TMF Health Quality Institute

Strategies to Reduce Preventable Hospital Utilization by Addressing Behavioral Health Needs

Issue 5 Integrate Behavioral Health Screening, Intervention and Follow-Up

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:

48% Relative Reduction in 90-Day Readmissions

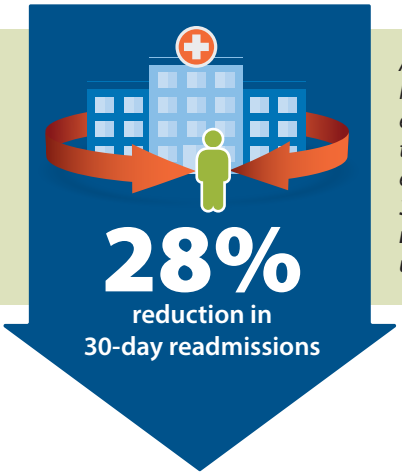
Hospitals affiliated with the University of Michigan tested and evaluated a care model for post-discharge depression. The model included six sessions of telehealth cognitive behavioral therapy, self-management support and care navigation. For patients who fully engaged in the program, there was a 48% relative reduction in 90-day readmissions (Mitchell et al., 2022).

19% Decrease in Admissions for Medically Complex Patients

Early behavioral health intervention through integrated care models in primary care settings was associated with a 19% decrease in hospital admissions for medically complex patients. This helped improve mental health symptom control and adherence to medical treatment (Unützer et al., 2013).

What Is It:

Addressing mental health and substance use as part of a primary care visit, emergency department visit or inpatient stay calls for the inclusion of behavioral health team members who can accurately assess, diagnose and treat behavioral health conditions at the point of care. Many patients have undiagnosed or undertreated mental health or substance use disorders that can significantly affect their chronic disease management, recovery, hospital utilization and overall health outcomes. By including mental health assessments and interventions as part of the medical visit, providers can approach patients' needs in a more holistic way, provide care in a more familiar setting and improve early identification of behavioral health needs. Medical providers then refer patients with unmanaged conditions—such as those requiring lifestyle modifications, stress-related symptoms (e.g., chronic headaches, gastrointestinal distress, panic-related chest pain), chronic pain, and co-occurring mental health or substance use issues—to behavioral health specialists for appropriate support.



*As an example, hospitals in Bronx, New York that implemented embedded behavioral health treatment teams to manage patients experienced a **28% reduction in 30-day readmissions related to medical complications of substance use** (Johnson et al., 2020).*

What I Can Do:

- Screen and assess patients for underlying mental health and substance use conditions upon admission and in primary care
- Coordinate care to treat severe and persistent mental health conditions and substance use disorders
- Comanage both medical and behavioral health conditions
- Provide evidence-based behavioral health treatments and time-limited therapy in primary care
- Use a registry to support active care management and outreach to patients receiving behavioral health treatments

Resources:

- Primary Care Behavioral Health Toolkit
- Integrating Behavioral Health Care into Primary Care: Advancing Primary Care Innovation in Medicaid Managed Care
- Behavioral Health Integration: Treating the whole person

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Where It's Happening:

At the Center for Health Care Services, each patient is assigned a behavioral health consultant (BHC) who meets with the patient as part of their first primary care visit. Each patient receives a comprehensive assessment that screens for a wide range of mental health, substance use conditions and management of chronic medical conditions. Once the assessment is complete, BHCs provide interventions to improve overall functioning for mental, emotional and medical conditions. Interventions use evidence-based treatments modified for use in primary care and focus on improving sleep, diet, medication follow-through, problem-solving, stress management, mental health symptom management, relationship issues and the resolution of past trauma. This first session is generally 20 to 40 minutes.

When patients' level of functioning is significantly diminished, BHCs may refer the patient to a higher level of care or additional community-based services. BHCs also provide consultation to primary care providers and work closely with members of the psychiatry team to ensure patients receive collaborative care. Follow-up with patients is flexible and can be done virtually or in person; this may be a quick check-in or a full session, or it may coincide with another existing appointment. All patients are rescreened throughout treatment to track improvement with updates occurring in patient-directed care plans that are shared across teams. Partnering hospitals have reported significant decreases in hospital utilization that they attribute to the comprehensive primary care approach and the accessible behavioral health treatment offered by the center.

Houston Methodist has integrated a behavioral health social worker in the emergency department to complete assessments (e.g., GAD-7, PHQ-9, AUDIT-C AUD, SDOH) and interviews to understand patients' contextual factors. The attending psychiatrist provides initial treatment services. If a patient has a high risk for admission, the social worker and a transition coach consult with the patient and/or family directly. After the consultation, the social worker organizes a case conference to co-create a patient-driven care plan outlining short- and long-term goals, self-management strategies, social support and internal and external behavioral health referrals. This will specifically include coordination with primary care clinics and federally qualified health clinics that have imbedded behavioral health clinicians for ongoing management. The resulting patient-directed care plan summarizes the patients' goals and the treatment plan. The care plan is accessible through the electronic health record, including to external partners. The program's performance indicator for behavioral health and substance abuse emergency department visit rate reduction indicates there has been a 56% decrease in patient readmissions and a 65% decrease in emergency department revisits. By instituting a transitional care program, patients who are at high risk of returning to the hospital can be offered the chance to have follow-up telephone calls and home visits post-discharge as the program strives to keep targeted patients out of the hospital for 30 days (Basit et al., 2016).