

Location, Location, Location

Providing Physical Health Care in Other Settings to Increase Access

by The Health Foundation of Greater Cincinnati



Reclaiming 25 Years of Life

Integrating Physical and Mental Health Care to Reduce Health Disparities for People with Severe Mental Illnesses

Despite dramatic improvements in the overall health of people living in the U.S. over the last 50 years, some groups of people have higher than average rates of certain illnesses and premature death, also known as health disparities. One such group is people with severe mental illnesses.

Over 1.8 million people in the U.S.—or 1 out of every 17 people—have a severe mental illness such as schizophrenia, bipolar disorder, or major clinical depression.¹ Beyond the price paid in human suffering, recent estimates suggest that severe mental illnesses cost our society \$193.2 billion in lost earnings per year.²

This policy brief will present an overview of the health disparities of people with severe mental illnesses, some of the factors that contribute to these disparities, and two strategies that can be used to address these disparities.

What is a Health Disparity?

According to the National Institutes of Health, health disparities are differences in the incidence, prevalence, mortality, and burden of disease among specific populations.³ The Minority Health and Health Disparities Research and Education Act of 2000 states that “a population is a health disparity population if... there is a significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality, or survival rates in the population as compared to the health status of the general population.”⁴

Health Disparities of People with Severe Mental Illnesses

Shorter Life Expectancy

Based on an examination of death records from 1976 to 1985, researchers estimated that patients with schizophrenia died 15 years earlier than the general population during that period.⁵ The amount of lost life for people with severe mental illnesses seems to be increasing. By 2000, people with severe mental illnesses in the U.S. were dying at twice the rate of and approximately 25 years earlier than the general population.⁶

Physical Health Problems

Several recent studies have found that people with severe mental illnesses have much poorer physical health than the general population.^{7,8,9} Between 50–74% of people with severe mental illnesses have at least one serious chronic physical illness, such as heart disease, hypertension, or diabetes.^{10,11} Of the premature deaths of people with severe mental illnesses from 1976–1985, 60% were due to medical conditions such as cardiovascular, metabolic, and infectious diseases that are preventable and treatable.¹²

Chronic illnesses also create an economic burden, and prevention and early treatment are important to keeping costs down. According to a recent study by the Milken Institute, seven chronic diseases—cancer; diabetes; heart disease; hypertension (high blood pressure); mental disorders, including, but not

limited to, severe mental illnesses; pulmonary conditions; and stroke—result in \$1 trillion annually in healthcare costs and lost worker productivity.¹³ About 40% of the \$1 trillion is attributed to just three diseases that are largely preventable: heart disease (\$156 billion), hypertension (\$69 billion),¹⁴ and diabetes (\$174 billion).¹⁵ The Milken Institute study also reported that although there were 162 million cases of the seven chronic illnesses, only 100 million people were affected.¹⁶ This means that many people have more than one of these illnesses.

Limited Access to Physical Health Care

On top of having a shorter life expectancy and higher rates of serious physical illnesses, people with severe mental illnesses often have limited access to physical health care. This includes tests, screenings, and early treatment to reduce known risk factors for heart disease—such as hypertension, elevated lipids, and obesity¹⁷—and the diagnosis and management of diabetes.¹⁸ Research has also shown that people with severe mental illnesses get fewer routine preventive services,¹⁹ get worse diabetes care,²⁰ and have lower rates of getting needed cardiovascular procedures than the general population.²¹

Factors Affecting the Physical Health of People with Severe Mental Illnesses

Individual-Level Factors

Many people with severe mental illnesses have a number of symptoms that can make day-to-day life more difficult. They and their families may focus so intently on their mental illness symptoms that they may not recognize or correctly identify physical health symptoms. Symptoms of mental illnesses—such as depression, fearfulness, or social instability—may also interfere with recognizing physical symptoms or with seeking help for physical problems. In addition, some people with severe mental illnesses make lifestyle choices—such

as tobacco use, alcohol and other drug use, lack of exercise, and poor eating habits—that put them at greater risk for disease and premature death.²² For example, people with mental illnesses are 66–75% more likely to use tobacco than people who do not have mental illnesses.²³

By the time many people with severe mental illnesses seek care for physical health problems, their problems are so advanced that they often go to an emergency room (ER) or have to be admitted to a hospital for treatment, both of which are costly solutions for preventable problems.²⁴ ER and hospital staff may not be aware of the person's severe mental illness, which can complicate treatment and make communication between staff and patients less effective.

Many treatment options for people with severe mental illnesses can also affect physical health. Some psychiatric medications have side effects including increased risk for weight gain, diabetes, high cholesterol, insulin resistance, and metabolic syndrome.²⁵ While these medications can reduce mental illness symptoms, the side effects can damage a person's physical health or make life so uncomfortable a person stops taking his or her medications. Because many people with severe mental illnesses don't get regular physical health care, they are probably also not being monitored carefully for side effects that increase risk for physical disease, which is vital for their overall health.²⁶

Provider-Level Factors

Primary care and mental health treatment providers can also affect how people with severe mental illnesses get care for physical health problems. Doctors, nurses, and other primary care providers may lack the skills or confidence to comfortably and effectively treat people with severe mental illnesses. They also lack sufficient time to address multiple physical and mental health problems during a typical office visit, which includes only about 15–20 minutes of patient-doctor contact on average.²⁷ And while nurses and physician's assistants have

additional contact time with patients, that time is spent on physical health information. Likewise, mental health treatment providers may not recognize and or screen for physical health conditions and may not have the time or expertise to deal with both the mental and physical health problems of patients during a visit.

Difficulty in or lack of communication between physical health and mental health treatment providers is also a factor. Each type of provider has a different practice style, vocabulary, and culture that can make communication difficult. In addition, both types of providers have an agreement of confidentiality with their patients. And although patients can choose to let their multiple providers share information, the patient has to think about this and give permission. Providers may not ask the patient about other care providers when they discuss with whom information can be shared. In

addition, because physical health and mental health care are usually provided in different locations, there are few opportunities for providers to interact.

System-Level Factors

The current U.S. healthcare system separates treatment for physical and mental illnesses. The physical and mental health care systems have different treatment guidelines, payment rates, rules, and provider qualifications and specialties. Each system is used to providing a specific set of services and referring people to other systems for services outside of what they provide. Typically, the systems do not talk to each other about treatment practices or how they refer patients. The lack of coordination and communication between the physical and mental health care systems can hamper the efforts of a person with severe mental illness to get the care they need.



Katie¹ is short, heavy, and wears baggy pants and layers of clothing. She carries a large bag filled with a variety of interesting things: a purse, papers, notebooks, pens, little figurines she likes, and

other trinkets. She is a poet and a person with schizophrenia.

Katie first came to the Consumer Wellness clinic (in Cincinnati, Ohio) about a year after it opened. “I’ve been watching you for a year and decided to come to you for a physical. You don’t have any prejudices and you treat everyone alike,” she told one of the staff.

Her first visit included a complete history and physical examination including screenings for diabetes, high blood pressure, anemia, and other conditions. Katie had two serious and previously untreated problems: diabetes and tachycardia. Katie was very receptive to learning about diabetes. She understood the need to avoid foods high in sugar and was faithful in taking her medication to control her blood sugar. Her sugar and insulin returned to normal levels.

The cause of the tachycardia was not so obvious. Katie was highly anxious and afraid of teens in the neighborhood who made fun of her. Several times, while waiting for the bus, she had an “attack” where her heart would race and she felt like she was going to pass out. The paramedics would check her blood sugar and other signs. All tests were negative, except the continued fast heartbeat. Was she having an anxiety attack? A reaction to medication? Or another problem?

After many months, the staff at the Consumer Wellness clinic convinced Katie to see a cardiologist about the tachycardia. Katie only agreed when she was sure the cardiologist was kind as well as competent. The cardiologist determined that her tachycardia was probably due to her psychotropic medications, and her psychiatrist decreased the dosage of one of her stronger prescriptions.

Katie is now doing very well. She has had no further episodes at the bus stop, and she now volunteers as a peer support specialist to help other people with mental illnesses. Katie keeps her appointments, comes in for regular checkups, and has even agreed to a pap test and mammogram.

¹ Names have been changed to preserve confidentiality.

Payment for services is another barrier to getting care. Insurance benefits for mental health services are typically more restricted and more heavily managed than benefits for physical health services. Insurance plans may not cover physical health screening, care management, and other preventive services if they happen in a mental health treatment provider's office. Although a few insurance plans will cover basic mental health services provided in a physical health treatment setting, these services are very limited and may not meet the needs of people with severe mental illnesses.

Effects of Stigma

The stigma associated with mental illness in our society reaches across all levels—client, provider, and system—and affects how and whether people with severe mental illnesses get physical and mental health care. According to the Merriam-Webster Dictionary, stigma is “a mark of shame or discredit.”²⁸ Research has documented the stigma faced by people with severe mental illnesses.²⁹ The most commonly reported experiences involve hearing negative comments by others or seeing negative depictions of mental illness in the media.³⁰ After confronting stigma, people with severe mental illnesses often report lowered self-esteem, loss of confidence, and in some cases, an increase in anxiety and depression.³¹ In addition, stigma has been associated with non-adherence to prescribed treatment regimens among people with severe mental illnesses.³²

Stigma can interfere with establishing the therapeutic relationship necessary between a patient and provider. If people with mental illnesses experience stigma from a healthcare provider, they become less likely to seek healthcare, less likely to disclose health concerns, and less trustful of healthcare providers in the future.³³ In studies related to stigma, people with severe mental illnesses have reported that during physical health care encounters, they are often treated as less competent by providers and are spoken to disrespectfully or impatiently.³⁴ They also

reported that providers frequently disbelieve their physical complaints and discourage them from setting their expectations for recovery and quality of life at too high a level.³⁵ It has also been suggested that the effects of stigma have resulted in a lack of depth and breadth of available physical health care services for people with severe mental illnesses.^{36,37,38,39}

Using Integrated Care to Reduce Disparities

In order to reduce the health disparities of people with severe mental illnesses, physical and mental health care need to be delivered in new ways. The traditional model is that people get physical health care in primary care settings and mental health care in mental health care settings. This model assumes that people have the resources and ability to get to and coordinate care between two places. It also assumes that they feel comfortable, safe, and respected while receiving care from the two places.

People with severe mental illnesses may not be able to coordinate their care between two settings or feel comfortable, safe, or respected in a primary care setting. When the traditional model of getting physical and mental health care in two places makes it harder for a person to reach their personal wellness goals, that person should have the choice of where he or she gets physical health care. Offering physical and mental health care in a single location takes into account the resources, needs, abilities, and feelings of the individual at that time.

This does not mean that people with mental illnesses should not be allowed to get physical health care in a traditional primary care setting. Many people with mental illnesses do get physical health care in this way and feel comfortable, safe, and respected in these settings. They, their families, and the people who provide their care help to coordinate that care. Further, some primary care providers offer mental health treatment within their primary care setting. This also works for some people

with mental illnesses. However, these two approaches do not work for everyone with a mental illness. Integrated care models should be available so that all people with mental illnesses can get physical health care in a place that meets their needs.

Two integrated care models—embedded primary care and unified care—have been found to be effective in delivering physical and mental health care to people with severe mental illnesses and address many of the factors that contribute to health disparities among this group.⁴⁰ These two models deliver physical health care in an established mental health care setting. They both use continuity, coordination, and comprehensiveness of care, hallmarks of integrated care delivery.

Embedded Primary Care

One type of integrated care delivery brings physical health care services into existing mental health care programs.⁴¹ For people with severe mental illnesses, the mental health care provider is a familiar and trusted point of contact with the health system. The person feels comfortable and may be more likely to share information about physical health problems. In embedded primary care, two provider organizations are involved: a physical health care organization and a mental health care organization. Staff of the physical health care organization work at—not for—the mental health care organization.

Embedded primary care programs overcome several barriers seen in traditional care delivery. The physical health care providers in an embedded primary care program are better equipped—in experience, time, and resources—to address the multiple and complex issues of people with severe mental illnesses. Embedded primary care programs have natural opportunities for collaborative approaches to care, thus enabling continuity of care and comprehensive treatment. In addition, embedded primary care allows for enhanced communication between physical and mental

health care providers, making coordination of care easier.

One challenge of embedded primary care is the patient's records. Because two organizations are involved, there are two sets of patient records. The patient needs to give permission to both organizations to share records and treatment information with each other.

Another challenge is related to public and private insurance payments for care. On the public insurance side, Medicaid pays federally qualified health centers (FQHCs) a higher rate for primary care visits than it pays providers without FQHC status. If a mental health treatment provider has a large percentage of clients who are insured by Medicaid, that providers should look for an FQHC to partner with on an embedded care program.

Managed care and other private insurance plans typically handle physical and mental health care under separate contracts and specify that physical health care is provided in primary care settings and mental health care is provided in mental health care settings. Insurance plans often will not pay for physical health care that is provided outside of a provider's designated office or an urgent care center or hospital. Also, if an insurance plan requires the person to have a primary care physician (PCP), that plan often does not pay for care provided by someone other than the PCP without prior authorization. Embedded primary care programs, therefore, have to be designated as a practice site for a primary care provider. In addition, clients may have to select that primary care provider as their PCP.

Finally, current payment systems do not pay providers for time spent talking with a patient's other health care providers. So in an embedded primary care program, physical health care providers are not paid for time spent coordinating care with the mental health treatment providers, and vice versa.

Unified Care

Another type of integrated care delivery also offers physical and mental health care at one place,⁴² but only one provider organization is involved. That organization has licensed staff that provide physical and mental health care. Unified care programs provide many of the same benefits as embedded primary care programs with added economic efficiency. Multidisciplinary treatment teams provide comprehensive care for all of a client's needs. Most unified care programs also use a single, unified medical record for each client. This allows for enhanced communication between providers and more coordinated care.⁴³

Unified care programs do not have as many funding challenges because payers consider these programs to be qualified physical and mental health providers. Unified care programs also usually see costs savings because of shared administrative, billing, and other functions. One challenge, though, is that some insurance plans won't pay for two encounters with staff of the same organization on the same day. This could happen when a person has both a mental and physical health care appointment on the same day. Although this is more convenient for the patient, it causes problems with insurance billing and payment. Unified care programs need to consider this and find ways to work with insurance plans to receive payment in these cases.

What Can Be Done to Integrate Physical and Mental Health Care

People dealing with the day-to-day challenges of living with severe mental illnesses should not have to face the additional burden of a shorter life expectancy, undiagnosed and untreated physical diseases, and other health disparities. However, research shows that people with severe mental illnesses face significant health disparities and don't get sufficient physical

health care. Integrating mental and physical health care gives people with severe mental illnesses increased access to physical health care and more choices in where they get their care. To support integrated physical and mental health care, individuals, providers, and health care systems can take the following actions.

Individual-Level Steps

People with severe mental illnesses and their families can:

- ✦ get regular physical health checkups
- ✦ advocate for integrated care
- ✦ demand individualized care that is focused on total recovery and wellness, including physical and mental health care concerns

Provider-Level Steps

Mental health care providers can:

- ✦ screen for, assess, and treat high-risk conditions such as heart disease, diabetes, and high blood pressure
- ✦ offer wellness and lifestyle education on nutrition and eating habits, exercise, smoking, alcohol and other drug use, and other physical health conditions
- ✦ screen for, treat, and monitor physical health side effects caused by medications taken for severe mental illnesses
- ✦ include people with co-occurring physical and mental health problems in planning and delivering an integrated care model

Physical health care providers can:

- ✦ work with mental health care providers to offer physical health care to people with severe mental illnesses
- ✦ learn more about severe mental illnesses and how to talk to and work with people with severe mental illnesses

System-Level Steps

The health care system—which includes physical and mental health care—can:

- ♦ recognize and support integrated care as a necessary component of overall wellness
- ♦ require, regulate, and fund mental health care providers to screen for, assess, and mental and physical health conditions

Public and private payment sources for health care services—including insurance companies and federal, state, and local governments—can:

- ♦ pay for physical health services delivered in mental health care settings by licensed

physical health care providers at the same rates as if these services were delivered in a primary care setting

- ♦ provide regulatory and financial support for integration and wellness initiatives for people with severe mental illnesses
- ♦ consider mental health care organizations with licensed physical health care staff to be primary care settings for purposes of payment and treatment authorization

End Notes

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About *Location, Location, Location* & The Health Foundation of Greater Cincinnati

Since 1997, The Health Foundation of Greater Cincinnati has invested over \$100 million to address health needs in the 20-county region surrounding Cincinnati and specifically on access to healthcare. Our series *Location, Location, Location: Providing Physical Health Care in Other Settings to Increase Access* looks at how access to care can be improved by providing healthcare in a place that makes sense for certain populations. The publications in this series include:

- ♦ *Reclaiming 25 Years of Life: Integrating Physical and Mental Health Care to Reduce Health Disparities for People with Severe Mental Illnesses* (October 2008)
- ♦ *A Prescription for Success: How School-Based Health Centers Increase Access to Care for Children* (November 2008)
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