

Call to Action for Successful Healthcare Transformation *The Interdependence of Physical and Behavioral Health*

The intense spotlight of healthcare reform is focused on the enormous challenges—as well as the opportunities—involved in transforming a “broken” service delivery system. There is general consensus about the **need for change**, but significant uncertainty about moving forward to **make change happen**.

This is remarkably similar to the struggle experienced by individuals with chronic medical conditions. They recognize the **need** to improve their health by exercising, managing stress, not overeating, and other activities. Yet, they lack the skills, motivation, or confidence to actually **change** their behavior.

One of the most challenging hurdles of healthcare reform: **How to deal more effectively with the interdependence of physical and behavioral health**. The current delivery system fails to consider behavioral health as a contributing factor to total health, despite indisputable evidence of the “mind-body connection”.

Impact of Behavioral Health on Society and Economy

Behavioral health issues have a substantial—and often underestimated—impact on the social and economic costs of healthcare. Depression and anxiety burdened the United States economy by \$138 billion in 2000.¹ Mental health disorders are currently the leading cause of disability in the United States for ages 15–44² and comprise an enormous share of Medicaid expenses.

Behavioral health factors decrease workforce productivity and significantly undermine wellness promotion. **Depression and stress are the highest individual contributors to productivity impairment—more so than physical inactivity, weight, cholesterol, glucose, blood pressure, tobacco use, nutrition, or alcohol use.**³ A study supported by the Centers for Disease Control and Prevention reported that depressed adults were significantly more likely than those without depression to report the following health risk behaviors or health conditions: lack of physical activity, smoking, binge drinking, obesity, high blood pressure, high cholesterol, and poor health.⁴

Overwhelming stresses on the healthcare delivery system are attributed to behavioral health conditions. The direct burden on hospitals is demonstrated by a 2007 national study in which 12% of emergency department visits were related to mental health and substance abuse, and 40% of these emergency visits resulted in hospital admission.⁵ A 20-year study by Kaiser Permanente found that 60% of all medical visits were by the “worried well” with no diagnosable disorder at all.⁶

Co-Occurrence of Physical and Behavioral Health Conditions

Recent studies show that individuals with severe mental illness (including major depressive disorder, bipolar disorder, schizophrenia, and schizoaffective disorder) have mortality rates that are two to three times higher than the general population. Approximately 60% of this excess mortality is due to physical illness.⁷ The association is attributed to negative effects of mental conditions on health habits, poor adherence with medical regimens, and direct adverse physiologic effects.⁸



Individuals with chronic medical diseases demonstrate a greater risk for behavioral health conditions, leading to increased complications, healthcare utilization, and mortality. Patients with chronic physical health illnesses are two to three times more likely to suffer from depression than healthy individuals.⁹ Major depression has been diagnosed in 45% of individuals hospitalized after myocardial infarction¹⁰, with significantly higher death rates for depressed patients.¹¹ Depressive symptoms are also predictive of experiencing a stroke.¹²

The negative impact of co-occurrence is not limited to depressive disorders. Among asthma patients, anxiety is associated with more frequent visits to primary care providers and emergency departments.¹³ Patients with generalized anxiety disorder often have multiple medical comorbidities, including migraine, rheumatoid arthritis, peptic ulcer disease, irritable bowel syndrome, coronary heart disease, hyperthyroidism, diabetes, asthma, and chronic obstructive pulmonary disease.¹⁴

Transforming the Healthcare System: Use of Evidence-Based Interventions

Despite the prevalence, interdependence, and substantial impact of co-occurring physical and behavioral health conditions, **proven interventions are available.**

Research evidence demonstrates that early identification and treatment of behavioral disorders can result in improved adherence, positive outcomes, and cost-effectiveness. Brief psychotherapy has been found to decrease health care utilization by 10–33%.¹⁵ A comprehensive meta-analysis concluded that 90% of studies report decreased medical utilization following psychological intervention.¹⁶

Behavioral health interventions are effective in improving outcomes for specific chronic diseases. Coronary heart disease patients treated with antidepressants are 91% more likely to have reduced inpatient service costs, and 72% more likely to have reduced office-based costs.¹⁷ Among cancer patients, cognitive-behavioral therapy was associated with significantly decreased depressive symptoms¹⁸, decreased pain¹⁹, reduced symptomatic distress, and subsequent improvement in cellular immune function.²⁰ In a diabetic population, treatment for depression improves glycemic control, compliance with treatment, psychosocial functioning, and quality of life.²¹

Call to Action: Proactive Screening and Intervention at Key Contact Points

Nearly half of all Americans will meet DSM-IV criteria for a behavioral health disorder during their life.²² Most go untreated or poorly treated, even if they are active consumers of medical care services.²³

One solution to this problem is proactive, routine screening at Primary Care Physician offices.

Over 50% of a physician's caseload consists of patients with medical ailments related to psychological factors.²⁴ Physical discomfort—headaches, sleep disturbance, gastrointestinal symptoms—from psychological distress is a common reason to seek medical care, even without a diagnosable psychiatric disorder.²⁵ Over two-thirds of patients with depression in primary care settings first present with somatic symptoms, resulting in unnecessary medical tests and delayed treatment.²⁶

Increased focus on behavioral health problems in hospital settings is also highly recommended.

One in five hospital stays include a mental health condition as a principal or secondary diagnosis.²⁷ The traditional intervention—if any—is to suggest outpatient services, with no follow up. This leads to substantially higher readmission rates.



Use of advanced technologies and “extender” services are highly promising innovations.

Some health plans and large group practices are analyzing claims data on a retrospective basis to identify high-risk individuals for increased outreach. New tele-health and web-based interventions have been implemented with positive results. These solutions use evidence-based treatment guidelines, while mitigating the stigma of behavioral health disorders.

Extensive research validates the interdependence of physical and behavioral health, as well as the substantial social and economic impact of co-occurring health problems. Effective, evidence-based interventions are available, but have not been widely implemented. Healthcare reform offers new opportunities to move beyond understanding the need for change. Making change happen is critical to achieve meaningful and successful transformation of our healthcare system.

HCSpecialists is a California-based business collaborating with healthcare organizations to optimize resources and improve patient outcomes. We have extensive experience in implementing solutions that integrate physical and behavioral healthcare, while achieving administrative savings and medical cost offset.

For more information about how HCSpecialists can help your organization to make change happen, visit our website: hcspecialists.com or email info@hcspecialists.com.



References

1. Ustun, T.B., Ayuso-Mateos, J.L., Chatterji, S., et al. (2004). Global burden of depressive disorders in the year 2000. *Br J Psychiatry*;184:386-92.
2. World Health Organization: The global burden of disease: 2004 update. Available at: http://www.who.int/healthinfo/global_burden_disease/2004_report_update/en/index.html
3. Lenneman, J., Schwartz, S., Giuseffi, D. L., & Wang, C. (2011). Productivity and health: an application of three perspectives to measuring productivity. *Journal of Occupational and Environmental Medicine (JOEM)*, 53 (1): 55-61.
4. Daniel, J., Honey, W., Landen, M., et al. (2005). Mental health in the United States: health risk behaviors and conditions among persons with depression--New Mexico, 2003. *Morbidity and Mortality Wkly Report*; (39): 989-91.
5. Owens, P., Mutter, R.L., & Stocks, C. (2010). Mental health and substance abuse-related emergency department visits among adults, 2007. Rockville, MD: Agency for Healthcare Research and Quality. Available at: <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb92.pdf>.
6. Cummings, N.A. & VandenBos, G.R. (1981). The twenty years Kaiser-Permanente experience with psychotherapy and medical utilization: implication for national health policy and national health insurance. *Health Policy Quarterly*, 1:159-175.
7. De Hert, M., Correll, C.U., Bobes, J. et al. (2011). Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. *World Psychiatry*;10:52-77.
8. Katon, W.J. (2003). Clinical and health services relationships between major depression, depressive symptoms, and general medical illness. *Biol Psychiatry*. 54(3): 216-26.
9. National Institute for Health and Clinical Excellence. (2009). Depression in Adults with a Chronic Physical Health Problem: Treatment and Management. NICE Clinical Guideline 91. Available at: <http://www.nice.org.uk/nicemedia/live/12327/45909/45909.pdf>
10. Fauerbach, J., Bush, D.E., Thombs, B.D., McCann, U.D., et al. (2005). Depression following myocardial infarction: A prospective relationship with ongoing health and function. *Psychosomatics*, 46(4), 355.
11. Frasure-Smith, N., Lesperance, F., & Talajic, M. (1993). Depression following myocardial infarction: Impact on 6-month survival. *JAMA*, 270, 1819-1196.
12. Ohira, T., Iso, H., Satoh, S., Sankai, T., Tanigawa, T., Ogawa, Y., et al. (2001). Prospective study of depressive symptoms and risk of stroke among Japanese. *Stroke*; 32: 903-908.
13. ten Brinke, A., Ouwerkerk, M.E., Zwinderman, A.H., Spinhoven, P., & Bel E.H. (2001). Psychopathology in patients with severe asthma is associated with increased health care utilization. *Am J Respir Crit Care Med*;163:1093-1096.
14. Culpepper, L. (2009). Generalized anxiety disorder and medical illness. *J Clin Psychiatry*;70 (Suppl 2):20-4.
15. Mumford, E., Schlesinger, H.J., Glass, G.V., et al. (1984). A new look at evidence about reduced cost of medical utilization following mental health treatment. *Am J Psychiatry*, 141:1145-1158.
16. Chiles, J.A., Lambert, M.J., & Hatch, A.L. (1999). The impact of psychological interventions on medical cost offset: A meta-analytic review. *Clinical Psychology: Science and Practice*; 6: 204-220.
17. Thompson, D., Hylan, T.R., McMullen, W., Romeis, M.E., Buesching, D., & Oster, G. (1998). Predictors of a medical-offset effect among patients receiving antidepressant therapy. *The American Journal of Psychiatry*, 155(6), 824-827.
18. Greer, S., Moorey, S., Baruch, J.D., et al. (1992). Adjuvant psychological therapy for patients with cancer: a prospective randomised trial. *British Medical Journal*; 304 (6828): 675-80.
19. Dalton, J.A., Keefe, F.J., Carlson, J., et al. (2004). Tailoring cognitive-behavioral treatment for cancer pain. *Pain Manag Nurs.*; 5: 3-18.
20. McGregor, B.A., Antoni, M.H., Boyers, A., et al. (2004). Cognitive-behavioral stress management increases benefit finding and immune function among women with early-stage breast cancer. *J Psychosom Res.*; 56: 1-8.
21. Williams, J. W., Jr., Katon, W., Lin, E. H, Noel, P. H., Worchel, J., Cornell, J., et al. (2004). The effectiveness of depression care management on diabetes-related outcomes in older patients. *Ann Intern Med*; 140:1015-1024.
22. Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters. E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry*; 62(6): 593-602.
23. Wang, P.S., Lane, M., Olfson, M., Pincus, H.A., Wells, K.B., & Kessler, R.C. (2005). Twelve-month use of mental health services in the United States: results from the National Comorbidity Survey Replication. *Arch Gen Psychiatry*; 62(6): 629-40.
24. VandenBos, G.R. & DeLeon, P.H. (1988). The use of psychotherapy to improve physical health. *Psychotherapy*; 25, 335-343.
25. Sobel, D.S. (2000). The cost-effectiveness of mind-body medicine interventions. *Prog Brain Res*; 122: 393-412.
26. Kirmayer, L.J., Robbins, J.M., Dworkind, M., et al. (1993). Somatization and the recognition of depression and anxiety in primary care. *American Journal of Psychiatry*; 150: 734-741.
27. Saba, D., Levit, K. & Elixhauser, A. (2008) Hospital stays related to mental health, 2006. Rockville, MD: Agency for Healthcare Research and Quality. Available at: <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb62.pdf>.