ACCESS-SMI: Advancing Collaborative Care to Ensure Systematic Screening in Severe Mental Illness

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Background

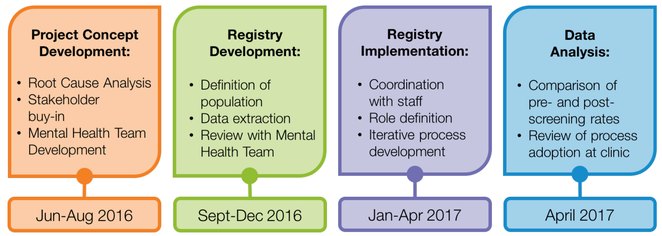
- The life expectancy of those with severe mental illness (SMI) is 10-25 years lower than the general population[1].
- Existing collaborative care models do not specifically address working with people with SMI in primary care settings.[2]
- Although many people with SMI are seen in community mental health clinics, a number of SMI patients are solely treated in primary care.
- Studies have shown screening rates for this population to be about 30% for metabolic abnormalities, 7% for HIV, and 5% for Hepatitis C.

Project Goal

- To implement a modified collaborative care model[3] for people with SMI being treated in a community primary care clinic

Methods

- Prospective cohort study to evaluate the feasibility of implementation of an SMI registry in an urban primary care clinic
- Full registry population included psychotic spectrum disorder and borderline personality disorder.
  - The study population included a subset of patients with a diagnosis of schizophrenia, schizoaffective disorder, or other psychosis *(see Table 1)*.
- A population management tool was used to create the registry list from the electronic health record.
- We evaluated metabolic and infectious disease monitoring and post-implementation study populations *(see Table 2)*.
- Outcome measures were based on RE-AIM framework[4]:
  - **Reach**: Was the registry created? Were patients needing labs identified?
  - **Effectiveness**: Were more patients screened overall?
  - **Adoption**: Was patient-centered team utilized? Were patients needing labs discussed at meetings?
  - **Implementation**: Was outreach to patients in cohort performed?
  - **Maintenance**: Were protocols maintained after the study period?



Tables and Figures

Table 1: Demographic Information

Variable	*Pre Intervention % (n) (N=34)*	*Post Intervention % (n) (N=49)*
Age, *mean (SD)*	*45.7 (13.2)*	*47.3 (13.1)*
18-32	18% (6)	16% (8)
33-48	32% (11)	31% (15)
49-63	41% (14)	43% (21)
64-78	9% (3)	10% (5)
Race/Ethnicity		
White	41% (14)	55% (27)
Black/African American	35% (12)	25% (12)
Asian	6% (2)	4% (2)
American Indian/Alaska Native	9% (3)	2% (1)
Other	9% (3)	14% (7)
Gender		
Female	12% (4)	16% (8)
Psychiatric Diagnosis		
Schizophrenia	100% (34)	39% (19)
Other Psychosis	0% (0)	43% (21)
Schizoaffective Disorder	0% (0)	18% (9)

Table 2: Laboratory Screening Rates

Laboratory Test	*Pre Intervention % (n) (N=34)*	*Post Intervention % (n) (N=49)*	*P-Value*
Low-Density Lipoprotein (LDL)	38% (13)	57% (28)	.09
Hemoglobin A1c	47% (16)	51% (25)	.72
Hepatitis C	21% (7)	47% (23)	**.01**
HIV	24% (8)	51% (25)	**.01**

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Results

- For the purposes of this study, SMI was defined as a diagnosis of schizophrenia, schizoaffective disorder, or psychosis[2].
- A collaborative care model for SMI based in primary care was feasible to implement at a primary care clinic, and the population-based approach demonstrated a significant increase in screening labs post-intervention (*see Table 2*).
- Outcome measures were collected per the RE-AIM framework[4]:
  - **Reach**: The registry was created. Patients needing labs were identified. Barriers to screening included lack of provider ordering and patient refusal/no-show despite an onsite phlebotomist.
  - **Effectiveness**: Screening rates increased overall, especially among HIV and Hepatitis C *(see Table 2)*.
  - **Adoption**: The patient-centered team was utilized. Patients needing labs were discussed at meetings. Labs were scheduled.
  - **Implementation**: Patient outreach was performed.
  - **Maintenance**: Protocols were preliminarily maintained after the study period. Given demonstrated improvement in screening rates, the clinic will continue to use the registry for these patients.

Discussion

- A collaborative care model for SMI based in primary care was feasible to implement at a primary care clinic.
- The collaborative care model for SMI had early evidence of success, including improved screening for HIV and Hepatitis C.
- Limitations included:
  - Challenges surrounding manually updating the registry may impact sustainability.
- Future directions include:
  - Need for a larger study examining patient-level outcomes (e.g., improved mental or physical health) with a model such as this
  - If feasible, this registry model could be implemented at other clinic locations.

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