

THE ROLE OF A PAYOR ADVISORY BOARD IN MANAGED MENTAL HEALTH CARE: THE IBM APPROACH

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ABSTRACT: In 1990 IBM Corporation initiated a novel mental health plan. This paper describes the IBM plan and the development of the relationship between IBM, and its managed care vendor and an independent mental health advisory board. Areas in which effective collaboration were established are discussed, such as provider credentialing standards, development of clinical review processes, among others. Two years following implementation of the program, it was found that utilization costs had decreased by 7%.

The assumption that managed care services assure accountability and superior quality is untested and unproven. The marketing of managed mental health care has emphasized the bottom line and has, too often, ignored careful examination of provider behaviors and review approaches designed to monitor the activities and quality control standards of the managed care vendor.

This article describes the International Business Machines Corporation's (IBM) mental health care program, its use of an independent advisory board, and the work of its managed care vendor, American PsychManagement (APM). Also discussed is the evolution of a process, initiated in 1990, for monitoring the quality of care, and holding the vendor accountable for the

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delivery of services to its beneficiaries. So far as we know, no other managed mental health care program has used an independent advisory board, hired by the payor, to help develop criteria, protocols and procedures, and to attempt to ensure quality services through quality improvement programs, consultation and audit activities. The focus of this article is on the development and operation of such a board, its impact on IBM's mental health care program, and, the unique partnership established among IBM, APM and the Board.

IBM, like other major employers, has held its contractors and suppliers accountable for the quality of products and services delivered. However, it did not have internal staff with sufficient expertise in mental health care service delivery systems to monitor the quality of care that a mental health services vendor was providing. For its employee assistance program (EAP), there was a consulting group in place auditing the clinical quality of the vendors. It was therefore a logical step for IBM to call on outside consultants, largely from academia, whose careers had been devoted to the study and administration of mental health programs. In addition, most board members selected were also clinicians with considerable private practice experience.

The EAP provides up to eight free visits with a professional counselor for a wide range of personal problems including many that might be covered under the mental health care program. Psychologists and clinical social workers hired by the two vendors provide these services away from IBM premises. The mental health care program provides beneficiaries access to independently licensed practitioners in their own offices and is covered by the IBM medical benefit plans as outlined below.

DEVELOPING THE NEW IBM PROGRAM

During 1988, the IBM benefits staff, together with consultants, began to examine ways in which the increase in mental health costs could be brought under control without endangering the scope and quality of benefits beneficiaries had come to expect. The team's goal was to maintain or improve such benefits while seeking innovative ways to contain the precipitous rise in benefit expense. They were convinced that, with greater flexibility in benefits design and by using alternate types of mental health care, it would be possible to effect a sophisticated program that would meet these goals.

One possibility that the study group considered was a preferred provider network. If the network were large enough, most of the then current providers might be covered. Practitioners at the time included psychiatrists, clinical psychologists, and, in some settings, supervised clinical social workers; facility coverage focused on acute care hospitals, with little utilization of day/partial treatment or structured outpatient substance abuse programs. Could such a

network be broadened to include other mental health professionals, facilities, and programs? Would negotiated fee schedules for practitioners and facilities reduce costs significantly, but not upset the provider community more than might be acceptable to IBM? Who could manage such a network? Could the quality of care be improved by more carefully defining eligible providers?

Could the employee assistance program be expanded to play a role in a larger mental health program? Perhaps as a gatekeeper? Perhaps as a referral service? Could the EAPs "manage" a remodeled IBM mental health care program? Would the EAP vendors and a new managed care vendor, working together, improve the quality of mental health services made available to IBM beneficiaries?

The IBM hospitalization plan included a utilization review service for psychiatric inpatients in acute care settings that had proved a useful first step in ensuring appropriate, medically necessary care. Would it make sense to expand this service to encompass a broader range of facilities, such as residential treatment centers and half-way houses that were not then covered by the IBM plans?

Many other employers were contracting with managed care vendors. Should IBM simply maintain the existing benefits and turn the administration of those benefits over to such a company? Why not charge a vendor with the responsibility of closer utilization review and the occasional approval of benefits not normally covered by the benefit plan? Also, would it be reasonable to charge such a vendor with holding costs in line?

After a year of deliberation, IBM concluded that an amalgam of the programs made the most sense. The plan that emerged was to solicit bids and select a managed care vendor to provide a quality mental health care program with features that IBM had been unable to find in any of the managed care firms that had been studied. Specific employee concerns are addressed through the new program. For example, employees told IBM that, while the company had excellent coverage, they were uncomfortable, in some instances, with the quality of care they receive. They seemed particularly anxious about knowing where to go for help; to locate the right practitioner or facility to evaluate and treat a problem (in fact, an IBM employee survey found many employees were using the yellow pages to do this). In situations where acute care was initially appropriate, but was no longer required, employees indicated that they needed a wider choice of clinical options than had been traditionally covered under the benefits plan. Thus, the program that was finally developed would include a large provider network, a resource and referral telephone service, utilization review for both inpatient and outpatient services, a case management staff that would provide flexible benefits when the patient's best health interests would be better served than by existing benefits. Key to the plan would be clinical quality assurance and audit mechanisms. Clinical quality oversight would be assigned to an independent mental health advisory board.

ROLE OF IBM WFS WORKFORCE SOLUTIONS BENEFITS STAFF

The IBM WFS Workforce Solutions benefits staff oversees the management of the program. (WFS Workforce Solutions is an IBM Company formed in 1992 to provide personnel services for all IBM businesses and for outside firms.) WFS is charged with ensuring that accessibility, flexibility, and quality that were originally built into the program (utilizing its specialized partnership with the vendor and the advisory board) are maintained.

THE IBM MENTAL HEALTH CARE PROGRAM

In 1990 IBM selected American PsychManagement (APM), a company specializing in managing mental health care, to develop and implement its program. Elements of the program include:

- A resource and referral service, staffed by master's level psychiatric nurses and social workers, available 24 hours a day, seven days a week.
- Comprehensive case management services that provide the ability to authorize coverage for care not otherwise supported under IBM's plans.
- A utilization review program for inpatient care, and for outpatient care exceeding 20 visits. (Studies of IBM mental health benefits had shown that about one-half of funds spent for outpatient care were for beneficiaries requiring more than 20 visits in a given year.)
- An extensive preferred provider network. Most practitioners and facilities who were then serving IBM beneficiaries were invited to join. As the program matured, the network has been redefined based upon quality standards determined by APM and the Board.
- An advisory board of independent mental health professionals oversees the quality of care.

BENEFITS

Inpatient treatment rendered within the network provides up to 365 days every three years at 100% reimbursement, whereas in out-of-network facilities, reimbursement provides for up to 90 days at 80%; and from 91-365 days at 50%.

Within the network, outpatient treatment is reimbursed at 80% of established professional fees up to \$15,000, and at 50% of that rate from \$15,000 to \$25,000 for those using in-network providers. The rates are established for each discipline separately by geographic region. Out-of-network care is covered at 50% of the usual and prevailing rate up to \$25,000.

In addition, for individuals with a continuing need for ambulatory services, particularly in order to avoid hospitalization or the exacerbation of serious illness, case management services may be used that may extend outpatient benefits. For those who need continued inpatient care, but at less than acute care levels, APM case management works with providers to place patients in residential treatment centers, halfway houses, or other alternatives such as structured outpatient treatment programs. (These alternatives had not been eligible for coverage under the IBM medical benefit plans but were designed into the new mental health care program.)

THE MENTAL HEALTH ADVISORY BOARD

In March 1990, the first meeting of the IBM Mental Health Advisory Board was held. The Board's role in oversight of clinical quality was contractually identified. There are five members: three psychiatrists, a psychologist, and a social worker. Each member of the Board has extensive experience in the study of measures of quality and in applying such measures to practice.

The Board met monthly through the end of 1991. Since 1992, the meetings have been held quarterly with APM leadership and staff in attendance at most meetings.

One of the early activities of the Board was the provision of oversight in the development of the clinical referral line. Emphasis was on determining the urgency of a call, and in establishing protocols and scripts for the referral line clinicians to ensure that urgent and emergency calls were rapidly and effectively handled.

The development of the referral line script was a good example of how deeply involved the Board became in the details of clinical operations. Overall, the Board members felt that the initial script was more formal than necessary. For example, the opening greeting should include a phrase such as "How can I help you?," rather than seek identifying data that could be readily obtained later in the discussion once a friendly relationship had been established.

In the process of developing the script, many ancillary but related issues required resolution:

- (1) Is the role of the referral line clinician to perform triage as originally proposed by APM? For many reasons, both clinical and administrative, the Board decided that the role was more one of problem definition sufficient to make an appropriate referral. (The concept of triage calls for more information and clinical expertise than could reasonably be expected from a telephone discussion with a referral line nurse.)

- (2) What determines that a beneficiary requires an emergency referral and how should emergencies be handled? A detailed definition and flow chart prepared by APM was approved. Considerable discussion during the second and third meetings focused on alternative methods of managing the emergency

patient. A variety of scenarios were reviewed with specific actions decided for each. Some would involve IBM medical departments; most would make use of the nearest emergency room with a psychiatrist available. In the latter case, when the caller wished, the APM clinician will call the facility to determine the availability of appropriate evaluation and care, and arrange for the patient to go, and then, make a follow-up call to determine the outcome.

(3) What constitutes an "urgent" referral? The Board accepted APM's suggestion that urgent would mean the necessity to have a patient seen within two business days. The caller is asked if they feel the need for help in the next day or two. If they do, the clinician offers to facilitate an appointment for the patient. Many patients accept this assistance, but some accept referrals and make their own appointment. The referral line clinician makes an independent judgment and may urge the patient to accept a referral as soon as possible. The clinician makes a follow-up call within 48 hours to see if further assistance is required.

(4) What dictates that a caller be referred to a psychiatrist, rather than to a psychologist or other mental health professional? A detailed protocol was developed that includes: prior hospitalization, a history of the use of psychotropic medication, suicidal ideation, psychotic symptoms, and, expressed preference for a psychiatrist.

(5) After considerable dialogue, including recommendations from the EAP vendors, the Board decided to have the referral line clinician offer EAP services to all callers who did not present urgent or emergency situations.

Among the agenda items the Board considered in the early stage of the program was a monthly review of the clinical referral line, network operations, and clinical operations. In addition, confidentiality issues, quality assurance issues and procedures, definitions of terms, vendor staffing, protocols, monitoring and audit procedures were discussed. Much attention was focused on developing criteria for credentialing network practitioners. This task is extraordinary considering the different licensing laws for clinical social workers and psychologists in the 50 states. For instance, there are differences in qualifications for licensure, in levels of licensure, in confidentiality statutes, and the impact of grandfathering clauses. After considerable discussion, APM and the Board agreed on a set of qualifications that were recommended to IBM and which ensured basic competencies for providers.

It is clearly expensive to develop large networks and to carefully credential and then update data on individual practitioners on a regular basis. This is particularly true in situations where individual practitioners may see relatively few cases through a single managed care program. The data available for analysis may not be adequate to arrive at judgment about competence, or effectiveness of the treatment process. Yet the process is very important. Evidence of egregious care and data about providers generating inap-

appropriately high costs or lengths of stay may provide some data after the fact, i.e., when problems may have already become serious. As a first step, the Board was concerned with establishing standards for practitioners that reflect a high level of training and preparation for practice. Initially the Board and the vendor had disagreements about provider credentialing. The Board and IBM insisted on a more rigorous process than had been used for other APM contracts. Over time, the Board's criteria were accepted and served as the basis for credentialing.

Another area of importance is the adequacy of the data available about providers. Is the information on individual practitioners or a facility's past performance readily accessible to those who are referring patients for care? Are areas of specialty expertise readily available? How have areas of specialty practice been identified and checked? What special characteristics of practitioners (age, gender, languages spoken, ethnicity) are a matter of record to meet client preferences? Do we really know the competency of providers recommended? Systems were developed jointly by the Board and APM to make these data available.

MONITORING THE VENDOR

On an ongoing basis, the WFS benefits staff monitors APM's services, including claims adjudication and the quality of APM's overall customer service to IBM beneficiaries and to providers.

The Board, however, uses the IBM-APM contract as the basis for establishing performance expectations for APM. The contract contains a well-developed overview of services to be provided by APM, divided into topic areas such as network services, clinical resource and referral services, utilization review, case management, key interfaces, and quality assurance with subcategories specifying tasks under each heading. APM performance in each area is evaluated annually by the Board.

APM is also responsible for monitoring and assuring the quality of the services provided by the practitioners and facilities in its network. What are the measures that serve as proxies for the existence of quality clinical services? This is a question for which a monitoring plan emerged. An emphasis is placed upon demonstrating continuity of care, identifying, and reviewing sources of unusually high recidivism, and identifying and reviewing practitioners with unusual practice patterns. APM is able to address each of these areas by examining claims data. An adequately powerful and flexible management information system (MIS) is essential to this and all other aspects of the APM QA program, hence APM's MIS capabilities in this regard receive ongoing scrutiny by the Board.

QUALITY IMPROVEMENT SYSTEM

Good QA plans are subject to discussion, debate, and compromise among the monitors and the monitored, and the APM QA plan is no exception. A solid QA foundation has now been developed. Because of the large number of potential QA tasks in project of this size, priorities had to be set. For each key project area, the challenge was to come up with measures that are acceptable means of addressing the question, "How do we know that component X is doing its job?"

Inserting the Mental Health Advisory Board between the payor and the vendor, with responsibility for ensuring a quality mental health care program, set up the potential for conflict and possible resentment by APM of the complex role of the Board. After all, it was the Board that not only had to approve APM's practices, but was charged with measuring its performance that, to some extent, would affect its annual fees.

Board members were keenly sensitive to such issues. Their expectations for the program were high. While the Board was demanding an innovative, effective, and high quality package, and had a clear vision of what that package should look like, they were aware of the sensibilities of a competent APM clinical staff who had their own ideas about the shape of the program.

While consistently firm in its guidance of the program, and with IBM staff uniformly supportive of its positions, the Board's goal was to develop a collaborative relationship with the APM clinical staff. An important corporate understanding at IBM is that employees expect that their benefit structure is adequate to provide for high quality services. They exercise their rights to protest if services do not meet identified standards. IBM and Workforce Solutions staff consistently supported Board-vendor collaboration in order to promote quality services. Several events allowed for the growth of collaboration. The first example is the development of the quality assurance program.

Early on, there were differences between APM on the one hand and the Board and IBM on the other, over what constitutes a good quality assurance system. APM proposed a QA committee, composed of senior managers, that would meet once a month to review the ongoing operations on the separate IBM Unit of APM. The Board felt strongly that quality assurance and, later, quality improvement programs could only be accomplished by the dedication of major resources to bolster the management information system to produce detailed reports on every aspect of APM's clinical and business systems. Indeed, such a system appeared to be called for in the APM-IBM contract.

Initially these two perspectives were far apart. The costs of modifying the software to program the system to produce the reports requested by the Board would be enormous. Even so, the Board continued to press for a program that would allow it to properly monitor APM's clinical activities.

The situation was eventually resolved with assistance from APM's parent company, Value Health, which accepted the IBM/Board position and assigned staff from Value Health Sciences (a sister company with significant expertise in the systems area) to work with APM and the Board in developing the new MIS system. APM also hired a professional QA staff to manage the internal operations involved in helping to design and implement the program.

From the time of that key decision on, true collaboration took place. Value Health Sciences, APM, IBM, and the Board worked as a single team with the goal of producing a comprehensive QA MIS program to monitor the IBM Mental Health Care Program. At the same time, it became clear to the growing APM that the implementation of the new "quality improvement plan" can assure quality care while containing costs and at the same time allow APM to use the same or similar MIS programs for other client contracts.

A second example of the maturing of the partnership among the Board, IBM and APM began as the Board commenced auditing of the program in late 1991. Three audit subcommittees were created: quality assurance, network operations, and clinical affairs. The work of the clinical "team" is described as an example.

On its first audit visit to APM headquarters, the focus was on randomly selected clinical files. After two days of review and discussion with staff, problems were identified in the records system and in the managed care practices that were recorded and (more important, not recorded) in records. A detailed formal report was filed and shared with IBM and APM. A second two-day visit a month later led to increased understanding by the clinical team of APM operations and more suggestions to APM staff. A third visit facilitated communications between the clinical team and APM and agreement as to processes necessary to bring systems into compliance with the clinical team's expectations.

APM clinicians looked increasingly to Board members for support of the common goals. Clinical audit visits later involved more dialogue between clinical staff and the Board team. A constructive partnership has now been established with agendas focused on solving clinical issues, instead of only on measuring performance.

By early 1992 detailed quarterly reports were generated for the Board to monitor most aspects of the clinical referral line, network operations, and case management services. Table 1 lists a sample of the sections of the quarterly reports. Additional reports continue to be added and subtracted to and from the system.

In addition to such statistical data, anecdotal reports are sent to the Board on all emergency and urgent cases. Having established criteria for the clinical staff, the Board also monitors their credentials and performance.

TABLE 1
Illustrative Clinical Quality Reports

Clinical Referral Line

Telephone System Statistics
 Timeliness of Referrals
 Problem Type Report by Age
 Ability to Meet Beneficiaries Requests Regarding Providers
 Severity of Calls by Time of Day
 Timeliness of Referral by Severity of Call

Network Operations

Credentialed Facilities by Type
 Summary of Practitioner Network Applications
 Reasons Individuals Refuse to Join Network
 Regional Analysis of Facility Density
 Network Practitioner Audit
 Summary of Visits to Practitioners and Facilities
 Summary of Network Practitioner Complaints by Discipline

Author's copy

Case Management

Timeliness of Initial Certification by Facility Type
 Frequency of Outpatient Concurrent Review
 Case Management Compliance Audit
 Disposition of Cases by Review Determination
 Summary of Treatment Modifications

PROGRAM STATUS

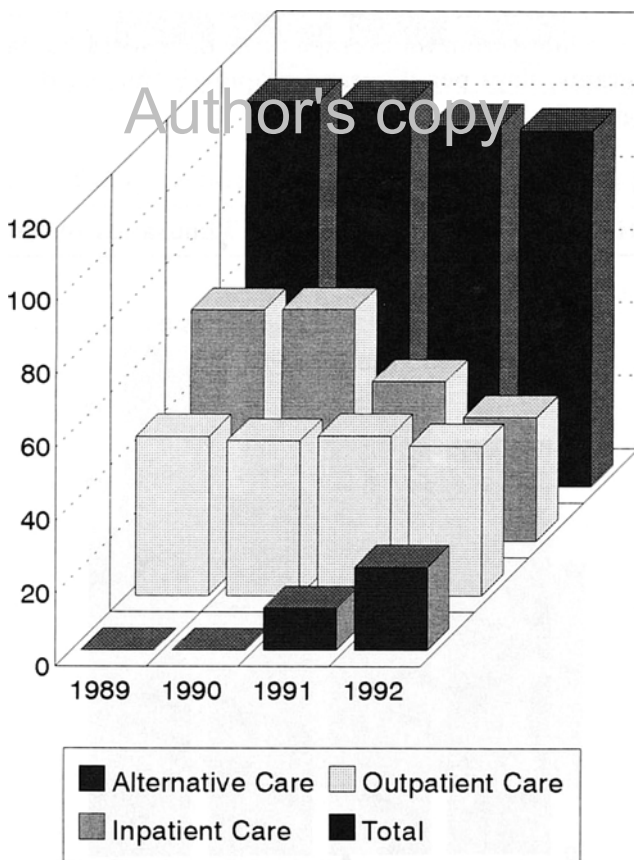
By the end of 1992, more than 19,000 employees, retirees, and their dependents had telephoned for assistance. Thousands of additional calls have been received from practitioners, facilities, claims administrators, beneficiaries, and others asking for information on, or clarification of the program. Approximately 2,100 individuals have been referred to case management, and of that number, more than 1,000 have been placed in alternative treatment settings, instead of in an inpatient, acute care, hospital environment. Providers have generally been very cooperative and supportive of the program. Some 22,000 practitioners and 1,300 facilities and programs have signed up for the network throughout the country.

PROGRAM EXPERIENCE

The resource and referral line and the case management activities began in July 1990 and the network operations were phased in over 18 months starting in October 1990. The entire program was not available to all beneficiaries until 1992. Data reported for the years prior to 1992 then, do not represent the influence of a fully operational system, but rather, the activities of a program getting under way.

One of the original goals established by IBM when planning the program was to stabilize mental health care costs that had been escalating dramatically. For the two years prior to the new mental health care program, total costs were about \$105.5 million per year; during the first two years of the managed care program, total utilization costs dropped to just under \$98 million (Figure 1).

FIGURE 1
Utilization Data—Cost in Millions of Dollars



Costs in unchanged, unmanaged programs of other payors continued to rise.

The number of covered lives remained essentially unchanged. For example, in 1990 there were 250,484 active employees, employees on leave, and, retirees (as well as their dependents) in the "member" population. In 1992 the comparable number was 249,566. Savings are not based upon reductions in the covered population.

Another goal was to make available alternative levels of care appropriate to patient medical needs. Acute care inpatient costs were reduced by about one half when the managed care program was fully implemented. Alternative care costs rose from zero to \$22.9 million dollars. Outpatient costs remained stable.

Perhaps as a result of case management or perhaps because of use of alternate care facilities (or more likely both), inpatient costs per admission fell from a pre-program level of about \$15.5 thousand to \$11.5 thousand (Figure 2). Inpatient costs per day decreased from a high of \$531 in 1990 to \$344 in 1992 (Figure 3) These figures average all 24-hour care facility costs including acute and alternate care settings.

Lengths of stay for acute care, day treatment, and structured outpatient programs were reduced from an average of 29 days to 14.86 days (Figure 4). For these programs, days per thousand employees moved down from about 179/1,000 (Figure 5).

FIGURE 2
Inpatient Cost per Admission (In Thousands of Dollars)

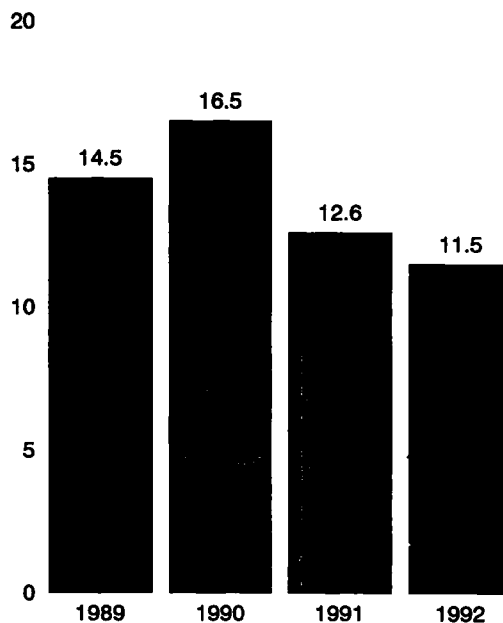


FIGURE 3
Inpatient Cost per Day (Dollars)

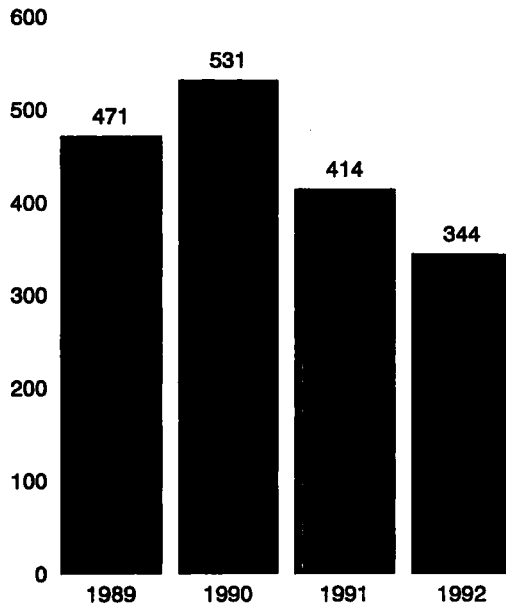
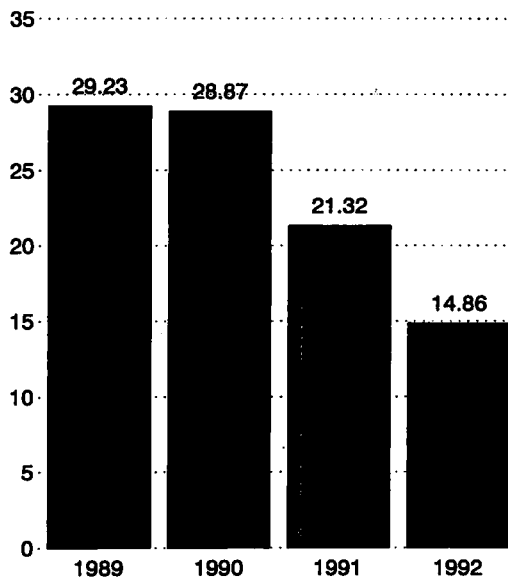
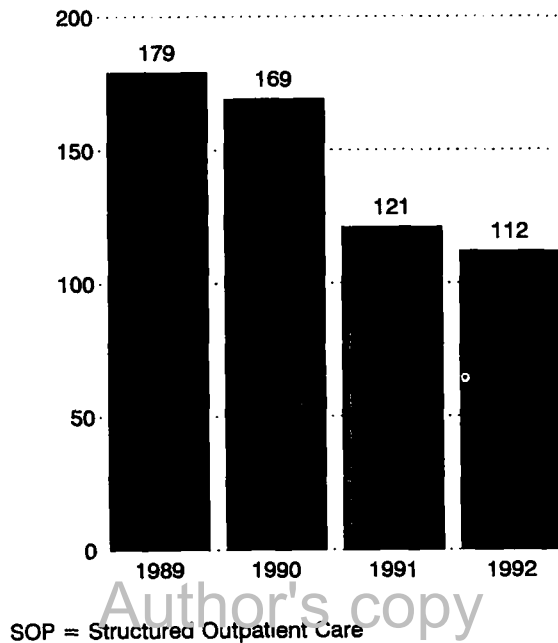


FIGURE 4
Length of Stay: Acute Care, Day Treatment, and SOP



SOP = Structured Outpatient Care

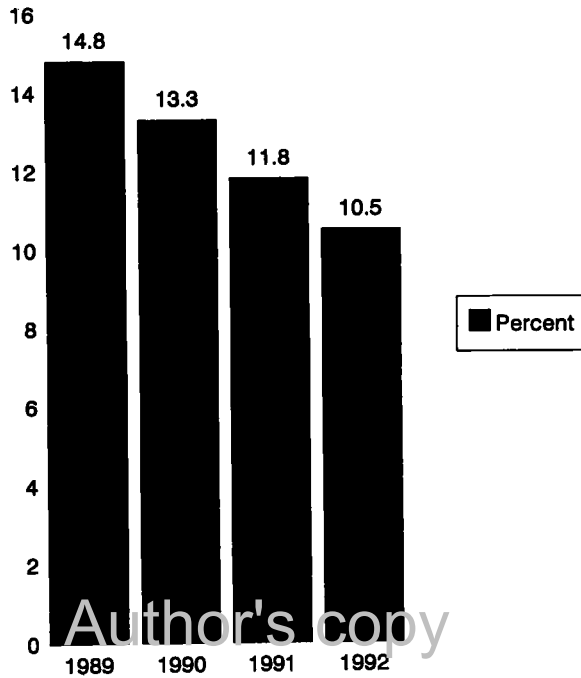
FIGURE 5
Days per Thousand: Acute Care, Day Treatment, and SOP



Mental health care utilization costs, including substance abuse treatment, as a percentage of all IBM medical benefits, (major medical, surgical, and hospitalization) decreased by more than 1% each year from 1989 to 1992 (from 14.8% to 10.5%) (Figure 6).

It should be noted that since 1992 all trends demonstrated by the above data have been maintained. The cost trend, in particular, has shown further reductions. As noted, total costs in 1992 were \$98 million. In 1993 this figure dropped to \$59.2, and to approximately \$46 million in 1994.

FIGURE 6
Mental Health Utilization Costs as Percent of Total Medical Costs



CONCLUSION

While there may be little valid evidence that managed care services ensure accountability and superior quality, we believe that programs such as described in this article provide data to support the hypothesis that such services can achieve both.