



**COMMUNITY PARTNERS IN CARE**  
Compañeros Comunitarios en la Salud



# Community Partners in Care (CPIC)

## Community Engagement and Planning Framework

### Workbook

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*Photos provided by: Healthy African American Families,  
SPA 6 CPIC Conference*



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## CPIC Partners

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**SPA 4**

QueensCare Family Clinics  
Assistance League of Southern California Hollywood Senior Multipurpose Center  
Gateways Hospital and Mental Health Center  
QueensCare Health & Faith Partnership  
Behavioral Health Services, Inc.  
PATH (People Assisting the Homeless)  
Village Health Foundation  
AIDS Healthcare Foundation

**SPA 6**

Watts Healthcare Corporation  
House of Uhuru  
United Women in Transition  
Bryant Temple African Methodist Episcopal Church  
HOPICS (Homeless Outreach Program Integrated Care Systems)  
Volunteers of America  
South Central Prevention Coalition  
Kedren Acute Psychiatric Hospital and Community Mental Health Center  
Children's Institute, Inc.  
People Coordinated Services of Southern California, Inc.

Personal Involvement Center, Inc.  
His Sheltering Arms, Inc.  
Augustus F. Hawkins Family Mental Health Center  
Kedren West Adams Calworks  
Free N' One  
All Peoples Christian Center  
National Family Life and Education Center  
Curves  
T.H.E. Clinic, Inc.  
Healthy African American Families  
Shields for Families  
New Vision Church of Jesus Christ



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# Table of Contents

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## **Introduction: Community Engagement and Planning Intervention** 7

Mission Statement

Our Goals

## **Approach** 17

Overview

Collaborative Care as traditionally defined

New Approach to Partnered Collaborative Care

Stages

## **Intervention Working Group Membership** 23

Membership

Co-Chairs

## **Work Plan** 27

## **CEP Workgroup Resources** 27

## **Structure: Working Group Meetings** 31

## **A Frame** 33

## ***The Story of Stone Soup*** 36

## **Resources: (Options for Working Groups)** 37

## **Glossary** 39

## **List of Contacts** 43



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# Community Engagement and Planning Intervention

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**T**hank you for joining us in the **Community Engagement and Planning (CEP)** Intervention Workgroup for the **Community Partners in Care (CPIC)** research project, funded by the **National Institute of Mental Health**.

The CPIC project is testing a new way to implement quality improvement programs for depression at the community level. CPIC was developed because we recognize the expertise of community providers and their knowledge of their community. We understand the limits of medical models of depression that focus on the suffering individual



\*\* Bolded words defined in glossary (p.45), definitions in document.



rather than the larger social or environmental context. We recognize the limits of existing treatment models for depression that have been implemented in research studies while many promising models have not yet been prioritized for evaluation.

CPIC, the research project, is described in more detail in a separate document, “Community Partners in Care Study Overview and Resource Guide.” That document also includes information on the **Collaborative Care Model for Depression**. In addition, that document describes the **Community-Partnered Participatory Research (CPPR)** approach that is being followed by this project. \*\*

Briefly, the CPIC study is an evaluation of two ways of improving depression care in the community. One is the Resources for Services (RS) intervention and the other is the CEP intervention. The group of agencies implementing the RS intervention will receive a toolkit and technical assistance to develop a quality improvement program for depression care within each individual agency.

The CEP intervention consists of a group of agencies working together to develop a multi-agency, community plan to improve depression care in Los Angeles. You and your agency will

*Definitions at a glance:*

**Community Engagement and Planning (CEP)** is the CPIC Intervention condition that involves a group of agencies working together to implement a quality improvement program for depression.

**Community Partners in Care (CPIC)** is a 5 year study funded by the National Institute of Mental Health to determine whether a community Partnered participatory Research Approach (CEP: Community Engagement and Planning) as compared to a regular training (RS: Resources for Services) is more effective in the implementation of Partners in Care, an evidence-based collaborative care model for treating depression.

**National Institute of Mental Health** is one of the branches of the National Institutes of Health. The mission of NIMH is to transform the understanding and treatment of mental illnesses through basic and clinical research, paving the way for prevention, recovery and cure. The NIMH does this through the funding and support of scientific research to prevent and to cure mental illnesses.

**Collaborative Care** in healthcare management and academic circles refers to efforts to address an illness such as depression from a “systems” perspective that encompasses all stakeholders or people and organizations relevant to the problem.

**Community-Partnered Participatory Research (CPPR)** is a research model that utilizes an equal community and university research partnership to improve health outcomes

**Healthy African American Families II (HAAF)** is a non-profit, community serving agency located in South Los Angeles. HAAF’s mission is to improve the health outcomes of the African American and Latino communities in Los Angeles County. They are committed to enhancing the quality of care and advancing social progress through education, training, and collaborative partnering with community, academia, researchers, and government.

work together in the CEP Intervention Workgroup (also referred to as the workgroup) with other agencies.

In this document, we review the mission and goals that the CPIC study is asking your workgroup to take on over the next 4 months. We describe a suggested approach to conducting the workgroups over the next several months. Our suggestions include tips about how the CEP intervention workgroups should be structured (leadership, membership, meeting minutes, voting) and how to create action plans for your group.

Although the CPIC study encourages the workgroups to set their own agenda, we do offer resources and suggestions to support the planning process.

These resources include a **Community Engagement Manual** that describes how to utilize a participatory process for research and community planning. A participatory process involves all stakeholders in making a contribution in assessing, planning, implementing, and evaluating solutions to health problems. The Community Engagement Manual was based on many years of experience that **Healthy African American Families (HAAF)** has with engaging local communities around important health issues.

An additional resource is the CPIC collaborative care toolkit, which includes tools for community agencies that work with persons living with depression. This toolkit was initially developed by the **UCLA Health Services Research Center** and the **RAND Corporation** as part of the **Community Partners in Care (CPIC)** project. These materials have been shown to improve depression outcomes, especially for African American and Latinos with depression who participated in the study. The toolkit includes patient educational materials, patient screening materials, cognitive behavioral therapy manuals, medication algorithms for antidepressants, and care management guides.

**Resources:**

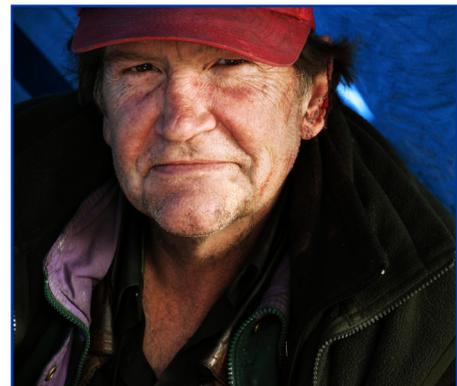
- Community Engagement Manual
- Partners in Care toolkit

**Community Partners in Care (CPIC)** is a collaborative research project that is being conducted by community organizations, community members in South LA/ Hollywood, and academic institutions. Our goal is to learn the best way to reduce the burden that depression places on communities of color and other vulnerable populations in South Los Angeles (SPA 6) and Hollywood-Metro LA (SPA 4).



## Mission Statement

**T**he mission of the CEP intervention is to bring community-based organizations and other community stakeholders together with academic partners to develop and implement a pilot plan to address depression in our Los Angeles communities. The intent is to better serve and improve outcomes for people in the communities of South Los Angeles and Hollywood who are living with depression. The CEP intervention is designed to support participating agencies in building on their own resources and strengths to serve persons living with depression. In doing so, agencies will work together to create a community infrastructure for depression care.



**safety-net** is a term used to describe a collection of services provided by the state or other institutions such as friendly societies, including welfare, unemployment benefit, universal healthcare, homeless shelters, and sometimes subsidized services such as public transport, which prevent individuals from falling into poverty beyond a certain level.

**A**s we know, there is very little support for people with depression in our communities. We ask the CEP intervention workgroup to try to “reweave” the **safety-net** to assure that clients with depression receive help to recover. For example, the agencies may decide to combine existing traditional services for depression (access to therapy and medications) with new outreach programs or treatment programs.

We encourage the participating agencies in the CEP intervention workgroups to develop a plan that considers cultural competence, responsiveness to client and provider preferences for services, quality of services, and expansion of the community’s capacity to address the issue of depression. In addition, the CPIC study team hopes that the CEP intervention workgroup promotes respect for the priorities and resources of individual agencies, providers, clients, and community members, while being mindful of the economic strain on everyone at this time.

**F**inally, we hope the CEP Intervention workgroup shares our enthusiasm to support agencies in training providers, community leaders, and their academic partners in the participatory planning process. True community partnership and planning only occur when people are equally and jointly invested in the vision, valley, and victory of a planning process. We hope you will share our vision for equitable and transparent community planning that allows everyone to make a contribution to improving services and outcomes for depression in Los Angeles.

The work we are doing together in this initiative is also designed to be useful to other communities dealing with depression. During the year-long implementation of the community plan the CPIC steering council will be collecting data to better understand the effectiveness of the plan. By documenting a model that supports communities in reducing the impact of depression, the evaluation data may be useful to communities throughout the nation that want to obtain resources to implement similar programs.



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# Our Goals

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There are two goals for CPIC. First, this initiative is designed to assist the community with developing an effective plan to implement a range of services for depression. Second, this initiative would like to produce data that can be used to support communities seeking resources and policy changes to support **dissemination** of effective depression programs over time. For example, the information and resources developed by this project can be brought to existing community coalitions for consideration for **implementation**, during the **community dissemination phase**. In this way, we hope to support existing community infrastructures to address the issue of depression in our community.

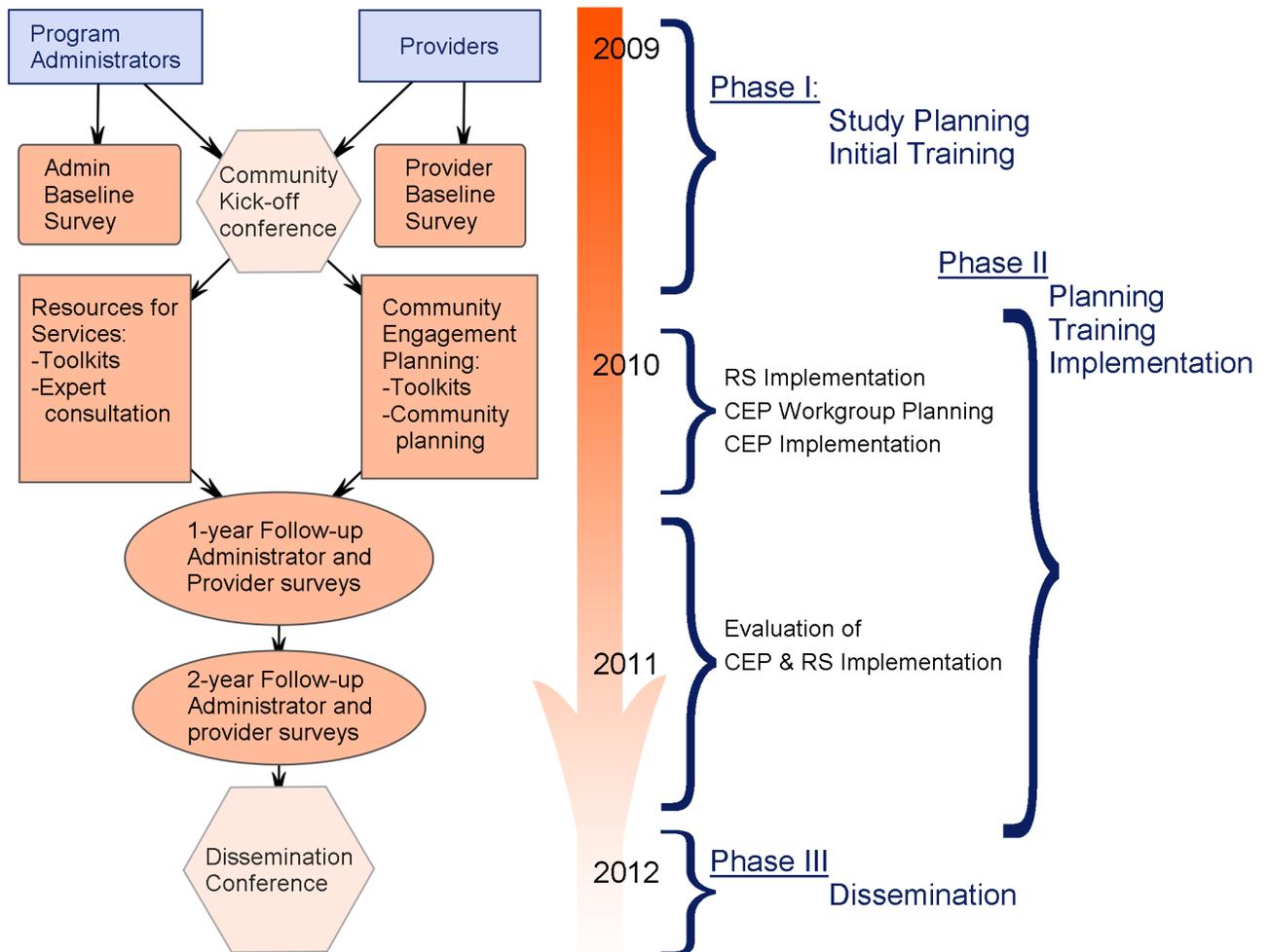
**Dissemination** is the process of communicating the procedures and findings from an assessment, in CIPC, the pilot phase, to relevant audiences in a timely, impartial, and consistent fashion.

**Implementation** is the process of putting a concept or a plan into practice.

**Community Dissemination Phase** will be after the initial pilot phase of the project where we will communicate the procedures and findings to relevant audiences (policy makers, community agencies, health care providers, mental health care providers).

One of our first tasks in the CEP Workgroup is to review and revise the following goals of the Community Engagement and Planning Intervention together:

1. To form a community-academic working group (CEP Intervention working group)



2. Within a four-month timeframe, develop a multi-agency **Community Plan** to increase capacity for depression services in the community. This plan should include training for providers from diverse disciplines in evidence-based and innovative practices to help people living with depression.

3. Implement the **Community Plan** in partnership with the **CPIC council** and **clinical services group** for one year. The CEP workgroup is invited to form an Implementation Council to ensure that their plan is implemented in a manner that is consistent with the workgroup's vision. The Implementation Council will consist of CEP workgroup members who will meet monthly during the implementation phase to assess how the plan implementation is working and to make any necessary course corrections.
4. To disseminate the broader community in whatever works better.
5. To be informed by the **core values of community engagement**, such as equal leadership and respectful engagement among all working group members.
6. After a year of implementing our plan, to work with the CPIC Council to plan and implement **dissemination** of the lessons learned by our initiative.

**Community Plan** within the Community Partners in Care study is the plan that the CEP group will develop to address depression during their 4 month planning process.

**CPIC Council (or Executive Council)** is the leadership group for the CPIC Study that is comprised of representatives of all the agency and academic partners in the project.

**Clinical Services Group** is the community academic subcommittee that is responsible for putting together the Clinical Care Materials in Resources for Services and for the Community Engagement and Planning workgroups for the Community Partners in Care study.

**Community Engagement** is the participation of members of a community in assessing, planning, implementing, and evaluating solutions to problems that affect them.

**Dissemination** is the process of communicating the procedures and findings from an assessment, in CIPC, the pilot phase, to relevant audiences in a timely, impartial, and consistent fashion.

**Core Values of Community Engagement:** Respect for diversity, openness, equality, redirected power (empowerment), asset-based approach.

# Approach

**T**he overall approach of the CEP Intervention is to “support a village” of agencies, community stakeholders, and academic partners working together to improve current services and outcomes for persons living with depression.

This intervention supports adaptation and implementation of evidence-based service delivery programs for depression (based on a model called the “collaborative care model of chronic disease management”). It can also be integrated with programs and complementary services that may improve outcomes for people living with depression in our community.



## Collaborative Care as traditionally defined

**T**he term “collaborative care” was coined in health care management and academic circles. It refers to efforts to address a chronic illness such as depression or diabetes from a “systems” perspective that encompasses all stakeholders (people and organizations) relevant to the problem. This model includes the following:

- Clients are prepared and encouraged to take a more active role in their own care.
- Providers work in multi-disciplinary teams to think through the stages of assessment and treatment. These teams include many different kinds of providers, including specialists and care managers among others.
- Providers with specialized training review and consider how best to implement certain evidence-based practices
- Clients are supported by a “care manager” that helps the client navigate the system and coordinates care decisions with other providers in the team.
- Administrators try to work-out any problems in the system, such as the lack of an effective information system, or not having staff at the right time or place where they are needed.

This kind of model has been shown to work well for many major disease conditions including depression. However, it is difficult to assemble all the different pieces of the model given the resource constraints of safety-net organizations.

## New Approach to Partnered Collaborative Care

**T**he Community Engagement and Planning intervention takes a step beyond collaborative care as traditionally defined. It adapts the model by distributing different depression care tasks to different agencies. Each agency may not have the resources to implement all the components of the collaborative care model. However primary care, mental health, social services, faith-based, health advocacy agencies, and community trusted locations together have all the components. In addition, they have some components that traditional systems lack such as spiritual counseling and peer support. Together these agencies can implement collaborative care in an effective and innovative way to build a village for depression care. This village will have the capacity to fill gaps in services, provide staff and providers training, try new outreach strategies, and connect with other valued community resources and services.



## Stages

**T**he intervention will be developed and implemented in six stages:

1. **Community Partners in Care Kick-Off Conference:** *All* participating agencies and individuals were invited to a one-day kick-off conference. This conference provided an overview of the Community Partners in Care initiative and an introduction to the CPIC Toolkit and collaborative care model, which are the basis for *both* interventions (RS and CEP).
2. **Community Engagement and Planning:** After the kick-off conference, agency sites and programs and academic partners that are assigned to Community Engagement and Planning were asked to participate in an orientation meeting. At this meeting, the goals and resources of the intervention condition will be introduced. Following the orientation, CEP workgroup members will have a period of 4-5 months to meet regularly to develop a written community plan. The plan should outline how training and services delivery for depression will be implemented in the CPIC pilot phase.



**3. Implementing the Community Plan:** The **pilot phase** will begin with a series of trainings for providers, case workers, and outreach workers, according to the community plan developed by the CEP working group. For one year following the trainings, the CEP intervention working group will continue to problem-solve and refine their plan based on feedback from those using it in the community. This stage may include tracking outcomes, providing support for providers delivering services such as cognitive behavioral therapy or outreach.

**Pilot (or pilot phase)** is a study done on a trial basis to determine the potential of a larger and more in-depth study of the same subject matter.

**Policy Advisory Board** is a group of local and national policy experts and elected officials who advise the study about potential policy opportunities and about improving the study's fit to make the outcomes relevant to policy makers.

**4. Community Dialogue:** The CPIC research team will develop a preliminary analysis of the study data and develop summary information on the main outcomes for the two intervention conditions (RS and CEP). The CPIC Steering Council will host a **Community Dialogue** to discuss the implications of study findings. Based on this discussion, the those at the table will develop policy recommendations to reduce the impact of depression in the community. Community leaders from the interventions may be asked to share their experiences in delivering or receiving services under the CEP Intervention. These testimonials will provide a complementary source of information to the formal data analyses and findings.

**Community Dialogue** within a CPPR project is the discussion of a community health concern in an open public forum.

**5. Community Dissemination:** Based on the Community Dialogue recommendations the CPIC Steering Council and the CEP intervention workgroup will lead the **dissemination** of the model found to be most effective for improving depression outcomes. Dissemination activities, such as trainings, will be open to all and we hope to include many community agencies that did not participate in the pilot phase.

**Dissemination** is the process of taking the lessons learned from an assessment and applying them widely in other settings.



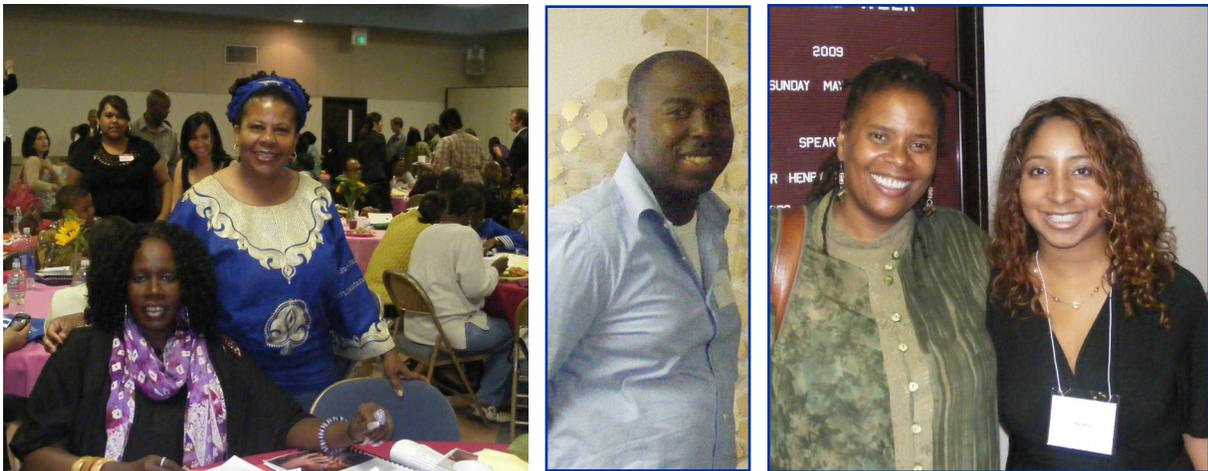
Photo courtesy of QueensCare Health and Faith Partnership

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## Membership

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**T**he suggested membership for the CEP workgroup will consist of representatives from participating agencies and programs, academic partners from the CPIC Council, and community members representing communities of color and vulnerable populations. Each organization or program assigned to this condition will be asked to send 1-2 planning leaders to workgroup meetings. These leaders will consult with others in their organization as needed to receive guidance with special issues, such as clinical services.



## Co-Chairs

**T**he workgroup will have 2-4 community co-chairs and 1-2 academic co-chairs to help set agendas, run meetings, facilitate follow-up and document the plan. The leadership selection will be one of the first activities of the working group, at the Community Engagement and Planning Orientation or shortly thereafter. Staff from the CPIC initiative will also be available to support the meetings and the work, such as organizing meetings, taking minutes, helping with literature searches, and collecting other materials.

*Co-Chair coaching:* Intervention Leaders (community and academic) will have a brief coaching session in facilitating the group according to the principles of Community Partnered Participatory Research, which focuses on equal partnership and respectful engagement, as well as effective work management strategies. This session will be lead by members of the CPIC Council.

## Work Plan

**E**ach meeting should not exceed 2 hours. We suggest that for most meetings, the entire group meet together for 15 minutes to review the agenda, then break-out into groups for approximately 1 hour to work on all agenda items, and reconvene for 30 minutes to review progress and priorities for the next meeting. We would hope that the process to develop a community plan for depression care can take place over 4 months - with two meetings per month of 2 hours apiece. The suggested products for the groups at the end will be a) a training on a community plan for depression care; b) a written training guide for depression care; c) a committee and plan to oversee implementation of the plan.



One other point that should be emphasized is that the work for this project is entirely voluntary and participants are free to participate as they are able to do so without any adverse consequences for not participating. We understand if people are not able to attend every meeting due other commitments. We value your participation at every level.

Your community—academic facilitators and the co-chairs for each group—will be the parties leading the sessions. However, your participation is so valuable. At any point in time, please let us know if you feel the group is moving too quickly, too slowly, or in a direction you are not comfortable with. These groups are for you. In addition, there are some resources / funding for informal ‘get togethers’ with food and drink - if you would like to get to know your fellow participants better. To make these resources available, please just ask the project facilitators and they will help with any scheduling and planning.

And last - please have fun and make sure this work is meaningful for you and our community.



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# CEP Workgroup Resources

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**T**he study has developed some special resources to support the CEP Workgroup in its work. First, the CPIC toolkit includes manuals and clinical tools for therapists, primary care providers, care managers, and outreach workers. The CEP Workgroup will also have a meeting facilitator, an assistant who will schedule meetings, prepare agendas, take notes and share the minutes, access to an agency networking tool, support from the CPIC clinical services committee (an internist, two psychiatrists, two psychologists), and a modest budget to hire consultants.



## 1. The CPIC Toolkit Includes:

- **Clinician Toolkit:** Includes the Clinician Guide to Depression Assessment and Management in Collaborative Care and a quick reference guide companion. The Clinician Guide provides clinical decision aids (algorithms) for depression evaluation and treatment, an appendix on commonly used antidepressants, and patient hand-outs.
- **Therapist Toolkit:** Includes manuals for Cognitive Behavioral Therapy and tools for intake and assessment, tracking therapy process and outcomes, coordination of care, and patient hand-outs.
- **Care Manager Toolkit:** A guidebook, intake and assessment tools, forms for tracking treatment process and outcomes, care coordination tools, and patient hand-outs.
- **Patient Education Materials:** Brochures in English and Spanish, a self-help book titled “Beating Depression”, a Spanish-language “fotonovela” about depression, and DVDs in English and Spanish about depression.
- **The Expert Leader Toolkit:** Presentations on how to introduce others to the CPIC toolkit.
- **Administrator Toolkit:** A Team-Building Worksheet and a guide on how to use the CPIC materials.

## 2. Meeting Resources:

An expert facilitator and an assistant will help schedule meetings, draft and distribute agendas, keep and share minutes, and coordinate group activities.

## 3. Consultants:

The Workgroup may want to invite consultants to conduct specific tasks on their behalf such as develop training materials, design patient education materials that are culturally appropriate for their clients, or to help write the community plan. A modest budget will be available to the CEP workgroup for this purpose.

## 4. Agency Networking Tools

OurVillage is a social networking tool developed by and for community members and academics working in partnership on projects to improve health and mental health. The intent of this tool is to facilitate project collaboration between and among community and academic partners. Members of the CEP workgroup may find this site useful for connecting with partners, finding new partners, and collaborating on projects with other academic and community members.

**S**ome of the useful features of this website include:

- **Connecting with other agencies and organizations** - You can search the other members of OurVillage to find agencies and organizations you are currently working with, and connect with them on the site as “partners”. You can also search the members to find new agencies and organizations you would like to partner with. This can be especially helpful for filling gaps in service needs of your agency’s clients.
- **Maps of you and your partners** - Once you have made connections with “partners”, OurVillage provides 2 ways you can see your network. One is a Google map showing your physical location as well as the physical locations of all your partners. The second is a network map with circles representing you and your partners, and lines showing the connections between you and your partners, and between your partners and their partners on the site.
- **Share documents with your partners** - OurVillage allows you to post documents to share in your own Media Gallery, and the Media Galleries of groups that you are a member of.
- **“Blogs”, forums, and discussions** - OurVillage can also be used for blogging, discussion forums, and private discussions between you and your partners. There are help pages to assist you with these features of the site.

To start using OurVillage, contact Susan Stockdale (sstockdale@med-net.ucla.edu or 310-794-3732) to receive information about how to set up an account. Once you are a member of OurVillage, you can join the CEP workgroup and begin working on a plan to improve depression care in your community.

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## Structure: Working Group Meetings

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**T**he working group will meet twice a month for 4 months to develop the Community Plan to improve depression care for their area.

The partnered working group will continue to meet during the implementation of the pilot to review their experiences and to make “course corrections”. Examples of “course corrections” may include changes in training, collaboration agreements, or consultation. These meetings will occur every other month over the course of a year.





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## A Frame

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**T**he frame is designed to arrive at a written Community Plan for Depression Care in our Los Angeles. Currently, in community safety net settings, there is little access to care for those with depression. Although we (the CPIC Council) know that the goal of creating a comprehensive, community plan for depression is rather ambitious, we hope that this group shares this goal. The group should feel free to use its experience, creativity, and judgment to arrive at a plan that works for your community.

We imagine that a comprehensive community plan will consist of the following:

1. Developing a network to care for people with depression
2. Depression Training and Supervision
3. Evaluating how well the community plan works



In order to implement these components during the year-long pilot phase, here are some suggestions for what the workgroup should try to accomplish during the four month planning process:

1. Selecting and modifying elements of the CPIC Toolkit that will be utilized during the pilot phase
2. Identifying and compiling a list of cultural competency resources, which may include complementary programs that already exist in the community.
3. Identifying or “mapping” the referral lines, resources, and staff from CEP agencies who can work together in getting clients what they need.
4. Developing and finalizing a plan for “support” or “supervision” for staff that are trained under the plan.
5. Identifying potential leaders from the community to partner with academics in providing trainings in components to providers and staff in participating CEP agencies.
6. Planning the actual training conferences. These are the activities, or actions plan, for those with more clinical or direct client contact or program managers.

These activities will be supported by staff from the CPIC study as well as investigators who have experience with many of these activities.

**A**n additional component of the work plan, for administrators and program managers, is to develop an administrative plan to permit and facilitate across-agency collaboration. This includes:

1. Developing a vision for collaborating in depression care, including understanding what makes that a win-win for different agencies;
2. Understanding differences in client eligibility as well as scope of services so that a navigation plan can be developed, of how clients will flow within and across agencies for needed services;
3. Developing any needed **MOUs** or agreements to facilitate sharing clients and referral information that include a focus on being HIPAA compliant;
4. Setting up a plan to provide team oversight of implementation during the pilot phase; and
5. Helping the clinical/program staff group in planning for the training conferences and solving administrative problems related to their scope of activities.

**Memorandum of Understanding (MOU)** is an agreement between partners. In the case of the CPIC study (a type of Community Partnered Participatory Research study), an MOU outlines specific partner roles and responsibilities, organizational structure, and how decisions are made.

# An Activity:

## The Story of Stone Soup

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Once upon a time, in Eastern Europe, there was a great famine. People hoarded whatever food they could find, hiding it even from their friends and neighbors. One day a peddler drove his wagon into a village, sold a few of his wares, and began asking questions as if he planned to stay for the night. "There's not a bite to eat in the whole province," he was told. "Better keep moving on." "Oh, I have everything I need," he said. "In fact, I was thinking of making some stone soup to share with all of you." He pulled an iron cauldron from his wagon, filled it with water, and built a fire under it.

Then, with great ceremony, he drew an ordinary-looking stone from a velvet bag and dropped it into the water. By now, hearing the rumor of food, most of the villagers had come to the square or watched from their windows. As the peddler sniffed the "broth" and licked his lips in anticipation, hunger began to overcome the villagers' skepticism. "Ahh," the peddler said to himself rather loudly, "I do like a tasty stone soup. Of course, stone soup with CABBAGE — that's hard to beat." Soon a villager approached hesitantly, holding a cabbage he'd retrieved from its hiding place, and added it to the pot. "Capital!" cried the peddler. "You know, I once had stone soup with cabbage and a bit of salt beef as well, and it was fit for a king." The village butcher managed to find some salt beef...and so it went, through potatoes, onions, carrots, mushrooms, and so on, until there was indeed a delicious meal for all.

The villagers offered the peddler a great deal of money for the magic stone, but he refused to sell and traveled on the next day. And from that time on, long after the famine had ended, they reminisced about the finest soup they'd ever had.

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# CPIC Materials:

(Options for Working Groups)

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- **CPIC - Why are we doing this study (Story Book Version)**
- **CPIC - What is the Community Engagement and Planning Intervention? (Story Book Version)**
- **Full CPPR Guidebook**
- **Guide to Collaborative Care for Depression (website and Clinical Services Group)**
  - Description of Collaborative Care
  - Specific Resources for Collaborative Care
  - Clinical Services Group and Consultant Request Form
- **Outreach Worker Training Toolkit**
- **Cultural Competency Training Resources**
- **Working Group Contact Information**
- **Tools for Working Groups:**
  - Agency Networking Tool
  - Library of MOUs and Client Consents
- **CPIC Action Plan**



# Glossary

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**Clinical Services Group** is the community academic subcommittee that is responsible for putting together the Clinical Care Materials in Resources for Services and for the Community Engagement and Planning workgroups for the Community Partners in Care study.

**Collaborative Care** in healthcare management and academic circles refers to efforts to address an illness such as depression from a “systems” perspective that encompasses all stakeholders or people and organizations relevant to the problem.

**Community Dialogue** within a CPPR project is the discussion of a community health concern in an open public forum.

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**Community Partners in Care (CPIC)** is a 5 year study funded by the National Institute of Mental Health to determine whether a community Partnered participatory Research Approach (CEP: Community Engagement and Planning as compared to a regular training (RS: Resources for Services) is more effective in the implementation of Partners in Care, an evidence based collaborative care model for treating depression.

**Community Plan** within the Community Partners in Care study is the plan that the CEP group will develop to address depression during their 4 month planning process.

**Community-Partnered Participatory Research (CPPR)** is a research model that utilizes an equal community and university research partnership to improve health outcomes.

**CPIC Council (or Executive Council)** is the leadership group for the CPIC Study that is comprised of representatives of all the agency and academic partners in the project.

**Dissemination** is the process of communicating the procedures and findings from an assessment, in CIPC, the pilot phase, to relevant audiences in a timely, impartial, and consistent fashion.

**Health Disparities** refer to gaps in the quality of health and health care across racial, ethnic and socioeconomic groups. Disparities are population-specific differences in the presence of disease, health outcomes, or access to health care.

**Healthy African American Families II (HAAF)** is a non-profit, community serving agency located in South Los Angeles. HAAF's mission is to improve the health outcomes of the African American and Latino communities in Los Angeles County. They are committed to enhancing the quality of care and advancing social progress through education, training, and collaborative partnering with community, academia, researchers, and government.

**Implementation** is the process of putting a concept or a plan into practice.

**Memorandum of Understanding (MOU)** is an agreement between partners. In the case of the CPIC study (a type of Community Partnered Participatory Research study), an MOU outlines specific partner roles and responsibilities, organizational structure, and how decisions are made.

**National Institutes of Health (NIH)** is a part of the U.S. Department of Health and Human Services, is the primary Federal agency for conducting and supporting medical research. Helping to lead the way toward important medical discoveries that improve people's health and save lives, NIH scientists investigate ways to prevent disease as well as the causes, treatments, and even cures for common and rare diseases. Composed of 27 Institutes and Centers, the NIH provides leadership and financial support to researchers in every state and throughout the world.

**National Institute of Mental Health (NIMH)** is a one of the branches of the National Institutes of Health. The mission of NIMH is to transform the understanding and treatment of mental illnesses through basic and clinical research, paving the way for prevention, recovery and cure. The NIMH does this through the funding and support of scientific research to prevent and to cure mental illnesses.

**Partnered Evaluation** Evaluation has been defined as systematic investigation of the merit, worth, or significance of an object. In public health, evaluation is generally used to ascertain the value of a program or intervention. A partnered evaluation has both academic and community partners involved in every step of evaluation.

**Pilot (or pilot phase)** is a study done on a trial basis to determine the potential of a larger and more in-depth study of the same subject matter.

**Policy Advisory Board** is a group of local and national policy experts and elected officials who advise the study about potential policy opportunities and about improving the study's fit to make the outcomes relevant to policy makers.

**The RAND Corporation** is based in Santa Monica and its mission is to help improve policy and decisionmaking through research and analysis. RAND's research is commissioned by a wide range of sources.

**Resources for Services (RS)** is the CPIC intervention condition that involves applying the collaborative care tools within agencies to implement a quality improvement program for depression.

**Safety-Net** is a term used to describe a collection of services provided by the state or other institutions such as friendly societies, including welfare, unemployment benefit, universal healthcare, homeless shelters, and sometimes subsidized services such as public transport, which prevent individuals from falling into poverty beyond a certain level.

**The UCLA Health Services Research Center** is a part of the Semel Institute for Neuroscience and Human Behavior in the Department of Psychiatry and Bio-behavioral Sciences at the David Geffen School of Medicine at UCLA. Their mission is to improve health policy, health care, and quality of life for people with psychiatric and neurologic disorders. Integrating expertise from the fields of medicine, public health, public policy and social science, we focus on issues pertaining to the delivery and quality of treatment, health care policy and quality of life.

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# NOTES