TMF Health Quality Institute

Strategies to Reduce Preventable Hospital Utilization by Addressing Behavioral Health Needs

Issue 2 Coordinating Interdisciplinary Teams

This nine-part series developed by TMF Health Quality Institute explores the integration of evidence-based strategies that identify and address underlying behavioral health needs as an approach to reducing preventable hospital utilization.

What Is the Evidence:

13.9% Fewer ED Visits

An integrated team program in two rural Oregon counties targeting Medicaid patients with complex conditions saw emergency department (ED) visits drop by 13.9%, or 6.1 fewer visits per 100 people, and avoidable ED visits fall by 38.9%, or 2.3 fewer visits per 100 people (Currier et al., 2023).

68% Decrease in ED Transports

A community paramedicine pilot in Port Angeles, Washington, involving 1,697 high-risk individuals led to a 63% drop in 911 calls and a 68% decrease in ED transports by connecting emergency medical services (EMS) with local health care and social services (United Healthcare, 2024).

What Is It:

Coordinated interdisciplinary care involves a team of health care professionals from different disciplines working collaboratively to address the physical and psychological needs of patients during hospitalization and into the primary care setting or the community after discharge. These teams often include medical providers, nurses, case managers, behavioral health clinicians, community health workers, pharmacists, dietitians, peer support specialists and administrative staff (Summers et al., 2023). They work to identify factors impacting the patient's utilization, the issues that the patient believes are most important, underlying needs, friends and family who can be supportive, resources that may be needed, referrals and gaps in care that could increase chances for admission.

As part of the team, an integrated behavioral clinician will assess, diagnose and treat the condition at the point of care and support medical providers with cases that involve unmanaged medical conditions that require lifestyle change support, stress-related conditions (e.g., chronic headaches, stomach aches, panic-related chest pain), chronic pain, mental health and conditions related to substance use. Peer support specialists have learned to manage their own behavioral health conditions and have experience navigating the behavioral health system, which can prove invaluable for individuals working to manage behavioral health conditions within the community (Summers et al., 2023). Coordinated interdisciplinary care teams are particularly effective when they include a care coordinator who acts as a single point of contact to monitor patient progress, tracks referrals and coordinates care between providers, including behavioral health providers. This team-based approach improves access to appropriate treatment, facilitates early intervention and reduces the risk of preventable hospital utilization.

What I Can Do:

- Include team members in your interdisciplinary team with skill sets that best meet the needs of your population
- Assign dedicated care coordinators to facilitate seamless transitions for patients
- Hold interdisciplinary team meetings to review complex cases
- Enable real-time electronic health record access to synchronize patient records for all team members
- Assign care managers to coordinate between acute care and primary care teams for high-risk patients
- Include peer support specialists
- Integrate EMS, police and faith-based partners
- Implement real-time patient monitoring that tracks vital signs, symptoms and medication follow-through
- Develop care coordination dashboards to centralize data tracking for the entire health care team
- Train care teams in evidence-based decision-making

Resources:

- A framework for interprofessional team collaboration in a hospital setting: Advancing team competencies and behaviors
- Integrated Care Teams Playbook
- Quick Guide: Resources for Preventing Avoidable Readmissions
- Team-Based Care Toolkit
- Reducing Hospital Readmissions: A Case for Integrated Analytics

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Where It's Happening:

The Southwest Texas Crisis Collaborative—a division of the Southwest Texas Regional Advisory Council located in San Antonio—created the Program for Intensive Care Coordination. A core aspect of the program is an interdisciplinary care team with a care coordinator organizing the team and resources around the patient. This program focuses on patients who have been identified as high-utilizers of medical services and works to reduce the use of and impact on 911 and hospital systems with intensive case management.

The team addresses both medical and non-medical drivers of health and helps to address whole-person care, including psychiatric and physical needs. This program assists patients with scheduling follow-up appointments and provides wrap-around services, if needed. Care coordinators reach out to patients to assess their needs and connect them with a multidisciplinary team, all while maintaining consistent engagement with patients to ensure adequate care is provided and to empower patients to share in decision-making with their medical team. In addition to the core multidisciplinary team comprised of medical providers, behavioral health providers and nurse care managers, the extended team includes community stakeholders who can provide access to resources, the police department, the fire department, EMS, psychiatric emergency services, mobile integrated care and the Center for Health Care Services, a Certified Comprehensive Community Behavioral Health Center.

The Center for Health Care Services—a comprehensive community behavioral health center based in San Antonio, Texas—successfully expanded their interdisciplinary team in outpatient clinics that serve individuals frequently discharged from acute care hospitals with serious mental illness, substance use disorder and homelessness. Each clinic has an interdisciplinary care team that includes a primary care provider, a registered nurse care coordinator—who oversees the management of its patient-centered care plans and navigates specialty appointments—care managers and navigators—who both work to ensure patients remain on track with their appointments. When needed, the teams also include peer support specialists who assist patients, especially those who are socially isolated or in need of a companion for specialty services. Every primary care provider is paired with a behavioral health consultant (BHC), who is available on demand. BHCs are licensed psychologists, licensed clinical social workers or licensed professional counselors who meet with high-need patients prior to their primary care visits to help them prepare, reduce anxiety and streamline the appointment process. They also play a central role in coordinating care with psychiatric providers when behavioral health conditions may require medication, which contributes to improved treatment adherence and clinical outcomes.