

**Supplementary Technical Appendix for  
The Effects of Collaborative Care Training on Case Managers' Perceived Depression-  
Related Services Delivery**

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## 1. CPIC Training participation

Attendance at trainings was assessed by names on sign-in logs or self-reported in-house trainings on the follow-up survey in which a respondent was asked:

*Have you specifically received any of the following types of training through the CPIC study in the last 6 months (including in-person Workshops, online Webinars, conference calls, or one-on-one consultations)?*

*Please check what kind of CPIC training you received in the last 6 months:*

*(check all that apply)*

*CPIC Cognitive Behavior Therapy (CBT) training*

*CPIC Case Management/Outreach training*

*CPIC Medication Management training*

*Other CPIC training (please list): \_\_\_\_\_*

As shown in Table S1, the observed agreement between the logs of participation and self-report was 75% ((33+55)/117). Of survey respondents (N=109), the estimated kappa coefficient =.60, 95% CI=(.45, .75) indicating a moderate agreement.

**Table S1. Distribution of training participation based on sign-in logs or self-report**

| Self-report in-house trainings | On sign-in log | Overall (N=117) | RS (N=59) | CEP (N=58) |
|--------------------------------|----------------|-----------------|-----------|------------|
| Yes                            | Yes            | 33              | 4         | 29         |
| Yes                            | No             | 10              | 9         | 1          |
| No                             | Yes            | 11              | 1         | 10         |
| No                             | No             | 55              | 40        | 15         |
| Missing data                   | Yes            | 3               | 1         | 2          |
| Missing data                   | No             | 5               | 4         | 1          |

A sensitivity analysis using alternative definitions produced similar results on training participation (Table S2).

**Table S2. Percentage of training participation based on sign-in logs or self-report at one-year follow-up**

| Variables  | Unadjusted estimates <sup>a</sup> |         |    |    |         |    |    | Adjusted analysis <sup>b</sup> |      |              |       |
|--|-----------------------------------|---------|----|----|---------|----|----|--------------------------------|------|--------------|-------|
|  | Total N                           | RS      |    |    | CEP     |    |    | p                              | OR   | CEP vs RS    |       |
|  |                                   | Total N | N  | %  | Total N | N  | %  |                                |      | 95%CI        | p     |
| Training participation based on sing-in logs         | 117                               | 59      | 6  | 10 | 58      | 41 | 71 | <.001                          | 29.9 | 8.7 to 103.4 | <.001 |
| Training participation, self-reported                | 109                               | 54      | 13 | 24 | 55      | 30 | 55 | .001                           | 4.0  | 1.4 to 11.3  | .01   |
| Training participation, sign-in log or self-reported | 112                               | 55      | 15 | 27 | 57      | 42 | 74 | <.001                          | 7.8  | 2.9 to 20.9  | <.001 |

<sup>a</sup> Raw data without weighting or imputation. The total N reflects the number of respondents at one-year follow-up

<sup>b</sup> Adjusted analyses used multiply imputed data (N=117). Data were weighted for eligible sample for enrollment; logistic regression models adjusted for sector (healthcare versus social-community), and provider type (licensed versus unlicensed) and accounted for the design effect of the cluster randomization



## 2. Bivariate Correlations among Measurements

Bivariate correlations among the main study variables at baseline assessment are presented in Table S3. Within the domain of care practices, depression care techniques were positively associated with depression case management. Four variables within the domain of depression knowledge and attitudes were not significantly associated. Across domains, perception of depression skill was positively associated with both depression care techniques and depression case management; personal depression stigma was positively associated with depression case management; community services provision was associated with number of system barriers.

**Table S3. Bivariate correlations**

| <b>Care practices</b>                     | <b>1</b> | <b>2</b> | <b>3</b> | <b>4</b> | <b>5</b> | <b>6</b> | <b>7</b> |
|---|----------|----------|----------|----------|----------|----------|----------|
| <b>1</b> Depression care techniques       | -        |          |          |          |          |          |          |
| <b>2</b> Depression case management       | .83**    | -        |          |          |          |          |          |
| <b>3</b> Community services provision     | .002     | -.06     | -        |          |          |          |          |
| <b>Depression knowledge and attitudes</b> |          |          |          |          |          |          |          |
| <b>4</b> Perceived depression knowledge   | -.17     | -.09     | .05      | -        |          |          |          |
| <b>5</b> Perception of depression skill   | .53**    | .60**    | -.02     | -.12     | -        |          |          |
| <b>6</b> Personal depression stigma       | .17      | .21*     | .06      | -.09     | .19      | -        |          |
| <b>7</b> N of system barriers             | .098     | .04      | -.39*    | .02      | .02      | .23      | -        |

p<.05, \*\* p<.01, No asterisk = non-significant

**Figure: Provider Participation Profile**



