IMPACT:
Evidence-based depression treatment in primary care

Rita Haverkamp, MSN, APRN, BC, CNS
Virna Little, PsyD, LCSW-R, SAP
IMPACT: A Practical Approach to Team Based Depression Care

Virna Little, PsyD, LCSW-r
What is Depression?

Common: 20 million people / year suffer from a depressive illness

Disabling: a leading cause of disability (WHO)

Curable or treatable: appropriate treatment helps most people
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
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 $

Unützer et al, JAMA, 1997
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 Depressed Adults get Effective Treatment

- Only ~ half are treated.

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

- Many (if not most) prefer treatment by their primary care physician and PCPs prescribe majority of antidepressants.
Depression Treatment in Primary Care

- Only about half of depressed adults are treated
- Only 20 – 40 % show substantial improvement over 12 months
- Increasing use of antidepressants but treatment is often not effective
  - Early treatment dropout
  - Staying on ineffective meds too long
- Little access to evidence-based psychosocial treatments
Barriers to Effective Depression Care

Knowledge and attitudes

- “I didn’t know what hit me …”
- Stigma of mental illness: “I am not crazy”
- Fallacy of good reasons: “Isn’t depression just a part of ‘being sick’ or ‘normal aging’”
Barriers to Effective Depression Care

Challenges in primary care

- Limited time and competing priorities: medical illness, pain, life stressors
- 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”
- Poor access to mental health expertise
1970s – 1980s: screening for depression:
- Screening may be necessary but is not sufficient

1990s: improved referral to mental health care:
- Only 50% follow-up on referrals and few receive a full course of treatment

1993: AHCPR (now AHRQ) practice guidelines:
- Provider training based on guidelines: guidelines and provider education may be necessary but are not sufficient

Since 1990:
- Over 30 studies in the US and abroad document that systematic collaborative care is more effective than usual care for depression (Gilbody et al, Arch Int Med; 2006). Recent research also supports cost-effectiveness of this approach.
Evidence for Collaborative Care for Depression

Metaanalysis by Gilbody et al, Archives of Internal Medicine; 2006

37 trials of collaborative care for depression in primary care (US and Europe)
- cc consistently more effective than usual care
- successful programs include:
  - active care management (not case management)
  - support of medication management in primary care
  - psychiatric consultation

Unutzer et al, Report to President’s Commission on Mental Health; Psychiatric Services 2006.
Evidence-based ‘team care’ for depression

<table>
<thead>
<tr>
<th>TWO PROCESSES</th>
<th>TWO NEW ‘TEAM MEMBERS’</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Care Manager</td>
</tr>
</tbody>
</table>
| 1. Systematic diagnosis and outcomes tracking | - Patient education / self management support  
- Close follow-up to make sure pts don’t ‘fall through the cracks’ | - Caseload consultation for care manager and PCP (population-based)  
- Diagnostic consultation on difficult cases |
| e.g., PHQ-9 to facilitate diagnosis and track depression outcomes | | |
| 2. Stepped Care | - Support anti-depressant Rx by PCP  
- Brief counseling (behavioral activation, PST-PC, CBT, IPT)  
- Facilitate treatment change / referral to mental health  
- Relapse prevention | - Consultation focused on patients not improving as expected  
- Recommendations for additional treatment / referral according to evidence-based guidelines |
The IMPACT Study

Funded by
John A. Hartford Foundation
California Healthcare Foundation
IMPACT 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, Linqui Tang, Ian Cook. PST-PC experts: Patricia Arean, Mark Hegel

Study sites
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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

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
Design:
1,801 depressed older adults with major depression and/or dysthymia (chronic depression) randomly assigned to IMPACT or to Care as Usual

Usual Care:
Primary care or referral to specialty mental health

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 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

Treatment Protocol

(1) Education,
(2) Behavioral Activation / Pleasant Events Scheduling

AND

(3) a) Antidepressant medication
    usually an SSRI or other newer antidepressant

    OR

    b) Problem Solving Treatment in Primary Care
       (PST-PC)
       6-8 individual sessions followed by monthly group
       maintenance sessions

(4) Maintenance and Relapse Prevention Plan for patients in
    remission
Stepped Care

Systematic outcomes tracking
Patient Health Questionnaire (PHQ-9)

Treatment adjustment as needed
- based on clinical outcomes
- according to evidence-based algorithm
- in consultation with team psychiatrist

Relapse prevention
**PATIENT HEALTH QUESTIONNAIRE (PHQ-9)**

**NAME:** John Q. Sample

*Over the last 2 weeks, how often have you been bothered by any of the following problems? (use "✓" to indicate your answer)*

<table>
<thead>
<tr>
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<th>Not at all</th>
<th>Several Days</th>
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<td>1</td>
<td>✓</td>
<td>3</td>
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<td>2</td>
<td>3</td>
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<td>3. Trouble falling or staying asleep, or sleeping too much</td>
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<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

*add columns: 2 + 10 + 3 = 15*

**TOTAL:** 15

---

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all
- Somewhat difficult ✓
- Very difficult
- Extremely difficult

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## IMPACT Participant Characteristics

<table>
<thead>
<tr>
<th>Characteristic</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><strong>African American</strong></td>
<td>12 %</td>
</tr>
<tr>
<td><strong>Latino</strong></td>
<td>8 %</td>
</tr>
<tr>
<td><strong>All others</strong></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>
</tr>
</tbody>
</table>

* No significant baseline differences between intervention and usual care.
Improved Satisfaction with Depression Care

(% Excellent, Very Good)

Usual Care
IMPACT

P = .2375
P < .0001
P < .0001

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

Better Physical Function

SF-12 Physical Function Component Summary Score (PCS-12)

Fewer thoughts of suicide

Unutzer et al, JAGS 2006
IMPACT Findings Robust Across Diverse Organizations

50% or greater improvement in depression at 12 months

Participating Organizations
50% or greater improvement in depression at 12 months

Areán et al. Medical Care, 2005
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

“\textit{I got my life back}”

Photo credit: J. Lott, Seattle Times
IMPACT in the ‘real world’

Example: Kaiser Permanente

Pilot Study
- Compare 284 clients in ‘adapted program’ with 140 usual care patients and 140 intervention patients in the IMPACT study (Grypma et al, 2006)

Dissemination
- Implementing program at ~10 regional medical centers at KPSC and several clinics at KP Northwest
### Fewer care manager contacts

<table>
<thead>
<tr>
<th>Category</th>
<th>IMPACT Study</th>
<th>Post-Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total contacts</td>
<td>18.9</td>
<td>7.9</td>
</tr>
<tr>
<td>Clinic visits</td>
<td>10.2</td>
<td>5.1</td>
</tr>
<tr>
<td>Phone calls</td>
<td>8.7</td>
<td>2.8</td>
</tr>
</tbody>
</table>

IMPACT Remains Effective

>= 50% drop in PHQ-9 depression scores

## Long (4 year) Cost effectiveness

<table>
<thead>
<tr>
<th>Cost Category</th>
<th>Overall cost in $ (mean)</th>
<th>Intervention group cost in $ (mean, 95% CI)</th>
<th>Usual care group cost in $ (mean, 95% CI)</th>
<th>Difference in $ (mean, 95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMPACT Intervention cost</td>
<td>NA</td>
<td>522 (495, 550)</td>
<td>0 (0, 0)</td>
<td>522 (495, 550)</td>
</tr>
<tr>
<td>Outpatient mental health costs</td>
<td>661</td>
<td>558 (362, 753)</td>
<td>767 (561, 974)</td>
<td>-210 (-494, 75)</td>
</tr>
<tr>
<td>Pharmacy costs</td>
<td>7284</td>
<td>6,942 (6062, 7822)</td>
<td>7,636 (6287, 8984)</td>
<td>-694 (-2304, 916)</td>
</tr>
<tr>
<td>Other outpatient costs</td>
<td>14306</td>
<td>14,160 (12899, 15421)</td>
<td>14,456 (12909, 16002)</td>
<td>-296 (-2291, 1700)</td>
</tr>
<tr>
<td>Total outpatient cost</td>
<td>22516</td>
<td>22,182 (20368, 23996)</td>
<td>22,859 (20470, 25247)</td>
<td>-677 (-3676, 2323)</td>
</tr>
<tr>
<td>Inpatient medical costs</td>
<td>8452</td>
<td>7,179 (5450, 8908)</td>
<td>9,757 (6455, 13059)</td>
<td>-2578 (-6305, 1149)</td>
</tr>
<tr>
<td>Inpatient mental health / substance abuse costs</td>
<td>114</td>
<td>61 (-8, 129)</td>
<td>169 (-2, 340)</td>
<td>-108 (-292, 76)</td>
</tr>
<tr>
<td>Total health care cost over 4 years</td>
<td>31082</td>
<td>29,422 (26479, 32365)</td>
<td>32,785 (27648, 37921)</td>
<td>-3363 (-9282, 2557)</td>
</tr>
</tbody>
</table>
Long (4 year) Cost effectiveness

IMPACT 4-year cost analysis

Total cost

Year 1-2

Year 3-4

Cost difference (IV - UC)

Source: Unützer, et al. (under review).
## Institute for Urban Family Health

<table>
<thead>
<tr>
<th>Age at enrollment:</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>71.6 years</td>
<td>69.0%</td>
</tr>
<tr>
<td>Range</td>
<td>60 – 99 years</td>
<td>31.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender:</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>165</td>
<td>90.0%</td>
</tr>
<tr>
<td>Male</td>
<td>74</td>
<td>10.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity:</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>90</td>
<td>37.7%</td>
</tr>
<tr>
<td>African American</td>
<td>70</td>
<td>29.3%</td>
</tr>
<tr>
<td>Caucasian</td>
<td>56</td>
<td>23.4%</td>
</tr>
<tr>
<td>Other</td>
<td>23</td>
<td>9.6%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital Status:</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>44</td>
<td>47.8%</td>
</tr>
<tr>
<td>Single, Widowed, Divorced/separated</td>
<td>48</td>
<td>52.2%</td>
</tr>
</tbody>
</table>
IMPACT Effective for Depression

Mean PHQ-9 Depression Scores

<table>
<thead>
<tr>
<th>Time</th>
<th>Mean Depression Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial</td>
<td>14.03</td>
</tr>
<tr>
<td>3 Months</td>
<td>8.14</td>
</tr>
<tr>
<td>6 months</td>
<td>7.91</td>
</tr>
</tbody>
</table>
Change in Depression
Initial to 6 months

Initial PHQ-9 Depression Scores

6 Month PHQ-9 Depression Scores
(Mean Score of 7.91)
“It is good to see that mental health is once again becoming part of the medical Interview, as so much of our patient's health depends on their mental well being.”

- Dr. Eric Gayle

“Project IMPACT has allowed me to incorporate a new tool (PHQ-9) into my primary care practice, which has improved the accuracy of my diagnosis while increasing my efficiency and productivity as well. It helped me identify patients I initially overlooked.”

- Dr. Joseph Lurio (68th Street)
Bridging the divide between mental health & medical care

- Mental health is part of overall health
- Treat mental health disorders where the patient is / feels most comfortable receiving care
  - Established doctor-patient relationship an important foundation of trust
  - Less stigma
  - Better coordination with medical care
Patients and providers report high rates of satisfaction with collaborative care for depression

- Unutzer et al, JAMA 2002
- Levine et al, Gen Hosp Psychiatry 2005
- Saur et al, submitted
Depression Care Manager: Core Skills

Actively engages the patient in a therapeutic alliance
Conducts initial assessment and follow-up visits
Educates about depression and goals/expectations of treatment
Elicits preferences and encourages treatment adherence

Provides
- Education
- Close monitoring / follow-up (PHQ-9)
- Antidepressant management (including side effect management)
- Brief, structured psychotherapy (PST-PC)
- Pleasant Events Scheduling / Behavioral Activation
Depression Care Manager: Core Skills (con’t)

Tracks **depressive symptoms and treatment response (PHQ-9)**

Consults **with team psychiatrist**

Collaborates **closely with patient’s primary care provider (PCP)**

Provides **follow-up and recommendations to PCP who prescribes antidepressants**

Facilitates **referrals to specialty care and community resources**

Prepares for **relapse prevention**
Depression Care Manager: The Facilitating Presence

Actively engages the patient in a therapeutic alliance by:

- Eliciting concerns
- Providing information
- Clarifying preferences
- Encouraging informed decision-making
- Conveying hopefulness
- Teaching skills
- Monitoring progress
- Reinforcing self-management
Initial Visit

- Assessment
- Education
- Discuss treatment options / plans
- Coordinate care with PCP
- Start initial treatment plan
- Arrange follow-up contact
  - in person or by phone
  - in one week or earlier
- Document initial visit
Care manager video clip: Initial assessment
**Project Impact**
**Initial Assessment**

To (Primary care clinician):  

Mr./Ms.: ___________________________________________  

MRI#: ___________________________________________

Today’s date: 03/20/2000

has been identified by the Impact study team to have symptoms of depression. S/he attended an initial educational session on 03/20/2000 and has received the video tape and educational brochure on depression treatment.

### Depression Symptoms

(bold face indicates the symptom that bothers the patient the most)

<table>
<thead>
<tr>
<th>Major Depression (5/9 symptoms for &gt; 2 weeks)</th>
<th>Dysthymia (3/7 symptoms for &gt; 2 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Depressed mood *</td>
<td>* Depressed mood *</td>
</tr>
<tr>
<td>* Loss of interest or pleasure *</td>
<td>Diminished ability to think or concentrate</td>
</tr>
<tr>
<td>Diminished ability to think or concentrate</td>
<td>Fatigue / Loss of energy</td>
</tr>
<tr>
<td>Fatigue / Loss of energy</td>
<td>Sleep disturbance</td>
</tr>
<tr>
<td>Worthless / Guilty</td>
<td>Poor appetite or overeating</td>
</tr>
<tr>
<td>Thoughts of death or suicide</td>
<td>Low self-esteem</td>
</tr>
<tr>
<td>Sleep disturbance (Sleeps __ hrs/night)</td>
<td>Feelings of hopelessness</td>
</tr>
<tr>
<td>Appetite / Weight change (____ lbs.)</td>
<td>PHQ depression score: 23 / 27 (severe)</td>
</tr>
<tr>
<td>Physical agitation or slowness</td>
<td></td>
</tr>
</tbody>
</table>

a. Activities affected: ☑ social ☑ personal ☑ family ☑ work
b. # bed days last month: 4  c. # restricted days last month: 26
d. Family history of depression? ☑ e. Patient last felt good 1 mos ago

### Other Symptoms:

- Anxiety
- Pain (Score: 10 / 10), no active SI, one attempt age 40

### Current Medical Problems:

- Fibromyalgia
- Angina
- Migraines, occasional intestinal blockage

### Current Medications

(Bold print indicates medications which may contribute to depression)
- Trazodone 50mg hs
- Clonazepam, Effexor: 2 years on this, Atalact, Vicodin, Vitamins, Inhaler

### Allergies:

- Sulfa, ASA, Morrin, Morphine, Myfloxin

### Stressors:

In '96 lost their business, their retirement money was lost with the business. Neither of them can find a job now.

### Strengths and Resources:

- Daughter, Son, Husband

### Pleasant activities:

- Kiwanis

### Prior treatments:

- Antidepressant(s) (Helpful), Psychotherapy

Patient is now interested in:

- Antidepressant, Psychotherapy

### Last TSH:

2.26 uIU/ml Date: 11/09/1999

### Provisional Diagnostic Impression:

- Major Depression, Dysthymia

### Other Comments:

Patient attended anxiety and depression classes in Psychiatry without success in controlling symptoms. She was on Prozac 6 years ago for a brief time. She thinks it may not have been a complete trial on this med. She has been depressed at times in her life and it is worse now. Effexor helped her in the beginning but not as much recently. She also feels ill on it.

### Patient question(s) for the primary care provider:

---

Assessed by: Rita Haverkamp, MSN, RN, CNS  

Primary Care Provider: ____________________________  

Phone Number: 619-589-3313
Patient Health Questionnaire
PHQ-9

- Assists with depression diagnosis
- Helps tracks 9 core symptoms of depression over time
- Easy to use
- Patients become familiar with it
- Can be done over the phone
- A good teaching tool
PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: John Q. Sample

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use "✓" to indicate your answer)

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<td></td>
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<td>1</td>
<td>✓</td>
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<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(add columns: 2 + 10 + 3)

TOTAL: 15

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.)

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

   Not difficult at all
   Somewhat difficult ✓
   Very difficult
   Extremely difficult

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Understanding the PHQ-9 Score

PHQ 9 Score = 0 - 4: No Depression

PHQ-9 Score = 5 - 9: Mild Depression

PHQ-9 Score = 10 - 14: Moderate Depression

PHQ-9 Score > 15: Severe Depression
‘Don’t argue’ about whether or not patient has depression => focus on symptoms and symptom resolution.

Give hope!

“You don’t have to feel this way.”

“This can be treated.”

Educate patient about depression to reduce resistance from stigma

Depression as a medical condition

We have good treatments for this
Many older adults know little or nothing about depression

Few older adults think of depression is a medical / “health” problem

Older adults may feel like they should “handle it themselves”

About 60% of people aged 65 and older believe it is “normal” for people to get depressed as they age
Depression affects the body, behavior, and thinking. *Physical symptoms may be the most apparent.*

The ‘cycle of depression model’

Depression can almost always be treated with antidepressant medications or psychotherapy.

Recovery from depression is the rule, not the exception

…but relapse is common if treatment discontinued

Minor tranquilizers, drugs, and alcohol can make depression worse, not better.
The ‘Cycle of Depression’

- **STRESSORS**
  - Medical Illness
  - Family Problems
  - Work Problems

- **THOUGHTS & FEELINGS**
  - Negative thoughts
  - Low self esteem
  - Sadness
  - Hopelessness

- **PHYSICAL PROBLEMS**
  - Poor sleep
  - Pain
  - Low Energy
  - Poor concentration

- **BEHAVIOR**
  - Social Withdrawal
  - Decreased activities
  - Decreased productivity
Patient, PCP & Care Manager all involved in making the treatment plan

Treatment plans are ‘individualized’ because patients differ in

- medical comorbidity
- psychiatric comorbidity
- prior history of depression and treatment
- current treatments
- treatment preferences
- treatment response
Patient Education
About Antidepressants

Key messages
- How do these medications work?
  By restoring a chemical imbalance in the brain
- There are several options (over 20 available medications)

Anticipate
- Patient concerns about medications
- Side effects (these can be managed)
- Problems with adherence

Reinforce
- Need for continuation or maintenance treatment to prevent relapse even after the patient feels better
Behavioral Activation

Depression $\Rightarrow$ inactivity and withdrawal

= downward cycle of doing less and feeling worse

- Awareness of this pattern can help some patients understand the purpose and benefit of behavioral activation
Behavioral Activation

Objective:

Reduce depression by gradually increasing engagement in pleasant and enjoyable activities that are client identified

- Decrease negative emotional response
- Decrease avoidance patterns
“Activity scheduling is ... relatively uncomplicated, time-efficient and does not require complex skills from patients or therapist. This meta-analysis found clear indications that it is effective.”

“Among more severely depressed patients, behavioral activation was comparable to antidepressant medication, and both significantly outperformed cognitive therapy.”
Problem Solving
Treatment

- Evidence-based
- Common Sense
- Brief
- Practical to Apply
- Easily Learned by Therapist and Patient
- High Patient Acceptance and Satisfaction
- Designed for primary care
Psychotherapy

Pros:
- No medication side effects
- Learned skills retained after treatment
- Addresses interpersonal / real life problems
- Accommodates patient who doesn’t want medications
- Alternative for poor response to medications

Cons:
- May take longer to work (6-12 sessions)
- More time consuming
- May not be as effective for severe major depression
- Requires staff training and may vary by provider
## PST-PC vs. Usual Psychotherapy

<table>
<thead>
<tr>
<th>Treatment Issue</th>
<th>PST-PC</th>
<th>Psychotherapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist:</td>
<td>Multi-Specialty</td>
<td>Mental Health</td>
</tr>
<tr>
<td>Session duration:</td>
<td>30-Minutes</td>
<td>≥ One Hour</td>
</tr>
<tr>
<td>Tx Duration:</td>
<td>4-8 Sessions</td>
<td>&gt;10 Sessions</td>
</tr>
<tr>
<td>Total Tx Time:</td>
<td>2-5 Hours</td>
<td>≥ 10 Hours</td>
</tr>
</tbody>
</table>
A. Understand the link between current problems in living and current symptoms.

B. Use a systematic problem-solving strategy.

C. Engage in pleasant, social and physical activities.
Follow-Up Contacts

Weekly or every other week during acute treatment phase
- In person or by telephone to evaluate depression severity (PHQ-9) treatment response

Initial focus on
- adherence to medications
- discuss side effects
- follow-up on activation and PST plans

Later focus on
- complete resolution of symptoms and restoration of functioning
- long term treatment adherence
**Treatment Response**

**Full response:** At least 50% reduction in PHQ-9 score (or less than 5)

**Partial response:** Reduction in PHQ-9 of less than 50%

**No response:** No reduction or increase in PHQ-9 score
Most patients will need treatment adjustments

Only 30 – 50% of patients will have a complete response to initial treatment

Remaining 50 – 70% will require at least one change in treatment to get better
Seek consultation with psychiatrist when patient ...

Is severely depressed (PHQ-9 score $\geq 20$)
Fails to respond to treatment
Has complicating mental health diagnosis, such as personality disorder or substance abuse
Is bipolar or psychotic
Has current substance dependence
Is suicidal or homicidal
Tracking is an essential function in the IMPACT program
- can be accomplished in many different ways
- should be based on needs, resources
- each has pros/cons
http://impact-uw.org

FREE materials:
- Treatment manuals
- Planning guides
- Forms
- Job descriptions
- Much more

Training:
- Schedule of in-person training
- 10 module online training program (free)

Evidence:
- More information about the evidence base for IMPACT
IMPACT Web-based Learning

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

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.

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Thank You

The IMPACT Implementation Center is located in the Department of Psychiatry at the University of Washington in Seattle.

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