

**Section 1: Title page = 1 page maximum, font size not less than 11 point, may be single spaced**

Please include these items in the order listed:

**a. Title / Name of Partnership:** Community Partners in Care

**b. Partnership Representative:**

**Name:** Bowen Chung, MD, MSHS

**Title/Position:** Assistant Professor-in-Residence (Associate Professor-in-Residence approved for July 1, 2015)

**Organization/Affiliation:** 1) Center for Health Services and Society, Semel Institute for Neuroscience and Behavior, David Geffen School of Medicine at UCLA, Los Angeles, CA; 2) RAND Corporation, Santa Monica CA; 3) Los Angeles County Department of Mental Health Services; 4) Harbor-UCLA Medical Center, Department of Psychiatry, Torrance, CA; 5) Los Angeles Biomedical Research Institute, Torrance, CA; 6) Healthy African American II, Los Angeles, CA

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**c. How did you hear about the CCPH Annual Award?** Community Campus Partnerships for Health Listerv

**d. Application abstract (250 word maximum)**

Community Partners in Care (CPIC) is a community-academic partnership that uses Community Partnered, Participatory Research (CPPR) to build community capacity to improve quality of life of clients with depression in under-resourced communities of color through rigorous partnered research. CPPR involves a partnered Council supporting work groups using two-way knowledge exchange and equal authority over decisions, under principles of transparency, trust, and respect. After developing the approach in the Witness for Wellness initiative, CPIC was funded as a partnered trial to implement quality improvement for depression across healthcare, social services, and community-based agencies in communities of color, especially African Americans and Latinos, in Los Angeles County (LAC). The CPIC Council randomized over 90 programs from barber shops to clinics to either outreach plus technical assistance to individual agencies or to community engagement and planning to develop a network to implement depression programs. The community engagement approach was more effective at improving 6-month client mental health quality of life, reducing risk factors for homelessness, increasing physical activity, and reducing behavioral health hospitalizations while shifting services toward community programs, with evidence of further improvement at 12 months. The Council was awarded the 2014 Team Science Award of the Association of Clinical and Translational Science. The CPIC model was proposed by LAC Department of Mental Health Services as the County's response to behavioral health under expanded Medicaid, approved by the Board of Supervisors in 2014. The Council is now assisting the County in implementing and evaluating this plan.

**Section 2: List of Partners = 2 page maximum, font size not less than 11 point, may be single spaced**

What organizations and individuals comprise your partnership? Please list them and include a one-sentence description of each.

**AIDS Healthcare Foundation:** *A Nonprofit provider of prevention services, testing, and healthcare for HIV.*

**All People's Christian Center:** *Community Center that provides social and educational services and activities.*

**Amanecer Community Counseling Services:** *Community-based nonprofit organization that provides mental health services and domestic violence counseling to low-income and homeless people.*

**Asian American Drug Abuse Program:** *Nonprofit organization that provides substance abuse services.*

**Assistance League of Southern California:** *Agency that provides social services to improve the lives of at-risk children and families.*

**Agustus Hawkins Mental Health Center:** *Organization that provides a variety of outpatient mental health services to adult and youth.*

**Avalon Carver Community Center:** *Community coalition that provides services for the physical, mental, and spiritual needs of individuals and families of south central Los Angeles.*

**Black Women for Wellness:** *A nonprofit corporation that is committed to healing, educating, and supporting Black Women and girls.*

**Bryant Temple African Methodist Episcopal Church:** *African Methodist Episcopal church in Los Angeles.*

**Charles Drew University of Medicine and Science:** *A private, nonprofit, nonsectarian, medical and health sciences institution located in Watts-Willowbrook area of South Los Angeles.*

**Children's Bureau:** *Agency that provides a variety of services to improve the overall health and well-being of our nation's children and families.*

**Children's Institute, Inc.:** *A nonprofit organization specializing in the treatment and prevention of child abuse and neglect.*

**City of Los Angeles Department of Recreation and Parks:** *Social service agency in the city that operates and maintains parks, recreation centers, youth camps, sports programs, and programs for senior citizens.*

**Clinica Monsenor Oscar Romero:** *A nonprofit FQHC that provides comprehensive medical services to low-income men, women, and children living in Los Angeles County.*

**Downtown Women's Center:** *Agency that provides housing, medical and mental health services, social networks, and financial security to end homelessness.*

**Drew Child Development Corp.:** *Social Service agency that provides children with a safe and stable environment to obtain school readiness for success and promote child welfare.*

**Free-N-One:** *Community agency that provides services and treatment for recovery, codependence, and drug prevention.*

**Gateways Hospital:** *Nonprofit organization providing acute in-patient, residential, and out-patient services to mentally ill adolescents and adults.*

**Healthy African American Families II:** *A nonprofit community serving agency improves health outcomes of African American, Latino, and Korean communities.*

**His Sheltering Arms:** *A treatment center that provides gender-specific, personalized medical and psychotherapeutic treatment for women suffering from alcohol and substance abuse addictions.*

**Homeless Outreach Program/Integrated Care System:** *Agency that is dedicated to provide high quality social services with an emphasis on behavioral health and housing stability.*

**Hope Street Family Center:** *A resource center that promotes community health, education, and recreation and seeks to educate children, strengthen families and transform the community.*

**INMED Mothernet Los Angeles:** *An international humanitarian organization that provides children with necessary medicines and medical care.*

**Institute for Black Parenting:** *An adoption and social welfare agency that places orphaned Black children into stable households and provides services for family preservation and family reunification.*

**Jewish Family Services Los Angeles:** *A multiservice agency that provides services to strengthen individual, family, and community life.*

**JWCH Institute, Inc.:** *A private nonprofit health agency that supports patient care, education, and research.*

**Kaiser Permanente Watts Counseling & Learning Center:** *A nonprofit Community Benefit program that provides counseling, outreach, and educational services to residents of the Watts community.*

**Kedren Mental Health Center:** *A community health center that uses a collaborative and holistic approach to address educational, health, and mental health needs of residents in SPA 6.*

**LAC + USC Healthcare Network:** *A Level-One trauma center that offers medical, mental health, protective, and social services to victims of family violence and sexual assault.*

**Los Angeles Christian Health Centers:** *It is a Federally Qualified Health Center that provides quality, comprehensive healthcare to the homeless and underserved.*

**Los Angeles County Department of Mental Health:** *The largest county mental health department that operates 75 program sites and offers mental health services to people of all ages to support hope, wellness, and recovery.*

**Los Angeles Urban League:** *A community agency that offers job training, job placement, youth achievement and business development programs to promote advancement of equal opportunities.*

**NAMI Urban Los Angeles:** *A nonprofit, volunteer organization that provides education support and advocacy for families dealing with mental illnesses.*

**New Vision Church of Jesus Christ:** *A Non-Denomination Christian organization led by Rev. Ronald Wright.*

**Para Los Niños:** *A nonprofit organization that creates academic success and social well-being for children through early education centers, charter schools, and wellness centers for mental health services.*

**People Assisting the Homeless:** *Agencies that work together to provide supportive services, permanent housing development, and support for homeless families.*

**People Coordinated Services:** *A multiservice agency that provides services for Youth and Family, Substance Abuse Prevention, Intervention and Treatment, and Senior Services.*

**Personal Involvement Center, Inc:** *A nonprofit community based social service agency that provides services to youth and families.*

**QueensCare Health & Faith Partnership:** *A parish nursing program that delivers free and low cost health promotion and disease- prevention services in churches, schools, and other social service organizations.*

**Skid Row Housing Trust:** *An organization that provides permanent supportive housing for people that experience homelessness, extreme poverty, poor health, disabilities, mental illness and/or addiction.*

**South Central Prevention Coalition:** *A community coalition that combats alcohol and other drug abuse problems.*

**St. John's Well Child & Family Center:** *A nonprofit children's health care center that provides primary care services and supportive services that address families' educational and socio-economic needs.*

**St. Thomas the Apostle Church:** *An Episcopal Church that is part of the Anglican Communion.*

**THE Clinic, Inc.-** *A wellness center that provides affordable preventive, primary and behavioral health care services.*

**The Saban Free Clinic:** *A Federally Qualified Health Center that provides comprehensive, affordable, and dependable quality health care services.*

**United Women in Transition:** *A community coalition that transforms social and economic conditions that foster addiction, crime, violence, and poverty.*

**Volunteers of America:** *A charity that offers human service programs such as housing and healthcare.*

**Watts Health Foundation:** *A Federally Qualified Health Center that offers a range of services including clinical, preventative, specialty, and ancillary services.*

**Watts Labor Community Action Center:** *A nonprofit community-based, human services organization dedicated to improve the quality of life for South Central Los Angeles residents.*

### **Section 3: Essay = 12 page maximum, font size not less than 11 point, may be single spaced**

Please answer these questions in the order listed:

#### **1. *What is the history/background of how and why your partnership started?***

Community Partners in Care (CPIC)<sup>1</sup> represents a community-academic partnership based on Los Angeles that has used a Community Partnered Participatory Research approach to translate and to disseminate the benefits of NIH-funded, evidence-based, depression care interventions together with under-resourced, minority communities in Los Angeles since 2003. The current lead institutional partners are Healthy African American Families II (a South Los Angeles health advocacy agency), the County of Los Angeles Department of Mental Health, the UCLA Center for Health Services and Society, and the RAND Corporation.

Over ten years ago, some of the academic leaders completed a major national study, Partners in Care, suggesting that implementing a chronic disease management approach, collaborative care for depression in primary care sites, improved quality of care for both whites and minorities (African Americans and Latinos) but led to 4-5 times the outcomes improvements for minorities as for whites, both initially and over 5-10 years of follow-up.<sup>2-5</sup> A key question that emerged from Partners in Care was how to translate the promise of high quality care for depression into a public health reality in low-income, communities of color. However, little was known about how to engage underserved groups in either NIH-funded mental health research or efforts to improve depression services in the community.

In 2003, Dr. Kenneth Wells of UCLA and RAND, the PI of Partners in Care, approached Loretta Jones, CEO of Healthy African American Families II (HAAFII), a leading health advocacy organization in South Los Angeles, to determine how to apply the findings of that study as summarized above to communities of color in Los Angeles.<sup>6</sup> This initiated a remarkable partnership based on a manualized variant of community-based participatory research and NIH-defined principles of community engagement, Community Partnered Participatory Research.<sup>7,8,9</sup> The first application of this model to depression was in the Witness for Wellness Initiative, and involved scientists from UCLA, RAND, and Charles R Drew, other institutions, investigators from multiple disciplines at senior and junior levels, and many community partners involving more than 100 agencies in Los Angeles County.<sup>6,10-12</sup> As a research fellow in the UCLA Clinical Scholars Program the year this partnership and the Witness for Wellness Initiative began, I was able to observe and “witness” the evolution of this approach first hand, led one of the three main working groups on stigma reduction,<sup>10,12</sup> participated in the Council over the full 12 years since its inception, led the design paper for its mature phase in Community Partners in Care,<sup>13</sup> and was privileged to lead the main 12-month outcomes paper for that initiative.<sup>14</sup> As documented below, I have seen many community and academic members of the Council and the large community be transformed, including myself, as the partnership grew from an idea and blending of different approaches to a major partnered research effort that last year, won the 2014 Team Science Award from Association of Clinical and Translational Science, the first applied research team to win such an award.

#### **2. *What are the mission and goals of your partnership, and how were they determined?***

CPIC began as noted above, from discussions of two key leaders, and a quick check for community relevance indicated that depression was viewed as a “silent killer” that “no one could talk about.” Based on this initial feedback, leaders of Healthy African American Families II (HAAFII) hosted a planning meeting in April 2003 with the current lead academic partners, UCLA and RAND, as well as the County Los Angeles Department of Mental Health and other community agencies over bi-weekly meetings over several months to develop a collaborative partnership agreement or memorandum of understanding based on CPPR principles, share perspectives and views on depression, and plan a Kick-off conference to gauge broader interest. Expecting about 100 participants, the leaders had to turn away people after over 500 community members showed up to participate in a day-long discussion of depression and its impact on the community and how to move forward, in July 2003. Subsequently, about 90 participants met to frame the first large phase (Witness for Wellness)<sup>6</sup> with working groups to address societal stigma about depression (Talking Wellness),<sup>10,12</sup> improving services (Building Wellness),<sup>16</sup> and addressing policy (Supporting Wellness).<sup>11</sup> The goal was to develop an approach to depression emanating from the partnership, supported and owned by community that could build community capacity for

wellness.

After several years of work that had many signature accomplishments, including becoming the only grass-roots community partner to participate in the planning for services under the Mental Health Services Act for Los Angeles County as well as scientific publications, a retreat to develop a vision for next steps was hosted at RAND. That led to a vision for community centers of excellence for mental wellness, for which the partnership received a planning grant from the California Endowment;<sup>17</sup> and for a research study that would clarify the added value of this community co-led approach to services improvement and research, over more standard improvement approaches of the time, particularly, technical assistance such as from a disease management firm. This became the mission of Community Partners in Care, which was funded in 2007 by the National Institute of Mental Health with collateral funding by the Robert Wood Johnson Foundation and California Community Foundation, and later, the National Library of Medicine and the UCLA Clinical and Translational Science Institute (NIH) and most recently, National Institute for Minority Health and Health Disparities (NIMHD) and Patient Centered Outcomes Research Institute (PCORI). Over this period, the mission of the CPIC became: *To support community and academic co-leadership to build capacity of communities and policy makers to sustainably maintain and improve services across the community to address depression and lead to mental wellness, for all in the community.*<sup>18</sup>

### **3. How does your partnership define “community” and how do you interpret that definition in the composition, mission, goals and activities of your partnership?**

Our partnership uses the NIH definition of community, *“groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people.”*<sup>19</sup> We have used this definition of community in several ways in both CPIC. Our work in CPIC was focused on low-income, mostly minority (African American and Latino) individuals in two geographically defined communities, South Los Angeles and Hollywood Metro, used by LA County for services planning. This definition of community for purposes of our partnership and the research study defined our mission, goals, the development of our partnership network, as well as in once or twice a year, open community conferences, where our partnership reported project progress and results, as well as obtain feedback on future project goals and directions.<sup>20</sup>

### **4. What is the governance structure and decision making process for your partnership?**

*“We’re a partnership. There’s no us (community) and them (researchers) like in other projects I’ve been involved with.” – Community Partner*

Our partnership has used the CPPR approach from its inception and into our current CPIC work. CPPR was developed by Loretta Jones, CEO of Healthy African American Families II in the early 1990’s as a model used by the Centers for Disease Control to address the epidemic of pre-term delivery and infant mortality in low-income, urban communities. CPPR uses principles of respect, two-way knowledge exchange, and community engagement to build trust while involving a multi-disciplinary team (scientists, policy makers, patients, community members) in all stages of research.<sup>7-9</sup> A council representing all stakeholder perspectives guides the initiative and supports workgroups to develop and implement components, reporting back to the larger community through once or twice a year, community conferences for feedback and to obtain support. A signed memorandum between lead institutional partners outlines CPPR principles, roles and responsibilities partnership structure, shared data ownership, resource allocation, scientific manuscript authorship, and handling disagreements between partners. (Appendix A)

In our partnership, we have a Council of diverse stakeholders, including patients, providers, community members and investigators to coordinate the study and facilitate input through community meetings and advisory boards. The Council supports working groups on issues such as measures and study design, that are co-led by community or client and academic members following principles that emphasize respect, development of trust, equal authority, respect for differences and a focus on community strengths and capacity building; as well as goals of improving research quality and productivity through rigorous, partnered science. CPPR principles and procedures are outlined in a memorandum of understanding (MOU) signed by institutional representatives, clients, and community members. The MOU addresses the study goals, data ownership, partner roles, and handling of disagreements.

Major decisions are handled by vote of the Council and within workgroups. Monetary resources, findings, presentations, and other products are considered shared resources. Daily decisions are handled by a Council representing a set of diverse stakeholders such as clients. Study findings and resources are provided to the community through conferences, websites, presentations to agencies and local media such as radio shows. Experienced community advocates under the leadership of Healthy African American Families II help assure honest dialogue and sharing of perspectives. Academic and community “coaches” support new members. In addition, clients and community members interact with policy and healthcare leaders. For example, community and academic partners co-presented CPIC findings to congressional staffers and representatives of CMS and the Veteran’s Administration in DC. These approaches have strengthened client leadership and increased community hope and policymaker commitment to change.

We use procedures to facilitate inclusion of diverse stakeholders in research, such as hosting workshops with open discussions of the history of research abuses, the meaning of scientific equipoise, and the role of randomization in reducing bias.<sup>23</sup> We hire community members as survey staff and use community leaders to co-train staff to increase input into and trust in data collection and analysis. Similarly, we adapt interventions with community input. We have used use a “storyteller’s circle”, an approach to increase client voice. In a storytellers’ circle, partners present summaries of de-identified client interviews (i.e., narratives) to stimulate reflection and understanding of client perspectives across the project leadership.

**5. What funding supports your partnership and how are decisions made about (a) which funding sources to pursue, (b) what entity serves as fiscal agent and (c) how funding is allocated?**

- a) Over the years, our funding has been from the Robert Wood Johnson Foundation, the National Institute of Mental Health, the California Community Foundation, the UCLA Clinical and Translational Science Institute, the National Institute on Minority Health and Health Disparities, the Patient Centered Outcomes Research Institute, the UCLA David Geffen School of Medicine, the UCLA Health System, the RAND Corporation Health Program, the Magic Johnson Foundation, the California Endowment, and the National Library of Medicine.
- b) The fiscal agent for the grants have been: 1) RAND Corporation, 2) UCLA Center for Health Services and Society, Semel Institute for Neuroscience, David Geffen School of Medicine, 3) the Los Angeles Biomedical Research Institute.
- c) Allocation of all funding is overseen by the CPIC Executive Council’s lead institutions’ representatives, Healthy African American Families II, RAND Corporation, and UCLA. Funding decisions and requests are discussed openly at meetings of the full Council. All Council members have access to information on all budgets. We follow a rough formula of 33% for community, 33% for academics, and 33% for shared data/products. This formula applies across diverse funding sources as a whole rather than necessarily project to project; and over time, it has become increasingly difficult to tell what is for community or academics or data, as the enterprise has clearly benefited not only from funding but from recognition that benefits all involved. For example, the ACTS 2014 Team Science Award recognized over 120 community and academic leaders involved in CPIC.<sup>15</sup>

**6. What community-campus partnership strategies does your partnership pursue, and how do these help to achieve your mission and goals?**

*“Coming to the conferences between UCLA and HAAF (Healthy African American Families) over the last 10 years about depression has increased my awareness of my health and what is going on with me. I know now the different signs of depression and that has helped me.” Community / Patient Conference Participant*

Our partnership uses a CPPR approach based on two-way knowledge exchange in which clients and community members are invited to share perspectives and educate each other, enhanced through community engagement activities that translate concepts into actions or stories (e.g., co-led workgroups, book clubs, storytellers’circles) in all aspects of our work over the last 12 years. We use procedures to facilitate inclusion of diverse stakeholders in research, such as hosting workshops with open discussions of the history of research abuses, the meaning of scientific equipoise, and the role of randomization in reducing bias. We hire community members as survey staff and use community leaders to co-train staff to increase

input into and trust in data collection and analysis. Similarly, we adapt interventions with community input. We have used a “storyteller’s circle”, an approach to increase client voice. In a storytellers’ circle, partners present summaries of de-identified client interviews (i.e., narratives) to stimulate reflection and understanding of client perspectives across the project leadership.

When understanding is achieved, community members /clients and academics co-lead the presentation of this understanding to communities. Over the last 12 years, we have held a number of community events. In 2003, we sponsored and evaluated a number of events and exhibits at the Pan African Film and Arts Festival in South Los Angeles that was summarized in a manuscript in the American Journal of Public Health.<sup>12-13</sup> Since the start of our work together, we have held free, community conferences once or twice a year to obtain broad feedback on our partnership’s plans, as well as to share the results of our work. Between 100 and 300 individuals attend each conference. And in our CPIC project, we held 166 trainings on depression collaborative care over 242.5 hours to over 500 staff from over 74 diverse agencies (e.g. primary care, mental health, substance abuse, senior centers, parks and recreation, churches, social services agencies, child welfare, barber shops and beauty salons).<sup>22</sup> These trainings were provided without cost to participants or agencies. At the trainings, we provided continuing education credits to licensed staff, food, and copies via flashdrives / printed workbooks of all training materials. We use modest stipends, food at meetings and other strategies to provide benefits for clients and other stakeholders who are not being compensated directly for participation as leaders. Where possible, we support all members in development goals. For example, a community member hired to do survey work was then hired as a Congressional health deputy. Trainings are provided for free, and we provide recognition and/or continuing education certificates. We designate consumer coaches to be paid as consultants, include community subcontracts, and provide payments to community coalitions. Our payments compensate community members for an estimated 90-minute meeting each month plus one hour of homework. We employ an “on and off the bus” policy so that participants can take breaks.

### **7. How does your partnership assess and reflect on progress towards your mission and goals, and how is this information used by the partnership?**

*“Working with Academia has increased my awareness of what researchers do. They are now getting an understanding of what is important to us patients. Collaborating with them has increased my trust with them.” - Community Stakeholder*

The CPPR framework for implementing CPIC promotes self-reflection on the salience of race and builds community capacity to use research. At most CPIC executive council meetings, community conferences, and workgroup meetings, the partnership asks meeting participants to complete meeting reflection worksheets to obtain feedback on the whether the meeting / work adhered to partnership principles, on partnership progress, and to make suggestions for improving the equity of future meetings. An evaluation sub-committee comprised of community and academic partners summarize and analyze these data for the partnership and offer presentations to the CPIC Executive Committee regarding the process of the partnership. Similarly at community conferences, we have utilized audience response systems to obtain real-time feedback from a group of audience members on project outcomes and future plans.

Feedback at most meetings is obtained through brief reflection sheets and also suggestion boxes are used. Summaries are provided at the following meeting, with examples of changes made in policy or programs in response to feedback.

Attention to race, gender, and class within the partnership is an explicit focus on most workgroup meetings and in all aspects of the project. For example, the leadership team held workshops on race and culture prior to hosting community conferences, attended to race in training survey staff, and hosted a panel on the legacy of the Tuskegee study and meaning of scientific equipoise to arrive at consensus over the CPIC study’s randomization design.<sup>23</sup> In addition, we also use games and exercises to reinforce positive values. For example, we held a discovery game to match names to discoveries by African American inventors. We developed a “mixed tape” of people’s favorite resiliency songs, played in between sometimes difficult discussions when there were tensions in the partnership. This allowed greater in-depth discussion of

conflicts, followed by strong bonding around common interests (singing, dancing) and then resolution.

**8. What outcomes or results have been achieved by your partnership and what evidence can you provide to support these?**

*“[The researchers] now look to us [patients] to ask us how to do research instead of just going off on their own.”*  
– Pluscedia Williams, Patient Study Partner

In addition to being a partnership, CPIC was a randomized, comparative-effectiveness trial comparing two interventions, *Resources for Services (RS)* or technical assistance to individual healthcare and community-based agencies to implement depression QI programs, versus *Community Engagement and Planning (CEP)* or community engagement to support healthcare and community-based agencies as network partners in integrated behavioral health, including task-shifting of depression QI activities to community-based agencies.<sup>24,25</sup> For example, primary care settings may provide medication while substance abuse settings provide case management for shared clients. Both interventions (*RS*, *CEP*) use the same evidence-based depression QI toolkits. CPIC was implemented in two Los Angeles communities of color with stakeholder co-leadership using Community-Partnered Participatory Research (CPPR) to build trust and equitable partnerships. Unlike prior QI studies in primary care, CPIC implemented depression QI in both RS and CEP across primary care, mental health, substance abuse, social services, faith-based, and other agencies to increase depression services access in healthcare shortage areas. Within each community, matched agencies were randomized to RS or CEP. Among 4440 screened clients (95.5% of approached) from 95 programs, 40% were African American, 45% Latino and the rest other; 50% were uninsured; 23% were employed and 65% had family income <\$10K.<sup>26,27</sup> Over 50% of depression-related contacts were outside of healthcare. At six-month client follow-up, CEP relative to RS significantly improved the primary outcome of mental health-related quality of life, and improved physical activity, reduced homelessness risk factors (homelessness, food insecurity, eviction, financial crisis) and behavioral health hospitalizations and shifted outpatient services from specialty medication visits toward primary care, faith-based and park depression services.<sup>28,29</sup> The 12-month results suggest modest continuing benefit under CEP relative to RS in terms of mental health quality of life and decreased hospitalizations, but findings are sensitive to modeling.<sup>14</sup> There were no intervention effects on depression treatments or symptoms, suggesting an alternative mechanism for main effects, such as social stabilization through task shifting to community agencies. These findings have been documented in several publications.

Before the publication of the baseline and 6-month outcome findings (but after findings were known to the Council), the LAC Department of Mental Health (DMH) with Departments of Public Health (DPH) and Health Services (DHS) proposed the Healthy Neighborhood Initiative to meet increased capacity needs for community behavioral health homes under expanded Medicaid. The Initiative is explicitly based on the CPIC evidence and approach and over time, intends to propose to combine agency coordination for shared behavioral health clients while also engaging neighborhood coalitions to address one or more locally prioritized social determinants of mental health. The proposal was approved by the LAC Board of Supervisors in 2014 as part of the LAC Strategic Plan,<sup>30</sup> and has progressed to the planning phase with piloting in 5 neighborhoods selected for strong existing coalitions. A separate, but linked initiative, also called a “Health Neighborhood Initiative” led by the LA Care, the Medicaid insurance plan in LA County and the largest Medicaid insurer in the United States with over 1.7 enrollees, will be piloted in 4 separate communities in late 2014 and early 2015 as an approach for providing physical health. The CPIC Council was invited to held design, implement and evaluate both Health Neighborhood Initiatives.

In addition, the CPIC Council was invited to present the CPIC approach to the California Mental Health Services Act Commission and to the pro-Temp of the Senate in 2014. As a result, a California Behavioral Health Center of Excellence was funded by the state with the Health Neighborhood Initiative and further development of the CPIC approach and dissemination to the state as lead goals. This effort is now supporting the development of the pilot phase of Health Neighborhood Initiatives in LAC, which includes support for academic and community partners as co-leaders of this effort.

**9. How does your partnership strive for equity and justice within the partnership?**

*“Our work gives voice to the voiceless...” Community partner during a data analysis workgroup.*

The CPPR principles guiding our partnership have an explicit focus on equity and justice in all activities and



aspects of our project. As noted above, our CPPR principles include respect, transparency, power-sharing, joint decision-making, and two way capacity development in all project activities. The application of these principles within our partnership's structure and activities "level the playing field" for all project participants. For example, the CPPR approach of two-way capacity and respect building allows project participants from the head of large public mental health system to the researcher to the homeless person to make equal contributions to project goals. In this particular situation, the most important resource may be the a homeless person sharing their lived experience which may be the most valuable contribution to improving the project and partnership's capacity to improve health outcomes.

The CPPR approach used by our project is consistent with the health equity action research trajectory (HEART) described by Thomas et al.<sup>31</sup> Within this framework, Thomas et al. define 3 existing generations of research to overcome health disparities, including: 1) documenting disparities; 2) understanding causes; and 3) identifying and evaluating interventions. While calling for more 3rd generation studies, Thomas and colleagues noted their limitations, including interventions not inclusive of structural determinants of health and analyses that treat race as a demographic variable rather than accounting for the broader context of communities of color. The HEART approach to research to eliminate racial / ethnic disparities in health is based on bioethics principles of justice to facilitate action to eliminate disparities through research. Specific recommendations include using public health critical race praxis based on critical race theory, addressing structural determinants of health in interventions and evaluations, and explicit self-reflection among researchers based on critical race theory. Examples of suggested activities include workshops to raise consciousness of the salience of race, integrating community perspectives in research, action to understand and address race as a social construct, support for community priorities for research, mechanisms for self-critique and building capacity to use research products in the community. Explicitly addressing disparities in race, gender, and class has been central to our entire partnership.

In addition, we also work hard to assure equity in distribution of benefits of the initiative across academic and community partners. For example, we co-present regularly, have resources to send community and academic partners to national meetings, co-author publications, and share all major recognitions. This has led over time to diverse outcomes, such as having 3 academic leaders being invited speak to pay tribute to a senior pastor who has been a leader in the CPIC work, at this retirement celebration hosted by leaders of the African American ministries that he has supported in South Los Angeles.

#### **10. To what do you attribute your success as a partnership?**

*"[The researchers] now look to us [community member] to ask us how to do research instead of just going off on their own." – Pluscedia Williams, Community Study Partner*

The key reason for the success of our partnership has been the commitment of all our partners to the CPPR principles and structure, and to each other as individuals and to the communities served as a whole. When we began with Witness for Wellness, many in the community doubted whether the UCLA/RAND academic partners would have the sensitivity and staying power in the community. Examples of problematic prior attempts were told repeatedly, of researchers walking away from the community or "taking the data." Doubt also existed about the wisdom of addressing mental health, for example, whether it would lead to ignoring deeper underlying social and environmental injustices leading to mental health problems (e.g. social determinants of mental health and disparities). Even key leaders have had their challenges over time; Wells and Jones for example, have written how they used package wrappers with stars on them to remain connected and positive when addressing conflicts early in their relationship. But in such examples lies a key reason for success—searching for the opportunity to remain connected despite conflict, staying connected as people who respect one another.

Another key factor has been the breadth and depth within and across community and academic participants, and the development of key junior investigators and junior community leaders. For example, the entire community partnership celebrated when Chung (the proposer for this award) was granted tenure this year at UCLA. One research fellow developing in the partnership went on to become the late Ted Kennedy's senior

health advisor; a community leader became the co-director of the methods core of our Partnered Research Center, and so forth. Over time, our partnership's commitment research excellence has been appreciated by the partnership and the community-at-large, as it has brought new opportunities for leadership in services, for example, in the Health Neighborhood Initiative.

The diversity of partnership, including policymakers and unaffiliated community members and patients, has also been a key factor. For example, early in the partnership at a conference introducing the CPIC intervention models to about 200 community representatives, a spokesperson from the White House who had been part of Witness for Wellness when a fellow, called to answer questions about the Affordable Care Act then being proposed, and an NIMH project officer called to thank the community for participating in and co-designing the project. Afterwards, community members reflected out loud: "We are speaking to the White House!"

Another key factor has been the steadfast reliance on two-way knowledge exchange such that everyone contributes their expertise in their own way, and thus has an opportunity to contribute and be in an equal exchange. This equality and exchange also then has an equivalent in shared growth and development, as the example above of the academic participation in a minister's retirement celebration, illustrates.

### **11. What lessons have you learned about community-campus partnerships that you believe are important to share with others?**

The first lesson learned, is that community-campus partnerships are highly rewarding on both sides. That is, even though they can be a lot of work and involve periods of conflicts, the joint capacity building and two-way knowledge exchange are sources of rich growth and development and result in meaningful accomplishments and relationships.

The second lesson learned, is that even highly difficult and stigmatized topics that have not been the source of community conversation, can, through community campus partnerships, become the source of conversation, improved services, and improved outcomes. We did not know at the outset, that we would be able to actually make some progress in improving outcomes for persons with depression.

The third lesson learned, is that community insights are critical to capture and can be sources of real innovation and discovery. For example, it was the community participants who thought that homelessness might be affected by addressing depression, and otherwise we might not have included homeless individuals in the study or tracked homeless outcomes, and this was one of the most significant (to academics) unexpected (but to community expected) findings of CPIC.

The fourth lessons learned, is that even with a successful partnership one must be prepared for "bruises" or unexpected snags or difficulties or even adverse outcomes, and in some cases even, to celebrate them as its own kind of victory. As one example, the CPIC approach to selecting randomization as a basis for comparison by including discussions of the legacy of Tuskegee and advantages of scientific equipoise in partnership discussions, was to be presented at the American Statistical Association Meeting in Toronto, and it was to be presented by our lead statistician (Thomas Belin, PhD, Professor of Biostatistics, Fielding School of Public Health, UCLA) and a community partner (Andrea Jones, Healthy African American Families II staff person). At the Canada border, Jones was delayed in crossing because the guards did not believe that an African American community member was going to present at this meeting. As a result, she missed the opening dinner honoring the presenters. Subsequently, she was able to prove that she was presenting at the meeting and arrived on time for her joint presentation with Tom Belin.<sup>23</sup> While this could have been viewed as traumatic, it was viewed in the community as a sign of great honor, because it was subsequently learned that she was the first community member to present at this leading meeting. To this day, this story is repeated as part of the legacy of CPIC, and an honor for this community member, who also went on to become a recipient of the 2014 Team Science Award. Over time, we have learned to anticipate some unexpected consequences like this, and either facilitate a good solution in advance or be prepared with experienced "coaches" whether for community or academics, afterwards.

The fifth lesson, is that communities, if given the chance to understand the context and details, can design, implement, be partners in analyzing, and co-present highly rigorous, partnered research. Further, there are

many advantages in using this partnered approach for academics, including the discovery opportunities noted above, as well as recognition opportunities and personal satisfaction. In particular, we have learned that community members in the context of this kind of active community campus partnership, value and expect academics to do their best with their capacities to bring science to the partnership—provided it is paired with the wisdom, experiences, and evidence of community members. That is, one does not have to pretend that one is not an academic scientist, even if one has to learn how to be one in partnership.

The sixth lesson, is that we have learned that a partnered approach to improving depression services, leads to a more overall successful outcome for clients (e.g., improved quality of life) and probably for systems (e.g., reduced hospitalizations) as does an approach based on technical assistance. To our knowledge, CPIC is one of the only randomized trials of the added value of a CBPR-based approach over an alternative to improve health and social outcomes.

**12. Partnerships can lead and inspire transformation at societal, institutional, organizational and personal levels. How does your partnership exemplify transformation?**

Our partnership has had examples of transformation at every level: personal, organizational, institutional, and societal transformation. Our partnership has focused on leadership and capacity development at every level of the partnership.

At the individual level, many of the grassroots community partners have become national leaders as a result of our partnership. For example, one individual, Pluscedia Williams, started as a community workgroup participant in the Witness for Wellness project. Through the support offered within the project to help her come to terms with her own depression and to develop leadership skills, Ms. Williams has gone on to become a national leader as past president of the National Community Based Organization Network that emerged from the Community-Based Public Health caucus of the American Public Health Association to encourage the support and development of individuals representing community-based public health organizations nationally. In addition, she has become a Community Faculty member at Charles Drew University in Los Angeles, a member of the Scientific Advisory Committee at the Los Angeles Biomedical Research Institute, and a co-investigator on the PCORI-funded Community Partners in Care 3-year, client follow-up study.

Community Partners in Care has several substantial “wins” for all the partners over the last several years. Based on the Community Partners in Care 6-month outcome findings, the LAC Department of Mental Health (DMH) with Departments of Public Health (DPH) and Health Services (DHS) proposed the Healthy Neighborhood Initiative to meet increased capacity needs for community behavioral health homes under expanded Medicaid. The Initiative is explicitly based on the CPIC evidence and approach and over time, intends to propose to combine agency coordination for shared behavioral health clients while also engaging neighborhood coalitions to address one or more locally prioritized social determinants of mental health. The proposal was approved by the LAC Board of Supervisors in 2014 as part of the LAC Strategic Plan, and has progressed to the planning phase with piloting in 5 neighborhoods selected for strong existing coalitions. This is an important victory for all of our partners in that we were able to take partnered scientific findings and assure they may be incorporated in “real-time” into large-scale health services development. Another major “win” for the Community Partners in Care Council is winning the Association of Clinical and Translational Science’s 2014 Team Science Award, the first applied research group to win this national award. This award is quite a victory for our partnership and the field of participatory research in showing that strong partnerships adhering to participatory research principles can conduct rigorous science that can affect policy change.

**13. By what process did you decide to apply for the CCPH Annual Award and draft this application?**

As with any major decision in our partnership, our application for this award was approved by a unanimous vote by all lead CPIC partnerships institutions. It also seemed appropriate, that an individual who started off as a fellow and then this year was granted academic tenure at UCLA, based on the decade of supporting the CPIC work, would lead the application. I am honored to do so.

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**Section 4: Supporting documentation = 10 page maximum, font size not less than 10 point, may be single spaced**

1. "Promising Practices of Meaningful Community Engagement in the Conduct of Research," Patient Centered Outcomes Research Institute Webinar, September 19, 2013, 1:10-1:25pm, Ken Wells and patient partners- Loretta Jones and Pluscedia Williams. <http://www.pcori.org/assets/2013/09/PCORI-Promising-Practices-of-Meaningful-Engagement-091913.pdf>
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5. Community Partners in Care Memorandum of Understanding (Appendix A – see attached)
6. 2014 Association of Clinical and Translational Science Award Letter (Appendix B – see attached)

## **Community Partners in Care (CPIC) Collaboration Agreement**

This MEMORANDUM OF UNDERSTANDING is hereby made and entered into by and between the RAND Corporation (RAND), the University of California, Los Angeles (UCLA), the University of Southern California (USC), QueensCare Health & Faith Partnership (QCHFP), QueensCare Family Clinics (QCFC), Healthy African American Families (HAAF), Los Angeles Urban Health League (LAUL), and COPE Health Solutions (COPE), and all organizations and/or individuals who agree to become a participating academic and community partners in CPIC after January 1<sup>st</sup>, 2008. The name and signatures of these organizations and individuals are found on the Addendum.

This Collaboration Agreement establishes the principles of community participatory research that are generally applied in projects carried out between academic and community partners. Under this agreement, all the parties involved serve as a guardian for these research principles on behalf of community, and facilitate the equal participation in community research of collaborating communities and academic partners.

### **PART I: Partnership Principles and Procedures**

**Community Participatory Research Principles:** This project will follow principles of community participatory research (Minkler and Wallerstein, 2002). The underlying principles are:

- 1) The project seeks to enhance the community's welfare through empowering the community to address its own health issues.
- 2) The project will be designed to increase community academic knowledge of the issue.
- 3) Community and academic participants will be involved in all project phases, including planning, implementation, research and evaluation, analysis, interpretation, and dissemination.
  - a. Community participants and academic researchers contribute to the shaping of the project issues and scope.
  - b. Interested members of the community and community agencies will be provided opportunities to participate in the research process.
  - c. Project membership is considered to be open and inclusive of those who wish to join and are willing to participate actively, rather than closed or exclusive in membership.
  - d. This project will have a Steering Council, consisting of both academic and community partners who agree to commit to regular meetings and have an oversight role. The Council will be co-lead by both an academic and community partner. The Council will be convened by the co-chairs or their designees from within the same organization. The Council will attend to barriers to participation, and uphold the principles of this agreement. The Council will also set a policy for authorship of products from the project, after the formal project phase is concluded. The usual expected policy will

be circulating the product/press release/presentation abstract to the co-signatories of the agreement for comments. A broader circulation list may be designated by majority vote of the Steering Council.

- e. The Steering Council will also have a Partnership Development Subcommittee, Products and Dissemination Subcommittee, and an Executive Committee co-lead by an academic and community partner. The Partnership Development Subcommittee will be responsible for brokering relationships with organizations that will aid in identifying community agencies that may serve as recruitment sites for the project. The Products and Dissemination Subcommittee will provide oversight for product and dissemination issues. The Executive committee will consist of one representative from each partner organization. The Executive Committee will be available for time sensitive decision making and approvals.
  - f. This project will have three workgroups; Operations, Methods, and Intervention. Each workgroup will be co-lead by an academic and community partner. The Methods workgroup will consist of three committees; Measures, Design, and the Implementation Evaluation Committee. Each committee will also be co-lead by an academic and community partner.
  - g. All participating members (academic and community participants) are acknowledged as having expertise and commitment that is relevant to the scope of the project.
  - h. Community participants will be partnered with academic participants in analytic issues, including interpretation, synthesis, and verification of conclusions, and supported as needed in the research and scientific methodology.
  - i. Community participants will be partnered with academic participants in identifying the relevant project outcomes.
  - j. The project will periodically assess the experience of participating for community and academic participants and attend to their concerns.
- 4) The project may consider the political, social, and economic determinants of the main health issue addressed by the project.
  - 5) Mechanisms to voice and resolve differences of opinion or concerns about fairness of the process will be implemented through the Steering Council, and each participating agency will have one vote.
  - 6) Dissemination of the research results will be the responsibility of all project participants, and academic and community partners will have opportunities for presentations and publications, under the governing conditions of the Council (see below).



**Rights, Conflicts, and Responsibilities:** Acknowledging that conflicts in partnership most commonly arise over financial matters, credit for work, and responsibility and opportunities for publication and dissemination, the following sections present principles and models for handling those issues within the project.

Financial Arrangements: Each partnership agency contributes to the project at least in part through in-kind contributions, particularly in development phases. Academic and community partners will work together to consider their specific needs for funding activities related to the project and their overall needs for financial stability. Resources have been allocated to each of the lead partner agencies in the parent study, CPIC. Additional resources will be sought through add-on studies. Partners will collaborate to determine the best agency fits for these additional studies. Plans for developing financial support for the project, including services and research, will be submitted to the Steering Council for review for fairness and equity in relation to partner need given the project, prior to submission.

Authorship for Product and Publications Development and Presentations: This is a community-based participatory research project, in which academic centers and community agencies participate as full partners in all phases of the project. This means that the project design, data collection, analysis and interpretation of data, publications, presentations, and other products will be generated with community participation. Participation of individuals in particular products will be based on participation in the work supporting the product, with oversight of the relationships and resolution of any disputes through the Council. We will follow usual journal guidelines regarding authorship on papers. Authors will be expected to contribute to papers and be responsive to reviewer concerns in a timely manner (i.e., within two weeks or as designated by the Council). Some papers may have a group of participants acknowledged with a shorter list of authors, spanning the major categories of participants. Research Works developed jointly by academic centers and community partners shall be jointly owned by all contributing partners, and decisions regarding marketing and distribution shall be jointly made by all contributing partners. In general, research works shall be disseminated for public benefit, either freely or at nominal charge to cover distribution/processing fees.

Ordinary journal policy is for the paper's first (or senior, sometimes last) author to decide on authorship list and order, but the Steering Council will resolve disputes and has the right to review overall fairness of the process. At the Council level, the full Council will discuss and act as advisory, but the final resolution will be by majority vote among the main partners who have executed the Collaboration Agreement.

Data Ownership: At the end of the project or at reasonable interim stages, each academic and community site/partner will retain a copy of the full de-identified data file, based on Council review and recommendations. Issues of ownership of the data will be regulated by the Council. Any site owning data, or participating in collecting data for the project, must review its role through their internal IRB and/or sign a certificate of compliance with the lead academic IRB for the project. Even if a participating

site/partner is minimally involved in the project or not entitled to the full de-identified data file, they will receive a summary of the data.

Internal Review Board Responsibility: It is requested that each participating community partner have at least one participating member (i.e., the Council representative) complete a certification of training for human subjects research through the lead academic partner's Internal Review Board (IRB) website (e.g., UCLA). Each participating partner should determine the status of its own IRB board, and develop plans to coordinate any IRB review through its agency with the review(s) of other participating IRBs.

Review of Papers, Products, and Press Releases: During the life of the project, submitted research papers and abstracts for presentations will be circulated to the Council and to lead participants of partner sites at least one week and preferably two weeks prior to their submission for review and comment. There will be a 5-10 day turn around time for comments to the lead author. Each product will have one or two lead individuals to permit accountability.

While input and full exchange among participating partners is encouraged, consistent with usual scientific policy, partners will not have the right to block submission or enforce changes on scientific papers. Rather, it is expected that the first or senior author of each project will review comments from partners, discuss major differences of opinion with the partners involved, and circulate the final version to partners. If substantial disagreements over interpretation remain, then the lead author (first and/or senior) will include a statement in the discussion section, clarifying the nature of the disagreement in interpretation among Council members for the project. The dissenting Council member(s) also have the right to submit a letter to the journal's editor for publication concerning their disagreement in interpretation.

Similarly, products for community release and presentation will be circulated for comments to community and academic partners, providing a one-to-two week turn around time.

Disputes concerning fairness in authorship or concerning the fairness of internal review, including adherence to the principles of this agreement, will be resolved in discussion by the Council. The deciding vote is by majority vote among the co-signatories of the Collaboration Agreement. The Council also has the right to request a review of disputes over scientific issues by outside scientists and community members. An author/project participant who is not a member of the Council also has the right to request that the Council grant an independent review.

The intent of this agreement is that a balanced consideration will be given to community and academic perspectives in interpretation and presentation. If necessary, the Council has the right to request, in advance of project development, equal academic and community co-leaders.

The Council will develop a plan for handling press releases to ensure coordination with press offices of academic and community partner agencies. For example, press release responsibilities may be handled by the organization of the lead author of a given product; may rotate among participating agencies with press offices; or be delegated to one agency's press office, with coordinating support from other agency press offices. This issue will be overseen by the Products and Dissemination Steering subcommittee.

## **PART II Project Description: Community Partners in Care**

The project "Community Partners in Care" is a community participatory research partnership project involving the RAND Corporation (RAND), the University of California, Los Angeles (UCLA), the University of Southern California (USC), QueensCare Health & Faith Partnership (QCHFP), QueensCare Family Clinics (QCFC), Healthy African American Families (HAAF), Los Angeles Urban Health League (LAUL), and COPE Health Solutions (COPE).

The purpose of this project is to build a network of partners in the community to collectively make quality depression care available to those who need it in the community. The premise is that a network of partner agencies will provide better care than disconnected agencies that address a single piece of the puzzle. The participating agencies and clinics will include social service agencies, mental health facilities, primary care facilities, substance abuse agencies, and faith-based ministries and churches.

These network agencies will be the experimental group (or intervention group), and will receive toolkits from previously successful projects that significantly improved depression and other social indicators such as employment. These improvements were found in minority and low-income populations, and the improvements lasted over time. In addition to the toolkits, the agencies in the experimental group will receive training including toolkits use and strategies for improving care. They will receive general support in network-building with other agencies. Network agencies will come together to determine how to work together as a team, share resources (e.g., information and staff time), learn from each other, and provide the best services possible.

Agencies will be recruited and randomly assigned to be in an experimental group or a comparison group. The comparison group will receive training in the same toolkits as the network agencies, but will not have the support of the network team.

The project will screen approximately 5,000 clients who go to both groups of social service agencies. The clients will be screened for depressive symptoms. Approximately 600 clients will be enrolled in the study. Their outcomes (such as depressive symptoms) will be compared with those who go to the comparison group agencies. In order to determine whether the project makes a difference over a longer period of time, the study will follow the clients and survey them periodically over three years.

The study will also look at the effectiveness of the network-building process itself. The agencies and providers will participate in focus groups and complete surveys to see if their participation changes the way they usually provide services. Another dimension the study will look at is whether an agency's past experience in implementing quality improvement programs makes a difference in client outcomes.


The model of partnership that the network-building is based comes from an ongoing project in Los Angeles, Witness for Wellness. This project has created a successful community and academic partnership for addressing depression in the community. This partnership model is described in the January, 2007 issue of the *Journal of the American Medical Association* (Jones and Wells).


### **PART III: Termination of Agreement**

Any agency may terminate this MOU by giving the other agencies ninety (90) days written notice. Termination of this MOU by any agency shall not affect any phase of the study. Any agency wishing to terminate this MOU shall allow them sufficient time to complete any activities/tasks that if left incomplete can prevent the study from moving forward.

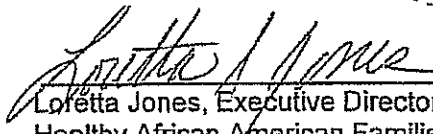
**PART IV: Agreement Signatures**

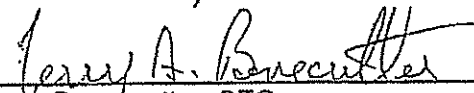
The following parties represent the main participating academic and community partners. The signatures indicate agreement with the terms of this agreement.

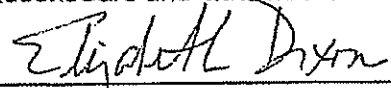
  
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Joanne Shelby, Director  
Contract & Grant Services, RAND DATE 12/19/2007


  
\_\_\_\_\_  
Jeanne Miranda, Professor  
University of California, Los Angeles DATE 12/20/07

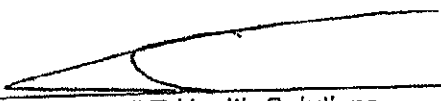
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Leopoldo Cabassa, Assistant Professor  
School of Social Work, University of Southern California

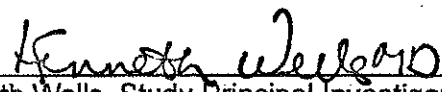
  
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Lofetta Jones, Executive Director  
Healthy African American Families DATE 12/29/07

  
\_\_\_\_\_  
Terry Bonnetcutter, CEO  
QueensCare and QueensCare Family Clinics DATE 12/31/07

  
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Elizabeth Dixon, Director  
QueensCare Health and Faith Partnership DATE 12/18/07


  
\_\_\_\_\_  
Anthony Maddox, Interim Chief Neighborhood Officer  
Los Angeles Urban League DATE 02/14/2008

  
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Allen Miller, CEO, COPE Health Solutions DATE 1/5/08

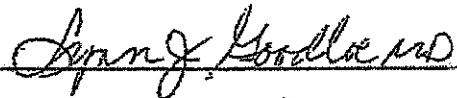
  
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Kenneth Wells, Study Principal Investigator  
RAND Corporation DATE 12/19/07

**Addendum to Community Partners in Care (CPIC) Collaboration Agreement**

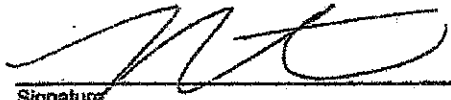
The purpose of this addendum is to obtain signatures of organizations and/or individuals who, after January 1<sup>st</sup>, 2008, agree to represent the main participating academic and community partners in CPIC. The signatures indicate agreement with the terms of this memorandum of understanding as it stands. Addendums may change roles and responsibilities.

 DATE 2/25/09  
Signature

Henry van Oudenstroom, PhD/CEO  
Full Name, Title, Organization

 DATE 9/23/08  
Signature

President National Alliance on Mental Illness (NAMI)  
Full Name, Title, Organization Urban Los Angeles Chapter (NAMI UrbanLA)

 DATE 9/23/08  
Signature

Executive Director  
Full Name, Title, Organization

 DATE 4/27/10  
Signature

Janet Kelly, Executive Director, PATH  
Full Name, Title, Organization

\_\_\_\_\_  
Signature DATE  / /

\_\_\_\_\_  
Full Name, Title, Organization

Nomination Letter Community Partners in Care  
Appendix B: 2014 Association for Clinical and Translational Science Award Letter  
March 19, 2014

Kenneth B. Wells, MD, MPH  
Director, Center for Health Services and Society  
UCLA David Geffen School of Medicine  
UCLA Psych and Behavior Sciences  
BOX 957082, Ste 300, UCLA Wilshire Cntr  
Los Angeles, CA 90095

Dear Dr. Wells,

It is our great pleasure to inform you that the Community Partners in Care Council has been selected as the 2014 winner of the Team Science Award in recognition of your team's success in the translation of research discoveries into clinical applications and eventually widespread clinical practice. We look forward to seeing you in Washington, DC at *Translational Science 2014*, the joint annual meeting of ACTS and AFMR.

The meeting will take place April 9-11, 2014 at the Omni Shoreham, Washington DC. The award includes complimentary registration for the meeting. Additionally, you will receive an honorarium of \$1,000 and reimbursement for up to \$500 in travel expenses. You will be given three minutes to present remarks prior to a plenary session at the meeting.

Personally and on behalf of our organizations we thank you for your team's numerous contributions to clinical and translational science. Your team's efforts are an inspiration to all of us.

Best Regards,

A handwritten signature in black ink, appearing to read "Michael Lichtenstein". The signature is fluid and cursive, with a long horizontal flourish extending to the right.

Michael Lichtenstein, MD  
Joint Awards Committee Chair