Integrating Behavioral Health into Primary Care

Scoping Document and Report Components for May 1, 2015 CEPAC Public Meeting

Note: Public comments on this document will be accepted through **January 23, 2015** by email to info@icer-review.org

Background:

Up to 70% of physician visits are for issues with a behavioral health (i.e., mental health or substance use) component, and an equal proportion of adults with behavioral health conditions have a comorbid physical health issue. Patients with chronic illnesses such as diabetes, obesity, cancer, or asthma are more likely to experience mental illness (Katon, 2011). Moreover, care for patients with comorbid behavioral health conditions can cost 2-3 times more than for patients without these comorbidities (Milliman, 2012), and these individuals have shorter life expectancies than the average person (Druss, 2011). Additional health care costs related to behavioral health comorbidities were estimated to be $293 billion in 2012, with approximately 217 million days of work lost annually to behavioral health conditions, costing $17 billion/year (Milliman, 2012).

Project Aim:

Integration of behavioral health into primary care is designed to improve screening and treatment in primary care settings through systematic coordination and collaboration among health care providers to address both physical health and behavioral health needs. ICER's report for CEPAC will assess the evidence on the comparative clinical effectiveness and value of efforts to integrate behavioral health into primary care; identify the components potentially associated with successful integration; and evaluate the legal, regulatory, and financial landscape for behavioral health integration (BHI) in New England. The report will also include an overview of lessons learned from national and regional experts to identify potential innovations and solutions for BHI in New England states.

Conceptual Framework:

SAMHSA/HRSA has proposed a model with six levels of integration in three main categories. These three categories are shown below, along with patient populations of potential interest for this evaluation:

Population	Coordinated Care	Co-Located Care	Integrated Care
1. Depression/anxiety			
2. Serious mental illness			
3. Alcohol abuse			
4. Drug abuse			

Source: Heath B, Wise Romero P, and Reynolds K. A Standard Framework for Levels of Integrated Healthcare. Washington D.C. SAMHSA-HRSA Center for Integrated Health Solutions. March 2013.

Outcomes for patients in special populations (e.g., diabetes, pregnancy) will be presented separately when available in sufficient detail.

Scope of the Assessment:

The proposed scope for this assessment is described below using the PICOTS (Population, Intervention, Comparators, Outcomes, Timing, Settings) framework.

Population

The primary population of interest will include patients with depression and/or anxiety, as these represent the most common mental health conditions seen in primary care. Forms of depression will include acute, chronic, persistent, and postpartum depression. Anxiety disorders will include generalized anxiety, panic, posttraumatic stress disorder (PTSD), phobias, social anxiety, health anxiety, and obsessive compulsive disorder (OCD).

Studies that include patients with other serious mental illnesses (e.g., bipolar disorder, schizophrenia) as well as alcohol and/or substance use disorders will be included as long as >50% of the population studied is diagnosed with depression and/or anxiety. This inclusion criteria is designed to focus the assessment on studies that involve management and triage of patients presenting in the primary care setting, and to exclude those focusing on the delivery of primary care services in settings where patients are receiving specialized treatment for serious mental illness and/or substance abuse.

Interventions

As mentioned above, interventions and models representing multiple levels of integration will be of interest, including coordinated care, co-located care, and integrated care models. The SAMSHA-HRSA framework further describes these levels of integration according to six levels of collaboration:

Coordinated care

1. Minimal collaboration: referral network to providers at another site
2. Basic collaboration: periodic communication about shared patients

Co-located care

3. Basic collaboration: primary care and behavioral providers share facility but maintain separate cultures and develop separate treatment plans for patients
4. Close collaboration: providers share records and some systems integration

Integrated care

5. Close collaboration approaching an integrated practice: providers develop and implement collaborative treatment planning for shared patients but not for other patients
6. Full collaboration in a merged integrated practice for all patients: providers develop and implement collaborative treatment planning for all patients

Comparators

Comparators of interest will be current models of “usual care”, which may take multiple forms. In some cases the comparator may be a limited intervention, such as provider education regarding screening and referral for depression and anxiety.

Outcomes

Outcomes of interest will include the impact of behavioral health integration on:

- Mortality
- Relevant medical outcomes, such as the incidence of cardiovascular events and stroke
- Changes in depression and/or anxiety symptoms based on data from validated scales (e.g., Beck Depression Inventory, Hamilton Rating Scale for Depression)
- Health-related quality of life
- Ratings of patient and clinician satisfaction
- Economic outcomes, including payer costs and patient productivity

Timing

We will limit studies to those with at least 6 months of follow-up to allow for adequate assessment of program impact.

Settings

While study participants could be identified in multiple settings (e.g., inpatient, specialized mental health), we will only include studies if the BHI intervention was delivered predominantly in a primary care setting, and/or when the model of BHI focuses predominantly on improving the ability of primary care clinicians to manage behavioral health issues.

Key Questions:

- Does integration of behavioral health into primary care improve patient outcomes (e.g., mental and physical symptoms, chronic conditions such as hypertension and diabetes, mortality)?
- Does integration of behavioral health into primary care improve patient experience of care?
- Are specific levels of integration most effective for specific types of patients?
- What integration components are highly correlated with successful outcomes?
- What are the cost impacts of integrating behavioral health into primary care, and how do cost impacts differ for different levels of integration?
- What do policy experts believe are the most important implementation lessons learned from trying to integrate behavioral health into primary care?

References:

Benjamin G. Druss and Elizabeth Reisinger Walker. Mental Disorders and Medical Comorbidity, February 2011, Robert Wood Johnson Foundation.

Wayne J. Katon. Epidemiology and Treatment of Depression in Patients with Chronic Medical Illness, *Dialogues in Clinical Neuroscience*, March 2011, 13(1): 7–23.

Stephen P. Melek. Bending the Healthcare Cost Curve through Financially Sustainable Medical Behavioral Integration, July 2012, Milliman.

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