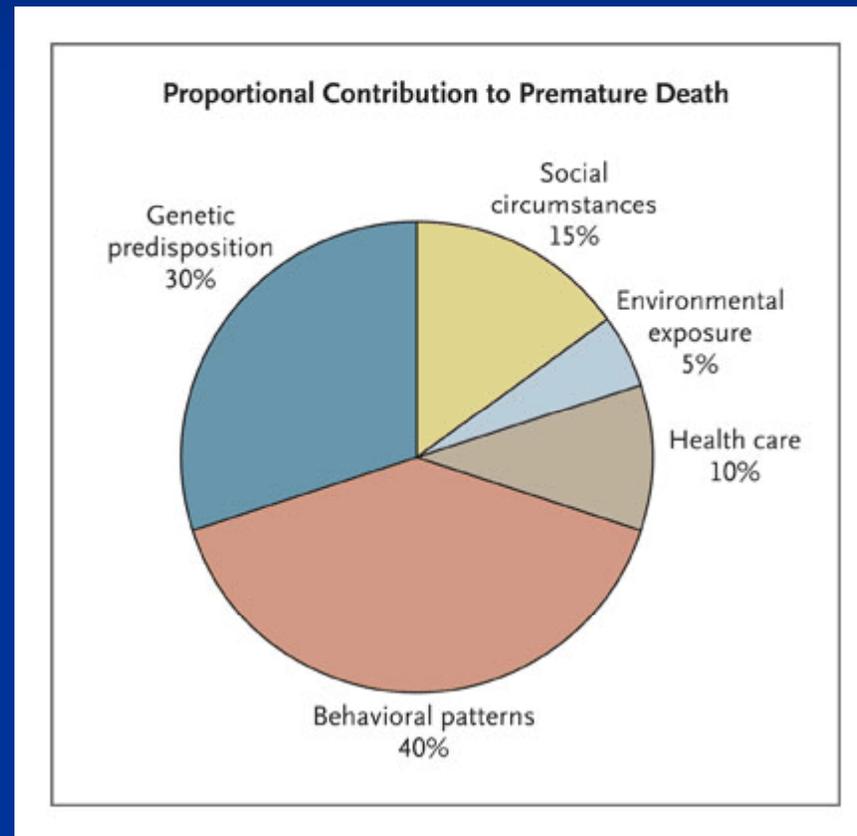


Improving Health and Healthcare in Community Mental Health Settings

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April 28, 2010

Causes of Premature Death in the General Population¹



1. Schroeder S. N Engl J Med. 2007 Sep 20;357(12):1221-8.

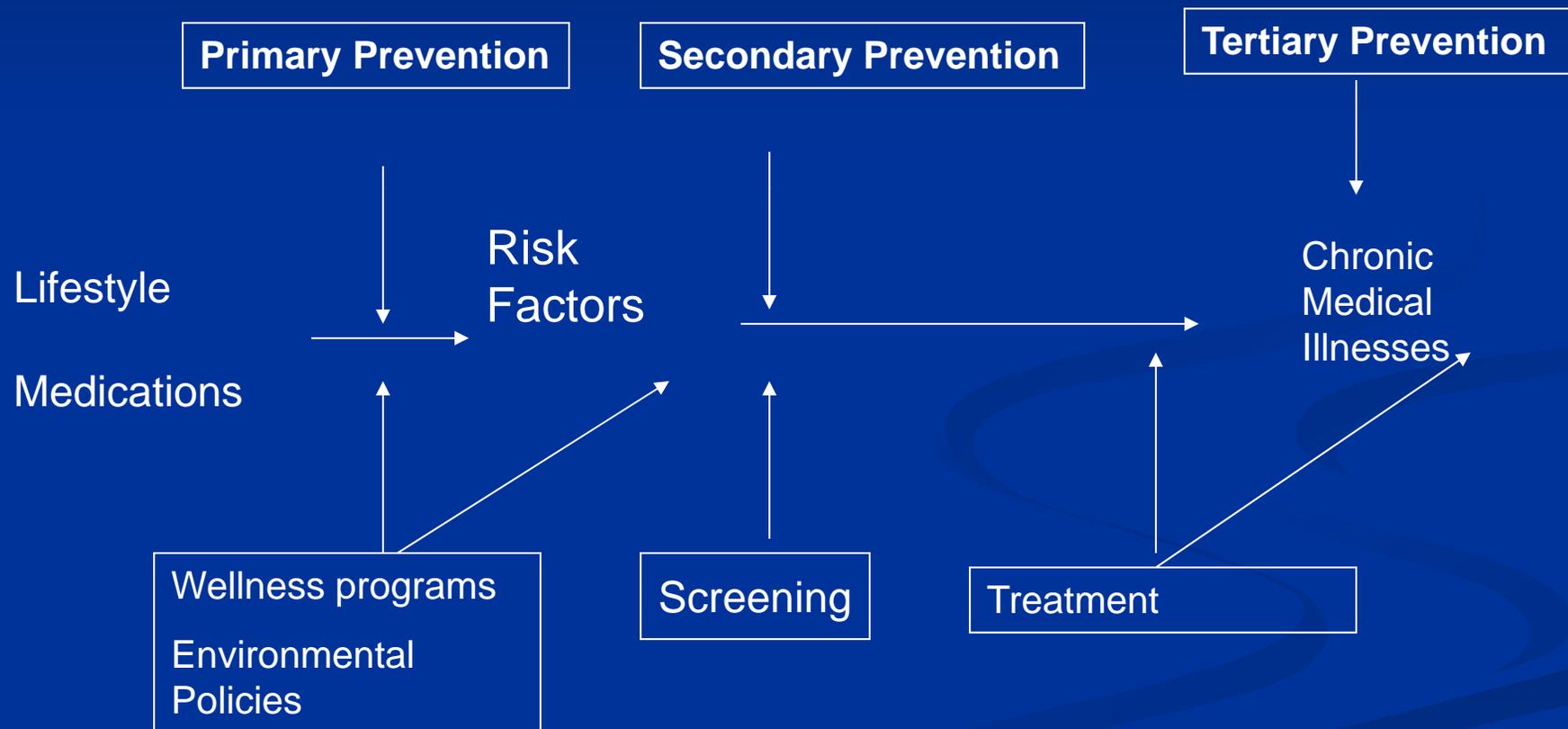
Causes of Excess Mortality In Persons With SMI

- Lifestyle Issues: Smoking poor diet, and reduced physical activity¹
- Social and Environmental Issues: Excess rates of poverty and social disadvantage²
- Poor quality of medical care³
- Effects of psychotropic medications⁴

1. de Leon J, Diaz FJ. Schizophr Res 2005;76: 135–157, Compton M et al Harv Rev Psychiatry. 2006 Jul-Aug;14(4):212-22.
2. Wilton et al Soc Sci Med 2004 58: 25-39
3. Mitchell A. Br J Psychiatry. 2009 Jun;194(6):491-9.
4. Newcomer J. J Clin Psychiatry. 2007;68 Suppl 4:8-13. Review.

**A Public Health Approach to
Improving Health and Healthcare in
Persons with SMI**

A Public Health Approach To Reducing Mortality



Examples of Primary Prevention

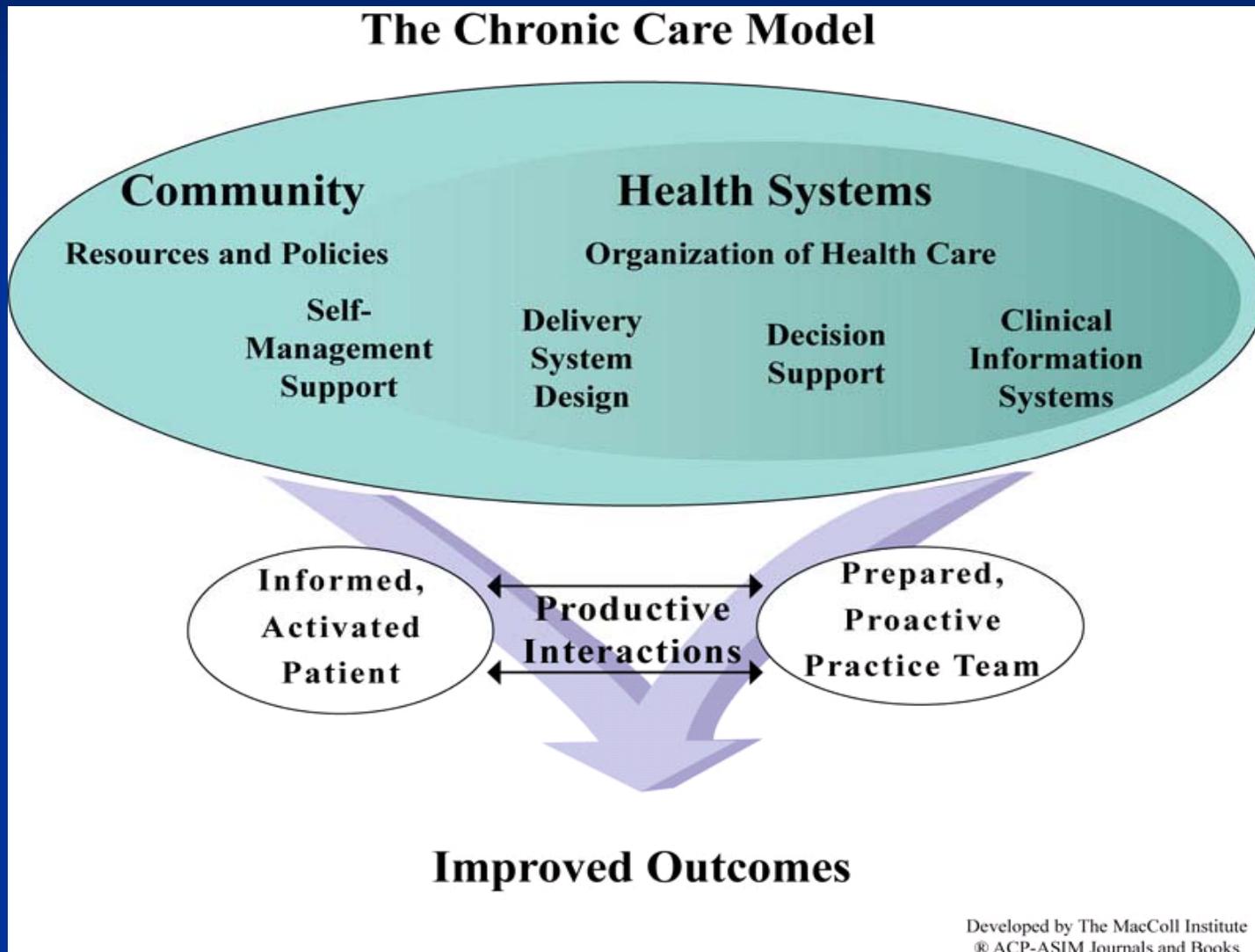
- Make psychiatric facilities smoke-free (NASMHPD 2007)
- Provide access to exercise facilities either onsite or in the community

Secondary Prevention

- A growing number of MH sites are screening for common medical problems e.g. diabetes, hypertension, high cholesterol in their patients
- However, few sites can follow-up for persons who screen positive; fewer than 1/2 have any referral capacity and fewer than 1/3 can provide medical services onsite¹

1. Druss et al. Psychiatr Serv. 2008 Aug;59(8):917-20.

Tertiary Prevention: Effective Treatment of Chronic Illness



Applying the Chronic Care Model for persons with SMI

- Developing an Informed, Activated Patient
- Using Information Technology
- Developing a Prepared, Proactive Practice Team

Activating Patients: The HARP (Health and Recovery Peer) Program

- Pilot study adapted the Chronic Disease Self-Management Program (CDSMP), for MH Consumers (n=80)
- CDSMP is the most widely developed peer-led self-management intervention used in general medical settings.
- 6 group sessions involve action planning and feedback, modeling of behaviors, training in specific disease management techniques.

1. Funded by NIMH R34MH078583\

2. Lorig K et al. Med Care. 2001 Nov;39(11):1217-23.

Adapting the CDSMP for Persons with SMI

- Qualitative methods and work with MH consumer leaders and the developer of the program used to adapt the CDSMP for MH consumers
- Modifications included changing the materials to a lower health literacy level, addition of a self-management record, and changes to allow low-income individuals to engage in healthier diet and exercise

1. Funded by NIMH R34MH078583\

2. Lorig K et al. Med Care. 2001 Nov;39(11):1217-23.

Outcomes

- Patient activation (measure of self-management): 7.7% relative improvement in HARP vs. 5.7% decline in control, $p < 0.05$
- Likelihood of a primary care visit: 68.4% vs. 51.9%, $p = 0.046$
- Health related quality of life, physical activity, and medication adherence: Improvements of comparable magnitude to those seen in general populations.

Using Information Technology: A Personal Health Record for Persons with SMI

- Goal is to adapt and disseminate a Personal Health Record for MH Consumers
- Will study impact of record on patient activation and on quality of care

1. Funded by AHRQ R18HS017829
2. Druss et al Schizophrenia Research January 2010

What is an Electronic Personal Health Record (PHR)?

- “An electronic application through which individuals can access, manage, and share health information”¹
- Like an Electronic Medical Record, a PHR
 - Enhances exchange of information across the health system
 - Maintains privacy of information
- Unlike an Electronic Medical Record
 - Is under control of the patient rather than the health system
 - Contains information across multiple providers
 - May also include health goals and other personal information

1. Markle Foundation 2003

Shared Care Plan

- Perhaps the best established community-based Electronic Personal Health Record; developed at Peace Health in Bellingham, WA.
- Developed using principles of user-centered design, with initial plan created by a group of patients with chronic medical conditions



MyHealthRecord

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Get your own **FREE** My Health Record.

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Johnnie D Thomas, RN
 7/27/1969, 40 years old, female

- [Edit Johnnie's Registration](#)
- [Printout Options](#)
- [Privacy Summary](#)
- [Who's Accessed My Care Plan?](#)

- Home
- Care Team**
- About Me
- Diagnoses
- Next Steps
- Health Log
- Medications
- Allergies
- History
- Documents

Important: Do not use your browser's back or forward buttons, as this may cause unusual results.

Emergency Contact [\(Help\)](#)

Your Emergency Contact is the person you would like called first should you have an emergency. Your Backup Emergency Contact is the person you would like called if your primary Emergency Contact is unavailable.

[Add New](#)

Contact	Name	Phone Number	Alternate Phone Number
No Emergency Contact record. Please click "Add New" to add a new Emergency Contact.			

Care Team Members [\(Help\)](#)

Care Team Members are people and/or organizations who help you manage your health. Anyone who you feel has a role in your health care can be part of your Care Team.

[Add New](#)

Appts.	Name	Contact	Role/Description	Access Level	Comments	Action
	Johnnie Thomas, RN	johnniethomas@usa.net	Patient	Fully Edit		Edit
	John Doe	svonese@emory.edu	Spiritual Support	View Only		Edit Delete
	John Doe	janeygirlatl@yahoo.com	Nurse	Fully Edit		Edit Delete
	Dr. Jane Smith	(404) 555-1212 janeygirlatl@yahoo.com		No Access		Edit Delete
	Community Clinicians		Emergencies & Treatment	Fully Edit	Click [Edit] to adjust clinical access to your Health Records.	Edit

Invited Care Team Members

Name	Date Invited	Status	Contact	Role/Description	Electronic Access Level	Action
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Implementing the PHR

- RN Clinical specialist helps patients enter data, set and achieve goals.
- Local MH peer center provides computer training classes and internet access

Randomized Trial

- Randomized trial of PHR vs. Usual Care for patients with one or more chronic medical condition (n=150)
- Outcomes: Patient activation, provider management of chronic illness, quality of medical care.

Care Delivery: Building a Medical Home for People with SMI

- Collocated Models: Bring care onsite
- Facilitated Referral: Link to community medical providers
- Partnership: Develop a relationship between a CMHC and medical provider

Providing Care Onsite

- Advantages: Potential for maximal integration of services, control over services provided
- Disadvantages: Requires substantial economies of scale, financing may be difficult
- Sites to implement: Large, quasi integrated systems such as the VA or HMOs.

Collocated Care Example: Integrated Care Clinic

- Medical care for a VA mental health clinic provided onsite through a multidisciplinary team
- Nurse Practitioner provided most medical care, RN was case manager, family practitioner supervised
- Clinic staff emphasized patient education, preventive services, close contact with MH providers

Druss BG et al. Integrated care for patients with serious mental disorders: a randomized trial. [Archives of General Psychiatry](#) 2001; 58: 861-8

Service Use

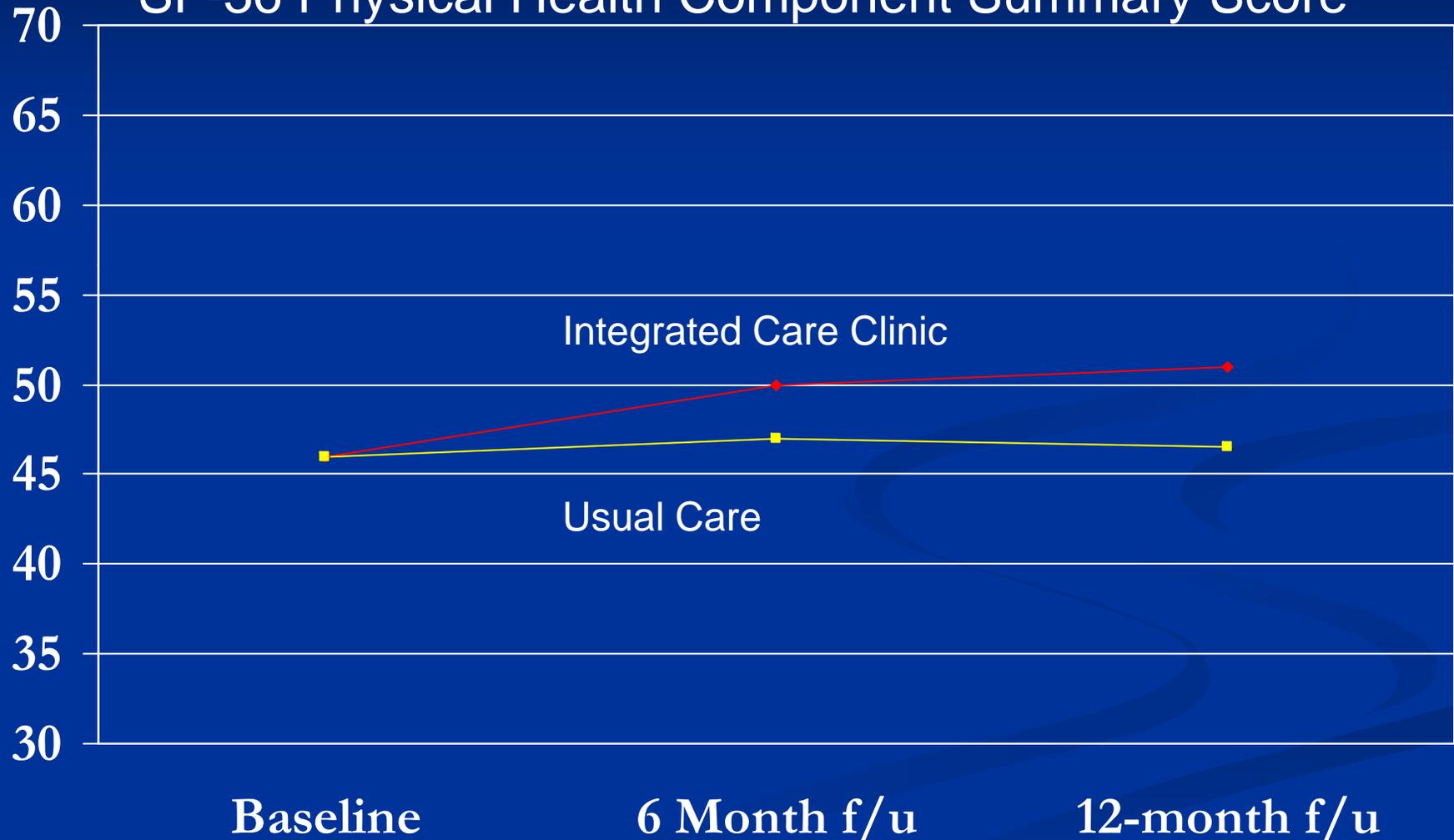
	Integrated Care (n=61)	Usual Care (n=59)	P value¹
Primary Care Visits			
Any Visit ¹	91.5%	72.1%	0.006
Mean Visits ¹	3.9	2.3	0.04
Medical ER Visits			
Any Visit ¹	12.9%	24.6%	0.03
Mean Visits	1.0	1.4	0.61

Preventive Services

Domain	Integrated Care Better	Usual Care Better	Same
Coordination:	Med list, Problem List		
Physical Exam:	Weight, BP, Rectal, Flex. Sig.		
Lab Tests:	Diabetes; hepatitis; cholesterol; TB		Hemoccult
Vaccination:	Influenza	Pneumonia	
Education:	exercise, nutrition, Smoking, DNR		

Health Outcomes

SF-36 Physical Health Component Summary Score



Referral Model

- Advantages: Easy to implement, can retrain existing care management staff
- Disadvantages: Care is only as good as available community resources
- Sites: CMHCs, clinics.

PCARE

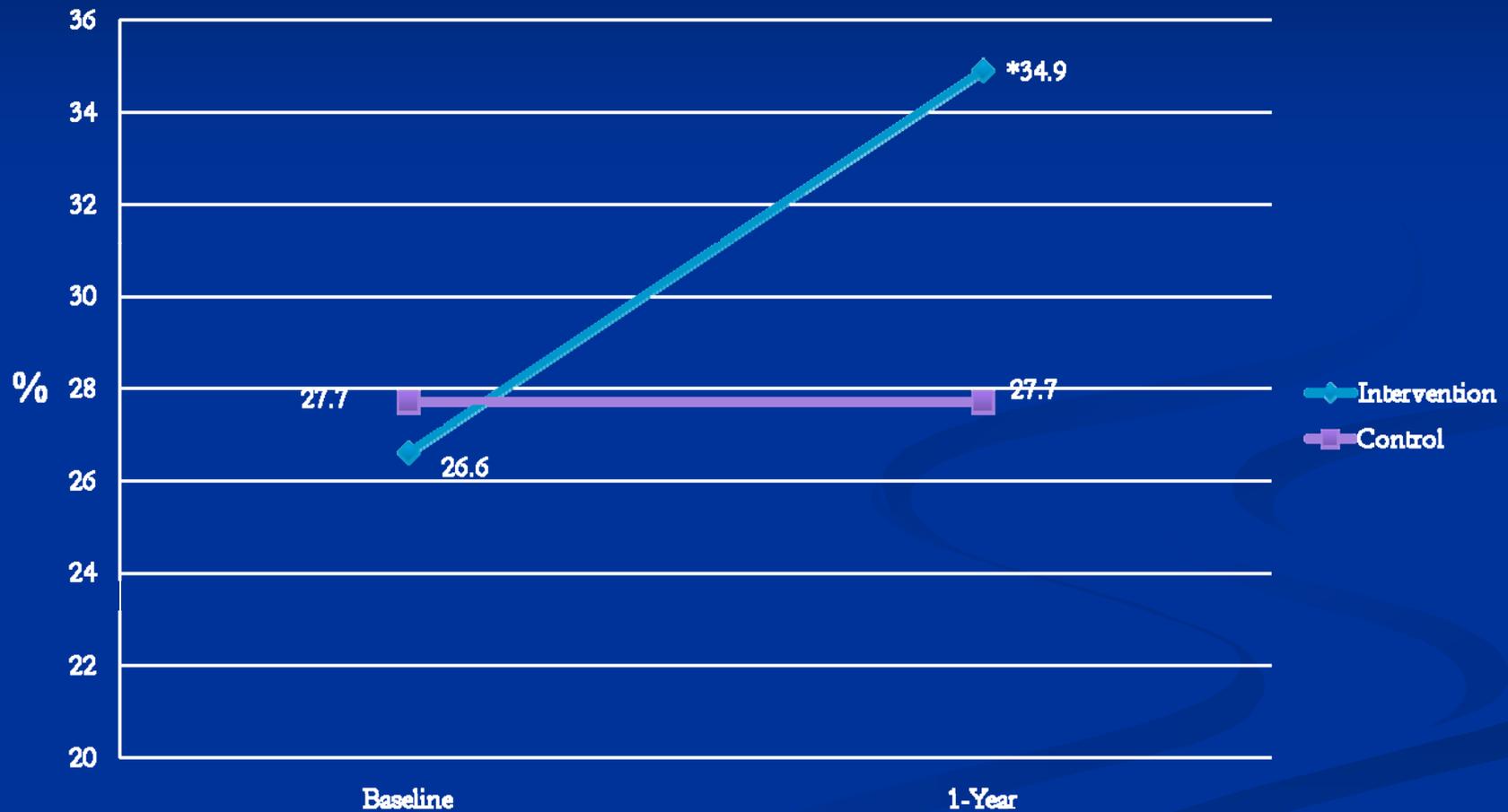
- PCARE (Primary Care Access, Referral, and Evaluation) studying a medical nurse-care manager to improve primary care for persons with SMI (n=407).
- Case managers do “whatever it takes” to get consumers the primary care they need.
- Many clients required addressing basic needs (housing, substance use) in the service of improving medical care.

Percentage of Preventive Services Obtained for PCARE vs. Control



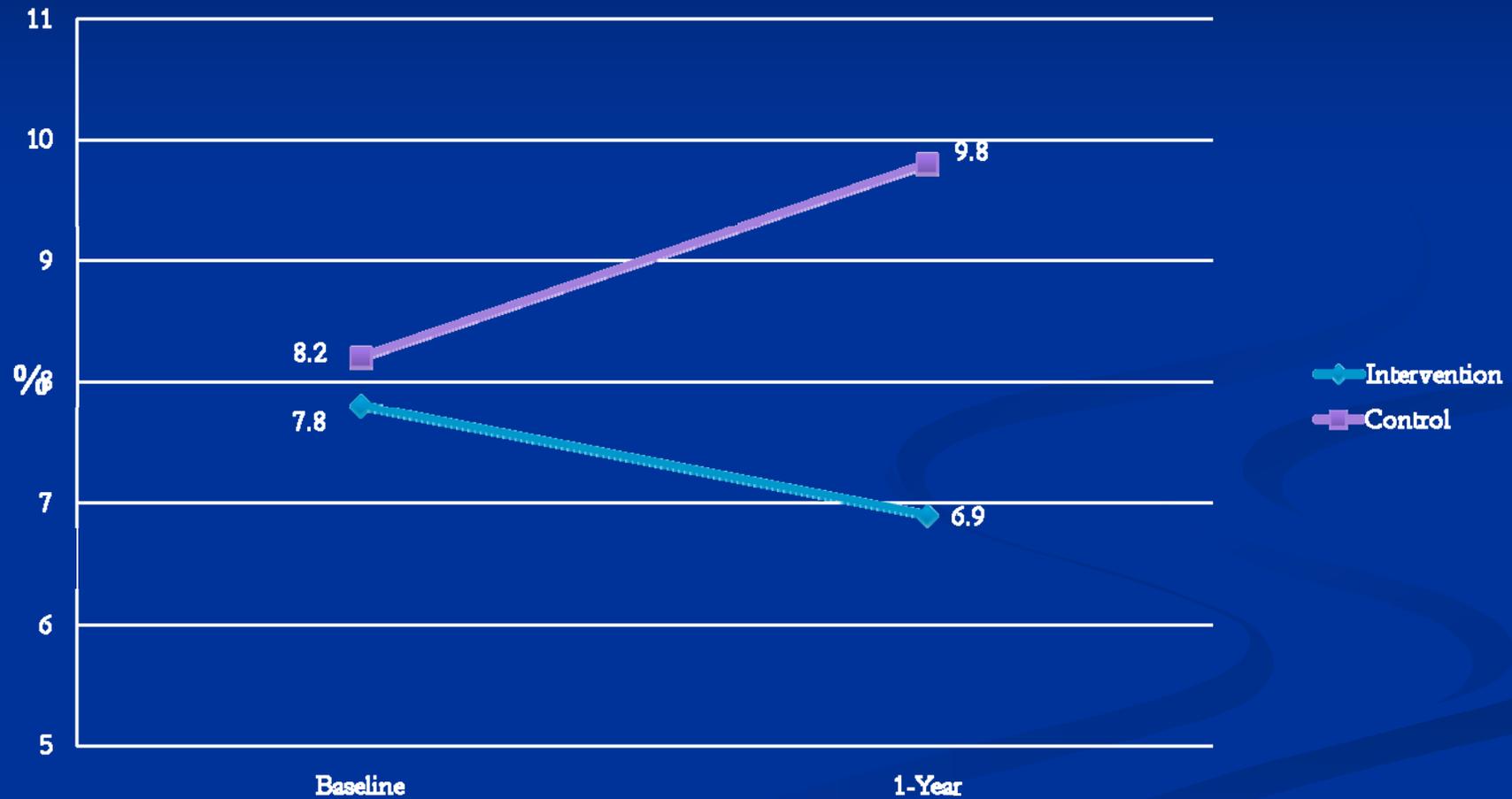
$P < 0.001$ for group*time interaction

Percentage of Cardiometabolic Services Obtained for PCARE vs. Control



$P < 0.001$ for group*time interaction

Framingham Score for 10-year Cardiometabolic Risk for PCARE vs. Control



P=0.02 at 6 months

Partnership Based Models

- Advantages: Access both to onsite staff and full resources of partner site for more complex problems.
- Disadvantages: Need to identify and develop relationship with partner
- Sites: CMHCs with available partners

The HOME study

- HOME study (Health Outcomes, Monitoring and Evaluation) will establish a partnership-based medical home for persons with SMI.
- Community Health Center (FQHC) is establishing a satellite clinic onsite at a Community Mental Health Center
- A physician assistant and nurse care manager will provide all health care for a cohort of individuals with cardiometabolic problems
- Electronic health records will be used to a “virtual medical home spanning the two systems.

Conclusions

- The long history and complex causes of morbidity and mortality in persons with SMI indicates what a challenging task it will be to remediate it.
- However, a confluence of events now provide a window for change to improve health and healthcare in this vulnerable population.