Pediatric and Adolescent Collaborative Care Roundtable

FINAL REPORT

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MEADOWS
MENTAL HEALTH
POLICY INSTITUTE

Meadows Mental Health Policy Institute

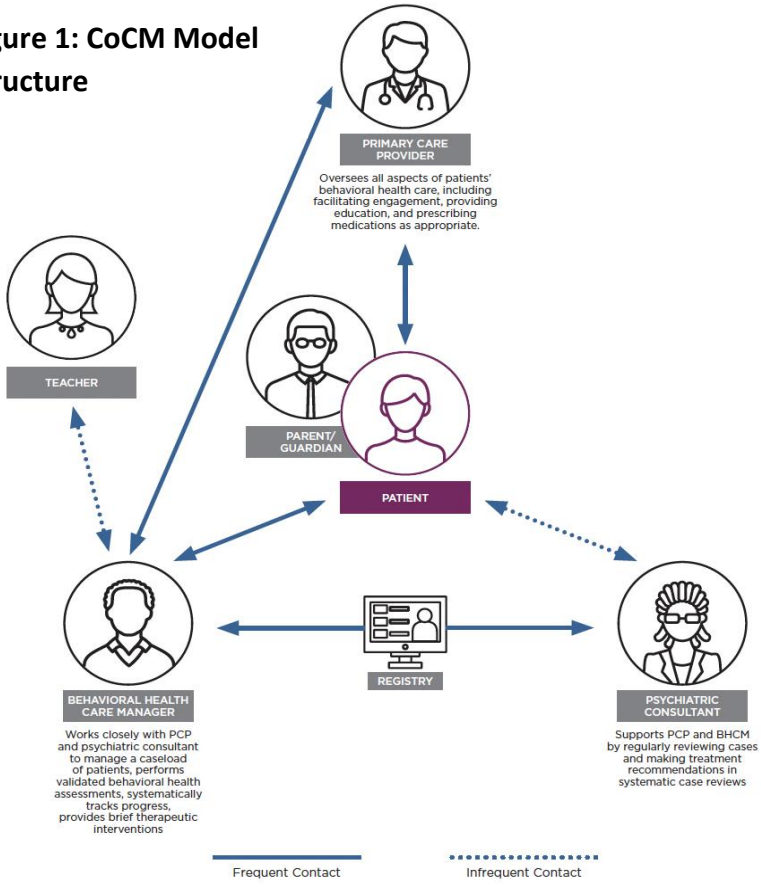
Pediatric and Adolescent Collaborative Care Roundtable

Background

Even before the COVID-19 pandemic began, every leading indicator related to mental health and addiction was worsening for youth and adults.[1,2] Nearly half of teenagers in the U.S. report they struggle with persistent feelings of sadness and hopelessness.[3] Youth are also reporting serious thoughts of suicide at disturbing rates: 20% of high school students and 11% of transition-age youth (ages 18-25),[4] with the rate of suicide among Black youth growing at alarming rates.[5] Simultaneously, severe shortages in the overall behavioral health workforce make it all but impossible to meet the current need with specialty providers,[6] particularly in underserved communities.[7] Half of all mental health conditions manifest by age 14,[8] and yet children and youth are waiting an average of eight to 10 years before they access care.[9] This demonstrates that we are missing an opportunity to intervene at a time when services can have the most impact.

The collaborative care model (CoCM) is the integrated behavioral health model with the strongest evidence base to effectively address the needs of our mental health care system, including for youth and children.[10,11,12,13] CoCM enables a pediatric primary care provider (PCP) or pediatrician, psychiatric consultant, and behavioral health care manager (BHCM) to support the patient and their family in a primary care office by using a patient registry to track and follow the patient's progress. In an integrated care approach under the clinical direction of the PCP, this CoCM team works together to detect and provide evidence-based interventions for common mental health

Figure 1: CoCM Model Structure



problems, measure the patient's progress toward treatment targets, and adjust the patient's treatment plan when appropriate. When implementing CoCM, medically focused visits include screening for common behavioral health disorders (e.g., depression or anxiety); the team offers enrollment into the CoCM program if a behavioral health need is detected and then proceeds accordingly (see Figure 1).

Research background

The research validating pediatric integrated behavioral health care models, including studies implementing CoCM, are limited. A recent systematic review highlighted the paucity of pediatric CoCM implementation studies, reporting that most pediatric integrated behavioral health studies focused on population-based care, measurement-based care, and the provision of evidence-based mental health services.[14] However, as described in Table 1, a few key studies have focused on pediatric CoCM in patients with the following diagnoses: depression, ADHD, behavior problems, and anxiety.[15,16,17,18,19,20] All the studies included in Table 1 feature integrated behavioral health models with the core elements of CoCM. Comparison groups varied across research design types from some studies comparing between standard treatment and control groups (i.e., treatment as usual or enhanced usual care)[21,22,23,24] to others comparing across implementations in different clinics.[25,26] Some studies examined both patient and provider outcomes to consider the feasibility and effectiveness of CoCM.[27,28]

Table 1: Summary of Existing Literature						
Study (Type)	**Age**	**Diagnosis**	**Inclusion Criteria**	**Exclusion Criteria**	**Comparison Group(s)**	**Findings**
Kolko et al, 2014 (Cluster RCT)	5-12 years old	Behavior problems, ADHD, and Anxiety	Patients meeting clinical cutoff for externalizing behavior sub score on PSC-17	Diagnosis (e.g., bipolar disorder), emergent symptoms (e.g., suicidal intent), or parallel treatment	Enhanced usual care which included brief psychoeducation, a facilitated referral to local mental health provider, and the option receive ADHD meds from PCP	CoCM was associated with enhanced: (1) access to and completion of behavioral health services, (2) child and parental out-comes, (3) consumer satisfaction, (4) and provider efficacy and skill to treat ADHD.
Richardson et al, 2014 (RCT)	13-17 years old	Depression	PHQ-2, PHQ-9 x 2 with CDRS-R > 42 or positive for MDD on KSIADS	Suicidal plan or recent attempt, bipolar disorder, CRAFFT $\geq$5, parallel treatment, developmental delay	Usual care which included a letter with test results and follow-up information to both parents and PCPs	Participation in CoCM resulted in greater improvement in depressive symptoms at 12 months as compared to usual care.
Silverstein et al, 2015 (Randomized Comparative Effectiveness)	6-12 years old	ADHD	PCP initiated evaluation for ADHD based on parent report	Existing ADHD, ASD, bipolar disorder, parallel treatment	Basic versus enhanced groups modeled from CoCM with enhanced care including additional training to care managers to address 3 common reasons for ADHD symptoms persistence	Children in the enhanced care arm experienced better symptom trajectories. Using lay care managers to address barriers to engagement and challenging child behaviors could have some added benefit.
Parkhurst et al, 2021 (Non-randomized, non-controlled)	6-18 years old	Mild-moderate Anxiety, Depression, or complex ADHD	Referred from participating pediatric providers	N/A	N/A	Patients experienced significant improvement in ADHD and Anxiety symptoms and pediatrician attitudes and access to care substantially improved.
Shippee et al, 2018 (Retrospective Cohort)	12-17 years old, 18 years old and in high school	Depression	Depression diagnosis - a score of ≥ 10 on PHQ-A	Diagnosis of bipolar disorder	Usual care which included a PCP or provision of a list of community providers	Participants in EMERALD had better adjusted rates of depression remission and treatment response than the patients in the comparison group.
Myers et al, 2010 (Non-randomized, non-controlled)	6-12 years old	ADHD	Diagnosed with ADHD by pediatricians at well-child appointment	N/A	N/A	Patients at the urban and rural sites showed comparable reductions in ADHD symptoms. Staff expressed the need for more administrative support in implementing the model.

Improvements across all the studies were seen in patients who received care through CoCM, though differences in the implementation of the model were apparent between studies. These variations in CoCM implementation and the limited number of studies contribute to the lack of documented consensus surrounding CoCM workflow, diagnostic scope, age ranges, and staffing.

Inaugural Pediatric and Adolescent CoCM Roundtable

With the primary goal of achieving and documenting expert consensus on key pediatric and adolescent CoCM implementation elements, the Meadows Mental Health Policy Institute (Meadows Institute), in partnership with Dell Medical School, hosted the Inaugural Pediatric and Adolescent Collaborative Care Roundtable at the University of Texas at Austin Dell Medical School on January 26 and 27, 2023. Twenty of the nation's preeminent experts in pediatric CoCM participated in this two-day event, sharing their experiences regarding real-world pediatric and adolescent CoCM implementation across dimensions. The group discussed key facilitators and barriers to implementation and how to support a high-fidelity, broad-based uptake of pediatric and adolescent CoCM.

Methodology of Analysis

In preparation of the roundtable, Meadows Institute staff met twice weekly to plan five months prior to the event and completed a literature review to identify leading pediatric CoCM experts across the county. A steering committee, comprised of the Meadows Institute team and two external national pediatric CoCM experts, was developed to assist with the planning process and develop the roundtable structural framework. An invitation list was created using snowball sampling to identify individuals either with a national CoCM presence, experience with real-world pediatric CoCM implementation, or a history of involvement with formal research studies evaluating pediatric CoCM. With all individuals invited to participate attending the roundtable, there were 21 total participants. Participant characteristics are outlined in Table 2**.**

During the two-day event, participants carefully reviewed five topics: the pediatric and adolescent population, the work of the BHCM, engagement, operational feasibility/sustainability, and evaluation. Each topic was introduced by a member from the steering committee before the larger group broke into smaller groups for a 45-minute discussion of specific questions related to each topic. Different combinations of individuals were selected for each small group discussion to ensure that all participants directly interacted with each other. Following the small group discussions, all participants rejoined the large group to share key findings and further discuss the topic at hand for an additional 45 minutes. These small and large group sessions were not recorded, but comprehensive notes were taken and compiled into detailed summaries.

Table 2: Participant Characteristics (N=21)		
Characteristic	**Category**	**Number (%)**
Region of Work	NE	6 (0.29)
	MW	3 (0.14)
	S	9 (0.43)
	W	3 (0.14)
Institution Type	Academic Medical	12 (0.57)
	Non-Academic Medical	8 (0.38)
	Other	1 (0.05)
Training, Background, or License	MD/DO	12 (0.57)
	ARNP/PA-C	1 (0.05)
	PhD/PsyD	4 (0.19)
	Master's Degree (Clinical)	2 (0.10)
	Master's Degree (Non-Clinical)	1 (0.05)
	Other	1 (0.05)
Work Type	Pediatrics	2 (0.10)
	Child Psychiatry	8 (0.38)
	Child Psychology	4 (0.19)
	Adult Psychiatry	3 (0.14)
	Adult Medicine	1 (0.05)
	Behavioral Health Care Manager (BHCM)	1 (0.05)
	Other	3 (0.14)
Work Focus	Primary Research	4 (0.19)
	Primary Clinical	11 (0.52)
	Other	6 (0.29)

Following the event, a roundtable evaluation team comprised of Meadows Institute staff was developed to conduct an in-depth review of the notes, systematically identifying key findings from each topic. At least two team members reviewed the notes from each small and large group session and then met to discuss their key findings. Discrepancies were discussed and resolved, and the group collectively identified and described emergent themes. All evaluation team members contributed to the drafting and review of this manuscript.

Results Summary

Overall, the roundtable findings highlight some of the unique considerations of pediatric CoCM, such as structuring clinical operations, facilitating stakeholder engagement, and carefully defining the BHCM role in the context of the individual's background and skills. **Participants overwhelmingly agreed that pediatric CoCM is an immediately actionable and practical solution to the current pediatric mental health crisis nationwide.** We summarize salient points of consensus and areas requiring further exploration within each of the five pediatric CoCM topic areas discussed during the roundtable:

Topic 1: The Pediatric CoCM Treatment Population

Participants agreed on the importance of conducting a comprehensive institutional needs assessment prior to CoCM implementation in a health system, noting that it should include

meaningful input from key stakeholders, including the health system, the community, patients, and families, among others. Additionally, participants agreed that CoCM, which has been primarily evaluated in adult-focused studies to date, is most easily adapted in the pediatric population for adolescents who are 12 years and older. Although the most treated behavioral health conditions in published pediatric CoCM studies were noted as depression, anxiety, and ADHD, participants agreed on the importance of considering more than just formal diagnosis when defining a program's treatment scope. Participants voiced varying opinions on exactly which additional measures or elements should be considered in pediatric CoCM, such as functional status, subjective distress, and measurable symptom elements. Some participants advocated for a model that transcended diagnosis altogether since formal diagnosis may be elusive for pediatric patients and lead to stigmatization in certain contexts. Despite this sentiment, participants universally acknowledged that a diagnostic code is required in pediatric CoCM for billing purposes.

Several participants suggested CoCM is structured differently for patients of different age ranges (e.g., 4-8 and 9-12) due to the notable heterogeneity in mental and physical health problems across the child and adolescent age spectrum. Others, however, thought that this could be a cumbersome or overly prescriptive process. Additionally, participants did not agree on a maximum patient acuity or illness severity level that is appropriate for pediatric CoCM. Some felt that pediatric CoCM was most appropriate for mild or moderate behavioral health problems (as with the adult population), while others reported that such treatment scope restrictions were impractical and did not adequately respond to the current pediatric behavioral health access crisis. Two areas for further exploration include the importance of building programs based on age cohorts and the exact diagnostic scope that can benefit from CoCM.

Topic 2: The Work of the BHCM

Participants generally agreed that BHCM skill sets in pediatric CoCM can be grouped into three categories: inherent skills (e.g., a natural tendency toward empathy), foundational skills (e.g., case management, outcome measurement), and discretionary skills (e.g., evidence-based brief interventions). The participants also agreed that hiring BHCMs without a formal clinical background would make pediatric CoCM program staff more representative of the surrounding community, but that hiring BHCMs with more formal credentials or clinical experience could allow for the high-fidelity delivery of evidence-based brief psychotherapy interventions.

However, various attendees maintained that additional exploration is needed to determine whether more or less experienced BHCMs should be hired in specific real-world implementation scenarios. Participants also concluded that additional exploration is needed to determine whether it is most advantageous for one or multiple individuals to simultaneously fill the BHCM role (due to its multiple responsibilities and requisite skill sets), and whether the psychiatric consultant should have a formal child and adolescent background. Tension was noted between delivering the highest level of evidence-based treatment and providing care that improves the status quo, while also being sustainable over time given real-world staffing and financial limitations.

Topic 3: Pediatric CoCM Engagement

Participants generally agreed that pediatric CoCM requires a multifaceted approach for engaging the patient, family, pediatrician, and school, with multiple strategies and considerations being suggested for each group. For patients and families, participants agreed that transparency is critical at the outset regarding cost, expectations for the program, privacy, confidentiality, and CoCM team member roles. For pediatricians, participants recommended considering direct reimbursement with work relative value units (wRVUs), while also noting the importance of putting CoCM into appropriate context with other local or regional integrated care models (e.g., child psychiatry telephone consultation programs), as well as not creating overly narrow program inclusion or exclusion criteria. Participants noted that schools and teachers can provide valuable information about the patient's functional status and response to treatment, especially with ADHD, but also agreed that the nature of this interaction varies by age and diagnosis.

Additional exploration was thought to be needed surrounding the optimal time points for school engagement in a pediatric CoCM episode of care. While some recommended engaging with schools shortly after the intake visit, others contended that it is more favorable to wait for a more organic recruitment of external stakeholders' perceptions or support.

Topic 4: Operational Feasibility and Sustainability

Participants agreed that it is important for BHCMs are trained in the applicable state and regional CoCM confidentiality and consent laws, which include pediatric patient assent in some cases. Participants also shared concerns that adult CoCM reimbursement rates are inadequate for pediatric patients, as the BHCM and clinical team typically spends more time with pediatric, rather than adult, patients. Since the valuation of CoCM billing codes is predicated on expected time and effort for treating adult populations, participants felt reimbursement for pediatric and adolescent models were inadequate in many cases. Participants agreed that the additional effort expended by BHCMs in delivering pediatric and adolescent CoCM must be reflected either through a higher code valuation or relaxation of billing code unit limits.

Topic 5: Evaluation

All participants recognized the importance of measuring outcomes in pediatric CoCM and noted that, regardless of which tools are used, the clinical team should be cognizant of the limitations and advantages of each one. Participants agreed that ideal measurement tools should be available in multiple languages, take a reasonable amount of time to complete, and are validated for both screening and ongoing assessments over time. Additionally, as with the program inclusion and exclusion criteria described above, participants noted that treatment progress measures should assess domains beyond diagnoses and symptoms alone, including social drivers of health, functional status, adverse childhood experiences, and school or family input, among others. The same was thought to be true when determining a patient's readiness for discharge. For overall program evaluation, participants agreed that quantitative measures, including referral counts, utilization, and clinical improvement rates, are of paramount

importance. There was also agreement that qualitative feedback from patients, families, schools, and pediatricians can be beneficial.

Action Items and Key Next Steps

Several action items emerged from all five topic areas during the structured roundtable discussions. These key next steps for pediatric CoCM provide a roadmap for practices, health system leaders, and policymakers to efficiently scale the model while maintaining fidelity to implementation best practices. Example action items include: creation of documents with wide applicability, such as a pediatric CoCM needs assessment template; guidance on how to train BHCMs to interact effectively with schools; and an advocacy framework for increasing pediatric CoCM reimbursement rates. Action items are summarized in Table 3.

Table 3: Pediatric Roundtable Action Items

Topic	Action Items
1. The Pediatric CoCM Population	• Pediatric CoCM health system and community gap analysis template • Guides for establishing behavioral health diagnoses and utilizing virtual mental health care delivery in patients under 18 years old
2. The Work of the BHCM	• Training resources guide with expected cost and time duration for foundational and discretionary skills • Scripting for the BHCM to perform specific pediatric CoCM tasks
3. Engagement	• Focus groups for key stakeholders (e.g., parents, teachers, pediatricians) • Standardized explanation for the pediatric integrated behavioral health continuum with school-based mental health programs (e.g., TCHATT in Texas), child psychiatry access programs, and CoCM • List of common CoCM-related terminology with informationally accessible definitions
4. Operational Feasibility and Sustainability	• State-level consent and confidentiality resource document for pediatric mental health • Focus groups, training modules, and best practices for working with schools • Billing guide for pediatric CoCM that includes discussion of hybrid billing strategies • Advocacy for increased pediatric CoCM reimbursement • Patient/family-facing documents describing the benefits of pediatric CoCM • Pediatric CoCM cost and revenue projections for different types of health systems
5. Evaluation	• Repository for pediatric-focused screening tools and measures with key features such as age range, target symptoms, duration, and languages available • Outline of strategies for pediatric CoCM program evaluation

Limitations

While the roundtable discussions provided valuable new insights into the real-world practice of pediatric CoCM, formal research on the model remains limited in scope, which restricts the ability to draw large-scale conclusions regarding challenges and successes in implementation beyond anecdotal experiences. Our findings have a number of limitations. First, for roundtable participants, a convenience sampling strategy with additional snowball sampling was employed. Prospective participants were individually selected by the Meadows Institute team because of their clinical or implementation expertise and known contributions to the scientific literature. It is possible that potentially valuable contributors were unintentionally excluded because they were unknown to the team, thus not identified through snowball sampling. Second, most roundtable participants were from a mental health background. Gathering input from a broader array of participants in the pediatric physical health and care management spaces could have been more beneficial in identifying best practices for high-quality pediatric CoCM implementation. Third, while diverse, the participants did not fully reflect the demographics of most pediatric CoCM teams, nor the populations being served. It is possible that getting input from a participant group that better reflects the demographics of most pediatric CoCM teams could identify additional barriers and best practices for pediatric CoCM implementation among different demographic populations. Despite these limitations, we believe that our findings will be a valuable contribution to the literature by informing future pediatric CoCM research, policy recommendations, and advocacy efforts.

Conclusions

Overall, there was consensus among participants that pediatric CoCM is being successfully implemented nationwide and that it is an immediately actionable and practical solution to the current pediatric mental health crisis. The roundtable and its associated findings are important initial steps to providing clarity around best practices for scaling pediatric CoCM implementation. In addition to providing foundational insights, the roundtable shed light on areas that require additional conversations and potentially more in-depth evaluation, while also identifying strategies to mitigate identified knowledge gaps. Consensus was achieved for several unique considerations of pediatric CoCM implementation, especially in the areas of clinical operations, stakeholder engagement, and program evaluation. At the same time, further exploration is needed in certain areas, such as the specific role of the BHCM, credentials of the psychiatric consultant, and specific program inclusion and exclusion criteria. The Meadows Institute, in partnership with other organizations, will continue to build on these findings to promote behavioral health access and equity for children and adolescents in Texas and across the nation.

Acknowledgements

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Appendix / Attachment: Participant and facilitator lists from the Inaugural Pediatric Collaborative Care Model (CoCM) Roundtable

Participant List			
Name	**Title**	**Organization**	**Region**
Caroline Fisher MD PhD	Principal, Psychiatrist, Mental Health Systems Consultant	Germane & Wise Mental Health Systems Consulting, LLC	Oregon
Sourav Sengupta, MD, MPH	Associate Professor of Psychiatry & Pediatrics	Jacobs School of Medicine and Biomedical Sciences, University at Buffalo	New York
John T. Parkhurst, PhD	Child and Adolescent Psychologist, Coordinator, Mood Anxiety ADHD Collaborative Care (MAACC) Program	The Pritzker Department of Psychiatry and Behavioral Health, Ann & Robert H. Lurie Children's Hospital of Chicago	Chicago
Matthew Biel, MD, MSc	Marriott Chair in Child, Adolescent, and Family Mental Health Professor, Vice Chair and Division Chief of Child and Adolescent Psychiatry	Georgetown University Medical Center and MedStar Georgetown University Hospital	Washington, D.C.
Larry Wissow, MD, MPH	Vice Chair for Child and Adolescent Psychiatry; Division Chief, Child Psychiatry and Behavioral Sciences; Professor of Psychiatry and Behavioral Sciences	Seattle Children's	Seattle
Roshni Koli, MD	Chief Medical Officer	Meadows Mental Health Policy Institute	Austin
Laura Richardson, MD, MPH	Professor of Pediatrics and Adolescent Medicine	University of Washington School of Medicine and Seattle Children’s Hospital	Seattle

David J Kolko, PhD	Professor of Psychiatry, Pediatrics, Psychology, and Clinical and Translational Science	University of Pittsburgh Department of Psychiatry	Pennsylvania
Mark S. Borer, MD, DLFAPA, DLFAACAP	Child and Adolescent Psychiatrist	Psychiatric Access for Central Delaware, P.A.	Delaware
Barry Sarvet, MD	Chair of Psychiatry, Baystate Health Professor and Chair, Department of Psychiatry	UMass Chan Medical School -Baystate	Massachusetts
Carol L. Alter, MD	Professor and Associate Chair, Department of Psychiatry	Dell Medical School, University of Texas, Austin	Austin
Hani Talebi, Ph.D	Chief Clinical Officer and Senior Vice President for Health System Integration	Meadows Mental Health Policy Institute	Austin
Andrew D. Carlo, MD MPH	Vice President Of Health System Integration	Meadows Mental Health Policy Institute	Chicago
Clare McNutt, PA-C, MSHS	Vice President of Primary Care Innovation	Meadows Mental Health Policy Institute	Maryland
Jessica Lyons MS, LMFT	Co-Founder, Aloft Integrated Wellness Clinical Advisor, Mirah	Aloft Integrated Wellness	New Hampshire
J. Nathan Copeland, MD, MPH	Medical Director, Duke Primary Care Behavioral Health Program Medical Director, PHMO Behavioral Health Specialty Case Review	Duke Department of Psychiatry & Behavioral Sciences	North Carolina
Sheryl Janz, LCPC	Licensed Clinical Professional Counselor and Behavioral Care Coordinator	Minooka Healthcare Center, Morris Hospital	Illinois
Kristin Kroeger	Chief of Policy, Programs, & Partnerships	American Psychiatric Association	Virginia
Deborah Cohen, Ph.D, MSW	Assistant Professor, Department of Psychiatry and Behavioral Sciences	Steve Hicks School of Social Work, University of Texas at Austin	Austin

Jacqueline Posada, MD	Assistant Professor in the Department of Psychiatry and Behavioral Sciences	Dell Medical School at the University of Texas at Austin	Austin

Facilitator List			
Name	**Title**	**Organization**	**Region**
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