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

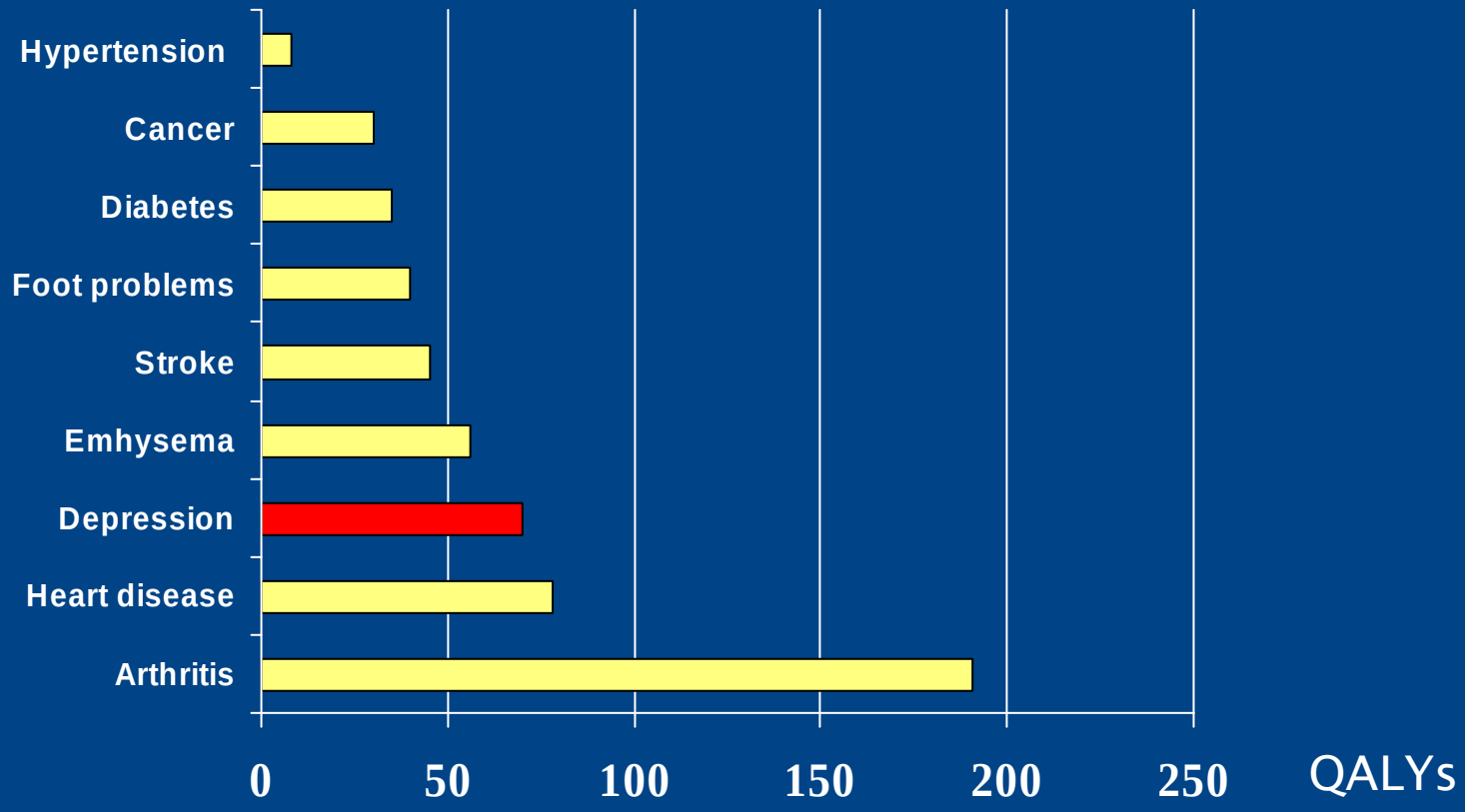
Loss of interest/ pleasure …. plus

- 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

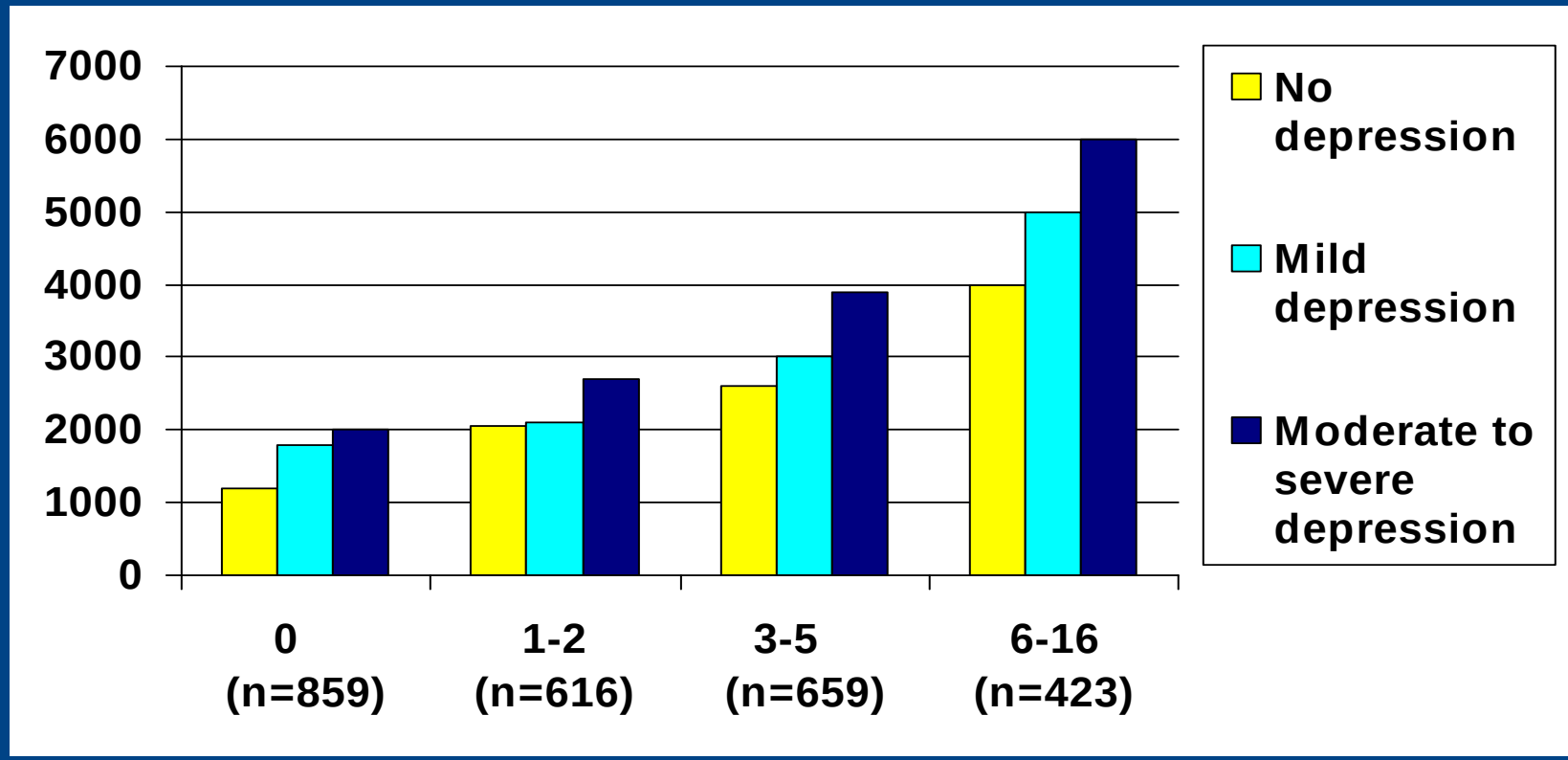
Depression takes a large toll on quality of life



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:

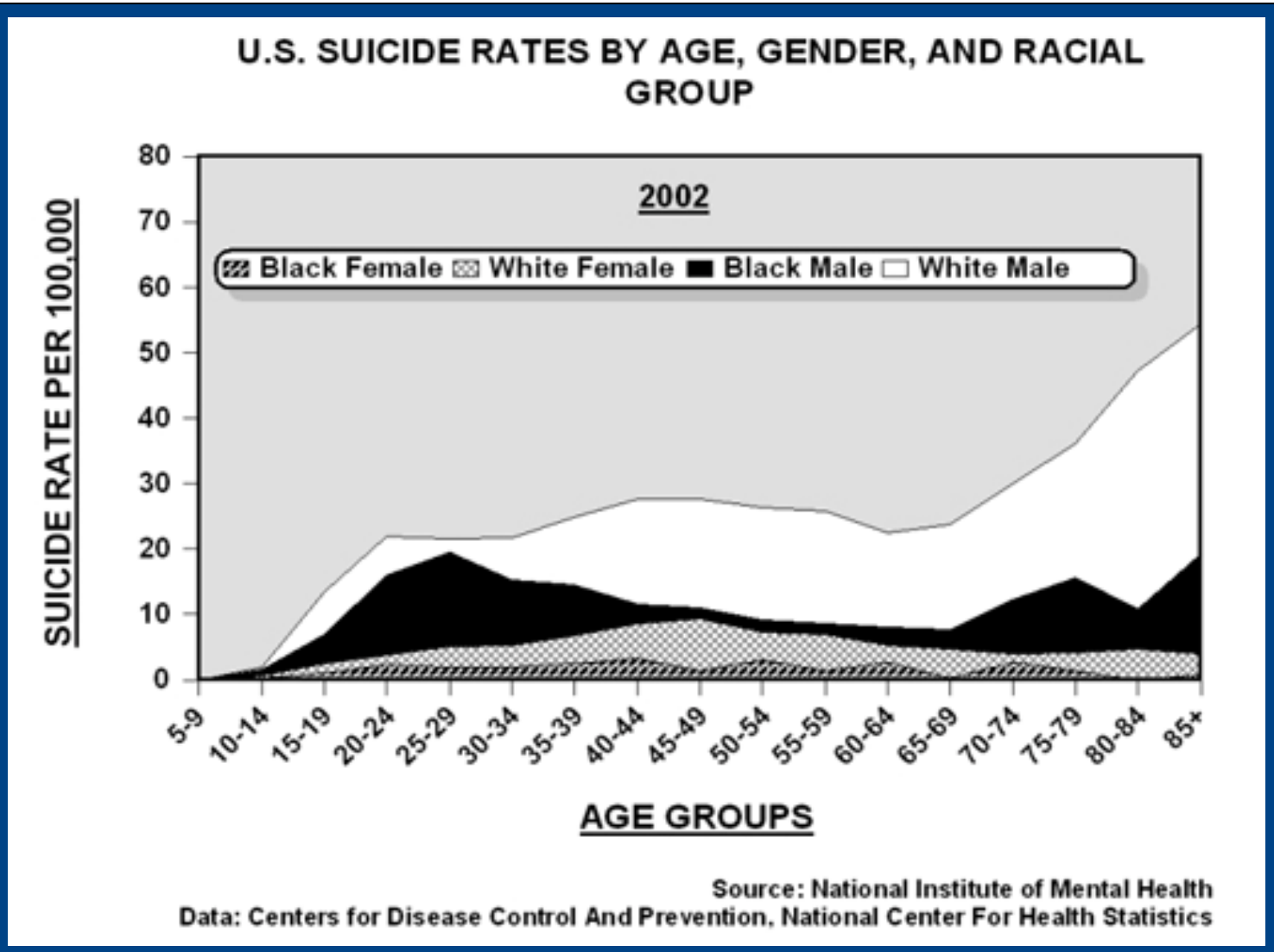
Annual Health Costs in 1995 $



Unützer et al, JAMA, 1997

Depression is deadly

Older adults have the highest rate of suicide.



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

Brief history of QI for Depression in Primary Care

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

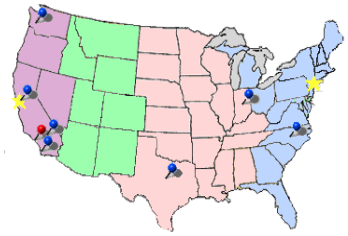
Unutzer et al, Report to President's Commisson on Mental Health; Psychiatric Services 2006.

Evidence-based 'team care' for depression

TWO PROCESSES	TWO NEW 'TEAM MEMBERS'	
	Care Manager	Consulting Psychiatrist
1. Systematic diagnosis and outcomes tracking e.g., PHQ-9 to facilitate diagnosis and track depression outcomes	- 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
2. Stepped Care a) Change treatment according to evidence-based algorithm if patient is not improving b) Relapse prevention once patient is improved	- 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

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

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 Methods

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

Unützer et al, *Med Care* 2001; 39(8):785-99

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

Unützer et al, *Med Care* 2001; 39(8):785-99

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 DATE: _____

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

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	✓	3
2. Feeling down, depressed, or hopeless	0	✓	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	✓	3
4. Feeling tired or having little energy	0	1	2	✓
5. Poor appetite or overeating	0	✓	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	✓	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	✓	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	✓	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	✓	1	2	3
add columns:		2	+ 10	+ 3
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). **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	

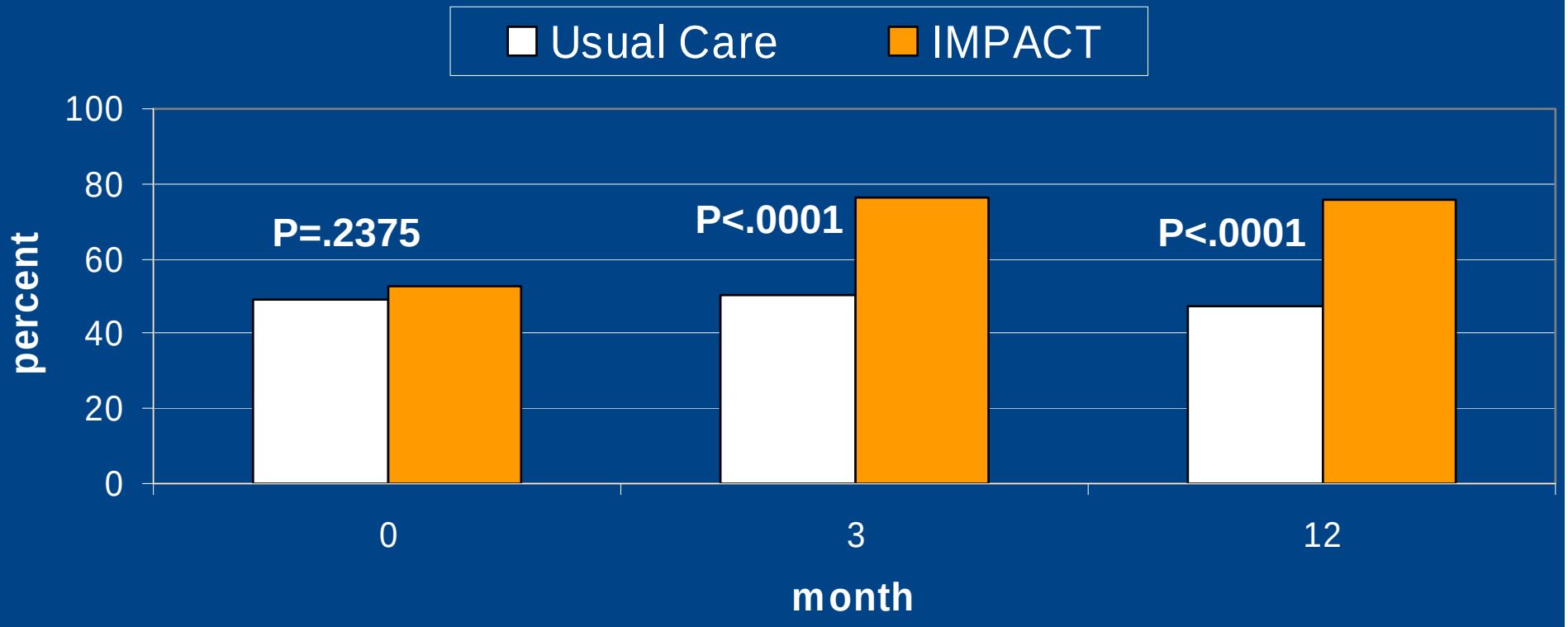
IMPACT Participant Characteristics

	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.

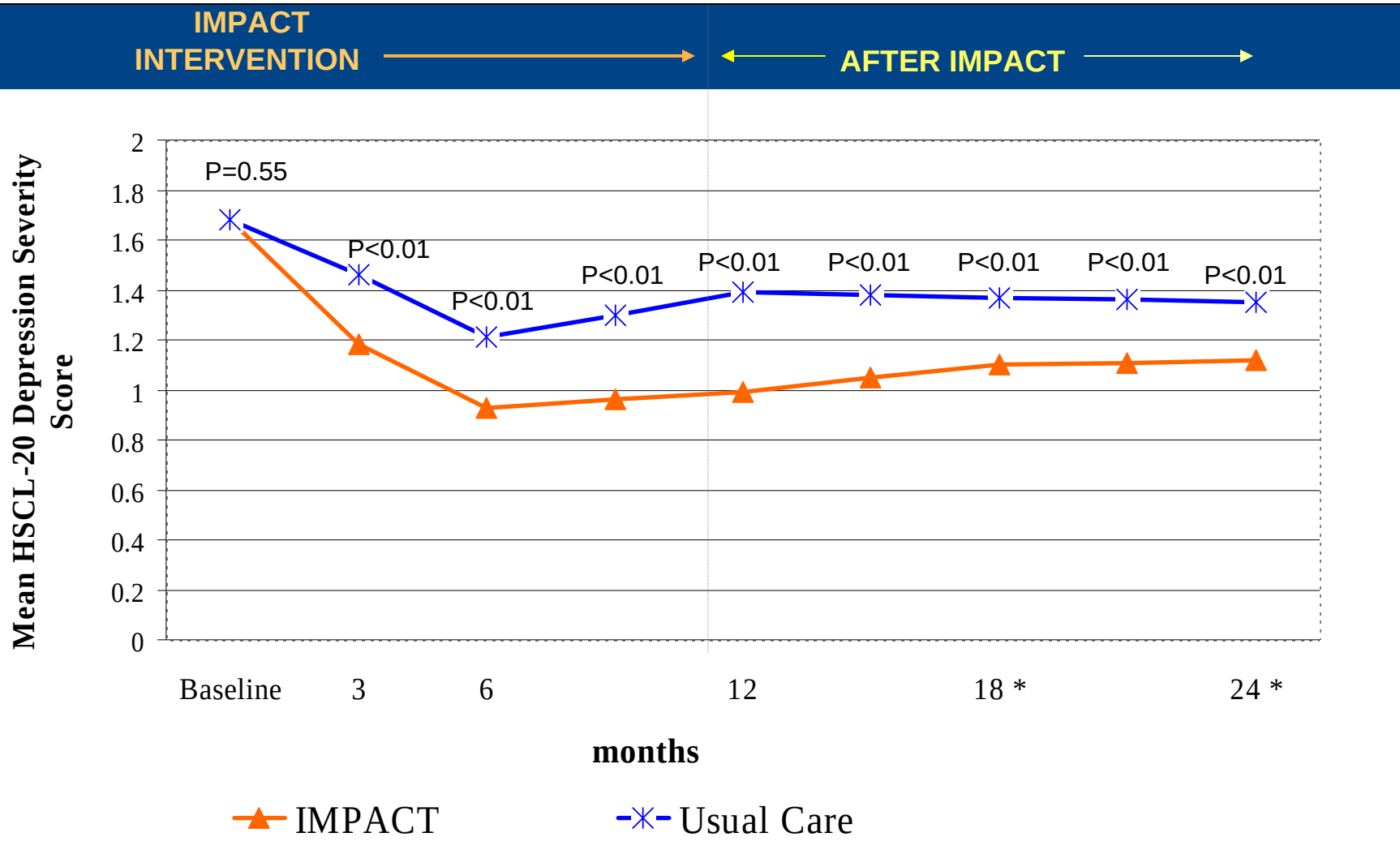
Improved Satisfaction with Depression Care

(% Excellent, Very Good)



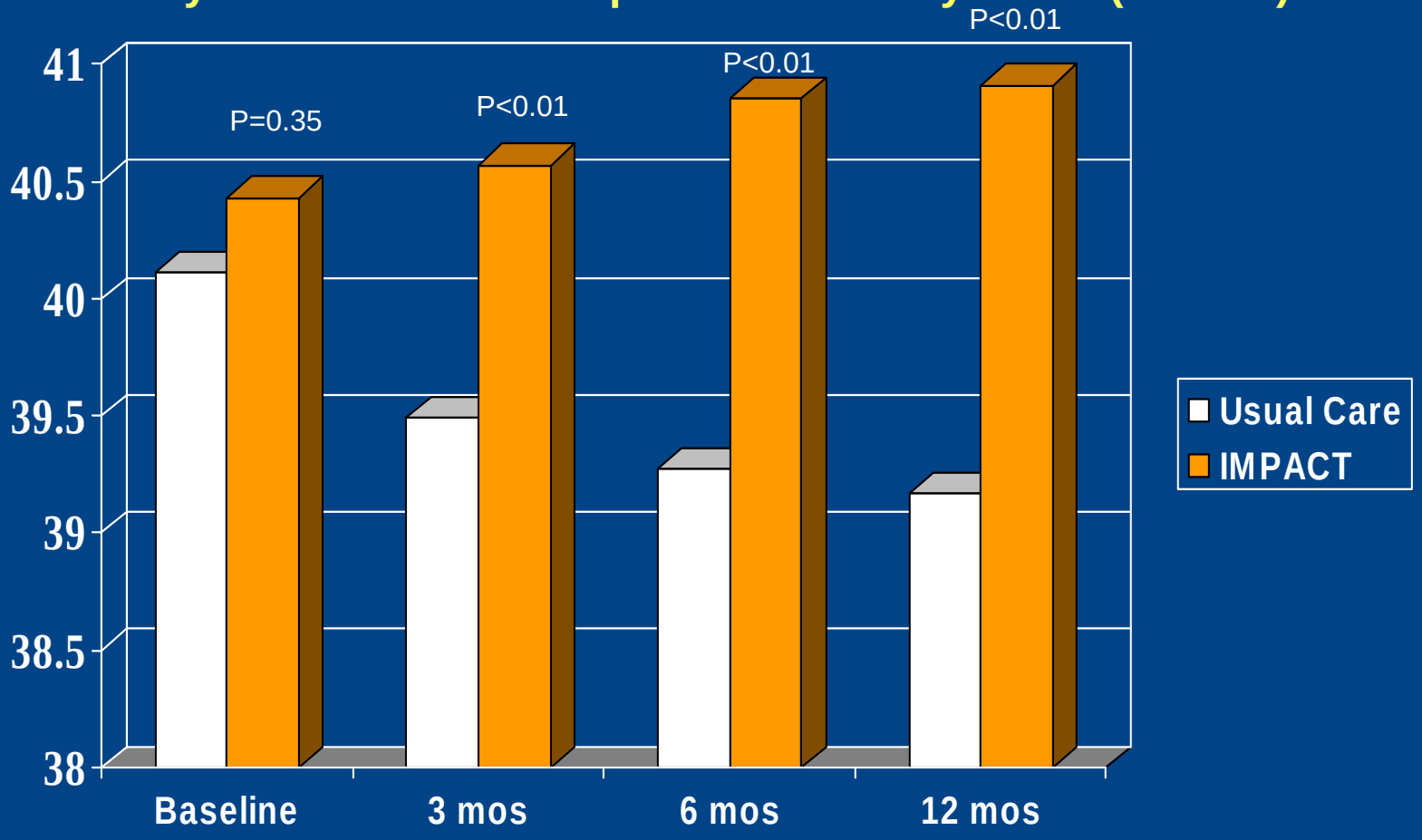
Unützer et al, JAMA 2002; 288:2836-2845

IMPACT: Doubles the Effectiveness of Usual Care for Depression



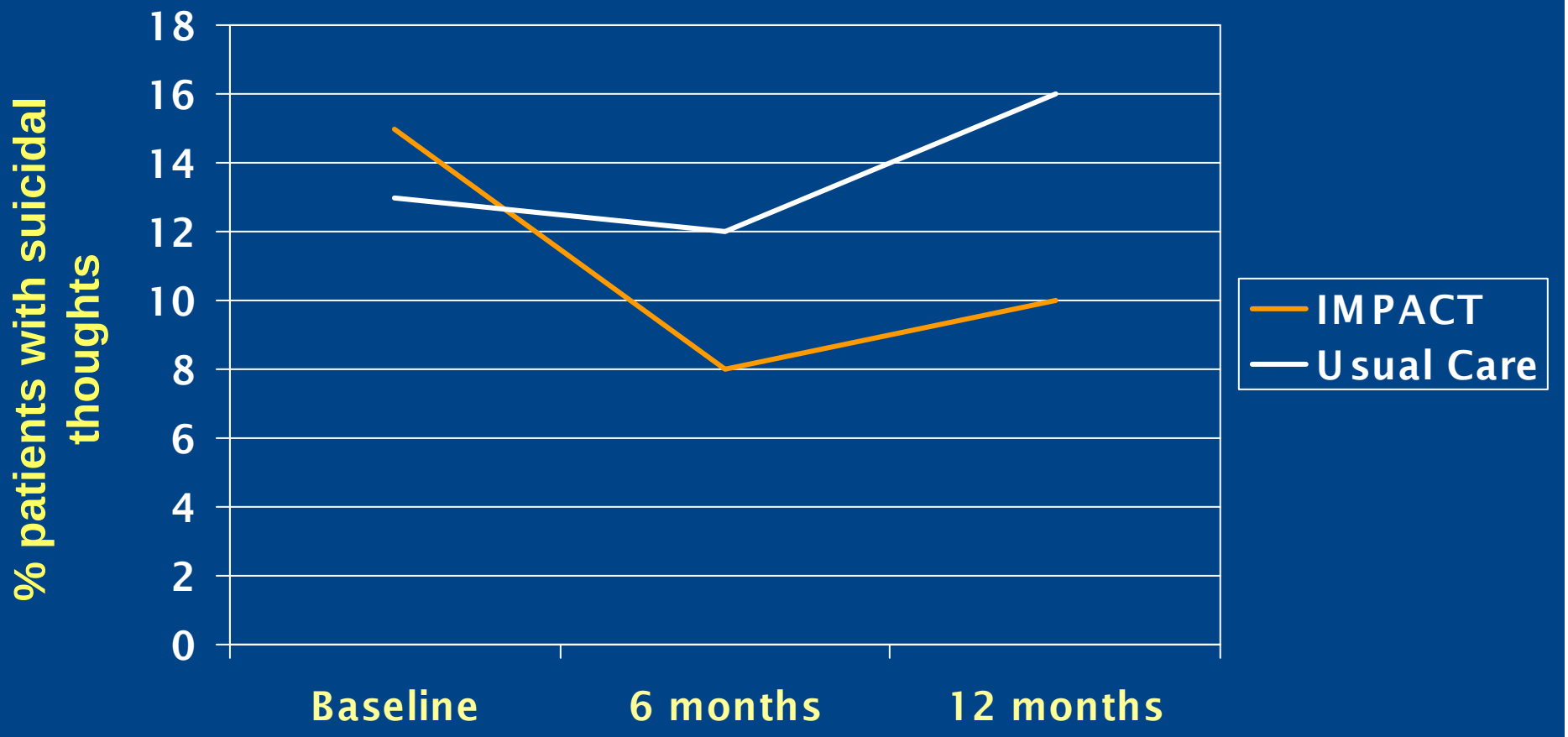
Hunkeler et al, *BMJ*, 2006.

Better Physical Function



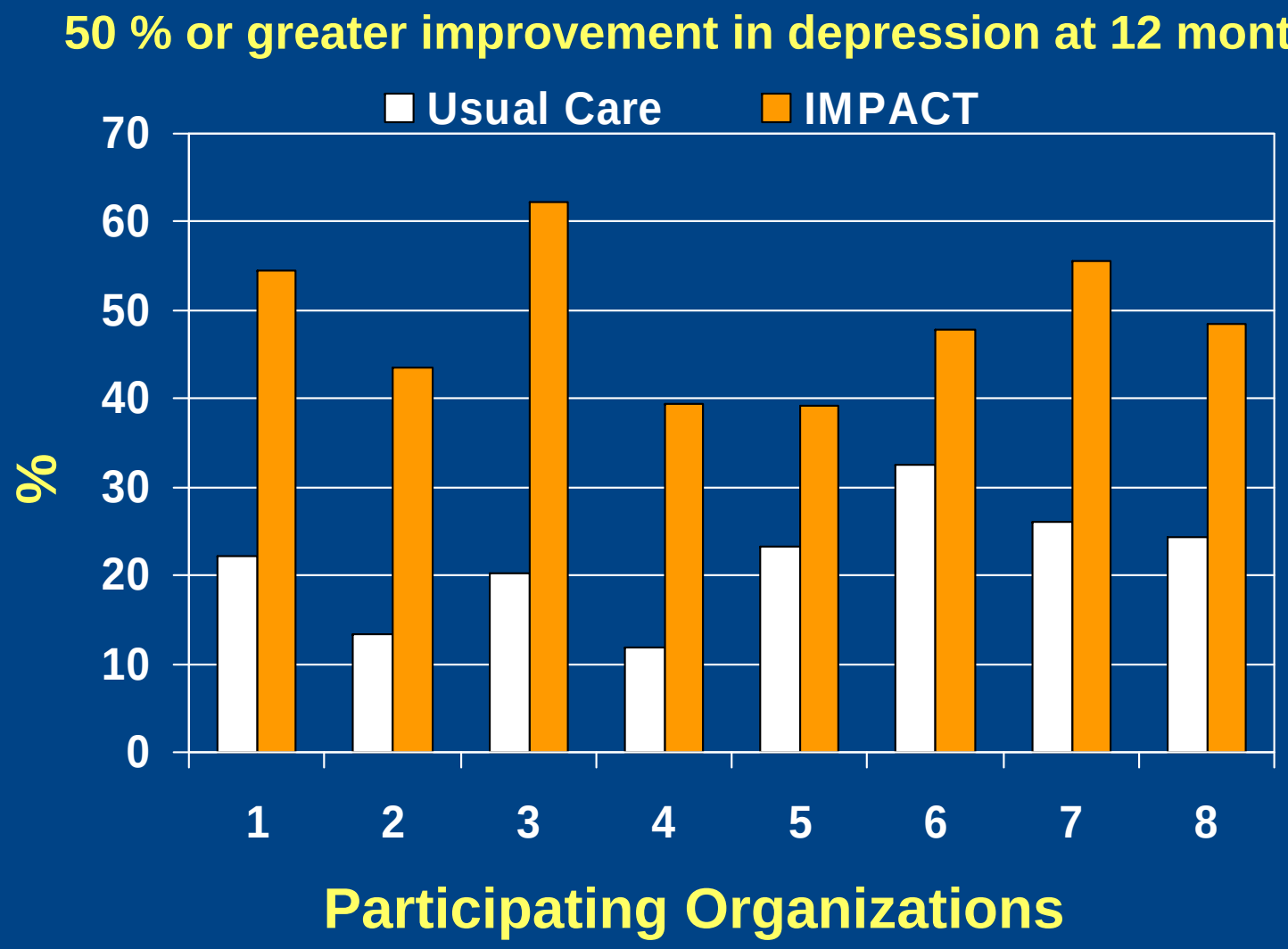
Callahan et al, *JAGS* 2005; 53:367-373.

Fewer thoughts of suicide

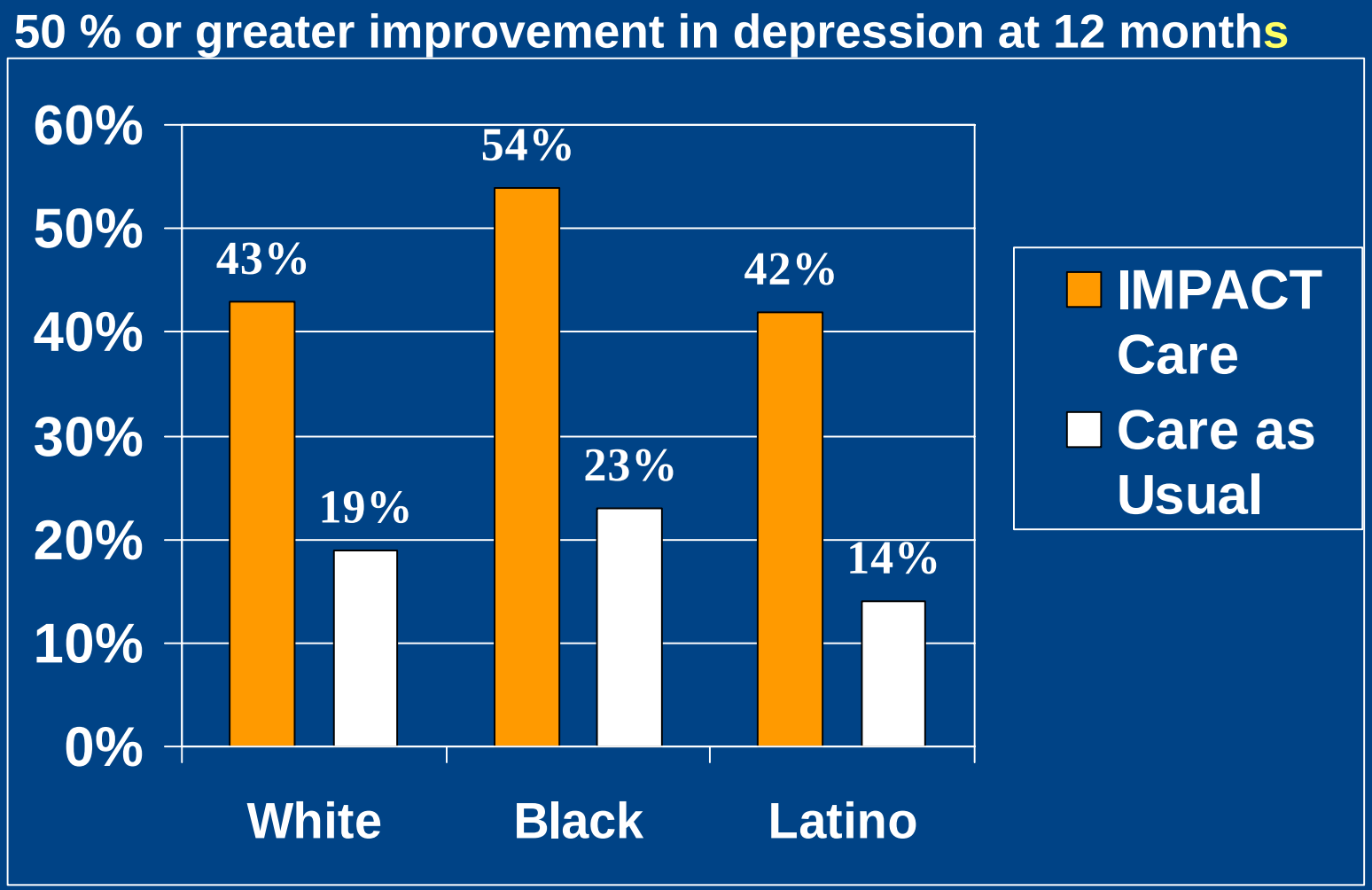


Unutzer et al, JAGS 2006

IMPACT Findings Robust Across Diverse Organizations



IMPACT Care Benefits Ethnic Minority Populations



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

Photo credit: J. Lott, Seattle Times

"I got my life back"

IMPACT in the 'real world'

Example: Kaiser Permanente

Pilot Study

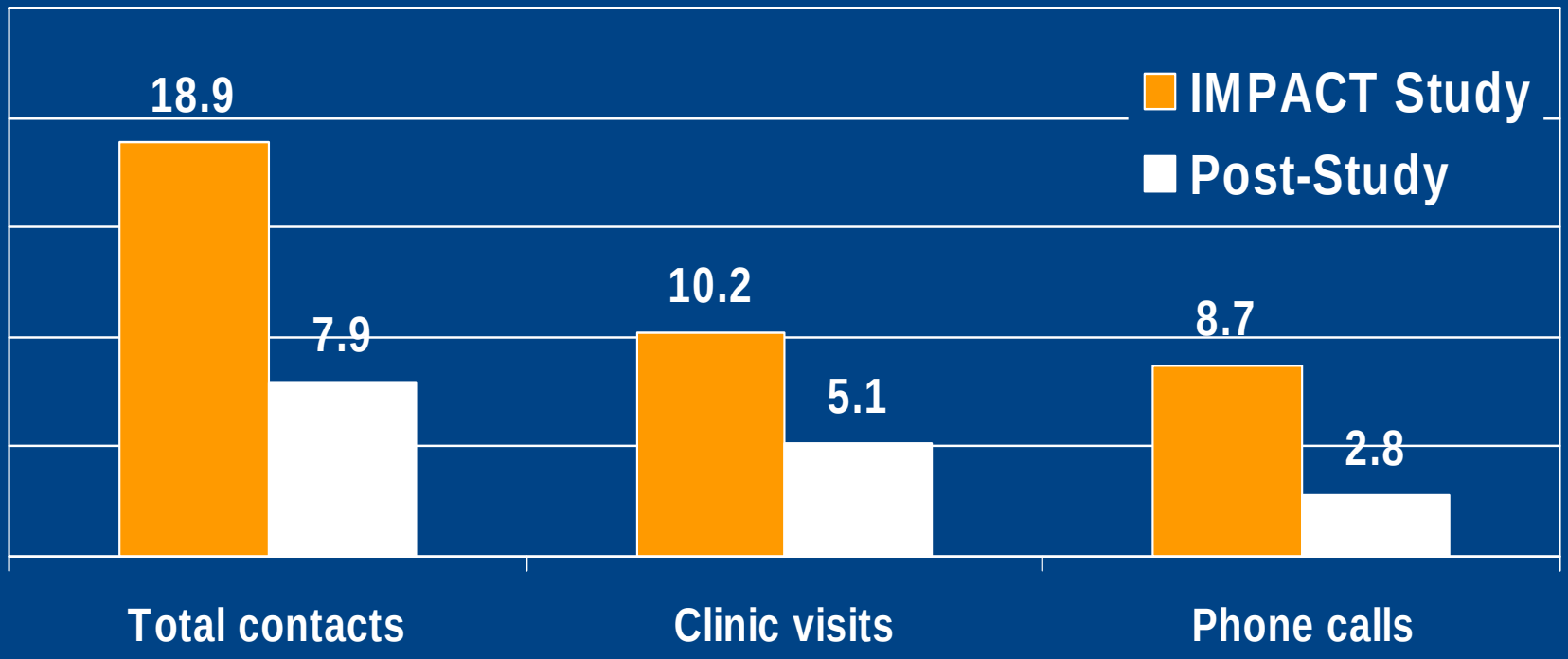
- Compare 284 clients in 'adapted program' with 140 usual care patients and 140 intervention patients in the IMPACT study (Grypma et al, 2006)

Dissemination

- Implementing program at ~ 10 regional medical centers at KPSC and several clinics at KP Northwest

KPSC – San Diego
'After IMPACT'

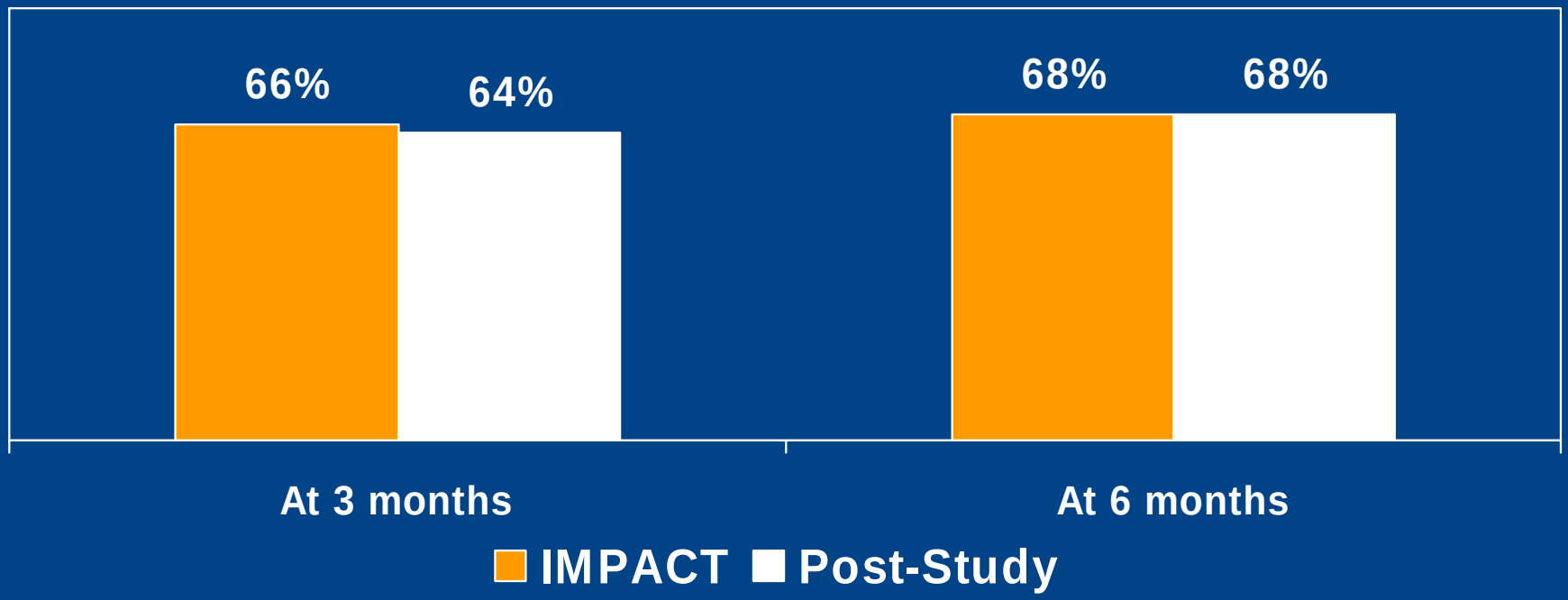
Fewer care manager contacts



Grypma et al, *General Hospital Psychiatry*, 2006.

IMPACT Remains Effective

>= 50 % drop in PHQ-9 depression scores

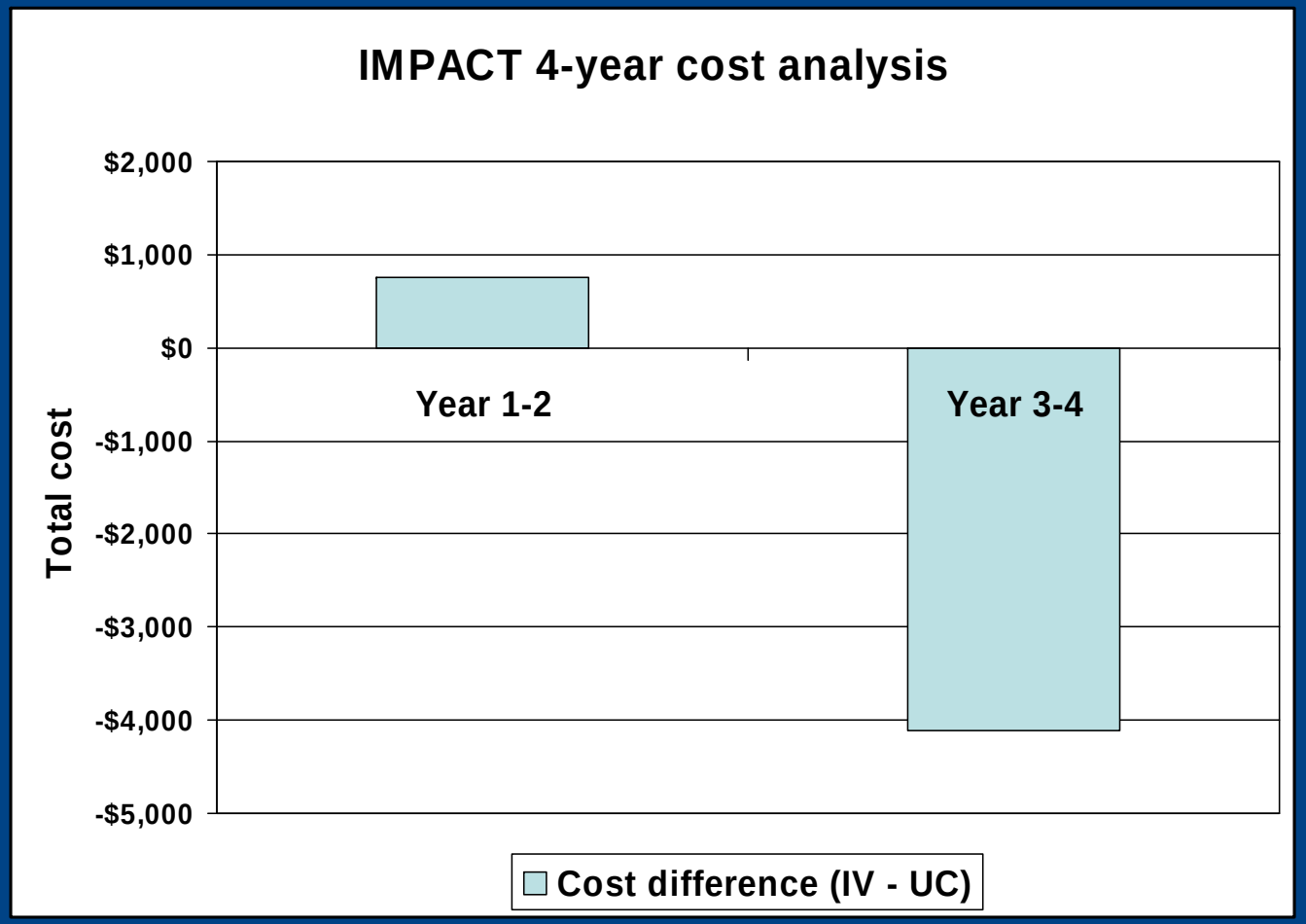


Grypma et al, *General Hospital Psychiatry*, 2006.

Long (4 year) Cost effectiveness

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

Long (4 year) Cost effectiveness

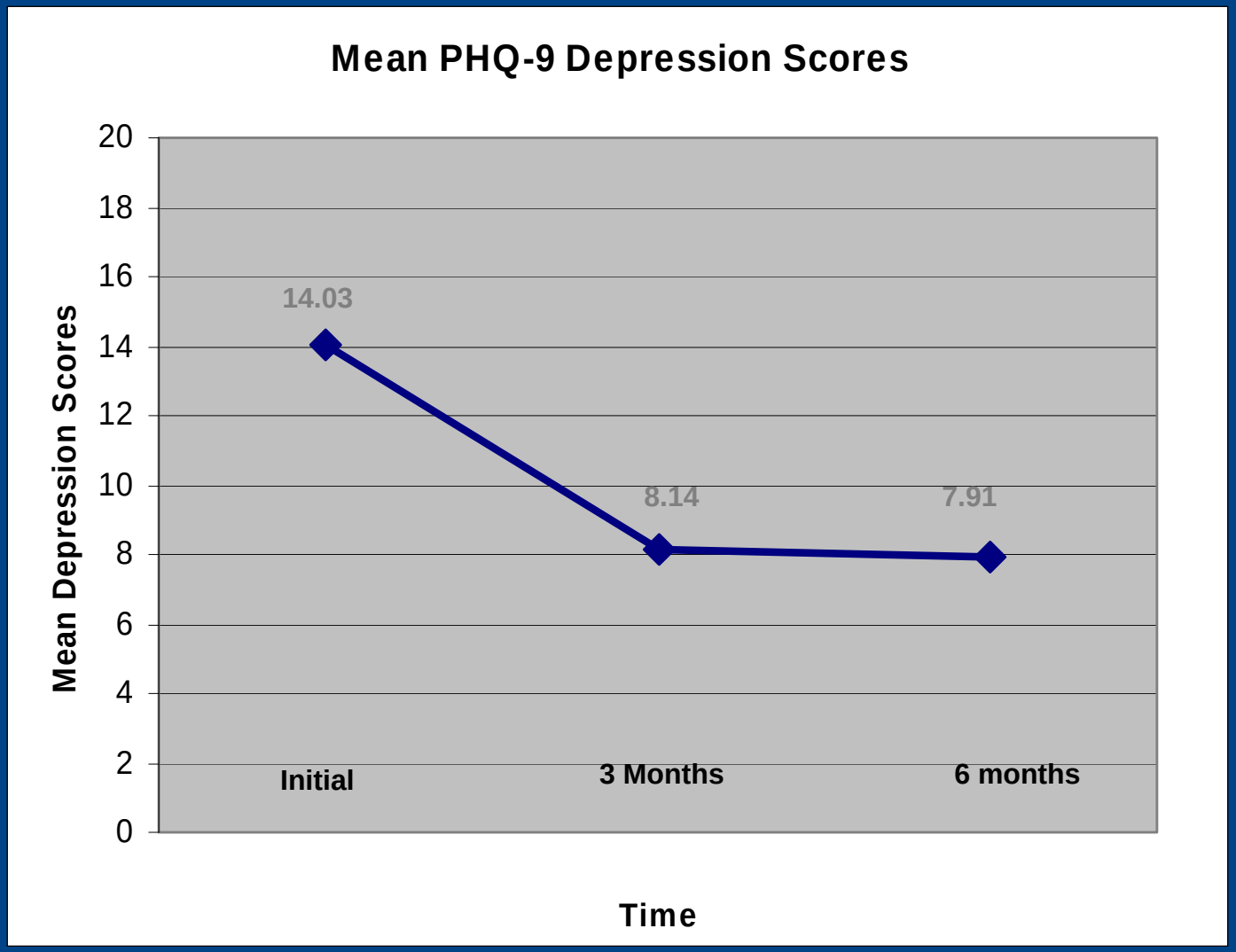


Source: Unützer, et al. (under review).

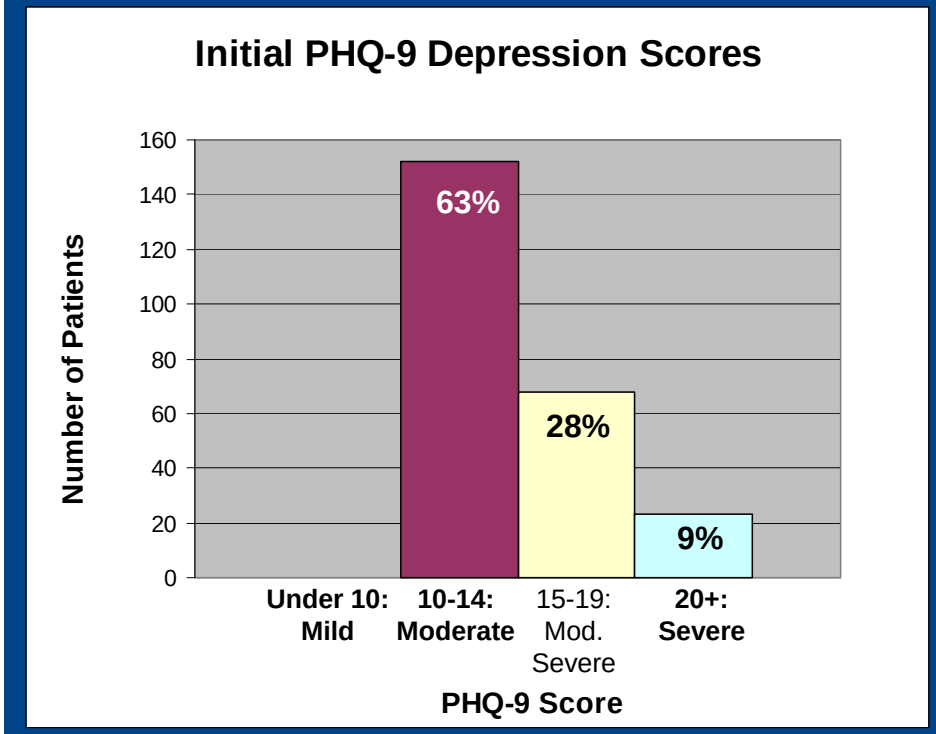
Institute for Urban Family Health

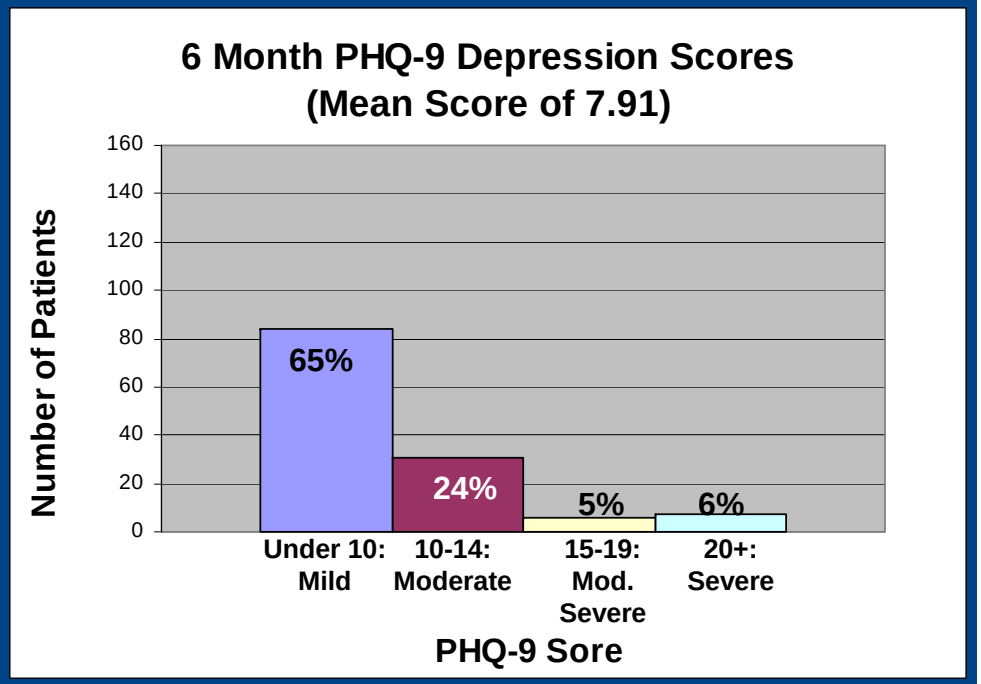
	Number	Percent
Age at enrollment:		
Mean	71.6 years	
Range	60 – 99 years	
Gender:		
Female	165	69.0%
Male	74	31.0%
Ethnicity:		
Hispanic	90	37.7%
African American	70	29.3%
Caucasian	56	23.4%
Other	23	9.6%
Marital Status:		
Married	44	47.8%
Single, Widowed, Divorced/separated	48	52.2%

IMPACT Effective for Depression



Change in Depression Initial to 6 months

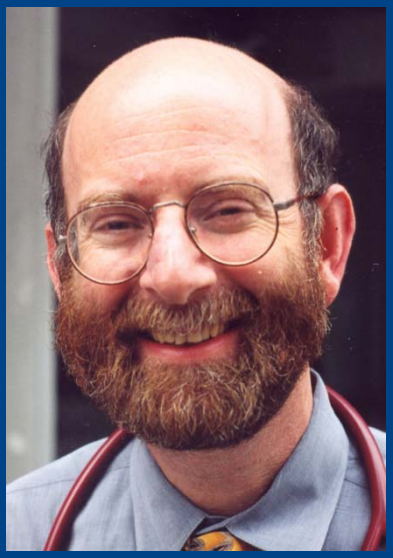




A word from providers…

"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

Collaborative Care benefits patients & providers

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) :* **Today's date:** 03/29/2000

Mr./Ms.: _____ *MR#:* _____

has been identified by the **Impact** study team to have symptoms of depression. S/he attended an initial educational session on 03/29/2000 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*)

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

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 : Fibromalgia,Angina, Migraines, occasional intestional blockage.

Current Medications *(Bold print indicates medications which may contribute to depression)*

Trazodone 50mgs hs, Clonazapine, Effexor- 2 years on this, Atalact, Vicodin, Vitamins, Inhaler

Allergies : Sulfa, ASA. Motrin, Morphine,Myfoxin

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 : Kiwainas

Prior treatments : Antidepressant(s) (Helpful), Psychotherapy

Patient is **now** interested in: Antidepressant, Psychotherapy

Last TSH : 2.26 µU/ml Date: 11/09/1999

Provisional Diagnostic Impression : Major Depression, Dysthymia

Other Comments : Patient attended anxiety and depression classes in Psychiatry without sucess 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 *Phone Number:* 619-589-3313

Primary Care Provider: *Phone Number:* _____

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

IMPACT

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: John Q. Sample DATE: _____

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

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	✓	3
2. Feeling down, depressed, or hopeless	0	✓	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	✓	3
4. Feeling tired or having little energy	0	1	2	✓
5. Poor appetite or overeating	0	✓	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	✓	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	✓	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	✓	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	✓	1	2	3
add columns:		2	+ 10	+ 3
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). **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: _____

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

PHQ-9:
Discussing score with patient

'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

Attitudes & Beliefs About Depression Among Older Adults

- 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

Patient Education

Depression affects the body, behavior, and thinking.

Physical symptoms may be the most apparent.

The 'cycle of depression model'

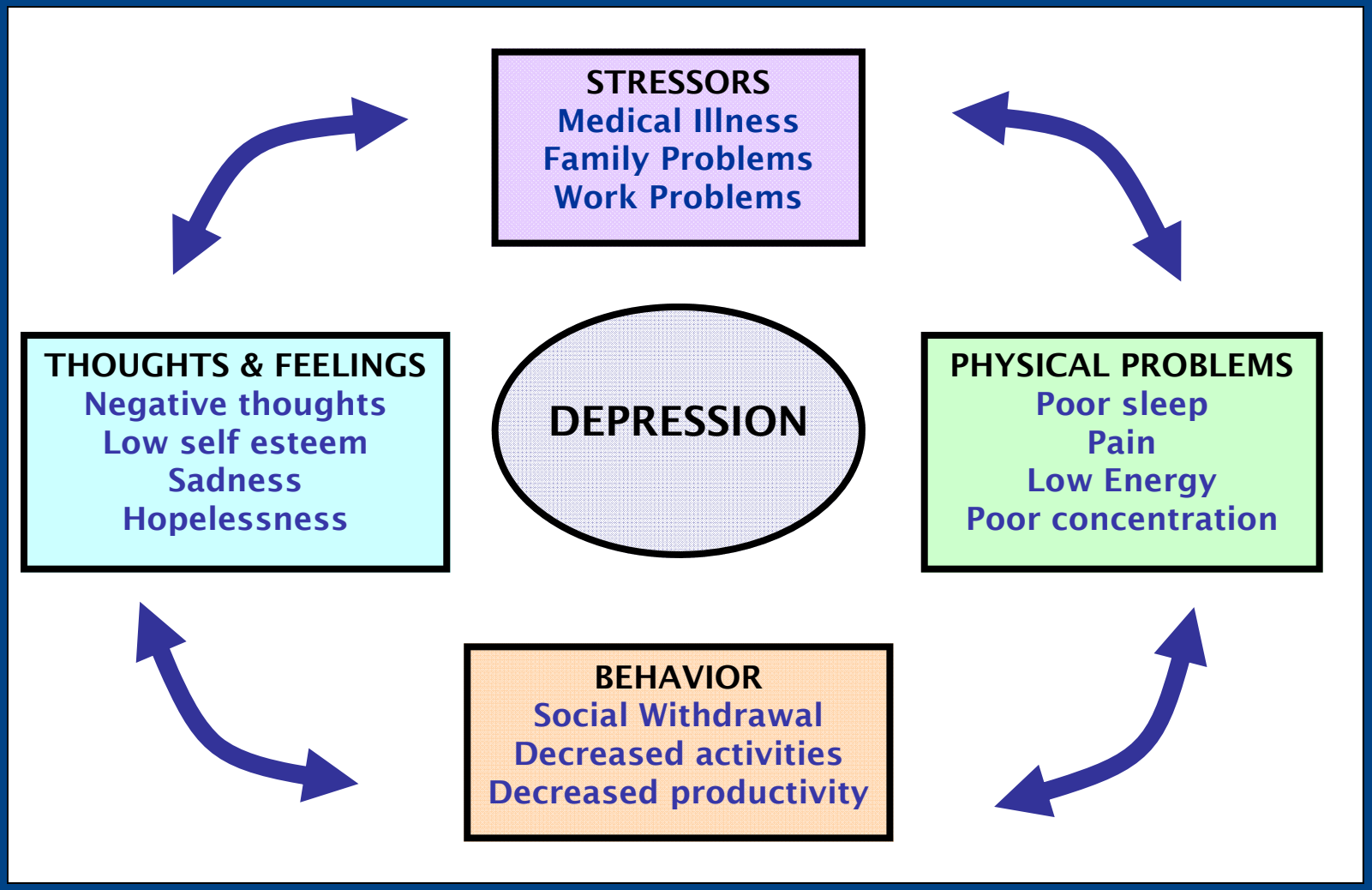
Depression can almost always be treated with antidepressant medications or psychotherapy.

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'



Treatment Planning

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 ⇨ 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**

Evidence

"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."

- Cuijpers P, et al. Behavioral activation treatments of depression: A meta-analysis. April 2007 Clinical Psychology Review 27(3):318-326.

"Among more severely depressed patients, behavioral activation was comparable to antidepressant medication, and both significantly outperformed cognitive therapy."

- Dimidjian S, et al. Randomized trial of behavioral activation, cognitive therapy, and antidepressant medication in the acute treatment of adults with major depression. August 2006. J Consult Clin Psychol 74(4):658-70.

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

Treatment Issue	PST-PC	Psychotherapy
Therapist:	Multi-Specialty	Mental Health
Session duration:	30-Minutes	≥ One Hour
Tx Duration:	4-8 Sessions	≥10 Sessions
Total Tx Time:	2-5 Hours	≥ 10 Hours

Three Broad Goals of PST-PC

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 ≥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 Systems

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

View Account: A. Bond / Log Out

- Home
- Learning Modules
  - 1 Depression in Primary Care
  - 2 IMPACT Trial
  - 2 IMPACT Key Components
  - 1 Treatments Planning/Tracking
  - 3 Treatments: Antidepressants
  - 2 Treatments: Behavioral Activation
  - 1 Treatments: PST
  - 1 Psychiatric Consultation
  - 3 Integrating with Disease Mngmt.
  - 3 Implementing IMPACT
- Sign Up for CNE Credit
- Contact Us
- IMPACT Website

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.

Continuting Nursing Credit Available

To receive continuing education credit, please go to the "Sign Up For CNE" and follow the instructions. The blue circle icon 3 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

Dedicated to improving health care for older Americans

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