November 2023

PBGH Behavioral Health Survey Issue Brief

PBGH Patient Assessment Survey

Introduction

Purchasers have expressed longstanding concerns about the availability and quality of mental health care, and these concerns have increased since the onset of the COVID-19 pandemic.

According to data supplied by the American Psychiatric Association, employees with unresolved depression experience a 35% reduction in productivity, contributing to a loss to the U.S. economy of $210.5 billion a year in absenteeism, reduced productivity, and medical costs.[1] Even after taking other health risks – like smoking and obesity – into account, employees at high risk of depression had the highest health care costs during the three years after an initial health risk assessment.[2,3] In both government and commercially insured populations, around 60% of healthcare spend is attributable to the roughly 23% of the population diagnosed with behavioral health conditions.[4]

The COVID-19 pandemic brought attention to the prevalence of depression and other behavioral health conditions as well as the disparities and inequities in health outcomes that exist for racial and ethnic groups. Most racial and ethnic groups overall have similar or lower incidence of mental health issues compared to whites, but they often bear a disproportionately high burden of disability resulting from mental health issues.[5] As the initial identification and diagnosis of mental health needs often occurs in primary care, there are opportunities for more consistent screening, equitable care and subsequent diagnosis of mental health needs. By measuring individual's experience in the primary care setting through the Patient Assessment Survey, the Purchaser Business Group on Health (PBGH) sought to better understand the current state of screening for mental health and access to mental health services in California.

Background

Purchasers have expressed longstanding concerns about the availability and quality of mental health care, and these concerns have increased since the onset of the COVID-19 pandemic. Questions have been raised about access to care, physician attention to behavioral health issues, timeliness of care, and, ultimately, whether patients believe their needs are being addressed.[6,7] All of these concerns may be expressed to a greater or lesser degree by specific patient groups defined by language, race/ethnicity, insurance coverage, or educational background.[8]

This issue brief provides an overview of both the performance of specific behavioral health screening and referral services in primary care and recent changes in patients' perceived quality of care. California physician groups have been collecting patient experience reports from a statewide standardized survey, called the Patient Assessment Survey (PAS), for many years. Recent surveys included supplemental questions about patients' experience with behavioral health care during physician visits that occurred in the Fall of 2020 and Fall of 2021. PBGH conducted surveys of 17,659 California primary care patients who received care in Q3 2020 and an additional 14,785 patients receiving care in Q3 2021 to understand their access to and receipt of mental health services.

The PAS survey asks about several milestones in the typical care process.

1. Did the provider ask about any mental health symptoms the person experienced? This report refers to this as "screening."
2. For those who were screened and felt they needed mental health care, did the provider recommend any mental health service, such as a referral to counseling or medication?
3. For those who did have a recommended service, did they get the care they needed and did they get it in a timely way?

Summary of Key Findings and Trends

Key Findings

California primary care practices have an important opportunity to improve depression and other mental health screening based on a statewide survey to understand patients' access to and receipt of mental health services. Moreover, access and service delivery were rated lower by Asians or Asian Americans (henceforth termed "Asians"), Blacks and Native Americans and by non-English speaking patients. PBGH administered surveys to 17,659 California primary care patients who received care from August to October 2020 and an additional 15,513 patients receiving care from August to October 2021 to understand their experience.

- Fewer than 44% of patients reported being screened for depression during a primary care visit. Among Medicaid enrollees, 49% reported being screened.
- Screening rates in primary care showed a small but significant increase from 2020 to 2021, moving from 43.9% to 45.1% statewide (p=0.038).
- Of those who felt they needed mental health care in 2020, and for whom their doctor recommended it, 77% were able to receive care and 73% said their care was available in a timely way. Both of these rates declined significantly by 2021 – to 73% able to receive care and 68% getting care in a timely way (p=0.000).
- For patients who felt they needed care but it was not recommended by their doctor, it was even harder to access care. Just slightly over one-third of patients who felt they needed care stated that they received care in a timely way, e.g., 37% in 2020 and 35% in 2021.
- The rate of getting needed care for those reporting Fair or Poor mental health fell from 54% to 51% between 2020 and 2021.
- The survey results indicate far lower mental health screening, referral, and service delivery results for Asians or Asian-Americans, particularly those not speaking English, with non-English speaking Asians 19% less likely to be screened and 10% less likely to get needed care.
- Blacks and Native Americans also reported significantly lower ability to access care, e.g., 6.9% less likely in 2020 and 9.3% less likely in 2021.
- Across all racial and ethnic groups, the primary language spoken at home strongly influences the results with non-English speakers less likely to be screened for depression or obtain needed care. English speakers were 9% more likely to be screened for depression and 10% more likely to get mental health care in a timely way than non-English speakers.

Implications

The answers to these questions are important for several audiences.

- Health care providers should use the data to identify gaps in screening and referral practices across the care continuum and consider more intentional follow-up to ensure that all patients are getting recommended care.
- Purchasers and payers should examine these data to see if current payment and network policies are achieving desired results.
- Policymakers need to understand whether people with mental health concerns are being identified, have access to appropriate providers, and are ultimately getting the care they need. In addition, they need to understand if these needs are more acute for specific, traditionally undeserved groups.

Results

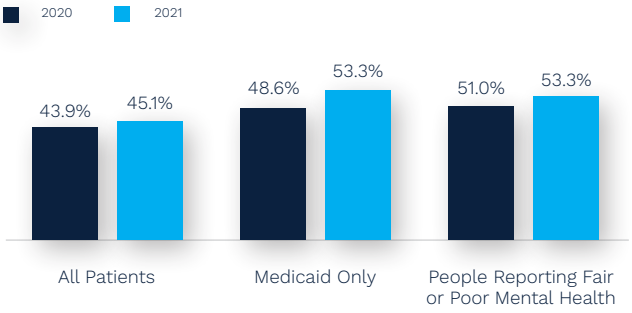
There are many reports of increased mental health burden associated with the COVID-19 pandemic.[9] The rate of self-reported depression and anxiety symptoms in the PAS survey increased slightly (but significantly) between 2020 and 2021 – from 16.5% to 17.5% of respondents. The change in self-reported mental health burden may have been small during this period because the second survey window occurred after the general adoption of vaccines and the lessening of COVID-19 restrictions in late 2021.[10]

1. Depression Screening

In California medical groups, screening for mental health concerns remains low: under 45% in primary care and about 20% in specialty care. Primary care providers were somewhat more likely to screen those who were experiencing lower mental health, screening about 52% of those self-rating their mental health as Fair or Poor compared to 43% of those self-rating as Excellent, Very Good or Good. Medicaid providers do slightly better – screening about 53% of their patients. The higher screening rates by Medicaid providers may be attributed to federal, annual reporting requirements for community health centers to screen for depression.,[11,12] Note that higher screening rates have been reported from many primary care networks that have worked to increase these rates through focused quality improvement initiatives. UCSF primary care practices, for example, improved their screening rate up to 89% by 2019[13] and Cleveland Clinic reported a 69% rate in 2016.[14]

Screening rates in California primary care showed a small but statistically significant increase from 2020 to 2021, moving from 43.9% to 45.1% statewide (p=0.038). Medicaid primary care providers showed an even greater improvement, going from 48.6% to 53.3% (p=0.011). (See Table 1.) Specialty practices did not show any gains in screening rates. Screening rates were about 10% lower in urgent care settings compared with routine primary care appointments.

Table 1: Trends in Screening for Mental Health (2020-2021)



2. Physician Referral Services

These data do not indicate the results of depression screening. Instead, we evaluated whether patients who believed they needed behavioral health care reported being screened and subsequently referred for care.[15] The rate of physician referral to mental health services for those who were screened (regardless of the outcome of the screening) declined slightly between 2020 and 2021, from 38.1% to 37.6%

3. Ability to Get Needed Care

Of those who felt they needed mental health care in 2020, and for whom their doctor recommended it, 77% were able to receive care and 73% said their care was available in a timely way. Both of these rates declined significantly by 2021 – to 73% able to receive care and 68% getting care in a timely way (p=0.000). (See Table 2.)

Patients who said they needed care and also self-rated their mental health status as “Fair” or “Poor” had less success getting mental health care than those with higher self-rated mental health who also said they needed it. Only 51% of those rating their mental health as “Fair” or “Poor” successfully got mental health care compared to 70% of those reporting “Good” to “Excellent” self-rated mental health. (See Table 2.)

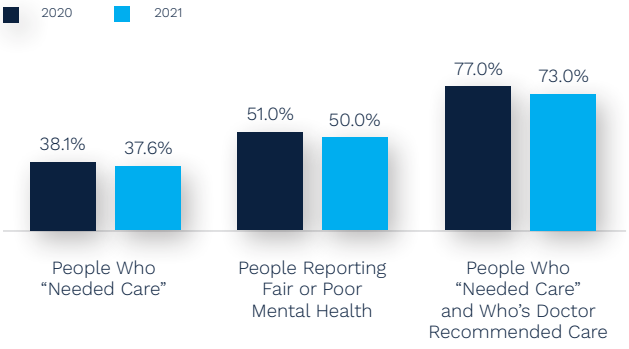
Overall, these findings suggest less than optimal behavioral health care – screening rates below 50% and more than one-fourth of people with self-identified symptoms at a primary care visit not able to get care in a timely way. But California PCPs performed better at screening and recommending care for those patients who reported more serious mental health burden than for those with lesser need. Despite the better screening activity, providers failed to help many of these sicker patients actually receive needed mental health care. In the 2020 sample, for example, of the 12.5% who self-reported “Fair” or “Poor” mental health, 51% said they were screened (versus 43% of those reporting better mental health), 40% said their doctor recommended care (versus 16% of those in better health), but only 53% said they received needed care (versus 58% of those in better health).

By late 2021, those with fair or poor self-reported mental health experienced somewhat better rates of screening (per Table 1) and care recommendations, but their rate of actually getting care fell significantly. The rate screened went from 51% to 53%, the rate of getting a physician recommendation went from 40% to 42%, but the rate of getting needed care fell from 53% to 50%. (See Table 2.)

The data suggests that primary care doctors became more aware of addressing mental health needs by late 2021, but the barriers to actually getting mental health care for those in need did not diminish. It’s also worth contrasting these rates with the higher rates of getting care reported above. Note that for those who felt a need for care, had higher self-rated mental health and whose doctor recommended it, access was fairly good. But for those who reported poor or fair mental health, access was not good even with their PCP’s recommendation. In other words, the low 40% rate of recommended care for those in worse mental health translates to poor access to needed care.

Related to this are the respondents who felt that they needed mental health care but care was not recommended by the doctor; for these respondents, it was harder to access care and the rate at which they were able to access care declined between 2020 and 2021. In 2020, 56% of those who said they needed care were “always” able to get it but just 37% saying they got it in a timely way. By 2021, only 51% were always able to get it and only 35% got it in a timely way. This decline in access between the two survey windows also occurred in terms of addressing unmet physical health needs; 65% of those reporting physical health symptoms were able to “always” get care in 2020 and this fell to 62% a year later.

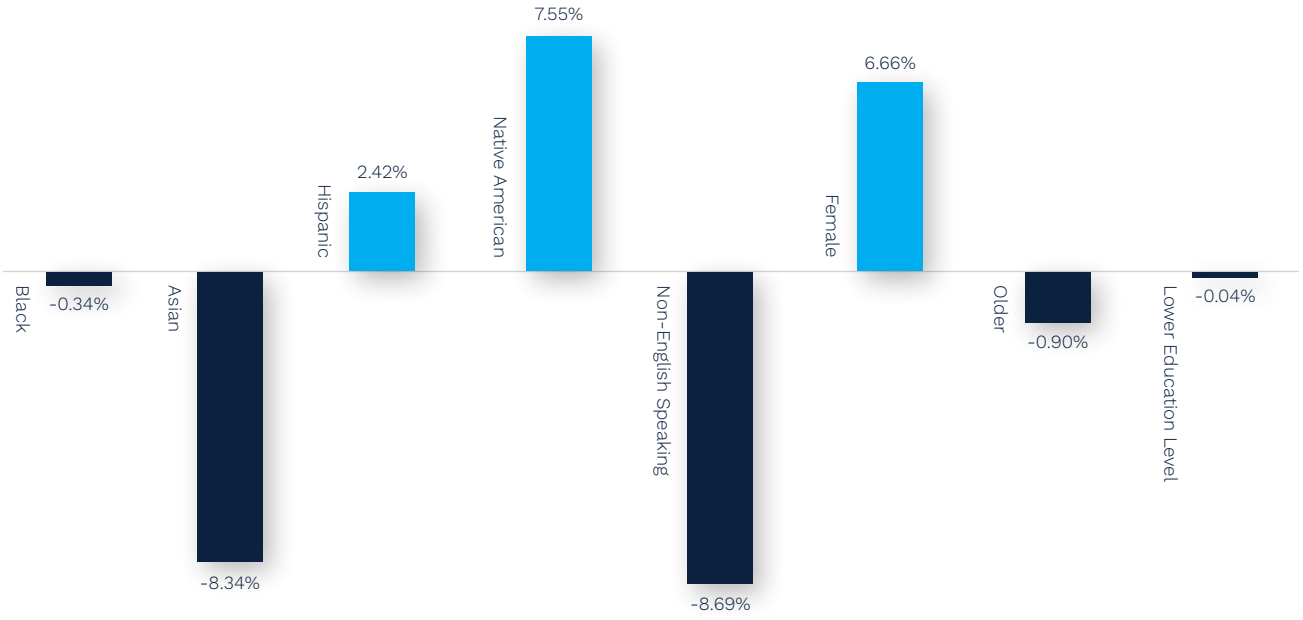
Table 2: Trend in Receiving Mental Health Services in a Timely Way (2020 - 2021)

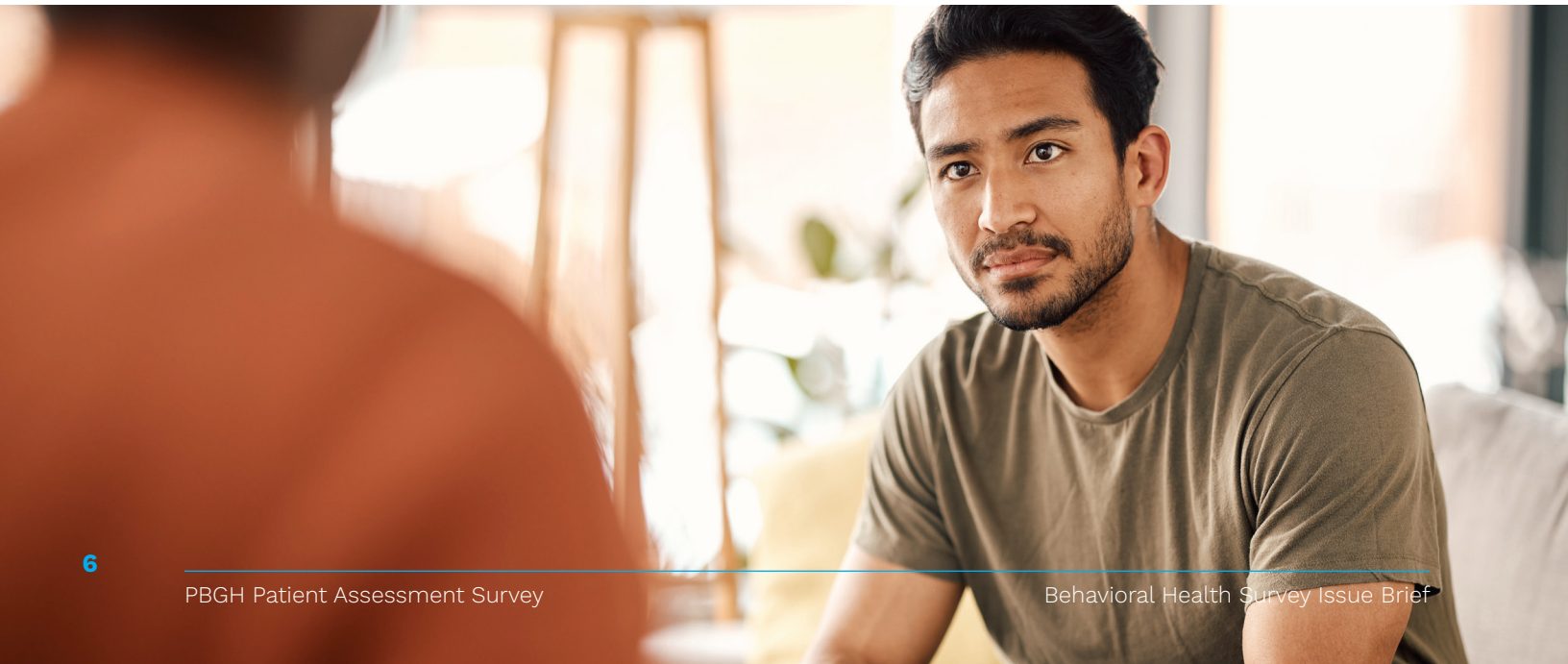


4. Disparities in Screening, Referral, and Getting Needed Care

The survey data across both survey years reveal some care patterns that reflect disparities in access to needed care. Patients who said they felt they needed mental health care were more likely to be younger, female, college-educated and white. The average self-reported mental health score was correspondingly lower for those groups. For the most part, physician screening rates reflected this pattern, though providers were more likely to screen patients who were Hispanic or Black despite those groups reporting lower rates of self-identified need. (See Table 3.)

Table 3: Disparities in Screening for Mental Health Concerns

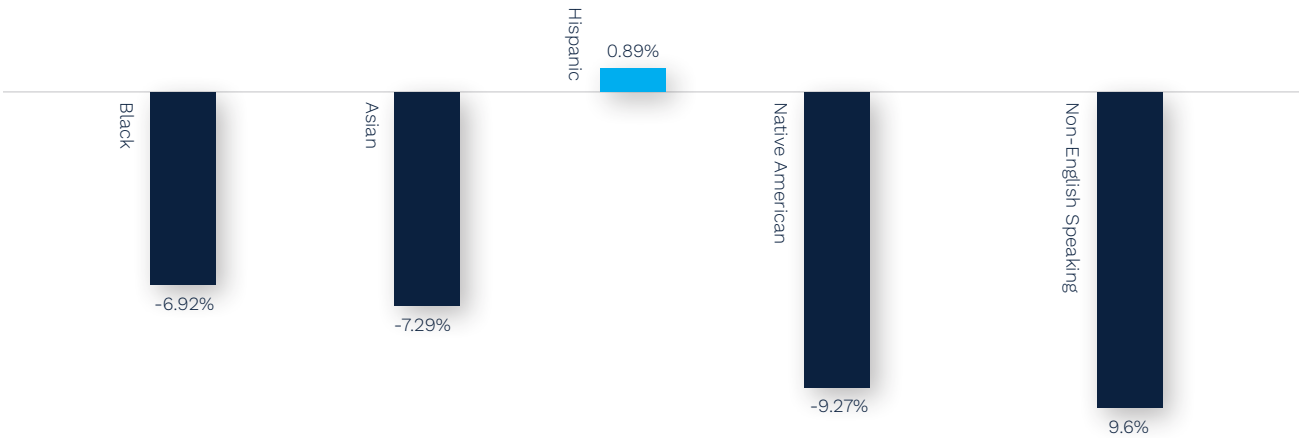




Of those who felt they needed care, respondents identifying themselves as Black, Native American or Asian were least likely to ultimately get mental health care. (See Table 4.)

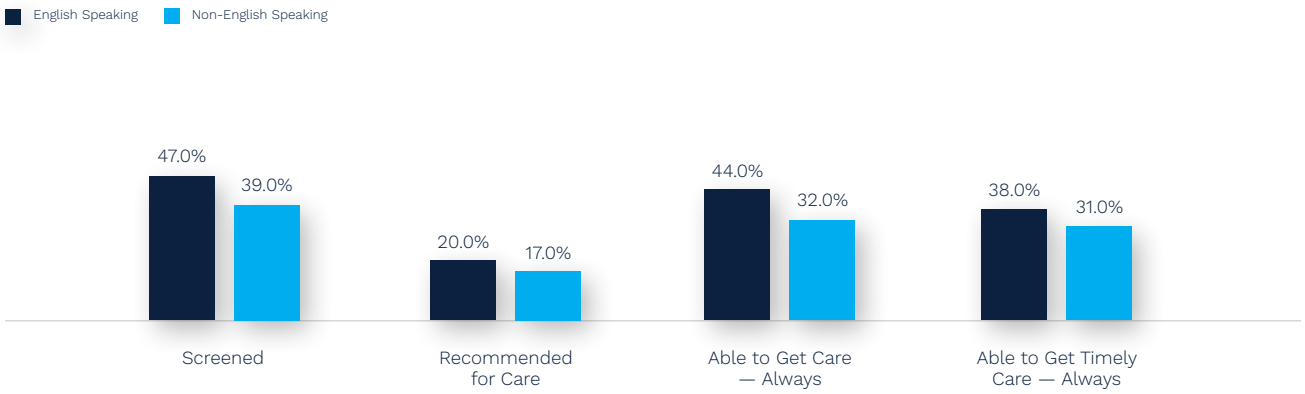
The survey results indicate far lower mental health screening, referral and service delivery results for Asians, particularly those not speaking English. Asians reported better mental health than the general population, but English-speaking Asian Americans were 8% less likely to be screened, and non-English speaking Asians were 19% less likely to be screened. Similarly, of those who felt they needed care, Asians were about 10% less likely to get it. English-speaking Hispanics were able to get care at rates similar to the general population, but non-English speaking Hispanics were 3% less likely to get it and 9% less likely to get it in a timely way.

Table 4: Access to Mental Health Services in a Timely Way by Race/Ethnicity Compared to White English-Speakers



The disparities in mental health care revealed by the survey are more strongly associated with the primary language spoken at home than with racial or ethnic group or educational attainment. English-speakers are consistently more likely to be screened, have care recommended and be able to get care. (See Table 5.)

Table 5: Disparities in Mental Health Service Provision by Primary Language Spoken



Summary

The rate at which California physicians screen and provide follow-up recommendations for mental health needs remains low but showed signs of modest improvement between 2020 and 2021. Unfortunately, the small improvements in screening and referral are not matched by more frequent reports of successful receipt of mental health care.

Asians and non-English speakers of all backgrounds are significantly less likely to be screened, referred and ultimately receive needed mental health care. Blacks and Native Americans also reported significantly lower rates in their ability to access care. This survey does not shed light on the causes of poor access to care, beyond the low rate of physician screening and referral. But the fact that those in better mental health and English speakers are more likely to get needed care may suggest that broader community factors continue to limit access. Certainly, people with poorer mental health as well as those with limited English skills may have more difficulty navigating the health care system and therefore accessing needed health care services.

Endnotes

1 https://www.mcleanhospital.org/essential/what-employers-need-know-about-mental-health-workplace

2 Goetzel RZ, Anderson DR, Whitmer RW, et al; Health Enhancement Research Organization (HERO) Research Committee. The relationship between modifiable health risks and health care expenditures: an analysis of the multi-employer HERO health risk and cost database. J Occup Environ Med. 1998;40(10):843–854.

3 Goetzel RZ, Pei X, Tabrizi MJ, et al. Ten modifiable health risk factors are linked to more than one-fifth of employer-employee health care spending. Health Aff. 2012;31(11):2474–2484.

4 Coe EH and Enomoto K, "Returning to Resilience: The Impact of COVID-19 on Mental Health and Substance Use" April 2, 2020, McKinsey.com.

5 https://www.psychiatry.org/File%20Library/Psychiatrists/Cultural-Competency/Mental-Health-Disparities/Mental-Health-Facts-for-Diverse-Populations.pdf

6 Pfefferbaum B, North CS. Mental Health and the Covid-19 Pandemic. N Engl J Med. 2020 Aug 6;383(6):510-512. doi: 10.1056/NEJMp2008017. Epub 2020 Apr 13. PMID: 32283003.

7 Nielsen M, Levkovich N. COVID-19 and mental health in America: Crisis and opportunity? Fam Syst Health. 2020 Dec;38(4):482-485. doi: 10.1037/fsh0000577. PMID: 33591784.

8 Shim RS. Mental Health Inequities in the Context of COVID-19. JAMA Netw Open. 2020 Sep 1;3(9):e2020104. doi: 10.1001/jamanetworkopen.2020.20104. PMID: 32876681.

9 Jia H, Guerin RJ, Barile JP, Okun AH, McKnight-Eily L, Blumberg SJ, Njai R, Thompson WW. National and State Trends in Anxiety and Depression Severity Scores Among Adults During the COVID-19 Pandemic - United States, 2020-2021. MMWR Morb Mortal Wkly Rep. 2021 Oct 8;70(40):1427-1432. doi: 10.15585/mmwr.mm7040e3. PMID: 34618798.

10 Jia et al reported that nationally, "the average depression severity score increased 14.8% from August 19-31, 2020, to December 9-21, 2020 (APC = 1.7%) and then decreased 24.8% from December 9-21, 2020, to May 26-June 7, 2021 (APC = -2.8%)." Ibid.

11 https://www.cms.gov/files/document/sgm-clearinghouse-uds.pdf

12 https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/clinical-measures-handout.pdf

13 Garcia ME, Hinton L, Neuhaus J, Feldman M, Livaudais-Toman J, Karliner LS. Equitability of Depression Screening After Implementation of General Adult Screening in Primary Care. JAMA Netw Open. 2022;5(8):e2227658. doi:10.1001/jamanetworkopen.2022.27658

14 Pfoh ER, Janmey I, Anand A, Martinez KA, Katzan I, Rothberg MB. The Impact of Systematic Depression Screening in Primary Care on Depression Identification and Treatment in a Large Health Care System: A Cohort Study. J Gen Intern Med. 2020 Nov;35(11):3141-3147. doi: 10.1007/s11606-020-05856-5. Epub 2020 Jun 3. PMID: 32495093; PMCID: PMC7661597.

15 We validated that the self-report "need for care" measure correlates with other measures. For example, 56% of those reporting Fair or Poor mental health expressed a "need for care" vs 5% of those reporting Excellent or Very Good mental health.

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About the Purchaser Business Group on Health (PBGH)

Purchaser Business Group on Health (PBGH) is a nonprofit coalition representing nearly 40 private employers and public entities across the U.S. that collectively spend $350 billion annually purchasing health care services for more than 21 million Americans and their families. PBGH has a 30-year track record of incubating new, disruptive operational programs in partnership with large employers and other health care purchasers. Our initiatives are designed to test innovative methods and scale successful approaches that lower health care costs and increase quality across the U.S.

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