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The Definitive Guide to Integrated Care

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Executive Summary

Integrated care is no longer the future—it's now. Integration drives the market as the expectation and best practice that providers across the care continuum must leverage to achieve and maintain quality, effective healthcare services. Without it, care becomes siloed, cumbersome and expensive.

It's no secret to you the benefits of connected care are abundant:

- Empower your organization to deliver holistic services
- Improve clinical outcomes
- Boost staff and client satisfaction
- Grow and diversify business lines
- Help you become a preferred partner with payers and health plans
- Create operational efficiencies
- Boosts your bottom line

And more.

Knowing the value of integrated care and achieving it can be two different things. No matter where you are in your integrated care journey, this interactive guide can move you toward your vision by walking you through how to:

- **Build a strong foundation:** A comprehensive, intuitive and data-driven technology platform that works across the care continuum is at the core of a strong foundation for integrated care. To successfully leverage an integrated platform, providers need an IT partner who understands your complex needs—clinical, operational and financial.
- **Prove your value:** Demonstrating outcomes and success of your services and programs helps you not only become a partner of choice but strengthens organizational stability and financial outcomes. Discover how tracking performance and quality measures helps prove your value to payers and support an integrated care approach.
- **Impact consumer outcomes:** Providing quality, effective and person-centered care is at the heart of what you do. And the right technology will empower your care delivery, not inhibit it. Access to an integrated and holistic view of a consumer's health journey at the point of care helps improve care outcomes while lowering cost of care.

Netsmart is committed to equipping you to deliver integrated, value-based care now and in the future. Together, we can redefine care delivery in the communities we collectively serve. Let's get started.

SECTION 1:

Build a strong foundation

A comprehensive, intuitive and data-driven technology platform that works across the care continuum is at the core of a strong foundation for integrated care. To successfully leverage an integrated platform, providers need an IT partner who understands your complex needs – clinical, operational and financial.

Blog: 4 strategies for building a solid foundation of integration

by Danielle Ross
Chief Information Officer, Netsmart

When health information remains siloed between disparate systems, provider organizations miss the opportunity for true coordination and informed care. Having an integrated, data-driven electronic health record (EHR) platform that works across the care continuum is essential when building a solid foundation for comprehensive care.

Creating a secure and scalable foundation that supports data sharing beyond the four walls of your organization not only promotes an integrated care model, but boosts time savings, addresses provider shortages and improves outcomes.

In a recent webinar, Balance Agility + Stability In 4 Steps, the presenters and I took a deeper dive into the importance of building a foundation for integrated care, resulting in better care coordination and clinician satisfaction. 4 key takeaways from the May webinar included:

- **Identify your foundational needs and vision for organizational stability.** Every year, I work with dozens of healthcare agencies to help them review their operations, analyzing processes regarding resources, training, technology, billing issues and more. Building strategy is her expertise – understanding what your agency needs and wants beforehand is key.
- **Discover simple strategies for sharing critical information with providers from external sources at the point of care.** While sharing and receiving data seamlessly outside the four walls of your organization might sound complicated, implementing the right technologies make it simple. Does your organization have the proper tools, technologies and workflows in place to make integrated care a reality?
- **Ensure your model is built to support clinician and consumer satisfaction, as well as prove ROI.** In addition to being strong and scalable, your model needs to make clinicians' lives easier, support consumer experience and provide data-based outcomes. A foundation built to grow with you and those you serve while collecting and reporting outcomes to prove success is essential, especially in the world of value-based care.
- **Learn how to innovate and pivot as market forces demand or opportunities arise—while strengthening your organizational sustainability**. If 2020 taught us anything, it was the importance of adapting and persevering through change. Industry and community demand constantly fluctuate, therefore swiftly adjusting to new market needs will help your organization stay both competitive and agile.

Building an integrated foundation for coordinated care is key for organizations to improve outcomes and inform their care delivery. Check out the recorded webinar to learn more!

Success Story: The Villages of Indiana

Are you using your EHR to its full potential?

SUCCESS STORY **HUMAN SERVICES**

At a glance

Community
- Human Services

Organization
- The Villages of Indiana

Location
- Bloomington, Indiana

Challenges
- Reliant on paper for key workflows
- Delays to place children in foster homes
- Inefficient workflows and reporting
- Lack of internal IT resources

Solutions
- myEvolv® CareRecord™
- Netsmart IT Managed Services

Results
- More efficient workflows
- More time for direct care with families
- Quicker placement in foster homes
- Higher staff satisfaction
- Faster reporting process

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The Villages of Indiana sees big gains after optimizing its EHR system

About The Villages of Indiana

The Villages of Indiana, founded in 1978, is Indiana's largest not-for-profit child and family services agency, serving more than 3,000 children and their families every day.

Since 2008, The Villages has placed more than 700 children with forever families, and 9 out of 10 children in their foster care program are placed in a single home. Additionally, over 90 percent of those children were adopted by their Villages foster family. The Villages is among the two percent of child and family services agencies that are fully accredited.

Challenges

When The Villages went through reaccreditation, the Council on Accreditation (COA) provided leadership with a summary of staff feedback. While most feedback was positive, the agency learned they needed to make better use of technology, specifically its electronic health record (EHR).

At the time, The Villages was using the EHR simply as an electronic file cabinet, not anywhere near its full potential. Leadership decided to tap Netsmart experts to help the agency use the EHR to its fullest capacity, which included adding key workflows in the system that had previously been paper workflows.

The cumbersome paper processes overlapped with EHR workflows, causing staff to spend too much time on documentation and not enough time with children and families. "Because most of our staff are out visiting families and children each day, they need to be able to document care and services directly into the EHR, rather than take notes and update the system after they get home from work," said Amy Sanderson, director of Quality Assurance and Information.

> "We knew that without good use of our technology, we wouldn't be sustainable."
>
> Brenda Chapin
> Vice President of Program Administration

Two other big challenges included completing monthly state reports promptly and expediting the agency's licensure process. Each foster care family must obtain a state license, which requires detailed information.

"The faster we receive information to get families licensed, the less time children must wait to be placed in a home," said Sanderson. "If we don't have enough approved foster homes, we have to turn away children."

Solution

The Villages took action to improve its use of the EHR, integrate billing and clinical processes, and optimize the system to boost efficiencies.

Leadership turned to Netsmart IT Managed Services to help the agency think in new ways to solve its challenges. "We knew that without good use of our technology, we wouldn't be sustainable," said Brenda Chapin, vice president of Program Administration.

> "Our Netsmart advisor not only had expertise with the EHR, she also understood foster care."
>
> Brenda Chapin
> Vice President of Program Administration

A mobile office

"We set up a technology steering committee and met regularly to focus on how our EHR could help meet business goals," said Chapin. Together, Netsmart and The Villages built out their foster care program within the EHR. Doing so meant staff would have a "mobile office" for providing care in the field, boosting efficiency, productivity and staff satisfaction.

"Our Netsmart advisor not only had expertise with the EHR, she also understood foster care," says Chapin. "With Netsmart, we gained a team of licensing, administrative, billing and technology specialists to help us improve the way we operate across the entire organization."

> "The faster we receive information to get families licensed, the less time children must wait to be placed in a home."
>
> Amy Sanderson
> Director of Quality Assurance and Information

"From a business perspective, we've seen a strong financial reward because of increased efficiencies and productivity," said Chapin. By optimizing the EHR, The Villages has been able to place children in foster homes sooner, which means they can serve more families.

"Time is a precious commodity when you work in social services," said Chapin. "Reducing documentation time and streamlining administrative tasks gives us more time to work with families."

Results

Staff got relief from administrative tasks and saved time by not having to search for records in multiple places. As a result, The Villages **reduced the number of days spent on monthly state reports by 40 percent.**

What used to take staff 10 days to complete a monthly state report now takes six days. With one source of truth inside one system, staff can eliminate confusion caused by back and forth exchange of spreadsheets and paper files.

Additionally, being able to access the EHR while in the field allows staff to complete documentation in real-time, rather than back in the office or late at night. The result? Increased job satisfaction, more time helping families and children, and more peace of mind.

"One of my team members shared that she sleeps better at night because she gets most of her work done while she is with her clients…nothing hangs over her head at night," said Sanderson.

"We've waited so long for an EHR like this, and now it's here," is something Destiny Laster, EHR specialist, says she hears from her staff a lot.

"We feel like we're ahead of the technology curve versus behind it," said Chapin. "By optimizing our technology, we can spend more time serving children and families. That's the best part—Netsmart helped make this possible."

IT Managed Services impact:

- Streamlined clinical and financial workflows
- Reduced time to complete state reports by 40 percent
- Improved staff satisfaction with the ability to document in the field, rather than after work
- Increased speed in which children could be placed in foster homes because of a more efficient licensure process

> "We feel like we're ahead of the technology curve versus behind it."
>
> Brenda Chapin
> Vice President of Program Administration

New efficiencies reduced the number of days spent on monthly state reports by 40 percent.

Advice for others

When asked what advice to give to others experiencing similar challenges, Chapin says:

- Clean up your workflows before making changes to the system
- Get staff involved and vet their needs, so the technology meets their requirements
- Form a super user support group to continually refine and evaluate the system
- Keep communication open so you can constantly respond to user feedback

Learn more about Netsmart IT Managed Services at: www.ntst.com/CareFabric/Plexus-Services/Full-IT-Shared-Services

About Netsmart IT Managed Services

Netsmart IT Managed Services helps free your staff to focus more on providing care. Keeping your EHR and IT environment running smoothly requires constant attention and the availability of skilled resources. Yet, many organizations are overwhelmed by rapidly changing technology and business demands, not to mention retaining proper IT talent. Our IT Managed Services can make your job easier, so you can focus on your core mission of helping others.

SECTION 2:

Prove your value

Demonstrating outcomes and success of your services and programs helps you not only become a partner of choice but strengthens organizational stability and financial outcomes. Discover how tracking performance and quality measures helps prove your value to payers and support an integrated care approach.

Whitepaper: Maximize success with performance and quality measures

Don’t let your organization get left behind

Stakeholders at all levels of the human services industry are focusing on performance and outcome measures as tools for improving quality of care and reducing healthcare costs, regardless of their care delivery model.

Executive summary

With the shift from volume to value ramping up across the healthcare industry, there has been an increased focus on healthcare quality, particularly among the organizations serving consumers with chronic conditions and complex support needs. Stakeholders at all levels of the human services industry are focusing on performance and outcome measures as tools for improving quality of care and reducing healthcare costs, regardless of their care delivery model.[1] These measures are increasingly tied to reimbursement.[2]

Due to standardized measures and data collection practice, physical health has long seen positive clinical outcomes, improvements in quality of care, increases in consumer satisfaction and cost savings for both the consumer and the provider organization. Behavioral health, unfortunately, has missed out on these benefits, with many agencies only in recent years beginning to implement and collect data on quality measurements. One challenge that has mitigated the adoption of quality measures in behavioral health is symptoms and conditions don’t offer the same concrete, binary measures and outcomes as physical health. Therefore, many of the current behavioral healthcare quality measurements have been process-based or have only a cursory connection to behavioral health. To truly operate as a consumer-centric entity, behavioral health care organizations need quality measures that support a focus on consumer outcomes, satisfaction and engagement.

Organizations serving consumers with chronic conditions and complex support needs should be advocating for standardized data collection for behavioral health services. To be sustainable in this complex, value-based care market, provider organizations will need to build a new business model—this includes creating new partnerships, developing innovative service lines, and creating a sound technology infrastructure. The agencies governing behavioral health need to be pushed to develop standardized outcome measures and data collection that focuses less on process-based measures and more on measures that truly track clinical outcomes and recovery. This standardization would help improve consumer behavioral health outcomes and save both the consumer and provider organization time and money related to health costs and conditions.

1 Kilbourne, et al. (2018, Feb 17). *Measuring and improving the quality of mental health care: a global perspective.* World Psychiatry. 17(1); 30-38. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5775149/

2 New England Journal of Medicine Catalyst Newsletter. (2018 Mar.) *What is Pay for Performance in Healthcare?* Retrieved from https://catalyst.nejm.org/pay-for-performance-in-healthcare/

Leveraging technology is essential to gain value and build a sustainable strategy. Without the right tools, it will be increasingly difficult for organizations to quantitatively demonstrate their value to payers and other stakeholders. Building a comprehensive technology infrastructure is critical in both improving performance and reducing costs. A comprehensive electronic health record (EHR) is the key to creating a system that collects the right data and enables a variety of teams to be strategic in identifying the behavioral health needs of their consumer population. Organizations must ensure their EHR has the capability to collect, calculate and report on the various quality measures required under both current and future performance-based contracts.

Don't let your organization get left behind—make sure you are equipped with the right technology to support quality measurements to not only compete, but thrive in the new value-based care environment.

A comprehensive EHR is the keystone to creating a system that collects the right data and enables a variety of teams to be strategic in identifying the behavioral health needs of their consumer population.

The rise of performance measures

Only one-third of consumers with mental health issues receive adequate mental healthcare, and less than half of those with Medicare/Medicaid receive adequate follow up after hospitalization.[3] Individuals with depression only receive effective care 57.7% of the time, and individuals with alcohol dependence receive effective care only 10.5% of the time—the lowest of any condition.[4] The National Committee of Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) measures show only half of individuals with mental health and substance use needs receive recommended care.[5] Lower quality care and outcomes in behavioral health lead to poor health outcomes and higher healthcare costs, making the need for quality measurements to improve consumer outcomes even greater.

Yet quality measurement in behavioral health care tends to be more complicated than physical health care, mostly because in physical health, many of the quality and performance measures are concrete and binary. For example, if a consumer has diabetes, a provider can measure whether their hemoglobin A1c went up or down. This is a quantifiable measure that can demonstrate a positive or negative outcome. Unfortunately, these concrete measurements are not readily available in behavioral health. For example, for a consumer with schizophrenia, there is no singular way to measure progress in recovery and there is no industry-wide agreement on what that progress and recovery should look like.

This puts behavioral health care at a disadvantage compared to physical health care, which has been using well-established performance measures for years.[6] Most performance measures have been generally relegated to "process measures," or checking to confirm that certain events have occurred—i.e., was a consumer screened for depression, or was a consumer with schizophrenia taking antipsychotic medications screened for diabetes. This poses a great need for the entire behavioral health industry—the need for standardization of data collection and quality measures.

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3 Kilbourne, et al. (2018, Feb 17). *Measuring and improving the quality of mental health care: a global perspective.* World Psychiatry. 17(1); 30-38. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5775149/

4 New England Journal of Medicine Catalyst Newsletter. (2018 Mar.) *What is Pay for Performance in Healthcare?* Retrieved from https://catalyst.nejm.org/pay-for-performance-in-healthcare/

5 Pincus, H.A., et al. (2016, Jun). *Quality Measures For Mental Health And Substance use: Gaps, Opportunities, And Challenges*. Health Affairs. 35(6). Retrieved from https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0027

6 New England Journal of Medicine Catalyst Newsletter. (2018 Mar.) What is Pay for Performance in Healthcare? Retrieved from https://catalyst.nejm.org/pay-for-performance-in-healthcare/

Standardized data collection and measures would allow provider organizations to provide higher quality care to consumers, which in turn would result in overall improved health outcomes and cost savings for the consumer. With these cost savings and health improvements, behavioral health organizations improve their sustainability despite changing models of care.

In recent years, there has been a greater emphasis on improving the quality of behavioral healthcare, while also focusing on reducing costs. Quality has been a priority on the legislative front for the past 10 years. The Patient Protection and Affordable Care Act (PPACA), the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, and the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 all have some aspect tied to quality of care—whether it's provisions to improve outcomes or linking payments to quality of care, these reforms provide increased resources and requirements to assess the quality of care consumers receive.[7] Since the passage of these reforms, quality measures have been effectively used in various care delivery models to improve quality of care and consumer outcomes. This effectiveness is evident in self-reported data, such as the Centers for Medicare and Medicaid Services (CMS) Star ratings, as well as through reviews of claims data, research studies and provider reports. Some quality of care process measures, such as appropriate pharmacotherapy, continuity of care and psychotherapy use, have even been associated with reduced mortality and symptom severity.[8]

Improving quality outcomes doesn't necessarily mean you need to change your organization or how you run your program. Sometimes, quality outcomes can be improved through small changes to processes or by sharing different aspects of consumer data within your organization. Regardless of which strategies organizations use to improve behavioral health outcomes, one thing is key: Provider organizations must be able to substantiate the value of their services. The real question is how?

Provider case study

Intermountain Medical Group has been able to improve the value of care for individuals they serve by providing coordinated behavioral health care. By sharing data and empowering their physical and behavioral health care teams to collaborate, the organization has seen improvements in consumer outcomes and a **$115 lower overall annual cost per member**.[9]

7 American Psychiatric Association. (2018.) *MIPS Quality Performance Category: 2018 Performance/2020 Payment.* Retrieved from https://www.psychiatry.org/psychiatrists/practice/practice-management/coding-reimbursement-medicare-and-medicaid/payment-reform/toolkit/2018-quality-performance-category

8 Kilbourne, et al. (2018, Feb 17). *Measuring and improving the quality of mental health care: a global perspective.* World Psychiatry. 17(1); 30-38. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5775149/

9 OPEN MINDS. (2019, Feb.). *Where Are We On The Road To Value?: The 2019 OPEN MINDS Performance Management Executive Survey.* Retrieved from https://www.openminds.com/market-intelligence/resources/where-are-we-on-the-road-to-value-the-2019-open-minds-performance-management-executive-survey/

The need to substantiate the value of your services

The current formula in behavioral health involves collecting data, measuring performance and creating clinical interventions. While this formula has worked in the past, it's in dire need of evolution if provider organizations want to compete and thrive in the new value-based environment. Robust reporting should be incorporated into day-to-day activities and workflows to prove the value of services. Implementing a standardized tool to capture data allows behavioral health organizations to collect longitudinal data that can tie quantitative value—both clinical and financial—to efforts to improve care. This data can then be used in performance dashboards to identify appropriate evidence-based practices for populations and even provide alerts notifying gaps in care. Imagine having real time data that proactively notifies the care team at the point of care when there are clinical gaps so those inefficiencies could be addressed sooner, potentially saving clinician time and organizational dollars, while also improving consumer outcomes.

The ability to collect and share data is important not only to internal performance management—many new payment methods are linking reimbursement with demonstrated performance improvement. These payment arrangements use scores from quality and performance measures to reward or penalize provider organizations. Organizations under these payment arrangements are at financial risk for their overall performance but can receive bonus payments based on improvements. In 2014, 40% of all commercial in-network payments were value-oriented.[10] Since that time, there has been a push for more value-based payment arrangements appearing in a variety of formats.

In 2015, Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA), which rewards clinical professionals for value rather than volume, streamlines several quality programs under the Merit-Based Incentive Payments System (MIPS) and provides bonus payments for participating in alternative payment models (APMs). Through this program, provider organizations may choose from a menu of quality metrics to achieve increased reimbursement. In order to receive a bonus payment or reward, organizations must be able to effectively and quantitatively demonstrate their performance improvements in four categories: resource use, clinical practice improvement activities, meaningful use of EHR technology, and quality. They will also receive positive, negative or neutral changes to their Medicare Part B payment.[11]

Examples of MIPS quality measures for psychiatrists[12]

- Adult Major Depressive Disorder (MDD): Suicide risk assessment
- Preventive care and screening: Screening for clinical depression and follow-up plan
- Initiation and engagement of alcohol and other drug dependence treatment
- Falls screening: Screening for future fall risk
- Dementia cognitive assessment
- Bipolar disorder and major depression: Appraisal for alcohol or chemical substance use

10 Delbanco, S. (2014, Sep). *Following The ACA: The Payment Reform Landscape: Value-Oriented National Scorecard on Payment Reform.* Health Affairs. Retrieved from https://www.healthaffairs.org/do/10.1377/hblog20140930.041710/full/

11 Centers for Medicare and Medicaid Services. *The Medicare Access & CHIP Reauthorization Act of 2015: Path To Value.* Retrieved from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-LAN-PPT.pdf

12 American Psychiatric Association. (2018.) *MIPS Quality Performance Category: 2018 Performance/2020 Payment.* Retrieved from https://www.psychiatry.org/psychiatrists/practice/practice-management/coding-reimbursement-medicare-and-medicaid/payment-reform/toolkit/2018-quality-performance-category

Medicare has also implemented other value-based financing systems that are designed to improve hospital performance, including the Hospital Readmission Reduction Program, the Hospital Value-Based Purchasing (VBP) Program and the Hospital-Acquired Condition Reduction Program. Each of these programs promote better clinical outcomes and improved consumer experience by putting the hospitals at risk for possible payment reductions.[13] The Centers for Medicare and Medicaid Services (CMS) has also designed other, similar Medicare programs to address performance through alternative payment models at other types of provider organizations, including the Skilled-Nursing Facility Value-Based Program and the Health Home Value-Based Program.[14]

In the commercial space, 90% of payers and 81% of hospitals have implemented some mix of value-based reimbursement and fee-for-service. For example, Blue Cross Blue Shield has endorsed value-based reimbursements by changing payment incentives to encourage reduced admissions, readmissions, emergency room visits and high-cost interventions, proactively enabling access to preventative care and the management of chronic conditions. These changes improved overall quality of care and efficiency, resulting in a $500 million savings in 2012.[15]

In fact, the use of value-based reimbursement among specialty provider organizations (mental health, addictions, children's services, autism, I/DD, etc.) is on the rise.

In a 2019 survey conducted by OPEN MINDS, 69% of respondents were participating in value-based reimbursement (VBR). Fifty-eight percent of respondents were achieving revenue from these arrangements with primary care and Federally Qualified Health Center (FQHC) respondents experiencing the highest revenues of specialties; 74%.[16]

While many of these outcomes and performance-based programs are rooted in hospital systems, they are creating an environment built on performance expectations and setting the stage for a healthcare system built around outcomes measurement.

As VBR continues to gain traction in the behavioral health market, there are some existing care delivery models that provide insights and practices that can be expanded to meet the rising payer and health plan demand for better demonstration of value. A few of the care delivery models best positioned for future expansion include accountable care organizations (ACOs), integrated delivery networks (IDNs), certified community behavioral health clinics (CCBHCs), prescription drug monitoring programs (PDMPs), Medicaid managed long-term services and supports (MLTSS) programs, and health home initiatives.

As VBR continues to gain traction in the behavioral health market, there are some existing care delivery models that provide insights and practices that can be expanded to meet the rising payer and health plan demand for better demonstration of value.

13 Medicare.gov. *Linking quality to payment.* Retrieved from https://www.medicare.gov/hospitalcompare/linking-quality-to-payment.html

14 Centers for Medicare and Medicaid Services. (2018, Jul). *What are the value-based programs?* Retrieved from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html

15 Brown, B., MBA. *Why You Need to Understand Value-Based Reimbursement and How to Survive It.* Retrieved from https://www.healthcatalyst.com/understand-value-based-reimbursement

16 OPEN MINDS. (2019, Feb.). *Where Are We On The Road To Value?: The 2019 OPEN MINDS Performance Management Executive Survey.* Retrieved from https://www.openminds.com/market-intelligence/resources/where-are-we-on-the-road-to-value-the-2019-open-minds-performance-management-executive-survey/

Certified Community Behavioral Health Clinics (CCBHCs)

CCBHCs represent a significant step forward in improving outcomes, aligning provider payment with outcomes and recovery, and decreasing the cost of care. CCBHCs must coordinate care across the full spectrum of healthcare services—physical, behavioral and social services—and form required partnerships with other specialty organizations.[17]

There are two primary funding streams for CCBHC development and operations. The **Medicaid State CCBHC Financing Demonstration Program** launched in 2017 with 66 clinics across 8 demonstration states and has since grown to 10 states. The state-certified clinics operate under a Prospective Payment System (PPS) to receive enhanced Medicaid funding for reimbursable behavioral health services.[18] This demonstration program offers a vital opportunity to create a nationally recognized mental health community-based provider system focused on improving the care and well-being for consumers.[19]

The second funding source, **SAMHSA CCBHC Expansion Grants**, are awarded directly to providers to increase access to and improve quality of mental health and substance use disorder treatment services. The 2-year grants are awarded to CCBHCs or community-based behavioral health clinics that may not yet be certified but meet the certification criteria and can be certified within 4 months of award.

Organizations participating in the CCBHC state demonstration program are required to report on six critical domains. Other provider organizations should still ensure they have the tools necessary to begin complex analytics and reporting on quality measures. This preparation will enable provider organizations to allow adequate time for preparation and implementation, while also providing added benefits to consumers.

Tips and tricks[20]

- Ensure you have the right workflows in place (both throughout the organization and in your EHR) to encourage follow-ups, appointment alerts and referrals.
- Find ONC-certified health information technology to support increased integration of physical and behavioral health services.
- Determine the reporting and analytics capabilities within your current or future systems to track the availability of services and aggregate clinical data.
- Be sure you have an EHR that supports evidence-based practices and behavioral health-specific workflows and data.

The CCBHC impact[21]

- 340 CCBHCs are in operation
- 50% provide same-day access to care
- 84% see clients for their first a ppointment within one week
- 93% see clients within 10 days (the national average wait time is 48 days)
- 89% offer one or more forms of Medication-Assisted Treatment (compared to only 56% of substance use clinics nationwide)

Required measures for quality bonus payment:

- Follow-up after hospitalization for mental illness (adult age groups)
- Follow-up after hospitalization for mental illness (child/adolescents)
- Adherence to antipsychotics for individuals with schizophrenia
- Initiation and engagement of alcohol and other drug dependence treatment
- Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
- Child and adolescent MDD: Suicide risk assessment

Additional eligible measures:

- Follow-up care for children prescribed Attention Deficit Hyperactivity Disorder (ADHD) medication
- Screening for clinical depression and follow-up plan
- Antidepressant medication management
- Plan all-cause readmission rate
- Depression remission at twelve months-adults

17 Threnhauser, S.C., MPA. (2016, Dec). CCBHCs Are Moving Forward – What This Means If Your State Isn't Moving Forward. Retrieved from https://www.openminds.com/market-intelligence/executive-briefings/ccbhcs-moving-forward-means-even-organization-not-eight-states/

18 Otsuka America Pharmaceutical, Inc., Lundbeck, LLC, & OPEN MINDS. (2018, Apr). *Trends In Behavioral Health: A Reference Guide On The U.S. Behavioral Health Financing & Delivery System*. Retrieved from https://www.psychu.org/trends-behavioral-health-reference-guide-u-s-behavioral-health-financing-delivery-system/.

19 Ibid.

20 Netsmart. CCBHC FAQ. Retrieved from https://www.ntst.com/CCBHC/FAQ.aspx

21 National Council for Mental Wellbeing. (2021, May). CCBHC Impact Report. Retrieved from https://www.thenationalcouncil.org/wp-content/uploads/2021/05/052421_CCBHC_ImpactReport_DataHighlights_2021.pdf?daf=375ateTbd56

Accountable Care Organizations (ACOs)

Originally a Medicaid model of care, accountable care organizations (ACOs) have been taking root across all payer systems over the last decade. This model was initially created for Medicare under the Patient Protection and Affordable Care Act (PPACA), but state Medicaid programs and commercial health plans have also adopted similar models. Under this model, a group of organizations form an agreement to supply care coordination and deliver services for specific populations.

ACO performance is gauged based on financial and quality benchmarks.[22] The ACO model incentivizes groups of provider organizations to deliver high-quality care, while lowering care cost by offering the organization a portion of the savings generated.[23] ACOs provide the industry with a successful service delivery model that focuses on improving care coordination to ultimately increase care quality and reduce costs.

This model allows provider organizations to bring the focus back to the consumer while remaining sustainable. When consumers receive quality care, it increases overall health and wellness, decreases the need for costly healthcare services, and increases consumer satisfaction. This counts as a win for the consumer and the provider organization.

ACOs are currently required to report on quality measures in four domains, all focusing on improving consumer health and experience. Provider organizations are given reporting templates to follow to ensure every ACO is providing the same reports across the nation. This type of standardization allows for benchmarking across the industry, furthering the emphasis on improving consumer health through coordinated care.

Tips and tricks

- Ensure your EHR has robust reporting capabilities to compile and export the necessary reports for your contracts.
- Set up visual dashboards and create workflows that increase utilization to keep data and information top of mind among care teams.
- Determine if your EHR is equipped with predictive analytics and can identify gaps in care for your behavioral health clinicians and enable clinicians to utilize this information for preventative measures.
- Develop a shared platform across all users in your care coordination team to allow provider organizations to identify behavioral health concerns and address the whole person so consumers receive the best possible care.

ACO quality scoring domains and measures[24]

- **Patient/caregiver experience:** Eight individual survey module measures
- **Care coordination/patient safety:** 10 measures, one of which being the EHR measure
- **Preventive health:** Eight measures focused on screenings and other preventative care practices
- **Clinical care for at-risk population:** Four measures, three of which are individual measures while one is a two-component diabetes composite measure

22 Otsuka America Pharmaceutical, Inc., Lundbeck, LLC, & OPEN MINDS. (2018, Apr). Trends In Behavioral Health: A Reference Guide On The U.S. Behavioral Health Financing & Delivery System. Retrieved from https://www.psychu.org/trends-behavioral-health-reference-guide-u-s-behavioral-health-financing-delivery-system/.

23 OPEN MINDS. 2018. The 2018 OPEN MINDS Medicare ACO Update: A Four-Year Trends Report. Retrieved from https://s11042.pcdn.co/wp-content/uploads/indres/OpenMinds_Report_MedicareACOs_020918_alm.pdf

24 Centers for Medicare and Medicaid Services. (2018, Jan.). Medicare Shared Savings Program: Accountable Care Organization (ACO) 2018 Quality Measures: Narrative Specifications Document. Retrieved from https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/2018-reporting-year-narrative-specifications.pdf

Integrated Delivery Networks (IDNs)

Integrated delivery networks (IDNs) are one of the most common hospital collaborations. An IDN is a formal system of provider organizations and health systems that aims to improve consumer care while reducing costs and preventable readmissions.[25] These systems, however, set themselves apart by offering a comprehensive array of complementary services, including preventative and acute care services. By being in control of every aspect of care delivery, from offering their own health plans to managing and operating care sites, IDNs are uniquely positioned to assess the care needs of their local populations and address social determinants of health.

This opens the door for IDNs to focus on the behavioral and physical health issues most prevalent in the populations they serve by offering and providing needed services and reducing unnecessary services.[26] This model offers the industry a unique collaborative approach to assessing the care needs of populations to improve the quality of services provided.

IDNs provide a way to address the shortage in behavioral health professionals and address major health concerns and issues in local communities, such as the opioid epidemic and drug overdose-related deaths. By taking an integrated approach to care delivery for populations, this model increases care coordination to ensure each consumer has easy access to behavioral and physical healthcare services. By focusing on and addressing individual consumer needs and the health concerns of local populations, consumers are increasingly likely to receive high-quality care to ensure they get and remain healthy. This means lower health-related costs for the consumer, as well as greater cost savings and increased sustainability for the provider organization.

IDN outcomes measure categories[28]

- Assessment and screening (e.g. Follow-up for positive screenings for potential substance use disorder and/or depression)
- HEDIS-based effectiveness of care measures (e.g. Antidepressant medication management—continuation phase)
- Community mental health center timeliness measures (e.g. first psychiatrist visit timeliness)
- Patient experience of care (e.g. Adult experience of care survey)
- Emergency department (ED) use and follow-up (e.g. Frequent (4+ per year) ED use in the behavioral health population)
- Inpatient hospital use and follow-up (e.g. Follow-up after hospitalization for mental illness within 7 days)
- Opioid prescribing (e.g. extended daily dosage of opioids greater than 120mg morphine equivalent dose)

New Hampshire case study

New Hampshire is currently conducting a five-year demonstration with IDNs across seven regions.

These IDNs will receive payments for performance based on key milestones and quality indicators. During year three (2018) of the demonstration, IDN payments were also tied to measures related to access, quality and utilization.

To promote accountability across each region, IDNs are measured using both state-specific and IDN-specific metrics. During the demonstration, IDNs are at risk for losing funds for poor performance, up to 15% of funds or $4.5 million, through year five.

By meeting process and quality measures, IDNs can see large cost savings on top of the performance payments. One IDN in the demonstration has already reported **savings in 2017 of nearly $1.2 million**.[27]

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26 Ibid.

27 McCullough, B. (2018, Oct). *Integrated Delivery Networks Aim to Transform Behavioral Health for New Hampshire Medicaid Beneficiaries.* Retrieved from https://www.urac.org/blog/integrated-delivery-networks-aim-transform-behavioral-health-new-hampshire-medicaid

28 New Hampshire Department of Health and Human Services. (2017, Mar). *Review of DSRIP Outcome Measures.* Retrieved from https://www.dhhs.nh.gov/dphs/oqai/documents/dsrip-idn-rep-measure-rev-032317.pdf

Prescription Drug Monitoring Program (PDMP)

A Prescription Drug Monitoring Program (PDMP) is an electronic database that collects and tracks data on controlled substance prescriptions for a specific population. These programs are operated at the state level and can be queried along with PDMPs in other states, HIEs and Carequality to allow healthcare provider organizations and pharmacists to see a consumer's complete medical history regardless of where services or prescriptions were provided.[29] PDMPs aim to improve the quality of care for individuals by informing clinical practice and protecting at-risk consumers.[30] A PDMP can alert provider organizations to potential dangers when making treatment decisions and aid law enforcement agencies in the detection and prevention of fraud, drug use and criminal diversion of controlled substances.[31]

PDMPs offer the industry a valuable resource for improving quality measurements related to treatment decisions and prescribing by offering state and sometimes multi-state-wide data collection of prescriptions. These programs can also improve CMS MIPS scores, as PDMP use falls under the improvement activities category, which counts for 15% of a provider's final score. Other activities related to the PDMP also increase scoring, as both consultation of (weighted high) and registration in (weighted medium) your state's PDMP are subcategories in Patient Safety and Practice Assessment.[32]

Tips and tricks

- Improve the impact of PDMPs by ensuring your system is accessible to relevant parties.
- Ensure your system can collect real-time data and provide timely analysis.
- Reduce the chances of data errors by integrating PDMP data with all other technology systems, including the EHR, health information exchanges and electronic prescribing systems.
- Ensure PDMPs can be queried as part of the clinical workflow.

These unique programs enable provider organizations to make sound clinical decisions to help prevent controlled substance use and misuse.[33] By ensuring prescription-controlled substances aren't misused, PDMPs improve health outcomes for both individual consumers and communities. PDMPs become even more useful to communities when data is made available in a timely manner as part of the clinical workflow.

Since PDMPs can work together and with other organizations, there is an increased need for data standardization and sharing. Increased data sharing and standardization would create more complete, accurate and timely prescription histories available across all provider organizations for the best chance at improving prescribing practices and reducing prescription drug misuse. PDMPs become increasingly effective as provider organizations adopt best practices, such as collecting data on method of payment including cash, using a proven method to match/link the same person's records, and integrating PDMP reports with health information exchanges.[34]

PDMP best practices categories

- Data collection and data quality
- Data linking and analysis
- User access and report dissemination
- Enrollment, outreach, education and utilization
- PDMP promotion
- Inter-organization coordination
- PDMP usability, progress and impact

29 Centers for Disease Control. (2017, Oct). *What States Need to Know about PDMPs.* Retrieved from https://www.cdc.gov/drugoverdose/pdmp/states.html

30 Ibid.

31 Pennsylvania Department of Health. *Prescription Drug Monitoring Program Questions & Answers (Q&A).* Retrieved from https://www.health.pa.gov/topics/programs/PDMP/Pages/QA.aspx

32 Lutz, J. (2018, Oct). *MIPS and PDMP Usage: How they work together. AffirmHealth.* Retrieved from https://www.affirmhealth.com/blog/mips-and-pdmp.-how-they-work-together

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Medicaid Managed Long-Term Services and Supports (MLTSS)

MLTSS refers to the delivery of long-term services and supports (LTSS) through capitated managed care programs. Through these programs, states contract with health plans to deliver support and services to individuals with disabilities of all ages who need assistance to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs) to ensure these individuals can live independently in the setting of their choice. LTSS services can be provided in care facilities, such as a nursing homes and intermediate care facilities, as well as in home and community-based settings.[35]

There are no standardized measures required for programs providing LTSS, but a set of measures has been established by the National Committee for Quality Assurance (NCQA) and Mathematica Policy Research through contract with the Centers for Medicare and Medicaid Services (CMS).[36] These measures, while not required by CMS, can be used by states, managed care plans and other stakeholders for quality improvement. The measures focus on aspects of care related to assessment, care planning and care coordination for organizations providing LTSS services.[37]

Without comprehensive and standardized data points and collection methods, linking payments to plan performance and quality of care becomes increasingly difficult. With an industry shifting to value-based care, the trend to link payments to performance and quality will likely move into the MLTSS field soon.[38]

Tips and tricks

- Improve the impact of MLTSS by ensuring your system is collecting relevant clinical and financial data.
- Ensure your system can collect and analyze data to uncover meaningful information and determine quality care and outcomes.
- Conduct data sharing or create data exchanges with other providers in your integrated care network to ensure each consumer is receiving whole-person care in the lowest acuity setting.

Organizations must be prepared to not just collect data on their consumers and services, but analyze this data and determine changes needed to ensure each consumer is receiving high-quality care. This kind of data and collection standardization will allow organizations to prove their value and empower consumers to make more informed choices about the care they and their loved ones receive.[39]

LTSS measures[40]

- Long-term services and supports comprehensive assessment and update
- Long-term services and supports comprehensive care plan and update
- Long-term services and supports shared care plan with primary care practitioner
- Long-term services and supports reassessment/care plan update after inpatient discharge
- Screening, risk assessment and plan of care to prevent future falls
- Long-term services and supports admission to an institution from the community
- Long-term services and supports minimizing institutional length of stay
- Long-term services and supports successful transition after long-term institutional stay

35 Lutz, J. (2018, Oct). *MIPS and PDMP Usage: How they work together. AffirmHealth.* Retrieved from https://www.affirmhealth.com/blog/mips-and-pdmp.-how-they-work-together

36 Centers for Medicare & Medicaid Services. (2018, Sep). *Measures for Medicaid Managed Long Term Services & Supports Plans: Technical Specifications and Resource Manual.* Retrieved from https://www.medicaid.gov/medicaid/managed-care/downloads/ltss/mltss_assess_care_plan_tech_specs.pdf.

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The Comprehensive Child Welfare Information System Rule

The Comprehensive Child Welfare Information System (CCWIS) rule is designed to help child and family service organizations improve outcomes, enhance data collection and modernize technology and information systems. Data drives outcomes, therefore, CCWIS places a strong emphasis on case management data collection, which has lacked sufficiently in child and family agencies in the past compared to other behavioral health entities.

CCWIS replaces the Statewide or Tribal Automated Child Welfare Information System (S/TACWIS) regulations, which were initially created in 1993. This former rule aimed to help child and family staff manage their caseloads and abide by federal reporting requirements. However, these systems acted as a “one-size-fits-all”, function-based approach that did not meet the unique and individual needs of different agencies across the country.

CCWIS gives child and family agencies the ability to use technology that best serves their programs and allows them to share information with multiple systems. Organizations who decide to transition into a CCWIS model will experience more flexibility and customization when it comes to their information technology and can better support their program and client needs through data collection and sharing. Although optional, agencies who implement CCWIS will receive extra federal funding and more favorable reimbursements to ensure requirements are being met while creating interventions to help children and families where necessary. It is essential for child and family services providers gather and share health information in order to improve outcomes, adjust programs based on needs and prove operational measurements.

System enhancements necessary to meet CCWIS requirements

- Bi-directional data exchange with courts
- Bi-directional data exchange with education systems
- Bi-directional data exchange with the Medicaid Management Information System
- Data quality plan

Required data exchanges

A CCWIS must support collaboration, interoperability, and data sharing with a new data exchange that is efficient, economicaland effective. Data exchanges are required for the following entities:

- Courts
- Education
- Medicaid
- Child welfare contributing system
- Ancillary child welfare systems used by agency staff

Source: The Comprehensive Child Welfare Information System Final Rule (https://www.acf.hhs.gov/sites/default/files/cb/ccwis_faqs.pdf)

Health Homes

Health homes aim to improve outcomes for consumers with chronic conditions by coordinating services across the spectrum of care, including physical health, behavioral health, and sometimes long-term services and support (LTSS) and social support services. As of January 2019, 37 unique health home models have been developed across 22 states and the District of Columbia. Each model focuses on improving care coordination and care management for consumers in order to improve healthcare quality and reduce costs.[41]

These person-centered models allow provider organizations to deliver services in a variety of settings, as long as care is coordinated and managed by the care team.[42] To follow current payment and care delivery reform efforts, a set of core quality measures have been developed for health homes to assess consumer health outcomes.[43] These core measures include eight quality measures and three utilization measures that health home provider organizations are required to report on in order to receive payment.[44] The measures focus on behavioral health and preventive care, as well as areas of care related to screening, care coordination and disease management. While provider organizations are required to report on each core measure, the full set of core metrics will be reported in aggregate at the state level.[45]

Tips and tricks

- Ensure technology systems are optimized for integrated care with the ability to link and share data between all care providers.
- Incorporate technology into workflows to ensure accurate and timely data collection.
- Increase the impact of health home services by ensuring your technology can analyze consumer data across providers and send alerts for any preventive care needed.

With this push toward providing integrated care and increasing care coordination, behavioral health provider organizations must ensure they have systems in place that can accurately share data between all provider organizations and care team members. Provider organizations in the physical and behavioral health industry, as well as those providing long-term services and support, will need workflows in place to ensure data is collected and shared with all organizations that are part of the consumer's care team.[46]

Along with the core health home measures provided by state programs, CMS also expects to receive data on specific goals and measures identified by the state. This reporting will allow for consistency across states for benchmarking and comparison, while also allowing states to use their individual quality metrics to determine health home outcomes.[47]

Health homes place a large focus on promoting access and coordination of care, improving care management and outcomes, and reducing costs, all while remaining person-centered and providing team-based care.

2019 health home care set of quality measure[48]

- Initiation and engagement of alcohol and other drug abuse or dependence treatment
- Controlling high blood pressure
- Screening for depression and follow-up plan
- Follow-up after hospitalization for mental illness
- Plan all-cause readmissions
- Adult Body Mass Index Assessment
- Prevention Quality Indication (PQI) 92: Chronic Conditions Composite

2019 utilization measures

- Admissions to an institution from the community
- Ambulatory care: ED visits
- Inpatient utilization

41 National MLTSS Health Plan Association. (2017, Apr.). *Model LTSS Performance Measurement and Network Adequacy Standards for States.* Retrieved from http://mltss.org/wp-content/uploads/2017/05/MLTSS-Association-Quality-Framework-Domains-and-Measures-042117.pdf.

42 Ibid.

43 Centers for Medicare & Medicaid Services. (2019, Jan.). *Medicaid Health Homes: An Overview.* Retrieved from https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/hh-overview-fact-sheet.pdf.

44 Department of Health & Human Services. Center for Medicare & Medicaid Services. (2013, Jan.). *Re: Health Home Core Quality Measures.* Retrieved from https://www.medicaid.gov/federal-policy-guidance/downloads/smd-13-001.pdf.

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Building the right technology infrastructure to maximize your organization's success

Technology plays a key role in successfully operating under varying care delivery models. Without the right technology, organizations will struggle to succeed in a value-based environment. The right tools and technology will allow organizations to easily capture, calculate and report on the varying quality measures required from multiple payers across the behavioral health care industry.

The optimal tool organizations can use to maximize their success is a robust EHR that provides unique fields for quality measurement reporting integrated into workflows. While most provider organizations already have an EHR, how do you know if it has the features you need? What functionality should you incorporate and use to maximize your success? There are six key features that your EHR system needs to have in order to optimize your ability to manage performance and improve outcomes:

1	**A shared EHR platform across all users:**
	By implementing a shared EHR platform across all users in your system, care can be coordinated across settings and throughout your organization. This allows all members of the care team to receive a whole-person view of each consumer's care record, including medical history and treatment plans. By granting all members of a care team access to the whole-person view, they can take a coordinated approach to improving each aspect of a consumer's care—improving quality and outcomes.
2	**Integrated workflows across all clinical, financial and operational staff:**
	Having your EHR integrated into daily workflows across all clinical, financial and operational staff allows your organization to reduce duplicative tasks and data entry while simultaneously increasing efficiency. This boost in efficiency could contribute greatly to improvements in quality and outcome measurement scores for your organization and care delivery system.
3	**Customizable measures for each type of contract:**
	Each contract an organization has secured will have its own requirements and quality measures. To fulfill those contractual obligations, organizations need to have the capability to collect data and report on each of those measures. The system should have common measures included but also allow for customization for each type of contract and reporting structure your organization has. With customizable measures, your EHR enables easy data collection and analysis to simplify the complex calculations necessary for reporting on each of the unique quality measurements required.
4	**Ability to proactively identify gaps in care:**
	In a value-based environment with a large focus on improving the quality of care provided, gaps in care are a major area of concern for clinical teams and organizations. Identifying these gaps in care can be incredibly difficult for organizations without an EHR that supports predictive analytics. Analytics that are incorporated into workflows along the care path can easily pinpoint gaps in care and alert clinical teams so those gaps can be addressed. By integrating predictive analytics into your workflow, an EHR can offer clinical teams a reminder about assessments or questions to eliminate gaps in care before they occur.
5	**Robust reporting and visual dashboards:**
	In an environment focused on improving quality, outcomes are at the heart of the system. While your EHR is already collecting data, simple data collection isn't enough. An EHR built to empower your organization needs to include robust reporting and visual dashboards to allow organizations to conduct outcomes management. Visual dashboards allow easy viewing and identification of the positive and negative status of measures over time without the need to sift through large amounts of data to get there. Robust reporting produces insights into clinician caseloads and allows organizations to review performance from an outcomes management perspective. With real-time data visible in dashboards, data is displayed in a way that appeals to most users, so the headache of conducting complex calculations for measures is removed, allowing staff more time to focus on providing quality care.

>> continued on next page

6	**Calculate measures in real-time:** If your EHR is collecting and monitoring real-time data, it absolutely needs to calculate measures in real-time. Organizations can't operate from an outcomes management perspective without the ability to always know what those quality and performance outcome scores are. Real-time calculation of measures enables organizations to be proactive with their approach to care, instead of needing to be reactive to fix the problem after it's already cost your team valuable dollars. These real-time measurement calculations can be used across the organization to identify areas of improvement so they can be addressed as quickly as possible. Without these calculations, your staff will lose out on time providing services to spend conducting complex calculations for your measure reporting.

The case is clear. Without the ability to easily collect, calculate and report on performance and quality measures, an organization is in for a long, tough journey in this new value-based environment. Make sure you have the right EHR with all the necessary functionality to succeed.

Demonstrating your value to gain competitive advantage

As VBR adoption and competition in the market continue to grow, the ability to measure performance and demonstrate value will be key to competitive advantage. The first strategic question for executive teams of behavioral health organizations is what to measure. These organizations have many customers: payers, health plans, consumer advocacy organizations, consumers and families, regulators, and donors, to name just a few. Selecting critical indicators of performance is crucial.

The second strategic issue is creating the technology platform that automates the measurement of these performance indicators. A flexible system that can aggregate information in a way that is useful to executives, managers and service professionals alike is essential.

Lastly, executive teams need to develop a strategic approach to use these performance measures. Internally, performance measures fuel process improvement and the refinement of best practices across the organization. Externally, the ability to demonstrate performance—and value—is the critical differentiator.[49]

The shift to consumer-centric and value-based care is ongoing and ever-evolving. Building new partnerships and developing the technology infrastructure you need now will help to prepare your organization to build a sustainable strategy for the future.

49 Kaiser, L.S. & Lee, T. H., M.D. (2015, Oct). *Turning Value-Based Health care into a Real Business Model.* Harvard Business Review. Retrieved from https://hbr.org/2015/10/turning-value-based-health-care-into-a-real-business-model.

Article: Integrated care: What's the big to-do?

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There is a lot that goes into delivering quality healthcare to individuals. While the goal is to serve one and all, factors such as complex conditions, homelessness, unemployment and access to care can still leave populations underserved. As providers work to improve outcomes and reduce health disparities, it's important to they have the tools to do just that. The ability to seamlessly share data, implement a strong virtual care strategy and integrate services across the care continuum can be imperative to meet these goals.

Better serving underserved populations

Recently, Dennis Morrison, Ph.D., Neal Tilghman, MPA and Tricia Zerger, MA discussed the importance of not only reaching underserved communities, but offering holistic, data-driven services regardless of where care is being delivered.

"We can't just look at a person in a silo anymore and say my job is behavioral health, and physical and social health goes elsewhere," Morrison said. "That's just not the case anymore."

Integrating care leads to better health outcomes, increased operational revenue and expanded service lines. This has never been more important, and the statistics speak for themselves. 40% of US adults report having a mental health or substance use disorder, and one in 12 people rely on Federally Qualified Health Centers (FQHCs) for care. Between 30-80% of primary care visits are driven in part by behavioral health issues, and nearly half do not follow up with a mental health specialist after referral from their primary care provider. These numbers display the importance of integrating primary care and behavioral health services.

Ideally, behavioral health services would be available within the primary care facility, however this isn't always feasible due to staff shortages or physical distance. Therefore, organizations can leverage both integrated technology and virtual care options to ensure the individual is seeking appropriate additional care post visit. Technology that allows the primary care provider to share health information with other providers, paired with alternative care options such as telehealth, better supports individuals in underserved communities.

While integrated care is not necessarily new, it's important for providers at all service levels to understand the opportunities and not limit themselves by a typical definition of integrated care.

"Sometimes we fall into a trap of having a very narrow definition of integrated care," Tilghman said. "But today there are multiple permutations of how we integrate care, which can help us advance serving the underserved."

There are four recommendations organizations can take to integrate care:

- **Integrate physical and virtual care with outside providers:** This approach is similar to the example above, with behavioral health services being made available within the primary care space. When physical presence is not viable, organizations can use data sharing tools and virtual care options to connect with outside providers who can make informed and accurate decisions based on shared documentation, regardless of setting.
- **Human services organization partners with a primary care provider:** In this case, providers can partner with an FQHC, merge with an FQHC or even become one themselves. This reorganization ensures individuals are cared for holistically within one provider unit. It's a seamless transition for the consumer and helps prevent potential gaps in care.
- **Become an integrated care system:** When organizations become actual integrated care systems, they can facilitate risk-based contracting and manage complex populations. Serving as an integrated care system not only cares for individuals, but for specific populations and the community health as a whole.
- **Use solutions that compliment or expand the electronic health record:** To successfully integrate care and prosper in a value-based market, providers must use solutions that compliment or expand the EHR.

Going beyond the EHR

Providers across all service lines need solutions that capture data at the point of care, regardless of where or how its delivered, especially as virtual and home-based care continue to grow.

Data-driven platforms that allow organizations to manage a diverse workforce, predict and mitigate risk, and support alternative payment models are vital in achieving population health management, and in turn effectively treating underserved communities.

Just as technology must go beyond the EHR, organizations' virtual care strategy must go beyond telehealth. Digital self-help tools, dictation tools,

electronic visit verification (EVV), mobile capabilities and screening tools are just some of the solutions organizations can implement in addition to telehealth.

Virtual care is here to stay, therefore optimizing additional solutions to diversity your virtual portfolio will expand access to care, coordinate services and improve outcomes, especially for those in underserved populations.

The biggest takeway?

Integrated care works—and it's essential to meet the needs of underserved populations, addressing social determinants of health and positively impacting outcomes and revenue.

"Technology is powerful and is critical to whole person care," Zerger said. "Find a partner and platform that delivers solutions and services that capture the full picture of a person's health. This includes everything from behavioral health, addiction treatment and primary care."

SECTION 3:

Impact consumer outcomes

Providing quality, effective and person-centered care is at the heart of what you do. And the right technology will empower your care delivery, not inhibit it. Access to an integrated and holistic view of a consumer's health journey at the point of care helps improve care outcomes while lowering cost of care.

Infographic: It's time to give integrated care the attention it deserves

It's time to give integrated care the attention it deserves…THE COST IS TOO GREAT

THE PROBLEM

Healthcare spending is higher for individuals with co-occurring physical and behavioral health conditions

5% of your patients account for **50%** of spending

Who is your 5%?

Patients spanning both **chronic medical** and **behavioral health** or **substance use** conditions

Healthcare costs for these individuals are **4x the cost of care** for individuals without co-occurring conditions

Behavioral Health Affects Physical Health in a **BIG WAY**

% of adults with medical conditions also have behavioral health conditions

Patients most likely to be readmitted:

#2 Behavioral health discharges

#5 Alcohol/substance use discharges

Primary care physicians and mental health specialists are INEXTRICABLY LINKED

30-80% of all primary care visits are driven, in part, by behavioral health issues

60% of mental health care visits are directed to a PCP

THE IMPACT

Poor care transitions cost:

$25-$45 billion

$12 billion of those costs are considered avoidable

READMISSIONS are costly for hospitals

$41.3 billion

spent by hospitals to treat patients readmitted within 30 days of discharge

THE SOLUTION

Technology built to address behavioral health

FEATURES

- Tailored treatment plans
- Data sharing between behavioral and physical IT
- Decision support
- Triggered coding for accurate reimbursement
- Patient and family engagement with care plan

BENEFITS

- Improved care coordination
- Lower costs
- Reduced readmissions
- Compliant information exchange
- Increased behavioral health clinician satisfation

Netsmart

SOURCES:

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Whitepaper: Why integrated technology is the future for post-acute care

A single integrated platform

myUnity® by Netsmart offers a single integrated platform that can share information across multiple systems and care settings.

Regulatory pressures, complex billing systems, tightening reimbursements and staff shortages in healthcare are not changing. To survive and thrive, home care, hospice and senior living providers will need to prove outcomes, measure results and integrate clinical and financial information.

Post-acute care providers, especially those who offer multiple lines of business (e.g. home care, senior care, skilled nursing, etc.), are often logging into multiple systems across their care settings. Doing so has a cost. And that cost comes in the form of hassle and inconvenience for your staff, siloed care, poor care transitions, census decline and low Five-Star Quality Ratings, not to mention lower margins and higher costs for your business.

But it doesn't have to be that way. Here are five reasons why an integrated technology platform can improve your overall business and help you deliver better care.

1

More efficient care transitions

Transitioning care settings should not take so long that they interrupt delivery of care. An integrated platform allows you to maintain a single record, streamlining the process from referral to admission, which means a person can receive care quickly.

What's more, as an individual moves across the continuum of care within your organization, an integrated platform moves the relevant data with them.

When someone moves from assisted living to skilled nursing, all the information immediately moves with them, including the care plan, demographics, names of physicians, allergies, related parties, diagnosis, medications and scheduling. What does that mean for your staff? No manual or duplicate entry, less risk of error and better clinician and resident experience.

2

Less administrative burdens

The shortage of home health and personal care aides is growing: The number of aides needed will grow by 47 percent from 2016 to 2026, according to the Bureau of Labor Statistics. To find and retain the best people, you need modern, convenient and easy-to-use technology that reduces administrative work so staff can spend more time on care. Disconnected tools, several sets of login credentials and multiple systems to master further complicates staff workflow.

Equally important to staff satisfaction is strong communication. It takes a great team to deliver great care to the people you serve. One of the hallmarks of high-performing teams is the ability to communicate across all care teams. A single, integrated platform can be the fuel that drives interdisciplinary communication between the different roles and individuals on your care team.

3

Analytics and population health management

Taking the data from your electronic health record (EHR) to drive better outcomes is key to improving the health of the people you serve. To survive in a value-based reimbursement economy, you need an interoperable platform with analytics, connectivity, population health management and electronic referral management capabilities. Disparate systems, multiple spreadsheets and siloed care approaches won't work as healthcare moves from a fee-based to outcomes-based system.

By using a platform that can aggregate information across your entire organization, you gain the ability to measure quality, optimize processes and report outcomes to health systems and payers. You also get a global view of what is happening across your organization, as well as a specific view of a wing or section of a certain facility. Doing so enables you to derive meaningful insights from the data and make changes to improve care.

4

Connections with hospitals and other providers

Interoperability, the ability to exchange data across different technology systems, is one of the biggest barriers to value-based payment adoption. This will be critical if you want to truly deliver person-centered, value-based care. To track costs, you need data that flows across all systems of care.

An EHR platform that can connect with other healthcare entities gives you the information you need to see a complete picture of a person's health. This connection to the broader healthcare community also enables seamless care coordination and smoother patient transitions, which helps you deliver better care, improve outcomes and reduce costs.

By using a platform with a single connection point, you become connected with healthcare partners across the community. This allows your organization to solidify its position as a preferred referral partner, which is critical as networks continue to narrow.

5

Supports person-centered care

Outcomes are far more likely to improve when providers can collaborate and coordinate a person's care. With one integrated platform, senior living, home care and hospice providers can leverage one system, making it easy to converge clinical, operational and financial workflows. This platform eliminates inefficient, disconnected workflows caused by disparate systems and paper-based processes, all of which hinder the clinician and patient experience, increase your supply costs and interrupt your cash flow because of rejected claims.

As healthcare continues to move to an outcomes-based, person-centered model, it's no secret that it will take more than a traditional EHR for organizations to succeed and thrive.

And that means having a platform that provides you with one patient record, one care plan, one unified bill and a single sign-on for every staff member, all critical elements as the patient and staff experience moves to the forefront.

If you are looking to drive efficiencies, boost referrals, and improve staff and patient experience in your organization, Netsmart can help.

As the largest post-acute care technology provider, our cloud-based platform, myUnity, goes beyond a traditional EHR to make it easier for you to measure results, improve outcomes, and integrate clinical and financial information.

To find out what we can do for you:

- Visit www.ntst.com/myUnity
- Request a demo: www.ntst.com/Request-a-Demo
- Contact a Netsmart representative: 800.472.5509

Success Story: Ohioans Home Healthcare

Less recruiting issues and higher patient satisfaction

SUCCESS STORY **HOME HEALTH**

At a glance

Community
- Home Health

Organization
- Ohioans Home Healthcare

Location
- 34 counties throughout Ohio and Michigan

Challenges
- Staff recruiting difficulties
- Incomplete and disorganized clinical documentation
- Frustrated clinical staff

Solution
- Netsmart myUnity®

Results
- Agency growth and expansion from 50 to over 2,500 patients today
- Improved clinical and patient satisfaction
- 88% of patients recommend the agency
- More accurate clinical documentation
- Streamline coding and billing

Netsmart

Ohioans Home Healthcare creates a culture of satisfaction with an easy-to-use EHR

Ohioans Home Healthcare was founded in 2007. With more than 25 years of combined industry experience, the company vision has always remained the same—to provide outstanding, quality care and customer service for clients within the comfort of their own homes. Since inception, it has added seven additional branch locations, servicing 34 counties throughout Ohio and Michigan.

Challenge

When Josh Adams took over as CEO of Ohioans Home Healthcare in 2011, he realized that employee satisfaction would be central to the agency's success.

"When we started out, we had a small group of employees who had all worked together at another agency, just six or seven of us," said Kimberly Schmeltz, RN, Director of Operations at Ohioans Home Healthcare. "Josh and the team realized the importance of keeping those people happy. From our previous experience, we saw such a positive difference when we had a nurse who loved her job and enjoyed her work."

A few years after taking the reins at the Perrysburg, Ohio-based home healthcare agency, Adams and other leaders noticed that many of the homecare nurses were using big plastic bins to transport reams of paperwork. The leaders figured that the nurses simply couldn't be happy with the situation.

This practice prompted leaders to examine the nurses' day-to-day work lives more closely, and they realized the need to improve clinical documentation practices so that nurses could more keenly focus their attention on patients.

The agency launched a search for a new EHR that clinicians could be trained on quickly, would result in a high level of user adoption and ultimately increase employee satisfaction.

> "We don't feel desperate for staff. In fact, about 85% of our new employees come to us as a referral from somebody else."
>
> Kimberly Schmeltz, RN
> Director of Operations, Ohioans Home Healthcare

"We needed to have a smooth transition to an electronic system for our field staff. We were working with nurses who had never utilized any form of electronic charting, and we were transferring them from their paper documentation to learning to use a device and software," Schmeltz said.

Solution

After examining several options, Ohioans' leaders decided to implement myUnity—citing its ease of use as one of the key deciding factors. "It's very user friendly. The initial training with our nurses only took about an hour. The screens in myUnity are so simple. The nurses only see what they need to see, and it's very simplistic for them," Schmeltz said.

Indeed, the EHR has been widely adopted for clinical documentation. They grab their iPads, and they're good to go," Schmeltz said.

Results

Ohioans is also experiencing:

More streamlined documentation

"With the electronic system in place, the nurses have said goodbye to the all the paper disorganization that they had been dealing with. Now, they can simply document care on their iPads and they are done," Schmeltz said. In addition, these on-site capabilities make it easier for nurses to more accurately document care.

Improved overall agency workflow

Our clinicians may not live close to our office locations, which meant they had to travel long distances to courier the paperwork to the office. With the EHR in place, clinical documentation is sent electronically, making it possible to streamline the entire coding and billing process.

Enhanced patient care

myUnity has created customized forms that perfectly match the specific needs of Ohioans nurses, enabling nurses to more keenly focus on patient care. "When a nurse arrives in a home, she can quickly fill out what she needs to and then turn her attention to the patient," Schmeltz said. "She's not spending a lot of time on back-end processes or trying to figure out how to navigate the system. She can focus on the patient while she is there."

The agency has grown from just seven employees serving 50 patients in 2011 to more than 350 employees who serve about 2,500 patients today.

Being able to focus on patient care resonates with the type of nurses who work at Ohioans. "We attract nurses who want to be nurses for the right reasons. They want to provide one-on-one patient care and went to nursing school because they really wanted to see people improve and see the outcomes," Schmeltz said. "A nurse in a hospital might get to see a patient for one or two days. But here at Ohioans, the nurses get to see the patient from beginning to end and leave the patients when they have reached a state of independence."

Improved customer service

The EHR also is used to track patient satisfaction. "We call every patient within 48 hours of opening their case to make sure everything is going well, that their nurse is a good match and that they're satisfied so far. We use tracking and reporting systems in myUnity to manage all of that," Schmeltz said.

Experience the right kind of growth

The utilization of the EHR is one factor that is helping the agency continue to grow while it stays true to its vision of unparalleled employee satisfaction. In fact, the agency has grown from just seven employees serving 50 patients in 2011 to more than 350 employees who serve about 2,500 patients today.

This growth is occurring in an environment where employees are truly satisfied with the care experience. In 2015-2018, Ohioans finished on top of the Toledo area's midsize companies category in The Blade's Top Workplaces competition.

The agency is also finding it easier to recruit nurses, even as other care providers struggle to attract clinical staff. “Being a nurse, I get emails and calls every day from organizations offering huge incentives, sign-on bonuses and other perks. It makes me smile because we don’t have to go that far. We don’t feel desperate for staff. In fact, about 85% of our new employees come to us as a referral from somebody else,” Schmeltz said.

Such satisfaction is contagious—as patients also seem to be happy with the care they are receiving. “The same type of word of mouth is helping with patients. They’re going to their doctors’ offices and saying great things about their nurse. Everywhere they go, they’re talking about how their nurse helps them or some experience that they had. That word of mouth has been great for us,” said Schmeltz.

“This is what we set out to accomplish years ago. We knew that if we concentrated on making our clinicians happy, we could make our patients happy—and our agency would grow. But perhaps most important, we projected that our agency would grow by offering a high quality patient care experience, and that is exactly what has happened,” Schmeltz said.

> “Patient satisfaction surveys published on the CMS Home Health Compare sites indicate that patients rated the overall care from the home health agency at a 91%, compared to 82% Ohio Average and 84% National Average.”

Kimberly Schmeltz, RN
Director of Operations, Ohioans Home Healthcare

Learn more about Netsmart clients at www.ntst.com/Resources-and-Insights/Success-Stories

About Netsmart

Netsmart designs, builds and delivers electronic health records (EHRs), solutions and services that are powerful, intuitive and easy-to-use. Our platform provides accurate, up-to-date information that is easily accessible to care team members in behavioral health, home care, senior living and social services. We make the complex simple and personalized so our clients can concentrate on what they do best: provide services and treatment that support whole-person care.

By leveraging the powerful Netsmart network, care providers can seamlessly and securely integrate information across communities, collaborate on the most effective treatments and improve outcomes for those in their care. Our streamlined systems and personalized workflows put relevant information at the fingertips of users when and where they need it.

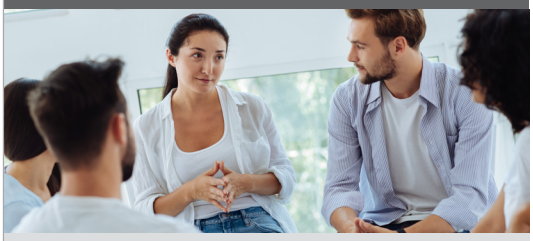
For 50 years, Netsmart has been committed to providing a common platform to integrate care.

1.800.472.5509 | www.ntst.com

Success Story: Metrocare

Making integrated care a reality

SUCCESS STORY **BEHAVIORAL HEALTH**



At a glance

Community
- Behavioral Health

Organization
- Metrocare

Location
- North Texas

Challenges
- Lack of shared data between care setting and multiple providers

Solutions
- CarePOV™ Medical Note for Psychiatry
- CarePOV Medical Note for Primary Care

Results
- Ability to deliver whole-person care through one shared platform

Netsmart

Metrocare partners with Netsmart to enhance coordination and integration

About Metrocare

As the largest provider of mental health care services in North Texas, Metrocare provides a unique variety of services to both children and adults in Dallas County. In addition to behavioral health care, Metrocare delivers primary care and clinical care services, along with service opportunities for veterans and their families, in-house pharmacies, housing and supportive social services. By treating both physical and behavioral health under one roof, Metrocare takes a whole-person care approach to serve its community.

The challenge

An estimated 29% of adults with medical conditions also have mental health conditions. Therefore, a pertinent component to successful whole-person care is integrated data, which allows providers to have visibility into the care path, documentation, medication, treatment plans and more from both primary care and mental health perspectives in one electronic health record (EHR).

Before their partnership with Netsmart, Metrocare was attempting to share the same EHR, but some primary care data had to be kept in hard copy charts. This approach led to inherent challenges in sharing the right data and ensuring communication was not only occurring but streamlined.

“Many of the patients seen by our behavioral health providers often have medical conditions that require the expertise of a primary care provider,” primary care provider Stephanie Okeke APRN, FNP-BC said. “The Netsmart CarePOV Medical Note has improved communication

> “The Netsmart CarePOV Medical Note has improved communication between the clinics, thus fostering a team-oriented approach to patient care.”
>
> Stephanie Okeke, APRN, FNP-BC
> Primary care provider

between the clinics, thus fostering a team-oriented approach to patient care. This approach has made checking medication interactions easier and improved treatment adherence in our patients."

Two care lines, one platform

After adopting Netsmart CarePOV Medical Note for Psychiatry and CarePOV Medical Note for Primary Care in 2018, Metrocare providers now successfully deliver whole-person care through one shared platform. Today, both primary care and behavioral health providers share data, including vitals, medications, allergies, problems, labs and more in one face sheet within the single EHR.

Medical Note empowers the provider to make informed care decisions with easy-to-access medical information. Providers can easily print medication lists and view notes from other care providers without having to click to numerous screens. Shared vitals and unreviewed labs available on one page help the organization save money and resources while providing more efficient care, as they can prevent duplicate tests and quickly access previously documented information in the note.

"Having access to more of an individual's information, both for behavioral health and primary care, allows us to provide better care," Chief Medical Officer, Dr. Judith Hunter, said. "With Medical Note, we have the opportunity to review labs that each division has completed. This ability prevents redundancy and saves both time and financial resources. It can also save our patients from having to make multiple trips to get lab work done."

Medical Note is integrated in the Netsmart myAvatar™ EHR within a console view where users can easily view their past notes, treatment plans and what was discussed during the individual's last visit. This saves doctors and nurse practitioners time and makes viewing past documentation accessible and convenient before, during and after the appointment.

> "Netsmart is not just going to tell us what we need. Netsmart is willing to ask what do you like, what don't you like? And that's good for everyone."
>
> Dr. John Bennett
> Medical Director

"Going through the old record to look for previous notes was a challenge," Medical Director, Dr. John Bennett, said. "With the Medical Note widget, I can click on what I want to look through and use a filter to narrow it down even more. I can now look at other notes while I have my current note open. That's really helped the workflow."

Automated CPT Code

In addition to automatic shared information capabilities across both primary care and behavioral health, Medical Note also has a built-in calculated CPT code feature. Before using Medical Note, Metrocare physicians and advanced practice nurses had to choose and count the necessary elements to calculate the code rather than the code being calculated directly from the documentation, which could lead to inadvertent coding errors. With Netsmart, the CPT code is auto-calculated at the end of the session based on the provider's documentation. Recommending the appropriate CPT code can help prevent both over-coding and under-coding. When the user gets to the finalization screen, Medical Note gives the calculated code with the option to override the code if they choose.

"The Medical Note CPT auto-code is great for consistency," Bennett said. "The auto-code is accurate, and that's what matters. It's a great benefit of Medical Note."

Physician-prescriber workgroup

Overall, Medical Note for primary care and psychiatry has made integrated care a reality by allowing the provider team to view the clients as a whole person by having all of their health data in a single platform. In order to fully optimize and improve the platform, Netsmart started a physician-prescriber workgroup that was formed for Medical Note end users. Dr. Bennett serves as the co-chair of the group. The goal is to harvest the ideas and experiences of those who are actively using Medical Note every day to continually take advantage of a truly integrated approach to care.

"It's great to openly talk about improvement," Bennett said. "Netsmart is not just going to tell us what we need. Netsmart is willing to ask what do you like, what don't you like? And that's good for everyone."

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> Chief Medical Officer

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For more than 50 years, Netsmart has been committed to providing a common platform to integrate care. SIMPLE. PERSONAL. POWERFUL. Our more than 2,300 associates work hand-in-hand with our 680,000+ users at our clients across the U.S. to develop and deploy technology that automates and coordinates everything from clinical to financial to administrative.

Learn more about how Netsmart is changing the face of healthcare today. Visit www.ntst.com, call 1-800-472-5509, follow us on our CareThreads Blog, LinkedIn and Twitter, like us on Facebook or visit us on YouTube. Netsmart is pleased to support the EveryDayMatters® Foundation, which was established for behavioral health, care at home, senior living and social services organizations to learn from each other and share their causes and stories.