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CT SIM CAB TWEET CHATS AND COMMUNITY CONVERSATIONS REPORT

NOVEMBER 2016 - AUGUST 2017

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HEALTHCARE ACCESS TWEETCHAT – BY QUYEN TRUONG

OVERVIEW: On Monday, November 21, 2016, we organized a tweetchat on healthcare access issues. The event was co-organized with a small coalition of social media specialists who are interested in healthcare, including: Aldon Hynes from Community Health Center (CHC) – a community-based healthcare center in Middletown, Thomas Burr from NAMI-CT – a leading statewide mental health organization for families and people in recovery from mental health issues, and SIM CAB's contractor North Central Regional Mental Health Board (NCRMHB). Together, we created an Eventbrite with directions to join the tweetchat in Spanish and English. We all posted the event on our Facebook and Twitter newsfeeds, included the tweetchat in our various newsletters (whose reach totals over 75,000 people), and reached out to relevant community partners like Hartford Behavioral Health, Hispanic Health Council, Health Equity Solutions, and Access Health CT. We personally reached out to and recruited community members to participate in the tweetchat.

TWEETCHAT: The day of the event, NCRMHB hosted a tweetchat session at our offices in Hartford. Participants included Way To Go CT Director Danielle Herbert, LGBT activist Shane Putney, NCRMHB staff Marcia DuFore and Quyen Truong, PMO staff Shiu-Yu Schiller and Deanna Chaparro, SIM CAB member Kevin Galvin, and CHC staff Aldon Hynes and Meaghan Lyver. During the event, we projected tweets to SIM onto the big screen so we could discuss those tweets and strategize how to answer them. The lead moderator was NCRMHB.

OUTCOME: The total number of tweet impressions (number of views of *#cthealthchat* tweets) was 7,571. The *#cthealthchat* tweet advertising the tweetchat earned 190 impressions alone. The tweetchat attracted over a dozen new followers, one of which is a famous New Haven chef and another with a following of 132,000 people. This is significant social media exposure for SIM. One of SIM's biggest critics participated in the tweetchat and gave positive feedback about SIM CAB's current efforts. Moving forward, NCRMHB will gather relevant analytics data from SIM, CHC, and NAMI to better understand the tweetchat's full reach.

DIABETES TWEETCHAT – BY QUYEN TRUONG

OVERVIEW: On Wednesday, January 25, 2017, we organized a tweetchat on diabetes. The event was co-organized with a small coalition of social media specialists who are interested in healthcare, including: Aldon Hynes from Community Health Center (CHC), Thomas Burr from NAMI-CT, and SIM CAB's contractor North Central Regional Mental Health Board (NCRMHB). Together, we created an Eventbrite with directions to join the tweetchat. We all posted the event on our Facebook and Twitter newsfeeds, included the tweetchat in our various newsletters (whose reach totals over 75,000 people), and reached out to relevant community partners like Data Haven, Health Equity Solutions, and Advocacy Unlimited. We also reached out to past tweetchat participants and the #HCSMCT (Health Care Social Media CT) group.

TWEETCHAT: The day of the event, NCRMHB hosted a tweetchat session at our offices in Hartford. Participants included NCRMHB staff Marcia DuFore and Quyen Truong, SIM CAB members Kevin Galvin, Nanfi Lubogo, and Arlene Murphy, NAMI staff Thomas Burr, and CHC staff Aldon Hynes and Meaghan Lyver. The lead moderator was NCRMHB.

OUTCOME: The total number of tweet impressions (number of views of *#cthealthchat* tweets) was over 10,500. The tweetchat attracted around 20 active participant ("tweeters"). Moving forward, NCRMHB will continue to organize monthly tweetchats as a way to connect people with SIM CAB.

COMMUNITY WELLNESS AND RECOVERY FORUMS – BY MARCIA DUFORE

OVERVIEW: Over the course of 6 months from February through July 2017, members of the CT Recovery and Wellness Coalition (CRWC) organized a series of Community Conversations for improving crisis care for people struggling with mental health and/or addiction issues. CWRC is an effort supported by the SIM CAB, the Department of Mental Health and Addiction Services (DMHAS), and the Substance Abuse and Mental Health Services Administration's (SAMHSA) Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) grant. CWRC's Vision: Connecticut communities will support people in their time of need in a manner that respects individuals' culture, dignity, hopes, and rights.

The project was led by Cross Street Training and Academic Center (CSTAC), a faith-based organization associated with Cross Street AME Zion Church.   Project leaders hoped to enhance the role faith-based organizations, church leaders, persons in recovery and community advocates as essential partners in Connecticut's efforts to improve and sustain crisis response, intervention, and treatment.

Conversations were structured as facilitated dialogues led by members of the CWRC. The Conversations offered opportunities for people from different communities and varied perspectives to learn from each other, identify resources, and develop strategies for enhancing crisis care in Connecticut communities. They were hosted by Cross Street AME Zion Church in Middletown and engaged 70 different participants over the course of the six sessions (average of 23 participants per session). Participants included individuals in recovery from mental health or addiction problems (30%), family members (31%), representatives of the faith community (20%), behavioral health providers (22%), and law enforcement (5%). Of note was the coming together of three Ministerial Alliances from Middletown, Hartford and New Britain for addressing behavioral health and community issues. Participants reported that they came to learn, connect with others, and help their communities.   Each Conversation followed an arc starting with making connections and an introduction to the topic. We continued to delve deeper into the topic/issue and how services

help. We explored related challenges and how we respond to them. Finally, we identified actions steps we can take to improve care in in our communities.

WHAT WE LEARNED: Participants joined the discussion for a variety of reasons. Most wanted to learn more about the topic and resources. Several shared personal experiences and attended with intention to help others. Many had experience with seeking help for themselves or a loved in crisis. Participants saw crisis response as multifaceted and were looking for caring communities where people can reach out and recover together. Representatives of the faith community (from primarily Black Christian churches) wanted to start or further develop recovery supports within their churches, but also wanted to be acknowledged for the work they are already doing.

Participants expressed a desire for more community outreach to combat stigma and promote greater access to resources. We need new, creative approaches to reach the people who need to hear about these issues, but are who are not coming to our forums. We need to understand addiction as a disease for which there are a variety of treatment approaches and many paths to recovery. We need to affirm and promote more community-based and natural supports. Mental health and addiction issues have an impact on the entire family, not just the struggling person, so we need communities to be more supportive and understanding of all those affected. We need the treatment system to understand that medication is not the only, nor even the right solution for many people. Inaccurate diagnoses and issues with prescribed medications (side effects, cost, ineffective) were discussed as common problems. We need rapid access to care and a coordinated continuum of care that includes prevention, intervention, and follow-up post crisis.

A full session was devoted to understanding culture and cultural differences.   Participants willingly explored their own sources of bias and discussed many aspects of difference beyond language, ethnicity, and age. Making a connection and helping other people feel safe, valued, and respected were considered most important even when cultural or language differences exist between individuals and helpers. It is still critically important to recruit and train more persons of color for work in behavioral health (the need to re-invigorate the DMHAS-funded PACCT program was mentioned several times), ensure access to interpretation and translation where needed, and advocate for more peer support and Community Health Workers (CHWs) in all aspects of healthcare.

One session was devoted to pastoral care and the need to better integrate pastoral care into the full continuum of services available to people struggling with mental health or addiction issues. Participants discussed factors that divide the church from the health community and why the church's resources for healing are relegated to the outskirts of behavioral health system. On one hand, churches are viewed as places of safety, kindness, sensitivity, and compassion. On the other hand, church people recognized they can come across as judgmental, exclusive, and only concerned with saving souls. Pastors were encouraged to 1) conduct asset mapping within their churches to better understand internal resources and community needs, 2) develop or enhance health ministries, and 3) become knowledgeable and shore up community partnerships to become a hub that connects congregants with external resources as needed.

The last session was devoted to building coalitions with law enforcement. Police officers described the tools available for responding to mental health and addiction crises. Officers shared their frustration with their role as first responders and the lack of referral options for people who need help. Participants discussed conflicting roles of law enforcement – often called upon as a show of force, or "the muscle" in crisis situations, but also called upon to exercise restraint, sensitivity, and patience in situations of mental health crisis. All participants agreed about the need for more training, communication, coalition building, advocacy, and resource development.

RECOMMENDATIONS: At the beginning and end of each session, participants completed surveys that provide detail about the demographics of the group, reasons for participating, and offer feedback about the sessions and suggestions for improvement. (See Appendix on page 5 for greater detail). All but one participant rated their experiences with the Conversations as good or very good. Most indicated their participation had a positive impact on their understanding of

healthcare, knowledge of resources, and ability to talk about mental health and addiction. Participants most appreciated meeting new people, hearing from experts, and sharing their own voices. Suggestions for future sessions included: meeting more often, offering Conversations in more locations and during the day, shorter sessions, more visuals, and using the learnings to spur action.

At the end of each session, participants were asked to imagine a world in which their various ideas about living in responsive, caring communities could become a reality. They were asked to brainstorm what would be some of the first steps needed to get there and select two of their most "doable" ideas for further action.

The following ideas represent opportunities for further action by the CWRC, state agencies, policy makers, and leaders at the state and local level:

1. Educate:
    a. Conduct community outreach – identify additional partners and get them to the table.
    b. Convene key stakeholders in organizing a "proactive citizenry" identifying and responding to community issues. Be intentional about engaging diverse groups and faith communities. Raise funds and provide ongoing training for community coalition work.
    c. Conduct workplace trainings about how to recognize and respond to sign of mental distress.
    d. Counteract stigma with more conversations/education with people in recovery as "living proof" participants. Use radio and public service announcements to reach wider audiences.
    e. Conduct more training for early intervention with children at risk due to trauma or abuse.
    f. Infiltrate existing "mentoring groups" and the companies that donate to them (Boys and Girls Clubs, Big Brother/Big Sisters, Boy Scouts, Girl Scouts) with protective information for children, youth and their families.
2. Advocate:
    a. Use legislative hearings and breakfasts to influence policy makers.
    b. Work with NAMI to reach more families with training and support. Ensure families are included in treatment with their loved ones when appropriate.
    c. Require hospitals and insurance companies to make follow-up calls to patients after discharge.
3. Build Resources:
    a. Identify and obtain new sources of funding for services. Identify and direct funding to programs that work.
    b. Build or enhance on-line resource navigation assistance tools. Tailor on-line and hardcopy resource tools for use by culturally diverse audiences.
    c. Conduct asset mapping in local churches and convene with emergency response teams and other church alliances to share ideas.
    d. Move churches into more prevention roles, i.e., strengthening, resilience, positive behaviors.
        i. Develop respite options in churches
        ii. Establish or enhance health ministries in churches.
4. Workforce Development:
    a. Increase the pool of mental health and addiction specialists who are persons of color or at least culturally competent.
    b. Develop more peer support, faith-based, and support groups for children coming from substance/alcohol affected environments.
    c. Expand use of Recovery Coaches in hospitals. Identify other places where Recovery Coaches would be helpful (schools, Mobile Crisis Teams, walking the beat with police officers, etc.).
    d. Recruit, certify, and employ more Community Health Workers.

NEXT STEPS: Participants hope their work and insights will lead to positive change and their recommendations will be used to influence policy and policy makers at the state and local level. Interest was sparked in other areas of our region and resulted in plans to lead two more series of coalition building Conversations this fall in Hartford and North Central Connecticut. In New Britain, one church stepped up its involvement with the establishment of a recovery and health ministry, led by a church member newly certified as a recovery coach. DMHAS has begun meetings with providers of Mobile Crisis services and plans to enhance their role and services. Two new initiatives, one led by DMHAS and another

led by CTSAC are focused on building up the capacity of Black churches to offer recovery support services and lead advocacy efforts to address health inequities in their communities.

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UCONN HEALTH STUDENTS COMMUNITY CONVERSATION – BY TANYA MILLER

OVERVIEW: In the summer of 2017, University of Connecticut student Tanya Miller gathered a group of her college-aged peers in her summer health leaders program to discuss healthcare. Tanya's program engaged young adults who are all interested in a healthcare career. About 10 young adults from UConn came to share their perspectives on the Affordable Care Act and to engage in a community conversation about how to ensure better access to healthcare for people.

Pre-Survey Results

- What participants most looked forward to was listening to others and learning more about healthcare; this shows a very receptive population that is eager to learn.
- **Email** is the best way of reaching young adults (63%).
- Young adults use social media frequently and throughout the day and think **Facebook** is the platform they'd most likely use to learn/talk about healthcare.
  - This demonstrates that the CAB is on the right track with Focus #3 outputs ("Other Platforms" includes Facebook, webpage, twitter). I think the webpage should be updated because it is a useful resource / not replaceable, having an up-to-date Facebook page would be a great way of bringing in new (especially young) people.
- All participants had some form of health insurance, although none of them were personally responsible for it and none of them were on Medicaid.
- There is **no one major influencer of health care understanding** among young adults; the results were split pretty equally among family/friends, TV/radio, and school
- Most participants spoke English as their first language (88%), although two people knew someone who had used an interpreter for a medical appointment (either themselves or someone else).
- Most participants felt comfortable with their doctors and that they knew a lot about healthcare.
- **Most participants were female, black or African American, Christian, and had at least one parent or guardian with some college background.**
- The participants were fairly split as to whether or not they felt their religion affects how they view health care (38% yes, 50% no, 12% don't know).
- The average household income was fairly evenly distributed among the brackets, with $35,000-$49,999 being the most common (43%) and none in the $150,000 or more bracket.
  - As of 2017, the federal poverty line (FPL) for a family of 3 is $20,420 and for a family of 4 is $24,600.
  - According to the National Center for Children in Poverty, on average, in order to meet basic needs, families actually need an income roughly double what the federal poverty line (FPL) is. If a family is below this number, they are considered to be low income. Thus, for 2017, a low income family of 3 would make less than $40,840 and family of 4 would have to make less than $49,200. Of course, the exact numbers / what is sustainable varies by location in the US.

GROUP DISCUSSION - ***Session 1: Making Connections***

- The group defined being healthy as a balance, and shared a variety of things that they do in their own lives to try to be healthy. This included cutting back on junk food, getting enough sleep, and videogames (as a way of mental relaxing and disconnecting from the world).

    - Some expressed the fact that they **tend to exercise more when they're at school**.
- Participants spoke about their experiences of knowing someone with **depression**. They mentioned how one should be mindful of their words, be available if someone needs/wants to talk, and look out because those suffering from depression may not be who you expect them to be.
    - This awareness of depression is good to see, especially considering the prevalence of depression. In 2015 the NIH estimated that roughly 6.7% of all U.S. adults had had at least one major depressive episode the previous year.
    - On the other hand, the fact that this is the only mental health issue that was brought up (nothing on addiction issues or eating disorders for instance) makes me wonder how well young adults understand these other issues. Is it a lack of knowledge or a lack of comfort in discussing them?
- Participants discussed how **where you live affects your access to healthcare**, even varying neighborhood to neighborhood. They also talked about the unfortunate reality that healthier food tends to be much more expensive.
- Even though all participants had health insurance, one person spoke about how a lot of their friends go to clinics because they don't have insurance.

GROUP DISCUSSION - ***Session 2: Discussing Politics***

- All participants expressed a **dislike for the Senate Health Care Bill (SHCB)**. Various concerns included that it doesn't help the average person at all and only serves the interests of insurance companies.
- Participants saw how this bill would affect America in the long term.
    - Many young girls who rely on Planned Parenthood would be hurt.
    - **Oral health disparities** would increase since oral health is typically assumed to be the least essential (which is not actually the case), and thus many people would likely lose their dental insurance.
    - Young adults' trust in health care would decrease since they are highly skeptical of this bill. They will also be less likely to use health care even when they seriously need it because of the high out of pocket expense it would burden them with (ex: price of ambulance).
- Participants were **highly aware of how transportation issues, low socioeconomic status, and language barriers are very serious and common obstacles** that stop patients from receiving quality health care.

- One person talked about how they appreciate when the demographic breakdown of a health care providers reflects the community that they serves, because this helps the patient connect to their caregivers.

GROUP DISCUSSION - ***Session 3: Talking About Our Challenges***

- **Organized events** (like this community conversation) are very important because many young adults have an interest and motivation to talk about health care issues, but they tend not to be the ones who start the conversation.
- Participants discussed how they tend not to use the health care services on their own campuses because money and acceptance of insurance is a concern. Some voiced that they **didn't know what their insurance did and did not cover**.
- One person mentioned how they don't trust over the counter medications and believe that their body can heal on its own.

GROUP DISCUSSION - ***Session 4: How Are We Responding to Challenges?***

- There was a general consensus that they all had access to health care, so the participants brainstormed why some people might not:
    - Money in general
    - Transportation issues
    - **Lack of knowledge** of what one's insurance covers so they don't use a certain service
    - Insurance provided by employer doesn't cover a particular service
    - Lack of knowledge, in general (ex: some people go to the ER for a toothache because they think this is cheaper than going to see a dentist)
- No one knew of any particular resources for people without health care besides free clinics in general
- Participants said that **outreach and advocacy** would improve health care in their communities
    - This shows the need / interest from young adults for organizations like the CAB and NCRMHB

Post-Survey Results

- Participants felt that the community conversation increased their understanding of health care and interest in discussing it. They thought the event was easy to understand and useful. Plus, they didn't feel judged by their peers.
- However, about **½ of participants felt that the listening session didn't change their ability to talk about mental health or addiction issues**.
- Additionally, only 66% of participants felt that the community conversation increased their ability to identify health care resources.
- In the future, they suggested to consider the length of the listening session (too long) and to provide more information.

Suggestions + Thoughts for Future Listening Sessions

- Adding a "none" option to the post-survey question that asks "what can be improved?" because four people typed this into the "other" box since it wasn't an option
- Add "atheism" as an option for the religious affiliation question on the pre-survey
- Have a 2nd handout to go over as a group, but one that is more visual
- Send people home with a brochure providing useful and empowering information