Using Information Technology to improve physical health care in mental health settings

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What do we want the IT to do?

To support

The aims of the Intercollegiate Working Group were to recommend ways to:

- improve the physical health and healthcare of adults of working age with SMI, so that their life expectancy is the same as adults without SMI
- reduce the rate of ill health experienced by adults with SMI during their lifetime, so that their rate of physical co-morbidity is no greater than for adults without SMI (Royal College of Psychiatrists, 2013).
Long Term Conditions

• The greatest cause of morbidity and mortality amongst people with severe mental illness is long term conditions (LTCs)—
  • Diabetes
  • Cardiovascular Disease
  • Respiratory Disease
  • Cancer

• 46% of people with a SMI also have an LTC (nationally it is 25%)
IT and Physical Care

• We need to monitor health outcomes to be able to demonstrate improvements

• We need to monitor health outcomes for
  • Individuals
  • Units/Trusts
  • Nationally

• We know how to do this, as primary care has been doing it for years

• We need to use primary care IT systems to monitor physical health outcomes
This is Cliff:

A 50 year-old male

Bi-polar Disorder

Diabetes diagnosed 5 years ago

It took two years to see improvement in his mental health symptoms and signs

Now:
Fundoscopy
Renal Function

- Diabetes is a common cause of renal failure
- Renal failure is an independent cardiovascular risk factor
- Dosage of medication may need to be altered to reflect poor renal function
The IT system

• Brings up an alert that the medication he is taking (lithium) requires regular monitoring
• Alerts the prescriber if there is a potential medication interaction (e.g. lithium and NSAIDs)
• Alerts the clinician that renal function is declining and that some medication may need their dose reducing
• Alerts the clinician if the patient does not attend for a scheduled appointment
• Other alerts....
Did you know...

• Glycaemic control is better in the medium secure unit, than in the high secure unit at WLMHT.
• The process of care at both centres is better than in the community
• The outcomes of care, apart from glycaemic control, are the same, but not as good as in the community

AND

• It only took 10 minutes to get this data from the computer system
National Diabetes Audit

• The NDA is a national audit that involves all acute Trusts and all primary care – but not mental health services
• We were able to extract the data that is used in the NDA
• The software needed for this audit is built into the GP practice computer system that we installed at the two units
• RECOMMENDATION: all mental health trusts should participate in the NDA.
Cardiovascular Risk – QRISK2

The chance of suffering a heart attack or stroke in the next 10 years

The proportion of people with QRISK2 scores at a long term in-patient unit

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>High risk (&gt;20%)</td>
<td>6.99%</td>
<td>2.96%</td>
<td>2.11%</td>
</tr>
<tr>
<td>Medium risk (10 – 20%)</td>
<td>6.45%</td>
<td>1.48%</td>
<td>2.82%</td>
</tr>
<tr>
<td>Low risk (&lt;10%)</td>
<td>86.5%</td>
<td>95.5%</td>
<td>95.1%</td>
</tr>
</tbody>
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Did you know...

- The IT system can calculate the QRISK2 score for the entire practice population as a “batch” calculation, and then present the high risk patients.
- Research can combine databases from individual practices – for example the three high secure hospitals shared data on QRISK2.
- It is also possible to combine the databases with acute hospital activity databases – opening up a whole set of new research and development questions - IAPT.
Funding – what does it cost?

- To install and deliver training and maintenance equivalent to a small/single handed practice (up to 10 users) the cost is around £30K
- Annual maintenance (depending on system) is considerably less
- Generates income through rapid delivery of CQUIN data – which in most Trusts greatly exceeds £30K
- Provides a more consistent level of care – auditable, searchable
Nationally

• To deliver on parity of care we need to monitor LTCs for people with SMI
• The WHO recommend such an approach – national monitoring of LTCs – we need to do this for people with SMI
• The WHO have developed software, training packages, information for Low and Middle Income Countries – eSTEPs Programme
• That approach is more sophisticated than the current mental health settings approach to LTC management
Nationally

• We need a national committee to oversee and lead this process
• We need specific physical health guidelines for people with SMI
• The CQC needs to have the skills and knowledge to review care and specifically to look at clinical outcomes
• The CQUIN and the QOF should monitor and incentivise the same clinical processes and outcomes
Liaison Physician – a new role

• The “reverse” of a liaison psychiatrist
• A subspecialty – GP, general physician, or older peoples’ physician who provides physical health care in a mental health setting
• Provides leadership
• Provides teaching
• Acts as a focus for research and development
Liaison Physician – a new role

- A training programme
- Career progression
- Adoption by one or more Royal Colleges to support the development of this role
In summary

• An appropriate IT system will deliver high quality physical health care
• It will demonstrate improved care for both individuals and Trusts
• It will act as a focus for research and development
• It is affordable, and would fulfil exactly the premise of the CQUIN payments
• Linked to a new subspecialty of liaison physician, the opportunities to provide a step change in the way that physical health care is delivered is considerable.
Thank you

Dr. Alan Cohen