Introduction
Approximately 5-7 million children with unmet mental health needs live in the United States. As the prevalence of mental health issues has increased, without sufficient growth in workforce capacity, primary care providers have increasingly been tasked with responsibility for management of illnesses they never planned to treat.

Background
Cambridge Health Alliance (CHA) in Massachusetts, has a longstanding commitment to vulnerable and diverse patients in the public sector, who are at greater risk for barriers to care. Cultural factors can introduce an additional layer of complexity in assisting children and their families with their mental health needs. The on-site pediatric - mental health C-L team helps bridge that gap.

Objective
The objective of this presentation is to introduce cases exemplifying different degrees of integrated care experienced by child and adolescent psychiatry fellows in their work in the Collaborative Practice Model at CHA and to further awareness of the process by which this model has been carried out.

Methods/Case Examples
- Using a “Collaborative Practice Model” CHA pediatrics, child psychiatrists, trainees, nurses, medical assistants and family support specialists provide families whose children have mental health needs the chance to be evaluated, and have treatment recommendations provided to them. In a highly coordinated fashion, onsite within their primary care clinic using actively integrated processes.
- Child psychiatry fellows “huddle” with the PCP before embarking on the evaluation, to gather background information as well as to understand the goals of the consultation.
- The C-L team is flexible with regard to seeing youth and caregivers in various individual or group combinations to gather different perspectives. After the evaluation, the team connects with the PCP again, to confer regarding development and communication of interventions (which are then jointly “owned” by the PCP and the integrated team.)

Evaluation Example (Level 2)
- Sixteen year old Trinidadian-American male
- CC: “disturbed concentration.”
- Sx: clarified by pediatrician to be atypical and without medical cause.
- Embedded child psychiatry consultation the next day in his regular pediatrics clinic.
- Guardians, response latency and, at times, frank thought blocking.
- Had begun sleeping in his mother’s bed
- Guarded, response latency and, at times, frank thought blocking.
- Referral was made for the Evaluation Example patient to follow-up with treatment in the Mental Health Clinic (MHC).
- The child psychiatry team was able to

Objectives
- Treatment of the patient and family’s needs.
- Identify children who may benefit.
- Use the C-L team to develop a treatment plan.
- The team connects with the PCP again, to confer regarding development and communication of interventions (which are then jointly “owned” by the PCP and the integrated team.)

Results/Conclusions

Discussion:
Further expansion of models such as this will narrow the divide between the physical and mental healthcare domains as physical and mental healthcare providers collaborate in real time to address and support the total care needs of each patient and family via shared practice.

System wide collaboration, including schools, child welfare, housing, among others, offer the opportunity to improve care by addressing social determinants of health.

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Bibliography

Collaborative Practice Model: Applications of AACAP Best Principles
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