Using participatory methods to enhance patient-centred mental health care in a federally qualified community health center serving a Mexican American farmworker community

Maia Ingram MPH,* Ken A. Schachter MD MBA,† Jill Guernsey de Zapien BA,‡
Patricia M. Herman PhD§ and Scott C. Carvajal PhD MPH¶

*Program Director, †Assistant Professor, ‡Associate Dean, ¶Professor, University of Arizona College of Public Health, Tucson, AZ and §Senior Behavioral Scientist, Rand Corporation, Santa Monica, CA, USA

Abstract

Correspondence

Maia Ingram MPH
Program Director
University of Arizona College of Public Health
1295 N. Martin
Tucson
AZ 85724
USA
E-mail: maiai@email.arizona.edu

Accepted for publication

17 September 2014

Keywords: mental health, community health workers, community-based participatory research, patient centred care, primary care

Background Mexican American farmworkers experience high rates of mental health conditions; however, it is difficult for them to access care. Patient-centred care is a systems-wide approach to improving the delivery of services for diverse populations in the primary care setting.

Aim We describe the application of community-based participatory research methods to assess and address gaps in perceptions of mental health care between providers and migrant workers living in a US–Mexico Border community.

Setting A federally qualified health centre (FQHC) serving a community of approximately 60 000 agricultural workers who live in Yuma County and harvest vegetables during the winter season.

Design We conducted patient focus groups ($n = 64$) and FQHC staff interviews ($n = 16$) to explore attributes and dimensions of patient-centred mental health care.

Results Patients and staff both prioritized increased access to mental health care and patient-centred care, while patients were more concerned with interpersonal care and providers with coordination of care. All participants stressed the relationship between life events and mental health and the centrality of family in care. Patients also emphasized the importance of a good attitude, the ability to solve problems, positive family relationships and reliance on faith. Patients suggested that the FQHC inform patients about mental health resources, provide community informational talks to address stigma, and offer support groups.

Discussion The participatory approach of this qualitative study resulted in a wealth of data regarding patient preferences that will enable the FQHC to develop protocols and training to provide patient-centred mental health-care services for their community.

Persistent stress from financial instability, low-wage employment, acculturation and discrimination leave many Mexican Americans vulnerable to depression, anxiety and other mental health conditions.¹ Mexican-origin farmworkers living on the US–Mexico Border confront additional stressors related to physically demanding and hazardous working conditions, sporadic employment, and concern over mixed immigration status of family members.² Additionally, given the high prevalence of diabetes among Mexican Americans,³ many face depression as a co-morbidity of the disease.^{4–6} Unfortunately, the majority of these farmworkers will be unlikely to access mental health services.¹ Those who do receive care typically do so in a primary care setting, and most often in a federally qualified community or migrant health centre (FQHC) funded by the US government to meet the health needs of vulnerable populations.⁷ As many as half of the patients in these clinics serving low-income and minority populations experience anxiety, depression and other mood disorders.^{8–10} While 70% of FQHCs provide mental health counselling and treatment,¹¹ mental health services in these settings are often inadequate due to high patient volume, communication barriers,¹² lack of patient coordination¹⁰ and poor follow-up.^{1,9,13}

Patient-centred care offers a systems-wide approach to identify and respond to mental health issues among Mexican Americans in the primary care setting. The 2010 Patient Affordable Care Act (ACA)¹⁴ embraces patient-centred medical care as a means not only to improve health outcomes, but also to address inequalities in care among ethnic, minority and low-income populations. Primary care settings are the nucleus of the patient-centred approach and are becoming widely recognized as a critical and rapidly growing venue for the delivery of mental health services.^{9,15,16} For example, in caring for patients with chronic disease, primary care physicians often encounter concurrent depression and anxiety that, left untreated, will adversely impact the course of the chronic illness.¹⁷ In fact, when chronic disease and

mental health problems are not treated concurrently there is a risk that both conditions will worsen.¹⁸ The attitudes of both patients and providers towards depression and treatment, however, pose challenges to successful primary and behavioural care integration.¹⁹ Patient-centred primary care is an approach designed to help medical providers better recognize patient agendas and thus better meet their medical and emotional needs.²⁰

Definitions of patient-centredness encompass six broad and related concepts: exploring the experience and expectations of disease and illness; understanding the whole person; common ground on disease management; health promotion; the patient-provider relationship; and recognizing the limitations of time.²¹ Studies have shown that communication, the patient-provider relationship and health promotion are the most important dimensions of patient-centred care for individual patients²² and that interventions designed to increase patient-centred care have a positive impact on patient satisfaction.²¹ However, other dimensions of patient-centred care, such as comprehensiveness of services, cultural sensitivity, family centred care and whole-person care are not well researched,²³ and there is insufficient investigation regarding differences in the experience of patient-centred care within diverse populations.²⁴ Responding effectively to patient preferences requires a clear understanding of the way in which patients assess primary care services;²⁵ thus it is necessary to identify patient preferences by talking directly to patients.²⁶ To improve our understanding and practice of patient-centred care within diverse primary care settings, participatory methods need to be employed with specific populations in which the consumer is central to exploring patient preferences. In this article, we describe the application of community-based participatory research methods to assess and address differences in perceptions of care between providers and an extremely vulnerable patient population of Hispanic migrant workers living in a US–Mexico Border community.

Setting

Yuma County, located on the Arizona Sonora border, is an important region for the US agricultural industry due to the climatic conditions that allow for a vital winter growing season. Residents of South Yuma County are over 90% Mexican/Mexican American and experience high levels of unemployment during the off-season. Many farmworker families live below the poverty line. A recent household survey, found that 20% of farmworkers in Yuma reported experiencing depression for more than 2 weeks in the previous 12 months.²⁷ Stressors were related to their foreign/minority status within a hostile political environment, the need to speak better English, and working far from families. Despite this high prevalence, mental health services are difficult to access in Yuma County. Farmworkers covered by government-funded insurance are served by a regional behavioural health provider that provides most of its services in the city of Yuma are served by a regional mental health provider that provides most of its services in the city of Yuma. Thus, in rural border communities, the time and distance to reach services, limited transportation options and inflexible work hours are additional barriers to care. The general shortage of mental health services in the County means that even patients with private insurance have difficulty accessing a provider. Given the dearth of mental health specialists, the FQHC serving this region recognizes the importance of mental health as an integral component of physical wellness, particularly with respect to paediatric care, maternal health and chronic disease management.

Methods

Community-based participatory research (CBPR) is a collaborative approach between researchers and community members that seeks to ensure that the knowledge gained is used to address the issue under study to the benefit of the community involved.²⁸ Action-oriented research in health-care settings can result in

improvements to health-care delivery, particularly when the research process is internal to the health organization and involves patients, providers, staff and administrators across the stages of the research.²⁹ In this project, the spectrum of research activities extended from problem definition, development of research methodology and data collection and interpretation, through application of results to develop strategies to improve mental health care.

The clinical and academic partners had the advantage of over a decade of prior work together evaluating community health worker (CHW) interventions creating an essential foundation for building trust and confidence in addressing sensitive questions regarding the quality of health-care service delivery in the clinic.³⁰ From the outset, the team regarded the CHW approach as the most effective means to authentically engage the patient community in discussing mental health and their perceptions of clinic services. CHWs are community members who work both inside the clinic and in their communities to increase health-care utilization, provide health education, and help patients navigate the service delivery system.³¹ In the clinic, providers recognize CHWs as patient advocates who bridge the gap between the clinic and the community and work to ensure patient needs are met. The four CHWs who worked on this study identify closely with the migrant farmworker population. They were all born in a US–Mexico Border town and worked and/or have family members working in the fields. While all four share Spanish as their first language, two are fully bilingual and two are learning English. Thus, the CHWs played a vital role in both representing the FQHC patient voice in the study as well as facilitating patient involvement in research activities. Participatory methods included as follows: (i) convening a stakeholder group to oversee implementation of the study; (ii) CHW-facilitated focus groups with FQHC patients; and (iii) interviews with FQHC providers and staff. Participants were consented based on protocol approved by the academic partner's Human Subjects Protection Programme/Institutional Review Board.

Stakeholder group

To ensure on-going and active participation of the health-care team, we convened a stakeholder group responsible for first articulating the current context of mental health issues within the clinical setting, and subsequently for reviewing study data and integrating findings into new models of care. The twelve-member stakeholder group consisted of one internist and one paediatrician, two medical assistants, two front desk staff, one board member (also a patient), one patient, the Director of Outreach and two CHWs involved in the research. The first task of the stakeholder group was to identify and describe the points in the current health-care delivery system in which the FQHC and the patient might interact about mental health beginning in the community and continuing through clinic reception, triage, examination and follow-up. In addition to working actively as a group to guide and synthesize the research, stakeholders reviewed focus group and interview questions.

Focus groups

The CHWs conducted eight focus groups with a total of 64 patients from the two FQHC border community clinics. Past and current CHW outreach and education activities contributed to a strong community presence and established high levels of trust between CHWs and patients, which mitigated concerns about patient discomfort with the open discussion of mental health issues. The research team trained the CHWs in focus group facilitation and human subject's protection, and the CHWs contributed actively to the development and refinement of focus group questions. With guidance from the academic partner, the CHWs used medical records to identify and randomly select eligible patients who could represent different perspectives on mental illness based on the following criteria: individuals aged 25–45 with no particular illness; individuals 45 and older; individuals diagnosed with a chronic illness; and individuals in the broader

patient population experiencing general health issues. The CHWs began the focus groups by explaining to participants that they had been invited as representatives of their community and emphasized the importance of their participation in addressing the services being provided by the clinic. Focus group questions explored community definitions and experiences of mental health and illness, help-seeking practices of patients, the role of family members, barriers to care in the clinic and the community, currently available mental health resources, and how the clinic could improve mental health service delivery within and outside the clinic. The importance of the cultural and linguistic role of the CHWs in facilitating the discussion was underscored by the fact that nearly all of the patients preferred to communicate in Spanish regardless of their English proficiency.

FQHC employee interviews

The purpose of the interview was to gain perspective from the broad range of FQHC employees who interacted with patients in the course of regular visits. As the external partners more able to ensure confidentiality, two academic partners conducted 15 interviews with FQHC administration (the medical director and the nurse director), medical providers (two internists, two paediatricians, one obstetrician, one FNP), two medical assistants, two front desk staff and one person from medical records. The interview questions mirrored those of the focus group, but in a structured format. The questions for medical providers differed only in that, we also asked them about what kinds of mental health issues they encountered in their daily practice, and how they identified and responded to them.

Data analysis

The academic partner recorded and transcribed focus group and interview data. To capture the broad array of potential patient-centered attributes that might emerge from the qualitative

data but also ground the analysis in established research, we developed a codebook based upon a 'conceptual map' of patient preferences developed by Cheraghi-Sohi, *et al.*²⁵ The map was an ideal tool because it included a comprehensive literature review and reflected the broad range of attributes of relevance to patients. The map consisted of six attributes of care from the patient perspective with several dimensions defining each attribute. We elaborated on the definitions of the attributes and the dimensions using characteristics identified in the literature related to the integration of mental health in the primary care setting and qualities of particular relevance to Latino and Mexican American farmworker patients referenced in Table 1. While the codebook relied upon previously developed attributes, the qualitative research approach allowed us to tailor definitions to this FQHC population. Two academic partners coded the focus group and interview data using N-Vivo 10 software QSR, International. Based on an inter-rater agreement level of 80%, we then discussed and recoded attributes in which we were in disagreement. One academic partner summarized the attributes and subcategories to create definitions within the context of the FQHC patient experience. A second partner reviewed and refined the definitions. We differentiated references to each attribute and dimension by patient, provider and staff to highlight the varying perspectives, explanations and priorities between those providing and those receiving services.

Results

With the one exception noted above, patients, providers and staff were all asked the same questions. Thus, at a basic level of analysis, we were able to compare the proportion of references coded to each attribute and dimension in Table 1 to gain insight into the relevant importance of these characteristics to each group. The distribution of references by attribute was similar, with approximately one-third in each group coded as patient-centred care and one-quarter as access to care. A smaller proportion

of patients referenced care coordination compared to providers and staff, while a greater proportion referenced interpersonal communication. Greater variation in the distribution of references occurred in the dimensions of attributes. For example, within care coordination, *patient education and outreach* from the clinic was responsible for approximately half of all references among patients, yet were barely mentioned by providers or staff. Conversely, a large proportion of providers and staff referenced *monitoring, follow up and coordination*. *Treatment protocol* was relevant to providers, but less so to patients and staff. Within patient-centred care, the *experiences and expectations of patients* were most often referenced by all groups. Within interpersonal care *clarity of communication and respect for patients* were more often referenced by patients than providers and staff, and *explanation* was most often referenced by providers. Within access to care, *knowledge of and location of services* was of concern to patients but not mentioned by staff or providers.

On a more substantive level, closer examination of responses coded to the dimensions of the attributes of patient-centred mental health care displayed in Table 1 allowed us to define each subcategory from the perspective of patients, providers and staff and to identify areas of commonality and difference. Scrutinizing the data related to interpersonal care, for example, *respect for patients* was commonly understood as a need for courtesy in the reception area. For patients however, *respect* extended to:

not being left in the consulting rooms for extended periods waiting for a doctor,

Would it be possible when we come for an appointment to spend less time in the waiting room, because an hour makes you a bit desperate with no way to leave.

the desire to have the provider look at them when speaking,

The doctor should look at you in the face when they speak to you and not be focused on other things.

Table 1 Attributes and dimensions of patient-centered behavioral health care for Mexican American farmworkers

Attributes	Dimensions	Definitions
Continuity/Coordination of Care ^{9,23,34}	Outreach/Education ⁹	Integration of mental health services within primary care setting
	Screening and identification ⁹	Community outreach and education on mental health
	Active role of patients ⁹	Formal processes for screening and diagnosis
	Monitoring and follow up ⁹	Patients motivated to take part in their care
	Treatment protocols for providers ⁹	Monitoring of progress
	Coordination among providers ⁹	Development of a treatment plan
Interpersonal Care ²³		Communication between primary care and mental health specialists
	Patience ²³	Interaction between patients and all clinical staff
	Compassion ^{1,23}	Taking time
	Respect ²³	Providers are willing to be less detached and more personal
Access to Care ^{9,23}	Clarity of communication ^{1,9,23}	Communication style
	Explanation ²³	Language; reluctance to express doubt, confusion or disagreement
		Communication on diagnosis and treatment
	Clinic location ^{1,23}	Barriers and underutilization of mental health services among Latinos
	Waiting time ^{1,23}	Primary care services are more accessible and less stigmatizing
	Hours of service ²³	Long wait times for appointments
	Availability of specific practitioners ^{9,23}	Farmworkers unable to take off work for appointment
	Transportation ¹	Culturally competent mental health specialists in rural settings
Patient-centered care ^{1,23}	Cost of services ¹	Rural nature of farmworker communities
	Insurance coverage ¹	Lack of insurance/co-pay
		High rate of uninsured among Latinos and Latino children
	Knowledge of services ¹	Lack of knowledge of where to seek help
	Cultural competency ^{1,11,23}	Patient/community context and perspective on services
		Understanding and appreciation of cultural differences within, among, and between groups
	Health seeking behaviors ¹	Physical manifestation of mental health ailment
	Family centered ^{1,23,31,32}	Family as part of care team
	Patient experiences/expectations ^{1,23}	How patients define mental health
	Health promotion and wellness ^{23,29}	Beyond treatment of a condition
	Patient as person ^{23,30,33}	Recognition of context of patients' lives
	Sharing power and responsibility ^{23,29}	Engaging in partnership with patients

and providers giving patients time to voice their concerns.

You want to explain, and at times they don't even give you time to speak. It would be better if they asked: How are you? What do you need? What is worrying you? That they take a breath and let a person speak.

For this Spanish-speaking population, respect also referred to the desire for interpreters to

translate word-for-word rather than offer abbreviated summaries.

Another dimension, *clarity of communication*, was commonly understood by all groups as the need to overcome language barriers and the desire for clinic staff to use appropriate, non-medical language to ensure patient understanding of the diagnosis. However, patients additionally emphasized that providers should

not expect patients to ask questions about mental health because they don't know enough to ask.

Sometimes we stay quiet because we don't know what services they could give us and we don't know what (illness) we have. My mother says that the reason she goes to the doctor is to find out what she has- you're the doctor, how am I going to ask?

Patients suggested that therefore doctors should initiate conversations about the patients' well-being with simple questions such as 'How are you feeling?' Further, patients expressed a desire for better communication about their diagnoses and reasons for referrals: 'When they refer you to a doctor they should tell you where you are you going and why; a lot of people don't know so they don't go.'

To share the large amount of data with stakeholders in a precise and useful way, the academic partners included a summary of the commonalities and differences among the three groups for each attribute and dimension. Table 2 provides an example of the detailed compilation of shared and patient-exclusive definitions of the dimensions of the attribute patient-centred care. Both FQHC staff and patients recognized the relationship between life events and mental health and the centrality of family in mental health care. However, absent from the shared understanding was recognition of the importance of a positive life outlook. If integrated into mental health-care delivery, this concept, expressed exclusively by patients, could potentially transform patient-provider interaction or the services provided by the clinic.

The way you think, what you do each day, the more positively you think, the better your life will be- the way in which you grow in society and with your family.

In the dimension of *patient experiences*, patients repeatedly expressed sources of good mental health as a good attitude, the ability to take control of and solve problems, positive family relationships and reliance on faith.

To be ready to meet each day and be optimistic in front of your children. In order to move for-

ward you have be positive and not think so much about your problems.

In addition to recognizing barriers to accessing mental health services, patients also defined *health seeking behaviours* in terms of their own efforts to deal with problems that were causing emotional distress:

Problems are solved in two ways, taking things calmly and putting yourself in God's hands.

While FQHC providers and staff did not address *health promotion* as it pertained to mental health, patients had several suggestions that included providing information, support groups and group activities.

They should offer us more information about mental health in order to overcome or to live with these problems. To be more informed about mental health.

Offer support groups where a patient can unburden themselves and be heard.

In terms of *sharing power and responsibility*, providers expressed a concern that patients be accountable for their care and follow up on recommendations.

It is important for the patient, the acceptance of their problem. If they agree they have a problem, they are more willing to be cooperative and compliance with the treatment and follow-up.

Patients, on the other hand, continued to emphasize the need for tools, information, skills and resources to address mental health in their community.

A patient is not going to ask for help, but if you offer information about mental health, we would find out what services (the FQHC) offers and take initiative to make their own appointment.

Patient, provider and staff references to dimension of care coordination also stood out for their differences. While the *monitoring, follow-up, & coordination* between primary care and mental health services was clearly more salient to clinic staff, patients had concrete recommendations on how to improve care not referenced by providers. With respect to *outreach*

Table 2 Patient and provider/staff definitions of the dimensions of patient-centred care

Dimension	Shared definitions	Patient only definitions
Cultural Sensitivity	<ul style="list-style-type: none"> • Stigma causes patients to avoid seeking help. • Patients can't/won't access services because providers don't speak Spanish. • Services need to be culturally appropriate. 	<ul style="list-style-type: none"> • Mental health is a positive life attitude. • Language issues negatively impact emotional health. • Patients don't seek care due to concerns about immigration status. • Faith is a source of emotional strength for patients.
Health seeking behaviours	<ul style="list-style-type: none"> • Patients prefer to receive care, internal to primary care agency. • Patients don't follow up on referrals. • Patients may go to Mexico for treatment. • Patients don't think of mental health as a medical issue. 	<ul style="list-style-type: none"> • Patients address issues by trying to reflect on and resolve their problems and to make decisions. • Patients with mental health issues may be isolated in their home. • Patients may rely on faith as source of assistance.
Family centred approach	<ul style="list-style-type: none"> • Issues with children are a major source of stress for parents. • Patients are responsible for and have issues caring for patients. • Providers should ask about what is happening in patients' families. 	<ul style="list-style-type: none"> • Talking with your family is key to emotional wellness. • Feeling good about your family is key to emotional wellness. • You have to have good emotional health to care for your children and their issues.
Experience/expectations of patient	<ul style="list-style-type: none"> • Mental health issues are common among adults and children. • Hormonal issues cause Mental health issues. • Tragedy and loss are related to Mental health. • Mental health issues are expressed through physical complaints. • Patients don't recognize they have Mental health issues. 	<ul style="list-style-type: none"> • Memory loss is a concern. • Being ill causes people to become depressed. • Mental health can be both internal and external. • Being unable to solve problems causes Mental health issues.
Health promotion and wellness		<ul style="list-style-type: none"> • Support/motivational groups. • People need activities to do. • Positive outlook is the way to stay emotionally healthy. • Patients prefer to solve problems on their own.
Patient as person	<ul style="list-style-type: none"> • Life context (death in the family, issues with children) has mental health implications. • Patients don't want to be seen as crazy. 	<ul style="list-style-type: none"> • Patients want positive communication from their provider. • Patients want to be asked how they are doing.
Sharing power and responsibility	<ul style="list-style-type: none"> • Patients want information to address BH issues. 	<p>Provider only</p> <ul style="list-style-type: none"> • Patient needs to be accountable. • Providers offer patients options. • Acceptance of the problem leads to better follow up.

and education, patients suggested that the clinic informs patients about resources for mental health, provide community informational talks

to address mental health stigma, and schedule classes and groups to address mental health issues. In *motivating patients to take an active*

role, patients suggested motivational groups, reassuring the patient that treatment can be effective and ensuring that the patient agrees with the treatment. For *screening and identification of mental health issues*, patients and staff agreed that patient affect is the best sign of emotional distress, and that facial expression, crying, insomnia and unexplained physical complaints are indicators that providers should screen for mental health issues. Perhaps counter to preconceptions of this population, patients stated that providers should directly ask about emotional changes and how a patient is feeling in their home and in their marriage.

Even though they are not psychologists, they could maybe ask how we are feeling psychologically. You don't go to the doctor until you can't stand the pain anymore, and you forget all the questions you were going to ask. But, the doctors ask very few questions because they are doctors. And it might have to do with your mental state.

When providers employed these communication techniques, it appeared to have a positive effect. Several providers acknowledged the positive impact of spending additional time with their patients to focus on their personal lives as a means of improving mental health.

Well, even a little bit of depression is very tragic for them. They're feeling bad. They don't feel like they can function, even if it's just circumstantial problem...things that could be resolved with a little bit of sitting and talking to somebody to give some guidance for coping, how to cope. Even 15 minutes of talking will help them.

Discussion

The results of this qualitative inquiry represent an integrated approach to defining the attributes and dimensions of patient-centred mental health care within a specific primary care setting.²⁵ Patients and providers were most in agreement regarding the difficulty of accessing mental health services, reflecting the scarcity of mental health providers in this rural community. As the Affordable Care Act in the US expands coverage for mental health, adding

mental health services in FQHCs would appear to be both increasingly feasible and, in the population studied, a patient preference.

Our findings further validate studies that emphasize the importance of the patient-provider relationship and specifically provider communication style.²⁵ In their review of patient-centred care outcomes, Rathert *et al.* suggest that emotional support may be more important to certain types of patients than others and that this support may expedite patient motivation and follow-through more than involvement in the technical aspects of their treatment.^{32,33} The benefit of our study was to further define emotional support for patients in a rural farmworker community within the dimensions of interpersonal care. The content of patient responses underscores the importance of emotional support for issues not directly related to their physical health on patient outcomes.^{32,33}

In accordance with the participatory research approach, the research partners presented the compiled data to the stakeholder group highlighting the commonalities and differences between the three groups of participants. The stakeholders sought to address each comment within the current structure and resource constraints of their health-care delivery system. In addition, they made long-term recommendations to the FQHC management that would require securing additional resources, the most prominent of which was the addition of a case manager to ensure follow-up on all mental health referrals. They suggested that the CHWs could expand their current health promotion outreach efforts to include mental health issues. The extent to which recommendations are carried out will depend upon forces outside of the research partnership. However, it should be noted that in prioritizing mental health as the focus of the research the FQHC CEO had already expressed a commitment to the issue. Meanwhile, over the course of the meetings, the stakeholders themselves, and particularly the CHWs, described a transformation in their own ability to look for and recognize mental health concerns among patients.

The major limitation of this study is the substantial clinical commitment in both time and resources to conduct focus groups and interviews, analyse and compile data, and ultimately to integrate findings to develop or enhance mental health-care delivery systems. This type of study would be more challenging in a clinical setting that did not include CHWs. The CHWs were ideally situated to recruit patients and had already established trust with the patient population, enabling them to facilitate patient focus group conversations in their native language on a sensitive health issue. Perhaps most importantly, in their existing role as a conduit between the clinic and the community, the CHWs gave the project validity with patients in terms of the FQHC actually taking action on their recommendations. The CHW approach also addressed the lack of patient participation in the stakeholder group. In our experience, CHWs can more effectively mediate the participation of marginalized communities in discussions about how the FQHC could best address the culturally sensitive issue of mental health care.^{34,35}

While the overall attributes of patient-centred care provide a road map for clinics to develop models of care that are more responsive to patient needs and thus more likely to achieve patient outcomes, putting patient-centred care into practice in a specific setting can be greatly aided by this intensive, participatory process. As a qualitative study, the purpose of the data is to further explore and define the constructs of patient-centred care within a vulnerable population rather than be generalizable to health-care consumers.

Conclusion

In this paper, we describe a participatory research process in which clinic stakeholders identified the delivery of mental health services as an area of concern and subsequently sought to engage a spectrum of patients, providers and staff in describing this sensitive issue and developing recommendations to improve services. The abundant data resulting from this

effort will enable the FQHC to develop protocols and training to better provide patient-centred mental health care services for their community. A further benefit of this process was the generation of concrete outreach and health promotion recommendations emerging from the patient focus groups, the provision of which would theoretically increase satisfaction with care and utilization of mental health services. Many of the recommendations reflected a patient preference that the clinic participate in informing the community about the nature and importance of mental illness and in reducing the stigma of seeking services. They also reflected a desire on the part of the patient population to be active in their care, not necessarily in the clinical realm, but in developing coping strategies to address daily stress. They further suggest that the FQHC might provide a forum for people to share and address these stressors.

Acknowledgements

The authors would like to acknowledge the partnership of the Sunset Community Health Center in carrying out this research and the Sunset Community Health Workers who participated in research activities.

Funding

This publication was supported through a Patient Centered Outcomes Research Institute (PCORI) Pilot Project Funding Award.

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