

*Behavioral Consultation and Primary Care:
A Guide to Integrating Services, 2nd Edition*

Epilogue

As noted in the Introduction, the integration of behavioral health into primary care is happening, and happening quickly. Doors are opening for behavioral health professionals to participate in the health care system in a manner and scope never seen before. Integration represents a once-in-a-generation opportunity to broaden the scope and influence of the behavioral health professions, while simultaneously improving the population's health. Whether this opportunity is realized, or missed, hinges to a great extent on *how* we integrate.

Both of us have, in our consulting and training work, been called in to help a clinic replace a failed “integrated” service with one that utilizes the PCBH model. What we have observed is that, almost without exception, when a service fails it is because of one fatal flaw: a failure to understand and appreciate primary care. The reality is that primary care is an incredibly important, and powerful, part of a good health care system. Barbara Starfield famously taught us all that countries with the most robust primary care have the healthiest populations. And while it might not be as flashy as the operating room, and might not raise adrenaline like the emergency room, we owe much of our health to good primary care. Even with all of its problems, primary care is a place where miracles happen everyday.

Unfortunately, many integrators seem to believe that what primary care needs is a good dose of specialty care. Instead of the accessibility so central to primary care, they build an integrated service that requires burdensome paperwork for a PCP to refer a

patient, or one that allows schedules to fill up with meetings and follow-up visits; instead of working as a generalist, they focus only on helping with certain populations or problems; instead of seeing the high patient volume so crucial to primary care, they insist on long visits that reduce productivity to a trickle; or instead of working a team-based approach, they discourage interruptions, hunker down in their offices, and focus solely on patient care. The theme behind all of this is the same: it is a failure to understand and appreciate what primary care is all about.

To be sure, primary care needs help. Indeed, it is so desperate for help that it will often accept whatever it is given. Even an “integrated” behavioral health service that sees just a handful of patients a day is likely to be better than no behavioral health service. Like the saying, “You don’t know what you don’t know,” PCPs will often accept such a service, and even praise it, not realizing that integration can offer so much more. After all, most PCPs have learned to accept their lot. They have grown accustomed to promises of reform that fall short, and to “quality improvements” that seem only to add to their workload. Integration, they may assume, is just another idea that sounds good, but that produces little real change.

Such a state is where integration may end up if we don’t do it right. If not done right, integration becomes a “nicety” rather than a “necessity.” That is, it becomes a service that the primary care staff views as nice to have, but not one they view as a necessary part of care. Services that are a nicety are often the first ones cut during tough budget times, as they generally do little to affect the lives of either patients or staff. They certainly don’t fulfill the potential that integration represents. When done right, however, integration becomes a necessity. In such services, the primary care providers complain if

the behavioral health provider takes a vacation, and they prioritize behavioral health staff over other positions when budgets are being crafted. Services that are a necessity, in other words, are making a difference.

Integrated services that use the PCBH model commonly come to be viewed as a necessity rather than a nicety. Primary care providers commonly come to rely on BHCs to get through the day more efficiently and to provide better care to their patients. Patients commonly come to appreciate and expect the higher level of care they receive from their enhanced medical home team. When a BHC service is functioning as intended, it does nothing but grow. All of this results from the simple fact that the PCBH model was developed by and for primary care. Rather than attempting to impose a specialty-based approach in primary care, the PCBH model embraces the primary care approach and mirrors it. It was built to help PCPs rather than replace them, and to align with the goals of primary care, rather than change them. The PCBH model stems from a belief in primary care, plain and simple. For integration to succeed, we will need more integrators who share this belief.

That is why we thank you, the reader, for your interest in this book and in this model. We know that our readers are innovators with heart and passion, because we have been privileged enough to have met so many of you. We know you want to make a difference, and will not be satisfied with an integrated service that is merely a nicety. As you go about your work, remember to believe in primary care, and in the potential that integration has if it is done right. Ms. Johnson, our patient from the Introduction, realizes the value of this work. It has made a difference in her life. For Ms. Johnson and the millions more like her, let's do this right.

