Advisory Board

Behavioral health cheat sheets

Understand the challenges we face — and get tactics to overcome them

Complimentary research

Overview

The U.S. behavioral health system is being pushed to its breaking point. The demand for service is unprecedented, the provider workforce is exhausted, and the recent investment in startups and new technology meant to create a more accessible system may be exacerbating its inequities.

Advisory Board has identified behavioral health as one of healthcare's most pressing cross-industry challenges. There are no magic bullets to solve the issues we face, but our researchers are continuously scanning the market to identify novel approaches and unconventional success stories in the behavioral health space.

These cheat sheets will help you understand how issues like inequity and the workforce shortage present themselves in behavioral health. And this research will describe how progressive organizations are incorporating tactics such as trauma-informed care, safe haven cafés, and collaborative care models to provide more effective care.

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CHEAT SHEET

Inequities in behavioral health

How inequities in behavioral health impact patients and health care stakeholders

By Sophia Duke-Mosier & Darby Sullivan • Published – July 5, 2022 • 10 min read

Key takeaways

- Regardless of demographic group, patients with behavioral health conditions experience unique inequities compared to patients with only physical health conditions.
- Within the behavioral health sector, certain demographic groups experience worse outcomes than others — often people of color, individuals with low incomes, insufficient insurance coverage, and/or with serious mental illness diagnoses.
- Inequities in behavioral health impact the financial outcomes of health care organizations.

What is it?

Behavioral health needs are worsening. There was a 28.5% increase in drug overdose deaths during the 12-month period ending in April 2021 compared to the previous year.

The pandemic and its ripple effects only exacerbated an existing crisis in the U.S. The behavioral health care sector struggles with a unique "meta" inequity that makes progress intractable:

- Inter-sector inequities: Regardless of demographic group, patients with behavioral health conditions experience unique inequities in access and outcomes compared to patients with only physical health conditions. For example, Americans with depression, bipolar disorder, or other serious mental illnesses die 15-30 years younger than those without mental illness.[1]
- Intra-sector inequities: Within the behavioral health sector, certain demographic groups experience worse outcomes than others — often patients of color, those with low incomes and insufficient insurance coverage, and/or those with serious mental illness diagnoses.

Source: "Drug Overdose Deaths in the U.S. Top 100,000 Annually," CDC, November 17, 2021; "The Largest Health Disparity We Don't Talk About," New York Times, May 2018, The Largest Health Disparity We Don't Talk About - The New York Times (nytimes.com);

1. The New York Times

Evidence of inequities

Inequities between demographic groups

Race and ethnicity	White middle-class women are more likely to receive a call back from therapists (20% of the time) compared to Black working-class men (1% of the time).[1] 48% of white adults received mental health services, compared to 31% of Black and Hispanic adults and 22% of Asian adults.[2]
Sexual orientation/ gender identity	LGBTQ+ individuals are 2.5 times more likely to experience depression, anxiety, and substance misuse compared to heterosexual, cisgender individuals.[2] The rate of suicide is highest in middle-aged white men. In 2020, men died by suicide 3.88 times more than women.[3]
Age	6.4% of adults ages 25+ have a substance use disorder compared to up to 20% of adults ages 65+.[4]
Socioeconomic status	62% of Medicaid beneficiaries have a co-morbid behavioral health condition compared to 40% of commercially insured patients.[5]
Language	Between 2014 and 2019, the Hispanic population in the United States grew by almost 5% but Spanish-language behavioral health services dropped by almost 18% in the same time period.[6]
Location	60.61% of rural areas are mental health professional shortage areas as of April 2022.[7]

1. Journal of Health and Social Behavior
2. Among adults with any mental illness, American Psychiatric Association
3. American Foundation for Suicide Prevention
4. Substance Abuse and Mental Health Services Administration
5. Based on analysis of adults hospitalized in Massachusetts acute care hospitals between July 1, 2017 and June 30, 2018.
6. American Psychiatric Association
7. U.S. Department of Health & Human Services

Source: "Behavioral Health and Readmissions in Massachusetts Acute Care Hospitals," Center for Health Information and Analysis; "Diversity & Health Equity Education: Lesbian, Gay, Bisexual, Transgender and Queer/Questioning," American Psychiatric Association; "Downward National Trends in Mental Health Treatment Offered in Spanish: State Differences by Proportion of Hispanic Residents," American Psychiatric Association, May 3, 2022; "Key Substance Use and Mental Health Indicators in the United States, SAMHSA, September 2018;" "Mental Health Disparities: Diverse Populations," American Psychiatric Association, December 19, 2017; "Shortage Areas," Health Resources & Services Administration, April 1,2022; "Suicide statistics," American Foundation for Suicide Prevention," February 17, 2022; "The Largest Health Disparity We Don't Talk About," New York Times, May 2018.

How does it impact healthcare organizations?

While behavioral health disparities have clear negative impacts for patients, they also have severe financial consequences for health care organizations.

Provider organizations

Provider organizations struggle to effectively care for patients with untreated behavioral health conditions. These unmet needs can exacerbate physical conditions and make it challenging for patients to adhere to care plans. Some patients may show up in the emergency department when their symptoms become severe, leading to avoidable costs and limited capacity consumed by less profitable cases.

Many provider organizations report a mismatch of expertise needed to treat presenting conditions and a lack of follow-up resources for patients in crisis. This strains staff workflow and morale.

Health plans

Health plans also face the financial burden of unnecessary utilization. For example, out of a population of 21 million insured individuals, those with both high-cost behavioral health conditions constituted 5.7% of the population but accounted for 44% of overall medical costs of the entire population.[1]

Life sciences companies

Life sciences companies that produce behavioral health therapeutics have a vested interest in reducing stigma, improving access to care, and supporting adherence to treatment. However, even life sciences companies without specific behavioral health products are impacted by disparities because patients with unmet behavioral health needs are less able to adhere to other prescribed treatments.

1. Milliman

Source: "How do individuals with behavioral health conditions contribute to physical and total healthcare spending," Milliman, August 13, 2020, https://www.milliman.com/en/insight/How-do-individuals-with-behavioral-health-conditions-contribute-to-physical

Conversations you should be having

01 Assess current inequities by collecting patient and member data with the ability to stratify outcomes and treatment by race, ethnicity, gender, age, and language (REGAL) data at a minimum.

02 Reflect on the ways that your organization or sector may be inadvertently exacerbating inequities in behavioral health.

03 Invest more in existing community-based efforts and follow their lead.

04 Be mindful of terminology and break down stigma by having open conversations around behavioral health.

These conversations are intended to help uncover behavioral health inequities and ways to address them, so that patients receive equitable treatment, regardless of identity.

CHEAT SHEET

Behavioral healthcare workforce shortage

Addressing growing demand of behavioral health services with limited professionals

By Sydney Moondra & Kate Vonderhaar Johnson • Published – June 30, 2022 • 10 min read

Key takeaways

- The behavioral health workforce shortage isn't exclusive to a particular type of clinician and includes a wide variety of professionals across the care continuum.
- The sheer number of professionals isn't the only facet of the behavioral health workforce shortage. Even if a professional is easily available in a patient's community, they may not accept all insurance or have the right clinical expertise for a patient's specific condition. The current workforce also lacks robust representation from marginalized populations, limiting choice for patients hoping to work with a professional who shares aspects of their identity.
- Factors affecting the supply of behavioral health professionals include high retirement rates with low entry rates, cumbersome reimbursement methods, emotional burnout, and policy and credential restrictions.

What is it?

There has been a long-standing mismatch between the demand for behavioral health services and available supply of behavioral health professionals. Even before the Covid-19 pandemic dramatically increased behavioral health needs, the Department of Health and Human Services estimated that by 2025, the supply of psychiatrists would fall short of demand by 25%.

The behavioral health workforce includes a wide array of roles that provide support to patients. Below is a non-exhaustive list of the most common behavioral health professionals. Licensure and certification for these jobs vary by specialty and state. Compared to the national job market's overall projected growth rate of 7.7% from 2020 to 2030, the demand for nearly every type of behavioral health professional is significant.

Role	Description	Education	Percent employment growth estimated between 2020-2030[1]
Psychiatrist	Psychiatrists are physicians who diagnose mental health conditions through evaluation and testing and can prescribe medication. They are able to provide talk therapy, but often focus specifically on medication management.	Medical degree (MD)	12.5%
Clinical Psychologist	These clinicians are trained to make diagnoses through evaluation and testing and provide behavioral therapy. Clinical psychologists work in a variety of settings including hospitals, independent practices, and schools.	Doctor of psychology degree (PsyD) or less commonly a PhD in psychology	10.4%

Source: "National Projections of Supply and Demand for Selected Behavioral Health Practitioners: 2013-2025," November 2016, *Health Resources and Services Administration/National Center for Health Workforce Analysis: Substance Abuse and Mental Health Services Administration/Office of Policy, Planning, and Innovation*; "Shortage Areas," *Health Resources and Services Administration Bureau of Health Workforce (BHW), Division of Policy and Shortage Designation (DPSD)*; "Types of Mental Health Professionals," *Mental Health America*; "Types of Mental Health Professionals," April 2020, *National Alliance on Mental Illness*; Advisory Board interviews and analysis.

WHAT IS IT? (CONT.)

Role	Description	Education	Percent employment growth estimated between 2020-2030
Counselor, Therapist (often used interchangeably)	These professionals evaluate individuals' mental health and use therapeutic techniques (such as psychodynamic therapy, cognitive behavioral therapy, play therapy, and exposure therapy) to provide care. This large category includes many job titles depending on the treatment setting and specialty. Common examples include Marriage and Family therapist (LMFT), Licensed Professional Counselor (LPC), and Licensed Mental Health Counselor (LMHC). [2]	Master's Degree in behavioral health related field	16.6%[1]
Psychiatric Nurse	Psychiatric nurses assist in assessing, diagnosing, and treating mental health conditions. In some states, they are qualified to prescribe medications.	Master's degree or doctorate in nursing, with specialization in psychiatry	7.4%
Clinical Social Worker	This group provides case management, advocacy services, education, and can assist with care delivery. Licensed clinical social workers are also able to provide counseling services.	Master's degree in social work (MSW)	14.9%
Community Health Worker	These individuals support patients through a variety of means including community outreach, client advocacy, and health education. These includes roles like health educator, public health aide, and health coach.	Highly variable based on state and employer but generally requires completion of a training program	21.0%
Certified Peer Specialists	These specialists are trained and certified individuals, often with lived experience of a behavioral health condition, who assist with recovery by providing support, mentoring, and guidance.	Training through certified peer support program. Hours and educational requirements vary	13.3%[3]

1. This represents the average percent employment growth rate of marriage and family therapists, rehabilitation counselors, and substance abuse, behavioral disorder, and mental health counselors.
2. Professionals who have "L" (meaning licensed) in their title have completed a minimum number of supervised hours to practice independently.
3. This is line item "Community and Social Service Specialists, all other" as "peer specialists" is not specified in the data.

Source: "National Projections of Supply and Demand for Selected Behavioral Health Practitioners: 2013-2025," November 2016, *Health Resources and Services Administration/National Center for Health Workforce Analysis;* "Types of Mental Health Professionals," Mental Health America; "Types of Mental Health Professionals," April 2020, National Alliance on Mental Illness; Advisory Board interviews and analysis.

WHAT IS IT? (CONT.)

To meet growing demand, the behavioral health workforce must include not only enough professionals by sheer numbers but also professionals who:

Match patients' geographic area

Offer affordable rates and accept patients' insurance

Have training to provide culturally humble care

Have the expertise required to treat patients' specific behavioral health conditions

Have capacity to treat new patients

Source: Advisory Board interviews and analysis.

Why does it matter?

A shortage of behavioral health professionals worsens access challenges for patients seeking care. It can take patients up to several months to find a provider — without the guarantee that they are the right fit.

When patients are unable to access preventative or low acuity care, their conditions often become more complex and severe. They may ultimately receive behavioral health care treatment in high acuity, high-cost sites of care like emergency rooms that often lack the resources and infrastructure needed to provide effective care. Furthermore, insufficient treatment of behavioral health conditions can worsen a patient's other comorbidities, increasing total cost of care.

A shortage in the behavioral health workforce also impacts equity. Some patients can access the limited professionals available more easily than others, which widens the gap in patient outcomes. For example, white middle-class women are more likely to receive a call back from therapists compared to Black working-class men (20% vs 1% of the time).[1] Geographic disparities in access persist too, as 45% of the U.S. population (151 million Americans) live in a designated mental health professional shortage area.[2] Telehealth can help support patients in areas without a sufficient supply of locally practicing professionals, but many rural or low-income patients do not have broadband internet access. And some severe mental illnesses can't be treated exclusively via telehealth.

1. Data from the Journal of Health and Social Behavior
2. Data from Health and Human Services data in June 2022

Source: Kuglemass, H., "'Sorry, I'm Not Accepting New Patients' An Audit Study in Access to Mental Health Care," June 2016, *Journal of Health and Social Behavior*; "Shortage Areas," *Health Resources and Services Administration Bureau of Health Workforce (BHW), Division of Policy and Shortage Designation (DPSD);* Advisory Board interviews and analysis.

How does it work?

There are several factors influencing the number and type of behavioral health professionals in the workforce:

Insufficient pipeline of professionals entering the field

The current rate of growth in the behavioral health workforce isn't enough to meet demand. Merritt Hawkins estimates that with nearly 60% of all practicing psychiatrists at least 55 years old, the industry could soon see a disproportionately high retirement rate compared to the number of psychiatrists entering the field. For many, behavioral health has become an unappealing sector of health care to join, especially considering increased acuity and demand of behavioral health needs as a result of Covid-19.

There is also a significant lack of representation of professionals with marginalized identities entering the workforce, making it difficult for some patients who wish to see a provider of a similar background. Being a professional with a particular identity doesn't guarantee the ability to deliver culturally humble or sensitive care — all behavioral health professionals must be able to provide culturally sensitive care for all patients. However, a diverse workforce provides more choice for patients who prefer to see a similarly identifying provider or need care in certain languages.

Inadequate and cumbersome reimbursement

Reimbursement structures for behavioral health care professionals are highly variable across states, professions, and payers. Participating in multiple health plans involves considerable paperwork for clinicians in return for reimbursement levels that may not feel worth the administrative burden. According to data from MACPAC[1], only 62% of psychiatrists accept commercial or Medicare insurance, just 35% accept Medicaid, while other clinicians don't accept insurance at all.

Source: Bishop, T., "Acceptance of Insurance by Psychiatrists and the Implication for Access to Mental Health Care," February 2014, *Jama Psychiatry;* Bresnick, J., "PCPs, Psychiatrists Much Less Likely to Accept Medicaid," 2019, *Health Payer Intelligence;* "Physician Supply Considerations: The Emerging Shortage of Medical Specialists," 2021, *Merritt Hawkins;* Advisory Board interviews and analysis.

1. Medicaid and CHIP Payment and Access Commission (MACPAC)

HOW DOES IT WORK? (CONT.)

Emotional labor and burnout

Behavioral health work is challenging and requires a significant amount of emotional labor from professionals. Along with other factors, emotional exhaustion from this field of work has contributed to 78% of psychiatrists reporting symptoms of high levels of burnout.[1] Without adequate support, the workforce is primed for rapid burnout and higher levels of turnover.

Policy and credentialing limitations

Federal and state policies regulate which behavioral health professionals can be reimbursed for certain types of care, along with where and how they may deliver that care. For example, policies may prevent a clinician in one state from delivering tele-behavioral care to a patient in a different state. The pandemic loosened these restrictions, for some temporarily and others permanently.

1. Data from The American Journal of Psychiatry

Source: Summers, R., "Well-Being, Burnout, and Depression Among North American Psychiatrists: The State of Our Profession," July 2020, *The American Journal of Psychiatry;* Advisory Board interviews and analysis.

Conversations you should be having

01 How are we investing in emotional support for our current behavioral health workforce? How can we reduce the administrative burden of their work?

02 Which patients in our community have a harder time accessing behavioral health care? What could we do to make access more equitable?

03 How can we partner with local stakeholders to build a diverse pipeline of behavioral health professionals for the roles with greatest demand?

04 Which state or federal policy changes would have the biggest impact on our ability to better meet behavioral health demand?

These conversations will help craft your approach to addressing the growing demand of behavioral health services with a limited supply of professionals.

CHEAT SHEET

Trauma-informed care

Why it's an essential framework for patient care and how to get started

By Darby Sullivan & Micha'le Simmons • Published – July 17, 2022 • 5 min read

Key takeaways

- Trauma has significant and enduring negative impacts on patients' health outcomes and is often an underlying barrier to effective self-management.
- Trauma-informed care requires that health care organizations make a cultural shift and equip care teams to address existing patient trauma. They must also adjust policies to avoid inadvertently re-traumatizing patients.

What is it?

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), trauma includes any experience that is "physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being." This can include enduring natural disasters, childhood abuse or neglect, interpersonal or community violence, systemic oppression, and/or discrimination. Additionally, trauma is often “contagious” and can be transmitted through generations, communities, and discriminatory societal systems. Trauma is an underlying risk factor for both the clinical and social complexity of high-risk patients. Without addressing the lingering impact of trauma, care teams will find limited success stabilizing patients in need.

Trauma-informed care is an institution-wide cultural shift that addresses patients’ underlying trauma and builds resilience. Health care organizations can do so by prioritizing the well-being of staff, developing training and tools to ready staff for successful patient interactions, and connecting patients with holistic follow-up care. Trauma-informed care centers on five principles: safety, choice, collaboration, trust, and empowerment. Under this approach, care teams and clinical leaders can create an environment that mitigates barriers to care.

Source: “Trauma,” SAMHSA-HRSA Center for Integrated Health Solutions; “What is Trauma-Informed Care?” University at Buffalo, 2015; Kimberg, L, “Beyond Compassion: Caring for Women with a History of Trauma,” Hive Symposium, 2016; Advisory Board interviews and analysis.

Why we can't ignore it

Health care organizations must adopt trauma-informed care to effectively manage the holistic needs of patients and meaningfully improve health outcomes. This approach prevents hospitals and health systems from unknowingly re-traumatizing patients, sowing patient distrust and alienation, and interfering with care plan adherence.

Trauma is widespread with severe clinical impacts

Studies indicate that as many as 90% of Americans have been exposed to traumatic events as defined by DSM-5[1] criteria. Unaddressed trauma across the life span can lead to long-term health consequences and is often a predictor of further trauma. The clinical impact of trauma in childhood, also called adverse childhood experiences (ACEs), is especially well studied. Patients with four or more ACEs are 4 times more likely to have COPD, 10 times more likely to use intravenous drugs, and 12 times more likely to attempt suicide.

IMPACT OF SIX OR MORE ACEs

20

Reduced years of life expectancy

Ways health systems can re-traumatize patients

Health care organizations that fail to understand the impact of trauma on health and take steps to mitigate these risk factors are at risk of re-traumatizing their most vulnerable patients. Common missteps include:

- Asking patients to retell sensitive or upsetting stories
- Requiring patients to disrobe for procedures
- Misgendering transgender or gender non-conforming patients
- Overworking burned out care teams
- Lacking mechanisms to root out implicit bias and institutional inequities

Source: Brown DW, et al., "Adverse Childhood Experiences and the Risk of Premature Mortality," American Journal of Preventive Medicine, November 2009; "Here's Why You Can't Overlook Trauma-Informed Care," Advisory Board's Care Transformation Center, June 2019; Kilpatrick DG, et al., "National Estimates of Exposure to Traumatic Events and PTSD Prevalence Using DSM-IV and DSM-5 Criteria," Journal of Traumatic Stress, October 2013; Felitti V, et al., "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults," American Journal of Preventive Medicine, 1998; Advisory Board interviews and analysis.

1. *Diagnostic and Statistical Manual* fifth edition.

How does it work?

To deliver trauma-informed care, start with an internal cultural shift that protects and uplifts the dignity and emotional well-being of all staff. Patient and staff relationships don't exist in a vacuum. They are part of the ecosystem of the entire organization. Nurture a positive work environment that mitigates stress and burnout so that frontline staff are emotionally prepared to support patients who have experienced trauma. Tactics include: paying staff a living wage, investing in diversity and inclusion initiatives, supporting a healthy work/life balance, and providing the support and tools to build clinical staff resilience.

Next, equip staff with the skills and tools to effectively provide education, conduct screens, and care for patients with underlying trauma. Distribute baseline surveys to identify staff's abilities to deal with stress and conflict. Then, launch an educational campaign to explain the foundational components of trauma-informed care, including how to avoid re-traumatizing patients. Train clinical staff on how to provide education about the effects of trauma on health, screen for and discuss traumatic events with patients, and build patient trust through patient-centered communication. Interventions should take a collaborative, strengths-based approach to support the resilience of trauma survivors.

Finally, connect patients with follow-up support to address mental health, clinical health, and social needs stemming from traumatic experiences to improve overall health. Provide options, but allow patients to decide and take ownership over their care. Resources should meet the full range of patients' clinical and non-clinical needs. In particular, staff should partner with community behavioral health providers to expand access to necessary treatment.

Source: "Trauma-Informed Care in Behavioral Health Services," Substance Abuse and Mental Health Services Administration, 2014; "Here's Why You Can't Overlook Trauma-Informed Care," Advisory Board's Care Transformation Center, June 2019; Advisory Board interviews and analysis.

Steps leaders should take

01 Conduct detailed research on the major causes of trauma in your communities, including quantitative analyses and input from patients and community leaders.

02 Identify clinical champions and form a working group on trauma-informed care to identify internal focus areas.

03 Ensure leadership commitment to creating a trauma-informed organizational culture.

04 Identify community-based partners who can help design trauma-informed policies and interventions.

05 Determine a strategy for training care teams on trauma-informed principles and how to adjust existing workflows.

06 Catalog and address current policies and procedures that could cause re-traumatization.

Conversations about trauma are difficult — from both the patient and clinician perspective. However, organizations must be proactive about addressing how trauma impacts health outcomes. Health care leaders have an opportunity to facilitate consistent community and patient participation throughout their journey to create a trauma-informed culture.

Source: Advisory Board interviews and analysis.

CHEAT SHEET

Collaborative care model

Embedding a behavioral health provider in a PCP office

By Sally Kim & Adam Jacobs • Published – March 19, 2022 • 15 min read

Key takeaways

- Backed by a great deal of research, the collaborative care model (CoCM) is one of the best programs for integrating medical and mental healthcare.
- The CoCM embeds behavioral health providers in a PCP office to increase access.
- The model's focus on depression and anxiety helps quickly identify and treat the two most common mental health illnesses.
- The CoCM is designed to cut through the access and stigma barriers that prevent patients from accessing behavioral health care.

What is it?

Integrated behavioral health care combines physical and mental health care to collaboratively address issues identified during primary care visits. Primary care providers (PCPs) and behavioral health (BH) specialists work together to address mental health and behaviors that affect physical health.

The collaborative care model (CoCM) is a specific type of integrated care in which PCPs and embedded BH providers — in one office — treat common mental health conditions. The CoCM's guiding principles are:

- A focus on depression and anxiety, the most common BH conditions
- Universal screening for all patients
- An embedded BH care manager, ready for a warm handoff from the PCP
- Behavioral health care delivered inside the PCP office
- Consulting psychiatrist on standby to assist with referrals or treatment

The CoCM, which was first conceived 20 years ago, has evolved over time. Three variations on the CoCM that have become popular in practice are:

Telephone-based: Several programs use a BH professional to deliver care over the phone, rather than in person.

Illness-specific: Designed to target anxiety specifically, the Coordinated Anxiety Learning and Management (CALM) intervention builds on the CoCM by spending more time educating patients on the nature of their condition before diving into Cognitive Behavioral Therapy.

Screening-focused: Intermountain Healthcare's variant of the CoCM puts more emphasis on screening, using a questionnaire significantly more detailed than the GAD-7[1] or PHQ-9[2] to begin their integration workflow.

1. General Anxiety Disorder #7, a patient health questionnaire.
2. Patient Health Questionnaire #9, a patient health measure of depression.

Why does it matter?

Higher-quality care

Mental illnesses are some of the most common and destructive illnesses worldwide. While evidence-based practices for behavioral health care exist, most people in need don't receive effective care due to stigma, lack of access to mental health specialists, and patients prematurely halting treatment. The CoCM helps people get the coordinated care they need in a familiar setting.

Under the CoCM, a patient can walk into their PCP office for a sore throat, wellness check, or a therapy session with the BH care manager without any other patients knowing the purpose of the visit. Some patients may decline treatment when forced to visit a BH provider office for the first time due to the stigma of mental illness. While many patients may not have access to a behavioral health clinic or specialist, most people have access to a primary care provider, which, in a collaborative care setting, could expand access to mental health care. This integrated approach to mental health treatment makes it more accessible than traditional care protocols.

Currently, the behavioral health terrain is deeply fragmented. Without behavioral health integration, patients, PCPs, and BH providers are siloed, preventing them from coordinating care on key patient indicators such as treatment progress and medication adherence. With the CoCM, patients receive higher-quality care because it is coordinated between all the different treatment plans they may already be receiving.

WHY DOES IT MATTER? (CONT.)

Reduced costs

Costs spike when BH conditions are left untreated. There are estimates that unaddressed behavioral health issues cost almost $68 billion per year in the United States.

As the CoCM is a PCP-centric model, it allows for easier treatment of comorbidities. Sixty percent of patients with a behavioral health illness carry a comorbid chronic physical condition. The collaborative care model can treat multiple diagnoses at once.

86

Days to remission of depression under the collaborative care model compared to **614 days** under typical care

79

Studies associate the CoCM with significant improvements in depression and anxiety when compared to typical care

Source: Garrison GM, *et al.* "Time to Remission for Depression with Collaborative Care Management (CCM) in Primary Care" *Journal of American Board Family Medicine.* January 2016. Archer J, *et al.* Collaborative care for depression and anxiety problems." Cochrane Database of Systematic Reviews 2012, Issue 10, https://www.cochrane.org/CD006525/DEPRESSN_collaborative-care-for-people-with-depression-and-anxiety.

How does it work?

Secure initial investment to set up the model

The CoCM can take time and be costly to launch, given that it requires new staff members and office procedures. Often, providers rely on grants to fund the embedded BH care manager and maintenance costs. One survey found that 78% of integrated care clinics reported covering costs with grant funding. The Institute for Clinician and Economic Reform found that organizations would need to invest anywhere from $3 to $22 per member per month to implement and sustain the collaborative care model.

Health plans, however, will also need to ensure that this doesn't mean members have to pay this additional fee out of their own pockets. First-time patients in the CoCM could end up stuck with a copay from both their PCP and their BH provider. Health plans utilizing the CoCM should ensure that their claims process doesn't charge members for both copays. Plans often justify the additional up-front costs of implementing the CoCM by pointing to the litany of quantitative metrics the CoCM performs against, such as the PHQ-9.

Embed BH provider in PCP office

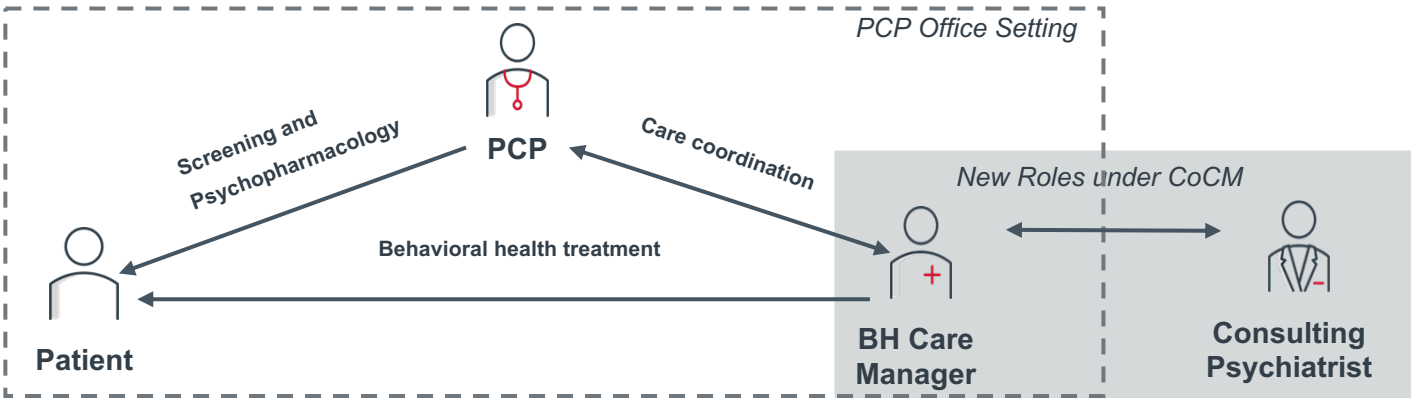
The BH care manager embedded in each PCP office could be a social worker, psychologist, master's level clinician, or other licensed behavioral health professional. If the behavioral health condition requires treatment, the mental health professional can deliver therapy in the PCP office for as long as necessary. Should the condition require medication, the patient's PCP can collaborate with the BH care manager and prescribe appropriately. This collaborative approach doesn't require a set number of staff in each office — only the introduction of a BH care manager, allowing the program to scale depending on the size of the office. The collaborative care model stands apart from other integration models for behavioral health care because of its potential to serve any community, regardless of size.

Source: "Enhancing patient outcomes and health system value through integration of behavioral health into primary care," ICER, June 2015, https://icer.org/wp-content/uploads/2020/10/BHI_Policy_Brief_060215.pdf. "The Colorado blueprint for promoting integrated care sustainability," Denver, CO: The Colorado Health Foundation, 2012.

HOW DOES IT WORK? (CONT.)

Some PCPs may support the implementation of a collaborative care model. But their staff may disapprove, disliking cooperation with "outsiders" who aren't fully fledged members of the practice. Health plans instituting the CoCM with provider partners need to keep company culture top-of-mind when hiring BH care managers, to ensure seamless integration.

The collaborative care model structure



Set up triage protocols for severe mental illness

The CoCM does not focus on treating high-acuity behavioral health conditions. The program can't use its signature in-office treatment protocols for complex issues like substance use disorders, OCD, PTSD, ADHD, and other similar conditions due to their treatment complexity. While the model isn't designed for high-acuity conditions, there are protocols in place to ensure even the most complex, chronic patients can receive care.

In the event of a seriously mentally ill patient, the behavioral health care manager can turn to a consulting psychiatrist who serves several BH care managers as shown in the graphic above. The psychiatrist can make a referral, take on the patient themselves, and/or prescribe medicine.

Source: "Enhancing patient outcomes and health system value through integration of behavioral health into primary care," ICER, June 2015, https://icer.org/wp-content/uploads/2020/10/BHI_Policy_Brief_060215.pdf

Conversations you should be having

01 Determine what models your provider partners currently have in place for behavioral health care integration.

02 Find out how well the current integration models are performing against your desired behavioral health metrics.

03 Decide if you should work with select provider partners to implement the collaborative care model.

04 Determine what supports your provider partners need from you to integrate behavioral health care.

These conversations might uncover the need to audit your current behavioral health integration efforts to ensure a comprehensive and scalable approach.

CHEAT SHEET

Safe haven cafés

Understand the challenges we face — and get tactics to overcome them

By Isis Monteiro • Published – March 4, 2022 • 10 min read

Key takeaways

- Safe Haven Cafés are alternatives to the emergency department (ED) for patients experiencing behavioral or mental health needs. Safe Haven Cafés are safe, calm outpatient spaces located on or near a hospital campus. Patients can relax in these spaces, receive support from mental health clinicians and peer support workers, learn self-management skills, and access follow-up resources.
- The specifics of each Safe Haven Café — including range of services, number and skill mix of staff, hours of operation, and referral pathways — differ across locations to best suit patient needs and staff capacity.
- Safe Haven Cafés can improve patient experience, improve outcomes, and reduce mental health-related ED presentations — which can lead to cost savings for providers.
- Key hurdles to creating Safe Haven Cafés are capital and operational costs, particularly in contexts where government funding for the program is unavailable. Staff supply can be another hurdle.

What are they?

Safe Haven Cafés, sometimes called Crisis Cafés, are designated areas on or near a hospital campus that provide a calm, safe alternative to the emergency department for patients experiencing behavioral or mental health needs. They can be housed in sub-acute units, new or repurposed buildings or office spaces, or community clinics. The goal of Safe Haven Cafés is to de-escalate patients experiencing a behavioral or mental health crisis and connect those patients with self-management tools and skills, as well as follow-up resources or treatments.

Safe Haven Cafés originated in 2014 in Aldershot, England, and were first replicated internationally in Melbourne, Australia, four years later. Since 2018, several Australian states — including New South Wales and Western Australia — have implemented the model as part of their strategies to reduce suicides by improving access to mental health services and expanding ED alternatives for psychiatric patients.

1. Inpatient care management relies more heavily on RNs and social workers to staff their programs.

Source: Advisory Board interviews and analysis.

Why do they matter?

Health systems around the world are facing unprecedented demand for emergency services, and psychiatric patients make up a significant portion of this demand. For example, in Australia there were 310,471 ED presentations related to mental health across all public systems between 2019-2020. And in the U.K., 83,500 ED presentations between 2020-2021 were patients with depressive disorder. Emergency departments are often not the most appropriate site of care for patients experiencing a mental or behavioral health need. The hectic environment of an ED may exacerbate mental health conditions and lead to a “dehumanizing” patient experience.

Safe Haven Cafés are gaining prominence across the U.K. and Australia because they help alleviate capacity pressures by providing a safe, effective option for patients who would otherwise contribute to overwhelming ED demand. These spaces reduce ED presentations and admissions that are related to mental health issues, leading to cost savings for providers. The Safe Haven Café at St. Vincent Hospital in Melbourne, for instance, produced an estimated cost savings of $33,860AUD in 2018 by diverting patients away from the ED.

This model is especially timely given that providers are working to shift access points and services away from the hospital and toward new sites and modalities. Factors driving this push include sustainability pressures caused by increased patient demand, changes in consumer preferences, out-of-hospital payment parity, the rise of flexible staffing models, and the Covid-19 pandemic.

How do they work?

Existing Safe Haven Cafés are typically funded through government block grants and involve ongoing collaboration between hospitals, community partners, nonprofit organizations, and volunteers.

Salaries and wages for mental health clinicians and peer support workers may comprise more than 90% of recurring operational costs. Other recurring costs include overhead and goods and services, including hot drinks and snacks. Capital investment will largely depend on the location of the Safe Haven Café. Organizations repurposing existing spaces will have substantially lower up-front and recurring investments.

Most Safe Haven Cafés are open only during off-hours that coincide with peaks in psychiatric presentations to the ED. Some locations are testing 24/7 services and virtual models.

Patients generally access Safe Haven Cafés three ways:

1. **Drop-in.** Most Safe Haven Cafés are open to the public with few exceptions, including patients needing urgent medical intervention or under the influence of substances. Exclusion criteria vary by location.

2. **ED referral or triage**. Most Safe Haven Cafés don't require referrals, but those still in pilot phase may initially restrict access to curb demand. More commonly, patients who present to the ED are escorted to the Safe Haven Café by a peer support worker or other staff member without a referral.

3. **Police department triage.** Safe Haven Cafés may also work with police departments to automatically transfer patients to the site.

Source: Advisory Board, "Enrollment and graduation aren't just for students: Clear guidelines optimize care management programs," Care Transformation Blog; Advisory Board interviews and analysis.

How do they work? (continued)

The level of care provided at Safe Haven Cafés depends on the number and skill mix of staff. Safe Haven Cafés are typically staffed by hospital or third-party **mental health clinicians; peer support workers with lived experience** of mental or behavioral health needs; and unpaid **community volunteers**. Staff most often provide non-clinical services, such as emotional support, self-management skills training, referrals to follow-up specialist or inpatient services, and access to local resources.

Up to 80% of patients return for subsequent visits and bring in other patients by sharing their positive experiences.

Source: Advisory Board, "Enrollment and graduation aren't just for students: Clear guidelines optimize care management programs," Care Transformation Blog; Advisory Board interviews and analysis.

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Questions to consider

01 What are the specific needs of your patient population and who is best equipped to deliver those services?

02 Where is the most cost-efficient and accessible location for a Safe Haven Café in your area?

03 How can you best capture and incorporate feedback to continuously improve patient and staff experience?

04 What funding is needed and available, and how can you secure it?

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