Implementing a Metabolic Initiative in a Community Mental Health Clinic

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Introduction by the column editors: This new column demonstrates the use of an electronic mailing list (e-list) to generate a collaborative problem-solving process. The process is modeled on key features of the academic curriculum of the Columbia University Public Psychiatry Fellowship (PPF) at New York State Psychiatric Institute (ppf.hs.columbia.edu). The fellowship, which prepares psychiatrists for leadership roles in the public sector, emphasizes the importance of understanding systems and working collaboratively in teams to solve problems.

PPF alumni who encounter a management problem at their work site are asked to present the problem to current PPF fellows and faculty and to lead a discussion aimed at developing solutions. The idea of replicating this process in a column using the PPF alumni e-list was conceived during a discussion between Jules M. Ranz, M.D., PPF director, and Maria Oquendo, M.D., vice-chair for education, Department of Psychiatry, Columbia University Medical Center.

The problem discussed in this first column was presented to the e-list by Dianna Dragatsi, M.D., a PPF alumna. Dr. Dragatsi sent an e-mail to the PPF e-list in November 2008 describing the Inwood Clinic, which she has been directing since 2004. She outlined problems that clinic staff encountered while implementing an initiative to monitor the metabolic effects of second-generation antipsychotics after a study had demonstrated the need for such monitoring at the clinic. This column presents excerpts from the ensuing dialogue with the 11 PPF alumni and three fellows who responded on the e-list. It concludes with a description of resulting changes at the Inwood Clinic.

Readers of Psychiatric Services are invited to submit management problems to Dr. Ranz at jmr1@columbia.edu, who will select problems to the PPF e-list and work with Susan M. Deakins, M.D., associate director of the fellowship, to help submitters summarize discussions in future columns.

The Inwood Clinic is part of the Washington Heights Community Service (WHCS), a comprehensive, community-based program for people with severe and persistent mental illness. Founded in 1965, WHCS is a state-operated program that has a census of about 1,000 patients. A patient survey conducted in 2008 by the New York State Office of Mental Health showed that 96% of the WHCS patients had cooking facilities, adequate transportation, and a primary care physician.

The Inwood Clinic has two programs, the outpatient program and the continuing day treatment program (CDTP), and has a census of approximately 400 patients. Lunch is provided for CDTP patients daily. Twice a week it is prepared at NYSPI by kitchen staff supervised by a nutritionist, and three times a week it is prepared in the clinic by a mental health therapy aide, who makes food, such as rice and beans, compatible with cultural preferences.

The need for metabolic monitoring
It is well known that second-generation antipsychotics are associated with negative metabolic consequences (1).
Patients who take these medications have mortality rates higher than those of the general population and often fail to follow through with the medical care recommendations of their primary care physicians.

In 2005 the NYSPI clinical director, David Hellerstein, M.D., reviewed the causes of death of WHCS patients over the previous five years and found a high rate of death from cardiovascular and diabetes-related factors [2]. At that time the Inwood Clinic conducted an informal exercise group and a health and nutrition group for CDTP patients. Weight and fasting blood tests were loosely monitored by the patient’s individual psychiatrist. As a result of Dr. Hellerstein’s study, the health and nutrition group lengthened its meeting time and staff placed a scale, educational posters, and plastic models of food portions in the meeting room. All patients in the CDTP were given water bottles, and many were given pedometers paid for by an independent grant. Patients received education about body mass index (BMI) and were encouraged to report their weight each time they saw their psychiatrist. Despite these interventions, there was little change in patients’ health status.

In 2007 Julie Kelso, M.D., a fellow in the Columbia University Public Psychiatry Fellowship (PPF) program, created a health monitoring form that was disseminated to staff at both the Audubon and Inwood Clinics. Staff at the Audubon Clinic CDTP completed a form for each patient once. At the Inwood Clinic clinicians could choose between completing the form or documenting health monitoring indices in their progress notes for each patient. The inpatient unit began including key health monitoring values in a separate section of patients’ discharge summaries, which made the information readily accessible to outpatient clinicians. However, clinicians in the outpatient clinic did not consistently continue to use the health monitoring form.

In 2007–2008 Christina Manguri- an, M.D., another fellow in the PPF program, studied the impact on patient health status of a culturally tailored educational nutrition group at the Inwood Clinic. The intervention group was initially led by both a dedicated research nutritionist and a staff nurse. When, as planned, the patients began to lead the group, the nurse continued as a coleader of the group along with patient leaders—otherwise the group would have dissolved. Most patients lost weight [3].

The problem
To demonstrate the efficacy of interventions to improve the physical health of consumers with severe and persistent mental illness who are taking second-generation antipsychotics, most studies have required the presence of a dedicated research nutritionist-nurse [4–6]. Two factors prevent the Inwood Clinic from hiring such a staff member: budgetary constraints and the fact that exercise or nutrition groups in CDTP mental health services are not covered under New York State Medicaid guidelines. Therefore, implementing a program to monitor metabolic effects of second-generation antipsychotics is essentially an unfunded initiative. The literature recommends monitoring of patients’ weight, blood pressure, BMI, and waist circumference and the results of ongoing fasting blood tests, especially for patients taking second-generation antipsychotics [7]. Patients also need to maintain contact with their primary care physician and receive information relevant to their health and nutrition.

How can a mental health clinic help patients improve their physical health without compromising the time and energy necessary to deal with their mental health issues? Inwood Clinic psychiatrists are already burdened by time-consuming paperwork demands. They would prefer not to complete an additional cardiometabolic monitoring form; instead, they would prefer to document the required indices in the progress notes, as they do currently with other important indices, such as lithium and divalproex sodium levels. Tracking information by using this system, however, is difficult, especially when long-term trends need to be monitored. Among community psychiatrists what standards are being used?

E-list dialogue
Below are excerpts from a dialogue that took place between Dr. Dragatsi and e-list members after this problem was submitted to the PPF e-list.

Most respondents began by expressing empathy in regard to the problem of limited resources. For example, one noted, “There is variable buy-in to these [health] initiatives and a limit to what people can do in an environment where productivity and financial solvency are forefront. It would certainly make a difference if we could bill for integrated health services, if we could pay for medical staff lines, if we could include colocated medical satellites, and if we were simply not so stretched.”

When I [Dr. Dragatsi] pointed out a potential downside to the status quo—“Do you think we may one day be liable for having not been more aggressive in addressing metabolic factors?”—respondents described what they had been able to do given limited resources. One said, “I believe that metabolic issues related to second-generation antipsychotics are a major issue. We have evidence-based practices, [but] we can’t afford to implement them. So I weigh patients when I see them every three to four months, check a fasting blood sugar once a year, talk about exercise and diet, and encourage cross-tapers to aripiprazole and ziprasidone. I try to do that quickly along with everything else.”

I noted that many of the Inwood Clinic psychiatrists “are concerned that patients may not follow-up when abnormal parameters are found.” I suggested incorporating loose recommendations for what to do with abnormal findings into the progress note.” An e-list member responded, “The greater issue is what we should do once they are diagnosed and are on waiting lists for primary care appointments and weight management groups.”

Some respondents suggested simple monitoring systems. For example, one said, “I created a physician progress note that has [metabolic monitoring] prompts and a [mental status exam] check-off that forces docs to address all pertinent issues.” I replied, “I do like the idea of incorporating metabolic monitoring para-
eters. . . . Nurses carry their own
do not currently have the set-up to
Association] and APA [American Psy-
oped by ADA [American Diabetes
the M.D. will order and follow-up
blood pressure, waist, and weight and
R.N. has dedicated time to check
settings. One said, “We are currently try-
ing to work out a system where one
R.N. has dedicated time to monitor metabolic param-
Nurses carry their own
cases and, lead groups, administer
long-acting injectable medications,
draw bloods.”

Other e-list participants pointed out possibilities for interventions.
“One thing to consider is that you have a ready-made forum for doing
health education and promoting
more skill-building through your
lunch program. . . . You could enlist
both the therapy aide and consumers in redesigning the lunch fare.” Another
asked, “Are there other feasible,
more creative approaches to exercise? Maybe taking a motivational ap-
proach in defining the problem, to
help lure your consumers out of the
precontemplation stage.” I respond-
ed, “I like your thinking out of the
box. One of our psychiatrists used to
give prescriptions to use a bike three
times a week for 20 minutes but pa-
tient motivation waned.”

Another respondent pointed out
the value of requiring a health moni-
toring form, which “forced me to dis-
cuss issues of exercise and diet with
my patients more than I might have.”
I replied, “While I appreciate the
comprehensiveness of your form, I
wonder if having to complete such an
extensive form would lead to lower
physician compliance?” Another re-
pondent added, “We have focused on making things as easy as possible: a
few prompts on a form, automatic
blood pressure cuffs, workbooks that
are fun and easy to use.”

Some respondents commented on
changes that they hoped to achieve. One hoped to “partner with the pre-
dominant primary care clinics of the
patients to offer the nutrition and ex-
ercise interventions.” I replied, “We
actually had a joint team meeting with
the closest medical clinic. Our first
goal was to improve access to each
other, which has worked somewhat.
In truth, however, the medical clinic
is also overwhelmed and may balk at
the idea of providing these additional
services.”

An e-list member added, “The so-
lution to this problem will involve exactly
what you are attempting to do here—discussion between different
clinicians and administrators to share
ideas and support each other as we try
to figure out how to cost-effectively
and efficiently get this done for the
people we serve in the community.”
I asked the list, “Should we be lob-
bying our administrators for more re-
ources to address metabolic factors
(such as extra R.N. lines), or would this
further deter us from attending to our patients’ primary reason for seeing us—their mental health
needs?” In response an e-list mem-
ber wrote, “We may have to advocate
for [New York State] Medicaid
guidelines to be changed to make ex-
cise and nutrition groups billable as
we [psychiatrists] will need to have
resources.”

Changes implemented
Coincidentally, in January 2009, two
months after the problem was posted
on the PPF e-list, New York State be-
gan an initiative to require outpatient
clinics to monitor BMI, blood pres-
sure, and smoking status by using
MHARS, the state’s computerized
mental health automated medical
record system. The PPF e-list discus-
sion was instrumental in helping the
Inwood Clinic to make realistic deci-
sions about which additional meta-
bolic parameters to monitor and how
to effectively implement a monitoring
system. On the basis of staff availabil-
ity at the clinic, I decided that fasting
blood tests, weight, blood pressure,
and smoking status should be moni-
tored for all patients. Psychiatrists are
expected to monitor their patients’
weights on scales already in their of-
cines and then to send patients to the
nurses’ station, where a nurse will
measure their blood pressure and
draw blood for fasting blood tests.
Blood pressure, weight, and smoking
status are entered into MHARS by a
mental health therapy aid who is also
a peer counselor. This individual also
provides counseling on these issues to
patients in the health and nutrition
group.

To facilitate documentation in the
paper medical record and close monitoring of these measures by the
psychiatrist, a new progress note to be
completed quarterly has been created
with prompts for the desired values. The psychiatrist will record
the patient’s smoking status, blood
pressure, and weight quarterly. Be-
cause taking the time to calculate
BMI might present a barrier to docu-
mentation in the progress notes, weight will be monitored instead.
When height and weight are entered
into MHARS, the BMI is automati-
cally calculated. Psychiatrists order
the first set of blood tests before anti-
tipsychotic medication is initiated.
For patients who are given an an-
tipsychotic prescription for the first
time, psychiatrists are expected to
monitor fasting blood test results
and blood pressure at least three
times a year for the first year. For all
other patients, fasting blood tests are
monitored yearly unless otherwise
indicated.

The focus of the 2007 WHCS an-
ual meeting was on the metabolic
consequences of antipsychotic use.
As a result, clinicians are well in-
formed on the subject. For patients,
metabolic issues continue to be ad-
dressed in the medication and the
health and nutrition groups. A walk-
ing group conducted by a peer coun-
selor is being considered, even
though it is a non-Medicaid billable
service. Exercise continues to be
provided in the Relaxation Through
Yoga group.

To ensure ongoing communication
with the primary care physician, the
patient will be given a copy of any ab-
normal lab results together with a
completed preprinted form to alert
the primary care physician of the
need for medical follow-up. The case
manager will be responsible for en-
suring that the patient’s medical appointment is scheduled within two months of the abnormal findings or earlier, depending on the psychiatrist’s determination.

A problem for many mental health clinics is that Medicaid does not allow for paraprofessional staff to monitor metabolic issues and clinics cannot charge Medicaid to implement metabolic initiatives such as nutrition and exercise groups that do not have a mental health focus. The clinic’s administrative staff are considering whether to pursue several options suggested by e-list respondents. One recommended forming a coalition of public-sector psychiatrists to lobby New York State to change these regulations. Another suggested obtaining funds from pharmaceutical companies to address metabolic issues. Such funding could be used to buy pedometers and subsidize gym memberships via a lottery or other means.

Conclusions
Engaging with PPF alumni and fellows via the e-list provided an invaluable tool for realistic implementation of policies to address cardiometabolic monitoring. Given mounting evidence of what should be done and the limitations faced by “real-world” public psychiatrists, the PPF e-list input was both sound and comforting and highlighted the fact that everyone is trying to solve the same problem with limited resources. There is no universal solution. Realistic implementation of evidence-based practices depends on local circumstances. The discussion highlights the importance of the need for ongoing communication among clinicians, administrators and researchers to ensure the best possible outcomes for our patients.

References

First-Person Accounts Invited for Column

Patients, family members, and mental health professionals are invited to submit first-person accounts of experiences with mental illness and treatment for the Personal Accounts column in Psychiatric Services. Maximum length is 1,600 words.

Material to be considered for publication should be sent to the column editor, Jeffrey L. Geller, M.D., M.P.H., at the Department of Psychiatry, University of Massachusetts Medical School, 55 Lake Ave. North, Worcester, MA 01655 (e-mail: jeffrey.geller@umassmed.edu). Authors may publish under a pseudonym if they wish.