

Chapter 9: Access to Physical Healthcare

The purpose of this chapter is to describe access to physical healthcare for mental health consumers and substance abuse clients, including existing resources, strengths of current programs, and needs. The chapter includes narrative information gathered through focus groups and personal interviews, as well as existing data from state agencies and other sources.

A. Existing Resources and Strengths

The appointment of ODMHSAS Commissioner Terry Cline to the position of Cabinet Secretary for Health in 2004 has been a positive step for ODMHSAS, bringing more exposure and access on statewide issues related to mental health and substance abuse. Dr. Cline's dual appointment also creates a platform from which to heighten awareness and influence activities related to existing healthcare disparities.

In June 2006, the Oklahoma Health Care Authority initiated the O-EPIC Premium Assistance Program, which pays part of the health plan premiums of people who cannot access private health coverage through their employer. This plan extends coverage to uninsured self-employed individuals, workers whose employers do not provide health coverage, workers who are not eligible to participate in their employer's health plan, sole proprietors not eligible for small group health coverage, and the unemployed who are currently seeking work. Many people served by ODMHSAS will be eligible to participate in this program, which has the potential to alleviate the healthcare disparities described above by increasing access to health insurance for people with mental health and substance abuse problems.

Medicaid prescription and inpatient hospitalization benefits were increased in 2004, providing improved access to additional primary health services for service recipients covered. Case management services are used to link clients to medical, vision, and dental services. Other resources available for the non-Medicaid population include the OU Health Sciences Center in Oklahoma City and the OU Tulsa-College of Medicine, which provide indigent medical care. Many communities rely on local resources for health care, such as clinics, homeless clinics, county health departments, and *pro bono* health care providers. Tribal governments, the Indian Health Service, and urban Indian programs also provide health services. Dental services are provided in local communities through free dental clinics and *pro bono* providers, and in the state hospitals. Community mental health centers are encouraged to use flexible funds from ODMHSAS to purchase individual medical, vision and dental services for consumers. There are a growing number of federally qualified health centers in Oklahoma. While the total is still small, their presence should improve access to health care among low income consumers.

B. Needs and Existing Barriers

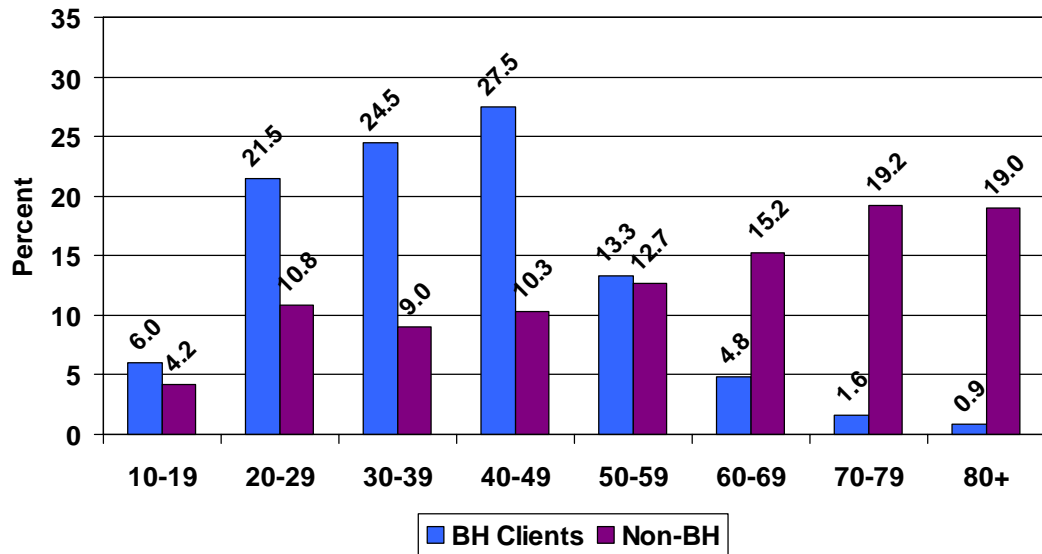
Unmet Needs

To determine why behavioral health clients are hospitalized for physical health problems in Oklahoma, ODMHSAS collaborated with the Oklahoma State Department of Health (OSDH) to study recipients of publicly funded behavioral health treatment and

hospital-based physical health treatment (Moore and Leeper, 2006). Patient-identifying data from the 2002-2003 Oklahoma Hospital Inpatient Discharge Data (HIDD) System were linked to data from the ODMHSAS Integrated Client Information System (ICIS) using probabilistic matching. The HIDD data included discharge records from hospitals providing physical care. Non-state psychiatric hospital data were excluded from the dataset for this analysis. The data from ICIS included records for clients admitted and served from 2000 through 2004 and were split into three cohorts: clients who received mental health treatment only (MH only), substance abuse treatment only (SA only) , and mental health and substance abuse treatment (dual-treated). Of the 127,905 clients who received ODMHSAS-funded treatment from 2000-2004, 26,327 were found in the HIDD data. The rate of hospital discharges among behavioral health clients who received both mental health and substance abuse treatment was 31%, compared to 18% among the general population. The average number of discharges among behavioral health clients was 7.4, compared to 2.0 among people who did not receive behavioral health services.

Evaluation of the demographics of hospitalized ODMHSAS clients compared to non-ODMHSAS hospitalized people found no substantive difference in gender or race. There was a substantive difference in age. The percent of people who received ODMHSAS-funded services peaked at ages 40-49 and declined at older ages, while the rate of those who did not receive services from ODMHSAS steadily increased from younger age groups to the 70-79 and 80 or older age groups (see Exhibit 9.1). These findings indicate that persons age 20-29 who receive mental health and/or substance abuse services are more than twice as likely to be hospitalized for a medical condition as those who do not receive these services. This trend reverses at age 60. This may be due to the fact that individuals who have a mental health or addictive disorder do not live as long as others and that older people are less likely to receive mental health and substance abuse services.

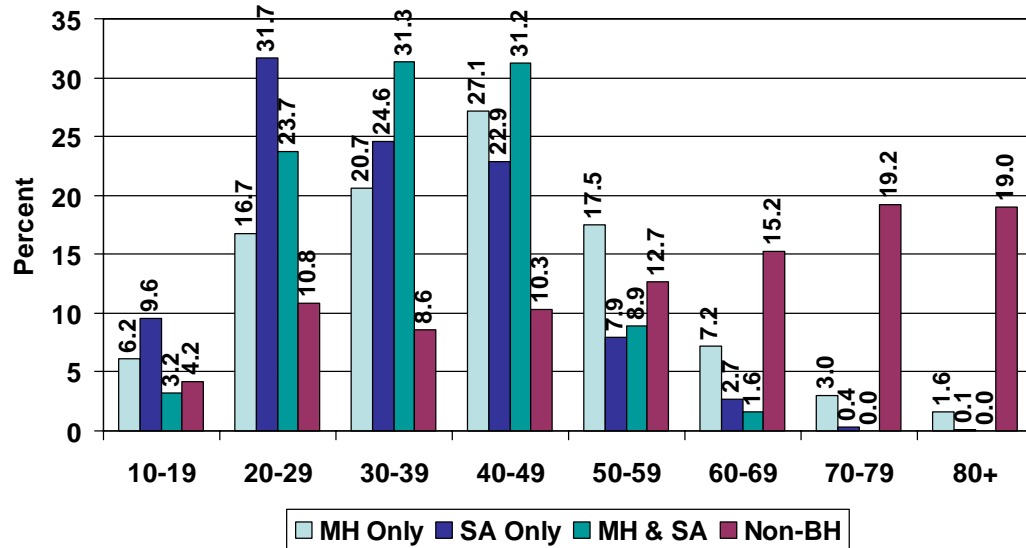
**Exhibit 9.1
Rate of Hospitalization
by Age**



Analysis of age at time of hospital discharge among the cohorts indicated the rate of MH- only clients peaked at ages 40-9, SA-only clients peaked at ages 20-29, and dual-treated clients peaked at ages 30-49, as shown in Exhibit 9.2.

Additional analyses of these data included the principal diagnosis of ODMHSAS clients who were discharged from hospitals compared to non-ODMHSAS clients. As shown in Exhibit 9.3, when comparing ODMHSAS clients to non-ODMHSAS clients, there was a higher percent of clients hospitalized from digestive disorders, injury and poisoning, and symptoms, signs and ill-defined conditions. Digestive disorders include appendicitis, bile duct disorders, cancers, constipation, diagnosis and treatment, diarrhea, and dyspepsia. Injury and poisonings include fractures, sprains and strains, intracranial injuries, internal injuries, injury to blood vessels, and poisoning by drugs, medicinal and biological substances. Symptoms, signs and ill-defined conditions include abnormal results of laboratory or other investigative procedures, and ill-defined conditions for which no classifiable diagnosis elsewhere is recorded

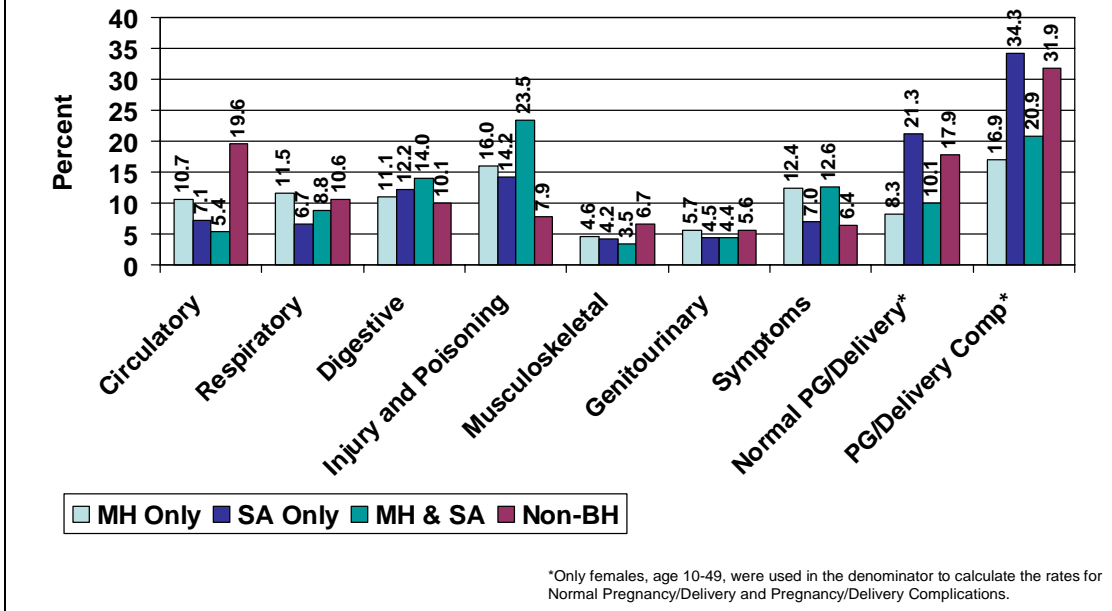
Exhibit 9.2.
Rate of Hospitalization by Age by Cohort



In addition, as shown in Exhibit 9.3, ODMHSAS clients who received mental health services only had a higher rate of respiratory diagnosis than the other groups. Diseases and disorders of the respiratory system can affect any part of the respiratory tract and range from trivial to life-threatening. Examples include laryngitis, bronchitis, asthma, and tuberculosis. Among the people discharged from the hospital in 2002 or 2003, ODMHSAS clients had a higher rate of asthma than non-ODMHSAS clients (MH only, 20.2%; SA only, 18.8%, dual-treated, 27.6%; non-ODMHSAS, 7.8%).

Among the ODMHSAS female clients age 10-49 who received substance abuse treatment only, 21.3 percent were hospitalized for normal pregnancy or delivery, compared to 17.9 percent of females of the same age who did not receive ODMHSAS-funded services. In addition, 34.3 percent of the ODMHSAS female clients age 10-49 who received substance abuse treatment only were hospitalized for pregnancy or delivery complications, compared to 31.9 percent females of the same age who did not receive ODMHSAS-funded services. Additional analysis of these data revealed that the primary reason for the complications was an addictive disorder.

**Exhibit 9.3.
ICD-9 Principle Diagnosis
Top Categories for Hospitalizations**



Policies

Many adults receiving services in the mental health and substance abuse systems have little or no access to physical healthcare or to vision, dental and hearing services. While there are some linkages in place, ODMHSAS lacks a comprehensive policy to assure that its clients get the medical care they need. Because research shows that people with mental health and substance problems have more physical health problems than the general public, and that many psychiatric drugs put patients at higher risk of obesity, diabetes, heart disease and other illnesses, this is a major policy concern.

As focus group participants pointed out, a large percentage of the Department’s clients have no health coverage at all, due to a number of state and federal policies. Single adults without children are not eligible for Medicaid in Oklahoma, and federal policies bar people with substance abuse disorders from receiving Medicare unless they have an additional disability. For people with psychiatric disabilities, it often takes two years or more to receive Medicare after application. Many mental health and substance clients who are employed work at low-wage jobs that do not offer health insurance. Clients in these categories currently rely on an inadequate patchwork of hospital charity care, free clinics, Community Health Centers, university clinics, and local charities for their health care needs.

Practices/Services

Family members, consumers and providers all reported that access to medical care was difficult if not impossible for many consumers. While this is clearly most acute for people with no private or public insurance, it was also cited as an issue for people on

Medicaid, and in some communities, for people with Medicare. Some consumers with no insurance rely on federally funded Community Health Centers (CHCs), but many noted that access is not guaranteed: “There’s no public transportation [to the CHC], so many of us have a hard time getting there. You have to get there first thing in the morning or you don’t get in, and you may have to wait all day to be seen. They use a sliding scale payment system, and some people can’t even afford this.” In one focus group, more than 75% of the consumers reported that they had urgent needs for dental care, and that they relied on a university dental clinic that had a 6-8 month waiting list.

The Medicaid program in Oklahoma offers very limited vision and dental care, so even consumers with Medicaid must rely on the Lions and other local charities for vision care, and on widely scattered free dental clinics, most of which provide only extractions. Many people with Medicare reported no problems accessing physical health care, but in some communities, there are no providers willing to accept new Medicare patients.

Providers serving homeless people noted that medical hospitals often discharge people to shelters who have serious, even life-threatening illnesses, including people with amputations and those recovering from heart surgery; one shelter staff reported that a person with a tracheotomy was sent to the shelter from a hospital with no oxygen supply. Shelters are not equipped to serve people with such serious medical needs, and staff said that there are no facilities willing to serve these individuals.

A staff member noted that there is a system-wide need for better integration of physical health care and fitness with mental health services. Her colleagues in the focus group added that the mental health system does a poor job of ruling out physiological causes for behavioral symptoms, and may be treating people for psychiatric problems who really have a physical illness.

References:

Moore, B. and Leeper, T. (2006, May 31). *Linking Behavioral and Physical Health Records to Evaluate Co-morbid Conditions*. Presented at the 2006 Joint National Conference in Washington, D.C.