

University of Southern California

USC Minority Services Research Group

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USC Minority Services Research Group

The Minority Services Research Group (MSRG) is a multidisciplinary research group that seeks to improve access to quality mental health care for underserved, minority populations. Based at the USC Department of Psychiatry, the MSRG is an umbrella organization that includes academic researchers from multiple institutions as well as community partners collaborating on several research projects. Its stated mission is “to improve the lives of underserved minority populations through community-based, culturally sensitive, patient-centered intervention research that aims to reduce disparities in access to quality mental health care.”

The MSRG maintains a close relationship with the UCLA Health Services Research Center. Dr. Isabel Lagomasino heads the MSRG and received her training in the NIMH UCLA Faculty Scholars Program, directed by Dr. Ken Wells. All ongoing MSRG research grants include the key participation of Center faculty and staff. In addition, the MSRG receives a subcontract from the Center, the LAC+USC Research Development Unit, whose aims are to develop and evaluate evidence-based, culturally appropriate, and sustainable quality improvement interventions within county agencies and to support the research career development of investigators working within these agencies. While helping provide needed research infrastructure, this tie has facilitated mentorship from senior faculty at UCLA and RAND as well as research opportunities and mentorship for residents, post-doctoral candidates, and junior faculty.

The future goal of the MSRG is to secure national funding as a developing research center. Such a center would provide research infrastructure for academic and community partners to engage in future research focused on addressing the critical health care needs of underserved minority communities and would provide valuable research training opportunities for medical students, residents, post-doctoral candidates, and junior faculty.

Patient-Centered Depression Care in the Public Sector

PARTNERS: Isabel T. Lagomasino, Megan Dwight-Johnson, Principal Investigators
USC, UCLA, University of Washington, and LAC+USC Healthcare Network

BACKGROUND/RATIONALE: This study addresses the critical question of how to make depression care more responsive to the needs of consumers in primary care clinics serving low-income Latinos. Recent studies have demonstrated the feasibility and effectiveness of practice-based interventions to improve care for depression in primary care; however, few have included a substantial Latino sample or addressed issues of sustainability. Developing depression care interventions that are sustainable in public sector systems will require accommodating patient preferences for care, the capacities of providers, and the priorities of practice administrators. However, there has been no explicit, documented strategy for incorporating patient treatment preferences into practice. This may be especially important for socially disadvantaged populations that have historically underutilized mental health services, perhaps in part because interventions have not been tailored to their needs. Indeed, little is understood about the nature of depression treatment preferences of low-income Latinos, who are unlikely to have had any exposure to quality depression care. Similarly, the priorities and capabilities of public sector primary care clinics in regards to depression care have not been clearly delineated. In this proposal, we develop methods to better understand the treatment priorities of low-income Latinos and the clinics that serve them in order to identify strategies for incorporating these preferences into treatment interventions.

OBJECTIVE(S): This project seeks to understand the depression treatment preferences and barriers to care of low-income Latino patients, medical providers, and system administrators in public sector primary care settings and to incorporate this information into locally relevant, sustainable depression treatment programs.

METHODS: The study takes place in 3 large public sector primary care centers. We first assess depression treatment preferences and resources of patients, providers, and administrators. Next, we conduct a randomized controlled trial of a standardized depression intervention at each clinic to provide consumers, clinicians, and administrators with a treatment exposure. Following the intervention, we examine whether stated preferences correspond to actual behaviors, and whether stated preferences change with treatment exposure and outcome. We examine provider and administrator preferences and attitudes before and after the intervention. Finally, we conduct a multi-stakeholder process to prioritize patient-oriented goals given practice and resource constraints.

FINDINGS / RESULTS: Of 1428 potential patient subjects that have been approached, 517 have been eligible and agreed to be screened. 145 (28%) were study eligible, of which 117 (81% of eligible) enrolled in the study. Of the 102 subjects with data is available for analysis, 91 (89%) are female, 45 (44%) are married, 64 (63%) are unemployed, 43 (42%) have < 6 years of education, 84 (83%) are Latino, and 76 (74%) have a yearly household income of < \$15,000. Thirty-nine (38%) report lifetime counseling, 36 (35%) report lifetime use of medication for mental health problems, and 49 (48%) report perceived need for depression treatment. In the baseline conjoint analysis preference survey, subjects are significantly more likely to prefer treatment in the primary care vs. mental health setting. Preferences for treatment type and format are not significant in this

preliminary analysis. Strategies to reduce barriers to depression care, such as bus passes and telephone appointments, significantly improve odds of treatment acceptance. Family involvement and format of educational materials are not currently significant. Cost is significant in treatment choice. Baseline assessments have been completed with 24 primary care clinicians. Physicians saw or supervised the care of 58 patients on average per week, 33% of whom they estimated had depression. Providers perceive depression treatment as important in primary care but hindered by lack of time with patients, lack of linkage between mental health and primary care, competing demands of medical illness, and stigma about depression and medications. Providers prefer on-site collaborative depression care over current care. Several family practice physicians enjoy providing limited counseling themselves and indeed practice some principles of problem solving therapy and behavioral activation. Providers view addressing the psychosocial stressors and practical needs of their patients as an important component of depression care but perceive lack of motivation and energy from depression as a significant barrier to patient engagement in care.

STATUS: Patient subject recruitment and enrollment is actively underway in the three clinics. Baseline interviews with administrators are being completed.

IMPACT: This study aims to improve depression care in public sector, primary care systems serving low-income minority patients by consulting constituents to make care more patient-centered and sustainable. In order to develop patient-centered care, it is essential to understand and accommodate patient treatment preferences that are clinically reasonable; including provider and administrator priorities in the design of depression interventions may lead to better implementation and greater sustainability. Our study will provide methods for assessing preferences for depression care and for tailoring the implementation of depression interventions to make them relevant to local populations and resources. These are critical steps for disseminating evidence-based practice strategies. Furthermore, information about how patient and provider preferences for care and perceptions of treatment barriers change after depression treatment can be used to develop more effective and targeted educational interventions. This study will provide valuable information for health care providers, administrators, and policy makers who aim to reduce disparities in depression care for low-income and minority populations. The study also addresses needs to develop ways to integrate mental health services into primary care, to conduct effectiveness trials of depression care in “real world” public care systems, and to perform culturally sensitive research.

Self-Management of Depression and Medical Illness

PARTNERS: Isabel T. Lagomasino, Megan Dwight-Johnson, Principal Investigators
USC, UCLA, University of Washington, Stanford University, and LAC+USC Healthcare Network

BACKGROUND / RATIONALE: Depression is common but frequently undetected and untreated among medical patients, leading to significant decrements in functioning and quality of life. Low-income minorities may be especially prone to suffer from both depression and physical illness, while being less likely to receive care for either. Quality improvement interventions for depression in primary care have improved better care and outcomes, but are often costly and difficult to sustain, especially in resource-poor health systems. Additionally, although preferred by most patients, psychotherapy is particularly difficult to deliver in the medical sector. Developing an effective, low-cost, culturally relevant, sustainable, psychosocial treatment for primary care patients with depression and chronic medical illness is thus an important public health goal.

OBJECTIVE(S): This study seeks to use a theoretically-driven, systematic method to adapt group self-management programs developed and proven effective for persons with chronic medical illness for patients who also have depression.

METHODS: First, we use two existing high quality datasets of group self-management trials (the Chronic Disease Self-Management Program (CDSMP) and the Spanish Arthritis Self-Management Program (SASMP)), to examine the depression and medical outcomes of patients with co-morbid conditions and to explore predictors of response and intervention mechanisms, guided by an adapted conceptual model of the interactions between depression and medical illness. Second, guided by these results, we collect qualitative data from depressed persons in self-management groups and their group leaders to explore unmet needs and potential program adaptations. Third, an expert panel uses findings to adapt the programs as necessary and develops a manualized program protocol in preparation for a future randomized trial.

FINDINGS / RESULTS: Final models for the secondary data analyses are currently being elucidated. Initial analyses of the CDSMP and SASMP indicate that depressive symptoms are common among group participants. Among CDSMP participants, the mean baseline Center for Epidemiologic Studies Depression Scale (CESD) score was 16.218 (SD 9.384) for intervention patients and 14.866 (SD 9.817) for controls (scores ≥ 16 suggest probable depressive disorder). Differences in baseline scores between both groups were not significant. Among SASMP participants, the mean baseline CESD score was 20.764 (SD 12.256) for intervention patients and 18.949 (SD 11.534) for controls; half of the sample had a baseline score ≥ 19 . Among the quartile of subjects in the SASMP with the highest baseline CESD scores (mean score 36.38 (SD 5.43) for intervention patients, 35.69 (SD 6.39) for controls), those in the intervention were significantly more likely to experience an improvement in depressive symptoms ($t=-4.47$, $p<.0001$). Compared to those without depressive symptoms, subjects with CESD scores ≥ 16 in both the CDSMP and SASMP appeared to have better medical outcomes.

STATUS: The first stage secondary analyses are currently being completed and planning is underway for the second stage, in which self-management groups will be done with persons who have depression and medical illness.

IMPACT: This study aims to make both scientific and public health contributions. Our study will contribute to a conceptual understanding of the relationship between depression and physical illness. The study will also inform the science of program adaptation by developing a systematic, theoretically-driven approach for adapting patient self-management group programs developed and proven effective for patients with chronic medical illness for patients who also have depression. Such an adapted program may address an important public health need by creating an effective, low-cost, sustainable, culturally relevant, psychosocial treatment for primary care patients with depression and chronic medical illness. These programs would be responsive to recommendations by the Institute of Medicine to improve the quality of health care in 20 priority areas, including both depression and patient self-management, to develop culturally appropriate education programs for minority populations, and to develop patient-centered healthcare interventions. Such programs also answer calls for developing ways to integrate mental health services into primary care, for primary care interventions that address multiple chronic conditions, and for conducting practical trials that are relevant to clinical practice.

Improving Depression Care for Older Minorities in the Public Sector

PARTNERS: Isabel T. Lagomasino, Principal Investigator
USC, UCLA, University of Washington, and LAC+USC Healthcare Network

BACKGROUND/RATIONALE: Depressive disorders affect 5-10% of older primary care patients, although rates may be higher among Latinos, especially among immigrants and those less acculturated. Despite a growing evidence base for the treatment of geriatric depression, only half of depressed older adults receive mental health care; fewer than 10% receive specialty mental health services. Treatment rates are even lower for low-income, ethnic minorities who may be more ill and disabled, may lack adequate insurance and have different treatment preferences, and who frequently face barriers to accessing care

OBJECTIVE(S): This pilot project seeks to examine current depression care in a public sector geriatric clinic that serves mostly Spanish-speaking Latinos and to pilot study assessments and treatments in order to lay the necessary groundwork for a large study of quality improvement for depressed older minorities.

METHODS: First, we conduct a chart review of new admissions within the past year to a geriatric county clinic in order to establish current rates of depression and patterns of depression treatment. Second, we conduct a prospective feasibility study with newly admitted patients who are identified on the Geriatric Depression Scale-15 and the Patient Health Questionnaire-9 to have a depressive disorder. Enrolled patients will complete a baseline assessment regarding their treatment preferences and barriers to care and then entered into a 6-month collaborative care intervention based on Improving Mood-Promoting Access to Collaborative Treatment (IMPACT), a multi-site, randomized trial of collaborative care for geriatric depression in primary care. Patients will be offered their choice of treatments, including antidepressant medication or 6-8 sessions of a structured psychotherapy, Problem Solving Treatment in Primary Care (PST-PC). Patients, family members, and clinic medical providers will be interviewed at program end to assess the feasibility, acceptability, and possible effectiveness of the intervention. A specific focus will include the experience of older, Spanish-speaking Latinos with the PST-PC.

FINDINGS/RESULTS: This project is commencing in July of 2006.

STATUS: Chart review and intervention activities will commence in July of 2006.

IMPACT: This study seeks to inform efforts to disseminate evidence-based, collaborative care interventions for geriatric depression. We examine the current prevalence and treatment rates of depression in a public county clinic serving low-income, mostly Latino older adults and pilot assessments and treatments for use in a future randomized trial. We examine the feasibility and acceptability of PST-PC among older, Spanish-speaking adults, and explore possible treatment adaptations. This information will be critical to tailoring the implementation of depression interventions for minority elders by addressing their needs and those of their providers.

Improving Depression Care for the Medically Indigent in a County Emergency Department

PARTNERS: Sarita A. Mohanty, Principal Investigator
USC, UCLA, LAC+USC Healthcare Network, Coalition for Community Health, Los Angeles
County Department of Mental Health

BACKGROUND/RATIONALE: Evidence-based quality improvement interventions have been found to be effective for improving depression care and outcomes in primary care settings, including public sector primary care sites. However, vulnerable low-income and minority populations often lack timely access to regular medical care and rely on medical emergency departments as a surrogate for primary care. Patients are rarely screened or offered treatment for depression in these settings. The LAC+USC emergency department provides care to ethnically diverse patients, the majority of whom are low-income and uninsured, but does not currently screen for depression on a systematic basis nor have an established referral process for patients in need of outpatient psychiatric services.

OBJECTIVE(S): This study seeks to develop, implement, and evaluate a culturally relevant, low-cost intervention that will improve access to depression care in emergency department settings.

METHODS: Trained lay community health workers (*promotoras*) will be trained to screen adult patients in the medical emergency department waiting areas for depression using the Patient Health Questionnaire-9. A total of 100 depressed patients will be randomized to a 3-month depression intervention or wait list control. Intervention subjects will receive depression education from the *promotora* and will be entered into a stepped care algorithm in which they will be allowed to choose either antidepressant medication treatment from a psychiatrist or 6-8 weeks of Problem Solving Therapy (PST) from a study social worker. Study subjects will be surveyed at baseline, 3-months, and 6-months to assess intervention feasibility, acceptability, and effectiveness.

FINDINGS/RESULTS: This study is commencing in July of 2006.

STATUS: Patient screening and intervention activities are commencing in July of 2006.

IMPACT: This study seeks to improve access to depression care in a public sector emergency department that serves low-income minorities who often lack a source of regular medical care. Study results will be used to refine the proposed intervention and to prepare an application for a large randomized trial. An effective emergency department intervention has the potential to have significant public health impact and to improve the quality of life for depressed, low-income minority patients by linking those without a regular source of care to needed evaluation and treatment, promoting more appropriate use of medical services and potentially reducing health care costs, and impacting community social norms and attitudes regarding depression.

Attending partners

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Partner organizations

LAC+USC Healthcare Network was founded in 1885 as a partnership between the County of Los Angeles and USC. The LAC+USC Healthcare Network is the nation's largest academic medical center and the largest single provider of health care in Los Angeles County. In 2004, the network provided more than one million ambulatory care visits; 40% of patients were uninsured and 68% were Latino. Although outpatient services are integrated into three large comprehensive health centers, the network partners with over 200 community clinics to provide primary care services and specialty care. Services are run by the Los Angeles County Department of Health Services and mental Health and staffed by university physicians.

COPE Health Solutions (COPE) is a nonprofit health care corporation whose mission is *Make Communities Healthier*. Since 1995, COPE has leveraged core competencies in the areas of strategic planning, hospital and health systems operations, health professions education, and preventive health services to grow into a diverse healthcare services, consulting and solutions company. These competencies uniquely qualify COPE to assist healthcare systems, safety net hospitals, clinics and other healthcare agencies with their strategic planning, performance measurement, customer service and related needs. COPE provides consulting, strategic and operational services to a variety of health care agencies and providers in five counties throughout Southern California and has developed strategies for replication of effective programs and services throughout the United States.

In partnership with the LAC+USC Healthcare Network and a number of community clinics, COPE has developed and implemented the Camino de Salud Network, a system that provides managed care for the uninsured and under-insured. The Vision of the Camino de Salud Network is a sustainable health care system with neighborhood access to primary care; enhanced access to specialty and diagnostic care; and the coordination of primary care with inpatient and outpatient specialty and diagnostic services.

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