TMF Health Quality Institute

Strategies to Reduce Preventable Hospital Utilization by Addressing Behavioral Health Needs

Issue 4 Develop Patient-Directed Care Plans and Coordinated Discharge Plans to Support Transitions of Care

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:

15% Decrease in 30-Day Readmission Rates

In a performance improvement study, Park-Clinton et al. (2023) implemented a 25-item checklist addressing behavioral issues used to create a patient-directed care plan for vulnerable populations with comorbidities. Over the 16-week trial period, they reduced 30-day readmission rates from 19% to 4%.

88% Reduction in 30-Day Readmissions Rates

St Luke's University Health Network in Pennsylvania developed the Behavioral Health High-Utilizer Care Program, which included a detailed care plan, to help reduce preventable hospital utilization for eligible patients with behavioral health diagnoses. After 24 months, 30-day readmissions were reduced by 88% (Stanton, 2025).

Health Literacy Lowers Readmission Rates

A meta-analysis completed by Becker et al., 2021, found that the use of understandable language, written instructions, drawings and teach-back were highly correlated with lower readmission rates.

What Is It:

Patient Directed Care Plans

A patient-directed care plan is a personalized health care plan developed during a hospital stay or an initial primary care visit in collaboration with the patient and caregiver to address their specific health care needs, preferences and goals. Care plans emphasize active patient and caregiver participation and shared decision-making to ensure that the plan includes the patient's perspective. In addition to goals for care, they may also include medication reconciliation, mental health treatment recommendations and treatment plans, social need resource referrals and follow-up approaches (e.g., phone calls, text messages, mailed reminders) (Saluja et al., 2019).

Discharge Plans

Comprehensive, well-organized discharge plans have been shown to be an effective intervention to reduce readmissions (Hunt-O'Conner et al., 2021). For the discharge plan to be effective, it needs to include several components, including detailed medication instructions, structured handoffs to primary care and behavioral health providers, community resource referrals, a plan for early follow-up, patient and caregiver education that informs what to expect during the recovery process and a review of warning signs and scheduled appointments. Discharge plans should use clear, simple communication methods to convey information.

Motivational Interviewing

Motivational interviewing is among the most effective ways to collaborate with a patient and caregiver about a care plan or discharge plan. Motivational interviewing can create motivation for change, enhance treatment adherence and foster more collaborative relationships with health care providers. By identifying their own reasons for wanting change, motivational interviewing empowers patients to take responsibility for their health.

What I Can Do:

- Train all staff in motivational interviewing
- Establish discharge protocols tailored to patients' needs
- Identify what matters most to each patient and align the clinical goals accordingly
- Ensure that care plans are accessible to all providers involved in patient care
- Use remote monitoring for high-risk patients to track vital signs, symptoms and medication compliance
- Consider a care conference for patients with complex needs to ensure that all people involved in patient care are unified in their treatment approach
- Provide patients with comprehensive discharge plans that anticipate their personalized needs

Resources:

- CMS Connected Care Toolkit
- Oregon Care Planning Toolkit
- Harvard Patient-Centered Discharge Toolkit
- BOOST Project for Discharge Planning

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Where It's Happening:

At Houston Methodist, all staff members are training in and use motivational interviewing to engage patients during the assessment and care plan process. Patients receive an in-depth assessment coving medical, behavioral health, level of support, substance use and situational factors. Assessments are conducted by all relevant team members, which may include a case manager, registered nurse, clinical pharmacist, behavioral health social worker and transition coach. After the assessments have been conducted, the behavioral health social worker and transition coach coordinate recommendations from other team members and review options for behavioral health treatment and medication plans, mitigate barriers to access and help with lifestyle habits.

Once all of the needed information is gathered, a case conference is organized with the patient, their caregiver and any relevant interdisciplinary clinical team members to create a patient-driven care plan defining their values, short- and long-term goals, self-management strategies, social support and internal and external resource referrals. Once the plan is complete, it is shared electronically with the primary care clinic or federally qualified health center for ongoing management. In many cases, the recipients have integrated behavioral health clinicians available to provide ongoing treatment and coordination. The discharge plan includes instructions and tasks that need to be completed post-discharge, as well as follow-up appointments and contact information.