

Welcome to the **EQUALLYWELL** 2020 webinar series

Topic 2:

Supporting the physical health of older people's mental health service consumers: practice improvement ideas building on what we know and what we have

Presented by:

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Dr Carmelo Aquilina, SWS LHD

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Mr Brian Tomney, NS LHD



15 September 2020

Dr Rod McKay

Older People's Mental Health Clinical Advisor, Mental Health Branch, NSW Ministry of Health

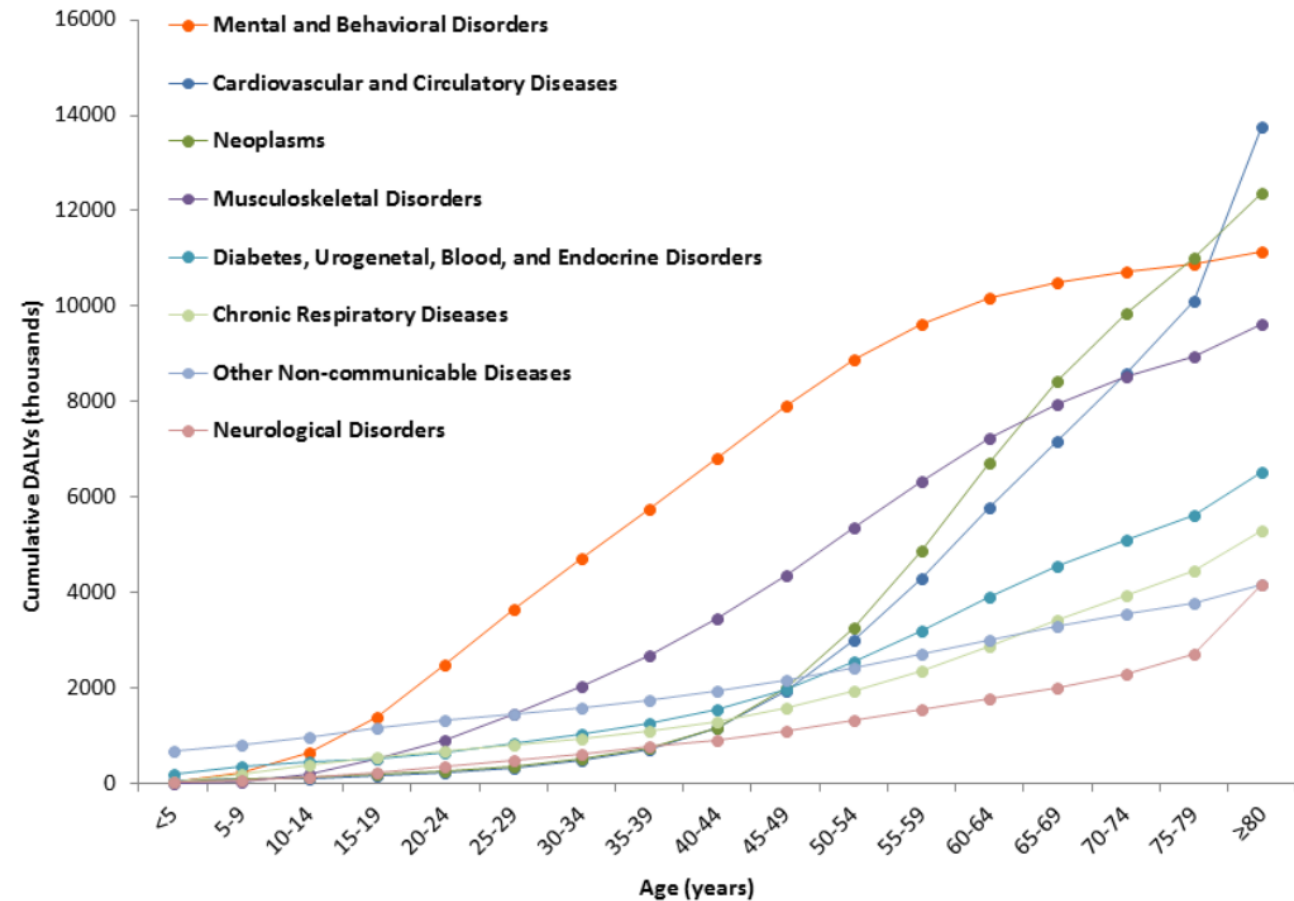
Director, Psychiatry and Mental Health Programs, NSW Health Education and Training Institute (HETI)



Maintaining and improving the physical health of older people with mental illness: Building on what we have and know

- ▶ Older people have evolving health needs that tend to increase with age
 - ▶ Large evidence base
 - ▶ A traditional strength of older persons' mental health teams and geriatric medical teams
 - ▶ But those moving into the field often not comfortable with their role

Cumulative U.S. DALYs for the Leading Disease/Disorder Categories by Age (2010)



Addressing the physical health of older people with mental illness: what are the challenges/gaps?

- ▶ **Clinician attitudes towards older people with severe mental illness and physical illness**
 - ▶ Challenge of managing physical healthcare needs in addition to mental health issues
 - ▶ Many older adults with severe mental illness and physical health needs are 'falling through the gap', with a lack of clarity about where responsibility lies
 - ▶ More collaboration between services and ongoing clinician education is required

Clifton et al, 'An exploration of clinician attitudes toward older adults experiencing mental and physical health problems in the UK' (International Journal of Ageing and Society, 7 (1), 2016)



Building on what we have and know

- ▶ People with serious mental illness often have complex physical health needs
 - ▶ Growing evidence base
- ▶ That continue into later life



Addressing the physical health of older people with mental illness: what are the challenges/gaps?

- ▶ **Under-assessment and under-treatment of physical health problems in older people with schizophrenia**
 - ▶ Despite known risks of obesity, diabetes, hypertension, etc only 51% patients received BMI recording, 21% had evidence of assessment of all 9 key physical health measures
 - ▶ Among those with high blood sugar, only recorded evidence of 53.5% receiving appropriate intervention
 - ▶ Despite this, most patients reported that they were satisfied with the physical health care they received

Crawford et al 'Assessment and treatment of physical health problems among people with schizophrenia' (British Journal of Psychiatry, 205, 2014)



Building on what we have and know

- ▶ Older people with mental illness have often received limited attention in
 - ▶ Practice
 - ▶ Policy development
 - ▶ Research



How are OPMH services responding to physical health needs?

- ▶ NSW OPMH annual benchmarking self-audit results against range of good practice standards, indicate OPMH services challenged by a number of standards relating to physical health care:
 - ▶ Involvement of GPs (in pre-admission processes, initial assessment and care, care coordination)
 - ▶ Access to nursing staff trained in IV medication and fluids, SC fluids in inpatient settings
 - ▶ Physical examination of older consumers in the community
 - ▶ Action about falls prevention (especially in the community)
- ▶ NSW OPMH community Model of Care evaluation
 - ▶ Confirms challenges re physical health assessment, accessing skilled staff for assessment and management (physios, dietitians, GPs), other self-audit findings



How are OPMH services responding to physical health needs? (cont.)

- ▶ In NSW, measure of consumer experience of mental health services ('Your Experience of Services' or 'YES' questionnaire) includes specific set of questions re physical health care
- ▶ YES results for OPMH services indicate:
 - ▶ **High** level of information/advice provided about healthy eating and diet, exercise and physical activity
 - ▶ **Medium** level of information/advice provided about possible side effects of medications (slightly better in community services), alcohol and drug use (better in community services), smoking (where relevant)
 - ▶ **Low** level of information/advice about sexual health
- ▶ High consumer satisfaction with OPMH services



What does this mean for care?

- High physical and mental health co-morbidity in older people - integrated care imperative
- Understanding of risks and complexities specific to older people with mental illness
- Improving assessment and treatment in known physical health risk areas (eg cardiovascular conditions, obesity, diabetes)
- Looking within OPMH services at attitudes to physical health care and collaborative care, staff skills and staffing profiles, collaboration (esp. with GPs), advice to consumers on physical health issues
- Empowering older people with mental illness around their physical health



Strategies and practice ideas – 2019 reflections

- ▶ Explicit **focus** on physical health care in **policies and models of care**
 - ▶ NSW Health Policy Directive (*Physical Health Care within Mental Health Services*) and Guideline (*Physical Health Care of Mental Health Consumers*)
 - ▶ NSW OPMH community and inpatient models of care
- ▶ Explicit **practice focus** in statewide OPMH benchmarking and annual self-audit process to support reflect practice and quality improvement
 - ▶ Self-audit standards and collaborative data and practice discussions
- ▶ Strategies/programs to promote **integrated care** for mental and physical health problems in primary care settings
- ▶ **Measuring and monitoring** practice, including through consumer feedback (YES consumer questionnaire)
- ▶ **Focused statewide practice improvement work**



Key messages – 2019 reflections

- ▶ Systematic **improvement** of the physical healthcare of older people with mental illness accessing mental health services is difficult
- ▶ Systematic **action** to improve the physical healthcare of older people with mental illness accessing mental health services is difficult, but possible
- ▶ There are **factors** that appear likely **to increase the probability that action will lead to improved health outcomes**, but evidence for this is weak
- ▶ We need to
 - ▶ Have **specific actions** to improve the physical health outcomes of older people with mental illness
 - ▶ **Improve the evidence base** regarding what works to improve the physical health outcomes of older people with mental illness
 - ▶ Work collaboratively and continually work to build trust between partners
- ▶ **Focussed statewide practice improvement** work addresses these points



Dr Kate Jackson

Director, Older People's Mental Health Policy Unit, Mental Health Branch, NSW Ministry of Health



OPMH Physical Health Practice Improvement Project

- ▶ **Builds on** previous statewide recovery-oriented practice improvement project methodology
- ▶ Aims to promote improvements in physical health assessment & care of OPMH service consumers
- ▶ Includes OPMH community and inpatient services across NSW
- ▶ Seeks practice improvement within OPMH services and through OPMH service collaboration with consumers, carers and service partners
- ▶ Uses an opt-in, 'start where you can' approach to progress local projects
- ▶ Supported by statewide project steering group, targeted literature review, toolkit and other practical resources
- ▶ Local leadership from project champions and supporting managers
- ▶ Encourages consumer consultation and collaboration, and ideally co-design



▶ Encourages evaluation

Health

“Overall, the number and scope of truly tested interventions remain limited, and strategies for implementation and scaling up of programmes with a strong evidence base are scarce.”

Liu et al (2017)

Project Plan



Key project partnerships

- ▶ Charles Sturt University – supporting literature review, and research and evaluation support for statewide and local project
- ▶ NSW Clinical Excellence Commission – supporting local project planning and implementation in line with evidence-based quality improvement methods
- ▶ NEAMI – working with Local Health District older people’s mental health services to adapt and trial the NEAMI health prompt with older people
- ▶ Flourish NSW – working with a Local Health District older people’s mental health service to evaluate use of Flourish health prompt cards with older people
- ▶ And a range of other statewide and local project partners



Evidence to support implementation: Current research status

- ▶ International search, last 15 years—
older persons/mental illness/ physical health/comorbidity
- ▶ 241 articles identified- after screening 82 studies identified –
only 13 describe and report the impacts of programs/interventions.

Categories	General Population			Older People		
	Title	Relevant	Met criteria	Title	Relevant	Met criteria
Screening (uptake only)	70	44	22		5	2
Psychosocial and consumer focussed	134	54	4		7	3
Exercise and physical activity	183	59	19		6	0
Int. & care coordination	183	158	119		7	3
Other (*all of the above -nurse delivered)	587	83	40*		55	5

Screening, psychosocial & exercise approaches

Screening

- ▶ Konz et al (2014) screening detecting increased number of abnormalities including hypertension, diabetes, dyslipidaemia.

Psychosocial

- ▶ Bartels et al. (2014a) HOPES – increased participation in preventative health care. Increased vision, hearing, breast and cervical cancer screening.
- ▶ Pratt et al (2017) HOPES-I improved capacity to report physical symptoms
- ▶ Bartels et al (2014b) I-IMR – sig improvement in managing diabetes, not diff in other physical health indices.

Physical activity

- ▶ No research on the impact of PA programs on physical health of older people living with mental illness

This is quite surprising given the well-documented effects of exercise on older persons' physical health, mental health, balance and cognitive functioning!

Integrated/coordinated care

Few studies with older people.

(Most studies describe including physical health care as 'integrated care')

- ▶ Bogner et al., 2007 PROSPECT Primary care decreased severe mental illness mortality compared to usual care
- ▶ Unitzer et al., (2002). IMPACT Collaborative care better than usual care
- ▶ Bartels et al., 2004. Integrated care better than enhance referral.

Research studies by linkage category and type

Broad linkage category	Linkage type	Clinical (#)	Service delivery (#)	Economic (#)
Direct collaborative activities	Link working	0	0	0
	Co-location	1	0	0
	Consultation liaison	0	0	0
	Care management	3	0	0
Agreed guidelines	Specific treatment protocols	2	0	0
	Stepped care	0	0	0
Communication systems	Enhanced communication	0	0	0
	Enhanced referral	1	0	0
	Electronic Communication System	0	0	0
Service agreements	Service or formal work agreement	0	0	0

Scope of local practice improvement projects and collaborative approach

- ▶ Local practice improvement projects relate to:
 - ▶ Screening, assessment and referral pathways (5 LHDs)
 - ▶ Empowering consumers to promote their own physical health (5 LHDs)
 - ▶ Physical activity/exercise initiatives (3 LHDs)
- ▶ Collaborative sub-group meetings held to help build collaboration across project and research teams undertaking projects in similar areas



Building on what we know and what we have

- ▶ Theme of work to date is that older people with mental illness have different needs from other age groups, but tools and approaches can be adapted to meet their particular needs
- ▶ Profiling three different projects being progressed under the NSW OPMH physical health practice improvement project
 - ▶ **South Western Sydney LHD:** Building on the Canadian 'Fountain of Health' resource and leveraging international collaboration (**Dr Carmelo Aquilina**)
 - ▶ **NEAMI:** The NEAMI older people's health prompt project, building on existing NEAMI health prompt (**Mr Steve Suttie**)
 - ▶ **Northern Sydney LHD:** Building on and adapting existing work on physical health screening and assessment in adult mental health and OPMH services (**Mr Brian Tomney**)



Dr Carmelo Aquilina

South Western Sydney LHD





fountain of health

PROMOTING

POSITIVE HEALTH

IN OLDER PEOPLE

Dr Carmelo Aquilina

Clinical Director , OPMH SWS LHD

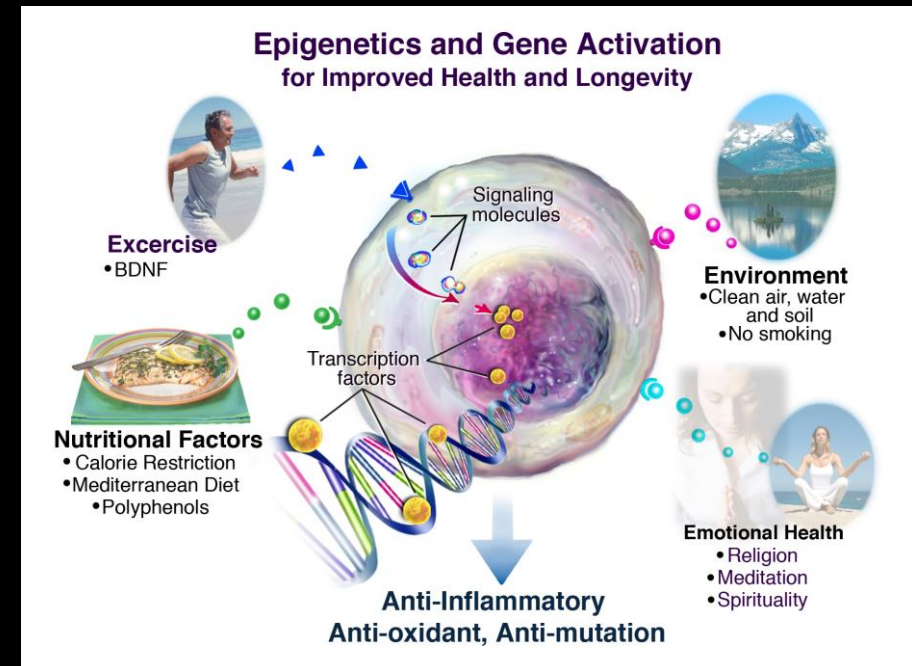
Nature vs Nurture

25%



Ljungquist B, et al (1998) The effect of genetic factors for longevity: a comparison of identical and fraternal twins in the Swedish Twin Registry. *The Journals of Gerontology Series A: Biological Sciences and Medical Sciences* 53.6 M441-M446.

75%



<http://www.josephmaroon.com/epigenetics-living-smarter/>

Health promotion Vs health intervention



“A great deal is known about the science of how to change health-related behaviour. The scientific literature is extensive and evidence-based guidelinescarefully describe how health behaviour change interventions can be made part of standard health and social care practice. “

“We need to change the way we as health professionals work with the public. individual support for patientsthat steers away from information giving and towards empowering and motivating individuals to generate their own solutions to their problems”

“Current public health policy stresses the potential of cumulative, small changes in individual behaviour to produce significant advancements in population health”

Kelly, M. P., & Barker, M. (2016). Why is changing health-related behaviour so difficult?. *Public health*, 136, 109–116. doi:10.1016/j.puhe.2016.03.030



fountain of health

5

minutes

Clinical Tools for

- primary prevention
- reducing relapses
- promoting resilience
- Empowering patients
- Giving behaviour modification tools for clinicians

Criteria : >40 year age no dementia



Social activity



TRY

- Go out with a friend
- Connect with phone, email, skype
- Challenge yourself to say yes to opportunities
- Know local groups or venues
- Start a new hobby /interest/cause

Physical activity



TRY

- Walk
- do more errands and normal work
- Join an exercise group or gym
- Get exercise equipment in house
- Try a new activity e.g. yoga,tai chi
- Practise balance exercises
- Go to your GP for a check up

Positive thinking



TRY

- Mindfulness and meditation
- Gratitude list
- 'problem solving' skills e.g. time chunking
- Strengths assessment
- Self-compassion exercise

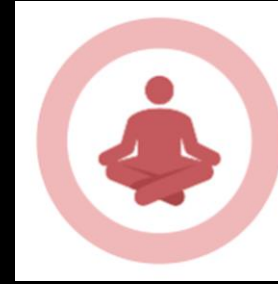
Mental activity



TRY

- Try something new e.g. courses , classes, book clubs
- Read, brain games e.g. chess, sudoku
- Use a computer to stimulate interests
- Change routine
- Healthy eating
- Enough sleep

Mental health promotion



TRY

- Stress management techniques
- Deep breathing & relaxation
- Massage, yoga
- Healthy eating
- Sleep
- Self-compassion exercises
- Set positive goal daily

PATIENT

HEALTH PROFESSIONAL

FIRST ENCOUNTER

Introduction

Helping success research valuable

- I
- I
- I
- I

S.M.A.R.T.

Specific take?
Measurable
Action-oriented
Realistic
Time-Limited
month?

Questions

-
-
-
-

Note: Dr.

App: we

Livingston
Chatter
Yates L.
Levy B.
Grosman
Vengher
Wen C.J.

Stoplight Scripts

Assessing Readiness for Health Change and Responding to Your Patient



Your patients will respond in different ways at different times to the invitation to behaviour change. Using the metaphor of a stop light, they might say: "No" (red light-unready), "Maybe" (yellow light- ambivalent), or "Yes" (green light-ready to go). The following outlines ways to respond to all of these situations.



Navigating a Red Light Response:

- Patient responses such as "No, Not ready, Can't, Won't" are perfectly fair and very common responses at any given visit! We can all be in a "red light" zone for healthy behaviour on any given day.
- Simply inviting the health behaviour change is an intervention and gets people thinking. Data shows that the invitation from a care provider is enough to trigger subsequent readiness.

Red Light- Clinician Responses:

- Acknowledge in a non-judgmental way and normalize the response with, "Fair enough" or "I hear you!". The issue has been noted and can be talked about again at a subsequent visit. It is not your job to make anyone do anything!



Typical Yellow Light Responses:

- I would but... Maybe next month... I just don't feel motivated but I know I should... If I weren't _____(depressed/so anxious/dealing with this medical condition), then I would.... If I had time I would...

Yellow Light- Clinician Response:

- Empathize with the ambivalence and limitations mentioned. Normalize that health change is hard and that most of us struggle to make change happen.
- Invite one very small behavior change in a target health area. Choosing something that is meaningful to the patient can also help. For example, "Even with the (time limitations/lack of motivation etc.)...would you consider setting one really small goal and just see how it goes? Is there a very small change you can think of that would still be meaningful to you? No goal is ever too small and if it doesn't happen, no problem..."



Even for a keen Green Light Patient- Clinician Response:

- Even for the enthusiasts, remember to keep the goal very small. Focus on concrete, or "S.M.A.R.T." goals - Specific, Measurable, Action-oriented, Realistic and Time-limited. The more specific and doable the goal is, the more likely the patient will succeed.

PATIENT

HEALTH
PROFESSIONAL

FIRST ENCOUNTER

Goal sheet

Pre-intervention
Questionnaire

Introduction

Goal setting

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Patient

THE USE

Take Home Goal Sheet

Goal Doc Sheet for Clinicians

Clinician Initials: _____ Location of Practice (province): _____

Please record your patient's goal-setting and attainment on this form.

Patient Initials: _____ Age: _____ Gender: _____

VISIT #1: Assess Baseline & Set a Goal: Date (MM/DD/YY): _____

Please record patient's Health & Resilience Questionnaire Pre-score here: _____/50

Record patient's S.M.A.R.T. goal (Physical Activity, Social Activity, Brain Challenge, or Other)
Goal: _____

Did you invite this patient to use The Wellness App? (wellnessapp.ca)

Yes ☐ No ☐

How likely do you think the patient is to use The Wellness App?

Likely ☐ Unlikely ☐ Not Sure ☐

VISIT #2: Check-in on Goal: Date (MM/DD/YY): _____

Goal Attainment: To what extent did this patient meet their goal? (check one)

No change	Partially Achieved Goal	Fully Achieved Goal	Exceeded Goal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Well-being: To what extent does the patient feel that working toward this goal has impacted their well-being? (check one)

No Change	Slightly Improved	Moderately Improved	Greatly Improved
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please record patient's Health & Resilience Questionnaire Post-score here: _____/50

Did your patient use The Wellness App? Yes ☐ No ☐ Not Sure ☐

If the patient offers feedback on this process or use of The Wellness App, please share it here
Comment: _____

Health & Resilience Post-Intervention Questionnaire

Find out how you are doing
(circle **one** number for each question)

1. How would you rate you

0 1 2

Not at all connected

2. How would you rate you

0 1 2

Not at all interested

3. Using your own definition

0 1 2

Least successful

4. How would you rate you needed it?

0 1 2

Not at all likely

5. How would you rate you

0 1 2

Not at all active

Patient Initials: _____

App: wellnessapp.ca

Clinicians &

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The Brain Health & Wellness Project



Goal Doc Sheet for Clinicians

Clinician Initials: _____ Location of Practice (province): _____

Please record your patient's goal-setting and attainment on this form.

Patient Initials: _____ Age: _____ Gender: _____

VISIT #1: Assess Baseline & Set a Goal: Date (MM/DD/YY): _____

Please record patient's Health & Resilience Questionnaire Pre-score here: _____/50

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Goal: _____

Did you invite this patient to use The Wellness App? (wellnessapp.ca)

Yes ☐ No ☐

How likely do you think the patient is to use The Wellness App?

Likely ☐ Unlikely ☐ Not Sure ☐

VISIT #2: Check-in on Goal: Date (MM/DD/YY): _____

Goal Attainment: To what extent did this patient meet their goal? (check one)

No change Partially Achieved Goal Fully Achieved Goal Exceeded Goal

☐ ☐ ☐ ☐

Well-being: To what extent does the patient feel that working toward this goal has impacted their well-being? (check one)

No Change Slightly Improved Moderately Improved Greatly Improved

☐ ☐ ☐ ☐

Please record patient's Health & Resilience Questionnaire Post-score here: _____/50

Did your patient use The Wellness App? Yes ☐ No ☐ Not Sure ☐

If the patient offers feedback on this process or use of The Wellness App, please share it here
Comment: _____

App: wellnessapp.ca Email: info@wellnessapp.ca Toll free line: 1-833-722-2151 Fax: 888-458-9440

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SECOND ENCOUNTER

sheet

vention
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Post intervention
questionnaire

etting

Goal attainment
Well-being

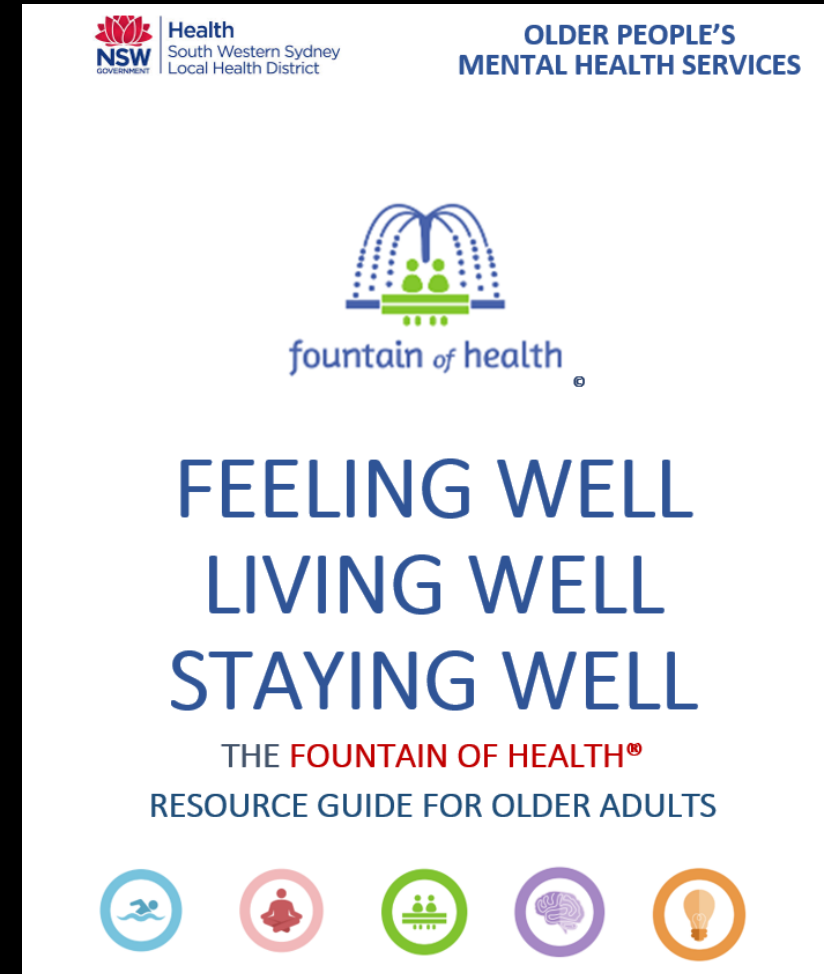
Results from Canada

Used by

- Nurses (25%)
- Social worker (19%)
- Doctor (19%)
- OTs (7%)
- Other (30%)
- Easy (86%)
- Time-efficient (78%)
- Acceptable to patients (72%)
- Most patients exceeded (15%) or had full (40%) or partial (35%) attainment of health goal in 1 month

Next Steps

- Piloting taking place
- Resource Booklet being produced
- Use tools (unmodified for 10-20 patients)
- Database provided by Canada
- Anonymised sheets to Canada
- Training session run by FoH @ Canada
- Review scripts for OPMH
- Cross-validation opportunity for FoH outcomes with Wellbeing Assessment



Mr. Steve Suttie
NEAMI National



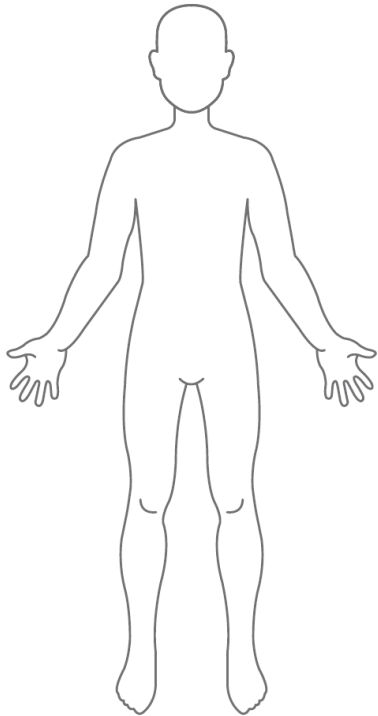
Neami National's Health Prompt

Stephen Suttie



HEALTH PROMPT

PLEASE INDICATE ON THE PICTURE BELOW AREAS ON YOUR BODY THAT YOU MAY BE FEELING WORRIED OR CONCERNED ABOUT:



Please share any other health concerns:

HEALTH PROMPT

INTRODUCTION (Please read to consumers)

Thank you for agreeing to take part in this brief prompt about your health. I am going to ask you some questions to help establish whether your health needs are being met and identify areas you may like support with. Whilst we are interested in knowing about your health, please be assured that this information will be treated as strictly confidential.

Consumer Name:		Service Site:	
Gender/Sex:		Age:	
Date Completed:		Review Date:	

Questions		Yes	No	N/A
1.	Do you have a regular GP?			
2.	Are you satisfied with the relationship you have with your GP?			
3.	Have you had your blood pressure checked in the last 6 months?			
4.	Have you had your cholesterol checked in the last year?			
5.	Have you had your blood sugar levels checked in the last 3 years?			
6.	Do you do 30 minutes of moderate exercise 5 days per week?			
7.	Do you have at least 2 alcohol free days per week?			
8.	Do you eat 2 serves of fruit per day? Example of 1 serve of Fruit: 1 medium apple/banana or a handful of grapes			
9.	Do you eat 5 or more servings of vegetables per day? Example of 1 serve of veg: ½ cup of cooked veg or 1 cup of salad			
10.	Do you feel you drink enough water? 2L or 8 glasses is the average recommendation			
11.	Is your waist measurement below 88cm (women) or 102cm (men)?			
12.	Have you checked your skin for changes in the last 3 months?			
13.	Have you had your eyes checked in the past 2 years?			
14.	Can you hear and understand things easily?			
15.	Are you a non-smoker?			
16.	Have you had a dental check-up in the last 6 months?			
17.	Are you able to keep your balance and have not fallen recently?			
18.	Are your feet free from sores, blisters and swelling?			
19.	Are you satisfied with the quality of your sleep?			
20.	Do you feel you have enough information about the medications you are currently taking?			
21.	When feeling stressed or emotionally unwell, do you have someone you can contact?			
22.	Do you feel that you have healthy bladder and bowel function?			
23.	If over 50, have you spoken to your doctor about bowel cancer?			
24.	Do you have anyone to contact regarding your sexual health?			
25.	Is your pap smear/cervical screening test up to date?			
26.	Have you had your breasts checked by a doctor in the last year?			
27.	If over 50, have you had a mammogram in the last 2 years?			
28.	If over 50, have you discussed prostate cancer screening with your doctor in the last year?			

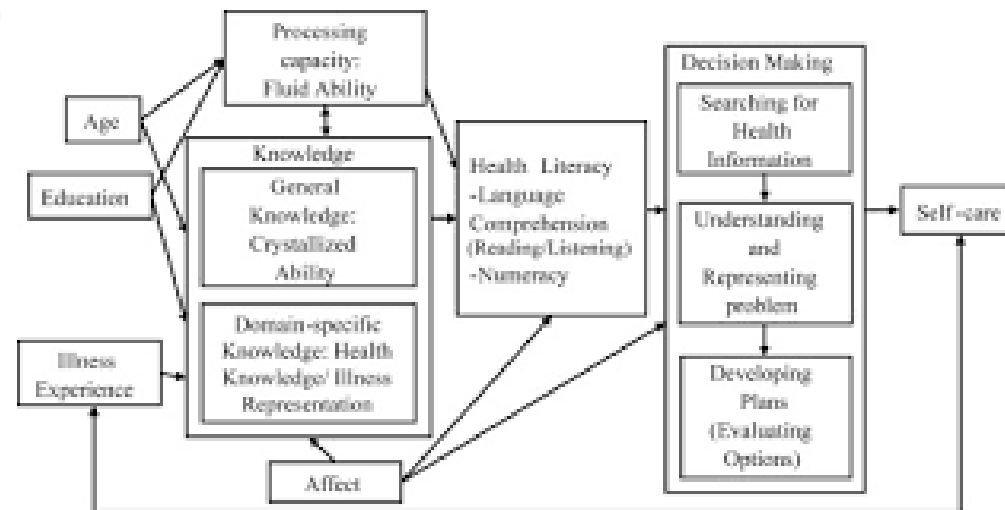
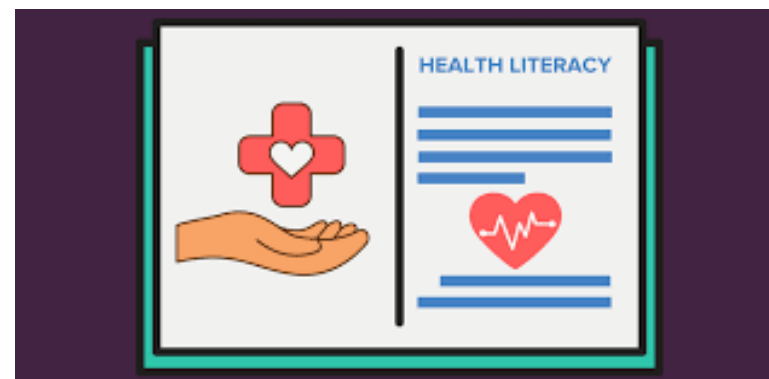
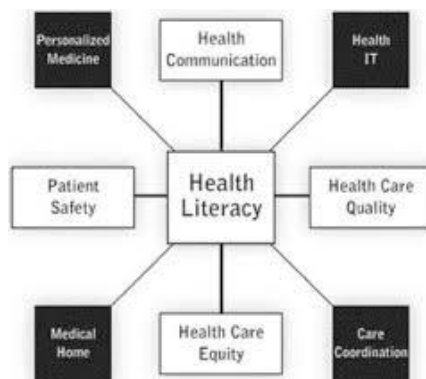
If you answered no to any of these questions, it is important for you to follow up with your G.P. and talk to your support worker regarding any support you may require.

Health Prompt

..is a Physical health screening resource

- Designed to reflect a:
 - Strengths-based approach
 - Recovery orientate approach
 - Holistic approach
- 28 questions
- National recommendations for screening, administering and consuming
- Information and Practice Guidelines Document

Health Literacy



健康提示

介绍 (请读给消费者听)

感谢您同意参加这一简短的健康提示调查。我会问您一些问题，这些问题有助于确定您的健康需要是否得到满足，并且找出您可能希望获得支持的方面。我们有意了解您的健康情况，但请放心我们将对这些信息严加保密。

消费者姓名:		服务地点:	
性别:		年龄:	
完成日期:		调查日期:	

问题	是	否
您是否有固定的全科医生 (GP) ?		
您对自己与全科医生 (GP) 的关系是否感到满意?		
您在过去 6 个月中是否检查过血压?		
您在过去一年中是否检查过胆固醇?		
您在过去一年中是否检查过血糖水平?		
您是否每周 5 天、每天做 30 分钟中度锻炼?		
您是否每周至少有 2 天不喝酒?		
您是否每天吃 2 份水果? 例如: 1 份水果 = 1 个中等大小的苹果 / 香蕉或一把葡萄		
您是否每天吃 5 份以上的蔬菜? 例如: 1 份蔬菜 = ½ 杯煮熟的蔬菜或 1 杯色拉		
您是否觉得自己喝的水足够? 建议平均喝 2 升或 8 杯水		
您的腰围是否低于 88 厘米 (女) 或 100 厘米 (男)?		
您在过去一年中是否检查过皮肤?		
您在过去两年中是否检查过眼睛?		
您是否可以轻松地听明白事情?		
您是否不吸烟?		
您在过去 6 个月中是否做过牙科检查?		
您是否能保持平衡并且最近没有跌倒过?		
您的足部是否有脚疮、水泡和肿胀?		
您是否对自己的睡眠质量感到满意?		
您是否觉得自己对目前所服用的药物掌握有足够的信息?		
在感到精神紧张或不适时, 您是否有可以联系的人?		
您是否觉得自己的大小便功能正常?		
如果您年满 50 岁, 您是否向医生咨询过肠癌的情况?		
对于自己的性健康, 您是否有可以联系的人?		
仅限女性回答:		
您在过去 2 年中是否做过巴氏涂片检查?		
您在过去一年中是否找医生检查过乳房?		
如果您年满 50 岁, 您在过去 2 年中是否做过乳房 X 光检查?		
仅限男性回答:		
如果您年满 45 岁, 您在过去一年中是否检查过前列腺?		

如果您对其任何问题回答“否”，请务必找全科医生跟进，并向支持工作者查询您可能需要的任何支持。

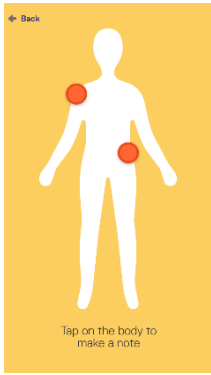
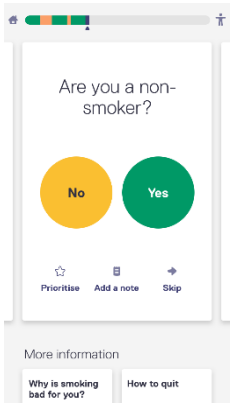
18. Are your feet free from sores, blisters and swelling?



My Physical Health Prompt
Pictorial Guide

Health Prompt Types

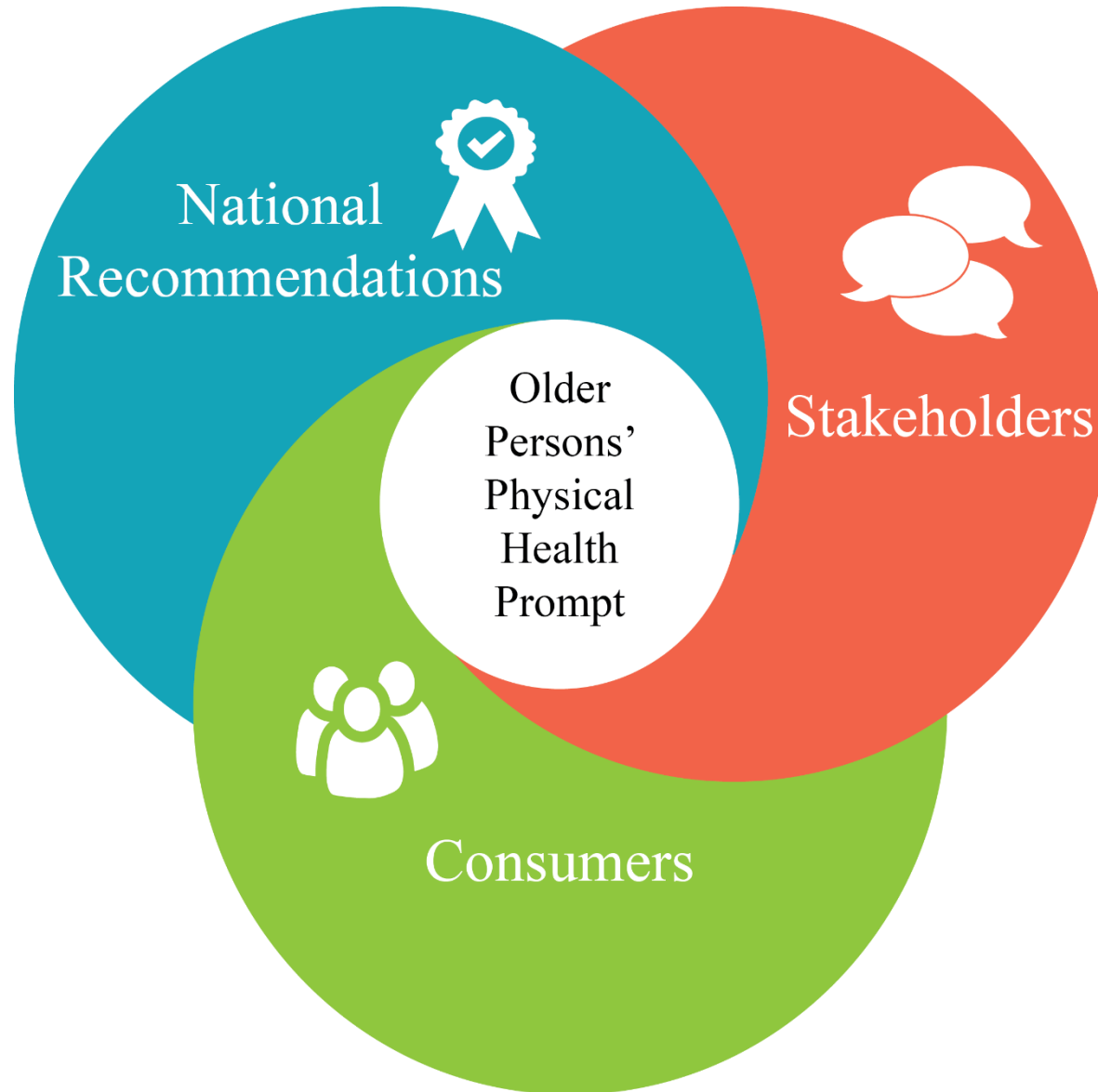
- Pictorial
 - (low literacy)
 - Aboriginal and Torres Strait Islander
- App
 - (my e-health prompt)
- Translations
 - Somali
 - Mandarin
 - Auslan
 - <https://youtu.be/GFUIFRNyxDO>



Health Prompt - Auslan version



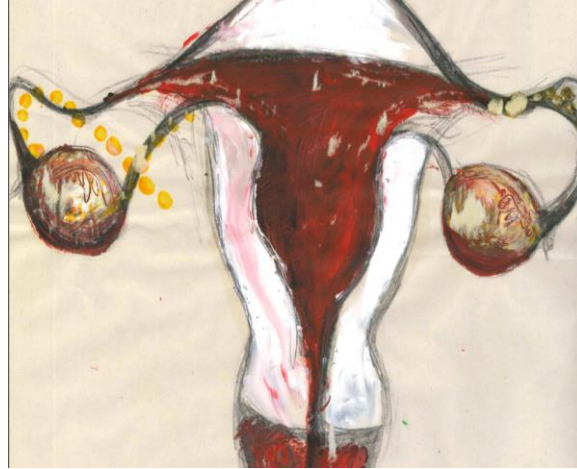
- NSW Health Guidelines
- National bodies (eg. Heart Foundation, Cancer Council)
- National Ageing Research Institute (NARI)
- Evidence based research



- Neami Health & Wellbeing
- Organisations

- Paid and unpaid from older person services

Co-designing the Pictorial Health Prompt



* DENTITION + PATIENT

- * BALANCE: RE-TAKE PHOTO AS "SEE-SAW"
- * FEET: HEALTHY vs UNHEALTHY
- * SLEEP: SOMEONE ASLEEP IN BED
W SMILE + "Zzz"
- * MEDICATION: BACK/FRONT OF BOX?
- * CONTACT: TWO PEOPLE TOGETHER -
ONE CONCERNED + ONE WORRIED
- * BOWEL FUNCTION ✓ CONTINENCE FOUNDATION
BOWEL ON PAGE 6 with BREAST CHECK: 11/10/10





For more information contact;

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Mr. Brian Tomney
Clinical Nurse Consultant
Northern Sydney LHD



**Northern Sydney LHD
Older People's Community Mental Health Service
Physical Health Care Practice Improvement Project**



Northern Sydney Community OPMHS

- ▶ NSLHD OPMHS serves a population of 950,00, distributed across 9 LGA s over an area of 900km². Approximately 16% of the population are over the age of 65
- ▶ NSLHD residents compare favourably on most socioeconomic and health status indicators with the rest of NSW, but there are identifiable areas and population sub-groups with higher needs
- ▶ NSLHD has the highest population of residents aged 85 and over of all NSW LHDs
- ▶ The community OPMHS is made up of 4 multidisciplinary teams based in Hornsby Ku-ring-gai, Ryde, Northern Beaches and North Shore
- ▶ The strategic governance of the service comes under the OPMHS Program Manager while the individual services come under the operational management of their respective area Service Directors. Three OPMHS community services fall under the governance of the Mental Health Drug and Alcohol Service while the Royal North Shore OPMHS reports to the Aged Care Service

Our Project

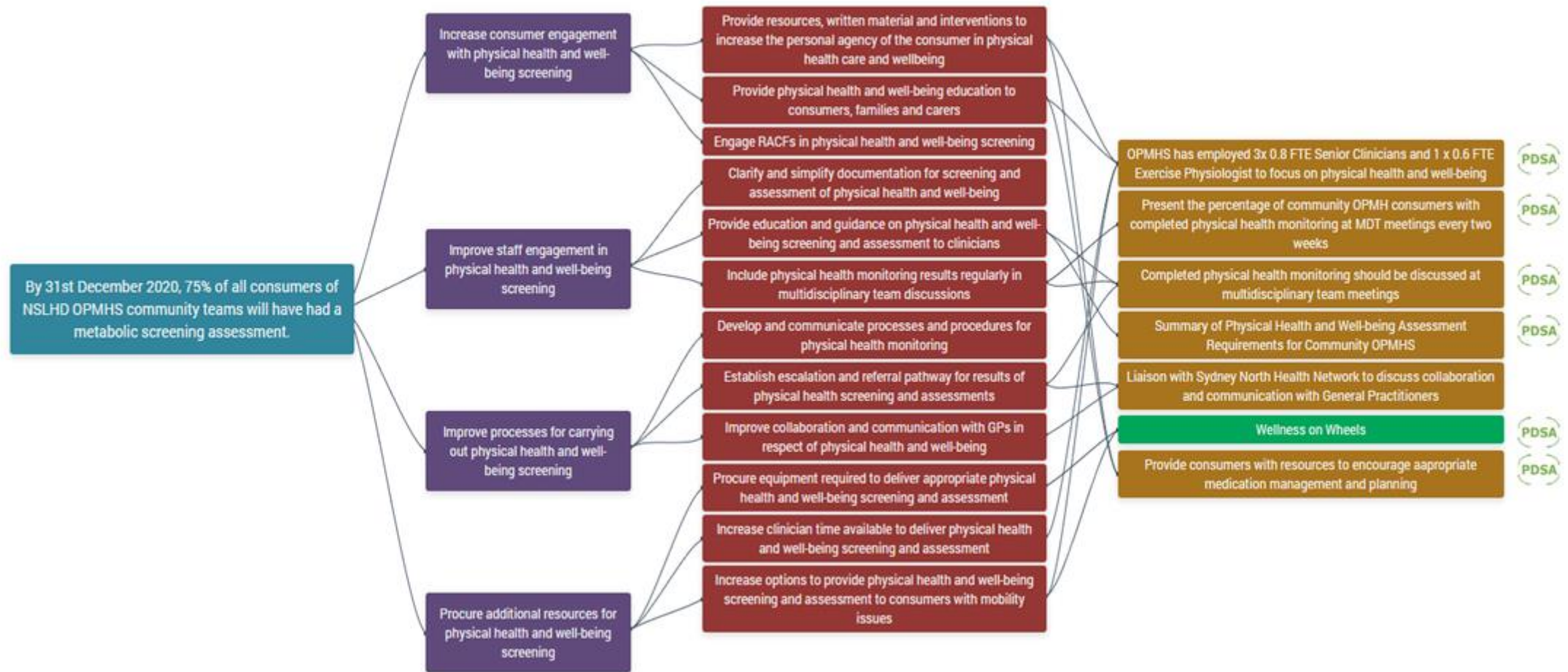
- ▶ The aim of our project is that by 31st December 2020, 75% of all NSLHD community OPMHS consumers will have had a metabolic screening assessment.
- ▶ An audit in early March 2020 of baseline measures for OPMHS consumers showed that in the four community teams, only between less than 1% and 30% of consumers had a metabolic screening assessment completed.
- ▶ Literature reviews detailed the poor physical health of people with severe mental illness including increased risk of cardiovascular disease, metabolic syndrome and diabetes on a background of increased level of smoking and lower levels of physical activity
- ▶ It was decided by the Project Working Group that increasing the rate of metabolic screening for our consumers would provide a clear, measurable and beneficial project objective.



Project methodology

- ▶ A project working group was formed at the end of 2019 with representatives from each of the four OPMHS community teams and from the NSLHD OPMHS Executive team. In June 2020 , through OPMHS Growth funding we were able to recruit three Senior Mental Health Clinicians to our three MHDA teams as well as a part time Exercise Physiologist to work across these three teams. These clinicians were employed to focus on the physical health and wellbeing of OPMHS consumers and were added to the project working group.
- ▶ The group meets monthly with most people attending in person.
- ▶ Myself and another member of the working group attended the two day Clinical Excellence Commission Improvement Science Workshop in January 2020 and it was decided that we would adopt this methodology for our project





Project Driver Diagram

- ▶ I have found compiling and regularly updating the Driver Diagram helpful in planning and structuring the project.
- ▶ It has been used by the project working party in every meeting to review progress to date and to plan and agree upon future interventions and PDSA cycles.
- ▶ Once the project objective had been agreed, the working group followed the CEC methodology and carried out a brainstorming and affinity diagram exercise to identify the root causes of the problem we were trying to solve. The group worked in silence , writing the causes of our problem on post –it notes. These were then grouped and reformulated into actions that the project team could take. The category headings became the primary drivers with the statements under each heading becoming secondary drivers.



Interventions – Wellness on Wheels



Wellness on Wheels (WOW)

Wellness on wheels will focus on facilitating early health and wellbeing assessment and screening for consumers of OPMHS. Interventions provided will be patient centered, recovery focused and culturally sensitive and include:-

Monitoring potential side effects of prescribed medication.

Promote healthy lifestyles

Facilitate routine screening of physical health problems.

Facilitate comprehensive screening for gambling, drug & alcohol and smoking use and referral for specialist support as necessary.



**OPMHS—Ryde Community
Mental Health Service.
39-41 Fourth Avenue,
East Wood
NSW 2122**

02 9858 7888



Wellness on wheels



Tel: 9858 9777



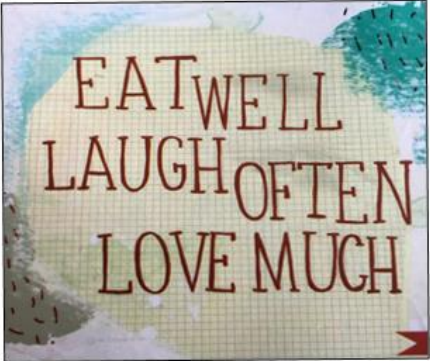
or

Mental Health Crisis Line:


1800 011 511

Information and Education


Northern Beaches Older Peoples' Mental Health Service



Health & Wellness Program

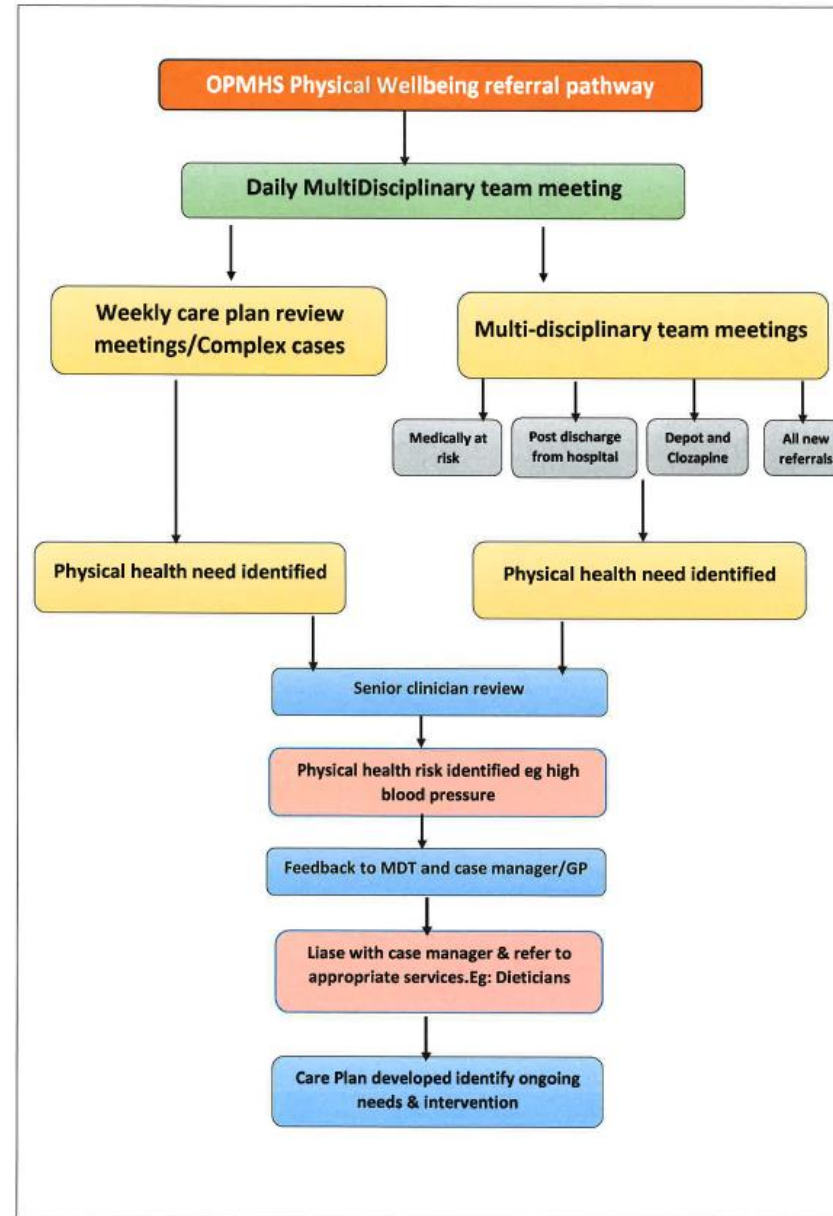


Northern Beaches Mental Health Service
OPMH
612-624 Pittwater Rd
BROOKVALE NSW 2100
Tel 02 9388 5366 Fax 02 9388 5192



Health
Northern Sydney
Local Health District

Review of process

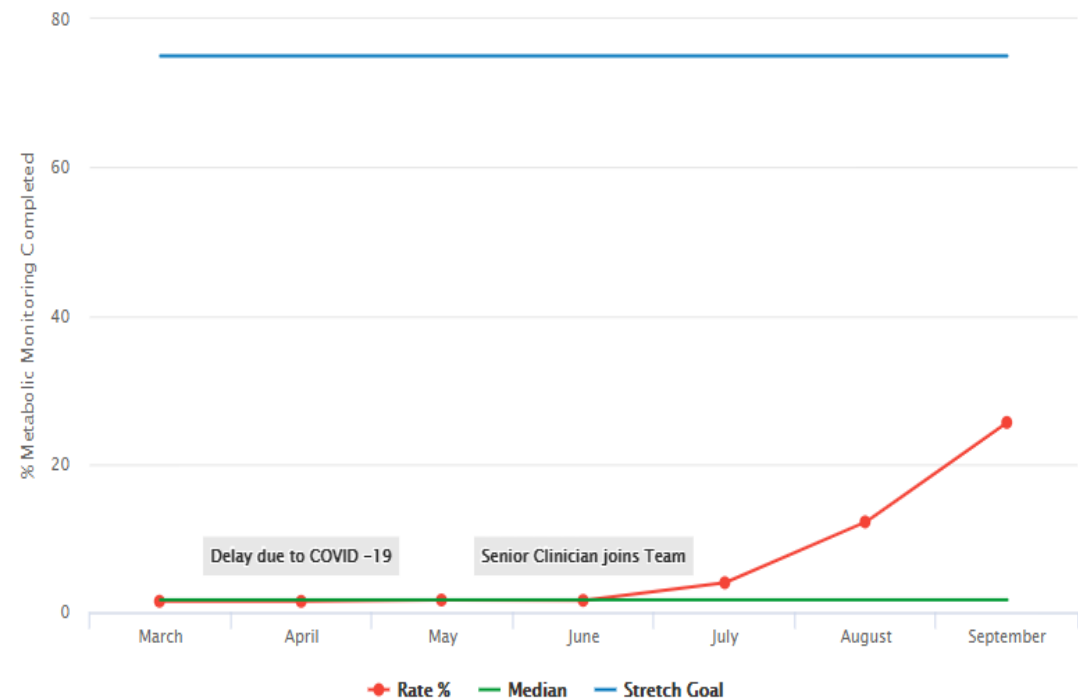


Results so far

7900 - Metabolic Monitoring - Ryde



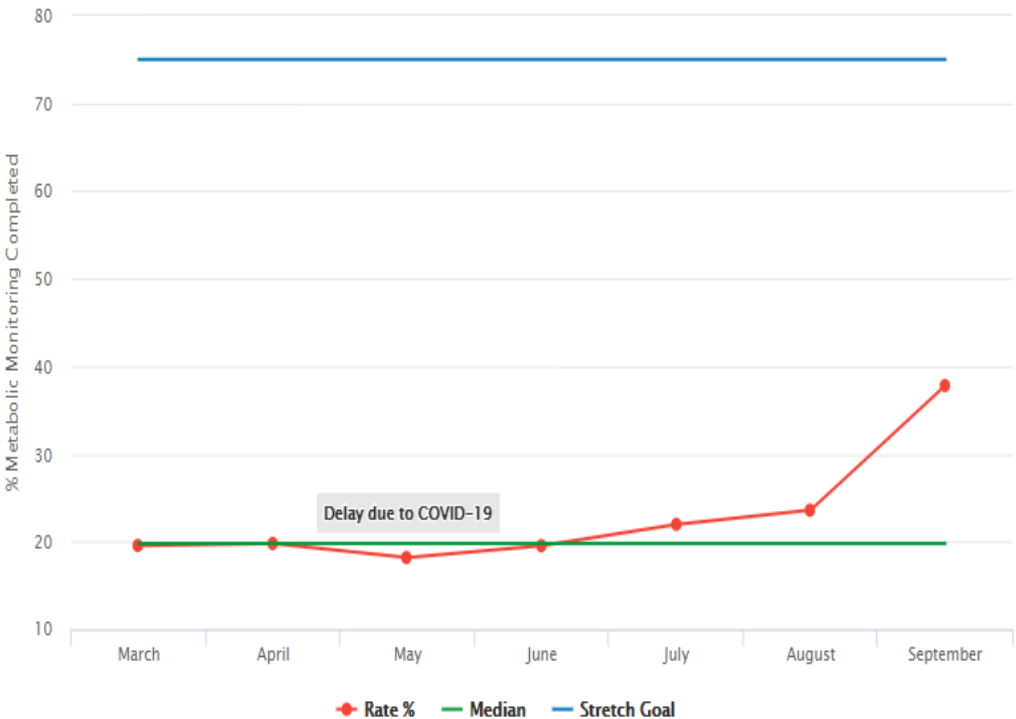
Metabolic Monitoring - Ryde



7907 - Metabolic Monitoring - Hornsby

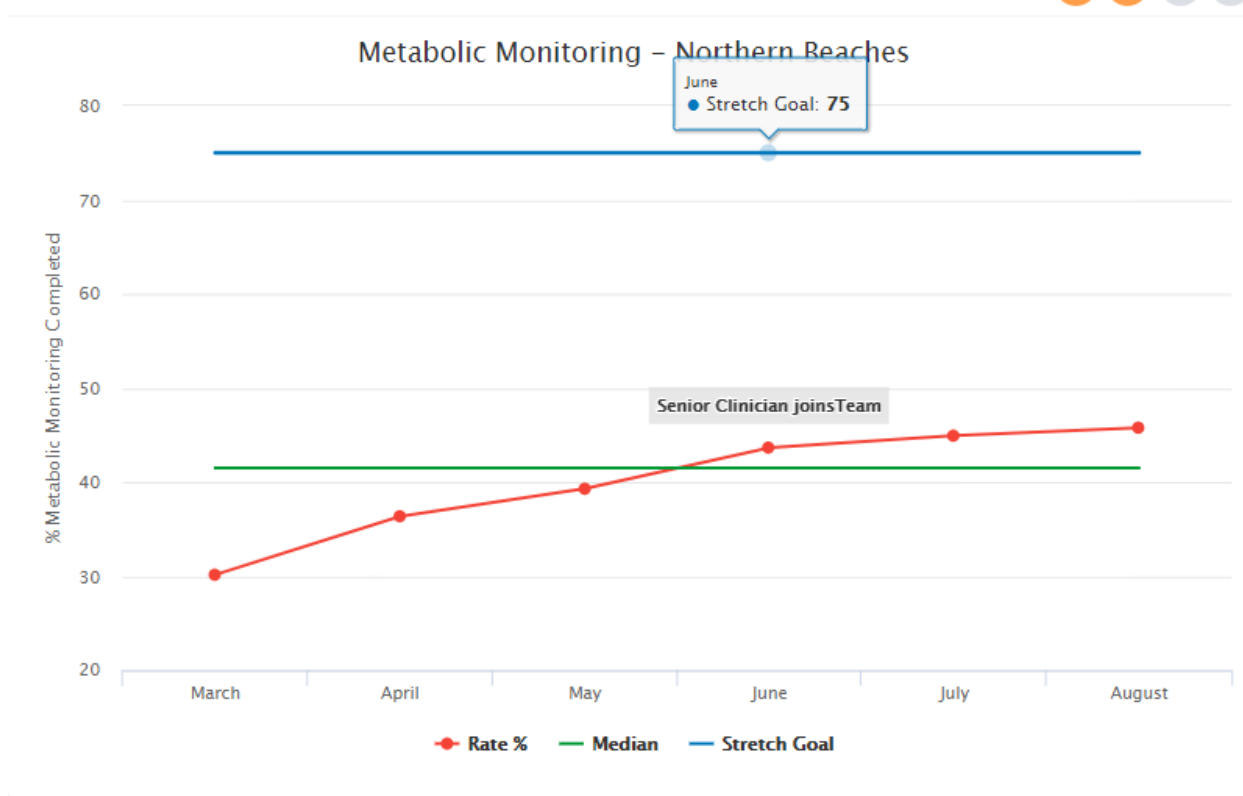


Metabolic Monitoring - Hornsby



Results so far

7908 - Metabolic Monitoring - Northern Beaches



Challenges

- ▶ COVID-19 led to a 3 month delay. Some staff still working from home some of the time.
- ▶ Staff movements have meant changes in the project working party
- ▶ Uncertainty around current policy and procedures for physical health assessment.
- ▶ Lack of resources for physical health assessment.
- ▶ Uncertainty around medico-legal implications of doing regular physical health monitoring eg escalation procedures, what do we do with the results
- ▶ Uncertainty over referral pathways
- ▶ Lack of consumer involvement
- ▶ Some blurring of the boundary between the physical health care improvement project and the role of our newly appointed senior mental health clinicians and exercise physiologist



What now

- ▶ Continue work to raise physical health issues as routine in consumer assessments, MDT case reviews and in care planning.
- ▶ Further engagement of staff in physical health and wellbeing assessments
- ▶ Continue to inform GPs about the project and communicate results of physical health assessments
- ▶ Further discussion required around procedures for recording and communicating results of physical health assessments as well as escalation procedures when there are results of concern
- ▶ Ensure consumer involvement in the project eg all leaflets and consumer information distributed will be reviewed by consumers



Questions and discussion

Supporting the physical health of older people's mental health service consumers:
practice improvement ideas building on what we know and what we have

Presented by:

Dr Rod McKay, NSW Health/HETI
Dr Kate Jackson, NSW Health

Dr Carmelo Aquilina, SWS LHD
Mr Steve Suttie, NEAMI
Mr Brian Tomney, NS LHD

