October 27, 2023

Elisabeth Uphoff Kato, M.D., M.R.P.
Task Order Officer
Center for Evidence and Practice Improvement
Agency for Healthcare Research and Quality
5600 Fishers Lane
Rockville, MD 20857

<u>Re</u>: <u>Strategies for Integrating Behavioral Health & Primary Care: Draft Strategic Review - Comments</u>

Dear Dr. Kato,

<u>Introduction:</u> NHMH – No Health without Mental Health , joined by the undersigned allied organizations

American Association on Health & Disability
Clinical Social Work Association
International Society for Psychiatric Mental Health Nurses
Lakeshore Foundation and
Policy Center for Maternal Mental Health,

appreciate the additional foundational information the Agency for Healthcare Research Quality's (AHRQ) systematic review of behavioral health integration (BHI) approaches and their implementation, contributes to the field. The review makes clear that integration, while progressing over the past 15 years, remains young, under-developed and evolving, as evidenced by the review's multiple references to insufficiency of studies to provide evidence for much of the five questions posed.

We commend the AHRQ review for accomplishing several important objectives: (a) rigorously assembling the known evidence base, limited as it is, in the BHI field, providing a helpful evidence baseline; (b) setting forth specific areas for needed future research in integration - including an area largely omitted to date - the patient/family perspective, priorities, and experience; and (c) providing a valuable information tool for clinicians, clinical administrators, policymakers, and researchers *who may need to make decisions now* on integration programs and policies.

Our comments focus on two areas: (1) a suggestion for an organizing principle that would be consistent with existing widely accepted categorization approach on this issue, and (2) recommendations for inclusion of relevant items omitted from the AHRQ draft.

<u>ORGANIZING PRINCIPLE:</u>

We believe it may be helpful to achieve maximum spread, reach and deeper utilization of the AHRQ's new information to reorganize the topics covered by the review questions around four key aspects of

behavioral health and primary care integration: Standards/Quality, Payment, Workforce, and Technology. Adopting an approach introduced by a bipartisan healthcare policy think tank (Bipartisan Policy Center's "Tackling America's Mental Health and Addiction Crisis through Primary Care Integration," March 2021, https://bipartisanpolicy.org/report/behavioral-health-2021/) and widely used since.

Adopting this organizing principle could allow for AHRQ's target audiences to quickly and easily see how the new information fits into the existing, larger clinical care and policy discussion big picture, and where the integration field needs to go from here. It may also provide greater understanding of the inter-relationships of the different key aspects. And help audiences maintain a common mental construct when dealing with expected future integration implementation challenges and developments such as new models, hybrid models and model variations. Finally, adopting this organizing approach could provide external audiences (Congress, public) with a consistent structure and format framework on this issue. There is already good alignment between the two approaches:

Standardization and Quality of Care (incl Quality Measurement)

Existing: establish new core service components necessary for BHI; identify a set of standardized quality and performance measures for integrating practices across all programs;

AHRQ: standardize the description of BHI implementation strategies; describe effectiveness of BHI approaches; identify components of BHI integrated care quality measurement as first step in delivering effective MH/SUDs care to patients;

Payment

Existing: drive integration in new and existing value-based payment models; provide financial assistance; require (shared) accountability; build integration into existing Medicaid MCOs, Medicare ACOs and MA plans payment models;

AHRQ: measures and metric to monitor/evaluate integration approaches; system resilience, new purposes of a system, and value-based care delivery and payment; lack of identified sustainable integration financial models;

Workforce

Existing: national technical assistance program to provide training needed to deliver integrated care and participate in value-based payment models; expand Medicare coverage for additional BH provider types; increase scholarship opportunities and pipeline program to diversify/broaden workforce; training, technical assistance, access to larger pool of BH providers for both consults and referrals

AHRQ: care team members roles, clinical care workflows; organizational and professional cultures;

Technology

Existing: test model giving financial incentives for BH clinicians to adopt EHRs and facilitate information exchange between/amongst providers; make Medicare coverage of telehealth services permanent;

AHRQ: insufficient EHR systems as barrier to healthcare team's communications, collaboration; connection between adequate HIT technology supporting integration and practice clinical workflow design.

ITEMS RECOMMENDED FOR INCLUSION:

We suggest the following areas of behavioral health integration strategies and implementation be explored and discussed in the final AHRQ strategic review:

(a) <u>BHI with Chronic Medical Condition Treatment:</u> It is generally understood that integration of behavioral health and primary care may have the greatest potential not only to increase access to behavioral care, but also, importantly, to improve both *physical* and behavioral health outcomes for large numbers of people. This was touched on briefly in the review: "Behavioral health outcomes were consistently better with behavioral health and primary care integration across all factors, but the hypothesized impact on physical health measures was not always realized," Ch. 7, p. 85, 2nd para. Regrettably, no mention was made of the landmark 2010 TEAMcare study which set the standard for the most successful physical-behavioral integration outcomes realized in a RCT trial targeting depression *plus* common chronic medical conditions diabetes and cardiovascular disease (Katon, W, Collaborative Care for Patients with Depression and Chronic Illness, *N Engl J Med*, 2010, 363:27; McGregor, R., Lin, E., Katon, W., TEAMcare – An Integrated Multi-Condition Collaboration Care Program for Chronic Illness and Depression, *J. Ambulatory Care Management,* April-June 2011, Vol. 34,No. 2, pp 152-162; Rundell, J.R., et al, The COMPASS Initiative: Implementing a Complex Integrated Care Program, *General Hospital Psychiatry*, 2016). Given CMS's priority focus on future care of co-morbid Medicare beneficiaries with behavioral and chronic medical conditions, and given that TEAMcare remains today the most powerful exemplar of a highly successful clinical implementation of a complex care intervention in a vast array of settings that led to meaningful improvements in patient outcomes physical and behavioral, it should be referenced in the AHRQ review, and be the launchpad for future research studies.

(b) <u>Patient Engagement in Behavioral Health Integration</u>: There is a dearth of studies on patient engagement in the delivery of behavioral integration in primary care, as reflected in its absence from the strategic review. For example, we believe areas not covered but which should be examined in future research, include: (i) what has been the patient and provider response to various BHI approaches in terms of meeting their needs? (ii) how is the patient-provider relationship altered, if at all, in the delivery of integrated care? and (iii) what specifically could, or should, be the patient's role as a key member of the integrated healthcare team?

We believe the AHRQ review should prominently state that more information and data urgently need to be developed regarding patient preferences, experiences and priorities, building on the Healthcare Experiences Survey (HCES) patient survey tool mentioned. We recommend the AHRQ review cite specific areas for future research on the topic, given its centrality to achieving improved outcomes (Coleman, K., et al, Understanding the Experience of Care Managers and Relationship with Patient Outcomes, *General Hospital Psychiatry* (2016). These specific areas should include patient-reported outcomes (PROs and

PRO/PMs); studies on patient preferences to have their mental health care delivered face-to-face (Stanford University School of Medicine/Rock Health, Consumer Adoption Survey, 2022); patient role and responsibility as member of the integrated healthcare team; patient priority for treat-to-target to combat clinical inertia; need for a system to engage patients in their integrated care; lack of patient-centered quality measures beyond HCES; and patient support for a PIP (Practice Integration Profile) patient companion for routine data collection.

© Inclusion of DOD and VHA along with Civilian Integration Implementation Experience: There are many lessons to be learned from the military healthy system's MHS) substantial track record on behavioral health integration. The extensive 27-year legacy and history of DOD and VHA principally with implementation of the PCBH model, has long been recognized. For example, it has been described in multiple special issues of the *Journal of Clinical Psychology in Medical Settings*. We noted only one discrete reference in the AHRQ review to the 2018 Veteran Health Administration study on provider training (Ch. 6, p. 82-3). We highly recommend AHRQ include reference to the substantial scientific literature on MHS integration research studies, with key researchers including Landoll, R.R., Maggio, L., Cervero R., Quinlan, J., Nielsen M. and Waggoner, K. Because so many of the leading researchers in PCBH come from DOD/VHA settings, there has in recent years been significant cross-fertilization among military and civilian integration researchers. The MHS has an advantage in its closed system in its uniformity of standard of care across all settings, and its ability to measures outcomes. However, a disadvantage military integration researchers face is that being federal government officials, they are not able to engage in legislative advocacy. This is a body of in-depth relevant research work that should be included I any strategic evidence review.

With best regards,

NHMH – No Health without Mental Health
Florence C. Fee, J.D., M.A.
Executive Director

Clinical Social Work Association
Laura W. Groshong, LCSW
Director Policy & Practice

American Association on Health & Disability
E. Clarke Ross, D.P.A.
Public Policy Director

Lakeshore Foundation
E. Clarke Ross, D.P.A.
Washington Representative

International Society for Psychiatric Mental Health Nurses
Sally Raphel
Policy Committee Chair

Policy Center for Maternal Mental Health
Joy Burkhard
Executive Director