

Community Partners in Care (CPIC)

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Executive Statement

Depression is a major cause of morbidity worldwide; there are known disparities in access, quality and outcomes of care. Research shows that African Americans and Hispanics consistently suffer from health and healthcare disparities and are underrepresented in research.¹ Quality Improvement (QI) programs for depression can reduce outcome disparities for African Americans and Latinos compared to whites, but are seldom implemented in public sector agencies and rarely includes agencies such as substance abuse or faith-based that also serves depressed clients. The investigators and partners fielded Community Partners in Care (CPIC), a group-level randomized trial of diverse safety net providers working together to implement depression quality improvement programs in two communities of color in Los Angeles, California, USA. Using a community approach was important for several reasons. First, this approach has been recommended for addressing health disparities.² Second, a community approach allows for public participation and community partnerships to come together to work towards increasing the relevance of clinical research and supports the promotion and adoption of research findings in under-resourced communities.³⁻⁴ Last, a community approach where academic and community partnerships are the hallmark of the research process to address depression in under-resourced communities recognizes the importance of mutual transfer of expertise and insight into the issues of concern, shared decision-making, and shared ownership of the expertise, data, and products of the collaboration, all of which are at the crux of this project.³⁻⁴

Problem

Disparities in access to care for depression and care outcomes (e.g., behavioral health hospitalizations, physical activity, homelessness, etc.) persist.

Recommendations

1. Community coalitions across multiple services sectors should be engaged to develop effective strategies to improve health and social outcomes for depression in under resourced communities.
2. Mental health disparities can be addressed through direct partnership with community stakeholders collaborating in evidence-based strategies adapted to the community context.

Introduction

Depression contributes to disability worldwide.⁵⁻⁷ Disparities in access to services, quality care and outcomes of depression care exist especially among people living in areas of urban poverty. In fact, in the two communities of color in Los Angeles, California, USA, the mental health needs of African Americans and Latinos living in areas of urban poverty are coupled with high rates of morbidity and mortality and low educational attainment and insurance coverage.⁸ These data highlight the gap in programming available to improve depression among racial and ethnic minorities. Additionally, these data suggest that there is a growing need for programs that improve the quality of care for depression in primary care settings.

In response to this concern, Partners in Care (PIC) emerged. PIC quality improvement (QI) programs for depression in primary care, relative to usual care have shown to reduce outcome disparities in underrepresented communities such as African Americans and Latinos relative to non-Hispanic whites.⁵⁻⁷ QI programs for depression in primary care also increased chances of patients receiving preferred treatments.⁵⁻⁷ Such QI programs are seldom available in safety-net communities facing multiple disparities in health and social determinants of health. Depressed clients with multiple needs must prioritize among them or coordinate multiple services; yet depressed clients have limited self-efficacy (i.e., limited ability to regulate their emotions).

One option is to build capacity across service sectors to address depression and coordinate services that fit clients' priorities for outcomes. A recent Institute of Medicine report calls for an approach to coordinate medical and public health programs to improve long-term quality of life for chronic conditions.⁹ Such models have not been developed to address depression disparities until the Community Partners In Care (CPIC) project emerged.

“I was embarrassed and afraid that I would lose my job if anyone found out about my depression. . . Being a part of this project has changed the way that I talk about depression. . . This project has helped my body, mind, and soul to be a better person”.
- Puscedia Williams

About the Innovation

CPIC compared the effectiveness of diverse safety net providers working together to a technical assistance approach to implement quality improvement (QI) on clients' mental health-related quality of life (MHRQL) and services use. The safety net providers approach invited administrators to bi-weekly meetings for 5 months to build training capacity for toolkits and networks for services; ensured that planning was co-led by community and academic Council members; followed Community-Partnered Participatory Research principles (i.e., equal authority for decisions and two-way knowledge exchange); provided safety net providers councils with a workbook for developing written implantation plans tailored to the community; and monitored plan implementation with course corrections as needed.⁵⁻⁷



The technical assistance approach offered toolkits under the “train-the-trainer” paradigm through webinars plus site visits to primary care for each community; included a nurse care manager, licensed psychologist cognitive behavioral therapy (CBT) trainer, three expert board-certified psychiatrists for medication management; and QI support staff and community service administrator to support participation and cultural competence.⁵⁻⁷

Both approaches were a part of the intervention, as we hypothesized that diverse safety net providers working together would be more effective than technical assistance in improving 3-year depression outcomes and that clients would prioritize quality of life. We expected to find gaps in provider capacities to address client priorities that network strategies could address.

These approaches were compared because we wanted to determine how depressed clients in under-resourced communities prioritized diverse health and social outcomes, how depressed clients identified their preferences for services to address priority outcomes, and ultimately identify the capacities of providers to respond to depressed clients' priorities in order to generate recommendations for building capacity to better address clients' priorities. In other words, we wanted to understand the effectiveness of diverse safety net providers working together in promoting access to culturally appropriate depression treatment programs among African Americans and Latinos in two communities of color in Los Angeles, California, USA. In total, 1018 under-represented depressed clients were tracked at baseline, 6 months and 12 months.

Impact

The CPIC approach of diverse safety net providers working together relative to technical assistance improved depression QI across sectors in under-resourced communities at baseline, 6 months and 12 months in the following areas:

- Increased Mental Health Related Quality of Life (MHRQL),
- Reduced behavioral health hospitalizations,
- Increased physical activity,
- Reduced homelessness risk factors,
- Decreased mental health specialty medication management visits and
- Increased use of faith-based and park center depression services.

Recommendations

Community coalitions across multiple services sectors should be engaged to develop strategies to improve health and social outcomes for depression in under-resourced communities.

Building coalitions that involve community members and key stakeholders are critical for the success of multiple sectors working together to engage under-resourced communities to improve health and social outcomes. Coalitions that are collaborative, flexible, purposeful, and respect the beliefs and culture of the community contribute to lasting partnerships. These partners can then engage the broader community through tailored outreach efforts and by creating individualized programs/plans to effectively coordinate care for depression. In addition, these coalitions can serve as knowledge hubs through exchange, exploration of ideas, and support to ensure implemented approaches are specific to the community.

Mental health disparities can be addressed through direct partnerships with community stakeholders delivering adapted evidence-based strategies.

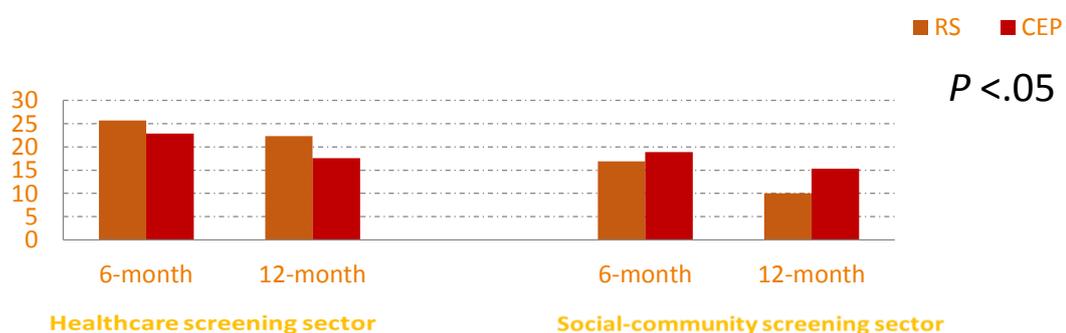
Implementing evidence-based strategies that are co-led by academic and community partnerships, tailored to the needs of the community, includes key stakeholders, and activate community networks (e.g., primary care, faith-based and community centers) to address depression across health and community-based programs are found to be effective. Additionally, strategies that are able to expand the capacity of a community through trainings, planning meetings, and problem-solving techniques can lead to lasting collaborations. Strategies specifically adapted to the unique needs of the community context can address mental health disparities and increase equity by including all parties as equal partners in each phase of the process and ultimately improving health and social outcomes for depression in under-resourced communities.

Communities can help develop innovative strategies to help prevent depression and strengthen mental health of under-resourced communities.

Innovative strategies that are co-developed by academic and community partnerships, with community input can be successful preventing depression and developing resilience. Additionally, the methods used must be transparent (i.e. clear and easily understood), cultivate trust, and demonstrate an understanding of depression in the respective community.

In order to prevent depression and strengthen the mental health of highly stressed groups in under-resourced communities, strategies should move beyond the discourse of “what is wrong,” and focus on what is going well or right. This establishes trust, respect, and cultivates a platform for knowledge exchange, all of which are at the crux of identifying and developing ways to prevent depression and strengthening the mental health in highly stressed and under resourced communities.

Number of outpatient contacts for depression all sectors, interaction significant at 12 months



Limitations

- To date, this intervention has only been studied in two communities in Los Angeles
- The intervention did not improve depression overall

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