
View Abstract

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TITLE: BREAKING SAD: IMPROVING CHRONIC ILLNESS THROUGH THE IMPACT COLLABORATIVE CARE MODEL FOR MANAGEMENT OF DEPRESSION IN AN URBAN UNDERSERVED PRIMARY CARE PRACTICE

ABSTRACT BODY:

Statement of Problem or Question (one sentence): Does the IMPACT model improve engagement and chronic disease management in a lower socioeconomic Afro-Caribbean Central Brooklyn population?

Learning Objectives 1: Will interdisciplinary collaborative care (CC) embedded in primary care (PC) help patients manage depression and improve self-management of chronic disease?

Learning Objectives 2: Can a population health registry for patients living with depression help primary care providers (PCP) understand the impact of CC on our patients?

Description of Program/Intervention, including organizational context (e.g. inpatient vs. outpatient, practice or community characteristics) : The 2010 Collaborative Care for Patients with Depression and Chronic Illnesses trial^[1] studied the IMPACT CC model for depression^[2] on chronic disease control in 14 Washington State PC clinics. This protocol-driven, patient-centered intervention significantly improved control of medical disease and depression.

NYC Health + Hospitals/Kings County treats primarily Afro-Caribbean and African American patients. A 2007 study showed only 45% of African Americans and 24% of Caribbean blacks diagnosed with major depressive disorder receive treatment.^[3] In 2012, NYCH+H adopted the IMPACT model to improve diagnosis and treatment of depression in our population.

PHQ-9 questionnaire is administered to all PC patients. PCP introduce patients with moderate depression^[4] (score ≥ 10) to an embedded mental health social worker (MHSW) and offer CC. Enrolled patients receive team-based counseling (MHSW, psychiatrist, PCP) with motivational interviewing, problem solving and medical therapy, and concrete resources to address social determinants of health. The NYCH+H Population Health Registry tracks screening rate and yield, enrollment, monthly contact rate, improvement rate, and need for psychiatric consultation or treatment change.

400 patients enrolled in CC at NYCH+H/Kings County between 2016 to 2019; 161 graduated (sustained PHQ-9 < 9) and were included. Patients who declined, were deceased, or lost to follow up were excluded.

Measures of success (discuss qualitative and/or quantitative metrics which will be used to evaluate program/intervention): A retrospective chart review compared systolic and diastolic blood pressure, BMI and Hgb A1C values within 3 months prior to enrollment to measurements in the 3 months after graduation.

Findings to Date (it is not sufficient to state findings will be discussed): Graduates from CC had a statistically significant improvement in systolic blood pressure from 133.86 mmHg to 127.29 (p < 0.0005), an improvement of 6.566 mmHg. Diastolic blood pressures improved from 76.37 mmHg to 73.16 mmHg (p < 0.009). BMI decreased from 29.79 kg/m² to 27.12 kg/m² (p < 0.001), an improvement of 2.67 kg/m². Hgb A1C values decreased from 7.553 to 7.174; (p < 0.059); an improvement of 0.3794.

Key Lessons for Dissemination (what can others take away for implementation to their practice or community?): Interdisciplinary CC for depression embedded in PC improves engagement and may decrease stigma around diagnosis and treatment. Longitudinal population health registry data showed that lessons learned in the IMPACT study are applicable to our inner city, low socioeconomic status Afro-Caribbean patients

with regards to hypertension, obesity, and diabetes self-management.

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