

**The Lewin Group**  
**Assessing Organizational Ability To Support Client Self-Management**  
**July 19, 2017**  
**12:30 p.m. EDT**

**Alexis Estomin:** Hi. Thank you so much. Good afternoon everyone, and thank you for joining us today for our webinar on assessing organizational ability to support client self-management.

This is the second webinar in a series of three webinars on self-management support. The first webinar in the series was developed by the Centers for Integrated Health Solutions and focused on peer-led interventions to increase activation for self-management of chronic physical and behavioral health conditions. You can access a recording of this webinar by clicking the link in the resources section on your screen.

Today's webinar is going to be interactive, with 45-minutes of presenter-led discussion followed by 15 minutes of presenter and participant discussions. There will be an opportunity for questions and answers at the end of the webinar, so please submit your questions to us using the chat function.

A copy of the slides and a recording of the presentation will be made available at <https://resourcesforintegratedcare.com/>.

This webinar is developed by the Lewin Group in collaboration with the SAMHSA-HRSA Center for Integrated Health Solutions. It's hosted by the Medicare-Medicaid Coordination Office Resources for Integrated Care or RIC.

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The Medicare Medicaid Coordination Office in the Centers for Medicare and Medicaid Services (CMS) ensures that beneficiaries enrolled in Medicare and Medicaid have access to seamless, high-quality health care that includes the full range of covered services in both programs. To support providers in their efforts to deliver more integrated, coordinated care to Medicare-Medicaid enrollees, MMCO is developing technical assistance and actionable tools based on successful innovations and care models, such as this webinar.

I'd like to take a moment to introduce our speakers for today. My name is Alexis Estomin and I am a Federal Health and Human Services Consultant with the Lewin Group. I lead efforts to support behavioral health organizations and providers in delivering behavioral health and other health services under the Technical Assistance to Support Providers in Providing Care to Medicare-Medicaid Enrollees contract with the Medicare-Medicaid Coordination Office.

We'll also be hearing from Larry Davidson. Larry Davidson is a professor of psychiatry and director of the program for recovery and community health of the school of medicine at Yale University. His research has focused on processes of recovery and self-care in serious mental illnesses and addictions, the development and evaluation of innovative recovery-oriented practices, including peer-delivered recovery

supports, and designing and evaluating policies to promote the transformation of behavioral health systems to the provision of recovery-oriented, person-centered, and culturally-responsive care. In addition to being a recipient of psychiatric care, Dr. Davidson has produced over 375 publications.

Kristin Davis joins us from Thresholds. Doctor Davis earned her doctorate in Health Communication, and after teaching at colleges and universities in the Chicago area, is now the Director of Evaluation at Thresholds. She has written peer-reviewed papers, spoke at numerous conferences and conducted in-person trainings and behavioral health topics.

Our last presenter is Larry Fricks. Larry Fricks is the Director of the Appalachian Consulting Group and Deputy Director of the SAMHSA-HRSA Center for Integrated Health Solutions. For 13 years he served as Georgia's Director of the Office of Consumer Relations and Recovery in the Division of Mental Health, Developmental Disabilities and Addictive Diseases. A founder of the Georgia Mental Health Consumer Network and Georgia's Peer Specialist Training and Certification, he has a journalism degree from the University of Georgia and has won numerous journalism awards.

To provide a brief overview of our presentation today, Larry Davidson will introduce self-management support, and I will review RIC's Self-Management Support Organizational Assessment Tool. Kristin Davis will discuss how her organization used the SMS OAT to assess capacity for self-management support, and Larry Fricks will discuss what a culture of recovery looks like and values for whole health self-management. We will then move into questions and answers.

I just wanted to quickly review our learning objectives for today, and then I'll hand it off to Larry Davidson for his presentation.

After this webinar, you will be able to define the importance of self-management support in serving clients managing mental illness or substance use conditions; recognize your organization's ability to support self-management activities using the Self-Management Support Organizational Assessment Tool; and also identify best practices for expanding the capacity to integrate support for self-management.

At this time, I'm going to hand off the presentation to Dr. Larry Davidson. Larry, please go ahead.

**Larry Davidson:** Thank you, and thank you for joining us today for this webinar.

You'll see here at the top that the Institute of Medicine defines self-management as the tasks that individuals must undertake to live well with one or more chronic conditions. Ordinarily, we think of that in the context of chronic diseases like diabetes or asthma or hypertension. It's only fairly recently that we've begun to consider that it is possible to live well with a serious mental illness or substance use disorder.

For many decades prior, these were illnesses that we didn't really think of as illnesses per say, and even if we did think of them as illnesses, we thought of them as chronic, debilitating and even progressive. They weren't things that we thought people could live a good life with.

But over the last 30 years with the Recovery Movement, we've now come to understand that you can live well in the face of an ongoing mental illness or substance use disorder, and that it's very possible and important for persons with behavioral health conditions to learn how to do so just like persons with chronic physical conditions.

What we've learned from the Recovery Movement is that many people diagnosed with a serious mental illness or substance use disorder will be able to recover fully over time. The statistics on different

illnesses vary but in each case, there are many examples of people being able to recover fully from even disorders like schizophrenia or addiction.

However, not everyone is going to recover fully, and what the Recovery Movement has focused equally on is the possibility of learning to live a full life in the face of an ongoing condition. Something that we're coming to call personal recovery as compared to clinical recovery.

It's essential in the pursuit of personal recovery to learn the self-management skills that are possible given the condition that the person has, and that has become a central focus for behavioral health care.

This means we've shifted, or are making a shift in paradigm in behavioral health, from viewing treatment as something that expert providers do to clients who are passive recipients of care or, at best, are supposed to follow the instructions that the providers to needing people to take a more active and collaborative role in their own recovery and in their individual lives. Organizations need to make this paradigm shift as well as care providers.

How does one go about supporting self-management? What does it involve? We start by eliciting and understanding the person's own perspective on their situation, including what they understand about the illness that they have or that we think they have or that we're trying to educate them about. But we need to understand first where they're coming from so we can meet them where they're at, so to speak.

Then, we engage them in a collaborative decision making process where they can articulate their needs, preferences and goals and we can situate the treatment and education self-management process in the context of those personal strengths and where the person is trying to get to in their day-to-day lives.

This leads to activating the person to learn and exercise the self-care skills that we try to teach them. It sounds like the first webinar in this series focus squarely on this process of activation. It has become a very important part of the process to understand that people need encouragement, they need role modeling, they need lots of things in order to start to believe that they can manage these conditions because they, like most us, originally thought of these things as derailments from life rather than as something that one can learn to master in the context of one's everyday life.

So activation involves a significant amount of work in getting people to believe that it's possible and that they have the wherewithal to do so. This involves focusing on things like self-efficacy and locus of control, helping people have hope that it's possible to live a better life and that they can play an important role in doing so.

Then, comes the process of mobilizing the natural supports in the person's life, typically family members, friends, and other staff who are part of the multidisciplinary team, who can encourage and reinforce the use of these self-care skills on a day-to-day basis.

And finally, in the spirit of seeing the person, the patient, the client, as a collaborative partner in the process, we elicit their feedback on how we can improve the acceptability, quality and effectiveness of the care we offer.

I'm going to go to the next slide and turn this back to Alexis.

**Alexis Estomin:** Thanks, Larry. I'm going to take some time to walk through the Self-Management Support Organizational Assessment Tool or SMS OAT.

Self-management has been demonstrated to increase individuals' satisfaction with health care, reduce the cost of care, and improve health outcomes for persons with a variety of chronic health conditions. Self-management is especially applicable to individuals with serious mental illness and to those with substance abuse conditions. Persons with serious mental illness or substance abuse conditions can use self-management skills to manage their behavioral and physical conditions, maintain their overall health, and maximize their quality of life.

To give some background, the Lewin Group developed the tool in collaboration with CMS along with the input of subject matter experts in consumer-centered care, self-management support, and care coordination. The tool is derived from the experience of behavioral health clinicians, primary care clinicians, and individuals with expertise in implementing self-management support.

Further, the tool is built upon the foundation that supporting self-management involves a shift away from a more traditional model of care to one that is client-centric and supports shared decision-making. To facilitate this change, means staff and organizations must structure and deliver care in ways that honor individuals' perspectives on their health care, treatment, and relationships with providers. It may also mean the adoption of new organizational processes to teach individuals the skills to manage their conditions and health over time and to collaborate with their health care providers to make decisions about their care. Self-management support also involves actively engaging a client's natural supports who can play a positive, but nonprofessional, role in recovery.

Within any organization, this is likely to involve changing organizational cultures and setting new role expectations and service priorities. Behavioral health organizations can anticipate needing to innovate, acquire external support, dedicate time and resources, and commit to effect change and achieve this vision of person-centered and integrated care.

The goal of the tool is to help administrators, providers or other service delivery staff in behavioral health and primary care organizations serving individuals with serious mental illness or substance abuse conditions. Ultimately, the tool intends to raise awareness of the features of client interactions and care processes consistent with self-management support, provide a blueprint or a roadmap to assess self-management support activities and also highlight examples of ways that organizations can expand the capacity to integrate self-management support.

Our tool is broken into three main sections. The first section is focused on self-management support foundations which includes three subsections.

The first is client activation. Supporting clients to take active roles in their own care is essential to their recovery and increases care integration and coordination to meet their needs and goals. This support includes offering a range of options that facilitate meaningful choices by clients as well as access to care and medical records.

The second subsection is self-management support and care planning. Care planning and self-management support helps the care team, clients, and also their natural supports focused on intervention to manage symptoms while supporting clients in pursuing their self-identified goals.

While it is typically the client who works with one staff member in particular such as the primary clinician, nurse, social worker or care specialist to develop the plan, the entire care team should be available for the planning meeting so that short-term objectives and the respective roles of each person involved are clear.

The last subsection is supporting self-management with care teams. Clients in their natural supports benefit from services that range from medical care and home health services, to supported housing, supported education or employment and also peer support.

A care or recovery team can best provide the range of services and often includes providers from different disciplines in setting clients and natural support. The care team may also partner with outside organizations and can help clients and their supports coordinate the range of medical care and other services to meet their goals. Ongoing communication and collaboration among the members of this team, outside of periodic and more formal care planning discussions can provide essential cohesion and avoid care that is not aligned with client goals.

The second section of the tool is on monitoring self-management support activities. Ongoing monitoring is needed to ensure that your organization staff or care teams continue to meet client needs and provide the necessary follow-up to help clients achieve and maintain their health. Collecting and assessing feedback from persons with behavioral help and substance abuse conditions as well as their natural supports improves the quality and responsiveness of care.

The OAT itself is a self-assessment tool, which is available online through an interactive forum, a downloadable PDF, and also an interactive Excel tally score sheet. You can save your answers to review with your staff and co-workers either by downloading a PDF of your responses in the online version of the tool or by saving your completed Excel file. This can serve as a reference for your organization to consider potential areas of opportunity for improvement or focus.

Our team recommends that you ask at least two staff to review the elements of self-management support in sections one and two of our tool independently with the following instructions in mind. We recommend that you consider the prior three-month period of care delivery and the clients you or your care team served when answering the questions. You should choose one response for each question, and it's important to remember that there's no right or wrong answer. Just make your best guess. The tool is intended to facilitate a team discussion about your organization's self-management services.

On the right of the screen, you'll see a screenshot of the tool itself. Each section includes introductory language regarding section's topic and also a set of self-assessment questions.

To break down what elements of the tool look like and how they're scored, we can go through an example. The first item is, do staff and providers communicate with clients in a manner that promotes and maintains dignity and respect? The question is followed with a bit of a description as well as some examples of best practices, In this case, an example is do staff offer private places to discuss care, care concerns or schedule appointments.

The question then prompts you to consider a few different factors. How often does this occur? Are there policies in place and staff trainings available? Does the organization consider client feedback? Your answers to these three questions will determine your overall score for the elements.

In this case, we just provided an example of someone that might have answered this question. A person that answers sometimes, never, and yes will get a total score of two for this particular item. Then you can also select whether this is a priority for your organization. Your scores for each element are then added up for sections one and two of the Organizational Assessment Tool.

For the first section, if you score an 81 to 125, your organization has a strong foundation for self-management support. A 41 to 80 indicates that your organization has some of the necessary foundational elements for self-management support, and the score of 40 or less means that your organization needs to

build a foundation for self-management support. You might want to consider the overall importance of self-management to the needs of your clients and how self-management needs that with your organizational priorities and procedures.

For the second section, the max score you can get is a 35, indicating that your organization has a strong foundation of procedures to monitor self-management support activities. If you score a 13 to 23, this means that you have some foundational elements in place, and a score of 12 or less means that there are opportunities to improve or create procedures to support activity monitoring.

You can take these results and use them to inform conversations with your organization about opportunities for improvement and how best to move forward. The SMS OAT provides examples of strategies organizations can take to improve different elements of self-management support delivery.

The last section of the tool includes other resources to implement self-management support services for individuals with serious mental illness and other chronic conditions. These include resources both developed by the Resources for Integrated Care team as well as external resources, some of which we will introduce towards the end of this seminar.

You can find the SMS OAT at the link on the screen along with several client handouts and our Action Plan Selection Guide which will be explored in our follow-up webinar scheduled for next Wednesday, July 26.

At this time, I'm going to turn the presentation over to Dr. Davis from Thresholds to tell us a bit how her team was able to administer the SMS OAT to improve workflow processes. Kristin, if you want to go ahead?

**Kristin Davis:** Sure, thanks, Alexis.

Before I talk about our process of using the tool and our outcomes, I'll briefly introduce Thresholds and provide the context in which we first used the tool.

Thresholds is a large mental health and substance abuse agency in Chicago and seven counties in Illinois, providing ongoing comprehensive support to 5,000 consumers or members, which is what we call the folks that receive services from us a year.

Now we touch, via our mobile assessment units and our crisis intervention teams, another 10,000 a year, but we see 5,000 on a regular basis.

We provide this regular support via 120 clinical teams and via our three integrated healthcare FQHC partners.

Thresholds' teams are comprised of social workers, psychiatric rehabilitation staff, peer staff, support to get employment and education staff, often a nurse, an RN, and then a part-time psychiatrist.

The support ranges from traditional case management support to medication monitoring, to supported houses, supported education and employment, to peer support and, of course, illness self-management support.

Thresholds used, thus far, the SMS OAT tool as preparatory to a pilot initiative designed to reduce unplanned, inpatient use by a small group of our consumers who have the most complex social and health needs.

The pilot involved stratifying our consumers on just four of our teams based on their past ER and hospital use. We identified our highest users, which was about 5% of those consumers, and then we provided our pilot teams with relevant clinical and social determinant data in the form of an interactive dashboard targeting this high-risk group.

Now, because Thresholds is so large, we wanted to start the initiative on a small scale and determine how the interactive dashboard report drives care as well as what clinical practices made the most difference in helping members reduce unplanned use of in-patient services.

So today, what I'd like to do is just provide a brief description of the role that the tool played in this pilot and what we learned from using it.

Okay, our process. We asked the four teams to work with their high need members/consumers differently and reallocate resources. We assessed the team's illness management, or illness self-management support capacity, as we knew this type of activity would be a key component to reducing unplanned inpatient use. Excessive reliance on inpatient services is really a good proxy for members or consumers who are not managing their illnesses as well as they could.

So after having introduced the project to the teams, we sent the tool to the four team leaders, to the quality staff who is dedicated to those teams, to the program directors over the teams, and then one last higher-up person, the vice president who oversaw the programs for those teams.

Each of these staff scored the tool on their own, and evaluation staff then met with this group in person a couple of weeks later, and we facilitated the comparing of scores and identifying areas of shared understanding and disagreement. This provided an opportunity for people to ask questions of each other, of course, and to discuss in a little bit more detail some of the items on the tool. Based on the results from this meeting, we drew up a provisional plan to prepare for the pilot.

Now, it's important to say we ended up using the tool not only to assess our capacity to do illness management support but also structure conversation about what illness self-management support looks like from the perspective of those staff on the ground given their unique workflow and what their needs and barriers are.

So what did we learn about our capacity? What did the tool tell us? Well, a few things. Overall, I think the project teams scored themselves highly on the first subscale of the self-management support foundation, activating clients to engage in self-management which, as Alexis mentioned, includes items like do staff communicate with clients in ways that promote dignity and respect and are consumers involved in care planning, et cetera?

Staff assessed capacity less favorably on a few items on the second self-management foundation subscale supporting self-management with care teams. In particular, visit preparation and follow-up on self-management support visits were identified as areas for improvement.

The group agreed on a change to workflow as a result, and in some ways, this change to workflow is up for a step. I think we're going to do some more process analysis to see what else we might do. But initially what the teams have done is set aside time in a weekly strength-based meeting to prepare for upcoming visits and share follow-up from previous visits for this group as high need consumers. And also this meeting allows for a clearer definition of roles of who's going to do what and when.

In terms of self-management and care planning, the project team realized during the scoring meeting that they could leverage our existing FQHC partnerships, partnerships which really are marked by good care coordination and data sharing. The staff used the interactive dashboard to identify any high-need consumer or member who wasn't linked to one of our integrated care partners and really just took advantage of what is a teachable moment by talking to consumers about the benefits of the care coordination with our partners but also about the importance of regular primary care.

So in short, staff encouraged our consumers who weren't linked to one of our FQHC partner, integrated care partners, to go to them for their primary care needs.

As for the second part of the tool, the monitoring self-management support and the interactive dashboard report itself, we've realized that teams didn't feel comfortable entirely using the interactive dashboard report without some training and support. So we expanded the role of the quality improvement consultant to support the teams in using the dashboards, helping them identify care gaps, understand what we might do to fill them and, at the same time, to collaborate with the teams to address any particularly difficult clinical issues. The QI staff also ensured a consistent focus on the self-management support practices.

So that is just a quick shot of what the interactive dashboard looks like. There's a pretty detailed description of the consumer in the box at the top, and I think what you're seeing now are some data on the ER admissions and hospital admissions broken out separately with a total on the far left.

What overall lessons did we learn in using the tool? We're going to use the tool with other teams as we begin to use this kind of population health approach to identify and work differently with some of our folks who were not managing their illnesses well.

As I mentioned before, this tool is a great way to start a structured conversation about illness self-management support, as well as a formal means to assess organizational capacity. I think illness self-management support is just a key activity when you begin to think about what's going to make a difference in terms of value-based care.

The SMS OAT also showed us that staff welcomes support in being able to prioritize, and that prioritization is a little bit tricky with the day-to-day work that they are involved in.

Now, I'm going to pass it over to Larry.

**Larry Fricks:** Thank you and welcome all.

I think before we talk about recovery, we've got to think about how big the impact and stigma is in discrimination. Rosalynn Carter, former first lady of the United States, said the mental health program is still our biggest challenge. Even with all the improvements we've made, it's just something you've got to consider when you're looking at recovery.

Our recovery story is one of our most important tools for connection and building a sense of a trust. It's very important that we train on how to tell our recovery story.

There were times when we tell that story, and we spend too much time on the illness side. We don't have succinct points to make, but it has a real impact, such as briefly describing the situation when you were having the most difficult time and what helped you move from where you were to where you are now. What did you do? What did others do? What did you have to do to overcome to get where you are today? What are some of the strengths and skills that support your recovery?



Those sort of questions help us to organize our recovery story. If you see that going on and you see the support and also the skills for it, you get a sense that there is an understanding of how important the recovery story is and how that differentiates us.

We focus on the strengths of the individual rather than the illness. I experienced this in my recovery from bipolar illness and also addiction. I just experienced over and over again that when somebody became aware of my diagnosis, their behavior changed toward me. They started to see me through that diagnosis, but this is a real issue for peers in integrated care.

We're hearing stories that when peers see a primary care doctor and they see a diagnosis of schizophrenia or bipolar illness, there is often a behavior change. All of a sudden, they wonder if symptoms you came in for are related to your illness. So I think this is really important because once again this discrimination tends to help people focus on our illness.

Ensuring the over-riding theme in everything is recovery. One of my favorite stories comes out of Michigan. There's a behavioral health program there that when you're in the lobby, there is a continuous loop of people telling their recovery story. Even before you walk in, you see someone in treatment, and you're being reminded of recovery and that all of us had a recovery, and you're hearing these stories.

Promoting peer-led groups; you look at AA, which was established in 1935, and one of its pillars is that people in recovery lead their group. They go into the program and see non-peer staff leaving the groups. My question then and there, why aren't you having people with experience running that group?

Promoting meaningful employment. I think employment is treatment. I know it sounds strange but so many of us may have been experiencing some recovery when we got meaningful work. It has really added to our recovery; it gave us a sense of meaning and purpose.

I got a real lesson in Georgia. We started the Georgia Health Consumer Network about 27 years ago. We asked attendees at our conferences what their top priority was. Almost every year, it was employment. People were saying, "You know what? I really don't need more time with my psychiatrist. I really don't need different meds. What I need is meaning and purpose that employment brings to me."

A goal that the individual earns is a foundation to recovery. I hear people say, "Well, you know, he just won't follow his treatment plan." If it is something that was built in his own person-centered planning, he will be more likely to participate. Ownership is the key. Also, understanding the personal benefit of reaching the goal and ensuring everyone has input into program development and evaluation.

Now if you're in a program, and it's obvious that the activities and what's going on there has the input from people that use the service, you're going to see a much higher level of excitement and involvement. Also, programs where they're able to tell their success stories are a positive addition.

Now, it just always uplifts me. I had been hospitalized three times in the mid-80s, and I'd really given up. There is a lot of loss that's often associated with my illness. I mean, there is a loss of job, my marriage fell apart, loss of self-esteem, loss of a sense that my life could ever return to a sense of fulfillment. It was peers that changed that. I went to a meeting of the depression and bipolar support lines. Having people share their success stories was the big factor.

In a program, bringing in people to share their stories is a big factor for hope. It's a big activator of self-management.

Employing a significant workforce of peer providers. There is just so much research out there, and Larry Davidson has a lot of it. The living experience, the connection and the trust from a peer, there's an amount of evidence that it may be the most important thing of activating self-management. If you see that and you see a workforce of peer providers, you know that that program is investing in recovery agents.

Engaging in whole health activities. Recovery is mind and body. For so long, people focused on just from the neck up, and what we know is it's the whole person you've got to look at in recovery. So, we are big on this whole health and promoting the whole person.

Promoting trauma-informed services. For years, people would not talk about trauma. They say it will re-traumatize them. It's really then that people with lived experience of trauma demand that change. If you see that that's being addressed, then you know you've got a program that is more tuned in to what's going on in people's lives.

Training consumers to write their own progress notes. There's no reason we can't write our own notes. Why does the clinician have to write our notes? We can be trained to do that and we have more ownership of it.

Educating staff and consumers on the definition and dynamics of recovery. People don't know what recovery is. I think it's worth investing in staff and consumers. Evaluate it, look at me, and talk to me about it.

Then, teaching skills for problem-solving. Most peers have never been taught skills to problem-solve. If you're going to self-manage, you need a skill to do that. So, when we train peer specialists, we include a problem-solving approach. It lets you step outside of the problem and get more objectives, and the steps that you can take to get a hold of what the problem clearly is. A clearly stated problem is most of the success, and lots of times, people don't know how to clearly state that problem.

Then, you're teaching skills for combating negative self-talk. Negative self-talk just undermines recovery. If I have a negative self image, you can come up to me and say nine positive things, but if you say one not so positive, I'm going to reach out and grab that one because that matches up with my self-image.

Because of discrimination, negative self-talk can really be an issue. I mean, everybody has negative thoughts and engages in negative self-talk. That's not the problem. The problem is when this spirals downward, the people end up defining themselves in absolute permanent negative language. We teach skills on how to deal with that.

At the Center for Integrated Health Solutions, we came up with a set of values for Whole Health Self-Management. Now, some of these are closely related to recovery, but what we're trying to do is have people see recovery as a form of whole health and looking at it as a whole person.

The first one is for whole health, all services support whole health, mind and body.

Then, hope; activating and sustaining hope for whole health is the expectation for all individuals served.

Then, strength-based; services and supports focus on and individual's strengths and potential for whole health.

Peer support; Peer support is integral to all whole health planning, services, and ongoing support.

Trauma informed care; services are trauma-informed, understanding, recognizing and responding to the role of traumatic life events, experiences, and its effects on an individual's whole health.

Person-centered goals; individuals set whole health goals as a result of extensive person-centered planning that focus on their strengths, supports, skills, values, culture, and preferences.

Shared decision-making. This is so important because there's a real power differential between a psychiatrist and someone in recovery. So a lot of that goes back to the stigma of discrimination, and it goes back to the belief that we can never trust our thoughts, especially if we've experienced psychosis.

We teach a thing called shared decision-making. In terms of partnership, the doctor or the nurse may be an expert on symptoms and on medications. We have to be an expert on self-management. In shared decision-making, health care providers build partnerships with individuals receiving services to make informed treatment decisions together.

Then, self-management competencies; staff develop skills, knowledge and supports to promote whole health self-management.

Then resiliency; evidence-based resiliency factors that promote whole health are a foundation of services and supports. We're big now on resiliency factors because in my own recovery restful sleep was the key. I learned from Dr. Fred Goodwin who used to be at the National Center for Mental Health. He told me that if I could manage my sleep, I was much more likely to not have a manic episode. It has been the bedrock in my recovery.

In our inner work and training, we introduce these resiliency factors, and interestingly enough, it is now in evidence that a strong support network may be the most important health factor in a person's life; it trumps everything else. So pay more attention to resiliency. Look in the secondary and tertiary prevention. It's very important to understand what helps you be resilient and practice that.

Then community resources and supports; services that promote community support including family, friends and housing, employment, education and recreation.

That wraps up my slides. We do have some resources. We have a link to our peer providers on our CIHS website. We have the SAMHSA Wellness Initiative and we have Whole Health Action Management (WHAM). That is something I am involved with training. Then, I really like this toolkit.

I always like to mention WRAP, which is Mary Ellen Copeland's work. It is such a foundation for this whole concept of self-management.

**Alexis Estomin:** Thanks so much, Larry.

At this time, we can go into our session for some of the questions and answers.

If you have any questions for our presenters today, please feel free to submit them through the question-and-answer function on the webinar platform. We have a few questions from folks that we'll take at this time.

The first question that came for us today was what is a natural support? I'm happy to answer that question since we talked about natural supports when we introduced the Self-Management Support Organizational Assessment Tool.

A natural support is someone who cares about the client and that the client can ask for support. This might include a family member, a friend, a neighbor, a co-worker, employer, a sponsor, a coach or maybe even your landlord.

We have another question that came through our chat function that I'd like to field to Kristin if you're on the line. The question that came through is how do you work around the issue of client's losing their eligibility for disability benefits if they obtain too much income from employment opportunities that are helping with their mental health?

**Kristin Davis:** Sure. So that's a great question. We, of course, battle that issue regularly, and I'm probably not the best person to answer all the different ways we try to work with it. There are benefit counselors at Thresholds dedicated to just benefit counseling. I know that they will work with members who are working and have exceeded the limit and are in danger of losing their benefits. Unfortunately, that's probably the best answer I'm able to give. I don't know if anyone else has a response.

**Larry Davidson:** Well, I think that individual benefit counseling is the most useful because there are number of different federal programs which have been developed in the last 15 years to try to ease the transition from disability to employment. The benefit counselors are in the best positions to know who's eligible for what kind of program.

It's understood that getting off disability is the most significant disincentive to working. So the federal government has been experimenting with different ways of trying to ease that transition. People who are knowledgeable about that are the ones who need to be in the room with the client.

**Alexis Estomin:** Great. Thank you.

Kristin, this is another question for you. Is your organization planning to re-administer the SMS OAT following some of the next steps that you have discussed?

**Kristin Davis:** Yeah, we are going to begin to roll out. What I'm referring to is this population health approach or initiative focusing on improving our illness management self-support capacity. To do that, we will prepare any other team that comes online using the interactive dashboard and working with our members who are in and out of the hospital or ER more frequently. Feedback from the team, which I didn't explicitly say in my slides, was positive.

They not only appreciated the opportunity just to sit down and take the time out of their day to talk about some of these issues, but really felt like some of the things that we put in place are working and making their lives a little bit easier.

So that's a long answer, and the short answer is yes, we plan to use it as we take a stepwise approach bringing other programs online.

**Alexis Estomin:** Great. Thanks so much, Kristin.

I have another question that came through. Larry Fricks, I'll throw this to you, and then Larry Davidson, if you could maybe chime in with any other answers you may have.

The question is, is there a resource for teaching skills for problem solving and combating negative self-talk? Any resources that you all would recommend?

**Larry Fricks:** Well, what we teach in the peers-based training is called catch it, check it, and change it. You catch it early on and it draws no negative thoughts from moving from fact story. Negative self-talk usually starts with a fact, but somehow our negative image loses it over a story that is not necessarily true. Then, check it against what is actually happening and you stick with the facts, and then change it to more appropriately reflect reality.

So we teach that to peer specialists; catch it, check it, change it.

**Alexis Estomin:** Thank you.

Okay. Well, I think we can go ahead and close out at this time.

Thank you all so much for joining with us today. If you could please complete our brief evaluation of the webinar, so that we can continue to deliver high-quality presentations.

If you have any questions for us, please email them to [RIC@Lewin.com](mailto:RIC@Lewin.com). Thank you again!