Health Management Strategies For Recovery

The Role of Care Management and Care Coordination

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Components of Our HMSR Project

- On-Site Primary Care
- Nurse Care Management
- Medical Case Management
- Peer Health Mentoring
- Diabetes Education
- Ten Week Illness Management Curriculum
- Community Health Education Lectures
- Nutrition Education

The Health Care Team

- Nurse Care Managers are employed at each of the three sites and serve as the liaison between the client and the treatment team; both internal and external providers. They provide direct care and health consultation to the clients, as well as overseeing and supporting their Wellness Plan.
- The PBHCI Project Coordinator is responsible for the coordination, implementation and expansion of the project across the three BH sites and is the liaison between CommuniCare agencies and the FQHC.
- Primary Care APRN from the FQHC offers screening, treatment and follow-up medical services to consumers at each of the agencies.
- Medical Case Managers from the FQHC provides comprehensive case management services to each client enrolled in the program and work closely with the health care team AND external providers.
- Medical Directors from each of the BH agencies AND the FQHC provide supervision and leadership support on the project. In addition, they facilitate and/or serve as speakers in community forums.
- A licensed Dietician / Nutritionist, whose career has been focused on individuals with SPMI, provides both staff and consumer education, individual consultation to clients and serves as a group co-facilitator for the nutritional sessions.
- Diabetes Educator to provide group and individual consultation to those at-risk or diagnosed.
- Peer Health Mentors are embedded at each BH site and have an integral role on the Health Care Team. They support consumers in their recovery goals and provide advocacy, education and case management. They are trained in the HMSR Group Curriculum and subsequently serve as co-facilitators in designated sessions.
- Behavioral Health Clinicians and Case Managers are core to the Health Care Team. Through training and education on primary care services and the HMSR model, they incorporate health and wellness interventions into their everyday work with individual clients.

Enrollment and Activity Data

Target	Year One- Ending Sept. 30, 2010	Year Two- Ending Sept. 30, 2011	Year Three- Second quarter ending March 31, 2012
Total health screenings	250	567 (cumulatively) 317 new screenings	728
Total enrolled in primary care	129	336 207 new patients	445
Total enrolled in wellness activities (peer health mentoring, 10-week wellness curriculum and/or health education)	66	282 216 new wellness participants	381
Total service linkages (specialty care referrals, weight loss, smoking cessation)	245	405 160 new service linkages	475

Preliminary Results and Outcomes

Co-Morbidity Data

- A sample of 175 enrollees with baseline and follow-up primary care visits were assessed for changes in Body Mass Index. A total of 44 (25%) either maintained (in the normal BMI category) or improved their BMI status.
- A sample of 213 primary care enrollees were assessed on changes in blood pressure. Out of the 35 in the stage I hypertensive group (diastolic blood pressure > 90 & <100, systolic blood pressure (>140 & <160), 7 (or 20%) converted to normal blood pressure status. Seventeen (48.5%) converted to prehypertensive status (<140/90). All 9 enrollees diagnosed with stage II hypertension (>160/100) converted to either the prehypertensive (4) or hypertensive stage I (5).
- There is still not enough data to assess changes in cholesterol or glucose levels.

Essential Functions of the Nurse Care Managers

- Conducts Initial Health Screenings
- Processes All Registration Paperwork and Makes Initial Appointment with PC Provider
- Collaborates With Peer Health Mentor to Initiate Periodic Reassessments
- Develops Wellness Plans for Each Enrollee
- Collaborates with Medical Case Manager to ensure Smooth Continuity of Care
- Assists With Management of Primary Care Schedule
- Collaborates With External Primary Care Providers

Care Coordination in the Context of a Team

- Regular discussions about more acute and complex clinical cases with the primary care team
- Routing of patient issues- nurse care manager to medical case manager to APRN (medication refills, medical concerns, insurance authorization issues)
- Team meetings to refine process – scheduling, referrals, self-pay patients…
- Case conferences

Tools to Assist in Assuring Continuity of Care

- Customized screens in the electronic record system that document vitals and progress for each follow-up visit
- Customized screens in the electronic health record system that document all primary care visits including medical diagnoses, lab results and medications
- Paper primary care exam notes integrated into the behavioral health client chart for each visit
- Regular communication with the medical case manager and behavioral health clinicians

Vision for Nurse Care Management in the Behavioral Health Setting

- More intensive care management focused on medical and behavioral health stabilization
- Team meetings with behavioral health clinicians and prescribers to assure smooth continuity of care
- Exchange of pertinent medical information with outside providers
- Conduct health screenings and follow-up visits to track progress
- Create and follow-up with wellness goals-encourage participation in wellness activities