An Avoidable Tragedy – The Relationship of Premature Death and Serious Mental Illness

National Council Fact Sheet - June 2007

New research indicates that people with serious mental illness - which include schizophrenia, bipolar disorder, and major clinical depression – die, on average, 25 years earlier than the general population. Sixty percent of premature deaths in persons with schizophrenia are due to medical conditions such as cardiovascular, pulmonary and infectious disease.

Unfortunately, people with serious mental illness also suffer from a high prevalence of modifiable risk factors, in particular obesity and tobacco use. Compounding this problem, people with serious mental illness have poorer access to established monitoring and treatment guidelines for physical health conditions.

Our nation's healthcare system tends to be fragmented, with increased reliance on specialists who address very focused aspects of the health/illness continuum.

Fragmentation is most notable in the separation between the treatment for mental and physical illnesses. This separation is an artifact of how services have been funded historically, with the preponderance of funding for mental illness treatment coming from states and directed toward state psychiatric facilities that were often - literally and figuratively - far away from the mainstream of medical delivery.

Cardiovascular Disease (CVD) Risk Factors

Modifiable Risk Factors	Estimated Prevalence and Relative Risk (RR)	
	Schizophrenia	Bipolar Disorder
Obesity	45-55%, 1.5-2X RR[1]	26%[5]
Smoking	50-80%, 2-3X RR[2]	55%[6]
Diabetes	10-14%, 2X RR[3]	10%[7]
Hypertension	≥18%[4]	15%[5]
Dyslipidemia	Up to 5X RR[8]	

1. Davidson, S. et al. *Aust NZ J Psychiatry.* 2001:35:196-202. 2. Allison, DB, et al. *J Clin Psychiatry.* 1999:60:215-220. 3. Dixon L, et al. *J Nerv Ment Dis.* 1999:187:496-502. 4. Herran A, et al. *Schizophr Res.* 2000:41:373-381. 5. McElroy SL, et al. *J Clin Psychiatry.* 2002:63:207-213. 6. Ucok A, et al. Psychiatry Clin Neurosci. 2004:58:434-437. 7. Cassidy F, et al. *Am J Psychiatry.* 1999:156:1417-1420. 8. Allebeck. Schizophr Bull. 1999:15(1)81-89.

<u>What Can Be Done to Address this Tragedy?</u>

There are solutions to this epidemic of premature death and morbidity among persons with mental illness. Policy makers can provide the policies, resources, and leadership to close this gap. We will have accomplished this goal when we can say that:

- Adequate funding is available to allow every provider of public mental health services to assess the physical health status as well as mental status of clients served in the public mental health system.

- States are learning from and following the examples of states such as Missouri and Louisiana, which are implementing primary care medical home initiatives with explicit mechanisms and financing integrated treatment between the mental health and primary care providers for coordination of services.

- State legislatures can create the policy infrastructure through statute or regulation to ensure that there is a strong working partnership between community mental health and community health provider organizations. These policies can define roles for these organizations, establish referral protocols, or allow for the cross-placement and reimbursement of clinical staff.

Disease Management: Another Promising Approach

Usual medical care often fails to meet the needs of chronically ill patients, even in managed, integrated delivery systems. The medical literature suggests strategies to improve outcomes in these patients. Effective interventions tend to fall into one of five areas: the use of evidence-based, planned care; reorganization of practice systems and provider roles; improved patient self-management support; increased access to expertise; and greater availability of clinical information. The challenge is to organize these components into an integrated system of chronic illness care. One approach to meeting these goals is through the creation of disease management programs.

Disease management (DM) is an approach to care coordination for individuals with chronic or persistent medical conditions for two important reasons: improved quality of care and decreased cost. Quality is improved because treatment is coordinated across the spectrum of care for individuals with these conditions using evidence-based practice guidelines and education on illness self-management. States have also been able to reduce costs through this approach.

The Centers for Medicaid and Medicare Services (CMS) issued a letter to state Medicaid directors encouraging the adoption of DM. Currently, DM is now widely used in states for asthma, diabetes, hypertension and other persistent medical conditions, and increasingly for enrollees with serious mental illnesses.

Washington State Example

On June 28, CMS approved a state plan amendment (SPA) for Washington State that uses the Benchmark Plan option to offer regular Medicaid State plan services plus disease management (DM) services to adult Medicaid recipients with complex medical needs. The benchmark State plan option provides States with the opportunity to offer an alternative benefit package to beneficiaries without regard to comparability of services, a traditional Medicaid requirement.

Medicaid recipients statewide will be identified by a contractor based on claims history, referred by a provider, or may be self-referred. Eligible recipients include those who are diagnosed with certain chronic medical conditions, including: diabetes, heart failure, coronary artery disease, cerebrovascular disease, renal failure, and chronic pain associated with musculoskeletal conditions and other chronic illnesses, including co-morbid depression and/or anxiety.

In addition to the traditional State Medicaid plan services, individuals enrolled in the DM program will receive assistance in locating a primary care provider ("Medical Home") and additional benefits tailored to specific health needs, including:

- Condition-specific education;
- Access to a nurse call line;
- Regularly scheduled telephonic health care management and support; and
- Care coordination, including feedback to the primary care physician.

For a list of sources or other questions, contact Tammy Seltzer at 301-984-6200 x234 or tammys@nccbh.org

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The National Council for Community Behavioral Healthcare is a not-for-profit, 501(c)(3) association of 1,300 behavioral healthcare organizations. Our members offer medical, social, psychological, and rehabilitation services in community settings to help people with mental illnesses and addiction disorders recover and lead productive lives.