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CONFERENCE ABSTRACT

Five year evaluation of an integrated care initiative to improve the physical health of people living with severe mental illness: The Living Well, Living Longer program

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Introduction

Eighty percent of people living with severe mental illness have a coexisting physical health condition such as diabetes or hypertension. They are six times more likely to die from cardiovascular disease compared to the general population and have a reduced life expectancy of 14- 23 years. These statistics impact 2-3% of the population and the mortality gap continues to grow.

Description

The Living Well, Living Longer (LWLL) program integrates physical health into the routine care of people with severe mental illness. The program is built on four stages of screening, detection, initiation of treatment and ongoing management and has implemented three key strategies to improve health outcomes. Firstly, the Collaborative Centre for Cardiometabolic Health in Psychosis (ccCHiP), a multidisciplinary clinic where consumers see eight metabolic health specialists in one afternoon. Secondly, Mental Health Shared Care (MHSC) introduces a formalised care arrangement with the consumer's GP. Thirdly, community lifestyle clinicians (dietitians, exercise physiologists, smoking cessation counsellors) implement individualised achievable health behaviour change goals.

Aim

The strategies described each have integration of physical and mental health at their core and integrate with each other to provide the consumer with a seamless journey. The aim is to improve health outcomes through the integration of physical and mental health.

Targeted population

LWLL targets care coordinated consumers within Sydney Local Health District. Key stakeholders include consumers and carers, GPs, care coordinators, lifestyle clinicians and other specialist clinicians.

Timeline

The LWLL program commenced in 2014 alongside ccCHiP to ensure the clinic was fully integrated with community mental health services. MHSC was piloted in 2017 and rolled out across the district in 2018. All initiatives rely on an annual cycle of care.

Highlights

The ccCHiP clinic reviews over 400 people annually and integrates with MHSC and community lifestyle clinicians for ongoing management. MHSC has formally linked over 650 consumers with 264 GPs. Community lifestyle clinicians engage ~500 individuals annually through individual interventions or group programs.

Sustainability & Transferability

LWLL initiatives are now the routine approach to providing comprehensive integrated healthcare. Care coordinators are orientated to LWLL with targets to increase referrals and engagement. Furthermore, LWLL funds permanent staffing enhancements including peer support workers, nurse practitioners and shared care coordinators who play a key role in championing LWLL engagement within teams. All LWLL strategies could be transferred to other health districts.

Conclusions

LWLL initiatives have positively impacted hundreds of mental health consumers. A recent audit found that average weight and waist of consumers managed under LWLL has reduced by 5kg and 6cm respectively over three years. Further analysis is underway to validate these findings.

Discussions

The challenges of implementation are plentiful, ranging from amotivation of consumers to time constraints on care coordinators & GPs. However with the commitment of all to address the significant health disparities that exist within this vulnerable cohort, significant advances can be made.

Lessons Learned

The integrated care approaches within LWLL can lead to improved screening, detection, treatment and management of the physical health of people living with severe & enduring mental illness.