CAPITAL AREA BEHAVIORAL
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Best Practice Models to Increase Psychiatric Access

Nearly 40 million Americans experience serious mental health diagnoses in the course of one year; however, over half of them do not or cannot receive treatment (Breitinger, 2023). Navigating the mental health care system comes with many challenges. Be it due to staff shortages, identifying the right provider, or the cost of accessing mental health care. Currently, we are experiencing a shortage of qualified psychiatric care providers. In response to this, the Provider Relations Committee (PRC) have developed a tool box of best practice models to improve or increase psychiatric access that providers can use to incorporate in their practice. Please note that the Primary Care Behavioral Health (PCBH) model and Collaborative Care Model (CCM) are not models that behavioral health providers can apply to their clinical setting; however, these models can improve access to psychiatric care in our overall health system. Additional information will be provided further into this summary.

Below are three best practice models identified that could potentially improve psychiatric care access in clinical settings:

- Open access
- Task shifting
- Telehealth.

Open access means a provider has same-day walk-in appointments available on a first-come, first-served basis; therefore, scheduling an appointment is not necessary. This model is said to reduce or eliminate delays in patient care without the addition of resources (Edgman-Levitan et al., 2017). Increase in the amount of lead time has been associated with increased no-show rates. Successful implementation of open access can reduce the no-show rate by decreasing the lead time (Mazaheri Habibi et al., 2024). There's evidence that the open access model increases access to care which results in higher levels of patient and physician satisfaction (Edgman-Levitan et al., 2017). Patient demand for appointments reduces due to patients being able to see their own clinician more often (Edgman-Levitan et al., 2017). In addition, open access scheduling with preferred physicians can lead to a decrease in missed appointments rates (Gant-Farley et al., 2021).

Continuity of care is enhanced when patients are able to see their personal physician which has been linked with both improved health care and higher patient satisfaction (Edgman-Levitan et al., 2017). Lastly, cost and efficiency savings are noted in medical practices. A decrease in the number of no-shows results from a reduction in wait times and thusly, clinical time is used more efficiently and less staff time is required to manage the backlog of patients and no-shows (Edgman-Levitan et al., 2017). Studies have also

shown that the implementation of open access leads to decreased costs and increased clinic profits (Mazaheri Habibi et al., 2024).

Task shifting is when clearly delineated responsibilities are moved from highly skilled staff to staff with less expertise who have completed specific competency-based training (Datta et al., 2023; van Schalkwyk et al., 2020). In mental health settings, the care of uncomplicated patients who require straightforward clinical decision-making are shifted to Physician Assistants (PAs) or Certified Registered Nurse Practitioners (CRNPs) that have specialized training in mental health so that psychiatrists can spend more time working with patients who have complex, unstructured clinical problems which require greater expertise (Breitinger, 2023; van Schalkwyk et al., 2020). The PAs work under the supervision of psychiatrists. Although there are 125,000 certified PAs practicing in the U.S., only 1.3% of them work in psychiatry (Breitinger, 2023).

Task shifting can address healthcare resource shortages and permit physicians in primary care to deliver more complex care and expand access to healthcare (Datta et al., 2023). The World Health Organization (WHO) has contributed to addressing the health worker shortage by developing a guideline on task shifting (Datta et al., 2023). Task shifting permits a health system to utilize its existing resources (e.g., staff) in a more efficient manner which can reduce barriers in service delivery and expand staff capacity (Datta et al., 2023). Task shifting is not limited to moving tasks from one person to the next - it also includes the use of technology.

There are various opportunities to utilize existing technology such as clinical decision support (CDS) systems, electronic health records (EHRs), and augmented intelligence that can automate certain duties and enable continuous teamwork (Datta et al., 2023; van Schalkwyk et al., 2020). CDS systems can offer real-time information and guidance to assist less-experienced providers make informed decisions (Datta et al., 2023). EHRs can allow PAs or nurse practitioners (NPs) to obtain comprehensive treatment directives from a physician or review patients medical history, lab and/or testing results, and make recommendations to the physician in a secure and efficient manner (Datta et al., 2023). Specific duties such as prescribing a medication and dosage for a patient can be automated by augmented intelligence (Datta et al., 2023). Another way task shifting has been implemented is by encouraging patients to use mobile (mHealth) apps to monitor their health status and communicate with their medical providers (Datta et al., 2023).

It is important to note that one of the key factors in effectively implementing task shifting in healthcare is ensuring that staff who have less expertise are being supervised by a highly skilled physician to maintain quality healthcare (Datta et al., 2023; van Schalkwyk et al., 2020). In addition to this, the European Commission expert panel provided a range of considerations to help in determining if tasks can or should be shifted (van Schalkwyk et al., 2020):

1. It’s essential that there’s clarity regarding why task shifting is being considered.
2. Careful preparation. Staffs’ ability to perform the new task (s) assigned needs to be assessed. Staff may be required to complete additional training, if necessary.

3. Identify potential legal or regulatory barriers to the shifting of tasks. Can or *should* they be changed?
4. Identify whether existing payment systems act as a barrier. Will payers only reimburse certain procedures if they are assumed by specific health providers?
5. A systems perspective is important as it allows wider considerations to be taken into account. Meaning, task shifting could potentially influence the level of interest in, demand for, entry into and retention in certain professions within healthcare.

Telehealth is the use of video conferencing and/or telephone to conduct mental health visits.

There's evidence that technology-based tools that deliver standard cognitive behavioral therapy (CBT) are just as effective as in-person therapy (Breitinger, 2023). According to Kaiser Family Foundation (KFF), 36% of telehealth outpatient visits were primarily for a mental health or substance use diagnosis by the period of March-August 2021, compared to 24% a year earlier, and 11% two years earlier (Lo et al., 2022).

There's evidence that telehealth increases access to mental health care (Jancsura et al., 2024). Telehealth provides flexibility for patients by reducing transportation barriers to accessing care, decreasing the amount of time patients miss work or school, and reducing potentially exposure to illness particularly for those who are immunocompromised. (Jancsura et al., 2024; Mayo Clinic Staff, 2022). In addition, telehealth is beneficial for individuals with limited mobility (physically) and diagnosed with disabilities, chronic conditions, or for people who live in remote locations such as rural areas (Jancsura et al., 2024; Mayo Clinic Staff, 2022). It was reported that about 55% of patients who relied on telehealth to receive outpatient mental health and substance use services were from rural areas compared to those in urban areas (35%) (Lo et al., 2022). KFF reported that between the period March-August 2021, rural residents were more likely to utilize telehealth for mental health and substance use diagnoses visits (55%) compared to urban residents (35%) (Lo et al., 2022).

Telehealth can also improve follow-up rates. In one study, the no-show rate for telehealth visits (7.5%) was statistically significantly lower than the baseline no-show rate for in-office visits prior to the COVID-19 pandemic (29.8%) and during the pandemic (36%) (Drerup et al., 2021). In addition, patients reported overall satisfaction with their telehealth visits which was similar to patients who had in-office visits (Drerup et al., 2021). Telehealth is also useful for certain specialty areas such as endocrinology or nutrition among others where the appointment is mainly informative as opposed to other specialties which may rely more heavily on physical exam.

Providers can also benefit from telehealth utilization. There's a correlation between telehealth and a decrease in staffing costs (Jancsura et al., 2024). In addition, there's evidence of improved physician retention and recruitment, especially for rural areas (Jancsura et al., 2024). Providers can also make use of technology in their practice by

utilizing telementoring or what the Department of Human Services calls interprofessional consultations in Pennsylvania (*ref.* MA Bulleting 33-24-01).

Interprofessional consultations are encounters that involve the beneficiary's treating physician or other health care practitioner requesting the recommendation or treatment advice of a physician or other qualified health care practitioner with specific specialty expertise to assist the treating physician with the beneficiary's care without face-to-face contact between the consulting practitioner and the patient. This bulletin applies to MA enrolled independent medical/surgical clinics, physicians, certified nurse midwives, certified nurse practitioners, physician assistants, podiatrists, certain dentist specialists, and psychologists. Furthermore, as stated in the bulletin, "Interprofessional consultation services are intended to expand access to specialty care and foster interdisciplinary input on beneficiary care. They are not intended to be a replacement for direct specialty care when such care is clinically indicated."

As previously mentioned, these next two models cannot be applied in mental health clinical settings; however, they can be applied in physical health settings to improve access to psychiatric care in our overall health system:

- Primary Care Behavioral Health (PCBH)
- Collaborative Care Model (CCM)

The **Collaborative Care Model (CCM)** embeds Behavioral Health (BH) specialists within the primary care setting. Behavioral health integration is critical to effective, whole person care. The notion is that patients most interact with the health care system in primary care practices, therefore, incorporating front-line practitioners and screening processes within primary care practice settings increases access to patients who would not have otherwise accessed it in a mental health outpatient clinic (Reist et al., 2022). The CCM is delivered by a team of specialists comprised of the primary care provider (PCP), a behavioral health care manager, and a psychiatric consultant (AHIP, 2023). This team approach promotes and supports population-based, patient-centered care (APA, n.d.). A systematic review revealed strong evidence that collaborative care is effective for improving depression outcomes in ethnic/racial minority populations (APA, n.d.). Racial and ethnic minority groups appear to greatly benefit from collaborative care compared to the majority populations - indicating that these methods could potentially reduce racial/ethnic disparities in access to and outcomes of mental health care (APA, n.d.; Reist et al., 2022).

There are five essential features of the Collaborative Care Model (CCM): patient-centered team care; population-based care; measurement-based treatment to target; evidence-based care; and accountable care (APA, n.d.).

1. Patient-centered team care involves collaborations between primary care and behavioral health providers in utilizing shared care plans that integrates patient goals (APA, n.d.). Ideally, both providers should be in a location that the patient is most comfortable and familiar with.

2. Population-based care occurs when the care team shares a classified group of patients that is tracked in a registry to ensure that patients are being monitored (APA, n.d.). If there's a lack of improvement, then mental health specialists would be assigned to provide caseload-focused consultation.
3. Measurement-based treatment to target means that the patients have treatment plans that clearly states their personal goals and the intended clinical outcomes and are routinely measured by evidenced-based tools (APA, n.d.).
4. Evidence-based care is offering patients treatments that have research evidence to support their effectiveness in treating the target conditions (APA, n.d.).
5. Accountable care is when providers are accountable and reimbursed for quality of care and clinical outcomes (APA, n.d.).

The CCM is intended to closely monitor the progress of the subset of patients in primary care practice settings who have been diagnosed with a serious, chronic mental health diagnosis (APA, 2019).

The **Primary Care Behavioral Health (PCBH)** model is a team-based primary care approach that involves managing behavioral health problems and biopsychosocially influenced health conditions (Aguilar & Philip, 2022; APA, 2019). The primary goal is to enhance the primary care team's ability to manage and treat such problems and conditions. A behavioral health consultant (BHC), who is typically a licensed behavioral health professional, is incorporated in the primary care team. The BHC supports the primary care provider (PCP) and team by functioning as both a generalist and an educator who delivers high volume services that are accessible, team-based, and a routine part of primary care (Aguilar & Philip, 2022). All patients in primary care practices can access PCBH services, not just those with serious, chronic mental health diagnoses (APA, 2019).

There's research evidence that reflects an improvement in functioning and high levels of satisfaction for mostly all patients receiving PCBH services (Aguilar & Philip, 2022; APA, 2022). There's also evidence that team-based PCBH care decrease provider burn-out and improves provider satisfaction (Aguilar & Philip, 2022; APA, 2022). The PCBH model allows providers to treat patients with more complex needs (APA, 2022). Improvements in clinical outcomes as a result of the PCBH model have been associated with more satisfied providers (APA, 2022). The PCBH model creates a supportive practice environment due to team collaboration (APA, 2022). Several studies have shown that the implementation of the PCBH have resulted in cost savings as it relates to decreased use of the hospitalizations (Aguilar & Philip, 2022; APA, 2022).

Considering this information, behavioral health providers are encouraged to collaborate with their clients' primary care providers (PCP), especially those who have incorporated one of these two models, to determine if there are clients who could be referred out to the PCP for med management. Particularly clients who are less complex, requiring straightforward clinical decision-making to manage their symptoms. This collaboration could potentially increase access to psychiatric care in our network.

Please note that this is not an exhaustive list. The best practice models listed have a considerable amount of research evidence to support their efficacy in expanding access to psychiatric care. In addition, providers are not required to implement any of these models these are simply suggestions. Our hope is that with proper identification and implementation of these best practice models, there will be an increase in psychiatric access in our provider network.

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