Five Clinical Trends Impacting Healthcare Today

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Healthcare has always been a rapidly changing industry. That is more true today than ever before. Here are five trends that are currently affecting the future of healthcare. Many of these are specific to behavioral healthcare. All are connected to each other and influence each other in a variety of ways. They are:

- Consumer-Directed Healthcare
- Increased Accountability
- Changing Demographics And Attitudes
- New Clinical Delivery Model
- Personalized Medicine

**Consumer-Directed Healthcare**

Today’s healthcare consumers are moving away from their traditional roles as being passive recipients of healthcare services to their current roles as active participants. In some circles, even the term “patient” is viewed as a pejorative implying the passive role, one in which providers do things “to” patients rather than “with” them. Certainly, the Internet has contributed to this via shifting demographics (see below). As we progress, the focus of the healthcare system will shift from a clinician-centric world to a consumer-centric world as consumers demand more say over their own healthcare. It is doubtful that the “customer-choice” model espoused by a large number of politicians will take hold. Their predictions presuppose that a rational consumer will make health choices based solely on published outcomes data which will lead to cost savings via increased competition among providers. Behavioral economics has taught us that consumers are rarely rational, even about purchasing commodity goods. It is doubtful they will be more so about something as emotionally charged as healthcare. Nonetheless, the trend towards consumer choice and demonstration of value is going to occur and providers will need to be ready for consumers who will “shop around” for non-emergency services.

Those receiving health insurance through employer-sponsored plans are finding that consumer-directed healthcare carries forward into the financial parameters of the plan. The consumer is given a financial incentive of lower premium cost to pick a consumer-directed health plan (CDHP) with higher deductible and potential out-of-pocket cost, over the traditional plan design. The design puts more front-end payment in the hands of the consumer with the hope that they will want to control costs and as a result tend to become more directly involved in the selection and usage of health care services.

**CDHPs consist of three parts:**

- A health plan with a relatively high deductible level that provides financial security for more severe illnesses. Many preventive care services are covered at 100%, as stipulated by the Affordable Care Act; some plans expanded the list and those services are typically covered with only a small copayment.

- A health fund that the consumer controls. Employers can make contributions into the health fund of their employees. Funds in the account (HSA or HRA) can be used to pay for expenses before the deductible is met. Any unused funds typically roll over from year to year and can accumulate into a significant balance.

- Information tools are provided to the consumer to help them make better health care decisions. These may include health and wellness information and information on providers and the cost of services.
Increased Accountability for Clinical Data-Based Decisions and Outcomes

Behavioral healthcare has had a reputation of being “soft” and without measurable clinical outcomes. While this view may be popular, it is not because the data were absent but more due to the fact that data was not being used. Payers particularly have grown tired of this lack of clinical accountability and are demanding providers show demonstrable clinical change. Consequently, the need for measurable clinical quality will continue to increase, requiring providers to measure and report what and how they are doing. Perhaps more importantly, behavioral health providers will need to learn how to manage using this data.

The combination of a culture that does not hold clinicians accountable to measurable outcomes, the use of fee-for-service reimbursement methodologies that, in essence, pay for “trying” rather than “doing” and a significant number of clinicians who believe what they do is more art than science has led to an industry that is ill-prepared for the coming increase in clinical accountability. Many providers and provider agencies will have to learn not just what to measure and how to measure but also how to integrate measurement into their culture.

Graduate training programs are not preparing clinicians for this future either. Though exceptions exist, the rigidity of academic curricula prevents fast changes from occurring. For example, electronic health records (EHRs) are well-established in the provider community yet few graduate training programs offer their students even basic EHR training.

As measurement of clinical processes becomes more ubiquitous, the aggregation of those data to allow benchmarking and advanced analysis also becomes common. Clinicians and managers will need help making the transition to using data to manage the people in their charge. The push will be towards those treatment interventions that produce more favorable outcomes for specific types of patients.

The other major opportunity for increased accountability is to provide real-time advice to clinicians about the best treatments for the client sitting in front of them. The amount of information about clinical efficacy published each year exceeds the clinician’s ability to stay informed about best practices. Traditional models of continuing education are inadequate to the task as well. Clinicians need a “just in time” delivery mechanism about what is known to be effective. This can only be done through an electronic delivery mechanism. It will need to be delivered when they need it so they can use the information to change the trajectory of treatment in real-time. Without such a system, clinicians could be held accountable for providing substandard, or even inappropriate, care solely because they had no way of knowing what the current research showed.

Changing Demographics and Attitudes Towards Technology, Healthcare and Privacy

As younger people access healthcare, their expectations about the general healthcare system including behavioral healthcare, are very different than older generations. This generation is made up of computer “natives” who have never lived in a world where computers and the Internet do not exist. They volunteer personal information in ways that surprise older generations and their needs for privacy and confidentiality are much lower. While not immune to the stigma around mental illness and addictions, this generation is less judgmental about such things and more willing to share their own personal struggles with these problems. They find the ways the healthcare system works to be antiquated and unhelpful. Most every aspect of their lives can be conducted online. They communicate, study, manage finances, conduct research and date online but they cannot communicate with their healthcare providers nor complete basic activities such as make an appointment or see their bill. Our rationale for not providing these services usually centers on confidentiality.
and protection of their anonymity. But these are our concerns, not theirs. They cannot understand why they must physically come to a provider’s office for anything and they are appalled that we ask them to fill out paper documents. They assume we are communicating with other healthcare providers about their care and do not understand our preoccupation with privacy. They are a group that would prefer to use many of the online tools described in the “New Clinical Delivery Mechanisms” section below. Sitting in a room with a therapist is not their preferred means of receiving care. However, many of their peers are becoming clinicians and they too are appalled at the lack of electronic tools available to them. Electronic health records are expected not differentiators. As these young providers get established in organizations, dissonance between the old guard and the new is inevitable.

New Clinical Delivery Model

The traditional model of mental health care delivery has not changed much in the past 50 years. Individual, group and case management treatments are still the staples of this industry. The reasons for this lack of change are many, including fee-for-service payments which incent a “do more, make more” mentality, lack of a strong reason to change among clinicians and graduate training programs that teach traditional models help perpetuate the usual and customary way of providing care. While these traditional delivery models will likely continue to be part of the suite of services, much work has been done in developing new, sometimes automated, delivery mechanisms.

In countries such as Australia and the United Kingdom, the use of Computerized Cognitive Behavioral Therapy (CCBT) has been readily accepted. These tools automate clinical protocols for mild to moderately distressed individuals living with anxiety, depression, substance use disorders and many other concerns. Primary barriers to widespread implementation of these tools in the United States focus on lack of reimbursement and lack of training.

The use of closed social media tools to provide support for people suffering from like disorders is also rapidly gaining acceptance other countries. The sites are similar to but different than open sites such as Facebook. Clinicians monitor them but maintain a supportive role in the background and intervene only when necessary. For many people, these sites provide a positive adjunct to their traditional therapy and, for some, become their primary means of emotional support.

Both the computerized treatment tools and the closed social media tools will gain greater adoption in the US once the reimbursement barrier is breached. Organizations that are reimbursed through a traditional fee-for-service model have little incentive to use new tools. However, those whose primary reimbursement is through capitation have greater reason to use these kinds of tools. But, providers and managers will need training on which tools to use and how to best use them. There is little written in American literature on how a clinician uses CCBT as a part of the clinical services suite or what is the role of a closed online social media in the treatment and care of people with serious mental illnesses. Other countries are addressing these problems and it would behoove the United States to look to them for guidance.

Personalized Medicine

Every medical and psychological treatment only answers the question “what works best for most” not “what works best for you.” That is rapidly changing as new tools allow care to be personalized at the individual level. Genomics research started the trend. Mapping the human genome brought with it the promise of being able to codify the genetic causes of diseases and to identify variations among individuals. This allowed drugs to be designed not for a population of people with same diagnosis but for individuals based on their unique genetic profile and physiology. However, identifying the genetic underpinnings of diseases has proven harder than expected. There has been progress, to be sure, but for areas like behavioral healthcare, the genetic causes of diseases like schizophrenia are no closer to discovery than they were 10 years ago.
On the other hand, there have been very encouraging developments using genetic data to determine medication responsiveness. For example, one company has developed a genetic test to determine whether an individual will be responsive to olanzapine (trade name Zyprexa), a popular antipsychotic medication. Using only a saliva sample, the test can quickly determine if the patient has a high or low likelihood to respond to the drug. Using this test will allow clinicians to bypass the usual protocol of “try-fail-try another drug.” In addition, the cost of genetic sequencing machines has dropped precipitously such that an office-based genetic sequencer can be had for around $1,000. These trends suggest that genomic data will be an integral part of the healthcare of the future.

Although the term personalized medicine started with genomic-specific treatment, personalized medicine has extended to include the use of technology, care process or discovery enabling a level of personalization not previously feasible or practical. Key to the discovery and definition of care process to deliver personalized medicine will be the ability to aggregate and analyze large data sets. This so-called “Big Data” has been used very successfully in other industries to yield significant improvements in quality and cost. The premise is that buried with the large data set are the unique and specific individual and context of care parameters that can better predict or correlate to risks and/or treatment responses. Genetically-matched medication only define that the medication given will work as designed at the cellular level; there are many other aspects of care that is influenced by both intrinsic and extrinsic factors.

General healthcare is beginning to use these tools as well but behavioral healthcare has been slower to adopt them. This is due at least in part to the lack of standardization of data elements in behavioral healthcare and the lack of an information infrastructure that would allow for easy submission of data to a centralized repository. The latter problem is exacerbated by the concerns about privacy and confidentiality in this industry. Nonetheless, preliminary work that has been done in this area by researchers such as Centerstone Research Institute (CRI) has yielded very positive results. In one study, CRI researchers were able to develop probability statements that predicted differential treatment effectiveness for 70% of individuals using only the data available to them at the time of intake. Subsequent refining of that model has pushed that number to over 80%. Coupled with the increased need for measurement and outcomes as described above, the aggregation and analysis of large data sets culled from many organizations provides another opportunity for personalized medicine, this one driven not by genomic data but by the analysis of very large data sets.

**Summary**

The clinical world is changing rapidly. New tools are becoming available for clinicians and consumers. As our industry matures, consumers will take more control of their own healthcare and clinicians will move from being exclusively care providers to being coordinators of care. Face to face clinical care will decrease in popularity and will be replaced by virtual therapies. Those services that do require traditional treatment will be specialized and offer better utilization of clinician skills. Those who wish to be a part of this next generation of healthcare must stop asking themselves “What can I do?” and begin asking themselves “What can ONLY I do?”
THE NETSMART DIFFERENCE

As the nation’s largest provider of behavioral health EHRs, Netsmart is uniquely positioned to accomplish the goal of driving the clinical agenda on behalf of our industry. A powerful, virtual knowledge-to-practice loop can only be fully realized through a very large sample size of organizations. Thus Netsmart, with our resources, clients and partners, has the ability to put this vision into action. By tapping into our expansive client base, we are creating solutions and services that use and analyze data to continually refine clinical approaches that improve decision-making, treatment, and outcomes; and providing a growing base of benchmark, quality and performance data that help provider organizations improve the business of treatment delivery.

ABOUT NETSMART

Through innovative and interactive solutions and services, Netsmart leads the health and human services industry in transforming the way care is delivered. Our expertise in helping organizations navigate their way through Meaningful Use and Accountable Care shows our commitment to partnering with organizations of all sizes to ensure they have the technology and know-how they need to deliver the highest level of care to those they serve. Healthcare today is an ever-changing, rapidly-evolving world. Organizations must seek technology partners who understand their current needs and have their pulse on the industry to envision how needs can be met in the future. Our obligation is to guide our clients through this rapidly changing environment by providing them with solutions and services that help improve outcomes and reduce costs. We help our clients adapt to these changes so that they can reach their goals and improve the health of the populations they serve.

Providers can utilize Netsmart solutions to meet Accountable Care and all Stage 1 criteria for Meaningful Use of an EHR, avoiding the need to integrate solutions from multiple vendors. Netsmart’s Meaningful Use-related solutions include a Complete ARRA-Certified EHR, e-prescribing, connectivity to health information exchanges, consumer Web portal, and a platform to capture and share outcomes data. Our community of users, the largest in the industry, is already sharing best practices on how to make the internal process changes needed to ensure a smooth path to Meaningful Use.

Netsmart is committed to helping health and human services providers deliver effective, recovery-based care with Netsmart CareFabric™, a tightly woven framework of innovative clinical and business solutions and services that supports integrated, coordinated delivery of health services across the spectrum of care. Moving forward at the speed of thought, we are at the forefront of healthcare innovation and we continue to evolve our services and solutions to meet the needs of our clients today and in the future. Our goal is ensuring that our clients in behavioral health, public health, substance abuse and addiction services emerge from the healthcare reform era as leaders in their respective fields of specialization.

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Dr. Chuang received his Doctor of Medicine degree from the University of Toronto and a Master of Science degree in Administrative Medicine from the University of Wisconsin. He currently serves as an Adjunct Assistant Professor at the University of Missouri. He also continues to engage with public/private sector efforts around data standards and quality, currently as a member of the National Quality Forum Health Information Technology Advisory Committee (HITAC).

Before joining Netsmart, Dr. Chuang’s experience includes serving as Senior Vice President, Health Risk Management for Lockton Benefit Group, developing care management and clinical decision support systems at CIGNA Corporation, serving as Director and Vice President at Cerner Corporation and clinical leadership positions at TherapyEdge, Inc., Click4Care, McKessonHBOC, Wellport Health Plan and HealthSource-Provident Administrators, Inc.