Optimizing Behavioral Health Access and Treatment Within Our Existing Delivery System

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The Menges Group

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Introduction

- Evidence continues to accumulate showing that the US population overall -- and the Medicaid population in particular -- is falling far short of accessing needed behavioral health (BH) therapy and medications.
- BH provider capacity shortfalls are, appropriately, often a focal point of efforts to create improvements.
- While important effort and innovation is underway to broaden the future **supply** of BH providers, including creating increased access to BH services in primary care and other medical settings, this edition explores potential opportunities to deploy the **existing** BH delivery system in a manner that can free up capacity to better serve persons who are accessing too few BH services (including many who are currently receiving none whatsoever).
- Our focus in these slides is particularly on reducing gaps in BH care for the Medicaid population.

The Standard Psychotherapy Model is Incredibly Capacity-Consuming

One Provider Is Fully Dedicated to One Patient for One Hour

This ratio worsens once factoring in time spent scheduling/re-scheduling visits, cataloging and reviewing notes, processing prescriptions, invoicing, complying with payer requirements, etc.

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Can We Reimagine the Psychotherapy Model (for some patients) to Get More Medicaid Enrollees Into Care?

- In what situations can therapy visits and assessments be successfully conducted in less time?
  - If the average visit duration can be decreased (with shorter "maintenance check-ins" for some patients), a provider's capacity opens up to also support some persons who are currently not in care.
- Similarly, to what extent can the timeframe between visits be widened for *some* patients at no/minimal clinical detriment, to free up some of a provider's capacity?
- Can the overall mix of care move more towards group therapy, better leveraging the provider's time and creating a peer support dynamic among patients with similar needs?
  - 5 persons receiving only individual therapy once every two weeks would require 130 annual hours of therapist clinical time. If these persons received alternating sessions of individual therapy and group therapy (with all five participating), the therapist time dedicated to these five persons would drop to 78 hours – a 40% reduction. Note that under such a reconfiguration the provider's non-therapy time burden for these five persons would not likely be reduced much, if at all.
  - Increased group therapy is not realistic for providers not trained in (or comfortable with) this model, nor for many patients based on their diagnoses, preferences, and other circumstances. Many patients may be receiving too much group therapy and too little individual support. Nonetheless, the benefits of group therapy warrant consideration – particularly in Medicaid with *so many* enrollees not receiving adequate BH care.

Telehealth Policies and Practice Approaches Are Key to Leveraging Available BH Provider Capacity

Telehealth Advantages for Providers

- Current commuting time can be converted to patient care time.
- Considerable reduction in practice costs occurs, especially if provider reaches 100% virtual model.
- Time spent maintaining a business office outside the home is also freed up.
- Providers can equally support a patient from vast set of locations (e.g., when away from home).
- Reduction in missed appointments due to the corresponding patient convenience.

Telehealth Advantages for Patients

- A **much** wider set of providers can be accessed.
- Commuting to receive care is no longer needed. Telehealth via phones and personal computers saves time, eliminates transportation costs, and reduces childcare coverage challenges.
- All the above makes appointments easier to attend.

For patients and providers, video meetings (Teams, Zoom, etc.) preserve some of the advantages that face-to-face interactions hold over purely telephonic conversations. However, further advantages of face-to-face visits (e.g., better ability to identify/assess tremors) exist and also need to be considered at the "one patient" level.

A Significant Gap in BH Medication Access Exists – But an Ample Pill Supply is Available

"Water water everywhere…. But not a drop to drink."

Opportunity Examples for Health Plans

- Take systematic, strong and immediate action when a BH refill is seemingly missed. This involves outreach to the prescribing provider, pharmacy, enrollee, and/or caregiver, most often using low-cost technology "pings".
- Aggressively outreach to persons (and their prescribers) when access to BH medications has stopped– especially for persons who previously received BH crisis level care and/or have conditions that generally require pharmacological treatment.
- Identify through data analytics members whose conditions typically warrant BH medication regimens – but who are yet to access any BH medications. Work to connect members to providers who can conduct further assessments; then partner with these providers to introduce medication support where deemed appropriate.
- Extend days supply -- where legally permissible -- for persons with a good adherence track record. (This parallels for enrollees what health plans often do in removing prior authorization requirements for physicians who are almost never experiencing a denial).
- Use mail service more often. Opportunities to enhance mail service particularly exist in Medicaid, e.g., for persons with longstanding eligibility, and who have a safe/stable mailbox. Existing mail service policies sometimes presume *all* Medicaid enrollees have neither of these characteristics.
- Deliver more education and outreach support to overcome patient reluctance to taking and maintaining recommended BH medications (e.g., to address unwelcome side effects such as weight gain).

A Few More "Ask the Audience" Questions

- When is/isn't the value of face-to-face visits worth crowding out many persons from receiving *any* BH care – given that conversational care can be delivered via telehealth (and that more patient care per provider can occur via telehealth than via face-to-face interaction)?
- How should we create value-based payment incentives for BH providers to treat persons who have unmet needs? For example, is the second half-hour of assessment/treatment/therapy for a person already in consistent care as clinically beneficial as the first half-hour for a person who is currently without care? These dynamics and questions also apply to interjecting more group therapy, and to widening the interval between some existing patient visits – so that more persons can be treated.
- How can we compensate front-line BH providers better – particularly when they widen their involvement serving the Medicaid population and successfully eliminate gaps in BH care?
- Should any of the regulatory protections that prevent suboptimal prescribing outcomes -- but which also inhibit access to BH medications for persons with current unmet needs -- be revisited?
- How can we do more to identify and address situations where a person has stopped their BH regimen?
- Are we doing all we can to make optimal use of existing BH provider capacity as we work to increase the overall supply of BH providers?

5 Slide Series Overview

Our 5 Slide Series is typically a monthly publication whereby we briefly discuss/address a selected topic outside the confines of our client engagements. The Menges Group has developed a variety of datasets that we use to support our 5 Slide Series and client projects.

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