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Managed Mental Health Care of Eating-Disordered Employees

The controversial area of managed mental health care has emerged as a challenge to fundamental assumptions about client care. Those assumptions—in such areas as diagnosis, treatment protocol, cost effectiveness, cost outcome, standards of care, professional training models, and client entitlement—are being scrutinized by health professionals and consumers alike.

In this article, selected issues and assumptions are examined as they apply to the managed mental health care of eating-disordered employees. (An eating-disordered employee is one who exhibits the symptoms of anorexia nervosa, bulimia nervosa, or compulsive eating. The symptoms of these disorders include binge eating, starvation, purging, and distorted body image.) Focus is placed on assumptions regarding the continuum of care and standards for utilization review. Examples of cost-effectiveness are provided.

Managed mental health care has evolved as a direct result of spiraling health costs. Employers set the range of benefits depending on the insurance plan purchased. Out of obligation to clients' well-being, employee assistance and mental health professionals are required to help employees manage their resources effectively and responsibly. Unfortunately, that obligation has not been carried out by every practitioner, or for every employee.

The time has come for the employee assistance program (EAP) and mental health fields to examine the delivery, outcome, and cost of services, as well as the percentage of relapse. To the extent that such an examination can be achieved, consumers and professionals will benefit. To the extent that it cannot be done, consumers will be underserved or, at worst, misserved.

Ideal managed mental health care makes the following assumptions:

- Clients should be provided the most effectual, most cost-effective, least restrictive treatment setting, which, at the same time, gives good service;

• Clients are entitled to the full range of benefits for which the employer pays; and

• In terms of accountability, mental health care providers should take a proactive, scientist-practitioner approach to their clients and the organizations that pay for the practitioners' services. A scientist-practitioner approach integrates the best empirical data into practice and assumes that applied, clinical decisions are data-based.

In any mental health care insurance program (e.g., an indemnity plan, health maintenance organization [HMO], or preferred provider organization [PPO]) there are certain restrictions on mental health and chemical dependence treatment benefits. An employee assistance professional must help the employee determine whether treatment can be adequately performed within the parameters of his or her existing insurance and financial resources. This determination must be reached before the employee embarks upon a course of treatment. If appropriate systems of care cannot be provided, the employee may be required to utilize whatever public resources are available. As with all benefits plans, when the benefits limit is reached, the employee must either absorb the further cost of treatment or terminate treatment.

The least restrictive care setting should make maximum use of the employee's benefits, and, at the same time, save the employee money. The least restrictive setting is one that allows the client as much freedom as possible to continue daily living activities, given the client's symptoms. In that way, the employee receives the care that he or she needs, and receives it in a cost-effective manner. For example, in emergency or acute-care situations, an eating-disordered employee should be stabilized, then transferred to the least restrictive care option (e.g., freestanding psychiatric facility, hospital alternative, intensive outpatient program, or outpatient program). Inpatient care can cost $7,000 per week, or more; intensive outpatient care can cost $300 per week.[1] The cost difference between inpatient and outpatient care can represent a significant savings for the employee.

Along the continuum of care, the selection of a practitioner becomes an issue in the professional community when some practitioners are excluded from providing services for a benefits plan because they do not happen to have the credentials approved by the plan, are not part of an HMO or PPO contract, or decline to accept assignment from a particular plan. That becomes a problem when comparatively few professionals specialize in treating eating disorders or when the insurance plan does not cover eating disorders. (For example, of 2,000–3,000 therapists in Denver, Colorado, only approximately 50–75 belong to the Eating Disorder Professionals of Colorado.) This is a complex issue even in geographic areas where an abundance of mental health care providers exist; it is a much more complex issue in rural areas where there may be a shortage of such providers.

It is necessary to evaluate the cost-effectiveness of services and to continually review the effectiveness of treatment

An attitude of entitlement (i.e., "I am entitled to the best possible care, regardless of cost or appropriateness") can contribute to a subtle enabling process by the eating-disorder treatment community. Many treatment providers fail to set clear limits on the number of times they are willing to work with a client. Providers that do not set such limits contribute to the proliferation of managed care because employers and employees doubt that professionals can effectively police themselves. For example, when the length of inpatient stays averaged 29 days and the typical insurance plan covered 30 days, patients somehow were able to be discharged when the insurance money ran out.

On the proactive side, it is common for an eating-disordered employee or dependent to jump from provider to provider or not to follow through on treatment recommendations. An appropriate intervention would be for the treatment community to make continued care contingent upon compliance with treatment recommendations.

An employee does not have carte blanche about the care he or she receives. Treatment providers should not adhere blindly to the assumption that a client is entitled to the best care, at any cost. That is particularly true in the current state of psychotherapy outcome research (which, for the most part, is inconclusive and needs greater specificity), problems with diagnostic reliability, and the cost of treatment (which sometimes is unrelated to outcome).[2]

As Cummings noted, "Not all practitioners are created equal."[3] Neither are the delivery systems of eating-disordered mental health services. It is necessary to evaluate the cost-effectiveness of services and to continually review the effectiveness of treatment.

Ideally, EAPs should develop managed mental health care management information systems that will help determine which professionals can provide creative, cost-effective services. However, some qualified clinicians who do not think as scientist-practitioners may have difficulty providing the types of outcome data needed for the EAP case manager to perform his or her duties effectively.

Under insurance plans that include certain diagnoses but exclude others, the issue of diagnosis becomes both a business concern and a personal concern. For example, if a client meets the clinical criteria for both bulimia and depression, and if eating disorders are excluded from insurance coverage, the clinician is likely to list the depression diagnosis first. This is the first modification of the full extent of the diagnostic information. At many insurance companies,

he Diagnostic and Statistical Manual of Mental Disorders-III-R (DSM-III-R) diagnosis is converted to the International Classification of Diseases-9 (ICD-9) code. The conversion further distorts the data and lays the groundwork for a dual misdiagnosis. The EAP/managed care utilization review committee then bases its recommendation for length of stay on misinformation. Employee assistance professionals may need to negotiate with the insurance company to ensure coverage for eating disorders. If the insurance plan cannot be changed, then the eating-disorder professional should present the employee's salient eating-disorder symptoms to the third-party payors without trying to secure for the employee benefits that were not bought initially.

Utilization review is the evaluation of clinical services using objective criteria to ensure that services rendered are needed and are provided at the appropriate level of care. Such a review can be conducted on a preauthorization, concurrent, or retrospective basis.

Utilization review can be time-consuming for the EAP and the eating-disorder practitioner because of the need to respond to requests for treatment plan reviews and to complete paperwork. The utilization review is performed with the employee's welfare and financial circumstances in mind. The utilization review process can be an opportunity to assess and communicate clearly about a particular employee. It is a professional growth opportunity that can directly benefit consumers. The benefit is derived from refining services so that they become more effective and efficient, defining which clients do best in various systems, and considering the relationships between the costs of service and the quality of service.

Case Management

There is significant diversity of symptom frequency, intensity, and duration among the various eating-disorder diagnoses.[4] Related to the symptom diversity is the challenge to the professionals in the field to test assumptions regarding severity and treatment. The criteria for managing an eating-disordered employee along the continuum of care will require ongoing refinement in each community relative to available resources and professional effectiveness. In selectively reviewing the continuum of care criteria from five eating-disorder treatment programs, there appears to be considerable variance, inconsistency, and lack of specificity (See sidebar).

Inpatient treatment usually is the most expensive and intrusive in the employee's life. Such treatment is necessary for the person who is suicidal, who might hurt someone else, or who is gravely disabled. The suicidal eating-disordered employee who has the capability to take her or his own life, and has a plan, the means, and intent to do so should be hospitalized on an acute-care basis. The employee who is most likely to meet the gravely disabled criteria is an anorexic who repeatedly fails to maintain weight at adequate levels for electrolyte stability. Some anorexics can live at weights between 55 and 70 pounds, maintain relative medical stability, and be on disability leaves from their jobs (and, therefore, ineligible for committal for reasons of imminent danger or grave disability). Often, a hospital stay of several days to two weeks is sufficient to stabilize such patients. They then would be transferred to a hospital-alternative facility, day care, intensive outpatient, or outpatient therapy.

Length-of-Stay Complications

Other factors can complicate the length of stay of an eating-disordered employee. A diagnosis of posttraumatic stress disorder and depression is frequent with eating-disordered patients. The degree of trauma is often associated with treatment complications or relapse. The following examples are based on composite cases of a Colorado-based provider.

An anorexic referred by the EAP of her father's employer was hospitalized eight times in 13 years prior to referral. She was in her mid-20s,

weighed 58 pounds, was 5 feet 1 inch tall, exhibited severe starvation symptoms, and was suicidal. The client had a history of multiple sexual and physical abuse as a child. She was a chronic anorexic who could not maintain a stable weight and medical condition. The provider worked with the client on an inpatient basis for eight months; the client then left treatment, against medical advice, at a stable medical weight of 75 pounds. The treatment plan was to teach the client to be a stable anorexic rather than to try to "cure" the anorexia, because of the severe physical and emotional trauma, as well as her treatment history. The utilization review committee approved this strategy, as the client had a multimillion-dollar inpatient policy which had thus far cost approximately $600,000. The client left treatment prior to acquiring the living skills needed to function outside the hospital. The further hospitalization necessary to impart the living skills would have cost an additional $275,000. The provider advised the client that if she failed to return to the hospital within one week, the provider would no longer treat her. She chose not to return to the hospital, and the provider terminated treatment. In the ensuing months she was hospitalized by programs in other parts of the country. Her insurance company discontinued the inpatient benefits for noncompliance with treatment.

The degree of trauma that the eating-disordered employee experiences also affects the continuum of care decision. If the client is not in imminent danger and not gravely disabled, he or she can be managed in an outpatient program. For example, one bulimia client, in her mid-30s with a history of alcohol and other drug abuse and emotional abuse, was referred to a provider with the restriction that she only be treated for her eating disorder in an intensive outpatient format. She was to be hospitalized only in case of emergency. The client was vomiting 20 to 40 times per day and using more than 20 laxatives per day. She was admitted to hospitals once or twice per month on medical emergencies during the six months before referral to the provider. The cost to the company—in terms of work time lost, productivity, and medical expenses—was significant. The new provider treated the client intensively for the first month and in group sessions only for the next 18 months. During this period, the client was hospitalized only twice for medical emergencies related to relapses. She maintained her employment; estimated cost savings to the company's self-insured plan was approximately $90,000.

One case involving a 15-year-old, 105-pound female anorexic illustrates that four physicians (a family practitioner and three psychiatrists) did not understand the continuum of care for that patient. The physicians recommended inpatient treatment; they prescribed antidepressants. The insurance company requested a second opinion. A review of the case revealed that the client had not received adequate outpatient treatment and may have been placed on antidepressants prematurely; her starvation symptoms were still present, and it was not known if the depression would subside after she was re-fed (i.e., after she received enough food to attain a healthy weight). Furthermore, there were significant unaddressed challenges with the client's family. The client was referred for intensive outpatient treatment in a program with a strong family focus. The client began eating three meals per day. She regained her weight and her depressive symptoms were alleviated. The estimated savings—outpatient versus inpatient—was approximately $120,000.

Summary

It is important for the EAP and eating-disorder professional to be creative and to continually reexamine their assumptions about treating eating disordered employees. More than 95% of the eating-disordered clients of one Colorado-based EAP provider can be managed in outpatient or intensive outpatient settings.[5] Outpatient-based cognitive behavioral techniques have been successful in managing many clients who initially were advised that an inpatient program might be necessary.[6] The least restrictive option should be tried first; that step ensures that the case manager has data needed to support recommendation for a more intensive and more expensive option. The statistics for eating-disordered employees are alarming: 15–20% of anorexics die;[7] bulimia patients experience a 40% relapse rate;[8] obese patients have a 90% relapse rate after five years.[9] Those facts strongly suggest that eating-disordered employees be managed for long-term recovery. ■

Note: See page 64 for a list of references.

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