

# The Imperative for Health Care Reform

A number of forces have converged to create a climate for change in health care. National, state and local resources are limited and opportunities for more efficient and effective health care are two crucial forces at play.

## National Economics

Our nation has suffered the deepest economic downturn since World War II. Known as the Great Recession, the decline from December 2007 hit bottom by February of 2010, with a resulting loss of 9 million jobs, a near doubling of the unemployment rate, lengthening in the duration of unemployment, and cuts to incomes and work hours for millions of Americans. Added to these stresses, many families experienced losses to personal wealth from declining home prices.<sup>1</sup> The recovery from the crisis has been much less robust than hoped for.<sup>2</sup>

This year, economic growth continues to be much slower than anticipated and the somewhat improved employment picture shows deterioration. Contributing to the sluggish economic growth is flat household spending, higher food and energy prices, a depressed housing sector, and weak corporate investment.<sup>3</sup> The slower pace of recovery is expected to continue into 2012.

As our nation struggles with a recession and prepares for the implementation of rapidly changing health care reforms, it does so with the understanding that its public and private health expenditures are growing at rates outpacing those of comparable countries. Moreover, the higher levels of spending are not translating into better health outcomes.<sup>4</sup>

Nationally, the prevalence and disabling effects of mental illness and substance abuse disorders (collectively termed “behavioral health disorders”) contribute to the escalating cost of health care. Nonetheless, research shows that, for mental health and substance abuse spending in the United States, growth has been at a slightly slower rate than gross domestic product and has shrunk as a share of *all* health spending.<sup>5</sup> The slight decline in spending may continue with the introduction of Mental Health Parity and Addiction Equity Act of 2008 and the Affordable Care Act (ACA) of 2010, as people with behavioral disorders and their families experience improved access and better integrated behavioral health care. This outlook, however, is tempered by the reality of the current recession and the challenges states and localities are facing in its midst.

## How the States Are Faring

According to an analysis by the Center on Budget and Policy Priorities, states' newly enacted budgets for fiscal year 2012 (beginning July 2011) show four successive years of slowing revenues and budget cuts of historic proportions. Depressed revenues, higher costs of providing services such as Medicaid, and the depletion of emergency federal stimulus funding have all contributed to states' deep spending cuts and a slowing pace to the economy. Of 44 states providing the Center with data, for example, 36 projected less state revenue in 2012 (adjusted for inflation) than they did during the fiscal year when the recession began. As with previous recessions, the effects are expected to be more profound and to persist for several years.<sup>6</sup>

In addition to the loss of federal stimulus funding to fill budget gaps, states now face the threat of sizeable reductions by Congress in "non-security discretionary" spending, which goes to states in the form of funding for critical areas such as education, health care, and human services. In coping with such adverse economic conditions, states are enacting significant cuts to spending—particularly in education and health care where states typically spend the most—and many are looking to preserve or improve essential public services through operational efficiencies.<sup>7</sup>

### Recessionary Pressures in New York State

Under Governor Cuomo's leadership, our State has created a plan in partnership with many stakeholders to address serious fiscal challenges. The plan calls for fundamental transformation of government by putting the State's fiscal house in order, radically redesigning governmental structures and operations, restoring integrity and performance to state government, and strengthening the State for future generations. Key components of the plan include:

- An emergency financial plan to close the \$10 billion deficit in the 2011–12 budget, without borrowing or raising taxes
- Redesign and rightsizing of State government through the newly created State Agency and Government Efficiency (SAGE) Commission
- Redesign of the State Medicaid program via the newly created Medicaid Redesign Team (MRT), to save money initially as part of the 2011–12 budget and thereafter to identify efficiencies and cost savings in the Medicaid program

#### Vision for Reform

"It is of compelling public importance that the State conduct a fundamental restructuring of its Medicaid program to achieve measurable improvement in health outcomes, sustainable cost control and a more efficient administrative structure."

*Governor Andrew M. Cuomo  
January 5, 2011*

- Provision of mandate relief by review of unfunded and underfunded mandates imposed by the State government on school districts, local governments, and other local taxing districts so they may better control their expenses
- Redesign of education to create incentives that reward school districts for student performance and the adoption of management efficiency policies
- Transformation of the economy through an ambitious economic development agenda that seeks to help government facilitate job creation<sup>8</sup>

The budget contained no new taxes, included two-year appropriations for education and Medicaid, and set a ceiling for the growth of both education and Medicaid spending.

## **Efficient and Effective Health Care for Medicaid Beneficiaries**

### **Providing Good Care to Adults with Serious Mental Illness**

Nationally, about 50 percent of people experience some mental illness in their lifetime. About one-quarter of these individuals have some mental illness (e.g., anxiety, mild depression, attention deficit/hyperactivity disorder [ADHD]) within a given year. About 10 to 15 percent of this cohort are mildly affected, yet most get no care even though an adequate “dose” of brief therapy would be indicated. When care is received, it often involves self-help and medication and most of care is provided by primary care physicians.

For the approximate 6–7 percent of Medicaid beneficiaries in NYS who receive specialty care each year:

- About 5–7 percent has mild impairment (e.g., moderate depression, well-controlled bipolar disorder and schizophrenia). About half of these individuals receive care, which generally should include combined therapy.
- About 5 percent of children and 3–5 percent of adults experience severe impairment (e.g., schizophrenia, bipolar illness, serious posttraumatic stress disorder [PTSD], obsessive-compulsive disorder, multiple trauma) that require continuous, integrated and mobile treatment with services aimed at engagement in care, rehabilitation, medication therapy and peer support. Most of this treatment takes place in the public mental health system.

The importance of care is illustrated by what we know about depression, for example, among women who bear children and children of mothers who are depressed. About 10–15 percent of women experience depressive episodes during pregnancy (about 7–10 percent major depression) and about 15 percent experience depression in the first three months following delivery,<sup>9</sup> with 25 percent of women having an onset of depression between six months and one year after delivery.<sup>10</sup>

For mothers who receive Temporary Assistance to Needy Families support, the rates of depression are even greater, estimated between 30–45 percent.<sup>11</sup> A majority of children whose

mothers are depressed develop mental health problems. Fortunately, though, when the mothers receive treatment, the mental health problems of about half of the children resolve. Given that depression, while serious, is treatable and improves functioning for mothers and their children, it is troubling that up to two-thirds of the depressive episodes are not recognized by providers and less than one-third receive treatment.<sup>12,13</sup>

Currently, care received by people with mental illness is not well integrated. Often mental health care itself is fragmented and discontinuous, with a person receiving medications, psychotherapy, rehabilitation, support, and addiction treatment in different locations by different providers. Such care often takes place in the absence of health information technology that would enable more coordinated care. Education, employment, and housing supports—all crucial to sustaining recovery in a person's community and natural environs—are available only to a minority of people in need.

Integrated primary health and mental health care for high-risk adults with serious mental illness, when done well, has significant potential to improve overall health and quality of life, while reducing the costly disabling effects of illness.<sup>14</sup> Helping these individuals and their families toward recovery requires:

- Team-based, continuous and titrated treatment based on the best scientific evidence
- Integrated care:
  - One master care plan of care supported by integrated health information technology and care management approaches
  - Medication treatment and management, for many people an important adjunct to coping successfully with symptoms
  - Relevant psychosocial support (e.g., wellness management, peer support, respite services to avoid hospitalization)
  - Substance abuse treatment when indicated, relying upon integrated dual disorders treatment
  - Assured provision of resources and supports that sustain recovery and productive community living:
    - Stable housing
    - Benefits/benefits counseling
    - Employment/education
    - Medical care

Such treatment addresses clinical characteristics unique to serious mental illness. Psychiatric illnesses can be marked by periods of intermittent wellness and illness, and by disordered thinking and behavior. When people are most in need of care the very symptoms of illness impede their abilities to obtain treatment. Moreover, the symptoms can impair a person's abilities to carry out day to day (e.g., bathing, eating poorly) tasks, as well as other critical functions (e.g., taking medications, keeping medical appointments, paying rent). The nature of

serious mental illness, therefore, requires effective clinical interventions (e.g., case management, peer outreach and engagement, electronic medical records) to help people navigate through such periods.

Another clinical characteristic unique to serious mental illness and of priority for the mental health system is preventing and reducing the risk of suicide. For people with serious mental illness, suicide prevention measures are critical following emergency psychiatric care and inpatient care—the times when the risk of suicide is greatest for these individuals.

### ***Necessity of Integrated Primary Care in Mental Health Treatment***

Many adults with serious mental illness experience difficulty in navigating the broad array of service options. Added to this, the current service system does not always ensure access to individuals with the highest needs, services provided by different clinicians are not always well-coordinated, and payments for services are not always structured to provide incentives that promote recovery.

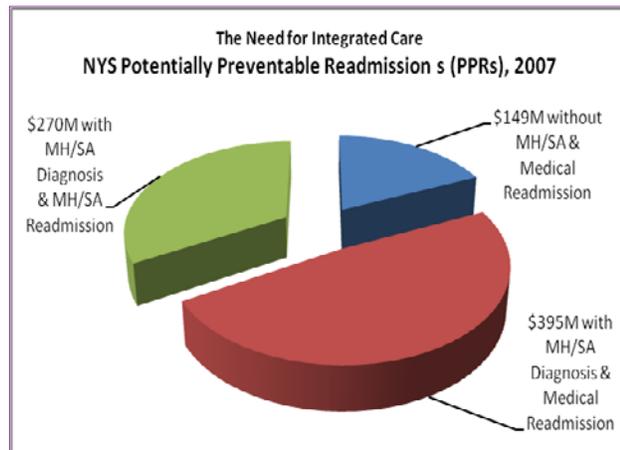
In 2008, New York City and State government leaders, faced with a number of tragic events linked to fragmentation of care, convened a panel to examine and recommend actions to improve the public safety while enhancing the care of high need individuals with serious mental illness. The Panel found that the system in place was not as effective as it might be in coordinating care across agencies or in engaging people who dropped out of or had been lost to care. It recommended creating “care monitoring” teams to improve accountability and reduce service failures.

Teams were piloted in Brooklyn and expanded citywide. They used Medicaid claims and other State administrative data to identify people with high need and serious mental illness who were at risk for lapses in care, overused inpatient and emergency services, and had poor outcomes. The pilot showed success in using claims data to identify individuals with serious mental illness and high service needs who may have been in need of outreach and engagement. Many were found not to be engaged in adequate and appropriate services, and re-engaging them in care was impeded by limits on information sharing across systems of care. Of note is that people enrolled in full-benefit managed care plans were just as likely to be identified by the pilot as those in fee-for-service Medicaid.

The NYS experience with care monitoring highlights the critical nature of integrated, coordinated care for people living with serious mental illness. And, for people with serious mental illness, “integrated care” demands that we treat the whole person and family with the core of essential elements noted in the previous section.

**Figure1: The Need for Integrated Care**

Other data from the State Department of Health (DOH) reinforce the need for integrated care. Potentially preventable readmission data from 2007 show higher costs for medical hospital readmissions for people diagnosed with behavioral disorders, suggesting that good management of behavioral disorders might help in avoiding readmissions and realizing substantial savings from possibly preventable readmissions<sup>15</sup> to medical or behavioral inpatient settings for people identified as having behavioral disorders.



People with serious mental illness have higher rates of medical co-morbid conditions than the general population. The prevalence of diabetes, high lipids, hypertension, and obesity, for example—all modifiable risk factors for cardiovascular disease—is approximately 1.5 to 2 times more than for the general population.<sup>16</sup> Nonetheless, people with serious mental illness receive fewer routine preventative services, less-than-adequate diabetes care, and lower rates of treatment for cardiovascular disease (e.g., cardiac catheterization, drug therapy of proven benefit following heart attack).<sup>17</sup> A number of barriers to integrated care may be at play, from poor access to mainstream health care, the effects of poverty, stigma and discrimination, and cultural issues.

### **Providing Good Care to Children with Serious Emotional Disturbance and Their Families**

The data describing the scope of serious emotional disturbance for children and society are compelling:

- Worldwide, neuropsychiatric disorders are the main cause of disease burden in high-income countries for children and young adults between 10 and 24 years of age.<sup>18</sup>
- More children in the United States suffer from psychiatric illness than from cancer, blindness, autism, developmental disability and autoimmune deficiency syndrome (AIDS) combined.
- Only 3 out of 10 children with a special education label of serious emotional disturbance graduate with a standard high school diploma.<sup>19</sup>
- Adverse experiences in childhood (e.g., recurrent abuse, parent has mental illness, parents' divorce) are seen as drivers of a majority of adult chronic illnesses.<sup>20</sup>
- Approximately 20 percent of children with an emotional disturbance receive specialty treatment.<sup>21</sup>

- A majority of children in youth and juvenile justice settings and many children in foster care are diagnosed with serious emotional disturbance.<sup>22</sup>
- Among 15- to 24-year olds, suicide accounts for 12.2 percent of all deaths annually.<sup>23</sup>

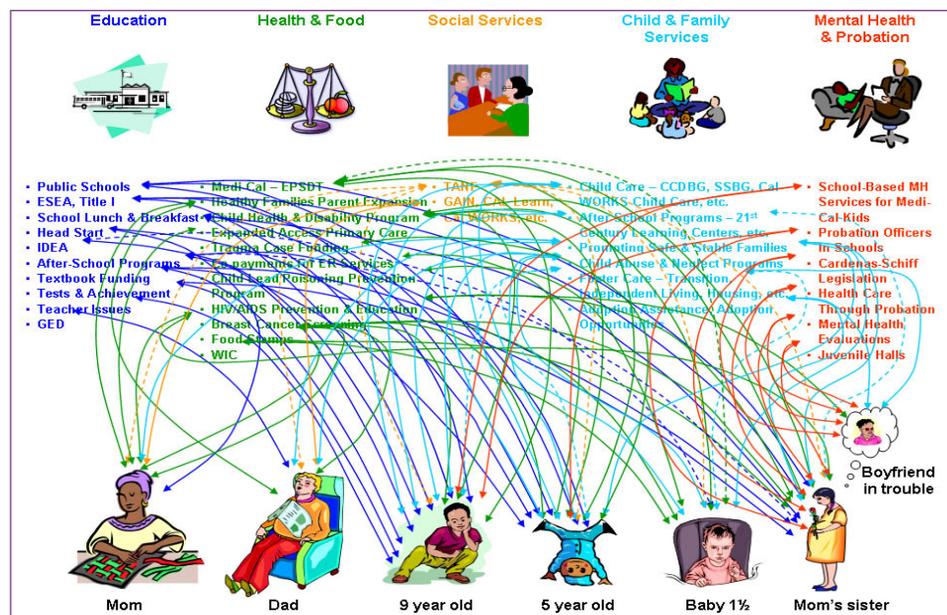
Increasing rates of childhood chronic conditions (with obesity, asthma and ADHD highly prevalent) portend of large increases in disease burden into adulthood. Rising rates result in greater private and public healthcare and disability expenditures, less ability for those affected to participate fully in the workforce, and a diminished quality of life<sup>24</sup>

Developmental and environmental risks that present early in a child’s life (e.g., child abuse, learning problems) reduce a child’s ability to develop healthy relationships and to function independently. As children move through the middle and teen years, problems may manifest as depression, anxiety, conduct disorder, PTSD, and substance abuse.

Without intervention in the early years (e.g., treating maternal depression) and targeted therapies thereafter, when clinically indicated (e.g., treating depression, ADHD), the impacts can be great. Youth may then require more use of emergency behavioral services and residential treatment, become involved in the juvenile justice system, fail to stay in school, and be at risk for suicide.

**Figure 2: Challenges to Integrating Care across Service Systems**

In NYS, the [Children’s Plan](#) provides a strong foundation for more integrated care across the child-serving agencies. Nonetheless, formidable barriers to integrated care continue to exist. Margaret Dunkle of George Washington University provides more than a hint of just how challenging



it can be to provide integrated care in her depiction showing how 40+ programs might touch one Los Angeles family (see Figure 2).<sup>25</sup> The illustration underscores the importance of ensuring that State agencies and service providers are accountable to individual families for more integrated and effective care. Medicaid redesign provides a natural opportunity for such a return through investments in early preventive and therapeutic interventions that forestall the development of school failure, suicide, criminal justice involvement, and homelessness into adulthood.

**Promoting Care Management for Children and Families**

Specialized approaches that should be included in care management affecting children and families should be premised on the principles of the Child and Adolescent Services System Program (CASSP)<sup>26</sup> and the domains of priority outlined in the Children’s Plan as summarized in Figure 3.

**Figure 3**  
**Principles and Domains of Priority underlying Care for Children and Families**

<b>The Children’s Plan Domains</b>	<b>CASSP Core Principles</b>
Social and emotional development and learning form a foundation for success in school, in work and in life.	Child-centered services meet the individual needs of the child, consider the child's family and community contexts, and are developmentally appropriate, strengths-based and child-specific.
Every action should strengthen our capacity to engage and support families in raising children with emotional health and resilience.	Family-focused services recognize the family as the primary support system for the child and that it participates as a full partner in all stages of the decision-making and treatment planning process.
One-family, one-plan: Ensuring integrated and effective services and supports.	Community-based services, whenever possible, are delivered in the child's home community, drawing on formal and informal resources to promote the child's successful participation in the community.
The right service is available at the right time and in the right amounts.	Multi-system services are planned in collaboration with all the child-serving systems involved in the child's life.
An adequately sized workforce that is culturally competent and steeped in a new paradigm of integrated, family-driven care must be developed and sustained.	Culturally competent services recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, languages, rituals, and practices characteristic to the family's cultural group.
	Least restrictive/Least intrusive services take place in settings that are the most appropriate and natural for the child and family and are the least restrictive and intrusive to meet the needs of the child and family.

Consonant with these values and principles, ongoing planning for care management for children and families in New York should:

- Employ targeted, focused prevention efforts such as positive parenting programs
- Reduce the nine-year gap between when behavioral problems first show up and when treatment starts through enhanced pediatric and mental health clinical partnerships

- Provide specialty behavioral treatment to children with serious emotional disturbance and their families using current evidence-based interventions
- Draw on effective, less costly and highly valued expertise of youth and family support services
- Take into account the complexity of children’s mental health financing and more closely align payment and care strategies

Medicaid redesign offers opportunities to anchor care for children and families in integrated, multidisciplinary approaches that realize efficiencies, effective use of clinical treatment, and support for emotional well-being and resilience.

<sup>1</sup> Dudley WC. (2011, June). *Road to recovery: Remarks by President Dudley at the Brooklyn Chamber of Commerce*. Federal Reserve Bank of New York. Available online at <http://www.newyorkfed.org/newsevents/speeches/2011/dud110610.html>.

<sup>2</sup> Bernanke B. (2011, August 26). The near- and longer-term prospects for the U.S. economy. Available online at <http://www.federalreserve.gov/newsevents/speech/bernanke20110826a.htm>.

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<sup>4</sup> Kaiser Family Foundation. (2011, April). *Health care spending in the United States and selected OECD countries*, April 2011. Available online at <http://www.kff.org/insurance/snapshot/OECD042111.cfm>.

<sup>5</sup> Mark TL, Levit KR, Vandivort-Warren R et al. (2011). Changes in US spending on mental health and substance abuse treatment, 1986-2005, and implications for policy. *Health Affairs*, 30, 284–293.

<sup>6</sup> McNichol E, Oliff P & Johnson N. (2011, June 17). *States continue to feel recession’s impact*. Center on Budget and Policy Priorities. Available online at <http://www.cbpp.org/cms/?fa=view&id=711>.

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<sup>8</sup> More information on the plan outlined by Governor Cuomo during his January 2011 State of the State speech is available online at <http://www.governor.ny.gov/press/01052011stateofthestate>.

<sup>9</sup> Gaynes BN, Gavin N, Meltzer-Brody S, et al. (2005). Perinatal depression: Prevalence, screening accuracy, and screening outcomes. *Evidence Reports/Technology Assessments, No. 119*. Rockville, MD: Agency for Healthcare Research and Quality.

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- <sup>14</sup> World Health Organization. (2007). Integrating mental health services into primary health care. Geneva: Author. Available online at [http://www.who.int/mental\\_health/policy/services/en/index.html](http://www.who.int/mental_health/policy/services/en/index.html) <sup>↗</sup>.
- <sup>15</sup> A potentially preventable readmission (PPR) is a readmission within 15 days that is *clinically related* to the initial hospital admission.
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- <sup>17</sup> Newcomer & Hennekens, 2007.
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