

Launching Forward: The Integration of Behavioral Health in Primary Care as a Key Strategy for Promoting Young Child Wellness

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In 2008, the Substance Abuse and Mental Health Services Administration (SAMHSA) created a national grant program, Project LAUNCH (Linking Actions for Unmet Needs in Children's Health), to improve behavioral health and developmental outcomes for young children through the incorporation of prevention and wellness promotion practices in key early childhood settings. Project LAUNCH supports states, tribal nations, and territories to improve coordination across early childhood systems and implement 5 core strategies of prevention and promotion. This article focuses on the lessons learned from 1 of the 5 core strategies: integration of behavioral health into primary care for young children. This paper analyzes the experiences of a sample of Project LAUNCH grantees, describing 10 common elements of integration approaches and exploring some of the challenges of promoting health and preventing social, emotional, and behavioral problems at a population level.

More than ever before, research has documented the importance of the first 5 years of life as a critical time for laying the foundation for healthy social and emotional development and mental health. Book-ended by the landmark National Academy of Sciences study *Neurons to Neighborhoods* (Committee on Integrating the Science of Early Childhood Development, Youth and Families Board on Children, National Research Council, 2000), and the recently released study by Jones, Greenberg, and Crowley (2015) on the relationship between kindergarteners' social competence and adult well-being, researchers have established linkages between this developmental period and lifelong health and wellness. Health economists have similarly documented the returns on investing in early childhood development (Heckman & Masterov, 2007). At the same time, emerging

neurodevelopmental research has documented the impact of toxic stress and adversity on the young child, including greatly increased risks of social, cognitive, and behavioral problems (Dong et al., 2004; Edwards, Holden, Felitti, & Anda, 2003; Felitti et al., 1998). However, it is also clear that early intervention can mitigate or reduce the impact of these adversities and return children to a healthy developmental trajectory (National Scientific Council on the Developing Child, 2005/2014). The early years are a crucial time for promoting overall health and well-being, laying the foundation for school readiness and educational success and preventing developmental and behavioral health problems that can have an impact over a lifetime (National Research Council and Institute of Medicine, 2009).

Although important federal investments have been made in early childhood, in many places the child-serving system remains a patchwork of different services that are fragmented and disconnected. Excellent programs are funded in early education, child care, pediatric care, and home visiting; however, until recently and in many places these efforts were poorly coordinated and neglected to focus on the social, emotional, and behavioral health of young children and their families. In an effort to address this gap through a comprehensive public health approach, in 2008 the Substance Abuse and Mental Health Services Administration (SAMHSA) in the U.S. Department of Health and Human Services created a national grant program entitled Project LAUNCH (Linking Actions for Unmet Need in Children's Health). Project LAUNCH's public health approach to promoting mental health includes regularly monitoring all children in a community—beginning at birth—to ensure that they are on track developmentally and behaviorally and identifying children at increased risk for or showing early signs of behavioral issues. Rather than waiting for disorders to emerge, Project LAUNCH connects with children and

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families in their natural settings to monitor, promote wellness, prevent illness, and link to treatment in ways that are accessible and nonstigmatizing. Focusing on children from birth (or prenatally) through age 8 years, Project LAUNCH supports states, tribal nations, and territories to improve coordination across systems and to implement five core strategies of prevention and promotion that have been identified as evidence-supported and critical to healthy development. The five core strategies are (a) developmental and behavioral screening in a range of child-serving settings, (b) mental health consultation in early care and education, (c) enhanced home visiting with a focus on social and emotional development, (d) family strengthening and parent support, and (e) integration of behavioral health into primary care.

A total of 55 Project LAUNCH grants have been awarded. Although multisite evaluation data are still forthcoming, individual grantee evaluations suggest improvements at multiple levels: child outcomes, including reductions in behavioral issues and increases in social and cognitive skills; family outcomes, such as reductions in parental stress and depression; provider outcomes, such as increased knowledge about social/emotional development; and community-level outcomes, such as improved coordination and collaboration across child-serving systems.

The purpose of this paper is to describe and examine one of the strategies engaged in by the Project LAUNCH grantees: the integration of behavioral health into primary care. The practice of integration has been a focus of more national attention since the passage of the Patient Protection and Affordable Care Act, and Project LAUNCH grantees provide a unique perspective on this work. Although most of the existing policy, programming, and research on integration has centered on the adult health-care system, or on serving children with chronic health or behavioral health conditions, this paper analyzes the experiences of Project LAUNCH grantees who are integrating preventive care and the promotion of health in primary care settings. The care being provided is not limited to those experiencing chronic medical or behavioral health conditions; it is available to the general population of young children and their families and is intended to address nascent concerns raised by primary care providers and/or parents. It is an integration approach that seeks to increase primary care provider and parent knowledge and impart strategies to promote healthy social and emotional development and well-being.

Integration of Preventive Behavioral Health in Pediatric Primary Care: A New Approach

Historically, models of integrated care have been concentrated on treatment for those with diagnosed medical and behavioral health disorders and have been studied more extensively in internal family medicine practices than in pediatric settings (Collins, Hewson, Munger, & Wade, 2010). These studies have also provided some evidence of impact; for example, large randomized trials studying depression management in integrated settings have shown that utilizing case managers (nurses, social workers, psychologists, etc.) has promoted successful outcomes for adult patients (Katon et al., 1997). In 2012, a randomized controlled trial demonstrated parental satisfaction, increased service use, and clinical improvement for children with behavioral problems after incorporating trained master's level mental health clinicians into pediatric practices (Kolko, Campo, Kilbourne, & Kelleher, 2012).

Less well-developed and well-studied are models for integrating population-level, prevention-oriented care into pediatric primary care settings with a goal of promoting wellness and detecting and preventing mental, emotional, and behavioral disorders among young children and their families. Well-child visits in pediatric primary care offer one of the most consistent opportunities for professionals to observe and monitor children's development over time, and parents with developmental or behavioral concerns are most likely to turn first to their pediatricians. Indeed, research shows that pediatricians' recommendations are the best predictor of parents seeking help for their preschoolers' behavior problems (Fantom, MacDonald, & Harvey, 2008; Lavigne et al., 1993).

There has been concern voiced about the discrepancy between the presenting behavioral issues of children and parents seeking guidance from their primary care providers and the capacity (e.g., time, training, and infrastructure) of primary care practices. Pediatricians themselves have identified several challenges that make it difficult to address mental health issues (Nichols, 2014), including the following:

- The challenge of evaluating mental health problems in general pediatric practice when the expectation is a 15-min patient visit
- The lack of training for pediatricians on developmental and behavioral issues, including trauma and toxic stress
- The shortage of high-quality mental health professionals to whom they can refer young children
- The lack of a system for ongoing care coordination between physicians and mental health providers

Although the above challenges are significant, the passage of the Affordable Care Act (ACA), and the momentum in transforming practices into patient-centered medical homes, create timely opportunities for integrated approaches that consider mental and physical wellness together. The patient-centered medical home is a model that has been endorsed by the American Academy of Family Physicians and the American Academy of Pediatrics (among others) and aims to transform the delivery of primary care to include prevention and wellness promotion delivered by multidisciplinary teams (Croghan & Brown, 2010). Furthermore, the ACA requires that essential health benefits include behavioral health, preventive and wellness services, and chronic disease management, and the ACA makes care coordination a reimbursable service (Croghan & Brown, 2010).

Although policy-makers continue to hammer out details concretizing how the ACA will be implemented, there is a pressing need to test models of integrated care. Recent national survey data indicate that only 17% of pediatricians have a mental health clinician working in their primary care practice (Guevara, Greenbaum, Shera, Bauer, & Schwartz, 2009) whereas far more children and their families will seek care for behavioral challenges. It has been estimated that as many as 40% of children and adolescents experience behavioral issues that do not meet diagnostic criteria for behavioral health disorders, and it is suggested that "primary care physicians need tools and communication skills to identify emerging mental health problems, engage families in determining an appropriate course of action, and monitor outcomes when diagnosis is uncertain." (Croghan & Brown, 2010, p. 7). Not only do we need to study and share models of integration in primary

care settings that are working, we need to look at the full continuum of behavioral health services, and not only treatment for children with chronic conditions, but also strategies that promote wellness, provide early detection, and help those with emerging problems to find appropriate treatment. In this paper we present 10 elements of an integrated approach that emerged from studying the experiences of a small group of Project LAUNCH grantees. In so doing, we hope to contribute to the articulation of a model for preventive, integrated pediatric care that promotes healthy development at the population level and addresses behavioral problems in the earliest years of life.

Method

Data Collection

The efforts described here represent a qualitative case study approach designed to examine models of integrated care being implemented in primary care settings by a subset of Project LAUNCH grantees. Qualitative data were collected using three methods:

- (1) Telephone interviews were conducted with project directors and key project staff. The interview protocol included three categories of questions: description of the components of the grantee's model, implementation challenges and barriers, and funding strategies. The interview data were compiled and coded for setting, staffing patterns, training, and implementation approaches.
- (2) Four follow-up, open-ended survey questions were sent to all participating grantees to address areas in which interview data were missing from some sites in the original round of interviews. The survey questions focused on sustainability and financing mechanisms as well as a description of implementation processes.
- (3) A content analysis of semiannual progress reports for each of the six grantees.

Site Selection

From 55 funded grantees, the list of potential participating grantees was narrowed to the 18 in the first two cohorts because these grantees were further along in their development at the time of the study (e.g., in the fourth or fifth year of their grants). It was also determined that it would be advantageous to have representation from a diversity of service settings (e.g., private practices, community health centers) and geographic diversity across urban, suburban, and rural areas. Project officers were asked to nominate grantees based on these criteria, and six sites were identified. Participation was voluntary and all grantees who were nominated agreed to participate. All six of the grantees who participated in the study are integrating care in multiple primary care settings; this includes federally qualified health centers, private pediatric clinics, a private obstetrical clinic, hospital clinics (university-affiliated teaching hospitals and private hospitals), community health centers, and one public health department. These grantees are integrating care in rural ($n = 2$), urban ($n = 3$), and suburban ($n = 3$) communities.

Results

Analysis of the qualitative data yielded 10 essential components in the grantees' approaches to integrating care. These components are (a) embedded mental health consultants, (b) inclusion of a family partner/navigator, (c) cross-training, (d) behavioral health screening, (e) wellness promotion and prevention as part of the well-child visit, (f) warm hand-off, (g) assessment and brief intervention, (h) parenting groups and health promotion activities, (i) shared recordkeeping, and (j) care coordination.

Embedded Mental Health Consultants

A cornerstone of the integrated model for all of the sites was the embedding of a master's level mental health clinician (usually known as a mental health consultant) within the primary care setting. The mental health consultant is someone with specialized training in infant/early childhood mental health and child development as well as experience providing child and family mental health services. In all sites the mental health consultant's role included health and wellness promotion, early identification of developmental and behavioral issues, parent support and education, and brief preventive interventions for children and/or caregivers. The role played by the mental health consultant was notably distinct from that of a mental health clinician providing ongoing, long-term behavioral health treatment.

Examples of typical mental health consultant activities described by the sites included being available to join a pediatrician during a well-child visit when a behavioral problem was presented by a parent, following the visit with a more in-depth assessment with the family to understand the context of the problem and to offer parenting support and strategies, a limited number of follow-up visits to monitor the issue, and facilitated referral for more specialized or long-term treatment when needed. In summary, the mental health consultant offered assessment, brief intervention, and linkages to specialty care but did not provide long-term or intensive treatment services. In this sample of grantees, the mental health consultant was most often a licensed clinical social worker. Some sites also utilized a clinical psychologist to address complex diagnoses or "complicated family situations" and/or worked with a psychiatrist for medication and diagnostic consultation.

Inclusion of a Family Partner/Navigator

In addition to a mental health consultant, five of the six sites identified a family navigator or family partner¹ as a key member of the integration team. As one program described it, a family partner is "someone who has raised children with challenging behaviors and/or in environments with risk factors for social/emotional problems" and "who has training in how to help families access community resources and services." Navigators combine elements of peer support with case management and care coordination. Services delivered included linkages to screening, goal setting,

¹For the purposes of this article, the terms *family partner* and *family navigator* are used interchangeably. Some also refer to this individual as a parent consultant.

education about positive parenting practices, and ongoing assistance identifying and accessing community-based resources.

Grantees spoke passionately about the importance and the unique role of the family navigator. One staff member observed how addressing basic needs is often a “gateway to addressing behavioral or mental health issues.” Another grantee noted that the family navigator works in close partnership with the mental health consultant, allowing for a seamless flow in services. She also described how the family navigator plays an important role representing a family perspective on the integrated team, raising awareness in general about family experiences within the community and sometimes serving as a bridge or advocate for a particular family with the rest of the treatment team. In addition, the family navigator greatly supported the primary care practice in connecting with community resources and facilitating successful referrals.

Cross-Training

Sites varied in their approaches to training, but shared two goals: (a) helping primary care staff be optimally equipped to promote social and emotional health and address behavioral health issues and (b) helping integrated staff (e.g., mental health consultants and family navigators) to understand the culture and processes of the primary care practice and learn about physical health issues common in pediatric settings.

Grantees engaged in two main modes of cross-training: one involved intensive, off-site training that provided dedicated time for the whole team (including administrative and medical staff, mental health consultants, and family navigators) to increase interdisciplinary knowledge and establish clear partnership expectations and processes for working together (as one site put it, “to build bridges across two very different cultures”). The other model involved training that was integrated into the regular work week, often involving a combination of formal training and informal case consultation. For example, in one site mental health staff led weekly grand rounds that provided opportunities to learn about behavioral health issues through case illustration. Typical topics included developmental and behavioral screening, interventions for young children who have experienced trauma, attachment issues in infants and young children, and screening for substance abuse and perinatal depression. Grand rounds alternated with provider meetings led by the primary care staff with presentations on various medical topics and clinical case discussions.

One of the six sites took an alternative approach to training that included training all staff in the integrated setting on an evidence-based intervention, the Positive Parenting Program, or Triple P (Sanders, Markie-Dadds, & Turner, 2002). This program is designed to be implemented by a wide range of professionals and provides a common framework and language for primary care staff, the mental health consultant, and the family navigator to use when talking with parents about their own and their children’s behavior. The model includes peer-to-peer support for providers, which promoted case discussions and coordination across the primary care and integrated staff working in the clinic, and because other community providers were also trained in and using the model it also facilitated enhanced communication across a wide spectrum of community agencies.

Behavioral Health Screening

All six grantees included screening for developmental and behavioral issues as a critical component of their integration models. Grantees described several activities that comprised their approach to screening. These included (a) introducing standardized developmental and social/emotional screening instruments to the practice (if not used previously) or adding to the frequency or types of screenings being conducted to ensure that social and emotional development and other behavioral health issues (e.g., perinatal depression) were being monitored; (b) implementing processes to facilitate timely completion of screens (such as screening instruments that are completed and sent in electronically via secure server before the visit, tablets for the waiting room, and staff or volunteers who help families to complete screens before the visit in the waiting room); (c) providing practices with tools, resources, and training to support primary care providers in talking with parents about screening results and about social and emotional milestones in the primary care visit; (d) implementing processes for moving from screening to further assessment by the mental health consultant and/or referral for treatment; and (e) strengthening linkages with community providers to help facilitate successful referrals and coordinated care.

Wellness Promotion and Prevention as Part of the Well-Child Visit

Another common element involved activities designed to support health-care providers in promoting healthy social and emotional development during the well-child visit. All sites offered training by the mental health consultants intended to increase the primary care provider’s comfort in offering anticipatory guidance to families, particularly with regard to social, emotional, and behavioral issues. This included information about what to expect regarding a child’s stage of development as well as guidance to assist in developmentally appropriate parenting. The mental health consultants provided resources on behavioral health topics and shared current research and strategies for addressing issues that may interfere with healthy development such as trauma, prolonged separation, and parental depression.

All sites encouraged the primary care provider to bring promotional activities into well-child visits. For five of the six grantees, the mental health consultant sometimes joined the primary care provider in the examination room and assisted with this function. For the sixth grantee, the mental health consultant was never part of the well-child visit, but the primary care provider conducted a “warm hand-off” to the mental health consultant or family navigator at the conclusion of the visit when there was a behavioral health concern or the need for assistance with accessing community resources.

Warm Hand-Off

One of the benefits of having an integrated mental health consultant in a pediatric practice is the opportunity for a primary care provider to have immediate access to someone who can provide in-depth assessment of behavioral concerns, brief intervention, care planning, and linkages to community-based resources and

specialty care. The *warm hand-off* is a term used to describe the means by which a primary care provider can directly introduce a family to an embedded mental health consultant or family partner at the time of the child's medical visit. The benefit of the warm hand-off is not only the likelihood of immediate care, but also the conferring of trust from the primary care provider to the mental health team in a nonstigmatized and familiar setting. All six sites in this study included the warm hand-off as a component of their integrated models. According to the sites, sometimes the trigger for a warm hand-off was a concern that a parent raised in the course of a visit; other times the trigger was a score on a screen that indicated that further assessment of a developmental or behavioral issue, or a parental behavioral health issue, was warranted. In addition, a warm hand-off might result from a parent asking to directly meet with the mental health consultant.

Sites described three major benefits of the warm hand-off: (a) an opportunity to explore a parent's concerns even when they might be "subclinical," thereby preventatively addressing issues that, if left unchecked, might progress to more significant problems; (b) the opportunity to engage families who are facing complex or significant challenges but who may be reluctant to directly seek treatment. The offer of a "light touch" of parenting support or help addressing some basic needs can over time, as trust and relationships deepen, enable more significant issues to be explored and addressed; and finally (c) the fluidity and flexibility to be maximally responsive to a family's needs over time. As one program staff member noted, "it is not atypical for a family to weave in and out of service. After an initial problem is resolved the family may not come in for a while, then they come back for a well-child visit and it becomes apparent to the doc that there are issues going on that need attention, and the whole cycle starts again."

Assessment and Brief Intervention

The warm hand-off often results in in-depth assessment of a concern and the implementation of a brief preventive intervention. Assessment in the integrated model was described in two ways. First, when a concern emerged in the course of the primary care visit (e.g., a mother who screened positive for depression), this often triggered a behavioral health assessment by the mental health consultant involving some combination of clinical interview and standardized assessment tools. The assessment enabled a deeper understanding of a behavioral or mental health concern and could then lead to a brief intervention or referral for more intensive treatment as needed.

In addition, in most sites, when a concern led a family to meet with the mental health consultant or family navigator, an intake assessment was conducted for the development of a family care plan: a holistic and strengths-based assessment of needs, resources, and goals that extend beyond the immediate issue to a more comprehensive understanding of the family's situation. The assessment process helps the integrated team to understand the social determinants that are impacting the child and family's well-being and to be responsive to the needs and goals that the family identifies as priorities. This rich understanding of the family helps to inform the primary care team in a way that the limited length of a well-child visit does not always permit. This plan can be updated and reevaluated over time as the family achieves goals, resolves concerns, and encounters new challenges.

Although the sites were largely focused on promotion and prevention rather than treatment, most mental health consultants routinely engaged families in brief, evidence-based preventive interventions to address behavioral health or parenting concerns. Most of the sites limited their interventions to six sessions, referring children and families to community-based providers if longer-term or specialized care was needed. Examples of brief and preventive interventions being implemented include Positive Parenting Program, or Triple P (Sanders et al., 2002); Parent Child Interaction Therapy (PCIT; Funderburk, Gurwitsch, & Nelson, 2006); and motivational interviewing.

Parenting Groups and Health Promotion Activities

Five of six sites offered parenting support and education groups to improve family health, parenting, and social support. Examples include the Centering Pregnancy group care model (Baldwin, 2006) co-led by the primary care provider and mental health consultant and evidence-based parenting education groups such as the Incredible Years (Webster-Stratton, 1999), Triple P (Sanders et al., 2002), and Nurturing Parenting (Kaplan & Bavolek, 2007). Some sites have also utilized integrated staff to offer health promotion and family strengthening activities such as parent-child play groups designed to educate about developmental milestones and field trips to introduce parents to free cultural opportunities that promote children's cognitive, physical, and social development. Although these activities are clearly not medical in nature, one site observed that health promotion activities—particularly those for more socially isolated families—helped strengthen the connection between the physicians and the communities they serve.

Shared Recordkeeping

Essential to a truly integrated system are those structural factors that enable all of the members of the care team to work together with a shared understanding of the patient and family. This includes ensuring that members of the treatment team are aware of all aspects of the care being delivered and have the opportunity to regularly communicate. Integrated sites had different ways of ensuring that communication was effective. All six of the grantees reported shared recordkeeping, most typically with the mental health consultant and/or family navigator entering notes into the medical record (sometimes but not always an electronic health record). One grantee also reported work on a larger systems effort at the state level that would allow some of these data (such as screening data) to be entered into a global system that could be accessed by providers in different settings.

Care Coordination

Sites were consistent in their emphasis on the need for care coordination, but they varied in terms of how this was achieved. Grantees invested time in conducting comprehensive assessments to gain an informed understanding of the child and family and some of their assets, strengths, and challenges. Care coordination was viewed as an opportunity to ensure that all members of the

team, including primary care providers, could benefit from this enhanced understanding and a shared conceptualization of the family's strengths and challenges. Two of the grantees reported that teams engaged in formal, regular meetings devoted solely to this goal of coordinating care. The four remaining sites reported a mix of care coordination "on the go" (e.g., before or after a warm hand-off) combined with staff meetings or at other times designated for case discussions.

Beyond the 10 common elements that emerged from the qualitative study of these six sites, a concern discussed by all of the all grantees was how to sustain the integrated models that they had created (or enhanced) through their grants when federal funding ended. Two challenges that all of the sites grappled with were how to fund integrated, preventive behavioral health services and how to evaluate their programs so as to measure and document value added or cost savings and to inform continuous refinement of their models.

Financing

Determining a cost benefit for integrated care is underway in many quarters. Among the grantees we interviewed, one had conducted a study of their family navigator program and found a return on investment of \$8.54 saved for each dollar invested when health-care costs and social costs were aggregated (Custer, 2013). The grantees in this sample were all working actively, with some success, to find opportunities to fund prevention and promotion activities. Two of the sites have succeeded in having their embedded staff hired as part of the medical home team, but sustaining the salaries of integrated staff can be challenging. Unlike a mental health clinician who is providing billable treatment services to patients with behavioral health diagnoses, many aspects of the care described here (e.g., the flexibility to be available for a warm hand-off, the opportunity to do a comprehensive assessment and provide parenting support even without a diagnosis) are traditionally hard to recoup through third-party billing. One site is at work on Medicaid billing codes for child consultation linked with a physical diagnosis; another is pursuing codes for interdisciplinary treatment team meetings and dyadic or parent-only sessions. A third grantee reported success in getting their medical providers to begin billing for screening for the first time; they also succeeded in getting Medicaid reimbursement for their more extensive assessments, but only after an arduous process of getting their embedded mental health staff credentialed as members of the medical home team. Other strategies that the grantees have used include leveraging county and state dollars set aside for integrated services, accessing community mental health funds and state mental health block grant funds, and building integrated services into other federal funding streams such as the Race to the Top Early Learning Challenge grants. One grantee is seeking university hospital funding whereas another has recently succeeded in securing foundation money to replicate their integrated model in a new site.

Site-Specific Evaluation of Integration Efforts

At the time of the interviews conducted for the purposes of this paper, all six sites were still engaged in ongoing evaluation of their

integrated models, and although none of the evaluations had been completed, some promising interim findings had emerged. The variations in methodology and rigor across sites suggests that there is much work to be done in the area of demonstrating the effectiveness of integrated preventive models; however, there were some commonalities in the approaches to evaluation that might be instructive. The sites interviewed were looking at four broad categories of outcomes: systems, providers, families, and children. Each of these types of outcomes will be discussed briefly here.

Systems outcomes were primarily described qualitatively and were collected via reviews of administrative records, key informant interviews, provider surveys, and implementation data. Systems outcomes included changes in policies, practices, funding, and service delivery. Examples of systems changes included widespread changes in screening practices and the merger of a federally qualified health center and a community mental health center that stemmed from successes in integrating care.

All sites collected provider outcome data. The method used was a combination of provider surveys given to integrated staff (non-standardized, self-report instruments), key informant interviews, and focus groups. Provider surveys were administered at regular intervals and multiple time points so that changes in provider knowledge and practice could be tracked over time. Examples of data collected included self-reported knowledge of children's social/emotional and behavioral health, knowledge of developmental screening tools, and knowledge of available options for follow-up services. Changes in provider practice and attitudes over time included self-reported changes in the use of mental health consultation services, use of screening instruments, and attention to mental and behavioral health issues and parent/child interactions. Limitations of the data are that they are all based on self-report and nonstandardized instruments were used. Another avenue that was not explored by any of these sites was collecting data from parents regarding any perceived changes in provider attitude or behavior (and satisfaction with providers) as a result of the integrated model of care.

Parent outcome data ranged across the six sites. All of the sites included nonstandardized measures of parent satisfaction and parent perceptions of child well-being. Two of the sites collected pre- and postdata using standardized measures of parent well-being, including the Parenting Stress Index (Abidin, 1997), the Protective Factors Survey (Counts, Buffington, Chang-Rios, Rasmussen, & Preacher, 2010), and the Patient Health Questionnaire-9 (Kroenke, Spitzer, & Williams, 2001). One additional site used a measure created by a model developer that had not yet been validated to look at parent confidence and parents' perceptions about their role as parents. Results are limited by methodology and instruments, but they suggest that parent outcome data represent a promising avenue for assessing integrated care. Significant reductions in parental depression and parental stress using standardized measures underscore the need for continued rigorous exploration in this area.

Similarly, rigorous evaluation findings for child outcomes are limited but promising. Three of the sites were using a standardized instrument of child behavior, such as the Child Behavior Checklist (Achenbach, 2009), to look at changes in child behaviors over time: one of the three sites used a quasi-experimental design and the other two collected pre- and post-test data. Only one of the sites had child outcome data to report at the time of the interviews.

Using the Child Behavior Checklist, this grantee reported a statistically significant drop in children's problem behavior scores from baseline to 12-month follow-up; this finding was for children (6–8 years old) who participated in LAUNCH services across three primary care settings.

Discussion

An examination of the behavioral health integration practices among a sample of six Project LAUNCH grantees yielded interesting commonalities in approach. Although there were some variations among sites in terms of specific strategies, a group of 10 common elements emerged from the qualitative data. Although preliminary and exploratory in nature, these data begin to articulate a model for promoting health and preventing social, emotional, and behavioral problems within a general pediatric primary care population. At the same time, the findings from this small study indicated that there is still much work to be done, particularly in the areas of financing and building an evidence base that demonstrates effectiveness. Although the ACA holds the promise of funding more prevention and a wider array of health promotion activities, many aspects of operationalizing the ACA remain to be worked out. The sites interviewed are demonstrating some initial successes in finding mechanisms to sustain their integrated work, but there is a need for leadership in creating mechanisms, models, and policies for funding this form of preventive care if it is to be adopted on a larger scale.

Demonstrating the health and other social benefits of integrated care is critical. Developing and evaluating models of preventive integration will precede a willingness to fund such models. As noted earlier in this article, there is some evidence in the literature to suggest positive outcomes associated with integrated care, but these tend to be for adults and related to treatment rather than prevention and promotion activities. The grantees involved in this qualitative study are all conducting individual program evaluations, and some promising findings have emerged from their work; however, a limitation of these individual evaluation efforts is the lack of consistency across sites in methodology and measures.

Conclusion

Although work remains to be done in terms of viable funding mechanisms and expanding the evidence base to support integrated care, it is important to articulate and refine models that promote healthy development at a population level and that address developmental and behavioral problems before they become costly to families and society. This paper attempts to describe some facets of integrated care implemented in pediatric practices by six Project LAUNCH grantees in hopes that this will contribute to an ongoing discussion of the need, and effective strategies, for integrated care for young children and families with a focus on promotion and prevention. Now, as models for family centered health homes are concretized in practice, it is a critical moment to build the policies, guidelines, workforce, evidence base, and cost structures that will enable more widespread uptake of this promising approach.

Keywords: wellness promotion; pediatrics; integration of behavioral health into primary care; Project LAUNCH; mental health consultation

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