DHS
Oregon Department of Human Services

Activities for Addressing
Morbidity and Mortality in People with Serious Mental Illness

This matrix was developed from the Morbidity and Mortality in People with Serious Mental Illness report from NASMHPD (October 2006). People with serious mental illness (SMI) die, on average, 25 years earlier than the general population. State studies document recent increases in death rates over those previously reported. This is a serious public health problem for the people served by out state mental health systems. While suicide and injury account for about 30-40% of excess mortality, 60% of premature deaths in persons with schizophrenia are due to medical conditions such as cardiovascular, pulmonary and infectious diseases.

Level	***Goals***	***Activity***	***Examples***	***Activities in Oregon***
Provider/ Clinician	**1. Adopt as Policy that Mental Health and Physical Healthcare Should Be Integrated.**	The methods to achieve integration will vary from provider to provider, but the commitment of leadership to achieving integration will be critical to addressing the issues of morbidity and mortality in the population with SMI. Depending on the model adopted, assure that the operational details, staffing, and financing are aligned to achieve the goal of integrated care.		
	2. Help Individuals to Understand the Hopeful Message of Recovery, Enabling their Engagement as Equal Partners in Care and Treatment.	***Person-centered care:*** The pathway to recovery and health will be different for each individual. The ***principle partnership must be with the people we serve***.		
	3. Support Wellness and Empowerment of Persons Served, to Improve Mental and Physical Well-Being	***a. Support personal empowerment and individual responsibility, enabling individuals to make healthy choices for recovery to promote their individual recovery efforts; this means engaging people with SMI in their health care in new ways.***		

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	4. Ensure the Provision of Quality, Evidence-Based Physical and mental Health Care by Provider Agencies and Clinicians	***a. Utilize the system transformation recommendations from the New Freedom Commission, Institute of Medicine and SAMHSA to achieve a more person-centered mental health system.***	*1	
		b. Implement standards of care for prevention, screening and treatment in the context of better access to health care.	*2	
		c. Improve comprehensive health care evaluations.	*3	
		d. Assure that all initiatives to address morbidity and mortality have concrete goals, timeframes and specific steps. Gather performance measurement data and use to manage overall system performance.		
	5. Implement Care Coordination Models	***a. Assure that there is a specific practitioner in the MH system who is identified as the responsible party for each person's medical health care needs being addressed and who assures coordination all services***.	*4	

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***1. Specifically, implement the following selected recommendations, as identified in the IOM report, and modified to address the morbidity and mortality issues. Direct care providers should:**

- Support individual decision making and treatment preferences (regarding physical health as well as mental health, giving information to make healthy choices, such as weight implications of psychotropic drugs, education about the effects of smoking, obesity and lack of exercise)
- Use illness self-management practices (expand opportunities for individuals to practice and develop decision making skills in regard to physical as well as mental health)
- Have effective linkages with community resources (including access to health care and engage families and other collateral service providers in understanding how to support individuals in maintaining their healthy choices)
- Screen for co-morbid conditions (obesity, diabetes, high blood pressure)
- Routinely assess treatment outcomes (physical as well as mental health)
- Routinely share clinical information with other providers (primary and specialty health care providers as well as mental health providers)
- Practice evidence-based care coordination (coordinate care of the whole person). (See Appendix F for the full summary of IOM recommendations for all stakeholder groups.)

***2. First-line therapies for all lipid and nonlipid risk factors associated with the metabolic syndrome are weight reduction and increased physical activity, which will effectively reduce all of these risk factors…Beyond the underlying risk factors, therapies directed against the lipid and nonlipid risk factors of the metabolic syndrome will reduce CHD risk. These include treatment of hypertension, use of aspirin in patients with CHD…and treatment of elevated triglycerides and low HDL cholesterol…liii Management of the metabolic syndrome in the general population has a two-fold objective:**

- Reduce underlying causes (i.e., obesity and physical inactivity)
- Treat associated nonlipid and lipid risk factors

Using the monitoring tools recommended here, assure consistent diabetes screening for all individuals actively being served by the public mental health system. Assure priority for those receiving second generation antipsychotic medications and/or high risk ethnic populations.

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***3. Current approaches to "comprehensive evaluation" lack: important clinical details; important clinical assessment, diagnostic and treatment prompts and reminders; and standardized approaches. They are often multidisciplinary, but not interdisciplinary and therefore often redundant. The conceptual standards for truly comprehensive evaluations include:**

- Has to be timely.
- Has to have uniform initiation and follow-up criteria regardless of time or setting.
  - Has to cover all the important clinical areas: functional and behavioral declines, medical, psychiatric and iatrogenic conditions, and psychosocial and environmental stressors.
  - Within each clinical area, has to rule out important clinical details and conditions.
  - Has to structure and guide the clinical team through the assessment, formulation, diagnostic, and treatment stages of the evaluation so that no clinical details identified in any stage are forgotten.
- Has to be interdisciplinary and adaptable to all types of settings and clinical teams.
  - Allows flexibility in narrative-based assessments at any level: network, facility, unit or service.
  - Has to be user friendly to all types of health care disciplines.
  - Has to be efficient and streamlined from start to finish (report generation).
- Has to be seamless from one point of care to the next with all the important historical clinical information from the most recent comprehensive evaluation being forwarded automatically.
- Network-connected and secure with only PCs and a Server (either site-based or hosted).
  - All inputted or accessed clinical data is automatically linked to the specific assessor or reader for total compliance with medical-legal and HIPAA notification regulations.
  - All inputted clinical data is setup to be reviewed and then either edited or approved via the clinical supervisor before it becomes medical record.
  - Does not require any other form of electronic health record (HER) to completely function.
- Can exchange clinical information with other types of EHR to ensure the most accurate and up to date information being used during the comprehensive evaluation process.

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***4. Assure health status assessment and planning are a part of treatment planning and goal setting for every person with SMI, throughout the system.**