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Psychologists and Pediatricians in the Primary Care Sandbox: Communication is Key to Cooperative Play

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Abstract

Recent literature, public policy, and funding opportunities call attention to the need for better increased integration of health and mental health care services in primary care settings so as to best meet the needs of children and families. There are many benefits to such integration, but pediatric primary care providers (PCPs) face multiple barriers to identifying and managing patients with mental health difficulties. One way to address this problem is through the integration of psychologists into primary care settings who can collaborate with PCPs to provide integrated behavioral health care to youth and families. However, there are challenges to collaboration, which include differences in training, professional cultures, and expectations held by professionals from various disciplines. Effective communication is a key component in supporting interprofessional collaboration between primary care providers and psychologists working in primary care settings. This paper reviews aspects of pediatric medicine culture, critical components of communication, and strategies to improve communication. Three case examples are presented in which some of these challenges have been successfully addressed. Implications and future directions are discussed.

Keywords Pediatric primary care · Interprofessional collaboration · Team-based care for children · Integrated behavioral healthcare

Recent literature (Wissow, van Ginneken, & Rahman, 2016), public policy (ACA; P.L. 111–148), and funding opportunities (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014) have called attention to the importance of better integration of health and mental health care services to best meet the needs of children and families seeking primary care services (Ward-Zimmerman & Cannata, 2012), while a comprehensive meta-analysis (Asarnow, Rozenman, Wiblin, & Zeltzer, 2015) has documented the benefits of integrated care. As Stancin (2016) has noted, it is imperative that the field move beyond the generally agreed upon goal of integrated pediatric primary care to focus on implementation, which the literature has begun to reflect. However, successful integration of mental health and pediatric primary care is a complex process that requires more than a shared practice location. As psychologists and pediatric primary care providers (PCPs) increasingly find themselves together in the pediatric "sandbox" caring for

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children with mental health issues, specialized knowledge, skills, and support are needed to promote effective communication. For professionals in these two disciplines, which have both marked similarities and differences in their training and practice models, this communication is imperative. Unfortunately, breakdown in communication can negatively affect clinical care as well as efforts toward mental health integration. In this paper, we address several critical aspects of effective communication in integrated pediatric primary care practice based on empirical research and then highlight our own experiences through three programmatic examples, concluding with a discussion of potential implications.

Pediatric Culture

Several structural components of clinical care delivery differ between pediatrics and psychology, which are important to acknowledge in order to better facilitate effective communication and successful integration of psychologists in pediatric primary care clinics. Unlike traditional outpatient mental health services, pediatric primary care is fast-paced, with only 15 minutes allocated for most visits. This time is used to engage in a number of activities, including performing a full physical exam, soliciting and responding to patient and parent concerns, discussing a variety of preventive health topics (e.g., safety, nutrition, physical exercise, maturation), completing school forms, introducing upcoming lab or immunization needs, reviewing and discussing completed screening tools, and providing advice to guide parenting and behavior until the next visit (Hagen, Shaw, & Duncan, 2008). This is in clear contrast to traditional mental health visits that typically last an hour and are often delivered weekly or bi-weekly over the course of several months. Consequently, communication difficulties can occur in busy primary care clinics where PCPs and psychologists may not have opportunities to discuss or coordinate care for mutual patients. Additionally, psychologists may need to adapt their style to provide brief interventions that can be delivered quickly during primary care visits while being mindful of the clinic flow.

Pediatric primary care also differs from traditional mental health services in that primary care is delivered by a medical team. In addition to the PCP, the pediatric practice includes administrative staff, medical assistants, nurses, care coordinators, and others to ensure patients' needs are met and that the office workflow is efficient. It is noteworthy that, in the course of a visit, patients will interact with at least three to five practice staff (NCQA, 2011). For example, they will be checked in by administrative staff, vital signs will be taken by a medical assistant, and the nurse will administer vaccinations. Outpatient mental health services, whether in a clinic or private practice setting, are generally much more reliant on the psychologist to provide intervention, as well as care coordination, if indicated. Furthermore, due to the emphasis placed on confidentiality, a release of information is often required before the psychologist communicates with other professionals. Therefore, psychologists working in primary care must be cognizant of the importance of effectively communicating with all members of the medical team, each of whom may have valuable information to provide about a patient or family. Additionally, psychologists must be mindful of how to share information with the medical team in ways that both respect patient confidentiality and do not alienate the psychologist from the rest of the medical team.

Psychologists practicing in integrated care or collaborative settings must also be familiar with the concept of the medical home, an increasingly central aspect of primary care culture. Originally developed for children with special health care needs, the model has evolved to encompass best practice in both pediatric and adult primary care (American Academy of Pediatrics, 2004). A medical home provides access outside of traditional office hours, continuity of care with a team of providers who work in partnership with families, linkage to medical and non-medical services outside of the practice, care that is coordinated across all services that patients use, and services that meet the needs of all patients in a context that is respectful of their cultural and religious beliefs. While the medical home model provides opportunities for psychologists, there may be challenges as well particularly those related to professional roles and responsibilities (Anderson et al., 2014; Kazak, Nash, Hiroto, & Kaslow, 2017). For example, ethical and legal dilemmas may emerge from differences in the professions' ethical codes (e.g., guidelines about confidentiality, multiple relationships) as well as from particular situations that may arise in practice (e.g., Hudgins, Rose, Fifield, & Arnault, 2013; Reiter & Runyon, 2013; Runyan, Robinson, & Gould, 2013; Williamson et al., 2017).

Although pediatric PCPs often see children with emerging mental health concerns, medical providers' knowledge and comfort with assessment and intervention for mental health concerns varies greatly. Even given this context of differing cultures, psychologists have a unique opportunity to support pediatric PCPs in providing interventions for their patients presenting with mental health concerns, to consult with PCPs, and to act as specialists to whom the PCPs can refer. However, this requires effective communication between the PCP and psychologist to determine which patients require a referral to the psychologist versus those that can be effectively managed by the PCP. While there will likely be challenges, especially initially, the various strategies, outlined in the following section, can be used to facilitate effective communication between pediatric PCPs and psychologists.

Strategies to Improve Communication

Despite the fact that collaboration between pediatric PCPs and psychologists is beneficial to both professions as well as the patients with whom they work, various barriers including limited opportunities to build relationships and limited time for consultation may interfere with communication between psychologists and PCPs. However, there are many strategies that may improve communication, starting with increasing the frequency of communication between the two professions. Surveys of pediatric PCPs indicate that they are interested in building consultative relationships with psychologists and enjoy working with psychologists (Torrence et al., 2014), but relatively few report having such relationships (Pidano, Kimmelblatt, & Neace, 2011). Additionally, the majority of pediatric PCPs report that they receive no communication back from psychologists after making a referral (Bunik et al., 2013; Guevara, Greenbaum, Shera, Bauer, & Schwarz, 2009), despite the fact that the HIPAA Privacy Rule allows for communication between two health care providers as part of treatment, with or without patient authorization (Tynan & Woods, 2013). Although there are various reasons for this lack of communication, it is important for psychologists to recognize and appreciate the value in improving communication with PCPs as well as be aware of how and when to provide this information. For example, many pediatric PCPs are interested in receiving written communication about diagnosis and treatment progress, requests for a medication evaluation, and alerts about frequent no shows, early termination, and aftercare recommendations after termination of therapy (Ward-Zimmerman & Cannata, 2012). Although these activities are not billable and may require considerable time and effort on the part of psychologists, effective communication with PCPs at these points in treatment may lead to better care for families who are difficult to engage in treatment. Additionally, the use of a standardized form may save time and improve communication. For example, the American Academy of Pediatrics published a one-page Primary Care Referral and Feedback Form which can be used throughout the treatment process for brief communication to pediatric providers (American Academy of Pediatrics, 2010). Consistent with this, Pidano, Marcaly, Ihde, Kurowski, and Whitcomb (2011) reported that using a simple form to communicate in writing was related to pediatric PCPs' greater satisfaction with partnerships with mental health providers; further, Arora et al. (2017) found that a written summary of communication subsequent to consultation with mental health providers was endorsed by PCPs as a facilitator to engagement in consultation and underscored as a recommendation for other mental health consultation partnerships.

In addition to increasing the frequency of communication regarding referrals made by pediatric PCPs to psychologists, psychologists may also seek to build relationships with PCPs who may become future referral sources. Many pediatric PCPs report interest in receiving additional training on common behavioral health concerns in childhood (Pidano et al., 2011) and psychologists have the expertise and ability to provide such trainings. Engaging in these activities not only can provide information to pediatric PCPs, but could also be an important opportunity for psychologists to share information about their practice, expertise, approach to treatment, and to clarify the information that pediatricians would like to receive after making a referral. Although this requires a time investment for the psychologist, it is likely to result in better working relationships, better patient care, and could also lead to more referrals.

Earlier collaborative relationships between trainees from both professions are also likely to improve later communication. Interprofessional training has gained increased attention in recent years (Rozensky & Janicke, 2012; Stancin & Perrin, 2014). With such approaches, psychologists and pediatric PCPs are trained in similar settings, attend similar didactic seminars, and work with each other on a frequent basis over the course of their education. Such training is valuable because it allows for relationship building early in one's career and provides each profession the opportunity to better understand and appreciate each other, trust each other, as well as learn basic skills to enhance their practice (Bunik et al., 2013). Additionally, given the changing landscape of healthcare, it is likely to be advantageous for both PCPs and psychologists to take part in such training approaches. For psychologists who did not have the opportunity to train alongside their pediatric colleagues, it is critical that they educate themselves about pediatric practice or find continuing education courses to obtain this knowledge. Psychologists should be familiar with the types of services provided by pediatric PCPs, terms and language used by PCPs, as well as the expectations that PCPs have for working with psychologists (Glueck, 2015). Psychologists who understand the challenges of a particular pediatric practice as well as the perceived needs of the practitioners are more likely to develop successful relationships with their medical colleagues (Ward-Zimmerman & Cannata, 2012), which will thereby promote better communication.

Despite potential barriers to collaboration noted, the good news is that, in the context of consistent, effective, and on-going communication, psychologists and PCPs have successfully created effective models of collaborative and integrated care. Table 1 summarizes some of the key communications strategies mentioned above, while in the following section, we briefly review three examples of psychologists and pediatricians working together to develop interdisciplinary teams characterized by clear and consistent

Table 1 Summary of communication challenges and strategies and methods to improve communication

Challenge	Strategy	Method
Medical and psychology trainees have separate educational tracks and often train in different settings	Increase opportunities for interprofessional training and interaction	Create interprofessional training opportunities during graduate school to develop collaborative relationships between both professions early in their training Train practicing PCPs and psychologists in similar settings, e.g., attend didactic seminars/grand rounds together Attend interprofessional team conferences or case conferences Develop a mutually beneficial clinical research partnership
Cultural differences between medicine and psychology	Increase familiarity with each profession's culture	Become familiar with services offered by each, and terms and language used by each profession Psychology graduate programs may offer courses or didactic trainings in pediatric psychology Established psychologists may wish to seek out trainings or conference presentations about this topic
Pediatricians lack training in child mental health	Psychologists can provide opportunities for pediatricians	Offer trainings about common behavioral or mental health concerns such as child tantrums, attention-deficit/hyperactivity disorder, or anxiety Consider providing training onsite in pediatric practice offices (e.g., "lunch and learn") Use these opportunities to build relationships as well as provide content
Minimal contact between practicing pediatricians and psychologists	Increase frequency of communication	Develop relationships with local pediatricians through offering trainings, discussing mutual patients, or sharing information about how to facilitate the referral process Build additional opportunities for consultation relationships Coordinate use of electronic medical health records
Pediatricians do not receive feedback about patients they refer for therapy	Formalize channels for communication	Use a standardized communication tool to provide information about the status of a referral, a patient's progress in treatment, or challenges that arise during the treatment process Encourage PCPs to identify a "point person" or mental health care coordinator in the practice, if possible

PCP primary care provider

communication, appreciation, and respect. While these three examples are not all drawn from pediatric primary care settings, we believe that the strategies employed and lessons learned are all applicable to that context.

Communication in a Children's Hospital

This first illustrative prototype of the development of a well-functioning interprofessional team is the School Age Clinic (SAC) at a large Children's Hospital affiliated with an academic school of medicine. The SAC serves urban children of diverse cultural and socioeconomic backgrounds who experience difficulties with attention and learning. Beginning in the 1990s, the SAC was a consultative practice led by a single pediatrician who provided medication consultation to children with learning and attention challenges, while also serving as a place for pediatric residents to gain mental health training and experience. Within the past decades, with the increasing presence of specialists in academic medical settings, the staffing of the SAC had expanded to include psychologists, developmental-behavioral pediatricians, occupational therapists and nurses, and their trainees. These overlapping growth curves, the expansion of specialties and expansion of trainees, resulted in mild-to-moderate disruption within the SAC and provided great opportunity for strategic reorganization.

Consistent with Bélanger and Rodríguez (2008), the development of a well-functioning, cooperative practice team requires investment of time and resources focused upon team building. For example, an early career child and adolescent psychologist was recruited to serve as the clinical coordinator of the SAC with the goal of increasing both the clinical and training outcomes of the interdisciplinary clinic. This psychologist and her supervisors were able to pair expansion of the SAC to specialty mental health contract funds, typically used to support the psychology training programs within Children's Hospital. These specialty mental health funds allowed for the reimbursement of periodic interprofessional treatment conferences, and to fund the participation of team members in a weekly care conference (see Table 1). This investment supported an infrastructure for enhanced communication among interprofessional team members, as well as opportunities for shared decision-making, team building, and promotion of a team-based organizational identity.

While the coordinating psychologist and her colleagues immediately saw evidence of the positive impact of funded time for the interprofessional case conference with respect to enhanced communication, challenges and conflicts can be expected to arise when professionals representing diverse professional traditions and practices confer together. One immediate effect was the emergence of conflict or disagreement regarding professional practice standards or approaches. For example, with respect to patient screening and assessment practices, it became evident that the pediatricians and psychologists approached interviews and data gathering in very different ways. Pediatric-trained team members demonstrated a preference for assessment and screening tools freely available on a variety of Internet-based professional organizational sites, whereas psychologically trained team members demonstrated a preference for standardized and normed instruments available from test publishers, requiring expenditures of time and money. In the initial case conferences, tense discussions unfolded regarding screening and assessment practices, sometimes linked to hot-button topics of ethical standards. Team building required the development of trust and the coordinating psychologist's cool-headed leadership during discussions helped evolve an interprofessional team identity within the SAC clinic, which now seeks consensus, not compromises, regarding interprofessional practice. The current interprofessional assessment practice within the SAC represents an amalgam of pediatric and psychological approaches, flexible and patient-centered, and all professions have developed appreciation for different pathways to gathering data and presentation.

The coordinating psychologist of SAC used additional strategies highlighted by Bélanger and Rodríguez (2008) within the clinic, allowing team members to articulate any needs for support. Distinct mini-teams of interprofessional staff were created and assigned to patients for intake, treatment planning, and follow-up. SAC program leaders also invested specialty mental health funds to provide all trainees with dedicated supervision time allotted during the SAC clinic day to ensure that trainee's clinical services were well formulated and enacted. Clinical productivity outcomes of the integration of primary care and specialty care providers in the SAC have included a sustained increase in the numbers of patients served, and an increase in clinical revenues. Supervising psychology faculty report an enhanced sense of mission, purpose of staff serving the SAC clinic, and trainee evaluations reflect enhanced satisfaction of trainees within the clinic. Finally, qualitative feedback from pediatric providers has been positive. One pediatric specialist shared the following, "This psychologist's leadership style has promoted a climate of congeniality and mutual respect, and has enhanced appreciation between disciplines regarding the skills and approaches of different disciplines. This climate of respect has made interdisciplinary practice more fluid and ultimately better for our pediatric patients."

Communication Leading to Collaborative Research Partnerships

As previously described, psychologists and pediatricians devote many intense years to education and training, most often along paths that do not intersect (Bunik et al., 2013;

Talen & Valeras, 2013). The successful strategy outlined above integrated pediatricians and psychologists in targeted co-training in clinical practice (see Table 1). We turn to a second prototype which illustrates a clinical research partnership between a psychologist and a primary care pediatrician who had joined the pediatric faculty with aspirations to develop health promotion projects to serve underserved pediatric populations (see Table 1). While the two faculty members had divergent professional backgrounds, and initially had divergent skills and interests in specific underserved populations, their convergent interests in parent training as a health promotion practice served to incubate and nurture the development of an enduring clinical research partnership.

The psychologist had been recruited to a postdoctoral fellowship following his training at the hospital where he showed great interest in bringing evidence-based parent-training practice into the clinical service. Throughout his training years, he collaborated with a respected researcher and program developer with national and international training partners, achieving certification by the developer to train others in the practice. The psychologist joined the hospital staff and aimed to provide a culturally sensitive, evidence-based parent-training intervention, *The Incredible Years*® (Webster-Stratton, 2008) to underserved families within the program's community mental health clinic. His training certification supported his role within the psychology internship and fellowship programs, and he evolved into a recognized expert in parent-training practices.

This psychologist was promoted to the academic faculty, and was encouraged to develop research mentorships. The psychologist initiated a partnership with a primary care pediatrician who held an early career development award with a focus upon health promotion research. The pediatrician's research interests included development of innovative positive parenting models for the Filipino community, a natural fit for the psychologist. The partnership began initially as a discussion between professionals with mutual interests in parent training, but soon evolved into co-training, with the pediatrician participating in trainings led by the psychologist to provide group leaders with the skills to deliver the evidence-based parent-training program. Following the initial training, the psychologist was encouraged by the pediatrician to train a team of her research assistants to deliver the parent-training program within a community church serving immigrant Filipino families. The psychologist and pediatrician created an interprofessional clinical research lab which allowed the pediatrician to deploy an evidence-based parenting practice in community-based abuse prevention research project (see Table 1). The psychologist later linked this academic pediatrician to the developer who had initiated the development of primary care intervention models of her training series.

This research partnership suggests that strategies for developing organizational change and promoting cooperative interprofessional practice (Bélanger & Rodríguez, 2008) have applications to research organizations serving primary care clinics and populations. The development of a well-functioning research team operating within primary care settings requires flexible and locally adaptable organizational structures. For example, consider that the partners' initial collaborations focused upon training a cohort of Filipino parents and grandparents to conduct parent-training sessions consistent with the fidelity expectations of the parent-training program's developer. These community-based parent group sessions utilized a very different infrastructure of resources than what would be needed for later implementation in primary care setting. Moving the intervention from a community church to the primary care setting challenged the team, as group leaders needed to meet the professional certifications expected of professionals working in an academic medical center. Bélanger and Rodríguez (2008) also identify the central role of the general practitioner as a strategy for developing an effective interprofessional team in primary care settings, and the research team made numerous visits to pediatric faculty meetings before initiating their clinical research project, allowing primary care physicians to have input into the project design and implementation.

Implementation of their parent-training group research project within the physical confines of the busy primary care clinic proved to be an impossibility, even during the later evening clinic times most convenient for working parents. Resolution of this space challenge required flexibility and creativity, and was made possible by drawing upon prevention and early intervention funds available within the program's specialty mental health service. Prevention and early intervention funds are intended to support field-based preventative services and avert future mental health crises. These funds were used to secure access to the hospital's child care facility, immediately adjacent to the hospital's primary care clinic. This facility proved to be an excellent location for parent-training sessions, and was staffed with child development experts who were funded to provide child care to support the parent group meetings.

The training and research partnership has proven invaluable to the underserved families through the project, but has also provided academic advancement opportunities for both professionals. The PCP provided the following qualitative feedback regarding this partnership: "As a primary care physician and health disparities researcher, partnering with a psychologist has been critical to our ability to engage underserved immigrant populations in evidence-based parenting interventions. This partnership has enabled us to successfully move toward creating a culture of healthy parenting and mental health in a population at high risk for adolescent mental health disparities." The partnership has enhanced the

fundability of health promotion practice research applications submitted by an interprofessional team, which now enjoys a number of collaborative projects, including designation as Robert Wood Johnson Foundation Clinical Scholars, an interdisciplinary clinical team addressing complex health care problems in their communities.

Communication in a Co-located Integrated Behavioral Health Model

The Frankel Psychotherapy Program is an example of a co-located integrated behavioral health model. Behavioral health services are delivered at a community-based primary care clinic consisting of Pediatric and Family Medicine practices that are part of a larger Midwestern academic medical center. The mission of the Frankel Program is to improve access to evidence-based behavioral health services for children and families who are primarily Medicaid recipients, within their primary care setting, serving as a family-centered medical home. The Frankel Program is an initiative partially supported by donor funds to help offset the cost of the behavioral health Frankel clinicians. The academic medical center's Department of Psychiatry also supports the program.

The Frankel Program's interprofessional behavioral healthcare team consists of a clinical child psychologist, clinical child psychology postdoctoral fellows, physicians, social workers, administrative mangers, and support staff. Referrals to the Frankel Program began with social workers who worked closely with the PCPs. Social workers triaged families ensuring a "warm handoff" to Frankel clinicians and effective communication with families and between providers.

Appropriate referrals include families that could benefit from behavioral health services and will continue to be co-managed by the clinic-based PCP. Reasons for referral include an array of emotional and behavioral problems including: anxiety, depression, trauma, ADHD and/or other disruptive behaviors disorders, and non-adherence to medical regimens, with symptom severity falling within the mild-to-moderate ranges. Inappropriate referrals include: medication consultations; acutely suicidal/homicidal behavior, or other acute crisis situations; recent discharge from a psychiatric hospitalization; and/or presence of psychotic symptoms.

Consistent with a stepped care model (Bower & Gilbody, 2005), in our primary care clinics, the Frankel Program falls along a continuum of behavioral health services available to children and families. We work collaboratively as a team to determine whether Frankel is the program that is appropriately matched given the child's/family's needs. Regarding Frankel, the first step is PCPs' referral of their pediatric patients (age 3–17 years) whom they suspect may have an emotional, behavioral, or other psychiatric concern that may benefit from integrated care. The second step is the triage process; a social work coordinator considers the "goodness of fit" of the family/Frankel Program with consideration of other options for clinic-based behavioral health services. This step is also necessary, as we have learned that it is not uncommon for PCPs to refer families to more than one behavioral health service at a time in an effort to "cover all bases." This approach of multiple referrals led to "goodness of fit" problems for families that, in turn, contributed to caregivers' frustration with appointments deemed unnecessary and longer wait times for the right programs. To aid with program fit, social work references a behavioral health services decision tree to determine which program(s) is best suited to meet the family's needs whether the family is referred to Frankel and/or another pediatric behavioral health program. Social work considers the following questions such as: Is the PCP/family seeking psychiatric medication consultation/management and/or diagnostic clarification? Does the child also present with a chronic medical condition? Social work also consults program leads, if necessary. Notably, the Frankel Program is the only clinic-based pediatric behavioral health resource with a provision of psychotherapy.

As a third step to check the Frankel Program's appropriateness for families, caregivers are engaged in a brief telephone screen with clinic staff in which the aforementioned questions are asked to rule out inappropriate referrals. Clinic staff are trained to understand that all such questions must be answered "no" before a family can be scheduled for its initial Frankel appointment. Example questions are as follows: "Has your child been recently [past month] discharged from a psychiatric (emotional and/or behavioral health-related) hospitalization?" and "Has your child made a suicide attempt or a plan to kill him/herself within the last 6 months?" Three of the six questions are related to suicide/homicide and psychotic symptoms and, if answered in the affirmative, designated a "red call," which means the caregiver is immediately routed to a social worker or a nurse. For other screening questions answered affirmatively, social work is also involved to help the family link with the behavioral health service that may be more rightly suited to their child's needs, which may also include community-based referrals. Our university-based child psychiatry clinic is also a referral option for families whose child may benefit from more intensive, "stepped up" specialized services.

Finally, the Frankel Program has recently evolved to include a diagnostic assessment clinic that meets twice monthly. This clinic is akin to an intake in which diagnostic assessments, impressions, and treatment recommendations are shared with the family. It also serves as a final check to ensure "goodness of fit" with Frankel Psychotherapy Program services. Families are assessed in the Frankel Diagnostic Clinic before intervention is initiated. The Frankel

Program director meets with all Frankel clinicians that presently include clinical child psychology postdoctoral fellows and licensed Master's level clinical social workers to triage families deemed appropriate for Frankel psychotherapy services. Social work is consulted when the Frankel Program is determined not to be the right fit for a family. For example, the Frankel team may determine that a "stepped up" level of care is warranted. The Frankel Program is appropriately matched to serve families seeking preventative/early intervention behavioral health services. Measurement-based outcomes completed by youth, caregivers, and other collateral informants (e.g., teachers), along with Frankel clinicians' impressions, are taken into account throughout treatment to help guide behavioral health decision-making as occurs, for example, when services are "stepped down" from bi-weekly to less frequent booster sessions through termination within the Frankel Program.

A number of procedures facilitate effective communication between the Frankel clinicians and PCPs. Following the initial behavioral health appointment, Frankel clinicians route details of the encounter, including preliminary findings, the psychological diagnostic assessment, and treatment recommendations/plan to the referring PCP. Clinicians also route information on subsequent key encounters to the PCPs, with brief messages highlighting the rationale for the communication, such as a concern about medication side effects or remarkable changes (positive and/or negative) in the youth's symptom presentation. It is important to note that both providers have access to all encounters at any given time due to the shared electronic medical record. However, PCPs communicated that the routing of encounters that particularly warrant their attention is preferred. Additionally, throughout the course of the youth's care in the Frankel Program, clinicians and PCPs communicate via in basket messages, which is also a feature of the shared electronic medical record. For example, PCPs send messages requesting information (e.g., teacher report forms) as well as to communicate information about psychiatric medication changes (see Table 1).

Monthly interprofessional meetings with the Frankel Program director, clinic's medical director who is also a referring PCP, administrative manager, social workers, and support staff (call center, insurance/billing representatives, referral/scheduling coordinator) were integral to the program's success (see Table 1). Team meetings resulted in the implementation of strategies that improved Frankel's visibility and increased communication between professionals, which resulted in changes in Frankel practices. For example, a program-specific referral phrase ("Frankel") was created in the shared electronic medical record, as it was realized that the existing referral process resulted in delays in insurance authorizations, which adversely impacted scheduling of families' initial Frankel appointment. Additionally, discussions during interprofessional meetings were integral to the aforementioned Frankel Program expansion that resulted in a diagnostic evaluation clinic as well as a Saturday morning psychotherapy clinic, allowing even more families to benefit from this co-located behavioral health approach. These meetings occur less frequently as the Frankel Program has become better integrated in the clinic's standard operating procedures.

After nearly a year pilot of the weekend psychotherapy clinic, it was discontinued based on families' feedback indicating a preference for weekday afterschool/evening hours for return visits. Thus, we expanded our Monday and Tuesday evening psychotherapy clinic to Wednesdays overlapping with the extended hours the clinic provides for primary care services, Mondays–Wednesdays until 7 p.m. Other positive clinic practice changes that occurred due to communication included more clinic support staff trained in Frankel program-specific procedures and the inclusion of more clinic staff working on the Frankel program operations.

Because it important to consider the unique needs/circumstances of potential implementation sites, we recommend a collaborative approach including discussions with stakeholders, for example, around meeting frequency and preferred communication methods among providers and staff. Although the Frankel Program is supported in part via donor funds, logistical/operational procedures are driven via standard clinical practices within the PCP clinics. Given our multi-pronged communication strategy, we engage in an iterative process tweaking program operations based of stakeholders' feedback and input from other sources. Thus, dependent upon the system of care, our program practices may or may not be transportable. Therefore, individual- and system-level tailoring is strongly recommended to determine the "goodness of fit" of the Frankel Program processes in other systems seeking an integrated behavioral health approach.

A program evaluation, supported by the State's Department of Community Health Medicaid Match grant, conducted with families referred to the Frankel Program between September 2012 and June 2015 was referenced to provide demographic information of the Frankel Program population. Participant demographics during the aforementioned timeframe included 105 children/adolescents (57.1% male) referred for integrated care, Frankel services. Seventy-two (68.6%) of these families initiated services. Regarding race/ethnicity, 55.6% were African American, 34.7% Caucasian, 9.7% Other, and 87.5% Non-Latino. These numbers remain representative of the Frankel Program population. As part of our evaluation, Frankel Program satisfaction was obtained from four referring PCPs. All reported being very to mostly satisfied with the Frankel Program overall and with the services provided to their patients. Moreover, PCPs described being very to mostly satisfied with Frankel

clinicians' communication with them about their patients' functioning. One PCP shared the following, "I have had patients who have truly appreciated everything Frankel fellows have done to help with them and their families…having their involvement in the care of my patients has been enormously helpful to my patients who have been able to take part."

As is the case with many new initiatives, we also encounter barriers, which are addressed through effective communication practices and programmatic adjustments. For example, although assessment measures were available via our web-based outcome measurement system for youth and caregiver reports, many families lacked technology access to complete the measures prior to their appointments and the clinic lacked space to provide computer stations separate from the psychotherapy session rooms. Thus, the program moved to paper measures to allow for more flexibility with administration such as caregiver completion of a measure in the wait-room while their child is meeting with the Frankel clinician.

Overall, we learned the importance of flexibility, cultural adaptations (broadly defined to encompass the clinic setting and family's background), and effective communication to better meet the needs of the children and families the Frankel Program serves.

As illustrated by these three examples, interprofessional partnerships built upon foundations of effective communication and partnership can develop in many ways and provide a range of benefits and outcomes. These illustrations further provide qualitative accounts of psychology's holistic, person, and family-centered traditions that may contribute to the quality of pediatric clinical services, training, and research.

Discussion

Due to a variety of cultural differences between members of both professions, challenges to the collaboration between child health and mental health providers exist (Stancin & Perrin, 2014). As there is a critical need for increased behavioral health integration in pediatric primary care settings (Rozensky & Janicke, 2012), individuals across both professions remain committed to supporting successful collaboration efforts (Kolko & Perrin, 2014). However, shifts in the professional identify and practice of child pediatric psychologists will need to be made in order to effectively execute such efforts and adapt to the pediatric primary care context.

Accordingly, this article sought to support such efforts by addressing one key area of difference between both professions: communication. Specifically, subsequent to a review of the challenges that exist to interprofessional collaboration between psychologists and PCPs, the importance of effective communication to bridge collaborative efforts across disciplines was discussed. Further, we proposed the need for psychologists to have a solid understanding of these potential barriers and be well versed in skills and activities that might potentially overcome such barriers. We offered potential solutions to such obstacles, drawn from both the extant literature base as well as our experiences in integrated behavioral health efforts, which we expanded on via the provision of case examples of successful collaborations.

Throughout our review, we touched upon several key suggestions to improve communication across providers, with the goal of impacting behavioral health integration efforts. We contended that increased frequency of communication between psychologists and PCPs is needed to address challenges with communication. Further, we proposed methods to increase the frequency of communication between these professionals via, for instance, building opportunities for consultative relationships and providing written communication subsequent to referrals and co-treatment. Additionally, we suggested that improved relationships between these professionals be built. Moreover, we indicated that psychologists with access to information desired by PCPs might seek to offer trainings for the latter. Finally, we underscored the need for additional training opportunities (at both the graduate level and via continuing education). Throughout, we highlight the importance of formal partnerships across professions being built on trust and characterized by respect for the unique skills each brings to the partnership (see Table 1).

Efforts to successfully facilitate interprofessional collaboration between pediatric PCPs and psychologists are underway, as we demonstrated in our case examples. However, future training efforts will be needed to continue to support such clinical endeavors. Specifically, in order to develop and maintain effective collaborations, pediatric psychologists will need to be fluent in reimbursement mechanisms in the primary care setting, a crucial barrier to the integration of behavioral health in pediatric primary care (Kautz, Mauch, & Smith, 2008). Further, though increasingly ubiquitous, all pediatric psychologists working in integrated behavioral health will need to be skilled in their use of electronic medical records to facilitate communication efforts (Knowles, 2009). Moreover, to provide the bases upon which such collaborative efforts will grow, psychologists will be required to gain and maintain their understanding of emotional and behavioral sequelae to common medical concerns seen in pediatric primary care settings (McDaniel et al., 2014), as well as those assessment, prevention, and intervention methods that will be suitable for use within this context (Arora, Stephan, Becker, & Wissow, 2017; Kolko & Perrin, 2014). Finally, psychologists may be required to solidify their research and evaluation skills, particularly those in program evaluation and quality improvement methodologies, as they

seek to market their unique skills suitable for the primary care setting (Palermo et al., 2014). Generally, additional research on, and subsequent dissemination of, effective methods for engaging in such efforts will support the continued integration of behavioral health efforts in pediatric primary care settings.

An emphasis on the above skills could occur via a number of training experiences (Rozensky & Janicke, 2012; Stancin & Perrin, 2014), including program-specific didactic training with pediatric residents, continuing education opportunities within hospital or community clinic settings, or interprofessional conferences sponsored by relevant national associations (e.g., American Academy of Pediatrics, American Psychological Association; American Psychiatric Association).

The above is well summarized by the recently published Competencies for Psychology Practice in Primary Care (McDaniel et al., 2014), which outlines competencies and training recommendations that can inform the training of psychologists working in pediatric primary care settings (Sturm & Stancin, 2013). Competencies across six broad areas (i.e., science, systems, professionalism, relationships, application, and education) are endorsed (McDaniel et al., 2014). Relatedly, though not directed exclusively to psychologists, SAMSHA's "Core Competencies for Integrated Behavioral Health and Primary Care" (Hoge, Morris, Larala, Pomerantz, & Farley, 2014), which outlines competencies for behavioral health and primary care providers across a number of domains (i.e., interprofessional collaboration, collaboration and teamwork, screening and assessment, care planning and care coordination, intervention, cultural competence and adaptation, systems-oriented practice, practice-based learning and quality improvement, and informatics) also provides a guidepost for future directions in training psychologists to work in integrated, primary care settings.

It is critical for the current and future advancement of pediatric psychology that these professionals receive specialized training in pediatric primary care integration. In this era of continued opportunities for creative and effective collaborations in increasing access to and improving the quality of behavioral health care for youth, it is our hope that this article will contribute to the growing literature base on the methods to overcome barriers and support effective communication in the primary care sandbox.

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Compliance with Ethical Standards

Conflict of interest Anne E. Pidano, Prerna Arora, Polly Y. Gipson, Bradley O. Hudson, and Kriston B. Schellinger declare that they have no conflicts of interest.

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