TMF Health Quality Institute

Strategies to Reduce Preventable Hospital Utilization by Addressing Behavioral Health Needs

Issue 8 Ensure Interoperability with Electronic Communication

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% Reduction in 30-Day Readmissions

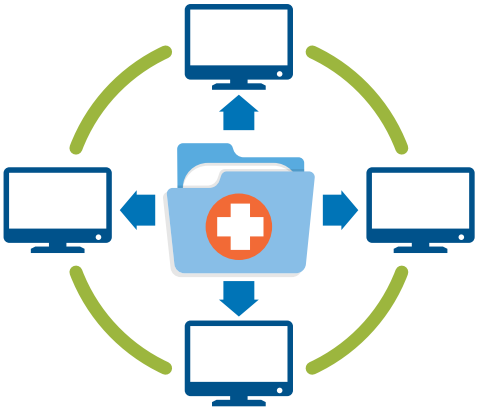
Enhanced interoperability between hospital, primary care and behavioral health electronic health records (EHRs) was associated with a 15% reduction in 30-day readmission rates by enabling timely information sharing and coordinated care transitions in a study completed in New York (Vest et al., 2014).

26% Reduction in Readmissions

A three-year retrospective cohort study evaluated a virtual transition of care clinic at UC San Diego Health, where hospitalist-led video or phone visits provided medication reconciliation, symptom checks, care coordination and rapid follow-up after discharge. For the more than 2,300 patients who used the virtual clinic, there was 26% reduction in readmissions (Horman et al., 2025)

What Is It:

Leveraging electronic communication in health care involves using EHRs and other digital communication tools to improve information sharing, care coordination and patient monitoring during and after hospitalization. Two-way communication and shared electronic records ensure that primary care providers receive timely and comprehensive information, which supports better follow-up care and reduces gaps that may otherwise lead to avoidable hospital readmissions (Munchof et al., 2020).



EHRs can be used to identify patients at higher risk for complications or readmissions by analyzing screening assessments, International Classification of Diseases, 10th Revision, (ICD-10) and billing data, which enables early intervention, such as psychiatric referrals or behavioral health screenings (Brom et al., 2020). For example, EHRs can help flag undiagnosed or untreated behavioral health conditions by identifying patterns in emergency visits, missed appointments or medication nonadherence—signals often associated with mental health challenges. Additionally, electronic communication between hospitals and primary care providers is essential during care transitions, particularly for high-risk patients or those with complex medication regimens (Munchof et al., 2020). This is especially important for patients with behavioral health conditions, as ensuring continuity in psychiatric medication management, therapy follow-ups or substance use treatment can prevent relapse and subsequent readmissions.

What I Can Do:

- Improve patient-provider communication with secure digital tools, automated reminders, symptom tracking and real-time health care access to reduce readmissions
- Develop a secure digital communication platform that integrates patient portals, mobile apps and text messaging
- Implement automated appointment reminders to ensure timely follow-ups
- Enable real-time symptom monitoring and alerts for early intervention
- Provide digital medication adherence reminders
- Offer secure messaging for direct patient-provider communication
- Employ wearable devices for continuous health monitoring and risk detection

Resources:

- Application Programming Interfaces (APIs) and Relevant Standards and Implementation Guides (IGs)
- Home Health Care Reducing Readmissions Toolkit
- Comagine Reducing Avoidable Readmissions Gap Assessment Tool
- Reducing 30-Day Readmission Rates Using Data Analytics and Transitional Care Management Protocols

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Where It's Happening:

The Harris Center for Mental Health and Intellectual and Developmental Disabilities Services is an authorized community mental health center (CMHC) located in Harris County, Texas. There are 39 CMHCs covering all 254 counties in the state. These centers leverage local resources and government funding to improve access to low-cost treatments for mental health, intellectual disabilities and substance use disorders. The Harris Center employs over 2,600 staff and reached 96,000 individuals annually, as of 2023, and it is the largest public behavioral health authority in Texas.

The Harris Center employs a robust care coordination model that has reduced emergency department visits and hospitalizations among patients who are high utilizers of services. Through contracts with local hospitals and facilities, the center improves coordination and referral processes by sharing EHRs. When a shared patient is admitted, Harris Center staff can access the admission details and collaborate with the treatment team to initiate the warm handoff process. Staff also meet with the patient at discharge to arrange follow-up appointments, address needs and barriers, and support the transition to lower levels of care. Additionally, the Harris Center operates an access hotline to connect patients with case management services and provide information about nearby walk-in clinics for timely aftercare. For urgent needs, mobile crisis outreach teams and a crisis hotline are available.

In some instances, it may not be possible for different EHRs to be interoperable. To address this, hospitals need to ensure that patient information can be provided to patients' primary care physicians. At Houston Methodist Hospital, a patient-centered EHR is essential to the warm handoff process for a smooth and safe transition between the hospital and primary care or specialist. This line of communication and coordination is maintained by the involved behavioral health social worker. Houston Methodist Hospital provides patients with a copy of the personal health record to take to the primary care physician for follow-up visits. The transition coach will aid the patient in completing the documentation, if needed, thereby ensuring all involved providers are informed of the care being provided.