Health Care
Innovation Initiative

Tennessee Health Care Innovation Initiative

"It's my hope that we can provide quality health care for more Tennesseans while transforming the relationship among health care users, providers and payers. If Tennessee can do that, we all win."

– Governor Haslam's address to a joint session of the state Legislature, March 2013

We are **deeply committed** to reforming the way that we pay for healthcare in Tennessee

Our goal is to **pay for outcomes and for quality care**, and to reward strongly performing physicians

We plan to have value-based payment account for the **majority of healthcare spend** within the next three to five years

By **aligning on common approaches** we will see greater impact and ease the transition for providers

We appreciate that hospitals, medical providers, and payers have all demonstrated a **sincere willingness** to move toward payment reform

By working together, we can make significant progress toward **sustainable medical costs and improving care**

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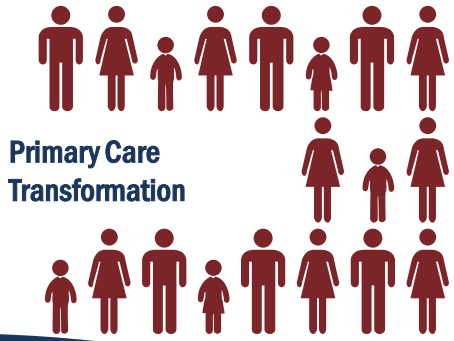
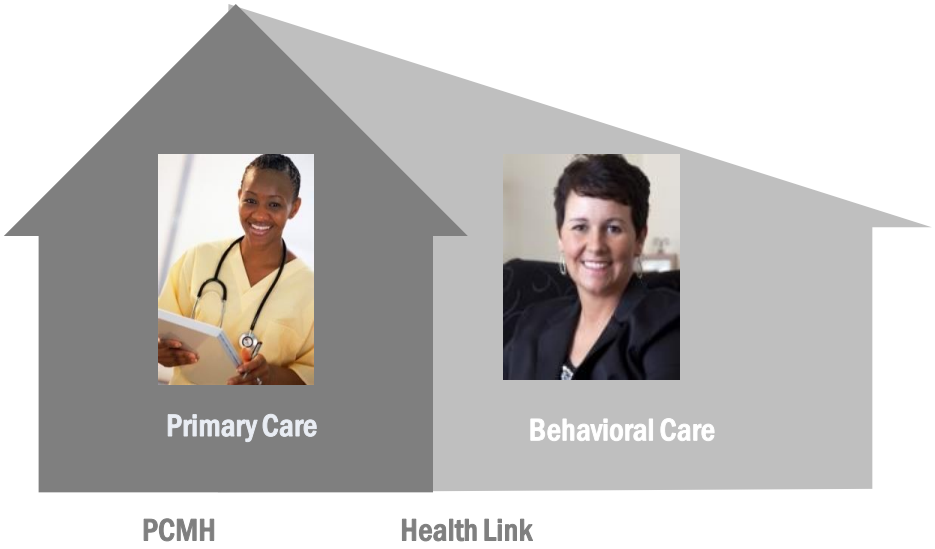
Tennessee's Three Strategies

	Source of value	Strategy elements	Examples
 Primary Care Transformation	• Maintaining a person's health overtime • Coordinating care by specialists • Avoiding episode events when appropriate	• Patient Centered Medical Homes • Tennessee Health Link for people with serious and persistent mental illness • Care coordination tool with Hospital and ED admission provider alerts	• Encouraging primary prevention for healthy consumers and coordinated care for the chronically ill • Coordinating primary and behavioral health for people with SPMI
 Episodes of Care	• Achieving a specific patient objective, including associated upstream and downstream cost and quality	• Retrospective Episodes of Care	• Wave 1: Perinatal, joint replacement, asthma exacerbation • Wave 2: COPD, colonoscopy, cholecystectomy, PCI • 75 episodes by 2019
 Long Term Services and Supports	• Provide long-term services and supports (LTSS) that are high quality in the areas that matter most to recipients	• Quality and acuity adjusted payments for LTSS services • Value-based purchasing for enhanced respiratory care • Workforce development	• Aligning payment with value and quality for nursing facilities (NFs) and home and community based care (HCBS) • Training for providers

Primary Care Transformation: Strategy

Most medical costs occur outside of the office of a primary care physician (PCP), but PCPs can guide many decisions that impact those broader costs, improving cost efficiency and care quality.

Patient Centered Medical Homes focus on prevention and management of chronic disease, seek to increase coordinated and integrated care across multidisciplinary provider teams, and improved wellness and preventive care. Tennessee Health Link will further incorporate behavioral care for TennCare members with severe and persistent mental illness.



- Primary care providers are responsible for proactively managing their attributed patient's health care.
- Rewards for reduced avoidable ED visits and hospitalizations, more coordinated care, and improved quality of care.
- Training and technical assistance supports to providers.
- Regular reports to providers on the quality and efficiency of the care their attributed patients receive.
- Primary care providers are alerted when their attributed patients are admitted, discharged, or transferred to the hospital or emergency department.

Objectives of PCMH and Health Link are to improve patient outcomes through increased coordination

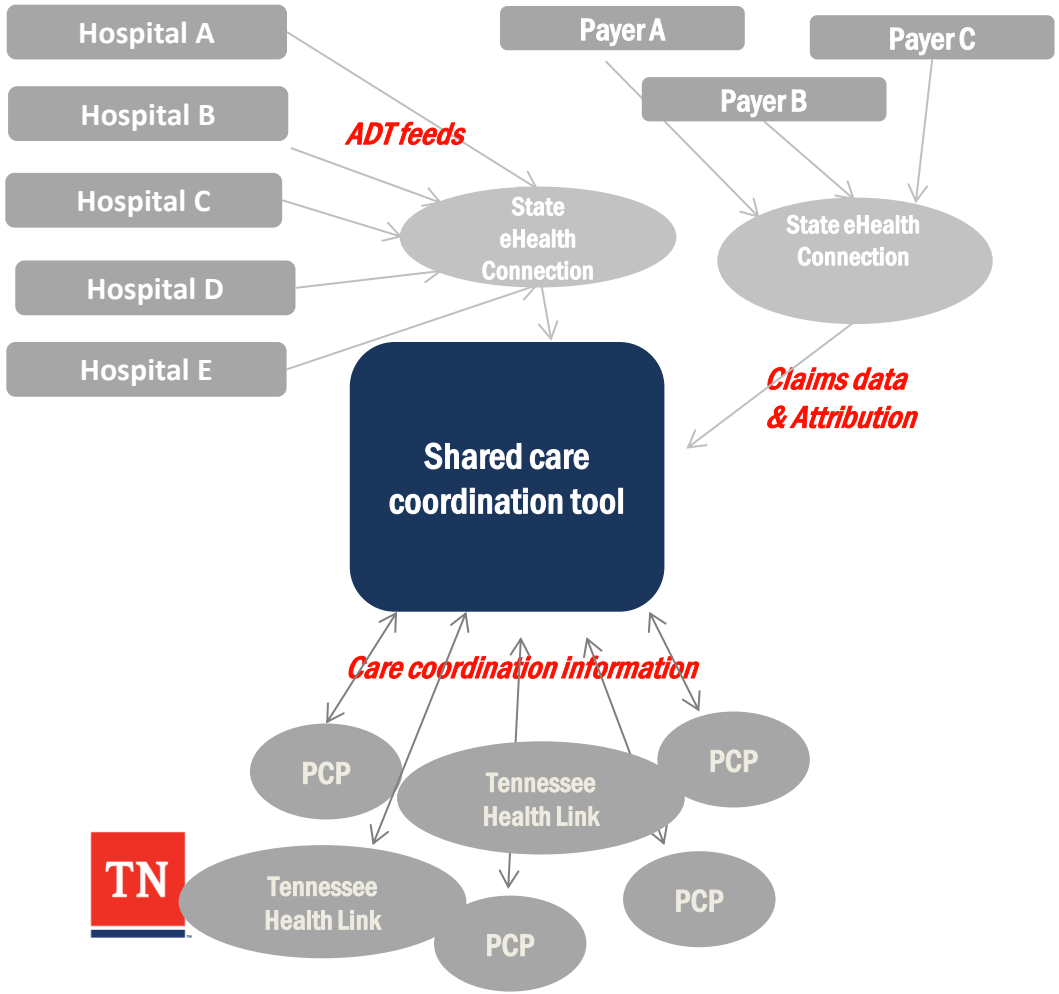
	PCMH: Holistic approach to care coordination for all patients	**Health Link:** Coordinated approach for highest-needs behavioral health members
Access	▪ Ensure access to the **full spectrum of needed care for all patients**[1], including those with long-term services and supports needs	▪ Ensure access to a **range of behavioral-health related supports** aligned with level of need
Joint decision making	▪ Foster joint decision making across the **continuum of care providers**	▪ Foster joint decision making across **behavioral and other health providers**
Mindsets	▪ Instill awareness of **quality, cost, and patient access** across range of providers	▪ Instill awareness of **interaction of behavioral and physical health needs** including quality and cost impact
Sources of value	▪ **Expected sources of value** to include – Appropriateness of care setting[2] – Appropriateness of treatment[3] – Improved patient treatment compliance – Referrals to high-value providers – Reduced readmissions	▪ **Expected sources of value** to include – Appropriateness of behavioral health care setting / forms of delivery – Choice of behavioral healthcare providers – Referrals to high-value providers – Medication management

Primary care transformation aims to enhance coordination and integration across behavioral and physical health

1 E.g., Extended office hours, open scheduling
2 E.g., Reduction in unnecessary ED visits and inpatient admissions; shift to lower cost facilities
3 E.g., Improved medical management, appropriate length of stay, effective resource utilization

Primary Care Transformation: CCT

A multi-payer shared care coordination tool will allow primary care providers to implement better care coordination in their offices.



- Notifies providers if any of their attributed patients have had hospital or ED admissions, discharges, and transfers (ADTs)
- Identifies patients risk scores
- Generates, displays, and records closure of gaps-in-care
- Pilot starting June 2016

Primary Care Transformation: Overall Timeline

Tennessee's timeline for PCMH and Tennessee Health Link rollout:

2016	2017	2018
• June - August: Pilot of Care Coordination Tool • September: Provider training and technical assistance begins • October: Launch Tennessee Health Link statewide for TennCare members with acute Behavioral Health needs	• Jan: Launch PCMH Wave 1 practices • Provider training and technical assistance ongoing	• Jan: Expand PCMH to Wave 2 practices • Provider training and technical assistance ongoing

Tennessee's goal is to enroll 65% of TennCare members in a PCMH practice by 2020

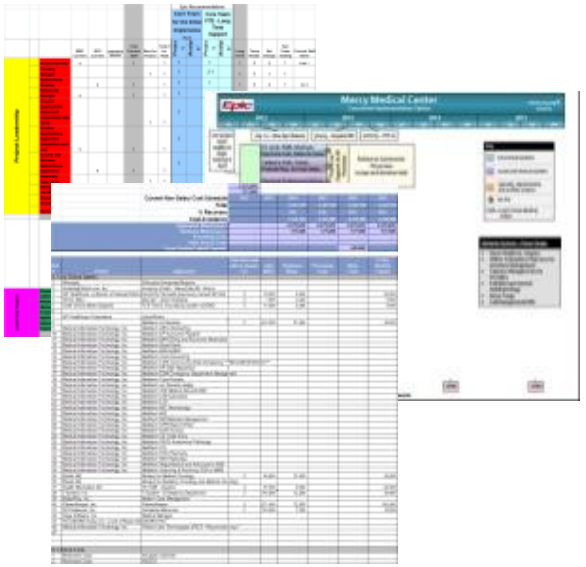

TN
Division of
Health Care
Finance & Administration
eHealth

eHealth Connection to Support the Care Coordination Tool

- The eHealth Connection supports the strategies of Tennessee's Health Care Innovation Initiative.
- The eHealth Connection will connects hospital Admission, Discharge, and Transfer (ADT) data to the care coordination tool.
- Our goal is to connect 140 hospitals around the state.

How the eHealth Connection works

- Supports HCFA patient applications providing baseline data for encounters
- Real time submission of data
- Data received is validated for Medicaid eligibility, only validated information is stored, non validated information is deleted
- Providers see only their patients' information
- ANSI HL7 versions 2.3.1 or 2.5.1
- Web service protocol



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