Leading the way forward for CCBHCs

Netsmart and National Council Population Health Partnership
Presenters

- **Joe Parks, M.D.** - Medical Director, National Council for Mental Wellbeing
- **Brent McGinty** - President/CEO, Missouri Behavioral Health Council
- **Scott Green** - SVP & Managing Director, Netsmart
Agenda

• National Council and Netsmart support of CCBHCs
• Objectives of the partnership
• How CCBHCs benefit
• Case Study: Missouri Behavioral Health Council
• Technology to support the vision
Dr. Joe Parks - Medical Director, National Council for Mental Wellbeing
Shared Values: Enabling success and growth of CCBHCs

- Consistent, long-term advocates of integrated care and CCBHC model
- Direct support of agencies adopting CCBHC model
  - National Council’s CCBHC Success Center assists organizations with implementation, data requirements and more
  - 133 (~25%) CCBHCs use Netsmart solutions
- Improving quality and assuring accountability through data performance measurement
- Aligned missions – support providers in delivering whole-person care that improves the lives of consumers in their community
Objectives of the Partnership

• Support CCBHC participants to adopt new approaches of coordinating care, sharing data, and operationalizing population health

• Support state Medicaid departments to implement CCBHC in a manner that is provider friendly, transparent, and creates a true coordination needed for whole person care

• Support the adoption of proven care coordination technology and population health management by working toward a shared-cost model (ex: MO model)

• Create a nationwide CCBHC data repository to enable research, advocacy, and sharing of best practices

• Ensure the value of services delivered by CCBHC sites is captured and funding model is sustained
What are we proposing?

• Share data at regional/state level for effective care coordination and identification of best practices
• Join national de-identified data repository to help establish nationwide benchmarks and contribute to advocacy efforts
• Share costs by purchasing CareManager as a group
• CCBHCs with any brand of EMR can participate
Status of Participation in the CCBHC Model

- States where clinics have received expansion grants
- States selected for the CCBHC demonstration
- Independent statewide implementation
- No CCBHCs

There are **431 CCBHCs** in the U.S., across 41 states, Guam and Washington, D.C.
Care Coordination: *The “Linchpin” of CCBHC*

- Care coordination required with:
  - FQHCs/rural health clinics
  - Inpatient psychiatry and detoxification
  - Post-detoxification step-down services
  - Residential programs
  - Other social services providers, including
    - Schools
    - Child welfare agencies
    - Juvenile and criminal justice agencies and facilities
    - Indian Health Service youth regional treatment centers
    - Child placing agencies for therapeutic foster care service
  - Department of Veterans Affairs facilities
  - Inpatient acute care hospitals and hospital outpatient clinics
CCBHC Integration Requirements

• Coordinates care across the spectrum of health services, including access to high-quality physical health
• Determine any medications prescribed by other providers and provide information to other prescribers
• Population health management and interoperability
• Contact within 24 hours of ER or Hospital discharge
• Assessment of need for medical care and a physical exam
• Primary care screening and monitoring of key health indicators and health risk
• Staff training in integration
Targeting Population Health

PPS provides resources and incentives to target population health. CCBHCs are:

• Hiring dedicated population health analysts, clinicians, other staff
• Using data analysis to understand utilization and risk among client population
• Developing care pathways to ensure comprehensive, assertive service delivery to high-risk populations
• Strengthening integration with primary care to help clients manage chronic physical health conditions that are cost drivers
• Partnering with hospitals to streamline care transitions and prevent readmission
• Assessing for non-health needs that are determinants of health (e.g. housing, food, etc.)
CCBHC: An Ideal Crisis System Platform

• CCBHCs are required to provide crisis call line, 24/7 mobile crisis teams, crisis stabilization, and emergency crisis intervention

• Many also provide:
  • ER diversion
  • Crisis Stabilization/Drop-in Centers
  • Co-response with police/EMS
  • Diversion of calls and mobile response instead of police
Comprehensive client flow monitoring data system

• Centralized data system for client flow

• Systematic level of care assessment

• Available Resource identification

• Data system reporting

• Prompt reporting for care coordination
Client Tracking System Capacities

- Notify involved providers of an encounter with crisis services
- Create and access care plans for individuals who may need care coordination
- Identifying individual clients in need of follow up
- Report quality improvement data
- Identifies individuals who have patterns of frequent utilization of crisis services
- Ability to share information with other data systems (interoperability)
- Identify and analyze patterns of high utilization or high risk
Brent McGinty - President/CEO, Missouri Behavioral Health Council
Missouri History of Integrated Care and Data

- **2008**
  - 25-Year Mortality Study
  - Nurse Care Managers
  - Medicaid claims data (diagnosis, procedures, pharmacy)

- **2010**
  - Chronic Disease Prevalence Studies
  - Metabolic Screening & High Cost/Risk Outreach
  - Vitals, Labs, Health Risk Factors (Metabolic Screening)

- **2012**
  - Section 2703, Affordable Care Act
  - 26 Behavioral Healthcare Homes
  - Hospitalizations + ER Visits

- **2017**
  - Excellence in Mental Health Act
  - 15 Certified Community Behavioral Health Clinics
  - Medicaid Eligibility + Hospital Follow Up + Health Risk Profile

**Statewide Care Management & Population Health Tool**

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*TheNationalCouncil.org*
Health Information Landscape

34 organizations

Department of Mental Health

Data Integration

MBHC CLIVE Data Warehouse

CareManager
Driving quality care in the field.

CareManager combines Medicaid claims data + DMH client detail + hospital and ER notifications + clinical data from providers to:

- Alert the Care Team of ER and hospital events
- Assess populations for risk
- Monitor health outcomes
- Identify gaps in care

Measures Reporting
Measuring quality real-time.

Opportunities

IPA/Payor Access
Independent assessment and crisis centers
State Reporting

Populations can be further stratified by:

- Medicaid Coverage or MCO
- Program Enrollment
- CCBHO-specific or State Totals
- Team Role or Staff Name

National Council for Mental Wellbeing

TheNationalCouncil.org
Missouri CCBHCs

23% Increase in patient access to care
Overall increase in patients served from baseline to Year 3

Missourian’s Served by CCBHCs
- Baseline: 119,002
- Year 1: 121,431
- Year 2: 140,884
- Year 3: 146,665

2,993 Veterans Served by CCBHCs
Overall increase in veterans served from baseline to Year 3

Improving Outcomes & Access to Care
Missouri’s Impact Report | Year 3

Reducing Hospital & ER Utilization
- ER Visits: 28% decrease
- Hospital: 24% decrease

CCBHCs continue to reduce the number of patients with 1 or more ER or hospital encounter

Providing Medication Assisted Treatment
- 101% increase in medication-assisted treatment

TheNationalCouncil.org
### Missouri CCBHCs

#### Measuring Progress & Improvement

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Adult Follow Up</th>
<th>Youth Follow Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow Up After Hospitalization in 30 Days</td>
<td>74%</td>
<td>78%</td>
</tr>
<tr>
<td>Follow Up After Mental Health ER Visit in 30 Days</td>
<td>70%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome</th>
<th>DY1</th>
<th>DY2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication</td>
<td>83%</td>
<td>91%</td>
</tr>
<tr>
<td>Plan All-Cause Readmissions Rate</td>
<td>26% in DY1</td>
<td>23% in DY2</td>
</tr>
</tbody>
</table>

#### Prevention Screening

<table>
<thead>
<tr>
<th>Screening</th>
<th>Adult</th>
<th>Youth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metabolic Syndrome Screening</td>
<td>91%</td>
<td>90%</td>
</tr>
<tr>
<td>Suicide Risk Assessment for Depression</td>
<td>88%</td>
<td>90%</td>
</tr>
<tr>
<td>Weight Assessment &amp; Follow Up</td>
<td>67%</td>
<td>91%</td>
</tr>
</tbody>
</table>

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**Missouri Success**

53,295 Referrals from law enforcement

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**Missouri CCBHCs**

**Measuring Progress & Improvement**

- Adult Follow Up After Hospitalization in 30 Days: 74%
- Youth Follow Up After Hospitalization in 30 Days: 78%
- Adult Follow Up After Mental Health ER Visit in 30 Days: 70%
- Follow Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication | Continuation & Maintenance Phase: 83% in DY1, 91% in DY2
- Plan All-Cause Readmissions Rate: 26% in DY1, 23% in DY2

**Prevention Screening**

- Metabolic Syndrome Screening: Adult 91%, Youth 90%
- Suicide Risk Assessment for Depression: Adult 88%, Youth 90%
- Weight Assessment & Follow Up: Adult 67%, Youth 91%

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**National Council for Mental Wellbeing**

[TheNationalCouncil.org](http://TheNationalCouncil.org)
Building a Data-Driven Culture
to thrive in a value-based world

CareManager
Provider
Care Management
Risk Stratification
Custom Reporting

Population Health
Provider, State, Association, Payors
Measures
Outcomes

Data Warehouse
Provider Admin, State, Association, Payors
Evaluations
Advocacy
Social Factors of Health
“Start where you are. Use what you have. Do what you can.”

Arthur Ashe
Scott Green - SVP & Managing Director, Netsmart
What Does this Partnership Mean to You?

Technology is ready to support your CCBHC

- Data aggregation capabilities make this possible
  - Aggregating data from multiple EHRs
  - Aggregating data from multiple sources (Jail, HIEs, State, MCOs)
  - Eliminating data blackholes

- Strength in numbers
  - Amplifies your voice with partners and stakeholders (claims data)
  - Economies of Scale
  - #BetterTogether

- Power in data
  - Awareness of what is happening in your state
  - Increased effectiveness of advocacy
  - Ability to demonstrate value of services

Use Case: AsOne IPA, NY

“Gathering and utilizing data with visibility into shared clinical dashboards and key performance indicators are vital to their approach toward clinical integration between AsOne providers who may be unknowingly treating the same patients or clients.

Aggregating data across their network of providers as well as external providers throughout the healthcare continuum will help AsOne better understand and serve their shared population.

Tracking all healthcare interactions for individuals changes how healthcare is currently administered, transitioning from a piecemeal of services treatment approach to one that is more holistic.”

Press release - AsOne Healthcare IPA and Netsmart Partner to Utilize Care Coordination and Data to Enable Success in a Value-Based Payment Environment
Agency/State vs. National Council Use Cases

Agency/State System
- Data managed State/Association
- Identified patient-level PHI
- State-level users with system wide access, provider users with agency-specific access
- Data sourced by aggregated connected systems and individual EHRs
- Dedicated environments per agency/state
- Training provided for state/agency level users per environment

National Council System
- Data managed by National Council
- Aggregate data at agency-ZIP level
- Data sourced from state system(s)
- One single aggregate environment for National Council
- Research and advocacy efforts driven/controlled by National Council
Agency Views: Actionable Alerts and Tasks

- ER Visits
- Hospitalizations
- Medicaid Eligibility
- Metabolic Screening Completion
Available Views: Quality Metrics

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
<th>Percentage</th>
<th>Results</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>MoCo 0036</td>
<td>Asthma Medication Adherence (Adult)</td>
<td>0%</td>
<td>0/115</td>
<td>Goal 70%</td>
</tr>
<tr>
<td>MoCo 0059</td>
<td>Blood Pressure Control for Diabetes (Adult)</td>
<td>65%</td>
<td>2248/3458</td>
<td>Goal 85%</td>
</tr>
<tr>
<td>MoCo 0059</td>
<td>Hemoglobin HbA1c Control for Diabetes (Adult)</td>
<td>59%</td>
<td>2031/3458</td>
<td>Goal 80%</td>
</tr>
</tbody>
</table>
Available Views – Quality Metrics Benchmarking

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**Data Transparency**

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### Missouri Quality Measures - Adult

<table>
<thead>
<tr>
<th>Agency</th>
<th>Measure</th>
<th>Values</th>
<th>Managed</th>
<th>Flagged</th>
<th>%Managed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Population</td>
<td>2016</td>
<td>2019</td>
<td>2018</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Asthma Medication Adherence (Adult)</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>33.33%</td>
</tr>
<tr>
<td></td>
<td>Blood Pressure Control for Diabetes (Adult)</td>
<td>76</td>
<td>47</td>
<td>29</td>
<td>61.84%</td>
</tr>
<tr>
<td></td>
<td>Blood Pressure Control for Hypertension (Adult)</td>
<td>114</td>
<td>55</td>
<td>43</td>
<td>57.03%</td>
</tr>
<tr>
<td></td>
<td>Body Mass Index Control (Adult)</td>
<td>368</td>
<td>81</td>
<td>307</td>
<td>81.65%</td>
</tr>
<tr>
<td></td>
<td>Hemoglobin A1c Control for Diabetes (Adult)</td>
<td>76</td>
<td>40</td>
<td>27</td>
<td>64.15%</td>
</tr>
<tr>
<td></td>
<td>LDL Control for Cardiovascular Disease (Adult)</td>
<td>45</td>
<td>14</td>
<td>11</td>
<td>58.89%</td>
</tr>
<tr>
<td></td>
<td>LDL Control for Diabetes (Adult)</td>
<td>76</td>
<td>43</td>
<td>33</td>
<td>44.26%</td>
</tr>
<tr>
<td></td>
<td>Metabolic Screening Complete (Adult)</td>
<td>400</td>
<td>302</td>
<td>40</td>
<td>0.57%</td>
</tr>
<tr>
<td></td>
<td>Tonsil Use Control (Adult)</td>
<td>108</td>
<td>108</td>
<td>9</td>
<td>36.22%</td>
</tr>
<tr>
<td>Arthur Center</td>
<td>Asthma Medication Adherence (Adult)</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0.02%</td>
</tr>
<tr>
<td></td>
<td>Blood Pressure Control for Diabetes (Adult)</td>
<td>55</td>
<td>41</td>
<td>14</td>
<td>74.55%</td>
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<tr>
<td></td>
<td>Blood Pressure Control for Hypertension (Adult)</td>
<td>76</td>
<td>55</td>
<td>29</td>
<td>78.23%</td>
</tr>
<tr>
<td></td>
<td>Body Mass Index Control (Adult)</td>
<td>200</td>
<td>37</td>
<td>211</td>
<td>15.68%</td>
</tr>
<tr>
<td></td>
<td>Hemoglobin A1c Control for Diabetes (Adult)</td>
<td>55</td>
<td>38</td>
<td>17</td>
<td>69.11%</td>
</tr>
</tbody>
</table>
Available Views: Health Risk Profile

Health Risk Profile

### Demographics
- **NAME**: Blaine L Bambooson
- **DCN #**: 5378434
- **NURSE CARE MANAGER ASSIGNMENT**: Cecilia Rahardjo
- **DATE OF BIRTH / AGE**: 06/06/1981, 36 years, Adult
- **GENDER**: Male
- **RACE**: Caucasian

### Risk Summary

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Score</th>
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<tbody>
<tr>
<td>Metabolic Screening</td>
<td>6.5</td>
</tr>
<tr>
<td>Physical Health Diagnosis</td>
<td>3</td>
</tr>
<tr>
<td>Medication Use</td>
<td>2.2</td>
</tr>
<tr>
<td>ER &amp; Hospitalizations</td>
<td>3</td>
</tr>
<tr>
<td><strong>TOTAL RISK SCORE</strong></td>
<td></td>
</tr>
</tbody>
</table>

- **MODERATE-HIGH RISK**: 14.7

### Risk Factors

- **Metabolic Screening Profile**
- **Diagnosis**:
  - Physical, Behavioral, Substance Use, Developmental Disability, Other Chronic Conditions
- **Medication Use**
- **ER & Hospitalizations**
  - Housing, Employment Status
  - PHQ-9, Suicide Risk
  - Functional Assessment Scores

### Client Profile

- **Demographics**
- **Program Enrollment**
- **Health Plan**
Available Views: Claims History

<table>
<thead>
<tr>
<th>Service Date</th>
<th>Billing Provider</th>
<th>Rendering Provider</th>
<th>Place of Service</th>
<th>Claim Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>07/24/2017</td>
<td>MERCY CLINIC SPRINGFIELD COMMUNITIES</td>
<td></td>
<td>Urgent Care Facility</td>
<td>5555512021105</td>
</tr>
<tr>
<td>07/24/2017</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>07/19/2017</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>06/28/2017</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>06/25/2017</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>06/25/2017</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
Available Views: Population Insights

Overview

- **Distinct Client Count**: 287,295
- **Number of Vitals Readings**: 349,001
- **Number of Encounters**: 34,790,899
- **Number of Hallmark Events**: 548,023
- **Number of Plans**: 998,456
- **Number of Labs**: 1,446,276
- **Number of Med orders**: 19,459,806
Q&A
Next Steps & Contact Info

• CCBHC Success Center
  • https://www.thenationalcouncil.org/ccbhc-success-center/

• Julie Hiett
  • jhiett@ntst.com

• Brent McGinty
  • bmcginty@mobhc.org