

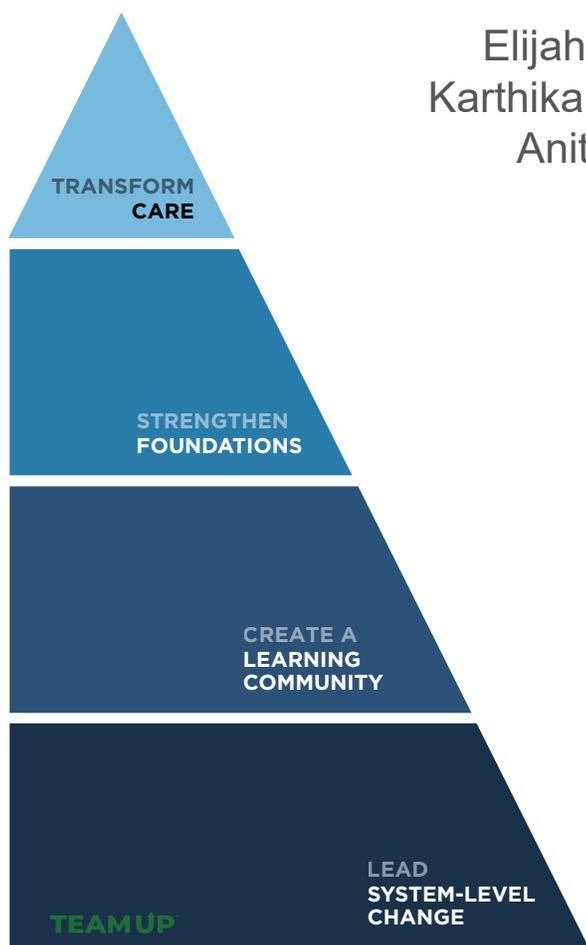
Pediatric Behavioral Health Landscape Analysis: Georgia's Opportunity for Integrated Behavioral Health Care

Executive Summary

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Introduction

Georgia is currently experiencing a youth mental health crisis characterized by rising rates of suicidal ideation, depression, anxiety, and other behavioral health (BH) needs.¹ In response, significant investments including the expansion of school-based initiatives, workforce training and development, and enhanced crisis response have been made by the state.¹ Integrated behavioral health (IBH), which ensures prompt access to BH services within primary care pediatric practices in federally qualified health centers (FQHCs), can further strengthen Georgia's response to the youth mental health crisis.

The [TEAM UP Scaling and Sustainability Center](#) (TEAM UP) equips FQHCs to implement IBH, ensuring all children and youth have swift and equitable access to care. With support from the [Jesse Parker Williams Foundation](#), TEAM UP was engaged to expand the capacity of FQHCs in the five-county area of Atlanta (Fulton, DeKalb, Cobb, Gwinnett, and Clayton) to provide comprehensive BH services. This collective project is referred to as *TEAMing UP for Georgia*.

TEAMing UP for Georgia began with the development of a landscape analysis of the pediatric behavioral healthcare system. The landscape analysis included a comprehensive review of over fifty documents and resources and over twenty-five interviews with key informants across the healthcare system, as well as representatives from FQHCs. A standardized template was used to collate relevant information from resources and interviews. System-level analyses examined the administrative, financing, policy, and workforce efforts that shape access to and delivery of pediatric BH services. Practice-level analyses explored how FQHCs currently identify, manage, and coordinate care for children and youth with BH needs across common IBH care team roles: primary care providers (PCPs), psychiatrists, behavioral health clinicians (BHCs), community health workers (CHWs), and peer support specialists (PSSs). This document provides an executive summary of the landscape analysis.

System-Level Overview of Pediatric Behavioral Healthcare

Primary care and BH care in Georgia are organized through distinct system structures. Primary care is overseen by the [Primary Care Office \(PCO\)](#), which provides needs assessments, technical assistance and collaboration, workforce recruitment and retention, and legislative oversight.² In addition, the [Georgia Primary Care Association \(GPCA\)](#), which is a membership organization for FQHCs, supports FQHCs through ongoing training and technical assistance, workforce development, and leadership guidance.³ Georgia's BH delivery system is comprised of a variety of state agencies that affect how FQHCs refer patients, coordinate care, and deliver services. The major state agencies include the [Department of Behavioral Health and Developmental Disabilities \(DBHDD\)](#) which oversees Georgia's public safety-net BH services, the [Department of Community Health \(DCH\)](#) which is responsible for coverage policies including Medicaid and Children's Health Insurance Programs (CHIP), and the [Department of Human Services \(DHS\)](#) which administers a range of programs that support children and families.⁴⁻⁶ As a result of the distinct system structures for primary care and behavioral health, FQHCs often navigate multiple agencies, payment mechanisms, and referral pathways to connect children and families to needed services.

The majority of Georgia's children and youth are publicly insured with approximately 1.3 million (53%) being covered by Medicaid or PeachCare for Kids®, Georgia's CHIP.^{1,7} Thus, reimbursement processes for IBH within FQHCs are largely tied to public coverage. Currently, there are existing pathways that allow FQHCs to receive reimbursement for BH services delivered

by PCPs and licensed BHCs.⁸ Georgia recently established reimbursement processes for PSSs services, though this is relatively new and not widely operationalized in FQHCs.⁹ Services completed by CHWs are not currently reimbursable, but legislative actions are underway to codify CHW contributions to service delivery, an important step towards future reimbursement and sustainability of the role.¹⁰ Challenges related to administrative complexity, mixed workforce readiness, and limited operational support/infrastructure impact existing and emerging reimbursement pathways for IBH. Across interviews and document review, administrative complexity emerged as a recurring factor shaping FQHCs' ability to consistently operationalize available reimbursement pathways and sustain BH service delivery in primary care settings.

Access to pediatric BH services in Georgia depends on coordination across multiple care settings and systems. Primary care practices, [school based health centers \(SBHCs\)](#), early childhood programs, and community BH providers each play distinct roles in identifying needs and delivering services. Georgia has 34 FQHCs with over 230 clinic sites across the state's 159 counties.¹¹ SBHCs extend primary care access to pediatric patients with over 125 sites across Georgia.¹² In addition, Georgia has made distinct investments in early childhood BH and development through interventions like child-parent psychotherapy and in programs like [Babies Can't Wait](#).^{13,14} Finally, Georgia has a robust public, BH safety-net delivery system through [Community Service Boards \(CSBs\)](#) and [Certified Community Behavioral Health Centers \(CCBHCs\)](#).^{15,16} These community organizations provide critical access to BH services for Georgia's most vulnerable populations. Collectively, no single setting can meet the full range of BH needs for children and families; access to BH services relies on coordination across FQHCs, SBHCs, CSBs, CCBHCs, and other specialty and community-based providers.

Federally Qualified Health Center Insights on Integrated Behavioral Healthcare

Our analysis of interviews with FQHC representatives revealed consistent themes regarding how IBH roles are staffed, supported, and integrated into primary care. Beyond their role in assessing and diagnosing BH needs, PCPs commonly prescribe first-line medications for routine BH needs. Management of second-line medications and more complex BH needs are less frequently addressed within FQHCs. Psychiatrists support the management of complex pediatric BH needs, though availability within FQHCs is often limited to part time or consultative support, or simply unavailable. FQHCs varied in the availability and capacity of BHCs; staffed BHCs were most often recent graduates with limited experience working in IBH settings. CHWs and PSSs were not commonly employed by FQHCs, though a subset of the typical responsibilities of CHWs and PSSs was sometimes completed by other FQHC staff. FQHCs described strong interest in building out their IBH care teams and in accessing opportunities for infrastructure and workforce development support to do so.

Several workforce development programs and organizations were named by FQHCs for each distinct IBH care team role. For PCPs, [Georgia Mental Health Access in Pediatrics \(GMAP\)](#) provides access to BH consultation and referral support with the goal of increasing comfort in managing common BH needs.¹⁷ Though psychiatry was generally limited in FQHCs, [Project Extension for Community Healthcare Outcomes \(ECHO\)](#), was described as an important connector to pediatric psychiatry support.¹⁸ [Resilient Georgia](#), which is a statewide workforce development program, offers training in trauma-informed care, infant and early childhood BH, and patient-centered pediatric primary care for BHCs.¹⁹ A variety of organizations across Georgia have developed trainings for CHWs that vary in scope. The [Department of Public Health](#) and

[Atlanta Regional Collaborative for Health Improvement \(ARCHI\)](#) serve as the primary conveners for CHWs.^{20,21} PSSs are more commonly embedded within community BH settings; integration of PSSs within FQHCs remains limited, with ongoing questions related to role clarity, supervision, and operational fit.

FQHCs support access to pediatric BH services through screening, referral, and coordination with external providers, including Georgia's public BH system. For BH services that cannot be provided within primary care settings, FQHCs most commonly refer children and youth to CSBs/CCBHCs, specialty clinics, and private practices. From this vantage point, access to care is shaped by referral capacity, coordination with external providers, and practice-level approaches to referrals and follow-up. Investment in IBH within FQHCs may reduce the current over-capacity of CSBs/CCBHCs and other specialty clinics. Improved coordination between FQHCs, CSBs/CCBHCs, and other specialty clinics may further support timely access to appropriate services while maintaining continuity and quality of care.

Regional variation significantly influences BH service delivery in Georgia. The state is often described as comprising of three distinct regions: Metropolitan (Metro) Georgia, Northern Georgia, and Southern Georgia. Metro Georgia, formally referred to as the [Atlanta-Sandy Springs-Alpharetta, GA Metropolitan Statistical Area \(MSA\)](#), refers to the 29-county region that is home to 6.3 million residents.^{22–24} While service availability is greater in this region, FQHCs described ongoing challenges related to navigating complex systems of care, addressing linguistic and cultural needs, and coordinating services across multiple providers. In the rural regions of Georgia, FQHCs described a paucity of medical services including shortages in PCPs and other BH providers, transportation barriers, and limited specialty-service capacity. Collectively, these challenges affect the early identification of BH and developmental needs and timely access to services.

Implications

Findings from this landscape analysis highlight several priority areas where focused planning and capacity-building efforts could strengthen the delivery and sustainability of pediatric IBH within FQHCs. These considerations reflect consistent themes raised across system- and practice-level interviews and are grounded in observed gaps between existing policy, infrastructure, and on-the-ground practice. Operational and implementation support to strengthen FQHC capacity to deliver IBH would build upon the expressed readiness and commitment to pediatric IBH. Optimizing utilization of existing training opportunities, like those offered by Resilient Georgia and ARCHI, can expand the BH workforce. Continued alignment between organizations that serve as established conveners and local experts can collectively strengthen efforts to build IBH capacity within the state. These organizations include, but are not limited to, [Mindworks Georgia](#), which convenes state and non-governmental organizations to coordinate BH care efforts and the GPCA, which convenes FQHCs and offers comprehensive technical assistance and training opportunities.^{3,25} Successful IBH capacity building efforts will need to consider the distinct needs of FQHCs within Metro Georgia and more rural areas of Georgia; approaches that are responsive to the regional context and tailored to local operational realities will ensure long-term sustainability. Last, the development of consistent and feasible approaches to document and assess processes related to IBH are needed to inform implementation efforts. Access to such data can support advocacy efforts related to billing and reimbursement.

Conclusion

Findings from the *TEAMing UP for Georgia* landscape analysis showcase the meaningful investments in BH infrastructure, workforce development, and community-based service delivery that Georgia has made. FQHCs expressed the value of pediatric IBH to address the youth mental health crisis, and a need for operational infrastructure and implementation support to translate existing buy-in and readiness into consistent workflows and sustained care coordination. Collaborative efforts that build on existing infrastructure across the state are essential to improving FQHC IBH capacity. The *TEAMing UP for Georgia* Project presents an opportunity to generate practice-grounded learning to inform ongoing efforts related to reimbursement, workforce development, and the long-term sustainability of pediatric IBH.

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