Integrating Behavioral Health and Pediatric Primary Care

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UCSF Center for Excellence in Primary Care and the Center for Care Innovations
Who are we?
Facilitating Care Integration

Nearly half of adults with health issues report problems with the coordination of their care in the United States. As Community Health Centers (CHCs) and other safety net settings transform into Patient-Centered Medical Homes, their role in the larger medical neighborhood will become pronounced. However, challenges with care coordination are magnified in the safety net setting and continue to be increasingly complex.

In 2014, the UCSF Center for Excellence in Primary Care, with funding from the Blue Shield of California Foundation, completed a comprehensive literature review outlining strategies CHCs use to integrate into the medical neighborhood in the domains of primary care-specialty care, primary care-diagnostic imaging, primary care-pharmacy, primary care-oral health and primary care-hospital care. A conceptual model which was used to classify innovations and strategies for integration can be found in the full report here.

The UCSF Center for Excellence in Primary Care has partnered with the Center for Care Innovations to develop this online resource center. The purpose of this Care Integration site is to disseminate...
Financial Disclosures

- Dr. Talmi has no relevant financial relationship with any commercial interests.
Objectives

• Identify opportunities for delivering integrated behavioral health services in pediatric primary care settings and discuss common barriers and challenges.

• Describe the development of a model of integrated behavioral health services designed to address mental health, behavior and development in a pediatric residency training clinic.
Why primary care?

- 121,000,000 visits (< 15 years old)
- 64,000,000 visits (< 4 years old)
- Type of insurance
  - 60% private insurance
- Routine infant/child well-child check
  - **34,000,000 visits/year***
- Reasons for visit
  - Well-child checks (routine, health supervision)
  - Sick visits (acute)
  - Treatment of chronic conditions

* 11 recommended visits in the first 4 years (7 in the first year)
Access Issues

• Access to a medical home is a challenge, especially for children with public insurance

• Access to *mental health* services for children is even more problematic

• Access typically afforded when problem becomes very impairing or approaches serious emotional disturbance

• Psychiatric interventions are less successful for more impaired children
Why focus on behavioral health services?

Figure 1. Expenditures for the five most costly conditions in children, 2011

- Mental disorders: $13.8 billion
- Asthma/COPD: $11.8 billion
- Trauma: $6.8 billion
- Acute bronchitis and URI: $3.3 billion
- Other media: $3.2 billion

Source: Center for Financing, Access, and Cost Trends, AHRQ, Household Component of the Medical Expenditure Panel Survey, 2011
Why address mental and behavioral health in primary care?

- More than 20% of children and adolescents have a diagnosable mental health problem
- Only 20% of those receive adequate treatment
- Access to medical services for children with public insurance (e.g., Medicaid) is difficult
How many pediatric patients/families are we really talking about?

- 15 – 25% of pediatric patients have significant psychopathology, high functional impairment, psychiatric comorbidity (Connor et al., 2006)
- 18% meet full criteria and 14% subthreshold (Briggs-Gowan et al., 2003)
- Only 17.7% of parents reporting elevated behavior problems in children actually told their providers about it (Ellingson et al., 2004)
AAP Bright Futures

- Developmentally based approach to address children’s health in the context of family and community
- New edition 2008 emphasizes mental health screening more e.g. one month visit, 2 ½ year visit
- Importance of training all levels of trainees the mix of what can and can be dealt with in office setting
Expectations in Primary Care

- Guidelines for Health Supervision
- Standard Pediatric Residency Training
- Bright Futures
- Family needs and concerns
- Physical and emotional health
- What makes a difference?
- What can realistically get addressed?
What are the behavioral and mental health issues that emerge in pediatric primary care?

- Developmental delays/disabilities & risk for delays
- Functional impairment
- Psychosocial risk factors/stressors
- School difficulties
- Congenital anomalies/syndromes
- Mental health disorders
- Trauma, grief, loss including abuse/neglect
- Parent concerns – is this normal? When will it stop? Can we do something about it?
Project CLIMB: Consultation Liaison in Mental Health and Behavior

INTEGRATING BEHAVIORAL HEALTH INTO PEDIATRIC PRIMARY CARE
Generously Funded By:
with special thanks to Children’s Hospital Colorado Foundation and Kathy Crawley and Jennie Dawe

- American Academy of Child and Adolescent Psychiatry
  - Access Initiative Grant
- Rose Community Foundation:
  - Access to Mental Health Services
  - CLIMB to Community
- The Colorado Health Foundation
  - Pediatric Resident Education
- Caring for Colorado
- Walton Family Foundation
  - CLIMB to Community
- Liberty Mutual
- Denver Post Season to Share
Child Health Clinic

• Children’s Hospital Colorado
• Large Urban Primary Care Teaching Clinic
• Low income = >90% Medicaid/SCHIP
• 29,000 visits per year
• 60% of visits for zero to 3 years
• 56% Hispanic, 40% Spanish Primary Language
• Pod based clinic design
• Dissemination to community based clinics
Our Team

Administration:
- Maya Bunik, MD, MSPH
- Kelly Galloway, RN
- Ayelet Talmi, PhD

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- Michelle Mills, MD
- Amy Nash, MD
- Rupa Narra, MD
- Nicole Schlesinger, MD
- Teri Schreiner, MD
- Heather Wade, MD

And many more...


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Research Interns: Hamid Hadi, Traci Lien, MD, Iman Mohamed, Cody Murphy, BA, Molly Nowles, BA, Shagun Pawar, BA, Nick Pesavento, Clare Rudman, Danica Taylor, BA, Jen Trout, BA, Zeke Volkert, MD, Tyler Weigang, MPH
CLIMB...how we started

- Partnership of Psychiatry and Pediatrics
- Initial Health Foundation funding

Started with:

- Developmental screening (>85% rates)
- Added pregnancy-related depression screening
- Built foundation of collaboration and co-management of two disciplines
- Planned for sustainability with funds from ASQ & Dept of Peds making it whole
Initial challenges: Administrative issues and implementation/process details

- Assemble an oversight committee
- Identify and create SPACE for the program
- Publicize and promote to Faculty, Residents, Staff, Students, Community providers
- Change management theory
- Description of responsibilities e.g. screening tools distributed and collected
- Create a patient database
- Coordinate visits and materials with appointment and check-in staff
- Renegotiate procedures based on trying things out
- Who “owns” the program? Who supports the program? Who pays for the program?
MARY NAVIN, RN
AMBULATORY PRACTICE ADMINISTRATOR
Getting started…

• Hanging around
• Being helpful
• Building relationships
• Meetings and more meetings
• Trying “something” out
• Calling that “something” a pilot
• Measuring change and impact – quality improvement
• Asking for feedback
• Using the feedback to make the program better
**Initial Challenges: Whose patient is it?**

**“My Patients”:**
- Unaware of behavioral health issues
- Belief that things will get better
- Belief that families will not go or benefit from MH services
- I don’t want to own this
- Don’t ask, don’t tell

**“Our Patients”:**
- Aware of behavioral health issues
- Belief that MH will help things get better
- Families will go if someone here in the office can see them
- We own this together

**“Your Patients”:**
- Aware of behavioral health issues
- Belief that MH will help things get better
- Families will go if someone here in the office can see them
- I don’t want to own this
Program and Services

- Developmental Screening Initiative (Child)
- Pregnancy related depression (PRD) screening (Caregiver, Child, Family)
- Healthy Steps for Young Children & MIECHV (Child, Caregiver, Family)
- Baby & Me at the CHC (Child, Caregiver, Family)
- Case-based consultation (Child, Caregiver, Family)
- Care coordination, triage, and referral (Child, Caregiver, Family)
- Psychopharmacology consultations (Child)
- Counseling and brief therapy services (Child, Caregiver, Family)
- CLIMB to Community pilot (Child, Caregiver, Family)
- Training and education (Providers/Health Professionals)
  - Formal didactics
  - Precepting trainees
  - Collaborative care
* Mothers of patients birth to 4 months were screened for pregnancy-related depression
Developmental Screening and Closing the Referral Loop

Figure 1. Early Intervention Referrals for Abnormal Screening Results: Completed Evaluations and PCP Documentation

Talmi A, Bunik M Pediatrics 2014
ASQ and EI Findings

• Developmental screening and referral is necessary but not sufficient.
• Success of developmental screening process depends on enhancing referral completion.
• An intervention providing phone follow-up and assistance with referral yielded higher rates of referral and greater provider knowledge of referral outcomes.

Talmi A, Bunik M Pediatrics 2014
CORNET Study: Collaborative Care Levels

- **Exclusive Referral:** mental health/behavioral care is referred out to local resources

- **Traditional Care:** mental health/behavioral care is provided by the pediatrician based on the provider’s comfort level and available resources; i.e., some conditions treated and more complex conditions referred to local resources

- **Phone Consultation Model:** pediatric behavioral/mental health specialist is available for phone consultation during the visit, which provides guidance in evaluation and triage of these issues.

- **Enhanced Care:** pediatric behavioral/mental health specialist has an office in the pediatric clinic setting that allows for easy referral, but requires a return visit to see the specialist

- **Integrated / Collaborative Care** Co-location of developmental, behavioral, and mental health consultants, or direct service providers available for consultation at the time of identification by the pediatric provider without the need for a return visit
Pediatric Residency Survey In Mental Health in Primary Care

PRISM_PC

Enhanced 22%
Integrated 13%
Exclusive Referral 10%
Phone Consultation 2%
Traditional 53%

Bunik M et al. Acad Peds 2013
A Step in the Right Direction
Healthy Steps for Young Children (www.healthysteps.org)

- Provide enhanced developmental services in pediatric primary care settings;
- Focus on developing a close relationship between the clinician and the family in order to address the physical, socioemotional, and cognitive development of babies and young children;
- Currently used in 18 residency training programs nationally
- MIECHV funding to expand our program and develop new sites across Colorado
- Baby & Me at the CHC
- (Child, Caregiver, Family)
Content analysis of well-child visits, Healthy Steps vs. control (Buchholz & Talmi, 2012)

- Breast Feeding: 17% Healthy Steps, 70% control
  - Healthy Steps: 70%
  - Control: 17%
- Postpartum depression: 11% Healthy Steps, 48% control
  - Healthy Steps: 48%
  - Control: 11%
- How parent is feeling: 6% Healthy Steps, 75% control
  - Healthy Steps: 75%
  - Control: 6%
- Child Care: 3% Healthy Steps, 23% control
  - Healthy Steps: 23%
  - Control: 3%
- Home Safety: 56% Healthy Steps, 90% control
  - Healthy Steps: 90%
  - Control: 56%
- Temperament: 0% Healthy Steps, 28% control
  - Healthy Steps: 28%
  - Control: 0%
- Promoting healthy eating: 6% Healthy Steps, 28% control
  - Healthy Steps: 28%
  - Control: 6%
- Sleep: 28% Healthy Steps, 63% control
  - Healthy Steps: 63%
  - Control: 28%
- Daytime/Nighttime routines: 0% Healthy Steps, 35% control
  - Healthy Steps: 35%
  - Control: 0%
- Importance of Play: 3% Healthy Steps, 33% control
  - Healthy Steps: 33%
  - Control: 3%
- Social Skills: 3% Healthy Steps, 38% control
  - Healthy Steps: 38%
  - Control: 3%
- Language Development: 8% Healthy Steps, 35% control
  - Healthy Steps: 35%
  - Control: 8%

* ≤ 0.03
** ≤ 0.01
Baby & Me at the CHC
Pregnancy-Related Depression

- Formal screening at well-child visits from birth to four months using *Edinburgh Postnatal Depression Scale* (Cox et al., 1987)

- Primary care services
  - Training for providers
  - Psychoeducation
  - Support to mothers
  - Referral
  - Electronic medical record

- System changes
  - Capacity building

- (Caregiver, Child, Family)
And How are You Doing?

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - As much as I always could
   - Not quite so much now
   - Definitely not so much now
   - Not at all

2. I have looked forward with enjoyment to things
   - As much as I ever did
   - Rather less than I used to
   - Definitely less than I used to
   - Hardly at all

3. I have blamed myself unnecessarily when things went wrong
   - Yes, most of the time
   - Yes, some of the time
   - Not very often
   - No, never

4. I have been anxious or worried for no good reason
   - No, not at all
   - Hardly ever
   - Yes, sometimes
   - Yes, very often

5. I have felt scared or panicky for no very good reason
   - Yes, quite a lot
   - Yes, sometimes
   - No, not much
   - No, not at all

6. Things have been getting on top of me
   - Yes, most of the time I haven’t been able to cope at all
   - Yes, sometimes I haven’t been coping as well as usual
   - No, most of the time I have coped quite well
   - No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping
   - Yes, most of the time
   - Yes, sometimes
   - Not very often
   - No, not at all

8. I have felt sad or miserable
   - Yes, most of the time
   - Yes, quite often
   - Not very often
   - No, not at all

9. I have been so unhappy that I have been crying
   - Yes, most of the time
   - Yes, quite often
   - Only occasionally
   - No, never

10. The thought of harming myself has occurred to me
    - Yes, quite often
    - Sometimes
    - Hardly ever
    - Never
Pregnancy-Related Depressive Symptoms Guidance

For anyone who works with women of childbearing age or their children

**Background**

**Goals to reduce depressive:**
- Decrease risk factors
- Early identification
- Improve treatment

**Protective Factors**
- Balanced nutrition, physical activity and healthy sleep
- Family planning for an intended pregnancy
- Personal & household social and material support
- Parenting confidence

**Risk Factors**
- Personal history of major or postpartum depression
- Family history of postpartum depression
- Team pregnancy
- History of substance use or interpersonal violence
- Unplanned or unwanted pregnancy

**Pregnancy-related depressive symptoms can occur during pregnancy through one year postpartum**

- Anxiety symptoms common co-occur
- May include intrusive/irrational thoughts
- Mom may appear detached/hypervigilant
- Suicidal ideation may be present

**Baby Blues:** ~80% of women may experience

- Birth to 2 weeks postpartum
- Resolves in approx. 14 days
- Racial/ethnic minorities
- No suicidal ideation

**Starting the Conversation**

1. **Address Stigma**
   - “More women feel anxious or depressed during pregnancy or postpartum.”
   - “A woman deserves to feel well.”
   - “Many effective treatment options are available.”

2. **Explore Expectations**
   - Pregnancy and postpartum experiences and expectations vary.
   - “What are you thinking about being pregnant to a new mother?”
   - “What has surprised you about being pregnant/being a new mom?”
   - “What has it been like for you to take care of your baby?”
   - “What beliefs or practices related to pregnancy or soon after the baby is born are continuing/will continue to help?”

3. **Explore Social Support**

**Screening**

When implementing screening, consider other services & resources that may be needed:
- Medical providers to prescribe medication
- Mental health and specialty services
- A practice to address suicide risk

**When to Screen**
- Preconception & interconception
- Each trimester throughout pregnancy
- At postpartum visits
- Well-child visits up to 1 year postpartum

**Who Could Screen**
- Medical providers
- Mental health providers
- Community-based providers
- Early childhood practitioners

**What Brief Screening Tool to Start With**

Edinburgh-3 Brief Screen

<table>
<thead>
<tr>
<th>Edinburgh-3 Brief Screen in the past 7 days</th>
<th>Score: 14 should receive further screening and assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have blamed myself unnecessarily when things went wrong</td>
<td>Yes, most of the time (1)  Yes, some of the time (2) No, never (0)</td>
</tr>
<tr>
<td>I have felt that things had gone wrong</td>
<td>Yes, most of the time (1)  Yes, some of the time (2) No, never (0)</td>
</tr>
<tr>
<td>I have felt guilty or worthless for no good reason</td>
<td>Not at all (0)  A little (1)  Quite a bit (2)  Extremely (3)</td>
</tr>
<tr>
<td>I have felt scared or frightened for no good reason</td>
<td>Not at all (0)  A little (1)  Quite a bit (2)  Extremely (3)</td>
</tr>
<tr>
<td>I have felt down or sad</td>
<td>Not at all (0)  A little (1)  Quite a bit (2)  Extremely (3)</td>
</tr>
<tr>
<td>I have felt that I am not good enough or not as much (1)  No, not at all (0)</td>
<td></td>
</tr>
</tbody>
</table>

Total score x 10/3 = screen score

Refer women with depressive symptoms to a medical or mental health provider for further assessment.
A FAMILY’S EXPERIENCE
Integrated Care and Teaching

• UC Pediatrics Training Program –
  ▪ Hospital-Based and Specialty Focused
• Appeal to a wide range and number of trainees—
  ▪ 42 pediatric residents for continuity clinic,
  ▪ 36 pediatric residents for general clinic,
  ▪ 24 family medicine,
  ▪ 24 medical students,
  ▪ 24 physician assistant students per year
• Teach importance of screening tools as they go out into practice (PPD- EPDS, ASQ- Dev & SE, Vanderbilt’s, IEP reports, etc.)
• Behavior and developmental issues are difficult to teach but the ‘right here, right now’ approach of this integrated system works for learning and for our families’ seeing a busy teaching clinic as their medical home
Training Example 1: The 1-2 week visit

“Many new caregivers feel overwhelmed by caring for an infant. How are you doing?”

Some mothers actually get pretty anxious or depressed after they have delivered their baby.

We’re asking all mothers of infants under 4 months of age to answer these 10 questions.

Could you fill this out?
How to respond?

Actually, my boyfriend is not very supportive and doesn’t really want to have this baby!

Well, he is just a bum isn’t he!
That sounds pretty difficult. Are there others who are supportive of you? Would you like to meet other women who are looking for support as well? Can I see you back here in the clinic soon?
JACINTA COOPER, MD, PHD MEDICAL STUDENT (NOW CHIEF RESIDENT)
Ongoing challenges: Reimbursement and sustainability

- Health & Behavior Codes
- Psychiatric Consultation reimbursement
- Mental Health Carve-outs
- Developmental screening
- Long-term sustainability now with pediatric departmental support
- Grants and philanthropic support
- Advocacy and policy at the systems level
Dissemination: CLIMB to Community

• CLIMB to Community intends to implement and evaluate the sustainability of integrated behavioral health services in community-based pediatric primary care practices serving publicly insured children by disseminating the Project CLIMB model.

• Expansion of integrated behavioral health services will improve the health outcomes for publicly insured children ages 0-18 through increased access to behavioral health services.
<table>
<thead>
<tr>
<th>Themes Discussed with Patients and Families:</th>
<th>Pretest $M (SD)$</th>
<th>Posttest $M (SD)$</th>
<th>$t$</th>
<th>$df$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Talked with Parents About Spouse/Partner Support of Parenting Efforts - increased practice</td>
<td>1.63 (1.06)</td>
<td>2.17 (0.41)</td>
<td>-1.18*</td>
<td>.17</td>
</tr>
<tr>
<td>Talked with Patients About Adherence/Compliance Problems - increased practice</td>
<td>1.75 (1.17)</td>
<td>2.00 (0.63)</td>
<td>-0.47*</td>
<td>.26</td>
</tr>
<tr>
<td>Talked with Patients About Pregnancy-Related Depression - increased practice</td>
<td>0.88 (0.84)</td>
<td>1.00 (0.00)</td>
<td>-0.36**</td>
<td>.00</td>
</tr>
<tr>
<td><strong>Provider Beliefs &amp; Confidence About Health Supervision:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatricians should inquire about child social, emotional, and behavior development as part of anticipatory guidance - belief increased</td>
<td>4.50 (0.76)</td>
<td>5.00 (0.00)</td>
<td>-1.60**</td>
<td>.00</td>
</tr>
<tr>
<td><strong>Barriers to Providing Services in Specific Areas:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time Limitations as Barrier for Providing Services for Family Psychosocial Problems - belief increased</td>
<td>4.14 (0.38)</td>
<td>4.50 (0.55)</td>
<td>-1.39*</td>
<td>.22</td>
</tr>
<tr>
<td>Lack of Non-Physician Office Staff to Perform Assessments as Barrier for Providing Services for Family Psychosocial Problems - belief increased</td>
<td>3.29 (1.13)</td>
<td>4.17 (0.41)</td>
<td>-1.83*</td>
<td>.17</td>
</tr>
<tr>
<td>Lack of Non-Physician Office Staff to Perform Assessments as Barrier for Providing Services for Child Social, Emotional, and Behavior Development - belief increased</td>
<td>3.00 (1.41)</td>
<td>3.67 (0.52)</td>
<td>-1.09*</td>
<td>.21</td>
</tr>
<tr>
<td>Lack of Non-Physician Office Staff to Perform Assessments as Barrier for Providing Services for Emotional Disturbance in Caregivers - belief increased</td>
<td>3.43 (1.27)</td>
<td>4.17 (0.41)</td>
<td>-1.36**</td>
<td>.17</td>
</tr>
<tr>
<td><strong>Barriers to Making a Referral in Specific Areas:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Lack of Culturally Sensitive Services as Barrier to Referral for Child Social, Emotional, and Behavior Development - belief increased</td>
<td>3.00 (0.82)</td>
<td>3.17 (1.72)</td>
<td>-0.23*</td>
<td>.70</td>
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<tr>
<td>Not Enough Time to Find Referrals as Barrier for Making a Referral for Problems with Development - belief increased</td>
<td>2.71 (0.95)</td>
<td>3.33 (1.51)</td>
<td>-0.90*</td>
<td>.62</td>
</tr>
</tbody>
</table>

*p < .05, **p < .01; Note: Only significant results presented.
Systems Issues

- Maternal Infant Early Childhood Home Visitation (MIECHV) federal funding
- State Innovations Model (SIM) - $65M
- Office of Early Childhood
- Regional Care Collaboratives
- Behavioral Health Organizations
What we learned along the way

Challenges

• Design a service that uniquely meets needs
• Attend to implementation and process details
• Train in the model
• Whose patient is it?
• Long-term sustainability

Lessons

• Build relationships, meet often, engage stakeholders
• Set up systems that allow for ongoing evaluation, QI, and scholarship
• Practice change requires practice
• Develop protocols together
• Pilot, partner, and proactively seek funding
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