

WHITE PAPER

How Social Factors Impact Care for Patients With Bipolar Disorder

Bipolar disorder type 1 (BD-1) is a serious mental illness that can be significantly impacted by social and economic factors. A recent large-scale study, led by [Christie Teigland, Ph.D.](#), and colleagues, examined how social drivers of health (SDOH) influence hospitalization, as well as healthcare costs for patients with BD-1. Their work highlights important disparities in care and outcomes, particularly for those covered by Medicaid.

The burden of bipolar disorder

Bipolar disorder is a chronic mental illness characterized by episodes of mania and depression that can have profound impacts on many aspects of a person's life. Bipolar disorder type 1 (BD-1), defined by the presence of at least one manic episode, affects approximately 1% of the population and typically emerges between 20–30 years of age. Patients with BD-1 face higher rates of suicide, decreased life expectancy, and increased prevalence of other health conditions compared to the general population. While effective treatments exist, many patients with BD-1 struggle to access appropriate care. Understanding the factors influencing hospitalization rates and overall healthcare costs is crucial for improving outcomes for this vulnerable population.

Examining social drivers of health

In recent years, there has been growing recognition of the role that social and economic factors play in shaping health outcomes. These [social drivers of health](#) include income, education, housing, and social support. For individuals with serious mental illnesses like bipolar disorder, SDOH can have a particularly strong influence on the burden of illness and access to care.

This study set out to examine how various SDOH impact hospitalization rates and healthcare costs for patients with BD-1. The research team conducted a large retrospective study using commercial and Medicaid insurance claims data, analyzing information on over 240,000 patients diagnosed with BD-1 between 2016 and 2018. Linking patients' medical information to neighbourhood-level SDOH data allowed them to examine household income, education levels, home ownership, and English language proficiency. They then used statistical models to assess how these social factors related to hospitalization rates and overall healthcare costs after accounting for other patient characteristics.





A tale of two insurance populations

By including both commercially insured and Medicaid patients, researchers were able to make comparisons between two very different populations in terms of socioeconomic status and social risk factors. The Medicaid population, which made up about 75% of the study sample, had significantly higher rates of chronic medical conditions and social risk factors compared to the commercially insured group. Medicaid patients were likelier to have low incomes, lower education levels, and limited English proficiency. They were also less likely to be married or own their own homes.

These differences in social risk factors translated to striking disparities in healthcare utilization and costs. Medicaid patients had much higher rates of hospitalization (35% vs 22%) and emergency department visits (64% vs 40%) compared to commercially insured patients. The average annual healthcare costs were also substantially higher for Medicaid patients (\$21,474 compared to \$15,379 for those with commercial insurance).



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The impact of income and language barriers

For Medicaid patients, lower household income was strongly associated with higher hospitalizations. Those in the lowest income bracket (less than \$30,000 per year) were 16% more likely to be hospitalized compared to those earning \$75,000 or more. Interestingly, this relationship between income and hospitalizations was not seen in the commercially insured population. This suggests that the impact of low income on healthcare utilization may be particularly pronounced for those relying on public insurance.

One of the most striking findings was related to English language proficiency. For commercially insured patients, those with limited English proficiency were nearly twice as likely to be hospitalized and had more than double the healthcare costs compared to proficient English speakers. However, the opposite pattern was seen in the Medicaid population – those with limited English proficiency had 40% fewer hospitalizations and 43% lower costs.

The researchers suggest this surprising finding may indicate serious [barriers to accessing care for non-English speaking Medicaid patients](#). While lower utilization led to lower costs, it likely represents unmet healthcare needs rather than better health since this population had higher rates of hospitalizations and costs overall. This highlights a potential area of significant health inequity that warrants further investigation and intervention.



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Looking at age and gender

The study also revealed some interesting patterns related to age and gender. Across both insurance groups, older patients were less likely to be hospitalized but had higher overall healthcare costs. This may reflect a shift toward more outpatient and pharmaceutical care as patients age, as well as an increasing burden of disease (onset of chronic conditions) as people age.

Gender differences were also apparent, with female patients having slightly lower hospitalization rates but higher overall costs in the commercially insured group. In the Medicaid population, women had lower hospitalization rates but similar costs to men. These findings add nuance to our understanding of how bipolar disorder manifests and is treated across different demographic groups.

Geographic and provider factors

The researchers further examined how geographic factors and access to mental health providers influenced outcomes. Patients living in rural areas generally had lower hospitalization rates and costs than those in urban settings. This was true for both insurance groups, though the effect was more pronounced for commercially insured patients.

Interestingly, living in an area with an abundance of mental health providers was associated with higher hospitalization rates compared to areas with provider shortages. The researchers suggest this could indicate that better access to mental health care leads to more appropriate hospitalizations when needed. However, it could also reflect other underlying treatment patterns and the availability of services between areas.

Implications for health equity

The findings of this study have important implications for efforts to improve health equity in mental health care. The stark differences in social risk factors and healthcare utilization between Medicaid and commercially insured populations highlight the need for targeted interventions to address disparities.

The researchers emphasize that the association between limited English proficiency and lower healthcare utilization in the Medicaid population is particularly concerning. This suggests that language barriers may prevent some patients from accessing needed care, potentially leading to worse health outcomes.

The strong relationship between income and hospitalization rates in the Medicaid population also underscores the importance of addressing poverty and its associated stressors as part of comprehensive mental health care. While Medicaid provides crucial insurance coverage, it's clear that other social and economic factors continue to influence health outcomes for low-income patients with bipolar disorder.

Next steps in research and treatment

While this study provides valuable new insights, the researchers emphasize that more research is needed to fully understand the complex relationships between social factors and health outcomes in bipolar disorder.

Other areas for future study include examining racial and ethnic disparities in more detail, investigating the impact of specific social interventions, and exploring how findings might differ for other mental health conditions.

By shedding light on the critical role of social drivers in bipolar disorder care, this research underscores the need for healthcare systems to look beyond clinical factors and address the broader life circumstances that shape patients' health and well-being. With further study and targeted interventions, there is hope for reducing disparities and improving outcomes for all patients living with bipolar disorder.

Read the first installment of this three-part series on SDOH research, [“Improving Access to CAR T-Cell Therapy for Patients With Lymphoma”](#)

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Teigland C, Mohammadi I, Agatep BC, Boskovic DH, Sajatovic M. Relationship between social determinants of health and hospitalizations and costs among patients with bipolar disorder 1. J Manag Care Spec Pharm. 2024 Jan;30(1):72-85. doi: 10.18553/jmcp.2024.30.1.72.

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Christie Teigland leads the design and implementation of studies focused on quality measurement, health equity, and health economics and outcomes research. She works closely with health plans, providers, and life science organizations to develop actionable, real-world data insights.

Dr. Teigland co-chaired the National Quality Forum (NQF) Scientific Methods Panel for four years and served on the Pharmacy Quality Alliance (PQA) Quality Measure Expert Panel and as co-chair of PQA's Health Equity Technical Expert Panel, as well as on many Centers for Medicare & Medicaid Services (CMS) expert panels. She has served as principal investigator on large foundation and government-funded projects over two decades focused on improving healthcare quality.

Dr. Teigland earned her Ph.D. in Economics and Econometric Forecasting from the University of New York at Albany.

