

Role of Behavioral Health Professionals in a Collaborative Stepped Care Treatment Model for Depression in Primary Care: Project IMPACT

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We describe a new collaborative stepped care treatment model for depression in primary care that was recently tested in Project IMPACT, a multi-site, randomized, controlled study with older adults (Unutzer, Katon, Williams, Callahan, Harpole, Hunkeler, Hoffing, Arean, Hegel, Schoenbaum, Oishi, & Langston, 2001). We present in particular detail the role of the central figure in this model, the Depression Clinical Specialist, a behavioral health professional (a psychologist or psychiatric nurse) trained to coordinate the delivery of a flexible, multicomponent intervention that includes antidepressant medications and brief psychotherapy (Problem-Solving Treatment for Primary Care). We describe the training program for these specialists and present two patient case studies demonstrating the stepped care model in practice. Finally, we discuss the issues

involved in implementing this model and review recent changes in training and reimbursement practices for behavioral health professionals, suggesting the viability of the model for the future.

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Recent systematic reviews have confirmed the efficacy of pharmacological and psychotherapy treatments for late-life

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depression (Williams, Mulrow, Chiquette, Noel, Aguilar, & Cornell, 2000; Scogin & McElreath, 1994). Based upon these and other recent findings, in 1997 the NIMH issued a consensus statement concluding that psychotherapies, especially those involving standardized approaches, were effective treatments for late-life depression (Lebowitz, Pearson, Schneider, Reynolds, Alexopoulos, Bruce, Conwell, Katz, Meyers, Morrison, Mossey, Niederehe, & Parmelee, 1997). Although no single standardized approach was found to have a consistent advantage, the statement noted that problem-solving treatment, cognitive-behavioral therapy, and interpersonal therapy have demonstrated robust efficacy in a variety of settings (Lebowitz, et al., 1997).

In spite of the clinical efficacy of medications and psychotherapy demonstrated in controlled trials, depressed older adults often do not receive treatment for depression (Unutzer, Simon, Belin, Datt, Katon, & Patrick, 2000). Improving the effectiveness of care for depression in primary care, where older adults receive the majority of their medical care, will most likely require changes in the structural and cultural aspects of service delivery (Heinrich, 2000). To date, the most rigorous evaluation of such changes comes from studies of collaborative care models that integrate behavioral health professionals (BHPs—psychiatrists, psychologists, and psychiatric nurses) into the primary care setting to support medication management and to provide consultation and brief psychotherapy (Katon, Von Korff, Lin, Walker, Simon, Bush, Robinson, & Russo, 1995; Katon, Robinson, VonKorff, Lin, Bush, Ludman, Simon, & Walker, 1996; Wells, Sherbourne, Schoenbaum, Duan, Meredith, Unutzer, Miranda, Carney, & Rubenstein, 2000). These studies found that, when compared with care as usual, such collaborative care models improve adherence to antidepressant medication, improve patient satisfaction with care, improve acute treatment outcomes for patients with major

depression, and increase primary care physician satisfaction with their own level of care for depression.

During the acute treatment phase in one study of collaborative care, the costs per case of depression improved were lower for collaborative care than usual primary care for depression (VonKorff, Katon, Bush, Lin, Simon, Saunders, Ludman, Walker, & Unutzer, 1998). In particular, the integration of non-psychiatrist BHPs, such as psychologists (Katon, et al., 1996; VonKorff, et al., 1998) and registered nurses (Wells, et al., 2000; Schoenbaum, Unutzer, Sherbourne, Duan, Rubenstein, Miranda, Meredith, Carney, & Wells, 2001), results in improved quality of depression care and outcomes at a modest cost per case of depression improved. These studies indicate that collaborative care may have added value for the care of major depression in primary care.

Survey data suggest that most patients express a preference for their medical and behavioral health providers to communicate about their care (Mauksch, Tucker, Katon, Russo, Cameron, Walker, & Spitzer, 2001). However, traditionally separate medical and behavioral health care systems create multiple barriers to such communication. In an era in which primary care physicians are being asked to “do more with less time,” the integration of BHPs into the primary care clinic can assist the physician with patient education, symptom monitoring, and reinforcement of adherence to medication treatment. BHPs can also provide evidence-based psychotherapy, an intervention that primary care physicians are by and large not trained to deliver. To promote the integration of BHPs into primary care, briefer and more practical models of psychotherapy for depression are being developed and tested (Hegel, Barrett, & Oxman, 2000; Williams, Barrett, Oxman, Frank, Katon, Sullivan, Cornell, & Sengupta, 2000; Arean, Hegel, & Reynolds, 2001; Barrett, Williams, Oxman, Frank, Katon, Sullivan, Hegel, Cornell, &

Sengupta, 2001). Providing even a brief psychotherapy in primary care is a challenging undertaking. Nonetheless, given that approximately 30 percent of depressed primary care patients cannot take or prefer not to take medications (Scott & Freeman, 1992; Priest, Vize, Roberts, & Tylee, 1996; Brody, Khaliq, & Thompson, 1997), it is important to have non-pharmacologic interventions available. BHPs may be ideally suited for the combined roles of medication support and delivery of brief therapy.

In this paper we describe the role of the BHP in a recently completed study of an intervention for late-life depression in primary care (Project IMPACT). This role includes a combination of traditional and innovative practice elements. The BHP delivers traditional services such as brief psychotherapy and care management in collaboration with the primary care providers. In addition, the BHP is trained to monitor response to medication and to coordinate treatment delivery according to a "stepped care" algorithm. The entire intervention model is aided and guided by an electronic clinical information system.

PROJECT IMPACT

Project IMPACT was a multi-site trial of a collaborative, stepped care treatment program for late life depression in primary care that integrates brief psychotherapy and medication management (Unutzer, et al., 2001). At each of 18 participating primary care clinics, older adults meeting diagnostic criteria for major depression and/or dysthymia were randomly assigned to a collaborative stepped care program or to care as usual. In the intervention program, a depression clinical specialist (DCS—a psychologist or a psychiatric nurse) in the primary care clinic worked with patients and their primary care physicians for up to 12 months. The goal was to improve depression by supporting the use of antidepressant medications and/or providing a course of

Problem Solving Treatment for Primary Care (PST-PC, described below).

For intervention patients the DCS conducted an initial assessment of depressive symptoms, level of functioning, and comorbid medical and psychiatric illness. To promote maximal generalizability of the study, very few exclusion criteria were included. Patients were excluded only for current problem drinking, a major psychiatric illness (i.e., schizophrenia or bipolar disorder), acute suicide risk, or severe cognitive impairment. The DCS educated the patient about depression using a brochure and videotape (Harpole, Steffens, & Saur, 1999; Oishi & Unutzer, 1999). The DCS discussed initial treatment options with the patient, including either antidepressant medications or PST-PC, based on patient preference, and developed a treatment plan according to a stepped care treatment protocol (Unutzer, et al., 2001) in consultation with the patient's primary care physician. The DCS then followed the patient with weekly or bi-weekly in-clinic or telephone contacts.

In Step 1 of stepped care treatment the patient and primary care provider were encouraged to initiate treatment for 8 to 12 weeks. Patients whose depression was in remission at the end of Step 1 received a relapse prevention plan and were followed with monthly contacts in clinic or by phone. Patients not achieving a complete response were considered for a change in treatment in Step 2 (a change in antidepressants, a switch from medications to PST-PC or vice versa, or a combination of antidepressants and PST-PC if there was a partial response to either treatment in Step 1). Patients who were not improved after 10 weeks of Step 2 treatment are considered for a psychiatric consultation in the primary care clinic (about 10 percent of cases in the current study) and additional changes in treatment plan (Step 3 treatment).

The primary care provider was given regular updates on the patient's progress. The DCS met weekly with a team

psychiatrist to review the caseload and to discuss patients not responding to treatment as expected. The DCS used an internet-based clinical information system to record, view, and summarize patient contacts. Caseload summaries and standardized depression severity ratings were reviewed with the treatment team to determine if patients were responding to treatment or whether or not a change in treatment was needed. The clinical information system also reminded the DCS if an intervention patient had not had a recorded contact during the acute treatment phase or if a patient spent more than 12 weeks on what appeared to be ineffective treatment.

DCS caseloads varied depending on the amount of time the DCS worked on the project but were as high as 85 patients in active treatment at any given time for a full-time DCS. The data on the outcomes of the IMPACT treatment model are pending at this time. However, the intervention was successfully integrated at all 18 participating primary care clinics, and feedback indicated that it was well received by both patients and their primary care providers.

PROBLEM SOLVING TREATMENT OF DEPRESSION FOR PRIMARY CARE

The problem-solving treatment used in IMPACT is adapted from problem-solving therapy models developed for the mental health sector (e.g., Nezu, Nezu, & Perri 1989; Catalan, Gath, Bond, Day, & Hall, 1991). To distinguish the primary care version of problem-solving treatment from the parent models, we refer to it as "Problem-Solving Treatment for Primary Care." PST-PC is designed for the environment of a busy primary care clinic; sessions fit into 30-minute clinic visits (with the exception of the first visit, which lasts for 60 minutes) and total length of treatment is four to eight sessions.

PST-PC is a skills-based intervention in which there are three main goals. First, the

patients' depressive symptoms are identified and linked with their problems in living. Second, the problems are defined and clarified. Third, an attempt is made to solve the problems in a structured way. The theorized mechanism of change is that the process of reasserting control over problems leads to increased hopefulness and self-efficacy, which in turn leads to improved mood. A PST-PC treatment session consists of seven consecutive stages (outlined in the Table) that are applied to at least one problem area per treatment session (See Hegel, Barrett, & Oxman, 2000, for a more thorough description of PST-PC). Early treatment sessions often focus on the more manageable problem areas with the goal of learning the problem solving strategy, while mid-treatment and later sessions often address the more complex problem areas. In randomized controlled studies, PST-PC has been shown to be an effective treatment for major depression (Mynors-Wallis, Gath, Lloyd-Thomas, & Tomlinson, 1995; Mynors-Wallis, Gath, Day, & Baker, 2000), and possibly dysthymia and minor depression (Williams, Barrett, Oxman, et al., 2000; Barrett, et al., 2001).

Challenges to the Delivery of PST-PC with Older Adults

In conducting this study with older adults it became apparent that changes in health status, memory, and cognitive processing made psychotherapy delivery more challenging than for younger adults (Gallagher-Thompson, Hanley-Peterson, & Thompson, 1990). The most important problems addressed for these older depressed adults were the slower learning rate and diminished capacity to attend to task. To address these issues we increased the number of possible sessions from six to eight so that there was more of an opportunity to practice the problem-solving skills being taught. We also created a strategy based on Thompson's (Thompson, 1986) "say-it, show-it, do-it" that

TABLE 1

*The Seven Stages of PST-PC***Stage 1: Defining the Problem**

- Specific, feasible problem
- Described in objective terms
- Problem explored and clarified
- Complex problem broken down

Stage 2: Establishing Realistic Goals for Problem Resolution

- Goal is objective
- Described in behavioral terms
- Goal is achievable

Stage 3: Generating Multiple Solution Alternatives

- Brainstorming is facilitated
- Solutions come from patient
- Withhold judgment

Stage 4: Implementing Decision-Making Guidelines

- Consider “pros” and “cons” for each solution
- Solutions are compared to each other
- Psychosocial resources are addressed

Stage 5: Evaluating and Choosing the Solution(s)

- Deliberate, systematic process
- Solutions satisfy the goals
- Negative impact is limited

Stage 6: Implementing the Preferred Solution(s)

- Specific tasks are identified
- Tasks are relevant to solution
- Tasks are within the patient’s repertoire

Stage 7: Evaluating the Outcome

- Review all assigned tasks
- Exploration of failure
- Renew problem solving if necessary

we call “cue and review.” The DCS explains each step of problem solving, assists the patient as necessary to complete the step, and then reviews what the patient just accomplished. At the end of the session the entire process is briefly reviewed. Once the patient is familiar with the problem-solving strategy, the therapist begins to prompt the patient to generate the steps independently so that the patient can gain autonomy over the problem-solving process. In addition to these strategies, we made further

modifications that included enlarging and simplifying the PST-PC worksheet and training staff in redirection methods to be used when patients had difficulty tracking the discussion.

In addition, many patients enrolled in this study were at high risk for relapse due to long depression histories and chronic medical illnesses. To minimize the likelihood of relapse following acute treatment, we added monthly maintenance group PST-PC meetings for patients who responded to

treatment. These maintenance groups were meant to reinforce the skills acquired during the acute phase of treatment, and to prevent relapse of depression. Patients responding to PST-PC treatment met on a monthly basis with the DCS, with new members being added as they “graduated” from acute treatment, for up to one year. Occasionally more than one group was necessary to accommodate higher numbers of patients (typically 4 to 8 members per group). During the meeting, the group reviewed problem-solving skills, discussed any problems that occurred the month before, and applied the PST-PC strategy to one or two problems. These problems were derived from a relevant situation for a group member or focused on more generic problems for older adults, such as coping with loss or chronic illness.

DCS Training Program for PST-PC in Project IMPACT

In project IMPACT the DCSs were psychologists and psychiatric nurses. The first and fifth authors (MTH and PAA) conducted all PST-PC training. To be certified to deliver PST-PC for the study, the DCSs attended an eight-hour workshop to learn (a) the therapeutic rationale for PST-PC, (b) how to orient the patient to treatment, and (c) how to conduct a PST-PC session. Workshop training materials included didactic instruction, viewing of videotapes demonstrating proper PST-PC procedures, and an opportunity to role-play with expert feedback. Subsequent to the workshop, the DCSs treated five training cases at their own sites. Training consisted of six sessions of PST-PC for each patient for a total of 30 treatment visits over the five training cases. Sessions one, three, and five for each patient were videotaped and reviewed by the trainer using the PST-PC treatment integrity scale developed from earlier research (Hegel, Barrett, & Oxman, 2000). Each DCS received 15 feedback sessions (three audiotaped sessions for five patients) provided by phone.

A strong correlation was found between the number of treatment sessions completed and the treatment integrity scale ratings ($r = 0.78$). IMPACT therapists ultimately achieved a level of performance that was superior to that of therapists trained for the previous study ($F=5.91, p < .001$) (Hegel, Barrett, & Oxman, 2000).

CASE EXAMPLES

Case 1

Mrs. T.: Medications (Step 1) followed by PST-PC (Step 2)

Step 1. Mrs. T. was a retired 68-year-old who suffered from long-standing depression and complained, “I just don’t want to do anything.” Mrs. T. met diagnostic criteria for dysthymia and was moderately depressed. Current symptoms included lack of interest, low energy, overeating, and sleeping problems. Her symptoms worsened about two years prior when her husband had a stroke, leaving him disabled and dependent. Mrs. T. had been taking fluoxetine 20 mg per day for approximately seven years and described it as helpful but not sufficient to eliminate completely her depressive symptoms. Earlier attempts to increase the dose of fluoxetine had failed because of increased side effects. Given her problems adjusting to life with a disabled husband, she chose to start PST-PC rather than make a medication change, although she chose to remain on her current dose of medication.

Step 2. In the first PST-PC session a problem list was created which included problems relating to her husband, low frustration tolerance, arthritis pain, lack of exercise, obesity, a cluttered home office, and many unfinished household tasks. As a starting point for learning the PST-PC skills, Mrs. T. chose to address her lack of exercise. Potential solutions included using an exercise cycle, walking the dog, and working in the yard. Mrs. T. chose walking the dog around the neighborhood because of the exercise benefit for her and the dog, as well as the

opportunity to socialize with neighbors. Homework steps included selecting days and times to walk, determining the length of the walk, and deciding on a main route as well as alternative routes to prevent boredom.

At the second session Mrs. T. reported being able to follow her plan of walking the dog three times per week. She expressed an interest in next working on her cluttered office with the goal of organizing it so she could find things as needed. Solutions included hiring someone to organize the office, organizing it herself, or having a relative do it. She chose to do the organization herself because she felt it was easier to discard papers as necessary as well as being the least expensive option. She committed herself to completing the task by scheduling specific times to organize the office, sort through papers, file kept materials, and rearrange the office.

At the third session Mrs. T. reported that she was successful in organizing her office and experienced further improvement in her mood. She chose now to focus on her weight concerns. Solutions considered included a decrease in her total caloric intake, a further increase in her activity level, and creating a meal schedule separate from her husband's. She chose to decrease her total caloric intake in addition to creating a specific meal schedule because she felt these options were more under her control and would have the least negative impact on her husband. Steps to achieve the solution included planning meals, selecting the "right" foods when shopping, choosing more vegetables, cutting back on starches and portion size, and deciding the time of meals to coordinate with other activities.

At the fourth session, Mrs. T. reported that she was successful in changing her eating habits by planning her meals and decreasing her portion size at each meal. She had also maintained her exercise routine of walking the dog three times per week. Combined, these efforts resulted in a weight loss of five pounds. Her mood remained vastly

improved. During this session, she chose to address her lack of intimacy with her husband. Upon exploration, the problem was related to her concern about her husband's physical condition. She expressed the goal of increasing physical contact with him. Solutions included hugging him more frequently, verbalizing her feelings and concerns to her husband, having sexual intercourse, and "intimate touching" (i.e., mutual masturbation). She chose the solutions of hugging her husband and verbalizing her feelings, as well as speaking with his doctor to discuss potential physical limitations he may have for intercourse. Her action plan included first taking some planned time to think about how to approach the topic and then displaying intimacy with touches and hugs, and expressing words of affection.

Mrs. T. reported successful interactions with her husband when she arrived at the fifth session, having found satisfaction for both of them ultimately through intimate touching. Because her depressive symptoms had decreased and stabilized, a relapse prevention plan with monthly follow-up sessions was put into place. Mrs. T. identified cues such as overeating, lack of motivation, and interrupted sleep as potential warning signs of a depression relapse and her signal to initiate contact for further assistance. At this point, she was moved to the PST-PC maintenance group.

Mrs. T. was an active participant in the maintenance group. She initiated the first problem to discuss (i.e., "how one opens up in a group of strangers to talk about problems") and addressed her concerns freely as they arose. Toward the end of her year in the study, however, her husband died. Although she seemed to be handling this loss well, she expressed interest in individual follow-up sessions in addition to the PST-PC monthly group meetings.

The individual work conducted during this difficult time consisted of reviewing the problem solving skills and applying them to

this new change. New problems included deciding what to do with her husband's belongings and determining how to spend her time (e.g., traveling to see her son). Within three weeks of resuming individual work, she again was reporting a relative absence of depressive symptoms. One year after starting treatment Mrs. T. was feeling well, had created an active independent lifestyle (e.g., visiting friends, traveling more, and tending to her own health), and her sleep problems had ceased. The treatment plan included remaining on fluoxetine 20 mg daily for an additional year due to Mrs. T.'s high risk for relapse.

Case 2

Mrs. S.: PST-PC (Step 1) followed by medication (Steps 2 and 3)

Step 1. Mrs. S., a 77-year-old divorced female, presented with 10 years of depressed mood with chronic fatigue, frequent tearfulness, obesity, and low self-esteem. At initial assessment she was moderately depressed and met diagnostic criteria for both major depression and dysthymia. She had been treated with sertraline 100 mg for almost three years but did not feel this helped.

Mrs. S. described herself as "tired due to a traumatic life." She described a history of a poor marriage to an abusive ex-husband. The divorce left her with limited finances and estrangement from one of her two sons. She worked as a practical nurse at a local hospital for decades and particularly enjoyed working with infants. Knee problems forced her retirement 10 years earlier. She had not felt needed since. Medical conditions included spinal stenosis, peripheral edema, cellulitis, incontinence due to a spastic bladder, a 150-pound weight gain over ten years, and hypertension. Mrs. S. initially selected PST-PC feeling that previous antidepressant therapy was not helpful. In discussing her preferences with the treatment team it was decided that due to previous episodes and current symptoms, if Mrs. S. did not show a

significant positive response to PST-PC by five weeks, the addition of an antidepressant should be considered.

Her initial problem list included the following: updating legal arrangements such as her will; disorganized legal paperwork; disarray of her house; difficulty with daily tasks due to poor health; limited finances; difficulty expressing her needs and being assertive with others; procrastinating on daily tasks and particularly with letter writing; dissatisfaction with her present church; frustration about the lack of communication from her physician; and feelings of being unneeded and unwanted.

Mrs. S. chose to initially address the fact that she was not expressing her needs to her sons. Her stated goal was to express specific needs to one of her sons. She considered the following potential solutions: spend more time visiting at his house; ask him and his family to visit her home; ask him for help with legal papers; and request his help with the specific task of clothes shopping. She chose to ask him for help organizing her legal papers and documents. Although this choice included the negative aspect of confronting painful memories (as related to the legal items connected to her past marriage) she ultimately selected it because it would allow her to accomplish the two important goals of connecting with her son and making progress on the task of organizing her papers. Steps involved gathering boxes, calling her son (saying, "You've been after me to accomplish this. I can do it with your help. Will you help me?"), and scheduling a date and time for the project. She also committed to engaging in regular pleasant activities such as playing cards and working on crafts.

At the second session her depression remained unchanged. She reported having only gathered the boxes. Unable to enlist her son's assistance due to his busy schedule, she postponed the paperwork project until he was available. She did, however, accomplish the task of speaking and expressing her needs to her son, and she felt

some degree of satisfaction with her efforts. In this session she focused on undone household tasks. Her goals were to clean shelves in the kitchen, take down the Christmas tree decorations, and clean out the closet. She brainstormed five potential solutions including setting the alarm for 7 a.m., scheduling a time for the tree tasks, setting a deadline for the tree, calling the thrift store for an appointment to bring in the closet items, and cleaning a few items from the shelves while doing the dishes. Her action plan included rising daily at 7 a.m., calling the thrift store, and setting the specific deadline for the tree.

At the third session Mrs. S.'s depression was no better in spite of having completed all of her homework tasks. In keeping with the agreed treatment contract the PST-PC was continued. Her defined problem for this session was the disorderly house preventing her from inviting company. Her goal was to straighten the house, especially the guest room and bedroom. She brainstormed solutions such as dusting the house, vacuuming the house, and enlisting a yard worker. She chose all solutions, estimating that completing less than all of the tasks would leave her too far short of her goal. Her plans to achieve the solution included pacing herself with dusting and vacuuming on alternating days, along with frequent rest periods, and calling the yard worker on Wednesday while continuing to arise at 7 a.m.

At the fourth session (week 5 in treatment) her depression had become severe. Her progress with homework was limited as several tasks were prevented by pain. She had called the yard worker and completed working on her closet but due to pain was up by 7 a.m. on only two days. Her defined problem for this session was the pain's interference with her tasks. Her goal was to find ways to accomplish the tasks, even though she was experiencing pain. Her potential solutions included further efforts toward pacing herself by doing one kitchen

shelf after breakfast and one after lunch, dividing dusting between Tuesday and Thursday afternoons, and vacuuming on Friday mornings when her energy level was likely to be high. Her chosen solution was to pursue all items, thinking that the added element of pacing would ensure success, and she expressed optimism about combining pacing and attacking tasks during periods of high energy.

Step 2. In spite of considerable success between visits, Mrs. S. remained severely depressed at the fifth session. At this point she agreed to begin a trial of citalopram, starting at 10 mg daily and increasing to 40 mg as necessary. Two weeks later she was still not substantially improved. Nonetheless, she continued to show progress on her problems, having completed two kitchen shelves, mopped the kitchen floor, dusted, vacuumed, and even begun sorting and shredding unneeded documents despite her pain as she continued to pace herself appropriately. In consultation with the primary care physician, the dose of citalopram was increased to 20 mg per day.

At the sixth session (week 10 of treatment) her depression had improved only slightly and therefore her citalopram was increased to 30 mg. She continued to report complete success with homework and a very high satisfaction level with this. She also revealed achieving an important insight regarding her increased effectiveness when breaking tasks into manageable chunks. Before developing depression and physical problems her style was to work long hours without breaks. She took great pride in this and had been emotionally struggling with the loss of this ability and came to realize that some of her depression was related to this loss.

Continuing with the theme of pacing herself with household chores, she chose to go through boxes in the garage and decide what to give away. She developed the solutions of taking the boxes onto the patio and working there, breaking up the two hours

into 30-minute sections, and asking a friend to help. She liked the idea of working on the patio because it would get her outdoors and thought having a friend to help would make the job more pleasant.

Step 3. By week 25 of treatment, with combined medication (citalopram 40 mg) and PST-PC maintenance therapy, Mrs. S. had improved substantially although the symptoms of fatigue and low energy remained nearly every day. The team psychiatrist suggested that the addition of a small amount of a psychostimulant (methylphenidate 5 mg) might improve the long-standing fatigue and low energy. Also at this time the patient began to follow a low carbohydrate diet. No improvement in energy level was noted by week 30, therefore the methylphenidate was increased to 10 mg.

At the end of the study (week 53) Mrs. S. remained significantly improved with fatigue occurring on approximately half of all days rather than daily. She had lost 50 pounds and was consequently able to discontinue her blood pressure medication. She was participating in a weight management support group, continued the principle of breaking tasks into manageable chunks, and reported good progress in keeping up with her house.

DISCUSSION

It has long been recognized that the primary care medical setting is well designed to manage acute medical problems but is not well prepared to manage chronic illness (Wagner, Austin, & VonKorff, 1996; VonKorff, Gruman, Schaefer, Curry, & Wagner, 1997). These deficits in the system of care are relevant for all primary care patients but are particularly critical for older adults with their greater illness burden. The primary care setting is also not well designed for detection and treatment of psychological disorders, a process that is often time consuming in the diagnosis stage and may

require more frequent follow-up than for other conditions. Recognizing the time constraints and practice burdens faced by primary care providers, a number of organizations are now engaged in a redesign of primary care by developing collaborative relationships with allied health professionals and specialists and constructing patient care teams for patients with chronic illnesses (Wagner, Burns, Broadhead, Yarnall, Sigmon, & Gaynes, 2000). Project IMPACT represents an application of such a collaborative care model for the treatment of depression in older adults in primary care settings. The intervention model provides additional resources that improve the ability of the clinical practice to deliver guideline-concordant evidence-based treatments such as antidepressant medications and brief, structured psychotherapy.

In the current reality of primary care medicine, several barriers impede the progress of such practice redesign. These include a lack of MBHO and HMO reimbursement for the DCS care management services and a lack of BHPs trained to provide behavioral health care in primary care settings. BHPs working as depression clinical specialists must have a home in the primary care clinic alongside the physicians, mid-level providers, nurses, nutritionists, etc. They must also be responsive to the primary care system, offering brief interventions to those who can be managed in primary care and referring patients who are not making progress in that setting for further specialized behavioral health care. In the past, BHPs were not prepared to work in primary care settings. They typically practiced in a separate space bearing little resemblance to a medical setting and offered longer-term, more traditional psychotherapies. They kept different clinic schedules, separate clinical records, and rarely communicated with the referring primary care providers. Such a completely separate behavioral health care

system must be modified if effective integrated collaborative care is to be achieved.

There are promising signs that the chasm between mental health and primary care is shrinking. More than ever before, BHPs are being prepared to practice in medical settings, are breaking out of old molds of practice, and are beginning to be reimbursed for their efforts. This is evidenced by (a) several large staff model HMOs (e.g., Kaiser Permanente, Group Health Cooperative of Puget Sound, and HealthPartners) routinely including behavioral medicine therapists on the staff of their primary care clinics; (b) growing emphasis in clinical psychology training programs (predoctoral and postdoctoral) on preparing psychologists to practice in primary care and other medical settings (Anderson & Lovejoy, 2000; Twilling, Sockell, & Sommers, 2000); (c) a new multidisciplinary association established with the specific mission of promoting integrated collaborative care in primary care (Collaborative Family Health Care Association); (d) psychology predoctoral internship programs recently being included for subsidies under Medicare's Graduate Medical Education (GME) program by the U.S. Department of Health and Human Services, which will increase the number of trained psychologists practicing in medical settings; and (e) HCFA establishing new CPT codes allowing BHPs to bill third-party payers for services incident to physical illness and disease.

Based on these recent trends we suggest that more BHPs should be practicing in primary care settings in the future. To guide their efforts they will rely upon brief evidence-based psychotherapies designed for primary care, such as PST-PC, and models of collaborative stepped care, such as is demonstrated in Project IMPACT. Research efforts to design and test such interventions must therefore continue in parallel with the expanding movement toward integrated collaborative care.

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