



## **Integration of Behavioral Health into Primary Care**

### **Final Questions for Deliberation: May 1, 2015 Public Meeting**

#### **Definitions**

For the purposes of this CEPAC report/meeting, we use the following definitions:

- *Behavioral health integration (BHI)* into primary care refers to screening and treatment to address both physical health and behavioral health needs in primary care settings through systematic coordination and collaboration among health care providers.
- *Behavioral health* is defined broadly by AHRQ to include mental health and substance use disorders, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization. This report focuses on programs to address mental illness and/or substance use disorders that are frequently diagnosed and managed in primary care settings and not on programs that address the other issues identified above OR serious mental illness (SMI), addiction, or serious alcohol abuse.
- *Collaborative Care Model (CCM)* is an approach that integrates treatment for mood and anxiety disorders into primary care settings and has these components: 1) care coordination and care management, 2) regular/proactive monitoring and treatment to target using validated clinical rating scales, and 3) regular supervision of case manager by a mental health professional. The IMPACT model is the most studied example of a CCM.
- Other models of integration may involve co-location of providers including social workers, psychologists, or psychiatrists in primary care settings; or completely integrated practices that include shared treatment plans, shared electronic health records (EHRs), and other components.

## Voting Questions

1. Is the evidence adequate to demonstrate that interventions to integrate behavioral health into primary care using the **Collaborative Care Model (CCM)** have better outcomes than usual care in terms of:
  - a. *Improvement in anxiety and/or depression?*  
Yes                  No
  - b. *Intermediate health outcomes in patients with diabetes? (e.g., reduction in HBA1c levels, blood pressure, etc.)*  
Yes                  No
  - c. *Improvement in quality of life?*  
Yes                  No
2. Is the evidence adequate to demonstrate that interventions to integrate behavioral health into primary care **other than the CCM** have better outcomes than usual care in terms of:
  - a. *Improvement in anxiety and/or depression?*  
Yes                  No
  - b. *Intermediate health outcomes in patients with diabetes? (e.g., reduction in HBA1c levels, blood pressure, etc.)*  
Yes                  No
  - c. *Improvement in quality of life?*  
Yes                  No
3. Is the evidence adequate to demonstrate that interventions to integrate behavioral health into primary care using the **CCM** improve *patient satisfaction* vs. usual care?
  - a. Yes                  b. No
4. Is the evidence adequate to demonstrate that interventions to integrate behavioral health into primary care **other than the CCM** improve *patient satisfaction* vs. usual care?
  - a. Yes                  b. No
5. Given the available evidence, what is the *care value\** of **CCM** vs. usual care?
  - a. Low                  b. Reasonable                  c. High
6. Given the available evidence, what is the overall *health system value\*\** of **CCM**?
  - a. Low                  b. Reasonable                  c. High
7. Given the available evidence, what is the *care value\** of integration interventions **other than the CCM** vs. usual care?
  - a. Low                  b. Reasonable                  c. High

8. Given the available evidence, what is the overall *health system value*\*\* of integration interventions **other than the CCM**?
- a. Low                      b. Reasonable                      c. High

## Value Assessment Framework

\* **Care value** is a judgment comparing the average per-patient costs, clinical outcomes, and broader health effects of two alternative interventions or approaches to care.

There are four elements to consider when deliberating on care value:

1. **Comparative clinical effectiveness** is a judgment of the overall difference in clinical outcomes between two interventions (or between an intervention and placebo), tempered by the level of certainty possible given the strengths and weaknesses of the body of evidence. CEPAC now uses the ICER Evidence Rating Matrix as its conceptual framework for considering comparative clinical effectiveness.
2. **Incremental cost per outcomes achieved** is the average per-patient incremental cost of one intervention compared to another to achieve a desired “health gain,” such as an additional stroke prevented, case of cancer diagnosed, or gain of a year of life. Alternative interventions are compared in terms of cost per unit of effectiveness, and the resulting comparison is presented as a ratio: a “cost per outcome achieved.” Relative certainty in the cost and outcome estimates continues to be a consideration.
3. **Additional benefits** refers to any significant benefits offered by the intervention to caregivers, the delivery system, or other patients in the health care system that would not have been captured in the available “clinical” evidence. Examples of potential additional benefits include mechanisms of treatment delivery that require many fewer visits to the clinician’s office, treatment outcomes that reduce disparities across various patient groups, and new mechanisms of action for treatments of clinical conditions (e.g., mental illness) that have demonstrated low rates of response to currently available treatments. For each intervention evaluated, it will be open to discussion whether additional benefits such as these are important enough to factor into the overall judgment of care value. There is no quantitative measure for additional benefits.
4. **Contextual considerations** can include ethical, legal, or other issues (but not cost) that influence the relative priority of illnesses and interventions. Examples of contextual considerations include whether there are currently any existing treatments for the condition, whether the condition severely affects quality of life or not, and whether the condition affects priority populations. There is no quantitative measure for the role of contextual considerations in an overall judgment of care value.

CEPAC will use this conceptual description of the elements of care value when deliberating on the evidence and voting. The CEPAC Panel will be asked to vote whether interventions represent a “high,” “reasonable,” or “low” care value.

**\*\* *Health system value* is a judgment of the affordability of the short-term budget impact that would occur with a change to a new care option for all eligible patients, assuming the current price and payment structure.**

Usually, the care value and the health care system value of an intervention or approach to care will align, whether it is “high,” “reasonable,” or “low.” For example, a treatment that is judged to represent high care value from the perspective of per-patient costs and benefits will almost always represent a high health system value as well. But health system value also takes into consideration the short-term effects of the potential budget impact of a change in care across the entire population of patients. Rarely, when the additional per-patient costs for a new care option are multiplied by the number of potential patients treated, the short-term budget impact of a new intervention of reasonable or even high care value could be so substantial that the intervention would be “unaffordable” unless the health system severely restricts its use, delays or cancels other valuable care programs, or undermines access to affordable health insurance for all patients by sharply increasing health care premiums. Under these circumstances, unmanaged change to a new care option could cause significant harm across the entire health system, in the short-term possibly even outweighing the good provided by use of the new care option itself.

To consider this possibility, CEPAC reviews estimates of the potential budget impact for a change in care as measured by the estimated increase in “per-member-per-month” health care premiums that would be needed to fund a new care option in its first year of use were all eligible patients to be treated. It should be noted that if, after considering potential budget impact, a health intervention judged to have high care value receives a judgment of “low” health system value from CEPAC, this does not imply that the health system should not adopt the intervention; rather, the vote indicates that policy makers should consider implementing mechanisms related to patient selection, step therapy, pricing, and/or financing to ensure that the short-term budget impact of a high care value intervention does not lead to more harm than good. CEPAC votes on health system value will therefore serve an important function by highlighting situations when policymakers need to take action and work together to align care value with health system value.