2018 Fact Sheet
Integrating Behavioral Health into General Medical Care

Overview
The Integrating Behavioral Health into General Medical Care Initiative was launched in 2015 to guide Physician Organizations (POs) through a participation-based collaborative process to focus work on specific, self-identified measures. Twelve PGIP Physician Organizations, representing about 65 practice units participated in Cohort 2 of this initiative which reached approximately 219,000 patients.

Background
Integrating behavioral health into general medical care can improve health outcomes and reduce costs. For example, the coexistence of depression and diabetes in patients is associated with 4.5 times higher healthcare expenditures compared to patients without depression[i]. However, successful depression treatment is associated with lower subsequent healthcare use and expense[ii].

There is an association between depression treatment and healthcare expenditures among individuals with other chronic conditions. Among individuals with dyslipidemia, Type 2 diabetes and coronary artery disease, existing either alone or as comorbid conditions, antidepressant medication adherence improved adherence to coexisting disease medications, which reduced one-year healthcare expenditures[iii].

Goals and objectives
- Improve communication and information exchange between primary care physicians and behavioral health specialists
- Improve continuity of care across settings
- Improve self-management for patients with behavioral health and other chronic conditions, leading to better outcomes
- Improve member outcomes in key Health Effectiveness Data and Information Set (HEDIS®) measures related to behavioral health

Initiative design
The Integrating Behavioral Health into General Medical Care Initiative focuses on improving processes and communication among behavioral health specialists, primary care physicians and other clinicians, to result in improved outcomes for patients.

The initiative uses a collaborative model where a cohort group of POs work together to implement projects to improve behavioral health outcomes. POs are rewarded for participation in collaborative activities and completion of specific quality improvement activities identified in the PO quality

improvement plan. The initiative reward is based on a points-based system and not on meeting predetermined performance expectations.

Participation criteria

Cohort 2 of the initiative began in March 2017 and will run through March 2018. All interested POs completed a readiness assessment prior to the final selection of participants. Interested POs will have an opportunity to submit a readiness assessment in first quarter 2018 for possible participation in Cohort 3.

To be eligible, POs must:

- Demonstrate leadership commitment to this work
- Include providers who deliver behavioral health services
- Be willing to commit resources to the goals of this initiative
- Have at least two practice units that use a registry and are willing to include psychiatric diagnoses in the registry
- Are willing to use a behavioral health specialist referral process as defined through the concepts of Patient-Centered Medical Home Neighbor

Evaluation

Participating POs are required to attend the kickoff meeting, complete homework activities, and attend regular cohort meetings.

Physician Organizations are expected to use rapid cycle quality improvement (such as Plan, Do, Study, Act) or other similar model to identify areas for clinical or process improvement. The improvement should build a collaborative environment between behavioral health specialists and physicians. Physician Organizations are expected to clearly identify an area for quality improvement, a methodology for addressing the problem, and a clear goal. Physician Organizations must be able to document their plan to identify areas of improvement and the methodology to address the problem.

Results

Physician Organizations were asked to identify at least one, but not more than three focus areas. Of the 12 participating POs, the following focus areas were selected:

- Office integration/care teams – 8 POs
- Community resources and referral process systems – 5 POs
- HEDIS measures – 1 POs
- Depression screening – 10 POs
- Integrated pharmacists – 3 POs
- Telehealth and telepsychiatry – 4 POs
- Use of ADTs – 2 POs

- Use of registries - 2 POs

Each participating PO met or exceeded at least one of the measures identified in their Quality Improvement Plan. This participation-based initiative uses rapid-cycle improvement models, such as Plan, Do, Study, Act.

For additional information about this initiative contact:
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About Value Partnerships
Over a decade of innovation, Value Partnerships is a collection of clinically-oriented initiatives among Michigan physicians, hospitals, and Blue Cross Blue Shield of Michigan that are improving clinical quality, reducing health complications, controlling cost trends, eliminating errors, and improving healthcare outcomes throughout Michigan.

About PGIP
PGIP, a BCBSM **Value Partnerships** program, encourages, and rewards practitioners to more effectively manage patient populations and build an infrastructure to more robustly measure and monitor care quality. Over **40** Physician Organizations across the state of Michigan - representing nearly **20,000 primary care physicians and specialists** - are working together in PGIP to improve the delivery of healthcare for Michigan Blues members.

PGIP is cultivating a healthier future for all Michigan residents by catalyzing an all-payer system. Patients throughout the state, regardless of payer, benefit from improved care processes developed in the PGIP provider community.

For additional information about PGIP:
Send an email to valuepartnerships@bcbsm.com.

Visit our website at www.valuepartnerships.com.

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[i] Egede LE, Zheng D, Simpson K. Comorbid depression is associated with increased health care use and expenditures in individuals with diabetes. Diabetes Care. 2002;25(3):464–70.
[ii] Simon GE, Khandker RK, Ichikawa L, Operskalski BH. Recovery from depression predicts lower health services costs. J Clin Psychiatry. 2006;67(8):1226–31.
[iii] Katon W, Cantrell CR, Sokol MC, Chiao E, Gdovin JM. Impact of antidepressant drug adherence on comorbid medication use and resource utilization. Arch Intern Med. 2005;165(21):2497–503.