GermanIMPACT: A Collaborative Care Model for Late-Life Depression in the German Primary Care Context

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STUDY INFORMATION

GermanIMPACT is an ongoing cluster-randomized controlled trial on the implementation of a collaborative, stepped care model to treat late-life depression in German primary care. We developed the concept as an evidence-based adaptation of a successful US American model (IMPACT). GermanIMPACT is funded by the German Federal Ministry of Education and Research.

BACKGROUND

Late-Life Depression: A Primary Care Challenge

- Prevalence of major depression in individuals aged 75+: 9.3%-13.9% for higher vs. lower social class; 37.4% [Sapolinsky et al., 2010]
- Depression as key risk factor for suicide in later life, especially in conjunction with poverty, disability, and social isolation
- Late-life depression causes high indirect costs (Köth et al., 2020)
- Symptoms often falsely interpreted as part of the normal aging process (e.g., sleep disorders, social withdrawal, anhedonia)
- Increased risk of institutionalization of mental disorders among older adults in Germany
- Lack of knowledge about treatability of depression
- Limited time for screening, follow-up, and practitioner-patient conversation in primary care; treatment of health issues often perceived as more urgent
- Protracted mental health issues (e.g., depression) needed
- Limited access to mental health specialists
- High risk of chronicity

The IMPACT Model

- Evidence-based treatment of depression
- Collaborative care provided by a general practitioner (GP), a care manager (CM), and a consulting/ supervising mental health specialist (MHS)
- The CM, typically a trained nurse or social worker, supports the treatment initiated by the GP by means of proactive and continuous follow-up with the patient
- Stepped care intervention tailored to the patient's individual needs (optimal treatment results, minimal costs)

Effectiveness

- Unutzer et al. (2008): ICT: 50% symptom reduction in 45% of patients receiving IMPACT treatment and significantly reduced medical expenses over 4-year follow-up
- Thota et al. (2012): meta-analysis: evidence for symptom reduction (SMD = 0.14)
- Successful pilot implementation in Europe (e.g., Huijbregts et al., 2013; Menchetti et al., 2013; Richards et al., 2013)

STUDY DESIGN

Recruitment and Randomization

- Each study center (city) will enroll 30 GP offices within a defined radius
- GP offices are randomly assigned to intervention and control group
- GPs screen and enroll patients (recruitment goal: 150 patients per city)

Inclusion criteria:
- Age: >60
- Moderate symptoms of depression (PHQ-9 Score: 10 – 14)

Exclusion criteria:
- Alcohol or drug abuse
- Severe cognitive impairment (e.g., dementia)
- Bipolar disorder
- Psychotic disorder or severe behavioral symptoms
- Obsessive compulsive disorder
- Suicidal ideation and other warning signs of suicide
- Active non-pharmacological (or combined) depression treatment by a specialist at time of inclusion

Intervention Techniques Provided by CM

- Patient education
- Identification and integration of positive activities into the daily routine
- Case management and referral prevention
- Training in problem-solving techniques as needed

Study Outcomes

- Primary Outcomes
  - Change of PHQ-9 score from baseline to end of intervention (month 12)
- Secondary Outcomes
  - Quality of life (EQ-5D; EuroQol Group 1990)
  - Resource utilization (FIMA, Bock et al., 2014)
  - Comorbidity (CDI; Bierler et al., 2000; Czob, T.; Spitzer et al., 2000; CFG, Klaassen et al., 2004)
  - Resilience (R-15, Supper et al. 2008)
- Depression-related behavior (Supper et al., 2003)
- Problem-solving skills (Fulch, Beck & Wattle, 2012, unpublished manuscript)

Project Recruitment

Recruited GP offices that were able to enroll patients: 66 total
- Hamburg: 35 (17 in IG, 18 in CG)
- Hamburg: 31 (20 in IG, 11 in CG)
- Freiburg: 31 of the patients in the IG have quit treatment prematurely, but are still participating in the study

Additional GP offices had to be recruited because some of the enrolled offices were unable to identify or enroll patients, other offices quit their enrollment efforts prematurely. We believe that this happened for several reasons:
- Informing and screening patients for study inclusion is a time-consuming process that cannot easily be integrated into the GPs' tight schedules
- The inclusion criteria were too narrowly defined (PHQ-9 score, age) to find enough eligible patients during the limited time frame
- Patients were not sufficiently motivated to participate.

References