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Breaking Sad: Improving Chronic Illness Through The Impact Collaborative Care Model For Management of Depression In An Urban Underserved Primary Care Practice

The 2010 Collaborative Care for Patients with Depression and Chronic Illnesses trial studied the IMPACT CC model for depression 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. 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 (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 and were included. Patients who declined, were deceased, or lost to follow up were excluded. 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. Graduates from CC had a statistically significant improvement in systolic blood pressure and diastolic blood pressures. BMI and Hgb A1C values decreased as well. Longitudinal population health registry data showed that lessons learned in the IMPACT study are applicable to our inner city, low socioeconomic population with regards to hypertension, obesity, and diabetes self-management.

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