Community Mental Health Summit

Cochise County

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Tuesday
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What we'll be discussing!

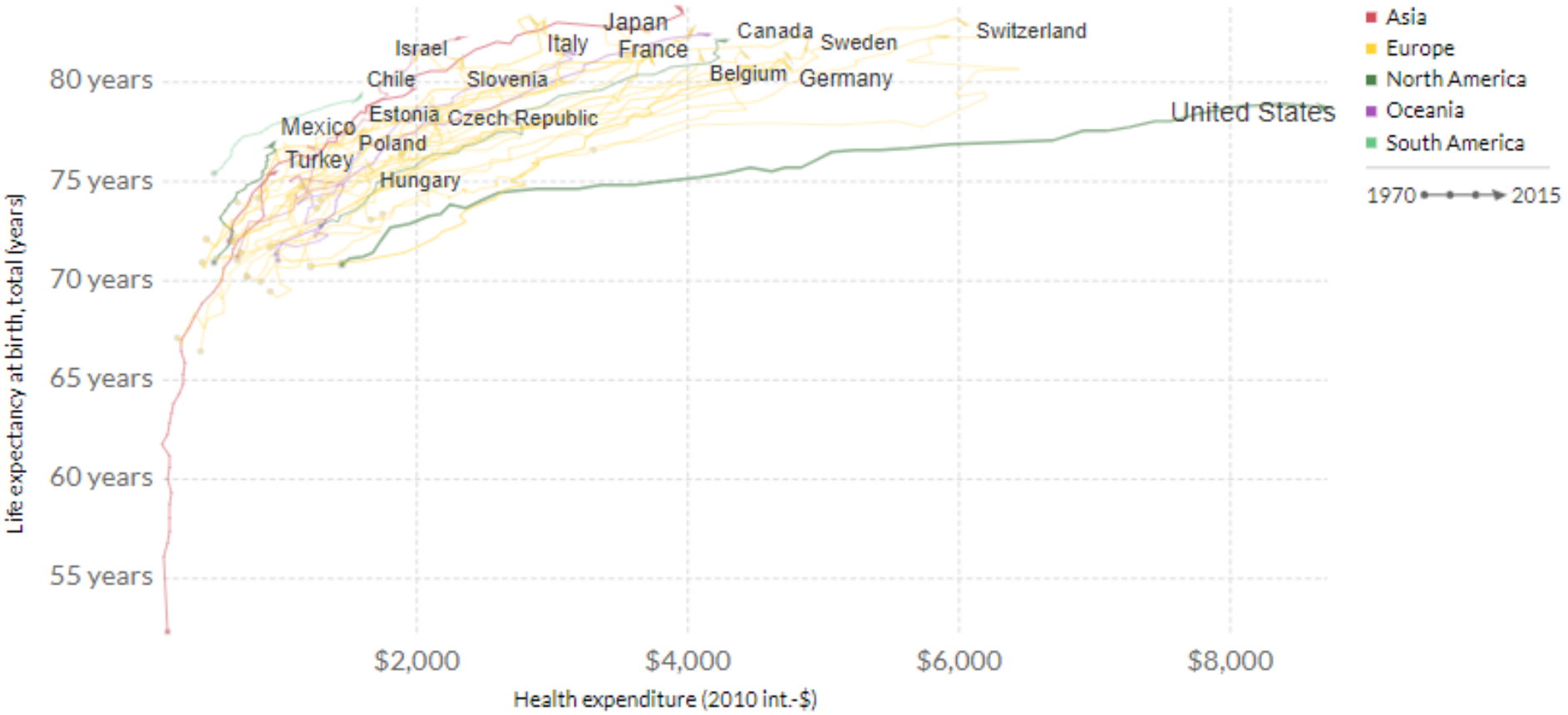
- The toughest job in the world!
- Engaging vs Activating People
- The Role of Values, Relationships, and Measurement to Improve Community Health

What's the toughest job in the world?

Life expectancy vs. health expenditure, 1970 to 2015

Health financing is reported as the annual per capita health expenditure and is adjusted for inflation and price level differences between countries (measured in 2010 international dollars).

Our World in Data



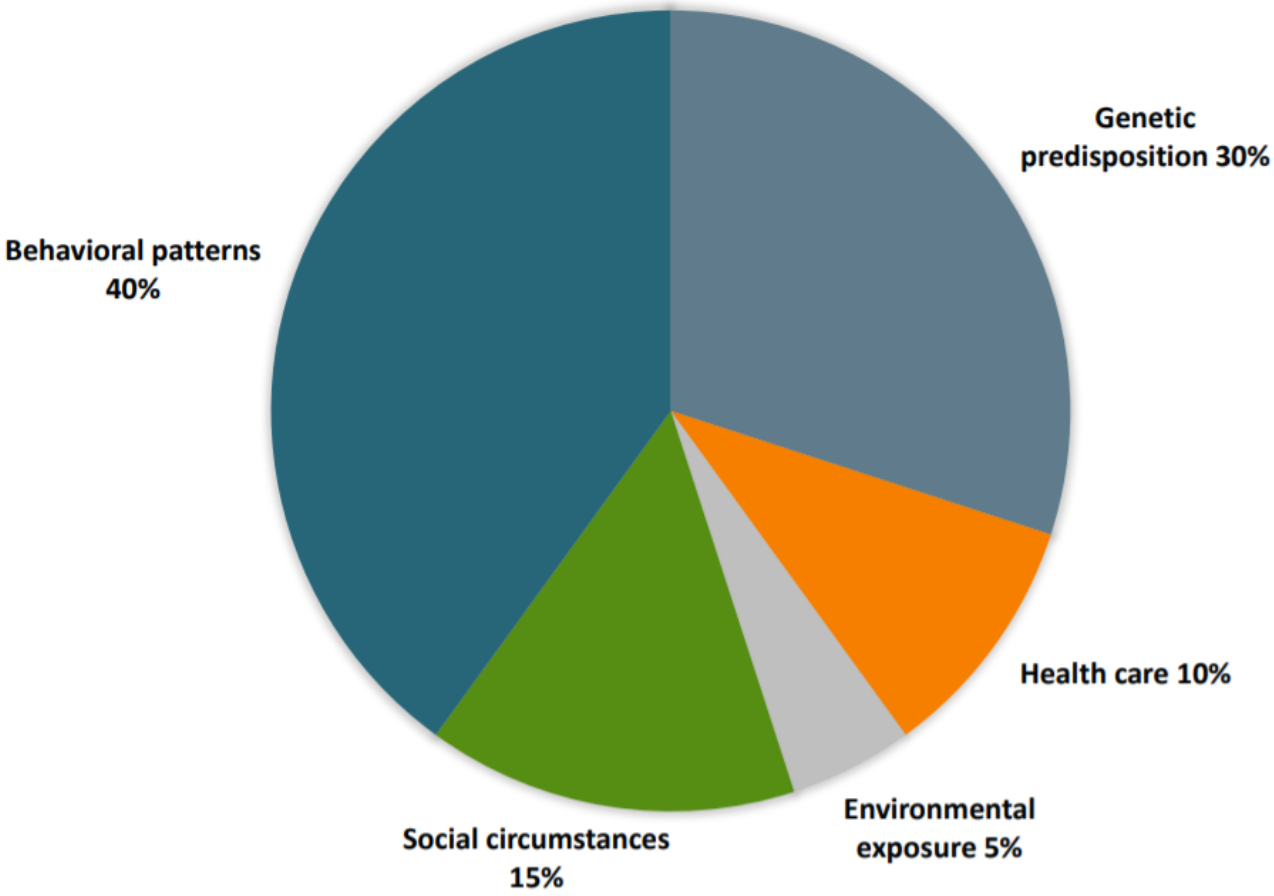
Source: World Bank, Health Expenditure and Financing - OECDstat (2017)

Commonwealth Fund Mirror, Mirror Report on Eleven Industrialized "High Income" Countries

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING	**2**	**9**	**10**	**8**	**3**	**4**	**4**	**6**	**6**	**1**	**11**
Care Process +	2	6	9	8	4	3	10	11	7	1	5
Access +	4	10	9	2	1	7	5	6	8	3	11
Administrative Efficiency +	1	6	11	6	9	2	4	5	8	3	10
Equity +	7	9	10	6	2	8	5	3	4	1	11
Health Care Outcomes +	1	9	5	8	6	7	3	2	4	10	11

Commonwealth Fund Mirror, Mirror 2017: International Comparison Reflects Flaws & Opportunities for Better U.S. Health Care. By Eric C. Schneider, Dana O. Sarnak, David Squires, Arnav Shah & Michelle M. Doty

PROPORTIONAL CONTRIBUTION TO PREMATURE DEATH



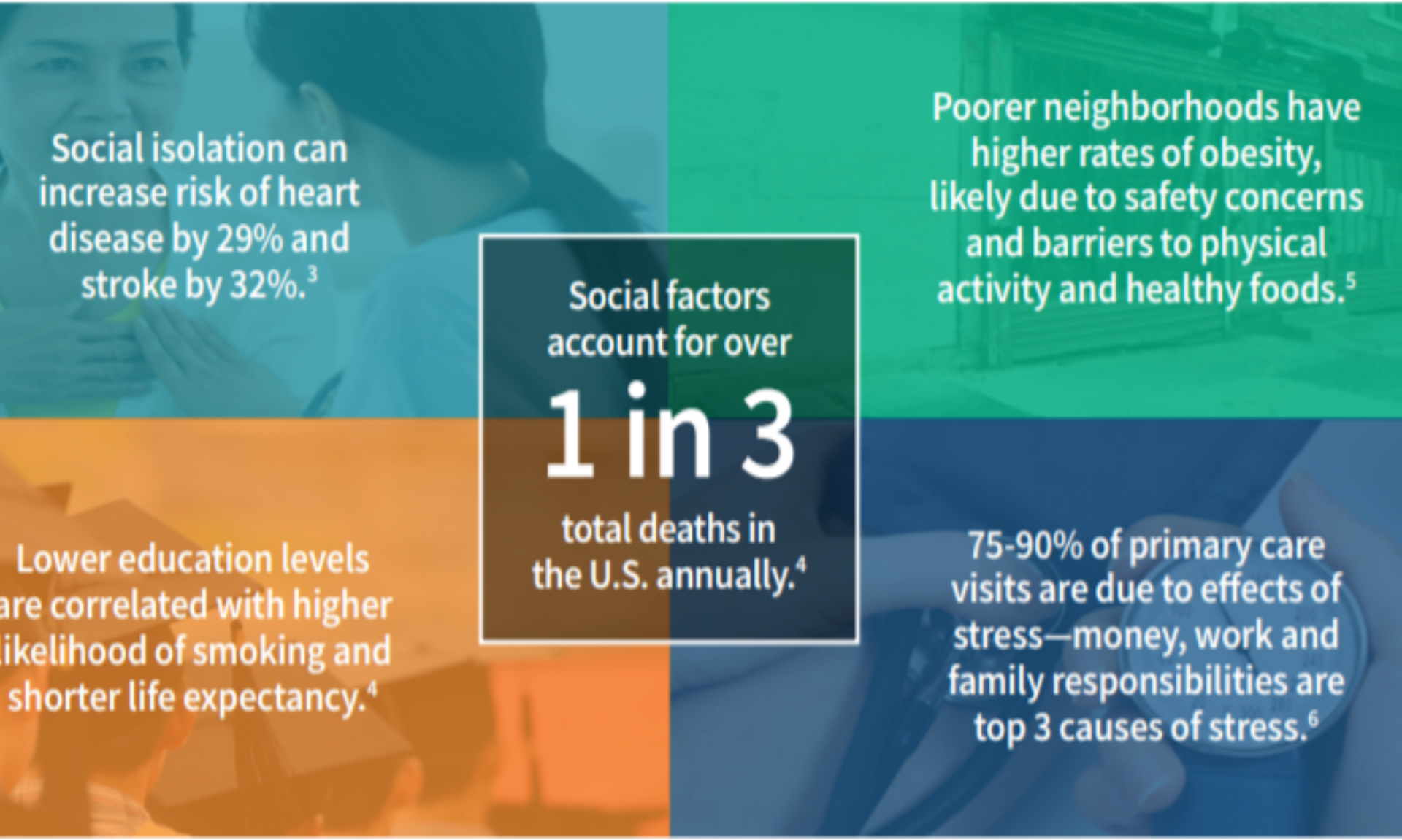
McGinnis et al. The case for more active policy attention to health promotion. *Health Affairs*. 2002;21(2):78-93.

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education			
Support	Walkability				

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

THE HENRY J. KAISER FAMILY FOUNDATION


Social isolation can increase risk of heart disease by 29% and stroke by 32%.[3]
Poorer neighborhoods have higher rates of obesity, likely due to safety concerns and barriers to physical activity and healthy foods.[5]
Social factors account for over
1 in 3
total deaths in the U.S. annually.[4]
Lower education levels are correlated with higher likelihood of smoking and shorter life expectancy.[4]
75-90% of primary care visits are due to effects of stress—money, work and family responsibilities are top 3 causes of stress.[6]

Suicide

- In 2017 suicide was the 10th leading cause of death overall in the United States, claiming the lives of 47,173 people.

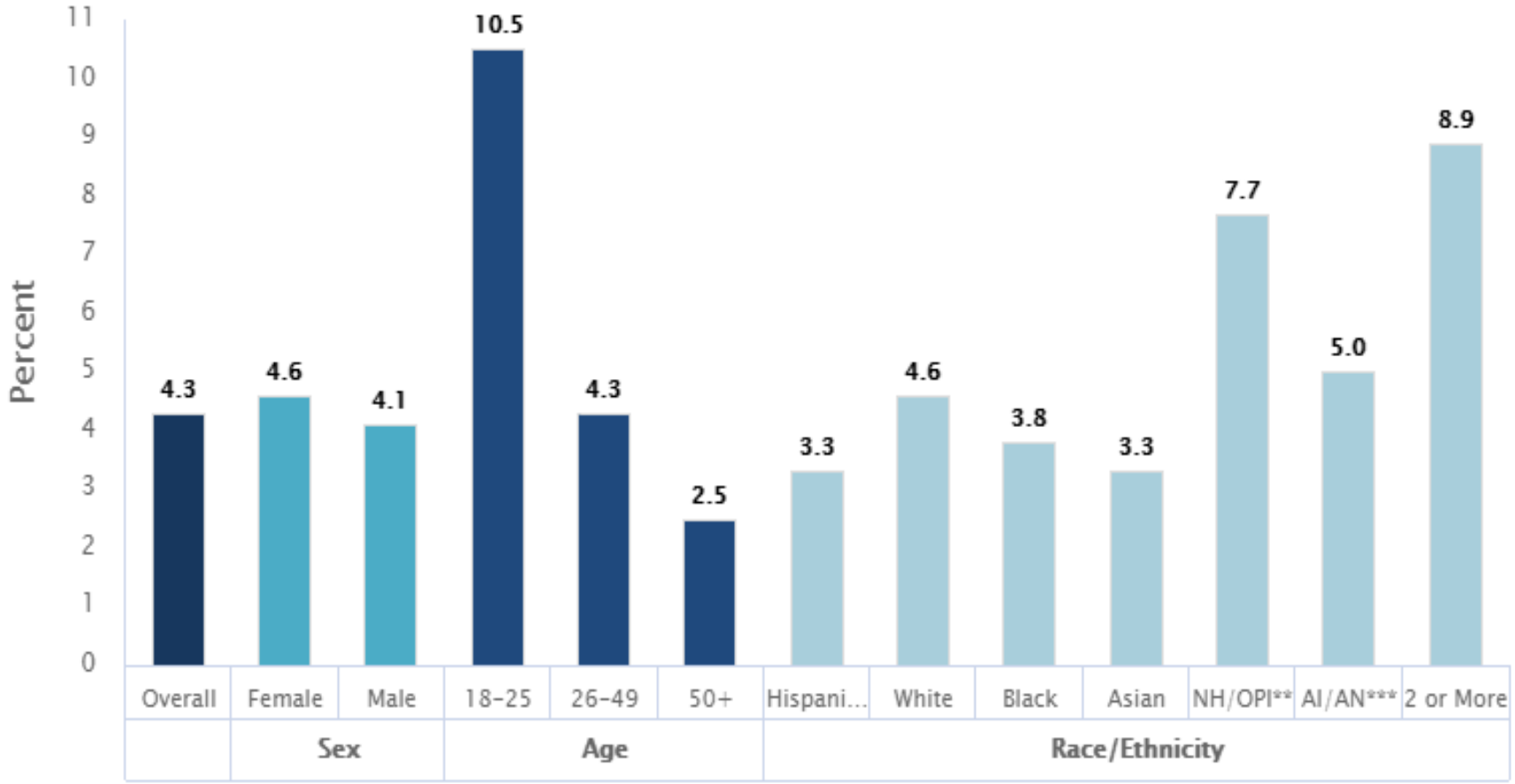
- Suicide was the 2nd leading cause of death among individuals between the ages of 10 and 34, and the 4th leading cause of death among individuals between the ages of 35 and 54.

- There were more than twice as many suicides (47,173) in the United States as there were homicides (19,510).

Source: Hedegaard, H., et al. (2018). Suicide rates in the United States continue to increase. NCHS Data Brief No. 309. National Center for Health Statistics. Available at www.cdc.gov/nchs/products/databriefs/db309.htm.

Past Year Prevalence of Suicidal Thoughts Among U.S. Adults (2017)

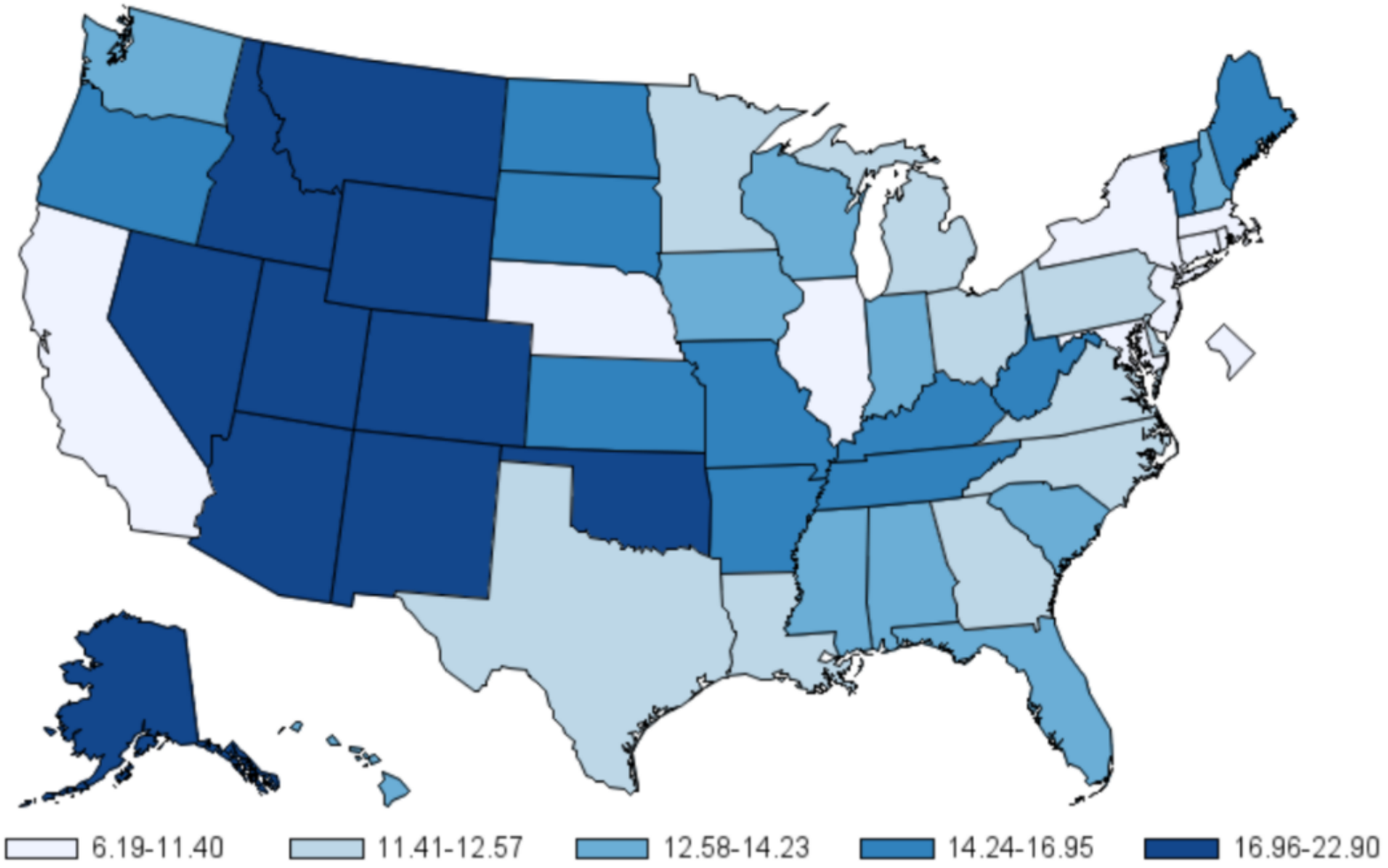
Data Courtesy of SAMHSA



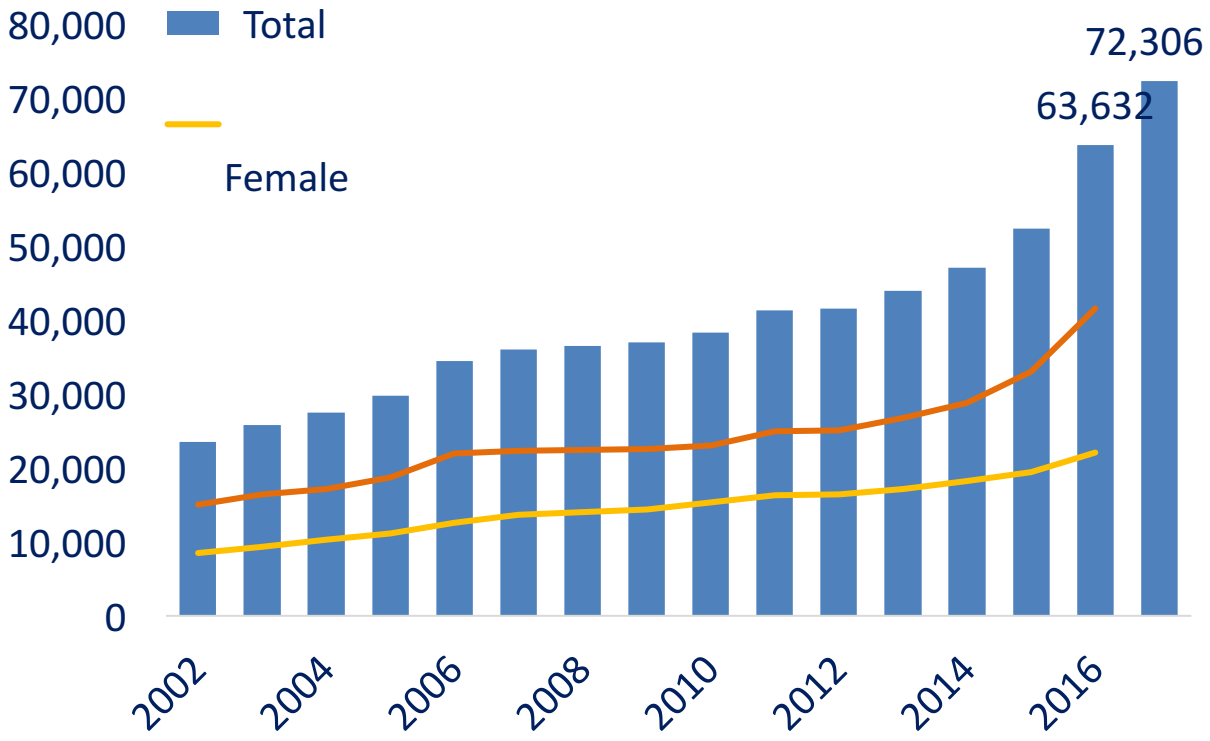
*All other groups are non-Hispanic or Latino / **NH/OPI = Native Hawaiian / Other Pacific Islander / ***AI/AN = American Indian / Alaskan Native

Suicide Rates in the United States
(by state; per 100,000; average 2008–2014)

Data Courtesy of CDC

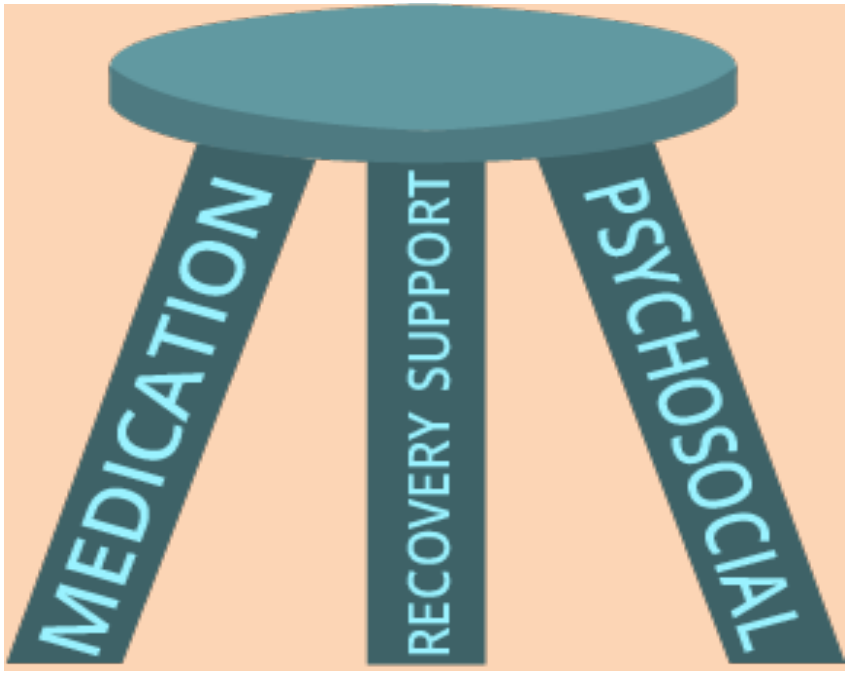


National Overdose Deaths: Number of Deaths Involving All Drugs



Source: National Center for Health Statistics, CDC Wonder

Medication Assisted Treatment (MAT)



ZEROSUICIDE

because one life lost is one too many

Suicide Safer Care


Substance Abuse
Mental Health
Primary Care

Trauma Informed Care

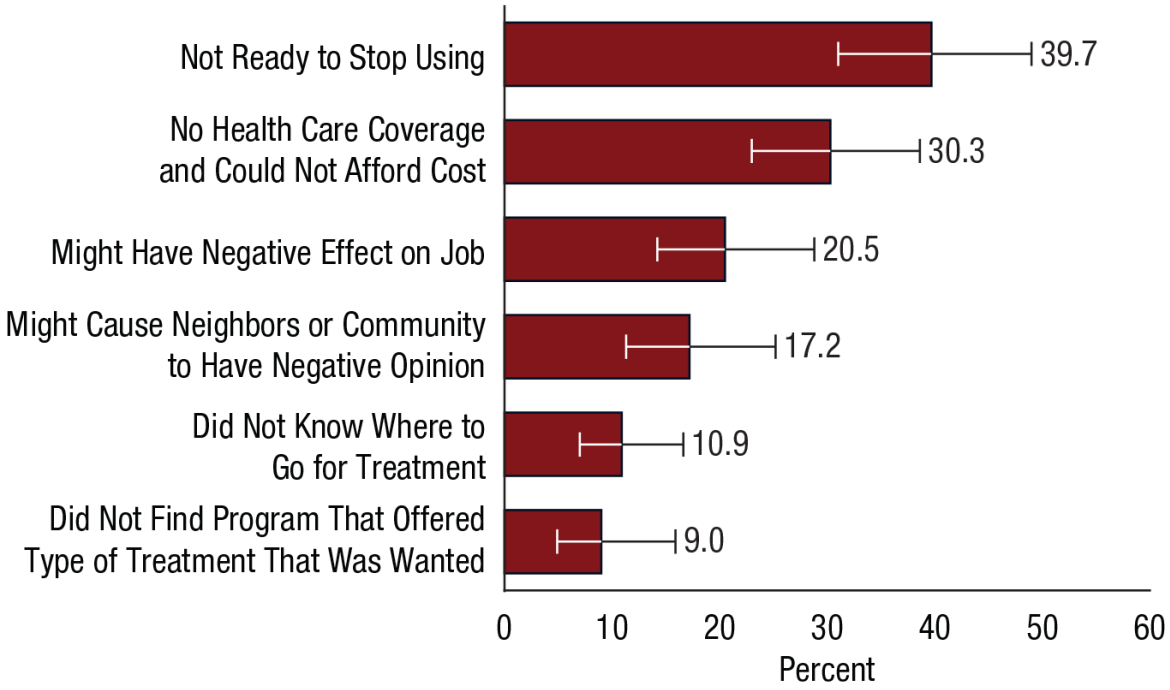
Motivational Interviewing

Crisis Intervention Team (CIT) Training

Alternative Courts

Systems of Care & Recovery Oriented Systems of Care

Reasons for Not Receiving Substance Use Treatment in the Past Year among People Aged 12 or Older Who Felt They Needed Treatment in the Past Year: Percentages, 2017



Note: Respondents could indicate multiple reasons for not receiving substance use treatment; thus, these response categories are not mutually exclusive.

Healthcare/Social Services…

Terms Worth Defining as a Community

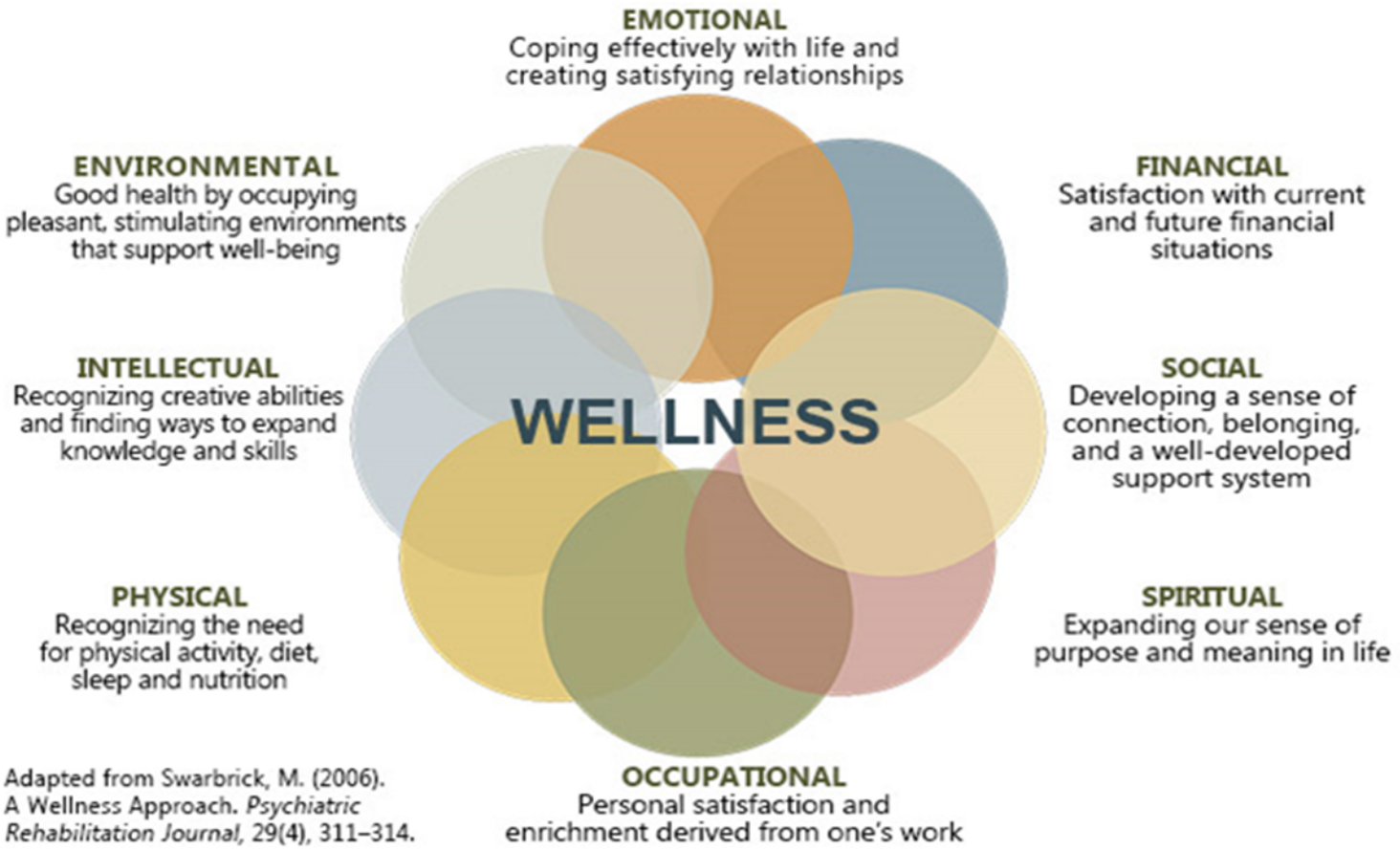
Wellness

Recovery

Engagement

Activation

SAMHSA's 8 Dimensions of Wellness



Adapted from Swarbrick, M. (2006). A Wellness Approach. *Psychiatric Rehabilitation Journal*, 29(4), 311–314.

Defining Recovery

A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

SAMHSA, 2011

- **Health** – managing one's disease and supporting physical and emotional wellness
- **Home** – having a stable and safe place to live
- **Purpose** – conducting meaningful life activities
- **Community** – having social relationships and social networks

We don't see things as they are;
We see things as we are.

-Anais Nin

Seeing isn't believing.
Believing is seeing.

-Little Elf Judy

...

Engagement vs. Activation

- ***Engagement***: A broader concept, including patient activation, the interventions designed to increase it & the patient behavior that results from it

- ***Patient Activation***: Understanding one's own role in the care process & having the knowledge, skills & confidence to take on that role. Activation is broader than earlier concepts such as locus of control, self-efficacy, & readiness to change, which typically focus on changing one specific behavior. Activation is associated with a wider range of outcomes than these previous concepts.

-When Patient Activation Levels Change, Health Outcomes And Costs Change, Too. Green, Hibbard, et al. Health Aff (Millwood). 2015 Mar;34(3):431-7.

Correlates of Activation

- Reduced Cost
- Improved Health Outcomes
- Follow through on Treatment Recommendations
- Seeking Out Information/Collaboration in Care

-Green, Hibbard, et al. 2015 When Patient Activation Levels Change, Health Outcomes And Costs Change, Too

Staff Benefit…

- Improvements in the staff experience (Atwood et al., 2016; Coulmont et al., 2013; McClelland et al., 2016)
- Improved staff retention (Coulmont et al., 2013)
- Reduction in job stress (Bosch et al., 2012)
- Greater satisfaction with interactions with patients (Bozic et al., 2013)
- Lower rates of staff burnout (Gazelle et al., 2015; Nelson et al., 2014)
- Increased compassion (McClelland et al., 2016; Riess et al., 2012)

Out with the old in with new…

$$\frac{\textbf{Care Experience} + \textbf{Outcomes}}{\$} = \boldsymbol{Value}$$

Service Provided x Number of Times = *Payment*

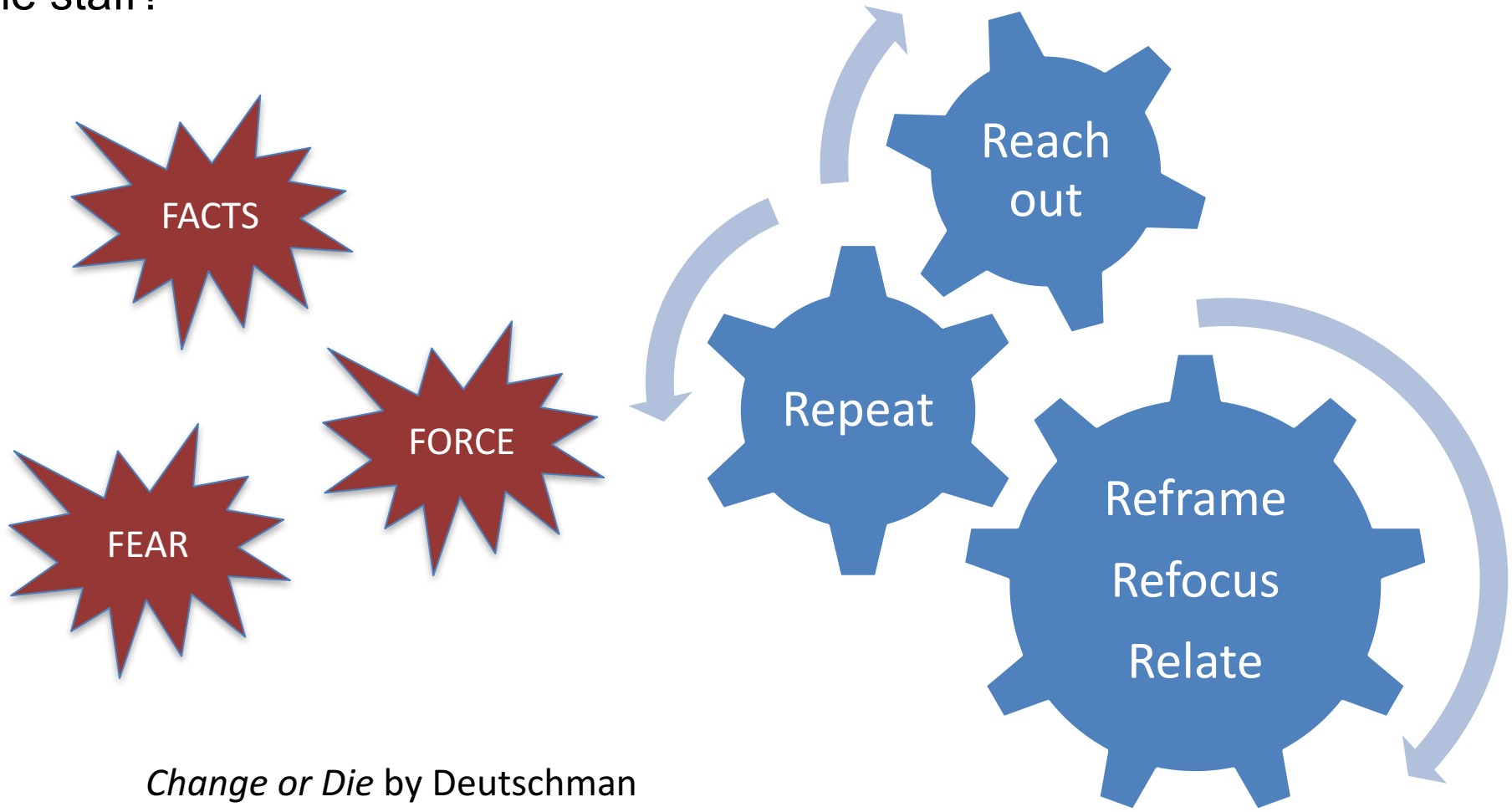
Bandura's Theory of Self-Efficacy

- A person's belief in their capacity to successfully perform a particular task.
- Along with goal-setting, self-efficacy is one of the most powerful motivational predictors of how well a person will perform at almost any endeavor.
- Determines effort, persistence, and strategy in the accomplishment of tasks.

-Gerd R Nydock

Creating Services Focused on the Experience of Care

How is change messaged by your staff to consumers & by leadership to the staff?



Change or Die by Deutschman

Shame & Compassion Trap

- When care is delivered with compassion and empathy, research demonstrates that health outcomes are improved (Del Canale et al., 2012; Haslam, 2007; Hojat et al., 2011; Kelley et al., 2014; Rakel et al., 2011).

- Shame (generated by self or others) from not achieving a targeted outcome/behavior results in likelihood of repeating the unwanted behavior.

- Compassion/Self-Compassion works better than shame to motivate someone to change if they have a defined future-self (recovered-self).

-*The Willpower Instinct,* Kelly Mc Gonigal

Ok, fine but How is this done and Who is doing this?

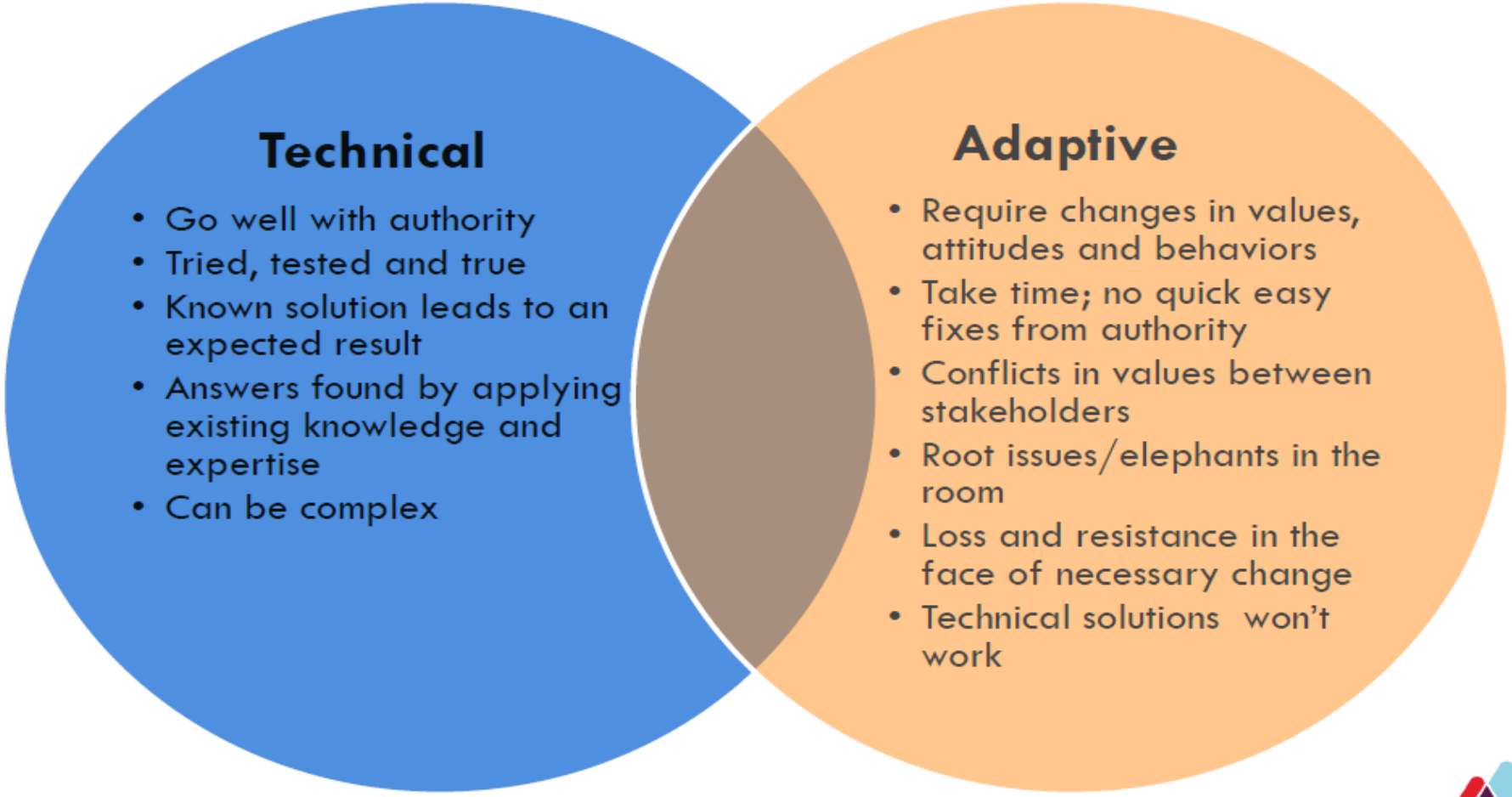
How?

1. Focus on Shared Values, Principles & Practices
2. Create & Maintain Strong Relationships
3. Measure Care Coordination!

Who?

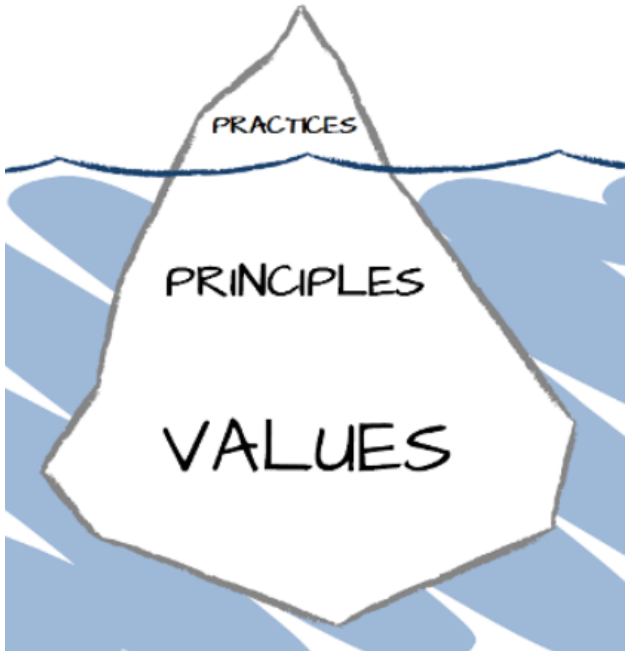
- UCLA
- Ardmore, OK
- Rapid City, SD

Technical vs. Adaptive Challenges



the DELTA CENTER
for a thriving safety net

Values => Principles => Practices => Norms



Values (*What matters most*):

- Timeliness
- Effectiveness
- Measurement
- Safety
- Transparency
- Respect
- Compassion

Practices (*Where Principles are Enacted*):

- Protocol for breakdown Declarations
- Care Coor. Meetings

Principles (*Agreed on Rules*):

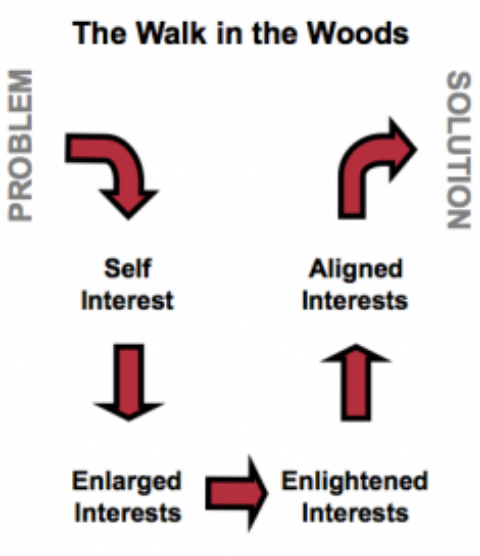
- We will use data to make decisions
- Conflict will be declared & constructive
- We will celebrate successes
- There will be no use of stigmatizing language

Norms (*"This is who we are and this is how we do our work!"*):

- Shared/agreed on mental models
- Expressed sum of the values, principles and practices

Creating & Maintaining Strong Relationships

- Work with whomever is willing to work
- Be willing to call your baby ugly
- Have a process for declaring and working through breakdowns
- Have a process for declaring and celebrating successes
- Learn from your consumers



Marcus, Leonard J., Dorn, Barry C., & McNulty, Eric J., "The Walk in the Woods: A Step-by-Step Method for Facilitating Interest-based Negotiation and Conflict Resolution." Negotiation Journal, 28(3), pp. 337-349, July 2012.

Care Coordination Defined!

The deliberate organization of care activities between two or more participants involved in a person's care to facilitate the appropriate delivery of services.

Source: McDonald KM, Sundaram V, Bravata DM, et al. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies, Volume 7—Care Coordination. Rockville, MD: Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services; June 2007.

Perspectives on Care Coordination

Patient & Family ask…

✓How easy is it for me to get the care I/my loved one needs?

Provider asks…

✓How easy is it for me to do my work?

System Representatives ask…

✓How easy is it for me to know care is effective & efficient?

Source: McDonald KM, Schultz E, Albin L, Pineda N, Lonhart J, Sundaram V, Smith-Spangler C,Brustrom J, and Malcolm E. Care Coordination Atlas Version 3 (Prepared by Stanford University under subcontract to Battelle on Contract No. 290-04-0020). AHRQ Publication No. 11-0023-EF. Rockville, MD: Agency for Healthcare Research and Quality. November 2010.

Provider Level Activities

1. Include Care Coordination in vision/mission
2. Common language/definitions for Care Coor
3. Policies/Protocols/Procedures detailing Care Coordination standards (that align w/ community standards)
4. Include Care Coordination in all job descriptions
5. Include Consumer & Natural Support education in care planning (e.g., Make Effective use of Safety/Crisis Planning Process/Documents)
6. Provide Care Coordination training for all staff
7. Establish cross agency agreements for referral and data sharing
8. Cross agency meetings for monitoring & post action reviews

UCLA CICARE

- CICARE is an evidence-based acronym that creates a standard process for interactions with patients, families, and colleagues.

- Our **Vision** is to heal humankind, one patient at a time, by improving health, alleviating suffering, and delivering acts of kindness.

- Our **Service Promise** is to create a welcoming, healing, caring, safe, and professional environment for our patients, their families, visitors and each other.

- UCLA Way: courtesy, respect, & professionalism

CICARE

With everyone on every encounter, we commit to:

- **Connect** with **Compassion** by addressing the patients as Mr./Ms. or by the name that they prefer.
- **Introduce** yourself with **Integrity** by stating your name & your role.
- **Communicate** with **Teamwork** what you are going to do, how long it is going to take, & how it will impact the patient.
- **Ask** with **Discovery** by anticipating the patient needs, questions, or concerns.
- **Respond** with **Respect** to patient questions or requests with immediacy.
- **Exit** with **Excellence** by ensuring all of the patient's needs are met.

Wellness Oriented Trauma Informed Care (WOTIC) Ardmore, OK

We will build a comprehensive framework for addressing behavioral health and trauma in Carter County by linking existing assets with new opportunities to shrink gaps and promote prevention.

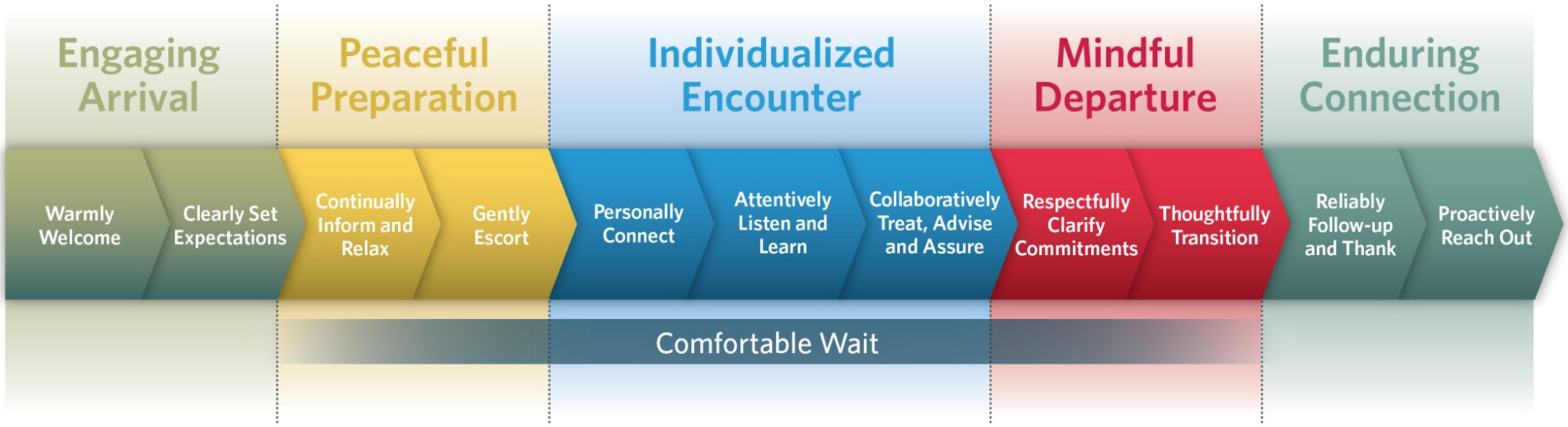
A photograph of the 42 volunteers from Noble Drilling and Fain-Porter Drilling companies taken before they secretly embarked for the United Kingdom on March 12, 1943, aboard HMS Queen Elizabeth, which had been converted into a troop transport ship. Photo courtesy of the Guy Woodward Collection, American Heritage Center, University of Wyoming.

Agreed Upon Care Coordination (CC) Standards

- **All Organizations will Provide Quick Assessment of their customers and staff:**
  - No wrong door philosophy
  - “We don’t need to be a healthcare provider to help!”
- **All partnering organizations know the CC standards and train/supervise their staff to the standards**
  - All orgs have lead CC person
  - All organizations will send person to CC meetings
- **All clients are immediately connected**
  - Warm handoff approach when possible
- **Follow-up w/ client if possible**
  - Track data

Mercy Signature Service

Patient Touchpoint Map



TIC CARE

T	**Take the time** to introduce yourself, your role and explain what you will be doing. Set realistic expectations and goals for your time with them.
I	**Intently listen** to their story and/or request. Be patient and persistent.
C	**Consistently and mindfully be aware of the language you use** when responding to the client's story and/or request.
C	**Connect the patient to others that may be able to meet any needs that are out of your scope of practice.**
A	**Ask the patient for their story** and try to anticipate their needs and questions. If applicable, provide ongoing choices and support.
R	**Respectfully respond and communicate at all times**, e.g., use Mr./Mrs., be validating and affirming.
E	**Ensure all patient needs are met** before exiting, make warm handoffs/referrals when possible. **Follow through** with what you say you will do.

Rapid City South Dakota Recovery-Oriented System of Care (ROSC)

…A shift away from crisis-oriented, deficit-focused, and professionally-directed models of care to a vision of care that is directed by people in recovery, emphasizes the reality and hope of long-term recovery, and recognizes the many pathways to healing for people with addiction and mental health challenges.*

- Prevent the development of SUD and MH conditions
- Intervene earlier in the progression of illnesses
- Reduce the harm caused by SUD and MH conditions
- Help people transition from recovery initiation to recovery maintenance
- Actively promote good quality of life, community health, and wellness for all

**Achara-Abrahams, I., Evans, A. C., & King, J. K. (2011). Recovery-focused behavioral health system transformation: A framework for change and lessons learned from Philadelphia. In J. F. Kelly & W. L. White (Eds.), Addiction recovery management: Theory, research and practice. (pp. 187- 208). Totowa, NJ: Humana Press.*

Care Campus

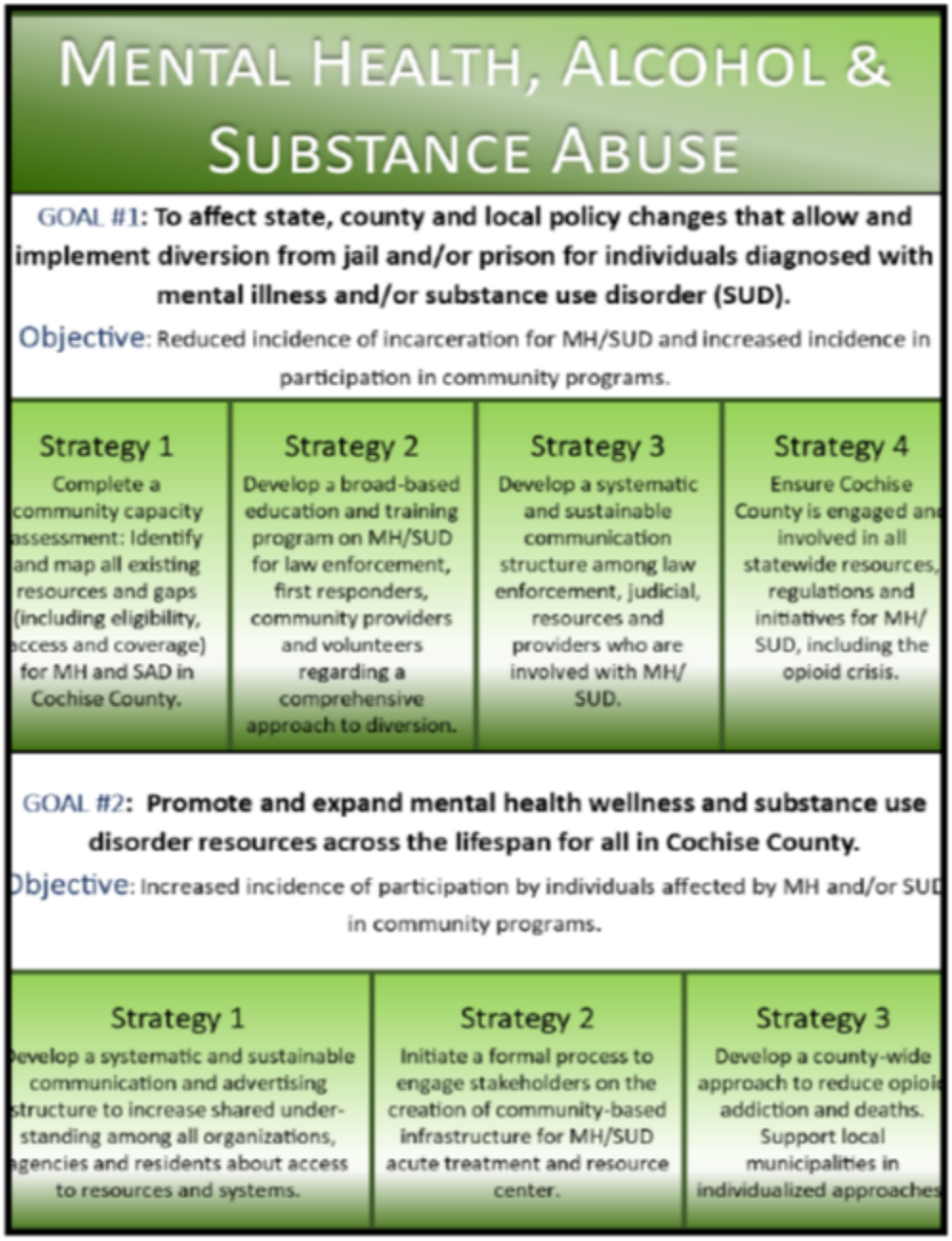
Next Steps for Rapid City!

- **Quality of Life Officers** to help engage, link and coordinate services
- Engaging the **Recovery Community** and **Tribal Council** to do walk throughs and develop murals for Care Campus
- Implement **Care Coordination Metrics** to see who is providing what care to whom and when

CHANGE

WHEN THE WINDS OF CHANGE BLOW HARD ENOUGH,
THE MOST TRIVIAL OF THINGS CAN TURN INTO DEADLY PROJECTILES.

Questions/Discussion


MENTAL HEALTH, ALCOHOL & SUBSTANCE ABUSE
GOAL #1: To affect state, county and local policy changes that allow and implement diversion from jail and/or prison for individuals diagnosed with mental illness and/or substance use disorder (SUD).
Objective: Reduced incidence of incarceration for MH/SUD and increased incidence in participation in community programs.
Strategy 1
Complete a community capacity assessment: Identify and map all existing resources and gaps (including eligibility, access and coverage) for MH and SAD in Cochise County.
Strategy 2
Develop a broad-based education and training program on MH/SUD for law enforcement, first responders, community providers and volunteers regarding a comprehensive approach to diversion.
Strategy 3
Develop a systematic and sustainable communication structure among law enforcement, judicial, resources and providers who are involved with MH/SUD.
Strategy 4
Ensure Cochise County is engaged and involved in all statewide resources, regulations and initiatives for MH/SUD, including the opioid crisis.
GOAL #2: Promote and expand mental health wellness and substance use disorder resources across the lifespan for all in Cochise County.
Objective: Increased incidence of participation by individuals affected by MH and/or SUD in community programs.
Strategy 1
Develop a systematic and sustainable communication and advertising structure to increase shared understanding among all organizations, agencies and residents about access to resources and systems.
Strategy 2
Initiate a formal process to engage stakeholders on the creation of community-based infrastructure for MH/SUD acute treatment and resource center.
Strategy 3
Develop a county-wide approach to reduce opioid addiction and deaths. Support local municipalities in individualized approaches