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The Commonwealth Fund

Advancing Behavioral Health Integration in Community Health Centers:

POLICY PATHWAYS TO WHOLE-PERSON CARE

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 Abstract

Background

Behavioral health needs in the US continue to rise, while access to care remains limited, particularly for populations with limited access to health care. Community Health Centers (CHCs), serving approximately 52 million patients, are key access points for integrated behavioral health services, offering team-based, community-driven models that expand access, reduce stigma, and improve care coordination.

Objective

To examine how high-performing CHCs implement behavioral health integration and assess the policy and financing factors that shape these efforts.

Methods

Qualitative interviews were conducted with leaders from ten CHCs and six national policy experts in Medicaid, payment reform, and community-based care.

Results

CHCs employ flexible, hybrid integration models that embed behavioral health within primary care through co-location, shared records, and team-based care. Hybrid integration includes leveraging specific components of different models or frameworks as well as deploying integration workflows in-person and virtually. Warm handoffs and multidisciplinary teams improve access, reduce stigma, and enhance chronic disease management. Workforce shortages and community partnerships significantly influence implementation. Medicaid policies and reimbursement structures remain critical determinants of sustainability, with barriers including same-day billing restrictions and limited payment for care coordination.

Conclusions

Integrated models were associated with improvements in patient engagement, chronic disease management, and care continuity across sites. Although behavioral health integration in CHCs improves access and supports whole-person care, implementation is constrained by workforce and policy challenges. Policy reforms that expand reimbursement, remove billing restrictions, and invest in workforce and data infrastructure are essential to scaling integrated care nationwide.

Executive Summary

Behavioral health conditions are among the most pressing public health challenges facing the United States. Demand for behavioral health services has increased sharply in recent years, yet access to care remains limited for many communities, particularly for low-income populations, rural residents, and individuals experiencing social and economic instability. Health Centers, which serve an estimated 52 million patients nationwide, have emerged as a critical access point for behavioral health services in communities with limited access to health care.

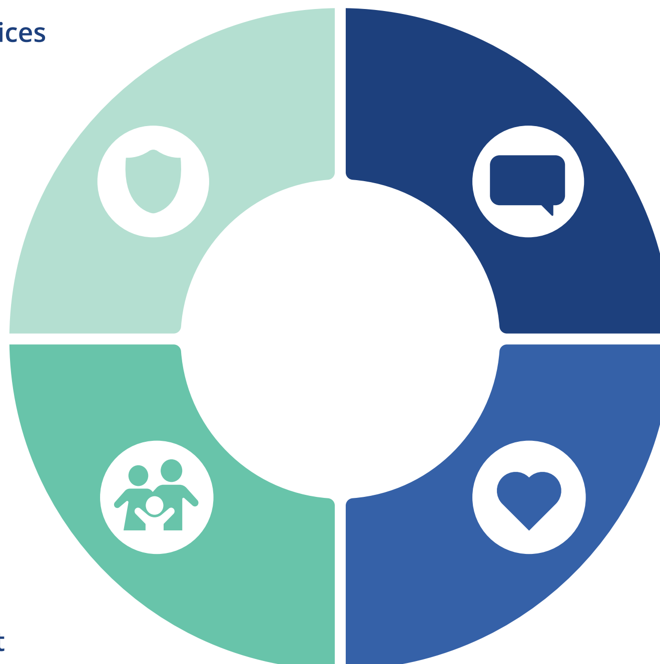
Behavioral health integration (BHI) is the systematic coordination of behavioral health and primary care services. BHI has become an increasingly central component of the CHC model of care. Integrating behavioral health within primary care settings improves access to treatment, reduces stigma associated with mental health services, and supports whole-person care for patients with complex medical and behavioral health needs.

With support from the Commonwealth Fund, the National Association of Community Health Centers (NACHC) conducted a qualitative study examining how leading health centers implement behavioral health integration and the policy environments shaping these efforts. The study included interviews with leaders from ten high-performing health centers from July to December 2025 and six national policy experts (January to February 2026) with experience in Medicaid policy, payment reform, and community-based health care delivery.

Key Findings

CHCs often mix and match elements of BHI integration models to fit their organizational structure and patient mix.

FIGURE 1. BEHAVIORAL HEALTH SERVICES COMMONLY OFFERED IN COMMUNITY HEALTH CENTERS



Across the health centers interviewed, behavioral health services are increasingly embedded within primary care teams through co-location of providers, shared electronic health records, and coordinated clinical workflows. Rather than adopting a single model, most organizations implement hybrid models intentionally combining elements from established frameworks such as the Primary Care Behavioral Health model, Collaborative Care Model, and Cherokee Health Systems model to fit their organizational structure, workforce capacity and patient population needs.

Integrated care teams typically include primary care providers, behavioral health clinicians, psychiatric consultants, care managers, and enabling services staff. Warm handoffs, where primary care providers introduce patients to behavioral health clinicians during the same visit, were widely identified as a defining feature of successful integration models, improving patient engagement and reducing barriers to treatment.

Integration expands access to care for populations with limited access to health care.

Embedding behavioral health services within primary care settings allows health centers to address mental health and substance use conditions earlier and more effectively. Integrated care reduces stigma and improves care continuity, particularly for populations who face significant barriers to accessing specialty behavioral health services. CHCs explained how integration is especially critical for children, adolescents and their families because behavioral health concerns often emerge during primary care visits rather than through specialty appointments. Integration within a trusted provider setting helps to reduce uncertainty by children and families who may be reluctant to seek care.

Several health centers reported improvements in patient engagement, chronic disease management, and functional outcomes when behavioral health services were incorporated into routine primary care. Integrated models also allow providers to address behavioral health conditions that contribute to poor management of chronic diseases such as diabetes, hypertension, and cardiovascular disease.

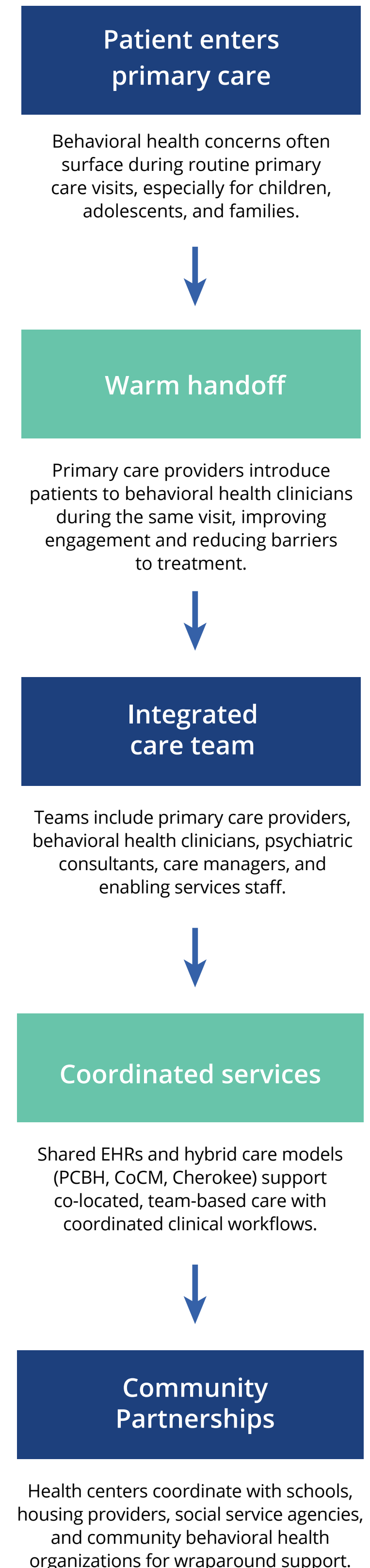
Workforce shortages and community partnerships shape integration strategies.

Workforce shortages, particularly in psychiatry and specialty behavioral health, remain one of the most significant barriers to expanding integrated care. Health centers are responding by adopting team-based care models that rely on licensed behavioral health clinicians, care managers, community health workers, and peer support specialists working alongside primary care providers.

Community partnerships also play a critical role in integration. Health centers frequently coordinate with community behavioral health organizations, schools, housing providers, and social service agencies to ensure patients receive comprehensive support beyond the clinical setting.

Components of BHI in CHCs

FIGURE 2. TYPICAL PATIENT PATHWAY THROUGH INTEGRATED BEHAVIORAL HEALTH CARE IN COMMUNITY HEALTH CENTERS



Policy and financing environments determine the sustainability of integrated care.

Medicaid policy, reimbursement structures, and regulatory environments strongly influence whether health centers can implement and sustain behavioral health integration. Payment policies that support team-based care such as telehealth coverage, flexible reimbursement structures, and care coordination payments, have helped some health centers expand integrated services.

However, significant policy barriers remain. Interviewees consistently identified same-day billing restrictions, inadequate reimbursement for team-based behavioral health activities, workforce regulatory barriers, and administrative documentation requirements as major obstacles to integration. In states where Medicaid policies limit reimbursement for behavioral health and primary care services provided during the same visit, health centers must separate services that are clinically designed to be delivered together.

Policy Priorities for Strengthening Behavioral Health Integration

The findings point to several opportunities for federal and state policymakers to strengthen behavioral health integration in CHCs.

First, policymakers should eliminate Medicaid billing restrictions that hinder health centers from delivering coordinated behavioral health and primary care services in a single visit. Removing same-day billing limitations would support warm handoffs and more efficient team-based care.

Payment models should better support the full scope of integrated care.

Second, payment models should better support the full scope of integrated care activities. Current reimbursement structures often prioritize formal psychotherapy visits, while failing to adequately reimburse the consultations, brief interventions, and care coordination activities that define effective integrated care. Greater state and provider education is needed to improve awareness and use of Medicaid and CHIP pathways for interprofessional consultation services.

Third, policymakers should strengthen behavioral health workforce pipelines by supporting interdisciplinary training programs, expanding flexible licensing policies, and investing in team-based care models that include behavioral health clinicians, community health workers, and peer specialists.

Fourth, sustained investment in health information technology and data infrastructure is needed to support integrated clinical workflows, improve care coordination, and strengthen community health management.

Implications for the U.S. Health System

CHCs provide a proven, scalable model for integrating behavioral health into primary care. By embedding behavioral health clinicians within multidisciplinary care teams and coordinating services across community partners, CHCs have demonstrated that integrated care can improve access, reduce stigma, and better address the complex needs of populations with limited access to care.

Strengthening behavioral health integration in CHCs represents a critical opportunity to expand access to mental health care, improve health care for all, and advance whole-person care across the U.S. health system.

Study Design and Methods

This study used a qualitative analysis design to examine how CHCs implement behavioral health integration and related care models, as well as the policy and operational factors shaping implementation. Qualitative interviews were selected as the primary data collection method because they allow for in-depth exploration of organizational strategies, implementation experiences, and policy perspectives that are not readily captured through quantitative data sources.

The study incorporated two complementary respondent groups: health center leaders and clinical staff responsible for implementing behavioral health integration, and national and state policy experts with knowledge of financing, regulatory environments, and health system innovation. Combining these perspectives allowed the study to examine both operational realities within CHCs and the broader policy context influencing program adoption and sustainability.

Health Center Sample and Recruitment

NACHC utilized the 2023 Uniform Data System (UDS) to identify Health Centers that were strong candidates for high levels of behavioral health integration. In addition, the team incorporated data from the Behavioral Health National Quality Leader (NQL) award badge, which is granted by HRSA based on a Health Center's performance on specific clinical quality measures. This badge served as the basis for an initial list of high-performing Health Centers. In 2023, five Health Centers received the Behavioral Health NQL badge.

To expand this list and develop a more comprehensive pool of potential interview candidates, the team identified the top five performing CHCs for two behavioral health-related clinical quality measures from the UDS, the Screening, Brief Intervention and Referral to Treatment (SBIRT) rate, the ratio of Medical to Behavioral Health Full-Time Equivalents (FTEs), and the ratio of Substance Use Disorder (SUD) to Mental Health FTEs.

These analyses yielded a total of 30 unique Health Centers. From this list, eight primary interview candidates were selected. To ensure geographic care for all and representation, one Health Center from Kansas and one from Florida that demonstrated excellence in behavioral health integration were added to round out the top 10. Participants included senior leadership and program staff directly involved in implementation, including:

- **Chief Executive Officers**
- **Chief Medical Officers**
- **Behavioral Health Directors**
- **Community Health leaders**
- **Program managers overseeing integrated care initiatives**

TABLE 1: CHARACTERISTICS OF PARTICIPATING COMMUNITY HEALTH CENTERS

Location	BH NQL	Health Center Name	State
Urban	Yes	GASTON FAMILY HEALTH SERVICES, INC. (Kintegra Health)*	NC
Rural	Yes	CHEROKEE HEALTH SYSTEMS (River Valley Health)*	TN
Rural	Yes	COMMUNITY CARE OF WEST VIRGINIA	WV
Rural	No	ATCHISON COMMUNITY HEALTH CLINIC (AllWays Community Health Center)*	KS
Urban	No	CHICAGO FAMILY HEALTH CENTER, INC.	IL
Urban	No	CITRUS HEALTH NETWORK, INC.	FL
Urban	No	FLORIDA ATLANTIC UNIVERSITY (FAU/NCHA)	FL
Urban	No	HIV/AIDS ALLIANCE FOR REGION TWO INC (Open Health Care Clinic)*	LA
Urban	No	HEART OF TEXAS COMMUNITY HEALTH CENTER, INC.	TX
Rural	No	PRIMARY HEALTH NETWORK	PA

**Note: Health center names in parentheses reflect the organization interviewed when different from the HRSA Uniform Data System reporting entity.*

Policy Interviews

Five additional interviews were conducted with national and state policy experts with experience in areas such as Medicaid policy, value-based payment models, behavioral health integration, and health center financing. These respondents were selected to provide insight into policy frameworks, payment mechanisms, and regulatory environments that influence CHC implementation strategies.

Data Collection

Interviews were conducted between June and November of 2025 by NACHC's research and policy teams. Each interview lasted approximately 60 to 90 minutes.

All interviews were conducted using a semi-structured interview guide, which included a combination of standardized questions and open-ended prompts designed to elicit detailed discussion of:

- **Organizational approaches to behavioral health integration**
- **Workforce models and staffing structures**
- **Financing and reimbursement mechanisms**
- **Technology and data infrastructure**
- **Partnerships with external organizations**
- **Implementation challenges and lessons learned**
- **Policy opportunities to support expansion and sustainability**

Separate but complementary interview guides were developed for CHC respondents and policy experts to reflect their respective perspectives. Interviews were conducted virtually using video conferencing platforms. With participant consent, interviews were documented through detailed notes and audio recordings to support accurate analysis.

Limitations and Future Exploration

As a qualitative study based on a purposive sample of interview participants, findings are not intended to be statistically representative of all CHCs nationally. Instead, the interviews provide detailed insights into implementation strategies, operational challenges, and policy environments experienced by selected organizations.

Additionally, the study relies on self-reported information from participants, which may reflect individual perspectives and organizational experiences. However, the inclusion of both CHC and policy expert interviews allowed for triangulation of perspectives and strengthened the interpretation of findings.

Despite these limitations, the interviews provide valuable insights into emerging models of behavioral health integration within CHCs and the policy conditions that support their implementation.

The State of Behavioral Health Integration in CHCs

Most CHCs now provide behavioral health services onsite, reflecting a decade-long shift toward whole-person, integrated care for underserved communities.

National Landscape

Behavioral health integration (BHI) has become a central component of care delivery within CHCs. Over the past decade, health centers have increasingly incorporated behavioral health services into primary care settings in response to growing demand for mental health and substance use disorder treatment, workforce shortages in specialty behavioral health care, and recognition of the strong relationship between behavioral health and chronic disease outcomes.[2]

CHCs are uniquely positioned to provide integrated behavioral health care because of their mission to deliver comprehensive, patient-centered services to medically underserved communities. Federally Qualified Health Centers operate under a model that emphasizes whole-person care, enabling services, and multidisciplinary care teams, which creates a strong foundation for integrating behavioral health into primary care settings[3]. As a result, most CHCs now provide some form of behavioral health services onsite or through coordinated referral networks.[4]

Several national trends have accelerated the adoption of behavioral health integration in CHCs. The prevalence of behavioral health conditions has increased nationally, particularly in the wake of the COVID-19 pandemic.[5] These needs are particularly pronounced among low-income populations, individuals experiencing housing instability, and communities facing structural barriers to care, each of which CHCs serve disproportionately.[6]

Expansion of telehealth services during the pandemic, including regulatory flexibilities and reimbursement changes, enabled CHCs to provide virtual counseling, psychiatric consultation, and medication management services using telehealth.[7]

Value-based care initiatives and alternative payment models have encouraged greater integration of behavioral health into primary care settings.[8] Programs such as Medicaid health homes, accountable care organizations, and other community health initiatives increasingly recognize the importance of addressing behavioral health conditions to improve overall health outcomes and reduce health care costs.[9] As a result, some health centers are participating in collaborative care models or other team-based approaches that include behavioral health consultation.[10]

Lastly, CHCs have increasingly incorporated behavioral health services into models that use care teams to address whole-person care and non-clinical factors of health. Behavioral health teams often work closely with community health workers, care coordinators, case managers, and other enabling services staff to address housing instability, food insecurity, transportation barriers, and other social needs that affect mental health and treatment adherence.[11]

Together, these trends reflect a broader shift toward integrated models of care in CHCs. Behavioral health integration has become a central component of care delivery within CHCs, reflecting growing evidence supporting collaborative care models and national efforts to integrate mental health and primary care services[12].

[2]: Heath B, Wise Romero P, and Reynolds K. A Standard Framework for Levels of Integrated Health care. Washington, D.C.SAMHSA-HRSA Center for Integrated Health Solutions. March 2013.
[3] Health Resources and Services Administration. (2023). Health center program requirements. U.S. Department of Health and Human Services. https://bphc.hrsa.gov
[4] Health Resources and Services Administration. (2023). 2022 Uniform Data System (UDS) national report. U.S. Department of Health and Human Services. https://bphc.hrsa.gov/data-reporting
[5] Czeisler MÉ , Lane RI, Petrosky E, et al. Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1049–1057. DOI: http://dx.doi.org/10.15585/mmwr.mm6932a1
[6] National Academies of Sciences, Engineering, and Medicine. (2017). Communities in action: Pathways to health equity. The National Academies Press. https://doi.org/10.17226/24624
[7] KFF. (2022). Changes in community health center patients and services during the COVID-19 pandemic. https://www.kff.org/medicaid/changes-in-community-health-center-patients-and-services-during-the-covid-19-pandemic/
[8] Centers for Medicare & Medicaid Services. (2024). Innovation Center strategy refresh. U.S. Department of Health and Human Services. https://innovation.cms.gov

Variation Across States and Policy Environments

While behavioral health integration has expanded across CHCs nationally, the scope, structure, and sustainability of these programs vary considerably across states. Differences in reimbursement structures, billing rules, and covered services can influence whether health centers are able to support co-located behavioral health staff, implement collaborative care models, or provide team-based behavioral health services within primary care settings[13]. For example, some states allow billing for same-day medical and behavioral health visits or reimburse collaborative care codes, while others maintain restrictions that limit integration. These policy differences contribute to substantial variation in how health centers design and sustain behavioral health programs.

[9] Centers for Medicare & Medicaid Services, Innovation Center Strategy Refresh (2024).
[10] Agency for Health care Research and Quality. (2023). Integration of behavioral health and primary care. U.S. Department of Health and Human Services. https://integrationacademy.ahrq.gov
[12] Peek CJ and the National Integration Academy Council. Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus. AHRQ Publication No.13-IP001-EF. Rockville, MD: Agency for Health care Research and Quality. 2013. Available at: http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf.
[13] Sabbatini, A. K., et al. (2022). Behavioral health integration in community health centers and its relationship to health care utilization. Psychiatric Services.
[14] Centers for Medicare & Medicaid Services. Innovation Center Strategy Refresh (2021).

Impact of Integration Across Patient Populations

Analysis of the interviews revealed a set of cross-cutting themes that describe how leading CHCs conceptualize, implement, and sustain behavioral health integration. While individual centers differed in size, geography, and patient populations, common patterns emerged across interviews related to integration models, implementation pathways, policy context, technology use, and observed outcomes.

Together, these themes illustrate how behavioral health integration is operationalized, highlighting both shared strategies and points of variation that reflect local context. The sections below synthesize these themes to describe prevailing approaches, enabling factors, and opportunities for continued advancement.

FIGURE 3. MAJOR THEMES EMERGING FROM HEALTH CENTER INTERVIEWS

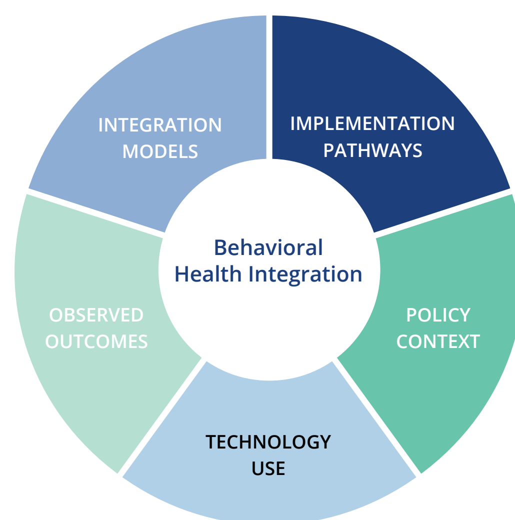


TABLE 2. CHARACTERISTICS OF INTERVIEWED HEALTH CENTERS AND BEHAVIORAL HEALTH INTEGRATION LEVELS

State	Rural/ Urban	Patient Count	Mental Health + SUD Total Visits	SAMHSA Level
NC	Urban	102,886	103,927	Integrated Level 6: Full Collaboration in a Transformed/ Merged Integrated Practice
TN	Rural	66,766	119,574	Integrated Level 6: Full Collaboration in a Transformed/ Merged Integrated Practice
WV	Rural	53,834	38,923	Co Located Level 4: Close Collaboration on Site with some System Integration
KS	Rural	3,657	2,331	Integrated Level 5: Close Collaboration Approaching an Integrated Practice
IL	Urban	28,816	13,308	Integrated Level 6: Full Collaboration in a Transformed/ Merged Integrated Practice
FL	Urban	29,552	151,700	Integrated Level 6: Full Collaboration in a Transformed/ Merged Integrated Practice
FL	Urban	1,283	2,209	Integrated Level 5: Close Collaboration Approaching an Integrated Practice
LA	Urban	14,125	11,128	Co Located Level 4: Close Collaboration on Site with some System Integration
TX	Urban	74,959	23,113	Integrated Level 6: Full Collaboration in a Transformed/ Merged Integrated Practice
PA	Rural	75,304	112,073	Integrated Level 5: Close Collaboration Approaching an Integrated Practice

Nearly all interviewees (n = 9) described intentional strategies to ensure integration of care models effectively serve diverse patient populations. CHC services are grounded in a community needs assessment, which helps organizations remain mission-driven and data-informed. To support equitable care, CHCs emphasized maintaining a workforce that reflects the communities served, ensuring robust ability for serving individuals with Limited English Proficiency, incorporating whole person care approaches into staff training, and leveraging community partnerships alongside Quality Improvement (QI) teams and task forces.

Three CHCs had mixed experiences regarding whether integration models or specific components of those models are effective across all patient populations. One CHC described their model as broadly effective, while two noted certain elements may require tailoring depending on the group. These differences may reflect the level of integration maturity.

The importance of integration of primary care and behavioral health was mentioned to better position health centers to address stigma, create safe, care for all environments for diverse populations, such as children and adolescents, immigrant communities and others. One health center described their integration model has led to an inclusive intake practice allowing for greater adaptability for various patient groups. Another interview highlighted how workforce shortages particularly among psychiatric specialists affected their model implementation specifically for providing integrated services for substance use disorders and severe mental illness care.

Ensuring Early Acess for Children and Adolescents

CHCs reported that behavioral health integration is especially critical for children and adolescents, who are increasingly presenting with conditions such as anxiety, depression, trauma-related symptoms, and behavioral disorders. Integrating behavioral health into pediatric and family medicine settings allows earlier identification through routine screening and timely intervention.

Integrated care models are especially valuable for young patients because behavioral health issues often emerge during primary care visits rather than through specialty services. Embedding behavioral health clinicians within pediatric care teams enables real-time consultation, brief interventions, and warm handoffs during the same visit. This approach improves access and engagement while reducing uncertainty by children and families who may be reluctant to seek care. Early intervention also supports better long-term outcomes by addressing behavioral, physical and developmental needs in a coordinated manner.

Several CHCs also extended their integrated care models through partnerships with schools, including school-based services, screening programs, or coordinated referral pathways. These partnerships help address common barriers to care such as transportation, scheduling constraints for working parents, and shortages of pediatric behavioral health specialists. By linking schools, families, and primary care providers, CHCs play a central role in supporting the mental health and developmental well-being of children and adolescents.

Steps to Equitable Behavioral Health Integration

Assess

Ground services in community needs assessments to stay mission-driven and data-informed across diverse populations.

Reflect

Build a workforce that reflects the communities served, with robust capacity for individuals with Limited English Proficiency.

Train

Incorporate whole-person care approaches into staff training alongside QI teams and community partnerships.

Integrate

Embed behavioral health into pediatric and family medicine teams for early screening, warm handoffs, and timely intervention.

Improving Outcomes for Adults with Chronic and Complex Conditions

Many patients receiving care at CHCs experience co-occurring physical and behavioral health conditions, including depression, anxiety, substance use disorders, and trauma-related conditions that complicate the management of chronic illnesses such as diabetes, hypertension, cardiovascular disease, and chronic pain. Interviewees emphasized that untreated behavioral health conditions can significantly affect a patient's ability to adhere to treatment plans, manage medications, attend appointments, and maintain lifestyle changes necessary for controlling chronic disease.

Untreated behavioral health conditions can significantly affect a patient's ability to adhere to treatment plans, manage medications, and attend appointments.

Health centers also described how integrated care models improve engagement among patients with complex health needs who frequently interact with the health care system. Behavioral health clinicians can support care coordination for patients with multiple conditions, assist with crisis management, and help stabilize patients who may otherwise rely on emergency departments or inpatient services. Interviewees reported that addressing behavioral health alongside physical health often leads to improvements in chronic disease management, increased patient engagement in care, and better overall functioning and quality of life for patients managing complex health conditions.

KEY FINDINGS

Untreated BH conditions affect:

- Treatment adherence
- Medication mgmt
- Appointment attendance
- Chronic disease control

INTEGRATED CARE REDUCES RELIANCE ON

Emergency departments

and inpatient services, by stabilizing patients earlier

OUTCOMES

- Improved chronic disease management
- Increased patient engagement in care
- Better overall functioning & quality of life

Enhancing Care for Individuals with Serious Mental Illness and Substance Use Disorders

CHCs also play a critical role in serving individuals with serious mental illness (SMI) and substance use disorders (SUD), populations that often face significant barriers to accessing coordinated medical and behavioral health care. Interviewees emphasized that integrating behavioral health within primary care settings helps address these gaps by providing a consistent point of entry into the health care system for individuals who may otherwise struggle to navigate specialty behavioral health services.

TABLE 3: BEHAVIORAL HEALTH SERVICE UTILIZATION AMONG PARTICIPATING HEALTH CENTERS

State	Rural/ Urban	Mental Health + SUD	SAMHSA Level	Alcohol-Related Disorders Visits	Other Substance Related Disorder Visits (Excluding Tobacco Use)	Anxiety disorder, including post-traumatic stress disorder visits (PTSD)
NC	Urban	103,927	Integrated Level 6	2382	5804	65339
TN	Rural	119,574	Integrated Level 6	14758	26710	116390
WV	Rural	38,923	Co Located Level 4:	3100	13982	45276
KS	Rural	2,331	Integrated Level 5	137	66	1260
IL	Urban	13,308	Integrated Level 6	895	1030	7368
FL	Urban	151,700	Integrated Level 6	5402	20191	46002
FL	Urban	2,209	Integrated Level 5	58	88	1172
LA	Urban	11,128	Co Located Level 4	490	1159	10388
TX	Urban	23,113	Integrated Level 6	1795	2350	21622
PA	Rural	112,073	Integrated Level 5	2055	2356	83169

**Note: Number of visits reported in 2024 Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS.*

At the same time, interviewees noted that many patients with SMI and complex substance use disorders require services beyond what can be provided within primary care settings alone. For these patients, partnerships with community mental health centers, inpatient psychiatric facilities, and substance use treatment programs are essential to ensure access to the full continuum of care. Health centers frequently coordinate referrals, share care plans, and support transitions between levels of care to help patients remain connected to primary care services. These coordinated approaches are particularly important for maintaining treatment stability, reducing hospitalizations, and supporting long-term recovery for individuals living with serious mental illness and substance use disorders.

Behavioral health screening is now part of routine prenatal and postpartum care.

Strengthening Support for Pregnant and Postpartum Patients

Several health centers described incorporating behavioral health screening into routine prenatal visits and postpartum check-ups, allowing care teams to detect symptoms of perinatal depression, anxiety, and trauma-related conditions. When concerns are identified, integrated care models enable immediate consultation with behavioral health clinicians through warm handoffs or coordinated follow-up appointments. Embedding behavioral health services within maternal health programs helps reduce stigma associated with seeking mental health care and increases the likelihood that patients engage in treatment.

Interviewees also emphasized the importance of coordinated care for pregnant and postpartum patients experiencing substance use disorders or other complex behavioral health needs. Integrated care teams may include obstetric providers, behavioral health clinicians, substance use specialists, and care managers who work together to support both maternal and infant health. In some health centers, these efforts extend beyond the clinic through partnerships with community programs that provide home visiting services, parenting support, and social services.

Adapting BHI for Rural Populations

Over half of the CHC interviewees reported adapting elements of their integration models based on rural versus urban settings, while four indicated that their model remains consistent across geographic settings. Adjustments most often include clinical workflows, scheduling and timing, and staff capacity, while core principles such as communication, and team-based coordination remained consistent across sites.

Differences in workforce and infrastructure drive many of these adaptations. Rural sites often operate with limited behavioral health staff and rely more heavily on cross-sector partnerships to address service gaps. In contrast, interviews highlight urban sites typically have access to larger provider networks and greater internal capacity to support integration.

Formal agreements like Memorandum of Understanding (MOUs) were consistently identified as key tools for establishing and maintaining partnerships. This reliance may be due to HRSA Health Center Program requirements or expectations to maintain collaborative arrangements.

Core principles such as communication and team-based coordination remained consistent across sites.

Interviews emphasized the importance of formal documentation when partnerships include information-sharing, referrals, or shared responsibilities. Agreements were also viewed as critical to ensure patients with limited access to health care can access necessary care without cost barriers.

CHC Implementation and Operationalization of Models

Interviews focused on understanding the adoption and application of four common models of service integration. The interviewed CHCs modeled their integration using the following: the Primary Care Behavioral Health (PCBH) model (n=7), Collaborative Care (CoCM) model (n=5), Chronic Care Model (CCM) (n=2) and the Cherokee Model (n=3). As health centers have varying levels of integration, which include coordination and co-location of primary care and behavioral health facilities and services, these interviews provide insight into the common elements CHCs adopt within their organizations.

TABLE 4: COMPARISON OF COMMON BEHAVIORAL HEALTH INTEGRATION MODELS USED BY CHCs

Model	Description	Key Staff	Key Conditions	Warm Handoffs
PCBH[14,15]	A team-based approach with an embedded Behavioral Health Consultant (BHC) and who is a core member of the primary care team.	BHC	BHC supports implementation of prevention, early detection and interventions across a health care site.	At initial screening, patient follow up as needed.
CoCM	Require Primary Care Providers (PCPs) to work with embedded Care Managers (CM) to provide evidence-based medication or treatments. Then, treatment plans are continued to be monitored and adjusted regularly by a consulting board-certified psychiatrist or a psychiatric nurse practitioner often located off-site.	PCP	Brief behavioral interventions and treatment support.	Not between PCP and Psychiatrist.
CCM[16]	A framework of six elements (community; health system; self-management support; delivery system design; decision support, and clinical information systems) to improve chronic care management across an organization.		The model can be used for a variety of chronic conditions and patient populations.	
Cherokee[17]	The Model embeds BHCs in primary care teams. PCPs screen all patients for mood and substance abuse disorders. Patients who screen positive for these conditions have their care co-managed with the BHC. The model focuses on roles rather than degrees or licenses and uses one shared electronic health record.	PCP BHC (self management and medication adherence)	The model conducts BH and SUD screenings for the entire patient population.	At initial screening, patient follow up and targeted interventions

[14]https://www.apa.org/health/behavioral-integration-fact-sheet
[15]https://doi.org/10.1007/s10880-017-9531-x
[16]https://www.act-center.org/application/files/1616/3511/6445/Model_Chronic_Care.pdf
[17]https://integrationacademy.ahrq.gov/expert-insight/success-stories/cherokee-health-systems

Participating CHCs implement hybrid, team-based BHI models that draw on these established frameworks. The ten CHCs select and combine elements from multiple models to fit the needs of their patient populations, workforce capacity, and local infrastructure. Rather than rigidly adhering to a single framework, most CHCs described their models as evolving and adaptable, reflecting the practical realities of patient demand, staffing constraints, and organizational priorities.

TABLE 5: BEHAVIORAL HEALTH INTEGRATION MODELS AND SAMHSA INTEGRATION LEVELS AMONG PARTICIPATING HEALTH CENTERS

State	Rural/ Urban	Site Coverage	Models	SAMHSA Level
NC	Urban	All Sites	PCBH	Integrated Level 6: Full Collaboration in a Transformed/ Merged Integrated Practice
TN	Rural	All Sites	PCBH Cherokee Model (Integrated PC and BH Model)	Integrated Level 6: Full Collaboration in a Transformed/ Merged Integrated Practice
WV	Rural	Some (Less than half) sites	CoCM CCM Other: Informal collaboration/ curb siding/consulation	Co Located Level 4: Close Collaboration on Site with some System Integration
KS	Rural	All Sites	CoCM Cherokee Model (Integrated PC and BH Model)	Integrated Level 5: Close Collaboration Approaching an Integrated Practice
IL	Urban	All Sites	PCBH	Integrated Level 6: Full Collaboration in a Transformed/ Merged Integrated Practice
FL	Urban	All Sites	Our integrated care approach is primarily modeled after the Cherokee Health Systems Model of Integrated care, incorporating some elements of the Primary Care Behavioral Health (PCBH) model to support team-based, population-focused behavioral health services within primary care.	Integrated Level 6: Full Collaboration in a Transformed/ Merged Integrated Practice We function as a unified system where behavioral health and primary care share care plans, workflows, and electronic health records; we engage in frequent and consistent team communication; we are co-located and our treatment plans are reviewed and co-signed by primary care providers to ensure alignment with overall health goals.
FL	Urban	All Sites	PCBH CoCM	Integrated Level 5: Close Collaboration Approaching an Integrated Practice
LA	Urban	All Sites	PCBH CoCM (Catalyst Program)	Co Located Level 4: Close Collaboration on Site with some System Integration
TX	Urban	All Sites	PCBH CCM	Integrated Level 6: Full Collaboration in a Transformed/ Merged Integrated Practice
PA	Rural	Most (more than half sites)	CoCM Other (not specified)	Integrated Level 5: Close Collaboration Approaching an Integrated Practice

Core Features of Integration

Across the ten CHCs, common features define effective integration.

- **Behavioral health clinicians** including LCSWs, psychologists, and psychiatrists are routinely embedded within primary care workflows, working alongside care managers, and enabling services staff, and primary care providers.
- **Co-location of behavioral and primary care providers** enables warm handoffs, where patients are introduced directly to a behavioral health clinician during the same visit, improving engagement, reducing stigma, and supporting timely intervention.
- **Shared electronic health records**, team-based care coordination and structured workflows allow multidisciplinary teams to address both behavioral and physical health needs within a single care episode.

These operational practices facilitate integrated care for complex patients and support community health management across CHCs' service area.

Implementation Pathways

CHCs described multiple approaches to implementing BHI, shaped by local context, leadership, workforce capacity, and financing conditions. Three common implementation pathways emerged:

- **Phased / Pilot-to-Scale Implementation (n = 6):** Most of the participating CHCs began with pilots targeting select sites, populations, or services and expanded over time. These pilots allowed teams to refine workflows, staffing models, and documentation processes as organizational capacity and reimbursement stabilized.
- **Incremental Organic Growth (n = 3):** Several CHCs gradually incorporated behavioral health services over multiple years, driven by workforce additions, leadership commitment, and iterative problem-solving rather than launching a formal pilot.
- **Early Comprehensive Adoption with Ongoing Refinement (n = 1):** One CHC implemented an integration model to address a comprehensive set of services at initiation, and has since focused on optimization, sustainability, and adaptation to the needs of patients and their organizational structure.

Across all pathways, CHCs highlighted the importance of clinical champions, executive leadership support, and continuous adaptation as essential enablers of successful integration.

FIGURE 4. COMMON PATHWAYS FOR BEHAVIORAL HEALTH INTEGRATION IMPLEMENTATION

Phased / Pilot-to-Scale Implementation (n = 6)

Began with pilots at select sites and expanded as workflows, staffing, and reimbursement stabilized.

Incremental Organic Growth (n = 3)

Gradually incorporated behavioral health services over multiple years through workforce additions and leadership commitment.

Early Comprehensive Adoption (n = 1)

Implemented a full integration model at launch, focusing since on optimization, sustainability, and ongoing refinement.

Operational Barriers and Adaptations

CHCs face a range of operational challenges that affect the implementation and sustainability of behavioral health integration. These barriers are multifaceted and arise from workforce limitations, infrastructure constraints, operational workflows, provider readiness, and policy or financing environments. These factors can constrain service delivery, particularly in settings with limited resources or complex patient needs.

- **Workforce capacity constraints:** A key operational challenge identified across CHCs includes workforce shortages. Limited availability of behavioral health specialists like psychiatrists, particularly in rural or smaller sites, restricts service capacity.
- **State-level policy and financing limitations:** Limited financial support, low reimbursement rates, and regulatory barriers compound operational challenges, hinder provider recruitment, retention, and sustainability of integrated care.
- **Care delivery and workflow adoption challenges:** Differences in documentation requirements and workflow between behavioral health and primary care staff require deliberate coordination. Interviewees discussed how behavioral health documentation takes longer than primary care. Workflow imbalance between therapists and other behavioral health professionals and primary care clinicians can also vary.
- **Staff readiness and training:** Providers' comfort with new practices, including routine behavioral health screening and asking sensitive questions, affects adoption and integration success.
- **Physical infrastructure limitations:** Space constraints including insufficient counseling rooms or shared workspaces can hinder co-location of behavioral health and primary care providers. This limitation can affect patient comfort and engagement, particularly for populations that may feel underserved. One interview described in some locations adding new providers may be limited by room availability. Such as when they added Licensed Professional Counselors (LPCs) for MAT/MOUD support in their CHC. Rural communities may face additional barriers like transportation.

One ongoing challenge is maintaining enough protected time and staffing for consistent warm handoff availability, but the embedded, team-based approach has been essential to making integration work."

Despite these challenges, CHCs sustain effective BHI by adapting workflows, optimizing space, leveraging technology, and building strong partnerships. These strategies enable CHCs to deliver coordinated, patient-centered care even in resource-constrained settings.

Leveraging Co-Location and Team-based Care

Co-location emerged as a central strategy for facilitating integration. In an urban CHC, behavioral health coordinators, psychiatric nurse practitioners, medical providers such as infectious disease, maternal-fetal medicine, and medication-assisted recovery programs are integrated into care management departments, tracking high-cost, high-utilizer patients and supporting real-time interdisciplinary care planning.

A rural health center relies on co-location combined with partnerships and telehealth to extend service reach, mitigating workforce and transportation limitations. Across these CHCs, co-location enables collaboration, warm handoffs, and a team-based workplace in which the focus shifts from individual disciplines to coordinated, patient centered care.

We've found some limitations with the model in practical application. The administrative and documentation requirements can be extensive and, at times, do not differ enough from traditional therapy to create the kind of scalability or efficiency the model aims for. For that reason, we primarily use a co-located model with a high degree of collaboration, allowing for flexibility and strong interdisciplinary teamwork without being bound to the strict parameters of the CoCM. This approach has proven both sustainable and effective across most of our sites."

Warm Handoffs

Warm handoffs emerged as one of the most frequently cited operational practices supporting behavioral health integration. Warm handoffs occur when a primary care provider introduces a patient directly to a behavioral health provider or case manager during the same visit, allowing for immediate engagement rather than a delayed referral. Warm handoffs may also be used as targeted strategies in follow up care, definitions vary across health CHCs. Interviewees consistently emphasized that this approach reduces barriers to behavioral health care, increases follow-through on referrals, and helps normalize behavioral health services as part of routine primary care.

Several health centers described warm handoffs as a routine part of clinical workflow when behavioral health needs arise during a primary care encounter. Several interviewees noted that warm handoffs reinforce a team-based delivery of care, where behavioral health providers, primary care clinicians, nurses, and support staff collaborate around the needs of the patient rather than operating in separate silos. Illustrating how these integrated patient visits differ from traditional behavioral health visits. As one clinician explained, integrated care shifts the focus from individual disciplines to coordinated patient care:

"We don't really see territory here, we see a clinic and a patient. We try to do a team approach to care."

"We don't really see territory here, we see a clinic and a patient. We try to do a team approach to care."

"We keep time open for same-day availability for warm handoffs with the medical providers."

Interviewees consistently described warm handoffs as one of the most practical and visible manifestations of behavioral health integration in day-to-day clinical practice. By enabling real-time collaboration between providers and reducing delays in accessing behavioral health services, warm handoffs help transform behavioral health from a referral-based service into a fully integrated component of primary care.

Community Partnerships as Integration Infrastructure

CHCs extend behavioral health integration beyond the clinic.

Across interviews, CHC leaders consistently described integration as a community-based ecosystem rather than a standalone clinical model. While services are often embedded within primary care teams, effective integration frequently requires coordination with external providers and community organizations. This may include community behavioral health agencies, public health departments, schools, housing organizations, food banks, and justice-system partners. Through referral networks, formal agreements, shared programs, and coordinated outreach efforts, CHCs extend the reach of integrated care into the broader community.

CHC leaders consistently described integration as a community-based ecosystem rather than a standalone clinical model.

Community partnerships play several important roles in behavioral health integration. First, they help address the continuum of care, particularly for patients who require specialized services such as intensive outpatient treatment, inpatient psychiatric care, or substance use disorder treatment. Second, partnerships connect patients with essential factors that influence health like housing assistance, transportation, food access programs, and employment services. Third, partnerships with schools, public health agencies, and community-based organizations help identify individuals who may not otherwise engage in care.

Interviewees emphasized that many of these partnerships are grounded in longstanding relationships that serve overlapping populations. In some cases, health centers provide clinical services directly within community settings such as homeless shelters or schools, while in others they coordinate care through referral agreements or collaborative programs. These arrangements reflect the broader mission of health centers to function as community-anchored institutions that address both medical and non-clinical factors of health.

Partnerships with Community Behavioral Health Providers

Partnerships with community behavioral health providers are a critical component for CHC integration. While many CHCs have expanded their internal behavioral health capacity, few are able to provide the full continuum of mental health and substance use disorder services within the primary care setting alone. As a result, many CHC interviewed rely on collaborative or referral relationships with community mental health centers, psychiatric hospitals, outpatient counseling programs, and substance use treatment providers to ensure that patients have access to appropriate levels of care.

These partnerships enable CHCs to manage mild to moderate behavioral health conditions within primary care while coordinating transitions to specialty services when needed. Ongoing communication, referral protocols, shared care planning, and hospitalization follow-up processes ensure continuity with primary care services.

In some cases, partnerships are more formalized through memoranda of understanding (MOUs), joint programs, or coordinated service delivery models. These collaborations facilitate warm handoffs between providers, shared case management, and coordinated outreach to patients with complex behavioral health needs. These collaborations expand local system capacity and are particularly important for patients with serious mental illness, co-occurring substance use disorders, or complex psychosocial needs extending the reach of integrated care beyond the CHC.

School-Based Linkages

Interviewees described a range of collaborative activities with schools, including providing

on-site behavioral health services, conducting screenings, and coordinating referrals between school staff and health center clinicians. In some communities, CHCs operate school-based or school-linked health programs that allow students to receive counseling, primary care, and behavioral health assessments within the school setting or through coordinated referral pathways to nearby health centers. These arrangements help reduce transportation challenges, parental work schedules, and stigma associated with seeking behavioral health treatment. School-based partnerships are particularly valuable in communities where children and adolescents face high levels of social and economic stress.

School partnerships also create opportunities for coordination among educators, school counselors, and health care providers. CHCs often work closely with school personnel to identify students experiencing behavioral health challenges, including anxiety, depression, whole person care, and substance use. Through these partnerships, CHCs can provide timely referrals and follow-up care while helping schools connect students and families with additional resources when needed.

FIGURE 5. KEY ELEMENTS OF CULTURALLY RESPONSIVE BEHAVIORAL HEALTH INTEGRATION

Multilingual & culturally representative staff

Hired to improve patient engagement across diverse communities

Whole-person care training

Extended to all staff — clinicians to front-desk

School partnerships reduce

- Transportation barriers
- Scheduling conflicts
- Stigma

Culturally Responsive and Community-Led Models

Some interviewed CHCs emphasized culturally responsive approaches to design behavioral health programs that are responsive to the communities they serve. Strategies often include hiring multilingual and culturally representative staff, engaging community organizations in program design, and adapting care delivery approaches that are accessible and welcoming to diverse populations. Multilingual and culturally competent staff improve patient engagement in behavioral health services. Several interviewees noted that multilingual providers are particularly important as behavioral health encounters can be challenging to conduct through interpretation alone.

Some health centers reported implementing whole person care approaches and designing clinical environments to foster trust, safety and comfort for patients. These efforts include training staff across all roles—from clinicians to front-desk personnel—to recognize the effects of whole person care and to provide consistent and respectful engagement with patients in all interactions. Many of the interviewed CHCs work closely with community-based organizations that have strong relationships with specific populations, including immigrant communities, Veterans, and homeless individuals. Creating welcoming clinical environments and fostering trust between patients and care teams were described as essential elements of effective behavioral health integration.

Workforce Models Supporting Behavioral Health Integration

Workforce capacity emerged as one of the most important determinants of successful behavioral health integration. As part of the HRSA Health Center Program, health center organizations are required to review their service area annually and to conduct a needs assessment of the current population every three years. These results are to inform and improve the delivery of services, making this national primary care network the most responsive to emerging patient needs. This evaluation tool allows CHCs to plan or adjust sites, services and staffing while also informing funding and financial strategies and decisions. All health center interviews were able to identify the most needed behavioral health service by population in their communities. The most frequent service types CHCs described were:

A high demand for pediatric and family outpatient behavioral health services. One urban provider noted community gaps to basic outpatient care and timely psychiatry appointments. Beyond therapy services, one rural provider described significant gaps in pediatric behavioral health, particularly in psychiatry, medication management, and services related to autism.

A major need is basic access to mental health providers to identify and diagnose previously unrecognized conditions. A few health centers identified high rates of depression, anxiety, bipolar disorder, and schizophrenia as a general population need but noted that some populations, such as individuals reentering the community from mental health facilities or jails may have very high rates of undiagnosed conditions.

A pressing need for individuals affected by substance use and overdose, intimate partner violence, and systemic challenges such as racism, homicide, and community violence. A rural CHC shared that there are also long wait times, often six months to a year, for substance use treatment beyond opioid-focused programs.

Team-Based and Interdisciplinary Care

Based on this data, nearly all interviews described behavioral health integration as a team-based model involving multiple disciplines working together rather than a single type of provider. Health centers explained how behavioral health clinicians, primary care providers, and support staff deliver coordinated, whole-person care.

Specialty referral models were not relied upon as often. Common disciplines mentioned included:

- **Primary care physicians, nurse practitioners, and physician assistants**
- **Psychiatrists and psychiatric nurse practitioners**
- **Psychologists**
- **Licensed clinical social workers, licensed marriage and family therapists, and licensed professional counselors**
- **Substance use health staff, community health workers and peer support specialists**
- **Behavioral health consultants**
- **Clinical Pharmacists**

TABLE 6: BEHAVIORAL HEALTH WORKFORCE AMONG PARTICIPATING HEALTH CENTERS

State	Rural/ Urban	Mental Health + SUD Total Visits	SAMHSA Level	Total BH FTEs	Psychiatrists	Licensed Clinical Psychologists	Licensed Clinical Social Workers
NC	Urban	103,927	Integrated Level 6	118.79	5,804	1	108.09
TN	Rural	119,574	Integrated Level 6	88.02	26,710	10.57	12.46
WV	Rural	38,923	Co Located Level 4	57.21	13,982	1.24	16.35
KS	Rural	2,331	Integrated Level 5	3.01	66	-	1.59
IL	Urban	13,308	Integrated Level 6	12.09	1,030	0.2	2.87
FL	Urban	151,700	Integrated Level 6	363.92	20,191	20.71	26.83
FL	Urban	2,209	Integrated Level 5	2.01	88	-	1
LA	Urban	11,128	Co Located Level 4	14.2	1,159	1	4.04
TX	Urban	23,113	Integrated Level 6	20.54	2,350	1	14.2
PA	Rural	112,073	Integrated Level 5	74.2	2,356	0.6	14.58

**Note: Number of FTEs reported in 2024 Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS.*

Some health centers described their ability to integrate into broader health and social service needs to strive towards whole-person care. These organizations included dental providers, nutritionists, optometrists and maternal health teams. These broader health services are an important opportunity for health center integration when these services are already co located within sites. **One urban health center utilizing both PCBH and CoCM shared,**

Dental services are also part of our integration model—patients are screened for dental needs, referred as appropriate, and educated on oral health as part of their behavioral health and overall wellness care.

Lastly CHCs also highlighted how operationalizing their model cannot be done without non-clinical staff like front desk, IT and informatic teams and billing and other operational roles. These team members largely support screening workflows, patient tracking and data collection, scheduling and follow-up to reduce patient adherence to care plans and reduce no-show rates.

Workforce Development and Training Pipelines

Several interviews highlighted that most behavioral health needs can be managed within primary care teams, with specialists reserved for higher-acuity cases. Illustrating the evolution of integration shifting from behavioral health as an added specialty service to strong primary care-based management. As one urban health center described:

> **"We found that most patients could be effectively treated by primary care teams, especially when supported by trained care managers, licensed social workers, and addiction medicine physicians, rather than relying on specialty psychiatry, which is limited and best preserved for higher-acuity cases. We also expanded our SDOH department, including licensed social workers and a Chief Impact Officer."**

Despite that all health centers interviewed acknowledged workforce shortages to have either impacted their organization's ability to implement or expand integration, several discussed focusing on providing integrated care training, education on team roles and responsibilities among other strategies to build a strong team infrastructure to meet the needs of their communities. Health Center leaders recognized that this training and education must occur when first implementing a model or piloting a model, providing ongoing education for all staff as well as onboarding for new employees. For example, two interviews explained,

> **"When we first implemented behavioral health integration, we built it directly into our behavioral health services rather than phasing it in or running a separate pilot. Starting around 2016, we developed the model within our outpatient behavioral health clinic and focused on educating both behavioral health and primary care providers about the integrated approach. Implementation involved a combination of staff education, provider engagement, and "selling in" the concept to ensure buy-in. Today, integration is fully embedded in our operations, and all new staff are introduced to the model as part of onboarding, making it the standard way we provide care."**

> **"We leverage team-based care to support behavioral health integration by fostering a culture of belonging and purpose among all staff members. We prioritize hiring individuals who align with our mission and take care to ensure every team member—clinical or support staff—feels valued and engaged in the care we provide. While our approach includes elements such as care managers, co-location, and shared treatment planning, a key strategy for success has been maintaining low staff turnover through strong organizational culture, consistent engagement from leadership, and active interaction with staff across all sites."**

One CHC interviewed had an advantage of being a Teaching Health Center as well as managing their own accredited training programs for psychology and psychiatry. This health center organization offers programming for: psychiatry residency, child & adolescent psychiatry residency, Doctoral psychology internships and post-Doctoral psychology residency. Health Center leaders acknowledged these opportunities have been essential to mitigate shortages.

As integrated care experience is highly valued by trainees, this health center is able educate clinicians earlier in their careers and capture the importance of the mission of health centers. This strong pipeline is trained with a community based primary care health center lens and often stay to become staff members. A key internal facilitator to this pipeline has been strong executive leadership which allowed the organization to prioritize staffing at each site and maintain embedded behavioral health providers despite broader staffing shortages.

Financing Behavioral Health Integration

As CHCs provide a wide range of primary health services, behavioral health and dental services, as well as diagnostic laboratory and radiology services, prenatal and perinatal care, cancer screenings, pediatric, emergency medical, pharmaceutical, patient case management, health education, and enabling services (e.g., outreach, transportation, and translation services) it is vital that health center be allowed to bill for the full scope of services they provide in a single patient visit. Unfortunately, six states have been identified by enacting policies that limit CHCs to either one encounter per patient per day (e.g., Indiana, Kentucky, New York, Utah) or up to two encounters per patient per day (e.g., California, Minnesota).

Interviews with national policy experts and leaders described how Medicaid same-day billing restrictions are a frequent obstacle for providers. This policy makes it harder for CHCs to offer coordinated care, do warm handoffs, or address multiple needs in one visit. Providers in these situations must choose which services to lose reimbursement for or navigate complex administrative workarounds which may discourage streamlined, whole-person care.

How to Potentially Influence Change on Same Day Billing

National policy experts and leaders emphasized that many stakeholders view same day billing policies as a major barrier to making integrated care feasible in Medicaid settings. The interviews suggested the following recommendations (if feasible based on available data) to help providers support policy changes.

Using real world data from states with flexibility on same-day billing vs states that do not provide flexibility.

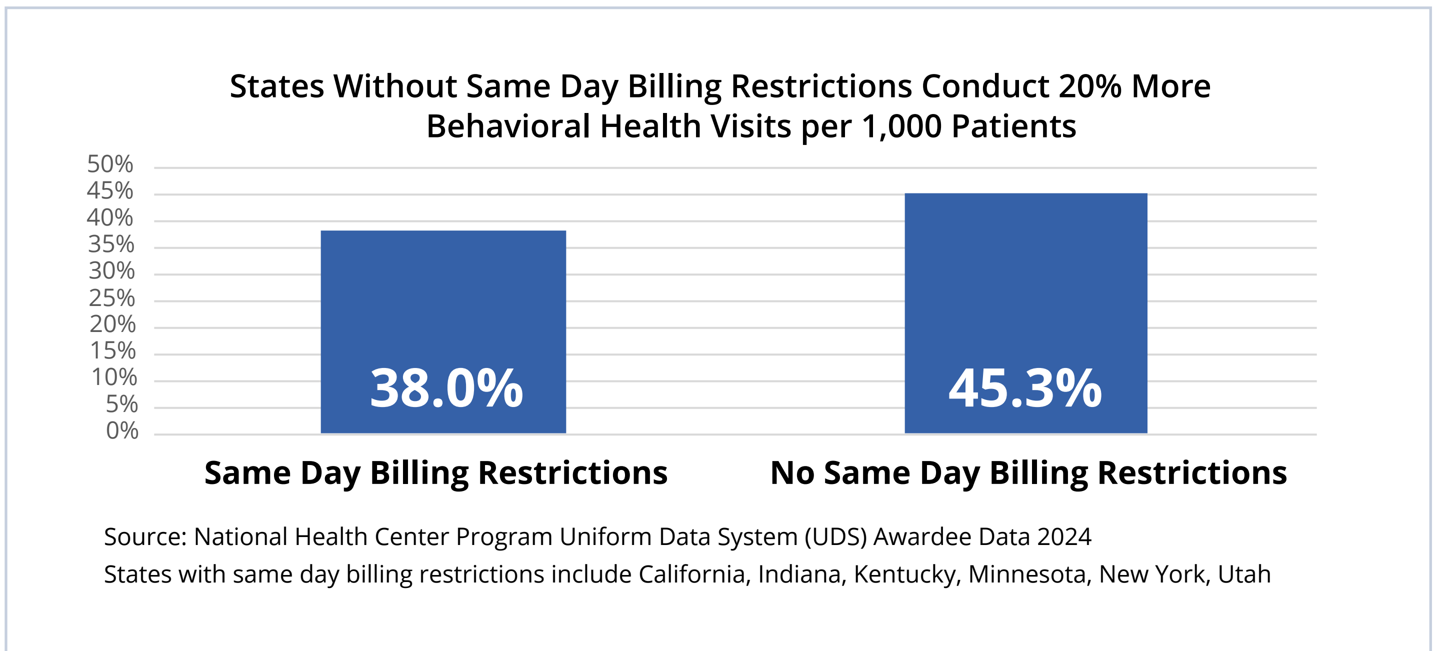
As data allows metrics that can be influential are same day visit utilization trends, no-show rates, completion of follow-up, wait times between referrals and behavioral health visit, clinical outcomes and patient experience. It would also be important to consider downstream costs like ED utilization for behavioral health needs, and total Medicaid spending per patient between these states.

Illustrating the financial impact on health centers by estimating revenue loss due to billing restrictions.

EHR data may be able to illustrate missed same-day billing opportunities. As well as the administrative burden with separate patient visits for providers and patients. Often multiple co-pays for Medicaid patients can become a financial barrier to receiving care.

Health centers located in states without same-day billing restrictions conducted approximately 45.3 behavioral health visits per 1,000 patients, compared with 38.0 visits per 1,000 patients in states that restrict same-day billing. This represents roughly a 20 percent higher volume of behavioral health visits in states where health centers can bill for behavioral health and medical services delivered during the same encounter.

This pattern is consistent with findings from interviews with CHC leaders and policy experts who described same-day billing limitations as a practical barrier to integrated care delivery. When reimbursement rules prevent providers from billing for both primary care and behavioral health services during the same visit, health centers must either schedule separate appointments or absorb unreimbursed services. In practice, these constraints can discourage warm handoffs and same-day behavioral health consultations, which are widely recognized as core components of effective behavioral health integration.



Source: National Health Center Program Uniform Data System (UDS) Awardee Data 2024
States with same day billing restrictions include California, Indiana, Kentucky, Minnesota, New York, Utah

PPS Modifications and Flexibilities

Two national policy organizations discussed how no single payment mechanism stands out as the most effective for supporting behavioral health integration. However, what might be the most effective is how CHCs can currently utilize their existing PPS/fee-for-service structure. Overall, most CHCs are still billing through FFS, while strengthening integration can help position CHCs toward value-based care models. These organizations noted the variation across states regarding the utilization of value-based care, care coordination payments, Per Member Per Month, hybrid payment models, and even global total-cost-of-care approaches can all be useful depending on the state's context and provider capacity.

One organization explained how the most sustainable integrated programs consistently use care coordination codes when those codes are reimbursable and when revenue cycle staff are trained to optimize them. For example, in the 2026 Medicare Physician Fee Schedule, CMS finalized three new optional add-con codes for Advance Primary Care Management services that would provide a complimentary behavioral health integration or CoCM service. From our CHCs sample these organizations are using a mix of tools with blended approaches to best achieve flexibility with financial stability.

TABLE 7: PRIMARY FUNDING AND PAYMENT MODELS WITHIN HEALTH CENTER INTERVIEW PARTICIPANTS

State	Rural/ Urban	Site Coverage	Models	SAMHSA Level	Primary Funding	Payment Models
NC	Urban	All Sites	PCBH	Integrated Level 6: Full Collaboration in a Transformed/ Merged Integrated Practice	Medicaid	1
TN	Rural	All Sites	PCBH Cherokee Model (Integrated PC and BH Model)	Integrated Level 6: Full Collaboration in a Transformed/ Merged Integrated Practice	State Agency FFS Medicaid Medicare 340B	Bundled Payment Value-Based Care
WV	Rural	Some (Less than half) sites	CoCM CCM Other: Informal collaboration/ curb siding/ consultation	Co Located Level 4: Close Collaboration on Site with some System Integration	FFS (WV Medicaid) Medicaid Medicare (Dual eligible patients with no copays)	Bundled Payment Value-Based Care While payment models have been somewhat helpful, they have proven to be more so a barrier. Coinsurance has been a barrier to engaging in models such as the Cherokee Model and/or CoCM.
KS	Rural	All Sites	CoCM Cherokee Model (Integrated PC and BH Model)	Integrated Level 5: Close Collaboration Approaching an Integrated Practice	FFS CCBHC Grant Medicaid Medicare 340B Other SAMHSA Grant	Other: FFS
IL	Urban	All Sites	PCBH	Integrated Level 6: Full Collaboration in a Transformed/ Merged Integrated Practice	FFS Other Federal Grant (330)	Other: p4p with certain MCOs plus FFS
FL	Urban	All Sites	Our integrated care approach is primarily modeled after the Cherokee Health Systems Model of Integrated care, incorporating some elements of the Primary Care Behavioral Health (PCBH) model to support team-based, population-focused behavioral health services within primary care.	Integrated Level 6: Full Collaboration in a Transformed/ Merged Integrated Practice We function as a unified system where behavioral health and primary care share care plans, workflows, and electronic health records; we engage in frequent and consistent team communication; we are co-located and our treatment plans are reviewed and co-signed by primary care providers to ensure alignment with overall health goals.	Fee for service CCBH Grant (one funding cycle) Medicaid Medicare 340B PCBI grant (one funding cycle) SAMHSA grant Funding for MAT program Low-income money pool	Value-based care, capitation Managed care contracts, marketplace

TABLE 7: PRIMARY FUNDING AND PAYMENT MODELS WITHIN HEALTH CENTER INTERVIEW PARTICIPANTS *(CONT.)*

State	Rural/ Urban	Site Coverage	Models	SAMHSA Level	Primary Funding	Payment Models
FL	Urban	All Sites	PCBH CoCM	Integrated Level 5: Close Collaboration Approaching an Integrated Practice	Medicaid Medicare	Bundled payments Sliding fee discount/ reduced fee scale for uninsured Third Party Commercial Payors
LA	Urban	All Sites	PCBH CoCM (Catalyst Program)	Co Located Level 4: Close Collaboration on Site with some System Integration	Fee for service Medicaid Promoting the Integration of Primary and Behavioral Health Care (PIPBHC) HRSA H8N Behavioral Health Services Expansion HRSA H8J Expanded Hours	Value-based care
TX	Urban	All Sites	PCBH CCM	Integrated Level 6: Full Collaboration in a Transformed/ Merged Integrated Practice	Fee for service Medicaid Medicare 340B HRSA Behavioral Health Services Expansion	Value-based care
PA	Rural	Most (more than half sites)	CoCM Other (not specified)	Integrated Level 5: Close Collaboration Approaching an Integrated Practice	FFS	Value-based care PPS Rates

TABLE 8: INSURANCE TYPE AMONG PARTICIPATING HEALTH CENTERS

State	Rural/ Urban	Total Patients	SAMHSA Level	Medicaid	Medicare	Uninsured	Private
NC	Urban	102886	Integrated Level 6	42235	14945	16326	29369
TN	Rural	66766	Integrated Level 6	25657	8644	16633	14876
WV	Rural	53834	Co Located Level 4	17824	9824	5123	21063
KS	Rural	3657	Integrated Level 5	736	415	1647	857
IL	Urban	28816	Integrated Level 6	20085	1497	4344	2890
FL	Urban	29552	Integrated Level 6	14866	3169	3919	6812
FL	Urban	1283	Integrated Level 5	267	151	569	296
LA	Urban	14125	Co Located Level 4	6240	875	4131	2879
TX	Urban	74959	Integrated Level 6	21895	9958	21495	20562
PA	Rural	75304	Integrated Level 5	28244	18291	4258	23638

**Note: Number of patients reported in 2024 Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS.*

Incorporating Technology and Artificial Intelligence in BHI

Technology infrastructure plays an important role in supporting behavioral health integration across CHCs, though the sophistication of digital tools varies widely across organizations. Across the interviews, health center leaders consistently described the electronic health record (EHR) as the foundational platform enabling collaboration between behavioral health and primary care providers. Most health centers reported using shared medical records that allow clinicians across disciplines to view patient histories, document encounters, and coordinate care within a single system.

At the same time, some interviewees described persistent challenges in achieving fully integrated information systems. For example, behavioral health documentation is sometimes partially segregated from primary care records due to privacy regulations or system limitations. One respondent described the difficulty of building truly integrated systems capable of supporting behavioral health and primary care workflows simultaneously:

> **“There still is a huge void…the technology needs to be developed to really manage a program like ours. We’re a fully integrated organization, but the technology still isn’t there.”**

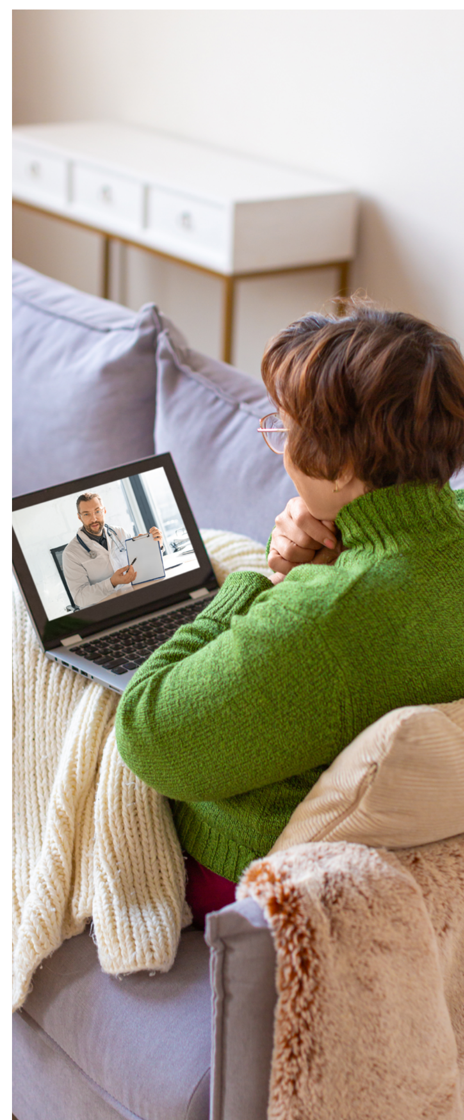
Telehealth and Technology-Enabled Care

Telehealth has become an important component of behavioral health service delivery in many health centers, particularly since the COVID-19 pandemic. Some health centers now offer behavioral health visits through video platforms or telephone encounters when patients are unable to attend in-person visits. One interviewee described how virtual visits allow patients to continue receiving counseling or medication management even when travel or scheduling barriers make clinic visits difficult:

> **“They have the opportunity to do a video visit if they cannot make it to the office.”**

Other CHCs described using telehealth to connect patients with remote behavioral health providers when on-site clinicians are unavailable. In some cases, telehealth supports virtual warm handoffs, allowing behavioral health clinicians to join primary care visits remotely.

> **“We were able to get Zoom screens in every exam room… so if someone needed a warm handoff we could immediately connect to that exam room and see the patient.”**



Health IT and Interoperability for Integrated Care

Although technology is widely recognized as an important enabler of behavioral health integration, interviewees consistently emphasized that existing systems still fall short of fully supporting integrated care models. Limitations in interoperability, data sharing, and workflow design often require health centers to develop workarounds or rely on manual coordination between providers.

Most CHCs (n = 8) described shared medical records, standardized screening tools, and documentation workflows that allow behavioral health and primary care staff to access patient information across disciplines, whereas only a few reported shared care plans, registries, or decision-support features.

Even when behavioral health and primary care providers use the same EHR platform, systems often require significant customization or internal effort to make information visible across disciplines. One CHC described how IT staff must invest substantial effort to enable even limited shared access between behavioral health and medical records:

There is no integration on an electronic health record level… whatever we have done… is because our IT staff has taken the time, not because the electronic health record companies are really doing it… Our IT staff has to move mountains just to give both sides minimal access so they can see the basic information for a patient.”

Data Analytics and Performance Measurement

Across interviews, CHCs reported (n = 5) a strong positive behavioral change among both clinical and non-clinical teams. A consistent theme across organizations was strengthened teamwork and collaboration. These workforce shifts were perceived to positively impact interactions with patients by fostering shared responsibility among providers and a deeper, mutual understanding of primary care and behavioral health roles.

Some CHCs noted that clinical staff became more comfortable engaging patients in sensitive conversations about behavioral health needs. This increased confidence enabled providers to effectively distinguish when patients would benefit from an integrated behavioral health support service versus a referral to specialty care. One urban CHC described how primary care physicians adopted the behavioral health techniques of motivational interviewing, into routine clinical visits. Additionally, behavioral health providers gained greater familiarity with primary care concepts, such as lab results and medication management that affect both physical and mental health. One interview shared that staff members began utilizing behavioral health services themselves more frequently.

Some CHCs (n = 2) were able to report patient outcomes and described a range of positive impacts that included measurable improvements in both physical and mental health, stronger chronic disease management (including control of diabetes, hypertension, and elevated cholesterol), high levels of patient satisfaction and meaningful improvements in patient’s daily functioning and quality of life. One CHC described how integrated behavioral health care services have helped patients manage anxiety effectively, allowing them to return to work or consistently engage in daily activities. Patients who previously struggled to leave their homes due to anxiety or fear were able to attend regular medical appointments.

Emerging Use of Artificial Intelligence

While artificial intelligence (AI) tools remain in the early stages of adoption within CHCs, a small number of interviewees reported experimenting with AI-enabled technologies designed to support clinical documentation and administrative workflows. These tools are primarily used to streamline note-taking and coding processes during patient visits. One health center described implementing AI-assisted documentation tools in primary care settings to improve efficiency and support clinical documentation:

> **“We’re currently using an AI tool that integrates with the provider’s documentation workflow... it helps streamline their notes and improves coding.”**

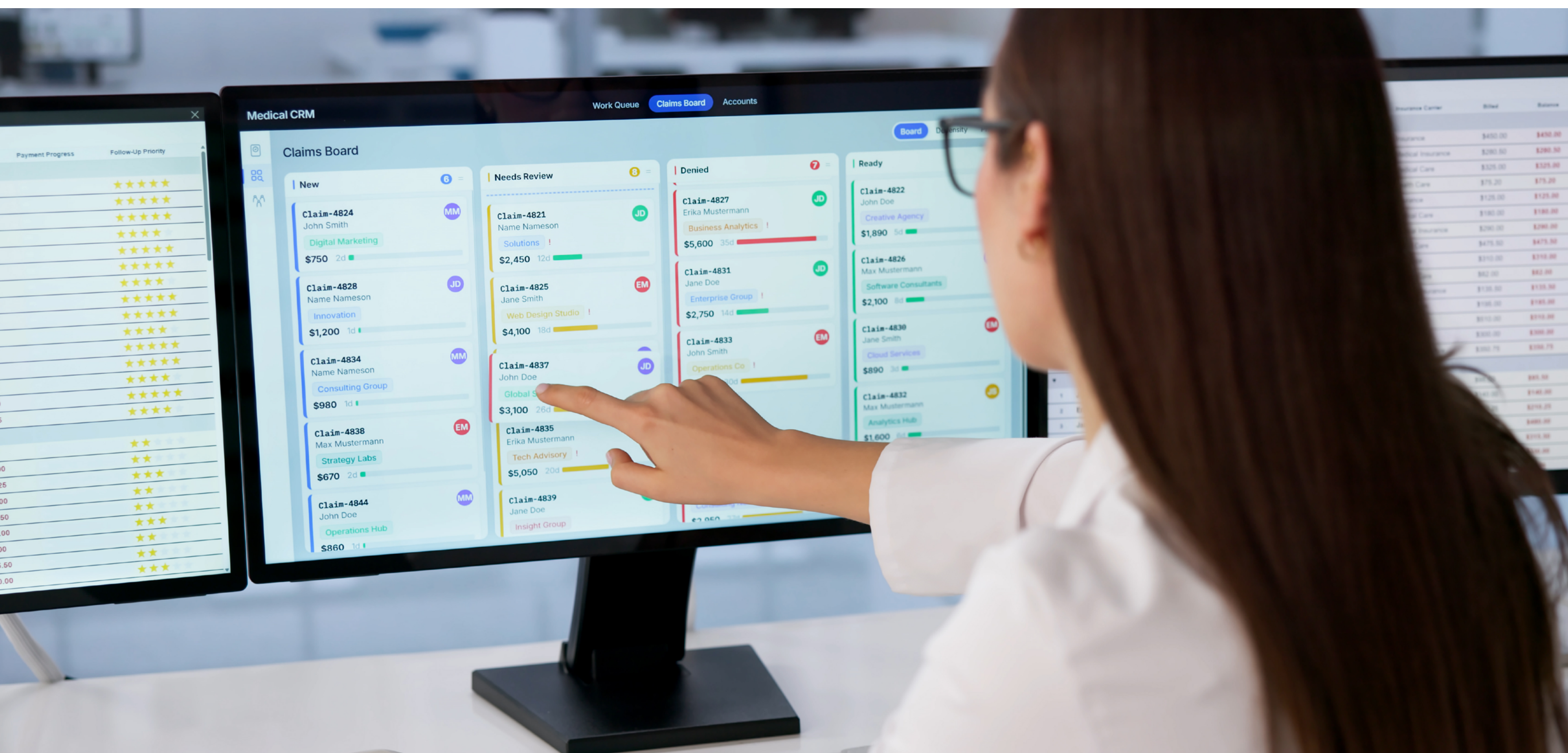
Privacy, Consent, and Data Governance

Privacy protections and consent requirements play a significant role in shaping how behavioral health information is documented and shared within integrated care environments. While CHCs widely support integrated models of care, interviewees noted that privacy regulations governing behavioral health and substance use disorder treatment can complicate efforts to maintain fully shared clinical records across care teams. As a result, many health centers must carefully balance the goals of coordinated care with legal and ethical obligations to protect sensitive patient information.

Several interviewees described the practical challenges associated with maintaining integrated records while complying with federal and state privacy rules, particularly those related to substance use disorder treatment. In some systems, behavioral health notes are partially segmented within the EHR or require additional consent before other providers can access them.

Interviewees also noted that consent procedures can add complexity to integrated care workflows. When behavioral health services involve substance use treatment or other protected information, health centers may need to obtain additional patient consent before sharing records with other members of the care team or with external partners. While these safeguards are critical for protecting patient privacy, they can slow information exchange and create administrative burdens for staff.

Interviewees emphasized that, even among these operational challenges, maintaining patient trust is essential to successful behavioral health care, and strong data governance frameworks and interoperability tools must maintain appropriate privacy protection. As behavioral health integration continues to expand, health centers will benefit from clearer regulatory guidance, improved EHR capabilities for managing consent and data sharing, and policies that support coordinated care while preserving patient confidentiality.



Administrative and Regulatory Barriers to Integration

Interview findings underscore that policy and reimbursement environments are decisive factors in whether and how CHCs can implement and sustain behavioral health integration. The most pervasive regulatory and policy barriers to behavioral health integration include:

- **Inadequate reimbursement rates (n = 7)**
- **Restrictions on billing for non-licensed or enabling staff (e.g., care managers, peers, or community health workers) (n = 6)**
- **Administrative and documentation requirements that increase burden without improving care delivery (n = 5) and**
- **Workforce-related policies such as licensing, supervision and scope of practice requirements (n=4)**

CHCs also cited documentation and compliance requirements that are misaligned with team-based care and disproportionately burdensome for behavioral health providers, creating workflow bottlenecks and limiting access. Workforce-related policies, particularly restrictive scope-of-practice and supervision requirements for psychiatric nurse practitioners and other clinicians, posed serious risks to service continuity. Across interviews, CHCs consistently reported that integration was enabled primarily through payment flexibility rather than prescriptive program mandates. These barriers and potential opportunities spread across Medicaid, Medicare and state policy environments.

Medicaid and Medicare

CHCs identified several persistent challenges within Medicaid and Medicare that limit the sustainability of integrated behavioral health services. The top cited challenge is the lack of reimbursement for the full range of activities that support integrated care. For example, psychologists in one CHC deliver consultations, care coordination, brief interventions, participate in team huddles and conduct warm handoffs services central to integration but are not reimbursable. CHCs may only receive reimbursement for a psychologists' services when a patient enters formal psychotherapy. Thus, creating a misalignment between payment policy and evidence-based models or care.

However, even when services are reimbursable, administrative requirements present additional hurdles for patients and their providers. Prior authorization requirements for therapy and crisis services were mentioned as an additional administrative burden and another factor that can delay important patient care. Co-pays and coinsurance within these insurance programs were also identified as deterrents that may discourage individuals and families from fully engaging in needed behavioral health services. As CHC's described the need for robust therapy services for their communities, there are reimbursement limitations for shorter therapy sessions and restrictions on billing therapy services to certain provider types which hinder flexibility in an interdisciplinary team-based care environment.

At the same time, CHC leaders acknowledge recent policy changes that support integration. Notably, the inclusion of Licensed Professional Counselors to bill Medicare and expanded policy support for telehealth services have represented meaningful progress. Continued alignment of reimbursement policy with integrated care delivery model will be essential to sustain and expand these efforts.

State Behavioral Health Integration Policy

State policy plays a central role in enabling, constraining, and shaping behavioral health integration within CHCs. Across interviews, health center leaders consistently emphasized that state-level decisions influence multiple aspects of care delivery, including patient access, covered services, same-day billing, and regulatory requirements.

State decisions regarding eligibility and benefits determine whether CHCs can deliver integrated services broadly or must limit them due to coverage gaps. Four CHCs interviewed were in Medicaid non-expansion states (TN, KS, FL and TX). This state decision created gaps for uninsured patients which health centers in these states had to navigate.

Conversely, states that have expanded coverage such as extending postpartum coverage, implemented new case management programs for children and pregnant women or allowing provisionally licensed behavioral health providers to practice have enabled CHCs to reach more members of their communities.

Payment policy is another critical factor in the financial sustainability of integration. As same day billing was discussed previously as a barrier for CHCs, some interviews described successful support efforts with state lawmakers to adopt same day billing to support patient care. In one state, promotion efforts with legislators and the governor helped address reimbursement barriers and push for coverage of services like intensive outpatient therapy. These changes have improved both care delivery and created a pathway to achieve financial stability to continuously leverage behavioral health providers within primary care.

State regulatory frameworks, including licensing and documentation, play a major role in shaping how integration is implemented. In some cases, CHC explained that the licensing and governing of licensed behavioral health centers or community mental health centers can allow CHCs to access certain behavioral health billing pathways or bring new regulatory requirements that can add extensive documentation which can make integration feasible or less feasible for CHCs. Another example described state-level scope-of-practice regulations for psychiatric mental health nurse practitioners, which require physician collaboration and can limit autonomous practice. In areas with workforce shortage, a policy like this can halt or significantly disrupt services. Lastly, local ordinances around harm reduction services or rules addressing homeless Individuals can also shape how a CHC delivers care.

CHCs reported that the most meaningful policy improvements occurred when state policymakers actively engaged with Primary Care Associations and health centers. Improvements in state CHC manuals, policies to streamline provider documentation, billing requirements and technology policies are opportunities to make a significant impact. Ongoing policy alignment will be necessary to sustain integration efforts and expand equitable access to behavioral health services across communities.

Policy Recommendations

Behavioral health integration is shaped not only by health care financing but also by a broader ecosystem of community and social policies at the local, state and federal levels. CHCs play a critical role in informing and advancing these policies through provider-led support and their real-world evidence. Given their frontline experience with the most diverse patient population, CHCs are uniquely positioned to identify policy gaps, practice informed solutions and drive meaningful changes for the whole health care system. The following recommendations outline key changes needed to strengthen and sustain behavioral health integration within CHCs.

Payment structures still largely treat behavioral health and primary care as separate services.

Federal Policy Priorities

Align CHC reimbursement policies with integrated, team-based care. Flexible reimbursement structures (PPS, encounter rates) and Section 330 funding can provide the financial stability needed to support behavioral health staff within interdisciplinary care teams. Several interviewees noted payment structures still largely treat behavioral health and primary care as separate services, creating challenges for organizations attempting to deliver fully integrated care. While CHCs are able to participate in the Medicare monthly care management programs, including BHI and CoCM, payment is not at parity with Medicare Part B in which CHC services are covered under. To advance access to behavioral health services, CMS should update by amending the Medicare physician fee schedule for the effective inclusion of CHCs to improve sustainability of and expand behavioral health integration in community-based, primary care. Additionally, there may be opportunities within the authority of CMS to expand and simplify billing for CoCM, PCBH and other models to support CHCs.

Stronger technical support for primary care practices to build capacity for behavioral health integration. With limited referral pathways due to provider shortages for behavioral health specialists and limited capacity at existing local mental health facilities and hospitals. CHCs can help to meet the demand but only with sustainable support from Congress and HRSA. Interviewees suggested that expanded workforce development programs and targeted funding for integrated care infrastructure would significantly strengthen the ability of CHCs to sustain and expand behavioral health integration nationally.

Expand and align Medicare and Medicaid recognition of reimbursable provider types. Under Medicare, CHC mental health visits are narrowly defined to include only a limited range of services, and Medicare regulations recognize only a narrow group of behavioral health clinicians. These services are limited to a psychiatric diagnostic evaluation (including medication services) provided by a mental health clinician and time-based therapy (including crisis therapy). Other practitioner groups can bill for services delivered by a broader range of staff as “auxiliary personnel” under “incident to” rule in the Medicare Physician Fee Schedule. However, CHCs do not have this flexibility as visits must include direct involvement from the billable CHC clinician to qualify for reimbursement. In the Medicaid program more behavioral health providers may be recognized by state agencies than the federal Medicare program to encourage integration, adding additional administrative complexity for CHCs.

Permanent authorization of telehealth flexibilities, including audio only, for behavioral health telehealth services. While ongoing extensions are valuable to CHC it is hard for providers to strategically plan for the long term to forecast financial plans. Currently the Medicare program reimburses CHC for telehealth medical visits at less than half the rate for in-person medical visits. Additional CMS policy considerations can include allowing integrated team members to deliver virtual services, clarify billing for telehealth across all provider types and ensure payment parity. Telehealth not only supports patient access to services but also supports CHCs that may not have onsite specialists, especially in rural and frontier communities.

State Actions

1

Remove Medicaid same-day billing restrictions. This core policy recommendation was repeatedly identified as foundational for integration, allowing warm handoffs, coordinated visits, and equitable valuation of behavioral and physical health services. This single state policy (legislative or regulatory) can enhance both care delivery and financial sustainability. This billing restriction must be eliminated across PPS, fee-for-service and managed care billing policies.

2

Align licensing and regulatory frameworks with integrated care models. Streamline provider licensing and documentation requirements that hinder integrated workflows Licensing for behavioral health providers can pose a challenge because most states have different licensing and governing entities for these provider types. Therefore, when a CHC wants to expand BH services, it can complicate integration. CHCs can play an important role in finding alignment across behavioral health and primary care reporting. Flexibility in state regulations such as the ability to hire provisionally licensed behavioral health providers and help to address workforce shortages and expand workforce development initiatives.

3

Encourage states to align policy and programs goals to support integration. States can set strategic direction across Medicaid, Departments of Health and other agencies addressing mental health services. One CHC described how there was a statewide push several years ago to promote the adoption of the Collaborative Care Model. State leadership and support made it easier for the CHC to align internally, secure buy-in, and build infrastructure around an evidence-based model. That focus provided momentum for the CHC to adopt collaborative care as one of their integration approaches. Governors, state Medicaid directors, state health and insurance commissioners along with state legislatures are in key leadership roles to align and advance integration.

Funding and Investment Priorities

State and federal funding streams are important for launching and expanding integration efforts. Sustaining behavioral health integration in CHCs often requires significant institutional investment beyond what is supported through traditional reimbursement. Interviewees emphasized that many of the core elements of integrated care, including embedding psychologists in primary care teams, supporting trainees, and coordinating care across providers, are not always directly reimbursed through existing payment structures.

Targeted federal and state funding streams (e.g., HRSA behavioral health grants, State Opioid Response funding, CARES grants) were critical for start-up and workforce expansion, though most CHCs emphasized that grant funding alone is insufficient for long-term sustainability.

Respondents also highlighted concerns about how behavioral health services are funded within the federally qualified health center system. These challenges point to the importance of sustained investment in workforce capacity, care coordination roles, and infrastructure that supports integrated care delivery. Nationally, CHCs have 18% uninsured rates , potentially facing high costs for uncompensated care. Limited funding for uninsured patients also can create major barriers for CHCs, because depending on the local prevalence of a lack of coverage can directly shape and even block the care pathways CHCs could offer.

In the context of H.R.1 and anticipated changes to Medicaid eligibility, enrollment and further program integrity initiatives the risk of coverage loss and increased administrative burden can destabilize CHC financial sustainability in the near and long term. Additionally, state responses to implement new requirements set by H.R. 1 may lead to shifts in payor mixes and reductions in Medicaid revenue placing additional pressure on delicate CHC integration models. Looking ahead, policymakers must urgently rethink beyond mechanisms to launch behavioral health services but rather how new investments can sustain ongoing operations and integration.

Grant funding alone is insufficient for long-term sustainability.

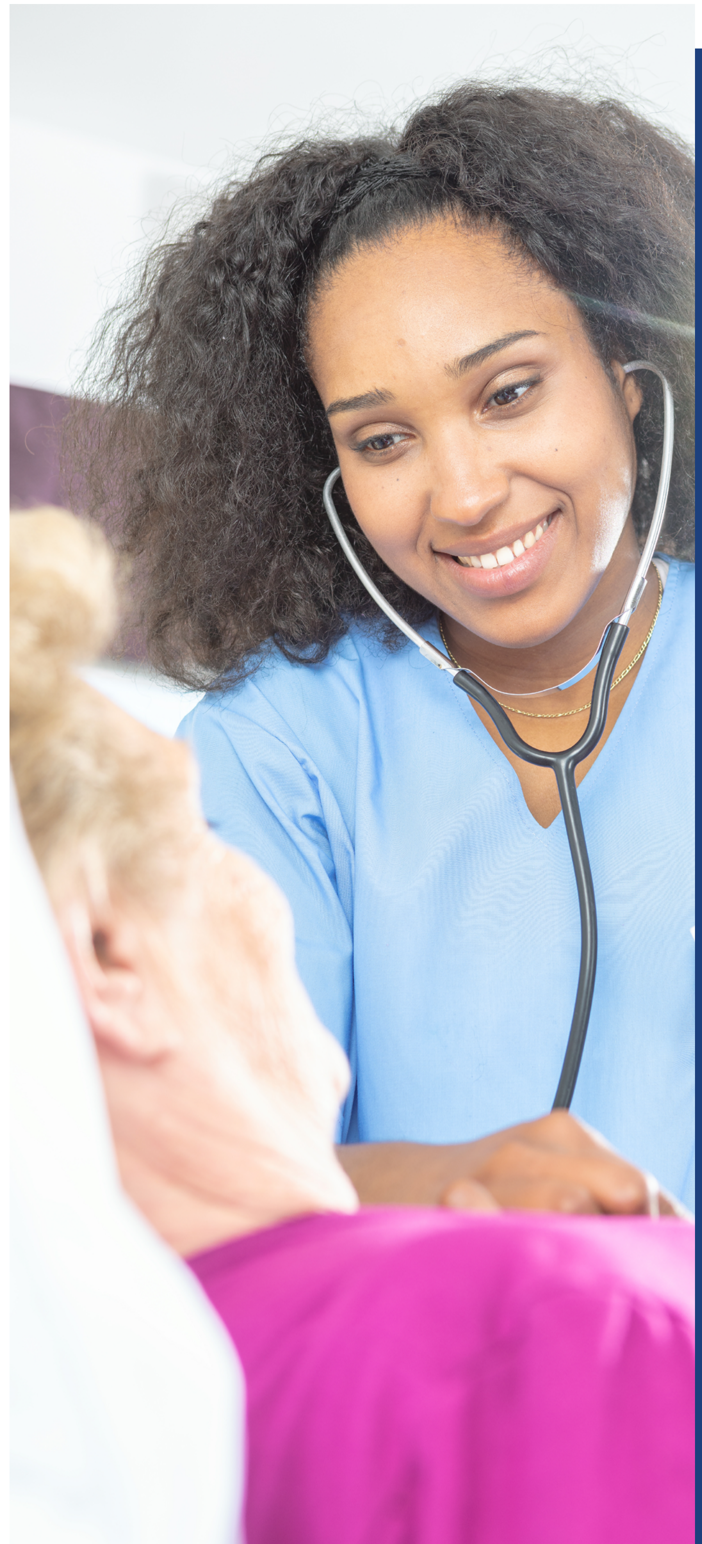
Implications for the U.S Health System

The experiences of CHCs offer important lessons for the broader U.S. health care system regarding the practical implementation of behavioral health integration. Unlike many health care organizations where behavioral health services remain siloed, CHCs have developed care models that integrate behavioral health into routine primary care workflows. These models are grounded in team-based care, co-location of services, behavioral health screening within primary care, and strong coordination between medical and behavioral health provider teams.

Across the interviews conducted for this study, health center leaders consistently emphasized that integration works best when behavioral health services are embedded directly within primary care settings rather than treated as a separate specialty service. Practices such as warm handoffs, shared care planning, and multidisciplinary care teams allow clinicians to address behavioral health needs in real time during primary care visits. This approach improves access to behavioral health services, as well as reducing stigma by normalizing behavioral health as part of overall health care.

The CHC model also demonstrates that integration does not require highly specialized infrastructure. Many health centers described starting with small teams, often a single behavioral health clinician embedded within a primary care clinic. Service integration was then expanded over time as demand and resources allowed. This incremental approach has enabled health centers to build sustainable integration models that are sensitive to local workforce availability, patient needs, and community partnerships.

These experiences suggest that behavioral health integration can be scaled across a variety of health care settings when organizations prioritize team-based care, flexible workforce models, and strong leadership support. The CHC model provides a practical blueprint for other primary care systems seeking to expand behavioral health capacity while improving coordination between medical and behavioral health services.



Conclusion

From Integration as Innovation to Integration as Standard Practice

The ten CHC and six policy interviews highlight both the complexity and the promise of integrating primary care and behavioral health services in community-based settings. Through interviews it is clear that no single model works in all contexts. Successful integration requires approaches that are tailored to each organization's unique circumstances and evolving needs. These insights point to distinct opportunities for funders and policymakers to strengthen CHC impacts. Targeted investments in care integration coupled with continued engagement with policymakers to ensure payment, workforce and regulatory policies reflect the realities of community-based care, are critical to sustainability and deepening integration efforts.

NACHC and Commonwealth's Ongoing Leadership Role

About The National Association of Community Health Centers

The National Association of Community Health Centers (NACHC) is the leading national membership organization dedicated to promoting Health Centers as the Employer, Provider, and Partner of choice in all communities and the foundation of the primary health care system in the United States. CHCs are the best and most innovative part of our nation's health system.

For sixty years, health centers have provided high-quality, comprehensive, and affordable primary and preventive care, as well as dental, behavioral health, pharmacy, vision, and other essential health services to America's most vulnerable, medically underserved patients in urban, rural, suburban, frontier, and island communities.

Today, health centers serve at least one in ten people and up to one in seven people at over 17,000 locations. This includes more than 6 million uninsured people, over 16 million Medicaid patients, over 3 million Medicare patients, and over 1.5 million homeless Individuals.

Appendix A:

INTERVIEWED HEALTH CENTERS

Location	Health Center Name	State	Integration	Models	SAMHSA Level
Urban	Gaston Family Health Services, Inc. (Kintegra Health)	NC	All Sites	PCBH	Integrated Level 6
Rural	Cherokee Health Systems (River Valley Health)	TN	All Sites	PCBH Cherokee Model (Integrated PC and BH Model)	Integrated Level 6
Rural	Community Care Of West Virginia	WV	Some (Less than half) sites	CoCM CCM Other: Informal collaboration/curb siding/consultation	Co Located Level 4
Rural	Atchison Community Health Clinic (Allways Community Health Center)	KS	All Sites	CoCM Cherokee Model (Integrated PC and BH Model)	Integrated Level 5
Urban	Chicago Family Health Center, Inc.	IL	All Sites	PCBH	Integrated Level 6
Urban	Citrus Health Network, Inc.	FL	All Sites	Their integrated care approach is primarily modeled after the Cherokee Health Systems Model, incorporating some elements of the PCBH model to support team-based, population-focused behavioral health services within primary care.	Integrated Level 6
Urban	Florida Atlantic University (Fau/Ncha)	FL	All Sites	PCBH CoCM	Integrated Level 5
Urban	HIV / AIDs Alliance For Region Two Inc. (Open Health Care Clinic)	LA	All Sites	PCBH CoCM (Catalyst Program)	Co Located Level 4
Urban	Heart Of Texas Community Health Center, Inc.	TX	All Sites	PCBH CCM	Integrated Level 6
Rural	Primary Health Network	PA	Most (more than half sites)	CoCM Other (not specified)	Integrated Level 5