



# *SAMHSA-HRSA Center for Integrated Health Solutions*

## **Chronic Disease Self-Management**

Lessons from the Field

# Presenters

## **Mary Moran LPC, MHSP**

WellConnect Health Home

PBHCI Project Director

Director of Integrated Care Centerstone of Tennessee

## **Jai E. Taylor MA Ed**

Wellness Coordinator

WellConnect Health Home Centerstone of Tennessee

## **Donald B. Williams, Jr. MA Ed**

Peer Wellness Coach

My Health, My Choice, My Life Centerstone of Tennessee

## **Centerstone of Tennessee**

Founded six decades ago, we provide a wide range of behavioral health services to 50,000 people of all ages annually. Centerstone operates more than 50 facilities and has more than 160 partnership locations across Middle Tennessee.

Focused on whole-person health, we provide psychiatric services; individual, marriage, family and group counseling; crisis services; intervention services; school-based and foster care support services; peer support services; life coaching; and integrated primary care.

# Centerstone and Unity Medical Clinic

Unity Physician Partners and Centerstone Health Partners, a subsidiary of Centerstone, joined forces to improve patient care and enhance the quality of healthcare.

The organizations formed a joint venture that cares for patients with physical and behavioral healthcare needs by establishing integrated care clinics. In Tennessee there are four integrated clinics located in the Nashville and Clarksville communities.

## **Centerstone of Tennessee's Integration Model**

Awarded Primary Behavioral Health Care Integration grant (PBHCI), SAMHSA, CMS funding October 2012; CARF accredited as a Behavioral Health Home in May 2015

### **Components:**

- Health Screening requested annually for all behavioral health clients
- Care coordination, care management and wellness coaching is offered to individuals with chronic conditions who receive behavioral health and primary care services at the integrated clinic

## **Why we decided to offer a Chronic Disease Self-Management Program**

Centerstone participates in *My Health, My Choice, My Life* program. Funded by the Tennessee Department of Mental Health through a federal grant, they provide individuals with self-directed tools, empowering them with the knowledge, resiliency and resources to improve their overall well-being and live purposeful lives. They use the Chronic Disease Self-Management Program (CDSMP) and Diabetes Self-Management Program (DSMP) + Peer Wellness coaching with high success.

<http://www.myhealthmychoicemylife.org/>

WellConnect, our PBHCI program, understood our enrollees would need wellness coaching to improve health outcomes and we knew this model had proven success.

# Our CDSM Program: Planning Process

**Who was involved in the planning?** The entire PBHCI team + *My Health, My Choice, My Life* staff; sought input from others as needed

**How often did the planning team meet?** Several weeks and then ongoing as needed

**What decisions had to be made?** How to get staff trained on EBT's, where to do it and be effective, with who, what resources did we need; Launched in group home

**What did we decide?** Start small use existing staff, don't wait

**What CDSM model did we select?** CDSM, DSM, Wellbody, Tobacco Free, NewR and WHAM

**How we identified the high priority population to engage?** Groups target individuals based on chronic conditions if possible, anyone enrolled in PBHCI grant is eligible.

**Which clients were you most interested in engaging?**

Those whose chronic conditions can improve with self-management

# Our CDSM Program: Implementation Process

## Who was involved in delivering the service?

WellConnect (PBHCI staff) Registered Nurse and Wellness Coaches and *My Health My Life My Choice* Peer Wellness Coach

## What knowledge and skills were needed to implement the program?

Understanding effects of chronic health conditions including Diabetes, Hypertension, High Cholesterol, smoking and being overweight and the impact on health. Training on an EBT's available.

## How were the group facilitators educated about the CDSM model and what CDSM model did you select?

*My Health My Life My Choice* trained facilitators in many EBT's, we were able to train entire team in Wellbody, CDSMP/DSM and Tobacco Free because of availability of master trainers in our state.



## **Chronic Disease Self-Management Program**

- Chronic Disease Self-Management Program (CDSMP) and Diabetes Self-Management Program (DSMP) were developed by the Stanford University Patient Education Center
- Implemented widely by the Administration on Aging, the Center for Disease; a lay-led participant education.
- Based on the principle that confident, knowledgeable individuals practicing self-management will be empowered to live a life of purpose and well-being.
- **Web Site:**  
<http://patienteducation.stanford.edu/programs/cdsmp.html>

## **The CDSM Program: Description of the program**

### **Content:**

- Participants are adults experiencing chronic health conditions; their family members, friends and caregivers can also participate.
- The program provides information and teaches practical skills on managing chronic health problems.
- Six workshops assist individuals in gaining and developing the knowledge, skills, and motivation they need to manage the day-to-day realities of their physical and mental health symptoms.

## **The CDSM Program: Description of the program Group Content**

**Session 1:** Action Plan, Workshop Overview/Homework

**Session 2:** Action Plan, Difficult Emotions

**Session 3:** Action Plan, Decisions to be Made, Food and Physical Activity Journal

**Session 4:** Action Plan, My Plate, Food and Physical Activity Journal

**Session 5:** Action Plan, Healthy Eating Guidelines, Medication Log, Food and Physical Activity Journal

**Session 6:** Action Plan

## **The CDSM Program: Description of the program Engagement**

**How were clients informed and invited to participate?** For groups, WellConnect (PBHCI) staff determine who might be interested in group, select location based on interest.

**Where and when was the CDSM program offered?** At a group home and at the integrated care clinics, (Peer centers also offer Wellness Groups through My Health, My Life My Choice but not to individuals who are receive integrated care)

**Who extends the invitation?** All individual are offered group and individual Wellness Coaching at enrollment and whenever a need arise or new group starts. We currently have 60+ individuals enrolled in individual Wellness Coaching; currently we are recruiting for groups. Groups have not been as well attended as we would like.

## **The CDSM Program: Description of the program Structure and Process**

**Who leads groups?** Most Wellness Coaches have experience personally or as a family member of living with a chronic health conditions. They are certified in the EBT they provide. CDSMP/DSMP requires two leaders.

**How often did the group meet?** Weekly for 6 weeks; 2.5 hours for CDSM/DSP closed group; other interventions 1 hour 6 weeks open group

**Prior to enrollment:** Establish baseline health status, current weight and BMI, CO level, blood pressure

**Is individual follow up part of the program?** Yes, individual wellness coaching and care coordination

**CDSM session process:** Follow-up from previous week action plan, break and low cost healthy snack planned by group, develop action plan for next week

# Evaluation and Use of Health Data

**Use of Health Information:** Use health information to inform development of groups and target individuals with similar health conditions

**Current evaluation used:** Monitoring biomarkers and NOMS/CDI for long term outcomes at 6 month intervals; comparing results to others who did not participate in Wellness Coaching

**Future Considerations:** Comparing outcomes for those enrolled in individual and group Wellness coaching to learn what is most effective; compare by EBT used

# Lessons Learned

## Challenges in implementing a CDSM program:

Finding and keeping qualified staff, initially trained fewer staff; resignations put our group Wellness Coaching on hold- now training all WellConnect staff as opportunities arise..

Participant preference for individual Wellness Coaching

## CDSM approach: What worked well and not so well

Structure of CDSP/DSM groups a challenge; groups are closed and are 2.5 hours long; currently offering Wellbody and Tobacco Free as alternatives For those who engage the results are very positive.

Found it helpful to offer individual coaching after group or if they drop out

## Client response to the CDSM program

Very positive even for those who don't complete group; response to serving healthy snacks is very positive

## **Final message and tips for organizations considering implementing a CDSM program**

- Delivering service with credentialed providers insures long-term funding stream
- Understand additional long term costs: CDSMP/DSMP requires a Stanford license, include initial cost of training and cost of maintaining certified workforce
- Be flexible- We have difficulty in engaging individuals in groups, have taken principles and done education individually
- Including individual wellness coaching is essential to maintaining gains for many individuals
- Collaborate with other Wellness initiatives in the community; we were able to build on the success of our Peer Centers and utilize TDMH funding to train our staff





# *SAMHSA-HRSA Center for Integrated Health Solutions*

## **Chronic Disease Self-Management Lessons from the Field** Center for Human Development Massachusetts

# Presenters

Judy Mazel, LCSW, Care Manager in Springfield, MA

Julia Polansky, LICSW, Care Manager in Holyoke, MA

Nancy Landry, Certified Peer Specialist working in both sites

# The Center For Human Development (CHD)

- over 70 programs, providing services to those just beginning in life to those struggling with aging issues, as well as people with mental illness, addictions, poverty, delinquency, developmental disabilities,
- Over 1400 employees in Western Massachusetts and Connecticut;
- In 2014, over 18,000 persons served by CHD

## **Our Primary care and Behavioral Health Integration Model**

Care Managers are located in the behavioral health clinics in Holyoke and Springfield; the Springfield site includes the day treatment program for the SMI population;

Both sites have their partnering FQHC provider present on site one day weekly providing medical care to the program enrollees

Care Managers access the FQHC EMR

## **Why we decided to explore offering a Chronic Disease Self-Management Program?**

- Aligned with the aims and purpose of integrated care
- Many of our clients with SMI have comorbidities including diabetes, obesity, hyperlipidemia, COPD, asthma, symptoms of GI distress, and many with chronic pain;
- Many are heavy tobacco users
- Nutrition/eating habits are poor, good nutrition knowledge is lacking
- Stress levels are high!

# Our CDSM Program: Planning

## The Planning Process

- Care Managers responsible for implementing the groups  
Email is the primary method of communication  
Most important logistic: location/day/time and work from there
- Stanford Chronic Disease Model is our training
- Going over caseloads, targeting people who expressed an interest in group work/educational offerings, people who were “frequent flyers” to the agency, talking to the NP and the CHD program/clinic nurses about possible attendees

# Our CDSM Program: Implementation

- The Implementation Process

Care Managers partnered with nursing staff and community residential staff to run the groups (need 2 leaders to run group)

- All leaders are CDSMP trained and are expected to lead groups once trained
- Flyers, word of mouth, consulting with NP and nursing staff, talking with direct care/residential staff
- All groups have been hosted at the CHD sites with the exception of one group held at our local NAMI office for NAMI staff
- The group leaders were responsible for securing attendees

## **The CDSM Program: Description of the structure, process and content and the program.**

- Group meets for 6 weeks for 2.5 hours same day/time  
CDSM offered periodically
- We have not provided any post-group follow-up
- You need a lot of wall space to hang 26 charts!
- Provide snacks
- We followed the Stanford CDSM model start to finish
- Be mindful of the time---it passes quickly!



# Key Elements of the CDSM Model

Topics covered: Mind/Body Connection; Action Planning, Problem-Solving; Dealing with Difficult Emotions; Physical Activity/Exercise; Making Decisions; Pain & Fatigue Management; Relaxation Techniques; Healthy Eating, Medication & Symptom Management

How we monitored progress? If you had challenges, what were they? Took HI's quarterly; Informal check-in with clients when we saw them

# Findings and Lessons Learned

- Having a manual that is more appropriate for the population we are working with;
- Perhaps specialty groups based on functioning level;
- We need to think more about follow up to see if any long-term benefit to people who participate
- Action Planning is a great tool!

# Findings and Lessons Learned

- Client engagement is critical- need for consistent and reliable attendance;
- Adaptations are needed to the classic Stanford Model
  - There is a lot of material to cover each week--full fidelity is difficult with the SMI population;
- Brainstorming, Paired Exercises, Action Planning
- Very Positive Client Response to the program
- Group facilitators Mostly positive

# Final message and tip for organizations considering implementing a CDSM program

Plan ahead! Re supplies, Leader/Co-leader; If able, over enroll so you have enough people attending

One person to corral people to group so you can start on time;

Keeping to the script can be a challenge;

Watch the clock so you complete each week's section!

Important to have 6 consecutive weeks-it breaks up the momentum and cohesion of the group if interrupted

**Poll Question: What best describes how valuable the Innovation Community has been for your organization. (Valuable information, tools, resources)**

- A. Very valuable**
- B. Valuable**
- C. Moderately valuable**
- D. Not valuable**

# Let's Chat

For the next webinar, I am inviting members of the CDSM Innovation Community to share their progress and any positive steps towards introducing one or more elements of a CDSM approach.

Please type in your name and organization if you would like to contribute your efforts.

This webinar will focus on what was practical and useful.

## For the Month of July

Dr. Salerno will continue to reach out to members and set up an individual consultation call. 60 % of members have had a call so far.

Next webinar July 30<sup>th</sup>- All Member contributions