CASE STUDY

Netsmart

Care Coordination Technology Supports Population Health Management

Category

Functional/Health Outcomes

Organization Name

Missouri Coalition for Community Behavioral Health

Organization Type

Community Mental Health Centers (CMHCs)

Other Partners

Missouri Department of Mental Health, Missouri Medicaid, Acute Care Health Systems, Primary Care, Federally Qualified Health Centers (FQHCs), Community Mental Health Centers (CMHCs)

Organization Description

The Missouri Coalition for Community Behavioral Healthcare represents Missouri's not-for-profit community mental health centers, as well as alcohol and drug abuse treatment agencies, affiliated community psychiatric rehabilitation service providers, and includes a clinical call center. There are 32 member agencies staffed with more than 9,500 individuals. Coalition members annually provide treatment and support services to approximately 250,000 people.

Project Description

Over the past two years, Netsmart has partnered with the Missouri Coalition to implement a care coordination and population health management solution that supports the Coalition's Community Mental Health Center (CMHC) Healthcare Homes. CMHCs provide community psychiatric rehabilitation services under the Medicaid Rehabilitation Option with sufficient capacity to sustain a viable Healthcare Home and are recognized by the Missouri Department of Mental Health to serve as CMHC Healthcare Homes. CMHC Healthcare Homes assist individuals in accessing needed health, behavioral health, and social services and supports; managing their mental illness and other chronic conditions; improving their general health; and developing and maintaining healthy lifestyles.

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LeadingAge CAST
center for aging services technologies

The LeadingAge Center for Aging Services Technologies (CAST) is focused on accelerating the development, evaluation and adoption of emerging technologies that will transform the aging experience. As an international coalition of more than 400 technology companies, aging-services organizations, businesses, research universities and government representatives, CAST works under the auspices of LeadingAge, an association of 6,000 not-for-profit organizations dedicated to expanding the world of possibilities for aging.

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This project offers practical approaches to implementing Healthcare Homes, as well as best practices in leveraging technology to address care for persons with multiple, varied, and complex needs, including co-occurring mental and physical health conditions, and supporting coordination between different providers.

System Type

Key components of the solution implemented include:

- Care coordination and population health platform to support value-based care and reimbursement
- Configurable rules engine to prioritize activities for individual care management
- Interoperability engine to support data exchange
- Patient engagement platform for self-guided therapy
- Data exchange to enable transitions of care (i.e. ergency Room alerting system)
- Collection and aggregation of clinical and claims data to view quality measures at individual and population levels and to identify gaps in care
- Clear views of analytics, care quality key performance indicators (KPIs) and organizational compliance to best practices
- Near real-time reporting for provider, Missouri Coalition and the State of Missouri reporting requirements.

The Netsmart CareManager™ solution supports the work of CMHC Healthcare Homes in Missouri. Netsmart CareManager is an EHR-agnostic care coordination solution that facilitates communication and information exchange across all care providers of an individual. It is used as part of the Healthcare Home and Disease Management 3700 project (also known as DM 3700) and supports the requirements for these programs. Depression and metabolic screening is critical to the success of these programs, as the Missouri Department of Mental Health and Missouri Coalition track the completion of these clinical elements. In addition, the identified quality measures within these two programs are also calculated and tracked. Gaps in care, alerts and notifications identify individuals who are outside the healthy range of a measure. Notification is sent to the care team to provide early intervention or treatment, helping an individual manage the condition in a healthy way.

System Embodiment/Benefits

Netsmart CareManager facilitates referrals and provides real-time alerts on emergency department visits, hospitalizations, gaps in care, allergies and other information essential for providing the right care at the right time, and essential to diagnosis and treatment of co-occurring health disorders. It also aggregates data to identify trends and manage the health of populations across care settings.

Key benefits:

- Tracks events and changes in condition wherever the individual is in the healthcare ecosystem
- Reduces cost of care with timely transitions to the appropriate level of care
- Highlights potential gaps in care, critical issues and social determinants of health
- Simplifies access to information while retaining privacy and security
- Provides a comprehensive view of the individual's medical, behavioral and social health
- Works with any EHR; cloud-based; accessible anywhere, anytime
- Highly intuitive with user-friendly interface
- Scalable to meet organizational size and structure
- Easy system administration with role- and permission-based client data access.

Business Model

Per member/per month (PMPM) payment model for the population attributed to the provider network. Ranges from on the low end of about $150 PMPM to on the high end of up to $400 PMPM for highly complex patients.

Implementation Approach

Implementation was led by the Missouri Department of Mental Health and the Missouri Coalition. Buy-in from agency leadership was extremely important to standardize implementation and pave the way for (Commission on Accredited Rehabilitation Facilities) CARF™ accreditation. In-house training was included in the implementation schedule.

Outcomes

The clinical and financial outcomes below represent historical performance of the Healthcare Homes program. Results reflect the effectiveness of the program under Dr. Parks' leadership. The project described in this case study is designed to build on the outcomes noted below.

Clinical

- 3-year reduction in A1C (Blood Sugar) Levels (Note: 7% of patients had uncontrolled A1C levels)
  - Healthcare Homes: from **10.1 to 8.6**
  - CMHC Healthcare Homes: **from 10.0 to 9.1**
  - **1 point drop in A1C Level =**
    - 21% decrease in diabetes-related deaths
    - 14% reduction in heart attacks
    - 31% reduction in microvascular complications
- Increase in Hospital Follow-Up
  - Overall from **32% of patients to 75%**
  - For medication reconciliation from **28% of patients to 68%**
- Reduced Hospitalizations (2009-2014, per 1,000, CMHC Healthcare Homes added in 2012)
  - Hospital stays: **38% decrease**
  - ER visits: **34% decrease**

Financial

- Healthcare Homes have saved Missouri an estimated **$36.3 million total, $60 PMPM**
- CMHC Healthcare Homes have saved Missouri **$31 million total, $98 PMPM**
- DM3700 subset saved: **$22.8 million total, $395 PMPM, 4,800 lives**

The above numbers are attributed to estimated cost savings of the Healthcare Home approach (https://www.mocoalition.org/health-homes).

Challenges and Pitfalls to Avoid

It's important to accurately estimate the time and number of training sessions needed for staff to understand the Healthcare Home delivery model. Organizations must also ensure there is sufficient funding in PMPM payments to allow physicians and other staff time to attend training. Small PMPM payments should also be included to local primary care providers (PCPs) and hospitals to work with the CMHCs and Healthcare homes.

Finally, organizations should calculate and plan for adequate staff-to-member ratios. For example, it was discovered that one full-time nurse care manager per 250 members is insufficient. For CMHCs, one full-time home health director per 500 members is too much. For primary care Healthcare Homes, one full-time home health director per 2,500 members is too little.

Lessons Learned/Advice to Share with Others

Over-communicate

Those involved in this project recommend weekly calls with practice coaches for individual sites, monthly conference calls for Healthcare Home administrators and care managers, and quarterly face-to-face learning collaborative meetings.

Keep It Simple

Wherever there is an opportunity or individual choice point, lean toward choosing the simplest solution. Establishing Healthcare Homes is complicated; take measures to simplify it up front. Address problem areas as they arise and don't worry about the finer points in your initial design.

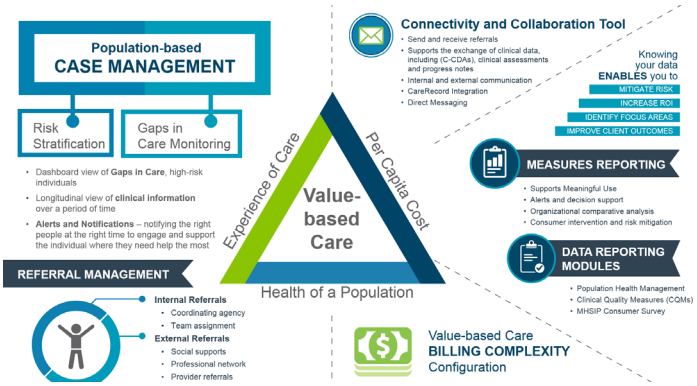
Keep It Moving

If you go for perfection in your program design, you will get lost in the details. Aim for a good, solid strategy that will address most issues up front, and use an incremental, iterative approach to improve results as the program moves forward. If you try to create a totally comprehensive plan before you implement, you'll never get started.

Direct Relevance to Post-Acute Transformative Care Models

This project is an example of how fee-for-service payments and siloed, isolated models of care are rapidly being replaced by care delivery models based on quality of care and outcomes, commonly called Value-Based Purchasing (VBP). This is directly applicable to long-term and post-acute care (LTPAC) providers as they assume the role of "quarterback," coordinating care with upstream organizations and home health and hospice providers. In fact, the Centers for Medicare and Medicaid Services (CMS) has designated a Skilled Nursing Facility Value-Based Purchasing Program (SNFVBP) for implementation in 2018.

Here is a basic framework for value-based purchasing in a post-acute setting.



VBP gives post-acute providers a multi-faceted channel to facilitate coordinated, integrated care. Providers are beginning to embrace many of the necessary skills to prepare for VBP, including managing episodic rate of service; fully utilizing the capabilities of their EHRs; fully optimizing data for clinical and operational planning; participating in health information exchanges; using clinical decision support tools; facilitating consumer-empowered care; and measuring systemic effectiveness.

Care management and referral management are key elements of value-based payments in post-acute. As an example, Netsmart and Cantex Continuing Care Network are in a strategic partnership to deploy an innovative “smart referral” management solution. The solution connects post-acute organizations to referring sources electronically, streamlines the acceptance/rejection process, manages intake workflows, and provides consistent and reliable operational, financial and performance reporting. The referral management solution also taps into the Netsmart network of more than 25,000 organizations and 560,000 providers across all 50 states. There are more than 1 million connections on the network, with more than 1,300 lab orders and 10 million clinical transactions per year.