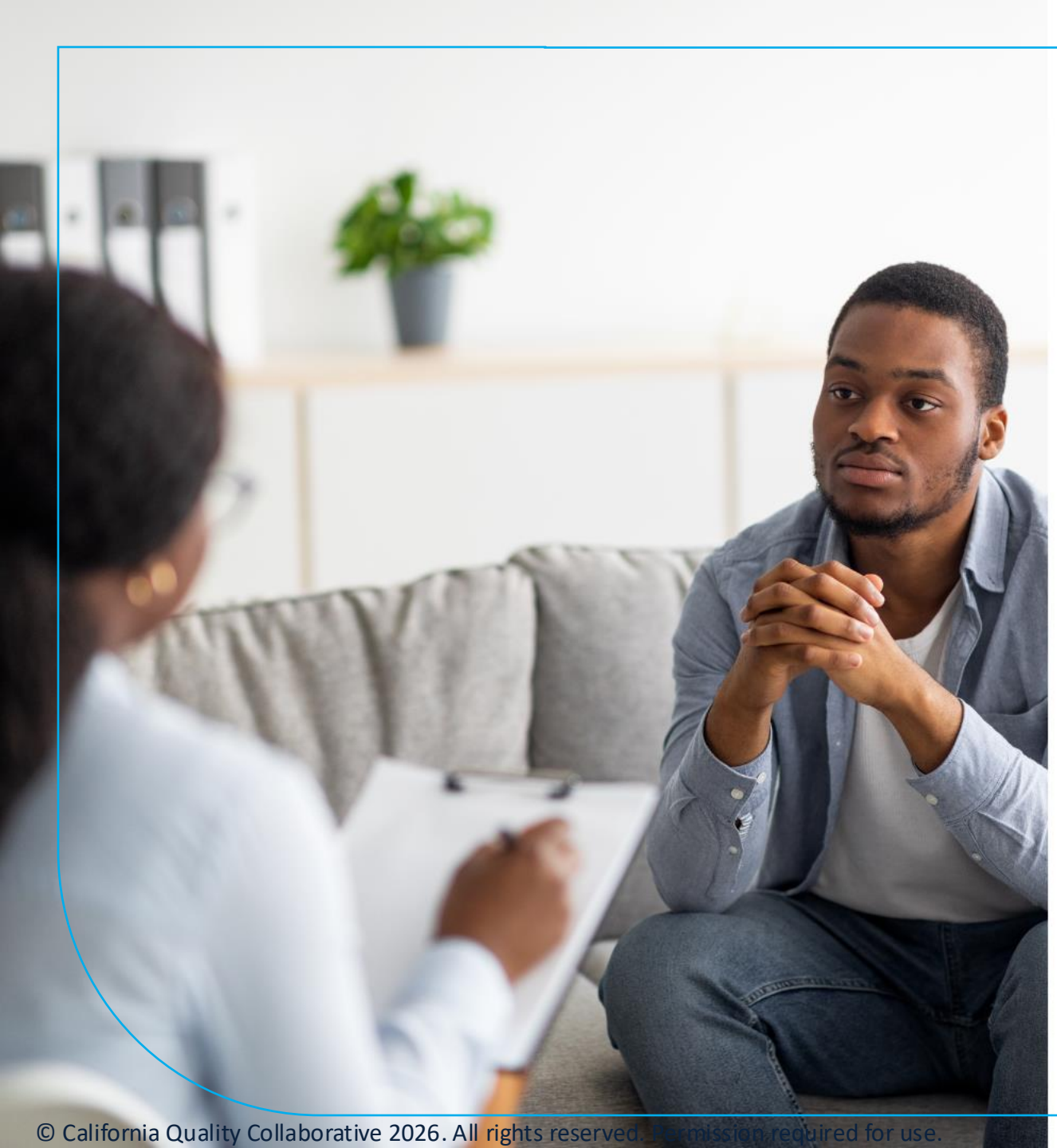
Share your name, role and organization in the chat and…

What is one win you had in January that you’re proud of?



Tuesday, February 10, 2026; 11 a.m. – 12 p.m.

Building a Connected System of Care

CalHIVE BHI Commons

California Quality Collaborative

Tech Tips

Welcome!

Add your organization to your name

Turn on video if possible

Engaging Today

Share questions in the chat or come off mute

Need help?

Direct message
Anna Baer
if you have any technical issues

Welcome!

CHINESE HOSPITAL & CLINICS

Riverside Family Physicians

San Francisco Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

perlmanclinic

Scripps

SHARP

POMONA VALLEY HOSPITAL MEDICAL CENTER

CalHIVE BHI | Program News

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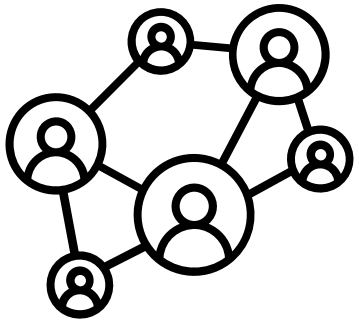
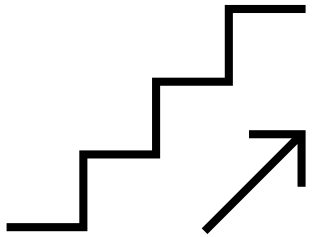
Our Objectives

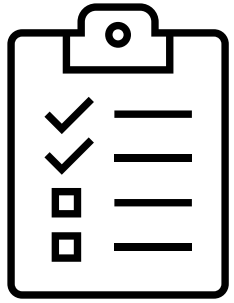
Today, we'll:



Map core components of an effective system of care and how partnerships can help facilitate a population health approach



Review step-up and step-down pathway concepts



Identify one practical strategy to strengthen coordination across primary care, behavioral health and community-based organizations

Building a System of Care: Your Experience

What has been your/your organization's **top challenge** with building a system of care?

Questions to consider today

- Where does your integrated system "fit" within the broader health care resources within your community?

- Understanding the resources around you, where is the greatest opportunity to improve connections to ease the way for your patients?

What is a System of Care?

- An **organized, coordinated network of services, supports and providers** designed to meet the complex needs of individuals in a holistic, person-centered and culturally responsive way

- Systems of care are **critical for patients with behavioral health, physical health or socially complex needs** to effectively support their care

Core Components of a System of Care

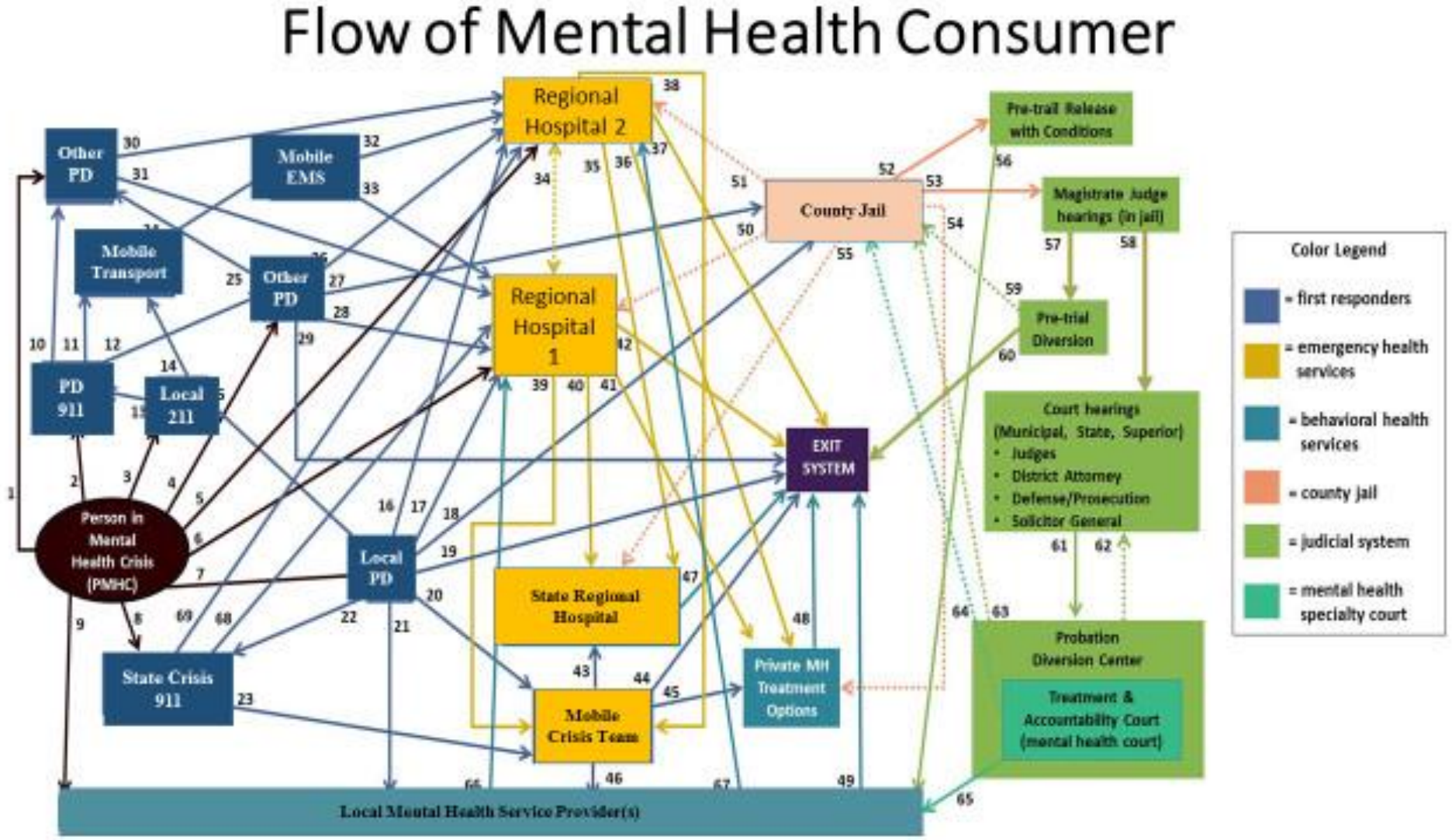
Bi-directional Coordination	• Medical, behavioral health, social services and community supports work together rather than in silos
Person- centered and Strength-based	• Care is built around the individual's goals and fostering resilience and autonomy according to their values, culture and lived experience, not just their diagnoses
Continuity-focused	• Smooth transitions between hospitals, outpatient care, community programs, schools, workplaces and home environments
Accessible and equitable	• Services are available when and where people need them, with attention to reducing barriers like cost, stigma, transportation or insurance complexity
Aligned incentives	• Providers, payers, community partners and sometimes clients themselves share responsibility for planning, quality and outcomes – supported by shared metrics

Goals of a System of Care

North Star: System that supports right level of care at right place at the right time

- Promote Continuous Engagement
- Seamless navigation with clear owner of process
- Enhance total health outcomes, with primary drivers identified and prioritized
- Avoid duplication and delays
- Decrease Costs
- Increased Patient Autonomy and Choice
- Enhance Patient Satisfaction

Patient Experience in the Mental Health Ecosystem



Link: Mental Health and the Ecosystem Flow to and from Effectiveness and Efficiency

Behavioral Health Continuum of Care

Self Care

Community Resources
Wellness
Digital Mental Health
Recovery & Relapse Promotion

Primary Care

Team-Based Care
Brief BH Interventions
Medication Intervention
Panel Management / Pop Health

Specialty BH

Community Mental Health
Intensive BH Interventions
Medication Management
Residential

Urgent / Crisis

ED
Hospitalization
Inpatient Care
Med Stabilization

Behavioral Health Integration
Collaborative Care
Primary Care Behavioral Health
SBIRT

BHI Workflows

Screening → Warm-Handoff and Initiation of Care → Initial Assessment → Follow-Up Care → Patient Re-engagement

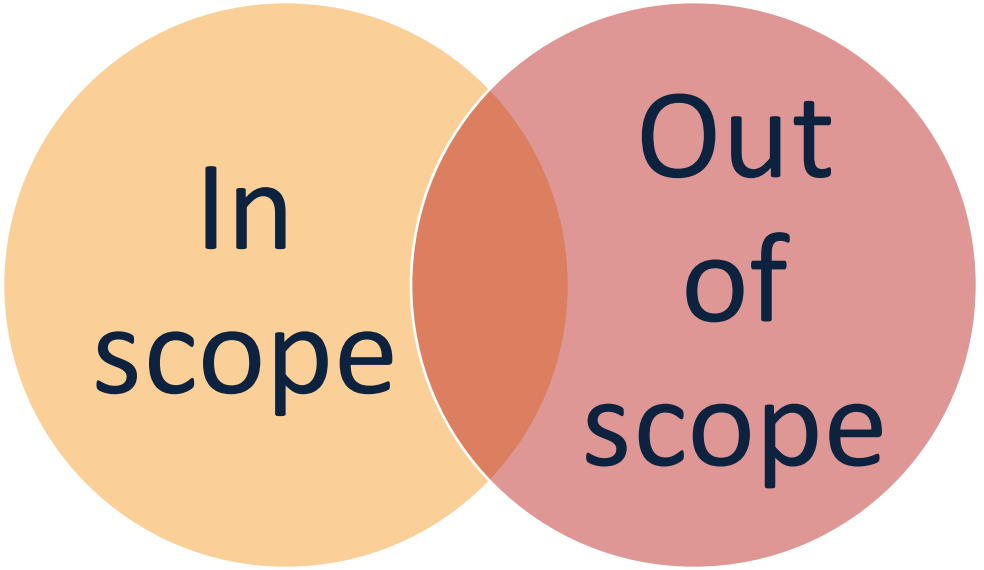
- Depression Remission or Response
  - CoCM - Built in monitoring
  - PCBH - Monitoring when back to see PCP: scrub; huddle; engage medical team
    - Leverage EHR/portal, MAs
- What are care pathways?
  - Internal (e.g., pain management, obesity, ECM)
  - External (e.g., community partners)
- When to discontinue services vs. refer out

Closing the Loop

Understanding Roles in Primary Care

Primary Care

- Screening, engagement, brief intervention, functional improvement, episodic care
- Mild/Moderate depression, anxiety, social stressors, health management, behavioral change
- ACT, CBT, Solution-Focused, Motivational Interviewing



Specialty BH Care

- Assessments, prolonged engagement, symptom reduction, recurrent
- Severe trauma/PTSD, Personality Disorders, Psychotic Disorders, Bipolar Disorder, OCD, Marital Issues
- TF-CBT, DBT, Interpersonal Therapy, Psychoanalytic, Gottman Therapy, Play Therapy

Shared (Context Specific)

- Regular Episodic care, Extended Brief Skill-building
- Severe MH conditions unwilling to engage in specialty care (e.g., PTSD, Bipolar, Borderline, OCD)
- ACT, CBT, Solution-Focused, Motivational Interviewing, DBT skills, Relationship/Interpersonal Skills, Visualization

When is it time to refer out or not refer out?

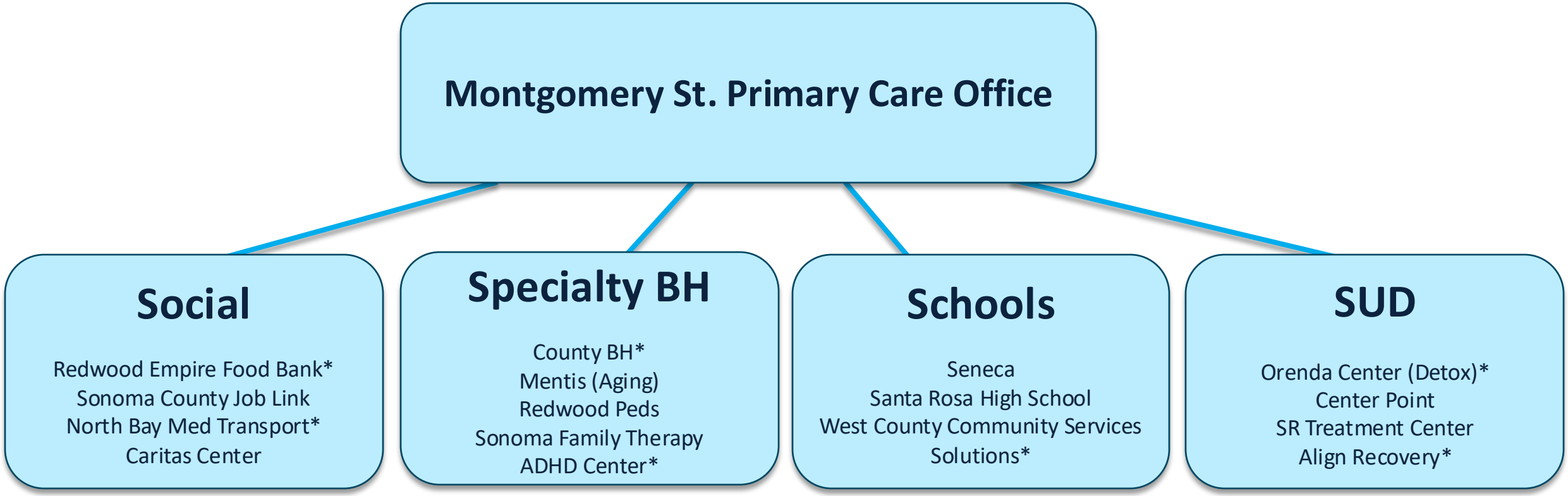
Transition to Community Resources:

1. Patient not getting better
2. Conditions requiring special expertise
3. Conditions requiring longer-term care
4. Need for recovery-based services (e.g., SMI)
5. Patient request

Tracking and Data

- Communication
- Proactive cues and processes to follow-up on care steps (both sides)
- Sharing outcomes and barriers
- Collaborative problem solving

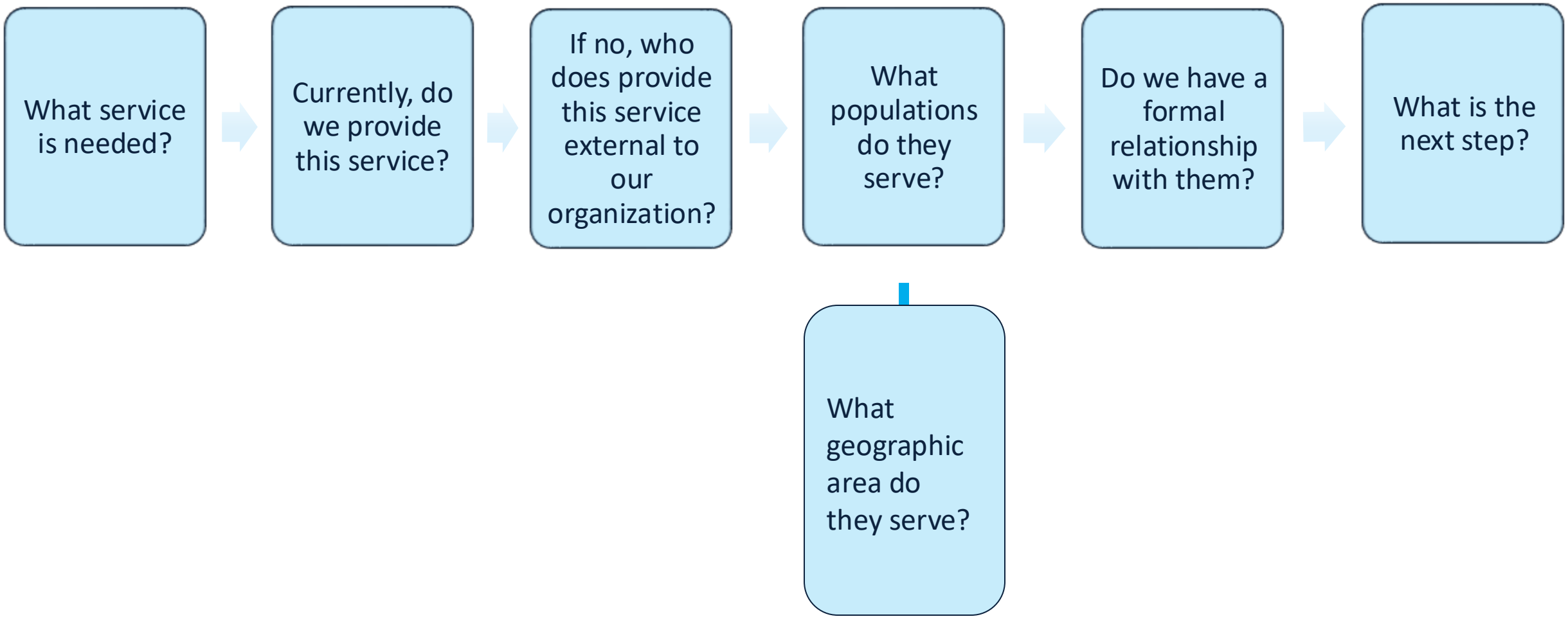
Partner Matrix



System of Care Examples

- Yakima Valley Farm Workers Clinic and MultiCare Hospital
- Providence's Communities of Care

Resource Mapping



Tactical Action Steps

1. **Map and standardize high-risk transitions -** Identify priority transitions (ED → primary care, inpatient → outpatient, primary care → specialty BH) and create **clear, shared workflows** with defined handoffs and timelines
    - Include in your BHI Playbook
2. **Designate a care transition lead -** Assign responsibility (e.g., care manager, BHC, RN) for **tracking referrals, follow-up completion, and patient engagement**, especially for high-risk populations
3. **Close the loop with patients and partners -** Implement systematic **follow-up within 48–72 hours** of transitions and confirm that care plans were understood, accessed, and adjusted as needed
4. **Measure and improve transitions as a system -** Track metrics such as referral completion, no-show rates, time to first follow-up, and patient experience; review regularly with internal teams and external partners

Discussion Questions

1. Who are potential partners in your market?
2. What's the status of that relationship?
3. Where might you have some in-roads to connect with them?
4. Are there aligned incentives or other regional/state initiatives where you may have shared benefit?
5. Where do you want to prioritize your efforts?

Takeaway

After today's webinar…

What is one action you can take to foster your next step in a system of care?

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Feedback please!

1. Please rate the value of today's webinar. *[select one]*
   - 5 - Excellent
   - 4 - Good
   - 3 - Average
   - 2 - Fair
   - 1 - Poor

2. Which objectives were achieved today? *[select multiple]*
   - Map core components of an effective system of care and how partnerships can help facilitate a population health approach
   - Review step-up and step-down pathway concepts
   - Identify one practical strategy to strengthen coordination across primary care, behavioral health and community-based organizations

Q1 2026 Sprint

JANUARY

Improvement Advising
- Plan In-Person Improvement Advising Site Visit (Q1 2026)

By Fri. 1/9 Cycle 7 Data Due

Tues. 1/13 (11-12)
CalHIVE BHI Commons – Advancing Integration Rates In Primary Care
- Analyze key factors that influence behavioral health integration process measure rates at your organization
- Develop one action step to apply data-driven approaches, including improving access disparities, to improve integration process measures

By Fri. 1/30 – Sustainability Plan Section 3 Part 2 Due

FEBRUARY

Improvement Advising
- Host In-Person Improvement Advising Site Visit (Q1- Early Q2 2026)

Tues. 2/10 (11-12)
CalHIVE BHI Commons – Building a Connected System of Care
- Map core components of an effective system of care and how partnerships with local systems and community resources enhance step-up and step-down pathways
- Identify one practical strategy to strengthen coordination across primary care, behavioral health, and community-based organizations to improve continuity of care for all patients

MARCH

Improvement Advising
- Host In-Person Improvement Advising Site Visit (Q1- Early Q2 2026)

Tues. 3/10 (11-12)
CalHIVE BHI Commons – Storytelling for Improvement and Impact
- Review elements of impactful storytelling
- Begin to brainstorm CalHIVE BHI Convening Storytelling assignment

Thurs. 3/12 (12-12:30) – Data Webinar – Cycle 8
- Review process and requirements for upcoming data cycle submission

Wed. 3/25 (12-1)
[OPT] Cal – IN Peer Group Meeting
- Connect and learn from integrated peers

Improvement Advising
Webinars
In Person Events
Data / Reporting
Assignments

California Quality Collaborative

Revised 1/26/26

Thank you!

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