SAMPLE CONSULTATION

MATTHEW THORNTON HEALTH PLAN

SUMMARY OF RECOMMENDATIONS OF MENTAL HEALTH CONSULTATION

J. Harold Berberick, Ed.D.

I. INTRODUCTION

In the delivery of health care services, it is important that mission, values and goals be articulated. In the context of a Health Maintenance Organization, this is important for the organization as a whole, but it is also important for subparts of the delivery system, for example, in the provision of mental health services. Members should receive the same high quality of care across the entire delivery system, whether the care is provided in the open network or in contracted group practices. The commitment to high quality must take into account the studied and unique needs of population sets and be sensitive to geographic considerations (i.e., urban vs. rural). *There should be an overall conceptual model and set of values and principles that constitute the foundation for mental health and substance abuse treatment at Matthew Thornton Health Plan.* This is important so that members, employer groups, staff, contracted providers and facilities have a clear understanding of the Plan's mission, beliefs, and priorities. It is further important for the Plan to declare its values and objectives so that it can evaluate its work.

II. CORE VALUES

Matthew Thornton Health Plan will strive to provide the highest quality mental health and substance abuse treatment possible based on the most current scientific knowledge and understanding of medical and management practice available in the field.

Mental health and substance abuse services should be provided with the underlying belief that it is critical for members to maintain all family, friendship, community and occupational supports during treatment, and to avoid the transference of members into unnecessary patienthood.

Matthew Thornton Health Plan will strive for consistency in the delivery of mental health and substance abuse services across all parts of the delivery system. Differences may occur, but, for example, should be based on the inherent needs of the population, rather than on vastly different treatment philosophies among clinicians and treatment programs.

The Plan will be eager to work with employer groups to tailor MH/SA treatment to meet the particular needs of their employees.

The provision of services should be based on the concept of managing illness rather than on benefit management. The greatest amount of care should be given to those with the greatest need.

Effective, high quality treatment is compatible with the concepts and principles of managed care.

The Plan will work very closely with primary care practitioners in order to promote the early identification and treatment of mental health and substance abuse disorders, and the integration of physical health and behavioral health initiatives.

The Plan should be proactive in fully informing members about their benefits and treatment.

III. FUNCTIONAL AREAS OF THE SYSTEM

Consistent with the new Behavioral Health NCQA standards, the functional areas of the system can be depicted as follows:

Chart I

FUNCTIONAL AREAS OF THE SYSTEM

Direct Services and Treatment	**Administration**	**Member/Network/ Facility/Relations**	**Quality Improvement Data Outcomes Primary Care**	**Provider Training**
1.Identification and access 2. Stabilization of acute	1.Administration 2. Planning 3. Management	1. Credentialing 2. Re-credentialing 3. Provider	1.Quality Improvement Program 2.Population	1.Theoretical concepts 2.Treatment techniques

illness		Profiling	based needs assessments	
3. Treatment	a. Day to day operations	4. Member rights	3.Management data collection	3. Procedures (i.e. electronic claims)
4. Sustenance	b. Utilization management	5. Member information	4. Member, provider satisfaction studies	
5. Case Management	c. Delegation		5. Outcome Studies	
6. Preventive health care services	d. MM record keeping		6. Primary care initiatives	
7. Ancillary and specialized services				

IV. RECOMMENDATIONS AND INITIATIVES

The following sections will summarize the major recommendations that have been made in the consultation time period; and additionally, relevant documents pertaining initiatives that have been completed or are underway are included in the appendices. *(The format for presenting the recommendations will follow the model depicted in Chart I.)*

A. DIRECT SERVICES AND TREATMENT

1. Recommendation – Needs Assessment and Crisis Management

Matthew Thornton Health Plan members should have access to a defined range of mental health and substance abuse services that include inpatient psychiatric and detoxification services, ambulatory outpatient treatment, intensive outpatient treatment, access and referral services, crisis assessment, intervention and stabilization services, psychopharmacology, day treatment, case management, respite care and home-based services.

Action Steps:

A comprehensive needs and program availability assessment to match the penetration and clinical profiles of members with currently available services in each geographic area should be undertaken. A plan should be developed for filling gaps in the continuum of care.

Expand responsibilities of existing "patient first" triage and access staff to include interface with Level of Care Assessment Centers to provide an additional level of review prior to hospitalization, to maximize potential for diversion, and to ensure that all pre-hospitalization communication is properly managed.

Triage staff will handle all aspects of case prior to inpatient admission or other acute care arrangements.

Clarify responsibilities of all Level of Care Assessment Centers. Review (establish) crisis contracts for consistency of requirements, fee schedules, renegotiate contracts as necessary.

(Refer to Appendix I for proposed standard format tool for evaluating Level of Care Assessment Centers.)

The Letter of Agreement with Southern New Hampshire Medical Center for after hours coverage has expired and has unclear specifications. A new contract has been proposed to SNHMC but has not yet been signed.

(Refer to Appendix II for copy of revised contract.)

2. Recommendation – Case Management

MTHP should develop a more formalized approach to Mental Health Case Management, which should include criteria for screening for Case Management intervention, and a description of Case Management services, including coordination of treatment, monitoring, outreach, follow-up, etc. A formalized program is important for cost containment reasons and to ensure that members with a history of overuse or underused of treatment, are at risk of hospitalization or have high-risk conditions, such as children with a diagnosis of mental illness and substance abuse receive high quality treatment. In addition to the clinical importance of this, a formalized Case Management Program is required to meet the performance standards of certain employer groups, such as Digital.

The Case Management Program should be incorporated into the request process from network providers for extended ambulatory benefits. Although MTHP has practice guidelines, these have not been tested in the field and disseminated to Network providers. *These guidelines or similar guidelines which have been developed elsewhere should be formulated into a decision tree process for the uniform approval of extended outpatient benefits and for determining those members who should be enrolled in Case Management.*

(Refer to Appendix III for a draft Case Management Policy.)

3. Recommendation – Psychiatric Medical Director

There is an urgent and immediate need for a Psychiatric Medical Director whose identification is with MTHP to provide clinical leadership for the Mental Health

program, to interact with MTHP and clinical leaders in the network and to provide predictable, dedicated collaboration with the Mental Health Specialty Care Coordinators around clinical matters and questions of medical necessity. Highest priority to recruit experienced Managed Care Psychiatrist with agreed-upon on-site availability arrangements. Minimum coverage: 5 FTE.

(Refer to Appendix IV for the Psychiatric Medical Director Job Description.)

4. Recommendation – Psychological Testing

Matthew Thornton Health Plan has not had consistent policies and procedures relating to the approval of psychological testing and testing for Hyperactivity/Attention Deficit Disorders.

During the past several months, a comprehensive policy for approving psychological testing based on clear medical necessity criteria has been developed and is ready for implementation. This policy was developed by J. Harold Berberick, Ed.D., working in close consultation with Gerald Pollak, Ph.D., a neuropsychologist from Seacoast Mental Health Center. Other psychologists in the provider network have also been consulted in the development of this policy.

Remaining Implementation Steps:

The final document needs to be approved at the next meeting of the Healthcare Policy Committee.

The new policy needs to be configured into the system so that claims will be paid.

A consulting arrangement needs to be worked out with Seacoast Mental Health Center to utilize the services of Dr. Pollak for approving and making recommendations for requests for psychological and neurological testing. Outside expertise is required in order to evaluate these requests properly.

A cover letter, a copy of the policy, and request forms need to be mailed to providers.

Criteria need to be developed and a process put into place for selecting a small sub-panel of providers, representative of the geography, to conduct evaluations for Attention Deficit Disorders.

(Refer to Appendix V for a copy of the policy on psychological and neuropsychological testing.)

5. Recommendation – Access Policy

NCQA and employer groups require that HMO's ensure adequate access for mental health and substance abuse services. Although Matthew Thornton has standards for access to medical services, standards for behavioral health for routine non-

symptomatic non-urgent symptomatic, urgent, and emergency treatment have not been established.

Action Step:

An access policy for mental health services should be approved by the Health Care Policy Committee at its next meeting.

(Refer to Appendix VI for the draft policy on Mental Health Access.)

B. ADMINISTRATION

1. Recommendation – control of inpatient costs and utilization

Implement consistent, preauthorization utilization management for managing inpatient care across the system. This should include a strong "pend/deny" process.

Matthew Thornton Utilization Management Policies and Practices should be incorporated into all inpatient contracts.

Specific working arrangements for managing inpatient care should be negotiated with the Clinics where there is shared risk responsibility for inpatient care. Although there is a 50/50 risk sharing arrangement for inpatient care, the actual responsibilities of MTHP and the Clinics for management of this risk have never been articulated. This should be done with a formal Memorandum of Understanding.

2. Recommendation – control of outpatient costs:

Reduce initial authorization of outpatient benefits from eight visits to five visits. This would result in savings and would comply with the state mandate.

Develop clear guidelines and procedures for approving extended outpatient benefits to include:

Practice guidelines

Referral to case management for consideration of extended benefits by third visit *(Refer to Appendix III)*

Clear process for Mental Health Specialty Care Coordinator

Immediate physician involvement in denials

Institute provider profiling system

The Memorandum of Understanding mentioned above with the Lahey-Hitchcock Clinics should also encompass the management of outpatient care, so that both clinical treatment and the mental health benefit are administered uniformly across the system.

3. Recommendation – Delegation

RE: Dartmouth Hitchcock Behavioral Health Systems

Revise contractual agreement between Dartmouth Hitchcock Behavioral Health Systems and Matthew Thornton Health Plan. This agreement was negotiated with the intention of giving West Central Services, et al., full clinical and financial risk for approximately 10,000 MTHP members in the Lebanon area. However, there are numerous problems with this agreement, the most important being that there is not a fully integrated delivery system in place that is capable of managing the at-risk population.

Follow-up:

This arrangement needs to be totally revisited from both a clinical and financial perspective.

If delegation as defined by NCQA is to occur, there should be a thorough review of the agency's capacity to assume delegated responsibility in those areas that are being considered for delegation.

The membership in the capitated agreement needs to be redefined. Approximately 50% of the membership as presently envisioned are outside of the agency's service area. *(Refer to Appendix VII.)*

The amount of the capitation, $6.00 pm/pm should be recalculated. It is at least $1.00 above actual MTHP mental health costs.

Following a careful clinical review of the service system, reevaluate the original decision to capitate. From a clinical and financial perspective, this may not be in the best interest of MTHP and members.

If a decision is made to continue with the delegated arrangement, the contract needs to be revised. Appendix VII also includes a Draft Addendum Agreement that outlines important areas in which the contract should be modified.

4. Recommendation – Record Keeping

Review all internal record keeping in the Mental Health Utilization Program to ensure that all necessary information is consistently being kept for purposes of documenting important UM activities, including denials and is sufficiently complete for NCQA and legal purposes.

C. MEMBER/NETWORK/FACILITY RELATIONS

1. Recommendation – Provider Subspecialties

A survey of all mental health providers should be undertaken to update provider information and, most importantly, to identify clinical sub-specialty areas in order to make the best possible clinical referral for outpatient services and to increase member satisfaction.

(Refer to Appendix VIII for a draft form to collect subspecialty data on providers.)

2. Recommendation – Facility Credentialing

In addition to credentialing individual providers, it is equally important to credential the mental health programs and facilities where MTHP members receive mental health services. In particular, it is important to credential programs which are not subject to inspection and licensure by another body such as JCAHO or the Departments of Mental Health and Public Health, etc. There is wide variation in the clinical leadership and supervision, staffing, clinical program standards, backup coverage, etc. in many of the programs to which Matthew Thornton refers members, i.e., Crisis Assessment Centers, Day Hospitals, etc. To begin this process, a tool in the form of a Request for information (RFI) has been drafted for inpatient services. Additional tools for Dialectic Behavior Therapy (DBT), day treatment, case management, etc. should be developed.

(Refer to Appendix IX for the inpatient RFI. As mentioned above, the tool for Psychiatric Crisis Services was included in Appendix I.)

D. QUALITY IMPROVEMENT, DATA OUTCOMES, ETC.

1. Recommendation – Quality Improvement

Historically, MTHP has not undertaken Quality Management and Improvement Activities specifically for the Mental Health Program. This is an important NCQA requirement. Although MTHP may eventually delegate responsibility for Quality Management Activities, it will continue to retain responsibility for such activities.

It is recommended that some modest Quality Management Activities in Mental Health be undertaken as soon as possible. These would include the following:

The approval of a Quality Improvement Plan by the Matthew Thornton Medical Management Quality Assurance Committee (MMQAC**).**

Establishing a Mental Health Quality Improvement Committee as a sub-committee of the MMQAC. This committee would include clinic and provider representation.

Undertaking at least one modest Quality Improvement Activity in the near future.

(A draft Quality Improvement Plan is included in Appendix X. Also included is a procedure for recording

Quality Screen Occurrences for inpatient mental health and ambulatory care. This would constitute an important first step in monitoring the quality of care in the mental health delivery system.)

2. Recommendation – Member Satisfaction

Although good practice requires that Health Maintenance Organizations conduct Behavioral Health Member Satisfaction Surveys, MTHP has not yet conducted such a survey. This is also a requirement of various employer purchaser groups such as Digital and the Massachusetts Health Care Purchaser Group. During the past several months, a small committee at Matthew Thornton Health Plan, which has included Judy Simoneau, Harold Berberick, Kathy Schoene, Kristi Chaput and more recently Kim Miller from Blue Cross, has been meeting to consolidate the efforts of previous committees in developing a process and instrument for conducting the first Matthew Thornton Member Satisfaction Survey. The work of the committee is now complete and the survey will be mailed to members in the near future. Follow-up surveys should be conducted at least annually.

(Refer to Appendix XI for a copy of the survey instrument.)

Follow-up:

Upon completion of the survey, the data will need to be analyzed and included in a final report with recommendations for review and approval by appropriate clinical committees and administration at MTHP, before distribution to employer groups, especially Digital and other interested parties.

3. Recommendation: Integration of Mental Health with Primary Care

In recent years, NCQA and employer groups have been emphasizing the importance of coordinating behavioral health and medical care in the Managed Care environment. This includes:

The exchange of relevant clinical information between behavioral health and general medical providers.

The early identification of mental health and substance abuse problems in primary care.

Training of primary care physicians in the appropriate use of psycho-pharmacological medications.

During the latter part of the year, MTHP made specific commitments to both Digital and the Mass Health Care Purchaser Groups (MHPG) with respect to the integration of mental health care and primary care. These initiatives are included in the MHPG and Digital Documents in Appendix XII and can be summarized as follows:

Completion of pilot Depression Identification Project in primary care using the Beck Depression and Anxiety inventories. This specifically applies to the Lahey Hitchcock

Clinics.

Development of pilot program among selected PCP's to assess risky drinking behavior in their patients.

Review tools and guidelines of these projects with representatives of the primary care community.

4. Recommendation – Digital

(Refer to Appendix XIII for important performance goals that apply specifically to Digital Equipment Corporation and require careful attention, follow-up and monitoring.)

SUMMARY OF APPENDICES

APPENDIX I

Evaluation tool for level of care assessment centers

APPENDIX II

Letter of agreement between Matthew Thornton Health Plan and Southern New Hampshire Medical Center

APPENDIX III

Case management policy

APPENDIX IV

Job description, Psychiatric Medical Director

APPENDIX V

Policy on psychological and neuropsychological testing

APPENDIX VI

Policy on mental health access

APPENDIX VII

Revised contract between Matthew Thornton Health Plan and Dartmouth Hitchcock Behavioral Health Systems

APPENDIX VIII

Mental health provider subspecialty data collection

APPENDIX IX

Psychiatric inpatient RFI

APPENDIX X

Mental health quality improvement plan

APPENDIX XI

Membership satisfaction survey instrument

APPENDIX XII

Depression identification project in primary care and risky drinking identification project

APPENDIX XIII

Digital performance goals

HOME