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The future of clinical service delivery is not either/or

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Introduction

The future of clinical service delivery is integrated, customized, personalized, data-driven and technology enabled. It is person-centered, with care and services provided in the setting and manner most appropriate to the needs of the individual, which changes alongside the individual as well as social and economic circumstances. The setting appropriate at the onset of symptoms and initial diagnosis is likely to evolve and adapt.

Consequently, the future of clinical service delivery is not either/or, either virtual or in-person, residential or home, hospital or rehab–it is multiple choice. Each point of contact will serve a unique purpose in the care continuum to ensure healthcare can achieve the triple aim of improved client experience, better outcomes at lower costs and improving the health of the overall population.

In no other sector of the healthcare industry is it more important that this long-term vision of service delivery be realized than in human services. Consumers who present with behavioral health issues often have at least one additional chronic health concern, and many have multiple comorbidities. This is true for individuals with mental health diagnoses, substance use disorders and intellectual/developmental disabilities (I/DD), as well as for consumers in need of child and family services and long-term care services and supports (LTSS). Care coordination is essential, all but demand some degree of integration between physical and mental health, as well as with social services.

One size does not fit all

According to the American Hospital Association, one in five Americans has a behavioral health disorder, and nearly 70% of consumers with behavioral health disorders have a medical comorbidity. At the same time, around 30% of adults with a medical condition also have a behavioral health disorder.

For example, anywhere from 15% to 30% of people with diabetes also have depression, which can lead to noncompliance with disease-management protocols. Noncompliance leads to other medical comorbidities such as neuropathy and coronary artery disease, which can be disabling.

Among consumers dually eligible for Medicaid and Medicare, 50% of those treated for a behavioral health disorder had four or more comorbid physical conditions.[1] Clearly, one treatment regimen or one provider type or setting for individuals with multiple diagnoses does not fit every situation. Treating the whole person demands a customized plan that takes into consideration an individual's physical and mental health, as well as his or her ability to access and pay for care and other social determinants of health (SDoH) such as food insecurity and homelessness.

1 Trend Watch, May 2019, American Hospital Association, www.aha.org

One delivery model does not fit every provider organization. As clinicians adapt to meet the needs of current and future consumer populations, they will be shaping and reshaping their service models to accommodate changing needs and demands, incorporating existing and emerging technologies to manage treatment protocols, coordinating between providers and delivering services in the most effective setting.

For decades, regulatory initiatives at the federal and state levels have endeavored to pivot clinical-care delivery to a more consumer-centric approach and to a reimbursement model that pays for outcomes rather than services provided: value vs. volume. But that has been easier said than done because the healthcare system in the United Sates is not a system at all, but interdependent clusters of organizations with sometimes competing missions, goals and incentives. Until recently, care coordination and integrated care delivery often ran contrary to these corporate interests.

Overcoming the barriers to person-centered, whole-person care

It is rare when an evolving political, social or economic trend–like the shift from volume to value–accelerates in response to a single event. Generally, a trend evolves over time, influenced by multiple factors in a more or less predictable pattern.

But the onset of the coronavirus was an event like no other. In a matter of weeks, every company in every industry had to rapidly adapt to a new environment, and none more profoundly than healthcare. In an instant, telecommuting shifted from a “nice to have” perk for trusted staff to the only way to ensure the continued viability of an organization.

Telehealth went from a “care delivery alternative for leading-edge provider organizations” to the only way to ensure essential healthcare services continued.

At the same time, federal and state governments had to move quickly to remove barriers that impeded operations, including loosening restrictions as to how, where, when and with which telehealth could be employed and increase dollars allocated to promote rapid adoption. Commercial payers followed suit in lifting restrictions on the use of telehealth and reimbursing for those services at the same rate as in-person sessions.

The COVID-19 crisis exposed three glaring hurdles to achieving whole-person care. One hurdle is accessibility to care for large segments of the population. There is a lack of access to physical healthcare, particularly in rural areas, but the shortage of mental health professionals is even more profound. The National Council for Behavioral Health reports that by 2025 the shortage of psychiatrists will be anywhere from 1,500 to more than 6,100 nationwide. A SAMSHA survey found that more than 6.5 million rural Americans have a mental illness, while a study published in the American Journal of Preventive Medicine showed that 65% of rural counties don’t have a psychiatrist, 47% don’t have a psychologist and 81% don’t have a psychiatric nurse practitioner.

A second hurdle to achieving person-centered care has been a lack of care coordination between providers of physical and behavioral health services. This is cause for concern, especially as behavioral health issues are often first

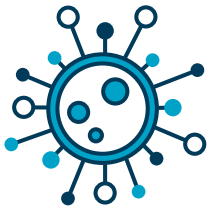
identified by a primary care physician (PCP). PCPs often are the gateways to mental health care, which makes more integration between care settings a necessity, a shift already well underway. The passage of the Patient Protection & Affordable Care Act in 2010 accelerated interest in integration. Removal of the ability to deny coverage for preexisting conditions, no annual and lifetime limits, medical loss ratio regulations, and behavioral health parity changed the financial equation for payers and for accountable care organizations (ACOs).

AHA Recommendations

The AHA recommends the following steps for both physical and behavioral health providers considering any degree of integration:

- Start somewhere; start small. Don't try to integrate behavioral health into the entire continuum of care all at once.
- Know and understand your population/community and their challenges and needs. Addressing the behavioral health problems will vary from community to community. It must start with a comprehensive community health needs assessment
- Figure out what already exists in the community, and where the gaps are. Decide how you can work collaboratively for a better outcome. Provider shortages and the need to serve more patients
- Use evidence-based, standardized behavioral health screening tools in all settings and document in the EHR.
- Use technology to distribute your limited behavioral health resources more efficiently and equitably through telehealth and virtual consults.
- Use electronic health information exchange and care management software to improve collaboration, handoffs and transitions in care.
- Familiarize providers with the growing number of consumer-facing behavioral health applications that consumers are using and help consumers use digital health tools when appropriate to manage their conditions.
- Measure the effects of behavioral health integration on key clinical, operational and financial performance indicators to show continuous improvement. Stress the goal of true transformation. Hospitals and health systems that follow these strategies as well as other practices from peers can move the needle on caring for the whole person—both mind and body.

Interoperability and the ability to exchange the data that supports person-centered care has grown through public and private collaborations such as Carequality and the Commonwell Alliance, while the ONC Interoperability and Information Blocking Rule created specific healthcare policy around industry interoperability standards and consumer access to information. Persons with a substance use disorder (SUD) or history of SUD treatment will have easier access to fully-informed, comprehensive healthcare with the passage of the Protecting Jessica Grubb's Legacy Act (The Legacy Act). The Legacy Act was included in the Coronavirus Aid, Relief, and Economic Security (CARES) Act passed by Congress and signed into law in March 2020. "Integration" became the preferred model to address the large proportion of healthcare resources needed by consumers with multiple chronic health conditions. Over the past decade, the concept of integration has morphed.



After COVID-19, there is no turning back from virtual care.

A third hurdle that has inhibited the evolution of whole-person care is reimbursement. Fee for services (FFS) does not work in a value-based delivery model for several reasons, not the least of which is cost containment–one of the primary goals of value-based models. FFS creates an expensive, labor and time-intensive administrative burden when paying for each service separately, which defeats the intent of paying for value not volume.

The answer? Bundled payments, or Case Rates. "Case Rates are a form of bundled payment that covers the cost of a 'case.' A Case Rate represents a predetermined amount of money paid to a provider organization to cover the average costs of all services needed to achieve a successful outcome for a given defined episode of care for an individual over an agreed upon time period."[2]

According to the National Council for Behavioral Health, Case Rates are important for two reasons.

(1) Case Rates provide greater flexibility to the provider and consumer regarding who provides services, what can be provided and where services can be provided. The consumer and provider decide and can be much more agile about what is provided.

(2) Case Rates have a two-part equation built into the process. First, if a care team selects a package of services for a consumer that is more cost-effective than other alternatives, the episode's actual cost may be lower than the Case Rate payment, allowing the provider to earn what some describe as a value bonus. The second value lever is to move waste (excess cost) through lean process improvement activities, achieving a lower unit cost than what was built into the Case Rate.[3]

As with other bundled payment models, Case Rates can lower the administrative costs as providers submit one encounter claim rather than billing for multiple providers, multiple times.

Virtual medical visits are up 455% (from 36 million to 200 million).

Necessity is the mother of invention

The onset of the COVID-19 pandemic was not the launching pad for telehealth, or more broadly, virtual care. – That transition has been decades in the making, but the industry likely will look back at the rapid escalation of remote, technology-enabled services during this time as the proving ground for virtual care. After COVID-19, there is no turning back from virtual care.

At the start of 2020, telehealth and virtual services were knocking at the door of healthcare, with a market estimated at $45 billion and set to grow 19.3% in the next six years (see Telemedicine Market Size). Roll forward one quarter and virtual care—that group of tech-enabled services like telehealth, remote monitoring, virtual reality treatment, asynchronous "store-and-forward" diagnostic services, and untold thousands of apps facilitating care, mindfulness, assessments, and recovery—have gone from strategic forethought to a lifeline for provider organizations and consumers alike.

To get a sense of the magnitude of change, predicted virtual medical visits are up 455% (from 36 million to 200 million), and actual weekly telehealth visits saw an almost 3,000% jump, from 10,000 to 300,000. Just a year ago, only 50% of

2 Creeping and Learning From Payment for Volume to Payment for Value: An Update on Behavioral Health Reform, National Council on Behavioral Health, www.thenationalcouncil.org, September 4, 2014

3. Ibid

specialty provider organizations reported providing some telehealth services. That varied — 63% of behavioral health organizations, 53% of primary care provider organizations, 39% of I/DD and long-term care provider organizations, and 35% of organizations serving children.

That number is near 100% now.

Many changes across the healthcare sector have made this possible. There is new reimbursement from many payers, the Office of Civil Rights (OCR) suspended some of the HIPAA security rules to provide telehealth services, and the Federation of State Medical Boards also reports that most states waived in-state licensure requirements for telehealth.

Until the pandemic occurred, the growth trajectory for the proportion of services delivered virtually was nowhere near mature because the virtual delivery system was in its infancy. Consumers were just getting used using tech-enabled services. Prior to this crisis, only 15% of consumers had used telehealth. But a survey from Sage Growth Partner (SGP) and Black Book Market Research, found that 59% of consumers report they are more likely to use telehealth now than before the crisis—including 33% who would change healthcare providers to do so.

Provider organizations' telehealth systems also are maturing. Organizations have made the switch to virtual care in record time. To maintain long-term success, other processes such as scheduling, clinical workflow, medical recordkeeping, and billing/reimbursement systems also need to evolve. Payers and health plans are still working to get their credentialing, authorization and claims payment systems "debugged."

And while electronic health records (EHRs) now are a fixture in virtually every provider setting, interoperability remains a challenge for some. Without EHRs, whole-person care remains elusive.

When the crisis period has passed, there will be more telehealth services delivered to more consumers. Most will be fully reimbursed by payers with the same considerations as physical healthcare services payments. The new reality of hybrid service delivery in integrated care settings may help achieve payment parity for mental health services what passing legislation could not: a meeting of the minds between consumers, providers, payers and policy makers.

There also will be more competition for those services. As we move forward, the questions for every human services organization is how to be "best in class" at providing virtual services, how to develop hybrid service delivery models that optimize the strengths of face-to-face and virtual service, and how to compete in a market where more dollars are virtual.[4]

Most human services organizations had less than a week to start or significantly expand virtual services and operations such as telehealth when stay-at-home orders swept the country. With new lessons learned in the trenches every day, providers and consumers are getting more comfortable with telehealth. Payers, regulators and technology vendors have all stepped up to the plate, making many "temporary" allowances to enable virtual care delivery.

4 Virtual Care Now & Forever? An Open Minds Executive Briefing by Monica E. Oss, May 22, 2020, www.openminds.com

Clinical care delivery: technology-enabled hybrid

What services will be virtual:

- Triage to assess appropriate care setting
- Follow up to onsite or inpatient care
- Maintenance and adherence to treatment protocols
- Access primary care providers and specialists, including mental and behavioral health for chronic health conditions and medication management
- Coaching and support for consumers managing chronic health conditions, including weight management and nutrition counseling
- Participate in physical therapy, occupational therapy and other modalities as a hybrid approach to in-person care for optimal health
- Monitor clinical signs of certain chronic medical conditions (e.g., blood pressure, blood glucose, other remote assessments)
- Case management for individuals who have difficulty accessing care (e.g., those who live in very rural settings, older adults, those with limited mobility)
- Follow up with consumers after hospitalization
- Deliver advance care planning and counseling to consumers and caregivers to document preferences if a life-threatening event or medical crisis occurs
- Provide non-emergent care to residents in long-term care facilities
- Provide education and training for HCP through peer-to-peer professional medical consultations (inpatient or outpatient) that are not locally available, particularly in rural areas

What services will be provided onsite:

- Physical examinations
- Services for consumers unable to effectively engage via technology solutions
- Emergency care for urgent care needs for sudden onset, physical or mental
- Acute care
- Uncontrolled serious mental illness
- Services designed to encourage interpersonal or community engagement
- Consumers presenting with urgent need for multiple professional interventions

But the key word is “temporary.” We know telehealth is here to stay. But to sustain virtual care in the long term, provider organizations must up their game quickly and replace the free or low-cost virtual visit platforms and makeshift operating procedures with a robust infrastructure for long-term virtual service delivery. This includes an EHR able to collect, store and report out the data needed to ensure excellence in consumer care, prompt and proper payments, and decision support to facilitate operational efficiencies and regulatory compliance.

Telehealth not for everyone

Of course, telehealth is not ideal for every consumer. Why is it important to understand what consumer groups are not a "best fit" for virtual services? These will be the "niches" in the market that will be immune from a pending era of out-of-area, price-based competition for therapy services delivered online. The likely winning market positioning is to develop deep expertise in specific specialty populations—and demonstrate superior performance.

Market positioning around specific specialties is not enough. Virtual care for special needs populations has a strong future, but we are going to have to consider what will make care more effective. The key is to understand the needs, preferences and outcomes of each consumer cohort. This goes beyond thinking about every consumer with a diagnostic condition as the same. The human services field needs to adopt consumer segmentation practices that are common in retail and hospitality businesses—what are the subgroups of consumers (by age, geography, education, comorbid conditions, etc.) who have specific preferences, and what market opportunities do those segments present?

Virtual care for special needs populations

In addition to this marketing approach, there are clinical practice initiatives that are likely to advance in the months and years ahead. Implementing Electronic Visit Verification (EVV) would support the delivery of services across home and community settings, enabling providers to focus on the individuals they serve by minimizing administrative burdens. Licensing and accreditation groups will develop more stringent standards, guidelines and training programs to make virtual care effective for special needs populations.

Telehealth is not the only tech-enabled innovation gaining traction

In its 2020 market survey, "Innovation Adoption Among Specialty Provider Organizations: The 2020 OPEN MINDS National Innovation Survey," OPEN MINDS confirmed that the biggest change in innovation adoption since 2019 has been in telehealth. Seventy-eight percent of specialty provider organizations and 88% of primary care organizations and federally qualified health centers (FQHC) are now using telehealth, an increase of 25 percentage points over 2019 for both.

After telehealth, peer support specialists (59%) and medication assisted treatment (MAT) for addictions (45%) were the most adopted innovation by specialty provider organizations. For primary care and FQHCs, the most adopted innovations were behavioral health/primary care service co-location (74%) and primary care medical homes (70%).

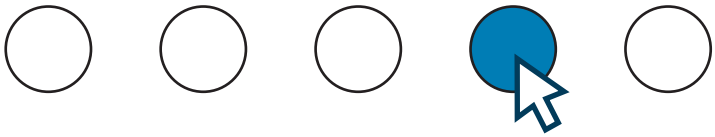
The biggest changes in specialty provider organizations, other than telehealth, were an 8% increase in the use of computerized cognitive behavioral therapy (eCBT) and an 11% drop in the number of organizations providing readmission prevention programs. In primary care and FQHCs, there was a 24% increase in the number of organizations offering peer support specialist and recovery self-management tools.

Not either/or but multiple choice in all provider settings

It is not possible to know which sectors of the healthcare market will adopt which technologies to deliver clinical care now and into the future. Just as it is not possible to know which healthcare entities will integrate with which other entities in the effort to provide cost-effective, whole-person care in the most appropriate setting.

There are just too many variables on all sides of the equation to say with certainty that behavioral health organizations will follow one path, while providers of addictions treatments or social services will follow the same or a different path.

However, it is possible to look to those adopting innovative technologies and organizational and payment models to get a glimpse of what the future holds for the industry. Regardless of the paths taken, we can say with certainty it's essential the future of clinical care delivery is integrated and person-centered. Through proper technology, best practice use and data sharing, clinical service delivery can better meet the needs of a diverse client community regardless of care setting.



About Netsmart

For more than 50 years, Netsmart has been committed to providing a common platform to integrate care. Netsmart provides a leading global telehealth solution to create a virtual connect healthcare community. The result enables collaboration across a network of more than 200 million patients, 600,000 providers and more than 25,000 organizations. With Netsmart Telehealth®, patients will have an unprecedented level of access to real-time quality care across multiple provider specialties. This comprehensive network brings healthcare directly to the consumer and offers the potential to drastically improve health outcomes and lower costs by allowing organizations to deliver care in the lowest acuity setting possible.