

Primary care in integrated settings (Veteran's Administration, Kaiser Permanente) Adult Mental Health: Serious Mental Illness

Benefit-cost estimates updated December 2019. Literature review updated May 2014.

Current estimates replace old estimates. Numbers will change over time as a result of model inputs and monetization methods.

The WSIPP benefit-cost analysis examines, on an apples-to-apples basis, the monetary value of programs or policies to determine whether the benefits from the program exceed its costs. WSIPP's research approach to identifying evidence-based programs and policies has three main steps. First, we determine "what works" (and what does not work) to improve outcomes using a statistical technique called meta-analysis. Second, we calculate whether the benefits of a program exceed its costs. Third, we estimate the risk of investing in a program by testing the sensitivity of our results. For more detail on our methods, see our [Technical Documentation](#).

Program Description: Behavioral health settings (mental health and substance abuse treatment centers) provide primary care for patients on site or nearby. This collection of studies was conducted at Veterans Administration facilities or facilities of Kaiser Permanente where patients might have more ready access to primary care than community-based treatment centers.

Benefit-Cost Summary Statistics Per Participant

Benefits to:

Taxpayers	\$480	Benefit to cost ratio	\$4.82
Participants	\$118	Benefits minus costs	\$928
Others	\$225	Chance the program will produce	
Indirect	\$349	benefits greater than the costs	52 %
Total benefits	\$1,171		
Net program cost	(\$243)		
Benefits minus cost	\$928		

The estimates shown are present value, life cycle benefits and costs. All dollars are expressed in the base year chosen for this analysis (2018). The chance the benefits exceed the costs are derived from a Monte Carlo risk analysis. The details on this, as well as the economic discount rates and other relevant parameters are described in our [Technical Documentation](#).

Meta-Analysis of Program Effects

Outcomes measured	Treatment age	No. of effect sizes	Treatment N	Adjusted effect sizes and standard errors used in the benefit-cost analysis						Unadjusted effect size (random effects model)	
				First time ES is estimated			Second time ES is estimated			ES	p-value
				ES	SE	Age	ES	SE	Age		
Alcohol use disorder	40	3	684	-0.001	0.124	41	0.000	0.186	44	-0.001	0.995
Blood pressure [^]	40	1	751	-0.168	0.071	41	n/a	n/a	n/a	-0.168	0.019
Blood sugar (HbA1c) [^]	40	1	751	0.225	0.105	41	n/a	n/a	n/a	0.225	0.033
Cholesterol [^]	40	1	751	0.071	0.122	41	n/a	n/a	n/a	0.071	0.562
Death	40	2	98	-0.077	0.160	41	n/a	n/a	n/a	-0.077	0.632
Emergency department visits	40	3	753	-0.090	0.105	41	0.000	0.000	42	-0.090	0.388
Hospitalization	40	5	10449	-0.050	0.060	41	0.000	0.000	42	-0.050	0.403
Hospitalization (psychiatric)	40	1	59	-0.068	0.293	41	0.000	0.000	42	-0.068	0.818
Illicit drug use disorder	40	2	643	-0.016	0.081	41	0.000	0.187	44	-0.016	0.845
Primary care visits [^]	40	2	417	0.531	0.188	41	n/a	n/a	n/a	0.531	0.005

[^]WSIPP's benefit-cost model does not monetize this outcome.

Meta-analysis is a statistical method to combine the results from separate studies on a program, policy, or topic in order to estimate its effect on an outcome. WSIPP systematically evaluates all credible evaluations we can locate on each topic. The outcomes measured are the types of program impacts that were measured in the research literature (for example, crime or educational attainment). Treatment N represents the total number of individuals or units in the treatment group across the included studies.

An effect size (ES) is a standard metric that summarizes the degree to which a program or policy affects a measured outcome. If the effect size is positive, the outcome increases. If the effect size is negative, the outcome decreases.

Adjusted effect sizes are used to calculate the benefits from our benefit cost model. WSIPP may adjust effect sizes based on methodological characteristics of the study. For example, we may adjust effect sizes when a study has a weak research design or when the program developer is involved in the research. The magnitude of these adjustments varies depending on the topic area.

WSIPP may also adjust the second ES measurement. Research shows the magnitude of some effect sizes decrease over time. For those effect sizes, we estimate outcome-based adjustments which we apply between the first time ES is estimated and the second time ES is estimated. We also report the unadjusted effect size to show the effect sizes before any adjustments have been made. More details about these adjustments can be found in our [Technical Documentation](#).

Detailed Monetary Benefit Estimates Per Participant

Affected outcome:	Resulting benefits: ¹	Benefits accrue to:				
		Taxpayers	Participants	Others ²	Indirect ³	Total
Illicit drug use disorder	Criminal justice system	\$0	\$0	\$0	\$0	\$0
Alcohol use disorder	Property loss associated with alcohol abuse or dependence	\$0	\$0	\$0	\$0	\$0
Illicit drug use disorder	Labor market earnings associated with illicit drug abuse or dependence	\$31	\$73	\$0	\$0	\$105
Hospitalization	Health care associated with general hospitalization	\$82	\$4	\$80	\$41	\$206
Hospitalization (psychiatric)	Health care associated with psychiatric hospitalization	\$306	\$4	\$69	\$153	\$532
Emergency department visits	Health care associated with emergency department visits	\$51	\$14	\$75	\$26	\$166
Illicit drug use disorder	Mortality associated with illicit drugs	\$10	\$23	\$0	\$251	\$284
Program cost	Adjustment for deadweight cost of program	\$0	\$0	\$0	(\$121)	(\$121)
Totals		\$480	\$118	\$225	\$349	\$1,171

¹In addition to the outcomes measured in the meta-analysis table, WSIPP measures benefits and costs estimated from other outcomes associated with those reported in the evaluation literature. For example, empirical research demonstrates that high school graduation leads to reduced crime. These associated measures provide a more complete picture of the detailed costs and benefits of the program.

²"Others" includes benefits to people other than taxpayers and participants. Depending on the program, it could include reductions in crime victimization, the economic benefits from a more educated workforce, and the benefits from employer-paid health insurance.

³"Indirect benefits" includes estimates of the net changes in the value of a statistical life and net changes in the deadweight costs of taxation.

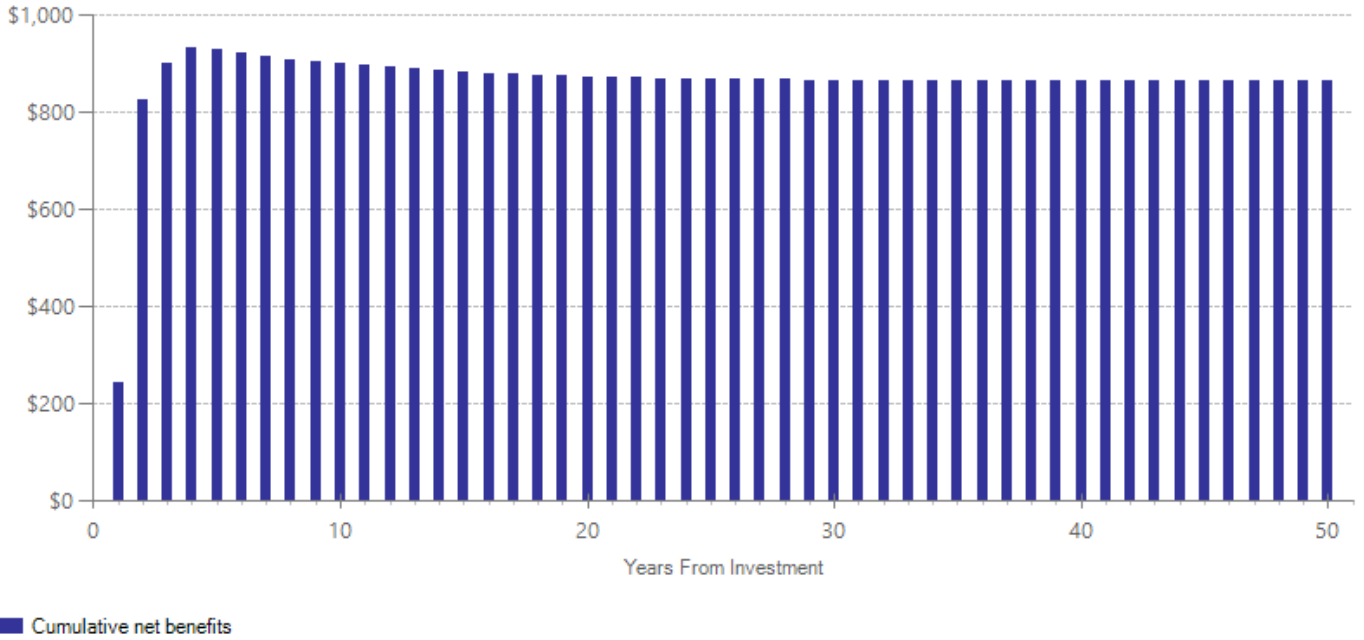
Detailed Annual Cost Estimates Per Participant

	Annual cost	Year dollars	Summary	
Program costs	\$228	2014	Present value of net program costs (in 2018 dollars)	(\$243)
Comparison costs	\$0	2014	Cost range (+ or -)	20 %

According to Saxon et al., (2006). Randomized trial of onsite versus referral primary medical care for veterans in addictions treatment. *Medical Care*, 44(4), 334-342, patients in the clinics with co-located primary care had an average of 1.1 more primary care visits than the comparison group in 12 months. We estimated additional cost of the program by multiplying 1.1 visits by the Medicaid enhanced payment rate for the longest primary care visit. See http://www.hca.wa.gov/medicaid/pages/aca_rates.aspx.

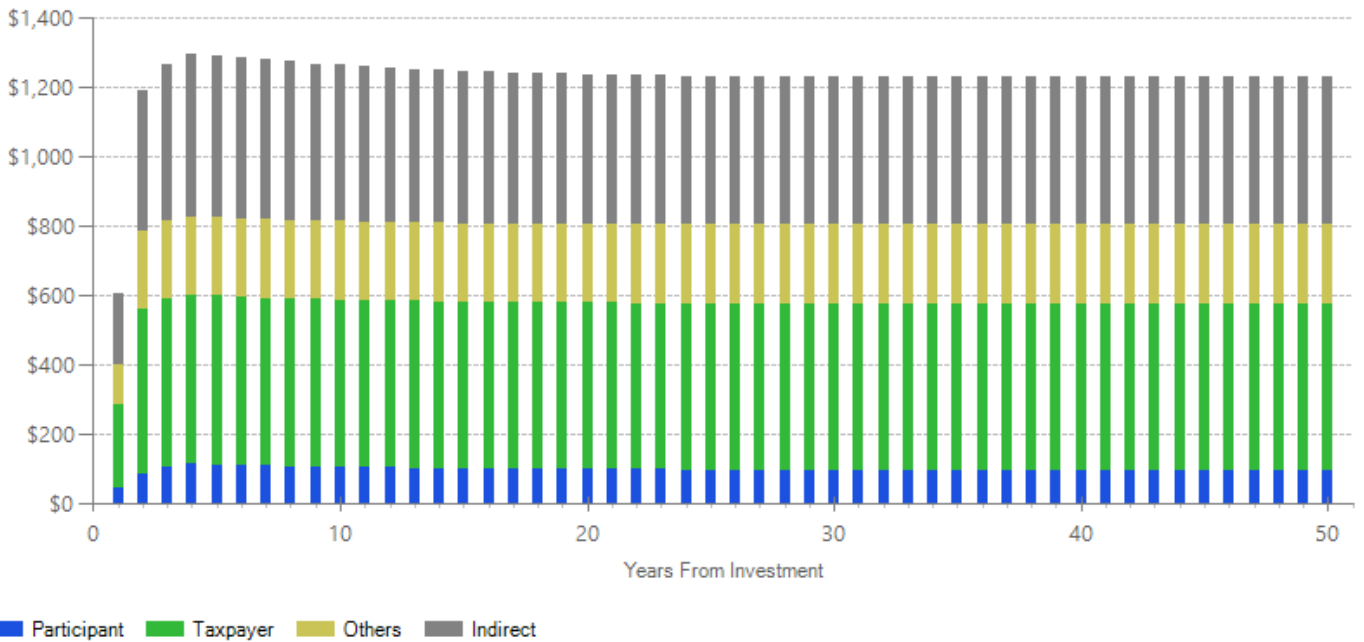
The figures shown are estimates of the costs to implement programs in Washington. The comparison group costs reflect either no treatment or treatment as usual, depending on how effect sizes were calculated in the meta-analysis. The cost range reported above reflects potential variation or uncertainty in the cost estimate; more detail can be found in our [Technical Documentation](#).

Benefits Minus Costs Over Time (Cumulative Discounted Dollars)

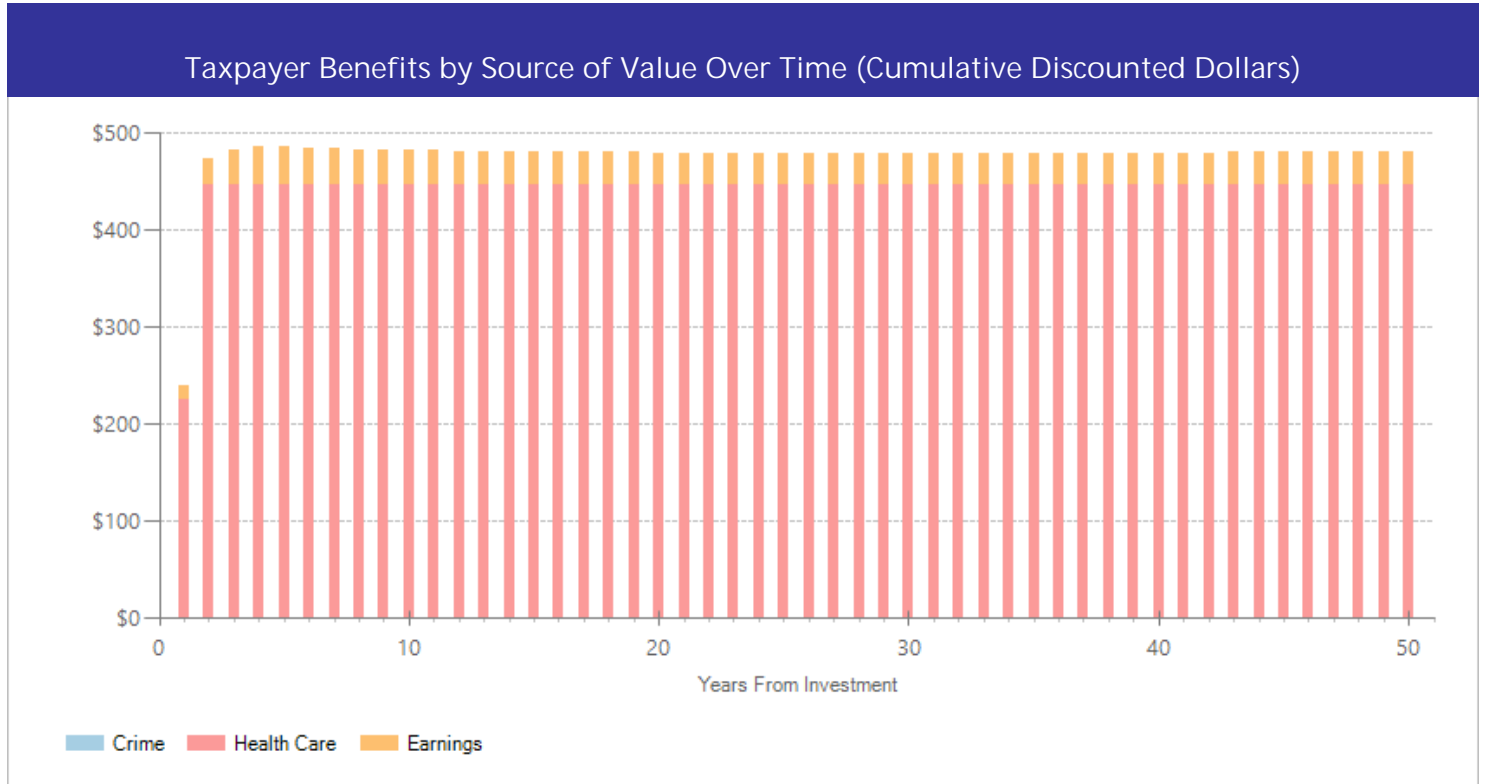


The graph above illustrates the estimated cumulative net benefits per-participant for the first fifty years beyond the initial investment in the program. We present these cash flows in discounted dollars. If the dollars are negative (bars below \$0 line), the cumulative benefits do not outweigh the cost of the program up to that point in time. The program breaks even when the dollars reach \$0. At this point, the total benefits to participants, taxpayers, and others, are equal to the cost of the program. If the dollars are above \$0, the benefits of the program exceed the initial investment.

Benefits by Perspective Over Time (Cumulative Discounted Dollars)



The graph above illustrates the breakdown of the estimated cumulative benefits (not including program costs) per-participant for the first fifty years beyond the initial investment in the program. These cash flows provide a breakdown of the classification of dollars over time into four perspectives: taxpayer, participant, others, and indirect. "Taxpayers" includes expected savings to government and expected increases in tax revenue. "Participants" includes expected increases in earnings and expenditures for items such as health care and college tuition. "Others" includes benefits to people other than taxpayers and participants. Depending on the program, it could include reductions in crime victimization, the economic benefits from a more educated workforce, and the benefits from employer-paid health insurance. "Indirect benefits" includes estimates of the changes in the value of a statistical life and changes in the deadweight costs of taxation. If a section of the bar is below the \$0 line, the program is creating a negative benefit, meaning a loss of value from that perspective.



The graph above focuses on the subset of estimated cumulative benefits that accrue to taxpayers. The cash flows are divided into the source of the value.

Citations Used in the Meta-Analysis

- Druss, B.G., Rohrbaugh, R.M., Levinson, C.M., & Rosenheck, R.A. (2001). Integrated medical care for patients with serious psychiatric illness: a randomized trial. *Archives of General Psychiatry, 58*(9), 861-8.
- Kilbourne, A.M., Pirraglia, P.A., Lai, Z., Bauer, M.S., Charns, M.P., Greenwald, D., . . . Yano, E.M. (2011). Quality of general medical care among patients with serious mental illness: does colocation of services matter?. *Psychiatric Services, 62*(8), 922-928.
- Parthasarathy, S., Mertens, J., Moore, C., & Weisner, C. (2003). Utilization and Cost Impact of Integrating Substance Abuse Treatment and Primary Care. *Medical Care, 41*(3), 357-367.
- Pirraglia, P.A., Kilbourne, A.M., Lai, Z., Friedmann, P.D., & O'Toole, T.P. (2011). Colocated general medical care and preventable hospital admissions for veterans with serious mental illness. *Psychiatric Services, 62*(5), 554-557.
- Saxon, A.J., Malte, C.A., Sloan, K.L., Baer, J.S., Calsyn, D.A., Nichol, P., . . . Kivlahan, D.R. (2006). Randomized Trial of Onsite Versus Referral Primary Medical Care for Veterans in Addictions Treatment. *Medical Care, 44*(4), 334-342.
- Weisner, C., Mertens, J., Parthasarathy, S., Moore, C., & Lu, Y. (2001). Integrating primary medical care with addiction treatment: A randomized controlled trial. *JAMA : The Journal of the American Medical Association, 286*(14), 1715-1723.
- Willenbring, M.L., & Olson, D.H. (1999). A randomized trial of integrated outpatient treatment for medically ill alcoholic men. *Archives of Internal Medicine, 159*(16), 1946-1952.
- Willenbring, M.L., Olson, D.H., & Bielinski, J. (1995). Integrated Outpatient Treatment for Medically Ill Alcoholic Men: Results from a Quasi-Experimental Study. *Journal of Studies on Alcohol, 56*(3), 337.

For further information, contact:
(360) 664-9800, institute@wsipp.wa.gov

Printed on 10-20-2021



Washington State Institute for Public Policy

The Washington State Legislature created the Washington State Institute for Public Policy in 1983. A Board of Directors—representing the legislature, the governor, and public universities—governs WSIPP and guides the development of all activities. WSIPP's mission is to carry out practical research, at legislative direction, on issues of importance to Washington State.