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Project description

This paper explores the potential role of telehealth in the expansion of mental health access for an inner-city Latinx population by engaging with providers and stakeholders of various community health centers in the South Lawndale community of Chicago—a community whose population is predominantly Latinx, low-income, and uninsured. While the literature and stakeholders cannot see telehealth surpassing or replacing standard face-to-face care, they see a lot of potential to make processes more efficient. Through analyzing the literature, survey data, interviews with stakeholders, and recruitment and education content, recommendations are made to 1) Move towards a mental health model that is more focused on preventative and trauma-focused care 2) Improve cultural-competency by encouraging the entry of Latinxs into the medical profession and by promoting cultural-competency training 3) Reframe and reposition the benefits of telehealth by channeling more funding and research into exploring the role of telehealth in addressing access 4) Use evidence to encourage the expansion of coverage for telehealth through CMS, private insurers, and employers and 5) Establish a clear legal framework to standardize the evaluation of telehealth interventions and provide a streamlined process for the licensing of providers.

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Exploring the Potential Role of Telehealth in the Expansion of Mental Health
Access for an Inner-City Latinx Population

by

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Abstract

This paper explores the potential role of telehealth in the expansion of mental health access for an inner-city Latinx population by engaging with providers and stakeholders of various community health centers in the South Lawndale community of Chicago—a community whose population is predominantly Latinx, low-income, and uninsured. While the literature and stakeholders cannot see telehealth surpassing or replacing standard face-to-face care, they see a lot of potential to make processes more efficient. Through analyzing the literature, survey data, interviews with stakeholders, and recruitment and education content, recommendations are made to 1) Move towards a mental health model that is more focused on preventative and trauma-focused care 2) Improve cultural-competency by encouraging the entry of Latinxs into the medical profession and by promoting cultural-competency training 3) Reframe and reposition the benefits of telehealth by channeling more funding and research into exploring the role of telehealth in addressing access 4) Use evidence to encourage the expansion of coverage for telehealth through CMS, private insurers, and employers and 5) Establish a clear legal framework to standardize the evaluation of telehealth interventions and provide a streamlined process for the licensing of providers.

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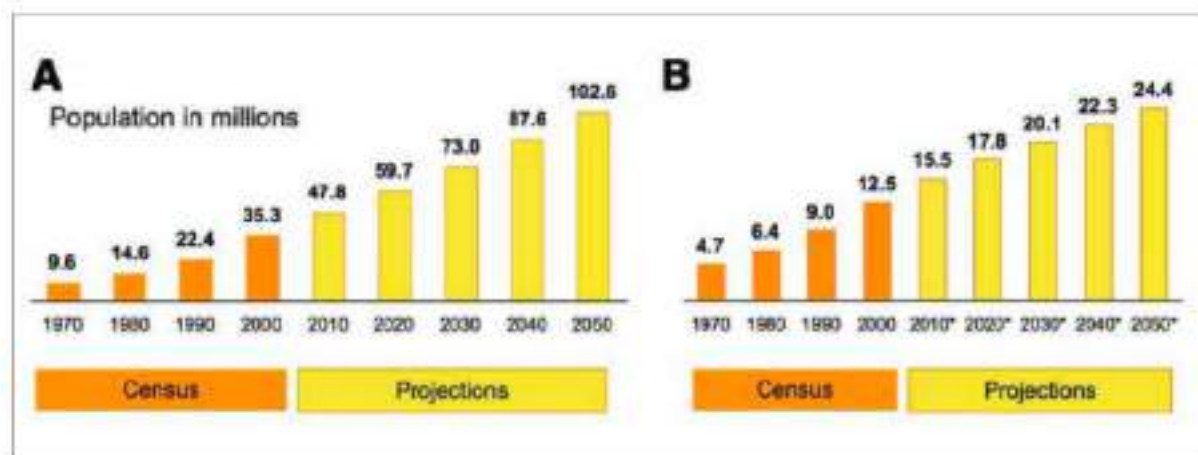
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Introduction

Mental health disorders affect 1 in 5 adults of the US population and only 41% of those adults reported having received mental health services in the past year (NSDUH 2014, NSDUH 2015). While Latinxs suffer from mental health disorders at a similar rate than non-Latinx Whites, they use mental health services at half the rate, and therefore their mental health care needs remain unmet (DHHS 2001; NLAAS 2004; NSDUH 2015; Roots to Wellness 2017). Addressing the needs of the Latinx community is becoming increasingly important as the Latinx population in the US is growing. Latinxs made up about 18% of the population in 2016 and the population continues to grow at a rate of about 2% annually (Pew Research 2016); estimates for the next couple of decades are found in the figure below (Figure 1).

Figure 1: (A) Hispanic population in the United State, 1970-2050. (B) Percentage Hispanic of total population in the United States, 1970-2050

Source: US Census Bureau, 1970, 1980, 1990, and 2000; Population projections, July 1, 2010 to July 1, 2050.



There are a number of factors that exacerbate the obstacles to accessing proper mental health care. There is currently a shortage of about 10,000-20,000 mental health providers in the

United States since most current practicing providers are projected to retire over the next 10 years and insufficient replacements are being trained (Bashshur et al. 2016). Additionally, the Association of American Medical Colleges (AAMC) projected that by 2025, there will be a shortage of 124,000 full-time physicians with 37% of the shortage being in primary care (Petterson et al. 2012). Given that up to 60% of all patients seen in primary care have a psychiatric disorder, this presents a crisis for the state of mental health care in the country; as a result, researchers have called for collaboration and care-coordination between primary care providers and psychiatrists in the primary care setting, especially since co-morbidities with chronic diseases are common (Chen 2013; Bashshur et al. 2016).

One of these structured models of care delivery and coordination is called the patient-centered medical home. This integrated and coordinated care, which is delivered through physician-led care teams, focuses on quality and safety and practices are committed to enhancing access to care, usually through culturally and linguistically-appropriate means (Abdouch 2016). A report by the World Health Organization (WHO) found that the primary care setting reduces the stigma and discrimination that mental health patients often face from both community and family members when attending mental health facilities along with leading to better health outcomes especially when linked to secondary services offered in the community (World Health Organization 2008). This is why the current primary care physician shortage can have a drastic effect on access to mental health services.

Where one goes to receive care depends on the quantity of services received, frequency of need, and costs (Figure 2). Patients can be treated as inpatients in long-term facilities such as psychiatric hospitals and prisons, in emergency settings such as emergency departments or acute-care hospitals, in community mental health clinics, or as outpatients in the primary care clinic.

The primary care clinic is the most prevalent setting but unfortunately, only 50% of patients seen by primary care physicians for mental health are accurately diagnosed (Bashshur et al. 2016). These inaccurate diagnoses are most likely due to the fact that primary care physicians are not specialized in mental health and are not adequately trained to provide these services. Thus, researchers have suggested that primary care physicians should work closely with other professionals such as psychologists, social workers, and nurse practitioners since they are not in short supply and are qualified to provide these services (Bashshur et al. 2016).

Figure 2: Healthcare Setting Depends on Quantity of Services Needed, Frequency of Need, and Costs

Source: World Health Organization 2008



With regards to access barriers facing the Latinx community specifically, the New Jersey Mental Health Institute's *Changing Minds, Advancing Mental Health for Hispanics* project, aimed at understanding the belief systems and barriers facing the at-risk Hispanic population, found that the major barriers to receiving mental health care were language barriers and lack of

health insurance (National Resource Center for Hispanic Mental Health 2002). Aside from these structural barriers, there were also a number of attitudinal barriers usually tied to cultural factors such as religion and beliefs about mental health illness causes and treatment. This suggests that once structural barriers are addressed, the Latinx community may benefit from culturally and linguistically-competent care which may expand access and utilization of specialty mental health care services. This will happen by addressing other factors such as stigma through raising awareness and educating on the difference between mental health conditions such as anxiety and depression and *locura* (being labeled crazy) (Roots to Wellness 2017).

Telehealth, which is the delivery of healthcare through the use of technology, has been discussed in the context of a fundamental change in healthcare and may help address many of the aforementioned barriers to access. The shift to value-based care has meant that there is more of a focus on improving safety, efficiency, and quality of healthcare (Van De Belt et al. 2010). The health reform movement calls for a bio-psychosocial approach through integrated care and the application of technology is likely to allow for cost-effective care that is more patient-centered with increased access (Waugh, Voyles, and Thomas 2015).

This paper will explore the potential role of telehealth, if any, in expanding mental health care access to an inner-city Latinx population. I will do this by analyzing existing data on services offered to Latinx communities in the Midwest and engaging with stakeholders to further assess the mental health care needs of the Latinx population in Chicago and to examine their thoughts on the role that telehealth could play in bridging these gaps in care and in delivering culturally-competent mental health care services to an inner-city Latinx population in Chicago.

Background

The city of Chicago has a large total uninsured population with an uninsured rate of 19.6%, relative to the national average of 13.3% percentage (“Community Snapshot: South Lawndale” 2016). In Chicago, 28.9% of the population is Latinx while the national Latinx population is about 18% (Pew Research 2016; Chicago Health Atlas 2017). Of the Latinx population living in Chicago, 18.5% of them are uninsured and of the segment of the population with insurance, only 65.4% report seeing a primary care provider (Chicago Health Atlas 2017). This number is alarming considering that most mental health care is now being delivered through primary care settings through an integrated health model. In Chicago, Latinx residents also suffer disproportionately from both chronic conditions and violence-induced trauma and Latinxs suffer from the highest youth depression rates of all other races at 37.6% (Chicago Health Atlas 2017). The combination of these statistics imply that many Latinxs in the community are not receiving routine clinical care, much less specialty services such as mental health care.

South Lawndale is a neighborhood in southwest Chicago. As of 1980, Latinxs have made up the majority of the population, mainly due to development and gentrification in Pilsen and other areas of the city that drove many Latinxs west (mainly Mexicans and Mexican-Americans) (Encyclopedia of Chicago 2010). In 2015, Latinxs made up 85.2% of the population in the South Lawndale neighborhood and 36.3% of its residents are uninsured (Statistical Atlas 2015; “Community Snapshot: South Lawndale” 2016; Chicago Health Atlas 2017). About a quarter of the neighborhood’s residents are undocumented and/or are working low-wage jobs (33.3% are earning income below the household poverty rate compared to 18.9% for the city of Chicago) and therefore are ineligible for health insurance or have inadequate coverage (Tsao 2014; Statistical Atlas 2015; Chicago Health Atlas 2017). As of 2015, more than half of the residents

did not have a high school diploma and more than one fourth of residents reported limited English proficiency which may have some implications when it comes to general literacy and health literacy (Statistical Atlas 2015; Chicago Health Atlas 2017). When asked in a survey how common violence is in their community, 72.8% of participants responded “extremely” or “likely” (“Community Snapshot: South Lawndale” 2016). The combination of these facts drastically restricts access and quality of care including mental health and highlights the need to address mental health care needs in the community, including trauma-focused care.

A report by Roots to Wellness (Enlace Chicago) published in 2014 reported that an estimated 21% of adults in South Lawndale suffered from mental illness and of those, only 30% were receiving counseling services (Roots to Wellness 2014). A second report titled “Assessing the Mental Health Needs of the Latinx Community on Chicago’s Southwest Side” published in 2017 looked into the barriers affecting the South Lawndale community among others on Chicago’s southwest side. It cited barriers to seeking access as being those related to being undocumented, lack of health insurance with mental health coverage, need for child care, lack of transportation or time due to work or other commitments, language barriers, inconvenient hours, perceived uselessness, family disapproval, and stigma. It found that US-born Mexican-Americans have higher rates of mental health conditions than foreign-born individuals and that only increase with length of US residence, possibly due to long-term discrimination, acculturation stress, and other stressors including poverty and work conditions (Roots to Wellness 2017).

In 2016, Chicago Mayor Rahm Emanuel partnered with the Chicago Department of Public Health to launch Healthy Chicago 2.0 to address the aforementioned disparities, along

with a plethora of other challenges facing healthcare not only in Chicago, but across the nation.

The plan had four overarching goals (Healthy Chicago 2017):

1. **Prioritize Health Equity:** Ensure that limited resources are allocated to areas where they are needed the most.
2. **Collaborative Effort:** Provide action steps for health care providers, businesses, faith-based organizations, and residents to work together to promote health.
3. **Social Determinants of Health:** Understand that health is impacted by number of factors, including economic opportunity, education, and public infrastructure.
4. **Using Data and Surveillance:** Make sure each goal and action step is measureable.

While the plan has only been in effect for a year, there have already been strides made to reach these goals. Indicators for the Latinx population are listed in the table below (with general citywide population baseline numbers in parentheses). As can be seen from Table A for the Latinx population, access to primary care physicians has increased by 6.8% and the uninsured population has dropped by 5.6% since the plan's inception (Chicago Health Atlas 2017):

Table A: Latinx Indicators from Rahm Emmanuel's Healthy Chicago 2.0

INDICATOR	BASELINE FOR LATINX POPULATION	2020 TARGET AND CHANGE FROM BASELINE
ACCESS TO PRIMARY CARE PHYSICIAN	68.4% (80.8%)	75.2%
NO HEALTH INSURANCE	28.1% (18.7%)	22.5%

Action teams have formed as a result of community partnerships and two of these action teams are responsible for promoting behavioral health and increasing access to health and human

services (Chicago Health Atlas 2017). Chicago, along with many major U.S cities, is trying to tackle these health issues and disparities by creating innovative ways to increase access and improve quality of care. This paper will look into the modality of telehealth and whether it can or cannot be an innovative way to address some of the issues mentioned above, either as a substitute for care or as a complement to other modalities of care.

Literature Review

The last decade has made way to a technology revolution and increased connectedness in all industries. In 2004, Web 2.0 was the term that emerged referencing the shift of the nature of the internet which went from being unidirectional to interactive where *users* are now allowed to add content and exchange information (Van De Belt et al. 2010). People rely increasingly on the internet every day and healthcare is not an exception. Patients are increasingly turning to the internet for their healthcare needs. In 2010, Google reported that 5% of internet searches were health-related (Van De Belt et al. 2010).

There have been many terms (Health 2.0, Medicine 2.0, Telehealth, Telemedicine, mHealth, eHealth) that have emerged as a result of the application of healthcare to Web 2.0 technologies. While there are many ways to define the various terms, a systematic review by Van de Belt and colleagues found that there are recurring concepts seen throughout the definitions including patients, technology, professionals, social networking, healthcare change, collaboration, and health information/content (Van De Belt et al. 2010). For the sake of this paper, telehealth will be the broader term used that covers telemedicine (healthcare delivery through medical services provided at a distance by physicians) and non-physician services such

as telenursing, telepharmacy, health education, and patient portals. It will also refer to mobile health which is the use of a smartphone to access telehealth services (monitoring for example). The application of technology to healthcare can be seen as having many uses that include providing disease prevention and wellness, monitoring and remote care, mobile decision-making, and emergency interventions (Varshney 2014).

Telehealth is well-positioned to be incorporated in a model where care is patient-centered, comprehensive, coordinated, accessible, and committed to quality and safety. Telehealth is meant to be more engaging for both patients and providers, allowing for active participation and interaction and an elevated sense of empowerment for both parties involved. With this new power, patients feel a deepened responsibility for their own healthcare since it allows them to feel a sense of personal choice and control. One study refers to this transfer of power as being from professionals-*controlled* to professionals-*managed* healthcare delivery (Varshney 2014). Patients now have the power to access a network of providers and providers have the ability to collaborate and collectively assess a patient regardless of where the patient or their colleagues are located at the time, since communication can be in real-time and health information is literally located at the tips of their fingers.

The emergence of store and forward technologies has also revolutionized telehealth, since they allow the advanced capabilities of capture, transmission, and storage of information for later use by specialists. It also speeds up the referral process and improves coordination of care between primary care doctors, specialists, and the rest of the health team (Bashshur et al. 2016; Japsen 2017). This allows for other trained professionals such as nurses or social workers to provide services, while storing information for specialists to view at a later time. This helps to mitigate the issue of physician shortage since it requires less time investment on the physician's

part. Telehealth can also lead to an extended and improved relationship between the patient and provider, allowing for the ease of scheduling of appointments (Kosowsky and Krawiec 2016).

The bidirectional nature of telehealth also allows for increased interaction between patients and others—whether it be healthcare professionals or the surrounding community. The introduction of social networking to the realm of healthcare allows for transparency between patients and the healthcare community, mediating the effects of asymmetric information that often arises from the patient not understanding his or her own health without the interpretation of his or her doctor. However, concerns have been raised with the use of social media in the realm of healthcare and these include questions of ethics, professionalism, privacy, confidentiality, and information quality (Grajales III et al. 2014). To try to combat this, providers are encouraged to disclose at maximum three indirect patient identifiers and to ignore patient requests through social media (Grajales III et al. 2014). While these are valid concerns, research has shown that the number of reported privacy and confidentiality violations using social media are very small; one study found that it was only 2% of the total number of physician profiles they evaluated (Grajales III et al. 2014). Particular strides are also being taken as far as information quality is concerned. The World Health Organization (WHO) requested a new *.health* internet domain which would be legislated and monitored according to strict quality criteria and prioritized by a group of industry partners during searches (Grajales III et al. 2014). The *.health* domain was released in July 2017 by internet registry company dotHealth and only allows validated sites to register that have been validated as a qualified member of the health industry (Greene 2017).

Unfortunately, several major barriers to the broad implementation of telehealth have been identified. One of the greater barriers includes reimbursement. In 2017, twenty-nine states and the District of Columbia have passed “parity” legislation, requiring third parties to reimburse for

telemedicine services (Agate 2017; Kosowsky and Krawiec 2016; Weinstein et al. 2014). While Medicare, Medicaid, and private insurance have expanded coverage over time, services are still limited. According to the Center for Medicare and Medicaid Services (CMS), a patient must meet the following requirements to receive reimbursement for a telehealth service (Bhat 2016):

1. Be in a health clinic or physician's office (approved "originating" site)
2. Originating site being located in a non-metro county or in a primary care or mental health geographic Health Professional Shortage Area located in a rural Census Tract of a metropolitan county
3. Communicate via live two-way video
4. Be one of twenty-two specifically defined services categorized as "those that mimic face-to-face between patients and their health care providers"

Because of the stringent requirements for reimbursement, Medicare has only spent \$14 million on telehealth services out of a total \$614 billion dollar budget and in 2014, only 1% of beneficiaries had received care remotely, lagging behind private payers such as UnitedHealthcare and Anthem who have planned to cover more than 20 million members by the end of 2016 (Bhat 2016). Reimbursement models are targeting the wrong metric, relying on geography rather than access. Currently 48 states provide *some* sort of telemedicine service (Marcoux and Vogenberg 2016). Medicare reimbursement for telehealth services is conditional on the originating site being in a non-metro county or in a shortage area, putting individuals living in urban areas at a disadvantage. As a result, 80% of Medicare beneficiaries living in nonrural areas do not have telehealth service coverage, yet the Medicare Payment Advisory Committee found that 44% of telehealth claims originated from urban areas (Agate 2017; Weinstein et al. 2014; Marcoux and Vogenberg 2016; Wicklund 2017).

However, this is being addressed by legislation such as the Telehealth Enhancement Act of 2015 and the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2016 which aim to remove originating sites barriers for access by

establishing a demonstration waiver program for eligible providers (Agate 2017; Marcoux and Vogenberg 2016). This is important because while rural areas suffer a shortage of doctors, shortage of appointments (waitlists) are a reality for many urban dwellers. An audit of primary care practices from ten states found that 80% of Medicare recipients in rural areas managed to get appointments, yet only 60% managed to in urban areas (Richards et al 2015).

Interstate medical licensure also presents a roadblock since the nature of telemedicine might often mean a physician is treating a patient in a different state. Some states have offered special telemedicine licenses that reduce the barriers and costs of practicing across state lines (Van De Belt et al. 2010). The Federation of State Medical Board's (FSMB) Interstate Medical Licensure Compact, which offers an expedited pathway to licensure for qualified physicians who wish to practice in more than one state, is a legislative piece which is on track to being adopted in twenty-six states by the end of 2017 (Agate 2017). The compact is voluntary for both states and physicians. While it offers a streamlined process for obtaining licensure across state lines, licensure is still required for each individual state in which they plan to practice. Other cited challenges that may arise with the widespread adoption of telehealth include upfront costs of infrastructure and equipment (including access to broadband internet), recruitment of teleconsultants, and questions of economic viability due to these initial upfront costs (Weinstein et al. 2014).

Telehealth is still in its early stages and stakeholders still believe there is not enough evidence to prove that telehealth will lead to fundamental changes in healthcare (Van De Belt et al. 2010). This lack of evidence might also be a reason that vital stakeholders have yet to become active parties in the development and implementation of telehealth. This includes the federal government who has immense influence on healthcare policy (Van De Belt et al. 2010). In 2012,

the Food and Drug Administration (FDA) was tasked with developing strategy and recommendations on a regulatory framework and was designated regulatory duties for health information technology, in conjunction with the Federal Commerce Commission (FCC) and the Office of the National Coordinator for Health Information Technology (ONC) (Marcoux and Vogenberg 2016). The Federal Trade Commission (FTC) on the other hand is responsible for protecting consumers from false or misleading claims and handles any data breaches of patient information (Marcoux and Vogenberg 2016).

Despite the aforementioned roadblocks, studies have identified several aspects that may increase the odds of a successful telehealth program. Unfortunately, a study found that telehealth is still underutilized with about with people reporting an average of 1.3 telehealth visits per year per patient; that same study found that telehealth visits save an average of \$126 per commercial telehealth visit and \$45 for Medicare-funded telehealth visits, valuing each visit at an average of \$50 per visit; these interventions have the potential to lead to reductions in long-term costs, more efficient processes, and they help meet the workload needs of professionals (Yamamoto 2014). A study by the University of California Davis Medical Center found that over a span of 18 years, telemedicine practices save patients about 9 years of travel time and about \$3 million in travel costs, not to mention it benefits the environment (Marcin et al. 2017). Telehealth will also help to address healthcare workforce shortages by filling in the gaps with other mental health personnel (creating more jobs for therapists, social workers, psychologists, and nurses) that provide direct service and act as liaisons while physicians make use of the store and forward option. This is especially important in the Latinx population since there is already a shortage of Latinx physicians and it is only worsening as overall population increases (Agate 2017). Since 1980, the Latinx population has risen by 243%, yet the number of Latinx physicians per 100,000 people

has decreased by 22% (Sanchez et al. 2015). This shortage is only exacerbated by the fact that young physicians are preferring to go into specialized care instead of primary care and as mentioned before, primary care is the main avenue for diagnosing mental health disorders.

The proliferation of technology use is also undeniable. Weinstein and colleagues predict that by 2020, 25-50% of all healthcare transactions will be electronically outsourced and they believe that 25% of all healthcare interactions could be by telehealth means (Weinstein et al. 2014). By 2013, over 50% of hospitals systems used some form of telehealth (Marcoux and Vogenberg 2016). Technology use is increasing, especially amongst Latinxs (Agate 2017). However, this use is limited since the number of Latinxs that rely on their smartphone for internet connectivity rose from 16% to 23% from 2013 to 2015 (Agate 2017). This puts them in a special position as a potential benefactor to mobile health interventions since these interventions can be accessed on a smartphone, but it also presents the challenge of expanding broadband access to underserved populations in order to implement on a wider level.

The use of linguistically and culturally-competent practices along with the use of community health workers within telehealth could help to combat the additional barriers of health literacy and establishing trust (Agate 2017). There is evidence that when Latinxs receive care from a bilingual and bicultural provider or professional interpreters, they are more likely to remain in care and report better outcomes and increased patient satisfaction (Fernandez et al. 2011; Dunlap et al. 2015); other studies found that patients report care that is more patient-centered and also report less medical errors (Perez-Escamilla 2009). Cultural-competent practices also result in increased access to a routine healthcare provider since trust is established (Perez-Escamilla 2009).

Many Latinxs also do not seek mental health care because they do not know they have access either due to uninsured status or fear of seeking care due to their legal standing. Studies have also found that among Latinx respondents that *do* seek care prefer to use informal services such as those offered through religious institutions or schools and prefer to seek primary care rather than specialty services for meeting mental health needs (National Resource Center for Hispanic Mental Health 2002; Villatoro, Morales, and Mays 2014). This is likely due to high levels of behavioral *familismo* among Latinx individuals (value that emphasizes strong family loyalty, closeness, and getting along with and contributing to wellbeing of nuclear family and close kin). This is important because this high level of familismo can also be a barrier to receiving mental health services at home since patients may not want their families to know they are seeking care.

There are a number of reasons why community health centers and faith-based centers such as churches are so important in seeking and receiving care and why incorporating cultural values such as *familismo* (emphasis on family) within interventions is so imperative. Latinxs subscribe to a different set of cultural assumptions surrounding their healthcare and these must be addressed. These are all reasons why the role of community patient navigators is essential for informing and connecting minority communities to the various mental health services available in various locations around their community and city. Studies have shown that adopting various modalities like using patient navigators or community health workers, not only facilitates health care access and improves care quality through advocacy and coordination, but also addresses issues related to distrust in providers and the health system that may result in the avoidance of the healthcare system altogether (Natale-Pereira et al 2011).

For example, community health workers can provide culturally-relevant health education, social support through the establishment of trust within the community, connection to services, and they also may serve as ambassadors to the healthcare system and policy makers along with leading as advocates in their community. These workers more often than not come from the community being served and many have been direct recipients of the services being offered and therefore can speak to them; therefore, they are often trusted members of the community and also avid advocates for residents' rights.

Community health workers can either be volunteers or paid employees. Those that support them being paid employees state that they should be fairly compensated for the work that they do; on the other hand, proponents for having community health workers be volunteers rather than paid employees suggest that this ensures that their allegiance remains with the community rather than the healthcare system or organization (Cherrington et al. 2010). One study called the Sowing the Seeds Health study that used community health workers as volunteers for education and advocacy purposes reported that the workers felt empowered because they were able to participate in the development of the community action plan and also liked the voluntary aspect of it because it eliminated unnecessary paperwork and bureaucratic processes allowing them to maintain a higher level of autonomy and creativity; however, studies also found that sustaining community health workers requires some form of reinforcement, even if non-monetary, such as community recognition or official integration as part of the health management team (Perez-Escamilla 2009; Cherrington et al. 2010). Models based on this modality have been found to not only increase prevalence of healthy behaviors through education but have also led to improvements in health outcomes (Perez-Escamilla 2009).

On a global scale, patients treated at community health centers have shown better physical health outcomes, mental health outcomes, and an improved quality of life than those treated in psychiatric hospitals (World Health Organization 2008). Furthermore, in the US, community health centers serve over 27 million patients (O'Donnell and Fletcher 2017). There has been an increase in the use of community health centers since the Affordable Care Act created a Community Health Center Trust Fund of \$11 billion to span 2012-2017—money which is to be used to expand access to 2.7 million additional people including 1.5 million uninsured individuals (Hawkins and Groves 2011). It expired in September 2017 and since then, Congress has passed Community Health Investment, Modernization, and Excellence Act of 2017 in an effort to expand funding (O'Donnell and Fletcher 2017). Community health centers can serve as medical homes that offer continuous primary and preventive care by improving access to timely screening and preventive services; services are often very cost-effective, with expenses being 24% lower than services received elsewhere (Hawkins and Groves 2011). However, challenges faced by both community patient navigators and community health clinics include their reliance on sustainable federal funding, Medicaid payments, and continued state investment (Hawkins and Groves 2011).

While the majority of evidence seems to be in the context of rural populations since telehealth intervention address the lack of service due to distance to a healthcare provider, studies conducted in urban settings, especially among minority populations have emerged, particularly those that use culturally-competent means to deliver service. For example, one study piloted a three-fold telehealth intervention to an African American population in Washington, DC with type 2 diabetes; the three modules included were a self-management module that had a culturally-competent action plan based on treatment plan and 30-minute biweekly video

conferences with a nurse in which the patient viewed short self-management videos or looked at educational material, a health education module which provided patients with culturally and age-appropriate videos and material on a variety of topics, and finally a social networking module linking intervention participants so they were able to exchange information and pose questions. The study found that patients in the treatment group not only reported better blood glucose levels, but also reported changed views on healthcare and physician visits, an improved relationship with their provider, and an appreciation for the convenience of healthcare from home. Finally, they reported increased knowledge of diabetes and improved adherence to diabetes management practices (Carter, Nunlee-Bland, and Callender 2011).

While telehealth has been applied extensively to chronic diseases care due to the potential to improve self-management through tele-monitoring and health education, there is little evidence on the promise of telepsychiatry, especially amongst a Latinx population. Studies argue that telemedicine is most useful in specialties that rely heavily on talking (e.g. psychiatry or therapy) or rely on laboratory services such as blood tests for chronic diseases such as diabetes (Japsen 2017; Marcin et al. 2017). Telepsychiatry services from the comfort of the patient's home have been found to lead to better compliance, outcomes, and patient satisfaction due to the ability to overcome the public stigma associated with seeking mental health care (Kosowsky and Krawiec 2016). A study by Grubaugh and colleagues showed that amongst a group of patients with post-traumatic stress disorder, both urban and rural patients were receptive to receiving mental and psychiatric services via telehealth (Grubaugh 2008). Hence, telehealth may be a way to overcome these challenges and make Latinxs more receptive to utilizing mental health services.

When looking though Medicare reimbursement numbers from 2010-2015, one can see a surmountable increase in telemental health use with the largest spike seen from 2012 with 158 cases to 25,566 in 2013 (Walsh and Goerlich 2017). These numbers are expected to keep increasing with the passage of mental health legislation including H.R 2646 also known as the Helping Families in Mental Health Crisis Act of 2016 and H.R 2680 aka Mental Health Reform Act of 2016 (NAMI 2016). These laws support screening and early intervention, community-based systems of care, enhancing the behavioral health workforce, development of evidence-based programs, increased leadership and accountability for federal mental health programs, increased access for at-risk populations, and the enforcement of mental health parity protections (Helping Families in Mental Health Crisis Act of 2016; NAMI 2016; Mental Health Reform Act of 2016).

Other recent pieces of legislation specifically aimed at increasing the use of telehealth with regards to providing mental health services have emerged. These include the Comprehensive Behavioral Health Reform and Recovery Act of 2016 which seeks to improve access to mental health and substance use disorder prevention, treatment, crisis, and recovery services using telehealth as a service and it allows states to apply for grant money (Comprehensive Behavioral Health Reform and Recovery Act of 2016). The Telehealth Innovation and Improvement Act of 2015 sought to address a number of issues: Medicare's lack of telehealth coverage, the discouragement of innovation, and its restricted access to specialized services (Marcoux and Vogenberg 2016). Telehealth has also garnered the attention of a number of public political figures. In 2014, Senators Bill Nelson (D-Florida) and John Thune (R-South Dakota) requested a system review report from the Agency for Healthcare Research and Quality (AHRQ) that found support for the effectiveness of telehealth for remote patient monitoring,

communication, and counseling (including psychotherapy) for behavioral health disorders (Marcoux and Vogenberg 2016).

Unfortunately, there is not a lot of evidence on the use of telepsychiatry amongst a Latinx population. This may be due to a variety of factors including the decreased utilization of mental health services by the Latinx population. A study by Peter Yellowlees and colleagues aimed to examine the feasibility and diagnostic reliability of telepsychiatry consultations in Spanish by having the consultations of 24 rural Spanish-speaking patients examined by Spanish-speaking psychiatrists and then the translated consultations examined by English-speaking psychiatrists. They found that these consultations were feasible, diagnostic reliability was achieved, and that cross-language consultations offered significant benefits over interpreter services including the potential to improve quality of care (Yellowlees et al 2013). Another study by Jenny Chong and Francisco Moreno divided 167 Hispanic patients into two groups (video webcam group and treatment as usual group). The treatment group (video webcam) consisted of monthly telepsychiatry sessions at the community health center for six months and these were provided by one of the two Hispanic psychiatrists. They found that those assigned to the treatment rated their working alliance with their psychiatrist and visit satisfaction higher (Chong and Moreno 2008).

While the use of telepsychiatry has been looked at, there does not seem to be enough evidence of any intervention carried out amongst an *urban* Latinx population. There are distinct barriers that affect urban populations in comparison to rural ones and the Latinx population faces a different set of challenges in regards to accessing mental care compared to other races. The combination of both of these characteristics put urban Latinxs at a particular vulnerable and disadvantaged position when it comes to seeking and receiving mental health services. There are

many structural barriers such as cost, lack of adequate insurance, and lack of funding that present the first barrier to accessing care. Aside from that, trust plays an immense role in the healthcare of the Latinx population: the services they choose to receive are very dependent on who refers them; this is why informal community institutions such as churches and schools and community health workers are so important. This paper will explore what role telehealth could play in addressing these needs.

Methodology

I used Bashshur and colleagues' definition of telehealth which refers to providing healthcare at a distance where distance extends beyond geography to include temporal, economic, cultural, and psychological factors (Bashshur et al. 2016). I have used the broad term 'telehealth' for the remainder of my paper, but I want to be clear that I mean it in term of mental health care.

Choosing a Neighborhood in Chicago

I used the Chicago Health Atlas and the Sinai Community Health Survey 2.0 to explore Chicago's demographics in order to choose a neighborhood that I believed would be representative and informative to study for the purposes of my paper. The Chicago Health Atlas reports on a variety of factors by zip code and by community area and it includes source information along with details on how the numbers were obtained in the community area profiles. The demographic information I was interested in looking at within the Latinx/Hispanic population included age, education, income, health insurance coverage, English proficiency,

behavioral health (mortality and morbidity) including treatment, avoidable emergency department visits, preventable hospitalizations, and overall health status.

I also used the Sinai Community Health Survey 2.0 from March 2017 and the accompanying report co-authored by Jana Hirschtick, Maureen Benjamins, and Sharon Homan. It includes similar but more recent demographic data and reports on other health outcome measures such as general health status, depression and anxiety, and post-traumatic stress disorder. Other factors I was interested in exploring were clinical care (insurance coverage, utilization, and unmet health care needs) and physical environmental factors (social cohesion and neighborhood safety). The neighborhood profile reports on ethnic composition, education, employment, and income levels.

Choosing South Lawndale

I chose South Lawndale as my population of interest for a number of reasons: over 50% of males and 40% of females reported their health being fair or poor (while nationally, the number is 12%), compared to the rest of Chicago, it had the highest number of avoidable ED visits at 6,753, had the highest uninsured population in the city at 32% (in comparison to Chicago's city average of 10%), and more than 85% of the population is Latinx (Chicago Health Atlas 2017, Hirschtick et al. 2017). Over 50% of the population also reported not having had graduated high school; English proficiency is low among residents with 38.9% reporting limited English proficiency (Chicago Health Atlas 2017). Within the city of Chicago, mood and depressive disorder hospitalizations were amongst the highest in the South Lawndale neighborhood; one of the factors leading up to this includes food insecurity which 45% of respondents reported (Hirschtick et al. 2017). South Lawndale has a rate of diagnosed depression

of 17% (Chicago Health Atlas 2017). It is also important to note that the rate of depression may be underestimated because this number only takes into account those *diagnosed*, therefore only those who are actively seeking out health services. The combination of these factors presented South Lawndale as the perfect community in which to roll out a hypothetical telehealth intervention since healthcare access—especially mental health care access—is very low.

Finally, my communication with the South Lawndale community was facilitated by my second reader and mentor, Dr. Arshiya Baig, a general internist from University of Chicago Medicine who does community-based research in the South Lawndale community. I attended a community stakeholder Change Advocacy Board (CAB) meeting with her on November 15th where I presented my project and they provided feedback and connected me to a number of individuals (behavioral health directors, psychologists, social workers, medical directors, program directors, and other staff) from various community health clinics, non-profit organizations, and advocacy organizations in the South Lawndale community.

Midwest Clinicians' Network (MWCN) Survey

I used the MWCN Survey which was a regional survey distributed by Dr. Arshiya Baig and her team in 2014 to examine what resources are currently available to Latinx patients in the Midwest and to assess culturally-competent attitudes and beliefs. The study surveyed 620 providers and staff within a network of over 100 community health centers in over 10 states including Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, Ohio, and Wisconsin. Since this study was diabetes-based, I chose to only look at the questions that addressed the cultural-competency more generally without asking specifically about diabetes. Since I am interested in looking at an inner-city Latinx population, I decided to filter my data by

looking only at respondents reporting their clinic to be in an urban area. I used the data from this survey to help inform my thesis in regards to what steps, if any, health centers across the Midwest were already taking to increase access, implement cultural-competent practices for Latinx patients, and improve health outcomes.

Interviews

After being connected with the potential candidates for interviews at the CAB meeting, I reached out to ten candidates via email explaining the purpose of my paper and seeking their involvement. Out of the ten candidates I reached out to, I was able to successfully schedule five interviews.

After obtaining approval through the University of Chicago's Institutional Review Board (IRB), I conducted semi-structured interviews regarding the characteristics of their patient population, the current state of mental health in the South Lawndale community, challenges the community faces, what services and resources are currently being offered, their use of technology, and perspectives on a hypothetical culturally-tailored telehealth intervention (see Appendix A). I also asked interviewees demographic questions such as race and ethnicity, country of birth, time living in the US, job title, time in role, and Spanish-speaking ability.

All interviews were recorded and transcribed. I analyzed the transcripts by taking notes on recurrent themes and notable insights. After the interviews, I followed up by soliciting any program or recruitment content they could send for my subsequent content analysis, such as brochures, flyers, and curricula.

Arturo Carrillo and Saint Anthony Hospital

Saint Anthony Hospital provides a range of services to residents of many underserved communities in west and southwest Chicago including medical care, social services, and community outreach. The mental health services provided as part of the Community Wellness Program are free of charge and come in the form of both individual and couples psychotherapy. Sessions are once a week and last about 45 minutes. Social workers also lead 12-week therapy and education sessions. The program mainly serves adults and seniors with a particular focus on low-income, uninsured or underinsured, high functioning individuals (meaning no severe mental psychiatric diagnosis or substance abuse problem). Since most of the patients are Spanish-speaking, the program's providers are all both bilingual and bicultural.

In order to learn more, I spoke to Arturo Carrillo, the program manager and director of Enlace Chicago's Roots to Wellness: Mental Health Coalition. As part of the mental health coalition, Mr. Carrillo holds monthly meetings with various stakeholders in the community to discuss prominent trends and initiatives in the mental health arena. He is a Mexican-American who reads, writes, and speaks Spanish fluently and has been in the role as program manager and coalition director for about three years but has been a part of the Community Wellness Program for 12 years.

Jessica Boland and Esperanza Health Centers

Esperanza Health Centers are a set of clinics that were established to provide service to the underserved Pilsen and Little Village communities in southwest Chicago. They were established as a Federally Qualified Health Center (FQHC) after Saint Anthony Hospital reported that its emergency room was being used for primary care by local residents, draining the

hospital's financial resources. Esperanza was established to provide an opportunity for locals to develop an ongoing relationship with a primary care physician and to provide needed services (social work, mental health, counseling, etc.).

The center's population includes children, adolescents, adults, and older adults. The patient population is predominantly Latinx—sometimes recent immigrants or first generation—often Spanish-speaking only or Spanish-preferred. A very high percentage falls at or below 100% of the poverty line and the center in South Lawndale sees a primarily undocumented population—therefore, because of ineligibility for insurance under the ACA, the majority of its patients are uninsured. Services are provided regardless of ability to pay. Like Saint Anthony Hospital, all of the center's providers and clinical staff are bilingual and bicultural (a condition of employment). Many of the front-line desk staff are often from the communities and neighborhoods that are being served. As a result, interpreters are not required.

To learn more, I spoke to Jessica Boland, the center's behavioral health director. Ms. Boland has been at Esperanza for four and half years and has been in the role of behavioral health director for three years. While she identifies as Caucasian and was born in the US, she reads, writes, and speaks fluent Spanish.

Andrea Muñoz and Jorge Prieto Family Health Center

Jorge Prieto Family Health Center was named in honor of an immigrant physician who spent years treating Chicago's Mexican immigrants and who was known for pioneering the practice of locating need in immigrant neighborhoods and establishing clinics and a relationship between providers and the communities they serve. The clinic is a family medicine residency training site that is part of the Cook County Health and Hospitals system. The patient population

is predominantly Spanish-speaking, Mexican-American, and primarily come from Little Village community.

Andrea Muñoz is a retiree of Jorge Prieto but is currently on the community board of the clinic. Before she retired, she worked for twenty five years for Cook County in which her final role consisted of coordinating with providers from three hospitals, Prieto Health Center, and two mobile clinics and getting them to realize that County patients should be held to the same quality standards as other patients coming from private institutions. While she identifies as Caucasian, she speaks, reads, and writes fluent Spanish.

Amanda Benitez and Enlace Chicago

Enlace Chicago started as the Little Village Development Corporation and was centered around community development and planning in the Little Village community. Over the years, they started receiving funding from various entities which allowed them to expand and build up their quality of life plan which currently focuses on four areas: violence prevention, education, community health, and immigration. Mental health currently lies at the intersection of both violence prevention and community health. There is a mental health team that engages in school based counseling, family group counseling, and street-based case management. Aside from the mental health team, Enlace has also worked with other stakeholders (such as Saint Anthony Hospital) to create a collaborative known as Roots to Wellness which provides an avenue for providers and community residents to discuss access to mental health services and other social supports in the community.

I decided to interview Amanda Benitez, who is the current Director of Community Health at Enlace and has been at the forefront of all recent initiatives. She has been at Enlace for the last

two and a half years and has been Director of Community Health for almost a year now. Since she partook in the survey and the most recent Roots to Wellness Report, her insight was incredibly important. While she identifies as Caucasian, she can read, write, and speak fluent Spanish.

Roxanna Chavez and the Center for Latino/a Mental Health

The Center for Latino/a Mental Health at the Chicago School of Professional Psychology was created by faculty in hopes of gaining a better understanding of Latinx culture. It was mainly created to support the development of cultural-competent mental health providers in order to increase access and improve quality of mental health services for the Latinx community. It has also been very important in advancing public understanding of mental illness, especially in the Latinx community. The center created the Latino/a Mental Health Providers Network which is a network of psychologists, social workers, counselors, case managers, and students and they meet quarterly for business and educational enrichment training.

Roxanna Chavez is working towards her masters in Counseling from the Chicago School of Professional Psychology. She is also the Student Program Developer and Special Event Coordinator for the Center of Latino/a Mental Health. She has been with the center for two years. Ms. Chavez identifies as Latina/Hispanic and speaks, reads, and writes Spanish fluently.

Content Analysis

After collecting all program and recruitment content, I sorted through them and decided to keep only the material that would be addressed directly to prospective patients—with the exception of curricula since I wanted to see how programs were being carried out. I decided to

manually analyze both the language being used and the presentation of the content and coded for common themes. I have included pictures of program content (Appendix B, C, and D).

Findings and Discussion

Resources and Services Available to Midwest Latinx Population

The Midwest Clinicians Network survey (Baig et al. 2014) had a total sample size of 620. Of the 620 respondents, 398 (64.2%) classified their clinic as being in an urban area while 218 (35.2%) reported it being in a suburban/rural area. Results of respondent demographics can be seen in the table below.

Table 1: Respondent Demographics

Demographics of Respondent	Overall	Urban Centers
Race: Hispanic or Latinx	6.4%	7.1%
Professional Role: Physician	40.0%	38.8%
Professional Role: Physician Assistant	9.8%	15.1%
Professional Role: Nurse Practitioner	17.4%	27.0%

To put things into perspective, Hispanics/Latinxs make up about 6.6% of the total population in those ten states; therefore, it seems promising that Latinxs seem to be proportionately represented in the survey. Over 80% of the respondents are either physicians, physician assistants or nurse practitioners and are prominently patient-facing and therefore first-hand witnesses to the center's everyday operations.

Community health centers often act as safety-net centers which often provide services to patients regardless of their inability to pay. Looking at insurance status, 63.4% reported serving a majority of uninsured patients, higher than the overall rate which included rural clinics as well. This shows that urban clinics are more likely to serve uninsured patients. Looking at cultural competency yielded the following results:

Table 2: Linguistic and Cultural Competency Measures

Language Ability	Overall	Urban Centers
Cannot speak to patients in Spanish at all	40.9%	40.2%
Cannot understand Spanish-speaking patients at all	31.8%	30.8%

Cultural Competency Measures	Overall	Urban Centers
No knowledge of cultural differences within community	33.7%	31.6%
No knowledge of difference in patient-doctor interactions	34.9%	34.4%
Has not personally received cultural competency training or has not received it in the last 5 years	47.5%	43.4%

This data is promising because it shows that more than half of the respondents reported knowing how to speak or understand Spanish to *some* extent. Small increases in cultural competence can be seen when comparing urban clinics to the overall rate. This makes sense considering urban clinics tend to be located in areas that are more culturally and linguistically diverse; therefore, this may lead to more cultural trainings out of necessity. However, the number of individuals having received cultural-competency training in the last five years is still alarming, because it means almost *half* of the respondents have not received any form of training.

Finally, specific resources and services offered to Latinx patients differed. Results are found in the table below.

Table 3: Tools Used to Address Cultural Competency

	Overall	Urban Centers
Spanish-speaking front desk staff*	69.6%	71.1%
Spanish-speaking providers*	37.4%	40.9%
On-site interpreters*	71.0%	74.2%

*available >50% of the time

	Overall	Urban Centers	If yes...how many find it effective?
Community outreach workers/Promotoras	64.0%	64.8%	79.6%
Faith or cultural-based community partnerships	34.6%	36.1%	65.3%
Telemedicine to provide access to linguistically or culturally concordant healthcare professionals	9.4%	7.1%	66.7%

While only 40.9% of respondents report having Spanish-speaking providers, there seems to be a high availability of Spanish-speaking staff available either through the form of front-office staff or interpreters. As specific services provided are looked at, one can see that the use of community outreach workers seems promising (and is the most common of the three services offered). Of those that use it, almost 80% deem it effective which may provide insight on the possible use of community health workers in a culturally-tailored intervention and the general acceptability of their use. Unfortunately, telemedicine is drastically underutilized overall but more so amongst urban centers, probably due to the fact that telehealth interventions have been

focused on rural areas for a variety of reasons. However, almost two thirds of urban center respondents that use it report it being effective.

Importance of Cultural Competency and Establishing Trust

From the interviews, there seems to be a general consensus that cultural-competency should be called cultural-sensitivity or cultural-awareness instead, since the term “cultural-competency” seems pretentious since it assumes full-competency can be reached. As Arturo Carrillo of Saint Anthony Hospital stated, “competency is never reached...you are always learning”. What is important is being mindful of cultural background, cultural beliefs, and other things that may impact perception of care and realizing that all of these may differ between different denominations of Latinxs (Mexicans, Puerto Ricans, Colombians, etc.). While none of the centers interviewed provided regular cultural competency trainings, all centers said that being bilingual is a requirement during the hiring process and being bicultural (identifying as partially or fully Latinx) or coming directly from the South Lawndale community is a requirement for front-line staff such as receptionists. While individual entities may not conduct cultural-competency trainings, the Center for Latino/a Mental Health provides formalized capacity-building training sessions for students and professionals. As Ms. Chavez of the Center for Latino/a Mental Health said, “we come up with the tool kit to train the trainers”. Roots to Wellness also developed a mental health training that takes place over six two-hour sessions (curriculum attached in Appendix D); this training emphasizes the importance of “listening responsibly” and remaining vigilant of ethical and cultural considerations.

There are a number of factors that are important to keep in mind when thinking about being culturally-responsive in the South Lawndale area. Due to the fact that many of the

residents are low-income and undocumented, they suffer many stressors that other populations do not. Many of these residents have suffered adverse rates of trauma in their life, either through exposure to violence, abuse, or trauma from their home country. Other sources of stress include acculturation and culture shock (the stress of having to straddle two cultures at once), and more recently, fears of immigration raids. This is why it is so important to provide trauma-focused care that will address these issues and also provide an open and welcoming platform where patients feel at liberty to talk about their problems. As Jessica Boland of Esperanza Health Centers stated, “making those connections between adverse life experiences and ways to kind of cope and entrust them [is important] so they don’t have to stay in the shadows so to speak so people can heal from those things”. Esperanza was also very explicit in the fact that neither the center nor its employees will cooperate with immigration authorities and they have worked hard to cultivate the trust in the community.

The value of familismo must also be addressed by any intervention catered towards a Latinx population. Latinxs place an extremely high value on families and social networks and place a lot of trust in these networks. This is why many centers not only use individual therapy but also incorporate group, family, and couples therapy. Mr. Carrillo emphasized that while their focus is on the individual, their support extends to the entire family as well since they hope to “provide a holistic view on how their family functions” and the patient has free reign to move between different types of therapies and programs. Similarly, Enlace Chicago offers family-based counseling through Community Health and Violence Prevention departments and the Center for Latino/a Mental Health also holds frequent psychoeducation sessions for elders, parents and their children, and also at schools. While some patients may want their family’s support, others may not want their families to know about what they are experiencing for fear of

being stigmatized or ostracized; therefore, telehealth at home may not be as effective at reducing stigma as originally thought for these patients. As Mr. Carrillo stated, “people also need a space for individual healing...so for us to allow a space to heal on an individual level is important but social isolation and family tensions and all these elements are all part of our model, so we will accommodate whatever is best suited”.

Community partnerships help provide what Amanda Benitez of Enlace Chicago called “collective impact”. This is why community partnerships are so important in expanding access since schools and churches are already a place patients frequent and they already trust the institution and the people. Enlace Chicago currently makes use of 5-7 networks around the community. The South Lawndale community seems to be well-connected, knowing all the resources that are available. It seems that all the resources go through schools and churches which are the main sites to connect patients to services. For example, Esperanza Health Centers hold a women support group and also facilitates a six-week dual support group/psychoeducation session for teen girls where they are able to talk about shared experiences like attending an urban high school, living in a socioeconomically disadvantaged community, and also straddling the cultural line of being second generation, being Americanized, but also having to adhere to parents and families’ cultural traditions and expectations. Other partnerships include those with neighborhood councils or partnering with other community organizations such as the TelpoChcalli Community Education Project or Latinos Conversando which does a lot of advocacy around immigration law.

As Andrea Muñoz of Jorge Prieto Family Health Center stated, “It [is] more acceptable in the patient’s mind to go to local church to talk to a priest or a social worker than to see a psychologist”. This is also where community health workers can come in. While not trained

healthcare professionals, they are trusted members of the community who have oftentimes been patients of the centers themselves so can talk from experience and are very knowledgeable about what resources are available. They also act as liaisons between the community and the health system. While they alone cannot expand access, they can act as “facilitators” especially when it comes to the prevention, health education, and advocacy components. As Ms. Muñoz stated, “talking in an informal setting over a cup of coffee might lend to a more honest sharing of information”.

How material is presented in recruitment material can also make all of the difference in whether someone decides to seek services or not because it is the initial point of contact with the patient and can work to foster trust. Ms. Benitez emphasized that the most important thing is being clear about what services there are, when and where they are held, costs and requirements, and making sure language does not contain jargon. Saint Anthony Hospital’s Community Wellness Program brochure (Appendix B) is explicit and clear as it explains each program offered and the requirements for it (including cost and citizenship requirements). The brochure also includes a section on resources and public benefits that may be available and is careful to explain that applying for these benefits will not harm immigration status.

The various centers’ recruitment flyers (Appendix C), on the other hand, are simplistic and include just enough information to capture attention; the information usually includes what is being offered, when, where, and who to contact. It is important to note that the flyers seem to be inviting with symbols and images that inspire peace, growth, and change (e.g. butterflies, trees, friends forming hearts). This is perhaps to foster trust and inspire the patient to take action. Finally, the wording on the flyers is active, promoting the sense that the patient is autonomous and is in control (demonstrated by the fist logo on the Roots to Wellness flyer). This feeling of

autonomy and control is also exhibited by the flyer calling for youth to a forum in which they can develop their own community identity “in a world that tells them who they are meant to be”. All of the flyers also tend to promote a sense of community and unity. For instance, Enlace Chicago’s community garden flyer emphasizes the values of community and family and its aim for the program was for the patient to take a step back and integrate themselves fully into the community—with animals, plants, and nature. The women support group (curriculum in Appendix D) also emphasizes empowerment and talking with other women who have had similar experiences.

Stigma is Not the Biggest Problem

Surprisingly, stigma is not the biggest obstacle facing the South Lawndale community. While some stakeholders still believe stigma plays *some* role and varies from person to person, some discredit it completely. Mr. Carrillo believes that “after being in the mental health field for 12 years, the Community Wellness Program’s long waitlist is a testament that stigma is not the biggest barrier.” He believes that the biggest problem is not stigma, but services that are not catering to the needs of the patients. He argues that patients want to form a personal relationship based on mutual trust and most of the time, they do not find that so they do not return.

Community partnerships also might help mediate the stigma by providing a different avenue to see a mental health provider. The same logic applies to using the integration of mental health specialty services into primary care. Sometimes people are more comfortable with saying they have to go see a doctor than saying they have to see a psychiatrist for a support group since it feels like a less threatening environment. Ms. Boland mentioned that at Esperanza, they usually have the primary care provider introduce the behavioral health provider the same day as

another appointment and by introducing them as a co-worker and friend, it already fosters a level of trust within the patient.

Another element to reducing stigma is educating and raising awareness in the community of the prevalence of mental health disorders in order to normalize mental health and promote the seeking out of services. Esperanza Health Centers and Saint Anthony do this by providing information at health fairs, engaging in presentations around the community, and participating in social media campaigns. Ms. Boland said that the goal is to talk about mental health as colloquially as we talk about nutrition or diabetes. The Center for Latino/a Mental Health also raises awareness through academic lectures, presentations, and their annual conference in hopes of advancing community knowledge of mental illness.

Lack of Resources

The biggest challenge facing the South Lawndale community in terms of accessing mental health care services is that there are simply not enough appointments to go around. While the neighborhood is well-connected and people are referred to appropriate providers, patients often face long waitlists of eight months to a year. It becomes a supply and demand problem. High-quality long-term trauma-focused care for low-income individuals is hard to come by in neighborhood like South Lawndale—especially if one is looking for culturally-competent providers. This not only leads to problems for the patients but for the providers as well. As Ms. Chavez stated, “[the caseload] puts more pressure on staff that are [available] which can lead to high burnout and high turnover, and none of this is good for the community.” This is why the mental health collaborative called Roots to Wellness was created—to figure out ways to maximize the limited resources available in the community. Ms. Benitez said that resources are

even more scarce when considering adult patients. The Community Wellness Program at Saint Anthony Hospital has always maintained a waiting list of at least six months since they only have four providers and while they try to refer out, many patients decide to remain on the waiting list. However, patients can lose hope while on the waiting list and due to this, Mr. Carrillo had said that Saint Anthony is piloting a text messaging system to keep patients engaged.

The lack of providers is likely due to a lack of funding, especially with regards to the recruitment and training of culturally-competent providers. For instance, Enlace Chicago uses some of its funds to train community health workers that were medical professionals in their home countries but have no licensing here in the US. The system also needs more funding in general. Mr. Carrillo strongly believes that community health should be treated like the Cook County Jail system which he claimed to be the “biggest mental health provider in the country”. He states that “we need to fund [healthcare] in a way that makes it accessible to everyone”. If financial structures do not change, he does not believe that the system will ever be sustainable to provide universal mental health care for minorities and low-income patients. Many providers also argue that the current mental healthcare system is very medicalized, aiming to provide treatment instead of preventative care and on top of that, high-quality trauma-focused care is scarce yet is imperative for a community such as this one.

Role of Technology in Healthcare

Surprisingly, many providers did not report much technology use in their health centers. Other than the standard technology use for electric medical records, the majority only used technology for processes such as intake, outreach, scheduling, prescriptions, and case management. For instance, Saint Anthony uses Google Forms to connect residents to various

services and maintains constant text communication with patients through WhatsApp. Other centers such as Esperanza Health Centers make use of patient portals where patients can communicate with providers and schedule or change appointments; they also use text message reminders. Overall, providers thought that technology was useful in terms of facilitating processes and making certain processes more efficient, allowing the time between the provider and patient to be maximized. In addition, providers see technology as a way to keep patients engaged in their care—either through patient portals or through periodic text messages.

However, providers simply do not see technology surpassing or replacing standard face-to-face care, *especially* when dealing with a population that relies so heavily on building relationships with their providers. As Ms. Muñoz stated, “body language and the level of communication [required for therapy] is more productive when the connection is more concrete...and face to face contact is an important piece of acceptability”. Besides that, Ms. Chavez believes that it is difficult to assess the risk level of a situation through telecommunication and this becomes a very dangerous area when it comes to trauma victims or suicidal patients. Along with that, patients already lack the comfort and trust to see providers within their community and communicating with an unknown provider from another community will add another layer of distrust. As Ms. Benitez stated, “patients must first overcome their fear and anxiety and therefore, in order for them to be receptive, the referral must come from trusted members of their community.”

Aside from overcoming their fear and anxiety, various systematic and structural barriers must be addressed. One of these barriers is ensuring that reimbursement models encompass telehealth. For instance, Esperanza Health Centers tried to provide telehealth services to its patients but quickly found that it was not a cost-effective modality since insurance companies

and Medicaid/Medicare could not reimburse for services provided by a federally qualified health center (FQHC) unless another provider was in the room with the patient (completely defeating the purpose). As Ms. Boland stated, “from our perspective, we are very interested in telehealth especially for those specialty services that are not widely available but current policy around healthcare, healthcare billing, and reimbursement does not make it feasible for us.” Other barriers include more structural ones like access to technology and to the internet and these must be addressed before anything can formally be rolled out. Ms. Boland and Ms. Muñoz mentioned stated that it is important to ensure everyone has access to the internet perhaps by offering low-cost or subsidized internet and also making sure older adults know how to work the platforms.

“if you invite technology, let’s not replace it for human contact” – Arturo Carrillo

Policy Recommendations

Recommendation 1: For underserved and uninsured communities, move towards a mental health model that is more focused on preventative and trauma-focused care

The current state of the mental health care system focuses on the medical model in which patients are diagnosed then treated either through hospitalization or medication. However, underserved and underinsured communities similar to the South Lawndale Latinx community need a different mental health care model that is more focused on preventative and trauma-focused care. Oftentimes, these individuals resort to the emergency room to receive both primary and specialty care since it is their only point of access, causing unnecessary expenses all around. This shift will require the collaboration between target communities and community health

workers, health care providers, the private sector (insurance companies, big pharmaceutical companies, and private companies), the government, and society as a whole. An understanding must also be reached that treatment has to be trauma-focused since many individuals in the South Lawndale community are victims of trauma either from their home countries or here in the US. Trauma often includes abuse and exposure to violence.

Recommendation 2: Improve cultural-competency by encouraging the entry of Latinxs into the medical profession and by promoting cultural-competency training

Increasing cultural-competency among healthcare providers treating these communities begins with increasing representation of underrepresented minorities in the healthcare profession and increasing the funding that goes into training these individuals. There is a shortage of Latinx physicians and on top of that, the few there are choose to go into specialty care instead of primary care. There must be a push to encourage young Latinxs to enter the medical profession by starting to empower them at an early age by providing pre-professional academic courses, presentations, and camps to learn about the profession. Along with this, reducing the costs and barriers to entrance to the medical profession must be addressed perhaps by evaluating the high cost of medical school and creating more scholarship and grant funds for Latinx students. In addition to this, providers might be incentivized (perhaps with stipends or other benefits) to relocate to underserved minority areas. For all providers serving minorities and individuals of different cultures, an annual mandatory cultural-competence training/continuing education module should be implemented to keep up with trends and cultural developments in order to maintain sensitivity and awareness and so providers can learn the appropriate to talk to their patients about their mental health concerns.

Recommendation 3: Reframe and reposition the benefits of telehealth by channeling more funding and research into exploring the role of telehealth in addressing access

As the World Health Organization (WHO) stated in 2008: “in order for integration of mental health to be successful in any healthcare modality, mental health must not only be incorporated into health policy and legislative frameworks, but must also be supported by senior leadership, resources, and governance” (World Health Organization 2008). In order for telehealth to be used in any capacity, a few barriers must be addressed. Providers continue to be hesitant to use telehealth for a variety of reasons including bureaucratic ones (such as difficulty in reimbursement for services and licensing) and the fact that they believe telehealth should not replace standard face to face mental health care, especially with regards to trauma-focused care.

While strides have already been taken to reframe and reposition the benefits of telehealth as an innovative way to increase access, more funding and research must be channeled in order to explore whether telehealth can be used to address access in any way that extends beyond physical geography; these must encompass telehealth’s ability to overcome economic, cultural, and psychological barriers.

Recommendation 4: Use evidence to encourage the expansion of coverage for telehealth through CMS, private insurers, and employers

Contingent on evidence, the research executed can lead to CMS’s expansion of coverage for telehealth services for both Medicare and Medicaid. These changes in coverage may lead to private companies also realizing the importance of providing telehealth services; there is already

a trend in this direction being seen with companies trying to develop their own telehealth platform such as United Healthcare and Blue Cross Blue Shield.

There also has to be a push to get more employers to add these services to their benefit packages, especially since many people rely on employers for insurance coverage. In fact, this is already a trend making news worldwide. A Forbes article written by Bruce Japsen on August 10, 2017 reported that by the end of 2018, 96% of employers' insurance plans will cover telehealth services, especially mental health services. They believe this surge is due to the opioid abuse epidemic and the general push for increased access to mental health services (Japsen 2017). Since then, Aon Consulting—an HR benefits consulting firm—has partnered with Teladoc (a telehealth company) to provide innovative telehealth solutions for their clients' benefit packages.

Recommendation 5: Establish a clear legal framework to standardize the evaluation of telehealth interventions and provide a streamlined process for the licensing of providers.

Regulatory policy-makers such as the FDA, FTC, FCC, ONC, and FSMB must work together to establish a clear legal framework that will standardize evaluation of telehealth interventions and provide a streamlined process for licensing. While the FSMB's Interstate Medical Licensure Compact has aided in facilitating getting licensed in more than one state, all parties involved should create a single standardized telemedicine license that would extend beyond state lines. Not only physicians should be able to use telehealth as a way of delivering care, but other mental health care professionals such as therapists, social workers, psychologists, and nurses since they are very important in seeking care and may help to bridge the physician shortage gap.

Future Directions

While this study was exploratory in nature, it shed valuable insight on the potential role of telehealth in the delivery of mental health care for an inner-city Latinx population. Future research should be conducted to gather other stakeholder perspectives on the perceived role of telehealth in delivering mental health care, especially in regards to underserved minority populations. These stakeholder perspectives should range from providers, policymakers, company executives, to patients themselves. All of these perspectives could add further insight to the niche that telehealth could fill in the delivery of mental health care.

In addition to this, studies should be conducted with Latinx urban populations in order to fill the gaps in the literature with regards to whether telehealth, in any capacity, could lead to improved patient satisfaction and improved health outcomes among inner-city Latinx populations. Contingent on the evidence, this research can be used to advocate for expanded coverage and funding for telehealth use in non-rural areas, especially for these underserved patients living in those areas.

Appendix A: Interview Guide

These questions are intended for open-ended qualitative interviews, so I will begin with the questions listed below and then follow-up on relevant portions of the interviewee's response

This project is aimed at assessing the mental health care needs of the Latinx population and evaluating the potential of a telehealth intervention in bridging these gaps

[Begin the audio-recording, say the date, health center or organization name, respondent ID number, and ask the respondent if they consent to participate.]

Y or N

Are you willing to have your quotes used in publications and presentations by the research team? Y or N

[Once the respondent responds to these two questions, as long as the respondent verbally consented to participate, begin the interview.]

- 1.) How would you describe your [PATIENT/CLIENT] population?
 - a. How would you describe their insurance status?
- 2.) What happens when a [PATIENT/CLIENT] does not speak English? Are there Spanish-speaking providers or interpreters available?
- 3.) What do you think it means to provide culturally-competent care?
- 4.) To the best of your knowledge, does your CENTER require [PROVIDERS/STAFF] to complete a cultural-competency training and if so, how often? If your center provides cultural competency training, what type of program do you provide or have you provided in the past?
- 5.) What do you believe is the biggest challenge facing a Latinx community with regards to receiving mental health care?
- 6.) What do you believe is the biggest challenge your center's [PATIENT/CLIENT] population faces and if so, what can CENTERS like yours and the surrounding community do to overcome this?
- 7.) To the best of your knowledge, does your CENTER partner with any churches or other community-based organizations or networks to provide health care or a social support system for patients with regards to mental health care?
 - a. If so, in what way?
- 8.) To the best of your knowledge, does your CENTER make any use of community health workers for mental health care?
 - a. If so, in what way?

- 9.) Can you tell me about a time your CENTER has offered a program or resource specifically tailored for a Latinx population for mental health care?
- 10.) How do you think your CENTER can improve the quality of mental health care that Latinx patients receive more broadly?
- a. Can you think of any programs/resources that you would like to see implemented?
- 11.) To the best of your knowledge, does your CENTER use any form of technology for its everyday functions? Examples may include patient portals, texting reminders, video-conferencing, etc.
- a. Do you believe it has made service delivery more or less effective and how?
- 12.) What do you know about telehealth and what are your feelings about using it as a method of healthcare delivery?
- a. What about as a supplement to regular face-to-face care?
- 13.) Do you think a Latinx population would benefit from a linguistically and culturally-tailored telehealth intervention for mental health care and if so, how?
- a. If a hypothetical telehealth intervention were developed for mental health care, what would you like to see from it?
 - i. What do you think are vital components that would possibly lead to increased access to quality care, higher treatment adherence, and perhaps better health outcomes among a Latinx patient population?
- 14.) Demographic questions
- a. What is your race/ethnicity?
 - b. Where were you born?
 - c. How long have you been living in the US?
 - d. Do you speak, read, or write Spanish?
 - e. What is your title or role at [CLINIC]?
 - f. How long have you been in your current role as [POSITION HERE]?
- 15.) Will you consent to including your name, the name of your health center, and job title when referencing your quotes in publications and presentations?

Appendix B: Brochures



COMMUNITY WELLNESS PROGRAM

Connecting you to the services you deserve



The goal of the Community Wellness Program is to support individuals and families who face the impacts of trauma, poverty, violence, discrimination, language barriers and limited health access to achieve an improved quality of life by offering free culturally respectful services out of two community wellness centers, as well as in various locations across communities.

FAMILY SUPPORT SERVICES

Promotes strong, healthy, parent-child relationships, as well as the social, emotional and intellectual development of young children.

Programs and Services are provided in the following areas:

- Little Explorers – An interactive parent-child play group for parents and children under four.
- Developmental Support Project – Provides education and support in the area of childhood development with parents and children up to eight years old, as well as training and technical assistance for pediatricians and family practice physicians.
- Adults and Children Together (ACT) against Violence – Parents Raising Safe Kids, an educational series for parents of children under ten years old.
- Adolescent and Parent Education (APE) – An educational series of nine classes for parents and adolescents in 5th through 9th grade.

MENTAL HEALTH SERVICES

Provides strengths-based, culturally responsive counseling services and emotional support to adults who have limited or no access to health insurance. Help is available for those experiencing depression, anxiety, the effects of trauma, or who are going through a difficult time or life transition.

Services are provided through:

- Individual Therapy – Weekly one-on-one appointments with a therapist in a safe, caring and confidential environment.
- Couples Therapy – Assists couples with addressing problems. Both partners meet together weekly with a therapist to improve communication and resolve conflicts.
- Groups – Give individuals the opportunity to interact with others in a safe environment and participate in therapist guided discussions focused on healing.

COMMUNITY WELLNESS PROGRAM

HEALTH EDUCATION

- Disease prevention and health promotion services aimed at achieving and maintaining a healthy lifestyle.
 - Health screenings (Blood Pressure, Glucose and BMI)
 - Community health workshops
 - Individualized health counseling provided by our Registered Nurses and certified diabetic educator
- Case Management Services
 - Medication assistance programs
 - Medical referrals
 - Connecting to medical homes
- Chronic disease management provided through our Certified Diabetes Center

HEALTH CARE ACCESS

Linking Families, Individuals and Seniors to Health Insurance, Public Benefits, Community Resources and Senior Wellness Programs.

Receive information and assistance in applying for:

- All Kids – Health insurance for pregnant women and children under the age of 19
- Medicaid – Health insurance for eligible parents
- SNAP (Food Stamps) – Food assistance for eligible children and adults
- Senior Resources – Medicare and Medicaid Savings Programs for eligible seniors
- Marketplace – Health care through the government's insurance

**Some public benefits are available regardless of immigration status. Citizenship applications will not be affected if you receive benefits for which you are eligible. Services are confidential; we value your privacy.*

For program access, please call 773.484.4385.

FAITH-BASED INITIATIVES

Collaborates with religious leaders of all denominations in order to maximize partnerships between faith-based institutions and Saint Anthony Hospital to promote health and well-being of parishioners and the community at-large.

FREE PREGNANCY TESTING

At multiple locations. No appointment necessary, all tests are confidential. For business hours, visit SAHChicago.org.

SAH Community Care Clinic
-Kedzie-
4455 South Kedzie Avenue
773.523.0400

SAH Community Care Clinic
-Brighton Park-
4177 South Archer Avenue
773.254.2222

Saint Anthony Hospital
Physician Center
2875 West 19th Street
773.484.4425

Community Wellness Center
-North Lawndale-
3810 West 19th Street
773.522.5299

Community Wellness Center
-Little Village-
2826 West Cermak Road
773.523.5079

Family & Community Services For Chicago's West and Southwest Neighborhoods

Services are free and offered in English and Spanish.

Upon request, some services and a variety of workshops can be provided at your school, church or agency. For more information, please call 773.523.5079 (Spanish) or 773.522.5299 (English).

SAHChicago.org





Center for Latino/a Mental Health

at The Chicago School of Professional Psychology

Who We Are

The Chicago School of Professional Psychology's Center for Latino/a Mental Health (CMLH) was created in response to the need for a greater understanding of the interaction between culture and mental health among Latino/as, and the specifics of how its expressions and therefore treatment may differ from the general population. The center's vision has been to generate scientific knowledge and provide students and professionals with formalized training in the cultural competencies necessary to work with Latino/a populations. The center has made a profound impact to the field of psychology and has been recognized for its efforts in advancing public understanding on mental illnesses, including being awarded by the American Psychiatric Foundation in 2010 with the *Award for Advancing Minority Mental Health*.

Education:

The need for culturally competent mental health professionals trained in the assessment and treatment of Latino/a clients is enormous. In response, the Center for Latino/a Mental Health places a strong emphasis on providing capacity-building training and resources in areas that are relevant to the provision of cultural competent services to Latino/a clients and their families. We provide Chicago School students with opportunities to attend colloquia and specialized presentations, as well as opportunities to break out of the classroom and learn in diverse cultural settings. CLMH supports students enrolled in the M.A. in Counseling Psychology, Latino/a Mental Health Concentration (LMH). Additionally, we are a resource for students enrolled in other graduate programs that wish to make use of our services.



Community Partnerships:

To further advance our impact in the Latino/a community, we forge partnerships with community and social service agencies that serve the Latino/a population.

A major contribution to the community has been the conception and ongoing development of the Latino/a Mental Health Providers Network. The network is a dynamic and ever-evolving association of psychologists, counselors, social workers, case managers, and students—who all have the same agenda of instilling culturally responsible care within the Latino/a community. The Latino/a Mental Health Providers Network composed of professionals and students meets quarterly for business and educational enrichment training.



Research Opportunities:

We aim to provide research opportunities for Chicago School students. These opportunities may include fellowships, as well as partnerships with faculty and community agencies to develop innovative research that will positively influence the diagnosis, treatment, and prevention of mental health problems among the Latino/a population.



Volunteer Prospects:

The center has developed numerous partnerships in the Chicagoland area to provide Chicago School students with networking and volunteer opportunities, in the Latino/a community.

CONFERENCE HISTORY

Originally named the International Hispanic/Latino Mental Health Campaign and Conference, the Latino/a Behavioral Health Conference began in 1991 with the goal of promoting mental health awareness within the Latino/a community. Since the beginning, the conference has encompassed mental health practitioners, social service professionals, government groups, private entities, and educators from the organizations that serve Latino/a populations in the greater Chicago area. To this day, the conference strives to increase the cultural competence, capacity for effective service delivery, and awareness of services barriers for all conference attendees. For the past years, the conference has been held as a daylong event and as reached up to 220 attendees. Each year, the conference

committee works diligently to assess the needs of not only the professionals who attend but also the topics impacting the Latino/a community.

Through the dedication and hard-work of the committee, the conference has been able to expand its targeted audiences, location, and activities throughout the day. As a conference attendee, it is our hope that you enjoy the additional amenities we have been able to provide this year and that you continue to join us biennially as we continue to grow as a conference.



**Talleres gratis para los niños y adultos
entre Mayo y Septiembre de cada año**

SEMBRANDO BAJO EL SOL
2612 S Trumbull, lunes y miércoles, 4 a 7 pm

LA CALABAZA
4172 W 25 St, martes y jueves, 4 a 7 pm

Beneficios de jardines comunitarios:

- Disminuye tu estrés y depresión, conoce a otras personas en tu comunidad, despeja tu mente y enfócate en ti mismo.
- Aprende acerca de animales, plantas y la naturaleza.
- La jardinería también provee beneficios de terapia ocupacional.
- Fomentamos la participación familiar.

Registraciones disponibles.

**Preguntas: Llame a María Herrera, Public Health Coordinator,
al 773-823-1062.**





logrando cambios juntos:

**EL BIENESTAR EMOCIONAL
EN MI COMUNIDAD**

Participe en ayudar y abogar para mas recursos para el bienestar emocional de todos en La Villita. Ven a compartir tus experiencias y escuchar sobre el trabajo de Raíces al Bienestar.

**10 AM - 12 PM | 22 DE NOVIEMBRE DEL 2016
ST. AGNES (2651 CENTRAL PARK AVENUE)**

Para más información comuníquese con: Sara Briseño, sbrisen@enlacechicago.org // 312-870-0235
www.rootstowellness.org



Raíces al Bienestar es
una colaborativa
convocada por Enlace
Chicago.



Little Village Youth: Beyond Statistics

Come and hear how community youth leaders develop a project to define their own identities in a world that tells them who they are meant to be.

Date: May 5, 2018

Time: 12:00 pm – 3:00 pm

Location: 2329 S. Troy Chicago IL 60623

Food and Drinks will be provided during the event!

RSVP by April 28th, 2018 to

Jacqueline Munoz - jmunoz@enlacechicago.org or (773) 629-0830

ESPERANZA
Little Village

Be Me, Be Healthy

3059 W. 26th St.
Chicago, IL 60623

An educational support group for adolescent girls ages 13 to 18 to discuss life experiences, healthy relationships and sexuality.

Un grupo de apoyo educacional para muchachas adolescentes entre las edades de 13 a 18 años que habla sobre temas como relaciones saludables, la sexualidad y las experiencias durante de esta etapa.

The eight week session starts March 6th / La sesión de ocho semanas empieza el 6 de marzo

Meetings are every Tuesday from 4:30 pm to 6 pm / Reuniones son cada martes de 4:30 pm a 6 pm

Location/ Lugar: Esperanza Little Village, 3059 W. 26th St.

Call Felipa for more info/ Llame a Felipa para más información: 773-916-4430



WOMEN'S SUPPORT GROUP

DATE: DECEMBER 2017-JUNE 2018
(TWICE A MONTH)

TIME: (TO BE DETERMINED)

LOCATION: (TO BE DETERMINED)

Benefits Include:

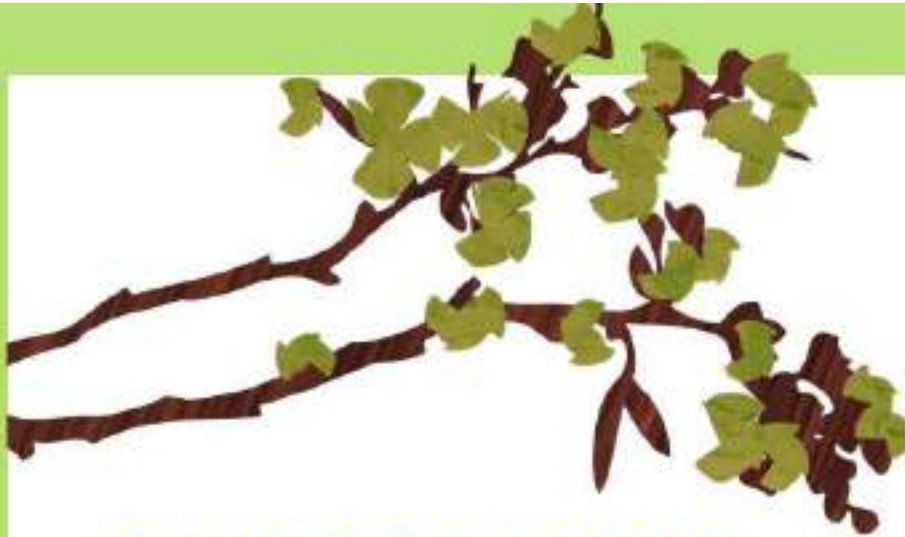
- Building New Friendships
- Receiving Social and Emotional Support
- Increasing Self-Esteem and Self-Empowerment
- Relieving Stress

FOR MORE INFORMATION CONTACT:

ENLACE'S HEALTH PROMOTERS

PHONE: 773-669-5490

EMAIL: PROMOTORXS@ENLACECHICAGO.ORG



GRUPO DE APOYO PARA MUJERES

FECHA: DICIEMBRE 2017-JUNIO 2018
(DOS VECES AL MES)

HORA: (PARA SER DETERMINADO)

UBICACIÓN: (PARA SER DETERMINADO)

Los Beneficios Incluyen:

- Construir Nuevas Amistades
- Recibir Apoyo Social y Emocional
- Aumentar La Autoestima y El Autoempoderamiento
- Aliviar El Estrés

PARA MÁS INFORMACIÓN CONTACTE:

PROMOTORAS DE ENLACE

TELÉFONO: 773-669-5490

CORREO ELECTRÓNICO: PROMOTORAS@ENLACECHICAGO.ORG

Appendix D: Curricula

Mental Health Training

This mental health training is provided by Roots to Wellness. This mental health training is 6 sessions long, 2 hours each session.

Session 1

Participants will be introduced to the work that Roots to Wellness does and have a discussion on what mental health is, as well as the barriers that residents have in regards to accessing mental health. Participants will also learn the crucial role that they play in mental health promotion and receive tips on how to "listen responsibly."

Session 2

Participants will learn about the 3 models of mental health. Participants will look at a case study and learn how these models can apply differently to mental health depending on the situation and context. Participants will also learn about the stages of change model and why it is crucial to understanding the work they do in the community.

Session 3

Participants will hear presentations from Roots to Wellness members on issues such as: domestic violence and sexual assault; depression, anxiety and stress; community violence issues pertaining youth; and severe and persistent mental illnesses.

Session 4

Participants will learn about the Roots to Wellness referral process and get acquainted with the referral forms and the service directory map.

Session 5

Participants will learn about what follow ups look like after a referral has been made. They will also learn about personal boundaries that they have to consider and also ethical considerations they should take. Participants will also learn about what to do in case a crisis situation occurs and what critical assessment looks like in that case.

Session 6

Participants will hear a presentation on self-care and how to avoid secondary trauma, compassion fatigue, and burn out. Participants will also receive their diplomas in this session due to completion of training.



For more information, contact info@rootstowellness.org.



Entrenamiento de Salud Mental

El entrenamiento de salud mental, es un entrenamiento dado por Raíces al Bienestar de 6 sesiones, 2 horas cada sesión.

Sesión 1

Los participantes serán introducidos al trabajo que Raíces al Bienestar hace y tendrán una discusión sobre lo que es la salud mental, así como las barreras que tienen los habitantes al acceso a la salud mental. Los participantes también aprenderán el papel fundamental que desempeñan en la promoción de la salud mental y recibirán consejos sobre cómo "escuchar responsable"

Sesión 2

Los participantes aprenderán sobre los 3 modelos de salud mental. Los participantes verán un estudio de casos y aprender cómo estos modelos pueden aplicarse de manera diferente dependiendo de la situación y el contexto en el caso. Los participantes también aprenderán acerca de el modelo llamado "etapas de cambio."

Sesión 3

Los participantes escucharán presentaciones de Raíces al Bienestar sobre temas tales como la violencia doméstica y asalto sexual; la depresión, la ansiedad y el estrés; violencia en la comunidad; temas relacionados con los jóvenes; y enfermedades mentales graves y persistentes.

Sesión 4

Los participantes aprenderán sobre el proceso que Raíces al Bienestar tiene para referir a gente y también podrán familiarizarse con los formularios y el directorio de servicios.

Sesión 5

Los participantes aprenderán acerca del proceso de seguimiento después que se ha hecho una referencia. También aprenderán acerca de los límites personales que tienen que considerar y también las consideraciones éticas que deben tomar. Los participantes también aprenderán acerca de qué hacer en caso de que se produzca una situación de crisis.

Sesión 6

Los participantes escucharán una presentación sobre el autocuidado y la forma de evitar el trauma secundario, fatiga de la compasión, y el desgaste. Los participantes también recibirán sus diplomas en esta sesión debido a la finalización de el entrenamiento.



Para obtener más información, contacte a info@rootstowellness.org.



Women's support group (*Mujeres progresando, mujeres avanzandose, mujeres mejorandose*)

Open group, 8 weeks

Dates: April 4 - May 23

1-1/2 hours per week (I will need 2 hours freed up in my schedule)

Wed. 1:30 -3:00 pm. (Elvira: 1:15 -3:15) *time is flexible, between 10 & 3, depending on availability of conference room*

Participants: 8-10 women, 21+, who have immigrated to U.S.

Language: Spanish

Temas:

1- Bienvenida:

Conociendonos

Que es el grupo de autoayuda?

Objetivos, normas y principios

2-Los costos emocionales de la migracion y la aculturacion

3- Manejo de las emociones

4- El autoestima

5- El empoderamiento

6- La comunicacion familiar

7- La resolucion de los conflictos

8- Resumen de los conceptos y temas

Supplies: nametags, pens, pencils, paper, markers, file folders, balloons,
White board & markers, eraser – or – flip chart

Bibliography

- 1) "A Closer Look at Mental Health Reform Legislation." NAMI: National Alliance on Mental Illness. Accessed November 17, 2017. <https://www.nami.org/Learn-More/Mental-Health-Public-Policy/Mental-Health-Reform/A-Closer-Look-at-Mental-Health-Reform-Legislation>
- 2) Abdouch, I. (2016). Patient-centered medical home. In *Family Medicine: Principles and Practice* (pp. 1793-1804). Springer International Publishing. DOI: 10.1007/978-3-319-04414-9_49
- 3) Agate S. Unlocking the Power of Telehealth: Increasing Access and Services in Underserved, Urban Areas. *Harvard Journal of Hispanic Policy; Cambridge*. 2017;29:85-96.
- 4) Any Mental Illness (AMI) Among Adults. (n.d.). Retrieved October 23, 2015, from <http://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-adults.shtml>
- 5) Baig, Arshiya A., Amanda Benitez, Cara A. Locklin, Amanda Campbell, Cynthia T. Schaefer, Loretta J. Heuer, Sang Mee Lee, Marla C. Solomon, Michael T. Quinn, Deborah L. Burnet, and Marshall H. Chin. "Community Health Center Provider and Staff's Spanish Language Ability and Cultural Awareness." *Journal of Health Care for the Poor and Underserved* 25, no. 2 (2014): 527-45. doi:10.1353/hpu.2014.0086
- 6) Bashshur, Rashid L., Gary W. Shannon, Noura Bashshur, and Peter M. Yellowlees. "The Empirical Evidence for Telemedicine Interventions in Mental Disorders." *Telemedicine and e-Health* 22, no. 2 (February 2016). doi:10.1089/tmj.2015.0206.

- 7) Bhat, Nisha. "Lifting Barriers to Telehealth." February 19, 2016. <https://nchc.org/lifting-barriers-to-telehealth/>.
- 8) Carter EL, Nunlee-Bland G, Callender C. A Patient-Centric, Provider-Assisted Diabetes Telehealth Self-management Intervention for Urban Minorities. *Perspect Health Inf Manag.* 2011;8(Winter). <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3035826/>. Accessed October 15, 2017.
- 9) Chen, Emily. "The Integration of Mental Health into Primary Care." *Harvard College Global Health Review*, Harvard University, 20 Apr. 2013, www.hcs.harvard.edu/hghr/online/the-integration-of-mental-health-into-primary-care/.
- 10) Cherrington, Andrea, Guadalupe X. Ayala, John P. Elder, Elva M. Arredondo, Mona Fouad, and Isabel Scarinci. "Recognizing the Diverse Roles of Community Health Workers in the Elimination of Health Disparities: From Paid Staff to Volunteers." *Ethnicity & Disease* 20, no. 2 (2010): 189–94.
- 11) Chicago Health Atlas 2017
- 12) Chong, Jenny, and Francisco Moreno. "Feasibility and Acceptability of Clinic-Based Telepsychiatry for Low-Income Hispanic Primary Care Patients." *Telemedicine and e-Health* 18, no. 4 (2012): 297-304. doi:10.1089/tmj.2011.0126.
- 13) *Community Snapshot: South Lawndale*. Report. Rush University Medical Center. Chicago, IL: Rush University, 2016. 1-6.
- 14) Dunlap, Jonathan L., Joshua D. Jaramillo, Raji Koppolu, Robert Wright, Fernando Mendoza, and Matias Bruzoni. "The effects of language concordant care on patient satisfaction and clinical understanding for Hispanic pediatric surgery patients." *Journal of*

Pediatric Surgery 50, no. 9 (September 2015): 1586-589.

doi:10.1016/j.jpedsurg.2014.12.020.

- 15) Encyclopedia of Chicago: Magallon, Frank S. Images of America: Chicago's Little Village: Lawndale-Crawford. Arcadia Publishing, Chicago IL: 2010.
- 16) Fernandez, Alicia, Dean Schillinger, E. Margaret Warton, Nancy Adler, Howard H. Moffet, Yael Schenker, M. Victoria Salgado, Ameena Ahmed, and Andrew J. Karter. "Language Barriers, Physician-Patient Language Concordance, and Glycemic Control Among Insured Latinos with Diabetes: The Diabetes Study of Northern California (DISTANCE)." *Journal of General Internal Medicine* 26, no. 2 (February 29, 2010): 170-76. doi:10.1007/s11606-010-1507-6.
- 17) Grajales III FJ, Sheps S, Ho K, Novak-Lauscher H, Eysenbach G. Social Media: A Review and Tutorial of Applications in Medicine and Health Care. *J Med Internet Res.* 2014;16(2). doi:10.2196/jmir.2912.
- 18) Greene, Tristan. "Medical Industry Embraces New .health Domain Extension." The Next Web. Last Modified July 20, 2017. <https://thenextweb.com/insider/2017/07/20/medical-websites-can-repeal-and-replace-com-with-health>
- 19) Grubaugh, Anouk L., Gregory D. Cain, Jon D. Elhai, Sarah L. Patrick, and B. Christopher Frueh. "Attitudes Toward Medical and Mental Health Care Delivered Via Telehealth Applications Among Rural and Urban Primary Care Patients." *The Journal of Nervous and Mental Disease* 196, no. 2 (February 2008): 166-70.
doi:10.1097/nmd.0b013e318162aa2d.

- 20) Hawkins, Dan, and Dashawn Groves. "The Future Role of Community Health Centers in a Changing Health Care Landscape." *Journal of Ambulatory Care Management* 34, no. 1 (2011): 90-99. doi:10.1097/jac.0b013e3182047e87.
- 21) "Healthy Chicago 2.0." City of Chicago . Accessed November 21, 2017.
<https://www.cityofchicago.org/city/en/depts/cdph/provdrs/healthychicago.html>.
- 22) Hirschtick JL, Benjamins MR, Homan S. Community Health Counts: Sinai Community Health Survey 2.0. Sinai Urban Health Institute, Sinai Health System. Chicago, IL. March 2017.
- 23) HR.4435 — 114th Congress: Comprehensive Behavioral Health Reform and Recovery Act of 2016. <https://www.congress.gov/bill/114th-congress/house-bill/4435>
- 24) Illinois' Undocumented Immigrant Population: A Summary of Recent Research by Rob Paral and Associates; By Fred Tsao, Illinois Coalition for Immigrant and Refugee Rights, February 2014
- 25) *Integrating Mental Health Into Primary Care: A Global Perspective*. Report. World Health Organization and World Organization of Family Doctors. Geneva, Switzerland: WHO Press, 2008. 1-206.
- 26) Japsen, Bruce. "Coverage For Mental Health Via Telemedicine Soars At U.S. Employers." *Pharma and Healthcare*. August 10, 2017. Accessed November 24, 2017.
<https://www.forbes.com/sites/brucejapsen/2017/08/10/coverage-for-mental-health-via-telemedicine-soars-at-u-s-employers/2/#7bc7f9808fc8>.
- 27) Kosowsky, Jeffrey J., and RJ Krawiec. *Empowering Patients with Telehealth*. Report. Deloitte Consulting, LLC. 2016. 1-16.

- 28) Marcin, James, Taylor Kaufman, Jamie Kisse, Jesse King, and Madan Dharman. "Telemedicine Saves Patients Time, Money." Newsroom. March 21, 2017. Accessed November 19, 2017. <https://www.ucdmc.ucdavis.edu/publish/news/newsroom/11887>.
- 29) Marcoux, Rita M., and F. Randy Vogenberg. 2016. "Telehealth: Applications From a Legal and Regulatory Perspective." *Pharmacy and Therapeutics* 41 (9):567–70.
- 30) Natale-Pereira, Ana, Kimberly R. Enard, Lucinda Nevarez, and Lovell A. Jones. "The Role of Patient Navigators in Eliminating Health Disparities." *Cancer* 117, no. S15 (2011): 3541-550. doi:10.1002/cncr.26264.
- 31) O'Donnell, Jane, and Holly Fletcher. "Congress Must Act by This Weekend or Millions Could Lose Help from Community Health Centers." *USA Today*, September 28, 2017. <https://www.usatoday.com/story/news/politics/2017/09/28/congress-must-act-weekend-9-millimmunity-health-center-funding-runs-out-weekend-if-congress-fails-ac/710310001/>.
- 32) Pérez-Escamilla R. Health care access among Latinos: implications for social and health reforms. *J Hisp High Educ* 2010;9:43–60.
- 33) Petterson, Stephen M., Winston R. Liaw, Robert L. Phillips, David L. Rabin, David S. Meyers, and Andrew W. Bazemore. 2012. "Projecting US Primary Care Physician Workforce Needs: 2010-2025." *The Annals of Family Medicine* 10 (6):503–9. <https://doi.org/10.1370/afm.1431>.
- 34) Richards, Michael R., Brendan Saloner, Genevieve M. Kenney, Karin V. Rhodes, and Daniel Polsky. "Availability of New Medicaid Patient Appointments and the Role of Rural Health Clinics." *Health Services Research* 51, no. 2 (June 26, 2015): 570-91. doi:10.1111/1475-6773.12334.

- 35) *Roots to Wellness: Mental Health Needs Assessment* (pp. 1-39, Rep.). (2014). Chicago, IL: Enlace Chicago.
- 36) *Roots to Wellness: Assessing the Mental Health Needs of the Latinx Community on Chicago's Southwest Side* (pp. 1-47, Rep.). (2017). Chicago, IL: Enlace Chicago.
- 37) Sánchez, Gloria, Theresa Nevarez, Werner Schink, and David E. Hayes-Bautista. "Latino Physicians in the United States, 1980–2010." *Academic Medicine* 90, no. 7 (July 2015): 906-12. doi:10.1097/acm.0000000000000619.
- 38) Stahl, Gus. "Health Impacts of Living in a City." *Global Citizen*. October 31, 2015. Accessed December 05, 2017. <https://www.globalcitizen.org/en/content/health-impacts-of-living-in-a-city/>.
- 39) Statistical Atlas Chicago 2015
- 40) Substance Abuse and Mental Health Services Administration, *Racial/Ethnic Differences in Mental Health Service Use among Adults*. HHS Publication No. SMA-15-4906. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015. Retrieved July 2017, from <https://www.samhsa.gov/data/sites/default/files/MHServicesUseAmongAdults/MHServices>
- 41) Substance Abuse and Mental Health Services Administration, *Results from the 2014 National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series H-50, HHS Publication No. (SMA) 15-4927. Rockville, MD: Substance Abuse and Mental Health Services Administration. (2015). Retrieved October 27, 2015 from <http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf>

- 42) S. 2680 — 114th Congress: Mental Health Reform Act of 2016.” www.GovTrack.us. 2016. November 17, 2017 <<https://www.govtrack.us/congress/bills/114/s2680>
- 43) Van De Belt TH, Engelen LJ, Berben SA, Schoonhoven L. Definition of Health 2.0 and Medicine 2.0: A Systematic Review. *J Med Internet Res*. 2010;12(2). doi:10.2196/jmir.1350.
- 44) Varshney U. Mobile health: Four emerging themes of research. *Decision Support Systems*. 2014;66(Supplement C):20-35. doi:10.1016/j.dss.2014.06.001.
- 45) Villatoro, Alice P., Eduardo S. Morales, and Vickie M. Mays. 2014. “Family Culture in Mental Health Help-Seeking and Utilization in a Nationally Representative Sample of Latinos in the United States: The NLAAS.” *The American Journal of Orthopsychiatry* 84 (4):353–63. <https://doi.org/10.1037/h0099844>.
- 46) Waugh, Maryann, Debbie Voyles, and Marshall R. Thomas. 2015. “Telepsychiatry: Benefits and Costs in a Changing Health-Care Environment.” *International Review of Psychiatry* 27 (6):558–68. <https://doi.org/10.3109/09540261.2015.1091291>.
- 47) Walsh, Tracy, and Cara Goerlich. "A Surprising Trend in Telehealth: It's Growing-But Not Where You Might Expect." The Growth Channel. March 30, 2017. Accessed November 17, 2017. <https://www.advisory.com/research/market-innovation-center/the-growth-channel/2017/03/growth-trends-telehealth>
- 48) Weinstein RS, Lopez AM, Joseph BA, et al. Telemedicine, Telehealth, and Mobile Health Applications That Work: Opportunities and Barriers. *The American Journal of Medicine*. 2014;127(3):183-187. doi:10.1016/j.amjmed.2013.09.032.

49) Wicklund, Erick. "GAO Report: Telehealth Troubles Tied to Reimbursement Barriers."

MHealthIntelligence. April 17, 2017. <https://mhealthintelligence.com/news/gao-report-telehealth-troubles-tied-to-reimbursement-barriers>.

50) Yamamoto, Dale H. *Assessment of the Feasibility and Cost of Replacing In-Person Care with Acute Care Telehealth Services*. Report. Red Quill Consulting, Inc. 2014.

51) Yellowlees, Peter M., Alberto Odor, Ana-Maria Iosif, Michelle Burke Parish, Najia Nafiz, Kesha Patrice, Glen Xiong, Robert Mccaron, Richard Sanchez, Enrique Ochoa, and Donald Hilty. "Transcultural Psychiatry Made Simple—Asynchronous Telepsychiatry as an Approach to Providing Culturally Relevant Care." *Telemedicine and e-Health* 19, no. 4 (April 2013): 259-64. doi:10.1089/tmj.2012.0077.

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EDUCATION

The University of Chicago

Chicago, IL

BA in Public Policy Studies, BA in Psychology, June 2018

Overall GPA: 3.652 Studied abroad in Rome, Italy

Awards: Dean's List ('14-15, '15-16, '16-17), Barbara Dougan Scholarship, ('16-17), Health Policy Scholar ('14-18), Senior Class Gift Committee ('18)

Relevant Coursework: Economics for Public Policy, Policy Analysis, Policy Implementation, Psychology for Policy Designers, Quantitative Methods for Public Policy, Urban Health, Health and Human Rights, Media and Psychology, The Social Psychology of Behavior in Organizations

RELEVANT EXPERIENCE

Center for Translational and Policy Research of Chronic Diseases

(June '16-Present)

Section of General Internal Medicine, University of Chicago Medicine

Research Assistant

- Construct asthma registry of 500+ children with asthma, adhering to appropriate protocol
- Develop and implement an integrated, comprehensive, and sustainable asthma school program drawing on existing literature and data
- Develop and implement research, education, and communication tools
- Analyze primary and secondary quantitative and qualitative data to arrive at policy recommendations
- Co-author clinical and evidence-based policy papers and presentations for publication
- Shadow primary-care physicians during clinic

GlobeMed, University of Chicago

(October '17-Present)

Local Partnerships Committee

- Help strengthen and scale local grassroots organizations through capacity-building to help grow their influence
- Generate grant proposals for developing projects
- Participate in global health case competitions

Right to Health and Social Struggles for Health in Colombia

(June '17-Aug '17)

Management and Policy Group, Universidad de Antioquia

Intern

- Explored Colombia's healthcare reform known as Law 100
- Provided assistance for Medellin's public health initiatives using needs-assessment
- Supported medical professionals on home care visits and health fairs around the city's communes, mainly directed at disabled community and their caregivers

Chicago Policy Research Team, University of Chicago

(January '17-Jun '17)

Student Consultant

- Collaborated with various stakeholders to analyze housing market in Chicago
- Conducted and transcribed 4 focus group interviews with voucher holders from community
- Utilized MS Excel to estimate optimal voucher subsidy required to ensure affordability of accessible housing units in opportunity areas and presented to Chicago Fair Housing Alliance
- Generated evidence-based report on six different areas of study that aimed to increase awareness, enforcement, and education surrounding the Housing Choice Voucher program

ACTIVITIES

- Pi Beta Phi ('14-Present)
- Organization of Latin American Students, *Co-President* ('16-17) *Social Chair* ('15-18)
- Colombians at UChicago, *Social Chair* ('17-18)
- Questbridge Scholars Network, *Secretary* ('14-16)

SKILLS

- **Computer Skills:** SPSS, STATA, NVivo, REDCap, Epic Systems, MS Outlook, MS Excel, MS Word, MS PowerPoint, MS Publisher, Adobe InDesign, GoAnimate Videos
- **Language Skills:** Fluent Spanish, Intermediate Italian
- **Interests:** Health Policy, Public Health, Health Equity, Health Consulting, Health Admin