TMF Health Quality Institute

Strategies to Reduce Preventable Hospital Utilization by Addressing Behavioral Health Needs

Issue 6 | Involve Community Health Workers

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:

38% Reduction in 30-Day Readmissions

Integrating community health workers (CHWs) into post-discharge care that includes behavioral health support for patients with chronic medical and mental health conditions at the University of Pennsylvania Health System was associated with a 38% reduction in 30-day hospital readmissions, as compared to usual care, demonstrating improved care coordination and patient engagement (Kangovi et al., 2020).

Return of $2.47 for Every Dollar Spent

CHW programs have demonstrated significant cost savings, with studies showing a return of $2.47 for every dollar spent (Kangovi et al., 2020). By addressing both health and social needs, including behavioral health challenges, CHWs play a critical role in preventing avoidable hospital readmissions and improving overall patient outcomes.

What Is It:

CHW integration involves incorporating trained, non-clinical health workers into the health care team to support patients as they manage their health and address aspects of their social determinants of health. A systematic review found CHW interventions that integrate behavioral health education and support reduced hospital readmissions by an average of 37% among high-risk populations by improving medication adherence and facilitating access to social and mental health resources (Viswanathan et al., 2010). CHWs help patients navigate community resources, provide education about chronic disease management and offer support to address social and economic barriers to care (Ferrer et al., 2022).

CHWs are increasingly involved in addressing behavioral health needs (e.g., providing psychoeducation, reducing stigma, connecting patients to mental health and substance use services), particularly for individuals who may be hesitant to seek formal behavioral health treatment (Garcini et al., 2022). In hospital settings, CHWs are often involved early in discharge planning and interdisciplinary care team meetings to help identify patient needs and set achievable health goals (Carter et al., 2021). When behavioral health needs are present, CHWs can support care coordination by helping patients access outpatient behavioral health services, reinforcing adherence to psychiatric medications and facilitating participation in peer support or recovery programs (Garcini et al., 2022). In a Medicaid population, patients supported by CHWs who provided behavioral health coaching and social determinant navigation experienced a 30% decrease in avoidable hospital readmissions within 90 days post-discharge (Jenkins et al., 2022).

After discharge, CHWs maintain contact with patients through home visits and phone calls to address gaps in care, assist with follow-up appointments and connect them to local services (Carter et al., 2021; Ferrer et al., 2022).

What I Can Do:

- Train CHWs in medication adherence education and social needs
- Implement home visits and remote check-ins for patients who are at high-risk
- Create a referral network to connect patients with community resources
- Address social determinants of health (e.g., transportation, food security, housing stability, financial concerns)

Resources:

- Community Health Worker Clinical Integration Toolkit
- CMS Guide of Reducing Disparities in Readmissions
- Building a Community Health Worker Program: The Key to Better Care, Better Outcomes, and Lower Costs

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Where It's Happening:

The Promotores program at University of Texas Health San Antonio was initiated through a Medicaid Section 1115 waiver to address uncontrolled Type 2 diabetes among adult Latino patients. Central to the initiative is a case management model that explores social and environmental factors often overlooked during routine clinical encounters. The program strategically pairs clinicians with CHWs to assess social determinants of health influencing patient outcomes. CHWs—residents of the same communities they serve—conduct home visits to identify barriers, such as limited access to nutritious food and psychosocial stressors, and they connect patients to relevant community resources. To address patient apprehension regarding home visits—often tied to fears of judgment or mandatory reporting—the program intentionally limits the number of visits to avoid overwhelming participants.

According to Robert Ferrer, MD, MPH, FAAFP, Director of the Promotores program, a key driver of its effectiveness has been the integration of robust data collection practices and the establishment of a registry for high-risk diabetic patients. Though initially a complex requirement of the Section 1115 waiver, this infrastructure enabled improved population health management by enhancing provider awareness and facilitating consistent patient tracking. By shifting from an individual-level to a population-based approach, UT Health implemented broader interventions, including systematic tracking of A1C levels, blood pressure, medication adherence and care continuity. These efforts have contributed to improved glycemic control, reduced hospital readmissions and measurable cost savings.