

# Patient and Practitioner Perspectives on Culturally Centered Integrated Care to Address Health Disparities in Primary Care

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## ABSTRACT

**Introduction:** Addressing the multifaceted health and mental health needs of ethnically and culturally diverse individuals is a challenge within the current health care system. Integrated care provides a promising approach to improve mental health treatment-seeking disparities; however, adaptation of care models to impact African Americans is lacking. Although resources to support engagement of diverse populations in depression care exist, little has been developed to tailor patient preferences in accessing and engaging mental health services that are integrated into primary care.

**Objective:** Our research seeks to add a cultural focus to the existing literature concerning integrated health care models to help address depression and selected co-occurring chronic health conditions in primary care settings.

**Methods:** Thirty-two adult patients of an integrated primary care clinic participated in focus groups discussing their individual health experiences. Nine health care practitioners/administrators from five different integrated practice settings in the Atlanta, GA, area participated in key informant interviews.

**Main Outcome Measures:** Transcripts were analyzed for key themes related to depression care, perceived unmet cultural needs, and desired adaptations.

**Results:** Common themes emerged such as the importance of peer-support and community engagement as areas of patient interest. Participants had good knowledge in recognizing depressive symptoms but were less knowledgeable about treatment options and expectations of treatment. The administrative and practitioner perspective suggests that patient preferences are valued and perceived as valid.

**Conclusion:** It is critical that strategies and models are developed to improve health care among underserved minorities because current models offer variable efficacy among this population.

lower than among whites.<sup>9-11</sup> National Survey of American Life findings revealed that lifetime prevalence of major depressive disorder was higher among whites (17.9%) than African Americans (10.4%), and African Americans experienced higher depression chronicity (56.5%) than whites (38.6%).<sup>9</sup> African Americans also are less likely to seek help for mental health issues,<sup>9,12</sup> and are more likely to have poorer access to mental health care and to receive poor-quality mental health care.<sup>13</sup> Discrimination and racism exacerbate their experience with depression,<sup>14</sup> which increases their overall disease burden. African Americans living at or below the poverty level report higher levels of psychological distress than those living above it, which points to poverty as a social determinant of mental health.<sup>15,16</sup>

The literature describes underuse of professional mental health services among the general US population.<sup>17,18</sup> Although studies have shown that the use of mental health services has risen, disparities in utilization still exist among racial and ethnic populations.<sup>19</sup> Several studies demonstrate that compared with their white counterparts, African Americans receive less mental health care.<sup>17-21</sup> According to the National Comorbidity Survey, there was no significant difference in depression prevalence between African American and white participants; however, African American participants were less likely to use professional mental health services.<sup>22</sup> In addition, the National Survey of American Life showed that among black Caribbean and African American populations, the

## INTRODUCTION

Approximately one-fourth of the US population is affected by one or more mental health conditions.<sup>1</sup> Approximately 8.7% of the world's population receives a diagnosis of depression at least once during their lifetime.<sup>2</sup> According to the World Health Organization, mental health conditions are the leading cause of decreased functionality, and depression is the second-leading cause of disability worldwide.<sup>3,4</sup> Disability caused by depression is commonly measured as disability-adjusted

life years (a combination of years of life lost to premature mortality and time lived in less than full health). Depression can have debilitating effects on interpersonal relationships and functional capacity and increase risk for chronic illnesses such as hypertension, diabetes, and cardiovascular disease. Depression has emerged as a primary concern to public health professionals who encounter patients with depression and co-occurring medical problems.<sup>5-8</sup>

The incidence and prevalence of depression among African Americans is generally

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degree to which one's racial/ethnic group is a minority within the US was associated with increased risk for psychiatric disorders.<sup>23</sup> These racial and ethnic differences support the need for research to address barriers associated with use of mental health services.

### Integrated Care Models in Culturally Diverse Populations

Most patients living with depression and other mental health conditions initially receive their diagnosis and treatment in primary health care settings (sometimes called the “de facto” mental health care system); consequently, there is potential to use models of integrated care to address health disparities among African Americans with depression.<sup>1,24-26</sup>

Integrated care models, when implemented with use of quality measurement-based care, substantially improve clinical outcomes for depression and other mental health conditions.<sup>27</sup> Although treatment is commonly initiated in the primary care setting, the literature demonstrates inconsistent practitioner approaches to address mental health conditions.<sup>28-31</sup> Most patients who are identified as having mental health issues including depression receive inadequate treatment in primary care offices.<sup>32</sup> Patients may have to overcome many barriers to access mental health treatment across service settings including limited access to care because of location, lack of transportation or mental health insurance, and issues related to low socioeconomic status.<sup>33-36</sup> For example, education level, a basic component of socioeconomic status, is strongly associated with health care. Education increases access to health information and occupational resources such as health insurance and promotes health literacy.<sup>37</sup> Conversely, low educational level, which is characteristic of poor and disadvantaged communities, increases risk for poor medical and mental health outcomes. African Americans are overrepresented in disadvantaged and vulnerable groups that include people who are incarcerated, poor, and homeless. There is also a cultural legacy of mistrust, stigma, and lack of understanding and respect between African Americans and practitioners and the health care system in general,<sup>38</sup> and these patients are less inclined to use specialty

mental health services than their white peers.<sup>39</sup> Most often, African Americans turn to friends, family, places of worship, and other informal sources of care and support.<sup>40</sup> These findings suggest that a culturally sensitive approach to mental health that accounts for barriers to access and treatment preferences is necessary to screen for and to treat mental health conditions within primary care settings.

Patients with depression are at a higher risk for at least one co-occurring chronic medical illness.<sup>41</sup> Integrated models of primary and mental health care are designed to enhance acceptability and availability of mental health services and enable collaborative care to address both physical and mental health needs.

Several evidence-based integrated care models that have been implemented in a variety of clinical settings have helped to remove perceived barriers to depression treatment for African Americans and for others.<sup>42</sup> The four-quadrant model, a commonly used conceptual framework, assigns treatment responsibility to primary health care clinics and specialty mental health care organizations on the basis of predominant needs.<sup>43</sup> Many primary care practices are now designated a patient-centered medical home (PCMH). A PCMH includes a medical staff and community member team that strives to improve health care outcomes within a community. PCMH recognition is contingent upon certification that behavioral health conditions are identified and addressed.<sup>44,45</sup> Many health care organizations attempt to improve clinical outcomes in a more cost-effective<sup>46</sup> and equitable manner<sup>47,48</sup> by encouraging PCMH model use, but initial assessments of practice efforts to transform to a PCMH model reveal minimal or no improvements in the patient experience.<sup>49</sup> Additional research on the community's role in care coordination, one of the key principles of the PCMH model, may provide valuable information on the ways in which formal and informal social networks influence stigma and serve as pathways to behavioral treatment for African American populations.<sup>43</sup>

The collaborative care model is associated with the strongest evidence for improved clinical outcomes, as demonstrated in the Improving Mood—Promoting Access to Collaborative Treatment model

in which primary care practitioners collaborate with a behavioral health consultant (BHC) to develop appropriate treatment plans.<sup>50</sup> This model emphasizes the use of clinical outcome measures and treatment-to-target to optimize depression care. Evidence-based care management practices, such as collaborative care management, also have demonstrated improved outcomes for patients with diabetes, cardiovascular disease, and depression.<sup>51-53</sup> Primary care practitioners who use collaborative care management receive support from a multidisciplinary mental health care team to help improve medication adherence, manage side effects, and develop a tracking system to identify those who are not improving.<sup>54</sup>

Although plentiful research has revealed the positive impact of addressing behavioral health issues in primary care settings and empirical evidence shows that integrated care can reduce health disparities, relatively little attention has focused on the unique needs of culturally diverse groups such as African Americans.<sup>42,55-57</sup> A 2016 literature review concluded that “Evidence is lacking about the effectiveness of integrated care offered in a culturally and linguistically competent, patient-centered framework that adequately addresses key concerns and barriers that affect populations at great risk for marginal health.”<sup>58</sup> To address this evidence gap, Project THRIVE (Towards Health Recovery and Vital Engagement) offers a promising approach. Project THRIVE is a health disparity research project designed to develop, implement, and evaluate a culturally centered model of integrated care in a predominantly African American population. This paper is the first publication of Project THRIVE research.

A paucity of qualitative research focuses on culturally centered integrated care approaches for African Americans, so the development phase of our project employs a mixed-methods approach. In particular, we aimed to identify factors important to a group of patients, practitioners, and clinic administrators when developing a patient-centered, culturally tailored integrated care model within a community-based family health care center primarily serving African Americans. This manuscript reports on the findings revealed in patient

focus groups and practitioner key informant interviews that were designed to examine perspectives on the key components of a culturally centered model of integrated care and presents implications for existing and emerging integrated care practices that serve culturally diverse populations.

## METHODS

The institutional review board at the Morehouse School of Medicine approved this project.

### Focus Group Recruitment

A convenience sample of 33 patients from the Comprehensive Family Healthcare Center (CFHC) participated in 9 focus groups comprising 4 to 6 patients per group. The CFHC, an urban, private nonprofit clinic with 7750 visits in 2014, is one of the 2 Morehouse Healthcare clinical sites. More than 100 Morehouse Healthcare physicians provide expertise across areas ranging from primary care to highly specialized treatments. The practice is integrated with Morehouse School of Medicine residents and students. As one of the largest physician groups in Georgia, Morehouse Healthcare provides medical support to nearly every major hospital and clinic in Atlanta, GA, with a focus on providing quality care to Atlanta's multicultural community. CFHC's patients are appropriately 90% African American, 40% seniors, 40% adults, and 20% children/adolescents, and most patients (85%) reside in underserved/at-risk/vulnerable communities in the Atlanta metropolitan area. However, mental/behavioral health services are limited and not located at the clinic site, so referrals to external resources often are necessary. Consequently, the focus groups were designed to gather information about the understanding of depression and mental illness, experiences in the CFHC, and thoughts on how to improve mental health care within the African American community. Eligible participants were African American, age 18 years or older, and staff-verified as registered at the CFHC. Recruitment flyers describing the opportunity were distributed in the waiting room. The recruitment flyer response rate was low, however, so 2 research staff members (both women), using recruitment scripts, met with patients

at the CFHC waiting room. Some patients signed up to participate at a later date, usually when they were scheduled for another visit. Other patients began to participate the moment they were recruited, with research staff prepared to begin once a minimum number of participants was achieved. Several male patients agreed to participate, so a male research staff member also participated in recruitment efforts to elicit potential response variation. Research staff used these approaches 1 to 2 days a week for 2 months, which increased the number of individuals who participated in the study.

### Focus Group and Survey Completion

Participants were either waiting for their appointment to begin, had just completed an appointment, or had come to the CFHC on a day when no appointment had been scheduled. Several participants who were waiting for appointments left before completing informed consent procedures or had to leave after study activities began. Each participant completed a patient satisfaction survey that gathered demographic information and assessed satisfaction with integrated behavioral health services and comfort levels with treatment and the treatment setting (see Figure 1; available online at [www.thepermanentjournal.org/files/2017/16-018-Figure1.pdf](http://www.thepermanentjournal.org/files/2017/16-018-Figure1.pdf)). The 10-minute survey was administered before beginning the focus group. Each 60-minute focus group was facilitated by 2 trained research team members. Questions covered 3 topics: views about depression and treatment, necessary cultural adaptations in the context of treatment in primary care, and perceived unmet cultural needs. The focus group guide and list of questions (Figure 2) is available online at [www.thepermanentjournal.org/files/2017/16-018-Figure2.pdf](http://www.thepermanentjournal.org/files/2017/16-018-Figure2.pdf). Each participant received a \$25 incentive upon completion of the focus group.

### Key Informant Interviews

After analyzing emerging themes, nine clinic practitioners and/or administrators were sampled and presented with focus group themes. These key informants had at least five years' experience in the clinic. These interviews helped to further inform development of the integrated care model

and identify whether factors deemed important to patients were viewed as relevant by the clinic.

## Analysis

The focus groups and key informant interviews were audio recorded and professionally transcribed. Transcripts were uploaded and analyzed using Dedoose Version 7.0.23 (SocioCultural Research Consultants, LLC, Los Angeles, CA), a Web application for managing, analyzing, and presenting qualitative and mixed-method research data. An investigator with expertise in qualitative research supervised the trained research assistants in transcript analysis. Each member of the team read the transcripts at least twice for overall understanding, with each member taking note of the statements that stood out to share in a group discussion. Responses were grouped based on discussion topics (depression care, necessary cultural adaptations, and perceived unmet cultural needs), and the lead investigator generated an initial set of codes using a combination of inductive and deductive approaches.<sup>59</sup> Two members of the research team reviewed the data again and independently applied codes from the finalized structure. The team then met to review discrepancies and resolve differences through in-depth discussion and consensus. Intercoder reliability was evaluated by using two transcripts that were not analyzed in the code development phase and assigning two team members to apply the codes.<sup>60</sup> After initial discussion of themes that stood out, a pile-sort method was used to group similar codes related to those themes. Transcript areas that were not coded by either researcher were reviewed to identify the presence of less salient themes.<sup>61</sup>

## RESULTS

A total of 33 patients participated in focus groups and completed the survey (Table 1). Descriptive statistics were calculated to summarize the results. All of the respondents were African American, and most were women (75.8%). About 40% identified as single (39.4%), and more than 50% had 2 or more children (51.5%). The sample was diverse in employment status, with 21.2% indicating they were unemployed, working full-time, or retired.

Almost 25% indicated they had less than a high school education (24.3%), and a majority of respondents lived in households with an annual income under \$14,999 (57.7%). Food service (24.2%), business/finance (12.1%), and administrative work (12.1%) were the most commonly reported professions among respondents. Most respondents had some form of health insurance coverage (87.9%), either through their employer, Medicaid, Medicare, or another insurer. Among respondents, 45.5% had never visited an integrated behavioral health clinic; however, some had visited an integrated behavioral health clinic 10 or more times (18.2%).

Table 2 details the overarching themes and illustrative quotes reflecting patient preferences for and practitioner/

administrator perspectives on cultural tailoring. The overarching themes of importance involved the desire for anonymous support groups in primary care, practitioner involvement in the community, a need for more culturally tailored education and culturally sensitive communication about mental health during clinical encounters, and the importance of addressing stigma.

**Ideas About Depression**

Focus group participants were asked about their knowledge and experience with depression. Many African Americans referred to “generational differences” regarding their ability to speak about depression. There was consensus that depression was a “treatable condition,” with

many participants noting that depression does not have any regard for socioeconomic background, education level, or race. Participants felt people with higher socioeconomic status were more willing to seek help, whereas those from poorer backgrounds continue to believe it is taboo to seek help. Participants could not describe the events that may cause depression in people with higher socioeconomic standing, but they believed depression in their communities was mainly caused by racial, social, and economic stressors; illicit substance use; and caregiver stress.

**Anonymous Groups**

A theme emerged in each focus group regarding the desire for a voluntary support group that would be held in the primary care clinic and provide an opportunity for patients to “try before they buy” mental health services. Of note, participants in each focus group mentioned the Alcoholics Anonymous model as an example of an approach that likely would be perceived as welcoming to reluctant individuals in need of services. Other participants said that having a behavioral health expert available to answer questions would be important when creating an environment of peer support.

**Community Involvement**

The importance of practitioners’ involvement in the community emerged as a theme in each group: Patients were more willing to engage in recommended mental health referrals if practitioners were active in their community. Patients mentioned that seeing practitioners at health fairs, church events, and community center informational sessions helps to open up lines of communication and would make them more comfortable discussing topics such as mental health. In turn, practitioners agreed that “being present in the community” and “being seen as part of the community” were important to establish trust and to more fully understand the environment in which their patients live.

**Culturally Tailored Education**

Participants said that clinic or community-based workshops that address stress management should focus on stressors related to race and social disadvantage.

**Table 1. Patient participant characteristics and satisfaction survey results (N = 33)**

Characteristic	No. (%)	Characteristic	No. (%)
<b>Sex</b>			
Men	7 (21.2)	<b>Highest level of education</b>	
Women	25 (75.8)	Less than high school	3 (9.1)
Unknown/not reported	1 (3.0)	Some high school	5 (15.2)
<b>Race/ethnicity</b>			
African American/black	33 (100.0)	High school graduate	5 (15.2)
<b>Marital status</b>			
Single	13 (39.4)	Technical or vocational school	3 (9.1)
Married	5 (15.2)	Some college	4 (12.1)
Divorced	6 (18.2)	College graduate	3 (9.1)
Widowed	3 (9.1)	Postgraduate/professional degree	5 (15.2)
Living together	4 (12.1)	Unknown/not reported	5 (15.2)
Unknown/not reported	2 (6.1)	<b>Total household income</b>	
<b>Number of children</b>			
None	3 (9.1)	Under \$5000	9 (27.3)
One	10 (30.3)	\$5000-\$9999	5 (15.2)
Two	6 (18.2)	\$10,000-\$14,999	5 (15.2)
Three	4 (12.1)	\$15,000-\$24,999	3 (9.1)
Four or more	7 (21.2)	\$25,000-\$34,999	5 (15.2)
Unknown/not reported	3 (9.1)	\$35,000-\$49,999	1 (3.0)
<b>Employment status</b>			
Unemployed	7 (21.2)	More than \$50,000	4 (12.1)
Part-time	2 (6.1)	Unknown/not reported	1 (3.0)
Full-time	7 (21.2)	<b>Health insurance coverage</b>	
Retired	7 (21.2)	Uninsured	3 (9.1)
Disabled	8 (24.2)	Employer insurance	8 (24.2)
Homemaker	2 (6.1)	Medicaid	12 (36.4)
		Medicare	11 (33.3)
		Health insurance other	1 (3.0)
		Health insurance none	1 (3.0)
		<b>Visits to integrated behavioral health clinic</b>	
		None	15 (45.5)
		1-5	10 (30.3)
		6-10	1 (3.0)
		10 or more	6 (18.2)
		<b>Satisfaction scale score</b>	33.34 (9.16)
		(n = 17, range 9 - 45), mean (SD)	

SD = standard deviation.

Table 2. Patient preferences for and practitioner/administrator perspectives on cultural tailoring	
Overarching theme	Illustrative quotes
<p><b>Anonymous groups</b> Refers to a group format that includes optional attendance and/or access to a behavioral health specialist</p>	<p><i>Patient</i></p> <p>"Anonymity is key to building trust." "Something like an AA thing but for depression." "I like the idea of a support group for depression but with an expert there to ask questions to." "A place where I would feel more comfortable asking questions."</p> <p><i>Practitioner/administrator</i></p> <p>"I could understand that because trust is an issue. You're not going to get it easily at first. This population tends to be suspicious of the medical system." "Sometimes the patients use the waiting room and talk about their health problems with each other."</p>
<p><b>Community involvement</b> Refers to primary care practitioner roles in the communities in which patients reside</p>	<p><i>Patient</i></p> <p>"We want to see our practitioners in our neighborhood." "I'll feel better meeting with someone [for mental health] if I saw them in the community." "What if there was a time when a physician could be at a gathering just to talk to people?"</p> <p><i>Practitioner/administrator</i></p> <p>"I think it's how patients view this particular health center. A lot of patients actually view it as a part of the community." "I'm looking at that as another outreach ... community interaction is important to the patient."</p>
<p><b>Culturally tailored education</b> Refers to the type of cultural tailoring that is needed for psychoeducation in primary care settings</p>	<p><i>Patient</i></p> <p>"I would want to hear about all the medications, like herbal too, and other alternative options." "Using [screening] questionnaires helps me feel the doctor is inviting that type of discussion." "Having an elder come and speak and explain things would help."</p> <p><i>Practitioner/administrator</i></p> <p>"If we had more background knowledge and more cultural awareness of this primary population that we serve on a daily basis, it could definitely improve the quality." "With some people you have to start with psychotherapy; they prefer that to medications."</p>
<p><b>Sensitive communication</b> Refers to the ways in which mental health issues and topics are approached in primary care settings</p>	<p><i>Patient</i></p> <p>"It takes time to get a person to open up about depression; I need my doctor to listen." "It's hard for a black man to reach out in the first place, so it's important to understand that."</p> <p><i>Practitioner/administrator</i></p> <p>"We have to be careful not to judge and to be humble when we're making [mental health] recommendations ... take their transportation options into account, too." "It helps when they realize that the two practitioners are communicating and you know what the other person is doing."</p>
<p><b>Find ways to fight stigma</b> Ideas about how stigmas can be addressed from a cultural perspective</p>	<p><i>Patient</i></p> <p>"If my family member was there they could ask questions." "The church is important, but that might keep a person from getting help." "If my doctor mentioned something that made them depressed, I can open up to see what they had to say."</p> <p><i>Practitioner/administrator</i></p> <p>"They feel like they should not be having any of these issues because they should be able to pray." "Get buy-in from faith-based organizations. We do some work with health ministries of different churches with our residents volunteering."</p>

Patients and practitioners both said that practitioners should feel comfortable discussing the meaning of mental illness from the patient's cultural perspective, and they should be able to provide culturally tailored education about treatment options. As an example, one practitioner cited examples of the ways in which patients' spiritual belief systems can be used to support mental health treatment.

### Sensitive Communication

Another theme focused on the ways in which practitioners can most effectively discuss mental health with their patients. Focus group participants recognized that discussions about mental well-being are sensitive and necessitate a unique level of comfort. Practitioners stated that more training and education are needed to increase comfort when discussing mental health diagnoses and treatment options.

### Ways to Fight Stigma

Participants stated that waiting room depression screening in primary care offices decreases the stigma associated with mental illness because screening conveys to patients the message that their practitioners are interested in their mental health. Many African American participants mentioned the importance of "the church" as both a protective factor and a potential source of stigma. Developing partnerships with the faith community was identified as an important step toward reducing the stigma of treatment seeking.

### DISCUSSION

Strategies and models must be developed to improve health care and eliminate health disparities among underserved minorities. When designing and implementing integrated care models, attention to cultural identity can help to ensure effective integrated services use. A qualitative approach to identifying common themes deemed important by both patients and practitioners/administrators is a first step toward improving cultural sensitivity of integrated care treatment implementation. Empirical exploration of these themes in a more diverse sample probably would clarify the importance of these elements and better inform design of culturally centered integrated care models.

These results will be used to inform model development and implementation of a culturally tailored integrated behavioral health intervention at selected primary care clinics in a large urban city. The focus of the implementation is to determine the feasibility and acceptability of using health information technology tools to facilitate behavioral health assessments and examine utilization rates, to assess co-occurring health conditions such as diabetes and hypertension, and to explore the impact of culturally sensitive approaches to integrated care. A pilot implementation of multidagnostic electronic assessment of mental health and substance use disorders was deemed feasible in a culturally diverse integrated care setting.<sup>62</sup>

A key feature of the next project phase, which incorporates the results of the present study, is use of Healthify (Healthify, Inc, New York, NY) an innovative computerized assessment tool that can help elucidate patients' social needs and treatment preferences. This tool can identify services and resources proximal to a patient's address such as battered women's shelters, self-help groups, faith-based organizations, substance abuse treatment centers, and advocacy organizations.

As a software-as-a-service solution that helps health care organizations address social service needs, Healthify is associated with an understanding of the social determinants of health. Social determinants of mental and behavioral health are the socioeconomic factors that influence how people learn, work, play, live, and age, which in turn affects their mental health and wellness.<sup>40</sup> Evaluating the effectiveness of integrating tools such as Healthify into workflows and existing system initiatives will demonstrate whether this resource can help address racial, social, and economic stressors that patients in the current study identified as driving depression.

The next phase of this project also will place a BHC in the primary care setting to address the needs of patients who screen positively for depression and have two of three clinically important conditions: obesity, diabetes, or hypertension. The role of the BHC as an integral member of the integrated care team is critical to successful implementation, and his or her consideration of patients'

cultural backgrounds will help to determine health care system access and quality. The BHC will need to engage patients in ways that reflect the outcomes of this study, including culturally informed family engagement, and provide patient education about health condition(s) in a culturally and linguistically appropriate manner. For example, the BHC will need to educate patients about the signs and symptoms of conditions for which they are at risk but use language that is free of stigma and is empowering. The BHC also will participate in practitioner training by shadowing primary care physicians, providing feedback about cultural sensitivity, and helping create modules that demonstrate culturally sensitive patient-practitioner interactions. These activities, which reflect the findings from the current study, will be assessed and evaluated for their impact on patient health outcomes and patient and practitioner efficacy.

The current findings can be used to develop constructs to include in future research using mixed-methods (qualitative and quantitative), culturally centered, and/or gender-specific methods for prevention and intervention approaches to address relevant psychosocial, sociocultural, and environmental factors that can promote mental health and wellness for culturally diverse populations. Study participants indicated that interacting with health care professionals who treat them in community settings is important to build rapport and improve communication. This feedback suggests that strengthening patient-practitioner rapport goes beyond interactions within the health center. Community engagement supports and fosters trust and respect between patients and practitioners. Many participants were from poor or working class communities, which can influence the ways in which people access care or their pathway to treatment.<sup>40</sup> Limited access to reliable transportation and inflexible work schedules may be challenges for individuals whose income is near the poverty line, which characterizes approximately half of this study's participants. A benefit associated with integrated care strategies that is particularly relevant to patients with limited resources is the opportunity to address medical and behavioral health needs in one visit.

Study results highlight the importance of decreasing stigma when designing behavioral health strategies that serve African American communities. Mental health screenings must be routine in primary care settings, and educational materials about common mental disorders must be available. Primary care practices can tailor health information to the local community by inviting patients to help design patient education materials about depression's signs and symptoms and ways to access community resources. A culturally centered integrated care model may help to inform, equip, and inspire professionals to strive for optimal care strategies.

Feedback from patients and practitioners in this study will help to provide direction for further engagement and offers insight for other practitioners and health systems that are looking for ways to address mental health disparities among African Americans.

Several limitations may influence interpretation of these findings. First, this study included a convenience sample of patients who varied by age, experience with depression and other mental health conditions, socioeconomic status, and other factors; consequently, the sample was not homogeneous. One method to validate qualitative data is to achieve data "saturation" or the point at which no new ideas are elicited. Although saturation was achieved regarding the three discussion topics and themes, it is possible that other relevant themes were not elicited. Purposive sampling by characteristics thought to be relevant in influencing perspectives on culturally centered integrated care (ie, age, gender, or experience with treatment) may strengthen future efforts to ensure that important factors to include in culturally centered models of integrated care are not excluded. Second, our methods did not include detailed field notes to accompany the recorded focus group transcripts, which limits our ability to attribute comments in a way that would better contextualize our results and inform whether these themes can be generalized to groups of African Americans in other settings. The demographic survey was administered to better characterize the sample and to facilitate result interpretation. Finally, this study included data from key informants

representing practitioners and administrators. Although this study was designed to elicit a broad set of perspectives from stakeholders, the limitations regarding generalizability of the findings apply to themes emerging from this group.

## CONCLUSION

This study highlights the need for more research on strategies to increase engagement of African Americans in integrated care settings who are at risk for or are currently experiencing depression. Study participants identified 3 primary themes: reducing mental health stigma, improving visibility of health care practitioners in the community, and the need for voluntary support groups for those who may be reluctant to seek care. Participants shared diverse perspectives on their behavioral health care experiences and observations of others in their community. These perspectives serve as potential points of intervention for public health practitioners, researchers, health care administrators, and others. Participant views on existing challenges and possible solutions related to access and quality of depression care in integrated care settings encourage stakeholders to consider cultural values and beliefs when designing program, practice, and policy interventions. The global disease burden of depression has been rising<sup>63</sup> and may continue to rise if disparities in health care among vulnerable communities, including African American communities, are not addressed. Although integrated care strategies have proven effective for medical and behavioral health problems, inattention to cultural factors may lead to an increased burden and a widening disparities gap. Although it is important to strengthen evidence-based practices that are effective among populations most in need, it is equally (if not more so) important to value community perspectives on improving depression treatment engagement in integrated care.

We acknowledge challenges to successful implementation of culturally tailored integrated care systems, namely, limited resources and funding. These limitations may present barriers at various levels, yet community voices must be acknowledged and incorporated in patient-centered care models. We must identify innovative

solutions that maximize the skills, knowledge, and experience that emerge from trusting relationships between patients and practitioners. The goal is to promote improved community health and increase use of focused, culturally tailored, patient-centered, multidisciplinary engagement, which may create the opportunity for a larger positive impact on vulnerable and disadvantaged communities. Integrated care approaches informed by evidence-based research can contribute to effective mechanisms to reduce mental illnesses stigma and build healthier communities. Furthermore, developing culturally centered tools and educational resources to bolster patient knowledge and a sense of ownership, alongside a compassionate team of practitioners, can empower communities. ❖

## Disclosure Statement

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