The IMPACT Model

Delivering Effective Depression Treatment in the Primary Care Setting
Presenters

Jürgen Unützer, MD, MPH, MA
Professor & Vice-Chair
Psychiatry and Behavioral Sciences, UW

Rita Haverkamp, MSN, PMHCNS-BC, CNS
Clinical Nurse Specialist
Kaiser Permanente Southern California

Marty Adelman, MA, CPRP
Mental Health Program Coordinator
San Diego Council of Community Clinics
University of Washington

AIMS CENTER
Advancing Integrated Mental Health Solutions

Building on 25 years of Research and Practice in Integrated Mental Health Care
Overview

- Integrated Mental Health Care
- The IMPACT Model
- Existing programs with lessons for implementation
66% of PCPs Report Poor Access to Mental Health Care for Their Patients

Cunningham PJ, Health Affairs 2009;28(3)490-501
Mental Disorders are Rarely the Only Health Problem

- Chronic Physical Pain: 25-50%
- Smoking, Obesity, Physical Inactivity: 40-70%
- Heart Disease: 10-30%
- Cancer: 10-20%
- Diabetes: 10-30%
- Neurologic Disorders: 10-20%

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Improving Care for Depression

Common
10% in primary care, more common in patients with chronic medical illnesses

Disabling
#2 cause of disability (WHO)

Expensive
50-100% higher health care costs (ED, inpatient, outpatient, pharmacy)

Deadly
Over 30,000 suicides / year
Evidence for Collaborative Care for Depression

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

• 37 trials of collaborative care for depression in primary care (US and Europe)
• CC consistently more effective than usual care
IMPACT Study

PCP supported by Behavioral Health Care Manager

Effective Collaboration

Informed, Active Patient

Practice Support

Measurement

Caseload-focused psychiatric consultation

Training

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# IMPACT Team Care Model

<table>
<thead>
<tr>
<th>TWO PROCESSES</th>
<th>TWO NEW ‘TEAM MEMBERS’</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Care Manager</td>
</tr>
<tr>
<td>1. Systematic diagnosis and outcomes tracking</td>
<td>- Patient education / self management support</td>
</tr>
<tr>
<td>PHQ-9 to facilitate diagnosis and track depression outcomes</td>
<td>- Close follow-up to make sure pts don’t ‘fall through the cracks’</td>
</tr>
<tr>
<td>2. Stepped Care</td>
<td>- Support anti-depressant Rx by PCP</td>
</tr>
<tr>
<td>a) Change treatment according to evidence-based algorithm if patient is not improving</td>
<td>- Brief counseling (behavioral activation, PST-PC, CBT, IPT)</td>
</tr>
<tr>
<td>b) Relapse prevention once patient is improved</td>
<td>- Facilitate treatment change / referral to mental health</td>
</tr>
</tbody>
</table>
**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.)

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>✓</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>✓</td>
<td>2</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>✓</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>✓</td>
<td>2</td>
</tr>
<tr>
<td>6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>✓</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>✓</td>
</tr>
<tr>
<td>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</td>
<td>0</td>
<td>1</td>
<td>✓</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead, or of hurting yourself in some way</td>
<td>✓</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

**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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Improved Satisfaction with Depression Care

(% Excellent, Very Good)

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

50 % or greater improvement in depression at 12 months

Unutzer et al, Psych Clin NA 2004
Better Physical Function

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

Baseline 3 mos 6 mos 12 mos

Usual Care

IMPACT

P<0.01

P=0.35

P<0.01

P<0.01

## Long-Term Cost Savings

<table>
<thead>
<tr>
<th>Cost Category</th>
<th>4-year costs in $</th>
<th>Intervention group cost in $</th>
<th>Usual care group cost in $</th>
<th>Difference in $</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMPACT program cost</td>
<td>522</td>
<td>0</td>
<td>522</td>
<td>522</td>
</tr>
<tr>
<td>Outpatient mental health costs</td>
<td>661</td>
<td>558</td>
<td>767</td>
<td>-210</td>
</tr>
<tr>
<td>Pharmacy costs</td>
<td>7,284</td>
<td>6,942</td>
<td>7,636</td>
<td>-694</td>
</tr>
<tr>
<td>Other outpatient costs</td>
<td>14,306</td>
<td>14,160</td>
<td>14,456</td>
<td>-296</td>
</tr>
<tr>
<td>Inpatient medical costs</td>
<td>8,452</td>
<td>7,179</td>
<td>9,757</td>
<td>-2578</td>
</tr>
<tr>
<td>Inpatient mental health / substance abuse costs</td>
<td>114</td>
<td>61</td>
<td>169</td>
<td>-108</td>
</tr>
<tr>
<td>Total health care cost</td>
<td><strong>31,082</strong></td>
<td><strong>29,422</strong></td>
<td><strong>32,785</strong></td>
<td><strong>-$3363</strong></td>
</tr>
</tbody>
</table>

Endorsements

- IOM Report
- Presidents New Freedom Commission on Mental Health
- National Business Group on Health
- AHRQ
- CDC Consensus Panel
- SAMHSA
  - National Registry of Evidence-Based Programs & Practices (NREPP)
### IMPACT Replication Studies

<table>
<thead>
<tr>
<th>Patient Population (Study Name)</th>
<th>Target Clinical Conditions</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult primary care patients (Pathways)</td>
<td>Diabetes and depression</td>
<td>Katon et al., 2004</td>
</tr>
<tr>
<td>Adult patients in safety net clinics (Project Dulce; Latinos)</td>
<td>Diabetes and depression</td>
<td>Gilmer et al., 2008</td>
</tr>
<tr>
<td>Adult patients in safety net clinics (Latino patients)</td>
<td>Diabetes and depression</td>
<td>Ell et al., 2010</td>
</tr>
<tr>
<td>Public sector oncology clinic (Latino patients)</td>
<td>Cancer and depression</td>
<td>Dwight-Johnson et al., 2005, Ell et al., 2008</td>
</tr>
<tr>
<td>HMO patients</td>
<td>Depression in primary care</td>
<td>Grypma et al., 2006</td>
</tr>
<tr>
<td>Adolescents in primary care</td>
<td>Adolescent depression</td>
<td>Richardson et al., 2009</td>
</tr>
<tr>
<td>Older adults</td>
<td>Arthritis and depression</td>
<td>Unützer et al., 2008</td>
</tr>
<tr>
<td>Acute coronary syndrome patients (COPES)</td>
<td>Coronary events and depression</td>
<td>Davidson et al., 2010</td>
</tr>
</tbody>
</table>
Over 4,000 providers trained in IMPACT Care

Clinicians Trained

Over 500 clinics

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Washington State
Mental Health Integration
Program (MHIP)
A Partnership to Promote Patient-Centered Collaboration

Community    Collaboration    Compassion    Care    Cost-effective

What is MHIP?

http://integratedcare-nw.org

Integration & Collaboration

The Mental Health Integration Program is a state-wide, patient-centered, integrated program serving clients with medical, mental health, and substance abuse needs. The program provides:

- High quality mental health screening and treatment
- An evidence- and outcome-based model of collaborative stepped care to treat common mental disorders

Results-oriented

Since the start of the program in January of 2008, MHIP has helped over 10,000 clients ages 0-100. Ongoing evaluation has shown substantial improvements in coordinated care and mental health outcomes.

Funding

- The Washington State Legislature provides dedicated funding to Community Health Plan of Washington to provide mental health services to clients on Disability Lifeline (formerly GA-U) around the state.
- In King County, the King County Veterans and Human Services Levy, Children’s Health Initiative, and the Mental Illness & Drug Dependency (MIDD) Action Plan increase access to MHIP through community health centers, public health centers, and other safety net clinics.
## MHIP

Best Practice Clinic Example

<table>
<thead>
<tr>
<th>Population</th>
<th>Mean baseline PHQ-9 depression score (0-27)</th>
<th>Follow-up (%)</th>
<th>Mean number of contacts</th>
<th>% with psych consultation</th>
<th>% with significant clinical improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disabled</td>
<td>17.0</td>
<td>96 %</td>
<td>12.7</td>
<td>82 %</td>
<td>50 %</td>
</tr>
<tr>
<td>Uninsured</td>
<td>17.0</td>
<td>93 %</td>
<td>10.6</td>
<td>90 %</td>
<td>53 %</td>
</tr>
<tr>
<td>Older Adults</td>
<td>16.0</td>
<td>92 %</td>
<td>14.3</td>
<td>89 %</td>
<td>54 %</td>
</tr>
</tbody>
</table>
# Integrated Care

## Team Building Process

<table>
<thead>
<tr>
<th>Integrated Care Tasks</th>
<th>Is This A Priority Task?</th>
<th>Is This Your Role Now?</th>
<th>If No, Whose Role?</th>
<th>Your Organization's Capacity with This Task?</th>
<th>Your Level of Comfort with This Task</th>
<th>Would You Like Training to Perform This Task?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify and Engage Patients</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>High</td>
<td>Med/Low</td>
</tr>
<tr>
<td>Identify People Who May Need Help</td>
<td></td>
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<tr>
<td>Screen for Behavioral Health Problems Using Valid Measures</td>
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<tr>
<td>Diagnose Behavioral Health Disorders</td>
<td></td>
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<tr>
<td>Engage Patient in Integrated Care Program</td>
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</tr>
<tr>
<td>Initiate and Provide Treatment</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>High</td>
<td>Med/Low</td>
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<tr>
<td>Perform Behavioral Health Assessment</td>
<td></td>
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<tr>
<td>Develop and Update Behavioral Health Treatment Plan</td>
<td></td>
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<tr>
<td>Patient Education about Symptoms &amp; Treatment Options</td>
<td></td>
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<tr>
<td>Prescribe Psychotropic Medications</td>
<td></td>
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<tr>
<td>Patient Education about Medications &amp; Side Effects</td>
<td></td>
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<tr>
<td>Brief Counseling, Activity Scheduling, Behavioral Activation</td>
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<tr>
<td>Evidence-based Psychotherapy (e.g. PST, CBT, IPT)</td>
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<tr>
<td>Identify and Treat Coexisting Medical Conditions</td>
<td></td>
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<tr>
<td>Facilitate Referral to Specialty Care or Social Services</td>
<td></td>
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<tr>
<td>Create and Support Relapse Prevention Plan</td>
<td></td>
<td></td>
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<tr>
<td>Track Treatment Outcomes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>High</td>
<td>Med/Low</td>
</tr>
<tr>
<td>Track Treatment Engagement and Adherence using Registry</td>
<td></td>
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<tr>
<td>Reach out to Patients who are Non-adherent or Disengaged</td>
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<tr>
<td>Track Patients’ Symptoms with Measurement Tool (e.g., PHQ-9)</td>
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<tr>
<td>Track Medication Side Effects &amp; Concerns</td>
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<tr>
<td>Track Outcome of Referrals and Other Treatments</td>
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</tr>
<tr>
<td>Adjust Treatment if Patients are Not Responding</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>High</td>
<td>Med/Low</td>
</tr>
<tr>
<td>Assess Need for Changes in Treatment</td>
<td></td>
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<tr>
<td>Facilitate Changes in Treatment / Treatment Plan as needed</td>
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<tr>
<td>Provide Case-load Focused Psychiatric Consultation</td>
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<tr>
<td>Provide In Person Psychiatric Assessment of Challenging Patients</td>
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</tr>
<tr>
<td>Other Tasks Important for Our Program (add tasks as needed)</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>High</td>
<td>Med/Low</td>
</tr>
<tr>
<td>Coordinate Communication Among All Team Members / Providers</td>
<td></td>
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<tr>
<td>Administrative Support for Program (e.g., Scheduling, Resources)</td>
<td></td>
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<tr>
<td>Clinical Supervision for Program</td>
<td></td>
<td></td>
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<tr>
<td>Training of Team Members in Behavioral Health</td>
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</tr>
<tr>
<td>1.</td>
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<td>2.</td>
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<td>3.</td>
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</tbody>
</table>

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# Program Staffing in Diverse Clinic Settings

<table>
<thead>
<tr>
<th>Clinic Population (mental health needs)</th>
<th>% of clinic population with need for care management</th>
<th>Typical caseload size for 1 FTE Care Manager</th>
<th># of unique primary care clinic patients to justify 1 FTE CM</th>
<th>Typical personnel requirement for 1,000 unique primary care patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low need (e.g., insured, employed)</td>
<td>2%</td>
<td>100</td>
<td>5000</td>
<td>0.2 (2 hrs / week)</td>
</tr>
<tr>
<td>Medium need (e.g., comorbid medical needs / chronic pain / substance abuse)</td>
<td>5%</td>
<td>75</td>
<td>1500</td>
<td>0.7 (3 hrs / week)</td>
</tr>
<tr>
<td>High need (e.g., safety-net population)*</td>
<td>15%</td>
<td>50</td>
<td>333</td>
<td>3 (12 hrs / week)</td>
</tr>
</tbody>
</table>
Summary:
Effective Integrated Care Programs

Effective multidisciplinary practice
- Efficient use of limited specialty mental health resources

Population focus
- Proactive care for a defined population of patients instead of ‘behavioral health urgent care’
- Registry to prevent people from ‘falling through the cracks’

Measurement-based stepped care
- Outcome measurement guides systematic application of evidence-based treatments
- Treatment to target
Rita Haverkamp, MSN, PMHCNS-BC, CNS
Clinical Nurse Specialist
Kaiser Permanente Southern California
IMPACT Dissemination at Kaiser Permanente

KPSC in IMPACT Study
  – (~ 280 participants in 1 clinic)

KPSC in San Diego after IMPACT
  – (2 clinics; Grypma et al, 2006)

KPSC Depression Initiative (Dreskin)
  – 13 regional medical centers serving 3 million members
Pilot Study

- Compare 284 clients in ‘adapted program’ with 140 usual care patients and 140 intervention patients in the IMPACT study
  (Grypma L, Haverkamp R, Little S, Unützer J, General Hospital Psychiatry, 2006)

Dissemination

- Implemented core components of program in 13 regional medical centers
Program Adaptations

Adults of all ages

Expanded team (medical assistant)

Added steps (‘depression class’)

Psychiatric supervision by telephone
KPSC – San Diego
‘After IMPACT’

Fewer care manager contacts

IMPACT Remains Effective

>= 50 % drop in PHQ-9 depression scores

Lower Total Health Care Costs

<table>
<thead>
<tr>
<th>Study Usual Care</th>
<th>Study IMPACT</th>
<th>Post Study IMPACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>$8,588</td>
<td>$7,949</td>
<td>$7,471</td>
</tr>
</tbody>
</table>

Kaiser Southern California Depression Program

– Dissemination

- Implementing program at 13 regional medical centers in KPSC (over 3 million members)
- Screening of all CVD, diabetic, COPD and patients 60-75
- Adding other patients with chronic conditions to this process over time
<table>
<thead>
<tr>
<th>Initial Screens January 1, 2009-December 31, 2009</th>
<th>0-4</th>
<th>5-9</th>
<th>10-14</th>
<th>15-19</th>
<th>20+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP MEDITCENTER</td>
<td>n</td>
<td>n</td>
<td>n</td>
<td>n</td>
<td>n</td>
<td>n</td>
</tr>
<tr>
<td>AV ANTELOPE VALLEY MED CTR AREA</td>
<td>1,575</td>
<td>109</td>
<td>90</td>
<td>40</td>
<td>28</td>
<td>1,842</td>
</tr>
<tr>
<td>KC BAKERSFIELD MED CENTER AREA</td>
<td>2,309</td>
<td>135</td>
<td>109</td>
<td>183</td>
<td>57</td>
<td>2,793</td>
</tr>
<tr>
<td>BP BALDWIN PARK MED CENTER</td>
<td>3,200</td>
<td>232</td>
<td>190</td>
<td>419</td>
<td>92</td>
<td>3,833</td>
</tr>
<tr>
<td>BF DOWNNEY MEDICAL CENTER AREA</td>
<td>4,215</td>
<td>633</td>
<td>377</td>
<td>271</td>
<td>110</td>
<td>5,546</td>
</tr>
<tr>
<td>FON FONTANA MEDICAL CENTER AREA</td>
<td>6,175</td>
<td>164</td>
<td>198</td>
<td>173</td>
<td>94</td>
<td>6,804</td>
</tr>
<tr>
<td>SB HARBOR CITY MED CENTER</td>
<td>2,772</td>
<td>103</td>
<td>138</td>
<td>95</td>
<td>47</td>
<td>3,155</td>
</tr>
<tr>
<td>OC ORANGE COUNTY MED CENTER AREA</td>
<td>4,494</td>
<td>258</td>
<td>193</td>
<td>119</td>
<td>79</td>
<td>5,144</td>
</tr>
<tr>
<td>PC PANORAMA MEDICAL CENTER AREA</td>
<td>4,847</td>
<td>288</td>
<td>263</td>
<td>150</td>
<td>75</td>
<td>5,623</td>
</tr>
<tr>
<td>RIV RIVERSIDE MEDICAL CENTER AREA</td>
<td>5,208</td>
<td>281</td>
<td>246</td>
<td>191</td>
<td>110</td>
<td>6,046</td>
</tr>
<tr>
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<td>368</td>
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<td><strong>Total</strong></td>
<td><strong>55,523</strong></td>
<td><strong>3,333</strong></td>
<td><strong>2,786</strong></td>
<td><strong>1,877</strong></td>
<td><strong>1,076</strong></td>
<td><strong>64,595</strong></td>
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</table>
PHQ-9 Initial Screening Results for Patients Scoring 10 or More
Complete Care Depression Program
Treatment Outcomes
January 1, 2009 – December 31, 2009 *

* Patients started the program any time in 2009, so some patients still receiving treatment after these results.
Marty Adelman, MA, CPRP
Mental Health Program Coordinator
San Diego Council of Community Clinics
CCC represents and supports 16 community clinic organizations operating over 100 sites in San Diego, Imperial and Riverside Counties.

Funding originates from Mental Health Services Act (prop 63) thru County of San Diego to Council of Community Clinics (CCC).

CCC subcontracts with 9 clinic organizations to provide mental health services at 16 sites.

Services first provided in February of 2007, with the majority of clinics initiating services in May of 2007.
Target population: Individuals with SMI/SED who are unfunded for mental health services:

Three Age Groups
- Children and Youth (ages 0-17)
- Adults (ages 18-59)
- Older Adults (ages 60 and over)

Two Treatment Models
- Specialty Pool Services (SPS)
- IMPACT

Outreach Component
- Senior Peer Promotora Program
“Traditional” model - “therapy” provided by mental health professional. Medication management provided by psychiatrist

- Maximum 13 visits for children and youth
- Maximum 12 visits for adults/older adults
- Medications – for up to 90 days, then pharmacy assistance programs (PAPs)

Short Term Treatment Model one year, those needing additional treatment are transitioned to County Mental Health providers

Achieves Co-location but not necessarily integration
IMPACT services

Up to 16 visits with a Depression Care Manager
Up to 4 visits with the PCP to prescribe and monitor medication
Treatment period of one year
Medication for a period of one year
Consulting psychiatry services provided by dually board certified psychiatrist/FP physician

Inherently integrated Model
Consulting Psychiatrist is built-in “Safety Net”
Essential Elements of IMPACT

1. Collaborative Care; DCM-PCP, DCM-psychiatrist
2. Depression Care Manager; treats, educates, monitors
3. Consulting Psychiatrist; consults primarily on those not who are not improving
4. Outcome Measurement; PHQ-9 administered at every visit
5. Stepped Care; treatment adjusted based on clinical outcomes
IMPACT clients complete PHQ-9 at each visit. Graph represents PHQ-9 scores for 947 A & OA’s. The average score at enrollment was 15.8. By session six, the average score was below 10. “N” indicates the number of clients in treatment at each session.
Cross Training DCM’s

Cross-training DCM’s to support PCPs in encouraging clients to make the necessary behavioral changes.

- Psychotropic Medications
- Diabetes
- Chronic pain
- Maternal Depression
- CVD/Heart Disease
- Link between Physical and Mental Health
Clients Served

February 1, 2007 – December 31, 2010

Clients Served by Age Range

- Youth: 320
- Adult: 132
- Older Adult: 3,135

Clients Served by Treatment Model

- SPS: 3,587
- IMPACT: 1,191

3,587 unduplicated clients served to date
Senior Peer Promotora Program

Specifically designed for Older Adults who are:

• Less likely to seek services on their own
• Less likely to identify their symptoms as depression
• More likely to isolate
• More likely to commit suicide

Promotoras Coordinators and Promotoras provide outreach, education and engagement activities to assist older adults and their families to access mental health and primary care services and stay in treatment
Meeting the DMH mandate

58.9% of clients who were approved for services by CCC (January 1, 2007 to June 30, 2010) had not been seen previously in the County Mental Health System.

30.4% of clients report that Spanish is their language preference compared to 16% of County clients.

43.7% of clients identify as Hispanic/Latino compared to 21% of County clients.
The project has successfully provided services to a population which is typically underserved due to the stigma associated with seeking and accepting MH services.

The project has likely made less impact on the morbidity disparity for those with SMI as only a small portion of those with SMI are seen in PC thru this project.
The Projects

Two projects achieving integration using differing approaches

MHSA

Primary Care

MH clinician

SAMHSA

NCM

Mental Health Program
Primary and Behavioral Healthcare Integration Project (PBHI)

• Four year project funded by SAMHSA
• One of initial 13 demonstration projects funded across the US

Nurse Care Managers (NCMs) embedded in MH programs, screening for;
• Diabetes
• Hypertension
• Hyperlipidemia (high cholesterol)
• Obesity
• Smoking
Between February 1 and September 29, 2010 NCM’s have screened 444 individuals

- **Gender**: male (176); female (268)
- **Age**: 18-24 years (18); 25-44 years (163); 45-64 years (243); 65+ (20)
- **Income**: <100% of FPL (378); 100-200% FPL (49); >200% FPL (11)
- **Insurance Status**: Medicaid/Medicare (177); Uninsured (263)
<table>
<thead>
<tr>
<th>Condition</th>
<th>Positive Screens</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>357/92</td>
<td>25.7%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>436/121</td>
<td>27.8%</td>
</tr>
<tr>
<td>Hyperlipidemia</td>
<td>353/177</td>
<td>50.1%</td>
</tr>
<tr>
<td>Obesity</td>
<td>436/233</td>
<td>53.4%</td>
</tr>
<tr>
<td>Smoking</td>
<td>433/153</td>
<td>35.3%</td>
</tr>
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</table>

Reaching those most at risk for premature illness and death.
Thank You

http://uwaims.org
Q: How are the providers incentivized to adopt this model of integrated care? do they bill differently for this care? If so, how? Please advise. Thank you!

This varies. In some cases, health plan or county / state contracts pay for the care manager / consulting psychiatrist’s services in primary care. In some cases, licensed care managers bill for the patient contacts. In some cases, the care management activities are incorporated in care management fees in the context of a Patient Centered Medical Home.

Q: How often do primary care physician and psychiatrist communicate about the patients’ care? Is there an ideal ratio of psychiatrist to primary care physician? What is the good patient panel size?

Most of the communication between PCP and Psychiatrist is conducted through the care manager who is based in primary care (a weekly scheduled review of all active cases and recommendations from the psychiatrist to the PCP), but PCPs and Psychiatrists do talk directly on occasion.

Q: Any advice on how to implement the IMPACT model to a large population?

Kaiser Permanente’s approach (outlined by Rita) is a fine example or the MHIP program (http://integratedcare-nw.org) or the DIAMOND program in Minnesota (see http://www.icsi.org/health_care_redesign_/diamond_35953/).

Q: What would be the key components of your program that has engaged the PCP's in the program?

Care management and psychiatry support makes their jobs easier. PCP visits become more productive / shorter. See Levine et al for a paper on PCP satisfaction with the program:


Q: Wondering if any type of CEUs credits are given.

Yes. We have given CEUs in various on-line or in person training activities. See training sections of AIMS (http://uwaims.org/) or IMPACT websites (http://impact-uw.org/).

Q: is there any data using this model within dialysis facilities?

Not that I am aware of.
Q: 1) Has there been any studies to see if the results at 12 months is maintained at 24 months?

YES. The results were largely maintained. See Hunkeler et al, BMJ:


2) What is the SF-12? Is this the same as VR-12?

SF-12 is a population health measure used in health services research (http://www.sf-36.org/tools/sf12.shtml).

3) Please define "older adults".

In the original IMPACT trial, we included patients age 60 and older.

Q: What specific backgrounds do the case managers have? as far as mental health, etc.

We do not use the term ‘case manager’ but rather ‘care manager’ because the individual is involved in providing care. The background varies. Mental health background is helpful but not absolutely required if adequate training and psychiatry support is available to support the care managers. We have trained nurses, social workers, licensed counselors and psychologists in the role of care manager. Some organizations have used Medical Assistants partnered with licensed professionals in this role.