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The Evolution of Integrated Care:

Emerging models and best practices

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Recently I was joined by Scott Green, senior VP and managing director of CareDimensions at Netsmart, and Brandie Williams, M.Ed, Ed.S, deputy executive director with Rappahannock Area Community Services, for an insightful presentation on integrated care.

Our session covered the following areas:

- Emerging market trends redefining integrated care
- Building an integrated care strategy
- Case study: How Rappahannock is building capabilities to deliver integrated care
- Technology essentials to support infrastructure and delivery

Emerging market drivers

Data continues to show the impact and correlation between addressing behavioral health needs in the primary care setting and vice versa. In many cases, we see individuals presenting in behavioral health settings with chronic physical health conditions that are going untreated.

A recent study by the Primary Care Collaborative (PCC) shows the interconnectedness of behavioral health and primary care:

- 80% of people with a behavioral health disorder will visit a primary care provider (PCP) at least once a year
- 50% of all behavioral health disorders are treated in primary care
- 67% of people with a behavioral health disorder do not get behavioral health treatment
- 30-50% of patient referrals from primary care to outpatient behavioral health do not make the first appointment
- Two thirds of PCPs report not being able to access outpatient behavioral health for patients

Source: *"Benefits of Integration of Behavioral Health,"* Primary Care Collaborative. https://thepcc.org/content/benefits-integration-behavioral-health

Statistics show why it's essential to integrate behavioral healthcare with primary care. And when you consider the increased cost of treating individuals with mental illness and chronic physical conditions, it's not surprising that the Center for Medicaid, and Medicare Innovation (CMMI) continues to focus on care models that promote the integration of primary care and behavioral health.

In addition to the growing recognition of the unmet primary care needs among individuals with mental illness, there are other market drivers for alignment with integrated care strategies, including:

- Financial incentives from care models and payers for co-located or collaborative approaches between medical and behavioral health
- Healthcare organizations seeking ways to expand and diversify their services and stay competitive in their markets

Building an integrated care strategy

As the concept of integrated care has evolved, the strategies to provide behavioral healthcare and primary care have also changed.

Care coordination and co-location strategies are used by behavioral health organizations to provide primary care to clients. Care coordination includes referring individuals to primary care partners, tracking follow-up and proactively coordinating care. Co-location involves bringing a physician or nurse practitioner into the organization. Fully integrated approaches include components from both care coordination and co-location strategies to deliver comprehensive and team-based care for individuals across service lines, such as behavioral health, primary care and addiction treatment. This typically involves shared data and care plans.

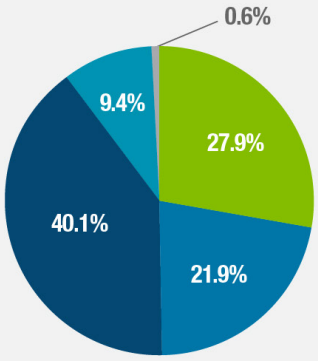
The Certified Community Behavioral Health Clinic (CCBHC) model was developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) in collaboration with the Centers for Medicare and Medicaid (CMS) as an outpatient, integrated care model. The CCBHC model was originally implemented in eight states in 2017.

A recent CCBHC Impact Report from the National Council for Mental Wellbeing shows that over 40 percent of CCBHCs are proactively coordinating care. They're doing more than providing primary care; they're identifying gaps in care, as well as making referrals to address social determinants of health.

Over 40% of CCBHCs are proactively coordinating care

CCBHCs Exceeding Minimum Integration/Coordination Requirements

- **Care coordination:** We provide referrals to our primary care partner(s), track follow-up and proactively coordinate care.
- **Fully integrated provider:** Our CCBHC is also a comprehensive primary care provider, and services are available in the same location(s).
- **Co-location arrangement:** Our primary care partner provides services on-site at our CCBHC location, we provide services on-site at the primary care location or both.
- **Referrals only:** We provide referrals to primary care organizations but do not actively track or coordinate care at this time.
- **N/A**



Source: "2024 CCBHC Impact Report," The National Council. https://www.thenationalcouncil.org/resources/2024-ccbhc-impact-report/

Missouri was one of the states selected for the CCBHC demonstration program in 2017. Netsmart began working with Missouri at that time because they needed shared technology that could be scaled to support their programs. But their state-wide integrated care initiatives predated that relationship, and it involves the Missouri Behavioral Health Council, a non-profit coalition of behavioral health agencies and two state agencies.

Since the implementation of the CCBHC program, Missouri has launched health homes to coordinate and provide care for the most vulnerable populations. The goals include lowering emergency department usage, reducing hospital admissions and readmissions, improved outcomes and quality of life for individuals and reduced healthcare costs. Their results are nothing less than amazing with more than $377 million in savings over seven years.

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Federally Qualified Health Centers (FQHCs)

The increasing demand for whole-person care in under resourced communities creates opportunities for organizations looking to diversify their service lines. FQHCs in particular are expanding their focus and expertise in mental health services and substance use disorder (SUD) treatment by also becoming CCBHC. This approach augments the mission of FQHCs to provide integrated care that supports improved outcomes.

FQHCs have strong community ties and processes in place to provide comprehensive primary care and preventive health services. This combination puts FQHCs in position to expand and improve tracking social determinants of health, and partner with social services providers to address health-related social needs.

CCBHCs are also expanding similarly, with many expanding their services by becoming FQHCs. In either scenario, the combination offers a powerful approach to providing truly integrated care, which will result in improving experience, better outcomes and more effective allocation of our resources in efforts to reduce cost.

Innovation in Behavioral Health model

The Innovation in Behavioral Health (IBH) model is the next evolution in integrated care. The IBH model will test a value-based payment approach that supports the integration of behavioral healthcare with physical healthcare and health-related social needs. IBH focuses on integrating primary care specifically within the behavioral health space. The goal is to improve care quality and health outcomes for individuals with moderate to severe mental health conditions and/or substance use disorders.

Specifically, the model goals include:

- Supporting behavioral health practices in delivering integrated care in outpatient settings
- Prioritizing close collaboration with primary care and other physical health providers
- Requiring participants to conduct screenings and assessments of behavioral health and primary care
- Support for closed loop referrals to other primary care providers and specialists for services out of scope

The CMS Innovation Center (CMMI) has recognized that behavioral health providers haven't had the same opportunities to receive incentives for adoption of healthcare technology and the ability to participate in value-based payment models. As a result, the IBH model is designed on a glide path model to incrementally introduce value-based payments and make it easier for providers to transition from fee-for-service payments. IBH also focuses on making behavioral health the lead in providing primary care.

Behavioral providers in states selected for the IBH model will be tasked with a care delivery framework that includes:

- Screening, assessing, and referring beneficiaries, as needed, for behavioral health and physical health conditions
- Leading an interprofessional care team to address the beneficiary's BH and PH conditions and HRSNs, adjusting the care plan as needed
- Supporting equitable care by implementing HRSN screenings, a population needs assessment and health equity plan

During the pre-implementation period, states and participants will receive funding to conduct activities that support the IBH care delivery framework. That funding will cover upgrading IT infrastructure, implementing population management tools, setting up telehealth capabilities and practice transformation activities, such as staff development and community outreach.

The CCBHC model continues to expand

It began with a two-year demonstration in eight states and 66 CCBHCs. This year, the model has expanded to 20 demonstration states. Nationwide expansion is planned to include all states within the next eight to 10 years. Currently there are 495 CCBHCs throughout 46 states, Puerto Rico and Washington, D.C.

The CCBHC model is having a positive impact on progress toward integrated care.

According to the 20224 CCBHC Impact Report from the National Council for Mental Wellbeing:

- 92% of Medicaid CCBHCs and grantees are engaging in one or more strategies to advance integrated care
- 43% of CCBHCs have created new positions specifically to support primary care
- 76% of Medicaid CCBHCs and grantees have increased referrals for primary care since becoming a CCBHC
- 28% of CCBHCs are comprehensive primary care providers with services available at the same location
- Supporting equitable care by implementing HRSN screenings, a population needs assessment and health equity plan

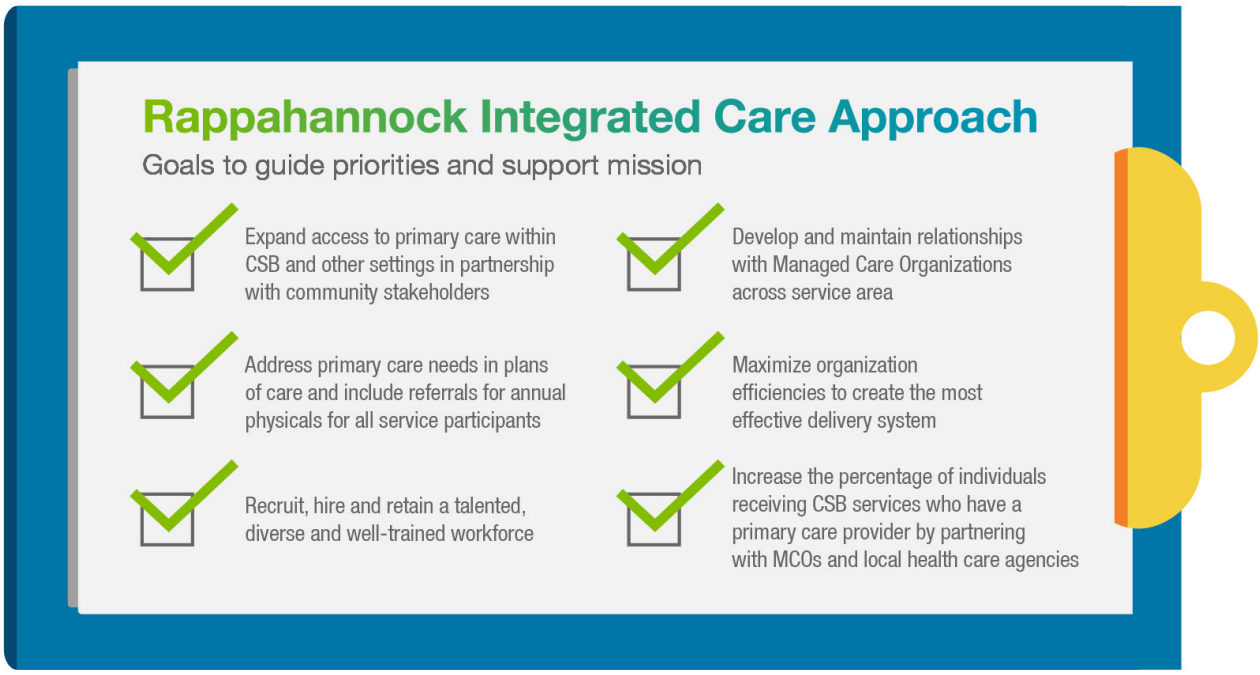
As the model expands and evolves, the positive impact of CCCHCs on the health and wellness of our most vulnerable populations will undoubtedly continue.

Rappahannock Area Community Services Board

Rappahannock Area Community Services Board (RACSB) is in Fredericksburg, Va. and serves 20,000 individuals each year. RACSB is one of 40 Community Services Boards that cover the state of Virginia. It offers a variety of services to individuals, some of whom are the most marginalized in the state.

Like many community agencies, throughout the COVID pandemic RACSB focused on maintaining services – being able to continue providing services in an extremely challenging landscape. As the health crisis subsided, the organization changed its focus to growth: how to best serve individuals, expand services and enhance the quality of its services.

The organization developed a strategic plan to focus on key goals to guide priorities, focus resources and support the mission.



"We need to be sure individuals have a primary care provider and have that nirvana of not just referring to care, but also knowing our individuals are actually accessing it and what the outcomes are."

While developing the strategic plan, RACSB recognized their service delivery was siloed, reflecting how the Viriginia payment systems work. RACSB was very intentional about moving toward integrated care but had no sources of additional funding. To begin making progress toward addressing primary care needs, they began collecting data on individuals receiving services for developmental disabilities.

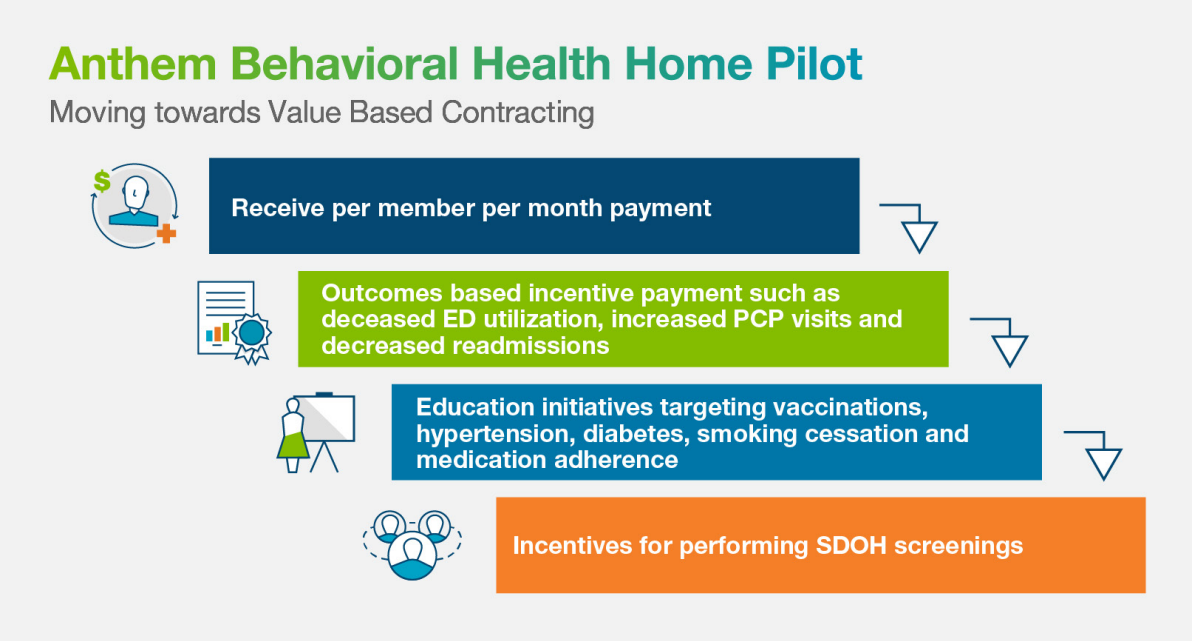
"We wanted to make sure that when an individual came to us, we asked about their primary care needs," explained Brandie Williams, deputy executive director with RACSB. "In every assessment and every intake, we made sure to identify any health needs and include them in the care plan along with goals. Gathering this data gave us a relatively easy starting place."

RACSB engaged in cross-agency training to make sure staff members were comfortable asking about medical concerns. They also worked with Aetna, the managed care organization (MCO) that accounts for a substantial portion of the organization's revenue, to create an effective care delivery system.

"The only way we're going to be successful and truly integrate care is if we're doing it efficiently and increasing the percentage of individuals receiving our services," Williams explained. "We need to be sure individuals have a primary care provider and have that nirvana of not just referring to care, but also knowing our individuals are actually accessing it and what the outcomes are."

In addition to gathering the data, RACSB had to be sure that data was easily available to clinicians without searching through multiple platforms. To accomplish that goal, RACSB turned to Netsmart to help them adopt tools to support access to health information exchanges, continuity of care documents, direct messaging secure inbox and referrals across care settings.

To combat the high cost of treating individuals with behavioral health issues and co-occurring, physical conditions, such as diabetes and hypertension, RACSB developed a home health pilot program in partnership with Anthem, the largest MCO in Virginia. In the program, RACSB receives a per member, per month fee for high-risk individuals, plus the opportunity for incentive payments based on improving the quality of care. The program has been successful; Aetna and RACSB are now partnering to develop a standardized screening to capture social determinants of health (SDOH).



Decision points for delivering integrated care

Where do you begin your journey to proving care integrated care? Start by exploring funding and reimbursement models available in your state and region. In addition to CCBHC and IBH funding, there may be additional opportunities with MCOs for partnering on projects such as the health home pilot Brandie Williams outlined.

Take a detailed look at the scope of the multi-disciplinary care team you'll need to assemble. You'll also need to plan for operational and staffing requirements to support additional administrative functions associated with expanded services.

Finally, evaluate your existing infrastructure — both physical and technological — for the possibility of supporting co-location or embedded primary care. From a technology standpoint, here's an overview of what you'll need to schedule, document, share and analyze data, and bill for integrated care:

- Multi-contributor documentation that provides visibility across care team members and visit types
- Data analytics and measures reporting capabilities that can combine information across service lines and meet program requirements
- Billing rules and functionality that support primary care services, including prospective payment systems

- Ability to perform screenings relevant to chronic conditions (e.g., diabetes) and assessments related to physical health and SDOH
- Centralized view of medications, vaccines and long acting injectables including integration with inventory management and public health registries
- Solutions that support scheduling different appointment types across multiple clinic locations, including telehealth and consumer portal

When you're ready to start your journey to integrated care, Netsmart is ready to help. We've been working with CCBHCs since the first demonstration states were designated in 2017. We're currently the technology provider for 178 CCBHCs in 38 states. We have both the experience and technology to help you plan the best pathway forward for your organization, as integrated care continues to grow and evolve.

For more information, visit our website.

About Netsmart

Netsmart is an industry-leading healthcare technology organization empowering providers to deliver value-based care to the individuals and communities they serve. The Netsmart CareFabric® platform serves as a unified, connected framework of solutions and services for human services, post-acute, payer and public sector communities. Together with our clients and Marketplace vendors, we develop and deliver innovative technology, including electronic health records (EHRs), interoperability, analytics, augmented intelligence (AI), population health management and telehealth solutions and services that assist organizations in transforming the care they deliver. The result has helped make a positive impact on the lives of more than 143 million individuals.

For more than 55 years, Netsmart has helped provider organizations in their efforts to improve the health and wellbeing of the communities we collectively serve. To learn more, visit ntst.com and connect with us on LinkedIn, Facebook or X.

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