

A Public Health Crisis: Morbidity and Mortality in SPMI Individuals

The Community Mental Health System Response?

**Florida Council
October 2010**

Co-occurrence of chronic medical disorders and complex health needs are an expectation, not an exception for the SPMI population

**“THE TRAGEDY,
20-25 YEARS OF LIFE LOST”**

Smoking

Obesity

Psychotropic Medications

Substance Abuse

Lack of Medical Care

Mortality Crisis

- **US Life Expectancy 2008 = 78 years**
- **Seriously Mentally Ill = 53 – 57 years**
 - **Comparable to Cameroon, Gabon, Democratic Republic of Congo**
- **Biggest Lifespan Disparity in U.S.**

Reduced Life Expectancy

Six Major Causes of Death in U.S and Increased Relative Risk in SPMI Population

- Cardiovascular Disease - 3.4 x**
- Lung Cancer – 3x**
- Stroke - 2x in age < 50**
- Respiratory Disease - 5x**
- Diabetes - 3.4x**
- Infectious Diseases – 3.4x**

High Rates of Chronic Illness

- ♦ **70% of SPMI Population Has a Chronic Health Condition**
 - **Mostly Pulmonary Disease/Lung Cancer/Diabetes**
- ♦ **50% Have Two or More Chronic Conditions**
- ♦ **42% Have Conditions Severe Enough to Limit Function**
- ♦ **Hep B Rates Increase 5x; Hep C 11x**

Health Risks for People with Chemical Addictions

- ♦ **Are likely to die 10-35 years earlier than the general population, depending on the rate of abuse**
- ♦ **Alcoholics are at increased risk for:**
 - **Cancer**
 - **Heart disease**
 - **Liver disease**
 - **Central nervous system damage**
- ♦ **Drug abusers are at increased risk for:**
 - **Weakened immune systems**
 - **HIV infections**

Higher Rates of Modifiable Risk Factors

- ◆ **Smoking**
- ◆ **Alcohol consumption**
- ◆ **Poor nutrition/obesity**
- ◆ **Lack of exercise**
- ◆ **“Unsafe” sexual behavior**
- ◆ **IV drug use**
- ◆ **Residence in group care facilities and homeless shelters (exposure to tuberculosis and other infectious diseases as well as less opportunity to modify individual nutritional practices)**

Modifiable Risk Factors Affected by Psychotropics

- ◆ **Overweight/Obesity**
- ◆ **Insulin Resistance**
- ◆ **Diabetes/Hyperglycemia**
- ◆ **Dyslipidemia (Abnormal Lipids)**

Prevalence of Psychiatric Disorders in Low-Income Primary Care Patients

Psychiatric Disorder	Low-Income Patients	General PC Population
At Least One Psychiatric Dx	51%	28%
Mood Disorder	33%	16%
Anxiety Disorder	36%	11%
Alcohol Abuse	17%	7%
Eating Disorder	10%	7%

- ◆ Only 35% of Low-Income Patients with a Psychiatric Diagnosis Saw Their PCP in the Last 3 Months
- ◆ 90% of Patients Preferred Integrated Care

Mauksch, et al, Journal of Family Practice, 2001

Smoking – The Principal Killer

Overview of the Problem

Individuals with mental illness and substance use disorders have higher rates of chronic health problems and premature death compared to general population due to long-term tobacco use

Joukamaa et al, 2001; Stuyt et al, 2004

Smoking Prevalence

- ◆ 85% of addicts and alcoholics are smokers
- ◆ 75% of those with SPMI are tobacco-dependent
- ◆ Rates of smoking are 2-4 times higher in the MI/SA population than among the general population
- ◆ Individuals with schizophrenia have extremely high rates of smoking – 90%
- ◆ 44% of all cigarettes consumed in the U.S. are consumed by individuals with a current mental disorder
- ◆ Most mentally ill individuals smoke and die due to smoking-caused diseases
- ◆ Nicotine use is a trigger for other substance use
- ◆ 200,000 of the 435,000 annual deaths from smoking occur among patients with chronic mental illness (CMI) and/or substance abuse
- 27% of consumer income went to cigarettes.
- 22% of consumers reported that they started smoking in a psychiatric setting

GENERAL POPULATION SMOKING RATE – 17-25%

Health Consequences of Smoking

- ♦ **Cancers**
 - Acute myeloid leukemia
 - Bladder and kidney
 - Cervical
 - Esophageal
 - Gastric
 - Laryngeal
 - Lung
 - Oral cavity and pharyngeal
 - Pancreatic
- ♦ **Pulmonary Diseases**
 - Acute (e.g., pneumonia)
 - Chronic (e.g., COPD)
- ♦ **Cardiovascular Diseases**
 - Abdominal aortic aneurysm
 - Coronary heart disease
 - Cerebrovascular disease
- Peripheral arterial disease
- Type 2 diabetes mellitus
- ♦ **Reproductive Effects**
 - Reduced fertility in women
 - Poor pregnancy outcomes (e.g., low birth weight, preterm delivery)
 - Infant mortality
- ♦ **Other Effects:**
 - Cataract
 - Osteoporosis
 - Periodontitis
 - Poor surgical outcomes
 - Cognitive decline

U.S. Department of Health and Human Services.

The Health Consequences of Smoking: A Report of the Surgeon General, 2004.

A Health Disparity Issue

- ◆ **A sizeable segment of the population is consuming tobacco 2-3x the rate of the rest of the population**
- ◆ **The system in which they receive care currently does little to change tobacco use**
- ◆ **The behavioral and primary health systems need a radical change to solve this problem**
- ◆ **Tobacco control/public health has largely ignored this issue**

Causes of Health Disparities

- ◆ Medications, especially the atypical antipsychotic drugs and their effects on weight gain, dyslipidemia and glucose metabolism
- ◆ High rates of smoking, lack of weight management/nutrition, and physical inactivity
- ◆ Lack of access to/utilization of preventive community health care, including health promotion services and resources
- ◆ Poverty
- ◆ Social isolation
- ◆ Separation of health and mental health into separate systems at the federal, state and local level with lack of coordinated infrastructure, policy, planning, quality improvement strategies, regulation or reimbursement

Consequences and Costs of Not Treating Tobacco in the Behavioral System

- ◆ **Increased Mortality**
- ◆ **Increased Morbidity**
- ◆ **Increased Use of Health Care Resources**
- ◆ **Decreased Quality of Life**
- ◆ **Increased Societal Costs, Including Costs to Employers**

Vulnerability Due to Higher Rates of:

- ◆ Homelessness
- ◆ Victimization/Trauma
- ◆ Unemployment
- ◆ Poverty
- ◆ Incarceration
- ◆ Social Isolation

Poor Access to Health Care

- ◆ An issue for all people with limited income, particularly preventive care
- ◆ Overuse of emergency and specialty care
- ◆ Complicated by mental illness
- ◆ Significantly lower rates of primary care
- ◆ Significantly lower rates of routine testing
- ◆ Very poor dental care
- ◆ Little integration of primary care and psychiatric care
- ◆ Lack of insurance for non-Medicaid enrollees
- ◆ No regular check-ups/preventive screens
- ◆ Co-morbid conditions undiagnosed
- ◆ Poor motivation to seek care
- ◆ Lack of consistency in care
- ◆ Fragmented systems

Unveiling the Tragic History

- ♦ **2003:**
 - **NRI Report to SAMHSA**
 - **New Freedom Commission Report**
- ♦ **2005-2008:**
 - **Publications in Professional Journals**
 - **NASMHPD Medical Director Council Reports**
- ♦ **2007:**
 - *USA Today* Front Page
 - **SAMHSA Wellness Summit**

NASMHPD Medical Directors Council Technical Papers

- ♦ **2005:**
 - **Integrating Behavioral Health and Primary Care**
- ♦ **2006:**
 - **Mortality and Morbidity in Persons with SMI**
 - **Smoking Policy and Treatment in Psychiatric Facilities**
- ♦ **2008:**
 - **Principles of Antipsychotic Prescribing**
 - **Obesity Reduction and Prevention Strategies for Persons with SMI**
 - **Measurement of Health Care Status for People with SMI**

Fifteenth
in a Series
of
Technical
Reports



Morbidity and Mortality in People with Serious Mental Illness

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DRAFT June 27, 2006



Mental illness linked to short life

**USA Today
Front Page
Thursday,
May 3, 2007**

How Can We Do Better?

The Goal

Improve health and reduce morbidity, mortality, and costs through greater coordination and integration of care provided by public and private behavioral health and physical health providers and community-based organizations.

Principles

- ♦ **Physical health care is a core service for persons with SPMI**
- ♦ **MH systems have a primary responsibility to ensure:**
 - **Access to preventive health care**
 - **Management and integration of medical care**
 - **Promote public health interventions**

Calls for Action

- ♦ **SAMSHA:**
 - Increase the average life span of those with mental illness by 10 years in 10 years.
- ♦ **NASMHPD**
 - 13th Technical Report
- ♦ **CDC, Healthy People 2010**
- ♦ **Health and Human Services; HealthierUS**
- ♦ **President's New Freedom Commission**
- ♦ **Bazelon Center For Mental Health Law**
- ♦ **NAMI/MHA**
- ♦ **Accountable Care Act**

The Pledge to Reduce Early Mortality

In September 2007, the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration convened a Wellness Summit at which the Pledge for Wellness was adopted:

The Wellness Pledge – 10 by 10

We envision

a future in which people with mental illnesses pursue optimal health, happiness, recovery, and a full and satisfying life in the community via access to a range of effective services, supports, and resources.

We pledge

to promote wellness for people with mental illnesses by taking action to prevent and reduce early mortality by 10 years over the next 10 year time period.

U.S. Health Delivery System

- ♦ The dominant models of providing health care in the United States separate the mind and body
- ♦ Separation has a negative impact on health care access, health care costs, and quality of care with a disproportionate share of the burden falling on women, the elderly, racial and ethnic minorities, and rural and immigrant populations

*(Health Care for the Whole Person
Statement of Vision and Principles,
American Psychological Association)*

Responding to the Challenge

Improving the quality of mental health and substance abuse care – and general health care – depends on the effective collaboration of all mental health, substance abuse, general health care, and other human service providers in coordinating the care of their patients

**(Institute of Medicine
Quality Chasm Series)**

Medical Needs Should Have Same Priority as MH Needs

- ◆ **Obtaining a “medical home” – a primary care provider responsible for overall coordination**
- ◆ **Medication adherence – just as important for non-MH meds**
- ◆ **Assisting in scheduling and keeping medical care appointments**
- ◆ **Sharing of information**

CMHA Issues

- **Lack of health status data/records**
- **Insufficient intake/lack of screening/medical information**
- **Lack of integration/collaboration/poor communication with primary care provider**
- **Lack of chronic care/disease management**
- **Lack of health indicators/measurement**
- **Insufficient surveillance/monitoring**
- **Lack of a public health approach to care**
- **Lack of integrated primary care practices or outposting MH staff in PC practices**

Vital Information on Health Indicators

- ◆ **Medical History**
- ◆ **Personal History of Diabetes, Hypertension, Cardiovascular Disease**
- ◆ **Weight/Height/BMI**
- ◆ **Blood Pressure**
- ◆ **Blood Glucose or HbA1C**
- ◆ **Lipid Profile**
- ◆ **Tobacco Use/History**
- ◆ **Substance Use/History**
- ◆ **Medication History/Current Medication list, with Dosages**
- ◆ **Social Supports**

What are the Problems with the Traditional System

- ♦ There are barriers to integrated care on multiple levels including clinical, financial, policy and organizational. These include:
 - Fragmentation of care; physical separation of providers
 - Separation of medical records; the left hand doesn't know what the right hand is doing
 - Limited communication between medical and mental health providers
 - Primary care is often responding to multiple presenting problems creating time management issues
 - Primary care providers often have limited training in psychiatric disorders and their treatment; half of those with mental disorders go undiagnosed in primary care
 - Primary care patients often have limited access to specialty mental health providers

Medical conditions adversely affect an individual's quality of life, relationships, employability, and integration into community life. Unless the mental health system addresses their root causes, these individuals will not be able to achieve the level of recovery that they may desire and is possible.

**It is essential in addressing
the morbidity and mortality
from chronic medical conditions that
the mental health system be aligned
with the public health system at the
state and local levels**

Goals of Integration

- ◆ **Improve Patient Adherence**
- ◆ **Support Patient Self-Management**
- ◆ **Agent of Behavioral Change**
- ◆ **Decrease Over- or Under-Utilization**
- ◆ **Reduce Health-Risk Behaviors and Increase Health-Enhancing Behaviors**
- ◆ **Monitor and Improve Population Outcomes**

Chronic Care Model

- ◆ **Medical Home – Foundation of Care**
- ◆ **Use of Interdisciplinary Teams**
- ◆ **Employment of Disease Management/Chronic Care Management Processes**
- ◆ **Medication Management**
- ◆ **Mental Health and Substance Abuse Care and Referrals**
- ◆ **Social Case Management**
- ◆ **Patient Empowerment and Education**
- ◆ **Family/Caregiver Involvement**
- ◆ **Collaboration with Community Providers**
- ◆ **Health Promotion/Preventive Health Care**

Recommendations – State Level

- ♦ **Seek state designation of people with SPMI as BOTH an at-risk and a health disparities population**
- ♦ **Establish coordinated mental health and general health care as a state health care priority**
- ♦ **Educate policy makers, funders, providers, individuals, families and communities about the public health issue and advocate for policies to reduce morbidity and mortality rates**
- ♦ **Advance the capacities of behavioral health providers to screen, assess and treat both mental health and general health care issues**
- ♦ **Provide for staffing, electronic records, reimbursement and linkages to improve coordination with physical health care providers**
- ♦ **Promote coordinated and integrated mental health and physical health care for persons with SPMI**

Recommendations – Local

1. BH Provider Care

- ♦ Provide quality medical care and mental health care
- ♦ Screen for general health with priority for high risk conditions
- ♦ Offer prevention and intervention especially for modifiable risk factors (obesity, abnormal glucose and lipid levels, high blood pressure, smoking, alcohol and drug use, etc.)
- ♦ Prescribers screen, monitor and intervene for medication risk factors related to treatment of SMI (e.g., risk of metabolic syndrome with use of second generation anti-psychotics)
- ♦ Treatment per practice guidelines (e.g., heart disease, diabetes, smoking cessation, use of novel anti-psychotics)

2. Care Coordination Models

- ♦ Assure that there is a specific practitioner in the MH system who is identified as the responsible party for assuring that each person's medical health care needs are being addressed and who assures coordination of all services.
- ♦ Routine sharing of clinical information with other providers (primary and specialty health care providers as well as mental health providers)
- ♦ Care integration where services are co-located

Recommendations – Local

3. **Support consumer wellness and empowerment to improve personal mental and physical well-being**
 - ◆ **Educate/share information so that individuals can make healthy choices regarding nutrition, tobacco use, exercise, implications of psychotropic drugs**
 - ◆ **Teach/support wellness self-management skills**
 - ◆ **Teach/support decision making skills**
 - ◆ **Use motivational interviewing techniques**
 - ◆ **Implement a physical health 'wellness' approach that is consistent with Recovery principles, including supports for smoking cessation, good nutrition, physical activity and healthy weight**
 - ◆ **Attend to cultural and language needs**
 - ◆ **Establish weight management program**
 - ◆ **Initiate nutritional counseling program**
 - ◆ **Educate mental health professionals on the importance of weight monitoring and weight reduction in people with SMPI**

Solutions

- ◆ **Prioritize the Public Health Problem**
Target Providers, Families and Clients
Focus on Prevention and Wellness
- ◆ **Track Morbidity and Mortality in Public Mental Health Populations**
- ◆ **Implement Established Standards of Care**
Prevention, Screening and Treatment
- ◆ **Improve Access to and Integration of Physical Health and Mental Health Care**

Behavioral Medicine – Enhancing Life

- ◆ **Management of psychosocial aspects of chronic and acute diseases**
- ◆ **Application of behavioral principles to address lifestyle and health risk issues**
- ◆ **Emphasis on prevention and self-help approaches, partnering with patients in a treatment approach that builds resiliency and encourages personal responsibility for health**
- ◆ **Consultation and co-management in the treatment of mental disorders and psychosocial issues**

Additional Slides

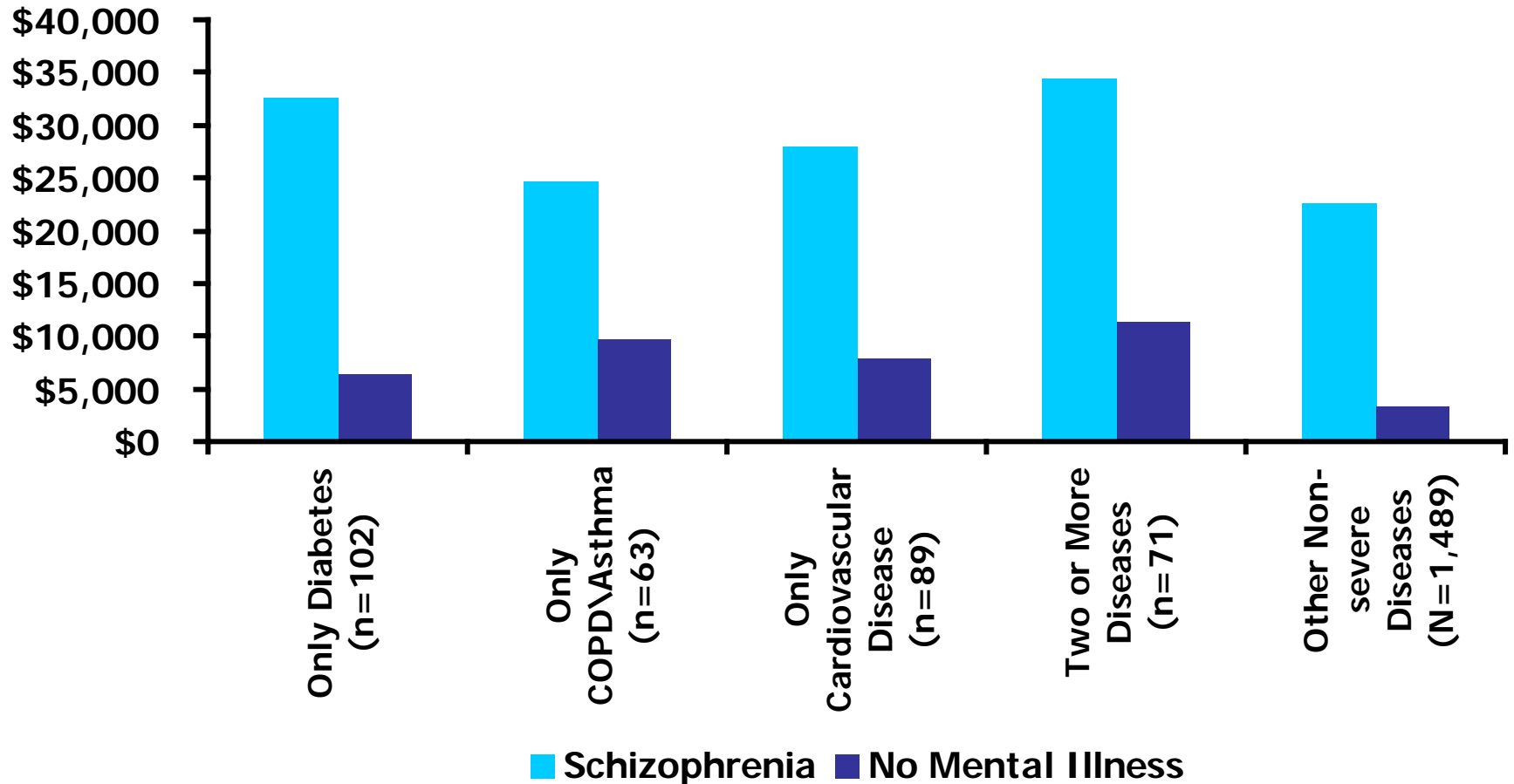
A Multi-State Study of Mortality Data: Years of Potential Life Lost

Year	AZ	MO	OK	RI	TX	UT	VA (IP only)
1997		26.3	25.1		28.5		
1998		27.3	25.1		28.8	29.3	15.5
1999	32.2	26.8	26.3		29.3	26.9	14.0
2000	31.8	27.9		24.9			13.5

Colton CW, Manderscheid RW. Prev Chronic Dis [serial online] 2006 Apr [date cited]. Available from:

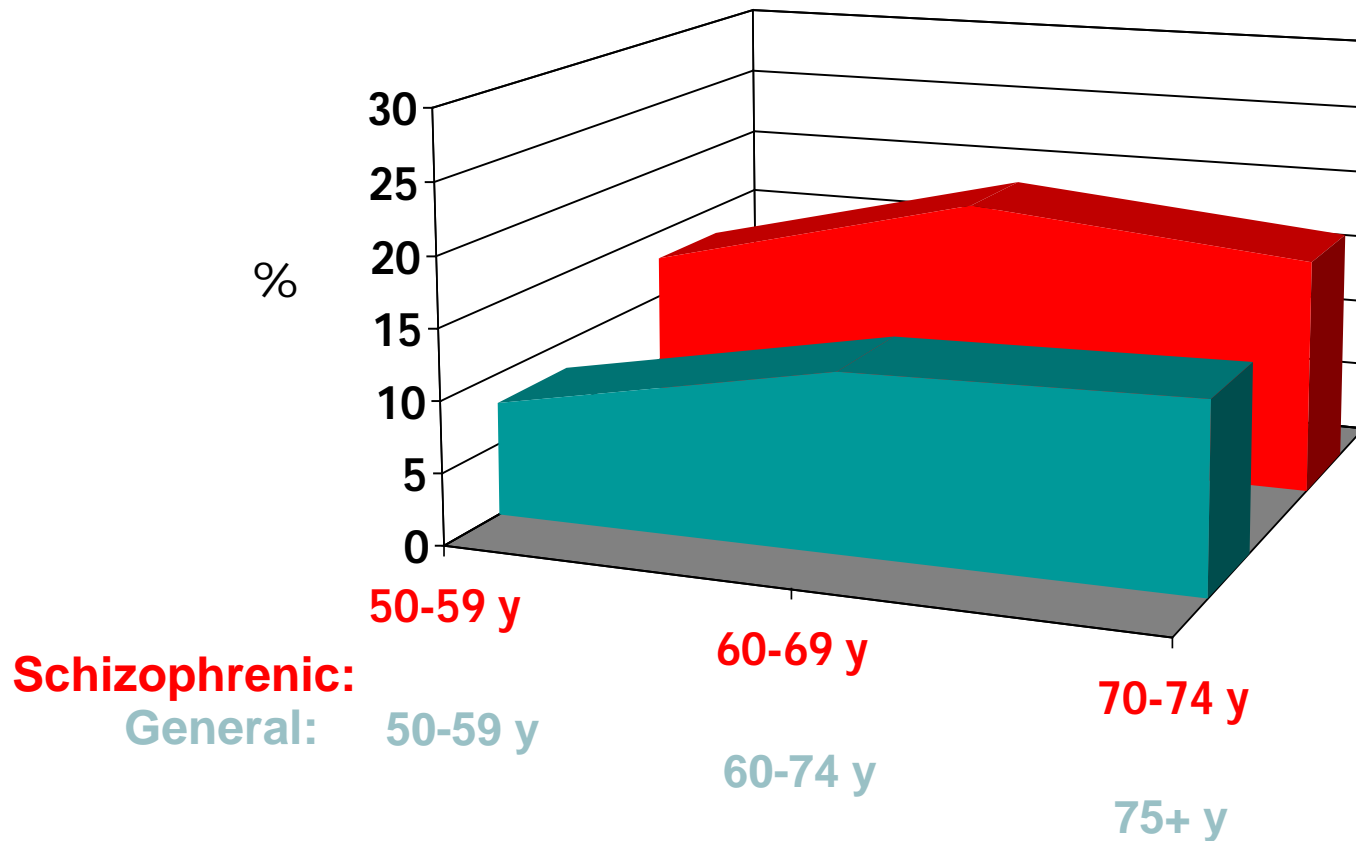
URL:http://www.cdc.gov/pcd/issues/2006/apr/05_0180.htm

Background: New Hampshire Medicaid TOTAL Expenditures (FY 2001)



Prevalence of Diabetes in General Population vs. Schizophrenic Population

- Diagnosed Diabetes, General Population
- Diagnosed Diabetes, Schizophrenic Patients

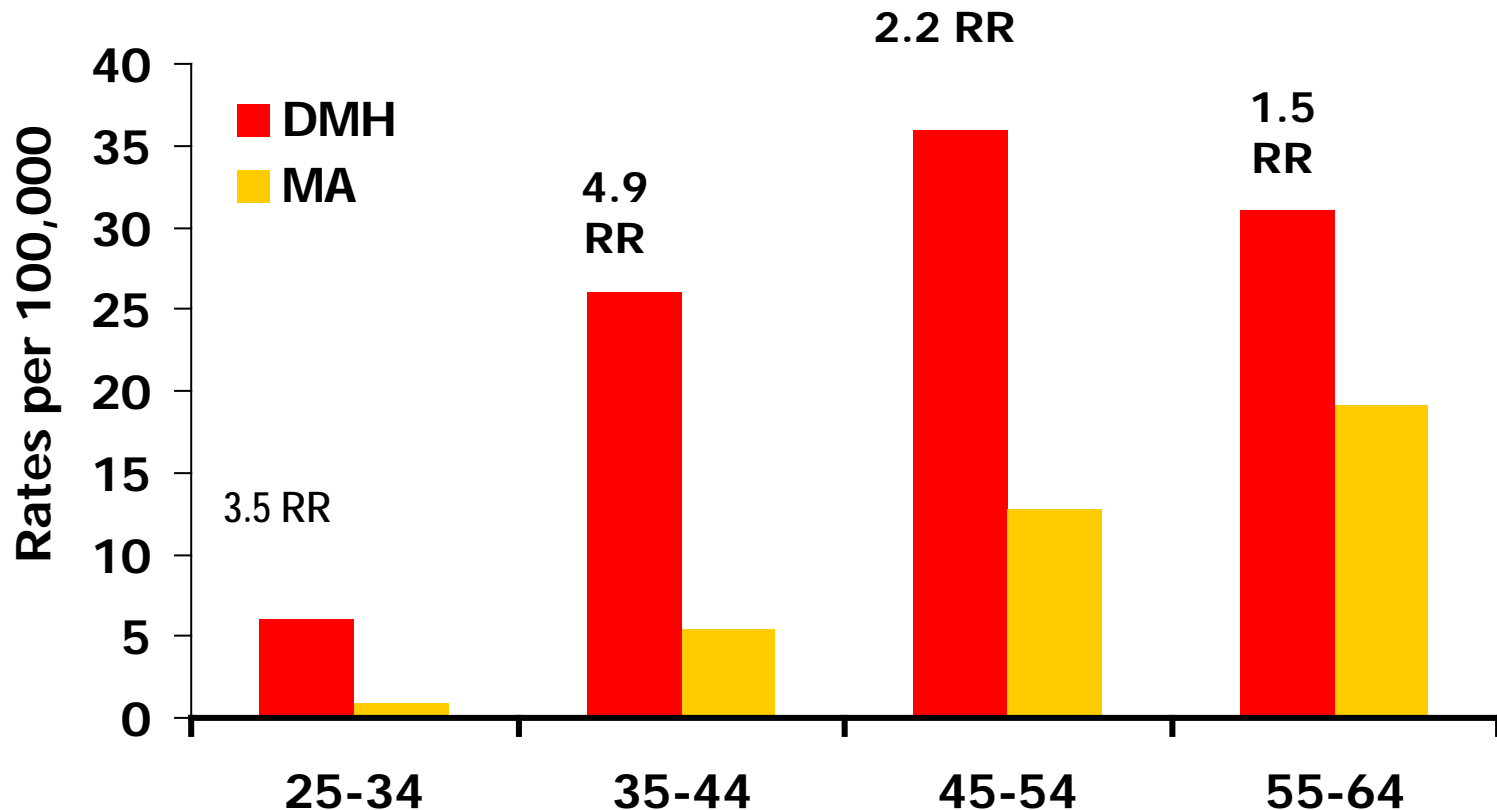


Cardiovascular Disease (CVD) Risk Factors

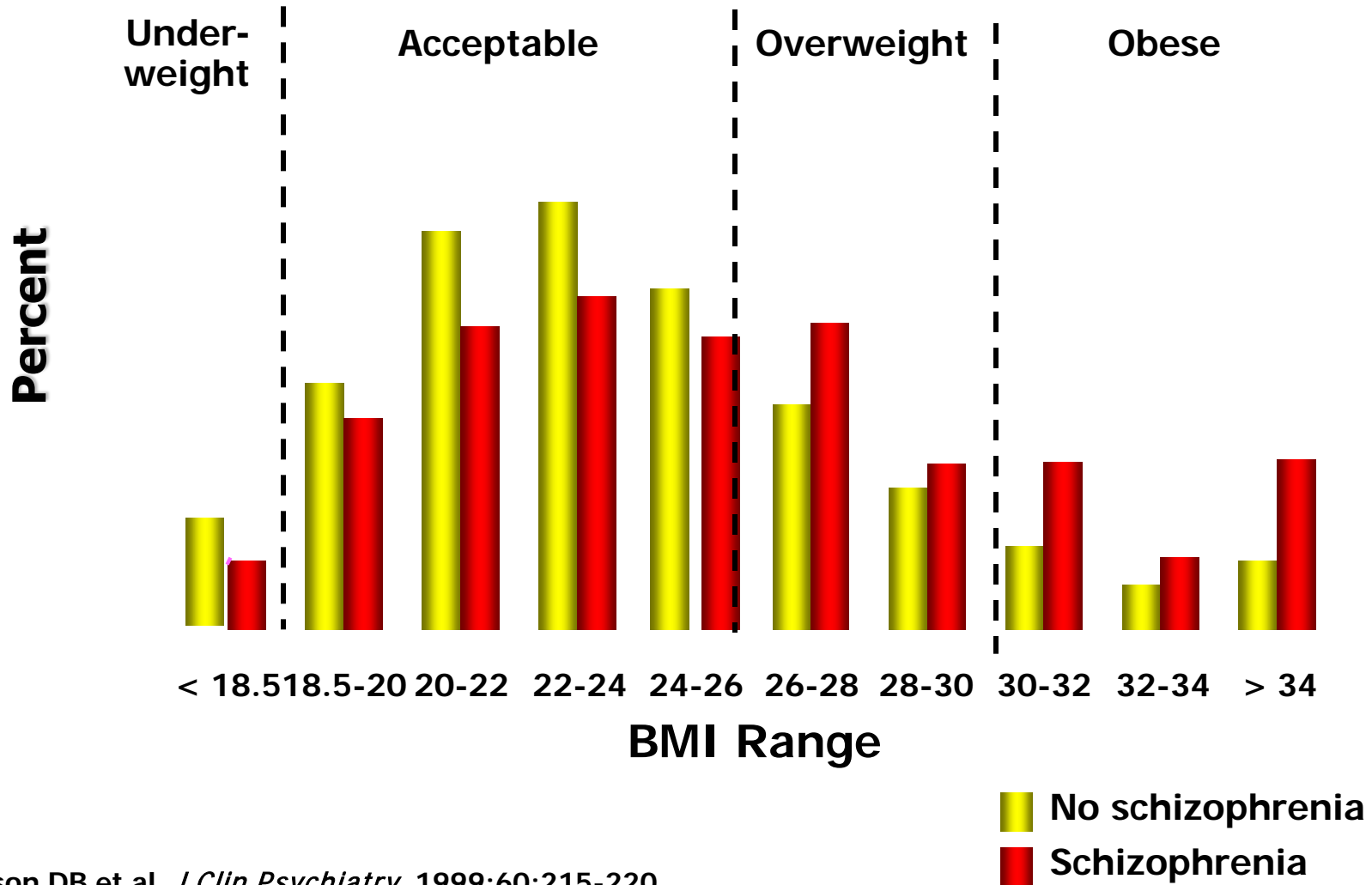
Modifiable Risk Factors	Estimated Prevalence and Relative Risk (RR)	
	Schizophrenia	Bipolar Disorder
Obesity	45–55%, 1.5-2X RR ¹	26% ⁵
Smoking	50–80%, 2-3X RR ²	55% ⁶
Diabetes	10–14%, 2X RR ³	10% ⁷
Hypertension	≥18% ⁴	15% ⁵
Dyslipidemia	Up to 5X RR ⁸	

1. Davidson S, et al. Aust N Z J Psychiatry. 2001;35:196-202. 2. Allison DB, et al. J Clin Psychiatry. 1999; 60:215-220. 3. Dixon L, et al. J Nerv Ment Dis. 1999;187:496-502. 4. Herran A, et al. Schizophr Res. 2000;41:373-381. 5. MeElroy SL, et al. J Clin Psychiatry. 2002;63:207-213. 6. Uçok A, et al. Psychiatry Clin Neurosci. 2004;58:434-437. 7. Cassidy F, et al. Am J Psychiatry. 1999;156:1417-1420. 8. Allebeck. Schizophr Bull. 1999;15(1)81-89.

Massachusetts Study: Deaths from Heart Disease by Age Group/DMH Enrollees with SPMI Compared to Massachusetts 1998-2000



BMI Distributions for General Population and Those With Schizophrenia (1989)



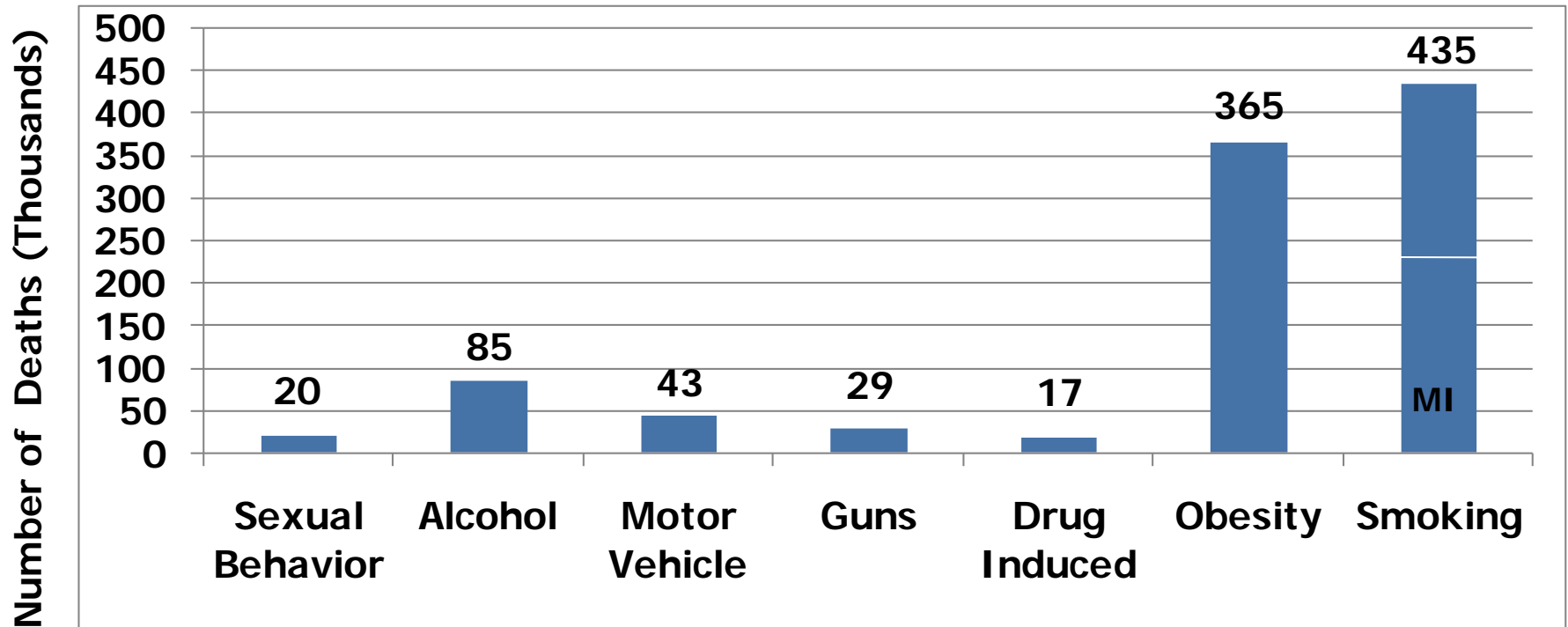
Mental Illness and Obesity

- ◆ Obesity is more prevalent in persons with SPMI than in the general population (Hoffman, 2005)
- ◆ A 2003 study (Strassnig et al) found that:
 - 19% of the SPMI population were normal body weight with a BMI within the range of 19-25
 - 22% were overweight with a BMI within the range of 25-30
 - 59% were obese with a BMI > 30
- ◆ SMI individuals with:
 - Depression have a 1.2 to 1.8 increased likelihood of being obese
 - Bipolar disorder have a 1.5 to 2.3 increased likelihood of being obese
 - Schizophrenia have a 3.5 increased likelihood of being obese (Simon et al, 2006; Coodin et al (2001))

Problem: SPMI and Reduced Use of Medical Services

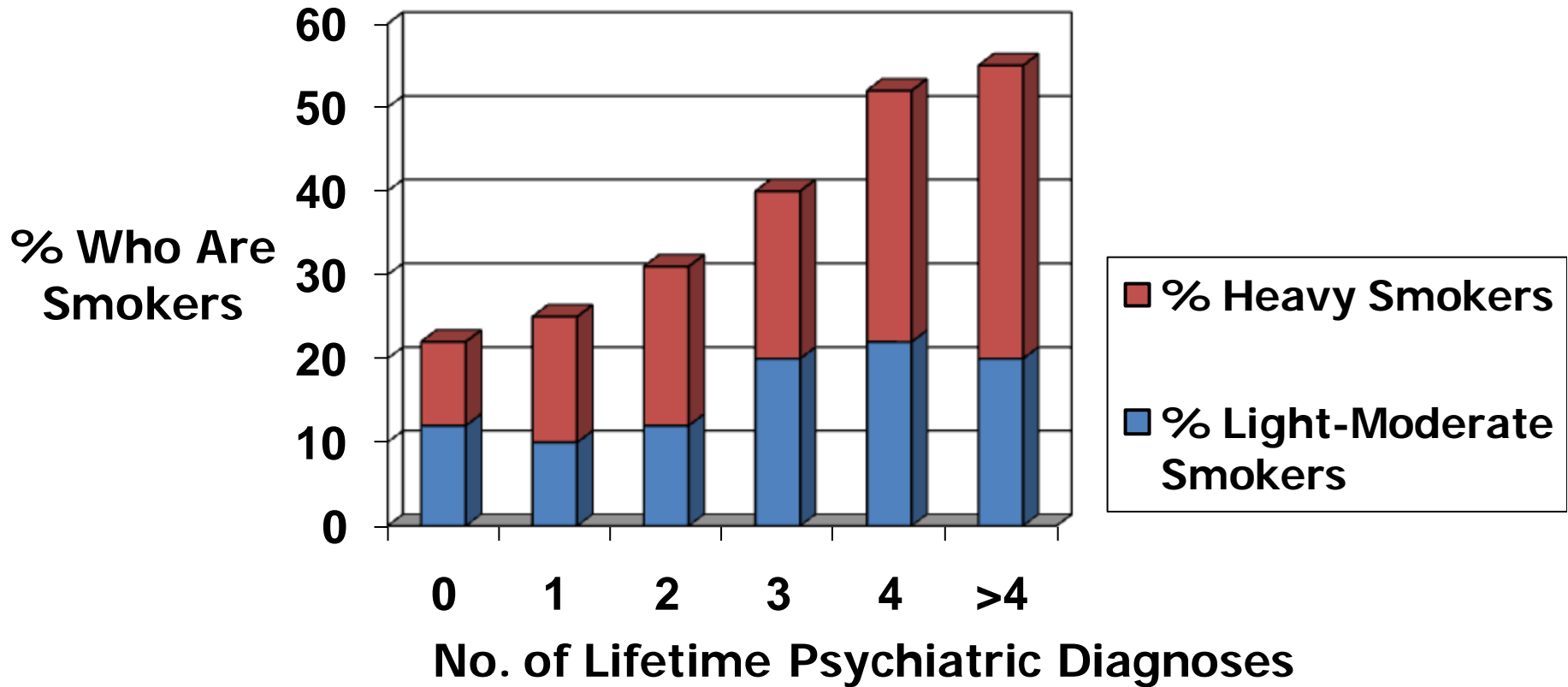
- ◆ **Fewer routine preventive services (Druss 2002)**
- ◆ **Worse diabetes care (Desai 2002, Frayne 2006)**
- ◆ **Lower rates of cardiovascular procedures (Druss 2000)**

Behavioral Causes of Annual Deaths in the U.S., 2000



Mokdad et al, JAMA 2004;291:1238-1245
Mokdad et al; JAMA. 2005; 293:293

Smoking Rates Compared to the Number of Lifetime Psychiatric Diagnoses



What is Integrated Health Care?

It is a system that attempts to bridge the gap that currently exists between the delivery of mental health care and general medical care

Obstacles to Integration

- ◆ **Patterns of financing**
- ◆ **Cultural differences**
- ◆ **Insufficient training in alternative care models**
- ◆ **Reluctance to engage patients**
- ◆ **Information sharing is difficult**
- ◆ **Perception of services by those with SPMI**
- ◆ **Infrastructure**
- ◆ **Technical issues**
- ◆ **Silo mentality**

How Well Are We Doing

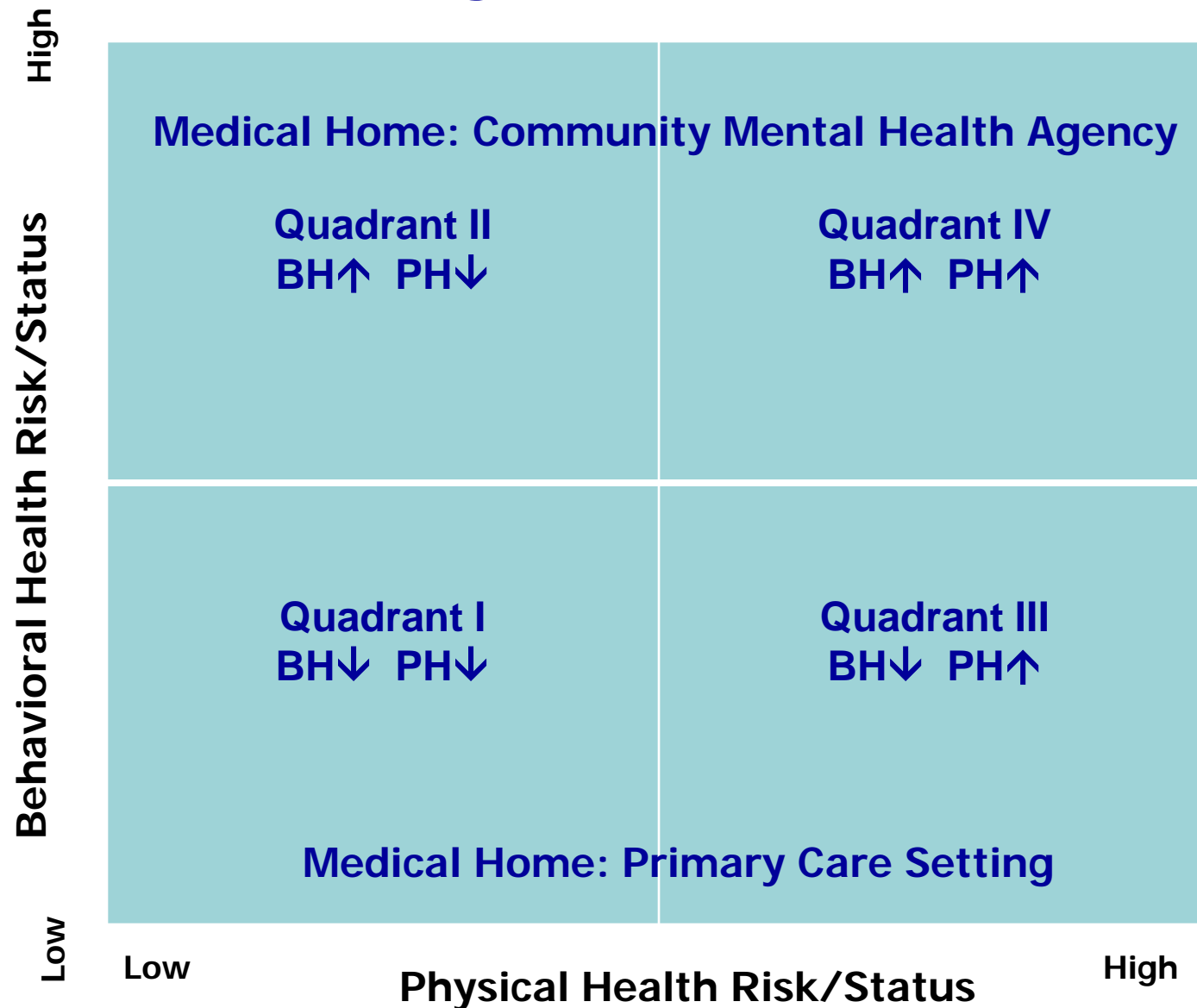
2007 NCCBH Member Survey

- ♦ **Capacity to Screen and Provide Care**
 - **2/3 Have Capacity to Screen for Common Medical Problems**
 - **1/2 Can Provide Treatment or Referral for Those Conditions**
 - **1/3 Can Provide some Medical Services Onsite**
- ♦ **Barriers to providing general medical services; problems in reimbursement, workforce limitations, physical plant constraints, and lack of community referral options**

Integrate Health Care into CMHC Care Mechanisms

- ♦ **Include health care goals in treatment plan**
- ♦ **Include healthy life style goals in treatment plan**
- ♦ **Identify your internal health care expert/champion**
- ♦ **A proven practice – nurse health care case manager**

The Four Quadrant Clinical Integration Model



Basic Operational Checklist for BH/PC Integration Programs

- ◆ Staff Orientation
- ◆ Steering Group Oversight
- ◆ Clarify Roles and Responsibilities
- ◆ Design and Decisions Using Data
- ◆ Communication Planning
- ◆ Patient Education Tools
- ◆ Physician Leadership
- ◆ Relationship Building
- ◆ Outcomes Monitoring
- ◆ Policy Development
- ◆ Fiscal and Reporting Issues
- ◆ Payer Issues
- ◆ Consultative Support

An Integration Checklist

Interest?	Pharmacy? Other Current Physical Health Systems/Services?
Needs Assessment/Current Medical Homes?	Medical Records System?
Extent of Consumer Co-Morbidities/Patient Health Status?	Payer Funding? Payer Interest?
FQHC or Affiliation Potential?	Location/Number of Sites?
Establish PC Practice/Hire PC Workforce?	PC/Health Network Competition?
Physical Plant Requirements/Changes?	Stakeholder Support?
Speciality Network?	Financing?
Consumer Demand?	Existing Medical Staff?
Provider Demand?	Hours of Operation?
PC-Based?	Medical Community Support?

Components of Integration Model of Care

Physical

- ◆ Physical Space
- ◆ Fiscal Management
- ◆ Labs, Pharmacy
- ◆ Location of Health Agency

Provider Roles

- ◆ Clinical Expertise
- ◆ Willingness for Collaboration
- ◆ Comfort with Shared Practice
- ◆ Communication
- ◆ Nurturance/Support

Structural

- ◆ Interpersonal Relationship
- ◆ Communication between Ancillary Staff and Provider
- ◆ Organization of Medical Records
- ◆ Provider Mix
- ◆ Points of Access to Providers
- ◆ Information Management

Consumer Roles

- ◆ Willingness for Partnership
- ◆ Communication
- ◆ Trust
- ◆ Openness
- ◆ Expectation for Care

NCCBH Primary Care-Mental Health Collaborative Care Project – Phase II

- ♦ **Establish screening and tracking processes**
- ♦ **Establish care manager/behavioral health consultant role**
- ♦ **Develop referral protocols from primary care to mental health care**
- ♦ **Develop referral protocols from mental health to primary care**
- ♦ **Improve communication mechanisms between primary care and mental health**
- ♦ **Establish measurement protocols regarding weight, lipids, and blood sugars for patients on antipsychotic medications**
- ♦ **Train PCPs in mood disorder/bipolar screenings and treatment**
- ♦ **Establish primary care services within BH settings**

Why Integrate Care?

It's The Right Thing To Do!

Medical Homes

- ◆ **Medical care and behavioral health care is provided in one location that is welcoming and easy to navigate**
- ◆ **Mental health and primary care clinicians work together as a single team for the benefit of the consumer**
- ◆ **The focus is on collaboration, wellness and recovery**

Medical Home Responsibilities

- ◆ **Screening**
- ◆ **Maintain up-to-date medical records**
- ◆ **Include health risks and interactions**
- ◆ **Develop triage and information sharing processes**
- ◆ **Forms: medical/social history, physician contract information, annual health care recommendations, health review checklist, medical encounter form**
- ◆ **Effective communication/information exchange between two systems**
- ◆ **Promote co-location**
- ◆ **Disease management**

Health Indicators

- ◆ **Indicators that identify untreated yet treatable conditions**
- ◆ **Indicators that are already defined and in use in general health care**
- ◆ **Indicators that are meaningful to consumers and culturally competent**
- ◆ **Primary prevention indicators (e.g., risk factor screening)**
- ◆ **Secondary prevention indicators (e.g., screening for current conditions)**
- ◆ **Tertiary prevention indicators (e.g., monitoring of specific indicators related to a current condition like blood pressure)**

Other Actions

- **NASMHPD Toolkit on Tobacco-Free Living in Psychiatric Settings: A Best-Practices Toolkit Promoting Wellness and Recovery**
- **NY requires metabolic screening in State-operated community services**
- **MO requires metabolic screening and adds Primary Care Nurses to CMHCs**
- **NJ surveys all mental health provider organizations on capacity to support wellness**