Netsmart

The Definitive Guide to Care Coordination:

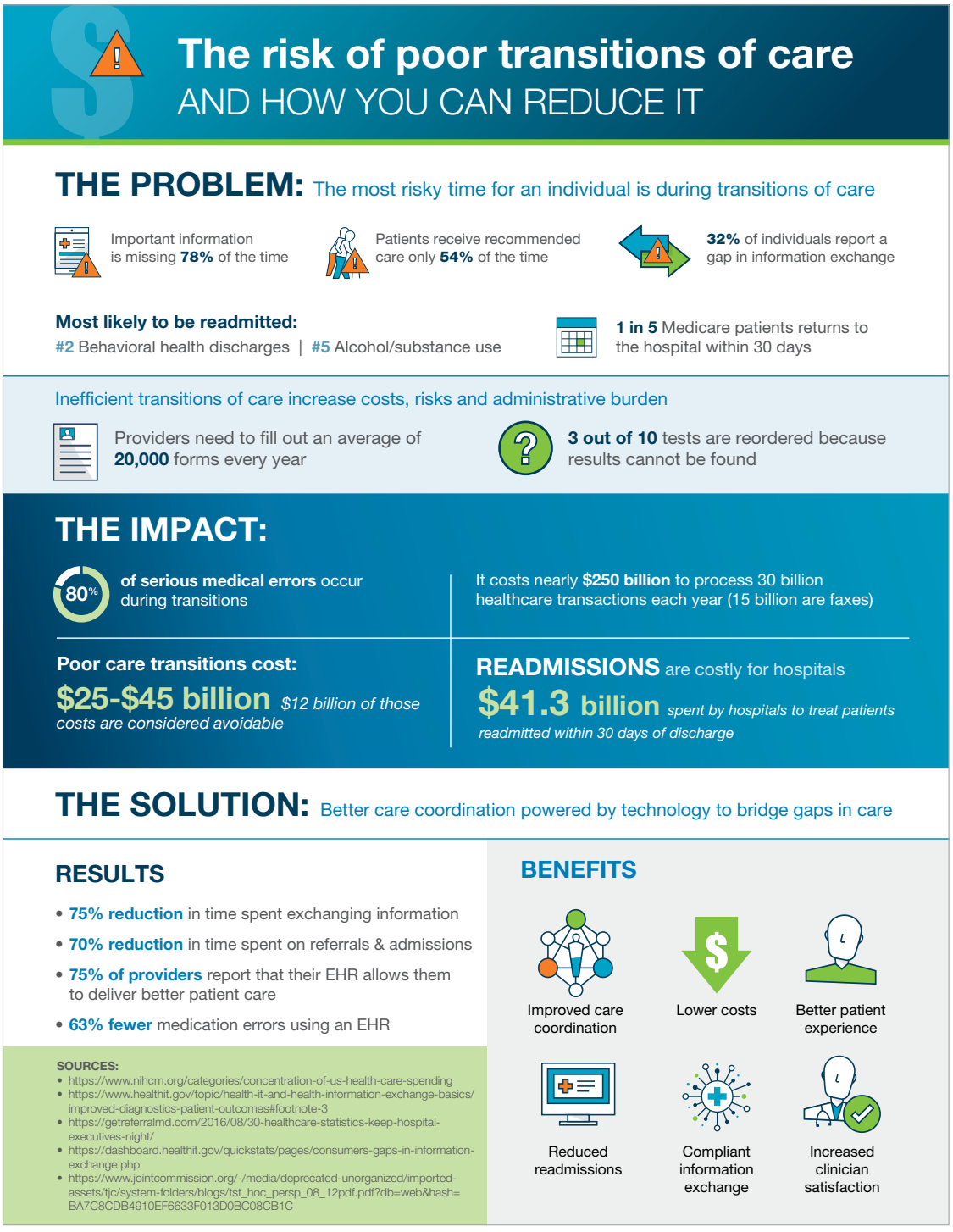
A one-stop shop for resources, use cases and best practices to achieve true care coordination throughout your provider organization

Table of Contents

Netsmart

Infographic: The risk of poor transitions of care

With 80% of serious medical errors occurring during transitions, and providers filling out an estimated 20,000 forms annually, the impact of transitions of care on consumer outcomes and administrative burden is undeniable.



Netsmart

Blog: Care transitions and addiction recovery—avoiding data gaps and communication silos

Drug addiction and avoiding relapse was new territory for us, and we thought we had done everything right to prevent inadvertent exposure to opioids.

I remember arriving at the ER with my dad, afraid. Not afraid of the swelling in my throat and difficulty breathing, but of the possibility I could relapse. I was newly sober—4 months—and had been down this road before. This was my second time getting sober, and I knew my disease needed very little reason to rear its ugly head. Good, bad and middle-of-the-road days had all been reasons to drink or use heroin in the past.

When we arrived at triage, I answered all the nurse's questions while a flow of secondary thoughts ran through my head. Should I tell him I was a recovering heroin addict? What if he judges me? Or treats me poorly? What if they give me something with an opiate that sets off the familiar craving and I'm once again "off to the races?"

"Do you have any allergies?"

My face got red and I stammered, "Umm, I… I… I can't have opiates."

He sighed and looked up from his computer. "Excuse me?"

"Umm, I'm allergic. Allergic to opiates."

"No, you're not. You can't be allergic to opiates."

My face got more red. "Well, I'm in recovery."

I desperately didn't want to say the words out loud. I had gotten comfortable announcing I was an alcoholic and addict in meetings, but it seemed an impossible leap to say it to a stranger who was already exasperated with me and who I knew dealt with drug seekers often. My dad saw my struggle and stepped in, telling the nurse that I was a former heroin addict and could not have any opioids. I was 24 at the time, and, although I was not a child, I felt very, very small.

We were brought into another room with several beds separated by curtains. The man in the bed next to me was the stereotypical picture of an addict—unkempt and disheveled. I remember overhearing nurses who were frustrated he was here for the second time that week asking for opiates. He was a frequent visitor in this ER, and it didn't seem like they believed his complaints.

The doctor examined me and diagnosed me with mononucleosis. He sat with my dad and me and said that after the swelling diminished, I'd be good to go home. After he left, a nurse came over with a syringe of medicine. She prepped my arm and was about to give me the shot when my dad stopped her and asked her what was in the medication.

"Morphine," she said.

A wave of fear and horror came over me.

I did everything right—I was upfront about my history and yet was still not only offered opiates, but offered them without warning.

"She can't have morphine! She's a former addict!" My dad was fuming. Drug addiction and avoiding relapse was new territory for us, and we thought we had done everything right to prevent inadvertent exposure to opioids.

My fear finally subsided a little while later, giving way to relief because I had a family member with me who knew my history and had the forethought to question what was in the syringe—even though we had already told the intake nurse that I couldn't have opioids. Not everyone is that lucky.

I was not treated as an "addict." I was right that I would be judged, but wrong about how. The triage nurse didn't communicate to other clinicians that I was an addict. So, they came to my bed and, by outward appearances, viewed me as a having-her-act-together grad student arriving with her father—I "couldn't" have been an addict. Not everyone is that privileged.

It wasn't easy for me to share my status as an alcoholic and heroin addict outside of a meeting. I did everything right—I was upfront about my history and yet not only was I still offered opiates, but they were offered without warning. I wonder what would happen if I were put in that situation and there was a mechanism for the triage nurse to collect and share my information with other providers.

Access to a person's complete health record, including substance use disorder (SUD) information, is essential for fully-informed diagnosis and treatment decisions. It also helps prevent risk of serious or even fatal drug interactions and unintended prescribing errors due to lack of complete patient information, as in the example above.

Netsmart has been a long-time advocate for updates to federal regulations to allow a person with an SUD or a history of diagnosis, treatment or referral for SUD to easily consent to share SUD-related health data with their treating providers.

The Protecting Jessica Grubb's Legacy Act, passed by Congress and signed into law as part of CARES Act in March 2020, includes significant statutory amendments that align 42 CFR Part 2 substance use treatment privacy regulations more closely with HIPAA while strengthening anti-discrimination protections and retaining strong penalties for information breaches. Netsmart will continue to advocate on behalf of our clients as part of the the Substance Abuse and Mental Health Services Administration (SAMHSA) rulemaking process related to the Legacy Act in 2021.

Blog: Time to improve care coordination? Start with technology and training

As a writer at Netsmart, I've often enumerated the importance of making information accessible across care settings. The right technology gives clinicians and caregivers the ability to collaborate and coordinate, two capabilities that significantly improve both outcomes and patient experience.

But, to be quite honest, I didn't grasp the true significance of those statements until I was navigating the care landscape for my mother.

Here is what lack of coordination and miscommunication looked like when I was on the patient side of communication.

The patient and family perspective

When my mother entered assisted living, she had a few manageable, chronic ailments: slight mobility issues and occasional short-term memory lapses. But, overall, she was in good shape, especially considering her age. As she would say, laughing, "What do you expect? I'm 90 years old!"

I switched her primary care to the doctor who regularly visited the facility, making it easier to coordinate her medications with staff. Her day-to-day caregivers were excellent, always pleasant, willing to answer my questions and help whenever asked.

All went well for five years, until her memory lapses became more frequent. She was, as the floor supervisor put it, "confused, but pleasantly confused." However, when she began trying to leave the facility without supervision, we had to transition her to a more secure floor. It was then, after this transition, that communication began to break down.

Communication gaps during care transitions

I asked she be tested for a urinary tract infection to eliminate a potential source of her confusion. Two weeks passed before I asked about the results, only to discover the request had not been passed along to the supervisor on her new floor.

By the time the test was done, she was quite ill and had to be hospitalized. Looking back, I should have followed up sooner or contacted her doctor to be sure the test was done. But, with no previous issues with staff communication, I didn't think it was necessary.

During my mother's hospitalization, I had a frank discussion with the hospitalist who offered advice on how to make an increasingly frail 95-year old as comfortable as possible.

We agreed to stop two medications that had side effects and no longer offered significant benefits to someone her age. Mom recovered in a few days and moved to a skilled nursing facility (SNF) affiliated with the hospital to regain her strength.

Medication reconciliation is a must

Upon admission, I made sure the SNF had correct records of all her information and medications and visited her every day to ensure all was going well. After two weeks of therapy, Mom was well enough to go back to assisted living.

Unfortunately, the SNF discharged her with the medication list from when she was admitted to the hospital, rather than the updated one. The error wasn't discovered until a few weeks later when she began experiencing the side effects we had been trying to avoid.

How did it happen? I have no idea. I was following her care very closely. The SNF had an electronic health record (EHR) and received the correct medication list from the hospital. Regardless, something went off track during the discharge process between the SNF and assisted living.

This was all quite frustrating because I know the staff members at the SNF and the assisted living facility were doing their best. Still, there were gaps in the technology, the training and the transition process that negatively impacted my mother's comfort and health.

A challenging juncture in the patient journey

It's clear that the breakdowns occurred when Mom went from one care setting to another. Her transition from assisted living to acute care went smoothly, but the move from skilled nursing back to assisted living did not. Even the move within the assisted living facility was problematic due to the missed request for a UTI test, which resulted in hospitalization.

My advice to patients and family members is to be hyper vigilant during transitions or care changes of any kind. Question everything and doublecheck everything. Be a pest, if necessary, be sure all information is present and correct. As someone deeply familiar with what could go wrong, I took all necessary steps to prevent mistakes. It still wasn't enough.

How to improve care coordination

For SNFs, be sure staff members are fully trained on your technology. Work with your nursing staff and your technology provider to set up workflows and protocols for admission and discharge that will minimize errors. The correct medication list was in the EHR—I know because the nurse went over the list with me when my mother was admitted. Despite this, no one caught the mistake at discharge.

For continuing care retirement communities and assisted living facilities, look into technology that creates a single record to document each resident's medications, physician instructions, therapies and preferences. The technology should support information sharing wherever a resident goes, within your walls or to another facility. It's unfair to ask staff members to rely on Post-it® notes, faxes or recollections to keep residents safe and healthy. Give them a system that helps them.

Finally, I want to emphasize that everyone in every care setting did their best for my mother. As the family member in charge of her care, I deeply appreciate the effort that went into keeping her healthy, happy and comfortable for so long. But there is room for improvement, and I believe training and technology can both go a long way to make care transitions smoother and safer.

Whitepaper: Charting the path to whole-person care

How to create value in a value-based healthcare environment

For more than a decade, value-based care has dominated the conversation regarding cost reduction and quality improvement strategies in healthcare. Due to the COVID-19 pandemic, the value-based approach is accelerating.

Despite the challenges the pandemic has created for the healthcare industry, many executives believe one central silver lining exists: a greater emphasis on the necessity to adopt new payment and care delivery models.

Healthcare costs continue to rise across the country. Even without a crisis, close to $1 trillion, or 25% of total healthcare spending, is spent each year in the US alone on 'non-value adding aspects' (e.g. administrative complexity, failure of care coordination, fraud and abuse, etc.) in the healthcare system.[1]

Close to $1 trillion is spent each year in the US alone on 'non-value adding aspects.'

These numbers are truly staggering and beg the question: Can you imagine how much we could achieve if these resources weren't wasted, but rather invested in better patient outcomes? In order to address these challenges, value-based care (VBC) models have been developed.

Impact of COVID-19 on value-based care

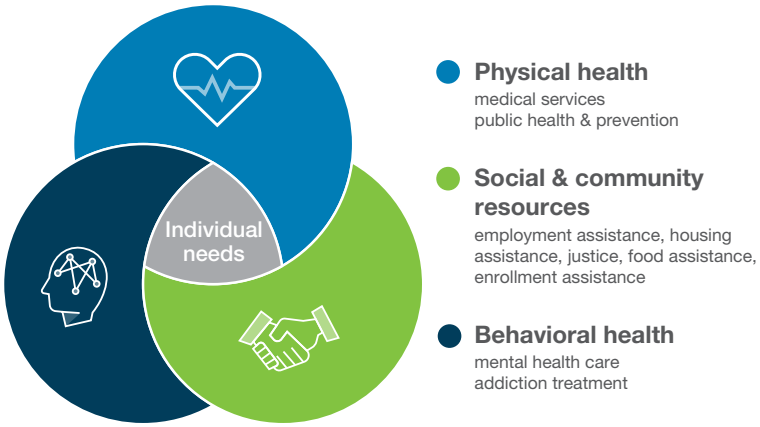
Inarguably, the COVID-19 pandemic will impact the future of healthcare systems and how care is delivered. Will the increased adoption of virtual care technologies, interoperable data platforms and standardized outcome measurement be the accelerator we need for VBC models to replace fee-for-service?

Initial VBC models focused extensively on acute care, providing incentives and penalties based on quality measures that include clinical care, patient-centered experience, safety, efficiency and cost reduction. As the most expensive care settings, hospitals are the logical starting point for value-based reimbursement. When an overarching goal is to reduce costs, look first to where most money is spent.

1 Moving Toward Value-Based Care: Will COVID-19 accelerate or slow down transformation? Philips Research; June 2020

Maintaining momentum

How can momentum be maintained the after the most obvious issues have been addressed? In other words, where do you go after you've harvested the low-hanging fruit? The answer may lie in a concept that is much older than value-based reimbursement: whole-person care.



The basic concept of whole-person care can be found in the World Health Organization's definition of health as "a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity," which was adopted in 1948.[2] However, the idea that physical condition is only one dimension of health has existed for the better part of two millennia, evident in Eastern medicine and the field of nursing, both of which have long embraced the concept of holistic care of the person.

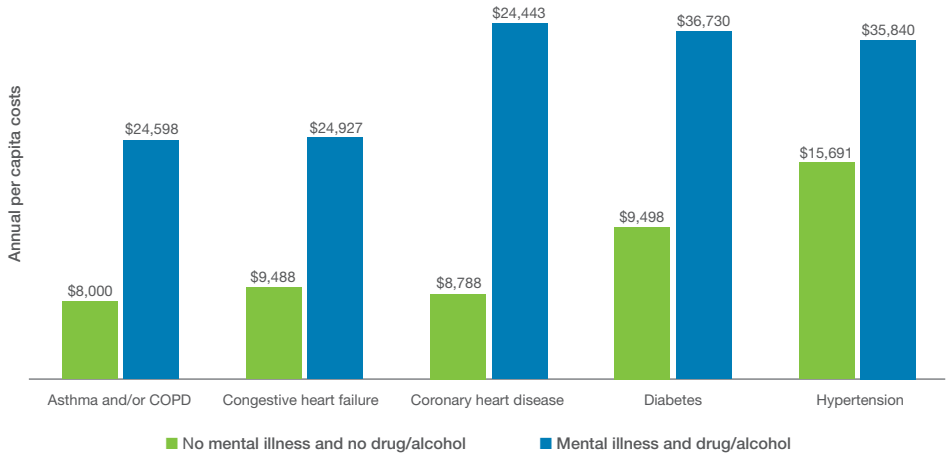
It wasn't until the late 1990s that the idea that healthcare should treat the physical, mental and social aspects of an individual's health began to take root in Western medicine. Noting the role stress played in disease and illness, medical schools, and some health systems, developed programs to address a broader idea of healthcare.

One such program was the Mindfulness-Based Stress Reduction program at Duke University Health System, spearheaded in 1998 by Jeffrey Brantley, MD, and would eventually become Duke Integrative Medicine. While this approach to a more comprehensive perspective on health may have been unusual 20 years ago, today, as healthcare costs spiral, providers are seeking solutions to improve outcomes and reduce cost. It's clear that the whole-person approach to care could potentially yield strong results in value-based care models.

The link between chronic diseases, mental illness and higher treatment expense has long been established. The cost of treating diabetes and a mental illness, for example, is nearly four times higher than treating patients with diabetes only.

2 Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19–22 June 1946; signed on 22 July 1947 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100); and entered into force on 7 April 1948.

Mental health comorbidities costs



Studies indicate that mental illness is common among the elderly, a population vulnerable to chronic illnesses. Up to 14 percent of older adults were found to meet the criteria for diagnosable anxiety disorder and 27 percent have symptoms of anxiety that impact their functioning. Depression is also prevalent with 27 percent of elderly patients assessed by behavioral health professionals meeting the criteria for major depression.[3] Left untreated, mental illness in the elderly can contribute to a loss of independence, slower healing from injuries and illness and a significant decrease in quality of life.

Clearing the way to value-based reimbursement and whole-person care

Despite the promise offered by the whole-person care approach, value-based care reimbursement models will not be able to tap into their potential if organizations don't plan to meet the challenges involved in providing care across multiple disciplines.

Post-acute care providers (home health, hospice and senior living facilities) and human services providers (community mental health centers, addiction treatment centers and social service agencies) must be proactive in arming themselves with the technology and the expertise to work as equal partners with healthcare systems.

Furthermore, the COVID-19 crisis is hitting hardest among individuals with poorly managed conditions, including diabetes, COPD, heart disease and obesity. These conditions are closely related to social determinants of health (SDoH).

Managing these populations heavily relies on seamless information exchange, telehealth, care coordination and consumer engagement.

These are the exact aspects that need to be accelerated to make whole-person care a reality and to implement value-based care delivery models.

3 Screening for Depression in Adults and Older Adults in Primary Care: An Updated Systematic Review. Agency for Healthcare Research and Quality; 2009

Post-acute care and human services providers are uniquely positioned to support acute care and primary care providers with relevant expertise in whole-person care.

Finally, the emphasis must be on reducing costs and improving outcomes that matter to the patient.[4] Those post-acute care and human services providers who can prove their value to payers will be the most successful as healthcare transforms.

Three strategies to prepare your organization

Post-acute care and human services providers are uniquely positioned to support acute care and primary care providers with relevant expertise in whole-person care.

In this role, they are poised (at last) to become key determinants in the success of value-based reimbursement strategies that can have a positive effect on healthcare delivery.

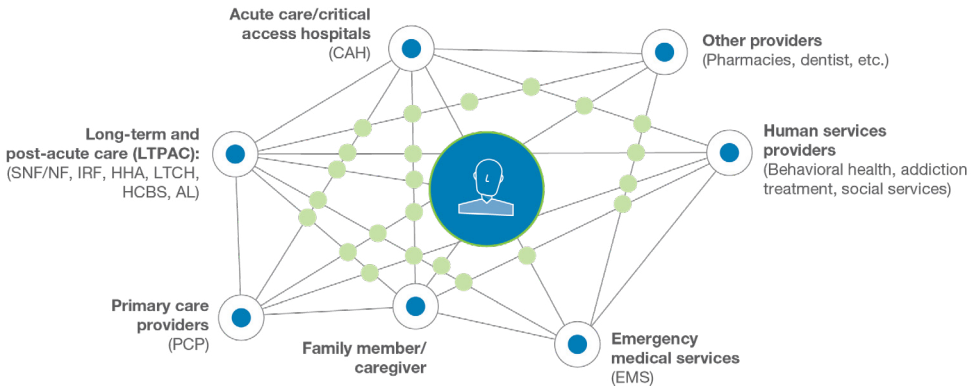
To be prepared, organizations need to carefully examine their strengths and weaknesses, building their capabilities in three key areas.

1 Interoperability

The electronic exchange of data and patient information across care settings is crucial for post-acute and behavioral healthcare providers if they are to realize the opportunities whole-person care presents. Public and private initiatives to overcome technology barriers have been underway for more than a decade and are starting to gain traction. In devising your interoperability strategy, look for a framework that supports the following functionality:

- **Bidirectional exchange** of data across systems–acute care, primary care, post-acute care and behavioral health systems
- **Network-to-network connectivity** that brings together electronic health record (EHR) vendors, record locator service (RLS) providers and other types of existing networks from the private sector and government

Data follows the person



4 Journey to Value: The State of Value-Based Reimbursement in 2016, ORC International; commissioned by McKesson Health Solutions; June 2016

- **Support for technical and policy agreements** that enable data flow between and among networks, platforms and geographies, much as the telecommunications industry did when linking cell phone networks
- **Incorporation of discrete data**, including lab results and health information exchange (HIE) information from external sources, into the workflow and treatment plans for individuals
- **Support for consent to send** and consent to query scenarios for HIEs

2 Consumer engagement

Broadening the scope of services and managing care across settings requires coordination among providers, as well as a high degree of consumer engagement. Episodes of care are longer in post-acute and behavioral healthcare. For chronic physical conditions, such as diabetes, hypertension or cardiomyopathy, and diagnoses of mental illness, such as schizophrenia, bipolar disease and anxiety disorders, ongoing care will be a lifelong necessity.

A strategic consumer engagement plan can support population health initiatives in a personal, yet non-intrusive, way, and further encourage healthier lifestyles.

To minimize treatment in costly, high-acuity settings, providers must be proactive in helping individuals stay on track with medications, therapy and diet, and support health and wellness over the long term. They can accomplish this by leveraging evidence-based treatment and patient-reported data to drive targeted interventions and programs that foster behavioral changes that will improve outcomes.

A patient portal that is integrated with the EHR can facilitate consumer engagement and simplify communication between providers and individuals or family members. Through a portal, individuals, or their caregivers, can schedule appointments, update personal information, check test results, request medication refills and complete self-assessments. A strategic consumer engagement plan can support population health initiatives, such as immunizations and smoking cessation, to select groups in a personal, yet non-intrusive, way and further encourage healthier lifestyles.

A patient portal also streamlines administrative functions by reducing phone calls from patients, as well as manual data entry of demographic information, assessments and other forms. As a result, organizations have additional resources available for providing care.

3 Accessibility of services

Integrating with acute care and primary care requires post-acute and human services providers to be sure their services are available when they're needed. In other words, you have to make it easy for hospitals and physicians to work with you. It's the logical next step beyond interoperability that allows true collaboration across care settings.

Automating the referral process with health systems provides a central intake point and supports faster, more consistent acceptances and rejections. Accepted referrals can be assigned to specific shared-risk programs, allowing better management and provision of care from the start of the episode. Patient

Post-acute and human services providers that can coordinate care across communities are going to be well-positioned for success—and in high demand—in a value-based care world.

information can be integrated with the EHR admission workflows, ensuring patients are receiving care at the appropriate level of acuity and resulting in smoother transitions of care and fewer medication errors.

Increasing accessibility can also take the form of employing telehealth technology that expands an organization's service area, particularly in rural areas or where there is little or no access to specialists or behavioral health services. A telehealth solution that supports fully integrated workflows within the EHR enables live healthcare visits, putting specialized care within reach during crises and expanding care options to existing clients.

Conclusion

Value-based reimbursement strategies must look beyond care provided within the four walls of hospitals and physicians' offices. Payers are looking for ways to reduce costs, enhance care coordination and improve outcomes.

Health systems are looking for preferred partners that can integrate services across care settings and partner with them to further reduce costs and ensure treatment is taking place at the appropriate level of acuity.

Post-acute and human services providers that can coordinate care across communities and manage the complexity and outcomes of community-based services, are going to be well-positioned for success—and in high demand—in a value-based care world.

About Netsmart

Netsmart (www.ntst.com) is a healthcare technology company that provides electronic health records, data analytics tools, care coordination, population health management, telehealth solutions and services. The powerful Netsmart network connects our more than 35,000 clients to the rest of healthcare to provide seamless and collaborative care for an individual. As the largest technology provider for behavioral health, home health, hospice, senior living and social services, Netsmart helps organizations improve the health and well-being of the communities we collectively serve.

Care coordination: 5-point checklist for human services providers

Do you have what's needed to successfully coordinate care?

1 2 3 4 5

INTEROPERABILITY	
☐	Exchange and integrate behavioral, physical and social determinants data at the point of care
☐	Manage incoming and outgoing referrals through automated, streamlined referral process
☐	Connect to a network of providers and support secure data sharing across health information exchanges (HIEs) and large interoperability frameworks, such as Carequality
☐	Exchange data with care coordinator, health plan and/or ACO, if participating
☐	Gain access to data from pharmacies, Prescription Drug Monitoring Programs (PDMPs), ACOs, hospitals and referral partners
DATA ANALYTICS	
☐	Access key performance indicators (KPIs) in real-time
☐	Link internal data (EHR, financial system, and HRIS) and incorporate data from other providers and from payers in order to produce real-time KPIs
☐	Aggregates data to identify trends and presents health and treatment outcomes for analytics-driven decision making
☐	Utilize a population health management platform that provides real-time data to identify who is most at risk and if there are any gaps in care
☐	Mitigate risk and increase ROI with quality measurements and operational analytics
☐	Notify the right people at the right time through alerts and notifications
INFRASTRUCTURE	
☐	Leverage a unified platform to help clinicians manage a person's care across multiple settings
☐	Manage all services across providers, track outcomes and simplify reporting
☐	Access integrated technology that provides secure messaging, updates individual information, complete assessments, and sign consents
☐	Review and electronically sign patient documents
☐	Leverage integrated mobile technology designed for all care settings and use of consumers and their designated caregivers
COMMUNICATION	
☐	Document in one solution and eliminate Excel spreadsheets
☐	Support care coordination & integrated care through secure communication across all care teams
☐	Retrieve comprehensive view of an individual's health record
PATIENT/FAMILY ENGAGEMENT	
☐	Collaborate between the individual/family and the care team through digital technology
☐	Utilize infrastructure that provides a seamless flow of information
☐	Facilitate access to information from all stakeholders to consumers and their caregivers
☐	Provide decision support tool for consumers and their caregivers

Care coordination: 5-point checklist for post-acute providers

Do you have what's needed to successfully coordinate care?

1 INTEROPERABILITY

- ☐ Exchange and integrate data seamlessly at the point of care
- ☐ Connect to a network of providers and support secure data sharing across health information exchanges (HIEs), referral partners and large interoperability frameworks, such as Carequality
- ☐ Manage incoming and outgoing referrals through automated, streamlined referral process

2 DATA ANALYTICS

- ☐ Access key performance indicators (KPIs) in real-time
- ☐ Aggregate data to identify trends and presents health outcomes for analytics-driven decision making
- ☐ Use data to identify standards/focus areas and discover gaps in care through internal benchmarks
- ☐ Utilize a population health management platform that provides real-time data to identify who is most at risk
- ☐ Mitigate risk and increase ROI with quality measurements and operational analytics

3 INFRASTRUCTURE

- ☐ Leverage a unified platform to help clinicians manage a person's care across multiple settings
- ☐ Manage all services across providers, track outcomes and simplify reporting
- ☐ Access integrated technology that provides secure messaging, updates individual information, completes assessments and sign consents
- ☐ Review and electronically sign patient documents
- ☐ Leverage integrated web-based technology and integrated mobile devices for all care settings

4 COMMUNICATION

- ☐ Notify the right people at the right time through alerts and notifications
- ☐ Simplify documentation to enable multi-disciplinary communication
- ☐ Retrieve comprehensive view of an individual's health record
- ☐ Support care coordination and integrated care through secure messaging or communication across all care teams
- ☐ Integrated inbound and outbound electronic faxing to assist in fast communicating of patients' needs

5 PATIENT/FAMILY ENGAGEMENT

- ☐ Collaborate between the individual/family and the care team through digital technology
- ☐ Utilize infrastructure that provides a seamless flow of information
- ☐ Facilitate access to information from all stakeholders to consumers and their caregivers
- ☐ Provide decision support for consumers and their caregivers

Success Story: Care Plus NJ

Finding success as a CCBHC

SUCCESS STORY **BEHAVIORAL HEALTH, SOCIAL SERVICES, PRIMARY CARE AND SUBSTANCE USE REHABILITATION SERVICES**

At a glance

Community
- Behavioral health, social services, primary care and substance use rehabilitation services

Organization
- Care Plus New Jersey

Location
- New Jersey

Challenges
- Succeed and serve in a value-based care model
- Meet the Certified Community Behavioral Health Center requirements

Solutions
- myEvolv®, CarePathways Measures Reporting, KPI Dashboards, Telehealth

Results
- Treatment adherence monitored, measured and reported to local, state and national stakeholders
- Increase in clients receiving care coordination and care management services
- 32% increase in clients receiving Medication Assisted Treatment (MAT)

Netsmart

Care Plus New Jersey's CCBHC journey

About Care Plus NJ

Care Plus NJ is a full-service community behavioral health center founded in 1978. The organization provides the entire continuum of care, as its services span from residential, conventional outpatient care, individual and group therapy, medication monitoring and more. Care Plus NJ also operates the 24/7 psycho-emergency program in the county, as well as a rapid access program for adults in order to divert hospitalization.

As Certified Community Behavioral Health Centers (CCBHCs) continue to populate the country, care coordination, data analytics and evidence-based practices are becoming the new norm for human services organizations. CCHBCs empower organizations to provide more effective care at a lower cost. In order to succeed and serve in a value-based care model, Care Plus New Jersey (Care Plus NJ) took the proper steps and facilitated new workflows in order to excel as a CCBHC.

Like many community-based organizations, Care Plus NJ saw the need to integrate traditional behavioral health services with primary care. Having already implemented integrated primary care services in their Paramus, New Jersey facility, Care Plus NJ was the first organization in New Jersey to receive a four-year Integrated Primary Care and Behavioral Healthcare Services grant in 2010. The organization's commitment to integrated care continued when it was certified as New Jersey's first Behavioral Health Home in 2014 and was one of seven CCBHCs in New Jersey in 2017.

> "We've now become like a well-oiled machine. Change can always be challenging at first, but through staff training, shifted workflows and the technology, we've been able to find success with it."
>
> Michelle Alkhalaileh
> CIO, Care Plus NJ

Implementation

Thanks to years of implementing various types of integrated primary care projects, the philosophical commitment to CCBHC status was not difficult for the Care Plus NJ staff. The culture was very open to the CCBHC goals supporting integration. However, high-level commitment and understanding is not the same as hands-on operations, and it was here that Care Plus NJ faced its biggest hurdles implementing CCBHC requirements.

New procedures and assessments had to be developed and implemented, and old workflows had to be redesigned. New and old data had to be integrated, aggregated and analyzed. Clinicians were now accountable for completing tasks that were foreign, and some existing processes had to be reworked to comply with the new CCBHC standards.

For example, assessment tools like the PHQ9 and the AUDIT were now required for all CCBHC clients. If the assessments were not completed, clinicians needed to know as soon as possible to remedy this deficit, but such feedback loops did not exist. Not only did Care Plus NJ have to train staff on how to use the instruments themselves, monitoring and reporting infrastructures had to be created to track and inform managers and clinicians as well. Despite these challenges, Care Plus NJ succeeded in getting not one CCBHC grant, but two.

“We’ve now become like a well-oiled machine,” Care Plus NJ CIO, Michelle Alkhalaileh, said. “Change can always be challenging at first, but through staff training, shifted workflows and the technology, we’ve been able to find success with it.”

How they did it

Care Plus NJ had a strategic plan in order to both qualify and achieve these grants.

“Right away, we created a core CCBHC clinical team,” Alkhalaileh said. “This team included clinical leadership, finance, quality assurance and others. We wanted to hear the voices of the people who were directly affected by the care delivery process.”

Data Results

- 12% increase in clients receiving services in the Addictive Services program
- 32% increase in clients receiving Medication Assisted Treatment (MAT)
- Established and implemented Ambulatory Withdrawal Management 1
- Organization-wide adoption and consistent utilization of Patient Health Questionnaire (PHQ9/PHQA) and Alcohol Use Disorders Identification Test (AUDIT)
- All staff obtaining and using client’s BMI and Tobacco Status
- Treatment adherence monitored, measured and reported to local, state and national stakeholders
- Increase in clients receiving care coordination/ care management services by Health Navigators
- Reduced waitlists for intake appointments
- 97% percent of consumers reported they would recommend Care Plus NJ to others

This strategy modeled after the Learning Communities promoted by the National Council, was extremely helpful in working out the kinks in proposed workflows, identifying new tools and processes that needed to be developed, and removing obsolete or irrelevant procedures. Once these processes were agreed upon, clinician training and orientation began. Some key implementation factors for Care Plus NJ included:

- **Orienting clinical staff to the whole picture.** Rather than simply training staff on just the specifics of their job or workflow, Care Plus NJ expanded their training to include the new workflows. This resulted in new perspectives and input from the clinical staff that otherwise would have been missed and increased ownership of the new processes by the clinicians. One example was streamlined electronic health record (EHR) forms based on clinician’s day-to-day experience.

- **Utilizing data to inform care.** Building on a culture that appreciated and used data regularly, Care Plus NJ added clinical and operational measures and reports to assist clinicians. For example, monthly deficiency reports let clinicians know what data elements were missing so they could remedy the deficiency.
- **Clinical decision support.** As part of the effort to use data to inform care, Care Plus NJ built alerts into the system using existing measures and tools. One example used item nine of the PHQ9, which asks about suicidal ideation. If that question had a positive response, the system displays it to the clinical staff in a way that subtly but effectively conveys the client's heightened suicidal risk.

The agency also developed a unique and creative way to use telehealth. In the event a client calls to cancel their clinical session, Care Plus NJ staff offers the client a telehealth appointment as an alternative. They used the Netsmart Care Pathways platform to manage and report required state and federal measures and to review the data in real time.

Challenges

Despite their success, there were challenges with Care Plus NJ's CCBHC implementation, some of which were internal and some externally imposed.

As an early adopter to CCBHC, Care Plus NJ didn't have the luxury of modeling their implementation on some other successful organization. Much had to be discovered or invented on the fly. Alkhalaileh credits Care Plus NJ's culture of primary care integration and openness to solving new problems as the reasons for success.

Externally imposed requirements continue to pose challenges today. Care Plus NJ has found that requirements for fidelity to the CCBHC model are sometimes at odds with other external requirements. For example, the requirement to assess for the initiation of alcohol or drugs. Many of Care Plus NJ substance use disorder (SUD) clients are served in intensive outpatient programs (IOP) where they are seen several times per week for several hours each time, usually in groups. The IOP CPT codes Care Plus NJ uses are not an eligible treatment encounter. Individual therapy is an eligible treatment encounter, however many clients will attend IOP and cancel their individual therapy session, thus resulting in the less than desired measure outcomes reporting. A similar problem exists with the Depression Screening and Follow-up measure. Family therapy is another ineligible service on the same day that the PHQA is administered.

> "Right away, we created a core CCBHC clinical team. This team included clinical leadership, finance, quality assurance and others. We wanted to hear the voices of the people who were directly affected by the care delivery process."
>
> Michelle Alkhalaileh
> CIO, Care Plus NJ

There is also the question of what will happen when the CCBHC funding ends. Will the reimbursement for the services be picked up by other payers? Will the move to value-based care finally occur? So far, interactions with other payers has not been encouraging in spite of the positive outcomes Care Plus NJ has demonstrated. Despite these concerns, Care Plus NJ is optimistic that the work done to move the organization to CCBHC status will yield positive benefits. The hard part of the transition is behind them, and Care Plus NJ is now positioned to do value-based care whenever the payer community reciprocates.

Moving forward

The organization has more enhancements in the works. They will be implementing the telehealth consumer app. They are moving their myEvolv EHR from on-premise to cloud-hosted, which will open up more efficiencies and opportunities. They are implementing a front desk kiosk that will allow easier data collection data

and measures for analysis and reporting. Finally, they are implementing a data analytics tool, KPI Dashboards, to deliver the data they need for timely analysis and monitoring. Currently, feedback to providers and managers is provided approximately one month after services are delivered, which is not timely enough.

"This tool will help us become even more real-time," Alkhalaileh said. "Right now, I'm not running measures until the next month. We want to leverage CarePathways to create a timely dashboard, showing our staff automatic, real-time updates."

When asked what advice Alkhalaileh would give to other CCBHC aspirants, she is quick to suggest they call Care Plus NJ or some other CCBHCs for advice. She encourages providers to attend the Netsmart CONNECTIONS conference both for the learning opportunities and the interaction with other attendees who are grappling with the same challenges. Because there are more resources available now than when Care Plus NJ started this journey in 2017, Alkhalaileh strongly encourages others to take advantage of those resources.

When asked if it was all worth it, Alkhalaileh response was an immediate, "Absolutely."

Learn more about Certified Community Behavioral Health Centers at: www.ntst.com/lp/CCBHC

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

Success Story: First Choice

Eliminating paper and improving organizational efficiency

SUCCESS STORY **HOME HEALTH AND HOSPICE**

At a glance

Community
- Home Health and Hospice

Location
- Orem, UT

Challenges
- Documentation was still on paper
- Improve efficiency of organization

Solution
- Netsmart AllDocs
- Netsmart Homecare™

Results
- Hospital readmission rates cut from 38% to 14-16%
- Patient admission time cut from 3-4 hours to less than one hour
- Claims denials slashed to near zero
- Clinician travel time cut approximately 70%
- Increased clinical productivity 17% by eliminating paper

Netsmart

First Choice Home Health and Hospice drives exponentially higher productivity, cuts hospital readmissions and realizes solid cost reductions

First Choice Home Health and Hospice started out with the modest goals of eliminating paper and improving the efficiency of its organization. But a transformative change took place that brought significant improvements in patient care, streamlined daily operations and delivered a dramatic reduction in its operational expenses—all made possible through Netsmart Homecare.

Experience

First Choice Home Health and Hospice was clear about its need for a fully electronic Homecare and Hospice solution. “We had a significant amount of staff in the back office constantly busy filing charts and performing data entry,” stated Beau Sorensen, Chief Financial Officer for First Choice Home Health and Hospice. “This was a huge waste of resources, making our initial motivation to go electronic primarily a cost savings issue.”

The organization knew what it wanted from a homecare solution. “We wanted an innovator—someone who would always push forward,” said Sorensen. “We performed an evaluation and knew that Netsmart was offering new mobility technology, as well as a full-electronic health record. We wanted to be as paperless as we could, and we felt that Netsmart could help us get that entire patient record out in the field electronically.”

> “Between eliminating paper charting and reducing unnecessary travel, we’re also seeing a 17 percent increase in clinician productivity. That increased productivity is directed entirely to revenue generating activity.”
>
> Beau Sorensen, Chief Financial Officer
> First Choice Home Health and Hospice

Solutions

Netsmart delivered a solution targeted specifically to the needs of homecare and hospice providers. The technology's ease-of-use and robust functionality won over skeptical new users. "We initially had some staff that were not computer savvy," said Sorensen. "But after using this intuitive system, they have come to appreciate the benefits of Netsmart. It makes their lives easier because they feel like they can access all patient information from one source."

Netsmart AllDocs was used to help drive the organization to a fully electronic environment, including pre-existing paper charts. All old paper records were scanned into the system through AllDocs and attached to the patient record. AllDocs proved a strong benefit to both the HR and Accounting departments of First Choice Home Health and Hospice as a way to streamline documentation. Beau Sorensen also uses the technology to prepare educational materials for his staff. "When we attend a conference, we load the audio files from the event into AllDocs," he said. "All information is available to staff that want to continue their education, and they can access it right from home."

Stellar care

Netsmart Homecare enabled the entire First Choice Home Health and Hospice team to communicate more effectively, raising the level of care for patients. "Out in the field, our clinicians can know what's going on with a patient, whether it's their visit, a visit from the aide earlier in the day or the PT's visit last week," said Sorensen. "They have the information they need to make good decisions in the field and, with the mobile application, they can document vitals, current treatments and status for the next clinician."

The combination of multi-disciplinary care functionality and predictive modeling is raising the quality of patient care. "We have noticed a significant difference in our patients' outcomes," said Sorensen. "We're using predictive modeling to identify outpatients with a diagnosis that makes them a candidate for hospital readmission. We focus on conditions that hospitals get penalized on, such as AMI, pneumonia and heart failure.

> "Prior to Netsmart Homecare, our readmission rate was 38 percent; now it has dropped to 14-16 percent."
>
> Beau Sorensen, Chief Financial Officer
> First Choice Home Health and Hospice

Once these patients are identified, we use Netsmart integration to telehealth to enable case managers to know immediately when patient measurements are performed. Prior to Netsmart Homecare, our readmission rate was 38 percent; now it has dropped to 14-16 percent." Hospital referrals for First Choice Home Health and Hospice are also up over 500 percent due in large part to the reduction in rehospitalization made possible with Netsmart Homecare.

Redefining productivity

The gains in productivity from customized assessments made possible through Netsmart Homecare were dramatic and immediate. Admit time has been cut from 3 to 4 hours to under one hour.

"We've also used the assessments, as well as audits, that show the number of authorized visits, to reduce our denials significantly," said Sorensen. "The result is that we have a much cleaner chart. Additional requests for documentation are now perfunctory, whereas before we needed to do a major audit to ensure that our coding was accurate." The result is a drop in First Choice Home Health and Hospice's denial rate from approximately 92 percent to near zero. At its height, A/R was over 90 days outstanding for the organization. After implementing Netsmart Homecare, A/R is now at 45 days.

"With the scheduling component, we enter the care criteria, and the system shows us the clinicians best suited for a job," says Sorensen. "We no longer have to sift through reams of HR data; the answer is right at our fingertips. With the mobile capabilities, we also no longer have to guess about a clinician's current location."

Meeting the unique demands of homecare/hospice

Netsmart Homecare keeps First Choice Home Health and Hospice ahead of the curve when its regulatory environment changes. “One of the nice things about Netsmart is that regulatory requirements are constantly updated; you are going to get what you need when you need it,” said Sorensen. “I remember that when PPS came into effect, there were homecare organizations that went out of business because they were not ready for it. Netsmart has always been on point with updates that allow us to continue to bill and not run into cash-flow issues.”

Netsmart Homecare also includes bereavement functionality that sets reminders of upcoming events and can automatically generate sympathy materials to go out to the client’s family.

Dramatically lower costs

Netsmart mobile application enables clinicians to accurately track mileage for purposes of reimbursement. Clinicians travel to and from First Choice Home Health and Hospice has dropped approximately 70 percent, as clinical workers no longer need to return to the office to deliver paper reports. Travel costs for the organization have been cut 25 percent since implementing the solution, for a savings of $60,000 annually. “Between eliminating paper charting and reducing unnecessary travel, we’re also seeing a 17 percent increase in clinician productivity,” said Sorensen. “That increased productivity is directed entirely to revenue-generating activity.”

Netsmart Homecare is driving even further reductions in operational expenses by helping the organization control staffing costs. Prior to Netsmart, First Choice Home Health and Hospice staffed four positions dedicated to filing charts and an additional two positions performing full-time data entry. This has all been replaced with one fulltime employee who works with Netsmart AllDocs to scan old paper charts—for only ¼ of their time. At an estimated $40,000 annual salary plus benefits per position, First Choice Home Health and Hospice is saving $200,000 annually. The operational efficiency afforded by the built-in auditing functionality of Netsmart Homecare enabled First Choice Home Health and Hospice to also cut two auditing staff positions for an additional savings of $85,000.

Netsmart Homecare transformed First Choice Home Health and Hospice into a tighter, more productive, more cost efficient and higher revenue-generating operation. The technology stands ready to also fuel the organization’s growth. “This system is very scalable,” declared Sorensen. “Netsmart had everything we needed to scale from 150 patients, to our current operation with multiple locations and many hundreds of patients. I’m sure they will keep pace with our plans well into the future.”

Learn more about Netsmart clients at www.ntst.com/Hear-From-Clients

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

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

Our more than 2,000 associates work hand-in-hand with our 600,000+ users in more than 25,000 organizations 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.

wp_347_20_v1