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

UCSF Health

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

Staff training on:
- behavioral health screening
- MH symptoms
- behavioral interventions
- health coaching

Leveraging the Psychiatric Nurse Practitioner role to:
- provide short term mental health services
- develop evidence based MH protocols
- support and train HCNs
- provide psychiatric recommendations to PCP and team

Team develops and implements:
-standard BH **screening**
-**escalation** and **treatment** protocols based on tenets of Collaborative Care

Health Care Navigators engage patient in:
- setting SMART goals
- **health care coaching for *depression and diabetes* to improve patient self-management**
- following up on PCP recommendations
- connecting to long term MH and additional resources

Ongoing monitoring of patients' clinical outcomes

Project Evaluation & Impact

TRAINING
- Completed Motivational Interviewing, Depression, PHQ-9 and GAD-7 screening, behavioral activation and Problem Solving Treatment trainings

PMHNP ROLE
- Provided PCP consultation, patient evaluation and short term management for patients with uncontrolled depression, unclear MH diagnoses or difficulty in accessing MH services
- Trained and supported HCNs in their work in patients

SCREENING
- All new CSP patients were screened with the PHQ-9 and GAD-7 on enrollment and underwent subsequent protocolized repeat follow up PHQ-9 and GAD-7 monitoring
- PHQ-9 flowsheets were incorporated into APeX to standardize documentation

HCN ENGAGES PATIENTS
- HCNs engaged each enrolled patient 1-4 times per month to set SMART goals, conduct health coaching, and improve care coordination

PATIENT OUTCOMES
- Average reduction in A1c of 2.5% points for patients that have graduated from CSP
- Average 48% reduction in PHQ9 for patients that screened ≥ 9 on intake
- On average a reduction in PHQ9 to <10 by graduation

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