Executive Summary

Advancing Late-Life Depression Treatment: The Care Partners Project (Phase 2)

Background

Late-life depression is a pressing public health concern among an aging U.S. population that is facing increasing chronic health issues. Research has demonstrated that collaborative care programs in which primary care physicians are supported by mental health professionals to treat depression in older adults can dramatically improve the effectiveness and cost-effectiveness of depression treatment.

The goal of the Care Partners project was to improve depression care through partnerships between primary care clinics and community-based organizations (CBOs) or family care partners. The project included two phases: phase 1 (2014-2017) and phase 2 (2017-2021) and an additional effort to support people during the COVID-19 pandemic. This report focuses on the second phase of the program.

Methods

A mixed-methods approach was used to examine outcomes of the Care Partners project. Interviews and focus groups with key stakeholders (e.g., care managers, primary care providers and administrators) from each site were conducted throughout the project. Additionally, program documents were reviewed to provide context. Quantitative data were collected in the Care Management Tracking System (CMTS) or electronic health records for each site. CMTS is a patient registry that contains data on process of care and depression outcomes.

Seven sites adapted IMPACT or PEARLS collaborative care by involving CBO staff or family members in late-life depression treatment.

COVID-19: Stay Connected

The Stay Connected Program was introduced in April 2020 to increase outreach and support to older adults experiencing isolation due to the COVID-19 pandemic.

Criteria:

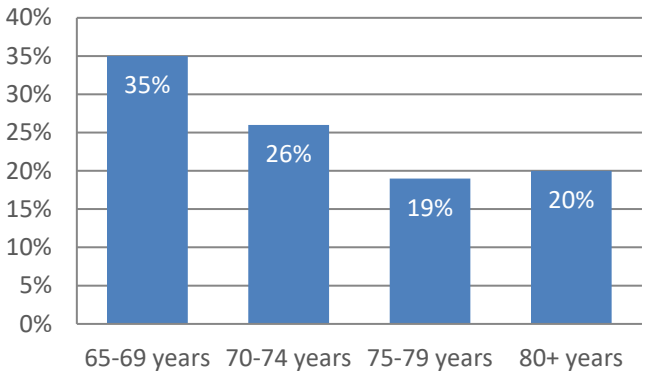
- "At-Risk" older adults with PHQ-9 < 10
- Depressed older adults with PHQ-9 ≥ 10
- Age lowered to 60 years or older

Program included:

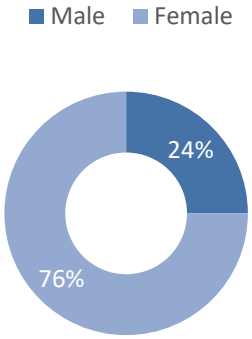
- Engagement and needs assessment
- Stay Connected follow-up calls
- Care team resource sheet
- Activities card
- https://cp.psychiatry.uw.edu/dissemination/covid-19-stay-connected/

Demographics

780 total patients enrolled *(65+, PHQ-9 ≥10)*



Patient Gender



Patient Demographics – Race and Ethnicity

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Program Exposure

Care Partners sites engaged patients through multiple points of contact. *(Age 65+, initial PHQ-9 ≥10 with follow-up PHQ-9)*

Contacts, mean	11
Completing follow-up (2+ contacts)	89%
At least 3 contacts with CBO for clinic-CBO partnership sites	75%
At least 3 contacts with family member for clinic-family partnership sites	55%
At least 1 psychiatric consult	75%

Clinical Outcomes

Patients enrolled in Care Partners showed significant improvement in their depression symptoms. *(Age 65+, initial PHQ ≥10 with follow-up PHQ-9)*

Baseline PHQ-9*, mean	15
PHQ-9 50% improvement or last PHQ-9 < 10 after 10 weeks	70%
PHQ-9 > 5+ point improvement	69%
PHQ-9 change baseline to last, mean	7.4 points

**The PHQ-9 is a well-validated 9 item instrument for both depression screening and treatment response. A score of 10 or more indicates high risk for clinical depression.*

Stay Connected

In response to the COVID-19 pandemic, sites engaged a broader set of patients, including those "at-risk" with initial PHQ-9 <10. Sites also increased telephone outreach. *(Age 60+, initial PHQ-9 <10)*

Total patients enrolled, baseline PHQ <10	133
Completed follow-up (2+ contacts)	79%
Mean number of phone visits per patient	4.2
Last PHQ-9 score < 10	87%
PHQ-9 change baseline to last, mean	1.4 points

From the field: Going Beyond Referrals

"The clinicians help the [CBO] to do their job better. [For example] if a [CBO care manager] was speaking about, "I'm frustrated I'm not making progress [with the patient]..." The clinicians could then speak to, "Well, let's talk a little bit about their diagnoses." And that helped us understand their behavior... It helped the [CBO] to not be discouraged when they didn't feel they were making progress... And it was a beautiful back and forth."
-CBO administrator

"Now when we call and ask for a resource, there actually is one. Before, we used to make referrals, and often patients would go somewhere, and that item doesn't actually exist, or they've run out of it. Now, by building these personal relationships [with the CBO], it made a huge difference."
-Clinic administrator

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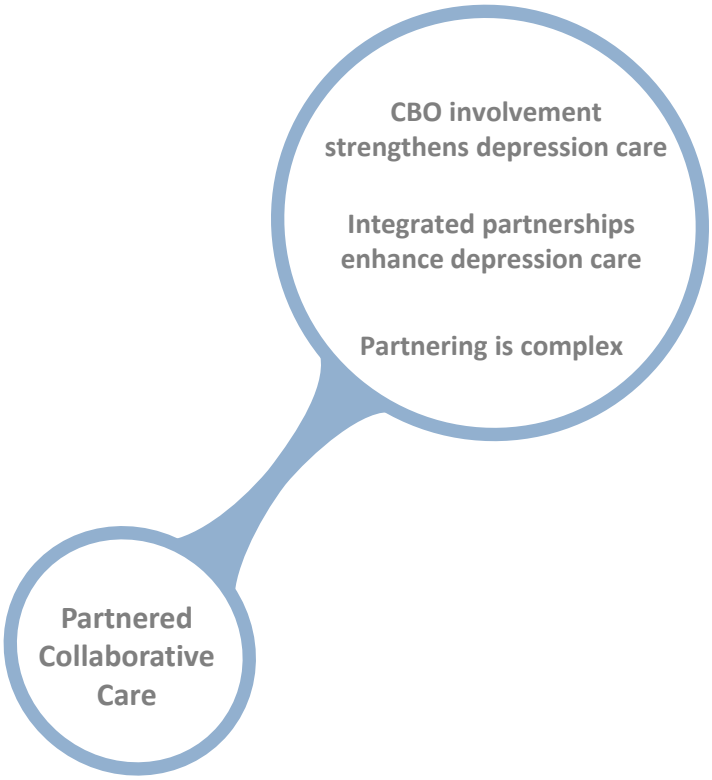
Findings

The objective of the Care Partners project was to develop innovate approaches to treatment of late-life depression and explore how including community partners and family members in collaborative care would impact depression treatment for older adults. Overall, including partners outside the traditional collaborative care model strengthened depression treatment. Through the ongoing technical assistance, training support and cross-site learning opportunities of the Care Partners project, the partnerships broadened care, improved patient outcomes, and expanded patient outreach to a diverse older adult population.

In this report, we identified 3 broad findings in the phase 2 data that highlight the dynamic nature of partnered depression care in everyday practice. We also connect these findings to lessons learned from the Care Partners project.



1 CBO involvement strengthens depression care

The clinic and CBO partnerships highlighted the direct and indirect value community-based organizations contributed to collaborative depression care. We found that CBOs added value by: (1) strengthening core aspects of existing depression care; and (2) adding new services to address social needs. CBOs also provided opportunities to reach culturally diverse older adults, understand patients' life context, and enhance trust between patients and providers.

2 Integrated partnerships enhance depression care for older adults

Partnerships reshaped and enhanced late-life depression care in two primary ways: (1) the partnerships fostered greater recognition among providers of the intersecting medical and social needs associated with late-life depression; and (2) depression care became more coordinated and effective as partnerships developed. These results suggest moving health and social care partnerships beyond traditional referral models may strengthen depression care for older adults and have the potential to improve treatment outcomes.

3 Partnering is complex

Partnering across organizations and with family members can be complex and challenging. Implementing the many elements of the intervention required changes to the broader organizations as well as strong interpersonal-level coordination and communication. Partnering required creating new workflows and expanding depression care teams to include multiple individuals across organizations. It also required building strong relationships and negotiating different organizational cultures often with unique paces, styles and priorities of work.

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Key Lessons Learned: Care delivery, Administration and Partnering

Community Health Workers (CHW) can effectively treat depression care through brief psychotherapy while addressing social determinants of health (SDOH).

Recognizing and addressing SDOH can directly improve depression symptoms. **Home visits** enhanced partners' ability to screen and address SDOH.

Engaging family in care is challenging but when introduced in the right situation, it can enhance depression care.

Data sharing is a major challenge. Exploring ways to efficiently share clinical information and avoid duplication in tracking is critical for care coordination.

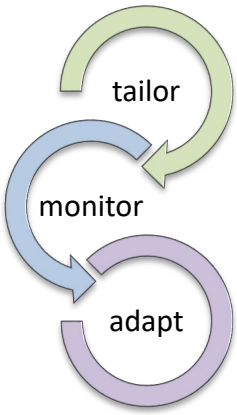
Developing a strong program identity and communicating successes can improve buy-in within organizations and with patients.

Moving beyond a referral model and finding ways to **integrate services and strengthen care coordination** enhances late-life depression care.

Partnering organizations often have very different organizational cultures and values. Sustainable partnerships **capitalize on and foster mutual respect** for these differences.

Partnerships benefit from **developing regular and efficient channels of communication** between key stakeholders at all levels within and across the organizations.

Getting buy-in and identifying champions at each organization is important for partnership success and sustainability.



Overarching Lesson: Collaborative care did not fit any of the programs directly out of the box. Throughout the Care Partners project, all sites went through a cyclical process requiring them to tailor, monitor, and adapt their programs and partnerships.

- Each partnership had to find ways to tailor their program to meet the needs of their special populations, for example clients with social needs, non-English speaking clients/patients, men, and family members all brought unique challenges and required tailored approaches.
- It is necessary to incorporate continuous monitoring of both program workflow and outcomes and the broader partnership. Plan, do, study, act (PDSA) cycles can be useful as well as a shared patient registry.
- Findings from monitoring can be used for adapting the program and responding to changing circumstances. Input from key stakeholders at different levels can help identify and implement necessary adaptations.

Implications for Archstone: Teams, Technology, and Training

Teamwork was important in both the delivery of depression care and in building and sustaining partnerships. The Care Partners project was based on the principle that evidence-based depression treatment could be strengthened by expanding the care team to include community partners. At both the individual and organizational levels, key elements of successful teamwork included shared commitment, trust, and regular communication.

Technology was foundational to the Care Partners project. It can facilitate care coordination and delivery, and clinical data and information sharing, but it can also create barriers if not well used. The importance of technology was underscored during the COVID-19 pandemic as sites began to use technology such as video conferencing and telehealth to connect with patients and facilitate cross-organizational collaboration and communication. Technology posed challenges for some sites. For example, some Care Partners partnerships struggled because they did not have technology to share patient data securely.

Training was essential for building and sustaining effective partnerships. Early on, training was important in helping staff become more familiar with resources of the partner agency, CMTS use, and new workflows. Training was also important to ensure that staff could deliver evidence-based depression care. Task-sharing across organizations required training of, for example, CBO staff in administering tools such as the PHQ-9. Additionally, continuous training was necessary to address staff turnover and new adaptations to the program.

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Future Directions

There are several promising directions for future work building on the Care Partners project.

- Explore use of technology to engage and effectively support more depressed older adults
- Explore ways to reduce financial barriers to implementing effective collaborative and partnered care
- Explore how a program like Care Partners could be best targeted for patients with unmet social needs/adverse social determinants of health
- Explore the use of partnered care for older adults with dementia and their caregivers
- Explore which types of depressed adults (e.g., frail) most benefit from a family intervention

Learning Collaborative: Community Partnerships to Improve Depression Care

With the generous support of the Archstone Foundation, the University of Washington (UW) and the University of California, Davis (UC Davis) invited primary care clinics and CBOs in California to join a twelve-month learning collaborative to improve depression care for older adults and reduce mental health disparities. The four selected clinic and CBO partnerships will work to build their partnerships and innovate to address patients' medical, behavioral, and social needs to improve care. The learning collaborative will run July 2021 through June 2022 to support the development and execution of quality improvement projects to improve depression care for older adults in partnership settings. Best practices and knowledge developed during the Care Partners project will be shared by UW and UC Davis experts to further support the efforts of the partnerships. Additional information: https://cp.psychiatry.uw.edu/learning-collaborative/

Products and Resources

- Care Partners website: https://cp.psychiatry.uw.edu/
- Video of Care Partners innovation: https://cp.psychiatry.uw.edu/dissemination/videos/
- Tip sheets for providing partnered collaborative care: https://cp.psychiatry.uw.edu/dissemination/tip-sheets/
- Publications and conference abstracts: https://cp.psychiatry.uw.edu/dissemination/publications/
- Implementation support material: https://cp.psychiatry.uw.edu/resources/