The Poor Health Status of Consumers of Mental Health Care: Prevalence, Quality of Care and Cost for Persons with SMI and Diabetes

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November 2007 APHA

What Do We Know About the Health Status of Persons with Serious Mental Illness?

Recent Multi-State Study 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

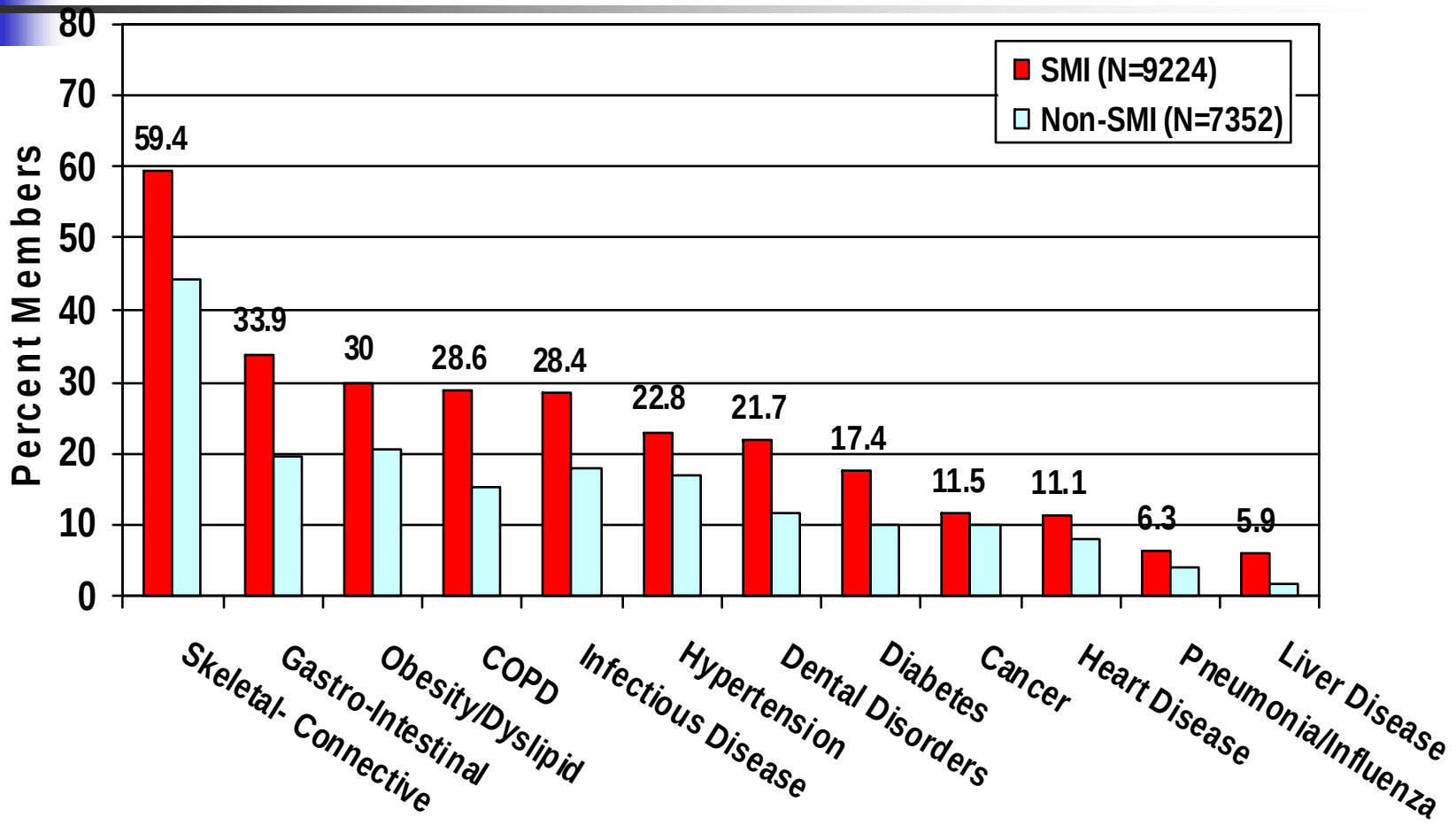
- Compared to the general population, persons with major mental illness typically lose more than 25 years of normal life span
- Cardiovascular Disease is associated with the largest number of deaths in the SMI population
- Deaths from heart disease exceed deaths from suicide

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

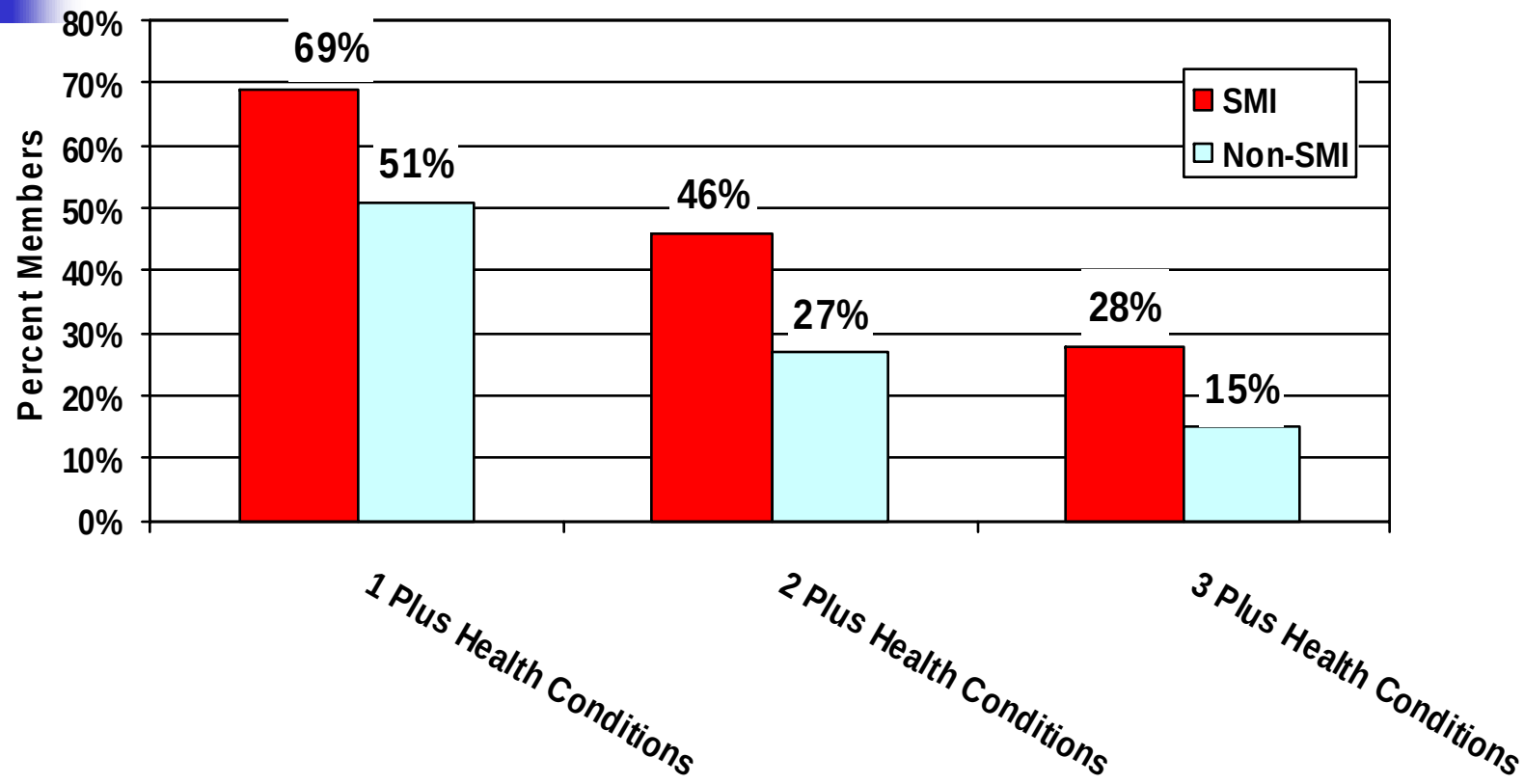
Maine SMI Health Study

Comparison of Medicaid Members with SMI to Medicaid members with no mental illness

Comparison of Health Disorders Between SMI & Non-SMI Groups in Maine Medicaid



Burden of Medical Illness



For Persons with SMI

Chronic Health Conditions Are an

Expectation

Not an Exception

Why Focus on Diabetes in SMI?

- Diabetes and pre-diabetes (metabolic syndrome) significantly increase the risk of cardiovascular disease which is the major cause of premature death in persons with SMI
- Maine Medicaid members with SMI have a significantly higher prevalence of diabetes and of risk factors for diabetes (obesity, dyslipidemia, hypertension

Prevalence of Diabetes and Risk Factors for Diabetes in 18-64 Year Old Maine Medicaid members

	SMI (n=9643)	Non-SMI (n=7449)
Diabetes	17.4%	10.2%
Obesity Dyslipidemia	30.3%	20.3%
Hypertension	22.8%	16.8%

Importance of Addressing Atypical Antipsychotic Medications in SMI

Modifiable Risk Factors Affected by Psychotropics

- Weight Gain/ Obesity
- Insulin resistance
- Diabetes/hyperglycaemia
- Dyslipidemia

Newcomer JW. *CNS Drugs* 2005;19(Supp 1):1.93.

When prescribing Atypical Antipsychotics, Use ADA/APA Monitoring Protocol

	Start	4 wks	8 wks	12 wk	qtrly	12 mos.	5 yrs.
Personal/family Hx	X					X	
Weight (BMI)	X	X	X	X	X		
Waist circumference	X					X	
Blood pressure	X			X		X	
Fasting glucose	X			X		X	
Fasting lipid profile	X			X		X ←	X

*More frequent assessments may be warranted based on clinical status

***Diabetes Care.* 27:596-601, 2004**

Not only psychotropics: Access and Quality of Care

Maine SMI Diabetes Study

Maine Medicaid Service Utilization

Service	SMI	Non SMI	Odds Ratio
General Outpatient	43.8%	52.5%	0.7*
General Inpatient	9.7%	6.4%	1.6*
Ambulance	3.4%	0.9%	3.7*
Emergency Room	37.1%	20.4%	2.3*
Physician	30.8%	39.1%	0.7*

Quality of Care Measures

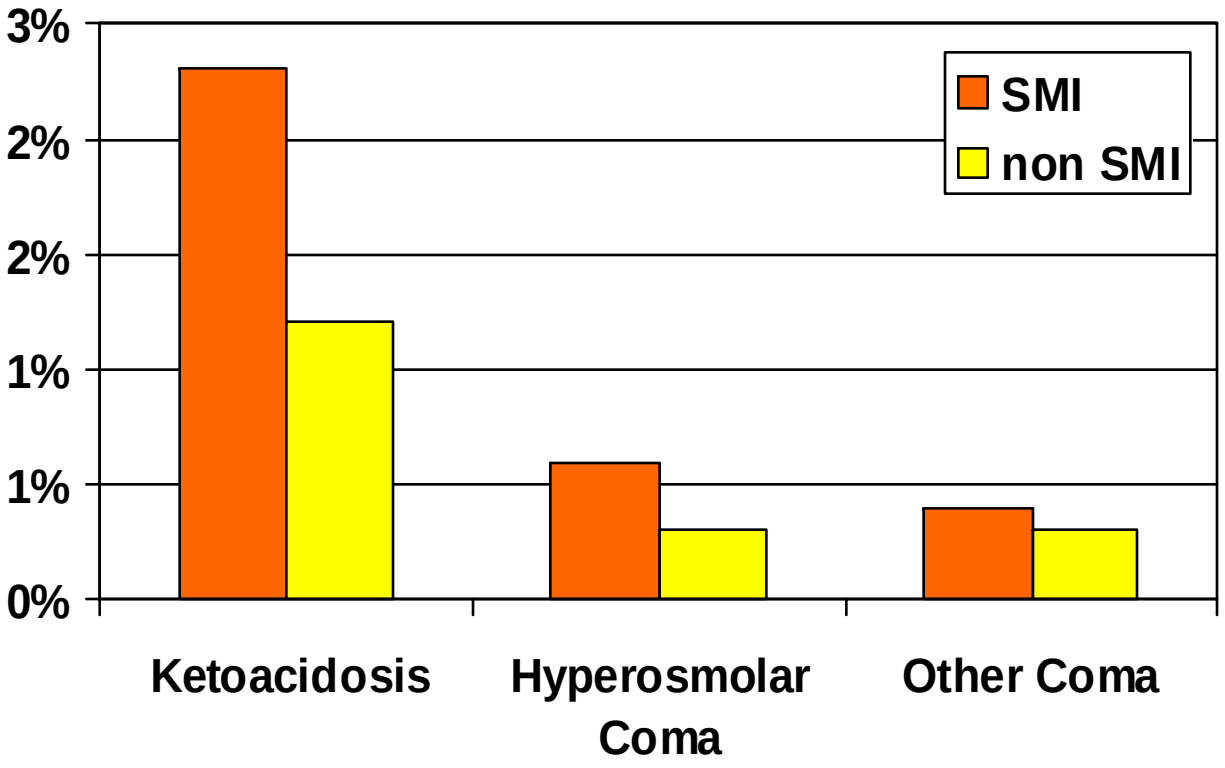
Test	SMI	non-SMI	Odds Ratio
HbA1c	38.6%	49.4%	0.6*
Lipid Profile	26.2%	34.3%	0.7*
Microalbuminuria	14.2%	19.2%	0.7*

Preliminary data: Meds for prevention of complications

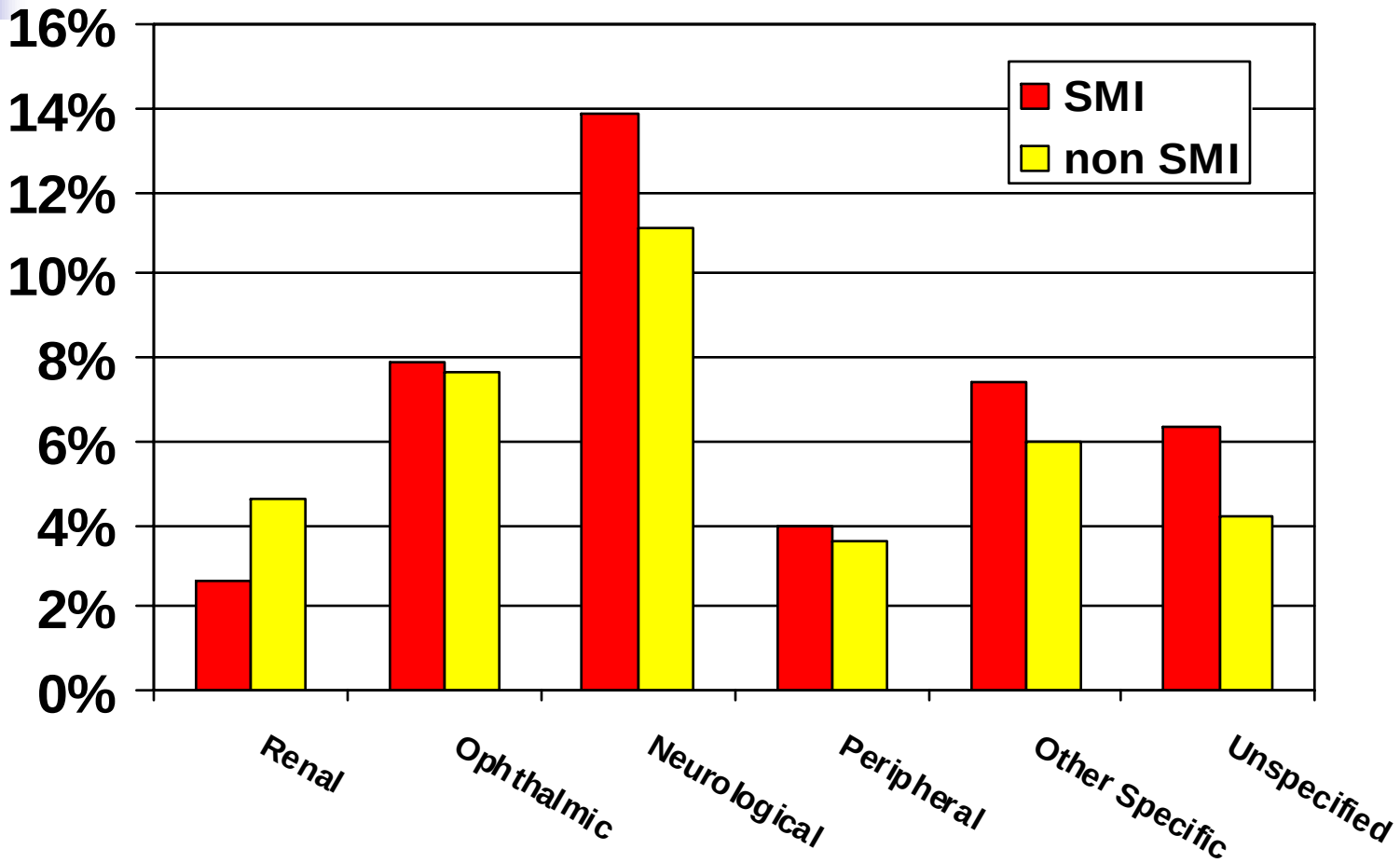
Medication	SMI	Non SMI
Anti-coagulants	10%	16.4%*
ACE/ARB (non-hypertensive pts)	25.8%	34.9%*

* $p<.05$

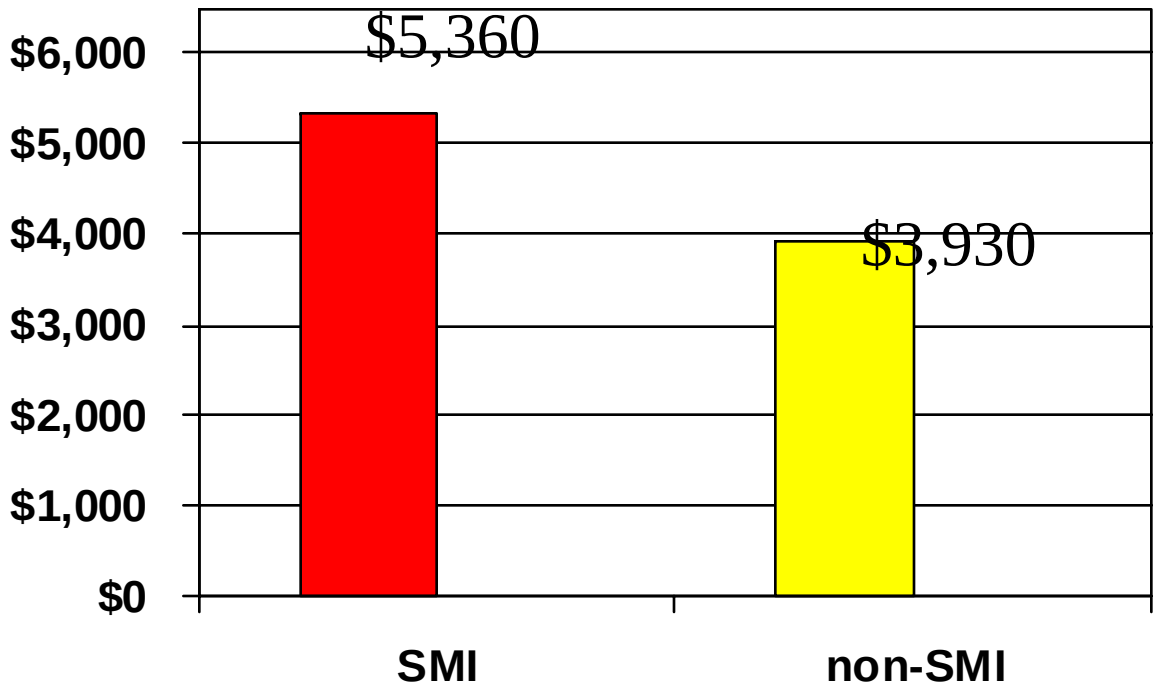
Short-Term Complications Maine SMI/Diabetes Study



Maine SMI study
Long-Term Complications



Maine SMI Diabetes Study: Diabetes Expenditures per Member per Year



Persons with SMI and Diabetes are a Health Disparities Group

- Almost 2X prevalence of diabetes
- High risk: obesity, smoking, dyslipidemia
- High utilization of hospital/ER
- Lower level of medical home
- Less access to quality diabetes care
- Poorer outcomes of diabetes care
- 1.4 times cost of diabetes care
- 2X times cost of psychiatric care

Implications for Policy and Program Development

How to make Mental Health Systems

Co-Occurring Capable

(co-occurrence of SMI and Chronic Health Conditions)

Tool Kit for Improving Diabetes Care for SMI population in Mental Health Systems -

- Tracking diagnosis and risk factors in initial assessment and ISP development

- Care pathways for psych prescribing: American Diabetes Association guidelines (track BMI, blood pressure, glucose, lipid); weight management support from outset as part of prescribing practice

Support for Diabetes Self Management: Education

- Education for consumers and mental health providers re nutrition, exercise, healthy lifestyle, healthy choices
- Education on health literacy – standards of care, best practices, self advocacy and shared decision making for diabetes care
- Education on diabetes self management

Support for Self management: Program Development

- Create Programs that identify, track and reduce risk
- Borrow from Workforce Programs: health risk assessment, personal health goals, mentor/coaching, peer support, volunteers, natural helpers
- Group and individual strategies
- Adaptation of existing diabetes education programming

Integration with Physical Health

- Co-Location
- Effective linkage to a welcoming medical home that delivers quality diabetes care
- Free flow of information between health care and mental health
- Infrastructure to guarantee support from mental health team for optimal interaction between patient and health care team (more than transportation)

Integrated Care Management

- Develop care management protocols directed at integrated support for both mental illness, diabetes and metabolic syndrome by mental health case managers
- Support for Self Management: “Know your numbers, ” Diabetes Self Care goals in ISP
- Support optimal interactions with medical system, health literacy

Don’t forget…

- **Linkage to CDC funded public health programs in diabetes prevention and control, cardiovascular disease, healthy weight, nutrition**
- **Linkage to community programs (YMCA: Ten Ways to add 2000 Steps)**
- **Environmental policies (e.g. vending machines, adoption of nutrition guidelines in group settings)**