EVERNORTH
Research Institute℠

IMPROVING CARE SERIES

PUTTING BEHAVIORAL HEALTH TOP OF MIND

The complexities and importance of patient journeys

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HEALTH SERVICES

OVERVIEW

Behavioral health is essential health

22% of people have a diagnosed behavioral condition. This group **drives 41%** of total health care spend.

In recent years, health care organizations, academia, policymakers and societies have broadly acknowledged the importance of behavioral health, with the COVID-19 pandemic serving as an inflection point as it relates to overall well-being.

Behavioral health encompasses individual and family well-being, as well as a wide range of conditions that differ in degree of intensity and impact. As with physical health, behavioral health affects patients in highly personal and unique ways. And both behavioral and physical health influence each other significantly to determine overall health.

This report is designed to support plans seeking to understand and improve care for behavioral health patient journeys. Evernorth Research Institute analyzed de-identified and aggregated administrative medical, behavioral and pharmacy claims data from 2021 to 2022. Data was sourced from a commercial and health exchange book of business consisting of over six million lives age 0–64. Some insights are based on individual studies conducted by Evernorth with varying time frames and populations.

You'll understand:

+ The behavioral health landscape, including the obstacles that must be overcome for treatment to begin and continue effectively.
+ The different care journeys for patients with behavioral health needs, including key insights for each journey.
+ The importance of a robust behavioral health ecosystem to support the complex needs of patients along their care journeys.

Definitions of common terms

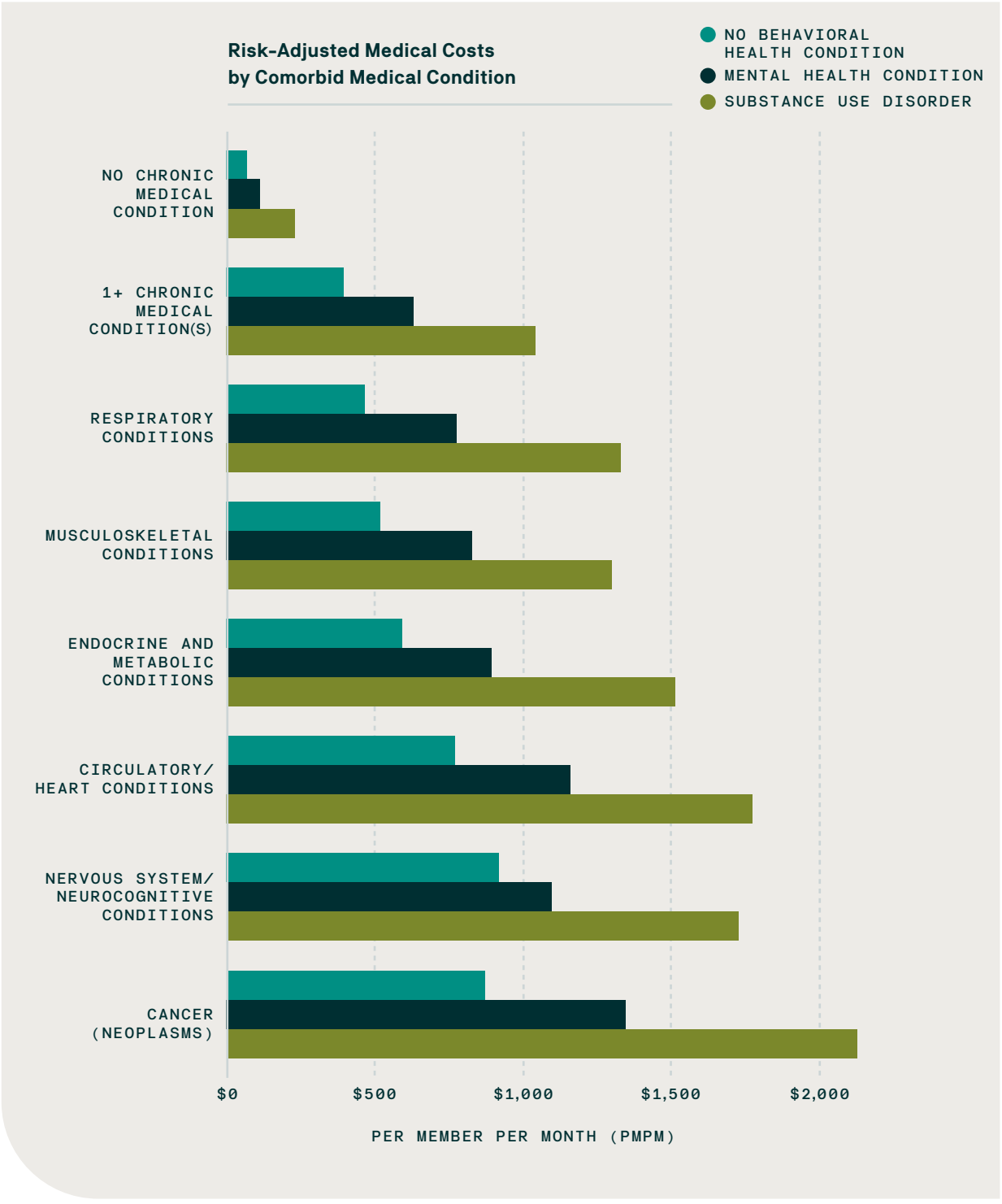
Behavioral health — Category including the promotion of mental health, resilience and well-being; the treatment of mental health and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities[1]

Behavioral conditions — Mental health and substance use disorders

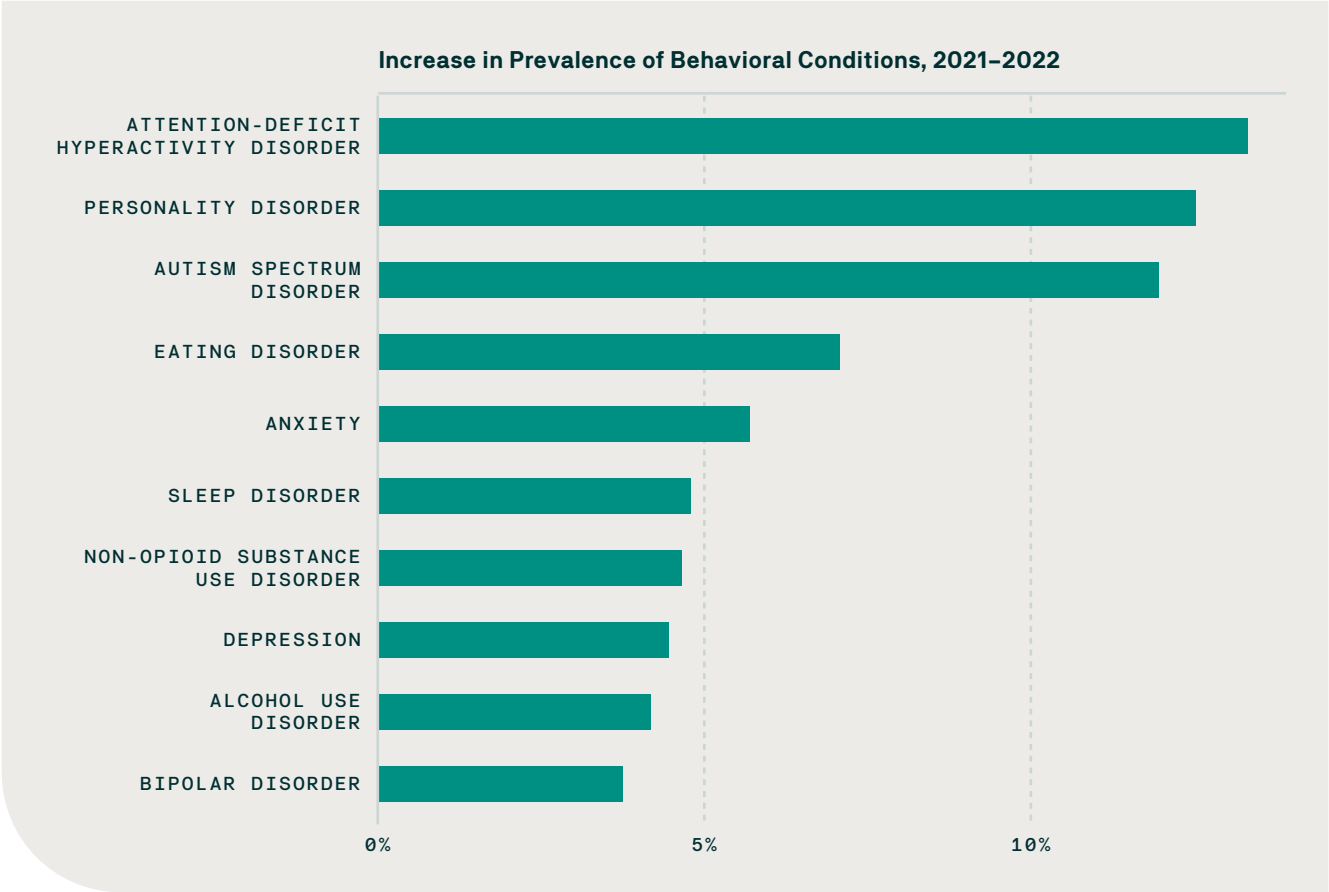
No behavioral care — Patient has no behavioral claims with a behavioral health provider and no behavioral medication claims

Comorbidities, prevalence and lack of treatment

Among patients with a behavioral condition, 87% also have one or more medical conditions, such as a circulatory condition, a musculoskeletal condition or cancer (neoplasm). When behavioral conditions go untreated, these comorbid medical conditions worsen, and the ability to function in workplaces, families and communities can be hindered. Moreover, costs for patients with a medical condition and behavioral condition are two to three times higher than for patients without a behavioral condition.



Behavioral health condition prevalence grew by 4% from 2021 to 2022. Increases vary by condition, with the largest occurring within attention-deficit hyperactivity disorder (ADHD), personality disorder and autism spectrum disorder.



50%+ of adults with a behavioral health diagnosis are not in active treatment[2]

Patients can languish without being diagnosed and receiving treatment. And our data shows that 10% of patients who do not have a behavioral health diagnosis go on to have a diagnosis in the next year, though external survey data suggests this number may be higher.[3]

How can plans better support patients on their behavioral health journeys?

We present **three key insights** for taking action and improving outcomes

INSIGHT

01 Improving care begins with recognizing the long and chaotic road to finding effective treatment

Obstacles to beginning care

11 years
is the average time from symptom onset to treatment[5]

The sooner a behavioral health condition is treated, the better the patient outcome and the lower the cost.[4] Yet, on average, it takes 11 years after the onset of mental health symptoms for someone to seek treatment,[5] leaving critical conditions undiagnosed and delaying effective treatment. Among those who eventually make contact with a treatment provider, delays range from 6 to 8 years for mood disorders and 9 to 23 years for anxiety disorders.[6]

These long delays can be attributed partly to factors such as underdiagnosis, stigma that remains despite progress, the cost of care and access challenges, as well as health equity disparities due to low income, race, ethnicity and other social determinants of health (SDOH).

Average Time from Symptom Onset to Treatment

Finding the right match

Identifying the right provider who meets personal preferences, has availability and addresses unique clinical needs can be difficult. Equally challenging is knowing the right level of intervention (e.g., app, peer support, coach, therapist, more intensive program) and the right type of provider (e.g., psychologist, psychiatrist, marriage and family counselor, social worker or even primary care physician).

Finding a provider who has demonstrated effectiveness in treating one's specific behavioral health condition is not easy. Well-established measures of quality are not uniformly adopted for behavioral care. Behavioral care can be measured through evidence-based screeners, such as the PHQ-9 or GAD-7, but reporting on these results is not industry standard and information is not necessarily communicated to patients.

The weight of waiting

150M+ people live in areas with a behavioral health professional shortage[7]

More than 150 million people[7] live in areas designated as having a behavioral health professional shortage. This can further complicate the journey to find the right provider and begin treatment. In just a few years, experts say the U.S. will be short between 14,280 and 31,109 psychiatrists,[8] psychologists and social workers, with other providers overextended as well.[7] The shortage of child psychiatrists is even more dire. The 10,000 in practice cannot possibly treat the more than 15 million youth in need of their expertise.[9]

According to the American Psychological Association's (APA's) 2021 survey, psychologists reported a significant increase in demand for their services since the start of the pandemic, with 60% indicating they had no openings or incoming patients.[10]

of psychologists said they had no openings for incoming patients[10]

With a severe shortage of providers comes extended delays to see the few who are available. Long waits for behavioral health treatment are a nationwide problem, with reports of patients waiting an average of five or six weeks for care in community clinics, Department of Veterans Affairs facilities and private offices from Maryland to California.[11]

INSIGHT

02

The care journey is highly personal. Understanding this allows for more personalized and precise navigation of care.

Personas are a valuable tool to help visualize the distinct care journeys of patients based on their behavioral health utilization data.

Behavioral Health Care Journey Personas

Willing Engagers

Patients receiving treatment for a behavioral health condition with a behavioral health provider

Self-Directed Seekers

Patients seeking treatment for a behavioral health condition with a medical provider

Complex Copers

Patients receiving treatment primarily for a physical health condition and their behavioral health condition surfaces multiple times

Silent Sufferers

Patients receiving treatment primarily for a physical health condition and their behavioral health condition surfaces just one time in a medical setting; patients who have not been diagnosed yet are also included

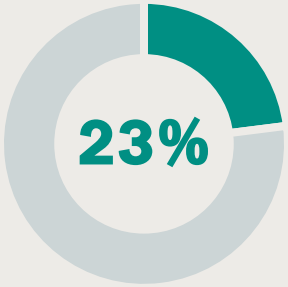
PERSONA

Willing Engagers

Less than half of patients with a diagnosed behavioral condition seek the most direct and appropriate treatment with a behavioral health provider. Compared with other personas, the biggest difference is the increased prevalence of high-acuity conditions (e.g., suicidal ideation, self-harm, bipolar disorder, schizophrenia and severe major depressive disorder). Many of these conditions require a higher-touch approach for adequate support. For the under-18-year-olds, there is a higher prevalence of reactive stress disorder, anxiety, depression, autism and suicidal ideation/suicide attempts.

Patients who have their second outpatient visit within 10 days are **2x more likely** to have three or more outpatient visits[12]

The main opportunity for Willing Engagers is increased persistence of care, with 23% of patients having only one or two behavioral outpatient visits. When patients have their second outpatient visit within 10 days, they are two times more likely to have three or more outpatient visits,[12] with several studies showing an association between the frequency of therapy sessions and symptom improvement.[13] Early identification of Willing Engagers who are not persisting in care, or need support for their complex behavioral health conditions, is key to improving clinical and quality outcomes.



of patients have only one or two behavioral outpatient visits

PERSONA

Self-Directed Seekers

With anxiety, depression and ADHD as the most-prevalent diagnoses, this population is treated mainly through medication prescribed by their medical providers, with 74% filling one or more behavioral prescriptions. Opportunities arise to supplement the critical role that non-behavioral, physical health providers play in treating behavioral health. This can include engaging providers around quality care metrics, such as drug adherence, the improvement of referral pathways and transfers to behavioral clinicians, and educating patients and providers about additional digital therapeutic options.

More than half of this segment has just one encounter for a behavioral health condition in a year

For the 26% of Self-Directed Seekers who are not filling a behavioral prescription or receiving behavioral services through their benefit, there may be a gap in treatment. There may be several factors underlying the treatment gap: Patients are less familiar with a behavioral health setting or are being seen in an acute care setting, such as the emergency department. In addition, more than half of this segment has just one encounter regarding their behavioral condition over the course of the year, so patients may not be fully aware of their diagnosis and next steps. These gaps could be addressed through provider and patient engagement about treatment options other than medication.

PERSONA

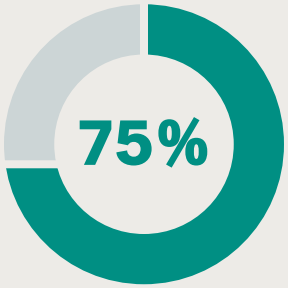
Complex Copers

The primary concern for these patients is their chronic medical condition, with 75% of the population—the highest percentage across all personas—having three or more chronic comorbid medical conditions. These patients tend to be older and live in areas with higher health equity disparities, indicating increased barriers to care. It is unclear how aware patients may be of their behavioral health condition because, while a clinician finds it significant enough to record multiple times, these behavioral diagnoses occur during times of medical need and may not be directly addressed with the patient.

$1,649 medical savings per patient per year (PPPY) when patients with diabetes and comorbid MDD receive sufficient behavioral care[14]

As discussed, patients with a chronic medical condition and comorbid behavioral condition account for 2–3 times higher costs than those without a behavioral condition. Our studies show that effective behavioral health treatment can reduce this spend. For example, patients with type II diabetes and major depressive disorder (MDD) who receive sufficient behavioral treatment show $1,649 PPPY medical savings compared with the patients who receive insufficient behavioral care.[14]

Within this persona, 33% may not be receiving behavioral care, as seen through their claims, and for those who are receiving behavioral medications, there is an opportunity for improving medication adherence and connection to behavioral outpatient care. This could be addressed through early identification of those with a comorbid chronic medical condition who are not likely to get appropriate behavioral care and through stronger coordination with medical providers and community support services.



of Complex Copers have three or more chronic comorbid medical conditions

PERSONA

Silent Sufferers

The Silent Sufferers are patients who are either undiagnosed or have been diagnosed only once by a medical provider but it was not the reason for their medical visit. In our claims-based analysis, more than 50% of this segment with a known behavioral diagnosis may not be receiving behavioral care, the lowest rate of behavioral care out of all personas.

More than 50% of this segment receives no behavioral care

This persona is also second highest for medical risk, supporting the need for consistent standardized screening during medical visits for timely diagnosis and treatment. Early identification of these patients and connection to behavioral care is important. For example, if a patient has an emergency room visit for chest pain that was related to anxiety or a panic attack, it is critical to connect that patient to behavioral health care to improve management of the anxiety and reduce future emergency room visits.

INSIGHT

03 Building a robust ecosystem is critical for guiding care and achieving measurable outcomes.

The distinct care journeys demonstrated by the patient personas emphasize the opportunity to connect care in a seamless manner. This can be achieved through four key steps:

STEP 1

Early identification and engagement

The most critical part of enabling someone to seek care is identifying the need in the first place. There are several ways:

+ Patients can self-identify their need and decide to seek care
+ Providers may refer their patients to care
+ Patients may find and engage with resources online
+ Plans can leverage artificial intelligence and machine learning (ML) to identify patients and predict needs in advance, based on health history, demographics, SDOH and more

The earlier someone is identified, the better the opportunity to provide support that drives improved measurable outcomes, such as connecting patients to the appropriate care pathway sooner, preventing avoidable escalations and reducing long-term costs of care.

Once identified, engaging patients requires a personalized approach. Understanding patient preferences, clinical needs and data can help inform the best ways to reach them, including email, text and/or phone.

STEP 2

Assessment and recommendation

Precision in care pathways—leveraging meaningful data, personalized screening tools and ML techniques—can also help ensure patients are identified for care that will best meet their needs and improve cost and quality outcomes. Continual learnings on patient preferences, right care matching and outcomes can be leveraged to generate refined care pathways on an ongoing basis.

STEP 3

Right care matching

Finding the right provider and right level of care is key to improving clinical and quality outcomes. Patient-to-provider matching can assist in identifying effective providers who meet patient preferences, such as demographics (e.g., age, gender, ethnicity) or personal experiences (e.g., parent, veteran). When patients stay with their provider, their second visit occurs 35 days earlier on average,[12] and one study showed that measurement-based provider matching can significantly improve patients' mental health outcomes.[15] To ensure quality care, real-time quality feedback powered by interoperability—the ability for different information systems, devices and applications (systems) to access, exchange, integrate and cooperatively use data—is critical.

STEP 4

Outcomes measurement

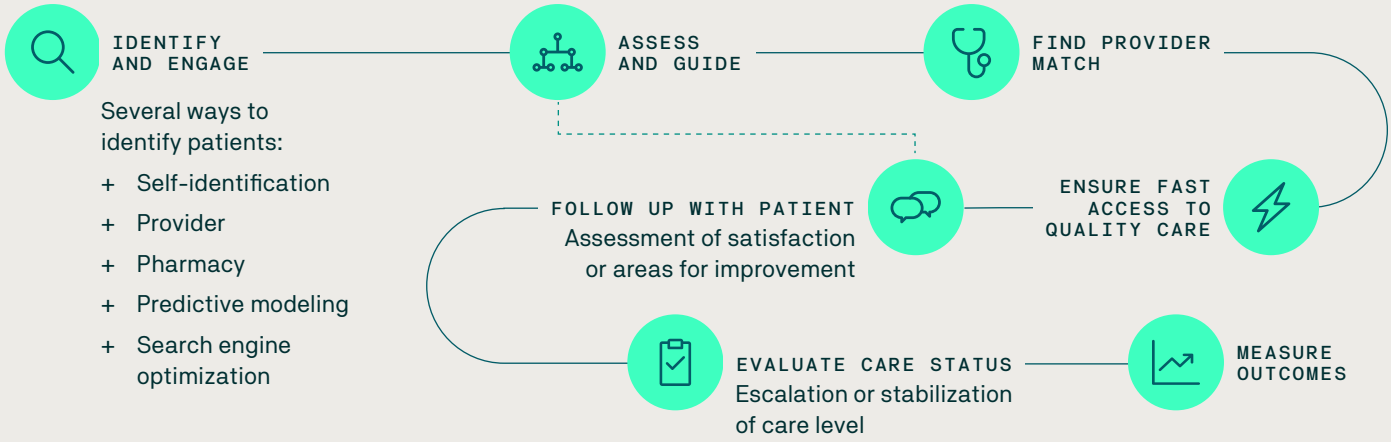
Up to $2,565 medical and pharmacy savings per patient over a 15-month period associated with behavioral health outpatient treatment[16]

To achieve a measurement-based care system, it is key to establish transparent outcomes based on multidimensional qualitative and quantitative metrics that offer insight into clinical decisions and longitudinal trends. In a recent published study, Evernorth identified that patients receiving behavioral health outpatient treatment show savings up to $2,565 per patient over a 15-month post-diagnosis period; savings continued 27 months post-diagnosis up to $3,321.[16]

Curating a guided behavioral journey that invites more patients with behavioral health needs into care and simplifies the journey is critical. The journey requires measurement for all stakeholders to practically inform care as well as demonstrate return on investment. Vital metrics to consider include:

+ Time to care
+ Therapeutic alliance
+ Behavioral outpatient treatment navigation
+ Medication adherence
+ Evidence-based screening
+ Patient-reported quality of life
+ Ecosystem navigation
+ Total cost of care

Seamless Coordination of Care



Moving Forward

The key insights presented in this report are just the initial steps that can help employers, health plans, providers, consultants and other health care stakeholders enrich their behavioral health offerings.

Contact us today for more details and other steps you can take to prioritize behavioral health.

Methodology

Data in this report is drawn from across Evernorth's commercial and health exchange book of business, which comprises a combination of small and large employers and health exchange patients. Claims were based on year-over-year analyses of 12-month periods from January 1, 2021, through December 31, 2022, for patients with continuous medical, behavioral and pharmacy eligibility.

Behavioral diagnoses were defined as any International Classification of Diseases 10th Revision (ICD-10) code starting with F (Fxx.xx) or suicidal ideation, suicide attempt and self-inflicted harm codes,[17] excluding F17 (nicotine dependence) and including Z7141, Z7142, Z7151 and Z7152 (drug counseling). Chronic medical conditions were defined using the Clinical Classifications Software (CCS) developed by the Agency for Healthcare Research and Quality (AHRQ).

Observations in the report are limited to analysis of administrative claims data and cannot account for services sought outside of claims.

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