Public Comments Received on "*Integrating Behavioral Health into Primary Care*"

Comments on CTAF Draft Report received by March 20, 2015

- Macaran A. Baird, MD, MS, Professor and Head, UMN Department of Family Medicine and Community Health, Minneapolis, MN
- Roger Kathol, MD, CPE, President, Cartesian Solutions, Inc., Burnsville, MN
- Jürgen Unützer, MD, MPH, MA, Professor and Chair, Psychiatry and Behavioral Sciences, University of Washington; Director, AIMS Center, Seattle, WA
- Saul Levin, MD, MPA, CEO and Medical Director, American Psychiatric Association, Arlington, VA
- Rachel Wick, Program Officer – Health Care and Coverage, Blue Shield of CA Foundation, San Francisco, CA
- Florence C. Fee, JD, MA, Executive Director, No Health without Mental Health (NHMH), San Francisco, CA – Arlington, VA

Comments on CEPAC Draft Report received by April 21, 2015

- Gregory K. Fritz, MD, Professor and Director, Division of Child and Adolescent Psychiatry, Vice Chair, Dept. of Psychiatry and Human Behavior, Warren Alpert Medical School of Brown University, Providence, RI
- Neil Korsen, MD, MS, Medical Director, Behavioral Health Integration, MaineHealth, Portland, ME
- Alexander Blount, EdD, Professor of Clinical Family Medicine, Director of Behavioral Science, Department of Family Medicine and Community Health, University of Massachusetts Medical School, Worcester, MA
- Jürgen Unützer, MD, MPH, MA, Professor and Chair, Psychiatry and Behavioral Sciences, University of Washington; Director, AIMS Center, Seattle, WA
- Saul Levin, MD, MPA, CEO and Medical Director, American Psychiatric Association, Arlington, VA

March 20, 2015

Dear Dr. Tice,

I have recently reviewed your technology assessment on Integrating Behavioral Health into Primary Care and am responding as an interested party. I am Professor and Head of the University of Minnesota, Department of Family Medicine and Community Health. For the past 30 years I have been involved in education, training and practice relating to integrating behavioral health into primary care. I was co-author of the IOM Report on Health and Behavior and a member of Managing Depression in Primary Care task forces for the MacArthur Foundation and RWJ Foundation. I am currently a member of the AHRQ sponsored National Integrating Behavioral Health and Primary Care Academy.

I am grateful for your diligent work in reviewing the literature on this topic and know it has taken a huge effort to review and interpret the published studies you have listed. I have participated in such endeavors and understand the reasons for being cautious in creating policies or recommendations based upon such reviews. California has already been doing much to integrate behavioral health into primary care and my sense is that you will help guide this effort with the goal of improving health and controlling costs.

My caution about your current draft is that much other work has been done by others to distinguish specific types of integration that adds value to primary care and does generate significant benefits in cost and quality especially when one considers the cost and quality impact of non-integrated and fragmented care. One recent source of relevant information has been assembled by the Patient-Centered Primary Care Collaborative (PCPCC) in their 2015 report "The Patient-Centered Medical Home's Impact on Cost and Quality". That report points to the need to integrate behavioral health into primary care effectively to show the benefits. It is somewhat more optimistic than your report as currently stated but is consistent with many your overall findings and recommendations including the need for changes in the reimbursement model away from fee-for-service. Showing the cost benefit has much to do with viewing the larger picture of health care costs that accelerate when care is fragmented vs integrated.

Thank you for your sincere efforts to improve the health of your citizens while controlling costs.

Sincerely,
Macaran A. Baird, MD

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March 20, 2015

Dr. Tice and colleagues,

I found out about your draft report yesterday and had a chance to review its content. As an internist and psychiatrist with 25 years in academic medicine that has worked at the interface of medicine and psychiatry during my entire professional career, I was astounded that a group with as limited knowledge of the interface of medical and behavioral health (BH) care would come out as strongly as it did related to the development of integrated medical and BH service delivery in primary care.

While the literature review was extensive, there was no attention given to the bigger picture in the report, i.e., 1) that the majority of medical patients with BH comorbidity have no access to BH services and refuse to access standalone BH services; 2) that untreated BH comorbidity in the medical setting is associated with annual doubling of total health costs, 80% of which are for medical services; and 3) that there are now models of BH intervention that demonstrate both clinical and economic value in primary care settings, particularly collaborative care.

It is apparent that the authors of this report lumped all BHI rather than differentiating value-added BHI for separate consideration. Whether this was because the authors, none of whom come from BH backgrounds, do not understand nor differentiate value-added from non-value-added BHI or just chose to ignore what to informed practitioners at the interface is obvious is uncertain. What is certain is that this report will set back access for medical patients with comorbid BH issues by decades in California and have a negative impact nationally on what many consider a major opportunity to contribute to the Triple Aim as “reformed” health care matures.

You may wish to read a slightly different take on the ability of BH to contribute to future health in primary care and other medical setting by reading a Chapter from a recently published book on ACOs by several national health care leaders, including a CEO of a major ACO (FP), a Brookings Institute policy physician (internist), a Milliman actuary, an MBA, and myself. It comes to a diametrically opposed conclusion but does not focus on “any BHI.” Rather, it looks at those that demonstrate evidence of value for the system. Without moving in the direction of value-added BHI, the system will continue to hemorrhage health care resources, mainly through excess medical spend, since medical patients with ineffectively treated BH (40% of medical patients) demonstrate medical treatment resistance and increased medical complications.

I commend you on your extensive review. I was on the AHRQ work group that reviewed treatment of depression in primary care and published its report. I know the extent of the work involved. I am just sad that you did not have sufficient background and experience in understanding the actual implementation of BHI to come up with a more accurate interpretation of findings.

Best.

Roger Kathol, M.D.

March 20, 2015

Institute for Clinical and Economic Review
RE: *Integrating Behavioral Health in Primary Care: A Technology Assessment*

On behalf of the University of Washington's AIMS Center, dedicated to Advancing Integrated Mental Health Solutions, I applaud your efforts to synthesize the latest evidence on the comparative clinical effectiveness and value of efforts to integrate behavioral health into primary care. As you know, the field of integrated care is fraught with inconsistent terminology and misinterpretations of what does and does not work. Reports like yours can help move us forward in understanding the data and implementing proven solutions. We have conducted over 20 years of research in integrated care and welcome this opportunity to comment on your report and share some lessons from our work in **Collaborative Care**, a specific type of integrated care developed at the University of Washington to treat depression and anxiety in primary care clinics.

In a 2008 evidence synthesis of the Collaborative Care model, AHRQ states

> *"Terminology around this type of care has become confusing. The terms Integrated Care and Collaborative Care have sometimes been used in what appears to be interchangeable ways, but at other times they reflect subtle but important differences. Historically, the Collaborative Care model was a term used in some of the earliest research on integrated care in the United States by Wayne Katon and his colleagues. Within the United States, the term Integrated Care has tended to be used, perhaps in part to distinguish other models from Katon's Collaborative Care Model."*[1]

We strongly suggest revising *Integrating Behavioral Health in Primary Care: A Technological Assessment* to accurately reflect the roubust empirical evidence for Collaborative Care and to minimize the chance that a misinterpretation of researchg findings will undermine support for policies that promote the adoption of Collaborative Care that has been shown to be effective and cost-effective.

Over 80 randomized controlled trials have demonstrated the clinical effectiveness of Collaborative Care in diverse practice settings with diverse patient populations.[2] The clinical improvement is substantial. Compared to usual care, Collaborative Care produces a 18.4% median absolute increase in patients with a response to depression treatment (i.e., 50% improvement in symptom severity) and a 16.7% median absolute increase in symptom remission.[3] A common misuse of the rigorous and robust scientific literature for Collaborative Care is to generalize it to other integrated care models that have not been proven to be effective. The implication of this misinterpretation has been the widespread proliferation of non-evidence based integrated care models.

Integrating Behavioral Health in Primary Care: A Technology Assessment appears to have made the reverse misinterpretation: taking insufficient empirical evidence for other integrated care models and applying it to the effectiveness of the Collaborative Care model. This is a potentially much more harmful

misinterpretation because it has the potential to impede policy development that promotes the adoption of the evidence-based Collaborative Care model.

We respectfully suggest the authors reinforce the following points to halt the misinterpretation of the evidence:

- Integration and collaboration are NOT the same thing. Collaboration is necessary to improve outcomes, but effective collaboration can be achieved with varying levels of 'integration' or co-location. Integration and co-location are not necessary for effective collaboration.

- There is little scientific evidence that integrating care in and of itself improves patient outcomes. Thus, it cannot be concluded with confidence that integration alone is sufficient to improve outcomes.

- It is invalid to conclude that Collaborative Care is ineffective because of the lack of scientific evidence for integration generally.

- When implemented as part of routine primary care, Collaborative Care improves patient outcomes. Widespread implementation of Collaborative Care has the potential to improve access to evidence based mental health treatment for millions of Americans in a highly cost-effective manner.

Terminology

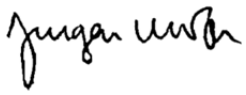
To fully comprehend the nuances of the scientific evidence, it is critical to understand the terminology. Developed by expert consensus, AHRQ defines Collaborative Care as "*Multiple providers, with their patients, combine perspectives to understand and identify the problems, opportunities, and treatments…to continually revise the treatment as needed to hit treatment goals".* [4] In contrast, it defines integrated care as "*Tightly integrated, on-site teamwork with unified care plan as a standard approach to care for designated populations*." [4] AHRQ concludes that in the Collaborative Care model, "*Significant improvements in symptom severity, treatment response, and remission were consistent across the integration levels*." [1] **In other words, the Collaborative Care model works, regardless of whether the collaborating providers are co-located and integrated.**

Your report misinterprets this finding and instead reports a "*lack of correlation between level of integration and treatment response.*" The AHRQ finding that co-location and integration are not correlated with outcomes must not be **mistakenly interpreted** to mean that the Collaborative Care model is not effective.

A further misinterpretation of the evidence stems from the report's use of the integrated care framework developed by SAMHSA/HRSA. This framework, which remains unpublished in the peer-reviewed scientific literature and has little empirical support, assumes that both collaboration and integration are necessary to improve outcomes. Combining collaboration and integration into a single integration index is contrary to the available evidence and thus, the conclusion that collaboration is not correlated with outcomes is unsubstantiated.

Collaborative Care has been proven to more effective than care as usual and to be clinically worth doing at a population level. Integrating behavioral health care into primary health care works well IF it's done right, and we should focus our collective efforts on putting the right pieces in place to facilitate implementation of evidence based integrated care programs such as Collaborative Care.

Sincerely,



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March 20, 2015

TO: The Institute for Clinical and Economic Review

RE: Integrating Behavioral Health in Primary Care: A Technology Assessment

The American Psychiatric Association (APA), the national medical specialty society representing over 36,000 psychiatric physicians, would like to submit comments in response to the report Integrating Behavioral Health in Primary Care: A Technology Assessment, which is to be reviewed by the California Technology Assessment Forum (CTAF). This is a very important and comprehensive report and the APA congratulates the Institute for Clinical and Economic Review and CTAF for synthesizing the evidence on the comparative clinical effectiveness and value of current efforts to integrate behavioral health into primary care.

Frequently lexicon issues can stand in the way of progress, creating a lack of clarity in what is being discussed. As the literature suggests, there are four key approaches to integrated care: medical or health homes, accountable care organizations, collaborative care models, and the location of medical services in specialty behavioral health facilities.

Our preferred way to discuss the integration of behavioral health in primary care and decrease confusion is to rank or categorize research and evidence for each of the four models. Where there is solid or emerging evidence on a model studied, the elements for the success of this model should be identified and defined.

For example, the elements of the collaborative care model (CCM) include: (1) care coordination and care management; (2) regular/proactive caseload monitoring and treatment to target using validated clinical rating scales; and (3) regular consultation for patients who do not show clinical improvement.[1] [2]

There is an extraordinary amount of evidence substantiating this very specific model. No other model of integration, or model mislabeled as collaborative care, has this level of evidence. Other models that may have some good evidence of success may or may not have some of the three elements that define CCM. These other models need scientific study and defining.

[1] Unützer, J. The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes, May 2013. http://medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-IRC-Collaborative-5-13.pdf
[2] Kuehn, B. Health Reform, Research Pave Way for Collaborative Care for Mental Illness, JAMA, June 19, 2013—Vol 309, No. 23 2425-6.

There are over eighty randomly controlled trails substantiating the evidence for the above defined collaborative care model. These studies demonstrate significant improvement across populations, settings, and outcome domains.[3] [4] The CCM evidence also indicates improvement for a variety of mental health disorders (beyond depression and anxiety) as well as for medical comorbidities. There have been numerous cost-effectiveness studies demonstrating that CCM provides good economic value.[5] Unützer found for every dollar spent on the CCM there was a return on investment of $6.50.[6]

The APA asks that CTAF base its decisions on the available science and not use an unsubstantiated framework. It is the APA's view that it is essential that the CTAF make bright-line distinctions where the evidence supports specific models such as CCM. CCM is population-based care, measurement-based care with caseload based review, and integration of psychiatry expertise into primary care. It clearly represents significant improvement and value over usual care.

We thank you for your consideration of our comments. If you have any questions or concerns, please contact Karen Sanders at (703) 907-8590 or ksanders@psych.org.

Sincerely,

Saul Levin, MD, MPA
CEO and Medical Director
American Psychiatric Association

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[3] Woltmann, E. Comparative Effectiveness of Collaborative Chronic Care Models for Mental Health Conditions Across Primary, Specialty, and Behavioral Health Care Settings: Systematic Review and Meta-Analysis. Am J Psychiatry 169:8, August 2012, 790-804

[4] Thota, A, Collaborative Care to Improve the Management of Depressive Disorders A Community Guide Systematic Review and Meta-Analysis, Am J Prev Med 2012;42(5):525–538.

[5] Jacob, V. Economics of Collaborative Care for Management of Depressive Disorders A Community Guide Systematic Review. Am J Prev Med 2012;42(5):539–549.

[6] Unützer, J. Long-term Cost Effects of Collaborative Care for Late-life Depression. AJMC 2008; 4 (2):95-100.

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March 20, 2015

To whom it may concern:

Thank you to the California Technology Assessment Forum (CTAF) and the Institute for Clinical and Economic Review (ICER) for their thoughtful analysis of the state of the field of behavioral health integration both nationally and in California. I am writing on behalf of Blue Shield of California Foundation to share our response to the draft report, "Integrating Behavioral Health into Primary Care," based on our efforts to advance behavioral health integration for low-income and underserved residents in California.

In June of 2014, Blue Shield of California Foundation launched a $1.3 million grantmaking initiative, *Advancing Behavioral Health Integration through Community Collaboration*. This initiative is designed to advance system-level integration of primary care, mental health, and substance use services for Medi-Cal recipients and underserved residents of California, and to ensure successful implementation of new mental health and substance use benefits available under Medi-Cal expansion and implementation of the Affordable Care Act. The grants are unique in that they require community health centers, mental health clinics, social service providers, county agencies, and Medi-Cal managed care plans to work together to advance integration across the spectrum of behavioral health needs.

There are a number of issues raised in CTAF/ICER's research that are reflective of what the Foundation has observed among its 10 grantee partners seeking to advance behavioral health integration in local communities across California:

- There is a strong belief, coupled with emerging practice-based evidence, that behavioral health integration is a critical and effective strategy for improving health outcomes among low-income Californians. The emergence of team-based care models that include a behavioral health professional who can conduct screening, brief intervention, counseling, care coordination and case management is a preferred approach in safety net settings. However, there is concern that the staffing ratios for behavioral health professionals in primary care settings is not yet commensurate with the level of need among the population, due to policy and financing barriers as well as workforce shortages.
- The financing of primary care, mental health and substance use services remains silo-ed and separate in California, creating barriers to the growth and expansion of integrated care. Medi-Cal managed care plans have responsibility for the mild to moderate mental health benefit, while counties retain responsibility for the seriously mentally ill. Counties may soon assume responsibility for developing a continuum of substance use treatment services under a pending Substance Use Disorders Services (SUDS) waiver. These financing silos pose challenges to providers at the local or county level who seek to integrate primary care and behavioral health, provide "whole-person care" and manage population health. An August 2014 report, "State Strategies for Integrating Physical and Behavioral Health Services in a Changing Medicaid Environment," further elucidates the challenges and potential solutions for states like California that have carved out behavioral health services.

- Improved care coordination is seen as an effective tool for managing across silo-ed financing and delivery systems. However, reimbursement for care coordination and real and perceived barriers related to confidentiality in information sharing across the three disciplines are barriers to more widespread use of care coordination in California. Both legal guidance and provider education are needed to overcome these barriers. A recent Foundation-funded report, "Opportunities for Whole Person Care in California," outlines some of these challenges.
- Federally Qualified Health Centers, a critical access point for a number of low-income and uninsured Californians, face additional challenges to financing integrated care, including the inability to bill for two visits on the same day and to seek reimbursement for behavioral health services provided by marriage and family therapists. A prospective payment system pilot project is being developed to test an alternative payment methodology for Federally Qualified Health Centers in California, but interim solutions are needed to more broadly address financing and workforce shortages that prevent further integration.
- The racial and ethnic diversity of California's population will require culturally responsive approaches to behavioral health integration that span clinical and community settings. The Statewide Strategic Plan to Address Mental Health Disparities, and Community Partners in Care's community-based participatory research on depression care in South Los Angeles and Hollywood-Metro LA offer insights into culturally responsive care and new approaches to integration that should be further explored.

In addition to its grantmaking, the Foundation has recently released a report, "Exploring Low Income Californians and Preferences of Low-Income Californians for Behavioral Health Care," that highlights results from a recent survey by Gary Langer Research and Associates. The survey finds that:

- Three in 10 low-income Californians say there's been a time in the past year when they've felt a need to talk with a healthcare professional about stress, emotional issues, drug or alcohol use, or related concerns. Yet only half of them actually did so.
- While 76 percent say it's extremely or very important to have access to a behavioral health counselor at their primary care facility, 52 percent say such counseling is available. Seventy-six percent also call substance abuse services highly important, yet only 42 percent say they can get this kind of help at their place of care.
- Behavioral health and substance abuse services generally are more likely to be available at facilities that also have healthcare coaches, team-based care, and patients who have continuity and connectedness. Patients at such facilities are more apt to be empowered to take a role in their care, and to give their facilities higher satisfaction ratings virtually across the board.

These findings are reflective of the evidence on the impact of integration on patient satisfaction, and also demonstrate patients' preference for behavioral health integration.

Once again, we are grateful for CTAF/ICER's attention to behavioral health integration and are happy to serve as a resource or answer any questions regarding the Foundation's work or learning in this area.

Best,

Rachel Wick
Program Officer – Health Care and Coverage
Blue Shield of California Foundation

No Health without Mental Health
www.nhmh.org • 501(c)(3) organization

March 23, 2015

Institute for Clinical and Economic Review

Re: **Nonprofit Patient Mental Health Advocacy Comment,**
"Integrating Behavioral Health in Primary Care: A Technology Asssessment"
March 5, 2015

NHMH – No Health without Mental Health, www.nhmh.org, a 501©(3) California patient advocacy organization, with branch office in Washington, D.C., and with a focused mission to expand access to quality, evidenced-based mental health care for patients in all settings, medical and specialty behavioral health, offers the following comments on the above-referenced ICER draft report:

- We urge ICER to consider the rigorous, robust scientific data that demonstrates the distinction between proven, evidence-based models of integrated medical/behavioral care, such as the collaborative care model, and other models of integrated care. The CC model has the most robust data to support its efficacy in improving health outcomes for patients. That essential point did not come across in the draft report. CC substantially improves patient outcomes for depression and anxiety in primary care. And as a nonprofit patient advocacy organization we know how important it is to keep a disciplined focus on outcomes, what is shown to work.

- Considerable confusion and over-simplification currently exists around the entire topic of behavioral integration in primary care. NHMH has a concern your report may inadvertently add to it, as presently written. However, this report could, on the other hand, go a long way to set an example in the health policy/scientific discussion arena by establishing a framework for discussion where there is strict adherence to rigorous scientific knowledge, precise definitions, and abundant supportive material reference (the latter you already seem to have done). ICER could contribute considerably to debate and discussion by making clear exactly what the term "integrated care" refers to, that is, its accepted consensus in the medical-scientific community, and make clear the distinction between models of integrated care proven effective favorably impacting patient outcomes, and those that do not. In that respect, the collaborative care model is presently in a class by itself showing substantial clinical improvement in outcomes. Your report needs to reflect that reality, and focus on how barriers to its wider scaling can be achieved.

- NHMH hopes that in future your Institute may focus on the need for adequate evidence-based collaborative care in the specialty mental health setting. While the seriously mentally ill in this setting are a small population, compared to patients with mild mental disorders, overwhelming data shows significant early mortality rates and long lapses between first symptoms and access to any treatment let alone diagnosis for the SMI. Yet, many of the principles found to be effective in behavioral health integration in primary care may also be applicable in integrating adequate, quality medical care for this patient population in specialty mental health care.

- We urge ICER to consider that evidence-based integrated care models such as collaborative care not only have the potential to improve access to evidence-based mental treatment for millions in the U.S., it also importantly has the potential, we believe, to gradually over time eliminate the pernicious social stigma that surrounds mental disorders in our culture today keeping many patients from even seeking treatment. That is why our independent nonprofit is so supportive of the collaborative care model: in simple terms, it gets what works to the patients…who desperately need it.

Respectfully submitted,

Florence C. Fee, J.D., M.A.
Executive Director

This is a very impressive piece of work. I see it as related to the Milliman Report (commissioned by the American Psychiatric Association in 2014) but more focused (on New England) and much more detailed. I think it is a substantial contribution that deserves wide dissemination.

My only criticism is that I couldn't find a description anywhere making it clear that these data are only dealing with adults in the adult health care arena. It appears that this was taken for granted, as a given. Two concerning assumptions follow: 1) that children's integrated pediatric and mental health needs and consequences are so similar to adults' that adult findings are readily applied to children, or 2) that because the costs of children's health care are small in comparison to adults', it's appropriate to ignore the former for now. In either case, it's problematic in my view—but I think this report should be clear up front as to which rationale is behind ignoring the unique aspects of integrated care as they apply to the pediatric population. GF

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Comments regarding CEPAC Review of Behavioral Health Integration

Thank you for providing this literature review and barriers study for behavioral health integration and for a thorough discussion of policy implications. I have some comments related to several aspects of the review and the conclusions reached. I look forward to further discussion with you on May 1.

My first comment relates to the choice of the SAMHSA Levels of Integration framework. This is a descriptive but not operational framework that does not capture the details of which components of integrated care are being used. One example of the shortcomings of this framework is that the Collaborative Care model, the most commonly tested model in the studies included in the evidence review, is assigned to multiple different levels in spite of the fact that the underlying model (that includes elements of primary care practice redesign, use of care managers to communicate with patients between visits to monitor treatment and barriers to adherence , and population review by consulting psychiatrists) is much more similar than different. A more functional, operational framework such as the AHRQ Lexicon, might be more useful to identify which elements of integration are included in a given implementation (and to study which elements are predictive of improved outcomes).

Another comment related to 'models' is that the various models described in the evidence review are really a variety of local adoptions and adaptations of a few basic approaches to integration:

- Collaborative care model, previously described
- Child psychiatry access model, which may include a triage function, a phone consult by child psychiatry, availability of formal psychiatry consultation, and a PCP educational component.
- Behavioral health consultant model – an onsite behavioral health clinician who helps manage the practice panel and can be accessed through a 'warm handoff'.

Confusion about models and levels would certainly contribute to lack of certainty about effectiveness of BHI in a real life setting.

Another concern that I have about the review is the relatively narrow perspective on which outcome measures should be included in looking for evidence of potential benefit of BHI vs. usual care. When we at MaineHealth made the decision to expand our focus from depression in primary care (after more than 5 years of grant funded work using the Collaborative Care model) to behavioral health integration, our goals related to issues broader than clinical outcomes. We knew the literature from Kessler and others about the small percentage of people who are referred to specialty behavioral health settings who even have one visit, so we wanted to improve access to this care by bringing the entry point to behavioral healthcare into a comfortable, familiar place – the primary care office. We also knew from our work with primary care practices on depression that the challenges of access and communication related to behavioral health care were a significant source of frustration in practice. We measure primary care provider satisfaction periodically as part of our program evaluation, and it is very clear that most primary care clinicians are very pleased to have integrated services available. We believe there may be an increase in provider productivity by adding this new member to the team, but have not yet had the access to data or resources to measure that. We intend to do so in the future.

The issue of cost impact of integration is challenging on a number of levels. You make the very important point on page 72 of the report that a modest increase in cost of care when adding integration may be acceptable (and even desirable) due to the chronic underfunding of both primary care and behavioral healthcare. Even so, as I do the math on the estimated PMPY costs for adding integration to primary care of $33 are very modest. Further, as I read the recent report by Milliman for the American Psychiatric Association, even modest success in the implementation of integration for people with chronic medical illnesses and co-morbid behavioral health conditions would more than offset that small increase. Knowing the lead author of that report and knowing actuaries in general, I suspect that is a conservative estimate of potential savings.

One other point regarding cost effectiveness or cost savings relates to what I think is the potential for integration as it matures. There are populations that have

substantial psychosocial components to their health conditions who currently receive low value care. Those groups include people with complex sets of chronic illnesses and socioeconomic challenges, those with common somatic symptoms, and those dealing with common life transitions such as new parents and those at the end of their lives. There will need to be evidence to help us understand how best to target and deliver services, but there is great opportunity to improve health, care and cost effectiveness for these populations. We are not doing very well in their care or outcomes now!

One other point relates to limiting the evidence review to randomized controlled trials. I understand that the RCT is considered the gold standard in terms of evidence for testing of the efficacy of a new treatment. My concern about its limitations in looking at impact of integration is that integration is a complex intervention that is substantially impacted by the context into which it is introduced, the degree of success of implementation, and the successful targeting of populations for which it is likely to be helpful. An example is the DIAMOND project in Minnesota. Collaborative care, the most evidence-based model of integration, was introduced to a large number of practices. It is my understanding that there is substantial variation in the uptake of the model and in the outcomes achieved from one practice and organization to another. Since the model is the same, that argues that the relevant question is not 'does collaborative care work?' but rather 'in what circumstances and for which patients does collaborative care work?' That question may best be answered by well-designed observational studies and qualitative methods.

Thank you again for all the work that was done to produce this important report, and for the opportunity to offer my thoughts. I look forward to a chance to talk about this further in Boston on May 1.

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Comment on the Draft Report – Integrating Behavioral Health into Primary Care

This study represents an impressive amount of work and analysis. It was carried out with care to represent the field fairly. I was one of the "experts" interviewed for the barriers chapter and found the people I spoke to knowledgeable and very open to whatever I offered. I think they did a nice job of summarizing the information they heard without letting any particular person's unique experience carry too much weight. They offer a balanced qualitative approach to understanding the barriers.

I think in the evidence section, their focus narrowed inappropriately and that their write up, while accurate in what it reports, fails to represent the field fairly. Their focus on disease based RCTs, I believe, needs to be balanced by the same sort of qualitative setting of the context that is used in the barriers chapter.

It is important to be able to explain one crucial contextual factor in the development of integrated behavioral health, why it is developing so broadly using models for which there is less clinical outcome evidence than there is for other models. In 2003*, I published a paper that addressed this question, and the discussion in that paper is apt today, though the data has long since gone out of date. The paper makes the point that there are multiple types of outcomes that are valued in the clinical community (increased access, provider satisfaction, patient satisfaction, improved adherence, cost effectiveness, and cost reduction) to name a few. The stakeholders in the integration of behavioral health integration might be:

a. The payers for healthcare, the employers, government health plans and private health plans who believe, with good reason, that targeted behavioral health integration will save on the cost of care.
b. The advocates of whole person care, those who are committed to the Patient Centered Medical Home as a model for the future of healthcare who have now made the integration of behavioral health a recommendation (PCPCC) or a requirement (NCQA) of PCMH designation.
c. People committed to access to care for mental health disorders (NAMI, SAMHSA) or substance abuse disorders (SAMHSA for SBIRT). All of these have endorsed the view that the vast majority of people with MH and SA needs will not go to mental health or substance abuse agencies, but will accept care for these in primary care.
d. Advocates for social justice in access to services. Since Surgeon General Satcher's report on race and culture in MH, the observation that ethnic and racial minorities are less likely to seek or accept services in specialty MH and SA settings, the issue of access and the role of BHI in access for minorities has been highlighted. Minorities prefer to get these services in primary care.
e. Medical administrators, both physicians and non-physicians, who have to maintain a stable physician/PCP workforce in primary care. The clear advantage in terms of physician satisfaction with their work that BHI

confers has been demonstrated making the anecdotal accounts of improved physician retention following BHI quite believable.

Many of these outcomes are easier to achieve than the remission from depression, but they are worth working toward for many practices, health plans, and state agencies, as long as better outcomes for depression also may be possible down the road. More physicians and administrators are finding that primary care without any way to support PCPs as they attempt to address mental health, substance abuse and the myriad health behavior needs they encounter is unacceptable on its face, once another approach is possible. A broader list of valued outcomes and therefore a much broader list of models that are achieving those outcomes would make the field more understandable to those who don't know it.

Finally, I want to ask that you re-think the use of the SAMHSA-HRSA standard levels. The basic distinctions of the system, coordinated care, co-located care and integrated care, were first used in the paper I mentioned earlier (Blount, 2003). By the time the levels system was put together, they had become a common set of distinctions in the field. What the authors of the levels did not see is that they were explicitly put forward as not being mutually exclusive and therefore not hierarchical. It is not uncommon to find practices in which some aspects are integrated, some are co-located and some are coordinated. These categories are meant to allow an observer to describe the relationship of medical and behavioral services in a particular service. They do not form a hierarchy of integration for a whole practice.

I hope these comments will be useful.

Alexander Blount

Blount, A. (2003). Integrated primary care: Organizing the evidence. *Families, Systems, & Health, 21*, 121-134.

April 21, 2015

Institute for Clinical and Economic Review
RE: *Integrating Behavioral Health in Primary Care*

On behalf of the University of Washington's AIMS Center, dedicated to Advancing Integrated Mental Health Solutions, I applaud your efforts to synthesize the latest evidence on the comparative clinical effectiveness and value of efforts to integrate behavioral health into primary care. As you know, the field of integrated care is fraught with inconsistent terminology and misinterpretations of what does and does not work. Reports like yours can help move us forward in understanding the data and implementing proven solutions. We have conducted over 20 years of research in integrated care and welcome this opportunity to comment on your report and share some lessons from our work in **Collaborative Care**, an evidence-based model of integrated care developed at the University of Washington to treat depression and anxiety in primary care clinics.

In a 2008 evidence synthesis of the Collaborative Care model, AHRQ states

> *"Terminology around this type of care has become confusing. The terms Integrated Care and Collaborative Care have sometimes been used in what appears to be interchangeable ways, but at other times they reflect subtle but important differences. Historically, the Collaborative Care model was a term used in some of the earliest research on integrated care in the United States by Wayne Katon and his colleagues. Within the United States, the term Integrated Care has tended to be used, perhaps in part to distinguish other models from Katon's Collaborative Care Model."*[1]

The AIMS Center defines Collaborative Care as a specific type of integrated care that operationalizes the principles of the chronic care model to improve access to evidence-based mental health treatments for primary care patients. Collaborative care is *measurement-based* with screening and monitoring of patient-reported outcomes over time to assess treatment response. It is *team-based* led by a primary care provider with support from a care manager and consultation from a mental health specialist who provides treatment recommendations for patients who are not achieving clinical goals. It is *population-based* whereby the care team uses a registry to monitor treatment engagement. It is *patient-centered* with proactive outreach to engage, activate, promote self-management and treatment adherence, and coordinate services. It is *evidence-based* with demonstrated cost-effectiveness in diverse practice settings and patient populations. It is *practice-tested* with sustained adoption in hundreds of clinics across the country. Finally, it is *accountable* for the care provided and for continuous quality improvement to meet care goals.

We strongly suggest revising *Integrating Behavioral Health in Primary Care* to accurately reflect the robust empirical evidence for Collaborative Care and to minimize the chance that a misinterpretation of research findings will undermine support for policies that promote the adoption of Collaborative Care that has been shown to be effective and cost-effective.

Over 80 randomized controlled trials have demonstrated the clinical effectiveness of Collaborative Care in diverse practice settings with diverse patient populations.[2] The clinical improvement is substantial. Compared to usual care, Collaborative Care produces a 18.4% median absolute increase in patients with a response to depression treatment (i.e., 50% improvement in symptom severity) and a 16.7% median absolute increase in symptom remission.[3] A common misuse of the rigorous and robust scientific literature for Collaborative Care is to generalize it to other integrated care models that have not been proven to be effective. The implication of this misinterpretation has been the widespread proliferation of non-evidence based integrated care models.

Integrating Behavioral Health in Primary Care appears to have made the reverse misinterpretation: taking insufficient empirical evidence for other integrated care models and applying it to the effectiveness of the Collaborative Care model. This is a potentially much more harmful misinterpretation because it has the potential to impede policy development that promotes the adoption of the evidence-based Collaborative Care model.

We respectfully suggest the authors reinforce the following points to halt the misinterpretation of the evidence:

- Integration and collaboration are NOT the same thing. Collaboration is necessary to improve outcomes, but effective collaboration can be achieved with varying levels of 'integration' or co-location. Integration and co-location are not necessary for effective collaboration.

- There is little scientific evidence that integrating care in and of itself improves patient outcomes. Thus, it cannot be concluded with confidence that integration alone is sufficient to improve outcomes.

- It is invalid to conclude that Collaborative Care is ineffective because of the lack of scientific evidence for integration generally.

- When implemented as part of routine primary care, Collaborative Care improves patient outcomes. Widespread implementation of Collaborative Care has the potential to improve access to evidence based mental health treatment for millions of Americans in a highly cost-effective manner.

Terminology

To fully comprehend the nuances of the scientific evidence, it is critical to understand the terminology. Developed by expert consensus, AHRQ defines Collaborative Care as "*Multiple providers, with their patients, combine perspectives to understand and identify the problems, opportunities, and treatments…to continually revise the treatment as needed to hit treatment goals".*[4] In contrast, it defines integrated care as "*Tightly integrated, on-site teamwork with unified care plan as a standard approach to care for designated populations*."[4] AHRQ concludes that in the Collaborative Care model, "*Significant improvements in symptom severity, treatment response, and remission were consistent*

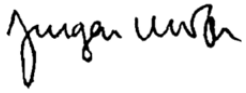
across the integration levels." [1] **In other words, the Collaborative Care model works, regardless of whether the collaborating providers are co-located and integrated.**

Your report misinterprets this finding and instead reports a "*lack of correlation between level of integration and treatment response.*" The AHRQ finding that co-location and integration are not correlated with outcomes must not be **mistakenly interpreted** to mean that the Collaborative Care model is not effective.

A further misinterpretation of the evidence stems from the report's use of the integrated care framework developed by SAMHSA/HRSA. This framework, which remains unpublished in the peer-reviewed scientific literature and has little empirical support, assumes that both collaboration and integration are necessary to improve outcomes. Combining collaboration and integration into a single integration index is contrary to the available evidence and thus, the conclusion that collaboration is not correlated with outcomes is unsubstantiated.

Collaborative Care has been proven to more effective than care as usual and to be clinically worth doing at a population level. Integrating behavioral health care into primary health care works well IF it's done right, and we should focus our collective efforts on putting the right pieces in place to facilitate implementation of evidence-based integrated care programs such as Collaborative Care.

Sincerely,



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April 20, 2015

Sarah Jane Reed, MSc
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RE: Integrating Behavioral Health in Primary Care

Dear Ms. Reed:

The American Psychiatric Association (APA), the national medical specialty society representing over 36,000 psychiatric physicians, is submitting comments in response to the draft report Integrating Behavioral Health into Primary Care, which is to be reviewed by the New England Comparative Effectiveness Public Advisory Council (CEPAC). This is a very important and comprehensive report, and the APA commends the Institute for Clinical and Economic Review (ICER) and CEPAC for its efforts to synthesize the evidence on the comparative clinical effectiveness and the value of current efforts to integrate behavioral health into primary care.

The APA also congratulates ICER and the California Technology Assessment Forum for making meaningful changes to the content of the report in the evidence presentation at the April 2nd public meeting. The presentation and voting questions provided a more realistic picture of the science behind the use of the collaborative care model when integrating behavioral health into primary care. The APA looks forward to the CEPAC's upcoming public meeting with questions for voting and the final papers from both CTAF and CEPAC.

Because of the disconnect between the both draft reports and the presentation at the CTAF meeting, the APA is submitting to CEPAC the same comments it submitted in March to CTAF. These comments continue to point to the collaborative care model as the only model that currently has a viable evidence base.

Comments

Frequently lexicon issues can stand in the way of progress, creating a lack of clarity in what is being discussed. As the literature suggests, there are four key approaches to

integrated care: medical or health homes, accountable care organizations, collaborative care models, and the location of medical services in specialty behavioral health facilities.

Our preferred way to discuss the integration of behavioral health in primary care and decrease confusion is to rank or categorize research and evidence for each of the four models. Where there is solid or emerging evidence on a model studied, the elements for the success of this model should be identified and defined.

For example, the elements of the collaborative care model (CCM) include: (1) care coordination and care management; (2) regular/proactive caseload monitoring and treatment to target using validated clinical rating scales; and (3) regular consultation for patients who do not show clinical improvement.[1] [2]

There is an extraordinary amount of evidence substantiating this very specific model. No other model of integration, or model mislabeled as collaborative care, has this level of evidence. Other models that may have some good evidence of success may or may not have some of the three elements that define CCM. These other models need scientific study and defining.

There are over eighty randomly controlled trails substantiating the evidence for the above defined collaborative care model. These studies demonstrate significant improvement across populations, settings, and outcome domains.[3] [4] The CCM evidence also indicates improvement for a variety of mental health disorders (beyond depression and anxiety) as well as for medical comorbidities. There have been numerous cost-effectiveness studies demonstrating that CCM provides good economic value.[5] Unützer found for every dollar spent on the CCM there was a return on investment of $6.50.[6]

The APA asks that CEPAC base its decisions on the available science and not use an unsubstantiated framework. It is the APA's view that it is essential that the CEPAC make bright-line distinctions where the evidence supports specific models such as CCM. CCM is population-based care, measurement-based care with caseload based review, and integration of psychiatry expertise into primary care. It clearly represents significant improvement and value over usual care.

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[6] Unützer, J. Long-term Cost Effects of Collaborative Care for Late-life Depression. AJMC 2008; 4 (2):95-100

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We thank you for your consideration of our comments. If you have any questions or concerns, please contact Karen Sanders at (703) 907-8590 or ksanders@psych.org.

Sincerely,

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CEO and Medical Director