Breaking New Ground:

Building an effective chronic disease management program within a CMHC setting

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Faculty Disclosures

The presenters of this session have NOT had any relevant financial relationships during the past 12 months.

Learning Objectives

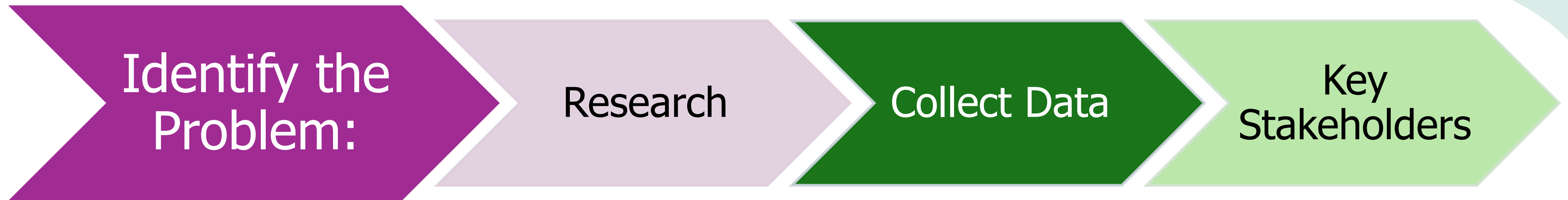
Recognize and appreciate the reasons for premature mortality of the SMI population

Identify at least three beneficial outcomes for clients when chronic disease management is addressed in the implementation of an integrated care program in a CMHC

Examine how transparency and demonstrating passion with your workforce can increase provider retention and improve client outcomes

Program Development

Step 1: Prepare

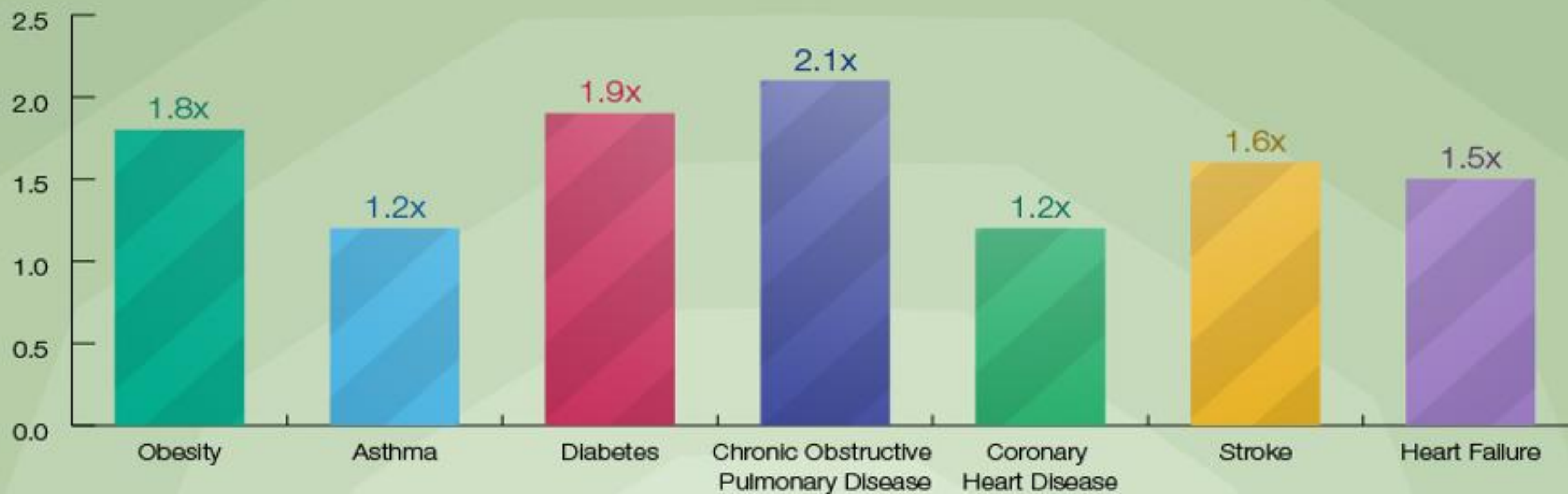


The Problem

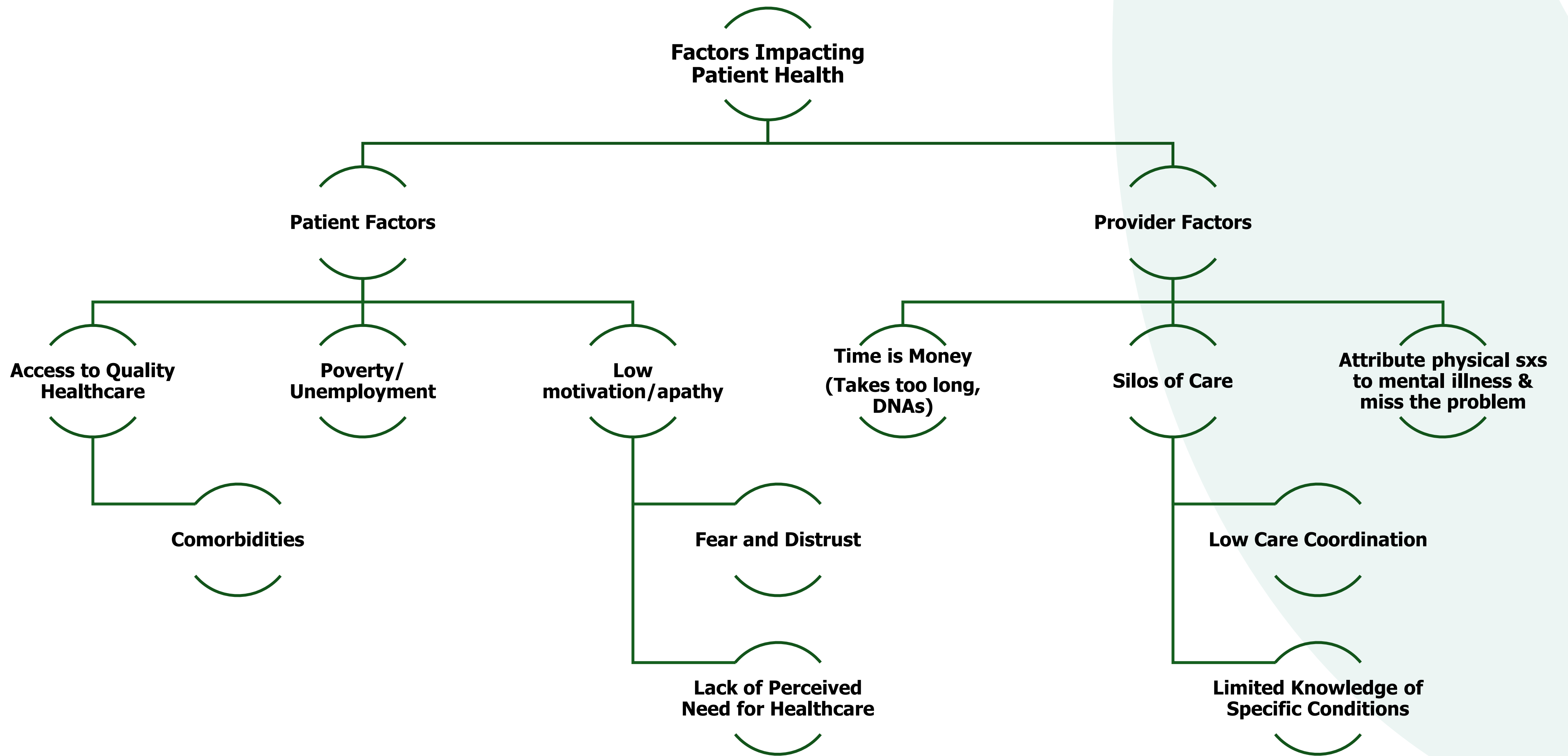
Individuals with SMI die up to 25 years earlier than the general population.

2 out of 3 deaths are from *preventable* chronic health conditions.

In the last 30 years, this gap has *WORSENED,* especially in rural communities (20% higher than urban areas).



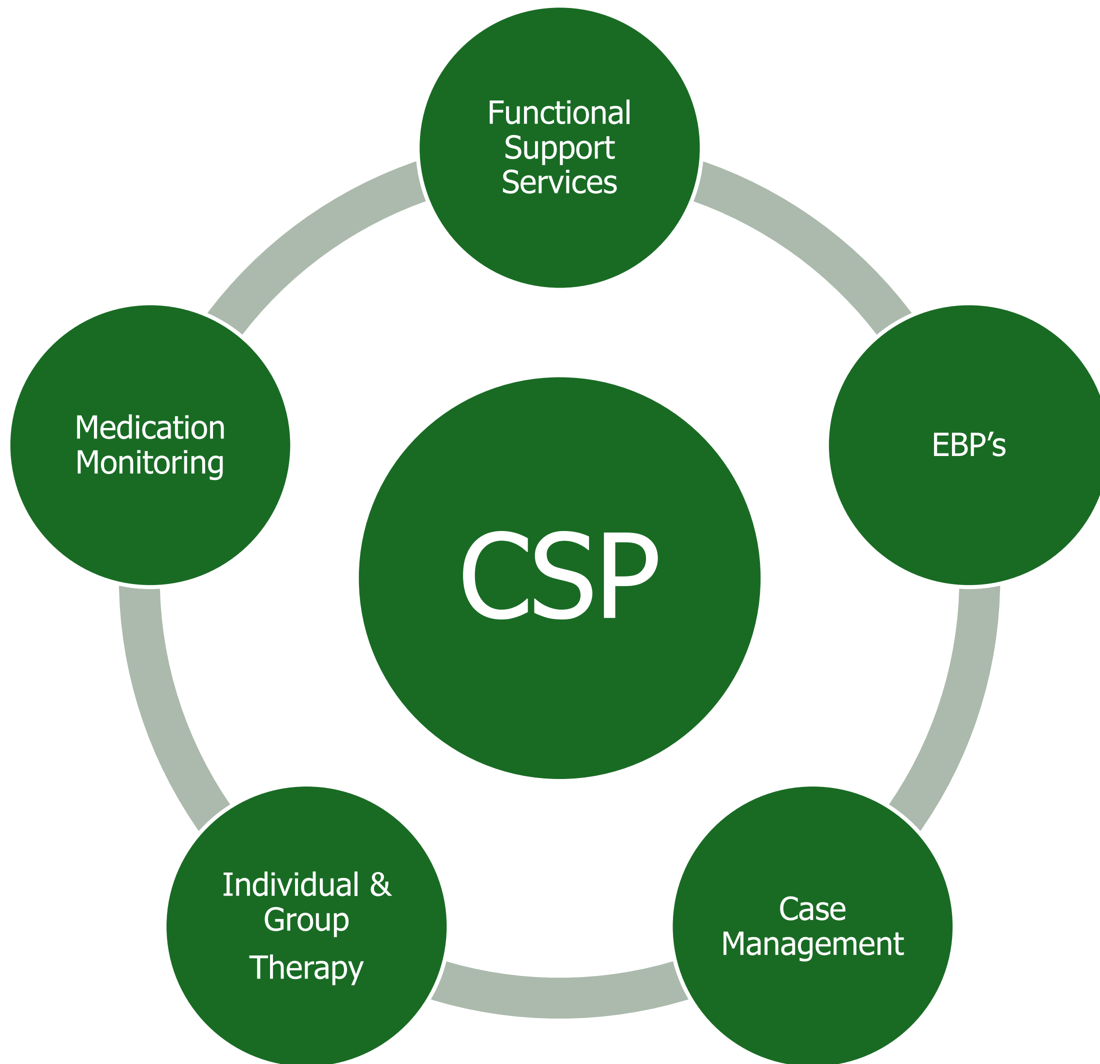
Public Health England, 2018


Factors Impacting Patient Health
Patient Factors
Provider Factors
Access to Quality Healthcare
Poverty/ Unemployment
Low motivation/apathy
Time is Money (Takes too long, DNAs)
Silos of Care
Attribute physical sxs to mental illness & miss the problem
Comorbidities
Fear and Distrust
Lack of Perceived Need for Healthcare
Low Care Coordination
Limited Knowledge of Specific Conditions

Clients
Public MH Authorities
Family Members
Stakeholder Groups
MH Providers
MH Leadership
Community Partners

Program Development

Step 2: Assess ~ Current Programming



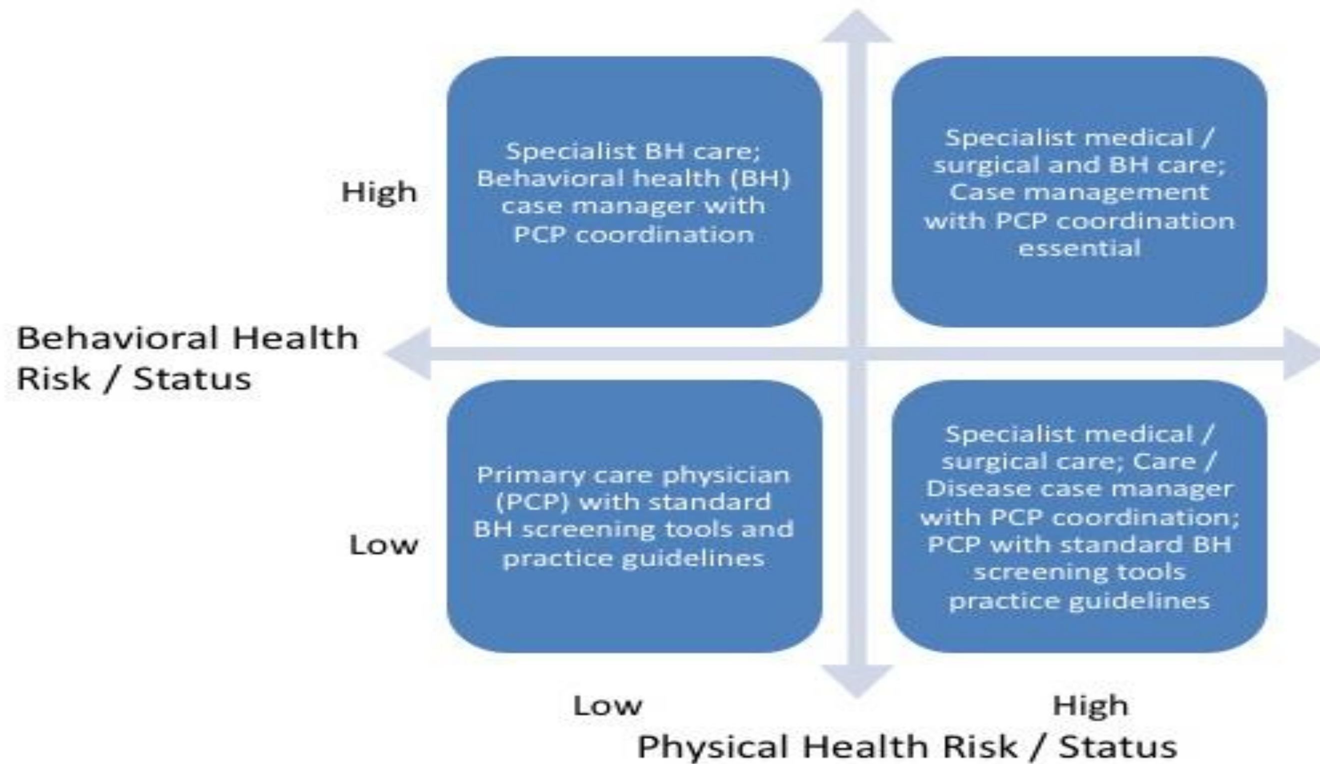
Community Support Program at CMHC

Step 2: Assess ~ Missing Pieces

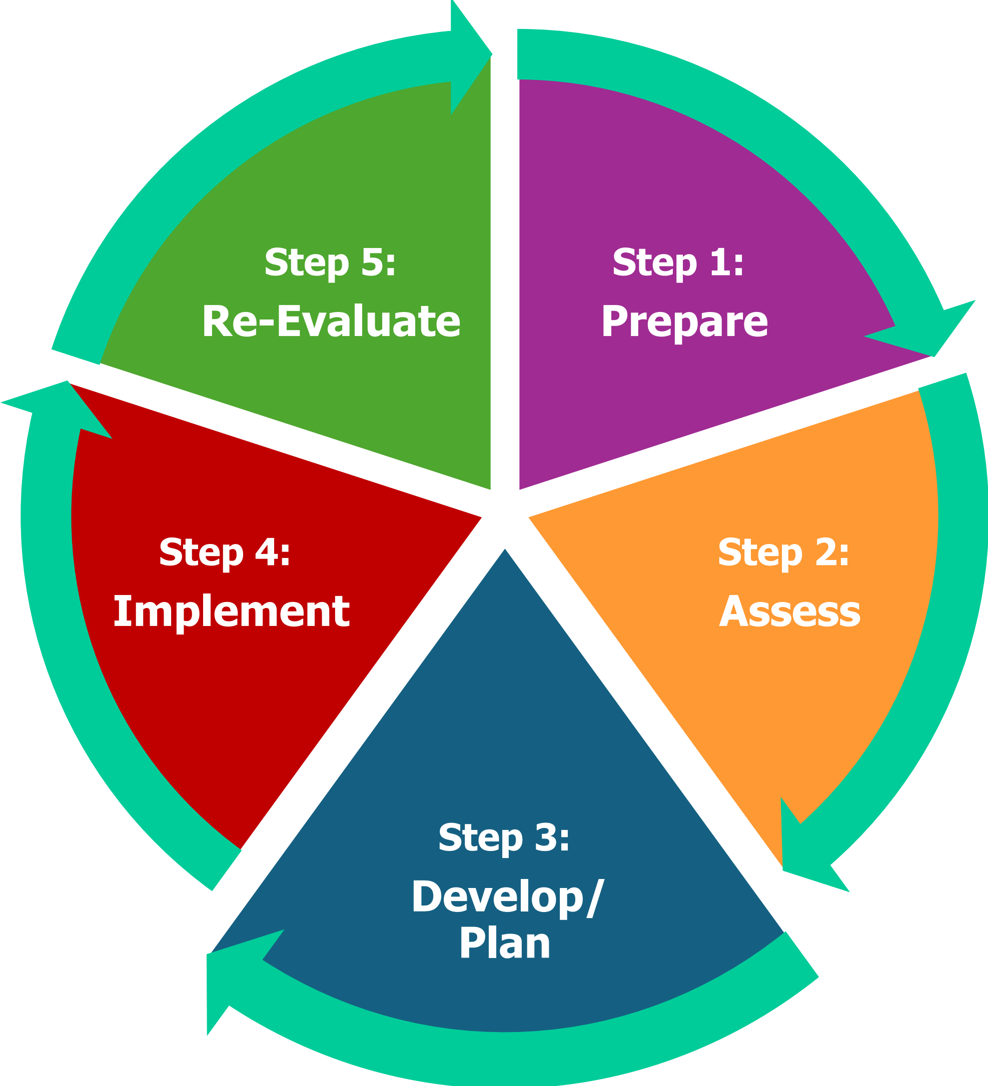
At Center for Life Management:

- On-site Primary Care
- Enhanced Wellness Coaching
- Chronic Disease Self-Management support

Step 2: Assess
~ Where do we go from here?



Program Development- Develop/Plan



Step 3: Develop & Plan

Preventative Services

- ✓Primary Care Partnership
- ✓Enhanced Wellness Coaching

Step 3: Develop & Plan

HEALTHY TOGETHER

- ✓ Partner with a FQHC
  - ✓ "Reverse Integration" with Lamprey Health Care
- ✓ One-stop for whole person care
  - ✓ Quality primary care in the same setting as their mental health care
- ✓ Provide high quality, accessible primary care to **ANY** CLM client over the age of 12 years old
- ✓ Focus on prevention and chronic care management
- ✓ Increased care collaboration
  - ✓ Weekly huddles
- ✓ Identify other gaps in care

Step 3: Develop & Plan

NEW You:

Nutrition, Education, & Wellness

- ✓ Wellness Coaches support clients with making important lifestyle changes to:
  - ✓ Reduce the risk of obesity, diabetes, and cardiovascular diseases;
  - ✓ Improve mental health symptoms, QOL, and longevity;
- ✓ Clients work with their Wellness Coach to create health and wellness goals with the desire to improve their overall quality of life;
- ✓ Provided by staff specialty trained in areas of:
  - ✓ nutrition, exercise physiology, kinesiology, physical therapy, yoga, occupational therapy, and more…

Step 3: Develop & Plan

Chronic Disease Management

QUADRANT IV

INTEGRATED CARE

Patient Parameters

High behavioral health needs; Active client of CMHC

High physical health needs; Active patient with a PCP

Chronic health conditions impacting functioning/mental health

Affiliated with an outside care agency, such as CFI/Hospice/Dialysis/Palliative Care

Service Menu (includes all of CSP)

Integrated Care Case Management

Healthy Together

NEW You Services

Behavioral Health Visiting Nurse

Functional Support Services, including FSS for Medical & MTS

Illness Management & Recovery

Possible Supported Employment

EBP Chronic Disease/Pain/Diabetes/Arthritis Groups

Medication Monitoring and Prescribing

Individual & Group Therapy

Program Development- Implement

Step 4: Implement

Integrated Care

Prevention

Chronic Disease Management

Implementation of Integrated Care at CLM

Integrated Care

Prevention

Healthy Together: Primary Care

NEW You: Wellness Coaching

Chronic Disease Management

CSP +

(Wrap-Around Care)

BH Visiting Nurse

Transitions Coordination

Chronic Disease Self-Management Groups

CSP +
(Wrap-Around Integrated Care)

All CSP Services, plus specialized chronic disease management services:

- ✓ Behavioral Health Visiting Nursing
- ✓ Transitions Coordination
- ✓ Chronic Disease Self-Management Groups

COMMUNITY Mental Health:
ALL services available in their home environment.

Behavioral Health Visiting Nursing (BHVN)

- FSS provided by a qualified nurse to improve the whole health of clients by addressing any mental health barriers that impact the client's ability to care for their physical health.
- This service includes tasks such as:
  - taking vitals regularly and communicating results with medical providers;
  - completion of nursing assessment to guide overall care;
  - medication training and support (MTS);
  - psychoeducation on chronic disease self-management;
  - internal and external care coordination with medical providers.

Transitions Coordination

Transitions Coordinator collaborates and communicates with in-patient medical facilities from admission to discharge with goals of:

1. Keeping the mental health team informed throughout hospital stay;
2. Documentation of care coordination during hospital stay;
3. Discharge planning, including:
   - Scheduling next appointments with their IC providers;
   - Primary care follow-up visit with Healthy Together;
   - Obtaining discharge summary and scanning into EMR

Chronic Disease Self-Management Groups

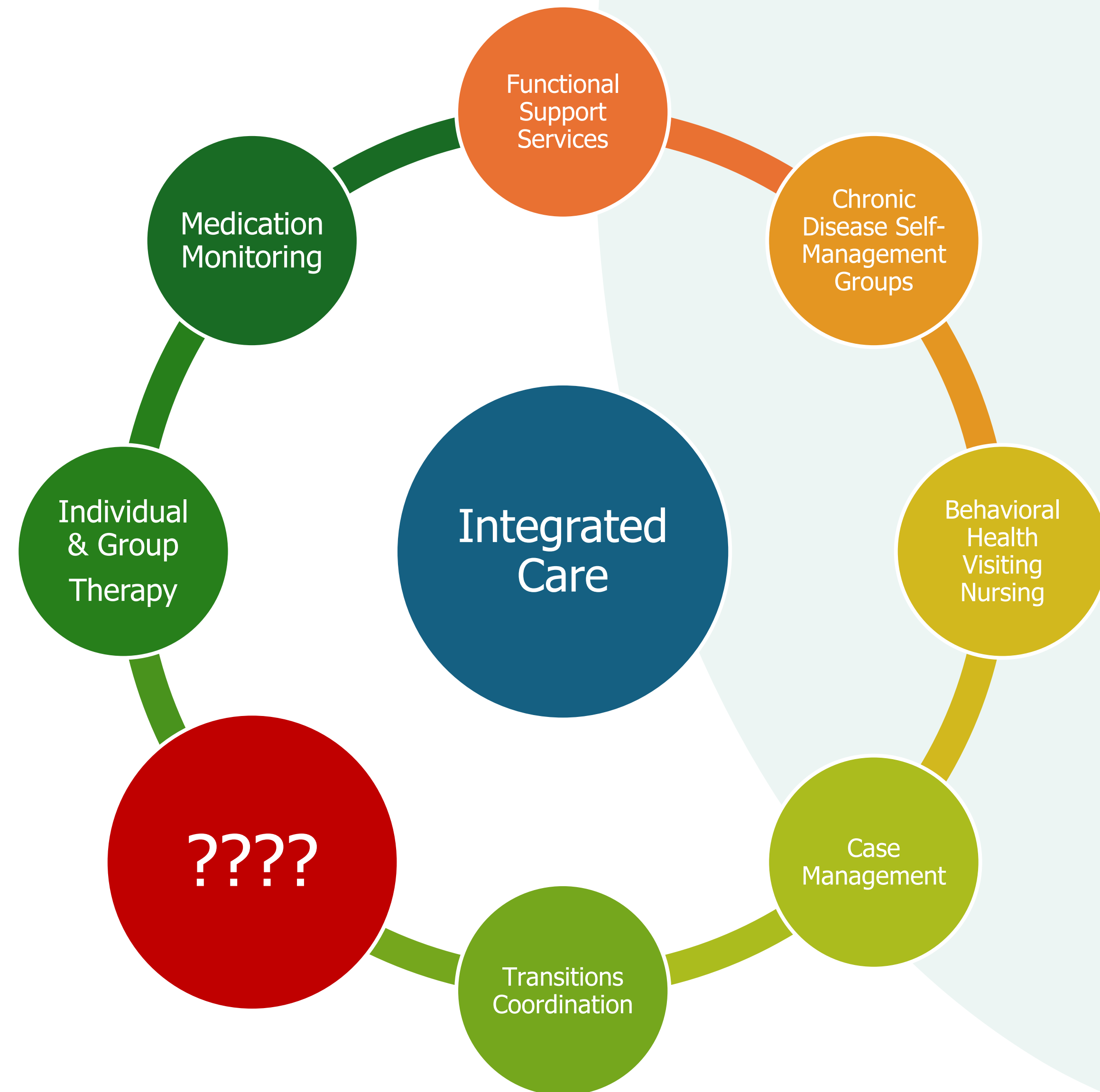
Evidence-Based Groups:

- Self-Management Resource Center Programs:
  - Chronic Disease Self-Management Program (CDSMP)
  - Chronic Pain Self-Management Program (CPSMP)
  - Diabetes Self-Management Program (DSMP)
- Arthritis Foundation Programs:
  - Walk with Ease
  - Tai Ji Quan: Moving for Better Balance

Program Development

Step 5: Re-evaluate (OFTEN)

Integrated Care Program at CLM



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Denise’s Journey

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Questions?