WHITEPAPER

Addressing the Behavioral Health Shortage Through Care Collaboration

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), there were over 20 million people, aged 12 or older, with a substance use disorder (SUD) and nearly 45 million adults with a mental health condition in the United States in 2016.[1]

The demand for behavioral health professionals continues to rise as the amount of people struggling with substance use or mental health disorders does, too. The shortage of behavioral health professionals combined with the rising costs of caring for complex behavioral health patients opens the door for care collaboration to create efficiencies that lead to reduced costs and better outcomes.

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Behavioral Health Shortage

The Health Resources & Services Administration (HRSA) conducted a workforce projection for a variety of behavioral health occupations. It has estimated major deficits for addiction counselors, psychiatrists, and mental health and school counselors between 2016 and 2030.[2] These shortages range from nearly 7,000 to over 40,000 needed behavioral health professionals.

Rural areas are facing an even bigger shortage. An analysis found that out of non-metropolitan counties in the US, nearly half lacked a psychologist, 65 percent lacked a psychiatrist, and over 80 percent lacked a psychiatric nurse practitioner.[3] The supply of behavioral health providers was even more dismal in counties with populations of less than 10,000.

The High Cost of Behavioral Health Conditions

Behavioral health conditions are costly to patients, the US healthcare system, and the national and global economy. Any effort in addressing the unsustainable costs of healthcare in the US must include strategies for reducing behavioral health spending.

America's Mental Health 2018, a comprehensive study of mental healthcare access, found that 42 percent of the population cited cost and poor insurance coverage as top barriers for accessing mental health care, with 25 percent reporting having to choose between getting treatment and paying for daily necessities.[4]

Basics: Behavioral Health

For the purpose of this whitepaper, behavioral health includes both mental health and substance use disorders. The term encompasses the prevention and treatment of these disorders by a variety of healthcare professionals such as physicians, nurses, social workers, psychiatrists, psychologists, and counselors.

According to one study, mental disorders ranked number one on the list of the most costly health conditions in the United States, with annual spending estimated to be over $200 billion.[5] Additionally, the US healthcare system spends around $35 billion per year treating SUDs across public and private payers.[6]

Social and economic costs for substance use disorders have been estimated at more than $400 billion in the US.[6] These include spending associated with compromised physical health, increased crime and violence (including costs incurred by the criminal justice system), neglect of children, and loss of productivity.

For mental disorders, lost earnings cost the US economy over $193 billion annually in productivity.[7] On a global scale, depression and anxiety disorders alone cost the world's 36 largest countries $935 billion per year in lost productivity, according to an analysis published in The Lancet.[8]

Overall, behavioral health disorders are among the most undermanaged, and therefore most expensive, conditions to treat—having significant impact on patients, health systems, and economies. Addressing these conditions through legislation and collaboration can help improve outcomes for patients, communities, and providers.

Government Initiatives

Around 10 million Americans with a behavioral health diagnosis are enrolled in Medicaid, making it the single largest payer for mental health services in the US.[9,10] Medicaid expansion and financing can help remove barriers and provide care to those who may not otherwise afford it.[9] This can help states provide consistent behavioral health care and allow individuals to qualify based on income, rather than disability, determinations.

In addition to Medicaid initiatives, some states have passed legislation to help provide expanded behavioral care—including legislation that addresses social determinants of care, which have been found to overlap with mental and behavioral health conditions.

According to a 2018 report by the US Department of Housing and Urban Development, nearly 36 percent of homeless persons have a chronic SUD and/or a severe mental illness.[11] By addressing social determinants of health, care teams can help address behavioral health conditions in their communities.

Several states are addressing the link between social determinants and behavioral health with targeted legislation. For example, California Senate Bill 1152, enacted in 2018, placed a range of requirements on hospitals for homeless patients.[12] These requirements include enhanced discharge plans, coordination with community providers, and logging hospital encounters. These discharge plans and coordination efforts help ensure outpatient behavioral health support.

The Role of Collaboration

Comorbidity

Over 68 percent of adults with a mental disorder have reported having at least one general medical condition.[14] Of those with a medical condition, 29 percent had a comorbid mental health disorder.

This overlap in medical and behavioral health conditions can make it more challenging to treat patients, due to the complexity of having comorbid conditions and the challenge of coordinating with a multitude of care team members. People with mental and substance use disorders are less likely to receive preventative care, as time and expertise constraints may prevent primary care providers from treating severe mental illness.[14] At the same time, mental health providers may not be able to treat medical conditions.

A report by The Synthesis Project on mental and medical comorbidity states, "At a system level, fragmentation and separation between the medical and mental health care systems result in individuals with comorbid conditions receiving care from multiple uncoordinated locations."[14] This uncoordinated care ultimately stunts progress in being able to treat both conditions effectively—negatively impacting patient health outcomes and increasing the cost of care.

Behavioral Health for Children

Announced in 2018, The Integrated Care for Kids (InCK) Model was designed to reduce expenditures and improve care quality for children covered by Medicaid and the Children's Health Insurance Program (CHIP).[13]

According to the US Department of Health and Human Services, one in three children enrolled in Medicaid and CHIP have behavioral health needs, yet only a third receive the care they need.[13] The InCK Model helps prevent, identify, and treat behavioral health concerns affecting children—including the impact of the opioid crisis.

42 CFR Part 2

Knowing the importance of collaboration, some may wonder why care coordination is not more readily accepted. One potential barrier to care coordination for behavioral health is the Federal Confidentiality of Alcohol and Drug Abuse Patient Records Regulations—more commonly known as 42 CFR Part 2. These regulations restrict the disclosure of any information by a Part 2 program that would identify a patient as having a substance use disorder.

Amendments in 2017 and 2018, along with proposed updates in 2019, have made it easier to share Part 2 information with relevant providers and eliminate some barriers to care coordination.[15,16,17] Yet, many electronic health record (EHR) systems, health information exchanges (HIEs), and other care coordination systems don't have the technological capability to share specific, consented information.[18] This means, despite amendments, care teams may never see certain pieces of critical information when making care decisions.

Implementing solutions to share behavioral health information in line with 42 CFR Part 2 consent requirements removes significant obstacles that care teams face when coordinating care for at-risk behavioral health patients.

Recommendations for Care Coordination

Improving the Quality of Health Care for Mental and Substance-Use Conditions, published by the Institute of Medicine of the National Academies, states that "care coordination is the outcome of effective collaboration."[19] The cited benefits and outcomes of coordinated care include preventing negative drug interactions and redundant care processes, reducing waste of healthcare system resources and of a patient's time, and promoting accurate diagnosis and treatment because all providers are receiving relevant information from all other providers caring for that patient.

Chapter five, "Coordinating Care for Better Mental, Substance-Use, and General Health", recommends several structures and processes that health care providers can use to promote collaboration and coordinated care.[19] These strategies include screening for comorbid conditions, collocation or integration of behavioral health care into primary care settings, shared patient records, and case or care management services. Lastly, the authors recommend formal agreements with external providers, which makes use of existing community resources and requires fewer resources than collocated services.

The following success stories showcase how care teams and organizations across the nation have implemented strategies similar to those mentioned in *Improving the Quality of Health Care for Mental and Substance-Use Conditions*. These successful strategies include case or care management services, sharing unified patient records and care plans, and integrating or outsourcing behavioral care to specialized programs developed with community resources to better care for these patients.

Success Stories

Sturdy Memorial Hospital

Sturdy Memorial Hospital (SMH)—a small, independent hospital in southeastern Massachusetts—experiences around 50,000 ED visits annually. But the 132-bed facility isn't affiliated with any other hospital, making it challenging to find beds or funding for their behavioral health patients. Brian Patel, MD, Chief Emergency Services and Associate Chief Quality Officer at SMH explained the biggest challenge staff face:

"Boarding of behavioral health patients is one of our biggest issues. We're trying to address ways to minimize ED boarding for these patients, and it begins with taking the time to stop and really look at these patients, evaluate their length of stay and dispositions, and develop a plan for reducing ED utilization."

Sturdy started gaining insight into behavioral health patients with patterns of high utilization using Collective's platform. Once identified, these patients were then assigned a case manager within an outpatient program to help them manage their complex conditions.

Sturdy Memorial Outcomes

Having case managers and a dedicated program has helped SMH *decrease ED utilization by enrolled behavioral health patients by 78 percent*—allowing patients to receive better care in more appropriate settings.[20]

Aspire Health Alliance

MassHealth, the Massachusetts Medicaid healthcare system, provides care for a quarter of the state's population. Of those lives, half of the state's budget is spent on helping a mere 5 percent of the population.

Aspire Health Alliance in Boston, Massachusetts, works to produce better healthcare outcomes for patients with complex needs—while reducing the cost of healthcare. Its Behavioral Health Community Partner (BHCP) program focuses on individuals struggling with behavioral health conditions, including substance use disorders, by connecting them to appropriate specialists with the goal of improving health outcomes and reducing unnecessary ED utilization.

However, many of these patients are affected by social determinants of health—such as homelessness—that make contacting them challenging. Getting these patients enrolled into the BHCP program seemed impossible when case managers were unable to even contact the patient.

To help boost communication and enrollment, Aspire began receiving real-time notifications each time a patient presented at the hospital. This notification would go immediately to the appropriate case manager, who could then call the hospital and coordinate a visit.

Being able to meet with these patients at the point of care, case managers were able to talk with patients about the BHCP program and other resources available. With this intervention, patient enrollment increased and better care followed. Deborah Jean Parsons, Director of Integrated Care at Aspire, explains:

"The event notifications are a way to find people and engage them while they're in the ED. In this acute state—this crisis state—we find a higher rate of engagement. If we send our people to the hospital, we can coordinate with a social worker to say 'Look, this is a free service from MassHealth for you. I'm here to help you get what you need; how can I help?'"

Aspire Outcomes

The results from visiting these patients during their hospital stay have been measurable and significant. Utilizing Collective's real-time notifications, Aspire Health Alliance has been able to *raise patient engagement from 20 percent to 50 percent—a 150 percent increase.*[21]

Northwest Physicians Network

Northwest Physicians Network (NPN)—an independent physician association in Tacoma, Washington—created a collaborative community effort with local fire departments and other providers after realizing there were a significant number of patients utilizing emergency medical services to address their complex conditions like substance use disorders and mental health conditions.

Pierce County received funding to launch the Mobile Community Intervention Response Team (MCIRT), consisting of two psychiatric advanced registered nurse practitioners, three registered nurses, seven care coordinators, and various other licensed mental health providers. This rapid response team was designed to provide the comprehensive behavioral care that emergency services were not equipped to provide.

Northwest Physicans Network Outcomes

The collaborative efforts between NPN, MCIRT, and Pierce County emergency services have paid off. The community has seen the following results:[22]

- 44 percent fewer 911 calls
- 47 percent decrease in EMS transport
- 36 percent reduction in ED visits
- 42 percent decrease in hospital admissions
- 31 percent drop in observation stays

Navos Mental Health Solutions

Navos Mental Health Solutions serves patients with moderate to severe mental health conditions and substance use disorders through residential, community, inpatient psychiatric hospital, outpatient, crisis, and afterhours services.

Tracking these complex patients that often visited a variety of care settings was a challenge. Jennifer Neumann, LICSW and Clinical Systems Analyst at Navos, explained:

"We weren't able to tell when our patients were in the hospital and when they were discharged. We might get a call from the hospital, or we might not. Often, it was not. This made it difficult to know who we should be following up with and when."

Navos turned to a care coordination platform to track and identify the highest risk patients. Navos staff could then work collaboratively with pharmacists, nurses, and other care team members to determine care plans that were then housed within the platform.

Additionally, Navos implemented the Peer Bridger Program to help patients struggling with substance use disorder or mental health conditions transition back into their homes and communities. Each peer has struggled with many of the same challenges and help guide patients in an empathetic and understanding way.

Navos Outcomes

Real-time notifications in combination with regularly generated reports has led to a *15 percent increase in 7-day follow-up rates* and patients being twice as likely to receive follow-up care within 30 days. Additionally, Navos has been able to *predict readmissions for their behavioral health patients with 92 percent accuracy* and make care decisions accordingly.[23]

Mid-Valley Behavioral Care Network

Mid-Valley Behavioral Care Network (BCN), located in Salem, Oregon, was looking for a better way to connect its case managers, psychiatrists, and therapists with members of the patient care team outside the network.

"Our care coordination had a huge gap because we had to wait for faxes to come in, and we had to hope the client would bring their discharge paperwork so we could see it" explains Lisa Parks, Quality Improvement Coordinate at the BCN.

Leadership at the BCN implemented Collective's care collaboration platform to connect providers at the BCN with hospitals via real-time notifications. With the platform, the BCN could run reports tracking patients with patterns of high emergency department (ED) utilization and those that had recently visited a hospital. Using these reports, case managers could then prioritize follow-up and work proactively with these patients post-discharge to avoid future readmissions.

Mid-Valley Outcomes

Ultimately, having timely access to relevant data helped the BCN not only improve care for patients with patterns of high ED utilization, but increased patient follow-up rates within seven days by 11 percent.[24] Parks concludes:

"We are seeing a really big difference in being able to track patients using these reports. Now, we're not in the dark on patient activity, and we don't have to wait for information. For behavioral health, this is a game changer."

About Collective Medical

Collective Medical provides the nation's largest and most effective network for care collaboration. Our risk-adjusted event notification and care collaboration platform spans across all points of care—including emergency departments, hospitals, payers, behavioral and physical ambulatory, and post-acute settings. This technology integrates seamlessly with existing workflows and allows providers to identify and support at-risk patients in real time—avoiding preventable admissions and utilization and providing better care.

Learn more at collectivemedical.com

Sources

1. Substance Abuse and Mental Health Services Administration. (2017). Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health. Retrieved from https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.pdf

2. Behavioral Health Workforce Projections. (2019, February 28). Retrieved December 18, 2019, from https://bhw.hrsa.gov/health-workforce-analysis/research/projections/behavioral-health-workforce-projections

3. Geographic Variation in the Supply of Selected Behavioral Health Providers. Andrilla, C. Holly A. et al. American Journal of Preventive Medicine, Volume 54, Issue 6, S199 - S207. Retrieved from https://www.ajpmonline.org/article/S0749-3797(18)30005-9/fulltext

4. New Study Reveals Lack of Access as Root Cause for Mental Health Crisis in America. (2018, October 10). Retrieved December 18, 2019, from https://www.thenationalcouncil.org/press-releases/new-study-reveals-lack-of-access-as-root-cause-for-mental-health-crisis-in-america/

5. Roehrig, C. (2016, June 1). Mental Disorders Top The List Of The Most Costly Conditions In The United States: $201 Billion. Retrieved December 18, 2019, from https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.1659?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub=pubmed

6. Substance Abuse and Mental Health Services Administration (US); Office of the Surgeon General (US). Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Washington (DC): U.S. Department of Health and Human Services; 2016 Nov. CHAPTER 6, HEALTH CARE SYSTEMS AND SUBSTANCE USE DISORDERS. Retrieved from: https://www.ncbi.nlm.nih.gov/books/NBK424848/

7. Kessler, R. C. et al. (2008, June 1). Individual and Societal Effects of Mental Disorders on Earnings in the United States: Results From the National Comorbidity Survey Replication. Retrieved December 18, 2019, from https://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.2008.08010126?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub=pubmed

8. Chisholm, D. et al. (2016, April 12). Scaling-up treatment of depression and anxiety: a global return on investment analysis. Retrieved December 18, 2019, from https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(16)30024-4/fulltext

Sources (Cont.)

9. NAMI. Medicaid and Mental Health. Retrieved December 18, 2019, from https://www.nami.org/Learn-More/Mental-Health-Public-Policy/National-Policy-Priorities/Medicaid-and-Mental-Health

10. Medicaid. Behavioral Health Services. Retrieved December 18, 2019, from https://www.medicaid.gov/medicaid/benefits/bhs/index.html

11. U.S. Department of Housing and Urban Development. (2018, November 13). HUD 2018 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations. Retrieved December 18, 2019, from https://files.hudexchange.info/reports/published/CoC_PopSub_NatlTerrDC_2018.pdf

12. SB-1152 Hospital patient discharge process: homeless patients. (2018, October 1). Retrieved December 18, 2019, from https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180SB1152

13. Integrated Care for Kids (InCK) Model. (2018, August 23). Retrieved December 18, 2019, from https://www.cms.gov/newsroom/fact-sheets/integrated-care-kids-inck-model

14. Druss, B. G., & Walker, E. R. Mental disorders and medical comorbidity. Retrieved December 18, 2019, from https://www.integration.samhsa.gov/workforce/mental_disorders_and_medical_comorbidity.pdf

15. Legal Action Center. What Substance Use Treatment Providers Should Know About Changes to Confidentiality Regulations (42 CFR Part 2) – 2017 Final Rule. Retrieved December 18, 2019, from https://lac.org/wp-content/uploads/2017/02/Part-2-Final-Rule-Summary.pdf

16. Legal Action Center. (2018, January 22). What Substance Use Treatment Providers Should Know About Changes to Confidentiality Regulations (42 CFR Part 2) – January 2018 Final Rule. Retrieved December 18, 2019, from https://lac.org/wp-content/uploads/2018/01/Jan-2018-Final-Rule-Synopsis.pdf

17. Pathy, V. (2019, September 26). Proposed regulation to protect privacy of substance abuse patients is an improvement, but is it enough? Retrieved December 18, 2019, from https://medcitynews.com/2019/09/proposed-regulation-to-protect-privacy-of-substance-abuse-patients-is-an-improvement-but-is-it-enough/?rf=1

18. SAMHSA-HRSA Center for Integrated Health Solutions. (2014, September). THE CURRENT STATE OF SHARING BEHAVIORAL HEALTH INFORMATION IN HEALTH INFORMATION EXCHANGES. Retrieved December 18, 2019, from https://www.integration.samhsa.gov/operations-administration/HIE_paper_FINAL.pdf

19. Institute of Medicine (US) Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders. Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. 5, Coordinating Care for Better Mental, Substance-Use, and General Health. Retrieved from: https://www.ncbi.nlm.nih.gov/books/NBK19833/

20. Siwicki, B. (2019, December 10). Care collaboration tech helps hospital reduce unnecessary psychiatric ED visits by 78%. Retrieved December 18, 2019, from https://www.healthcareitnews.com/news/care-collaboration-tech-helps-hospital-reduce-unnecessary-psychiatric-ed-visits-78

Sources (Cont.)

21. Siwicki, B. (2019, May 16). Care coordination network enables Aspire Health to best deploy case managers. Retrieved December 18, 2019, from https://www.healthcareitnews.com/news/care-coordination-network-enables-aspire-health-best-deploy-case-managers

22. Siwicki, B. (2019, August 23). Health data aggregation platform helps Northwest Physician Network drastically reduce ER care. Retrieved December 18, 2019, from https://www.healthcareitnews.com/news/health-data-aggregation-platform-helps-northwest-physician-network-drastically-reduce-er-care

23. Collective Medical. Navigating Coordination of Care for Behavioral Health Patients. Retrieved December 18, 2019, from https://collectivemedical.com/case-study/navigating-coordination-of-care-for-behavioral-health-patients/

24. Siwicki, B. (2019, June 7). Patient follow-up rate at mental health network soars with care coordination tech. Retrieved December 18, 2019, from https://www.healthcareitnews.com/news/patient-follow-rate-mental-health-network-soars-care-coordination-tech