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Authors

Gosdin, Melissa
Hoeft, Theresa
Henderson, Stuart
[et al.](#)

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BMJ Open Missing link: a qualitative analysis of community-based organisations' contributions to partnered collaborative care to treat late-life depression

Melissa M Gosdin ¹, Theresa Hoeft,² Stuart Henderson,³ Jenny Wagner,⁴ Ladson Hinton ⁵

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ABSTRACT

Objective Extending collaborative care, a model integrating mental health services into primary care, to include community-based organisations (CBOs) may improve older patient health outcomes by increasing access to care and addressing patients' social needs; however, little is known about how CBOs contribute to such partnered depression care. We explored how six primary care clinic and CBO partnerships came together to provide late-life depression care through the Care Partners funded in 2014.

Design 43 key informant interviews and 15 focus groups were conducted with care managers, administrators and primary care providers partnering to provide late-life depression care. Data were coded and analysed iteratively using qualitative thematic analysis.

Setting Six primary care clinic–CBO sites across California.

Participants Care managers, administrators and primary care providers participated in this study.

Results Three unique contributions of CBOs to depression care in these clinic–CBO partnerships were identified: (1) CBOs added new services that focus on social needs and enhanced depression care; (2) CBOs strengthened core aspects of collaborative care for depression; (3) CBOs provided new avenues for building connections and trust with underserved patients.

Conclusions CBOs, when partnered with clinics, enhanced both medical and social aspects of depression treatment for older adults. CBOs are well positioned to assist primary care clinics in treating the complex health needs of older adults by providing new and strengthening existing aspects of partnered depression care while building patient trust among culturally diverse populations.

BACKGROUND

Depression in older adults comes at a high cost to patients and their families. Late-life depression is common with major depression affecting 2–5% of community-dwelling older adults and 5–10% of older adults in primary care settings.^{1–5} Older adults' quality of life⁶ and ability to function are significantly affected⁷ and result in increased healthcare

STRENGTHS AND LIMITATIONS OF THIS STUDY

- ⇒ Use of key informant interviews and focus groups provided rich insights into the perspectives of care managers, administrators and primary care providers highlighting how organisations with different cultures partner to provide whole person late-life depression care.
- ⇒ Data collection was limited to those providing depression care and did not include patient perspectives due to challenges associated with cognitive impairment.
- ⇒ Data collection was complicated by the high staff turnover rate and changing direction in the community-based organisations and primary care clinics.

costs,^{8,9} family stress and increased suicide risk.¹⁰ Depression is the most important, and arguably the most treatable, risk factor for completed suicide,¹¹ yet is underdetected and undertreated,¹ likely due to patient, provider, organisational and societal barriers to recognising late-life depression.³ With the growing older adult population, there is a pressing need to engage and treat older adults with depression.¹²

Older adults often face several barriers to engaging in depression treatment. Comorbid physical illness often brings individuals into primary care and can occupy much of a provider's short visit with patients.⁴ Physical health concerns may take precedence especially when providers attribute a patient's mood to difficult life experiences including physical ailments, are less skilled with addressing behavioural health or feel there are few behavioural health resources in the community for the patient.³ Patients too may minimise depression symptoms.^{3–5} Other barriers to treatment include beliefs about inability to find a therapist, insurance or payment concerns, and transportation.⁵



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For numbered affiliations see end of article.

Correspondence to

Dr Melissa M Gosdin;
mmgosdin@ucdavis.edu

Depression can also moderate the relationship between access barriers such as transportation and unmet mental health needs,⁶ making it more challenging for patients to access care in the clinic. Finally, clinics' abilities to retain case management outreach support to help engage patients often fluctuate with grant funding.

Community-based organisations (CBOs) can help improve patient outreach and care. A CBO is a not-for-profit resource hub that provides specific services to the community or to target populations within a community.¹ A literature review on gaps in late-life depression care identified the involvement of caregivers outside the traditional care team—such as from CBOs and alternate care settings—as a priority research area.⁷ CBOs can expand the workforce addressing depression in the community (eg, senior centre staff, community health workers) improving identification of depression, access to care, engagement and potentially also quality of care.⁷ An initiative in California known as the Care Partners Project was launched in 2014 to explore ways CBOs offering social services to populations including underserved older adults could enhance late-life depression care. Eligibility for enrolment in Care Partners was 65 years of age or older, resident of California, and score of 10 or higher on the Patient Health Questionnaire (PHQ-9). Participants were referred to the programme by either the primary care clinic or the CBO.

Care Partners provided support for clinics and CBOs as they partnered to deliver collaborative care for late-life depression, a team-based model of care typically offered within primary care.³ Collaborative care involves sharing depression care tasks through a process known as task sharing (or task shifting),^{8,9} a process that for Care Partners was widened to include CBO staff and clinicians and to include depression screening, patient recruitment, elements of case management, patient education and behavioural interventions. Task sharing allows specialists to practise in teams to reach broader populations in need with the mental health specialist role shifting toward trainer, supervisor and consultant.⁷

We use the Care Partners Project qualitative data to examine the value CBOs bring to their clinic partners to better understand synergies between these organisations as they work in partnership.

METHODS

Background on Care Partners

Sample

A purposive sample of six Care Partners sites, or clinic–CBO partnerships, throughout California were included in this study. Participants were selected and contacted via email based on their active involvement in the planning and/or delivery of the Care Partners Project. The Care Partners Project, a larger, multisite initiative funded by the Archstone Foundation began in 2014 to provide collaborative care to older adults through primary care partnerships with CBOs or family care partners. Key stakeholders

including care managers, primary care physicians, psychiatric consultants and administrators at both clinics and CBOs were interviewed and participated in annual focus groups at multiple time points during this 6-year evaluation. Patients and familial caregivers were not included in the sample because many patients had cognitive impairments and the focus of the study was to better understand how care is provided at the organisational rather than individual level.

Data collection

Qualitative data were collected from key informant interviews with four to six representatives from each site. Interviews were conducted by phone or video conferencing using a semistructured interview guide (online supplemental material 1) to elicit perceived challenges, successes and lessons learnt pertaining to partnered collaborative care delivery. All interviews and focus groups were audio recorded and transcribed verbatim. 43 unique key informant interviews were conducted, each lasting approximately 60 min. Additionally, 10 focus groups consisting of care managers, primary care physicians, administrators and psychiatric consultants were conducted at annual gatherings with participants divided by their role in the Care Partners Project. Experienced PhD, MD and MA-level moderators and interviewers (MMG, TH, SH, JW and LH) asked open-ended questions regarding participants' experiences implementing the intervention, workflow, case management, communication across organisations and perceptions of sustainability (online supplemental material 2). Each focus group discussion lasted approximately 90 min. Participant demographics are as follows: 60% female, 35% male, 5% decline to state; 49% white, 23% Hispanic/Latino, 12% black or African American, and 7% Asian or Pacific Islander, and 9% other or decline to state. All participants had at least some college education, and 80% had at least a bachelor's degree.

Data analysis

Key informant interviews and focus groups were digitally recorded and transcribed verbatim. Qualitative thematic analysis was conducted to identify major themes relating to CBO contributions to depression care delivery.^{10,11} Investigator triangulation was used to ensure rigour. Researchers also adhered to the Consolidated Criteria for Reporting Qualitative Research Checklist. As part of the Care Partners Project evaluation, an interdisciplinary team of researchers in psychiatry, public health, health services and sociology collected and analysed qualitative data over a 4-year period. The research team (MMG, TH, SH, JW and LH) identified both a priori and emergent codes using an iterative process consisting of independent coding and weekly team meetings to validate initial codes and discuss data saturation.^{12,13} NVivo qualitative software was used to code, categorise and manage the data. A matrix was used to identify connections and codes within and across transcripts. Researchers also generated

analytical memos during the coding process which were discussed during weekly team meetings.

Patient and public involvement

None.

RESULTS

Three key themes emerged from the data illustrating how CBOs contribute to collaborative care for late-life depression: (1) CBOs added new services that focus on clients' social needs and enhanced depression care; (2) CBOs strengthened core aspects of collaborative depression care; (3) CBOs added new avenues for building connections and trust. We elaborate more on these themes below.

Adding new services traditionally outside of collaborative care

CBOs provided a variety of services to assist patients with social needs, including applying for affordable housing, transportation, providing educational classes, social support, food delivery and economic assistance. As social care has traditionally been viewed as outside of clinical care, primary care clinicians often lack time, awareness of or access to community programmes to support their patients. CBOs, however, often have extensive experience addressing social needs which is also frequently part of their organisational mission. A CBO staff member provided an example of services and support offered, describing a patient who received clinical services, but also participated in a motivational class focused on the psychosocial aspects of depression, which led to further support:

Well, this one patient, she was legally blind, so she wanted Meals on Wheels. She wanted an in-home caretaker. I helped her apply for Meals on Wheels... She came to the [name] class. She participated, she graduated. She was really like a loner. She didn't really have anybody so I asked her to try to make connections with her neighbors to see if her neighbors could come and check on her every once in a while. She's done that so now her neighbor takes her to the grocery store. (care manager, CBO)

Service providers often suggested that addressing unmet social needs directly decreased their patients' depression, measured quantitatively through the PHQ-9,¹⁴ commonly used to diagnose and monitor depression in primary care, and qualitatively in conversations between patients and their care team. For example, a clinic care manager described how providing home repairs had significantly decreased a patient's depression symptoms:

[The CBO] put her [the patient] in touch with lots of different services in her community. She was able to access this one service we have in [city] where they come to your home and if you meet a certain income bracket, they will do repairs. So, they replaced some of her windows and painted the outside of her house. ... This woman who went from a PHQ-9 [9 item Patient

Health Questionnaire] of at least 17 or 18 [a score of 16 or higher indicates severe depression] really went down to zero. She's even back doing some taxes for her clients and is out walking again. She really has [been] restored back to life.

Clinic-based service providers valued the services added by CBOs, particularly those beyond the scope of the clinics' resources and those that built on the CBO's relationships with other agencies in the community. The new services in their view had a lasting and positive mental health impact for the patient. A clinic care manager described benefits of partnering with a CBO:

... [programme referred by CBO] It's cash assistance for immigrants. So, it's for people that don't qualify for SSI [Supplemental Security Income] because of their legal status. So, she's a legal resident but not a US citizen. If you could just imagine someone coming in the first day and just to see a before and after picture, like several months. She just looks so much more confident and alive, and she still has a lot of challenges. She has a disabled son that she is dealing with... she's just come a long way and it's wonderful to see the change. And I feel like she feels that she has a team.

Another clinic care manager explained her experience working closely with a CBO to provide depression care. She said:

What amazes me about this [partnership]. Before I was having a hard time finding the resources for our seniors. Now, having the CBO next to us, or co-located in our same building has improved our integrated system. So that really impacted me because it makes a really big difference vs me calling the agencies and trying to connect them with other agencies outside our clinics. So, this really is helping not only to provide better services but also to make sure that our seniors don't fall through the cracks.

Strengthening core aspects of collaborative care

CBOs strengthened core aspects of existing depression care, for example, by relaying relevant patient information to healthcare providers, assisting with behavioural activation (brief psychotherapy) and motivational interviewing, and conducting needs assessments. The support for core elements of collaborative care often improved continuity of care. A CBO care manager described her role in behavioural activation and case management, as well as the impact these services had on a patient:

We met with her [the patient] and offered some supportive case management around finding a different caregiver because the person wasn't showing up regularly for appointments, and I provided some feedback and support with that process. We also made a behavioral activation goal to start reading again...

she was an avid reader. Her PHQ-9 went from a 12 or 14 to a 4.

Project staff at both clinics and CBOs discussed the value of having cross-organisational capacity and support as well as the added safety net CBOs provide for patients. CBOs enhanced continuity of care in a variety of ways. For example, CBO staff often relayed patient information to the clinics regarding needed medication adjustments, changes in patients' health or risk factors in patients' home environments. For example, a CBO care manager described their role in assisting with medication:

When we have an issue with a patient, let's say they have got the wrong medicine or they're not getting their calls answered. We call the clinic and explain what the situation is and they're typically willing to give that person an appointment, the same day, or the same week.

Another CBO staff member explained how they also worked with the clinic to facilitate adding medication to the patient's treatment plan:

Usually, we have had clients that have indicated that they're interested in medication and so we'll make a note of that and [the clinic care manager] will send that to one of the physicians to say, okay, maybe the therapy isn't enough. Maybe they need some type of antidepressant medication and we'll put in that request.

CBO care managers also strengthened core aspects of depression care by conducting patient needs assessments and evaluating risks in the home, as a CBO care manager described:

They have a lot of complicated medical stuff going on, or they need changes to their medications, or I've identified a risk, then I am in communication [with the patient's primary care provider]... have been going out to her [the patient] home pretty often just to kind of assess risks.

New avenues for building connections and trust

While offering new services and strengthening existing services, CBOs provided new avenues for building connections and trust. Experience working with culturally diverse older adults and the time and resources needed to understand patients' life context make CBOs an invaluable partner to clinics providing depression care. For example, many CBO staff share cultural backgrounds and/or live in the same communities as the patients/clients, which gave the care team a deeper understanding of the challenges their patients faced and allowed them to build rapport and trust. CBOs, due to their community networks and diverse client populations, added value to primary care by expanding reach to culturally diverse seniors. A clinic care manager described how the CBO

partner offered information in the clients' preferred language:

For us, the biggest benefit is being able to have these programs for the community. They don't know these free programs exist. We have a large Latino population here in [city]; it's the majority. So, the Latino population doesn't know that about these types of programs, or they think that they have a cost that they can't cover. When they see that we are giving this kind of information to the Latino people in their language and that they know that it's free—well these types of programs will always be beneficial for them.

In many cases, CBOs were also able to establish rapport and build trust through home visits while addressing client social needs. Extending depression care into patients' homes provided care managers a way to informally assess what services are needed and provided a safe environment for patients to discuss challenges or sensitive information. CBO care managers could then relay relevant information back to the clinic care team. Home visits were also beneficial to patients struggling with mobility issues or lack of reliable transportation. A clinic administrator highlights the details on social needs that could be assessed in a home visit:

There's so much observation that folks from [CBO] get when they go into the home. You really get this sense of not only their social determinants that are visible to you, but then also how they interact with their environment is really visible, and I think that that's really helpful for them as well... It was like, wow, this is totally different than having someone in an office setting.

DISCUSSION

Previous studies have shown that CBOs make valuable contributions to depression care, work that includes addressing social determinants of health among older adults, but targeting such populations can be challenging for clinics that may lack time and human power required to expand reach.^{15 16} Our paper highlights multiple ways in which primary care clinics and ultimately patients benefit from partnering with CBOs. CBOs made significant contributions to depression care as reported by staff at clinics and CBOs, highlighting the value of integrating social and clinical care when treating older adults. As illustrated throughout this paper, older adults have specific social needs that affect their overall health and well-being. Unmet social needs included assistance applying for social services, food and housing insecurity, and social and emotional support. These needs were largely addressed through home visits and connecting clients to local resources, including those offered by the CBO. Home visits allowed CBO care managers to assess and better provide whole person care to older adults with depression while increasing providers' understanding

and recognition of the ways health and social needs intersect with patients' depression. CBOs also assisted with core aspects of collaborative care such as medication adjustments, brief psychotherapy (eg, behavioural activation) and patient needs assessments. Our findings align with recent calls to integrate social care with primary care to better address patient needs.^{17 18}

Collaborating with CBOs to provide depression care to older adults is worth considering despite challenges that may arise when working across differential organisational cultures and hierarchical structures.^{19 20} Addressing social needs in primary care offers challenges such as maintaining up-to-date information on community resources and ensuring patients follow through on referrals.²¹ CBOs are in a unique position to assist clinics in providing depression care because they are often familiar with and well networked into their communities in terms of local resources and community assets, including culturally and linguistically sensitive care for socially, culturally and economically diverse seniors.

These findings suggest furthering efforts to transform health and social care partnerships beyond traditional referral models may strengthen depression care for older adults, especially among difficult-to-reach populations. Results from this work suggest that policymakers and clinic administrators should work together to expand payment reimbursement to include patients' social needs as CBOs can increase the number and type of services that impact depression among older adults (eg, home repairs, educational programming, home visits, access to social services). Mechanisms to share such reimbursements across clinic and CBO settings are also needed to support CBOs as they see a new influx of clients from these partnerships.

Limitations of this study

A limitation of this study is that some CBO–clinic partnerships evolved and changed form over time for varying reasons therefore limiting data collection. Turnover at the leadership level also presented challenges to data collection as key informant interviews were conducted with participants with varying levels of programme experience and knowledge. We are also limited in that we did not collect patient data on their experiences of care, which would be an important focus for further inquiry. Additionally, we did not collect familial caregiver data as the interviews were only with those who provided professional patient care services (either directly or indirectly). Such data were not collected as our focus was on understanding CBOs and their collaboration with primary care clinics at the organisational level. However, future studies exploring the role of familial caregivers would contribute to the existing literature while providing a deeper understanding of how CBOs and clinics integrate patient families into depression care.

The focus of the Care Partners Project was to better understand the workflow and process of providing care

to older adults; therefore, only those who provide patient care (either directly or indirectly) were included.

CONCLUSION

CBOs play a vital role in providing depression care to older adults. CBOs fill an important gap in late-life depression care by helping address unmet social needs. Their work adding and expanding existing services while establishing rapport and creating trust among patients who have intersecting levels of social disadvantage is valuable. Primary care clinics integrating mental healthcare should consider the intricate relationship between social and clinical needs when treating older adults and network with potential local CBO partners. These findings highlight that CBOs are well positioned to improve care for late-life depression; however, many lack the necessary resources to provide mental health services. This study shows how partnerships between clinics and CBOs may be mutually beneficial and strengthen patient care.

Author affiliations

¹Center for Healthcare Policy and Research, University of California Davis, Sacramento, California, USA

²Psychiatry & Behavioral Sciences School of Medicine, University of Washington, Seattle, Washington, USA

³Office of Evaluations, UC Davis School of Medicine, Sacramento, California, USA

⁴Department of Public Health Sciences, University of California Davis, Davis, California, USA

⁵Department of Psychiatry and Behavioral Sciences, University of California Davis, University of California, Davis, Sacramento, CA, USA

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Patient consent for publication Not applicable.

Ethics approval This study involves human participants. The Institutional Review Boards at the University of California, Davis and University of Washington determined the evaluation to be quality improvement and therefore exempt from human subjects' review; thus, neither written nor verbal consent was required by these ethics committees. However, we obtained verbal consent from all participants for their participation in all interviews and focus groups, which was documented by the interviewer at the beginning of the interview.

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ORCID iDs

Melissa M Gosdin <http://orcid.org/0000-0002-9936-0043>

Ladson Hinton <http://orcid.org/0000-0001-6198-8540>

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