Integrated Care and the Evolution of the Multidisciplinary Team

Mary Iftner Dobbins, MD[a,*], Sheila A. Thomas, MD[a], Stacy L. Stokes Melton, LCSW[b], Stacy Lee, LCSW[a]

KEYWORDS

• Integrated care • Behavioral health • Health care teams • Primary care psychiatry • Workforce development

KEY POINTS

- Primary care practice in the patient-centered medical home is transforming as new findings are considered in the context of population health and changes driven by health care reform.
- Research in neuroscience, epigenetics, human development, trauma-informed care, and population health describes the biologic chain of events linking life experiences with chronic medical and mental illnesses.
- Mental health professionals are increasingly being incorporated into the medical home as part of a team approach to the provision of care.
- These professionals use their skills in nontraditional models to customize care for each patient as indicated, creating an expanded definition of their specialty.
- "Integration" of primary care and mental health services engenders opportunity for enhanced clinical care, professional workforce development and support, more effective population health initiatives, and informed health care policy.

INTRODUCTION

Patient-Centered Care

Primary care disciplines continue to contribute a unique and vital perspective to the practice of medicine. Adapting with medical advances, societal changes, regulatory constraints, consumer expectations, and other professional demands, the goal of the primary care provider (PCP) has remained to care for the patient as a person. Professional competencies and culture may vary between the primary care disciplines, yet all continue to emphasize health promotion in addition to the treatment of illness.[1–4] Indeed, despite the compelling forces of market competition, skewed payment systems, growing socioeconomic disparities, and a culture that increasingly

[a] Department of Family and Community medicine, SIU School of Medicine, 520 North 4th Street, Springfield, IL 62794-9670, USA; [b] Department of Family and Community medicine, SIU Center for Family Medicine, Quincy, IL, USA
* Corresponding author.
E-mail address: mdobbins@siumed.edu

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calls for convenience and expediency, primary care disciplines have protected the concept of holistic, patient-centered care in the setting of a medical home.[5]

The PCP not only possesses a vast array of medical skills and knowledge, but also continuously attempts to customize care in the context of the patient's individual personality and life circumstances, including family and community environment. Subsequently, PCPs have been called on to address increasingly complex issues, often coordinating a variety of limited resources and fragmented systems of care, while attempting to maintain patient engagement and satisfaction—all within the time constraints and fast pace of a busy medical practice.

Health Care Teams

Recognizing that these care demands are not always met by an individual provider, most practices have adopted a team approach to patient care. This is not a new concept, as physicians and nurses have traditionally worked together to provide care, and most practices have acquired a network of professionals to which they refer. Larger practices commonly designate staff teams that work together consistently to provide improved workflow and continuity of care. Team members may also review schedules or otherwise anticipate patient needs, enhancing efficiency and quality of care.

These examples share the commonality of arising out of adaptations to daily clinical practice, modifying the skills and duties of traditional professional staff. Over time, however, many practices have also begun to more formally and proactively structure care teams, assimilating groups of professionals whose composition reflects the needs of the patient population, practice interests of the providers, and availability (or scarcity) of local resources.

Multidisciplinary teams may come together in a variety of ways, proactively constructed, by gradual evolution, or even opportunistically through funding opportunities or organizational changes. They may develop methodically and intentionally with predetermined goals, evaluation processes, and proscribed timeline, or may evolve more slowly and subtly as practice personnel gradually recognize and are able to respond to emerging patient needs.[6]

The composition for one practice setting may not be desired or even feasible for another. Even within a practice setting, teams may change over time secondary to the availability of resources, priorities of leadership, evolution with practice need, or attrition and neglect. There are, however, certain characteristics of successful multidisciplinary teams (**Box 1**). With attention to such details, medical practice remains flexible and responsive to changes in patient care needs.[6–8]

Box 1
Characteristics of successful teams

Shared vision

Well-defined goals and expectations

Strong yet receptive leadership

Appropriate support structures

Well-defined roles

Inter-professional respect

Clear and frequent communication

Intermittent self-evaluation

Adaptability

Team Composition

Traditional disciplines have evolved and new health care professions have emerged in response to a burgeoning need for health care services in an environment of limited financial resources. Many health care disciplines have developed formal subcategories of credentials, with various educational requirements and professional competencies. Subsequently, even "primary care teams" may be quite diverse, having evolved to include an array of medical professionals who, depending on licensure, payer source, and local regulations, work with varying degrees of collaboration, supervision, or independence (**Box 2**).

Box 2
Primary care teams

Physicians (MD and DO)

Advance practice nurses (APN)

Physician assistants

Nurses (registered, licensed practical)

Certified nursing assistants

Certified medical assistants

The role of the office nurse has been especially pivotal, offering the professional flexibility to adapt to a variety of practice needs and provide expertise in a number of specialized areas (**Box 3**). As resources allow, many primary care practices also recruit professionals credentialed traditionally in other disciplines (**Box 4**), whose "colocated" practice may remain fairly traditional, well-defined, and self-sustaining, and whose value is readily understood and accepted by both patients and practice staff.

Box 3
Diversity in nursing roles

Direct primary care practice (APN)

General clinical assistance

Procedures

Screening

Education

Counseling

Case management

Administration

Research

Box 4
"Colocated" services

Pharmacists

Dieticians

Lactation consultants

As the medical needs and systems of care become more complex, however, many practices have also created new positions (**Box 5**) that greatly expand the concept of patient care by working between agencies, coordinating services, and tracking resource use and health outcomes. Unlike the former positions, these may have more fluid definitions and boundaries, be funded in a number of creative ways, and be filled by professionals with a variety of educational backgrounds. Indeed, the success of these positions is often highly dependent on the individual's interpersonal skills, which facilitate patient engagement and the development of collaborative professional partnerships.

Box 5
"Interdisciplinary" professionals

Case manager

Care coordinator

Patient navigator

Often, the holistic and patient-centered approach to care uncovers needs more social or environmental in nature. These may be best addressed by recruiting team members that would not necessarily be considered to be "medical" professionals (**Box 6**). When expanding into other disciplines, team members may work on a part-time or contractual basis if it is not feasible for them to function as full-time practice employees. In fact, anyone who has direct contact with patients (**Box 7**) may become very important in patient engagement, satisfaction, and medical care, functionally becoming part of the care team even if in a more informal fashion. The most important member of the "team," however, may be the recipient of care, the patient.

Box 6
"Nonmedical" professionals

Social workers

Legal consultants

Patient advocates

Educators

Box 7
Informal team members

Scribes

Receptionists

Referral specialists

Billing personnel

Telephone nurses

Peer counselors

Interpreters

Custodians

Security staff

BEHAVIORAL HEALTH

Components of Behavioral Health

Primary care disciplines have long recognized ways in which the patient contributes to their own health and health care. An almost endless number of individual factors (Box 8) vary greatly from person to person. These factors, often not obviously apparent, fully considered, or truly understood by the professional, motivate patient actions and may potentially promote or compromise health and treatment, be affected by health-related concerns, or affect resiliency and adjustment to everyday stressors.

As the medical profession has begun to recognize the importance of lifestyle, habits, and self-care, more professional efforts have been undertaken to influence patient health-related behaviors, leading to the development of an approach to care commonly referred to as “behavioral health.”

Behavioral health is not a new concept; it has always been a part of primary care practice in some form, whether or not obviously recognized as such. In a more paternalistic era, it may have been somewhat concrete and prescriptive, telling a patient “what to do” to treat an illness, when to call, or when to present back to the office—all actionable behaviors on the part of the patient. Over time, however, a broader concept of behavioral health has become widely incorporated into the self-care emphasis of prenatal and health maintenance visits, and more targeted and formalized

Box 8
Personal characteristics

Personality

Cognitive skills

Executive function

General abilities

Resources

Education

Communication skills

Motivation

Habits

Interpersonal skills

Relationships

Life experiences

Spirituality

Cultural background

Trust

Bias

Expectations

Preferences

Fears

Coping skills

Self-regulation

programming is becoming more common for some adjustment problems, chronic illness, pain management, addictions, and mental health issues (Box 9).

Behavioral health = Engagement, Education, Motivation, Support

Whether formalized or not, all primary care practices provide some degree of behavioral health care, using a variety of models ranging from the use of written materials to individual appointments or group classes for education and support. The most effective behavioral health, however, expands on instruction and education to emphasize the importance of patient engagement, motivation, and support.[9–12]

Expansion of the Primary Care Team

Commonly, behavioral health services have been provided by the PCP, staff nurse or dietician, who does not necessarily require additional subspecialty training. Research in behavioral change, however, has also led to the inclusion of mental health professionals, who:

- Are adept at behavioral change techniques (motivational interviewing, supportive and cognitive-behavioral therapy, mindfulness and relaxation exercises)
- Facilitate patient engagement
- Explore the forces driving the behavior
- Recognize the need for more intensive mental health care
- Are familiar with a variety of additional resources

This has been especially helpful as PCPs, who have always recognized the interplay between mental and physical health, have begun to routinely use screening measures for substance abuse and mental health disorders. Secondarily, the inclusion of professionals trained in "mental health" has broadened both the breadth and depth of "behavioral health" (Fig. 1).

Programmatic Gaps

The practice of behavioral health has grown out of attempts to meet patient needs within the medical home. This development has been quite beneficial, as it has been customized per setting, and has also led to a more nuanced study of factors that affect health and quality of life. However, the development of behavioral health has also exposed gaps in traditional training models, as it has been considered to be an emerging type of care rather than a professional specialty. "Medical" professionals may struggle with the mental health aspects, and "mental health" providers may be unfamiliar with many aspects of medical illness, preventive care, and health maintenance. Many rely on some degree of cross-training.

From a practical point of view, the term "behavioral health" can cover a large variety of meanings and services, and may be used differently by professionals in different

Box 9
Areas of behavioral health

Self-care: safety, sleep, diet, weight management, exercise, general self-care

Adjustment Problems: grief, divorce

Chronic illness: obesity, diabetes, asthma, hypertension, pain management, addictions, mental illness

Fig. 1. Behavioral health/mental health spectrum. Behavioral health practices span from wellness to pathology, enhancing health and decreasing illness. Traditional mental health specialty care may be needed for a small percentage of a patient population.

settings. Likewise, the providers of behavioral health services may be known by a variety of titles and may have quite varied professional backgrounds, training, and credentials. Because this is such an important aspect of health care, however, programming continues to develop very quickly, with attempts to define "best practice" models for care and professional training that will promote integration of this type of patient care—paradoxically holistic yet "in between" traditional health care professions—into the medical home.

INTEGRATED CARE

Components of Integrated Care

Programmatic applications of these considerations have led to the concept of what is commonly called "integrated care." Historically considered from the perspective of the mental health disciplines, this is probably best described as the practice of using a mental health professional, typically a therapist (**Box 10**), within the medical setting and specifically emphasizes expansion of their service outside of colocated yet

Box 10
Integrated mental health professionals

Licensed clinical professional counselor (LCPC)

Licensed clinical social worker (LCSW)

Psychologist

Addiction specialist

Marriage and family counselor

Psychiatrist

traditional practice.[13,14] The integrated therapist may practice within the range of behavioral health concerns, but will also provide an additional expertise regarding mental health and substance abuse issues. As in medical practice, models and infrastructure may be quite varied; and the term does not indicate a standardized program. Conversely, however, "reverse integration" refers to the practice of using a medical professional within a mental health setting and typically consists of more traditional colocated services.[15–17]

Although a variety of professionals may provide this service, there are essential skill sets shared between all (**Box 11**). Customization is especially important, as emphasizing a colocated traditional model of the 1-hour therapy appointment will preclude the true integration of an expanded variety of clinical services, limit efforts at patient engagement, limit the number of patients assisted, and functionally isolate the therapist, stifling their ability to truly function as a member of the clinical treatment team.

Certainly, depending on available community resources and patient needs, some more traditional therapy visits may be provided, but should be considered as only a limited aspect of the therapist's role. The therapist who has experience with integrated care is, in fact, expanding the expertise of the discipline. In this context, being used for colocated traditional services, while technically allowing them to work at the top of their degree, is not functionally allowing them to work to the top of their ability, potentially wasting a valuable resource.

Clinical Aspects of Integrated Care

Clinical encounters will vary in duration, address a variety of issues, and use a variety of service techniques (**Box 12**). Because services will reflect the needs of the practice and, to some extent, the expertise and interests of the therapist, these may vary a great deal between settings. The employment of additional therapists is expected to expand types of services and flexibility in the provision of care, especially if team members coordinate their efforts. The common expectation, however, is for the therapist to create a visible presence in the clinical environment, readily available to be introduced to patients as they present for their primary care appointments, and easily accessed as a general resource for clinic staff.

The effective integrated therapist, while respecting the time constraints and professional boundaries of the clinical practice, will seek out contact with clinic staff members to develop familiarity and trust, encourage questions, and discuss services. This is not just a team-building role, but also assists in the ongoing assessment of clinical needs.

The ability to meet with a patient in need at the time of their medical appointment greatly facilitates patient engagement and follow-through with treatment recommendations, efficiency of clinic flow, and support of the medical staff.[14] To anticipate the need for assistance and plan accordingly for time and materials, many therapists

Box 11
Essential skills in behavioral health

Work with a variety of medical professionals with individual personalities in a fast-paced often high-stress setting

Quickly assess the needs of both the patient and the provider caring for the patient

Problem solve to provide a variety of interventions

Provide services in an adaptable, customized fashion

Box 12
Types of behavioral health assistance

Preclinic planning (huddles, schedule/chart review)

Provision of information, materials, resources

Patient deescalation

Assessment (brief or in depth)

Problem solving

Psychoeducation

Patient engagement

Linkage with additional care/services

Psychotherapy

Communication/coordination of care

Assessment of clinical needs

Program planning

routinely review the patients scheduled for the day, participate in preclinic "huddles," and otherwise routinely check in with clinic staff. However, the need for the therapist is frequently not anticipated until the provider is in the room with the patient. Subsequently, availability and responsiveness are of great importance.

The therapist may assist clinical staff by providing materials, suggesting resources, or otherwise answering questions, but typically will meet with the patient at the time of presentation, preferably introduced directly by the provider as a part of the clinical team. They may work in concert with the provider or complete the visit as the provider moves on with their schedule.

The encounter may be acute, as in the deescalation and in-depth assessment of a distraught patient. More commonly, however, it consists of psychoeducation, brief assessment and problem solving, or possibly just an introduction to facilitate engagement or schedule an appointment with the therapist.

Depending on clinic resources, scheduled visits with the therapist are usually arranged with the understanding that they may be interrupted if there is an acute clinic need. For certain patients, the therapist may suggest more intensive mental health services, including psychiatric care, and assist the provider in this referral process. If the therapist becomes aware of a medical concern during the course of their work with a patient, they facilitate communication with the referring provider to arrange further management.

Once a working relationship is established and services are well-understood, the provider may at times directly refer patients to the therapist without the intermediate step of the clinical introduction. However, caution should be taken not to jeopardize patient engagement, misuse the therapist as a resource, or overbook appointments at the expense of informal clinic availability (the main value of integrated care).

After an encounter, the therapist communicates with the provider to review outcomes and ongoing treatment planning. This may be done acutely if indicated, but oftentimes occurs in the form of brief weekly meetings or electronic communication. If the latter is used, consideration should be given regarding patient confidentiality and whether permanency within the medical record is desired. The therapist is always expected to provide routine documentation for any direct patient service.

The skills of the therapist are also easily applied as a practice consultant, who often can facilitate the patient experience and clinic flow, detect practice gaps, and develop programming to enhance employee health and decrease provider burnout.

The Role of the Psychiatrist

Psychiatrists may also provide services in the primary care setting, typically arranged as variations of colocated traditional practice. This arrangement can be especially helpful if intensive supportive services, a critical aspect of care for more severely ill psychiatric patients, are not needed or can be otherwise arranged.

Although typically more narrow in scope than the broad spectrum of behavioral health services provided by the integrated therapist, psychiatric care may also consist of a spectrum of services, including diagnostic evaluations, consultation sans direct treatment, and variations of limited medication management. Coverage and support issues typically preclude full ongoing psychiatric services within the primary care setting, however.

The availability of psychiatric treatment within the medical home decreases stigma, enhances patient engagement, and facilitates care.[16,18,19] In addition, the psychiatrist can assist in the determination of and facilitation for those who may need to be referred elsewhere for more intensive care. This is an important contribution to the cost-effective use of limited specialty resources, and has the added benefit of streamlining waiting time for the more severely ill. The psychiatrist who works closely with the integrated therapist can also develop a synergy and enhanced efficiency in the provision of patient care.

Similar to the integrated therapist, there are many ways in which a psychiatrist may expand their assistance in the practice. Having a presence in the clinic fosters better communication, understanding of the specialty, participation in comanagement and opportunities to function as an informal resource. In addition to patient care, the psychiatrist who provides liaison expertise can explore practice gaps, educational needs and population trends, and otherwise provide staff and program support. In general, the psychiatrist may provide psychiatric clinical services, but also provides psychiatric expertise to assist the PCPs in the care of their patients.

SYSTEMIC ASPECTS OF INTEGRATED CARE

Logistics

Most integrated care results in billable services, especially because there are a variety of additional codes that may be useful once there is an expansion upon traditional care (**Box 13**).[13,14] Even when certain services may not be directly billable, they provide

Box 13
Billing considerations

Variety of psychotherapy codes based on duration

Screening codes

Education codes

Complexity of interview

Crisis intervention

Group therapy

Coordination of services

value to patient care and may indirectly be contributing financially to the practice through enhanced provider efficiency. Most practices find it helpful to anticipate the amount of billing necessary to ensure the services of the therapist will be sustainable financially. It is of note that a therapist, who has a scheduled patient "no-show," may recoup that billing loss through the ability to participate in an unscheduled clinical encounter.

Planning should take into consideration special needs for space (especially for group sessions), staff support, supplies (especially for pediatric patients), screening tools, and brochures and printed materials as desired.

In addition to direct patient care, there are many systemic benefits to an integrated care approach. The introduction of integrated care complements case management and provides unique opportunities to track service use and outcomes at both the individual and population levels. Trends may emerge that indicate more targeted approaches to service in areas such as substance abuse, chronic pain management, diabetes/weight management, perinatal support, geriatric care, and developmental disabilities. Common contributing factors such as lack of transportation or food/housing insecurity may be identified. New practice-wide initiatives may be undertaken more effectively.

Stigma and Discomfort

In contrast with other practice innovations, integrating behavioral and mental health services may be significantly more vulnerable to the culture and attitude of office staff members at the individual level. Outdated yet pervasive stereotypes persist, and patients may be perceived as frightening, lazy, frustrating, or unworthy. Stigma may extend to the specialists and professional disciplines as well.[7] Additionally, mental health disciplines are often less familiar than other specialties, emergent symptoms are often ill-defined, services are poorly understood, and guidance for referral is often lacking. PCPs may fear "labeling" rather than "diagnosing" a patient, avoid potentially sensitive discussions, or feel awkward introducing the therapist and their services.

Communication and Language

Good communication is a challenge in any busy practice, especially in subjects historically treated with increased confidentiality. In addition, attempts to provide language for new concepts may have very different meanings to those with different backgrounds. For example, "warm hand-off," a phrase commonly used to refer to an in-person introduction, may be poorly accepted by those with a background of trauma or neglect. "Behaviorist," a term for the professional providing behavioral health services, may be rejected by those for whom it implies judgment or control.

Administration

The integrated professional constantly assesses clinical needs and responds in a fashion that is defining a new discipline, in essence adding the next layer to patient-centered care. However, administrative decisions are commonly based on traditional services in a "top-down" approach. Consideration should be given to compromise at the interface of the 2 approaches.[8]

OUTCOMES AND IMPLICATIONS

Clinical Care

Despite the lack of standardization or identity as a defined professional discipline, the integration of behavioral health care into the primary care setting has consistently demonstrated beneficial outcomes (**Box 14**). Patients remain more engaged, increase

Box 14
Outcomes of behavioral health care

Increased access to services

Increased patient engagement

Increased follow-through with treatment planning

Better response to care

Decreased stigma

Improved efficiency of care

Decreased overuse

Cost containment

Increased patient satisfaction

Increased provider satisfaction

their follow through with treatment plans, and have better response to care.[7,15,18,19] At the population level, this alleviates stigma, increases access to mental health services, enhances efficiency of care, decreases overuse of resources, and contains cost. Excessive primary care use is decreased, and education and support are systematized for the PCPs. In fact, this is a model of care that demonstrates increased satisfaction for both patients and providers.[7]

Medical Education

Although typically pursued for clinical reasons, integrated care provides significant educational opportunities for primary care staff through ongoing informal and formalized avenues. Discussion regarding both "what" is helpful and "why" quickly generalizes to systemized practice change. PCPs indicate a desire to learn more in regard to mental health care.[20,21] As practice gaps are identified, more structured programming can be provided through a variety of mechanisms, including staff meetings, quality assurance projects, or formalized continuing medical education offerings. In academic settings, where a designated curriculum may be instituted, this potential is profound. In fact, the Accreditation Council for Graduate Medical Education has formally recognized the need for training in behavioral/mental health in primary care programs.[22]

The implications for the education of mental health providers are equally as important, and new programming is beginning to address the concepts and skills necessary for this expanded type of practice.[6,8,17,20,21] Indeed, integrated clinics provide a unique opportunity for blended interdisciplinary educational efforts. Lessons learned from integrated care are especially expected to transform the practice of psychiatry. Not only will psychiatrists continue to improve the management of their patients' associated medical concerns, but for the first time have real opportunity to study the emergence of disorders in the clinical setting and explore the realm of preventative medicine—an approach of "primary care psychiatry."

Health Care Policy

Systems of care, professional training and licensure, funding mechanisms, and health policy have evolved over the years in a fashion that fails to adequately reduce disease and economic burden. However, new discoveries in neuroscience, epigenetics, trauma-informed care/toxic stress, and population health may truly be the "missing

link," demonstrating how environment and life experiences physically contribute to the development of (and therefore the management of) chronic disease.[23,24] Integrated care is poised to meet this need and to transform both health care and health care policy, built on the solid foundation of the patient-centered medical home.

REFERENCES

1. American Academy of Family Physicians. Available at: www.aafp.org. Accessed August 1, 2015.
2. American Academy of Pediatrics. Available at: www.aap.org. Accessed August 1, 2015.
3. American College of Physicians. Available at: www.acponline.org. Accessed August 1, 2015.
4. American Congress of Obstetricians and Gynecologists. Available at: www.acog.org. Accessed August 1, 2015.
5. Phillips RI, Pugno PA, Saultz JW, et al. Health is primary: family medicine for America's health. Ann Fam Med 2014;12(Suppl 1):S1–12.
6. Adams T, Orchard C, Houghton P, et al. The metamorphosis of a collaborative team: from creation to operation. J Interprof Care 2014;28(4):339–44.
7. Brawer P, Martielli R, Pye P, et al. St. Louis initiative for integrated care excellence (SLI^{2}CE): integrated-collaborative care on a large scale model. Fam Syst Health 2010;28(2):175.
8. Hern T, Burke Valeras A, Banker J, et al. Collaborative partnerships within integrated behavioral health and primary care. In: Talen M, Burke Valeras A, editors. Integrated behavioral health in primary care. New York: Springer; 2013. p. 209–27.
9. Marvel MK, Doherty WJ, Weiner E. Medical interviewing by exemplary family physicians. J Fam Pract 1998;47(5):343–8.
10. Mauksch LB, Dugdale DC, Dodson S, et al. Relationship, communication and efficiency in the patient encounter: creating a clinical model from a literature review. Arch Intern Med 2008;168(13):1387–95.
11. Fischetti LR, McCutchan FC. A contextual history of the behavioral sciences in family medicine revisited. Fam Syst Health 2002;20:113–29.
12. Oyama O, Kosch SG, Burg MA, et al. Understanding the scope and practice of behavioral medicine in family medicine. Fam Med 2009;41(8):578–84.
13. Substance Abuse and Mental Health Services Administration. Available at: www.Integration.SAMSHA.gov. Accessed March 3, 2015.
14. National Council on Behavioral Health. Available at: www.thenationalcouncil.org. Accessed March 1, 2015.
15. Ratzliff A, Christensen C, Unützer J. Building value-added teams to care for behavioral health needs in primary care. In: Summergrad P, Kathol R, editors. Integrated care in psychiatry. New York: Springer; 2014. p. 103–26.
16. Barth FD. Building and working with an integrative team. In: Barth FD, editor. Integrative clinical social work practice. New York: Springer; 2014. p. 119–30.
17. Ivbijaro G, Enum Y, Khan A, et al. Collaborative care: models for treatment of patients with complex medical-psychiatric conditions. Curr Psychiatry Rep 2014;16(11):1–12.
18. Oldham R, Hersevoort S. Integrated care: a population-based approach to consultation-liaison psychiatry. In: Leigh H, Strelzer J, editors. Handbook of consultation-liaison psychiatry. New York: Springer International Publishing; 2015. p. 115–28.

19. Unützer J, Katon W, Callahan C, et al. Collaborative-care management of late-life depression in the primary care setting. JAMA 2002;288(22):2836–45.
20. Thomas S, Dobbins M, Hill-Jordan J, et al. An investigation of primary care physicians attitudes toward psychiatry. Acad Psychiatry, in press.
21. Dobbins M, Roberts N, Vicari S, et al. The consultation conference: a mew model of collaboration for child psychiatry and primary care. Acad Psychiatry 2011;35(4):260–2.
22. Accreditation Council for Graduate Medical Education. Available at: www.acgme.org. Accessed March 1, 2015.
23. Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. Am J Prev Med 1998;14(4):245–58.
24. Garner A, Shonkoff J, the Committee on Psychosocial Aspects of Child and Family Health (Siegel B, Dobbins M, Earls M, McGuinn L, Pascoe J, and Wood D). Policy statement- early childhood adversity, toxic stress, and the role of the pediatrician: translating developmental science into lifelong health. Pediatrics 2012;129(1):e224–31. Elk Grove Village, IL. The American Academy of Pediatrics.