King County Behavioral Health and Recovery Division

Supporting Management of Medical Conditions:

An Overview for Non-Medical Behavioral Healthcare Staff

Supporting Management of Medical Conditions: An Overview for Non-Medical Behavioral Healthcare Staff

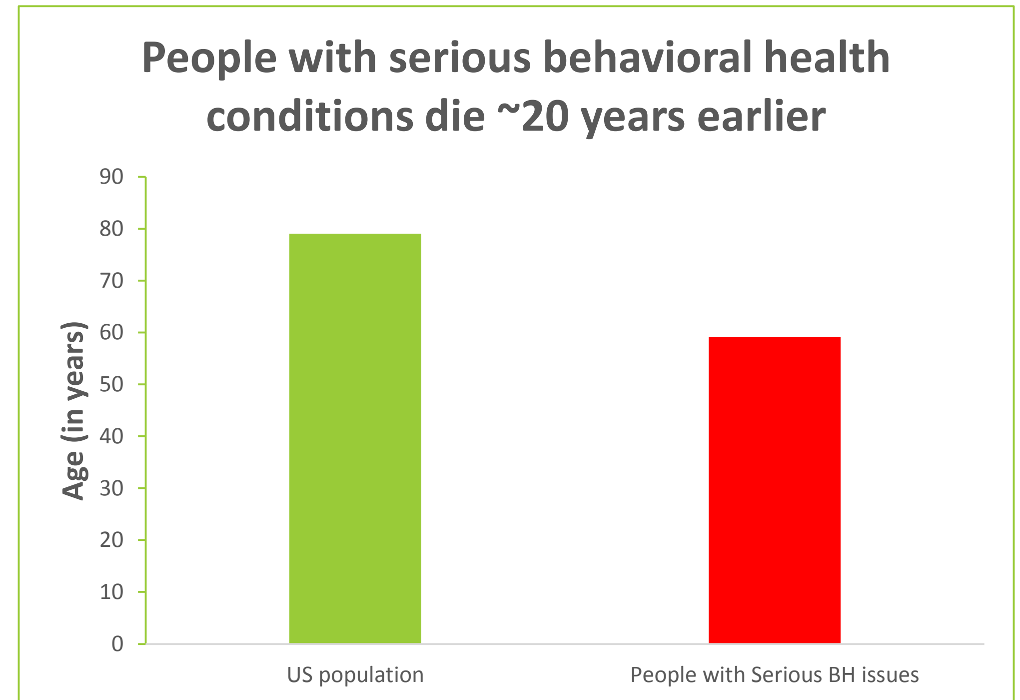
Learning objectives:

1. Recognize that people with behavioral health conditions are at high risk for chronic medical conditions
2. Develop comfort asking questions about 3 common chronic medical conditions, become familiar with their signs and symptoms, and what you can do to support management of them:
   - Hypertension
   - Diabetes
   - Asthma
3. Learn how to support individuals to use and make the most of their medical care
4. Understand how to support individuals' self-management of medical conditions

Why are medical conditions important for behavioral health clinicians?

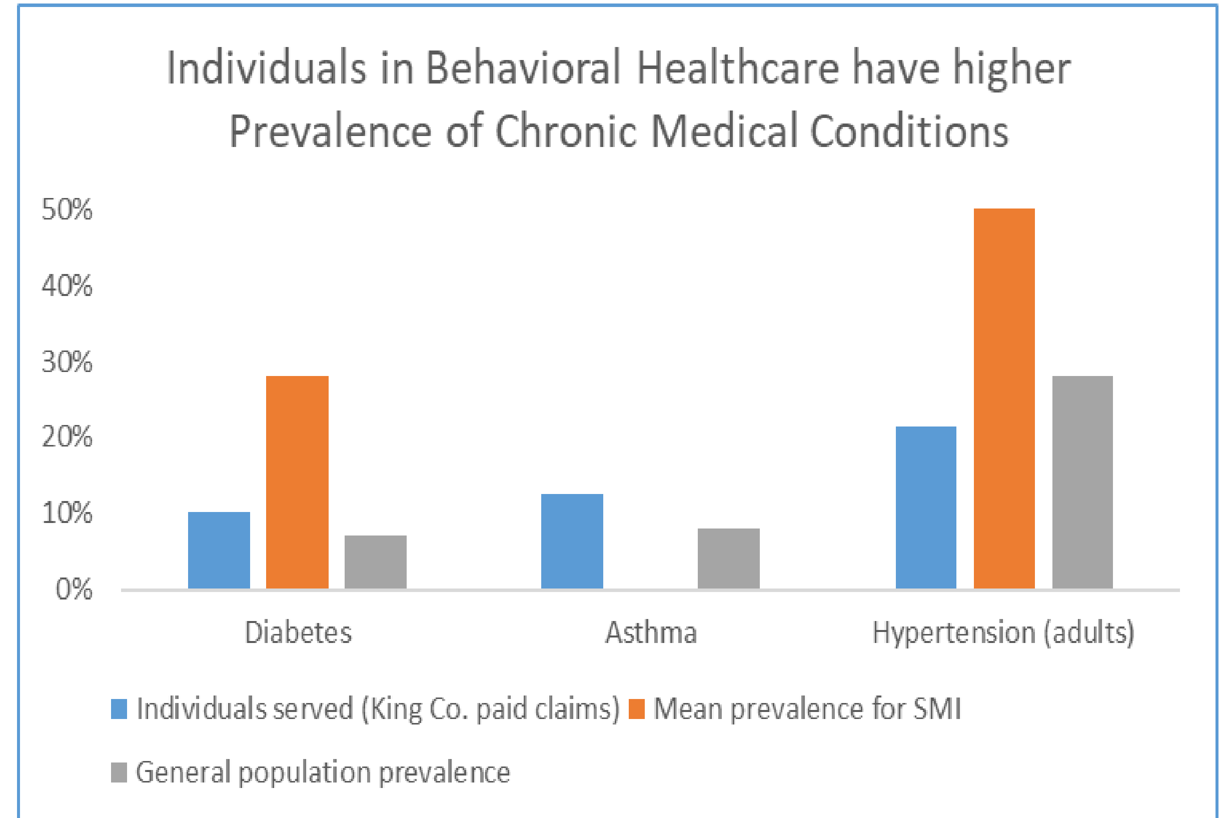
Why are medical conditions important for behavioral health clinicians?

- **Individuals with serious behavioral health (BH) conditions die over ~20 years earlier than the general population, with 60% of premature deaths due to <u>untreated, preventable medical conditions including:</u>**
  - Cardiovascular disease (high blood pressure, high cholesterol, etc.)
  - Diabetes
  - Respiratory conditions
- Almost 75% of people with Medicaid insurance and serious BH conditions have at least one treatable, chronic medical condition



What are common medical conditions among people see for behavioral healthcare?

- The most common medical conditions are: Hypertension, Diabetes, and Asthma
- Individuals seen for behavioral healthcare have ***higher rates of medical conditions*** than the general population
- Many individuals have unrecognized and untreated conditions



*Asthma prevalence not estimated for individuals with serious mental illness (SMI)

What are common risk factors for these conditions?

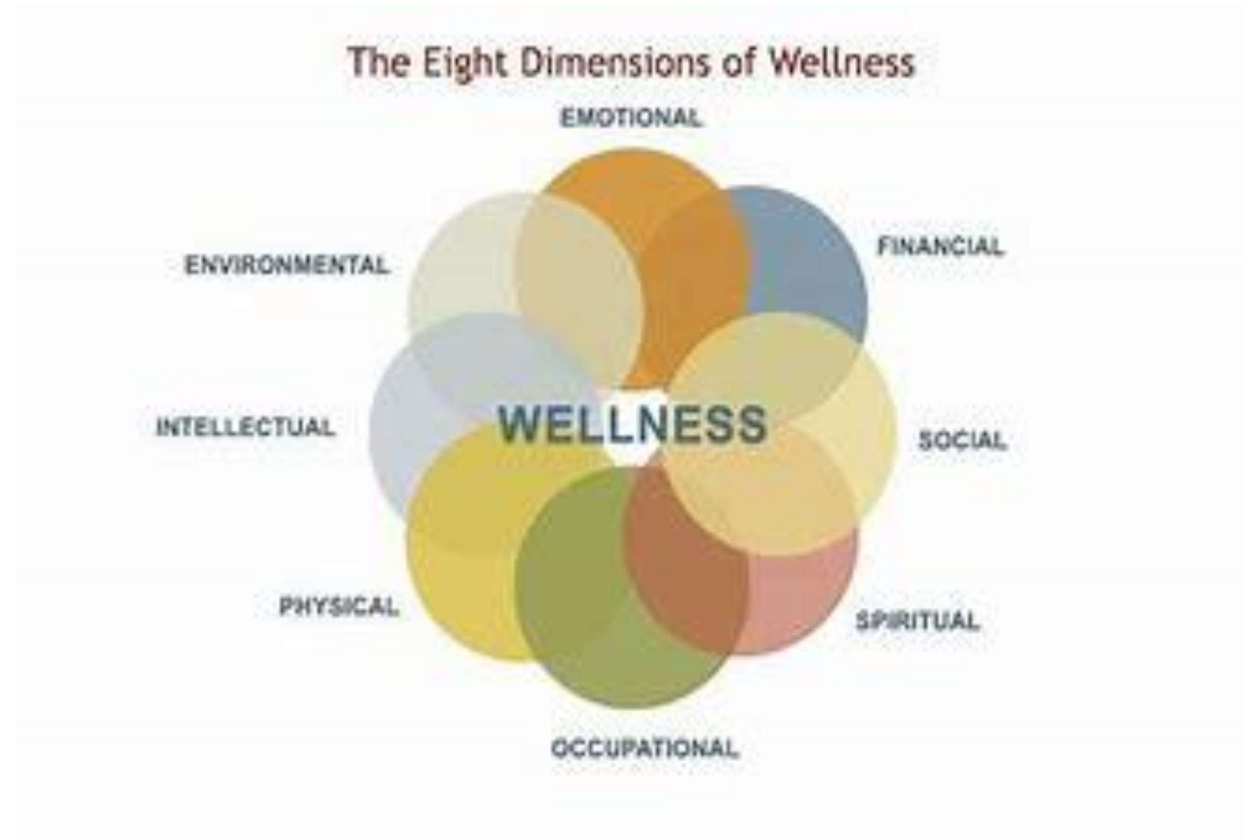
Common risk factors

- These medical conditions have modifiable risk factors in common:
  - Smoking
  - Overweight/obesity (Body mass index – BMI - >25)
  - Nutrition – high fats, carbohydrates, processed foods, and limited fruits and vegetables
  - Inactivity
  - Stress
  - Alcohol and drug use
- Some psychotropic medications can increase risk
- These risk factors occur at higher rates among individuals with behavioral health conditions
- Why? Poverty, lack of access to healthy foods, recreational activities and preventive care

How can BH staff help?

How can BH staff help?

1. Ask about and help identify the most common medical conditions – and their risk factors - among individuals served
2. Support people served to use medical care and follow treatment
3. Apply skills in helping people manage BH conditions to support self-management of medical conditions as part of whole-health and wellness care



Asking about medical conditions

Many people seen for BH care do not know they have certain medical conditions – especially hypertension (high blood pressure) and diabetes

What you can do – Ask questions and/or use checklists to obtain information:

- Medical history:
  - Current/past diagnoses of hypertension, diabetes, asthma or other conditions
  - Siblings or parents who have had these conditions
  - Current/past symptoms of these conditions – see later slides for detail
- Demographics associated with risk (age, ethnicity) – see later slides for how demographics related to specific conditions
- Social Determinants of Health (SDOH) that can impact care (e.g., housing, finances, transportation)

Asking about medical conditions cont'd

- Health behavior/lifestyle risk – if any endorsed, actions are indicated:
  - Exercise – Is person not getting at least 150 minutes/week (30 min./5 days/week) of at least moderate intensity?
  - Smoking – Does person smoke or vape?
  - Nutrition - Does person not have enough food to eat? What kinds of food eaten? (e.g., want mostly fruit/vegetables, lean proteins, low-fat dairy – and little fast food/processed food, red meat, caffeine, candy chips, soda, energy drinks)
  - Alcohol/substance use (e.g., use CAGE, GAIN-SS or other screener)
  - Stress – Does person feel stressed out, have difficulty coping with daily activities, crying a lot, shaky, fearful, avoidant, etc.

- Physiological risk – if any at problematic level, actions are indicated:
  - Weight/Body mass (BMI) – ask weight and calculate BMI = Wt. in lbs.*703/ht.in (BMI >=25 is overweight)
    - BMI calculator at: https://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmicalc.htm
  - Blood pressure – ask about most recent blood pressure check and/or help client check it if self-reading device available (see Hypertension slides for detail)
  - Hemoglobin A1c and/or blood glucose – ask about most recent check

Common strategies to support medical care

Many people seen for BH care have ***untreated*** medical conditions. People can be overwhelmed and get ‘lost’ in our complex healthcare system, sometimes resorting to use of urgent care and emergency rooms to get care.

Supporting medical care - What you can do

- Ask about use of primary care and urgent/emergency care:
  - Whether individual has a primary care doctor
  - When individual last saw doctor
  - Perception of stigma or discomfort with doctor or waiting room
- Ensure person recognizes and understands symptoms
- Share treatment information with medical care team
- Ensure individual engages with medical care – make appointments, provide appointment reminders and reminders to get periodic exams, go together, facilitate ‘warm handoff’
- Monitor and support medication adherence - identify how to get reminders, how to track side effects, what to do if missed dose, whom to call with questions
- Help individuals identify questions to ask doctors

Common strategies to support self-management

Chronic medical conditions all rely on self-management.

Supporting self-management - What you can do

Provide counseling, coaching and encouragement – and linkage to self-management classes, peer support, and education to address:

- Weight management – if >25 BMI coach and link to activity and nutrition resources/groups
- Nutrition – if nutrition problems indicated, coach and link to groups/classes, or dietician for healthy meal planning, shopping, and cooking. See www.ChooseMyPlate.gov
- Exercise – if not getting 150 min. week, consider referral to walking or exercise group/class
- Smoking/vaping – ask 5 As, counsel and refer to smoking cessation
- Alcohol/drug use – if problems indicated, assess further and refer to treatment if needed
- Stress reduction/coping – coach regarding coping strategies and asking for help with stress, anxiety, depression

Common support strategies - general

Supporting BOTH medical care and self-management – What you can do

Help individuals make ***small goals*** - assess their confidence in completing them. If needed, don't adjust confidence, adjust the goals!   Even small changes can make an impact on health!

Identify and help individual surmount barriers to medical care and self-management such as:

- identifying side effects
- Understanding instructions
- Facilitating access to care and effective communication with healthcare team
- Identifying transportation options
- Stabilizing finances to support healthy eating and active living
- Identifying physical activity opportunities
- Finding places to purchase healthy food
- Assisting with cooking skills and identifying a place to cook

Use motivational interviewing (MI) to bolster attitudes and willingness to change behavior and adhere to treatment to improve health – understanding that behavior change is challenging

Recognize that behavioral health symptoms (e.g., concentration, motivation, self-organization) can impact medical condition self-management and disease control.

Recognize that chronic medical conditions can negatively impact psychiatric symptoms and quality of life

Recognize that self-management and change is hard - there is no immediate consequence for non-adherence – and no immediate payoff for adherence.

Hypertension: What is it?

Definition: Hypertension (high blood pressure) is a common condition in which blood does not flow easily through the body's blood vessels to vital organs such as the heart, eyes and brain.

Prevalence: 1 in 3 Americans has hypertension. It is often called the 'silent killer' because 1 in 5 l
it and are unaware, underscoring the need to screen for it.

Impact: Having hypertension (HTN) puts a person at greater risk for stroke, heart attack, kidney fa
loss of vision and hardening of the arteries.

Risk factors: Hypertension commonly develops as people age – and is more common for individu
African American ethnicity, those with family history of the disease, and individuals with other m
conditions (e.g., diabetes, high cholesterol, kidney disease). Modifiable risk factors include:

- Smoking
- Overweight/obesity
- Nutrition
- Inactivity
- Stress
- Too much alcohol

Hypertension is more likely to develop among people with serious mental illnesses – especially those taking , taking second generation antipsychotic medications such as quetiapine, risperidone, olanzapine

Hypertension: identification and symptoms

How identified? A traditional blood pressure 'cuff' or self-reading device is used to assess blood pressure

What you can do – Ask about symptoms, medical history, SDOH and lifestyle. *Often there are NO symptoms* – but severe hypertension may result in the following:

- Shortness of breath
- Severe headache
- Dizziness or vertigo
- Nausea/vomiting
- Neck stiffness
- High heart rates
- Sensation of heart beating hard or irregularly
- Confusion, irritability
- Vision problems or vision loss
- Chest pain

Assist individual to check blood pressure

- For at least 30 minutes before measure, individual should not smoke, run, drink caffeine. And have individual relax, sitting for more that 5 minutes.
- Support individual's arm, with feet on the floor and back supported.
- Use correct cuff size.
- Read and record BP. The first number - **systolic** – is the pressure in blood vessels when heart beats. The second number – **diastolic** - is the pressure in blood vessels between heartbeats.

What to do with blood pressure readings?

Blood Pressure category	Systolic (SBP - number on top)	Diastolic (DBP - number on bottom)	When to check
Normal	Less than 120	Less than 80	Recheck annually*
Pre-hypertensive	120-129	Less than 80	Recheck annually*
Hypertensive – stage 1	130-139	80-89	Recheck annually*
Hypertensive – stage II	140 or higher	90 or higher	Monitor each visit. Discuss with medical staff
Hypertensive intervention	160 or higher	90 or higher	Ensure individual gets PCP follow-up and help to establish PCP if needed. Discuss with medical staff and repeat BP
Hypertensive crisis	180 or higher	120 or higher	May need ER/urgent care, especially if has symptoms. Discuss with medical staff

*More often (e.g., 2x/year) if there are risk factors – especially if taking antipsychotic medication

Hypertension: Supporting medical care

Treatment goal: blood pressure <140/90 or, if over age 60 then <150/90

Medical care involves:

- Antihypertensive medications
- Most people require more than one prescription

Supporting medical care – What you can do

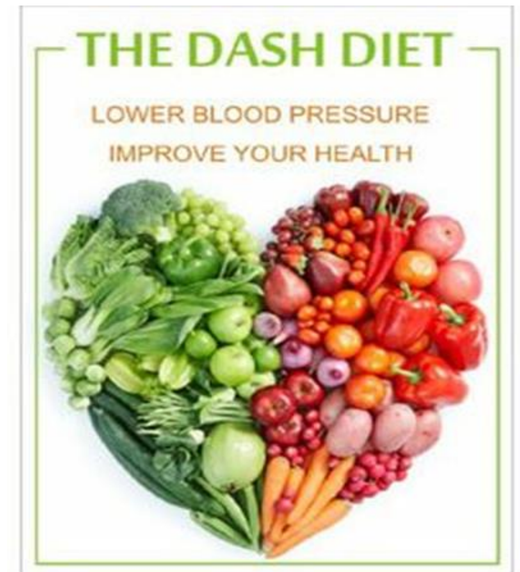
- Identify how person checks blood pressure daily - ask person to demonstrate how and where (e.g., home, pharmacy) they check and track readings
- Remind person to get annual screening and vaccinations
- Support 'common' strategies (e.g., ensure understanding of symptoms, facilitate connection to primary care and share information, monitor and support adherence, identify questions to ask doctors, etc.)

Keys: Check blood pressure regularly, support medication adherence and ensure individual sees doctor

Hypertension: Supporting self-management

Supporting self-management – What you can do

- Encourage and coach individual in low sodium diet – less than 1500mg/day (~3/4 tsp). This involves reducing processed foods, salt, and foods with high sodium (e.g., cheese, seafood, olives). The DASH diet (Dietary Approaches to Stop Hypertension) is recommended. Dietary changes can help blood pressure in two weeks!
- Support 'common' self-management strategies including coaching and referrals to classes, groups and resources for:
  - Weight management
  - Nutrition
  - Exercise
  - Smoking cessation
  - Reducing alcohol use
  - Stress reduction/coping
- Use motivational strategies and help individual make small goals, and identify and surmount barriers



Hypertension: Case example

Angela is 50-year-old female client who is diagnosed with Bipolar I disorder, Hypertension, and Alcohol use disorder. She is currently homeless, and is staying in shelters and in a tent city. Her food intake is sporadic, as she relies on food banks and day centers that serves breakfast and lunches. She often eats fast food as it is most convenient for her current living situation. Angela has been drinking on and off for last 20 years. Since she became homeless six months ago, she started to drink again, multiple times a week. Angela is not getting substance use treatment as she is minimizing having the need for it. She gets blood pressure checked when she comes in for mental health treatment. Most recent reading was 152/92 mmHg. She is not seeing primary care practitioner at the moment.

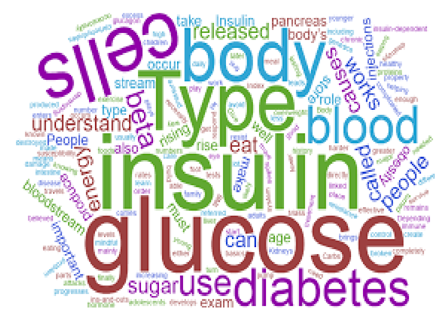
What you can do

- List problems and goals in treatment plan
- Talk with her about interaction of symptoms, situation and medical conditions
- Prioritize problems to address and use motivational strategies
- Refer her to resources
- Facilitate linkage to primary care

Diabetes: What is it?

Definition: Insulin is a hormone we all have that helps glucose (sugar) from food enter cells to become energy.

- Type 1 'insulin dependent' diabetes – insulin not made by body so needs to be injected (5% of cases)
- Type 2 – too little insulin or insulin 'resistance' so blood sugar (glucose) gets too high (95% of cases)



Prevalence: 1 in 10 people have diabetes and 28% do not know they have it, underscoring need to screen

Impact: Diabetes can lead to heart attacks, high blood pressure (stroke), kidneys and eye problems (blindness), teeth/gum and nerves problems (especially loss of sensation in legs and feet).

Risk factors: Diabetes commonly develops as people age, and is more common in women who have had a baby over 9 lbs, and individuals with hypertension or cardiovascular disease, or of African American, American Indian/Alaska Native, Asian American/Pacific Islander, or Hispanic/Latino ethnicity. Modifiable risk factors are:

- Smoking
- Overweight/obesity
- Nutrition
- Inactivity
- Stress
- Too much alcohol

Diabetes is more likely to develop among people with serious mental illnesses – especially those taking antipsychotics such as quetiapine, risperidone, olanzapine

Diabetes: Identification and symptoms

How identified? Hemoglobin A1c (blood sugar average over past 3 months) or fasting blood glucose taken as lab test or in-office fingerprick device.

What you can do - Ask about symptoms, medical history, SDOH, lifestyle.

Diabetes symptoms
•Increased thirst and hunger •Frequent urination •Weight loss •Fatigue •Blurred vision •Slow healing of wounds

Ensure individual has blood sugar checked if over 45 or has a risk factor (lab test or fingerprick device). Even kids can have pre-diabetes or diabetes!

What to do with blood sugar reading?

	Pre-Diabetes	Diabetes	Extremely high blood sugar	Hypoglycemia (low blood sugar)
Hemoglobin A1c	A1c=5.7-6.4	A1c is 6.5 or higher	•Deep, rapid breathing, •Dry skin and mouth, •Breath smelling fruity or like nail polish •Nausea, vomiting or stomach pain, •Decreased alertness, disorientation •Muscle stiffness and aches, •Headache and flushed face •Changes in gait, asymmetry in face	•Shakiness, weakness, lack of coordination •Nervousness, •Sweating, chills and clamminess, •Irritability confusion, •Rapid heartbeat, •Lightheadedness •Sleepiness •Blurred vision or seeing double, •Tingling or numbness of lips or tongue •Confusion or antagonistic behavior
Blood glucose	100-125 mg/dl	126 or higher		
What to do	Rescreen 2x/year*	Daily glucose check	Requires immediate medical attention	Take glucose tablets, regular soda or juice; if not resolved in 15 min. get medical attention

*Repeat screening every three years if no risk factors, but screen 2x/year for people with risk factors or taking second generation antipsychotics.

Diabetes: Supporting medical care

Treatment goal: A1c <=7.0 for people with DM

Medical care involves:

Type 1 - injectable insulin or always-connected insulin pump. Must monitor 4-6 times/days with finger prick or continuous monitor (under skin)

Type 2 – Medications such as Metformin (there are others). Insulin, if medications do not help.

Supporting medical care – What you can do

- Support daily glucose check and keeping records – ask individual to demonstrate how they check and bring records to doctor
- Ensure individual can identify symptoms and follows-up with primary care if there are changes
- Ask person to show you glucose tablet, pills, candy, juice that they should always carry
- Support 'common' strategies (e.g., ensure understanding of symptoms, facilitate connection to primary care and share information, monitor and support adherence, identify questions to ask doctors, etc)

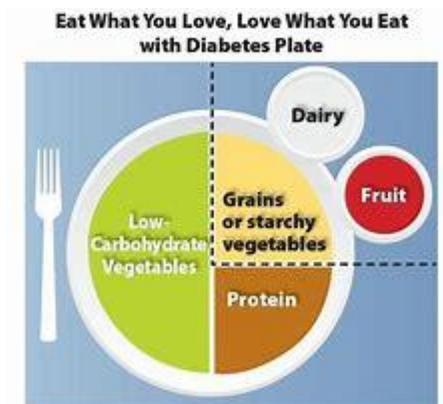
Keys - Ensure person gets periodic exams:

- Quarterly - Hemoglobin A1c lab
- Every 6 months
  - check BP (if advised to)
  - check feet for any injury
- Annually
  - Labs - lipid panel, urine, kidney check
  - Foot exam
  - Eye exam
  - Flu vaccine
  - Dental exam

Diabetes: Supporting self-management

Supporting self-management – What you can do:

- Facilitate person's enrollment in diabetes self-management education and support (DSME/S) if available in community
- Ask client about check feet daily for cuts, blisters, red spots or swelling
- Brush teeth and floss daily
- Support the 'common' self-management strategies including coaching and referrals to classes, groups and resources for:
  - Weight management
  - Nutrition - especially lowering sugar and carbohydrates, water instead of juice or soda
  - Exercise
  - Smoking cessation
  - Reducing alcohol use
  - Stress reduction/coping
- Use motivational strategies and help individual make small goals, and identify and surmount barriers



Diabetes: Case example

Donnie: a 50-year-old male in recovery from IV drug use and he has major depression and Type II Diabetes. He is overweight and states that he only uses the microwave for cooking at his studio apartment. Donnie lives alone and tends to not leave the house very often. Donnie smokes 1 pack per day of cigarettes, and states that though he wants to quit, he "can't." He misses about half of his scheduled appointments with his case manager. He is minimally engaged with his primary care doctor, and his last Hemoglobin A1C was high at 10%. Donnie has been to the ED twice in the last month for a foot infection that has contributed to decreased mobility.

What you can do

- List problems and goals in treatment plan
- Talk with him about interaction of symptoms, situation and medical conditions
- Prioritize problems to address and use motivational strategies
- Refer to resources
- Facilitate linkage to primary care

Asthma: What is it?

Definition: Asthma is characterized by intermittent and reversible narrowing of the bronchial tubes that bring air into the lungs, as well as extra mucus in the tubes, that make it difficult for air to get in and out of the lungs. It cannot be cured but can be controlled with medication.

Prevalence: About 7.6% of the U.S. population has asthma. Rates are higher for age 5-24 than in other age groups.

Impact: Poorly managed asthma can lead to death

Risk factors: Family history of asthma, allergies, smoking or exposure to it, air pollution, stress, physical activity, and exposure to chemicals used in farming, hairdressing and manufacturing.

Asthma: Identification and symptoms

How identified? Screening for asthma is done via tools that measure how much air is in the lungs.

What you can do - Ask about symptoms:
Have you…
"…had challenges w/breathing or deeply inhaling or coughing?"
"…had doctor ever talk to you about or prescribed something for asthma?"
"…ever used something to help breathe – such as an inhaler?"
"…do you smoke?" (smoking may be cause if symptoms happen concurrently)

Symptoms

- Shortness of breath (especially if causing trouble walking or talking)
- Coughing
- Wheezing
- Other symptoms that may be present (e.g., chest tightness, pain or pressure , sleep disturbance, feeling tired/lack of energy, blueness of lips or fingernail beds, racing heart, feeling lightheaded)

Asthma is considered not well-controlled if a person is: using quick-relief inhaler more than 2x/week, refilling it more than 2x/year, or waking up at night with symptoms more than 2x/month

Asthma: Supporting medical care

Treatment goal: no difficulties with breathing (no asthma attacks)

Medical care involves:

- **Medications**
  - Inhalers ("rescue" inhaler) – as needed to relieve acute symptoms – most common are albuterol and levalbuterol
  - Other medications – inhaled steroids for long-term control (assuming at least mild persistent asthma). May need additional meds too

Supporting medical care – What you can do

- Ask about fears/thoughts about future asthma attacks and participating in exercise
- Ask about medication adherence
- Ask about comfort using inhaler – and knowing what to do during asthma attack i.e., 4-6 puffs of inhaler and symptoms do not resolve within 15 minutes, go to ED
- Support 'common' strategies (e.g., ensure understanding of symptoms, facilitate connection to primary care and share information, monitor and support adherence, identify questions to ask doctors, etc.)

Key: Medication adherence is only about 50% in the general population, so discuss adherence

Asthma: Supporting self-management

Supporting self-management – What you can do

- Help individual create asthma plan with what to do if have symptoms:
  - Green - no problem – no symptoms, normal activity can proceed
  - Yellow - caution – symptoms present
  - Red - emergency – when to get help when symptoms not improved and impact walking/playing or talking) symptoms and responses
- Coach regarding avoiding triggers including: allergens/pollutants, aspirin/NSAIDS, and foods that provoke reflux (e.g., alcohol, caffeine, spicy foods, chocolate, soda, peppermint, tomatoes)
- Help individual create asthma symptom diary and remind to fill it out
- Support 'common' self-management strategies including coaching and referrals to classes, groups and resources for:
  - Weight management
  - Nutrition
  - Exercise
  - Smoking cessation
  - Reducing alcohol use
  - Stress reduction/coping
- Use motivational strategies and help individual make small goals, and identify and surmount barriers

Massachusetts Asthma Action Plan

Personal Best Peak Flow:

GO – You're Doing Well!

Use these daily controller medicines:

MEDICINE/ROUTE	HOW MUCH	HOW OFTEN/ WHEN

CAUTION – Slow Down!

Continue with green zone medicine and add:

MEDICINE/ROUTE	HOW MUCH	HOW OFTEN/ WHEN

CALL YOUR DOCTOR/ NURSE:

MEDICINE/ROUTE	HOW MUCH	HOW OFTEN/ WHEN

GET HELP FROM A DOCTOR NOW!

Asthma: Case example

R. is a child who came to our residential BRS foster placement.   When she was first seen when she was 8. She had been going from one short term placement to another for several months. Available records indicated that she had asthma and used an albuterol inhaler but no other history. She stated that she had been to the ER for breathing "sometimes".   Weight is normal and she likes sports. Inhaler use is triggered by high levels of distress, exercising and possibly high pollen counts. She has significant behavioral problems and PTSD that all seem to increase after family visits, often resulting in inhaler use.

What you can do

- List problems and goals in treatment plan
- Talk with them about interaction of BH symptoms, medical conditions and family context
- Prioritize problems to address, use motivational strategies and provide relevant BH treatment
- Refer to resources as needed
- Facilitate linkage to primary care

Recap – How BH staff can help support management of medical conditions

1. Ask about and help identify the most common medical conditions – and their risk factors - among individuals served
2. Support people served to use medical care and follow treatment
3. Apply skills in helping people manage BH conditions to support self-management of medical conditions as part of whole-health and wellness care

Recap – Asking about medical conditions

What you can do – Ask about:

- Medical history: current/past symptoms, diagnoses and family history of the conditions
- Demographics associated with risk: age, ethnicity
- Health behavior/lifestyle risk: exercise, nutrition, smoking, alcohol/drugs
- Physiological risk: BMI, blood pressure, blood sugar/glucose
- Social Determinants of Health (SDOH): housing, finances, transportation

Your good sense counts! If you "see something, say something". Let your medical staff know if you see or hear about signs or symptoms that make you feel that your client is not well.

Recap – Supporting medical care

You are an important part of the medical team!

- Ensure individual recognizes and understands symptoms
- Ask individual about use of primary care and urgent/emergency care
- Share treatment information with medical care team
- Ensure individual engages with medical care
- Monitor and support medication adherence
- Help individuals identify questions to ask doctors

You can help people get the most out of their medical appointments and care

You don't need to be a hero! You aren't going to "save" someone from having a medical condition but you can support them to help themselves

You have a big role in helping medical doctors provide the most effective care for people you serve

Recap – Supporting self-management

What you can do

- Provide coaching and linkage to self-management resources for:
  - Weight management
  - Nutrition
  - Exercise
  - Smoking/vaping cessation
  - Alcohol use reduction
  - Stress reduction/coping

- Help individuals make ***small goals***
- Identify and help individual surmount barriers to medical care and self-management
- Use motivational interviewing (MI) to bolster attitudes and willingness to change behavior and adhere to treatment to improve health
- Recognize that behavioral health symptoms can impact medical conditions and vice versa
- ***Recognize that self-management and behavior change is hard – and your help and support are essential!***

Resources

Hypertension

- https://www.resourcesforintegratedcare.com/sites/default/files/Hypertension%20Navigator%20Tip%20Sheet%20English%20Version.pdf

Diabetes

- https://www.resourcesforintegratedcare.com/sites/default/files/Diabetes%20Navigator%20Tip%20Sheet%20English%20Version.pdf
- Tip sheet and tracking form: https://www.cdc.gov/diabetes/ndep/pdfs/tips-to-help-you-stay-healthy.pdf
- Extended version of above: https://www.cdc.gov/diabetes/ndep/pdfs/4steps/4Steps-English.pdf
- Diabetes Prevention Program - lifestyle modification curriculum https://www.cdc.gov/diabetes/prevention/lifestyle-program/curriculum.html

Asthma

- https://www.resourcesforintegratedcare.com/sites/default/files/BH_Asthma_COPD_Naviation_Tip_Sheet.pdf

Chronic disease self-management (general)

- Chronic disease self-management program – https://www.selfmanagementresource.com/programs/small-group/chronic-disease-self-management/
- Action plan examples are in Relias “payer perspective” modules

Appendix – Case example details

Hypertension: Case example - detail

Angela is 50-year-old female client who is diagnosed with Bipolar I disorder, Hypertension, and Alcohol use disorder. She is currently homeless, and is staying in shelters and in a tent city. Her food intake is sporadic, as she relies on food banks and day centers that serves breakfast and lunches. She often eats fast food as it is most convenient for her current living situation. Angela has been drinking on and off for last 20 years. Since she became homeless six months ago, she started to drink again, multiple times a week. Angela is not getting substance use treatment as she is minimizing having the need for it. She gets blood pressure checked when she comes in for mental health treatment. Most recent reading was 152/92 mmHg. She is not seeing primary care practitioner at the moment.

What you can do

- List all problems and goals in treatment plan: These might include (1) stable place to stay (2) linkage to primary care providers (3) medication adherence, (4) determining way to get regular meals, (5) working on alcohol use and problems that it is causing
- Talk with her about interaction of symptoms, situation and medical conditions:
  - how homelessness is affecting managing symptoms of chronic diseases (Bipolar I and Hypertension) - including barriers to taking medications and nutrition.
  - how drinking is affecting her overall health
  - how her Bipolar disorder symptoms are affecting her management of hypertension (e.g., is she becoming symptomatic and not feeling that medication is needed? Is her disorganization affecting adherence or perception of reduced need for eating and sleeping?)
- Talk with her to prioritize 3 top problems to address – use motivational strategies
- Refer her to resources based on problem to be addressed (e.g., Coordinated Entry for All – CEA, food banks, centers that provide daily hot meals, primary care providers, substance use treatment, nutrition classes, stress management group, walking group and other exercise classes
- Facilitate linkage to primary care, ask about any past doctors she has liked (link if any and if feasible) or determine the closest clinic to where she has been staying, set up appointment with her, prepare questions with her in advance, attend with her, and address any barriers to attending such as transportation.

Diabetes: Case example - detail

Donnie: a 50-year-old male in recovery from IV drug use and he has major depression and Type II Diabetes. He is overweight and states that he only uses the microwave for cooking at his studio apartment. Donnie lives alone and tends to not leave the house very often. Donnie smokes 1 pack per day of cigarettes, and states that though he wants to quit, he "can't." He misses about half of his scheduled appointments with his case manager. He is minimally engaged with his primary care doctor, and his last Hemoglobin A1C was high at 10%. Donnie has been to the ED twice in the last month for a foot infection that has contributed to decreased mobility.

What you can do

- List problems in treatment plan: health-related issues including obesity and infection, smoking, isolation, attendance at appointments, depression
- Talk with him about interaction of symptoms, situation and medical conditions - how depression impacts diabetes (and vice versa), infection is hampering mobility and how better health and weight management could help; how smoking impacts health, how medical care could improve symptoms
- Prioritize problems to address – use motivational strategies to help determine priorities and move forward
- Refer to resources - such as food stamps, food banks, housing vouchers, meal programs
- Facilitate linkage to primary care – e.g., set up appointment with him, prepare questions with him in advance, attend with him, and address any barriers to attending such as transportation.

Asthma: Case example – detail

R. is a child who came to our residential BRS foster placement.   When she was first seen when she was 8. She had been going from one short term placement to another for several months. Available records indicated that she had asthma and used an albuterol inhaler but no other history. She stated that she had been to the ER for breathing “sometimes”.   Weight is normal and she likes sports. Inhaler use is triggered by high levels of distress, exercising and possibly high pollen counts. She has significant behavioral problems and PTSD that all seem to increase after family visits, often resulting in inhaler use.

What you can do

- List problems and goals in treatment plan
- Talk with them about interaction of BH symptoms, medical conditions and family context: Anxiety is often accompanied by rapid heart rate, increased breathing and shaking – these same sensations can also be part of an asthma attack and the attack can be worsened by fear response. A child who uses an inhaler and successfully reduce their asthma symptoms, they may associate the inhaler with this decrease and also use it for the rapid heart beat, difficulty breathing and shaking associated with fear. Foster carers may need support to manage or respond to asthma.   Encourage self-management for older children including learning about their asthma.
- Prioritize problems to address, use motivational strategies and provide BH treatment: Distress Tolerance Skills but avoid deep breathing as it is likely to be impossible during an asthma attack. Try interventions that improved ongoing health and mood stability like sensory breaks, regular exercise and good nutrition can decrease the risk as well.
- Refer to resources as needed
- Facilitate linkage to primary care provider (PCP): Contact PCP with any information you have about things associated with asthma (e.g., triggers, frequency, patterns. Ask medical providers about psychoeducation like adding an antihistamine in spring or behaviors you can encourage like exercise and the limits around it, that can help you and the provider improve PTSD and asthma symptoms. Helping them write a list of questions for their medical provider to answer.