

Depression Care Management: Evidence-based Programs

IMPACT



Depression Care in Primary Care

Few older adults receive effective treatment for late-life depression. Of those with depression, only half are diagnosed, and only 20 to 40 percent of those who are diagnosed and treated improve substantially over 12 months in traditional treatment scenarios.

The primary care setting offers several advantages for treating depression in older adults:

- Older adults prefer the primary care setting. Because they are more comfortable, they more readily discuss depression and its treatment.
- There is an established provider/patient relationship.
- Depression care can be coordinated with medical care.

IMPACT: Bringing Team Care to Late-Life Depression

Between 1998 and 2003, approximately 1,800 older adults participated in a landmark study to determine the effectiveness of a collaborative care management program for late-life depression. The program, known as Improving Mood—Promoting Access to Collaborative Treatment (IMPACT), focused on older adults with major and/or chronic depression who were receiving treatment in primary care clinics. Instead of “usual care” consisting of an antidepressant prescription and/or referral to a mental health specialist, study participants received evidence-based integrated care delivered by a collaborative team.

At the heart of the IMPACT model are two key processes. One process calls for systematic diagnosis and tracking of depression outcomes using diagnostic and screening tools such as the PHQ-9 questionnaire. The PHQ-9 is ideal because it is brief, widely used in primary care, and shown to be effective with geriatric patients. Based on the systematic measurement of depression symptoms, the care team can adjust treatment. In fact, stepped care — changing care if the patient is not improving — is the second key process in the IMPACT model.

Stepped care relies on mental health consultation to help guide care for patients not responding as expected. As a result, IMPACT adds two additional team members — a care manager and consulting psychiatrist — to assist the primary care provider. The care manager provides follow-up to make sure patients don't fall through the cracks. He or she educates patients about depression, supports antidepressants prescribed by the primary care provider, offers evidence-based psychotherapy, and engages patients in behavioral activation/social event scheduling. The care manager receives weekly caseload supervision from the consulting psychiatrist, who focuses on difficult cases and patients not responding as expected.

Lasting Impact

The results of the original IMPACT study were published in the December 2002 issue of *The Journal of the American Medical Association* (Unützer et al). Researchers reported that a collaborative care approach to late-life depression was twice as effective as usual care, with most patients seeing a 50 percent or greater improvement in depression at 12 months. Patients also reported greater satisfaction with their depression care, improved physical functioning, and fewer thoughts of suicide. Finally, IMPACT reduced total health care costs by about \$3,300 per patient over

Collaborative Care Management of Late-Life Depression in the Primary Care Setting: A Randomized Controlled Trial

OBJECTIVE: To determine the effectiveness of the Improving Mood/Promoting Access to Collaborative Treatment (IMPACT) collaborative care management program for late-life depression.

DESIGN: Randomized controlled trial with treatment from July 1999 to August 2003.

SETTING: Twelve primary care clinics from 6 health care organizations in 6 states.

PARTICIPANTS: A total of 1,800 patients aged 60 years or older with major depression (75% of whom were female).

INTERVENTIONS: Patients were randomly assigned to the IMPACT intervention (n=900) or to the usual care (n=900). Intervention patients had access for up to 12 months to a depression care manager who was trained in a manual and primary care and mental health consultation, case management, and support of antidepressant management by the primary care provider and physician at the participating primary care setting. Usual care consisted of usual care.

MEASUREMENTS AND MAIN RESULTS: Assessment of baseline and at 6, 12, and 18 months in depression, depression treatment, satisfaction with care, functional impairment, and quality of life.

RESULTS: At 12 months, 45% of intervention patients had a 50% or greater reduction in depression symptoms from baseline compared with 19% of usual care patients (p < .001). At 12 months, 37% of intervention patients had a 50% or greater improvement in depression symptoms compared with 19% of usual care patients (p < .001). At 12 months, 45% of intervention patients had a 50% or greater improvement in depression symptoms compared with 19% of usual care patients (p < .001). At 12 months, 45% of intervention patients had a 50% or greater improvement in depression symptoms compared with 19% of usual care patients (p < .001).

CONCLUSIONS: The IMPACT collaborative care model appears to be feasible and effective in the primary care setting for late-life depression. A wide range of primary care settings may use this model.

KEY WORDS: Depression, collaborative care, primary care, randomized controlled trial.

INTRODUCTION: Depression is a common and disabling condition that affects approximately 10% of the adult population in the United States. It is a leading cause of disability and is associated with increased mortality, morbidity, and health care costs. Depression is often underdiagnosed and undertreated, particularly in older adults. The primary care setting offers several advantages for treating depression in older adults, including the presence of an established provider/patient relationship and the ability to coordinate depression care with medical care. However, few older adults receive effective treatment for late-life depression. The IMPACT study was designed to evaluate the effectiveness of a collaborative care management program for late-life depression in the primary care setting.



Visit the IMPACT website for more information about evidence-based depression care:

<http://www.impact-uw.org>



The IMPACT Implementation Toolkit

Planning

Careful planning is important to implement IMPACT. The following tools, which can be found on the IMPACT website, can help your organization determine its readiness and overall needs.

- **Key Components**—You can use this checklist to understand the critical pieces of IMPACT you will need to implement.
- **Needs Assessment**—Use this resource to stimulate your thinking and get a clear sense of the barriers or challenges facing your practice or organization as it thinks about adopting IMPACT.
- **Fidelity Measure**—Fidelity to IMPACT's key components can be a useful starting point, and this simple scale will help you establish a metric.
- **Organizational Change**—Refer to these articles about organizational change to gain a deeper understanding of what it takes to move IMPACT from research to practice.

Building the Team

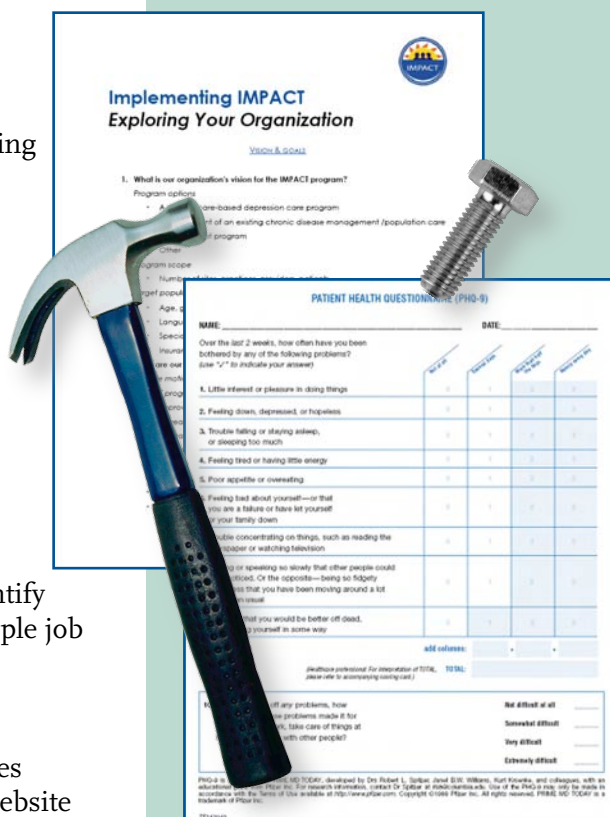
The IMPACT website includes worksheets that help organizations operationalize the activities of the different team members and identify changes in practice that will be necessary. The website also has sample job descriptions for the care manager and consulting psychiatrist.

Billing and Reimbursement

Billing and reimbursement for the kind of care management services provided in IMPACT can be complex. Resources on the IMPACT website can help you design a plan that will work for your organization.

Contact the IMPACT Implementation Center

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This Action Brief series is made possible through support from the National Association of Chronic Disease Directors, the National Council on Aging, and the Substance Abuse and Mental Health Services Administration.

This Action Brief complements a Webinar series on Healthy Aging and Depression as part of post-conference follow-up for the May 2008 conference, *Effective Programs to Treat Depression in Older Adults: Implementation Strategies for Community Agencies*, which was supported by the Centers for Disease Control and Prevention (CDC) Healthy Aging Program and organized by CDC's Prevention Research Centers-Healthy Aging Research Network.

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To learn more about related resources and initiatives, please visit the Healthy Aging Research Network at <http://www.prc-han.org>.