

Allegheny County HealthChoices Program Dual Diagnosis Report

presented by



306 Fourth Avenue, Pittsburgh, PA 15222
Phone: 412/325-1100 Fax 412/325-1111

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HealthChoices Behavioral Health Program Focus Quality Review:

Persons With A Dual Diagnosis

Prepared by
Allegheny HealthChoices, Inc.

Introduction

The challenges that providers encounter as they attempt to understand the needs of consumers and develop a treatment plan are significantly increased if the consumer has both a mental health and a substance abuse condition (dual diagnosis). Providers are encouraged by professional colleges and managed care organizations to follow practice guidelines for care developed for a number of disorders. Guidelines are available for many mental health or drug and alcohol illnesses; however, such guidelines may not address both conditions simultaneously. In addition, guidelines may not address the consumer's unique cultural, ethnic, or religious values. As a result, the consumer's needs may remain unmet or inadequately met. This problem is exacerbated by the historic lack of coordination of funding and treatment for these conditions in addition to the lack of agreement on the part of professionals regarding best practices.

Behavioral Health-Managed Care Organizations (BH-MCO) also face a variety of operational challenges in the areas of clinical, administration, and information systems. To address these challenges, the BH-MCO needs to have the ability to customize their coordination of outreach activities, intentionally communicate the plan of care, and proactively initiate contact. Other challenges pertain to the management of information systems and related confidentiality regulations. For example, some detailed information can only be monitored in the aggregate rather than at the consumer-level.

Additionally, people dealing with a dual diagnosis of mental illness and substance abuse confront many challenges, including the diagnosis of both conditions. The literature suggests that while 45-48% of people may have both mental illness and substance abuse issues, detection of dual diagnosis is low and often under reported. For example, in a 1999 study, the staff of a university hospital emergency room identified substance abuse problems in 2% of people with a mental illness. The same study found that the state hospital staff detected a 15% occurrence.¹ Another study confirms under reporting and suggests that reporting accuracy can be influenced by four variables: the consumer's state of sobriety at the time of the assessment, factors that enhance or detract from

¹ Wolford, G.L., Rosenberg, S.D., Drake, R.E., Muser, K.T. Oxman, T.E., Hoffman, D., Vidaver, R.M., Luckoor, R., & Carriere, K.L. (1999). Evaluation of Methods for Detecting Substance Use Disorder in Persons with Severe Mental Illness. *Psychology of Addictive Behaviors*, 13, 313-326.

accurate reporting (i.e. degree of rapport, confidentiality, etc.), short term motivation (i.e. fear of judgmental attitudes, threats, etc.), and the cognitive ability of the consumer (i.e. attention impairment, verbal comprehension, etc.).²

Diagnosing a person with a dual diagnosis condition can also be difficult since one condition may drive the other, cause exacerbation of symptoms, and/or mask the other condition. A person may present with an immediate need for detoxification, thus focusing on the drug and alcohol condition. However, the chemical abuse may have been brought on in an attempt to self medicate depression, anxiety, or negative symptoms of a mental illness. Likewise, it may be difficult to determine if a person with psychosis is experiencing chemical-induced hallucinations or if the hallucinations are a result of a mental illness. These symptoms may manifest several-fold in individuals with severe and persistent mental illness and substance abuse.

The barriers encountered by providers, BH-MCOs, and consumers are easily identified; however, the terminology used to describe this group of individuals is not as apparent. For the purpose of this report, the term dual diagnosis is used to represent individuals with a coexisting mental health and substance abuse disorder. The term MISA refers to a subset of the dual diagnosis population and describes people with *severe* and *persistent* mental illness as well as substance abuse issues.

This report concentrates on the broader definition of the dual diagnosis population, focuses on their needs versus their utilization patterns, and identifies some of the underlying barriers to providing effective care. Persons within the dual diagnosis population were compared to people who exclusively had a mental health diagnosis or a substance abuse diagnosis. Based on current literature, AHCI's assumption is that the service utilization patterns and expenditure should be different for persons within the dual diagnosis population, as compared to the mental health and substance abuse populations.

AHCI also compared the diagnostic and utilization findings to the *1999 Mental Health: A Report of the Surgeon General*. The report is the first of this nature from the Surgeon General and includes numerous studies and statistics that reinforce the breadth and scope of the problems underlying the management of care for the dual diagnosis population. Although some of the report's conclusions do not apply to the Medicaid population, the factors influencing the incidence of behavioral health issues, utilization patterns, and service access help to qualify the discussion.

AHCI's analysis revealed that adults with dual diagnosis represented 30% of the total adult consumers analyzed for this report; however, they utilized nearly half (52%) of the total expenditure. The diagnoses most common among the three populations were schizophrenia, bipolar disorder, major depression/depressive disorder, and opioid, alcohol, and cocaine abuse. The mix of services utilized by adults of all three

² National Institute on Drug Abuse Research Monograph, No. 172. *Treatment of Drug-Dependent Individuals With Comorbid Mental Disorders*, January 2001

populations was similar. Supplemental services represented 4% of services used by adults within the three populations.

During AHCI's initial analysis, several information system issues unfolded. The function of identifying persons within the three focus populations was somewhat difficult because of the lack of data in the clinical information system. These technical issues are outlined briefly on the following pages and contribute to the inability to precisely identify individuals within the dual diagnosis population. Furthermore, the technical issues factor into the integrity of related reports. AHCI strongly recommends that the technical issues be addressed in cooperation with Community Care and the County.

Defining the Data

The timeframe for this focus study is the 12-month period beginning January 1, 2000 and ending December 30, 2000. The people included in this report are those with one or more paid claims during the time period and are referred to as consumers.

Three distinct populations are presented based on the presence of diagnoses contained in PsychConsult. These populations are as follows:

- Dual Diagnosis (DD);
 - Any consumer with the presence of both mental health and substance abuse diagnoses in PsychConsult.
- Mental Health (MH);
 - Any consumer with the presence of only mental health diagnoses in PsychConsult.
- Substance Abuse (SA);
 - Any consumer with the presence of only substance abuse diagnoses in PsychConsult.

Service utilization information for the adult consumers in the focus study was taken from paid claims. This presents a more accurate picture of what HealthChoices services have been utilized. Authorization data shows only what services have been approved. Submitted claims are, in essence, verification that services were actually utilized.

As previously stated, information systems issues emerged during the process of identifying the study populations. Specifically, there were consumers who did not have a diagnosis entered into PsychConsult (Community Care's care management information system), but had a paid claim for behavioral health services.³ This represents 9% (1,445) of the total (unadjusted) number of adult consumers and 3% of the total expenditure. In an effort to

³ A diagnosis on the claim document is sufficient to pay a claim. The payment process does not require a matching diagnosis in the PsychConsult system.

improve the reliability of the data used for this report, calculations within the body of the report are based on an adjusted denominator that excludes the number of consumers and the dollars paid for services rendered to individuals without a diagnosis in PsychConsult.

Another issue AHCI identified during analysis was payment for services that did not appear to match the diagnostic population. For example, a person with only a diagnosis of major depression received outpatient drug and alcohol services. Another example is a person with a diagnosis of opioid dependency who received outpatient mental health services. While people should receive the necessary services to treat their illness/es, these examples speak to the integrity of some of the diagnostic information.

There were also a number of consumers within PsychConsult who were not assigned a tier level (tier levels are defined in Appendix A).

Given these issues, the analysis that follows is based on the following caveat. Trends identified in the report may be affected by an incomplete data set, including the under reporting of substance abuse conditions as compared to figures on prevalence found in the research literature.

Utilization by Diagnostic Populations

The following is an analysis of HealthChoices consumers by diagnostic population who accessed services during the study period. It represents only adult consumers, defined as persons 18 years or older, who had one or more paid claim(s) and a related diagnosis.

For the 12 months studied, Community Care paid claims totaling \$41,923,824 on behalf of 14,141 adult consumers. This is an average of \$2,965 per consumer.

The mental illness/substance abuse population represented \$21,563,573 of expenditure for a total of 4,253 unduplicated consumers. The average cost per consumer for this population was \$5,070.

A total of \$16,830,435 was paid for services utilized by 8,366 consumers within the mental health population. An average of \$2,012 was spent on each consumer, the lowest cost per consumer of the three populations.

The substance abuse population (1,522) had the lowest total expenditure, \$3,529,817, and an average of \$2,319 per consumer.

Chart 1.0
Percent of Adult Consumers by Diagnostic Population

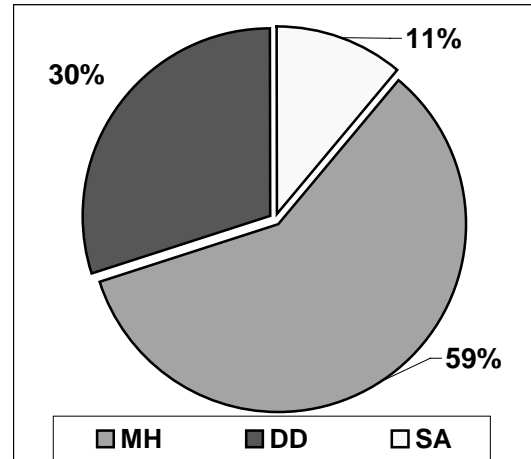
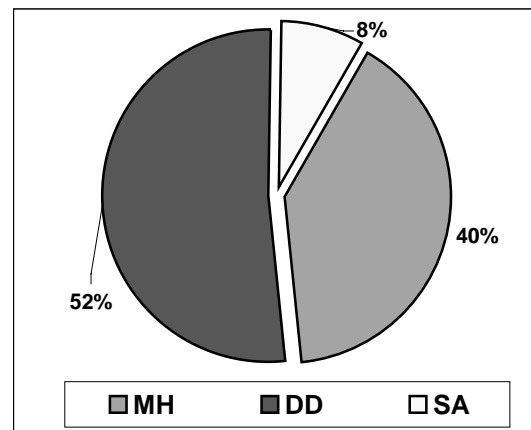


Chart 1.1
Percent of Total Expenditure by Diagnostic Population



Charts 1.0 and 1.1 compare the percent of total consumers to the percent of total expenditure for each diagnostic population.

Comparing and contrasting the two charts clearly illustrates that a larger percent of total dollars were spent on services for individuals identified as having more complicated conditions. AHCI would expect to see a larger gap between the number of consumers and the dollars spent on the dual diagnosis population. The dollars spent on the substance abuse population is nearly equal to the percent of consumers. However, the dual diagnosis population, which represents 30% of

total consumers, utilized 52% of total expenditure. Conversely, the mental health population, which represents 59% of total consumers, utilized 40% of total expenditure. This translates into a higher average cost per consumer for the dual diagnosis population.

Demographic Overview

When comparing the three populations in the study, AHCI found that the 22-44 year age group was the largest age group for all three populations. Dual diagnosis (53%) and mental health (69%) populations were predominantly composed of Caucasian consumers. The substance abuse population was 50% African American and 50% Caucasian. Female consumers utilized 66% of services within the mental health population, 55% within the dual diagnosis population, and 49% within the substance abuse population.

This compares with the overall utilization statistics for adults during the study period, most of whom were identified by the following demographic characteristics:

- 22-44 years of age (58%);
- Caucasian (60%);
- Female (61%); and
- Tier Three (66%).

AHCI also analyzed the three populations by tier assignment, as illustrated in Table 1.0. (Refer to Appendix A for a definition of the tier levels.)

Table 1.0

Tier Assignments Within the Three Diagnostic Populations

Tier	Dual Diagnosis	Mental Health	Substance Abuse
Tier One	25%	5%	<1%
Tier Two	31%	13%	67%
Tier Three	44%	82%	32%

The distributions of tier assignments vary across the three diagnostic populations. The percent of consumers assigned to Tier One is substantially larger for the dual diagnosis population than the other populations. This may be due to the complexity of managing coexisting conditions. For example, these individuals may be at greater risk for involuntary admissions to the state hospital system if both illnesses are not adequately identified and addressed. However, a prolonged stay or delay entering the system, by definition, may categorize them into Tier Two even though they may require the same intensity of services as a Tier One consumer.

Tier assignment distributions are significantly different for the mental health and substance abuse populations. The finding that 67% of people in the substance abuse population were assigned to Tier Two, by definition, conflicts with the presence of only a substance abuse diagnosis. Tier Two was designed for people with severe and persistent mental illness and one inpatient mental health admission. Community Care acknowledges that they have had difficulty in adequately assigning consumers with a substance abuse diagnosis to tiers.

Service Utilization by Diagnosis and Race

The information presented in this section reflects the expenditure, number of consumers, and cost per consumer as related to the diagnoses present on the claims submitted. The mental health diagnoses most prevalent for HealthChoices consumers in the three diagnostic populations were schizophrenia, major depression/depressive disorder, and bipolar disorder. A study conducted by the National Institute of Health found mood disorders, anxiety disorders, personality disorders, and psychotic disorders as the most common mental illnesses.⁴

The substance abuse diagnoses most prevalent for the three diagnostic populations were alcohol, cocaine, and opioid dependence/abuse. While the order in which the mental health and substance abuse diagnoses appear in each population varies, these diagnoses consistently represent the highest in terms of expenditure, number of consumers, and average cost. These findings are consistent with AHCI's assumptions since these diagnoses have been among the most common clinical diagnoses since the inception of the HealthChoices program.

The Surgeon General's Report cited evidence that socioeconomic factors such as income, training, education, and occupation influence the risk of mental illness. Individuals within the lowest socioeconomic strata are two and a half times more likely than persons in other strata to experience behavioral health problems. Stress and vulnerability to secondary poverty may increase the likelihood of mental illness, and was most often observed among African Americans included in the study.

Given this information, AHCI analyzed the difference between the percent of consumers by race for the top diagnoses of the three populations. The distribution patterns by race were similar for consumers within the dual diagnosis population. In contrast, the difference in the distribution by race for the other two populations was pronounced, as is illustrated in Charts 1.2 and 1.3.

Chart 1.2
Percent of Consumers Accessing Services Within the Mental Health Population

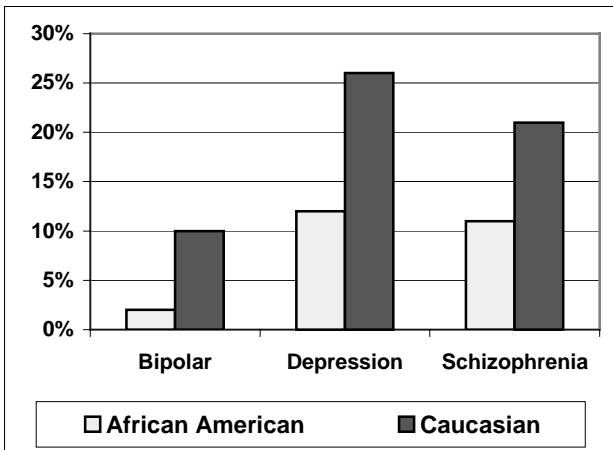
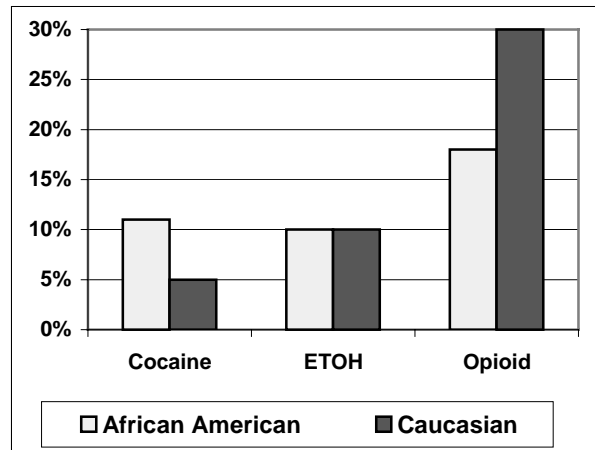


Chart 1.3
Percent of Consumers Accessing Services Within the Substance Abuse Population



Key:
 ETOH: Alcohol Abuse

⁴ U.S. Department of Health and Human Services. Treatment Improvement Protocol, Series 9. *Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse*. 1995

The charts clearly illustrate a disparity by race for the diagnoses with the highest volume within the mental health and substance abuse populations, with the exception of alcohol abuse. However, the relationship is the reverse of that described in the Surgeon General's Report. This may be because the study population in the Surgeon General's Report included people at all socioeconomic levels. Charts 1.2 and 1.3 represent only individuals that meet the poverty criteria as defined by the State for Medicaid eligibility.

Other contributing factors that may explain the racial differences include: cultural perspectives on illness and treatment, availability of suitable services and providers, and the methodology of identification. For example, African American people tend to seek help from non-traditional, community-based providers, faith-based providers, or care from their primary care provider.⁵ Others may decline group, individual, or medication therapy but agree to other programs. It is imperative that providers assess cultural values and the impact that they may have clinically, and in terms of the treatment plan and outcomes.

Service Utilization by Category of Service and Race

Service utilization was analyzed looking at services that were the most commonly accessed and represented the largest percent of paid claims for the study period. The findings were similar to the analysis of diagnostic populations by race. Individuals within the dual diagnosis population had the highest utilization. Utilization by race (African American and Caucasian) within this population was equitable. This is contrary to overall service utilization since the inception of the HealthChoices program. The services this population utilized most included: intensive case management, inpatient mental health, halfway house, and non-hospital rehabilitation.

Likewise, the services utilized most by the substance abuse population were accessed equally by race. These services included outpatient drug and alcohol and non-hospital rehabilitation services. The one exception was the utilization of methadone maintenance, which more African American consumers utilized than Caucasian consumers.

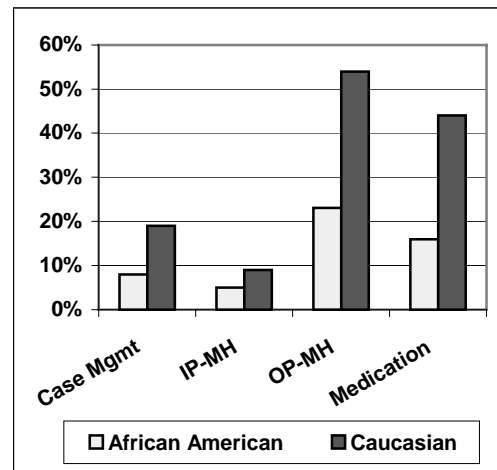
The greatest difference was in the services accessed by persons within the mental health population as seen in Chart 1.4 on the following page.

⁵ U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*, 1999

The Surgeon General’s Report claimed that many African American consumers often develop physical symptoms related to their mental illness and seek help from their primary care physician or a faith-based provider. This may explain why fewer African American consumers utilized outpatient mental health services as compared to Caucasian consumers.

It could also explain the low percent of African American consumers with medication checks. If African American consumers receive care from their primary care physician (including medication), they would not appear in the behavioral health data. Another possible explanation is that these consumers are not using medication as a course of treatment. Research suggests that medication is not a preferred treatment regime for many African American people.

Chart 1.4
Percent of the Mental Health Consumer Population Who Accessed Outpatient Services



Key:
Case Mgmt: Case management
IP-MH: Inpatient mental health
OP-MH: Outpatient mental health
Medication: Medication check

In contrast, The Surgeon General’s Report stated that African American people tend to utilize more inpatient behavioral health services by accessing them through the emergency room or crisis services. AHCI did not observe this finding with any of the three populations in the study. The range of utilization of emergency room and crisis services was 1-6% for the three populations, with Caucasian consumers accessing on the average of one to two percentage points more than Africa American consumers.

Supplemental Service Utilization by Adults

Supplemental services are services purchased by Community Care to augment the in-plan services. These services may be used to decrease the length of stay for intensive services. The supplemental services utilized by adult consumers were: community residential; drug and alcohol partial hospitalization; mental health outpatient practitioner; and targeted case management.

The total adjusted expenditure for supplemental services was \$1,571,716. This represents 4% of the total adjusted expenditure for the 1,126 adult consumers who utilized supplemental services. The average cost per consumer varied widely by population:

- Mental health population: \$2,713/consumer;
- Dual diagnosis population: \$1,344/consumer; and
- Substance abuse population: \$872/consumer.

The quantity of services accessed is small compared to the potential use. Supplemental services such as targeted case management have been shown to increase the individual's daily functional capacity, residential stability, and independence. Yet, two consumers for a total cost of \$204 used targeted case management. Substantial opportunity exists for expanding the use of supplemental and other non-traditional services given the cultural preferences previously discussed.

Conclusions

The struggle continues as the behavioral health system attempts to identify and provide treatment for persons with a dual diagnosis. Recognizing the limitations, AHCI believes that it is important to concentrate efforts on two domains.

The first domain is a fundamental understanding of what constitutes a cohesive approach to the identification, assessment, and treatment of persons with a dual diagnosis. People within the dual diagnosis population have different utilization patterns, have a high percent of the total expenditure, and may require more intensive levels of service. The Surgeon General's Report notes that early identification and coordination of services is a mechanism of primary prevention. One of the report's recommendations was targeted at providers and managed care organizations screening and identifying all individuals for both mental health and substance abuse disorders.

Additionally, the issue of engagement for consumers is also important. Involving the consumer in developing the treatment plan can avert engagement problems. Successful engagement is more likely if the consumer's basic needs are met (shelter, food, relationships, etc.). Maximizing the use of non-traditional services, base services, and services provided through the reinvestment plan may also enhance engagement and reduce the challenges that this at-risk population encounters.

The second domain is data collection mechanisms. Reporting and tracking should be a multi-faceted function that can be improved through provider education and communication between the providers and their funders. Issues of data integrity and the efficiency of data collection also need to be considered if identifying the dual diagnosis population and developing best practice standards that target their total needs is to be accomplished effectively.

AHCI acknowledges that addressing the needs of people with a mental health and substance abuse diagnoses extends beyond Allegheny County to a national level. Furthermore, there are no easy fixes for an issue that impacts consumers, family members, and providers – whole systems of care.

Appendix A

Tier Definitions

The definition of each adult tier is as follows:

- According to Community Care's tier system, Tier One (T1) consumers are the highest priority and include consumers who have had three or more inpatient episodes of care, are in a level of care other than outpatient, and have a diagnosis consistent with the Department of Public Welfare (DPW) standards for Serious and Persistent Mental Illness (SPMI).
- Tier Two (T2) includes those who have a diagnosis of SPMI, one inpatient episode, and belong to either the Social Security Income (SSI) or Federally Assisted Medical Assistance for General Assistance Recipients (FGA) categories of aid.
- Tier Three (T3) represents consumers that receive outpatient services. These consumers may have one or two inpatient episodes, but do not meet the rest of the criteria for Tier Two.