Applying Lessons From Behavioral Health Integration to Social Care Integration in Primary Care

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ABSTRACT

Interest and incentives are increasing around strategies whereby the health care sector can better identify and address patients' social and economic needs in the context of primary care delivery. This interest is likely to accelerate during the economic recession following the COVID-19 pandemic. Yet effective and sustainable strategies for integrating social care practices (eg, patient-facing social risk screening and activities to address identified needs) have not been clearly established. Lessons learned from more than 2 decades of research on behavioral health integration could be applied to efforts to integrate social care into primary care. In this article, we synthesize learnings from primary care and behavioral health care integration, and translate them into organizing principles with the goal of advancing social care integration practices to improve the health of both patients and communities.

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INTRODUCTION

Growing recognition that patients' social and economic needs influence health outcomes has led to new health care sector initiatives to identify and address those needs in the context of primary care delivery. This work is occurring both in the United States and globally as the importance of integrating health care and social care gains considerable attention.[1] The combination of the COVID-19 pandemic and its economic sequelae has accelerated interest in more systematically integrated care,[2-4] including expanding efforts to screen for social risks[5-7] and to leverage health care encounters to intervene on these risks.[8-10] In some settings, health care systems are using technology to increase capacity to provide social care,[11] while in others, systems are also developing and expanding staff capacity (eg, using community health worker models).[12-15] Emerging research suggests that patient navigation and referral programs can improve outcomes of health and health care use in selected settings.[8,9,16]

As efforts expand to better integrate social and medical care delivery, it is not surprising that implementation barriers have emerged. A recent National Academies of Sciences, Engineering, and Medicine report has highlighted the growing focus nationally on social care integration alongside looming implementation barriers, including lack of an adequately trained interdisciplinary workforce; poor infrastructure for interagency communication and data exchange; and financing models that fail to incentivize interdisciplinary care.[17] These challenges may sound familiar to those who have tracked the progress of behavioral health integration (BHI) in primary care over the last 2 decades. In fact, similar challenges have been faced, and in some cases, gradually dismantled, by BHI advocates across the United States, thereby providing opportunities to learn from this integration in terms of both successes and ongoing limitations. In this article, we identify 3 key lessons learned from BHI successes and challenges that are likely to help advance social care integration activities.

LESSONS LEARNED FROM BHI

BHI is a systematic collaborative approach to providing patient-centered care using a team of behavioral health and primary care clinicians.[18] Since the Surgeon General's pivotal report in 2001 on integration of mental health into primary care,[19] BHI practices have expanded to include a wide range of behavioral health programs provided in primary care practices; in some places, BHI now also involves providing primary care in behavioral health contexts. Overcoming challenges to BHI has required institutionalizing specific implementation building blocks. Three building blocks have played an outsized role in advancing BHI and are poised to inform social care: (1) consensus on behavioral health metrics and standards that can be used to support incentives for mental health screening and treatment; (2) team-based care facilitators (including colocated services and technology to support shared care for patients and team communication); and (3) context-appropriate adaptation. We discuss each of these building blocks in greater detail below and propose ways in which they could be translated to social care.

Establish Common Metrics, Related Medical Codes, and Incentives for Behavioral Health Needs Assessments and Treatment

BHI Context

The development of the 9-item Patient Health Questionnaire (PHQ-9) brief depression symptom measure in the late 1990s streamlined depression symptom measurement, enabling ready uptake of screening in fast-paced primary care settings.[20,21] The 2-item Patient Health Questionnaire (PHQ-2) further accelerated depression screening. The importance of a unified, codifiable measure in the field of depression, specifically, cannot be overstated. The PHQ-9 became widely used to compare clinic quality, initially only for screening but subsequently also for tracking and monitoring clinical care.[22] Reliance on these measures helped to garner pay-for-performance dollars that could facilitate other BHI infrastructure.

The implementation of billing codes and quality measures in BHI was gradual, but over time, these codes greatly enabled depression care and panel management activities. Early quality metrics for mental health screening were not as popular as physical health metrics (eg, metrics for diabetes) perhaps because mental health metrics were considered more intractable.[23] To incentivize mental health management activities including specialty referrals, however, during 2016-2018 the National Committee for Quality Assurance added Healthcare Effectiveness Data and Information Set quality metrics for having (1) PHQ-9 score documented during follow-up visits for patients with major depressive disorder or dysthymia; (2) documented remission or response within 4 to 8 months of an initially elevated PHQ-9 score; and (3) follow-up visits scheduled within 30 days if PHQ-9 screening was initially positive.[22]

Use of common metrics in BHI is not limited to depression. Other common measures have facilitated uptake and quality measure development for Screening, Brief Intervention, and Referral to Treatment programs, which focus on assessment for and treatment of substance use disorders.[24,25] As an example, the National Committee for Quality Assurance added a Healthcare Effectiveness Data and Information Set quality measure to track alcohol use and referrals; the committee also developed a learning collaborative to support health plans in adopting this measure.[26] The availability of Current Procedural Terminology billing codes also helped to facilitate reimbursement for Screening, Brief Intervention and Referral to Treatment screening and other behavioral health interventions in primary care.[27]

Translation to Social Care

There is little consensus on effective, valid social risk–screening tools in the United States. A stronger commitment to developing a common core of key social risk measures may speed the development of screening adoption and facilitate development of payment or reimbursement incentives as it did for depression and substance use screening. Medical codes that bridge measures across screening tools—for example, measures of food insecurity from different screening tools—could be used as an alternative while consensus on a common core of measures is developed.[28] Implementation research can help to establish how to use measures (eg, focusing on high-risk target populations, using electronic health record modules).

Common metrics can enable standardization of social care interventions and simultaneously provide data needed to gauge population-level initiatives related to social conditions. In depression treatment, standardization of measures was effective in part because the related incentives were not isolated to screening—they also incorporated strategies to promote panel management and follow-up mental health care, as well as provision of limited social care in cases where expertise aligns. Medical codes and payment models in the social care space will need to similarly ensure that common metrics not only increase screening practices, but also contribute to improved social health outcomes for individuals and populations. Possible sources of funding to support this social care work include Advanced Payment Models and Medicare Advantage plans.[29-31] Most recently, the American Medical Association and the Centers for Medicare and

Medicaid Services have set forth changes in the 2021 Evaluation and Management medical coding guidelines to ensure clinicians can account for their work with socially complex patients in fee-for-service billing.[32]

Reinforce Comprehensive Team-Based Primary Care and Strong Community Linkages

BHI Context

An early lesson in BHI was that even with incentives, clinicians often believed that screening in the absence of effective treatment teams was untenable.[33,34] As a result, efforts to reinforce comprehensive, team-based primary care and strong community linkages to mental health supports were critical facilitators for successful BHI. Primary care integration helped to decrease delays in mental health consultations and increased treatment adherence because patients were able to be seen in settings that were more accessible and potentially less stigmatizing. Colocation provided new opportunities to share practice culture across clinician groups.[18]

Improving BHI also required other team-based care reinforcements, including those related to technology. Technology was used to strengthen communication and cohesion among the team (eg, use of cell phones and instant messaging to communicate; data sharing and tracking of patient populations). Important examples of technology support in BHI included use of patient registries to support team-based patient reviews; ability of all team members to perform patient scheduling; and access to mental and physical health electronic health records for the entire team. Registries, particularly, continue to help teams organize and monitor consultation, education, and support services; follow changes in treatment; and track symptoms and outcomes,[35] especially in cases where primary care and behavioral health electronic health records are not seamless.

Translation to Social Care

As in behavioral health care, some socioeconomic barriers to health can be overcome through low-touch social care support from the primary care team, but many patients facing social and economic challenges will require more intensive and/or longer-term assistance from organizations equipped to provide social services, and just as importantly, collective advocacy to improve community social conditions. Challenges include determining which patients will benefit from differing levels and types of care, designing complementary programs that can support patients with specific needs, and developing robust partnerships and advocacy agendas to ensure needs are met both initially and over time. As in BHI, achieving these goals may require colocation of services, stepped models of care, workforce development (eg, training everyone on the team including front desk staff on addressing social needs), and increased reliance on technology to facilitate partnerships. The team should include someone with expertise in social care (eg, social workers).[17] As in BHI, this integration work will demand working through cultural differences across organizations[36] and possibly between the social care expert and the primary care team. Acknowledging these differences and working toward organizational integration of cultures can shift practice to advance whole-person care.

An added barrier to organizational alignment in social care integration is that there are few payment models that bridge clinical and nonclinical systems providing care. These models will need to be developed and scaled to facilitate effective integration. As with BHI, however, these efforts will be worthwhile because addressing social care needs in primary care and in partnership with community partners can improve access to services and destigmatize their uptake. In addition, by asking about social needs, clinicians may both build rapport with patients and help tailor their care to those needs (eg, offering nonrefrigerated medications to patients who are homeless).

Technology also will be needed to support cross-disciplinary, team-based care. This technology might involve direct communication modalities (eg, use of cell phones and instant messaging) and registries, but it also will need to expand to interagency data-sharing infrastructure. Innovative examples include San Diego County's 211 Community Information Exchange, which integrates key client data across medical and social institutions[37] and other community referral resource platforms, with the aim of increasing interorganizational communication and improving patient care and population health planning.[11]

Enable Evidence-Based Evolution and Context-Appropriate Adaptation

BHI Context

A third important aspect of BHI success involved using context-dependent adaptation to increase model adoption and improve care for specific populations. Although standardization of behavioral health measures was helpful to facilitate integration, implementing and scaling programs in clinic settings has also required that core models maintain flexibility to clinic context. One of the core models of primary care–based BHI that has been successfully adapted for use in different settings, for instance, is the collaborative care model (CoCM) based on the chronic care model.[38] The CoCM foundation includes a care manager, who offers both clinic visits and telephone

outreach; a psychiatric consultant; and a registry to track measurement-based care for all patients with diagnosable depression or anxiety.[35,39,40] This model has been successfully adapted to a range of health care delivery contexts.[41-43] The 5 principles of CoCM[44] are present in each of these adaptions, which differ in terms of staffing, setting, and condition of focus. A second core model for BHI is the behavioral health consultant model, which integrates these consultants into primary care clinics.[45] Some settings have successfully merged the CoCM and behavioral health consultant models to improve care for patients with varying levels of behavioral health needs.[46] Adaptations have involved preimplementation needs assessments that helped clinics overcome context-specific barriers and identify key unique facilitators of integrated activities.[47,48] The Exploration, Preparation, Implementation, Sustainment framework in implementation science has been applied in efforts to adapt the CoCM to different BHI contexts.[49,50]

Translation to Social Care

Social care interventions are frequently dependent on the community social resources landscape. Implementation will therefore depend on each local context, including unique population needs, community resources, partners, and other stakeholders.[51-54] Partnerships may include connections with local public health agencies and other organizations that can attend to both structural and policy drivers that are shaping patients' social conditions. Such partnerships can strengthen the availability of social care resources for both individual patients and communities. Involving these partners in the preimplementation needs assessment stage would thus improve both implementation and sustainability of social care interventions. Collectively, health care systems, public health agencies, and local community-based organizations can advocate for needed services in their area. Advocacy efforts such as this could in turn offer insights back to BHI. For instance, BHI advocacy is needed to address mental health resource shortages in rural and low-resource settings and to improve outreach and care for opioid use disorders or suicide risk.

BHI has also typically focused on individuals rather than connections to broader coalitions working on public health. Both BHI and social care integration can learn from larger campaigns such as antismoking efforts that resulted in actions by a broad coalition including health care. Universal screening and education allowed those in health care to support efforts with individuals *within* a broader strategy for policy and institutional changes that can have a much greater public health impact, as we have seen with antismoking efforts.

CONCLUSIONS

In 2008, the World Health Organization issued a report outlining a 7-point rationale for the integration of mental health and primary care services.[55] Many of the arguments they articulated translate easily into a rationale for better integrating social care into primary care. For example, the burden of social disadvantage is large; social and physical health problems are interwoven; an important and substantial treatment gap exists; primary care can increase access to treatment; and using primary care for social care can promote respect for basic human rights. There is also emerging evidence to suggest that social care integration activities can improve health[56-59] and decrease health care costs.[60-64]

As programs on social care integration develop, we can and should learn from the BHI movement. Applying BHI's hard-won lessons would mean developing core metrics and incentives, directing supports to the diverse team needed to facilitate interventions related to social and economic needs, and improving implementation and scaling efforts by enabling contextualization. Just as importantly, we should learn from the limited impact BHI has had on behavioral health outcomes at the population level, manifested most strikingly in the ongoing epidemics of suicides[65] and drug overdoses.[66] The effectiveness of primary care programs targeting both behavioral and social factors to improve health outcomes is ultimately more dependent on local, state, and federal policies that shape individual and community health than on health care–specific activities. Indeed, as BHI and social care integration efforts advance, their greatest impact may lie in deepening our collective commitment to ensuring that all people have the resources and relationships they need to attain and sustain good health.

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