

Title of Presentation: Mental Health Disparities: the poor health status of consumers of mental health care

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Introduction: Data has shown that persons with serious and persistent mental illness have a significantly elevated risk of early death, both from injuries and from natural causes, particularly from chronic heart and respiratory diseases and diabetes. These individuals have a high incidence of health risk behaviors, e.g. smoking, which may contribute to the chronic conditions that lead to premature death, but they may also have less access to health care in general, and to health care tailored to their particular needs. Given the traditional separation of health and mental health provider systems, screening and treatment of mental illness has not generally been integrated into health care delivery, but at the same time, neither has health care been emphasized in the delivery of mental health services. Since physical health issues can negatively impact mental health, and vice versa, it is crucial that mental health care and health care be fully integrated for our consumers to achieve the best possible quality of life and full recovery and engagement in community life. To rephrase the New Freedom Commission Goal, physical and mental health should be addressed with equal urgency in order to insure each individual's optimal health.

Hypotheses: 1) Prevalence of chronic medical conditions is high among persons with serious mental illness. Co-morbidity should be assumed to be the prevailing situation. 2) Co-occurring substance abuse further increases the prevalence and impact of medical conditions. 2) Preliminary data from several studies on Medicaid behavioral health expenditures in Maine suggest that persons with behavioral health conditions have higher costs for medical and surgical care than persons with purely medical chronic conditions. These medical expenditures increase the overall cost of care for this population. 3) The higher expenditures do not relate to a higher quality of medical care.

4) Tracking and management of medical conditions among persons with behavioral health conditions has implications for overall cost and efficacy of services, as well as for policy and planning for system design.

Method: Maine has 10,707 persons with serious and persistent mental illness enrolled in its case management and community support system. Of these, 7676 have Medicaid as their sole insurer. Given the data sharing available among state agencies in Maine, we have matched each of these consumers with their service and pharmacy data in the Medicaid information system to code medical diagnoses, all pharmacy data and utilization/cost of medical and surgical services, including emergency, hospital and outpatient visits. We are in the process of comparing utilization and costs of these medical services for those with serious mental illness, with and without co-occurring substance abuse, compared to Medicaid members matched by age and medical condition. Our state Medicaid agency is currently assessing the quality of diabetes care. Using the same measures, the quality of care for persons with diabetes and serious mental illness is being compared to the general quality of diabetes care. The quality of preventive care for our mental health consumers is also being analyzed, using the same measures (e.g. screening for cancer) that are used for the general Medicaid population. We are also comparing other quality measures in use in Maine, e.g. avoidable hospitalizations, emergency room visits that do not result in hospitalization, polypharmacy, multiple pharmacies, multiple prescribers and potentially adverse drug events, e.g. inappropriate drugs for the elderly and potentially adverse drug interactions.

Discussion: Developing models for collecting data across state agencies on the co-occurrence of chronic medical conditions with serious mental illness will provide a means to understand the interaction between mental health and health conditions. As a next step, we will be able; to compare the utilization and cost of psychiatric services for persons with and without chronic medical conditions, or for persons with high quality and lesser quality care for their medical conditions. Does having a high degree of medical comorbidity or worse medical outcomes lead to higher psychiatric utilization, or vice versa, does poorer psychiatric outcome lead to higher medical costs or poorer outcomes? As states engage in transformation of mental health systems, it will be essential to have a means of tracking overall health, because of the primary importance of health to the average citizen's perception of the quality of life and the importance of health as a recovery goal, but also to monitor unexpected consequences and cost shifting as a result of transformation activities. Having data about health status and health care delivery will also allow policy makers to understand the degree to which persons with serious mental illness are a distinct population with health care disparities, which is a first step in designing strategies to address those disparities.