Tennessee
Health Care Innovation Initiative

Provider Stakeholder Group Meeting

June 18, 2014

Agenda

SIM testing grant application

Episodes of care timeline

Primary care transformation

Update on Tennessee's SIM testing grant application

- Key dates:
  - Application: Due July 21, 2014
  - Notice of award: October 31, 2014
  - Testing period: January 1, 2015 – December 31, 2018
- Funding is available for up to 12 testing grants ranging from $20-100 million per state, based on size of the state and scope of the proposal. There will also be funding for up to 15 model design grants.
- The grant requires letters of support from stakeholders, including letters from each member of the payer coalition. The letters should attest to stakeholders' active engagement in the model and must contain specific information about how the stakeholders will contribute to the SIM process. We will be following up directly with provider stakeholder group members about a letter of support for the SIM application
- Tennessee's grant application will include the following:
  - Plan to Improve Population Health
  - Primary Care Transformation
  - Episodes of care
  - Long-term services and supports

Update on Tennessee's SIM testing grant application

	Existing Commitment to Payment and Delivery System Reform	Enhancements the SIM grant will support
Overall	▪ State of TN, payers, providers, employers, and the federal government are committed to moving from volume-based care to value based care.	▪ SIM funding will allow greater collaboration, alignment, and stakeholder input.
Episodes of care	▪ The state is committed to multi-payer (including commercial) episodes of care, including additional 41 episodes in waves every six months.	▪ SIM funding will provide support for making changes to episodes over time based on provider feedback and for the design and implementation of an additional 30 episodes.
Primary Care Transformation	▪ TennCare PCMH	▪ Multi-payer (including commercial) PCMH test in selected sites ▪ Health Homes
Long-term services and support	▪ The state is committed to aligning payment with value/quality for Nursing Facility services, Home and Community Based services, and for members receiving enhanced respiratory care.	▪ SIM funding will enhance mechanisms for collecting data on member experience of care.

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New episodes consulting services

- McKinsey was awarded the new episode of care consulting contract. The new five year contract will begin July 1, 2014.
- With SIM funding, McKinsey will design 71 episodes over the next five year; without funding, 41 episodes will be designed.
  - Though the next round of SIM funding will not be awarded until Fall 2014, we are moving forward with designing 4 new episodes in fall of 2014.

	2013	2014		2015		2016		2017		2018		2019
Design deadline	Previously designed	Q1-Q2	Q3-Q4	Q1-Q2	Q3-Q4	Q1-Q2	Q3-Q4	Q1-Q2	Q3-Q4	Q1-Q2	Q3-Q4	Q1-Q2
Number of Episodes (with SIM)	4	0	4	6	6	7	8	8	8	8	8	8
Number of Episodes (Without SIM)	4	0	3	3	3	3	4	5	5	5	5	5

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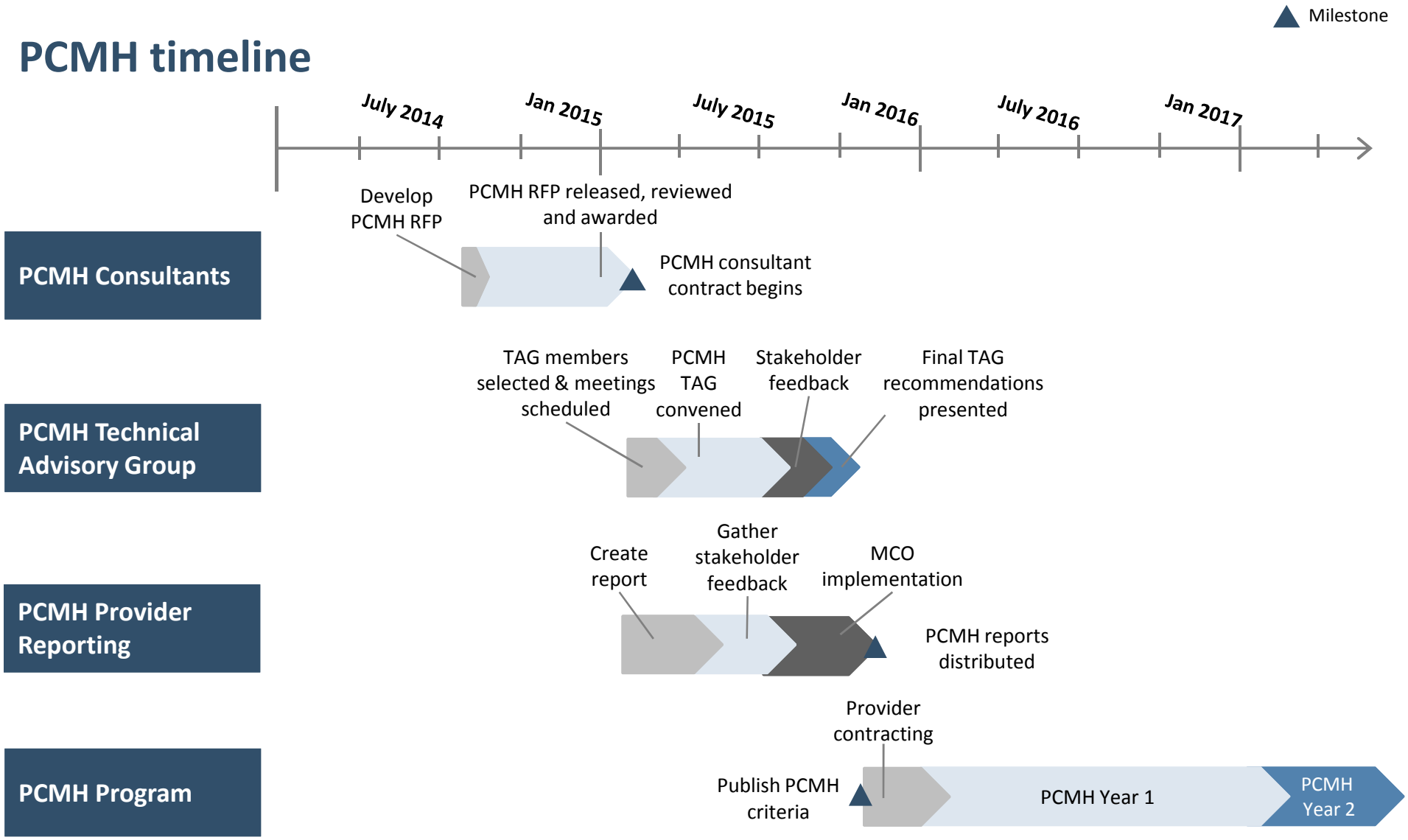
Primary care transformation

- Patient centered medical home
- Health homes

Goals of TennCare's PCMH program

- Reduced non-emergency ED use
- Reduced preventable hospitalizations
- Reduced readmissions
- Increased adherence to preventive care
- Increased pharmacy adherence
- Reduced duplication
- Improved health and patient experience

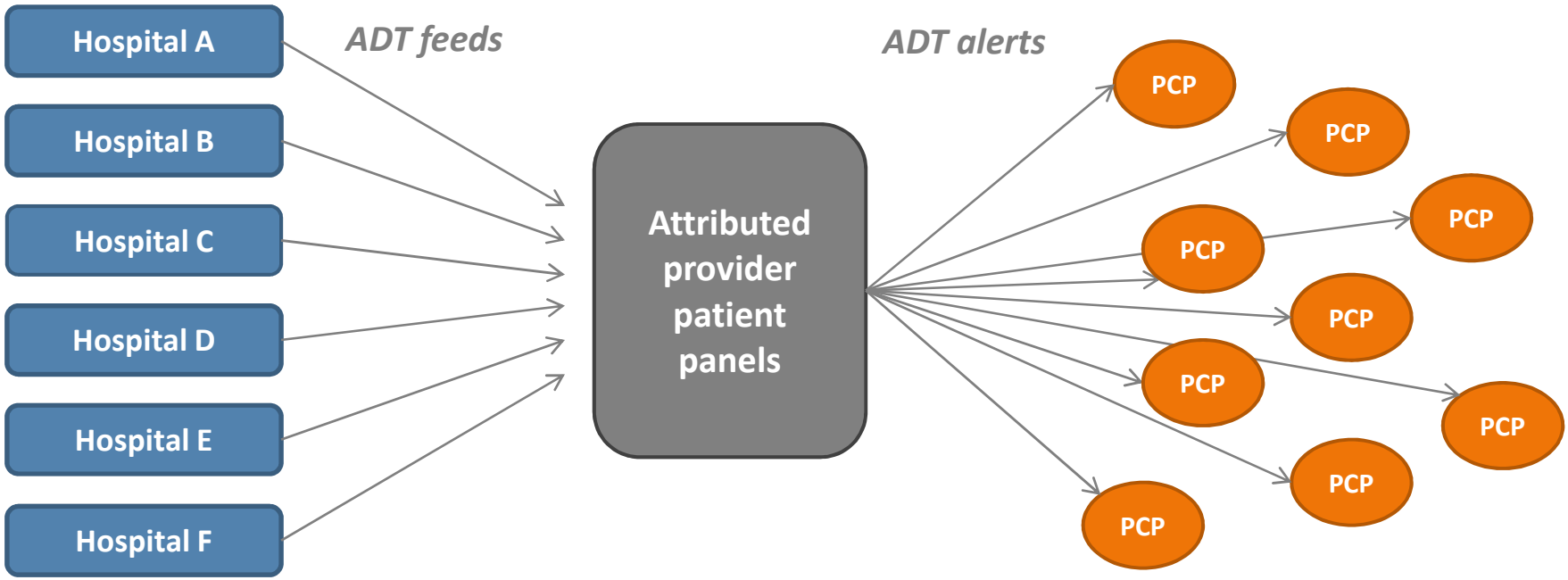
PCMH timeline



New MCO requirements to support primary care

Under the TennCare 2015 MCO contract, each MCO will be required to:

- Attribute all TennCare members to a primary care provider
- Provide Admission, Discharge and Transfer (ADT) data feeds to primary care providers



The initiative is looking at what additional alerts providers could receive, such as gaps in care, patient risk scores, and prescription fills.

Elements of the PCMH design

- Requirements of PCMHs
- Training and coaching
- Measure alignment on measures of quality and utilization (process and outcomes)
- Menu of options for payment
- Monthly or quarterly reporting
- Real time or daily information

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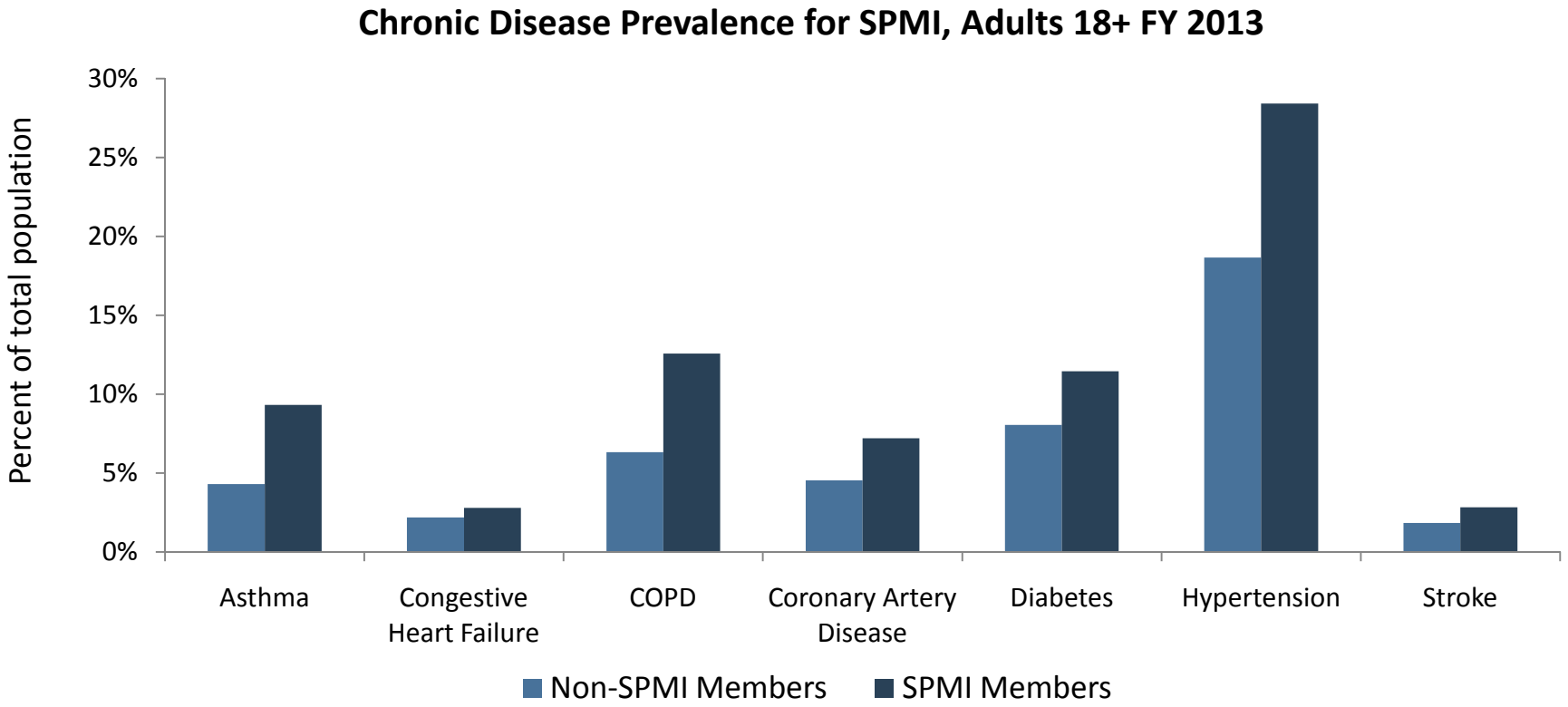
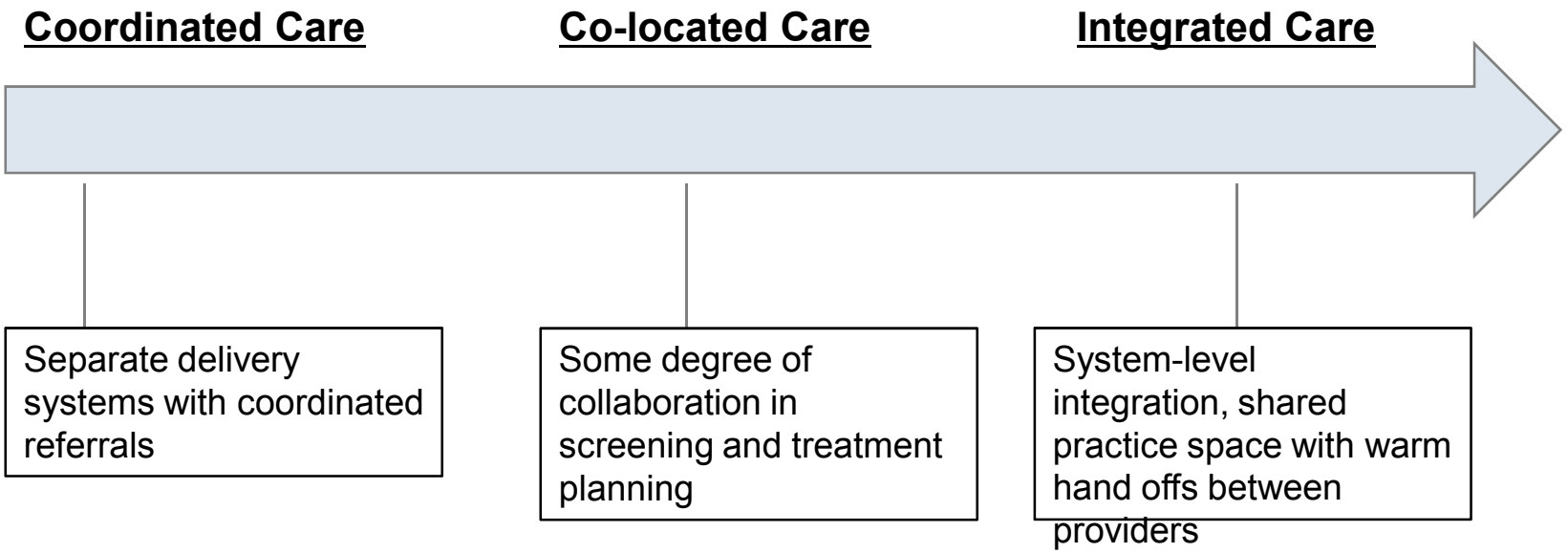
Chronic disease prevalence for SPMI

- TennCare's SPMI members have higher rates of asthma, congestive heart failure, COPD, coronary artery disease, diabetes, hypertension, and stroke as compared to non-SPMI TennCare members
- These members also have over twice as many Emergency Department visits (1,936 visits per 1,000) as compared to other TennCare members (891 visits per 1,000).



Continuum of Physical and Behavioral Health Care Integration

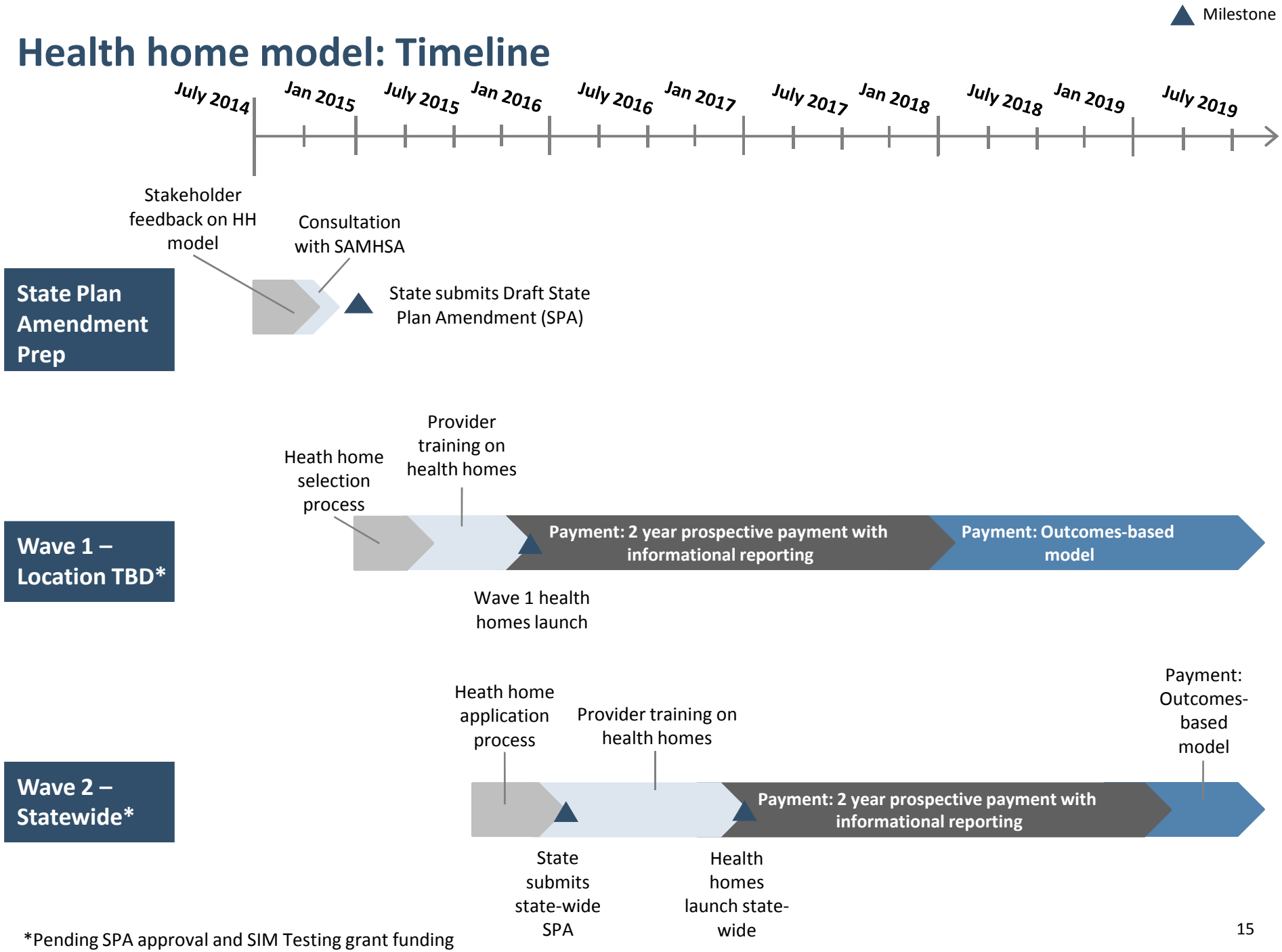
- Approaches to care fall along a continuum of collaboration/integration.
- Options range from coordinated care, where referrals for services are made to nearby providers based on screenings; co-location of mental health providers and PCPs; to full integration, where one provider group has the capacity to address both physical and mental health needs of a member.



Health home model

- As defined by CMS, a Health Home must provide six specific services beyond the clinical services offered by a typical primary care provider.
  - Comprehensive care management
  - Care coordination
  - Health promotion
  - Comprehensive transitional care
  - Individual and family support services
  - Referral to community and support services
- States can stagger roll out of Health Homes to different geographies and different target populations (chronic conditions vs. SPMI). Health Home services can not duplicate services a provider is already being reimbursed for and must be available to everyone in the defined population, in the designated geography, on day one of implementation.
- Federal Health Home funding allows for two years of enhanced payment to providers for each Health Home enrollee.

Health home model: Timeline



*Pending SPA approval and SIM Testing grant funding

Health home model: Evaluation measures

- ***CMS Health Home Core Quality Measures****
  - Adult Body Mass Index assessment
  - Ambulatory care sensitive condition admission
  - Care Transition- transition record transmitted to healthcare professional
  - Follow-up after hospitalization for mental illness
  - All cause readmission
  - Screening for clinical depression and follow-up plan
  - Initiation and engagement of alcohol and other drug dependence treatment
  - Controlling high blood pressure
- ***Health Home Outcome Measures***
  - Avoidable Emergency Department utilization
  - Avoidable in-patient admission and readmission rates

*Numerator is the number of patients receiving the care and the denominator is the number of patients eligible for the care.

Appendix

- Sources of value for PCMH

PCMH: Sources of value

Access during office hours

Problem

- Patient has a non-emergent health condition for which they are seeking care. Patient goes to the ED because it is convenient, but is unaware of who their PCP is, or the PCP is unable to see the patient.

PCMH theory of change

- The PCMH monitors ED visit utilization (with support from the MCO) and does active outreach and education to high utilizers on services available within the PCMH.
- The PCMH is engaged in active outreach to their patient panel to notify patients on how to access care through the PCMH.
- The PCMH offers clinical advice to the patient through one of the following processes:
  - A member of the care team provides clinical advice via telephone or secure electronic messaging, or
  - The PCMH has open office hours/open scheduling for walk-in appointments.

Sources of value

- Reduced visits to the ED to treat non-emergent conditions.
- Improved patient experience and continuity of care.

Access after office hours

Problem

- Patient visits the ED for non-emergent health care needs because primary care services are not available after hours or on weekends.

PCMH theory of change

- The PCMH provides after hours access to care and clinical advice through one of the following:
  - The PCMH offers extended weekend and nighttime hours to meet the needs of patients;
  - The PCMH develops a relationship with urgent care facility to provide after hours care to their patient panel; or
  - The PCMH offers telephonic or other remote access to patients for clinical advice from members of the care team (i.e. nurses, on-call physician, mid-level providers).
- PCMH documents all care received after hours and incorporates treatment and medication into the patient's care plan.

Sources of value

- Reduced visits to the ED to treat non-emergent conditions.
- Improved patient experience and continuity of care.

PCMH: Sources of value

Comprehensive health assessment and population management

Problem

- The PCP does not have sufficient information on the patient panel to effectively manage the health of the population.
- The PCP is unable to identify high risk patients and/or high cost patients to effectively manage their health.

PCMH theory of change

- The PCMH conducts comprehensive health assessments for all panel members seen by the practice.
- The PCMH uses the comprehensive health assessment to identify preventive care needs of all patients.
- The MCO uses comprehensive health assessments, claims data and referrals to identify high risk patients and share with the PCMH.
- Information from the comprehensive health assessment and the population management analysis informs the PCMH's workflow allocating the PCMH's attention to the needs of the patient panel.

Sources of value

- Improved well-being for high-risk patients who receive proactive outreach from the PCMH.
- Improved patient adherence to recommended preventive care.

Care management

Problem

- The patient receives duplicative and uncoordinated care across the health care system from multiple providers who do not share information on the patient's treatment, prescriptio n drug regimen, and overall health.

PCMH theory of change

- The PCMH serves as the quarterback for the overall care of the patient. The PCMH develops a individualized care plan for each patient that includes self-treatment goals and medication.
- The PCMH collects and coordinates clinical information on the services provided by other providers, including specialists, hospitals, and EDs, to incorporate into the care plan.
- The PCMH executes care based on the care plan, and updates after each PCMH visit, ED visit or inpatient admission.

Sources of value

- Reduced duplicative and unnecessary treatment as the PCMH is better informed about the treatment the patient has already received.
- Improved patient experience continuity of care.

PCMH: Sources of value

Medication management (reconciliation)

Problem

- Patient is prescribed additional medications as a result of a visit to a specialist, an inpatient stay at a hospital, or an ED visit.
- This medication either duplicates an existing medication, treats a side effect of a patient's existing medication, or has a bad interaction with the patient's exiting medication.

PCMH theory of change

- The PCMH finds out about the new medication through one of the following processes:
  - During a visit, a PCMH provider reviews the patient's med list as part of the routine updating of the patient's comprehensive health assessment and care plan;
  - The PBM/MCO sends the PCMH a polypharma list of patients with all patients that have above a certain number of prescriptions, and/or patients with prescriptions that are flagged for review as potentially problematic; or
  - The PCMH gets a notice of the new prescription for its patient from a direct feed on new prescriptions from the specialist, after-hours clinic, hospital/ED, and/or the MCO. The PCMH compares the new prescription to the patient's med list and notices the potential problem.
- The PCMH reaches out to the patient and, if necessary the prescribing physician proactively and works to change the patient's prescription.

Sources of value

- Reduced visits to the ED and readmissions to treat side effects of medication or adverse drug interactions.
- Improved patient well-being due to reduced side effects of medication or reduced adverse drug interactions.

PCMH: Sources of value

Medication management (education/adherence)

Problem	PCMH theory of change	Sources of value
– Patient is prescribed a new medication by the PCP. The patient does not understand why they have been prescribed a new drug and does not fill the prescription.	– During the office visit where a new medication is prescribed, the PCMH provides education to the patient and their family on why the medication is needed, how the medication should be taken, and potential side effects. – The MCO monitors claims data to identify patients who are not filling prescriptions. The PCMH uses this information to outreach to patients and encourage drug adherence. – The PCMH schedules a follow up call or outreaches to the patient to monitor any reactions to the new medication.	– Improved patient well-being due to improved health from increased drug adherence. – Reduced visits to the ED and inpatient admissions due to lack of adherence to prescribed drug regimen.

Support self-care process

Problem	PCMH theory of change	Sources of value
– A chronically ill patient's health continues to decline after prolonged treatment from their PCP. – The patient is non-compliant with diet and exercise recs, non-adherent on their medication, and uninformed about long-term health risks associated with their condition.	– The PCMH provides educational materials to the patient and their family about their condition. The PCMH discusses the information and identifies the patient's barriers to better health. – The PCMH, with the patient and their family, develops a self-care plan for the patient. The plan incorporates all of the actions the patient should take to improve their health and better manage their condition, including diet, exercise, drug adherence, routine visits, etc. This is incorporated into the patient's care plan and updated as needed. – The PCMH provides tools to the patient to help monitor their progress towards their self-care goals.	– Improved patient well-being by increased adherence to drugs and routine care. – Improved patient experience by engaging patients in their care and developing a personalized care plan to meet their needs.

PCMH: Sources of value

Coordinate with facilities and care transitions

Problem

- A patient is discharged from the hospital after an acute event. The discharging hospital provides the patient with either no instructions or a complex discharge instructions including new medications, follow up visits and new treatment instructions.
- The patient does not comply with the recommended follow-up routine.

PCMH theory of change

- The PCMH identifies inpatient discharges of panel members through one of the following:
  - Hospital discharge data;
  - MCO claims data; or
  - Routine outreach to high-risk patients
- The PCMH schedules a follow up visit with the patient to discuss their recent admission, or other appropriate services.
- The PCMH incorporates the admission and resulting treatment into the patient's individualized care plan and works with the patient to update, as needed.

Sources of value

- Reduced inpatient readmissions due to increased adherence to post-discharge instructions.
- Improved patient experience by creating continuity in the patient's care.