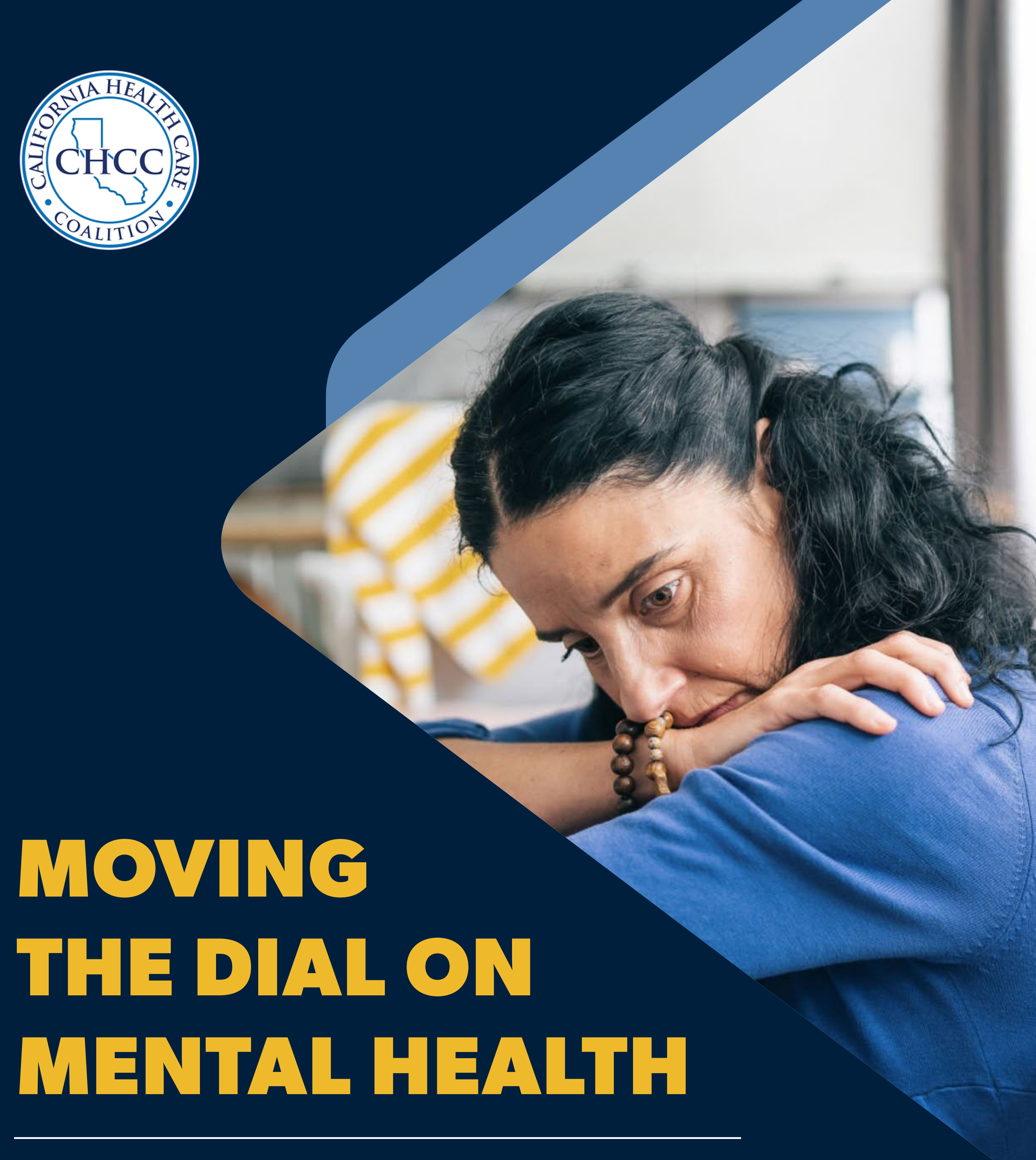

MOVING THE DIAL ON MENTAL HEALTH

How Purchasers Can Use Patient-Centered Outcomes Research for Better Access and Results

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This report was prepared by Ann Kempski, with guidance from Ken Stuart, President of the California Health Care Coalition, December 2024.

Executive Summary

Who We Are

The California Health Care Coalition (CHCC) is a membership organization comprised of labor-management health and welfare trusts (i.e., purchasers) representing approximately one million workers and their families (i.e., plan members). CHCC member health plans serve diverse workforces, occupations, and industries, including agriculture, construction, education, and health care across California.

Our Aims

CHCC members recognized a growing unmet need for effective, timely behavioral health services among our health plan members. With support from the Patient-Centered Outcomes Research Institute (PCORI), we developed an initiative to improve mental health care by incorporating Patient-Centered Outcomes Research (PCOR) and Comparative Effectiveness Research (CER) more intentionally in our role as health care purchasers.

The Patient-Centered Outcomes Research Institute (PCORI) is an independent, nonprofit research funding organization established by Congress in 2010. It seeks to empower patients and others with actionable information about their health and health care choices by funding patient-centered research, research infrastructure, and engagement in and dissemination of research findings.

Disclaimer

The statements and views expressed in this report are solely the responsibility of the authors and CHCC and do not necessarily represent the views of the Patient-Centered Outcomes Research, Institute (PCORI), its Board of Governors or Methodology Committee.

Our Project

We wanted to expand our ability to engage with patient-centered outcomes research (PCOR) and comparative effectiveness research (CER) and the role of research methods in evaluating benefits of health care interventions. We chose to focus on behavioral health PCOR/CER and related interventions because access to and appropriateness and effectiveness of behavioral health care are high priorities for CHCC members. As health care *purchasers* we make decisions to design, organize, procure and administer health benefits for a defined population of workers and their families.

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We also wanted to draft a framework to help purchasers incorporate PCOR/CER more deliberately in their decisions, functions, and responsibilities as purchasers, and improve the care and health outcomes of the workers and families we serve.

Methods

Using member focus groups and in-depth member interviews, we identified key issues, including access barriers, lack of integrated care, behavioral health workforce diversity and preparedness, and need for effective prevention strategies. In-depth interviews were conducted to gather details on health plan design, structure and organization and how they may affect access, care delivery, and care experience.

By engaging with PCOR/CER research, subject matter experts and leading practitioners, CHCC identified

interventions with a promising evidence base, potential to be adopted in the medium term, and relevant to the needs of CHCC members:

- Primary care and behavioral health integration
- Cognitive behavioral therapy for a range of behavioral health conditions
- Tele-behavioral health as an effective mode of care delivery
- Peer support workers to improve access and engagement for targeted conditions
- Mindfulness based programs for prevention, self-care, and management of targeted conditions
- A cautious approach to emerging drug therapies like ketamine compared to existing therapies

A brief description of each intervention is included in the report. We also developed a framework for purchasers to consider as they strive to improve mental health benefits. The framework prioritizes the following strategies and approaches:

- A data-driven, population health orientation to health benefit strategy
- A holistic, integrated approach to benefit design, administration, and member engagement
- Engagement by senior leaders from employer and labor organizations to support culture change and end stigma around mental health conditions
- Collaboration with other purchasers to create new opportunities and amplify purchaser voices with clinical leaders in delivery systems, insurers and other entities
- Bring data, evidence, and creativity to the full range of purchaser tools, authorities, decisions, and responsibilities

The framework reflects support from a range of experts and practitioners who generously shared their time, expertise, and perspectives with us. **A full list of acknowledgments can be found at the end of the report.**

GLOSSARY OF TERMS

PURCHASERS: organizations that buy health care services and benefits on behalf of a population. In this report, we use purchaser to refer to the organizations and persons who are the ultimate payers. Jointly sponsored employer-union health benefits funds are purchasers.

PLAN MEMBERS: plan members are the participants enrolled in the plan(s) sponsored by the labor-management health benefits funds.

THIRD-PARTY ADMINISTRATORS: organizations that perform administrative functions for an employer health benefits plan or employer-union sponsored plan. Insurance companies often serve as TPAs for such plans.

Introduction and Description of Project

Objectives of the purchaser framework for behavioral health

Our goal is to find opportunities **to incorporate patient-centered outcomes research and comparative effectiveness research more deliberately and routinely in our work as purchasers.** Health care coverage and delivery are increasingly complex, with the pace and cost of new therapies, technologies, and care settings demanding more attention from purchasers. Health benefits leaders buy care through rapidly changing intermediaries, including brokers, consultants, actuaries, health insurers and third-party administrators (TPAs), pharmacy benefits managers (PBMs), specialty pharmacies, and “point solution” providers addressing specific health risks and conditions.

Intermediaries help purchasers to design, organize and administer health benefits. They may obscure or assist purchasers’ view of the care their members receive depending on data and reports they provide to purchasers. Intermediaries can ease or inhibit purchaser dialogue with clinical leaders in care delivery and coverage roles. More communication between clinical leaders and purchasers can help both support changes—including adoption of PCOR/CER—that each can make to improve health outcomes.

Individually as health care purchasers, and collectively as a coalition of purchasers, we seek

- Solid evidence for behavioral health interventions for various conditions and risk factors
- More availability of evidence-based services in communities where plan members live and work
- Basic understanding of research methods and patient-centered outcomes research and comparative effectiveness research (PCOR/CER)
- Understanding of the roles organizations play to develop and evaluate evidence and standards. (i.e., Food and Drug Administration; National Institutes of Health, Patient-Centered Outcomes Research Institute, U.S. Preventive Services Task Force)

Developing the framework: discovery process

We began with a planning and discovery process that included CHCC member focus groups and in-depth one-on-one member interviews. Focus groups revealed widespread increases in demand for mental health and substance use disorder services worsened by the COVID-19 pandemic. Plan members often face barriers and delays when seeking behavioral health care. Many commercial insurance carriers and plans offer narrow networks of behavioral health clinicians and a short list of clinicians taking new patients, which can result in costly out-of-network care and delayed care. The turnover and shortages of behavioral health clinicians were worsened by the COVID-19 pandemic. Tele-behavioral health can improve access but may also fragment care, particularly between primary care and behavioral health.

Discussions revealed a cultural shift occurring in many workforces—particularly among younger workers—that is raising awareness and fostering dialogue around mental health. The stigma associated with mental health conditions and seeking care is diminishing. When seeking care, workers and families may fall through cracks in care and coverage systems. “Carved out” providers may undermine coordinated care and the flow of data across providers. Responsibilities for care coordination among clinical and payer entities can be unclear. Life stage transitions, such as moving from childhood to adolescence, to young adulthood, and after childbirth often mean new difficulties in finding or continuing specialized care. **A full summary of the facilitated focus group findings can be found in Appendix A**.

The top concerns and needs found in our discovery process include:

- Access barriers to timely, accurate, appropriate screening, diagnosis, and treatment
- A desire for behavioral health integration with primary care, but concern that primary care lacks resources and capacity to deliver integrated care
- Narrow networks lacking sufficient specialized care for children and other populations (i.e., LGBTQ persons), inaccurate provider directories maintained by commercial health plans
- Inadequate commercial plan oversight of network access and quality
- The behavioral health workforce lacks diversity in cultural backgrounds, languages, and training to serve California's diverse communities
- A lack of evidence to compare outcomes of drug and counseling therapies for similar conditions and populations
- A lack of awareness of effective prevention strategies for behavioral health and wellbeing

Consultation with PCOR/CER researchers and subject matter experts

The CHCC consulted with subject matter experts, researchers, clinicians and practitioners to identify behavioral health interventions with a solid evidence base for addressing the major concerns that we identified. We also considered behavioral health initiatives launched by very large California public and private health care purchasers and how we might align with them where appropriate and feasible. A list of the experts and practitioners with whom we consulted can be found in Acknowledgements.

Joy Melnikow, MD partnered with CHCC to create a patent-centered outcomes research curriculum tailored for health care purchasers. Dr. Melnikow and her team compiled useful resources for a non-academic audience along with lists of questions and considerations purchasers should prioritize as they organize and integrate mental health benefits into their plan offerings. These resources can be found in Appendix B.

Priority interventions selected

With support from experts and collaborators, we identified a set of PCOR/CER behavioral health research topics with potential to address CHCC's major concerns:

- Integrating primary care and behavioral health
- Offering tele-behavioral health as a covered benefit
- Promoting cognitive behavioral therapy (CBT) to treat a range of conditions
- Comparing pharmaceutical and non-pharmaceutical behavioral health interventions
- Leveraging peer support, group visits, and short-term coaching and counseling
- Facilitating mindfulness training for prevention and self-care as well as for treatment of anxiety, trauma, chronic pain and substance use disorders

	Behavioral health challenges identified	Interventions informed by PCOR/CER to address challenges
	Timely access to effective care, delays in screening, diagnosis and treatment, stigma	Behavioral health integration with primary care; tele-behavioral health
	Workforce shortages, turnover, diversity; low participation/inclusion in commercial networks	Peer support programs, health coaching, group sessions; tele-behavioral health models
	Need for prevention and self-care models, options tailored to different workforces	Evidence-based mindfulness program for preventing and managing anxiety, depression
	Ensuring care standards, reliability, safety, and good therapeutic matches	Cognitive behavioral therapy (CBT) as "first line" for many conditions; consider emerging pharmacological therapies with caution (i.e., ketamine, MDMA, etc.)

See Appendix B for a PCOR/CER curriculum developed with a leading expert and tailored to health care purchasers. See Acknowledgements for a list of the clinical leaders and subject matter experts we consulted.

Discussions revealed structural factors, such as clinician training, licensure and credentialing requirements, that may limit workforce expansion and adoption of evidence-based interventions. We considered the potential of very large public purchasers like Medicaid (i.e., Medi-Cal in California) and Medicare to drive systemic change at scale. Commercial payers often follow Medicare's coverage and payment policies. Medi-Cal, with its focus on underserved persons with complex needs, can foster new services that benefit communities broadly.

A framework emerged from the engagement process

We identified key components of a framework and strategy for behavioral health care. They also apply beyond behavioral health and include:

1. The approach to benefit design should be both holistic and data-driven
   - A population-based, data-informed approach
   - A holistic approach that considers body, mind, social, and emotional factors influencing health, and leverages community resources and opportunities for self-care options
   - An organizational strategy that engages employer and union leadership
   - A collaborative approach to learn faster and increase purchasers' collective impact through CHCC and similar coalitions
2. The health benefits plan goals, strategy and design should align, with tradeoffs managed
   - Do plan design components and related member outreach and education fit together to
     - produce an integrated set of benefits easily understood and accessed by members?
     - support care navigation, including for crisis care and care transitions?
     - minimize risks of members receiving low-value or unsafe care (for example, if out-of-network care is covered?
3. Consider the full range of purchaser tools, functions, authorities and responsibilities to improve behavioral health benefits
4. Opportunities to incorporate PCOR/CER into health plan purchasing decision

We explored opportunities for purchasers to

WAYS TO IMPROVE BEHAVIORAL HEALTH BENEFITS

Plan goals, design, administration	How covered benefits are organized (carve out, integrate)	Plan types (HMO, PPO)	Cost-sharing	Member outreach, support, feedback	Select vendors, contract terms	Review data, results, surveys	Comply with all laws, regs
A productive workforce, healthy members with high wellbeing							
Prevent, screen, intervene early; support healthy behaviors							
Prompt, convenient access to care							
Promote evidence-based care; avoid waste							
Minimize costs, burdens on members							
Support care coordination, navigation							
Predict, manage costs							

incorporate PCOR/CER findings to increase the likelihood of better care outcomes, including:

- Testing member outreach and engagement strategies and analyzing the impact on utilization
- Choosing vendors that use data, measurement, and promising payment models to promote prevention, early intervention, and crisis care pathways
- Requesting payment models between health plans/TPAs and physician practices that support behavioral health integration and tele-behavioral health
- Asking health plans/TPAs how they are easing the credentialing process for qualified therapists and coaches, streamlining prior authorization and payment, and using evidence and measurement to inform care authorization
- Contracting directly with service organizations and clinicians (without a plan intermediary); supporting local training programs to expand access; developing peer support programs
- Selecting plans that monitor access, network adequacy, appropriateness of care and measure and report care outcomes
- Offering free or discounted access to evidence-based mindfulness programs that support the needs of different workforces and occupations

SECTION 1

Key takeaways from focus groups and interviews

Demand for and utilization of behavioral health services have increased

- CHCC purchasers reported increased demand and utilization of behavioral health services, particularly among health care workers, school employees, and children of employees.
- Participants cited rising adoption of tele-behavioral health services and many use tele-behavioral health services and networks offered by major insurance carriers.
- A shortage of behavioral health clinicians was the single most pressing concern, followed by lack of diversity in specialty and background of professionals and long wait times for services.
- Inadequate systems for assessing mental health conditions and connecting people to the right level of care. Finding the right care for children and adolescents was a particular concern.

Care is fragmented, and patient experience is poor

- Most participants expressed deep frustration with current resources and systems for behavioral health care. Some cited bad member experiences in crisis circumstances with providers poorly equipped to triage, stabilize, and make prompt referral to specialty treatment.
- Limits on coverage, complex care authorization and reimbursement processes, and restrictive networks add to care delays and gaps.
- A lack of quality measures or other ways to assess the effectiveness of behavioral health programs and for what populations and conditions.
- Most participants viewed primary care screening as a barrier rather than a conduit for access to behavioral health services. Several cited short primary care visits leading to more prescribing of psychiatric medications without a process to monitor outcomes.

Wellbeing has moved from a "nice to have" to a front and center priority.

- Training and deploying peer counselors was seen as a potential strategy for diversifying the workforce, along with more pathways for training outside traditional four-year degrees

Systemic solutions are needed

- Several participants wanted to explore opportunities to advocate for systemic changes and collaborate with other purchasers to support more workforce training and reforms to streamline state licensure and insurer credentialing.

Key themes from CHCC focus groups conducted by Public Values Research of San Diego, California. The full report can be found in Appendix A.

Plan Design Descriptions from in-depth CHCC Member Interviews

In-depth interviews with leaders of several CHCC health care purchasers revealed that care fragmentation was exacerbated by divided responsibilities among vendors. As care treatments become more complex, costly, and specialized, new vendors have emerged to manage, oversee, and authorize components of patients' care and treatment journeys.

Structure of CHCC member plans

- **Most CHCC member health and welfare funds offer both a self-insured preferred provider organization (PPO) and a fully-insured Health Maintenance Organization (HMO) plan.** Both options have high enrollment shares. The populations served by CHCC member plans are fairly concentrated in specific geographies in California and include rural, suburban, and urban areas. In both fully insured and self-insured plans, the primary vendor may subcontract to a specialized entity for behavioral health services.
- **Most CHCC members have contracted for many years with "employee assistance programs" (EAPs) to provide a set of non-medication, non-diagnostic mental health benefits.** The EAPs are distinct from the medical benefit entity, which is typically an insurer serving as a third-party administrator (TPA). The HMO models include mental health services in the monthly premium paid for comprehensive benefits. The HMO and PPOs offer tele-behavioral health options, usually through a vendor and an "app".
- **Substance use disorder (SUD) treatment may be covered through a specialized vendor with its own intake process or included in the EAP.** Disreputable SUD providers forced purchasers and plans to take tighter control of SUD networks. Many limit coverage to in-network facilities due to high costs and poor quality. Chronic pain is a factor in SUD in certain occupations. Some CHCC members are contracting for specialized benefits to address musculoskeletal injuries that take a "mind-body" approach to pain.
- **Most PPO plans include a Prescription Benefit Manager (PBM) for the drug benefit, and the PBM may or may not be owned by the PPO.** CHCC members rely on PBMs to advise them on formulary decisions. Some psychiatric medications are subject to prior authorization or step therapy.
- **Insurers and other vendors are beginning to provide useful data and reports for plan sponsors to monitor access and utilization.** Large groups have their own data warehouses containing claims data. It can be hard to interpret certain data; for example, when a member (blinded to the plan) only has one or two visits with a therapist, is that a sign of a bad match? Is it a sign of access problems or improvement? Complaints can be an important source of actionable information for CHCC member plans.

Shift to wellbeing and holistic, home-grown and community-oriented approaches

- Some CHCC members are taking a comprehensive approach to mental health and wellbeing. Services may be delivered under direct contract, and include coaches, care navigators, and yoga, meditations, cooking and nutrition classes. The goal is to give workers and families more tools for wellbeing, self-care, and support for behavioral change. Wellbeing has moved from a "nice to have" to a front and center priority. These offerings can be co-located and tailored to the needs of the workforce. High acuity and specialized care are provided separately.
- The nature of certain jobs, i.e., long hours and commutes, multiple job sites, physical work that causes chronic pain, may make it difficult for members to establish and maintain a regular primary care. One group reported that 27% of its PPO enrollees had no primary care visit in the last year. Multi-channel, holistic outreach and engagement approaches encourage members to use care and resources they may need. Stigma around mental health and addiction persists. Peer support and education help to address stigma, culture and language barriers, and to support benefits education and navigation.

SECTION 2

Key takeaways from expert presentations and discussions

Behavioral health integration (BHI) was a major topic of our evidence reviews, presentations, and discussion. We expanded the interventions we considered beyond BHI as we heard from experts and gathered recommendations. We spoke with experts, including a former Chief Medical Officer of Covered California, California's Affordable Care Act marketplace; a former member of the US Preventive Services Task Force; a practicing therapist for a major HMO; and a leader of a large multi-specialty physician group. They named enablers and barriers to adoption of behavioral health integration (BHI) and other evidence-based interventions, like cognitive behavioral therapy (CBT) and peer support workers.

Below are the key takeaways from several presentations:

1. **Awareness of the evidence for behavioral health integration (BHI) and the collaborative care model is not the major barrier to adoption.** Clinical leaders and health plans alike are aware of the evidence for BHI and the collaborative care model and want to adopt the model but face barriers.
    - Barriers begin at the health plan, with the "carving out" or subcontracting of mental health service delivery to separate entities from the rest of medical care. Inadequate payment levels and models are another barrier, followed by the burden of collecting quality measures and documenting care. Practices may need start-up funding and technical support.
    - A medical group leader expressed a desire to provide BHI and be paid on a capitated basis, which requires behavioral health to be "carved in" with medical benefits. The group already coordinates care for many patients with co-occurring physical and mental health conditions under plan medical benefits while not being an in-network behavioral health provider.
    - While BHI increases patient screening and initial assessment, a therapist with an HMO noted that care delays occur in getting patients matched with a regular therapist and approved for enough sessions to improve outcomes.
2. **Widespread workforce shortages and a workforce still recovering from the stresses of the COVID-19 pandemic inhibit adoption of BHI**
    - One large purchaser noted that though it has contract language requiring primary care to screen patients for depression, it was difficult to enforce these terms during the pandemic.
    - To expand the workforce, California's Medicaid program, Medi-Cal, is covering services provided by new types of behavioral health workers, including certified peer support specialists. Certification includes an 80 hour training program and an exam.
3. **Addressing barriers to behavioral health integration**
    - And effort is underway to address the barriers, led by 3 major purchasers and purchaser coalitions, PBGH, Covered California, and CalPERs. Three major stakeholders—health plans, purchasers, and provider

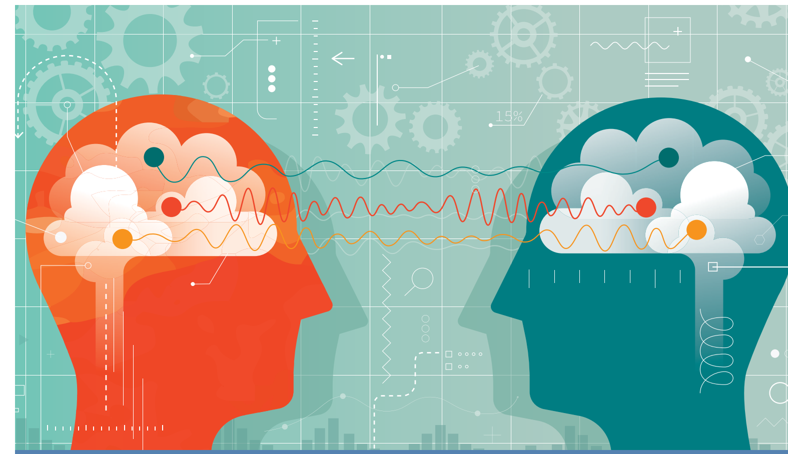
organizations---are working to streamline and standardize a model of advanced primary care and behavioral health integration.

- An initiative under California's Office of Health Care Affordability has set up a committee to provide recommendations to shift resources to primary care and behavioral health and strengthen BHI capacity.

4. **Clinical leaders agree that tele-behavioral health has a solid evidence base to support most behavioral health conditions and should be covered by purchasers.**
    - Many CHCC member plans offer tele-behavioral health through options from contracted health plans. Some cover subscription costs for digital mobile apps for self-care using mindfulness approaches.
    - If telehealth is not provided through a BHI model, it will be difficult to build a sustainable primary care-based integration model that can coordinate and deliver whole-person care.
5. **Purchasers should ask insurers and provider groups how they are ensuring cognitive behavioral therapy is used consistently as a "first line" therapy for many conditions.**
6. **Some labor-management purchasers are taking more tailored approaches such as**
    - using peer support programs for substance use disorder recovery
    - Using peer support to do outreach and engage workers who do not share common workplaces and speak multiple languages
    - finding or building their own wellbeing-focused programs to be more responsive to the demographics or lived experiences of the workforce
    - joining community-focused initiatives that train clinicians to screen for adverse childhood events (ACEs) and depression and refer patients to local resources
7. **Even with effective outreach strategies and multiple entry points for behavioral health care, behavioral health crises will occur.** Purchasers should ask both plans and delivery systems
    - what protocols they use to address crises promptly, and
    - provide specialized case management with authority to approve follow-up care
8. **Pharmaceuticals were the focus of a session with a pharmacist employed by a PBM and covered tops of interest, including**
    - the role of the FDA in the drug development and approval process
    - the role and process used by PBMs for formulary placement of new drugs, using emerging "psychedelics" as an example.

SECTION 3

Interventions with potential to improve behavioral health



During the planning and discovery stages of the project, we heard challenges that members faced in accessing behavioral health care. We explored concerns CHCC member plans expressed about, safety, and effectiveness of behavioral health care received by plan members. We looked for practical, community-oriented solutions that may improve access, patient-centeredness, and outcomes for common behavioral health conditions. We focused on solutions that could be implemented in the medium term, particularly if purchasers collaborate to request similar solutions from health plan and provider entities.

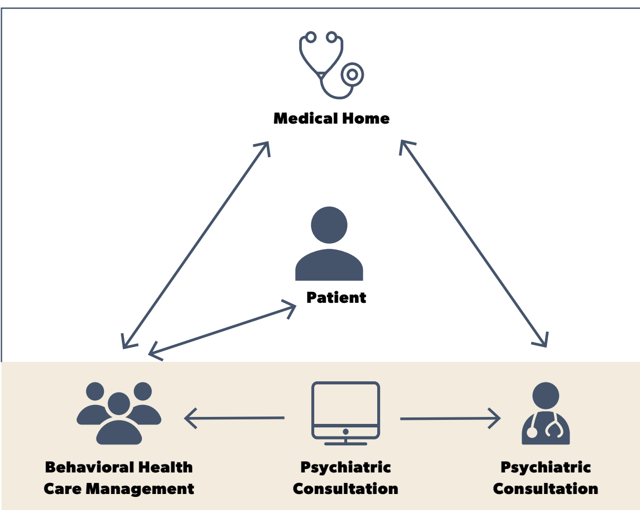
1. Behavioral health integration and collaborative care

With an estimated one in five U.S. adults living with a mental health condition, patients commonly present symptoms in primary care. Three-quarters of anti-depressants are prescribed by primary care clinicians. Some estimates suggest that 20% of primary care visits relate to mental health, yet many patients are not accurately diagnosed in primary care, due to time, training, and coverage constraints. There is an even bigger shortage of specialized behavioral health care in pediatrics compared with adults.

Patient outcomes can improve when primary care and behavioral health clinicians use a collaborative system of care, but integrating these services is challenging. Structural factors in primary care, such as bigger patient panels and shorter patient visits, are worsened by fee-for-service volume incentives and time burdens of preauthorization requests, billing and electronic medical record entry. Primary care practices are under-resourced. Many patients must access a behavioral health organization or network of providers (i.e., a “carve out”) separate from their plan’s medical benefits payer. This complexity can delay behavioral health referrals made in primary care and contribute to primary care clinicians’ reluctance to ask patients about behavioral health. Despite barriers in implementing behavioral health integration, research suggests a return on investment in the form of both better outcomes and lower overall system costs.

Evidence for BHI for populations, conditions

Models of behavioral health integration have been tested and evaluated and most have found improvements in mental health outcomes and medical outcomes of chronic disease in patients who have multiple conditions. The Psychiatric Collaborative Care Model (CoCM) was developed at the University of Washington in the 1990s and has been tested in randomized trials in many settings. The CoCM model embeds a consulting psychiatrist and behavioral health manager into primary care to support primary care clinicians to manage mild to moderate behavioral health issues. The physician prescribes while others on the team manage a patient registry, track care and symptoms, counsel patients, and advise the physician.



Source: The AIMS Center at the University of Washington

PCORI supported a study that randomly assigned patients who had screened positive for depression, post-traumatic stress disorder, bipolar disorder or both to two different tele-psychiatry interventions, tele-psychiatry collaborative care (TCC) and tele-psychiatry enhanced referral (TER). In the TCC model, care managers and consulting psychiatrists supported the primary care practice. In the TER model, tele-psychiatrists and tele-psychologists assumed responsibility for treatment typically provided virtually to patients at the primary care clinic. Both models improved outcomes by similar rates, including symptom severity, care satisfaction, and medication adherence. Since the TCC model requires less psychiatrist and psychologist time yet resulted in similar outcomes, it is a promising model to consider as shortages of psychiatrists and psychologists are severe.

In 2017, Medicare added billing codes to cover the CoCM model and general behavioral health integration (BHI) to support various integration and staffing models. Many commercial health plans followed Medicare in covering the codes and associated integration services. Medi-Cal, California's Medicaid program, covers the services. However, uptake of the codes has been slow across all payers as primary care practices face capacity constraints and adoption costs.

With persistent workforce shortages in both primary care and behavioral health, more flexible models of behavioral health integration are being tested that rely more on virtual integration and teams and care managers that can be supervised by offsite professionals. Outcomes for these models are more mixed and harder to evaluate. Researchers supported by PCORI developed an instrument, the Practice Integration Profile (PIP), designed to measure the degree or level of integration within a primary care clinic. The PIP instrument can be used in studies of behavioral health integration models.

2. Mindfulness-based programs and interventions

Research on the effectiveness of "mindfulness" based programs has increased dramatically over the last ten years. Mindfulness-based interventions are a type of mind-body practice that can help improve health and wellbeing through self-regulation and attention to the present moment. Mindfulness is a technique that typically involves breathing and meditation and being aware of what is happening in the present moment without judging the thoughts and feelings that may occur. Mindfulness may also involve yoga or other body awareness techniques. The goal is to become more aware of thoughts and feelings so they can be managed instead of being overwhelming.

Research on the effectiveness of "mindfulness" based programs has increased dramatically over the last ten years.

PCORI has supported mindfulness research for condition-specific and population subgroups, including for chronic pain, anxiety, and substance use disorder among adults, seniors, children, and people with autism. Some studies compare a well-defined mindfulness intervention with a similar intervention like yoga or compare intervention lengths or with pharmaceutical treatments, or in addition to pharmaceutical treatments.

Evidence for mindfulness practice interventions

Systematic reviews of the highest quality mindfulness studies find a modest positive impact on outcomes measured in various trials, which include levels of anxiety, cravings, sleep quality, and attention or distraction, for example. Increasingly, researchers are including brain scanning and biomarkers that may change during the practice of mindfulness, suggesting brain pathways or regions that are affected by some mindfulness interventions. Trials that measured improvements in self-reported wellbeing after mindfulness interventions also have showed positive results, suggesting mindfulness programs may have a protective or preventive effect on mental health.

A good study design should have a standardized intervention, and many mindfulness studies evaluate Mindfulness-based Stress Reduction (MBSR), an eight-week program developed by Jon Kabat-Zinn. However, the MBSR program might be too time demanding for some people. One challenge of evaluating any intervention is that participants may drop out before finishing the trial process, and the remaining participants may differ from those who dropped out in ways that bias the study results.

In a PCORI-sponsored study that looked at whether a mindfulness intervention could improve overall feelings of wellbeing (as opposed to improving a specific behavioral health condition), researchers compared two mindfulness interventions with different time commitments: one involved an eight week commitment and in-person sessions, while the other was virtual and only lasted three weeks. Results (based on a standardized questionnaire measuring wellbeing) suggest the shorter version of mindfulness training was associated with improvement in wellbeing and the results were "non-inferior" to the improvement measured in the longer program. A non-inferiority study tests whether a treatment (in this case, a shorter and web-based mindfulness program) is not materially worse than the active treatment it is being compared to).

3. Cognitive behavioral therapy (CBT)

Cognitive behavioral therapy (CBT) is a short, structured form of psychotherapy shown to be effective for a range of conditions, including depression, anxiety, panic disorder, obsessive compulsive disorder, and post-traumatic stress disorder. CBT works by helping people learn how to interrupt and change their thoughts and feelings—particularly negative ones—and develop and reinforce new ways to think and act. It can be used to augment the effectiveness of medication for depression. It is considered a "gold standard" for talk therapy because of the strength of evidence supporting it and because it gives people self-management tools and skills, yet it can be difficult to access because of a shortage of trained providers who participate in insurance networks. It can be difficult to verify that the key components of CBT are adhered to and reliably delivered in practice. Evidence from tele-behavioral studies indicates that CBT can be effectively delivered remotely.

CBT works by helping people learn how to interrupt and change their thoughts and feelings—particularly negative ones—and develop and reinforce new ways to think and act.

A study sponsored by PCORI compared CBT (delivered by phone) with yoga for older adults with high levels of worry. The yoga treatment resembled other mindfulness programs and included breathing techniques, movement, and meditation. Some participants were randomly assigned to the treatment options and some chose which intervention to receive. After 11 weeks, participants were measured on anxiety and sleep and both groups showed improvements in both measures, with the CBT group reporting fewer sleeping problems. The group that chose their treatment had the same program completion rates as those randomly assigned. The study suggests both types of interventions may offer improvement for anxiety.

Chronic pain can be disabling and contribute to depression and there is a need to find effective alternatives to opioid medications, which can cause harm. Cognitive behavioral therapy (CBT) and mindfulness-based therapy (MBT) can be effective and offer skills to cope safely with pain and improve functioning and wellbeing. PCORI is currently funding a large clinical trial that compares CBT and mindfulness-based training in persons treated long-term with opioids for chronic low back pain. The trial tested eight weekly therapist-led, two-hour group sessions, and home practice during the 12-month study and is now in peer review. If MBT demonstrates effectiveness when compared with CBT, MBT could become a first-line non-pharmacologic treatment option for this patient population. However, MBT, like CBT, also must be delivered with consistency by a trained provider.

4. Peer support workers and programs

Peer support programs have been implemented in a variety of health care and community settings to address a range of conditions, including substance use disorder, diabetes management, support for mental health conditions and loneliness, and improvements in birth outcomes. Peer navigation programs have also been evaluated. Many programs are delivered by people with lived experience with the same condition that is the focus of the program. Scholarly reviews have examined benefits of peer support programs and findings have been positive or mixed.

Peer support is based on shared experiences, mutual respect, and peer-to-peer learning. Expanding the availability of peer support specialists can help complement therapy and improve recovery outcomes. Peer support focuses on aid in daily living routines, social and emotional support, and helping to connect with resources and navigate care providers and care plans. Peer support workers often come from communities underrepresented in the behavioral health workforce and can provide support in a concordant language and cultural context to members of communities that are less likely to seek help or lack the ability or trust to navigate complex coverage and care systems. Peer specialists can be effective in integrated care models to help clinicians as well as clients and patients. A helpful resource on the role and effectiveness of peer support in behavioral health care is available (produced with support from PCORI) from Families USA.

Evidence for peer support, health coaching

While not clinicians, when provided with training and supervision, peer support workers have shown they can conduct group counseling sessions for trauma-related mental health conditions and substance use disorders and improve symptoms reported by participants according to a PCORI-funded study.

Health coaching is another approach to help patients identify and reach their health-related goals through education and personal support. Models of health coaching include community health workers or 'promotoras' in Latino communities, and care or case management that might be done by nurses or other licensed professionals to manage complex patients. Other models in community health centers use unlicensed health care workers in primary care teams to support chronic disease management.

Health coaches may provide patients with health-related information and navigation support and connection to community resources. They have shown effectiveness in improving management

of diabetes and lung disease and lowering cardiovascular risk factors. One PCORI-funded study observed health coaches in practice to describe and define their role in managing chronic disease with the goal of improving the training and use of health coaches in practice.

Variation across these roles, populations served, training, and activities performed reflects the adaptability of peer support models but can be challenging for evaluating them. Like behavioral health integration, it is difficult to identify the core elements that drive better outcomes. In addition, some standardization of the roles may be needed to secure funding and licensure or certification that is recognized across organizations. Many state Medicaid programs are setting up such programs and pathways for peer support workers.

Peer support in the workplace

Occupational safety and health programs have a long history in union-represented workplaces. While traditionally focused on reducing workplace hazards leading to injury and disease, unions have expanded the scope of these programs, which are often peer-led, to include behavioral health risks. The International Association of Fire Fighters, for example, has developed formal peer support programs. Peer support workers can also be part of a workplace outreach program, sharing resources and information about services available through the health and welfare fund or other options and helping to connect workers to services.

5. Emerging drug therapies

Medications play a significant role in managing mental health conditions in the U.S. According to the Centers for Disease Control and Prevention (CDC), 20% of adults aged 18 and older had received any mental health treatment in the past 12 months, including 16.5% who had taken prescription medication for their mental health and 10.1% who received any kind of therapy or counseling from a professional. Women were more likely than men to receive any treatment, and non-Hispanic white adults were most likely to have received any mental health treatment in the past 12 months. The use of mental health treatment rose during the COVID-19 pandemic.

Purchasers should have a basic understanding of the role of the Food and Drug Administration (FDA) in evaluating evidence for new medications. The FDA requires randomized clinical trials to show safety and efficacy of a medication to receive its approval. FDA approval also grants market exclusivity protections for new drugs it approves. Medications are often used in combination with psychotherapy, such as cognitive behavioral therapy. Mental health medications can affect people in diverse ways, and it may take multiple tries for patients and clinicians to find one that improves outcomes with tolerable side effects. Some cases and conditions are resistant to treatment, including medication.

Purchasers should have a basic understanding of the role of the Food and Drug Administration (FDA) in evaluating evidence for new medications.

Progress in developing new and better psychiatric drugs has been slow. Some psychiatric medications have developed from serendipitous findings in other drugs. Frustration has motivated some advocates and researchers to look to a class of “psychedelic” drugs for potential therapeutic application for some psychiatric disorders. Clinical trials are underway for some of these drugs with the intent to seek FDA approval.

Ketamine is a drug attracting a lot of interest as a treatment for treatment-resistant depression and other psychiatric conditions. It is a dissociative anesthetic approved decades ago by the FDA for sedation. The FDA has yet to approve ketamine by injection for any mental health condition. It is a controlled substance by the U.S. Drug Enforcement Administration, has serious risks, and must be given under clinical supervision. One form, known as esketamine, has been approved by the FDA for

treatment-resistant depression and is administered nasally. The FDA approved esketamine but required the drug only be administered under strict controls of a Risk Evaluation and Mitigation Strategy (REMS) to ensure any benefits of the drug outweigh its safety and abuse risks.

A PCORI-funded study of ketamine comparing it to electroconvulsive therapy (ECT) for treatment-resistance depression was published in *The New England Journal of Medicine* in 2023. The trial results for ketamine (by injection) were positive but modest. Industry rarely conducts comparative effectiveness studies because the FDA approval process requires showing efficacy compared to a placebo. The financial risk-return calculation for investors to seek FDA approval for a new application of a drug that is in generic status, such as ketamine, may be too low. Moreover, the practice of "off label" use permits prescribing a drug already on the market for more uses. As a public-private entity PCORI can play a vital role filling research gaps and helping find opportunities for existing treatments to improve health outcomes. CHCC produced a brief with a fuller discussion of the issues related to evidence, safety, and FDA approval.

SECTION 4

Engaging with insurers, delivery systems, consultants, other vendors

CHCC members and other purchasers are hesitant to disrupt long-term relationships with vendors and insurance carriers because it may create disruptions for plan members. At the same time, they may be dissatisfied with access and effectiveness of behavioral health delivery systems. What can they do to spur adoption of care models like behavioral health integration and change the composition and size of the behavioral health workforce available to members in the plan's network?

1. Contract directly for more control. Some purchasers are
   - contracting directly with behavioral health professionals to ensure member access for urgent care and referral needs;
   - co-locating behavioral health specialists in workplace-affiliated clinics to enable behavioral health integration.
2. Align with other purchasers on common data and information requests from vendors; share RFP language; call out services for subpopulations when assessing provider networks.
3. Align geographically with other purchasers
   - to support local community colleges to train behavioral health providers and non-clinical providers like peer support programs;
   - to grow local demand for evidence-based mindfulness programs (i.e., at YWCAs) and similar approaches to support wellbeing and people in recovery.
4. Leverage coalitions to learn what large purchasers are doing. Consider collaborations that amplify purchasers' collective voice with major insurers, health systems, and other vendors. Share reviews of vendors to inform decisions.

5. Call out subpopulations with unmet needs as you ask providers and health plans for more detail on their provider networks; ask about the demographics of using their platforms and services.
6. Provide multiple points of entry ("no wrong door") for plan members seeking behavioral health. Recognize that navigation support may be needed. For example, members who begin with the EAP may need to transition to another level of therapy, including medication.
7. Test and refine outreach and engagement tactics to promote awareness of services, conduct member experience surveys, and review complaints. Consider terminating contracts and switching to new providers if utilization, completion rates, and satisfaction levels remain low.
8. Request that insurers and TPAs require network providers to use health information exchanges to enable data to move across providers and support care coordination.

Conclusion

The California Health Care Coalition developed the purchaser's framework as we conducted a "deep dive" into behavioral health services and the experiences of our respective plan members. We focused our PCOR/CER learning on interventions that could address gaps in access and timely care experienced by our members. These include behavioral health integration, cognitive behavioral therapy, and tele-behavioral health. We explored solutions to the shortages of behavioral health workers who participate in health plan networks and share language, cultural, and other experiences who can meet our members' needs.

We are encouraged by evidence coming out of PCOR/CER—much of it sponsored by PCORI—for mindfulness and peer support programs that can be organized and sustained with community collaboration. In addition, we studied complex issues related to evidence for emerging pharmaceutical treatments. We appreciate the guidance we received from PCORI on this journey.

A holistic, data-informed and population health approach to purchasing and designing benefits can improve behavioral health benefits and help more broadly to build an integrated set of benefits that are easier to access and navigate. Data and evidence are necessary to implement an effective benefits strategy. A range of sources of valuable data can be found in public health and occupational and industry data collected by the CDC, as well as state-level sources of data on utilization trends and workforce.

Effective purchasing strategies require a robust and secure data ecosystem in which commercial payers and providers contribute cost, utilization, and outcomes data. Independent researchers also need robust data from the health care delivery system to develop better evidence that can inform decisions by purchasers and plan members.

Acknowledgements

The following collaborators, advisors, and experts shared their knowledge and experience with the California Health Care Coalition during the two-year project supported by the Patient-Centered Outcomes Research Institute.

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Libby Abbott joined California's Department of Health Care Access and Information (HCAI) in October 2023 as a Deputy Director to lead the Health Workforce Development team. Prior to joining HCAI, Libby was the Director of the Health Workforce Program at the Clinton Health Access Initiative, where she led a portfolio of technical assistance to the governments of 12 countries on health workforce planning, programs, and policy. In this capacity she worked closely with the governments of several countries – Ethiopia, Liberia, Malawi, and Rwanda – to design and launch national health workforce strategies, including supply and demand modeling to set workforce targets, pre-service scale up plans, and introducing new health professions training programs. Libby also has a background in research, monitoring, and evaluation. Libby holds two master's degrees in public health and international affairs from Columbia University.

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Joan Allen is a Government Relations Advocate for SEIU United Healthcare Workers West (SEIU-UHW), where she has worked in various roles to improve California's health care system for the benefit of patients, consumers, and health care workers. She currently covers issues related to health care, insurance, COVID-19 response, and elections. SEIU-UHW represents approximately 100,000 California health care workers and advocates for Healthcare Justice on behalf of both workers and patients. Allen previously worked for the City and County of San Francisco Department of Adult Probation, focusing on policies related to reentry services and improving coordination between the department and other aspects of the justice and public health systems. She earned a Master of Public Policy from the University of California, Berkeley and a BS in Political Science from Rice University.

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As a certified Wellness Coach, Author, Leadership Consultant and Internationally Renowned Speaker, Robert Cappuccio understands the weight and frustration of feeling like there is more out there for you. When you find the resources or expertise you need to clarify what "it" is, it usually comes in the form of someone telling you who you should be, what you should want, and ultimately why. The Self-help Antidote is about identifying the life YOU truly want, while optimizing the physical, emotional, and mental resources to live it. Robert's mission is simple: give you the tools and resources to discover and live in alignment with your values and on your terms. A life of success is one of both meaning and resilience, where you are the expert on who you are and who you want to be.

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Valerie Cornuelle has served as the Executive Director of California's Valued Trust (CVT) since 2011. She joined CVT in 2001 with responsibility for Operations, after as President of Priority Health Services, an HMO serving the San Joaquin Valley of Central California. Her career in healthcare spans across 30 years and includes work with other large health plan providers and hospital systems.

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As Vice President of Care Transformation, Crystal Eubanks advances strategy, program design and execution, partner engagement and business development within PBGH's Care Transformation portfolio of programs, initiatives and technical assistance. In this role, she leads the California Quality Collaborative (CQC) and its California Advanced Primary Care Initiative, in partnership with Integrated Healthcare Association, and oversees the Transform Maternity Care program. Crystal previously served as Senior Director, Care Redesign and developed technical bodies of work for behavioral health integration and practice facilitation, authored toolkits and learning resources, and served as an

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Crystal brings quality improvement, clinic operations and leadership experience from on-the-ground work with ambulatory and primary care delivery systems in the private and public sectors. Her passion for transforming chronic disease and behavioral health care through data- and value-driven innovation grew from her time serving as quality improvement director, coach and consultant for various community health centers and consortia, health care Managed Services Organizations and public health departments. Previously as Director of Quality and Data Analytics at LifeLong Medical Care, Crystal led care transformation and improvement initiatives to achieve multi-site recognition as a National Committee for Quality Assurance (NCQA) Level 3 Patient-Centered Medical Home and national recognition as a top performing health center. Crystal earned an MS in Health Care Quality from George Washington University School of Medicine and a BA in International Development from George Washington University.

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Emma Hoo has over two decades of experience supporting employer purchasers with PBGH. She directed several initiatives for PBGH to promote effective health management and provider accountability, focusing on care redesign and payment reform initiatives. She has served on the NCQA Disease Management Measurement Advisory Panel and National Quality Forum Behavioral Health Measures Committee. She has been a long-time member of the National Business Coalition on Health eValue8 Steering Committee and Value Purchasing Council and a founding member of the Private Exchange Evaluation Collaborative. She has authored papers on provider network management and design, consumer-directed health plans, ACOs and quality reporting requirements for health insurance exchanges. Hoo is a frequent presenter on value-purchasing, benefit design strategy, risk adjustment, disease management and consumer engagement.

STACEY HROUNTAS, CEO, Sharp Rees-Steely Medical Group

Promoted to her current position in 2012, Ms. Hrountas leads a staff of over 2,900 employees dedicated to the business systems of more than 700 primary care and specialty physicians of Sharp Rees-Stealy Medical Group.

Stacey has over 39 years of experience in the health care industry. She joined Sharp HealthCare in 1994 and has held several system-wide leadership positions including Vice President, Managed Care Contracting and Finance for Sharp HealthCare and its affiliated medical groups. She currently serves on the America's Physician Groups ("APG") and Integrated Healthcare Association ("IHA") boards of directors and executive committees, and the North County Business Chamber Board of Directors.

In 2023, Stacey was appointed to the California Office of Healthcare Affordability (OCHA) Advisory Commitee. She holds a Bachelor of Science degree in Kinesiology from UCLA, and a Master of Public Health degree in Health Services Administration from the Graduate School of Public Health at San Diego State University.

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LANCE LANG, MD, Health Policy Consultant

Lance Lang, MD is formerly Chief Medical Officer for Covered California and a respected physician leader in quality improvement in the state of California. He has served physician groups, purchasers, disease management companies and multi-stakeholder collaboratives. His expertise ranges across institutional boundaries from primary care redesign and payment reform to promoting reduction in hospital-acquired conditions with emphasis on the core components of team-based, patient-centered care in any setting; patient engagement and shared decision-making. He serves on the board of the National Quality Forum and is Clinical Professor of Family and Community Medicine at the University of California San Francisco Medical School.

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Doug McKeever provides executive leadership for the Plan Management, Outreach and Sales, Marketing, Communications and External Affairs, Policy, Eligibility andResearch, and Service Center divisions, with a staff of over 1,000 employees under his leadership. He is responsible for developing and implementing plans to increase growth and improve consumer services and health plan relations.

Doug has deep experience with the development and implementation of state and national policies relang to health benefits, as well as rate negotiation strategies. He leads the development and implementation of innovations in the health care marketplace and is responsible for implementing health care reform efforts that impact CoveredCalifornia customers.

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LAURA REDING, Chief Operating Officer, SEIU 775 Benefits Group

Laura Reding is the COO of SEIU 775 Benefits Group. In this role, she oversees the Health, Retirement, and Training Trusts which deliver health insurance, retirement, and training benefits to more than 55,000 home care workers in Washington state. Laura has 20 years of experience including care delivery, benefit purchasing and administration, utilization management, and healthcare operations. She holds a BA in psychology from the University of Notre Dame, a MS in counseling from the University of North Carolina and earned her MBA from the University of Washington.

MARGARET REHAYEM

Margaret Rehayem is an experienced health care leader who brings care and enthusiasm to her work in support of employer health care purchasers. She served as Vice-President of the National Alliance of Health Care Purchaser Coalitions until 2024, where she led national initiatives to increase member collaboration and help coalitions leverage their regional efforts at the national level to drive health, innovation, equity, and value. Her focus has been on health and wellbeing, total person health, as well as various areas in delivery and payment reform such as hospital pricing, drug management and high-cost claims. Previously, she served on the leadership team at the Midwest Business Group on Health, a leading business coalition in Chicago.

KEN STUART, Chairman, California Health Care Coalition

Ken retired in 2019 after a career of over 46 years serving in administrative and consulting roles for employee group benefit plans. From 1990-2019 he was administrative manager of the San Diego Electrical Health & Welfare Trust, San Diego Electrical Pension Trust and the NECA/IBEW Drug-Free Workforce Program. Previously he was employed for 16 years by one of the largest employee benefits consulting firms. His profession focus was in controlling employer plan sponsor health care costs in the best interest of all participants and contributing employers by utilizing programs and plan design methods to lower overall costs. The scope of his work included in-house claims administration and closely managing the performance of all involved health plans and service providers to ensure their level of service was of the highest quality and that fees/costs were reasonable.

CATHERINE TEARE, Associate Director, People-Centered Care, California Health Care Foundation

Catherine Teare is associate director of CHCF's People-Centered Care team, which works to ensure that Californians — particularly those enrolled in Medi-Cal — receive responsive, comprehensive, and coordinated care that supports their health and well-being. She leads the foundation's work on behavioral health care, including behavioral health integration in primary care and behavioral health interventions for high-cost populations. She also manages projects related to the county role in health care delivery and oral health care.

Catherine has worked at CHCF since 2011 and previously led the organization's efforts on enrollment in public programs, with a particular focus on consumer experience. Before joining the foundation, she worked as a consultant for safety-net health care providers, foundations, and local government, providing research and policy analysis in the areas of health care financing and delivery, public and private health insurance programs for children, adolescent health, reproductive health, HIV, and youth development. She also worked as director of policy for Children Now and as a health policy analyst for the National Center for Youth Law. She received a bachelor's degree in English from Yale College and a master's degree in public policy from the University of California, Berkeley.

AMY VILLEGAS, PhD, SVP Clinical Services & Benefit Administration, SimpleTherapy

A Fresno native, Dr. Villegas oversees clinical service delivery of Employee Assistance, Health/Wellness, Mental Health/Substance Use Disorder and Physical Medicine benefit programs provided for SimpleTherapy. Dr. Villegas manages our team to ensure those we serve receive clinically effective, high-quality care across our spectrum of services and disciplines covered. Dr. Villegas was one of the founders of Halcyon Behavioral in 2012 and has played a lead role in PhysMetrics, working over the years in all aspects of service provision including, member services, provider recruitment and relations, account management, business development, benefit review and build, claims processing, provider reimbursement, operations, and clinical services. Over the past ten (10) years she has focused on developing clinically guided solutions focused on optimal member experience through the recent move to mental health parity and in the ever-changing landscape of regulatory requirements. Since the merger of SimpleTherapy with Halcyon and PhysMetrics focus has expanded to include virtual service delivery, the integration of physical medicine and behavioral health services. Prior to 2012, Dr. Villegas was the Director of Clinical Services and Compliance for a Knox-Keene Licensed Behavioral Health Plan. Dr. Villegas has experience and training in developmental disabilities, autism services, and in forensic settings providing services to first responder populations. She has also functioned as an adjunct graduate program professor and has guest lectured for collegiate and professional populations on applied clinical techniques, research, and population specific topics. Dr. Villegas has been published in peer reviewed journals on various forensic and clinical topics.

KYLE ZIMMER, Director of Health and Safety for International Union of Operating Engineers Local 478 (Connecticut)

Kyle is certified as an OSHA Safety and Health specialist, qualified to train OSHA safety and health related topics and was an instructor of the IUOE National Training Fund in West Virginia where ho co-instructed training courses. Kyle is also the Director of the Member Assistance Program, a peer-to-peer program which helps assist union members and their families through lifestyle issues. He serves on many committees, including an Opioid Task Force of the North American Building Trades Union.

Appendix A

2023 CHCC MEMBER PURCHASERS AND STAKEHOLDER FOCUS GROUPS

Summary Report on Behavioral Health Services

MARCH 2023

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EXECUTIVE SUMMARY

Overview

In an ongoing effort to educate and serve its membership, the California Health Care Coalition (CHCC) contracted with Public Values Research to conduct a series of focus groups with member purchasers and other industry leaders to discuss behavioral health services in California. The purpose of the research was to better understand how CHCC can support its member purchasers in delivering accessible, effective, and affordable behavioral health care. The study addressed the perceived strengths and weaknesses of the current system, priorities and concerns, and opportunities for education and advocacy. Results from the research will be used to help guide strategy and outreach for CHCC.

The following document reflects the content of two online focus groups conducted on February 14, and February 21, 2023 with CHCC members and other industry leaders involved in behavioral health care. More than half the participants were CHCC member purchasers, including individuals representing educational and healthcare organizations. A total of six member purchasers attended the first group and two member purchasers and two industry leaders attended the second group for a total of 10 study participants. Each discussion lasted approximately 90 minutes. Each participant received an honorarium of $125 in appreciation of their time. Key findings from the research are presented below and on the following pages.

Key Themes

Trends in Behavioral Health Care

- **The majority of purchasers reported increased demand and utilization of behavioral health services, particularly among health care workers, school employees, and children of employees.** The change was attributed to trauma from the pandemic, followed by reduced stigma around the need for mental health support.
- Although employees' reasons for seeking treatment remain largely confidential, participants agreed that there seems to be an increase in trauma/PTSD treatment and the need for drug and alcohol programs.
- **Participants also cited the rising adoption of telemental health services among providers and carriers.** Many purchasers reported that they offer carved- out telemental health services sponsored by the major carriers.

Perceived Gaps in Care Delivery and Patient Experience

- **The majority of focus group participants expressed deep concern and frustration with current resources and systems of behavioral health care.** Participants cited the shortage of mental health professionals, lack of diversity among existing professionals, limited services for acute conditions, inadequate systems for connecting patients to appropriate care, limited coverage, and complex reimbursement practices.
- **A shortage of mental health professionals was the single, most pressing concern raised by focus group participants, followed by a lack of diversity among existing professionals and long wait times before receiving services, often spanning months.**

- **Inadequate systems for assessing the mental health needs of employees and connecting them with the appropriate level of care was also cited as a serious gap in the health care delivery system.** "People know when they have heartburn, or their arm is bothering them, their back is bothering them," reported one participant. "Then they know which direction to go down. What does anybody really know about what's wrong with them, other than maybe they're just not feeling right?"
- Finding appropriate care for children and adolescents was a particular concern due to a lack of clinicians with specialized training in working with children.
- **Limited coverage, a complex reimbursement process, and restrictive networks were also cited as key barriers preventing employees from receiving the behavioral health services they need.** Participants explained that PPO patients often have to pay "out of pocket" for services before seeking reimbursement. HMOs, such as Kaiser Permanente, restrict out of network care even when they lack the professional staff in-house to handle demand.
- The majority of participants agreed that individuals with serious mental illness or substance abuse problems are the most impacted by the shortage, particularly if treatment requires in-patient services.
- A minority of participants offered a different perspective on the experience of their employees covered by HMOs in which they observed that care for high- acuity cases were more likely to be covered.
- **The lack of quality measures to evaluate behavioral health programs was also identified as a serious problem that undermines purchasers' efforts to provide the best care for their employees.** The lack of quality metrics to evaluate mental health services was contrasted with robust systems for evaluating other types of healthcare services. In behavioral health, "All you really know is who's got credentials," summarized one participant.

Feedback on Proposed Solutions

Participants were presented with different strategies for addressing the shortage of behavioral health professionals and the lack of cultural and linguistic diversity within the profession.

- **Overall, the majority of participants expressed skepticism that any of the strategies proposed would solve the problem of limited access to behavioral health services, particularly for those with serious mental illness and substance abuse problems.** Access was largely viewed as a systemic problem that requires fundamental changes to how patients are screened for behavioral health services, how patients are routed to appropriate care, and payment systems.
- Group therapy, intensive outpatient care, and expanded telemental health coverage were all viewed as valuable for individuals with lower acuity conditions who tend to be well served by existing telehealth and EAP options. Some participants also raised concerns that group therapy might compromise employee privacy and deter individuals from participating..
- **Most participants viewed primary care screening as a barrier rather than a conduit for increasing access to behavioral health services.** Primary care physicians were described as lacking the time and training to effectively screen for mental health problems and more likely to prescribe medication rather than help a patient access other forms of treatment.
- **Training and deploying peer counselors was seen as an effective strategy for diversifying the pool of available professionals;** however, it was not perceived as a solution for addressing the more pressing crisis—improving access for those with serious mental illness or substance abuse problems.

Opportunities for CHCC

- **Purchasers expressed frustration at having to make decisions about behavioral health services with limited information about which treatments are most effective and for which populations.** This finding suggests that education addressing the effectiveness of different treatment options and the questions purchasers should be asking when choosing behavioral health packages may be valuable.
- Some participants reported that they would also be interested in learning how other organizations are solving these problems through case studies.
- **Several participants suggested that there may be opportunities for CHCC to advocate for systemic changes to the care delivery system to improve access, affordability, and quality.** Possible areas to address include the lack of integrated care between physical and behavioral health, the lack of effective triage systems for determining the appropriate level of care needed, the lack of flexibility to go outside of narrow HMO networks, reimbursement procedures for PPO patients, and quality metrics.

Conclusions

Healthcare purchasers face enormous pressures trying to provide timely, affordable, high-quality behavioral health services for their employees. The limited number of healthcare professionals coupled with limits on coverage, complex reimbursement procedures, and barriers to seeking care outside limited HMO networks combine to create almost insurmountable obstacles for many employees. Purchasers field complaints from employees who cannot find a therapist who takes their insurance, are constrained by limited options beyond telemental health, and who must endure long waits to receive care. The situation is even more severe for employees seeking care for children or adolescents, who require mental health professionals with specialized training. While EAP programs and telehealth options have improved access for mild and episodic conditions, most study participants agreed that these services are insufficient to deal with serious mental illness and substance abuse. Moreover, aside from cost and utilization, health care purchasers have minimal information about which treatments actually work, placing them in the difficult position of making purchasing choices without knowing the value of what they are buying. Finally, results suggest that without effective systems for screening patients to determine the level of care needed, existing behavioral health resources are used inefficiently, contributing to the shortage of providers.

To address these challenges, findings suggest that healthcare purchasers would benefit from education regarding which treatments are most effective and the type of questions they should consider when reviewing provider options, including the value and limits of telemental health and EAP programs. For employees who are not well served by these existing resources, CHCC might consider opportunities to advocate for systemic changes that would lead to a wider and more diverse pool of mental health professionals, among other benefits.

Healthcare purchasers and other industry leaders recognize that fragmented care is leading to poor care delivery and rising costs. The next steps are education to enable purchasers to be as effective as possible under the current constraints and ultimately to advocate for systemic changes that will improve behavioral health outcomes.

INTRODUCTION

Purpose

The need for behavioral health services in California is greater than ever. Trauma from the pandemic, social unrest, and rising inflation coupled with reduced stigma around the need for behavioral health services have combined to create unprecedented demand for therapists, clinical social workers, psychologists, psychiatrists and other mental health professionals. Even before the pandemic, the University of California San Francisco predicted that by 2028, demand for therapists in California would be 40% higher than supply.[1] Close to a third of California's 58 counties have no children and adolescent psychiatrists at all (American Academy of Child and Adolescent Psychiatry). Individuals seeking a clinician of color or one who speaks a language other than English face additional challenges trying to find the care they need. Moreover, fewer professionals accept insurance and those who do often require payment upfront, placing therapy out-of-reach for many lower- and middle-income earners.

California employers who purchase healthcare benefits for their employees are on the frontline of these problems—fielding complaints from employees who cannot find or afford the behavioral health services they need. To better understand the barriers and opportunities to improving the delivery of behavioral health services, the California Health Care Coalition (CHCC) contracted with Public Values Research to conduct a series of focus groups with member purchasers and industry leaders. The objectives of the research were to: (1) identify emerging trends in the field of behavioral health; (2) identify perceived gaps in existing systems of care; (3) solicit feedback on proposed solutions; and (4) identify opportunities for education and advocacy. Results from the research will be used to help inform CHCC strategy and programs.

Methodology

The following document reflects the content of two online focus groups conducted on February 14, and February 21, 2023 with members of the California Healthcare Coalition (CHCC) and other industry leaders involved in the delivery of behavioral health services. More than half the participants were CHCC member purchasers, including individuals representing educational and healthcare organizations. A total of six member purchasers attended the first group and two member purchasers and two industry leaders attended the second group for a total of 10 study participants.

Each discussion lasted approximately an hour and a half and was facilitated by the same moderator. Both discussions were conducted during business hours using Zoom. Discussions were recorded to ensure accuracy in preparing the analysis. Each participant received an honorarium of $125 in appreciation of their time. An email invitation to participate in the groups was sent to all CHCC member purchasers and those who were interested were provided additional information. The final determination as to which stakeholders were invited to participate in the discussion was left to the discretion of CHCC.

1 "California's Current and Future Behavioral Health Workforce." California Health Care Foundation, February 2018.

Limitations

As with all focus group research, data collected from these two focus groups does not represent a statistical sample and cannot be generalized with precision to all CHCC member purchasers and industry stakeholders. Results are reliable for identifying the general views, beliefs, and challenges healthcare purchasers and their employees face, but not for estimating the exact proportion of purchasers who share these views or engage in any particular practice.

Organization of Report

The remainder of this report is organized around the following topic areas:

- Trends that impact behavioral health purchasing;
- Perceived gaps in care delivery;
- Feedback on proposed solutions; and,
- Opportunities for CHCC.

Major and a minor trends are presented under each heading, accompanied by quotes from focus group participants.

CONTEXT AND BACKGROUND

Trends in Behavioral Health Care

Overview

To better understand the context in which healthcare purchasers make decisions about benefits and services, focus group participants were first asked to discuss trends they have observed in the healthcare industry and in behavioral health in particular. **Findings suggest that the majority of member purchasers face increased demand for behavioral health services from their employees, particularly among health care workers, school employees, and children of employees.** The rise in telemental health was also cited as an important change and both trends were attributed to the COVID-19 pandemic. Although employees' reasons for seeking treatment remain largely confidential, participants agreed that there seemed to be an increase in trauma/PTSD treatment and the need for drug and alcohol programs. Detailed findings are presented below.

Increased Demand

Participants described increased need for mental health services among their employees, ranging from mild conditions to acute mental illness and substance abuse; however, several purchasers conceded that they had not yet analyzed claims to confirm this impression. When asked why they thought demand had spiked, the majority of participants attributed the change to trauma from the pandemic, particularly for school employees and health care workers. "I think COVID, obviously has had a huge impact, particularly in the education market that we serve," explained one purchaser. Another participant agreed that many people are traumatized. "Social isolation during the pandemic clearly was a contributor. Fear, fear of the virus itself, trauma, both because of illness and death in families and what not. I think certainly social unrest. I do think we've leaned into mental health, which has been good, but it's also…contributed to more demand for treatment and services." Several participants commented specifically about the need for treatment for children and adolescents. "We've seen a big increase in our adolescent youth population," said one participant. "I think society in general is just feeling a little crazier."

Participants also described changing social attitudes about the need for mental health support. "There's more awareness in talking about it and acceptance… of mental health services, which is good. But I think it's taxing. We're seeing it tax the system even more."

Rise in Telehealth

Participants in both groups acknowledged the rising adoption of telemental health services among providers, carriers, and patients; even though some member organizations had only recently began these services. "I would agree in terms of trends for the next five years, more and more adoption (sic) of telehealth," explained one participant. "I think expanding telehealth and getting people more accustomed and willing to use it and think of it as a valuable resource, and not just a trend…Just think, you don't have to get in your car and go there." **Others thought telehealth was increasing access and might account for increased behavioral health claims**: "We are seeing more substance abuse, but it's just an uptick on everything, as we expanded access and made more deliberate efforts to make people aware. I think telehealth helps a lot with access.

PERCEIVED GAPS IN CARE DELIVERY

Overview

Focus group participants were asked how satisfied they were with the behavioral health services their employees receive now and whether they have observed any important gaps in care delivery. Results are presented below. **The majority of participants expressed deep concern and frustration with current resources and systems of behavioral health care,** citing the shortage of mental health professionals, lack of diversity among existing professionals, limited services for acute conditions, inadequate systems for connecting patients to appropriate care, limited coverage, and complex reimbursement practices.

Study participants, some of whom themselves have sought mental health services for family members, voiced strong opinions about the lack of care coordination and other burdens on employees when seeking behavioral health services. "Unless you've actually experienced it in your family, you don't know what you don't know…When you're experiencing it, it's all- encompassing. You could be in the healthcare business, and you've never dealt with a situation like this before. The idea that you will know which provider to go to and what questions to ask and what's the difference between X, Y, Z and this. Are there medications? And what's the difference between all these various diseases… You can't [over]state the complexity of what you're dealing with," shared one participant. "The patient in this instance is not their best advocate… they're not themselves, they're struggling. If you are on your own, and I imagine this happens in the Medicaid population more times than not, you might be on your own trying to navigate this. If you are, it makes it really hard."

A participant from a different group shared a similar experience: "I'll just give you an example…I have a grandchild that is trying to access these services, and there's a process where the plan will reimburse these medical expenses, but when you go to the provider, they say, 'We don't accept insurance. We need you to pay after every session. You're going to get a bill and we're going to expect payment.' Sometimes they don't give you the bill very quickly, and then you don't have a bill to submit to your provider to get reimbursed. Then, the administrator with the provider will be bureaucratic … and they'll make mistakes, and then you don't get reimbursed. Then your child is in the middle of this treatment where they can't get treated, and then you've got the attitudes that come up with not getting paid or getting paid late, or all of these things. You're trying to get some mental help, and you're just going crazier trying to get the mental help."

Shortage of Mental Health Professionals

A shortage of mental health professionals was the single, most pressing concern raised by focus group participants. "It's all a struggle all around," explained one healthcare purchaser, "but from our perspective… the number one problem is just a shortage of providers and solving that problem has to be done on a global level." In addition to problems of attrition among current behavioral health specialists, the industry is not attracting new talent, according to participants. "We've got to find that next generation of workers because right now, I've got to say, on the provider shortage side, it's a downward spiral. Folks are so burned out, and it's just putting so much more pressure on the people who are left." Behavioral health professionals, particularly lower-paid workers, have no incentive to select such a difficult path. "They're tough positions, and they're paying the same or less than you can get working at Target or Panda Express," explained one participant. "They're seeing a big migration out of those roles because if you can make the same amount of money and your biggest stress is stocking a shelf, that's a lot different than trying to help someone with mental illness."

Participants described their frustration with the excessively long waits for treatment, spanning months in some cases. "They're called shadow networks, where they say, 'Hey, we have Optum... then you start calling them, they're like, 'I do take Optum, but I don't have any appointments for eight weeks'... It becomes very challenging for a member to navigate because they get this list of eligible providers and they're in mental distress, they're trying to navigate through which of these individual providers can actually get them an appointment." Other participants described the wait extending months, particularly if the first practitioner is not a good match. "Mental health is very personal so that doesn't mean that person is going to jive with that first provider they see. That two month wait that they waited for, now becomes another two months because they don't get along with that provider, and there's definitely a shortage."

Finding appropriate care for children and adolescents was a particular concern. "I get calls all the time about children. That has really been the hardest, especially since COVID," said one participant. Others shared similar frustrations. "We can't find providers. It has definitely been difficult for children, whether it has been behavioral health or speech, those kinds of things. Then, even when you do find a provider... the waits are very long."

Lack of Diversity among Existing Professionals

The lack of diversity among behavioral health professionals was mentioned frequently by participants in both groups. "The other place we really do see a shortage in diversity of providers. This really hit our population during the Black Lives Matter movement, where we had a lot of ethnically diverse members who were looking for someone that they felt represented their identities, and had a really hard time. Giving a young, African-American woman, 'Here are five White guys in their 60s that you can see and talk about it.' Representing the communities we serve has been very, very challenging." Another participant agreed: "The shortage of providers, leads to the shortage of diversity, which means the less likely that [providers] are going to have that."

Limited Services for Acute Mental Illness and Substance Abuse

The majority of participants agreed that while limited behavioral health resources affect all employees, individuals with serious mental illness or substance abuse problems are the most impacted, particularly if treatment requires in-patient services. Participants reported that employees often express a preference for traditional, in-person therapy with trained professionals, but would likely benefit from more readily available services such as telehealth sessions, employers assistance programs (EAPs), and other support to address moderate, episodic events. "Frankly, that's where the biggest risk is, employees, spouses, and children who aren't getting adequate access and timely access for things that are potentially lethal," said one participant. "The issue of access is inverted with the seriousness of the illness," explained another participant. "If you have a relatively minor condition, very episodic, there are lots of programs that are being offered that are very responsive and timely for those types of services...If you have a serious mental illness, if you have a major depressive disorder, bipolar condition, schizophrenia. It's actually the onset of a new condition that is the biggest problem and often the most serious one that we're trying to deal with." Many purchasers agreed, describing the limits on EAPs and telehealth as no "substitute for a trained behavioral health specialist doing one-on-one."

Some participants suggested that access is not a serious problem for the majority of employees who have mild symptoms, although others suggested that cost is still a barrier (see section on "Limited Coverage"). "The idea that if what you need is care that can be delivered quickly and relatively inexpensively, like a weekly phone call or something like that, that seems to be around, which is great for people whose problems can be solved at that level of care. If you need a week's detox with medical professionals 24/7, something like that. That is almost impossible to find...I think a range of availability depending on the level of care that folks need."

A few participants offered a different perspective on the experience of their employees covered by HMOs, where care for acute illness is more likely to be covered. "It varies a lot by acuity," said one purchaser. "We have a lot of HMO plans, we're mostly HMO, and it seems like when a person comes in calling for a very severe acute challenge, substance abuse, things like that, they seem to be a lot more responsive than the folks are calling about generalized anxiety, chronic depression. That's where you are on your own."

Lack of an Effective Referral System

Inadequate systems for assessing the mental health needs of employees and connecting them with the appropriate level of care was cited as a serious gap in the health care delivery system. "People know when they have heartburn, or their arm is bothering them, their back is bothering them," reported one participant. "Then they know which direction to go down. What does anybody really know about what's wrong with them, other than maybe they're just not feeling right?"

Participants described employees who have to navigate the system and often failing to get the help they need. "Where I think plans can make the biggest difference is in more effective triage to get people to the providers they need…the level of intervention they need. I think the traditional plan model is like, 'Okay, what do you need? Here are 10 providers that may be able to do that for you. Call them and figure it out.' We had one member once who was a police officer who was almost [involved] in the shooting of a student, very traumatic, suffering from PTSD, and he got the list. It took him six or eight weeks to get in, finally sees that person and they're like, 'I'm a sleep therapist.'"

Some participants suggested that the shortage of professionals is due, in part, to a fragmented system of care in which resources, including mental health specialists, are not used efficiently. "Do we have enough mental health professionals? I think the answer is maybe. We're certainly not using them particularly effectively…Some of what they're doing could be handled by somebody else. I've heard people say that if in any specialty, if you used a cardiologist every time you had a [concern]…we wouldn't have enough cardiologists either. Unfortunately, the way that we've organized this system, we're not best at using our specialists."

Limited Coverage and Complex Reimbursement Practices

Limited coverage and a complex reimbursement process were also cited as key barriers preventing employees from receiving the behavioral health services they need. Multiple participants reported that private therapists often do not take insurance. "I think the crux of the problem really is the provider shortage because it's creating an environment for the provider to not have to take insurance. They're not motivated to need to, which creates a problem…A lot of members who struggle to get the mental healthcare they need, let alone to get reimbursed for it, and they can't afford to pay it." Patients who can afford to pay out of pocket and then submit forms for reimbursement, a difficult process. "You've got to go through all kinds of bureaucratic forms, filling out paperwork with your plan to get reimbursed. That takes times. It's just a challenge after challenge, after challenge," said one participant. HMOs, such as Kaiser Permanente, restrict out of network care even when they lack the professional staff in-house to meet demand. "It's really difficult to go out-of- network. Kaiser throws up so many barriers…and they just don't have some of the behavioral health specialists." Specialists with experience working with children was specifically raised as a limitation of HMOs. **Several participants argued that access becomes an equity issue, where wealthier individuals can afford to pay for services directly when coverage is denied or difficult.**

Some participants shared their personal experience trying to get care for family members. "I have not found a therapist yet that accepts payment from the plan. They all want to be paid directly and then get

reimbursed. Starting with that, and I'm not talking about Kaiser, I'm talking about a PPO plan where you can find an in-network provider. Finding that in-network provider is difficult, if not impossible, depending on where you live. Many times you'll go out-of-network because you need that provider…then that provider is not going to accept [insurance]…then they might not give you the codes you're needing, you didn't ask when you were there, so then you have to go back… It's just one thing after the other that stacks up on a person when they're just trying to get help."

Lack of Quality Metrics to Evaluate Behavioral Health Services

The lack of quality measures to evaluate behavioral health programs was also identified as a serious problem that undermines purchasers efforts to provide the best care for their employees. Findings suggest that data are usually limited to cost and utilization—that is, the volume and type of services employees accessed rather than the effectiveness of those treatments. Feedback from employees was also described as limited not only because employees are reluctant to share their experiences due to privacy concerns, but because they tend to focus on whether they received the care they wanted in their preferred setting, rather than the effectiveness of treatment.

When asked if they were satisfied with the services their employees receive, purchasers found the question difficult because of the lack of outcome data. "This is a really difficult one to get much data on. I think that one of the things that my members have flagged as on that cusp between access and quality is, are they getting seen in the setting that they want to be seen in. Are they getting pushed into a group visit rather than an individual visit? Where are they perceiving lower quality because of an access issue." Some participants felt strongly that providers should measure and share outcome data on the effectiveness of behavioral health services. "It feels like the carriers, through their networks to really compete, they're going to need to really step up their measurable data game, so that we have something to know, is this really working….none of us really know."

The lack of quality metrics to evaluate mental health services was contrasted with systems for evaluating other types of healthcare. "One of the things that I think is a struggle in mental health is there is no consistent quality measure. When we look, for example, we have the Office of the Patient Advocate in California where you can go in and see how all the medical groups are performing against key metrics and what that looks like. In mental health, it's a black box. Not sort of, it is completely a black box in understanding. So I think when we start talking about durations of stays, quality of outcomes, things like that, you would need that data to understand. If you're cutting back, are you cutting back in a way that's producing a better outcome and not just so that the next person can come in and get three-quarters treated," explained one participant. "If you look at other medical treatments, if you see the results for open heart surgery of C-sections versus normal delivery, there are all kinds of quality measure out there, mortality rates…In a way, you're lucky if you get a [mental health] provider," echoed a participant from the other group.

"We don't talk that much about the quality of behavioral healthcare…we're just hoping someone will see them [employee] before we have that interaction." Some participants reported that they look at the rate of screening for anxiety, depression, substance use, and other services among employees who are seeing their primary care provider and then whether those individuals received care as part of their disease management. "So, not specific to the quality of behavioral healthcare but behavioral healthcare being properly integrated with clinical physical care is a huge metric for us."

"All you really know is who's got credentials."

FEEDBACK ON PROPOSED SOLUTIONS

Overview

One objective of the research was to explore strategies for addressing the shortage of behavioral health professionals and the lack of cultural and linguistic diversity within the profession. Both groups were asked to discuss possible solutions for expanding the number of trained mental health professionals available to employees and how to use existing resources more effectively, including the role of primary care physicians in determining the level of care needed. In addition to this general discussion, participants in group two, which included industry leaders, were asked to discuss additional strategies including group therapy, training and deployment of peer support counselors, expanding of intensive outpatient care, and expanding telehealth options. **Overall, the majority of participants expressed skepticism that any of the strategies discussed would solve the problem of limited access, particularly for those with serious mental illness and substance abuse problems.** Access was largely viewed by participants as a systemic problem that would require fundamental changes to how patients are screened for behavioral health services, how patients are routed to appropriate care, and payment systems. Results are presented below.

Prior Authorization from Primary Care

Participants in both groups discussed the role of the primary physician in recognizing and referring patients to mental health services. Most participants, however, were more likely to view primary care as a barrier to behavioral health care rather than a conduit, whereby employees are required to take an additional step before they can access services. Primary care physicians were described as lacking the time and training to effectively screen for mental health problems and more likely to simply prescribe medication rather than help a patient access therapy. "I do think that most people are seeking treatment through primary care and many of them either get ignored or they don't get treated particularly well," commented one participant. "Ignored, in part, because primary care physicians weren't trained on this stuff. Secondly, they're actually quite concerned that they might find something and then have to deal with it… If somebody starts breaking down, what do they do for the rest of their …they don't necessarily have established relationships [so] that they can triage effectively." Going through the primary care physician "just makes it harder for the [employee] already struggling," echoed another participant.

Group Therapy

Next, participants discussed the advantages and disadvantages of directing employees to group therapy, thereby lowering costs and allowing a greater number of people to be treated by a single therapist. Most participants agreed that group talk therapy is valuable for individuals with lower acuity conditions, who are already well served by telehealth and EAP options, but does not address the more pressing shortage--finding care for the seriously ill. "Unless you are in stable condition, I don't know if the group therapy addresses that particular issue." A few participants saw value in the approach as addressing the problem of limited diversity among clinicians. "The reality is that the community of therapists and psychiatrists are not that diverse in general, not as diverse as the population at hand. Group therapy actually gives us the opportunity to be responsive, more responsive to more tailored communities."

Some participants raised concerns that group therapy might compromise employee privacy and deter individuals from participating. "I don't know that communities are ready for a teacher coming out and saying, 'I'm bipolar or I have schizophrenia.' It's like, 'Wait a minute, I don't want my kid in that class,'" suggested one participant. "Drugs and alcohol is another big issue. In our population, there might be some hesitancy to say, "I don't want my district to know…I'm around kids and this could mean my job if someone else sees me here."

Training and Deployment of Peer Support Counselors

Training and deploying peer support counselors to help support employees needing mental health services was also discussed as a strategy for easing the shortage of behavioral health professionals and for quickly diversifying the pool of clinicians. Training a new generation of counselors to supplement current clinical resources was a popular idea and several participants mentioned Kaiser Permanente's recent efforts to launch a similar training program. **While training counselors was seen as an effective strategy for diversifying the pool of available professionals, it was not perceived as a solution for addressing the more pressing crisis—treatment for those with serious mental illness or substance abuse problems.** One participant suggested that trained counselors could also provide triage services, screening and evaluating the level of mental health care needed. "That's a good start. I could be the ombudsman for my community. I have this base level of knowledge of how to spot certain conditions, and I know that I need to send you to this type of practitioner, and you to this psychiatrist…"

Expanding Intensive Outpatient Care

Reactions to the proposal that patients might be directed to intensive outpatient therapy and/or shorter in-patient care was not met with enthusiasm. Participants agreed that outpatient care is generally preferred but believed that outpatient care can rarely be substituted for in-patient services. "Yes, we should always have a bias to do things outpatient rather than inpatient if it works. There is such a spectrum you're dealing with here and some of these are very serious," explained one participant.

Expanding Telemental Health Coverage and Options

Most healthcare purchasers who participated in the study reported that they were offering telehealth services. While these services were viewed as valuable for employees with mild behavioral health conditions, most participants agreed that these services do not address the real shortage; namely, treatment for the seriously ill.

OPPORTUNITIES FOR CHCC

Overview

An important objective of the research was to identify educational and advocacy opportunities in which CHCC could better support its member purchasers as they make decisions about behavioral health benefits. Results are presented below.

Education

Initially, member purchasers had difficulty identifying specific educational topics or speakers they would like CHCC to provide. Some purchasers expressed frustration over employees' strong preference for specific types of behavioral health support, such as group verses individual therapy, or in-person opposed to online sessions. One purchaser reported that she did not believe that there was a shortage of therapists but rather that some employees think they need traditional, one-on-one, in person sessions with a psychologist or similarly credentialled professional and are not interested in the telemental health options that are available. What emerged out of this discussion, was an acknowledgement of the lack of effective triage services to determine what level of care an employee actually needs. This finding suggests, along with comments from other participants, that **CHCC member purchasers would likely benefit from a speaker series that addresses the value and limitations of widely available behavioral health services (such as EAPs and on-demand telehealth), the type of programs that are more effective for high- acuity conditions, and the questions purchasers might ask when evaluating different behavioral health packages.**

Advocacy

In addition to education, several participants suggested that there may be opportunities for CHCC to advocate for systemic changes to the care delivery system to improve access, affordability, and quality. **The study found that many purchasers and industry leaders are frustrated by the limitations of the current structure, including the lack of integrated care between physical and behavioral health, the lack of effective triage systems for determining the appropriate level of care needed, the lack of flexibility to go outside of narrow HMO networks when clinicians lack expertise in areas such as child psychology, and simpler reimbursement procedures for PPO patients.**

CONCLUSIONS

Healthcare purchasers face enormous pressures trying to provide timely, affordable, high-quality behavioral health services for their employees. The limited number of healthcare professionals coupled with limits on coverage, complex reimbursement procedures, and barriers to seeking care outside limited HMO networks combine to create almost insurmountable obstacles for many employees. Purchasers field complaints from employees who cannot find a therapist who takes their insurance, are constrained by limited options beyond telemental health, and who must endure long waits to receive care. The situation is even more severe for employees seeking care for children or adolescents, who require mental health professionals with specialized training. While EAP programs and telehealth options have improved access for mild and episodic conditions, most study participants agreed that these services are insufficient to deal with serious mental illness and substance abuse. Moreover, aside from cost and utilization, health care purchasers have minimal information about which treatments actually work, placing them in the difficult position of making purchasing choices without knowing the value of what they are buying. Finally, results suggest that without effective systems for screening patients to determine the level of care needed, existing behavioral health resources are used inefficiently, contributing to the shortage of providers.

To address these challenges, findings suggest that healthcare purchasers would benefit from education regarding which treatments are most effective and the type of questions they should consider when reviewing provider options, including the value and limits of telemental health and EAP programs. For employees who are not well served by these existing resources, CHCC might consider opportunities to advocate for systemic changes that would lead to a wider and more diverse pool of mental health professionals, among other benefits.

Healthcare purchasers and other industry leaders recognize that fragmented care is leading to poor care delivery and rising costs. The next steps are education to enable purchasers to be as effective as possible under the current constraints and ultimately to advocate for systemic changes that will improve behavioral health outcomes.

DISCUSSION GUIDES

2023 CHCC Member Purchasers and Stakeholder Focus Groups

CHCC Focus Groups Members Only (Group One) Facilitator Guide Final (2-10-23)

INTRODUCTION

Good Morning. Thank you for coming. My name is _______________. I'm with Public Values, an independent research firm hired by the California Healthcare Coalition (CHCC) to talk with you about your successes and challenges providing behavioral health benefits to your employees. **The purpose of today's focus group is to help CHCC better understand how it can support members in purchasing accessible and effective behavioral health services for their employees.**

GROUND RULES

Before we start the discussion, I want to go over a few things.

- First, everything said here is confidential. In the final report, we will not identify the name of individuals who participated in these discussions or the names of the companies they represent.
- We have colleagues from CHCC listening to this conversation and taking notes. We are also making a recording of the discussion so that we do not miss anything that you have to say.
- The discussion will last about 90 minutes.
- Do you have any questions before we begin?

PARTICIPANT INTRODUCTIONS/WARM UP

1. Let's start with a quick introduction. I know you are all acquainted, but I'm new to this group. So, can we quickly go around and tell me your name, the organization you work for, and how many employees you represent.

ACCESS TO SERVICES (Addressed in both groups)

Objective: Determine whether participants believe there is increased demand for behavioral health services and, if so, whether people can access the services they need.

2. Have you noticed a higher demand for behavioral health services in the last few years or has it remained fairly constant? (What types of services are most frequently requested?)
3. Some CHCC members provide coverage to what were called "essential workers" during the height of the pandemic. Are you aware of any programs designed specifically for these populations to address the trauma they experienced during the pandemic?
4. Walk me through the steps an employee goes through to access behavioral health services under your plan?
5. Thinking about the process your employees go through, do you consider it easy or difficult for people to access these services? [MOD: save comments about the quality of care for later in the discussion]
   - What are the road blocks that interfere with receiving treatment? (delays, costs?)
   - Is it harder to find care for adults or children?
   - Have you engaged in outreach to help employees access behavioral health benefits? (What have you provided and was it helpful?)
6. Do you provide a telehealth option for behavioral health services? [GET specifics: What is provided? What lead to the decision? What are the benefits/challenges to telehealth?]

QUALITY OF CARE (Addressed in both groups)

Objective: Document whether member purchasers are satisfied with the behavioral health services provided to their employees and how they evaluate the quality/efficacy of treatment.

7. How satisfied are you with the quality of behavioral care your employees are receiving?
8. How do you evaluate the quality of treatment, including whether the treatment is appropriate and effective?
9. Prior authorization is one tool used to avoid inappropriate care in advance. It's also a real point of friction for patients and clinicians. Any thoughts on the role of prior authorization in general and alternatives to it?
10. What additional information or oversight would be helpful?

CURRENT NEEDS AND PRIORITIES (Asked of members only)

Objective: Identify unmet needs of member purchasers and opportunities for CHCC to provide more support.

11. What is your greatest frustration around purchasing and providing behavioral health benefits?
12. What resources would you like CHCC to provide using its grant from PCORI to support member purchasers with regard to behavioral health?
13. What additional support or resources would you like CHCC to provide? [2]

TRENDS AND OPPORTUNITIES FOR CHCC (Addressed in both groups)

Objective: Identify emerging trends and opportunities for CHCC to serve members in the future.

14. Many of you have worked for in healthcare purchasing for many years. How has your industry changed over the last few years? What new trends are you seeing in the area of behavioral health?
    - How do you think these trends will affect costs over time?
    - Do you think these trends will improve access? What about quality?
15. Many people are turning to alternative therapies some as meditation, yoga, and cannabis. Do you think some of these alternative therapies should be covered by health insurance. Do you have any concerns?
16. What can CHCC do to support its member purchasers now and in the future?
17. CHCC is planning to use some of the grant money to host a series of meetings with behavioral health clinical leaders from California health plans and provider organizations to learn about strategies they are using to expand access and incorporate new evidence about what works for different conditions and populations. Would that activity be of interest to you? (Probe: Why/why not? What would you hope to learn?)

CLOSING

18. I have one last question: If you could wave a magic wand, what would you want California's behavioral health delivery and coverage system to look like?
19. Those are all the questions I have. Does anyone have something they would like to add? That concludes our discussion. Thank you all very much for your participation.

2 We could also test the appeal/value of specific services that CHCC might be considering.

CHCC Focus Groups Members and Non-Members (Group Two) Facilitator Guide Final (2-10-23)

INTRODUCTION

Good Morning. Thank you for coming. My name is ________________. I'm with Public Values, an independent research firm hired by the California Healthcare Coalition (CHCC) to talk with you about behavioral health services in California. Everyone here interfaces with the health care system from different vantage points and roles. **The purpose of today's focus group is to leverage your perspectives to help CHCC better understand how it can support its members who are responsible for purchasing behavioral health coverage for their employees.**

GROUND RULES

Before we start the discussion, I want to go over a few things.

- First, everything said here is confidential. In the final report, we will not identify the name of individuals who participated in these discussions.
- We have colleagues from CHCC listening to this conversation and taking notes. We are also making a recording of the discussion so that we do not miss anything that you have to say.
- The discussion will last about 90 minutes.
- Do you have any questions before we begin?

PARTICIPANT INTRODUCTIONS/WARM UP

1. Let's start with a quick introduction. Please introduce yourself by your first name and tell us the organization you work for and the kind of work you do.

ACCESS TO SERVICES

Objective: Determine whether participants believe there is increased demand for behavioral health services and, if so, whether people can access the services they need. (SAME AS GROUP #1)

2. Do you think the demand for behavioral health services has increased or remained fairly constant? (Probe: What do you attribute that to?)
3. Do you think most people who need behavioral health services are able to access those services? What are the road blocks that prevent people from getting treatment?
4. Do you think California—its health plans, providers, and state and local governments—are equipped to address this demand? Why or why not? [**If needed:** "President Biden has said we are in an unprecedented national mental health crisis and he has secured new funding for services and for strengthening the mental health workforce in many of the bills passed in the last two years. A fact sheet issued by the White House in March of last year noted that 2 of 5 adults report symptoms of anxiety and depression, and the grief, trauma, and physical isolation of the last two years have driven Americans to a breaking point."]
5. What do you think plans, providers, or government could do in the short term to increase access to behavioral health services?
6. I'd like to get your feedback on some strategies currently being considered to improve access to behavioral health services in California. Here's the first one... [MOD: Address one at a time asking, "Do you think that would increase the number of people who could be seen?"]
   a. Supporting more talk therapy through group visits and sessions.
   b. Short trainings and deployment of peer support counselors who might be able to provide more culturally appropriate support to certain communities.

   c. More intensive outpatient therapy options or shorter inpatient stays.
   d. Expanding tele-behavioral health coverage and options.
7. Is there anything you've heard recently that you think might help expand access to therapy?

QUALITY OF CARE

Objective: Document whether participants believe the behavioral health services provided to most residents are appropriate and effective and how they evaluate quality. (SIMILAR TO GROUP #1 but about residents rather than employees)

8. I'd like to turn the discussion to the quality of behavioral health services being provided to California residents. In general, do you think people who are able to access behavioral health services are receiving high-quality care?
9. What factors do you think are important in evaluating the quality of care, including whether the treatment is appropriate and effective
10. Prior authorization is one tool used to avoid inappropriate care in advance. It's also a real point of friction for patients and clinicians. Any thoughts on the role of prior authorization in general and alternatives to it?

TRENDS AND OPPORTUNITIES FOR CHCC

(Similar to Group #1 but going beyond what CHCC can do for members to include what CHCC can do to improve the delivery of health services for all residents.)

Objective: Identify emerging trends and opportunities for CHCC to improve the delivery of services for all California residents.

11. As you know, CHCC has received a grant to enable it to provide programming to learn more about what actually works in the behavioral health space. It's a big topic. How would you advise CHCC to narrow the scope and focus on a topic or two that might be most beneficial to the most members?
12. CHCC is planning to use some of the grant money to host a series of meetings with behavioral health clinical leaders from California health plans and provider organizations to learn about strategies they are using to expand access and incorporate new evidence about what works for different conditions and populations. Do you think that is a worthwhile activity?
13. Are you aware of any programs designed by or for specific occupations or industries to address the trauma they experienced during the pandemic? Do you think it's needed?
14. Many people are turning to alternative therapies such as meditation, yoga and Cannabis. Do you think some of these alternative therapies be covered by health insurance? Do you have any concerns?
15. There seems to be a link between chronic pain and depression, and sometimes a link between chronic pain and substance dependencies like opioids. Does this seem like a topic that would be worthwhile for CHCC to dig deeper on?
16. Are there other activities or experts that you think would be valuable as CHCC tries to advance an understanding of behavioral health care and identify what works, who it works for, and how we might encourage more providers and plan to deliver and offer such services?
17. How would you like to be involved with CHCC?

CLOSING

18. I have one last question: If you could wave a magic wand, what would you want California's behavioral health delivery and coverage system to look like?
19. Those are all the questions I have. Does anyone have something they would like to add? That concludes our discussion. Thank you all very much for your participation

Appendix B

INTRODUCTORY PATIENT-CENTERED OUTCOME RESEARCH CURRICULUM OUTLINE

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Building PCOR/CER Capacity Among Labor-Management Purchasers to Improve Mental Health

California Health Care Coalition (CHCC)

Funded by the Patient Cantered Outcomes Research Institute

2024

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DISCLAIMER

The statements and views presented in this report are solely the responsibility of the authors and do not necessarily represent the views of the Patient-Centered Outcomes Research Institute (PCORI), its Board of Governors or its Methodology Committee.

INTRODUCTION TO EVIDENCE-BASED TREATMENT

Insurance coverage questions for behavioral health care often revolve around the effectiveness and costs of different treatments and forms of care. Effective treatments are generally considered to be evidence-based.

These videos below will give you a quick overview:

1. **"Evidence-based" Treatment: What Does It Mean? (Veterans Health Administration):** https://www.youtube.com/watch?v=7dzkS0ioqqw&ab_channel=VeteransHealthAdministration
2. **The Process of Evidence-Based Practice: Interview with Danielle E. Parrish, Ph.D. (The Social Work Podcast)** This podcast discusses the definition and process of Evidence-based Practice: https://socialworkpodcast.blogspot.com/2011/03/process-of-evidence-based-practice.html

DEFINING YOUR BEHAVIORAL HEALTH OUTCOMES RESEARCH QUESTION

The first step in identifying evidence-based behavioral health care is to consider what your questions are. Is there a specific condition or treatment you'd like to focus on? It may be helpful to talk to a behavioral health professional (without financial conflicts of interest) to get a perspective on key questions related to coverage for behavioral health conditions. It may seem obvious what your question(s) is (are), but time invested on considering and defining your question(s) now will save you much more time in the future, keeping you from getting sidetracked or going down rabbit holes.

To learn more about how to define your question, see:

1. **How to Frame Your Evidence-Based Practice Question (Mount Sinai YouTube):** https://www.youtube.com/watch?v=E9sAG4OmaTQ

Typically, questions will involve the effectiveness of new Treatment A compared to existing Treatment B, and how these treatments work in the real world as well as in highly controlled trials. This type of research is known as comparative effectiveness research. It is important to remember that most studies done for FDA approval compare the treatment of interest to a placebo, or inactive control. Patient Centered Outcomes Research (PCOR) is focused on patient-centered questions such as:

1. "Given my personal characteristics, conditions, and preferences, what should I expect will
2. happen to me?"
3. "What are my options, and what are the potential benefits and harms of those options?"
4. "What can I do to improve the outcomes that are most important to me?"
5. "How can clinicians and the care delivery systems they work in help me make the best decisions about my health and health care?"

To develop clear research questions, it is important to make sure you have considered the **population** your question applies to, the **intervention**(s) you want to evaluate, the **comparison group** (Usual care? Specific alternative treatment? Placebo?), the **outcome**(s) that matter for patients, and the **time frame** over which the treatment takes place and when the outcomes are expected (Does the treatment take a long or short time to have an effect? Is the desired outcome maintained over time if the treatment is stopped, or does it need to be continued?).

The acronym for framing a question in this way is PICOT:

PICOT Component	Description
Population	Who does your question apply to?
Intervention	What treatment do you want to evaluate?
Comparison Group	What treatment do you want to compare the intervention to?
Outcome	What are you measuring?
Time Frame	How long will the intervention take to show its desired outcome?

INTRODUCTORY OVERVIEW OF SELECTED STUDY DESIGNS

Once you have defined your questions, think about what types of studies would best answer them.

For a brief overview of the types of study designs that may be relevant to your questions, see:

1. Types of Studies (Khan Academy): https://www.khanacademy.org/math/probability/xa88397b6:study-design/samples- surveys/v/types-studies-ap

These print resources can give you a deeper understanding:

2. Study Design: Part 1– An Overview and Classification (Ranganathan P, Aggarwal R; Perspectives in Clinical Research): https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6176693/pdf/PCR-9-184.pdf
3. Introduction to Study Design (Jeremy Howick; Oxford): https://www.cebm.ox.ac.uk/files/testing/cebm-study-design-april-20131.pdf

Table 1. Overview of Study Designs Reviewed in this Curriculum

Type of Study Design	Description
Interventional Studies	Experimental designs using control groups
Randomized Control Trial	Subjects have randomized assignment to intervention or control group
Observational Studies	Subjects are studied based on past, current, or future (prospectively) collected data which may describe the outcomes of different treatments. Statistical comparisons are made but no interventions are assigned to subjects.
Systematic Reviews & Meta- Reviews	An organized, comprehensive summary of the existing research on a question. If study designs and outcomes are similar enough, findings from different studies may be pooled in a mta-analysis.

INTERVENTIONAL STUDIES

Interventional studies test out a specific treatment, or intervention, on the population of interest. For example, an interventional study may test out a new treatment for postpartum depression, Treatment A, on new mothers. The intervention here would be Treatment A (vs. the standard of care, Treatment B).

To learn more about interventional studies, see:

1. **Study Designs: Part 4– Interventional Studies (Ranganathan P, Aggarwal R; Perspectives in Clinical Research):** https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6647894/pdf/PCR-10- 137.pdf

Randomized Controlled Trials (RCTs)

A common type of interventional studies is a randomized control trial (RCT), where the population of interest is randomized to one of two groups: 1) the control, where the group receives a placebo, usual care, or a specific existing treatment or 2) the intervention, in which the group does receive the treatment being studied (ex. a new medication). Well-conducted randomized controlled trials are generally considered to be the strongest design for individual studies of behavioral health and other health interventions, because individual (known or unknown) that might affect the outcome are randomly distributed between the groups. Blinded trials deliver the intervention in a manner that neither the researcher or the subject knows which treatment they received. This prevents the outcome being influenced by expectations of the intervention.

To learn more about what characterizes a well-conducted trial, see:

2. **UNC ERIC Notebook (UNC)** A clearly written print article on randomized controlled trials: https://sph.unc.edu/wp-content/uploads/sites/112/2015/07/nciph_ERIC10.pdf
3. **Randomized Controlled Trials (Cochrane Austria)** This video introduces various types of randomized controlled studies (RCTs) and discusses possible applications for different RCT designs: https://www.youtube.com/watch?v=XvWmfLwC9XA&ab_channel=CochraneAustria
4. **Study Design 101: Randomized Controlled Trial (GW Health Sciences Library**) Pros and Cons of RCTs with examples: https://guides.himmelfarb.gwu.edu/studydesign101/randomized-controlled-trial

OBSERVATIONAL STUDIES

RCTs may be unable to address certain questions, for example, due to the need for extremely large sample sizes to evaluate rare outcomes. Ethical concerns or strong population preferences may make an RCT untenable. For example, initial safety studies of new medications must be conducted before it is considered ethical to randomize patients and it is not feasible to randomize babies to be breast or bottle fed by their mothers. Observational studies can provide more information under these circumstances.

They also give us information about the effects of a treatment once it is more broadly disseminated in practice and used by people who were not included in the original RCT.

To learn more about observational studies, see the resources below:

1. **Observational Studies (Cochrane Austria)** This video deals with epidemiological study designs called observational studies .It gives an overview of the following types of observational studies: cohort studies, case-control studies, cross-sectional studies, case studies and case series, and ecological studies: https://www.youtube.com/watch?v=BYc3zCqdIVs&ab_channel=CochraneAustria
2. **Study Designs: Part 2– Descriptive Studies (Ranganathan P, Aggarwal R; Perspectives in Clinical Research):** https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6371702/pdf/PCR-10-34.pdf
3. **Study Designs: Part 3– Analytical observational studies (Ranganathan P, Aggarwal R; Perspectives in Clinical Research):** https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6463505/pdf/PCR-10-91.pdf

SYSTEMATIC REVIEWS AND META-ANALYSES

Well-done systematic reviews bring together quality-reviewed evidence to address a specific question. When available, systematic reviews may be the most useful type of study to summarize the evidence for a specific treatment or intervention. The authors have searched the literature, identified the relevant studies, and considered study quality in summarizing the evidence. If the studies' methods and outcomes are similar enough, statistical techniques to pool results, know as meta-analysis, may allow the evaluation of outcomes from the larger sample size of the pooled studies. Systematic reviews are limited by the number and quality of existing studies, however. Sometimes a comprehensive systematic review will find that the evidence is insufficient to reach a conclusion. This is not a negative finding about a treatment or intervention, but rather a call for more well-conducted studies on the topic. It tells us that this treatment or intervention may not have sufficient evidence for wide implementation.

To learn more about systematic reviews and meta-analysis, see the following resources:

1. **What are Systematic Reviews? (Cochrane video)** This video explains why systematic reviews are important and how they are done. This includes an explanation of how the effects of interventions are compared in order to provide evidence: https://www.youtube.com/watch?v=egJlW4vkb1Y&ab_channel=Cochrane
2. **Study Design 101: Systematic Review (GW Health Sciences Library)** A brief written description of a systematic review with examples: https://guides.himmelfarb.gwu.edu/studydesign101/systematic-review
3. **Study Designs: Part 7– Systematic Reviews (Ranganathan P, Aggarwal R; Perspectives in Clinical Research)** A more detailed written description of what is required to conduct a systematic review: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7342340/pdf/PCR-11-97.pdf

Examples of in-process and completed systematic reviews funded by PCORI can be found here: https://www.pcori.org/implementation-evidence/evidence-synthesis-reports-and-interactive- visualizations/systematic-reviews

How do you know when there is enough evidence to support adding coverage (or trying to improve access) for an evidence-based treatment?

Typically, multiple, consistent studies with strong designs showing favorable effects provide adequate evidence that a treatment works. If the comparison groups reflect current practice, you can have more confidence that a new treatment may add benefit over existing treatment(s). In general, if you identify a well-done recent systematic review that addresses your question you can have more confidence in your conclusions.

EXAMPLES OF ESTABLISHED BEHAVIORAL HEALTH TREATMENTS/INTERVENTIONS

When evaluating behavioral health coverage, you may want to consider how well strongly evidence-based treatments are covered, and whether beneficiary access is adequate. Different treatments may have different effectiveness in different individuals. Coverage is a key first step in providing treatment access to beneficiaries, but if the number of trained behavioral health providers is not adequate to meet demand, comprehensive coverage of evidence-based care will not ensure access to that care. Resources that can provide more information on some evidence-based behavioral health treatments are found below.

You may want to choose a topic to discuss as a group for each session. At least one evidence source (Systematic Review or RCT) is included for each of the topics listed, in addition to summary materials written in lay language. You can apply your new skills in evaluating research by assigning one of these studies ahead of time and discussing it with the group.

Cognitive Behavioral Therapy (CBT)

CBT is a relatively short, structured form of psychotherapy shown to be effective for a range of conditions (depression, anxiety disorder, panic disorder, obsessive compulsive disorder, post-traumatic stress disorder, for example). It can augment the effectiveness of medication for depression. Despite its demonstrated effectiveness, it may be difficult to access because of a relative shortage of trained providers that accept health insurance.

The resources below provide more information on CBT:

1. **How Does Cognitive Behavioral Therapy Work? (Psych Hub video):** https://www.youtube.com/watch?v=ZdyOwZ4_RnI&t=5s&ab_channel=PsychHub
2. **How Cognitive Behavior Therapy May Help Suicidal People (NY Times):** https://www.nytimes.com/2018/06/13/well/cognitive-behavior-therapy-suicide.html
3. **Cognitive Behavioral Therapy FACT SHEET (NAMI Michigan):** https://namimi.org/wp- content/uploads/2015/02/CBT_factsheet.pdf

You can read a recent systematic review on the effectiveness of CBT for various conditions:

4. David D, Cotet C, Matu S, Mogoase C, Stefan S. 50 years of rational-emotive and cognitive-behavioral therapy: A systematic review and meta-analysis. J Clin Psychol. 2018 Mar;74(3): 304-318. doi: 10.1002/jclp.22514. Epub 2017 Sep 12. PMID: 28898411; PMCID: PMC5836900.
   Find it at this link: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5836900/

CBT seems to work as well via telehealth as in person according to a recent systematic review:

5. Zandieh S, Abdollahzadeh SM, Sadeghirad B, Wang L, McCabe RE, Yao L, Inness BE, Pathak A, Couban RJ, Crandon H, Torabiardakani K, Bieling P, Busse JW. Therapist-guided remote versus in- person cognitive behavioural therapy: a systematic review and meta-analysis of randomized controlled trials. CMAJ. 2024 Mar 17;196(10):E327-E340. doi: 10.1503/cmaj.230274. PMID: 38499303; PMCID: PMC10948182.
   Find it at this link: https://www.cmaj.ca/content/196/10/E327.long

You can find out more about CBT studies funded by PCORI here: https://www.pcori.org/research/pcori-literature?&keyword=%22cognitive%20behavioral%20therapy%22

Comprehensive Treatment of First Episode Psychosis

Recent studies have demonstrated the beneficial effects on outcomes if symptoms of psychosis (which are often first signs of schizophrenia) are detected early and comprehensive, multidisciplinary treatment is initiated.

This lay language blog describes what is involved:

1. **How Should We Be Treating First-Episode Psychosis? (NAMI):** https://www.nami.org/Blogs/NAMI-Blog/March-2017/How-Should-We-Be-Treating-First- Episode-Psychosis

Paradoxically, comprehensive treatment of first episode psychosis is covered by Medi-Cal in California, but often not by commercial insurance plans as discussed in this NPR story:

2. **It keeps people with schizophrenia in school and on the job. Why won't insurance pay? (NPR):** https://www.npr.org/sections/health-shots/2024/01/02/1221097477/it-keeps-people-with-schizophrenia-in-school-and-on-the-job-why-wont-insurance-p

You can read a systematic review of studies on early treatment of first-episode psychosis here:

3. Correll CU, Galling B, Pawar A, Krivko A, Bonetto C, Ruggeri M, Craig TJ, Nordentoft M, Srihari VH, Guloksuz S, Hui CLM, Chen EYH, Valencia M, Juarez F, Robinson DG, Schooler NR, Brunette MF, Mueser KT, Rosenheck RA, Marcy P, Addington J, Estroff SE, Robinson J, Penn D, Severe JB, Kane JM. Comparison of Early Intervention Services vs Treatment as Usual for Early-Phase Psychosis: A Systematic Review, Meta-analysis, and Meta-regression. JAMA Psychiatry. 2018 Jun 1;75(6):555-565. doi: 10.1001/jamapsychiatry.2018.0623. PMID: 29800949; PMCID: PMC6137532.
   Find it at this link: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6137532/

The first U.S. trial was published in 2016:

4. Kane JM, Robinson DG, Schooler NR, Mueser KT, Penn DL, Rosenheck RA, Addington J, Brunette MF, Correll CU, Estroff SE, Marcy P, Robinson J, Meyer-Kalos PS, Gottlieb JD, Glynn SM, Lynde DW, Pipes R, Kurian BT, Miller AL, Azrin ST, Goldstein AB, Severe JB, Lin H, Sint KJ, John M, Heinssen RK. Comprehensive Versus Usual Community Care for First-Episode Psychosis: 2-Year Outcomes From the NIMH RAISE Early Treatment Program. Am J Psychiatry. 2016 Apr 1;173(4):362-72. doi: 10.1176/appi.ajp.2015.15050632. Epub 2015 Oct 20. PMID: 26481174; PMCID: PMC4981493.
   Find it at this link: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4981493/

Treatments for Depression

These Khan Academy videos summarize psychological therapies and medications used for treatment of depression:

1. **Psychological Therapies (Khan Academy video)** Outlines examples of treatments for depression including CBT, Cognitive Therapy, Behavioral Therapy, Interpersonal Therapy, and Psychodynamic Therapy: https://www.khanacademy.org/science/health-and-medicine/executive-systems-of-the-brain/depression-and-related-disorders/v/treatments-for-depression-psychological-therapies
2. **Treatments for depression with antidepressants (Khan Academy video):** https://www.khanacademy.org/science/health-and-medicine/executive-systems-of-the- brain/depression-and-related-disorders/v/treating-depression-with-antidepressants

Some people have depression that doesn't respond to standard medications and therapies. If resistant depression is severe, medications may be added to augment standard treatments. If initial augmentation strategies fail, sometimes an older treatment is used: electroconvulsive therapy (ECT). Ketamine is also sometimes used for resistant depression. The only form of ketamine that is FDA approved for treatment of resistant depression is a nasal spray, esketamine. Guidelines require that it be given in a physician's office, and it is expensive compared to alternative treatments used in resistant depression. Ketamine is also available as an oral medication and an IV infusion used for other purposes, but private ketamine clinics may dispense these as treatment for depression on a cash basis.

You can read more about ketamine treatments here:

1. **Ketamine for treatment-resistant depression: When and where is it safe? (Harvard Medical School):** https://www.health.harvard.edu/blog/ketamine-for-treatment-resistant-depression-when-and- where-is-it-safe-202208092797

ECT was recently compared in a randomized trial to intravenous ketamine, an anesthetic that has been used to treat resistant depression, though it is not FDA approved for this purpose.

2. **Anand A, Mathew SJ, Sanacora G, Murrough JW, Goes FS, Altinay M, Aloysi AS, Asghar-Ali AA, Barnett BS, Chang LC, Collins KA, Costi S, Iqbal S, Jha MK, Krishnan K, Malone DA, Nikayin S, Nissen SE, Ostroff RB, Reti IM, Wilkinson ST, Wolski K, Hu B. Ketamine versus ECT for Nonpsychotic Treatment-Resistant Major Depression. N Engl J Med. 2023 Jun 22;388(25):2315-2325. doi: 10.1056/NEJMoa2302399. Epub 2023 May 24. PMID: 37224232.** You can read the trial at this link: https://www.nejm.org/doi/10.1056/NEJMoa2302399?url_ver=Z39.88- 2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed

You can find more about studies on depression funded by PCORI here: https://www.pcori.org/research/pcori-literature?&keyword=depression&f%5b0%5d=article_type:2900

Behavioral Health Integration with Primary Care

Integration of primary care and behavioral health (the collaborative care model) has been shown in research studies to improve access to behavioral health and to improve health outcomes. Insurers can incentivize coverage for integrated care, for example by supporting reimbursement for both behavioral health and primary care visits at the same location on the same day.

You can learn more about this model and the evidence supporting its effectiveness through the resources listed below:

1. **Integrating Primary Care and Behavioral Health to Address the Behavioral Health Crisis (The Commonwealth Fund):** https://www.commonwealthfund.org/publications/explainer/2022/sep/integrating-primary- care-behavioral-health-address-crisis
2. **Making Progress on Integration of Behavioral Health Care and Other Medical Care (USC-Brookings):** https://www.brookings.edu/wp- content/uploads/2022/12/20221212_SIHP_IntegrationWhitePaperFinal.pdf
3. **What is Integrated Behavioral Health? (AHRQ):** https://integrationacademy.ahrq.gov/about/integrated-behavioral-health
4. **Integrating Behavioral Health in Primary Care: Overcoming Decades of Challenges (Health Affairs)**: https://www.healthaffairs.org/content/forefront/integrating-behavioral-health-primary-care-overcoming-decades-challenges
5. **The Role of the Collaborative Care Model in Reducing Mental Health Inequalities (APA):** https://www.psychiatry.org/getmedia/e24b9d4f-df28-43a1-8359-25cc4f9de661/APA-Role- CoCM-Reducing-Mental-Health-Inequities.pdf
6. **Learn About the Collaborative Care Model (APA):** https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/learn
7. **Fact Sheet. Behavioral Health Integration (APA):** https://www.apa.org/health/behavioral-health-factsheet.pdf
8. **Making Care Primary: An Important Advance for Integrated Behavioral Health Care (The Commonwealth Fund):** https://www.commonwealthfund.org/blog/2023/making-care-primary-integrated-behavioral- health-care

You can find more about PCOR funded studies of Behavioral Health Integration here: https://www.pcori.org/research/pcori- literature?&keyword=%22behavioral%20health%22&f%5b0%5d=article_type:2900

Other Topics

Particular groups, such as older adults or college students may respond better to specific kinds of interventions:

1. **Psychosocial Interventions for Older Adults With Serious Mental Illness (SAMHSA)** The guide provides considerations and strategies for interdisciplinary teams, peer specialists, clinicians, registered nurses, behavioral health organizations, and policy makers in understanding, selecting, and implementing evidence-based interventions that support older adults with serious mental illness: https://store.samhsa.gov/sites/default/files/pep21-06-05-001.pdf
2. **Prevention and Treatment of Anxiety, Depression, and Suicidal Thoughts and Behaviors Among College Students (SAMHSA)** This guide presents five evidence-based programs and practices that address the prevention and treatment of common mental health concerns: gatekeeper trainings, mindfulness-based stress reduction, acceptance and commitment therapy, cognitive behavioral therapy, and dialectical behavior therapy: https://www.samhsa.gov/resource/ebp/prevention-treatment-anxiety-college-students

A comprehensive redesign of the behavioral health care system is described in the report below:

1. **A Human-Centered Vision for Improving the Mental Health Care Ecosystem (Deloitte Insights) This report describes a model for improving behavioral health care based on reforms in the UK:** https://www2.deloitte.com/us/en/insights/industry/public-sector/mental-health-equity-and- creating-an-accessible-system.html
2. **Digital Therapeutics for Management and Treatment in Behavioral Health (SAMHSA)**
3. **This advisory introduces readers to digital therapeutics (DTx) and the benefits of their use in behavioral health.** Six DTx are currently FDA approved. The advisory describes the research, regulatory, and reimbursement implications for DTx as well as selection and implementation considerations: https://store.samhsa.gov/sites/default/files/pep23-06-00-001.pdf
4. **Therapy: Does It Work? (Science Vs.)**Our mental health has taken a turn for the worse the past couple of years. This podcast examines whether therapy can help. It can be a big investment of time and money. So is it worth it? How often does therapy really help people? It includes conversations with Jacquelyn Revere and psychologists Dr. Jonathan Shedler, Professor Bunmi Olatunji and Dr. Nancy McWilliams: https://gimletmedia.com/shows/science-vs/8whx33w
5. **Inside the Adolescent Mental Health Crisis (The Daily, The New York Times)** This podcast discusses a new set of risks has emerged. In 2019, 13 percent of adolescents reported having a major depressive episode, a 60 percent increase from 2007. And suicide rates, which had been stable from 2000 to 2007 among this group, leaped nearly 60 percent by 2018. We explore why this mental health crisis has become so widespread, and why many people have been unprepared to handle it: https://www.nytimes.com/2022/08/30/podcasts/the-daily/teens-mental-health-crisis.html

GENERAL QUESTIONS FOR PURCHASERS EVALUATING BEHAVIORAL HEALTH COVERAGE

When assessing potential behavioral health plans, review any provided documents including the Explanation of Benefits (EOB) but you may want to look beyond the EOB to get a clearer picture of the benefits from the beneficiary point of view. Consider the following questions for plans:

1. What changes are planned for behavioral health coverage in the next contract?
2. What steps are required for beneficiaries to access behavioral health care?
3. How can accessing behavioral health care become more transparent for our beneficiaries?
4. How many behavioral health care providers are in the network? How many are currently accepting new patients? How often is this information updated?
5. What specific types of therapy are available to beneficiaries? How many providers are trained to provide Cognitive Behavioral Therapy?
6. Does the behavioral health plan currently cover:
   - Integrated Behavioral Health with Primary Care? If yes, how many practices have adopted this model?
   - Comprehensive treatment for early psychosis?
   - Other treatments of interest (Fill In):

More Detailed Questions for Evaluating Behavioral Health Plans

1. Do you have a readily accessible list of behavioral health providers available for members and how is this typically accessed by members?
   a. What information is provided for the member? (i.e., If the provider is currently taking new patients, Provider's expertise and/ or training, Provider language and/ or cultural background, etc.)
   b. How often is this list updated and verified by the insurance company? How often are providers contacted to verify listed information?
2. How are mental health providers selected to participate in your network?
   a. How are providers vetted to ensure they use recommended evidence-based strategies and deliver positive health outcomes?
   b. How do you ensure adequate coverage of diverse (in expertise, degree, etc.) providers in our area? What do you consider as "adequate" coverage?
3. How do members learn about their health benefits?
   a. What resources can inform them about their behavioral health benefits? (i.e., Educational seminars, mailers/ emails, 24/7 advice line, etc.)
4. How does the plan ensure timely access to behavioral health care?
   a. What resources assist members to find and schedule an in-network provider?
   b. What is the average time to locate and have an appointment with a behavioral healthcare provider?
   c. What is the average time between the initial assessment (first appointment) and the next follow up appointment for plan members?
5. Are additional services provided under this plan such as Employee Assistance Programs, Mobile or Online Wellness Subscriptions (e.g., Headspace) and/ or Mental Health Wellness Programs available for members?

   a. Are there systems in place to connect members accessing these shorter-term services to longer term care if needed?

6. Does this plan support the collaborative care model or other evidence-based innovative behavioral healthcare models and if so, how?

EXERCISE: WHAT QUESTIONS DO YOU HAVE FOR A HEALTH PLAN REGARDING BEHAVIORAL HEALTH BENEFITS?

Please read the behavioral health plan marketing pamphlet. How many of the questions on the previous page are addressed in the brochure? **What are the most important questions you have for the health plan if you were considering adding this behavioral health plan for your members?** Jot these questions down and then discuss with your group. Which questions are most important to you?

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