

## Busting the Silos: How Integrated Mental Health, Substance Use, and Primary Services Care Can Save Money and Lives

### What's the Problem?

- **Depression and other mental health and substance use issues cost everyone money.** Depression is one of the top 10 conditions driving medical costs, ranking 7<sup>th</sup> in a national survey of employers. It is the greatest cause of productivity loss among workers.<sup>1</sup> People diagnosed with depression have nearly twice the annual health care costs of those without depression.<sup>2</sup> The cost burden to employers for workers with depression is estimated at \$6,000 per depressed worker per year.<sup>3</sup>
- **Over half of the people receiving Medicaid and Medicare have psychiatric illness.** 49% of Medicaid beneficiaries with disabilities have a psychiatric illness. 52% of those who have both Medicare and Medicaid have a psychiatric illness.<sup>4</sup>
- **On the state level, spending is almost four times greater for those with mental illness.** 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.<sup>5</sup> Studies in other states have arrived at similar conclusions.

### What's the Solution?

- **Integrate medical, mental health and substance use services.** 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."<sup>6</sup>



### Prove it.

- **Help diabetes, help depression. Help depression, help diabetes.** 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 can double the effectiveness of depression care resulting in improved physical functioning and decreased pain.<sup>7</sup>
- **Take care of your head, heal your heart.** Care management focused on the health status of people with serious mental illnesses has been shown to significantly improve risk scores for cardiovascular disease.<sup>8</sup>

- **Substance use hurts (and costs) everyone.** 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.<sup>9</sup>

## Better prevention. Better access. Bigger savings.

- **Substance use and depression screening saves money.** A ranking (based on clinically preventable burden and cost effectiveness) of 25 preventive services 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.<sup>10</sup>
- **Access=prevention.** 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).<sup>11, 8</sup>
- **Save big by addressing depression in the safety net population.** 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.<sup>12</sup>
- **Save big by addressing substance use.** 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.<sup>9</sup>

<sup>1</sup> 2009 Almanac of Chronic Disease. The impact of chronic disease on U.S. health and prosperity: A collection of statistics and commentary. Partnership to Fight Chronic Disease. <http://www.fightchronicdisease.org/>

<sup>2</sup> Simon G, Ormel J, VonKorff M, Barlow W. Health care costs associated with depressive and anxiety disorders in primary care. *Am J Psychiatry*. 1995;152:352-357

<sup>3</sup> Greenberg PE, Kessler RC, Nells TL, et al. Depression in the workplace: an economic perspective. In Feightner JP, Boyers WF, eds. *Selective Serotonin Reuptake Inhibitors: Advances in Basic Research and Clinical Practice*. 2nd ed. New York. Wiley and Sons; 1996.

<sup>4</sup> Kronick RG, Bella M, Gilmer TP. The faces of Medicaid III: Refining the portrait of people with multiple chronic conditions. Center for Health Care Strategies, Inc., October 2009.

<sup>5</sup> Beneficiary risk management: Prioritizing high risk SMI patients for case management/coordination. Presentation by JEN Associates, Cambridge, MA. California 1115 Waiver Behavioral Health Technical Work Group. February 2010

<sup>6</sup> Melek S, Norris D. Chronic conditions and comorbid psychological disorders. Milliman Research Report. July 2008.

<sup>7</sup> <http://impact-uw.org>

<sup>8</sup> Druss BG, von Esenwein SA, Compton MT, et al. A randomized trial of medical care management for community mental health settings: the Primary Care Access, Referral, and Evaluation (PCARE) study. *American Journal of Psychiatry*. 2010 Feb; 167(2):120-1.

<sup>9</sup> Weisner C. Cost Studies at Northern California Kaiser Permanente. Presentation to County Alcohol & Drug Program Administrators Association of California Sacramento, California. Jan. 28, 2010

<sup>10</sup> Maciosek MV, Coffield AB, Edwards NM, et al. Priorities among effective clinical preventive services: Results of a systematic review and analysis. *American Journal of Preventive Medicine*. 2006 Jul; 31(1):52-61.

<sup>11</sup> Druss BG, Rohrbach RM, Levinson CM, Rosenheck RA. Integrated medical care for patients with serious psychiatric illness: a randomized trial. *Archives of General Psychiatry*. 2001 Sep; 58(9):861-8.

<sup>12</sup> Thomas M. Colorado Access. Presentation at Robert Wood Johnson Foundation Depression in Primary Care Annual Meeting. February 2006.