# IMPACT Program:

## Improving Mood by Providing Access to Collaborative Treatment

NCIOM: MH SA Committee
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# Objective

- Provide an overview of IMPACT
- Explain one particular IMPACT implementation project
- Questions and discussion

# Introduction

IMPACT is an evidenced based program providing services for depression in older adults.

The program is supported by a three-year grant from the Kate B. Reynolds Charitable Trust and is offered in partnership with:

# One of Three Evidenced-Based Integration Models

- SBIRT: Screening Brief Intervention and Referral to Treatment
- PCBH: Primary Care Behavioral Health – BH Consult model within Primary Care
- Collaborative Care/IMPACT: Registry-based depression protocol

# Our Project Plan

- Implement IMPACT in three  practices in each of the two networks over a three year period = 6 practices.
- Implement IMPACT with full fidelity as defined in the evidenced-based protocols and AIMs Model. Utilize/build a registry.
- Evaluate: success, implementation needs, and ability to spread IMPACT across the state through the CCNC networks.

# IMPACT Study

- 1998-2003
- 1,801 adults
  - -60 and older
  - -major depression and/or chronic depression
- 18 primary care clinics across 5 states
  - -HMO, VA, & fee for service
- Randomized controlled groups:
  - - treatment as usual
  - -IMPACT treatment

# IMPACT Study Results

- Less depression (1/2 of IMPACT care reported 50% reduction in SX compared to 19% of TX usual)
- Less physical pain
- Better functioning
- Higher quality of life

- Greater patient and provider satisfaction
- Effective with minorities
- Cost effective

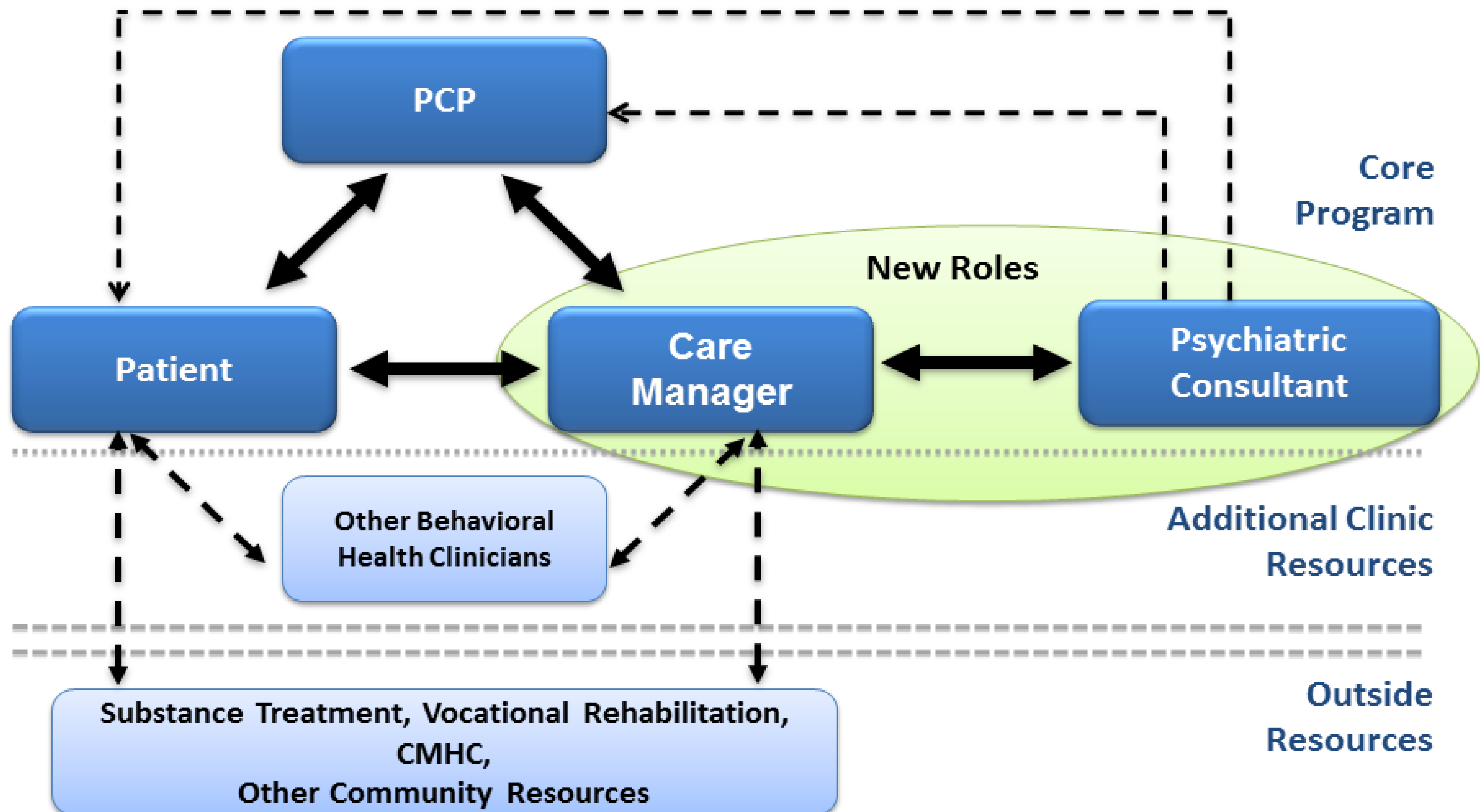
# Effectiveness

- At 12 months, about half of the patients receiving IMPACT care reported at least a 50 percent reduction in depressive symptoms (19% in usual care),
- Analysis of data: survey conducted one year after IMPACT shows that the benefits of the intervention persist after one year and last up to four years
- IMPACT patients experienced more than 100 additional depression-free days over a two-year period than those treated in usual care.

# Cost Effectiveness

- Average cost ~ $580./participant
- Cost of IMPACT to an insured older population ~ $1 /member/month (PMPM)
- Overall Health care in 4 yr period (IMPACT included) was ~ $3,300. less

# Collaborative Team Approach



# Primary Care Provider Role

- **Oversees** all aspects of patient care at the primary care clinic
- Makes/confirms **diagnoses** for depression using PHQ-9
- Starts **pharmacotherapy** as indicated (writes and refills all prescriptions).
- **Collaborates** with team members to stay informed about treatment progress and to make **treatment adjustments** if clinically indicated

# Care Manager Role

- **Educates** the patient about depression
- **Supports antidepressant therapy** prescribed by the patient's primary care provider if appropriate
- Offer a brief (six-eight session) course of **counseling**: Problem Solving Therapy and Behavioral Activation
- **Monitors** depression symptoms for treatment response (PHQ-9)
- Completes a **relapse prevention plan** with each patient who has improved
- Regularly **reviews** patients with the consulting psychiatrist using a shared **registry**

# Staffing in Diverse Clinic Settings

| Clinic Population | % of clinic population with need for depression care | Typical active* caseload for 1 FTE Care Manager | # of unique primary care clinic patients to justify 1 FTE Care Manager | Typical personnel requirement for 1,000 unique primary care patients | |
|---|---|---|---|---|---|
| | | | | FTE Care Manager | FTE Consulting Psychiatrist |
| **Low need** (e.g., insured, employed) | 2% | 100-125 | 5000 | 0.2 | 0.05 (2 hrs / week) |
| **Medium need**** (e.g., co-morbid medical needs / chronic pain / substance abuse) | 5% | 65-85 | 1500 | 0.7 | 0.07 (3 hrs / week) |
| **High need** (e.g., largely homeless, addicted) | 15% | 50 | 333 | 3 | 0.3 (12 hrs / week) |

* An active caseload includes patients in acute treatment and follow-up/maintenance prior to relapse prevention planning. While patients in acute treatment may need contact with the clinician more often, patients in the maintenance phase may only need to be contacted monthly by phone to insure a period of symptom stability before graduation from treatment.

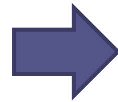
** Most FQHCs are considered medium need.

# Consulting Psychiatrist Role

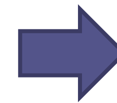
- **Supports** care managers and PCPs
- Provides regular (weekly) **consultation** on a caseload of patients, focusing on patients who are not improving clinically
- Provides **education and training** for primary care-based providers

# Work Flow I

All patients 60+ are given PHQ9 by front desk staff



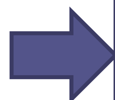
MA scores PHQ9 & notifies provider of scores 10+



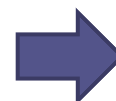
Provider educates patient about IMPACT and makes referral through EMR

# Work Flow II

ICM calls patient to schedule initial assessment within 72 hours



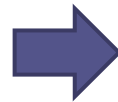
ICM engages patient in PST & behavioral activation



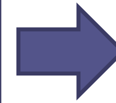
ICM tracks progress in EMR and initiates psychiatric case reviews

# Work Flow III

PCP Champs attend case review meetings to discuss pts who are not improving



ICM conducts relapse prevention and discharges pts who see improvement



ICM will make referral to behavioral health for patients who don't see improvement

# Our Preliminary Anecdotal Results and Findings

- Most patients are improving by the 10 week mark as evidenced by a 50% or more reduction in their scores
- Orientation/Education is important for patients and clinics
- Registry functionality is a necessity
- Pre-screening with PHQ2 is more effective than PHQ9 to determine eligibility in older adults

# Sustainability Considerations

- Fee for service
  - Chronic Care Management codes – Medicare
  - Psychotherapy codes – face to face
- Accountable care/capitation
  - Cost Savings and health outcomes
- Transition between payment models

# Questions and Discussion

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