WHOLE PERSON WELLNESS: INTEGRATING CARE TO IMPROVE PHYSICAL HEALTH OF PERSONS WITH SERIOUS MENTAL ILLNESS

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DISCLOSURE

This speaker has no conflicts of interest, commercial support or off-label use to disclose.
LEARNING OBJECTIVES

- Describe how an integrated system of care can impact the health of vulnerable populations, specifically those with serious mental illness.
- Identify three strategies to promote self-sufficiently in managing physical healthcare needs and promoting whole health concepts.
- Evaluate data supporting embedding primary care services and care coordination within a community mental health center.
Mental Illness affects 59 million people annually in US
   (as cited in NIMH, n.d.)

9.6 million of US have serious/severe mental illness (SMI)
   (as cited in NIMH, n.d.)
  Schizophrenia
  Bipolar Disorder
  Severe Depression

Mortality rates for persons with SMI are more than double that of the general population (Zolnierek, 2009)

Deaths are largely from treatable conditions, associated with modifiable risk factors (smoking, obesity, substance abuse) & inadequate medical care (Barry & Huskamp, 2011)
SYSTEM ISSUES

- Mental health and addiction treatment historically separated from the rest of medicine (Barry & Huskamp, 2011)
- Gaps in care, inappropriate care, disjointed care, redundant care and ↑ health costs (Kaiser Commission on Medicaid and the Uninsured, 2014)
- Calls for integrated care have been noted for several decades however, segregated systems of care have persisted.
- Affordable Care Act (ACA), Mental Health Parity and Addictions Equity Act (MHPAEA) of 2008, SAMHSA and HRSA
- Models of integration being implemented & evaluated (Barry & Huskamp, 2011)
BARRIERS TO OPTIMAL HEALTH FOR PEOPLE WITH MENTAL ILLNESS (SMIS):

- Increased incidence of modifiable risk factors – smoking, alcohol/substance abuse, STDs
- Medical conditions go un-identified and/or untreated which shortens life span
- Limited access to medical appointments for preventative and routine care
- Decreased access to quality care
Across disease states, the existence of mental illness seems to affect the quality of medical care (fewer preventative services, lower rates of CV procedures, worse diabetes care)

Lack of clarity of responsibility of physical health of people with SMIs

Lack of awareness of physical symptoms

Insurance – ability to apply, maintain, navigate
EVEN MORE BARRIERS

- Transportation issues
- Poor relationships with healthcare providers – lack of education, empathy, flexibility
- Limited continuity of care
- Complexities of Health System
MHA Village is a community based mental health center of Mental Health America of Los Angeles (MHALA)

- Founded in 1990 as a pilot project
- Pioneer of the recovery movement
- Provides support and assistance to its members in their recovery journey
- Mission – “To assist people with mental illnesses recognize their strengths and power to recover and achieve full participation in community life. Also, to encourage system-wide adoption of the practice and promotion of recovery and well being”
GUIDING PRINCIPLES
Quality Of Life
Community Focus
Whatever It Takes

RECOVERY-FOCUSED
CARE
Hope
Empowerment
Self-Responsibility
Meaningful Role in Life
FOUR QUADRANT CLINICAL INTEGRATION MODEL

Quadrant II
BH ↑  PH ↓

Quadrant IV
BH ↑  PH ↑

Quadrant I
BH ↓  PH ↓

Quadrant III
BH ↓  PH ↑

Behavioral Health Risk/Status
Low  High

Physical Health Risk/Status
Low  High
CLINIC OPERATIONS LOOKED SOMETHING LIKE THIS:

- Licensed Vocational Nurse (LVN) – MHALA employee
  - available ~ 30 hours per week

- MD – contracted outside provider
  - Long Beach Health Department

- Clinic – 6 hours per week with LVN and MD
  - 3 hours on Tuesday mornings (9am to 12 noon)
  - 3 hours on Thursday afternoons (2 pm to 5 pm)

- Funding - $98,000 granted for 12 month period
  - Covered staff salary (MD, LVN), medical supplies, medications, lab expenses
WHAT DID WE SEE.....?

98.5% members had other chief complaints that require acute resolution (cough, rash, toothache, spider bite, conjunctivitis, blood pressure or blood sugar out of control.

- Orthopedic / Musculoskeletal
  - Low back/shoulder/knee/ankle/finger joint pain, Fractures,
  - Bodily injuries from motor vehicular accidents

- Cardiovascular
  - Hypertension, Chest pain / coronary artery disease,
  - CHF, increased cholesterol, metabolic syndrome, heart murmur

- Infectious diseases

- Pulmonary
65 year old
Caucasian female
Strikingly elegant (all in pink) when she entered the exam room
SMI: Delusional Disorder
Me: What brought you here?
Her: Robert Brown is evil. He implanted electrodes in my head, all of the days of rape and torture. He killed my Mom and burnt our house. It is here (pointing to forehead). It is all here....Then talks about sex trafficking, labor laws, assassination and the Nazis
OTHERS

- 27 year old male with psychotic disorder NOS who just felt clumsy all his adult life (1st time diagnosis of Multiple Sclerosis)
- 60 year old female with major depression & marfans syndrome
- 62 year old male with severe anxiety disorder who was not able to walk a block without chest pain
- 61 year old Asian male with major depression & 1st time diagnosis of psoriasis & diabetes
- 68 year old female with major depression & > 2 years of intractable nausea & vomiting from severe reflux disease
- 57 year old Hispanic male with depression & probable liver cancer - (2) 1.5 cm nodules - growing over a liver infected with hepatitis C
- 62 year old male with major depression & skin cancer (confirmed by skin biopsy)
- 51 year old male with major depression & GAD with huge scrotal swelling
PRACTICAL TIPS AND IDEAS

1. During appointment, do not rush.

2. When you need to send the member to the ER or to specialists, insist on it. Look them in the eye and explain why. Explain your point until they get it in simple understandable language.

3. Offer members options; ER or no ER.

4. Simplify things for members. Give them few, specific instructions that are easy to follow.

5. Find allies to provide that much needed support.

6. Help direct the member towards the goal of wellness.

7. Communicate to the member the message that we are serious in taking care of your health.
6. Write things down for members. Provide print outs of plans of care, addresses, phone numbers, clinic hours of providers

7. Do medication reconciliation

8. Note drug interaction of medications (psychiatric medication), overlapping medications (polypharmacy)

9. Co-locate services if you can. Medical clinic visits in the same location as laundry, shower and mail services. Medical and psychiatric services in the same building, ideally within walking distance to ER, hospital and laboratory.

9. Be yourself. Project an image of transparency yet project an image of being in control. Admit it if you do not know the answer right away but promise that you’ll call them after you have looked it up or consulted with your peers. And do call them.

10. Enjoy seeing these members. Seize every opportunity to get to know what makes the members in front of you unique and build rapport from there.
WHAT WORKED? WHAT DIDN’T?

- Systems issues
- Member issues
- Strategies to promote success
- Know / learn community resources
PROGRAM APPROACH

- Community integration
- Empowering members to make health decisions
  - To advocate/understand their care
  - Switch doctors as desired
- Graduate from MH doesn’t mean losing your PCP
- Partnerships with the community
CURRENT STATUS

- Program update – 5 years later still going strong
- Impact of having this grant
- Community of Practice – NCBH Cancer Prevention and Control Initiative current cohort
LESSONS LEARNED/RECOMMENDATIONS

- Partnerships with Department of Health and Human Services, Department of Public Health, local hospitals and local FQH
- Rapport is key
- Keep focus on health and wellness
TAKE HOME POINTS

- Strategic partners
- Grant structure is important
- It CAN be done (even with limited resources)
- This is a worthy effort
REFERENCES

THANK YOU!