Minnesota Psychiatry Society Integration Initiative

Overview

The Minnesota Psychiatric Society (MPS) integration initiative is an attempt to create and/or support models of care and a reimbursement system that supports them in which patients with concurrent general medical and behavioral health illness in the medical setting can receive outcome changing behavioral health services in coordination with the general medical care that they are receiving. To this end, thirteen outpatient and one inpatient clinical programs sponsored by 7 care delivery organizations have been identified to participate in the MPS Integrated Care Network. Participants were chosen because they are either already providing or are willing to create clinical programs in which general medical and behavioral health professionals work hand in hand in the medical setting to improve the care of patients with comorbid medical and psychiatric illness.

Network Participants

Outpatient (includes general medical, pediatric, and oncologic; rural, suburban, and urban; culture sensitive; and telemedicine examples with a focus on high utilizers in several of the programs)

- <u>HealthPartners Hematology/Oncology Riverside Outpatient Clinic</u> (principal--Peggy Trezona)—*oncology clinic* to focus on psychosocial assessment and treatment of behavioral health issues oncology patients
- <u>Department of Family Medicine and Community Health, University of Minnesota</u> (principals—Eli Coleman, C.J. Peek, Mac Baird)—*three clinics* (North Memorial Family Physicians, Bethesda Family Physicians, Phalen Village Family Physicians [large Hmong population]) to focus on behavioral aspects in high service utilizers, somaticizers, and those with chronic medical illnesses (culture specific in Hmong population)
- <u>St. Mary's Duluth Clinic Health System</u> (principal—Faris Keeling)—*three clinics* (Ely Clinic [rural], Lakeside Clinic [suburban], General Medicine Clinic [urban] to focus on coordinated medical and psychiatric management of comorbid patients in the three settings
- <u>Mankato Clinic</u> (principals—Susie McConville, Carol Tilney)—*one pediatric behavioral health clinic* specializing and addressing the needs of diagnostically and therapeutically complex children and children with general medical conditions with complicating behavioral factors

- Human Development Center/Gateway Family Practice Clinic at Moose Lake (principals—Peter Miller, Bill Palmer, Glenn Anderson)—*one clinic* to focus on coordination of general medical and behavioral health responsibilities among staff with systematic follow-up procedures for those at risk for non-adherence. A telemedicine component is being developed
- Bethesda Clinics (principal—Frank Indihar)—*three clinics*: Memory Clinic, Medical Behavioral Outpatient Assessment and Treatment Center, and Brain Injury Assessment and Treatment Clinic
- Duluth Clinic International Falls (principals—Jeffrey Hardwig, Douglas Johnson, Sheila Hart)—*one multispecialty rural clinic* in which psychiatry is a part of the specialty group practicing in the same geographic location

Inpatient

- Bethesda Hospital (principal—Frank Indihar)—*one inpatient* integrated unit which includes services for both general adults and geriatric patients

Linking Integrated Care Models with New Reimbursement Models

Each of the participating programs have created their own version (model) of integrated care delivery. These clinical models are designed to work in each organization's system with specific clinician capabilities. All, however, include core components (see below) necessary for outcome change to occur in the patients treated and ultimately for total healthcare cost reduction.[1-4] Based on the clinical models of network participants, it is possible to identify the changes in the reimbursement environment necessary to support them (new reimbursement models). Since the MPS initiative was set up as a collaborative effort among providers, care delivery organizations, government agencies, health plans, and employers; it is anticipated that the reimbursement changes needed will be possible.

Core Clinical Components

Both Outpatient and Inpatient

- Active involvement of general or specialty medical and behavioral health staff and providers
- Shared administrative staff, e.g. coding, billing, staff organization
- Shared clinical information and records system

- A*ctive interaction* between general medical and behavioral health providers with joint clinician and staff accountability for patient health concerns, treatment, and outcomes
- Outcome measurement—domains include: general clinical and functional improvement, health care use/cost, disability/productivity, satisfaction, provider reimbursement
- Intra-network communication

Outpatient

1) Co-participation by general medical and behavioral health specialists in a general medical health service location
2) Timely mental health professional access (at least within 24 hours, but mostly within minutes to hours)
3) Proactive high risk case finding, e.g. triggers may include history of psychiatric illness, current psychiatric treatment, multiple medications, etc.
4) Cost saving training for general medical physicians, physician assistants, and clinical nurse specialists

Other core features that are encouraged include:

- the use of mental health teams in the medical setting
- active psychiatrist involvement
- patient adherence documentation and assistance

Inpatient programs

1) Co-administration by general medicine and psychiatry in the general medical setting
2) Focus on patients with comorbid, preferably high acuity, medical and psychiatric illness
3) Staffing by nurses trained in providing both medical and psychiatric nursing care
4) Consolidated medical and psychiatric policies, procedures, and safety features

Other features that are encouraged include:

- location in a tertiary care hospital
- involvement in health care personnel training
- acceptance of referrals from surrounding area physicians, hospitals, and health plan case and disease management personnel
- clinical and economic outcome measurement.

1. Kates N, Craven M. Shared mental health care. Update from the Collaborative Working Group of the College of Family Physicians of Canada and the Canadian Psychiatric Association. *Can Fam Physician.* 2002;48:936.
2. Katon W, Von Korff M, Lin E, et al. Improving primary care treatment of depression among patients with diabetes mellitus: the design of the pathways study. *Gen Hosp Psychiatry.* 2003;25(3):158-168.
3. Katon W, Russo J, Von Korff M, et al. Long-term effects of a collaborative care intervention in persistently depressed primary care patients. *J Gen Intern Med.* 2002;17(10):741-748.
4. Oxman TE, Dietrich AJ, Williams JW, Jr., Kroenke K. A three-component model for reengineering systems for the treatment of depression in primary care. *Psychosomatics.* 2002;43(6):441-450.