Chapter 9
Integrating Child Psychiatric Care

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Abstract Families bring concerns about behavioral health in their children to their pediatric primary care providers. New models of primary care are integrating behavioral health screening, assessment, monitoring, and treatment into office practice. The Pediatric Medical Home is such a model utilizing care coordination to ensure attention to the whole child. Resources created by the American Academy of Pediatrics and the American Academy of Child and Adolescent Psychiatry are available to support this practice transformation. A variety of integration models are described including co-location of behavioral health professionals and video and telephone consultations. Barriers, including reimbursement issues, training needs, space considerations, and family and medical team comfort, all will need to be addressed to make integrated care a reality. The Affordable Care Act with its support for accountable care organizations may help build integrated pediatric care and support the pediatric medical home as the location of both medical and behavioral health care for children and families.

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Background

Working Definition of Integration

In the context of child psychiatry in primary care, integration represents the capability of the pediatric primary care practice to address the behavioral health needs of children in the primary care setting. Integration may occur:

At the *provider* level: That is, a primary care provider who has sought and developed advanced expertise in child psychiatry and utilizes this expertise within his/her general practice.

At the *practice* level: That is, the practice has children's behavioral health experts working as part of the primary care team. These experts may or may not be physically present in the primary care office.

Non-integration represents a lack of such capability of the practice, such that the child and family are told that behavioral health problems lie outside of the direct scope of responsibility of the practice. When behavioral health problems are either inadvertently detected or presented by families, the patients are told to seek help elsewhere.

Notwithstanding a long-standing Western philosophical tradition of attempting to separate the mind from the body, there is increasing recognition that the behavioral health and overall health of children cannot be clearly distinguished from one another. The high volumes of behavioral health concerns brought to the attention of pediatric primary care providers reflect broad societal acceptance of this principle. Nonetheless, our pediatric health care system has taken longer to come to grips with this. Many, if not most, pediatric primary care providers lack adequate training and resources and feel ill prepared to provide appropriate attention to the behavioral health needs of their patients [1].

There are many lines of evidence demonstrating the relationship between child and adolescent behavioral health problems and overall health. For example, early childhood trauma has been demonstrated to have observable effects on the developing brain, and early childhood exposure to adverse life experiences has been shown to be associated with significant chronic physical health problems in adulthood [2, 3]. This understanding of extreme psychological stress as a "toxic" influence on the nervous system and the body has been embraced as a fundamental public health principle. Accordingly, pediatric primary care providers are tasked with identifying children who are subject to severe psychosocial stressors and ensuring that they receive appropriate psychosocial and psychiatric services to mitigate their effects [4].

Integrating child psychiatry services within pediatric primary care is frequently understood to be a solution to an access-to-care problem. Approximately one in five children suffers from behavioral health problems severe enough to cause significant impairment in functioning [5]. These needs, unmet by other community resources such as schools and community behavioral health services, present in the pediatric setting. Pediatric primary care providers find themselves unable to simply serve as

a clearinghouse, handing these patients off to children's behavioral health providers. Workforce shortages of child and adolescent psychiatrists are well documented across the United States [6], and referrals to child psychiatry services from pediatric settings frequently prove unsuccessful [7]. As a result, pediatricians are coming to the realization that they need child psychiatric resources and expertise that are truly connected to their practices helping them to meet the needs of these patients.

In addition to those children who have known behavioral health needs, there are many children whose behavioral health issues go unrecognized [8]. The vast majority of young children in the United States are seen by a pediatric primary care provider who is in a position to detect the presence of a behavioral health problem at an early stage, prior to the development of significant deviation in development and functioning. However, it has been clearly demonstrated that in the absence of systematic strategies to identify these children, the majority of behavioral health needs are not detected [9]. Universal screening of children in the primary care setting beginning in early childhood for behavioral health problems has been recommended [10]. In order for such screening in the primary care setting to be effective and sustainable, practices need the capability to follow up on positive findings. For example, positive responses on questionnaires call for further inquiry to determine clinical significance, and identified behavioral health needs call for further assessment and intervention planning. For these functions, the practice needs the expertise of child psychiatrists and other children's behavioral health professionals readily available if not integrated within the practice.

Actually, the concept of child and adolescent psychiatrists working closely with pediatricians is not new. Child psychiatry emerged as a distinct medical specialty in the 1950s at the intersection of pediatrics, developmental neurology, psychiatry, and social sciences. However, the profession's origins are in the child guidance clinic movement beginning in the early twentieth century [11]. In child guidance clinics, child and adolescent psychiatrist precursors were more aligned with human service and juvenile justice professionals than with their medical colleagues in pediatrics. To this day, child psychiatric services are provided in systems that are quite separated from the system of general health care services. As a result of this separation, ordinary transactions of referral and correspondence routinely occurring between pediatric primary care providers and regular pediatric subspecialists do not easily occur with child psychiatrists. In recent decades, this separation has been reinforced by separation in financing through the negotiation of behavioral health "carve-out" contracts by managed behavioral health organizations.

Fortunately, there is growing acceptance among policy makers, advocates, and stakeholders that child psychiatric services are a vital component of high-value pediatric primary care delivery. The patient-centered medical home model of pediatric primary care emphasizes principles such as accessibility, coordination, continuity of care, comprehensiveness, and cultural competence in addressing special health care needs of children. As behavioral health problems are among the most prevalent and costly of children's special health care needs, patient-centered medical homes will require tightly integrated child psychiatric resources in order to successfully implement this model. Accordingly, both the American Academy of Child and Adolescent Psychiatry and the American Academy of Pediatrics have been working to promote the collaboration and integration of behavioral health and primary care [12, 13].

Where We Are Now

Readiness of Health Care Professionals

The American Academy of Pediatrics has made children's behavioral health a strategic priority for the last decade. The publication by the AAP in 2002 of "Bright Futures in Practice: Mental Health" [14] strongly established behavioral health promotion as a fundamental aspect of pediatric primary care. Later, the organization's Children's Mental Health Task Force developed additional resources advancing and supporting the provision of behavioral health care in pediatric practice. The AAP Policy Statement "The Future of Pediatrics: Mental Health Competencies for Pediatric Primary Care" [15] published in 2009 specifically identified pediatricians as responsible for addressing the highly prevalent behavioral health needs of children and called on pediatricians to build collaborative relationships with behavioral health specialists.

Concurrently, the American Academy of Child and Adolescent Psychiatry (AACAP) has been working to advance the practice of collaboration with pediatric primary care within its membership. Members of this organization have partnered with AAP in all of their children's behavioral health initiatives. AACAP published its own policy statement on collaboration with pediatric medical professionals in 2008 [16] and later published a series of papers including a "Guide to building collaborative mental health partnerships in pediatric primary care" [17] and a set of "Best Principles for the Integration of Child Psychiatry into the Pediatric Health Home" [13]. This latter document proposed differential responsibilities and recommended collaborative practices for pediatric primary care providers and child and adolescent psychiatrists working together to meet the needs of children at four levels of progressive clinical complexity. At the lowest level of complexity, the pediatrician provides anticipatory guidance and routine behavioral health screening during well child care with the availability of a child psychiatrist for informal consultation regarding implementation of screening and interpretation of ambiguous clinical phenomena. The role of the child psychiatry specialist becomes more substantial at higher levels of patient complexity, moving to formal clinical consultation and assisting the pediatrician in treatment planning and monitoring. At the highest level of clinical complexity, the child psychiatry specialist assumes primary responsibility for the behavioral health treatment of patients with the pediatrician serving an advisory role regarding the impact of the psychiatric illness and its treatment on the patient's physical health.

There are also powerful economic forces driving pediatrics and child psychiatry together. There is no question that the accountable care organization (ACO) model of health care financing has been adopted as a dominant strategy for improving health care quality and containing health care costs in the United States. ACOs are groups or networks of health care providers financially accountable for achievement of quality outcome measures as well as the overall cost of care generated by a defined population of patients. The Patient Protection and Affordable Care Act

(ACA) signed into law in 2010 directed the Centers for Medicare and Medicaid Services to implement the Medicare Shared Savings Program that is based on an ACO financing model. The Act also called for the development of ACO models of Medicaid funding including pediatrics, and commercial insurance plans are similarly moving rapidly toward ACO contracting. The inherent strategy behind the ACO model is to provide a strong financial incentive to achieve positive individual and population health outcomes rather than the financial incentive to simply provide services. Strategies for achieving these outcomes include improved coordination of care, increased teamwork between primary care providers and specialists, early detection of disease, alternative payment methods, and a comprehensive patient-centered approach to primary care service delivery. Pediatric primary care providers are recognizing that partnering with child psychiatry specialists to provide timely access to behavioral health treatment in the primary care setting has the potential of ameliorating the course of psychiatric illness in future years and to improve physical health outcomes, thereby potentially improving the financial performance of their practice.

Models of Integration

Programmatic models for integrating child psychiatry within primary care have taken a variety of forms. By definition, all program implementations share the broad aims of enabling primary care delivery systems to address behavioral health needs of children and ensuring that behavioral health treatment is coordinated with physical health care. They differ however in their strategies and tactics to achieve these aims. The following two categories of integrated service delivery models have emerged across the United States: remote consultation models and co-located models. It should be noted that there is substantial variation within each and that hybrid models may have combined strategies from both.

Remote Consultation Model

Exemplified by the Massachusetts Child Psychiatry Access Project (MCPAP), remote consultation models provide collaborative behavioral health resources to primary care practices at a distance [18]. The MCPAP has six teams distributed across the entire state of Massachusetts offering the following services to enrolled pediatric primary care providers: (1) hotline access to indirect or "curbside" child psychiatry consultation, (2) expedited direct outpatient child psychiatry or psychological consultation, (3) telephone-based care coordination, and (4) educational resources. The reliable access to indirect and direct consultation services is designed to create a virtual presence of child psychiatry expertise for the primary care practice. Remote consultation models are proliferating across the United States, currently in various stages of development in 24 states.

Advantages

This type of service delivery model is especially suitable for population-based implementation across large regions. For example, MCPAP collaborates with over 1,200 pediatric primary care providers, covers 1.25 million children and adolescents, and provides over 20,000 encounters of service per year. Cost of the service is quite small on a per member per month basis; however, because the telephone consultation and care coordination are not ordinarily covered by insurance, the program is dependent upon dedicated public funding. The remote dedicated availability of the child psychiatrist allows the service to leverage the limited workforce of child psychiatrists across a large service area. The provision of consultation by child and adolescent psychiatrists along with allied children's behavioral health professionals allows for a comprehensive scope of practice including psychopharmacological questions and biological factors impacting behavioral health.

Limitations

The consultation model is inherently an on-demand system of delivery; therefore, the integration of behavioral health service is dependent upon the motivation of the pediatrician to engage with the service. This accounts for significant variability in the volume of behavioral health service delivery across practices. Lack of physical presence of child behavioral health professionals may be less preferable to pediatric primary care providers because it leaves them with more responsibility for direct assessment of children's behavioral health needs, a task which is relatively time consuming and for which they consider themselves inadequately prepared.

Co-located Model

In the present context, the term co-located describes a category of integrated behavioral health delivery, rather than the placement of a conventionally practicing behavioral health provider in a primary care space. Exemplified by the North Carolina's Primary Care-Children's Mental Health Initiative, in this model, one or more children's behavioral health professionals work within the pediatric primary care practice and practice as members of the primary care team. Licensed clinical social workers or psychologists, these providers deliver readily accessible informal consultation, clinical assessment, brief therapy, and case management. They may also help implement behavioral health screening protocols.

Advantages

Compared to remote consultation, this model provides more readily accessible assistance to the pediatric primary care clinician in the direct assessment of behavioral health needs and more opportunities for limited therapeutic services to be

offered within the primary care setting. The immediately available on-site behavioral health services are designed to improve accessibility to families, thereby reducing the likelihood of referral failures. Co-located behavioral health professionals are able to proactively engage with patients in the primary care setting, ensuring more consistent provision of behavioral health delivery within the practice and facilitating strategies for detection of behavioral health problems within the primary care panel.

Limitations

More personnel intensive and requiring additional space within the primary care setting, this model is not as readily scalable in comparison to remote consultation programs. In most regions of the United States, child and adolescent psychiatry workforce limitations preclude the generalized co-location of child and adolescent psychiatrists in primary care settings; therefore, these systems must come up with additional strategies to address questions regarding biomedical behavioral health factors. In the absence of these additional strategies, pediatric primary care providers may be left without adequate resources to guide the judicious use of psychiatric medications, to escalate care for patients not responding to initial treatments, or for complex patient assessments.

Vision for Integrated Service Delivery

Healthy development, ability to function in line with potential, and the capacity to approach adulthood with options, abilities, and self-direction are the ultimate goals of childhood and one goal of family life. We view integrated health care as collaborating with families to achieve the best possible outcome for each child. Integrated health care responds to concerns of the whole child. The integrated health team possesses the capacities to assess both physical and behavioral health status and development and to engage families in long-term partnerships for the purpose of health promotion and management of health problems. The integrated health care team ultimately includes all of the health and behavioral health care professionals involved in the care of a child and his/her family. This may include several different behavioral health professionals, care coordinators, psychotherapists, therapeutic mentors, and child and adolescent psychiatrists. In many instances comprehensive care for children with complex behavioral health needs will need a dedicated behavioral health team which collaborates with the medical team. This will require the efforts of all to work together, communicate, and coordinate plans.

A compelling strategy for achieving these goals builds upon the pediatric medical home model [19]. This model was originally developed to provide monitoring and care for children with special health care needs, often with an organized connection to subspecialty consultants as well a care coordinator monitoring disease status, treatment engagement, and utilizing an electronic medical record to monitor the patient's status and plan for needed treatments. Although initial pediatric

medical home implementations focused on chronic physical health problems, it has become evident that behavioral health problems are some of the most pressing special health care needs for children. In addition studies suggest that behavioral health concerns and problems are more common in children and adolescents with chronic health conditions. While behavioral health concerns occur in approximately 15–18 % of physically well children, the incidence of behavioral health concerns in chronically ill children is 25–30 % [20]. Care plans for these complex children will need to be comprehensive and integrated. Synergies with combined treatments can provide avenues for improvement in both physical and behavioral health. The incidence of comorbid chronic illness and behavioral health concerns varies depending on the child's age, chronic illness, and access to effective care. By noticing early signs of behavioral health problems in chronically ill children early recognition may lead to greater ease of treatment, reduced morbidity, and reduced costs of care. In order to be truly comprehensive, the pediatric medical home needs to encompass care for developmental and emotional/behavioral problems. In order for this to be possible, the recently emerging resources of consultation and co-located behavioral health services described in the previous section need to be incorporated into the pediatric medical home model.

Coordination of care is a central function of the pediatric medical home model. Care coordination in pediatric medical homes has been defined as "a patient and family-centered, assessment-driven, team-based activity designed to meet the needs of child and youth while enhancing the care giving capabilities of families. Care coordination addresses interrelated medical, social, developmental, behavioral, educational and financial needs in order to achieve optional health and wellness outcomes" [21]. This care coordination function needs to accomplish several tasks: family engagement [22], negotiation of problems with families, development of the treatment plan with the entire team, and management of communication with schools, services, and other professionals. Care coordination includes the capacity to access and collaborate with community resources, to empower families to own and direct treatment with the support of the treatment team, and to maintain the monitoring record ensuring necessary follow-up. Care coordination also can plan with the family an approach to treatment, evaluate progress and outcomes, consider and make available appropriate resources, and ensure the family's voice in the planning and executing care. Care management is a very specific set of skills which have been extensively described in the Integrated Care Management Manual by Kathol, Perez, and Cohen [23]. In the medical home model, care coordination is the collective responsibility of the entire primary care team and specific care coordination tasks may be provided by a variety of professionals.

Not only the primary care team will need to be expanded to include behavioral health professionals, but also members of the primary care team who are ordinarily accustomed to working with physical health issues will need to expand his/her skills in order to address behavioral health needs. For example, a nurse who acts as a care coordinator for chronically physically ill children will need to learn engagement skills with families with behaviorally challenged children as well as develop familiarity with community resources to assist them. A social worker or psychologist, trained in brief therapy, can perform the care coordination function in addition to performing

triage assessments, brief therapy for selected children and families, and ensuring successful referrals to specialty behavioral health care. A medical home care coordinator can also maintain communication with specialty behavioral health professionals and teams involved with specific children and families while ensuring effective ongoing monitoring of the child's physical health and development.

The acuity and chronicity of the family's social and behavioral needs will dictate the role of the medical home in a particular episode of care [13]. At times the specialty behavioral health professionals including child and adolescent psychiatry will be the primary resources involved with a child and family. It is essential, though, that the medical home be prepared to resume monitoring and management as the behavioral health concern is resolved or as the behavioral health professionals decrease their involvement.

Some health homes will care for significant numbers of minority families. Especially if these families are poor and experiencing multiple stresses, it may be difficult to engage them in medical or behavioral health care. Nonprofessional parent partners or family navigators who have unique knowledge of minority culture can be extremely helpful in engaging families, building trust in the treatment team, and orienting them to the treatment plan. These "parent partners" can also encourage families to take control of their child's treatment. These parent partners can also help build cultural competence in the pediatric medical home, reducing health disparities. Parent partners are especially valuable in inner city health center/medical homes. These centers can also be located in association with service centers providing assistance with housing, nutrition, and community activities.

Integrated care also provides opportunities to deliver comprehensive care for children impacted by both medical and behavioral health concerns. A depressed child may be failing to adhere to the self-management activities necessary to manage his/her diabetes or asthma effectively; an overweight child may be experiencing bullying at school and may be depressed. In situations like these building competency in managing a chronic illness or weight can lessen depression while treating depression can lead to enhanced focus upon managing the psychical challenge. This can be done utilizing a therapist within the physical space of the medical home or by a specialty professional with integration carried out by the care coordinator. Other special opportunities available in the integrated medical home include early intervention for emerging problems, building healthy habits as part of family life, primary and secondary prevention, and assisting families in becoming effective advocates for their children.

Barriers

A range of barriers can make integrated care a challenge to implement for children and families. Some of these relate to reimbursement and financial incentives, some are structurally related to practice and office organization, and many relate to patterns of practice and skill deficits in this kind of health care. Families may not expect or be comfortable with integrated care. Reluctance to share information and concerns about confidentiality can also be a barrier to integrated care for children and families.

Current reimbursement practices pay for face-to-face care and medical procedures for diagnosed conditions. Care coordination, verbal and phone consultation, and more than one medical visit in a day are not reimbursed. These services are necessary for truly integrated health care and allow for coordinated attention to physical, behavioral, and emotional issues. The ACA, through its promotion of ACOs, may allow for reimbursement for integrated care- and prevention-oriented activities. To make this a reality payment barriers will need to be surmounted.

Already existing small pediatric practices with one or two physicians may find co-located integrated care prohibitive in their office. A telephone care coordination and child and adolescent psychiatry consultation service (such as the MCPAP) can be helpful in supporting behavioral health care with these practices. A lack of office space for behavioral health assessments and treatment sessions is often a barrier in practices built and organized to provide solely medical care. These practices may not have a room for comfortable and confidential conversations with families. In some offices however completed space can be reconfigured to provide for this activity, which will be necessary for integrated care.

Many primary care physicians are uncomfortable assessing and diagnosing behavioral health concerns and were not trained to treat the problems they identify. Behavioral health clinicians may not be comfortable being the sole behavioral health professional in a pediatric practice. Medical care coordinators will need to learn to access behavioral health services and to collaborate with families with behavioral health challenges. The American Academy of Pediatrics has developed several resources to help pediatricians deliver and collaborate with behavioral health care. Bright Futures [14] and pediatric medical home [21] websites include a range of helpful resources including screening tools and guides to including behavioral health care in pediatric care. Pediatric offices and staffs will also need to be welcoming to behavioral health professionals and help them build competency and satisfaction in their work and camaraderie in the office setting.

Most families trust their child's doctor. They are comfortable coming to office visits and confiding in their pediatrician. A significant number of pediatric office visits center on behavioral concerns for children. However, some families may not expect or welcome behavioral health care at their physician's office. Confidentiality is also often a concern, and parents may be especially concerned about sharing information about behavioral health problems with schools. These parents may be worried that their child may experience stigma at school. Parents may also not trust their pediatrician to appropriately diagnose and treat behavioral health problems, especially if he or she has previously attempted to normalize problems that turned out to be serious and requiring specialized treatment.

Risks and Benefits

There are some risks to providing integrated care. By identifying greater numbers of children and providing them and their families treatment, there may be increased costs of care, and at times these costs may be spent on ineffective or inappropriate

treatments. In the short term, training, workforce development, and treatment costs are likely to increase. Cost offsets may occur in the short term if early identification and early implementation of treatments ultimately reduce the need for highly expensive and prolonged treatments. Cost reductions may also occur in reduced later health care needs or in cost reductions in other systems such as schools, child welfare and foster care, juvenile justice, and prison. These cost savings may take years to be realized. Outcome studies will be necessary to determine which treatments are effective for which patients and which problems. This evaluation process will also be expensive in itself. The system of integrated health care will need the resources and will to measure outcomes and participate in continuous quality improvements. Policy makers will need to monitor the downstream impacts of integrated health care on other public and private systems.

It will also be important to monitor treatment efficacy. Likewise, it will be important to ensure that evidence-based treatments are available in all systems of care and that they are carried out with fidelity by trained and supervised clinicians who are appropriately supported and reimbursed. Addressing aspects of society negatively affected by behavioral health problems in childhood will be essential. This will require thoughtful planning and public will focusing on the best developmental outcome for all children.

Benefits of widespread implementation of integrated health and behavioral health care fall into several categories. There may be greater satisfaction in providing care for all team members, enhanced family experiences of care, more appropriate use of resources, and opportunities to address health disparities and improve cultural competence in care. We could also expect enhanced opportunities for preventive care and potentially better health and behavioral health outcomes. Each of these benefits will require thoughtful approaches to team building and to enhancing family engagement with care. The system will also need to support multidisciplinary training and pay careful attention to measuring a wide range of functional and resource use outcomes. Health care teams will become more able to provide holistic care as attention to emotional well-being is part of every encounter. Child psychiatrists, nonmedical mental health professionals, parent partners, and other medical personnel can influence each other as they work together. Integrated care also provides enhanced opportunities for monitoring chronic behavioral health concerns of children utilizing electronic medical records and methodology used to monitor chronic medical illnesses.

Effecting Change

Efforts to integrate child psychiatry within primary care are building momentum; however, the field is still in its infancy. The fundamental changes in practice for both child psychiatry specialists and primary care providers will require significant commitment and investment of time.

Coalition Building

In essence, integrated child psychiatry services are the product of successful partnerships between child psychiatrists, other behavioral health professionals, primary care providers, and families. These partnerships must be replicated from the highest levels of system leadership all the way down to the level of the providers and their relationships with patients. States that have been most successful in advancing integrated child psychiatry services have long-standing advocacy coalitions raising awareness regarding the impact of unmet behavioral health needs and proposing solutions. In Massachusetts, for example, the Mental Health Task Force of the Chapter of the American Academy with a 15-year history of harnessing the efforts of a broad set of stakeholders including parents, pediatricians, child psychiatrists, social workers, psychologists, teachers, nurses, state government leaders, and insurance company representatives has been quite successful in promoting system changes.

Payment Reform

Current fee-for-service reimbursement codes are designed for conventional child psychiatry and pediatric care and do not provide reimbursement for many of the consultation and care coordination services needed for successful integration. Payment reform mechanisms are on the horizon; however, most child and adolescent psychiatrists continue to be paid on a fee-for-service basis. The payment reform mechanisms within the Patient Protection and ACA of 2010 are primarily focused on improving adult health care. Although new payment mechanisms are currently being piloted for public and private insurance plans covering children, it will be necessary to advocate for these plans to include a full range of collaborative children's behavioral health services within bundled primary care payments and to design outcome-based incentives to promote best practices in the identification and management of children's behavioral health problems.

Training

Significant changes in the training of all pediatric and behavioral health professionals will be necessary to make integrated health care the usual mode of practice. Child and adolescent psychiatry training will need to include an enhanced focus upon training in consultation liaison experiences and in collaboration with pediatric practitioners. Training in outpatient office-based consultations in pediatric medical homes and in telephone consultations will also be necessary. These experiences will need to be developed in most current programs as their focus has not been toward this work. Child and adolescent psychiatry residents will also need expanded

training in working as team members and in influencing team decision making and team actions when necessary even if they are not team leaders or present at all team meetings. Training experiences that pair pediatric or family medicine residents with child and adolescent psychiatry residents caring for patients with both medical and behavioral health problems or during primary care visits can be especially helpful.

Pediatric and family medicine residency programs will need to include training in all aspects of behavioral health. They will need to be focused on assessment and diagnosis, family engagement, parenting support, prevention, and treatment of problems identified. Training in the use of uncomplicated psychopharmacology for common childhood and adolescent behavioral health problems will also be necessary. The training of other behavioral health professionals will also need to include experiences working in pediatric medical homes. For some behavioral health professionals working in medical homes will become a career choice. They will need more intensive experiences in integrative care. These modifications of training will be enriching for all involved.

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