NO HEALTH *without* MENTAL HEALTH

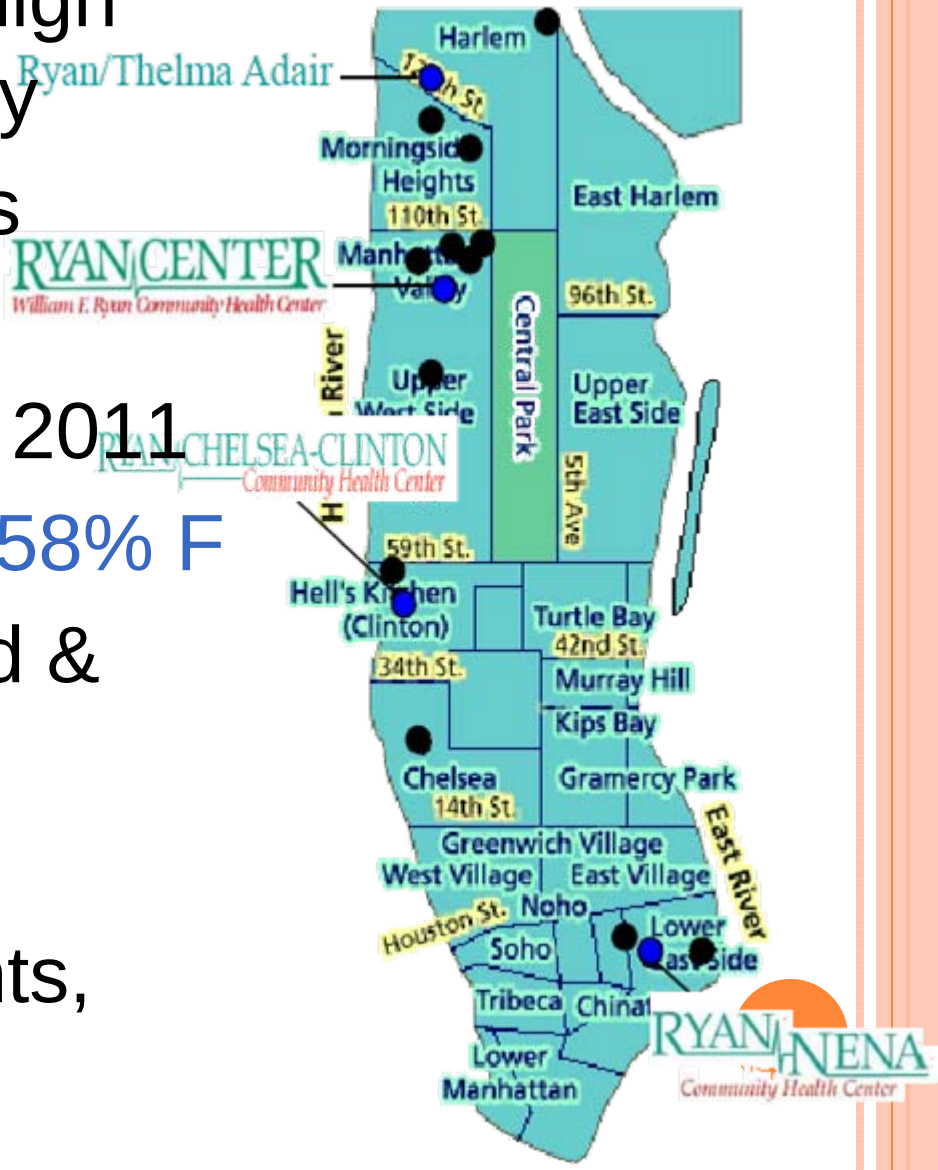
Nancy Andino, *LCSW*,
Patient Navigation Coordinator
William F. Ryan Community Health Center
110 West 97th Street
New York, NY 10025
www. ryancenter.org

LEARNING OBJECTIVES

- List 3 important characteristics of a Patient Navigation program
- Identify 3 important characteristic of a case which requires Patient Navigators and Mental Health professionals to work as a team.
- Identify two aspects of clinical supervision necessary to successfully serve patients with chronic conditions and mental health disorders in a Patient Navigation Program.

WILLIAM F. RYAN NETWORK

- Over 45 years providing high quality, affordable, primary care and support services
- Four main sites (16 total)
- 49,192 patients served in 2011
- Race: 74% minority Sex: 58% F
- Insurance: 27% uninsured & 67% public insurance
- Homeless: 2,645 (5%)
- Age: 34% pediatric patients, 57% adult, 10% 65+



PROGRAM

Program Focus	Navigator Skills
Health Care Disparities	**Advocacy**
Support and Guidance	**Culturally Sensitive / Interpersonal Skills / Awareness of Services**
Education	**Continuously Trained**
Care Coordination	**Health Care / Community Knowledge**
Health and Social Barriers	**Assessment / Problem Solving Skills**

CONNECTION

- **Diabetes**: 1 in 4 suffer from Depression; Mortality increases by 30% for Diabetics;

  Co-occurring disorders = severe symptoms from both conditions, increases work disability and medical services used more than those with Diabetes alone.

- **Hypertension**: Patients aware of Hypertension Diagnosis have higher risk of psychological distress

1. World Federation for Mental Health: Mental Health and Chronic Physical Illnesses, The need for Continued and Integrated Care Diabetes and Depression section, pg. 11; Diabetes and Mental Illnesses pg 12 .
2. 2. Hypertension Awareness and Psychological Distress Mark Hamer, G. David Batty, Emmanuel Stamatakis, Mika Kivimaki Hypertensionhyper.ahajournals.org *Hypertension. 2010; 56: 547-550* Published online before print July 12, 2010, doi: 10.1161/HYPERTENSIONAHA.110.153775 1

WITHOUT OVERSTEPPING SCOPE

- Clinical Supervision eliminates role confusion
- Strength-based supervision / Effective trainings
- Patients share different information with different providers.
- ***COORDINATION*** between MH and PN
- Informed patient can participate in a collaborative model resulting in appropriate services and referrals.

PATIENT EXAMPLE

- Maria has a diagnosis of diabetes and hypertension and *undiagnosed MH disorder*
- Unstable diabetes and hypertension despite Rx
- Domestic Violence at home
- Not receiving MH services at time of Intake
- Medical provider was not aware of patient's DV situation or home environment

BENEFITS OF PN

- Practitioners get assistance with helping patients achieve their health goals.
- Practitioners gain knowledge of patient's barriers to treatment.
- Practitioners treat a better informed patient ready to collaborate.
- Decreases the number of emergency room / walk in visits.
- The Patient Navigator becomes the Coordinator in coordinated care.

REFERENCES AND READING RECOMMENDATIONS

References:

1. World Federation for Mental Health: Mental Health and Chronic Physical Illnesses, The need for Continued and Integrated Care Diabetes and Depression section, pg. 11; Diabetes and Mental Illnesses pg 12 .
2. Hypertension Awareness and Psychological Distress Mark Hamer, G. David Batty, Emmanuel Stamatakis, Mika Kivimaki Hypertensionhyper.ahajournals.org *Hypertension. 2010; 56: 547-550* Published online before print July 12, 2010, doi: 10.1161/HYPERTENSIONAHA.110.153775 1

Reading Recommendations:

1. World Federation for Mental Health: Mental Health and Chronic Physical Illnesses, The need for Continued and Integrated Care
2. A Patient Navigator Manual for Latino Audiences: The Redes En Acción Experience
3. Tackling Care as Chronic Ailments Pile Up By JANE E. BRODY Published: February 21, 2011; New York Times
4. Multiple Chronic Conditions: A Strategic Framework; Optimum Health and Quality of Life for Individuals with Multiple Chronic Conditions : http://www.hhs.gov/ash/initiatives/mcc/mcc_framework.pdf
5. Chronic Care: Making the Case for Ongoing Care: By Anderson G; Robert Wood Johnson Foundation; Published 01/01/2010 http://www.rwjf.org/content/rwjf/en/research-publications/find-rwjf-research/2010/01/chronic-care.html