The Need for Coordinated Care for Depression, and the Need for Creative Innovation

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Abstract

Mental disorders are a major source of functional disability and add significantly to the health care and lost productivity costs of U.S. employers. Depression is also costing U.S. employers tens of billions of dollars every year in lost productivity time and costs for medical and therapeutic treatment through the current acute-care system. Patients who access behavioral health services have substantially higher total health care costs than those who do not. Opportunity exists for additional health care cost savings from more effective and timely treatment of depression, psychosocial and other behavioral health care disorders. The key starting point in making behavioral health care system changes is to identify the nature and scope of the problem. Employers and payers need to actively seek change in the system of mental healthcare delivery—operational, clinical and financial change.

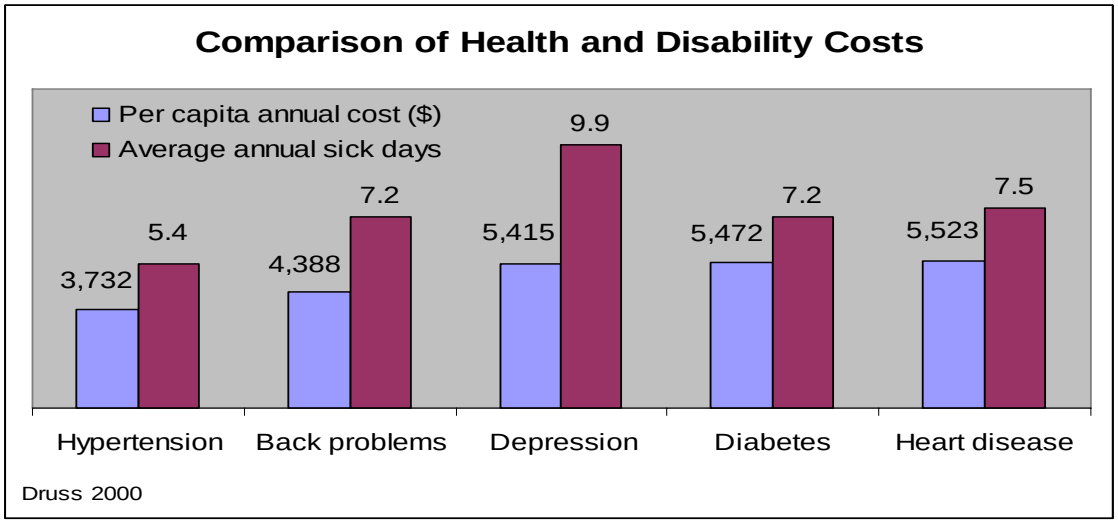
1. Introduction

Mental disorders are a major source of functional disability and add significantly to the health care and lost productivity costs of U.S. employers. Several industry trends are notable over the past decade, specifically:

- The large increase in treatment prevalence for mental disorders.
- The dramatic shift away from professional treatment to pharmaceutical treatment.
- The increasing role of primary care physicians (PCPs) in treating mental illness.
- The segregated physical and specialty mental health treatment and payment systems.

Depression is a widespread illness in America. A recent study reported in the *Journal of the American Medical Association* (JAMA) found that 16.2 percent of the U.S. adult population will experience depression at some point during their lifetime, and that 6.6 percent of U.S. adults suffered a major depressive episode in the past year. And this does not include the tens of millions of Americans who have psychosocial distress who do not qualify for a psychiatric diagnosis. In spite of its high prevalence, depression often goes undiagnosed and/or inappropriately treated (Young, Klap, Sherbourne and Wells, 2001).

Depression is also costing U.S. employers tens of billions of dollars every year in lost productivity time and costs for medical and therapeutic treatment through the current acute-care system. Employees with depression incur more sick days than those with hypertension, back problems, heart disease or diabetes, and per capita health and disability costs of depression are as high as those of diabetes and heart disease as shown in the following chart.



The current health care system in the United States treats depression in an episodic and fragmented manner, and rarely coordinates treatment of depression as a chronic condition among specialties. It is also often under-treated or mistreated when present with other chronic conditions such as cancer, heart disease and chronic lung disease. The current behavioral health care delivery system has evolved over the last decade, largely driven by employers seeking cost management and managed behavioral health care organizations (MBHOs) delivering "satisfactory" results. However, this evolutionary process has produced many system flaws which have been largely unsolved, if not unaddressed entirely.

The behavioral health care "carve-out" model has resulted in silos of health care delivery, with physical care being delivered in one silo and behavioral care delivered in a different silo, with little integration or collaboration between them. Each silo has its own needs, plans, interests and culture, which often clash. Financial incentives exist which result in inadequate, ineffective and inappropriate care. Employer costs skyrocket. Depressed patients all too often get the wrong treatment by the wrong providers. Regularly, PCPs just treat physical symptoms of depression, without identifying the underlying disorder. And if they do identify the disease in a patient, it often results in well-intentioned but misguided overuse of antidepressants. Most PCPs have insufficient time and understanding to educate patients on the course, duration, response and side effects of such treatment. Depression is costing employers far more than what is paid to MBHOs.

2. The Current Behavioral Health System

Mental disorders are prevalent in the United States and internationally. An estimated 22.1 percent of Americans ages 18 and older (about one in five adults) suffer

from a diagnosable mental disorder in a given year (Regier, Narrow, Rae, et al., 1993). This translates to about 48 million American adults. In addition, according to the World Health Organization, in the United States and other developed countries, major depression, bipolar disorder, schizophrenia and obsessive-compulsive disorder are each ranked among the top 10 conditions with the highest disease burden (a measure of the gap between current health status and ideal health status).

According to the World Health Organization, the cost of mental illness in the United States exceeds $160 billion annually in direct and indirect costs (World Health Organization, 2001). Direct costs account for $99 billion, and 80 percent of the estimated indirect costs are the direct result of lost productivity in the workplace (Stewart, Ricci, Chee, et al., 2003). This includes organic disorders such as depression, schizophrenia and compulsive disorders as well as behavioral conditions such as substance abuse.

Recently the cost of depression to U.S. employers has been estimated at $44 billion annually in lost productivity (Stewart, Ricci, Chee, et al., 2003). This cost excludes direct employer health care costs. As well, depression can increase the cost of physical healthcare because of its physically manifested symptoms and the fact that it can exacerbate underlying chronic physical conditions such as asthma or diabetes.

Between 1987 and 2000, spending on mental disorders in the United States increased from $9.9 billion to $34.4 billion, which represented the largest percentage increase in spending in the most common 15 medical conditions over this time period (Thorpe, Florence and Joski, 2004). The increase that was attributed to a rise in treatment prevalence was estimated at 59.2 percent, second only to cerebrovascular disease as the largest increase in treatment prevalence among the 15 conditions.

How much of our private health care insurance dollars are spent treating mental health disorders? In 1991, an estimated 4.3 percent of all private health care insurance expenditures were for mental health treatment (includes mental illness diagnosis and treatment only, and excludes medical consequences of mental health disorders and treatment of medical symptoms caused by mental disorders). In 2001, it was still at 4.3 percent. However, removing the prescription drug component yields an entirely different pattern. In 1991, 3.78 percent of all private health care insurance expenditures were for non-prescription mental health treatment. By 2001, this had dropped to 2.66 percent, a 30 percent decrease over the 10-year period (Mark, et al., 2004). This result can be largely attributed to the rapid expansion and success of managed behavioral health care by specialty vendors, which resulted in increased clinical efficiencies in specialty behavioral health care treatment. But these organizations manage treatment that is sought only in specialty mental health settings. The following facts show that

many people receive help for mental disorders or emotional distress from clinicians who are not mental health professionals (Patterson, Peek, et al., 2002).

- 50 percent of mental healthcare is delivered solely by PCPs,
- Two-thirds or more of all psychopharmacological drugs are prescribed by PCPs,
- 90 percent of the 10 most common presenting symptoms/complaints in the primary care setting have no organic basis,
- 50 percent to 70 percent of all primary care visits are primarily for psychosocial concerns, and
- In recent years, about 7 percent of patients visiting their PCP received psychotropic medications.

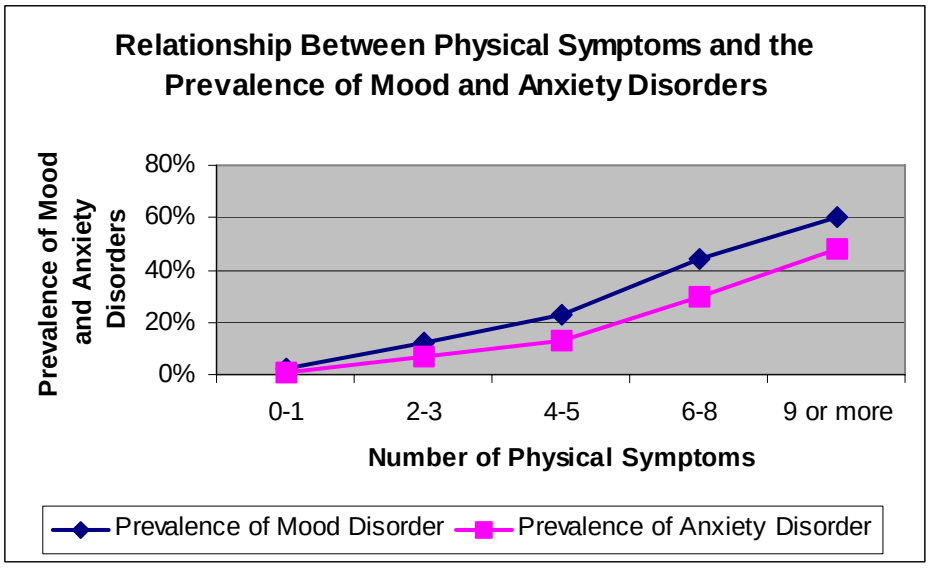
Is our current system of mental healthcare really working? Do payers know how much they are truly spending on mental health care treatment? Is the behavioral health care carve-out approach "the solution" to today's mental healthcare challenges? Are PCPs effectively treating mental health conditions? How much waste still exists in mental healthcare spending? Is it time for creative innovation in our U.S. health care system for behavioral health care?

3. The Current Fragmentation of Care

A significant event in the history of healthcare delivery in the United States was the development of separate and parallel systems of mental and physical care. MBHOs surfaced rapidly in the 1980s when behavioral health care costs were skyrocketing. Hospitals had swiftly expanded their psychiatric units as profit centers. At this time, the MBHO emerged and public programs, health plans and employers began to "carve-out" their behavioral health care to these organizations to save money.

Under a carve-out arrangement, a health plan contracts with an MBHO to administer and manage the specialty behavioral health services for its members. This is usually defined as care rendered by psychiatrists, psychologists, social workers and inpatient or intensive outpatient mental health and substance abuse treatment. Typically, MBHOs operate under a capitated arrangement and try to keep their specialty behavioral care costs low to make profits. Evidence suggests that MBHOs have been very successful in decreasing wasteful hospitalizations and improving efficiency (U.S. Public Health Service, 2000). MBHOs also provide focused management for behavioral cases and direct care to behavioral health specialists, which may offer better ability to promote quality care than care rendered by generalists. Many MBHOs have extensive networks and have negotiated relatively low fees, which helps reduce costs.

The majority of privately insured individuals (about 60 percent) would gain access to their insured mental health benefits from an MBHO, which is administered separately from their physical healthcare benefit. Herein lies a problem. Mental and physical health cannot be so easily separated. Mental illness often manifests in physical symptoms such as headaches, chest pain, fatigue, back pain, numbness and dyspnea. As the number of physical symptoms that a person suffers from increases, so does his or her likelihood of a psychiatric disorder. The graph below illustrates the relationship between number of physical symptoms and the prevalence of a mood disorder or anxiety disorder. The study suggests that multiple physical symptoms may signify a potentially treatable mood or anxiety disorder (Kroenke, Spitzer, Williams, et al., 1994).



This graph shows that, for people with six to eight physical symptoms, 30 percent of them will have a mood disorder and 45 percent of them will have an anxiety disorder. This relationship does not prove that behavioral conditions cause physical symptoms or vice versa. It does, however, demonstrate that physical and behavioral symptoms often coexist within the patient, especially as the number of physical symptoms increase.

In addition, mental health conditions, when co-occurring with physical conditions such as diabetes and heart disease, may impair an individual's ability to seek and stay on treatment, thus putting them at risk for increased morbidity (National Institutes of Mental Health, 2004). Administering mental and physical health through two distinct health care "silos" can make it more difficult to effectively treat either condition.

Employees who are depressed or highly stressed can have higher overall health care expenditures than those without these conditions, as demonstrated by the results of an analysis of 46,000 employees of six large healthcare purchasers. Ten different modifiable risk factors were studied, including tobacco use, sedentary lifestyle and high blood pressure. Employees that reported themselves as depressed incurred 70 percent higher expenditures than those who were not, and employees who were highly stressed incurred 46 percent higher expenditures than those who were not highly stressed (Goetzel, Anderson, Whitmer, et al., 1998).

When patients do seek treatment for a mental condition, the majority seek care from a PCP first. Only 3–6 percent of the insured population will seek treatment by a behavioral health specialist in any year. All others suffering from mental disorders go untreated or obtain treatment medically through their PCPs. Researchers estimate that close to 75 percent of patients seeking primary care treatment have behavioral or psychosocial issues affecting their health (Arizona Health Futures, 2003).

Mental health professionals commonly refer to the primary care setting as the *de facto mental healthcare delivery system.* But despite their best intentions, PCPs are often unable to fully understand and treat their patients' mental health concerns. This is partly due to time constraints that leave the physician unable to address much beyond the patient's physical complaint. Certain healthcare organizations may set standards for the number of patients a physician sees daily. Economic incentives exist for time- and cost-efficient practices. If a patient has a specific biomedical problem, the physician prescribes the appropriate treatment and moves on to the next appointment, assuming that the previous patient's needs were met. In a system where patients are allotted 10–15 minutes for a visit, multiple vague patient problems can be easily overlooked (Regier, Narrow, Rae, et al., 1993). PCPs are trained to diagnose and treat physical conditions quickly, but not as well trained for rapid diagnosis of behavioral disorders.

Identifying contributing mental health and social factors in the care of illness and injury and in health improvement is often difficult for patients and clinicians. Much of this difficulty is because of the legacy of separate and parallel systems of mental and physical care. This split also has had a major influence in the financing of care and insurance reimbursement where there are separate guidelines and fee schedules for what is covered. In many plans, reimbursement depends on meeting criteria for a specific diagnosis, and generally physical and mental diagnoses are distinct. Care managers can be effective in coordinating these various aspects of patient needs. But this focus occurs generally for high-cost patients, and many with mental disorders can fly under the case manager's radar. Disease management companies are having success in working with patients suffering from conditions such as asthma, diabetes and

congestive heart disease. But there has been less focus on mental illness, both as a stand-alone condition or coexisting with another chronic condition.

Today, physicians and mental health professionals usually practice in separate settings, focus on either body or mind, and ask different types of questions to arrive at a diagnosis and develop a treatment plan. Like physical conditions, mental conditions are characterized by specific symptoms and are diagnosed using clinical methods. They can now be diagnosed with the same reliability and accuracy as common physical conditions (World Health Organization, 2001). However, PCPs are often poorly trained in these diagnostic methods and may not recognize that the patient has a physical problem manifested from an underlying mental condition (Rost, Zhang, Fortney, et al., 1998). These patients are often treated for their physical symptoms and sent home only to return for symptomatic treatment by their PCPs again and again. These high utilizing patients represent a number who are over-serviced yet under-served by the current health care delivery system. While patients with behavioral disorders can achieve remission on their own without targeted treatment for their disorder, focused treatment for their behavioral disorder has a much greater likelihood for success than no treatment.

While medical education has made important strides in teaching students about the relationship between behavioral and physical health, too often practice follows the mind-body split. In its most polarized and stereotypical characterization, medical professionals are trained to address the physical health of patients. Although the patient's emotional and psychological health may exacerbate physical symptoms, they can be ignored, missed, overlooked, or not dealt with directly. In fact, physicians sometimes view physical health as distinct and separate from the emotional and psychological issues impacting a person's functioning. Likewise, mental health professionals sometimes address the emotional and psychological health of their patients without regard to physical condition. Many mental health practitioners view mental health disorders as their exclusive domain (Patterson, Peek, et al., 2002).

Patients themselves are not immune to separating health and illness issues into distinct physical and mental domains, often to their detriment. Patients are often reluctant or unable to identify feelings of sadness, worry or loneliness. These patients may be more comfortable offering physical complaints and will ignore the accompanying emotions, thus perpetuating the status quo of fragmented care (Patterson, Peek, et al., 2002).

4. Mental Health Spending Trends in Private Insurance

The pattern of spending on mental healthcare within the private insurance sector since the rapid growth of managed behavioral health care reveals some significant results:

- Mental health spending stayed fairly close to 3.5 percent of all health care spending during this period, although the rate has been increasing in the last several years.

- The use of psychotropic drugs to treat mental health conditions skyrocketed, averaging an increase of almost 20 percent per year.

Table 1 presents national estimates of private insurance expenditures on mental health spending between 1991 and 2001 by type of provider for mental health treatment (includes mental illness diagnosis and treatment only) (Mark, et al., 2004).

TABLE 1
Private Insurance Expenditures by Type of Provider (millions)

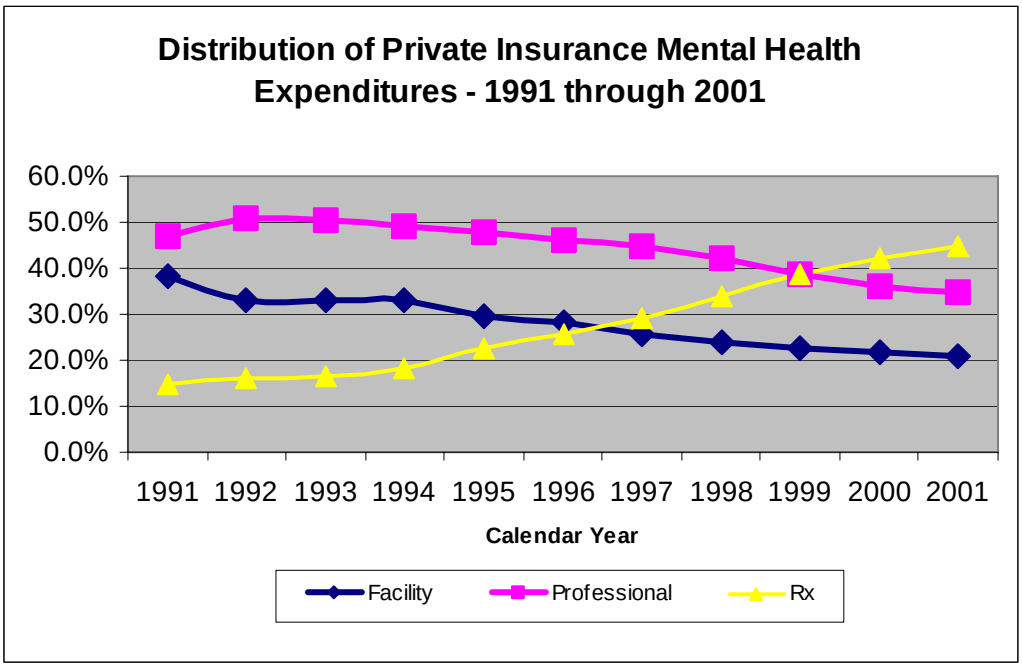
	Mental Health Expenditures								Percent of
Year	IP Hospital	OP Hospital	Residential	Psych MDs	Other MDs	Other Psych	Rx	Total	All Health
1991	$3,163	$240	$ 68	$1,815	$ 633	$1,828	$1,344	$ 9,091	3.58%
1992	$2,637	$261	$ 64	$1,806	$ 824	$1,929	$1,435	$ 8,956	3.27%
1993	$2,947	$246	$ 88	$1,896	$1,006	$2,090	$1,630	$ 9,903	3.32%
1994	$3,307	$197	$118	$2,117	$1,052	$2,240	$2,002	$11,033	3.54%
1995	$2,897	$261	$200	$2,295	$ 927	$2,238	$2,589	$11,407	3.47%
1996	$2,613	$330	$286	$2,146	$ 973	$2,127	$2,914	$11,389	3.31%
1997	$2,344	$413	$386	$2,027	$1,240	$2,190	$3,558	$12,158	3.38%
1998	$2,200	$492	$444	$1,959	$1,362	$2,187	$4,420	$13,064	3.42%
1999	$2,242	$481	$440	$1,891	$1,417	$2,141	$5,471	$14,083	3.42%
2000	$2,416	$497	$458	$1,976	$1,471	$2,192	$6,607	$15,617	3.48%
2001	$2,733	$502	$500	$2,224	$1,601	$2,392	$8,031	$17,983	3.62%

Table 2 presents these expenditures as a distribution of private insurance expenditures for mental health services during this decade by type of provider.

TABLE 2
Private Insurance Expenditures by Type of Provider – Distribution of Spending

Year	IP Hospital	OP Hospital	Residential	Psych MDs	Other MDs	Other Psych	Rx
1991	34.8%	2.6%	0.7%	20.0%	7.0%	20.1%	14.8%
1992	29.4%	2.9%	0.7%	20.2%	9.2%	21.5%	16.0%
1993	29.8%	2.5%	0.9%	19.1%	10.2%	21.1%	16.5%
1994	30.0%	1.8%	1.1%	19.2%	9.5%	20.3%	18.1%
1995	25.4%	2.3%	1.8%	20.1%	8.1%	19.6%	22.7%
1996	22.9%	2.9%	2.5%	18.8%	8.5%	18.7%	25.6%
1997	19.3%	3.4%	3.2%	16.7%	10.2%	18.0%	29.3%
1998	16.8%	3.8%	3.4%	15.0%	10.4%	16.7%	33.8%
1999	15.9%	3.4%	3.1%	13.4%	10.1%	15.2%	38.8%
2000	15.5%	3.2%	2.9%	12.7%	9.4%	14.0%	42.3%
2001	15.2%	2.8%	2.8%	12.4%	8.9%	13.3%	44.7%

The following chart presents a clear picture of the changing trends in private insurance spending on mental healthcare:

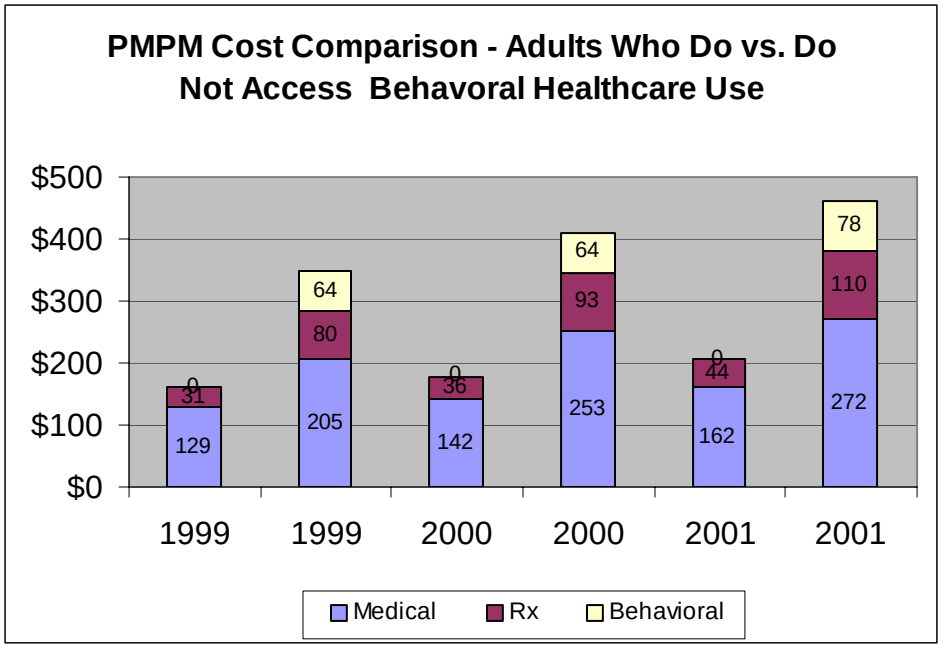


These data suggest several key trends:

- Prescription drug costs for mental health conditions may soon exceed costs from all other mental health provider types combined and make up more than 50 percent of all mental health spending.
- MBHOs have successfully managed IP hospital costs, but further savings opportunities may be harder to obtain.
- MBHOs have been successful in reducing total specialty (non-Rx) care costs for mental healthcare.
- The increase in use of OP hospital and residential treatment, which are lower cost options to acute IP stays, has leveled off.

5. Increased Costs for Physical Health Care Associated with Mental Health Conditions

Patients who access behavioral health services have substantially higher total health care costs than those who do not. The following chart compares costs over a three-year period for a large insured group that we have worked with, separately for adults with and without behavioral health service use. In each yearly pair of columns, the left column shows the medical and Rx costs for members that did not use behavioral health services during the year, and the right column shows the medical, Rx and behavioral health care costs for members who did use behavioral health care services during the year.



Medical costs were nearly 70 percent higher, and prescription drug costs were 155 percent higher for the adults that used behavioral health care services in the group. Total health care costs for adults using behavioral health care services averaged nearly 2.25 times the costs for adults that did not use behavioral health care services within this group. Whether behavioral illnesses led to additional physical health care or physical illnesses led to additional behavioral health care, there is clearly a pattern of increased physical and total health care expenditures for patients accessing behavioral health care.

6. Innovations in Care for Mental Health

So where do we go from here? How do we transform a fragmented system of mental healthcare that substantially lacks coordination with the physical health care system? How do we reduce inappropriate and ineffective treatment costs in primary care settings? How do we achieve creative disruption in a system in which mental and physical care are regularly treated as two distinct silos of care, where patients suffer despite the availability of effective treatments? How do we leverage the expertise and accomplishments of the specialty mental health sector into primary care and other health care delivery settings?

I believe that opportunity exists for additional health care cost savings from more effective and timely treatment of depression, psychosocial and other behavioral health care disorders. Such savings opportunities include a reduced number of office visits, fewer diagnostic tests and treatment of symptoms that arise from undiagnosed behavioral and psychosocial disorders, reduced inpatient expenses for acute behavioral illness cases that are prevented by earlier detection and treatment, reduced costs for patients suffering from chronic conditions (such as diabetes, heart disease, asthma, pulmonary disorders) with coexisting untreated depression or anxiety disorders and reduced emergency care services for patients ineffectively treated for their behavioral disorders. Additionally, more effective and appropriate use of psychotropic drugs is another valuable opportunity within health care today.

One solution that has been proposed is integrated care—providing specialty behavioral health care in the primary care setting. Integrated care makes sense in theory because the PCP is the first point of contact in most cases, many individuals perceive less social stigma in seeking care from a PCP as opposed to a behavioral health specialist, and providing behavioral health services in a primary care setting recognizes the interrelationship between physical and mental health. Many models and ideas have been proposed to integrate primary care and specialty behavioral care.

The collaborative care model is an integrated model developed to improve diagnosis and treatment at the front line, the PCP. The collaborative care model incorporates multi-disciplinary health care professionals to support the PCP in the care of mental illness. Many different variations of the collaborative care model have been studied in different settings that attempt to demonstrate the value of integrated care.

One such study, Improving Mood—Promoting Access to Collaborative Treatment (IMPACT), utilized care managers, specially trained nurses or psychologists, to work with the PCP to educate patients and track symptoms and medication side effects (Unutzer, et al., 2002). Other organizations have studied the impact of telephonic programs, using nurses to support and educate patients and provide feedback to the PCP regarding patient non-compliance and medication issues (Hunkeler, Meresman, et al., 2000; Simon, Manning, Pearson, et al., 2002). Kaiser Permanente in California was successful in using pharmacists as a liaison between PCPs and psychiatrists. Pharmacists provided telephone and in-person education and support to patients following their initial prescription of an anti-depressant by a PCP (Finley, Rens, Pont, et al., 2002). The pharmacists provided feedback to the PCP and consulted with psychiatrists when necessary.

In the above models, patients experienced significant reductions in measures of disease-specific severity and improvements in disability. The intervention groups in the above models also experienced improvements in rates of medication adherence. These studies suggest that using multi-disciplinary support for the PCP can improve the treatment and clinical outcomes for patients with mental illness seeking treatment in primary care settings.

Improvements in care have also been achieved by less intensive interventions. Several studies have shown improvements in adherence to clinical guidelines and improvement in disease burden as a result of providing PCPs with education, structured diagnostic tools, pharmacy reports, and computerized modules (Simon VonKorff, Rutter, et al., 2000).

In addition to published studies, several organizations are currently piloting innovative programs. The University of California, Blue Shield of California and United Behavioral Health (UBH) are researching the impact of aligned financial incentives and system integration. Under a grant funded by the Robert Wood Johnson Foundation, PCPs who undergo training in the treatment of depression are considered credentialed behavioral providers. These providers are given an additional fifteen minutes with depressed patients for which they can bill UBH for a medication management visit. In addition, PCPs are provided access to UBH psychiatrists for consultation, and a UBH

case manager coordinates patient care between PCPs, mental health specialists and community resources (Robert Wood Johnson Foundation Grant Detail, 2004).

Other innovative research projects currently underway include examining the effect of multidisciplinary group visit programs conducted in general internal medicine offices, studying the effect of adolescent and parental education to improve treatment adherence and follow-up for adolescents with depression and evaluating the impact of telephone follow-up to monitor mildly depressed patients (to identify which patients will benefit from further treatment, and to create an evidence-based assessment tool to assist in identifying mildly depressed patients that would benefit from antidepressant therapy) (Robert Wood Johnson Foundation Grant Detail, 2004).

7. The Need for Creative Innovation

Despite successful research programs and evidence supporting collaborative care in the treatment of mental illness, the behavioral health system remains quite fragmented and in need of cost-effective change. Several of the studies mentioned above show promise in improving care; however, putting successful study interventions into practice on a system-wide level presents many challenges. The most daunting barrier to system-wide change is misaligned financial incentives.

The current carve-out system tends to work well for MBHOs who try to keep their costs low. When a patient seeks health care from a PCP, the claim is incurred under the physical health plan, even if it has a mental health root. As well, medications used in the treatment of mental health conditions are not carved out to MBHOs. A typical health plan cost for behavioral health care is $2.50 per member per month (PMPM), yet the prescription cost for mental health medications may range from $5.00 to $7.00 PMPM. One large insured group we have worked with recently had its specialty managed behavioral care costs down to about $1.00 PMPM, yet their actual costs for antidepressants alone were over $4.00 PMPM! While substitution of effective pharmaceutical treatment for professional services may be a consequence of better therapy and quality, can better outcomes be demonstrated? How well are these medical costs being managed? Is there sufficient focus on effective and efficient delivery of mental health care in physical health care settings?

The current total behavioral health care system needs to build upon the success of the MBHOs. This redesign should include operational, clinical and financial enhancements. The very systems that were put into place in the 1980s and 1990s to contain specialty mental health costs, while very successful in their own right, are the same systems that are helping to drive other non-specialty mental health costs much

higher today. On the surface it appears that mental health spending is a small percentage of overall health spending and that the MBHOs are effectively containing all mental health costs. However, when looking at the entire mental health care cost picture, the perception changes. Treatment costs for mental healthcare are showing up in much larger proportions in the general medical sector. Many employers and payers may not even be aware of this spending.

8. Incremental Change

Changing today's behavioral health care system will take time and system-wide collaboration. In the meantime, organizations can make incremental changes to contain costs and improve the care of mental and behavioral conditions.

8.1 PCP Support

PCPs often see over 30 patients per day. In 15 minutes, they are expected to obtain enough information from a patient to make an accurate diagnosis, provide evidence-based treatment and provide patient education. Clearly, PCPs need additional tools and support. Easy-to-use diagnostic tools and treatment algorithms can save busy physicians valuable time. Information identifying patients who have not refilled their medications or who are in need of follow-up contact or visits provides physicians valuable clinical management information.

8.2 Drug Benefits

Drug benefit design can be an invaluable tool in evidence-based medicine. Substantial savings opportunities may exist where antidepressants are ineffectively or inappropriately utilized, and also where they are prescribed at dosage levels much lower than recommended by accepted clinical guidelines. The formulary can also be used as a tool to reduce unnecessary use of brand drugs and provide incentives for consumers to make wiser health care utilization choices when appropriate. For example, all antidepressants may not be equally cost-effective. And new agents to enhance monoamine neurotransmission continue to be developed and gain FDA approval (Eli Lilly's Cymbalta is one recent example that is a dual action serotonin and noradrenergic reuptake inhibitor).

8.3 Benefit Design

Benefit designs that create barriers to access such as higher co-pays or benefit limits for specialty behavioral health may be counterproductive. Such barriers can keep patients from seeking the right kind of mental health care and instead lead them to seek more frequent care of physical symptoms in medical settings.

8.4 Disease Management/Collaborative Care Programs

Support for patients suffering from mental and behavioral health conditions is essential. Like other chronic diseases, mental and behavioral conditions require ongoing care and education. Ensuring compliance to medications and treatment plans is the best way to ensure that patients can overcome the barriers of mental illness and return to living a healthy, satisfying and productive life.

9. A Place to Start

The key starting point in making behavioral health care system changes is to identify the nature and scope of the problem. For employers and health care payers, the first step is to quantify the true cost of behavioral health care for their employees or members and identify opportunities for improved care. To do this, we recommend that they:

- Identify the prevalence of behavioral health conditions in their covered populations, what percent are treated and where treatment occurs.
- Quantify spending on prescription medications used to treat mental illness and identify if and where there is waste (i.e. treatment adherence problems, under-dosing, overuse of brands, treatment switching issues and formulary design issues).
- Identify barriers that might preclude patients from seeking treatment by a mental health specialist (higher co-pays, benefit limits, network inadequacy, etc).
- Consider implementing programs that support integrated care and disease management for patients with mental illnesses, chronic pain, fatigue and similar conditions.

10. Conclusion

Is anyone satisfied with today's fragmented system of mental healthcare? The current disconnected systems of healthcare delivery often force providers and patients to choose between medical and behavioral healthcare. Because treatment of human health and illness does not break down into traditional either-or delivery structures, dissatisfaction may be felt by those involved. Patients continue to receive suboptimal care. Employers experience productivity or behavioral problems with employees with mental health conditions, and their medical and Rx costs attributable to mental disorders continue to rise.

Employers and payers need to actively seek change in the system of mental healthcare delivery—operational, clinical and financial change. They are the drivers of needed change. They should seek innovative ways to deliver better care to the millions of Americans that suffer from mental health disorders each year. The bottom line is that, like other areas of health care, mental health care costs are also increasing rapidly, and our segregated system of mental and physical health care may actually be driving some of these increases.

Many competing interests in health care today are competing for the "disease state management" dollars of health plans, employers and other payers. Is a focus on obesity, diabetes, cancer, heart disease or smoking cessation the best course for disease management innovations? Or is an integrated approach that realizes mental health care affects all of these conditions the highest priority?

I believe that by focusing on systems that get patients the right mental or physical health care at the right time by the right provider, by improving provider and patient education on mental and physical health issues, by improving patient adherence to drug treatment regimens and by aligning incentives in the physical and behavioral health care benefit plans and delivery systems, not only can health care be greatly improved, but the bottom line may be as well.

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