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Beyond interoperability:

Expanding the definition
of integrated care

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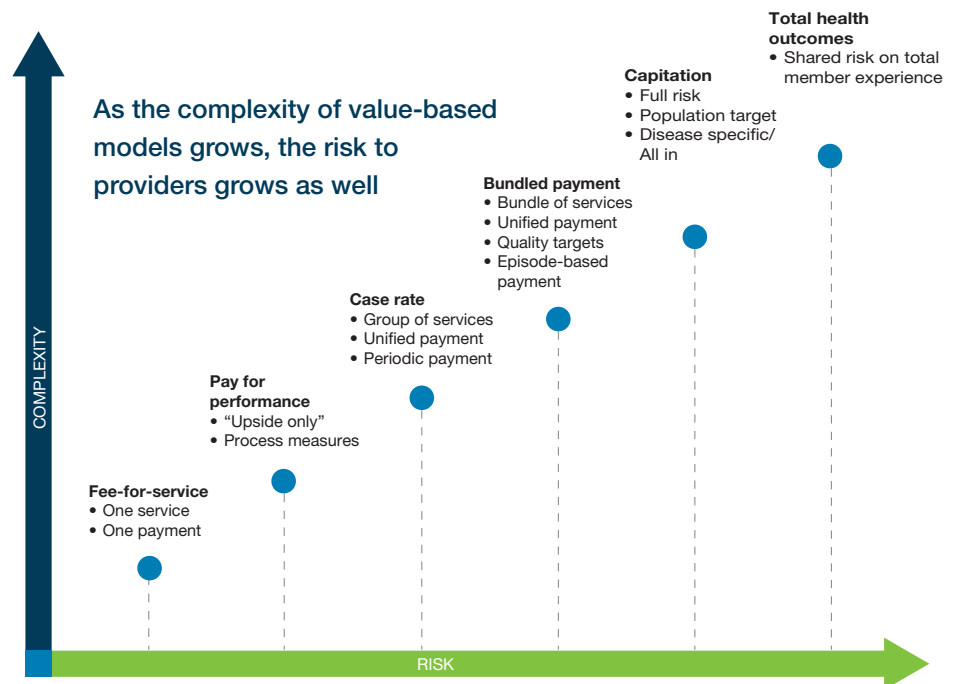
Expanding the definition of integrated care

Healthcare costs are rising at unsustainable rates. When treatment for the mind and treatment for the body are not integrated, the costs increase even more. Behavioral health comorbidities – where patients have both a mental illness or substance use disorder and a chronic medical condition – have been shown to drive costs two to three times higher than treating just the medical condition.¹

To address these issues, value-based care models, such as accountable care organizations (ACOs) and the Certified Community Behavioral Health Clinic (CCBHC), have been developed. Value-based care models all have similar goals:

- Lower costs by reducing institutional/inpatient care and emergency room usage, and ensuring appropriate level of care
- Drive consumer satisfaction by engaging consumers in their treatment
- Improve the value of services provided by improving outcomes and overall population health while reducing costs

The challenge for human services providers will be to manage both the complexity and the risk as payment methods shift to value-based payment models.



¹ *Economic Impact of Integrated Medical-Behavioral Healthcare*; Milliman, Inc. April 2014.

The implications for behavioral health providers are clear. They must deliver health services across modalities within an integrated and connected delivery system. Those systems must also allow them to identify and manage “high risk/cost” individuals.

Provider organizations are faced with serious decisions that relate to integrating existing core services with physical health services:

- Co-locate with a partner organization in a brick-and-mortar facility or engage in a virtual integration with multiple organizations
- Evaluate the need and determine financing for additional resources for new service lines, facility improvements, technical support and staff
- Develop a technology strategy that supports connectivity and communication, captures data and outcomes
- Determine how to drive standardization, process improvement and use of best practices across all services

Leveraging technology to support payment and clinical models

Of the challenges outlined, developing a technology strategy that supports interoperability and, ultimately, true care integration is perhaps the biggest obstacle.

Technology initiatives accelerate interoperability

Hub-to-hub exchange: The eHealth Exchange was started in 2006 as a federally led effort. In 2012, it was re-formed as “The Sequoia Project,” a public-private effort that focuses on hub-to-hub data exchange for very large health information exchanges (HIEs) and provider organizations, such as the Veterans Administration and Social Security Administration.

Push-based exchange: DirectTrust.org was formed in 2012 and focuses on shared agreements and a uniform certification process that exchange data through push-based protocols similar to secure email.

Pull-based exchange: Launched in 2013, CommonWell Health Alliance is a health information technology (HIT) vendor-driven interoperability initiative. It focuses on connectivity embedded in software solutions and working infrastructure.

Standards for discrete data exchange: The Argonaut Project (founded in 2014) supports defining the standards for the exchange of discrete data and “document” data, the current standard for health information exchange. Discrete data is captured and stored in a database with fields for each discrete value, making it easier to extract reports on a range of variables. Document data is text-driven and thus more difficult to query.

Network-to-network connectivity: In 2014, the Sequoia Project launched Carequality to support creating the policy and trust frameworks to enable intra-network exchange. The goal is to create rules of the road for vendors and their clients for the requirements for data sharing.

“ We look for ways to use data to drive clinical decision support at the point of care.”

Wes Williams
CIO, Mental Health Center of Denver

Public and private initiatives have been in the works for more than a decade to overcome technology barriers and speed up interoperability among providers and their systems. But compared to acute and primary care providers, behavioral health and human services lag in technology adoption, digitization and interoperability. Only half of human services organizations currently use an electronic health record (EHR). The digital divide extends beyond the adoption of the EHR – only 35% of behavioral health providers can send patient data to other organizations and less than one-quarter can receive it from other providers.

To adapt to new standards for value-based care and payment models, behavioral health providers must consider accelerating their adoption of technology to do the following:

- Bidirectional exchange of data across systems – acute care, primary care and behavioral health systems
- Communication with partners throughout the healthcare ecosystem to form a holistic view of individuals and population health
- Standardize and improve processes – best practices and capturing data and outcomes to track them as it becomes necessary

Behavioral health providers with an eye on the future are seeking ways to use technology in their transition to risk-based reimbursement models. Mental Health Center of Denver, known locally and nationally as a model for innovative and effective community behavioral healthcare, is one such organization.

The center provides treatment, prevention and outreach services to more than 45,000 in the Denver area each year. Adapting to value- and risk-based payment models means finding ways to improve outcomes, reduce costs and support the center’s mission: Enriching lives and minds by focusing on strengths and well-being.

“We look for ways to use data to drive clinical decision support at the point of care,” explained Wes Williams, CIO at the organization. “One of the ways we’ve done that is through a partnership with our EHR vendor, Netsmart, and RXRevu™, a prescription intelligence platform that helps identify the most effective medication at the best possible cost.

We can now provide prescription decision support, with recommendations integrating pharmacogenomics, clinical outcome data, medication cost, and clinical protocol adherence, to medical staff right at the point of prescribing,” Williams continued. “I think that’s one of the keys to adoption – make it easy for staff to use by putting the information right into their workflow.”

Care coordination and interoperability: practical applications

Interoperability and the ability to exchange health information are already changing and improving clinical practices in behavioral health.

Referral process automation

When inpatient psychiatric hospitals discharge patients and refer them to a community mental health center (CMHC), documentation is mailed and faxed to the CMHC, slowing the process and making follow-up difficult.

By adopting HIT that supports interoperability, organizations can automate referrals and securely send clinical information from the hospital to the CMHC where it is integrated directly into the EHR workflow. The referral can be reviewed, accepted or rejected, and an appointment time sent back to the hospital. After the initial encounter, updated clinical notes are sent to the hospital, creating a closed-loop referral process.

This connectivity can be expanded to other community service organizations, including crisis call centers. Through interoperability and connected networks, the calls can be turned into warm handoff referrals to either the inpatient facility or the outpatient CMHC.

Integration with acute care organizations

Acute care organizations can also benefit from an HIT integration platform, using it to reduce emergency department (ED) usage by people in need of psychiatric services. Better connectivity means faster and smoother transitions from the ED to the crisis stabilization unit of the inpatient psychiatric hospital or the community mental health clinic.

Once the referral has been accepted, direct communication between facilities can take place, transportation dispatched and patients transitioned to the appropriate care setting. As a result, ED resources and beds are freed up, and acute care organizations reduce the risk of readmission penalties.

The exchange of information also allows sharing seven-day follow-up information, meeting Health Effectiveness Data and Information Set (HEDIS) requirements and ensuring the correct treatment level is provided.

Community Mental Health Centers and Federally Qualified Health Centers

A significant push has been made to create integration models connecting CMHCs with Federally Qualified Health Centers (FQHCs), including grants funded through Substance Abuse and Mental Health Services Administration (SAMHSA). Providers can be co-located within brick-and-mortar facilities or a primary care provider organization and behavioral health clinic may agree to share a client population. Either way, connectivity technology must make it possible for both entities to work within their own systems that support clinical workflow for the services they provide.

Interoperability in these instances includes capturing referrals as noted previously, but also creating structured data to integrate medication lists, allergies and laboratory results into the health record. With that relationship established, data can be automatically sent across the network to keep the systems in sync when an encounter is closed within each of the systems. The result is a single view of a client across two modalities of care.

Care coordination and interoperability: technology requirements

The technologies and platforms that enable true interoperability integrate directly into the EHR. They leverage standards-based transaction and data elements to support connections on a broad scale, allowing visibility across care modalities and systems, and lay the groundwork for future expansion through network-to-network connectivity.

“ Clinical integration is really about defining processes that remove barriers and tying together disparate clinicians through workflows that have been optimized to benefit the whole person.”

Denis Morrison, PhD
Chief Clinical Officer, Netsmart

Making full use of the information this connectivity provides requires tools to aggregate the information for segmentation and stratification:

- Segmentation to define a population by relevant attributes
 - Identified by diagnosis, gender and utilization of services; usually static over time
 - Should include other practical factors, such as community, geographic location, etc.
 - There should be a degree of homogeneity in the group
- Stratification to identify the issues or conditions within the population and rank risk based on these factors
 - Offer a continuum spanning high risk/cost vs. low risk/cost
 - Should change over time as intervention and treatment are provided
 - Based on outcomes, workflows and treatment, and can be optimized for the entire population

The Missouri Coalition for Community Behavioral Healthcare, which represents 32 not-for-profit agencies in the state, is already using care coordination technology to support the industry-leading work of Missouri Healthcare Home teams. By integrating primary care and behavioral health, Health Homes seek to improve both the quality of care and health outcomes.

Aggregating clinical and claims data provides insights into the total health of an individual and the population, allowing the coalition to develop detailed risk stratification and monitor population health.

“Bringing clinical and claims data together into a single solution has proved successful because it not only allows for the holistic view of the population, but also automates and calculates the metrics at the aggregate and local level,” said Brent McGinty, CEO of Missouri Coalition. “But community mental health centers (CMHCs) and the state must work together to accomplish this goal.”

Beyond technology: Expanding the definition of integration

The technology to support interoperability will continue to evolve, unlocking even more opportunities for sharing information. But organizations whose aim is to integrate behavioral health and human services with acute and primary care need to expand their vision beyond the implementation technology.

The ability to access all the available data across the healthcare ecosystem isn't helpful,” said Dennis Morrison, PhD, chief clinical officer at Netsmart. “That's too much data that isn't contextualized to the care needs.

“Clinical integration is really about defining processes that remove barriers and tying together disparate clinicians through workflows that have been optimized to benefit the whole person,” he continued. “These workflows must be supported by more than static data, but rather information that is delivered in context with each area of service.”

Carmen Cantero of Citrus Health Network, one of the largest behavioral health providers in South Florida, agrees with Morrison's assessment.

“We're still missing some of the necessary elements,” stated Cantero who is quality improvement and compliance officer at Citrus. “We want to have more information available on what's impacting the patient, including the clinical aspect of the social determinants of health – housing, family support and other factors.”

As evidenced by the use cases outlined in this paper, interoperability continues to gain momentum as more organizations recognize the need to support whole-person care. But there is a long way to go for behavioral health organizations that aim at achieving true collaborative care.

As Cantero noted, people with mental illness diagnoses interact with a vast range of services, including the educational system, justice system, social service system and others. To encompass all these factors requires an expanded concept of integration that spans levels of care as well as care providers and modalities:

1. Patient-centered care
2. Population-based care
3. Measurement-based care
4. Evidence-based care
5. Accountable care

Addressing these five components of care gives providers a holistic view of each individual. Interoperability technology can support this view by integrating clinical workflows, assessments and evidence-based practices, and sharing the care plan across modalities of care: behavioral health, acute care, primary care and social services. Through data and analytics, organizations will also gain a better view of the populations served, supporting further refinement of best practices and evidence-based treatment.

As more organizations embrace this expanded definition and the technology that makes it possible, the silos of information that limit the effectiveness of treatment will be broken down. And all providers throughout the healthcare ecosystem will be able to leverage evidence-based practices to improve the clinical care pathways, produce more positive outcomes and lower costs.

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, care at home, 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. SIMPLE. PERSONAL. POWERFUL.

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