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SAVE MONEY, SAVE LIVES

By Michael B. Friedman

In his first State of the State Message, Governor Spitzer said, "We will … invest in better management of high-cost [Medicaid] cases involving patients with multiple chronic [physical and mental] illnesses—a relatively small number of cases that make up a disproportionately high cost to the system. … [This] will not just save money for patients and the state, but will lead to better overall care."

I think, and hope, that this statement means that New York State is on the verge of a major change in mental health and health policy—that mental health will become a priority of the health system and that health will become a priority of the mental health system. Perhaps, after many years of talk about integration of services, steps will be taken to end the current fragmentation of mental health and health services.

Two discoveries made in the past few years are driving this change.

(1) Several studies make it clear that the nation's health care expenditures are for disproportionately a small percentage of people. E.g. in NYS it appears that about 70% of Medicaid spending is for about 10% of the state's Medicaid recipients. Who are the 10%? A great many of them are people with serious and persistent mental illness and/or substance abuse disorders in addition to chronic health conditions.[1]

(2) A recent research study indicates that people with serious mental illnesses die – on average – 25 years younger than the general population.[2] (Earlier studies put it at 10 years. Horrible enough at that rate.)

Bottom line: people with mental and substance abuse disorders often have very high health care costs and people with serious mental illness are dying young because of poor health and poor health care. Meaningful integration of health and mental health services is the only way to address these problems.

Those of us who work in health and mental health policy should not have been surprised by the recent discoveries. It has been known for a very long time that depression, for example, complicates cardiac disease and drives up the costs of its treatment. And all of us who have worked with, had family, or been people with serious mental illness have known from terrible experiences that getting good health care is terribly difficult for this population. In fact, in the mid-1970s when I was working in a psychiatric rehabilitation program, I briefly considered

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[1] Wagner School of Public Service Center for Health and Public Service Research. "High Cost Medicaid Patients: An Analysis of New York City Medicaid High Cost Patients." United Hospital Fund. 2004.

[2] Colton and Manderscheid. "Congruencies in Increased Mortality Rates, Years of Potential Life Lost, and Causes of Death Among Public Mental Health Clients in Eight States," *Preventing Chronic Disease: Public Health Research, Practice, and Policy*, April 2006.

organizing a medical practice that specialized in serving people with serious mental illness. I never followed up on the idea and instead did what almost all of us in the provider community did – i.e. focused on the development of very important services – such as housing, outpatient treatment, psychiatric rehabilitation, case management, family and peer support, etc.—that were being increasingly funded via the Community Support Program and Medicaid. We built some remarkable service programs in the community – great programs, needed programs; but all along our clients, our family members, and our friends were dying virtually without notice.

Alarms were sounded along the way. For example in the late 80s and early 90s, Russell Massaro – then the Medical Director of OMH – talked frequently about research findings that indicated that 50% of the people with serious mental illness had serious, chronic health conditions, that only half of them had been diagnosed, and that fewer than half of the diagnosed cases got appropriate medical follow-up. And it wasn't just Dr. Massaro who pointed to problems of physical health. The report of the study that suggests life expectancy of people with serious mental illness is 25 years lower than the general population cites research going back to 1969.

I look back now with a sense of embarrassment that health has not been high on the mental health advocacy agenda. Objectively I understand that we were all doing and advocating for important other services and that it often takes a shock like the report that people with serious mental illness have a dramatically low life expectancy to rouse our awareness of what should have been obvious. I still feel we should have known.

But we're on it now. What should NYS do?

1. Make health a priority for the mental health system and make mental health—and people with serious mental illness and/or substance abuse disorders—a priority for the health system.

2. Make sure that people with serious mental illness have "a medical home" providing good primary care. And make sure that people receiving primary, specialty, home health, or emergency care get good mental health services when they need them.

3. Support the development of health maintenance, self-management, and peer support initiatives in programs serving high-risk populations.

4. Identity those with co-occurring severe, chronic physical, mental, and/or substance abuse disorders **by name** (using Medicaid claims data) and organize outreach programs to aggressively offer help.

5. Using these outreach programs, provide a person to work with these high-risk individuals one-on-one and face-to-face to develop an individualized services plan and to facilitate access to needed services, including housing and community supports as well as clinical care.

6. Institute a financing structure to support individualized services.

Suggestions 5-6 above are often called "managed care." I think this is a mistake, not only because the expression "managed care" complicates the politics of change, but also because managed care as practiced has evolved into a limited set of techniques. We probably need to think outside that box. In addition, the concept of managed care implicitly puts the responsibility for integrating health and mental health services outside the service providers. In fact, it is the mental health and health professionals, working in partnership with service recipients, who need

to do the integrating. This will require them to think differently about their roles and responsibilities and to modify their practice accordingly.

Clearly, a great many details need to be worked through. But Governor Spitzer's attention to co-occurring disorders gives reason to hope that New York State will act now to address the mental health needs of people with serious, chronic health conditions and to address the health needs of people with serious mental illness and/or substance abuse disorders. The only alternative is continued, preventable high mental health/health care costs and an awful lot of unnecessary deaths.

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