

Approaches to Supporting Self-management for Individuals with Serious Mental Illness

*A Guide to Resources, Promising Practices,
and Tools*

Prepared for:

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Submitted by:

The Lewin Group, Inc.

Institute for Healthcare Improvement

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The goal of the Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare & Medicaid Services (CMS) is to ensure beneficiaries enrolled in Medicare and Medicaid have access to seamless, high quality health care that includes the full range of covered services in both programs. To support these efforts, MMCO contracted with The Lewin Group, along with the Institute for Healthcare Improvement (IHI), to investigate provider-led practices that show promise in increasing provider capacity to deliver integrated care to Medicare-Medicaid enrollees. Based on its research, the Lewin team developed four guides that present resources, examples, and tools for providers interested in enhancing their ability to deliver integrated and coordinated care, including this one on *Approaches to Supporting Self-management for Individuals with Serious Mental Illness*.

MMCO directed the Lewin team to focus its investigation of promising practices on providers that serve individuals with physical disabilities, dementia or Alzheimer's disease, or serious mental illness. The team selected several provider-led practices through an iterative process based on an environmental scan and guidance from numerous experts. It also conducted site visits to selected practices to understand the core components that contributed to their success.

Based on the site visits and input from a Technical Evaluation Panel, the Lewin team identified four inter-dependent, high-level concepts that support the delivery of integrated, coordinated care:

- Integrating physical health services into behavioral health organizations
- Supporting self-management for adults with serious mental illness
- Workforce development to support care management
- Navigation services for individuals with severe mental illness

Approaches to Supporting Self-management for Individuals with Serious Mental Illness is based largely on information from the Greater Nashua Mental Health Center and the Montgomery County HealthConnections program. The practices used across these providers and program were supplemented with an environmental scan and key informant interviews with experts in this area.

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Introduction

The Institute of Medicine (IOM) defines self-management support as “the systematic provision of education and supportive interventions by health care staff to increase patients’ skills and confidence in managing their health problems, including regular assessment of progress and problems, goal setting, and problem-solving support.”¹ Self-management support is a collaborative process between providers and consumers that involves tailored education, skill-building in problem-solving, negotiating behavior changes, and engaging consumers in shared decisions about their health goals.

Often, a distinction is made between self-management of chronic medical conditions and wellness promotion *and* self-management of mental illness and recovery. The goal for the individual or consumer achieved via self-management is the same however – developing the skills to engage in self-care, goal setting, problem-solving, and communication with health care providers. Many persons affected by serious mental illness (SMI) have co-morbid conditions, making building

The goals of self-management support are closely aligned with those of the ‘Recovery’ model in behavioral health care which seeks to promote consumer self-care, self-advocacy and independence.

skills and engaging individuals more important than a focus on a particular condition.² Organizations and providers are beginning to shift their perspectives and view self-management support – which encompasses self-management of mental illness, behavioral conditions, healthy behaviors, chronic medical conditions, and life experiences and goals – as critical to patient recovery and improved health. This approach assumes that all consumers can engage in self-management.

Why is Self-management Support Important?

Provider support for self-management can improve individuals’ ability to manage their illnesses and health behaviors and to actively participate in their health care. The ability of providers to support self-management is essential to delivering comprehensive care because engaged and activated mental health consumers will support the coordination and integration of their behavioral and physical health services.

Evidence indicates that there is a positive relationship between supported self-management and improved health, cost-savings, and increased consumer efficacy and satisfaction with providers. Disease-specific health outcomes (including mental health and social function) are improved

¹ Adams K, Greiner AC, and Corrigan JM, Editors, Committee on the Crossing the Quality Chasm: Next Steps Toward a New Health Care System. Institute of Medicine’s 1st Annual Crossing the Quality Chasm Summit: A Focus on Communities Report: Chapter 5: Patient Self-Management Support. 2004;5(57-66).
http://www.nap.edu/openbook.php?record_id=11085&page=57

² In addition, psychiatric symptoms, cognitive impairment, chronic pain, substance use disorders, poverty or discrimination may impede some individuals’ ability to fully engage in self-care and medical treatment, and reach their daily life goals.

when self-management support is provided.^{3,4,5,6,7,8} Self-management support is also associated with lower costs due to avoided high-cost episodes such as crisis services and emergency room visits.⁹ Consumers engaged in self-management report greater satisfaction with their care and increased communication with providers.^{10,11,12,13} Self-management support activities may also provide organizational benefits. Primary care practices implementing self-management support activities with the help of The TIDES Foundation reported increased satisfaction, more meaningful interactions with patients, and the capacity to work as team.¹⁴

Changes in care delivery, payment, and quality measurement are underway that will increase opportunity and demand for robust self-management support activities. Payers and stakeholders are increasingly demanding care that is comprehensive and holistic, given the reality that most persons have or are at risk for multiple chronic conditions. Behavioral health

**Under the Affordable Care Act (ACA),
disease management and wellness
promotion are covered essential services**

³ Kennedy AP, Nelson E, Reeves D, Richardson G, Roberts C, Robinson A, et al. A randomized controlled trial to assess the effectiveness and cost of a patient orientated self-management approach to chronic inflammatory bowel disease. *Gut* 2004;53:1639-45.

⁴ Thsiananga JK, Kocher S, Weber C, Erny-Albrecht K, Berndt K, Nesser K. The Effect of nurse-led diabetes self-management education on glycosylated hemoglobin and cardiovascular risk factors: a meta-analysis. *Diab Educ* 2012. Jan-Feb 38(1): 108-23.

⁵ Warsi A, Wang PS, LaValley MP, Avorn J, Solomon DH. Self-management education programs in chronic disease: a systematic review and methodological critique of the literature. *Arch Intern Med.* 2004 Aug 9-23; 164(15):1641-9.

⁶ Druss BG, Zhao L, von Esenwein SA, Bona JR, Fricks L, Jenkins-Tucker S, Sterling E, DiClemente R, and Lorig K. The Health and Recovery Peer (HARP) Program: A Peer-Led Intervention to Improve Medical Self-Management for Persons with Serious Mental Illness. *Schizophr Res.* 2010 May; 118(1-3):264-70. Epub 2010 Feb 25.

⁷ Chafetz L, White M, Collins-Bride G, Cooper BA, Nickens J. Clinical trial of wellness training: health promotion for severely mentally ill adults. *J Nerv Ment Dis.* 2008 June 196(6):475-83.

⁸ Improved health was defined as improvements in SF-36 scores and Global Assessment of Function (GAF) scores.

⁹ Bodenheimer T, et al. Improving Primary care for Patients with Chronic Illness: The Chronic care Model, Part 2. *JAMA.* 2002;288(15): 1909-1914.

¹⁰ Davidson L, et al. Peer support among persons with severe mental illnesses: a review of evidence and experience. *World Psychiatry* 2012;11:123-128)

¹¹ Kennedy AP, Nelson E, Reeves D, Richardson G, Roberts C, Robinson A, et al. A randomised controlled trial to assess the effectiveness and cost of a patient orientated self management approach to chronic inflammatory bowel disease. *Gut* 2004;53:1639-45.

¹² Personal communication with Veenu Aulakh, MPH, Program Director at The TIDES Foundation, July 6, 2012.

¹³ Kennedy AP, Nelson E, Reeves D, Richardson G, Roberts C, Robinson A, et al. A randomised controlled trial to assess the effectiveness and cost of a patient orientated self management approach to chronic inflammatory bowel disease. *Gut* 2004;53:1639-45.

¹⁴ Personal communication with Veenu Aulakh, MPH, Program Director at TIDES, July 6, 2012 and Judith Schaefer, Director at the MacColl Foundation July 1, 2012.

providers who can deliver self-management support are effectively positioning themselves to be recognized by payers and stakeholders.

This guide aims to offer resources that may assist providers seeking to expand their capacity to deliver self-management support. In the sections that follow, readers will become familiar with key components of delivering self-management support. Included are promising practices of providers working with individuals with SMI who have put these components into practice. Factors and features associated with successful self-management support identified by experts in this field are described. Tools and resources for providers to implement key components of self-management support are offered in another section. We recognize that expanding capacity to support self-management requires investment and energy from multiple providers and stakeholders in our health care system. Our aim in this guide is to provide examples of how other organizations have begun this important work.

Components of Provider Support for Self-management

The Chronic Care Model developed by Dr. Edward Wagner identifies essential elements of a health system that lead to high quality and comprehensive care for chronic illness, including behavioral health conditions.¹⁵ The model identifies self-management support as a principal element leading to comprehensive care. According to this model, self-management support “empower[s] and prepare[s] patients to manage their health and health care.”¹⁶ In this model, providers acknowledge the central roles that patients play in their health and use a collaborative approach that supports decision-making and engagement by patients.

The evidence-base in self-management support suggests that structured and systematic delivery of tailored education and problem-solving skills through coaching will result in significant benefit to patients when integrated into medical care visits.¹⁷ However, there are many examples of effective support outside of medical office visits.¹⁸ Structured follow-up is another critical part of self-management support.

Building from this evidence, the California HealthCare Foundation outlined the following essential components of self-management support activities for providers:

- Give information
- Teach disease-specific skills to empower
- Negotiate health behavior change
- Provide training in problem-solving skills

¹⁵ The Chronic Care Model’s Definition of Self-Management Support. Improving Chronic Illness Care (ICIC) (funded by the Robert Wood Johnson Foundation). Accessed June 13, 2012 at http://www.improvingchroniccare.org/index.php?p=Self-Management_Support&s=22

¹⁶ Ibid

¹⁷ Kennedy AP, Nelson E, Reeves D, Richardson G, Roberts C, Robinson A, et al. A randomised controlled trial to assess the effectiveness and cost of a patient orientated self-management approach to chronic inflammatory bowel disease. *Gut* 2004;**53**:1639–45.

¹⁸ Bodenheimer T and Abramovitz S. Helping patients help themselves: how to implement self-management support. Prepared for the California Healthcare Foundation. December 2010. Accessed May 2012 at <http://www.chcf.org/publications/2010/12/helping-patients-help-themselves>.

- Assist with the emotional impact of having a chronic illness
- Provide regular and sustained follow-up
- Encourage active participation in managing illness.¹⁹

In the next sections, we describe these components in more detail and provide examples of how providers have adopted them for individuals with SMI.

Give Information

Consumers need tailored information about which activities will improve their health as well as education regarding why and how to engage

The Whole Health Action Management (WHAM) training provides opportunities for mental health consumers to gain information on managing health and supporting their peers.

in activities to improve their health. Information can be provided through print material, e.g., handouts about specific conditions, group classes, or one-on-one during patient-provider interactions, e.g., phone calls, office visits.

- The **Greater Nashua Mental Health Center (GNMHC)** offers consumers several opportunities for tailored information. The health center has partnered with a neighboring peer support organization -- Hope, Empowerment, Advocacy, Recovery, Towards Support (H.E.A.R.T.S) Peer Support Center -- to offer wellness promotion classes that educate consumers about activities to improve their health. These classes are specific to mental health and physical health conditions.
- At **GNMHC**, program and clinical leaders also designed a paper-based report card tool that gives health information specific to an individual consumer. It includes healthy weight goals, last weight measurement, a definition of normal blood pressure, and last blood pressure measurement. The report card provides tailored information to consumers about their health. It helps ensure that the broadest group of consumers possible receives information. (See tools section.)

Teach Disease Specific Skills to Empower

Skills related to managing illness symptoms and signs, medications, and other therapies for chronic for chronic mental illness and medical conditions can help consumers cope with illness and use health services more effectively. This may help a consumer determine whether to seek outpatient care or whether to visit an emergency room, for example.

A team at the Harlem Hospital used a one page “Harlem Family Action Plan” tool to set goals and negotiate behavior change during office visits.

¹⁹ Ibid

- **GNMHC** uses the evidence-based **Illness Management and Recovery Program (IMR)**, which provides consumers with skills and problem-solving approaches to manage mental illness symptoms. The philosophy at GNMHC is for the principles and approach of IMR to be part of the standard of care for all consumers served at the health center. The IMR is delivered by mental health clinicians at GNMHC, although it can be delivered by peers. Medical Director, Hisham Hafez, found that the IMR practice manuals and materials were dauntingly large. The IMR manuals were adapted and distilled into a manageable and easily portable binder for consumers (important, when so many users traveled to the Center on foot or by public transportation). GNMHC leaders found that even with the IMR as guide, the information needed to be personalized for individual consumers.
- **Montgomery County HealthConnections** is a navigator program serving adults with SMI and physical health conditions in Montgomery County, Pennsylvania. Nurse and mental health professional navigators teach disease-specific skills. Navigators use patient-level health information to identify conditions for skills increase. An integrated member profile combines mental health and physical health utilization and pharmacy data from health plans participating in the program and helps navigators identify conditions and skills for which individuals may need support.

Negotiate Health Behavior Change Collaboratively with Consumers

Health behavior change can be challenging for many individuals. In addition, health behavior change is likely one among several priorities for individuals affected by SMI. Providers need to be effective at negotiating change collaboratively with consumers. To do so, motivational interviewing and a person-centered planning perspective are two important strategies for providers working with consumers.

- At **Genesys**, an integrated health system in Flint, Michigan, nurse navigators negotiate health behavior change with individuals with chronic medical illness. The nurses use telephonic outreach to engage consumers and assist them in tailoring their behavior change plans and goals. Navigators document consumers' progress towards goals in the medical record and primary care physicians follow-up on health goals during office visits. In this system, nurse navigators are employed by Genesee health plan.
- Navigators in the **Montgomery County HealthConnections** program deliver self-management support to consumers. As part of this program, navigators receive training in motivational interviewing--a key skill that program leaders note is linked to collaborative negotiation. Patient-centered negotiation is facilitated by an 'Integrated Wellness Plan.' The navigators use this goal-setting tool to work with consumers to set goals in all domains of their life, identify treatment team members (including peer supports, therapists, or family) to help meet the goals, set a realistic time frame, and determine when they have achieved or adapted their goals.

The Integrated Wellness Plan tool developed by the Penn Foundation, a large specialty behavioral health provider in Montgomery County is provided in the tools section.

Consumers are asked if their Integrated

Wellness Plan should be shared with their primary care physicians or others. Peer support staff are invited to sit in on wellness planning sessions with consumers. In this program, navigators have information on office visits, emergency room use, and crisis services utilization, and medications, along with a 22-item Consumer Health Inventory completed by the consumer, which are used with the consumer to help identify patient goals. The Integrated Wellness Plan, once completed, also helps tailor the other activities performed by the navigator and tailors education and coaching.

Provide Training in Problem-solving Skills

The ability to manage and cope with problems as they emerge is important for consumers with any chronic illness. Several evidence-based interventions, as well as interviewing and listening techniques, are available to help providers increase consumers' problem-solving skills.

- As mentioned above, the **GNMHC** uses the IMR manual to teach and increase problem-solving skills.
- Pam Werner, Director in the Office of Consumer Direction, in **Department of Community Health in Michigan**, worked with 46 mental health centers across the state to begin using the Chronic Disease Self-Management Program (CDSMP) for mental health consumers. The CDSMP was delivered by trained peers. This self-management program teaches problem-solving skills across a range of conditions.

Assist with the Emotional Impact of Having a Chronic Illness

Chronic illness affects psychosocial functioning, which should be acknowledged by clinicians to support self-management. Clinicians can also set aside time within or apart from visits for consumers to share their stories and experiences. Providers can also refer consumers to 'story-telling' sessions and disease-specific support groups. Peer supports are a valuable resource who have first-hand experience with mental illness and can express empathy and establish trusting relationships with consumers. Peers can often instill a sense of hope for recovery, which has been demonstrated to improve patient activation. Peers can also engage in healthy behaviors with consumers (e.g., walking together or avoiding tobacco) and serve as a role model to consumers on how to manage their mental and physical health.²⁰

- The **GNMHC** partnered with the H.E.A.R.T.S Peer Support Center, which relieved GNMHC of directly supervising peer support staff. Consumers are offered peer support and determine whether they want to receive peer services. Peers encourage and support clients to attend wellness meetings and engage with them in healthy habits.
- The **Montgomery County HealthConnections** program incorporates peer supports into the care team that includes navigators, therapists, primary care and specialty physicians, and consumer-identified friends and family. Consumers assigned a navigator are also assigned peers. In this program, consumers can decide if peers are present during wellness planning sessions with navigators.

²⁰ Personal Communication with Larry Davidson, PhD, Director of the Yale Program for Recovery and Community Health, June 20, 2012.

Provide Regular and Sustained Follow-up

- Structured follow-up is a critical component of self-management support, as it builds upon previous encounters and sustains consumer engagement. For example, a timely 10-minute follow up call to the consumer to ask about the action plan can demonstrate that self-management support is not limited to health center visits. Another way to follow up with consumers is to ask about experiences at outside organizations, for example, “How was your (chronic disease management) class at the YMCA?”

The Integrated Wellness Plan used in the **Montgomery County HealthConnections** navigator program is completed at least every 90 days and is placed in a consumer’s clinical file at the participating behavioral health provider agency. This ensures that consumers and navigators engage in follow-up conversations to reflect on consumers’ experiences, challenges and success. Navigators can provide ongoing encouragement and continue planning around goals with consumers.

- At GNMHC, a report card tool assists clinicians in providing regular follow-up and continued conversations and goal setting with consumers. The report card is easily accessible in a consumer’s medical record and enables various staff at the mental health center to engage consumers and provide follow-up around physical health indicators and goals. GNMHC wants to increase clinicians’ use of the tool; not all mental health clinicians have used the report card tool regularly since implementation in February 2010. (see Appendix C)

Encourage Active Participation in Managing Illness

Active consumer participation in their care increases consumer satisfaction and clinician-consumer communication.^{21,22,23,24,25} In patient-centered medical home pilots led by The TIDES Foundation, supported individuals were better able to provide feedback to the providers about quality of care and goals. Consumers with SMI have also reported increased control and ability to bring about life changes when encouraged by providers or peers.²⁶

- LeeAnn Moyer, Deputy Administrator of Behavioral Health in Montgomery County and leader in the HealthConnections program, notes that a key function of the navigators in supporting self-management is to increase consumer self-advocacy. Peers also support self-advocacy among consumers in this program by role-modeling for consumers.
- Mara Huberlie, Program Director at GNMHC, notes that the report card tool developed and used in their program encourages consumers to ask questions of their clinicians

²¹Davidson L, et al. Peer support among persons with severe mental illnesses: a review of evidence and experience. *World Psychiatry* 2012;11:123-128)

²² Personal communication with Veenu Aulakh, MPH, Program Director at TIDES, July 6, 2012.

²³ Kennedy AP, Nelson E, Reeves D, Richardson G, Roberts C, Robinson A, et al. A randomised controlled trial to assess the effectiveness and cost of a patient orientated self management approach to chronic inflammatory bowel disease. *Gut* 2004;53:1639–45.

²⁴ Personal communication with Veenu Aulakh, MPH, Program Director at TIDES, July 6, 2012.

²⁵ Kennedy AP, Nelson E, Reeves D, Richardson G, Roberts C, Robinson A, et al. A randomised controlled trial to assess the effectiveness and cost of a patient orientated self management approach to chronic inflammatory bowel disease. *Gut* 2004;53:1639–45.

²⁶ Davidson L, et al. Peer support among persons with severe mental illnesses: a review of evidence and experience. *World Psychiatry* 2012;11:123-128)

related to physical health indicators included in the tool. She has found that the report card often triggers consumers to participate in wellness programs (e.g., smoking cessation or yoga class) at the Center because of discussions around the tool.

Context and Considerations

An organization that wishes to support self-management will need to evaluate how best to do so in the context of its leadership, vision and culture; business model; organizational structure, skills and processes; and consumers. However, our interviews with experts and leaders working to expand self-management support identified the following principles for providers that are considering adopting self-management support components. These are broadly applicable and increase the likelihood of a successful activity or program:

All patients can engage in and benefit from self-management support. Clinical providers know how to personalize care for the individual in front of them. Self-management support can be personalized as well and a participatory relationship between clinicians and consumers is strongly associated with promoting healthy behavior change.²⁷ Education, skill-building, and psychosocial support are most effective when it reflects the individual's level of need and level of activation.

Multiple approaches to support self-management are needed. Because there are several key components to self-management support, an organization will likely need a range of activities and resources to achieve these components, including patient materials, staff training, clinical workflow changes, telephonic-based support, and individual consumer health information. For example, a single activity in which consumers are offered or referred to wellness classes (even an evidence-based intervention) will not achieve self-management support for the broadest number of individuals served by the organization. Experiences in multiple organizations have demonstrated that few individuals participate in and complete class-based, self-management support.²⁸

Engage clinicians and use a team-based approach to support. In many clinical settings, a team-based approach to care is not easy to accomplish. However, experts have found that self-management support is easier to sustain and has a greater impact with consumers when there is a team involved. A focus on "skill-building" among clinical staff may also be an important starting place for organizations. Several trainings and resources for training clinical staff are included in the tools section.

Use peer supports if they are available. Peers/peer specialists or lay health workers are often an underused resource for self-management support. Peers can complement support delivered by providers and form part of the team described above. Partnering with a community-based organization or peer support organization is one option for specialty behavioral health providers. However, organizations may find that they need to invest time in establishing ways to integrate peer support into their organization and provide supervision and oversight to peers.²⁹

The tools section includes a guidance document that offers organizations specific advice and concrete actions for integrating peer supports.

²⁷ Norris SL, Engelgau MM, Narayan KM. Effectiveness of self-management training in type 2 diabetes. *Diab Care* 2001;24:561-587.

²⁸ Personal communication with Judith Schaefer, Peggy Swarbrick, Richard Birkel and Venu Aulakh in July 2012.

²⁹ Personal Communication with Larry Davidson, PhD, Director of the Yale Program for Recovery and Community Health, June 20, 2012.

Tools and Other Resources

Several tools and resources are included below. They are organized into the following categories: “Implementation resources for organizations,” “Training for clinicians delivering self-management support”, and “Tools to assist consumers in self-management.”

Implementation Resources for Organizations

Self-Management Support in Behavioral Health: Organizational Assessment Tool and Webinar

The Self-Management Support Organizational Assessment Tool (SMS OAT) is designed to assist behavioral health organizations in delivering self-management support to clients managing serious mental illness and/or substance abuse conditions. Supporting clients in managing their health is the responsibility of front-line providers, administrators, and recovery support leaders. This tool allows organizations to assess their capacity for delivering self-management support and also outlines a quality assurance process that facilitates ongoing organizational improvements in self-management support.

https://www.resourcesforintegratedcare.com/behavioral_health/self-management_support/tool/organizational_assessment_tool

The webinar focuses on assessing an organization’s ability to support client self-management, highlighting the SMS OAT. Following the webinar, participants should be able to define the importance of SMS in serving clients managing mental illness and/or substance use conditions, recognize their organization’s ability to support self-management activities using the SMS OAT, and identify best practices for expanding capacity to integrate support for self-management.

https://resourcesforintegratedcare.com/Behavioral_Health/2017_Self-Management_Support_Webinar_Series/Assessing_Organizational

List of States where Peer Support Services reimbursable under State Medicaid Plan

The List of States where Peer Support Services reimbursable under State Medicaid Plan developed by the Allen Daniels of the Pillars of Peer Support Services Initiative can be used by behavioral health organizations or even states considering using certified peer specialists reimbursable under Medicaid to provide self-management services to their patients.

[See Appendix D.](#)

<http://www.power2u.org/downloads/PillarsOfPeerSupportServiceReport.pdf>

Health Promotion Programs for Persons with Serious Mental Illness: What Works? A Systematic Review and Analysis of the Evidence Base in Published Research Literature on Exercise and Nutrition Programs.

This review authored by Dr. Stephen Bartels can be used by behavioral health organizations and providers to understand the effectiveness of physical activity and nutrition interventions for person with SMI, including recommendations (e.g., program duration).

<https://niatx.net/pdf/wicollaborative/HealthPromoSML.pdf>

Illness Management and Recovery (IMR) Evidence-Based Practices Kit

The IMR Evidence-Based Practices Kit issued by public officials, program leaders, mental health center administrators, and mental health practitioners in developing illness-management and recovery mental health programs that emphasize personal goal-setting and actionable strategies.

<http://store.samhsa.gov/product/Illness-Management-and-Recovery-Evidence-Based-Practices-EBP-KIT/SMA09-4463>

Peer support among persons with severe mental illnesses: a review of evidence and experience

This review authored by Larry Davidson of Yale University's Program for Recovery and Community Health in the School of Medicine can be used by practitioners seeking to use peer support as this review discusses common barriers and concerns program leaders have with respect to peer support and effective strategies for implementing peer services for persons with severe mental illness.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3363389/?tool=pubmed>

Partnering in Self-Management Support: A Toolkit for Clinicians by the New Health Partnerships

This Partnering in Self-Management Support: A Toolkit for Clinicians developed by the Institute for Healthcare Improvement (IHI) can be used by organizations implementing self-management support programs using the tools and examples enclosed in this toolkit.

<http://www.ihl.org/knowledge/Pages/Tools/SelfManagementToolkitforClinicians.aspx>

Provider Manual for the Diabetes Literacy and Numeracy Education Toolkit

This toolkit is a compilation of training and patient care tools developed by the Vanderbilt Diabetes Research and Training center for healthcare professionals to use to improve the educational interactions between diabetes providers and their patients.

<http://www.mc.vanderbilt.edu/documents/CDTR/files/dlnet-instructions%5B1%5D.pdf>

Self-Management Success Story Handouts

Provider support for self-management can improve individuals' ability to manage their illnesses and health behaviors and to actively participate in their health care. These six client handouts feature the success stories of individuals who have used self-management techniques to effectively manage their behavioral health and substance use conditions. The self-management success story handouts are available in English and Spanish.

<https://www.resourcesforintegratedcare.com/concept/client-handout/2016/self-management-stories>

Training for Clinicians Delivering Self-management Support

Tools to Support Clients with Self-Management Webinar

This webinar explores how behavioral health organizations and providers can implement Self-Management Support with their clients specifically focusing on action planning. There is an overview of tools and models for supporting self-management. Following this webinar, participants will be able to define the key elements of action planning with clients to promote

self-management, identify different evidence-based action planning selection guides, and define supportive conversations with clients on the self-management of chronic conditions and mental illness.

https://resourcesforintegratedcare.com/Behavioral_Health/2017_Self-Management_Support_Webinar_Series/Tools

What to Expect When You're Self-Managing Client Handout

This client handout is designed to support conversations with clients on the self-management of chronic conditions. It includes information on the purpose of self-management, what the client should expect from his or her care team, what the client may ask for from natural supports, and resources available to support his or her efforts to self-manage.

https://www.resourcesforintegratedcare.com/behavioral_health/self_management_support/client_handout

Self-Management Video

This video developed by the Improving Chronic Illness Care (ICIC) Foundation can be used to teach clinicians to goal-set, create an action plan and problem-solve to overcome self-management barriers.

http://www.improvingchroniccare.org/index.php?p=Watch_A_Planned_Care_Visit&s=221

Video on Collaborating with Patients

This video developed by the California HealthCare Foundation's Team Up for Health Initiative can be used by providers to learn a technique known as "motivational interviewing" as a means for partnering with patients to map out a plan for managing their condition.

<http://www.chcf.org/publications/2008/08/video-on-coaching-patients-for-successful-selfmanagement>

Training Curriculum for Health Coaches

This training curriculum developed by Tom Bodenheimer at the University of California San Francisco can be used by healthcare staff (primary care practices/clinics) to work with patients on medication reconciliations and adherence.

<https://cepc.ucsf.edu/health-coaching>

Video on Techniques for Effective Patient Self-Management

This video developed by the California Healthcare Foundation teaches clinicians basic strategies to help patients choose healthy behaviors and transform the patient-provider relationship.

<http://www.chcf.org/publications/2006/08/video-with-techniques-for-effective-patient-selfmanagement>

Motivating Change Online Programs

These online programs have been created by Kaiser Permanente Regional Health Education Online Learning. These modules address medication adherence, brief negotiation, and chronic conditions including diabetes, hypertension, congestive heart failure, and asthma.

<http://kphealtheducation.org>

Tools to Assist Consumers in Self-management (Problem-solving, Skill Building, and Goal Setting)

Wellness Recovery Action Plan (WRAP) Program

The WRAP program developed by Mary Ellen Copeland at the Copeland Center can be used by adults to self-manage their illness.

<http://wrapandrecoverybooks.com/store/>

Illness Management and Recovery (IMR) program

Illness Management and Recovery (IMR) program increases consumer ability to problem solve, manage illness and pursue personal recovery goals.

<http://store.samhsa.gov/product/Illness-Management-and-Recovery-Evidence-Based-Practices-EBP-KIT/SMA09-4463>

Chronic Disease Self- Management Program (CDSMP)

The Chronic Disease Self-Management Program (CDSMP) developed by Stanford University can be used by adults with chronic conditions (including SMI) who participated in a six week intervention that is led by a master trainer or leader who has undergone the CDSMP training.

<https://www.selfmanagementresource.com/about/>

My Action Plan for Better Health

This My Action Plan for Better Health developed by Harlem Hospital can be used by providers (nurse, provider, case manager) and patients to develop an action plan during the clinic visit. It is completed and filed in a patient's chart.

[See Appendix A.](#)

Report Card Tool

The Report Card tool developed by the Greater Nashua Mental Health Center/GNMHC is used by clinicians and consumers to begin discussions about physical health and patient goals and track health and goals over time.

[See Appendix B.](#)

Integrated Wellness Plan

The Integrated Wellness Plan developed by the Penn Foundation, a specialty behavioral health provider agency in Montgomery County, PA, can be used navigators or other clinicians to develop collaborative goals with consumers and provide follow-up over time.

[See Appendix B.](#)

Whole Health Action Management (WHAM) Action Plans

WHAM action plans can be used by the consumers to add their goals (including completion date) and 8 weekly action plans to reach goal (includes a confidence scale score).

Action Plan Selection Guide - A Tool For Self-Management Support

The Self-Management Support (SMS) Action Plan Selection Guide helps behavioral health providers choose action plans that best meet the needs of their clients and their organization. Action planning is particularly useful for clients with mental illness, substance use disorders, and/or chronic physical health conditions.

https://resourcesforintegratedcare.com/behavioral_health/self-management_support/tool/action_plan_guide

Acknowledgements

Contributors and Reviewers

- Veenu Aulakh MPH, Community Clinics at TIDES
- Richard Birkel PhD, National Council on Aging, Self-management Alliance Group
- Melanie Brown, MPH, MA, Substance Abuse and Mental Health Services Administration (SAMHSA)
- Deborah Bukovec, LSW, Magellan Behavioral Health of Pennsylvania, Inc.
- Allison Coker, SAMSHA
- Larry Davidson PhD, Yale Program for Recovery and Community Health
- Benjamin Druss MD, Department of Psychiatry, Emory University
- Hisham Hafez MD, Executive Director and Chief Medical Officer, Greater Nashua Mental Health Center
- Mara Huberlie MA, Director of Project Implementation & Continuing Education Greater Nashua Mental Health Center
- Kate Lorig RN, PhD, Stanford Education Center
- LeeAnn Moyer, Deputy Administrator of Behavioral Health, Montgomery County Department of Behavioral Health and Developmental Disabilities
- Sarah Ruiz, National Council on Aging, Self-management Alliance Group
- Judith Schaefer MPH, MacColl Center for Health Care Innovation, Group Health Research Institute
- Margaret Swarbrick PhD, University of Medicine and Dentistry of New Jersey

Appendix A: Action Plan Tool Used by Harlem Family Center

My Action Plan for Better Health
Harlem Family Center

	<p>This month I will:</p> <p>Improve my food Choices</p> <p>Reduce my stress</p> <p>Take my meds everyday</p> <p>Attend a support group</p> <p>Exercise more often</p> <p>Follow up with a medical appointment (go to the dentist)</p> <p>Cut down or stop smoking (or drinking or drug use)</p> <p>Other:</p>	<p>Describe it: (How, where, what, when, how often)</p> <p>Barriers (what might get in the way):</p> <p>Plans to over come barriers (what could you do to handle the barriers?):</p> <p>On a scale of 1 - 10: How important is this goal: (1 = Not important at all, 5 = somewhat important, 10 = the most important)</p> <p>On a scale of 1 - 10: How sure am I that I can make this goal: (1 = Not sure at all, 5 = somewhat sure, 10 = 100% sure)</p> <p>Follow up Plan:</p> <p>Signature:</p> <p>Clinician Signature:</p>
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Appendix B: Wellness Plan Used by Penn Foundation (a Behavioral Health Provider)

Page 1 of the Wellness Plan

Date: _____ Participant name: _____ DOB: _____ Case #: _____ Navigator: _____

Bucks Co Mont Co

Penn Foundation, Inc.
Integrated Wellness Recovery Plan

Who is involved in supporting me in my wellness?

Of those who support me, who should be invited to my Integrated Wellness Recovery Plan meetings?

The areas of my life that I would like to work on now are: (I rated the top 3)

- | Emotional Health | Physical Health | Spirituality | Relationships | Meaningful Activity | Living situation |
|---|---|---|---------------------------------------|---|---|
| <input type="checkbox"/> Medication | <input type="checkbox"/> Medication | <input type="checkbox"/> Church involvement | <input type="checkbox"/> Family | <input type="checkbox"/> Employment | <input type="checkbox"/> Housing |
| <input type="checkbox"/> Therapy | <input type="checkbox"/> Nutrition | <input type="checkbox"/> Spiritual activities | <input type="checkbox"/> Social | <input type="checkbox"/> Education | <input type="checkbox"/> Legal concerns |
| <input type="checkbox"/> Nutrition | <input type="checkbox"/> Physical Activity | <input type="checkbox"/> Service to others | <input type="checkbox"/> Professional | <input type="checkbox"/> Service to others | <input type="checkbox"/> Finances |
| <input type="checkbox"/> Physical Activity | <input type="checkbox"/> Restful Sleep | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Hobbies/Recreation | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Restful Sleep | <input type="checkbox"/> Relaxation/Stress Management | | | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Safety |
| <input type="checkbox"/> Relaxation/
Stress Management | <input type="checkbox"/> Other _____ | | | | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Other _____ | | | | | |

What am I doing to take care of my physical health?

What am I doing to take care of my emotional health?

What am I doing to take care of my substance use issues?

What are my concerns about my health and/or medication?

I. Behavioral Health Diagnoses:

III. Physical Health Diagnoses:

II. Personality/MR Diagnosis:

IV. Social/Cultural/Environmental Stressors:

Page 2 of the Wellness Plan

Date: _____ Participant name: _____ DOB: _____ Case #: _____ Navigator: _____

Goal #1 (Long-term) _____

Comments on Goal #1:

Short-term change goal: _____

Things I can count on about myself that will help me work towards achieving this goal:

I will know I'm achieving this goal when:	*Target dates:	Who will assist?	Outcome at Target date: (Achieve, Adapt, or Abandon)
1)			
2)			
3)			
4)			

Goal #2 (Long-term) _____

Comments on Goal #2:

Short-term change goal: _____

Things I can count on about myself that will help me work towards achieving this goal:

I will know I'm achieving this goal when:	*Target dates:	Who will assist?	Outcome at Target date: (Achieve, Adapt, or Abandon)
1)			
2)			
3)			
4)			

Page 3 of the Wellness Plan

Date: _____ Participant name: _____ DOB: _____ Case #: _____ Navigator: _____

Goal #3 (Long-term) _____

Comments on Goal #3:

Short-term change goal: _____

Things I can count on about myself that will help me work towards achieving this goal:

I will know I'm achieving this goal when: *Target dates: Who will assist? Outcome at Target date: (Achieve, Adapt, or Abandon)

- 1)
- 2)
- 3)
- 4)

*Evaluate action steps at least once every 90 days

How will this plan be communicated to my psychiatrist and/or primary care physician?

What else would I like my psychiatrist and/or physician to be aware of regarding my goals?

Areas that my psychiatrist and/or physician would like me to be aware of for my wellness plan:

Signatures:

Participant _____ date RN Navigator _____ date Recovery Coach _____ date

BH Navigator _____ date Outpatient Therapist _____ date Peer Support Specialist _____ date

(_____) _____ date (_____) _____ date (_____) _____ date

Appendix C: Report Card Tool from Greater Nashua Mental Health Center

The report card below is folded in half and double sided contains patient health care information such as medications, vital signs and lab results. The report card is also shared with the PCP and kept in the chart.

Front Cover of Report Card



Greater Nashua Mental Health Center
at Community Council
in partnership with
Lamprey Health Care

**Healthy Connections
Report Card**

Name: _____

Address: _____

Date of Birth: _____

Contact: _____

Allergies: _____

Psychiatrist: _____

Case Manager: _____

Primary Care Doc: _____

Back Cover of Report Card

Patient Health Care Information

Body Mass Index (BMI) is your weight in kilograms divided by your height in meters²

1. Normal: 18.5 - 24.0
2. Overweight: 25.0 - 29.9
3. Obese: 30 or greater

Normal Lipid Screening levels

1. Total Cholesterol= less than 200 mg/dl
2. LDL = less than 100 mg/dl
3. HDL= greater than 60 mg/dl
4. TG = less than 150 mg/dl

Fasting Plasma Glucose levels

1. Normal = 100 mg/dl or less
2. Pre-diabetes = 101-125 mg/dl
3. Diabetes Mellitus = 126 mg/dl or greater

Diabetes Mellitus Risk Factors

1. Age greater than 45
2. Physical Inactivity
3. Polycystic Ovary Syndrome
4. Hypertension (Blood Pressure greater than 140/90)
5. Overweight (BMI greater than 24)
6. Family History
7. History of diabetes during pregnancy or delivering a baby over 9 lbs.
8. Previously identified increased fasting glucose or glucose intolerance
9. HDL less than 35mg/dl for men, less than 40mg/dl for women and/or triglycerides greater than 150mg/dl.

Metabolic Syndrome is defined as three or more of the following Risk Factors:

1. **Abdominal Obesity:** a waist circumference of over 40 inches in men and 35 inches in women
2. **Triglycerides level** higher than 150 mg/dl
3. **HDL Cholesterol** level of less than 40 mg/dl in men and less than 50mg/dl in women
4. **Blood Pressure** - higher than 135/85
5. **Fasting Plasma Glucose** (Blood Sugar)- Higher than 110 mg/dl

Inner Left Page of Report Card

Inner Right Page of Report Card

List All Medications Including OTC	Initial	6 Mos.	12 Mos.	18 Mos.	24 Mos.	30 Mos.	36 Mos.	42 Mos.	48 Mos.
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									
11.									
12.									
Continued ✓ ↑									
Discontinued X ↓									
Increased Dose +									
Decreased Dose -									

Vital Signs:	Initial	6 Mos.	12 Mos.	18 Mos.	24 Mos.	30 Mos.	36 Mos.	42 Mos.	48 Mos.
Temperature									
Respiratory Rate									
Blood Pressure									
Pulse									
Weight									
Height									
Waist Circumference									
Body Mass Index									
Lipid Screening:									
Cholesterol									
LDL									
HDL									
TG									
Fasting Glucose									
H1AC									
Intraocular Pressure									
Nicotine Use:									
Cigarettes per day									
O ₂ Sat. level									
Spirometry									
Ethanol Use:									
# Drinks/day									
# Days /any drink									

Appendix D: States that Cover Peer Support Services Reimbursable Under Their Medicaid Programs

The 22 states listed below cover peer support services reimbursed under their Medicaid programs and provided via trained and certified peer specialists who could also provide self-management support to the consumers served in the behavioral health organizations implement self-management support programs.

Medicaid reimburses for peer support services such as counseling and other support services delivered directly to Medicaid beneficiaries (eligible adults) with mental health and/or substance use disorders. The range for reimbursements was between \$3 and \$19 per billable fifteen-minute increment. The average rate of reimbursement was \$10/fifteen-minute unit of service. Additionally, reimbursement must be based on an identified unit of service and be provided by one peer support provider, based on an approved, comprehensive, and individualized plan of care that includes specific individualized goals. Peer support providers should be self-identified consumers who are in recovery from mental illness and/or substance use disorders and, as a result, can better support Medicaid beneficiaries in the recovery process. Supervision and care coordination are core components of peer support services. Additionally, peer support providers must be sufficiently trained to deliver services.³⁰

Alabama
Arizona
Connecticut
Georgia
Iowa
Kansas
Maine
Michigan
Minnesota
Missouri
Nevada
New Jersey
North Carolina
Oklahoma
Oregon
Pennsylvania
South Carolina
Tennessee
Texas
Washington
Wisconsin
Wyoming

³⁰ Pillars of Peer Support: Transforming Mental Health Systems of Care through Peer Support Services Report based on The Pillars of Peer Support Services Summit at The Carter Center in Atlanta, GA on November 17-18, 2009; <https://www.power2u.org/downloads/PillarsOfPeerSupportServiceReport.pdf>

Appendix E: Provider Organizations Referenced in This Guide

Montgomery County HealthConnections Magellan Health Services

In 2008, the Center for Health Care Strategies (CHCS) launched a multi-state, national effort to improve quality and reduce expenditures for Medicaid beneficiaries with complex medical and behavioral health needs. Pennsylvania was among the states selected to participate in this effort. Pennsylvania implemented two pilots, SMI Innovation Initiatives, one in the southeastern (SE) and one in the southwestern part of the state. The SE Partnership, Montgomery County HealthConnections, included the following partners: Bucks, Delaware and Montgomery Counties; PA Dept of Public Welfare; CHCS; Magellan Behavioral Health and Keystone Mercy Health Plan. Each county was at liberty to implement the plan in different ways. The Montgomery County HealthConnections was developed collaboratively with several core specialty behavioral health provider agencies serving Montgomery County MA residents- Central MHMR; Creative Health Services; Abington Creekwood Center; Penn Foundation and Horizon House. Implementation commenced in June, 2009.

Phone: 877-769-9782

Website: www.MagellanofPA.com

Penn Foundation

Penn Foundation is a leading 501(c)(3) non-profit provider of community behavioral health services in southeastern Pennsylvania offering a wide-range of innovative programs, including Assertive Community Treatment, designed to meet various types and levels of mental, emotional, behavioral, and spiritual healthcare needs.

Address: 807 Lawn Avenue, Sellersville, PA 18960

Phone: (215) 257-6551

Website: <https://www.pennfoundation.org/>

Creative Health Services

Founded in 1957, Creative Health Services, Inc. is a non-profit community mental health center which provides behavioral healthcare to individuals in need of recovery and personal wellness. Over the past 50 years Creative Health Services has grown into a multi-service, multi-site organization serving over 5,000 adults, children and families each year throughout the Tri-County region. In addition, Creative Health Services maintains active collaborations with ten area school districts, the judiciary system, several United Ways, the Tri-County Community Network, and other human service agencies.

Address: 929 Willow Street, Pottstown, PA

Phone: (610) 326-7734

Website: <http://www.creativehs.org/>

Central Behavioral Health

Central Behavioral Health is the oldest private, not-for-profit, multi-service community mental health center in Montgomery County, PA. Central provides services to more than 4,000 individuals and families through specialized programs, covering a full spectrum of behavioral health services.

Address: 1100 Powell Street, Norristown, PA 19401

Phone: (610) 277-4600, X119

Website: <https://www.centralbh.org/>

Horizon House

Horizon House is a non-profit organization that provides community-based services to over 4,500 individuals throughout the Pennsylvania region. Horizon House's interventions include treatment and rehabilitation programs, service/resource coordination, housing, educational programs, and employment training and support.

Address: 3275 Stokley Street, Philadelphia, PA 19129-1128

Phone: (215) 386-3838

Website: <https://www.hhinc.org>

Abington Memorial Hospital

Abington Memorial Hospital (AMH) is a 665-bed, regional referral center and teaching hospital, which has been providing comprehensive services for people in Montgomery, Bucks and Philadelphia counties for more than 90 years.

Address: 1200 Old York Road, Abington, PA 19001

Phone: 215-481-2000

Website: <https://www.abingtonhealth.org/100/>

Genesys HealthWorks

HealthWorks is a population based model of care in which the health care system (Genesys in Flint, MI) has responsibility for the health and well-being of the population and also agrees to deliver the care required to maintain or improve the health of the population by focusing on health rather than a disease. Genesys HealthWorks brings an innovative approach to a self-management support system that focuses on cultivating relationships between the primary care physician, patient, and Health Navigator, to improve health. The unique role of the Health Navigator as part of the primary care practice team serves to: support patients, support providers, and provide links to community resources.

Address: Genesys HealthWorks, Genesys Health System, One Genesys Parkway, Grand, Blanc, MI 48439

Phone: 810-606-6256

Website: <https://www.commonwealthfund.org/publications/case-study/2010/jul/genesys-healthworks-pursuing-triple-aim-through-primary-care-based>

GNMHC

Greater Nashua Mental Health Center is a community –based specialty behavioral health provider that provides comprehensive mental health services. GNMHC is dedicated to helping families and individuals of all ages reach their full potential by providing state-of-the-art, evidence-based care that focuses on recovery. The services relate to substance abuse and other mental health or emotional challenges. GNMHC was founded in 1920.

Address: 7 Prospect Street, Nashua, NH 03060

Phone: 603-889-6147

Website: <http://www.gnmhc.org/>

Harlem Hospital Family Care Center (NYC Health + Hospitals/Harlem)

Harlem Hospital Family Care Center was established in 1987 to provide comprehensive medical, psychological and social services to HIV-infected children and their families. A dedicated team of health care professionals have served more than 2000 families in Central Harlem. The program provides a broad array of services to meet the evolving needs of children, women and families living with and affected by HIV/ AIDS.

Address: Department of Pediatrics, 506 Lenox Avenue, New York, NY 10037

Phone: 212-939-4040

Website: <https://www.nychealthandhospitals.org/harlem/>

PATH

Personal Action Towards Health is the (CDSMP) implemented at 43 community mental health centers across Michigan serving the 130,000 adults with SMI. Starting in 2005, the Michigan Department of Community Health (MDCH) and the Office of Services to the Aging (OSA) partnered to build a system for coordinating, implementing, and expanding the Stanford Chronic Disease Self-Management Program (CDSMP) referred to as Personal Action Towards Health (PATH) in Michigan. PATH was developed and tested by Stanford University to help adults with chronic or long-term health conditions (and their family, friends, caregivers) learn techniques and strategies for the day-to-day management of these conditions such as SMI. It is a six-week free or low cost workshop conducted in 2 1/2 hour sessions each week. Workshops are led by two trained leaders who may, themselves, have a long-term health condition. The workshop content is not disease specific; rather, it focuses on symptoms that are common to people with a variety of health conditions. Over the 6 weeks, emphasis is placed on creating personal action plans and setting practical, achievable goals. Topics include working with health care providers, relaxation, healthy eating, physical activity, communicating with family and friends, and managing symptoms, medications, pain and fatigue.

Address: Capitol View Building, 201 Townsend Street, Lansing, MI 48913

Phone: 517-335-4078

Website: <http://mihealthyprograms.org/>