Incorporating Trainees’ Development into a Multidisciplinary Training Model for Integrated Behavioral Health Within a Pediatric Continuity Clinic

Kimberly Kelsay, MDa,*, Maya Bunik, MD, MPHb, Melissa Buchholz, PsyDa, Bridget Burnett, PsyDa, Ayelet Talmi, PhDa,c

KEYWORDS
• Multidisciplinary training • Integrated mental health • Integrated behavioral health • Pediatrics • Medical home

KEY POINTS
• Integrated mental health and behavioral care for children requires multidisciplinary team members to work together to provide services.
• There are few descriptions of integrated care clinics that provide training across disciplines, including pediatrics, psychology, and psychiatry.
• Attending to developmental level of trainees is a helpful organizational framework when providing targeted education and training.
• Training within an integrated clinic allows multidisciplinary trainees the opportunity to observe and understand the other disciplines’ strengths and roles while simultaneously developing their own discipline-specific competencies within this model.

* Corresponding author. 13123 East 16th Avenue, Box 130, Aurora, CO 80045.
E-mail address: Kimberly.kelsay@childrenscolorado.org

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INTRODUCTION

There is increasing recognition that pediatric primary care providers should have a role in preventing, recognizing, and addressing mental and behavioral health problems. Integrated care is designed to support providers and their patients within the primary care medical home in order to achieve these goals. Integrated care models often include multidisciplinary team members. The primary care provider may be a pediatrician, family medicine provider, advanced practice nurse (APN), or physician’s assistant (PA) working with nurses, medical assistants, and office staff. Behavioral health team members may include psychologists, child and adolescent psychiatrists, social workers, other behavioral health clinicians, and case managers or care coordinators who may be family navigators, community health workers, or nurses.

This complex system of care requires different skill sets from various disciplines. Pediatrics\(^1\) and psychology\(^2\) both have statements regarding professional competencies in primary care settings, and child psychiatry is currently formulating these competencies. (See Wanjiku F.M. Njoroge and colleagues’ article, “Competencies and Training Guidelines for Behavioral Health Providers in Pediatric Primary Care,” in this issue.) Although some literature exists regarding training, most descriptions have not focused on the level or types of trainees. The literature does, however, identify training gaps and program descriptions. For example, pediatric residents training in a clinic without integrated mental health clinicians reported feeling unsupported and fearful of visits involving mental health concerns and that, at times, they ignored their patients’ mental health concerns.\(^3\) Pediatric residents training alongside psychology trainees reported feeling better prepared to collaborate with behavioral health providers (BHPs) than colleagues who did not train with psychologists in an integrated setting, yet they only reported feeling somewhat more often prepared for handling behavioral health issues on their own after graduation.\(^4\) The authors propose that targeting training to the professional developmental level of the learner is important for successfully imparting the knowledge, skills, and attitude to attain the necessary competencies. The authors describe a multidisciplinary, graduated model within a pediatric teaching clinic and lessons learned in this work.

SETTING

The integrated primary care clinic is described in Table 1.

Pediatric trainees and faculty provide most of the primary care within this academic pediatric primary care clinic, although APNs also serve as primary care providers within the clinic. As in similar academic institutions, medical students, family medicine residents, PA students, and other pediatric residents who have continuity clinics in external community sites provide pediatric care during their general ambulatory core month.

<table>
<thead>
<tr>
<th>Clinic Setting</th>
<th>Characteristics of Clinic Population</th>
<th>Care Provided</th>
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<tbody>
<tr>
<td>Urban</td>
<td>90% Publicly insured</td>
<td>Well child</td>
</tr>
<tr>
<td>Pediatric residency continuity clinic</td>
<td>Many different languages spoken</td>
<td>Sick visits</td>
</tr>
<tr>
<td>Affiliated with academic hospital</td>
<td>Many Spanish speakers</td>
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<tr>
<td></td>
<td>Young and school age predominantly</td>
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<td></td>
<td>Some adolescents</td>
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</table>
Psychology and psychiatry trainees and faculty provide integrated behavioral health care through Project CLIMB (Consultation and Liaison in Mental health and Behavior). The behavioral health team also includes a full-time licensed professional counselor who works for a community mental health center. Medical social work, family navigation, community health workers, and care coordination services are available to families when indicated.

Integrated care services were developed and implemented to better serve the needs of the community and simultaneously address the educational and professional practice competencies of the pediatric training program. As the clinic has evolved, it has also increasingly served the needs of psychology and child and adolescent psychiatry (CAP) training. The clinic continues to evolve; as new models and processes are incorporated in the clinic, care is taken to expand the workforce capacity by training providers to become competent in delivering integrated care services within other community-based systems. In addition, scholarship related to various aspects of this model has helped secure educational and clinical funding as well as provided opportunities for trainees and faculty to engage in scholarly activities.

The integrated behavioral health services and training efforts began in 2005, with grant funding from local foundations who were interested in both access to behavioral health services for underserved, hard-to-reach populations and training of pediatric health professionals in better addressing mental health, behavior, and development. The program has evolved significantly over the course of more than a decade. Following the initial development and implementation funding, behavioral health services have been sustained with billing from screening efforts, institutional support from the Department of Pediatrics leadership who recognized benefits of training and education for pediatric health professionals, grants to support expansion and training, and Department of Psychiatry funding for trainees. This article describes the current model and lessons learned as the model has been implemented and adjusted.

INTEGRATED CARE MODEL

Patients in the clinic are scheduled for appointments with their primary care pediatric provider, a faculty member, resident, or other trainee completing their core ambulatory month. The pediatric provider identifies the need to involve integrated mental health team members through the following mechanisms:

- Routine screening (eg, developmental screening, maternal depression, psychosocial screening, teen depression screening) (Table 2)
- Spontaneous identification of problems that are discussed or raised in the course of a visit

<table>
<thead>
<tr>
<th>Routine screeners</th>
<th>Visit Type/Population</th>
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</thead>
<tbody>
<tr>
<td>Ages and Stages Questionnaire</td>
<td>Well-child visits/aged 2 mo to 5 y</td>
</tr>
<tr>
<td>Edinburgh Postnatal Depression Scale</td>
<td>All visits/&lt;4 mo of age</td>
</tr>
<tr>
<td>Patient Health Questionnaire-9 A</td>
<td>All visits/11 y and older</td>
</tr>
<tr>
<td>Psychosocial Determinants of Health (clinic developed screener)</td>
<td>All well-child visits/all ages</td>
</tr>
</tbody>
</table>
Identification of needs before visits (e.g., family calls to schedule an appointment because of a concern or life event) or

Patient enrollment in prevention programs, such as HealthySteps, (a program targeting early childhood development and effective parenting in which well-child visits are conducted jointly with both medical trainees and psychologists with opportunities for home visitation, a warm line, and groups)

The flow of the integrated visits is flexible. Most commonly, the pediatric provider identifies a problem and then leaves the room to consult with the BHP. The BHP may then spend time with the family, discuss recommendations with the pediatrician, and wrap up with a visit together with the pediatric provider or separately. For example, a family that identifies concerns with infant sleep, feeding, or fussiness may have a preliminary conversation with the pediatric provider who then consults with the BHP and requests that the BHP go in to see the family. Alternatively, the BHP may join the pediatric provider as they assess and address development and concerns during a well-child visit or a visit that is targeted around a particular issue. A common example using this model is a family with concerns regarding their child’s ability to focus in school. There are also patient visits for which the pediatric provider and BHP decide together that the BHP does not need to see patients. A common example is a patient who is connected to mental health services in the community and is currently doing well. The various visit flows described earlier accommodate the patient’s needs while being targeted for the learners involved as described later.

DEVELOPMENTAL APPROACH TO LEARNERS

The integrated behavioral health services program was established within a teaching clinic to help trainees learn this model of care as they are developing their knowledge and attitudes of systems and their own identity as providers. Each discipline has specific foundational knowledge and a skill set to master as well as knowledge about their role within an integrated service model. The authors describe the developmental training model as it applies to each discipline. A common tenet across all disciplines is that training opportunities intensify as the trainees gain initial competencies in their respective fields. The assumption in this setting is that significant cross-disciplinary training is necessary to develop discipline-specific competencies for work in integrated care (Fig. 1).

Pediatric Residents and Others Training in Pediatrics

Pediatric trainees, beginning their outpatient work, are learning to manage and balance many goals, such as mastering the timing of outpatient care, practicing problem-focused care, combing targeted and open-ended questions, learning to make differential diagnoses, learning and applying normative developmental, implementing multiple practice guidelines, and learning to build alliances with children and families while also managing the other learning demands of pediatrics and the stress of intense training. Many are also learning about resources in a new community, institutional policies and procedures, and a new electronic health record system. The initial introduction to the behavioral health team of providers combines structured introduction, didactics, and natural opportunities for collaboration within the clinic. The goal is to meet trainees at their current capacity and gradually increase their work with the integrated BHP as their confidence and capacity increases.

The universal screening protocols are often the first opportunity for collaboration with the BHPs. For example, mothers of infants 4 months old or younger are given
the Edinburgh Postnatal Depression Scale. When following the clinic protocol, residents who find an elevated score of 10 or higher on the screener come to consult with BHP. Together, the BHP and pediatric resident investigate the elevated score, asking questions about caregiver well-being and the psychosocial circumstances that may contribute to distress during the early months of parenthood. In the course of discussing the case and explaining the role of the BHP, the residents learn about other areas and topics in which they could seek behavioral health consultation from the team. Pediatric residents are supported and encouraged to get assistance from the behavioral health team for concerns around psychosocial stress, family circumstances, developmental issues (eg, feeding, sleeping, daily routines, fussiness), and mental health issues. They learn to seek help in evaluating the need for an external behavioral health referral versus providing ongoing routine support from within primary care.

As the pediatric trainees gain confidence in their role and understand the potential collaboration with the BHP, they tend to use the opportunity to work with their BHP colleagues more frequently. During the collaborative visits with behavioral health team members, including psychiatry, for problems, such as attention-deficit/hyperactivity disorder (ADHD), the BHP may lead the visit until pediatric trainees gain the necessary knowledge and skills to lead these visits on their own. Often this is a gradual process that occurs over multiple collaborative cases, whereby the BHP is available to step in at any time during the visit.

In addition to continuity clinic, residents rotate through ambulatory pediatrics for 1-month core blocks. During these blocks, there is a 1-month didactic series that includes training the residents on topics such as depression, anxiety, pregnancy-related mood and anxiety disorders, and motivational interviewing. The behavioral health team leads these didactics. During the ambulatory month, pediatric residents also receive a 3-hour presentation on general development and parenting. During this training opportunity, members of the behavioral team review general development and use specific case examples to support the residents in their conceptualization and approach to manage very common early childhood concerns that often present in the context of pediatric primary care (eg, weaning a child from a pacifier, sleep concerns, toilet training, or typical toddler tantrums). The goal of this training opportunity is

Fig. 1. Training level and educational intervention.
Second- and third-year pediatric residents have a weekly appointment slot in their continuity clinic schedules saved for behavioral health appointments. The training team deliberately chose the second and third year because it was thought that the knowledge and skills gained in the first year increase the comfort and potential learning from these visits in the second year. These appointments, conducted together with a child and adolescent psychiatrist, provide residents with the opportunity to assess, treat, manage, follow, and triage children and adolescents with pediatric behavioral health needs. Initially, child and adolescent psychiatrists lead these appointments, teaching the pediatric residents how to assess, identify, and manage behavioral health concerns that are commonly seen in primary care (eg, ADHD, depression, anxiety, stress reactions). Although these behavioral health issues are routinely seen and managed in primary care, residents are less familiar and often think they are not equipped to independently manage them. The experience of comanaging these cases with psychiatrists during their primary care training is intended to support pediatric residents’ capacity to provide care when appropriate and triage to community-based mental health services if needed. By the end of their third year, pediatric residents demonstrate the knowledge, skills, and comfort to appropriately manage these cases.

Building on the routine primary care training, second-year residents rotate through the Breastfeeding Management Clinic with the Trifecta Model8 whereby the psychologist meets with families who are struggling in the first month postpartum with breastfeeding, caregiver well-being, and other stressors. The clinic uses an integrated model of care with a team comprised of a pediatrician certified in lactation, a lactation nurse, and a psychologist. Behavioral health and caregiver well-being play a central role in addressing breastfeeding from a family centered perspective. The first month of life is an adjustment period for parents on many levels; when feeding is not going well, it creates a crisis situation. Even in the most supportive environments, 80% of mothers report breastfeeding difficulties.9 The authors’ Trifecta team is a model multidisciplinary threesome whereby medicine, mechanics of lactation support, as well as behavioral health consultation work well together. It is critical early in training for clinicians to see that when care is integrated it is best for both patients and for team members. Third-year residents have career-focused education elective time and can elect to spend some of this time with psychiatry and psychology as they work in integrated care. Based on pediatric residents’ interests and gaps in training (eg, not having rotated in the authors’ clinic), they are able to select topic areas on which to focus and shadow cases related to those topics. Providers who are planning on a career in primary care most often choose this additional training to deepen their knowledge.

Other trainees, such as family medicine residents, medical and PA students, join the pediatric residents during a core month of pediatrics as part of their training. All trainees work alongside one another in an assigned pod for the month and participate in the ambulatory didactic series. As their experience occurs within a fully integrated clinic, they are also exposed to the BHPs during the course of their work and may interact with the BHPs while administering universal screening protocols, enrolling HealthySteps families, or during behavioral consults (Box 1).

**Psychologists**

Psychology trainees at all levels (extern, intern, and postdoctoral) are trained to be members of an integrated behavioral health team. Depending on the trainees’ prior experience working in pediatric health settings, trainees experience a graduated
First, they orient to working in primary care with multidisciplinary health professionals as their care-team partners. Next, they learn how to apply their behavioral health skills and tools to a fast-paced medical setting where they often see families for less time and with less frequency than is typical for outpatient behavioral health practice. Under the supervision of primary care psychologists, psychology trainees develop tools and practices that enable them to successfully support families and primary care providers in addressing a wide array of mental health, behavioral, and developmental issues. Finally, more advanced psychology trainees are able to cultivate individualized training plans that allow them to focus on populations of interest (e.g., early childhood, children with special health care needs) and develop scholarship projects that complement their clinical interests.

Psychology externs are advanced doctoral students, typically in their fourth or fifth year of doctoral programs in psychology. In order to work in the primary care setting, they must have completed a year of general pediatric psychology outpatient care at the hospital. The externship experience is usually their first in primary care working on multidisciplinary teams that include pediatric health professionals. Psychology externs are oriented to the primary care model through shadowing experiences and weekly supervision. They shadow both primary care providers and BHPs in order to learn the integrated model of care. Their caseloads are generally lower than other behavioral health trainees; they work closely with the supervising psychologists in managing cases, making recommendations, and providing consultation to primary care providers. Externs are expected to deliver 2 didactic trainings for pediatric health trainees over the course of their 12-month externship.

Psychology interns, who have completed their doctoral studies in psychology, spend a year doing intensive clinical training. Interns in the primary care track spend 50% of their time providing behavioral health services in primary care, working in the general pediatric clinic and in the adolescent parents’ clinic. These trainees come to the internship with a wide range of pediatric psychology experience. Many have previously worked either in primary care settings or in other pediatric health settings where they gained experience collaborating with medical professionals and interdisciplinary teams. If they are new to primary care, they are oriented similarly to the externs, with opportunities to shadow primary care and BHPs. They also receive weekly individual supervision from 2 primary care psychologists, one generalist and one focused
on adolescent parents. Interns participate in education and training of pediatric health trainees by delivering between 4 and 6 didactics during their internship. Interns also engage in scholarship, typically selecting an aspect of integrated behavioral health services that is of particular interest to them, developing a project, and presenting their findings at local and national meetings.

Postdoctoral fellows have completed their doctoral degree, including a full year of clinical internship. Fellows in the authors’ setting are selected for a general integrated behavioral health or an early childhood fellowship with a focus on treating the needs of very young children (aged birth through 5 years of age) in primary care settings. Primary care offers a unique opportunity for psychology trainees to interact with and treat very young children because it is the most common setting in which infants and toddlers present. Fellows rotate through clinic for 1 year and are typically in clinic between 2 and 6 half days each week. During their time in clinic, these fellows collaborate closely with the medical providers (both residents and other medical trainees and attending physicians) to meet the behavioral health needs of children. In addition to providing direct clinical care as members of the integrated team, primary care fellows engage in scholarship (30% time), such as generating scholarly research projects and posters, and developing and delivering trainings in the clinic and community related to integrated behavioral health care and education (one half-day of didactics per week). Irving B. Harris fellows, postdoctoral BHPs engaged in a yearlong Infant Mental Health and Child Development fellowship assigned to the pediatric primary care setting, also spend one full day per week in didactic training where they gain in-depth knowledge about infant and early childhood mental health. Fellows receive weekly individual supervision from primary care psychologists and are mentored by these psychologists in scholarly activities.

In addition to providing early childhood behavioral health integration services, early childhood fellows also carry a caseload of families enrolled in the HealthySteps program. HealthySteps is an evidence-based early childhood integrated behavioral health model that is embedded in pediatric primary care settings. The Harris fellows work with the medical providers to identify families who would benefit from enrollment in the program and then meet with these families and the primary care provider at every well-child visit until the child is 3 years old. The goal of the model is to provide enhanced, comprehensive well-child care to children aged birth to 3 years and their families by promoting close relationships between health care professionals and parents in addressing the physical, emotional, and intellectual growth and development of young children. HealthySteps also includes home visitation services for enrolled families. One to 2 home visits are offered to each family each year. At clinic and home visits, the fellows are trained to support children and families by providing parents with information and tools to enhance their child’s health and development.

Postdoctoral fellows who are being trained in the primary care clinic are expected to engage in teaching and scholarship activities, including facilitating didactic trainings and presentations to medical providers, presenting original scholarship products such as posters and conference presentations locally and nationally, and coauthoring articles with faculty. Most research conducted by trainees is related to program evaluation and quality improvement efforts. Fellows also have the opportunity to cosupervise summer research interns, public health students, and medical students in their research activities.

The early child fellows receive extensive training on the HealthySteps model. In turn, the trainees and faculty that implement the HealthySteps program use the HealthySteps strategies to enhance the medical trainees’ training. Most commonly, well-child visits are conducted jointly with the medical trainees so that they can be present
for the discussions around enhancing early childhood development and infant mental health. Another strategy involves bringing medical trainees on home visits with families, which provides an opportunity to observe the child and family in their natural environment (Table 3).

**Child and Adolescent Psychiatrists**

CAP trainees have had at least 3 years of general psychiatry training when they enter CAP training. During their first year of CAP training, they move from a patient-centered, individualistic approach commonly used in work with adults to a more family-centered, systems-based approach for work with infants, young children, and adolescents. In order to address the mental health needs of youths, CAP trainees must master normative and atypical development, comprehensive assessment, formulation and differential diagnosis, tenets of therapeutic interventions, and psychopharmacology. Although they have mastered building a therapeutic alliance with adult patients, treating youths requires building and maintaining an alliance with youth and their caregivers. During the first year of CAP training, education regarding integrated care begins with integrated systems of care model didactics.

As CAP trainees begin the second year, they have built their knowledge and skills for working with children and families and are developmentally prepared for more intensive training regarding integrated care. CAP trainees who are interested in a career in integrated care spend a half day per week for 6 months to a year in the clinic described earlier. Competencies for this rotation include rapid triage and assessment of patients within a pediatric setting, effective use of a problem-based approach combined with return visits, collaboration and communication with other providers, encouragement of the patient-primary care relationship and skills to teach, and assess and provide feedback to pediatric trainees.

The rotation begins with shadowing other disciplines. CAP trainees shadow pediatric well-patient visits and visits whereby psychologists are collaborating with pediatric providers. They also shadow psychiatry faculty as they work with pediatric residents who are assessing and intervening regarding patient problems, such as ADHD. These later visits eventually reverse; the psychiatry faculty shadow the CAP trainees as they

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<th>Table 3</th>
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<td><strong>Psychology-integrated behavioral health experiences</strong></td>
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<tr>
<td><strong>Psychology Training Level</strong></td>
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</table>
| Psychology externs | Shadow multidisciplines  
Low case loads  
More direct supervision  
Weekly supervision  
Deliver 2 didactics to core trainees |
| Psychology interns | 50% Clinic time  
More cases, less direct supervision  
Weekly supervision  
Scholarship |
| Psychology postdoctoral fellows | 50% Direct patient care  
30% Scholarship time  
Weekly supervision/mentorship  
Either primary care or EC focus  
EC focus: HealthySteps plus EC didactics |

Abbreviation: EC, early childhood.
accompany, teach, assess, and give feedback to pediatric residents during patient visits. As the CAP trainee demonstrates competency, the CAP faculty do not shadow these visits but precept with the pediatric and psychiatry trainee.

**Data**

**Learners**

**Pediatric trainees**
- Two-thirds of pediatric trainees rotate through integrated continuity clinic.
- More than 180 pediatric trainees have had primary care in the integrated care clinic over 11 years.
- Thirty-five trainees have spent additional time with psychiatry/psychology.

The medical trainees who participate in home visits with HealthSteps are encouraged to reflect on the experience, including how it potentially altered the way they conceptualize and ultimately treat their patients. One trainee said the following immediately after a home visit with her patient and the HealthySteps provider: “I learned that I am not just here to provide information, but to also learn from the family about everything that is happening in their lives that will impact my patient’s health.”

**Psychology trainees**
- 6 externs
- 20 interns
- 30 fellows

**Child and adolescent trainees**
- Eighteen child and adolescent fellows have received didactics regarding integrated care models.
- Seven have completed the integrated experience in training.

As part of an upcoming graduate medical education self-study process, a survey of trainees found that the trainees unanimously support changing the second-year experience from an elective to a standard rotation. As of next year, all 6 CAP trainees in the second year will complete this training.

**Other trainees who have participated in research and evaluation efforts with the behavioral health team**
- Undergraduate research interns
- Medical students
- Public health students

**Trainees that have gone on to work in integrated care settings** Of the psychology trainees who worked in the authors’ integrated primary care setting, more than 20% found jobs in integrated behavioral health services in a pediatric setting. Moreover, several of them were recruited to leadership positions in academic medical centers and community agencies to develop and implement integrated behavioral health programs in primary care settings.

Twenty-five percent of CAP trainees who have completed this elective have chosen jobs whereby integrated care is a significant focus of their work.

**Scholarship** Trainees have access to large retrospective dataset collected from an electronic medical record system using clinical informatics. Many of the projects involve quantitative and qualitative data analysis whereby trainees are mentored to apply mixed-methods approaches to understanding the types of services provided, family circumstances, and health outcomes (Table 4).
Patient-related outcomes Screening rates in the clinic are typically greater than 80% once screening efforts are piloted and initiated. Developmental screening is conducted at all well-child visits between birth and 5 years of age. Ongoing quality improvement efforts have enabled us to monitor screening and referral outcomes and provide guidance and training in order to ensure that children who need services are able to access community-based programs. Similarly, the protocol for pregnancy-related depression screening ensures that women who score 10 or greater have access to behavioral health consultation as soon as concerns are identified. Previous studies have shown that nearly 90% of mothers were screened between the newborn and 4-month well-child visit and of those whose scores were elevated, 71% had contact with a BHP around the time of their visit providing early intervention and potentially averting costs associated with untreated depression.

There are currently 427 families enrolled in the HealthySteps program. The program is staffed by 1.0 full time equivalent (FTE) of postdoctoral fellow time and 1.0 FTE licensed psychologist time. On average, the HealthySteps providers enroll 18 new families each month and conduct an average of 82 collaborative HealthySteps visits per month.

New developments in integrated systems Residents and other trainees also benefit from different initiatives and implementation efforts. Population health approaches drive pediatric primary care practices to manage patients’ needs using a new empirical lens. Pediatricians are uniquely suited to engage in screening and identifying psychosocial risk factors that may affect health and wellness. However, primary care providers may not feel comfortable addressing psychosocial issues that emerge in the context of screening. In implementing psychosocial screening processes in the authors’ training clinic, they relied heavily on the integrated behavioral health team to develop, pilot, secure grant funding for additional resources, implement, and evaluate psychosocial screening efforts. In order to ensure that all pediatric and behavioral health professionals and trainees had the necessary comfort and requisite skills to engage in psychosocial screening processes, the authors developed a half-day training for all staff, faculty, and trainees. The authors also conducted lunch and launch sessions to facilitate implementation and share changes from the pilot phase. By participating in these efforts, the trainees have gained skills and experience in modifying systems of care.

<table>
<thead>
<tr>
<th>Table 4</th>
<th>Scholarship projects</th>
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<tbody>
<tr>
<td>Scholarship Type</td>
<td>Scholarship Topics</td>
</tr>
<tr>
<td>&gt;100 Presentations</td>
<td>Pregnancy-related mood disorders and child and family well-being</td>
</tr>
<tr>
<td>15 Publications</td>
<td>Screening implementation</td>
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<tr>
<td></td>
<td>Children with asthma</td>
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<td>Children with weight management problems</td>
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<td>Children born prematurely</td>
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<td>Children with developmental needs</td>
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<td>Behavioral health and social determinants</td>
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<td>Integrated behavioral health and cultural factors</td>
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<td></td>
<td>Development of risk and protective factor coding system from EMR</td>
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Abbreviation: EMR, electronic medical record.

Training Model for Integrated Behavioral Health
SUMMARY

There are many pressures driving the move toward integrated behavioral health within primary care. These pressures include workforce shortages of BHPs and difficulties with access to behavioral care, the growing science supporting the conceptualizing of health as a developmental process that begins early in life, and the move toward prevention and population-based care. Integrated behavioral health care within a teaching pediatric continuity clinic has helped to serve the needs of the community, including achieving excellent quality of care metrics, such as a high percentage of standardized screening. In addition, the clinic has been instrumental in preparing providers of multiple disciplines to competently work within integrated systems of care.

The professional development of learners likely impacts the acquisition of knowledge, yet is often not taken into account as teaching/training models of integrated care are developed. For example, learners early in their professional training are tasked with acquiring basic competencies of their discipline while also adjusting to the stressors of intense training. Exposure to the complex structure of integrated behavioral health care at this level of training could be overwhelming without scaffolding and support. However, early exposure may add the benefit of learning the strengths and challenges other disciplines face within integrated systems of care and help to establish an integrated frame of reference, before habits of practicing in silos of care have become ingrained. The authors offer a model of increasing depth of experiences and opportunities for learning as other competencies are mastered and recommend the scaffolding and structure change as providers gain knowledge and skills.

Future work in this area will benefit when each discipline provides consensus guidelines for competencies with respect to integrated care. Pediatrics has defined mental health competencies for pediatricians\(^1\) but has not defined specific competencies related to how to practice within an integrated setting. Psychology has proposed guidelines,\(^2\) but these are not specific to integrated settings for children and youth and, thus, are limited with respect to prevention and health promotion especially for children from birth to 5 years of age. CAP is in the process of developing guidelines and consensus. (See Wanjiku F.M. Njoroge and colleagues’s article, “Competencies and Training Guidelines for Behavioral Health Providers in Pediatric Primary Care,” in this issue.) Having consensus guidelines will help each discipline function within an integrated setting to enhance patient outcomes and help the work of practice or system transformation for practices/systems that are moving toward integrated care models. Consensus guidelines will also help training directors define and share best practices for educating trainees to meet competencies in providing integrated care.

Studies of both the economic and health benefits of integrated care and the educational outcomes of training within these systems will also help move this field forward. As population health management becomes a priority for the field, having integrated services to address the full continuum of prevention, health promotion and well-being, consultation, and intervention will be in even greater demand. Understanding the immediate costs and long-term health and economic benefits will be essential for building an argument to support sustainable integrated services in pediatric settings. Likewise, having information and data regarding competencies and success of graduating providers will help build support for training programs. Clinician educators need both sources of data to obtain and sustain funding for training within integrated care models.


REFERENCES


