Meadows Mental Health Policy Institute

Integration and the Pediatric Behavioral Workforce (March 2022)

The Pediatric Mental Health Crisis is in Part a Workforce Crisis

As Surgeon General, Dr. Vivek Murthy warned late last year in America's first ever public health advisory focused on mental health,[1] even before COVID-19, mental illness among America's youth was already at a crisis point, and the pandemic has made it much worse. While that historic advisory emphasized the need to address the workforce, it perhaps understated the degree of the US's over-stretched and mis-deployed workforce. Recent estimates predict provider shortages across six behavioral health subspecialties surpassing a quarter of a million FTEs by 2025.[2] More alarmingly, the pediatric mental health workforce shortage will lead to long-term negative outcomes across countless dimensions, particularly underserved communities,[3] with pronounced inequities across communities of color.[4,5,6,7]

In addition to shortages, our pediatric mental health workforce is not well deployed up-stream in US primary care settings when compared to other industrialized nations.[8] This is a major reason why we do not detect and treat mental health needs until eight to ten years after symptoms emerge.[9] In addition, pediatric health care expenses are higher in the US than in almost all other industrialized countries,[10] while research consistently suggests that US pediatric health outcomes fall far below that of average citizens living in other developed nations.[11,12,13]

Thankfully, President Biden's Unity Agenda has elevated these needs into an opportunity for change, prioritizing strategies to increase capacity, connect more people to care, and create a continuum of support to address this national crisis, including primary care integration.[14]

Primary Care Integration as a Transformative, Scalable Response

Integration of mental health and substance use treatment is the strategy with the most potential to address pediatric workforce challenges by better leveraging both the pediatric primary care and behavioral health specialty care workforces.[15] In early 2021, comprehensive studies through both RAND and the Bipartisan Policy Center endorsed these strategies, including specific recommendations consistent with what we propose below.[16,17]

Specifically, two models best represent the effectiveness of addressing workforce shortages by treating patients in primary care instead of referring them to overwhelmed and understaffed specialty care systems: 1) the Collaborative Care Model (CoCM) and 2) Primary Care Behavioral Health (PCBH). As detailed further in Appendix One, CoCM and PCBH each have the potential to magnify the reach of our limited workforce many times over (CoCM can leverage psychiatrist time 3.5 times over and PCBH can leverage other licensed practitioner time 2.65 times over).

CoCM is the most extensively researched and evidence-based integration strategy to detect and treat mental health and substance use disorders before they become crises,[18] and it is now being implemented at scale in healthcare systems serving millions of Texans.[19] Importantly, CoCM is proven to work just as well for Black, Hispanic, and other communities of color,[20, 21] and PCBH has shown growing promise with pediatric populations.[22]

Though certain distinctions exist between the two population health approaches (*highlighted in Appendix Two, Figure 1, Comparison of Collaborative Care Model (CoCM) and Primary Care Behavioral Health (PCBH)*), both effectively address pediatric workforce shortages[23,24,25] by (a) sharing an interdisciplinary team-based structure, (b) treating a wide array of behavioral health presentations, (c) leading to stigma-reduction, (d) utilizing evidence-based measures to guide treatment planning and monitoring, (e) having dedicated insurance billing codes for long-term financial sustainability for practices, (f) allowing for real time availability of behavioral health care, (g) and employing brief, evidence-based interventions in a short-term care format to help patients access care sooner.

Primary Care Integration: A Financially Sustainable Workforce Solution

The need for lean staffing models is a consistent concern for pediatric health systems, and limited financial performance predictability often results in significant barriers to implementing new models of care.[26,27] Both CoCM and PCBH address this challenge through approved existing billing codes that are reimbursed by Medicare, most major commercial insurance plans, and most states' Medicaid plans. Texas, of note, is expected to activate Medicaid reimbursement for CoCM in CY 2022 which is driving implementation of CoCM and integration broadly.

In addition, American Rescue Plan Act (ARPA) funds have been deployed in Texas to accelerate implementation of integration in pediatric settings and overcome workforce shortages. The Meadows Mental Health Policy Institute is coordinating the distribution of $7 million in ARPA funds over the next two years to facilitate implementation of integrated pediatric care in 18 health systems reaching over 1 million Texas youth. Through this work, Texas is increasing the effectiveness and efficiency of primary care physicians, optimizing scarce psychiatric expertise, and reserving highly sought-after psychology expertise for specialty mental health needs.

Priority Solutions We Recommend

- Support widespread implementation of CoCM and PCBH as priority models to address the pediatric workforce shortage.
- Launch a CMS-led National Care-Coordination Initiative to deliver technical assistance, implementation tools, and a learning collaborative for implementers (similar to Recommendation 14 in the RAND report previously cited).[28] Congressional efforts such as the Collaborate in an Orderly and Cohesive Manner Act (H.R. 5218) by Rep. Fletcher

(D-TX) and Rep. Herrera Beutler (R-WA) could form the basis for such action, if broadened to include PCBH and scaled up to funding levels sufficient for national scaling (e.g., scaling Texas-based efforts nationally would cost about $100 million annually).

- Support reimbursement of CoCM and PCBH across all commercial and public payers to ensure financial sustainability of integration in primary care and pediatric settings. Given its central role in reaching children in poverty, a priority on Medicaid (including federal subsidies to increase rates and uptake by states) should be central to this action.

About Us

The Meadows Institute is a Texas-based non-profit policy research institute committed to improving the availability and quality of evidence-based mental health and substance use care. The Meadows Institute provides independent, nonpartisan, data-driven, and trusted policy and implementation guidance that creates systemic and equitable changes, so effective and efficient behavioral health care is available to everyone, when and where they need it.[29]

For questions regarding these comments, please contact Kacie Kelly, Senior Vice President for National Policy Implementation, at kkelly@mmhpi.org or (650) 279-3542 (m).

Appendix: Additional Information on CoCM and PCBH

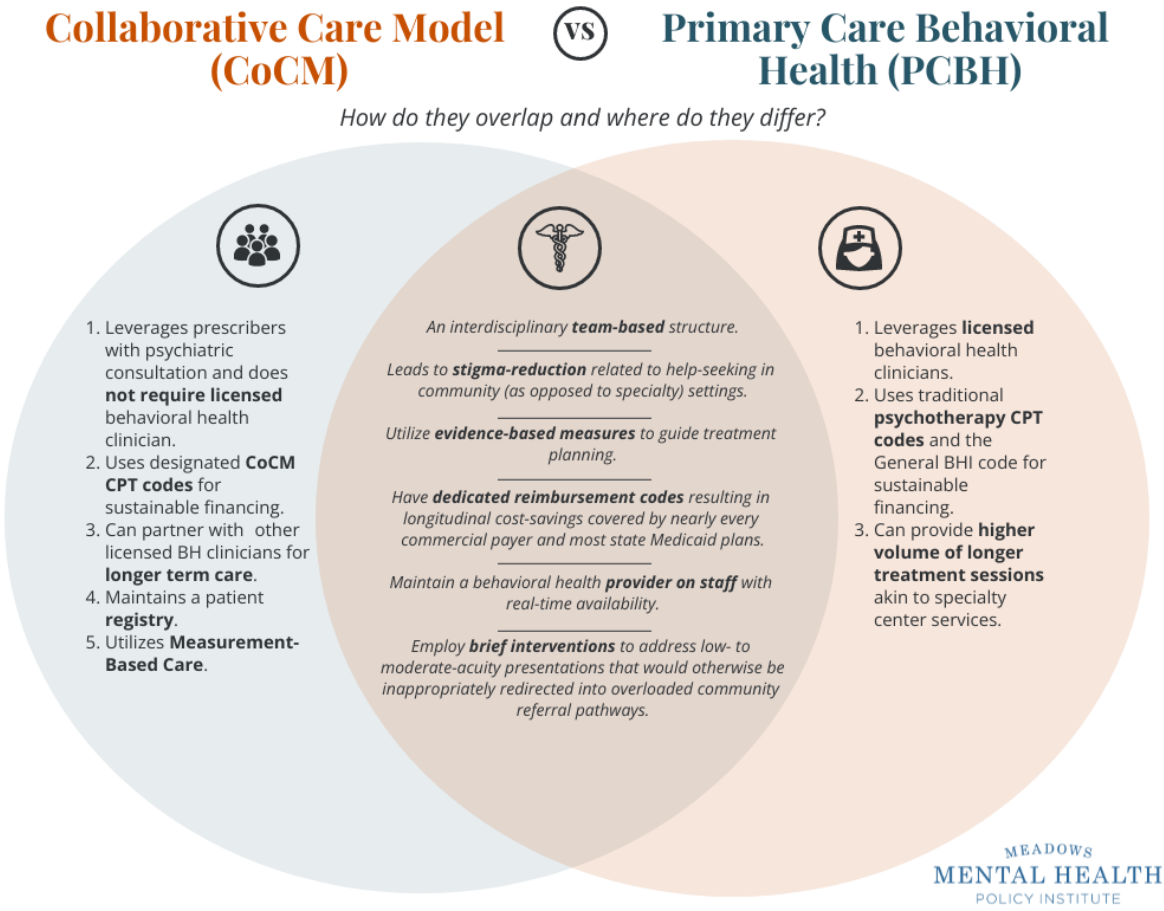
Table 1: Features of Collaborative Care Model (CoCM) Workforce Optimization	
Feature	**Data**
Patients Seen Annually in CoCM	225
Mean Caseload Size	75
Mean Duration of CoCM Treatment Episode	4 months
Behavioral health Care Manager FTE*	1.0 (40 hr/wk)
Psychiatric Consultant FTE†	0.05 (1-2 hr/wk)
New Patients Seen Annually by Psychiatric Consultant (in Traditional Care Model with Same FTE)	48-96
Yearly Psychiatric Consultant Time Leveraging Factor (midpoint / range)‡	3.5x / 2.3-4.7x

*The behavioral health care manager requires specialized training in CoCM. They must be trained to conduct a CoCM evaluation and to provide brief interventions in primary care. The behavioral health care manager does not have to be a licensed behavioral health clinician; many programs even make use of bachelors level staff. In addition, CoCM works just as well virtually with telehealth, as in person.
†The psychiatric consultant requires mental health training and must be able to prescribe the full range of psychiatric medications. Commonly, the psychiatric consultant is a physician (MD, DO), advanced practice nurse, or physician assistant.
‡Leveraging factor represents the quotient of the: (1) the range of estimated new patients reviewed annually by the psychiatric consultant through CoCM, and (2) estimated number of new patients seen independently by a psychiatric consultant in a traditional care model over a 48-week work year with 0.025-0.05 FTE (assuming a 1-hour intake visit).

Table 2: Features of PCBH Workforce Optimization	
Feature	**Data**
Patients Seen Annually in PCBH	126
Mean Caseload Size	42
Mean Duration of PCBH Treatment Episode	4 months
Psychologist/LCSW FTE*	1.0 (40 hr/wk)
New Patients Seen Annually by Psychologist/LCSW (in Traditional Care Model with Same FTE)	36-72
Yearly PCBH Provider Time Leveraging Factor (midpoint / range) ‡	2.65x / 1.8-3.5x

*The psychologist/LCSW requires specialized training in PCBH. They must be trained to conduct a PCBH evaluation and to provide brief interventions in primary care. The psychologist/LCSW is required to be a licensed behavioral health clinician.
‡Leveraging factor represents the quotient of the: (1) the range of estimated new patients reviewed annually by the psychologist/LCSW through PCBH, and (2) estimated number of new patients seen independently by a psychologist/LCSW in a traditional care model over a 48-week work year with 1.0 FTE (assuming a 1-hour intake visit).

Figure 1. Venn Diagram of Collaborative Care Model (CoCM) and Primary Care Behavioral Health (PCBH)



Endnotes

[1] The U.S. Surgeon General's Advisory. (2021). *Protecting youth mental health.* https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf

[2] Health Resources and Services Administration/National Center for Health Workforce Analysis; Substance Abuse and Mental Health Services Administration/Office of Policy, Planning, and Innovation. (2015). *National projections of supply and demand for behavioral health practitioners: 2013-2025.* https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/behavioral-health-2013-2025.pdf

[3] U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. (2020). *Using HRSA's health workforce simulation model to estimate the rural and non-rural health workforce.* https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/hwsm-rural-urban-methodology.pdf

[4] Ramchand, R., Gordon, J. A., & Pearson, J. L. (2021). Trends in suicide rates by race and ethnicity in the United States. *JAMA Network Open*, *4*(5), e2111563. https://doi.org/10.1001/jamanetworkopen.2021.11563

[5] Panchal, N., Kamal, R., Cox, C., & Garfield, R. (2021, February 10). *The implications of COVID-19 for mental health and substance use.* Kaiser Family Foundation.
[6] Kuchment, A., Hacker, H.K, Solis, D. (2020, December 19). *COVID's 'untold story': Texas Blacks and Latinos are dying in the prime of their lives*. The Dallas Morning News. https://www.dallasnews.com/news/2020/12/19/covids-untold-story-texas-blacks-and-latinos-are-dying-in-the-prime-of-their-lives/
[7] Hillis, S. D., Blenkinsop, A., Villaveces, A., Annor, F. B., Liburd, L., Massetti, G. M., Demissie, Z., Mercy, J. A., Nelson III, C. A., Cluver, L., Flaxman, S., Sherr, L., Donnelly, C. A., Ratmann, O., & Unwin, H. J. T. (2021). COVID-19–associated orphanhood and caregiver death in the United States. *Pediatrics*, *148*(6), e2021053760. https://doi.org/10.1542/peds.2021-053760
[8] Tikkanen, R., Fields, K., Williams III, R. D., & Abrams, M. K. (2020). *Mental health conditions and substance use: Comparing U.S. needs and treatment capacity with those in other high-income countries*. The Commonwealth Fund. https://www.commonwealthfund.org/publications/issue-briefs/2020/may/mental-health-conditions-substance-use-comparing-us-other-countries
[9] American Academy of Child & Adolescent Psychiatry. (2012). *Best principles for integration of child psychiatry into the pediatric health home*. https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/best_principles_for_integration_of_child_psychiatry_into_the_pediatric_health_home_2012.pdf
[10] Squires, D., & Anderson, C. (2015). U.S. health care from a global perspective: Spending, use of services, prices, and health in 13 countries. *Issue Brief (Commonwealth Fund)*, *15*, 1–15.
[11] Emanuel, E. J., Gudbranson, E., Van Parys, J., Gørtz, M., Helgeland, J., & Skinner, J. (2021). Comparing health outcomes of privileged US citizens with those of average residents of other developed countries. *JAMA Internal Medicine*, *181*(3), 339. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2774561
[12] Chen, A., Oster, E., & Williams, H. (2016). Why Is infant mortality higher in the United States than in Europe? *American Economic Journal: Economic Policy*, *8*(2), 89–124. https://www.aeaweb.org/articles?id=10.1257/pol.20140224
[13] OECD. (2019). *Health at a glance 2019: OECD indicators*. OECD. https://doi.org/10.1787/4dd50c09-en
[14] The White House. (2022, March 1). *FACT SHEET: President Biden to announce strategy to address our national mental health crisis, as part of Unity Agenda in his First State of the Union*. https://www.whitehouse.gov/briefing-room/statements-releases/2022/03/01/fact-sheet-president-biden-to-announce-strategy-to-address-our-national-mental-health-crisis-as-part-of-unity-agenda-in-his-first-state-of-the-union/
[15] Asarnow, Joan Rosenbaum, Rozenman, M., Wiblin, J., & Zeltzer, L. (2015). Integrated medical-behavioral care compared with usual primary care for child and adolescent behavioral health: A meta-analysis. *JAMA Pediatrics*, *169*(10), 929. https://jamanetwork.com/journals/jamapediatrics/fullarticle/2422331
[16] McBain, R. K., Eberhart, N. K., Breslau, J., Frank, L., Burnam, M. A., Kareddy, V., & Simmons, M. M. (2021). How to transform the U.S. mental health system: Evidence-based recommendations. RAND Corporation. https://www.rand.org/pubs/research_reports/RRA889-1.html
[17] BPC Behavioral Health Integration Task Force. (2021). *Tackling America's mental health and addiction crisis through primary care integration: Task force recommendations.* Bipartisan Policy Center. https://bipartisanpolicy.org/wp-content/uploads/2021/03/BPC_Behavioral-Health-Integration-report_R01.pdf
[18] Carlo, A. D., Barnett, B. S., & Unützer, J. (2021). Harnessing collaborative care to meet mental health demands in the era of COVID-19. *JAMA Psychiatry*, *78*(4), 355. https://doi.org/10.1001/jamapsychiatry.2020.3216
[19] Meadows Mental Health Policy Institute. (2021). *Lone star depression challenge.* https://mmhpi.org/the-lone-star-depression-challenge/
[20] Wells, K., Sherbourne, C., Schoenbaum, M., Ettner, S., Duan, N., Miranda, J., Unützer, J., & Rubenstein, L. (2004, April). Five-year impact of quality improvement for depression: Results of a group-level randomized controlled trial. *Archives of General Psychiatry, 61*(4), 378–386. https://pubmed.ncbi.nlm.nih.gov/15066896/

[21] Ell, K., Aranda, M. P., Xie, B., Lee, P-J., & Chou, C-P. (2010, June). Collaborative depression treatment in older and younger adults with physical illness: Pooled comparative analysis of three randomized clinical trials. *American Journal of Geriatric Psychiatry, 18*(6), 520–530. https://pubmed.ncbi.nlm.nih.gov/20220588/

[22] Remoue Gonzales, S., & Higgs, J. (2020). Perspectives on integrated behavioral health in pediatric care with immigrant children and adolescents in a Federally Qualified Health Center in Texas. *Clinical Child Psychology and Psychiatry*, *25*(3), 625–635. https://journals.sagepub.com/doi/10.1177/1359104520914724

[23] Covino, N. A. (2019). Developing the behavioral health workforce: Lessons from the states. *Administration and Policy in Mental Health and Mental Health Services Research*, *46*(6), 689–695. https://link.springer.com/article/10.1007/s10488-019-00963-w

[24] Lauerer, J. A., Marenakos, K. G., Gaffney, K., Ketron, C., & Huncik, K. (2018). Integrating behavioral health in the pediatric medical home. *Journal of Child and Adolescent Psychiatric Nursing*, *31*(1), 39–42. https://onlinelibrary.wiley.com/doi/10.1111/jcap.12195

[25] Kepley, H. O., & Streeter, R. A. (2018). Closing behavioral health workforce gaps: A HRSA program expanding direct mental health service access in underserved areas. *American Journal of Preventive Medicine*, *54*(6), S190–S191. https://www.ajpmonline.org/article/S0749-3797(18)31633-7/fulltext

[26] Sanchez, K. (2017). Collaborative care in real-world settings: Barriers and opportunities for sustainability. *Patient Preference and Adherence*, *Volume 11*, 71–74. https://www.dovepress.com/collaborative-care-in-real-world-settings-barriers-and-opportunities-f-peer-reviewed-fulltext-article-PPA

[27] Freeman, D. S., Manson, L., Howard, J., & Hornberger, J. (2018). Financing the primary care behavioral health model. *Journal of Clinical Psychology in Medical Settings*, *25*(2), 197–209. https://link.springer.com/article/10.1007/s10880-017-9529-4

[28] McBain, et al. (2021). Previously cited.

[29] The Meadows Institute website can be viewed here: https://mmhpi.org; our latest policy work here: https://mmhpi.org/work/policy-updates/; and our history here: https://mmhpi.org/about/story-mission/