Agenda

- Tennessee Health Link
- Partnership between HCFA, MCOs, Navigant and centers
- Introduction to Navigant
- Overview of Training Modalities
- Assessments and Coaching
- Key Milestones and Schedule
- Questions and Answers
Tennessee Health Link

Tennessee Health Link Went Live on December 1, 2016

Tennessee Health Link will coordinate health care services for TennCare members with the highest behavioral health needs. Health Link is meant to produce improved member outcomes, greater provider accountability and flexibility when it comes to the delivery of appropriate care for each individual, and improved cost control for the state.

Health Link providers are encouraged to ensure the best care setting for each member, offer expanded access to care, improve treatment adherence, and reduce hospital admissions. The program is built to encourage the integration of physical and behavioral health, as well as, mental health recovery, giving every member a chance to reach his or her full potential for living a rewarding and increasingly independent life in the community.
Navigant’s Team

Multi-Payer Medical Homes

Health Homes

Healthcare Delivery Transformation

Stakeholder Engagement

Tennessee’s Healthcare Environment
Navigant’s Team

Our team members have supported a variety of states, federal agencies and other entities with design, development and implementation of medical homes, health homes and other physical and behavioral health initiatives.

- Alabama
- Hawaii
- Illinois
- Iowa
- North Carolina
- Tennessee
- CMS Multi-payer Advanced Primary Care Practice
- CMS Comprehensive Primary Care Initiative
- Payers
- Providers
Navigant’s Team

Organizational Structure

Advisory Group and Facilitators
To support on-site coaches, finalize curricula and training content and facilitate trainings

Catherine Sreckovich – Project Director
Jennifer Hutchins – Project Manager

Betsy Walton: Training and Coaching Staff Manager
Denise Levis Hewson: PCMH Training Lead
William (Bo) Turner: Health Link Training Lead

Support Team
Practice Transformation Coaches
Training Coordinator
Meeting Coordinator
Others as Needs are Identified

Collaborate and coordinate with HCFA in all trainings and project phases

Chip Watkins
Mark Benninghoff
Chuck Cutler
Nicole Fetter
Jim Geraughty
Robin Bradley
Jenifer Mariencheck
Others as Needs Identified
Transformation, Technical Assistance and Training

• Contracted through January 2020 to provide technical assistance and training to centers participating in Health Link.

• Will conduct the following activities:
  ▫ Practice outreach
  ▫ Initial and semi-annual assessments
  ▫ Ongoing coaching and other training opportunities

• For Year 1, objectives include:
  ▫ Achieving consensus on goals, needs and areas of focus
  ▫ An agreed upon plan on how to achieve transformation
  ▫ Active involvement and engagement to achieve defined goals
  ▫ Progress on transformation
Training and Technical Assistance Modalities

- Large-format in-person trainings
- Webinars
- Recorded trainings
- Compendia of resources
- On-site coaching
- Learning Collaboratives

Curricula Delivery Modalities
# Overview of Training Modalities

<table>
<thead>
<tr>
<th>Modality</th>
<th>Description</th>
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</thead>
</table>
| Large Format Trainings    | • Will address topics that can benefit from in-person discussion and sharing of ideas among centers  
                             • Allow team time for center staff  
                             • Mix of informational presentations and small group discussions  
                             • Will occur at least quarterly in each Grand Region |
| Learning Collaboratives   | • Facilitate knowledge transfer among centers regarding successes, challenges, lessons learned and leading centers  
                             • Allow team time for center staff  
                             • Hands-on sessions  
                             • Will occur at least quarterly in each Grand Region |
| Webinars                  | • Provide a remote platform for presentation of further instruction for specific topics  
                             • Provides opportunity for questions posed to experts  
                             • Will occur at least quarterly  
                             • Will be taped |
# Overview of Training Modalities

<table>
<thead>
<tr>
<th>Modality</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recorded Trainings</td>
<td>• May be accessed at an individual’s convenience (e.g., to support training new staff and training existing staff on new topic) • Topics will be relevant to a large variety of providers across geographies</td>
</tr>
<tr>
<td>Compendia of Resources</td>
<td>• Materials will provided online to offer a large number of providers access to information and resources</td>
</tr>
</tbody>
</table>
# Examples of Assessment and Curricula Content Areas

<table>
<thead>
<tr>
<th>Content Areas</th>
<th>Sample Topics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transformation Overview and Basics</td>
<td>• Introduction to Health Homes and TN Health Link</td>
</tr>
<tr>
<td></td>
<td>• Stages of transformation and driver diagram</td>
</tr>
<tr>
<td></td>
<td>• Resources and shared learning</td>
</tr>
<tr>
<td>Change Management</td>
<td>• Implementing a change management model</td>
</tr>
<tr>
<td></td>
<td>• Redesigning care to serve as a Health Home</td>
</tr>
<tr>
<td></td>
<td>• Using change management knowledge to prepare the practice for transformation</td>
</tr>
<tr>
<td>Team-based Care and Practice Organization</td>
<td>• Team-based care and care coordination</td>
</tr>
<tr>
<td></td>
<td>• Role of practice team</td>
</tr>
<tr>
<td></td>
<td>• Characteristics of effective teams</td>
</tr>
<tr>
<td>Comprehensive Care Management and Support</td>
<td>• Comprehensive care management</td>
</tr>
<tr>
<td></td>
<td>• Population management</td>
</tr>
<tr>
<td></td>
<td>• Development of integrated care plan</td>
</tr>
</tbody>
</table>
## Examples of Assessment and Curricula Content Areas

<table>
<thead>
<tr>
<th>Module</th>
<th>Sample Competency Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Coordination</td>
<td>• Practice workflow redesign/clinical workflow management</td>
</tr>
<tr>
<td></td>
<td>• Coordination of care transitions</td>
</tr>
<tr>
<td></td>
<td>• Enhanced patient access</td>
</tr>
<tr>
<td>Behavioral Health Integration</td>
<td>• Unique population characteristics</td>
</tr>
<tr>
<td></td>
<td>• Behavioral health and primary care integration</td>
</tr>
<tr>
<td></td>
<td>• Working with primary care providers and specialists</td>
</tr>
<tr>
<td>Patient Engagement and Self-Care Support</td>
<td>• Motivational interviewing</td>
</tr>
<tr>
<td></td>
<td>• Supporting self-care and shared decision-making</td>
</tr>
<tr>
<td></td>
<td>• Tracking patient satisfaction</td>
</tr>
<tr>
<td>Use of Information Technology</td>
<td>• Electronic Health Records (EHRs) and Health Information Exchange (HIE)</td>
</tr>
<tr>
<td></td>
<td>• E-prescribing</td>
</tr>
<tr>
<td>Quality Improvement</td>
<td>• Model for improvement</td>
</tr>
<tr>
<td></td>
<td>• Understanding methodologies for quality improvement</td>
</tr>
<tr>
<td></td>
<td>• Use of metrics and reporting</td>
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</tbody>
</table>
### Anticipated Timeline and Events: Initial Assessments

<table>
<thead>
<tr>
<th>Dec - Jan</th>
<th>Jan - April</th>
<th>Jan - April</th>
<th>Jan - April</th>
<th>April</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Contact Health Link Administrator</td>
<td>• Conduct onsite assessments</td>
<td>• Discuss recommended training</td>
<td>• Develop individualized curricula</td>
<td>• Schedule onsite coaching</td>
</tr>
</tbody>
</table>
Philosophy and Approach: Initial Assessments

- Contact practice’s Health Link Administrator
  - Discuss assessment intent and approach and schedule onsite assessment
  - Discuss need for multiple meetings for centers with large number of sites
- Recommend all “Core Assessment Team” members attend full meeting
- “Core Assessment Team” comprised of the following practice staff:
  - Medical Director
  - Practice Manager
  - Health Link Administrator
  - Quality Improvement Director
  - Finance Manager
  - IT Support Lead
  - Care Coordinator/Care Manager
  - Office Staff Representative
  - Site Representatives
- One to two Navigant team members will attend the onsite assessment
- HCFA team members will attend as schedules allow
- Use an Assessment Tool to facilitate discussion with Core Assessment Team
Philosophy and Approach: Initial Assessments

- Estimate each onsite assessment will require 2-3 hours
- Conduct at the center level to determine current capabilities
- Some centers and their satellites are further along in transformation than others
- Use findings as baseline to determine level and frequency of recommended support
  - Generate information on topics for:
    - Individual practice needs for coaching and support
    - Webinars
    - Collaboratives
    - Topics for large conferences
  - Form the baseline for monitoring performance improvement and progress at the practice, region and state levels
Assessment Report Example

Health Link Initial Assessment Report

<table>
<thead>
<tr>
<th>Scoring</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
<th>Perfect</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

### Access

<table>
<thead>
<tr>
<th>Question</th>
<th>Your Answer</th>
<th>Region Answer</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the practice able to provide same-day appointments?</td>
<td>☐</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>Does the practice support scheduling and reducing barriers to adherence</td>
<td>☐</td>
<td>15</td>
<td>25</td>
</tr>
<tr>
<td>for medical and behavioral health appointments?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the practice able to provide routine and urgent care appointments</td>
<td>☐</td>
<td>15</td>
<td>20</td>
</tr>
<tr>
<td>outside regular business hours?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Health Promotion and Self-Management

<table>
<thead>
<tr>
<th>Question</th>
<th>Your Answer</th>
<th>Region Answer</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the practice educate the patient and his/her family on independent</td>
<td>☐</td>
<td>1</td>
<td>32</td>
</tr>
<tr>
<td>living skills with attainable and increasingly aspirational goals?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the practice provide educational resources, tracking tools and</td>
<td>☐</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>decision-making aids for self-management support?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Philosophy and Approach: Coaching

- Each center has the opportunity to receive up to one two-hour onsite coaching session per month for two years
  - Frequency to be determined based on initial assessment and agreement with practice leaders
  - Sessions will be grouped where possible and applicable
- Individualized curricula to be developed to focus on center needs
  - Sessions will focus on practical application of concepts explored during other training modalities offered
- Coaching may be relevant to both clinical and operational staff with requested attendance as relevant and determined by the center
Philosophy and Approach: Semi-Annual Assessments

- Conduct semi-annual assessments as more formal checkpoints than ongoing coaching sessions
- Use results to determine progress to date
- Based on progress, evaluate need for any changes to coaching or for corrective actions
- Develop findings reports
Upcoming Milestones

December 2016
• Begin provider outreach
• Begin webinars

January - April 2017
• Schedule and conduct initial assessments
• Conduct conference

Mid-April 2017
• Begin onsite coaching
Navigant Email Address

• General questions and comments can be submitted to an email mailbox but your primary source for answering questions will eventually be your coaches

providerassistance@navigant.com
THANK YOU