Ten (11) Strategies for a successful BH System

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Sept 2025

Sentara

Behavioral Health: Demand for Behavioral Health Creates Opportunity to Improve Population Health

IP Rising Tide of Acuity and Volume	65+
IP Discharges	+30%
ALOS	+3%
Bed Days	+34%

An increasing need for services treating comorbid conditions will challenge IP services.

Focusing on upstream care for Medicare- and MA-aged population (65+) will mitigate strong bed demand.

OP Visits and Procedures Are Growing	65+
OP Volumes Overall	+46%
E&M Visits	+42%
IOP and PHP	+56%
ECT and TMS	+83%

BH virtual health visits will see strong growth and make up a larger portion of psychotherapy visits over the next decade.

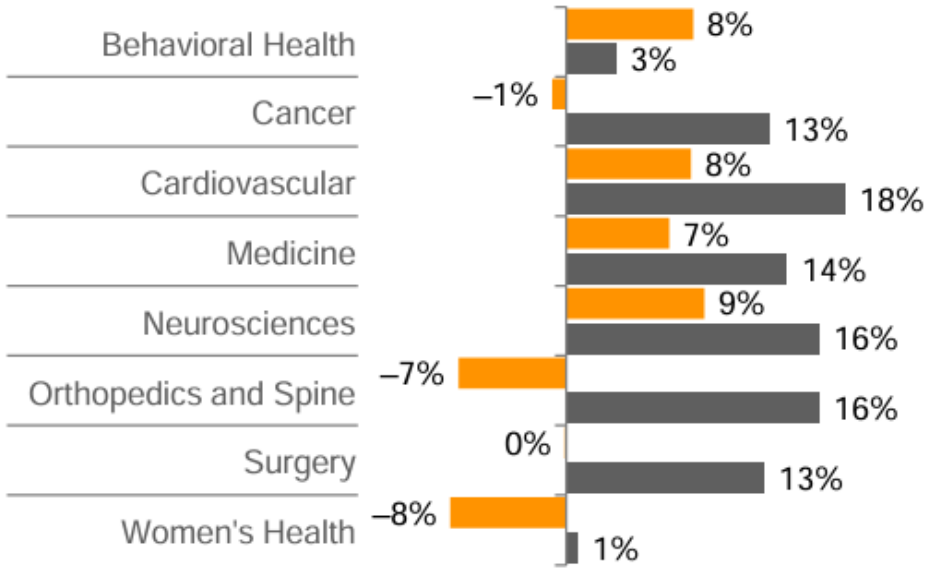
23%
In-person **psychotherapy** growth

50%
of **psychotherapy** visits will be delivered virtually in 2034 (vs **49%** in 2024).

Note: Analysis excludes 0–17 age group. Behavioral Health includes behavioral health service line and Poisonings—Commonly Abused Drugs CARE Family. E&M visits defined as procedures visits—evaluation and management, established patient visits—in person, established patient visits—virtual, new patient visits—in person, new patient visits—virtual. Percentages represent Sg2's 10-year growth forecast. BH = behavioral health; ECT = electroconvulsive therapy; IOP = intensive outpatient program; MA = Medicare Advantage; PHP = partial hospital program; TMS = transcranial magnetic stimulation. **Sources:** Impact of Change®, 2024; HCUP National Inpatient Sample (NIS). Healthcare Cost and Utilization Project (HCUP) 2019. Agency for Healthcare Research and Quality, Rockville, MD; Proprietary Sg2 All-Payer Claims Data Set, 2022; The following 2022 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claritas Pop-Facts®, 2024; Sg2 Analysis, 2024.

Utilization Trends Vary Across Service Lines

Inpatient Service Line Growth
US Market, Adults, 2024–2034



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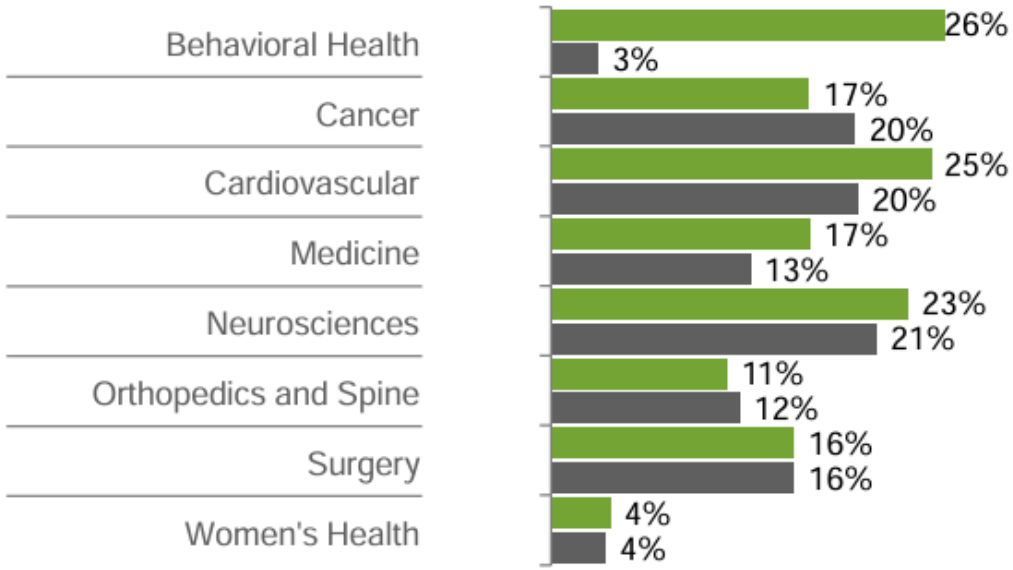

Sg2 IP Forecast | Population-Based Forecast | Sg2 OP Forecast

Note: Analysis excludes 0–17 age group. 0% indicates the forecast is flat (less than ±1%). Behavioral Health includes behavioral health service line and Poisonings—Commonly Abused Drugs CARE Family. Cardiovascular includes cardiology and vascular. Medicine includes allergy and immunology, dermatology, endocrinology, gastroenterology, genetics, hematology, hepatology, infectious diseases, nephrology, pulmonology, and rheumatology. Surgery includes burns and wounds, otolaryngology, general surgery, ophthalmology, and urology. **Sources:** Impact of Change®, 2024; HCUP National Inpatient Sample (NIS). Healthcare Cost and Utilization Project (HCUP) 2019. Agency for Healthcare Research and Quality, Rockville, MD; Proprietary Sg2 All-Payer Claims Data Set, 2022; The following 2022 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claritas Pop-Facts®, 2024; Sg2 Analysis, 2024.

Sg2 ANALYTICS

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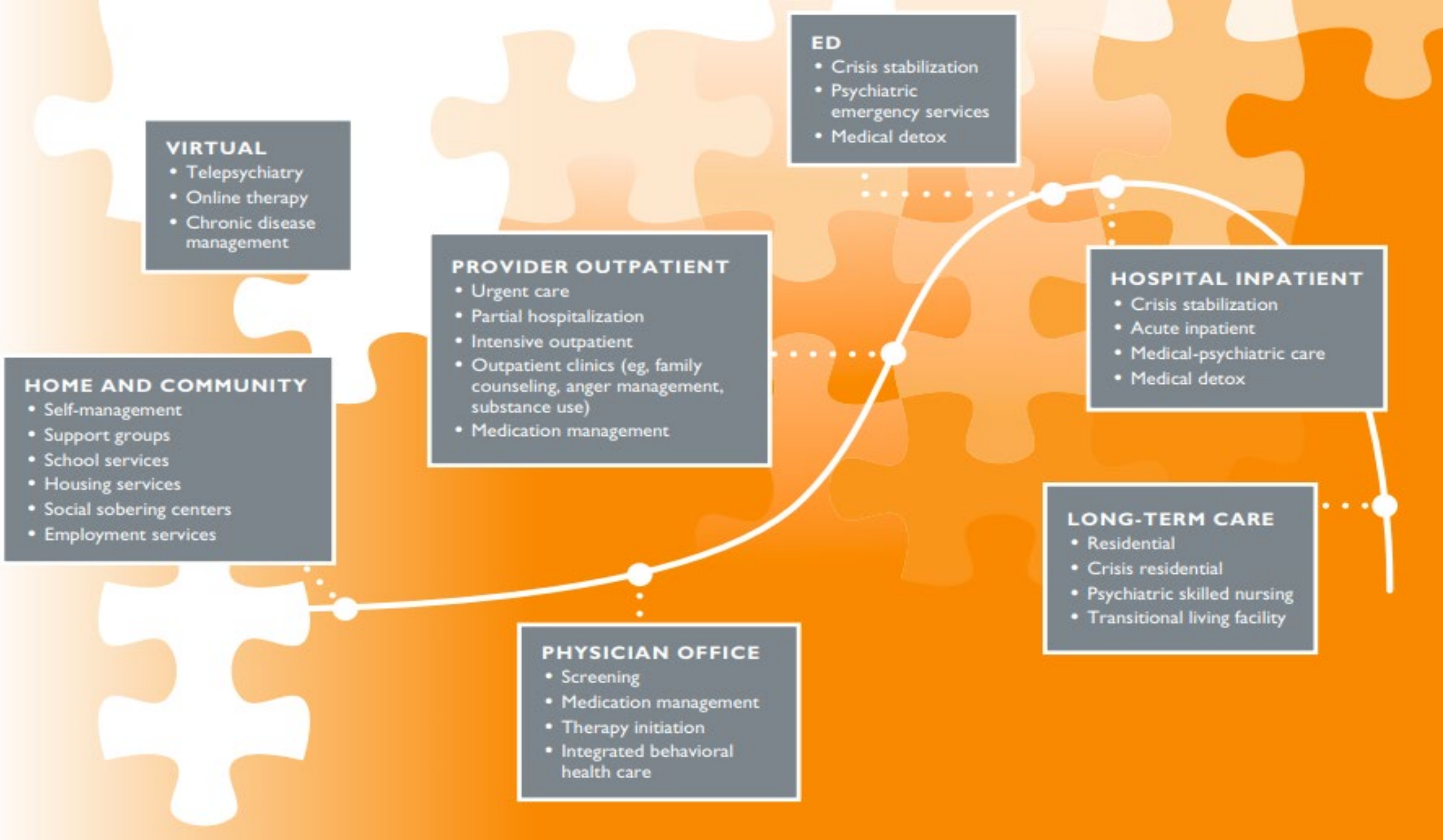
1. Build access points to guide patients to the right level and setting of care
2. Fully integrate BH into routine medical care (proactive, integrated care, everywhere)
3. Expand and enrich (virtual) offerings for improved access
4. Expand outpatient offerings as alternatives to inpatient and ED care
5. Optimally manage ED patients with behavioral health needs
6. Efficiently use psych inpatient beds/resources
7. Leverage technology as a workforce multiplier
8. Transition value of BH into population health management
9. Create niche programs that support the unique needs of the system's community and members
10. Implement and expand evidenced based practices that reduce unwarranted variations in care
11. Recruit, retain and continuously educate a robust BH workforce c/w the values of the community we serve to achieve the above objectives

Strategies for BH SL Clinical Services

#1

Build access points to guide patients to the right level and setting of care

Navigation


ED
• Crisis stabilization
• Psychiatric emergency services
• Medical detox
VIRTUAL
• Telepsychiatry
• Online therapy
• Chronic disease management
PROVIDER OUTPATIENT
• Urgent care
• Partial hospitalization
• Intensive outpatient
• Outpatient clinics (eg, family counseling, anger management, substance use)
• Medication management
HOSPITAL INPATIENT
• Crisis stabilization
• Acute inpatient
• Medical-psychiatric care
• Medical detox
HOME AND COMMUNITY
• Self-management
• Support groups
• School services
• Housing services
• Social sobering centers
• Employment services
LONG-TERM CARE
• Residential
• Crisis residential
• Psychiatric skilled nursing
• Transitional living facility
PHYSICIAN OFFICE
• Screening
• Medication management
• Therapy initiation
• Integrated behavioral health care

1. Build access points to guide patients to the right level and setting of care (Navigation)

Key point = expertise in knowing resources and getting the right kind of health care in the right setting

988 instead of 911

Change your voicemail announcements

CSBs

Mental Health First Aid (training)

Systems develop BH Access Phone Lines / Call Centers

"Easy button"

VMAP.org & APAL (expansions planned)

BH Navigators (Clinic, ED, IP embedded)

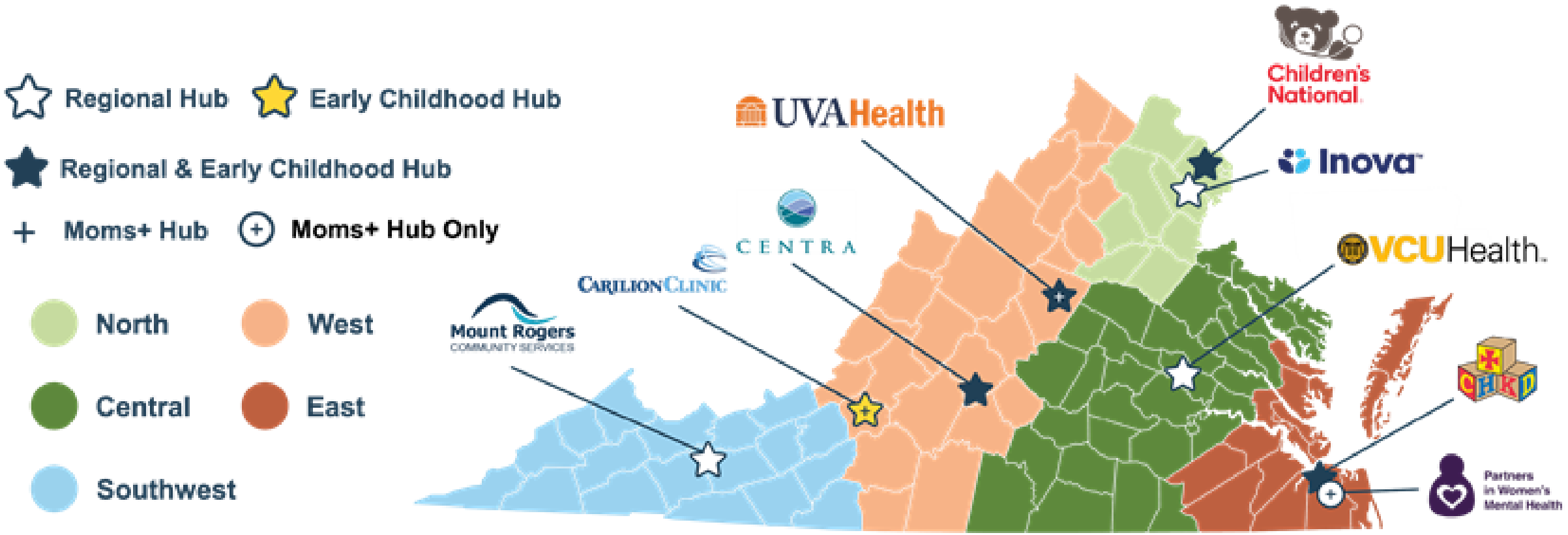
Discharge Clinics (for EDs, Hospitals)

PsychologyToday.com

State	Rank
Massachusetts	1
Connecticut	2
Maine	3
New York	4
New Jersey	5
District of Columbia	6
Vermont	7
New Hampshire	8
Hawaii	9
Pennsylvania	10
Michigan	11
Virginia	12
Wisconsin	13
Maryland	14
Illinois	15
Rhode Island	16
California	17
Delaware	18

Rank	State
1	Vermont
2	Maine
3	Massachusetts
4	District of Columbia
5	Rhode Island
6	Oregon
7	New York
8	New Hampshire
9	Connecticut
10	Pennsylvania
11	Wisconsin
12	Ohio
13	Iowa
14	Minnesota
15	Washington
16	New Mexico
17	Colorado
18	Indiana
19	Virginia

VMAP.org Line Hubs



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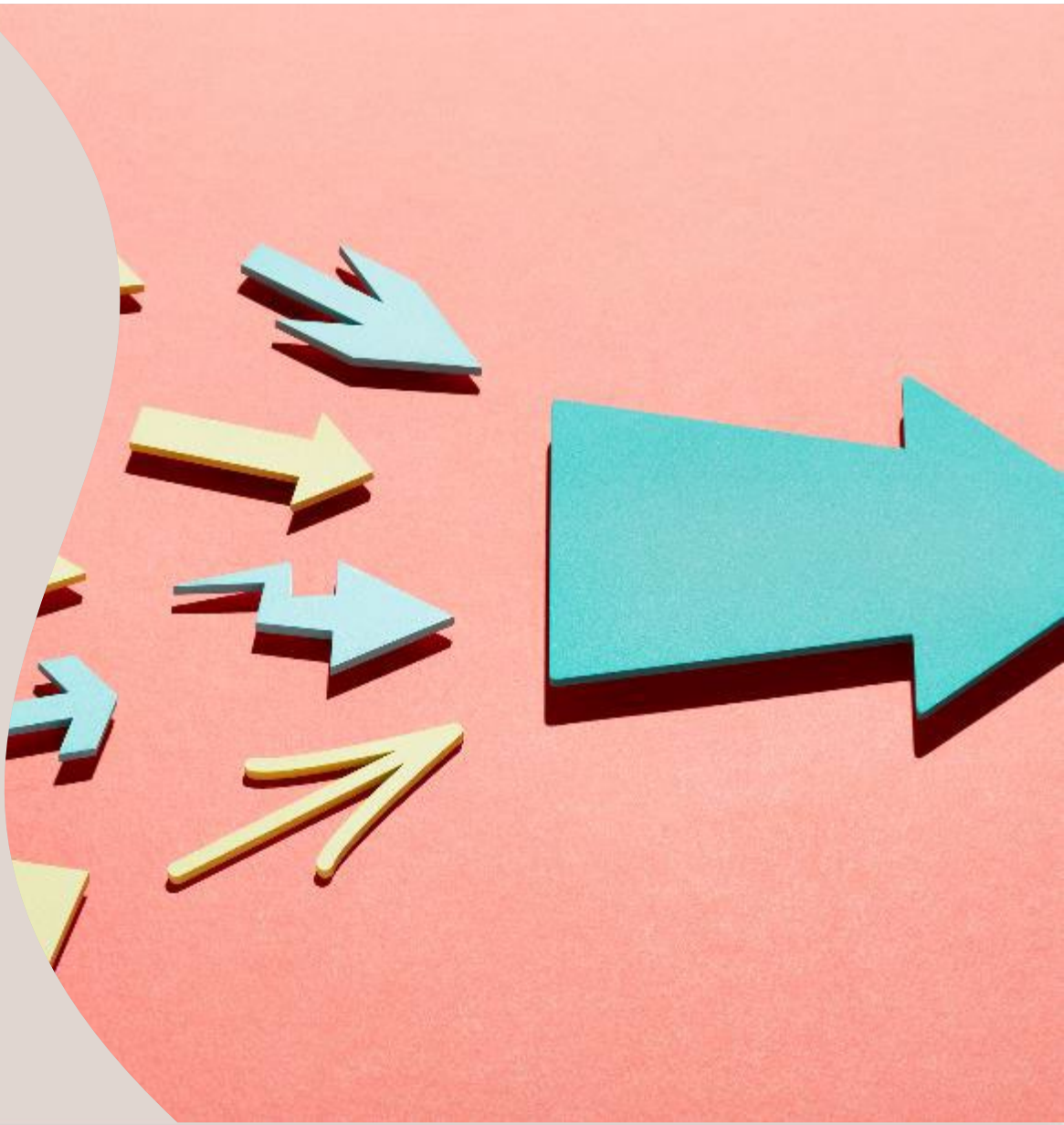
#2

Fully integrate BH into routine medical care (proactive, integrated care, everywhere)

Integration / Collaborative Care



Fully integrate BH into routine medical care (proactive, integrated care, everywhere)

EDs

- access to BH Navigators (CM, SW, BH Nursing) → licensed therapists (assessments, dx and disposition opinion)
- Psychiatrists/NPs/APPs for consultations
- Clinical Decision Units for BH → EmPATH Units (Emergency Psychiatric Assessment Treatment and Healing)

IP

- BH specific case managers
- Consult & Liaison Psychiatric program for med/surg consults (reduces LOS for both medical and psych/med patients)

Clinics

- Shared Access to records/patients
- Embedded CM/Navigators, Therapists, Psychologists
- Protocols for treatment built with psychiatric support
- Referrals to Psychiatry (traditional consults for severe/complex cases & eConsults for simpler cases)
- Integration model
  - Behavioral Health Integration
  - Collaborative Care Model (CoCM)

Coordinated		Co-located		Integrated	
Minimal collaboration *Level 1*	**Basic collaboration at a distance** *Level 2*	**Basic collaboration onsite** *Level 3*	**Close collaboration** *Level 4*	**Approaching an integrated practice** *Level 5*	**Fully integrated practice** *Level 6*
Clinical delivery					
Separate treatment plans, screening and assessment models	Sharing of some treatment plans based on provider relationships, screenings may be shared among providers	May use agreed-upon screening for more effective in-house referrals and share evidence-based practices, but separate treatment plans	Specific, standard screenings, collaborative treatment planning, some evidence-based practices shared	Consistent set of screenings guiding treatment interventions, collaborative treatment planning, and evidence-based practices	Universal medical and mental health screenings are standard practice with results available to all providers of care team
Patient experience					
Physical and mental health needs are treated as separate. Patients must handle separate appointments and practice sites on their own	Physical and mental health needs are treated separately, but records are shared. Patients are referred, but barriers to care can still exist	Patients' health needs are treated separately, but at same location. Proximity improves referral process	Patients' needs treated separately, but warm hand-offs occur to other providers, with improved referral and follow-up	A patient's needs are treated as a team for patients with multiple needs, separately for others, with care responsive to patient needs	All of a patient's physical and mental health care needs are treated seamlessly by a collaborative team

Note: Adapted from the Center for Integrated Health Solutions

Table: Healthy Minds Policy Initiative

The Coordinated Model – First Step to Integration

Shared Records – First Step to Integration

Many independent therapist and psych practices do not participate in EMRs, those that do may not elect to participate in HiTECH Act requirements

42 CFR part 2 – May prevent sharing of SUD related notes by providers

Rule was updated in Feb 2024

https://www.hhs.gov/hipaa/for-professionals/regulatory-initiatives/fact-sheet-42-cfr-part-2-final-rule/index.html

The Integrated Model

BHI Model (BH Integration, 99484)

- Requires PCP; BHCM and Psychiatric/BH Consultant are optional
- >20 minutes of clinical staff time for care management of general BH services
- Time spent on BH issues with patient outside of encounter time such as
  - Treatment teams to discuss and adjust patient assessment and plans
  - Collecting f/u PHQ9 for example
  - Contact with patient to keep pt integrated in team
  - Staff work under direction of PCP

BHI cpt 99484 ~$43 per unit, 1 unit a month

- If managing two or more chronic care conditions (one of which is BH) then consider CCM cpt codes 99490, 99493, 99487, 99489, 99491
- Reimbursement for CCM codes are generally greater than BHI code

Primacy Care Behavioral Health (PCBH) Model

- Requires PCP and a BH Provider
  - Originally designed with Psychologists (PsyD, PhD) as key part of team
- Implements practice-wide prevention and early identification and intervention strategies
- Offers targeted treatment for behavioral health conditions
  - suboptimal health behaviors exacerbating physical health concerns, and chronic health conditions across the lifespan
- Fee for Service Model (if BH provider is an appropriate billing provider)
- Can also qualify for BHI, CCM billing

Sources: MLN909432 April 2025; AIMS Center, APA.org; Rates = check with your individual plans

CoCM (Collaborative Care Model)

Team Based Approach

Requires: PCP, BH Care Manager and a Psychiatric Consultant

Chronic care management approach

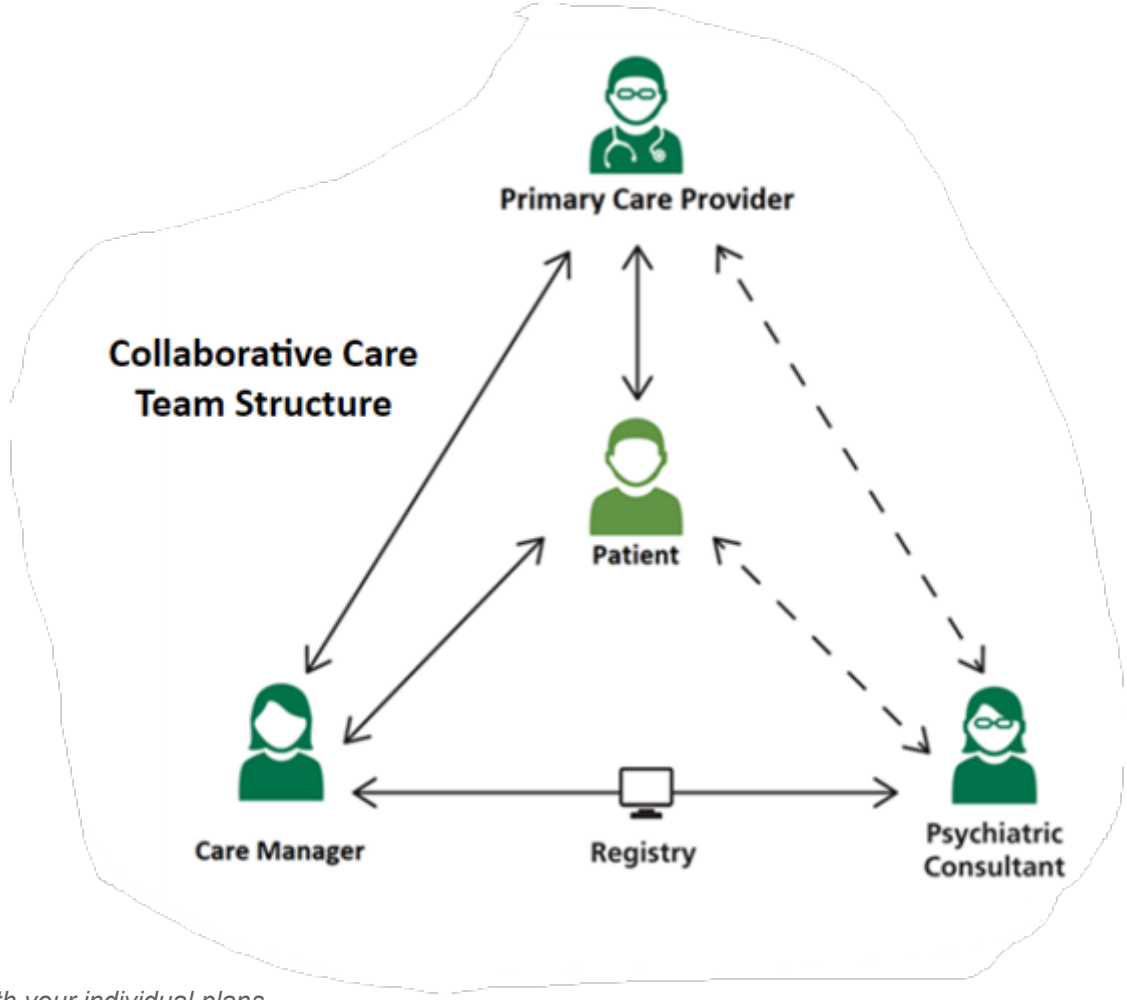
- Core Principles: Measurement-based care, population-based management, treat-to-target.
- PCP and Care Manager provide most of the direct care
- Psychiatrist provides suggestions for treatment plan changes
- Treatments
  - include psychopharmacological recommendations
  - brief psychoeducation or problem-solving skills training

Chronic Care Management revenue model

99492 (~$155), 99493 (~$104), 99494 (~$61),

G0512 (~$146, FQHC 1/mo, *doesn't require registry*)

G2214 (~$53)



Sources: MLN909432 April 2025; AIMS Center, APA.org; Rates = check with your individual plans

#3

Expand and enrich (virtual) offerings for improved access

Virtual Models for Access

Expand and enrich (virtual) offerings for improved access

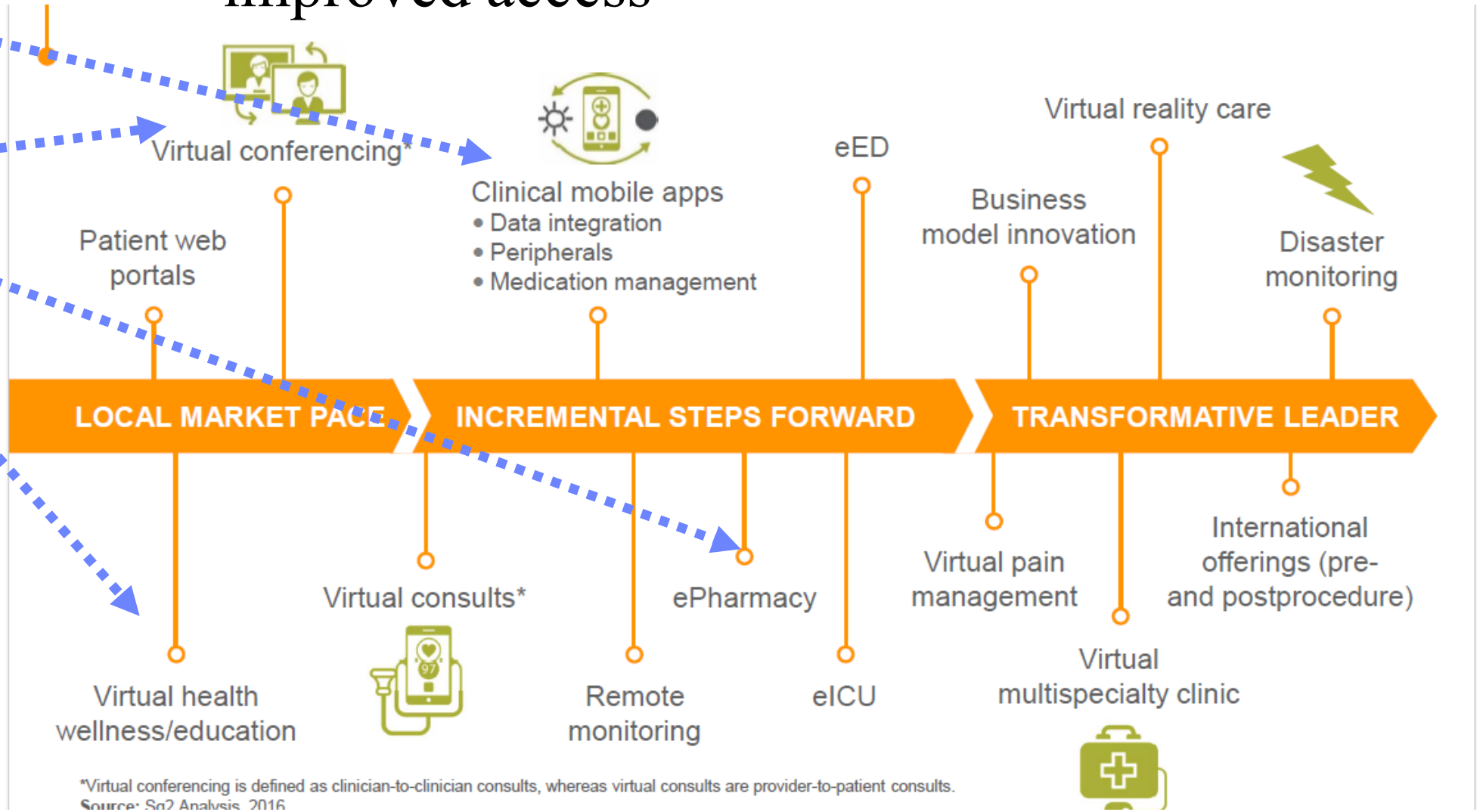
CBT-I Coach (VA)

ECHO (VMAP.org)

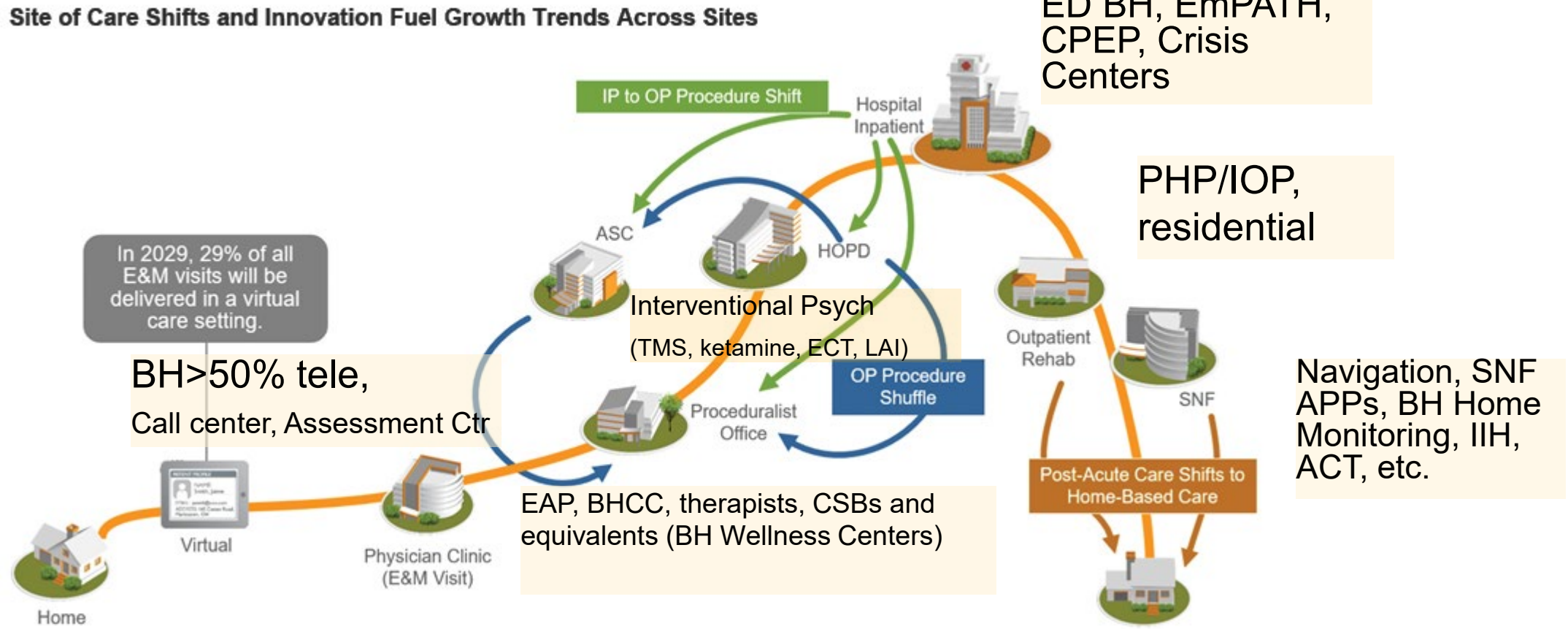
Amazon.com

988lifeline.org

Virtual Programs (groups)



Virtual, home-based care & tx away from inpatient hospitals continues as a trend



ED BH, EmPATH, CPEP, Crisis Centers

PHP/IOP, residential

BH>50% tele,

Call center, Assessment Ctr

EAP, BHCC, therapists, CSBs and equivalents (BH Wellness Centers)

Navigation, SNF APPs, BH Home Monitoring, IIH, ACT, etc.

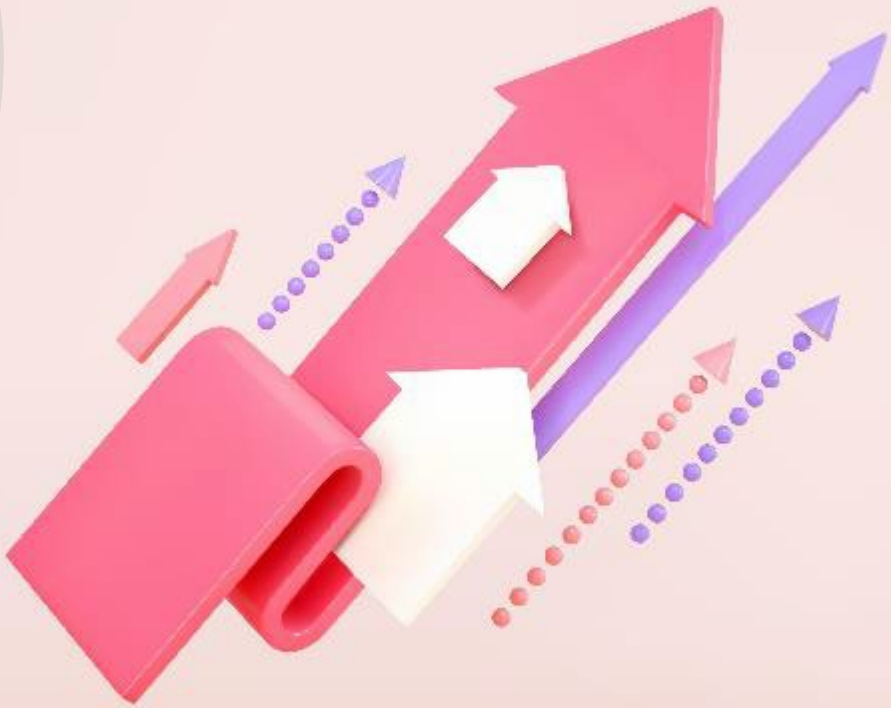
Source: https://www.sg2.com/blog/2021/sg2-2021-impact-of-change-forecast-postpandemic-recovery-rising-acuity-and-ambulatory-shifts

Note: Analysis excludes 0–17 age group. ASC = ambulatory surgery center; E&M = evaluation and management; HOPD = hospital outpatient department; SNF = skilled nursing facility. **Sources:** Impact of Change®, 2021; Proprietary Sg2 All-Payer Claims Data Set, 2018; The following 2018 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claritas Pop-Facts®, 2021; Sg2 Analysis, 2021

#4

Expand outpatient offerings as alternatives to inpatient and ED care

Access



Expanded Access – Alternatives to ED and Psych Units

PHP/IOP programs

- Facility based or community mental health based programs
- Alternatives to inpatient hospitalization
- PHP has group therapies, psychoeducation, skill building, psychiatrist evaluations/discharges with prn/weekly check ins (diagnoses, med management, etc.). Commute or Virtual. Generally, for mental health 12-15 day stays.
- IOP generally for substance use ~30-day stays – can be during the day or after 5pm, often 2-4 hours a day ~3 days a week; groups; may or may not have a psychiatrist

Normal clinic services but with extended or alternative hours

- After 5pm (ex. 10am – 7pm)
- Weekends (ex. Sat 12am- 6pm)

Crisis Stabilization Units (CSU) – Crisis Receiving Centers

- Commonwealth/State supported centers that offer alternatives to EDs – moderate to high BH acuity, w/ low to moderate medical acuity

Assessment Centers (hours vary, most utilized 5pm - 2am; offers evaluations with therapist +/- nurse, +/- peer support) - key is for assessment (diagnosis) + disposition

- works best with same week follow-ups or referrals into a php/iop program
- Works well as a community partner to EDs or CSUs

Virtual IOP (s)

Sentara's virtual IOP

- Open to state of Virginia residents
- Substance Use Disorders
- call (757) 395-1405
- fax (757) 222-5095

#5

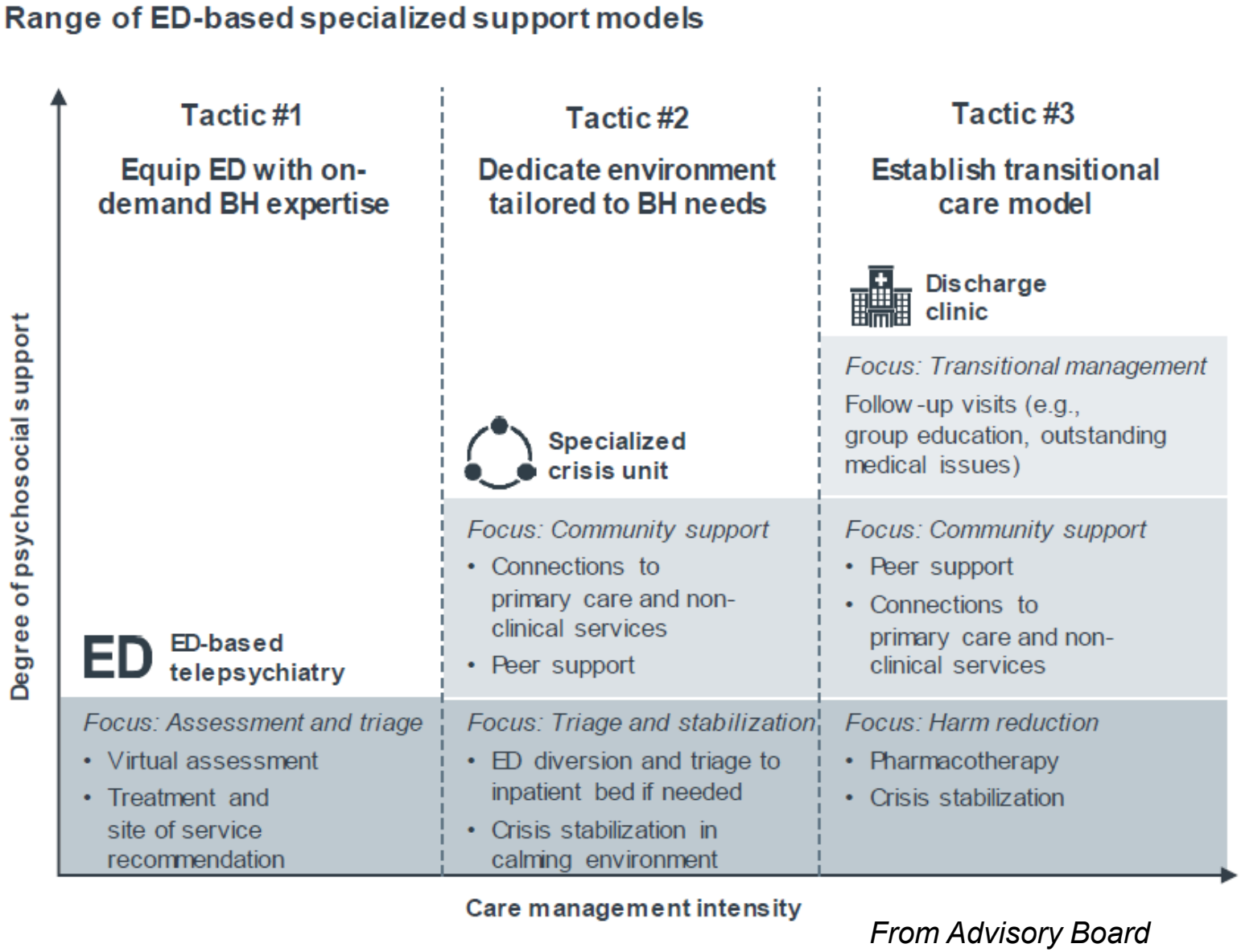
Optimally manage ED patients with behavioral health needs

ED BH Length of Stay and Bed Flow
Improve admission efficiency to system units
Improve financial performance for whole hospital

ED Interventions *--evolution*

In role of ED

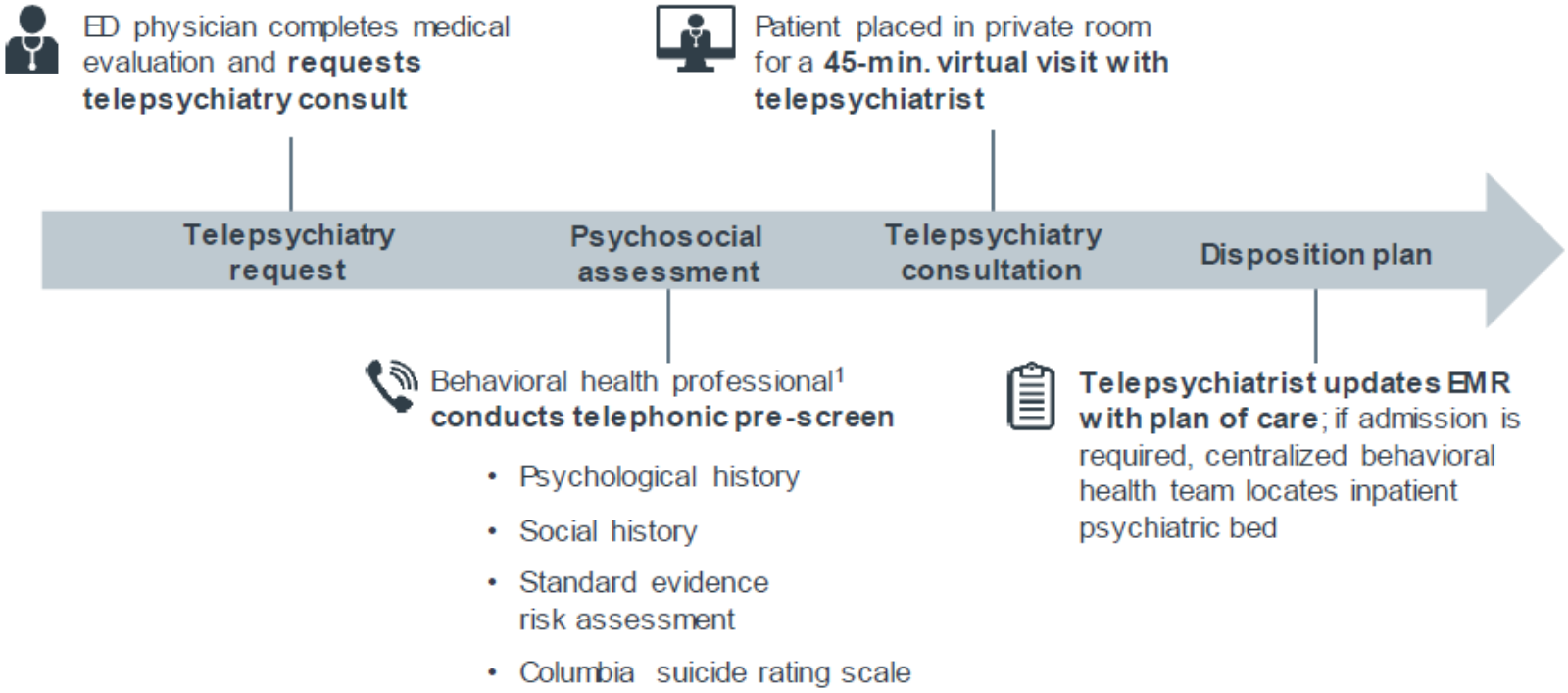
- Expand BH outside of ED docs & psychiatrists
- Leverage CSBs, ED BH navigators, ED BH licensed therapists, etc.,



From Advisory Board

Top of License

- ED BH models often use other "BH professionals" before the psychiatrist is involved



62% Overall **reduction in average LOS[2]** for behavioral health patients

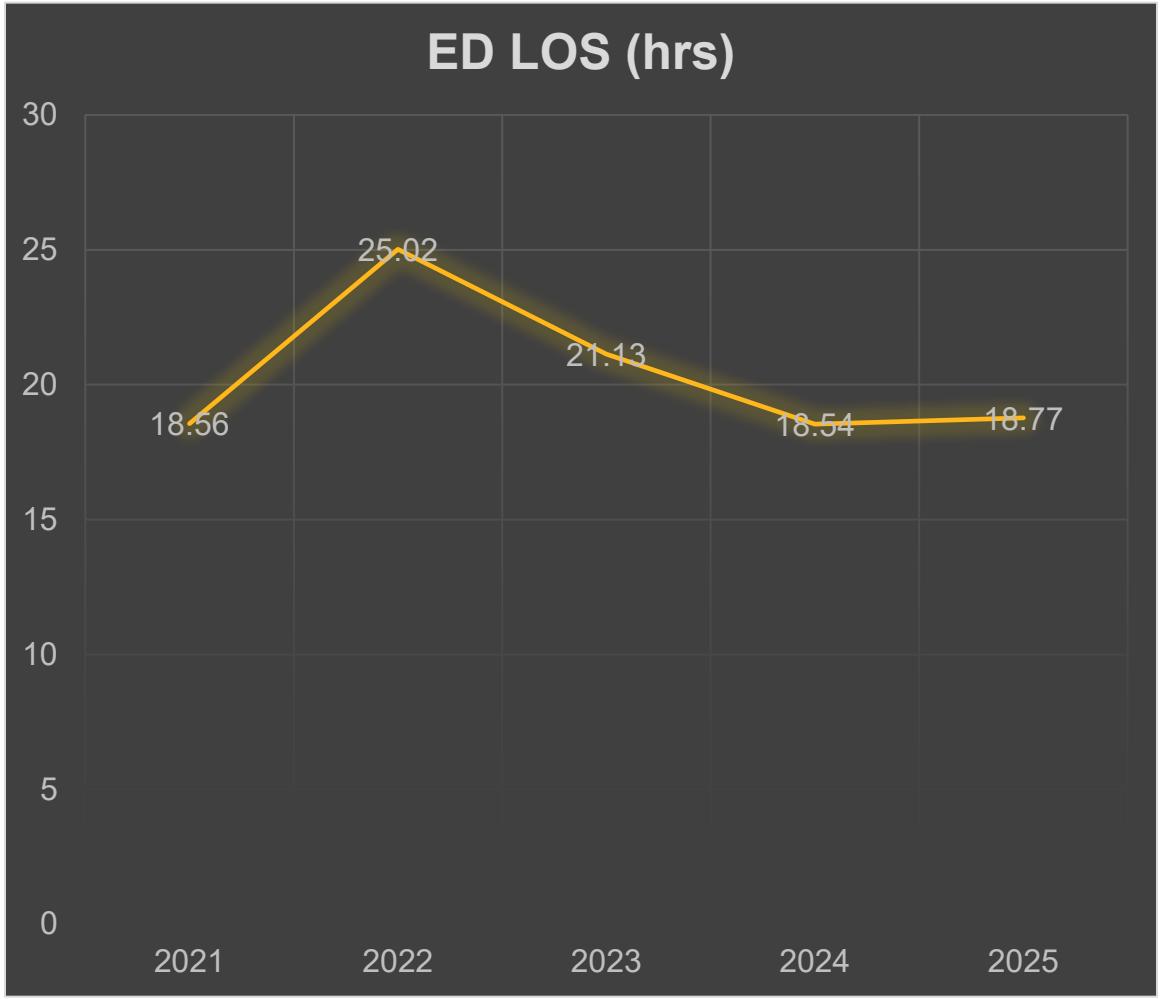
2.5 Median **hour decrease** in LOS of ED visit

Qualitative survey reveals positive patient experience

- ☑ No concerns with quality of telepsychiatry consult received
- ☑ Patients appreciate access to consultation
- ☑ Patients feel comfortable using virtual platform
- ☑ Patients report the consult service as helpful

From Advisory Board – case Atrium

Sentara - ED LOS with Psych Em Response team



Q1-Q2 Year over Year Performance					
	2021	**2022**	**2023**	**2024**	**2025**
ED LOS (hrs)	18.56	25.02	21.13	18.54	18.77

Q1-Q2 Year over Year Performance					
	2021	**2022**	**2023**	**2024**	**2025**
Volume	9966	10821	12146	11133	11147
%PERS	63%	77%	71%	73%	71%
BH Admit (Sentara)	1638	1861	1998	2038	2522
BH admit (non-Sentara)	2075	2069	2127	2172	2130
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Sentara - $10m improvement since 2022 due to ED BH LOS reduction

Financial Benefits (these are “soft savings”)

- **$9.742 million saved by reducing ED BH Patient Days since 2022**

Direct expenses, ED throughput, improved med/surg admissions, reducing left without being seen rates, as well as reduced direct coasts for boarding patients = $2264/day

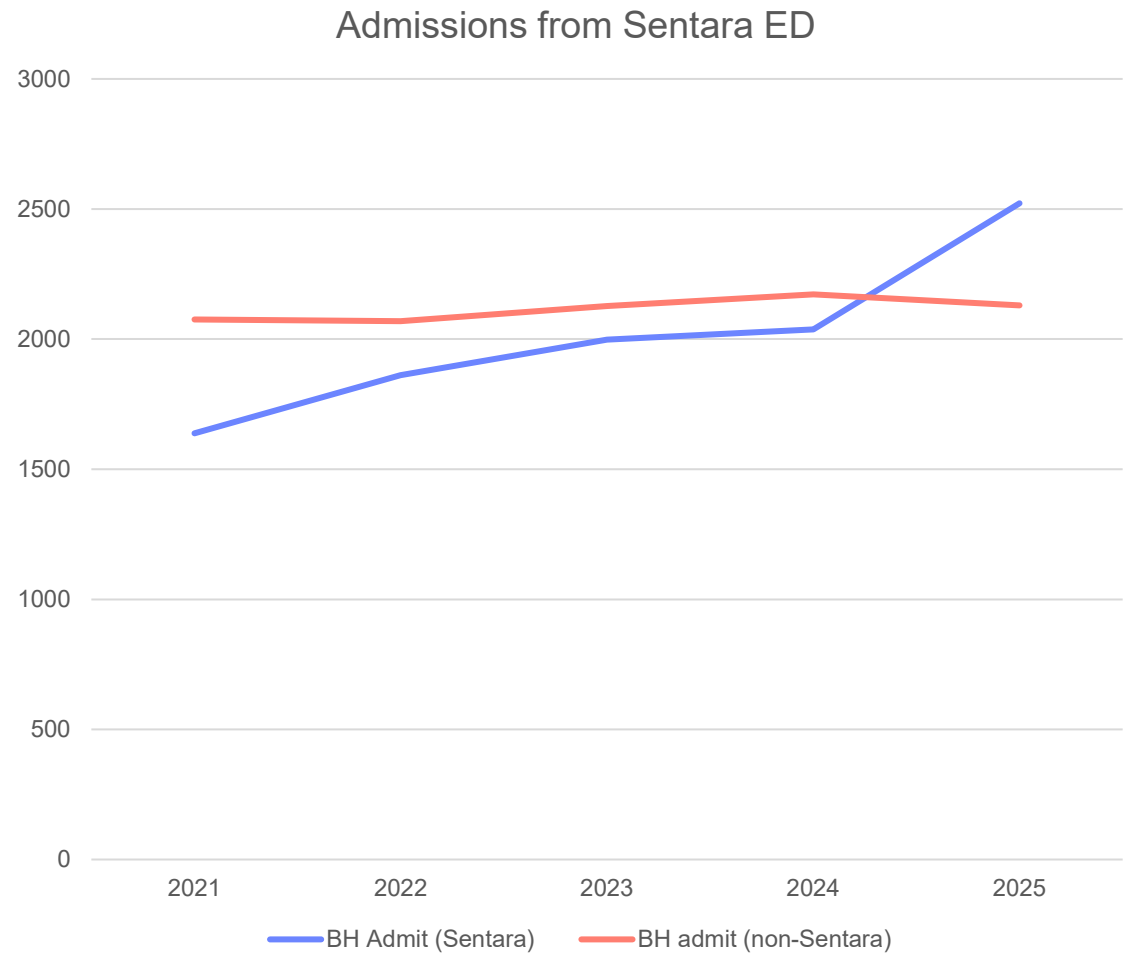
*Alakeson V, Pande N, Ludwig M. A plan to reduce emergency room “boarding” of psychiatric patients. *Health Aff (Millwood)* 2010;29(9):1637–42.

#6

Efficiently use Psych unit resources

BH unit LOS and margins (DRG vs. Per Diem)
BH unit coverage (staffing, physicians, locums)
Specific rules governing BH units (CMS, TJC, DNV)
Free Standing vs. Integrated BH unit

BH Admissions to Sentara > non-Sentara (first time in five years)



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#7

Leverage technology as a workforce multiplier

BH Workforce Shortage is extreme
Tech should amplify the impact of your available workforce
Telehealth is now standard
EHRs era of quicktext, templates, protocols, etc. still here
Era of AI is now here

AI for Notetaking

Dragon Ambient eXperience (DAX) – AI for clinical notes

(Epic, Microsoft, Dragon)

“After two weeks of use, it saves me about 1-2 hours a day in charting”

“Editing and not writing”

“Not static like copy forward notes”

DAX Copilot securely drafts clinical notes and can record in-office and telehealth patient visits – with patient consent – directly in Epic's Haiku mobile application. With the integration the EHR mobile app produces a draft note for immediate physician review and completion.

DAX reports a significant reduction in administrative burden, with 70% saying the AI tool embedded in the EHR reduced feelings of burnout and that it cut time spent on clinical documentation by 50%

“Nuance DAX use showed positive trends in provider engagement at no risk to patient safety, experience, or clinical documentation. There were no significant benefits to patient experience, documentation, or measures of provider productivity.” InterMountain Study 2024

https://pmc.ncbi.nlm.nih.gov/articles/PMC10990544/

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AI for Risk Prediction

Traditionally self harm risk prediction is hard. Who is safe to D/C, who would be IP, who should go to PHP/IOP? Etc.

Created AI to predict BH risk with ROC AUC of 8.6 (

Receiver Operating Characteristic curve and Area Under the Curve (ROC AUC): helps to understand how well a model can distinguish between positive and negative findings of binary model (ex. safe to home or not?)

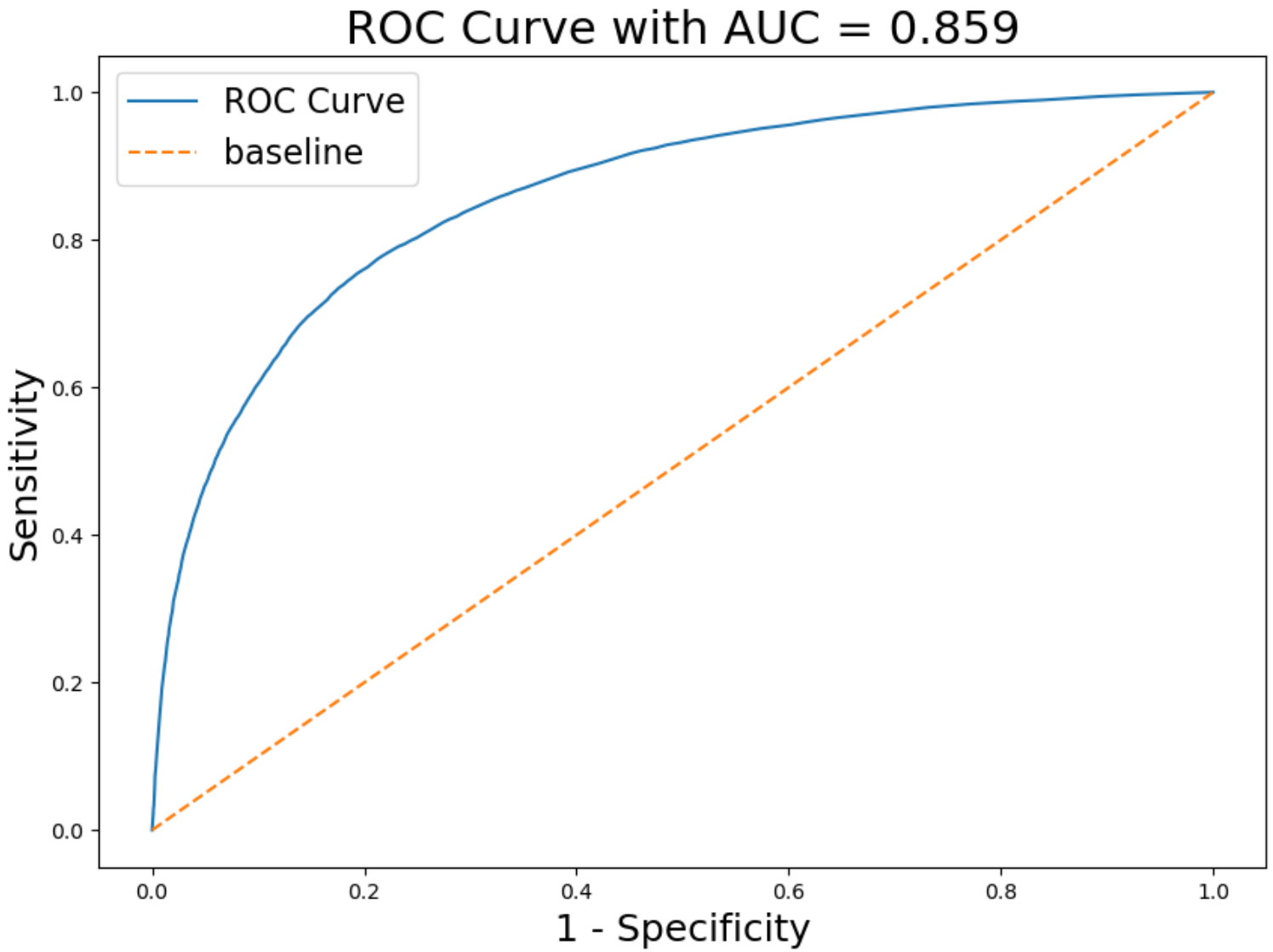
AOC ranges 0 to 1

Near 1: Excellent discriminative ability

0.6 – 0.7: Considered Good

0.5: No better than random guessing

Model Performance = excellent AUC



An AUC of 0.6 to 0.7 is considered “good”

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#8

Transition value of BH into population health management

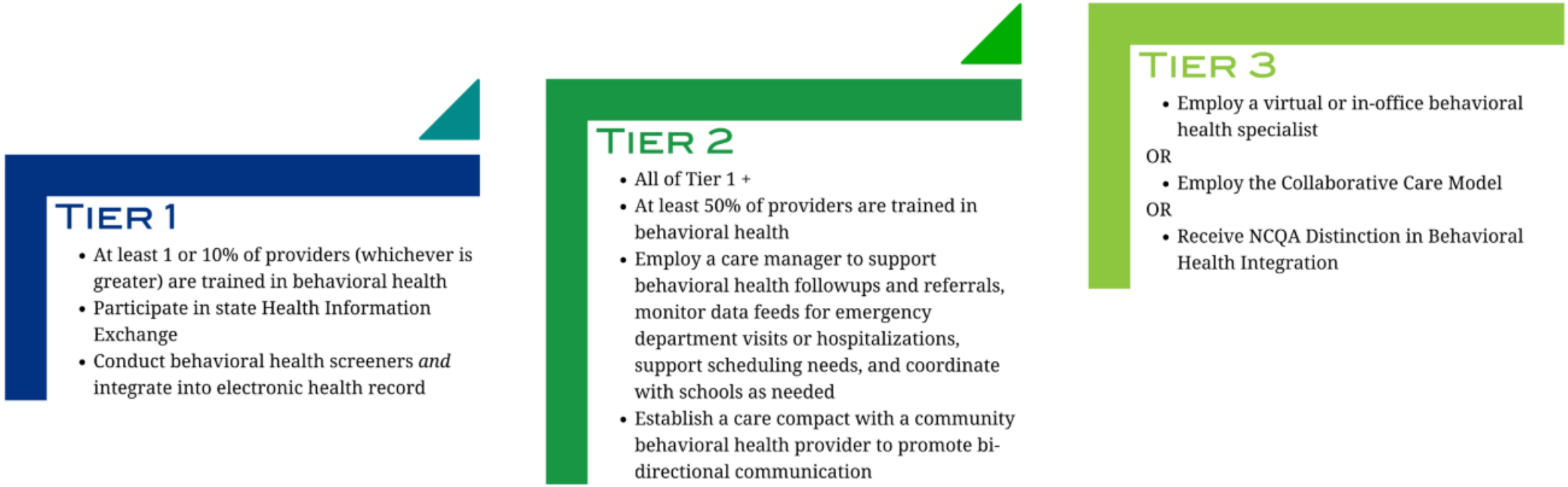
Margins are difficult, often impossible in fee for service model with BH

Margins are potentially very large in Pop Health Models with value-based care

Sentara – BHCC Value Based Model

- **Behavioral Health Care Center (BHCC) Value Based Model**
  - Health Plan side of Sentara "pre-purchased" slots to improve 7 to 30 day follow-up
  - Money invested in purchased slots used for BHCC seed money (physicians, APP, staff, operations, etc.)
  - BHCC patients
    - Reduced readmission rates by ~20% compared to other populations
    - Improved PMPM return on patients by about ~$296/month (2022) and $264/mo (2023)
    - Improved Medical Expense Ratio (MER) by 18% (2022), 7% (2023)
  - Opened another clinic Hampton Roads, VA based on this data
  - Planning a third clinic

Primary Pathways – Virginia Medicaid (Aetna, Sentara)



Participating practices will receive two types of payments from participating health plans:

1. *Upfront capacity-building payment to support infrastructure costs*
2. *Per member per month (PMPM) payments for all health plan patients based on tier (payments increase as tier increases)*

https://www.vahealthinnovation.org/primary-pathways/

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Incentive Models

Virginia DMAS Medicaid

Private Physicians State Directed Payment Program (supplemental payments) – includes “Substance Use Disorder - Screening, Brief Intervention and Referral to Treatment (SBIRT)”

Medicare MIPS

-Quality ID #134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan

#9

Create niche programs that support the unique needs of the system's community and members

Local/regional populations need local/regional solutions
Staff reflect/understand community demographics?

Geriatrics, Child/Adolescent
Perinatal/Postnatal, Bariatrics, Pain, Neuro, Plastics, Derm
LGBTQ+, Religious, Racial, SDOH

#10

Implement and expand evidenced based practices that reduce unwarranted variations in care

Use of screeners, metric-based care key
Lots of resources to help

Core Approach: Measurement-Based, Protocol-Driven Care

Adopt evidence-based clinical pathways: Use standardized guidelines (e.g., APA, AHRQ, NICE, Canadian Network for Mood and Anxiety Treatments [CANMAT]) as the backbone.

Measurement-Based Care (MBC): Require validated screening and follow-up tools for all patients (e.g., PHQ-9 for depression, GAD-7 for anxiety, ASRS for ADHD).

Tiered/stepped care protocols: Define what happens at each severity level (e.g., mild → brief interventions, moderate → SSRIs +/- therapy referral, severe → SSRIs + therapy +/- psychiatry).

Care team roles: Clearly define what PCPs do vs when they escalate to psychiatry/psychology vs other members (BH coaches, navigators, peer support, etc.).

Decision support tools in EHR: Embed order sets, flowsheets, and best practice alerts to prompt clinicians at the point of care.

Depression

Screening & Diagnosis: Annual PHQ-9 or PHQ-2 for all adults; full PHQ-9 for positives.

Protocol-based treatment:

- **Mild:** Watchful waiting, psychoeducation, digital CBT, +/- therapy
- **Moderate:** SSRI/SNRI, follow PHQ-9 every 4–6 weeks, +/- therapy.
- **Severe/complicated:** Same as Moderate, +/- referral to psychiatry, screen for bipolar, drug use, alcoholism
- **Positive suicidal thoughts on PHQ9?** Can use the Columbia-suicide Severity Rating Scale's Primary Care Screen with Triage Points

For suicidal patients can use the C-SSRS https://cssrs.columbia.edu/

- Remember: Use 988 over 911 whenever possible

Anxiety Disorders

Screening: GAD-7 routinely (esp. with anxiety/depression complaints).

Protocol-based care:

- **Mild:** Psychoeducation, CBT self-help programs.
- **Moderate:** First-line SSRI/SNRI, repeat GAD-7 q4–6 weeks.
- **Severe or treatment resistant:** Same as Moderate +/- Referral to psychiatry/psychology, screen for ptsd (PCL5), ocd (OCI-4, OCI-12, YBOCS), ETOH/drug use (SBIRT related pathways)

Special notes: Define when to avoid benzodiazepines as first-line (helps standardize prescribing). Deprescribing (benzo) protocols. Define benzo +/- opioids protocols.

ADHD (adult focus in primary care)

Screening: ASRS-v1.1 or Conners Adult ADHD Rating Scales.

Protocol-based care:

- **Confirm childhood onset & rule out mimics vs. comorbidities*** (depression, anxiety, sleep disorders such as OSA).
- **First-line:** atomoxetine, bupropion, stimulants (if no contraindications)
- **Standardize baseline monitoring** (BP, HR, substance use screen, PMP).
- **Define follow-up intervals** (initial monthly, then q3–6 months).

Decision aid: Use protocols for titration, monitoring, and diversion-risk reduction.

Factors to consider for “Adult ADHD”*

- Mimics vs. comorbidities are often the hardest thing to figure out
- Common diagnosis in population ~10% (age 4-17) and ~5% in adults.
- Family Hx important (ADHD has a strong family inheritance, up to 74%).
- Adult onset vs. delayed diagnosis:
  - Factors in delayed diagnosis: inattentive symptoms, **higher intelligence quotient (IQ), female sex, fewer externalizing behaviors (in childhood)**, higher socioeconomic status, and non-white maternal ethnicity
  - Would also add charisma and attractiveness to delayed diagnosis (my clinical observation, not evidenced based)

Key Resources for Protocol Building

AHRQ EPC Reports & Toolkits: Depression in Primary Care Toolkit https://integrationacademy.ahrq.gov/collaborative-care

APA Guidelines: https://psychiatryonline.org/guidelines

NICE Guidelines: Depression, ADHD, GAD protocols (very algorithmic, excellent for standardization). https://www.nice.org.uk/guidance

CANMAT Guidelines: https://www.canmat.org/

AIMS Center (University of Washington): Training and implementation resources for Collaborative Care. https://aims.uw.edu/resource-library/

Columbia Lighthouse Project (Suicide): C-SSRS https://cssrs.columbia.edu/

EHR Clinical Pathways: Templates with PHQ-9 (+/- C-SSRS) GAD-7, ASRS auto-scoring.

Common CPT Billing codes: CoCM: 99492, 99493, 99494, (G2214) - BHI: 99484 (G0323, G0511) - SBIRT: 99408, 99409, 99420 (G0396, G0397, G0442, H0049, H0050) - Screeners: 96160, 96127 (G0444) - Safety Planning Intervention: G0560; Follow-up Contacts Intervention: G0544; eConsults 99446-99449, 99451

Note: Because confusion about codes is common, you should verify your payers' policies. For instance, some plans require reporting of code 96160 for depression screening other than post-partum depression even though code 96127 is intended for reporting this service.

#11

Recruit, retain and continuously educate a robust BH workforce c/w the values of the community we serve

How does the BH workforce meet the needs of the population?

Summary = not very good, workforce shortage and maldistribution

Solutions: Expanding integrated care, leveraging health support workers (peer support), telehealth, team-based care (learning curve)

BH Workforce – Govt Health Workforce Report 2023

- Substantial shortages of addiction counselors, marriage and family therapists, mental health counselors, psychologists, and psychiatrists are projected to 2036.
- As of December 2023, more than half (169 million) of the U.S. population lives in a Mental Health Professional Shortage Area (Mental Health HPSA).
- Rural counties are more likely than urban counties to lack behavioral health providers. Residents of rural counties are also more likely to receive behavioral health services from primary care providers.

Source: https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/Behavioral-Health-Workforce-Brief-2023.pdf

- The majority of the BH workforce identifies as female and non-Hispanic White and may not be representative of the communities they serve.
- The lack of uniformity in BH providers' scope of practice (state to state), reimbursement challenges, and increased burnout hinder the accessibility of the BH workforce.
- Expanding integrated care, leveraging health support workers (peer support), and using telebehavioral health may help alleviate behavioral health workforce shortage and maldistribution.

Strategies – Hiring/Finding BH providers

More therapists in pipeline than prescribers.

Use usual and therapist specific sites to advertise.

Post-Covid world: Very important to note opportunities for tele/hybrid and distance work.

Post Ad and Wait:

For 1-2 prescribers and/or therapists, maybe posting an Ad will work. For psychiatrists, practicelink.com, practicematch.com, APA, state associations, loan repayment related, etc. can be successful.

Proactive (Go Find Them and Network):

If they don't apply or if you are planning a larger or longer-term growth strategy, you must go to where they are (specialty conferences, meetings, word-of-mouth, state association websites, residencies/training programs).

Notes: Setting up a booth? If you have an anchor provider, take them with you to the conference to "speed date" candidates. A Dyad of a recruiter + provider is more successful.

Proactive (Go Make Them):

If that fails, then train/make them. Become rotation/learning sites. Partner with programs for rotations. Use motivated staff.

Strategies – Sustainable Margins

Assumptions

- Ambulatory, fee-for-service model
- Therapists will pay for themselves and make margins.
- APPs will usually pay for themselves and have some margins
- Psychiatrists almost never pay for themselves (which is why most private psychiatrists are cash pay)

Use a pyramid structure of therapists and APPs (NPs/PAs) to offset the losses from the psychiatrists. A psychiatrist with 2-3 APPs and 4-8 therapists is often a sustainable model.

Attempt to hire psychiatrists that will do team-based care and work with APPs and therapists.

Psychiatrists & Team Based Care

- Traditionally, in the ambulatory setting, psychiatrists are trained in an intense 1:1 care. This model teaches that the 1:1 rapport is critical to successful outcomes and minimizes team-based care.
- Some psychiatry programs specifically train psychiatrists to avoid teams and/or supervision due to medicolegal concerns and quality concerns (ambulatory focused).
- Psychiatrists are versed in training students and residents. Many are also good with a limited number of therapists. However, most psychiatrists aren't adept at working with APPs.
- New models, experience and training programs are changing this tradition.
- Important to set expectations before hiring provider *especially if team-based care with APPs*. Compensation plan for supervision/collaboration is standard and have a diligent person (practice manager) keep track of collab/super requirements.

Questions?