

HEALTHCARE LEADERSHIP SUMMIT 2026

THE STATE OF BEHAVIORAL HEALTH INTEGRATION

A photograph of the San Diego skyline at sunset, with the city lights reflecting on the water. The image is on the left side of the slide, separated by a vertical blue line.

September 17, 2026 | San Diego, California

HEALTHCARE LEADERSHIP SUMMIT 2026

The State of Behavioral Health Integration



California Quality
Collaborative

Welcome to the Healthcare Leadership Summit 2026

The State of Behavioral Health Integration

Pointe Salon BC, 8:30–9:00 a.m.

HEALTHCARE
LEADERSHIP
SUMMIT 2026



California Quality
Collaborative

The California Quality Collaborative (CQC)



Together, we are advancing a higher standard of healthcare

For nearly two decades, health plans, providers and purchasers have entrusted the California Quality Collaborative to bring stakeholders together to align and co-design common solutions to shared challenges. This drives scalable, sustainable improvement across the healthcare delivery system.

CQC works with health plans and delivery system partners serving more than 20 million Californians, representing over half the state, translating collective action into measurable improvements in quality, equity and outcomes across the state.

How CQC Drives System Change

Care Delivery Transformation

Identifies and spreads best practices across the California delivery system through training and coaching

Statewide System Transformation

Multistakeholder Alignment

Drives adoption as a neutral convener, building consensus across partners for collective impact

Advancing the quality and efficiency of California's healthcare delivery system through scalable, measurable improvement

Thank You Summit Supporters!

SPONSORS



EXHIBITORS



Annual Impact Partners



Agenda

<i>Time</i>	<i>Pointe Salon BC</i>	<i>Pointe Salon A</i>
7:30 – 8:30 a.m.	<i>Networking Breakfast</i>	
8:30 – 9:00 a.m.	Welcome & Why We're Here	
9:00 – 9:50 a.m.	The State of Behavioral Health Integration in California	
10:00 – 11:00 a.m.	Building and Strengthening Integrated Care for Children and Adolescents	Advancing Patient-Centered Care Teams Through Integration
11:10 – 12:00 p.m.	Scaling Behavioral Health Integration Across California: Lessons from CalHIVE BHI	
12:00 – 1:00 p.m.	Networking Lunch	
1:00 – 2:20 p.m.	Optimizing Data and Measurement for Behavioral Health Integration	Innovations in Workforce Development
2:30 – 3:40 p.m.	Financing and Sustainability: The Road to Whole-Person Care, Whole-Person Payment	
3:40 – 4:00 p.m.	Closing & Commitments	



Event Logistics

CQC team

Look for team members
with gold ribbons

Restrooms

Breakout sessions

Next door in Pointe A Salon
(follow signage and staff guidance)

Discussion Tables

Add to list by registration table and
engage with peers at lunch

CQC Team



**Crystal
Eubanks**

Vice President,
Care Transformation



**Peter
Robertson**

Senior Director,
Practice Transformation



**Kristina
Mody**

Director,
Practice Transformation



**Lindsay
Petersen**

Associate Director,
Care Transformation



**Kerry
Donohue**

Senior Manager,
Equity & Transformation



**Anna
Elgart**

Senior Manager,
Communications



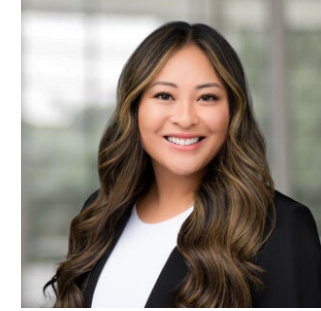
**Erika
Lind**

Senior Manager,
Education & Partnerships



**Anna
Baer**

Program Manager



**Julie
Malonzo**

Program Manager

2025 Behavioral Health Integration Initiative Impact

730K+

Californians served by eight organizations implementing BHI

70,000

Additional patients screened for depression through CQC support

31%

Improvement in depression screening for CQC participating practices

System Alignment

Alignment on BHI financing and advanced primary care definitions

Implementation

Momentum

BHI pilots, sustainability plans and playbooks developed for spread



View the full 2025 BHI Initiative Annual Report

Where We Started

Increasing behavioral health needs

Growing behavioral health need across state & populations

Fragmented systems

Behavioral health and medical care lived in separate systems, workflows and incentives

Primary care left to manage the gap

Teams expected to screen, follow up, and support patients—often without adequate infrastructure or workforce



Patient Experience Before Integration



Screened, but not supported

- Too often screening didn't lead to care

Referred elsewhere

- Patients were referred out, waited months or never connected at all

Lost in the handoff

- Burden shifted to patients to navigate complex, disconnected systems
- Especially difficult for patients facing language, trust or access barriers

What Happened and Where We Are Going

History statewide investment in BH transformation

- CYBHI, BH-Connect, Prop 1, CalAIM

Specific BHI levers

- OHCA BH in PC module, DMHC requirements

Opportunity to activate, together



Photo Sylvain Mauroux

Lesson 1. Integration, Integration, Integration

Integrated: Care, Networks,
County plans, Systems, Data.

Without a shared definition, it
is difficult to align
expectations, measurement,
and investments.

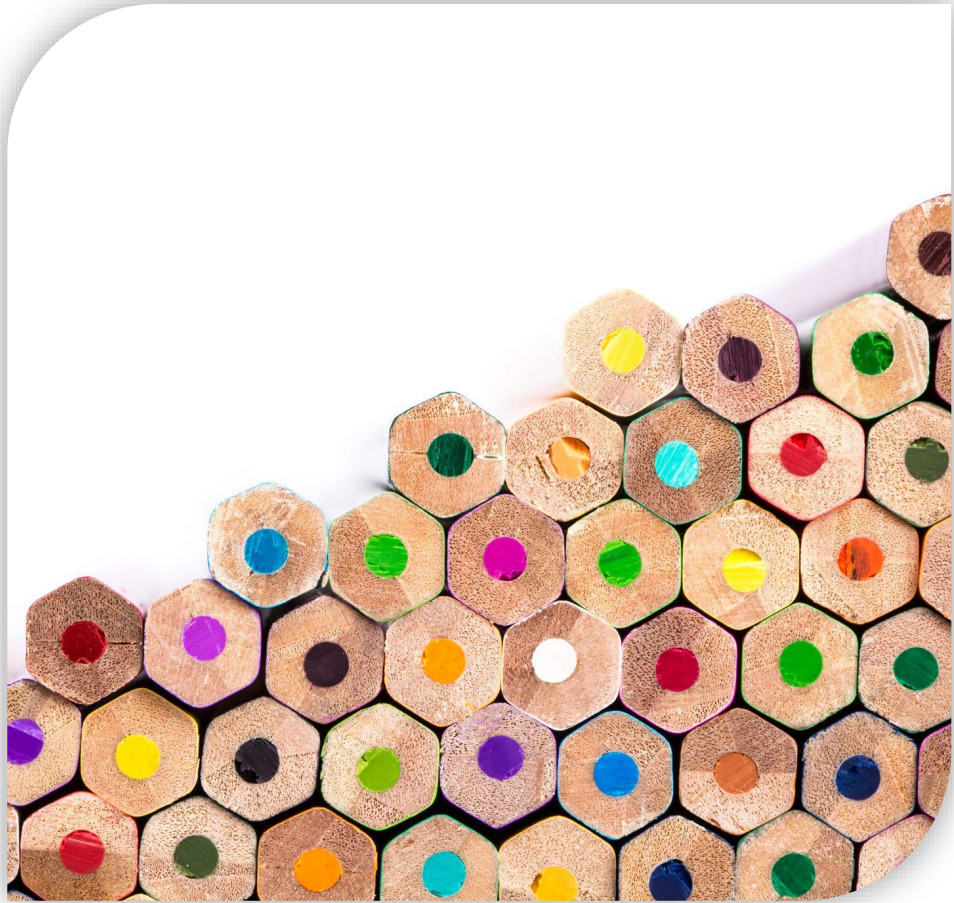


Lesson 2. Primary Care Teams Already Doing the Work

Primary care practices are often functioning as behavioral health hubs without adequate resources, staffing or payment to support that role.



Lesson 3. Think Creatively About the Workforce



Workforce shortages remain one of the greatest barriers to scaling integrated care, requiring new approaches rather than simply expanding existing pipelines.

Lesson 4. Early Screening and Intervention Works

Greatest opportunity for long-term impact: early identification, prevention and family-centered interventions.



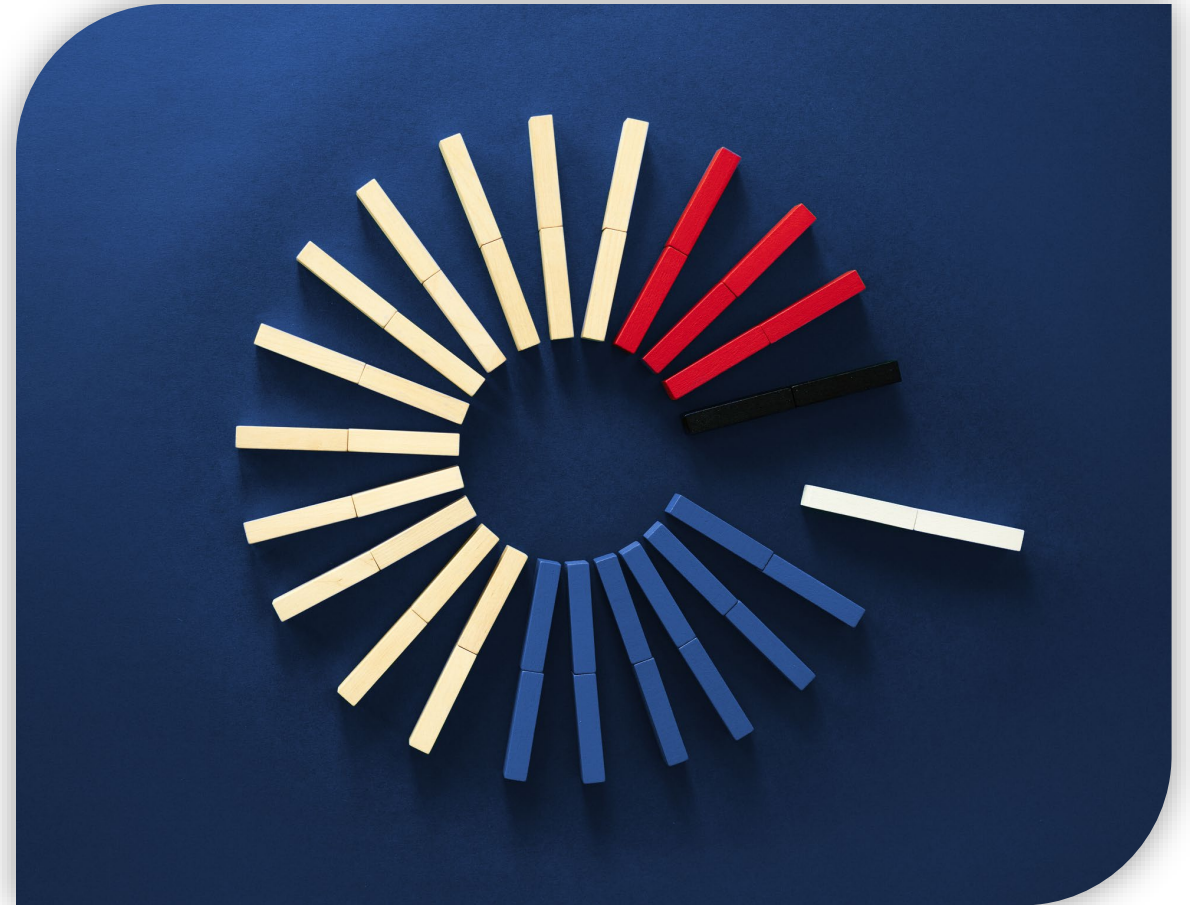
Lesson 5. Whole-Person Care, Whole-Person Payment



Integration will be impossible to sustain if payment systems don't reward prevention, coordination and improved outcomes.

Lesson 6. Integrated Care is Advanced Primary Care

Attributes of advanced primary care (team-based care, proactive population management, coordinated care, patient-centered services, prevention, and measurement-based improvement) includes integrated care.



CQC BHI Initiative Resources



Implementation Resources

Supporting providers: Billing and Coding Guide, Toolkits, BHI Curriculum



Payer Resources for BHI

Financing & strategy tools for plans: P4P Model, Pitch Deck, Data Sharing



BHI Training

Educational webinars & videos



Stakeholder Alignment

Statewide consensus on revised Advanced Primary Care attributes



Peer Group

Connection for integrated leaders across California



calquality.org/bhiwork

Activating Today



The State of Behavioral Health Integration in California

Pointe Salon BC, 9:00 – 9:50 a.m.

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SESSION SPEAKERS

The State of Behavioral Health Integration in California



Debbie Lindes

MD, MPH

California Department of
Health Care Access and
Information, Office of
Health Care Affordability



Raymond Tsai

MD

Purchaser Business
Group on Health



Carmen Katsarov

LPCC, CCM

CalOptima



Tam Nguyen

PhD

Sutter Health

HEALTHCARE LEADERSHIP SUMMIT 2026

THE STATE OF BEHAVIORAL HEALTH INTEGRATION

Coming Up At 10:00 a.m.

Pointe BC

Breakout Session: Building and Strengthening Integrated Care for Children and Adolescents

Highlights practical lessons on overcoming access challenges, aligning care teams and delivering coordinated services for pediatric integrated care.

Pointe A

Breakout Session: Advancing Patient-Centered Care Teams through Integration

Explores how organizations are transforming team-based care to support integration, with a focus on gathering and acting on patient feedback to improve the patient and caregiver experience.

Building and Strengthening Integrated Care for Children and Adolescents

Pointe Salon BC, 10:00 – 11:00 a.m.

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SESSION SPEAKERS

Building and Strengthening Integrated Care for Children and Adolescents



Anne Bird

MD

Rady Children's Health
San Diego; UC San Diego
Health



Hilary M. Bowers

MD, FAAP

Children's Primary Care
Medical Group



Nicole Carr-Lee

PsyD

Rady Children's Health
San Diego

Building and Strengthening Integrated Care for Children and Adolescents

September 17, 2026



Introductions



Anne Bird, MD
Medical Director
Rady Children's Health
University of California, San
Diego

UC San Diego Health



Hilary Bowers, MD
Senior Director of
Behavioral and Mental
Health Services

 **Children's Primary Care**
Medical Group



Nicole Carr-Lee, PsyD
Director of Behavioral
Health Integrated
Programs
Rady Children's Health

 **Rady Children's Health**

Overview and Objectives



- Rady Children's program model
- Three top tips from each presenter
- Break, video and Poll for priority discussion topics
- Discussion topics
- Take homes

BHI Cycle Toolkit

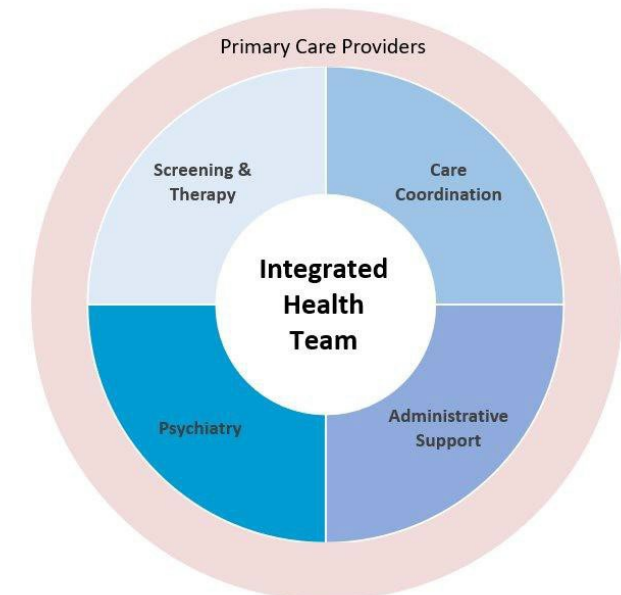
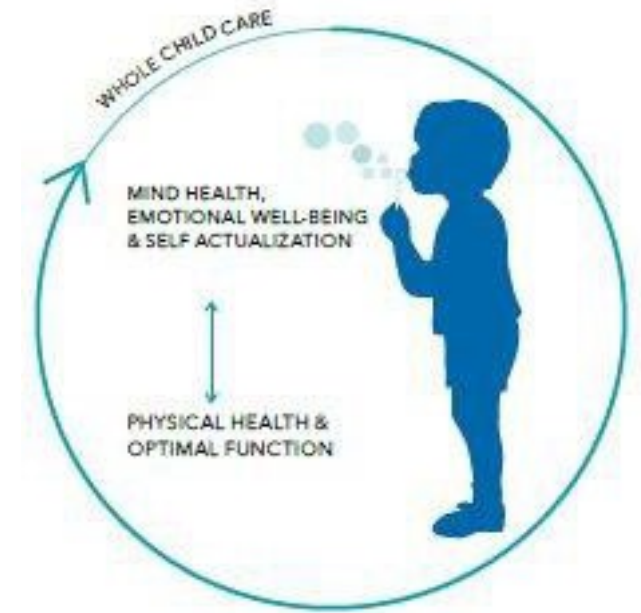


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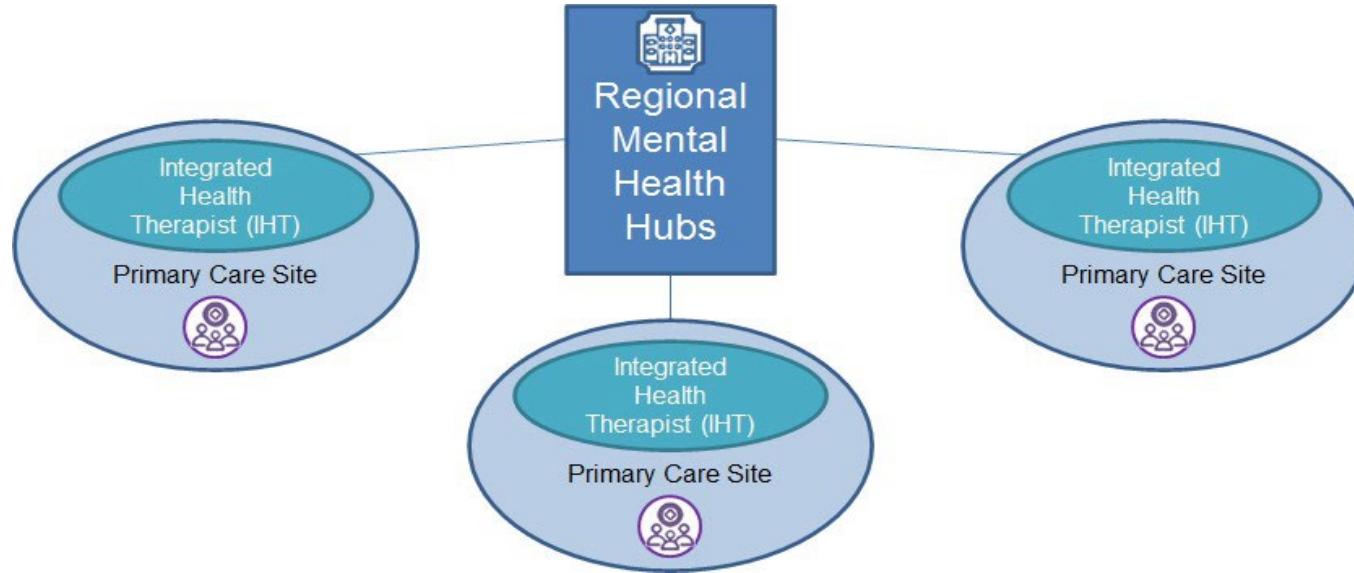


Mental Health Integration (MHI) Program Overview

- Located at select Children's Primary Care Medical Group (CPCMG), Children's Physicians Medical Group (CPMG), and Rady Children's Mental Health Integration Hub locations.
- Connects children and youth with an Integrated Health Therapist (IHT) or Integrated Health Psychiatrist.
- Provides easier access to mental health care.
- Identifies mental health concerns early.
- Provides evidence-based treatment that works.



MHI Hub & Spoke Model



Primary Care Spokes

- Warm Hand Offs
- Assessments
- Brief goal/solution-focused therapy (4-6 visits)
- Care Coordination
- Preventative work and lower complexity
- Co-manage with PCP

Mental Health Integration Hubs



- Brief goal/solution-focused therapy (<12 visits) +/-Groups
- Psychiatric consultations
- Care Coordination
- More complex pathology, higher risk
- Co-manage with PCP

Primary Care Mental Health Integration Network

Integrated Primary Care Clinic Sites



- CPCMGM Hemet
- CPCMGM Temecula Parkway
- CPCMGM Jefferson, Temecula
- CPCMGM Sanford, Oceanside
- CPMGM Children's Medical Group, San Marcos
- CPCMGM Citracado, Escondido*
- CPMGM Valle Verde Pediatrics, Poway*
- CPCMGM Alvarado, San Diego*
- CPMGM La Mesa Pediatrics
- CPCMGM Centre Medical Plaza, Chula Vista
- CPCMGM Menifee
- CPCMGM Children's Campus

Mental Health Integration Hubs



- Hemet Hub
- Encinitas Hub
- Mid-City Hub
- Chula Vista Hub

Interprofessional Psychiatry E-Consults



- All 21 remaining CPCMGM primary care sites

*Telehealth-based integration care sites

- ✓ Early Identification
- ✓ Early Intervention
- ✓ Early Recovery



Our Impact

Children and families we have helped:

- Treatment visits: 86,651
- Total children seen: 15,362
- Total Dyadic/preventative: 6,215
- Psychiatry E-consults: 127

*June 2020 through August 2026



Primary Care Role



- Pediatrician Champion
- Support of organizations
 - Primary Care
 - Specialty Care
 - Community Based Organizations (CBOs)
- Engagement

Education of Primary Care Clinicians

- Standardized training
 - REACH Institute: Patient-Centered Mental Health in Pediatric Primary Care (PPP Program)
- Onboarding new clinicians
- Ongoing education



Registry Conferences (Team meetings)

- Weekly interdisciplinary meeting with team
- Attendees
 - Primary Care Clinicians
 - Integrated Health Therapists
 - Clinical Supervisors
 - Administrative Team Members
 - Child & Adolescent Psychiatrist
 - Care Coordinators



Utilization of Child Psychiatry Resources – Population Health Approach



- Curbside consultations and team meetings
- E-consults
- In-person (or telehealth) evaluations
- Educate/support PCPs
 - Brown bag lunches
 - Online resources/video library
 - Personal connections
- Advocate for additional FTE and/or Advanced Practice Providers
- Statewide access programs Cal-MAP

Workforce Development & Training

- Systemic strategy of training, recruiting and retaining multidisciplinary teams:
 - Trainees --- New recruits --- Seasoned clinicians
- How can you do this:
 - Formal training rotations, and offering shadowing opportunities
 - In service program-wide training/teaching/education
 - On-boarding new recruits
 - Online resources/videos
 - Presentations and outreach



Team Engagement



Integrated care relies on tight interprofessional interdependence.

We know an engaged team directly improves patient outcomes.

- Engagement committee
 - Newsletter
 - Breakfast socials
 - Annual retreat
- Encourage communication and team meetings
- Culture of collaboration and support
 - *We are all in this together!*

Educating Therapists on Latest Integrated Care Interventions

- FAST – First Approach Skills Training Program out of Seattle Children's Hospital
- Access to Collaborative Family Healthcare Association (CFHA) for training and latest in integrated care
- Using grant funding to find additional training opportunities for clinical team members



Billing for Sustainability

- Billing for psychiatry, therapy, dyadic care services, and Community Health Workers
- Internal audits
 - Peer review
 - Quality control
- Important to create templates/schedules with these key concepts in mind:
 - Pace of integrated/primary care
 - No shows and late cancellations

4
4



Partnerships and Communication for Operational Success

- Identify internal and external stakeholders early
- Regular updates
- Engagement at all levels
 - Front line staff through executive level leaders



5-min transition

Please fill out this poll →



Integrated Workflows

- Universal screening
- Warm Handoffs
- Brief Targeted Interventions
- Population Health and Registry Tracking



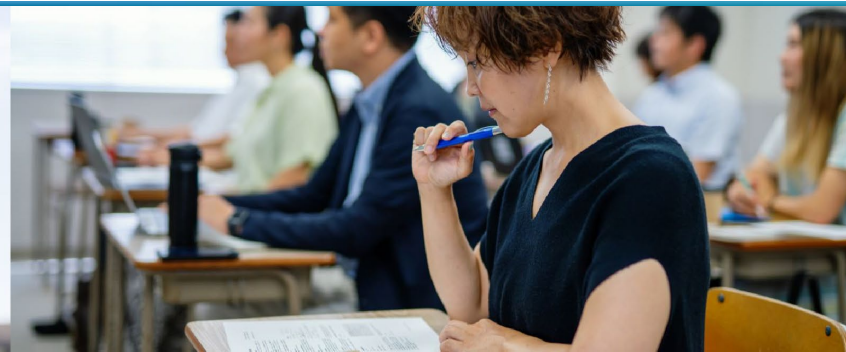
Integrated Team-Based Care

- Team membership and engagement
- Different professional cultures (Primary Care, Specialty Care, Community Organizations)
- Respect/alignment for other disciplines
- Frequent meetings & periodic in-person meetings
- Collaborative communication
- PCBH siloed payment model



Workforce Development

- Going upstream:
 - Lectures/talks at graduate schools
 - Resident medical/NP student rotations
 - Internships for therapists
- Educating on integrated health process
- Onboarding: Model-specific orientation, shadowing, and alignment



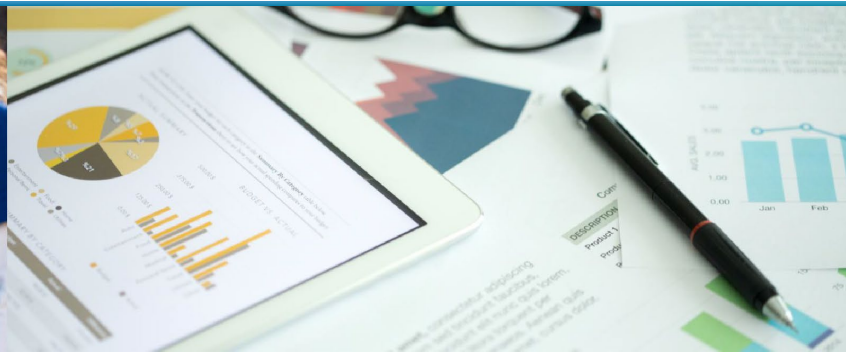
Screening & Measurement Informed Care

- Screening tools:
 - In MHI: PHQ9, GAD7, PSC17, C-SSRS
 - In primary care: PHQ9, GAD7, C-SSRS, PEARLS, ACES, SCARED, CRAFFT, PSC17, NICHQ
- Informing clinical treatment decisions
- Identifying referral opportunities
- Disseminating outcomes via publications and presentations
- Clinical outcomes
- Strategic program development



Financing and Sustainability

- Consider required targets based on visit type and scheduling
 - RVUs vs. More open templates for access
- Philanthropy
- Organizational support is essential
- Contract negotiation participation
- Advocacy at all levels (county, state, federal)



Engaging Payors/Partners

- Designate team members to communicate with payors
- Identify opportunities for advocacy based on challenges
- Knowledge of contracts
- Planned, frequent communication



Patient and Caregiver Engagement and Equity

- Patient satisfaction surveys
- Accessible to everyone at Primary Care site
- Patient welcome packets for families
- Care Coordinators with resources across catchment area
- Appointment reminders
- Cultural competency



Quality Improvement and Data

- Strategic support from IT
- Continuous bi-directional feedback opportunities
 - Both patient and provider experience
 - Consider anonymous surveys
- Leadership prioritize continuous improvement pilots



Take Home Tips





UC San Diego Health

Thank you!



Contact Info

- Anne Bird: abird@rchsd.org
- Hilary Bowers: hbowers@rchsd.org
- Nicole Carr-Lee: ncarrlee@rchsd.org

HEALTHCARE LEADERSHIP SUMMIT 2026

THE STATE OF BEHAVIORAL HEALTH INTEGRATION

Coming Up At 11:10 a.m.

Pointe BC

Panel: Scaling Behavioral Health Integration Across California: Lessons from CalHIVE BHI

Leaders from participating organizations of the CalHIVE Behavioral Health Integration improvement collaborative will share lessons learned from implementing and expanding integrated care across diverse organizations. The conversation will highlight how teams navigated variation across practice settings, leveraged data to guide improvement and built momentum beyond early implementation toward building sustainable, system-wide integration plan.

Advancing Patient-Centered Care Teams Through Integration

Pointe Salon A, 10:00 – 11:00 a.m.

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SESSION SPEAKERS

Advancing Patient-Centered Care Teams Through Integration



Lindsey Galli
PFCCpartners



Libby Hoy
PFCCpartners



Lawrence Lincoln
Lived Experience Advocate,
Lifelong Medical Care Board

Integrated on Paper, Integrated in Experience

Integrated Behavioral Healthcare through a Patient Perspective

Session Objectives

- Identify practical insights for building behavioral health integration that is person-centered.
- Explore what meaningful integrated care looks and feels like from the patient perspective.
- Learn how partnering with patients and family caregivers can identify gaps and co-design solutions.



MISSION

Center the inclusive human experience of health. Reinvent through radical collaboration. Be a catalyst for system transformation.



VISION

A health system transformed. One that works **with people** and **through communities** as a partner in their well-being.



VALUES

Equity

A brave space resolving the health challenges of today.

Inclusion

Create belonging for all people and all communities.

Diversity

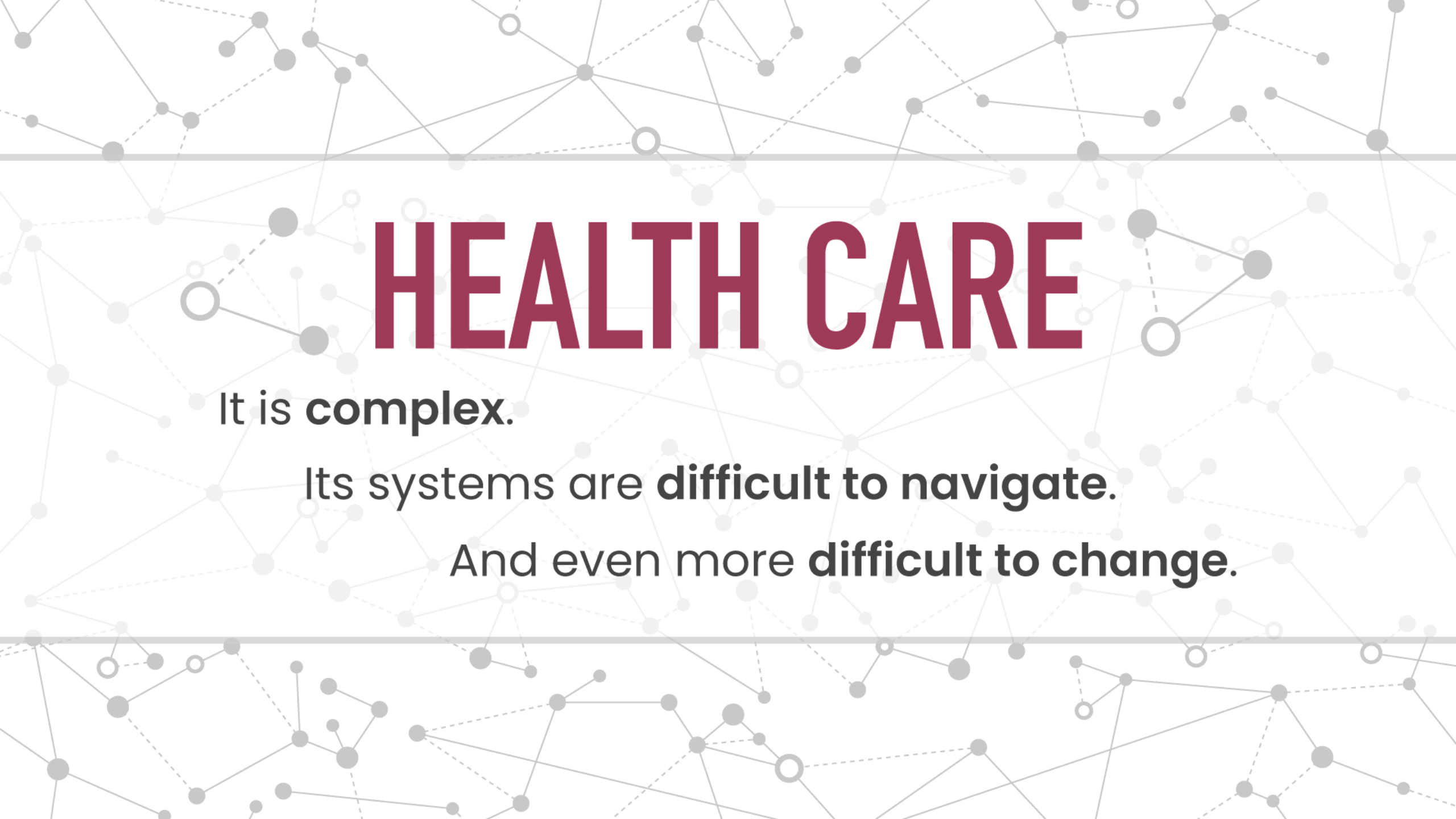
Differing perspectives are expected and respected.

Collaboration

Equitable and shared decision-making power.

Solution Focused

Acknowledge challenges only to resolve them.

A background graphic featuring a complex network of interconnected nodes and lines. The nodes are represented by small circles in various shades of gray, some solid and some hollow. They are connected by a web of thin, light gray lines, some of which are solid and others dashed, creating a sense of a dynamic, interconnected system. The overall layout is symmetrical and fills the entire frame.

HEALTH CARE

It is **complex.**

Its systems are **difficult to navigate.**

And even more **difficult to change.**



Opens space within the system
for patients and family caregivers
to drive improvements.





Fills the space with impactful people, stories, and insights.





Skills Development

Free training, capacity building, knowledge sharing, and skills exchange events



Community

Connect with diverse patient/family caregiver peers sharing ideas, insights, understanding, and support for one another.



Engagement Opportunities

Access to a growing number of projects and teams changing health care by engaging people with lived experience as partners.

PFANETWORK

Anchor

Imagine you're traveling for an important event (maybe this summit!).
Your flight gets canceled.

The airline tells you to contact the booking company.

The booking company tells you the airline needs to fix it.

The hotel says changing your reservation will require a fee.

Each person you speak with asks you to explain what happened again.

Everyone is polite. Everyone follows their process.

But no one seems responsible for helping you solve the whole problem.



Definitions

NOUN

Person-Centered Care

VERB

Patient-Family Engagement

OUTCOMES

**Equity • Quality
Affordability • Experience
Access • Safety**



Patient Family Partners

People using their lived experience to transform healthcare together



PFCCpartners
Patient & Family Centered Care

Lessons Learned: Engagement in Behavioral Health

- ✓ Recruitment takes time.
 - ✓ Hands-on direct recruitment was needed to build trusting relationships prior to engagement activity.
- ✓ Managing sensitive topics.
 - ✓ Create connections with trust brokers.
 - ✓ Ask the right questions.
- ✓ Engagement with limited resources.
 - ✓ Focus on what you can do and where you can learn from patient experiences.

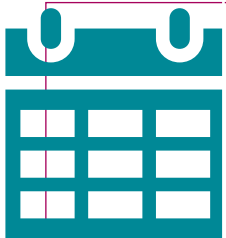
Key Insights from Patient Family Partners



Trust and relationships are foundational



Phone-based care reduced friction for some and created challenges for others



Weekly check-ins are critical and may improve medication management and overall outcomes



Psychological safety increases self-advocacy



Fireside Chat

With Libby Hoy and Lawrence Lincoln

Thank you!

Q & A

Stay connected

Libby@pfccpartners.com

Lindsey@pfccpartners.com

www.PFCCpartners.com

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Scaling Behavioral Health Integration Across California

Lessons from CalHIVE BHI

Pointe Salon BC, 11:10 – 12:00 p.m.

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PB
GH California Quality
Collaborative

SESSION SPEAKERS

Scaling Behavioral Health Integration Across California: Lessons from CalHIVE BHI



Dan Blocker

PhD, LMFT

Pomona Valley Hospital
Medical Center



Gurinder Dabhia

MD

Scripps Medical Group



Jiami Wu

Chinese Hospital



Lesley Manson

PsyD

College of Health
Solutions, ASU

CalHIVE BHI | Aims and Measurements

A three-year improvement collaborative (July 2023 – June 2026) focused on integrating behavioral health services into the primary care setting.

Collaborative Aim	Measured By
Define and implement a BH integration pathway for each participant	• Implementation Plan • Sustainability Plan
Increase access to BH within the primary care setting to support depression management and substance abuse issues	• Data: Global Measure Reporting • Data: Pilot Site Measures
Improve behavioral health and chronic disease outcomes across key indicators	• Data: Global Measure Reporting
Collect experience of providers integrating BH into primary care	• Communications / Publications • Stakeholder engagement



California Quality
Collaborative



Collaborative Family
Healthcare Association



Who We Started With

Diverse organizations

- Health systems, clinics, and teams across California

Different starting points

- Teams were at very different BHI stages—some early, some more established
- All practicing advanced primary care

Shared commitment

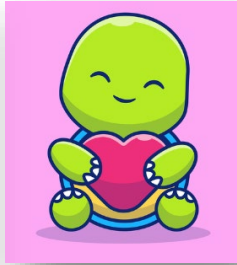
- United by a shared commitment to better care for patients and teams



8 participating orgs provide care to over 730,000 Californians across all major payers (commercial, Medicare, Medi-Cal)



How We Worked Together



“Elbow support” technical assistance

- Supported real implementation, with improvement advisors supporting assignments, tailored coaching and site visits

Shared learning

- Annual convenings, webinars, resources, storytelling, and peer exchange helped teams learn successful practices and from one another

Action + reflection

- Teams were actively redesigning workflows and testing change, and spreading what worked

What We Accomplished

More consistent integrated workflows

- Teams strengthened workflows, from screening to care
- Follow-up became more consistent and intentional

Measurable progress

- Measurement shifted from “reporting” to learning—helping teams understand what was working and make improvements

Improvements toward sustainability

- Cross-disciplinary teams made strides to billing and financial sustainability in BHI
- Strengthened roles (e.g., CHW, MA)

Team culture changes

- BHI is a team sport!

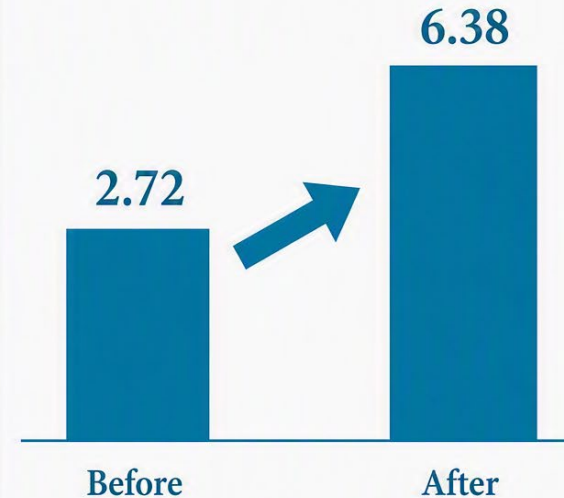


100%

of teams agreed or strongly agreed that *their organization* is better equipped to sustain BHI after the program.

Moved from average

2.72 assessment tool score (across domains)
to 6.38 assessment tool score
(across domains)

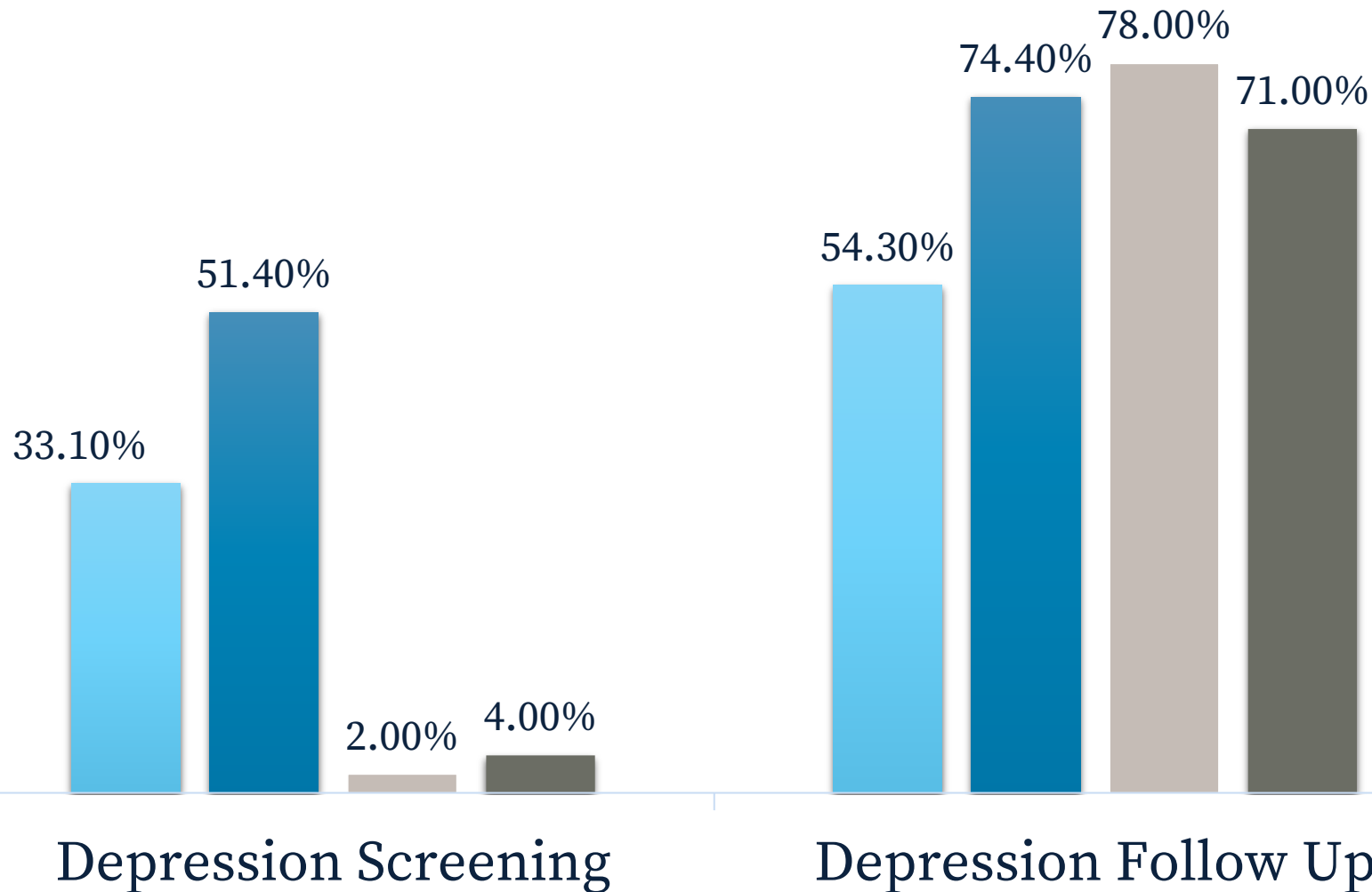


“It really helped the providers not feel like they had to do everything themselves.

There was finally someone else on the team who could take this on.”



Where We Improved



- **BHI implementation drove substantial gains in both screening (+55%) and follow-up (+37%) between 2023 and 2025.**
- **Screening remains primary improvement opportunity**

- CalHIVE BHI Groups - Dec. 2023
- CalHIVE BHI Groups - Dec. 2025
- Benchmark - Commercial HMO
- Benchmark - Medi-Cal Managed Care

What Changed for Patients and Teams



“

Sometimes it feels like a lot of people are just walking around with no route, no options, no hope...

I do know what that's like. And I don't feel like that now.

There's a lot of people I know who are just kind of **struggling** they don't know what to do. I'm like – there's **this thing out there** [integrated behavioral health], if I knew a way that everybody could get that, I would tell them.”

- Patient receiving Collaborative Care, listening session (February 2026)

“

These are patients who would not have followed up on their own, but because someone reached out and walked them through it, they actually got the care they needed.”



Trust

- Integrated care changed the experience for patients—care felt connected, not transactional

Consistency

- Regular touchpoints with BH built trust and momentum

Hope

- People felt supported, seen, and less alone
- For teams, integration became more feasible—and more meaningful

What We Learned



Secure strong
leadership support



Engage stakeholders
early and broadly



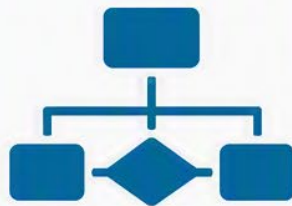
Use available resources
& avoid starting
from scratch



Invest in strong internal
team culture and training



Prioritize coaching
and external support



Clarify workflows
and roles early



Be realistic and
pace the work



Ensure financial
alignment and feasibility

5 primary care sites
Pilot site (Pomona)

- 11 physicians
- 18 family medicine residents.
- 62% Medi-Cal, 16% Medi-Care, 28% commercial insurance
- Patient population is 73% White and Hispanic
- 1 LMFT- pro-bono part-time provider



Where We Started & How We Grew

	12/2023	1/2026
Depression Screening	87%	90%
Depression Follow-Up	45%	68%
PHQ-9 Follow Up	31%	34.5%
# of BH providers	1	3*
Total Reimbursement	0\$	10,000 YTD

Lessons Learned and Where Are We Going

- If you can't be in the room, where it happens, you need to have an ally in the c-suite
- The ratio of 1:4 is really really important for sustainability
- Financial reimbursement builds our case to expand the number of behavioral health providers
- Pacing yourself. Bigger is not necessarily better
- Clear roles with designated people as integrated care managers to reinforce workflows and evaluate outcomes, and others assigned to providing the care
- Targeted ongoing integrated care training



Expert care with a personal touch



GURINDER DABHIA, MD

DIVISION HEAD & VICE CHAIR

PEDIATRICS

Team Introduction: **Scripps Health**

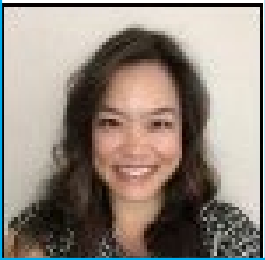
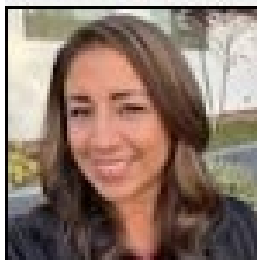


Organization Background

- Scripps Health
- 5 Hospitals, 30+ Ambulatory locations
- San Diego, CA

TEAM MASCOT

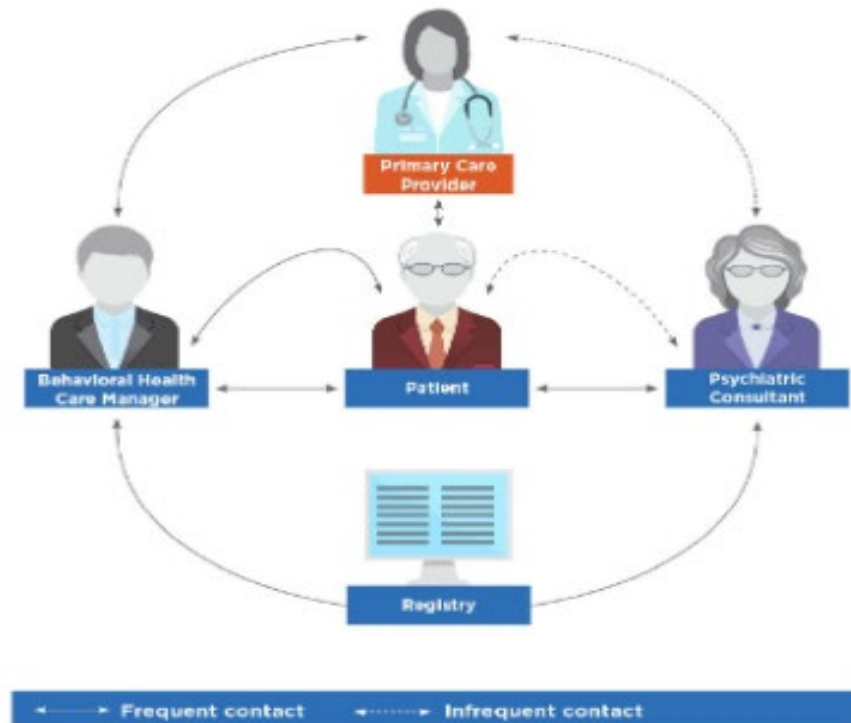


						
Vicki Diamond Director, Population Health Project Lead	Denise Coyle, MD FP Physician Clinical Leader	Gurinder Dabhia, MD Pediatric Physician Clinical Leader	Leslie Reynolds, NP Nurse Practitioner Clinical Leader	Jessica Guevara, RN Director, Clinic Operations Operations Manager	Amanda Schena Director, IS Info. Mgmt. Technical Expert	Kathy Wright Manager, IS Info. Mgmt. Quality/ Performance Lead

WHY?

- ❑ Prior to the Covid pandemic and increasing post-Covid, our patients (and the population) were having increased need for mental health support**
- ❑ In 2017, our Psychiatric Department was dissolved due various reasons**
- ❑ Consistent screening for anxiety and depression were being incorporated, without many reliable referral pathways**
- ❑ The mental and behavioral health needs were increasingly being managed by the PCPs**

PARTNERSHIP



3+ year CalHIVE guidance → CoCM Model

OUTCOMES DATA

(7/31/26)

10

PCPs

Participated in the initial pilot

445

Initial intakes

Completed through June 2026

60%

Improved

Within 90 days*

51%

Remission

PHQ-9 and/or GAD-7 below 5*

124

active patients in the June 2026 BHCM panel

100–116

**monthly CoCM CPT codes billed in
early 2026**

OUTCOMES – CONT'D

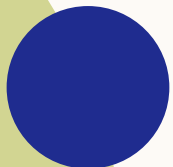
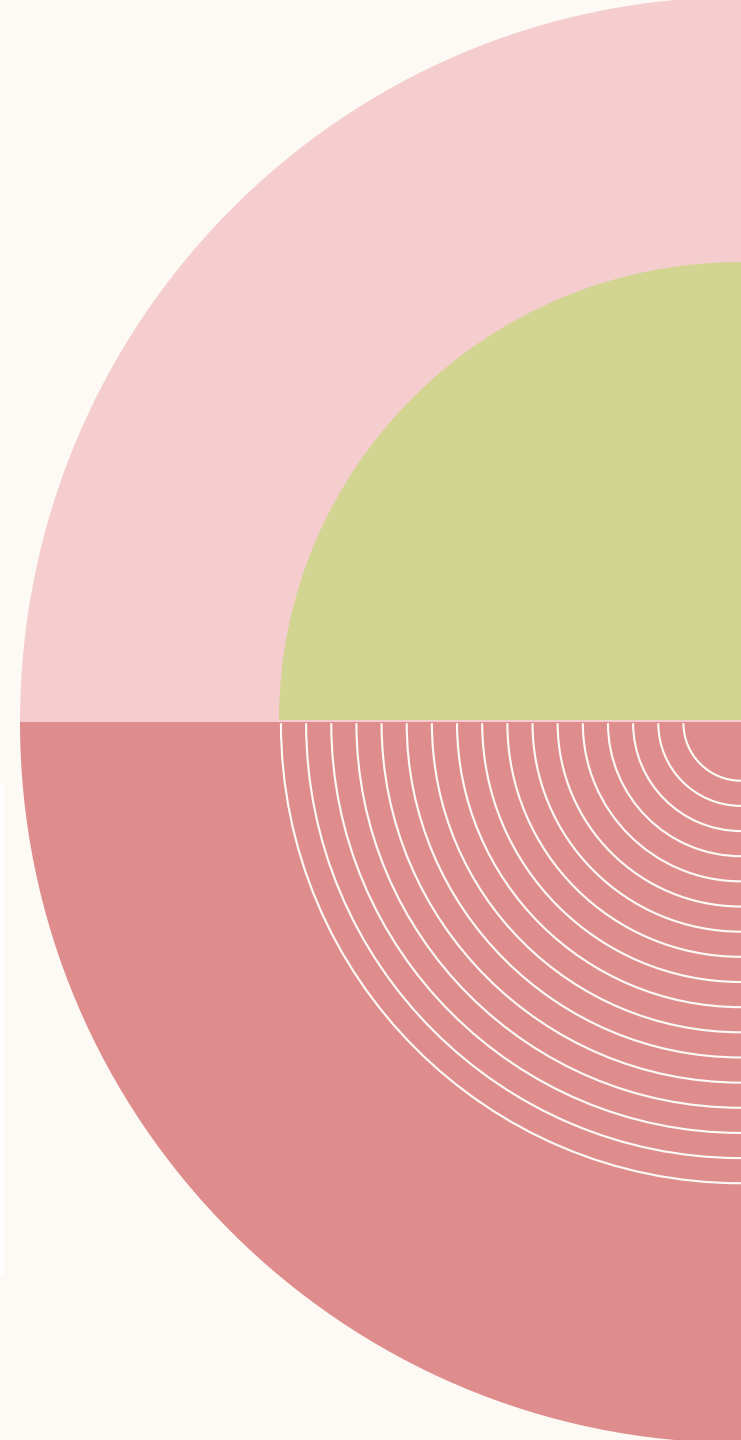
Behavioral Health Integration **fortifies primary care** by bringing together primary care and behavioral providers, working with patients and families, using a systematic approach to provide patient-centered care



- Patient outcomes
- Patient/family engagement
- Provider care/team satisfaction



- Administrative coordination
- Cost/utilization
- Provider care/team burnout



WHAT NEXT?

APPROVED CAPACITY

+4

**Behavioral Health
Care Managers**

Creates the capacity to establish CoCM
beyond the original pilot.

Approved growth is backed by demonstrated demand

The expansion decision is no longer “Does CoCM work?”

It is “How do we grow without diluting access or sustainability?”

HOW TO SPREAD?

01 Leadership endorsement Visible dyad support for adoption and local problem-solving.

02 Physician champion A credible clinical leader who can engage peers.

Governance keeps clinical outcomes, capacity, and spread decisions connected

The group owns four questions

- | | | |
|---|-----------------|--|
| 1 | Outcomes | Are patients improving? |
| 2 | Capacity | Are panels and referrals balanced? |
| 3 | Adoption | Are teams using the model as designed? |
| 4 | Spread | Which sites are ready next? |

Governance converts local learning into a repeatable division-wide model.



THANK YOU

Bringing Behavioral Health into Primary Care

Chinese Hospital's Integration Journey

Presented by: Jiami Wu, MPH
Director of Clinics, Chinese Hospital



**CHINESE
HOSPITAL
& CLINICS**

The Challenge: Behavioral Health in 2023

Patient Barriers

- **Access Issues:** Chinese-speaking and senior patients faced severe language barriers, long wait times, and heavy cultural stigma.
- **Fragmented Care:** Behavioral health was siloed from primary care, leading to missed early signs of depression and anxiety.
- **Inconsistent Follow-up:** Vulnerable patients frequently fell through the cracks without coordinated support.

Provider Strain

- **Overwhelming Needs:** Outpatient clinics saw rapidly growing mental health concerns among primary care populations.
- **Lack of Resources:** Primary care providers lacked the time, specialized tools, and embedded support to manage these needs.
- **Referral Bottlenecks:** Heavy reliance on a single full-time LMFT and outside external therapists caused severe delays.

Our Journey: Implementing the Collaborative Care Model (CoCM)



Impact & Strategic Value

30%

Increase in BH screening

125

Enrolled in CoCM (~60% agree rate)

95%

Of payers fully reimburse

Transforming Care at Chinese Hospital

- > **Culturally Responsive Approach:** Framing concerns around stress, sleep, and overall wellness (rather than mental illness) built trust and drastically improved engagement.
- > **Empowered Clinicians:** Embedded care managers and psychiatric consultations reduced provider burden and increased treatment confidence.
- > **Long-Term Strategy:** BHI is now a core part of our strategy to reduce systemic fragmentation and deliver equitable, patient-centered care.

HEALTHCARE LEADERSHIP SUMMIT 2026

THE STATE OF BEHAVIORAL HEALTH INTEGRATION

Coming Up At 1:00 p.m. after lunch

HEALTHCARE
LEADERSHIP
SUMMIT 2026

PB
GH California Quality
Collaborative



Pointe BC

Collaborative Labs: Optimizing Data and Measurement for Behavioral Health Integration

Selecting meaningful measures, aligning clinical and quality metrics and embedding data into day-to-day decision-making.



Pointe A

Collaborative Labs: Innovations in Workforce Development

Innovative approaches to building and sustaining the workforce needed to support integrated care, including emerging roles, training models and cross-sector partnerships.

Optimizing Data and Measurement for Behavioral Health Integration

Pointe Salon BC, 1:00 – 2:20 p.m.

HEALTHCARE
LEADERSHIP
SUMMIT 2026



California Quality
Collaborative

SESSION SPEAKERS

Optimizing Data and Measurement for Behavioral Health Integration



Jennifer Lenz
MPH

National Committee for
Quality Assurance



Liane Wardlow
PhD

West Health



Neftali Serrano
PsyD

Collaborative Family
Healthcare Association



William Sieber
PhD

UC San Diego
Integrated
Behavioral Health

From Consensus to National Adoption



LEARNINGS



Consensus on top conditions

Depth over breadth

Payer and policy experts aligned on a depth-first set centered on depression, anxiety & SUD that follows the full pathway: screening → follow-up → outcomes.



Measurement gaps

Closing the anxiety measurement gap

NCQA and West Health are scoping a measure built on follow-up and functioning, not screening alone. Conversations happening on a dementia measure.

COMMS & DISSEMINATION



Media [HealthLeaders](#), [Healthcare Innovation](#), and [San Diego Business Journal](#) articles published. r



BHOC26 Behavioral Healthcare Outcomes Consortium · Sep 8–10 – Dana Point, CA.



Innovation Summit West Health on the Quality Conversation panel · Oct 6, 2026 · Atlanta, GA.

Next Steps: A four-pillar strategy for the payer & policy workgroups to execute

Alignment

Shared national foundation across payers & standards bodies

Adoption

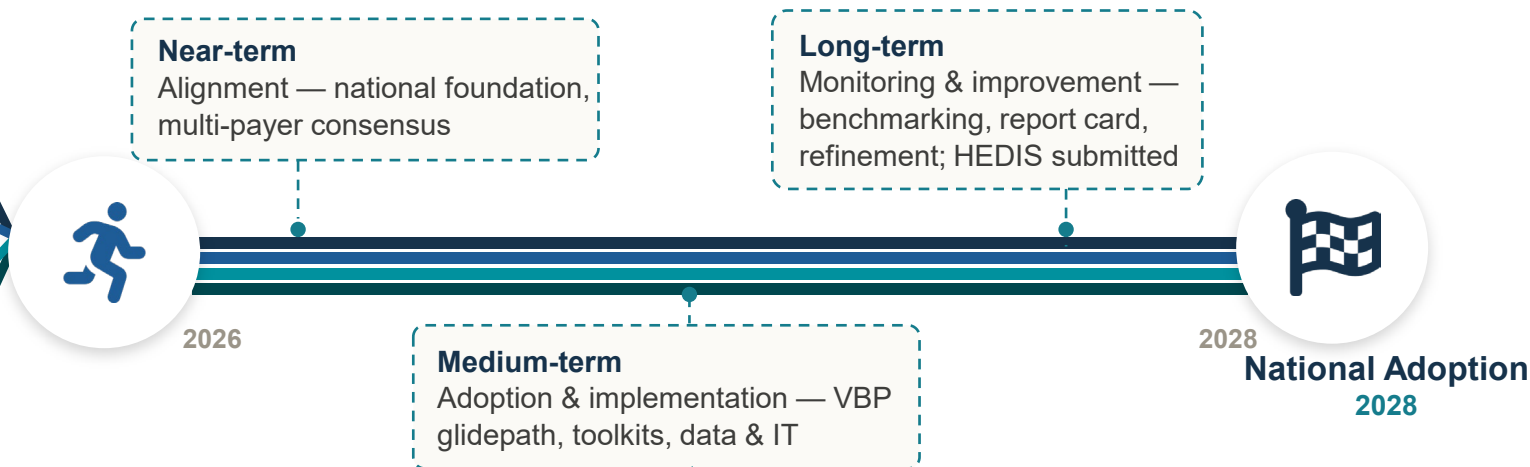
Market signals and incentives for uptake

Implementation

Feasible, scalable execution in real-world settings

Monitoring & improvement

Accountability and long-term sustainability



Making Proven Care Standard Care

~14M Lives, Five States



CURRENT STATE

- Primary care carries the BH burden without infrastructure
- No quality standards connecting care to payment
- 100+ behavioral health measures; no shared standard
- Outcomes for depression, anxiety & SUD go largely untracked

OUR FOCUS

Building the measurement and payment infrastructure to make proven care standard care

FUTURE STATE

- Team structures, registries & measurement tools embedded in primary care
- Outcomes visible & comparable across payers & health systems
- Shared quality standards for behavioral health, like ADA & AHA
- Value-based contracts tied to behavioral health outcomes

CALIFORNIA

ACTIVE · LIVE

~2.6M
covered lives

11 implementation
partners

Target #: 8 partners

MASSACHUSETTS

Contract Pending

~5.6M
covered lives

36 implementation
partners

Target #: 36 partners

TEXAS

Engaging

~5M
covered lives

Scoping 18
implementation
partners

Health System Partnerships:

ILLINOIS

Contract Pending

M Northwestern
Medicine®

~500K
covered lives

PENNSYLVANIA

Engaging

J Jefferson
HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

~400K
covered lives

A Different Approach

Early Stakeholder Input → Rapid Testing → Real-Time Refinement



WHAT MAKES THIS DIFFERENT

Built with payers and policymakers, in addition to clinicians

- Payer and policy workgroups provide input from the start, so strategies are adoptable, not aspirational.
- Multi-payer consensus creates one shared standard instead of competing scorecards.
- Line of sight to payment and implementation.

Rapid testing and real-time measure refinement

- Measures are tested in live health system settings, not modeled in the abstract.
- Short feedback loops allow specifications be tweaked as field data comes in and findings are realized.
- Gaps addressed as they surface.

Measure Area	Measure Name
Depression	Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)
	Depression Remission or Response for Adolescents and Adults (DRR-E)
Anxiety	Use of Anxiety Severity Measure
Substance Use	Screening, Brief Intervention, and Referral to Treatment (SBIRT)
	Assessed for SUD Treatment Needs Using a Standardized Screening Tool
	Unhealthy Alcohol Use Screening & Follow-Up (ASF-E)
	Tobacco Use Screening and Cessation Intervention (TSC-E)
Suicide Risk	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment
Functioning	Improvement or Maintenance of Functioning for Individuals with a Mental and/or Substance Use Disorder
Social Needs	Social Need Screening and Intervention (SNS-E)
Care Coordination	Follow-Up After Emergency Department Visit for Mental Illness (FUM)
	Follow-Up After Hospitalization for Mental Illness (FUH)
	Follow-Up After Emergency Department Visit for Substance Use (FUA)

The Measure Set

Full Pathway: Screening → Follow-Up → Outcomes



Measure Area	Measure Name
Depression	Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)
	Depression Remission or Response for Adolescents and Adults (DRR-E)
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WHAT MAKES THIS DIFFERENT

Built with payers and policymakers, not just clinicians

- Payer and policy workgroups provide input on the measure set from the start, so it is adoptable, not aspirational.
- Multi-payer consensus creates one shared standard instead of competing scorecards.
- Line of sight to payment: measures are designed to plug into value-based contracts.

Rapid testing and real-time measure refinement

- Measures are tested in live health system settings, not modeled in the abstract.
- Short feedback loops let specifications be tweaked as field data comes in.
- Gaps are closed as they surface.

Early Findings

Learnings from Measure Testing



Implementation is feasible, but reliable comparison requires stronger data capture

Testing across 11 California provider organizations identified three priorities for broader use.

100% data submission

56% Commercial results reportable

39% Medicare Advantage results reportable

1 Improve structured capture

- Standardized depression tools and Epic flowsheets supported stronger reporting.
- Inconsistent substance use tools and narrative fields created gaps.

2 Treat low volume carefully

- Small or zero eligible populations drove most non-reportable results.
- The constraint was denominator sufficiency, not failure to submit data.

3 Benchmark responsibly

- Variation was clearest in depression screening; selected follow-up results were consistent.
- Use pooled, member-weighted benchmarks with confidence intervals rather than rankings.

BOTTOM LINE Continue testing before broader benchmarking, while standardizing documentation and clarifying specifications.

Measurement Based Care Principles

Introduce

- Describe purpose and benefits of MBC particularly shared decision-making
- Discuss process for measure completion & use
- Build trust in clinical and MBC processes

1. Collect

- Complete measure(s) routinely per agreed schedule as standard part of integrated behavioral healthcare

3. Act

- Use data as part of a meaningful conversation to assess progress (or lack thereof)
- Informs joint decision-making on any needed adjustment(s) to goals or treatment

2. Share

- Score and interpret measure(s)
- Employ timely, non-judgmental and strengths-based feedback
- Discuss meaning of results together after each assessment & changes over time
- Connect data to patient's lived experience, goals for treatment, and intervention preferences



**Collaborative Family
Healthcare Association**

UC San Diego Health

Integrated Behavioral Health (IBH)

William J. Sieber, Ph.D.

Director, Integrated Behavioral Health

Chief, Division of Integrated Behavioral Health

Clinical Professor

Department of Family Medicine

Department of Psychiatry, NS

UCSDH IBH Plus

- Providers and Leadership/Organization
 - 24 licensed BHPs: Psychologists, LMFTs, LCSWs, MDs, DOs
 - 4 - 7 pre-licensed learners
 - Committee structure for diversity of tasks and optimize BHP buy-in
- 13 clinics: 6 faculty-led, 7 Community Care (not SOM)
- Each month we
 - Receive 500+ referrals
 - Complete 1200+ patient visits; provide 120-150 W.H.O.s
 - We see patients whose functioning level has changed recently and need skills to recover; we do not see patients with chronically low functioning levels, or those in need of long-term support or needing emergency psychiatric services.

IBH Plus: 3 Elements

Clinical care

Panel of patients for time-limited care

Warm Hand Offs

Groups

Primary Care Psychiatry

Professional development

Committee structure

Education/Learners (CEUs given)

Metrics/reports

Presentations/publications (\$ support)

Operational/Quality improvement

Peer review

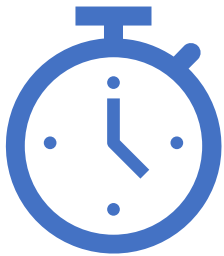
MBC

WHOs remotely

Collaborations with Population Health

What Do We Offer?

We aim to optimize access and continuity for patients. This is primarily achieved by offering time-limited (93% episodes $\leq$ 12 sessions) and focused psychotherapy, as well as warm hand-offs.



**Time-limited, focused
evidence-based care
(usually < 12 sessions)**



**Helps team expedite care
More appropriate referrals lowers wait
time**

Provider Workbench Report Development



Iterative
process



Close
collaboration
with Epic
Analyst



Inclusion of
most
frequently
used
measures



Easy access
to
longitudinal
data



Provider
feedback



Defining MBC for IBH

MBC within an interdisciplinary team is a:

- **Routine** evidence-based practice **using quantitative data over time** to **guide and inform patient-centered treatment decisions.**
- ***Clinical Process*** using reliable, valid data sources, such as **patient-reported progress and outcomes** of functioning and health behaviors, in a **collaborative manner with patients and their care team** to continually monitor and inform treatment.

MBC is...



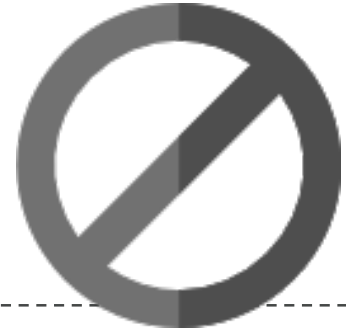
NOT program
evaluation or
evaluating
individual clinical
providers.



NOT solely driven
by an “expert
**Behavioral Health
Provider (BHP)**”
throughout the
clinical process.

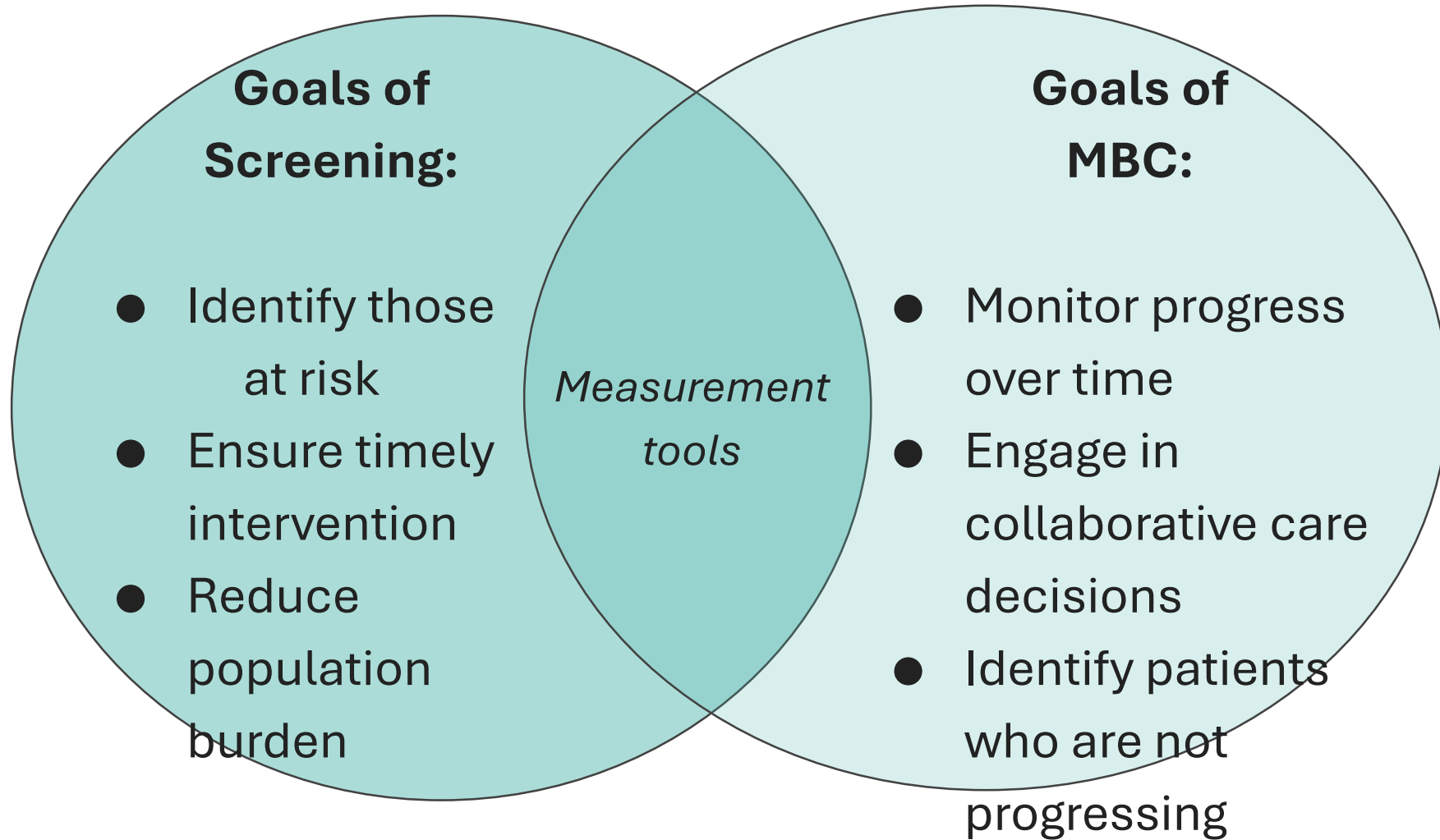


NOT a
“**medical model**”
of BH care

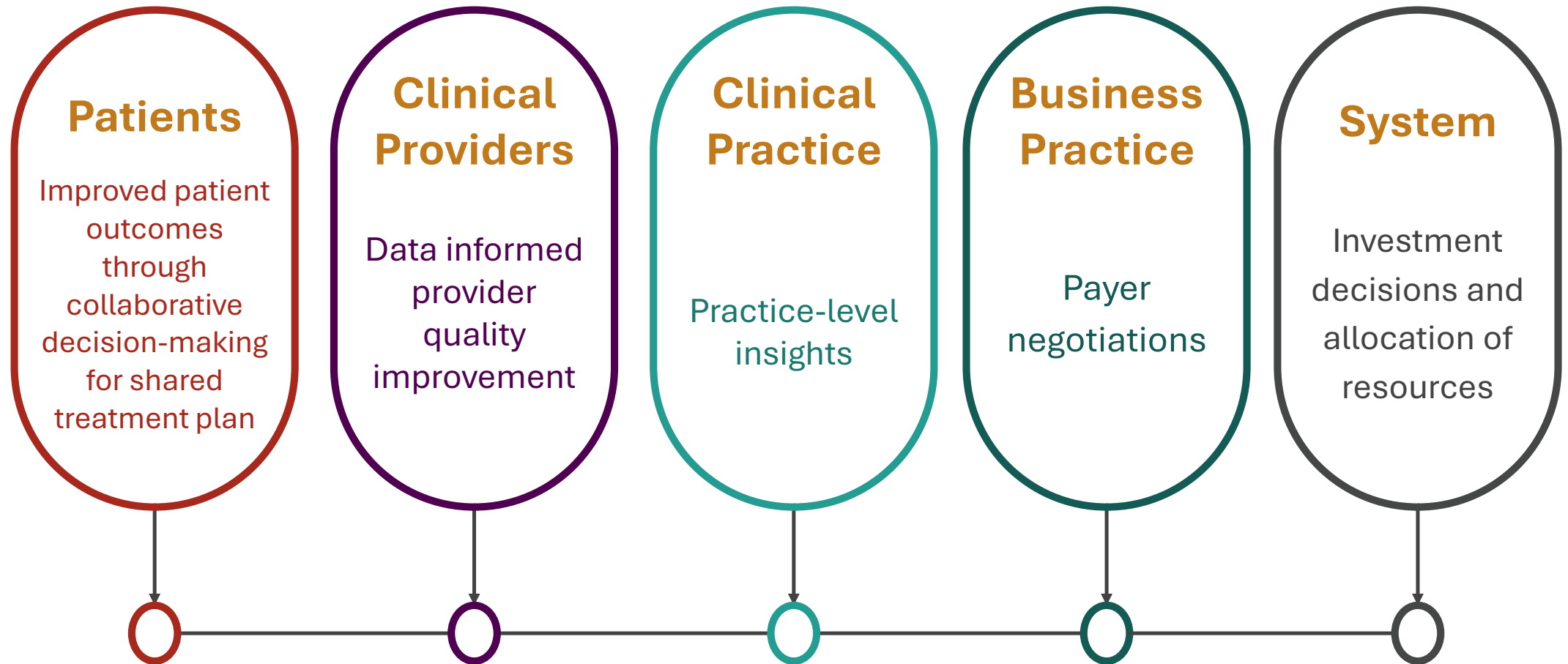


NOT meant to
replace clinical
judgment nor
stigmatize BHPs
as less effective.

Screening versus MBC



Using MBC to improve all aspects of population health



Collect, Share, and Act Framework

- **Collect**

- Administer and score/interpret validated PROMs of target issues
- Educate patients about MBC process – give the “why” during consent

- **Share**

- Inform the patient of their score and what it means; inform team as needed
- Discuss patient’s perception of the scores at this moment in time (accurate?)

- **Act**

- Use the data and the patient’s perceptions to inform any treatment changes
- Stay the course? Focus on something else? Different type of treatment needed? Ready to conclude treatment?

Why Perform Repeated Measurement?

- In a primary care clinical trial, the use of MBC (PHQ-9) in treating depression, compared to treatment as usual, resulted in a significantly higher response rate (67% vs 60%) and remission rate (47% vs 43%) for depression. (Zimmerman, 2019)
- Modify treatment
- Reinforce progress
- Support team-based care
- Clinician intuition includes bias
- People with depression have trouble noticing progress

Criticisms: not clinically relevant, 'accepted measures' not sensitive to change, etc.

Flowsheet Report

[Review Flowsheet](#)
⚠ Some recent data might be hidden

PHQ2 & PHQ9 Score Summary	11/14/2022	10/31/2022	9/9/2022	8/5/2022	7/18/2022	3/21/2022
PHQ 2 Score	1	1	4	4	4	6
PHQ 9 Score	3	8	12	14	12	20

PHQ Screen Suicidality History

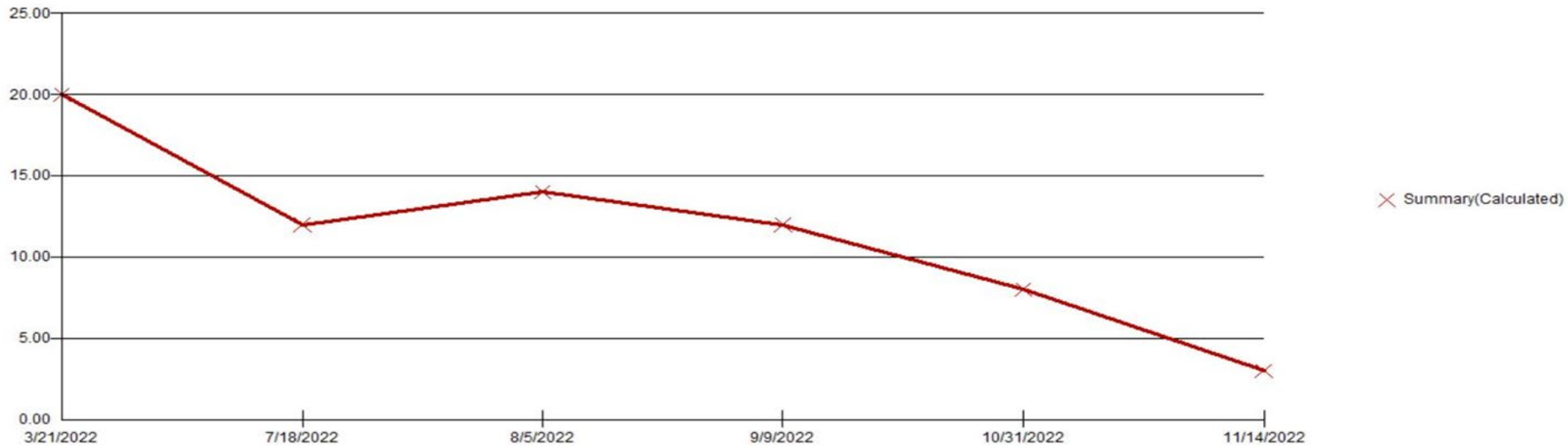
Thoughts that you would be better off dead, or of hurting yourself in some way	11/14/2022	10/31/2022	9/9/2022	8/5/2022	7/18/2022	3/21/2022
	0	0	0	0	2	2

PHQ Screen Functional History

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	11/14/2022	10/31/2022	9/9/2022	8/5/2022	7/18/2022	3/21/2022
	Somewhat difficult	Somewhat difficult	Not difficult at all	Somewhat difficult	Very difficult	Very difficult

[Review Flowsheet](#)
⚠ Some recent data might be hidden

Flowsheet Data



The graph shows the data in chronological order (3/21/2022 - 11/14/2022)

Promoting MBC and Use of Workbench Report

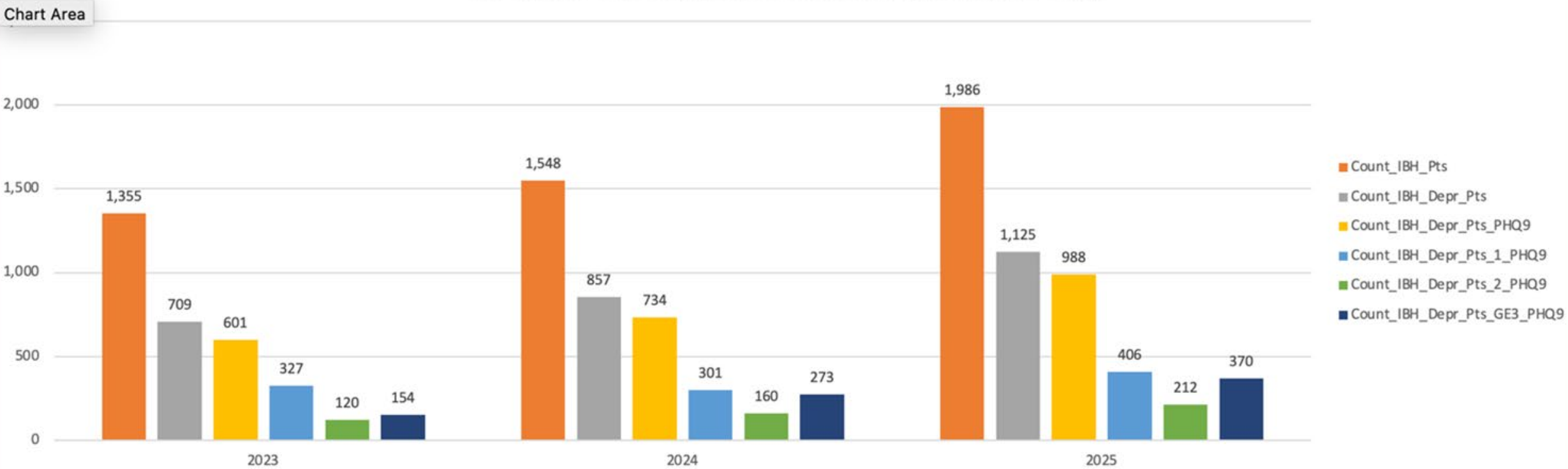


Frequent
education/re-
education of IBH
team regarding
aspects of
workbench report.



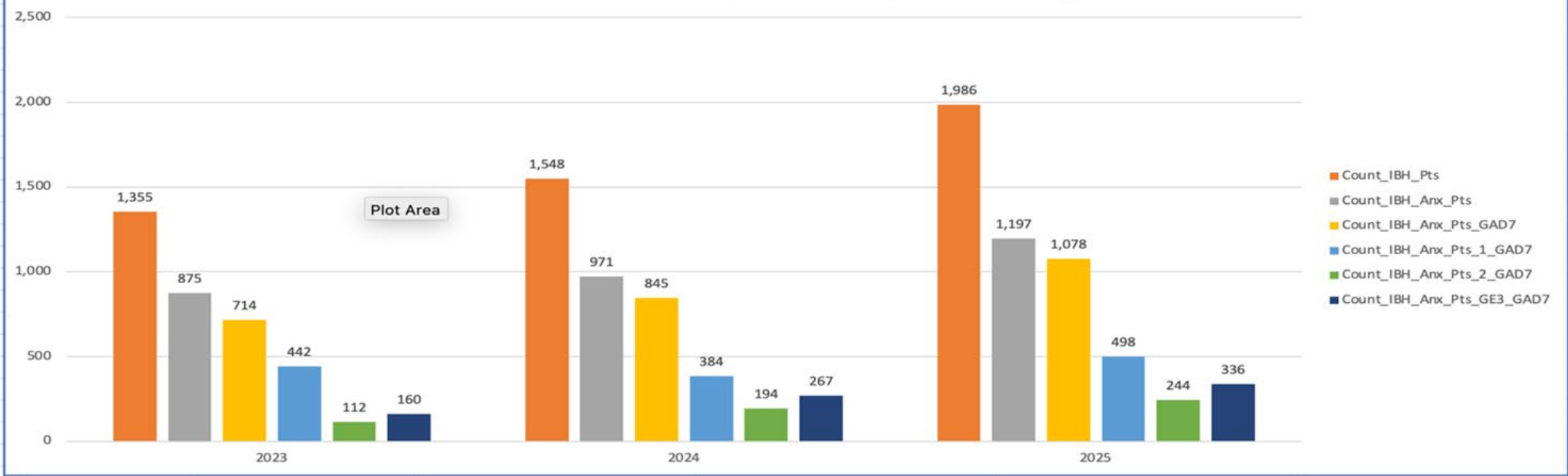
Surveying of all-staff
regarding
workbench
usage, MBC clinical
practices, and
opportunity to
provide feedback.

IBH Patients with Depression Dx and PHQ9 Questionnaire Usage



	2022		2023		2024		2025	
# w/ Dx	460.		709		857		1125	
any PHQ	363.	79%	601	85%	734	86%	988	88%
# w/ 1 admin	190.	41%	327	46%	301	35%	404	36%
# w/ 2 Admin	68.	15%	120	17%	160	19%	212	19%
# w/ > 2	105.	22%	154	22%	273	32%	370	33%

IBH Patients with Anxiety Dx and GAD7 Questionnaire Usage

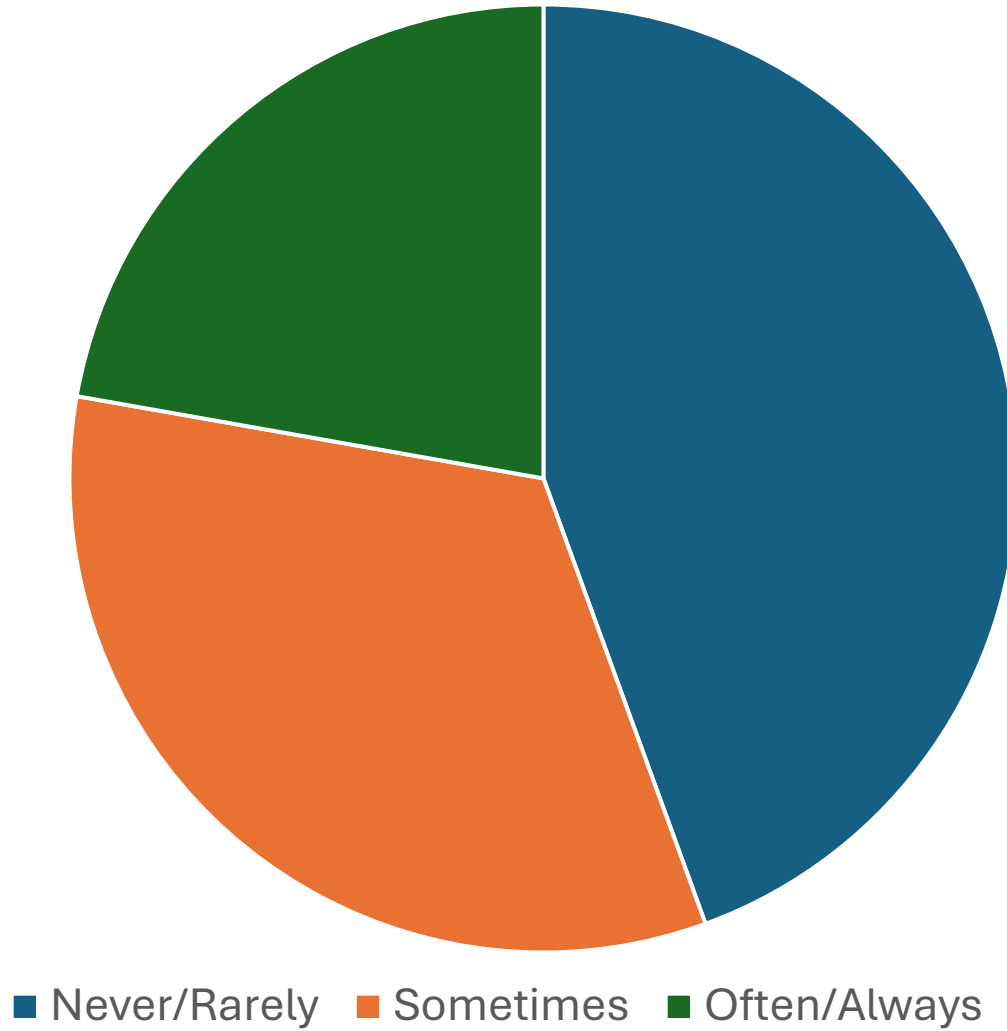


	2022	2023		2024		2025	
# w/ Dx	540		875		971		1197
any GAD-7	435	80%	714	82%	845	87%	1078
# w/ 1 admin	273	50%	442	51%	384	40%	498
# w/ 2 Admin	61	11%	112	13%	194	20%	244
# w/ > 2	101	18%	160	18%	267	28%	336

BHP Use of Measurement Based Care (MBC) — Survey Results Dashboard					
Total Responses: 18					
Summary Statistics — Percentage Questions					
Question	N	Mean (%)	Median (%)	Min (%)	Max (%)
Q1: Review Responses with Pt	17	75.9	80.0	10.0	100.0
Q2: Document Review in Note*	17	72.4	100.0	10.0	100.0
Q5: Address Score Discrepancy	16	70.0	80.0	10.0	100.0
Q9: Use Other Questionnaires	16	45.6	50.0	0.0	100.0

* Verification is conducted via Peer Review that induces this element of care

Q3: How Often Do You Access Epic Workbench?



Next step – Individual provider feedback

(% Dx patients with >2 administrations)

PHQ-9

Provider A	22%
Provider B	60%
Provider C	77%
Provider D	61%
Provider E	45%
Provider F	43%
Provider G	38%
Provider H	77%
Provider I	38%
Provider J	58%
Provider K	29%
Provider L	44%
Provider M	43%
Provider N	17%
Provider O	47%
Provider P	0%
Provider Q	34%
Provider R	76%

GAD-7

Provider A	25%
Provider B	67%
Provider C	75%
Provider D	67%
Provider E	20%
Provider F	49%
Provider G	43%
Provider H	76%
Provider I	45%
Provider J	59%
Provider K	40%
Provider L	44%
Provider M	29%
Provider N	7%
Provider O	50%
Provider P	0%
Provider Q	29%
Provider R	65%

Who is on your team?

Team members who may be needed to promote/support MBC:

- Providers/Clinicians: How many (BH and MD)?
- Tech/EHR lead
- Clinic/Operations manager
- RN/MA representative

Identify members on your team. What roles need to be filled?

Identify candidates to fill each role.

Identify the probable value of MBC for each member of your team (e.g., administrator – MBC supports VBC, provider - P4P reimbursement)

How might you educate each team member of their value?
Can you find patient examples or extract quantifiable data?

CFHA Tools for Choosing MBC Measures

- CFHA's "Top 40 Outcome Measures For Integrated Care: Repository Data Based On PAPERS Framework":
 - [CFHA Master Repository Document](#)
- MBC Workgroup page on CFHA Website:
 - <https://www.cfha.net/workgroups/measurement-based-care-workgroup/>
- Additional resources:
 - AIMS Center: <https://aims.uw.edu/measurement-based-treatment-to-target/>
 - APA: <https://www.apaservices.org/practice/measurement-based-care>

HEALTHCARE LEADERSHIP SUMMIT 2026

THE STATE OF BEHAVIORAL HEALTH INTEGRATION

What is the biggest challenge your organization faces in collecting, using and/or acting on data to drive improvement in integrated care?



menti.com
6457 0400

0 of 1 responded

Responses are hidden x

HEALTHCARE LEADERSHIP SUMMIT 2026

THE STATE OF BEHAVIORAL HEALTH INTEGRATION

Coming Up At 2:30 p.m.



Pointe BC

Panel: Financing and Sustainability: The Road to Whole-Person Care, Whole-Person Payment

This session will explore how providers, payers and purchasers are advancing payment approaches that support integrated delivery, including value-based models and multi-payer strategies. Panelists will share real-world examples of how organizations are navigating the shift from fragmented reimbursement to more coordinated, accountable payment structures.

Innovations in Workforce Development

Pointe Salon A, 1:00 – 2:20 p.m.

HEALTHCARE
LEADERSHIP
SUMMIT 2026



California Quality
Collaborative

SESSION SPEAKERS

Innovations in Workforce Development



Jeremy Fish
MD

John Muir Health



Katie Steele
PhD

Meadows Mental Health
Policy Institute



Julian Mitton
MD, MPH

Era Supports

What workforce challenges are most limiting BHI scale today? Select your top 2.



 **Mentimeter** 

Open Menti to edit 

Replace this slide 

Add Menti slides 



menti.com
6336 7267

Waiting for participants

ADVANCED PRIMARY CARE • WORKFORCE LEADERSHIP

Jeremy Fish, MD

Founding Residency Director, JMH Family Medicine Residency Program

Co-Training the Inter-Professional, Collaborative Leaders of Advanced Primary Care

Bringing Value-Based Payment Models to Inter-Professional Workforce Development for Advanced Primary Care



A Career Built on Growing California's Advanced Primary Care Workforce

80

RESIDENCY PROGRAMS STATEWIDE

Founder, CAFP California FM Residency Network

Built the network from the ground up -- now 80 family medicine residency programs across California.

2021

CAFP HONOR

California Family Physician of the Year

Recognized by CAFP for statewide contributions to the specialty.

FOUNDER

FOUNDING DIRECTOR

JMH Family Medicine Residency Program

Founding Residency Director of the John Muir Health program serving the East Bay, built around team-based, integrated care.

MCC

STATE ADVISORY

Member, Future of Medi-Cal Commission Advisory Group

Advising on the long-term direction of California's Medicaid program.

PCIN

NATIONAL NETWORK

California Rep., Primary Care Investment Network

Representing California in a national network strengthening primary care investment policy.

BHI

CQC ADVISORY

Member, CQC Behavioral Health Integration Advisory Cmte.

Guiding statewide efforts to make integrated behavioral health the default in primary care.



THE JMH MODEL

1

Who We Train

Family Medicine residents and Clinical PsyD trainees -- future clinicians and leaders in Primary Care Behavioral Health -- learning side by side from day one.

2

How We Train

Shared clinical sites, shared patients, and shared case conferences build genuine inter-professional fluency -- not a rotation, a partnership.

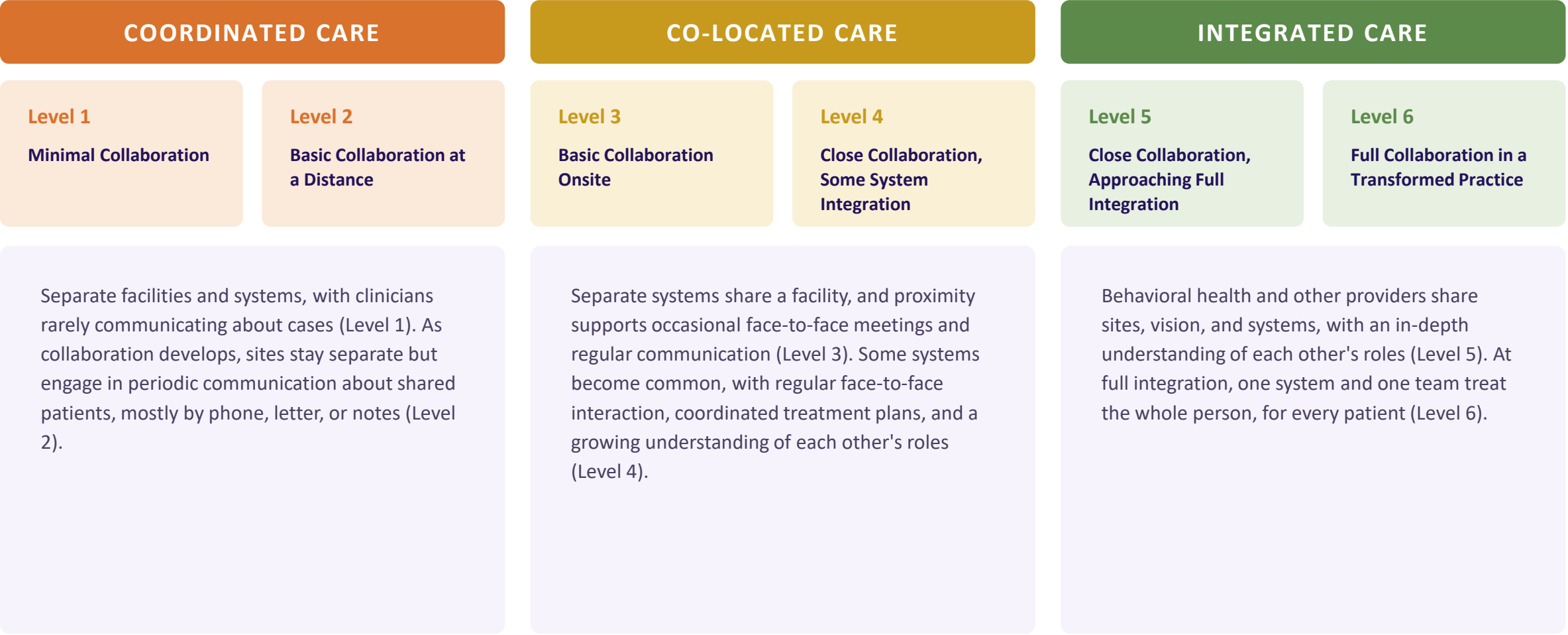
3

What We Produce

Inter-professional, collaborative leaders ready to build and run Advanced Primary Care teams across the Bay Area and California.



The JMH Model in Practice: Six Levels of Primary Care Behavioral Health Integration



THE BOLD VISION

500+

**COLLABORATIVELY TRAINED FM
PHYSICIANS**

*graduating each year, statewide**

240

BEHAVIORAL HEALTH SPECIALISTS

*co-trained each year, statewide**

160,000

INTEGRATED BH VISITS

*added in access each year, statewide**

Built by extrapolating the JMH co-training model -- roughly 2,000 behavioral health visits enabled per year through one FM-BH co-training partnership -- across all 80 CAFP California FM Residency Network programs.

** Estimates only. FM physician figure is a conservative, rounded estimate reflecting wide variation in program size; BH specialist and visit figures extrapolate the JMH model's co-training ratio and visit volume across all 80 network programs. Actual outcomes will vary by program size, region, and depth of BH training partnership.*



A CALL TO ACTION FOR CALIFORNIA HEALTHCARE

Build the collaborative, inter-professional workforce of the future through deliberate partnership between primary care GME and graduate-level training of behavioral health professionals -- targeted first at the regions facing the greatest shortfalls in both.

1

Pair the Pathways

Treat primary care GME expansion and graduate-level BH training as a single, co-designed workforce strategy -- not two separate pathways.

2

Target the Shortfall Regions

Prioritize state investment in the counties and regions with the deepest combined gaps in primary care and behavioral health capacity.

3

Fund the Model, Not Just the Slots

Support co-training infrastructure -- shared sites, shared supervision, shared curricula -
- so new positions produce integrated-care-ready clinicians from day one.

The JMH Model is the proof of concept. A statewide strategy is the next step.



Workforce Innovation & System Transformation

Katie Steele, PhD

Center for Health Systems Transformation

Meadows Mental Health Policy Institute

We Can't Recruit Our Way Out of This

| 148

More than 122 million Americans live in a federally designated shortage area and the gap is concentrated at the top of the licensure ladder

SHORTAGE PRESCRIBERS

Physicians
Psychiatrists
Nurse Practitioners
Physician Assistants

SHORTAGE LICENSED CLINICIANS

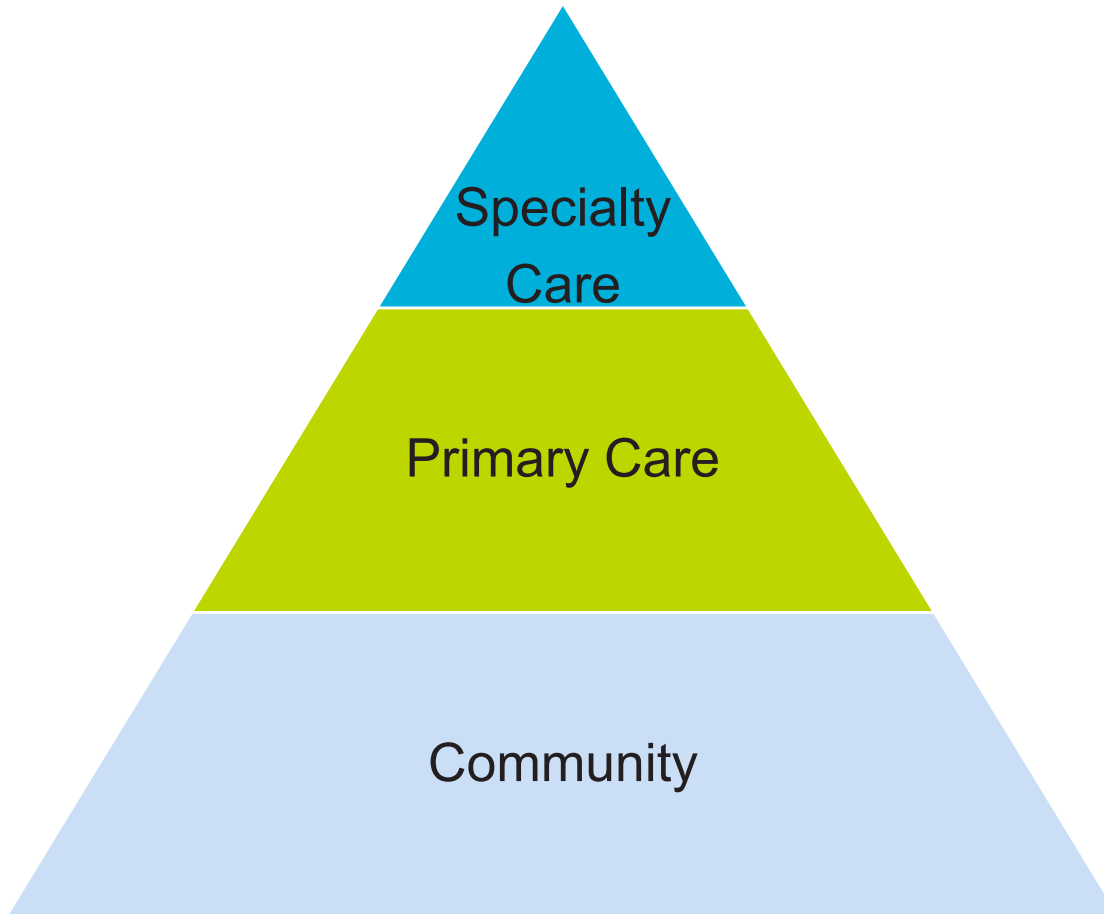
Psychologists
LPCs
LCSWs
LMFTs

ROOM TO GROW UNLICENSED PROVIDERS

Peer Support Workers
Community Health Workers
Care Managers
Doulas

Task Sharing: *we need all hands on deck*

| 149



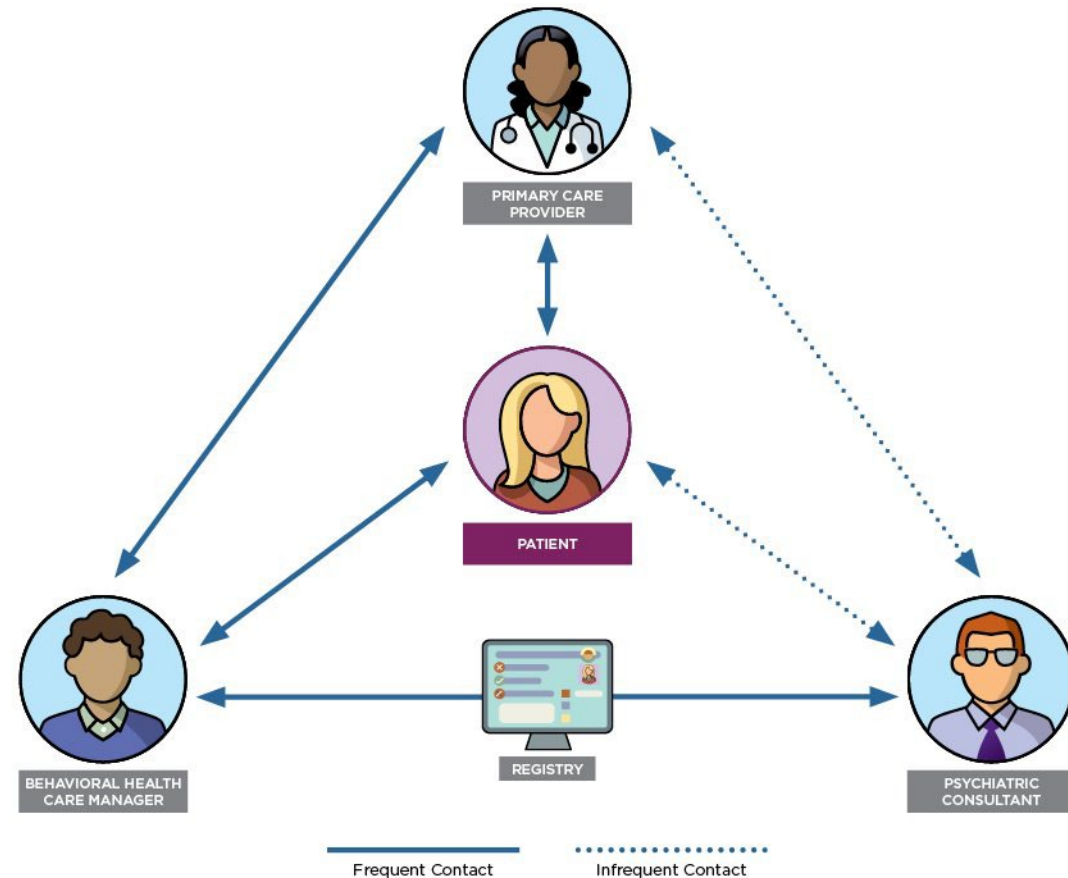
Most behavioral health need is met (or could be met) in primary care and community

- ✓ Clear scope of practice
- ✓ Competency-Based Training
- ✓ Structured Supervision

Collaborative Care (CoCM)

| 150

CoCM is a team-based, data-driven, patient-centered, population health approach to behavioral health integration.



Four Scalable Strategies

| 151

- Bachelor-level behavior health care managers in Collaborative Care
- Community members with a high school diploma or equivalency, trained for culturally grounded support
- Internship and practicum models for early-career staff
- Higher-education partnerships for competency-based pathways



Expanding Nontraditional Roles

| 152

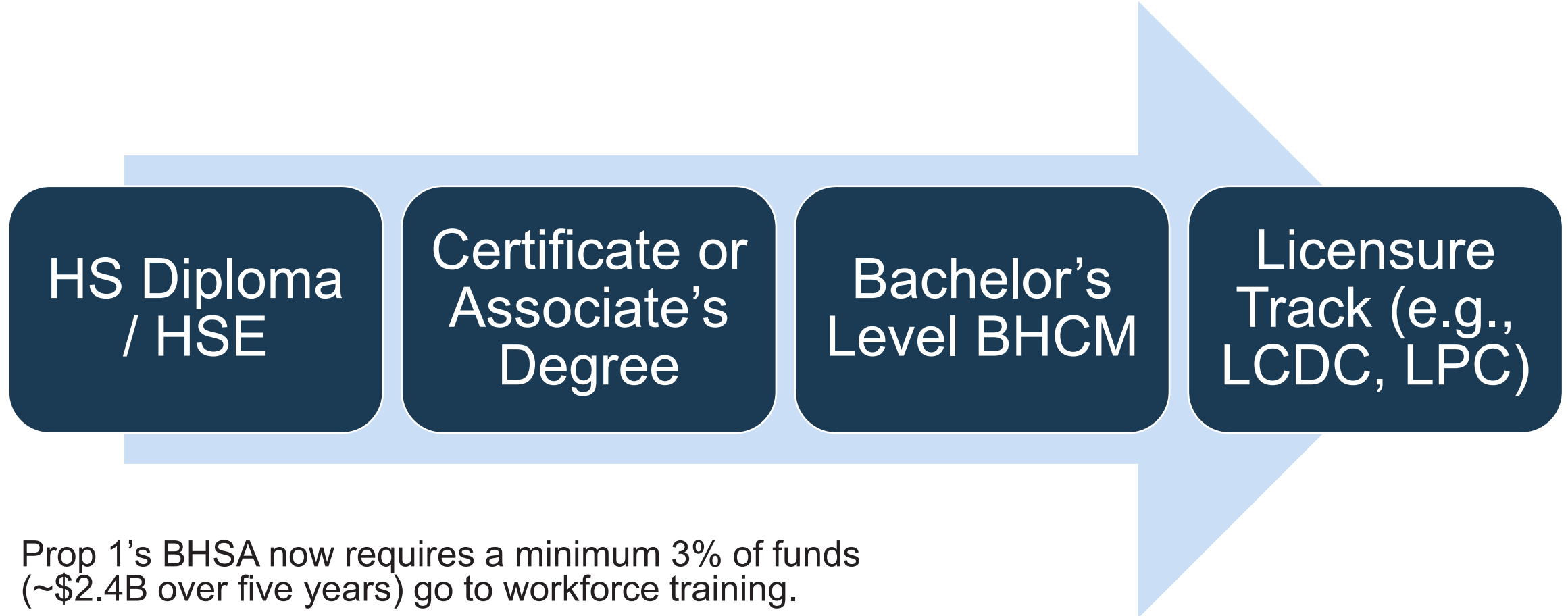
ROOM TO GROW
UNLICENSED
PROVIDERS

Peer Support Workers
Community Health Workers
Care Managers



Building Career Ladders: Stackable Credentials

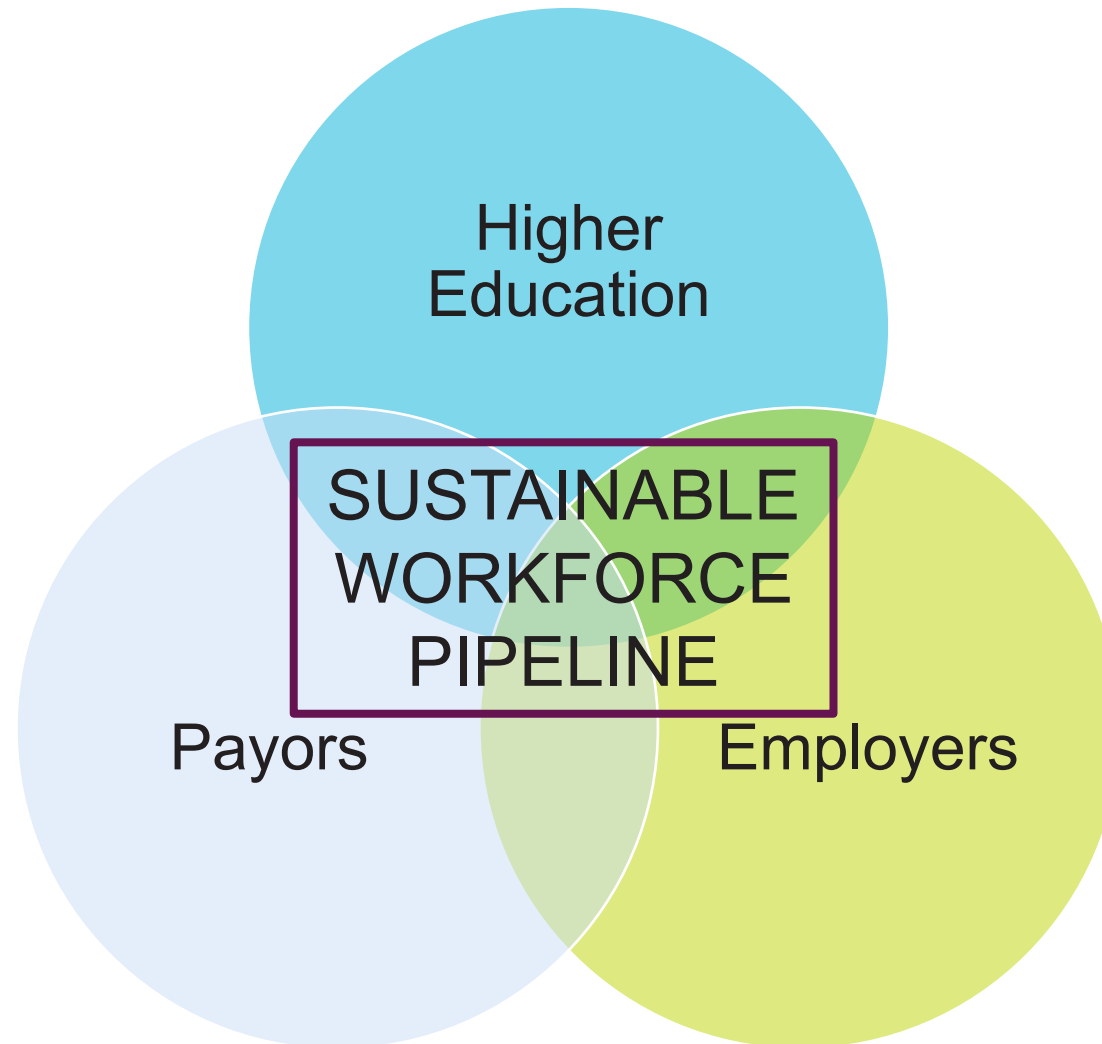
Multiple entry and exit points keep the pathway open at every level.



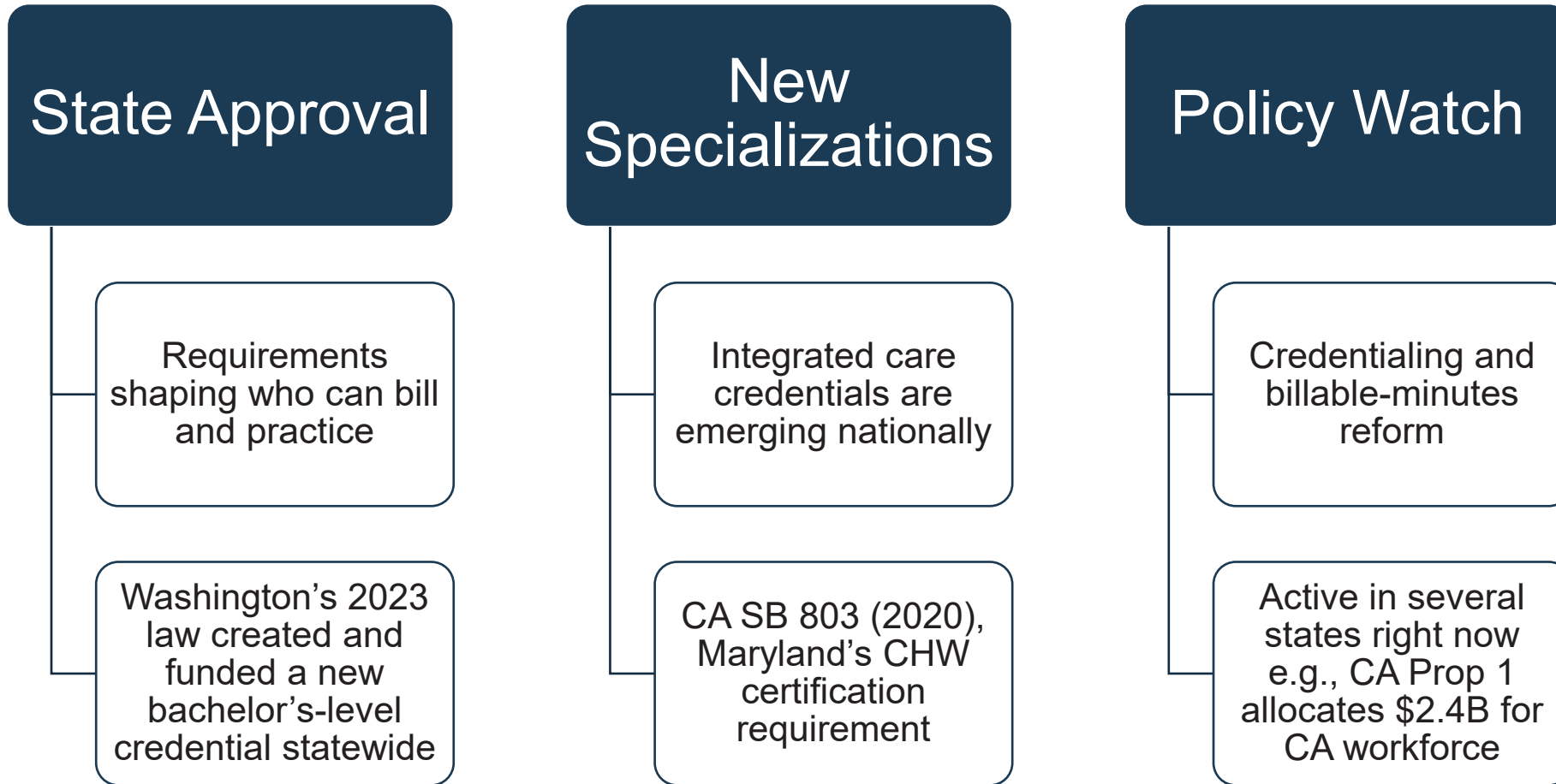
Prop 1's BHSA now requires a minimum 3% of funds (~\$2.4B over five years) go to workforce training.

Cross-Sector & Educational Partnerships

| 154



State Policy is Moving (Unevenly)



Key Takeaways

1

Develop and
Standardize
Competency-
Based Training

2

Align State
Level
Requirements
and Scope

3

Advance
Sustainable
Reimbursement
Structures

4

Invest in
Education
Partnerships

Thank You!

Katie Steele, PhD | ksteele@mmhpi.org

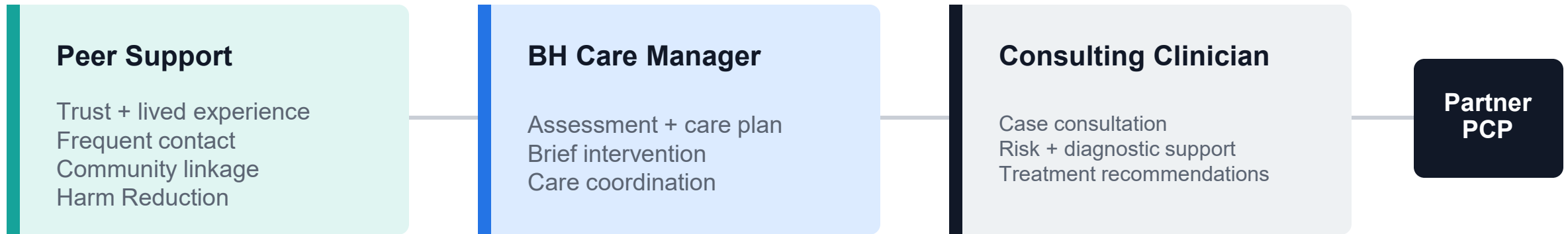
The next workforce innovation is about new roles *and* a better system around the team.

What Era Supports is learning from integrating peer support, collaborative care, and measurement-based care



Julian Mitton, MD, MPH • Head of Clinical Operations, Era Supports

Peers are not only an add-on. They expand what the care team can see and do, meeting patients where they are.



Task-sharing moves every role toward its highest-value work—while peer relationships keep care connected to patients' real lives. It also helps avoid burnout.

Shared structures and tools turn multidisciplinary staffing into true coordinated care

01

Measure

Validated assessments create a shared view of progress and risk. They hold the team accountable.

02

Review

Structured case review combines clinical judgment, peer insight, and patient priorities. Registries helps manage a population.

03

Act

Tiered outreach, clear ownership, tools that optimize activities and rapid follow-up translate data & decisions into care.

Enabling layer: shared registry • outreach planner • documentation standards • time tracking • AI-supported workflows/actions

Four moves can help strengthen the integrated behavioral health workforce

- 01

Practice at the top of license

Define scope, decision rights, and handoffs around the work—not hierarchy.
- 02

Redesign the care team

Embed peers and paraprofessionals in planning, case review, and accountability.
- 03

Invest in workforce excellence

Build supervision, manageable caseloads, career & training pathways, and tools that remove friction. Reduce cognitive load and facilitate efficiencies.
- 04

Align policy with the model

Create portable credentialing, training and reimbursement pathways for high quality peer & paraprofessional work within integrated behavioral health/CoCM.

Design the system so every team member can contribute and make meaningful contributions.

Get in touch:

Julian Mitton, MD MPH

Head of Clinical Operations, Era Supports

julian.mitton@erasupports.com

www.erasupports.com

Advancing collaborative care for substance use recovery



Collaborative Labs: Workforce

What workforce challenges are most limiting BHI scale today?

- Recruitment, retention, access, training, burnout, financing, supervision

Solutioning Together

- Introductions
- Biggest workforce gap
- Potential workforce solution (e.g., peers, CHWs, care managers, telepsychiatry, residency partnerships)
- One change needed to make it sustainable

HEALTHCARE LEADERSHIP SUMMIT 2026

THE STATE OF BEHAVIORAL HEALTH INTEGRATION

Coming Up At 2:30 p.m.



Pointe BC

Panel: Financing and Sustainability: The Road to Whole-Person Care, Whole-Person Payment

This session will explore how providers, payers and purchasers are advancing payment approaches that support integrated delivery, including value-based models and multi-payer strategies. Panelists will share real-world examples of how organizations are navigating the shift from fragmented reimbursement to more coordinated, accountable payment structures.

**HEALTHCARE
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Financing and Sustainability

The Road to Whole-Person Care, Whole-Person Payment

Pointe Salon BC, 2:30 – 3:30 p.m.

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SESSION SPEAKERS

Financing and Sustainability: The Road to Whole-Person Care, Whole-Person Payment



Chris Botts

American Medical
Association



Reshma Gupta

UC Davis Health



Lorin Scher

UC Davis Health



Caity Haas

Blue Shield of CA



Julia Logan

CalPERS



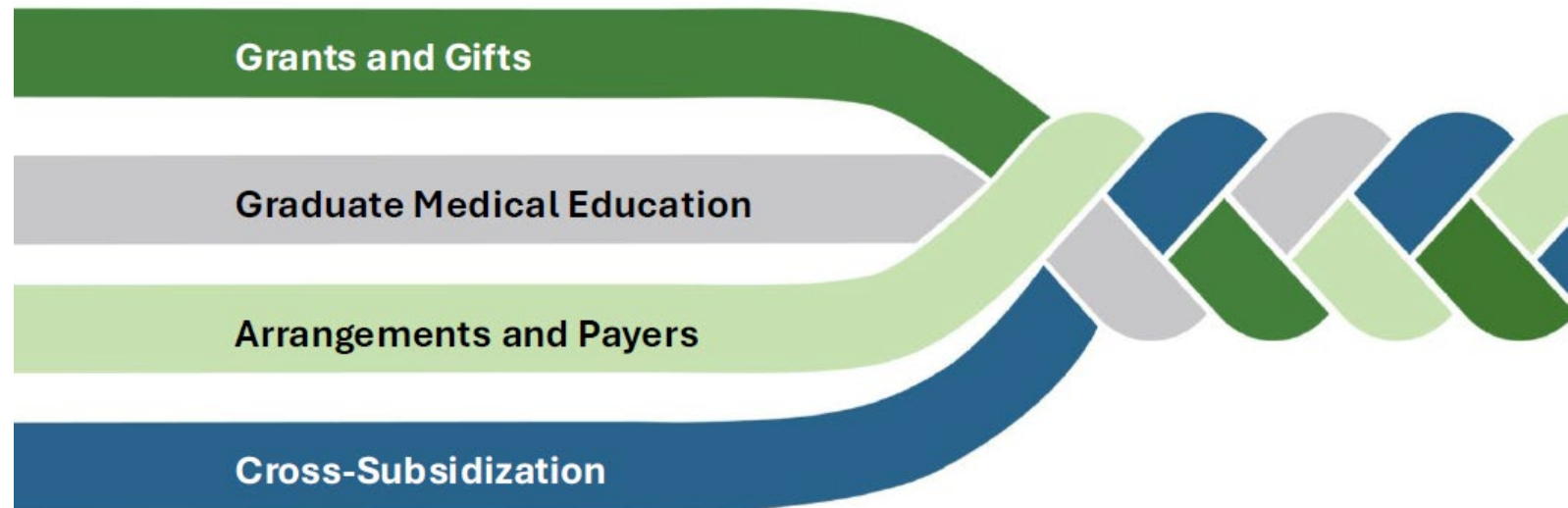
Financing & Sustainability: *The Road to Whole-Person Care, Whole Person Payment*

Chris Botts
Director, Value-Based Care
American Medical Association

September 17, 2026

Current State of BHI Financial “Sustainability”

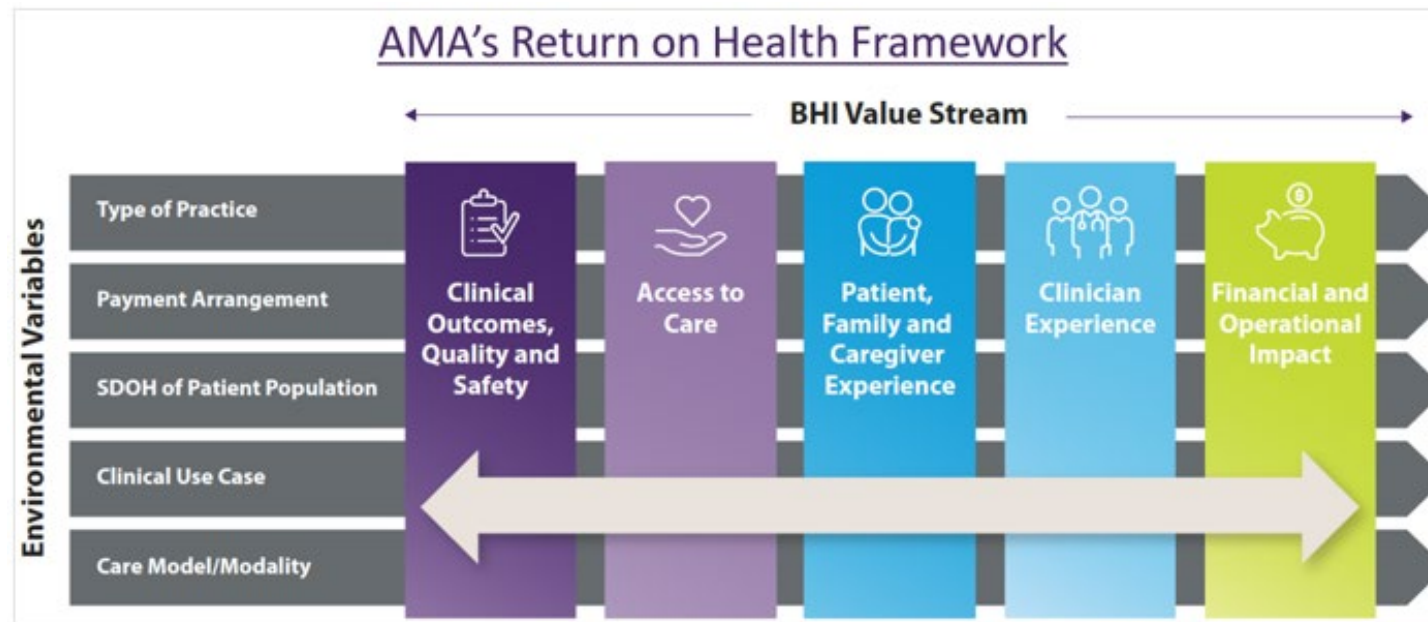
Organizations are attempting to combine diverse revenue streams to cover both billable and non-billable services while also navigating the possible transition from pure FFS to more value-based care arrangements



SOURCE: AHRQ Integration Academy; “IBH Financing Toolkit” ([link](#))

Defining & Demonstrating Value

Need to define what “value” looks like (and for who) and then work to align and operationalize the appropriate VBC arrangement accordingly.



SOURCE: AMA-Manatt Health; "Accelerating and Enhancing Behavioral Health Integration through Digitally Enabled Care: Opportunities and Challenges" ([link](#))

Overarching VBC Structure

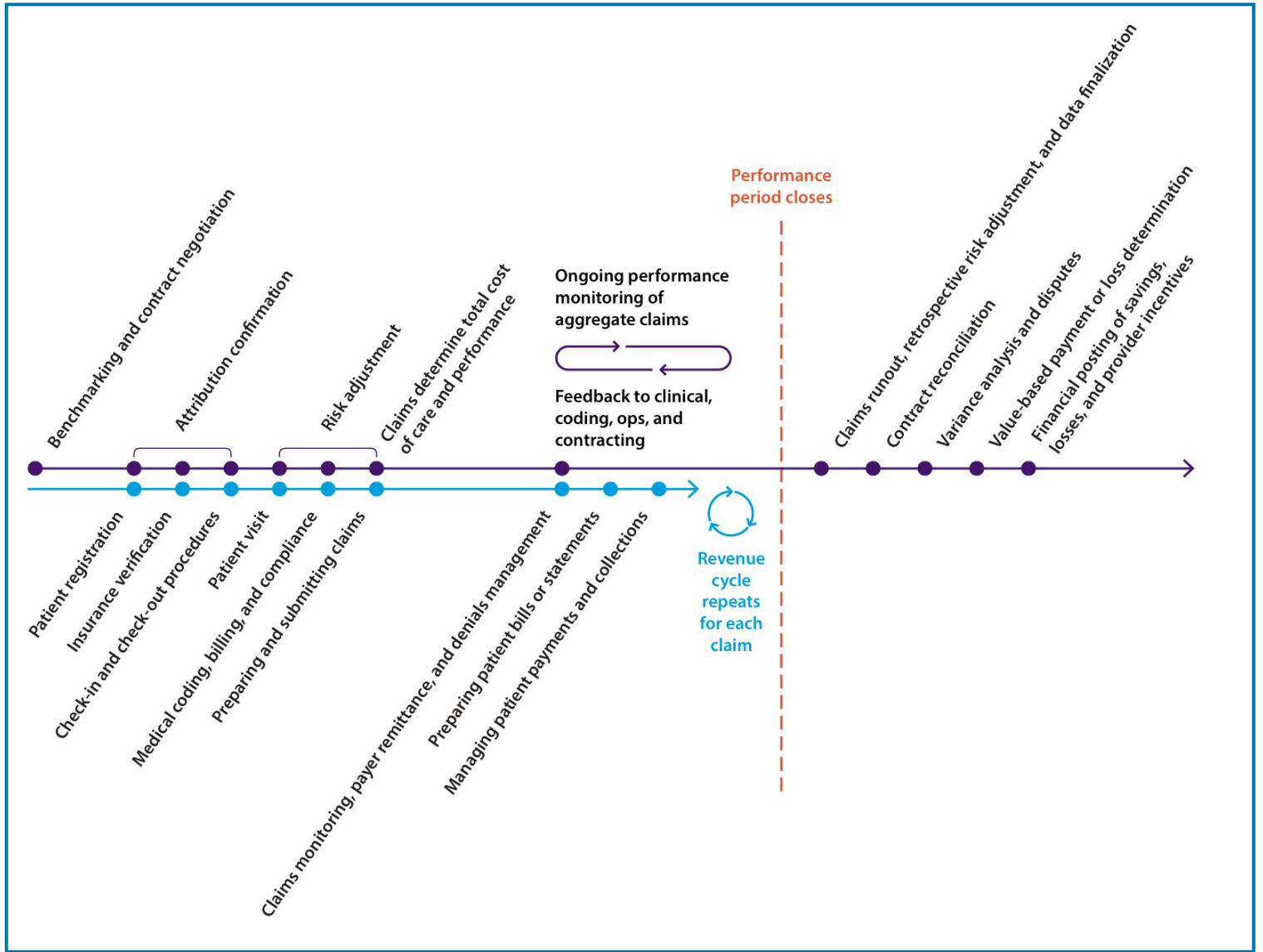
Care Delivery Transformation (and Patient Outcomes): Strength of alignment between BHI & VBC arrangements.

Payment Methodologies: Each arrangement incorporates a wide range of underlying payment methods, creating alignment issue (irrespective of BHI).

- Patient Attribution
- Benchmarking
- Risk Adjustment
- Quality Performance Evaluation & Impact on Payment
- Levels of Financial Risk
- Payment Timing & Accuracy
- Incentivizing for VBC Practice Participant Performance

More Unified RCM (Both FFS and VBC)

Increased opportunities for organizations to be compensated for achieving high-value outcomes at the patient and population level, rather than relying solely on volume of services.



SOURCE: AMA-LINUS Group; "A Physician's Guide to Effective Revenue Cycle Management for Value-Based Care" ([link](#))



Physicians' powerful ally in patient care

Bridging Psychiatry and Population Health

A UC Davis Partnership

Reshma Gupta, MD, MSHPM

Professor of Internal Medicine
Chief of Population Health & Accountable
Care, UC Davis Health
Population Health Leadership Team, UC
Office of the President

Lorin M. Scher, MD, FACLP

Professor & Vice-Chair, Psychiatry
Brophy Endowed Chair
Director, Integrated Behavioral Health
Services



UC Davis IBH Model

Structure Facilitates Partnerships

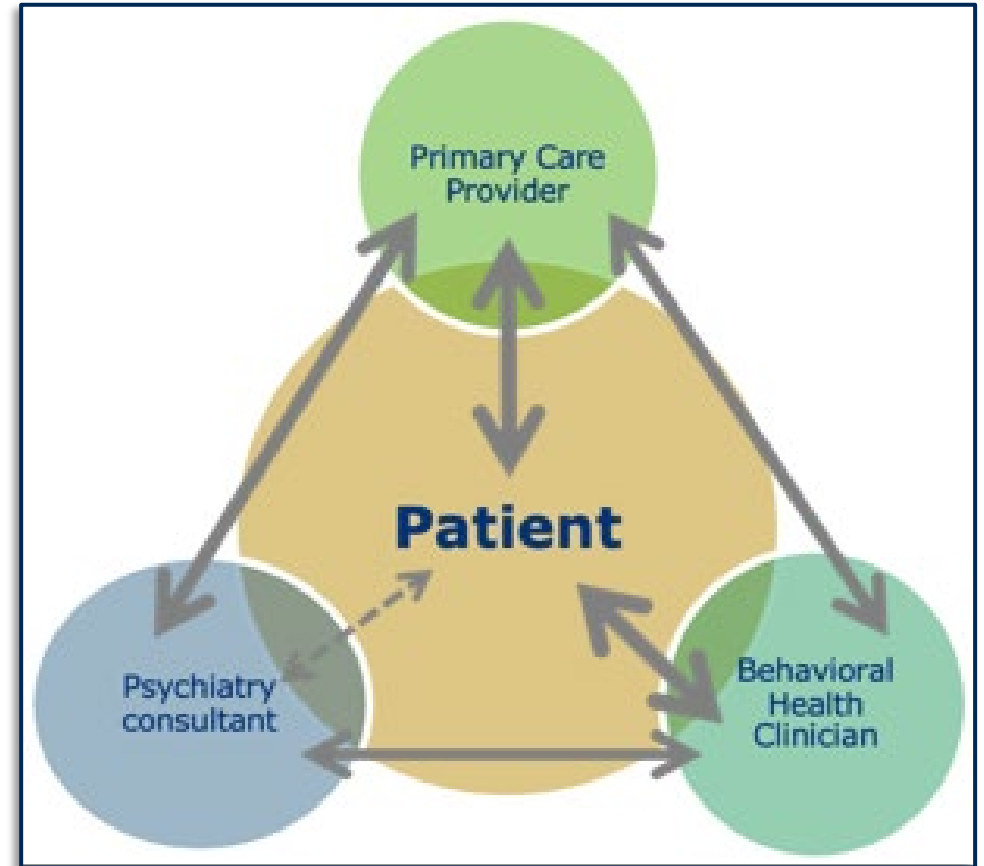


- ✓ PCP Engagement / Education
- ✓ Screening
- ✓ Psychiatry E-Consults
- ✓ Case Management
- ✓ Collaborative Care Model (CoCM)
- ✓ On-Site Psychiatry Consultation



Collaborative Care Model (CoCM)

- **Population Health Outcomes**
- **Reduces Total Cost of Care**
- **Provider Satisfaction and Productivity**
- **Patient Satisfaction**
- **Reduces Health Disparities & Stigma**



Unutzer 2002; Levine 2005; Areal 2005; Unutzer 2008; Bowen 2020; Hu 2020

Integrated Behavioral Health (IBH) Outcomes – Adult (2025-2026)

- **Access to Care**

- **35% of all new referrals** seen by IBH team

- **Depression Remission / Response**

- **70%** of all patients achieve a **response** to treatment within 12 weeks
 - Usual care is 19%
- **40%** of all patients are in **remission** within 12 weeks



Key Achievements w/ Increased new staffing model

Key Access Improvements:

- 40% increase in intakes over the past 2 years
- Patient visits doubled in the past 5 years
- 53% reduction in median lag time for new patients over the past 5 years

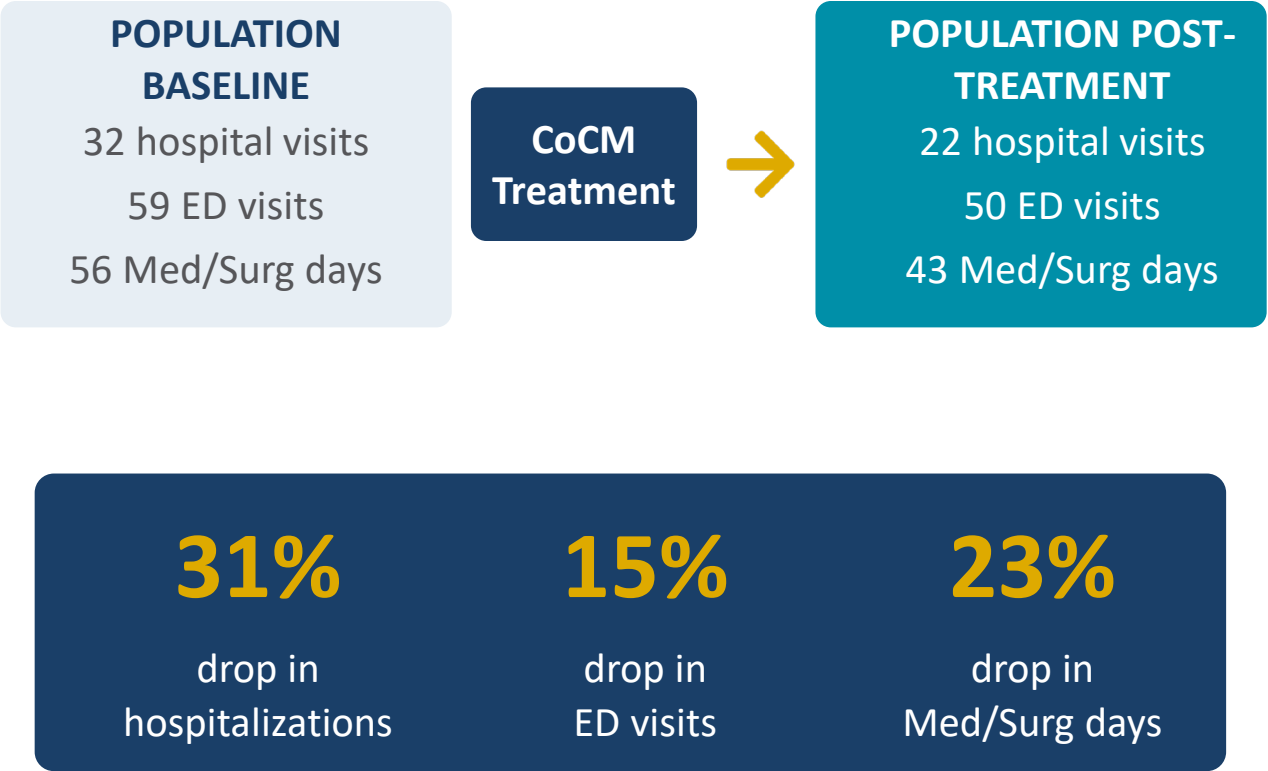
Population Health Focus

- Paired service expansion
- Screening; Treat-to-Target; Measurement-based care
- Tiered system of care



Hospital and Emergency Department Utilization

- 1 We reviewed all adult patients who completed Collaborative Care Model (CoCM) treatment between October 2022 and January 2024 (N=211). The average treatment duration was 143 days.
- 2 For each patient, we identified the 6-month period immediately prior to the start of treatment (baseline) and the 6-month period immediately following the treatment completion date.
- 3 We compared the ED and hospital utilization that occurred during each of these two time periods.



Financial Performance

1 Working with our Finance team, we identified key measures of cost related to avoidable ED visits and hospitalizations.

Measure	Definition
Avg Contribution Margin	(Payment for service) – (Variable cost of service)
Avg Net (Gain/Loss)	(Payment for service) – (Variable + fixed cost)

2 We calculated the potential cost savings for each visit avoided — comparing the CoCM population to a backfilled general-population patient (*trauma services excluded*).

\$26,900

CM (Non CoCMPatients)

–

\$17,110

CM (CoCM Patient)

= \$9,790

average cost differential per visit avoided

3 Cost Avoidance: visits avoided × average cost savings per visit = total estimated savings.

+ Billable Revenue + Value-based Care Contract Performance Revenue (Medicaid, Medicare, commercial)

\$100K

savings in contribution margin — this population

\$60K

savings in net gain (loss) — this population

\$400K

savings in contribution margin — if expanded

\$230K

savings in net gain (loss) — if expanded

Partnerships Required: What Makes Them Work



Rationale

- Population health scope is system-wide
- Focused beyond contract patients or primary care alone
- Outcomes help business & market strategy (payer, employer negotiations)



Relationships

- Integrated ties with operations & clinical leadership (prioritization, incentive bonuses)
- Finance partners to build the business case together
- Frequent meetings with executive leadership



Resources

- Integrated data model; access to analytics & dashboards
- Shared partnership in outlining evaluation
- Program management support
- Defined funding for incentive bonuses & recognition

Sustainability & value of partnership started as pilot



Scale & spread across organization with early results



Financial evaluation opened the flood gates



Integrated Care – the Critical Role of Health Plans

Caity Haas, LCSW, MHA

09/17/2026



WHY Health Plans should support Integrated Care

BOTTOM LINE

We are all impacted

We are all responsible



Better Health Outcomes

Proof point from AIMS



Lower Cost of Care

Proof point from AIMS



Patient & Provider Satisfaction

Proof point from AIMS



Increased Access

Proof point from AIMS



Stronger Support System

Proof point from AIMS

HOW Health Plans should support Integrated Care

Five Ways Health Plans Can Accelerate Collaborative Care Adoption

- 1** **ALIGN ACROSS PAYERS**
Providers need to be able to rely on their entire payer mix
- 2** **SUPPORT IMPLEMENTATION & SCALE**
Coordinate regular planning calls for resource mapping, financial planning and reporting & evaluation infrastructure. Provide technical support for EPIC builds. Be available for troubleshooting.
- 3** **DELIVER ONGOING OPERATIONAL SUPPORT**
Create a program with a consistent Point of Contact for billing/claims support and any questions.
- 4** **REMOVE ACCESS BARRIERS**
Increase access by removing member co-pays.
- 5** **CREATE SUSTAINABLE MODELS**
Increase co-pays, pay for performance and use incentives.

Change is needed across the board

GOVERNMENT

Ensure compliance with mandates that give specific, detailed requirements of plans and funding

PURCHASERS

Use RFPs to put pressure on plans to put resources toward supporting BHI

PAYERS

Deliver ongoing operational support, remove access barriers and support implementation

PROVIDERS

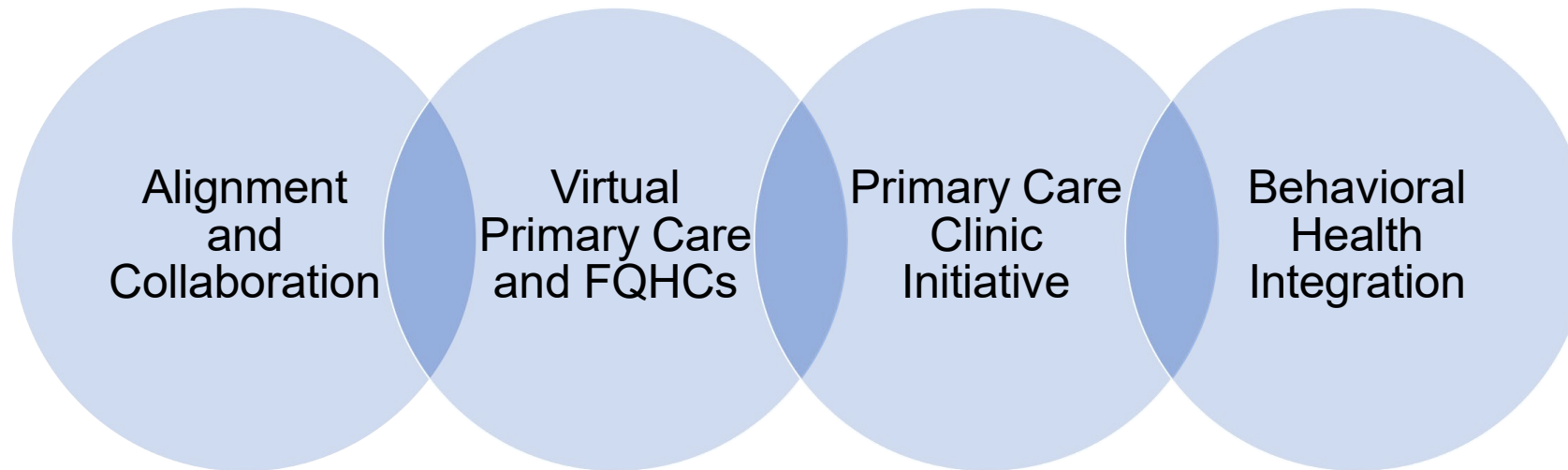
Implement and scale BHI models, standardize reporting, bill claims correctly

Creating Alignment and Incentives for Integrated Care

Julia Logan, MD
Chief Clinical Officer
CalPERS

Primary Care as the Principal Vehicle for

Transformation: *The Operating Model for Value*



Primary care: associated with better outcomes including lower mortality, improved member experience, equity, and lower costs.

Advancing Primary Care Access

Timely access to high-quality primary care is a challenge for our members

Key Goals

- Provide access to primary care
- Provide high-quality integrated primary care
- Disrupt problematic referral patterns

Solution



Partner with clinic vendor to establish high-quality primary care clinics for our members



Clinic vendor will staff and operate CalPERS-designated primary care clinics in access-challenged areas

Primary Care Clinics Initiative



Clinical Model

- Integrated Care including a designated behavioral health provider and shared medical record
- Same day access
- Accountability for engagement and outcomes, including financial “skin in the game”

HEALTHCARE LEADERSHIP SUMMIT 2026

THE STATE OF BEHAVIORAL HEALTH INTEGRATION

What is the biggest financing barrier your organization faces in sustaining BHI? Keep your response to 10 words or less

Data to prove the case

Not incorporating social work leadership!!

Not clear on how to bill effectively for services

Paying for WHO's

High patient deductibles

Carved out behavioral health.

Not getting paid

FQHC billing restrictions

Paying clinicians a competitive pay based on reimbursement rates

FQHC billing rules

Consistent reimbursement from all insurance plans

No way to bill.

→ Show responses

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HEALTHCARE LEADERSHIP SUMMIT 2026

THE STATE OF BEHAVIORAL HEALTH INTEGRATION

Closing Reflections

Pointe Salon BC, 3:40 – 4:00 p.m.

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October 15, 2026

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What is the biggest financing barrier your organization faces in sustaining BHI? Keep your response to 10 words or less

Responses can be up to 200 characters and will appear here.

You can group responses if you get more than 10.

Turn on voting so people can flag their favorite responses.

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What is the biggest challenge your organization faces in collecting, using and/or acting on data to drive improvement in integrated care?

Responses can be up to 200 characters and will appear here.

You can group responses if you get more than 10.

Turn on voting so people can flag their favorite responses.

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