Tennessee
Payment Reform Initiative

State Innovation Model Public Roundtable Meeting

September 25, 2013

PRELIMINARY WORKING DRAFT, SUBJECT TO CHANGE

State Innovation Model Public Roundtables

Meeting Topic	Date	Time
▪ Roundtable 1: Introduction to Payment Reform	June 26, 2013	10:00 – 12:00
▪ Roundtable 2: Healthcare Workforce	July 31, 2013	1:00 – 3:00
▪ Roundtable 3: Health Information Technology	August 26, 2013	1:00 – 3:00
▪ **Roundtable 4: Population Health and Behavioral Health**	**September 25, 2013**	**1:00 – 3:00**

Last Modified 9/23/2013 6:14 PM Eastern Standard Time

Printed

Agenda for today's State Innovation Model Public Roundtable meeting

Activity	Time	Owner
▪ Why we are here / vision for Tennessee	1:00 – 1:10	Dr. Wendy Long
▪ Progress with payment reform to date	1:10 – 1:25	Dr. Wendy Long
▪ Introducing our guest speakers	1:25 – 1:30	Dr. Wendy Long
▪ Perspective on population health in Tennessee	1:30 – 1:55	Dr. John Dreyzehner
▪ Perspective on behavioral health in Tennessee	1:55 – 2:30	Ellyn Wilbur
▪ Stakeholder discussion on population health and behavioral health in Tennessee	2:30 – 3:00	All participants

Agenda for State Innovation Model Public Roundtable meeting

- **Why we are here / vision for Tennessee**
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Vision for Tennessee Healthcare

- **At the direction of Governor Haslam**, Tennessee is **changing how the State pays for health care services**
- Within 3-5 years, the initiative aims to have value- and outcomes-based models account for the majority of health care spending.
- Payment reform will **reward high-quality care** and outcomes and **encourage clinical effectiveness**
- A coalition including TennCare, State Employee Benefits Administration, and major Tennessee insurance carriers is **working together** to **align incentives** in Tennessee
- The State of Tennessee has already been **awarded a grant** from the Federal Department of Health and Human Services to support payment reform.

"I believe Tennessee can also be a model for what true health care reform looks like."

"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."

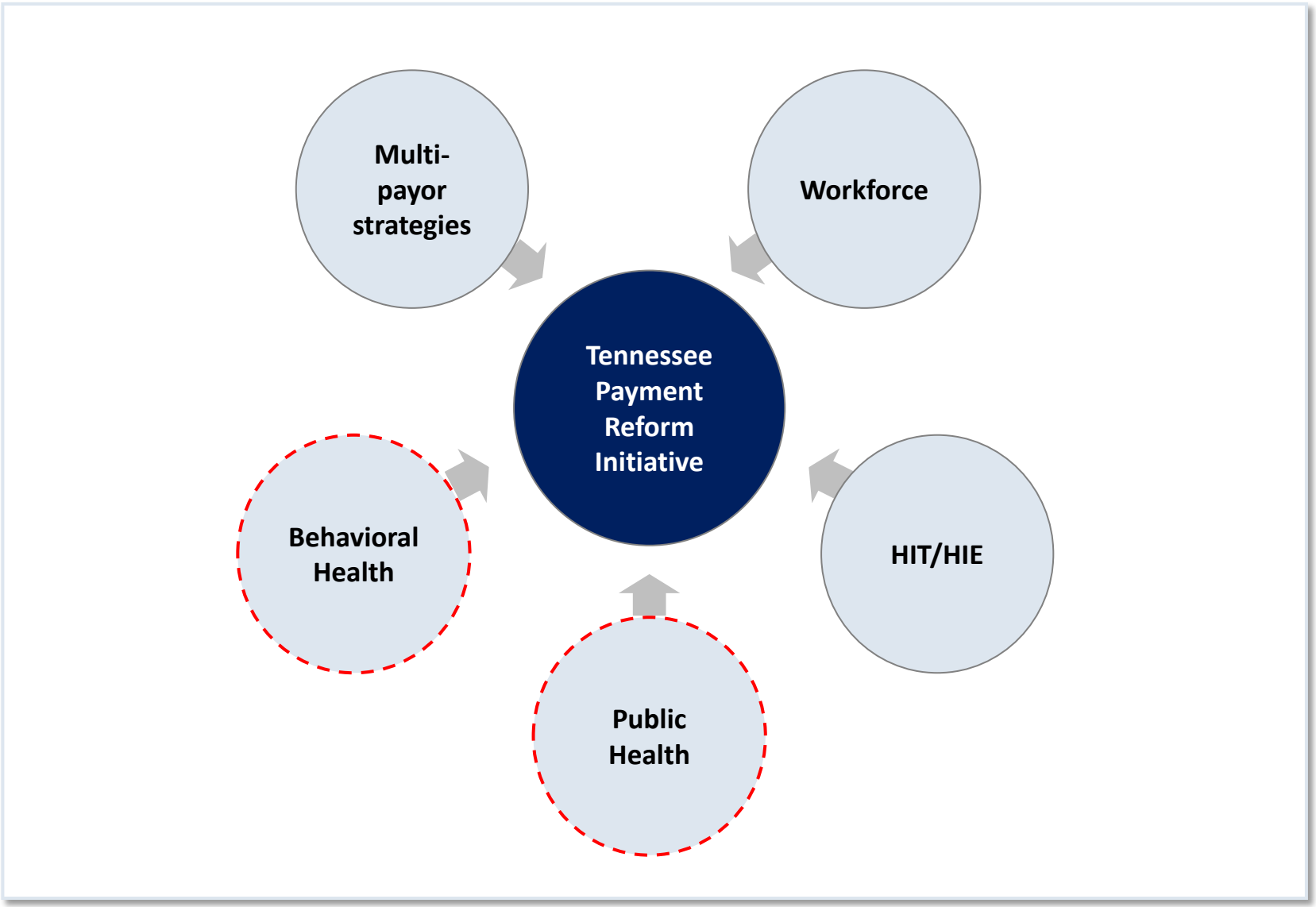
– Governor Haslam's address to a joint session of the State Legislature, March 2013

SOURCE: State of Tennessee Newsroom and Media Center

We have formed stakeholder committees that facilitate collaboration and incorporation of multiple perspectives in the overall reform initiative

Stakeholder group	A State Innovation Model Public Roundtables	B Provider Stakeholder Group	C Payment Reform Payer Coalition	D Employer Stakeholder Group	E Payment Reform Technical Advisory Groups
Stakeholders involved	Open to the public in person or by conference call: ▪ June 26, 10am-noon CT ▪ July 31, 1-3pm CT ▪ August 26, 1-3pm CT ▪ September 25, 1-3pm CT	Select providers meet regularly to advise on overall initiative implementation	State health care purchasers (TennCare, Benefits Administration) and major insurers meet regularly to advise on overall initiative implementation	Introductory webinar held on Thursday June 27 at 11am CT, and repeated on July 18 at 11 am CT Periodic engagement with employers and employer associations	Select clinicians meet to advise on each episode of care
Meeting rhythm	4 by October	Monthly	2 per month	2 by August	3-4 per episode

Multiple dimensions impact the Tennessee Payment Reform Initiative



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What actually *is* payment reform: The State's proposed payment innovation model includes "population" and "episode" based payment

	Basis of payment	TN Payment Reform Approach	Examples
Population-based	▪ Maintaining patient's health over time, coordinating care by specialists, and avoiding episode events when appropriate.	▪ Patient centered medical homes (PCMH)	▪ Encouraging primary prevention for healthy consumers and care for chronically ill, e.g., ▪ Obesity support for otherwise healthy person ▪ Management of congestive heart failure
Episode-based	▪ Achieving a specific patient objective at including all associated upstream and downstream care and cost	▪ Retrospective Episode Based Payment (REBP)	▪ Acute procedures (e.g., hip or knee replacement) ▪ Perinatal ▪ Acute outpatient care (e.g., asthma exacerbation) ▪ Most inpatient stays including post-acute care, readmissions ▪ Some behavior health ▪ Some cancers

How retrospective episodes work for patients and providers

Patients and providers deliver care as today (performance period)

1

Patients seek care and select providers as they do today

2

Providers submit claims as they do today

3

Payers reimburse for all services as they do today

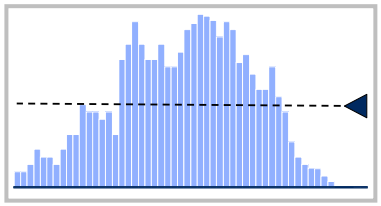
Calculate incentive payments based on outcomes after performance period (e.g. 12 months)

4

Review claims from the performance period to identify a 'Quarterback' for each episode

5

Payers calculate average cost per episode for each Quarterback[1]



Compare average costs to predetermined ''commendable' and 'acceptable' levels[2]

6

Providers will:

- Share savings: if avg. costs below commendable levels and quality targets met
- Pay part of excess cost: if avg costs are above acceptable level
- See no change in pay: if average costs are between commendable and acceptable levels

Initial episodes selected for the first wave

Episode selection driven by diversity considerations including

- Impacted population
- Therapeutic area
- Spend (TennCare and commercial)
- Quarterback (PAP)

Asthma Exacerbation

- Significant proportion of cost incurred at the hospital
- Captures pediatric patients
- Demands emergency response

Total Joint Replacement (Hip & Knee)

- Largely covered by commercial segment (vs. TennCare)
- Older patient population
- Primarily elective cases

Perinatal

- High case volume across commercial and TennCare
- Touches a large number of providers across the state

Clinical input from Tennessee providers for episode development

Each episode has a TAG of 5-7 Tennessee clinicians, plus medical representatives from each participating payer meeting 4-5 times

- **Technical Advisory Group meeting focus on:**
- **QUALITY OF CARE** -- Focus has been less about identifying economic sources of value and more about improving quality of patient care
- **FAIRNESS** -- Consensus that providers should be incentivized and not penalized for treating complex cases and should also be held accountable for inappropriate care
- **TRANSPARENCY** -- Emphasis has been on providers receiving as much information as possible on their individual performance

Episode design dimensions reviewed with technical advisors

Dimension	Description
1 Episode definition and scope of services	▪ What triggers an episode? ▪ What services / claims are included in calculating episode costs?
2 Episode exclusion criteria	▪ Are there episodes that should not be included in calculating episode costs? – Clinical exclusions – Business exclusions (e.g., not continuously enrolled)
3 Quarterback selection	▪ Who is the most appropriate quarterback (e.g., could be a facility or an individual provider)?
4 Episode adjustments	▪ How should a provider's cost be adjusted due to high-risk patients or other practice characteristics?
5 Quality metrics	▪ What quality metrics are most important to track? ▪ Should they be tracked or tied to episode-based payment?

A robust PCMH program is a natural complement to an episode-based payments program

Vision

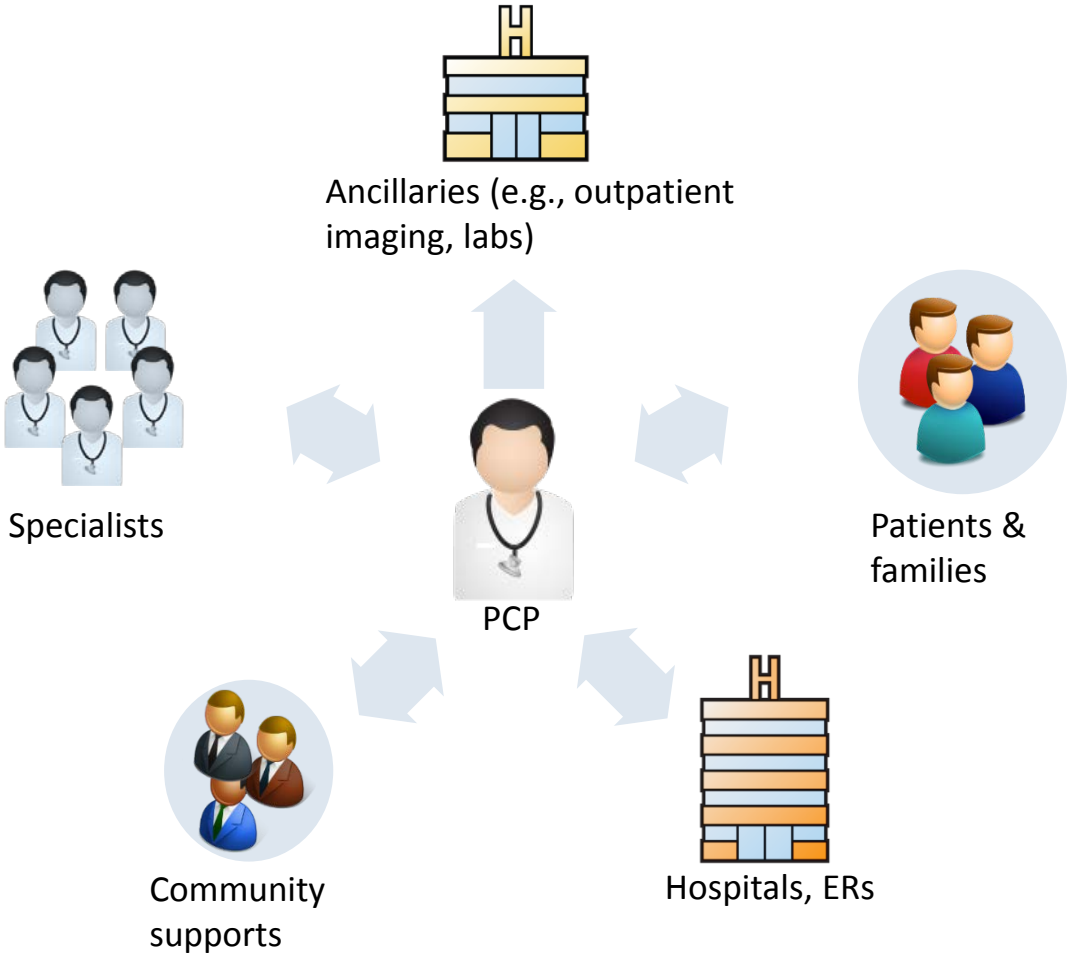
A team-based care delivery model led by a primary care provider that comprehensively manages a patient's health needs

Elements

- Providers are responsible for managing health across their patient panel
- Coordinated and integrated care across multidisciplinary provider teams
- Focus on prevention and management of chronic disease
- Expanded access
- Referrals to high-value providers (e.g., specialists)
- Improved wellness and preventative care
- Use of evidence-informed care

Why primary care and PCMH?

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



- The State is currently surveying the landscape to understand the scope of current PCMH efforts and barriers to scale
- In the coming months, Tennessee will be defining a strategy for the scale-up of PCMH programs

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Introducing our guest speakers: Dr. John Dreyzehner & Ellyn Wilbur

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Mission

Protect, promote and improve the health and prosperity of people in Tennessee

Vision

A recognized and trusted leader, partnering and engaging to make Tennessee one of the nation's 10 healthiest states

John Dreyzehner, MD, MPH

TennCare Payment Reform Initiative

September 25, 2013

TENNESSEE DEPARTMENT OF HEALTH

A Fence or an Ambulance?

TENNESSEE DEPARTMENT OF HEALTH

JOSEPH MALINS,
1844-1926

The Ambulance Down in the Valley

A poem by Joseph Malins 1895

TENNESSEE DEPARTMENT OF HEALTH

Tennessee public health nurses provide polio vaccinations 1963

State legislation created the first **Department of Public Health in 1923.**

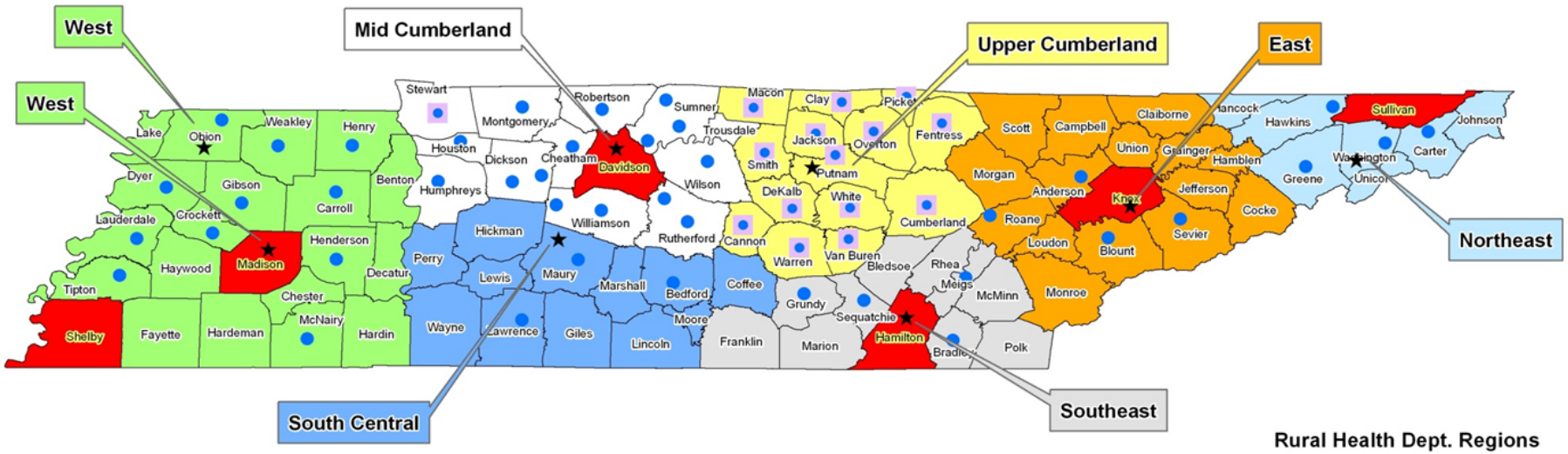
Typhoid fever vaccinations in rural South, 1930

Christiana Nurses Show off Their Crisp Uniforms

At Rutherford Co. HD, for rabies vaccine

Tennessee Department of Health

TDOH Local Health Department Sites, Rural Regional Offices, Primary Care Sites and FQHC's with Metro Health Departments



Tennessee Department of Health
Office of Policy Planning & Assessment
Surveillance, Epidemiology & Evaluation

Eugene Lindsay Bishop, MD, CPH
December 12, 1924 – February 5 1935

TABLE B

BIRTH RATES, AND DEATH RATES FROM CERTAIN CAUSES, FOR THE STATE OF TENNESSEE: 1917-1927.

	1927	1926	1925	1924	1923	1922	1921	1920	1919	1918	1917
DEATH RATES PER 1000 POPULATION:											
DEATHS - ALL CAUSES TOTAL	11.8	12.7	11.3	11.6	11.9	10.8	10.5	12.1	12.2	16.1	13.5
WHITE	10.2	11.1	9.7	9.8	10.3	9.5	9.3	10.7	10.8	14.0*	11.7*
COLORED	19.3	19.3	18.6	19.4	18.7	16.4	15.7	18.1	18.5	24.6*	20.6*
DEATH RATES PER 100,000 POPULATION:											
TYPHOID FEVER	21.2	25.0	26.2	24.1	21.4	20.6	25.6	18.5	27.5	29.9	38.3
MALARIA	6.1	6.1	6.5	7.0	9.0	12.9	12.8	8.7	10.9	13.4	20.4
SMALLPOX	0.1	0.2	0.2	0.5	0.1	0.4	0.4	0.5	0.5	0.6	0.2
MEASLES	5.5	11.0	2.0	10.5	20.8	0.7	3.0	10.7	6.9	17.1	32.0
SCARLET FEVER	1.9	1.6	1.3	1.4	1.4	1.6	1.5	2.2	1.3	1.4	1.6
WHOOPING COUGH	13.7	14.9	6.7	11.8	11.1	6.9	10.5	12.1	7.1	22.2	18.6
DIPHTHERIA	7.7	11.3	7.6	8.5	10.0	12.7	15.9	15.9	12.9	10.1	15.0
INFLUENZA	33.4	71.6	53.3	39.1	106.8	60.0	19.7	130.1	163.7	246.9	22.8
TUBERCULOSIS, ALL FORMS	133.5	146.9	136.1	146.4	151.0	147.6	135.2	158.5	163.8	197.6	191.3
TUBERCULOSIS, PULMONARY	119.0	129.4	118.5	128.0	135.3	131.3	119.3	138.9	145.5	177.9	170.6
TUBERCULOSIS, OTHER	14.4	17.5	17.6	18.4	15.8	16.2	15.9	19.6	18.3	19.7	20.6
CANCER, ALL FORMS	61.2	58.5	52.3	51.8	48.2	45.8	45.1	46.0	42.5	43.2	45.3
HEART DISEASE, ALL FORMS	120.8	122.8	111.9	111.5	100.8*	91.8*	94.5*	96.5*	93.0*	101.2*	106.6*
PNEUMONIA, ALL FORMS	88.8	111.4	87.5	106.7	106.3	101.2	84.6	108.2	88.7	160.0	125.6
DIARRHEA AND ENTERITIS, UNDER 2 YEARS	28.3	38.4	36.2	34.5	37.1	31.0	39.5	41.9	53.1	60.7	73.0
AUTOMOBILE ACCIDENTS	13.7	12.4	11.1	9.1	7.1	6.7	5.8	5.8	5.0	3.8	2.8
DEATH RATES PER 1000 LIVE BIRTHS											
INFANT MORTALITY (UNDER 1 YEAR)	72.2	79.3	75.3	78.[illegible]	79.9	72.9	71.3	86.9	89.6	96.1	95.5
MATERNAL MORTALITY	6.8	6.8	7.8	7.5	7.2	7.4	8.2	8.2	8.2	7.1	7.9
BIRTH RATES PER 1000 POPULATION											
BIRTHS TOTAL	22.0	22.7	21.7	22.3	21.9	22.2	23.1	21.7	20.4	21.6	21.9
WHITE	22.7	23.5	22.7	23.1	22.9	23.0	24.6	23.1	#	#	#
COLORED	19.0	19.4	17.3	18.0	17.2	16.7	16.6	15.7	#	#	#

A FOR THESE YEARS FROM U. C. CENSUS BUREAU: STATE TABULATIONS THS NOT TABULATED BY COLOR PRIOR TO 1920

STATE OF TENNESSEE
DEPARTMENT OF PUBLIC HEALTH

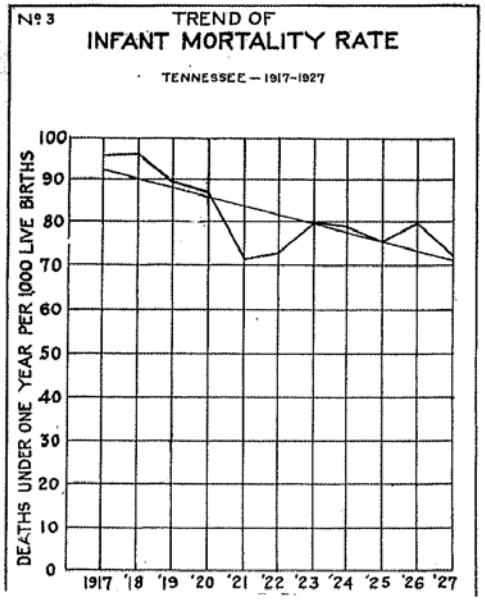
Annual Bulletin
OF
VITAL STATISTICS
FOR THE YEAR
1927

With Summary Tables
FOR THE PERIOD
1917-1927

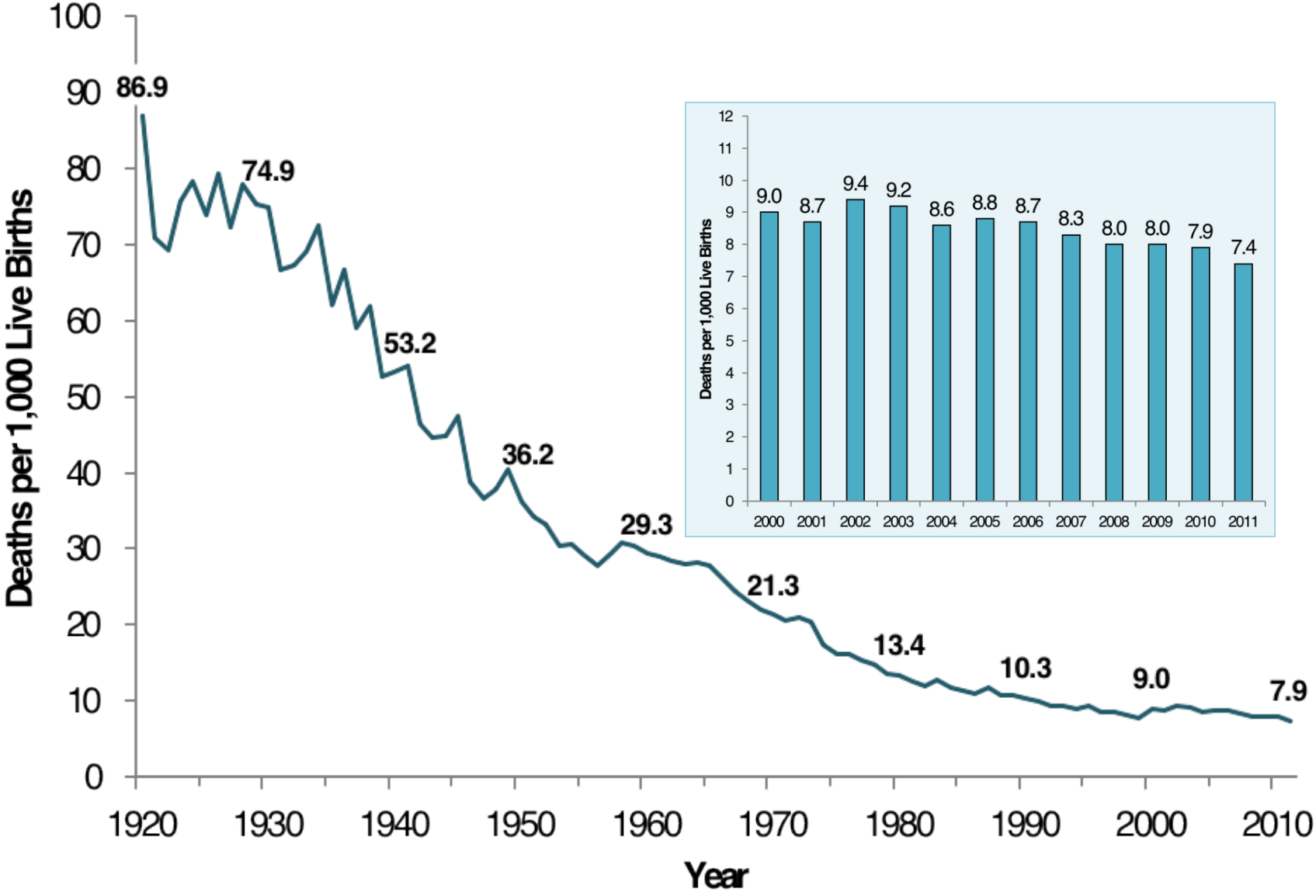
E. L. BISHOP, M. D., C. P. H.
Commissioner

NASHVILLE
1928

Eugene Lindsay Bishop, MD, CPH
December 12, 1924 - February 5, 1935

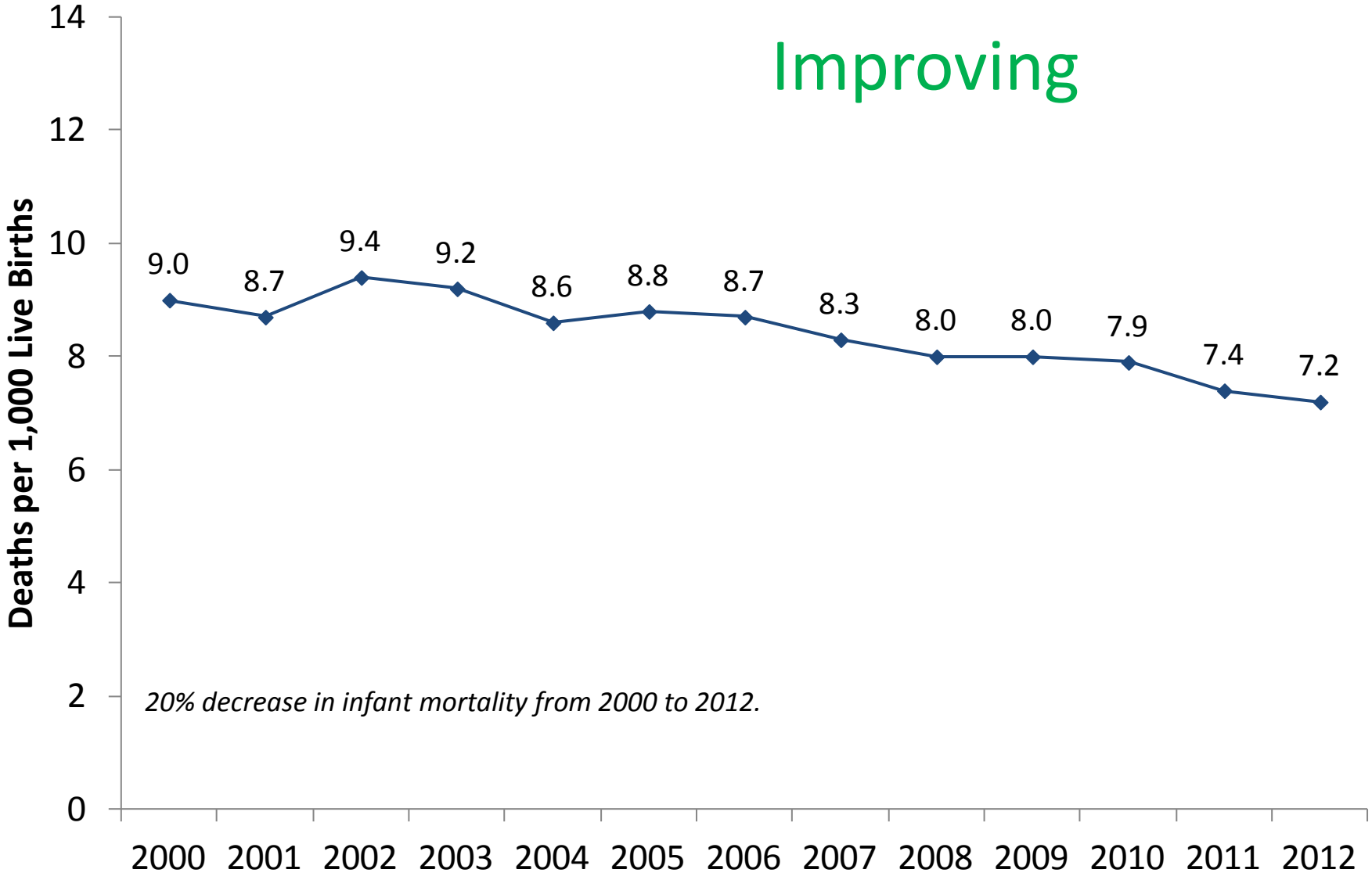


Infant Mortality Rate, Tennessee, 1920-2011



Tennessee Department of Health

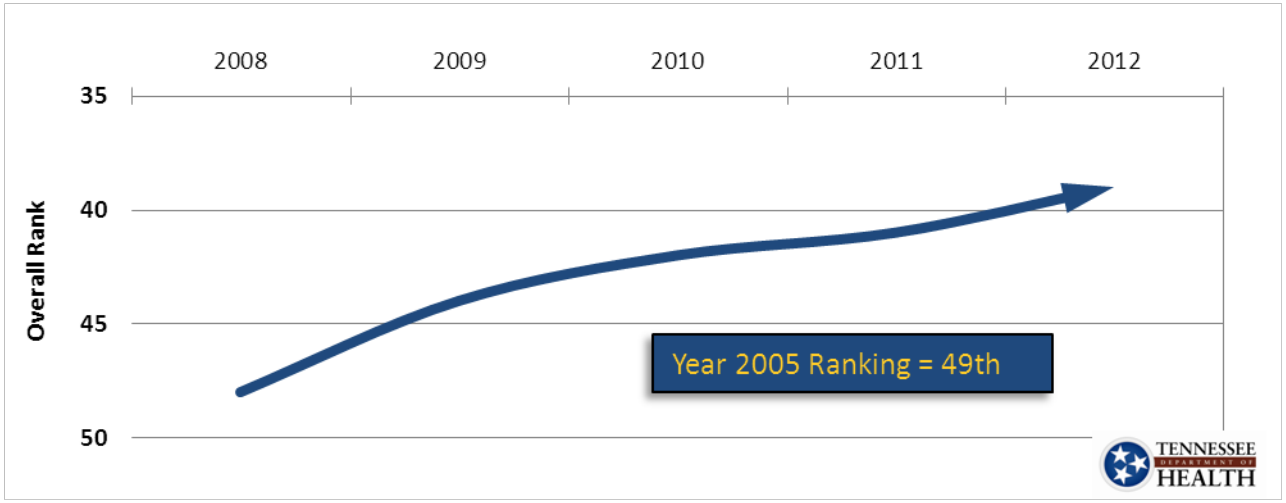
Infant Mortality Rate
Tennessee, 2000-2012



TENNESSEE DEPARTMENT OF HEALTH

Data sources: Tennessee Department of Health; Division of Policy, Planning and Assessment; Office of Health Statistics; Birth and Death Statistical Systems

Progress in Tennessee's State Health Ranking-
The Vision: To be in nation's top ten healthiest states



	2008	2009	2010	2011	2012
Overall Rank	48	44	42	41	39
Determinants	48	42	39	37	35
Outcomes	47	45	44	42	43

In order for Tennessee to move into the Top Ten states

Indicator and 2012 national ranking	*Tennessee Rate*	*Top Ten Rate*	*Amount of change required*
Infant mortality #45	8.1 deaths of infants before age one per 1,000 live births	Below 5.5 (#10 New York, Vermont, New Mexico)	Reduce number of infant deaths by 208 ***(Rate for 2011 dropped to 7.4)***
Smoking #36	23% of population over 18 smokes on a regular basis	Below 18.3% (#10 Colorado)	Help 20 out of 100 current smokers to quit and no new smokers.
Obesity #35	29.2% body mass index of over 30.0	Below 24.6% (#10 Montana)	Help 16 out of 100 obese persons to reduce BMI to under 30 and maintain the rest at healthy weight.

2012 America's Health Rankings, http://www.americashealthrankings.org/

Statistically significant improvements over <u>five years in :</u>

Early prenatal care
Cancer death rate
Cardiovascular death rate
Preventable hospitalizations
Low birth weight percentage
Air pollution
High school graduation percent

Only 5 of 25 measures did not improve from 2008-2012.

Many of Tennessee's rankings in national bottom quintile are linked to Sedentary Lifestyle (#48)

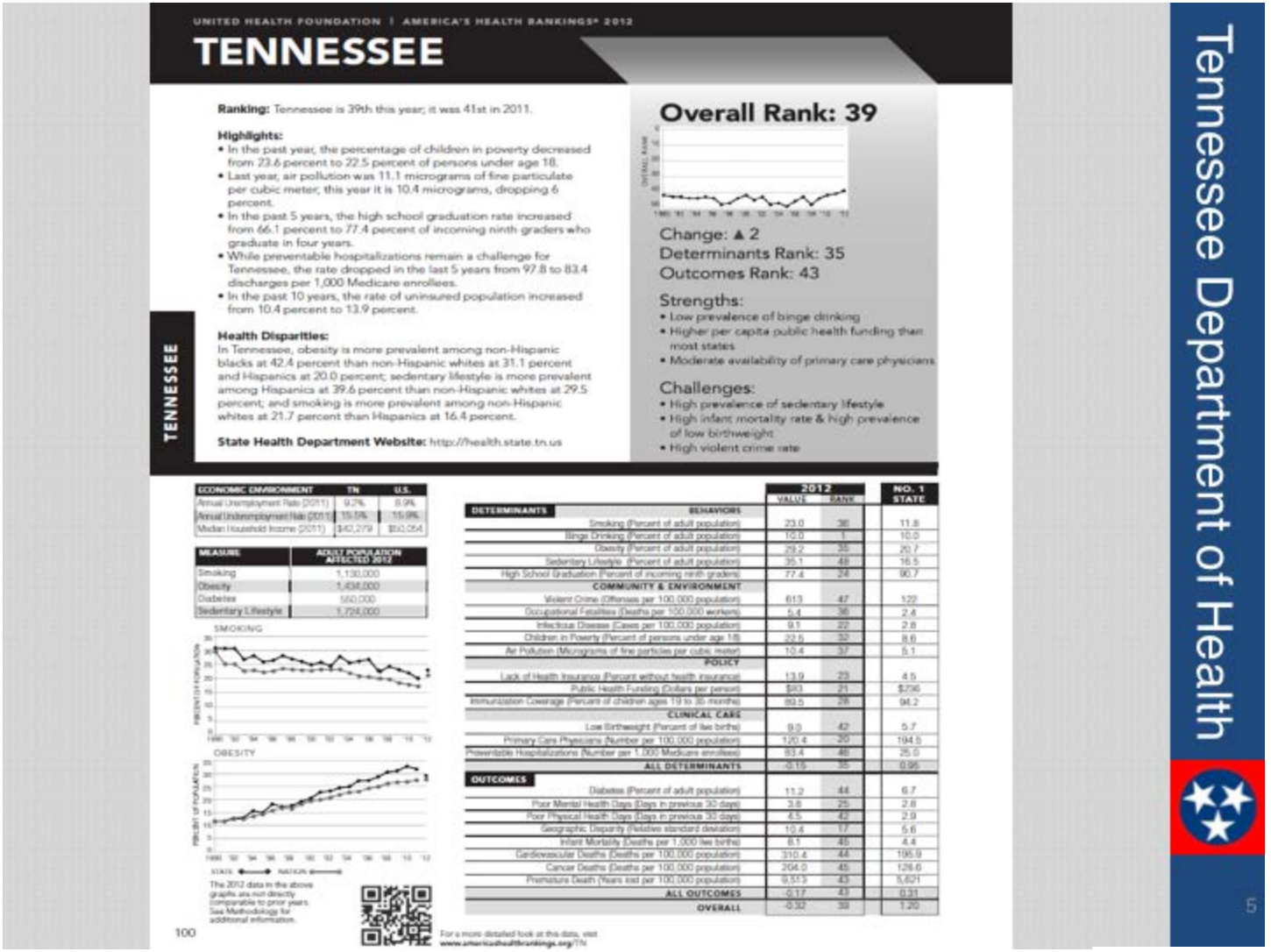
<u>Health Determinants</u>

#46 Preventable Medicare hospitalizations
#42 Low birth weight births

<u>Health Outcomes</u>

#46 Diabetes prevalence
#45 Cancer deaths
#44 Cardiovascular deaths
#43 Premature deaths
#42 Poor physical health days

Tennessee's 2012 National Health Ranking



UNITED HEALTH FOUNDATION | AMERICA'S HEALTH RANKINGS® 2012

TENNESSEE

Ranking: Tennessee is 39th this year; it was 41st in 2011.

Highlights:
- In the past year, the percentage of children in poverty decreased from 23.6 percent to 22.5 percent of persons under age 18.
- Last year, air pollution was 11.1 micrograms of fine particulate per cubic meter; this year it is 10.4 micrograms, dropping 6 percent.
- In the past 5 years, the high school graduation rate increased from 66.1 percent to 77.4 percent of incoming ninth graders who graduate in four years.
- While preventable hospitalizations remain a challenge for Tennessee, the rate dropped in the last 5 years from 97.8 to 83.4 discharges per 1,000 Medicare enrollees.
- In the past 10 years, the rate of uninsured population increased from 10.4 percent to 13.9 percent.

Health Disparities:
In Tennessee, obesity is more prevalent among non-Hispanic blacks at 42.4 percent than non-Hispanic whites at 31.1 percent and Hispanics at 20.0 percent; sedentary lifestyle is more prevalent among Hispanics at 39.6 percent than non-Hispanic whites at 29.5 percent; and smoking is more prevalent among non-Hispanic whites at 21.7 percent than Hispanics at 16.4 percent.

State Health Department Website: http://health.state.tn.us

TENNESSEE

Overall Rank: 39

Change: ▲ 2
Determinants Rank: 35
Outcomes Rank: 43

Strengths:
- Low prevalence of binge drinking
- Higher per capita public health funding than most states
- Moderate availability of primary care physicians

Challenges:
- High prevalence of sedentary lifestyle
- High infant mortality rate & high prevalence of low birthweight
- High violent crime rate

ECONOMIC ENVIRONMENT	TN	U.S.
Annual Unemployment Rate (2011)	9.2%	8.9%
Annual Underemployment Rate (2011)	15.5%	15.9%
Median Household Income (2011)	$40,279	$50,054

MEASURE	ADULT POPULATION AFFECTED 2012
Smoking	1,130,000
Obesity	1,434,000
Diabetes	560,000
Sedentary Lifestyle	1,724,000

SMOKING

OBESITY

STATE ◆—— NATION ◆——

The 2012 data in the above graphs are not directly comparable to prior years. See Methodology for additional information.

		2012 VALUE	2012 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	23.0	36	11.8
	Binge Drinking (Percent of adult population)	10.0	1	10.0
	Obesity (Percent of adult population)	29.2	35	20.7
	Sedentary Lifestyle (Percent of adult population)	35.1	48	16.5
	High School Graduation (Percent of incoming ninth graders)	77.4	24	90.7
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	613	47	122
	Occupational Fatalities (Deaths per 100,000 workers)	5.4	36	2.4
	Infectious Disease (Cases per 100,000 population)	9.1	22	2.8
	Children in Poverty (Percent of persons under age 18)	22.5	32	8.6
	Air Pollution (Micrograms of fine particles per cubic meter)	10.4	37	5.1
	POLICY			
	Lack of Health Insurance (Percent without health insurance)	13.9	23	4.5
	Public Health Funding (Dollars per person)	$80	21	$796
	Immunization Coverage (Percent of children ages 19 to 35 months)	89.5	28	96.2
	CLINICAL CARE			
	Low Birthweight (Percent of live births)	9.9	42	5.7
	Primary Care Physicians (Number per 100,000 population)	120.4	20	194.5
	Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	83.4	48	25.0
	ALL DETERMINANTS	-0.15	35	0.95
OUTCOMES				
	Diabetes (Percent of adult population)	11.2	44	6.7
	Poor Mental Health Days (Days in previous 30 days)	3.8	25	2.8
	Poor Physical Health Days (Days in previous 30 days)	4.5	42	2.9
	Geographic Disparity (Relative standard deviation)	10.4	17	5.6
	Infant Mortality (Deaths per 1,000 live births)	8.1	45	4.4
	Cardiovascular Deaths (Deaths per 100,000 population)	310.4	44	195.9
	Cancer Deaths (Deaths per 100,000 population)	206.0	45	126.6
	Premature Death (Years lost per 100,000 population)	9,513	43	5,621
	ALL OUTCOMES	-0.17	43	0.31
	OVERALL	-0.32	39	1.20

For a more detailed look at this data, visit www.americashealthrankings.org/TN

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Tennessee Department of Health

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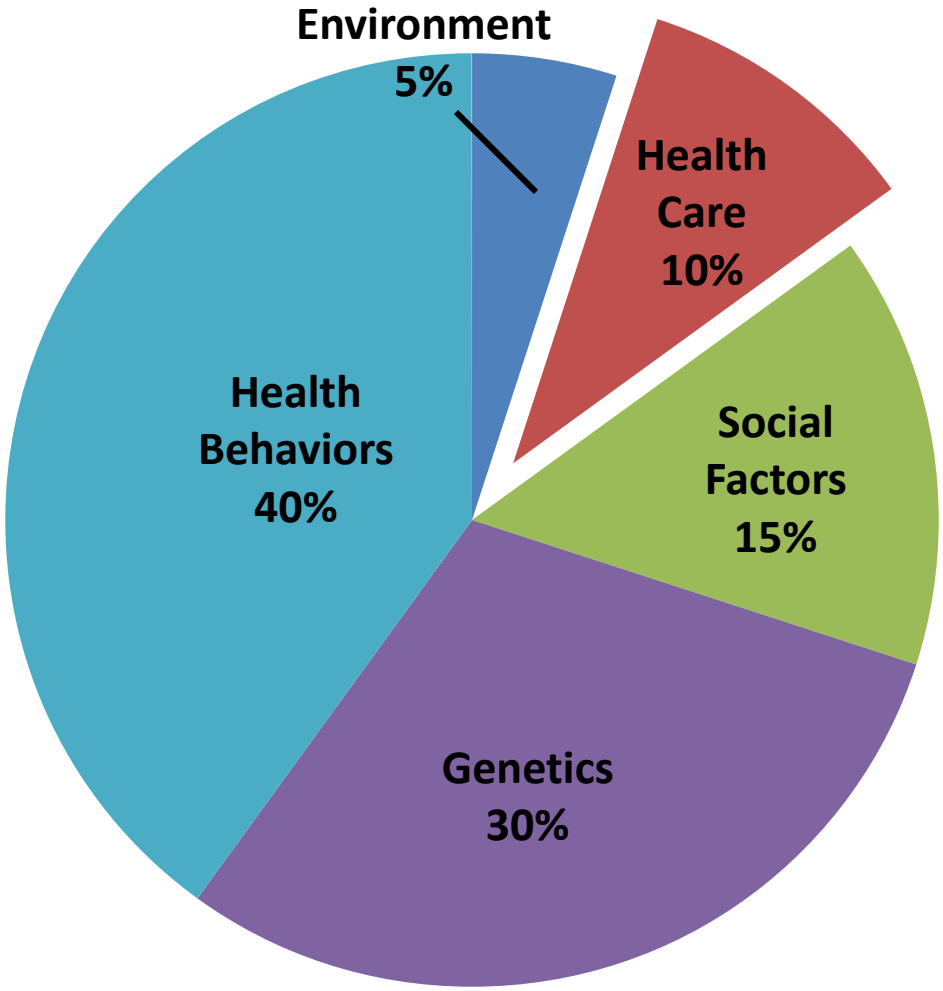
TENNESSEE DEPARTMENT OF HEALTH

2012 Healthcare Metrics in America's Health Ranking

- Geographic Disparity----------17th (10.4/ relative standard deviation)
- Primary Care Physicians----------20th (120/100,000)
- Infectious Disease----------22th (9/100,000)
- Lack of Health Insurance----------23rd (13.9% without insurance)
- Poor Physical Health Days---------42nd (4.5 days/ 30 days)
- Premature Death----------43rd (9.5 years lost/100,000)
- Diabetes----------44th (11.2% of adult population)
- Cardiovascular Deaths----------44th (310/100,000)
- Cancer Deaths----------45th (204/100,000)
- Preventable Hospitalizations------46th (83/1,000 Medicare enrollees)

TENNESSEE DEPARTMENT OF HEALTH

Determinants of "Health"

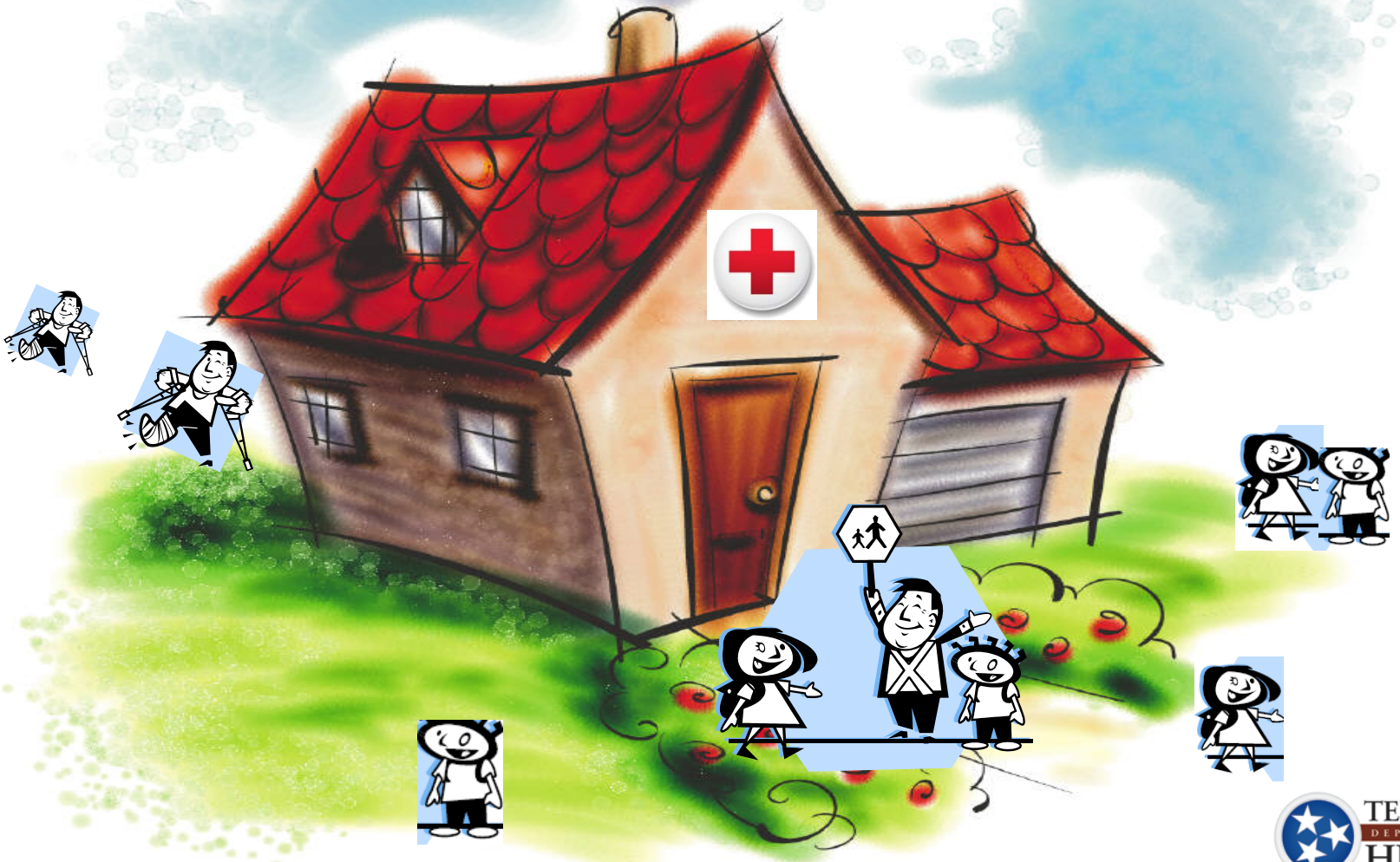


- **Health care** contributes a small amount to an individual's overall health and well-being
- Improving **Health** requires comprehensive focus: a public health approach

TENNESSEE DEPARTMENT OF HEALTH

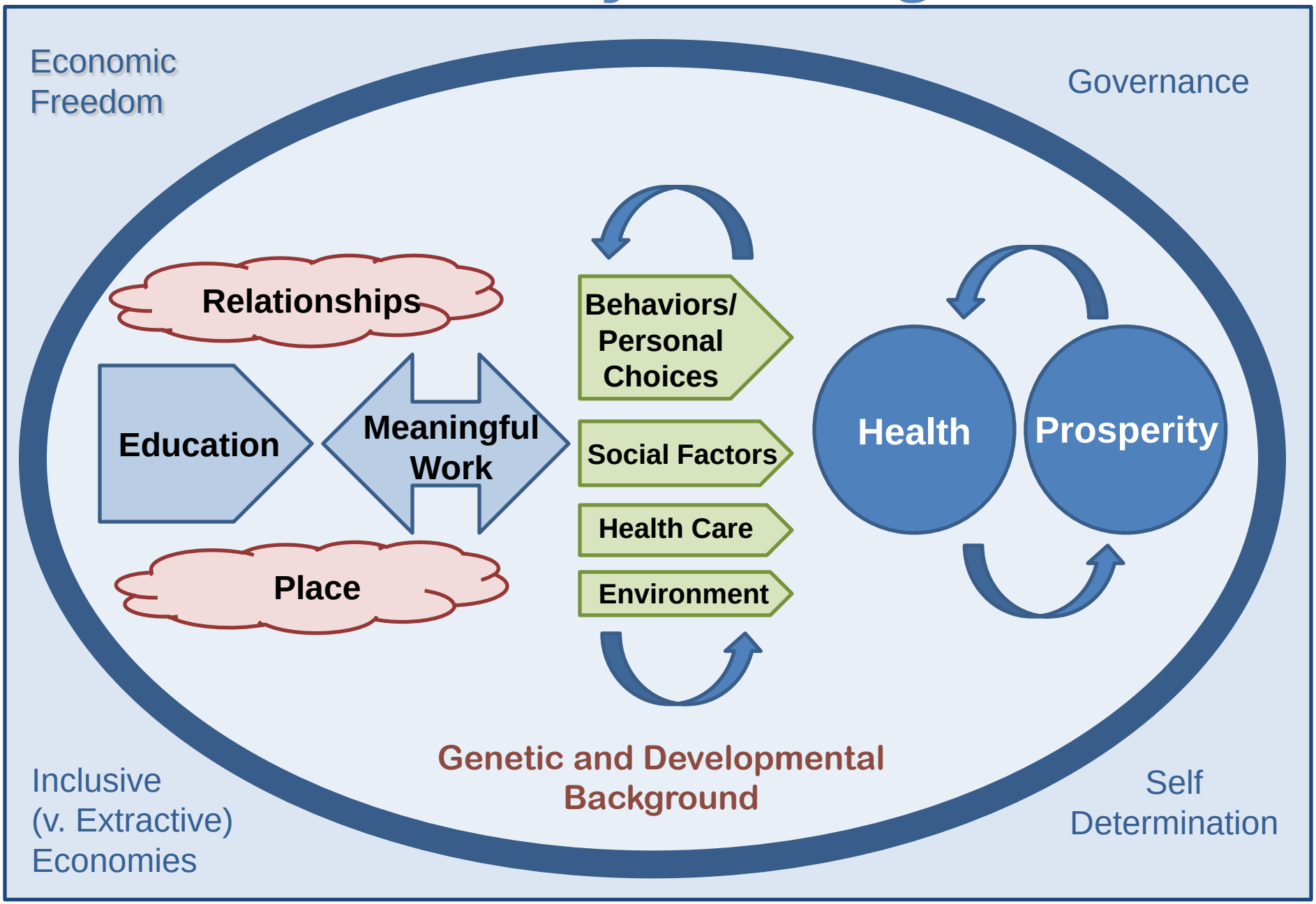
Sources: McGinnis JM & Foege WH. Actual causes of death in the United States. JAMA 1993: 270(18):2207-12 (Nov 10)
McGinnis JM, Williams-Russo P, & Knickman JR. The case for more active policy attention to health promotion. Health Affairs 2002; 21(2):78-93 (Mar).

Public *Health*: Guarding the Front Door of Healthcare

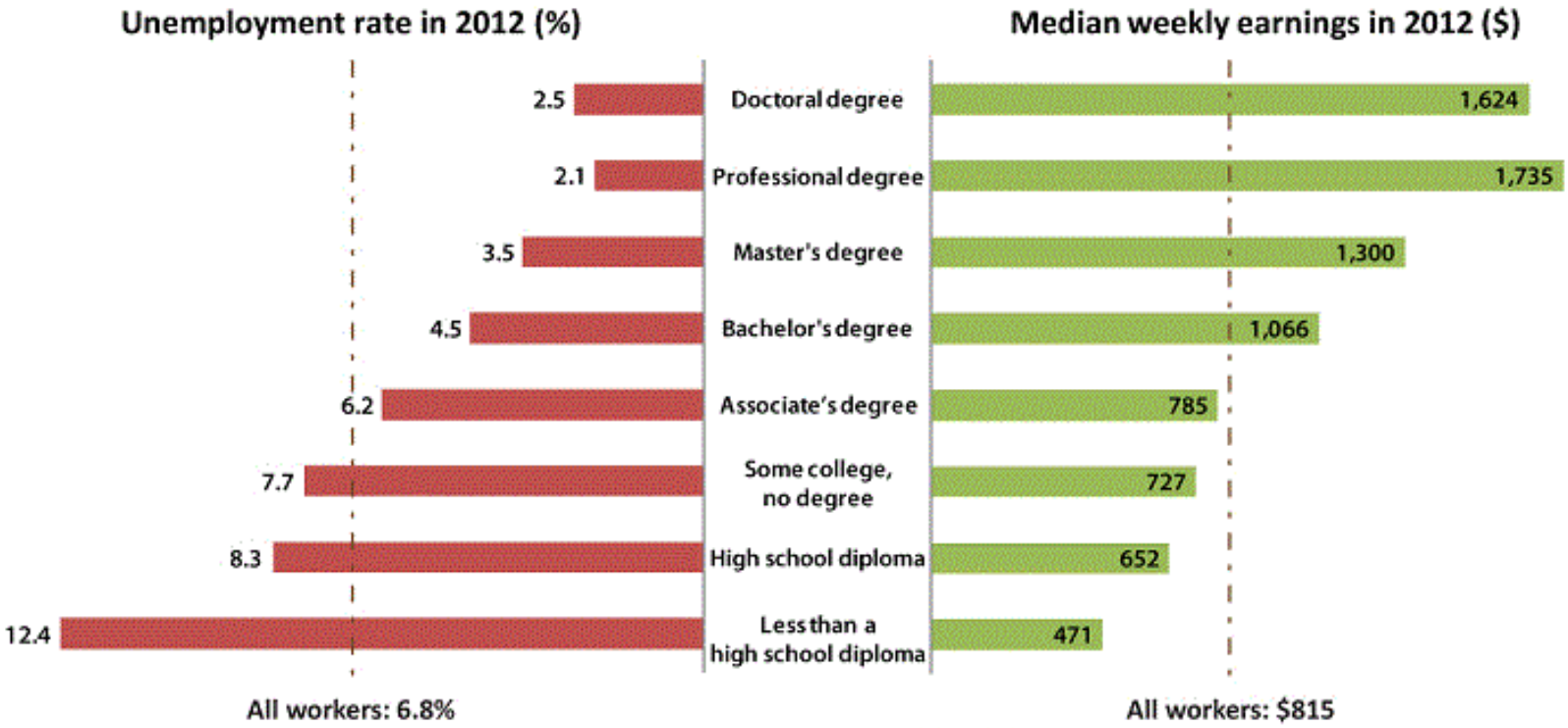


TENNESSEE DEPARTMENT OF HEALTH

A Healthy Paradigm



Earnings and Unemployment Rates by Education Attainment.



Drive to 55 Mission: Workforce Ready

Drug Dependent Newborns (Neonatal Abstinence Syndrome)

Surveillance Summary For the Week of September 15-21, 2013 (Week 38)[1]

Reporting Summary (Year-to-date)

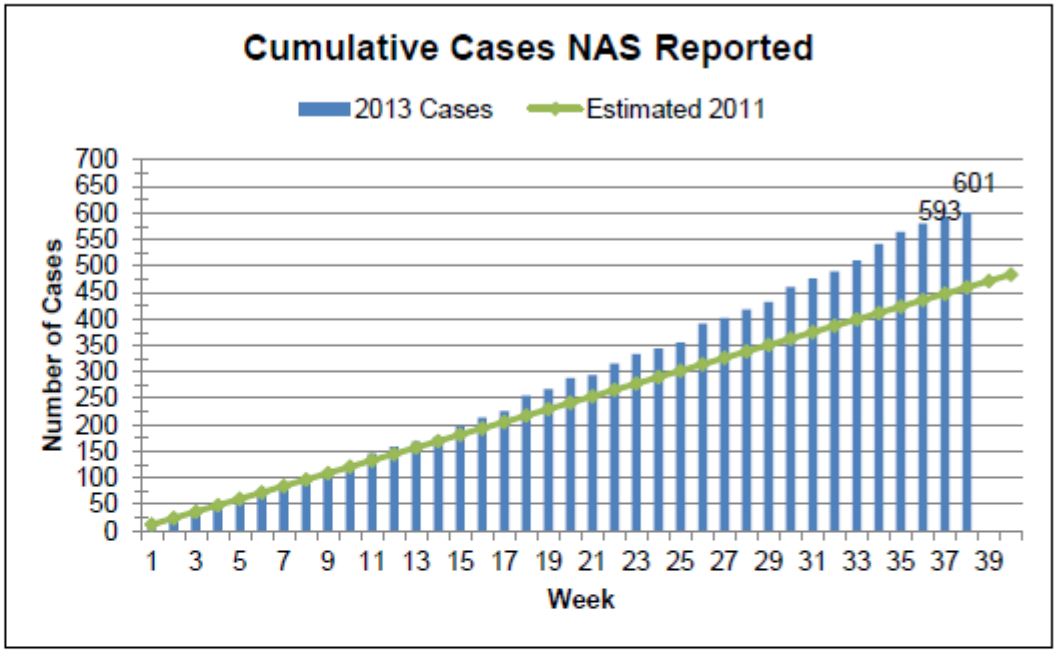
Cases Reported: **601**

Male: 348

Female: 253

Unique Hospitals Reporting: **48**

Maternal County of Residence (By Health Department Region)	# Cases	% Cases
Davidson	31	5.2%
East	158	26.3%
Hamilton	11	1.8%
Jackson/Madison	1	0.2%
Knox	66	11.0%
Mid-Cumberland	42	7.0%
North East	93	15.5%
Shelby	11	1.8%
South Central	20	3.3%
South East	10	1.7%
Sullivan	62	10.3%
Upper Cumberland	77	12.8%
West	19	3.2%
Total	**601**	**100%**



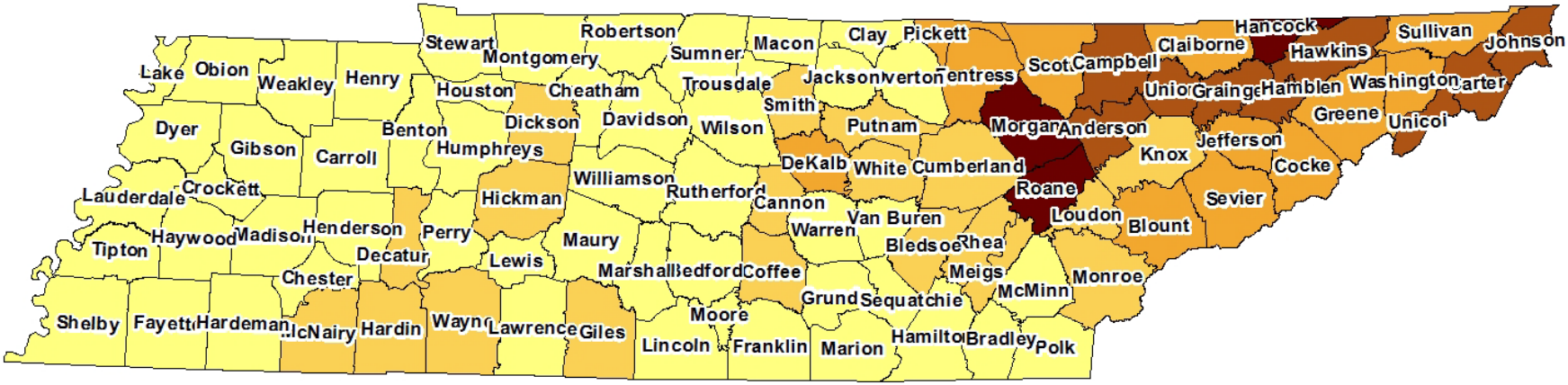
Source of Maternal Substance (if known)[2]	# Cases[2]	% Cases
Supervised replacement therapy	266	44.3%
Supervised pain therapy	130	21.6%
Therapy for psychiatric or neurological condition	47	7.8%
Prescription substance obtained WITHOUT a prescription	232	38.6%
Non-prescription substance	169	28.1%
No known exposure but clinical signs consistent with NAS	11	1.8%
No response	14	2.3%

1. *Summary reports are archived weekly at: http://health.tn.gov/MCH/NAS/NAS_Summary_Archive.shtml*
2. *Multiple maternal substances may be reported; therefore the total number of cases in this table may not match the total number of cases reported.*

Inpatient Hospitalizations with Any Diagnosis of Neonatal Abstinence Syndrome

All Patients Regardless of TennCare Status, Tennessee 2011

629 Unique Babies Suffering With NAS



Statewide Rate: 8.5/1,000

Rate per 1,000 Live Births

- 54.1 - 94.4
- 32.5 - 54.0
- 16.4 - 32.4
- 5.9 - 16.3
- 0.0 - 5.8

Data sources: Tennessee Department of Health; Office of Health Statistics; Hospital Discharge Data System (HDDS) and Birth Statistical System (BSS).

Numerator is number of inpatient hospitalizations with age less than one and any diagnosis of neonatal abstinence syndrome (ICD9-CM 779.5). HDDS records may contain up to 18 diagnoses. Infants were included in the numerator if any of these 18 fields were coded as neonatal abstinence syndrome. Note that these are discharge-level data and not unique patient data. For HDDS data, county is patient's county of residence.

Denominator is number of live births. For BSS data, county is mother's county of residence.

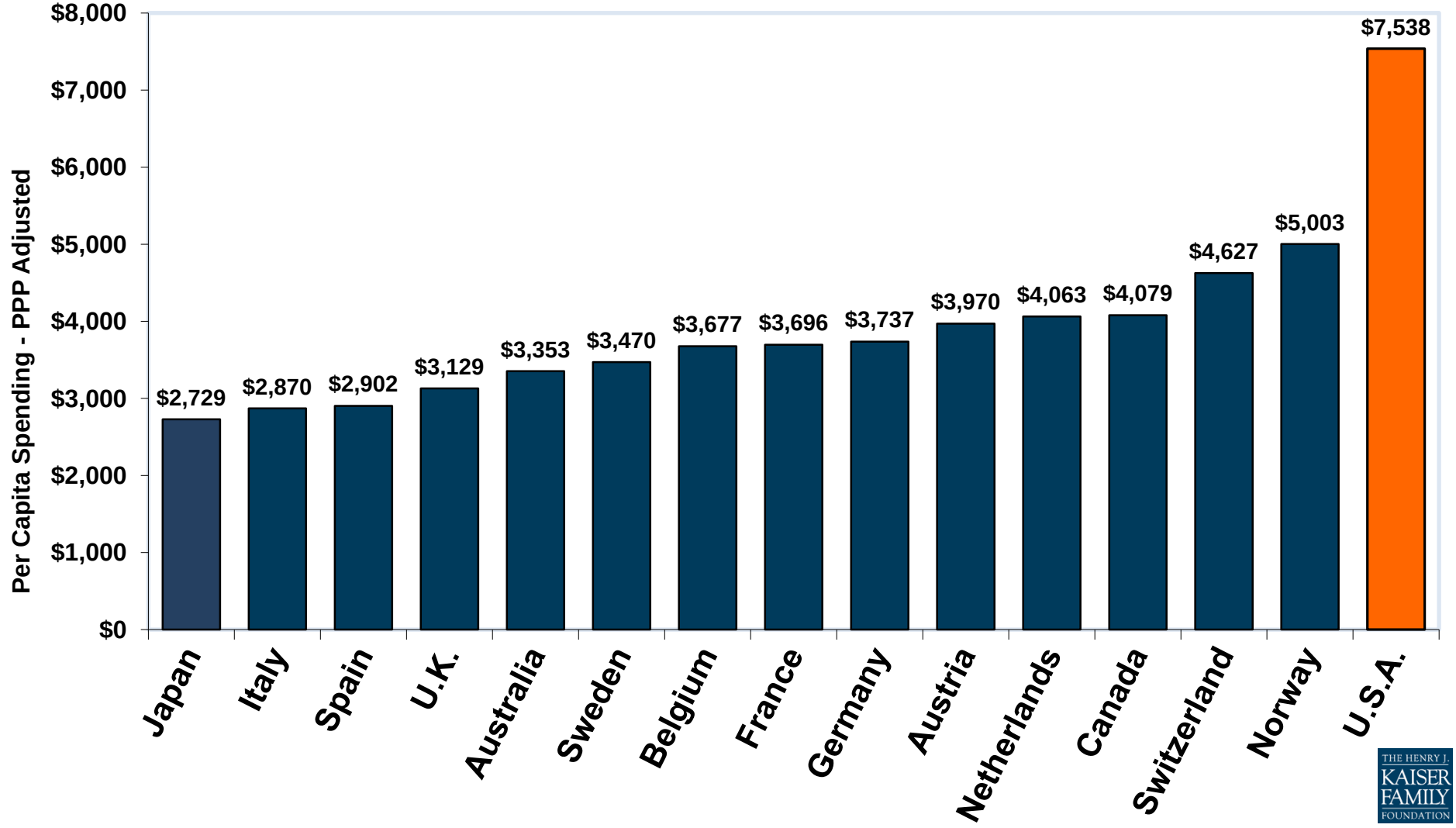
$66,973 average cost per baby paid for by TennCare(2012)

Three Levels of Health Protection

	PRIMARY Prevention	**SECONDARY** Prevention	**TERTIARY** Prevention
Definition	An intervention implemented before there is evidence of a disease or injury	An intervention implemented after a disease has begun, but before it is symptomatic.	An intervention implemented after a disease or injury is established
Intent	Reduce or eliminate causative risk factors (risk reduction)	Early identification (through screening) and treatment	Prevent sequelae (stop bad things from getting worse)
NAS Example	*Prevent addiction from occurring* *Prevent pregnancy*	*Screen pregnant women for substance use during prenatal visits and refer for treatment*	*Treat addicted women* *Treat babies with NAS*

Adapted from: Centers for Disease Control and Prevention. A Framework for Assessing the Effectiveness of Disease and Injury Prevention. MMWR. 1992; 41(RR-3); 001. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/00016403.htm

Total Health Expenditure per Capita, U.S. and Selected Countries, 2008



Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group; U.S. Department of Commerce, Bureau of Economic Analysis; and U.S. Bureau of the Census. Available at: https://www.cms.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp . Data from Australia and Japan are 2007 data. Figures for Belgium, Canada, Netherlands, Norway and Switzerland, are OECD estimates. Numbers are PPP adjusted.

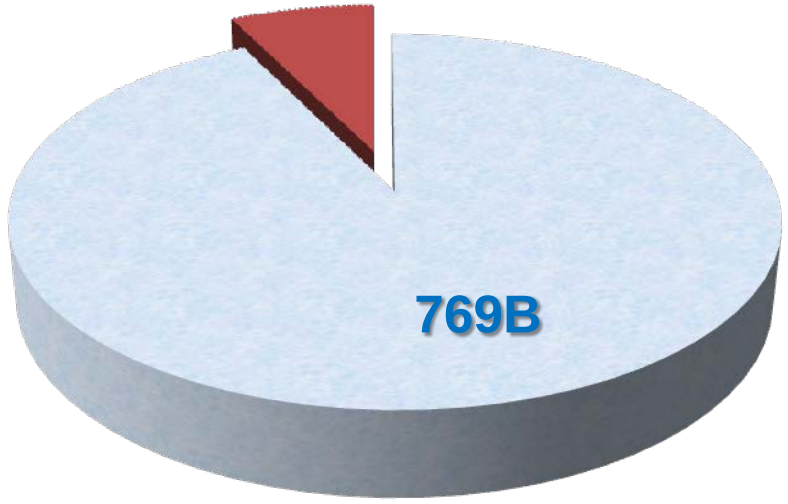
Federal Health Spending

Fed Budget: FY 2011 $3.6T

Medicare, Medicaid, and CHIP: 21%/ $769B

Public Health Discretionary Spending: 53.5B

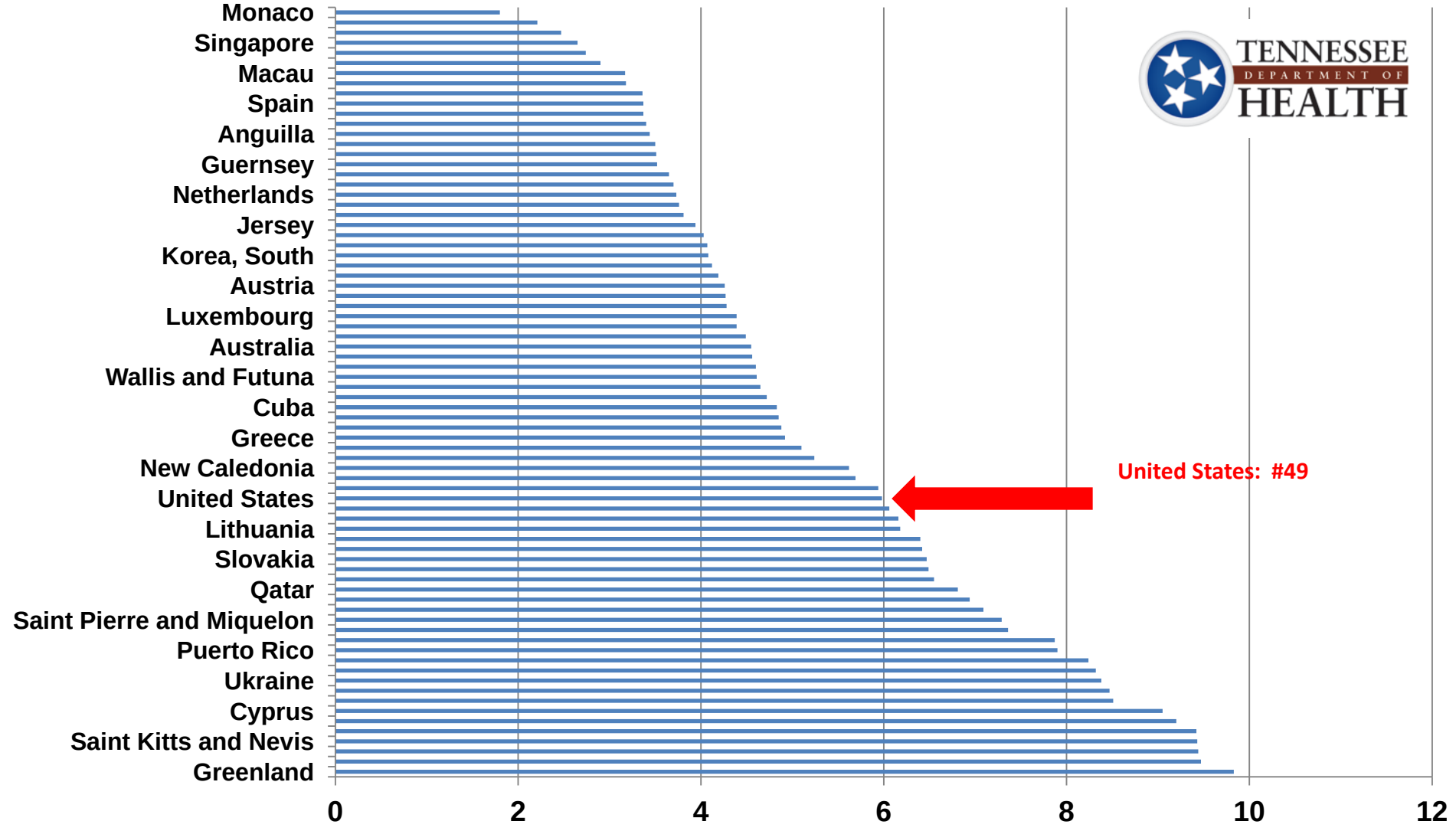
Ryan White, Community Health Centers, and Family Planning; all of CDC's budget (sans VFC program, but with section 317 immunizations) all of SAMSHA; all of NIH; all of the Indian Health Service; all of the AHRQ; all of FDA.



SS: 731B
Defense: 718B
Debt Interest: 230B

TENNESSEE DEPARTMENT OF HEALTH

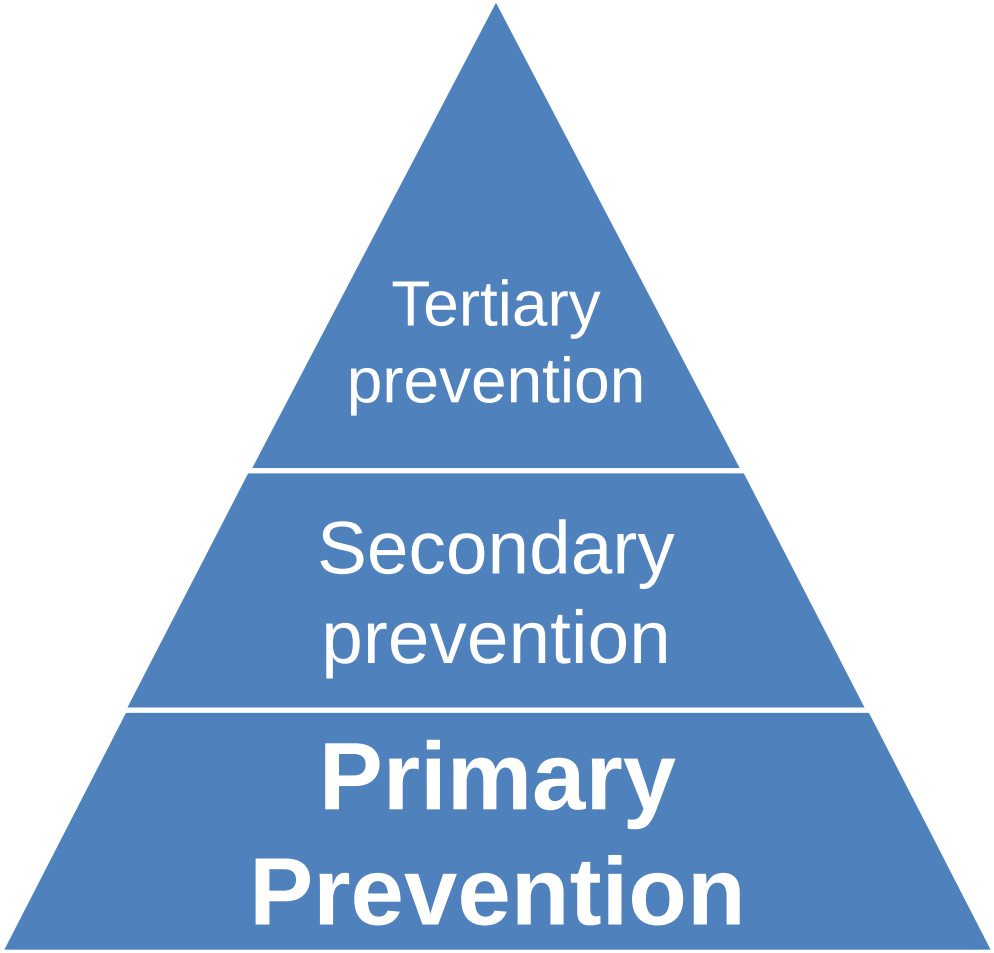
Infant Mortality Rate by Country, 2012



Source: CIA World Factbook. Available at: https://www.cia.gov/library/publications/the-world-factbook/rankorder/2091rank.html

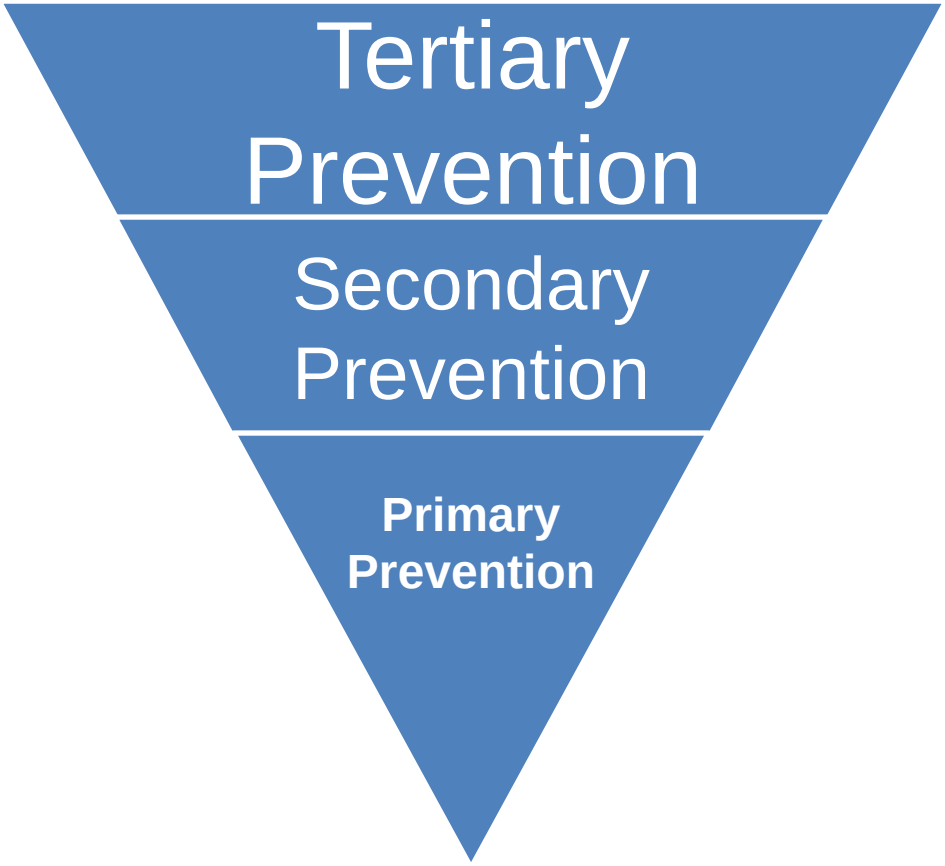

“ You can always
count on Americans
to do the right thing
- after they've tried
everything else.”
~ Winston Churchill

Prevention: The Past



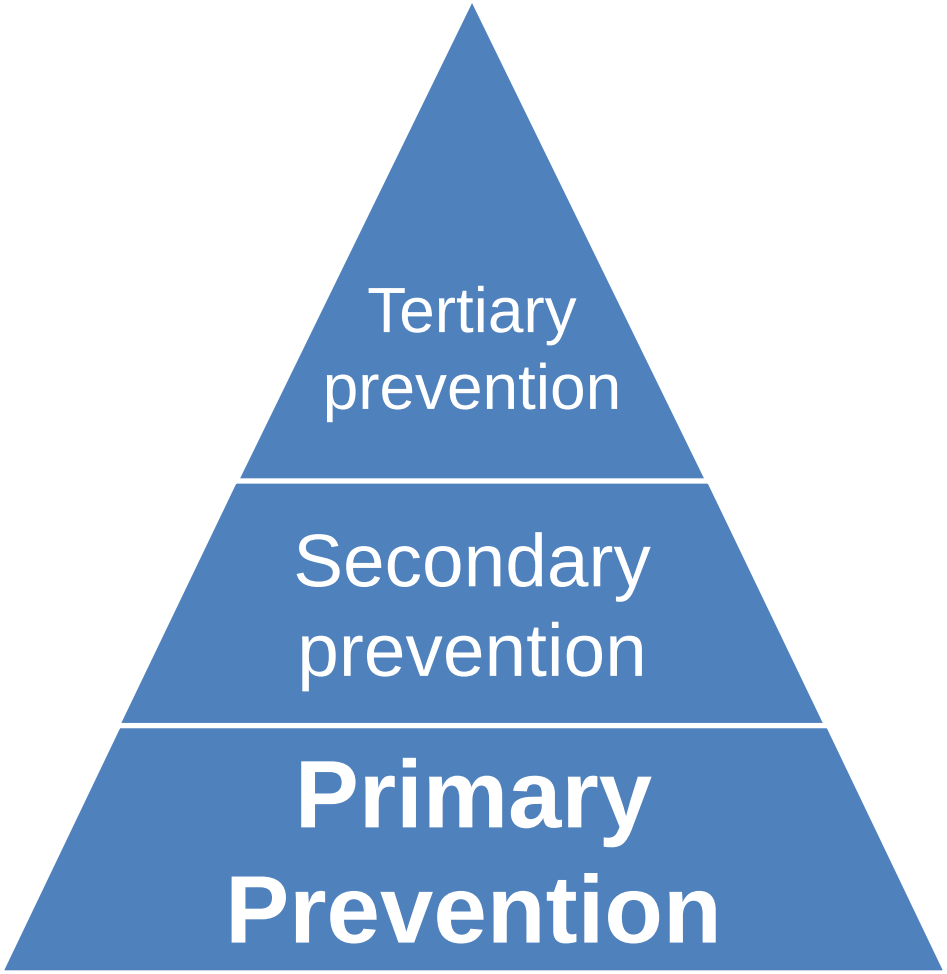
TENNESSEE DEPARTMENT OF HEALTH

Prevention: The Modern Era



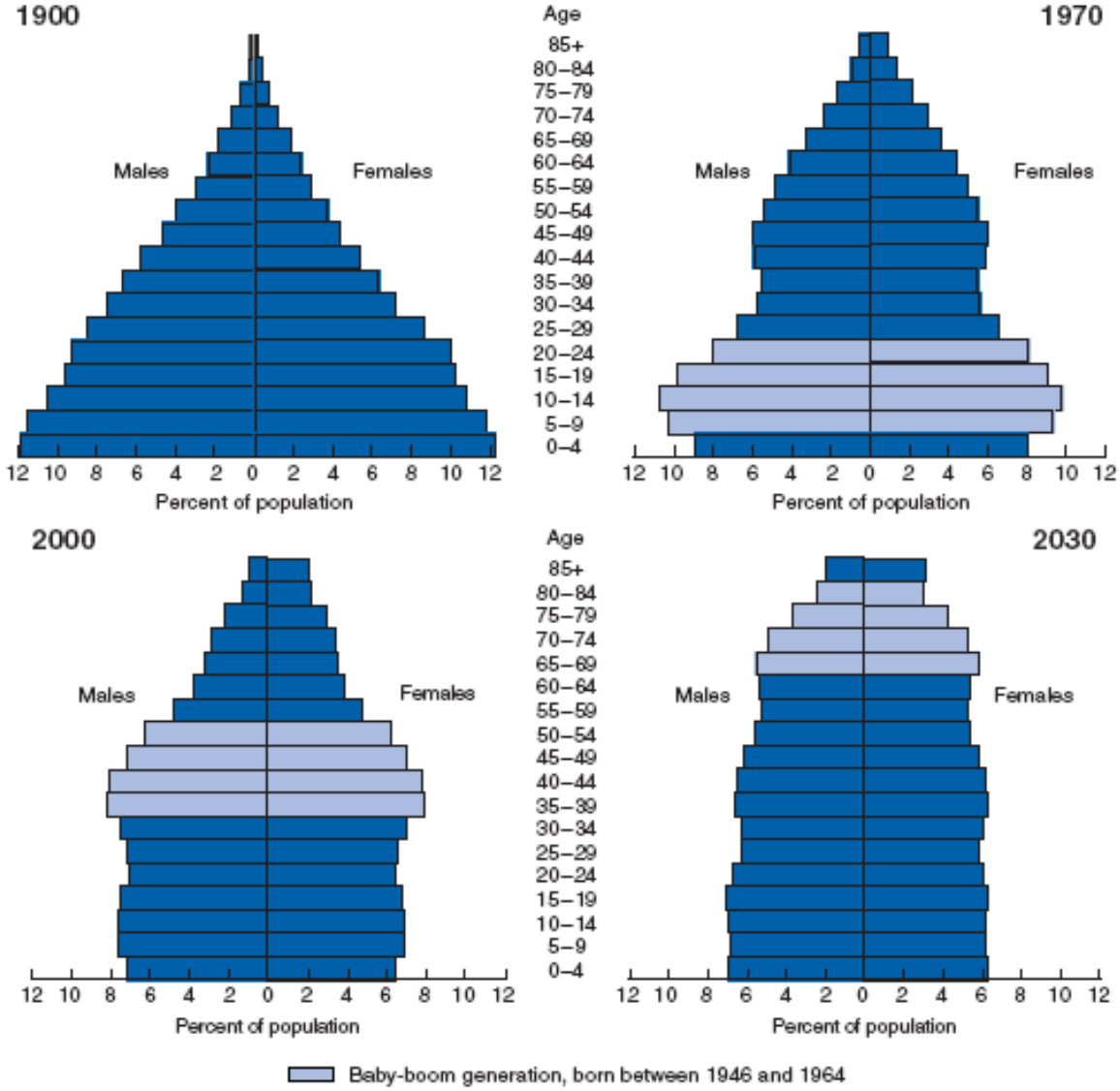
TENNESSEE DEPARTMENT OF HEALTH

Prevention: The Future



TENNESSEE DEPARTMENT OF HEALTH

The Dramatic Aging of America, 1900–2030



ureau of the Census. Adapted from: Himes CL. Elderly Americans. *Population Bulletin* 2002;56(4):4.

TNFORWARD

PERFORMANCE ★ ACCOUNTABILITY ★ EFFICIENCY

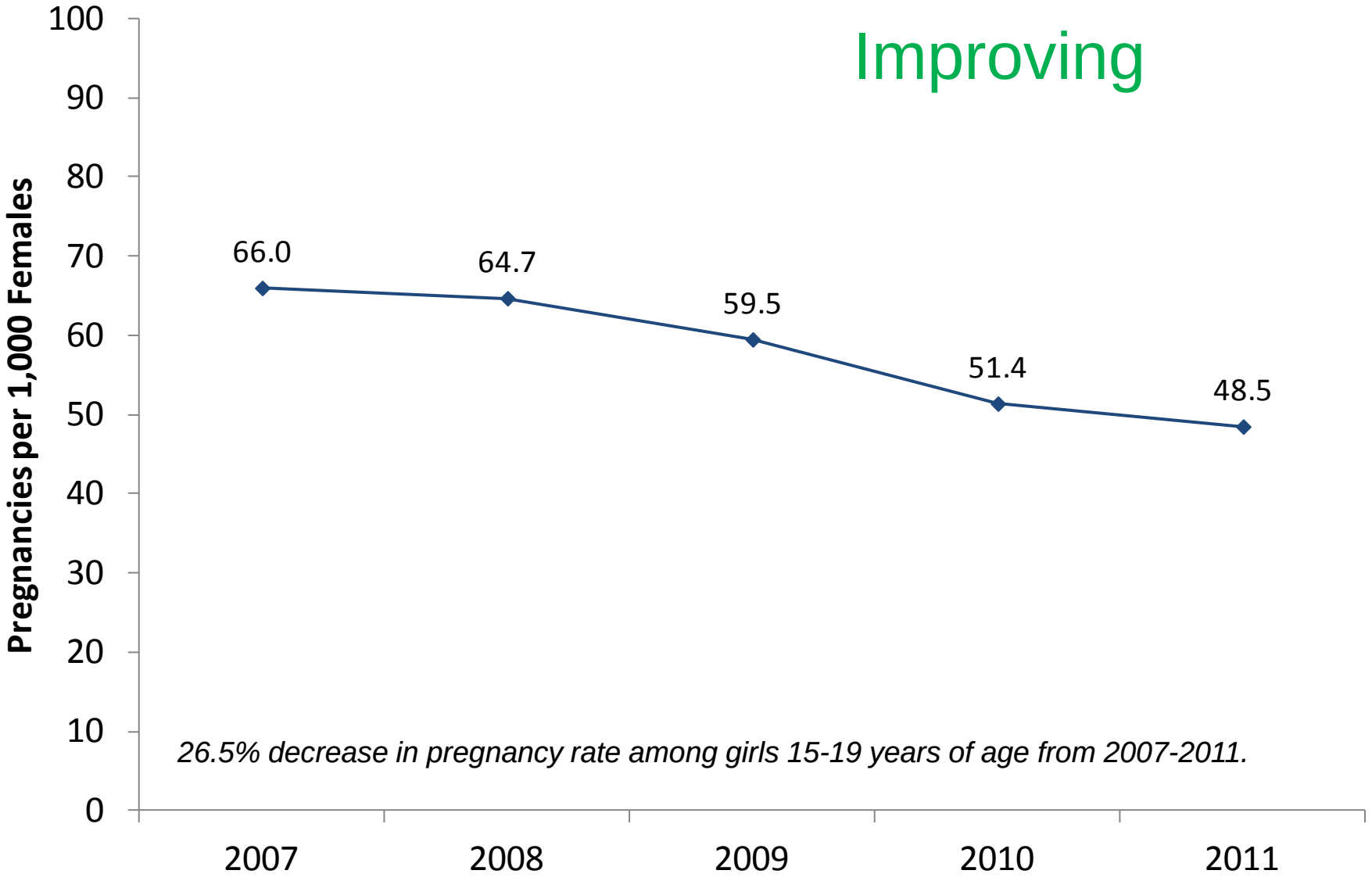
Home – Details & FAQs – Media – Top To Bottom Review – Dashboard – Get Involved –

— TENNESSEE DATA DASHBOARD —

Health & Welfare

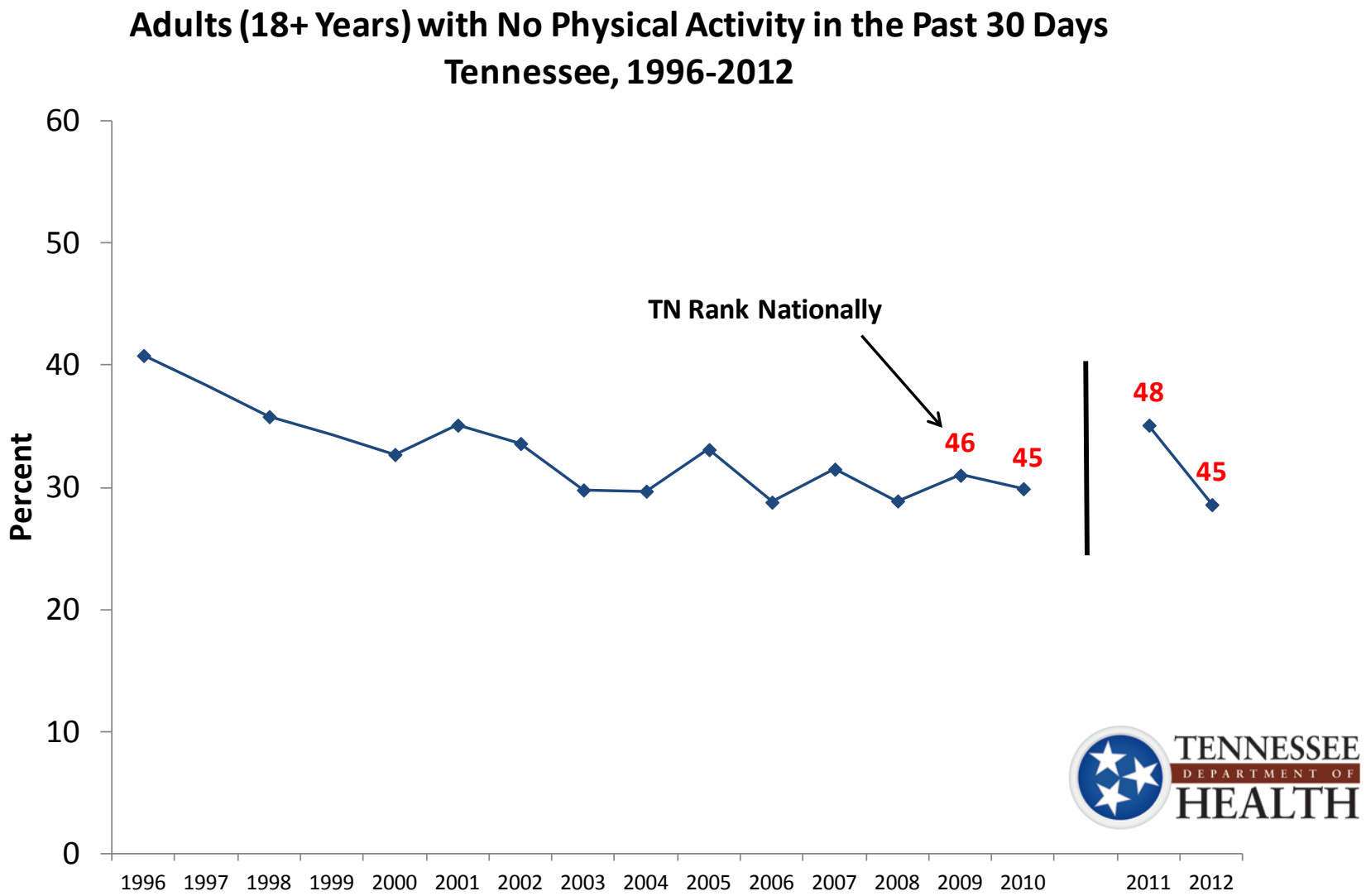
INFORMATION	CURRENT	RANK
Overall Health Ranking	39	
Smoking	24.9%	
Obesity	31.1%	
Infant Mortality *(per 1,000 live births)*	7.4	
Immunization Coverage	73.3% *(+/- 6.4%)*	
Teen Birth Rate *(per 1,000 women age 15-to-19)*	43.2	
Home and Community-Based Care	33.0%	
Average Time to Adoption *(in months)*	7.8	

Teen Pregnancy Rate -- 15-19 Year Olds
Tennessee, 2007-2011



Data sources: Tennessee Department of Health; Division of Policy, Planning and Assessment; Office of Health Statistics; Birth and Fetal Death Statistical Systems, Induced Termination of Pregnancy Data System and 2008 Revision of the 2003 Population Estimates and Projections; and the 2010-2011 US

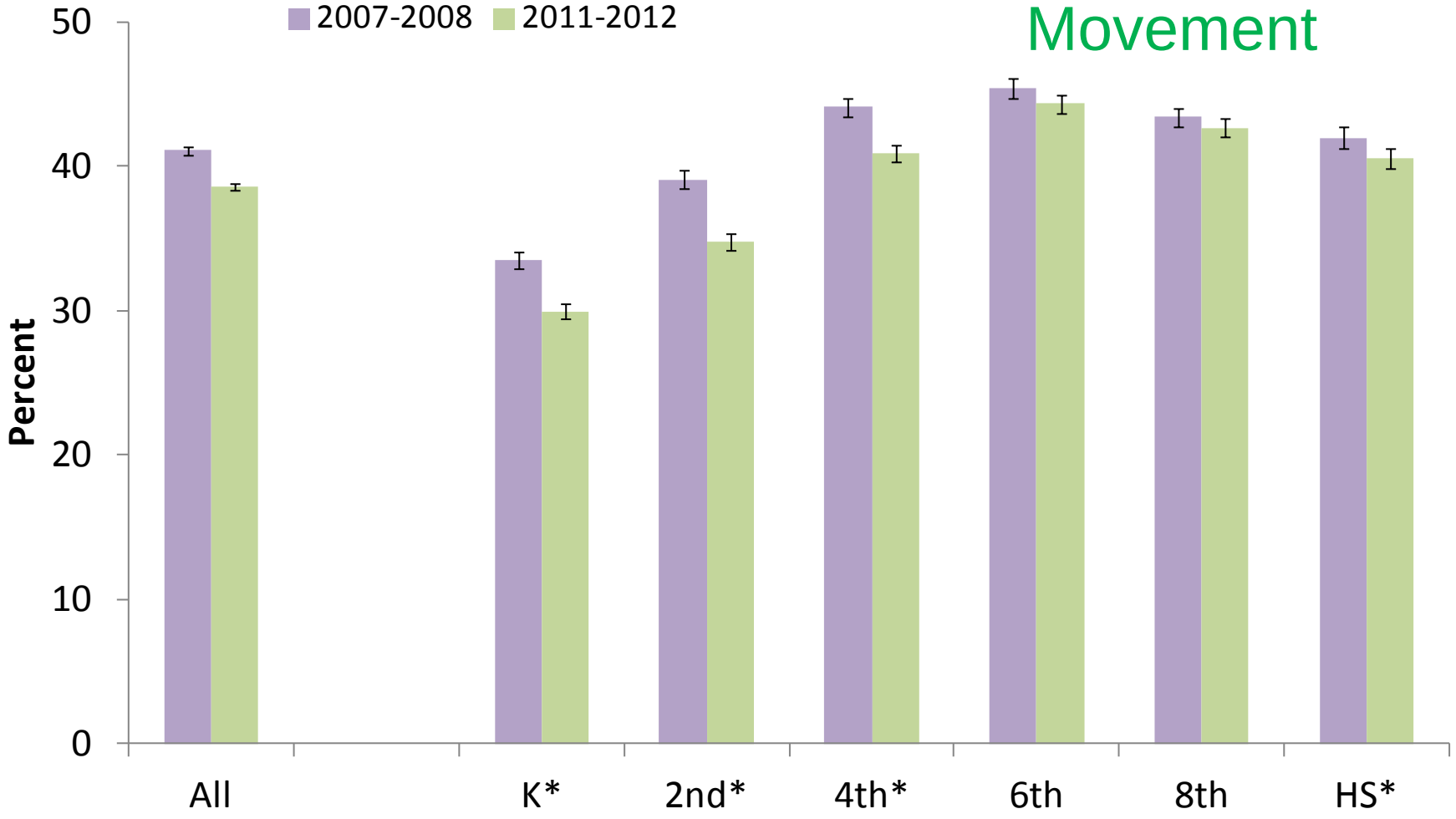
Physical Activity: Little Progress



Data source: Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1996-2012. Labels in red indicate TN rankings among 50 US states. ***Do not compare 2011-2012 BRFSS data to previous years. Due to changes in methods, comparisons are NOT valid and may be misleading.***

Overweight and Obesity Prevalence by Grade
Tennessee Public Schools, 2007-2008 and 2011-2012

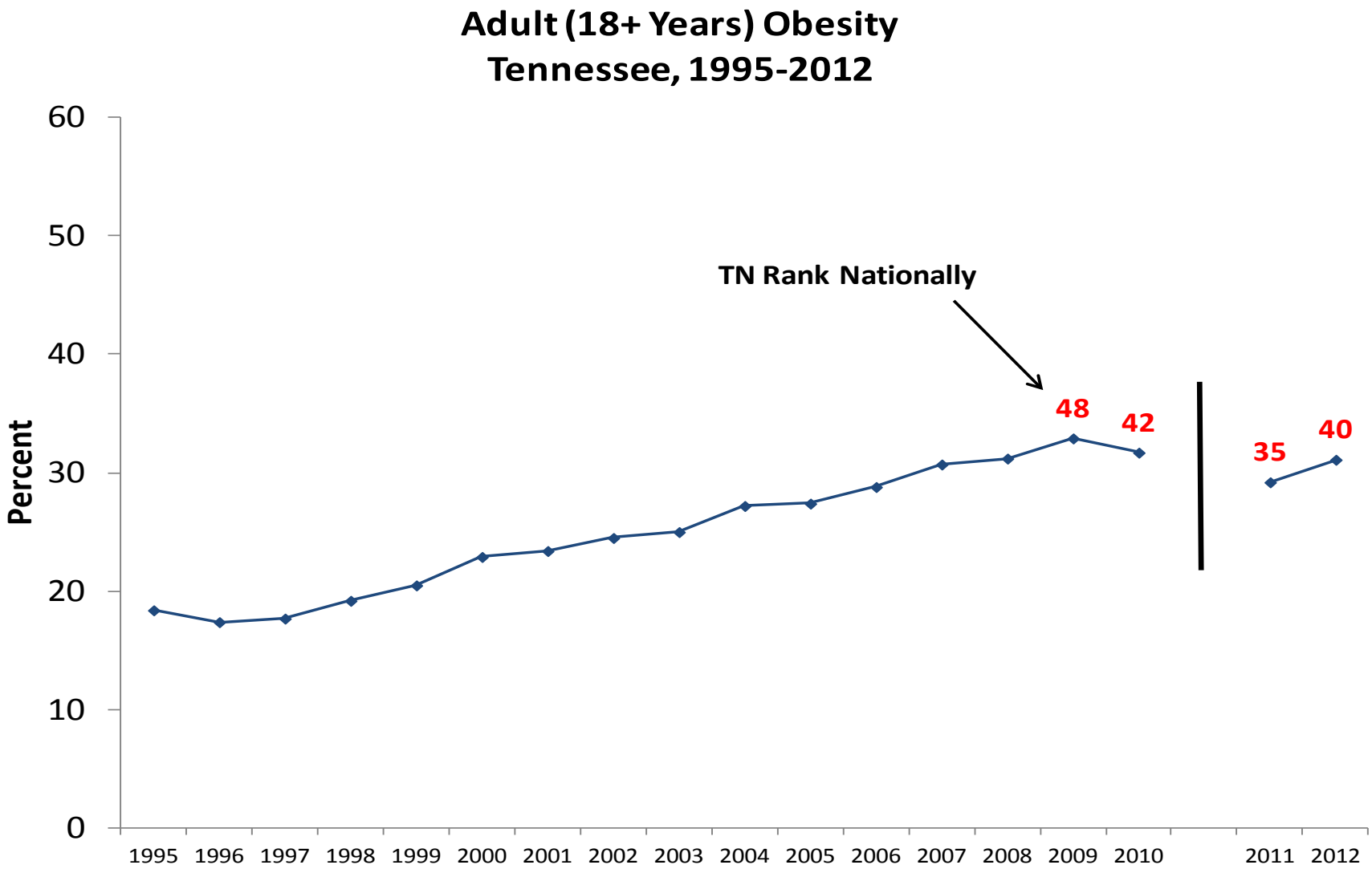
Encouraging Movement



Between 2007-2008 and 2011-2012 school years, the overweight and obesity prevalence among public school students decreased.

*Data source: Tennessee Department of Education's Office of Coordinated School Health. Overweight/obesity = BMI greater than or equal to the 85th percentile for children of the same age and sex. *The difference in prevalence between 2007-2008 and 2011-2012 is statistically significant based on non-overlapping 95%*

Obesity: Worrisome movement



Data source: Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1995-2012. Labels in red indicate TN rankings among 50 US states. Obesity = BMI ≥ 30.0. ***Do not compare 2011-2012 BRFSS data to previous years. Due to changes in methods, comparisons are NOT valid and may be***

HEALTHIER TENNESSEE

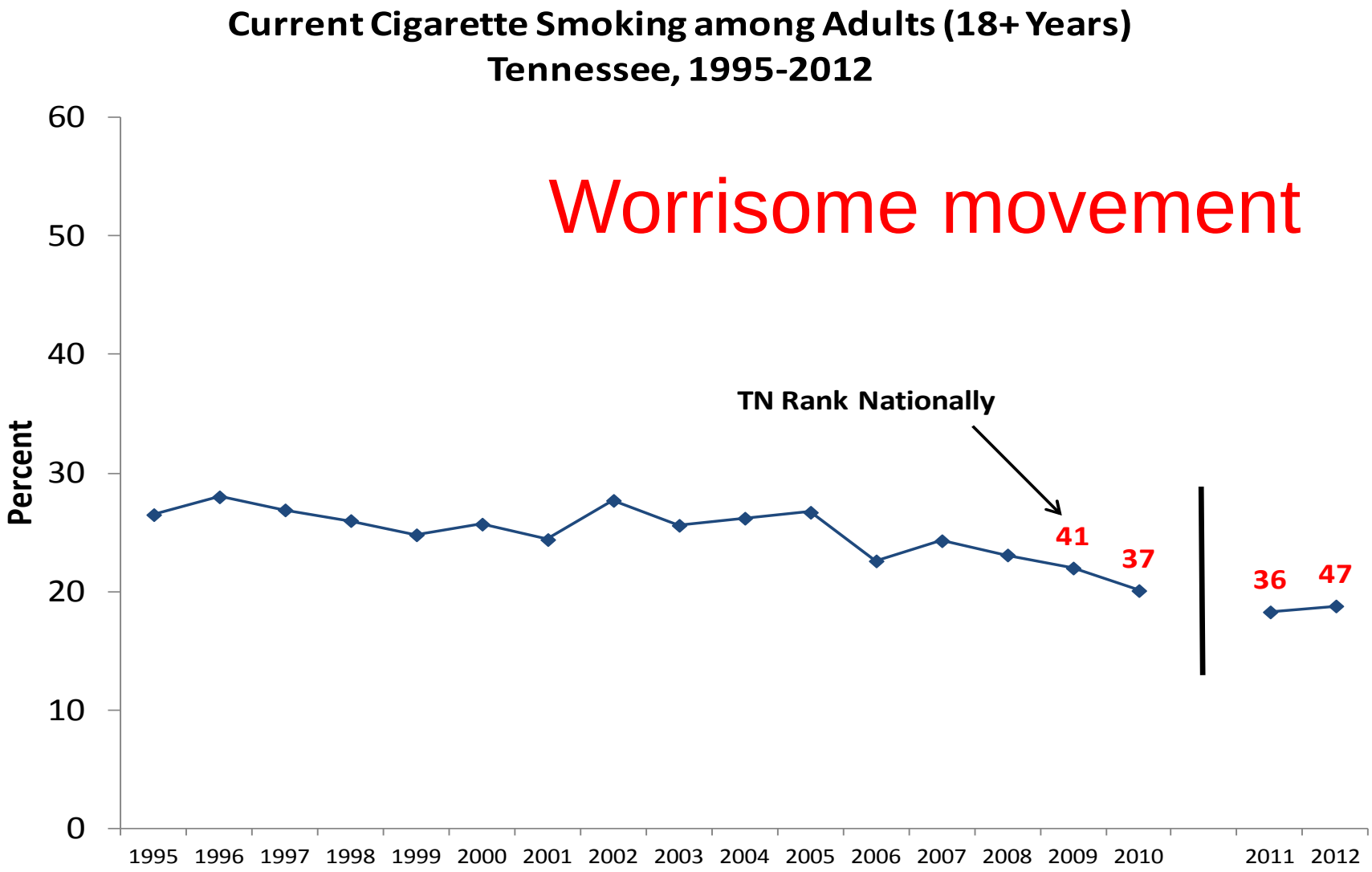
The Governor's Campaign for Health and Wellness

Governor creates health and wellness task force in Tennessee

NASHVILLE (AP): Jun 09, 2011

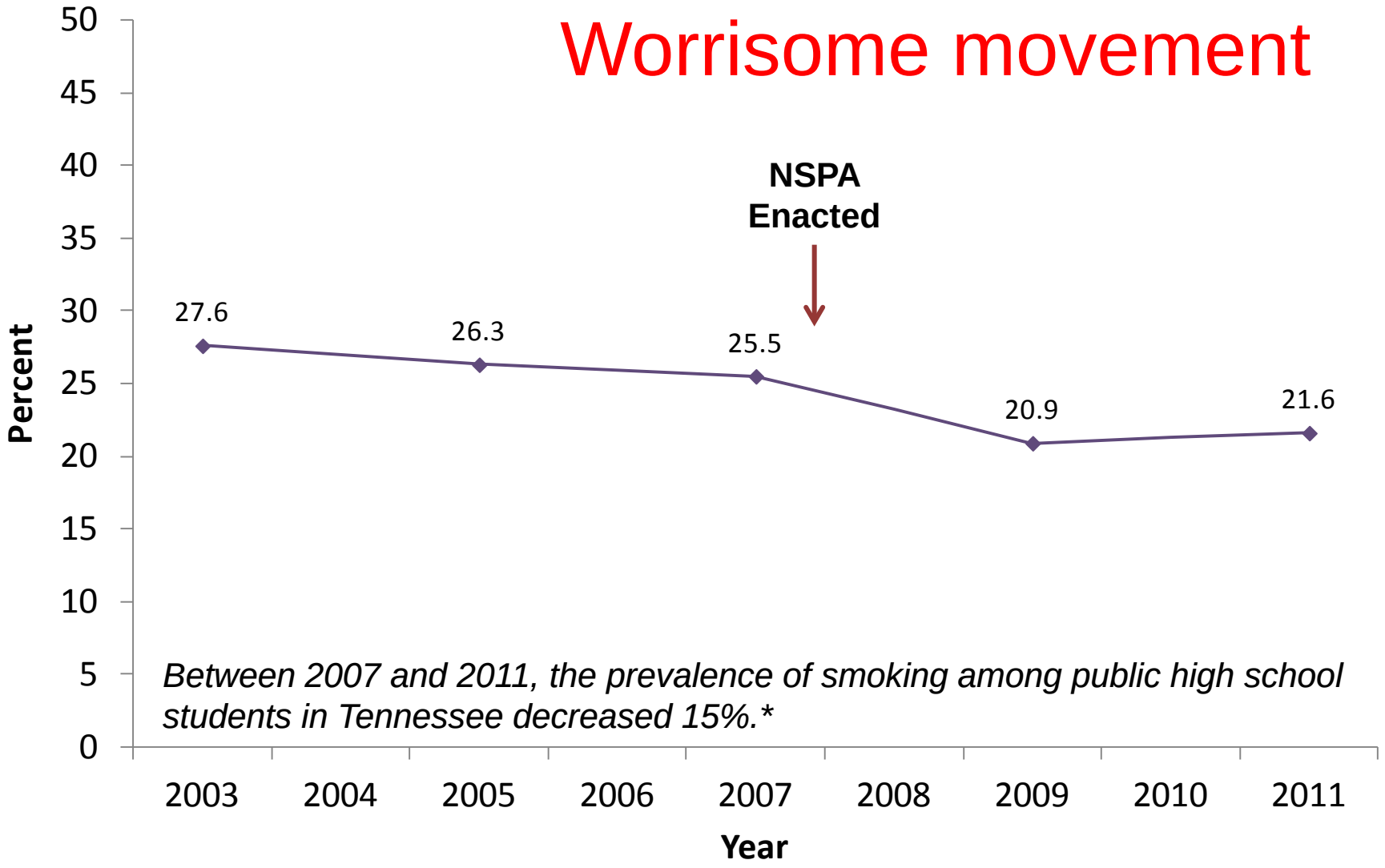
TENNESSEE DEPARTMENT OF HEALTH

Smoking: How are we Doing?



Data source: CDC - Behavioral Risk Factor Surveillance System Survey Data, 1995-2012. Labels in red indicate TN rankings among 50 US states.
Current smoker = smoked at least 100 cigarettes in their lifetime and currently smoke every day or some days.
Do not compare 2011-2012 BRFSS data to previous years. Due to changes in methods, comparisons are NOT valid and may be misleading.

Cigarette Smoking -- High School Students
Tennessee, 2003-2011

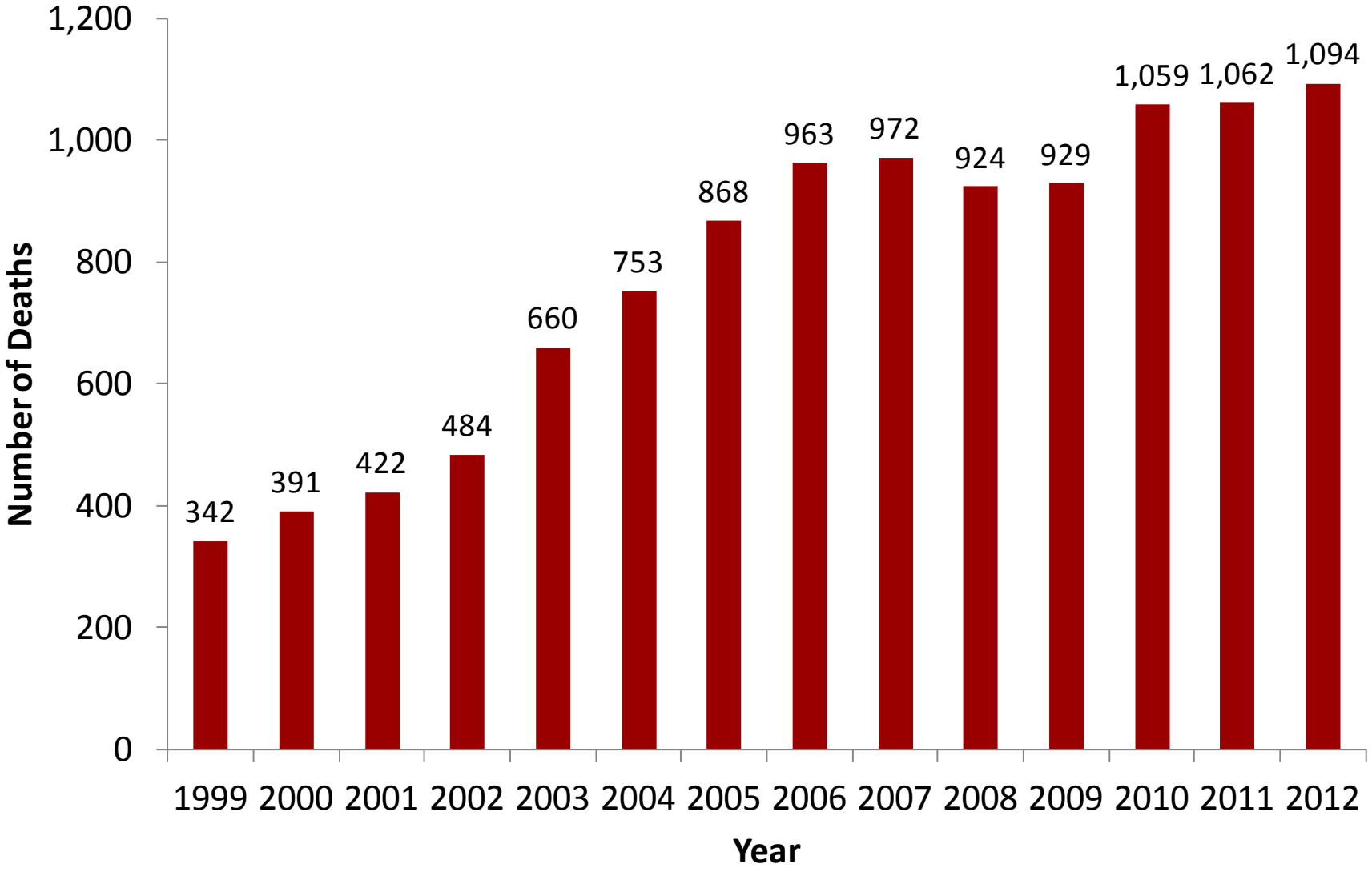


Data sources: Tennessee Department of Education; Youth Risk Behavior Surveillance System.
Public high school students who smoked cigarettes within the past 30 days. NSPA = Non-Smokers Protection Act.
**This difference was not statistically significant based on overlapping 95% confidence intervals.*

The Electronic Smoking Industry: Now Recruiting New Customers

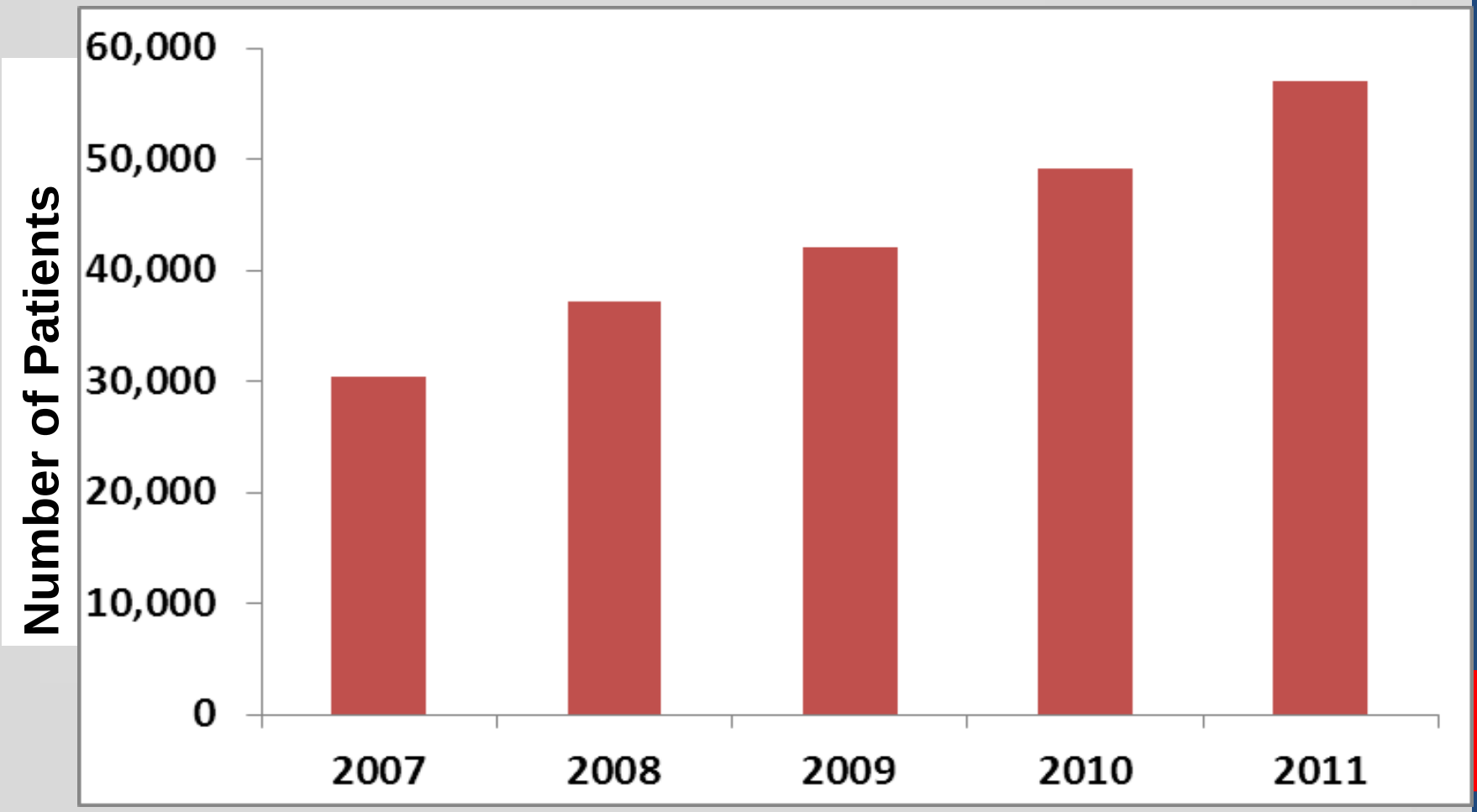
"The increased use of e-cigarettes by teens is deeply troubling," said CDC Director Tom Frieden, M.D., M.P.H. **"Nicotine is a highly addictive drug. Many teens who start with e-cigarettes may be condemned to struggling with a lifelong addiction to nicotine and conventional cigarettes."**

Deaths Due to Drug Overdose
Tennessee, 1999-2012

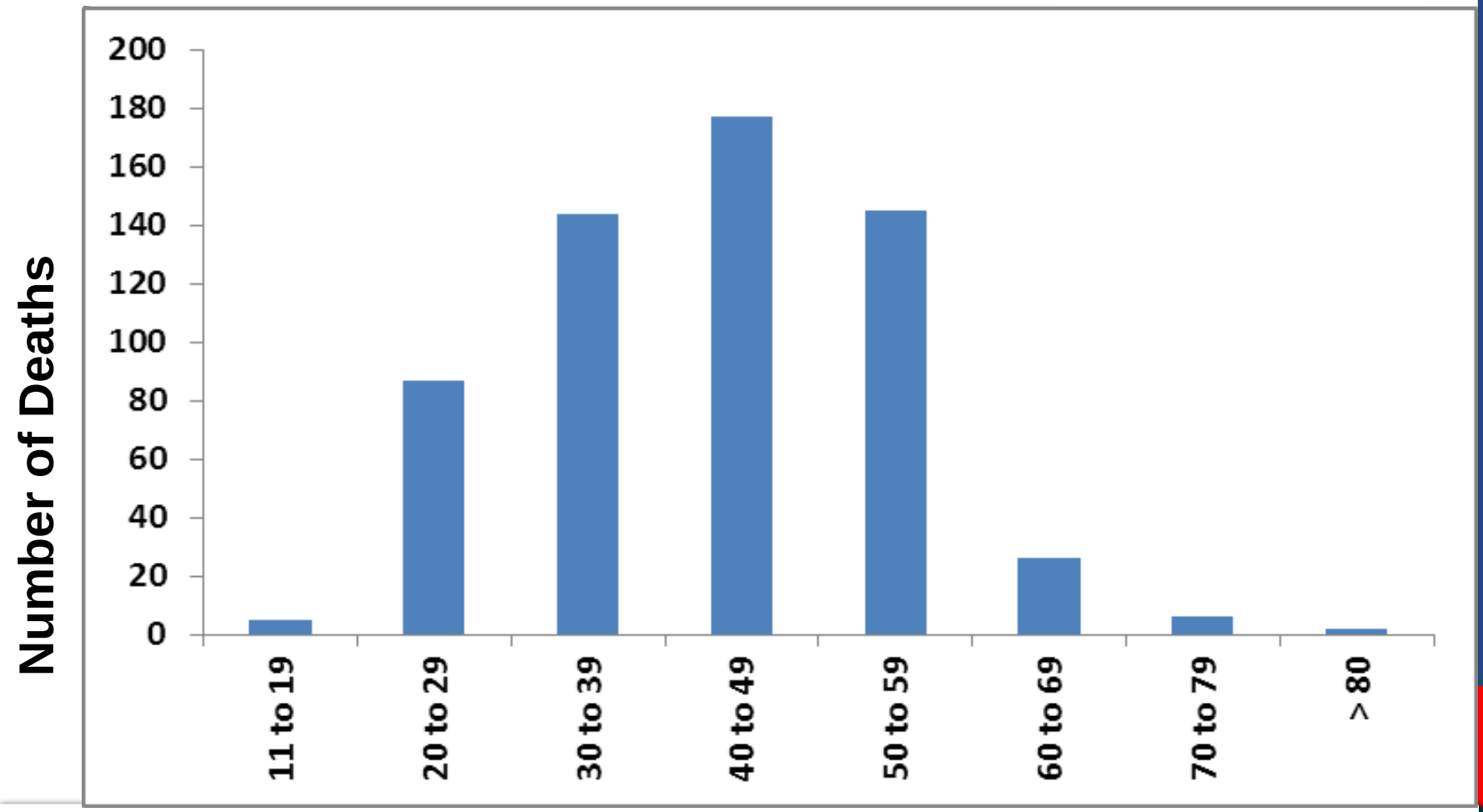


Data source: Tennessee Department of Health, Office of Health Statistics, Death Statistical System.
Overdose deaths were defined as having underlying cause of death ICD-10 codes X40-X44, X60-X64, X85, and Y10-Y14.

Number of Unique Patients Receiving Greater Than 100 MME of Opioids Daily

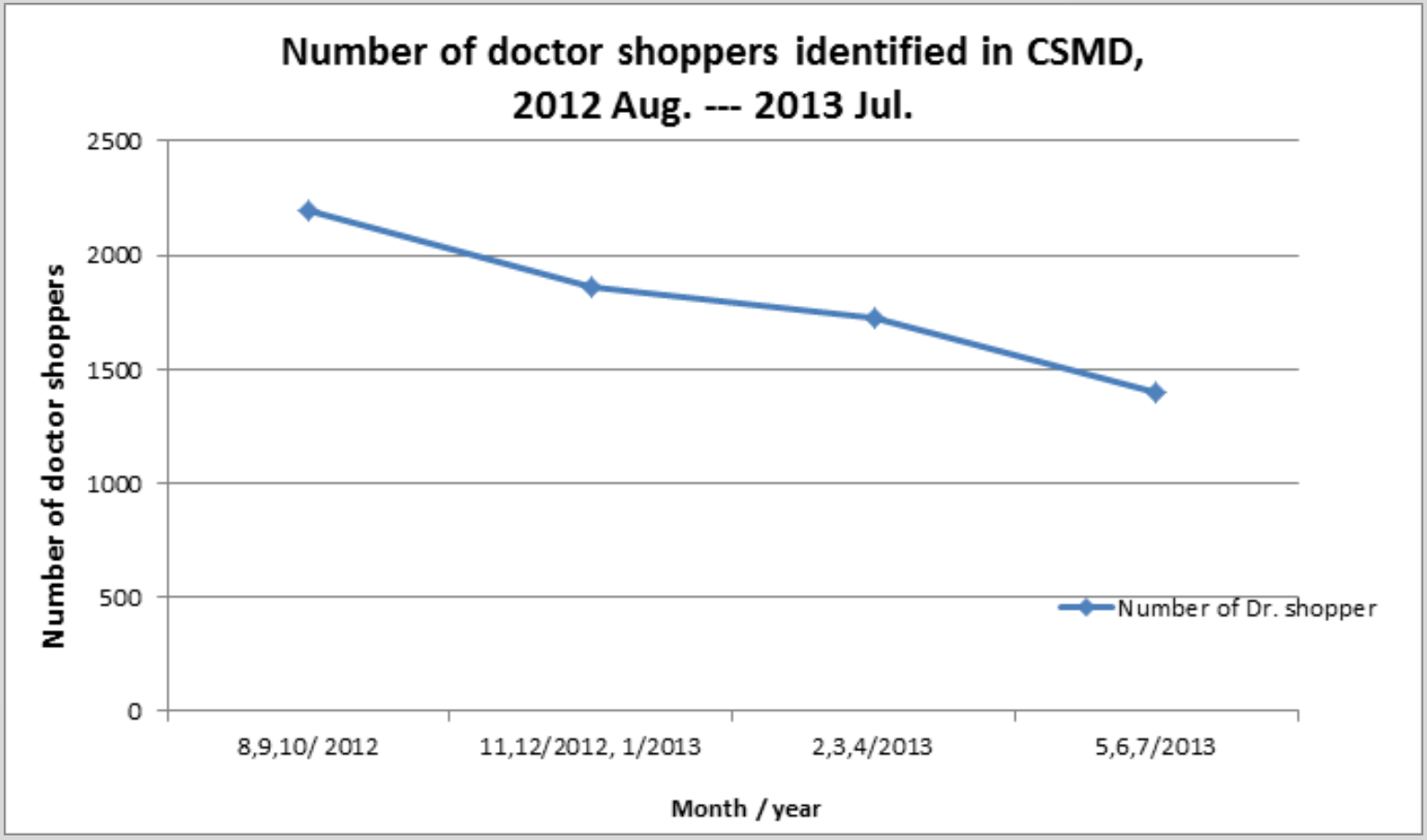


Deaths by Age Group, 2009–2010

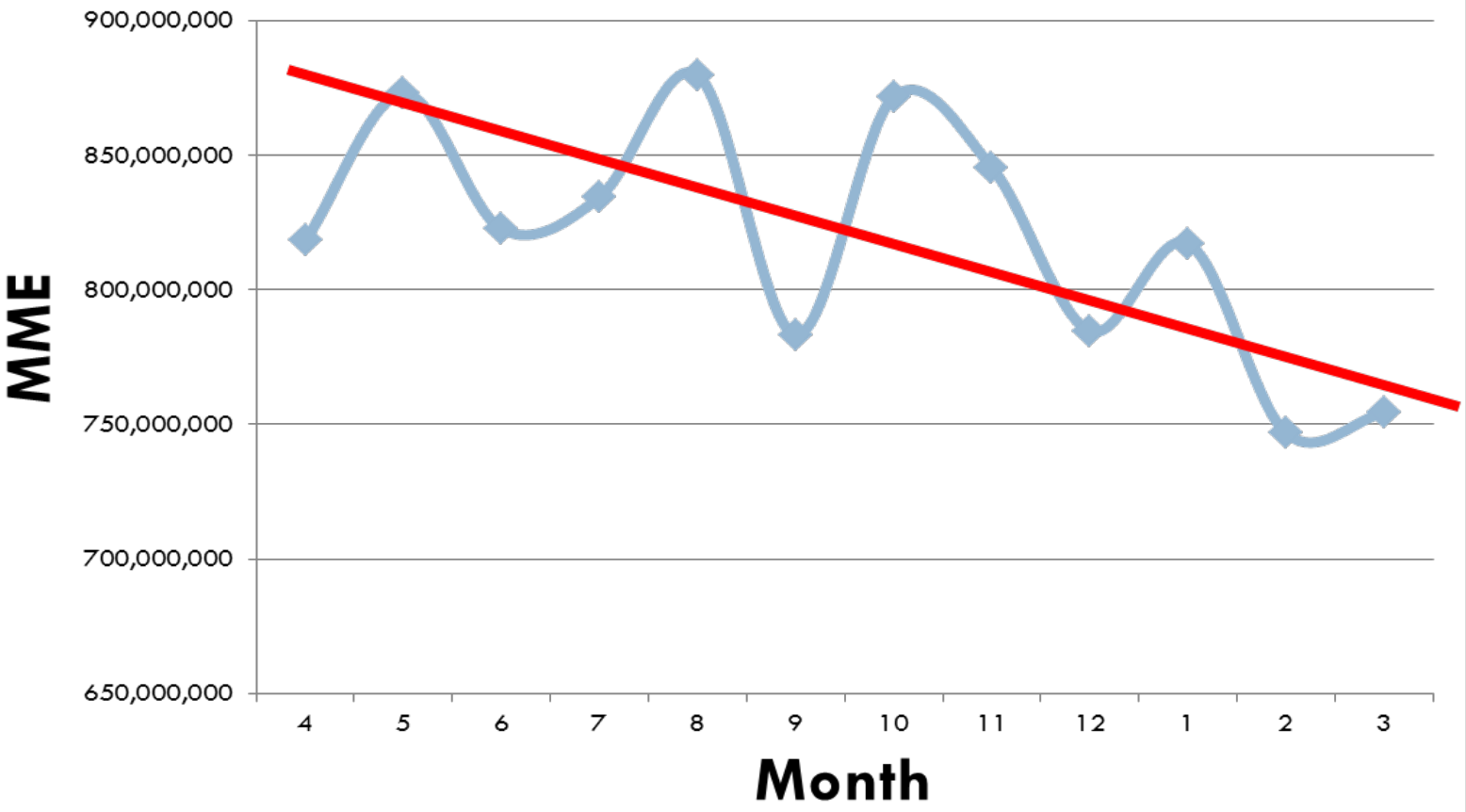


Pestronk
2012

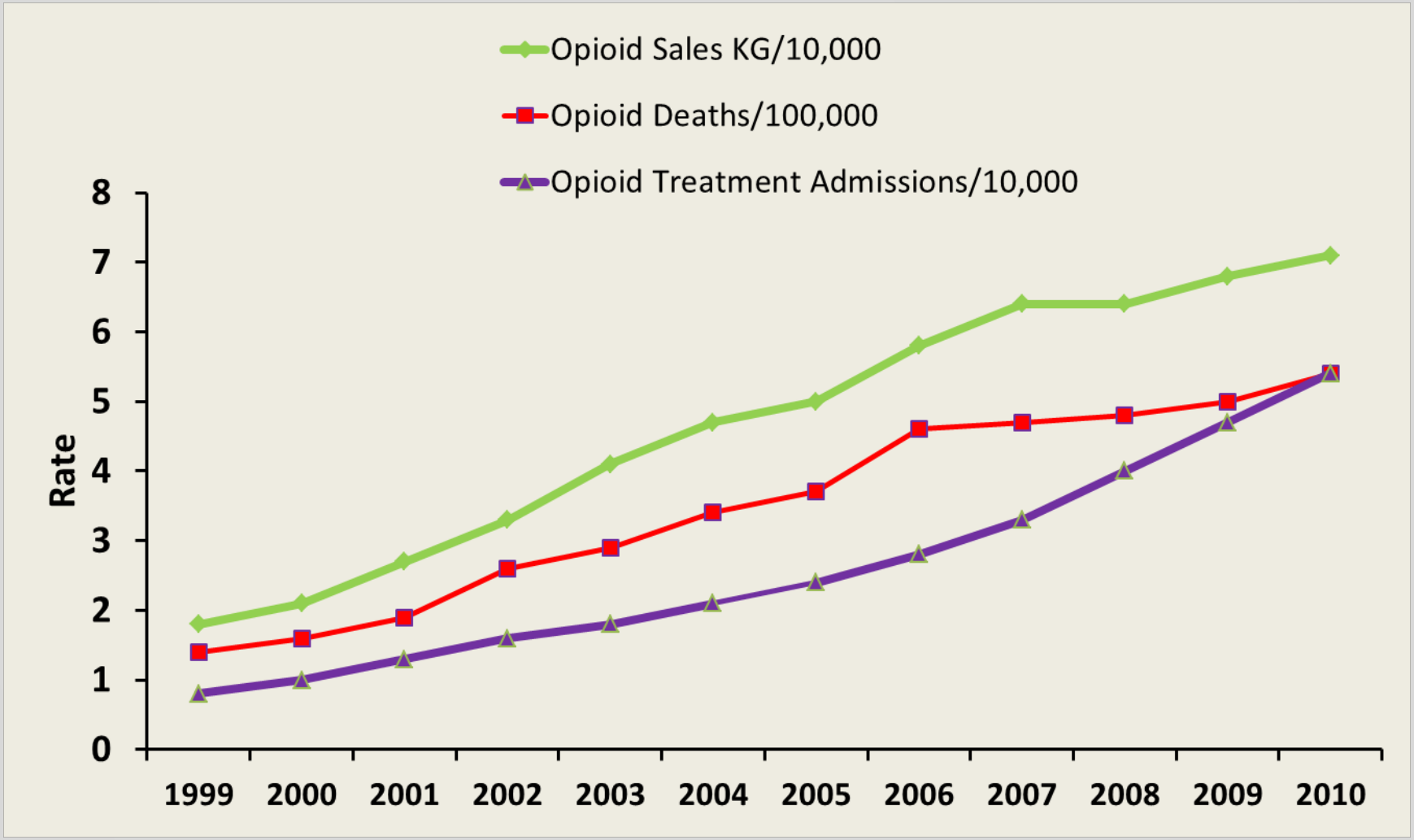
Doctor Shoppers: CDC Definition
5 prescribers and 5 pharmacies in 90 days



Total MME of Opioids 4/1/2012 - 3/31/2013



Opioid Sales, Treatment Admissions and Opioid-Related Overdose Death Rates — United States, 1999–2010



National Vital Statistics System, DEA's Automation of Reports and Consolidated Orders System, SAMHSA's TEDS

Tennessee Department of Health

Our Mission:

Protect , Promote and Improve

The health and prosperity of people

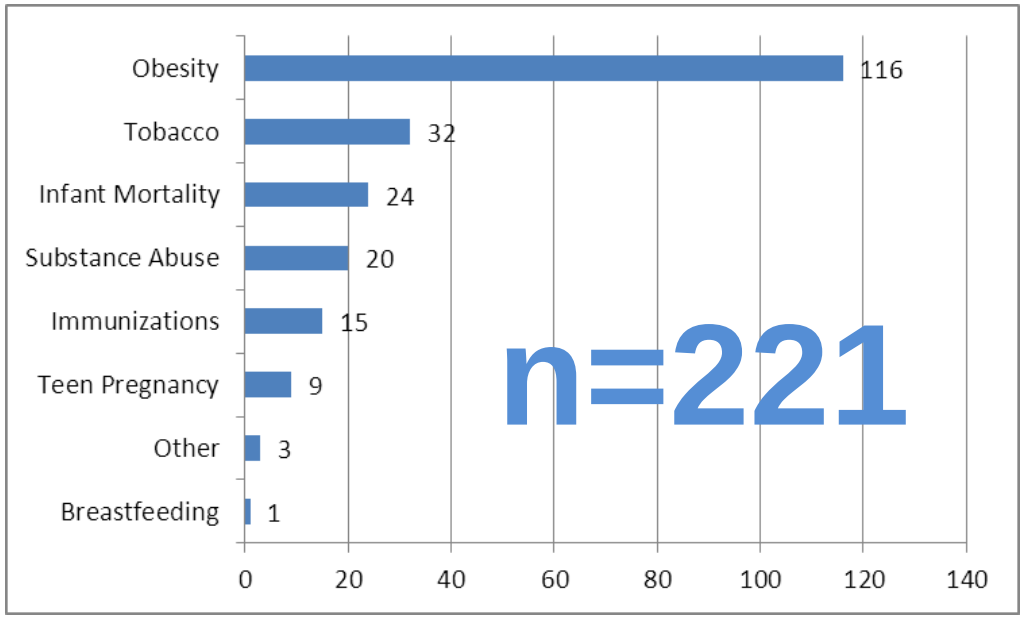
in Tennessee

The Commissioner's Goals

To achieve our unique competencies through community efforts in	To promote effective and efficient government through
Primary	People-Centered
Prevention	Performance
Initiatives	Improvement

Passionate People Innovating

PPI



TENNESSEE DEPARTMENT OF HEALTH

Disclaimer:

Views expressed by presenters external to the Tennessee Department of Health are their own and as such are not that of the Tennessee State Government. External presenters are not affiliated with Tennessee State Government, and their views and remarks do not necessarily reflect the policy of the State of Tennessee.

Agenda for State Innovation Model Public Roundtable meeting

- Why we are here / vision for Tennessee
- Progress with payment reform to date
- Introducing our guest speakers
- Perspectives on population health in Tennessee – Dr. John Dreyzehner
- **Perspectives on behavioral health in Tennessee – Ellyn Wilbur**
- Stakeholder discussion on population health and behavioral health

Behavioral Health in Tennessee

Tennessee Payment Reform Initiative

Public Roundtable Meeting

September 25, 2013

Nashville, TN

Ellyn Wilbur

Executive Director

Tennessee Association of Mental Health Organizations

www.tamho.org

What does the behavioral health system look like in Tennessee?

- National research suggests that 1 in 5 individuals will experience a mental health need at some point in their life and approximately 6% of the total will have a severe mental illness or severe emotional need.
- National research suggests that as many as 68% of adults with severe mental illness have co-morbid chronic physical conditions such as high blood pressure, diabetes or obesity.
- National research suggests that individuals with severe mental illness and co-morbid conditions die up to 25 years earlier than individuals without mental illness.

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What does the behavioral health system look like in Tennessee?

- Children have unique behavioral health needs and to successfully respond to their needs requires the involvement of the family or caregiver.
- Many of these youth have been exposed to trauma.
- National research indicates up to 75% of children in custody have a mental health need that requires treatment.

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Substance Use in Tennessee

A significant number of the adults and the youth represented in these numbers also have substance use disorders. Some estimate as many as **50%** have a co-occurring substance use issue.

The substance most abused in the public mental health system has shifted over the last 10 years from alcohol to prescription opioids. People receiving treatment in state funded programs in Tennessee were 3.5 times more likely to identify prescription opioids as their primary substance of abuse than the national average. [1]

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Substance Use in Tennessee

Among those with substance use disorders are vulnerable populations including:

- Veterans
- Victims of domestic violence
- Individuals who have experienced trauma
- Youth in the foster care system
- The LGBTQ population
- Transition aged youth
- Those involved in the criminal justice system

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Individuals Receiving Treatment in Tennessee

- In the most recent 12 month period ending March 2013, the community mental health centers in TN saw a total of **236,000** different individuals. Approximately one-third of these were children under the age of 18.[2]
- The CMHCs see on average somewhere between **85,000** and **90,000** people each month. Slightly less than half of this population has TennCare coverage. [3]
- Based on the most recent data available (2011), **16,590** adults received services in a drug or alcohol treatment center and **958** youth received similar services. [4]

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Individuals Receiving Treatment in Tennessee

Crisis Services

- In FY 2013, there were **227,010** calls made to the state-wide crisis telephone line, with **11,998** related to youth. [5]
- In FY 2013, a total of **67,242** in person crisis visits were made, with **7,481 or 11%** involving youth. [6]

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System Highlights

While the numbers seem daunting, we have much to be proud of in our behavioral health system. Some highlights:

- The Behavioral Health Safety Net is a state funded program administered by the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) that provides services to adults with mental illness who have limited income and no other payer source. In FY2013, **35,000** people were served through this program with more than **575,500** units of service provided.

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System Highlights

- Tennessee has a robust TennCare benefit package for behavioral health services that supports recovery.
- Federal grant funding is available to provide prevention and treatment services for substance use and mental health.
- Federal grant funding is available for Systems of Care planning and implementation for children and their families.
- The Creating Homes Initiative has created more than 8,000 housing options for people with mental illness since it began in 2000.

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System Highlights

- Tennessee has a nationally recognized suicide prevention program.
- *Best Practice Guidelines* have been developed for Services to Adults and Children to help assure high quality and consistency.
- There is an acknowledgement that those with lived experience greatly contribute to others' recovery. This is evidenced by Peer and Family Support Initiatives including 42 Peer Support Centers and a newly revised certification program for Peer Recovery Specialists.

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System Highlights

- There is a fully developed crisis system, including 8 crisis stabilization units for adults. Crisis response services are available to anyone 24 hours a day, 365 days a year.
- There are more efforts to integrate care at the provider level.
- Tennessee has implemented a multi-pronged plan to address prescription drug abuse in our state.
- There has been considerable growth in the provision of Telehealth services to help improve access to care, particularly in the rural areas of our state.

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System Highlights

- A curriculum titled Mental Health First Aid is being taught across the state (and country) to help educate citizens about how to recognize symptoms of mental illness, how to talk to someone with mental illness, and how and when to make a referral for services.
- Each of SAMHSA's 6 evidence based practices is operational to some extent in Tennessee .
- There is an awareness that in some instances, treatment can be more appropriate than incarceration. The first state-wide residential recovery court recently opened in Morgan County.

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System Challenges

- There is a greater demand for services than the current funding will support.
- There is a lack of qualified clinical staff available to meet the needs, particularly in the rural areas of our state.
- The increasing number of babies born addicted to drugs. Through August 2013, there were 564 babies born this year addicted, compared to an estimated 425 for the same time period in 2011. These babies frequently require an extended hospital stay and are **18 times** more likely to enter state custody than infants without these challenges.[7]

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System Challenges

- There is a concern about individuals who need behavioral health services and fall below 138% of poverty.
- For individuals who are eligible for coverage in the marketplace, the benefit package does not offer the services that we know are necessary to help adults with serious mental illness remain stable and youth with serious emotional issues achieve the best possible outcomes.

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System Challenges

- We know people get better care when the care is integrated and integrated care generally cost less, but there are some significant administrative barriers to achieving integration. We are hopeful that steps can be taken to help remove some of these barriers.
- The current payment methodology does not support collaboration, communication and coordination among clinicians in multiple disciplines. We are hopeful that the Payment Reform Initiative will address this challenge.

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System Challenges

- There is an insufficient data infrastructure to collect service and outcome data across state systems.
- Our system lacks a consistent process for sharing client data between health plans and providers.

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Examples of Tennessee Programs with Positive Results

- In-home services for children that have reduced the need for out- of- home placement.
- Case management services that have facilitated consumer engagement resulting in improved symptom management, housing stability, fewer inpatient days and reduced involvement with the criminal justice system.

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Examples of Tennessee Programs with Positive Results

- Services for children that utilize evidence based models that address trauma and improve youth health status.
- Co-occurring services that reduce substance use, reduce involvement with the criminal justice system and increase housing stability.
- School based programs that help youth stay in school, reduce substance use and juvenile court involvement, resulting in more successful and productive students .

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Examples of Tennessee Programs with Positive Results

- The Crisis Service continuum has significantly decreased the need for hospital beds and reduced the length of stay when an inpatient stay is necessary.
- Implementation of Wellness Programs that have improved individuals' behavioral and physical health.
- Implementation of programs designed to help individuals with mental illness move from homelessness to housing stability while improving their overall health status.

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Examples of Tennessee Programs with Positive Results

- Cherokee Health Systems has operated an integrated health home model in TN for more than 20 years. Their data substantiates improved health outcomes and lower costs.

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Promising Models

- Missouri began a new initiative 2 years ago in which the behavioral health provider was the “health home” for about 19,000 individuals. Preliminary results after the first year indicate that there was a 3% reduction in hospitalizations and a cost savings of approximately $4 million in hospital and emergency room costs.
- Colorado, Kansas and Oregon have also begun “health home” initiatives.

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Promising Models

- For Children and Youth: Child Parent Psychotherapy (CPP); Attachment, Self Regulation and Competency (ARC); Trauma Focused Cognitive Behavioral Therapy (TF-CBT); Parent Child Interaction Therapy (PCIT), among others.
- For Veterans and their families: Operation Stand Down, Not Alone, Saving Veteran Lives in Tennessee.
- The Aging Population: Chronic Care Model to address depression.

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Data Sources

1 - National Survey of Substance Abuse Treatment Services, 2011

2 - TAMHO Data Warehouse, 2013

3 - TAMHO Data Warehouse, 2013

4 - SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2010 and 2011 (2010 Data, Revised March 2012).

5 - Tennessee Department Mental Health and Substance Abuse Services, preliminary data for FY2013.

6 - Tennessee Department Mental Health and Substance Abuse Services, preliminary data for FY2013.

7 - State of Tennessee, DOH, Statewide Effort Addresses Problems of Babies Born Dependent on Addictive Drugs, November 27, 2012.

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The Tennessee Association of Mental Health Organizations (TAMHO) is a statewide trade association representing Community Mental Health Centers and other non-profit corporations that provide behavioral health services. These organizations meet the needs of Tennessee citizens of all ages who have mental illness and/or an addiction disorder. The TAMHO member organizations have been the virtual cornerstone of the Tennessee community-based behavioral health system since the 1950s and continue today as the primary provider network for community based care in Tennessee.

TAMHO member organizations provide mental health and addictions services to 90,000 of Tennessee's most vulnerable citizens each month. Services provided by the TAMHO network include:

Prevention, Education and Wellness: Includes programs for the prevention of addictions, violence, and suicide; early intervention; mental health and drug courts, jail diversion and community re-entry initiatives.

Psychiatric Rehabilitation: Programs that include peer support, illness management and recovery services, supported employment, and supported housing.

Community Based Services: Services include mental health case management, Programs for Community Treatment (PACT), intensive in-home services, school based services, therapeutic foster care, and jail liaison services

Clinic Based Services: Services include psychiatric evaluation and medication management; monitoring of core health indicators; individual, couples and family psychotherapy; psychological assessment; specialized treatments for trauma and addiction disorders and co-occurring disorders; partial hospitalization; intensive outpatient services; and forensic services.

Residential Services: Includes residential treatment services, group homes, independent housing.

Inpatient Services: Includes hospital based mental health and addiction disorder treatment services.

Crisis Services: Includes clinic based walk-in services, hospital based emergency evaluation, mobile crisis services, crisis respite, and crisis stabilization services.

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. . . TAMHO Member Organizations

REGULAR MEMBERS

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Robert N. Vero, Ed.D., Chief Executive Officer

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Agenda for State Innovation Model Public Roundtable meeting

- Why we are here / vision for Tennessee
- Progress with payment reform to date
- Introducing our guest speakers
- Perspectives on population health in Tennessee – Dr. John Dreyzehner
- Perspectives on behavioral health in Tennessee – Ellyn Wilbur
- **Stakeholder discussion on population health and behavioral health**

Understanding your perspective on population health and behavioral health

Questions to address from **your perspective**	
	Thoughts/reactions to population health and behavioral health perspectives in Tennessee
	Sharing with the State any other initiatives relating to population or behavioral health
	Ideas from the public on what should the State should include as part of its State Healthcare Innovation Plan (SHIP)

Thank you!

The State of TN has recently published a white paper on the Tennessee Payment Reform Initiative

To download/ read in PDF format, please visit
http://www.tn.gov/HCFA/forms/WhitePaper.pdf