The Business Case for Bidirectional Integrated Care:

Mental Health and Substance Use Services in Primary Care Settings and Primary Care Services in Specialty Mental Health and Substance Use Settings

Problem Statement

- Depression is one of the top 10 conditions driving medical costs, ranking 7th in a national survey of employers. It is the greatest cause of productivity loss among workers.[1] People diagnosed with depression have nearly twice the annual health care costs of those without depression.[2] The cost burden to employers for workers with depression is estimated at $6,000 per depressed worker per year.[3]
- 49% of Medicaid beneficiaries with disabilities have a psychiatric illness. 52% of those who have both Medicare and Medicaid have a psychiatric illness.[4]
- 11% of Californians in the fee for service Medi-Cal system have a serious mental illness. Healthcare spending for these individuals is 3.7 times greater than it is for all Medi-Cal fee-for-service enrollees—$14,365 per person per year compared with $3,914.[5]

Making the case still more compelling, a recent study has estimated that "if a 10% reduction can be made in the excess healthcare costs of patients with comorbid psychiatric disorders via an effective integrated medical-behavioral healthcare program, $5.4 million of healthcare savings could be achieved for each group of 100,000 insured members…the cost of doing nothing may exceed $300 billion per year in the United States."[6]

Without addressing the healthcare needs of persons with serious Mental Health/Substance Use (MH/SU) disorders and the MH/SU treatment needs of the whole population, it may be very difficult to achieve the three critical healthcare reform objectives articulated by the Institute for Healthcare Improvement's Triple Aim:

- Improve the health of the population
- Enhance the patient experience of care (including quality, access, and reliability)
- Reduce, or at least control, the per capita cost of total healthcare[7]

Research has proven that prevention works, MH/SU treatment is effective, and people with MH/SU disorders can recover with effective care and supports.

Improve the health of the population

- People with type 2 diabetes have nearly double the risk of depression. Studies have shown depression in diabetic patients is associated with poor glycemic control, increased risk for complications, functional disability and overall higher healthcare costs. There are treatment protocols that can double the effectiveness of depression care resulting in improved physical functioning and decreased pain.[8]
- Care management focused on the health status of people with serious mental illnesses has been shown to significantly improve risk scores for cardiovascular disease.[9]
- Improving the health of those with SU conditions may well benefit the health of their family members—In the Kaiser Northern California system, family members of patients with SU disorders had greater healthcare costs and were more likely to be diagnosed with a number of medical conditions than family members of similar persons without a SU condition. In follow up studies, if the family member with a SU condition was abstinent at one year after treatment, the healthcare costs of family members went down to the level of the control group.[10]

Enhance the patient experience of care (including quality, access, and reliability)

- A ranking (based on clinically preventable burden and cost effectiveness) of 25 preventive services recommended by the United States Preventative Services Task Force found that alcohol screening and intervention rated at the same level as colorectal cancer screening/treatment and hypertension screening/treatment. Depression screening/intervention rated at the same level as osteoporosis screening and cholesterol screening/treatment.[11]
- Individuals with serious mental illnesses have a 53% greater chance of being hospitalized for diabetes that could have been managed in an outpatient setting.[12]
- Adding attention to the healthcare needs of persons served in MH settings resulted in significantly improved access to routine preventive services (e.g. immunizations, hypertension screening and cholesterol screening).[13, 9]

Reduce, or at least control, the per capita cost of total healthcare

- There are numerous proven MH/SU treatments and protocols, often integrated with primary care, that have been shown to improve health status and reduce total healthcare expenditures, while others improve health status without adding additional costs.
- Depression care management for Medicaid enrollees can reduce overall healthcare costs by $2,040 per year with impressive reductions in emergency department visits and hospital days.[14]
- A Kaiser Northern California study showed that those who received SU treatment had a 35% reduction in inpatient cost, 39% reduction in ER cost, and a 26% reduction in total medical cost, compared with a matched control group.[10]

Healthcare reform legislation has linked the ability to demonstrate quality outcomes with managing costs. The changes underway in the healthcare environment—universal coverage, delivery system design, and payment reform—make bidirectional integration of MH/SU services with healthcare more important than ever before, especially in systems that historically have served the safety net population. The full report from which this abstract was created, *The Business Case for Bidirectional Integrated Care*,[15] contains information critical to both national and state level payment reform decisions.

Leadership at both state and county levels will be critical to success. Because all healthcare is local, everyone must work together to craft a set of local solutions that take advantage of the opportunities that will unfold under healthcare reform. Local leaders will need aligned leadership at the state level to ensure that the upcoming major changes in the healthcare system address the needs of Californians with mental health and substance use disorders.

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