LETTERS

Behavioral Health Integration Model

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BEHAVIORAL HEALTH INTEGRATION MODEL

Basu et al. developed sophisticated models of costs and revenue to evaluate the fiscal viability of two behavioral health integration models—the Collaborative Care Model (CoCM) and Primary Care Behavioral Health (PCBH).¹ They conclude that the CoCM model will take less staff time per patient and will generate more revenue.

The fiscal data flows from the models presented but an examination of the two models described raises serious concerns.

The authors define the first model (CoCM) as a nurse care manager providing telephonic care management only, with 1 hour per week of psychiatry time to supervise an active case-load of 120 patients with depression. No face-to-face time with a mental health provider is included in this model.

This definition does not match the CoCM model studied and described in the literature. Recommended staffing for psychiatric providers with an active panel of 120 patients is 4 hours per week, along with two or three care managers who provide face-to-face service and telephone contact.^{2,3} Of the more than 80 RCT studies of CoCM, none have used telephone contact only. Moreover, the time per patient calculations do not reflect the research cited by the authors. Basu et al. state that their telephone sessions are 35 minutes while the study they referenced indicates 51–60 minutes on average.

The second model, PCBH, includes a licensed mental health professional who bills for mental health services provided while embedded within the primary care clinic team. Basu et al. define behavioral treatment as eight 45-minute sessions.⁴ A recent review of evidence-based therapies delivered in primary care indicates effective treatment in 3–6 sessions.⁵ Thus, the course of therapy and total time for therapy in PCBH is shorter, not longer, than what would be done in the CoCM.

The two models as described do not accurately reflect existing models in terms of staffing, mode of services, and time per patient. All the cost data results from those assumptions and so are questionably valid. The independent variable, the two types of integrated care, do not align to CoCM or PCBH models described in the literature.² The basic models and independent variables to be compared are flawed, hence accurate financial conclusions cannot be reached.

In addition, as health care moves away from fee for service billing to payment for quality and outcome, the impact of improved clinical outcome has an impact on payment. Fiscal modeling therefore must include variables such as reductions in emergency visits and rehospitalizations. A model simply focused on reducing costs and increasing fee for service is not viable.

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Compliance with ethical standards:

Conflict of interest: The authors declare that they do not have a conflict of interest.

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