

THREE YEARS.

Here's what we built.

Aria Community Health Center

Behavioral Health Screening & Linkage

Beatrice Kastrati, Quality Manager

Whitney O'Neal, Compliance and Risk Manager

Christine Ehda, Director of Patient Financial Services

EPT Final Learning Community · Part 1 · [September 29 or October 1, 2026]



Aria Community Health Center

Who we are and who we serve



WHO SPEAKS HERE

Beatrice Kastrati, Quality Manager



1	Federally Qualified Health Center serving rural communities across Kings, Fresno, and Tulare Counties
2	Patients served: 37,103 patients served in 2025 • 73% Medi-Cal, 7% Medicare, 18% private insurance, 2% uninsured • 13,263 patients with limited English proficiency and 6,148 agricultural workers and family members served
3	Our EPT population of focus: Children and Youth
4	What this storyboard is about: Behavioral Health Screening & Linkage

Keep this to about 60 seconds. Your population of focus and the measure you are presenting on matter most — they tell the room whether your story is one they can use. Send us your logo as a full-size file ahead of time and we will place it for you.

Three Years Ago

Who we were before EPT

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Beatrice Kastrati, Quality Manager



What could you not do in 2023 that this work was going to require?

Where we were

- Depression screening was completed inconsistently across sites and visits.
- Screening often competed with other rooming tasks, creating variation in workflows and missed opportunities.
- Positive screens were not tracked through a centralized referral process.
- Behavioral health follow-up depended heavily on individual staff workflows rather than a standardized system.
- Screening rates were below our desired performance level, with only **55.0%** of patients receiving PHQ-2/PHQ-9 depression screening during the baseline period.



Jenelle Mason,
Chief
Administrative
Officer

Christine Ehda
Director of
Patient Financial
Services

Whitney O'Neal
Compliance and
Risk Manager

Beatrice Kastrati
Quality Manager

What Was Really Going On

What we found when we looked closer

WHO SPEAKS HERE

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Why was the gap there? And how did you find out — did you ask patients, ask staff, dig into the data?

What we learned

- Providers shared that adolescents were more likely to answer depression screening questions honestly when given privacy.
- Patient feedback showed that language preference and provider gender influenced whether behavioral health referrals were accepted.
- We learned that improving access required more than making referrals available; trust, privacy, and culturally responsive care were equally important.
- Consistent data collection and documentation allowed us to identify gaps, monitor progress, and improve follow-through on screening and referrals.

In their words

“If you ask a teenager about depression in front of their parent, you're not always getting the teenager's answer.”
— Aria provider during workflow discussions

“I didn't want to talk about it with a man, and it would have been easier if I could speak in Spanish.”
— Aria patient during a telephone survey

What We Built

The change we made, and who runs it

WHO SPEAKS HERE

Beatrice Kastrati, Quality Manager



What did you build or change? Name it — then name who does it, and when.

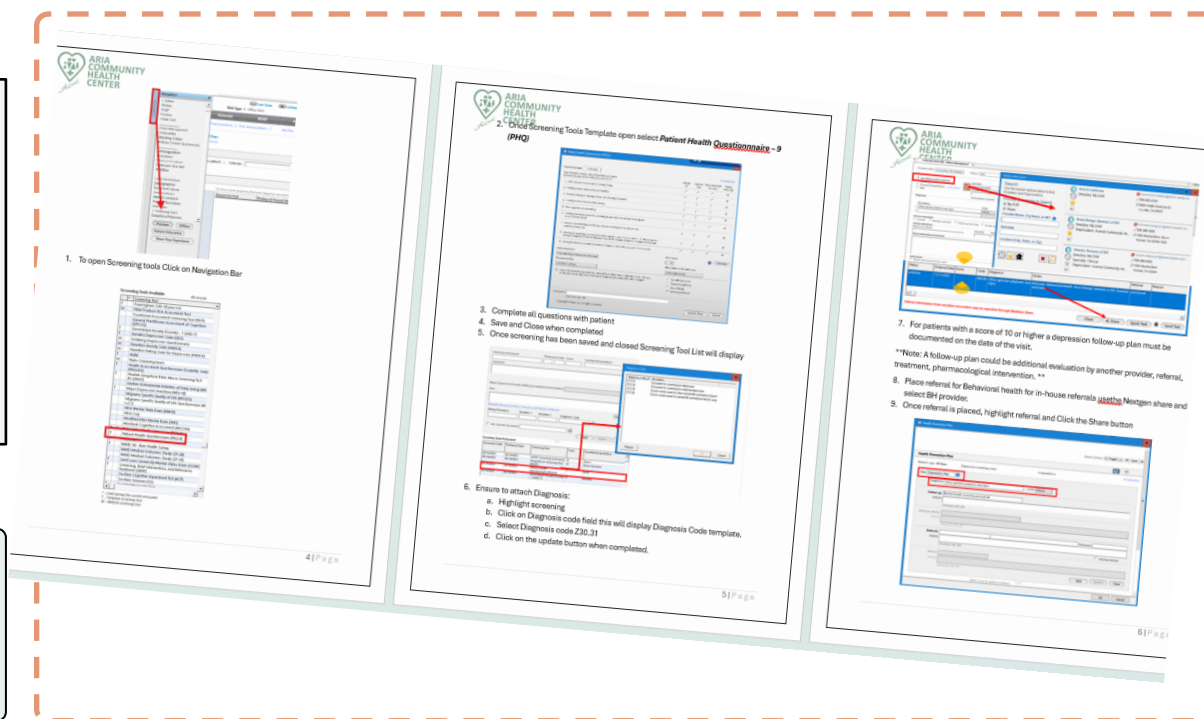
The change

- Every patient, every visit: PHQ-2 screening became the standard.
- Positive screens automatically advanced to PHQ-9 with risk-based intervention protocols.
- Standardized workflows, documentation, and staff accountability across sites.
- Centralized referral tracking through HealthViewX with follow-up and prioritization (STAT, Urgent, Routine).
- Ongoing staff training to ensure consistent screening and care coordination.

From the person who runs it

“

"If we're serious about behavioral health, screening can't depend on who is working that day. Every patient needs to be screened, every time."



What Happened

Our numbers, and what surprised us

WHO SPEAKS HERE
Beatrice Kastrati, Quality Manager



From 55.0%

To 69.2%

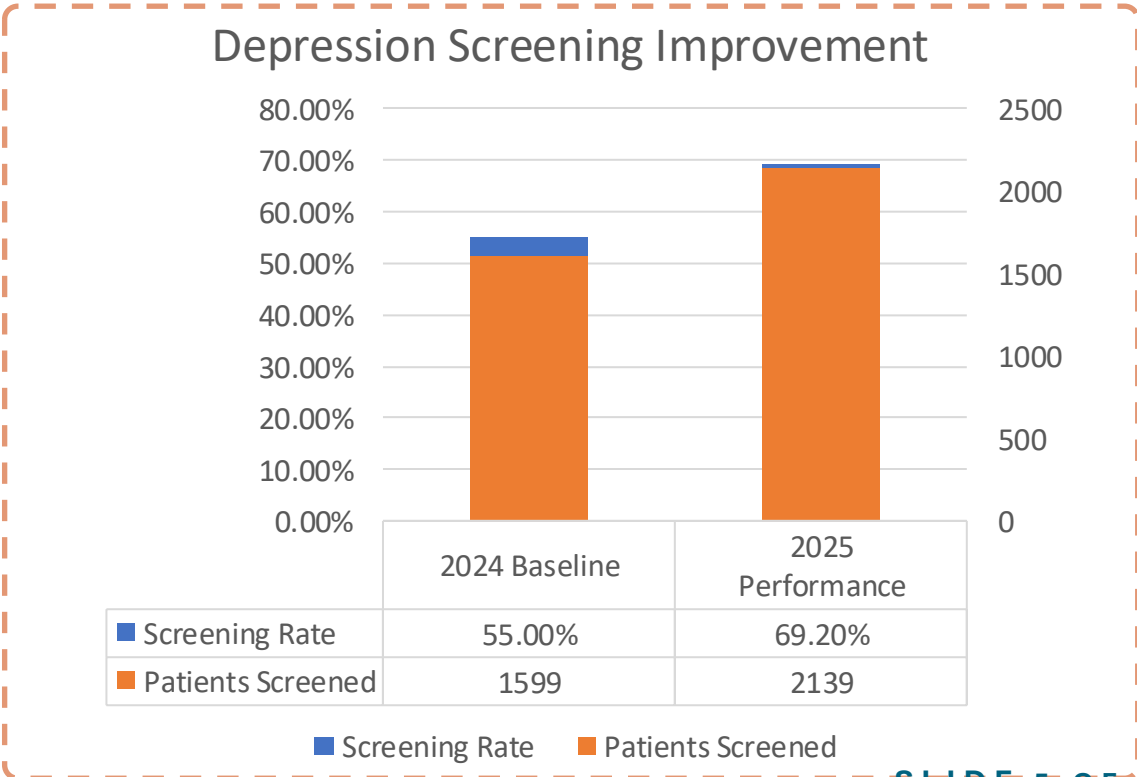
+540

The numbers, in a sentence

Depression Screening (PHQ-2/PHQ-9): Increased from 55.0% to 69.2% over one year, growing from 1,599 to 2,139 patients screened for depression and reaching 540 additional patients.

What did not go as planned — and what surprised you

Behavioral health workforce shortages created an unexpected challenge during implementation. Our in-house behavioral health team was reduced to two part-time providers, making it difficult to meet demand and limiting referral capacity. Referring patients to community providers was also challenging due to limited behavioral health resources in the Central Valley. We learned that improving screening is only one part of the equation; access to timely behavioral health services remains a significant barrier.



The Patient Behind the Number

One story behind the numbers

WHO SPEAKS HERE

Beatrice Kastrati, Quality Manager



“ *I was worried about how I would pay for counseling and whether I could keep my medical coverage.*

— Female Spanish speaking patient (not PoF), recently contacted by Care Coordination

And the story around it

A patient repeatedly missed well visits and had several PHQ-9 screenings with a score of 25. Because depression screening was embedded into our workflow and monitored through our care coordination process, staff identified the pattern and escalated the case to our Behavioral Health Director. The patient was contacted the same day, connected with a Spanish-speaking behavioral health provider, and received an urgent appointment. During the conversation, the patient shared concerns about cost and insurance coverage. The provider was able to explain available services, including FQHC sliding-fee options, and connect the patient to appropriate support. This experience reinforced an important lesson: screening identifies need, but trusted relationships, language-concordant care, and timely follow-up are often what turn a positive screen into actual engagement with services.



Brisana Newell, LCSW
Director of Behavioral Health

What We Can Do Now

The capability we did not have before

WHO SPEAKS HERE

Beatrice Kastrati, Quality Manager



We can now consistently screen patients for depression at every visit, identify concerns earlier, and connect patients to care through a standardized referral and follow-up process.

We can now systematically identify behavioral health needs as part of routine primary care by screening patients at every visit, using a standardized PHQ-2 to PHQ-9 workflow, and documenting results consistently across sites. Positive screens trigger clear risk assessment and triage protocols, ensuring patients receive an appropriate response based on their level of need. We also have a centralized referral and follow-up process that allows us to monitor referrals, prioritize urgent cases, and support patients through the next steps of care.

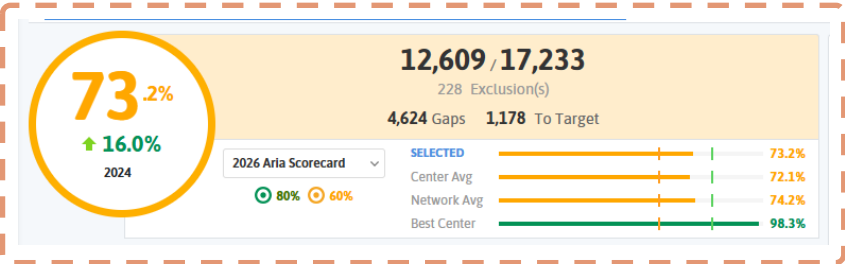
What it feels like now

“ Behavioral health screening is no longer something we try to fit into the visit. It is part of the visit.



And who does it reach?

Patients who may not have otherwise disclosed behavioral health concerns, including adolescents, Spanish-speaking patients, and individuals presenting for non-behavioral health concerns. By screening at every visit, we are identifying needs earlier and more consistently than before.



What It Took to Keep It Going

What it took, and what makes it sustainable

WHO SPEAKS HERE
Beatrice Kastrati, Quality Manager



What did it take to build and run, and what will keep it going?

What it took

- Purchased and implemented Phreesia in early 2026 to support pre-visit screening.
- Redesigned screening from annual PHQ-9 administration to a PHQ-2-first approach at every visit.
- Standardized workflows for screening, triage, suicide risk assessment, referral, and follow-up.
- Trained providers, medical assistants, referral coordinators, and support staff on new workflows and documentation requirements.
- Implemented centralized referral tracking through HealthViewX.

What makes it sustainable

Depression screening is now embedded into routine clinic operations. Every patient is screened at every visit using a standardized workflow, positive screens trigger defined triage protocols, and referrals are tracked through established processes. While Phreesia supports the workflow, the sustainability comes from standardized procedures, staff training, and accountability built into daily operations.

**Staff training and
workflow redesign**

**Routine staff
training and quality
monitoring**

**540 additional patients
screened for
depression
Patient cycle time
reduced from 69 to 48
minutes**

Say it in one sentence

By standardizing depression screening at every visit, implementing clear risk-based follow-up protocols, and creating a centralized referral process, Aria screened 540 additional patients while reducing average patient cycle time from 69 minutes to 48 minutes.

What We'd Tell You

What we'd tell another practice

WHO SPEAKS HERE

Beatrice Kastrati, Quality Manager



1

If you were doing this over, what is one thing you would do differently?

We would have focused earlier on behavioral health workforce capacity and referral availability. While we successfully improved screening and identification of patients with behavioral health needs, access to timely services remained challenging due to limited in-house staffing and shortages of behavioral health providers in the Central Valley. Earlier planning around workforce and referral partnerships would have strengthened the impact of the work.

2

Where would you like to build on this, or grow next?

Our next focus is strengthening access to behavioral health services after a positive screen. Since implementing this work, we have expanded our behavioral health team to six providers, including four female Spanish-speaking providers. We want to build on this foundation by improving referral completion, reducing barriers related to language and provider preference, and ensuring patients can access timely, culturally responsive behavioral health care.

3

Steal this from us.

Steal our PHQ-2-first, every-visit screening workflow. Making screening universal and embedding it into routine care helped us identify more patients while creating a more consistent path to follow-up. Screen every patient at every visit. The move from annual PHQ-9 screening to a PHQ-2-first, every-visit approach was our single biggest driver of improvement. Don't stop at screening. Pair universal screening with clear triage protocols and referral tracking so positive screens lead to action.

Your 90-Second Preview

Before rooms open, you pitch your story so people can choose where to go.

You will not present this slide — draft what you will say here. We will help you polish it.

We are Aria Community Health Center, a rural Federally Qualified Health Center serving more than 37,000 patients across Fresno and Tulare Counties. Through EPT, we redesigned our behavioral health screening process by moving from annual PHQ-9 screening to a PHQ-2-first approach at every visit, supported by standardized triage, referral, and follow-up workflows. As a result, depression screening increased from 55.0% to 69.2%, reaching 540 additional patients, while maintaining clinic efficiency. We also learned that improving screening is only part of the challenge. Access to behavioral health services, language preferences, provider choice, and workforce shortages all influence whether patients ultimately engage in care. If you're looking for practical strategies to increase screening rates, standardize workflows, and build a sustainable behavioral health screening process without adding burden to staff, we'd love to share what worked, what didn't, and what we learned along the way.

End on what they will get, not on what you did. That is what makes people choose your room.

THANK YOU

Questions?

[Practice name]

[Everyone who worked on this — not just who presented]

