

Pediatric Integrated Behavioral Health: A Primary Care Transformation Effort in Rhode Island

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ABSTRACT

In 2021, the U.S. Surgeon General issued an advisory on youth mental health, stating that the challenges that youth are facing are unprecedented, hard to navigate, and significantly impacting their mental health.¹ Through statewide quality improvement and collaborative learning models, the Care Transformation Collaborative of Rhode Island (CTC-RI) and PCMH-Kids have implemented innovative, pediatric integrated behavioral health (IBH) models to support pediatric medical homes in addressing youth mental health needs, reduce stigma, increase access, and improve care coordination. Early efforts focused on a traditional IBH model and practices were financially responsible for the IBH clinician; despite clinical successes, smaller practices could not sustain the model financially, so CTC-RI shifted its focus to an innovative model that removed financial risk from the practice. More recently, CTC-RI has launched initiatives to expand the pediatric team's capacity to manage the behavioral health needs of its patients and families by providing specialty skill building (e.g., sleep, anxiety, autism), and by adding community health workers to IBH teams. Results from these initiatives indicate that pediatric IBH models are an effective and essential element of advanced primary care.

KEYWORDS: pediatric integrated behavioral health; pediatric learning collaborative; advanced pediatric primary care; team-based care

INTRODUCTION

Over the past decade, the Care Transformation Collaborative of Rhode Island (CTC-RI) and PCMH-Kids have implemented innovative team-based approaches to help pediatric medical homes manage youth mental health needs. Prevention and health promotion are core values of pediatrics, and behavior, development, and emotional health are integral components of routine pediatric care, including developmental surveillance and screening for anxiety, depression, and substance use. Integrating behavioral health clinicians into the care team is an essential component of an advanced pediatric medical home.

In 2021, the U.S. Surgeon General issued an advisory on youth mental health, stating that the challenges that youth are facing are unprecedented, hard to navigate, and significantly impacting their mental health.¹ Approximately 20% of youth had a diagnosable condition, but the majority did not receive care. Rates of youth sadness, hopelessness, suicidal ideation, and emergency department utilization were already rising prior to the pandemic.

More recent national data from the CDC² indicate that 40% of adolescents reported persistent feelings of sadness and hopelessness, and 20% seriously considered suicide during the past year. Eleven percent of younger children had a diagnosed anxiety disorder, 8% had a diagnosed behavior disorder, and 4% had depression. In Rhode Island in 2021, 51.7% of female and 25.1% of male high school students reported persistent sadness/hopelessness, and 24.1% (female) and 10.6% (male) considered suicide. Among middle school students, 31.2% of females and 14.5% of males reported seriously thinking of suicide.

These trends underscore the need for scalable behavioral health models within pediatric primary care. Pediatricians and family medicine physicians have assumed a growing role in addressing behavioral health concerns despite limited training, resources and time. Even though most children with behavioral health needs do not receive care from a mental health provider, most see their pediatric provider at least once per year,³ and parents will often turn to their child's pediatrician first when behavioral or emotional concerns arise. Pediatric providers serve as de facto first-line mental health providers for many of our children, even though pediatricians report insufficient training to manage these concerns.⁴ Integrated behavioral health (IBH) models help bridge this gap by expanding behavioral health knowledge of practice teams overall, and by providing patients quick and direct access to a qualified behavioral health clinician.

CTC-RI AND PCMH-KIDS

CTC-RI's mission is to support the ongoing improvement and transformation of primary care in Rhode Island. Serving as a central hub, and working together with payers, providers, systems of care, government agencies, and community organizations, CTC-RI has supported practices in implementing innovative clinical models, successfully aligning

payers and scaling integrated behavioral health across the State. PCMH-Kids, incorporated into CTC-RI in 2015, works with stakeholders to develop high quality primary care for children and has impacted nearly all pediatric practices in Rhode Island. Together, CTC-RI and PCMH-Kids have been instrumental in building IBH capacity in adult, family, and pediatric practices.

Establishing the Foundation for Pediatric IBH in Rhode Island

CTC-RI and PCMH-Kids have been working steadily to expand the capacity of pediatric practices to address mental and behavioral health needs. Early PCMH-Kids’ efforts focused on supporting practices to become patient-centered medical homes (PCMH), creating more coordinated and comprehensive primary care by expanding care teams and improving access and communication. This included building partnerships with specialists and community resources and creating an engaged learning community of pediatric practices that highly values care coordination and team-based care.

After successfully transforming most Rhode Island pediatric practices into PCMHs, CTC-RI and PCMH-Kids shifted focus to integrating behavioral health clinicians into pediatric teams. In 2019, CTC-RI launched its first Pediatric IBH project with eight practices. Over the course of this project, the pandemic hit and led to a community-reported increase in behavioral health needs, and a decline in community behavioral health clinician availability. CTC-RI responded by focusing on further expansion of behavioral health capacity within pediatric teams.

This shift generated projects that expanded pediatric team behavioral health capacity in three ways: (1) pediatric skill-building on conditions such as sleep, restrictive eating, obesity, and anxiety; (2) adding community health workers (CHWs) to IBH teams; and (3) training pediatricians to conduct first-level autism assessments for children under age three.

Throughout these efforts, CTC-RI has implemented projects with varied structures to meet practice needs while consistently adopting a collaborative learning model. All projects include a trained practice facilitator who supports workflow redesign, quality improvement, and data collection, as well as opportunities for peer learning at designated project intervals.

CTC-RI became an ECHO® hub in 2022 to ensure quality delivery of virtual learning. This model, originally designed to connect specialists virtually to primary care, emphasizes community learning through an “all teach, all learn” approach. Typically,

a didactic presentation from a content expert is followed by a participant case presentation and group discussion. This format has been well-suited for expanding knowledge in specific content areas such as restrictive eating disorders, sleep, obesity, LGBTQ+ youth, and anxiety, and is often paired with a quality improvement project.

HIGHLIGHTED PROJECTS

Since 2019, CTC-RI has implemented more than a dozen projects focusing on pediatric mental health, with evolving goals aligned to community needs. The array of projects is summarized in **Table 1**, and three are spotlighted below.

Project Spotlight 1: Foundational work to integrate BH clinicians into primary care teams

The first pediatric IBH project launched in 2019 with eight pediatric practices in 2 two-year cohorts, representing diverse practice types (hospital clinics, community health centers, and smaller practices). CTC-RI established goals and deliverables with national IBH models, including robust behavioral health screening protocol, an onsite behavioral health clinician receiving warm hand-off, brief assessment and short-term intervention services, and triage and referral pathways for higher-intensity treatment. Practices were expected to hire an IBH clinician and report screening rates quarterly, while CTC-RI supported implementation, workflows, documentation, and billing.

COVID-19 was disruptive, yet practices continued implementing the model with as much fidelity as possible. They successfully incorporated at least three screenings for children, adolescents, and/or postpartum mothers, and, despite the challenge of vastly diminished well-child visits during the pandemic, they maintained or improved their population screening rates [**Table 2**]. The most notable increase was adolescent anxiety screening, which rose from near zero to 75% among implementing practices.

Practices met quarterly for didactic and peer learning on topics such as anxiety, psychotropic medication, somatic complaints, sleep, obesity, virtual IBH, NCQA Behavioral

Table 1. CTC-RI pediatric BH projects since 2019

Pediatric IBH Program Launch Cohorts	Building IBH Infrastructure, Quality, and Virtual Care	Team Capacity Expansion and Specialty Skill Building
<ul style="list-style-type: none"> Traditional Pediatric IBH implementation 	<ul style="list-style-type: none"> NCQA Behavioral Health Distinction Telehealth learning collaborative Integration of the DULCE model Collaboration with Foundation of Integrated Care (FIC) to test innovative IBH model 	<ul style="list-style-type: none"> Expanding teams with CHWs Pediatrician skill-building in Restrictive Eating Disorders, Obesity, Sleep, Anxiety, and LGBTQ+ Youth Training pediatric providers in first level autism assessments

Table 2. Aggregated baseline and final screening rates

Screening Tool	PSC 35	PHQ-A	GAD-7	CRAFFT	EPDS
Target Population	School Age	Adolescents	Adolescents	Adolescents	Postpartum
Total # of Practices	2	8	3	6	5
Baseline Rate	45%	54%	7%	37%	80%
Final Screening Rate	81%	82%	75%	70%	83%
Total % Increase	36%	28%	68%	33%	3%

Table 3. Baseline and final screening rates by the end of year 2

	Target Population and Screening Tool	Practice 1	Practice 2	Practice 3	Practice 4	Practice 5
Baseline Rate	Infancy (SWYC or ASQ)	68%	58%	66%	92%	62%
Final Screening Rate		83%	91%	74%	91%	83%
Baseline Rate	School Age (PSC)	0%	0%	0%	0%	0%
Final Screening Rate		9%	28%	17%	46%	37%
Baseline Rate	Adolescent (PHQ-9)	97%	94%	97%	65%	87%
Final Screening Rate		97%	98%	88%	75%	86%

(Practice 6 data unavailable)

Health Distinction, PediPRN/MomsPRN, and restrictive eating disorders. The IBH clinicians met virtually to facilitate peer support, enhancing shared learning and model fidelity.

Despite staffing turnover during the pandemic, all practices wanted to continue IBH after the project ended. Practices reported that IBH clinicians were central to patient care, pediatric team education, and care coordination, and their departure significantly strained pediatric teams. IBH clinicians increased practice comfort with behavioral health screening, family communication, and treatment planning.

Project Spotlight 2: Supporting IBH workforce development

Despite clinical success, financial sustainability remained a barrier, particularly for smaller practices. In response, CTC-RI partnered with the Foundation for Integrated Care (FIC) to support IBH implementation while minimizing financial risk. FIC places early-career behavioral health clinicians into primary care practices and provides supervision and IBH-specific training. Under this model, an FIC clinician works part-time in the pediatric practice and part-time providing outpatient therapy. Patients requiring longer-term therapy can be referred to FIC’s outpatient clinicians, allowing the IBH time to focus on brief interventions appropriate for primary care.

CTC-RI supported two cohorts of three practices each in one-year learning collaboratives. With monthly facilitation, practices established warm hand-off workflows, improved screening rates and cohort 2 added tracking of emergency room and hospital diversions. Cohort 1 generated 274

referrals to FIC clinicians during the project year, demonstrating rapid and successful adoption of the model.

Project Spotlight 3: Expanding the pediatric IBH team with CHWs

Pediatric IBH clinicians frequently manage high demand for behavioral health care coordination for children with complex needs. During and after the pandemic, the volume of clinical and care coordination highlighted the need to expand IBH teams even further. CTC-RI launched an IBH team expansion project to add and train community health workers (CHW) to support behavioral health care coordination, allowing BH clinicians to focus on direct care. CTC-RI collaborated with TEAM UP (Boston Medical Center) for CHW training, and with the Hassenfeld Child Health Innovation Institute at Brown University for evaluation

support. The two-year learning collaborative launched in August 2023 and included six practices.

With financial support and facilitation, practices hired CHWs and implemented screening improvement initiatives across all developmental levels. By project end, practices showed improved screening rates; notably none screened children ages 5–11 for social emotional concerns at baseline, but all had protocols by project end [Table 3].

CHW activity tracking revealed that 58% of needs addressed were behavioral health-related, 32% were material needs, and 10% involved both. Adding CHWs shifted practices toward more robust team-based care, extending IBH clinician capacity and allowing more timely access for patients. CHW contributions demonstrated the value of expanded teams in meeting complex family needs. Providers reported improved ability to connect families to follow-up care, and practices expressed a desire to maintain CHWs after project completion.

SUCCESSES AND CHALLENGES

Successes

The pediatric IBH initiatives undertaken by CTC-RI and PCMH-Kids demonstrate that both pediatric teams and patients benefit from IBH models. Pediatric primary care providers and staff increased behavioral health knowledge and developed greater confidence and comfort in discussing difficult topics with families. Connecting community experts and pediatric teams improved referral pathways and increased awareness of community resources. Expanded IBH teams decreased staff burden, reduced burnout, and

increased provider confidence and practice efficiency.

The benefits of behavioral health screening are well-documented⁵ and the American Academy of Pediatrics recommends developmental surveillance and behavioral or social-emotional screening throughout childhood.⁶ The learning collaboratives provided support for adopting BH screening protocols, and these tools are now embedded and considered standard care. As a result, providers can identify and address behavioral health or developmental concerns earlier and more effectively.

For patients, expanded IBH teams improved access to behavioral health services, and reduced stigma associated with care. Patient experience improved through the availability of multiple team members who could address and coordinate behavioral, developmental and social needs in the medical home.

Challenges

Despite these benefits, maintaining IBH teams in pediatric primary care remains challenging. Financial sustainability continues to be a primary concern for many practices, especially for smaller practices, as payments for behavioral health services often do not cover costs. CTC-RI and PCMH-Kids have advocated for alternative payment models that support advanced primary care models and allow IBH to be sustained regardless of practice size.

A second challenge is workforce capacity. The supply of behavioral health clinicians within primary care and at the community level does not meet demand. As a result, IBH clinicians must balance brief primary care-appropriate interventions with longer-term cases that cannot be transitioned to community providers, leading to reduced access and increased clinician burnout. Broader pediatric workforce constraints further complicate IBH implementation. A 2024 PCMH-Kids pediatric workforce survey showed substantial planned retirements and limited practice capacity for new patients, underscoring the importance of a stable primary care system for IBH success.

LOOKING AHEAD

CTC-RI and PCMH-Kids have been leaders in recognizing the value of pediatric IBH and creating innovative projects to meet the needs of diverse practices and patient populations. Sustainable pediatric IBH models require payment reforms that account for care coordination, screening, and short-term behavioral interventions that fall outside traditional fee-for-service payments. Although CTC-RI cannot directly support every practice in the State, it has demonstrated that advanced team-based care is essential to managing pediatric behavioral health needs statewide. Traditional models of IBH are not feasible for all practices given workforce shortages and financial constraints. However, CTC-RI and

PCMH-Kids have shown that pediatric behavioral health care can be improved through innovative models that reduce financial risk, expand care teams, and provide specialty skill-building for pediatric providers.

These demonstration projects highlight that flexible, team-based models are critical for strengthening the pediatric medical home's capacity to address behavioral health needs. As Rhode Island continues to refine its primary care infrastructure, pediatric IBH represents a core component of advanced primary care and a scalable strategy for meeting the mental health needs of children and adolescents.

Looking forward, Rhode Island has an opportunity to build on these demonstrations by aligning statewide pediatric mental health strategies with value-based payment, integrated workforce development, and data infrastructure. Stronger linkage between schools, primary care, and community mental health systems could create a more seamless continuum for youth and families. Continued investment in primary care transformation, coupled with policies that recognize behavioral health as core pediatric care, will be critical to ensuring that these innovations are not add-ons, but become standard care within pediatrics. As Rhode Island continues to refine its primary care infrastructure, pediatric IBH represents a core component of advanced primary care and a scalable strategy for meeting the mental health needs of children and adolescents.

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