

# **Implementation of Managed Mental Health Care**

*In a Fee-for Service Group Practice*

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# Implementation of Managed Mental Health Care

*In a Fee-for-Service Group Practice*

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In September, 1990, the Virginia Mason Medical Center (VMMC) Psychiatry and Psychology section agreed to assume responsibility for the management and provision of mental health and chemical dependency services to the HMO population of the Virginia Mason Health Plan (VMHP). Through a capitated arrangement, this fee-for-service group practice became responsible for all administrative and clinical tasks related to the provision of services. The group had, in effect, agreed to act as an HMO and provide specific services to a discrete population.

VMHP, the majority of which is owned by VMMC, has an enrollment of about 35,000 members and uses Virginia Mason providers and facilities whenever possible. As the enrollment grew in the late 1980s, management became increasingly concerned about the utilization and costs related to mental health and chemical dependency services.

In 1989, after a difficult year economically, the management of mental health and chemical dependency services and benefits was placed with an outside company. This experiment in cost control was unsuccessful. The company chosen did not have adequate time, resources or experience to prepare and execute such a complex task. In retrospect, the capitation rate was bid unrealistically low and accounting, record keeping, and patient flow systems were rudimentary and difficult to integrate with the VMHP systems. Clinic practitioners were dissatisfied with the external control over referrals, delays, uncertainties in authorizations, and the lack of integration between medical and mental health services.

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After only eight months' experience the clinic and health plan administrative boards decided not to renew the outside contract. The management of services was then awarded to the clinic's Section of Psychiatry and Psychology.

## Goals of the Project

In developing a program with significant service delivery and financial implications, the clinic and the health plan quickly established their goals:

- To be a managed care system, as opposed to a managed cost system; a system which functions within a philosophical framework that the delivery of appropriate care will be cost effective,
- To be a financially viable program that can meet costs through the capitation rate plus collected copayments,
- To provide accessible care to all health plan members,
- To provide quality care to all health plan members,
- To provide continuity of care through the availability of a full spectrum of services for which coverage is provided.

With the decision to internalize program management made and goals of the program established, a capitation rate was set for the management and delivery of services.

## The Program Development and Implementation Process

Time and staff resource limitations led to the hiring of a consultant to manage program development and implementation. The nature of the project and, in particular, the process orientation of mental health providers, led to consideration of the following criteria for an appropriate consultant:

- Program planning and implementation skills.
- Group process and facilitation skills.

- Understanding of mental health and chemical dependency.
- Understanding of managed care systems.
- Understanding of the operation and administration of large health care delivery systems.

The consultant hired employed a participatory model to manage the project and facilitate the efforts of staff in identifying and completing tasks. The basic premise in his approach was that all staff are experts in their specific areas. Five work groups were established and met on a regular basis to enhance communication between departments, avoid redundancies of efforts, solve problems, and act as sounding boards to ideas. Tasks identified by work groups were either completed by that group or individual members of the group.

1. *Steering Committee.* This consisted of those responsible for the success of the program: the administrator overseeing the operations of the Psychiatry and Psychology section; the managed mental health and chemical dependency medical director; and the consultant. This group reviewed the project's status on a weekly basis including the assignment and completion of tasks, the impact of decisions, and the identification of necessary activities.
2. *Systems Work Group.* This was a large work group with representatives from every department with tasks in the project. It included representatives from the Psychiatry and Psychology section, the health plan, information systems, finance, medical records, patient accounts, claims, telecommunications, public relations, scheduling, registration, facilities, etc. To assist in these efforts, the health plan also brought in a systems expert to facilitate development of referral management, claims processing, benefit tracking, and reporting systems.
3. *Policies and Procedures Work Group.* This consisted of members of the Psychiatry and Psychology section representing the various disciplines, subgroups and geographic locations of the section. In addition, it included the VMHP Director of Operations and the VMMC Psychiatry section administrator. Clinical and operational issues were addressed and a set of written policies and procedures established. Such issues as confidential records, the case management function, relationships with employee assistance programs, and referrals of fellow employees were addressed using a consensus decision model.
4. *Benefits Work Group.* Members of the Steering Committee met to clarify coverage and draft coverage policies. The group was joined by clinical experts on an as-needed basis. While this group developed policies, it was not empowered to change the member certificate of coverage; for those issues, rec-

ommendations were submitted to the clinic and health plan senior operations team.

5. *Hiring and Credentialing Work Group.* Representative members of the Psychiatry and Psychology section reviewed applications and made decisions on new therapists hired to meet anticipated demand generated by the program. They also participated in hiring the program case managers. In addition, this group credentialed individuals and institutions as part of the process of developing an out-of-clinic provider network.

### The Managed Mental Health and Chemical Dependency Service

The service was designed to meet the organizational goals related to access, quality, continuity of care, and financial viability. In addition, there was a strong desire for the program to have a clear reporting structure, a high level of patient and provider satisfaction, and efficient billing and claims processing.

#### *Case Management Function*

The focal point of the service are the three case management functions: (1) outpatient mental health; (2) inpatient mental health; and (3) outpatient and inpatient chemical dependency. These functions were developed with the idea that case management should be separate from assessment and treatment, and that providers should not case manage their own patients. It was decided to hire masters level clinicians (e.g., M.S.W., M.A., R.N., etc.) with significant experience to ensure effectiveness of the case management function, to keep the function clinical, to attain parity between case management and the delivery of care, and to enhance the relationship between case managers and providers of care. It is believed that these latter two points are essential to success of the service.

The overall responsibility of the case managers is to direct health plan members to the most appropriate services within the context of their coverage and the program delivery philosophy. They also play an important role in assisting management in capturing information for program planning and quality improvement. The following functions are considered necessary to successful case management:

- verify eligibility
- determine acuity and appropriate triage response
- collect clinical and demographic information
- describe coverage
- authorize/deny coverage for services
- monitor treatment plans
- process referrals
- report disposition to referring provider
- follow-up inpatient discharge

- initiate referral paperwork necessary for efficient billing and claims processing.

To enhance scheduling efficiency and patient satisfaction, the case managers also schedule the patient's first outpatient appointment for in-house visits. This is intended to increase compliance and decrease scheduling confusion. An automated appointment scheduling system makes this possible. These functions are all completed by case managers with assistance from the other members of the case management team.

### *Case Management Policies and Procedures*

The policy and procedure workgroup developed criteria and policies which assist case managers in triage and coverage authorization decisions. The triage criteria provide guidelines for case managers to direct patients to the most appropriate provider. The authorization policies and procedures provide a check and balance mechanism for the coverage of services. The three most important policies are as follows:

1. *Authorization of Outpatient Mental Health Services.* All authorizations must be made prior to the delivery of services. There are three types of authorizations: (1) assessment visits, which are up to two sessions for adults and up to four for children and adolescents; (2) initial treatment visits, which are the number of sessions the provider and case manager agree is appropriate; and (3) additional treatment visits, which are the number of sessions deemed appropriate given the treatment and termination plan. While the ability of clients to self-refer was retained, the service does not allow for scheduling an appointment with a provider unless one or more visits are pre-approved by a case manager.
2. *Authorization of Inpatient Mental Health Services.* Authorizations are for a number of days deemed medically necessary and appropriate by the case manager. Inpatient stays are continuously monitored, which is particularly important for the member since coverage for these services is quite limited. After-hours emergency admissions are authorized for up to three days by the on-call provider.
3. *Authorization of Chemical Dependency Services.* There are four categories of authorizations: (1) assessment services; (2) initial treatment services; (3) additional treatment services; and (4) emergency detoxification.

All authorizations, with the exception of those for emergency detoxification, must be made prior to the delivery of services. Given the range of patient needs and outpatient and inpatient programs available, the case manager has considerable flexibility in authorizing services. It is not assumed that full 21 or 28 day

inpatient programs will be authorized at one time; the case manager must be involved in treatment planning.

### *Case Management Team Structure*

A case management team was developed consisting of two clinical case managers, an intake screener, an office assistant, and a program coordinator. The case managers are both master's level clinicians; one with over 10 years experience as a direct service provider in an HMO outpatient mental health setting and the other an R.N. with an M.A. counseling degree who had inpatient mental health delivery and inpatient/outpatient case management experience in an HMO. The bachelor's level intake screener had experience in an inpatient setting and as an intake screener in an HMO setting.

The case management team reports to the section administrative manager, who also provides guidance on troubleshooting systems problems. The managed mental health and chemical dependency service medical director, a psychiatrist, provides clinical supervision and backup to the case managers.

An on-call system for after hours case management and clinical support was developed specifically for health plan members and consisted of the case managers and clinical staff. This system was backed up by the psychiatrists' call system. After three months of experience, the case management on-call system was transferred entirely to the psychiatrists' call system due to low volume.

### *Delivery System*

The delivery system utilized by the Managed MH/CD Service consists of Virginia Mason providers as well as a network of external providers and institutions.

To meet anticipated demand for outpatient mental health services, three master's level clinicians were hired as members of the VMHC Psychiatry and Psychology section. These clinicians' practices were dedicated to health plan clients for the first three months of the program. This was to ensure adequate access to services for this population. Expansion of their practice to include fee-for-service clients was to be considered after a three month period when demand for services from the VMHP population was better understood.

While it was agreed that the majority of services would be provided in-house, a network of community providers was developed. This included master's and doctorate prepared clinicians. The network serves the following purposes:

- To provide access in geographic regions where there are health plan members more than 20 minutes

travel time from a VMMC provider.

- To provide services not available in-house. For example, in-patient psychiatry is not available at the medical center hospital;
- To provide an outlet should the wait time for an in-house visit be unacceptably long.

*Patient and Information Flow*

Figure 1 shows how patients and information flows between the case management team and service delivery providers. Referrals are made into the case management team. A member of the team completes a telephone intake assessment and refers the patient to an appropriate provider for assessment. At the same time, the case manager authorizes coverage for the assessment services. After the assessment, the provider communicates the patient's needs to the case manager and together they agree on an appropriate treatment plan. Treatment services are authorized and the provider is expected to communicate back with the case manager on issues related to treatment planning and the authorization of additional services.

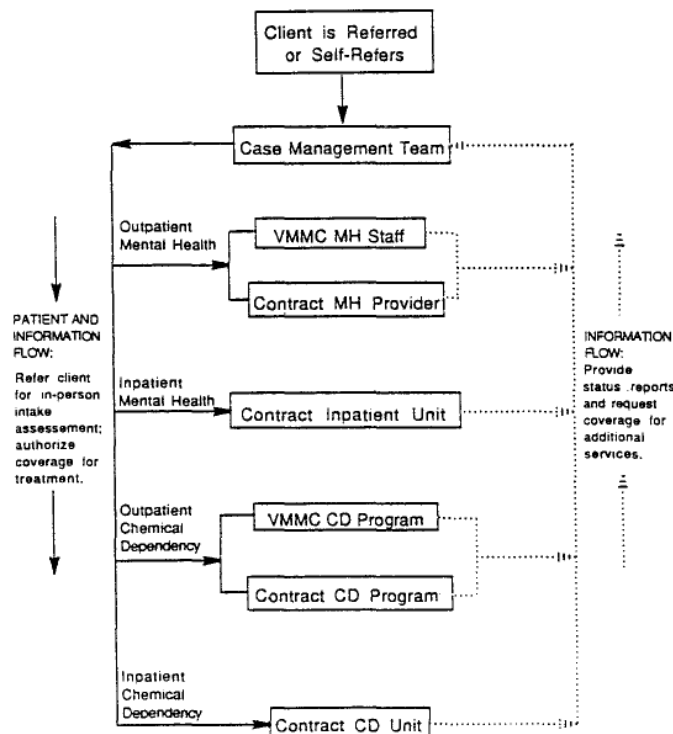
**Shifting Paradigms and Need for Education**

The assumption of responsibility for both the management and delivery of services to the health plan population represents a significant change for the VMMC Psychiatry and Psychology section.

The section of Psychiatry and Psychology, as of September 1990, consisted of seven psychiatrists, four clinical psychologists and eight master's level therapists. The section's practice model had been entirely fee-for-service based and included a consultation-liaison psychiatrist practicing in the medical center's hospital and an innovative intensive group program to treat more dysfunctional, but non-psychotic, patients. Inpatient psychiatric and chemical dependency patients were referred to area programs, with outpatient follow-up often returning to the section. Most section members spent one or more days each week providing services at satellite facilities.

The medical center's highly developed support systems (e.g., patient accounts, insurance, records transcription) encouraged service delivery productivity. Practitioners had no need to attend to financial arrangements nor track insurance benefits for those they were treating. Prior to mid-1990, there was no ability to identify health plan patients so that the clinician might plan treatment around the 20 visit annual limit; treatment plans were developed around the intensity

**FIGURE 1. VMMC MANAGED MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICE PATIENT AND INFORMATION FLOW**



and type of treatment intervention deemed clinically necessary.

The increasingly common practice of restricting covered visits and pre-authorizing care meant that changes in clinician behavior were necessary to shift towards briefer modes of therapy. Changing long-established patterns of behavior that are valued, for less familiar practice patterns of uncertain value is a challenge for any group; it is best accomplished by involving the entire group in the task.

Accordingly, a series of working groups was established to debate and define the parameters of patient care and areas of clinical responsibility for the existing practitioners, new clinicians, and new case managers. In addition, weekly section meetings were largely devoted to discussion and update of information on the coming changes. A series of presentations focusing on short-term therapy topics were also made. This immersion in restructuring practices, new protocols, and managed care concepts encouraged further reading and informal discussion. Longer-term practice adjustments will need to be assessed as the section gains more experience.

### Evaluating Success

After one year of operation it is felt that the Managed Mental Health service is achieving program goals without any significant change in the original delivery system design. Important to the clinicians involved is that both case managers and providers continue to dialogue about the underlying issue of making the delivery of appropriate care consistent with cost effectiveness in a capitated environment.

From an administrative perspective the program is financially on target at the end of one year. An important outcome to the medical center is that over 70 percent of VMHP patients seeking care have been referred to VMMC Psychiatry section providers whereas the prior year referral estimate is less than 30 percent.

Although some outside referrals are based on geographic constraints, the biggest outside expenditures have been for chemical dependency and inpatient psychiatric services. Starting June 1, 1991, the majority of chemical dependency patients have been referred to VMMC's new intensive outpatient service. The development of this service also meets a long-term goal of the Psychiatry and Psychology section.

Access to care is a high priority for case managers. To date, initial evaluations for urgent patients have been able to be scheduled within five working days, although there are some exceptions to this when specialized providers are requested by the client (e.g., women therapists in a specific geographical location).

Key to the perceived success of this program to both practitioners and patients has been the quality of the case management process. This is felt to be a direct

result of the qualifications and experience of the case managers. Their success lies in their ability to communicate with the client and sort through presenting issues and prior treatment history, as well as work at a peer level with practitioners in mutually setting treatment expectations.

Throughout the first year of experience, the case managers have become more specific in asking for subjective as well as factual information from practitioners to assist in case management. In particular, they ask for identification of a specific problem, indications of chronicity, and progress toward treatment goals. The intention is to set the tone for treatment termination planning. Although every client is viewed potentially as a "brief therapy" client, these questions assist in identifying patients who will likely need ongoing intermittent care as well as those who will need extensive services.

Paperwork for practitioners has been kept to a minimum but is absolutely required in order to obtain authorization for services past the evaluation session(s). All paperwork is used as a tool to communicate essential assessment and treatment progress information between the practitioner and the case manager. This minimizes the need for phone calls between providers and case managers. Additional paperwork required to ensure claims payment is handled by the support staff of the Managed Mental Health and Chemical Dependency Service.

Significant to the success of the Managed MH/CD Service is the time commitment of both support and administrative staff in managing the business/operational systems. In particular, this staff deals with claims processing, reporting, and cost tracking issues, reducing practitioner "paperwork" time. In addition, having the case managers' offices adjacent to the practitioners' promotes daily interaction and a sense of staff involvement that has enhanced integration of the new and existing programs and staff.

### Opportunities for the Future

As the delivery system and operating systems that support the process continue to be refined, the service is starting to look to the future.

The basic design of the service was developed with the possibility of expansion in mind. The program's initial success, both clinically and financially, is encouraging a serious look at the possibility of packaging the Managed MH/CD Service as a "carveout" that can be marketed directly to business concerns. In addition, of particular interest at this point is the potential of developing employee assistance program (EAP) services. Currently, an evaluation is underway to determine what opportunities and barriers there might be to such expansion. ■

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