Building on the Foundation:
Moving from Case Management to Care Management

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About Us

The **National Council for Behavioral Health** is the unifying voice of America's mental health and addictions treatment organizations. Together with over 3100 member organizations, serving 10 million adults, children and families living with mental illnesses and addictions, the National Council is committed to all Americans having access to comprehensive, high-quality care that affords every opportunity for recovery.

The National Council was instrumental in bringing Mental Health First Aid to the USA and more than 500,000 individuals have been trained. In 2014, the National Council merged with the State Associations of Addiction Services (SAAS). To learn more about the National Council, visit www.TheNationalCouncil.org.

Learning Objectives:

- Identify national health care trends that will affect your role
- List key components of care management
- Identify the differences and bridges between Physical Health and Behavioral Health cultures and strategies to address those differences.
- Develop strategies to help prepare people for Primary Care Practice appointments to increase self management and self advocacy.
- Understand basic chronic care principles and their application in diabetes and heart disease
- Identify and begin to apply strategies to help people change health behavior
- Develop an individual and team action plan to apply things learned in this training

Introductions

- What's gives you satisfaction/joy in your work?
- What is your greatest challenge?
- What question would you like answered today?

What is happening in health care?

- Push for improved outcomes: but how do we get there?
- New roles, changed roles, expanded roles
- New models, new payment systems

The U.S. has a *SICK CARE* System NOT a *HEALTH CARE* System

- **45%** of Americans have one or more chronic conditions
- Over half of these people receive their care from ***3 or more*** physicians
- Treating these conditions accounts for **75%** of direct medical care in the US

12% of Americans have 5+ chronic conditions…

- 41% of healthcare spending
- 32% visited ER at least once ($1,200 per visit, on average)
- Filled 6x the amount of prescriptions
- More than 50% have physical limitations that affect daily life
- 1 in 5 need help with daily tasks like cooking or paying bills
  - 34 million people provide unpaid care for adults 50+
  - Lost productivity could cost $794 billion by 2030

Thorpe, Kenneth. "Rising Chronic Disease Rates Portend Unsustainable Costs" June 20, 2017.

Critical Health Disparities

- Individuals with Serious Mental Illness are dying approximately 25 years earlier than the general population - Average age of death is 53.
- *Substance Use Disorders and the Person-Centered Healthcare Home* a 2010 report by B. Mauer finds that those with co-occurring MH/SUD were at greatest risk -- Average age of death is 45.

People with SMI are Dying of Preventable Causes (NASMHPD)

Higher Rates of Modifiable Risk Factors:

- Smoking
- Alcohol consumption
- Poor nutrition / obesity
- Lack of exercise
- Unsafe sexual behavior
- IV drug use
- Residence in group care facilities and homeless shelters

Vulnerability due to higher rates of:

- Homelessness
- Victimization / trauma
- Unemployment
- Poverty
- Incarceration
- Social isolation





Policy Recommendations: do you have a role?

- Improved medication adherence—save $105 billion per year
- Prevent chronic diseases—save $7 billion
  - Diabetes Prevention Program –adults 60+ who made lifestyle changes reduced diabetes risk by 71%
  - Potential to save $7 billion more if Medicare covered at-risk adults 60-64
- Increase access and promote behavior change—save $116 billion per year

*Thorpe, Kenneth. "**Rising Chronic Disease Rates Portend Unsustainable Costs" June 20, 2017.***

Wherever you are the foundation is the same…

Trauma Informed Care

Whole health & wellness integrated care practices

Recovery & Resilience framework/ practice

Family & Community Connections

Care coordination, care management & data driven care

Methods: MI, shared decision making, PST/BA, EBP Wellness

What is a Trauma-Informed Approach? How we can help.

A definition of trauma-informed approach incorporates three key elements: **(1) *realizing*** the prevalence of trauma; **(2) *recognizing*** how trauma affects all individuals involved with the program, organization, or system, including its own workforce; and **(3) *resisting re-traumatization*** and **(4) *responding*** by putting this knowledge into practice.

(SAMHSA, 2012)

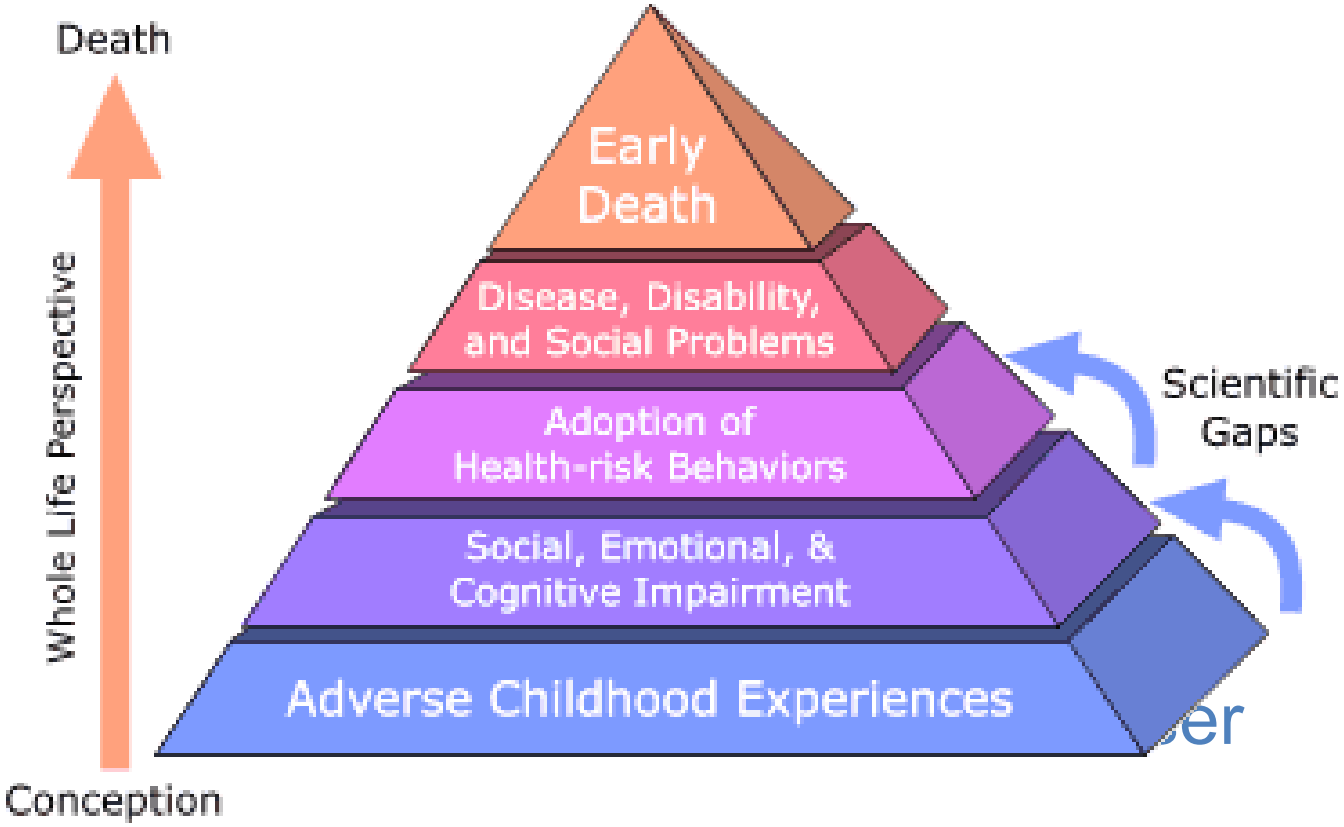
Trauma Shapes our Beliefs: broken trust

Worldview

Identity

Spirituality

Adverse Childhood Experiences Study (ACES)



Life-Long Physical, Mental & Behavioral Health Outcomes Linked to ACEs

- Alcohol, tobacco & other drug addiction
- Auto-immune disease
- Chronic obstructive pulmonary disease & ischemic heart disease
- Depression, anxiety & other mental illness
- Diabetes
- Multiple divorces
- Fetal death
- High risk sexual activity, STDs & unintended pregnancy
- Intimate partner violence—perpetration & victimization
- Liver disease
- Lung cancer
- Obesity
- Self-regulation & anger management problems
- Skeletal fractures
- Suicide attempts
- Work problems—including absenteeism, productivity & on-the-job injury

Trauma is a risk factor for Substance Abuse

Substance Abuse is a risk factor for Trauma

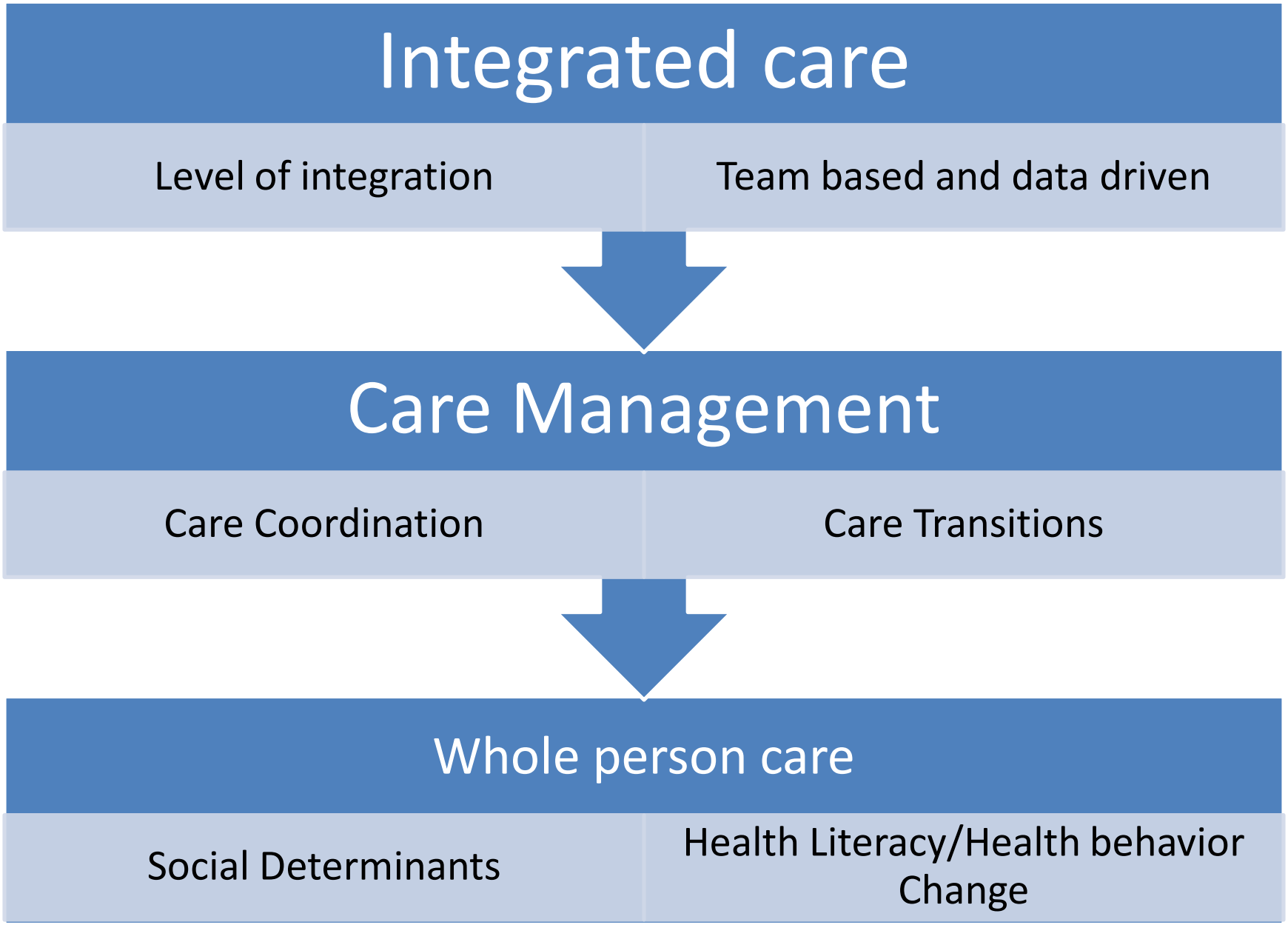
25-75% of survivors develop alcohol issues

Male and female sexual abuse survivors develop alcohol and drug disorders at a higher rate

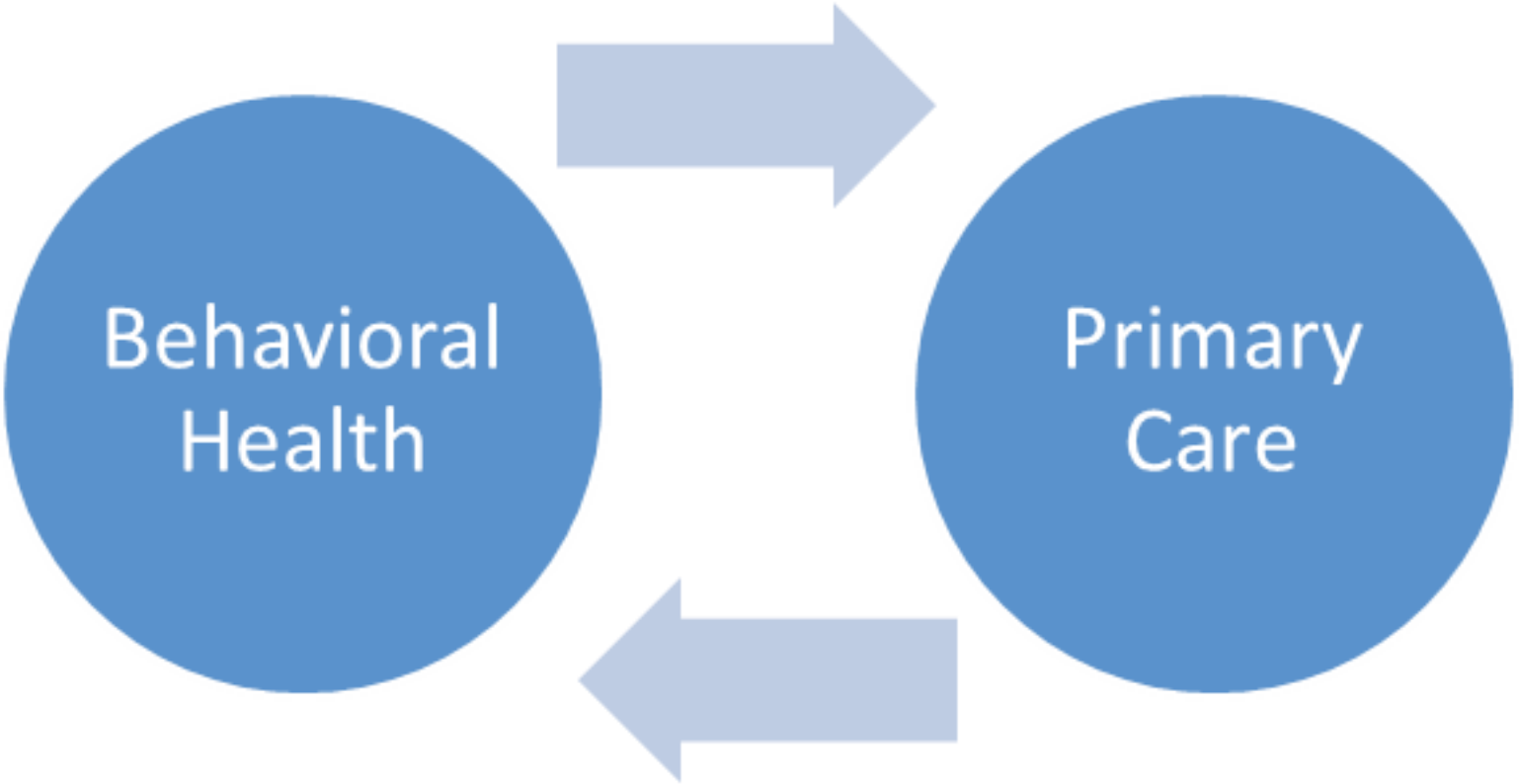
What does that mean for me?

- How are you implementing TI practices in your setting?
- “Look for what happened to you” and What’s strong in you rather than what’s wrong with you?

- Create safety


Integrated care
Level of integration
Team based and data driven
Care Management
Care Coordination
Care Transitions
Whole person care
Social Determinants
Health Literacy/Health behavior Change

What Is Integrated Health Care?

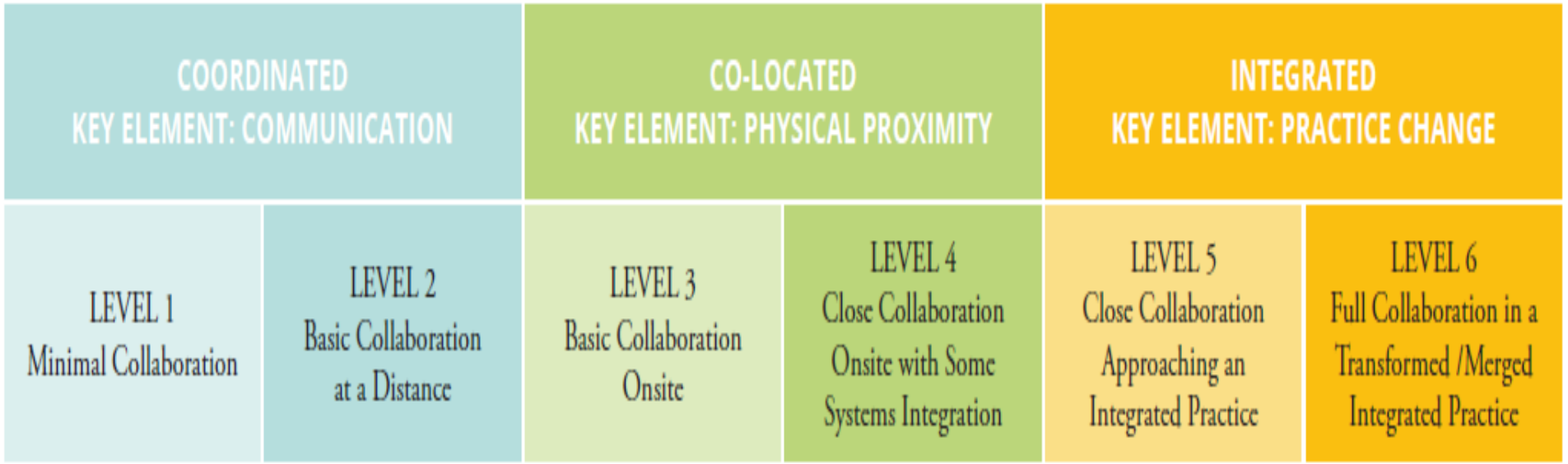


What is integrated care?

"Integrated care could be conceptualized as a set of processes expected to address a range of populations and health concerns, and targeted to particular outcomes. These processes could be performed under any number of different structural models, some of which may be more feasible or effective for achieving good outcomes in certain contexts."

Source: Kwan & Nease Chapter 5 The State of the Evidence for Integrated Behavioral Health in Primary Care (see http://farleyhealthpolicycenter.org/wp-content/uploads/2014/08/Kwan-Nease-2013-Evidence-for-integration.pdf)

Structural Models: can be bi-directional



One process: shared/team based care

"Results from a few of the studies suggested that shared care may be more effective in certain patient groups. These include patients with depression and other serious chronic mental health illness and those with high levels of morbidity at baseline such as the elderly and people with moderate to severe congestive cardiac failure."

Source: Effectiveness of shared care across the interface between primary and specialty care in chronic disease management (Review) 13 Copyright © 2007 The Cochrane Collaboration., JohnWiley & Sons, Ltd

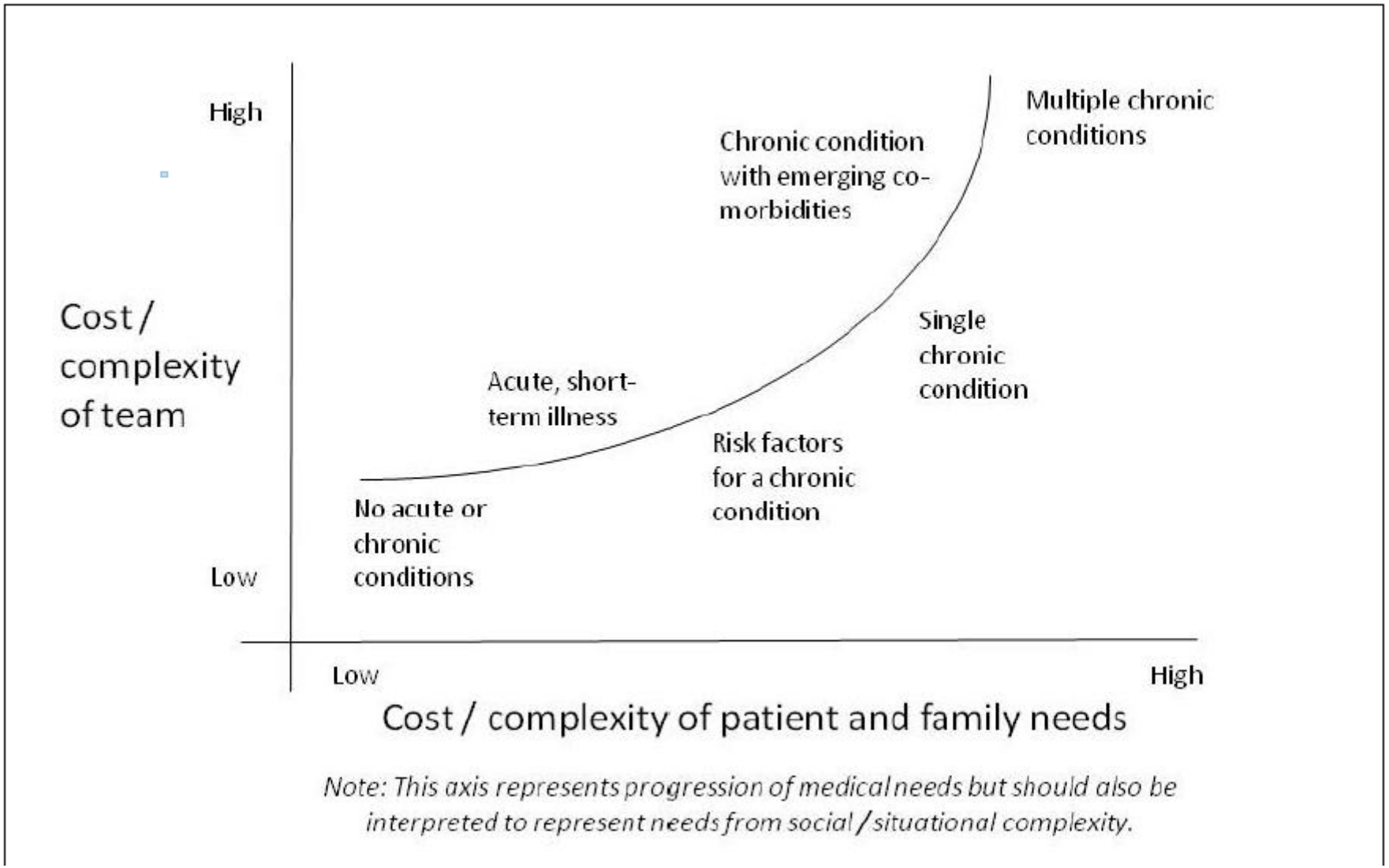
Team-Based Care (TBC)

Fundamental Definition

- **At least two health providers who work collaboratively with patients and their caregivers – to the extent preferred by patient—to accomplish shared goals and achieve coordinated, high quality care.[1]**
- **Inter-disciplinary (e.g., BH professional, PCP, SW, nutritionist, peer support specialist).[1]**
- **Clear roles, mutual trust, effective communication, measurable processes and outcomes.[2]**

[1]Adapted from ACA definitions of team in Sections 2703 and 3502

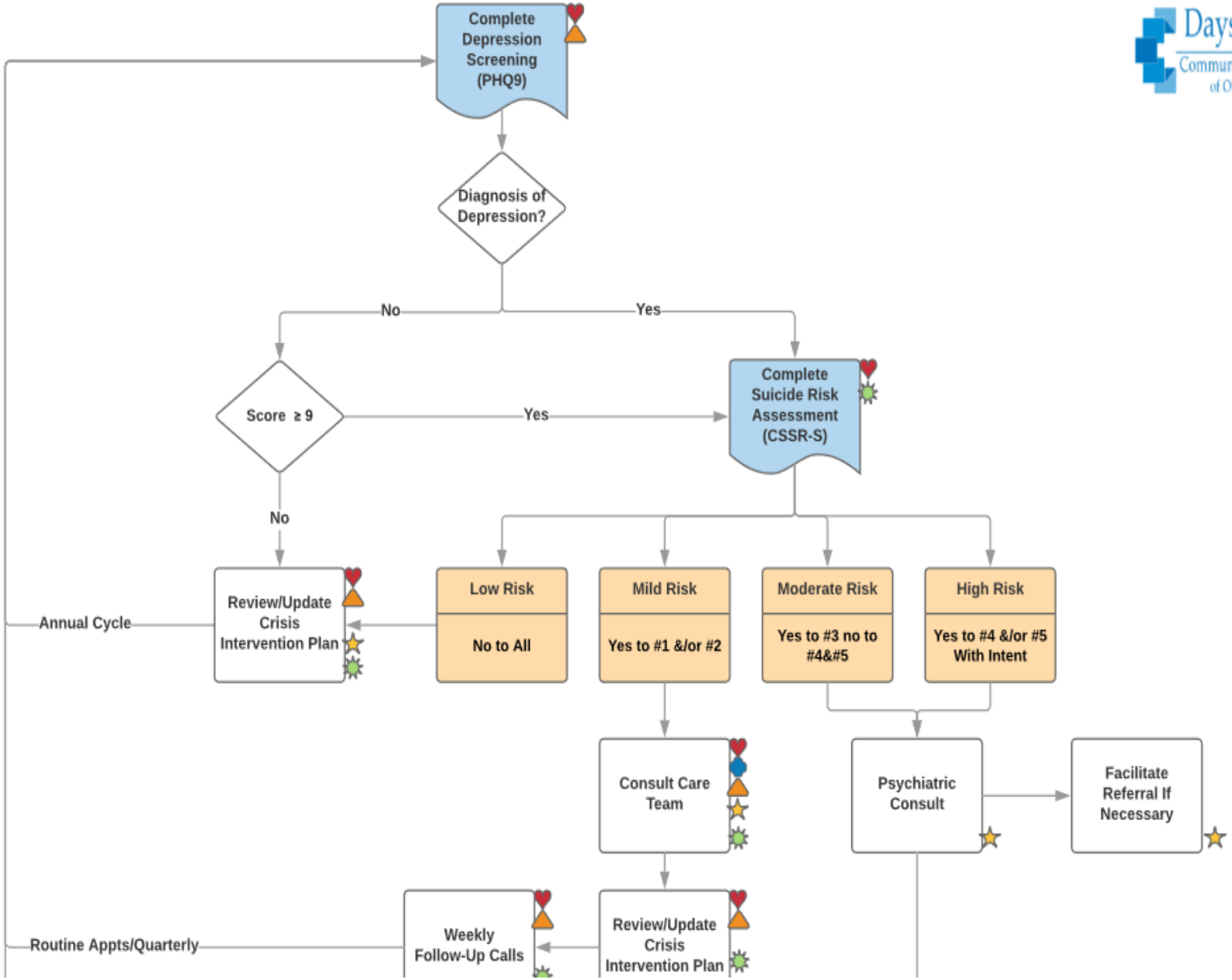
[2]IOM White Paper: Mitchell, Wynia, Golden et al (October 2012), Core Principles and Values of Effective Team-based Health Care.



Mitchell, P., M. Wynia, R. Golden, B. McNellis, S. Okun, C.E. Webb, V. Rohrbach, and I. Von Kohorn. 2012. Core principles & values of effective team-based health care. Discussion Paper, Institute of Medicine, Washington, DC. www.iom.edu/tbc.

One process: data driven care

- Standardized screening tools, rescreening in a predictable way
- Clinical pathways: standardize what we can to leave space for what we can't.
- Helps to predict costs and outcomes



Dayspring Community Services of Oklahoma

One process: Care Management

Care management refers to activities performed by health care professionals with a goal of achieving the person-centered treatment to target outcomes with the person.

Source: McDonald KM, Sundaram V, Bravata DM, et al. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies, Volume 7—Care Coordination. Rockville, MD: Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services; June 2007.

Examples of Care Management:

- Screening & Assessment
- Care planning
- Increasing health literacy through education
- Medication management & adherence support
- Risk stratification
- Population management
- Coordination of care transitions

Source: McDonald KM, Sundaram V, Bravata DM, et al. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies, Volume 7—Care Coordination. Rockville, MD: Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services; June 2007.

What is meant by "Transitions of Care"?

The movement of patients between health care locations, providers, or different levels of care within the same location, as their conditions and care needs change

Source: NTOCC

- **Across health states**: e.g., palliative care to hospice, or personal residence to assisted living
- **Between providers**: e.g., PCP to a psychiatrist, or acute care provider to a palliative care specialist
- **Within settings**: e.g., primary care to specialty care team, or intensive care unit (ICU) to ward/department
- **Between settings**: e.g., inpatient hospital to outpatient care, or ambulatory clinic to senior center

The heart of care coordination

"Go to the people. Live with them.

Learn from them. Love them.

Start with what they know. Build with what they have.

But with the best leaders, when the work is done, the task accomplished, the people will say 'We have done this ourselves."

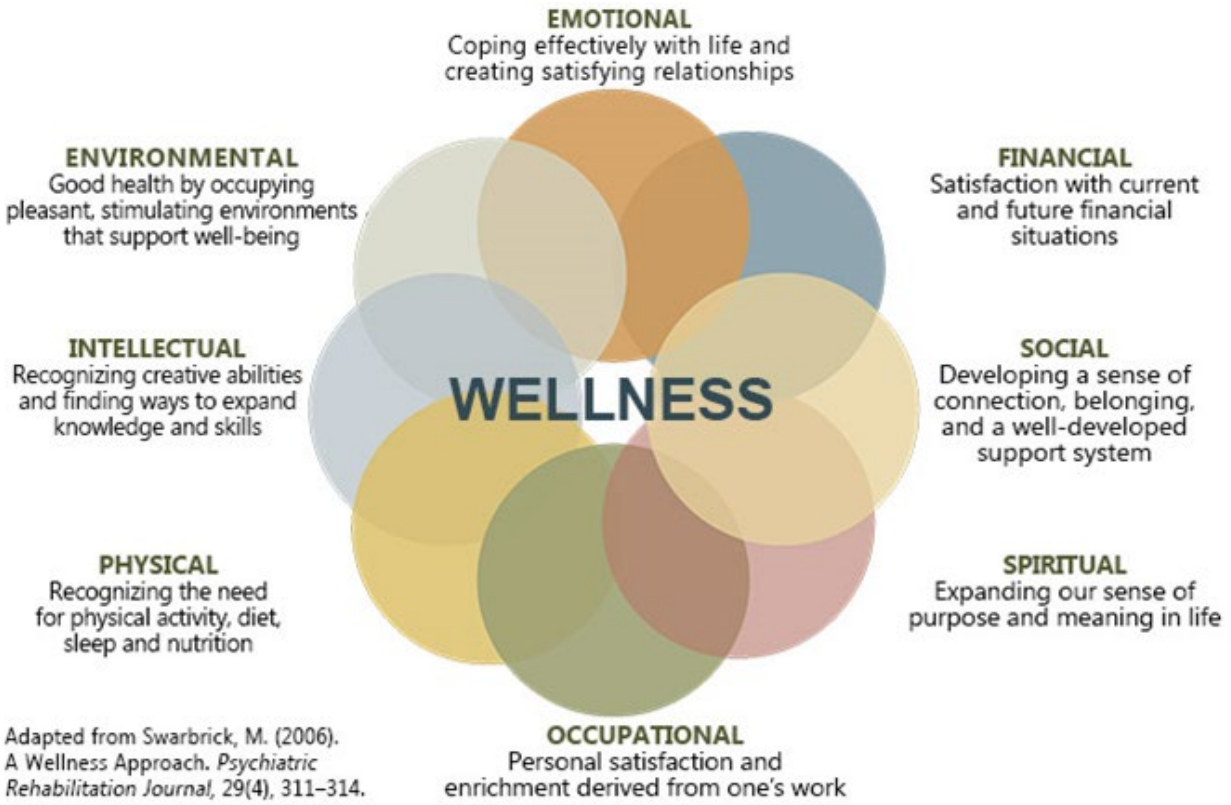
— Lao Tzu

Care Coordination Defined: a function and a role

"the deliberate organization of patient care activities between two or more participants involved in a patient's care to facilitate the appropriate delivery of health care services."

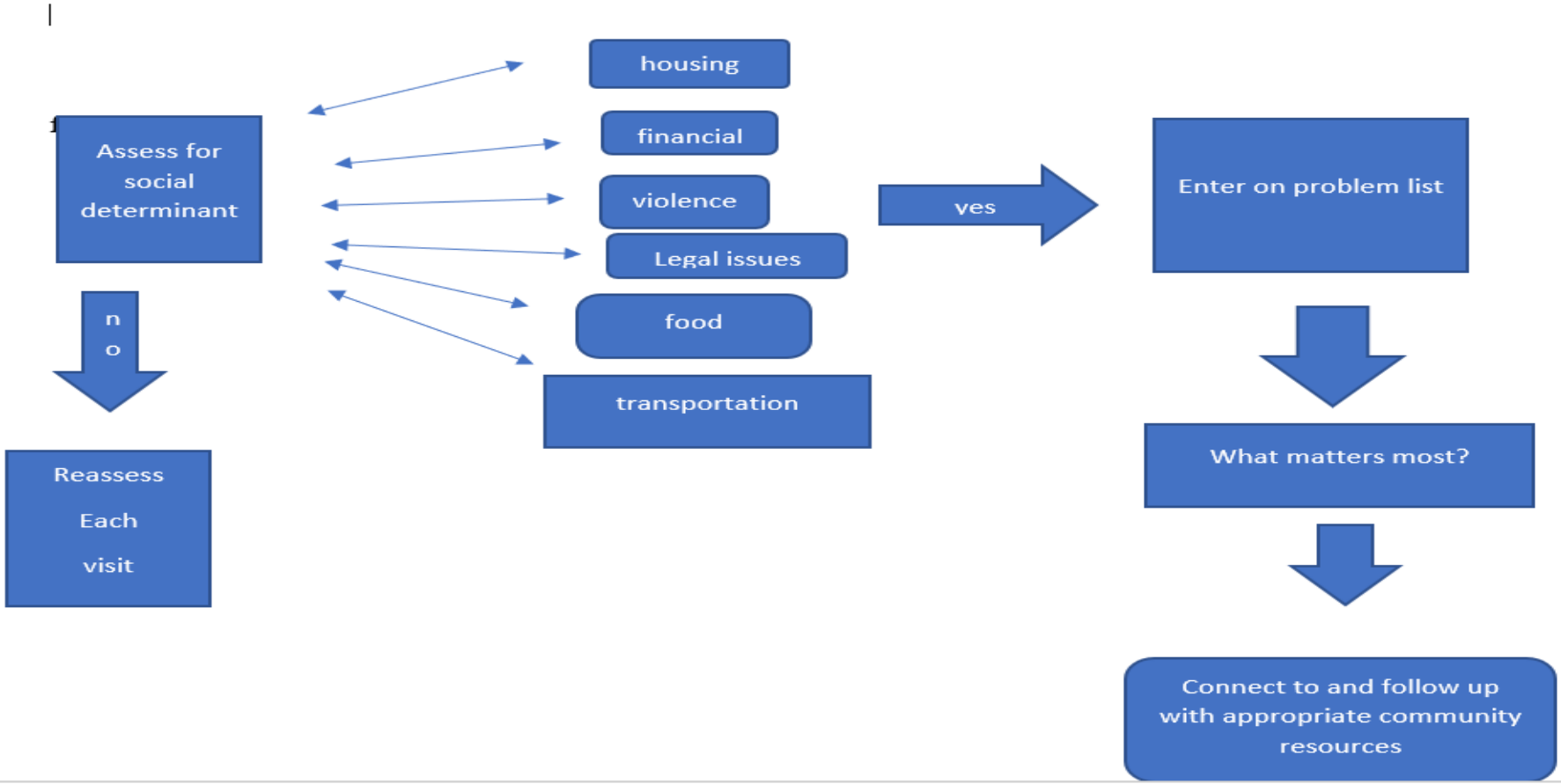
Source: McDonald KM, Sundaram V, Bravata DM, et al. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies, Volume 7—Care Coordination. Rockville, MD: Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services; June 2007.

How does your care coordination span these dimensions of wellness?



Adapted from Swarbrick, M. (2006). A Wellness Approach. *Psychiatric Rehabilitation Journal*, 29(4), 311–314.

Care coordination starts with assessment:



Deliberate…

https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf-

Living Situation

1. **What is your living situation today?**[3]
   - ☐ I have a steady place to live
   - ☐ I have a place to live today, but **I am worried** about losing it in the future
   - ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

2. **Think about the place you live. Do you have problems with any of the following?**[4]
   CHOOSE ALL THAT APPLY
   - ☐ Pests such as bugs, ants, or mice
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Lack of heat
   - ☐ Oven or stove not working
   - ☐ Smoke detectors missing or not working
   - ☐ Water leaks
   - ☐ None of the above

Food

Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months. [5]

3. **Within the past 12 months, you worried that your food would run out before you got money to buy more.**
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

Deliberate:

https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

Safety

Because violence and abuse happens to a lot of people and affects their health we are asking the following questions. [8]

7. **How often does anyone, including family and friends, physically hurt you?**
   - ☐ Never (1)
   - ☐ Rarely (2)
   - ☐ Sometimes (3)
   - ☐ Fairly often (4)
   - ☐ Frequently (5)

8. **How often does anyone, including family and friends, insult or talk down to you?**
   - ☐ Never (1)
   - ☐ Rarely (2)
   - ☐ Sometimes (3)
   - ☐ Fairly often (4)
   - ☐ Frequently (5)

9. **How often does anyone, including family and friends, threaten you with harm?**
   - ☐ Never (1)
   - ☐ Rarely (2)
   - ☐ Sometimes (3)
   - ☐ Fairly often (4)
   - ☐ Frequently (5)

10. **How often does anyone, including family and friends, scream or curse at you?**
    - ☐ Never (1)
    - ☐ Rarely (2)
    - ☐ Sometimes (3)
    - ☐ Fairly often (4)
    - ☐ Frequently (5)

A score of 11 or more when the numerical values for answers to questions 7-10 are added shows that the person might not be safe.

Deliberate:

Financial Strain

11. How hard is it for you to pay for the very basics like food, housing, medical care, and heating? Would you say it is:[9]

- ☐ Very hard
- ☐ Somewhat hard
- ☐ Not hard at all

Employment

12. Do you want help finding or keeping work or a job?[10]

- ☐ Yes, help finding work
- ☐ Yes, help keeping work
- ☐ I do not need or want help

Family and Community Support

13. If for any reason you need help with day-to-day activities such as bathing, preparing meals, shopping, managing finances, etc., do you get the help you need?[11]

- ☐ I don't need any help
- ☐ I get all the help I need
- ☐ I could use a little more help
- ☐ I need a lot more help

14. How often do you feel lonely or isolated from those around you?[12]

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

What matters most to you?

Care coordination with physical health providers: BRIDGING THE GAP

Care coordination requires partnership with physical health providers: Develop a Strategic Approach

- Who provides primary care to the individuals you serve?
- Identify top 3-5 and create a targeted outreach and communication plan
- How might you help them? What do you have to offer?
- Get to know the office manager/nurse

Building Partnerships with Primary Care

Relationship, Relationship, Relationship!

Demonstrate your value:

- Help people prepare for their visit
- Accompany individuals on visits as needed
- Provide additional information to the PCP
- Help create and maintain a medication list
- **Stress your skills at promoting self management**
- Do what you say you are going to do

Primary Care Visits

Helping people prepare for appointments:
Strategies for Coordination

- What are their concerns?
- What are their questions?
- Prioritize
- Establish your role
- Enlist other supporters
- Recognize the "intimidation factor"
- Develop a plan for "waiting"
- Role play strategies for communication and calming

Case management to care management requirements

- *Screening & Assessment*
- *Care planning*
- *Increasing health literacy through education*
- *Medication management & adherence support*

Which means we need to increase our own health literacy….and work with our team to support improved physical health.

Health Literacy

https://www.youtube.com/watch?v=ubPkdpGHWAQ

Common health problems

Metabolic Syndrome

Diabetes

Cardiovascular Disease

Cancer

Why is it important to identify MetS?

- MetS is associated with an elevated risk of:
  - Type 2 Diabetes (5x)
  - Cardiovascular disease (2x)
    - Cerebrovascular accident (2-4x)
    - Myocardial infarction (3-4x)
  - All cause mortality
- Other systemic effects include:
  - Renal, hepatic, skin, cardiovascular

Source: American Heart Association "What is Metabolic Syndrome" (2015)
Kaur J. 2014. A Comprehensive Review on Metabolic Syndrome. Cardiology Research and Practice. 2014: 1-21.

What is MetS? Clinical Definition

Modified NCEP ATPIII Guidelines

- Presence of 3 out of 5 of the following:

Blood glucose	≥100 (or taking hypoglycemic)
HDL	<40 (men) or < 35 (women)
Triglycerides	≥ 150 (or taking lipid lowering agents)
Waist circumference	>40 in (men) or > 35 in (women)
Blood pressure	≥ 130/85 (or taking anti-hypertensive)

Source: American Heart Association. "What is Metabolic Syndrome" (2015)

Evidence-Based Treatment of MetS:

Overview

- Routine monitoring of metabolic parameters
  - Body weight, abdominal circumference
  - Blood pressure
  - Blood glucose and lipids
- Interventions that target lifestyle modifications
  - Weight loss (5-10%)
  - Nutrition
  - Physical activity
- Evidence-based treatment guidelines for management of:
  - Dyslipidemia
  - Hypertension
  - Diabetes Type 2

Source: American Heart Association "What is Metabolic Syndrome" (2015)

One Nation Under Stress: Deaths of Despair

https://www.youtube.com/watch?v=uYVLaGOUHhA

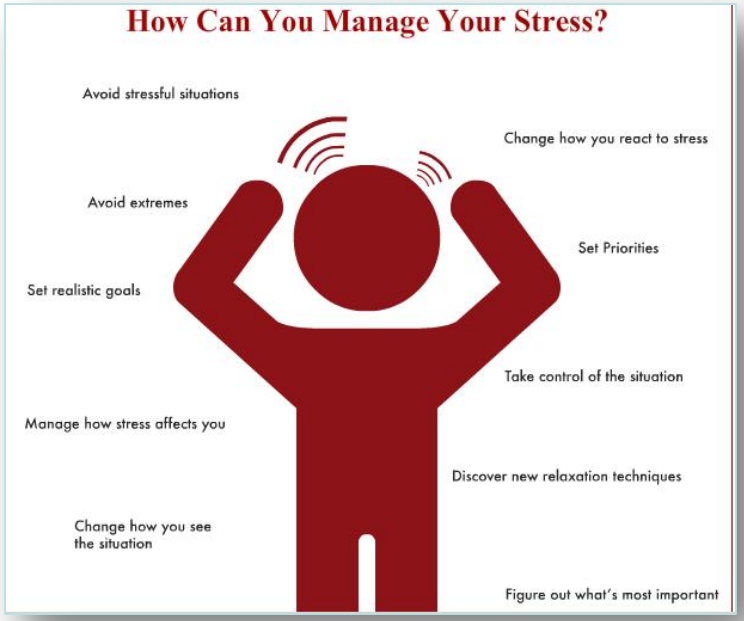
(5:50-11;40)

Reduce Stress

- **Causes:**
  - Individual and Collective
- **Effects:**
  - chronic adrenaline and cortisol
  - Higher blood pressure
  - Seems to impact insulin effectiveness
  - Psychological

Stress Reduction Interventions

What do you do to manage your stress?



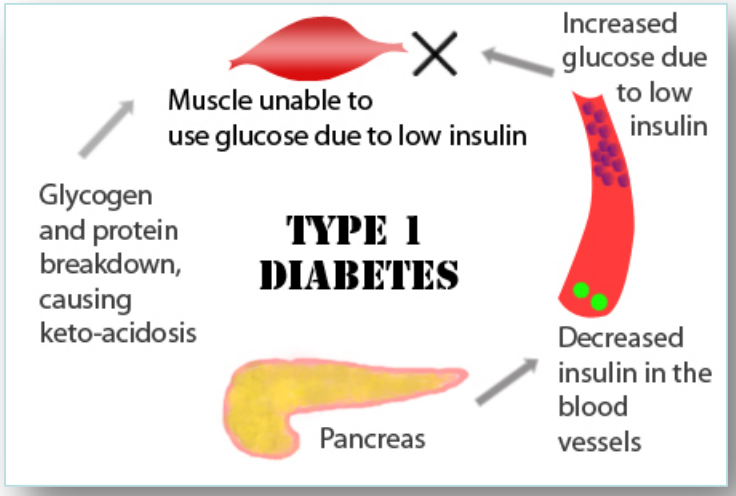
Diabetes:

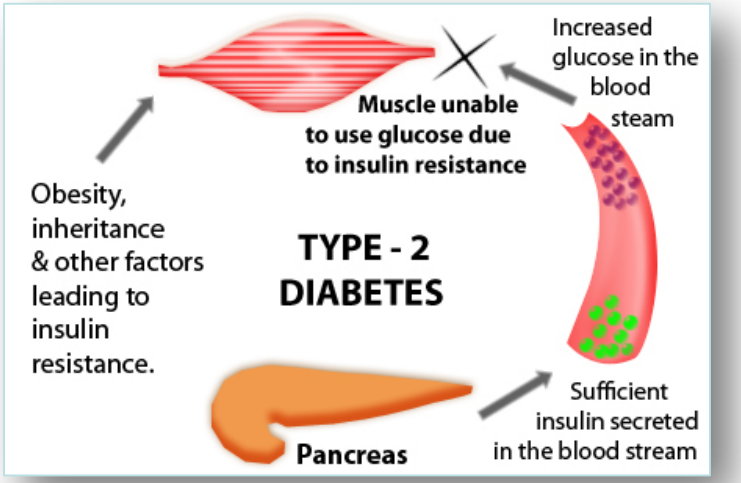
What is Diabetes?

- Your body changes most of the food you eat into glucose (a form of sugar). Insulin is a hormone produced by the pancreas that allows glucose to enter all the cells of your body and be used as energy.
- When you have Diabetes, the sugar builds up in your blood instead of moving into the cells. Too much sugar in the blood can lead to serious problems, including heart disease, damage to blood vessels and damage to the nerves and kidneys.
- 25.8 million people in US, 8.3% of population

Types of Diabetes

Type 1 Diabetes is an autoimmune disorder that occurs when the body stops making insulin





In type 2 Diabetes, the body either doesn't produce enough insulin or the cells ignore the insulin. Between 90-95% of people who are diagnosed with Diabetes have Type 2 Diabetes

Diabetes Risk Factors

You are at increased risk for Diabetes if:

- You're older than 45 years of age
- You're overweight
- You don't exercise regularly
- Your parent, brother, or sister has Diabetes
- You gave birth to a baby that weighed more than 9 pounds or you had gestational Diabetes while you were pregnant
- You're African American, Hispanic American/Latino, Native American, Asian American, or Pacific Islander
- Possible second generation anti-psychotics

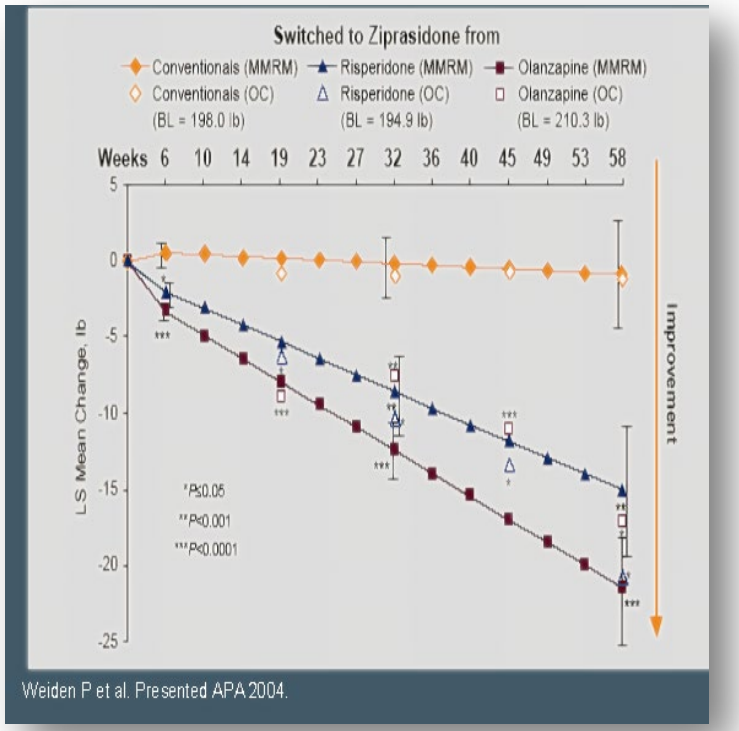
How many individuals on your caseload may be at risk?

How many have Diabetes?

Diabetes and Persons with SPMI

1 year Weight gain with atypicals:

- Olanzapine(Zyprexa): average across all doses is 15 pounds
- Quetipine (Seroquel): 8 pounds
- Risperdol (Risperidol): 4 pounds
- Ziprasidone (Geodon): 3 pounds
- Ariprizole (Abilify): 2 pounds



Symptoms of Diabetes

The early stages of Diabetes have very few symptoms, so you may not know you have the disease. But damage may already be happening to your eyes, your kidneys and your cardiovascular system even before you notice symptoms.

Symptoms of Diabetes may include:

- Extreme thirst
- Extreme hunger
- Frequent urination
- Sores or bruises that heal slowly
- Dry, itchy skin
- Unexplained weight loss
- Blurry vision
- Unusual tiredness or drowsiness
- Tingling or numbness in the hands or feet
- Frequent or recurring skin, gum, bladder or vaginal yeast infections

Managing Diabetes

The goal of Diabetes treatment is to keep your blood sugar level as close to normal as possible--not too high (called hyperglycemia) or too low (called hypoglycemia).

- The first step is to have a healthy diet and to exercise. This may mean you'll need to change your current diet and exercise habits. You'll also have to watch your weight (or lose weight if you are overweight) to help keep your blood sugar level as normal as possible. Even SMALL weight loss helps and exercise helps even without weight loss.
- Regularly checking your blood sugar is a key to helping you control it. Blood sugar checks can help you see how food, exercise, insulin or other medicine affects your level. Checking your blood sugar also allows you and your doctor to change your treatment plan if needed.
- Oral Medicines; Insulin Injections
- Foot care, eye care

Know Your Diabetes ABCs

Talk to your health care team about how to manage your **A**1C, **B**lood pressure, and **C**holesterol. This can help lower your chances of having a heart attack, stroke, or other diabetes problems. Here's what the **ABCs** of diabetes stand for:

A for the A1C test (A-one-C)

- It shows what your blood glucose has been over the last three months. The A1C goal for many people is below 7. High blood glucose can harm your heart and blood vessels, kidneys, feet, and eyes.

B for Blood pressure

- The goal for most people with diabetes is below 130/80.
- High blood pressure makes your heart work too hard. It can cause heart attack, stroke, and kidney disease.

C for Cholesterol (ko-LES-ter-ol)

- The LDL goal for people with diabetes is below 100.
  The HDL goal for men with diabetes is above 40.
  The HDL goal for women with diabetes is about 50.
- LDL or “bad” cholesterol can build up and clog your blood vessels. It can cause a heart attack or a stroke. HDL or “good” cholesterol helps remove cholesterol from your blood vessels.

How does a care manager help, how does the team engage?

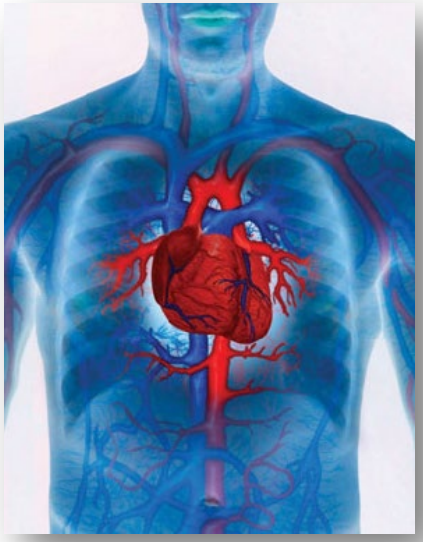
- Know who has diabetes
- Know that hyper or hypo glycemia can look like being under the influence
- Know the person's medical regimen and support through MI
- Care coordination with community resources
- With your team review HGBA1C, diet, exercise, foot care and eye care
- Use MI strategies to support smoking cessation

https://store.samhsa.gov/shin/content/SMA13-4780/SMA13-4780.pdf

Cardio Vascular Disease

What is Cardio Vascular Disease?

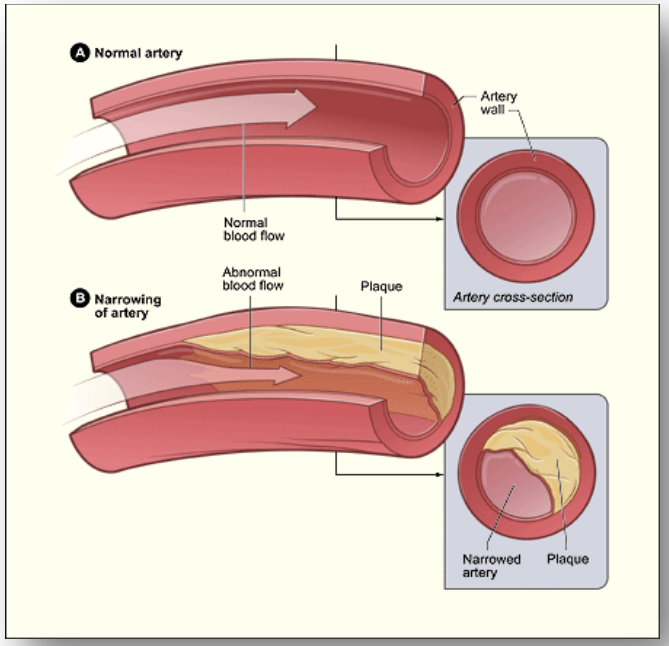
Cardio Vascular disease is a general term for a group of problems that affect your blood vessels, such as those that move blood through your heart and brain. People who have cardio vascular disease may have health problems such as:



- Coronary Artery Disease
- Heart Attack
- Stroke
- Hypertension

Cardio Vascular Disease: Coronary Artery Disease (CAD)

- Caused by a thickening of the inside walls of the coronary arteries. This thickening is called **atherosclerosis**.
- A fatty substance called **plaque** builds up inside the thickened walls of the arteries, blocking or slowing the flow of blood.
- If your heart muscle doesn't get enough blood to work properly, you may have angina or a heart attack. **Angina** is a squeezing pain or pressing feeling in your chest



Heart Attack: Symptoms

Men may feel like bad heartburn and/or experience one or more of the following :

- Feel a pressure or crushing pain in your chest, sometimes with sweating, dizziness, nausea, or vomiting.
- Feel pain that extends from your chest into the jaw, left arm or left shoulder
- Feel tightness in your chest
- Have shortness of breath for more than a couple of seconds
- Feel weak, lightheaded or faint
- Have sudden overwhelming fatigue

Heart Disease is the number one killer of women. Their symptoms may differ and women often ignore these symptoms:

- GI discomfort that is passed off as indigestion, acid reflux or gas
- Shortness of breath (feeling like you have been running when you are sitting still)
- Dizziness and lightheadedness
- Feeling of pressure and/or pain in the upper back

Cardio Vascular Disease: Hypertension (HTN)

- The number of Americans who have high blood pressure has increased dramatically
- Nearly 1,000 people die each day in the United States as a result of high blood pressure-related illnesses.
- The latest data show that nearly 1 in 3 American adults—approximately 70 million—have high blood pressure. About half of those with high blood pressure don't have it under control, even though many have insurance, are being treated with medicine, and have seen a doctor at least twice in the past year.

Hypertension

Systolic blood pressure is the measurement of the beat of the heart (top number

Diastolic is the heart at rest (bottom)

- Healthy: 120/80 (below)
- Early HTN: 120/80-140/90
- High : 140/90 or higher

Lifestyle for hypertension

*Lifestyle Modifications[1] (LM)

Modification	Recommendation	Approximate SBP** Reduction (Range)††
Weight reduction	Maintain normal body weight (body mass index 18.5–24.9 kg/m^2)	5–20 mm Hg/10kg
Adopt DASH††† eating plan	Consume a diet rich in fruits, vegetables, and lowfat dairy products with a reduced content of saturated and total fat	8–14 mm Hg
Dietary sodium reduction	Reduce dietary sodium intake to no more than 100 mmol per day (2.4 g sodium or 6 g sodium chloride)	2–8 mm Hg
Physical activity	Engage in regular aerobic physical activity such as brisk walking (at least 30 min per day, most days of the week which may be broken into shorter time intervals such as 10 minutes each of moderate or vigorous effort)	4–9 mm Hg
Moderation of alcohol consumption	Limit consumption to no more than 2 drinks (e.g. 24 oz. beer, 10 oz. wine, or 3 oz. 80-proof whiskey) per day in most men, and to no more than 1 drink per day in women and lighter weight persons	2–4 mm Hg

**SBP – systolic blood pressure

†† The effects of implementing these modifications are dose and time dependent, and could be greater for some individuals

†††DASH – Dietary Approaches to Stop Hypertension

Abbreviations

- ACEI – Angiotensin-Converting Enzyme Inhibitor
- ALDO – Aldosterone Antagonist
- CCB – Calcium Channel Blocker
- EF – Ejection Fraction

Source: https://millionhearts.hhs.gov/files/Hypertension-Protocol.pdf

Assessing for Stroke:

- Smile
- Talk
- Raise both arms
- Stick out your tongue

The Good News: Reducing Risks of Cardiovascular Disease

- Maintenance of ideal body weight (BMI = 18.5-25)
  - 35%-55% ↓ in CVD
- Maintenance of active lifestyle (~30-min walk daily)
  - 35%-55% ↓ in CVD
- Cigarette smoking cessation
  - ~ 50% ↓ in CVD

Hennekens CH. Circulation 1998;97:1095-1102; Rich-Edwards JW, et al. N Engl J Med 1995;332:1758-1766; Bassuk SS, Manson JE. J Appl Physiol 2005;99:1193-1204.

How does a care manager help?

- Lifestyle: diet, exercise, wellness programming referrals
- Education
- Care coordination with physical health/cardiology
- Motivational interviewing

http://www.heart.org/idc/groups/heart-public/@wcm/@hcm/documents/downloadable/ucm_300461.pdf

Smoking and Behavioral Health Challenges:

- Of the 440,000 annual tobacco-related deaths in the US, half are among people with a behavioral health disorder.
- Half of all deaths among people with serious mental illness are attributable to tobacco use.
- Treating tobacco addiction while simultaneously treating drug or alcohol addiction increases the likelihood of long-term abstinence by 25%.
- The rate of tobacco use among people with a behavioral health disorder ranges from 40% (major depression) to 98% (substance use disorder). Only 19% of the general population smokes.
- Implementing tobacco-free policies that prohibit tobacco use indoors and outdoors does not change patient attrition.
- 75% of people with a behavioral health disorder want to quit, and 65% tried to quit in the last year.

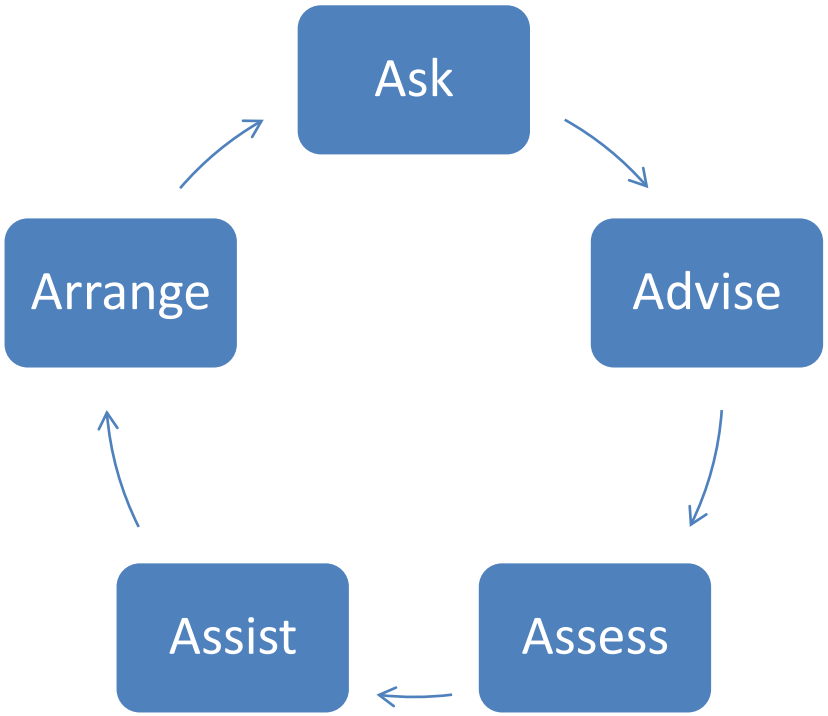
Can We Make a Difference?

People we serve

- ✓ Need to quit
- ✓ Want to quit
- ✓ Can quit

We can help.

Supporting Smoking Cessation: The Five A's



Tobacco dependence and use (current or former) is a chronic relapsing condition that requires repeated intervention and a systematic approach

http://www.integration.samhsa.gov/Smoking_Cessation_for_Persons_with_MI.pdf

Things to Watch Out For in people with SMI

- Nicotine withdrawal is more severe in this population
- Exacerbation of psychiatric disorder
- Possible side effects due to cessation induced increased in medication levels.

Proven Strategies for Success in Smoking

- Incorporate harm reduction approaches to smoking in wellness groups.
- Change language from smoking cessation (taking something away) to wellness
- Connect decreasing smoking to a desired goal
- Support development of alternative activities before working at smoking “cessation”
- Connect with local community based programs to support your efforts.

Cancer and Serious Mental Illness

- Individuals with a mental illness may die from cancer at a 2.6 times higher rate on account of late stage diagnosis and inadequate treatment and screenings.
- More than 50% of patients with terminal cancer have at least one psychiatric disorder.

Opioids and Chronic Pain

What can we do: Addressing Fear

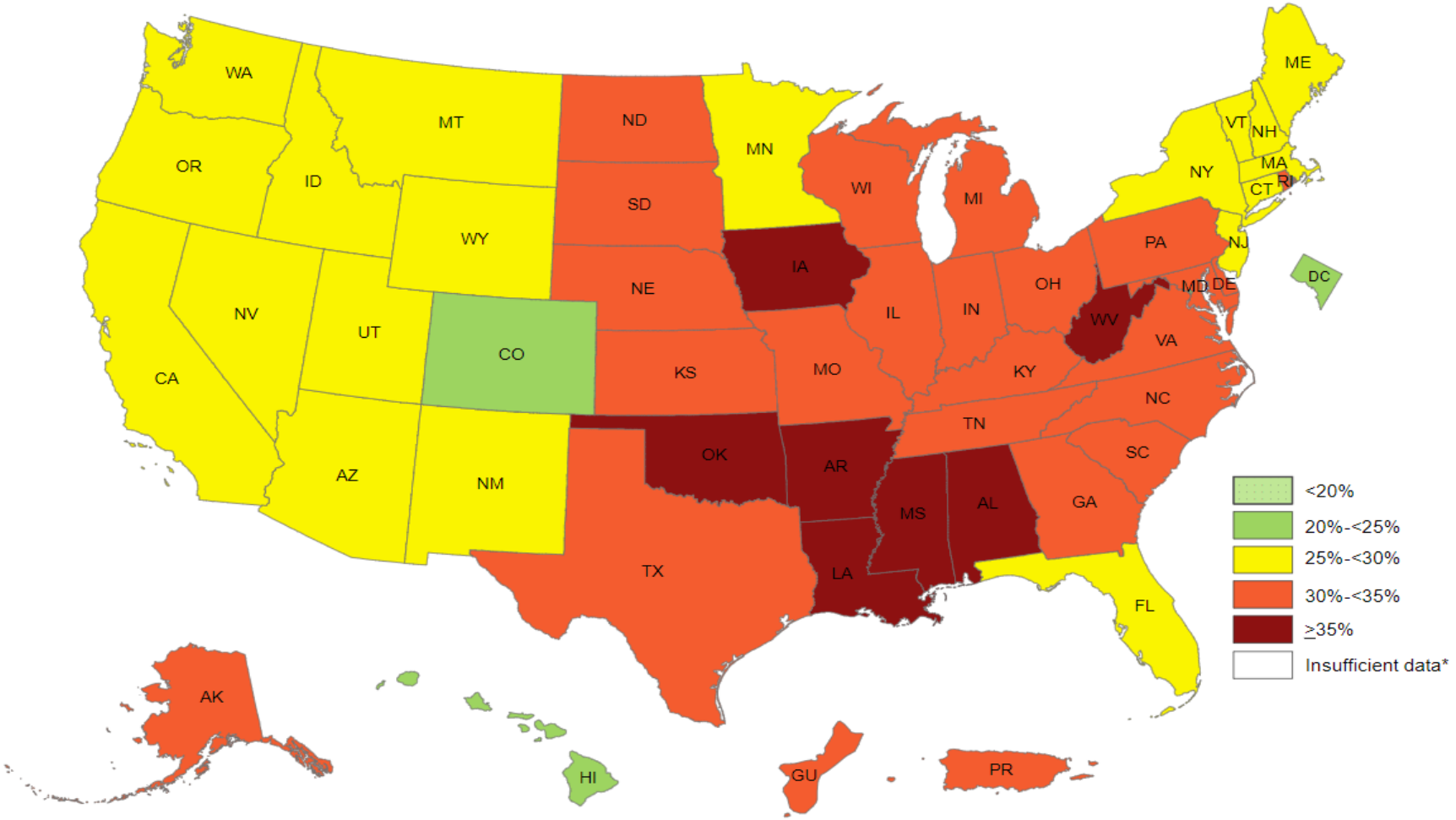
- "Get pain out of the driver's seat. Get the patient in the driver's seat."
- Educate about the connection between depression—lowers pain threshold and anxiety—increases muscle tension
- Fear that the pain represents continued/additional injury
- May lead to challenging behavior patterns
  - Activity avoidance
  - "Drug-seeking"

What can we do: Setting Expectations, providing support

- Explore alternative pain management strategies:
  - Relaxation, breathing
  - Exercise, activity, stress management
- Emphasize improved function rather than reduced pain
- Community support programs/treatment/MAT
- Eliminating pain is not a practical goal
  - Would require such doses of medication as to impair function
  - Pain has a protective purpose

Obesity

2017 Obesity Rates



Obesity Risk Factors for Persons with SMI

- Obesity: > 42% (vs. 28% gen pop)
- 3-6X greater risk of metabolic syndrome
- Regular Moderate Exercise < 20%
- Compared to the general population:
  - Fewer fruits and vegetables
  - More calories and saturated fats

Application to Challenging Behavior: What we eat

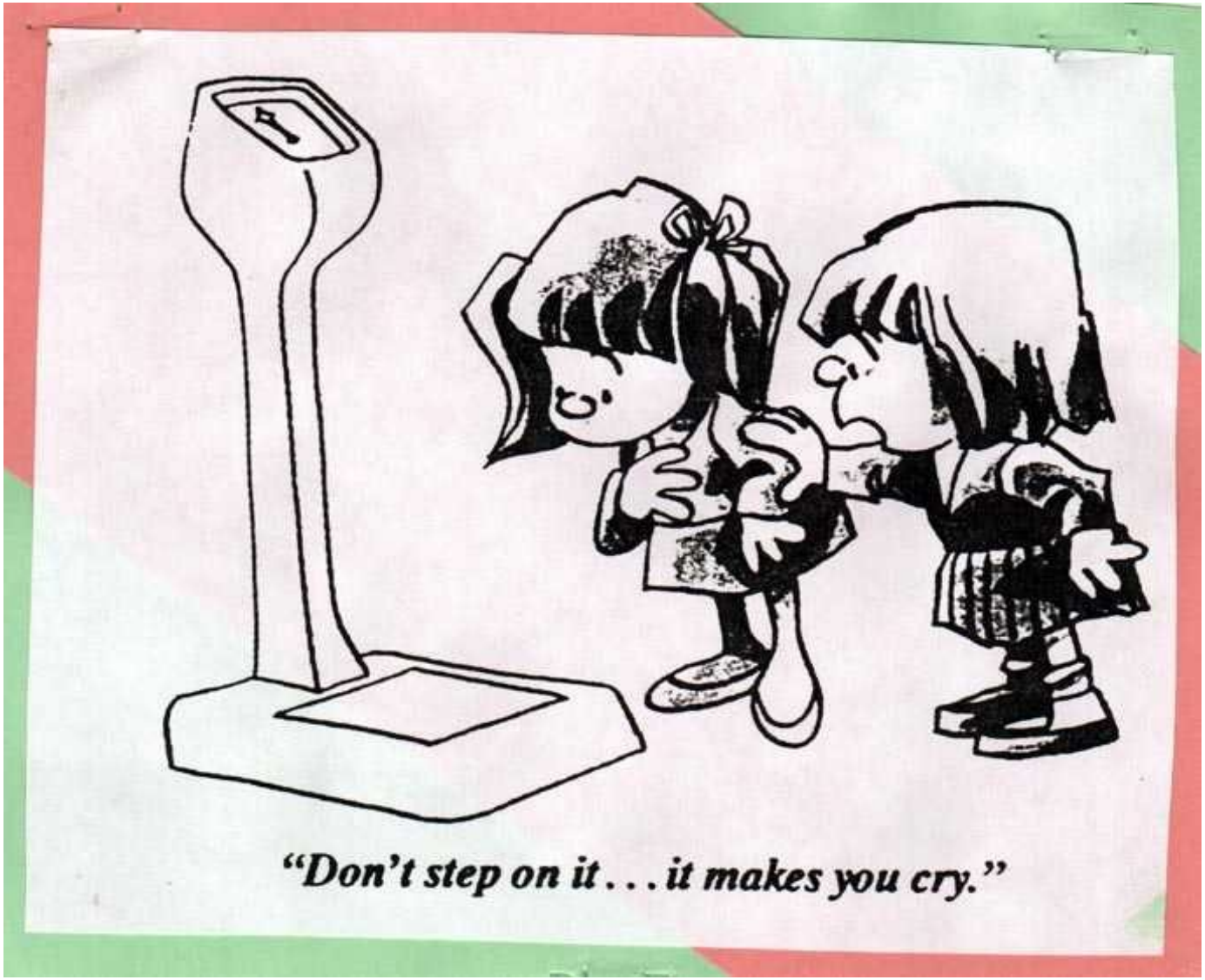
- Part of your role in navigation/care management is knowing where to get good information and having the basics in the face of conflicting information
- Conflicting information can overwhelm and undermine confidence
- Diet change is complicated by poverty
- Team based approach: community resources, motivational interviewing, support, education

Nutrition Basics

- Eat low
- Eat color
- Shop the outside aisle or an agenda for the inside
- Divide your plate
- Consider your portions
- Small loss=improved health

Proven Strategies for Success with Eating

- "Shop" with people at food banks
- Joint cooking projects with healthy food.
- Reach out to local extension services
- Participate in/start a community garden
- Use peer support staff as educators about healthy eating on a budget
- Serve healthy food at organizational events
- Try "culture" days where you introduce new foods from other cultures.


"Don't step on it . . . it makes you cry."

"Why does it take 6 weeks to lose 5 pounds, but only 1 day to gain it all back?"

Move your body!!!

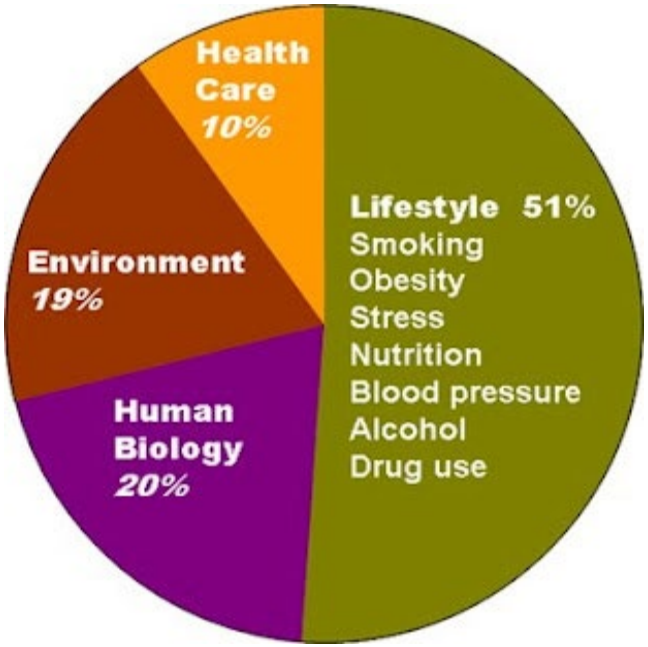
- Anything is better than nothing
- Adding a small change will improve health
- Small steps can lead to big changes
- Support and accountability contribute to change
- 3 months to make a habit
- (See resource list for websites that can help)

ALL IT TAKES IS ONE STEP FORWARD

Proven Strategies for Success In Motion!

- Incorporate chair exercise into groups
- Walk while talking
- Joint staff/participant walking competitions with pedometers
- Create walking “tracks” in your building
- Mark out walking trails in the neighborhood
- Form partnerships with local YMCA’s or fitness centers
- In home exercises: climbing stairs, walking in place etc.

Determinants Of Health --World Health Organization



Lifestyle 5X
Health Care

What Works in Change?

Think about a time in your own life when you successfully made a change in your lifestyle:

- What was the process like of *getting* to the change?
- What helped?
- What didn't help?

Think about a time you have supported someone else in making a change:

- What did you do that worked?

Transtheoretical Model

- **Stages of Change:**
  - Precontemplation
  - Contemplation
  - Preparation
  - Action
  - Maintenance
  - Relapse

Major Contributors: Prochaska & DiClemente

The Spirit of Motivational Interviewing

- Motivation is gained in the presence of active collaboration and shared decision making
- People have inherent resources for change when the change is connected to their goals, values and dreams
- Honoring the right not to change can make change possible.
- Empower the person as a consultant to you and the expert in their own life

Establishing Confidence

Use a Confidence Ruler: *how confident is the person that he or she can change the behavior?*

On a scale of 0 to 10, how CONFIDENT are you that you could make this change?

0____1____2____3____4____5____6____7____8____9____10

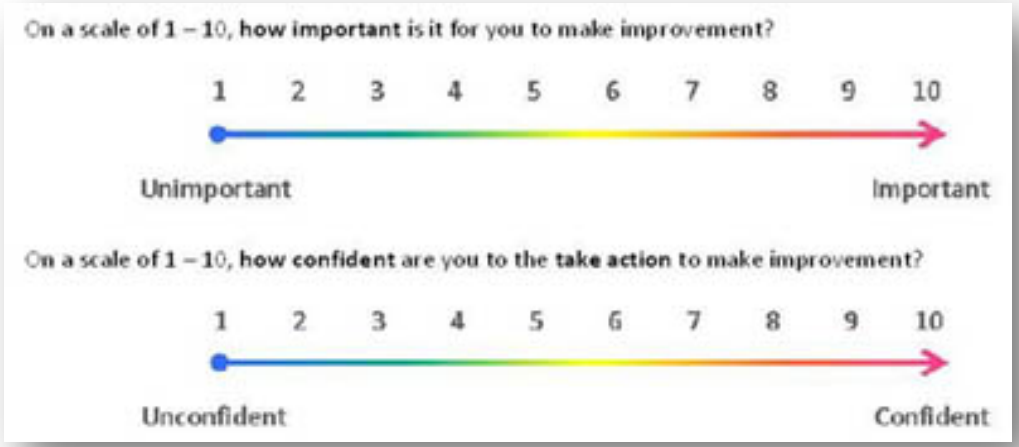
Not at all Confident — Extremely Confident

Developing a Change Plan

"Sometimes it's good to change your walking routine. Try walking around the block instead of wandering around the kitchen."

A Structure For Small Goals

- One way I want to improve my health….
- When I will start, what I will do….?
- How often will I do it….?
- What might get in the way and how can I address it?
- On a scale of 1-10, how confident am I that I can do this?
- When will we check in with each other again?



Principle for Care Managers

- Small incremental changes can make a BIG difference
- Small change plans solve your documentation woes
- Apply the rapid cycle change principles:
  - Plan
  - Do
  - Study
  - Act

Support makes a big difference

Celebrate SUCCESS!!!!

Use the knowledge and skills learned today to:

- Determine physical health risk factors
- Identify recommended health behavior changes
- Determine stage of change
- Use motivational interviewing to establish a target
- Establish readiness, confidence and commitment
- Develop small, measurable steps to create success and increase confidence

Developing your action plan (activity two)

- Based on what you heard today what concrete next step will you (or you as a team) take in the next 30 days to extend the work you have been doing in supporting whole health and wellness in a care management framework.

- *Change I/we want to make:*
- *What will be different if we do this?*
- *What are concrete steps?*

- *When will we check in with each other (or with someone)*

- *Who "owns" this plan—in other words makes sure we stick to it and see it through and learn from it:*

"In times of change, learners inherit the Earth, while the learned find themselves beautifully equipped to deal with a world that no longer exists"

-Eric Hoffer

Building on the Foundation:
Moving from Case Management to Care Management

Pam Pietruszewski
pamp@thenationalcouncil.org

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About Us

The **National Council for Behavioral Health** is the unifying voice of America's mental health and addictions treatment organizations. Together with over 3100 member organizations, serving 10 million adults, children and families living with mental illnesses and addictions, the National Council is committed to all Americans having access to comprehensive, high-quality care that affords every opportunity for recovery.

- Mental Health First Aid
- Merge with State Associations of Addiction Services (SAAS)

www.TheNationalCouncil.org

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Case to Care Training: What You Can Expect

1. Health care trends driving the need for change
2. Care management for whole health
3. Physical health disparities and modifiable risks
4. Supporting health behavior change
5. Action planning

What is happening in health care?

- New models, new payment systems
- Push for improved outcomes
- New roles, changed roles, expanded roles

The U.S. has a *SICK CARE* System NOT a *HEALTH CARE* System

- **45%** of Americans have one or more chronic conditions
- Over half of these people receive their care from ***3 or more*** physicians
- 12% of Americans Have **5+** chronic conditions
- More than **50%** have physical limitations affecting daily life

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Critical Health Disparities

Individuals with serious mental illness are dying approx 25 years earlier than the general population

- Average age of death = 53

Those with co-occurring MH/SUD were at greatest risk

- Average age of death is 45

Morbidity and Mortality in People with Serious Mental Illness, Parks J, et. al. 2006
Substance Use Disorders and the Person-Centered Healthcare Home, Mauer B. 2010

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People with SMI are Dying of Preventable Causes

Higher Rates of Modifiable Risk Factors:

- Smoking
- Alcohol consumption
- Poor nutrition / obesity
- Lack of exercise
- Unsafe sexual behavior
- IV drug use
- Residence in group care facilities and homeless shelters

Vulnerability due to higher rates of:

- Homelessness
- Victimization / trauma
- Unemployment
- Poverty
- Incarceration
- Social isolation

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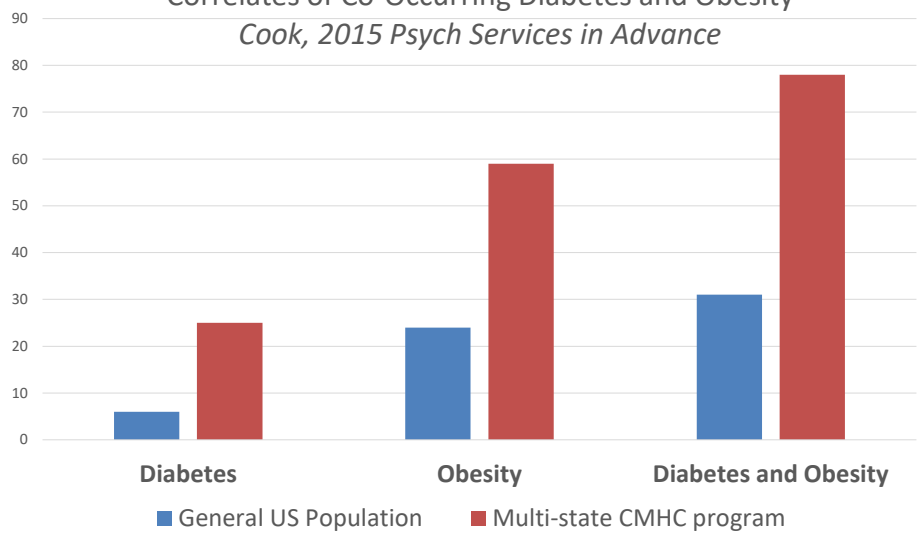
Among Those with Serious Mental Illness, Correlates of Co-Occurring Diabetes and Obesity

Cook, 2015 Psych Services in Advance



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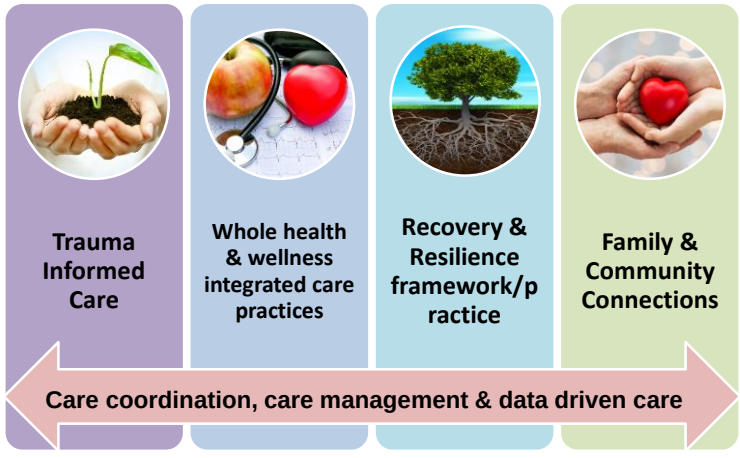
Wherever you are the foundation is the same



Methods: MI, shared decision making, PST/BA, EBP Wellness

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Trauma Shapes our Beliefs

Worldview

Identity

Spirituality

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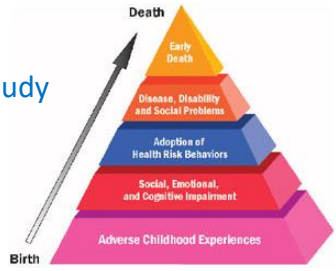
Trauma & Health

The Adverse Childhood Experiences Study
Felitti, 1998. Am J Prev Med.
acestoohigh.com



- **17,000** participants
- Almost **2/3** of participants reported **at least one** ACE
- **Constant presence of adrenaline and cortisol** can cause high blood pressure, raise glucose levels & increase cholesterol
- **Too much cortisol** can lead to osteoporosis, arthritis, GI disease, depression, anorexia nervosa, Cushing's syndrome, hyperthyroidism

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Life-Long Health Outcomes Linked to ACEs

- Alcohol, tobacco & other drug addiction
- Auto-immune disease
- Chronic obstructive pulmonary disease & ischemic heart disease
- Depression, anxiety & other mental illness
- Diabetes
- Multiple divorces
- Fetal death
- High risk sexual activity, STDs & unintended pregnancy
- Intimate partner violence—perpetration & victimization
- Liver disease
- Lung cancer
- Obesity
- Self-regulation & anger management problems
- Skeletal fractures
- Suicide attempts
- Work problems—including absenteeism, productivity & on-the-job injury

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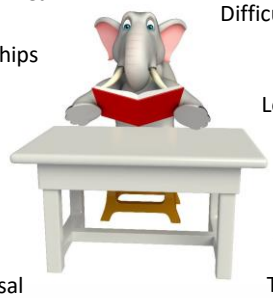
What's Sitting in the Room from Trauma



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What is a Trauma-Informed Approach?

1. ***Realizing*** the prevalence of trauma
2. ***Recognizing*** how trauma affects all individuals involved with the program, organization, or system, including its own workforce
3. ***Resisting re-traumatization***
4. ***Responding*** by putting this knowledge into practice

SAMHSA, 2012

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What is Integrated Care?

A set of **processes** expected to address
a **range of populations** and **health concerns**
and targeted to particular **outcomes.**

Kwan & Nease, 2014 . The State of the Evidence for Integrated Behavioral Health in Primary Care

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Levels of Integration

Coordinated		Co-located		Integrated	
1	2	3	4	5	6
Minimal Collaboration	Basic Collaboration at a Distance	Basic Collaboration Onsite	Close Collaboration Onsite with some System Integration	Close Collaboration Approaching an Integrated Practice	Full Collaboration in a Transformed / Merged Integrated Practice

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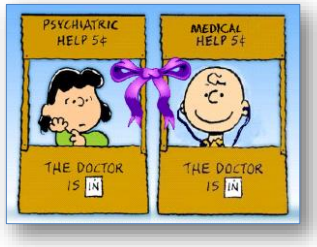
Team-Based Care

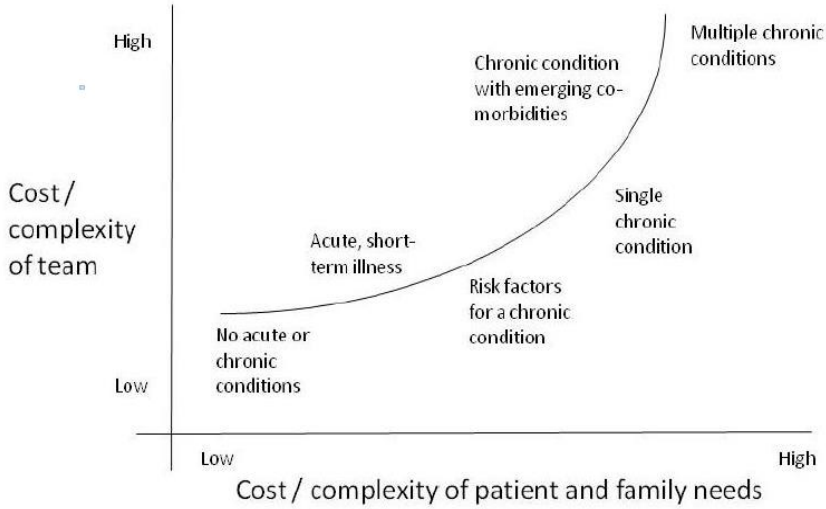


Clear roles, mutual trust, effective communication, measurable processes and outcomes. Mitchell, 2012. Core Principles & Values of Effective Team-based Health Care

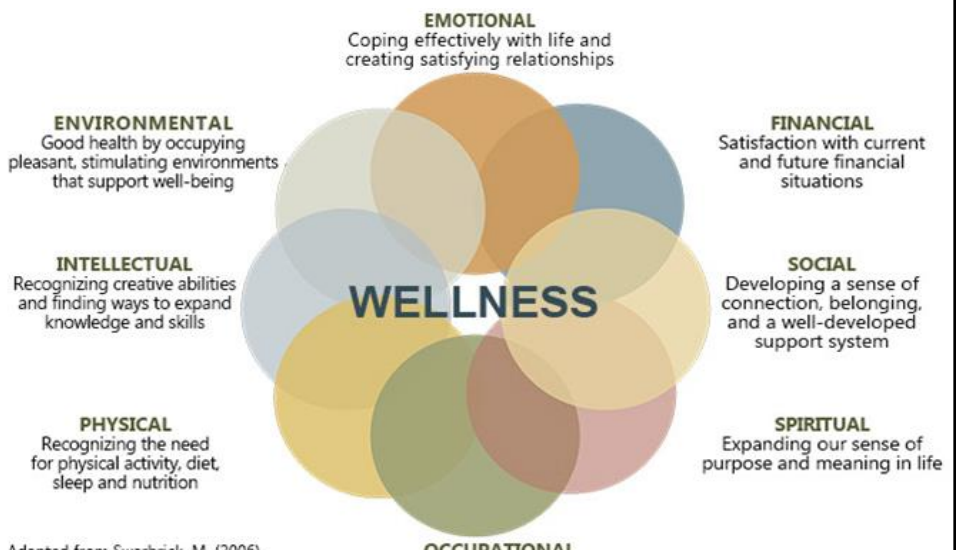
Shared care may be more effective in certain patient groups. These include patients with depression and other serious chronic mental health illness. Cochrane Collaboration, 2007. Effectiveness of shared care across the interface between primary and specialty care in chronic disease management

Complexities: Health, Social, Situational

Mitchell, 2012. Core principles & values of effective team-based health care.



How does your care coordination span these dimensions of wellness?



Adapted from Swarbrick, M. (2006). A Wellness Approach. *Psychiatric Rehabilitation Journal*, 29(4), 311–314.

Social Needs Screening Example www.healthleadsusa.org

	In the last 12 months*, did you ever **eat less than you felt you should** because there wasn't enough money for food?	Y N
	In the last 12 months, has the **electric, gas, oil, or water company threatened to shut off your services** in your home?	Y N
	Are you worried that in the next 2 months, you **may not have stable housing?**	Y N
	Do problems getting **child care make it difficult for you to work** or study? *(leave blank if you do not have children)*	Y N
$	In the last 12 months, have you [illegible] a doctor, **but could not because of cost?**	Y N
	[illegible] months, have you ever had to go without health care because you didn't have **a way to get there?**	Y N
	Do you ever need help **reading hospital materials?**	Y N
	I often feel that **I lack companionship.**	Y N
	Are any of your needs urgent? For example: I don't have food tonight, I don't have a place to sleep tonight	Y N
	If you checked YES to any boxes above, **would you like to receive assistance** with any of these needs?	Y N

What matters most to you?

Transitions of Care

The movement of patients between health care locations, providers, or different levels of care within the same location, as their conditions and care needs change

- **Across health states**: Ex: personal residence to assisted living
- **Between providers**: Ex: PCP to a psychiatrist
- **Within settings**: Ex: primary care to specialty care team
- **Between settings**: Ex: inpatient hospital to outpatient care

Source: NTOCC

Care Management

Activities performed by health care professionals with a goal of achieving the person-centered treatment to target outcomes with the person.

McDonald, 2007 Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies, Volume 7—Care Coordination.

Examples of Care Management

- Screening & Assessment
- Care planning
- Increasing health literacy through education
- Medication management & adherence support
- Risk stratification
- Population management
- Coordination of care transitions

McDonald, 2007 Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies, Volume 7—Care Coordination.

Case Management	Care Management
Might go along to a doctor's appointment	Sees their role as an active partner with physical health. Knows not only PCP but others on care team
Takes the person grocery shopping	Works with the person at the grocery store to implement recommendations related to nutrition
May know from the assessment that the person has physical health issues but focus is on BH	Engages the person on the connection between physical and behavioral health to activate management strategies that support health behavior change

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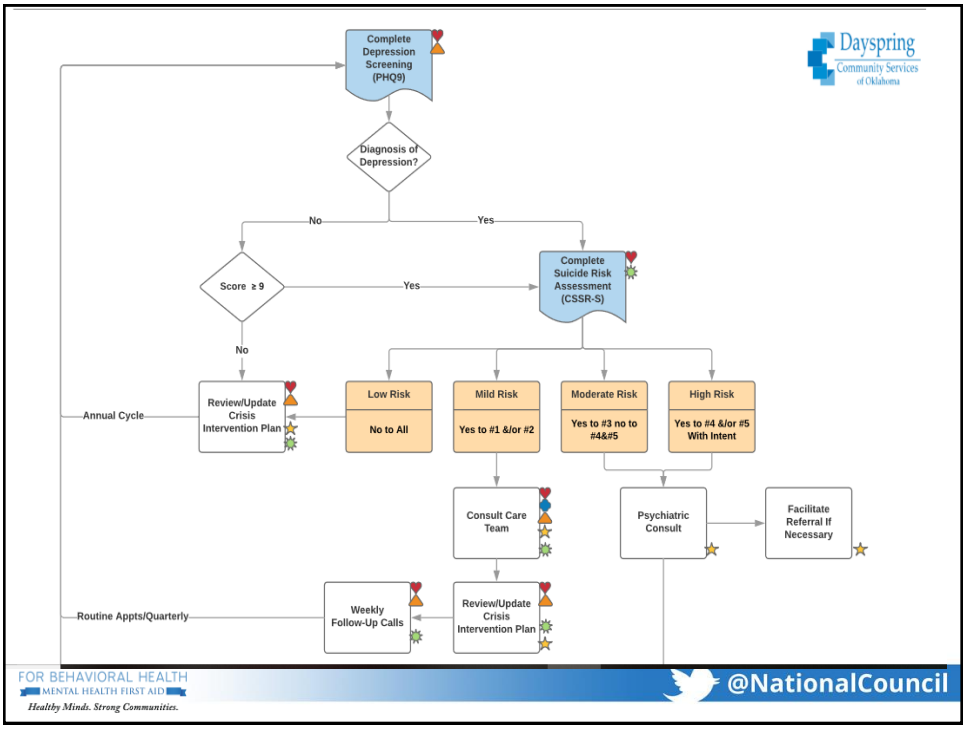
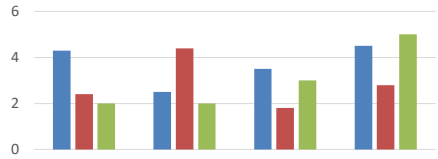
Data Driven Care

- When we track data it changes the work.
- Standardized screening tools with rescreening in a predictable way: A1c? BP? Depression? Substance use?
- Clinical pathways to standardize what we can - which leaves space for what we can't
- Helps to predict costs and outcomes



What Do You Measure?



- Hospitalizations
- ED Visits
- Show rates
- Time between sessions
- Productivity
- Caseloads

- Length of Treatment
- Trends in assessment data: PHQ-9, GAD-7, Audit-C, BMI, BP, A1c
- Length of Service
- Progress note completion

Bridging the Gap: Care Coordination with Physical Health Providers

Understanding the Cultures

Primary Care

- Brief, problem focused communication
- Immediate solution driven care
- Productivity measured in terms of number of patients seen
- Many evidence based interventions, disease management as standard part of practice

Behavioral Health

- Process oriented
- Long term planning and coordination
- Productivity measured in units of service
- Individualized approach with evidence based interventions moving into practice

Preparing for PC Visits

- What are the concerns? Questions? Priorities?
- Help create and maintain medication list
- Enlist other caregivers/supports
- Recognize the intimidation factor
- Develop a plan for "waiting"

- What will be your role?
  - Providing additional information to the PC team
  - Stress your skills at promoting self-management
  - Follow-up, closing loops, checking back

Why Do We Need to Know About Medical Issues?

Yarborough, 2017 Am J Prev Med

- "Interventions that directly address **cardiometabolic risks**, such as weight loss and smoking cessation programs, may be more beneficial to **long-term health** among people with mental illnesses."
- "Poor outcomes may result, at least in part, from **biases or misperceptions** that people with serious mental illnesses do not care about or prioritize their physical health."
- We can help people develop **knowledge and skills** to participate in their own health care.

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Metabolic Syndrome (MetS)

3 or more of the following

Blood glucose	≥100 (or taking hypoglycemic)
HDL	<40 (men) or < 35 (women)
Triglycerides	≥ 150 (or taking lipid lowering agents)
Waist circumference	>40 in (men) or > 35 in (women)
Blood pressure	≥ 130/85 (or taking anti-hypertensive)

Source: American Heart Association, 2015. Modified NCEP ATPIII Guidelines

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Why is it important to identify MetS?

Associated with an elevated risk of:

- Type 2 Diabetes (5x)
- Cardiovascular disease (2x)
- All cause mortality

Other systemic effects include:

- Renal, hepatic, skin, cardiovascular

American Heart Association "What is Metabolic Syndrome" (2015); Kaur J. 2014. A Comprehensive Review on Metabolic Syndrome. Cardiology Research and Practice. 2014: 1-21.

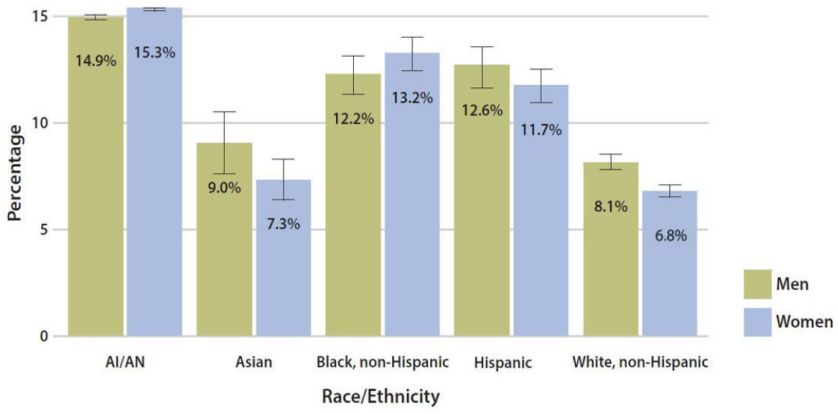
Clinical guidelines for MetS screening upon initiation or continuation of second generation antipsychotics:

BP, BMI, blood glucose, lipid profile check every 6 months

Barnes, 2015 BMJ Open; Cooper, 2016 J Psychopharmacol; DeHert, 2009 Eur Psychiatry

Diabetes

Age-adjusted prevalence of diagnosed diabetes in the U.S. by race/ethnicity and sex among adults age 18+. (CDC 2013-2015)



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What is Diabetes?

- The body changes most of the **food** we eat into **glucose**.
- **Insulin** is a hormone produced by the pancreas that **allows glucose to enter all the cells** of our body and used as energy.
- With diabetes, the **sugar builds up in your blood** instead of moving into the cells. Too much sugar in the blood can lead to serious problems, including **heart disease, damage to blood vessels and damage to the nerves and kidneys**.
- Goal for most people w/ diabetes = **A1c** (tested every 3 months) **below 7**.

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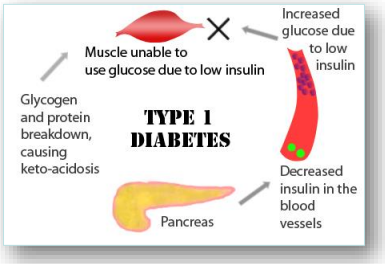
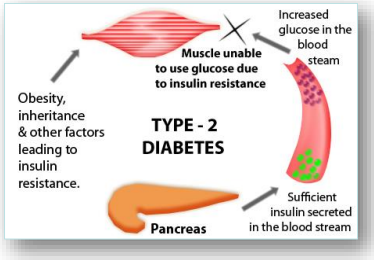
Types of Diabetes

Type 1:
Body stops making insulin



Type 2:

Body either doesn't produce enough insulin or the cells ignore the insulin.



Between 90-95% of people diagnosed with diabetes have Type 2

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Diabetes Risk Factors

- > 45 years of age
- Overweight
- Don't exercise regularly
- Parent, brother, or sister has diabetes
- Gave birth to a baby that weighed more than 9 pounds or gestational diabetes while pregnant
- African American, Hispanic American/Latino, Native American, Asian American, or Pacific Islander
- Possible second generation anti-psychotics

How many individuals on your caseload may be at risk?

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Symptoms of Diabetes

Early stages have very few symptoms. But damage may already be happening to your eyes, your kidneys and your cardiovascular system even before you notice symptoms.

- Extreme thirst
- Extreme hunger
- Frequent urination
- Sores or bruises that heal slowly
- Dry, itchy skin
- Unexplained weight loss
- Blurry vision
- Unusual tiredness or drowsiness
- Tingling or numbness in the hands or feet
- Frequent or recurring skin, gum, bladder or vaginal yeast infections

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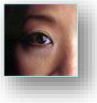
Diabetes:
How Does a Care Manager Help?

Check blood sugar - informs how food, exercise, insulin, other medications affects levels. Too high/too low can look like being under the influence.

Check feet daily - risk of nerve damage & circulation problems. Wear socks. Test bath water. Avoid tight fitting shoes.



Systemic effects of disease can impact blood vessels in the eyes. Annual eye exam. BP within normal limits. Decrease/ stop tobacco use.

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What is Cardiovascular Disease?

A general term for **a group of problems that affect blood vessels**, such as those that move blood through your **heart and brain**.

People who have cardiovascular disease may have health problems such as:

- Coronary Artery Disease
- Heart Attack
- Stroke
- Hypertension

Hypertension (HTN)

- Approximately 1 in 3 American adults have high blood pressure.
- About half of those with high blood pressure don't have it under control, even though many have insurance, are being treated with medicine, and have seen a doctor at least twice in the past year.

Hypertension (HTN)

Systolic blood pressure:
The measurement of the beat of the heart

Diastolic blood pressure:
The heart at rest

Healthy: below 120/80
Early HTN: 120/80-140/90
High : 140/90 or higher

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Heart Attack: Symptoms

Men

- Pressure or crushing pain in the chest, sometimes with sweating, dizziness, nausea, or vomiting.
- Pain that extends from the chest into the jaw, left arm or left shoulder
- Tightness in the chest
- Shortness of breath for more than a couple of seconds
- Feel weak, lightheaded or faint
- Sudden overwhelming fatigue

Women

- GI discomfort that is passed off as indigestion, acid reflux or gas
- Shortness of breath (feeling like have been running when are sitting still)
- Dizziness and lightheadedness
- Feeling of pressure and/or pain in the upper back

Heart Disease is the #1 killer of women.

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Heart Health: How Does a Care Manager Help?

Ideal body weight:  CVD risk ↓ 35-55%

Active lifestyle:  CVD risk ↓ 35-55%

Bassuk 2005 Appl Physiol

Tobacco cessation:  CVD risk ↓ at least 50%

Stress

Causes: Individual and Collective

Effects:

- Chronic adrenaline, increased cortisol
- Higher blood pressure
- Seems to impact insulin effectiveness
- Psychological

Stress Reduction

- We are in high stress jobs, absorbing other people's stress.
- Working with clients experiencing trauma increases our levels of cortisol (so does checking phone 24/7!)
- Evidence suggests that providers who have healthy lifestyle behaviors are more likely to recommend such behaviors to patients.

What do you do to manage your stress?

https://www.youtube.com/watch?v=4Bs0qUB3BHQ

Tobacco and Behavioral Health

- Of the 440,000 annual tobacco-related deaths in the US, **half are among people with a behavioral health disorder**.
- Treating tobacco addiction while **simultaneously** treating drug or alcohol addiction increases the likelihood of long-term abstinence by 25%.
- The rate of tobacco use among people with a behavioral health disorder ranges from **40-90%**.
- Only **19%** of the general population smokes.

Can We Make a Difference?

- As many as **80%** of clients in substance use disorder treatment have expressed an interest in tobacco cessation. (Prochaska 2004. J Consult & Clin Psych)
- "People with mental illness **are as motivated** to stop as people without mental illness **but** they are more nicotine-dependent and less likely to seek out and receive appropriate interventions tailored to their needs." (Firth, 2019. The Lancet)

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Things to Watch For

Boksa, 2017 J Psychiatry Neurosci
Firth, 2019 The Lancet

Smoking is associated with the development or **progression** of some psychiatric disorders.

Nicotine can interfere with the ability of some antipsychotic medications to be absorbed properly, thus **not getting the true benefit** because of nicotine use.

Cessation can **reduce** depression and anxiety with an effect size at least as great as for antidepressant treatments – in both the gen population and people with psychiatric disorders.

Abrupt cessation can change the dynamics of many psychotropic meds. Prescriber may need to make dose adjustments.

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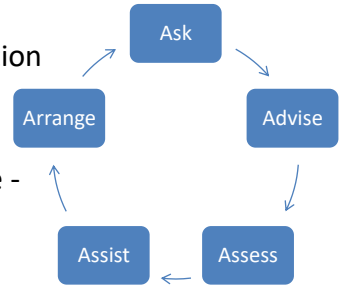
Tobacco: How Does a Care Manager Help?

- Helping people quit is everyone's job. Not just the smoking cessation specialist.
- Change language from smoking cessation (taking something away) to wellness.
- Tobacco free campus sends a message - practice what we preach!



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What is One Drink?

12 oz beer
5 oz table wine
1.5 oz hard liquor (brandy, gin, vodka, whiskey)

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Low-Risk Drinking Guidelines

NIAAA, 2010

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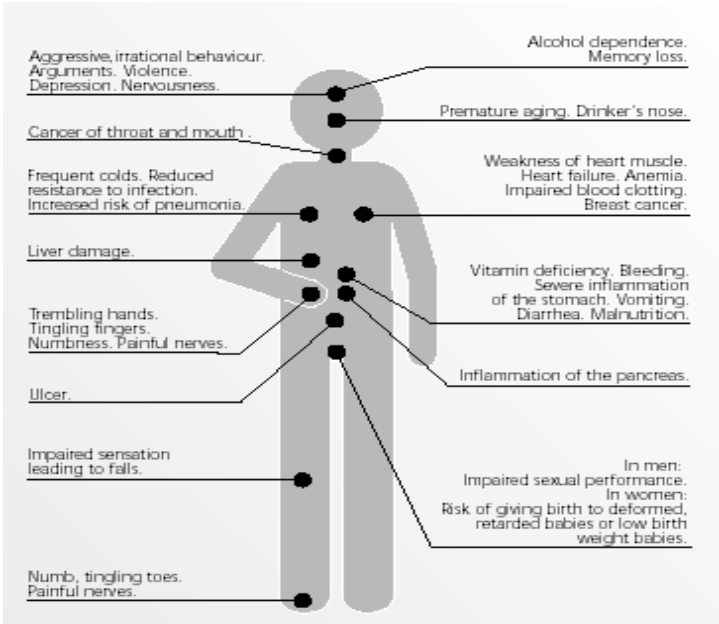
Effects of High-Risk Drinking



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Diabetes and Alcohol use

- Alcohol lowers blood sugar when consumed on an empty stomach – insulin goes into overdrive
- Always check blood sugar before drinking and always eat when drinking
- Discuss if and how to safely include alcohol into your meal plan.

www.healthgrades.com Medical Reviewer: William C. Lloyd III, MD, FACS. Last Review Date: Feb 23, 2016

Sample of medications in which excessive alcohol use is contraindicated:

Antibiotics
Antidepressants
Antihistamines
Barbiturates
Benzodiazepines
Histamine H2 receptor agonists
Muscle relaxants
Nonopioid pain medications and anti-inflammatory agents
Opioids
Warfarin

http://pubs.niaaa.nih.gov/publications/Medicine/Harmful_Interactions.pdf
NIH Publication No. 13–5329
Published 2003, Revised 2014

Marijuana and Mental Health

If a person already has a genetic predisposition…

1 time use	1.2x increased risk for **schizophrenia**
50+ times used	6.7x increased risk for **schizophrenia**
Weekly use	2x increased risk for **depression & anxiety**
Daily use	5x increased risk for **depression & anxiety**

Lynskey, Arch Gen Psychiatry, 2004; Patton, British Medical Journal, 2002; Zammit, BMJ, 2002; Degenhardt, Addiction. 2012

Chronic Pain & Mood Connection

- Depression lowers pain threshold
- Anxiety increases muscle tension
- May lead to activity avoidance
- Increased use of pain relievers

Other Substances: How Does a Care Manager Help?

- Be mindful of stigmatizing language
- Discuss substance use in terms of health
- Harm reduction
- Expectations: Improved function rather than reduced pain
- Relaxation, breathing, mindfullness
- Community support programs/treatment/MAT

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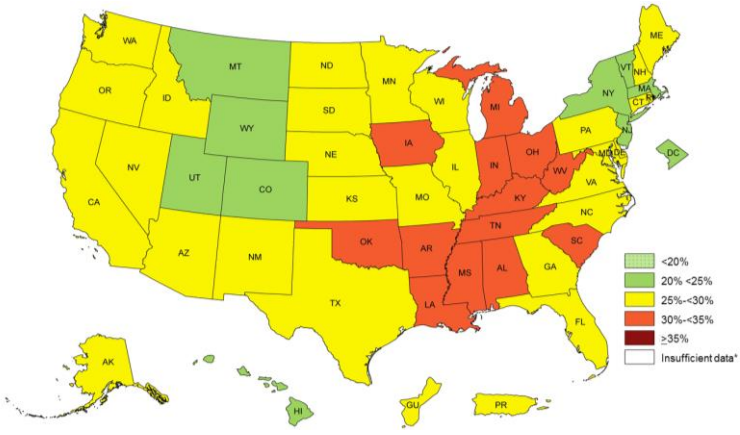
Prevalence[1] of Self-Reported Obesity Among U.S. Adults by State and Territory, BRFSS, 2012

[1] Prevalence estimates reflect BRFSS methodological changes started in 2011. These estimates should not be compared to prevalence estimates before 2011.



CDC

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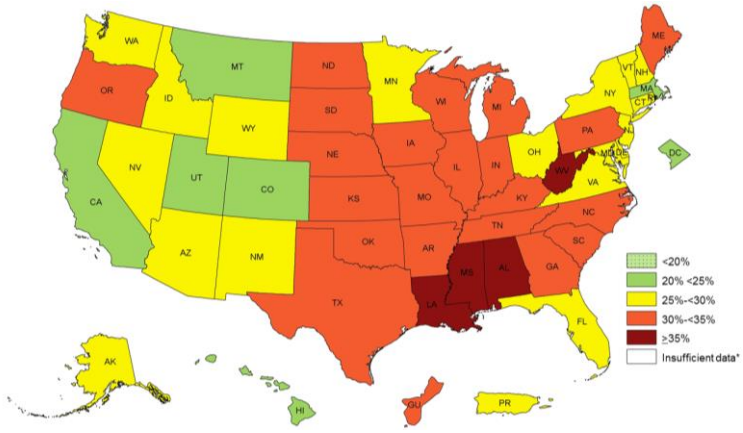

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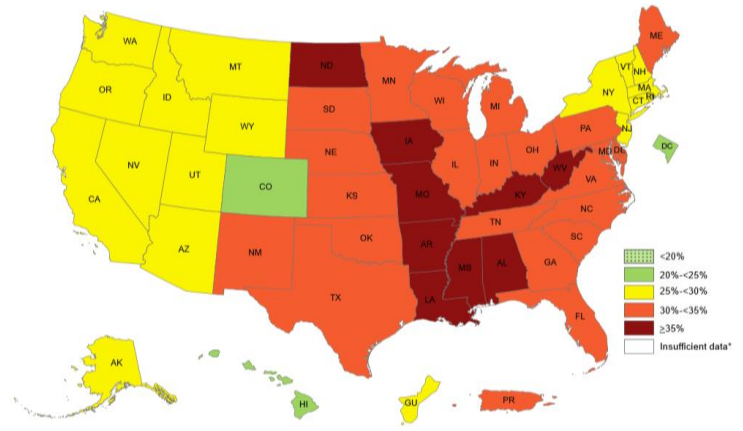

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Obesity and Serious Mental Illnesses

- Prevalence: >42% (vs. 28% gen pop)
- 3-6X greater risk of metabolic syndrome
- 1 yr weight gain w/atypical antipsychotics can range 2-15 lbs
  - "Weight gain associated with drugs for psychosis is not usually dose-dependent, so dose reduction will not be effective in reducing weight. Simon 2009 J Clin Psychiatry
- Compared to the general population:
  - Fewer fruits and vegetables
  - More calories and saturated fats

www.uconnruddcenter.org

Nutrition: How Does a Care Manager Help?

- Shop with people at food banks
- Joint cooking projects with healthy food.
- Reach out to local extension services
- Participate in/start a community garden
- Use peer support staff as educators about healthy eating on a budget
- Serve healthy food at organizational events
- Explore cultural importance, relevance, connections

Over the last 50 years we **slowly forgot** the importance of a healthy lifestyle **because** there is so much that can be done through medication and surgeries and other interventions. - John Duperly, MD

Physical activity has the ability to prevent or manage chronic disease in a way that **no pill or other intervention** does. – Adrian Hutber, PhD

Even when physicians promote exercise to a patient, they might not know **how** to provide specific advice or **what** community resources might be available for support. Health Affairs, Sept 2015

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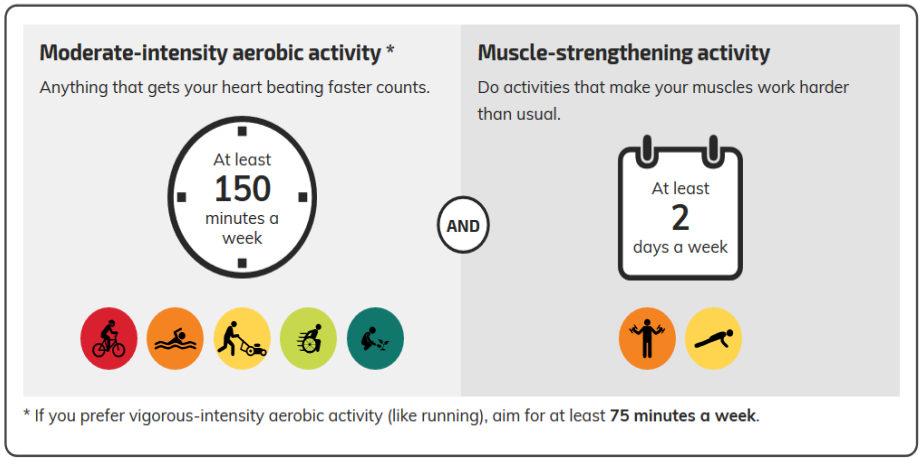
How much activity do adults need?

https://health.gov/moveyourway/



- Any amount of physical activity has health benefits
- Move more, sit less

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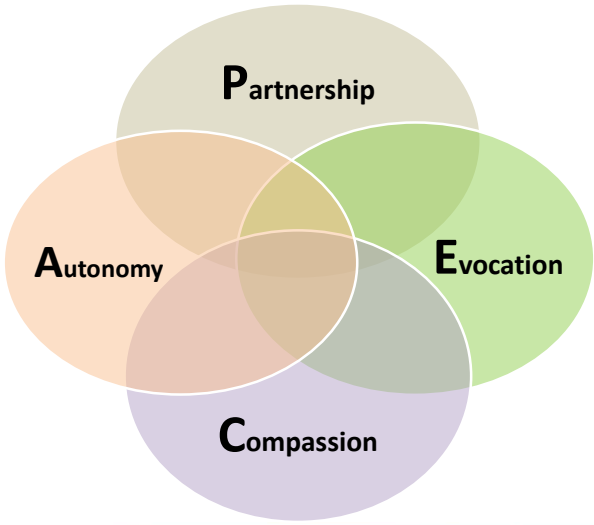
Physical Activity: How Does a Care Manager Help?

- Walk while talking
- Staff/participant walking competitions with pedometers
- Create walking "tracks" in your building
- Incorporate chair exercise into groups
- Form partnerships with local fitness centers, community exercise to reduce loneliness
- In home exercises: climbing stairs, walking in place etc.
- Not viewing exercise as exercise

Motivational interviewing (MI)
is a collaborative conversation style
for strengthening a person's own
motivation and commitment to change.

Miller & Rollnick, 2012

The Spirit of Motivational Interviewing



Open-Ended Questions to Elicit Change Talk

- What would need to happen for you to want to make a change? (**D**esire)
- How would you do it if you decided? (**A**bility)
- What are the three best reasons? (**R**eason)
- What's most important to you? (**N**eed)

Affirmations & Reflective Listening

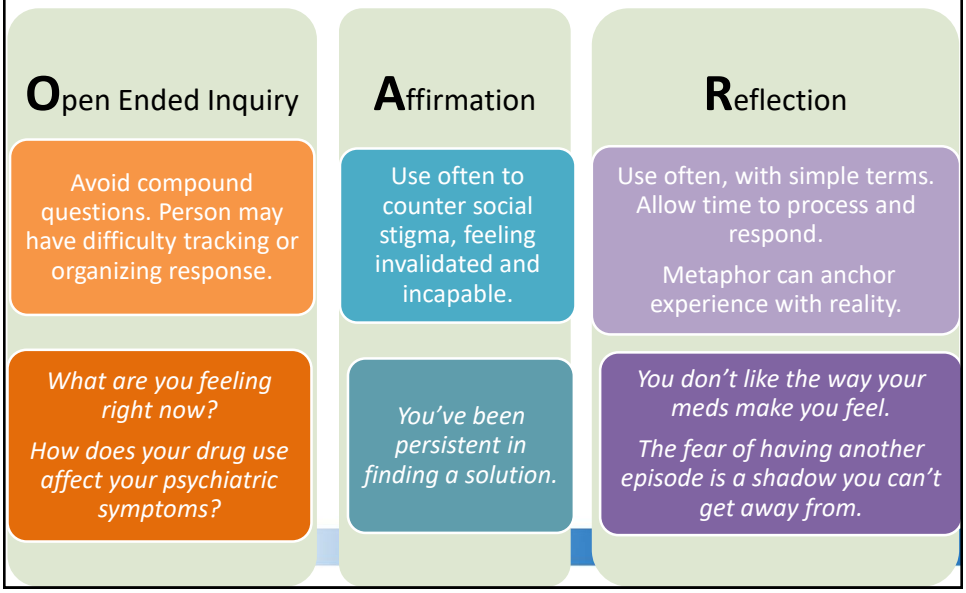
- What you hear, what you observe
- Genuine, direct reinforcements
- Demonstrates understanding

Cognitive Impairments and Disordered Thinking

- Attention & concentration
- Short term memory
- Organizing information
- Paranoia
- Veering from logical pathways

Dual Diagnosis Motivational Interviewing (DDMI)

Martino 2002 J Subst Abuse Treat



MI Success Factors for Med Adherence in Clients with Schizophrenia

Dobber 2018 BMC Psychiatry

- **Trusting relationship:** Empathy, acceptance and understanding. Client allowed to tell their story and express their ambivalence.
- **Ability to adapt to client:** Open ended questions & reflections rather than forcing facts and ignoring client's perception. Express both sides of ambivalence.
- **Link goals with change:** Reflect stated goals & values AND client's willingness/ability to change for them.

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The Core of Care Management: Authentic Relationships

Grinberg 2016 Population Health Management

Security	• Reliable home visits • Attentive and present
Genuineness	• Interest in me as a person not just a patient • Empathic curiosity
Continuity	• Contact frequency • Follow up • Relationship and trust

What engages people right away is when we can meet their most immediate/important need

Developing Your Action Plan

Based on what you heard today what concrete next step will you (or you as a team) take in the next 30 days to extend what you have been doing in supporting whole health and wellness in a care management framework?

1. One change we want to make	
2. What will be different when we do this	
3. Specific steps	
4. When we will check back in with each other	
5. Who will hold us accountable to this change	

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In times of change, learners inherit the Earth, while the learned find themselves beautifully equipped to deal with a world that no longer exists.

- Eric Hoffer

Thank you for the work you do!

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