Managed Care: Recovery Enhancer or Inhibitor?

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Colorado Health Networks, an equal partnership between ValueOptions, a national behavioral managed care company, and eight community mental health centers (CMHCs) serving 43 counties began operating in September 1995. The partnership features a shared governance arrangement in which the managed care company and the CMHCs have equal votes on all matters.

As part of the implementation strategy, I (SF, the first author) firmly believed that recovery and self-help processes would have to be integrated into the routine delivery of care if the partnership was to be successful in fulfilling its goals of both cost containment and improved outcomes for the persons served. "Recovery" as used in this context and in the mental health community does not refer to a 12-step process. Instead, recovery is about a person's regaining meaning and purpose in his or her life after the catastrophic events associated with severe mental illness (1).

To help drive this philosophical change in the partnership, I brought in a consumer leader who had deeply influenced my thinking—Ed Knight, Ph.D. Ed had convinced me that the integration of self-help and recovery work into the program and the introduction of the tools and techniques of psychiatric rehabilitation (2) not only would represent the best utilization management strategy for the partnership but also would produce outcomes that would make consumers its best spokespersons.

The psychiatric rehabilitation curriculum is built on a foundation of empowerment. As consumers begin to take control of their lives, the need for alternatives or adjuncts to traditional treatment, such as self-help groups and consumer-operated drop-in centers, increases. As consumers become involved in these activities, they form social networks that address the negative effects of isolation and decrease the demand for high-end services.

Five years later it is clear that self-help and recovery programs work. Colorado Health Networks has created more than 70 self-help groups. It has four consumer-operated drop-in centers, and four others are on the drawing board. The recovery model suggests that adjuncts and alternatives to formal treatment, involvement in self-help groups, and social opportunities at local drop-in centers foster empowerment and provide opportunities for a more meaningful life.

There is hard evidence to support our belief that these processes work (3,4). Studies were completed under a grant from the National Institute of Mental Health to researchers at Berkeley to evaluate the impact of the Colorado managed care capitation project. The results showed that the project accomplished several objectives. The number of persons with severe mental illness served by the project increased significantly. The suicide rate and substance abuse decreased significantly, as did use of hospitalization. Social contacts increased significantly, as did participants' ability to carry out activities of daily living.

Managed care as an enhancer

We believe that the adoption of managed care principles and strategies played a major role in the shift to a recovery-based program model. Managed care gave major incentives to providers to adopt innovative treatment approaches. One of the CMHC executive directors recently stated, "We couldn't have made these changes in how we deliver care without managed care. Before managed care, all our strategies focused on maintaining our financial base." This CMHC has recently successfully dropped half of its outpatient commitment orders and documented the maturation process that occurs when people no longer view themselves as "infantile" and needing the coercion associated with outpatient commitment.

In addition, this CMHC has dropped its requirement that a client must attend its partial program for six hours a day to gain access to housing. It has documented the use of the Boston University psychiatric rehabilitation technology (2) to move people successfully into the community with the natural support provided by self-help groups. These groups of four to six consumers are naturally clustered in section 8 housing in several locations where consumers are living independently.

The major enhancer in the Colorado model was the movement to capitation. Under state rules, the CMHCs are permitted to reinvest savings in improvements to the system as long as they meet certain criteria. Savings from capitation have served as a major source of funding for the psychiatric rehabilitation training and resources

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needed to move to a recovery-based system of care. Providers' resistance to a model that differed significantly from the traditional community support program philosophy so prevalent in public-sector programs had to be addressed. This change has not occurred overnight. In fact, training has represented a major commitment of dollars from each CMHC partner to accomplish the outcomes described here.

Managed care as an inhibitor

We encountered four major inhibitors related to managed care. First, staff resistance existed not only toward the concept of recovery but also toward managed care. Both are viewed as threats to secure income and continued expanding job markets. Second, although not in the case of Colorado Health Networks, managed care entities are often not familiar with research on mutual support and rehabilitation and they have traditional views of persons with mental illness as incapable.

Third, unlike Colorado, where the CMHCs and the managed care entity are equal partners, many states use a different type of arrangement in which the managed care entity negotiates discounted fees for the services of providers in the network. This approach provides managers and boards of provider organizations no incentive to change. Another disincentive is managed care contracts that are poorly designed by state buyers. Failure to ensure that providers have year-to-year rollover of savings or reinvestment of funds from savings can squelch providers' incentive to change. In requests for proposals, state buyers may refuse to permit the development of partnerships between managed care entities and providers, which can also hinder incentives.

Fourth, we met with some suspicion on the part of consumers, who thought that self-help was a dodge to cut services. These negative attitudes were overcome by the ongoing availability of high-quality services in sufficient amounts. Savings resulted from the provision of such services reducing high-end costs such as hospitalization. Two other important factors included a discharge planning process in local hospitals that worked to connect people with our program and reliable, fast access to our services, which cuts time to first appointment.

Lessons learned

Ten major lessons have emerged from our work over the past five years.

First, the provision of self-help services, if done properly, can have an impact beyond what might be anticipated, as demonstrated by the population-based evidence described above. Second, the resistance of professionals can be successfully addressed if concepts and skills are put in place to fill the vacuum created when we are able to acknowledge that we were not getting the kind of results we expected from our interventions of the past. Many of our clinicians have experienced satisfaction from helping a client address a major barrier to recovery. Clinicians have told us that they would likely have not taken such an approach with a client without the new skills and techniques learned through their participation in the Boston University psychiatric rehabilitation training curriculum.

Third, resistance is not a one-time phenomenon, nor do all participants experience it simultaneously. The use of skilled trainers with the ability to listen and respond thoughtfully has been very important to our efforts. The skill to deviate from a planned module to allow for a structured dialogue about resistance has been an invaluable tool when we've needed to take a step back in order to proceed forward.

The fourth lesson learned is that the opportunities created by self-help groups and drop-in centers for persons with serious mental illness to begin to build social networks through access to leisure activities should not be underestimated. They represent a powerful complementary activity to services provided by staff.

Fifth, perseverance and commitment to change are the most important ingredients to achieving this level of systems change. Sixth, personnel changes are often necessary. One of our CMHC executive directors has used the phrase "educate, rotate, terminate" to describe his tiered approach to dealing with employees who continue to resist the changes in philosophy and treatment now in place at his center. It has occasionally been necessary to terminate persons in major leadership roles who ultimately could not make the leap.

Seventh, capitation has been the single most important benefit of managed care in providing the resources to support this paradigm shift. We would not have been able to increase the number of persons with serious mental illness served and to serve persons with more severe illnesses if we did not have the freedom to shift dollars and support new directions without worrying about the security of our financial base. Without capitation and the reinvestment policy, there would have been no incentive for providers to adopt new approaches to treating persons with serious mental illness.

The eighth lesson learned is that there is a clearly defined set of clinical competencies that support recovery and empowerment. Providers serving persons with serious mental illness should be able to demonstrate these competencies. At the core is a belief in the restoration of hope and in the ability of each individual to find meaningful activity in their daily lives.

Ninth, self-help and recovery represent the best utilization management strategies we have today. Tenth, it takes leadership both at the CMHC level and in the managed care organization to go the course. ♦

References

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