Identifying Health Center Behavioral Health "Bright Spots"

Introduction

Integrated behavioral health or primary care behavioral health, is "*care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse [sic] conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.*"[1]

Health centers provide health care services to the nation's most vulnerable populations, including behavioral health care.[2] Behavioral health care providers at health centers served more than 2.5 million patients for mental health and almost 300,000 substance use disorder patients in 2020; this does not include the large number of patients receiving behavioral health services from primary care providers (for example, depression screening, medication-assisted treatment).[3] Provision of behavioral health services at health centers has increased by more than 1 million patients over the past five years, an increase of almost 50% (substance use disorder patients have more than doubled during this time period).[4]

Given health centers experience providing integrative behavioral health (IBH) and the evidence that IBH models increase access to care and improve outcomes,[5-6] it is important to identify successful models within health centers that can be replicated to improve care. This study describes an approach for identifying high-performing (bright spot) Health Resources and Services Administration (HRSA) Health Center Program awardees and look-alikes for in-depth study of IBH models. We also compare the geographic, organizational, and patient characteristics of bright spots with low-performing (which we refer to as cold spots) health centers.

The Problem

While health centers have increased their behavioral health care capacity and experienced increasing numbers of behavioral health patients, large numbers of people still have unmet behavioral health needs.[7] Despite barriers to accessing behavioral health services at health centers, including funding[8-9] and staffing shortages,[9-10] health centers offer a way to close gaps in accessing behavioral health care for those most in need. The problem is that health centers have varying levels of IBH capacity[11] and IBH models within health centers vary widely,[12-13] with some research suggesting that local factors have the largest influence.[14] Thus, to understand successful IBH models we need to target health centers with in-depth qualitative research to identify IBH models for health centers that account for local context. However, a targeted approach is needed to compare models for high and low performing health centers given the time and cost to study the more than 1,500 health centers.

Our Innovation

Using Uniform System Data (UDS) from HRSA, we stratified health centers based on their percentage of mental health patients (> 50th percentile) and their depression remission adjusted quartile rankings (AQRs;

rank 1 and 4). AQRs are adjusted by patient and organizational characteristics, with health centers ranked by quartiles based on their observed vs. expected rate.[15] Focusing on health centers in the top 50th percentile for percentage of mental health patients, bright spots and cold spots were identified as those in the depression remission top and bottom AQRs, respectively. We performed t-tests to explore differences between characteristics of bright spots and cold spots.

Figure 1 displays bright spot (n=132) and cold spot health centers (n=93) across the U.S. Bright spots are located in 42 states, with almost half coming from eight states (California [11], Texas [11], Illinois [7], Louisiana [7], New York [7], Ohio [6], Pennsylvania [6], and Tennessee [6]). Bright spot health centers are noticeably absent in southern states east of Louisiana, as Alabama, Georgia, and Mississippi have no bright spot health centers. Similar to bright spots, cold spot health centers are spread across 38 states with five states having at least five cold spot health centers, including California (9), New York (7), Illinois (6), Massachusetts (5), and New Mexico (5). Cold spot health centers are more likely to be located in urban areas compared to bright spot health centers (76.3% vs. 62.9%).

Figure 1: Health Center Bright Spots & Cold Spots

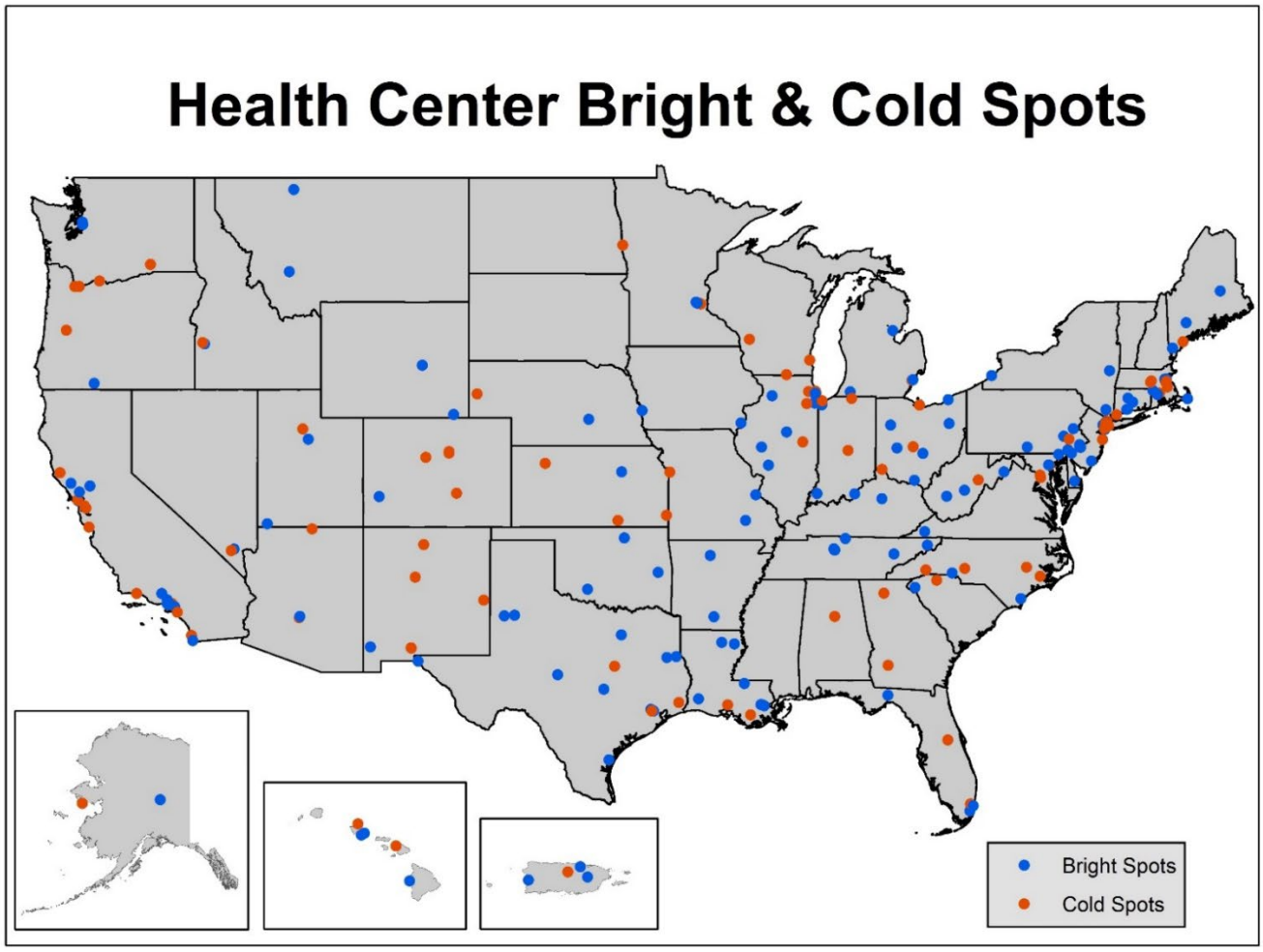

Table 1 compares the characteristics of bright spot and cold spot health centers. Overall, there are few significant differences among patient and organizational characteristics, though cold spot health centers have significantly higher percentages of patients that are uninsured, minority, Hispanic, and best served in a language other than English. Bright spot health centers have significantly better clinical quality scores for several measures, including depression screening, and significantly lower costs per patient when compared to cold spot health centers.

Table 1: Characteristics of Bright Spot and Cold Spot Health Centers

	Bright Spots	Cold Spots	All
# of Health Centers	132	93	1,169
Patient Characteristics			
# of Patients	20,215	20,609	22,493
% Black	21.5	27.1	22.0
% Minority***	52.6	68.3	55.2
% Hispanic**	27.3	37.9	29.0
% Uninsured*	23.1	27.8	22.7
% Medicaid	35.0	37.5	36.0
% Poverty	65.6	69.9	64.4
% Homeless	7.2	10.9	6.6
% Best Served in Language Other Than English***	17.7	27.2	20.1
Clinical Quality			
% Depression Screening*	71.6	65.7	65.3
% Patients Age 3-16 with BMI Percentile/Counseling*	63.1	56.9	59.0
% Patients Age 18+ with BMI and Follow-Up**	71.3	63.0	66.1
% Patients Blood Pressure Under Control**	59.6	55.6	58.1
Cost & Utilization			
Costs per Patient*	1,266	1,521	1,284
% Mental Health Patients	16.3	15.6	10.7
% Substance Use Disorder Patients	2.2	2.9	1.8
% Enabling Services Patients	9.2	10.7	8.1

*p<=.05; **p<=.01; ***p<=.001

This research describes an approach for identifying high-performing (bright spot) health centers as it relates to mental health. Despite serving similar populations to low-performing, cold spot health centers, bright spots have better overall clinical quality outcomes and lower costs per patient. Research has shown that successful IBH models improve outcomes but can vary significantly across health centers and depend largely on local, place-based factors.[12] Thus, it is important to target qualitative research at high-performing health centers to understand successful IBH models.

Next Steps

Next steps are to identify a sample of peer bright spot and cold spot health centers that could be targeted for in-depth qualitative research to better understand successful IBH models that could be applied to lower-performing health centers.

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