COMMUNITY PARTNERS IN CARE
Compañeros Comunitarios en la Salud

Long-Term Outcomes of Community Engagement in Quality Improvement for Depression:

What Happened in CPIC at 3-year Follow-up?

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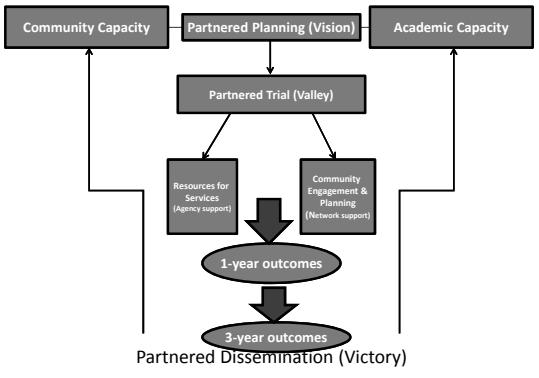
How can we translate the benefits of high quality depression care into better lives for under-resourced, communities of color today?

"Little is known about the independent contribution of community linkages to improving health and behavioral health outcomes."—SAMSHA 2012

Key Features of CPPR

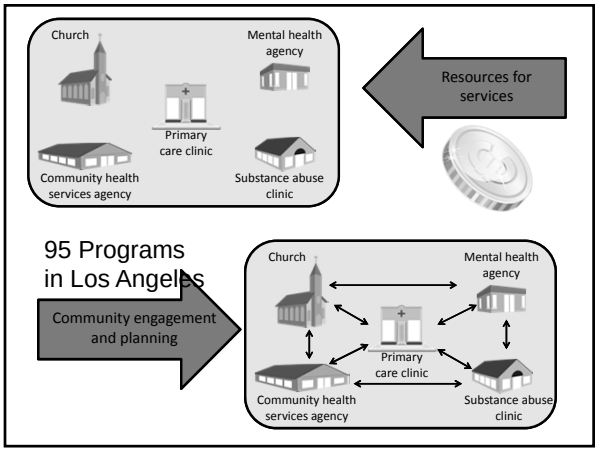
- Core Principles
  - Equal power sharing and respect
  - Find the win-win
  - Support partner capacity/strength-based
- Structure
  - Partnered Council frames and guides initiative
  - Community Partnership Forum for broad input
  - Partnered Work Groups
    - Develop action plans for community approval
    - Implement and evaluate approved plans
    - Disseminate programs and findings
- Stages: Vision, Valley and Victory—equally important
- Jones and Wells, 2007; Wells and Jones 2009; www.communitytrials.org; Jones et al., 2009

Community Partners in Care (CPIC)



Design of CPIC

- 2 Communities: > 2 million residents
- 93 programs in 50 agencies (MH, PCP, substance abuse, social services, homeless, faith-based, community centers, hair salons, exercise clubs)
- Programs randomized to Resources for Services (RS) for technical assistance to individual agencies or Community Engagement and Planning (CEP) to implement *quality improvement programs for depression adapted to diverse agencies*
- 4436 clients screened for depression; of 1322 depressed, 1246 enrolled, 981 completed baseline; 759 6 months; 733 12 months; 599 3 years (analytic sample N=980 baseline or 3 year data)

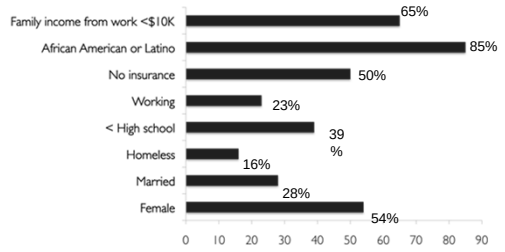


CPIC collaborative care

- Team management (IMPACT)
- Clinical assessment, medication management and alternative health practices (PIC)
- Cognitive behavioral therapy for depression (We Care, Munoz and Miranda)
- Care management/case management/health workers (PIC, MHIT/New Orleans)
- Patient education resources (PIC)
- CEP: Support for networks to develop, modify training, and innovate in services delivery led to "resiliency classes" on CBT concepts (BRICH)

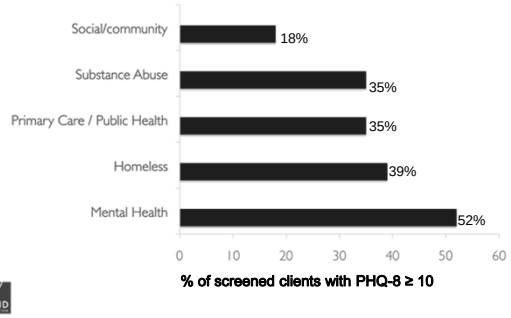
Clients Are Diverse

(N = 4,440, mean age 47 years)



Client Depression Common Across Program Types

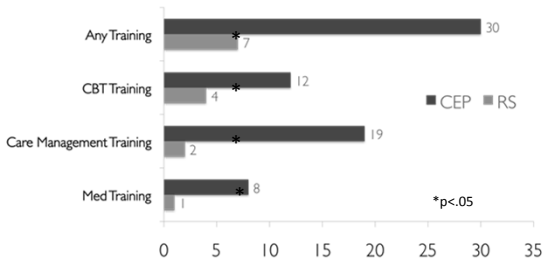
(N=4,440)



% of screened clients with PHQ-8 ≥ 10

Staff Participation in Trainings

(N=1,622)



Percent of All Program Staff

Summary of 6-month Client Outcomes

- **Both CEP and RS improved client mental health quality of life**
- **CEP was more effective than RS in**
  - improving mental health quality of life and physical activity
  - reducing homelessness risk
  - reducing behavioral health hospitalizations
- **CEP shifted** outpatient depression services away from specialty medication visits toward primary care, faith-based and park services for depression
- **BUT: No difference in depressive symptoms, use of antidepressants or healthcare counseling for depression**
  - *–So mechanism is not more "formal" treatment*

12-month Client Outcomes

- Modest continuing improvements at 12 months relative to baseline in mental health related quality of life for CEP vs. RS
- Continued reduction in behavioral health hospitalizations for CEP at 12 months
- Findings somewhat sensitive to analysis methods
- Over the year, more improvement in mental health and less hospitalization in CEP

3-Year Follow-up Hypotheses

Long-term effects of CEP over RS:

- PRIMARY: Health-related quality of life (mental health or physical health) given long-effects of depression QI in Partners in Care
- Secondary: Long-term patient learning from CEP network activation (reduced barriers, increased self-efficacy, services shifts), especially for community sector with limited depression services

Analysis Plan

- Partnered Analysis with stakeholder input
- Intent to treat: Model 1 main intervention effects; Model 2 main effect &interaction of intervention and sector (health/community)
- Covariates (age, community, education, race/ethnicity, 12-month depressive disorder), adjusted for cluster at program level, weighted for response, multiple imputation for missing data (item, wave)

Baseline for Analytic Sample (N=980)

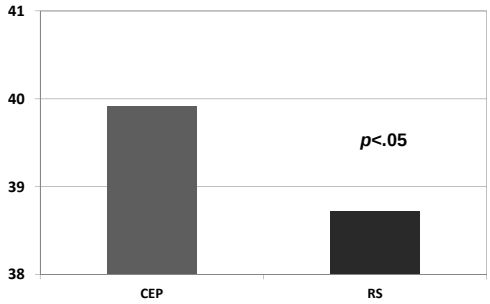
- No significant differences by interventions status for combined sample in baseline patient demographic or clinical measures
- Within community sector, one significant difference (age, CEP older by 6 years than RS on average) out of 17 tested
- Majority ethnic minority, under federal poverty level, with depressive disorder and multiple chronic medical conditions

Main 3-Year Findings Model 1 (Main Effects)

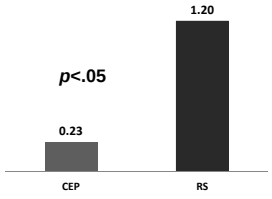
CEP over RS (each $p<.05$):

- Small improvement in physical health-related quality of life (about 1 scale point)
- Fewer inpatient nights for behavioral health (.2 versus 1.2)
- Higher % with community sector (36 vs 28%) or faith-based (15 vs 9%) depression service
- Higher % use mood stabilizers (6.4 vs. 2.5%)

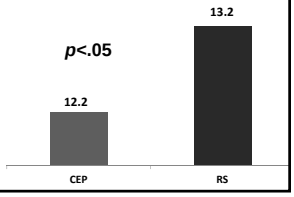
SF-12 Physical Health Overall (0-100 perfect health) mean



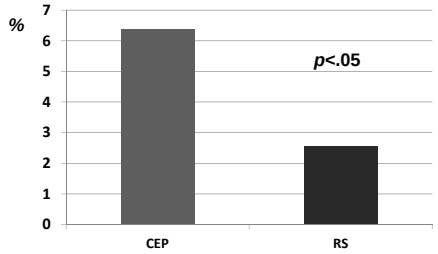
Number of nights hospitalized for any behavioral health problem



Number of visits to religious places past 6 mo, mean



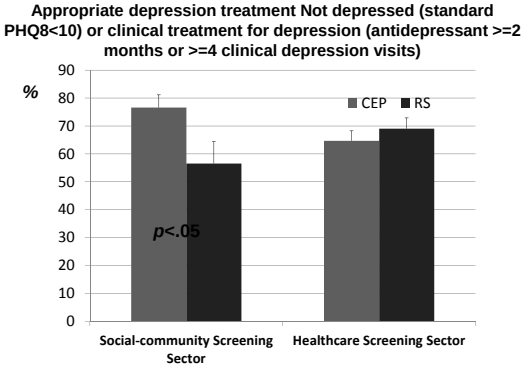
Use of any mood stabilizer past 6 months



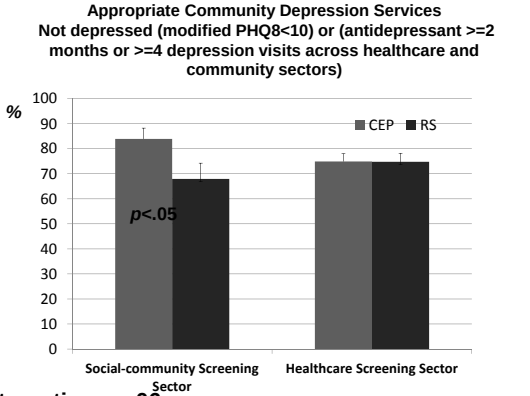
Interaction (I) and Main Effects Within Sector (Model 2)

CEP Over RS [(I) = significant interaction]

- Within healthcare, increased physical health quality of life, % with any community sector depression visit (I), any faith-based depression visit and mean social service visits for depression (I)
- Within community sector, lower % with perceived barrier to care (I), greater self-efficacy to manage depression (I),higher % with any healthcare for depression (I); more PCP visits (I), PCP visits for depression, use of antidepressants (I), antipsychotics (I), and greater overall appropriate depression treatment (either not depressed or in treatment, i.e., antidepressants or depression counseling in PCP or MH specialty visits)



Interaction: p=.04



Interaction p=.06

Interpretation

- Long-term changes in utilization from community network activation, with higher use of services from the alternative sector from which clients were identified
- Greater quality depression care for community sector (equity)
- More community support for healthcare
- Slight improvement in physical-health quality of life and fewer hospital nights or behavioral health conditions overall—long after training

Policy Impact

- LAC Agencies (DMH lead) proposed Health Neighborhood Initiative to coordinate behavioral health services and address social determinants of mental health in 8 pilot neighborhoods – underway
- California Center of Excellence for Behavioral Health funded in part to support this effort
- PCORI Community and Patient Partnered Research Network Centers of Excellence (LAC and New Orleans) based on CPIC

2014 ACTS Team Science Award
2015 Campus-Community Partnerships for Health Annual Award

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