Interventions to Improve Health Care among the Underserved

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The Cycle of Comorbidity

“I’m sick from head to toe” (Dominican women with depression, hypertension, diabetes, and arthritis).

“If you have a problem with depression, you eat or smoke and it affects your heart. So, your heart says to your mind: listen, I’m eating a lot or it affects your cholesterol or it affects the sugar . . . so that affects your mind . . . from there comes the depression to eat more. The circle comes again to eat more and smoke more” (Dominican man with schizophrenia, diabetes, and high cholesterol).

Fragmented Care

“Our patients, partly because of their illnesses. . . cultural and language issues, and. . . because the system is not very well organized they often get lost in the system . . .

The patients just get overwhelmed. . . you’re not feeling well, you may have symptoms of psychosis; you don’t speak the language, and you’re trying to figure out what office to go to; it can be overwhelming, and patients get frustrated and don’t get the care that they need” (Administrator).

Source: Cabassa & Gomez, Unpublished Report, 2014

Objectives

- Discuss health disparities among Latinos with SMI
- Present factors that shape the health care experiences of Latinos with SMI
- Present a culturally-adapted health care manager intervention for Latinos with SMI

Compared to the general population, people with SMI have shorter life expectancies (20 years shorter for men; 15 years shorter for women) largely due to cardiovascular disease.

Sources: Laursen et al., 2014; SAMHSA-HRSA Center for Integrated Health Solutions; Walker et al., 2015
Is There a Double Health Burden for Latinos with SMI?

- Some evidence indicating increased risk for:
  - Cardiovascular-related mortality
  - Diabetes mellitus
  - Metabolic syndrome
  - Negative metabolic abnormalities (e.g., weight gain) associated with taking second-generation antipsychotic medications

- Evidence is inconclusive
  - Small samples sizes (n = 4-260)
  - Mostly clinical samples
  - Few analyses stratified by Latino sub-group and gender


Modifiable Risk Factors

- Environment
  - Unstable housing
  - Poverty
  - Food environment

- Medical Care
  - Underuse of services
  - Poor quality of care
  - Lack of care coordination

- Health Behaviors
  - Smoking
  - Sedentary lifestyle
  - Unhealthy diets

Sources: Allison et al., 2009; Cabassa et al., 2014; Newcomer et al., 2007
Stressed Health Care System

Fragmented care
Long waiting times

Language barriers
High staff turnover

Perceived Discrimination and Stigma

Perceived Discrimination in the Health Care System (N = 40)

- 75% reported that racism is a problem in the health care system.

- People are treated unjustly in the health care system because:
  - They are Latino/a: 60%
  - They do not speak English very well: 68%
  - They have a serious mental illness: 65%
  - They are immigrants: 83%
  - They are Black: 65%


Example of Stigma Experience

“One time it happened in the hospital. My stomach hurt and I kept telling them, but they just gave me a Tylenol. I ended up passing out. It was my appendix . . . They just did not believe me” (Puerto Rican female with schizophrenia).

Primary Health Care Experiences of Latinos with SMI

Stressed Health Care System
- Fragmented care
- Long waiting times
- Language barriers
- High staff turnover

Perceived Discrimination and Stigma
- Positive
  - Personal attention
  - Warmth & friendliness
  - Culturally congruent style
- Negative
  - Impersonal
  - Rushed
  - Disrespectful

Low levels of patient-centered care

Health Care Manager Interventions Can Address Many of These Barriers to Care

- Care coordination/ System navigation
- Goal setting
- Patient activation
- Problem solving
- Reduce fragmented care and language barriers
- Cope with perceived discrimination, improve patient-provider interactions, and increase patient-centered care

Sources: Bartels et al., 2004; Druss et al., 2010; Kilbourne et al., 2008
Primary Care Assessment Referral and Evaluation (PCARE) Intervention

Assessment and Planning
1. Comprehensive health assessment

Care Coordination
1. Provider outreach
2. Facilitates monitoring and management

Client Activation
1. Health education
2. Action planning

Proximal Outcomes
1. Receipt of preventive primary care (↑)

Distal Outcome
1. Health and mental health-related quality of life (↑)
2. General health status (↑)

Source: Druss et al., 2010

Local Implementation Gap

- Use of health care manager interventions with Latina/os with SMI is unknown

- The influence of culture on the health care of people with SMI is often ignored

- Can social workers be health care managers?

Few systematic and collaborative intervention planning models exist to inform adaptations of health care manager interventions to local settings

Local Context

- Public outpatient mental health clinic in Upper Manhattan
- Latina/o adults with serious mental illness
- Staffing
  - Social workers
  - Psychiatrists
  - Peer Specialist
  - Psychiatric nurses
- Patients referred to local primary care clinics for primary care services

Why Adaptations are Needed in the Implementation of Interventions?

- Dynamic social process shaped by context
- Requires mutual-adaptation
- Collaborative endeavor

Sources: Cabassa, 2016; Chambers et al., 2016; Proctor et al., 2009
Collaborative Intervention Planning Framework

Stakeholders → Researchers

Community Advisory Board
Using Intervention Mapping

Intervention Preparation Projects (e.g., focus groups, stakeholder interviews)

Modified Intervention with an Implementation Plan

CBPR Principles
- Shared health concerns
- Ownership
- Co-learning
- Capacity building

Key Framework Characteristics

• CBPR principles helped foster partnership between stakeholders

• Intervention mapping provided the means of putting the partnership into action

**Intervention Mapping: Adaptation Steps**

1. **Step 1:** Setting the Stage
2. **Step 2:** Problem Analysis
3. **Step 3:** Review of Intervention Objectives and Theory
4. **Step 4:** Development of Adapted Intervention
5. **Step 5:** Development of Implementation Plan
6. **Step 6:** Evaluation

Sources: Bartholomew et al., 2006; Tortolero et al., 2005

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**Bridges to Better Health and Wellness (B2BHW)**

- **Bridge, monitor and coordinate**
  - Mental Health Providers
  - Health Care Manager
  - Primary Care Providers

- **B2BHW Characteristics:**
  - Adapted from PCARE
  - 12 month program
  - At least, monthly visits with health care manager
  - Delivered by social workers (MSW)

- **Coach, connects coordinates**
  - Patient and support system
Provider and Cultural Adaptations

Provider Adaptations

Cultural Adaptations: Surface Level
- Bilingual HCM
- Educational Materials
- Personal Health Record

Cultural Adaptation: Deep Level
- Cultural Formulation Interview
- Patient Activation Check List
- Problem Solving Module


Provider Adaptations: Care Coordination

Original PCARE Trial
- Mental Health Clinic (MHC)
- Primary Care Clinic (PCC)

B2BHW Study
- MHC
- PCC

Cultural Adaptations (Surface Level): Health-Related Fotonovelas

- To improve clients’ knowledge of health conditions
- To model appropriate interactions with medical providers
- To model self-management behaviors to cope with chronic medical conditions

Cultural Adaptations (Deep Level): Cultural Formulation Interview for Health

**Health Assessment**
- Biographical data
- Family and emergency contacts
- Current medical providers
- Medical insurance
- Personal and social history
- Current medications
- Past medical history
- Mental health and substance abuse history
- Health literacy
- A short review of systems
- Preventive care history
- Health habits and patterns
- Vital signs (weight/height/blood pressure/waist circumference)

**CFI-H**
- Person-centered interview
- Focuses on the person’s illness narrative
- Conveys personalismo, warmth, and respect

Sources: Cabassa et al., 2014; Lewis-Fernández et al., 2014
**B2BHW Logic Model**

**Assessment and Planning**
1. Comprehensive health assessment
   - CFI for health
   - Attention to cultural norms and values

**Care Coordination**
1. Provider outreach
   - Care coordination plan
   - Personal health record
2. Facilitates monitoring and management
   - Preventive and CVD care tracking tool

**Client Activation**
1. Health education
2. Action planning
3. Problem-solving
4. Visit activation checklist

**Proximal Outcomes**
1. Receipt of preventive primary care (↑)
2. Patient assessment of chronic illness care (↑)
3. Patient activation (↑)
4. Self-efficacy (↑)

**Distal Outcome**
1. Health and mental health-related quality of life (↑)
2. General health status (↑)

**Intervention Mapping: Adaptation Steps**

- **Step 1:** Setting the Stage
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- **Step 6:** Evaluation
Study Aims

• Test the feasibility of delivering B2BHW using social workers

• Examine the acceptability of B2BHW among Latino clients

• Explore intervention effects on:
  • Patient activation
  • Self-efficacy
  • Perceptions of chronic illness care quality
  • Receipt of preventive primary care
  • Physical and mental health-related quality of life

Methods

• Setting: Public outpatient mental health clinic serving predominantly Latino adults with SMI in New York City

• Design:
  • 12 month pre-post one-group design
  • Structured interviews and medical chart abstractions at baseline, 6, and 12 months
  • 3 post-intervention focus group

• Sample: N = 34 Latinos with SMI and at risk for cardiovascular disease

• Fidelity: Intervention manual, review and fidelity coding of audio recorded health care manager sessions, and monthly supervision meetings

• Analysis: Content analysis of focus group data and linear mixed model adjusting for health care manager assignment
Measures

• **Feasibility**: Recruitment, assessment completion, and treatment attendance

• **Acceptability**: Client satisfaction questionnaire and focus group data

• **Intervention Outcomes**:
  • Patient activation
  • Self-efficacy
  • Patients’ Assessment of Chronic Illness Care
  • Receipt of preventive primary care
  • Physical and mental health-related quality of life

RESULTS
Study Flow

54 Referrals
10/01/13 ~ 10/15/14

8 Refused to Participate
2 Lost in Referral

34 Enrolled and Completed Baseline
M/K/D: 14 Q: 15

10 Excluded
7 CtoC/ Mini-Cog

4 Dropouts
1 Lost to Follow-up

29 Completed Study
3 Focus Groups (N=16)

Recruitment Rate: 77%

Treatment Completion Rate: 85%

6M: 29
12M: 29

Feasibility

• 85.3% (29/34) completed the intervention

• Average # of visits: 10.07 (sd = 1.79) out of 12, median 10, range 5-13
  • 93% attended 9 or more visits

• 5 people dropped out of the study
  • 4 by the second visit
  • 1 by the third visit
Health Care Manager Time

- Total Time: 80.26 minutes
- In Session: 47.51 minutes
- Care Coordination: 15.11 minutes
- Charting: 10.16 minutes
- Client Outreach: 7.46 minutes

Sample Characteristics (N = 34)

- Female = 67.6%
- Mean age = 54 (sd = 11.5)
- Mean years of education = 10.4 (sd = 3.9)
- Place of Birth:
  - US: 11.8%
  - Dominican Republic: 73.5%
  - Puerto Rico: 2.9%
  - Other: 11.8%
- Language:
  - Monolingual Spanish: 73.5%
  - Bilingual: 26.5%
- Perceived health (Poor/Fair) = 64.7%
- Physical Health Chart Diagnoses:
  - Obese: 62.5%
  - High cholesterol: 75%
  - Diabetes: 47%
  - Hypertension: 62%
  - Arthritis: 21.9%
- Mean # of chronic medical conditions: 2.81 (sd = 1.62)
- Used Primary Care Services in the past 12 months: 97%
- Average number of visit past 12 months:
  - Primary Care: 3.65 (sd = 2.52)
  - ER: 0.56 (sd = 1.07)
Mental Health Characteristics (N = 34)

- Mental Health Chart Diagnosis
  - Schizophrenia = 6.3%
  - Schizoaffective Disorder = 40.6%
  - Major Depression = 25%
  - Bipolar Disorder = 25%
  - Major Depression with Psychotic Features = 18.8%

- Mean # of hospitalizations for MH in past 12 months: 0.59 (1.28), range (0-7)

- Mean # of ER visits for mental disorders in the past 12 Months: 0.65 (1.30), range (0-7)

Acceptability of B2BHW (N = 29)

- 93% rated the quality of services as good/excellent

- 86% indicated B2BHW met most/all of their health needs

- 97% were mostly/very satisfied with the amount of help they received from B2BHW

- 100% reported that:
  - B2BHW helped them deal more effectively with their physical health
  - Would recommend B2BHW to a friend
What Participants Liked Most about B2BHW (N = 29)

- Health Education: 89.7%
- Relationship with HCM: 75.9%
- Care Coordination: 44.8%
- Activation: 41.4%
- Health Monitoring: 27.6%
- Health Benefits: 20.7%

B2BHW Initial Impact
Patient-Centered and Health Outcomes

- Significant improvements in patient-centered outcomes from baseline to 12 months:
  - **Patient Activation**: 56.8 to 72.03, $p < 0.01$, $ES = 0.56$
  - **Self-Efficacy**:
    - Talking with doctor: 7.62 to 8.89, $p < 0.01$, $ES = 0.49$
    - Managing chronic illness: 5.57 to 6.88, $p < 0.01$, $ES = 0.55$
  - **Patients’ Assessment of Chronic Illness Care: Health Care Manager**: Total: 2.81 to 4.08, $p < 0.01$, $ES = 0.63$

- No significant improvements in health-related quality of life (SF-12) and health outcomes (e.g., weight, blood pressure) were found.

Receipt of Preventive Primary Care Services

<table>
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<tr>
<th>Service</th>
<th>Baseline</th>
<th>12 Months</th>
<th>Note: Adjusted for HCM assignment * $p \leq 0.05$, ** $p \leq 0.01$, *** $p \leq 0.001$</th>
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<tbody>
<tr>
<td>Total***</td>
<td>29.8</td>
<td>54.9</td>
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<tr>
<td>PCP Edu***</td>
<td>44.7</td>
<td>54.9</td>
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Discussion

- Latina/os with SMI face a constellation of barriers accessing and using primary care
- Culturally-adapted health care manager programs like B2BHW can help reduce these barriers
- B2BHW was feasible to deliver by social workers
- Over the course of 12-months, we saw significant improvements in:
  - Patient activation
  - Self-efficacy
  - Patients’ assessment of the chronic illness care
  - Receipt of preventive primary care services

Limitations

- One site
- Early adopters
- Small sample
- Single-group design
Conclusions

- Local adaptations can help address local needs and local implementation gaps
- Adapting interventions with stakeholders rather than for stakeholders
- Develop the science of adaptations: replication and effectiveness

Thank You // Gracias

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