7 COMMON BEHAVIORAL HEALTH INTEGRATION MISTAKES YOU CAN AVOID

by Caroline Fisher MD PhD

1 Confusing Co-localization with integration.

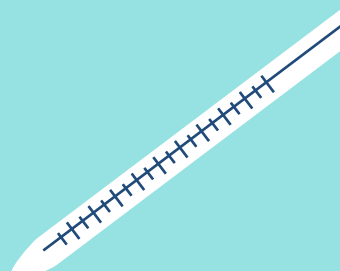
Just putting a mental health provider in a primary care office won't solve the problem. The provider will quickly fill up their caseload and it will be back to the same old struggles. To get the benefit of increased efficiency, better access and better treatment, you have to change the treatment model itself.

2 Using higher-than-necessary credentials.

To paraphrase Professor Strunk, never use a 25 cent provider when a nickel provider will do. The Collaborative Care initiative depends on everyone working at the top of their license, so don't assign your doctoral level psychologist to do what a Master's prepared therapist can do. If what your office needs is someone to make phone calls, use a CMA. Don't pay for what you don't need.

3 Believing Health Integration only applies to Social Workers, Psychologists or Psychiatrists

A good BHI will incorporate all types and levels of providers to meet your patients' needs, with each kind of provider working to provide the care most likely to help your patients achieve remission and delivering it in the way that the most patients can benefit.



4 Believing that training specific to integrated care is not necessary.

With a new model, everyone needs to know exactly what the job is and each individual on the team has to have the skills they need to support the rest of the team. Systems that have used a "regular" CMA, a life coach, or a receptionist to fill the mental health specialist role have been quickly disappointed, as have those who have tried to deploy a conventionally trained social worker or psychologist with just a bare-bones understanding of BHI. It's like putting a soccer player on a football team.

5 Not selling the PCP's on the model first.

If the primary care providers do not understand and agree with the system, they will prevent it being successful. We have had our best success by first explaining the model and the research behind the model, then putting a functional model in place with one practice so that the other physicians can see it working, while having the mental health team members on site and visible to the PCP's, actively seeking them out to discuss their patients.

6 Believing a specific primary care office is too unique for a standardized BHI approach.

While different offices may need some customization, primary care physicians have neither the time nor, in general, the knowledge base to create their own behavioral health integration. Systems that have allowed each office to "make their own" have been disappointed in their results and have been faced with the problem of multiple employees in the same job title doing different things. Further, the offices are left without the expertise to know whether those employees are doing a good job.

7 Not setting up an advantageous billing system.

Bundled billing and the new Collaborative Care CPT codes can bring in more revenue but require a clear system of time tracking. This is an opportunity to make your EMR work for you to track each the time spent by each participant in care.