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Key Messages re Role of Behavioral Health Integration in Chronic Disease Prevention and Treatment

1) Medical and behavioral conditions are closely intertwined, their care and treatment must provide for both in a comprehensive, coordinated fashion including use of interdisciplinary care teams, which care delivery national surveys consistently show the American public wants by a large majority.

2) Nearly 40% of patients with a chronic medical condition also have a co-occurring mental health or substance use disorder as well (Kathol et al, 2015). Additionally, 40% of patients with a primary medical reason for their ED visit, have a behavioral health co-morbidity (Richmond et al, 2017). In acute general hospital settings, 25%-35% of general medical admissions consistently have behavioral health co-morbidity (Kathol, 2015). Half of patients with serious mental illness have one or more chronic medical conditions (Druss & Walker, 2011).

3) Medical patients with largely untreated co-morbid behavioral health condition: (1) are medical illness treatment resistant, (2) experience persistent medical symptoms and more chronic illness complications, (3) report greater impairment, (4) use more disability days, and (5) have a doubling of total health care costs when compared to medical patients without behavioral health comorbidity (Kathol et al, 2005; Katon & Seelig, 2008; Prince et al). Additionally, (6) respond in a worse way to treatment for chronic medical issues; (7) have more impairment; (8) have persistent, poorly treated medical illness; (9) have more complications; (10) have less satisfaction with medical care, and (11) have higher mortality than patients with chronic medical conditions alone (Chang et al, 2011; Druss, Zhao, Von Esenwein, Morrato & Marcus, 2011).

4) Thus, patients with co-morbid chronic medical and mental health conditions accrue greater health costs when compared to similar patients without co-morbid mental health concerns. The presence of any chronic (medical) condition doubles the cost of care for a patient as compared to the general population. If a mental health condition also exists, the total cost for that patient doubles again, across all payers (Milliman, 2018; Melek et al, 2015). These comorbid patients are high users of care given their difficulty stabilizing and often overwhelm the healthcare system.

5) There is growing evidence that integration of behavioral health services into primary care can generate downstream medical savings by improving management of co-morbid chronic disease and behavioral health concerns (Reiss-Brennan et al, 2016).

6) Payment models that move from fee-for-service toward value-based, global, capitated payments, promote collaboration and the inclusion of behavioral health as a part of the primary care team (Miller et al, 2017).

7) One cannot limit the benefits of integration to a single advantage, rather must consider the totality of the value when analyzing the effects of integration. The impact of integrating behavioral health in primary care may be substantial both clinically and financially, with far-reading positive influence from medical clinicians and patients at the practice level, to population health and total health care cost improvement.

8) Since the impact of integration is potentially, and increasingly shown to be, so pervasive, this approach to patient care should be viewed as an exemplary model for affecting positive and fundamental change in the health care system (Ross et al, 2018).

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