Living Well, Living Longer

Working together for better health in people living with mental illness

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Summary

- Context
- Establishment of Living Well Living Longer Programme
- ccCHiP Metabolic Clinics
- Community Strategies
- Strategies to Support the Programme

Why Living Well?

Life expectancy in people living with significant and enduring mental illness is 15-25+ years less than the general population.

Most early death is due to cardiovascular and metabolic disease.

People living with mental illness are less likely to be screened and treated for physical health problems than the general population.

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Local Context

- 2 busy inpatient units focussed on rapid stabilisation of inpatients' mental health and maintaining patient flow
- 5 Community Health Centres with 3,500 people under care coordination managing contemporary level activity with 1980s level resources
- ccCHiP metabolic clinic for Concord inpatients

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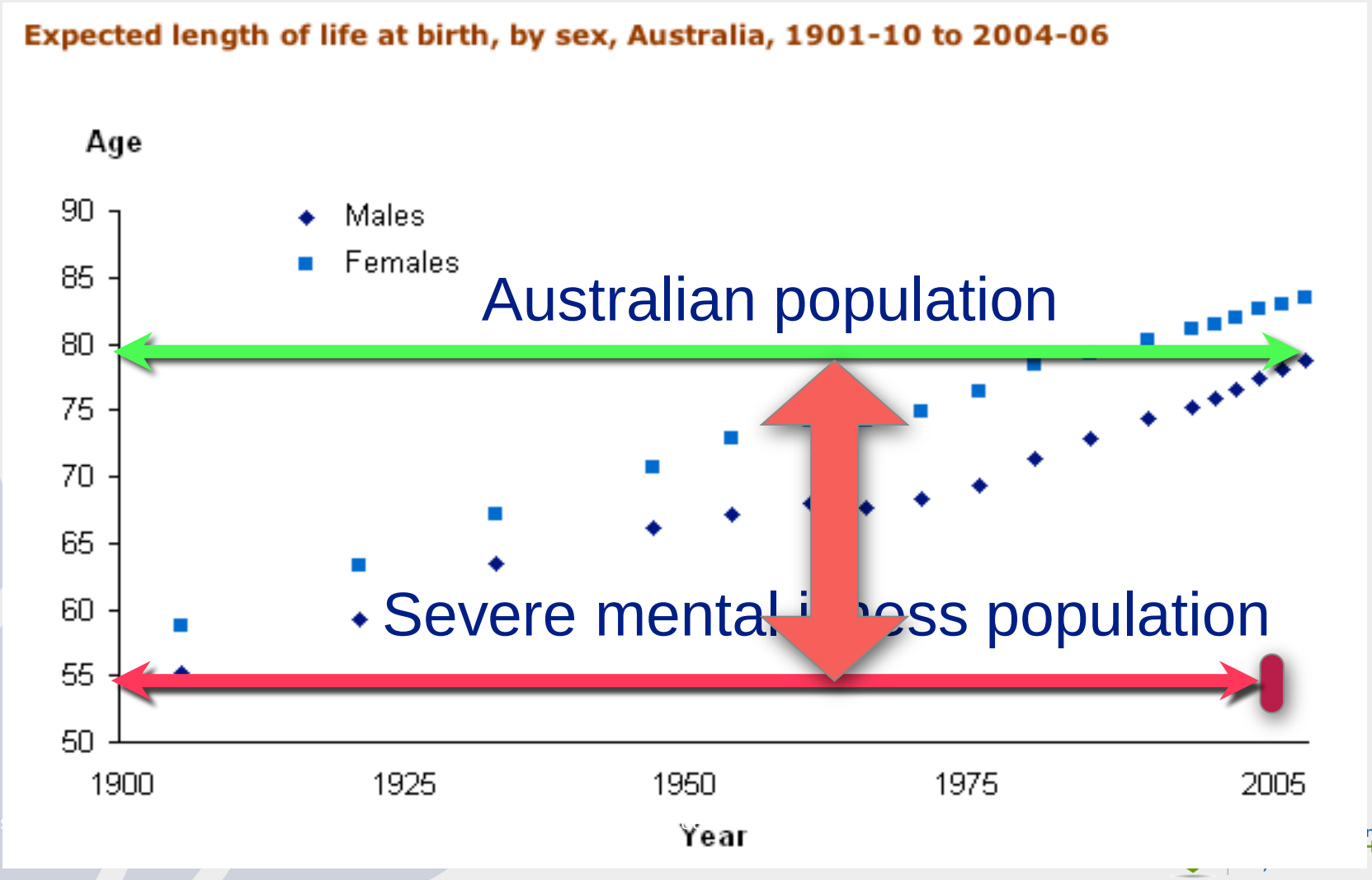
Life Expectancy Gap



Sources

Living Well, Living Longer Programme

- District-wide approach to improve access to health care and health outcomes for mental health consumers.
- Steering Committee:
  - Co-chaired by Dr Teresa Anderson, CE and Sue Sacker, Deputy CEO, Schizophrenia Fellowship of NSW.
  - Consumer and carer representatives
  - NGO, primary care and research partners
  - Clinical specialties such as cardiology and endocrinology, oral health, education, and mental health.

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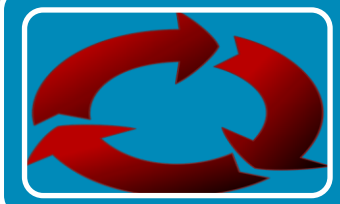
Guiding Framework

Consumers are less likely to receive metabolic screening

Diagnostic overshadowing: Symptoms attributed to mental illness

Less intensive/appropriate treatments offered e.g. in cardiac disease



Follow up is often missed / reactive approach to care

Stretch Targets

Year 1	• Service planning
Year 2	• 20% of consumers in Assertive Outreach and Early Intervention at Level 4
Year 3	• 40% of consumers at Level 4
Year 4	• 60% of consumers at Level 4
Year 5	• 80% of consumers at Level 4

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Expanded ccCHIP Clinic

One-stop specialist review of cardiometabolic health:

- Psychopharmocology review
- Cardiology assessment and investigations
- Endocrinology review
- Dietetics & Exercise physiology assessments
- Dental assessment
- Sleep screen

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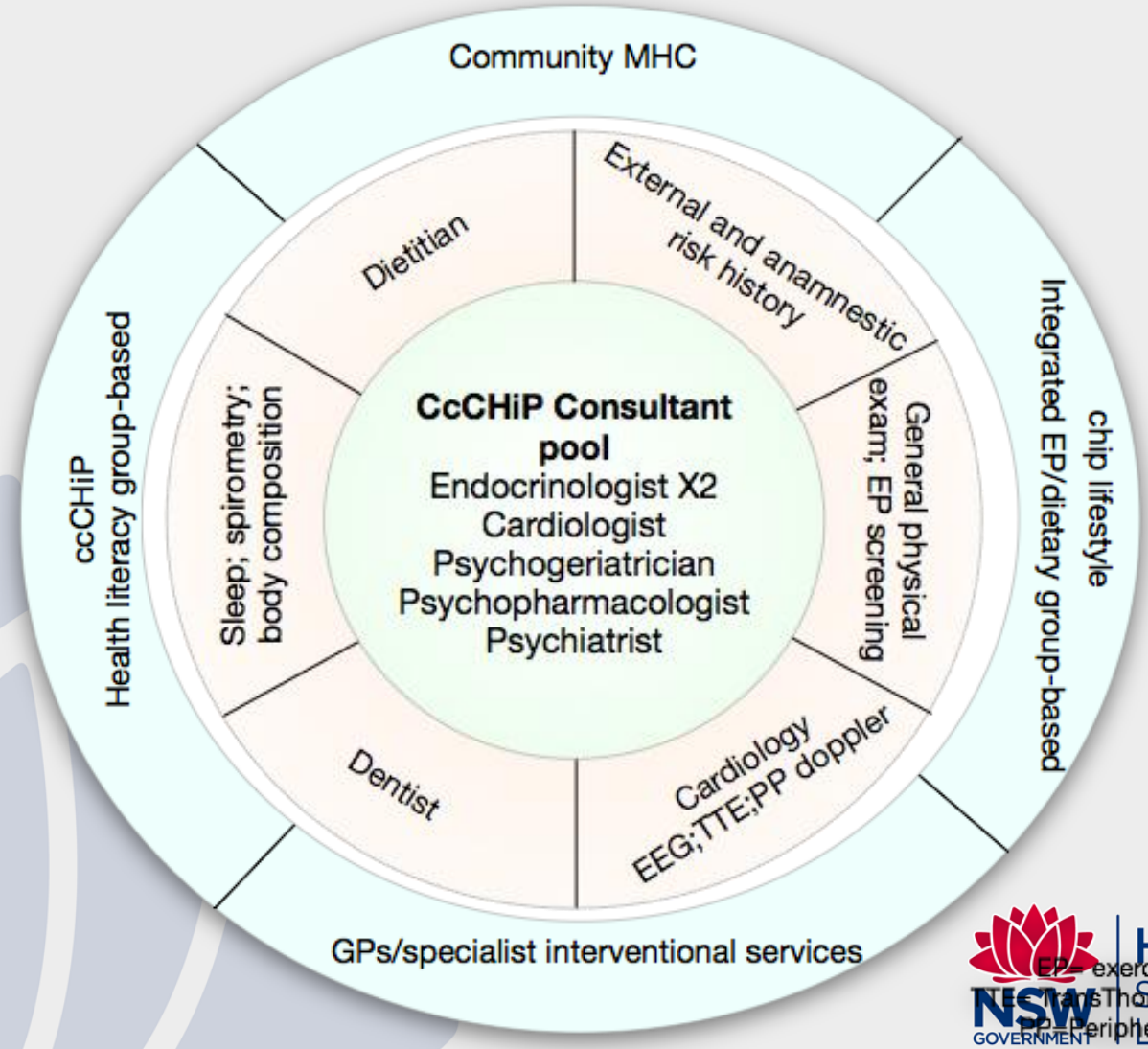
Multimodal clinic structure



EP- exercise physiologist
TTE- TransThoracic Echocardiogram
PP- Peripheral pulse doppler

ccCHIP Clinics

Collaborative Centre for Cardiometabolic Health in Psychosis

- Outpatient clinic started at Concord Medical Centre, May 2014
- Initial target consumers under Community MH team care
- Expanded to Charles Perkins Centre, Aug 2015 – GP referrals
- 300 attendances since inception.
- Target 250 attendances per year
- Detailed reports for GPs and community teams
- Access to exercise physiology groups
- Supported by Health Pathway

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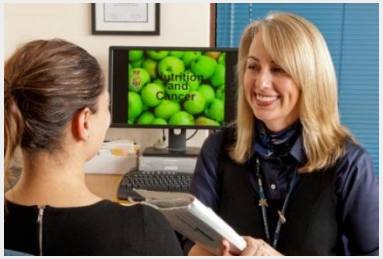
Ongoing Management

- NSW Health policy stipulates physical exams on initial contact and yearly
- Medical staffing challenge → not feasible
- Forms sent to GPs → not successful
- The challenge – how does the Mental Health Service better engage Primary Care?
- Initial focus on teams providing intensive input – Early intervention in Psychosis, Assertive Outreach

Collaboration with Primary Care



- Primary care forms the linchpin to health care in Australia.
- People living with mental illness attend GPs more often than the gen pop, but less likely to receive screening and preventative medicine.
- Expanding on partnership with Inner West Sydney Medicare Local – GP Co-location clinics, GP shared care
- Enrolled in Agency for Clinical Innovation Clinical Redesign programme

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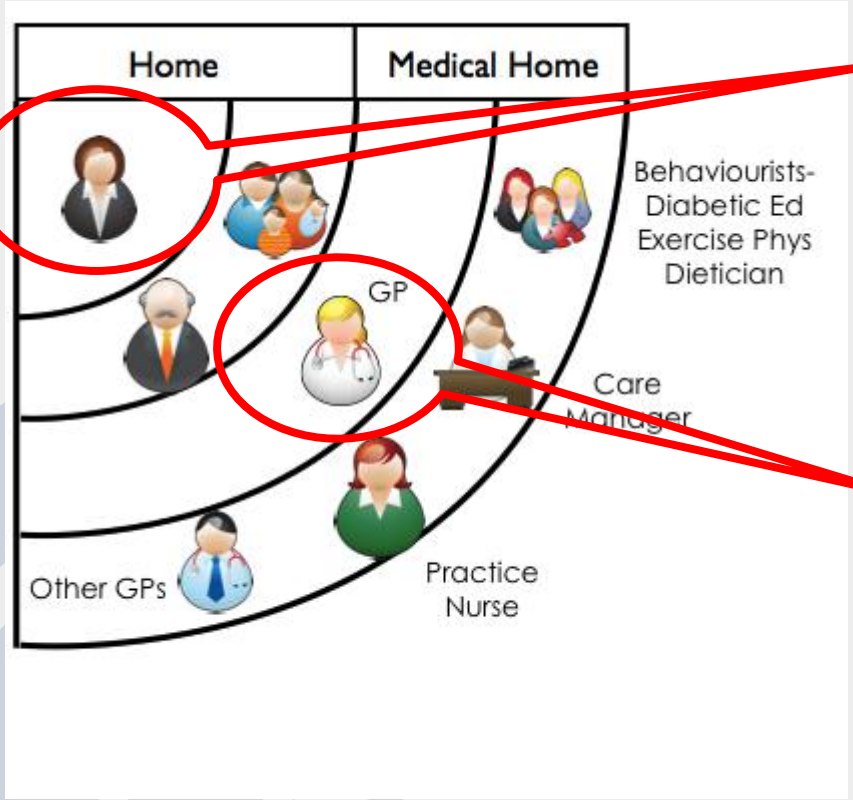
Why Collaborative Care?
Patient-Centred Medical Home



22% of consumers have annual health check: reactive engagement in health care

62% of consumers report having a GP

Some visit multiple GPs

Australian Centre for the Medical Home (medicalhome.org.au)

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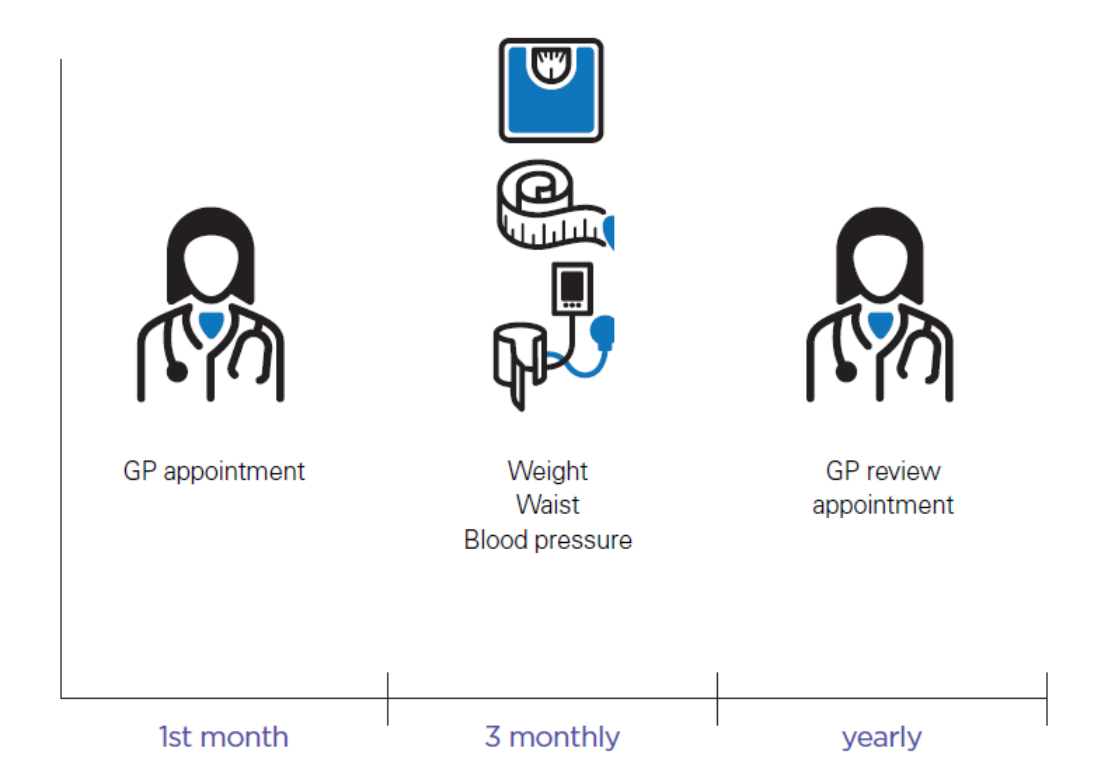
Collaborative Care Consumer Journey



Collaborative Care Checklist

Action	GP	Care Coordinator	Psychiatrist
Obs: Blood pressure, waist, weight (3-monthly)		X	
Order/review annual blood tests			
Scripts – physical health meds			
Scripts – mental health meds			
Order and review blood levels (e.g. lithium)			
ccCHIP or other cardiometabolic clinic referral			
Routine cardiac test (ECG) if indicated			
Clozapine ECG/ echo and blood levels		X	X
Other:			

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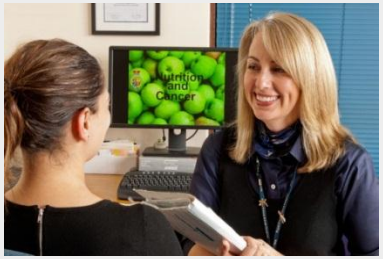
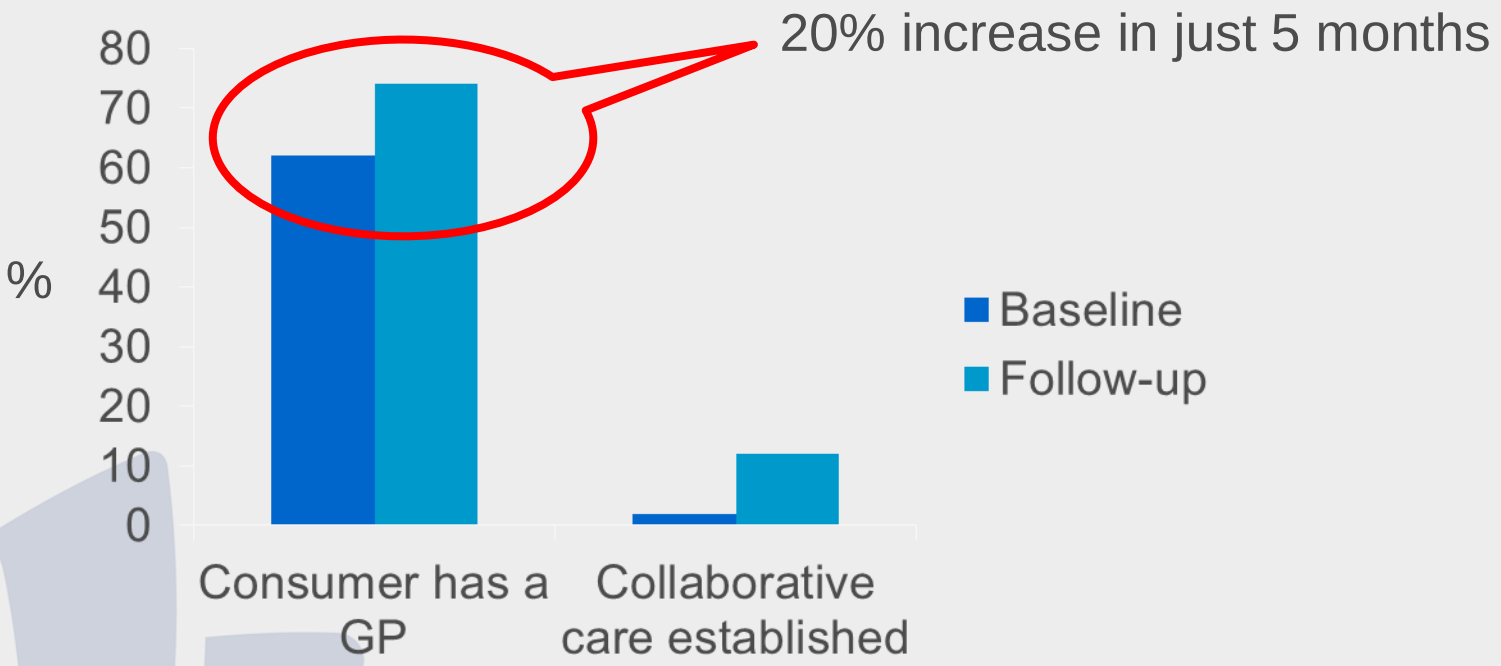
Preliminary Results





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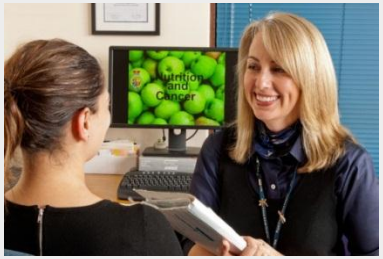

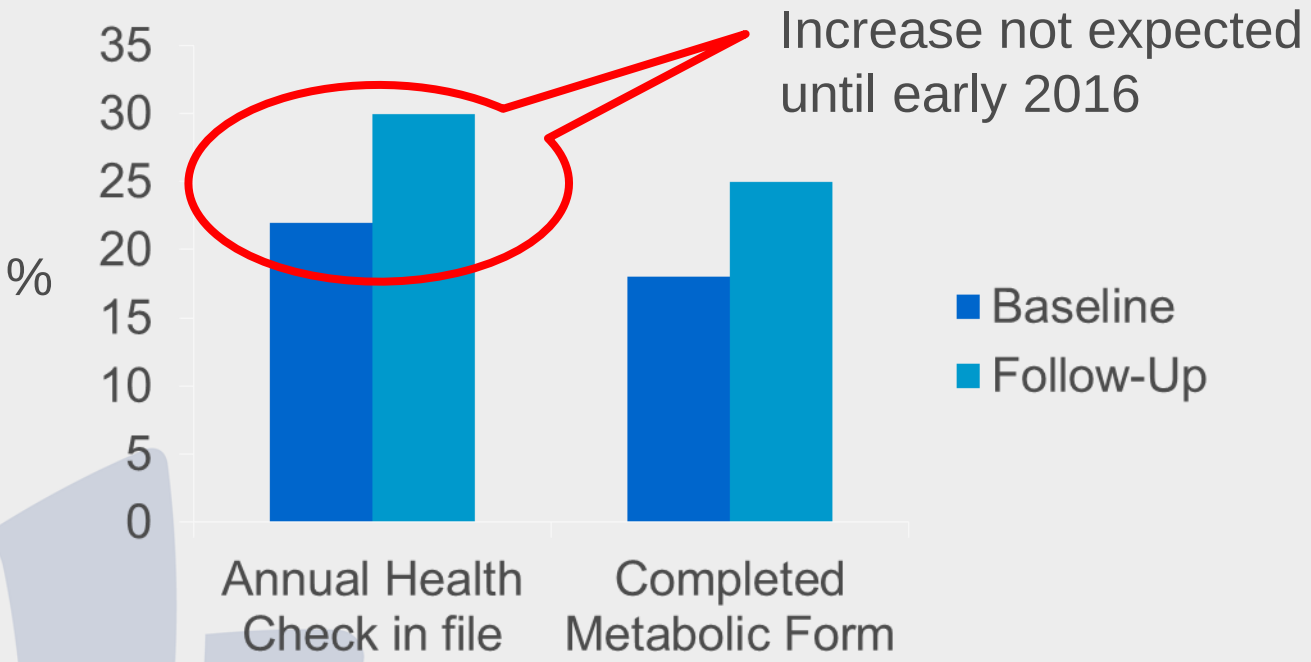

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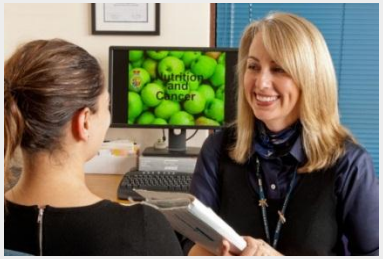
Collaborative Care: Next Steps



- Comprehensive evaluation including consumer, GP and staff feedback.
- Embed checklist in GP Management Plan: expanding utility of joint visits
- Co-location: exploring Mental Health in-reach into general practices
- Transition to PHN provides opportunity to leverage new ideas and expand the reach of new models of care.

Rollout to all Community teams

- Shift of focus - mental and physical health as equal priorities, care coordinators of all disciplines taking primary responsibility, and mandating of metabolic monitoring
- Key features of guidelines
  - Promoting GP engagement
  - Routine metabolic monitoring
  - Referral to ccCHIP
- Changes in practice and culture

Annual Cycle of Physical Health Monitoring

Month 1

- Baseline observations
- GP connection
- Ask client to obtain GP physical health screen

3-monthly

- Physical health observations in metabolic monitoring form (MMF)
- Escalate abnormal findings as per protocol

Yearly

- GP health check, and update GP details on file
- ccCHiP assessment/review
- Blood test for MMF

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Implementation Strategy

- Team based training in metabolic observations
- Standardised and high quality equipment
- Escalation Strategy for abnormal blood pressure using Metabolic Monitoring form parameters

Strategies to Support the Programme

- Peer Workers
- Diet, exercise and smoking cessation
- Mobile App

Supported by NSW Health Integrated Care Planning and Innovation Fund ‘innovator’ grant

- Monitoring of Critical Incidents – Mortality Review

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Peer Support: driving consumer-led care

- NSW Health Integrated Care funding received for Four Peer Support Worker positions for 2 years
- Model of care and professional networks developed in collaboration with Partners in Recovery and Schizophrenia Fellowship .
- Camperdown and Croydon Community MH Core Teams
- Working individually with consumers for ~3 months, to:
  - Connect consumers with their preferred GP
  - Identify health goals (e.g. being more active)
  - Commence healthy eating, exercise, and/or other activities.

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Peer Support

- New staff commenced in Aug/Sept.
- Currently connected with ~30 consumers:
  - Going on a walk with consumers to assist in getting active
  - Exploring healthy eating options, on their weekly shop
  - Referral to community-based activities such as the Brightside programme
- Ongoing training, including Cert IV in mental health peer work
- Core Team workforce development to support understanding of and engagement with peer worker roles

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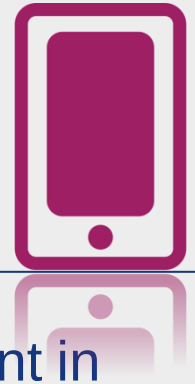
Diet, exercise and smoking cessation

- Community Mental Health and ccCHiP exercise physiologists & dietitians.
- Individual & group activities

- Focus on metabolic syndrome, malnutrition, and clients who are motivated to change.
- Tobacco treatment clinics within Drug Health

Motivation: Mobile App



- Developing an ios app to support consumer engagement in healthy lifestyles:
  - Lifestyle (exercise, diet, sleep, smoking),
  - GP connections
  - Personal access to health indicators currently kept in medical records (blood pressure, weight and waist)

Mortality Review

- Current process for review of critical incidents focuses on misadventure.
- However, around half of client deaths are due to natural causes.
- Mortality review working group established to collect, collate and review information on deaths by natural causes.
- Recommendations and patterns to inform future service design and delivery.

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Summary

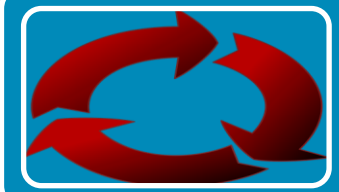
GP Registration

Metabolic Monitoring

ccCHiP Clinic Assessment

GP Collaborative Care Planning

Exercise/ Diet/ Smoking cessation



Annual GP health review

Peer Support Workers

Thank you

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