ALLIANCE for HEALTH EQUITY

Hospitals and Communities Improving Health Across Chicago and Cook County

Healthcare and Community Collaboration to Improve Mental Health: Early learnings from the work of the Alliance for Health Equity in Chicago and Cook County

January 16, 2018

Jess Lynch, Illinois Public Health Institute

Welcome and Introductions

ALLIANCE for HEALTH EQUITY

Hospitals and Communities Improving Health Across Chicago and Cook County

Merger of: Health Impact Collaborative of Cook County + Healthy Chicago Hospital Collaborative

Health Impact Collaborative of Cook County

HEALTHY CHICAGO HOSPITAL COLLABORATIVE

Illinois Public Health Institute (IPHI) is the backbone organization

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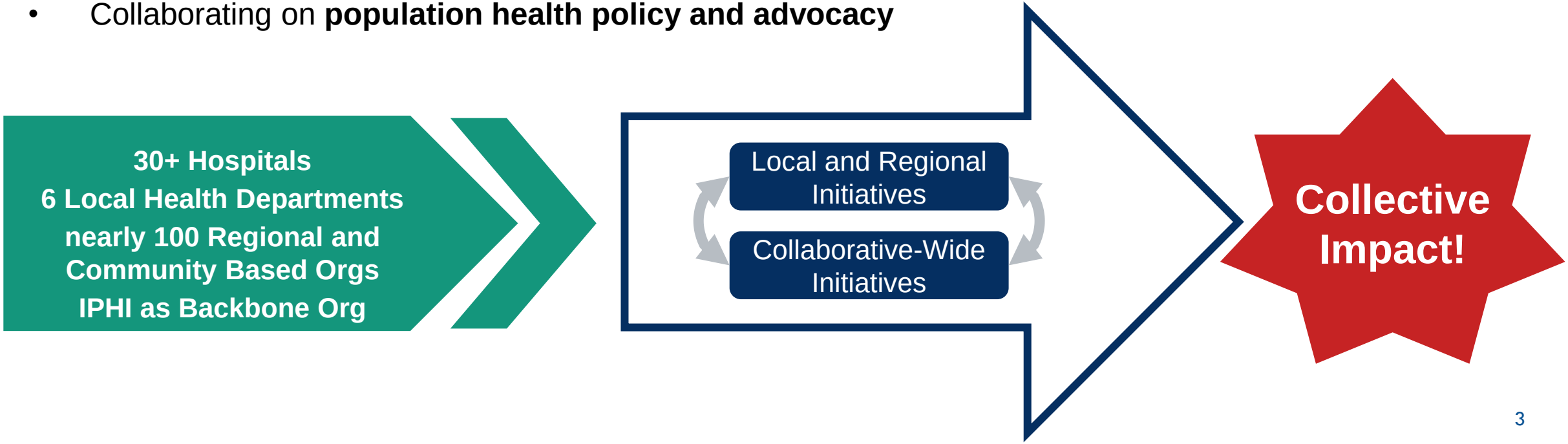
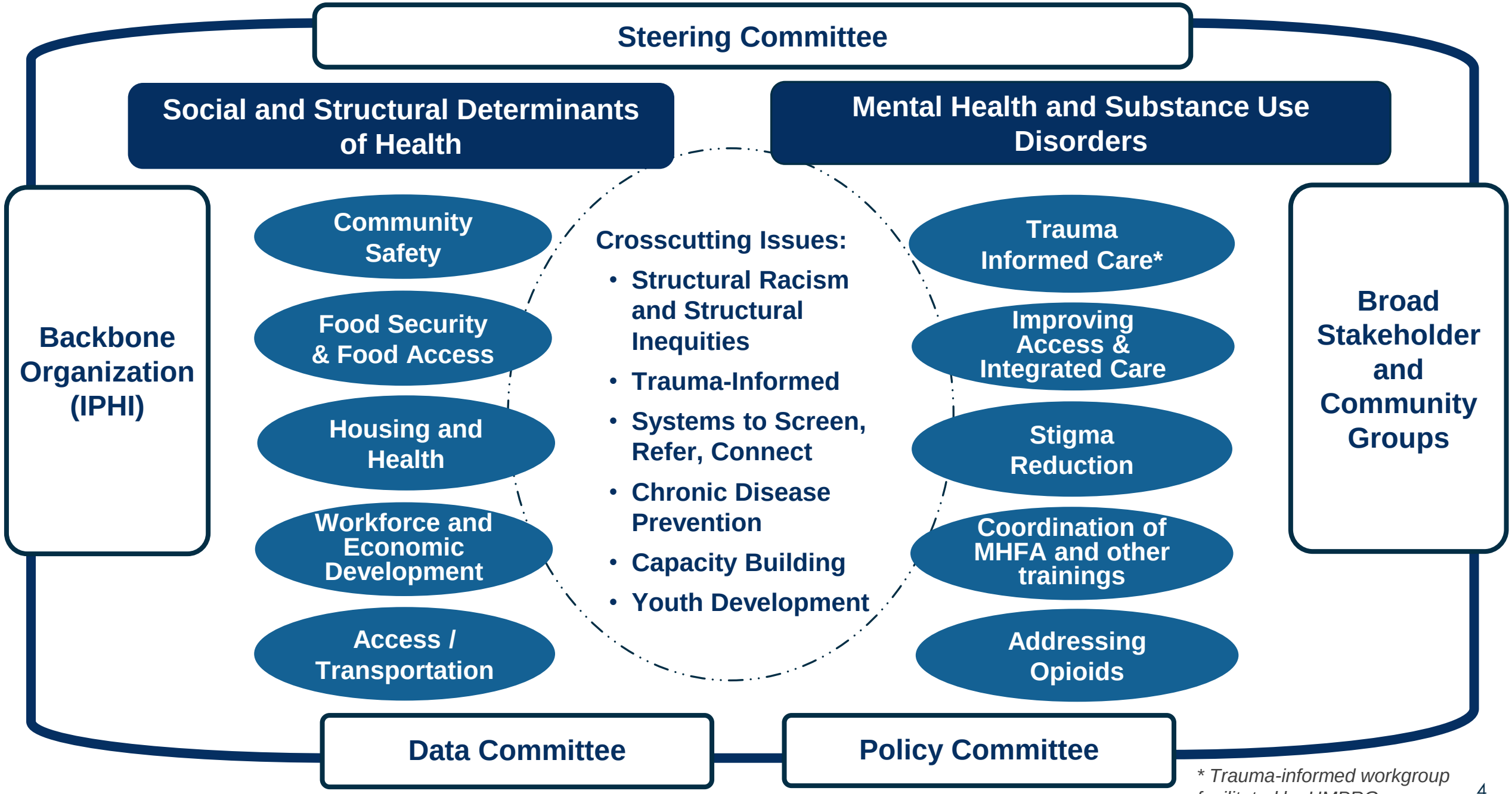
Collective Purpose

ALLIANCE for HEALTH EQUITY
Hospitals and Communities Improving Health Across Chicago and Cook County

Improve population and community health by:

- Advancing **health equity**
- **Capacity building, shared learning, and connecting** local initiatives
- Addressing **social and structural determinants of health**
- Developing broad city/county wide initiatives and **creating systems**
- Engaging **community partners** and working collaboratively with community leaders
- Developing **data** systems for population health to support shared impact measurement and community assessment
- Collaborating on **population health policy and advocacy**





** Trauma-informed workgroup facilitated by HMPRG*

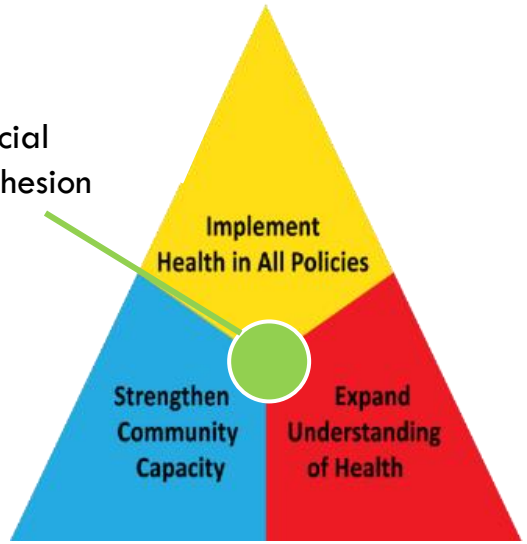
Current Hospital Members (and several others in discussions)

Examples of Additional Partners

Key Frameworks for Health Equity

HEALTHY CHICAGO 2.0

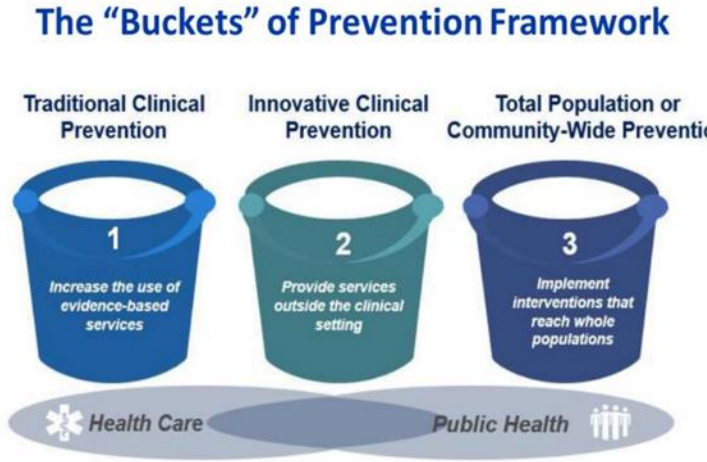
Cook County Public Health
Promoting health. Preventing disease. *Protecting you.*

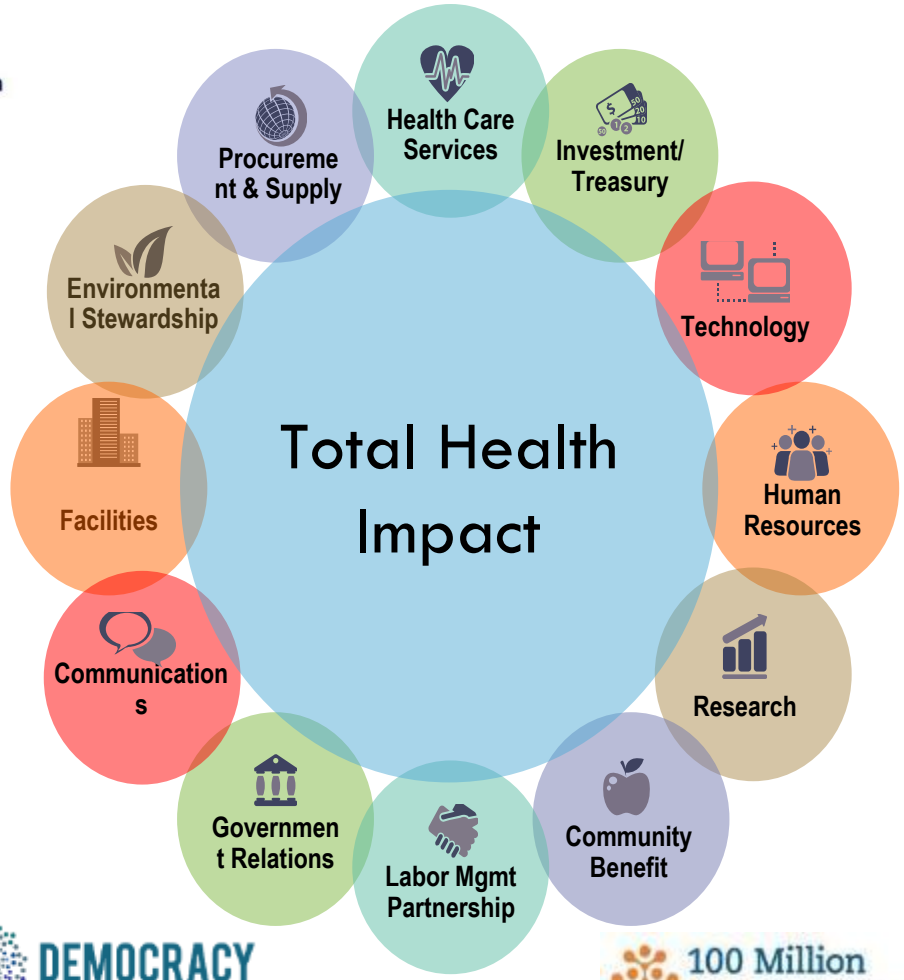


"Triple Aim for Health Equity", ASTHO & Minnesota Department of Public Health

Institute for Healthcare Improvement

5-component framework for health equity





DEMOCRACY COLLABORATIVE

KAISER PERMANENTE
Center for Total Health

100 Million Healthier Lives

Engage | Catalyze | Discover | Invest | Advocate

8

Collaborative Assessment

2015-2016

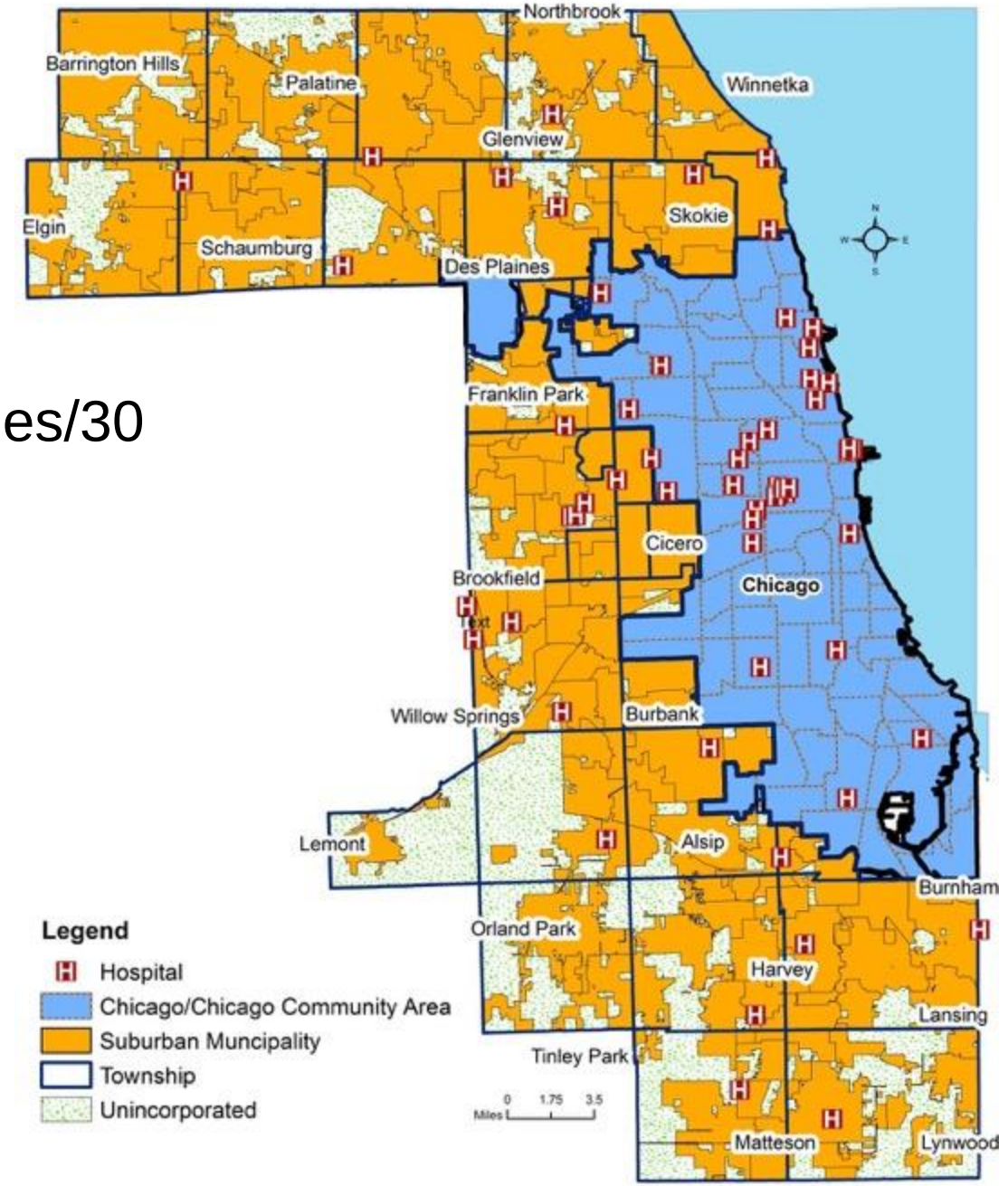
Setting: Chicago & Cook County

- Population: 5.24 million residents

- City of Chicago: 77 community areas
- Cook County Suburbs: 130 municipalities/30 townships

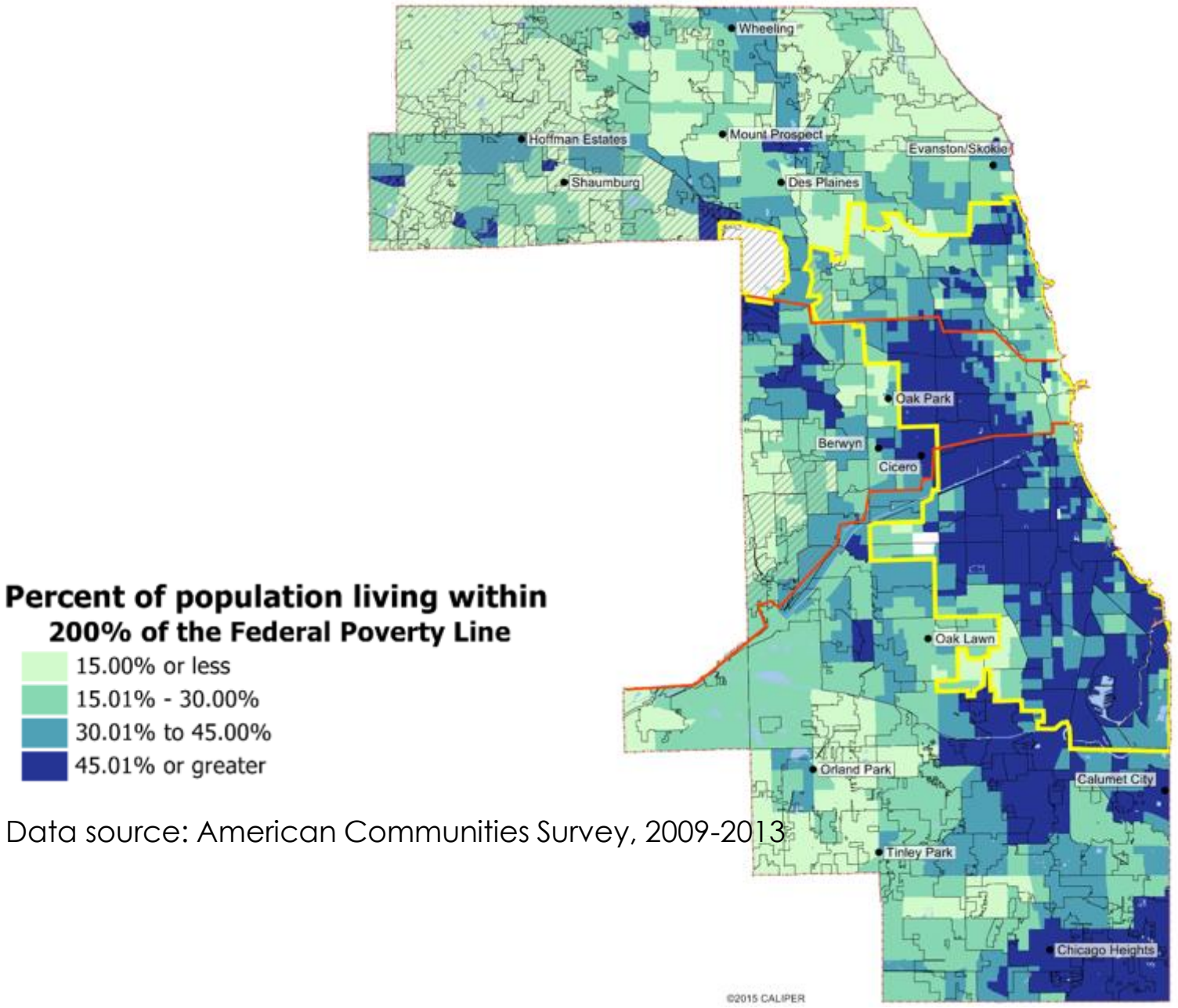
- 6 certified local health departments

- 40+ hospitals



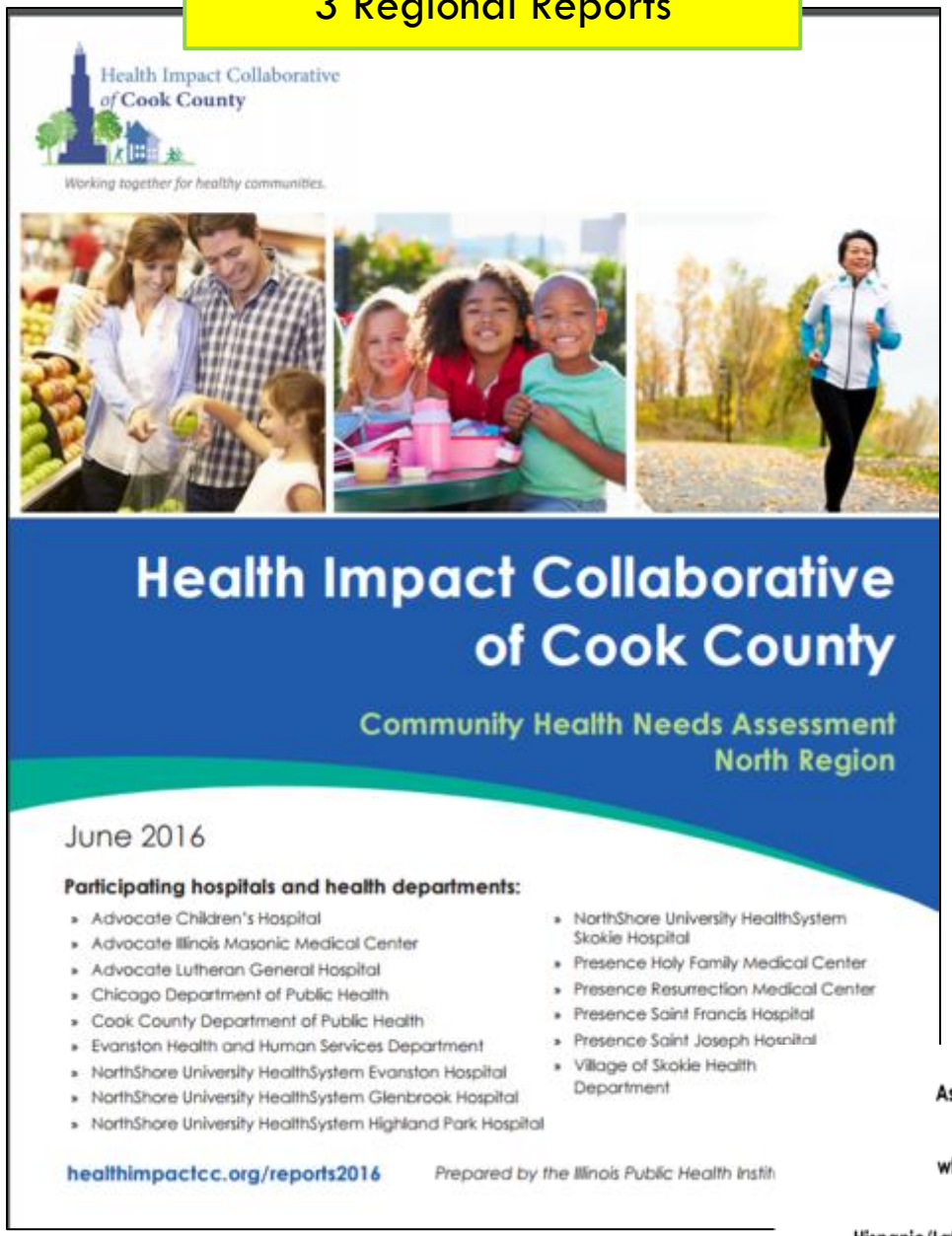
Source: Cook County Department of Public Health

Substantial Economic Inequities

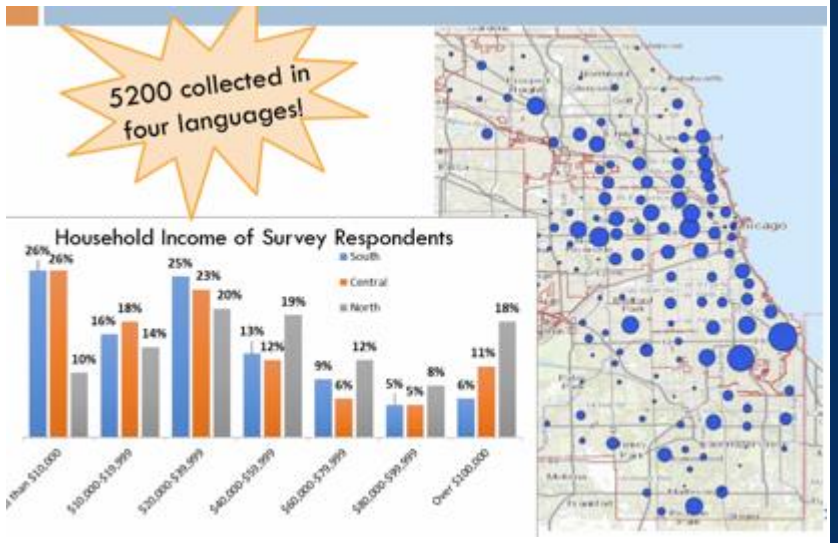


Data source: American Communities Survey, 2009-2013

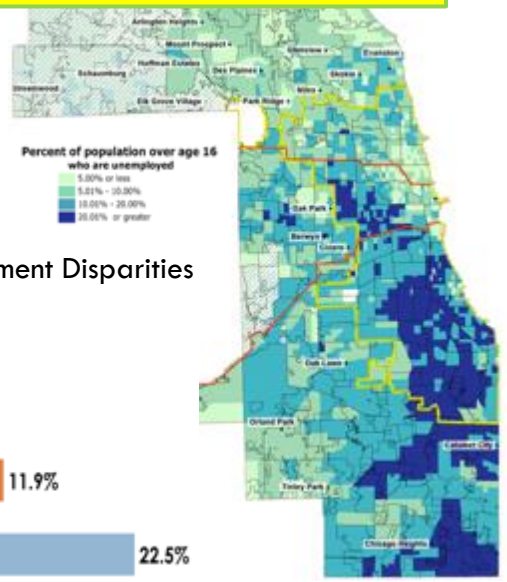
3 Regional Reports



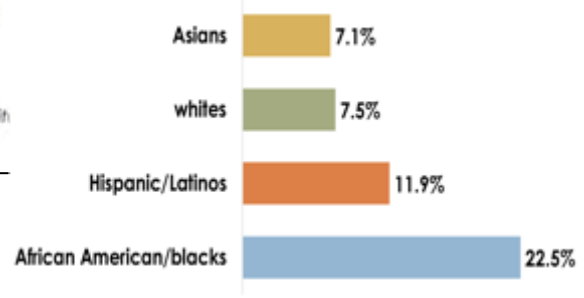
Extensive Community Input



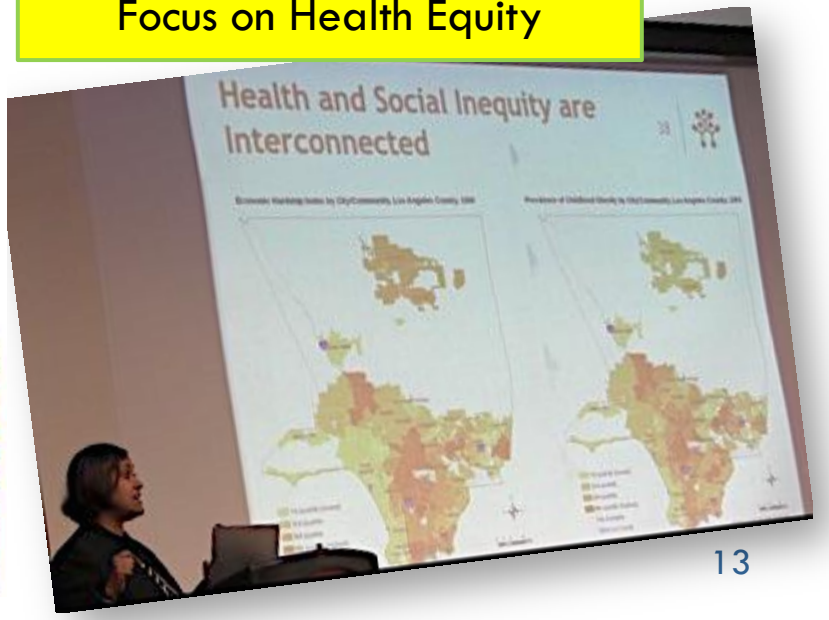
Data Analysis across Chicago and Suburban Cook County



Unemployment Disparities

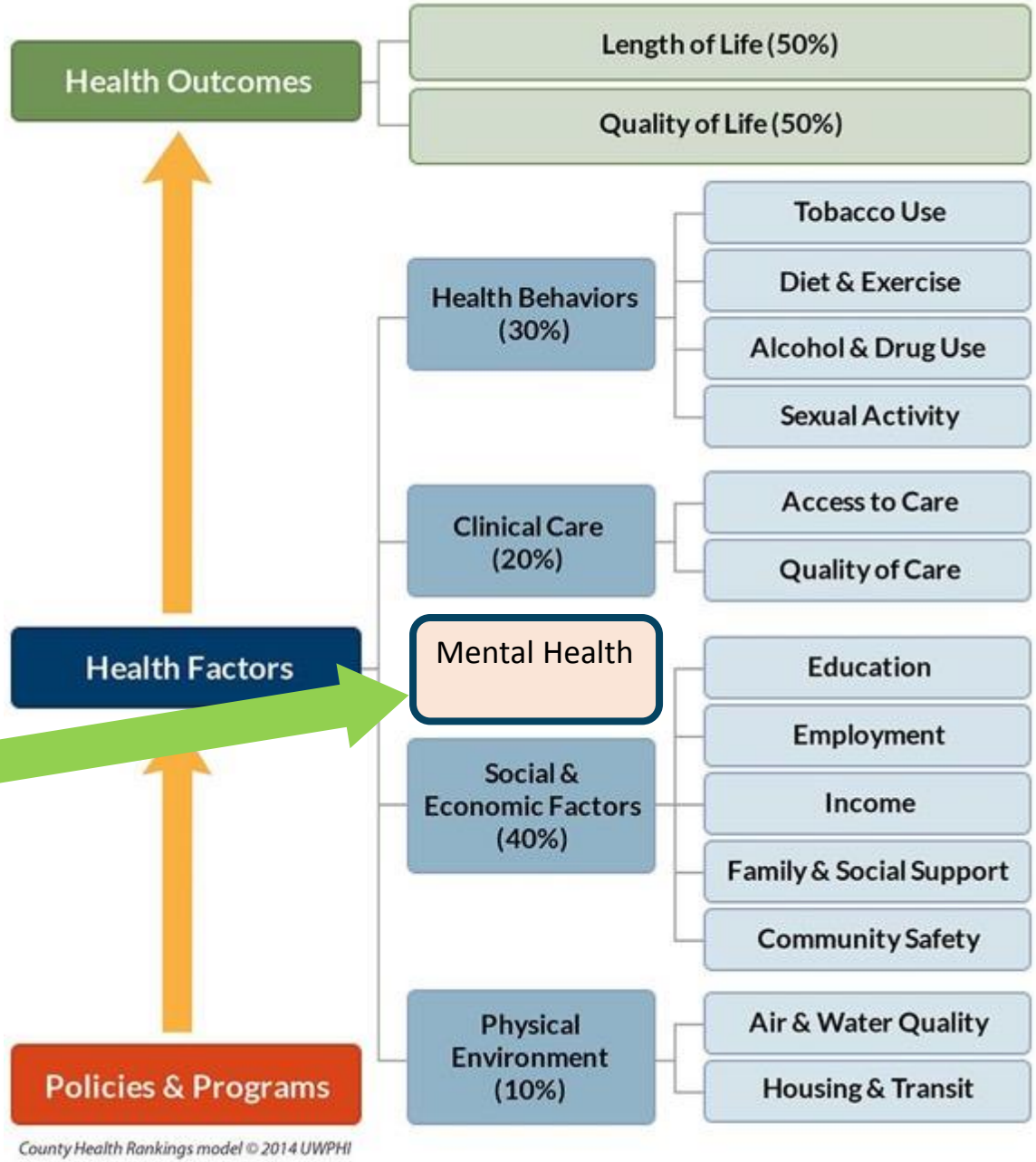


Focus on Health Equity



COUNTY HEALTH RANKINGS MODEL AS FRAMEWORK FOR ASSESSMENT INDICATORS

Inclusion of Behavioral Health Indicators



HEALTHY CHICAGO 2.0 SUPPORTER

Cook County Dept. of Public Health
Promoting health. Preventing disease. Protecting you.

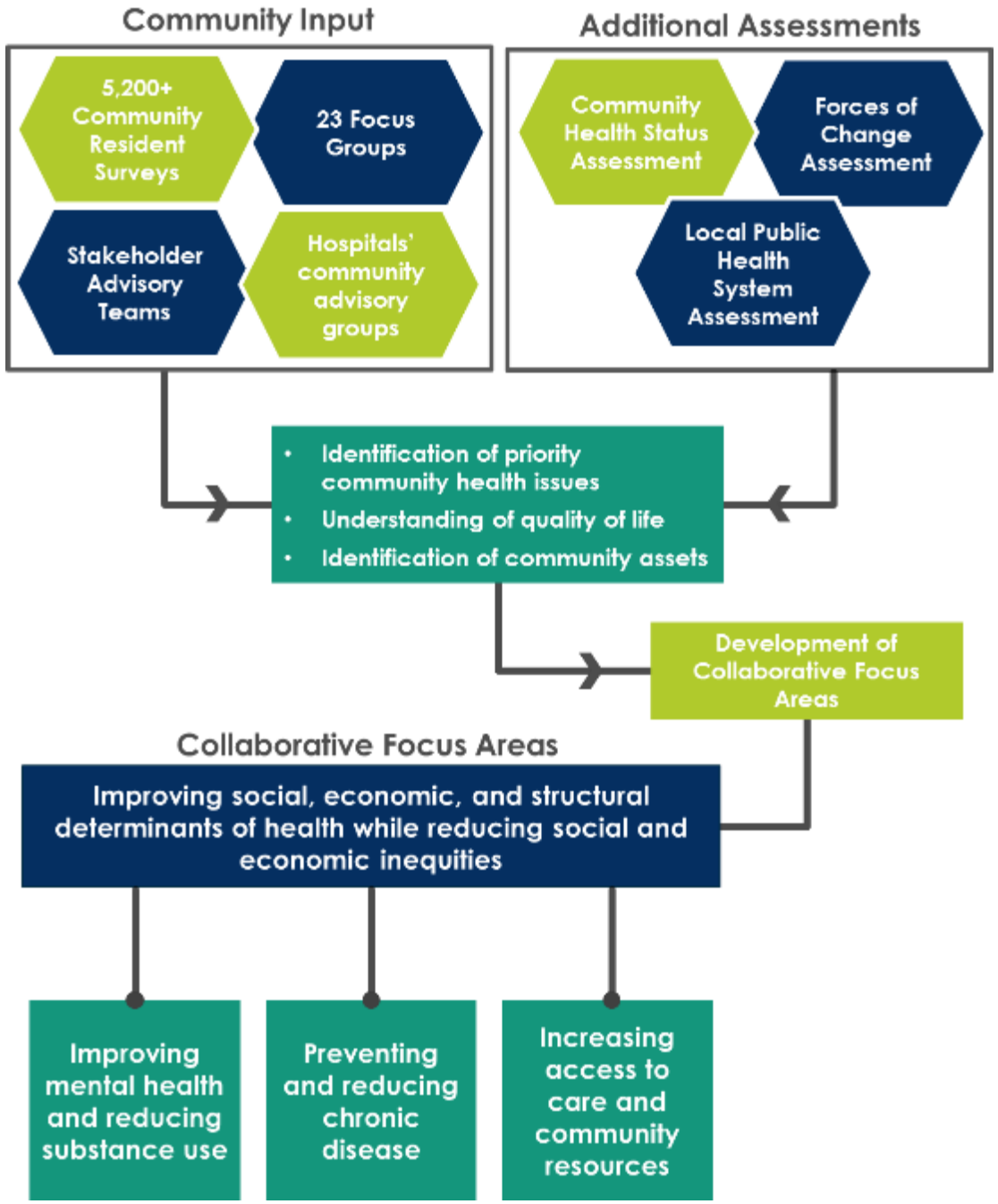
Health Impact Collaborative of Cook County

Working together for healthy communities.

We used the MAPP model to conduct CHNAs within Cook County, incorporating data from Healthy Chicago 2.0 and WePLAN

Community Input

- 5,000+ Community Residents Surveys
- 23 Focus Groups
- Stakeholder Advisory Teams
- Hospital's Community Advisory Groups
- Action Teams



Overview of Focus Group Findings for CHNA

Major Community Health Factors Identified by Focus Group Participants

Priority Populations that Focus Group Participants Identified

- Caregivers
- Children and adolescents
- Homeless individuals or families
- Immigrants
- Incarcerated or formerly incarcerated
- Individuals living with mental illness
- Individuals with intellectual disabilities
- Individuals with physical disabilities
- Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Asexual individuals (LGBTQIA)
- Low-income communities
- Marginalized racial and ethnic groups
- Older adults
- Single parents
- Veterans
- Women

Health Impact Collaborative of Cook County

Working together for healthy communities.

2015-2016 Collaborative CHNA Priorities

Focus Areas and Key Community Health Needs

Improving social, economic, and structural determinants of health while reducing social and economic inequities.

- Economic inequities and poverty
- Education inequities
- Healthy environment
- Housing and transportation
- Safety and violence
- Structural racism

Improving mental health & reducing substance use disorders.

- Overall access to services and funding
- Integrative care
- Mental Health First Aid and addressing stigma
- Violence and trauma, and ties to mental health

Preventing and reducing chronic disease.

- Focus on risk factors - nutrition, physical activity, and tobacco
- Healthy environment

Increasing access to care & community resources.

- Cultural & linguistic competency/ humility
- Health literacy
- Access to healthcare and social services, and navigating the system, particularly for uninsured and underinsured
- Linkages between healthcare providers and community-based organizations for prevention

Note: Policy and data strategies are cross-cutting across all four focus areas.

Mental Health and Substance Use Disorders

- Peer Support Services
- Mental Health First Aid (MHFA)
- Anti-Stigma Initiatives
- Housing
- Addressing Opioids
- Integrated Care

Planning and Implementation Vision

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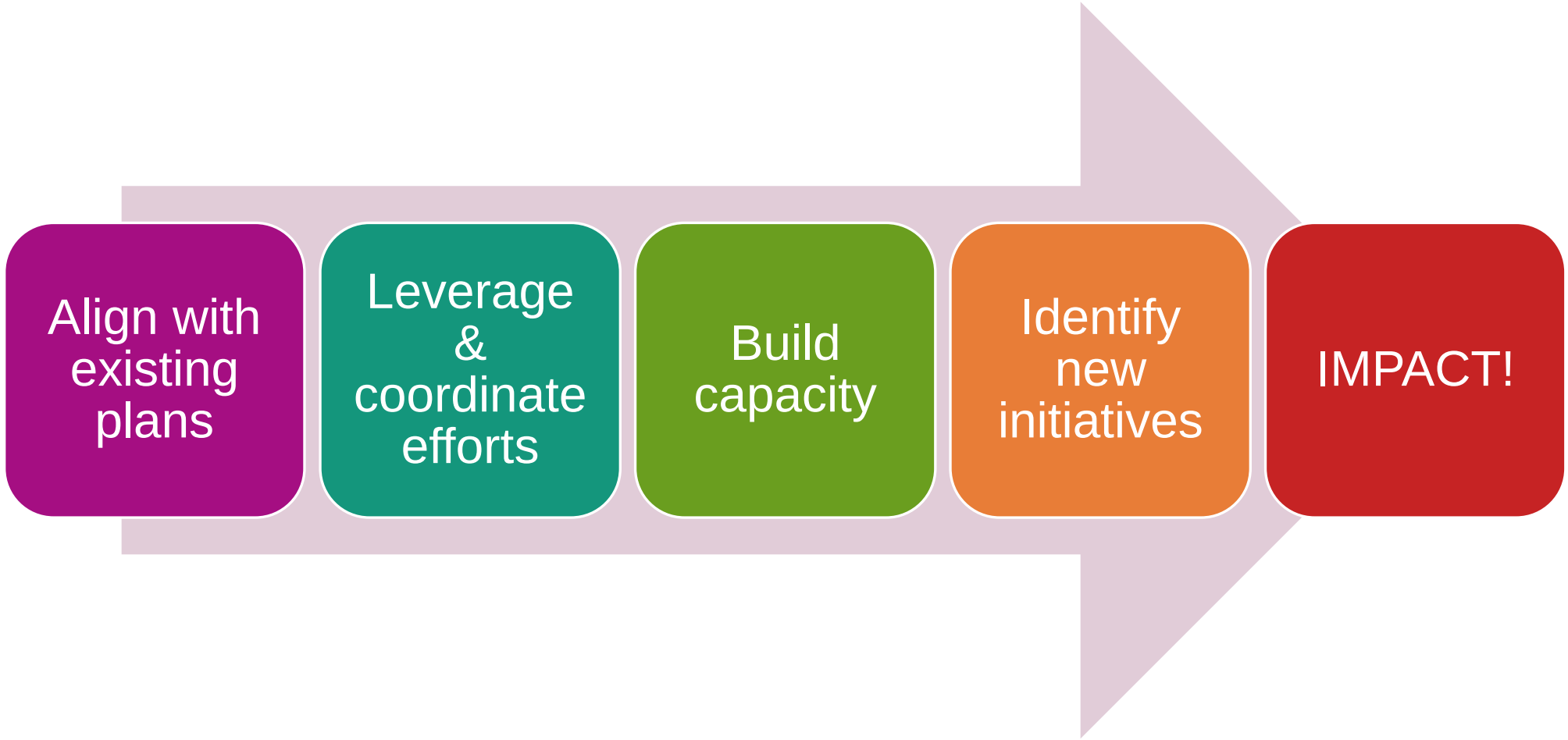

Anti-Stigma Initiatives

Review of Stigma Reduction Strategies

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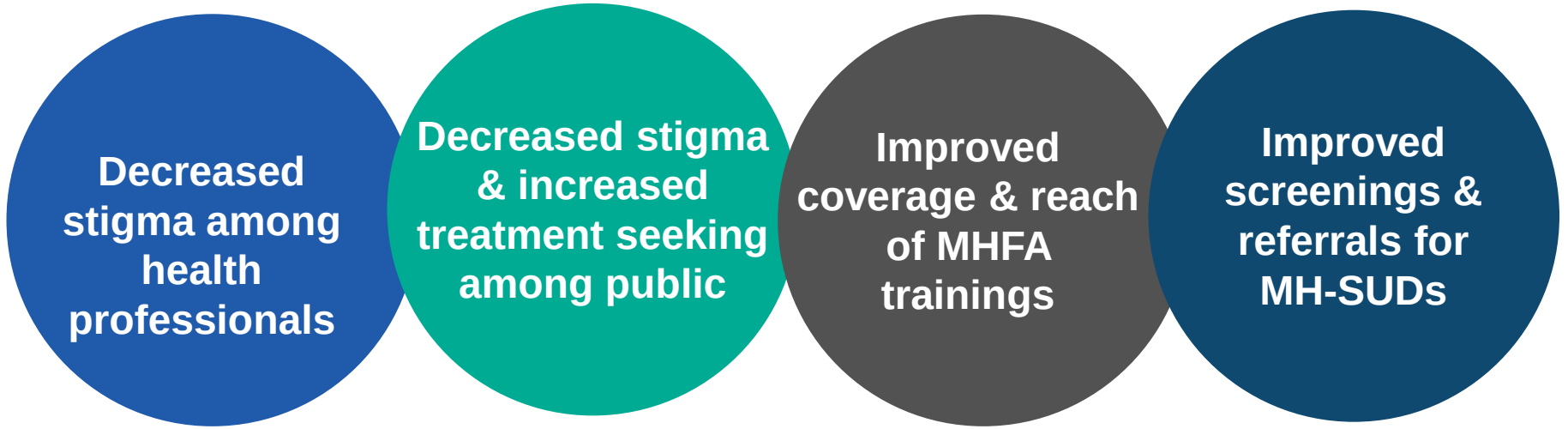
The Action Team has developed a multi-pronged approach to stigma reduction that includes contact, education, public awareness, empowerment, and provider focused strategies.

Goals and Activities



- Development of CEUs in Ethics and Cultural Competency
- Expand peer support services
- Align with trauma-informed work

- Create framework for multi-pronged stigma initiative
- Implement models for faith community and healthcare partnerships for mental health
- “Know Your Rights” Campaign

- Facilitate improved coordination between MHFA providers
- Develop processes to track impact of MHFA over time
- Align with efforts to catalog health resources

- Align with efforts to catalog health resources
- Support efforts to create integrated data systems
- Develop aligned policy agendas

Multi-pronged approaches to reduce stigma

Previous research has shown the effectiveness of multi-pronged approaches to reducing stigma

Examples of Different Strategies for Stigma Reduction

Contact-Based Strategies
- Peer Navigators, Peer Support Specialists, etc.
- Personal testimony and interaction with individuals who have lived experience
- Art exhibits

Education-Based Strategies
- Workshops for youth
- School-based programs for young children
- Workplace programs

Public Awareness Strategies
- Public events with speeches by officials, religious leaders, and teachers
- Special endorsement days by sports teams
- Engagement of trusted community leaders

Empowerment Focused Strategies
- Employment programs
- Consumer-focused grants, such as scholarships
- Community organizing
- Political advocacy

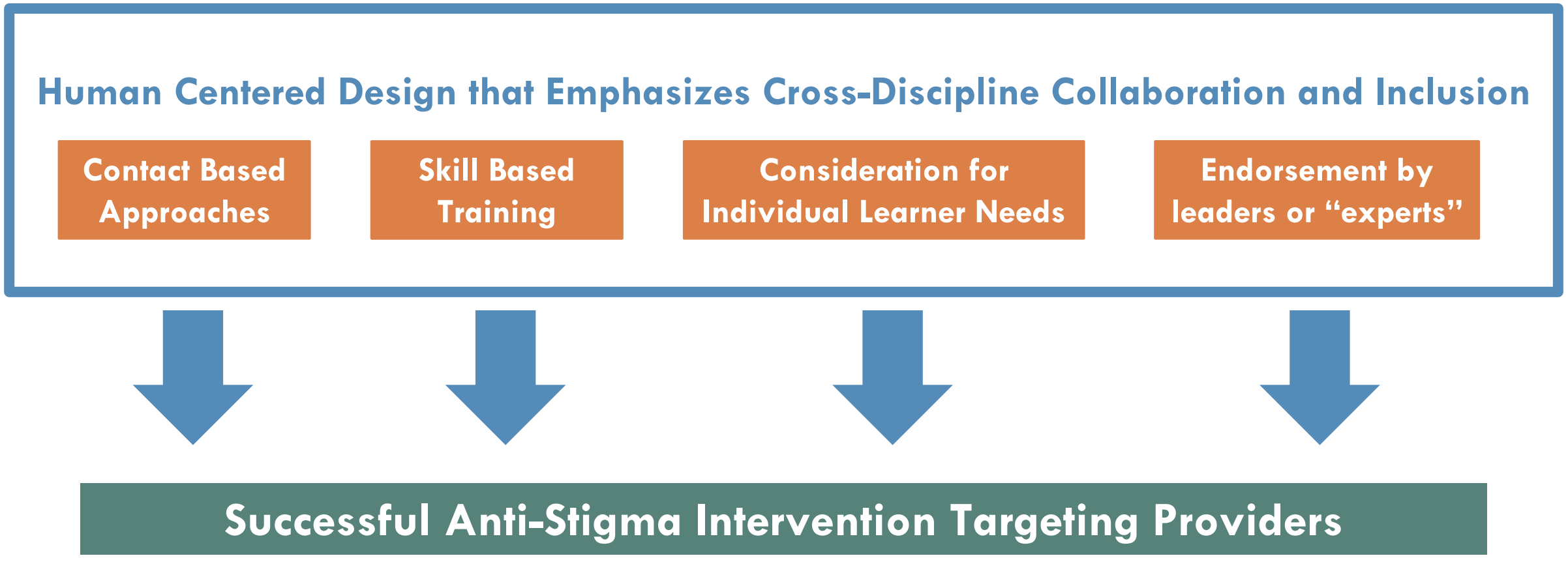
Clinical/Provider Focused Strategies
- Provider education programs
- Peer Navigators, Certified Recovery Support Specialists
- Free medical consultations
- Workplace programs

Reference: Martin, N. and Johnston, V. (2007) A Time for Action: Tackling stigma and discrimination. Report to the Mental Health Commission of Canada. http://www.multiculturalmentalhealth.ca/wp-content/uploads/2013/10/Stigma_TimeforAction_MHCommission.pdf

Addressing Stigma with Providers

- We decided to start with continuing education for LCSWs because of approaching re-certification deadline, and we are also providing CEUs for LCPCs

Framework for Developing Interventions to Combat Stigma in Providers



Reference: Ungar, T., Knaak, S., & Szeto, A. (2016). Theoretical and Practical Considerations for Combating Mental Illness Stigma in Health Care. Community Mental Health Journal, 52, 262-271. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4805707/

Stigma and Hope CEU Program

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The Alliance for Health Equity in **partnership with Advocate Christ Medical Center, Maryville Academy, and the Center for Community Health Equity** provided two CEU programs in November 2017 for **behavioral health professionals**

Session 1: **November 10, 2017**
Session 2: **November 17, 2017**

Session 1: **Advocate Christ Medical Center**
Session 2: **Rush University Medical Center**

CEU credits for both sessions were provided by **Maryville Academy**

Presenters were **Dr. Madeline Ofina** (Staff Psychologist for the VA) and **Ali Poole** (Trainer for Thresholds, with past experience as a peer support specialist)

93 behavioral health professionals total attended the sessions

84 session attendees completed evaluations

During the sessions, participants learned to:

- ✓ Define behavioral health stigma
- ✓ Identify how stigma occurs in their clinics/units/facilities
- ✓ Identify stigma in their work settings
- ✓ Address stigma through a behavioral health recovery approach

Stigma and Hope CEU Program

What Went Well

- Participants appeared to be engaged in the session and thought it was relevant to their work
- Many participants shared the specific ways that they were going to use the information in their work
    - Some of the supervisor-level providers indicated that they planned to make systems-level changes to their organizations
- Participants appreciated the perspective of a consumer that was also a provider and highly recommended that this contact component be included in any future learning sessions
- The session was timely with approaching licensing deadlines and both sessions were filled to capacity
- There was immediate interest in expanding the program to other professions such as educators and RNs

What Could Be Improved

- It was recommended that we be more inclusive of different behavioral health professions when providing CEU credits
    - CRSS, RNs, etc.
- Participants wished that there were more opportunities for networking
- Although most respondents to the evaluation agreed that the learning objectives were reasonable based on the length of the program (99%, n=84), many recommended making the program longer

Peer Support Services

- Exploratory research by Eunhye Grace Lee and Leah Barth, IPHI

Peer Provider Roles

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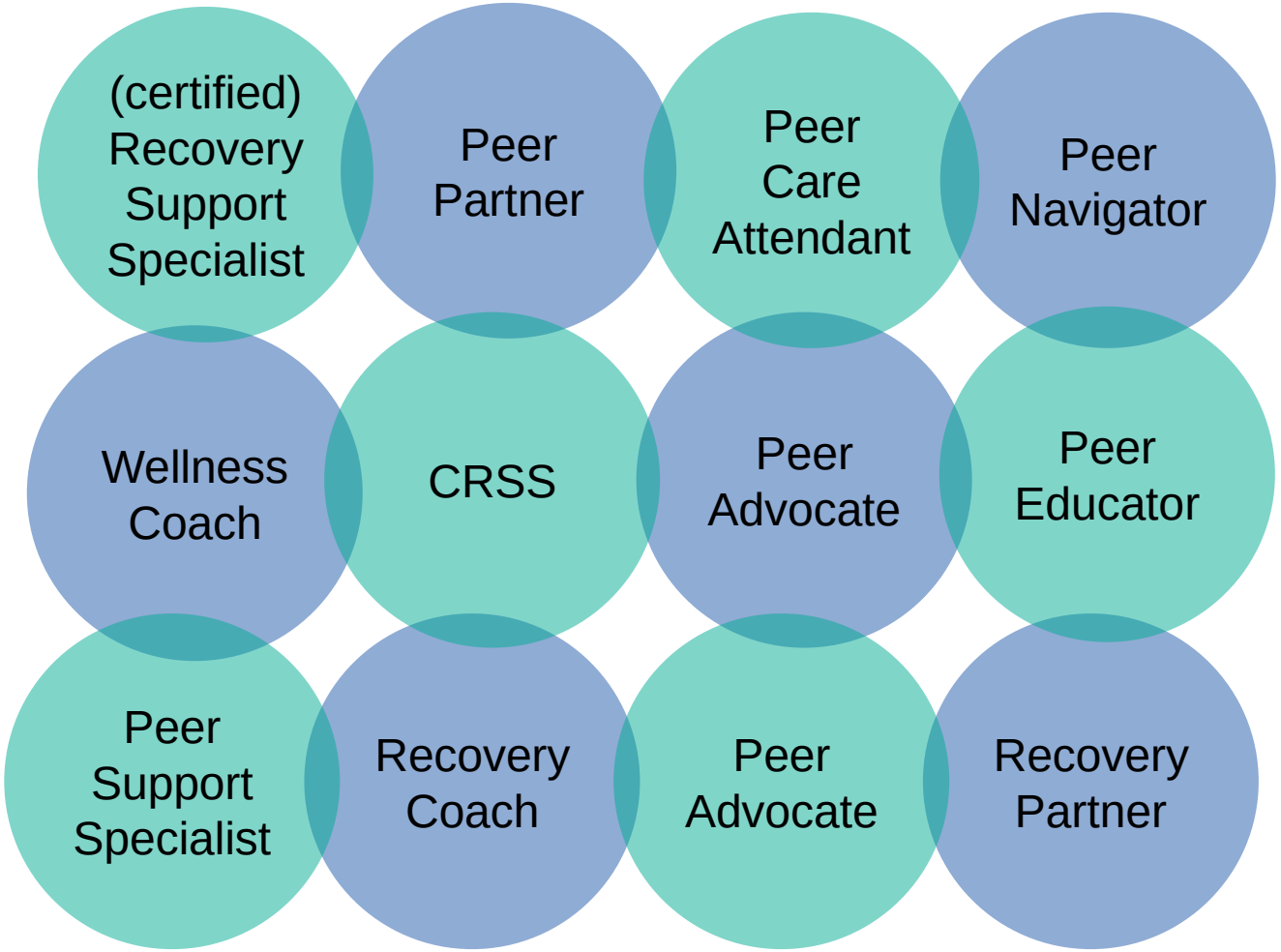
Examples of Peer Roles by Title

- Resident Counselor
- Peer Educator
- Outreach Specialist
- Telephone Support Specialist
- Forensic Peer Specialist
- Peer Evaluator
- Employment/Job Coach
- Peer Navigators and Peer Whole Health and Wellness Coaches



Gagne, C., J. Olivet and L. Davis. 2012. Equipping Behavioral Health Systems & Authorities to Promote Peer Specialist/Peer Recovery Coaching Services. Rockville, Maryland: Substance Abuse and Mental Health Services Administration: US Department of Health and Human Services.

Peer Provider Roles

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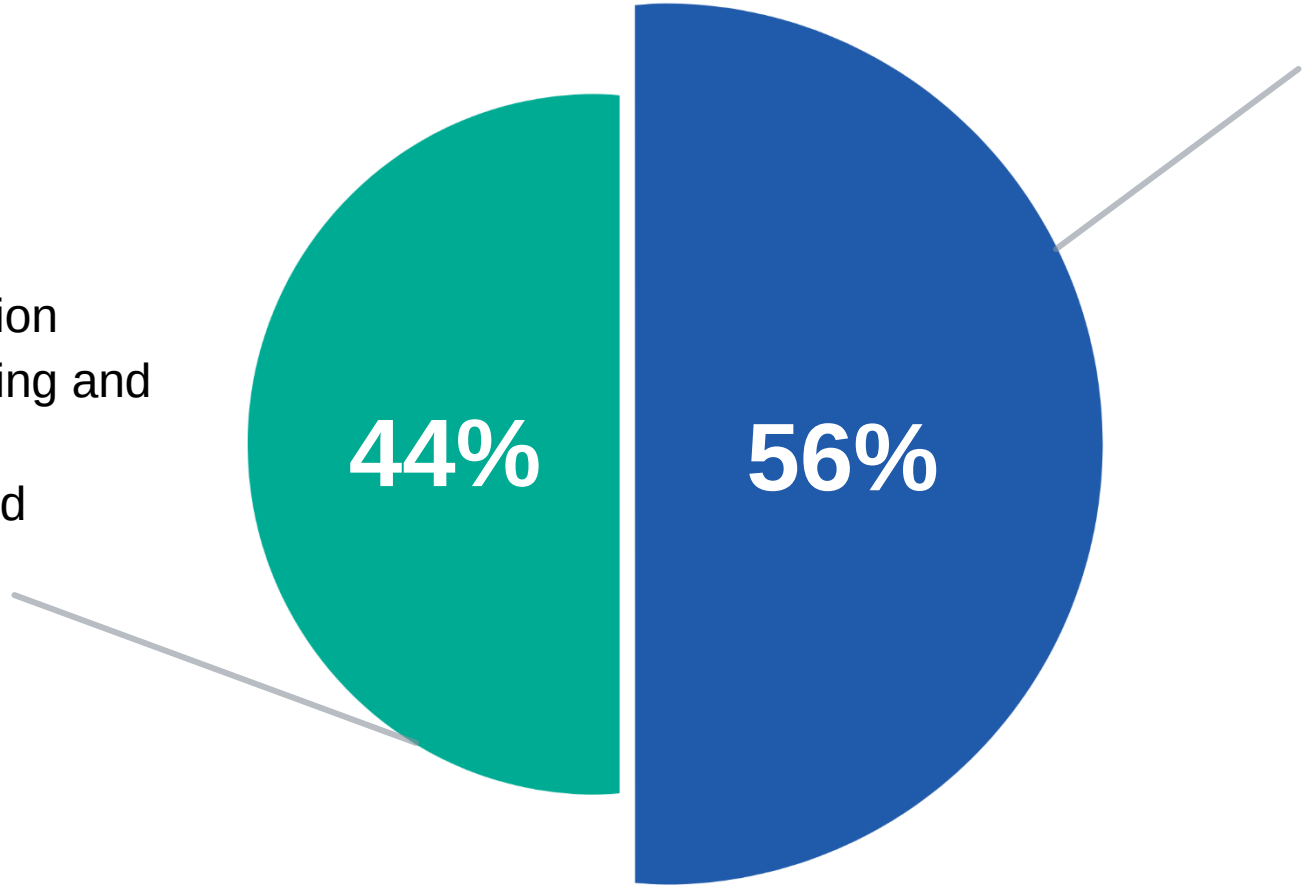
A study of peer providers found that they spend about 56% of their time working directly with clients **(direct work)** and 44% of their time doing other tasks that support their work with clients **(indirect work)**.

Indirect Work

- Administration
- Team communication
- Information gathering and verification
- Group planning and development
- Other



Direct Work

- Experiential sharing
- Relationship building
- Socializing/self-esteem building
- Advocacy
- Group facilitation

Source: Jacobson, N., Trojanowski, L., & Dewa, C. S. (2012). What do peer support workers do? A job description. BMC Health Services Research, 12, 205.

Workforce Landscape

Peer providers are employed in a variety of settings.

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Traditional Settings

- Hospitals
- Primary care
- Inpatient and outpatient treatment centers
- Community behavioral health
- Home health services

Peer-Run Settings

- Peer-Run Respites
- Drop-In Centers/ Peer-Run Self-Help Centers
- Recovery Community Centers

Integrated Settings

- Assertive Community Treatment Teams
- Crisis Stabilization Units
- Mobile Crisis Teams
- Medication-Assisted Recovery Services Programs
- Peer-Bridger Program

Criminal Justice Settings

- Transitional housing facilities
- Jails and prisons

Source: Chapman, S., Blash, L., and Chan, K. (2015). The Peer Provider Workforce in Behavioral Health: A Landscape Analysis. San Francisco, CA: UCSF Health Workforce Research Center on Long-Term Care.

Barriers to Implementing Peer Support Services

Barriers to Implementing Peer Support Services in Behavioral Healthcare Settings

- A lack of organizational commitment
- Poor organizational understanding of the peer provider's role
- A lack of consensus about peers providers' core competencies
- A lack of supervision
- Financial issues
- Balancing dual roles as a peer provider
  - Dual role stress
  - Role conflict and confusion
  - Loss of disability benefits due to income
  - Fear of asking for help
  - Fear of job loss
  - Lack of anonymity
  - Misunderstanding own role
  - Burnout and turnover

Barriers to Implementing Peer Support Services in Peer-Run Programs

- The lack of necessary infrastructure and skills
- The lack of organizational commitment

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Source: Grant EA et. al. (2010) Creation of the Pillars of Peer Support Services: Transforming Mental Health Systems of Care

Financial Infrastructure

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State Medicaid programs can be federally reimbursed for peer services, if they meet several requirements.

- Medicaid billed peer support services must have certain core components.
- Additional information can be found at the link below.

States may choose to deliver peer support services through several Medicaid funding authorities in the Social Security Act. The following current authorities have been used by States to date:

- Section 1905(a)(13)
- 1915(b) Waiver Authority
- 1915(c) Waiver Authority
- State plan amendment

Core components of peer support services

Supervision

- Must be provided by a competent mental health professionals
- The amount, duration and scope of supervision will vary depending on State Practice Acts

Care-Coordination

- Must be coordinated within the comprehensive, individualized plan of care
- A person-centered planning process

Training/Credentialing

- Must complete training and certification as defined by the State
- Must demonstrate the ability to support the recovery of others from mental illness and/or SUD
- Ongoing continuing educational requirements

Source: Smith, D. G. (2007). Letter to State Medicaid Directors (Publication No. SMDL# 07-011). *Center for Medicaid and State Operations, US Department of Health and Human Services, Washington, DC. Retrieved from* http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD081507A.pdf .

Financial Infrastructure

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Public Sector vs Private Sector Implementation of Peer Services

- The peer workforce is expanding rapidly, and peer providers are working in a variety of settings in the public behavioral healthcare system.
- Unfortunately, peer support services have not expanded as much into the private behavioral healthcare system.
- Private insurance companies and the private behavioral healthcare system need to be shown the outcomes for people that receive peer support services and the cost savings attained by keeping people out of critical care such as hospitals and crisis units.

Source: Mental Health America (2015) Peer Services Toolkit: A Guide to Advancing and Implementing Peer-run Behavioral Health Services
https://www.mentalhealthamerica.net/sites/default/files/Peer_Services_Toolkit%204-2015.pdf

Utilization of Peer Support Providers in States

Illinois

- Certified Recovery Support Specialist (CRSS): competency based and experience based
- Recovery support activities can be billed under Medicaid Rule 132 services which are authorized to be provided an MHP (Mental Health Professional) level, including Community Support, Psychosocial Rehabilitation (PSR), Vocational Services, Outreach and Engagement, and others
- **The number of CRSS-certified individuals in IL is 208 in 2017**

Georgia

- First state to have Medicaid-recognized whole health and wellness peer support provided by certified peer support providers (in place since 2001)
- GA built on this peer support foundation in 2012 when CMS approved a state plan amendment to add a whole health and wellness component to the service.
- Whole Health Action Management (WHAM)
  - Peer-led, developed by SAMHSA-HRSA Center for Integrated Health Solutions, includes: • Person-Centered Goals • Weekly Action Plan • Daily/Weekly Personal Log • One-to-One Peer Support • Weekly Peer Support Group
- Billing: HCPCS (Healthcare Common Procedure Coding System) Billing Code
- Fee for service; peer supports are reimbursed as a stand-alone Medicaid-funded service provided to individuals or in groups.
  - range from $18.15 to $36.65 per 15-minute unit

Sources: https://nashp.org/wp-content/uploads/2016/01/Peer-Supports.pdf
http://www.illinoismentalhealthcollaborative.com/consumers/crss/Illinois_Model_For_Mental_Health_CRSS.pdf
Kaufman, L., Brooks, W., Steinley-Bumgarner, M., Stevens-Manser, S. 2012. Peer Specialist Training and Certification Programs: A National Overview. University of Texas at Austin Center for Social Work Research.

CRSS and CHWs –
Recommendations from 2016 IL CHW Advisory Board

"3. CHWs should have a basic understanding of behavioral and mental health.

Behavioral/mental health issues have been found to be confounding factors to poor management of chronic illnesses such as diabetes, hypertension, etc. For example, the Mental Health First Aid course offers a basic understanding of behavioral and mental health conditions and is geared towards non-clinicians and non-behavioral healthprofessionals.

4. For CHWs who plan to or are working specifically in the field of behavioral and mental health, we recommend the following:

a. Cross-training or dual certification (e.g. certified recovery support specialist credential) for CHWs with lived experience in substance abuse or mental illness.

b. CHW trainings in this area should utilize best or promising practice guidelines for peer competencies in behavioral health (mental health and substance abuse) from state and national experts (e.g. Illinois Certified Recovery Support Specialists [CRSS], Substance Abuse and Mental Health Services Administration [SAMHSA] staff, and professionals involved in Screening, Brief Intervention and Referral to Treatment [SBIRT] and Trauma Informed Care)"

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Source: IL CHW Advisory Board. (2016). Community Health Workers in Illinois - A Value-Driven Solution for Population Health.

Essential Components of Successful Peer Programs

Implementation of peer support services is strengthened when there is/are:

- Clear job and service descriptions
- Strong program commitment
- A consumer and provider friendly organizational culture
- A culturally diverse peer workforce
- Quality supervision
- Professional advancement opportunities
- Opportunities for peer workforce development
- Research and evaluation components to programs

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Source: Grant EA et. al. (2010) Creation of the Pillars of Peer Support Services: Transforming Mental Health Systems of Care

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Mental Health First Aid (MHFA)

Mental Health Training Models

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Training	Target Populations
Mental Health First Aid (MHFA)	For Community Members
eCPR	For Community Members
Psychological First Aid	For Mental Health Professionals
Crisis Intervention Team Program (CIT)	For Law Enforcement Officers
First Episode Psychosis (FEP)	For states and programs interested in implementing Coordinated Specialty Care (CSC)
Question, Persuade, and Refer (QPR) Gatekeeper Training for Suicide Prevention	"Gatekeepers" which can include anyone who is strategically positioned to recognize and refer someone at risk of suicide such as parents, friends, neighbors, teachers, coaches, caseworkers, and police officers
Screening, Brief Intervention, and Referral to Treatment (SBIRT)	For primary health care, mental health, and clinical social workers in primary care centers, hospital emergency rooms, trauma centers
Recovery-Oriented Systems of Care (ROSC)	Partnership among specialty treatment, primary care, and mental health.
Trauma-Informed Approaches	Framework used in behavioral health and other sectors

Outcomes for MHFA training from the Literature

- **Increased mental health literacy** and mental health awareness
- **Acquired knowledge** of: signs of distress, mental illness symptoms, diagnoses, and prevalence (especially psychosis), suicide risk, recovery from mental illness and mental health crises
- **Increased ability to identify signs, symptoms, and risk factors** for mental illness
- **Increased empathy** towards those who experience mental illness and increased appreciation for the complexities of mental illness
- **Decreased fear, aversion, and avoidance** of people with mental illness or acute distress and increased awareness of their humanity
- **Decreased personal stigma** towards people who experience mental illness or substance use disorders
- **Increased confidence and intention to help** people in distress
- **Increased agreement between participants and primary care physician recommendations** for mental health problems

MHFA Coordination

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Overarching goals

A. Improve coordination and evaluation of Mental Health First Aid trainings
   - To improve existing MHFA programs and enhance impact of trainings happening across Cook County
   - To learn about the effects of MHFA on participants' knowledge and attitudes
   - To learn more about how participants are using MHFA

B. Identify follow-up needs for those trained in MHFA and communities they live in

C. Improve the community's ability to access information about Mental Health First Aid trainings

D. Align workgroup activities with efforts to catalog health resources.

Two Web Applications –

1 – for use by Alliance for Health Equity partners for tracking/evaluation and planning purposes

2 – for Public Use to provide more easily-accessible info about available trainings

Coordination Across Training Providers for Evaluation –

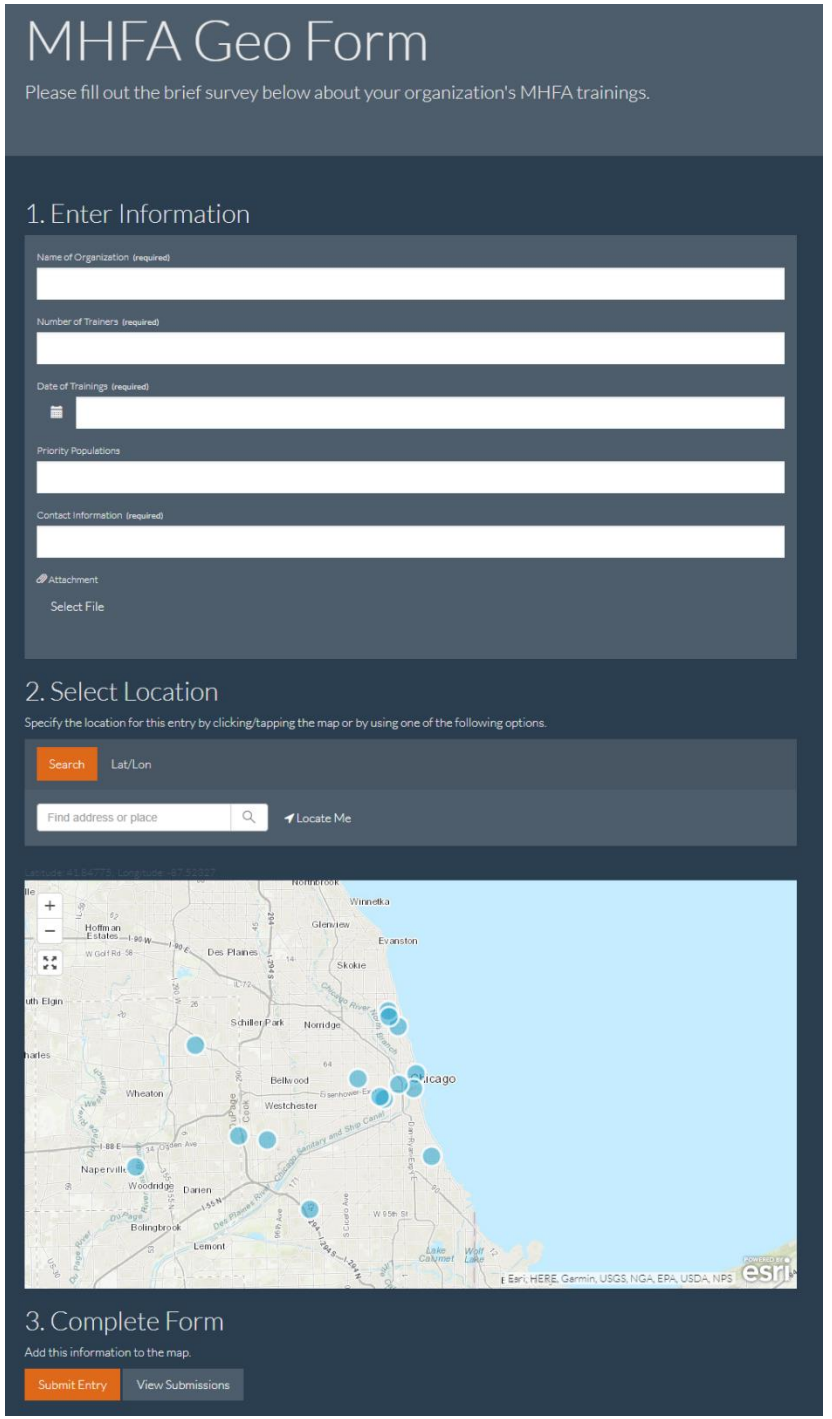
* Particular interest in follow-up with training participants a few months after training received

Public Facing Application

Notes:

- Information from partners outside the Alliance is collected through a short form
- This information would also sync with internal application for Alliance partners

- **Metrics in Mock-Up Form**
  - Name of organization
  - Number of trainers
  - Date of trainings
  - Priority populations
  - Contact information



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Public Facing Application

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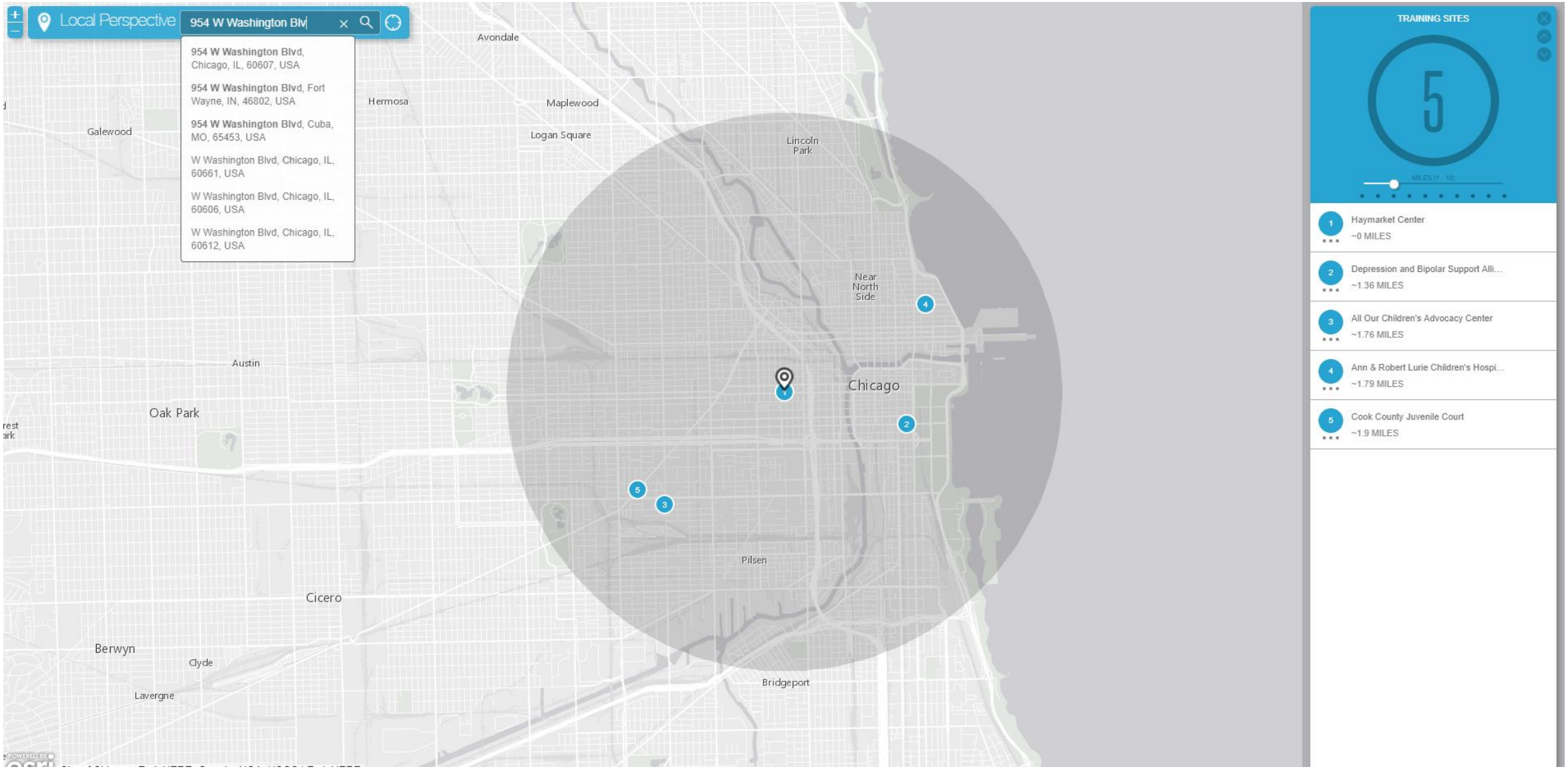
Results of data collection (GeoForm Completion) are presented in a minimalist map interface



MHFA Evaluation Metrics

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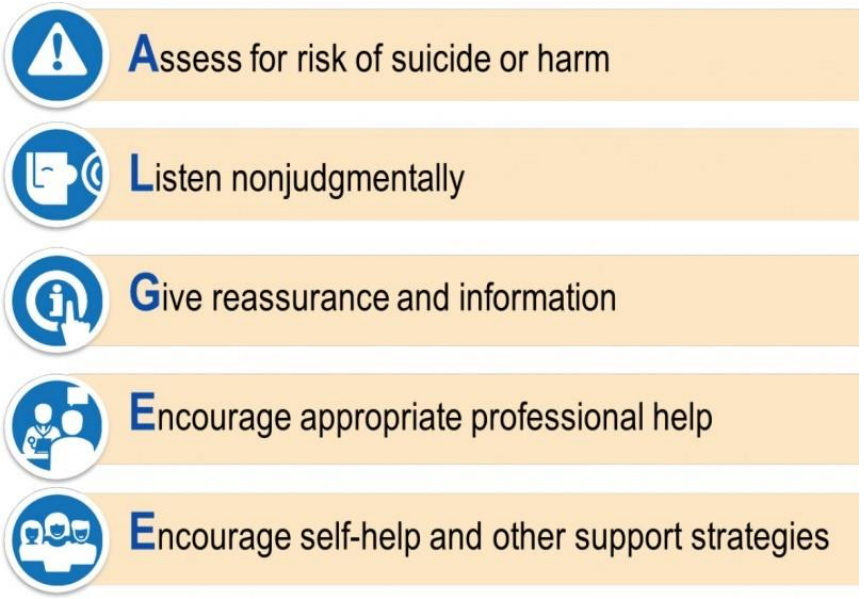
Evaluation Notes from MHFA Subcommittee Mtg on November 9, 2017

Metrics that can be gathered from previous evaluations

- Training location (Address)
- Number trained
- Training/curriculum format (Adult, youth, older adult, language, etc.)
- MHFA Post-Test administered at end of training

Additional metrics that the subcommittee is most interested in tracking

- Priority populations/Target audience
- Curriculum focus (What organizations and participants hoped to get out of the training i.e. Behavioral health resources, specific needs like high suicide rates, etc.)
- How participants heard about the training
- Satisfaction with the course
- ALGEE questions
- Follow up at 3- and 6-months to see how participants use training, and what additional needs they identify



High-Level MHFA Evaluation and Follow-up Plan

DRAFT

Indicator	Pre-test (Before Start of Training)	Post-test (At End of Training)	Follow-up #1 (3 mos)	Follow-up #2 (6 mos)
Stigma	X	X		X
Personal Mental Health	X	X		X
Confidence in using MHFA		X	X	X
Knowledge of mental health/ beliefs about treatment	X	X		X
Perceived value of MHFA			X	
Experience applying MHFA			X	X
Experiences/challenges referring people to professional services			X	X
How MHFA has changed participants' outlook, attitudes, etc.		X		X

Proposed Timeline for MHFA Coordination

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January-March 2018

- Finalize pilot evaluation metrics
- Pilot orgs submit previous evaluation/tracking data to IPHI staff
- Begin development of internally facing web application and develop strategies for long-term maintenance
- Pilot orgs begin collecting new shared evaluation/tracking data

April-May 2018

- Launch internally facing web application
- Begin development of externally facing application
- Begin collecting information about upcoming trainings from partners

June-August 2018

- Launch externally facing web application
- Implement strategies for long-term maintenance of applications
- Evaluate application use with pilot organizations
- Present initial results of web application use to committee and partners

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Trauma Informed Hospitals

Slides from Health and Medicine Policy Research Group and Illinois ACE Response Collaborative (Margie Schaps and Audrey Stillerman)

The Four "R'S: Key Assumptions in a Trauma-Informed Approach

A program, organization, or system that is trauma-informed ***realizes*** the widespread impact of trauma and understands potential paths for recovery; ***recognizes*** the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and ***responds*** by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively ***resist re-traumatization***.

Hospital as a Traumatized and Trauma-Informed Community

Staff and patients are carrying the burden of ACEs.

Hospitals can address these issues by:

- Following SAMSHA guidelines for Trauma-Informed Institutions
- Policies
- Hiring practices
- Staff training
- Developing leaders and champions
- Aligning with other hospital priorities and mandates

Information on this slide largely from The Center for Childhood Resilience - Lurie Children's Hospital

Ten Implementation Domains

1. Governance and Leadership
2. Policy
3. Physical Environment
4. Engagement and Involvement
5. Cross Sector Collaboration
6. Screening, Assessment, Treatment Services
7. Training and Workforce Development
8. Progress Monitoring and Quality Assurance
9. Financing
10. Evaluation

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Additional Updates and Discussion

- Housing
- Addressing Opioids
- Integrated Care

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