
Netsmart

Familiar Faces/Coordinated Care

Netsmart's Approach

Informing decisions on the population served

Using data from referral sources, county and community organizations, etc.

Enabling informed decisions on those needing and/or accepted into care

Applying rules and best practices to place into level of care

Automating the intake process and alerting the care team

Enabling the creation of cohorts and appropriate care team views

Creating a whole person view with ALL data on an individual

Applying governance, consent, and program-based rules and permissions to the data set

Using machine learning to drive needed reactive and proactive steps

Going beyond "Data Insights" to drive driving outcomes through action

Auto-generation of tasks and worklists for Care Teams

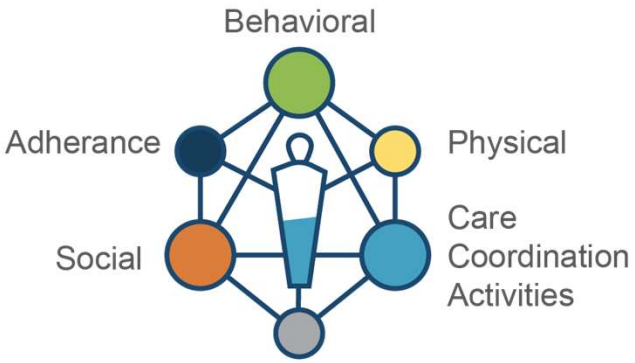
Multi Faceted views available to care team for checks and balances

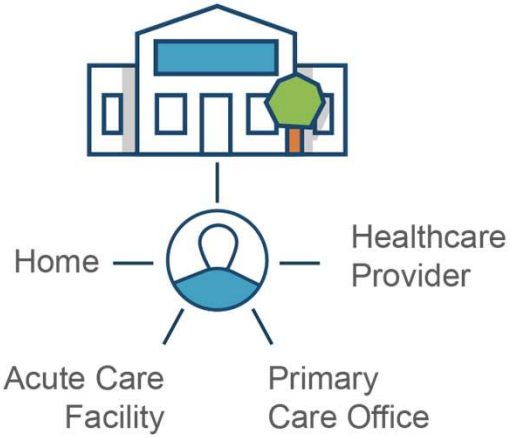
Closed loop referrals

Care Coordination and Population Health

The right care at the right time

Identifying Strengths and Barriers of Care



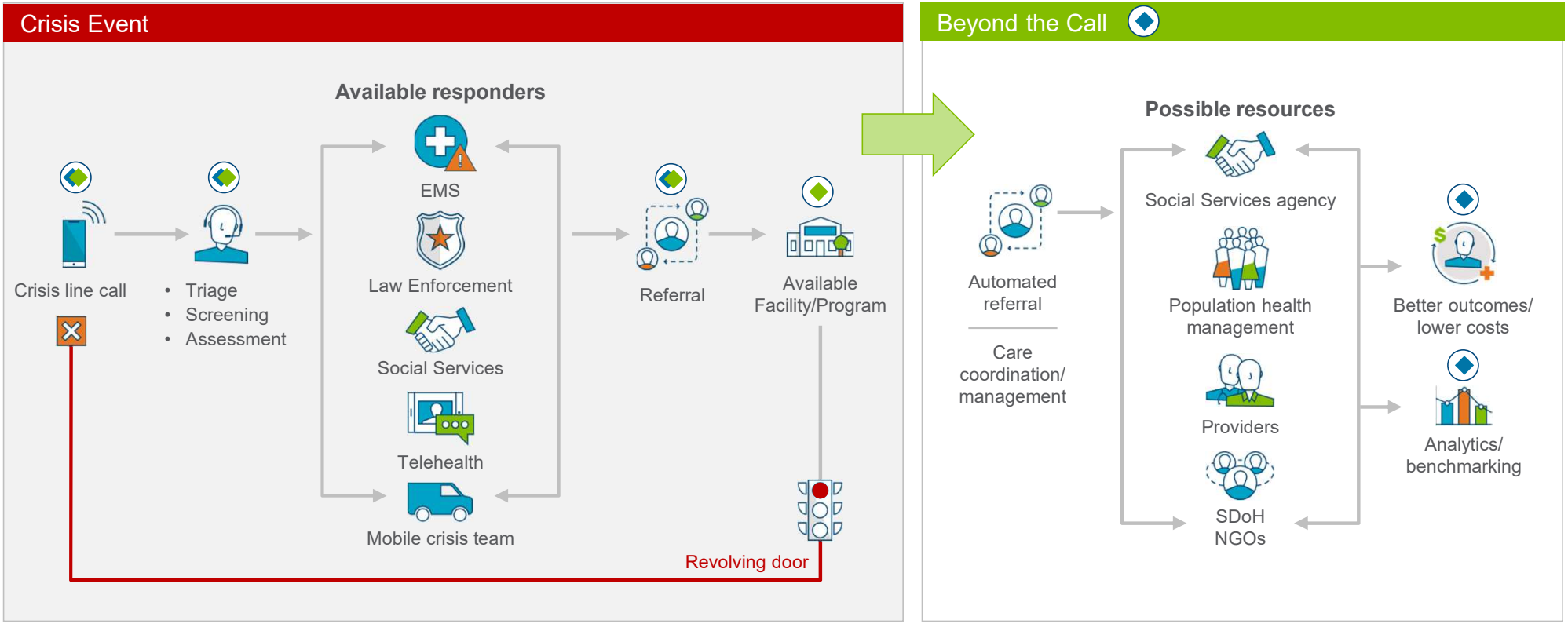


Identifying High Risk Populations

- Population Health
- Client Tracking
- Care Coordination
- Care Planning
- Alerts & Notifications
- Integrates with any EHR

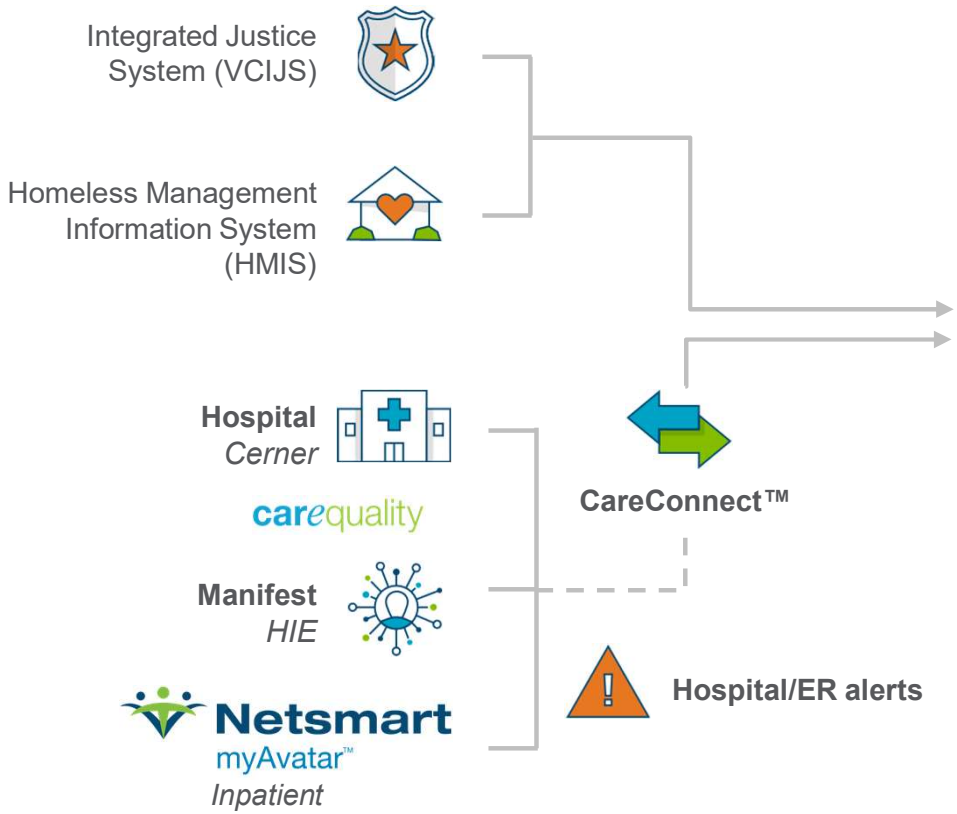
Supporting Whole-person Care through Crisis

Seamless Care Transitions



Bamboo OpenBeds® Netsmart

Ventura County Care Coordination Platform



Full Person Profile

Care coordination for two populations:

- Persons with severe mental illness (SMI) and/or substance use disorder (SUD) and/or PCP co-diagnosis
- CA Identified Full-service Partnership
  High acuity, familiar faces, well known with law enforcement, hospital, etc.

Bernalillo County Resource Re-Entry

County Behavioral Health

Resource Re-Entry Center

CARES Campus

SDoH Assessment and Care Plan

Population Health Management Platform

Alerts and business rules | Analytics and metrics | Automated workflows

Care coordination | Interoperability

Behavioral Health
Sapphire

Offender Management System (OMS)

Transition planners:

- Work with inmates prior to release
- Transition to community post-release

Assessment | Schools | Demographics | Supports | Diagnosis

Behavioral Health

Substance Use

Housing and Transportation

Social Services

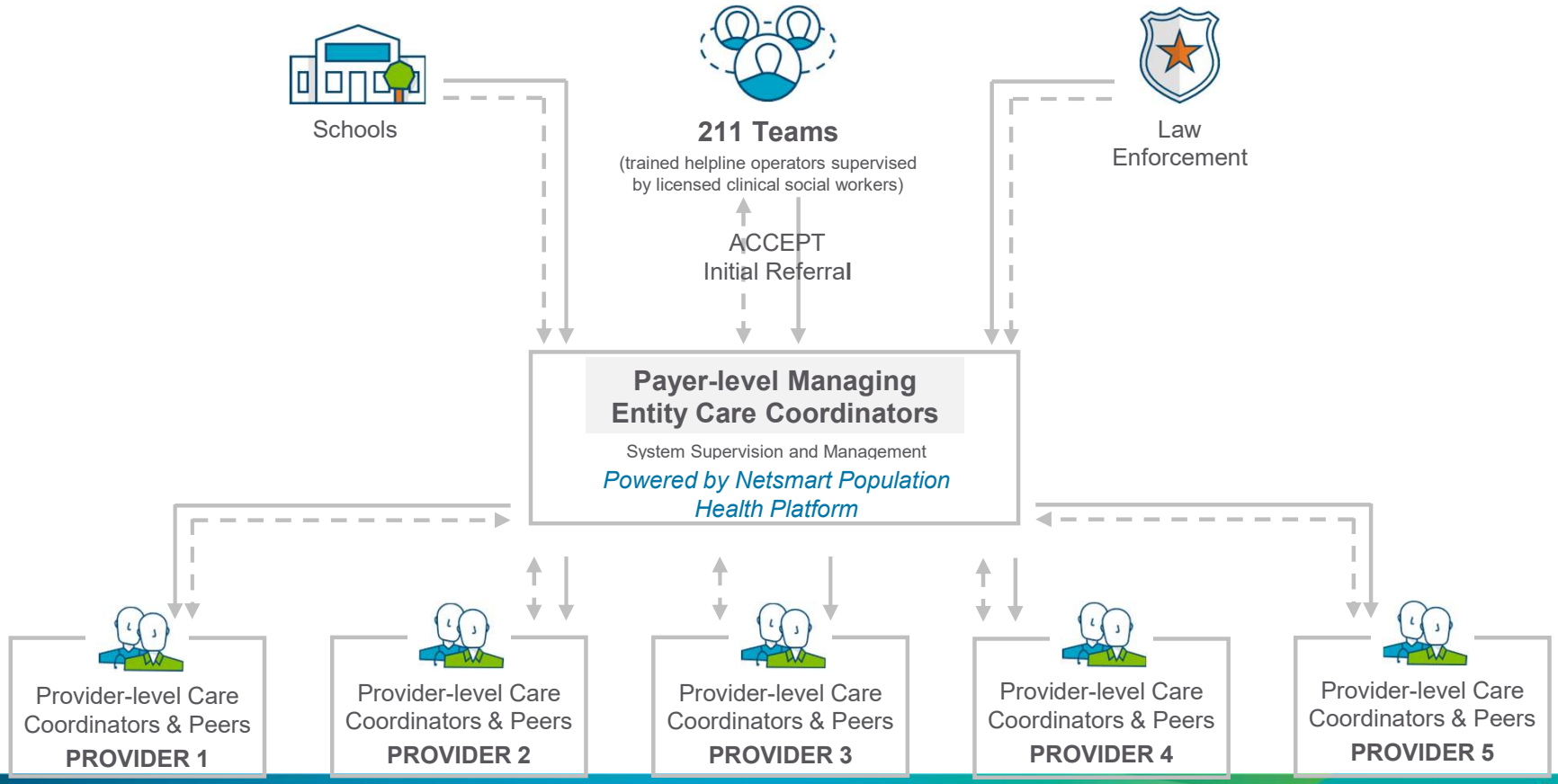
Medical

Long-term Supports

Case Management

Education and Training

Thriving Mind Care Coordination Collaboration: Payer and Provider Data Sharing



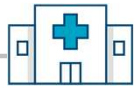
Population Health Management Platform

Statewide crisis management in Missouri

Care Manager View

- Crisis follow up at a population and individual view
- Data driven workflows and task management
- Alerts and reminders
- Medicaid claims, including prescription fills
- Risk profile

Robust EHR Data
33 CMHCs
11 EHR vendors



ER and Hospital
Alerts

Population Health Platform

- Care coordination
- Analytics
- State and provider CCBHC measures
- Standardized dataset

200k+
providers in referral network

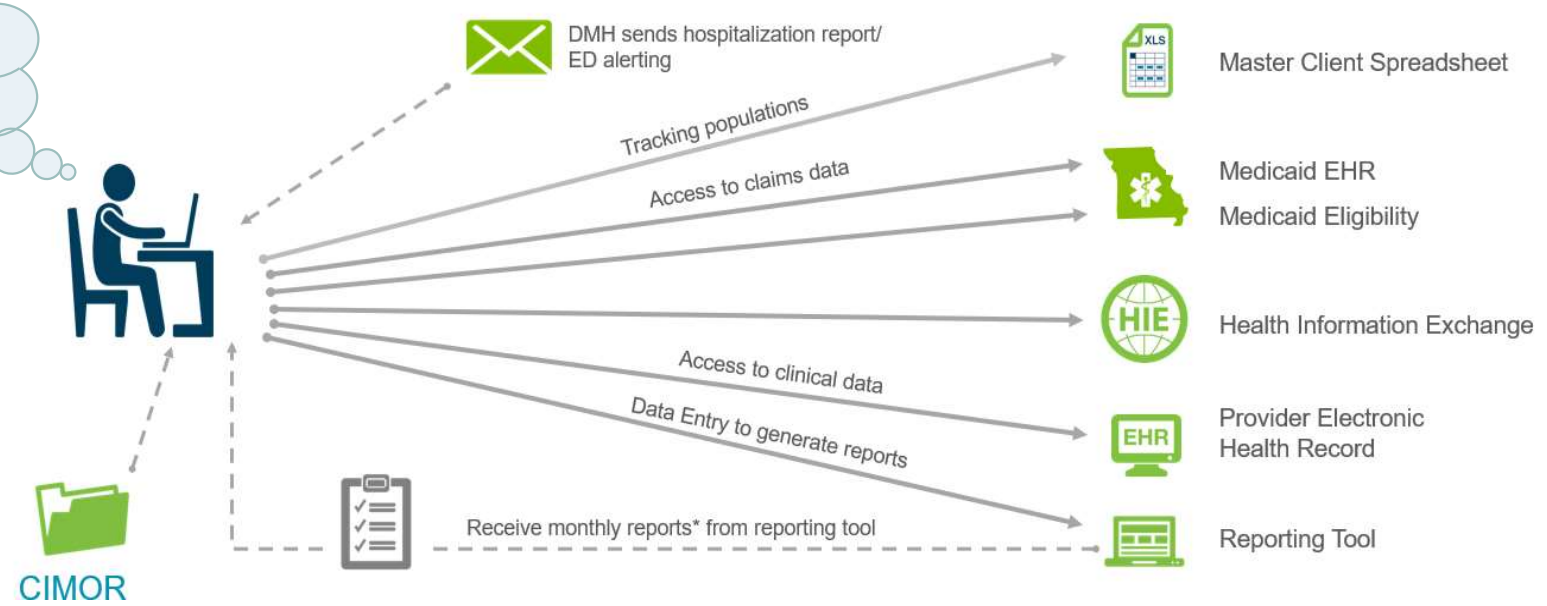
45M+
Medicaid claims

Crisis Management
Netsmart + Bamboo OpenBeds

Medicaid
Claims

Evaluation of the workflow to gather information.
Conclusion: It's a hot mess – we need a one stop shop.

How can we eliminate the silos and integrate our data?



"Case Managers spend roughly 40% of their time searching for patient data"[1]

[1] Population Health Management: A Roadmap for Provider-Based Automation in a New Era of Healthcare, Institute for Health Technology Transformation, Casey Alida et al.

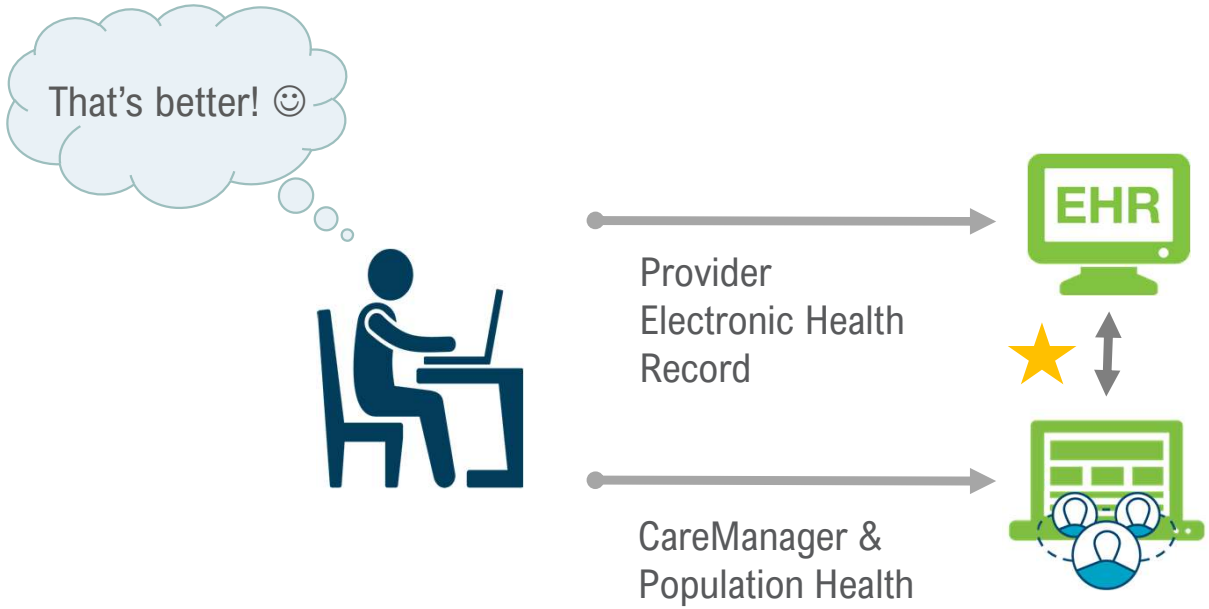
Data Needs Assessment | "Shopping List"

One Stop Shop | Aggregate and display meaningful data in one system for behavioral health providers to inform their day

(claims data, hospital and ER notifications, clinical data, assessment scores, demographics)

- Access to data in **near real-time** (daily)
- Eliminate double entry of clinical data - **interoperability with EHRs**
- **Custom reporting** from the aggregate data set at the state and provider level
- Automated **risk stratification** methodology
- Display data in a meaningful way to enable **population health** in team workflows

The new and improved workflow with integrated data that is near real-time and actionable.



Front Line Operations
Care Management/Coordination View

Quality Measures and Reporting
Population Health Data View

State Outcomes
Analytics and Compliance View

- Daily **alerts** of hospital and ER encounters
- Access to claims data + Medicaid eligibility
- **Assess** populations for risk
- **Monitor** health outcomes
- **Manage** interventions to address gaps in care
- DIY Reports
- State Reporting Requirements

Predicting Hospitalization Case Study

Behavior Health Client

- Use EHR and Claims to develop machine learning model that predicts Hospitalization Risk Score for each patient
- Variety of data from demographics, geographic, medications, labs, vitals, Dx, clinical history
- Achieved 80% accuracy in-line with industry studies
- Predict 1-year and 3-year risk score for each patient
- Develop composite index on data features to identify multi-factor risk drivers

Missouri's Impact Report | Year 5

Improving Outcomes & Access to Care

Law Enforcement Collaboration

"Many communities continue to face pervasive gaps in mental health services, especially crisis services, placing a heavy burden on law enforcement agencies and, in particular, officers. Without access to appropriate alternatives, officers are often left with a set of poor choices: leave people in potentially harmful situations, bring them to hospital emergency departments, or arrest them.

Publication from Bureau of Justice Assistance & Council of State Governments Justice Center, April 2019

22,438

Total referrals from law enforcement in one year

July2021-June2022

41%

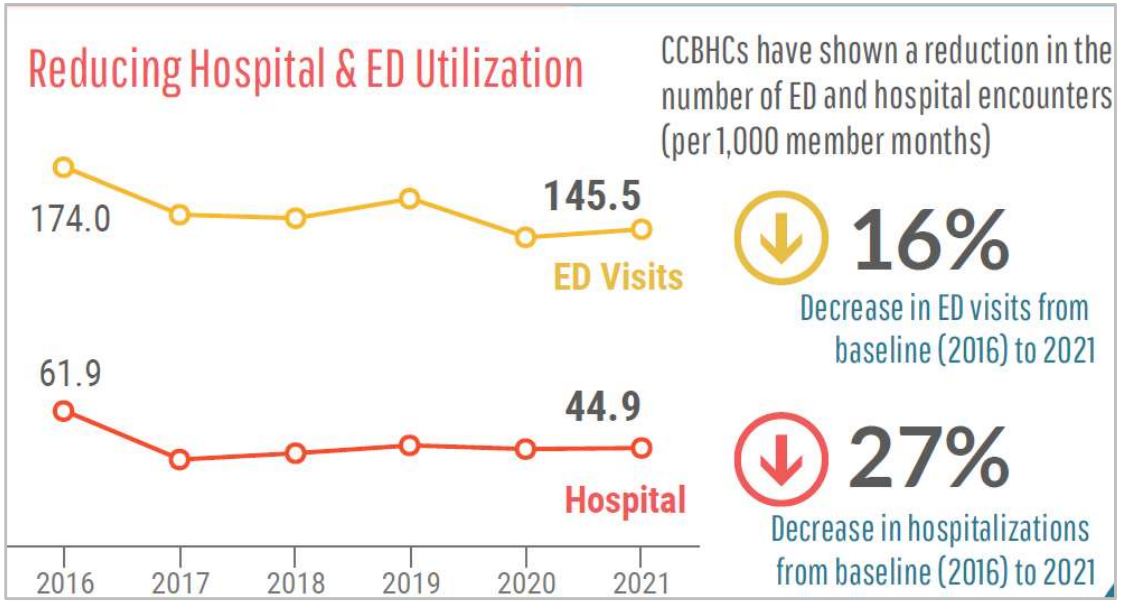
Increase in number of referrals from the previous year

Missouri's Impact Report | Year 5

Improving Outcomes & Access to Care

Reducing Hospital & ED Utilization

CCBHCs have shown a reduction in the number of ED and hospital encounters (per 1,000 member months)



16%
Decrease in ED visits from baseline (2016) to 2021

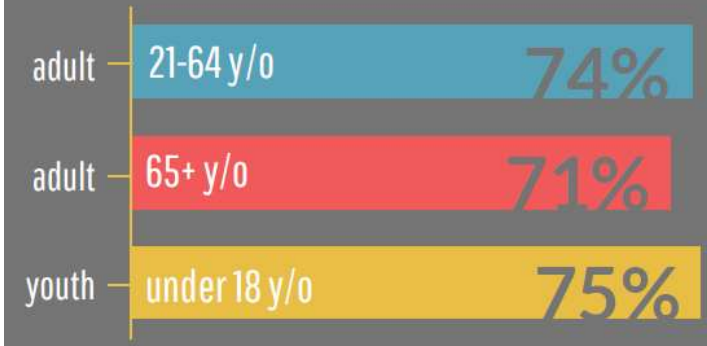
27%
Decrease in hospitalizations from baseline (2016) to 2021

Follow Up After Emergency Department Visit for Mental Illness in 7 & 30 Days (adults)

41% 7 days

66% 30 days

Follow Up After Hospitalization for Mental Illness in 30 Days



Netsmart

Observations when it comes to data…

Engage Stakeholders.

Build Your Team.

Project Manager, Data Analyst, Data Advisory Board

EHR Connections.

Funding Resources.

Data Governance and Data Transparency.

Market Your Outcomes.

Keep Thinking Ahead.

(e.g. hot spot areas for mobile clinics, social factors of health, future programs)

Results You Can Count On

CareManager: Strong ROI Delivered in Three Key Value Areas

OPTIMIZE REVENUE

1%
INCREASE in revenue due to new referrals and/or added grant funding

IMPROVE QUALITY OF CARE

10%
REDUCTION in annual costs of care for value-based contracts

5%
REDUCTION in annual costs of care for high-cost/high-risk populations

80%
LESS time on double entry of clinical data

20%
REDUCTION in ED visits and re-admissions

INCREASE OPERATIONAL EFFICIENCIES

40%
REDUCTION in time spent coordinating treatment across partner providers

40%
REDUCTION in time spent on reporting and analytics

50%
REDUCTION in time spent on case load management

All statistics collected by third-party research firm:

HOBSON & COMPANY

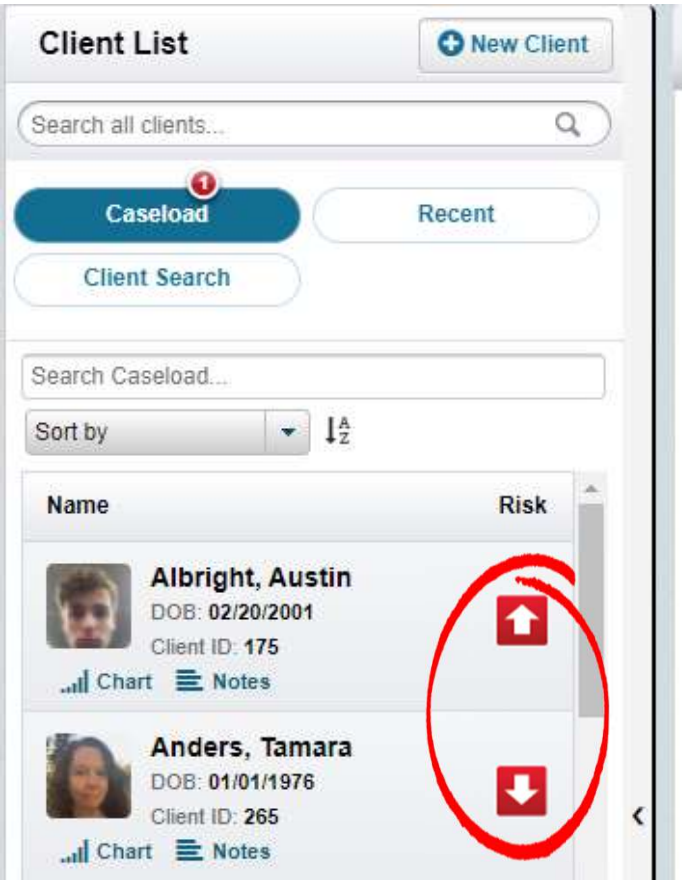
Making a Difference

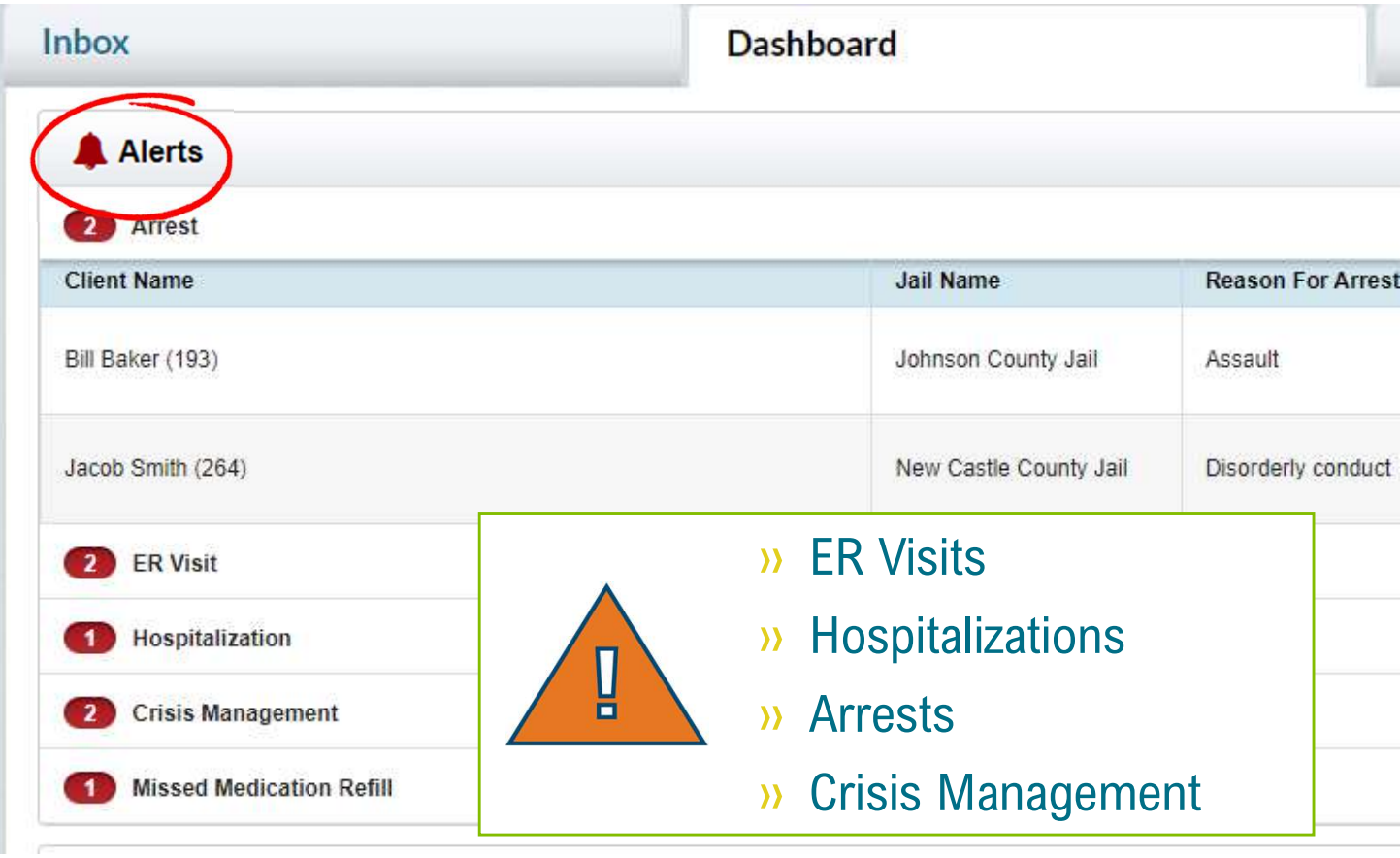
#1 Human Services

technology platform
for 6 consecutive years

CareManager

DEMO PATIENT DATA ONLY



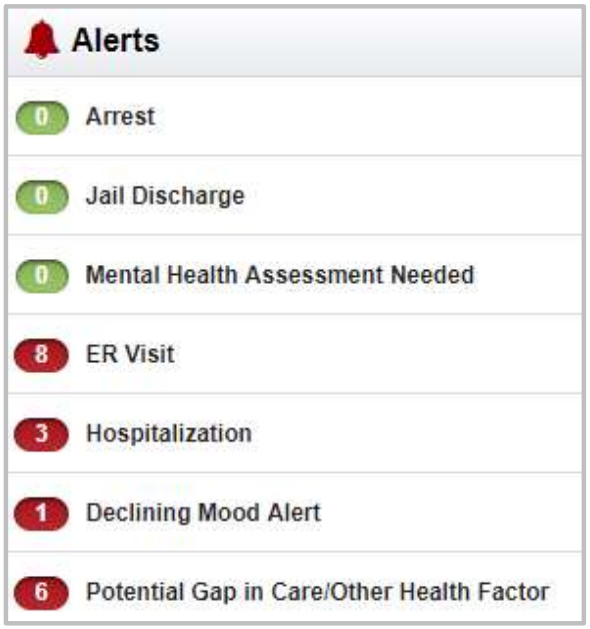


- ER Visits
- Hospitalizations
- Arrests
- Crisis Management

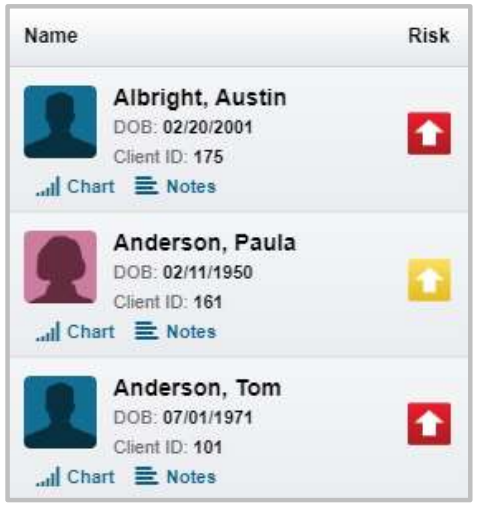
Population-Based Care Management

Gaps in care monitoring at the individual level

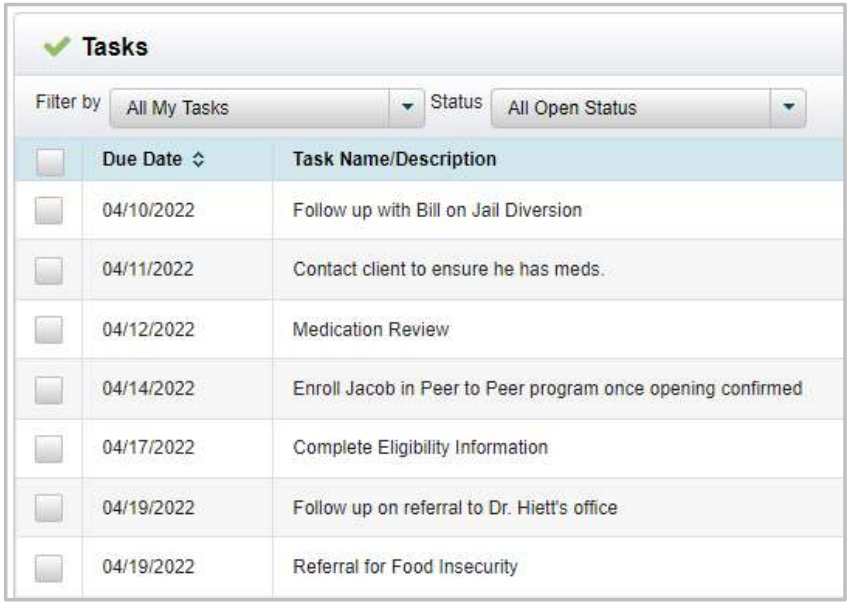
Real-time alerting



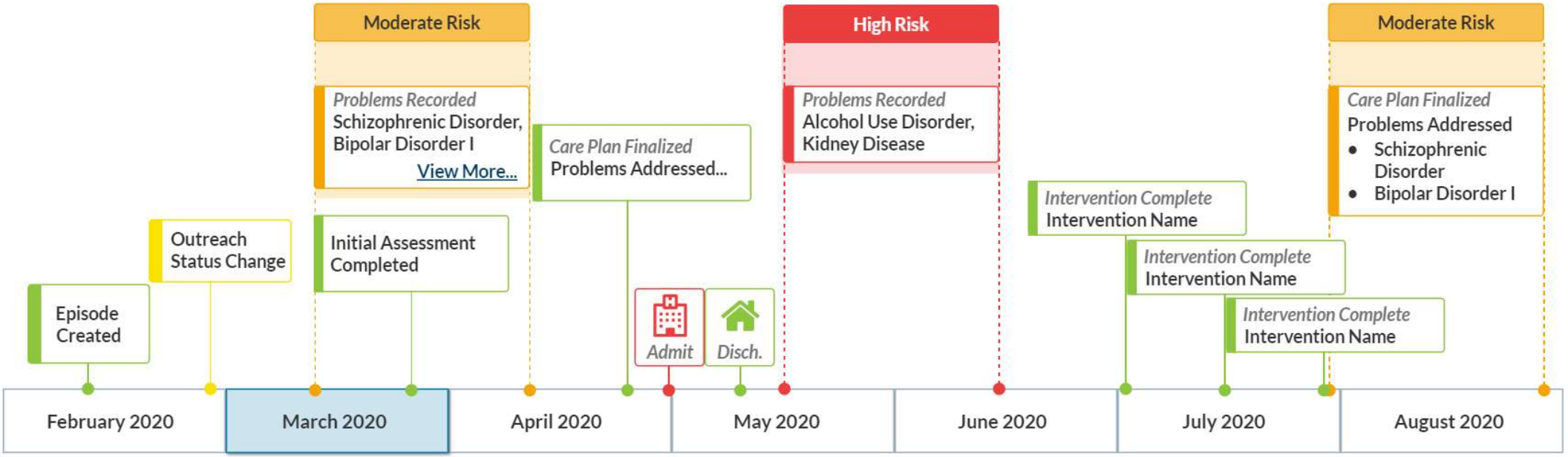
Risk stratification and caseload management



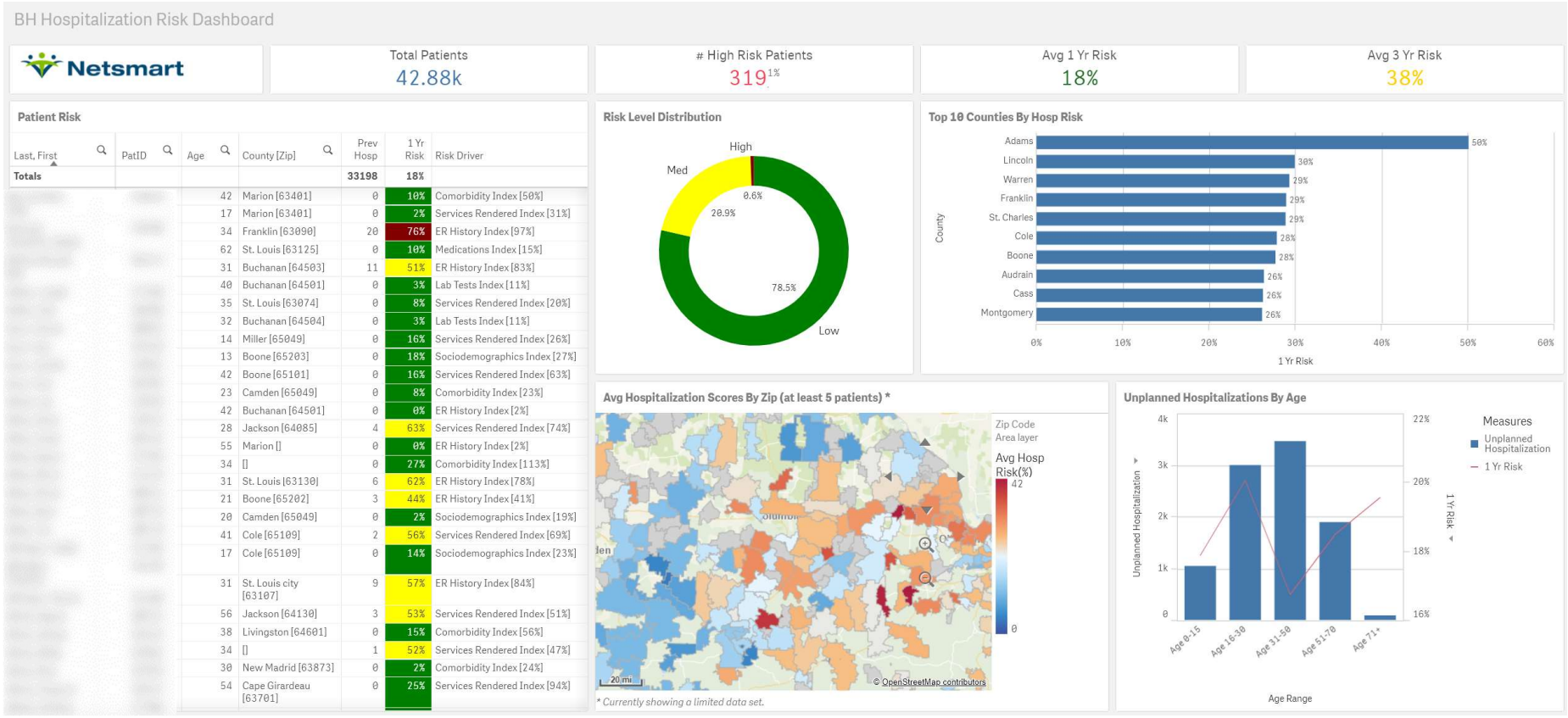
Task management



Longitudinal View Across Care Continuum



Behavior Health Hospital Risk Dashboard



Q+A

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