

The Cohort Management Program: Optimizing Chronic Illness and Depression Management Through Team-based Care

Care Support Program

Office of Population Health

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Background

- Chronic conditions are the leading cause of death and disability in the United States and account for 83% of overall healthcare spending
- Chronic physical illness accompanied by major depressive disorder (MDD) is associated with approximately **doubling of the likelihood of health care utilization** but MDD often goes undiagnosed

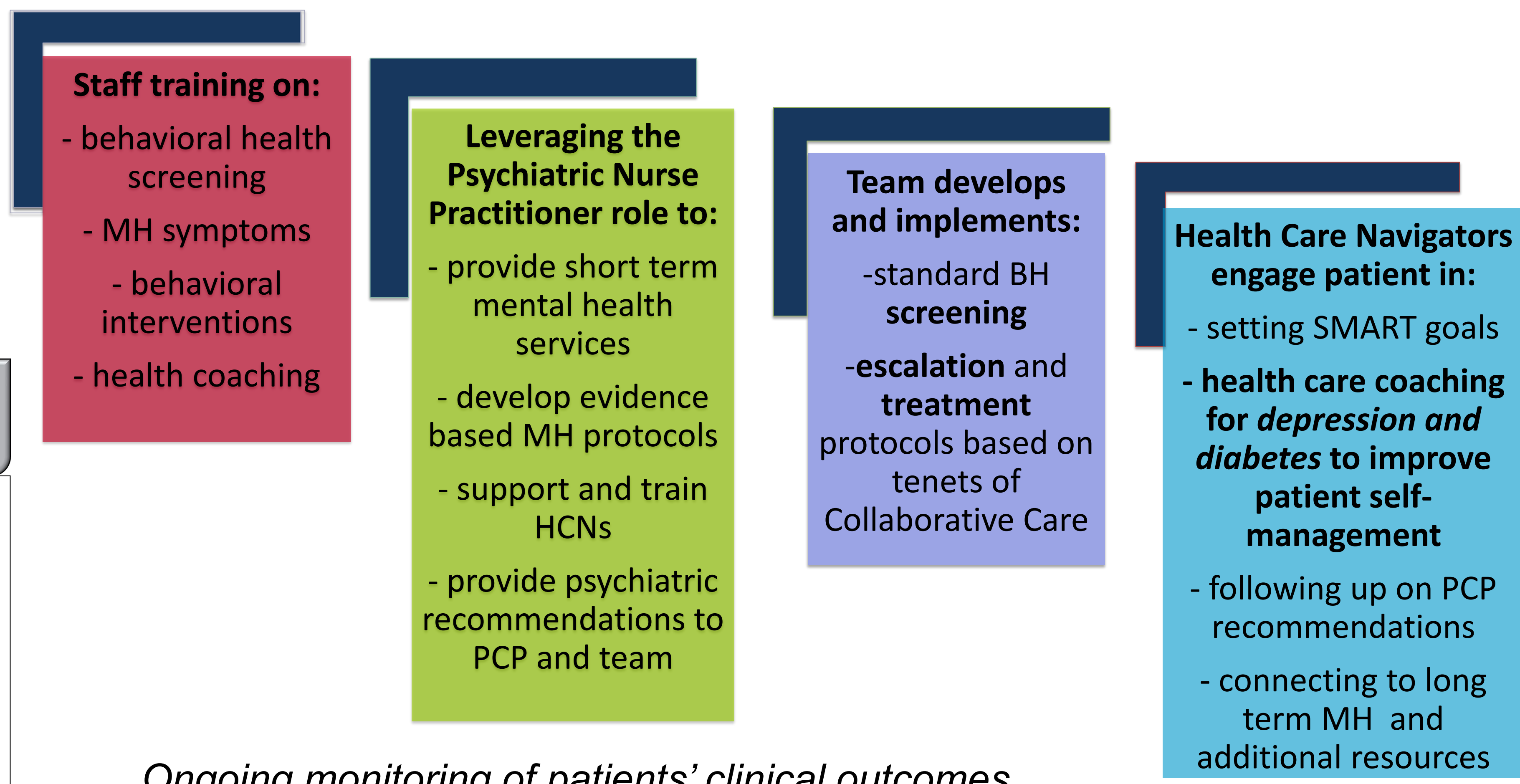
The Care Support Program (CSP) aims to support patients with chronic conditions and their PCPs, to improve outcomes and increase access to behavioral health (BH) services, but challenges include:

- Screening for depression in primary care CSP patients is not standardized, meaning patients depressive symptoms may go unrecognized
- Minimal use of APeX mental health (MH) documentation tools
- Gaps in awareness and management of mental illness
- Limited access to MH treatment options

Project Goals

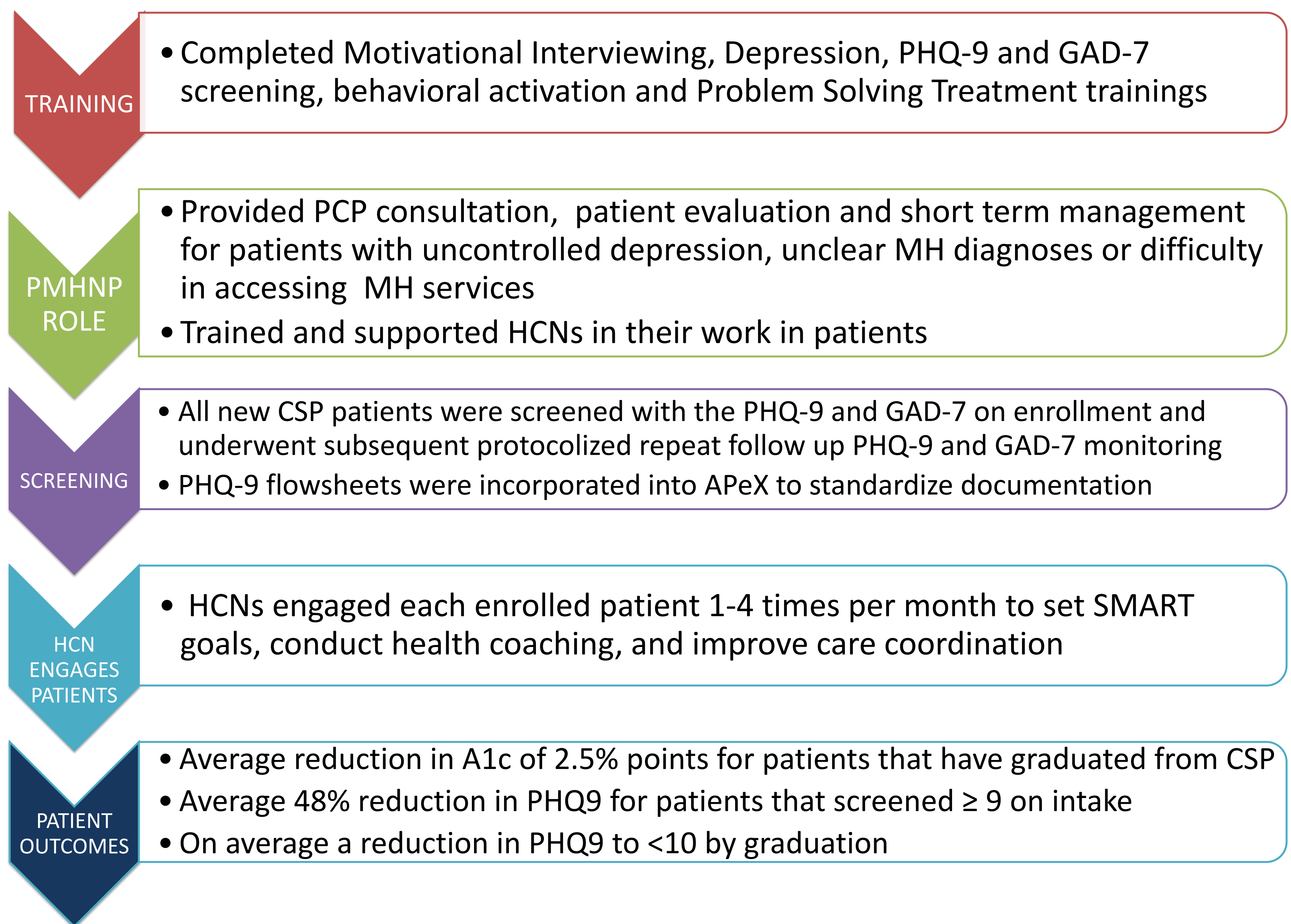
- Develop a new initiative designed to focus on improving outcomes in a cohort of diabetic patients
- Begin routine PHQ9 screening and documentation for all willing CSP patients
- Utilize the Psychiatric Nurse Practitioner role to develop and implement protocols for step-wise identification, treatment to target, consultation and coordination of care for CSP patients with mental illness
- Develop standard internal MH escalation procedures
- Train CSP staff on standard mental health symptoms, screening, and behavioral interventions
- Reduce diabetes cohort's average A1c by < 0.5% points
- Reduce patient's PHQ9 scores to on average <10 or by half

Project Plan and Interventions



Ongoing monitoring of patients' clinical outcomes

Project Evaluation & Impact



Next Steps, Dissemination & Lessons Learned

Next Steps:

- Refine and expand enrollment criteria leveraging Population Health Analytics to include additional chronic conditions – focusing next on HTN

Dissemination:

- Clear improvements were shown with the use of the PMHNP and HCN dyad team to improve outcomes for patients with co-morbid depression and diabetes. This has potential for further dissemination and testing in other primary care settings and with additional chronic conditions

Lessons Learned:

- Challenges and importance of provider and patient engagement
- Need for creative use of limited resources and collaboration with outside services