

Elimination of Behavioral Health Wait Times: Impact on “Avoidable” Medical Visits, Productivity, and Revenues

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Objective: Delayed access to behavioral health services results in poor outcomes and higher costs. This brief report describes the elimination of a 702-person behavioral health waitlist through phase-based care (PBC), an innovative approach that aligns behavioral health resources with new patients with high-acuity need.

Methods: Two PBC clinics, one triage and another high-acuity treatment, were established. Comparisons of pre-post interventions analyzed nonbehavioral health medical encounters, behavioral health productivity, and no-show rates.

Results: Of 702 waitlisted persons, 614 attended triage clinics within 3.5 months, with patients needing acute care (37%)

entering the treatment clinic within 2 weeks. Following evaluation, the waitlisted patients had 23% fewer medical encounters per month ($p < 0.001$), behavioral health revenues increased 29% ($p < 0.001$), behavioral health visits increased 165% ($p < 0.001$), health evaluations increased 287% ($p < 0.001$), and no-shows decreased 33% ($p < 0.001$).

Conclusions: Reallocating resources to new patients and those needing acute care resulted in increased behavioral health evaluations and productivity and reduced non-behavioral health services without adding staff.

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Delayed access to behavioral health care is associated with symptom deterioration, poor outcomes, and high no-show rates (1, 2). In addition, inadequate access to care is projected to cost nearly \$500 billion per year in “avoidable” use of emergency departments by patients specifically needing behavioral health care (3). Community mental health centers and federally qualified health centers (FQHCs), the “safety nets” for Medicaid and uninsured patients, have average wait times of 10 weeks (4), but that figure represents the initial evaluations, not full engagement in care. Understaffing is the standard explanation for these backlogs (4), yet an innovative approach to behavioral health services—phase-based care (PBC)—challenges this notion by demonstrating rapid engagement within 1 or 2 weeks without additional staff (5). This is accomplished through organizational shifts in scheduling, treatment, and resource allocation that prioritize new patients and those needing acute care.

Community behavioral health clinics usually schedule patients at 1–3-month intervals regardless of clinical acuity, even after years of stability. This practice, mandated by some state regulations (6), can usurp 50% of psychiatric

providers’ and therapists’ hours (5), with no-show rates of up to 50% (7). PBC realigns therapists’ and providers’ clinical hours to provide timely care to new patients and those with high-acuity issues, using other staff and modalities to maintain stability and wellness. This report describes the impact of PBC on avoidable nonbehavioral

HIGHLIGHTS

- The phase-based care (PBC) model was developed to address the persistent problem of long waitlists in community mental health clinics.
- PBC was implemented in a federally qualified health center serving a diverse patient population in New Orleans that had been facing a waitlist of more than 700 patients.
- The waitlist was eliminated over a 3.5-month intervention period, resulting in significant postintervention improvements, including reduction in “avoidable” medical visits and increased productivity and revenue, without requiring additional resources.

health medical services, as well as on productivity, no-show rates, and financial outcomes at an FQHC.

PBC, described fully elsewhere (5), requires five transformative changes to the traditional modes of scheduling and engaging behavioral health patients, with the goal of shifting 70% of clinical resources to new and high-acuity patients. In brief, the following modifications are essential to PBC: weekly clinics, multidisciplinary teams, weekly team meetings, measurement-based care and data monitoring, and algorithms to adjust staffing.

Weekly clinics provide scheduled appointments as well as the option of same-day walk-ins. Multidisciplinary treatment teams, typically comprising psychiatric providers, therapists, case managers, nurses, and peer counselors, coordinate resource utilization according to clinical needs. At weekly team meetings, care plans of high-acuity patients are reviewed and adjusted if needed. Measurement-based care uses rating scales, obtained at every “touch” or patient encounter with the care team, to inform acuity levels. Finally, algorithms, which are based on new referral rates, projected hours of various treatment modalities needed to resolve an acute episode, and other variables, are used to guide staffing levels.

CrescentCare, an FQHC serving the New Orleans region, provides medical, behavioral, dental, women’s, and pediatric outpatient care annually to more than 13,500 patients, primarily those receiving Medicaid or who are uninsured. To access the behavioral health program, patients must be referred from one of the medical services. All referred patients are routinely placed on the waitlist regardless of diagnosis or acuity. Patients with substance use disorders are referred through a different pathway and are not included in this report.

When faced with a waitlist of 702 patients in October 2022, CrescentCare’s behavioral health leadership recognized its obligation to better meet the needs of its patients and solicited help through PBC. During the 3-month PBC orientation, examination of the backlog determined it was largely due to CrescentCare’s culture of scheduling patients at 1- to 4-week intervals for follow-up, despite no-show rates of 50%. These scheduled appointments resulted in inadequate staff time to evaluate and engage new and high-acuity patients. The stated goal of the PBC initiative was to eliminate the waitlist within 3 months and rapidly engage high-acuity waitlisted patients.

METHODS

The FQHC treatment team used two PBC clinics: a triage clinic projected to evaluate all waitlisted patients within 3 months and a treatment clinic to provide patients needing acute care immediate engagement with a multidisciplinary PBC treatment team. To design the PBC triage clinic, the team estimated that 600 of the 702 waitlisted patients would participate, or about 50 patients per week for 12 weeks. The team attempted to contact all waitlisted persons twice for a 30-minute triage appointment. They

scheduled triage appointments, eight per 3-hour clinic twice per week, overbooking to account for no-shows, within 2 weeks of phone contact. With these assumptions, the PBC algorithms projected the triage clinic would require about 40 person-hours of clinician time per week for the initial 3 months.

After 1 month of the triage clinic, the clinicians’ impressions of acuity, guided by results from the Patient Health Questionnaire–9 (8), Generalized Anxiety Disorder–7 (9), and Readiness for Therapy Questionnaire (10) and weekly team meeting discussions, led to the projection that approximately a third of patients triaged would need the high-acuity, multidisciplinary PBC treatment clinic.

To develop PBC algorithms for the treatment clinic, the clinical team started with their projected number of high-acuity patients after triage and factored in anticipated no-show rates, resources required to achieve recovery, average time to recovery, and staff vacations allotment. The algorithms projected that the PBC treatment clinic should start with 4 hours per week of therapy time, which would incrementally increase to 36 hours per week by month 3. Low-acuity patients would undergo traditional, non-PBC behavioral health care.

Psychiatric providers engaged in the treatment clinic, dedicating several hours per week and participating in weekly team meetings. Patients who had prior relationships with psychiatrists at the FQHC who were not associated with the PBC treatment clinic would continue to engage with their provider and would receive only therapy and case management services through the PBC treatment clinic. To allocate sufficient therapy hours per week to the PBC clinics, each of eight therapists identified 10 to 15 disengaged or stable patients for referral to group therapy, peer support, case management, or discharge.

This observational report relied on a retrospective analysis of CrescentCare’s electronic health records that compared average monthly data of the preintervention (July 1, 2022–February 23, 2023) and postintervention (March 23, 2023–July 31, 2023) periods. Of the 702 waitlisted persons, 614 attended triage evaluation; for these patients, the team examined the impact of eliminating the waitlist on nonbehavioral health medical encounters and the associated change in revenues. Patient visits were measured as mean per patient per month (PPPM), and staff productivity was captured via completed behavioral health evaluations and treatment encounters per therapist per month (PTPM) to account for variations in the number of therapists. We used total encounters PTPM as a proxy measure for productivity and revenues per month as a proxy for financial outcomes. In addition, we examined no-show rates between the two periods for the overall behavioral health program. We obtained statistical significance of each pre-post comparison via t test with a significance level of $p < 0.05$.

Because the intervention was planned and implemented as a quality improvement process of organizational change

to eliminate wait times, there was no randomization or blinding. All data were deidentified. Institutional review board review was not required.

RESULTS

The mean \pm SD age of the 614-patient cohort was 39.2 ± 13.4 years, with 42% (N=259) identifying as female, 40% (N=244) as male, and 18% (N=111) as transgender or other (the high percentage of transgender individuals is not surprising given CrescentCare's focus on serving gender-diverse populations). For race-ethnicity, 46% (N=283) of patients self-identified as non-Hispanic White, 31% (N=192) non-Hispanic Black, 16% (N=95) Hispanic, and 7% (N=44) other. After triage evaluation, 229 (37%) patients engaged with the weekly high-acuity PBC treatment clinic within 2 weeks, 357 (58%) were referred to traditional individual therapy, 152 (25%) accessed case management services, and 30 (5%) were referred to group therapy. Sixty-five percent (N=399) of patients were diagnosed as having anxiety disorders, 49% (N=301) mood disorders, 15% (N=92) personality disorders, and 2% (N=12) schizophrenia or non-mood-related psychotic disorders.

As shown in Table 1, a comparison of pre- and post-intervention encounters per month for the waitlisted cohort indicates that nonbehavioral health medical visits declined from 0.43 to 0.33 PPPM (23%, $p < 0.001$), and behavioral health visits increased from 0.17 to 0.45 PPPM (165%, $p < 0.001$). New behavioral health evaluations PTPM increased from 3.1 to 12.0 (287%, $p < 0.001$). The average monthly revenue PPPM associated with this cohort for both medical and nonmedical encounters increased by 29%, from \$136 to \$175, which translates to almost \$24,000 increased revenue per month ($p < 0.001$). For the entire behavioral health clinic, no-show rates decreased from 52% to 35% (33%, $p < 0.001$).

DISCUSSION

This report indicates that PBC may ameliorate problems associated with delayed behavioral health care by reducing avoidable medical encounters and behavioral health no-show rates and increasing behavioral health productivity and revenue. Reports describing avoidable overutilization of medical resources because of unmet behavioral health needs are based on population studies of patients visiting medical settings for behavioral health evaluation or treatment. These studies do not account for additional obstacles to behavioral health care, such as stigma and financial barriers, that are not dependent on the lack of access (11). This pilot report suggests that patients who are already engaged in an FQHC and who have accepted referral to behavioral health care, thus eliminating both financial and stigma barriers, contribute to avoidable nonbehavioral health medical services while waiting for behavioral health services.

TABLE 1. Pre-post phase-based care (PBC) intervention of the waitlisted cohort (N=614)^a

Outcome variable	Pre-PBC (July 1, 2022– February 23, 2023)	Post-PBC (March 23, 2023–July 31, 2023)	% difference
Behavioral health evaluations completed PTPM	3.1	12.0	287
No-show rate at behavioral health clinic (%)	52	35	–33
Mean behavioral health visit counts PPPM	0.17	0.45	165
Mean nonbehavioral health medical visit counts PPPM	0.43	0.33	–23
Mean monthly revenue PPPM	\$136	\$175	29

^a Pre-post comparisons were statistically significant for each variable listed ($p < .001$). PPPM, per patient per month; PTPM, per therapist per month.

This report found that significant cultural transformations were required to implement PBC. The ingrained belief that stable patients must be scheduled at routine intervals was challenged and dispelled, permitting reallocation of therapy resources to the waitlisted patients. Treatment teams comprising psychiatric providers, therapists, case managers, peer counselors, and expanded group programs conveyed additional clinical benefits of a multidisciplinary approach (12). Clinics with scheduled appointments as well as same-day walk-in options benefited relapsing patients via immediate re-engagement instead of an appointment at some future scheduled date (13). Rating instruments, not routinely used in behavioral health settings (14), were welcomed into both the triage and treatment clinics as tools to inform—not dictate—acuity state and guide treatment plan changes in real time.

Although we were unable to precisely monitor staffing hours pre- and postintervention, increased PPPM revenues, resulting from higher behavioral health productivity and lower no-show rates, were a fiscal “win” for the FQHC. These results therefore suggest that improving access to behavioral health care via PBC may also convey significant financial benefits to health care organizations and thus provide an economic rationale for sustainability. PBC has been implemented in over 15 clinics across the United States, and current results support the likelihood of its being scalable and sustainable (5).

This study had several limitations. Because of the observational nature of the study, making causal interpretations of the results is difficult. Also, the results cannot be extrapolated to other sites of avoidable nonbehavioral health care utilization, including emergency departments, visits to which are major contributors to health care costs.

In future studies, we will examine such utilization patterns via analyses of health insurance claims data, which would capture care utilization patterns outside of a defined FQHC.

CONCLUSIONS

This report describes the elimination of a 702-person waitlist within 3.5 months via algorithm-based rational reallocation of existing resources without additional staff. PBC triage and treatment clinics resulted in significant reduction in avoidable medical costs and increased productivity and revenue for the FQHC. Further studies are needed to establish the replicability and generalizability of the PBC clinic model.

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Dr. Rosen and Ms. Hoy, cofounders of Care Connect LLC, consult with community behavioral health programs, including CrescentCare, a federally qualified health center, to enhance efficiency and outcomes and to increase access to behavioral health services. Dr. Rosen is also the chief executive officer and Ms. Hoy a subcontractor of Summit Behavioral Health. Dr. Maeng served as a statistician for this study and received payment for the service.

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