

INTEGRATING HEALTH BEHAVIOR CHANGE INTO PRIMARY CARE

A Policy Brief from the Society of Behavioral Medicine

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Introduction:

The U.S. Centers for Disease Control (CDC) estimated that in 2005, 133 million people, or almost half of all Americans, lived with at least one chronic condition, such as heart disease, various types of cancer, diabetes, chronic obstructive lung diseases, stroke, etc. The CDC also estimates that these chronic diseases account for 75% of the nation's \$2 trillion medical care costs [1]. Health behaviors (e.g., tobacco use, eating habits, sedentary lifestyle, and alcohol use) account for a significant proportion of the reasons why individuals develop chronic diseases, and how those diseases progress [2]. Changing health behaviors is therefore critical to reducing health care costs. This policy brief highlights the evidence and need for integrating behavioral health in the primary care setting.

Background:

Most adult patients with chronic diseases are managed in primary care clinics (e.g., family medicine or internal medicine) [3]. Primary care providers (i.e., physicians, physician assistants, and nurse practitioners) provide the vast majority of behavioral health care in primary care settings [4, 5]. Although they are well trained in physical medicine, these providers often lack training and/or the time to advise patients how to change their health behaviors in an optimal manner [6, 7]. Behavior change experts, such as clinical health psychologists, who are trained in evidence-based interventions, can be **integrated in the primary care setting** with medical providers to help patients improve their health through behavior changes [8, 9, 10].

An integrated primary care (IPC) model allows patients to be seen in the primary care clinic by clinical health psychologists in the same way that patients see their primary care medical provider [8, 10-12]. Evidence-based behavioral interventions to eliminate tobacco use, improve diet, increase physical activity and reduce alcohol consumption can thus be offered to a much larger proportion of the population. Modest gains in individuals' health-related behavior can result in a profound public health impact when applied broadly at the population level – particularly in diverse populations [13].

Key Research Findings

- It is estimated that over half of the patients seen in primary care can benefit from health behavior changes [14].
- Interventions delivered in the IPC model have been shown to be effective in helping patients change the behavioral and lifestyle problems which are known to contribute to high levels of disease related risk factors, morbidity and mortality [12, 15, 16, 17].
- A high degree of collaboration in an integrated team model has been shown to maximize effectiveness, reduce barriers to care and improve efficiency as much as 200-300% in assisting patients in achieving positive health outcomes [18-20].
- Interventions to change health behaviors are an effective way of reducing unnecessary medical usage and costs.
- One study shows that medical costs of patients with chronic diseases reduced by 20% if these patients received IPC behavioral health interventions, but *increased* by 17% to 27% if they were treated in traditional (non-IPC) office settings [21].

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- Another study of non-diabetic patients showed that lifestyle (behavioral) changes reduced the incidence of diabetes by 58% compared to patients who received the placebo therapy [22].
- One analysis of 91 studies showed that medical utilization decreased by an average of 15.7% over baseline following behavioral intervention, compared with an increase of 12.3% without behavioral intervention, and thus yielded an overall 28% cost return [23]. These studies included an IPC model and other behavioral interventions.
- IPC models have also been shown to be effective in improving adherence to medical regimens as well as the treatment of psychological symptoms such as major depression and anxiety [8, 14, 24, 25].

Policy Implications:

Medicare carriers are now reimbursing for health and behavior services, but if meaningful public health gains are to be realized, widespread adoption of IPC models is paramount. Without reimbursement for behavioral health services, this model is not sustainable. Although research clearly indicates positive cost returns for the added services, several policy, practice and educational barriers have forestalled widespread adoption and implementation of these models in practice.

- As of July, 2006, only an estimated 50 private health plans were reimbursing for these behavioral health services [26]. All private health plans should be encouraged to reimburse for these services.
- Insurance companies and other third-party payers need to both include and promote health and behavior services offered to enrollees.
- Employers need to purchase and provide health and behavior benefits to their employees for management of chronic health conditions, as well as mental and psychosocial problems, with financial incentives to do so.
- Organized labor has an opportunity to offer health and behavioral services through union-based health plans. Labor organizations can also urge employers to purchase these benefits from third party payers.
- Physicians and other health care providers need to be educated about the benefits of integrated primary care so that they become advocates for health and behavioral services on behalf of their patients.
- Federal initiatives, such as the Patient Centered Primary Care Collaborative, need to include IPC models as a critical component of the team-based approach to the financing and delivery of healthcare services.
- The Centers for Medicare and Medicaid Services as well as other federal agencies need to fund long-term projects and evaluations of IPC models to demonstrate its continued validity in providing improved care and eventually reducing healthcare costs.

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