

Health Services 100

Lab 7

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Agenda

- Evaluation
- Mental Health Services
- Elderly/Long-Term Care
- Race and Ethnic Disparities

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What Is Mental Illness?

- “Conditions characterized by alterations in thinking, mood or behavior associated with distress and/or impaired functioning”

Common Symptoms

- Anxiety
 - Fear and dread
- Psychosis
 - Hallucinations and delusions
- Mood disturbance
 - Prolonged sadness or euphoria
- Cognitive impairment
 - Ability to organize, process, and recall information

Mental Illness Is Common

- In any year, 21% of U.S. adults experience a mental disorder
 - 15% have comorbid substance disorders
- 3% suffer from severe and persistent mental illness, e.g., schizophrenia
 - 50% have comorbid substance disorder
- Comparable figures for children and adolescents are 21% overall and 5% with serious emotional disturbance

Mental Illness is Costly

- Mental illness and substance disorders often have early onset, so high lifetime costs
 - Reduced employment and work productivity
 - Increased work absenteeism and disability
 - Violence and motor vehicle accidents
 - Child abuse and teenage pregnancy
 - Marital instability
 - Homelessness

Treatment Costs

- Treatment for mental disorders = \$69 billion, or 7.3% of total care costs in 1996
- Substance abuse treatment = \$13 billion
- Despite the high cost of MH/SA services, often cost-effective because the social costs of psychiatric disorders are so high
- Prevention less of an option:
 - Etiology of psychiatric disorders usually uncertain
 - Little work done on prevention focuses primarily on children

Who Pays for MH Services?

- 52.6% of MH expenditures are publicly funded
 - Medicaid (18.9%)
 - Direct state and local funding (17.3%)
 - Medicare (14.4%)
 - Other Federal funding (2.0%)
- 47.4% paid by private parties
 - Private insurance (26.9%)
 - Out-of-pocket expenditures (17.4%)
 - Other private funds (3.2%)

What is the Money Spent On?

- Of the \$69 billion spent in 1996:
 - 33% psychiatric and general hospital stays
 - 4% residential treatment centers for children
 - 7% nursing home, home health agencies
 - 18% outpatient mental health clinics
 - 10% psychiatrists
 - 5% generalist physicians
 - 14% psychologists and social workers
 - 9% outpatient psychotropic drugs

Deinstitutionalization

- Since 1960s/70s, setting of care has shifted from inpatient to community-based with the “deinstitutionalization” of many long-term psychiatric inpatients
 - Number of psychiatric inpatient days declined by 11.3 million from ‘88-’94
- Theory was that patients would receive community treatment and become independent
- Reality was that the community-based mental health system was inadequate for severe and persistent mental illness

How is MH Care Delivered?

- System fragmented, four sectors:
 - Mental health specialty
 - General medical
 - Human services, e.g., social welfare, schools
 - Voluntary support network
- Informal caregivers also play important role

Utilization ≠ Need

- 15% of adults obtain mental health services each year, but only half have a diagnosable disorder
 - Only one-third of adults with diagnosable disorders get services
 - 4.5% of adults without diagnosable disorder receive services
- 21% of children utilize mental health care
 - More than 50% of children with diagnosable disorders do not receive treatment

Barriers to Mental Health Care

- Fragmentation of financing and delivery system
- Stigma
- Poor geographic access to MH specialists
- Financial constraints due to inadequate insurance coverage
- Failure of healthcare providers to identify the mental health needs of their patients
- Lack of cultural sensitivity

How is MH Different?

- Greater stigma, especially among certain groups, e.g., elderly, ethnic minorities
- Greater information deficits
 - Cognitive and perceptual impairment
 - Lack of family to act as healthcare proxies
- Greater variability due to uncertainty about diagnosis and treatment effectiveness
 - DSM is the only “gold standard” for diagnoses
 - Difficult to standardize psychosocial treatments

How is MH Different?

- Larger role of state and local government in both financing and delivery
- Greater reliance on general medical instead of specialty sector
- Different reimbursement methodology for psychiatric facilities and general hospitals
- Less generous coverage under both private and public insurance programs

Why is Insurance Coverage Worse for MH/SA?

- Stigma
- Moral hazard
- Adverse selection

Moral Hazard

- Moral hazard is much larger for MH services than medical care
- MH costs increase twice as much as medical costs when cost-sharing requirements are lowered
 - May be due to desirability of services among people without clearcut need
- Insurer response is to increase cost-sharing or use “gatekeeping” mechanism

Adverse Selection

- Persons with mental disorders more likely to self-select into generous insurance plans
 - Disorders often chronic and severe
 - Patients have higher medical as well as behavioral health care costs
 - Risk adjustment doesn't work well enough to compensate plans for enrolling sickest patients
- Insurer response is to avoid these patients by offering minimal MH/SA coverage and poor quality in a “rush to the bottom”

Federal MH Parity Legislation

- Federal MH Parity Act of 1996: Plans offering a MH benefit could not have lower annual and lifetime spending limits on MH than medical benefit
 - Number of employers were exempt
 - Did not prevent plans from requiring higher cost-sharing for MH, imposing visit limits, or dropping MH benefits altogether
- Because the Federal law is weak, there has been a push to pass state parity legislation

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Multiple Dimensions of Health

- As the population ages, health deteriorates along multiple dimensions of health:
 - Physical health
 - ❖ Self assessed health, chronic conditions, functioning
 - Mental health
 - Social health

ADLs

- Transferring
- Bathing
- Dressing
- Eating
- Using the toilet
- Walking

IADLs

- Cooking
- Shopping
- Paying the bills
- Using the telephone
- Light housework
- Heavy housework

What Is Long Term Care?

- The array of medical, social, and support services for individuals in nursing homes or in the community, who for an extended period of time, are dependent on others for physical assistance

Or more simply...

- The assistance that is needed to managed as independently and decently as possible when disabilities undermine capacities

Goals of Long Term Care

- Promote and maintain health
- Promote independent functioning
- Promote quality of life

Users of Long Term Care

- Short term users
 - Those with acute injury or illness who will completely recover
 - Temporary functional disabilities
 - Complex care in the short term
- Long term users
 - Multiple physical, mental, and/or social problems
 - Permanent functional disabilities (ADLs, IADLs) increasing with age
 - Differing complexity of care

LTC Provider: Hospitals

- Long term hospital: psychiatric, rehab
- Rehabilitation unit
- Skilled nursing unit
- Geriatric care unit
- Adult day care, hospice, home care, outpatient rehab, etc.

LTC Provider: Nursing Homes

- Types
 - Board and care
 - Intermediate
 - Skilled nursing
- Continuous supervision and/or care

LTC Provider: Home Health

- Homebound
- Skilled Care
 - Nursing care by RN or LVN
 - PT, OT, respiratory therapy, etc.
 - Medical social services, nutrition counseling
- Homemaking/home health aid
 - Personal care, bathing, grooming
 - Cooking, transportation, shopping, cleaning, etc.

LTC Provider: Hospice

- Care for the terminally ill
- To improve quality of life, not to treat
- Continuous comprehensive care
- Accredited and certified
- Care available for 90-180 days
- Cancer patients are predominant
- Medicare and private insurance payers

LTC Provider: Adult Day Care

- Daytime care
- Spectrum of ambulatory and social services
- Fast growing
- Mostly nonprofit and affiliated with other providers of LTC
- Medicaid and private payers
- Licensing and certification not universal
- Older, frail, women, live with others, cognitively impaired clients

What LTC Policies are Needed?

- Adequate clinical information systems
- Better coverage of chronic care
- Better coverage for coordination of care services
- Better patient choice in using LTC
- More information to help make decisions

What LTC Policies are Needed?

- Elderly can't afford their medications
- Prevalence of more disabling conditions
- Heterogeneity of the population
- Lack of comprehensive coverage for some
- More coverage for medical than social long term services

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Evidence of Disparities

- Cancer diagnostic tests, treatment, and pain management
 - Unequal treatment results in higher mortality rates among minorities
- HIV/AIDS care, treatment, and access to Rx
 - African Americans less likely than Whites to receive HAART, protease inhibitors, etc.
 - These differences in care, treatments, and access lead to poorer survival rates among African-Americans

Sources of Disparities

- “Blame the patient...minorities...”
 - Refuse recommended services
 - Adhere poorly to treatment regimens
 - Delay seeking care

Biological

- Human genome project
 - Different races share 99.9% of DNA
 - Greater variations within races than between races

Cultural

- Language needs
- Degree of trust/mistrust of system
 - Familiarity in navigating the system
 - ❖ Governed by years in US, generation
 - ❖ Assimilation, acculturation, bi- or multi-culturalism

Source of Disparities

- “Blame the system...”
 - Lack of interpreters
 - ❖ 14 million LEP
 - Geographic variation
 - ❖ Rural/urban/exurb/suburb
- Providers must use cognitive shortcuts in 10-15 minute encounter
- Stereotypic, prejudice and bias in a cost-containment environment could be sources of disparities

System Reforms

- Increase the proportion of underrepresented US racial and ethnic minorities among health professionals
- Provide greater resources to the US DHHS Office for Civil Rights to enforce civil rights laws
- Structure payment systems to ensure adequate supply of services to minority patients and limit provider incentives that may promote disparities
- Support the use of interpretation services where community need exists

Group Exercise

- Propose a California state program to provide language interpretation services to the Medi-Cal and Healthy Families population
 - Keep in mind state deficits
 - Possibly use non-state governmental funding, e.g., private foundation, etc.