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July 8, 2011

Ms. Beth Rosenfeld
Policy Branch Chief
Office of Policy and Program Development
Bureau of Primary Health Care
Health Resources and Services Administration
5600 Fishers Lane
Rockville, MD 20857

Re: Designation of people with serious mental illnesses as a special medically underserved population

Dear Ms. Rosenfeld:

As national health care reform proceeds, an unprecedented number of people will become newly eligible for coverage. Many of these previously uninsured individuals will have serious mental illnesses and significant substance use and medical co-morbidities. Most will join a group of individuals, served by public mental health agencies, that has one of the highest morbidity and mortality rates of any group in America's public health system. Yet, despite this group's disproportionately high morbidity and mortality rates and its identification as one of the subgroups most at risk of high healthcare costs and poor health care quality, it has received limited attention from the healthcare system. However, as the national healthcare system shifts its focus from illness to prevention and wellness promotion, and seeks greater efficiency and effectiveness in health care delivery, meeting the health care needs of individuals with serious mental illnesses in a comprehensive and integrated fashion will assume major importance.

The Affordable Care Act contains a number of provisions that benefit people diagnosed with mental illnesses. These include provisions related to expanded eligibility for coverage, the Medicaid Medical Home Pilot, and the funding for co-location of primary and specialty health care in community behavioral health settings. However, none of these provisions are sufficiently responsive to the needs of people who have been diagnosed with *serious* mental illnesses. Unfortunately, Federally Qualified Behavioral Health Centers (FQBHCs)ⁱ, a promising concept designed

ⁱ Alakeson et al, "Specialty Care Medical Homes for People with Severe, Persistent Mental Disorders," Health Affairs 2010;29 (5):867 – 73; Jarvis, D., "Healthcare Payment Reform and the Behavioral Health Safety Net: What's on the Horizon for the Community Behavioral Health System," National Council for Community Behavioral Healthcare, 2009



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to align the behavioral health and general healthcare safety nets to better meet the needs of this group, was not included in the final law.

As people with serious mental illnesses continue to die from preventable causes, we have an urgent need to identify alternative approaches to effectively and cost-efficiently meet the comprehensive healthcare needs of this group. We would therefore like to propose that HRSA consider designating people with serious mental illnesses as a special medically underserved population. This would support the creation of FQHCs designed to meet the comprehensive health care needs of a highly vulnerable, costly to serve sub-population: children and adults diagnosed with or at risk of serious mental illnesses and/or co-occurring disorders.

Research findings regarding this group provide ample justification for this designation. They include:

- Under-recognition and under- treatment of physical health issues;
- Disproportionately high rates of serious disease and death;
- Disproportionately high rates of childhood and adult trauma and other adverse experiences shown to negatively impact long-term physical and behavioral health;
- Significantly higher healthcare costs
- The negative impact on health status of separate behavioral health and physical health care systems;
- the inadequacy of current models of healthcare for this population

Health disparities of people with serious mental illnesses

Research has shown that people with serious mental illness, particularly those receiving services in the public mental health system, have disproportionately high rates of serious disease and death. They die an average of twenty-five years earlier than the general population.ⁱⁱ These excessively high rates of illness and death are tied to the prevalence of largely preventable medical conditions such as heart and blood vessel diseases, diabetes, lung diseases and infectious diseases. These conditions, in turn, are linked to higher rates of modifiable risk factors among people with serious mental illness. These include smoking, drug and alcohol use, poor nutrition and obesity, lack of safe and stable housing, unsafe sexual behaviors, and inadequate access to quality primary and specialty health care.ⁱⁱⁱ

The result, as research documents, is that people with serious mental illness have excessively high rates of emergency room usage. They have less access to preventive screenings and routine monitoring for chronic illnesses, less access to evidence-based treatment, and less ongoing, coordinated care.^{iv} These health care disparities are so significant that people with serious mental illnesses, when taken as a group, are analogous to groups such that are federally designated as medically underserved special populations and targeted for federally supported primary care services, such as homeless individuals and migrant workers.

Many factors contribute to inadequate access to quality health care and poor health outcomes. Barriers to access include stigma, transportation barriers, the unwillingness of many community providers to treat Medicaid patients, and lack of health insurance or fluctuating health insurance status. Other factors contributing to poor health outcomes include the cognitive impairments inherent in psychotic disorders that make it especially difficult for individuals with serious mental illnesses to build trust with healthcare providers and to navigate through complex health care systems. Atypical antipsychotic medications, widely used in the treatment of serious mental illnesses, have been shown to increase the risk of chronic diseases such as diabetes and cardiovascular disorders.

ⁱⁱ Parks, J., Svendsen, D., Singer, P., Foti, M., Mauer, B. Morbidity and Mortality in People with Serious Mental Illness, National Association of State Mental Health Program Directors, 2006

ⁱⁱⁱ Mauer, B. Behavioral Health/Primary Care Integration and the Person-Centered Health Care Home, www.the-nationalcouncil.org/Resource-Center

^{iv} Lurie, Barbara Demming, "Partners in Health Primary Care/County Mental Health Collaboration Toolkit," October 2009;" Behavioral Health and the Patient-Centered Medical Home (PCMH)," presentation available at www.pcpcc.net/files/pcpcc-behavioral-health-pcmh_101209.ppt. Accessed 4.6.10

Histories of abuse and trauma are important contributing factors. Researchers have documented that people receiving treatment for serious mental illnesses frequently have a history of childhood sexual and/or physical abuse placing them at higher risk for negative health outcomes than the general population. The Adverse Childhood Experiences (ACES) study, conducted jointly by the Centers for Disease Control and Kaiser Permanente revealed a strong association between childhood abuse and adverse experiences such as household dysfunction and negative health outcomes in later life. These include substance abuse, depression, intimate partner violence, attempted suicides, and chronic diseases such as heart disease, liver disease and chronic obstructive pulmonary disease.^v

Finally, the separation of physical and behavioral healthcare into two independent systems results in fragmented and uncoordinated care, and healthcare providers who do not understand the needs of individuals with serious mental illnesses, and cannot devote the time needed to deliver quality care to them, and to coordinate that care with their behavioral health providers.^{vi} While specialty behavioral health care providers frequently serve as de facto health homes for these individuals, the majority do not have the resources to focus on the unmanaged physical health issues.

Health care costs for people with mental illnesses and /or substance use issues are among the highest

In “Rethinking Care for Medicaid’s Highest Need, Highest Costs Populations”, the Center for Healthcare Strategies stated “a significant portion of overall Medicaid spending is for people with mental illness and for co-occurring chronic health conditions which are disproportionately represented. People with mental illnesses are significantly represented in the group of approximately 5% of Medicaid beneficiaries who account for 50% of spending (because more than 80% of them have 3 or more chronic conditions)”^{vii}

Other recent studies echo these findings. The Robert Wood Foundation’s recent study “Mental Disorders and Medical Co morbidity,” reported that more than half of people with disabilities on Medicaid who have a psychiatric condition also have claims for diabetes, cardiovascular disease and pulmonary diseases, experiencing much higher rates of these illnesses than those who do not have psychiatric conditions.^{viii}

United Hospital Fund’s Report “Providing Care to Medicaid Beneficiaries with Behavioral Health Conditions: Challenges for New York” found that the physical health care costs for Medicaid recipients with mental health conditions was 32% higher than comparable spending for Medicaid beneficiaries without mental health conditions. It noted that the rates for chronic illnesses such as heart disease, hypertension, asthma and chronic obstructive pulmonary disease were 30% to 60% higher in beneficiaries with mental health conditions versus those without mental health conditions. Beneficiaries with substance use conditions had medical co-morbidity rates from 50% to 300% higher than those without substance use conditions. Mean Medicaid spending for individuals with mental health conditions (\$28, 451) was nearly twice that of beneficiaries without mental health conditions (\$15, 964). Likewise, mean Medicaid spending for beneficiaries with substance use conditions was \$27,839 versus spending for beneficiaries without substance use conditions (\$18,051).^{ix}

^v Vincent J. Felitti, MD, FACP, Robert F. Anda, MD, MS, Dale Nordenberg, MD, David F. Williamson, MS, PhD, Alison M. Spitz, MS, MPH, Valerie Edwards, BA, Mary P. Koss, PhD, James S. Marks, MD, MPH “The Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults (The Adverse Childhood Experiences (ACE Study),” Am J Prev 1998, 14 (4)

^{vi} Nace, David K., MD “Implementing a Collaborative Care Plan to Improve Patient Outcomes in Behavioral Health,” presentation available at www.pcpcc.net/resources

^{vii}The Center for Healthcare Strategies “Rethinking Care for Medicaid’s Highest- Need, Highest- Cost Populations,” April 2009

^{viii}Goodall, S., Druss, B.G., Reisinger Walker, E., “Mental Disorders and Medical Comorbidity,” Research Synthesis Report No. 21, The Synthesis Project, The Robert Wood Johnson Foundation, February 2011

^{ix} Patchias, E.M. and Birnbaum, M. “Providing Care to Medicaid Beneficiaries with Behavioral Health Conditions: Challenges for New York,” Medicaid Institute at United Hospital Fund, 2011

Existing health care systems and models of care do not meet the needs of this group.

Providing integrated care to people with serious mental illnesses has been shown to improve access to and use of primary and preventive care and to reduce costly emergency room visits.^x However, most of the attempts to address this issue e.g., through co-locating primary care in community behavioral health settings, fall short of true integration and have proven to be less effective than expected. In fact, the recent white paper “Integrating Mental Health Treatment into the Patient Centered Medical Home” from the Agency for Healthcare Research and Quality highlights the need to identify optimal approaches to meeting the health care needs of people with serious mental illnesses.^{xi}

Designating people with serious mental illnesses as a special medically underserved population

Federal health care regulations have long recognized and attempted to address the health disparities experienced by specific populations as a result of their lack of access to quality healthcare. Homeless individuals, people living in public housing projects, and migrant and farm workers are federally designated special medically underserved populations. Disease- specific federal programs focus on the special needs of people with HIV/AIDS, Hansen’s disease and black lung disease. Ethnicity/race specific programs focus on the needs of medically underserved groups such as native Hawaiians. The health disparities experienced by individuals with serious mental illnesses are analogous to these other groups. We propose that HRSA consider designating them as a special medically underserved population, paving the way for the development of a total healthcare model more responsive to their needs.

Creating Federally Qualified Health Centers Designed for Individuals with Serious Mental Illnesses

While there is consensus on the value of patient-centered health care homes, particularly for those with chronic illnesses, the concept of a patient-centered health care home has not been adapted for people with serious mental illnesses and co-occurring disorders. We believe that a Federally Qualified Health Center designed to meet the needs of this medically underserved group will substantially improve the access to and use of healthcare services by people with serious mental illnesses for preventive, acute and chronic care, increase their ability to self-manage chronic illnesses, and strengthen communication, collaboration and coordination between their medical, psychiatric and rehabilitation care providers. This, in turn, will result in improved health status and quality of life for this group and an eventual reduction in health care costs, as emergency room visits are reduced and chronic illnesses more effectively managed.

I would greatly appreciate an opportunity to meet with you to further discuss the ideas outlined in this letter, as well as your thoughts on approaches to improving the health status of this medically underserved population.

Sincerely,

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^x Druss, B. et al “Integrated medical care for patients with serious psychiatric illness,” Archives of General Psychiatry, Vol.58, September 2001 and Boardman, J., “Healthcare access and integration for adults with serious mental illness: five years later,” Health and Education Services ,Inc. Presented to the National Council on Community Behavioral Healthcare Conference, May 2008.

^{xi} Croghan, T.W. and Brown, J.D., “Integrating Mental Health Treatment into the Patient Centered Medical Home,” Agency for Healthcare Research and Quality, June 2010