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

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Report Produced by the TEAM UP Scaling and Sustainability Center

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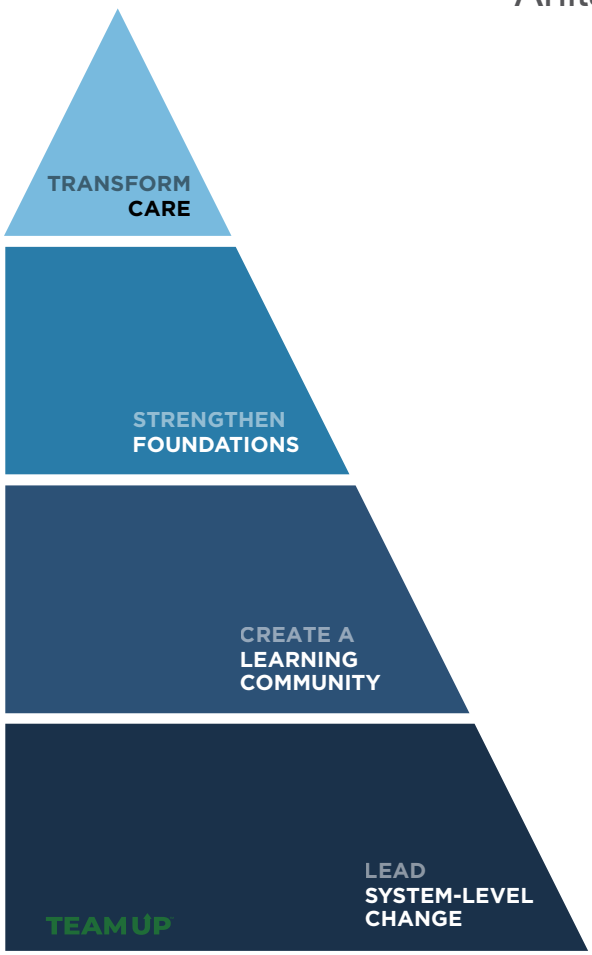

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BOSTON MEDICAL CENTER

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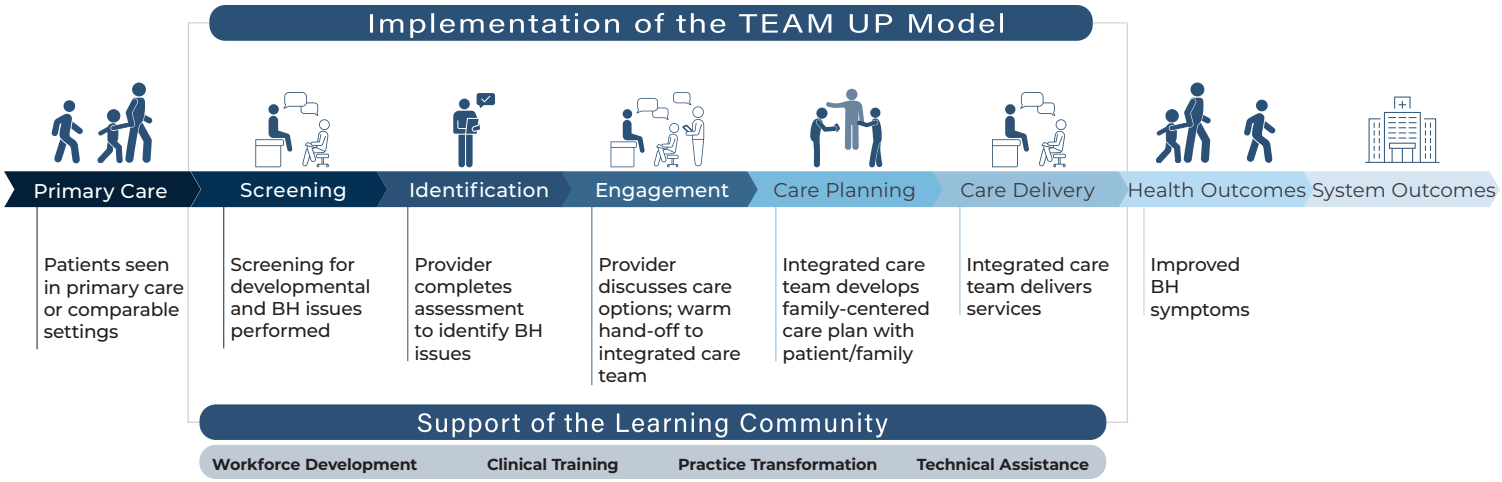
Introduction

Current Status of Georgia's Pediatric Behavioral Health Landscape

Georgia's youth mental health crisis is characterized by rising rates of suicidal ideation, depression, anxiety, and other behavioral health (BH) needs that disproportionately impact structurally marginalized communities.[1] In response, Georgia has invested in key strategies including the expansion of school-based initiatives, workforce training to support BH service delivery, and enhanced crisis response services.[1] Integrating behavioral health services in pediatric primary care represents an additional approach to further strengthen the state's response to the youth mental health crisis. Figure 1 showcases the care pathway for primary care with integrated behavioral health (IBH) services.

Figure 1: Integrated Behavioral Health Pathway



Federally Qualified Health Centers (FQHCs) play a central role in delivering primary care services within structurally marginalized communities. In 2024, Georgia FQHCs provided care to more than 200,000 patients under the age of 18.[2] FQHCs serve as the medical home and the most consistent point of contact with the healthcare system for many children and families. However, capacity to consistently identify and manage BH needs within pediatric primary care is limited.[2,3] Expanding FQHCs' IBH capacity offers a promising opportunity to expand access to evidence-informed BH services to all Georgians.

Description of the TEAM UP Scaling & Sustainability Center and TEAMing UP for Georgia

The mission of the TEAM UP Scaling and Sustainability Center (hereafter TEAM UP) is to equip FQHCs to integrate BH services to ensure all children and youth have equitable access to BH care. TEAM UP does this through the implementation, scale, and long-term sustainability of evidence-informed integrated pediatric BH care. The TEAM UP Model™ utilizes an integrated, multidisciplinary care team of behavioral health clinicians (BHCs), community health workers (CHWs), and primary care providers (PCPs) to address the full spectrum of BH needs among all children and families in their care. The model focuses on promotion of healthy development, early identification of emerging BH needs, and swift access to care. TEAM UP provides comprehensive clinical training and technical assistance paired with revenue optimization and advocacy efforts to bolster broader practice, policy, and system-building efforts to sustain improvements long-term.

TEAM UP has demonstrated positive impacts on children and families, the BH workforce, and the broader healthcare system. Implementation of the TEAM UP model has resulted in improved identification of pediatric BH needs, increased receipt of BH services, and improved BH symptoms over time.[4,5] Staff members working within TEAM UP FQHCs reported increased workforce satisfaction, improved collaboration, and greater professional fulfillment.[6,7] In addition, these same staff members experienced lower overall levels of professional burnout when compared to national averages.[6] Implementation of the TEAM UP model has increased engagement in primary care visits without significant change in avoidable health care utilization or cost.[8,9] Collectively, TEAM UP is well positioned to advance pediatric IBH capacity in Georgia FQHCs.

With support from the Jesse Parker Williams Foundation (JPWF), TEAM UP will partner with FQHCs in the five-county metropolitan area of Atlanta (Fulton, DeKalb, Cobb, Gwinnett, and Clayton) to expand pediatric IBH capacity. This collective work is aptly named *TEAMing UP for Georgia*. To inform this effort, TEAM UP conducted a landscape analysis of Georgia's pediatric behavioral healthcare system. The purpose of this landscape analysis is to identify strategic investments within FQHCs that have the strong potential to positively impact capacity to address the BH needs of the pediatric patient population. It outlines the strengths, gaps, and opportunities within the primary care environment to inform priority investment areas that support IBH within FQHCs.

Landscape Analysis Methodology

TEAM UP's landscape analysis was undertaken between September and December 2025. TEAM UP conducted over twenty-five interviews with system-level key informants and FQHC leadership across Georgia. Appendix A contains a complete list of organizations engaged in the landscape analysis. In addition, a comprehensive review of over fifty documents and publicly available sources relevant to pediatric BH policy, financing, and service delivery were reviewed. TEAM UP developed a standardized questionnaire that was used for all interviews and a standardized template to collate information from relevant documents. Important themes from interviews and documents were synthesized and categorized based on their contribution to the system- and practice-level BH landscape. Systems-level analyses examine the policy, administrative, workforce, and financing environment that shapes access to and delivery of pediatric BH services across the state. Practice-level analyses focus on how FQHCs currently identify, manage, and coordinate care for children and youth with BH needs, including variation in practice readiness, staffing models, workflows, and regional context. This process produced a comprehensive understanding of the pediatric BH landscape of Georgia.

Structure of the Landscape Analysis

This landscape analysis is organized into three main sections. Section 1, System-Level Overview of Pediatric Behavioral Healthcare, outlines the administrative structure, available payment models, access points, and the range of pertinent legislation that shape BH service delivery within FQHCs. Section 2, FQHC Insights on Integrated Behavioral Health, details the available workforce, service delivery and coordination within and by FQHCs, and variation in patient population and health care access across Georgia. Please note that findings from this section are largely informed from a subset of FQHCs that were engaged in the landscape analysis and may not represent the collective response of all FQHCs across the state. Section 3, Implications, details priority areas and opportunities for further investment to support the delivery and sustainability of pediatric IBH services within FQHCs.

System-Level Overview of Pediatric Behavioral Healthcare

This section provides an overview of the system-level context shaping pediatric behavioral healthcare delivery in Georgia. It describes the organizational structure governing primary care and BH, including the roles of key state agencies and membership organizations. Payment and reimbursement models that influence access to and sustainability of pediatric BH services are outlined, along with the primary healthcare access points through which children and families receive care. The section also reviews recent legislative and policy actions that have expanded BH coverage and service capacity across settings. Together, this overview situates pediatric IBH within Georgia's broader policy, financing, and service delivery environment.

Organizational Structure

Primary Care Structure

The Primary Care Office (PCO), which is contained within the State Office of Rural Health, oversees Georgia's primary care, including FQHCs. The PCO supports primary care through statewide needs assessments, technical assistance and collaboration, healthcare workforce recruitment and retention, and oversight on pertinent legislation and grants.[10] Primary care is also supported by the Georgia Primary Care Association (GPCA), which is a membership organization for FQHCs. The GPCA supports the continued development and expansion of FQHCs through ongoing training and technical assistance, workforce development, and leadership guidance.[11]

Behavioral Health Structure

Primary care and BH in Georgia are organized through distinct system structures. BH agencies shape coverage, financing, and service availability for BH services, the majority of which are provided by community-based organizations and specialty clinics. This structure directly affects how primary care practices refer patients, coordinate care, and access services for children and families.

The Department of Behavioral Health and Developmental Disabilities (DBHDD) oversees Georgia's public safety-net BH services.[12] The Department of Community Health (DCH) is responsible for financing and coverage policy including Medicaid and Children's Health Insurance Programs (CHIP).[13] The Department of Human Services (DHS) administers a range of programs that support children and families, including SNAP benefits, Temporary Assistance for Needy Families (TANF), and other related services.[14] Appendix B contains a complete list and description of all key state agencies. These state agencies function in concert to provide a comprehensive range of BH services available to all Georgians.

Payment Models

Coverage and reimbursement structures play a central role in shaping access to and sustainability of pediatric IBH. A significant portion of Georgia's children and youth are covered by Medicaid and PeachCare for Kids®, Georgia's CHIP. Pediatric BH service delivery within FQHCs is closely tied to the public coverage landscape as well as to state-level policy and associated reimbursement frameworks. Collectively, this payment structure establishes a steady revenue stream for IBH; however, several factors should be considered to achieve long-term sustainability.

Medicaid and PeachCare for Kids

The majority of Georgia's children and youth are publicly insured. Among all children in Georgia, approximately 1.3 million (53%) are covered by Medicaid or PeachCare for Kids®, which represents roughly 70% of total program enrollment (CMS, 2025).[1,15] Enrollment varies by geographic location, with children living in rural areas enrolled in Medicaid or PeachCare for Kids® at nearly twice the rate of those living in urban areas.[1]

Georgia DCH currently contracts with four Care Management Organizations (CMOs): Amerigroup, CareSource, Wellcare, and Peach State Health Plan.* Each CMO maintains its own operational requirements and reimbursement processes, contributing to variation in how BH services are financed and administered. In addition, there are several programs that help ensure BH coverage for Georgia's pediatric population. Georgia Families oversees the delivery of general physical health care and BH services for children enrolled in Medicaid and PeachCare for Kids®.[17] Georgia Families 360 is the managed care program for children and youth in the foster care system and contracts with Amerigroup to provide BH coverage to this population.[17] See Appendix B for more detail.

Medicaid Coverage Expansions Through the 1115 Waiver

Georgia's Section 1115 Waiver, known as the Pathways to Coverage™ program, represents a targeted policy effort to expand access to affordable health coverage for adults who would not otherwise qualify for Medicaid, without adopting full Medicaid expansion.[17] While primarily focused on adult coverage, the waiver has implications for family-level stability and access to child- and family-related services, particularly among vulnerable populations. The program extends Medicaid coverage to adults with incomes up to 100% of the Federal Poverty Level who meet work, training, or volunteer requirements, potentially influencing continuity of care and engagement with health systems for families with children.

Reimbursement Opportunities for IBH

The DCH publishes maximum allowable Medicaid reimbursement rates for covered services, which establish reimbursement ceilings for services delivered to Medicaid and CHIP beneficiaries.[18] While reimbursement levels vary by service and provider type, existing pathways allow FQHCs to receive reimbursement for BH services delivered by PCPs and licensed BHCs. In addition, certified peer support specialists (PSS) may also contribute to service delivery, though these roles are not widely operationalized within FQHCs. Despite the availability of reimbursement for BH services, FQHCs experience barriers to BH financing. The primary barriers are related to administrative complexity, including limited clarity around billing rules and regulations, current procedural terminology (CPT) code applicability, credentialing requirements, and payer specific processes to obtain reimbursement.

CHW related reimbursement represents an additional potential pathway to support financial sustainability of BH services. Georgia is working to professionalize the CHW role and codify its contributions to service delivery, which is an important step towards reimbursement.[19,20] Legislation to formalize certification is currently in process, and reimbursement for CHW-related services is expected in 2028-2029. In the interim, FQHCs and other organizations that employ CHWs continue to rely primarily on grant funding programs and operational budgets to support the role.

*In 2025, Wellcare merged with Peach State Health Plans (PSHP) and is now operating under PSHP.[16]

Legislative and Policy Actions Affecting Reimbursement

Several legislative and policy actions have expanded BH coverage and strengthened the financial viability of IBH service delivery (see Appendix C). Legislation supports early screening for BH and developmental needs and establishes reimbursement pathways for covered services. In addition, legislation has helped resolve barriers to billing and reimbursement for BH services within FQHCs and other community-based organizations. Nonetheless, FQHCs still face challenges with PSS service reimbursement despite the passing of State Plan Amendment (SPA) 24-003, which created reimbursement for PSS-delivered services.[21] Bolstered by advocacy efforts, Georgia legislation is expected to pass House Bill 291 which will establish a certification process for CHWs.[19,20,22] The certification process is the first step to establishing a reimbursement pathway for CHW service delivery.

A detailed summary of relevant legislation is included in Appendix C.

Longer-Term Funding Considerations

FQHCs can strengthen financial sustainability by diversifying their funding sources. Blended financing approaches, including grants and philanthropic support, may provide flexibility while new reimbursement pathways develop and stabilize. Ongoing advocacy and evaluation efforts can further support long-term sustainability of IBH. Data demonstrating effectiveness and impact of IBH within FQHCs have proven to be effective in achieving higher reimbursement rates and improving coverage of needed services.[23,24] Limited reimbursement mechanisms continue to impact the sustainability of pediatric IBH. This is largely the result of administrative complexity, mixed workforce readiness, and limited operational support/infrastructure needed to fully leverage existing and emerging reimbursement pathways. Despite these challenges, there are promising opportunities to achieve long-term sustainability of IBH.

Health Care Access Points

Access to pediatric BH services in Georgia depends on coordination across multiple care settings and systems. Primary care practices, school-based settings, early childhood programs, and community BH providers each play distinct roles in identifying needs, delivering services, and supporting referral and follow-up. Currently, no single setting can meet the full range of BH needs for children and families. Effective access to BH services relies on coordination across FQHCs, Community Service Boards (CSBs), Certified Community Behavioral Health Centers (CCBHCs), and other specialty and community-based providers. The sections below describe access points through which children and families receive care and highlight how these settings interact within Georgia's broader BH system.

Primary Care Settings

Pediatric primary care in Georgia is delivered through a range of practice types, including: FQHCs, school based health centers (SBHCs), hospital-affiliated practices, and private practices. In many cases, SBHCs are sponsored by FQHCs and operate as satellite sites or extensions of FQHCs.

FQHCs provide essential services to vulnerable and historically marginalized populations.[4] Georgia has 34 FQHCs, with over 230 clinic sites across 129 of the state's 159 counties.[25,26] Approximately 69% of patients seen within Georgia's FQHCs are uninsured or publicly

insured.[25,26] Among those patients 50% identify as Black or African American, 35% as White, 14% identify as Hispanic, 1% as Asian, and 1% identify with more than one race.[25,26] In 2024, over 200,000 patients 18 years of age or younger received care within a Georgia FQHC.[2]

Beyond their central role in pediatric care delivery, FQHCs vary in their capacity to address pediatric BH needs. This variation is most often shaped by workforce availability, organizational capacity and considerations related to the financial sustainability of BH services.

School-Based Health Centers

SBHCs play an important role in extending primary care to pediatric patients, given their routine attendance at school. Currently, there are over 125 SBHCs in Georgia that provide healthcare access to over 80,000 students, school staff, and in some cases, community members.[27] SBHCs are a critical access point to primary care within rural communities.

Though not always within SBHCs, Georgia has made a significant investment in expanding access to BH services through the Apex Program. Funded through DBHDD, the Apex Program operates in over 500 schools across the state, with approximately 78% of Apex schools situated in rural areas.[28] The majority of Apex funding has been used to build the BH workforce within schools and to strengthen coordination with community-based mental health providers. Alignment with SBHCs and associated initiatives present opportunities to leverage existing investments in pediatric BH.

Early Childhood Behavioral Health Organizations & Clinics

Georgia has made significant investments in early childhood (0-5 years) focused BH interventions. The Department of Early Care and Learning (DECAL) convenes the Infant and Early Childhood Mental Health (IECMH) Task Force, which is a cross-agency collaborative focused on relevant policy, finance, workforce development, and promotion/prevention efforts.[29] The IECMH Task Force invested in child-parent psychotherapy (CPP), which is an evidence-based treatment model for children 0-5 years old that have experienced traumatic events.[30] CPP focuses on strengthening the relationship between the child and the caregiver.[30] The IECMH Task Force has provided pathways for reimbursement for BHCs using CPP within a variety of outpatient settings.[31] In addition, the Georgia Association for Infant Mental Health (GA-AIMH) has helped train over 100 BHCs in CPP.[1]

Early Intervention (EI) and Developmental-Behavioral Pediatrics (DBP) programs serve as common BH and developmental access points for the early childhood population. Georgia's Department of Public Health (DPH) administers the state's EI programming called Babies Can't Wait which provides coordinated services for infants and toddlers with special needs and support/resources to caregivers that ensure their child's learning and development.[32] There are a variety of DBP clinics throughout the state; the Children's Healthcare of Atlanta (CHOA)'s DBP clinic is the primary clinic for the metro-Atlanta area.

Collectively, Georgia has made significant investments in caring for the early childhood population through specialty and community-based service delivery organizations. However, as is often true with referrals to specialty care, such services require significant administrative investment and care coordination by PCPs, including those in FQHCs (more details on care coordination

barriers can be found in section below titled, “Behavioral Health Care Access & Referrals”). Further administrative support and workforce development would improve the utilization of services for the early childhood population.

Community Service Boards and Certified Community Behavioral Health Centers

Established in 1993, Community Service Boards (CSBs) are public safety-net institutions that provide services for mental illness, intellectual and developmental disabilities, and addictive diseases, regardless of insurance status or ability to pay.[33] CSBs provide care to individuals older than five years of age. There are 22 CSBs that serve the state’s 159 counties.[33–35] CSBs are governed locally through individualized Boards of Directors, resulting in variation in service, capacity, and delivery approaches across regions.[33–35]

Over the past several years, Georgia has advanced policy actions to expand BH service capacity across care settings. Through a series of approved SPAs, the state has established Certified Community Behavioral Health Clinics (CCBHCs) and added Behavioral Support Aides for in-home and community-based services.[36,37] CCBHCs are a new service delivery model within the public BH system to further address BH and developmental needs across the lifespan (inclusive of children under 5 years old).[38] CCBHCs place a specific emphasis on 24-hour crisis care and care coordination between BH, physical health care, social services, and other systems.[38] CCBHCs will be governed by the DBHDD and are expected to be operational in 2026.[38]

A detailed timeline of relevant SPAs that expand the BH safety-net and increase access points for children, youth, and families is included in Appendix D.

CSBs are common referral sites for FQHCs. Following the identification of a BH or developmental concern, FQHCs often refer pediatric patients to their local CSB. Given CSBs’ role as the state’s mental health safety-net, wait times for therapeutic services can extend for several months. Once operational, CCBHCs are expected to serve as a complementary referral source for FQHCs, with the potential to expand service capacity and support more timely access to BH services.

Federally Qualified Health Center Insights on Integrated Behavioral Health

This section presents insights from FQHCs on how pediatric BH care is supported within primary care settings across Georgia. It describes BH workforce roles and capacity within FQHCs, including how BH-related roles are staffed, supported, and incorporated into care teams. The section also examines how FQHCs identify BH needs, coordinate referrals, and support access to community-based and specialty services. Finally, it highlights regional variation in workforce availability, service access, and referral pathways, reflecting differences in local context across the state.

Overview of Georgia’s Integrated Behavioral Health Workforce

The BH workforce within FQHCs primarily includes the following roles:
Primary Care Providers (PCPs), Psychiatrists, Behavioral Health Clinicians (BHCs), Community Health Workers (CHWs), and Peer Support Specialists (PSSs). A brief description of each of these roles is included in Appendix E.

Our analysis of interviews with FQHC representatives revealed consistent themes regarding how these roles are staffed, supported, and integrated into care teams. Beyond their role in assessing and diagnosing BH needs, PCPs commonly prescribe first-line medications for routine BH needs, such as attention deficit and hyperactivity disorder, depression, and anxiety. Management of second-line medications and more complex BH needs are less frequently addressed within FQHCs. Psychiatrists support the management of BH needs for children and youth, though availability within FQHCs is often limited to part time or consultative support, or simply unavailable.

FQHCs described concerns about ensuring that patients are seen for specialized services following a referral, despite having varied staff roles to support the referral process. There was an expressed need for a standardized approach to manage referral tracking and follow-up for the pediatric patient population. The CHW role was identified as being suited to support care coordination, given that they are commonly representatives from the community that they serve and can leverage their extensive knowledge of community resources.

Across these roles, FQHCs described cross-cutting workforce considerations including hiring challenges and workforce shortages. Among FQHCs interested in integrating BHCs, CHWs, and PSSs, supervision and role support were identified as potential challenges. FQHCs also expressed interest in continued access to professional development and training related to pediatric BH across care team roles, particularly to support the onboarding of new staff members.

Integrated Behavioral Health Workforce Development

Primary Care Provider

Several initiatives support pediatric PCPs by strengthening their ability to identify, manage, and coordinate care for children with BH needs. These efforts primarily focus on consultation, training, and peer learning related to mild-to-moderate BH and developmental needs. For example, Georgia Mental Health Access in Pediatrics (GMAP), organized by DBHDD, provides access to BH consultation and referral support with the goal of increasing provider comfort managing common BH needs.[39] In addition, CHOA offers training in pediatric BH and supports IBH related efforts through clinical and educational programs, including convening The Children's Care Network (TCCN). FQHC leaders noted that awareness of and engagement with these resources varies, which influences how consistently they are incorporated into routine pediatric care.

Child and Adolescent Psychiatry

Availability of psychiatry within FQHCs is very limited, and psychiatric support is not uniformly embedded across practices. Child and adolescent psychiatrists support pediatric BH care within FQHCs through consultative expertise, particularly when children and youth present with more complex BH needs.

Psychiatry expertise is available through consultation and specialty support models that aim to extend access to primary care settings. Key resources include Project Extension for Community Healthcare Outcomes (ECHO), which connects community-based providers with pediatric specialists through virtual, interactive, case-based learning focused on common pediatric BH needs.

In addition to consultation-based support, a dedicated training pathway has been established to increase pediatric psychiatry support.[40] CHOA, in partnership with Emory University, is training Psychiatric-Mental Health Nurse Practitioners through a program focused on pediatric mental health and child and adolescent care, contributing to longer-term psychiatry workforce capacity.

Behavioral Health Clinician

Workforce development efforts for BHCs focus on expanding the supply of trained providers and strengthening pediatric- and trauma-informed practices. These initiatives are particularly relevant given ongoing workforce shortages and availability of pediatric BH expertise within FQHCs. Resilient Georgia is a statewide workforce development program designed to address BH workforce shortages.[41] This program offers training in trauma-informed care, infant and early childhood BH, and patient-centered pediatric primary care. Resilient Georgia also participates in the National Mental Health Workforce Acceleration Collaborative, which aims to increase the number of licensed clinicians across Georgia.[42] FQHCs noted that although training opportunities are available, additional factors such as supervision, funding, and role alignment influence whether trained clinicians can be hired and retained in FQHCs.

Community Health Worker and Peer Support Specialist

CHWs and PSSs represent community-based workforce roles that can support care coordination, engagement, and continuity of BH services. CHWs are supported through a combination of training programs, professional networks, and advocacy efforts, with a particular concentration in and around Atlanta. These supports emphasize workforce development, standardization of core competencies, and expansion of community-based care roles. The Atlanta Regional Collaborative for Health Improvement (ARCHI), in collaboration with DPH, trains and deploys CHWs statewide and convenes the Georgia CHW Network to provide peer connection, onboarding support, and technical assistance.[20] Academic institutions, including Emory School of Nursing and Morehouse School of Medicine, offer CHW training programs that have informed core competencies across the state. Additional organizations, such as the Fulton–DeKalb Hospital Authority and United Way of Greater Atlanta, support CHW employment and training through local investments and grant funding. At the policy and system level, Georgia Watch leads advocacy efforts related to CHW certification and reimbursement and convenes the Georgia CHW Advocacy Coalition.[19] The Georgia DPH serves as a key convener for CHW-related training initiatives and legislative efforts.[43] Together, these efforts reflect a growing infrastructure for CHWs.

Despite the significant investment in CHWs, there are opportunities to strengthen the CHW role in pediatrics and IBH. Many existing CHW training efforts are not specific to pediatric IBH. Training related to BH includes Mental Health First Aid, which equips community members with the tools needed to recognize, understand and respond to signs of mental health or substance use challenges.[44] In addition, FQHCs described variability in how CHWs are integrated into pediatric primary care teams and uncertainty regarding supervision and reimbursement pathways. While current efforts provide a helpful foundation for the CHW workforce, additional role specific training and operational support could further strengthen the contributions of CHWs in pediatric IBH.

PSSs are part of Georgia's broader BH workforce and are recognized for their role in supporting engagement, navigation, and recovery-oriented care. PSSs are more commonly embedded within community BH settings, and recent policy changes have created reimbursement pathways for peer-delivered services. Integration of PSSs within FQHCs remains limited, with ongoing questions related to role clarity, supervision, and operational fit. As CHW certification efforts advance, there are opportunities to better align PSS and CHW roles, including potential pathways that recognize prior training and experience.

Behavioral Health Care Access & Referrals

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.

Screening, Referral, and Follow-Up Pathways

Routine BH screening is recommended by the American Academy of Pediatrics (AAP) and Bright Futures as a strategy to support early and consistent identification of BH and developmental needs.[45] In addition, there are a variety of quality care metrics that utilize screening-related outcomes, which directly influence federal funds and grants available to FQHCs.[2,46,47] In Georgia, as in many other states, routine BH screening is not a mandated regulatory requirement. Though varied, FQHCs who participated in the landscape analysis reported conducting some routine screening. Appendix F contains the complete list of BH screening instruments used by the FQHCs that participated in interviews.

FQHCs consistently reported that approaches to addressing BH needs vary and are influenced by provider comfort, knowledge, and capacity. FQHCs indicated that standardized pathways for managing common BH needs within primary care could be improved with efforts to create greater consistency. FQHCs also expressed interest in workflows designed to strengthen follow-up and care continuity, including completing a handoff to other members of the care team on the same day or shortly after meeting with the PCP (warm handoff).

Access to Specialized Services

Referrals to specialized services are a routine component of pediatric care. Examples of these services for the pediatric patient population include: DBP, EI, Applied Behavioral Analysis (ABA) Therapy, outpatient and home-based therapeutic services, substance use disorder treatment, and emergency services. Descriptions of these services are provided in Appendix G. Availability of specialty services varies by region. While many services are available within the Atlanta area, FQHCs reported that access to specialty services often involves extensive wait times. As distance from the Atlanta area increases, availability of specialty services becomes more limited. Rural FQHCs cited transportation as a significant barrier to accessing specialty care.

FQHCs described concerns about ensuring that patients are seen for specialized services following a referral, despite having varied staff roles to support the referral process. There was an expressed need for a standardized approach to manage referral tracking and follow-up for the pediatric patient population. The CHW role was identified as being suited to support care coordination, given that they are commonly representatives from the community that they serve and can leverage their extensive knowledge of community resources.

Regional Variation

Georgia is home to roughly 11.2 million residents living across diverse geographic areas.[48] In the context of BH service delivery, the state is often described as comprising three distinct regions: Metropolitan (Metro) Georgia, Northern Georgia, and Southern Georgia. Each region differs in demographic characteristics and availability of BH resources. Metro Georgia, formally referred to as Atlanta-Sandy Springs-Alpharetta, GA Metropolitan Statistical Area (MSA), is the 29-county region that is home to 6.3 million residents.[49,50] As of 2024, Metro Georgia is the sixth-largest metropolitan region in the United States and is a significant immigration hub with roughly 1.2 million immigrants.[49,51] 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 rural regions of Georgia, paucity of medical care constrains access to primary care. FQHCs described a shortage of PCPs, including pediatricians and obstetric providers, which limits routine access to care for children and families and often requires travel over long distances to establish or maintain care. In addition, rural areas face pronounced shortages of BH providers, including outpatient clinicians, child psychiatry, and specialty developmental services.[41,52]

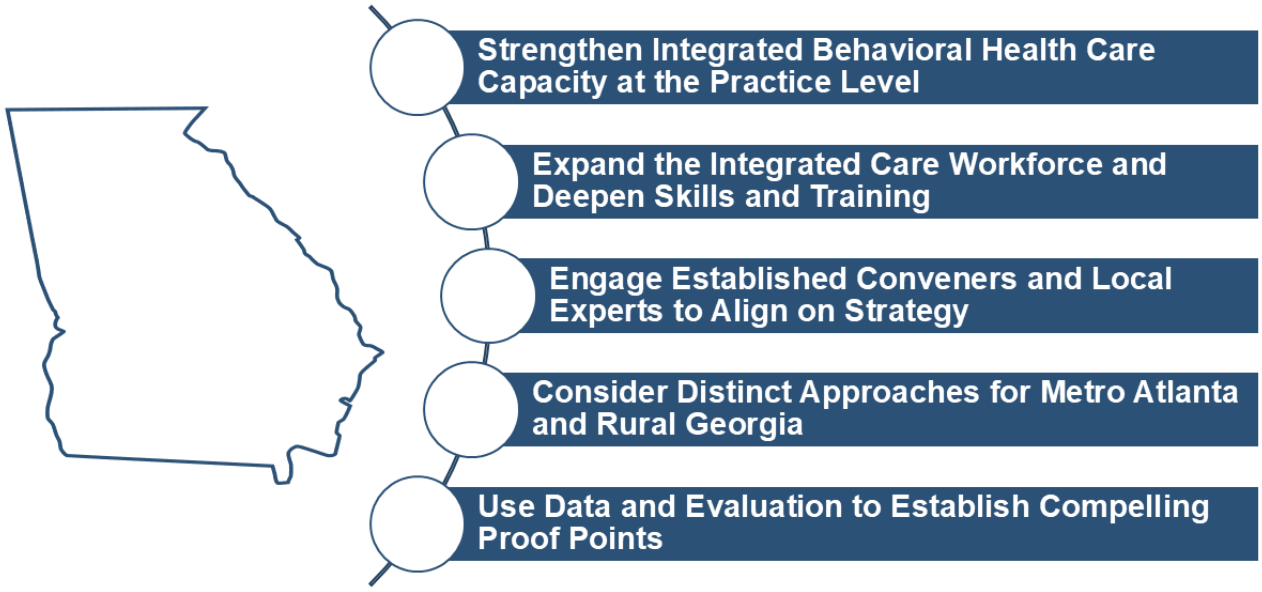
Together, these constraints affect both early identification of BH and developmental needs and timely access to services following referrals. Within this context, FQHCs serve as one of the few consistent access points for pediatric care in many rural communities but reported ongoing challenges in securing BH services for their pediatric patients. These challenges include long travel distances, transportation barriers, extended wait-times for referred services, and limited local specialty capacity. Across regions, BH related stigma and workforce shortages further shape access to care for children and families.

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. The analysis underscores meaningful differences between Metro Atlanta and rural regions that affect implementation, including workforce availability, transportation access, linguistic diversity, and proximity to specialty services. Planning approaches that account for these regional differences is important to ensure that capacity-building efforts are feasible, responsive, and aligned with local conditions.

The priority areas below reflect where targeted support, coordination, and investment may have the greatest impact in advancing pediatric IBH capacity in Georgia FQHCs (Figure 2).

Figure 2: Priority Areas for Advancing Integrated Behavioral Health Capacity



Strengthening Integrated Behavioral Health Capacity at the Practice Level

There is a clear opportunity to provide operational and implementation support to strengthen FQHC capacity to deliver IBH. FQHC leaders described an established commitment to IBH and an existing foundation on which to build. Interviews identified routine BH screening practices and emerging workflows to support same-day or near-term BH services. These findings indicate that participating FQHCs have already made meaningful investments in integrated care and are positioned to further strengthen and sustain these efforts with appropriate support.

While screening and early identification are already occurring in some practices, FQHCs described challenges developing consistent workflows and communication pathways to support handoffs from PCPs to BHCs, CHWs, or PSSs following identification of a BH or developmental need. FQHCs highlighted the value of technical assistance to support workflow development and implementation, including clarifying roles, defining handoff logistics, and establishing feedback loops to the care team. Standardized process mapping was identified as a practical tool to support more consistent delivery of BH services within pediatric primary care.

Overall, FQHCs described readiness to strengthen pediatric IBH with targeted operational infrastructure and implementation support. Given that Georgia FQHCs serve over 200,000 patients under 18 years annually, strengthening IBH infrastructure offers an opportunity to reach a large pediatric population.

Expanding Workforce Skills and Training

FQHCs described workforce factors that affect their ability to expand pediatric IBH, including recruiting BH staff with pediatric BH experience, onboarding clinicians into integrated care roles, and ensuring access to appropriate supervision and training to support delivery of BH services. As such, the importance of training and professional development specific to pediatric integrated care roles was noted. Partnerships with established workforce development organizations,

like Resilient Georgia and ARCHI, are critical to expanding the IBH workforce. However, interviewees described variability in awareness of available training opportunities and differences in the ability to access training opportunities due to time, staffing, and operational constraints. These factors influence how consistent training can be incorporated into routine practice. Encouraging utilization of training opportunities and addressing barriers to consistent training will support IBH implementation in FQHCs

Engaging Established Conveners and Local Experts to Align on Strategy

Several organizations operate across roles and sectors to promote coordination, shared learning, and alignment in pediatric BH. These efforts focus on system-level collaboration rather than workforce training alone. Mindworks Georgia, convened by DBHDD, brings together state agencies and nongovernmental organizations to coordinate efforts at the system-level that support child and youth BH through collective impact.[53] The Mindworks Whole Person Health Workgroup specifically focuses on strengthening care coordination and expanding IBH services.[53] Georgia Primary Care Association (GPCA) convenes FQHCs statewide and provides training and technical assistance related to primary care operations. Through these activities, GPCA supports information sharing across FQHCs and facilitates dissemination of guidance related to policy changes, reimbursement, workforce initiatives, and other considerations relevant to pediatric BH. FQHC leaders described the GPCA as a key source of information and coordination, particularly in relation to statewide initiatives that affect FQHC operations. These organizations play complementary roles in supporting pediatric BH across the state. Greater alignment across their existing efforts could collectively strengthen support for FQHCs.

Considering Distinct Approaches for Metro Atlanta and Rural Georgia

Regional variation across Georgia has direct implications for planning pediatric IBH efforts. Differences across Metro Georgia, Northern Georgia, and Southern Georgia include population density, linguistic diversity, workforce availability, transportation access, and proximity to BH and specialty services. FQHCs in Northern and Southern Georgia tend to serve more rural communities and often rely on SBHCs and smaller clinical teams to reach children across large geographic areas. These FQHCs frequently describe transportation barriers and limited availability of referral options. In contrast, FQHCs in Metro Atlanta operate in densely populated and linguistically diverse communities, with greater availability of BH providers but continued challenges related to workforce shortages, service demand, and language access. These findings underscore the importance of planning approaches that are responsive to regional context and tailored to local operational realities.

Data and Evaluation to Establish a Proof Point

Data and evaluation are important for supporting the planning, implementation, and sustainability of pediatric IBH within FQHCs. Consistent and feasible approaches to documenting screening, care processes, and referral pathways can support shared understanding of how IBH improves access to BH services. At the practice-level, data and evaluation can surface operational challenges and problem points that impact the delivery of BH services. At a system-level, data and evaluation supports advocacy efforts related to billing and reimbursement, workforce retention and development, and sustainability of IBH in primary care settings.

Conclusion

This landscape analysis was completed to inform *TEAMing UP for Georgia*, the current project supported by the Jesse Parker Williams Foundation to strengthen pediatric IBH capacity within FQHCs in the five-county Atlanta area. Findings indicate that Georgia has made meaningful investments in BH infrastructure, workforce development, and community-based service delivery, and that FQHCs serve as a consistent access point for children and families.

FQHC leaders consistently demonstrated a clear understanding of the value of IBH and described strong interest in moving beyond early capacity-building toward more comprehensive implementation. The primary need identified was not additional motivation to pursue IBH, but operational infrastructure and implementation support to translate both existing buy-in and emerging practice readiness into consistent workflows and sustained care coordination.

This work would be undertaken in collaboration with local leaders and partners to strengthen system-level capacity and reduce barriers to accessing BH services. Given Georgia's current policy and financing environment, the project also presents an opportunity to generate practice-grounded learning that can inform ongoing efforts related to reimbursement, workforce development, and the long-term sustainability of pediatric IBH in Georgia.

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Appendix

Appendix A: Informants Engaged in the Landscape Analysis

Systems-Level Key Informants
Atlanta Regional Collaborative for Health Improvement
Children's Healthcare of Atlanta
Department of Behavioral Health and Developmental Disabilities
Fulton Dekalb Hospital Authority
Georgia Association of Community Service Boards
Georgia Chapter of the American Academy of Pediatrics
Georgia Early Education Alliance for Ready Students
Georgia Primary Care Association
Georgia Watch
Mindworks Georgia
One World Link
PARTNERS in Equity at Emory University
Public Works Alliance
Resilient Georgia
United Way of Greater Atlanta
Wellstar Family Medicine

Practice-Level Informants
Nine FQHCs that represented both urban and rural areas of Georgia were engaged.

Appendix B: State Agencies that Influence Georgia's Behavioral Health Landscape

State Agency	
Department of Behavioral Health and Developmental Disabilities (DBHDD)[12]	DBHDD is Georgia's public safety net that serves people who are uninsured, insured by Medicaid, and those with few resources or healthcare options. DBHDD primarily operates state hospitals and community-based services that help people with mental health challenges, substance use disorders, intellectual and developmental disabilities, or any combination of these. FQHCs work closely with the service organizations operated by DBHDD, as these organizations of common key referral sites for FQHCs.
Department of Community Health (DCH)[13]	DCH serves as the state's lead agency for Medicaid and PeachCare for Kids®. DCH oversees Georgia Families, ensures the delivery of physical and behavioral health services for children enrolled in Medicaid and PeachCare for Kids® and Georgia Families 360, which is the managed care organization for children and youth in the foster care system. DCH provides access to affordable, quality health care to millions of Georgians, including some of the state's most vulnerable and underserved populations.
Department of Human Services (DHS)[14]	DHS delivers a wide range of human services designed to promote self-sufficiency, safety, and well-being for all Georgians. Some of these services include the Child Support Services and the Division of Family and Children Services. In addition, DHS helps address health related social needs by issuing SNAP benefits, enrolling individuals in Medicaid, offering Temporary Assistance for Needy Families, and variety of other support services and innovative programs to help families in need.
Department of Public Health (DPH)[54]	DPH leads Georgia's disease prevention, injury and disability response, and health and well-being promotion. DPH collaborates with Georgia's 159 county health departments and 18 public health districts. DPH has led and organized funding and advocacy initiatives for community health workers (CHWs) in Georgia and has assumed responsibility for the ongoing presence and certification standards for CHWs across the state.
Department of Education (GaDOE)[55]	GaDOE oversees public education throughout the state, ensuring that laws and regulations pertaining to education are followed and that state and federal money appropriated for education is properly allocated to local school systems. In the Fall of 2025, the GaDOE oversaw the allocation of $19.6 million dollars to school districts seeking to expand mental health services and supports to children in the school system.

Other notable state agencies that influence the BH and wellbeing of children and families include the Department of Early Care and Learning (DECAL), the Georgia Vocational Rehabilitation Agency (GVRA), and the Department of Juvenile Justice (DJJ).

Appendix C: Legislation Establishing Behavioral Health Financial Feasibility within Primary Care

Legislation	
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)[56, 57]	Federally, CMS requires early and periodic screening, diagnostic, and treatment (EPSDT) coverage among individuals aged 21 years younger are through Medicaid/CHIP. EPSDT provides a coverage pathway for emergent behavioral health needs that can be addressed within the primary care setting. EPDST is a foundational law at the federal level that sets a baseline standard for BH care.
The Georgia Mental Health Parity Act (House Bill [HB] 1013)[58]	HB1013 was signed into law in April 2022 and requires coverage for mental health care for children, adolescents, and adults in accordance with the federal Mental Health Parity and Addiction Equity Act. In addition, HB1013 stipulates that CMOs for Medicaid and CHIP comply with a minimum 85% medical loss ratio, which guarantees that at least 85 cents of each dollar in Medicaid/CHIP revenue received by CMOs is spent on healthcare services for Medicaid/CHIP recipients.
Insurance Code §33-21A-13[59]	This insurance code solidified the coverage of mental health and substance use related services provided within primary care facilities. This code established that CMOs and insurers must reimburse mental health and substance use related services equivalent to physical health services.
SPA 24-0003[21]	Expanded the list of licensed behavioral health professionals that are able to bill and obtain reimbursement for behavioral services delivered. Prior to SPA 24-003, FQHCs could only receive reimbursement for services completed by a select, often limiting group of licensed behavioral health professionals.
SPA 23-0100[36] & SPA 24-0008[37]	Expanded the coverage of behavioral health services within select community behavioral health clinics, with specified reimbursement rates. These community behavioral health clinics are common referral sites for FQHCs.

Appendix D: Timeline of Approved Georgia State Plan Amendments

2023

SPA 22-0006[60]
March 17, 2023

Behavioral Support Aides added as anew service in Georgia, that will provide in-home behavioral support aides to children in the home and community-based settings. It was made effective on July 1, 2022.

SPA 23-0006[61]
July 01, 2023

Adds the Pathways Beneficiaries as a mandatory population enrolled in managed care. Pathways to Coverage is an innovative program that creates a new pathway to Medicaid coverage and healthier communities. s an innovative program that creates a new pathway to Medicaid coverage and healthier communities. It was made effective on July 01, 2023.

2024

SPA 24-0003[21]
August 22, 2024

Allows licensed professional counselors, licensed marriage and family therapists, and certified peer specialists to deliver services and be reimbursed by FQHCs. It was made effective on April 04, 2024

SPA 24-0008[37]
October 23, 2024

Modifies the reimbursement rates for community behavioral health services, adds community health workers to the list of acceptable practitioners, and updated the accreditation language. It was made effective on July 01, 2024.

SPA 24-0013[62]
January 08, 2025

Georgia formally agrees to comply with the federal provisions regarding mandatory reporting for the Core Set of Children's Health Care Quality Measures for Medicaid and the CHIP, and the behavioral health measures on the Core Set of Adult Health Care Quality Measures for Medicaid. It was made effective on December 30, 2024.

2025

SPA 23-0010[36]
May 22, 2025

Established coverage of CCBHCs and reimbursement of CCBHC services. It was made effective on July 01, 2024.

2026

HB 291[22]
March 06, 2025
Open Legislation

The Georgia House of Representatives passed this bill to establish the certification process for Community Health workers; it was tabled by the senate and is up for review in early 2026.

Read a complete list of all Georgia Approved State Plan Amendments.

Appendix E: Common BH Provider Roles in FQHCs

Specialized Services	
Behavioral Health Clinicians (BHCs)	BHCs vary in clinical training and educational background with the majority of BHCs holding credentials such as: licensed clinical social worker (LCSW), licensed marriage and family therapist (LMFT), and licensed professional counselor (LPC). BHCs provide therapeutic care to children and youth, though they tend to focus on the older adolescent population, less so on the younger patient population.
Community Health Workers (CHWs)	CHWs are frontline health workers who are trusted members of and/or have a demonstrated working knowledge of the community and individuals served.[13] Though CHWs vary in their primary responsibilities within FQHCs, they often support care engagement, patient/caregiver education, and care coordination.
Peer Support Specialists (PSS)	PSS are individuals who are trained and certified to provide ongoing support to individuals and their families receiving mental health and/or substance use recovery supports and services. PSS leverage their lived experience to support skills-building, problem-solving, and other supportive services.[12]
Primary Care Providers (PCPs)	PCPs vary in their clinical training and educational background but typically consist of medical doctors (MDs), nurse practitioners (NPs), and physician assistants (PAs). PCPs are essential in identifying emerging BH and developmental needs in children and youth. Though varied, PCPs are often comfortable in prescribing first-line medications for common pediatric behavioral health needs in pediatrics, including attention deficit hyperactivity disorder, depression, and anxiety.
Psychiatrists	Psychiatrists are medical doctors specializing in the diagnosis and treatment of behavioral health conditions, using a combination of medication and therapy. Depending on their medical training, psychiatrists vary in their comfort prescribing to the pediatric populations. Psychiatrist generally provided consultation support to PCPs and maintaining a limited caseload of patients.

Appendix F: Behavioral Health Screening Instruments Used in FQHCs Engaged in the Landscape Assessment

Behavioral Health Screening Instruments
Ages and Stages-3 (ASQ-3)
Ask Suicide-Screening Questions (ASQ)
Drug Abuse Screening Test-10 (DAS-10)
Edinberg Postnatal Depression Scale (EPDS)
Modified Checklist for Autism in Toddlers (MCHAT)
NICHQ Vanderbilt Assessment
Parents' Evaluation of Developmental Status (PEDS)
Patient Health Questionnaire-2 (PHQ2)
Patient Health Questionnaire-9 (PHQ9)
Pediatric Symptom Checklist-17 (PSC-17)
Screen for Child Anxiety Related Disorders (SCARED)
Survey of Well-being of Young Children (SWYC)

Appendix G: Specialized Services for Common Referral Pathways in FQHCs

Specialized Services	
Applied Behavioral Analysis (ABA) Therapy	A specialized therapeutic technique used to treat children with Autism Spectrum Disorder (ASD).
Developmental-Behavioral Pediatrics (DBP)	A subspecialty of pediatrics that focuses on evaluating and managing children with a range of developmental and behavioral needs, including ASD.
Early Intervention	Programs for infants and young children (typically birth to 3 years old) that have developmental delays or are at risk of a developmental delay.
Emergency Services	Range of services delivered, typically within a hospital-based setting, to manage emergent and serious behavioral health needs.
Home-based Therapeutic Service	Therapeutic services that occur within the patient's home.
Outpatient Therapeutic Services	Typical outpatient behavioral health services provided a licensed behavioral health professional. Services in this setting typically consist of hour-long sessions that occur on a regular basis over long periods of time.
Substance Use Disorder Treatment/Medication Assisted Treatment	Services pertaining to the treatment and management of patients using substances.

Commonly Used Abbreviations

Abbreviation	Full Name
AAP	American Academy of Pediatrics
ABA	Applied Behavioral Analysis Therapy
ARCHI	Atlanta Regional Collaborative for Health Improvement
ASD	Autism Spectrum Disorder
BH	Behavioral Health
BHC	Behavioral Health Clinician
CCBHC	Certified Community Behavioral Health Center
CHW	Community Health Worker
CHIP	Child Health Insurance Program
CHOA	Children's Healthcare of Atlanta
CMO	Care Management Organization
CMS	Centers for Medicare and Medicaid Services
CPP	Child-Parent Psychotherapy
CPT	Current Procedural Terminology
CSB	Community Service Board
DBHDD	Department of Behavioral Health and Developmental Disabilities
DBP	Developmental Behavioral Pediatrics
DCH	Department of Community Health
DECAL	Department of Early Care and Learning
DHS	Department of Human Services
DJJ	Department of Juvenile Justice
DPH	Department of Public Health
ECHO	Extension for Community Healthcare Outcomes
EI	Early Intervention
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
FQHC	Federally Qualified Health Center
GA-AIMH	Georgia Association for Infant Mental Health
GaDOE	Georgia Department of Education
GEEARS	Georgia Early Education Alliance for Ready Students
GMAP	Georgia Mental Health Access in Pediatrics
GPCA	Georgia Primary Care Association
GVRA	Georgia Vocational Rehabilitation Agency

Abbreviation	Full Name
HB	House Bill
IBH	Integrated Behavioral Health
IECMH	Infant and Early Childhood Mental Health
JPWF	Jesse Parker Williams Foundation
LCSW	Licensed Clinical Social Worker
LMFT	Licensed Marriage and Family Therapist
LPC	Licensed Professional Counselor
MD	Medical Doctor
MSA	Metropolitan Statistical Areas
NP	Nurse Practitioner
PA	Physician's Assistant
PCO	Primary Care Office
PCP	Primary Care Provider
PSS	Peer Support Specialist
SBHC	School Based Health Center
SPA	State Plan Amendment
TCCN	The Children's Care Network
TEAM UP	TEAM UP Scaling and Sustainability Center