M3 Information™

Why Employers Should Focus on Measurement-Based Care for Mental Health and Substance Use Disorders

Every day, the nation's large and small businesses, providers of health insurance coverage for almost 156 million employees and their families [1], face the consequences of our society's poor track-record with mental health and substance use disorders (MHSUD). Beyond the unquantifiable pain, suffering, and turmoil these conditions bring to employees' lives, companies pay significant financial costs for the lost productivity and elevated medical expenses traceable to unrecognized and untreated MHSUD.[2,3]

Given the prevalence of unrecognized MHSUD in society, it is not surprising that employers bear a large part of the resulting burden. Depression, for example, was found to have an economic impact of more than $210 billion in 2010, only 45-47% of which was attributable to direct treatment costs. For most large employers, antidepressants are among the top three classes of drugs in their spending on pharmaceuticals. Up to $105 billion could be attributed to lost productivity, absenteeism, and disability resulting from depression.[4] Anxiety is an even more prevalent condition than depression, affecting 22% of the population in any given year, most of whom do not receive effective treatment.[5] The costs associated with anxiety are comparable to those of depression. [6]

Employers increasingly recognize that our health care system fails to meet their MHSUD needs, and they are looking for tools to help employees and their families connect with the resources that will help them avoid undue suffering and unnecessary costs.

> "Mental health is a topic everyone can relate to. And we're seeing more and more businesses recognizing the impact of mental health – 50% of all long-term sickness relates to mental health. Any employer of any size who looks at people who are off sick long-term will recognize this – and all businesses recognize the benefits of workers in good mental health, as they're engaged and fully productive."
>
> Sam Wyatt, BUPA
>
> (http://www.forbes.com/sites/hesterlacey/2014/03/19/mental-health-at-work-what-every-team-leader-should-know/#55e76e934ae7)

30% to 40% of Americans experience MHSUD at some point in their lives, and about half of this number would benefit from professional help in a given year.[7] Yet as many as two-thirds of people meeting the clinical criteria for diagnosis of a mental health or substance use disorder receive no treatment at all for their condition. [8,9] With most Americans still accessing health insurance through their employers, it is important to recognize that coverage alone does not guarantee access to appropriate care. Employers need some way to gauge the value received for their outlay.

Undetected mental health and substance use disorders contribute dramatically to poor outcomes for conditions such as heart disease, asthma, and diabetes. Unchecked, the resulting rise in the cost of care in turn leads to higher premiums for employers and employees.[10] People with depression are twice as likely to develop coronary artery disease or to have a stroke – and four times as likely to die within six months once a heart attack strikes. Failure to address these comorbidities has a demonstrable financial cost, as well as a human one. In reporting on last year's release of a World Health

Organization report, Forbes clearly presented the stakes at the global level: "In April, 2016 the World Health Organization released a groundbreaking study that established a definitive link between mental health and economic productivity. The findings were both depressing and hopeful. On the downside, depression and anxiety disorders cost the world nearly U.S. $1 trillion annually. On the upside, every dollar invested in treating anxiety and depression disorders leads to a return of $4 in terms of the ability to work and thus contribute to the economy."[12]

"…depression and anxiety cost the world nearly $1 trillion annually. On the upside, every dollar invested in treating these disorders leads to a return of $4 in terms of the ability to work and thus to contribute to the economy."
FORBES, 2016

(http://www.forbes.com/sites/hbsworkingknowledge/2016/06/29/the-1-trillion-link-between-mental-health-and-economic-productivty/#74513681295a)

In the U.S., growing awareness points to an approach that integrates care for mental health and substance use disorders into the broader health care system. It is estimated that effective integration of this sort could save $26 billion to $48 billion annually in the nation's health care costs.[13] This approach must start with access to care. A recent study found that of the 8.4% of subjects found to have depression, only 28.7% had received any treatment.[14] Employers faced with the higher costs associated with untreated mental illnesses stand to save money if they can incentivize early identification of symptoms and appropriate follow-up interventions. One revealing study found that only 41% of those with MHSUD receive treatment in any given year, and only 28% receive care from a psychiatrist or other mental health specialist. Non-specialists, mainly primary care physicians, provide care to 38% of those with MHSUDs, with some individuals seeing both specialists and non-specialists. The study also found that just 13% of those treated by non-specialists received minimally adequate treatment, as opposed to almost half of those whose treatment came from specialists – itself a troubling statistic.[15]

"We know that treatment of depression and anxiety makes good sense for health and wellbeing; this new study confirms that it makes sound economic sense too."
Dr. Margaret Chan, director general, World Health Organization

(https://www.theguardian.com/global-development/2016/apr/12/50-million-years-work-lost-anxiety-depression-world-health-organisation-who)

The current state of affairs argues for a smarter, business-wise approach to health care purchasing and delivery for the major private payers, i.e. the nation's employers, large and small. Fundamental to this business-wise approach is an understanding of which treatments are effective. As it stands, there is much evidence that a high proportion of the treatment currently being delivered is ineffective. For example, a nationwide survey conducted in 2012 and 2013 by the Agency for Healthcare Quality and Research found that of those treated for depression, only 30% had, in fact, screened positive for the disorder.[16] One implication of this finding is that resources are being wasted on inaccurately diagnosed patients. Like payers, the specialists and non-specialists providing care – and their patients – stand to gain from improved understanding of symptoms and effective treatments.

Drawing on a broad range of scientific literature, the Kennedy Forum in 2015 published a white paper calling for behavioral

health and primary care providers to implement a system of "measurement-based care" to improve clinical outcomes for each patient.[17] Measurement-based care accurately and consistently screens and identifies patients at risk for mental health issues and allows providers to monitor treatment effectiveness over time. As the Kennedy Forum explains, measurement-based care is the practice of basing clinical care on client data collected throughout treatment. It is based on the use of systematic, patient reported outcome measures, including a variety of symptom rating scales.

"Measurement-based care will help providers determine whether the treatment is working and facilitate treatment adjustments, consultations, or referrals for higher intensity services when patients are not improving as expected," the paper explained.

The Kennedy Forum's purpose in publishing its Issue Brief was to establish measurement-based care for behavioral health as a standard of care. In addition to their health care purchasing decisions, employers will find that measurement-based care can help with their selection of wellness programs, EAPs, and other benefits they offer their employees.

Relying on measurement-based care is particularly important as payers transition from traditional fee-for-service payment to value-based purchasing approaches that recognize, for example, the costs of co-morbid conditions and the benefits of whole-person care, prevention, and wellness. As employers negotiate with health plans, it will be important to ensure that the plans require providers to use quantitative measures to document the progress patients are making (or not) under prescribed treatment protocols.

"Measurement-based care will help providers determine whether the treatment is working and facilitate treatment adjustments, consultations, or referrals for higher intensity services when patients are not improving as expected."
The Kennedy Forum

The Kennedy Forum (2015) Fixing Behavioral Health Care in America: A National Call for Measurement-Based Care in the Delivery of Behavioral Health Services. Available from: https://www.thekennedyforum.org/resources

Use of standardized instruments provides purchasers the assurance that care for MHSUD is being monitored, that effective treatments will be noted and continued, and ineffective approaches recognized and stopped. Measurement-based care also has substantial implications for the broader system, as it promises to curb the waste of health care dollars accruing from unexamined and ineffective behavioral health interventions.

One further benefit of standardized use of measurement-based care is that it will ultimately yield a body of data reflecting, for the first time, the treatment experiences of a broad array of clinicians and patients. Clinicians will be able to access information about the effectiveness of different treatments in real-life settings, moving the field towards more effective – and more cost-effective – treatment decisions. For employers, who in many instances are the purchasers, this development will result in a more productive workforce and significant cost savings.

The M3 Checklist is a prime example of a single, multidimensional assessment tool. Written to a 5th-grade reading level, the checklist can generally be completed in 3 – 4 minutes. It produces a score analogous to the values of a lipid panel or the reading of a blood pressure gauge, along with a profile identifying areas needing further attention. Each successive score can then be compared with the results of earlier tests so that, over time, trends can be identified and the effectiveness of treatment determined.

M3 Information™

References

[1] Kaiser Family Foundation, State Health Facts, timeframe: 2015, found at: http://kff.org/other/state-indicator/total-population

[2] U. S. Department of Health and Human Services. (1999). Mental health: A report of the Surgeon General - Executive summary. Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health. Available from: www.surgeongeneral.gov/library/mentalhealth/toc.html

[3] Kessler, R. C., Chiu, W. T., Demler, O., Merikangas, K. R., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 617-627.

[4]Greenberg et al. The Economic Burden of Adults with Major Depressive Disorder in the U.S. (2005 and 2010). Journal of Clinical Psychiatry 2015, 76.2 (2015): 155-162.

[5] Kessler RC, Petukhova M, Sampson NA, et al. Twelve-month and lifetime prevalence and lifetime morbid risk of anxiety and mood disorders in the United States. Int J Methods Psychiatr Res, 21(3); (2012): 169-184

[6] Kessler, R.C., Greenberg, P.E., (2002), The Economic Burden of Anxiety and Stress Disorders, Neuropsychopharmacology: The Fifth Generation of Progress, 67: 981-992

[7] U. S. Department of Health and Human Services. Mental health: A report of the Surgeon General - Executive summary.

[8]Kessler, R. C., Chiu, W. T., Demler, O., Merikangas, K. R., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 617-627.

[9] 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. Archives of General Psychiatry, 62, 629-640.

[10] Kessler, R. C., Berglunhd, P., Chiu, W. T., Demler, O., Heeringa, S., Hiripi, E., Jin, R., Pennell, B., Walters, E., Zaslavsky, A., & Zheng, H. The US National Comorbidity Survey Replication (NCS-R): Design and Field Procedures. Journal of Methods in Psychiatric Research, 2004; 13:69–92. Available from: www.hcp.med.harvard.edu/wmh/publishedpaper_kessler_design.pdf McVeigh, K.H., Sederer, L.I., Silver, L., & Levy, J. Integrating Care for Medical and Mental Illnesses. Preventing Chronic Disease, 3.2 (2006), A33.

[12] http://www.forbes.com/sites/hbsworkingknowledge/2016/06/29/the-1-trillion-link-between-mental-health-and-economic-productivity/#-12355c45295a

[13]Milliman. Economic Impact of Integrated Medical-Behavioral Healthcare: Implications for Psychiatry. April 2014.

[14]JAMA Intern Med. Published online August 29, 2016. doi:10.1001/jamainternmed.2016.5057

[15]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. Archives of General Psychiatry, 62, 629-640.

[16]JAMA Intern Med. Published online August 29, 2016. doi:10.1001/jamainternmed.2016.5057

[17]The Kennedy Forum (2015) Fixing Behavioral Health Care in America: A National Call for Measurement-Based Care in the Delivery of Behavioral Health Services. Available from: https://www.thekennedyforum.org/resources