Editorial

Why integrated care already owns the future

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Integrated care has certainly arrived in the primary care clinic. Evidence and momentum began building 20 years ago with the demonstrated effectiveness of collaborative care programs for depression and anxiety disorders in primary care (1). Since then, various forms of integrated care have been repeatedly proven effective across a range of care settings, patient populations, languages and cultures (2). Initial success in the treatment of depression was extended to care of other common mental health and substance use disorders (3). As a signal of that success, the US Preventive Services Task Force now recommends routine screening for depression in primary care. The previous qualification to limit screening to settings where ‘depression care supports are in place’ is now replaced by a recommendation that ‘screening be implemented with adequate systems in place’ (4). The availability of effective mental health services for primary care patients is now an expectation rather than an aspiration.

But, integrated care seems to be arriving in the clinic just as the doctor is leaving the building—for at least part of her practice time. Primary care is evolving to include a much wider range of services, including telehealth visits, asynchronous messaging and even live chat. Some of the innovations of early integrated care models, such as shared visits and ‘warm hand-offs’, depended on co-location of mental health and primary care providers. Those face-to-face forms of collaborative care no longer seem necessary, or even possible, when the primary care physician and her patient are often not in the same building. Primary care does not always occur in real life. Facetime is now the name of an app rather than a face-to-face encounter. We can expect this shift away from bricks-and-mortar primary care to accelerate. The new health care joint venture by Amazon, JPMorgan and Berkshire Hathaway is expected to rely heavily on telehealth and virtual care. This evolution will be driven by both consumer demand for more convenient care and business imperatives for more efficient care. The so-called Fourth Industrial Revolution will change health care more slowly than it has changed other industries but that change will certainly come. Primary care of the future will resemble other modern industries: more flexible, more convenient and more consumer centred. Patients will expect to communicate with primary care physicians via text, phone and video in addition to face-to-face.

This evolution of primary care should cause us to re-examine the essential or active ingredients of integrated care. Integrated care is not defined by simple co-location or traditional face-to-face consultation. In fact, development of the original models for collaborative care was motivated by a previous finding that traditional psychiatric consultation in primary care did not improve quality of care or patient outcomes (5). In addition, some of the early trials

of integrated care or collaborative care were conducted in primary care clinics with co-located mental health providers (1). Co-located mental health providers delivering traditional consultation services were the control or placebo condition against which integrated care programs were proven superior.

While a surface view of integrated care might focus on co-location, the core elements of integrated care instead emphasize communication and coordination (3). A shared care plan may require shared records, but it does not necessarily require shared office space. Systematic follow-up programs, a central element of integrated care models, emphasize systematic outreach to patients not present in the clinic. We could say that key ingredients of integrated care actually foreshadowed or even facilitated the deconstruction of traditional bricks-and-mortar primary care. Four aspects of integrated care are especially relevant: task shifting, evidence-based decision support, telehealth and flexibility in duration of encounters.

The history of integrated care models could be written in terms of task shifting. The original collaborative care models shifted tasks from primary care physicians to doctoral-level mental health providers—psychiatrists and psychologists (1). Subsequent iterations shifted some tasks—especially outreach, monitoring and coordination—from those doctoral-level providers to nurses or masters prepared mental health clinicians (1,6). More recent versions have automated some outreach and monitoring tasks, taking advantage of communication tools embedded in modern electronic health record systems (7).

Evidence-based decision support was an established component of integrated care before it spread to mental health specialty practice. The earliest integrated care programs were developed and tested in the days of paper medical records (1). Nevertheless, those programs included systematic assessment of outcomes, tracking of treatment adherence and rule-based recommendations for treatment adjustment. The effectiveness of measurement-based depression care was demonstrated in primary care long before it spread to mental health specialty care (3,8). Over the last 20 years, evidence-based decision support tools have grown more efficient and more sophisticated, taking advantage of modern medical informatics.

Integrated care programs were also early adopters of telehealth technologies. Efforts to improve depression treatment in primary care initially adopted telephone encounters for outreach and monitoring and progressed to using the telephone as a primary tool for delivering psychotherapy and pharmacotherapy (9,10). Those innovations then spread ‘upstream’ from primary care back to mental health specialty care. Similarly, use of online messaging for

depression treatment was first tested in primary care (7). In both cases, innovation was driven by the intersection of unmet need and a relatively ‘blank slate’ of mental health service delivery.

Finally, integrated care programs led the way in diversifying the ‘serving size’ for mental health treatment. While mental health specialty care remained committed to the 50-minute psychotherapy hour and the 20-minute medication check visit, primary care-based programs experimented with briefer therapy sessions and brief telephone medication visits (9). In order to serve those who do not seek mental health specialty care, integrated care programs developed more consumer-driven (rather than provider driven) menus of care delivery options.

Integrated care models are well adapted to thrive during the Fourth Industrial Revolution in health care. Because integrated care has embraced flexibility and disruption, integrated care models will succeed—or even dominate—in a future that will demand flexibility.

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