



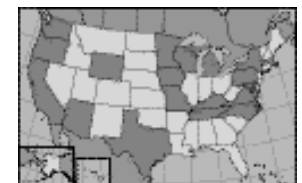
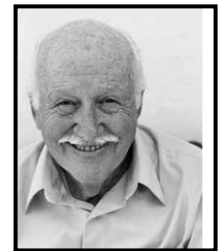
IMPACT

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

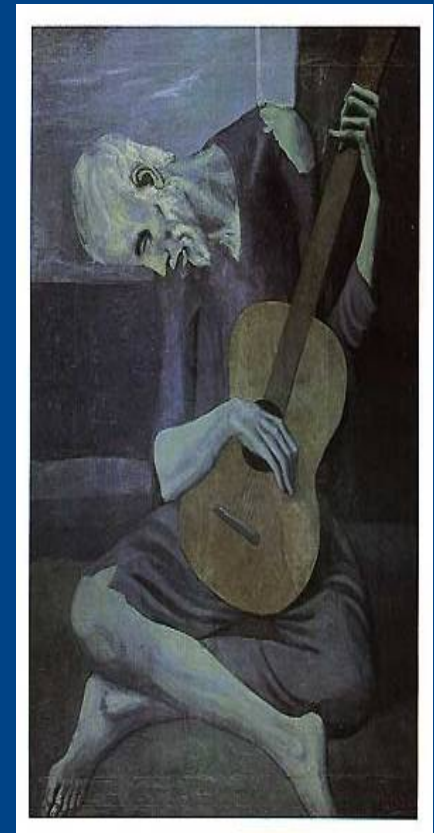
Pervasive depressed mood / sadness

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

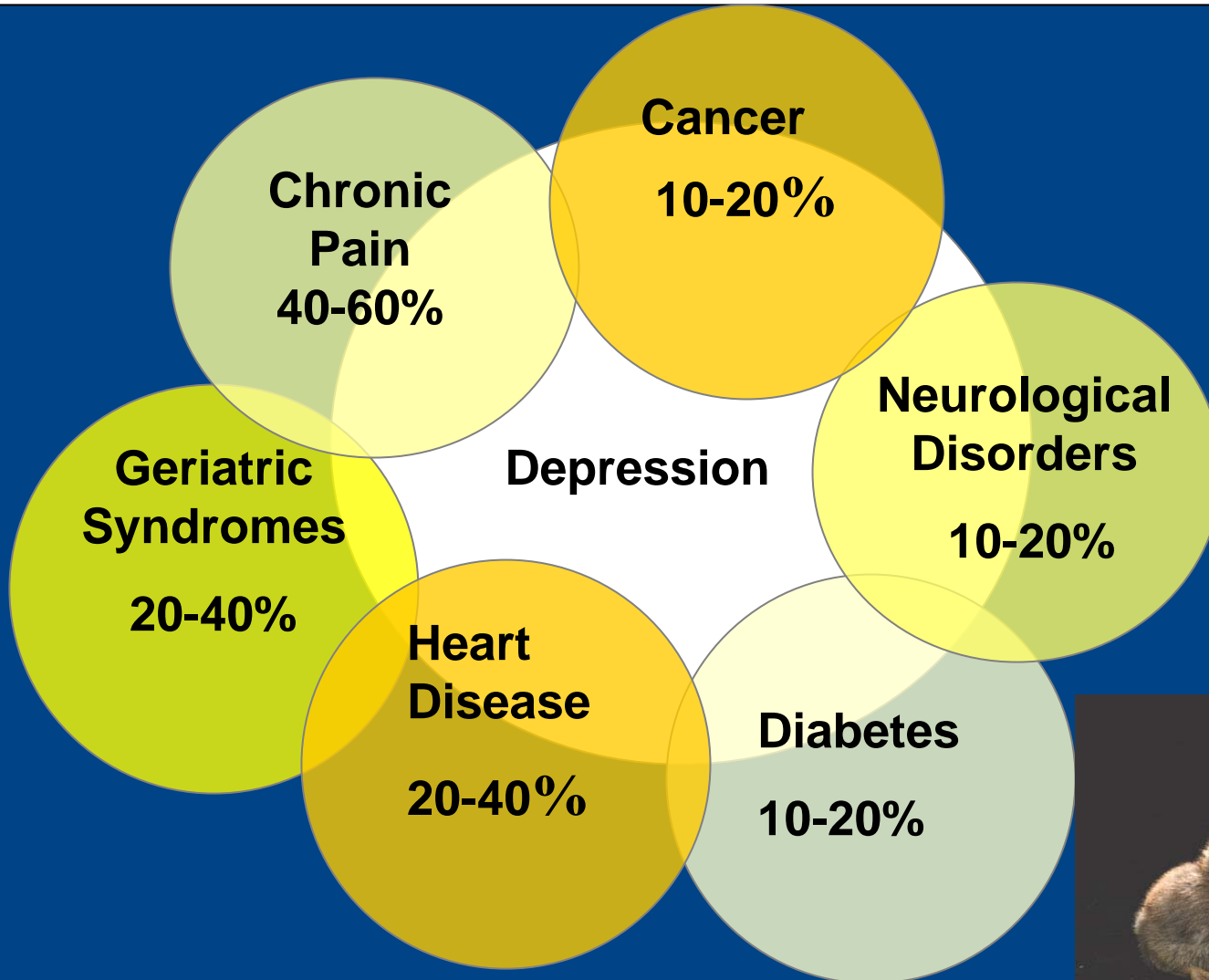
If untreated, depression can last for years.

Often complicated by chronic medical disorders, chronic pain, anxiety, cognitive impairment, grief/ bereavement, substance abuse



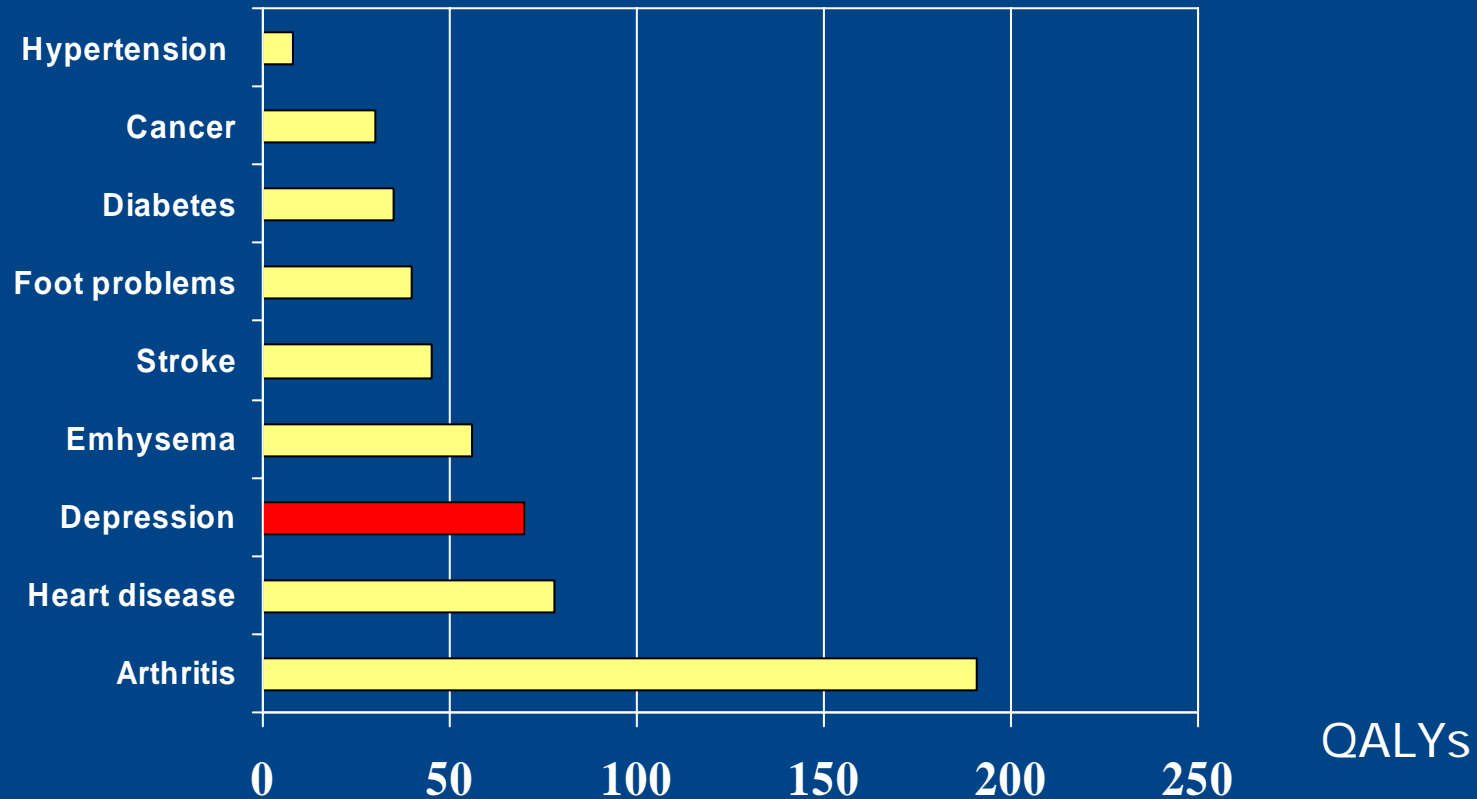


In late-life, depression is rarely the only health problem





Depression takes a large toll on quality of life



Quality Adjusted Life Years (QALYs) 'lost' in 2,558 older adults over 4 years.
Adjusted for age, gender, and comorbid medical conditions.

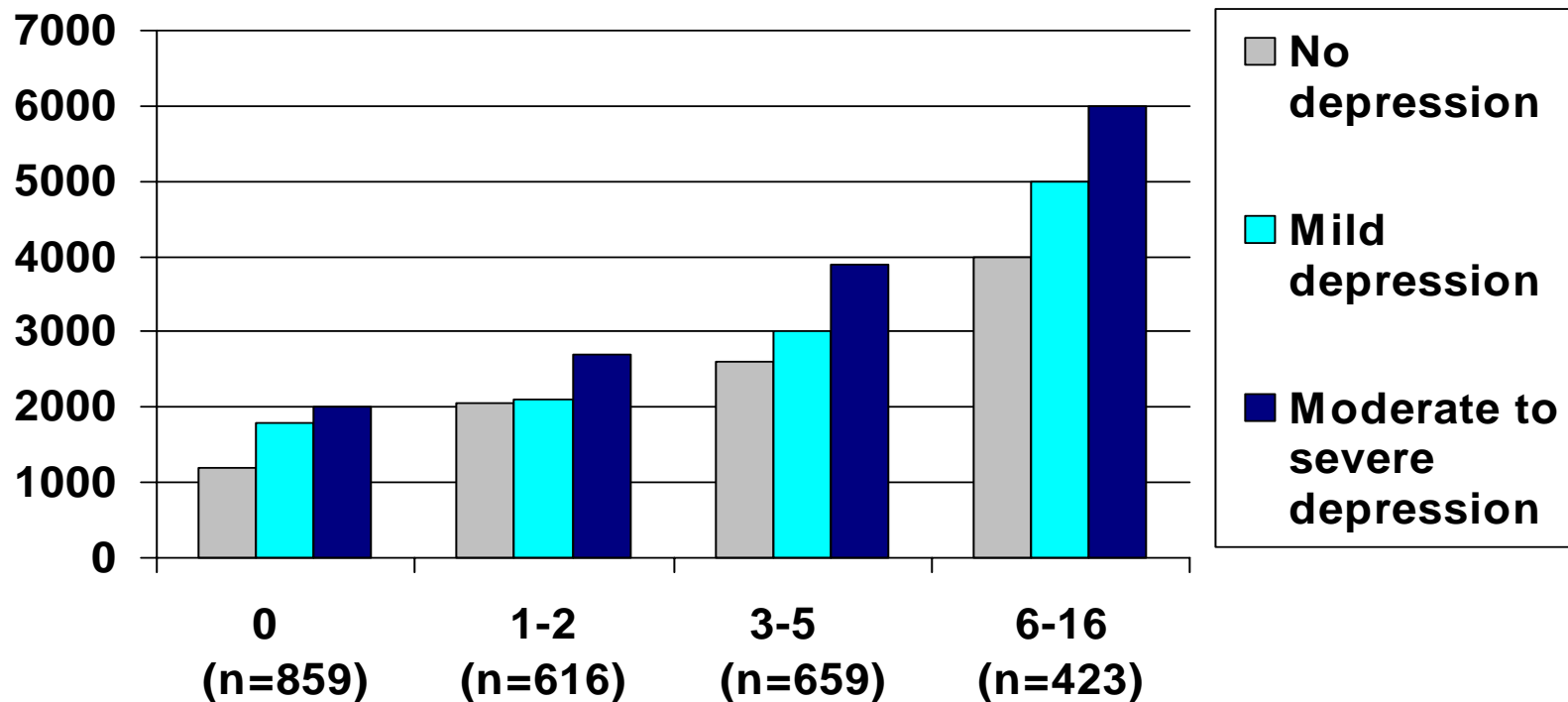
Unützer et al, Intl Psychogeriatrics, 2000



Depression is expensive:

Annual Health Costs in 1995 \$

\$

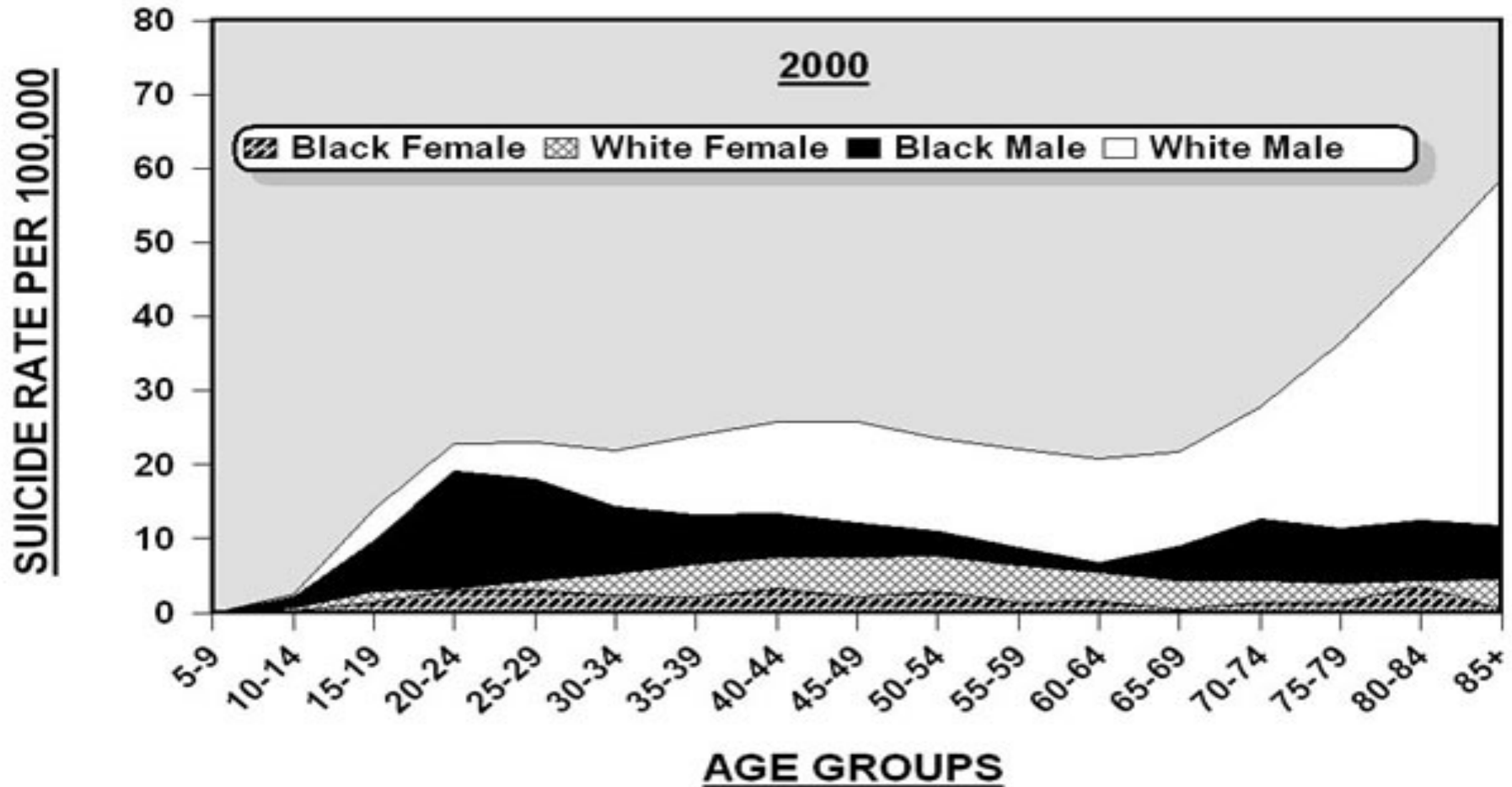


Chronic disease score



Depression is deadly

Older adults have the highest rate of suicide.



Source: National Institute of Mental Health
Data: Centers for Disease Control And Prevention, National Center For Health Statistics



Few Older Adults receive Effective Treatment

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
- But: only one in five older adults treated for depression in primary care improve



One-Year Service Use by Depressed Adults

AGE GROUP

18-64

65 +

(N = 1,382)

(N = 113)

Inpatient Mental Health
(MH)

4%

3%

ER visit for MH

4%

1%

Outpatient Mental
Health

25%

8%

Primary care visit
addressing

45%

49%

Mental Health Needs



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



IMPACT Study

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

Jürgen Unützer (PI), Sabine Oishi, Diane Powers, Michael Schoenbaum, Tom Belin, Linqi Tang, Ian Cook. PST-PC experts: Patricia Arean, Mark Hegel

Study sites

University of Washington / Group Health Cooperative

Wayne Katon (PI), Elizabeth Lin (Co-PI), Paul Ciechanowski

Duke University

Linda Harpole (PI), Eugene Oddone (Co-PI), David Steffens

Kaiser Permanente, Southern CA (La Mesa, CA)

Richard Della Penna (Co-PI), Lydia Grypma (Co-PI), Mark Zweifach, MD, Rita Haverkamp, RN, MSN, CNS

Indiana University

Christopher Callahan (PI), Kurt. Kroenke, Hugh. Hendrie (Co-PI)

UT Health Sciences Center at San Antonio

John Williams (PI), Polly Hitchcock-Noel (Co-PI), Jason Worchel

Kaiser Permanente, Northern CA

Enid Hunkeler (PI), Patricia Arean (Co-PI)

Desert Medical Group

Marc Hoffing (PI); Stuart Levine (Co-PI)

Study advisory board

Lisa Goodale (NDMDA), Rick Birkel (NAMI), Thomas Oxman, Kenneth Wells, Cathy Sherbourne, Lisa Rubenstein, Howard Goldman



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.



IMPACT Study Participants

	N = 1,801*
Female	65 %
Mean age (SD)	71.2 (7.5)
Non-white	23 %
African American	12 %
Latino	8 %
All others	3 %
Major depression + dysthymia	53 %
Cognitive impairment at screening	35 %
Mean chronic medical diseases (out of 10)	3.2
Antidepressant use in 3 months prior to study	42 %

* No significant baseline differences between intervention and usual care.



IMPACT Team Care Model



**Prepared, Pro-active
Practice Team**

**Effective
Collaboration**



**Informed, Activated
Patient**



Practice Support





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



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



Maintenance Treatment

After patient is 'in remission' from acute episode
fewer than 2 depressive symptoms
a PHQ-9 score less than 5

Make a relapse prevention plan in consultation with PCP

Follow the patient monthly

- by telephone (OR)
- in a maintenance group

**Bring patient back in for further evaluation & treatment
if symptoms recur**



Evidence-Based Depression Care Management

Identify and track depressed patients

- a. Case finding (screening, referral) -> confirm diagnosis
- b. Proactive follow-up & tracking (PHQ-9)

Change treatment if patient not improving

Relapse prevention plan for patients in remission

Enhance patient self-management

- a. Education
- b. Brief Therapy: Behavioral Activation / Problem Solving

Support additional treatment

- a. Primary Care (Antidepressant Medications)
- b. Specialty Mental Health Care / Psychotherapy

Mental health consultation for difficult cases

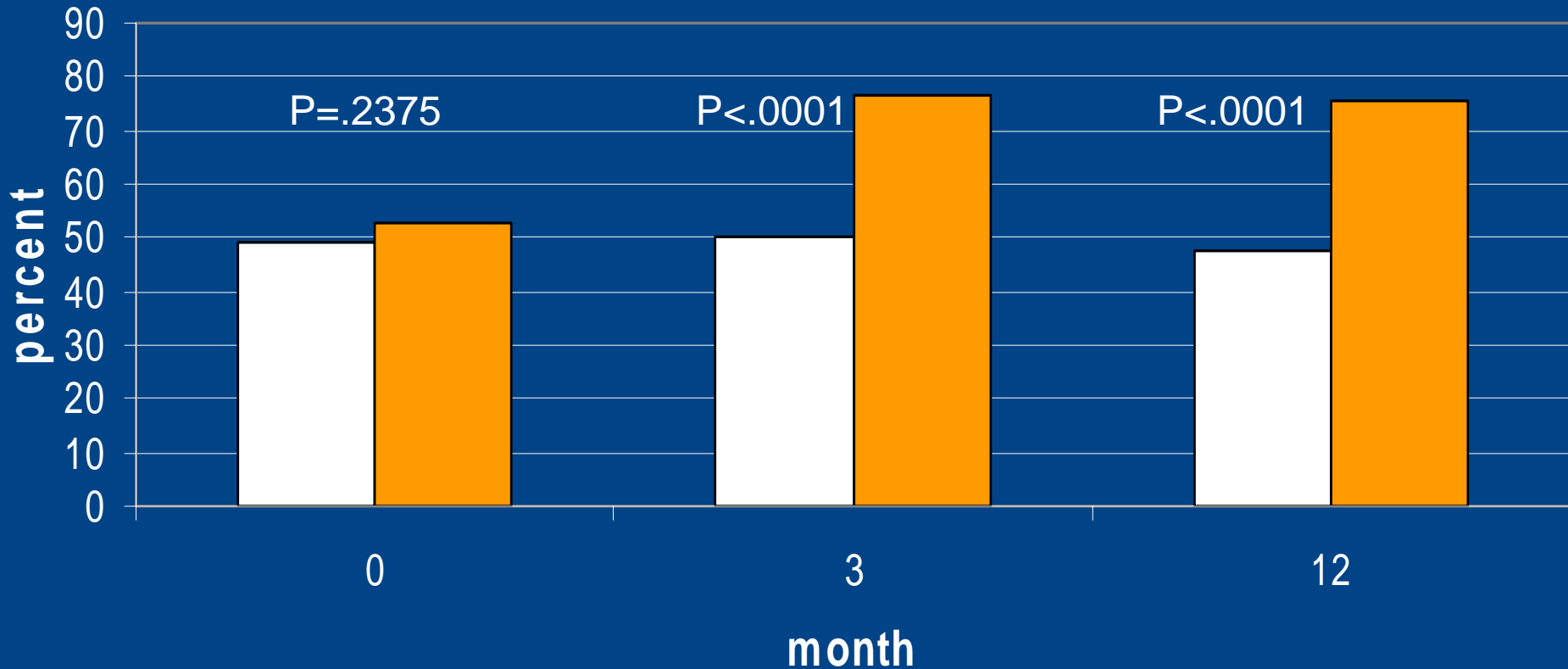
- a. Caseload supervision / consultation for care managers
- b. Psychiatry consultation for treatment nonresponders



Improved Satisfaction with Depression Care

(% Excellent, Very Good)

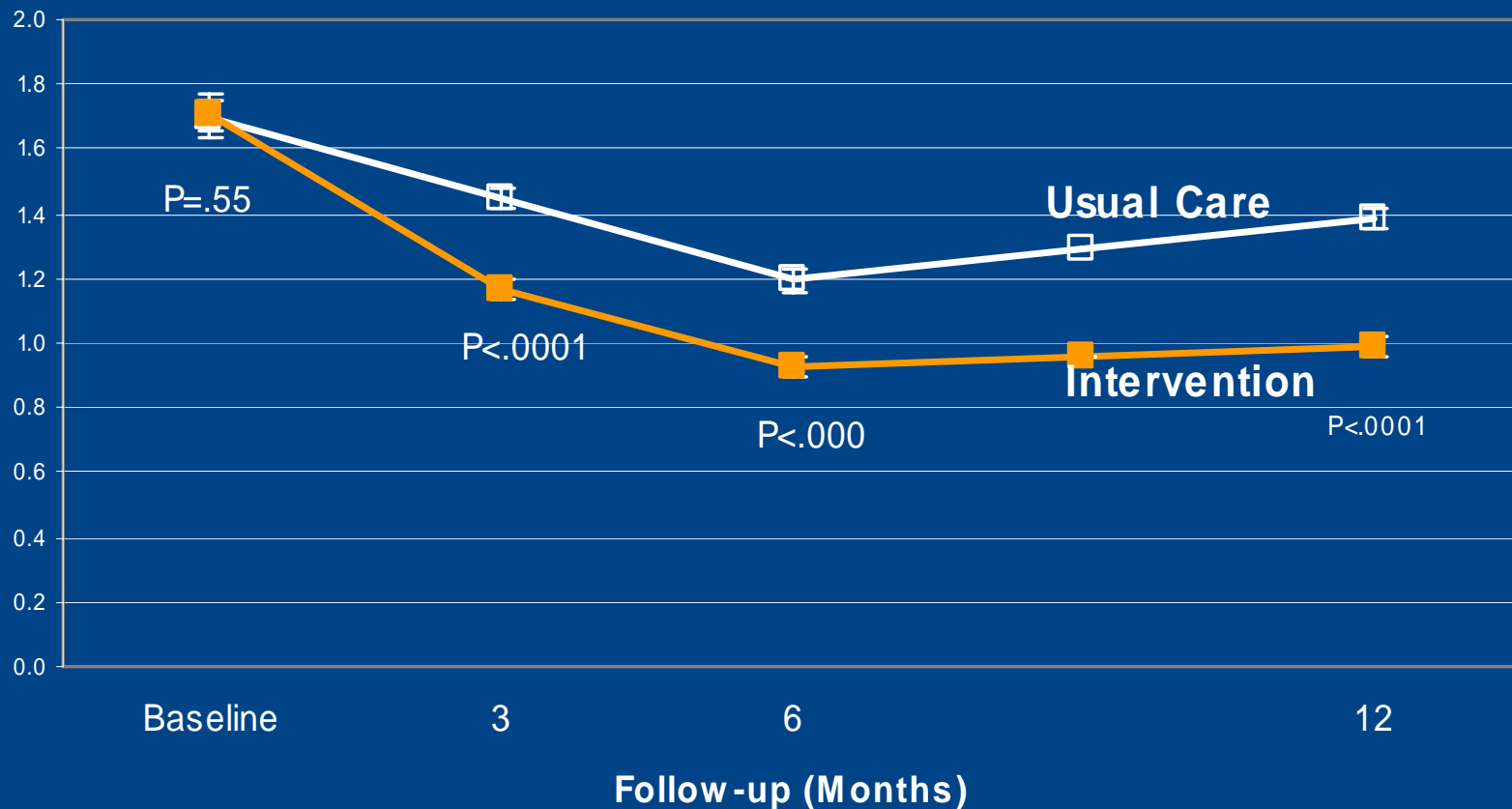
■ Usual Care ■ Intervention





IMPACT: Doubles the Effectiveness of Usual Care for Depression

Mean HSCL-20 Depression Severity Score



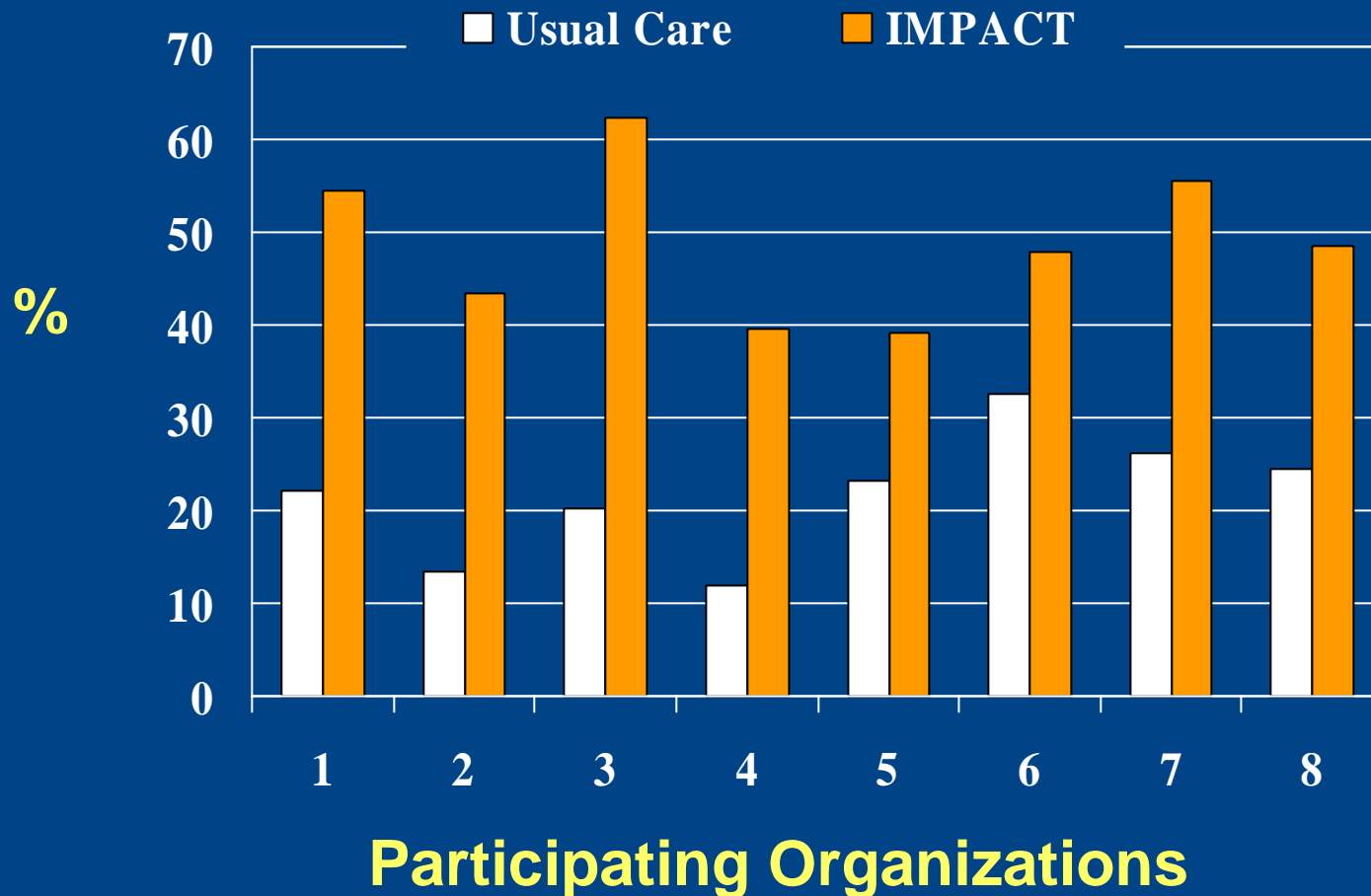
Unutzer. *JAMA* 2002; 288:2836-2845



Findings Robust Across Diverse Health Care Organizations

TREATMENT RESPONSE

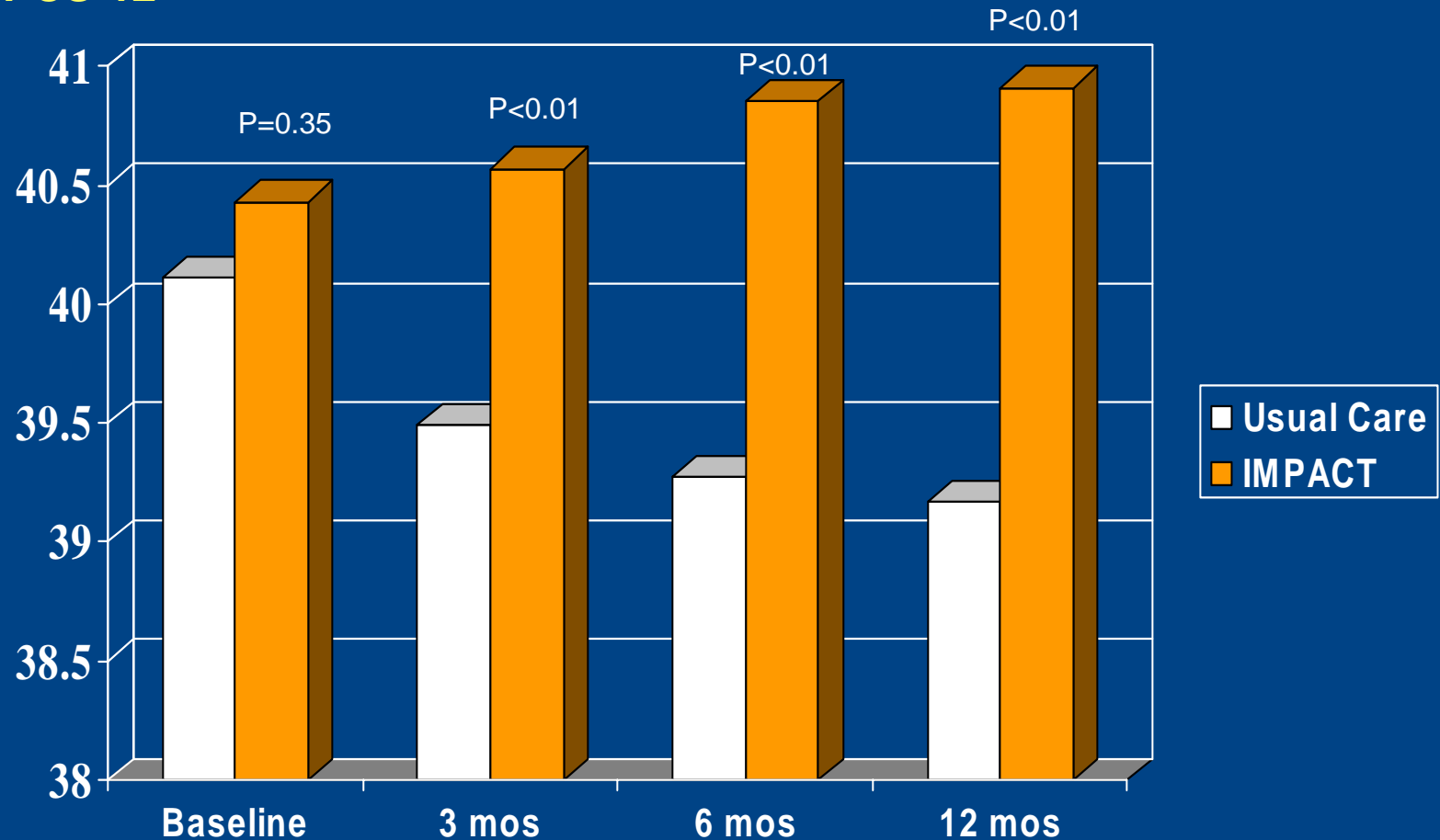
50 % or greater improvement in depression at 12 months





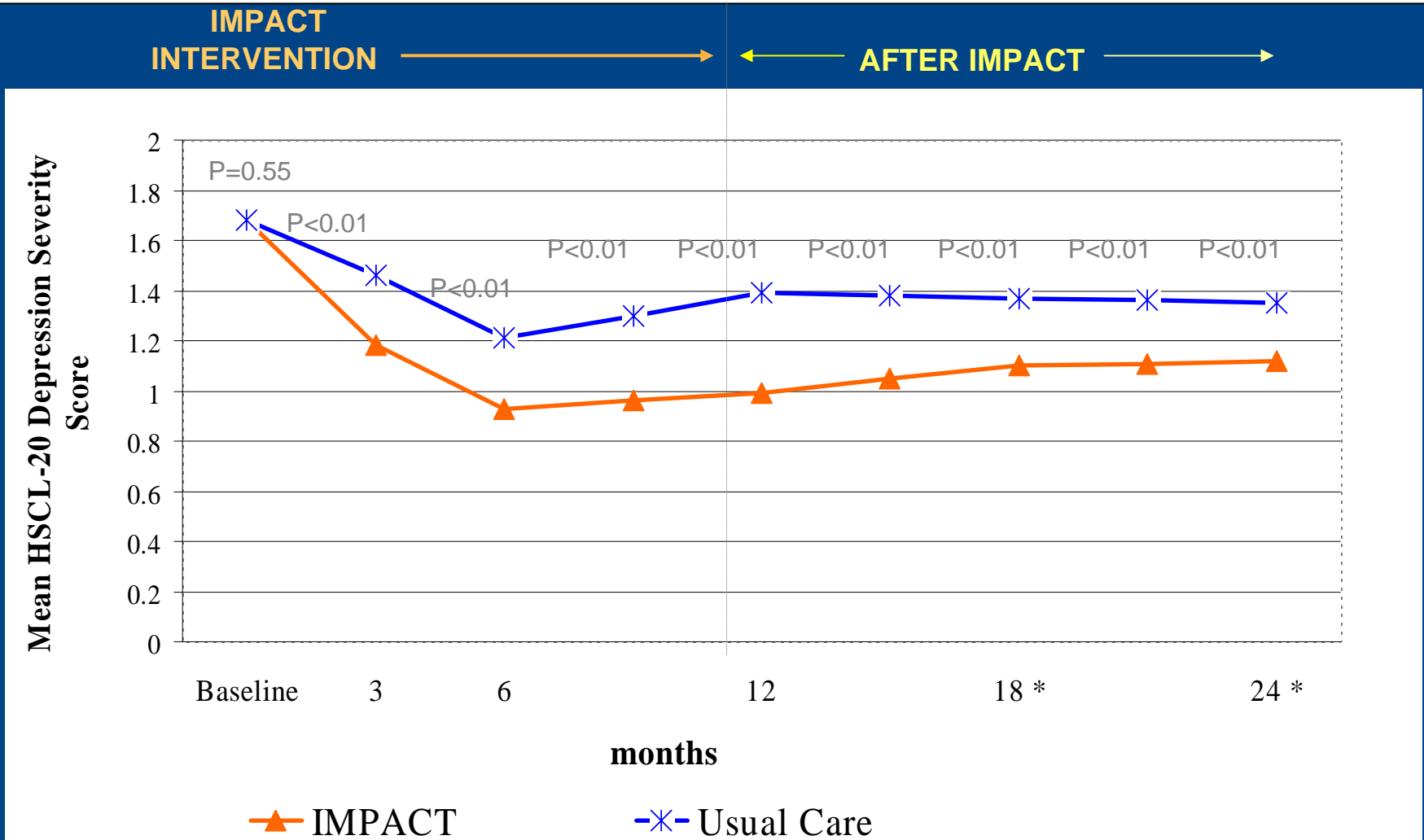
Better Physical Function

PCS-12





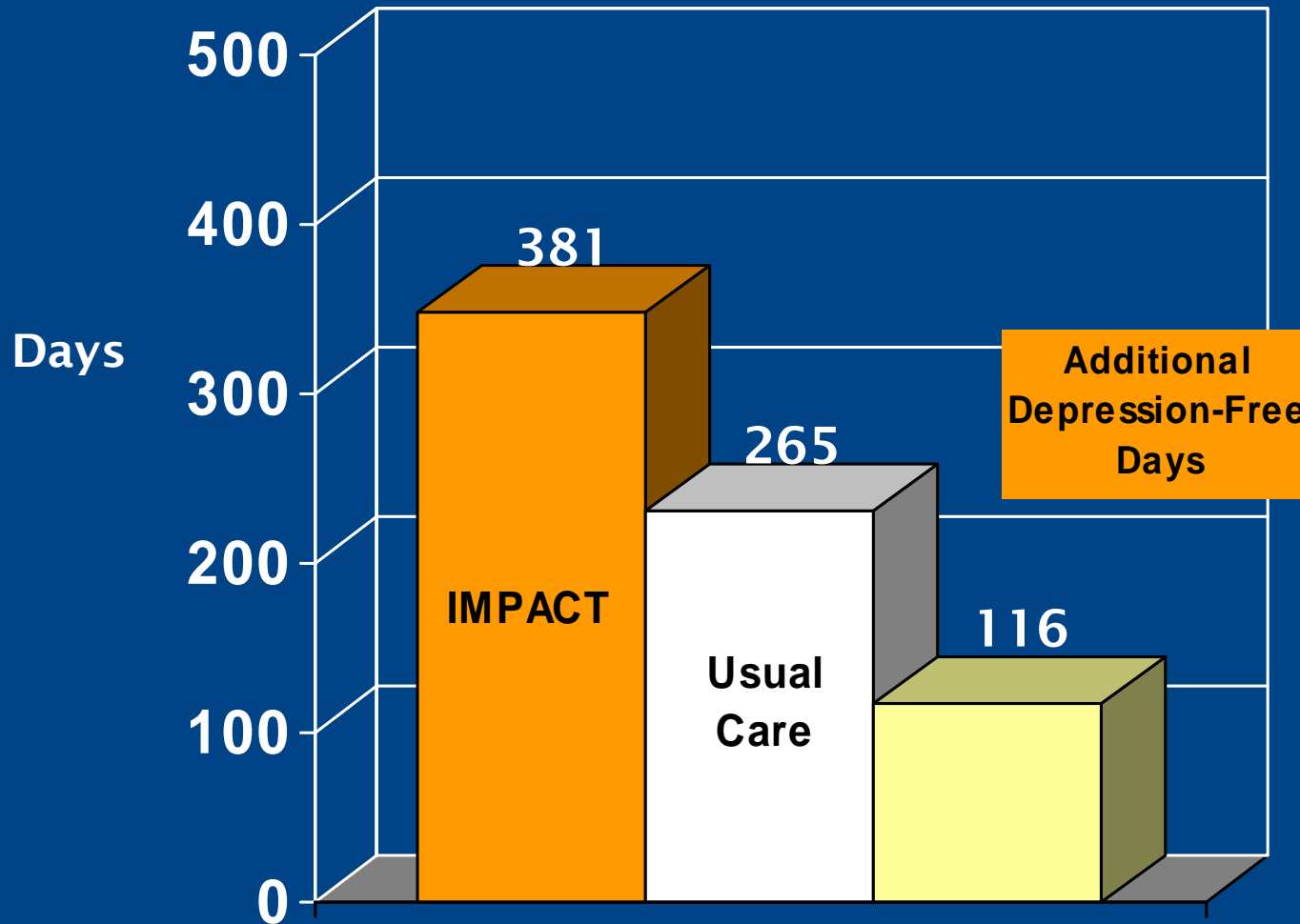
Effects persist even 1 year after the program ends





IMPACT in Diabetes

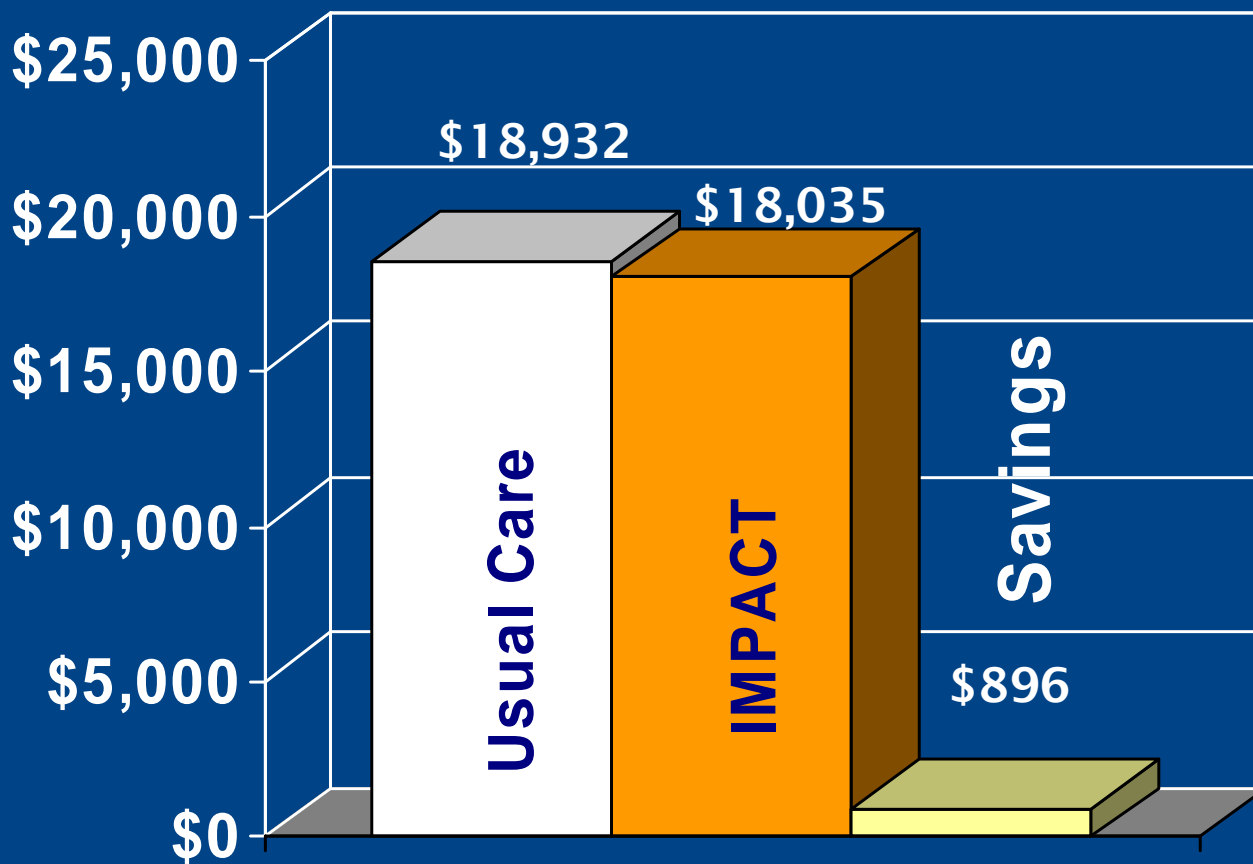
116 more Depression-Free Days over 2 Years





IMPACT in Diabetes

Lower Health Care Costs





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



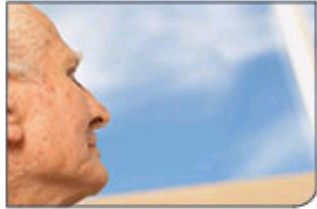
Photo credit: J. Lott, Seattle Times

“I got my life back”



Moving IMPACT from Research to Practice

John A. Hartford Foundation



IMPACT

Improving mood - promoting access to collaborative treatment for late life depression



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One in ten older adults visiting a physician suffers from depression.

IMPACT Depression care doubles the effectiveness of depression treatment.



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SUCCESS STORIES

Based on the strength of research evidence supporting the IMPACT model, health care organizations in several states have worked with us to implement the program.

Learn from colleagues who have implemented **IMPACT**

[Ask a question.](#)
[Offer advice.](#)



Most IMPACT materials, training, consultation and other assistance to adapt and implement IMPACT is offered FREE thanks to the generous support of the

JOHN A. HARTFORD FOUNDATION

Dedicated to Improving Health Care for Older Americans





IMPACT Dissemination

<http://impact-uw.org>

Resources for Implementation





Impact Training In Person and on the Web

**Trained over
500 providers**

IMPACT
Improving mood - promoting access to collaborative treatment for late life depression

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 - Tools
 - > Training
 - Expert Consultation
- IMPACT Community

Training

There are several options for clinicians and organizations who wish to train in the IMPACT model. These include a web-based training system, workshops, and [individual or case-based consultation](#).

Web-based Training Program:
coming soon

Training Workshops:

Date(s)	Location	Organization
April 9-10, 2006	Orlando, FL	National Council for Behavioral Healthca day IMPACT worksl
November 9, 2005	Renton, WA	Valley Medical Cen Medical Education I
October 29, 2005	Seattle, WA	University of Washii Nursing Education / Primary and Acute IMPACT workshop
		Collaborative Famili

IMPACT Web-based Learning
Web-based Training in the Evidence-based IMPACT Model of Depression Care

View Account: A. Bond / Log Out

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/or 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 blue circle icon indicates available CNE credits for that particular module.

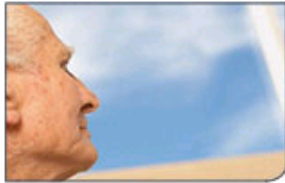
The Instructors

- Jürgen Unützer, 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 Community

<http://impact-uw.org>



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Participating Organizations

The map below shows states with individuals or organizations working with us to implement the IMPACT model or key components of the program. Moving your mouse over a state will tell you the total number for each state. [Contact us](#) if you would like to learn more about activities in your state.

