

Quality of Health Care for Persons with Serious Mental Illness and Diabetes

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Goal

Data has shown that persons with serious mental illness (SMI) have a significantly elevated incidence of diabetes and also the prediabetic state known as metabolic syndrome, both of which increase the risk of heart disease. Besides the burden of living with diabetes, persons with SMI have an increased risk of early death, both from diabetes and from cardiovascular disease. Prevention and management of diabetes among this population may be more difficult because these individuals have increased health risk behaviors (e.g. obesity, poor nutrition, physical inactivity), which are difficult to modify, but there also may be difficulties accessing general health care as well as diabetes specific quality care. The traditional fragmentation and lack of integration between primary health care and the mental health care systems may be another contributor to the provision of inadequate diabetes care for this population. This study examines the relationship between risk factors, quality and utilization of health care, co-morbid conditions, pharmacology, and outcomes for diabetes among Medicaid enrollees with and without SMI.

Hypotheses

1). Persons with serious mental illness will have higher rate of risk factors such as high blood pressure, disorders of lipid metabolism, obesity, metabolic syndrome and smoking; 2). Persons with serious mental illness will have higher rates of short term and long term complications of diabetes; 3) Use of emergency room, ambulance, and acute medical inpatient services will be higher, and use of primary care and diabetes education services will be lower among the persons with serious mental illness; 4) Persons with SMI will have a lower level of diabetes specific quality care indicators; 5) Among persons with SMI, poorer outcomes will be associated with higher utilization of specific psychotropic medications linked with weight gain, metabolic syndrome and diabetes.

Method

9223 Maine Medicaid-only members with SMI are matched with a random sample of 7356 Medicaid members without SMI. 16.5 % (1810) the SMI enrollees have diabetes as compared to 10.1% (1404) of the non-SMI comparison group. Medicaid data is currently being analyzed for all encounters and procedures, diagnoses, pharmacy data, laboratory procedures and expenditures for medical and surgical services, including emergency, hospital and outpatient visits for SMI and non-SMI enrollees with diabetes. Maine Medicaid data will also be analyzed for general preventive care, e.g. immunizations, mammogram, pap smear, as well as for HEDIS quality of care measures for diabetes (Hemoglobin A1C, foot and eye exam, lipid profile). Data will be analyzed for complications of diabetes as well as for ambulatory sensitive conditions, e.g. ketoacidosis and diabetic coma. Data on persons with SMI will be examined for relationships between prevalence of diabetes, risk factors, outcome and the use of specific psychotropic medications. Similar analyses will be done on data for the population with elements of the prediabetic state known as metabolic syndrome.

Results



Preliminary analysis reveals that per member per year expenditures for diabetes are significantly higher for MaineCare recipients with SMI (\$5295) as compared to those without (\$3739). While Hemoglobin A1C and lipid screening is comparable for the two groups, persons with SMI utilize more high cost emergency room, ambulance and hospital services and less utilization of community services. Further analyses of quality of care, adverse outcomes and risk factors will clarify the nature of disparities for the SMI population that warrant special focus in the state's health and mental health care policy and planning. Data on access, outcome and risk factors, including risk from psychotropic drugs, will permit the development of focused interventions to reduce the prevalence, morbidity and mortality for diabetes in the SMI population. As states engage in transformation of mental health systems, it will be essential to have methods for tracking prevalence of illness and utilization of medical services for the SMI population because of the importance of including health as a recovery goal but also for monitoring unexpected consequences and cost shifting as a result of mental health or health system changes.