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Integrated care for children: a shared training model

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What problem was addressed? Innovation in both training and practice is sorely needed to address the escalating prevalence of mental health needs among children and adolescents, noted by the Centre for Disease Control to be present among one in every five children in the USA, and recently identified as among the most frequent, and most expensive, conditions confronting paediatricians in general practice. At the same time, the role of social determinants of health, including adverse childhood experiences, is now widely recognised as a driver of health and mental health morbidity, generating calls to address disparities in access to and quality of child mental health treatment.

Emerging evidence exists that medical care provided by interdisciplinary, cross-specialty teams is more effective than routine care.[1] Our goal in piloting shared training for paediatric residents and child psychiatry fellows was to increase familiarity with the added value of integrated, team-based approaches in primary care, as well as proficiency in delivering services through a collaborative practice model.

What was tried? Building on health care reform initiatives within the USA and updated ACGME Milestones, we created an elective curriculum to promote competencies in integrated care. Child psychiatry fellows and paediatric residents, from separate institutions, participated, their training programmes having previously had no overlap. Our 'Collaborative Practice Training Model' placed paired trainees in a diverse, community-based, primary care clinic one afternoon a week for 6–9 months. The trainees were team-taught by child psychiatry and paediatric attending physicians from the faculty. In addition, a peer–peer family support specialist (FSS), joined the integrated team, helping to facilitate engagement and foster cultural sensitivity.

Within the paediatric continuity clinic, the paired trainees and the FSS participated in 'huddles' regarding children referred for mental health evaluation and others with potential needs for consultation. Child psychiatry fellows provided both 'curbside', and 'face-to-face' child and family consultations to their paediatric counterparts. On-site mentorship regarding clinical assessments, interdisciplinary collaboration and health policy, including the role of peer-to-peer parent support, was interwoven throughout the elective.

What lessons were learned? This pilot provided cross-training experiences for the trainees and gave faculty members a chance to develop a curriculum to promote skills in shared practice. A brief survey of trainees' attitudes towards providing integrated care allowed us to qualitatively explore whether early participation in collaborative practice by trainees could increase the likelihood of valuing integrated care and influence future career directions.

The greatest anticipated barriers, noted by both groups, included possible time, space and workload burdens. However, paediatric residents noted their workload actually was reduced through collaboration and child psychiatry fellows noted the added value of integrated care was so great that they would 'make time' for collaborative practice after training.

All respondents stated that cross-specialty training was useful, yielding 'greater understanding of the whole patient' and mutual appreciation of each other's skill sets. Trainees enjoyed working across specialties and observed that richer patient histories and broader ownership of the treatment plan were obtained via the integrated care team approach. This pilot demonstrates the feasibility of implementing small-scale training innovations that promote collaborative practice. The next challenge will be taking it to scale.

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