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What if Outpatient Care Was Reimagined into Something Better?

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Many behavioral health providers have pain points with outpatient programming including reimbursement gaps, maintaining a prepared workforce to meet growing demand, and administrative burden—particularly intake paperwork creating barriers to outpatient care. According to the National Council for Mental Wellbeing CCBHC Impact Study in 2022, the national average for waitlists for services was 49 days while in some states it is far worse with families waiting as long as 13 weeks to receive an intake and then waiting for a treatment appointment (MA Provider Association says 13.6 weeks for initial assessment). The frequency of care is also impacted by workforce shortages and the increased demand for behavioral health and it is not uncommon for individuals to have 4-6 weeks between sessions.

Yet outpatient behavioral health remains the backbone of the behavioral health continuum. Grounded in the history of psychotherapy, most graduate programs focus on training advancements made in the 1950s (Rogerian therapy) and 1960s (Cognitive therapy) forcing provider organizations to continually train the next generation in effective care. Even evidence-based practices such as Dialectical Behavioral Therapy (which was initiated in the late 1970s) are difficult to find. The result is that most outpatient psychotherapy is an individual provider's mix of techniques which may or may not be grounded in evidence or effectiveness. Often provider organizations and payors remain tied to this outdated treatment history and underlying assumptions:

- Weekly or regular psychotherapy is central to improvement;
- Commitment to the 50-minute appointment;
- Relationship with the therapist is the lever of change and the therapist is the expert;

- Insight is the goal and development of the self; and
- Measurement or quantitative outcomes are hard to capture.

These assumptions and models are ill equipped for current behavioral health needs across populations. Children and youth have increasing rates of suicidal ideation and attempts and the causes are complex—social media, political discord, gender identity and policies against affirming care, and fears about climate change. Substance use care has shifted to community-based care, harm reduction and medication assisted treatment. Individuals with serious mental illness are increasingly living on the streets or in justice settings. Rarely standard outpatient care is the right answer for this complexity. Public sector behavioral health is tied to outpatient models because of payment models and regulatory structures as well as historic foundational assumptions. However, we are approaching a tipping point with barriers to access, workforce shortages and private sector models outpacing change in the public sector. It is time to engage in creative destruction of outpatient care and build the models of the future.

Creative destruction is the deliberate dismantling of long-standing processes, procedures, assumptions and long-term beliefs to make room for innovation, to enhance and improve outcomes and to build efficiency.
How do we do this?

1. Start by listening to individuals seeking care.
What do we hear? More choices at the front door and access to peers at that point in their care. They want on demand support (short and brief interventions) that feels more like coaching than therapy—they want to learn to apply new skills in the moment. They want services delivered in daily life and in the community. The notion of therapy is not always clear and many stakeholders say they don't know how to "use it."

2. Question core assumptions and historical ties and dismantle elements that are no longer effective.
My recommendations include:
Dismantle:

- "Gina Lasky therapy models "
- Brick and Mortar only efforts
- 50-minute hour appointments
- Provider centric models
- Single clinician models
- Reliance on traditional workforce
- Productivity only models
- "We are too special to measure"
- Expectations on accountability
- Under-paying workforce & lack of growth in opportunities
- Care coordination only
- Clinic and traditional approaches
- BH only

In favor of Creative Destruction:

- Adapt evidence-based approaches
- Community based approaches
- Brief sessions and on demand coaching
- Human centered design
- Team based care
- Tiered and valued non-traditional workforce
- Incentives and non-productivity models
- Measurement based care & demonstration of value
- Embrace high accountability
- Expanded roles and variety for workforce
- Care management for high risk
- Embrace technology supports (AI, App, other)
- Invest in saving lives & see the whole person as your responsibility

Other examples to consider include adapting the flow of outpatient to "burst care " to increase engagement and the dose of care through team based care; train providers in evidence based skills that can be taught in short bite size sessions and engage more coaching approaches; and build community based care with non-traditional workforce (see Open Source Wellness which is highly effective—watch the video). Public sector behavioral health providers have the expertise and the passion to build a new model of outpatient care and it has never been a better and more important time to lead the transformation towards effective care that is also meaningful and rewarding for the workforce.

Dr. Gina Lasky presented at the **mhca** 2023 Fall Conference in Scottsdale, Arizona. You can view the recording of her session, and many others, here in the searchable online library (mhca member login required): https://mhca.com/conference-presentations

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