



Advancing Behavioral Health Equity in Primary Care

Highlights from a Learning Collaborative for Safety Net Health Centers

Learning collaborative goals and activities

From October 2021 through May 2023, 14 safety net community health centers (CHCs) in California participated in a 20-month learning collaborative called Advancing Behavioral Health Equity in Primary Care (ABHE-PC). Developed by the Center for Care Innovations (CCI) and funded by the California Health Care Foundation, the key goal of the collaborative was to improve equity in mental health and substance abuse care (termed behavioral health [BH] or BH care) and social needs care (e.g., screening and referrals to transportation, housing, or nutrition supports). Achieving BH equity requires reducing disparities in access, improving patient experiences and trust to engage in care that is often stigmatized, and aligning CHC processes and systems to better serve priority populations who have unmet needs.

Participating CHCs developed teams comprised of leadership and staff from across their primary care, BH, and quality improvement departments. Teams participated in topical webinars and one-on-one coaching on topics, such as gathering and using information on patient experiences, supporting patient dignity, building a trauma-informed organization, and understanding the importance of the social drivers of BH. They also received training on creating a data-informed culture, developing dashboards and “run charts” for BH measures of care, and structuring cross-departmental huddles and supported care teams for better care coordination.

Key takeaways and resources

- CHC teams made (and maintained post-intervention) substantial, measurable improvement across a variety of factors, or “drivers,” known to support equitable behavioral health care.
- Sustained leadership engagement and continuity across the period of organizational change was associated with greater improvements in capacity, patient outcomes, and equity.
- Over a 6-month period, BH patients received more BH services 1-year post-intervention than they had received prior to the ABHE-PC learning collaborative.
- Depression screening rates increased, and adult diabetes control and hypertension outcomes improved overall and for priority populations. Depression remission also increased.

A toolkit of resources created during the program is posted on the [CCI Resource Center](#). A full evaluation report is available on the [American Institutes for Research \(AIR\) website](#).

How did CHCs implement changes to improve equity?

Developing a common understanding of need. At the start of the ABHE-PC learning collaborative program, all teams identified potential gaps in equitable care delivery by completing the CCI's **Capabilities Assessment Tool (CAT)**. They also conducted patient listening sessions and reviewed historical data on BH utilization and access. Where possible, teams reviewed information on patient populations known to have greater need or disparity in their communities. This included data review and interviews with Black, Latinx, Asian, Hawaiian Native and Pacific Islander, and Native American and Alaska Native people; LGBTQ populations; transitional age youth; people living with intellectual disabilities; and recent immigrants.

CAT results helped teams assess on a numeric scale where they stood in terms of primary and secondary drivers—systemic factors, such as organizational commitment and primary/BH care team integration—that can help or hinder progress toward health equity (see drivers listed in Exhibit 1). Team members (representing CHC leadership, clinic staff, primary care and BH providers, division managers, and data analysts) completed the CAT independently. Coaches reviewed drivers where staff selected different ratings and facilitated discussions to arrive at a consensus on a final rating incorporating the diversity of care team perspectives and experiences.

Tailoring specific aims and opportunities for deeper learning. Coaches and learning collaborative leadership used the baseline CAT scores to refine collaborative trainings and learning supports. Learning supports were geared toward helping CHCs develop and implement “change activities” to make progress on one or more primary drivers assessed in the CAT. In addition to the learning supports, coaches helped each CHC team track their progress using CAT results collected midway through the intervention. Coaches also helped teams complete and review quarterly implementation and outcomes data presented in data dashboards. Coaches helped teams design and implement **Plan-Do-Study-Act (PDSA) cycles**. PDSA workflows allow teams to test a new idea on a small scale, gather data on staff and patient experience with the change, and then refine the idea based on the feedback received. Finally, site visits to CHCs leading in the field of behavioral health and social care integration showed teams the BH best practices in action for brainstorming on additional improvements.

Evaluation approach and methods

AIR used a mixed-methods evaluation to assess the implementation and outcomes of the learning collaborative. Data supporting the evaluation spanned from January 2021 to June 2024 and included:

- Observations of ABHE-PC learning sessions and webinars
- An organizational capabilities assessment tool (CAT) self-assessment, developed and overseen by CCI
- A behavioral health service and screening inventory checklist
- Listening sessions with patients and participating CHC administrators, providers, and staff
- An online patient survey on quality of care, access, and experience (available in seven languages)
- A universal measure set (UMS) that captured staffing roles and licensing, care utilization, access, and mental health and physical health quality metrics, stratified by race, ethnicity, language, sexual orientation, and gender identity

Impact of the learning collaborative on CHC teams

ABHE-PC teams rated their capabilities on six primary and secondary drivers of equitable BH care (see Exhibit 1). Ratings occurred at baseline, midline, end line, and at 1-year post-implementation.

Exhibit 1. ABHE-PC Capabilities Assessment Tool Primary and Secondary Drivers

Primary Drivers	Secondary Drivers
Senior Leadership and Organizational Commitment	- Leading, planning, and creating an organizational culture that advances health equity - Listening to the voice of all patients - Hiring an equitable, inclusive, and diverse workforce
Data-Driven Systems	- Developing a culturally intelligent workforce - Adopting trauma-informed care best practices
Access to Care	- Leveraging integrated care registries to support BHE Population Health Management - Using data analysis and quality measures analysis and reporting to help achieve BHE
Integrated Care Team and Care Delivery	- Using appointment scheduling practices aligned with patient needs and preferences - Using multimodal visits (in person, alternative, or virtual) to reduce care barriers
Patient Activation and Self-Management	- Integrating mental health, substance use, and primary care services - Screening, assessment, and management of BH conditions (mental health and substance use disorders) done in culturally and linguistically competent manner - Embedding team-based care into integrated BH practices - Establishing clinical workflows for common BH comorbid conditions - Training staff for integrated care team roles and responsibilities
Community Partnerships	- Implementing care plans that activate patients' voices, providing empowering self-management supports, and leveraging digital tools (web, patient portal engagement tools) - Offering patient and caregiver education that is driven by patient preferences and advances health literacy
	- Putting agreements in place with community partners and encouraging them to actively engage in planning BHE initiatives - Sharing data with community partners to facilitate closed-looped referrals that advance BHE

 Based on CAT scores, all CHCs showed **significant improvement across all primary drivers** over the course of the intervention, and **improvement continued** (though at a slower rate) **1 year after the collaborative ended**. These achievements are notable given core learning collaborative activities started during the COVID-19 pandemic surge in January 2022, and while many participating CHCs faced substantial staff turnover.

 **Capabilities improved more in care teams that included a breadth of licensed BH staff and in teams with sustained leadership involvement.** AIR used a qualitative comparative analysis to explore whether team organizational context and level of engagement in learning supports were related to improvement in CAT scores. Improvement in driver scores was greater when specific team supports and structures were in place:

- Having a range of licensed BH staff types and the same organizational leader present and participating (i.e., no turnover) throughout the duration of the learning collaborative were important to improving organizational capabilities.
- Leadership engagement—measured by frequency of attendance in learning sessions and regular involvement in coaching sessions (where discussion included planning for systemic changes to processes, training, or data collection)—also was related to capability improvement.



Teams noted that working with professional coaches skilled in implementing integrated, trauma-informed BH care helped CHCs improve their organizational capabilities in data management. Self-

reported improvement in data management skills reported in the CAT, and improvement in UMS and dashboard data completeness and demographic stratifications, validated these qualitative findings and confirmed the importance of coaching. Teams initiated the program at different levels of readiness and varied in the time needed to envision and implement their approaches. Many teams needed to improve their data collection processes and data-informed culture before being able to track improvement for a priority population.

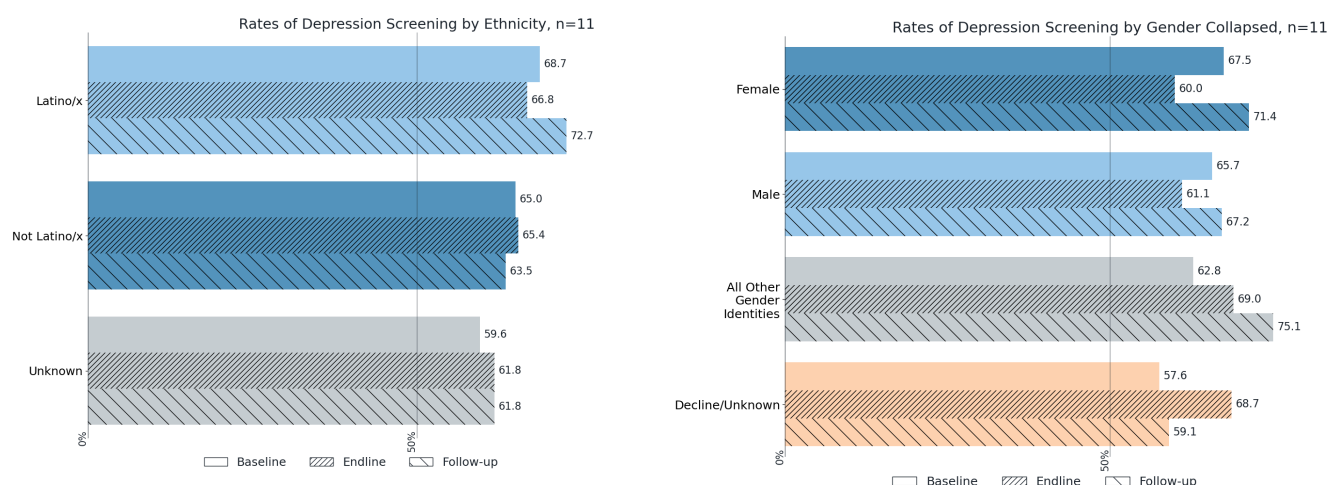
PDSA for cultural humility and data quality: One CHC decided to focus on sexual orientation and gender identity (SOGI) data collection. They prioritized this change activity after reviewing patient demographic data and finding a smaller than expected population of LGBTQ BH patients. The team discovered that this was a result of staff not entering SOGI data into the electronic health record (EHR). This team created trainings for staff to enhance their understanding of what SOGI data are, why these data are important, and where to capture these data in the EHR. As part of its continuous quality improvement processes, this team conducted surveys before and after the trainings to understand the knowledge gained by staff.

Improvements made for patients



Teams increased depression screening rates. Depression screening among patients diagnosed with depression increased from 62.8% to 69.5% during the learning collaborative. At follow-up, screening rates for Latinx patients had improved four percentage points and rates were higher than the overall average (Exhibit 2). Rates for all genders improved, but rates for Other Gender Identities (includes queer and trans) improved the most. The overall number of BH services received per BH patient increased over time, with the number of services to Black patients increasing the most.

Exhibit 2. Rates of Depression Screening by Ethnicity and Gender





Quality of mental health treatment plans and chronic illness management improved. Depression remission rates increased from 15.6% to 22.4%, high blood pressure control increased from 55.4% to 61.4%, and poor diabetes control decreased from 43.9% to 35.7%.



The CHC staffing mix improved, including the addition of more BH staff; this coincided with an increase in the number of adult patients with BH diagnoses and conditions. Increasing diagnoses could be due to more BH staff or due to changes and improvements in coordinating care team delivery, reducing stigma, improving cultural competence, and strengthening screening protocols and data capture.

A summary of BH measures related to outcomes and advancements in equity are shown in Exhibit 3:

Exhibit 3. Summary of Patient Outcomes from Baseline to One Year After Implementation (2021-2024) (n = 14)

Measure	Overall change	Indications of equity advancements
Clinical providers, enabling staff	▲ Improved 3 CHCs increased their licensed mental health staff ratio 9 CHCs increased the number of enabling staff (6 increased by 1.5 times) 6 CHCs increased substance use disorder provider ratio	▲ ▼ Mixed 2 CHCs increased percentage of providers on staff that are representative of the communities they serve 6 CHCs increased percentage of non-English-speaking providers on staff
Mental health and substance use disorder diagnoses	▲ Improved Mental Illness, depression, and anxiety identification increased 1 to 2 percentage points	▲ Improved identification - Rates higher than national averages for priority populations 1 year after implementation - Increase in Any Mental Illness driven by patients who preferred English; Spanish-speaking rates decreased; prevalence in Latinx and Black patients increased 5 and 11 percentage points, respectively - Depression increased >5 percentage points for Black, gay, and/or bisexual patients
Behavioral health care utilization	▲ Improved - Number of patients receiving BH services increased 7% - Number of services increased 41% - Services per patient receiving BH increased from 2.8 to 3.7	▲ Improved - Proportion of bisexual patients receiving BH services increased 41%, gay patients increased 57%, and Black patients increased 26% - Services for Black patients increased 113% - Ratio of services per BH patient increased for Spanish-speaking, Black, and Latinx patients (80%, 68%, and 28%, respectively); only Black patient rate exceeded the average

Measure	Overall change	Indications of equity advancements
Use of the PHQ-9 tool for depression (NQF 0712e)	▲ Improved – Cross-CHC average percentage of patients with depression diagnosis screened increased from 62% to 69%	▲ ▼ Mixed – Gender identity other than male or female: Increased 12 percentage points
Depression remission at 12 months (NQF 0710e)	▲ Improved – Cross-CHC average increased from 16% to 22%	◀ Stayed the same – Depression remission rates improved for most groups; however, Latinx populations showed less improvement
Controlling high blood pressure (NQF 0018)	▲ Improved – Cross-CHC average increased from 55% to 61%	◀ Stayed the same – Black patients' disparity remains in rate and level of improvement – Spanish-speaking patients stayed the same and in line with overall rate
Comprehensive diabetes care: Hemoglobin A1c poor control (>9.0%) (NQF 0059)	▲ Improved – Cross-CHC average decreased from 44% to 33%	▲ ▼ Mixed – Non-English-speaking patients drove decrease – Black patients showed improvement but of lower magnitude, and had higher rates compared to average at all time points
Initiation and engagement of alcohol and other drug dependence treatment (NQF 0004)	▲ ▼ Mixed – Initiation of treatment increased 27% to 33% – Engagement decreased from 27% to 14%	▼ Unable to assess
Closing the referral loop: Receipt of specialist report	▲ Improved – Increased from 52% to 64%	▼ Unable to assess
Engagement—behavioral health appointment encounter status	◀ Stayed the same – Cross-CHC average proportion cancelled or no-show: 35%	▼ Unable to assess
Days waiting for mental health or substance use appointment	◀ Stayed the same – Cross-CHC average days' waiting decreased from 26 to 24 days; 3 of 6 CHCs reporting met California standard of 10 days at one or more time points	▼ Unable to assess

Note. Measures that had only half of CHCs reporting at baseline resulted in a poor ability to generalize and, in some measures, low patient counts. Sexual orientation and gender identity (SOGI) data often contained a large proportion of population “unknown” in one or more periods for some measures and are not reported.



Patient experience ratings were high. Patients noted appreciation for **care coordination supports**, describing workflows (such as warm handoffs, in which primary care or front desk staff introduce patients to BH staff) and processes (such as clear, culturally sensitive depression screening) as supporting their own care-seeking behaviors. **Staffing changes** (e.g., adding BH navigators) to connect primary care and BH divisions also were experienced as supportive.

Patient experience with a warm handoff: *“Originally, I didn’t want to get behavioral health, but after I talked to her [the psychiatrist], she made me feel that it was really up to me, and I felt like she was the most helpful. Yes, they [primary care] actually had one of their staff walk me over. And if I was to have gone there myself, I probably would have chickened out. It gave me an introduction as to what my next steps should be.”*



Areas for improvement:

- Patients were generally pleased with the care they received. Those who felt that there could be care improvements said they would like more options for receiving their BH care (e.g., in person, more appointment availability, more providers).
- The number of BH services per BH patient increased, but the total number of patients receiving services and proportion of patients in need who received services decreased, indicating that additional staffing is needed to provide care within the larger diagnosed population.
- The secondary driver related to social needs screening, assessment, and management improved across the learning collaborative but at baseline and 1-year post-implementation, had the lowest average score. Few CHCs reported having consistent practices and partnerships developed as resources to address patients’ social needs, and these needs may be better addressed within a separate learning collaborative or with a longer implementation period.

PDSA for depression screening: *In an effort to obtain more accurate responses, one CHC began testing their initial depression screens via a written format rather than in a face-to-face interview. Patients received the Patient Health Questionnaire-4 (PHQ-4) form at reception, where they had privacy to complete it in the waiting room. If the PHQ-4 score prompted the PHQ-9 or the Generalized Anxiety Disorder-7 (GAD-7), the medical assistant then administered these surveys on paper or orally in the exam room. If patients scored high on either, the medical assistant informed them about a referral to behavioral health prior to the patient meeting with the primary care physician. This team also tested implementation with a small pilot group, using one physician’s patients before rolling out the written format to all providers. The Plan-Do-Study-Act cycles helped them test, monitor, and improve the process of administering the written format and helped define responsibilities. They collected feedback from front-office staff, medical assistants, and physicians along the way, adjusting as necessary, with improvements documented.*



Teams shared perspectives on sustainability, scalability, and enabling effects. All teams found their change to be scalable and sustainable; none indicated that they planned to stop doing their new activity but rather that they had identified steps to monitor and further refine their approach. Teams noted the ABHE-PC program helped their CHC implement a PDSA approach to pilot their change and modify their approach until they felt ready to scale. Teams had activities planned to sustain or scale, but in interviews, none noted that they had a formal sustainability plan for their change activities. Several teams noted that the ABHE-PC program enabled staff to apply what they learned from the program to other ongoing or related programs, which potentially multiplies the influence of the collaborative. For instance, one team mentioned how the ABHE-PC program had helped them improve their implementation of another program related to substance use.

After having been inspired by their work on the ABHE-PC learning collaborative, CHCs indicated wanting to continue to work on:

- Expanding their team to bridge gaps in care
- Using their EHR system to monitor and track patients who have been screened and to potentially create a registry
- Creating partnerships with additional community supports as resources for care managers
- Adding departments, including optometry and pharmacy
- Having BH providers educate primary care providers on types of support and evaluative services offered for LGBTQ patients



Conclusion

Participating teams in the ABHE-PC learning collaborative made notable improvements facilitated by staff leadership and engagement across primary care and BH departments. The flexibility of ABHE allowed cross-disciplinary teams from diverse care settings to define and implement change ideas that were most relevant for their context. Carving out space through collaborative meetings, huddles, and coaching sessions gave health care providers valued time to align and plan around improving BH care, and CHCs said that these spaces will continue to be needed for additional changes and scaling to occur. Future initiatives should be mindful of the impact of staff turnover and should build in frequent reminders on project aims and deliverable schedules to maintain team momentum and engagement, with pre-implementation supports to bolster data collection of BH measures and stratification.

