Mental Health Intensive Outpatient Programming: An Outcome and Satisfaction Evaluation of a Private Practice Model

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Mental Health Resources

The current economic climate of mental health care requires an adaptation of traditional treatment paradigms for practitioners to succeed in the marketplace. Psychologists have not really capitalized on their training and expertise in developing outpatient treatment models for acute care. A private practice outpatient program, based in crisis intervention and group therapy, is described. The effectiveness of a mental health intensive outpatient program (IOP) in a private practice setting is demonstrated. IOPs represent an opportunity for private practice groups to collaborate with larger systems of care while providing clinically effective, consumer friendly, and safe treatment for acute patients in traditional outpatient settings.

How can traditional clinical training be used in a market-sensitive manner? Solo practitioners in mom-and-pop operations are virtually extinct, psychotherapy is managed, and the private pay fee for service market is limited. How can one build a practice under such seemingly adverse circumstances? What will it take for psychologists to be recognized as the premier outpatient providers? How can psychologists demonstrate clinically effective outcomes and consumer satisfaction in a traditional private practice? Thriving in the current cost containment, economically driven health care environment requires a departure from the traditional psychotherapeutic service delivery models. Some historical trends point the way toward future practice adaptations.

During the 1980s, it was clearly demonstrated that the costs associated with inpatient adolescent and adult psychiatric and substance abuse treatment care typically exceeded the clinical benefits obtained when compared with outpatient care (e.g., Cummings, 1991; Kiesler, 1982; Miller & Hester, 1986). Other research demonstrated that day hospital programs could effectively substitute for inpatient hospitalization (e.g., Herz, 1982; Kiser, 1990; Piper, Rosie, Joyce, & Azim, 1996; Sledge et al., 1996). Now, 91% of specialty psychiatric hospitals provide partial hospitalization programs (PHPs), and 82% provide traditional outpatient services (National Association of Psychiatric Health Systems, 1998). As these systems of care integrate outpatient treatment modalities, how can private practice groups adapt, survive, and thrive?

The trends toward less restrictive but more intensive outpatient care are clear. An area of treatment that fills a niche between traditional outpatient psychotherapy and PHPs may be found in intensive outpatient programs (IOPs). IOPs typically offer 3 to 4 hr of structured programming 3 to 5 times a week (e.g., American Association of Community Psychiatrists, 1998; American Society of Addiction Medicine, 1991; Kiser, Lefkowitz, Kennedy, & Knight, 1996; Kiser et al., 1998). Obviously, the cost for 9 to 15 hr of programming per week is considerably less than the typical 30 hr per week of partial programs and far less than 24-hr care.

Although some literature has evaluated the effectiveness of IOPs, these studies have focused on substance abuse populations, with whom such innovations have traditionally been less reliant on private insurance for reimbursement (e.g., Gottheil, 1997; Gottheil, Weinstein, Sterling, Lundy, & Serota, 1998). In contrast to substance abuse populations, it has been demonstrated that mental health utilizers with primary diagnoses of affective disorders tend to be White women between the ages of 25 and 64 years (Benson, Milazzo-Sayre, Rosenstein, Johnson, & Manderscheid, 1992). Additionally, one would expect the treatment of substance abusers to be somewhat different than the treatment of psychiatric patients, making any subsequent generalizations from the treatment of substance abusers to psychiatric patients complicated, if not unwarranted. The absence of mental health IOPs, as well as outcome and satisfaction studies, served as the impetus for this project.

Practice Expansion

There are many variables to consider for practitioners interested in expanding an existing practice. Benefits and risks must be assessed from economic, operational, political, and community perspectives. Obtaining "buy in" from practitioners already in the practice must be garnered on the basis of sound clinical, economic, and philosophical grounds. In our multidisciplinary group practice, this entailed a concerted and cooperative effort to become "managed care friendly." We needed services that not only differentiated our practice from others but also demonstrated our commitment to managed care objectives. This entailed the provision of related services, such as crisis intervention, brief group psycho-
therapy (Wise, 1998), costly outpatient services targeted toward difficult-to-treat patients, comparative cost efficiencies, and so forth, while providing high-quality care.

Once we made the decision to expand, obtaining financing, constructing space, locating personnel, obtaining licensure, building referral systems, and obtaining reimbursement became primary objectives. Although the details of each of these issues are beyond the scope of this article, suffice it to say that each of these areas must be handled with proper care and guidance. For example, obtaining contracts with national managed care companies to deliver the service and obtain reimbursement was extremely time-consuming, delicate, and difficult. Hiring consultants who already had contacts in these areas was helpful in terms of saving time and giving the message that we were serious about our new endeavor. We knew, however, that without contracts from national (vs. local) referral sources, it would be exceedingly difficult for the program to survive because of the penetration rates of managed care organizations (MCOs) in our area and other local market factors.

Issues involved in the actual delivery of the service must also be addressed. These issues range from hiring employees or independent contractors to providing the services by the existing group members. An added problem is the fact that in our market, most MCO panels are closed to new members. This makes it extremely difficult to expand by adding new providers and creates a market pressure to integrate existing private practitioners who are already credentialled on the panels that we were interested in serving. Finally, the addition of this service created increased demands on clinical, managerial, and clerical staff, thereby increasing the costs associated with maintaining a practice.

Program Description

This mental health IOP was developed in response to the increasing pressure to provide less restrictive and more cost-efficient levels of care for those in acute psychological distress. Although it typically requires a relatively large organizational structure to deliver 30 hr of PHP care a week, an IOP delivering 9 to 15 hr of treatment a week is more manageable for a small multidisciplinary group practice. In fact, our program, which is licensed by the state, meets 3 to 5 days a week for 3 hr per day. Clients must have at least one Axis I diagnosis and cannot be imminently suicidal, homicidal, or psychotic. Clients who are suicidal, but willing to enter a firm "no harm" contract, are accepted. The IOP requires a large group room, conference room, restrooms, and so forth, that are handicap-accessible.

The IOP consists of three primary components: affective, cognitive, and physiological. The process group is a traditional psychodynamically oriented group with an emphasis on confronting resistance to change, identifying current and repetitive relationship problems, and facilitating the expression of affect. In contrast, the skills groups are designed to address coping skills deficits in such areas as assertiveness, relaxation training, anger management, self-talk, and the implementation of practical solutions. Special focus groups are highly contingent on individual and group needs. Frequent educational topics include coping with loss and grief, physical illness, job stress, aloneness, conflict resolution, pain management, and so forth. Relaxation training, pain management, acceptance of chronic medical illness, and stress management are addressed in the physiological component of the program. All individuals also see a psychiatrist for medication consultation and management.

Pretreatment Assessment

All patients go through an intake screening process. During this time, a current psychosocial history is obtained, along with a mental status evaluation, and numerous forms are completed. Patients are specifically assessed to be sure that they meet the admission criteria mentioned above.

All patients complete the Symptom Checklist-90—Revised (SCL-90–R; Derogatis, 1983) before beginning the IOP. The SCL-90–R has been repeatedly demonstrated to be a valid and reliable measure of therapy outcomes in a wide variety of settings with a diversity of patient populations (Derogatis & Lazarus, 1994; Ogles, Lambert, & Masters, 1996; Piotrowski & Keller, 1989; Waskow & Parloff, 1975). The SCL-90–R is a self-administered 90-item rating scale (0–4) that consists of nine psychological symptom dimensions (Somaticization, Obsessive–Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism).

In addition to the symptom scales, there are three additional global indices that assess broad domains of psychological distress. Positive Symptom Total is a measure of the total number of symptoms endorsed. The Positive Symptom Distress Index reflects the average intensity of symptoms endorsed. The Global Severity Index is an overall measure of general distress. The latter scale is often used as a single global measure of psychological distress in psychotherapy outcome studies because it uses data from both the total number of symptoms endorsed and the intensity level of distress (Ogles et al., 1996).

Client satisfaction has been viewed as an important component of quality care that predicts compliance with treatment plans, likelihood of returning for future care if necessary, and clinical outcomes (Donabedian, 1985; Johnson & Shaha, 1996). Furthermore, client satisfaction surveys provide data consistent with total quality management, which focuses on defining, developing, and improving work and clinical processes (Zastowny, Stratmann, Adams, & Fox, 1995). A client satisfaction questionnaire was also constructed and administered. Midway through an earlier pilot study (Wise, 1999), we decided to use a standardized satisfaction instrument and began to use the Client Satisfaction Questionnaire (Aftkisson & Zwick, 1982).

During the last week of treatment, patients took the final discharge SCL-90–R along with the client satisfaction survey. In addition, other data regarding total number of visits, pre- and post-Global Assessments of Functioning (GAFs), diagnoses, and so forth, were obtained from the patients' charts.

Reliable change indices (RCIs) were calculated on all pretreatment and posttreatment measures. RCIs were introduced by Jacobson and Truax (1991) to determine if the magnitude of statistically significant differences in psychotherapy outcome studies reflected measurement error or significant clinical change beyond that accounted for by such error. The basic formula is RCI = (X2 - X1)/standard error of difference, where X2 is the posttest score and X1 is the pretest score (Streiner, 1998). Significant results are those greater than ±1.96. RCIs were calculated to assure the reliability of the findings, given the relatively small sample size. An effort was made to obtain data on all clients.
admitted to the IOP. All participants who completed treatment, pre- and post-SCL-90–Rs, and client satisfaction surveys were included in the study.

Posttreatment Findings

Consistent with Benson et al.’s (1992) data, this sample (N = 42) could be described as predominantly White (83%) women (86%) whose average age was 38 years. Because of the low number of men (14%) in the study, the data from both men and women were combined for all statistical analyses. The average number of years of education was 13.5. Twenty-three (55%) were employed. Twenty-five (60%) were married, 11 (26%) were single, and 6 (14%) were divorced. The majority (83%) of the sample was diagnosed with major depression, and 55% (23) had at least a second Axis I diagnosis, whereas 76% (32) also received a comorbid personality disorder diagnosis, most frequently with mixed (48%) and borderline (45%) features. Obviously, these were complex cases with multiple diagnostic features and multiple corresponding symptom targets.

Indeed, at the beginning of treatment, the average GAF was 30.86, indicating major impairment in several areas of life. More specifically, the majority of these patients were unable to work or carry out household duties, ignored family and friends, or demonstrated some impairment in reality testing or communication. Many of these patients (36%) also had previous psychiatric admissions (M = 1.53). The majority of the IOP patients were direct admissions (64%), whereas the remainder of patients were discharged from the hospital after stabilization and then were admitted to the IOP. At the time the study was conducted, the average time since discharge from the IOP was 334 days, or approximately 11 months.

The IOP outpatient sample’s pretreatment SCL-90–R average raw scores were compared with those of Derogatis’s (1983) psychiatric inpatient normative group by using unpaired t tests. To further clarify the pretreatment condition of the IOP sample, we also compared their SCL-90–R results with a group of 100 recently admitted psychiatric inpatient consecutive referrals for psychological evaluations. This local psychiatric inpatient group completed their SCL-90–Rs on an average of 3 days after admission.

Figure 1 demonstrates that the IOP sample was significantly more impaired than both inpatient samples on seven of nine clinical scales. Furthermore, the IOP sample was significantly more impaired than both hospitalized samples on all three of the global measures of symptom severity and distress. The Positive Symptom Total is not presented in Figure 1 because it is based on a different metric. Nonetheless, unpaired t tests demonstrated that the IOP sample endorsed significantly more total symptoms than both the local inpatient (p < .005) and national inpatient (p < .0001) samples.

When the sample was examined on the basis of pretreatment and posttreatment ratings of psychiatric symptomatology as measured by the SCL-90–R, significant treatment effects were obtained (Figure 2). More specifically, the SCL-90–R demonstrated very significant pretreatment and posttreatment paired t-test differences on seven of nine clinical scales. The Phobic Anxiety and Paranoid Ideation scales did not demonstrate pretreatment or posttreatment
Figure 2. Pretreatment and posttreatment Symptom Checklist-90—Revised mean scores.

Table 1

<table>
<thead>
<tr>
<th>Item</th>
<th>M</th>
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<tbody>
<tr>
<td>1. How satisfied are you with the facilities?</td>
<td>5.75</td>
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<tr>
<td>2. How satisfied are you with the staff?</td>
<td>5.85</td>
</tr>
<tr>
<td>3. How satisfied are you with the admitting process?</td>
<td>5.40</td>
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<tr>
<td>4. How satisfied are you with the helpfulness of treatment?</td>
<td>5.80</td>
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<tr>
<td>5. How satisfied are you with the amount of treatment?</td>
<td>5.82</td>
</tr>
<tr>
<td>6. How satisfied are you with your aftercare plans?</td>
<td>5.64</td>
</tr>
<tr>
<td>7. How satisfied are you with the overall quality of service?</td>
<td>5.95</td>
</tr>
<tr>
<td>Mean overall rating</td>
<td>5.70</td>
</tr>
</tbody>
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Note. The questions were rated as follows: 1 = highly dissatisfied, 2 = moderately dissatisfied, 3 = slightly dissatisfied, 4 = slightly satisfied, 5 = moderately satisfied, and 6 = highly satisfied.
difficulties, and biases against trying new services and competitive marketplace pressures. Another limitation was using our own client satisfaction survey, rather than one on which normative data had been collected.

Practice Implications

A mental health IOP can be a very effective treatment modality that can be carried out in the context of a group private practice setting. Patients must be screened for severity of pathology, lethality, and manageability. Nonetheless, patients with complex cases involving multiple diagnoses, significant levels of psychopathology, and severely disrupted activities in daily living were effectively treated in this program. Patients symptomatically worse than those hospitalized demonstrated significant improvements across 11 of 13 indicators, including specific symptom ratings, global measures of distress, and GAF scores. IOPs represent an opportunity and a niche in the market to treat severely depressed and anxious individuals on an outpatient basis, provided appropriate medical backup and higher levels of care are available when needed.

Major problems involved with offering these services include the increased risks related to treating acute patients, the financial outlay involved in the start-up and staffing costs, and difficulties associated with maintaining a consistent flow of referrals. In fact, our program was inoperable for several months during the first year on two occasions because of a lack of sufficient referrals. Thus, we continued to experience the costs associated with operating the program, but the program was not generating any revenue. Providers need to be financially prepared to weather these lean times and use them as marketing opportunities.

Numerous obstacles to the acceptance of new services have been identified and include provider and insurer bias, challenges to traditional beliefs about service delivery, and competing interests invested in maintaining the status quo (e.g., Goldstein & Horgan, 1988; Hoge, Davidson, & Hill, 1993; Piper et al., 1996; Washston, 1997). It has been somewhat surprising to learn that insurers are reluctant to flex mental health benefits for IOPs, even when they are willing to do so for PHPs or when the alternative is hospitalization. Although we continue to anticipate difficulties in obtaining reimbursement for this service and some bias against a new alternative model of care, we have found increasing acceptance of what we have demonstrated to be a safe, clinically effective, less costly, less restrictive, and highly rated consumer friendly service delivery model. Discussing the program with case managers and working up the chain of command to decision makers is one way to build internal support for these endeavors.

Private practice groups can adapt to market pressures by developing and implementing effective outpatient programs. If private practitioners do not adapt to the multitude of forces driving health care delivery, other providers will be called on to meet these needs. Alternatively, providing effective clinical services that are valued by gatekeepers and supported with research can provide strategies for growing a practice (e.g., Wise, 1998). The results presented from an earlier pilot study (Wise, 1999) were used in our efforts to market the IOP to MCO case managers, psychiatrists, physicians, employee assistance counselors, and other practicing mental health professionals, which produced contacts with new referral sources as well as an increase in actual referrals.

Providing this level of care differentiates our practice from others in our area. It also facilitates collaboration with larger systems of care, including hospital and MCO affiliations. That is, MCOs use this program for urgent and emergent situations that require immediate outpatient stabilization and treatment. At times, some of these patients require short-term hospitalization for stabilization. Subsequently, when we refer these individuals for hospitalization, we follow them for continuity of care and transition them back to the IOP when feasible. Developing relationships with MCOs, inpatient units, and PHPs is necessary to provide this level of continuity. Similarly, practices must be prepared to triage urgent and emergent cases by keeping hours routinely available and inviting cases in crisis. IOPs offer an opportunity to position group practices for future business by becoming an important treatment component in larger delivery systems and demonstrating outstanding treatment results and extremely high client satisfaction while maintaining the client at home.

References


