Expanding the Collaborative Care Model in Michigan: Overcoming Barriers and Enhancing Sustainability

FINAL REPORT

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MEADOWS
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Contents

Introduction

The Collaborative Care Model (CoCM) is a financially sustainable integrated behavioral health model with the strongest evidence-base to effectively address the shortcomings of our current mental health care system.[1, 2, 3, 4] CoCM enables a primary care provider (PCP), psychiatric consultant, and behavioral health care manager (BHCM) to collaboratively support the patient and their family in the primary care setting by using a patient registry to track and follow the patient's progress. Through an integrated care approach and under the clinical direction of the PCP, the CoCM team works together to identify mental health needs early and provide evidence-based interventions as well as measure the patient's progress toward treatment targets and adjust the patient's treatment plan when appropriate.[5]

The Michigan Department of Health & Human Services (MDHHS), Blue Cross Blue Shield of Michigan (BCBSM), and philanthropic foundations including the Michigan Health Endowment Fund (The Health Fund), are invested in expanding the model's adoption across the state to improve access to evidence-based care for Michiganders. For years, they have championed CoCM's expansion through strategic initiatives such as enhanced reimbursement rates, grants to offset initial implementation costs, and comprehensive technical assistance. After five years of investment and expanded adoption of the model across the state, the Health Fund partnered with Meadows Mental Health Policy Institute (Meadows Institute) to complete both an impact assessment of the investments and an exploration of additional opportunities to sustain and expand adoption.

Approach

To simultaneously assess the impact of CoCM investments and explore expansion opportunities, the Meadows Institute conducted semi-structured interviews (SSIs) to capture firsthand experiences from health systems and key informant interviews (KIIs) to gather expert insights from stakeholders. Throughout our engagement efforts, we sought to identify

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[1] The United States Senate Committee on Finance. (n.d.). *Behavioral Health Care When Americans Need It: Ensuring Parity and Care Integration*. Retrieved October 30, 2024, from https://www.finance.senate.gov/hearings/behavioral-health-care-when-americans-need-it-ensuring-parity-and-care-integration

[2] 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://doi.org/10.1007/s10488-019-00963-w

[3] 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://doi.org/10.1111/jcap.12195

[4] 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://doi.org/10.1016/j.amepre.2018.03.006

[5] For more on the Collaborative Care Model, please see Appendix Four.

facilitators of successful CoCM adoption, barriers to scaling CoCM in Michigan, why a health system may have opted out of implementing CoCM, and key stakeholders' experiences with The Health Fund grant opportunities. Additionally, we sought an enhanced understanding of the current and future landscape of behavioral health integration in Michigan, with a particular focus on the expansion and sustainability of CoCM statewide. Armed with warm introductions, from The Health Fund, our team engaged both health systems and other key stakeholders, initiating discussions on their experience with implementing (or choosing not to implement) CoCM. The conversations, as outlined below, occurred between December 6, 2024, and December 19, 2024.

Table 1. Key Informant and Semi-structured Interviews

Organization	Contact	Format	Date
Health Systems			
Henry Ford Health System (Henry Ford)	Doree Ann Espiritu, MD, Medical Director of Adult and Pediatric Outpatient	SSI	12/6/2024
Michigan State University (MSU)	Andrea Wittenborn, PhD, Chair of Human Development and Child Studies	SSI	12/6/2024
Pine Rest Christian Mental Health Services (Pine Rest)	Amy VanDenTorn, LMSW, Appointed Regional Director of Outpatient & Recovery Services Tom Worm, LMSW, MPA, C-TAGME, Lead Behavioral Healthcare Manager	SSI	12/10/2024
Other Stakeholders			
Blue Cross Blue Shield of Michigan (BCBSM)	David Bye, Manager of Clinical Program Development Julia Isaacs, LMSW, Director of Behavioral Health Strategy and Planning	KII	12/19/2024
Michigan Center of Clinical Systems Improvement (Mi-CCSI)	Sue Vos, Program Director Thomas Dahlborg, Executive Director	KII	12/5/2024
Michigan Department of Health & Human Services (MDHHS)	Lisa Dilernia, Medicaid Policy Specialist Sam Rushman, Assistant Policy Specialist Janell Troutman, MSN, RN, Maternal and Infant Health Policy Specialist for Medicaid	KII	12/12/2024
PRISM	Gregory Dalak, MD, Program Director Debbra Snyder-Sclater, LLP, Project Manager Sarah Bernes, MPH, LMSW, MBA, Lead Clinical Training and Implementation Specialist Paul Pfeiffer, MD, Co-Director	KII	12/9/2024

Findings

In engaging key stakeholders across the state, each with a distinct CoCM experience (see Table 2, below), we identified both facilitators of CoCM implementation and barriers to its success. We also gained valuable insights from active, successful programs.

Table 2. Stakeholder Involvement with CoCM Implementation

Organization	Description	Grant Returned?	CoCM Active?
Health Systems			
Henry Ford	Received a Health Fund grant in 2019 for CoCM.	No	Yes
MSU	Received a Health Fund grant in 2019 to train six family medicine clinics in a perinatal CoCM.	No	Yes*
Pine Rest	Has not received a Health Fund grant but has received other CoCM grants.	N/A	Yes
Other Stakeholders			
BCBSM	Health insurance company that reimburses for CoCM delivery and provides CoCM training for providers.	No	N/A
Mi-CCSI	Initially provided CoCM training for one independent practice. Received subsequent funding from BCBSM to scale CoCM training.	No	No
MDHHS	Received a Health Fund grant in 2019 to implement CoCM reimbursement codes for patients with Medicaid.	No	N/A
PRISM	Received a Health Fund grant in 2019 to scale CoCM in 3 FQHCs and a prior grant in 2017 with a similar focus.	Yes	No

*Contact has only been maintained with two out of four practices over the past year, and they are actively continuing CoCM work. For the other two practices, changes in clinic workflows, including shifts in EHR access and state consultation, suggest they may still be using CoCM, although this is not confirmed.

CoCM Facilitators

Through our engagement, the Meadows Institute identified several stakeholder-suggested avenues for enhancing CoCM's implementation and expansion in the state, including both external and internal considerations.

Table 3. Stakeholder Identified CoCM Implementation/Expansion Facilitators

Stakeholder Identified Facilitators
External Factors
Financial Assistance
Funding played a critical role in securing buy-in from stakeholders across the health system, ultimately promoting both the launch and scaling of CoCM initiatives. An example of this is the startup funds the stakeholders received from the Health Fund's CoCM grant. These funds helped offset CoCM implementation expenses, either within their own health systems or those they partnered with. Another example is BCBSM's CoCM incentive program, which provided financial support to practices that implemented and sustained CoCM services. This program offered an incentive after implementation, along with continued funding, thereafter, helping to offset expenses and encourage long-term participation. While practices were required to meet specific criteria to qualify for these incentives—such as completing an initial CoCM training program and attesting to model fidelity—the additional funding played a crucial role in both implementing and sustaining CoCM services.
Expert Implementation Support
Many health systems underscored the critical role that experts at MDHHS, BCBSM, and philanthropic organizations played in their success. The health systems highlighted that accessibility to these entities and their institutional knowledge about integrated behavioral health care made CoCM implementation more manageable. Largely on an ad hoc basis, providers were able to connect with these entities for support as needs and/or questions arose. Health systems noted that beyond the grant itself, the Health Fund's CoCM grant's well-defined goals and supportive structure facilitated a smooth transition from standard treatment to CoCM, enabling them to focus on the nuances of integrating specific model requirements into their existing workflows.
Internal Considerations
CoCM Champions
The presence of dedicated CoCM champions within the health system played a crucial role in successful implementation. Internal advocates enhanced the effectiveness of the CoCM rollout by ensuring staff were well-equipped, engaged, and motivated. Additionally, their leadership helped maintain CoCM as a priority, preventing it from being overshadowed by any competing initiatives.
Data Performance Tracking
A robust dashboard was extremely impactful in monitoring CoCM performance and patient outcomes. These dashboards tracked key metrics such as wait times, remission rates, reductions in

Stakeholder Identified Facilitators
PHQ-9 and GAD-7 scores, and no-show rates. Providing real-time insights, data tracking enabled CoCM teams to assess the model's effectiveness and make data-informed decisions to improve patient care and workflow efficiency.
Relationships Between Primary Care Providers (PCPs) and Behavioral Health Care Managers (BHCMs)
Successful CoCM implementation relied on strong, collaborative relationships between PCPs and BHCMs. When PCPs and BHCMs worked closely together, they were able to effectively address patient needs, enhance engagement, and improve treatment adherence. Systems that prioritized relationship-building saw greater integration of behavioral health services within primary care, leading to a more cohesive care model and better patient outcomes.
Prior Experience with CoCM
In facilitating successful implementation, health systems noted the significance of prior knowledge and exposure to CoCM. Prior experience allowed organizations to create effective incentives and navigate challenges more efficiently.

Unsurprisingly, the stakeholder feedback gathered is aligned with both Meadows Institute experience with providing implementation support and technical assistance for CoCM implementation as well as recent scholarly articles, outlining the value of strong leadership and organizational commitment;[6] effective use of technology;[7] and technical assistance, training and workforce development.[8]

CoCM Implementation Barriers

Michigan CoCM stakeholders also shared several recurring barriers to both implementing and expanding CoCM, including financial, workforce, and operational challenges.

Table 4. Stakeholder Identified CoCM Implementation/Expansion Barriers

Stakeholder Identified Barriers
Financial Sustainability Concerns
While financial sustainability is critical to CoCM's long-term success, stakeholders identified challenges pertaining to economic viability such as:

[6] LePoire, E., Joseph, M., Heald, A., Gadbois, D., Jones, A., Russo, J., & Bowen, D. J. (2024). Barriers and facilitators to collaborative care implementation within the New York State Collaborative Care Medicaid Program. *BMC Health Services Research*, *24*(1), 505. https://doi.org/10.1186/s12913-024-10909-0

[7] Wood, E. et al., (2017), What are the barriers and facilitators to implementing Collaborative Care for depression? A systematic review, *Journal of Affective Disorders*, *214*, 26–43

[8] Unützer, J. et al., (2020), Variation In The Effectiveness Of Collaborative Care For Depression: Does It Matter Where You Get Your Care?, *Health Affairs (Project Hope)*, *39*(11), 1943–1950

Stakeholder Identified Barriers

- Practices do not often see immediate profitability. Because of that, practices should focus on increasing accessibility to evidence-based care and set realistic return-on-investment (ROI) expectations, typically within two years.
- Rejected CoCM claims significantly complicate the billing process and can lead to an unfortunate waste of staff time and resources within the health system. These rejections often arise from the intricate nature of CoCM billing procedure. Patterns of rejected claims can be demoralizing, as it represents an additional barrier to achieving financial sustainability.
- Michigan federally qualified health centers (FQHCs) and rural clinics have complicated Medicaid reimbursement protocols for CoCM service delivery. This creates substantial challenges, often rendering CoCM implementation impractical or unfeasible in this setting.

Workforce and Operational Challenges

CoCM's success relies heavily on strong community relationships and reliable staffing. While national and statewide workforce shortages have created significant challenges across various healthcare fields, CoCM team shortages are further exacerbated by the following:

- Staff attrition within the CoCM team impacts the development of lasting patient relationships. BHCMs, in particular, face high demands, juggling substantial patient caseloads alongside other responsibilities. This heavy workload makes it difficult to maintain balance, often contributing to staff turnover.
- Lack of education about integrated behavioral health models and CoCM, in particular, in high school, undergraduate and graduate programs, means individuals who might be good BHCM candidates are not always aware of the opportunities.
- Limited access to psychiatric consultants has also been a challenge. Moreover, psychiatric consultants frequently need training and assistance in shifting from autonomous practice to the integrated framework of CoCM, which takes time and resources.

Education and Engagement

Some health systems cited common patient engagement difficulties, such as patients failing to cancel appointments when they are unable to attend and low attendance at medical and mental health services as a significant obstacle. Across various health systems, there was also notable resistance to participating in the program from patients and providers, likely due to a lack of education around the efficiency and effectiveness of the model.

Extenuating Circumstances

Circumstantial challenges hindered the state's wider adoption of CoCM, particularly during the Health Fund's most recent funding cycle. The COVID-19 pandemic hindered many health systems' successful CoCM implementation, given they were required to redirect resources and efforts towards combatting the disease. Some health systems also noted that the original design of their CoCM program was for in-person delivery, which was effectively impossible during the pandemic. This was unfortunately compounded by the grant's limited timeline.

Again, as with the implementation facilitators, the stakeholder identified barriers are reflected in literature. For example, the practice changes required for CoCM implementation are associated with costs during the ramp-up period (e.g., funds to subsidize the BHCM and psychiatric consultant salaries while panels are being filled)[9] and these costs may discourage implementation of the model, despite evidence demonstrating CoCM's effectiveness and established reimbursement pathways.[10]

Successful Programs

The Meadows Institute was also able to glean insight from systems with sustained successful CoCM practices. We identified two programs as standout initiatives, both of which expressed high praise regarding the model's effectiveness and impact.

Provider Spotlight

Henry Ford Health System

At Henry Ford, patient engagement has been effective, particularly with the inclusion of a community health worker. There are many metrics Henry Ford tracks, including number of screenings conducted, the number of patients seen, wait times, remission rates, reductions in PHQ-9 and GAD-7 scores, and no-show rates. Their health system is also the birthplace for the zero-suicide approach, which they integrated into CoCM. [11]

Notably, they stated that their remission rates have been impressive; CoCM extends the clinical impact of prescribing behavioral health clinicians to as many as eight times the number of patients that they could serve individually.[12]

"We have saved lives," they stated, as evidenced by patient testimonies from those who have contemplated ending their lives.

[9] Meadows Mental Health Policy Institute. (2023). *Collaborative Care Implementation—Costs Across 10 United States Health Systems*. https://mmhpi.org/wp-content/uploads/2023/04/COCM_Costs_Across_Ten_US_Health_Systems.pdf

[10] Lombardi, B. M. et al., (2023), Examining the use of psychiatric collaborative care and behavioral health integration codes at federally qualified health centers: A mixed-methods study., *Families, Systems & Health: The Journal of Collaborative Family Healthcare*, *41*(4), 527–536

[11] CoCM is often not used for high acuity cases. When asked about this, Henry Ford stated there is an escalation point for patients who are suicidal and there is an "access point" with a nurse practitioner and a physician available to see these patients immediately, prescribe medications, and provide two visits while they await to get a connection with behavioral health services, which typically have an eight-week wait. Henry Ford pointed to having an almost immediate access to care through CoCM as filling a gap in their previous system.

[12] Carlo, A. D., McNutt, C., & Talebi, H. (2024). Extending the Clinical Impact of Behavioral Health Prescribing Clinicians Using the Collaborative Care Model (CoCM). *Journal of General Internal Medicine*, *39*(8), 1525–1527. https://doi.org/10.1007/s11606-024-08649-2

Provider Spotlight

Michigan State University

MSU considers its CoCM integration a success, having successfully trained 128 physicians, behavioral health professionals, and other CoCM staff. Their implementations demonstrated strong fidelity, with impressive screening rates: 96% of pregnant and postpartum individuals were screened post-implementation, and 70% of those identified as at risk were connected with behavioral health services—an increase from just 16% previously. This achievement is particularly notable given their programs were happening during the COVID-19 pandemic. MSU helped support their clinics by structuring workflow changes, enhancing electronic medical records for better tracking, providing workshops and refresher training for providers, and organizing psychiatric consultation meetings to support the clinics.

MSU staff said they faced discouragement at first but remained focused on the positive impact of their work, which paid off with high rates of both screenings and referrals to behavioral health services.

Recommendations

Participants predominantly viewed the grant administration process as straightforward and efficient. The support provided by the Health Fund emerged as a notable advantage, with staff offering valuable assistance throughout the administration of the grant. Overall, the experience was favorable; however, through conversations with the stakeholders, Meadows came up with a list of opportunities for enhancements to further facilitate the adoption and expansion of CoCM in Michigan.

Recommendations
General Recommendations
Advocate for Policy Modifications
Engage with policymakers to reduce administrative barriers, such as prior authorization requirements, and advocate for increased reimbursement rates for CoCM services under MI Medicaid, aiming for at least on par with Medicare or, ideally, exceeding it. Provide clear guidance to FQHCs on how to bill Medicaid for patients receiving care through CoCM. Consider using the 99 codes with the CPT rule to maximize flexibility.
Invest in Education on Integrated Behavioral Health & CoCM
Collaborate with organizations across Michigan to educate the broader population on the benefits of integrated behavioral health and CoCM in particular. Increasing awareness of the model should encourage more BHCMs to enter the field, helping to address workforce shortages. Additionally, increased awareness should enhance PCPs understanding of the model's benefits for their practices and reduce resistance to these programs.

Recommendations
Psychiatric Consultant Matching Program
Create a matching program to connect trained psychiatric consultants with CoCM programs in need, optimizing resource utilization and improving access to care.
Statewide Subsidized Registry
Create a CoCM registry financially subsidized by the state where CoCM team members can record outcome measures from validated behavioral health assessments and track each patient's progress over time. This centralized registry would consolidate all CoCM data within a single technological platform, streamlining data tracking and billing processes.
Michigan-Specific Educational Resources
Establish a statewide learning collaborative for CoCM programs to share knowledge, best practices, and lessons learned. This initiative should enable programs to learn from each other, fostering continuous improvement and capitalizing on the current success of existing programs. Publish case studies highlighting successful programs that demonstrate effective implementation and outcomes to inspire and advance others in the field.
Grant Recommendations
Partnership Alignment and Pathway to Sustainability
Continue providing startup funding to support the implementation and expansion of CoCM programs. This financial support is fundamental for more health systems to be able to launch CoCM programs. Identify and collaborate with other grants that align with organizational objectives to secure essential funding for the two-year implementation period. In conjunction with this collaboration, formulate a comprehensive sustainability strategy that extends beyond the grant period. This strategy should encompass a detailed budget that outlines ongoing funding requirements, identification of potential revenue streams (such as billing for services or partnerships with local healthcare providers), and proactive engagement with stakeholders to foster long-term commitment and support.
Continue to Collaborate with Statewide Partners
Continue fostering access to MDHHS, BCBSM, and other philanthropic organizations that are leaders in CoCM implementation and expansion. These relationships have been vital to the growth and success of CoCM across Michigan, and maintaining this support should ensure continued success and progress.
Built-in Support and Development for BHCM Workforce
Ensure the grant incorporates provisions for supporting behavioral health care managers, recognizing their essential role in project sustainability. This should include offering training and resources to enhance their skill sets, implementing mentorship programs to promote retention and growth, and establishing a feedback mechanism for continuous improvement. Investing in behavioral health care managers will cultivate a resilient and adaptable team.

Recommendations
Prioritize relationship-building between PCPs and BHCMs to enhance integration and create a more seamless, interconnected patient experience. Strengthening this collaboration should foster better communication, coordinated care, and improved patient outcomes.
Provide Enhanced Biling and Revenue Cycle Management Technical Assistance
Robust billing technical assistance should include the creation of a financial proforma to set realistic expectations for breakeven/profitability, initial billing training, and follow up support for denied claims and to analyze opportunities to optimize financial sustainability
Grant Process
Ensure that clear feedback is provided when proposals are declined, helping grantees understand areas for enhancement for future submissions. Allow for flexibility within the grant framework to foster the development of new ideas and innovative adaptations. Encourage health systems to appoint a CoCM champion. A CoCM champion should help drive the evolution and growth of these programs, ensuring CoCM remains a priority within the health system.
Grant Timeline
In circumstances where extensions are necessary, providing a one-year extension rather than a six-month option would be advantageous.

Next Steps

The Collaborative Care Model (CoCM) has become more prevalent in primary care settings across Michigan. Through this assessment, the Meadows Institute identified key facilitators that have driven its adoption, including strong support from Blue Cross Blue Shield of Michigan, Michigan Department of Health & Human Services, and philanthropic organizations including the Health Fund, as well as strategic grant funding and well-defined implementation structures. These factors have laid a strong foundation for the implementation of CoCM.

However, several barriers remain, including financial sustainability concerns, workforce shortages, and external factors. Addressing these challenges requires targeted policy advocacy and intentional support to ensure long-term success. To further scale CoCM across Michigan, it is essential to prioritize fiscal sustainability, continue strengthening and educating the workforce, and refine grant details.

Policymakers, healthcare providers, and funders can work collaboratively to enhance CoCM implementation strategies, enhance its long-term sustainability, and ultimately improve access to high-quality mental health care for patients across the state.

Appendices

Appendix One. Interview Questions

Questions for Semi Structured Interviews with Health Systems re: Health Systems

Introduction:

1. Were you familiar with the Collaborative Care model before learning about the grant?

2. What goals did you have when you applied for the CoCM grant?

3. What was your understanding of the specific objectives the grant aimed to achieve in terms of Collaborative Care?

4. What changes or improvements were made to your existing workflows to implement the Collaborative Care model?

5. How were the grant funds allocated across different aspects of the Collaborative Care model? Please give rough estimates out of 100%.
   a. Staffing
   b. Technology
   c. Training
   d. Patient education
   e. Other

6. Were there any unexpected costs and/or needs that arose during the implementation process?

Success of CoCM Implementation:

7. Would you define your CoCM integration as a success?

8. Is CoCM still a part of your health system?

9. What outcomes or metrics were established to measure the success of your CoCM implementation?
10. What feedback have you received from BHCMs and PCPs about the Collaborative Care model?

11. What feedback have you received from patients about the Collaborative Care model?

12. What key lessons have you learned from the implementation of the Collaborative Care model?

Barriers:

13. What were the biggest challenges in implementing the Collaborative Care model?

14. Were there any difficulties related to technology adoption or integration into existing systems?

15. How did you address challenges related to staff or patient buy-in to CoCM model?

Staff:

16. What challenges, if any, did you encounter in coordinating care across multiple providers?

17. Did you hire a BHCM from outside the organization, or were they a member of your existing team? Did they deliver services on-site or virtually?

18. Did you hire a psychiatric consultant from outside, or were they a member of your existing team? Was it on-site or virtual?

19. Did you need to hire new staff to take on the CoCM implementation?

20. Did you understand the time and resources a CoCM implementation would take?

Prior Behavioral Health Experience:

21. Did your health system have a history of behavioral health integration prior to the CoCM grant?

If yes,

a. What are the current and/or previous strategies (models) for behavioral health intervention that your health system has undertaken?
b. What successes have you had?
c. What barriers have you encountered?

If no,

d. Why not?

22. Do your clinics currently have universal behavioral health screenings (e.g., GAD-7, PHQ-9)?

e. If yes, and you do not have integrated behavioral health, how do your patients with BH needs receive BH care?

Feedback and Recommendations

23. How could the grant be structured differently to make it more effective?

24. What recommendations would you offer to other health systems looking to implement CoCM?

25. If you could go back and change any aspect of the implementation process, what would you do differently?

Appendix Two. Grant Fund Return Reasons

PRISM's Reasons for Returning Grant Funds

1. **Lack of Support**: The school-based project struggled to garner the necessary support to implement their plans effectively. There were difficulties in engaging and enrolling participants.
2. **Competing Funding**: A tragic event led to an influx of funding for school-based clinics, which redirected resources away from PRISM's proposed solutions, as clinics opted to use those funds for alternative initiatives.
3. **Specific Requirements**: The project faced barriers related to the types of school-based clinics needed for rollout. They could not gain interest and buy-in from the specific types required (e.g., needing 8 clinics with at least 2 each from urban, rural, and suburban areas). A less specific requirement would have made it easier to find suitable partners.
4. **Timing and Expertise**: There was a mismatch between the right experts and the wrong timing for the project, making it challenging to execute as planned.
5. **Political Environment**: The general political climate surrounding school-based health clinics added to the challenges, with some groups aiming to limit what could be done in these settings.
6. **Appreciation for MHEF**: They expressed gratitude for MHEF's focus in this area and showed interest in future projects, noting that the problem lay not with the grant itself, but with the project's requirements.

Appendix Three. In Depth Review of CoCM

The Collaborative Care Model (CoCM), which is predicated on the adult chronic care model, empowers a specially trained Behavioral Health Care Manager (BHCM) to practice in concert with PCPs and systematically evaluate patients' behavioral health care needs using common patient-reported outcome instruments (e.g., the 9-Item Patient Health Questionnaire for depression), all while receiving regular input and supervision from a designated psychiatric consultant.[13] In CoCM, a caseload approach and other population health methods are leveraged to treat common behavioral health concerns, such as depression or anxiety. A defined subgroup of patients within the primary care practice is identified and tracked through a registry. CoCM incorporates MBC and a treatment registry to help the team identify and measure key behavioral health symptoms over time. The Psychiatric Consultant provides treatment recommendations including medication, when indicated, for the PCP to consider and carry out. The BHCM delivers brief therapeutic interventions (e.g., motivational interviewing, behavioral activation) to help patients with their BH symptoms.

CoCM is extensively evidence based, with its efficacy being demonstrated by more than 90 randomized controlled trials (RCTs) and several meta-analyses across diverse diagnoses (e.g., depression, anxiety, bipolar disorder), patient populations (e.g., older adults, patients with chronic medical problems) and treatment settings (e.g., Federally Qualified Healthcare Centers, the Veterans Health Administration).[14] Additionally, CoCM has been shown to reduce racial and ethnic treatment outcome disparities[15] and is effective when implemented in rural[16] and underserved urban[17] treatment settings. Finally, CoCM has designated billing codes that are reimbursed by Medicare, most commercial payers, and a growing number of state Medicaid plans, leading the model to be financially sustainable.[18]

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[13] 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), 355–356. https://doi.org/10.1001/jamapsychiatry.2020.3216

[14] Archer, J., Bower, P., Gilbody, S., Lovell, K., Richards, D., Gask, L., Dickens, C., & Coventry, P. (2012). Collaborative care for depression and anxiety problems. *Cochrane Database of Systematic Reviews*, *10*. https://doi.org/10.1002/14651858.CD006525.pub2

[15] Hu, J., Wu, T., Damodaran, S., Tabb, K. M., Bauer, A., & Huang, H. (2020). The Effectiveness of Collaborative Care on Depression Outcomes for Racial/Ethnic Minority Populations in Primary Care: A Systematic Review. *Psychosomatics*, *61*(6), 632–644. https://doi.org/10.1016/j.psym.2020.03.007

[16] Unützer, J., Carlo, A. C., Arao, R., Vredevoogd, M., Fortney, J., Powers, D., & Russo, J. (2020). Variation In The Effectiveness Of Collaborative Care For Depression: Does It Matter Where You Get Your Care? *Health Affairs*, *39*(11), 1943. https://doi.org/10.1377/hlthaff.2019.01714

[17] Blackmore, M. A., Patel, U. B., Stein, D., Carleton, K. E., Ricketts, S. M., Ansari, A. M., & Chung, H. (2022). Collaborative Care for Low-Income Patients From Racial-Ethnic Minority Groups in Primary Care: Engagement and Clinical Outcomes. *Psychiatric Services*, *73*(8), 842–848. https://doi.org/10.1176/appi.ps.202000924

[18] Carlo, A. D., Corage Baden, A., McCarty, R. L., & Ratzliff, A. D. H. (2019). Early Health System Experiences with Collaborative Care (CoCM) Billing Codes: A Qualitative Study of Leadership and Support Staff. *Journal of General Internal Medicine*, *34*(10), 2150–2158. https://doi.org/10.1007/s11606-019-05195-0

Evidence-based Principles

CoCM has five primary evidence-based principles or pillars.

Patient-centered Team Care

CoCM is patient-centered, meaning that all care delivered through the model is done, to the greatest extent possible, with the patient's interests, preferences, and schedule in mind. All three core members of the CoCM team work together to achieve this goal.

Population-based Care

CoCM leverages a care team to screen an entire patient population and influence the care of far more patients than they would be able to see working on their own, allowing a whole population of patients to be carefully managed and enter treatment more quickly and preventing patients from falling through the cracks.

Measurement-based Treatment to Target

When outcomes are tracked in the CoCM treatment registry, the CoCM treatment team is responsible for ensuring that patients' outcome scores improve according to evidence-based metrics, such as response or remission.

Evidence-based Care

CoCM is itself evidence-based, and additionally, the model incorporates other evidence-based treatments, including medication prescribing guidelines (that may include the use of treatment algorithms) and brief interventions such as cognitive behavioral therapy, problem solving therapy, or motivational interviewing.

Accountable Care

In CoCM, the clinical team is incentivized to provide high-value care, as opposed to high-volume care. The team may regularly be presented with data on their patients' treatment progress, providing the opportunity for clinicians to continuously improve their treatment strategies.

Collaborative Care Model Clinical Workflow

CoCM presents an innovative approach to integrating behavioral health services within pediatric care settings, aiming to improve early identification of behavioral health needs and

access to youth mental health care. A broad-based overview of a pediatric CoCM program clinical workflow is as follows.

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 four 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 signs/symptoms are considered for referral to the CoCM program.

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(s) 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.

The BHCM connects with the patient and guardian via warm handoff in person, by telephone, or through secure messaging to schedule an intake visit. During this visit, the BHCM conducts a full behavioral health evaluation that explores current symptoms in addition to a comprehensive history of diagnoses, treatments (including medication and psychotherapy), higher acuity care, and comorbid 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 Generalized Anxiety Disorder-7 (GAD-7). 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.

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 treatment 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 treatment plan with recommendations from the rest of the CoCM team.

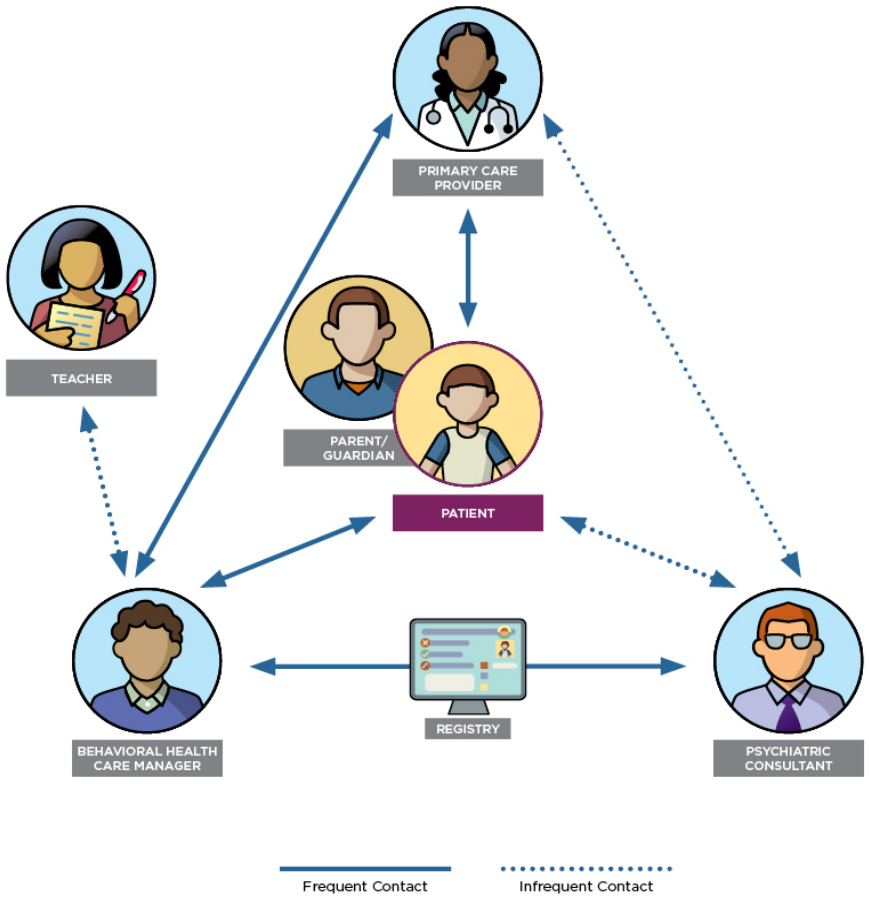
If the psychiatric consultant recommends medications and the pediatrician agrees, the pediatrician will write prescriptions and schedule a visit with the patient and guardian to discuss the recommended medications further. The pediatrician is always welcome to ask follow-up questions of the CoCM team. 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. In some cases, 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.

After the CoCM intake visit and initial recommendations, patients are followed closely by the BHCM. Typically, patients interact with the BHCM and potentially their guardians, 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 treatment plans for existing CoCM patients during case review sessions based on clinical progress. All treatment 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.

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 interaction 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 (if applicable), and

guidance on the use of key therapy skills interventions. After successful maintenance in relapse prevention for two to three months, patients are typically discharged from CoCM and back to the care by their pediatrician entirely. Patients are able to re-enroll in CoCM if clinically necessary.

Figure H1: Pediatric Collaborative Care Model



Primary care providers participating in the CCMP can access free CoCM technical assistance and implementation support at no cost, including billing support, one-on-one coaching, and workflow development. The New York State OMH tailors its technical assistance to each provider by administering an informal needs assessment and addressing their unique needs to support CoCM implementation. And yet, despite the efficacy demonstrated through CoCM, and the many accolades the state has received for piloting and implementing CoCM in New York, the model remains underutilized in the state and region. Funded through a managed care carve-out arrangement, state level policy and program decisions have created administrative hurdles further complicating the implementation of CoCM and making the process challenging for many providers.

Figure H2: Pediatric Collaborative Care Model Clinical Workflow