Health Literacy Training: A Model for Effective Implementation and Sustainability

Abstract

Topic: Training the mental health workforce to provide health promotion and support to people using their services for managing comorbid conditions is essential if full integration of physical and mental health is to become *a reality.* **Purpose:** The paper documents how a training model was explicitly designed to both extend curricula beyond the classroom in order to increase the frequency and quality of physical health interventions, and how implementation was supported by a strong project structure and a facilitative administration. **Sources Used:** The paper was informed by the workforce development literature, process observations, and key informant interviews. **Conclusions and Implications for Practice:** Passive dissemination cannot change practice. Buy-in and commitment from agency leaders facilitates collaboration between consultant-trainers and trainees. Organizations with strong implementation structures help ensure training uptake. A consideration when contracting with trainers is their understanding of the need for and willingness to commit to sustainability. Additionally, organizations would do well to approach workforce development using the lessons of implementation science.

Keywords: Workforce Development; Integrated Physical and Mental Health Care; Implementation Science; Health Literacy

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The Affordable Care Act (ACA) has the potential to reduce systems barriers to integrating physical health services into mental health care settings, including services like health promotion, illness management support, and health literacy education. Success in implementing integrated services is not assured, in part because it depends upon a workforce capable of expanding the scope of their work to include a deeper understanding of chronic physical health conditions, knowledge of how physical and mental health influence each other, and the skills needed to support people in hard-to-make lifestyle changes.

As part of a broad initiative to further integrate physical health literacy and self-management support into its service array, Thresholds, a large psychosocial rehabilitation center in Chicago, commissioned a training designed to prepare staff to work more effectively with members (a term originating with the clubhouse model of psychosocial care that puts a premium on the strengths of the individual rather than illness) with co-morbid physical health conditions. The prevalence of cardiovascular illnesses, diabetes, smoking, and obesity among Thresholds' members closely mirrors the disproportionately high rates among persons with serious mental illnesses nationally (Colton & Mandershied, 2006). The commissioned health literacy training curriculum is grounded in a recovery-oriented, strengths-based philosophy (Swarbrick & Nemec, 2014) and wellness principles. The purpose of this Education and Training column is to document how a strong implementation structure can work in tandem with a training model explicitly designed to extend curricula beyond the classroom and effect change in clinical practice. The design included critical components of successful workforce development, and benefited from an organizational culture that supports the change process, is outcome oriented, and has implementation-savvy program leadership.

Setting

Thresholds has 142 *outreach* teams, which are staffed by 900 clinical staff and serve 3900 individuals in the community, across Chicago and its suburbs. Currently, the agency houses two co-located primary care clinics, one on the north side of Chicago and one on the south side of Chicago.

Five teams from two programs were chosen to serve as pilot teams, with the hope that lessons learned would allow the intervention to be more efficiently brought to scale across the agency. Forty-four staff from six teams on Chicago's south and southwest sides participated in two full days of face-to-face training. The majority of trainees were women (54%, n=24), and 46% (n=20) were African American. Forty six percent (n=20) held Bachelor of Arts degree and the remainder held a master's degree. The average age was 38.84 (SD=10.56), with age ranging from 25 to 61.

Health and Wellness Training: Curriculum

A standardized health literacy training was adapted for use from an existing Wellness Coaching curriculum (Swarbrick, 2006; Swarbrick, 2014; Swarbrick, Murphy, Zechner, Spagnolo, & Gill, 2011). Content included how to have conversations about physical health, how to set Specific Measureable Achievable Realistic Timely (SMART) goals, and the use of motivational interviewing techniques to support change. Instruction was interactive, with discussions and application built in throughout. Trainees were provided a resource manual to access during practices, and an electronic version of the manual was provided to trainees for reference and for the agency to use in future trainings. Additional resources were placed in an internal electronic library that staff could easily access through a short-cut on their desktops. Links to information regarding common medical conditions, including appropriate health indicator ranges, were distributed to all staff for use in the field. Training objectives were to:

1. Increase knowledge of how to help members (individuals served) manage their health, of how to access relevant health information, and of how to support members to manage their specific illnesses.

2. Increase staff confidence in talking about and delivering physical health interventions.

3. Integrate what was taught into services-as-usual.

Health and Wellness Training: Principles in Practice

Six consensus-based principles for effective training informed the design (Leff, Leff, Chow, Cichocki, Phillips, & Joseph, 2007). The first two principles—that training *should be relevant to practice* and *should offer numerous opportunities for follow up*—are fundamental to training durability and played an important role in training implementation in this project. With support from the Thresholds leadership, the trainer-consultants engaged the staff-trainees by asking them to complete "pre-work" (Clark & Mayer, 2007), including a self-assessment in advance (My Life Check; www.heart.org) to raise awareness of health factors that apply to everyone, not just people using mental health services. Trainees had structured opportunities to discuss personal health goals during the training, so a self-assessment prepared trainees to consider areas where they might make a change in their own lives and to think about their own stage and process of change.

Trainees also prepared by identifying and approaching two members on their caseload who were interested in working on a physical health goal. By requesting that trainees identify members before the start of the training, the trainers were able to raise awareness of the health conditions and needs of individuals served prior to the training itself, ensuring training relevance to the job. Research suggests "acquiring new knowledge in the context of some professionally meaningful problem or situation will lead to more accessible knowledge, because the situational cues that will activate the knowledge are stored within the same cognitive structures" (Van Der Vleuten et al., 2000, p.247).

As discussed frequently in this Education and Training column, and in other literature (see, e.g., Stuart, Hoge, & Tondora, 2004), short-term didactic trainings are ineffective for practice change. To extend the training and focus on application, a six month follow-up period was built in for coaching and consultation. The follow-up consultations included calls every other week with the staff who attended the training. The call agenda consisted of discussion and problem-solving related to supporting individual members; review, clarification, and instruction on curriculum content; and general feedback and support.

Follow up coaching reinforced the training material, supported practice change through ongoing performance assessment, and allowed problem-solving around unforeseen barriers to putting the training into action. Calls also were used to identify treatment approaches for individual staff in the context of overall team-based care delivery.

Early into the follow-up phase of the project, Thresholds hired a manager of clinical best practices to assume a lead role in the day-to-day organization of the health and wellness initiative and to provide in-person support to staff. Together, the trainer-consultants and the manager of clinical best practices participated in the calls, modeling clinical skills, providing problem-solving support, and creating a space for trainees to share their experiences and receive feedback to enhance implementation. In addition, the follow-up calls provided an opportunity to assess staff competencies and provide booster sessions or target particular areas for remedial or enhanced instruction. For example, continued discussion was needed to improve staff understanding of developing and executing member-driven SMART goals, building on member's strengths, and providing stage based interventions.

To prepare and support the manager of clinical best practices, separate phone calls were scheduled with the trainer-consultants. Over time, the trainer-consultants faded their participation in the follow-up calls, with the manager of clinical best practices taking greater responsibility for setting the call agenda, orienting staff trainees, and facilitating discussions.

Lessons Learned: Training to Implementation

Insofar as sustainability of a new practice begins where training ends, a strong partnership with and commitment from the provider organization is key. The following were instrumental to the success of this project:

- *Oversight and Monitoring.* A steering committee was formed to oversee the pilot and relied on evaluation tools created by the Thresholds Evaluation Department, including a logic model and process and outcome data reports, which allowed for built-in opportunities for midcourse changes during the pilot and quick identification of a decline in activities that focus on health behavior change.

Insofar as practitioner performance is the outcome, methods of measuring staff activities to track program uptake are critical to long-term sustainability.

- *On the ground champion*. The appointed internal agency consultant (the manager of clinical best practices) served as a "bridge" between the trainers and staff and as an advocate and supporter of the project. Sustainability is contingent on having on-the-ground champions who encourage and facilitate efforts to implement change and can articulate the initiative goals to staff long after trainers are gone to keep staff motivated to use the training curriculum.

- *Start small and bring to sca***le**. Five teams were selected to be trained and pilot the health and wellness strategies. The initial application involved working with individuals who were stable in their motivation to initiate health behavior changes, allowing staff to practice the skills and techniques learned through trainings. Though a fully optimized workforce will be required to work with people in various stages of behavior change, working with two carefully selected individuals in the initial training period allowed staff to better hone their craft, preparing them to work later with individuals who appear less motivated to engage in behavior change.

Conclusion

A health and wellness curriculum and training format was designed to increase staff confidence in supporting members to help them manage and prevent medical issues from impeding recovery goals. An expanded training period, using both pre-training engagement activities and follow-up consultation, allowed the training model to span instruction and application. Buy-in and commitment from agency leaders facilitated collaboration between consultant-trainers and trainees, and a keen appreciation for implementation issues facilitated training uptake.

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