

This text is being provided in a rough draft format. Communication Access Realtime Translation (CART) is intended to facilitate realtime access to oral and aural communication. It is not meant to produce a verbatim record of the proceedings.

>> ROARA MICHAEL: Good afternoon, everyone and welcome to the SAMHSA-HRSA Center for Integrated Health Solutions webcast titled Understanding the Myths and Facts of Access to Primary Care For People with Mental Illness. My name is Roara Michael, CIHS Associate and your moderator for today's webinar.

As you may know, the SAMHSA-HRSA CIHS promotes the development of integrated primary and behavioral health including mental health and substance abuse services to better address the needs of individuals with mental health and substance abuse conditions, whether seeing a specialty behavioral health or primary care provider setting.

In addition to national webinars designed to help providers integrate care, the centers continue to lead, hosting practical tools and resources to the CIHS website, providing direct phone consultation to providers and stakeholder groups. And, directly working with SAMHSA Primary and behavioral healthcare integration grantees and HRSA funded safety net settings.

Before we get started, a couple of housekeeping items. To download the presentation slides, please click the drop-down menu labeled Event Resources on the bottom left of your screen. The slides are also available on the CIHS National Council website updated under the tab About Us\webinar.

During today's presentation, your slides will be automatically synchronized with the audio so you will not need to flip any slides to follow along. You will listen to audio through your computer speakers, so please ensure that they are on and the volume is up.

You may submit questions to the speakers at any time during the presentation by typing a question into the "ask a question" box in the lower left portion of your player.

Finally, if you need technical assistance, please click the question mark button in the upper right corner of your player to see a list of frequently asked questions and contact info for tech support if needed.

So, Mindy, I'll go ahead and pass it up to you to discuss today's learning objectives.

>> MINDY KLOWDEN: Hello, everyone, my name is Mindy Klowden, I am the Director of Technical Assistance with the Center for Integrated Health Solutions. And I just wanted to set the stage for what we're going to be doing in today's session.

Individuals with behavioral health conditions may not access primary care services for a wide

range of varied and complex reasons. Studies over the past decade have found that people with mental illness experience significant health disparities, including higher rates of chronic medical conditions, higher use of hospital emergency departments and increased rates of early death from preventable conditions. Integrating primary medical care into behavioral health settings is essential. But just because you build it does not mean that they will come or that clients will be actively engaged in services.

So in today's webinar, we are going to dive into what the research tells us about what barriers to care are out there and also what are some of the effective ways that providers can work to overcome those barriers.

So today's learning objectives are that we hope that you will leave with a better understanding of the main reasons why individuals with Serious Mental Illness may not access primary care, that you gain strategies for how to engage people with mental illness in primary care and also in wellness services, and that you identify some resources that you can access to get additional information on what you can do next to integrate primary care and wellness services.

So before we go to our speakers, we're going to run some questions to get a better sense of who is out there participating on this webinar. So, we would first like to ask, do you routinely ask your clients or patients if they have seen a primary care provider in the last year? Please respond yes, no, or I don't know. So we will give everyone a minute to do that.

The second poll question is, do you routinely ask your clients or patients about barriers to accessing primary care that they may be experiencing, and employ strategies such as care coordination services, use of your health staff or others to help mitigate those barriers? Yes? No? No but you would like to start doing so, or I don't know. Please respond now.

And thirdly, do you utilize the patient activation measure or other evidence-based tool to gauge the level of patient activation and self-efficacy? Please answer yes or no.

Okay, so hopefully everyone has had a moment to respond to the poll questions. Were we able to pull up the responses to the poll?

>> ROARA MICHAEL: So I can actually see the responses of the survey. I can just read them. I have it in my view. The first question, 80% said yes. About 20% [sounds like] said no and then, we have about 1% saying I do not know.

For the second question, we have about 64% saying yes, about 11% saying no, 17% saying no, but I want to start doing so and about 8% saying I don't know.

For the question, final question, 85% for no and 15% for yes.

>> MINDY: Thanks, Roara, and thank you everyone for participating in those questions. So I'm going to go ahead and introduce today's speakers. First, we have Dr. Leopoldo Cabassa, who is an Associate Professor at the Columbia University School of Social Work. He received his MSW and PhD at George Warren Brown School of Social Work, Washington University in St. Louis. His research blends quantitative and qualitative methods, implementation science, intervention research and community engagement to examine health disparities among racial or ethnic minorities with Serious Mental Illness and to inform the development and implementation of interventions to reduce these health inequities. His work has been supported by the National Institute of Mental Health, the Substance Abuse and Mental Health Services Administration, The Robert Wood Johnson foundation and the New York Office of Mental Health.

He recently completed a career development award from the National Institute of Mental Health focusing on implementing healthcare interventions for Hispanics with Serious Mental Illness. He is currently leading an RO1 [sounds like] which is also from the National Institute of Mental Health, testing the effectiveness and examining the implementation of the peer-led healthy lifestyle intervention in supporting housing agencies that are supporting diverse clients with Serious Mental Illness and are also overweight or obese.

Dr. Cabassa teaches graduate-level courses in research and evaluation methods, foundations of social work practice, implementation science and social work with Latino populations. He is a fellow of the New York Academy of Medicine and the Society of Social Work in Research and is a standing member of the Health Disparities and Equity Promotion Study Section for the National Institutes of Health.

After Leopoldo Cabassa speaks, we will have Dr. Chyrell D. Bellamy, PhD and MSW who is the Director of Peer Services and Research and an assistant professor of Yale University's Department of Psychiatry Program For Recovery and Community Health. Dr. Bellamy has experience as a front-line service provider, community educator and organizer, as a community and academic researcher and as a person in recovery. Her expertise includes developing and conducting community-based research initiatives, involving and partnering with people living with mental illness, substance abuse, HIV and experiences of incarceration -- particularly related to practice and research on socio-cultural pathways to recovery.

Dr. Bellamy received her PhD in the joint program in social work and social psychology from the University of Michigan, and her MSW and BA from Rutgers University. She did a post-doctoral fellowship at the Center for Mental Health and Criminal Justice Research at Rutgers University.

In her capacity currently as Director of Peer Services and Research, she provides instruction on Peer Curriculum Development and Training based on her research and practice experience with people employed as peer supporters, training and conducting research for people with lived experience, evaluation of the effectiveness of peer support and research and training on the development of culturally responsive community-based interventions. Dr. Bellamy has worked

on several initiatives including projects focused on community inclusion for people returning from jail and prison with experience of mental illness and substance abuse.

As we launch into the program, we just want to share that the views, opinions and content expressed in this presentation do not necessarily reflect the views, opinions or policies of the Center for Mental Health Services, the Substance Abuse and Mental Health Services Administration or the US Department of Health and Human Services.

Alright, Dr. Cabassa.

>> LEOPOLDO CABASSA: Wonderful, good afternoon everyone. First of all, we want to thank CIHS for the opportunity to present some of our work. I think this will be very appropriate for the audience and give us an opportunity to talk about the work that we've been doing in improving the physical health of people with Serious Mental Illness, particularly the Latino community and some of the work we have been doing here in New York.

Before we begin we just want to acknowledge our funders and the people who supported this work. This was funded in part from the New York State Office of Mental Health as well as several grants from the National Institute of Mental Health. And we had a great group of collaborators, highly multidisciplinary, from psychiatrist to social workers to peer specialists. And we work very closely with an outpatient mental health clinic. If you are in New York City, that was sort of the site for the study we have been doing, a lot of the work that we have done over the past several years.

So, what the presentation is going to focus today is on personal discussions of physical health disparities, but only among people with Serious Mental Illness, but also among Latinos with Serious Mental Illness and what do we know about the impact that both having a Serious Mental Illness and also being a racial and ethnic minority have on people's physical health, and particularly in their access to healthcare. So we're also going to talk about the experiences people have under accessing primary healthcare services and some of the factors that influence how they go to services, how they engage in care, the barriers and issues that come up.

Then we will end the presentation with discussion on a program that we culturally adapted to a healthcare [indiscernible] intervention to help improve their healthcare experiences, particularly connecting them to preventive primary care services here in New York. I'm happy to take questions at the end.

So, just to set the stage, as people have mentioned, people with Serious Mental Illness, people with schizophrenia, bipolar disorder, who are recovering from all of these conditions also experience major medical issues, particularly around cardiovascular disease. This cardiovascular disease really impacts people's life expectancy in which, compared to a general population, people with Serious Mental Illness have 20 years shorter life expectancy for men, 15 years shorter for women. This is largely due to cardiovascular disease, issues like diabetes, cancer, and

other chronic medical conditions.

But when we look at the intersection between race and ethnicity in Serious Mental Illness, there is this question as to whether there is a double health disparity or a double health burden given that we know that there are health disparities or inequities in health among Latinos in the United States and also health inequities among people with Serious Mental Illness. So, several years ago our group conducted a systematic lit review. What we found was, there was evidence for some increased risk, particularly among cardiovascular related mortality, diabetes, metabolic syndrome, and the negative metabolic abnormalities associated with taking second-generation antipsychotic...in particular, weight gain and issues regarding high cholesterol level.

However, this literature was inconclusive in the sense that most of the studies that were included were small samples from 4 to 260 people. Most of them are clinical samples, do these are people who are already in care and have already been connected either to primary care or mental health services and very few analysis actually stratified by Latino subgroups -- so, differences between Mexican, Puerto Rican, Cuban, other groups, and differences by gender. This was a very big limitation, because we know health outcomes and health disparities do differ by Latino groups and by and gender as well. So there is a lot of work to be done in this area to really clarify this health paradigm. But initial evidence indicates that there might be this double health paradigm, meaning that Latinos with Serious Mental Illness compared to non-Hispanic whites with Serious Mental Illness may be at increased risk for certain physical health issues.

When we look at, what are these factors that influence health disparities, there are many of them that go from the environment all the way to health behaviors. Today we are going to focus on those factors that influence medical care -- so, the underutilization of services, particularly primary care services and people in need, the poor quality of care that people may be receiving when they access primary care, for people with Serious Mental Illness and minority. And then the fragmentation of care, the lack of care coordination between the mental health service system and the primary care system. All of this is known to contribute to the poor physical health that people with Serious Mental Illness have. A lot of the work we are going to focus on today focuses on this area of medical care. And there are other interventions out there that have focused on the environment and health behaviors [indiscernible] a way to address this. But today we are going to focus on physical care.

When we first started this project we did a mixed method study. We interviewed Latinos with Serious Mental Illness about their experiences accessing primary care services. They were all people, all adults with Serious Mental Illness who were already connected to the public mental health system, where they were going to an outpatient mental health clinic. We wanted to learn how they connected to primary care, what happened when they went there. What type of experience did they have? And from those interviews, we did structured interviews with them about their experience. We did focus groups with those individuals, and we also reviewed their medical charts to understand their physical health needs.

What we found from there was a model that tried to capture their experiences. The first thing that was very clear was that almost everyone we interviewed, we interviewed 40 individuals, talked about navigating a stressed healthcare system. And this might not be news to anyone, but it's sort of people having a lot of problems with long waiting times in primary care, experiencing a high staff turnover, meaning that every time they go to a primary care physician, deal with a new person, they have to start the process again. And a lot of fragmented care, meaning when they went to a primary care clinic, there was a lot of problem in connecting them back to their mental health providers and vice versa. And even in New York we had a lot of people reporting language barriers, of not being able to find a provider or a receptionist, or anyone in primary care who could speak Spanish. That really impacted their access and use of services.

We also examined people's perception of discrimination and stigma. Remember, these are Latinos with Serious Mental Illness. We wanted to talk about, learn from them, do they experience any discrimination in accessing primary care services or any stigma related to that. What we were finding is that people reported high levels of racism. For example, 75% of people we talked to indicated that racism is a problem in the healthcare system. When we drilled down a little more, people were reporting that people are treated unjustly in the healthcare system for multiple identities. For being Latino, for not speaking English very well, for having a Serious Mental Illness, for being an immigrant or for being black.

This really impacted people's views of how they connected to primary care providers. In many ways, people talked about experiences of these things. So here's an example of a Latino female with schizophrenia talking about how she experienced stigma in an interaction going to the hospital. This is a classic example of diagnostic overshadowing, where someone comes to the hospital with a physical health problem and wants help for the physical condition, but once they get identified as someone having a mental disorder, he might not get the appropriate care, he might get dismissed and not even receive the care they need because of the mental illness taking priority over their physical health. This was a common type of experience in some of the people we are talking to.

Beyond the perceived discrimination and stigma, we also examined their relationship, the personal aspect of care between a person and their doctor. Once they got into care, what happened with that relationship between the person and their doctor, with a nurse, with a primary care physician. There we began to identify that some people had very good experiences where the doctor was culturally appropriate. There was a lot of personal attention, warmth and friendliness. Or the experience can be very negative, in which they were stigmatized, they felt they were rushed during those visits and that the care they were provided was rushed and disrespectful. That really impacted whether people returned to their primary care visits. So that interpersonal aspect of care became a really important, salient experience in their experience with care.

The we also saw low levels of patient centered care. For example, a patient reported they didn't know what medications they were taking, they reported their doctor didn't discuss decisions with

them about other medical health conditions and reporting low quality of interaction or care with the medical system. So those were all encompassing of their experiences with their healthcare.

Given these barriers, an issue that came up, we wanted to address them. One of the ways you can address some of these barriers is to create healthcare manager interventions, this is usually someone in the outpatient mental health setting who is helping someone navigate into primary care. So you address this care coordination and system navigation, making sure someone goes to primary care and comes back, and shares information between providers. Also, this healthcare manager can also help in goal setting and patient activation and problem solving and help the person get more engaged in their physical health services. This person is usually a registered nurse but it could also be a social worker, and in some instances can be a peer specialist who can take on this role with the right supervision and support.

We wanted to really understand how to take a health care manager intervention and adapt it to our Latino population. But when we started doing that we realized there was serious implementation gap. First of all, there were very little [indiscernible] out there that had been tested with Latinos, meaning randomized control trials that actually tested the impact of this intervention, this population. There were very few examples of that.

Another common element in this literature was that the influence of culture and language was often ignored. Meaning that once someone has a Serious Mental Illness, issues of race and ethnicity and language were often not talked about. This becomes really important because how people experience their physical health, how they expressed their physical health, how they relate to the healthcare system, all of that is influenced by cultural norms, by cultural belief. So we needed to really pick up an understanding of that.

Then, the aspect of, can social workers take on this role of the health care manager, given that in our setting, we had more social workers than nurses to take on this role.

So, do to address this particular issue, we develop an approach we can work with our local context. Our local context was a public outpatient mental health clinic in upper Manhattan that served large numbers of Latinos. Our staffing was mainly social workers, psychiatrist, peer specialists and some psychiatric nurses. Patients were often referred to a primary healthcare clinic outside our setting. Some people received primary care service that happened outside the clinic. So a lot of coordination, a lot of referral out. We needed an intervention focused on those aspects.

In order to do that, instead of all of us researchers [sounds like] figuring out a solution, we developed a collaborative approach in which we work very closely with our site, with our psychiatry, the social workers at this clinic, patients at this clinic, the administrator, and we formed this collaborative group to really understand the needs of that population and how to make this intervention fit with the local reality. And we use the principles of participatory research, as well as intervention mapping procedure, which is how to take an intervention and

adapt it step-by-step to the realities of practice.

So, in this, we developed what we call bridges to better health and wellness, which is an adaptive intervention from PCARE which is an established healthcare intervention they have been testing in Atlanta, Georgia by Ben Dross [sounds like] and his group. It's a 12 month program. Basically the healthcare manager is located at the outpatient mental health clinic and they meet at least monthly with the patient. It can be more but at least once a month. And it is delivered by a social worker.

The healthcare manager is serving as a bridge, as a monitor and coordinating between healthcare providers and primary providers and acts as a coach and connects and coordinates the services with the client. It's working, really, one-on-one with the client to understand what their physical health needs are, how to connect them to primary care and to make sure that every provider understands what's going on in coordinating and monitoring that care for everyone. So it becomes a real big advocate in the system

But given our population, we needed to do serious of adaptations to the intervention. We had to do adaptations on multiple levels. Adaptations at the provider level, given that the original intervention was delivered by registered nurses, and now we are using master level social workers. So we needed to make some adaptations in order for social workers to be trained on this type of intervention and to be supportive.

Then, given the patient population -- Latinos with Serious Mental Illness -- we needed to make intervention both at the surface and at a deep level. These adaptations are all around trying to make the intervention salient, that people can accept it, that it meets their needs and that people can engage in this type of program.

So let me give you some examples, some of the applications that we did. For example at the provider level, care coordination was very different. In the original trial, the care coordination was from one mental health clinic to one primary care clinic. In reality, in New York, goes from one mental health clinic to 17 primary care clinics with different configuration between very small clinics to very large federally qualified health centers. So we needed to do to a whole different coordination in terms of, for each of these, we needed to have a plan very specific for the healthcare manager -- how to contact the provider, what type of information they needed, who do we need to contact, how often. So for each contact, there was a care coordination plan developed so that was free-flowing of information between the healthcare manager and the primary care providers.

At the patient level, we had to develop better or different health education tools that were attractive to our Latino population. So we used health related photo-novellas, which basically are comic books that presents a soap opera narrative and uses language, visual characters, simple language both in English and Spanish, and the idea here is to entertain as well as educate the person with the health condition. So the one you're seeing here, Sweet Temptations, is all about

diabetes. And the idea is people get engaged in the material, so they learn something about what diabetes is and how to manage it. The idea is to make it as engaging as possible for the participants so that they can learn something on how to manage their diabetes in this case.

So, our pilot, basically, once we had developed the intervention we wanted to test it. We basically did a 12 Month pre-post one-group design at a outpatient mental health clinic. We did structured interviews beginning before the program began, six months into it, 12 month after it. Then a three post intervention focus group with the clients to really get a sense of how they experienced the program. We had 34 Latinos with Serious Mental Illness as well as at risk for cardiovascular disease, which means that they were active smokers, they were overweight or obese, BMI of 25 or above, they had hypertension and all diabetes or any of those. Then we analyze the content analysis of focus groups and then linear mixed model for the outcomes of the trial.

So, we examined feasibility, can we actually do that, can we recruit people, do people come to the assessment, do people come to intervention? We [indiscernible] the client satisfaction of people in the intervention, how well did they like the intervention or not? Then we explore intervention outcomes. We measure patient activation, which is a measure of people's engagement into their care. We measure self-efficacy, how well people feel confident talking to their primary care doctor confidence of managing their chronic illnesses? We measure their perceptions of chronic illness care, which is a really interesting measure that focuses on patients views of the care, as to whether the care they are receiving is patient centered. Meaning, is it addressing their decision-making? Is it activating, do people feel it's coordinating? So all of those outcomes from the patient perspective.

Then we also measure the receipt of preventive primary care, are people getting screening for cancer, for cholesterol, for high blood pressure levels. All these indications of preventive primary care. Vaccinations, as well. And then, physical and mental health related quality-of-life.

The results, basically, we had a sample that was mostly female. Most of the participants had 11, 12 years of education. They were mostly from the Dominican Republic. Mostly monolingual Spanish speakers. Lots of different medical conditions. On average, 2.8, almost 3 medical chronic conditions. What was interesting was most people had visited primary care services in the past year. Most people had gone to a primary service physician. However, they had a lot of issues connecting with the primary care physician, following up with that visit. Given that these are people with chronic mental illnesses, that follow up becomes really important to help them cope and manage their chronic medical illnesses.

In terms of the mental health diagnosis, people with [indiscernible] disorder, some depression, there are people who are receiving good mental health care, they are staying out of the hospital and staying out of the ER and receiving outpatient mental health care.

So, in terms of how people did with intervention, 85% of people, 29 out of 34 completed the

entire intervention, meaning that they went to all the visits over the course of a year. And 93% rated the quality of service as excellent. As you can see here, 86% indicated the program actually met most or all of their healthcare needs. And reported that it helped them deal with their physical health issues.

In terms of what people really liked about intervention, people reported like, in the [indiscernible] locations, all those materials we provided them around their diabetes, around their diet, around their exercise, all that health education provided by the healthcare management was really important. People really like the relationship they were able to form with their healthcare manager and this was really important because the healthcare manager was someone who was bilingual, who really spent time with them, and they really made personal connections with them and they also liked the care coordination, having someone help them navigate from one service to another.

In terms of outcomes, we saw significant improvement in patient centered outcomes from baseline to 12 months, particularly in patient activation, in self-efficacy, and the patient's assessment of chronic illness care -- this is the patient centered scale that I mentioned before. We saw all improvements over the course of 12 months in the people who participated. We did not see significant improvement in health-related quality of life or in other health outcomes in terms of weight, blood pressures. There was no statistically significant improvements over time.

We also saw a significant increase in the receipt of preventive primary care services from 29 to 54%. This was our main outcome, the people participating in this program over the course of a year, their rates of receiving primary care services, around physical exam, women's screening, labs, vaccinations, health education -- all of that increased significantly over the course of the study.

In the end, what we are finding it that Latinos with SMIs are facing a constellation of barriers accessing primary care. As we mentioned from the structural aspects of care, to their experiences with the healthcare system, as well as the experiences with their providers. We are beginning to find that our culturally adapted healthcare manager programs like Bridges can help reduce these barriers, reduce these disparities by creating connections between the patient and their provider. We have some promising results that this intervention was feasible to deliver by social workers and that the participants, given the opportunity, will participate. And over 12 months, we saw significant improvement in critical patient care outcomes -- Patient activation, self-efficacy, and the receipt of preventive primary care services.

Of course, our story has many limitations. It's a small sample in one site. This is a single group design so we didn't have a comparison group over the course, and that is some of the work we are planning to do in doing a more rigorous examination. This is also a very highly engaged community center, a community mental health site, meaning that they really wanted to do this project and were engaged in the process of adapting with other researchers, so I think that also helped in this process.

In the end, we have found that culturally adapted healthcare managers intervention that focuses on the local needs -- the local needs of the provider, the local needs of the client -- can help address the barriers Latinos face in not only accessing but using primary care services. Intervention does show promise for improving patient centered care outcomes and the receipt of preventive primary care services, and that we need future work to test whether this intervention has potential to work in other sites with other population and seeing if adding it to other services like wellness services, will it have an out impact in outcomes like weight or blood pressure and all those other things.

That's all I have, I'm happy to take questions. Here's my information. If anyone has any questions or want more information about Bridges to Better Health and Wellness or any of our work, feel free to email me. I'm more than happy to share some of the materials that we have and some of the lessons that we've learned in doing this intervention. Thank you for your time today.

>> MINDY KLOWDEN: Thank you, Leopoldo, we will just go on to our Peer Personal story of Bob Fortano.

>> BOB FORTANO: Hi, I'm a Peer Support Specialist at Connecticut Mental Health Center. I am on the Wellness Advisory Board. Most important, I'm a client at Connecticut Mental Health Center since 2006 and at the Wellness Center, since it opened at the Connecticut Mental Health Center.

Today I'm going to talk a little about my personal experiences as a client at the Wellness Center. And, some clients' experiences at the center opened up to a date of now. Since I'm in the Wellness Advisor Group, I do talk to a lot of clients at Connecticut Mental Health Center about the Wellness Center, good and bad.

My personal experience about the Center since it opened and being a part of the center, I was actually afraid to join it at first, because I haven't had insurance for years. And I was actually able to get physical care that I haven't had for years since I lost my job because of my illness.

My problem was physical care, I had no insurance. No Medicaid. And I needed health, but I could only go to the emergency room if I had a problem. I had no prevention care, is what I am saying. Nothing to keep me out of the ER. I was pushed there because I had no other place to go to if I had an illness. That experience of mine is, only since the center has opened, I've only had one time I was there, out of many times being there, that I had to wait a little over an hour and I found out they had a serious emergency there. Then I had to remember where I was. I'm at a mental health care center that has a physical health care center inside of a mental health facility. So I took a step back in my mind and realize that. It didn't upset me, considering the dozens of times in the last couple of years since the center has been open.

I was afraid to go to the Center when it first opened, because of the problems that I hear out in

the world with stigma and things like that. Because it was in the center, the Connecticut Mental Health Center, I felt safe and was going to give it a try. What I use the center for, really, is basic, basic needs. That is what you need when you go and have your blood pressure checked, have blood work done. I have my heart checked once a year. I get necessity shots that we need for the flu and different things like that. This is something everybody should be provided and I didn't have for close to 2 1/2 years since I lost my job.

I also think that the Center, being where it's located, really, really helped me to decide to go to it, being right in the mental health center. I use the Center, like I said, for basic needs. But when I needed specialty needs, they were right there. Right there to help me. I have no question at all. They helped me go to a skin specialist. I had to go to SMILE which is a cancer center in New Haven, Connecticut. And I get my eyes checked once a year, which, I never had my eyes checked before.

I know some of the clients here at Connecticut Mental Health Center would not go to the center at all when it first opened. I'm talking, for 10 or 15 years, I am talking to clients, some of them are my friends who haven't been to health centers for years, due to the fear of being stigmatized about their mental illness. And as I see, my physical health was getting worse and worse. My medications were good so I could advocate for myself at Connecticut Mental Health. As for some of my friends and other clients there, they weren't doing as good as I was doing and were afraid, even though we had opened up the center, to actually be a part of getting physical health. They were getting their mental health addressed but physical health, like the doctor had mentioned, would be neglected for years and years for a lot of my friends.

I try to push, as a peer support specialist, some of the people there at the center and friends to go. A lot of them are either that I find clients on my own, being a client there, that I see, in my own level, is that they don't go there. They haven't gone to other places because the number 1 reason, the number 1 reason my friends and I don't go is because I have no transportation to go to the doctors. Had no insurance. Transportation was a big thing.

Besides that, one of the big things was that stigma was [indiscernible], they wondered if they would have that in the center here. And honestly, to myself, some of my friends didn't care about themselves and were just lazy. They were mentally not there yet, where they knew how important, where they knew how important their physical health was, and how much your physical health and mental health are actually part of one with your body.

But actually, what was really good was that they have navigators at Connecticut Mental Health Network right in the center at CMHC and what they do is help bring clients. Well, they don't bring clients. What they do is, doctors and clinicians together with the client, if they agree to and want help, will bring them over, so that they aren't afraid to go by themselves. And, the navigators can take over from there.

Once the client is familiar with the people and meet everyone at the center, especially if they

have had generic experiences before in physical healthcare centers, a lot of [indiscernible] and prevention that stop them from going, really broke the barriers down by the Center being in a mental health facility. And for myself, that was really important, too.

If you put the clients and myself as a client together, we were probably applying that emergency room at [indiscernible] hospital a lot more than we should have been. If we just had help that we do have now. I see the center thriving for the hours that they are open and the emergency hours they are open. If you drop in, which I've had to once or twice, they're willing to see you. They are great at the center.

I really think that being part of the Wellness Advisory Board -- that was organized about three or four weeks after the wellness center was opened -- I wanted to personally give back, because I was doing so good, at Connecticut Mental Health Center. I wanted to help out physically with a lot of my friends and people at the center that needed to get healthy, basic health essentials, especially since it is found that people with mental illness die 20 to 25 years younger. That scared me. I never forgot that when my doctor told me that. I knew that I needed to take care of myself. You die 25 years younger than the total population. He participates once a month with it. They are very serious about trying to get people with mental illness like myself and a lot of the clients there to get physically well, to help themselves get better and live longer. I mean, that's what we all want. We want to live long. I want to live long.

Now that it's open, and it's been open for a few years, I see my friends thanking me for having them go. They are so much happier and healthier. And there's one thing that I see that they say, they feel safe. They feel safe there. And that makes me feel good because I feel safe, too. I get anxiety attacks. I have different issues with my mental wellness -- that's for another time -- but I do feel safe going to the center. I look forward to going there when I have a problem. They direct me in the right way in the right area I need to go to for specialists. The navigators are there to help me if I need.

You can't abuse it, but if you do need a ride, at the center, there's two navigators there with transportation who can bring you to a specialist, stay there with you if you don't have anybody to go with you. Something as simple as every five years or 10 years, a colonoscopy, if you have to go to the cancer center across the street, anything that you're afraid to go. A lot of clients don't have any family at all. I mean nobody, no brothers, sisters, parents.

I think that the Center, all in all, is a great thing to have right at the place that I go for mental health, because, it's right there. I don't even have to go out of my way if, some days, I'm feeling lazy or anything like that. Even myself, some days, not feeling top-notch. If I have an appointment I go to it, because it's right there, and it's going to help me just like my mental health doctors helped me in the past to get me where I am. I know the Wellness Center will get me where I'm going. At least, this wellness center, I know it will.

Finally, I'm just very grateful that we have a wellness center here in New Haven Connecticut that

is located in a mental health center. It's right here for me and all the clients that go to it. Thanks very much.

>> CHYRELL BELLAMY: Hi, this is Chyrell Bellamy. First of all, I just want to thank you all for having us today for this webinar. And, just to acknowledge folks who are on my [indiscernible] Project WE, a name that we chose because we are all in this together. In 2013, we were funded by PCORI by the grant titled Increasing Healthcare Choices and Improving Health Outcomes among Persons with Serious Mental Illness.

Very interesting process, as we were even developing the ideas for this grant, the impetus was that, at the same time the Connecticut Mental Health Center was just funded by [indiscernible] to develop a primary care center co-located there. So, one of our driving research questions or reasons for even applying for the PCORI Grant was, what happens when it doesn't work for everyone? I mean, we know that the location in a network for all people. Some people don't want to have their services located in the same facility. So people that [indiscernible] experience, people in recovery, they worked with us to develop a grant so that we can better understand some of the challenges, some of the barriers in the facility with the healthcare, even as part of PCORI, which I'm not going to talk about today. We developed a pilot, peer-driven, peer-design curriculum with Dr. Peggy (Margaret) Swarbrick, since they wanted to have in relation to holistic health.

So thank you very much, Dr. Cabassa, for laying out the overall challenges and issues related to primary health care for people with mental illness. We know that there are many systemic barriers for access to healthcare, primarily as related to the work that SAMHSA has been doing [indiscernible] these issues like lack of integration between primary and mental health care and separation of mental health services from other medical services.

Some of the facilitators have described the literature as well as based on our own experiences in this area include social support, especially from family and -- as Bob just mentioned -- also from friends and other providers, because many people are not currently involved with their families, unfortunately.

Continuity of care, seeing the same healthcare provider.

Reasonable income, and, dealing with some of the challenges related to access as care relates to income issues.

Teamwork and support that comes from working in a positive working environment for the staff that work in those facilities, as well as effective leadership and decision-making in those facilities.

So as I mentioned, this is based primarily on the receipt of a grant from SAMHSA to the Connecticut Mental Health Center and collaboration with the Cornell Scott Hill Health Center,

which is a federally-qualified health center, funding with SAMHSA for developing a co-located primary care center right at CMHC as Bob was talking about. The goal is to address client level factors such as skill training for clients patients and clients, nurse care management and coordination, health navigation, and then addressing, also, systemic barriers, such as, the main systemic barrier related to location in terms of [indiscernible], etc. we. Suggest having a co-located primary care center. As you can see, we have started to address some of those barriers. Having staff from one service, staff from the CMHC visit, on a regular basis, appointing care coordinators to liaise between services.

So the portion that we are going to talk about today from my PCORI grant is what the purpose barriers and facilitators to healthcare? Our PCORI research process was participatory, meaning it was co-developed and produced by people in recovery and patient partners.

Two of the questions that they were particularly interested in is, what are the barriers and facilitators to healthcare barriers for people served by CMHC? What do the patients say are there challenges to attend CMHC for mental health services? And two, what are some simple ways of addressing the barriers and building on what the participants say they feel are important to facilitating their access? So we also wanted to know, from a [indiscernible] perspective, how can we build what they say works well for them?

So as part of our method, just for this particular portion of the study, participants were recruited from the Wellness Center at CMHC. We used the barriers and facilitators scale, which was originally developed to assess barriers and facilitators to receiving healthcare for African-American men who have sex with men. I actually have that measure, if you're interested in seeing it. We modified it to address some of the specific questions that some of our partners and people in recovery partners wanted to make sure we addressed in terms of barriers and facilitators specific to their needs, as well.

So, just in terms of the characteristics of the sample, there were 200 for participants. Again, they were all clients and patients at the development Center. 62% were male. 37.5% female. And, .5% transgender. Average age was 45.3, but the range was 20 to 70.

African-Americans, largely, 47%. 36% white. 32% were Latino and Hispanic. 6% were Native American, and 6% were other. I just want you to know that CMHC also have a Hispanic clinic that provides mental health services for monolingual Spanish speaking individuals.

The rest of the characteristics include 67% never married or single. Education level achieved, the mean was about 11.6. Age of first hospitalization, and that actually relates to psychiatric hospitalization, the mean was 23.8. And the total lifetime hospitalizations, the mean was 9.25. And the total hospitalizations in the past year, with mean being 0.6.

So here are some of the barriers to receiving healthcare. We identified that the top 10 barriers...The first is you don't have a reliable source of transportation. As Bob said,

transportation is one of the major barriers that we all know about, are familiar with.

- 2: You have problems remembering the appointments.
- 3: You don't have stable housing.
- 4: You can't afford to pay for medical care.
- 5: Feeling too depressed to go to the doctor
- 6: Afraid we will have to make lifestyle changes
- 7: You have to wait too long to get an appointment, which is something that Bob was talking about.
- 8: You are afraid of what your healthcare provider will tell you.
- 9: You don't like to be reminded that you have a certain illness.

And, 10 and 11, you have to wait too long at the doctor's office. And the last one is, the medical appointment days and times are not convenient for you.

So, the top 10 facilitators to receiving healthcare services were:

- 1: You are currently receiving mental health treatment or services -- which is a good thing.
- 2: You like your healthcare provider.
- 3: You feel you can talk to your healthcare provider about your needs.
- 4: You feel your healthcare provider cares about you as a person.
- 5: You understand your healthcare provider's instructions.

So, a lot there with health literacy.

- 6: You look forward to taking charge of your healthcare -- related to, again, what Dr. Cabassa was talking about in terms of patient activation.
- 7: You are treated well by the staff in your doctor's office.
- 8: You feel your healthcare provider listens to you.

9: The days and times you can get appointments are convenient to you.

And 10: You have a system for remembering appointments.

So, just in terms of discussion, there were definitely some individual differences when we did further statistical analysis. Transportation was a barrier for all, regardless of gender, race, ethnicity, education and employment. And, feeling like you can talk to your healthcare provider about your needs was also huge, regardless of individual characteristics or differences.

I want to just talk about some of the barriers. You know, if you look at these, as some of the structural challenges, such as the result of poverty, such as transportation, housing, payment issues. Particularly for individuals who were not yet established in terms of Medicaid or Medicare. Difficulty with public health care such as long wait times, long wait times at the doctor's office and hours that might not be convenient. That might be inconvenient.

Something that hasn't been addressed is complications due to some of the emotional experiences about seeking healthcare. Many of our folks, as we know, have histories of trauma, a very large portion. And also, just feeling too depressed to go to the doctor and feeling too afraid of what it might mean to think about or act upon changing their lifestyles. And, being afraid of what the healthcare provider would tell you. In many ways, these things are probably no different to what people who don't have mental illness experience, just people who go to the doctors, in general. People often don't like to be reminded that they are ill.

Some of the facilitators, it's really important to that it's not just removing the barriers to receiving healthcare services. We also have to focus on some of the things that work. And, the interpersonal aspects are huge. And, those things, again, were echoed by Dr. Cabassa.

So, interpersonal aspects such as liking a provider, being able to talk with your provider, feeling your provider cares about you and listens to you. When we do qualitative research, 40 people [sounds like], as well, related to this issues of [indiscernible] facilitators, actually summed it up - - patient providers, people in recovery who assisted us with analysis -- they summed it up to they just wanted to be treated as a human, as a person, and to be listened to and heard and not to have their mental illness focused on as the issue. If they go to a doctor and talk about physical symptoms, that that's what they were there for, to talk about the physical symptoms -- not to have someone looking at their electronic health records to see that they have mental illness and then treating them accordingly.

But there are also some structural supports that need to be addressed. And in this case, it was being in mental health services. It's just as easily important [indiscernible]. Having systems for remembering appointments, having appointment times that are convenient and [indiscernible], a sense of agency is something that is needed. People need to, at least, feel a sense that they can control something about what they are trying to do in terms of self-management, that they are looking forward to taking charge of their healthcare needs.

I wanted to talk briefly about some of the things that CMHC did. As Bob mentioned, during his portion of the talk, it was crucial, the involvement of people like Bob on the Advisory Group for the Wellness Center, as well as on the advisory group for the PCORI grant. We able to give feedback to folks over at the Mental Health Center immediately about some of the challenges that were being talked about in the [indiscernible] committee, and they worked really hard at the Wellness Center to integrate those changes right away.

So some of the things that they were able to do is that, they accepted self referrals instead of requiring a referral by a mental health clinician, which is what the process was for, I think, the first two years or so. Yes. You know, actually, you know, this worked really well. And it makes sense, right? And also increasing self agency, you want people to be able to refer themselves to the primary care visit.

Accommodating "walk-in" visits, for individuals who present without an appointment, whether or not it's an urgent medical issue. So they also did that after the first, I think, two years, because this was an issue that folks said they wanted addressed.

Expanding the hours of services such as the on-site phlebotomy services in order to meet the needs of individuals, particularly those who work or have other commitments during the day that they had to attend to.

Additional processes include having a dedicated medical receptionist. This was like, really excellent, because individuals were able to walk up to the medical receptionist and make any changes that they needed to make in terms of their appointment. They could also receive a welcome present at the front door and in the waiting area by the medical receptionist. And this medical receptionist provided all the stats, the major stats, at the [indiscernible] center are made up of the medical stats from the Hill Health Center, the [indiscernible] center. So having them also assigned something, it can be a medical receptionist, was excellent.

The other thing that the folks who provide the medical services said worked really well for them was training them in the trauma informed care, person centered care and planning, and giving them a better understanding of what are some of the mental health issues and diagnoses, having more knowledge about, also, some of the social challenges, some of the emotional difficulties and challenges that many of the patients, clients, are faced with at the Wellness Center.

On top of that, that is sort of under the umbrella of recovery of oriented care. So while we did not start at the CMHC with doing this, we really understood that, in order for everyone to understand, to be on the same page with the work that is happening across the nation in terms of [indiscernible] healthcare and recovering education and [indiscernible] care, we wanted to make sure that the medical providers also were trained in how to do this. I think there's a lot of assumption when we use these terms such as "person-centered" and "person-care" that everyone knows what that means -- particularly within the context of, what does that mean when you are

working with individuals who have both mental health and behavioral health challenges as well as physical health challenges?

So, this slide here, person-centered healthcare, what healthcare providers said post training in this area, this was a specifically from the nursing staff that were involved who are providers in the Wellness Center. We believe, again, that the training, specifically, person-specific care really helps shape their thinking around this.

But one, every person is unique, thus, care plans need to be patient specific.

Two, use patient's own strengths to help guide their care plan, because, it's really important that we come from a strength perspective instead of using the deficits.

Three, while this is not just medical health, but also spiritual and emotional health, and we should incorporate this in healthcare plans. The nurses talked about, many of the times, the patients would present more socio-emotional challenges when they started talking to them rather than the physical health challenges.

And, four, care plans should include patient's goals, not just providers' goals for the patient.

The nursing staff and the medical staff at the Wellness Center also talked about collaboration of mental health and primary health staff. You know, we have to move beyond just having a co-located center, a primary care center in the mental health setting. True integration involves collaboration among mental health and primary health care staff.

So, some of their suggestions include a communication key flow of information should be appropriate and timely -- wwo, at a minimum, monthly meetings between clinicians and psychiatrist and staff of Wellness Clinic around patient care is really important. Especially for people who are presented with more high-level needs.

It's a teamwork process, number 3. As folks talked about, is one of the barriers, it's not just the doctor or the nurse that they see, but it's also people at the front desk that they come into contact with. It's the patient navigator, the medical assistant, the nurses, everyone is involved in this process. And, including the mental health providers at the organization.

Four, all staff must have continued training on mental health and behavioral health issues from a patient centered and recovery oriented perspective.

So, in conclusion, some tips would be to talk to people you serve, maybe try to use a barriers and facilitators measure or [indiscernible] to find out what are some of the barriers of the facilitators specific to the people you are serving your agency or organization.

Develop an active advisory group, where you're listening to the people. One thing that was key

to the development of the advisory group in this situation is that we had people with experiences, people in recovery, who did the interviewing, to find out, do people really want to be involved in these advisory groups? Because, they wanted to make sure that people were not there just as tokens.

Then, not just to listen, but to develop strategies together as a team. Facilitators of healthcare are essentially key elements of patient-centered care if we want to improve. And, a key to that is people being treated with dignity and respect, people being treated as if they are human. And understanding the barriers and facilitators to healthcare is only one step in that direction.

And, as I will push, training in the area of patient-centered, person-centered care, is essential, particularly for those who, as often is the case, are working in mental health facilities, coming from a recovery-oriented perspective, that takes that into consideration.

So, thank you so much for your time together from Project WE as well as Connecticut Mental Health Center, and thank you, Bob, for assisting me with that.

>> MINDY KLOWDEN: A special thank you from all of our presenters today, I can see already from the number of questions and comments I'm getting in the streaming, folks are really interested in what you have to say.

We are now going to have about 15 minutes for Q&A. I'm going to go ahead and get started from some of the things that I've been seeing coming in on the chatbox. One of the themes that has come up in the questions has been around cultural competency. Someone asks, "Is cultural competency actually happening?" Someone else commented about the shortage of clinicians from communities of color. A third person has been asking, "Is there any kind of a campaign up there, any effective tool for reducing stigma, particularly among Latino populations?"

So I'm going to put all the questions together and see if our presenters have some guidance and commentary on this.

>> LEOPOLDO CABASSA: This is Leopoldo. Those are great questions. In terms of training for cultural competence, one of the approaches that we took for the program, for Bridges To Better Health and Wellness was not to focus so much on the cultural competence as is commonly done, where we train people to work with Latino populations and African-American populations and Asians. We took a very different approach for corporate cultural competency. For us, a culture was absolutely at the heart of, what Chyrell was talking about, we started with the person we train our social workers to actually, as part of the assessment, do a cultural formation [sounds like] interview, which is basically an approach where you explore with your client, their own personal views of their health and their mental health issues. It gives them an opportunity to tell their stories from their perspective around, you know, what do they call their problems? How they coped? What do they fear about going to the doctor or coping with their condition? What are their hopes and aspirations? And, ground the entire relationship around the information that

is being collected in that interview.

This was hard, because we were collaborating with someone who developed the Cultural Formulation interview for [indiscernible] and we adopted [indiscernible]. So the [indiscernible] was really patient-centered, in really understanding the person from where they are coming from, their strength, their limitations, their aspirations, and giving them the opportunity to actually tell their stories, their concerns, and then integrate that information into the care they were provided. And it was part of really forming a true relationship with that healthcare manager. Because for many of our patients, our experience has been, very few professionals have actually asked the client these types of questions and given them the time and the opportunity to respectfully listen to them around this issue. We thought that was really important. That is the approach we took for the cultural competence element of it.

In terms of the stigma, the material that we were using, those photo-novellas helped destigmatize some of those health conditions in the sense that, it presents people in their community going through similar situations. These are stories of people, people that look like them. People that talk like them, that use the same sort of language. So it helps normalize, saying, other people in our community are also going through Type I diabetes, blood pressure, heart conditions, issues with their diet and medication. Then they can use that information to start conversation with their healthcare manager around that issue.

So that was the other obstacle. Stigma influences a lot of things. It's not only the stigma people receive from people in the communities. It's also stigma happening from providers, themselves -- particularly people who have not been trained to work with people with Serious Mental Illness, who understand where they're coming from and understand the journey of recovery that each person has. So, that's another aspect of this, really working with my primary care physicians around how to work with people who Serious Mental Illness, how to understand what the unique needs are, and what people want out of those interactions.

>> CHYRELL BELLAMY: You answered this very well, thank you so much. I will just echo in the cultural formulation, with [indiscernible] the Medical Director for the Hispanic clinic at CMHC, in training the residents and using the cultural formulation, as well, but also in doing training around cultural humility. I think there's a whole misnomer around cultural competency, like, do we ever become competent in one's culture? But I think, when we are able to first connect with our own culture, the fact that we all, as individuals, have culture, and understand how our own culture and our own worldviews might then impact or influence the ways in which we then interact with others as providers, as individuals, is key to this work

Recently, Bob Cole supported the CMHC as well as the psychiatry residents [sounds like], and folks from the advisory committee, Bob went to attend an Undoing Racism workshop for people from the The People's Institute for Survival and Beyond, we were there for two days, to again, understand this further. I think you can never get enough of it. You have to keep doing this, particularly, as [indiscernible] said, within the context of recognizing, there are differences in

coming from that person-centered perspective. And in terms of stigma, one of the big things that we know is, just having people with lived experience -- people in recovery from mental health, substance abuse challenges, are there to serve as welcome committees to offer hope, to share their experiences, to show how they navigated those healthcare systems. It's really important to reducing some of the stigma.

>> MINDY KLOWDEN: That's a really nice segue, there's a group of questions around peers, in particular, folks are asking, Bob, if you could speak a little bit more, to how you engage the peers that you work with in utilizing the center, what tools you found effective in talking with peers. Then also, there are some more general questions just around, "How can peers be used to support the coordination of care?"

>> BOB FORTANO: Peers, first of all, are really being utilized at Connecticut Mental Health Center now, as opposed to 10 years ago. We have lived experience. We've had drug problems, psychiatric problems, and we've been there. There's about seven or eight people I've seen [indiscernible] who are a Peer Support Specialist. And we have a desk when you walk in the Clinic of Medical Health, off on one side, they will give you any groups we have for the day, whether it be yoga, exercise, or different things like that. We can talk about that to them. If a client is going to like, the Wellness Center, and they want not to go by themselves, we can go with them into the Wellness Center, sit with them, talk with them, even go into the closed door if they want us to, with the doctor, just to be part of them and with them.

I feel a lot of the clients at Connecticut Mental Health are really opening up to peers more than clinicians or doctors, being, the reason, a lot of clients ask what the heck is a peer? What is a specialist? What is that all about? We tell them, I've been where you are. I may not want to go back there, but someday I may be there, but I was there. I've lived what you are living. We try to help them out of it. We try to be uplifting and supportive to the clients that are there. I know a couple of the clients who are doing well. They have the medications working right. They have been doing well for a couple years and they are looking to become a Peer Specialist.

We go to a lot of meetings at CMCH, like the [indiscernible] which is with the CEO of CMHC, which is issues with the mental health aspect of the center. So, the Wellness Center, there's different activities we participate in. We also, in addition to the navigators, if someone needs a ride home after something at CMHC, we can utilize some of the vans that they have there and take people home. Just did that last Thursday.

So there really is a lot of things we are utilized for, that I find, there is a safe cushion. Especially, as the new clients, people we don't even know, who come up to the peer desk and start talking to me, shaking my hand, like family, even I've ever met them before. It's a very rewarding feeling. They don't say it, but I see they feel safe at Connecticut Mental Health, feeling safe. The doctor shouldn't be above anybody, the doctor shouldn't be below anybody. No client should be above anybody, no client should be below anybody. I think peers, right off the bat, without knowing that, what I just said, we are there, to say, we've been there. We know what you're going through.

We are going to help you. As long as you need us, we're going to help you.

>> MINDY KLOWDEN: Thank you, Bob, that's such a valuable perspective. Another thing coming through in the questions is, a lot of folks are interested in knowing how the services are paid for, or services, care coordination, navigation services. A lot of people asking, is this really sustainable? Are funders supporting this kind of add on? What do you folks think about that?

>> CHYRELL BELLAMY: Personally, almost every grant I see right now has some type of peer related component. I know that, having been trained to [indiscernible] around the state, and also developed recovery support specialist training, it's in high demand, nationally. I think part of it is to not think of it as an add on, but in a sense, as an aspect of the work that we do. We need peers supporters just like we need social workers, just like we need mental health tacticians, etc. So, making it an essential duty is really important and then, working as an interdisciplinary team where everyone, then, can hold onto their own values and principles and bring that into, sort of, the group together. Both will go really far.

>> LEOPOLDO CABASSA: I [indiscernible] that as well. For the healthcare managers, one of the things we didn't present, but it was part of our project, was to determine what [indiscernible] of this intervention can we already bill for? There are certain activities that the clinics already do. So, some of the screening, some of the initial physical health assessments, some of the nurses that are already in those clinics and already bill for that. Then, some of the social workers can do some of the care management aspects which, in a lot of ways, [indiscernible] with coordinating care with other providers. Also, [indiscernible] for any clinic or any site that wants to take on this approach is to really examine what they already do and see if there is anything within their billing scheme that can take on certain aspects of this service. And some of them will be able to bill. Some of them will not, of course, depending on where you are. But there is a way of thinking through what you already do and how to reorganize and restructure what you do to take on some of these [indiscernible], particularly in a mental patient outpatient healthcare clinic that [indiscernible]. [indiscernible] will tell you they do spend a lot of time on the physical side of things because of the complex nature of the clients and the health conditions that they have and how [indiscernible] their mental health, as well. So it's really working closely with the site and really reconfiguring what can and cannot be billed. And a lot of work is being done right now and integrating health and mental health care and [indiscernible] is an integral part of that. So some funding is coming from those functions, especially in the patient medical centered homes [sounds like] and things like that because that is a central aspect of programs -- without [indiscernible] you can't really integrate.

>> MINDY KLOWDEN: There have been some concerns expressed in the chatbox about quality of care and health care settings particularly, and experience if there are people, family members observing [indiscernible] treatment, and if there is any guidance what consumers or family members can do to help appropriately file grievances and advocate for a better treatment. This was both within outpatient settings and it was also mentioned within emergency departments, if anything [indiscernible] can be done.

>> LEOPOLDO CABASSA: In the work that we did, one of the things was to really have conversation with the clients and if they were a family member, with the family member, with their permission, to talk about what is the care that people should be receiving. So if you have diabetes, what are the things you should be asking for? What are the things you should receive from your primary care physician and to have a clear understanding of what that is. We actually share that information with the client and their family members with their permission by using a personal health record that really lays out, here's what you're supposed to be getting and you are sharing this with your primary care physician. You are sharing this with your mental health care provider and the client. And that was sort of a record that the person kept and had all the information. So that helped beginning to clarify what is expected, what is the care that people need? What are the preventive care procedures, like Bob was saying -- a colonoscopy, when should you get that, how often, and that sort of thing. Those [indiscernible], we didn't even get into any of those components. We did advocate, a health care manager would advocate if they see anything wrong, do the client perceive what they need and to have someone there who can advocate in the process. But in terms of grievances in the ER, we didn't face that situation. But that's a question.

>> CHYRELL BELLAMY: I just want to say that all mental health centers should have client's rights officers and also the primary care facilities should have patient's rights. And, our supporters are also trained in advocacy. So, just having someone to go and talk to about what's going on, sometimes it's a point of clarification. Sometimes it's working with the peer provider directly to go and address the issues. Often, if it's an issue that's experienced by one person, it might be an issue that's experienced by others. So how can we figure out how to address it together? And that's the approach that we try to use, at least, at CMHC.

>> BOB FORTANO: Just to piggyback off that, I think at Connecticut Mental Health Center, they do it very well for the Wellness Center for CMHC, itself. If somebody can't advocate for themselves, a lot of people, I notice, have been coming up to us of peers and saying good things and a few bad things that they feel like they don't want to bring up with their clinician, if it's a psychiatric problem, or the Wellness Center if it's a problem. They just won't advocate for themselves. But what I see at the Center that's really great is there are drop boxes in the hallways, and there's even one right on the table on the Wellness Center that I've seen. You can write down things you like, don't like, like to see change, update, anything like that. Comments, questions, positive statements. You can say that at the Center being anonymous, and [indiscernible]. I helped fill out a few of those with patients. It was really nice to know they are getting their voice being heard without having to speak up in fear that they might have repercussion or that they might be afraid to go back into that place that they had the difficulty.

>> MINDY KLOWDEN: Unfortunately, we have many more questions than we have time to answer today. So I do want to point all of our audience members to some of the tools that we have available through the CIHS. We have a lot more information on our website about the need

for integrated care for persons with mental health and substance abuse disorders. We also have information about tools for our patient activation, including resources around motivational interviewing and patient activation measure, which was a tool that was mentioned earlier in the presentation today.

And, any question that was not able to be answered here or anyone looking for additional information on things like, how to implement peer services and bill for them? How do you begin the process of integrating [indiscernible] in mental health, anything like that, we have a number of resources on our website. And you can also contact us for a one hour, free consultation on any of these topics. And SAMHSA is able to help you in your process on your journey of integrating primary care and mental health.

>> ROARA MICHAEL: Thank you, Mindy. That's all that we have for today. Once again, a recording and transcription of the webinar will be available on the CIHS website. Once you exit the webinar you will be asked to complete a short survey. Please be sure to report your feedback on today's webinar.

Also, I would like to extend a huge thank you to our presenters for joining us on today's webinar. Thank you all and please stay tuned for more webinars in the near future. Have a great afternoon, everyone.