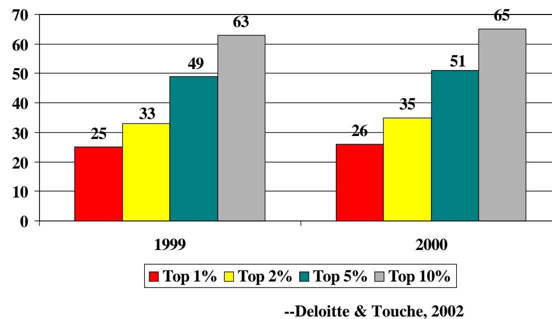
Minnesota Psychiatric Society Integrated General Medical and Behavioral Health Program Development Initiative

Task Force Executive Committee Members:

- Roger Kathol, Chair (Internist, Psychiatrist, Cartesian Solutions Consulting, Twin Cities)
- Julie Gerndt (Psychiatrist, Mankato)
- Peter Denhel (Pediatrician, Twin Cities)
- Brad Montgomery (Minnesota Medical Group Management Association, Health Front, Twin Cities)
- Mac Baird (Family Practice, University of MN)
- John Scanlan (Psychiatry, Blue Cross Blue Shield of MN)
- Read Sulik (Pediatrics, Child Psychiatry, St. Cloud)
- John Fredericks (Health Care Administration, Family Practice, PreferredOne)
- Frank Schiefelbein (Cattle Rancher, Health Care Advocate)
- William Dikel (Child Psychiatrist, President-Elect MPS, Twin Cities)
- Christina Rich (Lawyer, MN Medical Association)
- Ricka Stenerson (Risk Management, MN State Health Plan)
- Sheryl Niebuhr (Compensation Resource Manager, Psychologist, 3M)
- Karen Dickson (Psychiatrist, President MPS, Twin Cities)

Figure 1: Percent of Claims Costs for Complex Patients

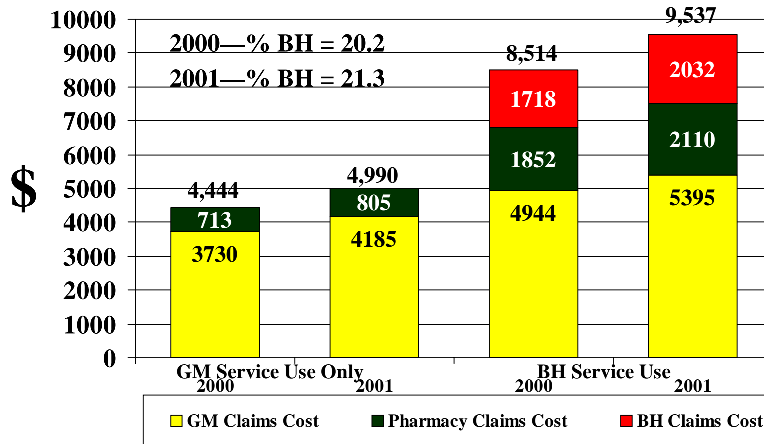


--Deloitte & Touche, 2002

Figure 1[1] demonstrates that the vast majority of health care costs are incurred by relatively few individuals. Many of the patients who fall into this high cost category are those who use behavioral health services (Figure 2). Importantly, nearly 80% of the total cost for these behavioral health patients are for general medical and pharmacy, not behavioral health, claims expenditures yet the communication and coordination of clinical services between general medical and behavioral health providers is minimal. In fact, the current system encourages service and cost shifting from the psychiatric to the medical sector and vice versa as independent medical and behavioral health business entities try to limit total dollars spent from their own respective budgets[2].

Figure 2: Annual Claims Expenditures for 250,000 Adults With and Without Behavioral Health Service Use

% of population:
General Medical (GM) Service Use: 74.9%
Behavioral Health (BH) Service Use: 10.0%
No Service Use: 15.1%



In an attempt to improve clinical outcomes and, ultimately, the costs associated with persistent behavioral health needs over time (Figure 3), members of the Minnesota Psychiatric Society have set up a Task Force charged with creating *8 to 10 outpatient*

Figure 3: Health Care Spending in 2001 for Patients with CD & MH Service Use in 2000

	n	Annual spending per member, $*
Service Use in 2000	**768**	**16,634**
Service Use in 2001	**768**	**12,506**
Well		**(1.5 X average annual cost)**
No Mental Health or Chemical Dependence	**250**	**5,729**
Better		**(2.4-3.4 X average annual cost)**
Mental Health Only	**281**	**12,736**
Chemical Dependence Only	**65**	**10,471**
Same		**(5.4 X average annual cost)**
Mental Health & Chemical Dependence	**172**	**22,752**

*based on CMS average annual cost for 2001

and 2 to 3 inpatient clinical environments designed to provide integrated general medical and behavioral health service. To accomplish this objective, a group of

Minnesota physician and non-physician leaders from industry, health plans, medical organizations, health care administration, government, and patient advocacy is seeking to identify hospitals and clinics (and the providers therein) interested in participating in a collaborative effort to link medical and psychiatric care using the core outcome changing components from models of general medical and behavioral health care integration which have undergone longitudinal investigation[3-9].

How Is This Initiative Different? Why Participate?

The MPS Task Force initiative is unique in the nation. It combines several important factors which could create clinical and economic environments which reverse adverse outcomes in some of the most difficult and expensive patients treated in Minnesota. Since participant clinics will create state of the art integrated care programs and health plans will collaborate by supporting "out of the box" reimbursement approaches which fairly compensate for and encourage coordinated general medical and behavioral health care, model integrated programs participating in this initiative could inform future improvements in care throughout Minnesota during coming years.

Participant program organizations and providers would experience:

- Task Force support for creating their own version (model) of integrated care delivery designed to work in their system as long as core features known to be effective in published reports and required for Task Force program participation (see below) are included.
- *The development of a reimbursement environment for general medical and behavioral health specialists and participant general medical hospitals and clinics conducive to coordinated assessment and treatment* of medical and psychiatric health care concerns or illness in the non-psychiatric setting. This will be done through collaboration between providers, care delivery organizations, government agencies, health plans, and employers. Each support system will be based on the model of integration established in each specific program with special attention to generalizability at a later date.

This initiative provides an opportunity for general hospitals and general medical or multispecialty clinics to improve access and coordination of general medical and behavioral health service for patients seen in the primary and specialty care setting. Through collaboration with government agencies and health plans, new ways to reimburse for both general medical and behavioral health services which do not fall within the typical payment parameters defined by independent behavioral health business practices will be agreed upon and initiated in the MPS participant clinics and inpatient programs. Special attention will be given to fee structures and authorization requirements for behavioral health so that the providers who will be working in non-psychiatric settings receive fair compensation for services provided and are not burdened by authorization hassles.

Using this approach, general hospitals, non-psychiatric clinics, and the general medical and behavioral health providers in both of these clinical settings can expect fair compensation for the services provided on par with other hospital and clinic services at the participating institution. Perhaps the most important reason for participating in this initiative, however, is that it should lead to timely psychiatrist and behavioral health team access, designed to complement and support non-psychiatrist physician behavioral health care; improved general medical and behavioral outcomes; and, ultimately, lower the cost of care for affected individuals within the institution served.

Program Participant Selection

Choice of program participants will be based on the program's ability to comply with core component requirements. The number of participant programs could be fewer than the desired number if entry requirements are not met. The Task Force will use the following guidelines for appropriateness for program entry:

I. The specific approach (model) used by any given general medical or multispecialty clinic or inpatient service can be based on an existing model or an adaptation of a known model as long as the core components are present. (To obtain additional information on existing models, contact Linda Vukelich at the Minnesota Psychiatric Society offices, l.vukelich@comcast.net.)

II. Some programs should be set up in metro and others in out-state Minnesota, including inpatient programs.

III. Existing programs will be approached first to see if they wish to participate, provided they adhere to core integrated program components.

IV. Preference will be given to programs that include measurement of clinical and economic outcomes.

V. Outpatient Programs
    - A. Core Components:
        1. Co-participation by general medical and behavioral health specialists in a general medical health service location
        2. Timely mental health professional access (within 24 hours, but mostly within minutes to hours)
        3. Collaborative care model with *active interaction*, best practice approaches (medication, psychotherapy, follow-up, outcome orientation), joint medical and behavioral health staff accountability for all patient health concerns
        4. Not only improved behavioral health access and treatment but also coordination of general medical and behavioral health service use with *aggressive maximization of medical intervention for documented illness and conservative use of medical testing and medical medication prescribing for unexplained physical complaints*.
        5. Improved access to augmented behavioral health approaches in the behavioral health sector for non-responders.

B. Encouraged features
    1. Use of mental health teams, e.g. psychiatrist, social service, nurse clinicians, therapists
    2. Active psychiatrist(s) involvement
    3. Proactive case finding, e.g. screening for high risk cases
    4. Mechanism for patient follow-up to insure adherence
    5. Clinical and economic outcome measurement
C. Referral Clinic—at least one participating clinic should be developed as a referral center for complex care patients

VI. Inpatient Programs
  A. Core Components
    1. Administered by general medicine and psychiatry in the general medical setting
    2. Focus on patients with comorbid medical and psychiatric illness
    3. High acuity general medical and psychiatric capabilities
    4. Administration by physicians with joint general medical and psychiatric training or co-medical directors; co-attending clinical physician coverage
    5. Specialized combined nurse training—medical and behavioral health capabilities
    6. Medical and psychiatric policies, procedures, and safety features
    7. Active and daily medical and psychiatric communication and coordination of services
  B. Encouraged features
    1. Tertiary care emphasis at participating hospital
    2. Involvement in health care personnel training
    3. Accepts referral from surrounding area physicians, hospitals, and health plan case and disease management personnel
    4. Clinical and economic outcome measurement

Participant Clinic or Inpatient Unit Support from Task Force

I. Education on integration models
  A. Preliminary for those considering setting up integrated programs
  B. More in-depth education and support for those chosen as participants
  C. Availability for support and consultation during creation and operation

II. Based on models chosen and clinical needs identified, will work with hospital and clinics, providers, and health plans/government agency/employers to reorganize reimbursement so that it allows direct clinical care related support for services at a level capable of meeting cost (and reasonable profit) requirements for professionals and sponsoring care delivery organizations.
  A. Outpatient and Inpatient—payment for psychiatric services (facility; direct physician and support personnel) in non-psychiatric setting

without hassle (preferably from medical benefits without differential copays, benefit limits, etc.)

B. Inpatient—payment for full general medical and psychiatric services in a single integrated medical setting without burdensome authorization procedures

C. Outpatient—payment for clinical services provided by health care support personnel to physicians and patients, e.g. clinical nurse specialists, etc.

III. Assistance in setting up standard outcome measurement procedures for participant programs

IV. Facilitate program and health plan communications—direct and face to face problem solving, coordination of health plan case and disease management with clinical services

V. Marshall political, organizational, and purchaser support

Application Procedure

Send application to Linda Vukelich, Executive Secretary, Minnesota Psychiatric Society, 4707 Highway 61, #232, St. Paul, MN 55110-3227. For more information, please contact Dr. Roger Kathol, 952-426-1626 or roger-kathol@attglobal.net. Initial application deadline is month day, 2004.

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