Integrated Practice: The Contribution of Health Literacy to Recovery-oriented Care

Melody Riefer: Good afternoon folks. Or good morning based on where you are in this part of the world. We are very glad that you could join us for the first in a series of webinars that will be looking at Recovering-oriented Approaches to Integrated health. And we are excited about this series. It's going to be four months, one a month where we tackle different aspects of this topic. In this month, we are going to be looking specifically at screening, intake, and monitoring. Before we get started a couple of housekeeping details. I do want to let you know that we are grateful to SAMHSA for providing us the resources and the time to be able to provide these webinars, but also, I want to let you know the views, opinions and content expressed in the presentation don't necessarily reflect the views, opinions or policies of the Center for Mental Health Services or the Substance Abuse Mental Health Services Administration or the Department of Health and Human Services. Rather, they are the thoughts and opinions of the presenters. If this is your first time in an Adobe connect webinar, I want to give you quick orientation to the space you are looking at. To the left of your screen you see the smiling faces of our presenters and we are really glad to have them here and I will give you a bit more information about them in a second. Right below that is a pod that has information and a link for being able to access the captioning information. Should you require or prefer to have life captioning during this webinar, just copy that link and open a new window and paste the link it'll take you there. That way you will be able to see the presentation as well as have access to live captioning.

Below that pod is a section labeled participant chat, and I see some of you are already in their chatting up the room. Thank you for doing that. One of the benefits of these webinars is that you can get to know each other and it's great to see where people are calling in from. We are happy to have you here and we are always glad to see such a variety of disciplines and practices represented in the folks who are participating. To the right is another pod labeled tech and topic questions. This is a really important pod or box to pay attention to. If you have any difficulty hearing while the presentation is taking place, you can let our support team know about that and they will troubleshoot with you. If your screen gets wonky, if you have any kind of other technical problems put the questions there. Also, if you have questions for our presenters or about this topic, please type those questions in this box. I will be in the background gathering the questions and saving them for the end of the session during which time we will go through as many questions as possible. And then look to your right one more time there is a pod labeled download materials. This is where you can click and download files that relate to today's presentation. That includes the PowerPoint slides, as well as a document that has some extra resource materials that you might want to look into if you're interested in learning more about this topic.

We will have CEUs and certificates of attendance available at the end of the webinar, and I will give you instructions about how to access that information when we reached the end of the presentation.

Now just before we get started, I want to have you answer a quick question if you would. If you notice, your screen just changed a little bit and it's a yes or no question, pretty easy but does your program or facility provide both physical and behavioral health services? We are just trying to get a sense of who is on the call and what orientation you have to those services and to the topics today.

I think traditionally we have seen these services be separated and that is changing some as indicated by the responses that you all are giving. Just click the radio button besides the yes or no. If you like to vote. If you look it's pretty close. 55% or so of the respondents are indicating that they do have both physical and behavioral health services at your facility. Okay thank you. That gives us a good impression of what you are experience is. So, let's go ahead and look at our topic for today.

Screening, intake, and monitoring have always been important aspects to the way services are provided. And ensuring that these are recovery oriented can be key to the activation or the jumping into of services because we want folks to feel welcomed and heard right from the giddyup. And so, the webinar kind of begs the question how do we manage that in integrated practices? We're lucky to have two professionals who have some great experience looking at this question and both from a practical direct service point of view but also as a research question, and so Suzanne Daub and Tracy Carney of Community Care Behavioral Health are our presenters today. They will walk us through some information, tell us a bit about their experiences, as well as tell us about the research they are doing in this area so that we can all benefit from this walk in their shoes. So, Tracy, I am going to hand this over to you. Thank you so much for being here and being willing to share your expertise.

Tracy Carney: Thank you Melody. It's a pleasure to be part of the webinar today. As a senior recovery specialist, I have the opportunity to support recovery and wellness initiatives in my work at Community Care Behavioral Health, and it's really an honor to be able to share some of this work with you all today. Let me tell you a little bit about Community Care. We are nonprofit behavioral health management care organization headquartered in Pittsburgh, Pennsylvania. We serve approximately 950,000 members in 39 of the 67 counties in Pennsylvania. Community Care is implemented a variety of innovative programs integrating behavioral and physical health care and we take active steps to make the principles of recovery foundational in all we do. One of the initiatives I've had the opportunity of working on the community care is the behavioral health home plus. I first became involved with the behavioral health home plus when I was working as a behavioral health peer specialist and program director for CMSU Behavioral Health Services. Our agency was one of the first in Pennsylvania to pilot the behavioral health home plus. The goal of the behavioral health home is to integrate physical healthcare into a behavioral health setting. It enhances the capacity of the behavioral health providers to assist the people they serve in addressing their

physical health needs. And it helps the individuals become better at managing their overall health.

So, what do we mean when we say integrated care? At the simplest level, integrated mental and physical health care occurs when mental health and primary care providers work together. They collaborate and coordinate care to address a person's whole health needs. 68% of adults with a mental health condition have a cooccurring medical condition and these health conditions do not fall neatly into psychiatric or physical categories. Over and over again we hear from people in recovery that they want treatment to be delivered in a holistic way, mind body and spirit.

Community cares mission is to improve the health and well-being of its members through the delivery of effective services. We have all heard the statistics that adults living with mental illness are becoming seriously ill and dying at a premature age. 15 to 25 years sooner than the general population even while under the care of the current mental health system they are developing chronic medical diseases that shorten their lives. Many premature deaths are due to cardiovascular, pulmonary, and infectious diseases. A particular concern among individuals we serve at Community Care if the occurrence of the metabolic syndrome associated with the use of atypical antipsychotic medication. This metabolic syndrome is a cluster of symptoms that increases an individual’s risk for diabetes and heart disease. We understand serious health problems are frequently caused or worsened by a person’s lifestyle. Things like poor diet and nutrition, smoking, physical inactivity, and substance use. Many of our members don’t access medical care for a variety of reasons, and their medical conditions go undiagnosed or untreated. Maybe you heard some of the reasons people give for not accessing medical healthcare, things like lack of transportation which is particularly true in our rural areas, feeling stigmatized in a medical health setting, or an inability to manage or coordinate the number of appointments. And another major reason we hear from individuals is issues related to trauma. We recognize that for many of our members there only point of contact for any kind of healthcare is their local community mental health center. Integrating physical healthcare into behavioral treatment settings just makes sense in addressing the whole health needs of the individual. But just helping someone access medical services is not enough. We recognize that helping a person access medical care is a great first step but supporting a person to act on the medical recommendations that are made is another matter altogether. These are two very different processes.

And this is the process of the behavioral health home plus model. In addition to coordinating care we wanted service delivery to focus on providing tools, education, and resources that promote behavioral health activation. With this in mind we sought out an evidence-based model developed specifically for coaching people with serious mental illnesses to make physical health behavioral changes. Dr. Peggy Swarbrick and her colleagues at Collaborative Support Programs of New Jersey developed a wellness coaching curriculum which was initially designed to train peer specialists to work as wellness coaches. Community Care worked with Dr. Peggy Swarbrick to modify the wellness coaching curriculum to not only work with peer specialists but also with mental health case managers and wellness nurses. What wellness coaching does is it builds a positive

supportive relationship between a coach and a person who wants to make changes in their physical health. Individuals receiving services work with their coach to develop person centered goals and they have a virtual team that coordinates physical and behavioral health needs and links them to the supported services. Before I tell you more about the behavioral health home plus and some of the tools we use I want to briefly share a research project Community Care has been involved with surrounding behavioral home called PCORI Optimal Health. My role in the project was working as an co-principle investigator representing the voice of people in recovery. From May 2013 to January 2017 Community Care in collaboration with the UPMC Center for High-Valued Health Care, the Behavioral Health Alliance of Pennsylvania, and other stakeholders participated in this research project funded through the Patient Centered Outcomes Research Institute. The study involved 1229 participants from 11 community mental health centers across Pennsylvania. The purpose of this study was to compare the effectiveness of two different behavioral health home models. We had a provider supported care model which employed a wellness nurse who focused on physical health and wellness within five community mental health centers. The other model was a self-directed care model which introduced physical health, self-management toolkit and resources in six of the centers. The aims of the study were to compare the effectiveness of these two models and improving the health status of individuals with serious mental illness, increasing patient activation and care, and improving engagement with primary and specialty physical healthcare. In both models, behavioral health agencies established a culture of wellness, they trained their direct service staff in wellness coaching, and they utilized a member high risk registry with key indicators of physical and behavioral health needs. What the research revealed was that both behavioral health home models led to an increase in engagement in primary and specialty care among the service users. And while both models showed significant increase in patient activation, the wellness nurse site showed quicker improvement and sustained increase in activation. There were also improvements in other areas including hope, quality of life, emerging care use, lab monitoring, medication adherence, and satisfaction with care. I have to say that I was delighted to see the positive health outcomes from the use of the behavioral health home model.

Currently, the behavioral health home plus model being implemented in the community mental health centers in Pennsylvania combines aspects of both these models. It includes the wellness nurse with physical health expertise as the lead navigator in the agency. The nurse is such a valuable resource to provide education and interventions in the agencies. All direct service staff, case managers, peer specialists, are trained in wellness coaching so they can serve as health navigators. Individuals receiving services are provided self-management tools, education and resources that encourage self-activation in their health and wellness. And strategies are implemented to improve engagement and coordination with primary care. Developing and sustaining an overall culture of wellness within the community mental health center is the key to success of the behavioral health home plus. Surprisingly, one of the outcomes that we did not expect to see was with the staff that was trained as wellness coaches. The case managers and the peer specialists all reported using what they were learning to develop their own physical health goals

and the culture of wellness seemed to be spreading through the whole agency. So where are we today?

The behavioral health home plus has been implanted in 49 community mental health centers in Pennsylvania serving adults and adolescents. And last year, SAMHSA's Program to Achieve Wellness awarded the behavioral health home plus model the recognition of excellence in wellness. Now I said we would look at some of the tools we used in the behavioral health home plus. All the tools are aimed in motivating change in promoting self-determination and self-management. But right now, I want you to imagine that you are a person coming into the community mental health center for treatment. Here is what your experience in addressing your physical health might look like. Upon intake, you meet with the health navigator. This health navigator is usually the nurse but it could be a case manager or a peer specialist, and the very first thing you would do is the physical health assessment. This initial assessment goes over the basics, it identifies your personal goals related to health, it identifies your primary care and mental health providers, it assesses things like vitals, labs, medication, smoking, pregnancy, any preventative health screening, recreational drug use, and it also screens for domestic violence. After this initial screening, you would be introduced and orientated to wellness coaching. Someone would explain the services and the role of the health navigator and your role and potential benefits to you. You would then be offered the opportunity to work with a health navigator and engage in wellness coaching. Wellness coaching is a program of choice. No one is forced into working with a health navigator. If you agree to participate, you would begin working with your health navigator using a tool called the physical wellness planning tool. This tool assists you to identify your strengths and needs and the physical dimension of wellness. The tool addresses eight areas. These areas are diet and nutrition, physical activity, sleep, relaxation and stress management, medical care and preventative screening, smoking sensation, taking medication effectively, and habits and routines. After you identify your strengths and needs in each of the eight areas, you would then prioritize the areas that are most important to you. When you have identified the area, then you would begin working with your health navigator on brainstorming ideas to identify and create a smart goal. This physical health goal you create would be specific, measurable, attainable, relevant, and time bound. You and your health navigator would meet regularly as part of the wellness coaching relationship to review progress on your goals and to address any barriers or challenges you may be facing. The goals created using the physical wellness planning tools are person centered and self-directed. The coaching processes keeps you in the driver seat and directing your healthcare needs while the health navigator provides resources, encouragement, and support. Wellness coaching uses many of the principles of recovery to address a person's physical health needs. Many of our members who were involved in wellness coaching report making progress on their physical health goals in areas such as weight loss, managing diabetes and high blood pressure, increasing exercise, and reducing or quitting smoking. They report the most important factor in their success is the support and encouragement from their health navigator.

We looked at the physical assessment and physical wellness planning tool. The next two tools on our list is the wellness online outcome and the

shared health outcomes tool. These tools are these are online monitoring tools available on community care E portal. Let’s look at the wellness online outcome tool. It is a key component of the behavioral health home plus because it provides feedback to the behavioral health provider on individual’s outlook towards the eight areas identified on their physical wellness planning tool. It gathers information about the person’s experience of their involvement in their physical healthcare. The information collected using this online tool conveys to the provider the level of importance the individual places on their healthcare, the current goal, and how they rate the progress. The wellness online outcome planning tool can be used to start a discussion about the individual’s health and wellness and can be a catalyst for planning for behavioral change. Information from this tool is provided routinely in aggregate to determine changes in the health and wellness of individuals being served by the behavioral health home.

At a minimum, the wellness online outcomes planning tool is completed twice a year for all individuals in the behavioral health home plus. Although I will say some providers integrate completion of this tool into the quarterly update of the agencies service or treatment plan. Information from the wellness online outcome tool can be entered directly into the E portal with the individual present, which is called the guided message, or using the data entry code where data received from the members transferred from a paper copy form into the E portal by the staff. Again, the use of this tools allows the individual receiving services to report their progress and communicate areas of importance to them. The individual has a clear voice in communicating their experience and progress and needs to their behavioral health provider.

The last tool on the list that I want to share with you today is the shared health outcomes tool. This tool provides individual and population level data on the agencies care coordination intervention. The agencies quality improvement team can use this information to gather knowledge about the general health concerns of the population served by the behavioral health home plus as well as the needs performance improvement. The shared health outcome tool tracks the number of contacts between individuals being served and the wellness nurse or health navigator, the number of completed physical health assessments and wellness plans, the number of primary care physician contacts and it also tracks pregnancy, BMI, the use of self-management tools, and the use of tobacco or other substances. The shared health outcomes tool is completed on the E portal once a month and this information is shared with providers these are the tools that we use in the screening, intake and monitoring in the behavioral health home plus.

We know that tools are only as good as the people who use them. The behavioral health home plus is implemented in the behavioral health agencies as a year-long learning collaborative. Developed by the Institute for Health Care Improvement, the learning collaborative is a group of organizations working together using a structured process to implement change and sustain it over time. Each agency establishes a quality improvement team who will evaluate their progress by tracking process measures and outcomes. One of the first steps in the behavioral home plus learning collaborative is of course to train the staff case

managers, peer specialist, and wellness nurses in wellness coaching. Training includes understanding wellness and recovery concepts, the basics of medical conditions, and communication and motivational interviewing. The learning collaborative has a focus on making connections and collaborating with primary care specialty practices within the community. And training on the online e-Portal. The staff is also trained in recovery principles and practices through Pat Deegan's CommonGround approach and key recovery concepts like personal medicine, shared decision-making, and the use of the recovery library. Currently there is a Recovery Academy designed by Pat Deegan and Associates to train the wellness nurses who come from medical settings in recovery principles, approaches, and practices. The behavioral health home plus is a way of integrating care that gives individuals in recovery the opportunity to address their whole health needs in a way that supports the self-direction, self-determination and person-centered planning. I just want to thank you for allowing me to share some of this with you today and we will have another poll coming up and I will turn it over to Melody.

Melody Riefer: Tracy, thanks so much for that information. I really enjoy hearing about the way all of the team members come together and get trained and it's not just one person who gets access to the resources and training but everybody is trained. So, before I hand this over to our next presenter, I want to give you an opportunity to answer another question. Have you in your own personal life had a primary care provider ask you about your mental health during a primary care visit? So, think about the last time you saw your internist or your cardiologist or whoever. But have you had a primary care provider ask about your mental health during a visit. Just click yes or no. We are not going to poke into your personal business. We want to try to get a sense for what's happening out there in the real world before we move on. The percentages are a little different with this poll question. A bit more of you are saying that you have had primary care doctors ask about your mental health during a visit. We'll find out how that is relevant, how that question is relevant, as our next presenter comes and shares information. Suzannah looking forward – Suzanne sorry, I just called you my colleague's name, Suzanne thank you for being here and I'm looking forward to what you have to share.

Suzanne Daub: Thank you Melody. Can everybody hear me okay?

Melody Riefer: You sound great.

Suzanne Daub: That's great. That poll, both poll answers are very interesting to me and honestly, I am very heartened to see that about 60% of folks say that they have been asked about their mental health condition by the primary care provider. That's a big change so let's talk a little bit about that. Tracy thank you so much for giving us such a nice overview about integrating services in the community of mental health so we are going to shift now and turn that over to the other side which is integrating behavioral health into primary care.

When we think about integration it’s very important that we really take a no wrong door approach to this. Because people with mental health challenges present it in all health settings and especially in primary care. So, that's what we are going to talk a little bit about here today if I can get my -- there we go.

Alright so, first let's go with why. Why integrate behavioral health into primary care? So, what you can see here is about half of all individuals receiving primary care present with psychiatric comorbidities. 50% of people walking through the door. 60% of all mental health conditions are treated in primary care. 75% of all psychotropic medications are written by primary care providers. When you think about it, it's really a happening place for mental health. So, what’s that about? There’s a lot of ways to understand that. Some of the big issues are barriers to accessing specialty mental health services. We talk here about cost of care, stigma, not enough providers, waiting list or poor service fit. And this is important. What I mean by poor service fit is, people just don't feel like specialty mental health, going to therapy or seeing a psychiatrist feels right for them. So here is what we know. We know that only about one in four people, when their primary care provider tells them go see a therapist. About 25% of folks actually make it to the first appointment. That’s a lot of people. 75% of folks are not going. So for this reason, we need to have a mental health system that meets people wherever they present the care. No wrong door approaches.

So, I think another way to look at why primary care providers encounter such high rates of mental health concerns relates to the high percentage of Americans with complex physical health conditions. Okay so I just want to let that sink in for a minute. Chronic medical conditions are the number one health problem in America. 45% of adults have at least one chronic condition. And most chronic conditions – or I should say a lot of them, come a long with mental health challenges even if it's adjusting to new a way of life they have to live if you want to be healthy. About 25% of diabetics suffer from depression, and when we step back and we look at that we see that not only can having depression worsen your health outcomes when you have diabetes, but it can add as much as 50% to the cost of care. So, we look at primary care as a natural one-stop shop and whole health can be addressed there for many people primary care is the right size intervention. We talked about that fit, it's a good fit. When you go to primary care what you're going to find is the focus is going to be on improving your functioning just like your physical health, it’s going to be like on improving your functioning, you're not going to do that the deep dive into what made you sick to begin with. For a lot of people who are not ready or are not even interested in taking a historical look at their mental health problems, they just want to feel better. This is a nice beginning step. It’s not too intimidating and it feels pretty manageable. But for many people, this is an entrée into mental health services that otherwise they may never have.

So, let's talk a little bit about behavioral health screening in primary care. And I want to say while I told you about all the ways in which primary care is a great place to integrate mental health, it's not without its problems. So right now, about 25 to 50% of depression is not recognized by primary care providers. You guys said about 60% of you have

been asked about depression and that's a really good step in the right direction. My guess is had we done that poll 10 years ago it would have been far fewer so we're headed in the right direction which is great because as we see here it's a big problem, 13 to 16% of adults are going to experience depression in their lifetime and 4 to 8% experience major depression in a given year. It's important that primary care providers have a way to ask because we cannot just count on people to say they are depressed. Again, we have stigma that factors into that but also if you are feeling physically poor, you may not recognize depression as an independent concern. You may feel like this is part of my overall health condition. I guess another way that folks might approach this is saying does the person look like they are struggling? And then I will ask. But we also know a lot of people are really good at faking it essentially. You know suffering in silence and not really disclosing how they are functioning. So, you can really look a lot better than you feel. Historically primary care providers haven't received a lot of training in this area, and so basically in 2002 that's when routine screening was recommended, since about that time, here we are almost about 20 years into that and generally I also want to say that that training, that screening protocol is covered by insurance. So, you know, so we have the recommendation and the support from insurance companies and it's really something that can be and should be done.

So, over these last 20 years there is a lot of screening tools that have been developed and I want to look at the most common ones which is the Patient Health Questionnaire Nine, or the PHQ Nine. And that is a nine-item depression scale. It happens to be one of the most validated tools in mental health. And keep in mind here it's a screening tool, it is not a diagnostic instrument. But it is a powerful tool to assist medical clinicians diagnosing depression and monitoring treatment response, so it can be used for both. Screening and monitoring. The nine items are based on the DSM, the diagnostic and statistical manual, and it has several advantages as a tool. It is short, it can be administered by someone without a lot of training, it might be a medical clinician, a medical assistant, it can be administered by telephone and it can be self-administered. It accesses symptom severity and functional impairment so it doesn't just say how many of these things are you experiencing but at the end, it has 10 questions that says now looking back and all these things how much is this impacting your functioning. The other areas where we see a lot of screening going on is we see postpartum depression screening, which is vital because that can really impact -- screening during pregnancy can really impact your postpartum experience. Postpartum depression as we know is very significant. Anxiety which might even in some communities be more prevalent than depression. Trauma which we know is huge because trauma is very tied to your medical condition. And substance use. Another area where people don't often come right out and say this is a problem but if asked, they will talk about that.

So, let me also say that as great as it is that 60% of you have been screened. The place where we are still working on getting uptake is on what we call finding. You can screen and then what does the provider do when they find right? So, screening protocols are relatively simple to develop and implement. And where things get a little bit harder is when they find someone who is depressed. It's not enough just to screen and

refer because as we have already established people don’t go. We have to work to develop that one-stop shop. Along the same lines during these last 25 years models of team care have started to show up. You will see that a lot in federally qualified health centers, you will see it a lot in armed services, places where they are treating folks in the armed services and you are starting little by little to see it in private medical offices. What happens is that the behavioral health professional is put onto the team and they become part of that care. They are working together side-by-side with the primary care provider. Some of the models that you might have heard about would be collaborative care which used to be called impact and primary care behavioral health which is sometimes called the BHC model for behavioral health consultation. Mental health in primary care looks very different from mental health in a psychotherapy office. It's primary care mental health. It's a different level of care. The mental health professional working with the team included on that team and the person receiving care you are trying to identify that person's most significant concern, so the care is person centered, and then most important here is that you are working off of one treatment plan and one chart, where everything is documented in one place and whole healthcare can really be provided. The other thing that might be different for most folks is that the care you get from a mental health provider is not always going to take place in an office like a therapy office. It's often going to take place in the exam room and chances are that this is going to be brief, a lot like primary care, maybe a little bit longer, a 20 to 30-minute visit but it’s going to be considerably shorter than when you go see a therapist. The other difference is that in primary health care you're going to see a lot more focus on health behavior change, so not just your emotional change but also changes in issues like helping you stop smoking, helping you with diet, helping you with exercise. Always you can improve your wellness.

Oaky, so I want to talk now a little bit about how the screening and monitoring together with mental health recovery. This is a great contribution. This is one of the biggest reasons that we love having behavioral health on the team because this is a chance for behavioral health providers to talk to primary care about recovery principles which really works in behavioral health. Let's look at person centered care. This is really important to tap into what is meaningful to you. What do you care about, what is going to be what steers you towards your wellness? Whole person care. Our colleague Pat Deegan will always say people don’t get treatment in the same way that a car gets tuned up. We want to really think about how is this right for this person because that is going to really motivate you to care and take action. Working together towards meaningful goals and identifying them because you need that to pursue managing a long-term condition. And just to finish up with these recovery oriented principles, trauma as identified as something that impacts health and mental health. We know a lot of out psychosocial trauma and this is something we need to really let providers know about, primary care providers know about. Shared decision-making. We are seeing uptake in this, we now have a center for shared decision-making at Dartmouth as well as in the Mayo Clinic so people are getting the idea that in order to make care work, they need to have the voice of the person who is receiving the care. So, the common thread is that in both cases here and with what Tracy described is individuals are supported in

becoming effective self-advocates. They are encouraged to speak up and providers are being trained on how to listen, how to share power, how to share responsibility with the person that they are treating. So we are hoping that by embedding these recovery principles into primary care, and of course into mental health, we begin to see that we can support people in making informed choices about what they want, think about what they want, what they want their outcomes to look like, how do you know if you feel better and what is a healthy and satisfying life look like. How do you move out of being held hostage by any kind of chronic condition be it physical or mental health?

Okay and Melody, I am going to turn it back to you.

Melody Riefer: Thank you so much Suzanne. I have to admit that I have a personal reason for caring about this because you mentioned specifically for instance that people with diabetes experience depression at a higher rate than the general population and I have a couple of chronic illnesses including diabetes that affects my wellness and so the difficulty of managing several types of physical conditions as well as the mental health diagnosis can really get complicated. So, this information is really both professional and personal. Thank you so much for bringing this to us. We do have some excellent questions that have come through. I would invite Suzanne, you, or Tracy to respond to the questions and we will try to get through several, even though we have some limited time. So let's dive in. One question that was asked is what was the patient activation assessment tool used during your study?

Suzanne Daub: Tracy do you want to take that?

Tracy Carney: I guess I don't quite understand the question.

Melody Riefer: Sure, you all mentioned an assessment tool that measured patient activation and the question was there I think the question was there a specific tool like something that has been validated or did you create the measure or how did you look at that?

Tracy Carney: Yes. The measure was created and we looked at certainly looked at individual claims data from folks as to how much they were accessing services and reuse the wellness tools that we did pick, and we did a lot of interviewing with the people that were participating in the study.

Melody Riefer: Okay. So, it wasn't a specific tool but rather a body of measurement that pointed to patient activation.

Tracy Carney: Yes. Correct.

Melody Riefer: Okay great. Great thank you.

And other question that was asked by a couple of people in different ways. Do people have a choice in participating in integrated health

services, and do they have a choice in who serves as their health navigator?

Tracy Carney: Melody this is Tracy. Can I backup for a minute? I apologize.

Melody Riefer: Sure.

Tracy Carney: We use the PAM, the Patient Activation Members. The patient activation measure we used was called the PAM, that's what we used in the study.

Melody Riefer: Oh okay.

Tracy Carney: That's for the question before.

Melody Riefer: And PAM is more universally accessible, and your research people did not create it in house?

Tracy Carney: Correct yes. Sorry about that.

Melody Riefer: No problem. It can be tricky answering questions on the fly.

Tracy Carney: I was going to say I am not the researcher in this thing so I am still learning and I came from this on how are we are asking the people the questions and don't have a lot of research knowledge.

Melody Riefer: And I will point our audience to the Participant Chat Pod where Laurie Curtis, my colleague on the spot, always is able to grab a quick reference and a link so she has put up a link to the PAM survey if anybody wants to look at that specifically. We will be our own team. And model integrated health approach by being a team. The next question was do folks have a choice participating in integrated health services and do they have a choice in who serves as their health navigator?

Tracy Carney: The answer to that is yes. In the sense of -- Suzanne, do you want me to take this?

Suzanne Daub: Go right ahead, it would have been my same answer.

Tracy Carney: When we use wellness coaching, we invite people into a process. The goal is not to force people into treatment they don't want. If they are satisfied with their physical health care and they feel they are on top of it, they don't have to work with a health navigator, so it is totally a program of choice. Again, it's a nice service.

Melody Riefer: Okay great. You all reference a couple of tools that you used in your study that were tied into the managed care part of the services. The question was do you know of any broadly available tools

that can be used for programs that may not have access to electronic records or to the tools that you use?

Suzanne Daub: First of all, let me say that I'm happy to tell you all that we will have are tools posted to a website hopefully by early fall. We are doing some revisions. The tools we talked about the health assessment, they will all be available and folks will be able to use those.

Melody Riefer: That's fantastic.

Suzanne Daub: Hopefully that will be on CBH.ORG and hopefully that answers the question.

Melody Riefer: Here is a question that I think really begins to approach some of the recovery principles that are foundational in the work that you all have done. How can we combat the false beliefs or myths some medical people hold about people with a mental health diagnosis or addiction issues? And I think this goes to some of the history of perhaps going to see your doctor and having your physical symptoms discounted because you have a mental health diagnosis.

Suzanna Daub: That's such a good question and I think it's even more pronounced for people with substance use disorders. So, I think this is very important and I think it's a place where people complain a lot so my sense is that, you know, we have the long way to go here. I think a very good way to speak with primary care providers about this kind of thing is kind of non-defensively, sort of neutrally. Just sort of giving them information so it might be hey, did you know that 68% of folks with psychiatric illness have comorbidities? Or hey did you know that 50% of the people that come to primary care are experiencing some kind of mental health problem? So, if you're just kind of giving them some facts and letting them sit with that and it begins to say I'm not unusual. In fact, half the people that walk in the door, maybe struggling the way I am. This may be something to pay attention to. And I think these kinds of small factual hey, did you know kind of comments begin to help them through the thinking of their own. That would be an approach I might suggest. Tracy do you have any ideas?

Tracy Carney: Yeah, one of the other things that I think is really helpful and I really do believe this is where the health navigator can be part of that. Certainly, having whether it's a peer specialist or a case manager but somebody to help you be able to prepare for a doctor visit to communicate clearly what you want to say to the doctor. I would love to say there is no stigma in physical health and that, you know, there is just stigma that is something we have to deal with. And again by having a mental health navigator you can really prepare well for an appointment to be able to clearly state what it is you want to say to the doctor and again sometimes it's your own voice is listened to. Other times you may need a little support around that. I think that's one of the benefits of having wellness coaching, having somebody support you through that process.

Melody Riefer: So, as a follow-up related to that is the health navigator able to go to an appointment with someone? Say if their prescriber is not on board with the integrated health services?

Tracy Carney: Yes, the answer to that is yes. They can go.

Melody Riefer: Okay. And the decision for that would be based on the person's wishes?

Tracy Carney: The person would ask for that help. Yes, that support. We don't ever tell people what to do but if somebody felt like a provider was not listening to them and they're really having pain and they're also somebody that is struggling with another area, they can ask that somebody can go with them to kind of to support them and help them to have their voice in that treatment setting.

Melody Riefer: It's really a very comprehensive approach to support. Thank you.

I hate that we are out of time but I need to share a couple of details with people as we prepare to wrap up. I wanted to remind everybody that recovery to practice really is about moving recovery into practice. It's not just theoretical. We want to make sure that throughout all of the services that people get, wherever they get those services, that home health community and purpose drives the focus and the person-centered care and people having their wishes respected are foundational to the work that we do. Recovery to practice as an initiative is supported by SAMHSA and they provide the time and the resources to be able to bring in experts and provide these webinars free of charge and we are really glad to have all of you participating. In addition to these webinars, we have a quarterly newsletter that you can get and we would invite you to sign up for this newsletter you just have to go to the website called the link is on the screen. And I also want to remind you that the next webinar in this series will be taking place on Wednesday, July 12, 1:00 Eastern time. If you don't live in the Eastern time zone, please adapt that time for your schedule. We want you to be here for all of the webinar. Recovery to Practice was really born out of a discipline-based curriculum that was developed by the various disciplines involved in mental health care. So, social worker, psychiatrist, psychologist, addiction professionals, nurses all have curricula on the RTP website so we would invite you to look at and find the best pieces of that and incorporated into your work.

The project also has a project that offers free on-demand courses approved for continuing medical education credits. If you are a psychiatrist or someone who needs CMEs, please follow the link on the slide and you can get all these links by downloading the presentation by the way. Also, we want you to have access to lots of information so we have five resources that you can review in five-minutes to see if the topic is of interest to you. Check out these titles and click on the

links and see what you can learn and how you can apply it in your work with other people.

As we wrap up, I want to be sure and remind you to register for the upcoming webinars to sign up for the newsletter, to check out the Recovery to Practice website for all of the previous webinars as they are archived there, and I want to remind you that you can get credits for attending these webinars that apply to a number of professional associations as well as the Psychiatric Rehabilitation Association and for many of the peer specialist continued education. And if you just need a certificate, you can get that from the download materials pod right now or if you need the continuing education hours, follow the link, complete a brief quiz, and the certificate is yours to grab when you complete your quiz. Be sure to right-click on the screen that has your certificate and grab it as a screen image because there is a bug in the system and we want to make sure you can print it. Right-click on the certificate and save it as a PDF and this is a copy that you can keep and submit to prove that you did this work. Any questions, give us a call. Or email us and know that we will be committed to continuing to bring you great information and resources to help inform your practice withh folks. You all have a great day and this concludes our webinar.

[Event concluded] >>