The Lewin Group
Providing Navigation Services for Clients with Serious Mental Illness
And Chronic Physical Health Conditions
August 28, 2017
2:00 p.m. EDT

Alana Nur: Good afternoon everyone, and thank you for joining us today for our webinar on Providing Navigation Services for Clients with Serious Mental Illness and Chronic Physical Health Conditions. This is the second webinar in a series of two webinars on Navigation Services. The first webinar on Assessing Organizational Ability to Provide Navigation Services was held last week and a recording will be available soon.

Today's webinar is going to be interactive with 45 minutes of presenter-led discussion, followed by 15 minutes of presenter and participant discussion. There will be an opportunity for questions and answers at the end of the webinar, so please submit your questions to us using the Chat function throughout the webinar. A copy of the slides and a recording of the presentation will be made available at https://resourcesforintegratedcare.com/.

The Centers for Medicare and Medicaid Services is accredited by the International Association for Continuing Education and Training (IACET). The Centers for Medicare and Medicaid Services complies with the ANSI/IACET Standard, which is recognized internationally as a standard of excellence in instructional practices. As a result of this accreditation, the Centers for Medicare and Medicaid Services is authorized to issue the IACET CEU.

To earn continuing education credit for this webinar, complete the post-test through the Centers for Medicare and Medicaid Services Learning Management System and score 80% or higher by midnight on September 18, 2017. More information is available on https://resourcesforintegratedcare.com/.

The Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare and Medicaid Services (CMS) ensures that beneficiaries enrolled in Medicare and Medicaid have access to seamless, high-quality healthcare that includes the full range of covered services in both programs. To support providers in their efforts to deliver more integrated, coordinated care to Medicare-Medicaid enrollees, MMCO is developing technical assistance and actionable tools based on successful innovations and care models, such as this webinar.

This webinar is developed by the Lewin Group and hosted by the Medicare-Medicaid Coordination Office, and Resources for Integrated Care, or RIC. My name is Alana Nur, and I am a Federal Health and Human Services Consultant at the Lewin Group, and I will be helping facilitate our webinar today. I'd like to take a moment to introduce our four speakers for today.

Dr. Alice Geis is the Director of Integrated Health at Trilogy Behavioral Healthcare, a community mental health center in Chicago. She is an Assistant Professor at Rush University where she teaches in the Master's and Doctoral Programs. She is Board Certified as a Psychiatric Mental Health Nurse Practitioner with Doctoral Preparation and Systems Leadership Nursing. She has held a number of clinical, administrative, academic and consulting roles, including

director of a hospital-based psychiatric homecare program, a member of the United Nations Team investigating war crimes in the former Yugoslavia and Program Development Consultant.

Kimberly Smathers has been employed by the Lewin Group, a healthcare and human services consulting firm, since May 2013 as a Federal Health and Human Services Managing Consultant. From 2008 to 2013, she was employed as Vice President of Business Development at Heartland Health Centers, a Chicago area federally qualified health center. Ms. Smathers leads efforts to support behavioral health organizations and providers in delivering behavioral health and other health services under the technical assistance to support providers and providing care to Medicare/Medicaid enrollees contracted with the Medicare-Medicaid Coordination Office at the Centers for Medicare and Medicaid Services.

Laurie Carrier is Board Certified in both family medicine and psychiatry. She is currently the Chief Medical Officer at Heartland Health Centers, a collection of federally qualified health centers based in schools, mental health centers and the community on the north side of Chicago. Previous to this she was the Director of Behavioral and Integrated Health since 2012. She works with an underserved population, including a large percentage of refugee and immigrant patients. She is an Assistant Professor at Northwestern University Feinberg School of Medicine in the Department of Family and Community Medicine. Dr. Carrier's interests lie primarily in the integration of medicine in psychiatry, and she is thrilled at the opportunity to work in several different settings where this is taking place.

TJ Thurlow is a community integrated health nurse at Trilogy Behavioral Healthcare and Rush University College of Nursing Office of Faculty Practice. TJ graduated with a Master's Degree in Nursing from Rush University. He has worked on an Assertive Community Treatment Team. During that time, he created tools for tracking and monitoring a variety of health parameters for his caseload, including tracking coordination of care, referrals and educational needs. Currently, he works as a clinic-based integrated health nurse assisting with team consultations, triage of behavioral and physical health concerns, group education services and coordination of care for clients.

To provide a brief overview of our presentation today, we will start out with a few polls, which I will get to in a moment. Alice Geis will provide an overview of Navigation Services, and Kimberly Smathers will review RIC's Navigation Tip Sheets. Laurie Carrier will present on Navigating Care for Clients with Serious Mental Illness and Chronic Physical Health Conditions. TJ Thurlow will share Best Practices for Providing Navigation Services for Clients from his on-the-ground perspective. We will then move on to questions and answers.

To provide an overview of the Learning Objectives for today, after today's webinar you will be able to identify key functions and services that navigators can provide; identify tangible steps to support individuals with Serious Mental Illness and Chronic Physical Health Conditions; and recognize ways to facilitate conversations with clients using RIC navigation Tip Sheets to manage chronic conditions as well as mental illness.

At this time, I'll turn the presentation over to Dr. Geis. Alice, please go ahead.

Alice Geis: Hi, I'm Alice Geis and thanks for joining the webinar. I look forward to your questions and comments at the end. What exactly are the key functions and services of Navigation? What is it that we expect navigators to do? Competencies should include these things.

Supporting linkages; with providers, yes, but also transportation, housing, food necessities. Modeling advocacy in coordination of care; this might mean doing the needed coordination, or teaching the client or other staff strategies for doing it. Good illness self-management requires both knowledge and self-advocacy skills. The Tip Sheets you'll hear about later are one example of how basic information can be communicated to clients at an appropriate level.

The need for more intensive communication is necessary when working with a vulnerable population in a sometimes fragmented health system. Navigators need to be able to do this. Lastly, navigators provide wellness and health promotion services.

One note about wellness, while we include this in our discussion of Navigation, it's fundamentally different from the other tasks of Navigation in that it involves treatment. However, historically these treatments are ones that have received limited or no reimbursement making them inaccessible to most people. I'm talking about weight management, smoking cessation, training and safe exercise regimens.

We'll talk later about who does which piece of Navigation. Wellness services look different depending on the level of the person providing it. Undergirding all of this work is the need to be able to develop and maintain positive working relationships with clients.

Why is it important to have the capacity to offer Navigation Services to people with a Serious Mental Illness, who also have long-term medical illnesses? Many individuals, including people with SMI, are members of vulnerable client populations and need assistance with Navigation. This might be due to symptoms impacting endurance, cognition, or affect regulation.

System issues which make the need for Navigation more pressing include our increasingly complex delivery system and other barriers to integrated and coordinated care. When thinking specifically about people with SMI, the importance is magnified by the high rates of medical and substance use comorbidities, and the high incidents of premature death due to modifiable risk factors.

We also need to align with the recovery model and client-centered care principles, as these have become central to our work. Take the example of tobacco dependence. Tobacco kills half its users across the world, and smoking rates are higher in the SMI population. Or, consider what we've learned from the ACE Study, the Adverse Childhood Experiences Study and follow-up work to that. Our clients tend to have histories of trauma. A person with an ACE score of 4 is 260% more likely to have COPD than a person with an ACE score of 0.

For those of you who attended the initial webinar in these series, you would have been doing some thinking about your organization and how well it supports the process of helping clients

navigate healthcare. We talked then about how certain things are necessary in order to support such services.

While it isn't the focus of today's presentation, I want to just mention some of these factors, the prerequisites for great Navigation Services, if you will. You need system support for Navigation, leadership, resources including adequate financial resources and workforce and training development tools. The Navigation Organizational Assessment Tool can help you perform a self-assessment and help guide an action plan to create or improve these elements.

I can give a quick example of how system support works. We did a system-wide intervention to move to a smoke-free campus. Smoking had been allowed outside the building on agency property and banned inside for many years, but all staff as well as the client counsel were involved in this.

One of the interventions that we set up was a small area specifically for people who were trying to quit smoking to meet with staff individually or in groups. This was named the "Cessation Station." There was a dedicated phone line to the Illinois Quit Line. We had a countdown to smoke-free campus stay in the lobby, a free Smoking Cessation group offered onsite to staff and other interventions. This couldn't have been accomplished without leadership support to involve all aspects of the organization.

Okay, so let's say you and yours understand the importance of providing healthcare and Navigation Services and you have the basic structure for doing so. What are the important elements to make sure to include in your program planning? You need to have the right people, the right tools, and the right framework to offer the best services.

Using the right people to provide the service means taking a look at your workforce. Pure Wellness coaches can accomplish many of the goals of Navigation. They do need support from providers or RNs. Integrated health nurses, sometimes referred to as care coordinators, can do an analysis of the client's Navigation needs and develop a plan which incorporates direct care needs, informational or teaching needs, health literacy and other factors which impact the client's ability to receive well-integrated services.

Social workers or care managers can use tools like Tip Sheets, which you'll be hearing about shortly, to support clients' understanding of medical comorbidities. They can provide expertise and research, resource identification, linkage to psychotherapy services and more.

One valuable outcome of quality Navigation is the prevention of overuse of providers in these activities. Some coordination of care must be done by physicians or nurse practitioners, such as consultation about the medical plan of care, but much of it can be accomplished by people at other levels. It's important to right-size and have people working to the top of their license and abilities.

Having the right tools to engage clients is important. There's a lot to choose from. TJ Thurlow will talk a little bit about some of the ones we've found useful in a bit. Sometimes they need to be

adapted to your setting, population or staff competencies. Some of the curricula or manuals are already adapted for use with people with SMI.

It's important to use evidence-based practices to the extent that they are available. These might include manualized curricula or toolkits that can be used for individual or group clinical interventions. Motivational interviewing aids are materials that educate navigators about special consideration for assisting individuals with SMI who have medical comorbidities.

Integrated treatment plans are a gold standard for working in an integrated way towards health goals, but realistically, it's not feasible in many settings for all providers as well as payor organizations that provide Navigation Services to be working from the same treatment plan. This makes having strong Navigation Services all the more important. From the peer wellness coach to the orthopedic surgeon, the more integrated the efforts on behalf of the client's health the better.

Here's an example of a couple of tools for working with clients on Smoking Cessation and links where you can find them.

We talked about getting buy-in from leadership, but having the right framework involves more than that. It involves being client-centered, really putting the person at the center of the treatment plan. Using motivational interviewing is very useful in the context of working with clients with multiple complex health problems. This framework can be used by many kinds of health navigators. It doesn't require someone credentialed at the level of a licensed psychotherapist.

Many organizations that work with people with comorbid substance use disorders as we do employ a framework of perm reduction. Some folks like to use a Prochaska & DiClemente Transtheoretical model, otherwise known as "Stages of Change." The overall approach health behavior change in a behavioral health organization must take into account the impact of psychiatric illness and a client's ability to change.

Here's an image of the Transtheoretical model. We often go over this in treatment groups and help clients place themselves on the continuum. Whether you use this model or another, it's vital to understand the client's current ability and willingness to move towards improved health in any given area.

So many factors can affect this. Rubrics and toolkits and decision trees no matter how evidence-based are only useful in the aggregate. Individuals are impacted by multiple factors that need to be taken into account. Besides the obvious, the mental and physical symptoms affecting the population we're discussing today, there are too many to be listed, but include genetics, cultural dietary habits or beliefs, cognitive ability and learning differences, health literacy levels, personal experience in the health system and trauma history. Those are just some thoughts on how you might look at the Transtheoretical model.

Now, I'll turn it back to Alana.

Alana Nur: Thank you so much, Alice. All right, next up we'll have Kimberly Smathers to describe the RIC Navigation Tip Sheets. Go ahead, Kimberly.

Kimberly Smathers: Thanks, Alana. As Dr. Geis noted, the intersection of Serious Mental Illness and physical health conditions creates unique challenges for clients and requires Navigation staff to understand standards of care for common physical health conditions, as well as the specific physical and social needs of individuals with Serious Mental Illness.

The Navigation Tip Sheets are intended to be practical and user-friendly resources that augment a navigator's understanding of the standards of care for chronic diseases that are prevalent in this population, and that also encourage consideration of specific challenges and risk factors these clients may face, support targeted strategies for clients' self-management, and lists warning signs that indicate the need to engage clinical staff.

The Navigation Tip Sheets are derived from the experiences of behavioral health clinicians, primary care clinicians and individuals with expertise in implementing Navigation Services with individuals with Serious Mental Illness. You can find the Tip Sheets in both English and Spanish at the link on the screen. They cover diabetes, hypertension, Smoking Cessation, HIV/AIDS, congestive heart failure, and asthma and COPD. We will focus on Diabetes and Smoking Cessation in particular in the remainder of today's webinar.

This is just a preview of the first page of the Smoking Cessation and Diabetes Tip Sheets to give you an idea what these look like. We will describe the content of these two Tip Sheets in more depth on the slides that follow.

The Smoking Cessation Tip Sheet provides basic information on smoking and its intersection with mental illness. The benefits of quitting are outlined, as well as potential withdrawal symptoms that might be encountered during cessation. Navigators will be able to reference key points to share with clients regarding impact to health, both on internal organs and external appearance, as well as information on the benefits of quitting even for older adults who have smoked for many years.

The Tip Sheets also link to additional resources that the navigator can use to bolster their own understanding or to share with clients. Finally, a checklist is included to support what's called the five As of Smoking Cessation, which Dr. Carrier will discuss in more depth in her section.

The Diabetes Tip Sheet provides basic information on diabetes and its intersection with mental illness, as well as background on common diabetes' symptoms and tests used for diagnosis and monitoring. Navigators will be able to reference practical tips for supporting clients, in addition to potential early warning signs that they can observe in their client interactions and, if needed, escalate the clinical staff. These might include a fruity breath smell that can be a sign of ketoacidosis, a life-threatening condition, potential behavioral changes, or issues with feet, such as noticing non-healing ulcers or infections.

The Tip Sheets also include a variety of actions for supporting clients that can be built into team workflows and referenced in preparation for client interactions. For example, the action list

includes prompts to provide support for daily glucose testing, if that's needed; to initiate regular discussions about lifestyle choices, barriers and strategies; and to provide clients with reminders for regular blood work and clinical exams.

I'll turn it over to Alana, thank you.

Alana Nur: Thank you, Kimberly. Next, Dr. Laurie Carrier will discuss Navigating Care for Clients with Serious Mental Illness and Chronic Physical Health Conditions. Laurie, please go ahead.

Laurie Carrier: Okay, thank you so much. It's important that the care team, including patient navigators have resources that support them in understanding standards of care for chronic health conditions in clients with SMI. They can address the psychological and social needs in addition to the physical needs. Also, what is important is to be able to notify and engage clinical staff when specific warning signs occur, as Kimberly mentioned in the Sheets. We'll talk about this a little bit more in diabetes.

Navigators can be particularly helpful in linking patients to the resources that will contribute to success in getting chronic conditions under control. This may include helping to shop for food, prepare meals, and get necessary equipment such as scales in heart failure, Glucometers in diabetes. It can also help in linking to exercise, complementary medicine and educational groups for added support.

Without access to the appropriate food and prep space, all the medications in the world will not help somebody's diabetes. Without electricity a nebulizer for an asthmatic is useless. Navigators can be essential in helping the SMI population and ensuring these necessary services are available for them.

In order to describe clinical utilization of Navigation Services, we decided to focus on two conditions that greatly affect the SMI population and actually contribute negatively to the other chronic conditions commonly affecting the SMI population. Today as we mentioned, we're going to focus on tobacco and diabetes, so we'll start with Smoking Cessation.

What we do know. Smoking is prevalent in the US with 44 million Americans currently smoking. When you ask them, 70% of smokers will say they're interested in quitting, but we know that only one-third actually consult a healthcare provider about quitting. If they do mention their interest to a provider, only one-third actually walk away with a prescription for pharmacotherapy, and 15% might be handed materials or offered counseling. We also know that without any external support, even people who really are motivated to quit will only be successful about 5% of the time.

Clients with SMI represent 44% of all smokers and have dependence rates up to three times that of the general population. They also suffer greater smoking-related medical illnesses and mortality, with smoking contributing to at least 50% of the deaths in these three common psychiatric conditions listed here.

There are a lot of theories on why the smoking rates are so high within the SMI population. These include biological predisposition, psychological and social reasons, but there's also research that shows that providers place quitting as a lower priority sometimes for a patient with SMI. Perhaps, there's concern about exacerbating psychiatric symptoms, or if a patient does exhibit psychiatric symptoms, preventative care measures have often taken a backseat. What we do know is that there are sometimes baseline psychiatric symptoms that will always be present, so we can't use that as an excuse not to talk about Smoking Cessation or other preventative care measures.

What we do know is that people with SMI actually want to quit as much as the general population and can successfully do so. While they do smoke at higher rates than the general population, their quit rates are actually quite close to that of the general population. With additional support and resources in place, they can be quite successful. This is really where Navigation support can be critical.

As Kimberly referenced on the Tip Sheet, the five A's for treating tobacco, these are the five A's. We expect the providers to actually do the first three at every visit. By providers I mean family physicians, and family providers as well as the psychiatric providers. No matter what the chief complaint is that day, or despite a client's current psychiatric symptoms, we do want to Ask, Advise and Assess. When we find somebody who is ready, we'll work with the health navigators on the last two A's. TJ will talk a little bit more about this later on.

We know a two-step approach is the most successful of all to Smoking Cessation. Medications help with the physical addiction, and counseling and therapy are essential to help with the behavioral change and psychological dependence.

So what works? This really can be done and reiterated by anybody working with the client. You really want all team members to be onboard. You want to provide an empathic environment, set a quit date ideally in about two to three weeks, and encourage clients to share that date with the folks around them so they can be supportive. You want to review past attempts; what worked, what didn't. Anticipate triggers or challenges in the attempt. Be culturally appropriate reflecting racial ethnic groups and cultural values.

If a patient is not ready to quit, help the patient with a smoking reduction goal. [Harm] reduction goes a long way, and if you can even reduce by a couple of cigarettes, then the next attempt for a quit is going to be that much easier. Also, it's important for a navigator to let a provider know if your client does successfully quit or cuts down considerably on their tobacco use, as it can affect the level of medication in the patient's system. Medication doses may need to be adjusted accordingly.

This slide is just to quickly note that research has shown different outcomes with different treatments for different mental illnesses. We can't treat every patient the same. It will mostly likely take a combination of pharmacological agents in conjunction with therapy to have the greatest success.

This graph shows the importance of bringing in the troops when it comes to quitting tobacco use. Unassisted were at about 5% chance, while with maximum assist this can be as high as 50%. Don't forget it is okay to try and try again. We say a relapse is not a setback, but just one step closer to a successful cessation.

We're going to talk about diabetes now. These are just some general basics about diabetes. It's a disease that affects how the body uses sugar, also known as glucose, one of the main energy sources. In Type 2 diabetes, which is what we'll focus on today, insulin that is a hormone in the body does not work well or too little exists. When glucose can no longer enter into the cells from the bloodstream, glucose levels can get too high. This can then cause serious damage to other parts of the body including the heart, kidneys, eyes and the nerves.

What are the risk factors for Type 2 diabetes? Being overweight is No. 1, but risk increases if you have any of the following: diabetes in family members; certain races and ethnicities (Native Americans, Hispanics, African-Americans and Asian Americans are all at increased risk). Also, if there's a history of gestational diabetes, hypertension, high cholesterol, vascular disease or inactive lifestyle, these are also all risk factors. Finally, unfortunately, anybody over the age of 45 is also at increased risk.

It's important to note that the medications we use to treat mental illness, particularly the cross of medications known as the atypical antipsychotics, do increase the risk of developing Type 2 diabetes. There are a lot of theories on why this is. One obvious reason is because we know it contributes to weight gain or can, but actually in 25% of cases weight gain is not present, but Type 2 diabetes can still develop. There are actually several factors at play.

While occasional diabetes can be controlled with diet alone, medications are often an important part of treatment but also have side effects. It can require regular glucose monitoring. In the case of glucose lowering agents such as insulin, it can be really high risk. It's always important to have a lot of support and education around these medications.

This is just a slide to show some examples of different agents. While there are some where daily glucose monitoring is not essential, such as Metformin, for the others that do lower glucose it's important to have a stable and reliable diet. In the event of illness or increased exercise, it's very difficult to manage without significant Navigation Services and support. You can imagine a new patient who has recently become homeless their diet's going to change. Their exercise levels are going to change, and so it could absolutely affect their medication regimen.

Just as essential with medications are the non-pharmacological treatments. This can include diet as we just spoke about, exercise, treatment of comorbid conditions (so foot changes, dilated eye exam, Smoking Cessation support very helpful). Then, immunizations they are also particular to being a diabetic. Here is where health navigators can also be particularly impactful.

There are some red flags that a navigator should alert providers or the clinical care team to. These include significant changes or trends in the glucose levels checked at home, so whether they are rising or decreasing. As Kimberly mentioned when she was talking about Tip Sheets, a fruity smell on the breath alone, or in conjunction with disorientated behavior or change in

mental status is a medical emergency for a diabetic. Client's should be encouraged to share with their provider increased urination or thirst, weight loss or fatigue as these can all be signs of worsening diabetes or underlying illness.

Other things to be aware of; diabetics are at higher risk for heart attacks. Because they are at risk for peripheral neuropathy or numbness in the feet, they might not even be aware or feel a foot ulcer. Navigators can help to look out for these and make providers aware that they occur. Finally, patients with diabetes are at a greater risk for depression. This also applies to a patient who has another mental illness already, such as schizophrenia. If depression is not addressed, it will be very hard to successfully treat the diabetes.

Now, I'm going to pass it back to Alana.

Alana Nur: Thank you so much, Laurie. Next, we'll have TJ discuss some best practices for implementing Navigation Services. TJ, please go ahead.

TJ Thurlow: Hi and thank you for joining us. I just want to touch a little bit on the role of the navigator and, specifically, my experiences being a health navigator and a nurse. Some of those items require doing assessments, either initial assessments or ongoing; participating in care planning; trying to engage with the provider and other coordination systems. Educating clients either in groups or individual therapy depending on their individual needs; reinforcement of illness self-management behaviors, making sure that they understand what needs to be done and that they're actually understanding and able to follow through and do those things. Helping manage referrals, motivational interviewing, and then, helping support them in choosing medications or understanding how to obtain their medications.

To talk a little bit about the Integrated Health Assessment, which is something that we use here with nursing, is we try and assess the key client factors here. Understanding their health literacy, their ability to tolerate groups, what their specific health goals are. One thing that we really need to focus on is identifying client strengths and deficits.

Strength is sort of an obvious definition, but deficits are anything that is going to prevent or delay a client in being able to achieve their optimal quality of life. This could be intolerance to group interventions, or an inability to read. There are a number of other things that could factor into this.

Identifying external client support systems and then the cognitive level of your client is really important. If you have somebody who has limited eyesight, or has a fourth grade education or never went to school at all, or is an immigrant and has never had any formal education in the United States, these are really important things to identify so that you can tailor your interventions to your patient.

Align your goals with your clients' motivations. This is really important to getting on the side of the clients and identifying things that they actually want to work on. While we as healthcare providers and navigators would love to see everybody quit smoking or be successful in their diabetes, sometimes that's not the client's goal. You really need to align your goals with the

client's goals and eventually if they experience some success with you and build some trust, they will come around to maybe identifying some of those things that you want to work with them on.

Evidence-based treatments are ideal, as was stated by Laurie. Delegate your responsibilities for your support. Here within our organization we have caseworkers who see clients far more frequently than we do in the clinic. Getting them to come in and support clients in the various things that they're doing; whether it be checking their glucose, making sure they're taking their meds effectively, reminding them to get to groups or making sure they have transportation to get to a support group is really helpful.

This also stems to inspiring others to action. We really want to motivate our clients through our own actions and showing them that we're really motivated to seeing what they're doing is really helpful for them to be more successful.

First, I'm going to talk a little bit about Smoking Cessation. One thing that we do after we have assessed a person with the Integrated Health Assessment is I like to use motivational interviewing. One tool that we use really commonly here is something called the Readiness Ruler, and as you can see on the slide there is a picture of one down on the lower right-hand corner.

We ask how confident they are in their ability to make a change and how important that change is to them. This helps us to sort of get to the main reason of why they're quitting. If that reason is external, like my doctor says that I could quit, we find that it's much less realistic for them to be able to achieve that goal, rather than for them finding some sort of internal motivation.

Smoking Cessation aids; identifying a support group, finding a medication that might work for them, these are really important features. These are conversations that we have with the provider and the client together as navigators.

Prescription considerations that make Smoking Cessation and getting people to be motivated in the moment that can be challenging are obtaining medications for people. Prior authorizations often miss the window of motivation for a client if they're in the office today and they say, I really want to quit smoking.

Waiting that 24 or 48 hours for a prior authorization to be processed and approved or denied can often delay somebody who has attempted quitting smoking by weeks or even months. Grants; we here use grants and other funds to obtain Nicotine Replacement Therapy and other Smoking Cessation aids in the moment so that we can get people started while we're waiting for approval from their managed care organization.

We continue to support people in their attempts to quit smoking throughout the process. Looking at people's goals and rechecking those goals is really important. Providing educational materials like the Tip Sheets stating what their symptoms are going to be, what their withdrawal symptoms are going to be, what sort of supports that they might need to be successful. Encouraging them to attend a group if they can tolerate one or are interested in doing that; engaging with their peers and their other support systems is really important.

Following practice guidelines and customizing those guidelines to fit the client's special needs are really important. Making sure that you are available for follow up; most people will attempt to quit smoking a number of times. If you can get them to like three months or so, they typically face their first real struggles with reintegrating into the parts of their social circles that often triggered smoking previously. So making sure that you really encourage them to continue to think about them being an ex-smoker and continue to celebrate those milestones with them, either months or years after they have done a successful quit that is really helpful.

Diabetes Management is the next thing that we like to discuss. Typically, on initial assessment what will happen is a provider will call and a client will get a brief assessment from their provider. They will call the navigator or myself into the clinic and it will be a conversation among myself, the provider and the client to sort of get an idea of where the client is in this moment and what they are doing, what they're willing to do and what they're willing to try.

That's where we start to individualize the care plan. Typically, I'll schedule a follow-up appointment after they have finished their appointment with their provider, so that we can do some education. It might be reviewing diet and exercise. It could be learning how to use the insulin pen for the first time, or how to check their blood sugar even.

The next step in there is to initiate any prior authorizations that are required for medication management of their diabetes. That might be anything from obtaining their Glucometer or any of their other durable medical equipment to getting a supply of medications.

Ongoing support and education; reinforcing illness self-management and encouraging them to check their blood sugar and check it often; assess their understanding of what exactly checking their blood sugar means; making sure they know what hypo and hyperglycemia signs and symptoms are so that they can assess themselves when they're out in the community and make sure that they are able to access healthcare in times of either very low or very high blood sugars, which can be medical emergencies.

Make sure that if you generate a health plan with your client and you're encouraging them to make a food log or an activity log or monitor their blood sugar in a log form, it can be really helpful to review that information. So that you can compare their blood glucose log readings to their diet and say, these days that you ate pizza for three days in a row you noticed that your blood sugars are much higher. What do you think we could do to support you in trying to manage this a little bit better? Eliciting ideas from the client is really important.

Making sure that you're referring them to resources that are important are going to be beneficial for them, be that occupational therapy for learning how to cook more healthy meals; psychoeducation; learning more about their diabetes in a group or a personal setting; and then making sure that they have resources and food stability. If you have a homeless client, making sure that they know where their food kitchens are and things like that.

I will pass this back to Alana.

Alana Nur: Thank you so much TJ. We're now going to open the floor for questions from the audience. Thank you for those who have submitted questions already. Please submit any additional questions you may have in the Chat function now and we'll get to as many of you as we can.

Let's start with a question for TJ. What tips do you have for having a good conversation with a provider and a client?

TJ Thurlow: The best tips that I have are asking a lot of questions. Make sure that when you come in that you ask the person about their diagnosis, and try and make sure it's a conversation that is very client-centered and not as much just the navigator and the provider taking and the client also being present, but not being engaged.

Alana Nur: Thank you so much, that's helpful. This could go to anyone, but maybe I'll start with you, Laurie. Are there additional considerations when clients have more than one physical condition, such as diabetes and the need to quit smoking?

Laurie Carrier: I think one of the main things is that you set goals that can address both of the chronic conditions. We're always goal setting with our patients. We're always bringing in navigators to assist in that, so if you can come up with a goal that really targets both. For example, instead of the cigarette after dinner, can you go for a walk? That's obviously going to benefit both the diabetes and it's going to benefit the Smoking Cessation goal. Trying to keep them all in the mix and thinking about how one can benefit the other, you can set one goal that helps to address more than one condition.

Alana Nur: Alice or TJ, anything else that you would add?

Alice Geis: Hi, this is Alice. Yes, I think that as the complexity increases I think we really need to monitor our clients' mental health in regards to this. A number of these medical comorbidities really constitute additional losses. These clients have already faced a lot of losses. Having a Serious Mental Illness, which often plunges them into poverty and the inability to work, sometimes family members don't understand and those relationships have been disrupted.

Quitting smoking can be a kind of loss in and of itself, if that's something that someone has used to aid and abet their social interactions. Schizophrenia, for example, causes deficits in those areas. As we pile up the medical comorbidities I think the sense of loss whether it's mobility, needing to use assistive devices, needing help from people when you really don't want it. I think we need to be mindful of this and also be mindful of the potential that past trauma is being reactivated. So that then is going to affect the pace of how you work with folks on these very important health goals. I hope that answers.

Alana Nur: Yes, absolutely. TJ, anything else you'd like to add as well?

TJ Thurlow: I think that really making sure that you're aligning your health goals and the things that you want to do with your client to their own priorities. It might be that they don't want to work on something, but you might be able to through a conversation and questions align it in

such a way that you can, like Laurie was saying, work on two health goals at the same time. With the example of like taking a walk after a meal rather than smoking a cigarette, or having that conversation about diabetes and waking and medication management.

Oftentimes, people are really motivated by reductions in medication loads, so aligning it so that you can say hey, I know you want to take less medications overall. Managing your diabetes or your smoking through exercise and through cessation is going to help you in the long run be able to obtain that goal of getting less meds.

Alana Nur: TJ, I'll keep you on the phone to ask you another question. How many patients do you generally manage and how many encounters would you say that you have per day?

TJ Thurlow: So in my typical day, I typically have encounters with about 10 to 15 people a day. I also participate in several groups where I do psychoeducation with it either being like depression management or diabetes or Smoking Cessation. Those I usually have once or twice a week and I usually am with maybe between 5 and 10 clients at a time for those.

Alana Nur: Great, thank you so much. Let's see, I'll turn this one to Alice, but anyone can jump in if they have additional things to add. When someone is discharged from a state hospital, what's the best way to connect with them and connect them with someone who may be able to support them?

Alice Geis: The question was when someone's discharged from a state hospital what's the best way to connect with them?

Alana Nur: Yes, connect them to someone who can support them, and reading into that giving them some help with Navigation Services and managing their conditions.

Alice Geis: I'm not sure I see a difference in type, but maybe just intensity from any other transition of care from a more acute to a less acute or a less restrictive environment. I think at first it's important to recognize the stress of the change itself, which I think we are often guilty of not doing in healthcare. For example, nurses in hospitals or doctors are fond of giving discharge instructions and people are anxious when they are in the hospital, so often they don't remember this. I learned that in home healthcare years ago.

I think getting connected early is really important to make sure that people don't run out of medications. Warm handoffs often are impossible in that particular situation, but to the extent possible meeting someone before they make the transition or certainly shortly thereafter and letting them know that they're going to have other help. Whether that's primary care psychiatry specialist, wellness programming and that kind of thing, so basically building the relationship early and connecting with the existing care team and understanding what the trajectory of treatment was in the other setting is crucial.

Alana Nur: Great, thank you Alice. This can go to any of you. Do you include home health aides as a provider and educate them?

Alice Geis: I think anybody who has the client's interests at heart, and the client agrees in terms of confidentiality to have involved, any person can be of assistance. So that might be a home health aide in a traditional homecare setting. It could be a family member. It could be a nonfamily member, but someone that the client thinks of as being part of their extended family, or someone who's willing to help them; maybe a reciprocal relationship of that sort.

So absolutely, what I think the Tip Sheets in all of this and what I tried to speak about is to make sure that the level of intervention is correct. Make sure that we're not putting something on someone who isn't educated at a higher level about the biological processes. For example, not putting too much on them and making sure they understand who they can call if they aren't sure how to help the client.

Alana Nur: Again, another one for any of you. What is the distinction and relationship between navigators and long-term supports and services' coordinators?

Laurie Carrier: As Alice spoke to ultimately the health navigator can be anyone, so we would consider them all navigators still in the patient's world in their current medical treatment. It would just be at what stage that that patient is moving in. There's a role for anyone who's actually going to be supportive to that patient.

Alana Nur: Great, thank you Laurie. A question for TJ, what cessation program do you use with your clients and is there anything that you use that's packaged, like the American Lung Association or the American Cancer Society?

TJ Thurlow: So, here within our organization we have sort of built based on some evidence-based practice and some experience from external nursing resources that we have within the area. We use a little bit of the American Heart Association. We use a lot of pieces of a lot of different toolsets and we integrate them together into one class that we do for our groups here.

We have a consultation specialist who developed a curriculum for us. This curriculum goes through a number of steps and phases where people get ready to quit smoking. Identify what sort of symptoms that they could experience, set a date, usually two to three weeks out from the initiation of the decision. That gives them time to make sure that they can have support systems in place and Smoking Cessation aids if they're going to go with a medication route available from their providers.

Alana Nur: Great, thank you so much TJ. This is a little bit of a longer question and I'll leave it open to suggestions from any of you. The presenter submitted the question and says, I'm a case manager out of County Medical Center in California. We have a large population of persons with Serious Mental Illness with multiple chronic diseases and who are homeless and use the emergency room as their primary care provider. Our physicians do not deem them as good candidates for insulin therapy and most often smoking replaces meals. Have any suggestions on how to get our population to engage and get involved in their own care?

Alice Geis: We're having trouble hearing the end of the question, but the case manager is our understanding works with SMI population who are intermittently homeless and use the emergency room as a primary source of treatment, is that correct?

Alana Nur: Yes, and they added that the physicians do not deem them as good candidates for insulin therapy and most often smoking replaces meals, so any suggestions on how to get their population to engage and get involved in their own care?

Alice Geis: Often these folks aren't good candidates for insulin therapy or Smoking Cessation, so how to engage? Engagement is the name of the game and we didn't talk a lot about outreach today, but that really is a crucial part of Navigation and is necessary. When people are using the emergency room and we're trying to engage them, we try to let them know that while they're open all the time they don't provide the kind of comprehensive care that we do. They don't provide the individualized care that we do.

We may be willing to work through them having higher hemoglobin A1C or higher glucose for a period of time. Because we know we're going to have outreach teams going out there and trying to find them and trying to work with them as we're moving them towards a better treatment set of protocols. I think having people who are really willing to do that, that have demonstrated ability to form those engaging relationships is so critical.

Alana Nur: Thank you, Alice. Laurie or TJ, is there anything else that you would add?

TJ Thurlow: Yes, I think that Alice really stated it well, but making sure that you are building those relationships with the clients, particularly ones who are hard to engage. Getting them to show up, encouraging them to stop by when they have questions or concerns, and making sure you have space and room available for triage when they want to come in and have questions or have somebody available to do a little bit of education.

It really helps to build the rapport with the client and that's how you can really make sure that you're continuing to support those clients. There's really no like wrong door to get them into the space and, again, just making sure that you're following through with the things that you've agreed to on you end so that they can feel like they're being supported from your side.

Laurie Carrier: This is Laurie. I was just going to talk a little bit about meds in that case, too. We have done some really creative things with medications, because obviously that's where the health navigators can be so helpful in terms of dosing insulin that would normally be maybe twice a day, but dosing it once a day. Having them come to the clinic in the morning and getting it that way.

Changing the meds to orals, but if you have outreach teams going to the houses and checking glucoses at certain times so that you can even kind of dose depending, or giving insulin in the home if you're lucky enough to have nursing that's going out. Or assisting patients in giving their own insulin and education, so yes, I just wanted to speak to the fact that we have done some kind of creative things with diabetes' medications with the help of navigators in order to get patients' diabetes under control.

Alana Nur: Thank you so much, Laurie, and from all three of you. If you have any additional questions, we will follow up with any that we didn't get to today. Feel free to email any additional questions that you have to RIC@lewin.com and we will follow up with you.

I thank you so much for joining us today. Please complete our brief evaluation of our webinar so that we can continue to deliver high-quality presentations. For more information on obtaining continuing education credits, please visit https://resourcesforintegratedcare.com/. If you have any questions, again, RIC@lewin.com and thank you so much for joining us today. Take care, everyone.