HEALTH CARE INNOVATION INITIATIVE

Patient Centered Medical Homes
Tennessee Health Link

September 18, 2018
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 providers.

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.
Patient Centered Medical Homes [PCMH]

is a comprehensive care delivery model designed to improve the quality of primary care services for TennCare members, the capabilities of and practice standards of primary care providers, and the overall value of health care delivered to the TennCare population.

**PCMH Organizations commit to:**
- Patient-centered access
- Team-based care
- Population health management
- Care management support
- Care coordination and care transitions
- Performance measurement and quality improvement

**PCMH Providers receive:**
- Ongoing financial support as well as financial rewards for high performance
- Training and custom curriculum
- Actionable quarterly reports on organization performance
- Access to a Care Coordination Tool with member level detail
Behavioral Health Needs

• TennCare members with significant behavioral health needs face various obstacles in accessing the care they need within the structure of a traditional health care system.

• Some identified barriers include:
  ▫ Limited access to primary care
  ▫ Fragmented care due to lack of coordination across the various physical and behavioral health providers
  ▫ Difficulty managing physical and behavioral health needs due to barriers such as lack of transportation and social supports

• Research indicates TennCare members with behavioral health needs are:
  ▫ almost 3 times more likely than an average member to be hospitalized
  ▫ almost 2 times as likely to present at an emergency room
Tennessee Health Link [THL]: Design and Implementation

- TennCare collaborated with all three Managed Care Organizations (Amerigroup, BlueCare and United Healthcare) and behavioral health providers to address the diverse needs of members requiring behavioral health services.
- **Tennessee Health Link** is a program that incentivizes increased care coordination for TennCare members with the highest behavioral health needs.
- The design of Health Link is based on the CMS/Federal Health Home model.
- Health Link launched statewide on December 1, 2016.
- Health Link is intended to work in conjunction with the Patient-Centered Medical Home (PCMH) program the State launched in January 2017.
# Tennessee Health Link: Member Eligibility Criteria

<table>
<thead>
<tr>
<th>Identification criteria</th>
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<td><strong>Category 1:</strong> Diagnostic criteria only</td>
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<td>Anytime during the last 6 months, diagnosis or code of:</td>
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<td>• Attempted suicide or self-injury</td>
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<td>• Bipolar disorder</td>
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<td>• Homicidal ideation</td>
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<td>• Schizophrenia</td>
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| **Category 2:** Diagnostic and utilization criteria |
| One or more behavioral health-related (a) inpatient admissions or (b) crisis stabilization unit admissions (18 or over), ED admissions (under 18), or residential treatment facility admissions; during the last 3 months WITH a diagnosis of: |
| • Abuse and psychological trauma |
| • Adjustment reaction |
| • Anxiety |
| • Conduct disorder |
| • Emotional disturbance of childhood and adolescence |
| • Major depression |
| • Other depression |
| • Other mood disorders |
| • Personality disorders |
| • Psychosis |
| • Psychosomatic disorders |
| • PTSD |
| • Somatoform disorders |
| • Substance use |
| • Other / unspecified |

| **Category 3:** Functional need |
| Provider documentation of functional need, to be attested to by the provider. Must meet Tennessee Health Link Medical Necessity Criteria. |
Tennessee Health Link: Activities

Health Link organizations use various activities to help members manage their healthcare including:

1. Comprehensive Care Management
2. Care Coordination
3. Health Promotion
4. Transitional Care
5. Patient & Family Support
6. Referral to social support
Tennessee Health Link: Performance Measures

• Quality metrics are tracked to ensure that Health Links are meeting specified quality performance levels and to provide them with information they can use to improve the quality of care they provide.

• Efficiency metrics are tracked to ensure that Health Links are meeting specified efficiency performance levels and to provide them with information they can use to improve the quality of care they provide.

• Providers receive quarterly Performance Reports from each MCO

• Quarterly Performance Reports to the Health Link agencies provide a snapshot of how the agency was performing over a look-back period
Tennessee Health Link: Agencies

Alliance Healthcare Services
Camelot Care Centers
CareMore Medical Group of Tennessee
Carey Counseling Center
Case Management
Centerstone
Cherokee Health Systems
Frontier Health
Generations Health Association
Health Connect America
Helen Ross McNabb Center

LifeCare Family Services
Mental Health Cooperative
Neighborhood Health
Omni Community Health
Pathways of Tennessee
Peninsula
Professional Care Services of West TN
Quinco Community Mental Health Center
Ridgeview Behavioral Health Services
Unity Management Services
Volunteer Behavioral Health Care System
Tennessee Health Link and its collaborative efforts with hospitals creates a story of hope, where science and a belief in human potential come together for positive outcomes.
Collaboration Goals:
• Decrease inpatient discharges
• Reduce unnecessary ED visits

3 Ways:
• Active THL members
• Attributed THL members
• Members transitioning within hospital setting

THL Key Activities:
• Comprehensive Care Management
• Care Coordination
• Health Promotion
• Transitional Care
• Member and Family Support
• Referral to Social Supports
Real Collaboration

- MHC care teams work shoulder to shoulder with area hospitals—both psychiatric and medical—to improve outcomes.
- The work of Nurse Liaisons enables MHC to work directly with hospitals to identify needs.
Continuity of Care

- Member specific plan of action
- Engagement
- Streamline point of contact
- Increase communication
- Follow up
- Follow through
Mandi Ryan, MSN - Director Healthcare Innovation
Andra Codrea, MS - Hospital Liaison Team Leader

Delivering Care That Changes People’s Lives
Care Coordination Tool

• Receive ADT Alerts Daily
• Outreach to Clients after ER or Hospitalizations
• Monitor High Utilizers
Transitional Care

- Collaborate with hospitals and other treatment facilities for discharge and transition planning
- Promote attendance at 7 day discharge appointment
Education and Prevention

• Improve understanding of appropriate emergency room utilization

• Improve self-management of health conditions and outcomes to reduce hospitalizations
Hospital Liaisons

• Link in Psychiatric Hospitals
• Increase Client Engagement
• Improve Treatment Compliance
• Reduce Readmissions
Thank You

• Questions? Email payment.reform@tn.gov or mary.c.shelton@tn.gov

• More information: https://www.tn.gov/tenncare/health-care-innovation.html