Integrated Care

Katherine Hobbs Knutson, MD, MPH

> *"The most fully integrated systems offer team-based care providing simultaneous or co-occurring BH and general medical treatment within the same visit."*

Integrated care is a popular topic, with substantial interest from general practitioners to behavioral health (BH) specialists to policy makers and public health officials, each seeking to improve access to, and quality of BH treatment for, youth. But the term "integrated care" has different meanings, depending on who, what, and in which location services are being integrated. Also, there are different levels of integration, each with its own potential benefits and challenges. As part of President Greg Fritz's initiative on integrated care, this overview may serve as a foundation for further discussion and development of novel service delivery systems.

In policy circles, integrated care is defined as any BH service or treatment provided in a general medical setting. In the medical community, "collaborative care" is another common term, usually referring to a case manager or care coordinator – with different levels of training from a Bachelor Degree to a Master's Degree in Social Work to a PhD in a psychology-related field – serving as a liaison between a general medical provider and a BH specialist, either within or outside of the general medical setting. However, some collaborative care models involve the case manager or care coordinator providing evidence-based brief BH treatment within the general medical setting for a defined patient population. Thus, the terms integrated care and collaborative care may overlap, highlighting the importance of defining "who" and "what" is being integrated, as the scope of service delivery may differ depending on the level of training and healthcare-related activities being performed.

There are also varying degrees of integration as described in Figure 1 (Collins et al. 2010). Non- or minimally integrated programs feature general practitioners and BH specialists operating at separate facilities with separate clinical systems and minimal communication. At the next level is basic integration – defined as providers operating in separate clinical systems but communicating periodically about common patients – practicing either at a separate or shared physical location. Increasing levels of integration occur when general medical providers and BH specialists share a physical location that also supports a common health record and treatment planning. The most fully integrated systems offer team-based care providing simultaneous or co-occurring BH and general medical treatment within the same visit. As one can see, each of these systems involves some degree of integration, but the resources required and patients' experiences and health outcomes are likely to differ depending on the level of collaboration, shared decision-making, and treatment planning.

Building on the 4-quadrant model (Mauer 2009) for BH and general medical service integration in Figure 2, the location, types of providers, and services or treatments offered vary depending on the complexity of patients' presenting problems. Patients with mild-to-moderate physical and/or BH problems may be well served in a primary care setting with integrated BH providers. For patients with severe or complex general medical conditions and comorbid mild-to-moderate BH disorders, a medical specialty setting with integrated BH providers may be appropriate. Finally, those with severe or complex BH problems and comorbid medical conditions may receive the most comprehensive care in specialty BH centers with integrated

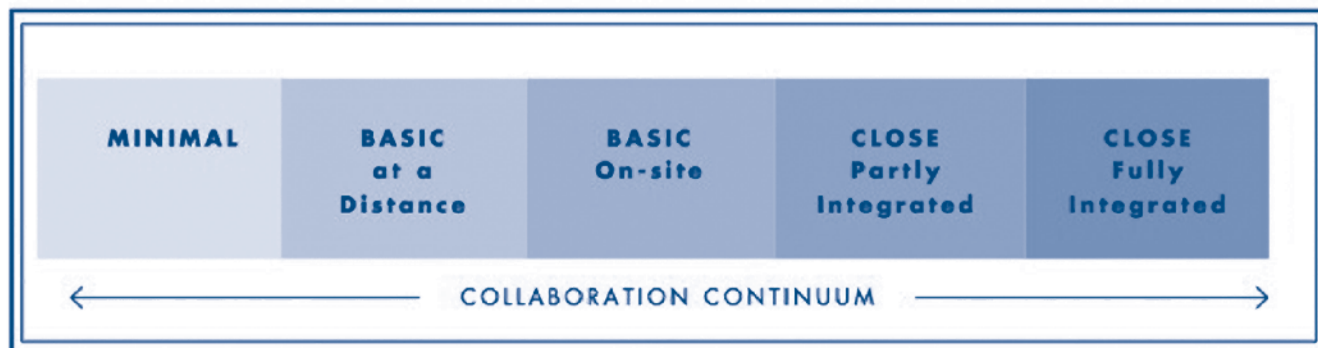

Figure 1. Source: "Evolving Models of Behavioral Health Integration in Primary Care" (Milbank Memorial Fund, 2010), p.14

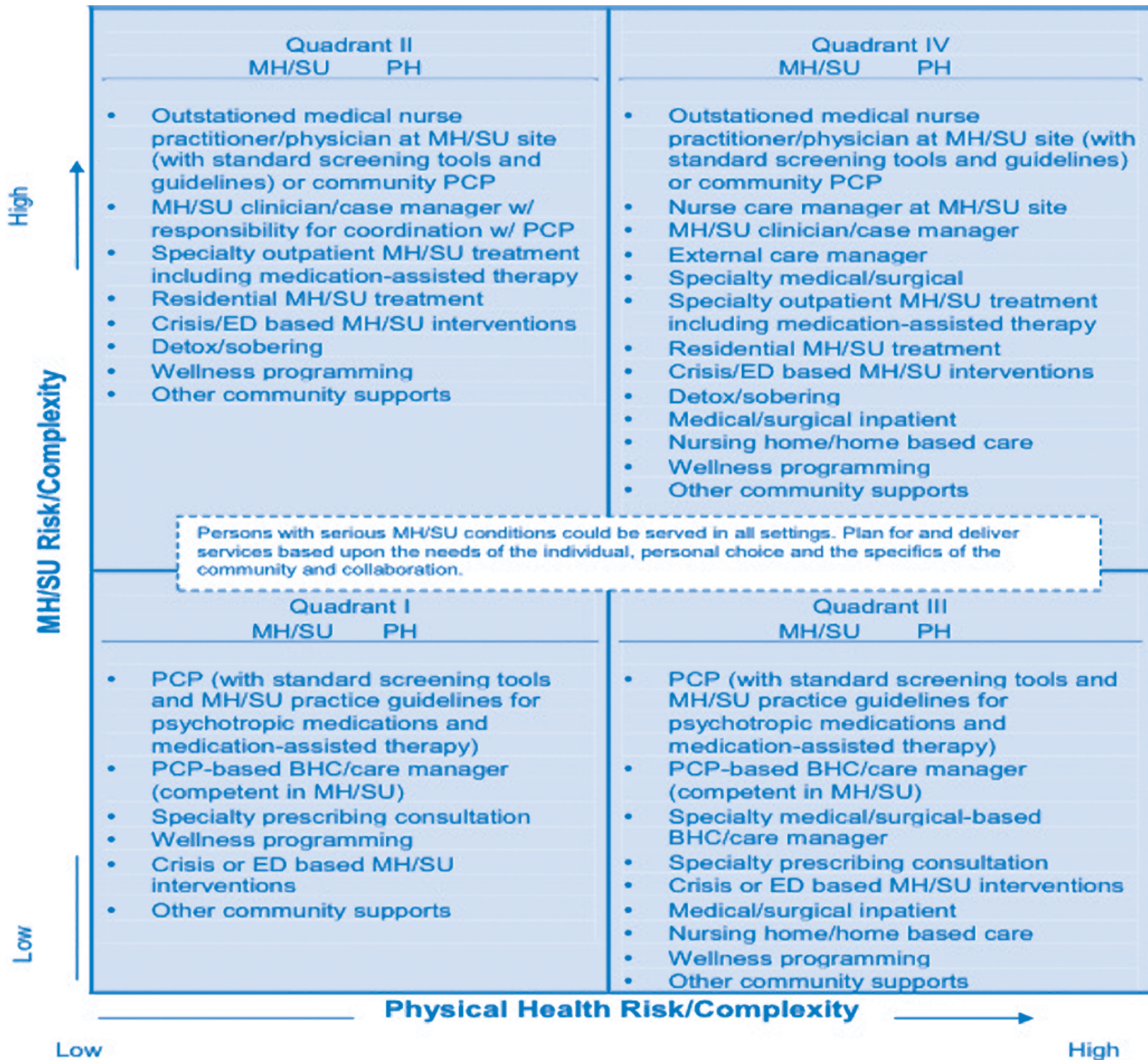

Figure 2. Source: Mauer, Barbara J.. "Behavioral Health/Primary Care Integration and the Person Centered Healthcare Home". April 2009. The National Council for Behavioral Health Care. Accessed 10.15.15.

general medical providers, or Health Homes. Thus, the location and type of providers should differ depending on the clinical presentation of the patient population, with increasing resources being devoted to those with more complex conditions. Of course, the next step in this model will be adding the "z" axis to incorporate the complicating factors of psychosocial problems and the social determinants of health for children and their families, as these often determine clinical complexity and health outcomes regardless of the type of general medical or BH condition.

There is substantial evidence for collaborative care for depression and anxiety in youth, defined as case managers or care coordinators – with varying levels of educational background – providing brief evidence-based treatment and care coordination within the primary care setting. Robust programs described in the medical literature include the Reaching Out to Adolescents with Depression (ROAD) program at the University of Washington at Seattle, Youth Partners in Care (YPIC) at the University of California at Los Angeles, and the Doctors' Office Collaborative Care (DOCC) program at Children's Hospital of Pittsburgh. We can broaden this research base to include other BH disorders and increasing levels of clinical and social complexity, and incorporate technology to overcome our current

continued on page 60

Integrated Care *continued from page 59*

resource limitations in child mental health. Finding where child and adolescent psychiatrists fit within these models is also vitally important, particularly given the current momentum supporting integrated care and our broad understanding of child development and treatment that may inform thoughtful program development.

Several payment systems exist to support integrated care. Many states are pursuing Health Homes for youth with severe BH problems, an option available as a result of the Affordable Care Act. Health Homes extend beyond integrated general medical and BH treatment to include comprehensive care management and care coordination; individual, family, and community support; and innovative use of health information technology. Additionally, several current healthcare payment and system reform initiatives are built on the Patient Centered Medical Home (PCMH) with defined levels of BH integration and care coordination services. States may pursue Medicaid 1915A and 1115 waivers to develop innovative service delivery and payment models, and these Medicaid funds may be blended with other sources such as grants from the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), and state and federal Child Protective Services and the Departments of Education and Justice. It is difficult to provide integrated care within traditional fee-for-service systems, so many healthcare systems have found creative ways to fund these initiatives.

Our current interest in integrated care involves a bit of dressing up an old idea, as several decades ago case managers and BH providers routinely were represented on primary care teams. There was a shift away from team-based care around the 1980-90s with the expansion of BH-specific managed care entities and separate payment systems for general medical and BH problems. But now there is renewed interest in service integration, given the prevalence and cost of chronic medical conditions that rely on behavioral change for modification, as well as healthcare systems that are taking on insurance risk and thus becoming fiscally responsible for high healthcare utilization, much of which is driven by comorbid BH disorders. Thus, in the general medical community, the iron is hot, and so in psychiatry, we have an opportunity to strike again. Let's partner with pediatrics, general medicine, and psychology and bring our expertise and knowledge to create service delivery and payment systems that work. ■

References

Collins C, Hewson DL, Munger R, Wade T (2010). Evolving Models of Behavioral Health Integration into Primary Care. NEW YORK: Milbank Memorial Fund. Available at: **www.milbank.org/uploads/documents/10430EvolvingCare/EvolvingCare.pdf.** Accessed 10.15.15.

Mauer BJ (2009). *Behavioral Health/Primary Care Integration and the Person Centered Healthcare Home.* Substance Abuse and Mental Health Services Administration. Washington, DC: The National Council for Behavioral Health Care. Accessed 10.15.15.

Dr. Knutson is a medical instructor in the Department of Psychiatry and Behavioral Sciences at Duke University School of Medicine. She may be reached at **hobbsknutson@icloud.com**.

JAACAP Connect is an online companion to the *Journal of the American Academy of Child and Adolescent Psychiatry* promoting the development of translational skills and publication as education. The field of child and adolescent psychiatry is rapidly changing, and translation of scientific literature into clinical practice is a vital skillset that takes years to develop. *Connect* engages clinicians in this process by offering brief articles based on trending observations by peers, and by facilitating development of lifelong learning skills via mentored authorship experiences. We work with students, trainees, early career, and seasoned physicians, regardless of previous publication experience, to develop brief science-based and skill-building articles.

www.jaacap.com/content/connect

connect@jaacap.org