

“We Already Do That”

Emerging Best Practices in Moving from Case Management to Care Management

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Objectives

1. Participants will be able to identify the similarities and differences between Case Management and Care Management.
2. Participants will be able to identify three emerging best practices for care managers in behavioral health organizations.
3. Participants will be able to identify staff training needs and supervision strategies that foster ongoing learning and sustainability

What is the Difference?

Sam is 30 years old, has bipolar disorder and IDDM, a foot sore and is at high risk for an amputation

How would a case manager and a care manager handle this differently... or would they?



Contrasts

Case Manager	Care Manager
Might go along to a doctor's appointment	Sees their role as an active partner with physical health, knows not only PCP but endocrinologist, Diabetic nurse education
	Actively engages the person about how they manage their diabetes because they have training Knows what they believe and fear related to their PH challenges
Takes the person grocery shopping	Works with the person at the grocery store to implement recommendations related to diet
Knows from the assessment that the person has diabetes but focuses on BH issues in planning	Actively engages the person about diabetes and how it connects to other issues, uses MI to support health behavior change
	Uses community resources to support management
	Supervision focuses on expanding the knowledge of both and interconnectedness

The WHY Behind the Change?

Critical Health Disparities

Individuals with Serious and Persistent Mental Illness are dying approximately 25 years earlier than the general population largely of preventable health conditions

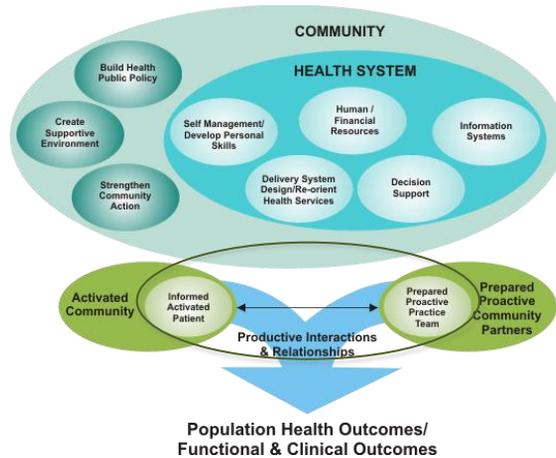
What we have been doing isn't working...



10 Emerging Best Practices



1. Health Problems Occur Within a Community System



Created by: Victoria Barr, Sylvia Robinson, Brenda Martin-Link, Lisa Underhill, Anita Drotts & Darlene Ravensdale (2002). Adapted from Glasgow, R., Orleans, C., Wagner, E., Curry S., Solberg, L. (2001). *Does the chronic care model also serve as a template for improving prevention?* *The Milbank Quarterly*, 79(4), 579–612, and The World Health Organization, Health and Welfare Canada and Canadian Public Health Association (1986). Ottawa Charter of Health Promotion.

2. Building Partnerships with Primary Care is Absolutely Critical!



- Understanding Cultural Differences
- Strategies for Building Partnerships
- Supporting people with PCP visits through preparation

Strategize, train and supervise—do it all over again

3. Knowledge of Chronic Medical Conditions is Key

Most Common Physical Health Problems
for Individuals with SPMI



- Metabolic Syndrome
- Diabetes
- Cardiovascular Disease
- Obesity
- Stress

4. Creating Opportunities Where There Were None Before

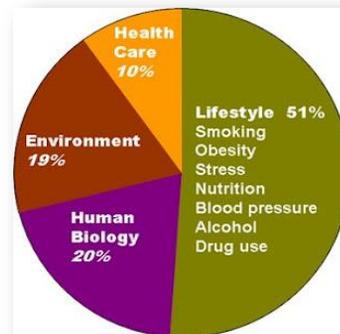
You can't make a change you don't know about or can't see



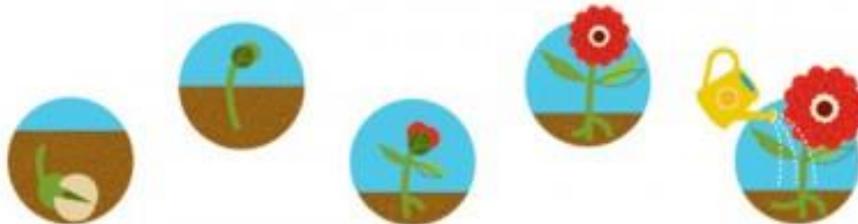
5. Developing Self Management Expertise is Essential: Learn Key Strategies for Promoting Health Behavior Change

Applying Motivational Interviewing to:

- Smoking Cessation
- Promoting Healthy Eating
- Increasing Exercise



6. Using Stage Wise Interventions Organizationally and in Individual Work



7. Real Goal Setting Connected to the Person's Hopes and Dreams



Writing IMPACT goals into Care Plans

- Improve
- Measurable
- Positively Stated
- Achievable
- Calls Forth Actions
- Time Limited

8. The Multi-Disciplinary Team is Key

*We train, hire and pay doctors to be cowboys. But it's pit crews we need...
To function this way, however, you must cultivate certain skills which are
uncommon in practice and often not taught. -- Atul Gawande*

- Develop the team
- Support the team
- Include nursing on the team



9. Supervise Toward the Practice Changes You Want to See



- Knowledge
- Skills
- Attitude

10. Build On What You Have, Expand to What You Need

