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Variation in Telemental Health Service Delivery at Health Centers by Staffing Composition and State

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Introduction

Federal and state regulatory and payment changes facilitated a rapid increase in telemental health at many outpatient health settings, such as federally qualified health centers (FQHCs), during the COVID-19 pandemic (Bridges et al., 2023; Demeke et al., 2021; Lombardi et al., 2023; North, 2021). Despite an increase in telemental health, it is unclear if delivery occurred similarly across the behavioral health clinician workforce within these FQHC community health centers. Some professions (e.g., psychiatrists) may have higher rates than others of telemental health delivery given established telehealth training and service provision opportunities (Fortney et al., 2015). Yet, previous work on telehealth suggests that there are no differences in the quantity of services delivered by provider type type (i.e., comparing advanced practice nurses, family nurse practitioners, or physician assistants to physicians (Adepoju et al., 2022). Any variation in telemental health delivery at community health centers may be attributable to organizational factors, including the size of the community health center, amount and type of grant funding received, patient and payor composition, and the geographical setting of the community health centers (Lombardi et al., 2022).

Research Questions

There is limited research on state variations in telemental health delivery at community health centers and whether there is variation in the workforce providing behavioral health services. This study sought to investigate these variations through three research questions: (1) Does telemental health delivery vary by mental health clinician type at health centers?; (2) Are there state variations in the types of mental health clinicians delivering telemental health in health centers?; (3) What factors, including mental health workforce staffing composition, predict health center delivery of telemental health care? We hypothesized that psychiatrists, a behavioral health workforce with a history of tele-psychiatry training and payment regulation (Deslich et al., 2013), provide a greater proportion of telemental healthcare than other types of behavioral health providers; we also expected state and other organizational characteristics to be associated with telemental health use.

Methods

Data were drawn from the 2021 Uniform Data System (UDS), a collection of aggregated organization-level administrative data required annually from all health centers that receive

Section 330 grants associated with the Public Service Act (BPHC-HRSA, 2022). UDS data include characteristics of the community health center and patient pool, as well as full-time equivalent (FTE) estimates for psychiatrists, psychologists, social workers, other licensed mental health clinicians, and other unlicensed personnel and support personnel. The primary dependent variable was the proportion of 2021 mental health encounters within a community health center organization that were delivered virtually. The proportion of telemental health delivery at the organization level and by clinician type was used to generate state maps to display between-state variation. As the dependent variable was a proportion (ranging from 0 to 1), beta regression was used to effectively handle the outcome metric (Douma & Weedon, 2019). Analyses were conducted in R using the betareg package.

Key Findings

This study used data limited to FQHC community health centers that receive Community Health Center grants for an analytic sample of 1,270 FQHC organizations. Organizations ranged in size and patient populations served, and on average had 7.9 health center sites. More than 21% of the patient sample was uninsured and organizations served a large share of patients who are Medicaid beneficiaries (43%). Community health centers served an average number of 23,040 patients in 2021, of which 11,368 were mental health service visits (12.1% of total encounters). Organizations reported that, on average, 43% of their mental health visits were delivered via telehealth, though variation in telemental health use by health centers was observed.

Workforce staffing varied across organizations. On average, there were 0.69 FTE of psychiatrists, 0.66 FTE of psychologists, 3.78 FTE of mental health social workers, 3.74 FTE of other licensed mental health clinicians, and 2.36 FTE of other non-licensed mental health professionals at a community health center organization. Different clinician groups had varying rates of telemental health delivery (i.e., psychiatrists delivered 61% of services virtually, social workers delivered 44%, and psychologists delivered 49%). There were also state variations in telemental health delivery by clinician type. For example, in North Dakota, psychiatrists delivered 100% of services virtually, as compared to 1% of psychiatrists in Mississippi. Only psychiatrists were significantly associated with telemental health at a community health center.

There was significant state-level variation in the virtual delivery of mental health services, with states ranging from 10.8% to 73.9% of telemental health delivery. Other than state and staffing composition, only one patient population characteristic and one community health center characteristic significantly predicted telemental health delivery: Community health centers that served a larger proportion of Asian identified patients had a higher rate of telemental health delivery. Community health centers with larger grant dollars per the number of patients served was also a significant predictor of telemental health delivery. For every $1 million per 1,000 patients, community health centers' proportion of telemental health care was 14% greater.

Policy Implications

Given recent expansions in telemental health service availability, community health centers will continue to experience ongoing expenses related to increased use of technology (Ellimoottil, 2021). Increased funding for community health centers could improve access to telemental health care, particularly for lower-income populations without a source of usual care (Myong et al., 2020). Additional funding could enable community health centers to offer salaries commensurate with those of competing employers (NACHC, 2022), hire behavioral health clinicians, purchase telecommunications equipment, and extend the number and types of behavioral health clinical services available. Organizations that offer funding opportunities for broadband and telehealth-related programs might also consider introducing funding opportunities specifically designed for community health centers to expand telemental health care access and delivery.

Policies that increase flexibility in the provider types and modalities of care allowed, such as through relaxed state scope of practice laws and regulations, could alleviate current staffing gaps. The lack of clinician types that historically are challenging to attract and retain at community health centers could be alleviated by easing state scope of practice laws and regulations to enable additional allied health care providers to provide more service (NACHC, 2022). Educating the workforce-in-training on policies that impact scope of practice allowances and their ability to work to the top of their license across modalities and settings may help recruit more providers to practice in underserved areas. To streamline the collection of regulatory information, policymakers might consider adoption of a centralized, open-access, internet-based database to house practice legislation by state and convening an expert group to maintain this hub.

Lastly, variability in Medicaid expansion status across states may further exacerbate disparities in access to care. Given that Medicaid is the single largest payer for mental health services in the U.S. (Zur et al., 2017), positive impacts of Medicaid expansion and increased insurance coverage may lead to growth in behavioral health service utilization (Breslau et al., 2020). Additionally, states that enacted policies permitting licensing across state lines may boast greater telemental health care access (Harju & Neufeld, 2020). Policies permitting telemental service delivery across state lines could facilitate and support continuity of care for established clients (Antoniotti, 2022).

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