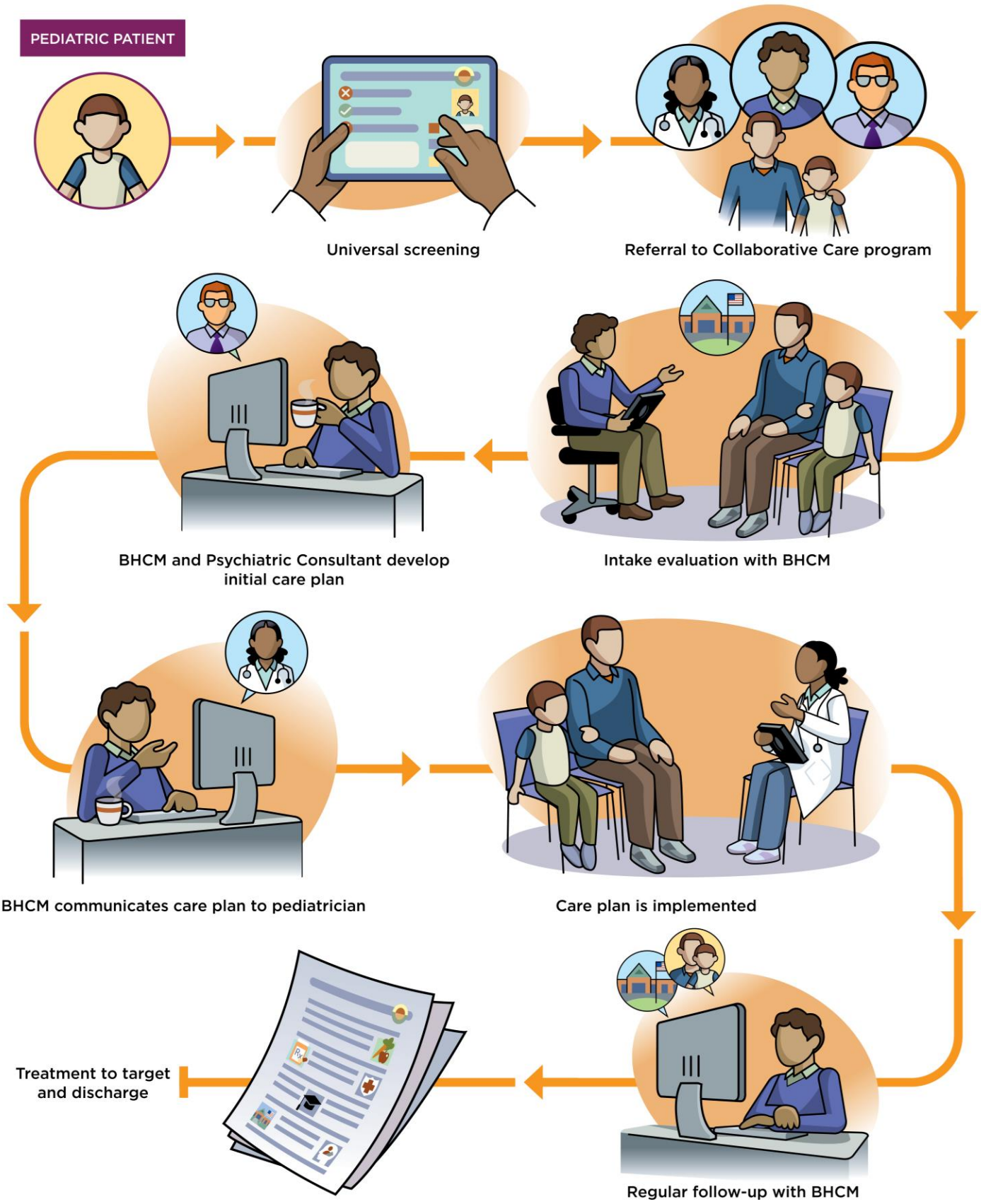
MEADOWS MENTAL HEALTH POLICY INSTITUTE

THE COLLABORATIVE CARE MODEL WORKFLOW



Collaborative Care Model

Pediatric Clinical Workflow

Clinical workflow details for implementing the collaborative care model (CoCM) with pediatric patients. The CoCM team refers to the pediatrician, the behavioral health care manager (BHCM), and the child and adolescent psychiatric consultant.

STEP 1 – Universal screening

Pediatric practice delivers universal screening at least annually for common behavioral health problems in childhood, such as depression, anxiety, and ADHD screening for parents using evidence-based behavioral health assessments (e.g., PHQ-A; PHQ-9).

STEP 2 – Referral to collaborative care model (CoCM) program

Patients who screen positive or display concerning behavioral health symptoms and meet program criteria are offered enrollment in CoCM by their pediatrician, who then engages in a consent discussion with the patient and parent/guardian (for minors) and facilitates a warm hand-off to the BHCM. Parents may also need their own referrals (e.g., OBGYN or community referral).

STEP 3 – Intake evaluation with behavioral health care manager (BHCM)

BHCM engages the patient and parent/guardian, answers remaining questions about the CoCM program, reviews the patient chart, and completes a full intake evaluation. BHCM enters evidence-based behavioral health assessments (e.g., PHQ-A) and other patient data into the CoCM patient treatment registry. If available, BHCM speaks to a representative from the patient's school to collect additional relevant information.

STEP 4 – BHCM and psychiatric consultant case review

In weekly case review sessions with a designated child and adolescent psychiatric consultant, the BHCM discusses new patients and existing patients who are not demonstrating adequate symptom improvement. They review diagnostic impressions and treatment recommendations, updating as indicated. Treatment planning may include medications, therapy, connection with school-based care, or other outside resources, depending on patient need, individual preferences, and service availability.

STEP 5 – Care plan development and updates

BHCM compiles care recommendations and diagnostic impressions into an intake report, updates the registry, makes any necessary referrals, and shares the care plan with the pediatrician. Additionally, the BHCM preliminarily discusses the care plan with the patient and parent/guardian, while answering any remaining questions.

STEP 6 – Pediatrician implements care plan

The pediatrician reviews the intake report, discusses diagnosis and treatment recommendations with patient and parent/guardian, answers questions, and starts medication if it is in line with their clinical judgment. If the pediatrician has questions or concerns about the care plan, they can discuss these with the rest of the CoCM team at any time.

STEP 7 – Regular follow-up assessments with BHCM

BHCM engages with the patient and parent/guardian (often twice a month), asking about experience with medication, measuring treatment response using evidence-based behavioral health assessments, engaging with the parent/guardian or school, reviewing patients' status weekly with the psychiatric consultant as indicated, delivering therapeutic interventions, coordinating with outside providers (if applicable), updating the registry, and documenting all findings in the medical record.

STEP 8 – Relapse prevention planning and discharge

Working in collaboration with the child and adolescent psychiatric consultant, the BHCM tracks patient outcomes until evidence-based symptom response or remission targets are met. Once patients have improved, they engage with the BHCM in relapse prevention planning and prepare for discharge from the CoCM program back to regular pediatric care.

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Pediatric Clinical Workflow

Detailed clinical workflow for implementing the collaborative care model (CoCM) with pediatric populations.

Screening and Referral

After adopting universal behavioral health screening, a pediatric practice must define the target population and diagnostic scope for its CoCM program. For example, a practice may define its target population as pediatric patients between the ages of 4 and 21, and its diagnostic scope as depression, anxiety, and ADHD. Patients in the target population who screen positive for conditions within the diagnostic scope or display concerning symptoms are considered for referral to the program. Additionally, pediatricians play an important role in screening parents for behavioral health concerns, including postpartum depression (PPD). Effective communication and collaboration between pediatricians, obstetricians, and other primary care providers are essential for early identification and coordinated management of PPD.

Typically, the pediatrician will inform the patient and their guardian of the program and offer them enrollment. For billing purposes, the pediatrician informs the patient and guardian that, depending on their health insurance, they may receive a monthly bill for CoCM services (i.e., cost sharing). This discussion between the pediatrician, patient (as developmentally appropriate), and guardian is considered the "consent process." Verbal consent must be documented in the medical record. Uninsured patients and their guardian should also be informed that they may receive a bill for CoCM services (though they may not be required to pay the bill due to sliding scale payment arrangements). If the patient is ultimately enrolled in CoCM, the pediatrician will connect them with the program's BHCM.

Intake Evaluation

The BHCM connects with the patient and guardian via warm handoff in person, by telephone, or through secure messaging to schedule intake visit. During this visit, the BHCM conducts a full behavioral health (BH) evaluation that explores current symptoms in addition to a comprehensive history of diagnoses, treatments (including medication and psychotherapy), higher acuity care, and co-morbid medical problems. In this evaluation, the BHCM also administers evidence-based assessments, such as the Patient Health Questionnaire-9 Modified for Adolescents (PHQ-A) and the Screen for Child Anxiety Related Disorders (SCARED). The BHCM may, with guardian permission, speak with a school representative to obtain BH assessment teacher reports (e.g., Vanderbilt Assessment Scale) or other relevant collateral information. The BHCM writes a draft report of the findings from the intake evaluation and enters demographic data, visit data, and assessment results into the patient registry.

Case Review, Plan Development

During weekly case reviews with the psychiatric consultant, the BHCM reviews the treatment registry broadly, with each patient considered for detailed discussion. The BHCM and psychiatric consultant typically discuss new patients and those with acute events; patients who are not responding to treatment or following up as scheduled with the BHCM are also prioritized. The BHCM, with help from the psychiatric consultant, develops a personalized care plan, which may include parent training, interaction with school-based care, medication recommendations, brief psychotherapy, and/or psychosocial interventions for new patients. This plan is then described in the BHCM's report, which is preliminarily discussed with the patient and guardian and sent to the pediatrician. The pediatrician then reviews the patient's care plan with recommendations from the rest of the CoCM team.

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Pediatric Clinical Workflow

Care Plan Implementation

If the psychiatric consultant recommends medications and the pediatrician agrees, the pediatrician will write prescriptions and schedule a visit with the patient and guardian to discuss the recommended medications further. The pediatrician is always welcome to ask follow-up questions of the CoCM team. Due to this bidirectional collaboration, CoCM provides valuable real-time education opportunities for pediatricians, rendering them more knowledgeable about relevant psychopharmacology during future patient encounters. When the CoCM team recommends specific psychotherapy, these services are typically delivered by the BHCM directly. The BHCM most commonly provides brief behavioral health interventions, such as motivational interviewing or behavioral activation, though other modalities or psychosocial interventions may be used as indicated. Patients can be referred to community providers (while still being followed in CoCM) if they require more extensive therapy, long-term therapy, or additional interventions for which the BHCM is not adequately trained.

Regular Follow-up Assessments

After the CoCM intake visit and initial recommendations, the BHCM closely follows the patients and their parents or guardian. Typically, patients interact with the BHCM a minimum of two times per month while in active treatment. During each interaction between the patient, guardian, and BHCM, the BHCM administers evidence-based assessments, and adds follow-up results to the treatment registry. The goal for each target symptom is remission, which is defined differently for each instrument. With the PHQ-A, for example, remission is defined as a score of less than five. Patient treatment response is also tracked, which is typically defined as a reduction from the baseline score of 50% or more with the PHQ-A. Of note, the choice of instruments is discretionary for each CoCM program. The BHCM and psychiatric consultant update care plans for existing CoCM patients during case review sessions based on clinical progress. All care plan updates, including updated medication recommendations, are sent to the pediatrician. Each patient is considered for review weekly in case review sessions with the psychiatric consultant (and is reviewed at least monthly). The BHCM also remains in close contact with the patient's guardian to discuss treatment recommendations and proposed changes. Additionally, the BHCM may remain in ongoing communication with school representatives or teachers, if indicated and permissible. On average, patients remain in the active treatment phase of the program for three to six months.

Relapse Prevention, Discharge

A patient moves from active treatment into the relapse prevention phase of the CoCM program when they achieve symptom response or remission. At this point, the patient's frequency of visits with the BHCM typically decreases to approximately once per month, and the clinical focus shifts to creating a plan to mitigate future worsening of symptoms. This relapse prevention plan integrates the patient's goals, medication recommendations, and guidance on the use of key therapy skills or interventions. After successful maintenance in relapse prevention for two to three months, patients are typically discharged from CoCM.