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Facilitating Rapid Access to Outpatient Mental Health and Substance Use Care

Connected and Strong

Seventh in a Series of Ten Technical Assistance Briefs to Foster Unity and Strengthen Continuity Across Crisis Response and Treatment

SAMHSA
Substance Abuse and Mental Health Services Administration

Facilitating Rapid Access to Outpatient Mental Health and Substance Use Care

Acknowledgments

Authors: Renee Boak, MPH & Joe Parks, MD

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Abstract

Timely access to behavioral health services is critical for individuals' health and well-being. When access to care is delayed, it results in negative impacts on people and can worsen health outcomes. While efforts have been made at the federal and state levels and within individual organizations to improve access to care, barriers continue to exist and were exacerbated by the COVID-19 pandemic. Due to the increased need for services, as well as the challenges of providing services in person during the pandemic, regulatory agencies made allowances that increased access to telehealth services; however, the demand could not be met. Adults have continued to report symptoms of anxiety and depression throughout the pandemic and its aftermath, and young people under age 18 have also been reporting concerning rates of emotional distress. In 2022 there were more deaths by suicide than in any other year in the US and the highest rate since 1941, highlighting the imperative for rapid access to care. Overdose rates also have been alarming, highlighting the ongoing challenges in providing sufficient substance use services to meet the need. In addition, racial and ethnic minorities, members of the LGBTQI+ community, and other populations experience disparities in access to care. This paper explores strategies that health care organizations can adopt to increase capacity and create timely access to behavioral health services.

Highlights

- Access to behavioral health services is complex and dependent upon a number of factors; organizations should consider various strategies and models to increase access to care within their own organizations and work with federal and state governments to consider regulatory changes that can increase access to care on a wider scale.
- A standardized approach for measuring access to care is necessary for health care providers and insurers to be able to fully understand who is being impacted and how.
- Despite health equity efforts, there are still disparities in access to behavioral health care.
- The COVID-19 pandemic increased the need for behavioral health care and altered how behavioral health services are provided.
- The crisis system plays a critical role in the behavioral health continuum of care and is key in creating and facilitating access to care.

Recommendations

1. Achieve network adequacy across all health plans.
2. Define rapid/same-day access.
3. Establish national standards for accessing behavioral health care.
4. Promote and support the expansion of models of care that support timely access to behavioral health services.
5. Engage in efforts to reduce disparities in access to care at federal, state, and local levels.
6. Provide funding and support agencies in developing their own strategies for increasing access to care at the organizational level.
7. Ensure that behavioral health care providers are aware of contract, licensing, and/or certification standards regarding access, as well as their obligations for reporting to the state and any grant funding requirements for access to care.
8. Equip agencies with the technology and staff expertise to collect and report on access data and engage in continuous quality improvement efforts to improve access to care and address disparities.
9. Encourage providers working with youth and adolescents to offer flexible hours for families to maximize access to services while minimizing conflicts with school and work.
10. Enable organizations to support individuals in accessing and understanding insurance benefits and to work with individuals seeking services—and the community—to understand and remove barriers to care, including transportation and childcare barriers.
11. Support organizations in hiring qualified and capable staff, providing staff with training in cultural sensitivity, and increasing accessibility for all populations within the community.

Introduction: Access to Behavioral Health Services

According to the Kaiser Family Foundation (KFF), in 2021, approximately 40% of adults reported symptoms of anxiety and depression, and 57% of female and 29% of male high school students reported experiencing persistent feelings of hopelessness and sadness (an increase of 10% and 2%, respectively, compared with 2019). In 2022, there were more deaths by suicide than in any other year in the US and the highest rate since 1941.[1] Overdose rates also increased by more than 10% between 2019 and 2021.[2] Altogether, the demand for services in mental health and substance use care has grown, yet access remains elusive and limited in many ways. Disparities in access to behavioral health services remain a problem for many populations in need of care.

Access to Care

In 1993, the Institute of Medicine defined *access to care* as "having the timely use of personal health services to achieve the best health outcomes."[3] The Agency for Healthcare Research and Quality (AHRQ) described the four components that constitute access to care: 1) insurance coverage, 2) a usual source of health care services, 3) timeliness, and 4) capable, qualified, and culturally competent providers.[4] Even President Biden's 2023 Unity Agenda addressed the need for increasing access and connecting more Americans to mental health care and discussed ways to do so.[5] As part of the 2024 series *Connected and Strong: Strategies for Accessible and Effective Crisis and Mental Health Services*,[6] this technical assistance paper aims to highlight many ways that policymakers and program providers are thinking about enhancing services across the psychiatric continuum of care—increasing access to care is a critical theme.

Addressing each of the components proposed by AHRQ reveals the complexity of the problem of access. In the US health care system, for example, insurance coverage is a key component of access. Without insurance, individuals may delay or not seek care out of concern for the cost of services. In states with Medicaid expansion, a lack of insurance coverage has become less of a concern, though some people remain uninsured. Historically, there also has been a disparity in the way insurance covers physical health and behavioral health that has meant mental health and substance use disorder services have not always been covered. The federal government has enacted various laws addressing these inequities in coverage, and though access to care has improved, there are still barriers and ensuring the parity of behavioral health care coverage remains a challenge. The *Behavioral Health Parity Playbook*[7] of the National Association of State Mental Health Program Directors (NASMHPD) and the *Essential Aspects of Parity: A Training Tool for Policymakers* by the Substance Abuse and Mental Health Services Administration (SAMHSA) offers a detailed analysis of parity and how behavioral health policymakers can foster parity compliance in their states.

The second component of access is a usual source of care, such as a primary care provider (PCP). Without one, individuals are less likely to receive screening and prevention services.[8] Screenings for depression, anxiety, and substance use are essential to early identification of behavioral health disorders. Many of these screenings are offered as part of routine care, which is why it is critical for individuals to be established with a health care provider. The KFF found that cost is often a barrier to routine care and that some people postpone care and forgo or delay purchasing prescription medication due to cost.[9]

Timeliness of care is the third key component of access, but there is no standardized definition or metric of timeliness organizations can use to measure their provision of timely care. Healthy People 2020 defined *timeliness* as "the system's capacity to provide care quickly after a need is recognized," but "quickly" was not specifically defined.[10] Organizations will often assess risk during a request for services, determining if the need for services is routine or urgent and responding with an appropriate level of timeliness. They may also promote open- or rapid-access scheduling, which supports timely access to care.

The fourth component of access involves the health care workforce. Health care service providers in any organization providing care need to be capable, qualified, and culturally competent; this is critical in creating opportunities for access to care for all, but especially for historically marginalized populations. Health care organizations must understand their communities and the populations that they serve. A lack of culturally competent staff may discourage people from accessing care due to concern that their identity or culture will not be understood or represented.

Although each of these elements is critical to ensuring access to care, timeliness is currently receiving more attention in the United States as many Americans have experienced increased behavioral health challenges since the onset of the COVID-19 pandemic. Between 2019 and 2020, Mental Health America (MHA) found that more than 50 million US adults (20%) experienced a mental health challenge, and more than a quarter of these adults (28%) were unable to receive care. Additionally, 15% of youth experienced a major depressive episode in the past year and more than 60% did not receive any mental health treatment.[11] In 2020, the National Alliance on Mental Illness (NAMI) found that 17.7 million people experienced delays or cancellations for mental health appointments, and 4.9 million people were unable to access any mental health care.[12]

Impact of Delayed/Not Received Health Care

When care is not provided promptly, outcomes worsen. People not receiving care in a timely manner can face a variety of negative outcomes, including not having important issues addressed (which can lead to nonadherence), relapsing on substances like opioids, running out of crucial medications like psychiatric medication, or even dying by suicide while waiting for care. Delayed access to treatment may also mean that, eventually, a higher level of care will be

required from emergency departments, crisis services, or inpatient psychiatric services and more expenses will be incurred than if the condition had been treated in an outpatient setting. Untreated mental health or substance use disorders not only can cause poor health outcomes for the people not receiving care, they also can have negative impacts for the other people in their lives. In May 2022, the National Council for Mental Wellbeing released results from its Access to Care Survey indicating that when people did not get mental health or substance use care, they also experienced negative impacts in their personal and professional lives (see **Figure 1**).

Figure 1: Impacts of Lack of Access to Mental Health and Substance Use Care

2022 Access to Care Survey Results. Washington, DC, National Council for Mental Wellbeing, 2023, p. 17. https://www.thenationalcouncil.org/resources/2022-access-to-care-survey-results/

Experiencing negative impacts in any of these areas can also exacerbate any mental health or substance use disorders, further contributing to negative health outcomes.

Federal Efforts to Improve Access to Care

For more than a decade, the federal government has enacted laws to address parity between physical and behavioral health care insurance coverage to improve access to care, but these laws have still not fully addressed the problem. The 2009 Mental Health Parity and Addiction Equity Act (MHPAEA) required all large group employer-based insurance plans to provide equivalent coverage of behavioral health and physical health services to increase coverage and access to behavioral health services; however, the requirement excluded small businesses with 50 or fewer employees, Medicaid Managed Care plans, and any health plans purchased through the marketplace.[13]

In 2010, the Affordable Care Act (ACA) was signed into law, which expanded access to health care coverage through health marketplace subsidies and state Medicaid programs. Between 2014 and 2015, the ACA supported increased access to behavioral health services for more than 62.5 million Americans.[14] The ACA extended coverage for young adults on their parents' health plans up to 26 years of age, regardless of whether they lived with their parents. This increase in age limit allowed many young adults to maintain their health care coverage under a parent's plan during potentially vulnerable times of employment.

In addition to expanding coverage for millions of people, the ACA provided greater protection for people with behavioral health disorders by ending discrimination against people with preexisting conditions, including mental and substance use disorders. Prior to the ACA, individuals could be denied health care insurance if they had a history of substance use or a mental health diagnosis, which, in many cases, meant they would not receive treatment for these conditions. To address the need for more qualified, capable, and culturally competent providers, the ACA required health plans offered through the marketplace to support provider choice and make information available about in-network and out-of-network providers. This is important because health plan networks are a key determinant of whether individuals are able to access care, particularly when services are provided out of network, which often results in denied claims or claims that are paid at a reduced rate.[15]

The 2018 Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment of Patients and Communities (SUPPORT) Act continued to push for improved access to behavioral health services with an emphasis on increasing access to treatment for individuals with an opioid use disorder (OUD). Key provisions in the SUPPORT Act included requiring the Children's Health Insurance Program (CHIP) to cover mental health and substance use disorder services, expanding provision of telehealth services for individuals with an OUD to individuals with Medicare, requiring coverage of screening and referrals for individuals with an OUD or other substance use disorders, and expanding provision of medication-assisted treatment services by allowing additional provider types to prescribe.[16] The American Hospital Association (AHA) believed the SUPPORT Act to be the most comprehensive response to the country's opioid epidemic to date;[17] the legislation removed restrictions to better support Medicare and Medicaid

beneficiaries in accessing opioid addiction treatment while aiming to decrease the overprescription of opioid medications.

Enforcement is one of the biggest challenges in ensuring parity. In 2022, the Department of Labor's Employee Benefits Security Administration engaged in more mental health parity investigations than any previous fiscal year.[18] The Consolidated Appropriations Act of 2021 provides the federal government with traction to better enforce parity laws across the country by allocating resources and tools so that all Americans have access to mental health and substance use disorder services.[19,20] The New York State Office of Mental Health created a list of red flags for health insurance plan members to increase awareness of potential violations of parity. Red flags included requiring preauthorization or prenotification for all substance use disorder or mental health services, refusing a course of treatment due to lack of progress, placing geographic limits on where an individual can receive services without having similar limitations for the provision of medical services, and having no in-network substance use or mental health providers accepting new patients within a reasonable distance.[21]

Other Factors Influencing Access to Care

Health care providers experience barriers in providing timely access to care when services are not sufficiently funded, making it difficult to recruit and retain staff and afford the administrative and technological support needed. Inadequate funding in the Medicaid system has resulted in agencies primarily funded by Medicaid being less competitive with other organizations in terms of provider salaries, which makes recruitment and retention difficult and turnover common. In addition, the large volume of telehealth services provided during the pandemic by staff working remotely has led to many staff not wanting to physically return to the workplace and seeking out new, remote employment.

It is well known that overall workforce shortages are looming large across a variety of industries. As highlighted in the 2024 NASMHPD paper *Connected and Strong*[22] and further reviewed in *Growing and Strengthening the Behavioral Health Crisis Response Workforce,*[23] the Biden Unity Agenda emphasized the critical need to strengthen the workforce moving forward to build a complete continuum of psychiatric care. In addition to the workforce shortages that are impacting the entire health care industry, individuals living in rural and remote counties may experience additional or amplified challenges in accessing behavioral health care. They may have great distances to travel to receive services in person, and in many rural communities, they may have limited or no options for public transportation and medical transport. Some communities are especially unable to attract and retain behavioral health care professionals.

Individuals can experience other barriers in access to care, including stigma, language or culture barriers, lack of childcare or transportation, and poor health literacy. Many individuals with serious mental illness experience feelings of stigma when discussing their behavioral health concerns with their PCP. Integration and care coordination are critical in supporting individuals

with serious mental illness in addressing their behavioral health care needs, which is why it is increasingly common to see primary care and behavioral health care providers create partnerships or co-location partnerships. In addition, health care providers must have bilingual staff or work with a translation company to be able to provide treatment services for individuals who do not speak English. Health care providers should regularly seek to understand barriers to care for the populations they serve and engage in continuous quality improvement efforts to address disparities.

The Impact of the COVID-19 Pandemic

The COVID-19 pandemic exacerbated challenges in accessing behavioral health care across the country and created additional barriers to care, even while the expansion of telehealth proved to be a catalyst for reforming certain clinical approaches to improving access. According to the AHA, utilization of behavioral health services decreased substantially between April and October 2020 in all states and for all ages from birth to 64 years.[24] In addition, the Centers for Disease Control and Prevention (CDC) found a sharp increase in adults experiencing behavioral health conditions following the onset of the pandemic, with LGBTQI+ communities, youth, and people of color disproportionately impacted.[25]

Partially in response to this need, the federal government passed the 2021 American Rescue Plan Act (ARPA), which allocated $1.5 billion for mental health and substance use prevention and treatment grants to states. In its 21st annual Medicaid budget survey, the KFF found that all responding states had one or more initiatives to expand behavioral health care in fiscal year 2021 and/or 2022. The survey found that more than half the states had plans to develop community-based mobile crisis services, and many states plan to continue covering telehealth services post-pandemic to maintain or increase access to behavioral health supports.[26]

The federal government ended the COVID-19 public health emergency on May 11, 2023, which returned many programs to their pre-pandemic state, effectively ending flexibilities that were provided during the pandemic to support behavioral health services. Recognizing the positive impact of the increased provision of telehealth services during the COVID-19 pandemic, states and regulatory and governing bodies, such as the Drug Enforcement Administration, are examining whether stopping any of these temporary telehealth provisions will impact access and/or further aggravate disparities.[27] Permanent changes for Medicare beneficiaries now allow for behavioral and mental telehealth services to be delivered using certain audio-only communication platforms. In addition, Medicare allows federally qualified health centers and rural health centers to be distant providers of behavioral and mental health care in beneficiaries' homes, meaning there is no longer a geographic restriction on service provision for the originating site.

Defining Access to Care/Rapid Access and Identifying Entry Points for Behavioral Health Services

Definitions

As noted, there are no specific definitions or parameters for what timeliness looks like in terms of access to care, and there is no standard or industry-wide definition for rapid access to care. Knowing that outcomes worsen when access to care is delayed, many organizations are working to create rapid, or fast, access to care and to define what that means for them.

Contracting and regulatory definitions of access are generally considered to be part of network adequacy standards. Network adequacy ensures that health plans are meeting their state's standards; however, there are no national standards for health plans, which results in variation in network adequacy across states as well as by health plan. Health plans determine how to measure their own network adequacy; for example, networks may assess time and distance among network providers, establish a minimum number of providers in the network based on health plan enrollees, or consider provision of telehealth services.[28] To equitably increase access to care, national standards for network adequacy should be developed to which all health plans would be accountable.

Many health care providers promote open-access scheduling to create rapid access to care. According to the AHRQ, open access—sometimes referred to as advanced access or same-day scheduling—is a method in which individuals are able to schedule an appointment on the same day they call to request services. Instead of booking out a provider's schedule for the weeks and months ahead, organizations using open access leave about half of the time slots available in a provider's schedule open to be scheduled on the day of the needed appointment.[29] The AHRQ found that an open access scheduling model provides several benefits, including:

Models of Scheduling

- Open access
- Same-day access
- Next-day access

- reduced or eliminated delays in care, typically resulting in higher levels of satisfaction with care;
- decreased appointment demand as individuals can meet with their providers more often;
- increased continuity of care, which is associated with better health outcomes and satisfaction with care; and
- increased cost savings and efficiency as staff spends less time managing no-shows and waiting lists.[30]

Other scheduling options include same-day and next-day access models. Organizations approach these scheduling models in their own way without a uniform standard or fidelity standard to meet.

The same scheduling models can be used for first appointments and follow-up appointments. Often, for a first appointment, there is a preliminary meeting and screening session that yields enough information to determine what type of provider is needed or how quickly the patient needs to be seen for a more complete assessment. Some of these are very basic and more of a triage function than a meaningful clinical intervention. However, for some clinics, first appointments include an entire biopsychosocial assessment that sets the stage for a treatment plan and follow-up care. It is important for organizations to be clear about when people can expect to receive their first meaningful clinical services and what those will look like. Individuals seeking service should be informed if they will have meaningful clinical support during the first interaction and, if not, what the average time is until a more complete appointment. With the current workforce challenges and shortages, implementing some of these practices is challenging, but communities across the country are exploring ways to realize these goals for first appointments and scheduling models.

Recognizing the importance of prioritizing based on need, health care providers may choose to assess risk and assign a priority status. According to Kaiser Permanente, *routine care* is the delivery of care that includes preventive health services and appointments for nonurgent symptoms. It is important that routine care is timely; however, routine needs do not require immediate or next-day response. *Urgent care* is for needs that are not life-threatening; they do not require an emergency level of response, but they do require a timelier response. *Emergency care* is required for conditions that are life-threatening.[31]

Defining the various components of access and the models for providing care is important for prioritizing need, standardizing access, and improving quality. Regardless of how these components are defined, there are additional factors that impact access to care, including implementation approaches that can improve rapid access to care.

Entry Points for Behavioral Health Services

Individuals often bring up concerns about feelings of depression, anxiety, or suicidal ideation with their PCP. The PCP may manage the condition or, if it is more severe, refer the patient to the behavioral health department, a substance use disorder specialist, or both, so that a psychiatrist and/or therapist can further assess and treat the patient.

PCPs should have established protocols for referring individuals for mental health, suicidal ideation, and substance use care and for referring individuals who have co-occurring conditions. As explained in the paper *Increasing Equitable Access to Care for Co-Occurring Mental Health and Substance Use Disorders*,[32] all too often, co-occurring conditions are poorly addressed if only one is treated. In addition, PCPs, OB-GYNs, and other practitioners should have in place

methods and processes for assessing risk for patients with more urgent psychiatric needs, such as those who present with thoughts or behaviors signaling acute risk of harm to themselves or others that requires emergency care, or if the risk is not emergent and urgent care is more appropriate.

There are several types of screening tools available. The Patient Health Questionnaire 9 (PHQ-9) is a standardized, self-administered depression screening tool that is used in primary care and behavioral health care settings. The PHQ-9A is a modified version of the tool designed for adolescents between ages 11 and 17. Individuals complete the questionnaire, often in the waiting or exam room. Each response has a point value, and the score indicates the severity of depression and the appropriate follow-up protocol.[33] There is also a PHQ-2, which is a two-question assessment that screens for suicide ideation. The PHQ-9 has been shown to be both a reliable and valid screening tool. The Columbia Suicide Severity Rating Scale (C-SSRS) is another brief assessment tool that screens for suicide risk and is often used in combination with the PHQ-9.[34]

For substance use disorders, health care providers often rely on the Screening, Brief Intervention, and Referral to Treatment (SBIRT) approach.[35] Like the PHQ-9, SBIRT is an evidence-based screening and assessment approach; SBIRT incorporates a method of screening, an intervention to help move the patient closer to treatment, and an appropriate referral.

Other screening tools used for behavioral health include the Pediatric Symptom Checklist (PSC) to screen for cognitive, emotional, and behavioral health needs in the adolescent population; the GAD-7 to screen for generalized anxiety disorder; and the Mood Disorder Questionnaire (MDQ), a self-administered tool that screens for bipolar disorder.[36] Screening tools can result in an individual's entry into behavioral health services, but individuals presenting with symptoms of more complex behavioral health conditions, like schizophrenia or an OUD, can be seen in outpatient specialty behavioral health clinics when they go there directly. Outpatient behavioral health clinics, such as community mental health centers, often have teams to support individuals with their behavioral health needs; team members may include psychiatrists, nurse practitioners, counselors, case managers, and individuals with lived experience. While some organizations have waiting lists that can delay access to treatment for weeks or even months, improving timely responses is part of the current policy direction many organizations are pursuing.

When individuals are identified to be a safety or self-harm risk, or if they are experiencing a behavioral health crisis in the community, calling the national 988 Suicide & Crisis Lifeline is an option as part of the continuum of care. This hotline is staffed by trained responders across the country to address acute needs and then provide support and referrals for ongoing care. In order for 988 and the crisis continuum to be fully effective, rapid access to mental health and substance use care via referrals from 988, mobile crisis, crisis stabilization and/or emergency departments is critical.

Additionally, more acute behavioral health needs can be addressed in urgent care clinics, crisis stabilization units, and mobile crisis response programs whose staff go to the site of the crisis. In

some cases, individuals may seek care through the emergency departments of hospitals; however, there are often other more accessible and cost-effective alternatives to address nonemergency behavioral health care needs. The Substance Abuse and Mental Health Services Administration (SAMHSA) 2020 *National Guidelines for Behavioral Health Crisis Care*[37] and other technical assistance papers by the National Council for Mental Wellbeing[38] and NASMHPD[39] provide recommendations and descriptions of crisis response services.

As the continuum of care is further developed, understanding the variety of resources within a community to help support an individual in a behavioral health crisis can be challenging. Urgent care clinics for physical health issues are often open into the evening hours and on weekends to create an avenue for urgent care needs that do not warrant a visit to the emergency department in medical contexts, and some are being used to also support behavioral health needs.[40] In addition to urgent care clinics, many communities across the country have mobile crisis programs. Mobile crisis response teams are most often made up of an interdisciplinary staff that may include counselors, individuals with lived experience (peers), and/or medical professionals. Mobile crisis teams assess risk and provide short-term care and support for individuals who are experiencing behavioral health crises. Care can be provided in the community, including in homes, and can support hospitalization or access to higher levels of care when appropriate. Mobile crisis response is often available outside of traditional business hours. After an immediate crisis has been addressed, the team often supports the individual in accessing long-term behavioral health support through referrals, warm handoffs, and care coordination. These avenues represent typical ways people enter the behavioral health service system, and there a variety of programs within this continuum of care to help people in need of care.

The Crisis Assistance Helping Out On The Streets (CAHOOTS) program is one example of a crisis service model designed to help people access care. This mobile crisis response team in Eugene, Oregon, was created in 1989 to improve the city's response to behavioral health crises and homelessness. It is an example of a mobile response service that has gotten attention as a potential model for communities. Developed through a collaboration of the city government, police department, fire department, emergency medical services, and the mental health community, the program now provides 24-hour crisis response to two cities in central Oregon and can respond to more than 65 calls per day.[41] CAHOOTS reports that it responded to more than 24,000 calls in 2019 and saved the City of Eugene around $8.5 million in public safety fees.[42] Based on CAHOOTS's success for more than 30 years, other cities around the country are developing similar models in which emergency response, crisis systems, and behavioral health professionals are available to address acute behavioral health needs and support access to ongoing care. These models represent the evolving network of options available for individuals to access services—through screening, general or specialty clinics available for more immediate needs, or mobile crisis-response teams. The foundational elements of access to care will continue to include systems that are growing to meet the needs of the community and connect Americans

to care.[43] The challenge now is to make services more immediately available through these various systems.

Rapid Access in an Outpatient Setting

Despite a growing number of pathways into care, all too often there are barriers to care, such as waiting lists and a lack of supply for the increasing demand. As such, there have been different approaches to maximizing rapid access to behavioral health services. The Same Day Access (SDA) model developed by MTM services has been used by many organizations to increase access to services by eliminating wait times. Unlike fast- or rapid-access models—where it can take up to 10 days to be seen by a health care professional—the SDA model offers an assessment on the day services are requested. Health care organizations that use the SDA model find that, on average, the intake process decreases from 3.5 hours to 1.5–2 hours; in addition, the first clinical appointment after the assessment usually takes place within 48 hours instead of 3–7 days. MTM has found that the SDA model increases staff and organizational efficiency by 10%–15%, which allows clinicians to provide additional intake and counseling services without having to hire additional staff.[44]

The SDA model consists of three key elements:

- The health care provider offers blocks of times where an individual can walk in and receive an assessment.
- When an individual walks into the clinic, a clinician completes a comprehensive diagnostic assessment and establishes at least one goal based on the reason the individual presented for services.
- The individual leaves with a return appointment for treatment (ideally within 8 days or less) and, if warranted, an appointment for a psychiatric evaluation (ideally within 3–5 days).

Within the SDA model, it is critical for the staff and the organization to be efficient with time. Organizations must be efficient in collaborative documentation, centralized scheduling, no-show management, and evidence/level of coverage understanding. In its work supporting SDA with health care providers across the country, MTM has identified common misapplications of the SDA model that include:

- offering walk-in access to complete paperwork and then scheduling the assessment once that paperwork has been completed;
- offering some walk-in access for assessment once per week or month while continuing to schedule most assessments; and
- having individuals arrive in the morning and then offering appointment slots for later in the day.

The SDA model has demonstrated a significant improvement in access to care by reducing the amount of time required to complete an intake process while lowering the cost of the intake. Many organizations take steps to create same-day access to care, but organizations that continue to schedule assessments, turn people away from same-day access due to capacity issues, or take more than 1 day to complete an assessment are not engaged in same-day access processes.[45] Findings suggest that open-access scheduling may reduce appointment scheduling wait times by 83% and no-show rates by 67%. It can double patient volume and increase provider productivity by 83%, while decreasing emergency and urgent care visits by 75%.[46]

MTM offers tailored support for organizations implementing the SDA model and can support health care providers in developing virtual SDA. For organizations considering whether the SDA model is right for them, MTM recommends:

- making sure the volume of new services is large enough to support SDA;
- illustrating how individuals spend time in the office during the intake process (i.e., creating a workflow);
- identifying clinician hours dedicated to assessments;
- coming up with a transition plan; and
- communicating the plan and updates.

Access Systems and Models

In addition to accessing specific crisis services like the 988 Suicide & Crisis Lifeline, mobile crisis response, and crisis stabilization, rapid and timely access to care is necessary to respond to referrals for ongoing care for persons exiting the crisis system and to reduce demand for crisis services. As emphasized in the NASMHPD 2022 compendium *From Crisis to Care: Building from 988 and Beyond for Mental Health Outcomes*,[47] a waiting list for access to routine care is also a list of persons at increased risk for experiencing a mental health or substance use disorder crisis prior to being seen.

Grassroots Approaches at the Community Level

Although some individuals will access care through their PCPs, others may seek help from friends and family. Because of the very critical role that such safety nets can play in supporting individuals, many organizations have developed strategies to help communities address mental health issues. SAMHSA, for example, has developed resources on planning and holding "community conversations" about mental health.[48,49] The goal of these types of resources is to help foster dialogue at the community level to break down stigma and teach people how to access care, whether for crisis or noncrisis situations. Another example is Mental Health First Aid (MHFA), a course that teaches people how to identify, understand, and respond to signs of mental health and substance use issues even when they have had no prior experience with them. The concept is similar to providing CPR training to nonmedical professionals using very basic

knowledge and skills. MHFA training provides easily understood, specific skills for individuals to reach out and provide support to someone who may be experiencing a mental health or substance use crisis.[50]

Crisis Services

The availability of crisis care services in a community is vital to access to care, and these services also can create linkages to outpatient behavioral health care. According to SAMHSA, "with nonexistent or inadequate crisis care, costs escalate due to an overdependence on restrictive, longer-term hospital stays, hospital readmissions, overuse of law enforcement, and human tragedies that result from a lack of access to care."[51] The establishment of the 988 Suicide & Crisis Lifeline and current efforts toward building a more robust crisis continuum of care are critical to maximizing access to care.

Telehealth Services

Provision of telehealth services for mental health and substance use disorders increased by almost 40% during the COVID-19 pandemic. Telehealth services allowed individuals to initiate or continue behavioral health services during the pandemic without increasing their risk of exposure to COVID-19.[52] Telehealth services also improve access for individuals who may experience barriers to care such as lack of transportation or childcare, great distances to travel, or difficulties in leaving the home. With the increased ease of telehealth services, technology companies can continue improving and innovating how individuals—especially individuals with Medicaid—can benefit from the use of digital platforms. As technologies develop, it will be important for leaders to stay abreast of them. The 2024 technical assistance paper *Innovative Uses of Technology to Enhance Access to Services within the Crisis Continuum*[53] details many ways that technologies are advancing and how they should be thought about as potential aids and used without introducing risks of poor quality of service delivery.

Integrated Physical and Behavioral Health

Integrating physical and behavioral health care can increase access to behavioral health treatment. Integrated care consists of multidisciplinary teams working together to support the physical health, mental health, and substance use needs of their patients. Organizations that offer integrated physical and behavioral health services create access to specialty behavioral health care within their own organization and can offer consultation support through the provider team. Although integration efforts look different across different organizations, the Commonwealth Fund has found several common elements of integrated practices:

- Provision of team-based care
- Universal screening for mental health, substance use, and physical health

- Shared information systems to improve care coordination
- Use of tools, such as registries and computer databases, that collect and organize health care information for a group of individuals with a characteristic in common in order to manage patient outcomes and availability of slots for care
- Partnerships with social and community behavioral support
- Person-centered treatment planning that allows for participation from family members and caregivers[54]

In addition to increasing access to behavioral health services, integrated care teams are better positioned to support health and wellness goals, provide annual screenings, use evidence-based practices, coordinate care, and leverage technology to support service delivery and improve health outcomes. Integrated care is supportive of improving access to services for individuals with co-occurring mental health and substance use disorders as well as individuals who have co-occurring behavioral health and/or developmental disabilities or traumatic brain injuries.

Certified Community Behavioral Health Clinics

To remove barriers in accessing care, Certified Community Behavioral Health Clinics (CCBHCs)[55] are set up with requirements that include serving all individuals regardless of their ability to pay, age, or place of residence. CCBHCs are required to meet timely access standards for routine and urgent needs that have been set forth by the Centers for Medicare and Medicaid Services, SAMHSA, and, where applicable, the state behavioral health authority.[56]

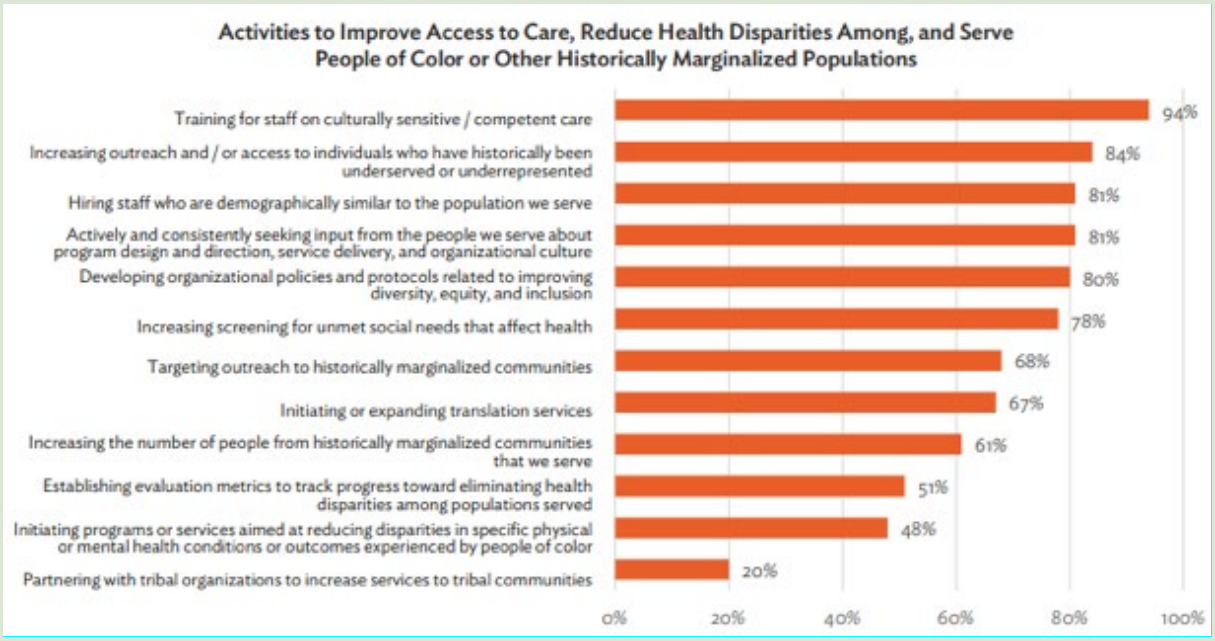
CCBHCs are required to conduct a community needs assessment every three years. The assessment informs the organization about who is being served, and it should identify any populations not being served and any barriers in accessing care. The needs assessment also details the primary languages of those receiving services—the CCBHC can use this information to support access by hiring bilingual staff, partnering with trained health care interpreters, and translating important documents (e.g., intake forms, sliding fee scales, and after-hours support) into the languages spoken by the populations it serves. In addition to supporting individuals with limited English proficiency, CCBHCs support individuals with hearing impairment through teletype lines.

According to the National Council for Mental Wellbeing's *2022 CCBHC Impact Report*, 100% of the responding CCBHCs agreed that their status as a CCBHC helps them improve access to care and reduce disparities.[57] **Figure 2** shows activities that CCBHCs undertook to improve access to care, address health disparities, and better serve people of color and other populations that have been historically marginalized.

Access to care extends to the physical environment for CCBCHCs. They should have a safe, functional, welcoming, and clean environment that is accessible for all individuals (i.e., with functioning elevators, handicap-accessible parking spaces, and wheelchair-accommodating door frames). CCBHCs serving large adolescent and/or youth populations may decide to create separate waiting areas that provide a welcoming, child-friendly environment with toys and books.

With their emphasis on care coordination and collaboration, CCBHCs support individuals in accessing other health care and social service providers, including physical health, housing, education, and employment services. CCBHCs also coordinate individuals' transitions between levels of care; CCBHC staff will work with individuals being discharged from hospitals and the hospital team to support the discharge and coordinate follow-up needs, including with ongoing medication prescriptions or referrals to another care provider.

Figure 2: Activities Undertaken by CCBHCs to Improve Access to Care



2022 CCBHC Impact Report. Washington, DC, National Council for Mental Wellbeing, 2022, p. 26. https://www.thenationalcouncil.org/resources/2022-ccbhc-impact-report/

Collaborative Care Model

Because PCPs are often the first to identify behavioral health needs in their patients, models that provide for collaborative opportunities with behavioral health specialists can be helpful in improving access to needed care. The University of Washington developed the Collaborative Care Model (CoCM), an integrated approach designed to treat anxiety and depression in a primary care setting. The CoCM has five core elements:[58]

1. Patient-centered and team-based care approach to service delivery: elevating the client voice and collaborating with the multidisciplinary treatment team to identify treatment goals.
2. Population health management: identifying populations of individuals and providing targeted interventions that improve health outcomes while reducing the overall cost of care.
3. Measure-based care (treat to target): using evidence-based tools to measure and monitor progress and adjust treatment plans as needed.
4. Evidence-based practices: using standardized and validated tools and practices to address behavioral health; common evidence-based practices include cognitive behavioral therapy, motivational interviewing, dialectical behavioral therapy, and assertive community treatment.
5. Accountable care: using health plans providing reimbursement for clinical outcomes and quality of care (value-based payment) and not a fee-for-service payment model.

In the CoCM model, the PCP prescribes medications and works with the behavioral health case manager and the consulting psychiatrist to address behavioral health care needs or concerns. To support patients in improving health, the CoCM provides education and skill-building in chronic disease management. To support care coordination and population health management, it is important that providers have protected time to engage in these efforts. CoCM has been shown to be one of the most effective approaches to increase access to mental health services.[59]

In 2018, CMS updated the Current Procedural Terminology (CPT) codes to include CoCM codes that allow practitioners to bill for the cumulative time that the team has spent providing services under CoCM.[60] Expanding CoCM CPT codes through Medicare Advantage and managed care organizations could result in payers being better able to represent and cover their total costs of care.

Child Psychiatry Access Programs

Most states across the country now have child psychiatry access programs, and the National Network of Child Psychiatry Access Programs (NNCPAP) is a clearing house that provides information about them (https://www.nncpap.org/). These programs have been developed over many years, beginning with the Massachusetts Child Psychiatry Access Program (MCPAP), which provides a system of regional consultation teams for children's behavioral health throughout Massachusetts that is designed to support PCPs, pediatricians, and others in

managing their pediatric patients (https://www.mcpap.com/). MCPAP for Moms also provides resources for obstetricians and PCPs caring for new moms (https://www.mcpapformoms.org/). For MCPAP, the goal is to improve access to behavioral health services for children by supporting pediatric teams in building competencies in

- screening, identification, and assessment;
- treating mild to moderate cases of behavioral health disorders using evidence-based practices; and
- making referrals and coordinating care for individuals who would benefit from community-based specialty behavioral health services.

Today, various funding streams help provide support for these types of programs. In Michigan, for example, the MC3 program relies on a combination of state funding, grant money from the Health Resources and Services Administration (HRSA), and funding from special initiatives, though much of the work began with donations from local foundations. The program expanded to include consultations with OB-GYNs for perinatal support, as well as expansions to work with school-based health centers and to develop means to train the next generation of practitioners.[61] As HRSA continues to help improve access by supporting child psychiatry access programs like these and through their Pediatric Mental Health Care Access Programs,[62] more innovations in these consultative models can be expected.

Veterans Choice Program

The Veterans Choice Program was developed to address barriers and support benefit-eligible veterans in accessing mental health care from providers outside of the Veterans Health Administration network. A key component of the program is that it allows veterans who have wait times of more than 30 days, or who are located more than 40 miles from the nearest Veterans Administration (VA) facility, to receive care that is paid for by the VA and delivered by contracted non-VA providers.[63] For the Veterans Choice Program to maximize its potential, it must develop a referral network and ensure an adequate number of capable, qualified, and culturally competent providers for veterans.[64]

Organizational Strategies to Improve Access to Care

Behavioral health care providers should engage in continuous quality improvement efforts with respect to care access; these efforts should include seeking input from individuals receiving services. It can be helpful for organizations to survey individuals receiving services on a regular basis to determine if their hours of operation are sufficient to provide care. Organizations serving children and adolescents should consider providing evening or weekend hours to minimize the amount of school patients must miss and time parents must take off from work for appointments.

Similarly, alternative clinic schedules can help provide options for adult patients who have a hard time making appointments during the workday. Organizations that expand their hours of operation can also offer their staff alternative schedules, which may be supportive of recruitment and retention efforts. The Institute for Healthcare Improvement (IHI) recommends asking individuals how they define access to care to ensure that needs are being met in the way that they are experienced.[65] It is also important for organizations to assess their physical space to ensure that it is compliant with the Americans with Disabilities Act, that the clinic space is large enough to accommodate the staff and the volume of individuals seeking in-person services, and that it provides a welcoming environment for all who enter.

Since lack of transportation is another barrier to care, health care providers that are in areas that can be easily accessed by public transportation and that have well-lit and well-maintained parking nearby may have certain advantages. Communities with robust public transportation systems should consider working with public transportation agencies to provide subsidized access and coordinate medical transportation where available. Transportation can be an especially vexing barrier in rural communities where public transportation is not widely available and individuals may have to travel greater distances to access care. Rural and frontier organizations should leverage telehealth services to improve access to care but also consider barriers in accessing broadband internet. Other strategies may include providing mobile clinics, like CAHOOTS or the Mobile Behavioral Health Clinic of Peninsula Community Health Services,[66] so that care can come to the individual, especially in remote areas.

To create access for diverse populations, health care providers need to be culturally competent. Organizations should provide regular trainings on cultural competency and provide administrative and technological support for population health management and health disparities. It is important to consider what are considered best practices to meet the needs of diverse populations, such as the implementation of culturally and linguistically appropriate services (CLAS) standards.[67] CLAS standards are designed to improve health equity and quality of care while eliminating disparities. CLAS standards provide guidance on how organizations can support individuals with limited English proficiency and who represent a variety of cultural backgrounds. The CLAS principal standard is for organizations to "provide effective, equitable, understandable, and respectful quality of care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other community needs."[68]

Behavioral health care providers can help maximize the likelihood of improving access by partnering with community-based organizations and engaging in targeted outreach efforts to underserved groups. Providing services in the community improves access to behavioral health care for individuals who may experience barriers in accessing clinic-based services. Behavioral health care and integrated care organizations should develop partnerships and consider providing services in schools, libraries, or other community-based organizations as well as working closely with the crisis and hospital systems to support transitions in levels of care.

Racial and Social Disparities in Access to Rapid Care

Although the MHPAEA and the ACA were intended to expand access to behavioral health services for low-income individuals through Medicaid expansion, not all states opted to expand Medicaid. In states where Medicaid was not expanded, there are larger populations of low-income racial and ethnic minorities. The KFF found that, in general, Black, Hispanic, and American Indian/Alaska Native (AI/AN) people fared worse in most measures of health and social determinants of health than their White counterparts, including the following:

- Nonelderly AI/AN (21%) and Hispanic (19%) people were more than twice as likely as their White counterparts (7%) to be uninsured as of 2021.
- Among adults with any mental health challenge, Black (39%), Hispanic (36%), and Asian (25%) adults were less likely than White (52%) adults to receive mental health services as of 2021.[69]

These alarming statistics provide a wake-up call about the need to drill down into reasons for these disparities and the importance of addressing them.

Children are another group for whom access to care has been troubling. The CDC reports that nearly one in five children have a mental, emotional, or behavioral health disorder; some families have difficulty finding a provider or attending in-person clinic appointments. The CDC's children's mental health program strategies "to improve access to mental health care for children include the following:

- Improving strategies to connect families to mental health care
- Understanding the gaps in the mental health workforce serving children
- Investigating how funding policies affect mental health care
- Understanding social determinants of health that make it harder for some families to gain access to mental health care"[70]

Health care providers working with youth and adolescents should coordinate with individuals and their families to maximize access to services while minimizing youth missing school or parents/guardians taking time off from work.

For rural Americans, there are unique barriers to taking care of their mental health. Among adults living in nonmetropolitan areas in 2020, only 48% of those experiencing a mental health challenge received treatment. Adults living in nonmetropolitan areas were twice as likely as those living in urban and suburban environments to not have broadband internet, limiting their access to telehealth services.[71] In addition to provider shortages, rural Americans may be disproportionately impacted by a lack of reliable transportation and confidence in their provider or health care organization. Individuals with limited English proficiency may also experience

concerns about communication and understanding of their culture. Health care providers working in rural and frontier counties need to determine how they will address barriers in access to care for their communities.

Organizations can address disparities in access to care by supporting individuals in accessing and understanding insurance benefits as well as working with individuals seeking services—and the community—to understand and remove barriers, including transportation and childcare barriers. Organizations can also hire qualified and capable staff and provide them with training and support to be culturally competent and accessible to all populations within the community.

Measures and Metrics for Rapid Access Industry Standards

The health care industry lacks a single standard definition for rapid access to care, however, there are models of care and scheduling practices that provide clear expectations and parameters around timely access to care.

CCBHCs are setting metrics on timeliness to determine whether services are meeting expectations. For example, when a person presents for services, CCBHCs are required to provide a preliminary screening and risk assessment that will determine whether the need for services is routine or urgent. They must provide services and complete an initial evaluation within 10 business days for routine needs and within one business day for urgent needs. For individuals who have already established care, they must provide a routine visit within 10 days of the request. Subject to more stringent state, federal, or accreditation standards, individuals will receive comprehensive evaluation within 60 days of their first request for services.[72,73] While SAMHSA determines how quickly CCBHCs must respond to routine and urgent needs, there is flexibility for an organization to define what routine and urgent needs look like in their CCBHC. CCBHCs funded by SAMHSA grants attest to SAMHSA in meeting availability and accessibility requirements and state-certified demonstration; CCBHCs funded by the Centers for Medicare and Medicaid Services are accountable to their state behavioral health authority.

Regardless of the model they use, behavioral health care providers need to be aware of access standards that are included in contract, licensing, and/or certification standards, as well as their reporting obligations to the state. Grant funding may also have requirements regarding access to care. Agencies must be equipped with the technology and staff expertise to collect and report on access data that is expected by the funding source and be ready to engage in continuous quality improvement efforts to improve access to care and address any disparities.

Conclusion

Timely access to behavioral health services is heavily dependent on the larger system of health care, including individual insurance status and the availability of a qualified, trained workforce.

In addition to promoting the 988 Suicide & Crisis Lifeline as a resource when an individual is experiencing thoughts of suicide or another behavioral health crisis, organizations may consider implementing models of care that address barriers to access. These include models that outline standards for access (e.g., CCBHCs and the Veterans Choice Program), support timely access to behavioral health services (e.g., integrated care or a CoCM), or create same-day access to care (e.g., the SDA model). Health care providers need to regularly assess need and capacity for services and seek to understand barriers in accessing care for the various populations in their communities. They must also work with crisis systems, hospitals, and other partners to create opportunities for timely referrals that support individuals in receiving the right level of care, at the right time, and in the right location.

Authors:

Renee Boak, MPH
Consultant, National Council for Mental Wellbeing

Joe Parks, MD
Medical Director, National Council for Mental Wellbeing

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