Managing Behavioral Health Care: An Employer's Perspective

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Employee life cycle events and behavioral health disorders impact productivity and well-being. Employers use wellness initiatives and employee assistance or work-family programs to help manage those factors that can distract employees from performing optimally. Employer-sponsored health benefits are designed to protect employees from the catastrophic costs of illness. However, today's plan designers struggle with employee and employer affordability that does not compromise quality or effectiveness. In 1990, Digital Equipment Corporation, Maynard, Mass., shifted its strategy from an indemnity model to a managed care model that uses health maintenance organizations. Comprehensive standards are used to ensure the delivery of quality behavioral health care that is cost effective, is delivered at the clinically appropriate levels, and uses a broad continuum of treatment approaches with measurable outcomes.
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In 1984, National Institute of Mental Health (NIMH) catchment studies[1] reported that 18% of the population had treatable behavioral health conditions. Further studies suggest that more than 5% of the population are clinically depressed at any given time and that alcohol and substance abuse affects 6% to 10% of the population.

Work populations are a microcosm of the general population and, as a result, are impacted by the prevalence of behavioral health problems. Occupational disability causes considerable economic losses when the cost of lost work days is added to the costs of accidents, waste, and lower productivity. Productivity loss takes the form of poor concentration, memory lapses, indecisiveness, errors and waste, injury, fatigue, apathy, or lack of self-confidence, all of which impact a worker's effectiveness. A recent study[2] estimated that depression alone accounts for lost work days that total a $12 billion loss per year and 1% to 2% of disabilities with a 4- to 6-week duration. Depressed individuals were absent from work at a rate 1.5 times the average, with a 20% reduction in productivity.

In 1989, the Washington Business Group on Health (WBGH), using a grant from NIMH for part of its Depression Awareness Research and Training program, formed the Employer Leadership Council to specifically discuss the impact of depression in the workplace. WBGH reported results of studies conducted at various corporations.[3] For example, Pacific Bell reported that depression accounted for 11% of all days lost and 50% of all mental health disorders among their employees. First National Bank of Chicago Employee Assistance Program (EAP) reported that 40% of all its referrals were for depression. A survey conducted by Wells Fargo Bank reported that 30% to 35% of respondents showed signs of depression.

In 1995, a telephone depression screening tool was offered to employers to use over a 3- to 4-month period. According to the final report sent to all employers who participated, utilization varied by employer and ranged from 2% to 8% of the workplace populations. Around 70% of the callers exhibited some symptoms of depression, while 10% showed signs of major depression requiring immediate intervention (Telephone Screening Program for Depression, National Depression Screening Project, Wellesley Hills, Mass., Douglas Jacobs, M.D., Director).

RATIONALE BEHIND HELPING EMPLOYEES

Why do companies get involved? First, today's competitive corporations need to recruit and retain a high-performing work force. In these "lean and mean" organizations, there is no "bench strength" to pick up the slack of an absent employee or to cover for an under-performing coworker. Second, workers are increasingly demanding a balance between their work lives and their personal lives. Third, the location of work is no longer necessarily the traditional office or factory but can include the home, the car, or a hotel or service van using computer links and video or telephone conferencing tools. Given this new backdrop and the evolving nature of work, the indirect costs of not treat-

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ing behavioral health problems can far exceed the direct cost of treating an episode of depression or another disorder. Fifty-five percent of the cost of depression is indirect.[2] Fourth, over the past 2 decades we have seen the shrinkage and fragmentation of community health care resources, including the community mental health system, which has made finding the help they need time-consuming and frustrating for employees, thereby lowering worker morale and productivity. Finally, in any major corporation, a variety of people have employee health and wellness as a component of their responsibilities and/or are impacted by an employee's health. Some departments in which these stakeholders work include the following:

- Human Resources
- Benefits
- Occupational Health
- Risk Management
- Environmental Health
- Safety
- Security

WHAT ARE SOME COMPANIES DOING ABOUT HEALTH CARE?

Programs are evolving that address the factors that distract employees from performing at optimal levels. Companies are starting to use primary, secondary, and tertiary prevention models to address their risk exposure. An increasing number of employers are developing wellness programs and health strategies with components that focus on physical fitness and early identification of disease or lifestyles that increase risk of illness or injury. These efforts also include comprehensive health education components and initiatives to help empower employees to use their health care system.

For example, Digital Equipment Corporation, Maynard, Mass., uses a "life-cycle approach" in designing its programs. Normal life events, such as getting married or entering a committed relationship, having (or adopting) a child, purchasing a home, getting a divorce, caring for a disabled adult or elder dependent, suffering a disability, or experiencing a serious illness require individuals to employ cognitive skills and strong coping mechanisms. Generally, access to various community-based resources is required to help the individual effectively manage the life event. Digital, like most major companies, has established employee assistance and work-family programs to assist employees by providing information, brief counseling, and access to extensive databases of community resources. These employer-sponsored programs are prepaid and cost the employee nothing. Many of these programs use a psychoeducational model and include strong educational components—a wide array of printed materials and periodic workplace seminars are provided. Essentially, these programs are positioned to intervene early and help normalize the life event. EAPs and work-family programs are part of a continuum of care with the goal of preventing use of the formal and more costly health care delivery in which illness (physical or behavioral) may be the result of prolonged unresolved stressors. In addition, Digital is looking to its health care providers to partner in the delivery of health promotion services and using the workplace as a site to deliver services. This poses a challenge for many systems of care since they are generally designed to respond to episodes of ill health versus managing the health risks of a population.

Table 1. Strategic Objectives in Design of New Health Care Plan

Quality—Ensure that employees receive quality (and continuously improving) health care
Access—Make services easily accessible to employees and their families
Choice—Offer multiple plans providing options for employees to select from
Cost-effectiveness—Plan cost management features and controls

HOW ARE SOME OF THE NEW HEALTH CARE PLANS DESIGNED?

Health care is the most costly component of any employee benefit program. Today's health plan designers struggle to provide both employee and employer affordability without compromising quality and effectiveness. Digital began to design its managed care strategy in the late 1980s in response to double digit percentage increases in its health care costs. More than 85% of employees were enrolled in Digital's self-insured benefit plan, which paid 100% of hospital costs; 80% for outpatient mental health care up to the first $2000, then 50% thereafter annually; and 80% for outpatient substance abuse care annually after the deductible was met. Projected costs into the 1990s made this indemnity plan, with precertification and concurrent review controls, unaffordable. Four key strategic objectives (Table 1) were established in framing the direction of a new health plan: quality, access, choice, and cost-effectiveness.

After careful review of various organized systems of care, Digital selected the health maintenance organization (HMO) as the delivery vehicle with the best track record of containing costs while sustaining quality. In order to provide choice to employees, Digital designed a point-of-service product to offer as an add-on to the HMO. In key cities, HMOs were competitively selected to become "HMO Partners" in offering a point-of-service option. Essentially, the point-of-service provides indemnity-type benefits with slightly higher deductibles and copayments than the standard plan; point-of-service benefit levels were changed to reflect a 70% reimbursement level after the deductible was met. The intent was to select high qual-

Table 2. Performance of 23 Health Maintenance Organizations (HMOs) on Behavior Health Performance Standards Established by Digital Equipment Corporation in 1995*

Standard	Meets Standard (N)	Working to Meet Standard (N)	Does Not Meet Standard (N)
No benefit limits exist	17	5	1
Provides adequate access to benefit for clinically appropriate care[a]	7	16	0
Has triage system with established guidelines			
Based on clinical criteria	21	2	0
Screen for case management	19	3	1
Assesses functional status of patients	17	6	0
Alternate levels of treatment exist			
Alternatives exist	20	3	0
Rehabilitation services exist	20	1	2
Collects data for outcome measures			
Efforts to evaluate outcomes initiated	21	2	0
Conform with HEDIS reporting guidelines	19	4	0
Uses total quality management approach			
Behavioral health staff participates in quality committees	19	4	0
HMO manages carve-out vendors[b]	12	1	2
Provides prevention/education program			
Provides regular behavioral health information to members	22	1	0
Offers workshops	14	8	1

*Abbreviation: HEDIS = Health Employer Data Information Set.
[a]Emergency care within 8 hours, urgent care within 48 hours, and nonurgent care within 10 days.
[b]Not all HMOs use carve-out system.

ity HMOs that offered competitive pricing in their markets. In theory, a quality delivery system with high user satisfaction should result in employees not feeling a need to look outside the plan for medical care under a point-of-service alternative. Digital selected a network manager to put this strategy into operation.

Standards were developed in order to ensure consistent quality and level of benefit across the United States. Specific standards focused on the following key areas:

- Access to care and member satisfaction
- Quality of care
- Mental health and substance abuse (behavioral health)
- Information management and reporting
- Financial controls

Anecdotal evidence and HMO site reviews in the late 1980s and 1990 suggested that the delivery of comprehensive, quality behavioral health services by HMOs varied widely from plan to plan. As a result, behavioral health was identified as an area requiring its own unique set of standards. The following nine key areas were identified:

- Benefit design
- Access
- Triage
- Treatment approach
- Case management
- Alternative treatment settings
- Outcome measurement
- Quality management
- Prevention/education/early intervention

PUTTING PLANS INTO PRACTICE AND MEETING THE STANDARDS

Today, some 50 HMOs come under a network management system that monitors plan performance against these standards. In 1995, a comprehensive set of standards significantly revised the initial 1991 standards. A "report card" approach emerged, with each standard representing "best practices" in the HMO industry. Each HMO was requested to prepare a self-report scorecard listing whether they met the standard, were working toward meeting the standard, or did not meet the standard.

Twenty-three of the largest HMOs in the United States, representing some 70% of U.S. insured employees, were assessed by the network managers to see how closely they match the 1995 Digital HMO Performance Standards for Behavioral Health (Table 2). More than 20 HMOs have a triage system with established guidelines based on clinical criteria for directing members to appropriate levels of care (Standard 3.3.1); provide alternative levels of treatment (Standard 3.6) and rehabilitation services (Standard 3.6.1); have initiated efforts to evaluate outcomes on the efficacy of treatment regimens (Standard 3.7.1); and provide regular behavioral health information to members

(Standard 3.9). Over half place no limit on benefits (Standard 3.1); routinely assess patients for functional status (Standard 3.4); conform with Health Employer Data Information Set (HEDIS) reporting guidelines (Standard 3.7.6); ask behavioral health staff to participate in quality committees (Standard 3.8.3); and offer workshops about behavioral health (Standard 3.9.1). Sixteen HMOs are working to meet Standard 3.2.3, which requires that patients are ensured adequate access to clinically appropriate behavioral health care (within 8 hours for emergency treatment, within 48 hours for urgent treatment, and within 10 days for nonurgent treatment).

There are many challenges in trying to apply consistent standards for an employer-sponsored health benefit plan across a geographically dispersed population, particularly when a number of diverse delivery systems are used. One challenge is being able to compare plan performance and quality. As a result, an increasing number of employers are partnering with the National Committee on Quality Assurance (NCQA), which requires that plans obtain certification, report data using the HEDIS, and use consistent instruments to measure member satisfaction. Employer purchasing groups, which enable employers to collectively leverage the health plans they competitively select to contract with, are forming in many regions of the country.

Many employer members of the Washington Business Group on Health, along with Digital, are advocating an organized system of care, responsible for an entire population, with integrated finance and delivery systems that provide comprehensive services across a broad continuum of delivery models, which is accountable to its consumers and purchasers while continuously improving.

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