Collaborative Care for Youth at Risk: Integrating Mental Health Across Pediatric Settings

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June 18, 2026

University Hospitals
Rainbow Babies & Children's
Cleveland | Ohio

SCHOOL OF MEDICINE
CASE WESTERN RESERVE UNIVERSITY

Objectives

- Examine various integrated care models and the key characteristics that influence their appropriateness for different clinical practices
- Describe various implementation strategies that facilitate successful adoption of collaborative care
- Understand policy-related factors, including reimbursement frameworks, that underpin the financial sustainability of collaborative care models

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Integrated Care: What is it. and how do we do it?

The Chronic Care Model

Five elements associated with improved outcomes:

1. Treatment employs **evidence-based guidelines**
2. Optimizing **practice organization** to implement those guidelines (including use of specialized non-physician providers and active follow up of patients
3. Improving **support for patient self-management**
4. Helping generalist providers **access specialist consultation**
5. Setting up **clinical information systems** that allow the practice to understand its overall success with patients

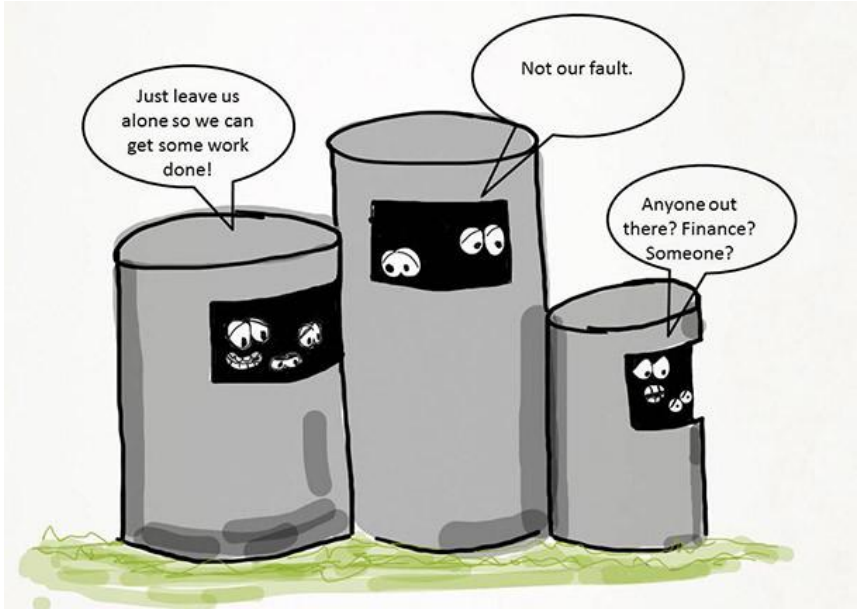
Wagner, 1996

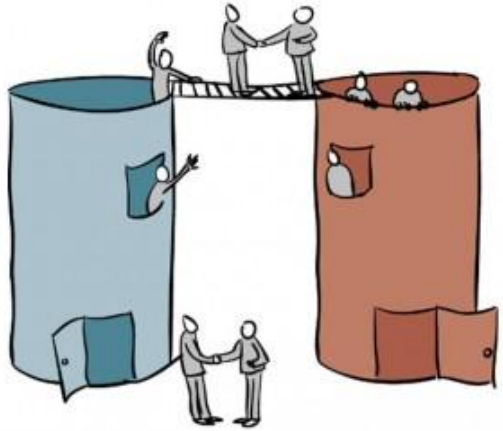
The Chronic Care Model

Core components include:

- A means of accurately diagnosing the target condition
- An evidence-based treatment protocol specifically for that diagnosis
- Non-physician staff with responsibility for carrying out and monitoring the results of the treatment, including
  1. Tracking patients
  2. Promoting adherence
  3. Making treatment adjustments as needed (“stepped care”)

Wagner, 1996





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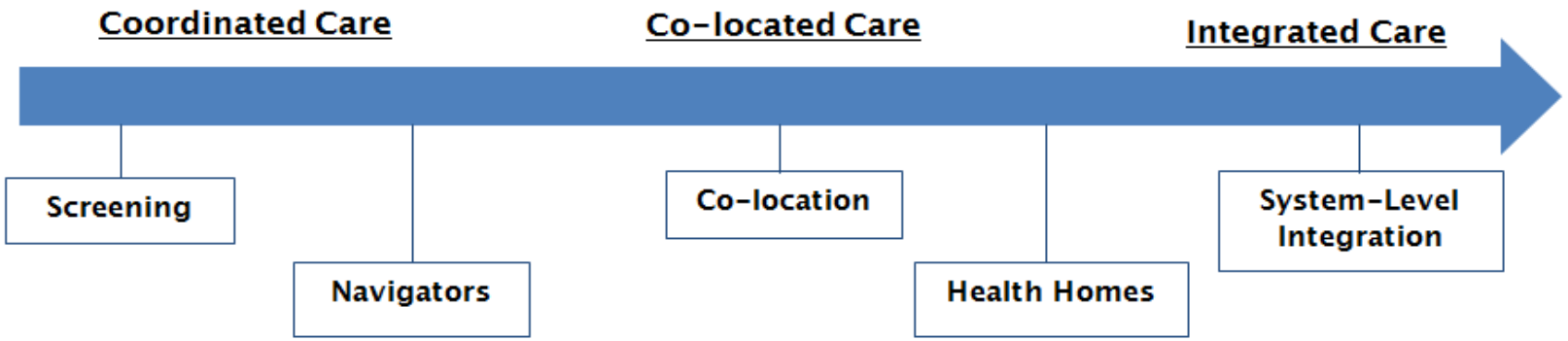
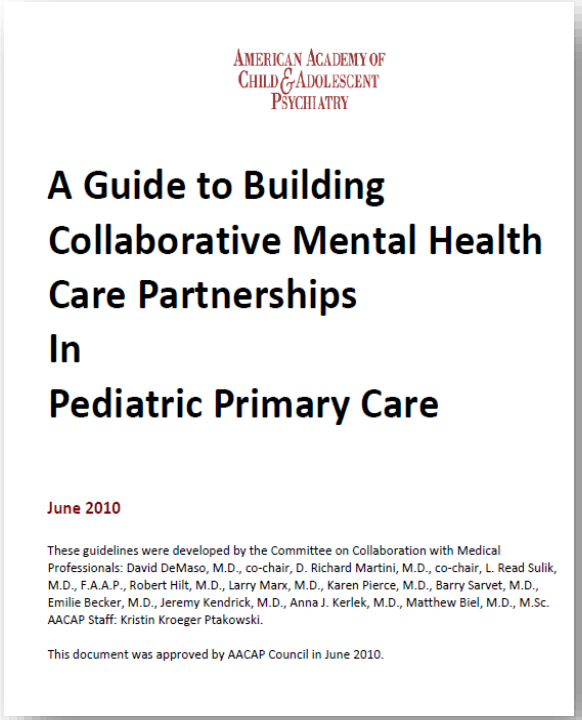
Continuum of Physical and Behavioral Health Care Integration



Nardone, 2014
Gerrity, 2016

Child Psychiatry's parallel process



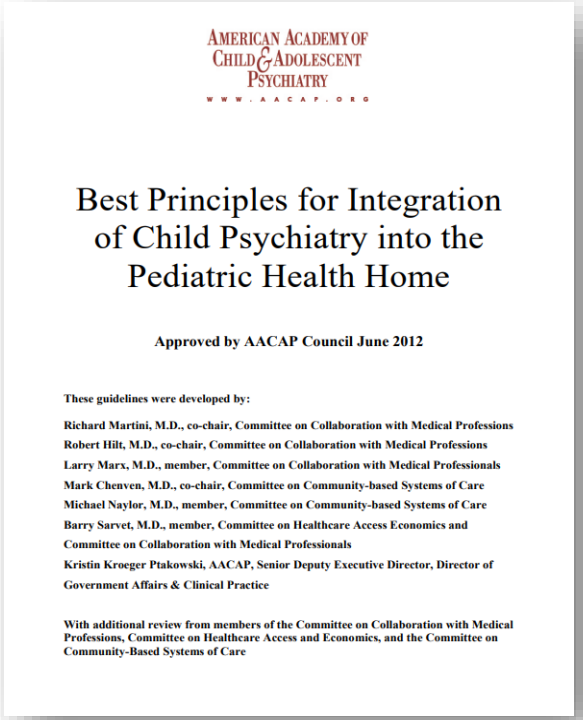
AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

A Guide to Building Collaborative Mental Health Care Partnerships In Pediatric Primary Care

June 2010

These guidelines were developed by the Committee on Collaboration with Medical Professionals: David DeMaso, M.D., co-chair, D. Richard Martini, M.D., co-chair, L. Read Sulik, M.D., F.A.A.P., Robert Hilt, M.D., Larry Marx, M.D., Karen Pierce, M.D., Barry Sarvet, M.D., Emilie Becker, M.D., Jeremy Kendrick, M.D., Anna J. Kerlek, M.D., Matthew Biel, M.D., M.Sc. AACAP Staff: Kristin Kroeger Ptakowski.

This document was approved by AACAP Council in June 2010.



AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY
WWW.AACAP.ORG

Best Principles for Integration of Child Psychiatry into the Pediatric Health Home

Approved by AACAP Council June 2012

These guidelines were developed by:

Richard Martini, M.D., co-chair, Committee on Collaboration with Medical Professions
Robert Hilt, M.D., co-chair, Committee on Collaboration with Medical Professions
Larry Marx, M.D., member, Committee on Collaboration with Medical Professionals
Mark Chenven, M.D., co-chair, Committee on Community-based Systems of Care
Michael Naylor, M.D., member, Committee on Community-based Systems of Care
Barry Sarvet, M.D., member, Committee on Healthcare Access Economics and Committee on Collaboration with Medical Professionals
Kristin Kroeger Ptakowski, AACAP, Senior Deputy Executive Director, Director of Government Affairs & Clinical Practice

With additional review from members of the Committee on Collaboration with Medical Professions, Committee on Healthcare Access and Economics, and the Committee on Community-Based Systems of Care

AAP on the same train..

POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Mental Health Competencies for Pediatric Practice

Jane Meschan Foy, MD, FAAP,[a] Cori M. Green, MD, MS, FAAP,[b] Marian F. Earls, MD, MTS, FAAP,[c] COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, MENTAL HEALTH LEADERSHIP WORK GROUP

This Policy Statement was reaffirmed May 2025.

TECHNICAL REPORT

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Achieving the Pediatric Mental Health Competencies

Cori M. Green, MD, MS, FAAP,[a] Jane Meschan Foy, MD, FAAP,[b] Marian F. Earls, MD, FAAP,[c] COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, MENTAL HEALTH LEADERSHIP WORK GROUP

This Technical Report was reaffirmed May 2025.

SAMHSA-HRSA's CIHS Levels of Integrated Care

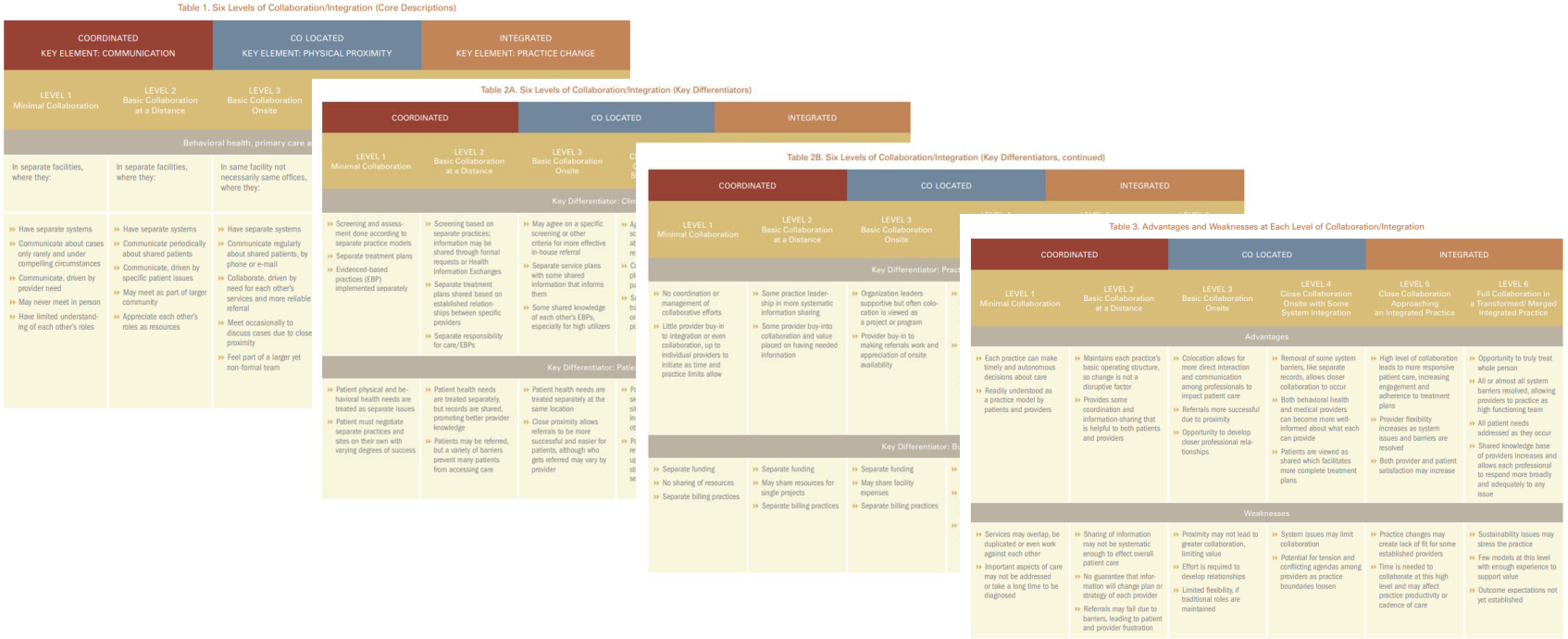


Table 1. Six Levels of Collaboration/Integration (Core Descriptions)

COORDINATED KEY ELEMENT: COMMUNICATION		CO LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite			
Behavioral health, primary care a					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:			
» Have separate systems » Communicate about cases only rarely and under compelling circumstances » Communicate, driven by provider need » May never meet in person » Have limited understanding of each other's roles	» Have separate systems » Communicate periodically about shared patients » Communicate, driven by specific patient issues » May meet as part of larger community » Appreciate each other's roles as resources	» Have separate systems » Communicate regularly about shared patients, by phone or e-mail » Collaborate, driven by need for each other's services and more reliable referral » Meet occasionally to discuss cases due to close proximity » Feel part of a larger yet non-formal team			

Table 2A. Six Levels of Collaboration/Integration (Key Differentiators)

COORDINATED		CO LOCATED		INTEGRATED	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite			
Key Differentiator: Cli					
» Screening and assessment done according to separate practice models » Separate treatment plans » Evidenced-based practices (EBP) implemented separately	» Screening based on separate practices; information may be shared through formal requests or Health Information Exchanges » Separate treatment plans shared based on established relationships between specific providers » Separate responsibility for care/EBPs	» May agree on a specific screening or other criteria for more effective in-house referral » Separate service plans with some shared information that informs them » Some shared knowledge of each other's EBPs, especially for high utilizers			
Key Differentiator: Patie					
» Patient physical and behavioral health needs are treated as separate issues » Patient must negotiate separate practices and sites on their own with varying degrees of success	» Patient health needs are treated separately, but records are shared, promoting better provider knowledge » Patients may be referred, but a variety of barriers prevent many patients from accessing care	» Patient health needs are treated separately at the same location » Close proximity allows referrals to be more successful and easier for patients, although who gets referred may vary by provider			

Table 2B. Six Levels of Collaboration/Integration (Key Differentiators, continued)

COORDINATED		CO LOCATED		INTEGRATED	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite			
Key Differentiator: Pract					
» No coordination or management of collaborative efforts » Little provider buy-in to integration or even collaboration, up to individual providers to initiate as time and practice limits allow	» Some practice leadership in more systematic information sharing » Some provider buy-into collaboration and value placed on having needed information	» Organization leaders supportive but often colocation is viewed as a project or program » Provider buy-in to making referrals work and appreciation of onsite availability			
Key Differentiator: B					
» Separate funding » No sharing of resources » Separate billing practices	» Separate funding » May share resources for single projects » Separate billing practices	» Separate funding » May share facility expenses » Separate billing practices			

Table 3. Advantages and Weaknesses at Each Level of Collaboration/Integration

COORDINATED		CO LOCATED		INTEGRATED	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Advantages					
» Each practice can make timely and autonomous decisions about care » Readily understood as a practice model by patients and providers	» Maintains each practice's basic operating structure, so change is not a disruptive factor » Provides some coordination and information-sharing that is helpful to both patients and providers	» Colocation allows for more direct interaction and communication among professionals to impact patient care » Referrals more successful due to proximity » Opportunity to develop closer professional relationships	» Removal of some system barriers, like separate records, allows closer collaboration to occur » Both behavioral health and medical providers can become more well-informed about what each can provide » Patients are viewed as shared which facilitates more complete treatment plans	» High level of collaboration leads to more responsive patient care, increasing engagement and adherence to treatment plans » Provider flexibility increases as system issues and barriers are resolved » Both provider and patient satisfaction may increase	» Opportunity to truly treat whole person » All or almost all system barriers resolved, allowing providers to practice as high functioning team » All patient needs addressed as they occur » Shared knowledge base of providers increases and allows each professional to respond more broadly and adequately to any issue
Weaknesses					
» Services may overlap, be duplicated or even work against each other » Important aspects of care may not be addressed or take a long time to be diagnosed	» Sharing of information may not be systematic enough to effect overall patient care » No guarantee that information will change plan or strategy of each provider » Referrals may fail due to barriers, leading to patient and provider frustration	» Proximity may not lead to greater collaboration, limiting value » Effort is required to develop relationships » Limited flexibility, if traditional roles are maintained	» System issues may limit collaboration » Potential for tension and conflicting agendas among providers as practice boundaries loosen	» Practice changes may create lack of fit for some established providers » Time is needed to collaborate at this high level and may affect practice productivity or cadence of care	» Sustainability issues may stress the practice » Few models at this level with enough experience to support value » Outcome expectations not yet established

SAMHSA-HRSA CENTER FOR INTEGRATED HEALTH SOLUTIONS

Center for Integrated Health Solutions, 2013

Comparative Models of Integrated Care

Characteristic	Collaborative Care	Primary Care Behavioral Health (PCBH)
Who delivers service	Behavioral Health Manager + Collaborating Psychiatrist	Psychologist, Counselor, SW
Location of service	In person, virtual, phone	In person
Services provided	Care management Brief evidence-based therapies Referral	Therapy, brief or longer Education to providers and staff Referral
How enrolled	Proactive, based on screening or automated processes Reactive based on provider referral or pt request	Reactive based on provider referral or pt request
Population management	Registry-based approach	Support care of all patients through education to PCPs & pts
Ideal caseload	40-90	Unknown/not defined
Treatment to Target	Yes	No
Outcome monitoring	Yes	No
Evidence-based improvement	Yes- Very strong evidence base for patient improvement	Growing evidence of particular programs
Billing	CoCM codes	Individual therapy codes, Health Behavior Assessment and Intervention
Ideal for	Mild to moderate depression and anxiety Targeted specific conditions	Populations with primarily psychological issues (children, young adults)

The Chronic Care Model: The Last Element

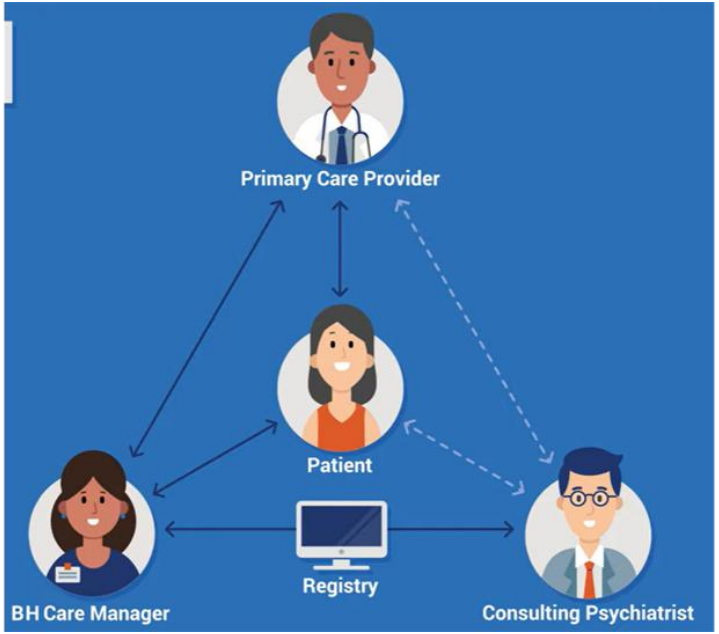
Collaboration between the PCP and a mental health specialist

- Formal and informal consultations
- Facilitate transition to specialty treatment when needed

Kilbourne 2004

Key Elements of the Collaborative Care Model (CoCM)

- Patient-Centered Team Care
- Population-Based Care
- Measurement-Based Treatment to Target
- Evidence-Based Care
- Accountable Care



Unutzer, 2002

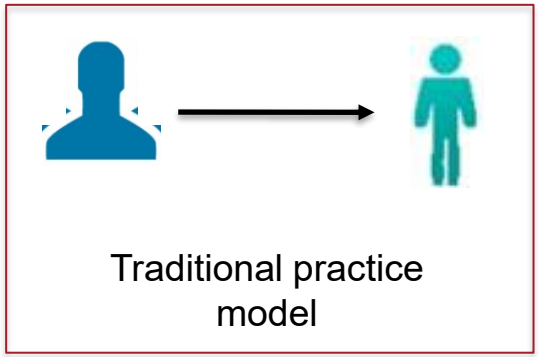
Advancing Integrated Mental Health Solutions, 2004

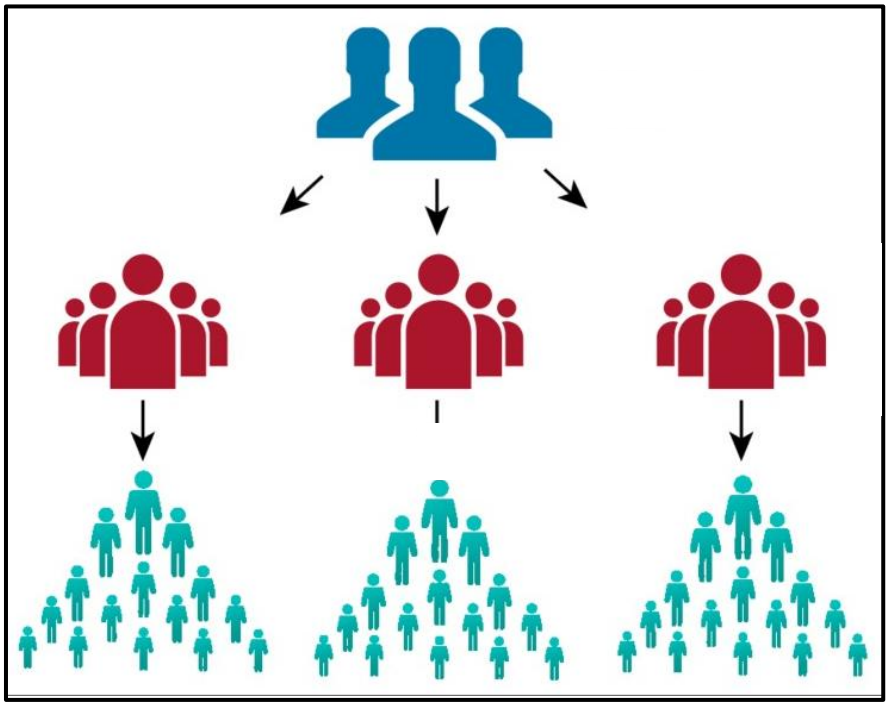
Collaborative Care Operational Elements

- Team communication in person, virtual, and via EHR
- Billing based on monthly time
- Support for referrals to other behavioral health specialists
- Weekly meetings to build community, ongoing skill-building, quality improvement

Behavioral Health Integration Services, 2025

Collaborative Care: Workforce Multiplier





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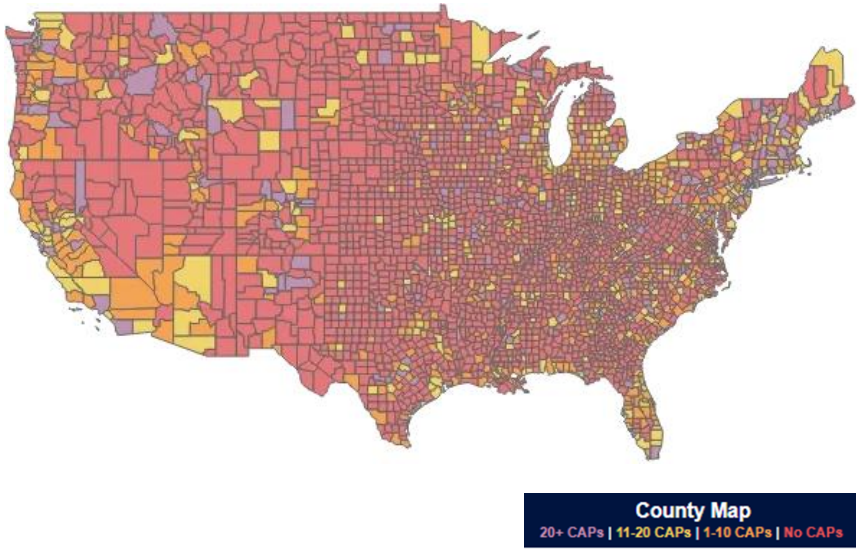
Pediatric Mental Health: a national crisis

- Almost 20% of children in the United States suffer from some form of a mental illness -only 20% of these children receive treatment
- In the U.S Half of all lifetime mental illnesses begin by age 14; three quarters by age 24
- The average delay between onset of symptoms and intervention for children is between **8 and 10 years** - critical developmental years in the life of a child.
- Only 25% of children who could benefit from treatment actually receive specialty mental health care

Perou, Centers for Disease Control and Prevention (CDC), 2013
Kessler, 2005

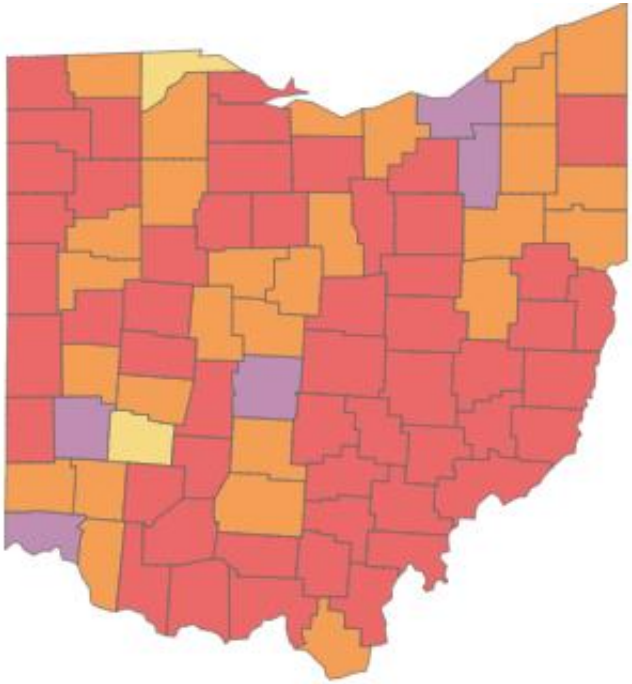
Child Psychiatry Workforce Shortage

- 12,000 child psychiatrists in the country, to cover 15 million children
- Current estimated need of CAPs: 30,000+
- Estimated growth of the pediatric population (0-18yo) is 30%, from 80 million to 112 million by 2050.



American Academy of Child and Adolescent Psychiatry, 2026

Workforce Distribution - Ohio



American Academy of Child and Adolescent Psychiatry, 2026

Access to Care

- For families that do seek specialty mental health services, 50% terminate treatment prematurely
  - lack of access
  - lack of transportation
  - child mental health professional shortages
  - stigma related to mental health disorders

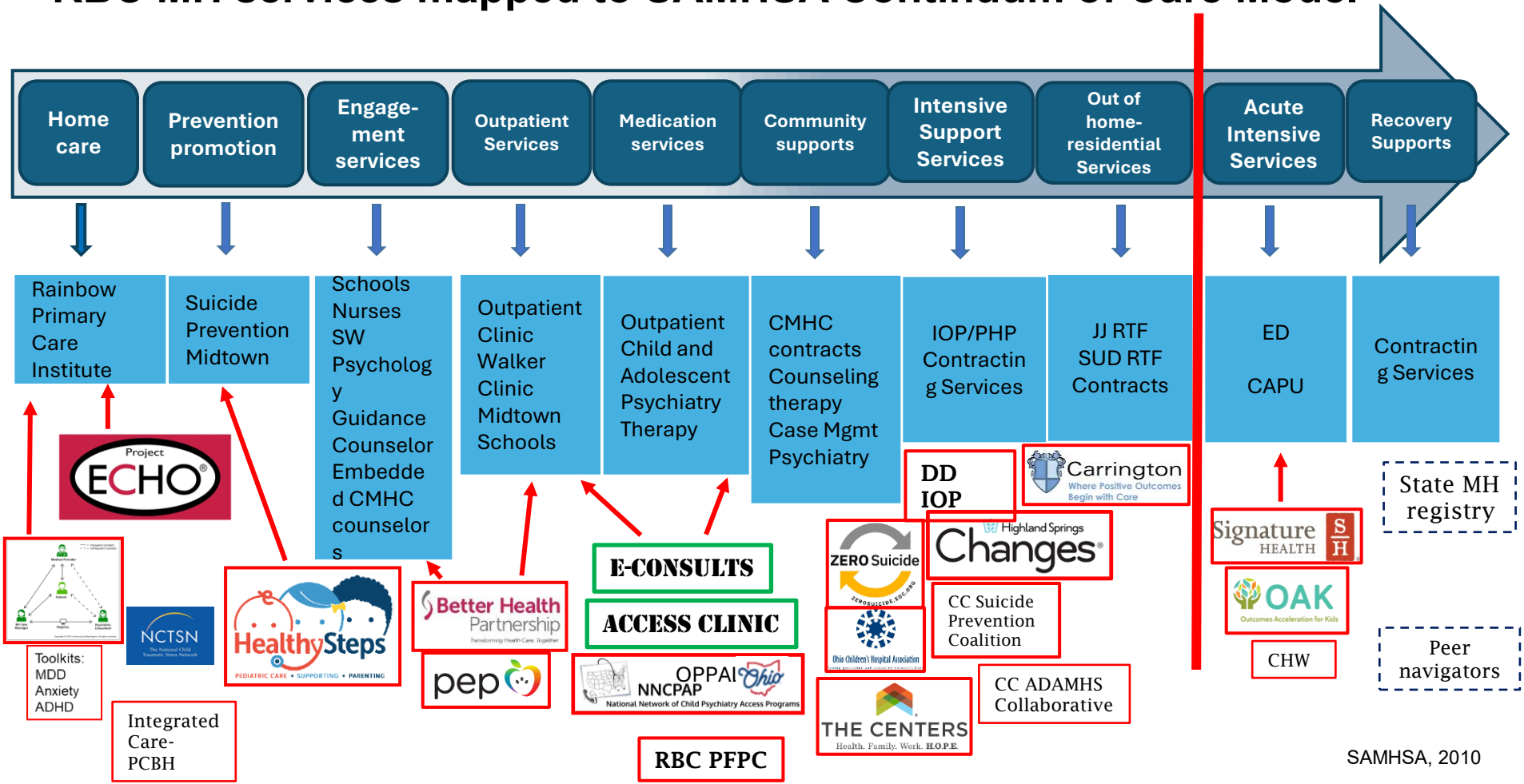
- Approximately 75% of children and adolescents with psychiatric disorders are seen in the pediatrician's office
- Behavioral health concerns account for 1/3 of pediatric office visits

Modi, 2022
Anderson, 2015

UH Rainbow Babies & Children's Hospital

University Hospitals
Rainbow Babies & Children's
Cleveland | Ohio

RBC MH services mapped to SAMHSA Continuum of Care Model

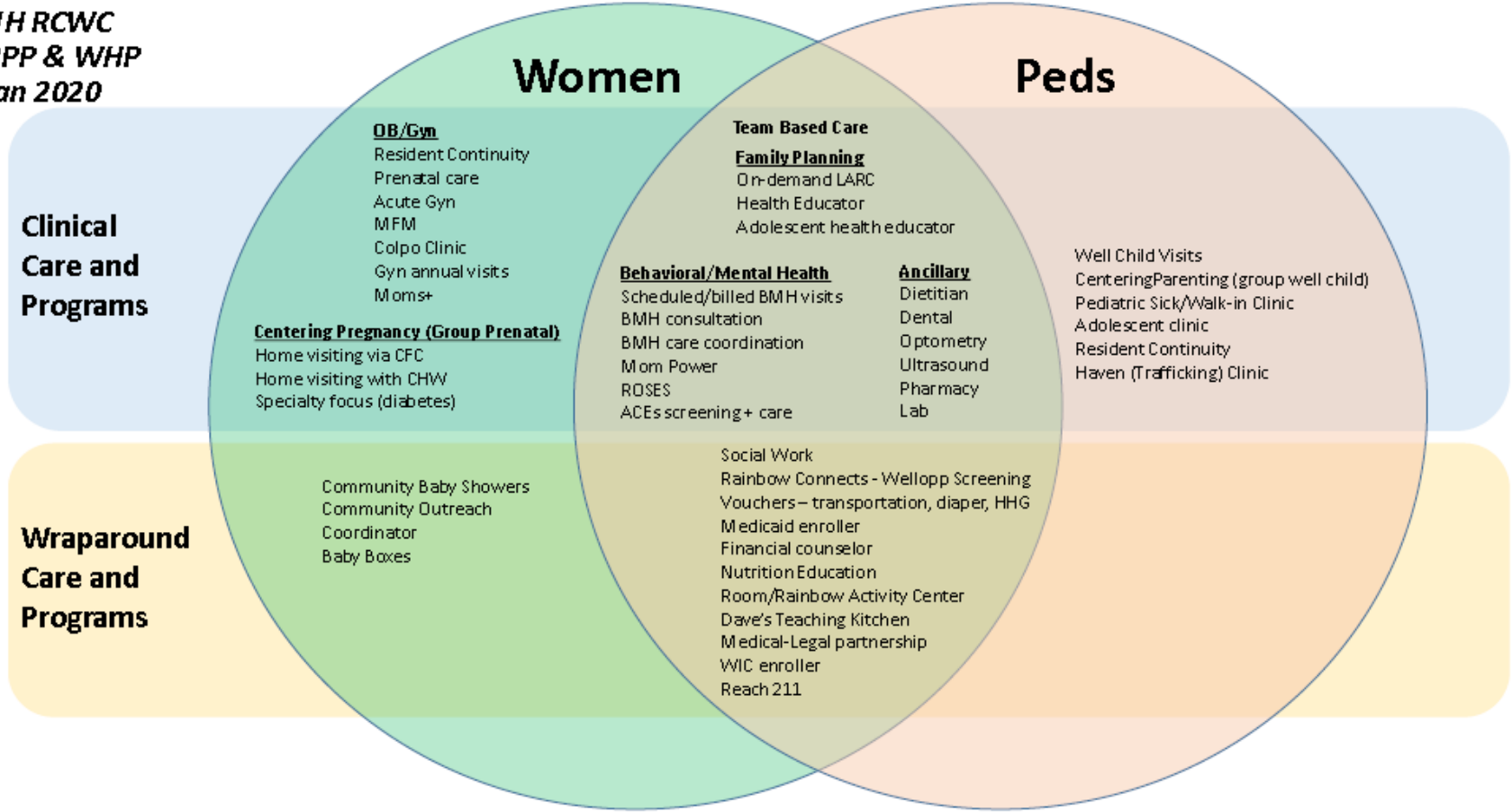


SAMHSA, 2010

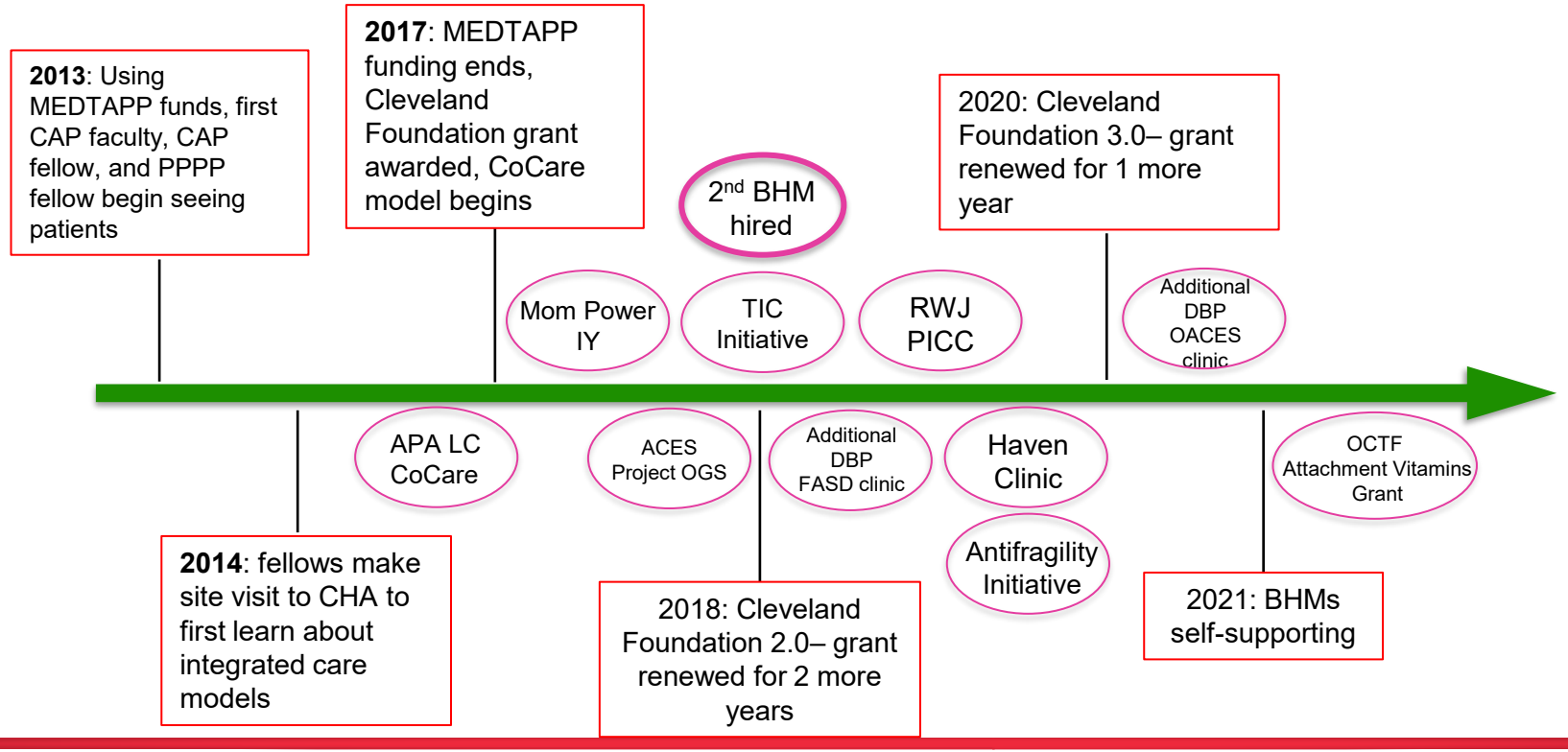
UH Rainbow Babies & Children's Ahuja Center for Women and Children

- Resident Continuity Clinic serving ~16,000 unique children and adolescents per year
  - 120+ physician trainees
  - 13 faculty and NPs
    - Range: 1-35 years in practice
- >85% patients with Medicaid as primary insurer
- High proportion of families in distress

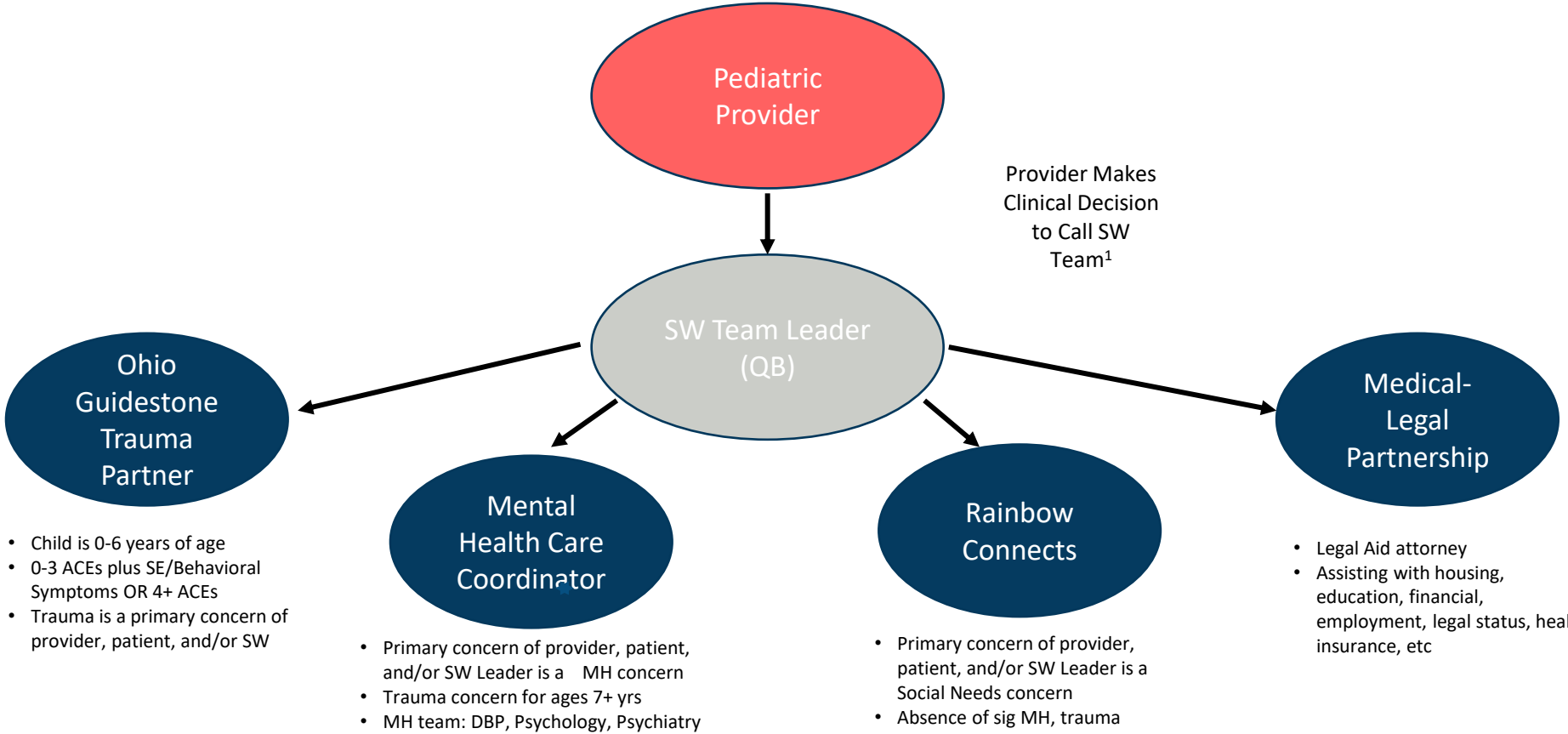
UH RCWC
RPP & WHP
Jan 2020



History of ental health at Rainbow Pediatric Practice



Rainbow Pediatric Practice: Psycho-Social Team Workflow



- Child is 0-6 years of age
- 0-3 ACEs plus SE/Behavioral Symptoms OR 4+ ACEs
- Trauma is a primary concern of provider, patient, and/or SW

- Primary concern of provider, patient, and/or SW Leader is a MH concern
- Trauma concern for ages 7+ yrs
- MH team: DBP, Psychology, Psychiatry

- Primary concern of provider, patient, and/or SW Leader is a Social Needs concern
- Absence of sig MH, trauma

- Legal Aid attorney
- Assisting with housing, education, financial, employment, legal status, health insurance, etc

Implementation Strategies

Core CoCM Component	UH-RCWC Adaptation/ Enhancement	Strategy – Train and Educate Stakeholders
Patient Centered Team: - PCP - BHM - Consulting Psychiatrist	Add: - Developmental Pediatrician - Pediatric Psychologist	- Stakeholder Engagement - Targeted on-boarding - Protected Time for Specialists

Core CoCM Component	UH-RCWC Adaptation/ Enhancement	Strategy - evaluative and iterative approaches
Measurement-Based Treatment to Target - Define condition with validated monitoring instruments	- Depression: PHQ - Anxiety: GAD-7, SCARED - ADHD: Vanderbilt - ASD: ADOS	- Continuing education - Audit and Feedback

Core CoCM Component	UH-RCWC Adaptation/ Enhancement	Strategy – change infrastructure
Population Based Care		
- Registry	- Custom registry build (web-based, HIPAA-secure)	- Infrastructure investments
- Systematic screening protocol	- BHC, PSC-17, MCHAT, PHQ-A	- Workflow optimization

Core CoCM Component	UH-RCWC Adaptation/ Enhancement	Strategy - Provide interactive assistance
Evidence-Based Treatments - Pharmacotherapy - Talk therapy (e.g., CBT/DBT/PA)	- PCIT - Intergenerational approaches (e.g., Mom Power, ROSES, Attachment Vitamins)	- Facilitation - local technical assistance - clinical supervision - train the trainer

Powell, 2015
Waltz, 2015

Examples of Continuing Education

CME Events
Pediatric Depression Toolkit
Women's MH Summit
Visiting Professorship

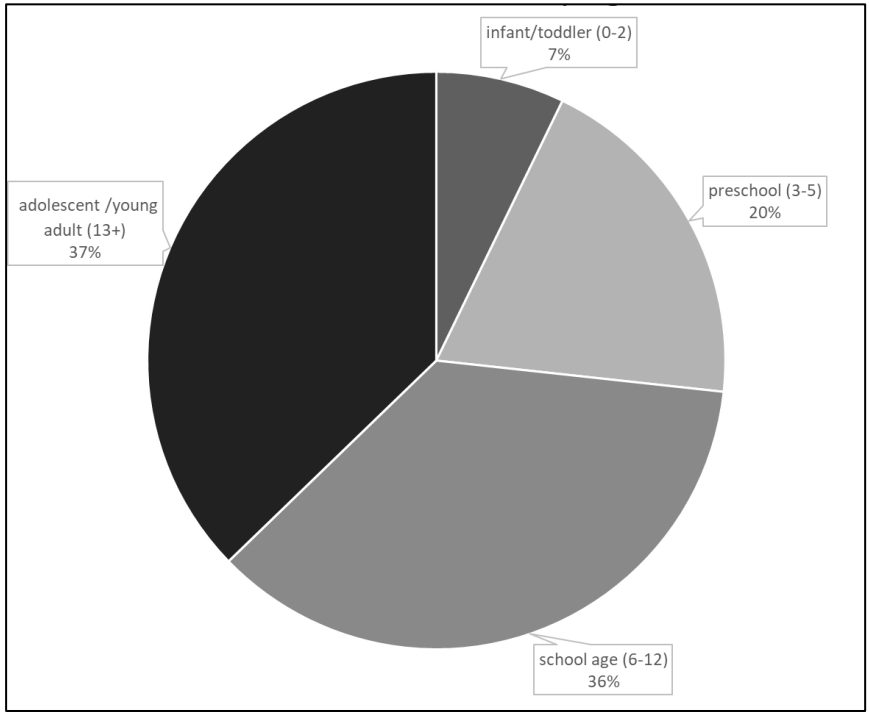
Grand Rounds
Martin Teicher, MD PhD
C. Neill Epperson, MD
Sarah Nagle-Yang, MD

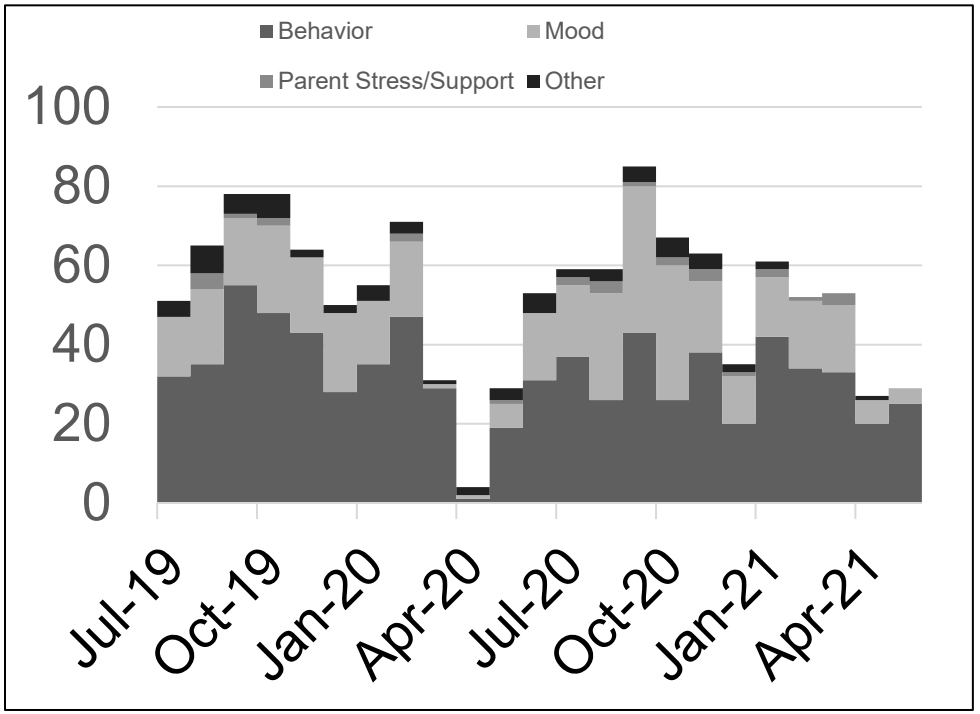
Trainings
De-escalation
Trauma-informed Care

Didactics
Monthly MH Case Conference
MH Boot Camp
Resident didactic modules
Adolescent Medicine Weekly didactics

Trainee Rotations
CAP fellow elective
Peds resident CAP continuity clinic
{Psychology intern}

RPP CoCM Referrals





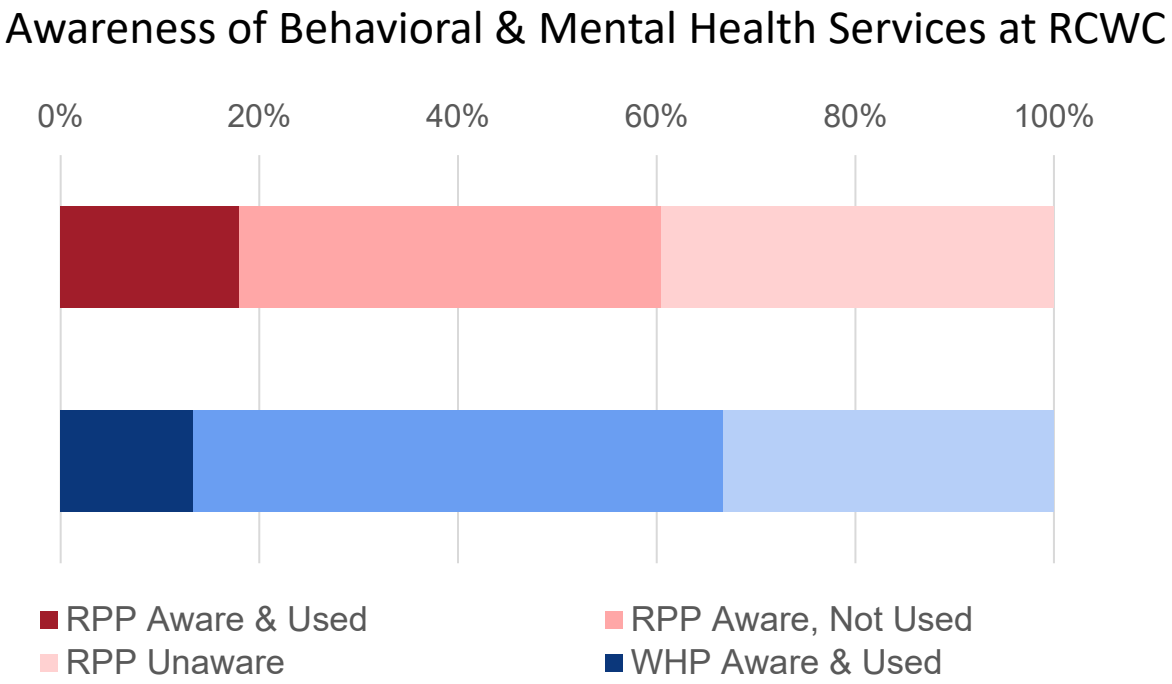
Clinician Perceptions

	2018	2019	2020
	N=24	N=29	N=24
Difficulty accessing Psychiatrist*	**50%**	**43%**	**36%**
Difficulty accessing Social Worker*	14%	13%	14%
Patient care is well coordinated**	34%	36%	51%
BMH coordinator improves clinician's experience**	62%	67%	80%
BMH specialists on-site improve experience**	**74%**	**78%**	**85%**

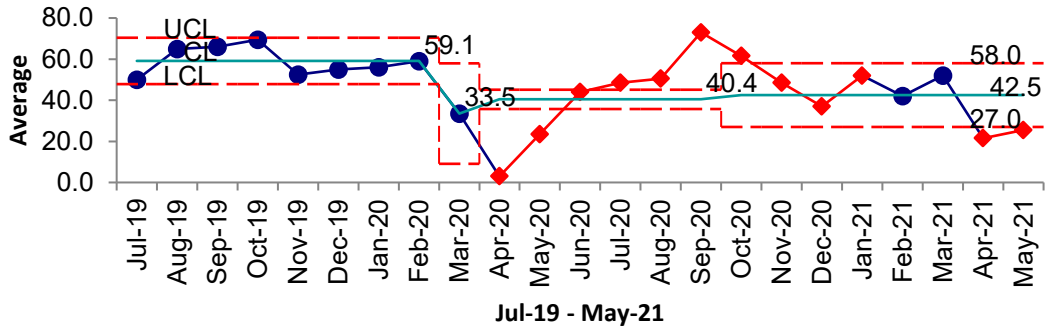
* Asked on 4-point Likert from 1- not at all difficult to 4-very difficult. Shown here are % responding 3 or 4
** Asked on 5-point Likert from 1-not at all true to 5-completely true. Shown here are % responding 4 or 5
Bold = p<0.05

Ronis, 2021

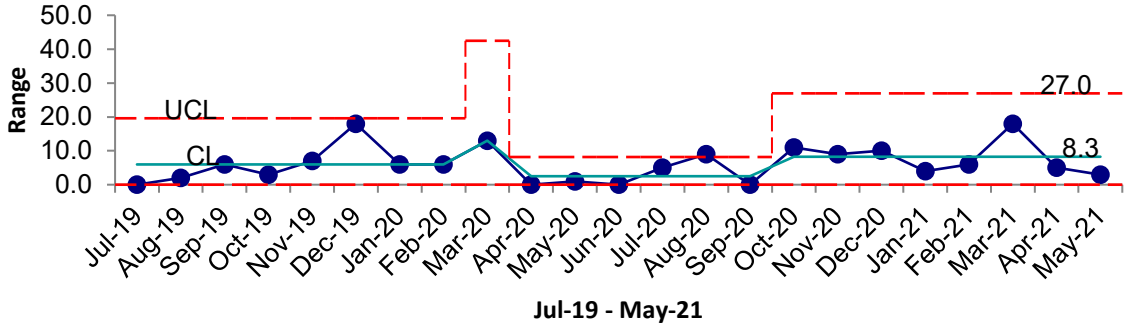
Patient and Family Perceptions



Referrals-Intakes - X Chart



Referrals-Intakes - R Chart



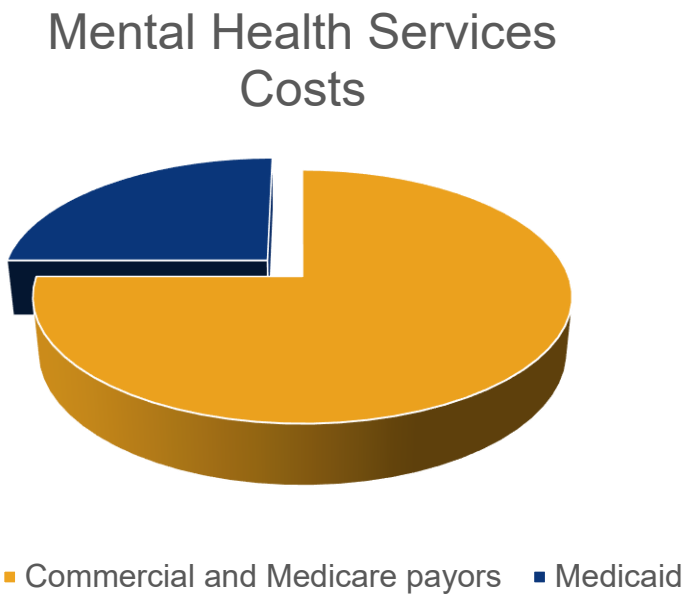
Implementation Strategies

Core CoCM Component	UH-RCWC Adaptation/ Enhancement	Strategy - Finances
Accountable Care - Reimburse for quality	- [philanthropic support]	- Access new funding - Alter incentive/ allowance structures

Economic Impact

- Mental health services costs in the U.S. reached $280 billion dollars in 2020
- One quarter of that was paid by Medicaid

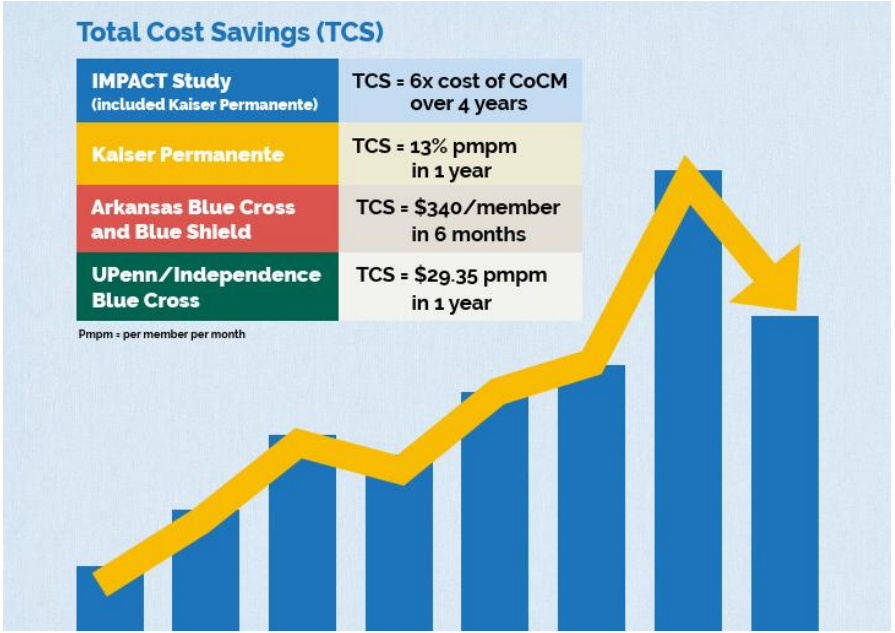
- Mental health expenditures account for 7% of total healthcare, but patients with mental health challenges account for 30% of total healthcare spending
- A study of 21 million lives found that the 5.7% of individuals with both medical and MHSUD claims accounted for 44% of all health care spending.



Abramson, 2024
Milliman, 2020

Financial Argument for CoCM

- **Increased Capacity:** One psychiatric consultant can typically impact 3–8 times more patients than through traditional 1:1 care.
- **Improved Equity:** Collaborative Care is one of the few interventions proven to reduce health disparities across race, ethnicity, and socioeconomic status.
- **Sustainable Funding:** CMS has established specific billing codes to make the model financially self-sustaining for providers
- **Return on Investment**: IMPACT study found ROI of 6:1 with implementation of Collaborative Care



Unutzer, 2008
Wolk, 2023
Bowman Family Foundation, 2025

Mapping CoCM activities onto BH Redesign Codes

Table 1. BHI Coding Summary

BHI Codes	Behavioral Health Care Manager or Clinical Staff Threshold Time	Assumed Billing Practitioner Time
Add-On CoCM (Any month) (CPT code 99494)	Each additional 30 minutes per calendar month	13 minutes
BHI Initiating Visit (AWV, IPPE, TCM or other qualifying E/M)†	N/A	Usual work for the visit code
CoCM First Month (CPT code 99492)	70 minutes per calendar month	30 minutes
CoCM Subsequent Months** (CPT code 99493)	60 minutes per calendar month	26 minutes
General BHI (CPT code 99484)	At least 20 minutes per calendar month	15 minutes
Initial or subsequent psychiatric collaborative care management (HCPCS code G2214)	30 minutes of behavioral health care manager time per calendar month	Usual work for the visit code

**CoCM is delivered monthly for an episode of care that ends when targeted treatment goals are met or there is failure to attain targeted treatment goals culminating in referral for direct psychiatric care, or there is a break in episode (no CoCM for 6 consecutive months).

†Annual Wellness Visit (AWV), Initial Preventive Physical Examination (IPPE), Transitional Care Management services (TCM).

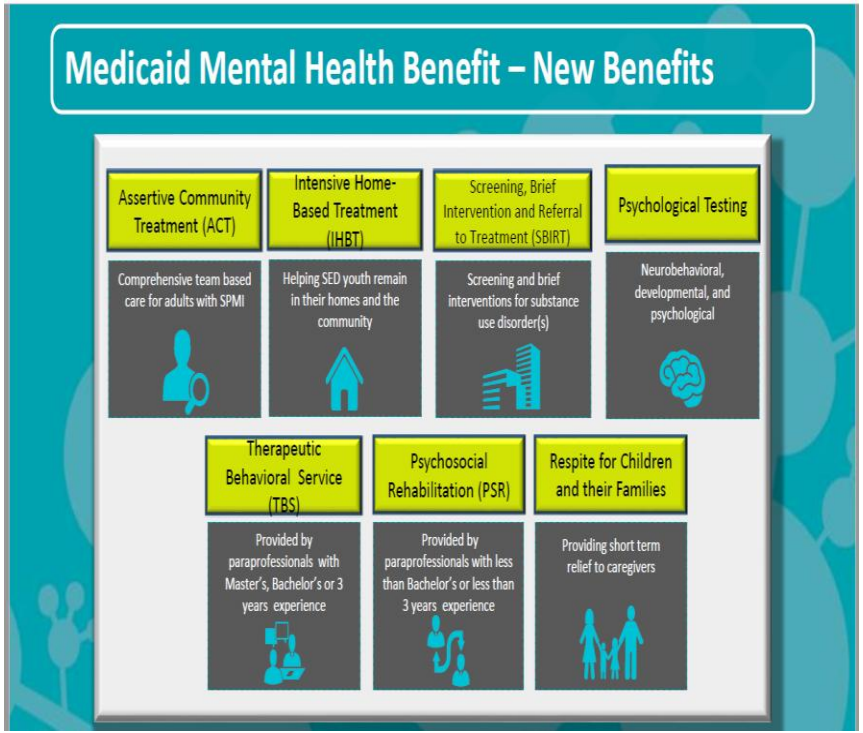
Full Code Descriptors

CPT code 99484 Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional time, per calendar month, with the following required elements:

- Initial assessment or follow-up monitoring, including the use of applicable validated rating scales
- Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes
- Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation
- Continuity of care with a designated member of the care team

CPT code 99492 Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements:

- Outreach to and engagement in treatment of a patient directed by the treating physician or other



Limits to Collaborative Care

- Characteristics of appropriate patients
- Characteristics of appropriate PCPs
- Billing structures/codes

A New Model: Healthy Steps

- Within the frame of PCBH
- A Risk-Stratified, Population-Based Model
- HS specialists are embedded in the practice and integrate with the primary care team
- Focus is on meeting the patient where they are:
  - Promotion and Prevention
  - Identify if milestones are reached
  - Connect families to additional services

Healthy Steps, Zero to Three, 2023

Infant & Early Childhood Mental Health Continuum of Supports and Services

Upstream → **Downstream**

Promotion

- Family strength and resilience
- Early learning resources
- Anticipatory guidance

Prevention

- Team-based well-child visits
- Universal screening
- Care Coordination and Systems Navigation
- Early Relational Health

Brief, Behavioral Health Early Intervention

- Intervention for risk factors and psychosocial stressors

Treatment for Diagnosis

- Diagnosis exists, evidence-based dyadic treatment

HealthySteps A Program of ZERO TO THREE

Healthy Steps, Zero to Three, 2023

The Healthy Steps Team at RPP

- HealthySteps Specialists:
- 1.7 FTE, including effort from licensed clinical psychologists, licensed professional clinical counsellor, licensed independent social worker, providing
  - Assessment
  - Brief intervention/consultation
  - Psychotherapy
  - Developmental evaluation

Supporting ~3500 unique children aged 0-3 years

Healthy Steps, Zero to Three, 2023

Program Reach and Activities, July 2024-June 2025

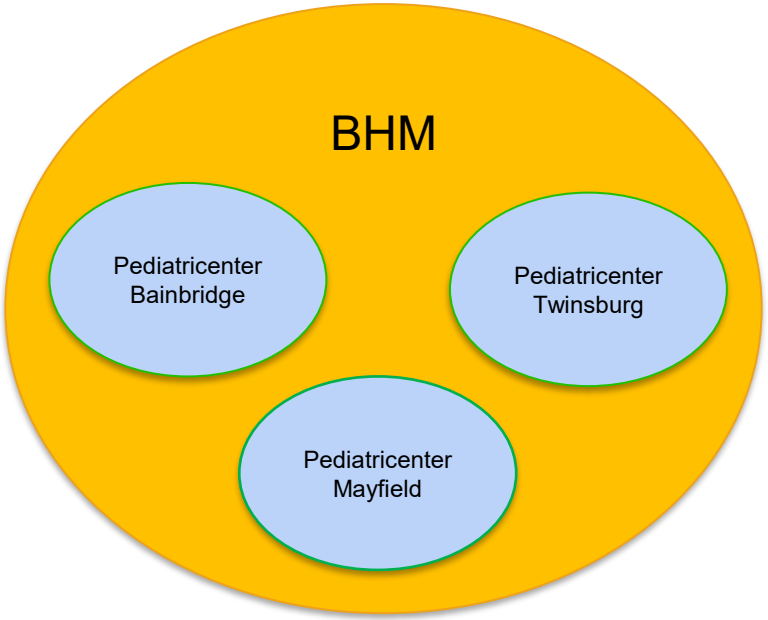
Tier	Reach	Activities
1 – Universal Screening & Prevention	- 3,075 of 3,365 (91%) children receiving care - 955 of 997 (96%) mothers with infants <6 months old	-Screened for developmental or safety concerns -Screened for post partum depression
2- Short-term supports, including brief behavioral intervention, ASD assessment	- 433 families total - 33 toddlers	 ASD assessment
3- Comprehensive Ongoing Preventive Services	191 families	Maternal mental health Early Intervention services Home visiting services Speech Therapy Food supports

Take 2

CoCM pilot in nonacademic community pediatric practices:
Rainbow Primary Care Institute

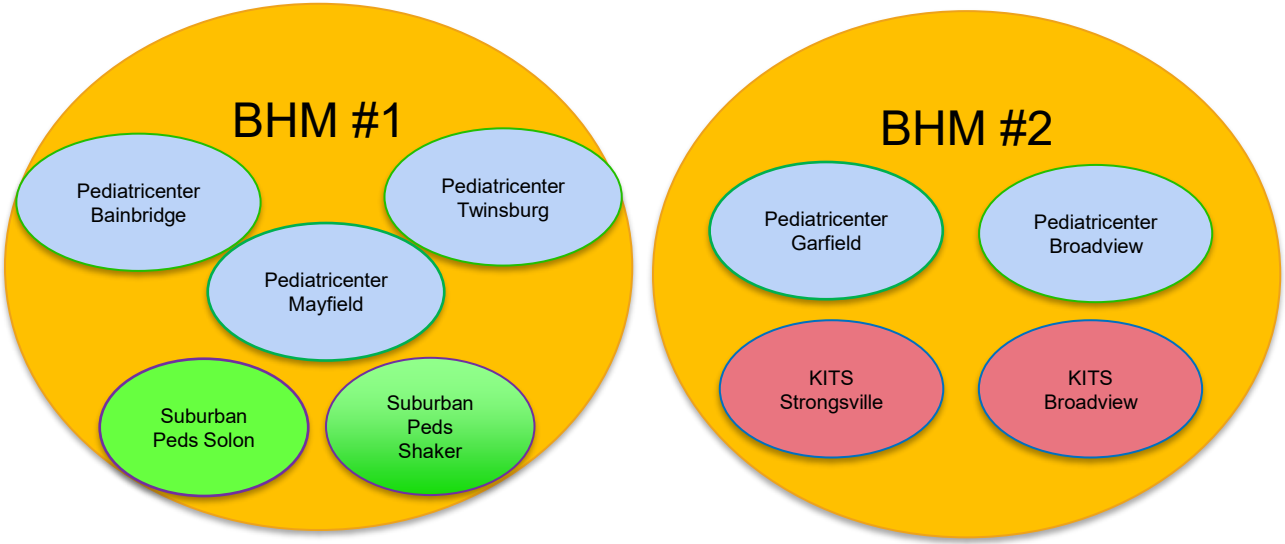
2022-2024 Proof of Concept

- 1 BHM
- 1 Psychiatrist
- 3 practice sites



2024: Program Design

- 2 Behavioral Health Coordinators
- 2 Psychiatrists



9 Referring Practice Sites

6 Sites with BHM presence*

32 Providers

RainbowECHO

Advancing Pediatric Behavioral & Mental Health Care Through Collaborative Learning

2021
Established

250+
Providers Trained

25+
Courses Offered

STATEWIDE
Provider Reach

WHAT IS RAINBOWECHO?

Established in 2021, RainbowECHO is the University Hospitals Rainbow Babies and Children's Project ECHO hub. Through virtual, didactic and case-based learning, RainbowECHO connects community providers with mental and behavioral health experts.

Our goal is to increase provider confidence and capacity to identify, assess, and manage pediatric behavioral and mental health concerns.

RELATIONSHIPS

OPPAL
Ohio Pediatric Psychiatry Access Line

OAK
Outcomes Acceleration for Kids

Collaborating with OPPAL and OAK to expand access to behavioral health resources, education, and specialist support for providers across Ohio.

AIMS CENTER
UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences
Advancing Integrated Care for Over 20 Years

Search ... Search

COLLABORATIVE CARE | TRAINING & SUPPORT | REGISTRIES | RESOURCES | AIMS CENTER

Training and Support Services

The AIMS Center offers a range of services that support the development and implementation of Collaborative Care.

TRAINING & SUPPORT

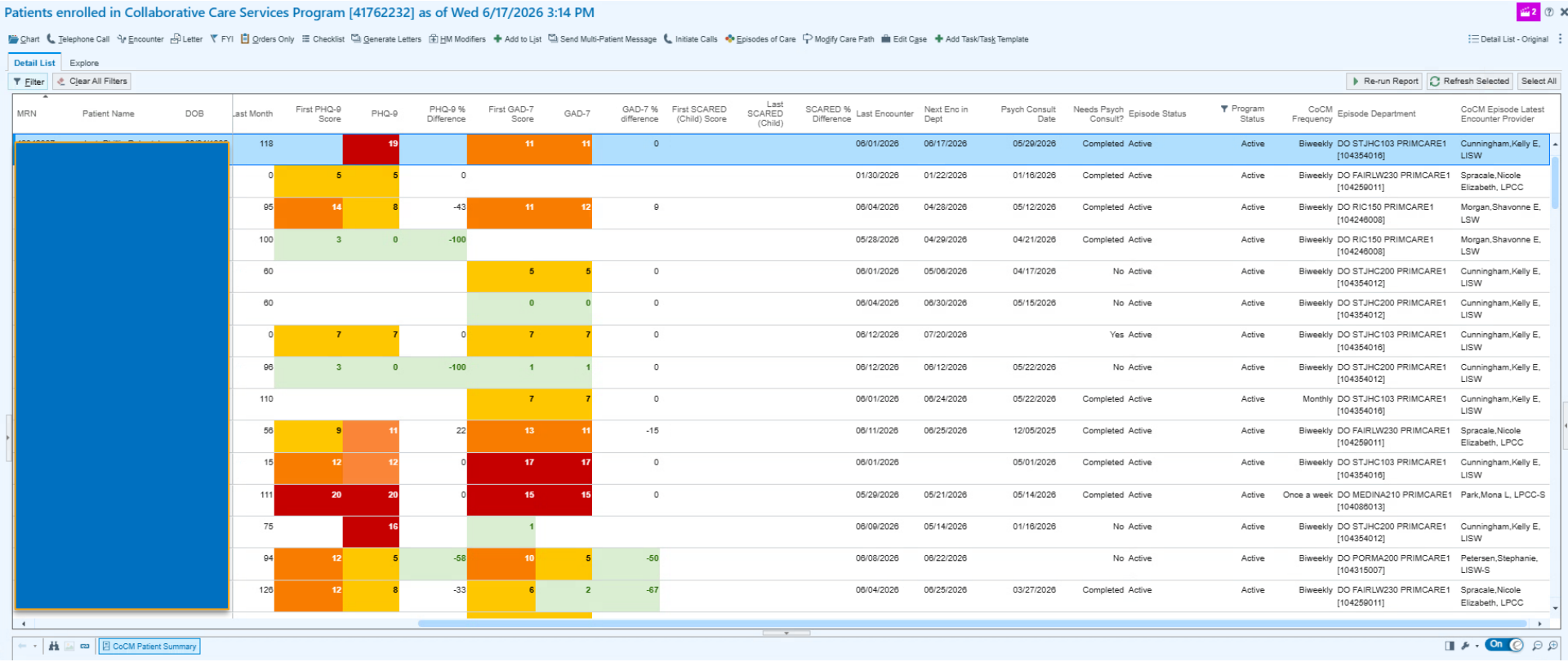
Training and Support Services

Online Trainings

- Behavioral Health Care Manager Training
- Psychiatric Consultant Training
- Primary Care Provider Training

Behavioral Interventions

- Problem Solving Treatment (PST) Training
  - Tier 1: A Course in Problem Solving Treatment
  - Tier 2: Problem Solving Treatment Certification
- Behavioral Activation (BA) Training
- First Approach Skills Training (FAST)



Patients enrolled in Collaborative Care Services Program [41762232] as of Wed 6/17/2026 3:14 PM

Chart | Telephone Call | Encounter | Letter | FYI | Orders Only | Checklist | Generate Letters | HM Modifiers | Add to List | Send Multi-Patient Message | Initiate Calls | Episodes of Care | Modify Care Path | Edit Case | Add Task/Task Template | Detail List - Original

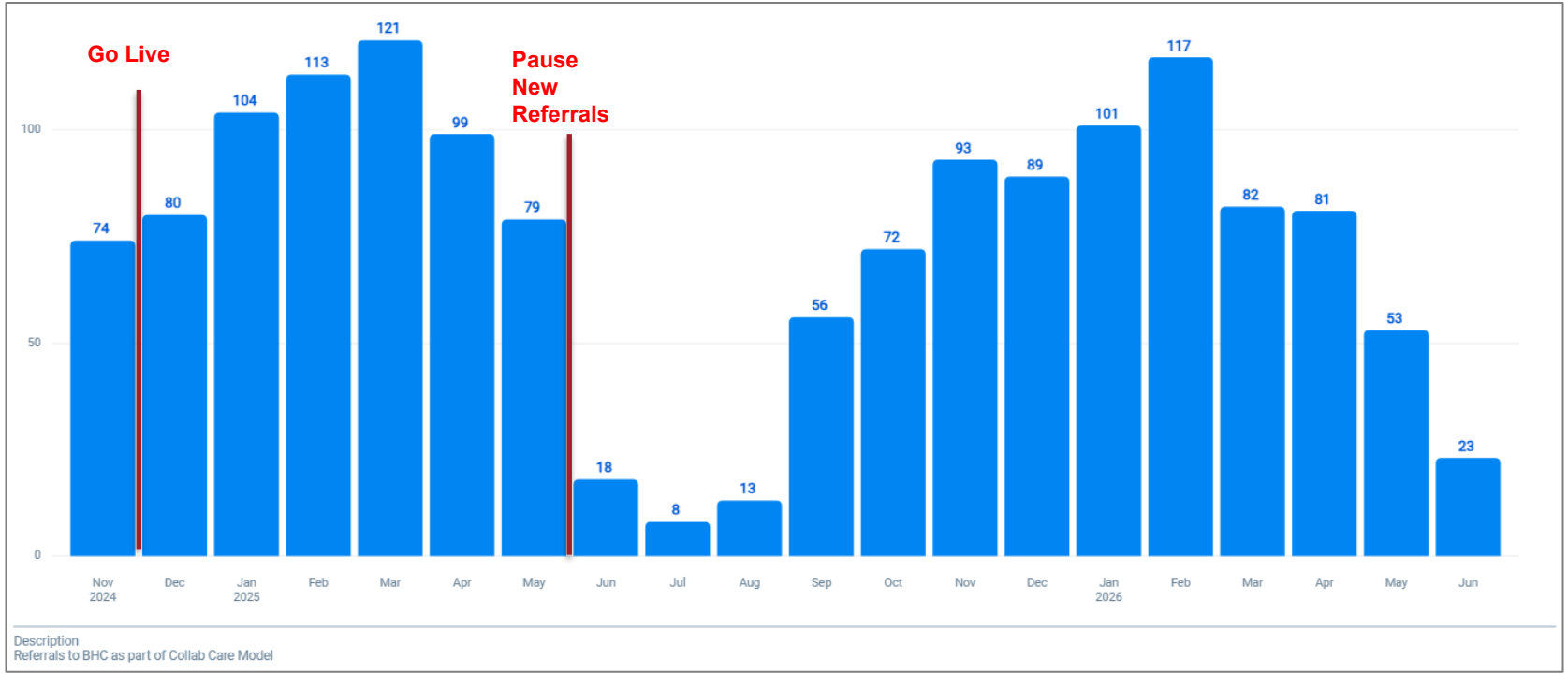
Detail List | Explore

Filter | Clear All Filters | Re-run Report | Refresh Selected | Select All

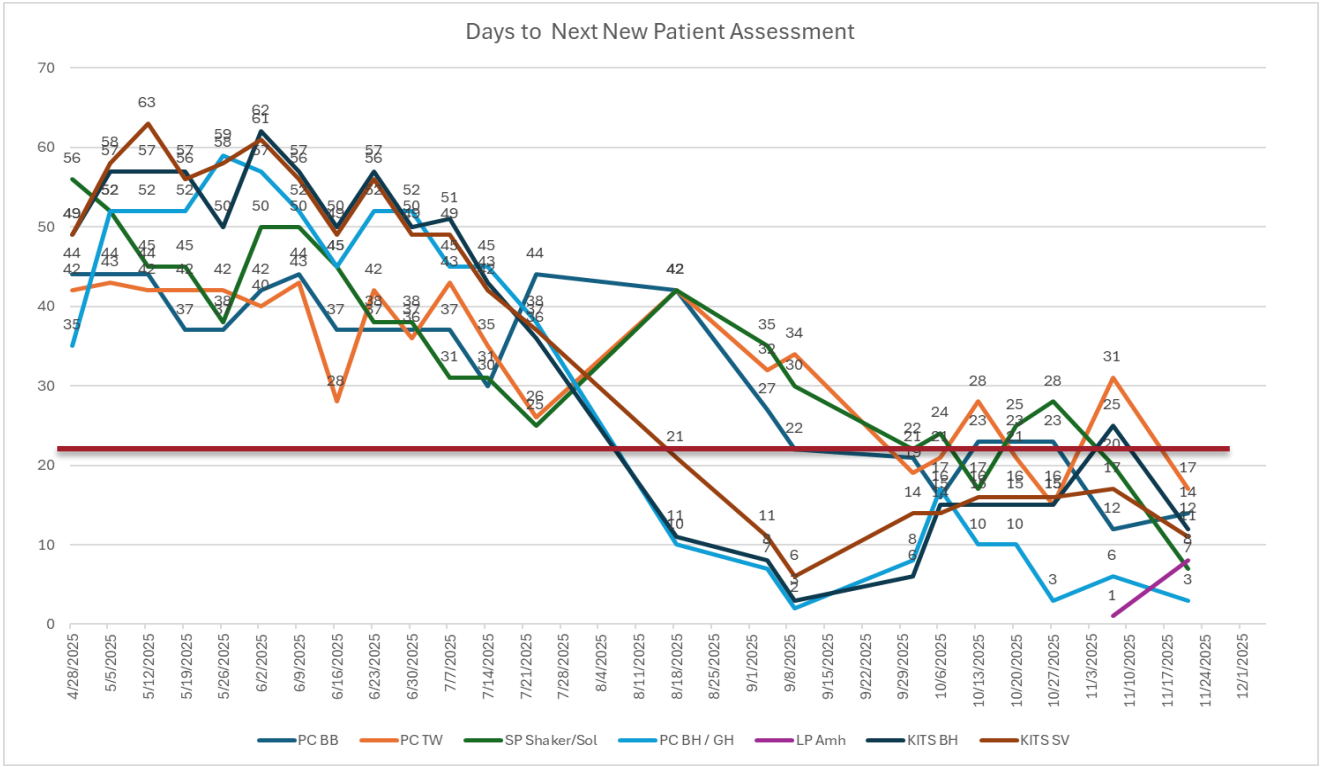
MRN	Patient Name	DOB	Last Month	First PHQ-9 Score	PHQ-9	PHQ-9 % Difference	First GAD-7 Score	GAD-7	GAD-7 % difference	First SCARED (Child) Score	Last SCARED (Child)	SCARED % Difference	Last Encounter	Next Enc in Dept	Psych Consult Date	Needs Psych Consult?	Episode Status	Program Status	CoCM Frequency	Episode Department	CoCM Episode Latest Encounter Provider
[redacted]			118		19		11	11	0				06/01/2026	06/17/2026	05/29/2026	Completed	Active	Active	Biweekly	DO STJHC103 PRIMCARE1 [104354016]	Cunningham,Kelly E, LISW
			0	5	5	0							01/30/2026	01/22/2026	01/16/2026	Completed	Active	Active	Biweekly	DO FAIRLW230 PRIMCARE1 [104259011]	Spracale,Nicole Elizabeth, LPCC
			95	14	8	-43	11	12	9				06/04/2026	04/28/2026	05/12/2026	Completed	Active	Active	Biweekly	DO RIC150 PRIMCARE1 [104246008]	Morgan,Shavonne E, LSW
			100	3	0	-100							05/28/2026	04/29/2026	04/21/2026	Completed	Active	Active	Biweekly	DO RIC150 PRIMCARE1 [104246008]	Morgan,Shavonne E, LSW
			60				5	5	0				06/01/2026	05/06/2026	04/17/2026	No	Active	Active	Biweekly	DO STJHC200 PRIMCARE1 [104354012]	Cunningham,Kelly E, LISW
			60				0	0	0				06/04/2026	06/30/2026	05/15/2026	No	Active	Active	Biweekly	DO STJHC200 PRIMCARE1 [104354012]	Cunningham,Kelly E, LISW
			0	7	7	0	7	7	0				06/12/2026	07/20/2026		Yes	Active	Active	Biweekly	DO STJHC103 PRIMCARE1 [104354016]	Cunningham,Kelly E, LISW
			96	3	0	-100	1	1	0				06/12/2026	06/12/2026	05/22/2026	No	Active	Active	Biweekly	DO STJHC200 PRIMCARE1 [104354012]	Cunningham,Kelly E, LISW
			110				7	7	0				06/01/2026	06/24/2026	05/22/2026	Completed	Active	Active	Monthly	DO STJHC103 PRIMCARE1 [104354016]	Cunningham,Kelly E, LISW
			56	9	11	22	13	11	-15				06/11/2026	06/25/2026	12/05/2025	Completed	Active	Active	Biweekly	DO FAIRLW230 PRIMCARE1 [104259011]	Spracale,Nicole Elizabeth, LPCC
			15	12	12	0	17	17	0				06/01/2026		05/01/2026	Completed	Active	Active	Biweekly	DO STJHC103 PRIMCARE1 [104354016]	Cunningham,Kelly E, LISW
			111	20	20	0	15	15	0				05/29/2026	05/21/2026	05/14/2026	Completed	Active	Active	Once a week	DO MEDINA210 PRIMCARE1 [104086013]	Park,Mona L, LPCC-S
			75		16		1						06/09/2026	05/14/2026	01/16/2026	No	Active	Active	Biweekly	DO STJHC200 PRIMCARE1 [104354012]	Cunningham,Kelly E, LISW
			94	12	5	-58	10	5	-50				06/08/2026	06/22/2026		No	Active	Active	Biweekly	DO PORMA200 PRIMCARE1 [104315007]	Petersen,Stephanie, LISW-S
			126	12	8	-33	6	2	-67				06/04/2026	06/25/2026	03/27/2026	Completed	Active	Active	Biweekly	DO FAIRLW230 PRIMCARE1 [104259011]	Spracale,Nicole Elizabeth, LPCC

CoCM Patient Summary

New Referrals to Program



Days* to Next New Patient Assessment

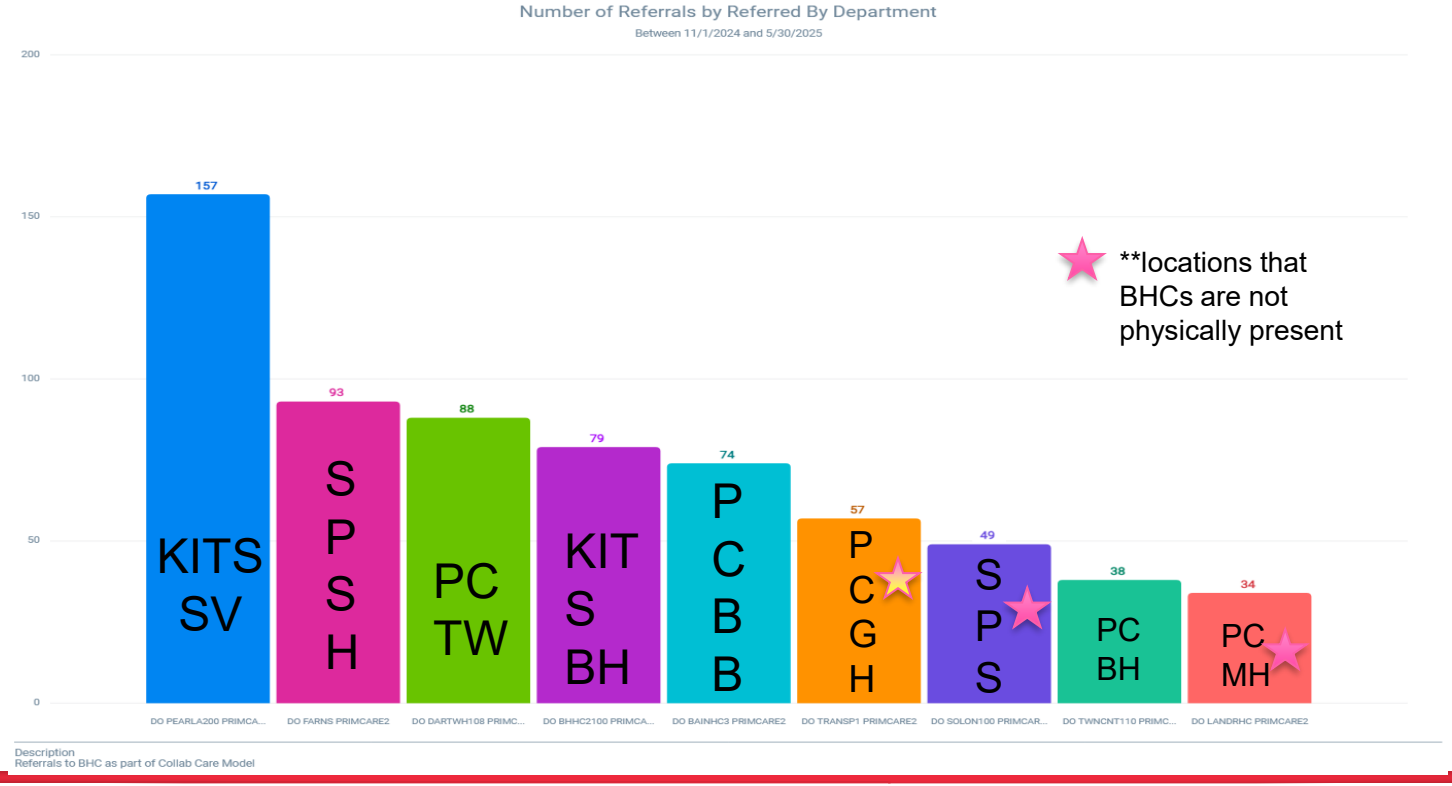


Key Metric:
Access to Care

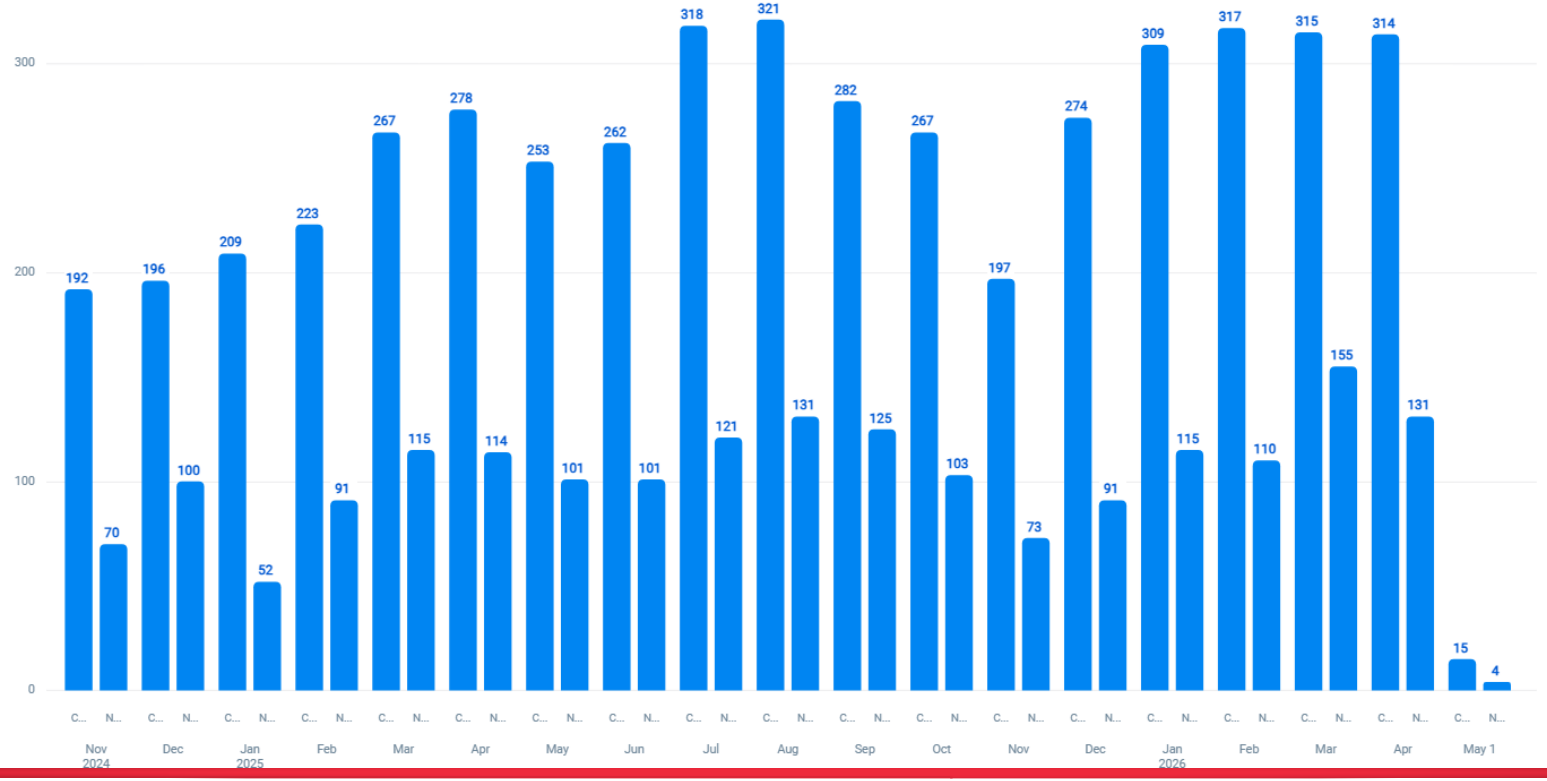
Goal: <21 Days

*Days = Calendar Days

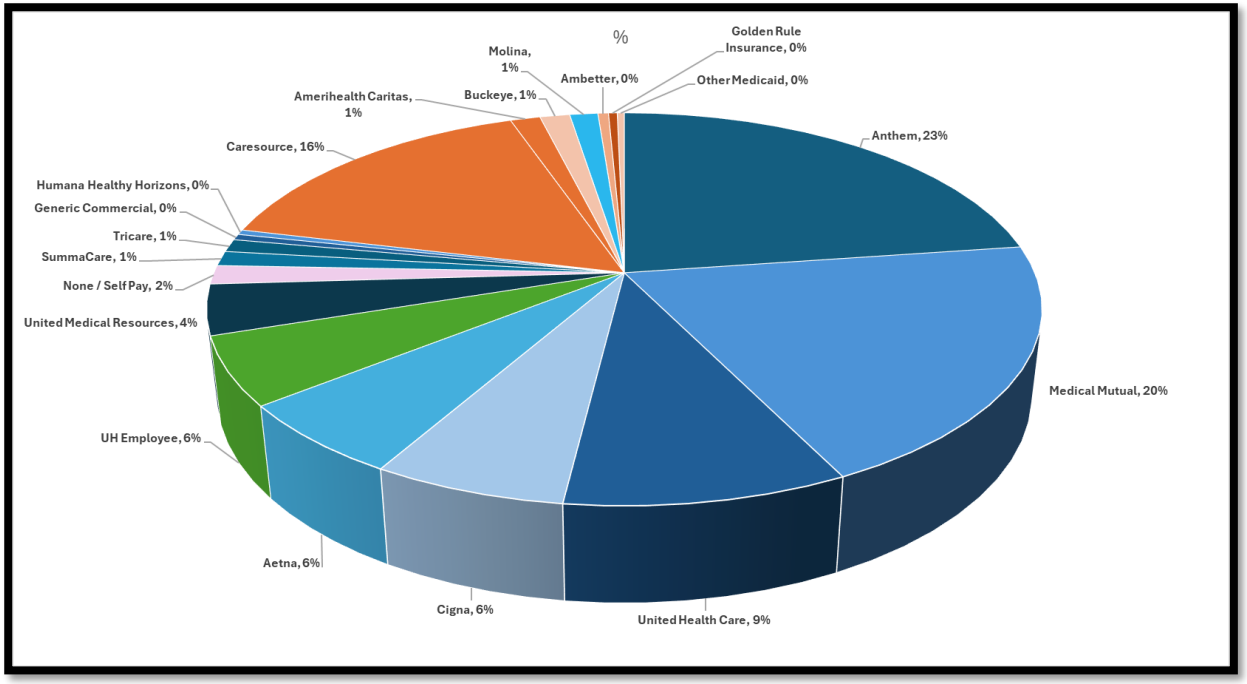
Referrals by Practice Site (7 months)



Number of visits by BHC: Completed and Not Completed



Payer Mix – Based on Patients Monthly Billing



Month	Medicaid Penetration
January	20%
February	23%
March	20%
April	30%
May	22%
June	21%
July	23%
August	18%
September	23%
October	20%
November	20%

YTD Medicaid Mix: 21%

2025 Milestones

- 3rd and 4th BHCs hired with Deployment Plan
- Data Analytics and Dashboard created - Population Impact and Value Metrics
  - TCOC
    ED Visits (Total and Mental Health)
  - PEX
  - Measures that align cross functionally with other efforts (OAK)
- Explore Program Model Adjustments
  - Lead BHC
  - Leverage Care Coordination support of PCP 7-day ED follow up
  - Triage / Assessment workflow

Expansion Across RPCI

November 2024

2 BHMs hired

9 Practice Sites:

- Pediatricenter (5)
- Suburban Pediatrics (2)
- Kids In The Sun (2)

September 2025

3rd BHM hired

October 2025

4th BHM hired

2 additional Practice Sites

7 additional PCPs

- Lorain Pediatrics
- Amherst Health Center

June 2026

Approval for 5th BHM

2 additional Practice Sites

11 additional PCPs

- Comprehensive Pediatrics
- Partners in Pediatrics

Takeaways

- Multiple models of integrated mental health care reflect a variety of practice profiles: self-examination can promote selection of a successful model
- Team is everything: find your champions
- Successful implementation requires close monitoring and response: choose your framework and fail fast, fail hard
- Consider sustainability from Day 1, based on health economic landscape and payor mix
- Expansion requires thoughtful scaling

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Merci
Danke
תודה
Gracias
Asante
谢谢
ありがとう
Thank you
شكرا
Grazie
Obrigado
Спасибо
धन्यवाद