# Collaborative Practice Model: Applications of AACAP Best Principles

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## 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 onsite pediatric- mental health C-L team helps bridge that gap. Since 2012, through a demonstration project led by Drs. Grimes and Hagan, CHA has provided child psychiatry trainees and pediatric residents the chance to work together on integrated teams at the Windsor St. Health Center near Boston.

## Logic Model (K.Grimes, 2014)

**Collaborative Practice Model: Logic Model for System Change**

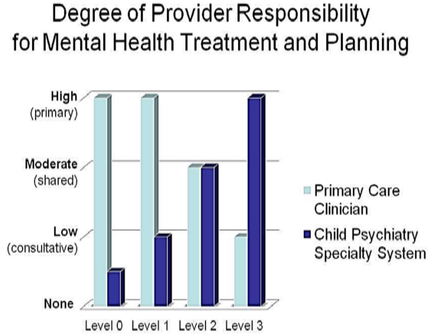
| Needs/ Opportunities | Interventions | | Outcomes | |
|---|---|---|---|---|
| Usual Care | Goals | Activities | Short-term | Long-term |
| •Delays in MH diagnosis and treatment in childhood | •Improve timeliness of MH care for children | •On-site access to MH specialty consultation<br>• Shared notes | •Improve clinic-based care coordination | •Reduce lifelong MH + medical morbidity within the population |
| •Linguistic and cultural barriers for families in need of care | •Improve communication, to and from, families | •Inclusion of Family Support Specialists on clinical team | •Patients accept MH consult onsite<br>•Fewer "no-shows" for evaluations | •Improved engagement with clinicians and care delivery |
| • Other challenges, such as transportation, missed work | •Improve health care access, minimizing travel, time and expense | •Integrated peds/ MH clinical visits for "curbside" consults; follow-up | •More input for clinicians; individualized treatment | •Increased adherence<br>•Greater efficiency |
| •High rate of discontinued MH care; "dropping-out" of treatment | •Improve MH monitoring and follow-up by integrated team | •Parent outreach and support<br>•Coordination among providers | •Improved rates of treatment completion; "Shared practice" | •Improved clinical outcomes and reduced expense in Peds and MH |
| •Fragmented care, within and across MH and Peds; low quality | •Multiple, reinforcing MH-Peds integration opportunities | •Bi-weekly Peds+ MH team meetings/access to informal consultation | •Changing clinician culture and practice<br>•Expectation of collaborative care | •System-wide health care transformation |

## 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 pediatricians, 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 recommendations (which are then jointly "owned" by the PCP and the integrated team.)




(AACAP, 2012)

**"Curbside" Example (Level 1)**

- Five year old boy lives with single-parent mother.
- Family emigrated from Central America.
- Child is easily tearful and irritable, reactive with difficulty self-soothing.
- Pediatrician initially made formal referral for child psychiatry evaluation.
- Parent could not miss work so getting the boy in for an evaluation would be hard.
-The case was discussed with the team who felt direct referral for individual therapy was appropriate.
-The child psychiatry team was able to locate a community therapist whose cultural, language and scheduling availability would match the patient and family's needs.

**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.
- Guarded, response latency and, at times, frank thought blocking.
- Had begun sleeping in his mother's bed
- Mother reported increased social isolation, internal preoccupation, and increased difficulty keeping up in school.
- "Under the radar" per school.
- No violence, or danger to self, still attending to ADLs.
-Resistant to referral but willing to follow-up in the primary care clinic.

**Treatment Example (Level 2 becomes Level 3)**

-Referral was made for the Evaluation Example patient to follow-up with treatment in the child outpatient psychiatry clinic.
-Child fellow on the integrated care team had space in outpatient clinic setting.
-Integrated care follow-up in the pediatrics clinic supported the patient feeling comfortable, despite his ongoing paranoia, with treatment in a mental health clinic (MHC).
- Subsequent visits in the mental health clinic led to further clarification of paranoid ideation but patient resistant to starting a medication trial.
- After close monitoring by the child fellow over several months in the MHC, the patient appeared relatively symptom free and had developed treatment plan if symptoms returned.

## Results/Conclusions

**Table 1**
**Demographic Distribution of Children Seen by Integrated Care Team**

| Primary Language | | Gender | |
|---|---|---|---|
| English | 56% | Male | 66% |
| Haitian Creole | 3% | Female | 34% |
| Spanish | 41% | | |
| | | | |
| **Race/Ethnicity** | | **Age** | |
| White | 3% | 4-5yo | 6% |
| Hispanic | 63% | 6-12 yo | 41% |
| Black | 25% | 13-15yo | 12% |
| Other | 9% | 16-19yo | 41% |

**Patient demographics** above show nearly half of the patients served speak a primary language other than English.
- Eighty-eight percent of patients seen are children of color.
**Impact of the model on care processes**: The examples highlight the model in its various applications.
- As the "Curbside" Example showed, sometimes the most effective intervention may be a systemic one instead of another individual evaluation.
-As the Evaluation Example demonstrates, the collaboration of the primary care clinician to the mental health clinician can reach patients that may otherwise face treatment access barriers.
**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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