Managed Care and the Integration of Substance Abuse Prevention and Early Intervention into Behavioral Health Programs

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There are mornings when I wake up, I feel I'm Methuselah. While I'm not actually Methuselah, but I have been in this field long enough to take a historical perspective. Let me begin with a couple of observations.

Following my residency and a couple of years in research and academics, I took various administrative positions in the public health sector, and then for the last 10 or 11 years have administered managed care organizations, – staff models, IPA's, indemnity review, and mental health carve-outs. During this time, I've seen much of the development of managed care and substance abuse treatment systems.

The initial challenge for these organizations was clearly the reduction of direct costs. The mental health/ substance abuse (MH/SA) areas were ripe for that kind of direct cost cutting.

Why were MH/SA areas prime targets? First, these problems had a relatively low penetration. As a result, there were fewer overall complaints related to management. Also, complaints ere less likely to be publicly voiced. Finally, at that time, cost-intensive treatment approaches were favored, without much evidence that they were more efficacious than less costly approaches. Hence, by controlling such approaches, management could affect direct costs without significant pushback or negative outcome. Over time, however, the question is increasingly asked - has the baby been tossed out with the bath water?

One of the reasons for this question may well be increased awareness of the data just presented by Dr. Goetzel of MEDSTAT. We hear the question increasingly from our clients, particularly large, self-funded employer groups who now realize that total costs equal not only direct costs of service but all the indirect costs as well (i.e., TC=DC+IC).

Indirect MH/SA costs include lost-time, absenteeism, disability, productivity impairment, litigation costs, recruitment costs, temporary costs, etc. For example, if someone is out on disability, it costs more than just salary maintenance. It costs money to replace the person, often at a premium. It has associated productivity costs in terms of decreased efficiency, morale, etc. Such costs easily add up to a lot more than the direct service provision cost and might be avoided or reduced if treatment returns the person to work and health functioning more efficiently.

HMOs and carve-out MBHOs, (managed behavioral healthcare organizations) do not bear the burden of indirect costs. We were rewarded on the basis of successful control of direct costs. Such reimbursement allows for cost-shifting to unseen and unaccounted-for indirect costs. Integrated HMO's have some investment in possible medical cost offset in deciding whether to increase mental health services in order to help control overall medical costs. But carve-out companies have no clear incentive to control for medical cost offsets.

Integrated HMOs probably had to deal a little more with the legitimacy of the medical costs offset in deciding whether they would increase mental health services in order to help control their overall medical costs. But carve-out type companies didn't have any indirect incentive to control the medical cost offsets.

Employers have realized that they bear the burden of underutilization that is reflected in indirect costs. And these employers have championed a new mindset, which favors incorporating workplace issues and associated costs into the mental health and substance abuse benefit program. They want up-front consideration of higher cost treatment if more effective treatment reduces overall costs; if earlier stage treatment may avoid associated sequels of the illness, if more intensive management or treatment can prevent relapse and additional utilization because of repeat hospitalization, or if preventive measures can be effective.

One of my jobs is to work closely with a number of large ValueOptions clients who are interested in redesigning their MH/SA benefit programs to accomplish goals of reducing total costs as opposed to direct service costs alone. These programs consider workplace effects on illness. Stress in the workplace is a common feature, particularly with changes occurring in the

workplace. Workplace events can cause or exacerbate illnesses such as anxiety, depression, alcoholism, or even physical illnesses.

Primary preventive efforts, such as those engaged in by EAPs, can potentially reduce some of this stress. Employer groups are willing to change their benefits design to accomplish this goal; this can be seen in the increased number of plans providing for payment for conditions previously excluded from coverage (such as v-codes.) Some benefit plans now even encourage things not traditionally considered as "treatment," such as parent education or stress management workshops. The goal behind this widening of coverage is clearly to "pay up front" for overall cost reduction.

Additional efforts are also desired to consider the effect of illness on the workplace. This is critically important to payers, because ill workers cause more than just the claims expenditures. They also cause costly workplace effects if they are not treated or are under-treated.

Customer complaints, poor morale, impaired productivity, disability, workplace violence -- all of these effects of illness on the workplace have definite costs associated with them. Efforts to better control the illness reduces these impacts, and thus reduces costs.

Tied in with this notion is a desire to incorporate the risk of adverse outcomes into medically necessary determination. Medical necessity is a difficult concept for some people. Different companies have different ways of looking at medical necessity assessment. In the past, however, most such assessment focused primarily on the clinical outcome. If two treatment approaches reduce depressive symptoms by the same amount on standardized measurement tools, those approaches are equally efficacious. Given equal efficacy, the least costly or least restrictive approach would be the "medically necessary" approach.

Newer management strategies, however, look at the risks associated with purely clinical outcome considerations. For example, if two persons treated for depression experience equal symptom reduction, but one loses his job, the treatments are NOT equally efficacious (considered in the broader context of life-role functioning). Consideration of individualized patient-specific factors

gives medical necessity determination a much wider confidence interval. We can consider the total cost/benefit of a more intensive treatment that accomplishes equal clinical improvement and meets additional social or workplace goals. For example, in earlier days of managed care, 28-day substance abuse programs were rarely certified because clinically they were considered to be no more efficacious than less costly outpatient approaches. But earlier intervention, or more intensive intervention for particular patients -- those with a clear risk for some significant adverse occurrence (e.g., those in safety-sensitive occupations) -- may well be more efficacious when considered in the total cost spectrum.

Such are the types of programs many large employer groups now seek, especially programs that utilize resources more effectively and thus bring about overall savings. Coordination is one key element of such programs. Effective coordination requires elimination of the traditional antagonism that exists between managed care and EAP organizations. Coordination is enhanced by close relationships with existing EAPs, or though provision of integrated EAP/managed health care programs. With such coordination, an EAP can engage in effective primary prevention efforts within the workplace, such as educational programs, stress reduction programs, and management training.

EAP ability to tap into workplace support and encouragement of treatment can also be an important factor in treatment success, as studies such as the Walsh study have shown. Most programs that combine EAP and managed mental health care, however, suffer from having dual access points. It is thus imperative that the systems work in tandem. EAPs can help mental health clinicians by coordinating job modification strategies, scheduling concerns, return-to-work programs, and supervisor education.

Confidentiality concerns that arise whenever two different systems interact can make coordination difficult, however. An example: one employer recently decided that everyone in substance abuse treatment should work with internal EAPs. They wanted the EAP involvement to be mandatory, but did not want to make any benefit plan change; they merely wanted the MH/SA case manager to contact the EAP and share treatment information without the permission of the patient. Despite the feeling of clients that it is their plan and they ought to be

able to do what they want, some things cannot be done. Proper means and legitimate ends have to be kept clearly in view when designing innovative programs.

On the MD/SA side, we deal more with secondary than with primary prevention. For example, we deal aggressively with substance abuse as a significant co-morbidity in the treatment of other conditions. We have expanded the amount of information that we obtain as part of making referrals and certifying treatment to tease out those conditions that, in fact, are either masked substance abuse problems or co-existing conditions such as depression and substance abuse.

Newer models of care management focus on three important points. The first is that care management transcends utilization review. We have heard from a number of clients -- and it was shocking at first, going so against the grain for cost controllers -- that the cost battle has been won. Quit fighting it! The mechanisms in place with network delivery systems, incentivized reimbursements, quality management, and targeted review effectively control costs. The old-fashioned utilization review strategy of matching each patient's symptoms with a particular level of care is becoming irrelevant to direct cost control. And such attempts may even be counterproductive.

Second, we compared the effects of earlier intervention and outpatient review to a model of later review for two clients. We found that earlier review actually prolonged treatment and increased costs, with no obvious positive effects.

Third, is an illustration from the literature. Some observers have noted that while various delivery systems may treat depression equally well from a clinical standpoint, residual disability and lost time may vary significantly across systems. If a care management intervention can guide treatment to both resolve depression as well as to focus on workplace issues through EAP coordination of ensuring a return to work focus as part of the treatment, it may well be that the person returns to work sooner, reducing total costs. Outcome "in context" may be improved as a result of that care management intervention.

Such efforts might increase direct costs in the short run. For example, a person referred to a specialized three-times-per-week program for people who are depressed and out of work, as compared to traditional once-a-week program for people who are depressed and out of work, as compared to traditional once-a-week individual psychotherapy, generates higher direct costs. But the overall effect on total costs might significantly offset this increase, especially if you consider not only workplace effects, but also patient satisfaction as part of the overall outcome.

The next issue we focus on is social/demographic problems and the risk of adverse outcomes in these areas. Outpatient treatment programs for substance abuse are demonstrably effective when pooled data are evaluated. A homeless person with no bus fare who is referred to such a program, however, is unlikely to respond. Such a person may need a 24-hour structured program for treatment along with an intensive social service effort to obtain some sort of housing, a supportive environment, and other things that would allow a person to continue treatment.

Patients who are non-compliant -- those with multiple episodes of treatment -- are suitable for long-term follow-up. Periodic care manager follow-up can ensure that the person is continuing treatment and can provide early intervention for relapse. Our new care management models recognize that there are problems that are not resolved by treatment alone. We are developing plans to resolve such problems within the care management relationship. A common example: Coexisting medical and mental health problems are treated in isolation with little or no coordination. A care manager, recognizing this problem, provides the link between mental health provider and the PCP, hopefully enhancing the overall outcome. As another example, a person calls in for routine marital counseling referral. If previous history indicates that the patient had battered his spouse while waiting for a routine appointment, the call can be dealt with as an emergency, thus avoiding an adverse outcome.

To summarize, the next generation of care management models consider not only clinical issues, but also workplace and life-role issues to effectively reduce total costs (not just direct costs.)

Any questions?

Question: Can you give us some perspective of the roles of EAP and managed care as they have evolved with regard to workplace function issues?

Answer: My own personal experience is that early on there was a real antagonism between EAP and managed mental health care organizations. To some degree, they were competing units. EAPs saw themselves as the proper gatekeepers to treatment services. In addition to economic competition, however, there were also traditionally different views toward treatment.

EAPs tended to focus more on substance abuse, favoring traditional treatments. Managed care companies were embracing nontraditional outpatient treatment programs. EAPs & MCOs marketed against each other in various ways. Managed care companies, for example, might emphasize potential direct cost increases with EAP gatekeepers or involvement. EAPs were eager to point out that EAPs are better able to deal with indirect costs and create a healthier, happier workplace.

Initially, the direct cost arguments appeared to win, and increasingly, I think, EAP's were increasingly moved to the side as managed care took on more and more of the role of gatekeeping and referral. EAP became consultants in this process. With the programs I'm working with right now, however, this consultant role has evolved to one of clinical leadership. Because of the EAP championing of indirect cost control, there has been this mandate that both entities work together, rather than oppose each other. I think one of the things that has led to this rapprochement is that EAP and MBHO philosophies have come closer together. The sort of rigid approach that managed care companies had toward utilization review has softened over time, whereas the dogmatic EAP approach to chemical dependency treatment has yielded to research data that says you can probably get equally efficacious treatments in a wide variety of settings.

Since the philosophies are no longer warring, there is now realization that each entity can do something that the other doesn't.

Question: A lot of what you've described has been viewed by many as being close to the ideal. I guess the two questions I would have are, one, how marketable a product is it? And two, how competitive is it from a cost standpoint?

Answer: That's the key problem, obviously. The model is very marketable because you can easily explain the potential benefits of using this sort of comprehensive rather than simplistic approach.

The problem, however, is that specific data to show effectiveness in some of those areas is not there yet. So I can talk about the approach being cost effective in terms of total cost, but it's hard for me to present proof. We're trying to gather exactly the kind of data that will let us see whether indeed we're accomplishing the goal that we set out to do.

As far as the issue of cost, it's the rare company that says, "Yes, increase my direct costs. I'm happy to see you do that." So with models in which at least some elements inherently involve more work—more labor-intensive and resource-intensive models—we're faced with the need to do more (accomplish more) with less.

The only way that we have been able to get around this constraint is to look much more closely at areas where we can reduce the cost of the service by more effective resource allocation. There's a whole subset of areas for which management does nothing, and we're merely wasting those resources.

If we could reapply those resources to care management areas for which we can demonstrate a "return on investment," we can show that what we did does have a cost impact, more than what it costs.

Over time, we would like to be able to shift resources to situations where we get a return on our investment, versus situations where we don't. Reduction of needless micromanagement will allow for cost control that will permit more creative care

management elsewhere.