## Utilizing Collaborative Care for Infants, Toddlers, and their Caregivers

Many health systems and payers across the country have committed to implementing the Collaborative Care Model (CoCM) and have invested resources into infrastructure to support the work. This infrastructure includes the creation and staffing of care teams, patient registries, IT system changes and upgrades, and training. While typically employed for adults and adolescents, CoCM is increasingly being utilized in pediatrics for children as young as four.

Health systems and payers are drawn to CoCM's strong evidence base.[1] Health systems and payers are also more interested in preventive behavioral and developmental care for infants, toddlers, and their caregivers, and are considering opportunities to leverage CoCM and its corresponding existing infrastructure for this population as well. Several of these entities have approached the HealthySteps National Office to better understand how CoCM, and specifically its associated billing infrastructure, could be used to help sustain HealthySteps. While there is significant potential to use CoCM to support preventive behavioral and developmental health care for young children, innovation and adaptation will be required.

## The Models

HealthySteps, an evidence-based program of ZERO TO THREE, transforms the promise of pediatric primary care through a unique team-based approach that integrates a HealthySteps Specialist, a child development and behavioral health prevention and promotion expert, into the health care team. Through a two-generation focus, HealthySteps supports the child as well as the caregiver-child dyad, strengthening early relational health and promoting healthy social emotional functioning. All children ages 0-3 and their families receive a tiered model of services, from universal screening to risk-stratified supports, including care coordination and onsite intervention, as needed. HealthySteps practices serve as trusted and valuable partners as families foster their children's healthy development.

CoCM, also an evidence-based integrated care model, developed at the University of Washington Advancing Integrated Mental Health Solutions (AIMS) Center, is used to treat common adult behavioral health conditions in medical settings like primary care; these conditions include depression, anxiety, post-traumatic stress disorder, alcohol, or substance use disorders and are among the most common and disabling health conditions worldwide. Based on principles of effective chronic illness care, CoCM focuses on tracking defined patient populations in a registry[2] to monitor

[1] Evidence Base for CoCM. Accessed January 9, 2024. https://aims.uw.edu/collaborative-care/evidence-base-cocm

[2] CoCM requires a care team to actively manage patient care using a caseload management registry in conjunction with the practice's electronic health record (EHR). https://aims.uw.edu/registries-for-collaborative-care/ Accessed April 11, 2024.

treatment progression. The individual patient's care plan focuses on measurement-based treatment to target and ensure the patient's goals and clinical outcomes are met.

## Distinct Aspects of Each Model

CoCM's success amongst adult, adolescent, and child populations and existing sustainability pathways makes it attractive when considering expanding an integrated behavioral health approach downward to include a focus on prevention and infants and toddlers. However, there are important differences between HealthySteps and CoCM that need to be recognized, including populations to be served and types of care to be provided.

First, while CoCM focuses on patients with established mental health concerns, HealthySteps focuses on providing support as early as possible with the goal of preventing more entrenched, long-term mental health concerns. Rather than emphasizing reduction in disease symptoms, the focus of HealthySteps is on promoting early relational health for the caregiver-child dyad, creating a foundation for lifelong mental health of the child and providing prevention-based support for the entire family. While some children/dyads may present with concerns (for instance around development, attachment, caregiver mental health, etc.), in general, the acuity levels are lower than are typically managed by CoCM, where diagnostic criteria, and therefore clinically significant levels of impairment, have already been met. In fact, many of the services provided within the HealthySteps model are based on "risk or rising risk" rather than a diagnosis, and, importantly, these risks may also include health-related social needs (e.g., housing or food insecurity).

The focus of support/intervention is also different across the models. HealthySteps is universal, supporting all children within the entire practice ages birth through three, and is two-generation focused (providing supports for the child and the caregiver-child dyad). CoCM is not universal and instead focuses on disease management for a subset of individual patients (e.g., those with depression or anxiety).

Additionally, the strong emphasis on formally tracking measurement-based care utilized in CoCM is not a focus in HealthySteps, due to both the preventive nature of the model and the inherent developmental variability in the early years of life. Measurement-based care relies on tracking screening scores over time, which is an oft-used proxy for treatment progress. While HealthySteps requires screenings as a core component of the model, the primary purpose of screening is to identify child and/or family concerns and initiate supporting interventions with families. Within HealthySteps, many factors are used to assess progress other than periodic screening scores (e.g., ensuring connections to needed resources and services, improving collaboration between team members and caregivers to promote improved child development over time, etc.).

Finally, a significant difference between HealthySteps and CoCM is the member composition of the care team. While both models utilize team-based care, a core component of CoCM is involvement of a

Psychiatrist Consultant.[3] HealthySteps, with its focus on primary prevention, does not include a Psychiatrist Consultant as part of the required implementation team (core members include a Physician Champion, Practice Manager, and the HealthySteps Specialist). Like CoCM, HealthySteps emphasizes collaboration between different team members, and additionally places significant value on fostering practice transformation with a focus on prevention and health promotion as opposed to treatment or management of a disease.

## Alignment

Both models centrally place an evidence- and team-based approach to care for patients in the primary care setting—with a strong emphasis on collaboration between physical and behavioral health providers. In both HealthySteps and CoCM, primary care practices are required to identify or hire a behavioral health specialist[4] with core knowledge and skills that match each model's goals.

In both models, integrated behavioral health, care management, and a team-based approach are key. The models both work to transform primary care practices and build up the skills of new and existing staff to best coordinate care to support improved patient outcomes, and in the case of HealthySteps, family health outcomes. Further, the HealthySteps Specialist collaborates closely with a physician(s) and other team members to recommend next steps to support the caregiver-child dyad and meet their behavioral and physical health needs. Similarly, with CoCM, a Psychiatrist Consultant and a Behavioral Health Care Manager play analogous roles to the HealthySteps Specialist and collaborate with a primary care provider using their complementary skillsets to care for patients with common mental health conditions such as depression or anxiety.

Primary health care often uses risk stratification to identify levels of care needed by different patients and to manage the population given finite clinic resources. HealthySteps and CoCM both utilize risk stratification to provide the appropriate level of care to patients—and in the case of HealthySteps, their families. HealthySteps is a universal model of care that provides a set of services, including developmental and family needs screenings and access to a Family Support Line, for all children birth through three and their families in a practice. Based on tiering, children and families can receive additional short-term or ongoing supports as needed (e.g., short-term child development and behavioral consults or positive parenting guidance). Other families identified with the highest level of risk also receive ongoing, preventive team-based well-child visits. This third tier of ongoing support is most comparable to CoCM where patients are identified as higher risk and placed in a registry to receive ongoing, team-based care, while needed, based on a qualifying diagnosis. However, based on the science suggesting the importance of the first three years of life, with HealthySteps, the families

[3] The Psychiatrist Consultant supports the prescribing medical provider and Behavioral Health Care Manager in treating patients with behavioral health problems. They will typically consult with the Behavioral Health Care Manager on a weekly basis to review the treatment plan and provide treatment suggestions for patients who are new or not improving as expected. https://aims.uw.edu/resource/psychiatric-consultant-role-and-job-description/ Accessed April 30, 2024.
The Psychiatric Consultant may suggest treatment modifications, in-person consultations, or specialty mental health services for clinically challenging patients. The Psychiatric Consultant does not normally see the patient or prescribe medications; however, they are available during business hours for ad-hoc consultation as needed. https://aims.uw.edu/team-structure/psychiatric-consultant-2/ Accessed April 30, 2024.
[4] HealthySteps Specialist in HealthySteps and a Behavioral Health Care Manager in CoCM.

with the highest level of risk are followed continuously through age three of the child, regardless of diagnosis.

## Policy Solutions

In some states, CoCM has attracted the attention of state Medicaid staff and legislators because of the model's evidence for cost savings and improved patient care. Many of these same policymakers, including payers, are investigating the possibility of extending CoCM billing codes to HealthySteps. The alignment between the models and the described purpose of the CoCM codes in centering team-based care, specialist consultation, and care management is apparent.

***Practices that are currently implementing CoCM*** for older children and adults are likely to be able to apply the model more easily to HealthySteps (e.g., leverage their existing team, infrastructure, workflows, and billing codes). This would be especially true for young children with an existing behavioral health diagnosis that are receiving HealthySteps services. Implementation would require following CoCM guidelines; for example, a patient with an established behavioral health diagnosis and defining metrics to monitor improvement. Using such an approach to measurement-based care within HealthySteps and primary care settings serving young children could potentially improve care delivery and result in additions to the literature base. In these existing CoCM practices, the psychiatrist could provide consultation and recommendations to children and families receiving HealthySteps services, although their work with young children would be very different than their work with adults and older children which often includes psychotropic medication as a first- or second-line intervention. Even within a practice already implementing CoCM, broader policy changes could support easier implementation with HealthySteps by expanding eligible consulting provider types.

***For HealthySteps sites that are not already implementing CoCM*** for older children and adults, the existing CoCM requirements and codes may not easily translate. In states where payers are considering CoCM billing codes as a potential future funding mechanism for HealthySteps, practices would need to adopt significant infrastructure changes and investments to access these billing codes (e.g., time-tracking, use of a registry to track progress, etc.).

Whether practices are implementing CoCM or not, there are several key tweaks policymakers should consider as they explore incorporating CoCM affiliated codes for care provided to infants and toddlers:

- Allow for z-codes to be used as a primary diagnosis (e.g., Z62.820, Z65.9, Z63.8.)[5] since young children often do not have diagnosable conditions.

[5] Colorado: https://leg.colorado.gov/sites/default/files/2023a_174_signed.pdf.
California: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/D84845A9-9DA6-434D-8B97-00CD24F101E7/nonspecmental.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO.
New York: "Psychotherapy Services: Medical Necessity" https://www.health.ny.gov/health_care/medicaid/program/update/2023/no02_2023-01.htm#:~:text=A%20diagnosis%20of%20%22Z65.,ICD%2D10%20code%20%22Z65.
Massachusetts: "Preventive Behavioral Health Services for Member Younger than 21" https://www.mass.gov/doc/managed-care-entity-bulletin-65-preventive-behavioral-health-services-for-members-younger-than-21-0/download.

- Provide guidance through State Medicaid to payers making clear that caregiver and/or dyadic concerns are considered part of behavioral health interventions in service of the child. For example, in the case of a caregiver with postpartum depression, guidance would make explicit that practices are able to include caregiver-child dyads on a registry, seek/provide dyadic interventions, and monitor progress.[6]
- Review CoCM guidelines and consider expanding eligible provider types and roles on practice teams to better meet the needs of patients who do not require consultation from a prescribing provider (e.g., psychiatrist or Advanced Practice Registered Nurse).

Whether or not policymakers have CoCM in mind, these policy solutions can positively impact the delivery of pediatric primary care, increase access to integrated behavioral health care, and build out a continuum of services across the life span.

[6] Massachusetts: "Preventive Behavioral Health Services for Member Younger than 21" https://www.mass.gov/doc/managed-care-entity-bulletin-65-preventive-behavioral-health-services-for-members-younger-than-21-0/download.