborative Treatment (IMPACT)
trial, an effectiveness study of collaborative care for late-life depression in 18
diverse primary care practices. Nine PCPs and 11 DCMs were interviewed to collect
information on specific roles in caring for depressed patients and their experiences
in working with depressed older men. All interviews were tape-recorded,
transcribed verbatim, and analyzed thematically in several steps using standard
qualitative data analysis techniques. RESULTS: The authors identified three general
approaches to building trust and talking about the depression: 1) an indirect
approach ("call it something else"), 2) a gradual approach ("building up to
depression"), and 3) a direct approach ("shock and awe"). The authors also found
specific strategies that PCPs and DCMs used to manage depression among elderly
male patients, such as increased monitoring of mood, treating somatic symptoms
first, medicalizing depression, and enlisting the cooperation of family. In our
interviews, enlisting family involvement was the most prominent strategy used by
clinicians. CONCLUSIONS: A variety of approaches and strategies are used by
clinicians for diagnosing and treating depressed older men. Clinicians change
strategies as a response to a patient’s compliance with treatment and the decision
about which strategy to pursue is usually made on an "on-the-go" basis throughout
the course of clinician-patient interaction. Based on clinicians’ experience,
depression management requires concerted efforts and persistence, and the family
seems to play an important role in how older men receive the diagnosis of
depression and adhere to clinicians' prescribed treatment. However, more research
is needed to discover the best way of engaging and working with family members
to facilitate effective depression care for older adults.

BACKGROUND: This article analyzed data from the intervention arm of a large treatment trial to demonstrate the importance of clinical severity, course, comorbidity, and treatment response in patient prognosis. METHODS: This is a secondary analysis of data from a large primary care-based geriatric depression treatment trial that analyzes outcomes from the measurement-based stepped-care intervention arm (N=871 patients) to determine: whether increasing severity levels of depression at baseline were linked with other factors associated with poor depression outcomes such as double depression, anxiety, medical disorders, and high levels of neuroticism and pain; and whether patients with increasing levels of depressive severity would have more intervention visits and treatment trials based on a stepped-care algorithm, but would be less likely to reach remission and have a greater likelihood of re-emerging depression in the year after intervention. RESULTS: Increasing levels of depression severity were a robust predictor of lack of remission and were associated with other clinical variables that have been associated with lack of remission in earlier studies such as double depression, anxiety, medical comorbidity, high neuroticism levels, and chronic pain. Patients with higher levels of severity received significantly more intervention visits, more months of antidepressant treatment and more antidepressant trials, but had fewer depression-free days during the 12-month intervention and in the postintervention year. CONCLUSION: Patients with higher levels of depression severity had worse clinical outcomes despite receiving greater intensity of treatment. A new classification of depression is proposed based on clinical severity, course of illness and treatment experience.


OBJECTIVE: Several common methods for measuring treatment response present a snapshot of depression symptoms. The construct of estimated depression-free days (DFDs) simultaneously captures treatment outcome and estimates the patient’s experience of depression over time. The study compared this measure with traditional measures used in depression treatment research. METHODS: This secondary data analysis was based on data from the Improving Mood-Promoting Access to Collaborative Treatment trial, a multisite depression treatment study conducted in 18 primary care clinics in five states and representing eight health care systems. The sample of older adults (N=906) had been randomly assigned to receive collaborative care for depression. Participants were aged 60 or older and met criteria for major depressive disorder, dysthymia, or both. Exclusion criteria included severe cognitive impairment, active substance abuse, active suicidal behavior, severe mental illness, and active treatment from a psychiatrist. The Patient Health Questionnaire (PHQ-9) and the Hopkins Symptom Checklist (HSCL-20) were used as outcome measures at four assessment points (baseline, three months, six months, and 12 months). Outcomes were computed for relative change, standardized differences, the proportion of improvement in depression, and DFDs. RESULTS: Using four assessment points improved the agreement between DFDs and the
course of symptom change between pre- and posttest measures. CONCLUSIONS: The DFD is a valid measure for estimating treatment outcomes that reflects the course of symptom change over time. When multiple assessments were conducted between the pre- and posttest periods, DFDs incorporated additional data yet remained easily interpreted. The DFD should be considered for reporting outcomes in depression research.


Objective. To design a bundled case rate for Collaborative Care for Depression (CCD) that aligns incentives with evidence-based depression care in primary care. Data Sources. A clinical information system used by all care managers in a randomized controlled trial of CCD for older primary care patients. Study Design. We conducted an empirical investigation of factors accounting for variation in CCD resource use over time and across patients. CCD resource use at the patient-episode and patient-month levels was measured by number of care manager contacts and direct patient contact time and analyzed with count data (Poisson or negative binomial) models. Principal Findings. Episode-level resource use varies substantially with patient’s time in the program. Monthly use declines sharply in the first 6 months regardless of treatment response or remission status, but it remains stable afterwards. An adjusted episode or monthly case rate design better matches payment with variation in resource use compared with a fixed design. Conclusions. Our findings lend support to an episode payment adjusted by number of months receiving CCD and a monthly payment adjusted by the ordinal month. Nonpayment tools including program certification and performance evaluation and reward systems are needed to fully align incentives.


OBJECTIVE: Depressed patients with comorbid post-traumatic stress disorder (PTSD) are more functionally impaired and may take longer to respond to depression treatment than patients without PTSD. This study examined the long-term effects of PTSD on depression severity, treatment response, and health care costs among older adults. METHODS: Patients were recruited from 18 primary care clinics in five states. A total of 1801 patients aged 60 years or older with major depression or dysthymia were randomized to Improving Mood Promoting Access to Collaborative Treatment (IMPACT) collaborative care or usual care. The study included 191 (10.6%) subjects who screened positive for PTSD. Depression severity, assessed by the Hopkins Depression Symptom Checklist, was used to estimate depression-free days (DFDs) over 24 months. Total health care costs included inpatient, outpatient, and pharmacy costs. RESULTS: Depressed patients with PTSD had higher depression severity than patients without PTSD symptoms at baseline. Over 2 years, intervention patients with PTSD symptoms had relatively the same benefits from collaborative care (99 more DFDs than usual care patients) as patients without PTSD.
(108 more DFDs than usual care) \( (p = 0.85) \). Total health care costs did not differ significantly for depressed patients with and without PTSD symptoms.

CONCLUSION: Depressed older adults with PTSD symptoms were more depressed at baseline, but collaborative care (compared to usual care) produced similar improvements in depression severity in both groups. This reduction of depression symptoms was observed for up to 12 months after the intervention ended, suggesting that long-term improvements in depression are possible with collaborative care in patients with and without PTSD symptoms.


BACKGROUND: Activity scheduling is an established component of evidenced-based treatment for late-life depression in primary care. We examined participant records from the Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) trial to identify activity scheduling strategies used in the context of successful depression care management (CM), associations of activity scheduling with self-reported activity engagement, and depression outcomes. METHODS: This study used observational mixed methods analysis of 4335 CM session notes from 597 participants in the intervention arm of the IMPACT trial. Grounded theory was used to identify 17 distinct activity categories from CM notes. Logistic regression was used to evaluate associations between activity scheduling, activity engagement, and depression outcomes at 12 months. All relevant institutional review boards approved the research protocol. RESULTS: Seventeen distinct activity categories were generated. Most patients worked on at least one social and one solitary activity during their course of treatment. Common activity categories included physical activity (32%), medication management (22%), active-non-physical (19%), and passive (14%) activities. We found significant, positive associations between activity scheduling, self-reported engagement in activities at 12 months, and depression outcomes at 12 months. CONCLUSION: Older primary care patients in CM for depression worked on a wide range of activities. Consistent with depression theory that has placed emphasis on social activities, the data indicate a benefit for intentional social engagement versus passive social and solitary activities. Care managers should encourage patients to balance instrumental activities (e.g., attending to medical problems) with social activities targeting direct interpersonal engagement. Copyright (c) 2012 John Wiley & Sons, Ltd.


Correlates of patient disclosure of suicide ideation to a primary care or mental health provider were identified. Secondary analyses of IMPACT trial data were conducted. Of the 107 patients 60 years of age or older who endorsed thoughts of ending their life at least "a little bit" during the past month, 53 indicated they had disclosed these thoughts to a mental health or primary care provider during this period. Multiple logistic regression was used to identify predictors of disclosure to a
provider. Significant predictors included poorer quality of life and prior mental health specialty treatment. Among participants endorsing thoughts of suicide, the likelihood of disclosing these thoughts to a provider was 2.96 times higher if they had a prior history of mental health specialty treatment and 1.56 times higher for every one-unit decrease in quality of life. Variation in disclosure of thoughts of suicide to a mental health or primary care provider depends, in part, on patient characteristics. Although the provision of evidence-based suicide risk assessment and guidelines could minimize unwanted variation and enhance disclosure, efforts to routinize the process of suicide risk assessment should also consider effective ways to lessen potential unintended consequences.