

Current clinical research related to the health of ethnic minority populations is essential to eliminate health disparities. Readers of *Ethnicity & Disease* may be interested in the progress and results of the following clinical trials. These trials describe only some of the exciting research performed in ethnic minority health; other current trials may be found at [www.clinicaltrials.gov](http://www.clinicaltrials.gov). The information below was accurate at press time; the study researchers should be contacted for more information.

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## CONTINUITY OF CARE AND OUTCOMES AFTER DISCHARGE FROM HOSPITAL

Sponsored by: Ottawa Health Research Institute

Continuity of care (COC) occurs when separate elements of patient care are connected. COC is made up primarily of continuity of provider and continuity of information. Many authorities believe that COC is essential to high-quality care. Previous studies have shown poor COC in varied populations. Many studies have shown that increased COC has been associated with improved intermediate outcomes. However, no study has definitively deter-

mined whether COC—or either of its components—is associated with important outcomes. The Ontario—Outcomes after the Hospitalization (Ontario-OATH) study will enroll 5900 adults who are discharged to the community from medical and surgical services from 13 teaching and community hospitals in five regions across Ontario. Patients will be followed for 6 months to record details about all interactions with the health-care system. This information

will give us a detailed measure of both provider and information continuity for all patients over time. The Ontario-OATH study will have the power to precisely determine whether COC is associated with time to urgent readmission or death after hospital discharge. Since COC is potentially modifiable, the Ontario-OATH study will give us essential information required for designing interventions to improve outcomes for patients after they are discharged from hospital.

Inclusion criteria: discharged to the community from medical and surgical services.

Study start: October 2002  
Study end: December 2009

This study is recruiting patients. Contact Carl van Walraven, MD, Ottawa Health Research Institute, Ottawa, Ontario, K1Y 4E9, Canada; phone: 613-761-4903.

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## EVALUATION OF CASE MANAGEMENT TO IMPROVE THE OUTPATIENT CARE OF ALCOHOL-RELATED DISORDERS

Sponsored by: University Hospital Freiburg

In the first funding phase, the project AQAH (Ambulantes Qualitätsmanagement Alkoholbezogener Störungen in der Hausärztlichen Praxis [Comprehensive Quality Management for Alcohol-Related Disorders in Primary Care]) systematically investigated three issues: 1) outpatient care system and evidence base for screening, diagnosis, and treatment; 2) a comprehensive quality management system

(CQM) consisting of documentation material, a pathway of care, and evidence-based practice guidelines; 3) effects of the CQM on the detection and treatment of alcohol-related disorders. In the second funding phase (a three-year bi-center project), the purpose is now to disseminate and transfer the CQM into routine care. The two steps are 1) to optimize the CQM approach and 2) to in-

vestigate the dissemination and transfer into routine care in a randomized trial. The paper-based AQAH-practice guidelines are transformed into an interactive electronic version with online patient documentation and evaluation, decision support measures, and links to specialists and an e-learning tool. After pilot testing in the AQAH study networks, an active transfer to the greater regions of Südbaden

and Südwürttemberg will be performed in a parallel-group, cluster, randomized, controlled trial with general practitioner practices as unit of randomization. Outcome data will be collected concerning the acceptance of the system and the quality of care delivered.

Use of the interactive electronic version of the CQM for alcohol-related disorders with special training for general

## CLINICAL RESEARCH

practitioners will be compared to use of the CQM with additional education for the whole practice team and organizational restructuring advice and a control

group that uses the CMQ without any special training.

Inclusion criteria: general practitioner, access to broadband internet.

Study start: July 2006  
Study end: November 2007

This study is not yet recruiting patients. Contact Daniela Ruf,

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## PATIENT-CENTERED DEPRESSION CARE FOR AFRICAN AMERICANS

Several studies document underutilization of outpatient specialty mental health services by African Americans. However, African Americans with depression are just as likely as Whites to receive care in primary care settings. Despite their use of primary care services, African American patients are less likely than Whites to be recognized as depressed, offered pharmacotherapy, and to initiate or complete pharmacotherapy or psychotherapy for depression. Compared to Whites, African American patients express stronger preferences for counseling and more negative attitudes toward antidepressant medication, the most common form of treatment of depression used by primary care physicians. African Americans are also more likely to see depression and its treatment through a spiritual or religious framework. Studies show that African Americans receive less optimal technical and interpersonal health care than do Whites for many conditions. Depression is a common chronic condition that results in substantial mor-

bidity, functional disability, and resource use. Despite the proven efficacy of pharmacotherapy and psychotherapy for treatment of depression, the gap between research findings and clinical practice is wide for management of depression in primary care. Recent intervention work has shown that quality improvement strategies for depression in primary care are effective. Research also shows that cultural adaptations can improve adherence and retention in care for ethnic minority patients.

We have created a patient-centered adaptation that includes many of the components of recent successful quality improvement interventions for depression in primary care. The proposed study compares a standard depression intervention for patients (delivered by a depression case manager) and physicians (review of guidelines and structured mental health consultation) to a patient-centered intervention for patients (incorporates patient activation, individual preferences, and cultural

sensitivity) and physicians (incorporates participatory communication skills training with individualized feedback on interactive CD-ROM). Thirty physicians and 250 patients will be randomized to either the standard interventions or the culturally tailored interventions. The main hypothesis is that patients in the patient-centered, culturally tailored intervention group will have higher remission rates from depression and lower levels of depressive symptoms at 12 months than patients in the standard intervention care group. Secondary outcomes will include patient receipt of guideline-concordant care, patient and physician satisfaction with care, patient-physician communication behaviors, patient and physician attitudes towards depression, and self-efficacy in managing depression. This study will add to knowledge about how to effectively engage African American patients in care of depression and serve as a prototype of how to incorporate patient-centeredness in programs to reduce racial and ethnic

disparities in health care for common conditions.

Inclusion criteria: age 18–75 years, two weeks or more of depressed mood/loss of interest in past year, one week or more of depressed mood or loss of interest in past month, self-defined African American ethnicity, ability to give written consent.

Exclusion criteria: current alcohol or drug abuse, history of mania, grief reaction or bereavement within the past two months, pregnancy, life expectancy less than one year, non-English speaking, current specialty mental health care, plan to change healthcare or primary care provider in next 12 months, active suicidal thoughts and plans, residing in United States for less than five years.

Study start: March 2004  
Study end: March 2008

This study is recruiting patients. Contact Bri K. Ghods, Johns Hopkins Medical Institutions, Baltimore, MD; phone: 410-522-6500 x. 263; bghods@jhmi.edu.