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Integrated Minds in Action: Applying the Comprehensive Health Integration Framework in School-Based Health Centers

July 22, 2026

2-3:30pm ET

Disclaimer

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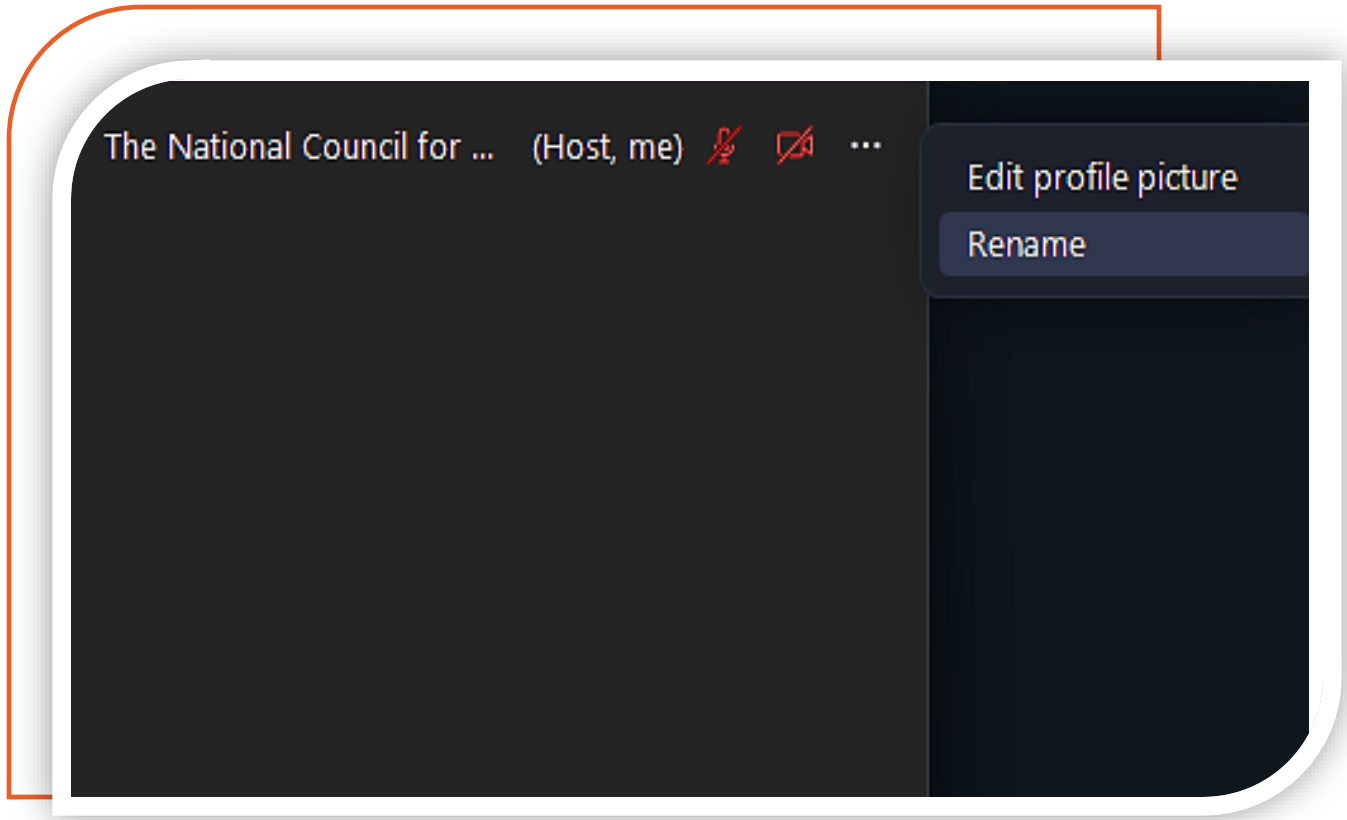

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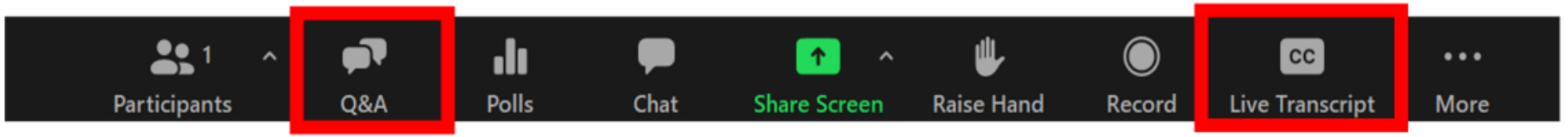

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About the Center of Excellence for Integrated Health Solutions (CoE-IHS)

- The National Council for Mental Wellbeing, through the National Center of Excellence for Integrated Health Solutions grant award from the Substance Abuse and Mental Health Administration (SAMHSA), is home to the newest **evidence-based resources, tools and support for organizations working to integrate primary and behavioral health care.**

- The CoE-IHS advances **bidirectional primary and behavioral health care integration by providing high quality, evidence-informed training and technical assistance (TTA) to a national audience, including a specific focus on the collaborative care model**. The CoE-IHS supports the improvement of integrated care models and provides training and technical assistance to health systems, health care providers and members of the public.

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Speaker Introduction

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Photo Credit: SBHA, 2016

School-Based Health Alliance

Transforming Health Care for Students

Our **Focus**

The School-Based Health Alliance Works to Support & Grow SBHCs

Policy	Standards	Data	Training
Establishes and advocates for national policy priorities	Promotes high-quality clinical practices and standards, including for telehealth	Supports data collection and reporting, evaluation, and research	Provides training, technical assistance, and consultation

We support the improvement of students' health via school-based health care by supporting and creating community and school partnerships.

Learning Objectives

By the end of the webinar, participants will be able to:

- **Describe** how the Comprehensive Health Integration (CHI) Framework's domains, subdomains and stages of integratedness can be applied to School-Based Health Center (SBHC) settings
- **Assess** current opportunities and gaps in integrated care within SBHC workflows, teams, partnerships and service delivery models
- **Consider** practical next steps for advancing integrated care in SBHCs using CHI-aligned strategies, resources and action planning tools

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Agenda

- Welcome and Introduction
- Understanding the Comprehensive Health Integration (CHI) Framework
- School-Based Health Centers (SBHC) Overview
- Applying CHI in School-Based Health Centers
- Exploring the Eight Domains of Integration
- Adapting CHI for SBHCs
- Resources and Discussion

What is the CHI Framework?

The CHI Framework provides guidance on implementing the integration of physical health (PH) and behavioral health (BH) to help providers, payers and population managers:

- Demonstrate the value produced by progress in integrated service delivery
- Provide initial and sustainable financing for integrated service delivery
- Take integrated services to scale in a large network or system of care
- Measure progress and facilitate improvement in organizing delivery of integrated services (“integratedness”)

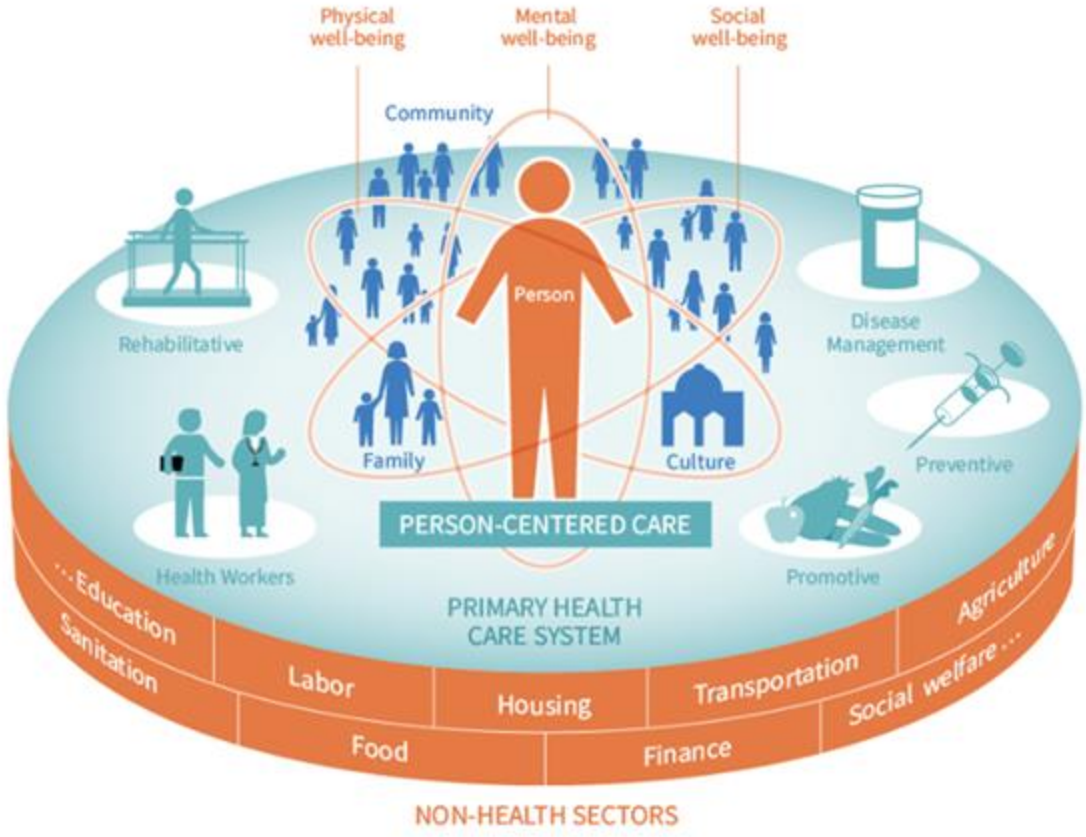

Photo Source: (Primary Health Care Performance Initiative, 2020)

Source: (National Council for Mental Wellbeing, 2025)

Photo Source: (Microsoft, 2026)

Integrated Services

- The provision and coordination by the treatment team of appropriately matched interventions for both PH and BH conditions in the setting in which the person is most naturally engaged

Integratedness

- The degree to which programs or practices are organized to deliver integrated PH and BH prevention and treatment services to individuals or populations
- A measure of both structural components (e.g., staffing) and care processes (e.g., screening) that support the extent to which "integrated services" in PH or BH settings are directly experienced by people served and delivered by service providers

Source: (National Council for Mental Wellbeing, 2025)

Eight Domains of Integration

Screening, Referral, and Follow-up

Prevention and Treatment of Common Conditions

Continuing Care Management

Self-Management Support

Inter-Disciplinary Teamwork

Systematic Measurement and Quality Improvement

Linkage with Community and Social Services

Administrative and Financial Sustainability

(National Council for Mental Wellbeing, 2025; Image source: Microsoft Stock Images)

The Three Integration Stages

Integration Stage 1:
Screening and Enhanced Referral

- Optimizes screening and "enhanced" referral processes
- Does not require significant investment
- Best practice for smaller practices/programs with fewer resources

Integration Stage 2:
Care Management and Consultation

- Includes robust program commitment to a set of screening and tracking processes with associated on-site care coordination and are management

Integration Stage 3:
Comprehensive Treatment and Population Management

- Typically requires comprehensive Physical Health (PH) and Behavioral Health (BH) staffing in a single organization (hospital, independent clinical practice, Federally Qualified Health Center (FQHC), etc.)
- Measures improved health outcomes along the Domains

Note: A program would identify as Stage 0 if they have no or limited integration for a domain or subdomain also known as historical practice.

Source: (National Council for Mental Wellbeing, 2025a & 2025b)

Source: (National Council for Mental Wellbeing, 2025)

How CHI Domains Connect to Common Integrated Care Practices

Domain 1: Screening & Referrals

- Includes PHQ-9, Body Mass Index (BMI) Screening, Brief Intervention, and Referral to Treatment (SBIRT), Adverse Childhood Experiences (ACEs) Screening, Risk Stratification

Domain 2: Prevention & Treatment

- Includes tracking routine prevention (developmental screening, colonoscopies) Motivational Interviewing, Problem Solving Treatment (Rx), Health Behavior Assessment and Intervention (HBAI), BH or PH medications, Medication Assisted Treatment (MAT), Behavioral Activation and brief interventions delivered by trained providers

Domain 3: Care Coordination

- Includes diabetes registry, Collaborative Care Model (CoCM) Registry, High and Low Touch Care Management

Domain 4: Self-Management Support

- Includes Patient Education Materials, Patient activation and goal-setting care plans, and collaborative, person-centered planning

Domain 5: Teamwork

- Includes Warm Handoffs, Interdisciplinary Collaboration, Behavioral Health Consultants (BHCs), and Registered Nurse (RN) Care Coordinators as team members

Domains 6–8: QI, Social & Environmental Factors, and Sustainability

- Includes tools (metrics; cost management; billing) to strengthen, improve, evaluate, and sustain integration in any setting

Source: (National Council for Mental Wellbeing, 2025)

Resources for Implementing the CHI

Revised White Paper	CHI Framework + Trackers	CHI Self-assessment Guide	Definitions and Examples Handbook
The narrative description of the CHI Framework defining its components (domains, stages, metrics, value, financing) and its application for states, providers and payers	The CHI Framework self-assessment tool and accompanying CHI Trackers allow users to document their baseline and plan and measure progress	The Guide provides step-by-step instructions to support interdisciplinary teams in using the CHI Framework self-assessment, ensuring consistent scoring and goal alignment	The Handbook provides definitions and context-tailored examples to ensure consistent language and understanding of CHI process

Access the suite of CHI Framework Resources here

Source: (National Council for Mental Wellbeing, 2025)

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What Is School-Based Health Care?

School-based health care is healthcare provided to students at school by a community healthcare organization in collaboration with school administration and health services staff.

This care includes, but is not limited to:

Primary care

Mental health

Oral health

Vision services

School-based health centers (SBHCs) offer the most comprehensive type of school-based health care. An SBHC is a collaborative effort among school administration, school health service staff, community-based healthcare organizations, and community members to make health services (at a minimum, primary care) available to students at school in a consistent location on a consistent schedule.

Source: (School-Based Health Alliance, n.d.)

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What is a School-Based Health Center (SBHC)?

SBHCs are a collaboration and shared commitment among a school, health care organizations, and a community

Source: (School-Based Health Alliance, 2026)

Photo Source: (Canva Stock Images, 2026)

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SBHCs Reduce Barriers For Students And Their Families

Transportation

Time

Language

Financial

SBHCs are planned and implemented via partnerships at the local level to meet the specific needs of the students, families, schools, and communities they serve

Source: (School-Based Health Alliance, n.d.)

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Mental Health in SBHCs: What We Know

- Mental Health services provided in schools can vary greatly. Every SBHC has different modalities, positions, resources, and relationships
- Co-locating behavioral health care services within the primary care SBHC services can help lower barriers to care access
- Annual Current Procedural Terminology (CPT) and International Classification of Diseases code updates, as well as staff training, will need to be done to ensure that behavioral health services are being reimbursed properly
  - Outreach may be required to get state Medicaid office to activate/turn on substance use services codes
  - Some state Medicaid programs have opened **Collaborative Care Model (CoCM) codes** for nonclinical staff billing under credentialed providers

The content on this slide is based on the professional experience/knowledge of the presenters.

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Alignment Between SBHCs & the CHI Framework

CHI framework supports core SBHC practices (e.g., prevention, early intervention and care coordination)

SBHCs rely on interdisciplinary teamwork—a foundational element of the CHI framework

SBHCs offer a strong platform to apply CHI principles in real-time

Both emphasize comprehensive, integrated care

Both designed to deliver accessible, student-centered services in familiar, trusted environments

Source: (School-Based Health Alliance, 2026)

Source: The content on this slide is based on the professional experience/knowledge of the presenters.

What Does a Highly Integrated SBHC Look Like?

- Universal screening for physical, behavioral, and social needs
- Warm handoffs between team members
- Shared care planning
- Regular interdisciplinary team huddles
- Referral tracking and follow-up
- Youth and family input in services
- Ongoing quality improvement
- Strong school and community partnerships

Photo Source: (Canva Stock Images, 2026)

Source: The content on this slide is based on the professional experience/knowledge of the presenters.

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Domain 1: Screening, Referrals, & Follow Up

Domain 1: Screening, Referrals, & Follow Up

Historical Practice (Stage 0)	Screening & Enhanced Referral (Stage 1)	Care Management and Consultation (Stage 2)	Comprehensive Treatment and Population Management (Stage 3)
1.1 Systematic screening for co-occurring conditions and risk factors			
No screening in place	*Screening for 1-2 co-occurring conditions*	*Screening for 2-3 co-occurring conditions*	*Screening for 3 or more co-occurring conditions*
Screening done as result of self-report	e.g., PHQ-2/9, GAD-7, S2BI, OR CRAFFT	e.g., Risk Assessment- PRAPARE, Bright Futures + PHQ-2/9	e.g., Risk Assessment, PHQ-2/9, +S2BI
		Provider tracking & follow-up provided	*Comprehensive data management system & tracking*

Source: (National Council for Mental Wellbeing, 2025, and based on the professional experience/knowledge of the presenters)

Domain 1: Screening, Referrals, & Follow Up

Historical Practice (Stage 0)	Screening & Enhanced Referral (Stage 1)	Care Management and Consultation (Stage 2)	Comprehensive Treatment and Population Management (Stage 3)
1.2 Systematic facilitation of referral and follow up			
External referrals with no memorandum of understanding (MOU)	*Referrals go to BH/PH provider with formal MOU*	*Integrated team member facilitate referral*	*Fully integrated team*
No tracking of referrals	e.g., BH provider in community	***SBHC Implementation Consideration: Care Coordinator follow up with referrals*** *Expectation of tracking*	e.g., BH/PH work together at the same site and provide services directly on site; majority of internal referrals; share electronic health record (EHR); ongoing communication and collaboration
	Expectation for info sharing		

Source: (National Council for Mental Wellbeing, 2025, and based on the professional experience/knowledge of the presenters)

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Domain 2: Integrated Prevention & Treatment

Domain 2: Integrated Prevention & Treatment

Historical Practice (Stage 0)	Screening & Enhanced Referral (Stage 1)	Care Management and Consultation (Stage 2)	Comprehensive Treatment and Population Management (Stage 3)
2.1 Use of evidence-based guidelines or protocols for prevention/risk mitigation related to co-occurring conditions			
No clear guidelines/policies in place/being followed	*Staff educated on importance of* education	*Staff educated on next steps (e.g., SBHC providers understand next steps for follow up)*	*Tracks population-wide prevention/risk mitigation efforts*
	One relevant prevention intervention e.g., Brief interventions	*Tracking/care coordination*	
	70% receiving intervention/follow up e.g., Connections to resources as needs uncovered	*Interventions and follow-up are routinely monitored*	
	*Infor sharing with partners (*e.g., MOU) and Return on Investment (ROI) in place to share info		

SBHC Implementation Consideration: SBHC providers are typically licensed, credentialed

SBHC Implementation Consideration: SBHCs may track trends and create programming based on identified needs

SBHC Implementation Consideration: Some SBHCs have care coordinators or Community Health Workers (CHWs)

SBHC Implementation Consideration: SBHCs would likely do this in terms of Continued Quality Improvement (CQI) initiatives

Source: (National Council for Mental Wellbeing, 2025, and based on the professional experience/knowledge of the presenters)

Domain 2: Integrated Prevention & Treatment

Historical Practice (Stage 0)	Screening & Enhanced Referral (Stage 1)	Care Management and Consultation (Stage 2)	Comprehensive Treatment and Population Management (Stage 3)
2.2 Use of evidence-based guidelines/protocols for nonpharmacologic treatment for co-occurring conditions			
No protocols in place-absent or not followed	*Evidence of ONE training or competency within the scope of practice (e.g., BH trained in CBT; PH trained in MI)*	*Evidence of TWO training or competency within the scope of practice (e.g., BH trained in CBT/DBT; PH trained in MI +BI)*	*Tracks intervention outcomes*
The frequency of intervention is less than the threshold	*70% receiving intervention at least once e.g., had at least 1 follow-up session with BH provider in SBHC*	*70% receiving intervention at least once (e.g., had at least 1 follow-up session with BH provider in SBHC)*	
		Care Management workflows for tracking (e.g., My Care Circle)	
		Measures Used to monitor progress (e.g., Repeat use of PHQ-9 to track depression)	

SBHC Implementation Consideration: SBHCs track interventions across the board—depression, anxiety, etc. Uses Data for ongoing Quality Improvement (QI)

Source: (National Council for Mental Wellbeing, 2025, and based on the professional experience/knowledge of the presenters)

Domain 2: Integrated Prevention & Treatment

Historical Practice (Stage 0)	Screening & Enhanced Referral (Stage 1)	Care Management and Consultation (Stage 2)	Comprehensive Treatment and Population Management (Stage 3)
2.3 Use of evidence-based guidelines/protocols for pharmacologic treatments for co-occurring conditions			
Limited prescribing does not meet criteria for further screening	*Protocols in place for initiation or continuation of medications (*e.g., Psychiatric Nurse Practitioner (NP), Psychiatrist, FNP via psych consult) will prescribe medications as indicated	*Formal relationship or consultation available to all providers* (e.g., internal consult available); Pediatric Mental Health Care Access (PMHCA) program	*Prescribers work on team (on-site virtually) to manage a variety of medications, (*e.g., some SBHCs have access to a psychiatrist, psych NPs, consult via the PMHCA program)
Medications are prescribed by referral ***SBHC Implementation Consideration: Some SBHCs do not prescribe psychotropic medications***	*70% of prescribes have a least some individuals who need ongoing med management (*e.g., routine follow up with SBHC providers for those on medications)	*Protocols in place for ongoing med management for >2 co-occurring conditions (*e.g., SBHC has protocols in place for med management and consultation)	*More than 70% receive medications from single care team, (*e.g., SBHC patients typically stay within SBHC if being prescribed medications)
		*Care Coordination to track med interventions, (*e.g., in SBHC this may be the BH provider who is working with patient)	*Tracks medication interventions and outcomes; (*e.g., Care coordinators help to track and SBHC engages in QI efforts to improve overall practice)
		*Measures Used to monitor progress (*e.g., Repeat use of PHQ-9 to track depression)	

Source: (National Council for Mental Wellbeing, 2025, and based on the professional experience/knowledge of the presenters)

Domain 2: Integrated Prevention & Treatment

Historical Practice (Stage 0)	Screening & Enhanced Referral (Stage 1)	Care Management and Consultation (Stage 2)	Comprehensive Treatment and Population Management (Stage 3)
2.4 Implementation of trauma and resilience-informed practices			
No systematic approach implemented to support trauma-informed care	*Policy or process to create a welcoming, trauma-informed center, (e.g., SBHC has policies in place; welcoming environment)*	*Policies for trauma-informed care strategies, (e.g., SBHC policy on TIC/strategies and interventions)*	*Trauma-informed strategies, policies, and procedures are fully implemented. (e.g., Trauma informed SBHC/Schools)*
Staff has not been trained in trauma-informed care	*Staff received training on trauma-informed care, (e.g. SBHC has annual trauma-informed care (TIC) training requirement; regular implementation-"what's going right for you")*	*One measure on satisfaction survey related to TIC, (e.g., SBHC has patient satisfaction survey that asks specific question about the environment)*	*Ongoing QI focused on person-centered trauma informed care,* ***SBHC Implementation Consideration: QI efforts in SBHCs look at improving practice for current and future patients***
		Staff training on TIC, strengths identification etc, (e.g., SBHC staff all receive regular and ongoing training	*Access & Capacity to trauma-informed behavioral interventions, (e.g., ideally these interventions are available at SBHC)*
		.Access to Consultation and referral, (e.g., BH provider in SBHC using Trauma-Focused Cognitive Behavioral Therapy (TF-CBT to work with patients	

Source: (National Council for Mental Wellbeing, 2025, and based on the professional experience/knowledge of the presenters)

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Domain 3: Ongoing Care Coordination

Domain 3: Ongoing Care Coordination

Historical Practice (Stage 0)	Screening & Enhanced Referral (Stage 1)	Care Management and Consultation (Stage 2)	Comprehensive Treatment and Population Management (Stage 3)
3.1 Ongoing care coordination for monitoring progress in the prevention of and intervention for co-occurring conditions			
No protocol in place for care coordination	*Routine process in place, (*e.g., SBHC refers to CHW or Care Coordinator for certain conditions, depression, substance use)	*Specific role and responsibility for care coordinator, (*e.g., SBHC hires care coordinator to address certain cases)	*Provide a continuum of care coordination, (*e.g., SBHC providing care coordinator for all needs, including BH + Social needs)
No protocol in place for tracking progress in prevention or treatment	*Treatment team has process to improve the Process, (*e.g., SBHC conducts regular reviews, engages in regular QI activities)	*Ongoing engagement by the care coordinator, (e.g., the SBHC care coordinator,* meets regularly with everyone on their caseload)	*Tracking tool or registry is utilized*
		*Care coordinators monitor progress and outcomes-implement QI as needed, (*e.g,. Regularly review with supervisors and make changes as needed)	*Tracking tool used to monitor cohort outcomes, (*e.g., SBHC use this information to improve services)

SBHC Implementation Consideration: Some SBHCs use EHRs, some use specific registry to track care coordinator efforts

Source: (National Council for Mental Wellbeing, 2025, and based on the professional experience/knowledge of the presenters)

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Domain 4: Personalized Self-Management Support

Domain 4: Personalized Self-Management Support

Historical Practice (Stage 0)	Screening & Enhanced Referral (Stage 1)	Care Management and Consultation (Stage 2)	Comprehensive Treatment and Population Management (Stage 3)
4.1 Use of personalized educational materials and skill-teaching interventions for people receiving services and their families.			
	Distribute brochures or explain conditions	Active coaching regarding behavior change and implementing skill-building strategies	
No formal education or skill-building beyond routine care	Students get basic education; materials may not be tailored beyond to youth	Use of goal-setting tools and other documentation in plans	

Source: (National Council for Mental Wellbeing, 2025, and based on the professional experience/knowledge of the presenters)

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Domain 5: Interdisciplinary Teamwork

Domain 5: Interdisciplinary Teamwork

Historical Practice (Stage 0)	Screening & Enhanced Referral (Stage 1)	Care Management and Consultation (Stage 2)	Comprehensive Treatment and Population Management (Stage 3)
5.1 Integrated care team composition			
Care team is BH or PH, not both	*Care team is BH or PH, person receiving services, and additional care team member assisting with initial screening process, (*e.g., Font desk staff assisting with initial collection of assessment tools and handoff to BH/PH provider)	*Interdisciplinary team with active participation from all team members, (*e.g., SBHC with BH, PH, and Dietitian, meeting regularly to discuss patients)	*PH and BH staff work with care coordinators to ensure that they are receiving all of the necessary services*
Integrated care team not needed	*Care manager/referral coordinator on staff but not dedicated to team, (i.e.,* SBHC with CC split between PH clinic and SBHC)	*BH Consultants or PH Consultants available to each team—*not applicable to SBHCs	*Peers and CHWs are included on treatment teams, (*e.g., Some SBHCs have CHWs)
		Routine access to consultation from psych	

SBHC Implementation Consideration: This varies in SBHCs, but collaboration is apparent for those that have care coordinators or community health workers

SBHC Implementation Consideration: SBHC sometimes has own psych provider or can receive consultation through PMHCA (Pediatric Mental Health Care Access (PMHCA) program

Source: (National Council for Mental Wellbeing, 2025, and based on the professional experience/knowledge of the presenters)

Domain 5: Interdisciplinary Teamwork

Historical Practice (Stage 0)	Screening & Enhanced Referral (Stage 1)	Care Management and Consultation (Stage 2)	Comprehensive Treatment and Population Management (Stage 3)
5.2 Integrated teamwork and sharing of clinical information			
Sharing of information between providers from different settings is not routine	*Organizational policy and staff training includes information about sharing of information,*	*Co-occurring issues are discussed at care team meetings or huddles.* (e.g., SBHCs conduct daily or weekly huddles to bring up patient concerns)	Routine electronic sharing and regularly utilizes technology (e.g,. Many SBHC utilize the same electronic health record)
	Requests for information are made directly to referral partners, (e.g., SBHC has MOU in place to be able to share information/provide referral to establish community partners)	*Documentation is available and viewable by all providers on care team,* (e.g., Some BH/PH are able to see notes within same department-some privacy protections still in place, like therapy notes)	*Organization and policies support bidirectional consent and information sharing.,* (e.g., Many SBHCs have bidirectional consents with school partners to allow for information sharing and wraparound support)
	Chart documentation of notes from referral providers is not routine, (e.g., A SBHC may document that the referral was made by the loop may remain open)	*Routine discussions, referrals, are in place with entire care team.,* (e.g., SBHC Care Coordinator plays an active role in ensuring services are referred and followed up on)	*Regular updates, and ongoing communication about status of services (in person, virtually),* (e.g., SBHC meet regularly to discuss patients and family needs)

SBHC Implementation Consideration: ***SBHA has a HIPAA/FERPA guide that has been shared widely in our field***

Source: (National Council for Mental Wellbeing, 2025, and based on the professional experience/knowledge of the presenters)

Domain 5: Interdisciplinary Teamwork

Historical Practice (Stage 0)	Screening & Enhanced Referral (Stage 1)	Care Management and Consultation (Stage 2)	Comprehensive Treatment and Population Management (Stage 3)
5.3 Integrated care team training and competency development			
Inconsistent staff training or competency expectations	*Basic training is provided to all staff about integrated care, (*e.g., SBHC 101 training for all new SBHC providers)	*Continuing education provided to all staff, (*e.g., SBHCs are encouraged to engage in continuing education)	*Systematic annual and continuing training is provided annually for all levels, (e.g.,* This will likely vary based on SBHC)
	*All staff are trained to competency, (*e.g. SBHC staff are trained in all of the necessary skills and competencies needed to work in SBHC)	*Routine training on how to document integrated care activities is provided to staff, (*i.e., All staff trained, not just CHWs, or Care Coordinators)	*Competency expectations relate to team-based care. Look at workflows, job descriptions, etc. (*e.g., SBHC should align current job descriptions with expectations for each provider and update them regularly)
		*Routine training is provided using team-based care principles, (*i.e., SBHC staff engage in training related to working together as a team)	*Process in place to routinely evaluate the integrate care competency expectations of all staff—(*e.g., This could be built into annual performance evaluations for SBHC staff)

Source: (National Council for Mental Wellbeing, 2025, and based on the professional experience/knowledge of the presenters)

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Domain 6: Systematic Quality Improvement

Domain 6: Systemic Quality Improvement

Historical Practice (Stage 0)	Screening & Enhanced Referral (Stage 1)	Care Management and Consultation (Stage 2)	Comprehensive Treatment and Population Management (Stage 3)
6.1 Use of quality metrics for improvement of integrated services			
Minimal use of QI activities	*QI process to measure baseline* (e.g., SBHC tracking completion of PHQ-9)	*QI process regularly measures baseline and improves process and outcome metrics,* (e.g., Over time SBHC can track and monitor progress)	*PH/BH improvement of process and outcome improvements are routinely incorporated into organizational processes* (e.g,. Capacity for this varies in SBHCs)
Satisfaction surveys does not meet criteria in Stage 1	*QI include method for direct feedback from people served,* (e.g., SBHC provide satisfaction surveys after visits)	*Involvement of interdisciplinary QI team,* (e.g., SBHCs often include providers from different disciplines to participate)	*Routine QI Process* (e.g., National Performance Measures, Seat time, etc.)
	Process QI related to screening are complied for reporting internally, (e.g., SBHC quality reports ran and reviewed by admin)	*Formal mechanism to compare process and outcome against benchmarks.* (e.g., Capacity for this varies in SBHCs)	*Ongoing systematic monitoring of at least two population outcome metrics* (e.g., Capacity for this varies in SBHCs)
	QI process results in measurable improvement in 1 or 2 metrics, (e.g., SBHC engage in PDSA to make changes)	*Routine tracking of measurable improvement* (e.g., Capacity for this varies in SBHCs)	*Routine efforts to track and continuously improve processes,* (e.g., This is an ongoing process for SBHCs)

Source: (National Council for Mental Wellbeing, 2025, and based on the professional experience/knowledge of the presenters)

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Domain 7: Community Interventions to Address Conditions that Affect Health and Wellbeing

Domain 7: Community Interventions to Address Social and Environmental Factors that Affect Health

Historical Practice (Stage 0)	Screening & Enhanced Referral (Stage 1)	Care Management and Consultation (Stage 2)	Comprehensive Treatment and Population Management (Stage 3)
7.1 Leveraging community services to reduce social and enviornmental impact on BH and PH.			
Identification of health-related social needs needs and interventions are not systematized.	*Routine screening for factors that affect health,* (e.g., SBHCs screen for food and housing insecurity during visits or intake)	*There is routine screening for two or three issues.* (e.g., SBHCs expand screening to address needs using standardized tools) (e.g., Bright Futures, WE CARE)	*Comprehensive, coordinated factors that affect health outcomes*
	Referrals for identified issues are made, (e.g., *SBHC* staff refer students to local food banks, shelters, or school liaisons)	*Care management interventions by treatment team,* (e.g., Multidisciplinary teams assist students in navigating barriers and service access)	
	Follow-up and referral coordination criteria not met. (e.g., Follow-up is informal or handled case-by-case)	*Written (formalized) agreements are in place.* (e.g., MOUs with key agencies support warm handoffs)	
	Interagency arrangements do not meet criteria	*Routine follow-up tracking of upstream health interventions.* (e.g., EHR or internal systems track referral outcomes)	

SBHC Implementation Consideration: ***SBHCs work collaboratively with schools and community partners to develop and implement shared care plans. They coordinate cross-agency services to support students facing multiple social risks. SBHCs often participate in or lead community-wide care coordination meetings and use data to monitor student needs and enhance the quality of services provided***

Source: (National Council for Mental Wellbeing, 2025, and based on the professional experience/knowledge of the presenters)

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Domain 8: Financial & Administrative Sustainability

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Historical Practice (Stage 0)	Screening & Enhanced Referral (Stage 1)	Care Management and Consultation (Stage 2)	Comprehensive Treatment and Population Management (Stage 3)
8.1 Financial Sustainability			
Financial sustainability does not meet criteria	*Finance staff collaborate with the clinical operations team.* (e.g., SBHC finance and clinical leads meet to review grant use and early billing options)	*Finance and clinical staff actively collaborate.* (e.g., Fiscal staff participate in care planning and quality improvement meetings)	*Clinical and financial leadership collaborate to provide direction.* (e.g., SBHC leaders co-develop strategy for integration funding and service optimization)
Payment is limited to one-time grants or funding	*Collaboration discussions have been initiated.* (e.g., Conversations with funders or FQHCs about sustainable payment models have begun)	*Collaborations with two or more payers/providers with metrics.* (e.g., SBHCs partner with MCOs or FQHCs to identify performance-linked funding goals)	*Implement metrics that demonstrate value.* (e.g., Programs track outcomes (attendance, reduced ER use) tied to incentive payments)
Limited expertise in billing or reimbursement	*Routine process for tracking and improving reimbursement.* (e.g., Teams begin using internal systems to monitor billable activities)	*At least 50% of services are covered by sustainable sources.* (e.g., Core services are supported through Medicaid, HRSA, and local contracts)	*At least 70% of costs covered by sustained funding or incentives.* (e.g., SBHCs leverage a blend of Medicaid, HRSA, and partner reimbursement to meet sustainability thresholds)
Limited capacity to optimize workflows or staffing	*Workflows and staff roles are optimized.* (e.g., Initial review of staff tasks and services that could be reimbursable)	*Team optimizes workflows and staff roles.* (e.g., SBHC adjusts workflows (BH intake, health ed) to support revenue generation)	*Track cost related to improved PH/BH outcomes.* (e.g., Systems evaluate financial return on integrated care delivery)

Source: (National Council for Mental Wellbeing, 2025; National Council for Mental Wellbeing, 2026; and based on the professional experience/knowledge of the presenters)

Domain 8: Financial and Administrative Sustainability

Historical Practice (Stage 0)	Screening & Enhanced Referral (Stage 1)	Care Management and Consultation (Stage 2)	Comprehensive Treatment and Population Management (Stage 3)
8.2 Administrative Sustainability			
Program is licensed with no or limited guidance for integrated care	*Written instructions exist for integrated screening.* (e.g., SBHCs have protocols for PH/BH/social needs screenings within current licensure)	*Instructions in place for integrated care management.* (e.g., SBHCs use standardized protocols for BH consults and care coordination)	*Program includes shared PH/BH arrangements across licenses.* (e.g., SBHCs function as integrated teams under one administrative model)
Does not meet criteria for screening and enhanced referral	*Procedures support basic documentation of integrated steps.* (e.g., EHR or forms include limited prompts to capture co-occurring needs)	*Procedures guide both individual and cross-role documentation.* (e.g., Teams share documentation practices across PH and BH (e.g., shared notes or flags)	*Organization provides documented instructions for cross-licensed care.* (e.g., Clear, role-specific guidelines ensure integrated care regardless of license type)
		Internal consultation processes are defined. (e.g., Warm handoffs and internal referrals follow a structured workflow)	*Guidance aligns with job scope and licensure standards.* (e.g., Onboarding and supervision are tailored to staff credentials and regulatory requirements)
		Meets standards for collaborative care models, if available. (e.g., Some SBHCs align with models like CCBHC or state-recognized collaborative care)	*Instructions are regularly updated to reflect evolving standards.* (e.g., SBHCs continuously revise processes to meet regulatory and care quality needs)

Source: (National Council for Mental Wellbeing, 2025; National Council for Mental Wellbeing, 2026; and based on the professional experience/knowledge of the presenters)

Adapting the CHI Framework For School-Based Health Centers

What does it Take?

- Contextualization of Language and Concepts
- Alignment with School Systems & Calendars
- Integration of Educational and Health Roles
- Data Sharing & Privacy Adjustments
- Modified Assessment Tools
- Inclusion of Youth Engagement as a Core Strategy
- Flexible Funding and Sustainability Planning
- Training & Capacity Building

Source: The content on this slide is based on the professional experience/knowledge of the presenters.

Youth and Family Engagement in Integrated Care

Examples:

- Student advisory councils
- Student feedback surveys
- Shared decision-making
- Family participation in care planning
- Peer support initiatives
- Youth-informed program design

Photo Source: (Canva Stock Images, 2026)

Source: The content on this slide is based on the professional experience/knowledge of the presenters.

Putting It Into Practice: A Sample SBHC Assessment

An SBHC has:

- Primary care and behavioral health providers on-site
- PHQ-9 and GAD-7 screening
- Warm handoffs between providers
- No care coordinator
- Limited referral tracking
- Annual satisfaction surveys
- No formal QI process

What **CHI Framework stage (0→3)** would you assign for these domains?

Historical Practice (Stage 0)	Screening & Enhanced Referral (Stage 1)	Care Management and Consultation (Stage 2)	Comprehensive Treatment and Population Management (Stage 3)

1: Screening, Referrals, and Follow-Up
3: Ongoing Care Coordination
5: Interdisciplinary Teamwork
6: Systematic Quality Improvement

Source: The content on this slide is based on the professional experience/knowledge of the presenters.

Potential Challenges

Structural and System-Level Barriers

- CHI Framework was designed for traditional primary care and behavioral health systems
- Full range of integrated services may not be feasible for SBHCs

Operational and Technical Challenges

- SBHC workflows may not align directly with the framework's domains
- Overlap between existing SBHC tools and the CHI framework

Relationship and Engagement Barriers

- School and SBHC staff likely not familiar with CHI concepts
- Framework does not fully account for youth and family engagement

Adaptation and Resource Limitations

- Time and staff capacity

Source: The content on this slide is based on the professional experience/knowledge of the presenters.

Applying CHI in Your SBHC

Ask Yourself:

- Which domain is our strongest?
- Which domain creates the biggest challenge?
- What stage are we currently operating in?
- What is one action we can take in the next 90 days?

Remember: Progress is not about reaching Stage 3 in every domain. It is about continuous improvement and intentional integration.

Action Planning

Poll: Which CHI domain is your strongest?

Eight Domains of Integration

All the processes identified in each domain are related specifically to addressing PH and BH issues in an integrated manner. The eight broad domains are:

1. Screening, referral and follow-up
2. Integrated prevention and treatment
3. Ongoing care coordination
4. Personalized self-management support
5. Interdisciplinary teamwork
6. Systematic quality improvement
7. Community interventions to address social and environmental factors that affect health
8. Financial and administrative sustainability

Action Planning

Poll: Which domain presents the biggest challenge?

Eight Domains of Integration

All the processes identified in each domain are related specifically to addressing PH and BH issues in an integrated manner. The eight broad domains are:

1. Screening, referral and follow-up
2. Integrated prevention and treatment
3. Ongoing care coordination
4. Personalized self-management support
5. Interdisciplinary teamwork
6. Systematic quality improvement
7. Community interventions to address social and environmental factors that affect health
8. Financial and administrative sustainability

Action Planning

Poll: Which domain would you prioritize over the next year?

Eight Domains of Integration

All the processes identified in each domain are related specifically to addressing PH and BH issues in an integrated manner. The eight broad domains are:

1. Screening, referral and follow-up
2. Integrated prevention and treatment
3. Ongoing care coordination
4. Personalized self-management support
5. Interdisciplinary teamwork
6. Systematic quality improvement
7. Community interventions to address social and environmental factors that affect health
8. Financial and administrative sustainability

Action Planning

Poll: What stage best describes your current level of integratedness?

Integration Stage 1:
Screening and Enhanced Referral

- Optimizes screening and "enhanced" referral processes
- Does not require significant investment
- Best practice for smaller practices/programs with fewer resources

Integration Stage 2:
Care Management and Consultation

- Includes robust program commitment to a set of screening and tracking processes with associated on-site care coordination and are management

Integration Stage 3: Comprehensive Treatment and Population Management

- Typically requires comprehensive Physical Health (PH) and Behavioral Health (BH) staffing in a single organization (hospital, independent clinical practice, Federally Qualified Health Center (FQHC), etc.)
- Measures improved health outcomes along the Domains

Note: A program would identify as Stage 0 if they have no or limited integration for a domain or subdomain also known as historical practice.

Source: (National Council for Mental Wellbeing, 2025)

Action Planning

Questions and Discussion

Resources to Explore

- The Comprehensive Health Integration (CHI) Framework
- School-Based Health Alliance Toolkits:
  - Quality Counts: Clinical Performance Measures
  - Quality Counts: Sustainable Business Practices
  - Quality Counts: Test Measures

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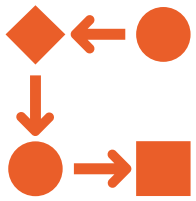

Implementing Models of Integrated Care

Access to Integrated Care

Population Health in Integrated Care

Workforce Development

Integrated Care Financing & Operations

Addressing Ongoing Workforce Challenges

Submit a Request!

Upcoming Events & Helpful Links

July 23rd
2-3 p.m. ET

CoE-IHS Panel: Supporting Your Team in the Collaborative Care Model: Lessons from the Field

Register Here

Aug. 5th
1-2 p.m. ET

CoE-IHS Webinar: Integrated Care in Action: Supporting Whole-Person Health and Recovery for People Experiencing Homelessness

Register Here

Aug. 11th
1-2 p.m. ET

CoE-IHS Webinar: Integrating Substance Use Prevention for Youth into Physical Health Care Systems

Register Here

Aug. 12th
1-2 p.m. ET

CoE-IHS Action Session: Enhancing your Toolkit: New CoCM Training Modules for your Care Team

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