Primary Health Care/Chronic Disease Management Initiative
In Review

In May 2010 we launched our Primary Health Care and Chronic Disease Management Initiative at CMHA Toronto

The goal of this initiative is to enhance primary health care and management of chronic diseases for our clients in four strategic areas:

1. Improving access
2. Partnership development
3. Education and health promotion and
4. Coordination of health service delivery

Responsiveness to our clients' needs is a key element of primary health care. We have been emphasizing the importance of:

- health promotion
- disease and injury prevention
- chronic disease management.

Our goal is to offer services that promote our clients' overall health and well being and improve access for them to primary health care in the community.

What We Know About Chronic Disease

- Chronic Disease is a global health issue. According to the World Health Organization, by the year 2030, chronic conditions will cause 75% of all deaths globally. The Ontario Health Quality Council reports that 80% of Ontarians aged 45 and older have a chronic health condition, and 70% of these have two or more chronic conditions.
- According to the report by the Substance Abuse and Mental Health Services Administration (SAMHSA 2012), adults aged 18 and older who have experienced any mental health issue in the past year had increased rates of high blood pressure, asthma, diabetes, heart disease, and stroke.
- Serious Mental Illness (SMI) is a significant risk factor for the development of chronic diseases. Compared with the general population people with SMI have higher rates of COPD, breast cancer, colon cancer, lung cancer, stroke and heart disease. Diabetes rates are two to four times higher, and people with SMI are twice as likely to die from cardiovascular disease.
- People with SMI die 25 years earlier than people without SMI
- Physical ailments are often misdiagnosed as psychological issues, which can result in physical symptoms being either missed or downplayed.
- Many clients with SMI cannot access primary care settings due to coverage issues, stigma, and the difficulties of fitting into the fast paced model of primary care.
- Some primary care physicians are reluctant to take on clients with complex needs or psychiatric diagnosis.

What We Learned About Our Clients

In November of 2010, the clients of our clinical programs were surveyed and it was noted that:

- 55% of clients had a known chronic disease
- 44% of those had two or more chronic diseases
- 86% of clients had a primary health care physician, and most had seen a primary health care physician in the past year.
- 63% reported that their chronic diseases were not being well managed or controlled by their primary health care physician
- 73% of client deaths reported were the result of chronic disease; the average age of deceased clients was 48.7; of those, 81% were male.

This data confirmed that our initiative is required to promote wellness for people with mental and substance use disorders by motivating individuals, organizations, and communities to take action and work toward improved cardiovascular health, decreased early mortality rates, and quality of life.

Highlights to Date

CECCAC Workshops

The Central East Community Care Access Centre provided a 10 week Chronic Disease Workshop to CMHA Clients in both English and Tamil.

Smoke Stoppers Group

Smoke Stoppers Groups were piloted in February 2012 in the West Office (partnering with CAMH) and in the East Office (partnering with Morrish Pharmacy). Clients were provided with different forms of Nicotine Replacement Therapy (NRT), such as the patch, gum, lozenges, and inhaler. The NRTs were given out on a weekly basis, which added to clients' motivation to return to the group for further learning and support. The success rate of the clients was closely linked to the NRT and support provided by the partner organizations.

CMHA will run this group again this summer, with Morrish Pharmacy providing education and support to clients in the east and in the west (via OTN).

Scarborough Centre for Healthy Communities

CMHA has partnered with Scarborough Centre for Healthy Communities (SCHC) - Diabetes Team. The Team will provide education to clients at the East Office regarding diabetes and self management, which will also be available to West Office clients via OTN. These workshops will be offered to clients on a regular basis.

Nurse Practitioner

In late April 2012, CMHA partnered with Anne Kwamie, Nurse Practitioner from Scarborough Centre for Healthy Communities. She provides primary health care services to clients at our East office every Friday. So far, Anne has seen 12 clients, providing them with physical assessments and ongoing care. Anne has addressed issues such as chronic disease management, prenatal care, blood work review, and prescription renewals. She has assisted clients in accessing specialists and has made referrals to endocrinologists and dieticians.

Ontario Telemedicine Network (OTN)

CMHA has two large telemedicine systems, one in the east and one in the west, which have been used primarily for educational and administrative events. This year we received two additional OTN medical carts for the Primary Health Care offices in the East and West to use for Telemedicine Clinical Events. OTN uses video cameras and monitors to connect clients to specialists who are not located near to them. This reduces travel time and expense for our clients.

During a Telemedicine Clinical Event, clients can see, hear, and talk to their health care professional, just as they would in a face-to-face appointment. We have a digital stethoscope and patient examination camera which enables the clinician on the monitor to hear the clients' heart beat and breathing, and examine their ear, nose, and throat. From January to April 2012, CMHA conducted 94 Telemedicine Clinical Events totaling 3,940 hours. We have formed partnerships with several specialists through OTN and the number is growing. Examples of clinical use include regular appointments for EI clients with a psychiatrist in York Region, a Respiratory Specialist providing care to clients in the North Bay area, a member of the community who consults with their psychotherapist in B.C., and our telemedicine RN providing nursing support to WICM team.

Metabolic Monitoring

The East and West ACT Teams and the Early Intervention program have been using TREAT software to screen for Metabolic Syndrome, and to date 80% of their clients have been screened. TREAT has proven to be a useful tool to open up conversations with clients regarding primary health care issues, and ensuring clients have appropriate services available to them if metabolic syndrome is suspected or detected. Our psychiatrists will use TREAT as a tool to assess whether certain medications prescribed are contributing to TREAT results.

ACT Now

The East ACT Programs piloted a six month project called ACT Now, a weight loss/healthy living/fitness challenge. Fifteen participants were registered and ten of those participants completed the program. Participants were expected to attend weekly health sessions, and were encouraged to exercise and to keep a daily food journal. Participants' weight and waist circumference were monitored. Incentive prizes were given out, and monthly prizes were given to participants who kept the best food/exercise journal and to the participant who lost the most weight in the month. As a group, they lost over 160 pounds and 45cm around the waist. ACT Now was so successful, that the project has now expanded to other CMHA programs.

Black Creek Community Health Centre

Black Creek Community Health Centre has a Diabetes Team which will be providing training to CMHA clinicians. As a result of this increased knowledge, our staff will be better equipped to address diabetes with their clients and will also be able to refer clients to Black Creek Community Health Centre to learn more about diabetes, and how to self manage their disease.

OCAN / CD

Data is being captured in OCAN and the CD survey on issues such as:

- Known physical health conditions
- Smoking status
- Connection to primary care physician

Clinical teams will be asked to share information regarding clients' participation in prevention activities, and reported in the Balanced Scorecard.

Coming Up

Team/Program Based Work

Programs are addressing PHC/Chronic Disease through various initiatives and groups such as walking groups, bowling, yoga, meditation, relaxation, concurrent disorder groups, and healthy cooking. We hope to continue to promote and provide similar programs throughout the agency.

Staff Training

Training will be delivered to teams at CMHA Toronto. This three hour training will be mandatory and will provide information on Chronic Disease Management and on psychotropic medications. The goal is to increase clinicians' capacity to assist clients in the management of their physical health care needs and promote the health and wellbeing of their clients.

Regional Diabetes Coordinating Centre

The Diabetes Regional Coordinating Centre - Central LHIN will be providing training for staff through their "Choices and Change" Workshop. This workshop trains staff how to assess clients' readiness to address their chronic disease(s), and how to motivate clients to make changes for self management and improve their overall well-being.