MINNESOTA COUNCIL of HEALTH PLANS

FEBRUARY 2008

A report from the Minnesota Council of Health Plans

Minnesota's Mental Health

Executive Summary

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Overview

In an effort to create a more comprehensive view of mental health care in Minnesota's managed care environment and report information that can spur improvements in care, the Minnesota Council of Health Plans collected and analyzed data from our member health plans to answer the questions:

- How many people have received a mental health diagnosis? Is there a difference between people who are enrolled in a plan all year and those who have gaps in coverage?
- What are the most frequent diagnoses? What do the data tell us about age and gender differences?
- What medications are most frequently used in the treatment of mental health diagnoses?
- What health services do people with mental health diagnoses use and what are the costs?
- In general, what do the data tell us and what can we learn about caring for Minnesotans who have mental health diagnoses?

First, we'll share with you important facts about mental illness.

Next, we'll outline our findings that have an impact on youth and seniors. While people of all ages have mental health diagnoses, the young and the old are especially at risk for mental illness.

To wrap up the report, we step back and take a broad look at our questions above about mental health diagnoses and use of services among members of our health plans. Here, you'll see age and gender differences that are consistent with national research, yet provide specific information about enrollees in Minnesota's health plans.

While much of the data lead to questions that require further discussions, this report is a step toward raising awareness and improving care for people with mental illness. The information is being shared with mental health practitioners, other health care providers, organizations working to improve the mental health care system and the community at large.

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Work is already underway by health plans and others to improve care for people with mental illness. A few examples of these efforts include:

- Health plans together provided $3.5 million in grants to community-based organizations through the establishment of the Community Mental Health Fund administered by the Minnesota Community Foundation.
- DIAMOND (Depression Improvement Across Minnesota – Offering a New Direction) initiative is working to identify a best practice model for depression care and then propose options for implementing the model throughout the state.
- MMHAG (The Minnesota Mental Health Action Group) is a coalition of consumers, advocacy groups, mental health professionals, mental health clinics, hospitals, health plans, state and local government leaders and others who are working together to solve problems and make improvements in mental health services. The initial work of MMHAG was to review dozens of past reports and studies, and the task force found much agreement on the major problems with the mental health system. The group then set out to create solutions to the problems.
- Depression prevention programs designed to identify members who are at risk and to offer support to members with mild, moderate, severe and complex cases of depression. This systematic approach to deliver evidence-based care for behavioral health conditions mirrors the approaches to preventing and treating other chronic conditions.
- Education and support through personalized depression management programs and personalized assistance lines that give members information, resources and referrals so they receive the support that will be most helpful to their personal needs.
- The MACSSA, Minnesota Association of County Social Service Administrators, work together with the county at the point where county and health plan work intersects. The group tackles many issues and concerns in order to create a system that is focused on individual patients, not the organizations that do the work.
- Access has been expanded to mental health practitioners, through increased payment rates to mental health specialists, foundation grants to create telemedicine communication systems and projects related to behavioral health care service interventions, accessibility and sustainability.

Members of MCHP involved in this work include:

- Blue Cross Blue Shield of Minnesota/Blue Plus
- FirstPlan of Minnesota
- HealthPartners
- Medica
- Metropolitan Health Plan
- PreferredOne
- UCare

Thanks to MCHP members, the claims data (no medical charts were reviewed) on 2.5 million members anonymously aggregated and analyzed for this report provide a broad overview of mental health treatment and diagnoses in the state. All medication use rates are based on members who had drug coverage as part of their benefit. It is important to note, that the report does not include data on any of the more than 112,600 people who receive their mental health care directly from the state or county. Of course, the report does not include data on other individuals who do not have health care coverage through MCHP members.

All data used in this report are from services provided in 2005 and rates are calculated on members who were enrolled for the entire year, unless noted. For more details on the source for the data and how it was collected, see pages 33 and 34.

Julie Brunner,
Executive Director
Minnesota Council of Health Plans

Minnesota Council of Health Plans

Summary of key findings

This report on mental health by the Minnesota Council of Health Plans is one of the most comprehensive assessments in Minnesota of the diagnosis and treatment of mental health conditions in the state. The study anonymously aggregated and analyzed claims data (no medical charts were reviewed) for 2.5 million members of Blue Cross Blue Shield of Minnesota, FirstPlan of Minnesota, HealthPartners, Medica, Metropolitan Health Plan, PreferredOne and UCare.

The Council study sought to determine how many people have received a mental health diagnosis, the most frequent diagnoses, age or gender differences, medication use and cost of care. The report is intended to provide greater understanding of mental health in our state and to further our collaborative work with others to improve mental health care.

Key findings

1. Nearly one in 10 children and adolescents age 20 and younger in Minnesota has a mental health diagnois. The most common diagnosis is attention-deficit/hyperactivity disorder, followed by depression and anxiety.
2. Ninety-seven percent of children receiving antidepressants do not receive follow up care recommended by the FDA.
3. One of 15 people with a mental health diagnosis received emergency or hospital services, which are more costly than other services.
4. Seniors who are diagnosed with a mental illness are taking three or more drugs that are potentially dangerous for elderly patients because of their adverse effects in older people, according to the Archives of Internal Medicine.

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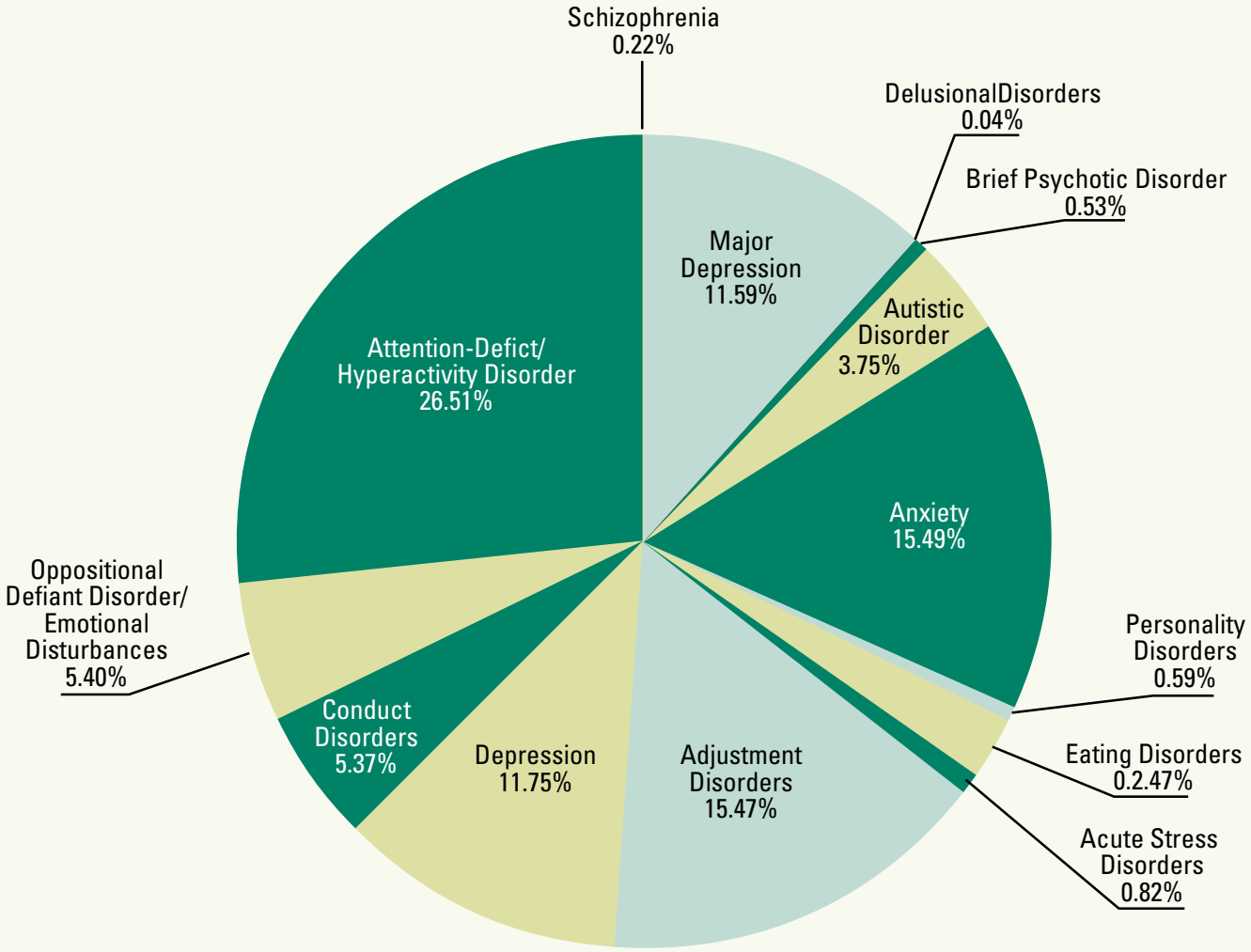
Key finding 1

Nearly one in 10 children in Minnesota has a mental health diagnosis.

Nearly one in 10 children and adolescents in the state has been diagnosed with a mental health condition. The most common diagnoses are attention-deficit/hyperactivity disorder and depression. This is similar to national rates.[1]

Mental Health Diagnosis Among 0 to 20 Year Olds

2005



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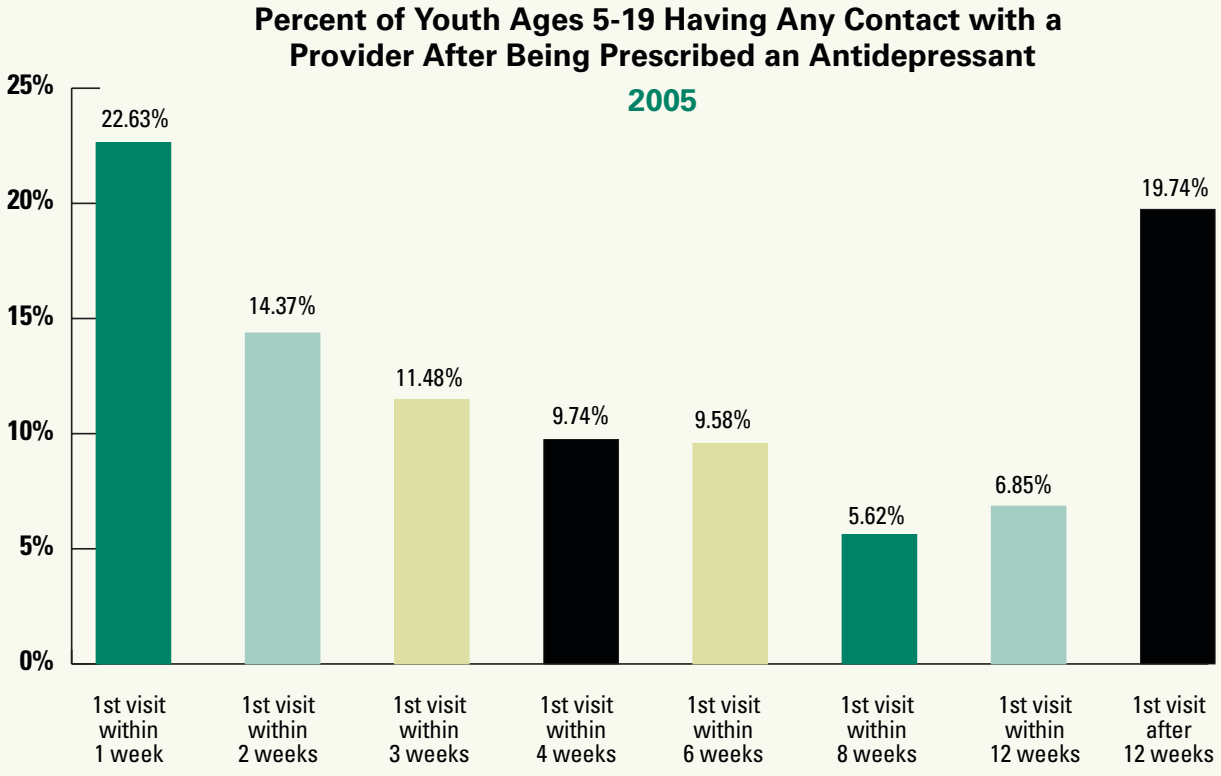
Key finding 2

97 percent of children receiving antidepressants do not receive follow-up care recommended by the FDA.

In 2004, the Food and Drug Administration issued a warning that use of antidepressants by children and adolescents increased the risk of suicidal thoughts and attempts. The FDA warning included recommendations that youth who are prescribed antidepressants should be observed for clinical worsening, thoughts of suicide or attempts, and unusual changes in behavior. The FDA took the additional step in the warning to recommend that observations include face-to-face contacts at regular intervals following diagnosis and use of antidepressant medications. A subset of the data in the MCHP study showed that fewer than 3 percent of youth who had filled prescriptions for antidepressants received the recommended follow-up care and 32 percent did not have a face-to-face visit with a health care provider until after six or more weeks after being prescribed an antidepressant.

Pecent of youth receiving FDA recommended care.

- 2.96 percent received at least one visit weekly during the first four weeks of treatment
- 2.25 percent received at least one office visit every other week the next four weeks
- 2.6 percent received at least one visit at 12 weeks



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Key finding 3

One of 15 people with a mental health diagnosis visited an emergency room or was hospitalized at least once during the year. This care is the most expensive.

In 2005, health plans spent nearly $611 million for mental health care on individuals who were enrolled with the health plan throughout the year. These costs included medications, emergency room visits, hospitalizations and outpatient services. Most of the cost went to medications ($251.2 million); however, hospital care ($143.1 million) and emergency room services ($11.4 million) each accounted for 7 percent of member care – the two most expensive treatment options.

Summary of hospital and emergency room useby individuals with a mental health diagnosis [2005]

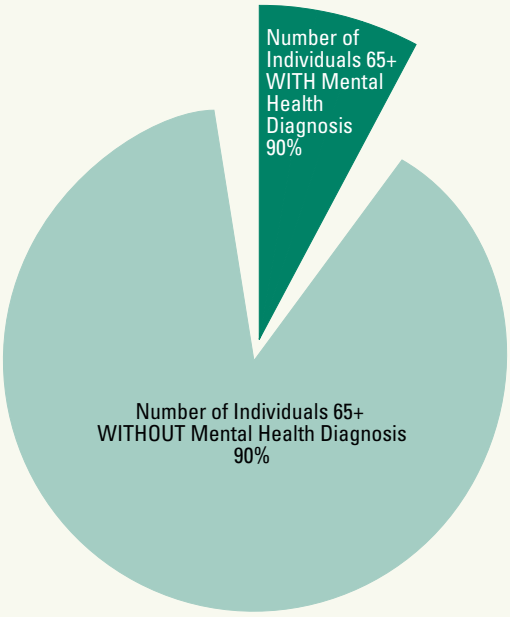
Service	# of individuals using service	% of individuals using service	$ spent on service for members enrolled throughout the year
Emergency room	17,851	6.51%	$11.5 million
Hospitalization	18,104	6.60%	$143.1 million

Key finding 4

Seniors who are diagnosed with a mental illness are taking three or more drugs that are potentially dangerous for elderly patients, according to the Archives of Internal Medicine.

Ten percent of people age 65 and older have mental health diagnoses. Those seniors are taking an average of 3.5 psychotropic medications including antipsychotic, sedatives, antidepressants and antianxiety. These drugs are included on the Beers List Set Criteria for the Safe Use of Medication from the Archives of Internal Medicine.[2] The Beers List identifies 48 individual medications to avoid in older adults. Although the list can be somewhat controversial, it is nonetheless important to understand the drugs being prescribed to older adults. In addition, the FDA issued a public health advisory in 2005 regarding the use of anti-psychotic medications used to treat elderly patients with dementia.

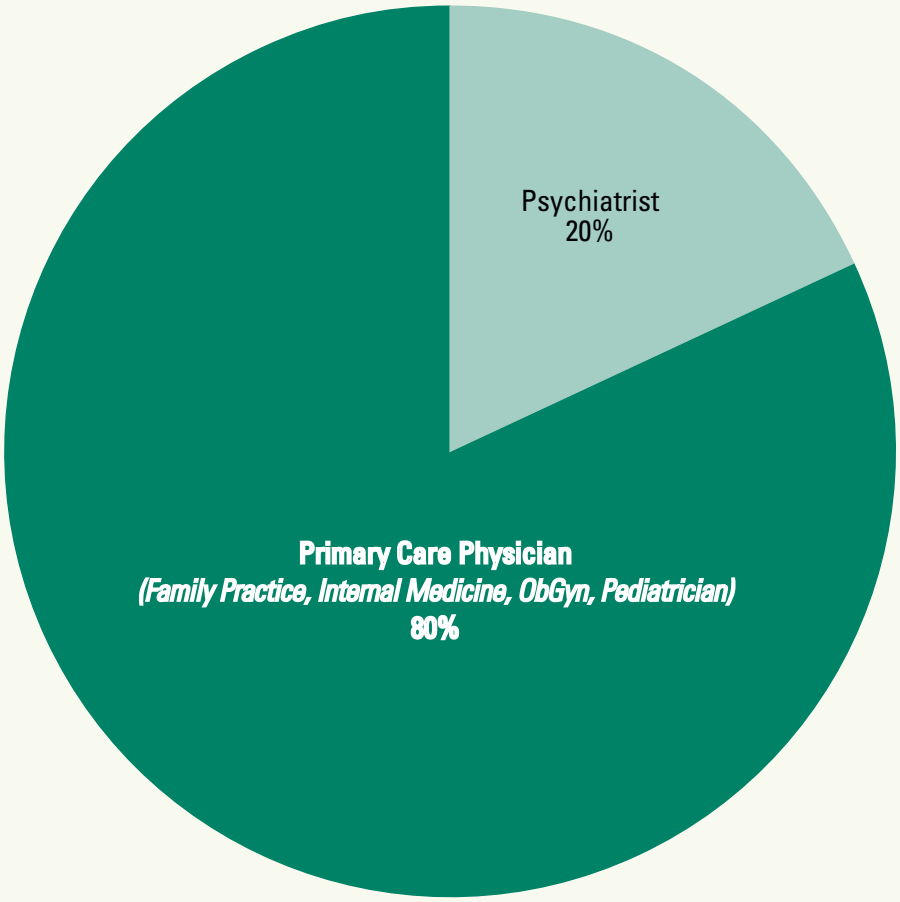
Percent of Seniors 65+ with a Mental Health Diagnosis



Other findings

- A subset of the data showed that more than 80 percent of the drugs used to treat mental illness in Minnesota are prescribed by primary care physicians in family practice, internal medicine and ob/gyn; 20 percent are prescribed by psychiatrists.

Licensure of Physicians Who Prescribe Mental Health Medications



- Of people with employer-based or individual coverage 12 percent have a mental health diagnosis, of the people covered through Medicare, 10 percent have a mental health diagnosis, of people enrolled in state public programs, 21 percent have a mental health diagnosis.

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Discussion

The findings in this report provide baseline details on mental health diagnoses in Minnesota. The report also points to the need for continued efforts to coordinate the systems of care better in order to ensure the best, most consistent care possible. DIAMOND, an initiative underway by doctors, health plans, employers and others is being established to identify and share the best treatment models for depression. Once this system is established, it can be expanded to improve the care and outcomes for patients with diagnoses other than depression.

The report also points to the need for families to be involved in the care of their loved ones. Parents must continue to ask questions and gain further understanding of the medications their children may take. Family members or friends of older Minnesotans can help ensure safer care for their loved ones by asking questions when drugs are prescribed. More details are on page 16 of this report. Some of the questions include:

- Does the doctor prescribing the medication know all the drugs and supplements you take?
- What is required while I am taking this medicine (tests or monitoring)?
- Is this the lowest dose possible?

Finally, it is important to remember that medications often are part of an overall treatment plan. A prescription without close follow-up is not a good treatment plan.

About the study

The study reviewed the 12-month claims experience (no medical charts were reviewed) for 2.5 million members/patients of all ages who were continuously enrolled in calendar year 2005 and received coverage through Blue Cross Blue Shield of Minnesota, FirstPlan of Minnesota, HealthPartners, Medica, Metropolitan Health Plan, PreferredOne and UCare. Together, these seven health plans provide coverage for more than four million people in Minnesota.

The report does not include data on any of the more than 112,600 people who receive their mental health care directly from the state or county. Of course, the report does not include data on other individuals who do not have health care coverage through MCHP members.

All data used in this report are from services provided in 2005 and rates are calculated on members who were enrolled for the entire year, unless noted. Medication rates are based on people enrolled who have drug coverage included in their benefits. In addition to facts highlighted in this summary, information on additional mental health diagnoses, medication use, and utilization as well as resources are part of the report.

Footnotes

1. Centers for Disease Control and Prevention, The Role of Public Health in Mental Health Promotion, September 2005

2. Updating the Beers Criteria for Potentially Inappropriate Medication Use in Older Adults, Results of a US Consensus Panel of Experts, Donna M. Fick, PhD, RN; James W. Cooper, PhD, RPh; William E. Wade, PharmD, FASHP, FCCP; Jennifer L. Waller, PhD; J. Ross Maclean, MD; Mark H. Beers, MD, *Archives of Internal Medicine,* 2003; 163:2716-2724.