

# KEY DRIVERS AND EVIDENCE

## For Integrating Behavioral Health



### Reduced Costs

Patients with behavioral health conditions can cost three times as much as patients without a behavioral health condition.<sup>1</sup> The addition of a behavioral health condition to one or more chronic physical conditions results in a sixty to seventy-five percent increase in health care costs per individual.<sup>2</sup> Depression alone has been linked to 50-100% higher direct and indirect costs.<sup>3</sup>

Integrated behavioral health can decrease overall medical costs through a variety of ways, including decreasing unnecessary use of emergency room and high-cost specialty care, improving adherence and lifestyle factors that contribute to physical illness, reducing sick days at work, and decreasing physician's workload. Annual cost savings of integrated physical and behavioral health services have been estimated at \$26-\$48 billion dollars.<sup>1</sup>



### Improved Health Outcomes

When healthcare providers practice in their own siloes, they focus on specific physical or behavioral health symptoms instead of taking a whole person approach, resulting in poorer health outcomes.<sup>4</sup> Overall, people with serious behavioral health difficulties have a shorter overall life expectancy, which is actually attributable to physical illnesses accrued in their lifetime.<sup>5</sup> Moreover, financial and stigma barriers often preclude a person from getting the necessary care.

Integrated behavioral health can improve overall health outcomes. Eliminating historically separate funding streams for physical and behavioral health eliminates common financial barriers to receiving appropriate care. A team-based, collaborative approach allows providers and practice teams to take a whole-person approach to care. This approach also decreases mental health stigma by normalizing the presence of behavioral health providers as part of the care team instead of a referral to follow-up with. A Cochrane review of trials for patients with depression and anxiety treated in a collaborative, integrated system found improvements in both clinical outcomes as well as overall patient satisfaction.<sup>6</sup>



### Greater Access to Care

Behavioral health services are often most needed and accessed outside of traditional mental health care settings. 31% of adult primary care visits are related to mental health,<sup>7</sup> however, two thirds of primary care providers report poor access to referrals for needed behavioral health services.<sup>8</sup> For children, while 70-80% of youth who obtain behavioral health services do so in school settings,<sup>9,10</sup> nearly 80% of youth with mental health needs still do not receive treatment.<sup>11</sup>

Integrating behavioral health providers in hospitals and practices increases access dramatically. No longer are physical and behavioral health services offered at different locations and in different systems of care; now whole person care is available within one appointment.

## References

- 1 Melek SP, Norris DT, Paulus J. Economic Impact of Integrated Medical-Behavioral Healthcare: Implications for Psychiatry. April, 2014. Retrieved from <http://www.psychiatry.org/File%20Library/Practice/Professional%20Interests/Integrated%20Care/Milliaman-APA-EconomicImpactofIntegratedMedicalBehavioralHealth-care2014.pdf>.
- 2 Boyd C, Weiss C, Wolff J, Clark R, Richards T. Clarifying Multimorbidity to Improve Targeting and Delivery of Clinical Services for Medicaid Populations. *Center for Health Care Strategies, Inc.* 2010 (Faces of Medicaid Data Series).
- 3 West Virginia State Innovation Model Grant. State Innovation Model (SIM) Grant: Behavioral Health Integration. Background and overview of models. [http://www.wvhicollaborative.wv.gov/Documents/West%20Virginia%20Integration%20Presentation\\_January%202016.pdf](http://www.wvhicollaborative.wv.gov/Documents/West%20Virginia%20Integration%20Presentation_January%202016.pdf). Accessed May 4, 2016.
- 4 Druss BG, Newcomer JW. Challenges and solutions to integrating mental and physical health care. *J Clin Psychiatry.* 2007;68(4):e09.
- 5 De Hert M, Correll CU, Bobes J, et al. Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. *World Psychiatry.* 2011;10(1):52-77.
- 6 Archer J, Bower P, Gilbody S, et al. Collaborative care for depression and anxiety problems. *Cochrane Database Syst Rev.* 2012;10:CD006525.
- 7 Centers for Disease Control and Prevention. Percentage of Mental-Health Related Primary Care Office Visits by Age Group – National Ambulatory Medical Care Survey, United States, 2010. *Morbidity and Mortality Weekly Report.* 2014;63(47):1118.
- 8 Clarke JL, Skoufalos A, Medalia A, Fendrick AM. Improving Health Outcomes for Patients with Depression: A Population Health Imperative. Report on an Expert Panel Meeting. *Population Health Management.* 2016;19(Suppl 2):S-1-S-12. doi:10.1089/pop.2016.0114.
- 9 Atkins MS, Hoagwood KE, Kutash K, Seidman E. Toward the Integration of Education and Mental Health in Schools. *Administration and policy in mental health.* 2010;37(1-2):40-47.
- 10 Costello EJ, He JP, Sampson NA, Kessler RC, Merikangas KR. Services for adolescents with psychiatric disorders: 12-month data from the National Comorbidity Survey-Adolescent. *Psychiatric services (Washington, DC).* 2014;65(3):359-366.
- 11 Kataoka SH, Zhang L, Wells KB. Unmet need for mental health care among US children: Variation by ethnicity and insurance status. *American Journal of Psychiatry.* 2002;159(9):1548-1555.

