

# Disease Management:

*Strategies for Success*

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**Tara Crawford & Natalie Fornelli**





# Why is there a Disease Management Program?

- What is Disease Management?
- Whole Person Approach
- Rehabilitation
  - Individualized/Person Centered
- Lewin Study
- Premature Mortality Rates

# Outcomes

- Cost Savings
- Health Outcomes
- Success Stories
- Trend Reports



# DM Survey Results

- Similarities
- Creativity
- Strengths
- Areas for Improvement





# Function in the Agency

- Separate DM Team
- Only addition is the outreach worker
  - Peer Specialist/MRSS-P
  - Client Volunteer
- Use existing team members
- Hybrid Teams

# Function in the Agency: Hybrid Teams

- BJC Behavioral Health & Family Guidance Center
- Bridgeway
- Community Treatment Inc. (COMTREA)
- Places for People



# Getting the most out of Cyber Access

- Address
- Pharmacy
- Primary Care Physician
- Health Home
- Hospitals
- CMHC
- Ambulance
- Home Health Provider
- Specialists



# Use of Cyber Access Information: Prior to Enrollment

- Preparation for Outreach
- Personalize Engagement Efforts
- Prioritization
  - Medical Need/Risk
  - Medicaid Costs\*
- Assessment





# Use of Cyber Access Information: After Enrollment

- Medicaid & Social Security
- Monitor client's health
  - Medication Adherence/Patterns
  - Major Medical Events
  - Use with consumer
- Care Coordination



# Cyber Access: Coordinating Care

- Identify Gaps
  - Drug Interactions
  - Patterns
  - Appropriate Procedures
  - Specialists and referrals
  - Coordinating care between providers

# Use of Cyber Access for/during Treatment

- Establishing Treatment Plans Goals
- Keeping up with medication list
- Continuity of Care Document

Healthy  
Living





# DM Hospital Certification Reports

- Limitations
- Actions taken:
  - Engage *and* enroll while hospitalized
  - Engage through agency's Hospital Liaisons
  - Coordinate with social workers to engage consumer
  - Determine client's interest through social worker
  - Social workers refer patients to agency for follow up
  - Visit consumer at hospital to engage
  - Outreach/engage consumer via telephone while hospitalized
  - Follow up with consumer via phone call or home visit after discharge
  - Contact Information



# Report use Examples

- **Family Guidance Center:** The LPN and CSS check the diagnosis column to determine if the hospitalization was due to mental health or physical health issues.
  - LPN will outreach if physical health
  - CSS will outreach if mental health
- **Places for People:** Reviews report weekly to prioritize, strategize outreach efforts.
- **Pathways:** Set up appointment to become a part of the hospital discharge aftercare plan.



# Report use Examples

- **ReDiscover:** Compare DM hospital lists to DM outreach lists.
  - Outreach case manager visits hospital the same day.
  - Talk to the hospital staff and involved parties while you are at the hospital with the client.
- **Bootheel:** Provide a personalized list of available services.
  - Client is more likely to agree to engagement from understanding specific ways services will benefit him/her.
  - Especially beneficial to clients who have refused or dropped out of services in the past.
- **SEMO:** Client has been difficult to locate.
  - Contact the hospital and speak to his/her nurse or doctor to find out what happened and what orders he/she will be given.
  - Speak to the client about how our agency could assist them.



# Outreach Methods: Steps

Prioritize List

Develop profiles

Develop welcome letters/packets

- Contact Person & Number
- Self addressed envelope
- Agency information/Brochure
- Consent to Treatment
- Release of Information
- Interest of Services Form

# Outreach Methods: Steps

- Assign Outreach Days & Outreach workers
  - Geography
  - Best team member to outreach
    - Personality
    - Knowledge
- Research
  - Contact/Locate



# Outreach Methods: Steps

- Send welcome letter
- Phone Calls
- Field Visits
  - Home
  - Hospital
  - Primary Care Physician
  - Community Providers
  - Public Service Agencies





# Example Efforts

- If not home, leave informational packets and contact information
- Leave list of resources that agency would be able to link the client with
- 24/7 call back number-Preferred Family Healthcare
- Personal Care Package-Lafayette House



# Example Efforts

- Places for People
  - Engage pharmacy to assist in engagement
  - Provide multiple options
  - Engage with multiple community providers
  - All consumers screened for DM status
- Bootheel
  - Preparation for initial direct contact
- Preferred Family Healthcare

# Detective Work



- *Cyber Access*
- *Emomed*
- *CIMOR*
- *EMR*
- *Casenet*
- *MO DOC Offender Search*
- *Local newspaper*
- *Facebook*
- *Google*
- *Twitter*
- *White Pages or phone book*
- *Mobile Patrol*
- *DFS/FSD*
- *Local Police Dept.*
- *Post Office-good for p.o. boxes*
- *Mobile Patrol*
- *Mapquest/GPS*
- *Google earth*
- *City or county Maps*
- *Friends*
- *Family*
- *Neighbors*
- *Landlords*
- *Mailperson*
- *whoever happens to be outside at time of visit, etc...*
- *Sex Offenders Registry*

RESEARCH

# Research/More Detective Work

- Hospitals
- PCPs
  - Call
  - In Person
  - Letter
  - Meet with client at appointment
- Jail
- Pharmacies
  - Call
  - In Person
  - Letter



# Training

- Minimal Training should include:
  - All agency staff
    - Overview-should know background
    - Understand Roles (what to do if determine consumer is DM 3700)
  - Direct treatment
    - Overview
    - Outreach/Engagement
      - Motivation Strategies
      - Communication Skills
      - Cyber Access
      - Locating individuals (utilize resources)
      - Outreach Toolkit
      - Essential Learning Recommendations-wellness website
      - Mortality & Morbidity of BH population
  - Outreach Worker
    - Investigating
    - Safety



# CSS Training

- DM overview
  - History
  - Eligibility
  - HCH if applicable
- Cyber Access
- Care Coordination
- Wellness Coaching





# Training Outline: Additional Ideas

- **TMC:** Each member of the DM 3700 team has a binder with information explaining the initiative and letters for clients and providers.
- **Places for People:** Training focuses on staff using personal skills and strengths to engage clients in ways that are most comfortable to the staff person.
- **Crider:** Builds in competency components for wellness coaching and motivational interviewing.

# Nurse's Role

- Medical evaluation/health screening
- Help develop treatment goals
- Metabolic Screenings
- Medication





# Nurse's Role

- Training
- Improve Health Literacy
- Educational Sessions
  - Individual/groups
- Links to Resources
  - Patient assistance programs
- Make Referrals

# Nurse's Role: Agency Examples

- Attend appointments
- Outreach
- Consult during the outreach process
- Coordinate care other health providers



# Engaging the Resistant

- Persistence and accountability
- Get to know your clients
- Get as many contacts as you can
- Outreach method



# Engaging the Resistant

- Timing & Flexibility
- Build Trust
- Build Rapport
- Support Self Efficacy



# Engaging the Resistant

- Team Approach vs Consistency
- Cost and Intent of program
- Holistic & Person Centered Care





# Engaging the Resistant: Places for People

1) individuals reluctant to start services

- Bad experiences, fear
- Informal approach, goal not to say NO
- Begin to build trust

2) individuals who agree to services but are hard to catch up with

- Approach-extended and constant assessment
- Learn barriers and contacts

On top of this, we work hard to make ourselves very accessible.

Providing cell phone numbers of staff, bus tickets, safe spaces, connecting to emergency housing and food pantries all can facilitate the helping relationship.

**DENIAL AIN'T JUST  
A RIVER IN EGYPT.**



**Mark Twain**

*American Author and Humorist*

(1835-1910)

*QuoteHD.com*

# Denial of Substance Use Disorders

- What do you do?
  - Introduce your services as health care
  - Include the 8 domains of wellness
  - Sell your other services (Medication services, HCH, community support)
  - Build trust



# Denial continued...

- Focus on medical issues and connecting with primary care
- Addressing housing instability
- Advocacy within the legal system
- Offer co-occurring/mental health services



# Denying SUD

- **Lafayette House:** We continue to discuss all needs of the individual and offer assistance with any of those issues the individual is willing to discuss/address.
  - Needs of children; child custody
  - Housing needs
  - Budgeting
  - Transportation
  - Clothing
  - Legal issues



# Denying SUD

- **Preferred:** Go back over and over; offer help in areas other than substance use/mental health
  - Leave packets in flower pots, inside doors, on porches, etc...
  - Unless the individual gives us a strong “no” then we revisit and encourage the person to hang onto the contact information in case they want it later.
  - We had an individual call almost 3 months after we left contact information and is now enrolled in CSTAR.

# Denying SUD

- **Burrell:** Focus on the health and wellness aspects of the client's life initially.
- Then...focus on areas that seem to be less threatening than their substance use issues
  - Filling out simple forms
  - Assist with getting basic needs met via resources- food, clothing for the kids, school supplies, legal aid, transportation
- Once further rapport has been established focus on identifying other needs then point those back to underlying issues which could be addressed with a counselor
  - Assistance in filing an order of protection, weight management, tobacco use, self-esteem issues, depression



# Remember...

- Goal of Outreach is to Enroll
  - Enroll ASAP
    - Brief Evaluation/30 Day Extension
- Care Coordination
  - Transfers
- Key reasons for engagement

# Example Dialogues

- Handout #1 - Example dialogues with consumer on DM outreach list
- Handout #2 - Example dialogues with other health care providers



# Questions?

[Tara.Crawford@dmh.mo.gov](mailto:Tara.Crawford@dmh.mo.gov)

[Natalie.Fornelli@dmh.mo.gov](mailto:Natalie.Fornelli@dmh.mo.gov)



