Behavioral Health Integration

Children and Youth Collaborative
Learning Exchange Toolkit

PBGH California Quality Collaborative

Table of Contents

Introduction

Children and adolescents today have higher rates of diagnosed anxiety and depression, as well as increases in social media use and decreases in physical activity and caregiver emotional well-being.[1] Early intervention for younger patients through behavioral health can address these needs, and can prevent significant impact later in life.[2] The need for improved access to behavioral health services for children, adolescents and their caregivers has never been greater. Integrating behavioral health is advanced primary care, supporting early identification and treatment of behavioral health concerns—ultimately enhancing quality of life and outcomes for patients, their families and caregivers.[3]

- **Adopting integrated behavioral health models breaks down barriers to access, driven by insurance network barriers, high costs and shortages in providers.** Many families face logistical challenges—such as lengthy wait times, lack of transportation or a limited network of providers—when seeking specialized mental health care. With behavioral health integration (BHI), a behavioral health provider meets with a patient and their family the same day as their primary care or pediatric visit. Brief behavioral health interventions are delivered in familiar, convenient locations, often at the same time as other routine care, relieving caregivers from taking more time off work and children from missing more school. This approach is often faster than seeking traditional mental health care with long wait lists, and allows for earlier identification and intervention, which is critical in preventing more serious issues later.
- **Integrated care fortifies primary care and pediatric care teams, increasing prevention for behavioral health and reducing stigma for children or caregivers seeking support.** By embedding behavioral health services into everyday settings like pediatric clinics and investing in universal screening for every patient, integrating behavioral health helps busy primary care and pediatric offices to deliver needed services by bridging physical and

Introduction (cont.)

mental care. Integration also normalizes mental health support; families are more likely to engage in mental health care when associated with a trusted primary care clinician or pediatrician, reducing the stigma often associated with seeking help.

- **Whole-child care supports families and caregivers.** BHI treats mental and physical health as interconnected, acknowledging that emotional well-being influences all aspects of a child's development. This coordinated care model ensures that all providers involved—pediatricians, therapists, educators—collaborate to support the child's comprehensive needs. BHI models empower family members and caregivers through education, counseling and resource navigation. Additionally, integrated care teams often include care coordinators or social workers who can connect families with resources related to housing, food, education or safety. Broader community-based support helps address root causes of mental health struggles, not just symptoms, and can improve health care equity by supporting populations most affected by social and structural health risks.

While integrated care can support patients, their families and the care teams they work with, the model requires organizational investment and practice transformation. There are also external factors making integrated care for children challenging, such as a lack of mental health providers, minimal research compared to the adult population and sustainable payment methods.

This toolkit includes successful approaches with actions to improve and scale integrated care for children and youth, as well as opportunities for industry stakeholders to champion this model of care.

About BHI-CYCLE

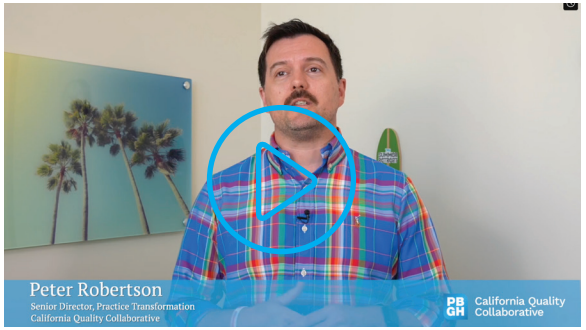
Program Overview

The California Quality Collaborative (CQC) ran the Behavioral Health Integration – Children and Youth Collaborative Learning Exchange (BHI-CYCLE), from October 2024 to June 2025 as part of the Behavioral Health Integration Initiative. BHI-CYCLE brought together California health care organizations experienced in integrating behavioral health services into primary care for children and youth. Goals of the learning collaborative were to:

- **Share** successful practices with a dynamic network of peer organizations
- **Spread** adoption of promising solutions addressing real-world challenges that improve delivery of integrated behavioral health care for children/youth
- **Showcase** successes in a public toolkit synthesizing participants' recommendations, experiences and contributions to the field

Organizations participating in the collaborative received:

- Funding ($7,500) to support the advancement of behavioral health integration
- Learner-centered monthly trainings with a network of peer health care organizations
- Site visit to clinical and operational expert



Hear Peter Robertson, Senior Director, Practice Transformation, California Quality Collaborative, describe the BHI-CYCLE program's unique approach.

Watch Video

Clinical and Operational Expert: Rady Children's Hospital San Diego

CQC partnered with Rady Children's Hospital San Diego, now part of Rady Children's Health, as the technical assistance clinical and operational leader and subject matter expert for BHI-CYCLE. Rady Children's is the largest provider of comprehensive pediatric medical services in the San Diego region and a leader in integrated behavioral health. In 2020, Rady Children's launched a primary care behavioral/mental health integration program that provides evidence-based mental health care through embedding mental health clinicians in pediatric primary care practices for easy, same-day access. This program is part of the Rady Children's Transforming Mental Health Initiative, which works toward effective prevention, early identification, mental health integration and treatment services, policy advocacy, education, workforce development and research to improve the mental health status of children and youth.

Listen to Anne Bird, M.D., Medical Program Director of Behavioral Health Integration, Rady Children's Hospital San Diego and Clinical Professor, UC San Diego Health talk about the Rady Children's Transforming Mental Health Initiative.

Watch Video

SPOTLIGHT: SITE VISIT

In early 2025, six BHI-CYCLE participating organizations convened at Rady Children's Hospital San Diego for a one-day site visit to observe integrated primary care in action and engage in learning discussions on BHI financing, patient intake and warm hand-offs. Access a video summary of the day.

BHI-CYCLE Participant Feedback

"It's helpful to remember that there are successful [integrated] pediatric programs out there, and we can learn from them. We don't have to reinvent the wheel. We can keep chipping away at something over time, and look at success over years rather than months."

—LifeLong Medical Care

"The time spent during the BHI-CYCLE training was not only informative but also allowed a time of reflection about our own project. We have used the concepts in the trainings to critically analyze our own work for continual improvement."

—AltaMed Health Services

"The webinars were particularly helpful as we got to hear from other teams and organizations. The community-learning aspect of the initiative was the most encouraging and helpful to us."

—Children's Hospital of Orange County

"I have a lot of hope in terms of how to move forward from having other examples to base what we're doing on that are all in alignment with our goals."

—San Francisco Health Network

"BHI-CYCLE renewed my momentum and motivation to advocate for BHI with anyone and everyone!"

—Program participant

"Connecting with others to share successes and challenges cultivated a community of support – this helped sustain our energy, encourage us and reinforce the positive power of integrated care!"

—Program participant

Participating Organizations

BHI-CYCLE supported six California-based organizations with the following qualifications:

- At least two years of experience in behavioral health integration in pediatric, primary care and/or family health settings (either the Collaborative Care or Primary Care Behavioral Health model)
- Identifies as Level 3 or above on the Six Levels of Collaboration/ Integration (SAMHSA-HRSA)

Coordinated		Co-Located		Integrated	
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**	**Level 6**
Minimal Collaboration	Basic Collaboration at a Distance	Basic Collaboration Onsite	Close Collaboration Onsite with Some System Integration	Close Collaboration Approaching an Integrated Practice	Full Collaboration in a Transformed/ Merged Integration Practice

BHI-CYCLE participating organizations included public and private hospital health systems and federally qualified health centers (FQHCs):

Organization	BHI-CYCLE Project Focus Area	Perspective
Alliance Medical Center multi-site Federally Qualifying Health Center (FQHC) in northern Sonoma county; serves 5,000 pediatric patients	• **Goal:** Support a team delivering care in person and remotely • **Progress made:** Defined roles while clarifying workflows and allow staff to maximize support	Maria Juarez Sanchez, LCSW, Director of Behavioral Health **"Having Rady Children's helped as I have taken their experiences and used them as a roadmap to success."**
AltaMed Health Services multi-site FQHC in Los Angeles and Orange counties; serves over 100,000 pediatric patients	• **Goal:** Identify high risk patients or those who screen positive for suicidal ideation and emphasize early intervention • **Progress made:** Implemented suicide screening workflow with a continued focus on improving connection with behavioral health staff and increasing warm hand-offs	Norma Perez, M.D., Director of ACEs Grants Lisette Robledo, M.D., Pediatrician, ACEs/BH Champion Watch video **"Every clinic has a different culture that we serve and really making sure that we're meeting needs and really identifying champions and figuring out the need and dealing with whatever specific challenges are present."**
Children's Hospital of Orange County now part of Rady Children's Health* — multi-site health system in Southern California serving over 150,000 patients	• **Goal:** Create a more specific workflow that utilizes the various mental health staff and resources within primary care • **Progress made:** Make workflow improvements supporting enhanced collaboration	Amy Hernandez, LCSW, Social Worker Sarah Ruiz, PhD, Psychologist Watch video **"One of the biggest challenges with our integrated primary care program has been sustainability and billing, just being able to bill appropriately for the services that we're providing, being able to sustain our program, and being able to grow."**

BHI-CYCLE participating organizations included public and private hospital health systems and federally qualified health centers (FQHCs):

Organization	BHI-CYCLE Project Focus Area	Perspective
LifeLong Medical Care a california health center LifeLong Medical Care multi-site FQHC in Alameda and Contra Costa counties; serves 14,000 pediatric patients	• **Goal:** Increase support for pediatric behavioral health clinicians by establishing pediatric BH Lead Clinician role and completing a needs assessment • **Progress made:** Recruited a lead pediatric behavioral health clinician; gained more clarity on dyadic care including how to bill	Carrie Cangelosi, LCSW, Behavioral Health Operations Director Watch video **"BHI-CYCLE has been really helpful, as we try to grow our pediatric behavioral health presence. Our pediatric therapists have told us that they just need more clinical support."**
Providence Providence Medical Group (Northern California) multi-site health system in Sonoma, Napa and Humboldt counties; serving 1,000 patients	• **Goal:** Provide deidentified ACEs (Adverse Childhood Experiences) screening to patients age 12+ during Well Child Checks and train office staff on workflow for addressing elevated ACE scores • **Progress made:** Launched a 3-month pilot with smartphrases in electronic health record (EHR) that identified additional patients	Cynthia Scott, PsyD, Behavioral Health Provider Watch video **"I just believe integrated care is the best way to provide care for our children and families."**
San Francisco Health Network SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH San Francisco Health Network multi-site public health system; serving 7,000 pediatric patients	• **Goal:** Improve team-based care, increase presence/visibility, and be able to operationalize behavioral health value in primary care setting as collaborators, educators and team members • **Progress made:** Made plan for telehealth follow ups and dyadic billing codes to improve penetration rate	Rachel Clee, LMFT, Assistant Director for PCBH Erin Meloty-Kapella, PhD, LMFT, PCBH Supervisor at CHC (former) Watch video **"BHI–CYCLE has been really valuable so far. Having other organizations who are doing this work to learn from because most of the integrated models of care at this time are really adult focused and have not been pediatric focused and so we've really wanted to engage with others doing the same work to see how they were doing it."**
CHINESE HOSPITAL Chinese Hospital (learning participant) health system in San Francisco and Daly City		

Toolkit

Using the Toolkit

This toolkit shares lessons learned from the BHI-CYCLE program for organizations already on their integrated journey and focused on improving care for children and youth. The toolkit is organized into seven key areas; each area includes a description and:

- **Proven practices:** recommended approaches for comprehensive clinical and operational integration
- **Adaptive solutions:** creative ways organizations have found to succeed in those areas based on geographical, organizational, financial and other factors
- **Case study:** examples from BHI-CYCLE participants

The key toolkit areas include:

- Integrated Model of Care for Children
- Integrated Workflows
- BHI Teams
- Screening & Measurement Informed Care
- Financing & Sustainability
- Patient and Caregiver Engagement & Equity
- Data & Quality Improvement

A list of acronyms is provided in the appendix.

THIS TOOLKIT IS TAILORED TO SUPPORT ORGANIZATIONS WITH EXISTING PEDIATRIC INTEGRATED PROGRAMS

Organizations beginning to implement BHI can start here.

Organizations expanding their integrated programs to include pediatric populations can start here.

Area 1: Integrated Model of Care for Children

Primary care for children and youth should address physical and mental health, supporting early identification, early intervention and early recovery of mental health. Integration embeds behavioral health providers at the primary care site as part of the team, where behavioral health providers (typically LCSWs, LMFTs, LPCCs, PhDs and PsyDs) can support children and families with a range of conditions, including anxiety, depression, ADHD, eating disorders, challenges with parenting, behavior and school and support for child development and well-being (e.g., sleep hygiene), among others. Many organizations supporting children and youth also utilize established models of integrated behavioral health, such as HealthySteps, and incorporate other family members in treatment by providing dyadic services (a Medi-Cal benefit).

Proven Practice

- Organizations should adopt an integration model that meets the needs of their patients and system, combining best practices of Primary Care Behavioral Health (PCBH) and Collaborative Care (CoCM), including a behavioral health provider with an evidence-based training background as part of a primary care team that includes screening & therapy, care coordination, administrative support and psychiatric consultation (typically MD, DO, NP), for patients and PCP teams.
- Primary care provider (PCP) engagement is a core success factor for integrated programs taking root in clinical and operational settings, from small clinics and medical groups to large health systems.
- Measurement-informed care (MIC) should be incorporated into the integrated clinical program to ensure quality of care (see Screening & Measurement Informed Care for greater detail).
- Integrated care needs to be part of a broader behavioral health ecosystem.
- Identify at least one primary care champion at each integrated clinic site.
- Organizational support is paramount for the model to be successful.

Adaptive Solutions

- Psychiatric consultations can be challenging for organizations given statewide provider shortage, especially in rural areas; organizations may access resources such as the California Child and Adolescent Mental Health Access Portal (Cal-MAP), a CalHOPE pediatric mental health care access program.
- Identify at least one primary care champion at health system-level.
- Integrated sites without a fully integrated network should ensure clear referral pathways for care not able to be provided internally (e.g., community-based mental health).

Case Study

Rady Children's Hospital San Diego's Mental Health Integration (MHI) program blends two widely adopted integrated care models, Primary Care Behavioral Health (PCBH) and Collaborative Care (CoCM), to help address primary care needs (high volumes of patients who need to be seen quickly) and extend capacities of mental health providers (who benefit from support by psychiatry to triage patients effectively, while continuing to see high volumes for brief intervention), while adopting core principles of PCBH, including a generalist approach and education, and the case registry approach required by CoCM.[4]

Rady Children's MHI uses a hub and spoke approach, including:

- Primary care "spokes," where integrated health therapists (IHT) are available onsite at primary care offices for warm hand-offs, assessments, brief solution-focused therapy (1-6 visits) and preventive work
- Mental health integration "hubs," where patients can receive support for more complex conditions through solution-focused therapy (<12 visits), and psychiatric consultation
- Both the spoke and the hub include care coordination and co-management with the primary care provider

A core success factor about the spread of the Rady Children's MHI clinical program has been partnership with existing hospital-affiliated primary care groups, including Children's Primary Care Medical Group (CPCMG) and Children's Physicians Medical Group (CPMG). All Rady Children's MHI primary care sites have a physician champion, EHR integration and shared integration workflows. Hilary Bowers, MD, FAAP, Director of Behavioral and Mental Health Services at CPCMG, shares about the launch of integrated care.

RADY CHILDREN'S WHOLE CHILD CARE

The Rady Children's Hospital San Diego's Transforming Mental Health Initiative and Mental Health Integration model are described in greater detail in 2023 **Frontiers in Psychiatry** article.

Area 2: Integrated Workflows

Integrated workflows outline how patients and their families move through each health care system—from identification via screening to treatment and follow-up, which may include care coordination that supports referrals for social needs—and how team members collaborate at each step. Workflows should be built intentionally with buy–in from team members, leadership and stakeholders at the program and institutional levels through frequent communication and feedback. Team leaders should use continuous quality improvement to refine workflows, making adaptations to best serve integrated teams and patients. Ideally, workflows are standardized across multi-site systems for training, scalability and sustainability, with clearly defined roles for each step, and should be reviewed and updated annually. Technology (e.g., electronic health records, registries, documentation notes) should be optimized to facilitate cross-team collaboration on workflows.

Proven Practice

- Each integrated program workflow should include: collaboration between the primary care provider and BH provider, the opportunity for the PCP to provide patient history, an assessment, a triage by the BH provider and a safety supplemental schedule for patients that require immediate support (such as in the case of suicidal ideation).
- Integrated teams should adopt warm hand-offs (WHO) between the primary care provider and the behavioral health provider, which has been shown to increase appointments in behavioral health, reduce no-shows and same-day cancellations and decrease loss to follow-up for BH and PCP visits, and decrease time to schedule or complete BH follow-up appointment.
  - Rady Children's developed the CHATS mnemonic to describe and standardize elements of a warm hand-off that includes: Convene, History, Assessment, Triage, Safety Supplemental Schedule[5]
- Terminology might need to be adapted for certain providers. For example, replacing the word referral with a more approachable term that emphasizes the team is all caring for the same patient, or introducing another member of your team instead of an outside member during a warm hand-off.
- In the Pathway Model workflow developed by Rady Children's, the PCP remains the medical home provider for the patient while receiving mental health treatment and integrated providers collaborate on a shared treatment plan for each child. The PCP refers patients to an Integrated Health Therapist via a WHO, often the same day. IHTs then provide 1-6 brief (30 minute) solution-focused sessions, with bridge services as needed to psychiatry, care coordination and longer-term mental health care.
- Setting session limits supports behavioral health providers' bandwidth and reinforces the population health scope; Rady Children's approach is to create realistic goals and then discharge the patient back to their PCP. Patients can be re-referred if additional needs arise in the future.
- Incorporate changes to the EHR, such as documentation templates, drop down menus and smart phrases, that match the flow of the integrated visit. Validate workflow updates align with what each provider type sees in the EHR.
- Meet with IT early to ensure data capture needs are requested.

Adaptive Solutions

- While WHOs can be challenging for organizations due to scheduling and financing constraints, teams should think creatively about how to incorporate them, which could include virtual or reverse WHOs (wherein the integrated BH provider visits the patient before the primary care provider), as well as using data to encourage WHO participation.

Case Study

- San Francisco Health Network aimed to improve the rate of their warm hand-offs at their pediatric clinic, with a goal of 50% improvement from a rate between 13 and 28%. Their team has implemented several improvements, including chart scrubbing, care team education and co-location.

Rady Children's developed the CHATS mnemonic to describe and standardize elements of a warm hand-off that includes: Convene, History, Assessment, Triage, Safety Supplemental Schedule

C Convene	The guardian, patient, primary care provider (PCP), and integrated health therapist (IHT) meet together during the visit to provide an introduction and discussion of the Primary Care Mental Health Integration Program (PCMHI).
H History	The PCP gives the background of the patient's history including relevant social history and mental health concerns. This should be done in front of the patient and guardian the majority of the time, with minimal discussion outside of the room.
A Assessment	The primary care provider openly discusses their assessment of the patient's presentation and how they feel patient could benefit from the integrated care involvement and expectations for treatment course. The PCP may exit if they choose to do so once all information is conveyed.
T Triage	The IHT triages care for patient including a discussion of whether it is expected the PCMHI length of treatment should suffice and if outside referrals are necessary.
S Safety Supplementals Schedule	The IHT performs a safety assessment if applicable. If it is decided that safety planning cannot be completed during limited warm hand-off time escalation of care including emergency services should be considered. The IHT may provide supplemental information including crisis resources, initial therapeutic assignments prior to formal evaluation, and any other applicable psychoeducation. The IHT helps facilitate scheduling of initial evaluation prior to patient leaving the office or provides best number for scheduling.

Area 3: BHI Teams

Integrated workflows are used by integrated teams that agree to follow a shared concept of team care with formal and informal collaboration processes with roles and cultures that blend. Organizations looking to support teams should include investment from leadership, strong communication, frequent and planned opportunities for collaboration, multidisciplinary training, shared purpose and mission and a culture of appreciation for team members.

Proven Practice

- Care team huddles support ongoing collaboration. While some medical providers may have behavioral health training and prefer to address patients' needs on their own, integrated providers should be part of care team huddles to discuss incoming patients and identify patients that may benefit from integrated behavioral health.
- Weekly registry conference is an essential, efficient time for the primary care providers, psychiatrist, behavioral health providers and care coordinators to support co-management of patients through a team-based review to address questions, provide multi-directional education and manage transitions of care. Meetings, which can be virtual, are scheduled over lunch, not clinical hours, with at least one PCP champion required to attend from each clinic, encouraging other providers to attend.
- Invest in PCP or provider training on brief, evidence-based behavioral therapy for youth and families; existing, trusted resources such as the First Approach Skills Training (FAST) Program trainings (some free) and the REACH Institute Training, specifically the primary care provider training. Organizations can consider making training mandatory and compensating physicians for training time.
- Consider a financial investment in the form of site-based behavioral health champion stipends for primary care providers when building the role. This role can help with many common challenges including engagement, increasing buy in and collaboration from other primary care providers, encouraging understanding about different ways of approaching patient care, bridging traditional medical care and behavioral care culture and troubleshooting when problems arise.
- Provide a one stop shop (internal website, shared folder) for all internal training materials, outside resources and ongoing education opportunities for BH staff and primary care providers.
- New employees should receive an overview of BHI workflows and basic education and training materials at orientation.
- Employees should be able to readily access up to date BHI workflow and procedural information.
- Having trainees from all disciplines is an important consideration to help with workforce development and recruitment pipeline.
- Collaboration happens at the internal behavioral health team-level and interdisciplinary collaboration. Specific actions in each area can include:

Within the Behavioral Health Team	Interdisciplinary Team
• Team meetings for treatment team • Group supervision and individual clinical supervision • Clinical team meetings • Shared EHR • Routine review of measurement informed care data • Review the patient PCP schedule and registry to ID patients	• Regular huddle (with primary care providers, MAs, RNs and BH provider in AM/PM huddle) • Warm hand-offs • Weekly registry conference • Primary care champions facilitate communication between PCPs and MHI clinicians (site-based) • Regular primary care champion lead meetings with behavioral health leadership to discuss and address challenges and state of integration • Psychiatric consultation to support primary care providers with medication management • Shared EHR (messaging, chat, chart review) • Routine review of data and metrics • Primary care provider training on changes to the integrated behavioral health care model or processes • Standardized education of primary care providers about screening tools, diagnosis, medication management, plan of care design for common mental health diagnoses (ADHD, anxiety, depression, eating disorders) • Site operations meetings (e.g., front desk and administration) to review workflows and processes

Area 3: BHI Teams

Integrated workflows are used by integrated teams that agree to follow a shared concept of team care with formal and informal collaboration processes with roles and cultures that blend. Organizations looking to support teams should include investment from leadership, strong communication, frequent and planned opportunities for collaboration, multidisciplinary training, shared purpose and mission and a culture of appreciation for team members.

Proven Practice

Training is a key collaboration opportunity within the team

For the Behavioral Health Team	For the Primary Care Provider Team
• Cross training and shadowing within the behavioral health teams • Reviewing internal training materials/videos on documentation, consent, and billing • Shadowing primary care providers during onboarding to understand the flow of patients within the primary care clinic	• Provide training/orientation to program at onboarding • Tailored trainings on protocols, processes, workflows (e.g. what is a warm hand-off and how do I do one) • Opportunities to meet with behavioral health staff and primary care provider champions

Adaptive Solutions

- Each PCP may have an individual approach for registry conference meetings: some may attend the full meeting, some attend for five minutes or not at all.
- Share asynchronous training and resources on integrated care for PCPs based on demand.
- Teams can consider a train-the-trainer model for provider training. Consider seeking grants for training.
- Don't recreate the wheel —leverage existing materials on integrated care for PCPs based on demand audiences, such as the American Academy of Pediatrics and the Integrated Health Topic series from Rady Children's.
- Team members spread at different sites might try a virtual huddle and utilize EHR chat options to help engage the team.

Case Study

Children's Hospital of Orange County (CHOC)* was looking to create a smooth "flow" in clinic that would help address prioritization by the medical team for multiple medical and physical health issues through improved communication and coordination. Their work in BHI-CYCLE built on observing successful practices optimizing the physical clinic set-up between physicians and behavioral health providers to improve engagement and improve buy-in with medical providers.

Area 4: Screening & Measurement Informed Care

A key successful principle is the use of MIC in which treatment decisions are based on data collected in patient-reported outcomes measures with validated measurement tools. By routinely collecting data using standardized and validated measures, subjective patient experiences and clinician observations are turned into more objective data. Recent research on the use of MIC in youth is promising, though evidence is less robust than for adults.[6]

Proven Practice

Successful practices using screening to support MIC cover four phases:

Phase 1: Planning/Pre-Implementation

- Define rationale for using each screener (e.g. population health screening, evaluation of clinical care and research, enhancing clinical decision-making and program quality, etc.).
- Determine how the program plans to collect and use the data, including patient responses (e.g. tablets set up at physical locations).

Phase 2: Implementation

- Prioritize ease of use of each tool selected (including EHR integration, aiming for automation); questionnaires should be set up to collect discrete data fields.
- Choose the cadence for collecting responses:
  - There may be screeners (e.g. GAD-7, PHQ) that will be collected at every patient visit.
  - Aim for streamlining and make improvement as you go.
- Train clinicians/staff on how to use the screening tool; create scripts to help support staff.
- Create energy and excitement around screening launch.

Phase 3: Interpretation

- As data is collected, review and interpret the information in line with goals and plans as identified in the planning phase. Display the data in a way that is easy to understand and disseminate to clinicians (e.g., via access and quality reports).
- Standardize screening tool implementation.

Phase 4: Continuous Quality Improvement

- Look for long-term trends.
- Track data over time for program outcomes and CQI.
- Screening data should be shared with providers with percentage of screeners by completed visit.

Adaptive Solutions

- For each screening, organizations should identify, at a minimum, the tool, the purpose, who screens and on what cadence and for what age range.
- If patients do not want to wait in clinic, identify alternative options including assigning via online means before the visit.
- Include patient education resources (e.g., Stress Busters) on patient-facing websites as additional information regarding positive screeners and community resources, including state resources such as Bright Life Kids and Soluna.
- Screening may start with pilot projects and grant funding.

Case Study

Providence Pediatrics in Santa Rosa was looking to implement Adverse Childhood Experiences (ACEs) screening for children aged twelve and older during their wellness checks to prevent toxic stress and offer practical tools for patients and their families. Their team received guidance on identifying what workflow to use when there is a positive ACEs score with or without a mental health need.

AltaMed Health Services established the ASQ standardized suicide risk assessment for patients screening positive on Question 9 of the PHQ-9 depression screener, based on feedback from the pediatric workgroup. Additional training was provided, with the nursing team to cascade additional resources. Their team received suggestions in BHI-CYCLE around ensuring behavioral health crisis protocols are in place.

SCREENING RELEVANT TO CHILDREN/YOUTH INCLUDE:

GAD-7 (Generalized Anxiety Disorder Questionnaire, anxiety screening)

SCARED (Screen for Child Anxiety Related Disorders, anxiety screening)

PHQ-9A (Patient Health Questionnaires, depression screening)

PSC-17 (Pediatric Symptom Checklist, general mental health screening tool designed for primary care practices that assesses the likelihood of finding any mental health disorder in a patient)

CGI (Clinical Global Impressions)

PEARLS (Pediatric Adverse Childhood Experiences (ACEs) and Related Live-Events Screener)

NICHQ Vanderbilt (screen to help providers diagnose attention deficit hyperactivity disorder, ADHD)

Area 5: Financing & Sustainability

Obtaining reimbursement for integrated behavioral health services in primary care can be challenging for both commercial and Medi-Cal providers, given California's complexity around the number of payers, prohibition of billing for same-day services for FQHCs delegation and "carve-out" plans that result in fragmentation and additional administrative challenges for providers.[8] Billing for integrated care requires a culture shift internally, as medical financing, billing and credentialing need to adopt new workflows and often work with new payer partners, while clinical and behavioral health providers need training and support to comply with documentation and authorization workflows. Additionally, many providers need to seek grant funding to support start-up implementation costs. The toolkit's conclusion identifies additional opportunities to fortify integrated care across the delivery system.

Proven Practice

- Identify and assess needs, barriers and current state to guide billing and financing decisions, using tools such as a pro-forma.
- Identify payer mix and which payment methodologies key payers use.
- Gain awareness of behavioral health carve-outs and carve-ins.
- Foster cross-department relationships internally through frequent communication between behavioral health team, primary care and finance/billing departments in order to address, understand and solve challenges.
- Adapt technology systems to simplify billing for provider and finance teams.
- Leaders and administrators should champion and resource integrated programs.
- Build partnerships with and educate other stakeholders in the organization who are involved in the billing process to improve communication and awareness of challenges.
- Provide training for front-line teams for specific coding and documentation processes, with re-training and peer review trainings as needed.
- Organizations need to set, monitor and adjust internal standards and benchmarks based on their model, staffing mix and patients for templated completed slots, PCP:IHT and PCP:psychiatry staffing ratios, and RVUs.
- Continuous monitoring of billing processes should occur to address and resolve challenges (e.g., denials, delays) early.

- FQHCs in California are not able to bill for same-day visits under the Prospective Payment System, a restriction that impacts their ability to fully implement integrated workflows such as warm hand-offs.[7]

Case Study

- LifeLong Medical Care was able to make the business case to allocate and hire for a lead pediatric behavioral health clinician.

Dyadic care is a benefit for Medi-Cal (California's Medicaid) patients and families under which health systems can provide and bill for integrated physical and behavioral health screenings and services for children under 21 years old and their parent(s)/caregiver.

"AUTOMATICALLY ROUTING CHARGES TO THE MENTAL HEALTH CARVE OUT PLAN IN OUR EHR WAS A GAME CHANGER!"

BHI-CYCLE PROGRAM PARTICIPANT

Area 6: Patient and Caregiver Engagement & Equity

Integrated care both supports and is best delivered in an environment that fosters patient and caregiver engagement, with a focus on health care equity and removing barriers to access that patients and their families may face.

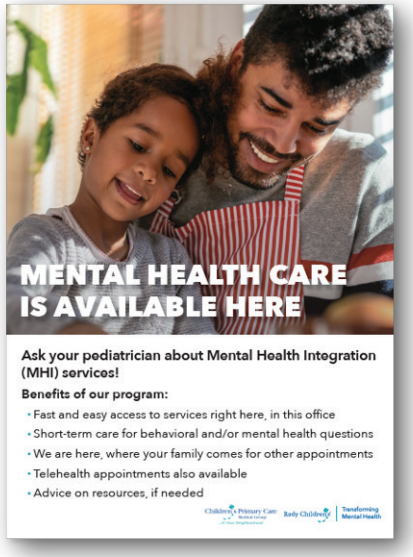
Proven Practice

- Leverage warm hand-offs to increase patient engagement in services, decrease stigma and enhance continuity of care.
- Educate primary care to discuss with families all aspects of their child's growth and development. Considering the example of a patient demonstrating signs of diabetes, the family would first come to their pediatrician for a history, physical and labs. If a patient or family has concerns about attention and focus, they would come to the pediatrician to discuss and have a history, physical and complete screening questionnaires.
- Utilize flexible terminology that meets patients and families where they are to encourage patient engagement in services, e.g. instead of "psychologist" or "integrated health therapist" try "coach" or "counselor."
- Provide education on whole-child care to dismantle mental health stigma and post information around the clinic translated into key languages.
- Recruit for, and hire, staff who speak primary languages of patients served to build engagement with patients in their primary or preferred language.
- Implement MIC to turn subjective patient experience and clinician observations into objective data.
- Optimize clinic space to be physically inviting for mental health care needs, as compared to standard medical health care.
- Utilize patient family satisfaction surveys to understand patient needs and maintain ongoing engagement with patient families.
  - Review feedback survey with behavioral health team and primary care providers to understand feedback holistically.

Adaptive Solutions

- Patients should have access to basic education materials outlining what BHI is and what services are available to them.
- If a warm hand-off is not possible, provide as much information as possible regarding who will follow up and when.
- If patients prefer not to speak with a behavioral health provider and want to continue follow-up with their PCP, the integrated behavioral health provider can still work with the PCP/care team to address issues and check in again at the next visit.
- Consider providing tele-translation options via services such as LanguageLine Solutions.

PATIENT FLYER



Area 7:
Quality Improvement & Data

All programs require continuous improvement, and integrated programs are no exception. As programs evolve from start-up, to more stable and structured, they become more sustainable and part of the culture and fiber of their clinics or health system. Consistent data collection and analysis are key to making informed decisions that lead to sustainable improvements.

Proven Practice

- Identify and track key measures and share with clinical teams; Rady Children's collects: visit volume, template utilization, completed visit, RVUs, access (time to next appointment), no show/late cancellation, MIC trends and Patient Satisfaction.
- Reports should be sent regularly (e.g., for leadership, weekly over email, monthly review in meetings).
- Share metrics with site-based champions, using data to provide a bit of healthy competition coupled with how to improve metrics.
- Invest in building ongoing collaborative relationships with primary care partners; a quick phone call can often address an emerging problem.
- Prioritize and ensure administrative time and support to nurture relationships between primary care leads and behavioral health staff, including regular meetings with behavioral clinical supervisors and primary care leads that can facilitate solving issues and creating solutions.
- Ensure education maintenance through refresher trainings annually, or as needed, and rounding from clinical leadership at primary care sites.
- Create growth pathways, such as leadership and professional development, for integrated behavioral health clinicians.

Adaptive Solutions

- Teams should use data they are collecting already and ensure it is shared with team members.

Case Study

- Alliance Medical Center offers in-person and virtual access to behavioral health providers as part of their integrated and behavioral health programs. In-person care has strengths, including improving team culture, onsite collaboration with other providers and confidential treatment environments; virtual care benefits include improved opportunity for patient same-day access, no travel time and reduced distractions. Challenges to each setting include limited office space, travel-time and limited clinical support for in-person integrated care and technology barriers for patients and staff, high no-show rate and limited productivity for remote care. Alliance decided to invest in team feedback sessions, internal behavioral health trainings and leveraging the remote team's experience and expertise to help onboard new trainees and associates.

Industry Opportunities

BHI solves for where the health care industry wants and needs to go in California—whole-person, advanced primary care—especially for young patients that benefit from early intervention. Yet, there are systemic factors that hamper patients and families to easily access primary care providers that have integrated behavioral health. Over the course of BHI-CYCLE, participants were asked to identify industry opportunities that could facilitate BHI for children and families, at the health system, payer and industry level.

Reimbursement

BHI financing needs to be supported, streamlined and simplified if provider organizations are to continue implementing and spreading this model. As integrated systems move beyond start-up implementation costs to ongoing program sustainability, low reimbursement rates make it difficult to sustain integrated care programs without institutional or philanthropic support.

- *"We would like to see improved reimbursement structures for medical providers who are implementing screenings and integrating behavioral health into their practices, specifically, practices that are able to provide warm hand-offs and coordinated care should be fairly compensated for the additional time and resources required to deliver comprehensive, integrated services. Enhancing reimbursement incentives would support sustainability and encourage more providers across California to adopt and maintain integrated care models for children and youth."*
- *"Advocating for higher reimbursement rates to represent the impact of integration and to allow programs to be able to sustain an integrated care model."*
- *"California should allow same day billing for medical and BH visits for FQHCs. Dyadic care takes a step toward this, but more could be done."*

Nicole Carr-Lee, PsyD, Director of Clinical Operations and Integration, Transforming Mental Health and Primary Care Mental Health Integration, Rady Children's Health, shares a story of a young patient supported by Rady Children's integrated program.

Watch Video

Physician champions

For integrated care to take root, physicians, especially the next generation, must champion the models. Rady Children's, for example, trains 4–10 pediatric residents per year via a two-week integrated care elective that includes clinical observation and didactic sessions in the primary care and specialty care settings.

- *"[Health systems] should connect with leaders and stakeholders at all levels (revenue cycle, contracts, billing/coding, physicians)."*
- *"Integrated care training should be included in pediatric residency and fellowship programs."*

Workforce development

Statewide workforce shortages make it difficult to recruit and retain behavioral health professionals, especially psychiatrists. These shortages are further exacerbated in more rural areas and among providers who speak multiple languages. Integrated sites can foster relationships with training institutions and local universities to support the workforce/ training pipeline.

- *"More education for clinicians during training, and physical space in pediatric clinics designed to support this type of care."*

Kristina Mody, Director, Practice Transformation, California Quality Collaborative reflects on learnings from organizations.

Watch Video

Conclusion

Integrating behavioral health into primary care is a key attribute of high-quality, patient-centered, whole-person care—Advanced Primary Care. De-siloing mental and physical health care bridges care delivery gaps and improves health, increases access and manages costs. All of California's health care stakeholders can work together to build an integrated system where mental and physical health are treated together—early, equitably and effectively, because every child deserves a future where they are seen, heard and supported.

ACRONYMS

BHI = behavioral health integration

CoCM = Collaborative Care Model

EHR = electronic health record

FQHC = federally qualified health center

IHT = integrated health therapists

MIC = measurement-informed care

PCBH = Primary Care Behavioral Health

PCP = primary care provider

WHO = warm hand-off

About the Authors

Authors:

Anna Baer, MID
Program Coordinator, California Quality Collaborative

Anne Bird, MD
Medical Program Director, Transforming Mental Health and Primary Care Mental Health Integration Rady Children's Health San Diego; Clinical Professor, University of California San Diego Health

Hilary Bowers, MD
Director of Behavioral and Mental Health Services, Children's Primary Care Medical Group; Health Sciences Assistant Clinical Professor, UC San Diego

Nicole Carr-Lee, PsyD
Director of Clinical Operations and Integration, Transforming Mental Health and Primary Care Mental Health Integration, Rady Children's Health

Domonique Hensler, MHA
Senior Director, Care Redesign, Transforming Mental Health and Primary Care Mental Health Integration, Rady Children's Health

Ben Metcalf
Head of Corporate Communications, Rady Children's Health

Kristina Mody, MPH
Director, Practice Transformation, California Quality Collaborative

Elizabeth Rains, MPH
Manager, Business Planning, Transforming Mental Health and Primary Care Mental Health Integration, Rady Children's Health

Isabelle Santos
Administrative Associative (former), Transforming Mental Health and Primary Care Mental Health Integration, Rady Children's Health

Jen Zubyk
Quality Improvement Advisor, Transforming Mental Health and Primary Care Mental Health Integration, Rady Children's Health

The California Quality Collaborative (CQC), a program of the Purchaser Business Group on Health, is a health care improvement program dedicated to helping care teams gain the expertise, infrastructure and tools they need to advance care quality, be patient-centered, improve efficiency and thrive in today's rapidly changing environment. CQC is committed to advancing the quality and efficiency of the health care delivery system across all payers, and its multiple initiatives bring together providers, health plans, the state and purchasers to align goals and take action to improve the value of health care for Californians.

The Transforming Mental Health Initiative at Rady Children's Hospital San Diego, now part of Rady Children's Health*, works toward effective prevention, early identification, mental health integration and treatment services, policy advocacy, education, workforce development and research to improve the mental health status of children and youth.

* Rady Children's Health, established in January 2025, brings together the nationally recognized expertise of Children's Hospital of Orange County (CHOC) and Rady Children's Hospital San Diego, both leaders in delivering safe, high-quality, compassionate care. With three hospitals, a growing network of primary and specialty care centers across six counties, and two of the region's Level 1 pediatric trauma centers, RCH is advancing the health and well-being of children in Southern California through pioneering research, innovative treatments, and family-centered care.

Acknowledgments

CQC's Behavioral Health Integration Initiative is made possible thanks to the generous support of the Centene Corporation.

This toolkit was informed by the experiences of the BHI-CYCLE learning participants. We thank them for their commitment to advancing whole-child care for the patients they serve and for their dedication to improving the lives of young Californians.

BHI-CYCLE Participants

Alliance Medical Center: Maria Juarez Sanchez, LCSW; Rosa E. Sanchez, MD

AltaMed Health Services: Emmanuel Okosisi, Project Coordinator; Alexandra Perez, Project Coordinator; Norma Perez, MD, Director of ACEs Grants; Lisette Robledo, MD, Pediatrician, ACEs/BH Champion

Children's Hospital of Orange County: Christopher Min, PhD, Psychologist; Amy Hernandez, LCSW, Social Worker; Sarah Ruiz, PhD, Psychologist

LifeLong Medical Care: Carrie Cangelosi, LCSW, Behavioral Health Operations Director; Emma Gomez, School Based Associate BH Director (former); Georgina Marin, Lead BH Community Health Worker (former)

Providence Medical Group: Sarah McVay, PsyD, Regional Manager of Integrated Behavioral Health; Cynthia Scott, PsyD, Behavioral Health Provider

San Francisco Health Network: Rachel Clee, LMFT, Assistant Director for PCBH; Erin Meloty-Kapella, PhD, LMFT, PCBH Supervisor at CHC (former)

Chinese Hospital learning participant: Ruby Li, Behavioral Health Coordinator; Lyra Ng, M.D., Pediatrician; Jiami Wu, Director of Clinics; Rain Zhang, Clinic Supervisor

Recommended Resources

Pediatric Integrated Resources

American Psychological Association. (n.d.). *Single-session interventions*. In *Population health*. Retrieved August 21, 2025, from https://www.apa.org/topics/population-health/single-session-interventions.html

Children's Hospital Association. (n.d.). *Behavioral Health Virtual Learning Series*. Retrieved from https://www.childrenshospitals.org/content/quality/webinar-series/behavioral-health-virtual-learning-series

Frontiers. (2023). *Developing an innovative pediatric integrated mental health care program: interdisciplinary team successes and challenges*. Retrieved from https://www.calquality.org/wp-content/uploads/2025/02/MHI-Frontiers-Article.pdf

Little, Virna. (2024). *Pediatric CoCM Pathway*. Retrieved from https://www.calquality.org/wp-content/uploads/2025/07/Pediatric-Care-Pathway.pdf

Mental Health Technology Transfer Center Network. (n.d.) *Pediatric Integrated Primary Care: An Implementation and Training Manual for Professionals*. Retrieved from https://www.calquality.org/wp-content/uploads/2025/07/Online_Pediatric-Integrated-Primary-Care.pdf

Rady Children's Hospital. (n.d.). *Behavioral Health: Providers and Educators*. Retrieved from https://www.rchsd.org/programs-services/behavioral-health/providers-and-educators/

Seattle Children's Hospital. (n.d.). *First Approach Skills Training (FAST) Program*. Retrieved from https://www.seattlechildrens.org/healthcare-professionals/community-providers/fast/

The REACH Institute. (n.d.). The REsource for Advancing Children's Health, from https://thereachinstitute.org/

University of Washington AIMS Center. (2023). *Pediatric Collaborative Care Implementation Guide*. Retrieved from https://aims.uw.edu/wordpress/wp-content/uploads/2023/06/Pediatric-CoCM-Implementation-Guide_Final-Reduced-Size.pdf

University of Washington CoLab for Community & Behavioral Health Policy. (n.d.). *Integrated Care Resources*. Retrieved from https://uwcolab.org/integrated-care-resources

Screening

ACEs Aware. (n.d.). *Stress Busters: Seven ways to manage stress*. Retrieved from https://www.acesaware.org/managestress/

ACEs Aware. (2021). *ACE screening sample scripts for pediatric clinical teams*. Retrieved from https://www.acesaware.org/wp-content/uploads/2021/09/ACEs-Aware-Sample-Scripts-for-Pediatric-Clinical-Teams.pdf

ACE Resource Network. (n.d.). *Number Story*. Retrieved from https://numberstory.org/

First 5 California. (n.d.). *Stronger Starts: Toxic stress support for caregivers*. Retrieved from https://first5california.strongerstarts.com/

Newman, S., & Eubanks, C. (2021, October). *CQC Toolkit: Implement Adverse Childhood Experiences (ACE) Screening in Primary Care*. California Quality Collaborative, Purchaser Business Group on Health. Retrieved from www.calquality.org/wp-content/uploads/2021/10/CQC_Toolkit-Implement-ACE-Screening-in-Primary-Care.pdf

Dyadic Services

California Primary Care Association. (n.d.). On Demand Training. Retrieved from https://cpca.org/CPCA/Training_Events/ON_DEMAND_TRAINING/CPCA/Store/On_Demand_Training.aspx?hkey=ab3b450e-68eb-4da9-ae54-9a6c07c7d679

Payment & Financing

California Quality Collaborative. (2024). *Sustainable behavioral health integration financing: Successful practices and opportunities*. Retrieved from https://www.calquality.org/wp-content/uploads/2024/10/CQC_BHI-FIN-Issue-Brief_October-2024.pdf

Value-Based Care Task Group. (2022). *Behavioral Health Integration in Pediatric Primary Care: A Roadmap to Value-Based Success*. Retrieved from https://static1.squarespace.com/static/5935ee95893fc011586f1304/t/635182355d81eb1bfeedc2b0/1666286136738/VBC+report_final+for+distribution.pdf

Financial Modeling Tools: Direct ROI Worksheet, Cost Savings ROI Worksheet, Pro Forma Template, Pro Forma Worksheet

California Quality Collaborative. (2025). Behavioral Health Integration Billing and Coding. Retrieved from https://www.calquality.org/wp-content/uploads/2025/08/CQC_Billing-and-Payment-Codes_CA_2025_Final.pdf

General Integration Resources for Organizations Not Yet Integrated

BHI Collaborative; American Medical Association. (2021). *Behavioral health integration compendium*. Retrieved from https://www.ama-assn.org/system/files/bhi-compendium.pdf

- California Quality Collaborative. (2022). *CQC Behavioral Health Integration Improvement Collaborative Curriculum*. Retrieved from https://www.calquality.org/cqc-behavioral-health-integration-improvement-collaborative-curriculum/
- California Quality Collaborative. (2024-2025). *Behavioral Health Integration Implementation Webinar Series*. Retrieved from https://www.calquality.org/event/bhi-webinar-series/
- Farley Health Policy Center. (2023) *The Building Blocks of Behavioral Health Integration Care Delivery Expectations Assessment*. Retrieved from https://www.calquality.org/wp-content/uploads/2025/01/BBs-BHI-Care-Delivery-Assessment-Tool-2023-1.pdf
- Mental Health Treatment and Resource Institute. (n.d.) *Directory: Collaborative Care Service Organizations, Providing CoCM Implementation Support and/or Staff to Health Systems and Primary Care Practices*. Retrieved from https://filesmhtari.org/CoCM_Service_Organizations_Directory.pdf

Endnotes

[1] Lebrun-Harris, L. A., Ghandour, R. M., Kogan, M. D., & Warren, M. D. (2022). Five-Year Trends in US Children's Health and Well-being, 2016-2020. *JAMA pediatrics*, 176(7), e220056. Retrieved from https://doi.org/10.1001/jamapediatrics.2022.0056

[2] Meadows Mental Health Policy Institute. (2020). *Policy Background Briefing: Collaborative Care*. Retrieved from https://mmhpi.org/wp-content/uploads/2020/12/CollaborativeCareBriefing.pdf

[3] California Children's Hospital Association. (2019). *Improving Behavioral Health Care for Children in California*. Retrieved from https://www.ccha.org/sites/default/files/document/documents/ccha-behavioral-health-white-paper.pdf?1575927706=

[4] Frontiers. (2023). *Developing an innovative pediatric integrated mental health care program: interdisciplinary team successes and challenges*. Retrieved from https://www.calquality.org/wp-content/uploads/2025/02/MHI-Frontiers-Article.pdf

[5] Frontiers

[6] Child Adolescent Psychiatric Cl in N Am 29 (2020) 587–599 https ://doi.org/10.1016/j.chc.2020.06.001 childpsych.theclinics.com 1056-4993/20

[7] Mody, K., & Nickel Nguy, M. (2024, October). *Sustainable Behavioral Health Integration (BHI) Financing: Successful Practices and Opportunities* (Issue Brief). California Quality Collaborative. Retrieved from https://www.calquality.org/wp-content/uploads/2024/10/CQC_BHI-FIN-Issue-Brief_October-2024.pdf

[8] California Primary Care Association (2025). 2025 Behavioral Health Survey Report. Retrieved from https://cpcaadmin.sharepoint.com/sites/CPCAPublicSite/Shared%20Documents/Forms/AllItems.aspx?id=%2Fsites%2FCPCAPublicSite%2FShared%20Documents%2FContent%2FBehavioral%20Health%2F2025%5FCPCA%5FBehavioral%5FHealth%5FSurvey%5FReport%2Epdf&parent=%2Fsites%2FCPCAPublicSite%2FShared%20Documents%2FContent%2FBehavioral%20Health&p=true&ga=1

PBGH California Quality Collaborative