STUDY TITLE: Piloting Approaches to Improve Cultural Sensitivity and Humility in the Care of Patients with Depression

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BACKGROUND: The Mental Health Research Network (MHRN) has published several papers in the past 5 years, under the leadership of Dr. Coleman, that have shown significant differences in mental health diagnosis rates and treatment adherence for racial/ethnic minority patients, especially in mood disorders such as depression.[1-5] We found that patients from racial/ethnic minority groups were less likely to refill their antidepressants than were non-Hispanic White patients (adjusted odd ratios ranged from 0.50-0.59).[2] In addition, we also found that racial/ethnic minority patients were less likely to return for a second psychotherapy visit in the 45 days after their initial visit when compared to non-Hispanic white patients (adjusted odds ratios ranged from 0.80 to 0.90).[3] Practices such as shared decision-making and cultural humility have been shown to improve uptake of and adherence to treatment.[6,7] However, these require substantial time commitment from healthcare systems and providers for training and implementation, leading to limited uptake in real-world practice settings.

SIGNIFICANCE: Some of the biggest drivers of change at Kaiser Permanente Southern California (KPSC) are the Healthcare Effectiveness Data and Information Set (HEDIS) metrics created and monitored by the National Committee for Quality Assurance (NCQA).[8] There are several behavioral health HEDIS metrics and KPSC consistently underperforms on those dedicated to antidepressant medication management (AMM).[9] This led to lost revenue for the health plan and numerous efforts at remediation that had limited effectiveness.

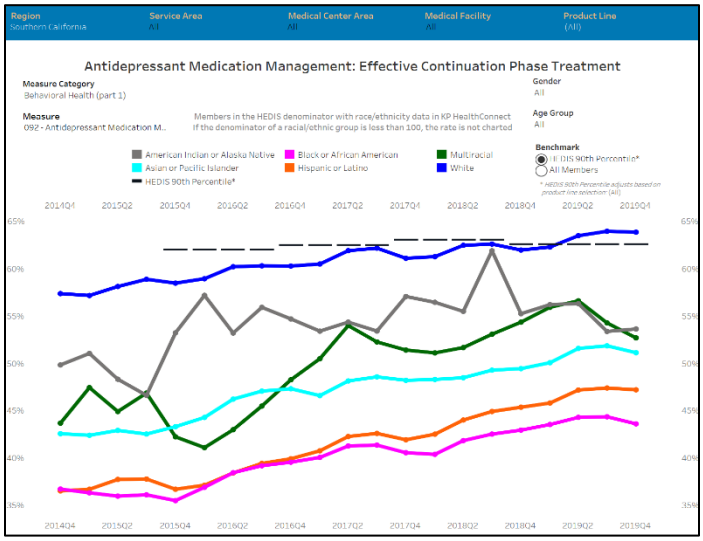

Figure 1 shows the marked disparities on the continuation phase of the AMM metric for KPSC adult patients in primary care and psychiatry. We believe that these disparities can eventually be mitigated by a two-fold approach: (1) implementing a culturally sensitive shared decision-making process in primary care for patients who are choosing their initial treatment for depression; and (2) improving the cultural humility of behavioral health providers when treating depression to improve therapeutic alliance, engagement, and thus adherence to treatment.

RESEARCH QUESTION: Can patient-centered approaches to depression treatment that emphasize cultural values and humility be developed and implemented with minimal impact on workflows and providers in three clinical settings: adult primary care, complete care (depression care management), and psychiatry?

STUDY AIMS: (1) To develop a culturally sensitive shared decision-making process for depression treatment options that can be easily implemented in adult primary care; and (2) To train therapists and depression care managers to apply cultural humility principles within the feedback informed care initiative.

APPROACH: We have chosen to work with two different ongoing KP regional and national initiatives which have made health equity a priority in their implementation: depression care in primary care settings[10] and feedback informed care in psychiatry.[11] This proposal is designed to pilot two approaches that will work within these two initiatives to *eventually* improve the treatment outcomes for depression in racial/ethnic minority patients at KPSC. The **first approach** is to develop a true culturally sensitive shared decision-making tool for depression treatment and a workflow that can be tested in adult primary care settings. We will conduct formative research to develop the tool and workflow with end users and then present our recommended process to the regional leadership in depression care at the end of the study to disseminate in 2022. The **second approach** is to develop a cultural humility training for feedback informed care in psychiatry and depression care management and provide this training to a group of "trainers" who would then train other staff. We will evaluate the impact of the training on the trainers and the dissemination and uptake of the training among psychiatry and depression care management staff.

For the **first approach**, we will work with Dr. Wang and Dr. Godoy in the departments of Family and Internal Medicine at the West Los Angeles and South Bay Medical Centers respectively to conduct 10 targeted provider interviews (physicians, social workers, and nurses in these departments) and four patient focus groups to understand the issues regarding depression diagnosis and treatment choices. Patients will be 50% non-Hispanic Black and 50% Hispanic who have a recent/new diagnosis of Major Depressive Disorder in the adult primary care setting and have picked up a medication for their depression. These patients are already monitored by Dr. Coleman as part of ongoing quality improvement for patients with new diagnoses of depression. We will also do a brief survey of patients (n = 200 completed surveys [n = 100 from each medical center; expected response rate of 25% and thus 800 will be outreached]) who are "fall outs" from the continuation phase of the AMM metric. These patients will also be non-Hispanic Black and Hispanic with an equal distribution across gender and age (18 – 39.99; 40 – 64.99; > 65 years old). Finally, we will work with a small group of patients (n = 2-3) in an ongoing co-design process throughout the proposed project.

For the **second approach**, we will work with Ms. Hamilton, Ms. Aunskul, Ms. Sandoval, and Dr. Tervalon to offer a cultural humility in mental healthcare "train the trainer" training to 10 therapists and depression care managers across the KPSC region. These people will be chosen by Ms. Hamilton and Ms. Aunskul. We will conduct feedback surveys following the training and work with each trainer to plan to train staff in psychiatry and depression care management. These trainings will also be evaluated using feedback surveys immediately following the training and then 3 – 6 months following the trainings to determine if staff are using the principles and materials from the curriculum and how they perceive it is working.

Outcomes for the first approach will be a shared decision-making tool and workflow for regional leadership in depression care at the end of the study to disseminate in 2022. Survey findings will also be summarized for why non-Hispanic Black and Hispanic patients may not be adhering to their depression medications. **Outcomes for the second approach** will be a cultural humility training for feedback informed care in psychiatry and depression care management as well as immediate evaluations following trainings and 3 – 6 months after trainings to understand self-perceived impact on practice behavior. We will also document the success with which other staff are trained by the "trainers" and the barriers and facilitators to disseminating this training. **Analyses** will primarily be descriptive and summative. Interviews will be summarized into themes addressed by the interview questions. Survey data will be summarized using descriptive statistics by different groups of patients participating in the survey (e.g. race, age, gender, medical center, type of medication, prescribing provider type, etc.).

DISSEMINATION: Internal dissemination is built into the outcomes for the proposal. In 2022 we will disseminate the SDM process and cultural humility training more widely throughout the departments of adult primary care, complete care, and psychiatry. External dissemination may include conference presentations and possibly publications, however, the focus will be on using the findings from the proposal to write externally funded grants to more widely and systematically test both approaches if they prove promising.

CLINICAL IMPLICATIONS AND IMPACT: Both approaches proposed for testing in 2021 have already been endorsed and requested by regional leadership in the respective areas. Because the time frame of the proposal is only 12 months, we will not be able to determine the impact of our approaches on patient outcomes. The goal of the proposal is to pilot processes we believe will affect outcomes and then use the learnings from the pilot to fully implement in 2022 and/or apply for external funding to support the testing/implementation of processes hypothesized to affect outcomes.

TIMELINE

Month	SDM Activity	FIC Activity
Jan	Set regular meetings Review what must be done to qualify for SDM Develop interview scripts and patient survey	Set regular meetings Assemble team to develop training Adapt training to FIC
Feb	Obtain IRB approval at KPSC and RAND	Adapt training to FIC Choose trainers and set up schedule
Mar	Conduct interviews and patient survey	Continue to develop/adapt training
Apr	Review results for interviews and survey Develop SDM tool and pilot test	Conduct trainings and do evaluation
May	Continue to develop SDM tool and pilot test	Conduct trainings and do evaluation
Jun	Conduct pilot test of SDM tool	Conduct trainings and do evaluation
Jul	Conduct pilot test of SDM tool	Begin follow-up assessments
Aug	Conduct pilot test of SDM tool	Do follow-up assessments Agree on dissemination plan
Sep	Summarize pilot test and determine next steps	Complete follow-up assessments Possibly disseminate training
Oct	Conduct additional interviews as needed Develop workflow	Possibly disseminate training
Nov	Present to leadership	Present to leadership
Dec	Prepare report and determine next steps	Prepare report and determine next steps
Abbreviations	**SDM = shared decision-making**	**FIC = Feedback Informed Care**

BUDGET

*Attached as a separate document.

REFERENCES

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