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Coordination of Care Between Behavioral Health and Primary Care Providers

Integrated care is the best practice model that addresses the whole health of an individual. While full integration is not always possible, behavioral health providers (BHPs) have the opportunity to improve coordination of care across disciplines by collaborating with clients and increasing outreach to primary care providers (PCPs), related service providers in a school setting, private setting, and other former or current behavioral/mental health consultants (if applicable). Through this collaboration, Autism180 can improve the safety and efficacy of services to support better outcomes for clients.

What concrete steps does Autism180 take to better partner with clients and overcome barriers to care coordination?

Speak with new clients about the advantages of coordination of care between BHPs and PCPs.

Ask the client to sign an authorization to exchange information with the member's PCP.

Autism180 will update the authorization document annually or as the member's needs or preferences change.

Help the client find a PCP if the client does not identify one.

Ask about the clients concerns.

Assess the client's understanding of his or her medical conditions and how they may interact with behavioral health issues.

Give a copy of a treatment summary to the client to share with the PCP or other providers.

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What can BHPs do to develop relationships with PCPs, and related service providers to improve care coordination?

Reach out to the PCP office, briefly explain the advantages of coordinating care, and ask how your offices might exchange information most easily to better serve the client.

For complex cases, Autism180 will consider a personal call to the PCP office to discuss the case. Include consultation regarding any current or historical adverse medication reactions.

How can BHPs build or enhance standard procedures for care coordination within their agencies?

Establish communication with the PCP as a routine part of service provision and documentation at service initiation, at discharge, and after significant changes in treatment occur. Integrate communication with the PCP into Individual Service Plans.