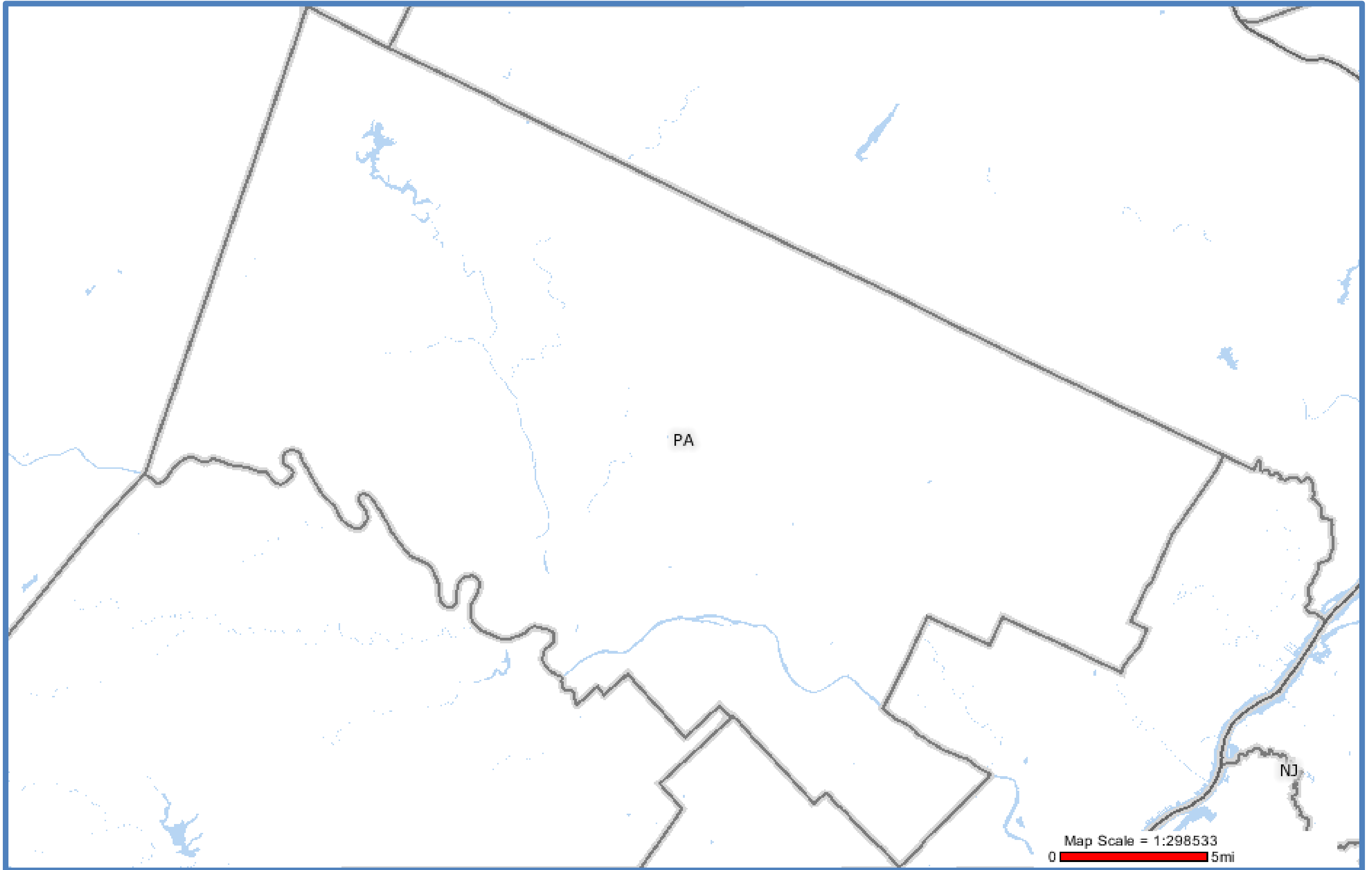


Community Health Needs Assessment: Medical Needs of Adults Experiencing a Mental Health Crisis in Montgomery County

Montgomery County Emergency Service
Norristown, PA

June 2015

Executive Summary

As a nonprofit hospital offering a range of emergency psychiatric and mental health service. MCES completes a community health needs assessment (CHNA) every three years. The key objectives of the CHNA are to identify the community served by the hospital and determine the health issues within that community. The CHNA must take into account input from persons who represent the interests of the community we serve and determine the scope and nature of pertinent unmet or underserved needs in that community.

Our CHNA is the subject of this report. It relates directly to our mission to meet the needs of persons in Montgomery County and adjacent communities who are experiencing a potentially life threatening psychiatric emergency or serious mental illness-linked crisis. Here we specifically look at the medical health needs of those we serve and what MCES can do to better serve these needs.

This report will be used to inform and guide our planning and delivery of our principal services including:

- Crisis/Suicide Hot Line
- Walk-in Crisis Center
- Emergency Psychiatric Evaluations
- Inpatient Psychiatric Care
- Crisis Residential Program
- Psychiatric Emergency Medical Service

These services are available 24/7 and provided on the basis of need and not on insurance coverage.

As applicable information from this report will also be used by our educational and community health promotional programs:

- Crisis Intervention Specialist (CIS) Program
- Suicide Prevention Program

Contents

Executive Summary 1

Introduction 3

Montgomery County Demographics 5

What is MCES's Community Health Mission? 6

What is a Community Health Needs Assessment? 7

What is the Scope of this Community Health Needs Assessment? 8

Medical Morbidity in Adults with Serious Mental Illness 11

What Health Needs are Present among MCES Patients? 13

Discussion of Findings 15

Medical Care Service Resource Inventory 17

What can be done to meet the Medical Needs of MCES patients? 19

Concluding Comments 20

References 21

Appendix

Introduction

This assessment has been undertaken for two reasons: (1) to identify unmet and underserved medical health needs among individuals experiencing a mental health crisis or potentially life threatening psychiatric emergency in Montgomery County, PA; and (2) to fulfill a mandate set for all nonprofit hospitals, both behavioral health and medical facilities, set by recent national health legislation.

A community health assessment is a process that uses quantitative and qualitative methods to systematically collect and analyze data to understand health within a specific community. An assessment includes information on risk factors, quality of life, morbidity, community assets, forces of change, social determinants of health and health inequity, and information on how well the public health system provides essential services.

Community health assessment data inform community decision-making, the prioritization of health problems, and the development, implementation, and evaluation of community health improvement plans.

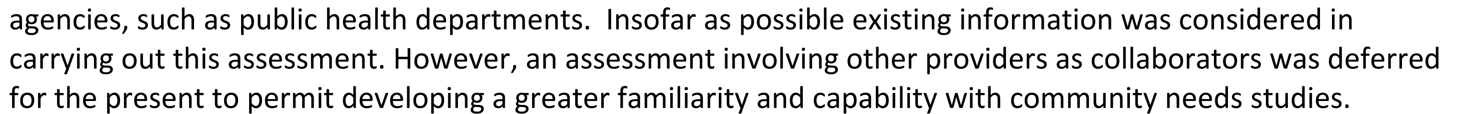
There are several questions that lend themselves to being informed by the community health needs assessment process. These include:

What health conditions exist in our community affecting those we serve?
How do our patients' medical needs affect their mental health wellness?
Why do health conditions exist among our patients?
What community resources are available to address our patients' health care needs?
What can we do to increase availability or facilitate access to needed health care services?
What recommendations can we propose?

MCES will begin to address these questions with this report.

The Affordable Care Act (Public Law No. 111-148), enacted March 23, 2010, and the Health Care Education Affordability Reconciliation Act of 2010 (Public Law No 111-152), enacted March 30, 2010 added Section 501[r] to the Internal Revenue Code, which affects hospital organizations that are 501[c]3 tax-exempt organizations. Section 2, one of the four additional requirements mandates tax-exempt hospital organizations to conduct a community health needs assessment (CHNA) every three years. The CHNA must include input from "persons who represent the broad interests community" and experts in public health. The new law also requires that: (1) the CHNA be "made widely available to the public; and (2) affected hospital organizations adopt an implementation strategy to meet the community health needs identified in the CHNA.

Section 9007 of the Affordable Care Act notes that 501(c)3 hospitals may incorporate information collected by other organizations, such as a public health agency or nonprofit organization; and be conducted in collaboration with other organizations, including related organizations, other hospitals, and state and local



agencies, such as public health departments. Insofar as possible existing information was considered in carrying out this assessment. However, an assessment involving other providers as collaborators was deferred for the present to permit developing a greater familiarity and capability with community needs studies.

Consistent with the ACA mandates this needs assessment will attempt to identify unmet and underserved needs pertinent to mission of Montgomery County Emergency Service (MCES). It will not attempt to evaluate the quality or effectiveness of the services offered by MCES or by other providers. The results of this study will be used, as indicated, in planning and implementing new or expanded MCES programs and services.

Montgomery County Demographics

Montgomery County is located in southeastern Pennsylvania in the metropolitan Philadelphia area. It occupies 487 square miles and shares borders with six other counties.

Montgomery County is the third most populous county in Pennsylvania after Philadelphia and Allegheny. According to the US Census Bureau:

- The county's total population in 2010 was 799,874 compared to 750,097 in 2000. The county population is projected to increase to 854,994 in 2020.
- Adults, age 18 years and older, numbered 616,370 in 2010. The county's median age is 40.6 years.
- Whites numbered 631,784 and represented 79% of the county's population in 2010. The county's nonwhite population was 168,090 compared to 110,078 in 2000, an increase of 52.7%. Nonwhites represented just under 15% of the population in 2000 and 21% in 2010.
- Almost 25% of the county population (186,805) resides in five municipalities: Abington (55310), Lansdale (16269), Lower Merion (57825), Norristown (34324), and Pottstown (22377).

The US Census Bureau's *American Community Survey 2008-2012* identified 51617 county residents, almost 7% of the population, as uninsured. Of these, 45034 were ages 18-64 and 519 were age 65 and over.

Historically, Montgomery County has ranked among the wealthiest counties in both the US and the state. The median county income in 2008-2012 was $78,984 versus $52,267 for the state as a whole. This places the county as the second most affluent in Pennsylvania, just slightly below Chester County.

In 2008-2012, 6.1% of county residents had incomes below the poverty level. The US Department of Labor sets the county's most recent unemployment rate at 5.7%. The Social Security Administration reported that there were 8239 Supplemental Security Income (SSI) recipients in the county in 2012.

What is MCES's Community Health Mission?

Broadly speaking, MCES is a psychiatric emergency response system. MCES offers an array of services to meet the needs of individuals in Montgomery County, Pennsylvania, and adjacent communities, and in other counties as resources permit, who are experiencing a potentially life-threatening psychiatric emergency or severe mental health crisis. These conditions are more fully defined and discussed in a subsequent section of this report.

MCES's primary services include:

- Acute inpatient psychiatric care
- Crisis center and crisis/suicide hot line
- Crisis Residential Program
- Psychiatric Emergency Medical Service (EMS)
- Crisis Intervention Specialist Program
- Suicide Prevention Program

MCES delivers these community health benefits:

- Emergency psychiatric evaluations 24/7 to determine if an individual is an imminent danger to herself/himself or to others
- Emergency voluntary/involuntary psychiatric hospitalization 24/7 assuring safety and stabilization, and treatment
- Provision or referral to appropriate services 24/7 for individuals whose care needs do not necessitate psychiatric hospitalization
- Crisis counseling on-site or by telephone 24/7 to assist individuals and families resolve behavioral health problems
- Emergency transport 24/7 to MCES or other facilities for evaluation or treatment
- Education of police officers and other professionals on identifying and safely helping individuals who may be experiencing psychiatric emergencies or mental health crises
- Information and education to the community and organizations on identifying and aiding individuals who may be at risk of suicide

What is a Community Health Needs Assessment?

A Community Health Needs Assessment (CHNA) is a measurement of the relative health or well-being of any given community. It is undertaken to identify the strengths and needs of the community, enable the community-wide establishment of health priorities and facilitate collaborative action planning directed at improving community health status and quality of life.

Information from a CHNA can be used in the development of strategies to address prioritized needs, with the goal of contributing to improvements in the community's health. A CHNA typically seeks to understand and document health status, behaviors and needs in the community served by the hospital.

The component of MCES that is a psychiatric hospital serves both a geographic and demographic community. The latter is a group of people having a particular characteristic in common. This report addresses the medical needs of adults with serious mental illness as represented by patients at MCES.

As defined by federal regulation, a serious mental illness is:

> A condition that affects "persons aged 18 or older who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within DSM-IV (APA, 1994) that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities" such as maintaining interpersonal relationships, activities of daily living, self-care, employment, and recreation. (Substance Abuse and Mental Health Services Administration, 2013, p. 11).

MCES decided to assess the medical needs of adults with serious mental illness because in recent years an increasing number of patients presenting at MCES for evaluation and admission have had health care needs which required the initiation or continuation of treatment during their inpatient stay. The study was limited to individuals who identified themselves as residents of Montgomery County at the time of admission.

The study was conducted using a purposive sample between July 1, 2014 and June 30, 2015. Patients on census during that period were identified in terms of (i) residence and (ii) documentation of one or more medical conditions in the medical history completed after their admission. Patients were informed of the purpose of the study and asked to participate. The MCES Patient Rights and Ethics Committee reviewed the purposes and methods to be used in this study.

What is the Scope of this Community Health Needs Assessment?

This section identifies the geographic scope of the needs assessment and the area of community health to be addressed.

Geographic Scope

MCES's primary service area is Montgomery County, PA. MCES responds to mental health emergency needs on the part of Montgomery County residents or mental health emergency needs on the part of residents of other areas while they are in Montgomery County. MCES also accepts referrals for inpatient psychiatric care involving individuals who may be residents of other counties.

MCES is the exclusive provider of involuntary emergency psychiatric evaluations and hospitalizations for adults (age 18 and over) for Montgomery County. As demand and capacity permit, MCES also provides voluntary psychiatric evaluations and hospitalizations for adults (age 18 and over) who are residents of Montgomery County or other areas.

The majority of calls to MCES's crisis hot line originate in Montgomery County, but calls from outside the county and outside the state are received every day. MCES is part of the National Suicide LifeLine Network and may receive calls to 1-800-273-TALK from any of the area codes in the greater southeastern region of Pennsylvania (Bucks, Chester, Delaware, Montgomery, and Philadelphia counties) for 610, 215, 267, and 484. MCES may also receive LifeLine calls from cell phones with these area codes regardless of the caller's actual location.

Because MCES is situated in Montgomery County and has working and referral relationships with other providers serving Montgomery County, this needs assessment will limit its geographical scope to Montgomery County.

Community Health Scope

MCES is a freestanding acute psychiatric hospital that in terms of mission, licensure, and capability only serves a narrow segment of the continuum of community health services. Specifically, MCES attempts to meet the needs of individuals in Montgomery County who are experiencing a mental health crisis or psychiatric emergency. These are described below:

> ***Mental Health Crisis:*** This is a temporary illness-related response to severe stress that ensues if coping efforts are overcome. It is usually recognized by the individual and has potential for either a positive or

negative outcome. It may require clinical intervention if it involves recurrence, but is not imminently life threatening. Common triggers are trauma, substance misuse, conflict, income or housing issues, and criminal justice contact. Retraumatization may occur at this stage. A mental health crisis may lead to a psychiatric emergency.   mental health crisis is a “complex crisis” which can lead to “episodes of mental illness in those already vulnerable.”

Situations involving mental health crises may follow trajectories that include intense feelings of personal distress (e.g., anxiety, depression, anger, panic, hopelessness), obvious changes in functioning (e.g., neglect of personal hygiene, unusual behavior) or catastrophic life events (e.g., disruptions in personal relationships, support systems or living arrangements; loss of autonomy or parental rights; victimization or natural disasters).

Psychiatric Emergency: A potentially life-threatening situation involving an acute disturbance of thought, mood, and/or behavior. It may be situational or illness-based and is generally not recognized by the individual. It involves behavior with the potential to rapidly lead to self-harm or harm to others. An immediate clinical intervention is indicated. Common psychiatric emergencies are exacerbations of psychosis, a suicide attempt or voicing serious intent and a specific plan, uncontrollable anxiety or panic, or homicidality. Psychiatric emergencies engender trauma that persists beyond the episode and heightens the risk of future episodes.

In 2013, the Montgomery County Department of Behavioral Health and Developmental Disabilities and the Pennsylvania Department of Public Welfare conducted separate crisis mental health needs assessment inquiries at the county and state levels. Rather than duplicate these efforts MCES decided to look at the health care needs of individuals affected by mental health crises and psychiatric emergencies.

Consultation with Individuals and Groups

MCES consulted a number of individuals and groups in the community with knowledge of the health care needs of person with serious mental illness for input on the focus of this study.

The individuals consulted included;

- Nancy Weiman, Deputy Administrator, Montgomery County Department of Behavioral Health and Developmental Disabilities
- Carol Caruso, Executive Director, National Alliance for Mental Illness (NAMI), Montgomery County, Norristown, PA
- Marina Cooney, MD, Main Line Health
- Paul De Marco, RN, Chief mental Health Delegate, Norristown, PA
- Lisa Kleiner, Public Health Management Corporation, Philadelphia, PA

- Julie Knudsen, MSW, Director of Government Affairs, Central Montgomery County Mental Health and Mental Retardation, Norristown, PA
- Laura Longstreet, Director of Business Development, Brooke Glen Behavioral Hospital
- Andrew Trentacoste, PhD, Executive Director, Creative Health Services, Pottstown, PA

The study was discussed at meetings of these groups:

- Montgomery County Community Support Program (CSP) – Mental health consumer advisory group
- Montgomery County Forensic Task Force – Consortium of behavioral health and criminal justice organizations

In addition to these external sources, MCES medical staff were consulted on MCES patient health needs:

- Naomi Finkel, RN
- Terry Ann Glauser, MD, MPH (MCES Board Member)
- Ginny Graves, RN
- Donald Kline, PhD
- Maria Miazga, CRNP
- Rocio Nell, MD
- Maryanne Perna, PA
- Julie Peticca
- Jordan Santina, DO

Medical Morbidity in Adults with Serious Mental illness

Physical and mental disorders commonly occur together but the psychiatric disorders are often misunderstood and misdiagnosed. The co-occurrence of mental and physical disorders seems to support the mind-body interaction (substance dualism) suggested by Descartes. It proposes that although the mind and body are distinctly different, they interact and affect each other. Changes in the body affect the mind and vice versa.

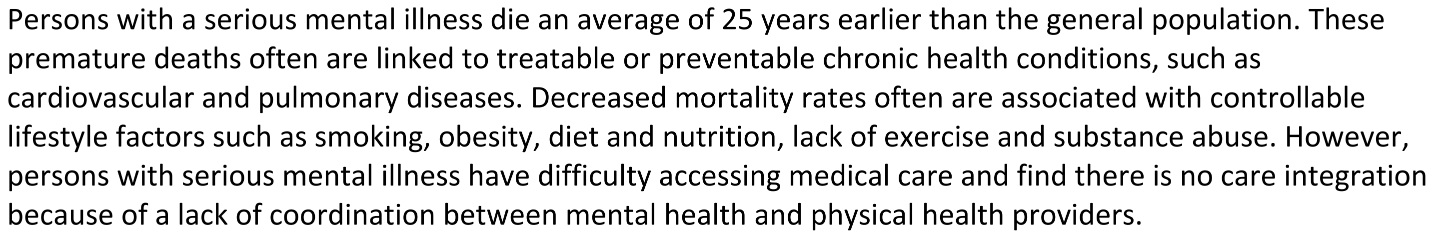
Psychiatric illness can:

Coexist with medical illness
Can exacerbate medical illness (noncompliance)
Be a presenting symptom of a medical illness (thyroid disease)
Coexist with substance abuse emergencies
Be a mimic for organic causes

General Findings from the Literature

Studies and research reviews show that people with serious mental illness in general and schizophrenia in particular are very likely to have high rates physical illness comorbidity:

- Diabetes patients with mental illness have been found to be less likely to receive standard levels of diabetes care from health care providers (Frayne et al. 2005)
- Arthritis sufferers with psychotic disorders are less likely to receive medical treatment for arthritis (Mitchell et al. 2009)
- Higher risk for cardiovascular morbidity and mortality has been found in individuals with schizophrenia than in the general population (Capasso et al. 2008)
- Elevated rates of hepatitis have been found in persons with serious mental illness compared to the general population (Mistler et al. 2006)
- The prevalence of chronic obstructive pulmonary disease (COPD) (i.e., chronic bronchitis and emphysema) is significantly higher in those with serious mental illness than in those without SMI (Himelhoch et al. 2004)
- A higher incidence of tuberculosis has been consistently found in patients with schizophrenia than in the general population (DeHert et al. 2011)
- Patients with chronic illnesses, including cardiovascular disease, cancer, and diabetes mellitus, have rates of psychiatric disorders ranging from 20% to 67%, depending on the medical illness (Evans and Charney 2003)



Persons with a serious mental illness die an average of 25 years earlier than the general population. These premature deaths often are linked to treatable or preventable chronic health conditions, such as cardiovascular and pulmonary diseases. Decreased mortality rates often are associated with controllable lifestyle factors such as smoking, obesity, diet and nutrition, lack of exercise and substance abuse. However, persons with serious mental illness have difficulty accessing medical care and find there is no care integration because of a lack of coordination between mental health and physical health providers.

Based on the literature the study attempted to determine health care needs among patients with SMI for these conditions:

- Asthma, Chronic Obstructive Pulmonary Disease, Other Respiratory Illness
- Cardiovascular Disease
- Diabetes
- Hepatitis
- Hypertension
- High Cholesterol

These are all chronic conditions or illnesses that can be physically debilitating over time. Each involves the need for ongoing medical management and self-care by the individual. In the absence of such care these conditions are prone to periodic exacerbation, possibly of a life threatening nature, requiring emergency medical attention.

Montgomery County Data

The Montgomery County Department of Behavioral Health and Developmental Disabilities and Magellan Behavioral Health of Pennsylvania, Inc., issued *Health Choices Health Connections Report to the Community* (2011) that provided the following data on individuals with serious mental illness:

- A steady increase is seen in the number of individuals in the Montgomery County HealthChoices program identified as having a serious mental illness since 2000, from 2,082 people in 2000 to 5,097 people in 2010. This is a rise of 145 percent in 10 years.

- In 2010, 50 percent of individuals in Montgomery County with a serious mental illness were aged 40 to 63. A greater number are females (59%). The most common diagnostic group represented mood disorders (70%) inclusive of the different types of bipolar and major depressive disorders. Schizophrenia and other psychotic disorders were the next most prevalent (28%).

What Health Needs are Present among MCES Patients?

A. Sample Demographics

Gender		
Male	34	45%
Female	41	55%

Race/Ethnicity		
Afro-American	26	35%
Asian	2	3%
Latino/Hispanic	9	12%
White	38	50%

Age		
18-24	8	11%
25-34	23	30%
35-44	11	15%
45-54	12	16%
55-64	16	21%
65/Over	5	7%

B. Sample Health Profile

Self-rating of Current Health Condition		
No Health Problems	5	7%
1-2 Health problems	23	31%
Many Health problems	10	13%
Don't Know	37	49%

Smoking/Use of Tobacco Products		
Currently Smoke	61	81%
Formerly Smoked	9	12%
Never Smoked	5	7%

Current Health Problems		
Asthma/COPD	22	29%
Cardiovascular Disease	15	20%
Diabetes	35	47%
Hepatitis	10	13%
Hypertension	28	37%
High Cholesterol	24	32%

C. Health Care Utilization and Barriers

Source of Health Care		
Primary Care Provider	33	44%
Community Health Clinic	9	12%
Hospital Emergency Department	8	11
None	25	33%

Most Recent Health Care Provider Visit		
Within Past 6 Months	16	21%
Within Past 12 Months	21	28%
More than 12 Months	11	15%
Don't Know	27	36%

Primary Obstacle to Accessing Health Care		
No Obstacles	15	20%
No Insurance	18	24%
No Current Provider	14	18%
No Transportation	20	27%
No Phone/Other	8	11%

Impediments to Maintaining Health		
Smoking	38	51%
Use/Abuse of Alcohol	27	36%
Rx/Street Drug Abuse	19	25%
Unstable Housing	15	20%
Poor Nutrition	6	8%
Rx Medication Side Effects	33	24%
Don't Know	10	13%

Discussion of Findings

In their self-identification of health care needs a comparatively small number of respondents (7%) stated that they had no health problems at the time of the interview. This may be a reflection that more than 50% of the sample were under age 45. Many potentially serious health problems do not manifest symptoms for several years and may go undiscovered in persons who do not get regular health examinations.

A relatively high percentage (81%) of respondents identified themselves as current smokers or users of other tobacco products. More than 50% cited smoking as an impediment to maintaining personal health. MCES, like other inpatient psychiatric facilities in the area, permits smoking. Less than 20% of those interviewed said that they never smoked or were former smokers. Given the health care consequences of smoking MCES must do more to discourage it among our patients (and staff).

Diabetes was cited as a current health problem by almost half of the respondents. Diabetes requires a careful and consistent management regimen that may be difficult for many persons with serious mental illness to follow. Glucose intolerance, as aspect of pre-diabetes, is linked to some psychiatric disorders. The prevalence of diabetes in our sample and in the population of persons with serious mental illness in general demands that MCES and other providers give it more attention.

More than one-third stated that they had been found to have hypertension. MCES checks the blood pressure of every individual receiving a psychiatric evaluation and monitors blood pressure on al inpatients. Hypertension is element of metabolic syndrome associated with antipsychotic medications taken prescribed for many persons with serious mental illness.

Just less than one-third identified high cholesterol and asthma or other respiratory conditions as health issues. High cholesterol may be undertreated and underdiagnosed in the sample as just less than half of the respondents said had visited a health care provider within the past twelve months. Asthma and other respiratory disorders are aggravated by smoking which is common in individuals with serious mental illness.

One-fifth of the respondents stated that they knew that they had some form of cardiovascular disease. Anecdotally, a number of respondents related that they had been told that they had atherosclerosis. Others said they had had “heart attacks” in the past. Those with serious cardiovascular disorders may be less likely to receive ongoing treatment, even something as basic as low dose aspirin therapy.

Hepatitis was identified as a health concern by 13% the patient surveyed. Hepatitis B and C are likely the types of the disease experienced by these individuals. Both may be contracted by exposure to blood or other fluids of others with these diseases as through sharing needles in drug use.

One-third of the respondents stated that they had no current source for receiving health care if needed. Just over two-fifths did answer that they had a primary care provider. 12% relied on community health clinics for care while 11% went to a hospital emergency department for care. These findings indicate that there is a clear need to connect persons with serious mental illness to a regular source of primary medical care and promote routine utilization. The next section of this report identifies available sources of primary health care in Montgomery County that serve persons with serious mental illness. Use of these services would enhance preventative care in the form of screenings, monitoring of known health care problems, and vaccinations for flu, pneumonia, and other maladies.

In terms of the principal barrier to accessing health care, most respondents (27%) named the lack of transportation. Slightly fewer (24%) of the respondents stated that having no insurance impeded their use of health care services when needed. This will likely improve as the Affordable Care Act takes hold. However, it is likely that many persons with serious mental illness may not realize that they are presently covered by health insurance, particularly Medical Assistance and/or Medicare, or could be eligible.

Almost 20% of the respondents said that the lack of a current provided was the reason that they did not use health care when they felt it necessary. Only one-fifth of those interviewed reported they had no problems accessing health care services.

When asked about what stood in the way of being able to maintain good health more than one-half of the respondents cited smoking. Tobacco use is a major contributor to the onset and exacerbation of respiratory disease, heart disease, and lung cancer.

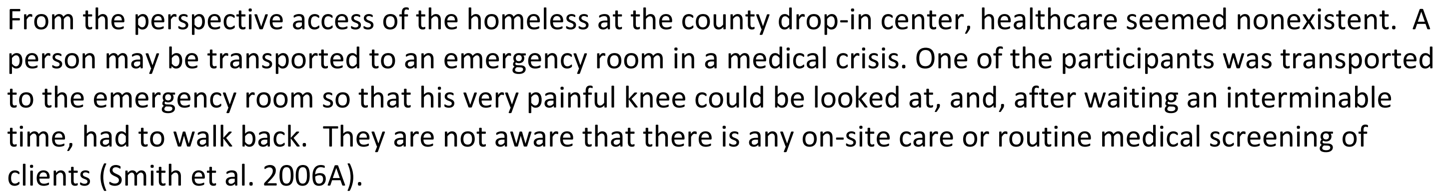
The next impediment that referenced was the use or abuse of alcohol (36%). The abuse of street drugs or prescription medications was identified as having a negative impact on their health by one-quarter of the respondents. One-fifth cited unstable housing and homelessness as a factor in less than optimal health. The side effects of prescribed psychotropic medications were seen as detrimental to overall health by 24% of respondents (e.g., the association of antipsychotic medications with metabolic syndrome – weight gain, diabetes, and hypertension).Poor nutrition or diet was seen as a problem by just less than 10%. Just over 10% of the respondents were unable to name any specific obstacle to maintaining good health.

Medical Care Service Resource Inventory

Sources of primary or specialty health care services to adults with serious mental illness and limited incomes and/or insurance coverage in Montgomery County:

- Community Health & Dental Care, Pottstown, PA – Provides adult and family medical care on a sliding fee scale for uninsured/underinsured
- Norristown Regional Health Center, Norristown, PA – Provides adult and family medical care on a sliding fee scale for uninsured/underinsured
- Montgomery County Department of Health, Norristown, Pottstown, Willow Grove, PA – Immunization clinics for uninsured; communicable disease screening, testing, treatment; TB and lead screening
- Healthlink Medical Center, Southampton, PA – Primary medical care for adults in Bucks and Montgomery counties who are employed, uninsured, and have incomes no higher than 200% of the Federal Poverty Guidelines
- Abington Health Center (Abington Health System), Blue Bell, Montgomeryville, Willow Grove, PA – Medically necessary care for qualified individuals without insurance, limited/exhausted coverage, and not covered by a government health insurance program, with household family income is less than 600% of the Federal Poverty Level (FPL)
- The Clinic, Phoenixville, PA – Primary medical care for adults in areas of Montgomery County within a 10-mile radius of clinic location; fee policy: "patients are asked to contribute to the extent that they find affordable"
- Victor J. Saracini Community Based Outpatient Clinic (VA), Horsham, PA – Primary medical care and behavioral health services for eligible Veterans in Montgomery County
- Spring City Community Based Outpatient Clinic (VA), Spring City, PA – Comprehensive medical care for eligible Veterans in Montgomery County

In general, medical resources are less plentiful in this region than in the rest of the county and access to specialty care for the medical assistance population and the uninsured is particularly problematic. They are often forced to rely on Philadelphia medical school services that often involve long delays and difficulties in arranging transportation (Smith et al. 2006B).



From the perspective access of the homeless at the county drop-in center, healthcare seemed nonexistent. A person may be transported to an emergency room in a medical crisis. One of the participants was transported to the emergency room so that his very painful knee could be looked at, and, after waiting an interminable time, had to walk back. They are not aware that there is any on-site care or routine medical screening of clients (Smith et al. 2006A).

Why, then, is access to this care so limited? The reasons for the lack of recognition, diagnosis, and application of appropriate treatments are many: the stigma of mental illness; the busy clinics that reduce the physicians' time to inquire about psychiatric or psychological symptoms; the reluctance of patients to bother the physician and distract him or her from the primary clinical problem; and the fact that mental health services are the first to be eliminated in budget crises and, hence, are often unavailable (Alter 2006).

Is the issue one of meeting the emergency mental health needs of patients with acute illness or symptoms of exacerbated chronic illness or meeting the medical needs of individuals with an acute mental health crisis or an exacerbated chronic mental illness?

The Nurse Navigator Program

In addition to the outpatient facilities listed above, individuals with serious mental illness may receive assistance meeting their health care needs through the Nurse Navigator Program. These are Registered Nurses who work collaboratively with individuals to coordinate care. The Navigators coordinate ongoing care for the individual. This could include helping the individual gain access to services, health and disease screening, and education regarding medications and diseases.

The Navigators act as a health advocate to help members receive ongoing and appropriate care. They are able to support clients in their homes, at medical appointments and evaluation, and facilitate and advocate for medical follow-up. In addition, some other services they are able to provide include: offering information and resources to members about help with tobacco cessation, exercise, dietary restrictions, and health maintenance. They will also notify the PCP and psychiatrist upon entry to/discharge from an inpatient hospitalization. The Navigators provide health monitoring for members on atypical antipsychotic medication. Navigators also help with barriers to adherence to medical and behavioral health care. Nurse Navigators are offered at:

- Central Montgomery Mental Health Mental Retardation, Norristown, PA
- Creative Health Services, Pottstown, PA
- Northwest Human Services, Lansdale, PA
- Penn Foundation, Sellersville, PA

What can be done to meet the Medical Needs of MCES patients?

Some of the health care problems that persons with SMI experience are similar to the problems some may have with mental health care. Effective utilization of both types of care requires the ability to use available information to recognize possible signs or symptoms, identify sources of help, act to minimize risk, and maintain well-being. This ability constitutes what is known as health care literacy. It is the extent to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. Health care literacy is a prerequisite to maintaining and regaining good health be it physical or mental. However, the nature of SMI and how it impacts those who struggle with it daily may impede achieving insight into health care issues. Moreover, even when a mental health consumer gains familiarity with their needs there may still be serious barriers to finding and accessing care. This means that mental health providers, the community mental health system, and health care resources must have supports in place to enable consumers to get the medical care they need.

Here are some things that MCES is already doing but can enhance and other measures that can be introduced:

- Review health care information and education resources to promote (i) awareness and understanding of any current or at-risk health care problems and (ii) making appropriate choices in relation to diet, physical activity, and smoking
- Teach and support health as well as mental health self-help and self-management skills through adoption of a health literacy approach.
- Schedule health education video showings in evenings on asthma, heart disease, diabetes, and other health problems common among patients
- Incorporate recovery principles into a patient health wellness approach encouraging smoking cessation, exercise, and healthy diet and nutrition
- Incorporate pertinent health management recommendations into discharge plans and include discussion of health care needs with family members and other supports
- As possible, identify every new admission's primary care provider and secure patient's authorization to notify PCP of hospitalization and share any relevant health information
- Review how patient health history information is gathered at admission
- Explore feasibility of having brief health screenings performed in the MCES Crisis Center on patients awaiting evaluation
- Make information on sources of primary health care in Montgomery County available to patients
- Explore feasibility of follow-up post-discharge home visits by MCES nurses or nurses from other agencies to identify and address obstacles to aftercare and meeting health care needs

MCES will also address these actions as appropriate in our Long Range Plan.

Concluding Comments:

Factors contributing to unmet and undertreated medical health needs among adults with serious mental illness can be broken down into three categories: patient-related issues, provider-related issues, and system-related issues. Patient-related issues include lack of information on the availability of health care resources, lack of accessibility (e.g., transportation) to use health care services, and lack of coverage to pay for all or part of necessary health care services. Provider-related issues include service availability in terms of geographic proximity to patients in need, scope of services offered, hours of operation, coverages accepted, willingness to serve indigent and uninsured patients, and practices to accommodate persons with SMI or other behavioral health problems. System-related issues include the lack of integration between medical and mental health services, fragmentation of services that make it difficult for persons with SMI to navigate the local health care system, lack of continuity of care, and no consensus on which system is responsible for assuring that the health care needs of persons with SMI are met.

These factors represent significant obstacles to meeting the health care needs of persons with SMI and minimizing the effect that unmet or undertreated medical needs have on recovery and mental health wellness in that population. These problems have been recognized but have generally only been addressed piecemeal. In part this is because, no provider or service system truly “owns” the responsibility for the physical health of persons with SMI. Ideally, stakeholders such as patients, mental health advocates, medical and mental health providers, payers, and governmental administrators and policy makers must come together to identify areas where feasible changes can be prioritized and implemented. This is unlikely to happen anytime soon given the uncertainties in national health care policies that most affect persons with SMI and the various “crises” besetting the mental health system. In the interim, mental health providers such as MCES must make enhancements within their own organizations and to reach out to health care providers in their service area to support positive health care outcomes for patients with SMI.

This was the first study of this nature undertaken by MCES. It basically represents a needs assessment demonstration project. Future studies of this nature will benefit from what was learned in this undertaking.

References:

Alter, C. (2006) "Meeting the Mental Health Needs of Patients with Chronic Medical Illness: A Crisis in Access" Psychiatric Times http://www.psychiatrictimes.com/articles/meeting-mental-health-needs-patients-chronic-medical-illness-crisis-access.

Capasso, R. et al. (2008) "Mortality in Schizophrenia and Schizoaffective Disorder in Olmstead County, Minnesota Cohort: 1950-2005" Schizophrenia Research 98 287-294.

Crews, C. et al. (1998) "Primary Care for Those with Severe and Persistent Mental Illness" Western Journal of Medicine 169 245-250.

DeHert, M. et al. (2011) "Physical Illness in Patients with Severe Mental Disorders. I. Prevalence, Impact of Medications, and Disparities in health care" World Psychiatry 10(1) 52-77.

Evans D. and Charney, D. (2003) "Mood disorders and medical illness: a major public health problem" Biological Psychiatry 54 177-180.

Frayne, S. et al. (2005) "Disparities in Diabetes Care: Impact of Mental Illness" Archives of Internal Medicine 165 2631-2638.

Himelhoch, S. et al. (2004) "Chronic Obstructive Pulmonary Disease among those with Serious Mental Illness" American Journal of Psychiatry 161 2317-2329.

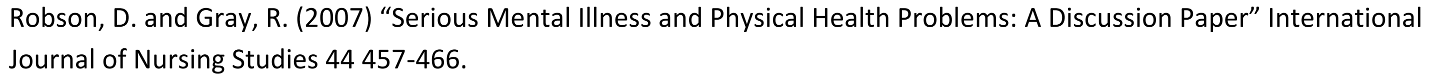
Lawrence, D. and Kisely, S. (2010) "Inequalities in Healthcare Provision for People with Severe Mental Illness" Journal of Psychopharmacology 24(11) Supplement 4 61-68.

Mistler, L. (2006) "Hepatitis C Treatment for People with Severe Mental Illness" Psychosomatics 47 93-107.

Mitchell, A. et al. (2009) "Quality of Medical Care for People with and without Comorbid Mental Illness and substance Misuse: Systematic Review of Comparative Studies" British Journal of Psychiatry 194 491-499.

Parks, J. et al. (Eds.) (2006) Morbidity and Mortality in People with Serious Mental Illness, Alexandria, VA: National Association of State Mental Health Program Directors

Public Health Management Corporation (2013) Tri-County Area Community Health Needs Assessment, Pottstown, PA: Pottstown Area Health & Wellness Foundation.



Robson, D. and Gray, R. (2007) “Serious Mental Illness and Physical Health Problems: A Discussion Paper” International Journal of Nursing Studies 44 457-466.

Smith, B. et al. (2006A) An Independent Assessment of the Health, Human Services, Cultural and Educational Needs of Montgomery County. Philadelphia: Fox School of Business and Management, Temple University.

Smith, B. et al. (2006B) An Independent Assessment of the Health, Human Services, Cultural and Educational Needs of Montgomery County, Central Region. Philadelphia: Fox School of Business and Management, Temple University.

Van Hasselt, F. et al. (2013) “Improvement of Care for the Physical Health of Patients with Severe Mental Illness: A Qualitative Study Assessing the View of Patients and Families BMC Health Services research 13 426-430.\

Appendix:

Selected Montgomery County Health Indicators

Access to Primary Care: This indicator reports the number of primary care physicians per 100,000 residents.

Report Area	Total Population, 2011	Total Primary Care Physicians, 2011	Primary Care Physicians/100,000
Montgomery County	804,210	1,322	164.38
Pennsylvania	12,742,886	12,428	97.53
United States	311,591,917	267,437	85.83

Data Source: US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File

Lack of a Consistent Source of Primary Care: This indicator reports the percentage of adults who self-report that they do not have at least one person who they think of as their personal doctor or health care provider.

Report Area	Total Population (Age 18+)	Total Adults Without Any Regular Doctor	%Adults Without Regular Doctor
Montgomery County	607,075	48,880	8.05%
Pennsylvania	9,857,384	1,056,761	10.72%
United States	235,375,690	45,514,047	19.34%

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System: 2006-10.

Poor General Health: Within the report area 10.50% of adults age 18 and older self-report having poor or fair health in response to the question "Would you say that in general your health is excellent, very good, good, fair, or poor?"

Report Area	Total Population Age 18+	Estimated Population with Poor or Fair Health	Percent Population with Poor or Fair Health
Montgomery County	607,075	63,743	10.50%
Pennsylvania	9,791,063	1,380,540	14.10%
United States	229,932,154	36,429,871	15.84%

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System: 2005-11.

Uninsured Population (Adults): The lack of health insurance is considered a *key driver* of health status. This indicator reports the percentage of adults age 18 to 64 without health insurance coverage.

Report Area	Total Population Age 18 - 64	Population with Medical Insurance	Percent Population With Medical Insurance	Population Without Medical Insurance	Percent Population Without Medical Insurance
Montgomery County	485,512	436,841	90%	48,671	10%
Pennsylvania	7,701,944	6,598,684	85.68%	1,103,260	14.32%
United States	190,888,983	150,591,311	78.89%	40,297,670	21.11%

Data Source: US Census Bureau, Small Area Health Insurance Estimates: 2011. Source geography: County.

Population Receiving Medicaid: This indicator reports the percentage of the population with insurance enrolled in Medicaid (or other means-tested public health insurance). This indicator is relevant because it assesses vulnerable populations which are more likely to have multiple health access, health status, and social support needs; when combined with poverty data, providers can use this measure to identify gaps in eligibility and enrollment.

Report Area	Total Population (For Whom Insurance Status is Determined)	Population with Any Health Insurance	Population Receiving Medicaid	Percent of Insured Population Receiving Medicaid
Montgomery County	787,060	735,443	65,211	8.87%
Pennsylvania	12,492,799	11,284,898	2,026,617	17.96%
United States	303,984,256	258,778,080	50,682,900	19.59%

Data Source: US Census Bureau, American Community Survey: 2008-12.