Behavioral Health Integration Initiative

Closing Care Gaps in Integrated Healthcare: Strategies for Improved Patient Outcomes

A Resource Guide for Integrated Behavioral Health (IBH) Staff and Supervisors

What Are Care Gaps?

Care gaps refer to missed opportunities for preventive, follow-up, or treatment interventions related to a patient's physical, behavioral, or social health needs. The IBH staff can use care gaps as clinical decision guides to determine what should happen during any given primary care visit to address the presenting problem, and to promote whole-person health across the lifespan.

Examples of How Care Gaps Support Whole Health

Before you launch a Patient Satisfaction Survey, it's essential to define what you want to learn. Ask yourself these questions.

- In Native and Indigenous communities, common primary care visit reasons often include chronic diseases (e.g., hypertension, diabetes) for adults and infectious diseases (e.g., strep throat) for children (Gibson, 2023).
- During a hypertension follow-up visit with a 55-year-old woman, a care gap prompt might remind the provider to:
    - Screen for mental health (e.g., PHQ-9 for depression)
- Review health behaviors (e.g., tobacco and alcohol use)
- Assess social relationships and safety (e.g., PRAPARE items: "How often do you see or talk to people you care about?" and questions on intimate partner violence)
    - Health related social needs: Housing stability, Food insecurity, access to healthcare.
- For a 3-year-old boy in the clinic for strep throat, care gaps might include:
    - Assessing social-emotional and cognitive development, speech, and language, and
    - Evaluating environmental risks (e.g., lead exposure, mold, secondhand smoke via PRAPARE).

Why It Matters

Preventive care saves lives, improves health outcomes, and lowers overall system costs by (Scott, 2025; Morrison, 2024):

- Preventing disease outright
- Detecting illnesses earlier when treatment is most effective.
- Supporting whole-person health rather than fragmented care

Closing care gaps improves patient outcomes, reduces costs, and supports whole-person care (American Hospital Association, 2014; Bipartisan Policy Center, 2021).

Integrated models can address these gaps through collaboration, data-driven care, and team-based approaches.

Why Do Care Gaps Occur?

- **Limited reminders or tracking systems:** Staff may not have a straightforward way to see when preventive services are due or completed.
- **Communication breakdowns:** Coordination challenges between primary care, psychiatry, and behavioral health lead to missed follow-ups or duplicated efforts.
- **Systemic or workflow barriers:** EMR limitations, staffing shortages, or unclear responsibilities delay interventions.
- **Siloed practice:** Providers focus only on presenting issues rather than comprehensive, coordinated care.

Common Care Gaps in Integrated Healthcare

A. Screening & Assessment

Missed or inconsistent:

- Developmental screenings at key child milestones
- Annual tobacco is screening for children, adolescents, and adults.
- PHQ-9 and GAD-7 at least once yearly (more frequently as indicated) Substance use (SBIRT) for youth and adults.
- Trauma
- Social Determinants of Health (SDOH) screenings (e.g., PRAPARE) annually

B. Follow-Up Care

- Lack of follow-up after a positive depression or substance use screen.
- Missed follow-up after hospitalizations for both physical and mental health conditions.
- Lack of follow-up by the IBH staff to ensure referrals (e.g., psychiatry, therapy, community resources) are completed.

C. Medication Management

- No adherence monitoring or missed labs for psychiatric medications.
- Refills issued without a current clinical review or recent visit.
- Lack of medication reconciliation between behavioral health and primary care

D. Chronic Condition Management

- Limited integration of behavioral health into management plans for diabetes, hypertension, or obesity
- Missed opportunities to address mood, motivation, or self-care behaviors influencing chronic disease control.

E. Equity & Access

- Lack of culturally responsive care or language support
- Barriers to access for underrepresented or rural populations
- Limited use of community-based partnerships to address cultural and contextual determinants of health.

Strategies for Staff

A. Direct Care Approaches

- **Proactive Screening:** Use stand documentation templates and EMR prompts for PHQ-9, GAD-7, SBIRT, ACEs.
- **Warm Hand-offs:** When possible, introduce patients directly to BH team members on the visit.
- **Patient Engagement:** Use motivational interviewing, teach-back, and culturally sensitive approaches.
- **Follow-up:** Schedule follow-ups before patients leave the clinic; use phone/text reminders.
- **Care Plans:** Collaboratively develop plans with medical + behavioral + social goals.

B. Documentation & Communication

- **Shared Notes:** Document in ways that support both medical and BH teams.
- **EMR Alerts:** Flag high-risk patients (e.g., suicidality, missed labs, uncontrolled chronic conditions).
- **Team Huddles:** Daily or weekly team check-ins to review patients at risk of falling through the cracks.

Strategies for Supervisors & Program Leaders

A. Building Systems to Close Gaps

- **Templates and Standard Operating procedures:** Develop clear, user-friendly documentation templates and SOPs that streamline workflow and prioritize ease of use.
- Ensure key data points related to care gaps are captured by the care team in structured, reportable fields that allow for efficient tracking, performance reporting, and quality improvement.
- **Data Tracking:** Regularly review care gap metrics (e.g., depression follow-up within 30 days, screening completion rates).
- **Workflow Mapping:** Identify breakdown points in referral, warm handoff, and follow-up.
- **Use of Registries:** Implement patient registries for depression, substance use, or chronic conditions to track progress.

B. Training & Support

- **Ongoing Staff Training:** Refreshers on screenings, culturally responsive care, motivational interviewing.
- **Supervision Practices:** Case consultation on patients with persistent care gaps.
- **Feedback Loops:** Share performance dashboards with staff; celebrate improvements.

C. System-Level Partnerships

- **Collaboration with External Providers:** Coordinate with hospitals, specialty care, and community-based supports.
- **Equity Focus:** Ensure interpreter services, community outreach, and culturally congruent care partnerships.

Tools & Resources

- **Checklists:** For screenings, follow-up, and documentation.
- Care Gap Registry Templates: Depression, diabetes + depression, SUD follow-up.
- **Sample Workflow Maps:** Warm handoff process, follow-up call scripts.
- **Staff Reflection Guide:** Questions for providers.
  - Did I screen for both behavioral and physical health conditions?
  - Did I close the loop on referrals/follow-up?
  - Did I address cultural, social, or language needs?

Key Takeaways

- Care gaps represent both missed tasks and opportunities for prevention and connection.
- Integrated Behavioral Health teams are essential in identifying, addressing, and closing these gaps.
- Using care gap alerts and registries helps ensure every patient encounter advances their whole-person well-being.
- Collaboration, data review, and culturally congruent care are central to reducing inequities and improving health outcomes.

References

American Hospital Association (2014). *Physical & Behavioral Health Integration Resources*. American Hospital Association. https://www.aha.org/behavioral-health-physical-behavioral-health-integration-resources

Bipartisan Policy Center (2021, March). *Tackling America's Mental Health and Addiction Crisis Through Primary Care Integration: Task Force Recommendation*. Bipartisan Policy Center. https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/03/BPC_Behavioral-Health-Integration-report_R03.pdf

Gibson, A. (2023, November 9). *Native American healthcare disparities: challenges and solutions*. Relias.com. https://www.relias.com/blog/native-american-healthcare-disparities

Morrison, A. (2024, August 16). The benefits of preventive care and regular health screenings. Complete Health. https://completehealth.com/blog/benefits-preventative-care-regular-health-screenings/

Scott, B. (2025, April 17). *Maintaining preventive coverage is vital to public health*. American Medical Association. https://www.ama-assn.org/about/leadership/maintaining-preventive-coverage-vital-public-health