

# **Behavioral Health Care Integration in Primary Care for Adults and Adolescents Sprint Learning Session #2**

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April 21, 2026

HealthChoices PCMH Learning Network

Suzanne Cohen, Senior Director of Population Health, Health Federation of Philadelphia

# Agenda

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1:00 – 1:10 p.m.	Welcome & Presentation of 2026 Sprint	Suzanne Cohen, Health Federation of Philadelphia
1:10 – 1:35 p.m.	Behavioral Health Integration: Best Practices and Lessons Learned	Joel McIntosh, Delaware Valley Community Health
1:35 – 2:20 p.m.	PCMH PDSA discussion	Laura Line, Health Federation of Philadelphia
2:20 – 2:30 p.m.	Sprint Timeline, Next Steps & Evaluation	Suzanne Cohen, Health Federation of Philadelphia

# Continuing Education Information

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In support of improving patient care, this activity has been planned and implemented by the University of Pittsburgh and The Jewish Healthcare Foundation. The University of Pittsburgh is jointly accredited by the **Accreditation Council for Continuing Medical Education (ACCME)** and **the American Nurses Credentialing Center (ANCC)**, to provide continuing education for the healthcare team. **1.5 hours are approved for this course.**

As a Jointly Accredited Organization, University of Pittsburgh is approved to offer social work continuing education by the **Association of Social Work Boards (ASWB)** Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. University of Pittsburgh maintains responsibility for this course. Social workers completing this course receive **1.5 continuing education credits.**

# Disclosures

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**No members** of the planning committee, speakers, presenters, authors, content reviewers and/or anyone else in a position to control the content of this education activity **have relevant financial relationships** with any entity producing, marketing, re-selling, or distributing health care goods or services, used on, or consumed by, patients **to disclose.**

# Disclaimer

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# The PCMH Learning Network

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*Designed to support the PCMHs and MCOs in:*

- ✓ Achieving the shared aims of the HealthChoices PCMH Program
- ✓ Identifying and acting on strategies in response to opportunities for improvement
- ✓ Developing an internal capacity to continuously learn, adapt, and improve

# Access today's slides online

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GO TO: [www.tomorrowshealthcare.org](http://www.tomorrowshealthcare.org)

**Your Login:** The email address you RSVP'd with  
**Your Password:** Welcome

*To get assistance or access for your colleagues:  
email J. at [ashenayi@jhf.org](mailto:ashenayi@jhf.org)*

# PCMH Online Community



*Keep track of upcoming sessions in "Events"* →

*Access session materials in "Learning Sessions" Including slides and webinar recording* ←

↑  
*Look for guides and tools in "Resources"*

# Learning Objectives for Today

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- ✓ Describe strategies that are effective in optimizing referral to and engagement with integrated behavioral health teams within primary care.
- ✓ Describe progress in planning quality improvement activities across participating PCMH practices.
- ✓ Identify potential approaches to implement quality improvement interventions.

# Behavioral Health Integration: Best Practices and Lessons Learned

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Joel McIntosh, LCSW, Director of Behavioral Health, Delaware Valley Community Health

# Integrating Behavioral Health Services: 3 Crucial components

- 1) Make it normal (Culture and Language)
- 2) Make it easy (Workflow and Access)
- 3) Make it visible and valuable

# Models of Integration: Integrated Practice Assessment Tool (IPAT)

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



# Make it easy.

- Closer physical proximity leads to closer collaboration
- Make it easy for Medical Providers to ask, and easy for BH Providers to say “Yes”
- Establish common language, especially when referring to BHCs
- Clear referral indicators (develops over time)
- Warm handoffs/Referrals: *“This just is how we do care here”*

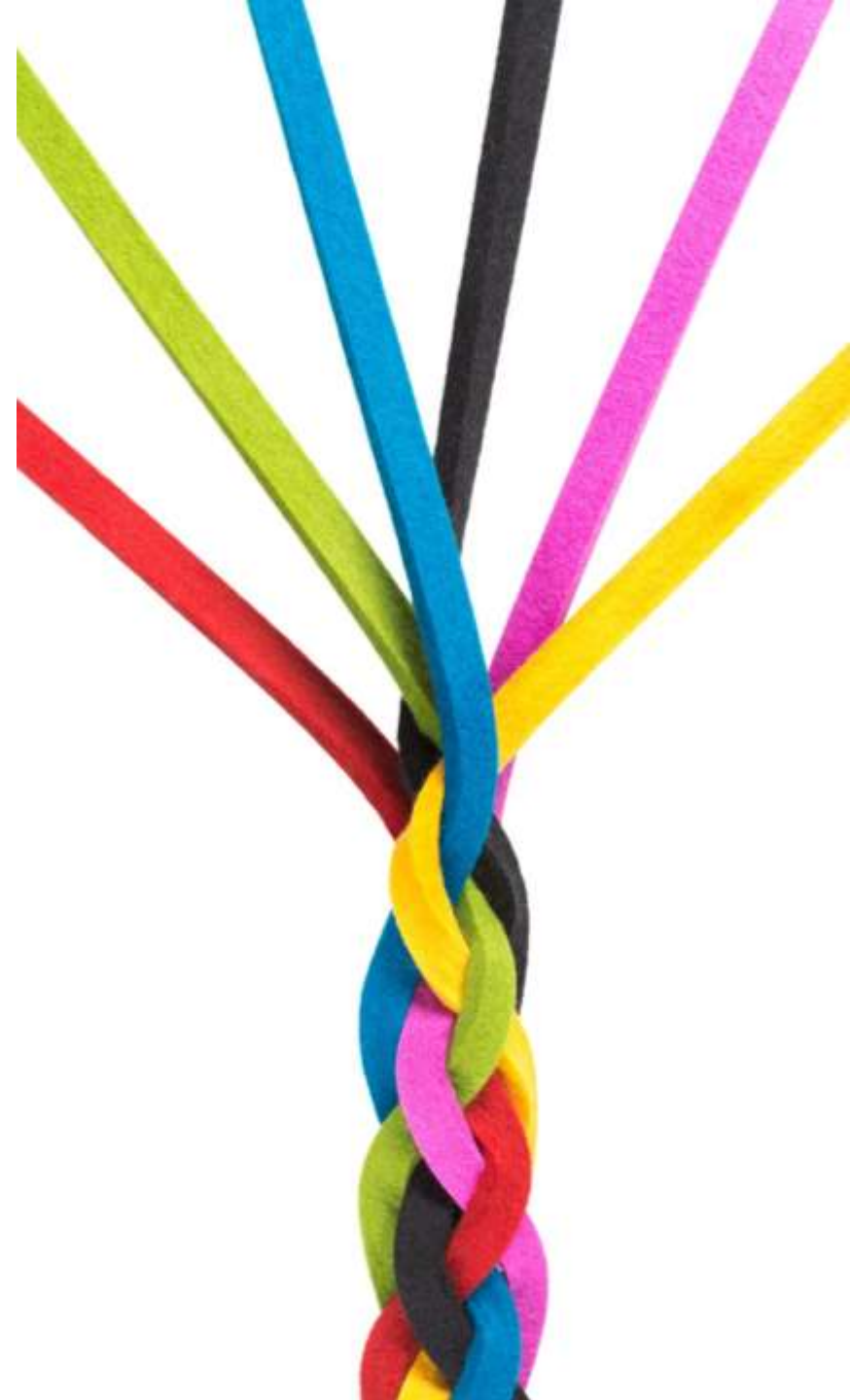


# Make it visible and valuable.

- Cross- pollination of cultures (care delivery and administrative)
- BHCs empowered to utilize their clinical expertise
- Routine pathways for communication and coordination
- High productivity: essential for model fidelity and financial sustainability.
- Success stories are shared often

# Make it normal.

- Culture shift: *“Not your patient or my patient-our patient”*
- Offering BHC services to patients is the norm
- BHC services: recommended with confidence and consistency.
- Leaders: understanding of the model and reinforce it.
- Support: Team connection, Joy and Psychological Safety.



Some common pain points...  
(ie. But what do we do about...?)



# Apprehensive medical staff



## Concerns:

- "I'm unclear of how to refer"
- "BHCs seem too busy/Not sure where to find them when I need them"
- "Not really sure what they do"
- "I forgot"
- "One more thing to do"
- "Didn't go well last time"

## Recommendations:

- Early inception, needs leader support
- Relationship building
- BH: Proactive, understands PCP burden
- Training AND follow-up reminders
- Provider champions/advisors
- Success stories & case reviews

# Unease about addressing MH concerns

## Concerns:

- "I don't know how to ask about mental health"
- "It might open pandora's box"
- "It's one more thing to do"
- "Mental health is not a PC issue"



## Recommendations:

- Consideration for recruitment
- Demystify the BH role/Empower BH as clinician
- Train your medical providers: BH competencies and pt care mgmt
- Not all/nothing
- Automated referral indicators (QI)

# Lack of role clarity

## Concerns:

- "Not really sure what a BHC does"
- BHC interventions deviate by BHC, and/or "drift" to therapy mode



## Recommendations:

- Define and understand your model (IPAT tool)
- Start with "bread and butter" areas
- Training, feedback, reinforcement
- BHCs: empowered and accountable
- Use it or lose it

# Resources:

- Integrated Practice Assessment Tool
- Free book (pdf format): Essentials for Treating Behavioral Health in Primary Care (CFHA.org)
- Sample Warm Handoff workflows
- Sample DVCH BHC Services flier
- How can a BHC help my patient? (BHC Treatment Objectives- for PCPs)



# Questions?

Contact:

Joel McIntosh

[mcintoshj@dvch.org](mailto:mcintoshj@dvch.org)

# PCMH PDSA Sharing

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# PCMH PDSA Sharing

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## PRACTICES

- AHN Primary Care Institute
- Berks Community Health Center
- CHOP
- Family First Health
- Family Practice Center
- PA Community Care Geisinger
- Pediatrics of NEPA
- Penn Medicine LGH Norlanco
- Public Health Management Corporation
- Tower Health – St. Christopher's Hospital for Children
- UPMC Central PA
- Wayne Memorial CHC
- Wright Center

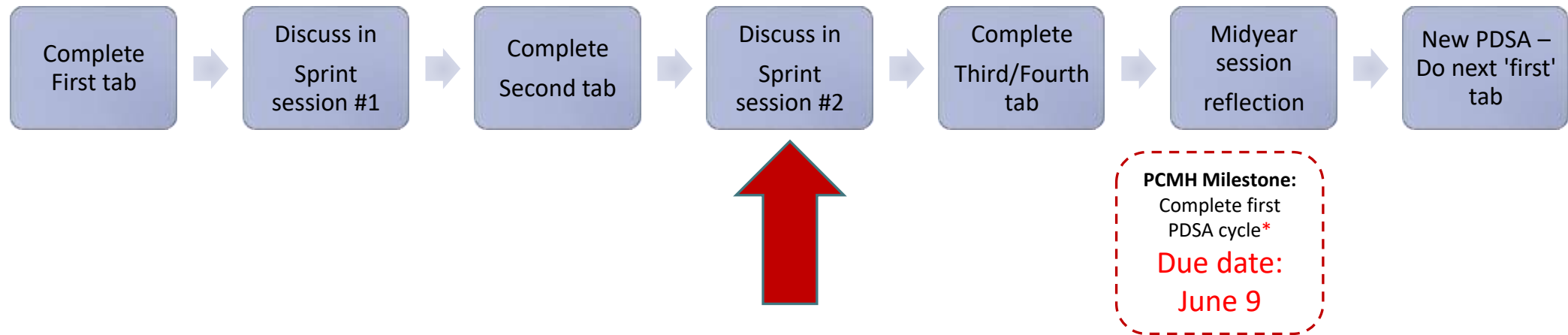
## QUESTIONS

- Describe the PDSA cycle goal
- Describe the specific intervention/approach and the steps the PCMH is taking to implement it
- How will you know this intervention/approach has taken hold
  - (in other words, what changes do you expect to see and how are you measuring these?)

# Sprint Timeline, Next Steps & Evaluation

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# PDSA Cycle One Wrap-Up



*\*If your PCMH does not reach the milestone or is at risk of not meeting the milestone, request TA from the PCMH Learning Network.*

*PDSA due dates are designed to prepare PCMHs for each session.*

A	B	C	D	E	F	G	H
1							
2	<b>PCMH Practice</b>	Enter PCMH Practice Name here	<b>Your contact Info</b>				
3	<b>Sprint</b>		<b>Name</b>				
4	<b>PDSA Submission by 2.27</b>	DUE: 2/27/2026	<b>Degree(s)</b>				
5			<b>Title</b>				
6	<b>Does the PCMH Learning Network have your PCMHs' approval to share this PDSA plan with your affiliated MCOs for alignment, coordination, and quality improvement purposes?</b>		<b>Organization</b>				
7			<b>Email Address</b>				
8			<b>Phone Number</b>				
9							
10							
11							
12							
13	<b>Problem Statement</b>	Please describe the problem that your team is working to improve and why this is important to your PCMH?					
14							
15	<b>QI Team</b>	Who on your team is assigned to improve this problem?					
16							
17	<b>Current Understanding</b>	Please describe your team's understanding of the current process and causes of the problem?					
18							

	A	B	C	D	E	F	G	H	I	J	K	L	M
19		<b>QI Goal</b>	What is your measurable goal to address this problem and improve the process?										
20													
21		<b>Proposed Change</b>	What are you planning to change in the process to achieve this goal?										
22													
23		<b>Measures to Track Change</b>	What measures are you planning to use to track whether the change was implemented as intended (e.g., a process measure) and whether this new process is moving towards your goal (e.g., an outcome measure)?										
24													
25		<b>Action Plan</b>	Who is doing what on your team by when to test this change and track the measures you described above?										
26													
27		<b>Studying</b>	When your PDSA cycle is in the first Study phase, what are the initial results from the data you are tracking? What are you learning?										
28													
29		<b>Acting</b>	When your PDSA cycle is in the first Act phase, what adjustments is your team planning to make? What are your next steps?										
30													
31		<b>Comments</b>	Please include any comments, questions, or suggestions for the 2026 PCMH Learning Network?										

2026 PCMH Learning Network

## Mid-Year Session June 2 9am to 10:30am

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### Mid-Year Session: Learning Across Sprints

- One high-performing PCMH in each Sprint presents their first PDSA cycle
- Guidance on updating your Plan based on the first PDSA cycle



# 2026 PCMH Learning Network 3<sup>rd</sup> and 4<sup>th</sup> Sprint Session

## Sprint Session 3

Thursday, July 9th at 9 – 10:30 am

- **LN** provides Tactical how-to information related to PCMHs' QI plans
- **PCMHs** share PDSA 2<sup>nd</sup> Cycle "Plan" through facilitated peer-to-peer learning
- **LN** provides guidance for completing 2<sup>nd</sup> cycle of Study and Act



## Sprint Session 4

Tuesday, October 6th at 1 – 2:30 pm

- **LN** provides Tactical how-to information related to PCMHs' QI plans
- **PCMHs** share 2<sup>nd</sup> Cycle of "Study" and "Act" through facilitated peer-to-peer learning
- **LN** provides guidance on completing PDSA cycles (e.g., standardizing and scaling improvements) and preparing for the final session



## 2026 PCMH Learning Network

**Final In-Person Session November 10 8:30 a.m. to 3:00 p.m.**

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### Final In-Person Session

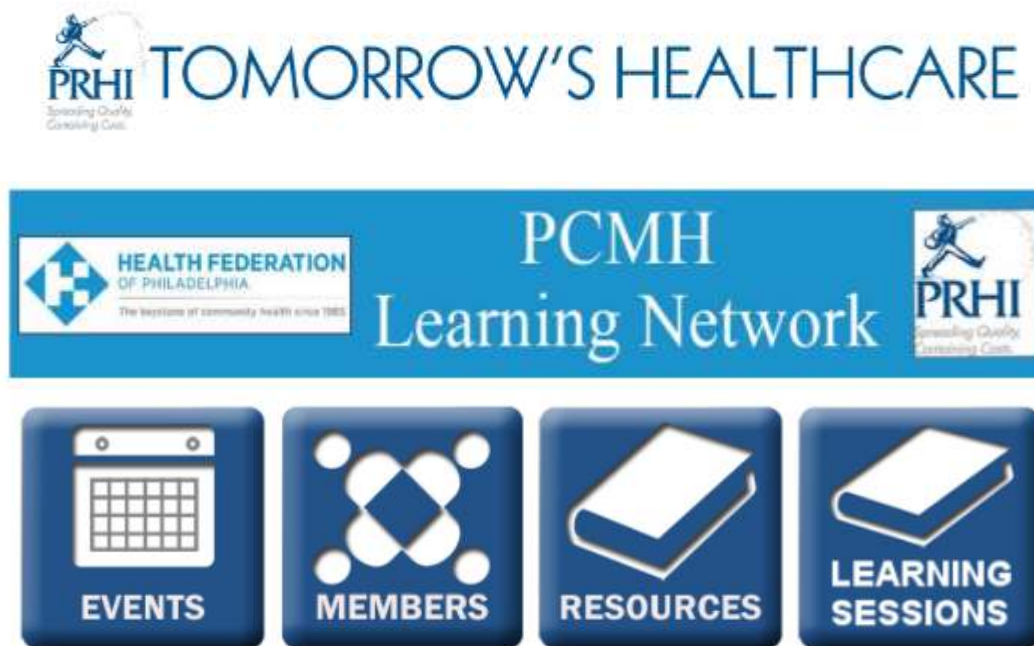
**PCMH  
Milestone:**  
Complete at  
least 2 PDSA  
cycles and share  
at the in-person  
event\*

- **PCMHs** share their completed PDSA cycles
- **LN** recognizes PCMHs with greatest improvements
- **LN** announces 2027 Sprints

# PCMH Online Community

<https://www.tomorrowshealthcare.org/>

Members of your PCMH's multi-disciplinary learning team will receive log-ins



- Access the session materials in “Learning Sessions”
- Look for guides and tools in “Resources”

# CEU Process

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You will receive a follow up email with links to:

Complete the survey at: <https://www.surveymonkey.com/r/9D7WTK8> 4/28/2026



1. Please be sure to designate which CEU credits you are requesting **CME, CNE, Social Worker or Certificate of Attendance**. If you already have an account with the UPMC Center for Continuing Education, **please be sure the email you enter on the survey matches the UPMC CCE account email that you create.**
2. The UPMC Center for Continuing Education will follow up with you via email after **4/28/2026** with instructions on how to claim your credits.
  - To prepare, we recommend you create an account with UPMC CCE via this website <https://cce.upmc.com>.

# Upcoming Sessions

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## Statewide Midyear Virtual Session:

June 2, 2026

9:00 am – 10:30 am

## Virtual Sprint Session #3

July 9, 2026

9:00 am – 10:30 am

## Virtual Sprint Session #4

October 6, 2026

1:00 pm – 2:30 pm

## Statewide End of Year In-Person

### Session:

November 10, 2026

8:00 am – 3:00 pm

# Supplemental Sessions

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## Sepsis in Primary Care Settings

June 4, 2026

5:00 pm – 6:00 pm

## HIV Screening, Prevention, and Treatment

July 9, 2026

5:00 pm – 6:00 pm

# Thank You!

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