KEY INFORMATION:

GRANTEE
Institute for Community Living, Inc.

GRANT TITLE
Integrated Wellness: Improving the Assessment and Management of Type II Diabetes in Adults with Serious Mental Illness

DATES
December 1, 2007 – January 13, 2012

GRANT AMOUNT
$567,066

FUNDING
2007 Setting the Standard: Advancing Best Practices in Diabetes Management Request for Proposals

Grant Outcome Report

Improving the Assessment and Management of Diabetes for Adults with Serious Mental Illness

The Problem

Individuals with serious mental illness are 2.3 times more likely to develop diabetes during their lifetime and 2.7 times more likely to die from diabetes-related complications. Increased diabetes prevalence among this population is partly a result of the use of antipsychotic medications, which have been associated with weight gain and diabetes, but also is linked to certain symptoms of mental illness that can make healthy lifestyle choices difficult to achieve. These physical and mental health co-morbidities not only reduce quality of life, but are associated with high hospital admission rates. While the Chronic Care Model (CCM) has proven effective as a framework for improving primary care within the general population, it has been only marginally applied to care for persons with serious mental illness. The Institute for Community Living (ICL), a provider of recovery and treatment services for people affected by or at risk for mental and developmental disabilities, sought to confront the significant challenge of poorly-controlled diabetes in those with serious mental illness. As part of the overall project, ICL and Urban Institute for Behavioral Health (UIBH) developed a partnership with 18 other nonprofit multiservice agencies serving similar populations. The project, known as the Diabetes Co-Morbidity Initiative (DCI), was designed to prepare behavioral health agency (BHA) staff members to help clients better manage their Type 2 diabetes. The role of BHA staff included providing diabetes education and self-management support in both one-on-one and group settings, and coordinating care between clients' BHAs and their medical providers.

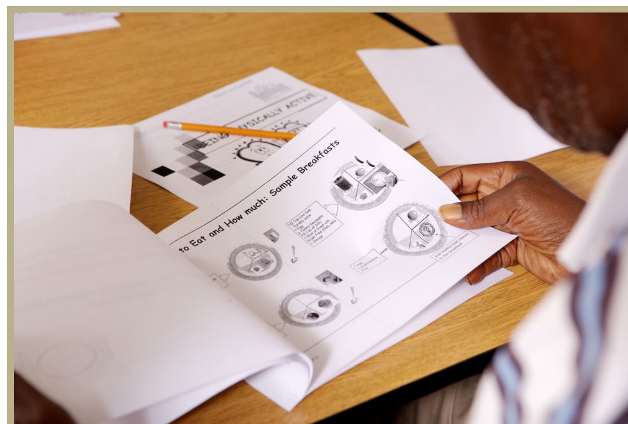
This project was funded under NYSHealth's 2007 *Setting the Standard: Advancing Best Practices in Diabetes Management* request for proposals (RFP). The goal of *Setting the Standard* was to move New York State's primary care system to adopt and spread best practices in disease management and establish them as the universal standard of care for patients with diabetes. At the time, multiple diabetes management programs already existed throughout New York State, along with established collaboratives to maximize the impact of these programs. Thus, NYSHealth expected

VOICE: 212-664-7656 FAX: 646-421-6029 MAIL: 1385 Broadway, 23rd Floor, New York NY 10018 WEB: www.NYSHealth.org

the grants made under the RFP to advance these programs and build systemwide capacity to support, sustain, and institutionalize these efforts. The CCM—a highly respected and accepted framework for approaching the improvements sought through this initiative—was a major reference point in the RFP.

Grant Activities and Outcomes

Under this grant, ICL intended to improve the quality of life and reduce morbidity and mortality for individuals with Type 2 diabetes and serious co-occurring mental illness in New York State. Toward that end, ICL used NYSHealth funding to form an interagency learning collaborative; develop an intervention package to inform better and more coordinated clinical care processes for integrated medical and psychiatric care; develop a disease registry and other data collection strategies to monitor outcomes; train staff members to oversee new care processes; ensure smooth implementation of the DCI; and create a DCI toolkit that could be distributed broadly. ICL's executive leadership strongly supported this project. The program met its goals related to producing training materials, securing program participation, and training staff members.



The interagency learning collaborative, which was led by ICL and UIBH and included representatives from eight partner organizations, designed a toolkit for improving diabetes support. This DCI toolkit was extensive and included elements such as guidelines for client assessment and diabetes screening; policies, procedures, and tools for care coordination; and training materials for both staff members and clients.

ICL and UIBH implemented the DCI at 19 BHAs in New York City, Long Island, Westchester, and Central New York, setting up a total of 44 programs. This exceeded their original target of 24 programs and 6 agencies. More than 20 additional agencies expressed an interest in the DCI toolkit following a conference presentation. Many BHAs have continued to use the DCI materials in the programs that participated in the initial rollout, and several—including Services for the Underserved, FEGS Health and Human Services, Catholic Charities, and ICL—have expanded its use to additional programs within their organization. The continued application of the DCI demonstrates BHAs' recognition of the need for an integrated wellness approach and the applicability of the DCI as a central component of that work.

VOICE: 212-664-7656 FAX: 646-421-6029 MAIL: 1385 Broadway, 23rd Floor, New York NY 10018 WEB: www.NYSHealth.org

During the grant period, ICL provided diabetes training to 324 staff members, exceeding its original training goals of 144–192 staff members. A diverse group of staff members participated in the trainings, including case managers, licensed social workers, psychologists, medical doctors, and food service providers. The diabetes self-management groups that were the core of the intervention were also led by a diverse array of staff members. A workbook containing diabetes education materials and self-care tools was central to the training and was well received. ICL planned to reproduce and sell licenses for the workbook and toolkit as a means of providing limited financial support for continuation of the program once grant funding ended.

Though it enrolled 414 clients into the DCI project, ICL fell short of its target for client participation on a per care manager basis. It originally aimed for 30 clients per care manager from each participating program. Participation was significantly lower, with an average of three to seven clients per care manager, in part because the DCI actively worked to train multiple care managers from each program to increase sustainability. Lower client numbers per agency were also partly attributed to the fact that participating program sizes varied, with a minority of programs having more than 30 clients with diabetes. In addition, client participation was voluntary, thus not all clients with diabetes chose to participate. On average, groups lasted four to six months, with dropout rates of 20–25% over the duration of the group.

ICL's program evaluation design included a review of diabetes registry data and focus groups with participating staff members and clients. Staff focus group data indicate that clients benefited from participation as evidenced by changes in diabetes self-care behaviors, including an increase in self-advocacy with medical providers and in obtaining recommended diabetes services such as eye and foot exams. However, ICL encountered challenges in gathering registry data from clients' medical providers, as most providers were not affiliated with the BHAs. Of the more than 400 providers who did submit data, only approximately one-third provided data at both baseline and follow-up. As a result of the small sample size of the data obtained for each outcome indicator, the findings should be interpreted with caution:

- The proportion of clients who received the six tests recommended by medical practitioners to help manage diabetes (A1c blood test, blood pressure, cholesterol test, kidney exam, eye exam, and foot exam) increased significantly.
- Clients showed evidence of improvements in their health behavior, most notably on items regarding choosing healthy foods. Other areas of improvement included checking their feet daily, increasing physical activity, and managing stress.

The design of a replicable program model and the spread of the DCI to additional BHAs and programs were explicit goals of the initiative. Therefore, some quality assurance procedures

VOICE: 212-664-7656 FAX: 646-421-6029 MAIL: 1385 Broadway, 23rd Floor, New York NY 10018 WEB: www.NYSHealth.org

were developed as part of the intervention package to ensure fidelity to the program design. Over the course of the initiative, a fidelity check was conducted with 9 of the 19 participating agencies to assess the level of consistency with the program model. One of the key steps of the implementation process was the use of ongoing check-in calls with each agency, alternating between group and individual agency calls. These calls were also supplemented by in-person learning sessions for agencies and as-needed site-specific individual consultations. No formal documentation of the implementation process at multiple programs was available to assess program consistency across agencies.

Participating programs also informed ICL that some primary care physicians and medical clinics were not as supportive in explaining health information to DCI patients. Some patients had such negative experiences that they worked with staff members to develop a directory of diabetes-friendly providers. ICL also found that DCI implementation challenges varied from urban to nonurban settings. Programs located in urban settings had access to transportation, but food retailers that provided fresh produce and healthier food choices were not located in their neighborhoods. In nonurban areas, healthy food choices were available, but affordable and accessible transportation was not.

The Future

The DCI project has continued beyond the grant period. Some agencies involved in the project have expanded the DCI to additional programs, while continuing DCI services in the original programs, suggesting that it has become a part of their agency culture. ICL's goal to expand beyond the 6 agencies targeted in the original proposal was met during the grant period when the DCI was implemented in 19 agencies and reached much of the New York City region. ICL continues to extend its work in diabetes and disease management and integrated health, and ICL's DCI staff members continue to:

- Provide informal support to agencies that continue to expand upon their initial program;
- Provide the diabetes self-management workbook at no cost to those agencies;
- Offer the DCI toolkit to agencies that express interest (e.g., at conference presentations);
- Raise funds to support a DCI website, along with Web-based learning and data collection tools; and
- Stay involved with community initiatives.

VOICE: 212-664-7656 FAX: 646-421-6029 MAIL: 1385 Broadway, 23rd Floor, New York NY 10018 WEB: www.NYSHealth.org

BACKGROUND INFORMATION:

ABOUT THE GRANTEE

The Institute for Community Living (ICL) is a multifaceted, multiborough behavioral health nonprofit organization. Formed in 1986, its mission is to assist individuals and families affected by mental and developmental disabilities. During its 26-year history, ICL has developed a broad array of programs and services to meet the needs of the community and consumers it serves, including community housing programs; community-based mental health clinics; a personal recovery-oriented services program; school-based and shelter-based treatment programs; a transitional residence for veterans; case management and assertive community treatment teams; family support services; and employment services. ICL's affiliate agency, Health Care Choices, is a federally qualified health center that offers dental, primary, and specialty care to people with serious mental illness and developmental disabilities. This network serves more than 10,000 consumers annually with a workforce in excess of 1,100 distributed throughout 100 programs in Brooklyn, Queens, the Bronx, and Manhattan, as well as in Montgomery County, PA. ICL is funded through diverse city, State and federal funding streams.

GRANTEE CONTACT

Jeanie Tse, M.D.
Associate Chief Medical Officer / Director of Integrated Health
Institute for Community Living, Inc.
40 Rector Street, 8th Floor
New York, NY 10006

Phone: (212) 385-3030 Ext. 3113
Fax: (212) 385-2380
E-mail: jtse@iclinc.net

NYSHEALTH CONTACT

Jacqueline Martinez Garcel

GRANT ID

1920882