Commonwealth of Massachusetts
Supreme Judicial Court

MENTAL HEALTH LEGAL ADVISORS COMMITTEE

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March 25, 2021

Health Policy Commission
50 Milk Street, 8th floor
Boston, MA 02109

RE: **Potential Modification of the Health Care Cost Growth Benchmark**

Dear Commissioners:

This testimony expands upon the verbal testimony of Mental Health Legal Advisors Committee[1] (MHLAC) at the March 24, 2021, Health Policy Commission (HPC) benchmark hearing.

Last year, the Massachusetts Association for Mental Health, Health Law Advocates, and MHLAC submitted testimony to the HPC that involved a healthcare problem that not only disables and kills people, but increases healthcare costs. That problem is medical discrimination due to diagnostic overshadowing (attributing physical symptoms to mental health issues) and implicit bias toward persons with psychiatric diagnoses. Despite extensive peer reviewed research documenting the existence of this problem and its detrimental effects,

[1] MHLAC is an agency under the Massachusetts Supreme Judicial Court that provides representation to low-income persons with psychiatric challenges. MHLAC also provides information and advice to any Commonwealth resident, including the legislature, other agencies and commissions on mental health legal matters. In this role, MHLAC has extensive hands-on experience regarding the barriers people with psychiatric diagnoses have with respect to accessing health care services and obtaining quality care once those services are obtained.

policymakers have largely ignored this issue in their decisions about healthcare delivery and structure.

Diagnostic overshadowing and stigma reduce quality of care.

Diagnostic overshadowing can be a matter of life and death. Examples of diagnostic overshadowing include attributing a thyroid condition to panic disorder, anaphylactic shock to anxiety disorder, heart disease to depression, and encephalitis and a tumor to schizophrenia.[2] Stigma, which includes disbelief of reports of pain by people with psychiatric diagnoses, has consequences ranging from dental surgery without sufficient Novocain to delayed diagnosis of cancer. Jennifer Niles asked that her experiences of discrimination be included in MHLAC's testimony:

> Both I and my ex-wife were given erroneous advice on physical health issues because of the existence of psychiatric diagnoses in our medical records.
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> My ex-wife's multiple sclerosis was missed due to doctors focusing only on mental health. When she became manic or experienced psychosis, no provider checked the reason for her behavior changes because they considered her "Bipolar 1." The drugs that were wrongly prescribed for a mental health condition resulted in sickness, medical leave, and job loss, declining mental health, and a very delayed diagnosis of MS, totaling around 14 years. My ex-wife is now physically disabled.
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> A few years ago, I was tested for Lyme disease. I used to suffer from anxiety, which is in my medical record. Despite the reactive bands showing an acute Lyme reading, my provider told me that my results were a 'false positive' and assumed my concerns about worsening joint pain were merely due to anxious thinking. I am fortunate enough to know doctors who agreed to review the test results. These doctors diagnosed acute Lyme and were adamant that I call back the original physician for antibiotic treatment. Only then did I get treatment. However, my medical records still did not reflect that I had a positive Lyme reading.

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[2] *See, e.g.,* A. Ponte, Catatonia in Anti-N-Methyl-D-Aspartate (NMDA) Receptor Encephalitis Misdiagnosed as Schizophrenia," 33 Acta Med. Port. 208 (2020).

> I eventually was "officially" diagnosed by a specialist who reviewed the labs and my symptoms and confirmed that it was a positive Lyme serum. Knowing that medical records over-emphasizing mental health conditions can influence the approach new providers take to physical complaints, I separately forwarded the specialist records to my new doctor. When a doctor chalks up a person's physical distress to mental health issues, it can damage the person's future care.

Even after being diagnosed with a condition, persons with psychiatric diagnoses receive fewer interventions than persons without mental health diagnoses. Again, this can be dangerous, particularly in the face of a virus that we know is more deadly if underlying conditions are not adequately treated.

Persons with mental illness are not imagining inferior care. In a recent study of emergency department doctors and nurses, providers admitted negative reactions to patients with mental illness, which reactions they perceived as affecting clinical decision-making and increasing risk to patient safety.[3]

[3] L. Isbell, *et al., Emotionally evocative patients in the emergency department: a mixed methods investigation of providers 'reported emotions and implications for patient safety*, 29 BMJ Qual. Saf. 803 (2020). See also, M. Geiss, *et al., Diagnostic Overshadowing of the Psychiatric Population in the Emergency Department: Physiological Factors Identified for an Early Warning System*, 24 J. Am. Pscyh. Nurses Assoc. 327, 329 (2018) (Co-existing mental and medical illness result in decreased life span and increased health care costs. "[I]n the psychiatric population a high heart rate is often assumed as a behavioral symptom of anxiety or agitation. Also contributing to the inappropriate placement and missed medical cues is that psychiatric patients seen in the emergency department are often quickly labeled as a "psychiatric problem." These patients are often not reassessed after this quick label is made leading to medical cues not being readily assessed, which may affect further clinical decline occurring and the need for medical emergent event.")

Myths exist about why people with mental illness die 15 to 30 years earlier than those without.

- The problem is *not* about access to mental health care.

  The majority of people with mental illness die from preventable and treatable conditions.[4]

- The problem is *not* access to healthcare providers.

  People with mental illness have more interaction with doctors than people without mental illness,[5] probably because of the need to go back time and again to get care for physical symptoms that they report.[6]

- The problem is *not* caused by the lifestyle choices of people with psychiatric diagnoses.

  Looking at the same condition, people with mental illness receive poorer care and have worse outcomes than people without mental illness. Excess mortality is not caused by lifestyle choices.[7]

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[4] Presentation by A. Kennedy, *et al., Disparities Faced by Individuals With Mental Health Problems: Creating Tools and Forging Pathways for Change*, at APA Mental Health Services Conference, Oct. 7, 2018.

[5] N. Liu, *et al., Excess mortality in persons with severe mental disorders: a multilevel intervention framework and priorities for clinical practice, policy and research agendas,* 16 World Psychiatry 30 (2017).

[6] See, M. Brodeur, *et al., Experience of being a frequent user of primary care and emergency department services: a qualitative systematic review and thematic synthesis*, BMJ Open (Sept. 9, 2020). Studies commonly report that frequent users of emergency departments have mental health diagnoses. "[T]he majority of studies described negative experiences, particularly pertaining to healthcare practitioners not listening and lacking respect towards patients. Many frequent users struggle to get their physicians to take them seriously, which may lead to their symptoms being ignored."

[7] N. Liu, *et al., Excess mortality in persons with severe mental disorders: a multilevel intervention framework and priorities for clinical practice, policy and research agendas,* 16 World Psychiatry 30 (2017) ("[S]tudies clearly demonstrate the role of factors beyond disorder-specific and lifestyle behaviours in excess mortality.")

Bottom line: Having a psychiatric diagnosis – not just one of "serious mental illness" – results in inferior physical health care because of diagnostic overshadowing and stigma.

Diagnostic overshadowing and stigma increase health care costs.

Because people with mental illness have difficulty finding health care providers who take their physical healthcare complaints seriously, they have visits with multiple doctors to diagnose their conditions instead of a single visit. Many arrive at the emergency department because of unbearable discomfort or because they do not know where else to turn. For others, delayed diagnoses and inadequate treatment after diagnosis necessitate more expensive interventions. Result: higher health care costs.

Integration of physical and behavioral healthcare must be monitored.

What constitutes integrated care is poorly defined. Researchers note that it is difficult to attribute any one strategy (e.g., case coordinator, more staff, change in professional roles, new units, staff relocation).[8] Despite the inconclusive results of research on whether integrated care results in an overall cost savings while maintaining quality of care, health care systems are being moved to adopt integrated models of care.[9]

There is extremely limited information on health outcomes of integrated care and a total dearth of research on what occurs to the physical healthcare of persons with psychiatric diagnoses when mental health becomes a prominent component in treatment planning.[10] In light of the negative impact of diagnostic overshadowing

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[8] A systematic review of 167 studies of integrated care found inconsistent or limited evidence except for perceived quality, patient satisfaction, and improved access to care, which offered stronger evidence. How quality and patient satisfaction were measured in those studies finding improvement in those areas was not discussed. The authors noted that no articles had double blinding or full randomization and thus none of the articles provided evidence considered to be "strong". Baxter, et al., *The effects of integrated care: a systematic review of UK and international evidence*, 18 BMC Health Serv. Research 1,3, 9 (2018).

[9] Baxter, et al., *The effects of integrated care: a systematic review of UK and international evidence*, 18 BMC Health Serv. Research 1, (2018) ("This review adds to the growing evidence that integrated care initiatives rarely lead to unequivocally positive effects, although the calls for integrated care have never been stronger.")

[10] E. Glicksman, *Your diagnosis was wrong. Could doctor bias have been a factor?*, Washington

and stigma toward persons with psychiatric diagnosis, promoting integration of mental and physical health services is irresponsible without monitoring the physical health care of persons with psychiatric diagnoses.

Decrease health care costs by offering alternative services.

Financial incentives to cut care such as capitation, bundling of services, and shared savings undermine quality of care and cannot be controlled by outcome measurements. Many quality measurements are related to process rather than health outcomes. Frequently the processes used as outcome measurements already have been put into practice as standard care. Other outcome measurements, like patient satisfaction, tend to be based on surveys that are overly broad and superficial, e.g., questions about friendliness of front desk staff/clinicians and waiting time for appointment.

Designating certain services as low value inhibits the delivery of person-centered care. What is low value to one individual may be critical to another.

The Health Policy Commission is well aware that shifting costs to patients is counterproductive and results in individuals forgoing medically necessary care. Deductibles for prescription medications, high co-pays, and "demand-side incentives" such as tiering should be eliminated. Tiering is primarily based on cost and can harm quality of care. For example, tiering of hospitals is based on outcomes for a sampling of common procedures, like knee replacement.[11] Should a patient need a service that has not been sampled, choosing a hospital on the basis of its tier is risky.[12]

Lower costs can be achieved by offering individuals alternative options to traditional medical treatment:

Post (Nov. 18,2019) ("People with mental illness may be affected the most by implicit assumptions overall .... Physicians focused on mental health may not notice a heart problem or may tie abdominal pain to depression or anxiety without testing.")

[11] Group Insurance Commission hearing, 2019 (description of tiering methodology).

[12] Hospitals that have more experience in a particular procedure have better outcomes with that procedure.

- Fund peer respites instead of investing in additional psychiatric hospital and inpatient beds.

- Encourage healthcare clinics to offer peer support and be open on weekends and evenings.

- Mandate insurance coverage of alternative modalities of mental health care, such as meditation, exercise groups, emotional support animals, art therapy.

Peer respite and alternative modalities of mental health care are more likely to lead to recovery because the person can choose their own path to recovery. These alternatives cost less than traditional services. These alternatives also have fewer negative side effects than some of the standard treatments. For example, psychotropic drugs can cause weight gain and organ damage, which in turn can lead to costly physical healthcare.

Social determinants should be treated as health care costs.

The Health Policy Commission also should galvanize more effective means to address social determinants of health. Currently, accountable care organizations address social determinants by engaging community partners, who then refer patients to underfunded government programs that cannot meet demand. Insurers and ACOs should directly contribute to the funding of housing programs. As there is substantial evidence that housing, food, and other elements of social determinants reduce healthcare expenditures, from which reductions insurers and ACOs benefit, it is reasonable to require insurers and ACOs to bear all or part of the cost to alleviate these unhealthy socio-economic and environmental conditions.

All of the issues discussed above are fundamental to health equity. Discrimination based on psychiatric diagnoses compounds racial discrimination.[13] Blacks are three times more likely to be misdiagnosed with schizophrenia, more likely to receive antipsychotics and at higher doses, and more likely to be hospitalized.[14] Studies show that Blacks are distrustful of the mental health system and alternative modalities of care such as those described above could provide viable options for mental health remediation. Finally, the economic situation of Blacks, Latinos, and other marginalized populations[15] calls for direct action by the healthcare system to improve social determinants of health, not exclusive reliance on government funding.

Policy must be informed by the expertise of people with lived experience.

Finally, commissions and task forces that devise policies affecting persons with psychiatric diagnoses should include in their membership persons who openly identify as having lived experience of mental health treatment, preferably persons with a history of advocating for their peers.[16]

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[13] One study that reviewed of 330 medical records of Black patients with psychiatric diagnoses found that approximately in over 20%, factors were present indicating biological issues such as "childhood mental retardation (MR), … Autism/Pervasive Developmental Disorder (PDD); … head injury causing Organic Brain Syndrome (OBS) or Temporal Lobe Epilepsy (TLE)…a history of chronic substance abuse prior to the development of psychiatric symptoms." C. Bell, *Misdiagnosis of African-Americans with Psychiatric Issues – Part II*, 27 J. Nat. Med. Assoc. 35 (2015).

[14] O. Anakwenze, *The Aversive Impact of Stigma on Black People Diagnosed with Schizophrenia* (2020) https://search.proquest.com/openview/ad5f3a177d8ad1781fbba6e5f6da5d53/1?pq-origsite=gscholar&cbl=44156 (last accessed 3/23/2021).

[15] No one should be labeled with mental illness for a natural response to living in poverty.

[16] Family members cannot substitute for peers as they do not share the same knowledge and perspective of people who have personally experienced intensive mental health treatment.

MHLAC looks forward to working with the HPC to contain costs and improve quality of care *for all*.

Sincerely,

Susan Fendell
Legislative Director and
Senior Health Care Analyst