

BEHAVIORAL HEALTH • 2026

# Missed Opportunities for Behavioral Health Services

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*Rethinking whole-person care in primary practice*

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# Objectives

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## **Pinpoint core service components**

Identify the essential elements of whole-person care within a practice.



## **Map effective integration paths**

Discover how to weave behavioral health into existing primary care workflows.



## **Assess community-level need**

Evaluate the behavioral health demand present in the populations you serve.



## **Tailor services to populations**

Match service offerings to the specific groups represented in your community.



## **Examine the role of AI**

Explore where artificial intelligence is reshaping behavioral health delivery.

# From episodic treatment to whole-person care

## Old Model

### Disease-centered, episodic treatment

- Symptoms treated in isolation
- Patient as passive recipient
- Visit-by-visit episodes of care
- Narrow focus on physical pathology

## Whole-Person Model

### Holistic, relationship-based care

- Patient engaged as active partner
- Physical, mental, emotional, social and spiritual dimensions addressed together
- Continuous, longitudinal relationships
- Focus on overall well-being, not just disease

CHAPTER 01

# How a practice looks different

*Standing out begins with seeing differently.*

Person

Partner

Team

Prevention



# Where practices need to think differently



## Treat the person, not the pathology

01

Move beyond isolated symptoms by asking what truly matters to each patient and weighing biological, behavioral, social, and environmental drivers — the social determinants of health.



## Integrate shared decision-making

02

Treat patients as experts in their own lives. Listen actively to their story and co-design care plans together, trading paternalistic instruction for genuine partnership.



## Expand the scope of the care team

03

Whole-person care reaches well beyond doctors and nurses, drawing on nutritionists, therapists, lifestyle coaches, and community health workers.



## Focus on Salutogenesis

04

Invest equally in creating health, building resilience, and preventing disease — not only in suppressing illness when it appears.

# Sustaining integrated BH in primary care

## Why sustainability matters

**Sustainable behavioral health depends on a fully integrated primary care model.**

A durable program ensures the essential resources are in place to support people living with behavioral and mental health conditions. **The strongest models are built around interlocking service components designed for whole-person care, ongoing community evaluation, and population-relevant programming.**

# Primary care behavioral health

*HBAI codes built for high-volume settings, delivering brief interventions and on-demand behavioral health access right where patients already are. 96156 96158, **96159** (add on) 96164 **96165** 96167 **96168** 96170, **96171***



## Warm handoffs

Real-time introductions from PCP to behavioral health clinician at the point of care.



## Same-day access

Behavioral health support available during the visit, eliminating referral delays.



## Brief interventions

Short, focused encounters and ongoing follow-up that fit primary care rhythms.

## Billing & coding

Providers in this model typically draw on Health and Behavior Assessment and Intervention (HBAI) codes

# Collaborative extended care

*The Collaborative Care extended model centers on population-based care for patients with moderate to severe behavioral health conditions. 99492 first month second month 99493 (60 min) 99494 add 30min (16-37min) G2214 (30min)*



## Patient registry

A shared tracking system keeps the population visible and follow-up accountable.



## BH care manager

A dedicated manager coordinates outreach, monitoring, and treatment adjustments.



## Psychiatric consultation

Indirect psychiatric expertise informs prescribing and clinical decisions.

## Codes

General BHI codes (including 99484). Note that General BHI codes do not require a behavioral health care manager or psychiatric consultant. 20 minutes per calendar month

PART TWO

# Opportunities

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*Where intervention is possible, but too often missed.*

**Screen**

**Refer**

**Engage**

**Follow up**



# Universal screening

Every patient is screened for behavioral health concerns — from substance and alcohol use to depression, anxiety, and other mental health conditions — so issues are caught when intervention can still change the trajectory.

## Universal screening covers

- Substance and alcohol use
- Depression and mood disorders
- Other common mental health conditions
- Risk factors uncovered through routine visits

## Cost it out

A simple equation for screening cost:

**Time per patient × Patients screened × Staff salary**

*Knowing the true cost is the first step to defending the investment.*

# Pediatric screening



## Routine developmental & behavioral

Screen at 9, 15, 18, 24, and 30 months — and any time a concern surfaces.



## Autism-specific

Administer dedicated tools (e.g., M-CHAT) at the 18- and 24-month visits.



## Vanderbilt ADHD Rating Scales

Structured ADHD assessment for school-age children and adolescents.



## PHQ-9 / PHQ-A

Detect depression in adolescents and older children.



## SCARED

Screen for anxiety-related disorders across pediatric ages.



## SDQ

Broad behavioral and emotional assessment in one short tool.



## ASQ Suicide Toolkit

Quick, evidence-based screening for suicide risk.



## BSTAD

Brief screener for tobacco, alcohol, and other substance use.



## DISCUSSION

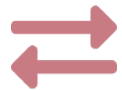
# What other screening opportunities come to mind?

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*Surface the gaps your team already sees in everyday practice.*

# Identifying missed opportunities

Surfacing missed opportunities means looking carefully at the moments where need is recognized but care never follows — and the visits where screening and intervention simply do not happen.



## Track warm-handoff failures

Catch the moments when a handoff was attempted but did not complete.



## Analyze screening rates

Compare expected coverage against actual administration across visits.



## Review patient-centered care gaps

Pinpoint where the patient's stated priorities fall out of the plan.



## Evaluate workflow inefficiencies

Find the friction points that quietly drop interventions from the visit.

# Data-driven metrics and screenings

## **Audit screening rates**

Track how often evidence-based tools — PHQ-2/9 for depression, GAD-7 for anxiety — are administered at new-patient and annual visits. Low rates flag missed detection.

## **Screen school-age children**

Capture how many children are screened for health-related barriers to learning during yearly wellness exams.

## **Positive screenings vs. referrals**

Find every patient who screened positive yet was not offered or did not receive follow-up intervention.

## **Warm handoff rates**

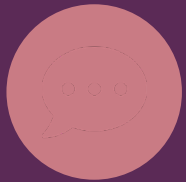
Measure how often PCPs bring behavioral health clinicians into the visit. A low rate compared to behavioral need signals missed intervention.

## **No-show rates**

Track missed and cancelled follow-up appointments to expose obstacles patients are facing in returning for care.

# Cultural and structural evaluation

*A practice's culture and structure shape every encounter. Examining them is essential to understanding why missed opportunities recur.*



## Culture

How clinicians and staff talk about behavioral health, and whether stigma quietly shapes who gets asked the right questions.



## Structure

Whether physical layout, scheduling, and staffing actually allow integrated care to occur during a visit.



## Equity

How language access, trust, and community representation influence who receives whole-person care.

# Examples of missed opportunities



## Positive screen, no referral

A PHQ-9 returns elevated, but the patient leaves without a connection to follow-up.



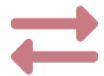
## Wellness visit without behavioral screening

An annual visit completes the physical checklist while skipping behavioral and emotional questions entirely.



## Pediatric milestone visits missed

A child skips a recommended developmental screening because no system flagged the gap.



## Failed warm handoff

A patient is told a behavioral health clinician is available, but the introduction never actually happens.



## Care plan ignores social drivers

Housing, food, or transportation barriers go undocumented and unaddressed in the plan.



## Lapsed follow-up after first visit

A patient with a new behavioral health concern is never re-engaged after the initial encounter.

PART THREE

# Population needs

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*Tailoring services to the people you actually serve.*

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IDD

Neuro

Seizures

Mood



# Population needs in focus

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## **Intellectual & developmental disorders**

Includes conditions present from early life that shape learning, communication, and daily function.



## **Neurodegenerative disorders**

Encompassing conditions such as Alzheimer's, Parkinson's, and motor neuron disease.



## **Seizure disorders**

Conditions characterized by recurrent seizures that require coordinated medical and behavioral support.



## **Emotional dysregulation**

Difficulty regulating emotional responses that disrupts daily life and relationships.



## **Mood disorders**

Conditions ranging from depression to bipolar spectrum that benefit from integrated care.

# Community engagement supports whole-person care



## Schools & early childhood

Partnering across education touchpoints catches behavioral needs before they escalate.



## Faith & community organizations

Trusted local groups extend access to people who would not enter a clinic first.



## Social services

Coordinated referrals to housing, food, and transportation programs anchor whole-person plans.



## Peer & lived-experience networks

Peer supports lower the barrier to engagement and sustain recovery.

# Metrics to monitor at the population level

## Audit screening rates

Track PHQ-2/9 and GAD-7 administration at new-patient and annual visits — low rates point to missed detection.

## School-age learning barriers

Track how many school-age children are screened for health barriers to learning during yearly wellness exams.

## Positive screens vs. referrals

Identify patients who screened positive but never received follow-up intervention.

## Warm handoff rates

Compare warm-handoff frequency to the prevalence of behavioral concerns — a gap signals missed intervention.

## No-show rates

Document missed and cancelled follow-ups to expose the practical barriers patients face.

# Clinical workflow and process review

*Mapping how a visit actually moves — not how it is supposed to — is where most missed opportunities reveal themselves.*

01

## Pre-visit prep

Review screening status, behavioral concerns, and prior follow-ups before the patient arrives.

02

## Intake & screening

Embed validated tools into the rooming workflow so behavioral data is collected reliably.

03

## Provider encounter

Discuss results, surface priorities with the patient, and trigger warm handoffs in the moment.

04

## Follow-up & registry

Close the loop with care management, follow-up scheduling, and registry tracking.

PART FOUR

# AI and BH

*Where AI is reshaping behavioral health workflows.*

**Detect**

**Personalize**

**Engage**

**Support**



# AI entering behavioral health

*Providers can put AI-driven engagement tools to work across the recovery journey, weaving them into mobile apps that meet patients in everyday moments.*



## Medication adherence

Schedule reminders, track side effects, and surface response patterns over time.



## Provider collaboration

Channel real-world data back to the care team to keep treatment decisions current.



## Mood monitoring

Track fluctuations and identify triggers so patients can act on patterns earlier.



## Self-care insights

Translate data into personalized recommendations that support informed self-management.

## Discussion questions for the group

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? Which missed opportunity surfaces most often in your own practice?

? Where does your workflow already enable warm handoffs — and where does it block them?

? How might community partnerships extend the reach of your behavioral health services?

? Where could AI realistically support your team in the next twelve months?

CLOSING

# Thank you

*For seeing the whole person.*

## Key takeaways



### Whole-person care

Treat the patient, not the pathology.



### Sustainable integration

Embed BH into primary care workflows.



### Surface the gaps

Track screening, handoffs, and follow-through.



### Reach beyond walls

Partner with communities and emerging tools.

