Tennessee Empowering MCO Providers: Increasing Health IT Functionality Reducing Reporting Burden

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### Tennessee Health Care Innovation Initiative

#### 3 Strategies

<table>
<thead>
<tr>
<th>Strategy elements</th>
<th>Examples</th>
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<tbody>
<tr>
<td>• Patient Centered Medical Homes</td>
<td>• Prevention</td>
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<tr>
<td>• Tennessee Health Link for people with the highest behavioral health needs</td>
<td>• Maintaining health</td>
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<td>• Care coordination tool</td>
<td>• Coordinating specialists</td>
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<td>• 48 Episodes of Care</td>
<td>• Avoiding preventable episodes of care</td>
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<td>• Quality and acuity adjusted payments for LTSS services</td>
<td>• Connecting behavioral and primary care</td>
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<td>• Value-based purchasing for enhanced respiratory care</td>
<td>• Perinatal</td>
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<td>• Workforce development</td>
<td>• Joint replacement</td>
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<td>• Asthma exacerbation</td>
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<td>• Colonoscopy</td>
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<td>• Cholecystectomy</td>
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<td>• ADHD</td>
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<td>• Payment for value and quality in nursing facilities and home and community based services</td>
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<td>• Training for providers</td>
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Tennessee Health Care Innovation Initiative Timeline

2013
- Vision taskforce
- Governor's Kickoff

2014
- 115 meetings

2015
- 237 meetings
- Episodes Design

2016
- 375 meetings
- Care Coordination Tool

2017
- 337 meetings
- PCMH and Health Link Design

2018
- 146 meetings
- Advanced Analytics

Planning

SIM Design

SIM Testing

PCMH and Health Link start

First episode report
First episode contracting
First episode performance period
First episode results

Enhanced respiratory care
ECF Choices starts
Nursing facility quality apps
Patient Centered Medical Home

Patient-Centered Medical Home (PCMH) is a comprehensive care delivery model designed to improve the quality of primary care services for TennCare members, the capabilities of primary care providers, and the overall value of health care delivered to the TennCare population.

- **67 primary care organizations** caring for 30% of TennCare members.
- **Over 300 sites** throughout the State.
Tennessee Health Link

Tennessee Health Link is a benefit with the primary purpose of coordinating health care services for TennCare members with the highest behavioral health needs.

- **22** Community Mental Health Centers and behavioral health providers
- **Over 200 sites** throughout Tennessee
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Michae...
MCO Payment Reform – Alignment
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Admission, Discharge and Transfer (ADTs) alerts

- Increase primary care and behavioral health provider follow up from emergency department (ED) and inpatient visits
- Help primary care and behavioral health providers find hard-to-reach patients
- Give providers an idea of when and where their patients are accessing the health care system
- Facilitate patient education on appropriate ED use
- Increase access to patients’ care history, as well as, diagnostic information when available
## ADTs: Useable and Valuable

<table>
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<tr>
<th>Useable</th>
<th>Valuable</th>
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<tr>
<td>• Web-based care coordination tool (CCT)</td>
<td>• Monthly payment to support care coordination, e.g., care coordinators spending time using the information in the tool</td>
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<td>• One tool for all MCOs</td>
<td>• Rewards to primary care for quality and efficiency in patient centered medical home</td>
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<td>• All hospitals sharing data</td>
<td>• Episodes of care: incentives to hospitals and specialists to avoid readmissions</td>
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<td>• Prioritization</td>
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<td>• Workflow design</td>
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Health Link – ADT Alerts

Below is an example of how our behavioral health providers are using this near real-time data today:
We can do this after we finish our long IT to-do list.

What is the benefit to hospitals?

How will you address [insert technical privacy question]?

What if payers use this to deny payment?

What They Heard

[Lack of technical expertise]

[Lack of trust]

[Lack of priority]

[Lack of 2-way benefit]

Sometimes [Talking To The Wrong Person]
What We Did

- Technical expertise through Audacious Inquiry (Ai)
- Priority created by THA Board (agreement to timeline)
- Hospitals can use data on readmission
- Long-term trusting partnership
- THA identified the correct person(s) at each hospital.

Lack of trust
Lack of technical expertise
Lack of priority
Lack of 2-way benefit

Priority created by THA Board (agreement to timeline)
Technical expertise through Audacious Inquiry (Ai)
Long-term trusting partnership
Hospitals can use data on readmission
THA identified the correct person(s) at each hospital.
Real-Time ADT Opportunity

• THA has a long-standing, mutually beneficial relationship with the TennCare bureau
  ▫ Addressing MCO issues
  ▫ Working to ensure fair, equitable reimbursement among hospitals
  ▫ Designing supplemental pool programs
  ▫ Educating hospitals on bureau initiatives

• THA was uniquely positioned to fulfil the needs of both TennCare and its members for the state’s ADT requirement
  ▫ **Member hospitals**: minimize the work effort and cost of compliance
  ▫ **TennCare**: receive all hospital ADT data from a single, centralized source

• Opportunity to expand the THA Health Information Network (HIN): THA members requested THA to “sit in the middle” (like UB claims data program)
THA ADT Data Collection – Member Benefits

- THA supported the initial system setup costs
- THA and its members control use of and access to ADT data
- THA leveraged existing data agreements and BAAs already in place with hospitals
- Simpler, more compliant way to provide ADT feeds to TennCare
  - All data standardization handled by Ai
  - Support for hospitals without an EHR
- Data available to hospitals for a variety of potential uses
  - Readmissions reduction programs
  - Transitional care management
  - Syndromic surveillance
- Ability to fulfil other requests for hospital ADT data from a centralized source
- THA can monitor eligibility and ADT performance for TennCare hospital Supplemental pools
TennCare ADT Data Flow
How It Works
Care Coordination Tool (CCT)

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

- Allows practices to view their attributed member panel
- Alerts providers of their attributed members’ hospital admissions, discharges, and transfers (ADT feeds) and tracks follow-up activities
- Identifies a provider’s attributed members’ risk scores
- Generates and displays gaps-in-care based on quality measures and tracks completion of activities
Care Coordination Tool

Altruista Health Guiding Care™
88% of TN Hospitals Statewide Sending ADTs
Care Coordination Tool: Provider Testimonials

- https://youtu.be/9Em69paklfY
Ai and the [THA] team worked seamlessly with our IT department, setting up the connection and exchanging data within days. I am excited to both contribute to and use the tools this ADT feed creates. We are confident our ability to exceed our current level of community healthcare delivery is strongly enhanced with this project. I am also certain our State and residents within it will reap positive benefits as we can now better align resources to provide the appropriate, proactive care in settings with the best outcomes at the lowest cost. Finally, the ability to aggregate State-wide data also allows [THA] to focus all caregivers towards similar goals, making Tennessee a significantly healthier State.”

- Randy Davis
President/CEO, NorthCrest Medical Center
Hospital Perspectives

Maury Regional Health found the process of establishing the ADT feed to be very easy. The feed was very standard and quickly implemented. Ai was easy to work with in operationalizing the ADT. The information available to the providers in our community will be valuable as they coordinate patient care.”

- Alan Watson
  CEO, Maury Regional Health System
We had a patient we’d been treating since 1993 for schizophrenia. When we started receiving [ADT] feeds from the hospitals, we discovered that she would come to our office and then immediately head to the ER for treatment of her physical health conditions. This was a real opportunity for us to improve care.”

- Pam Womack
CEO, Mental Health Cooperative
Provider Perspectives

”The ability to see all of ADT records for one of our members in one place is particularly useful so we can outreach to members who frequent the ER.”

- Mary Smith
Covenant Care Practices
# Key Learnings & Best Practices

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<thead>
<tr>
<th>Category</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Work Effort</strong></td>
<td>• Underestimated level of effort to engage hospitals (e.g., data agreements, security assessments)</td>
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<td>• Underestimated level of effort to execute (e.g., resourcing, timing, competing priorities)</td>
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<tr>
<td><strong>Operational Ownership</strong></td>
<td>• This is more than a technology initiative at the hospital- and state-levels (requires collaboration between finance, operations, IT, and clinical staff)</td>
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<td><strong>Hospital Association Partnership</strong></td>
<td>• THA member response to state’s initiative created a proposal from THA to execute the ADT program</td>
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<td>• Value of hospital association partnership and existing relationship with state hospitals</td>
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<td><strong>Vendor Expertise</strong></td>
<td>• Having specialized expertise from vendor partnerships was critical to success (Audacious Inquiry &amp; Altruista)</td>
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<td><strong>Funding</strong></td>
<td>• Able to use existing hospital assessment to create a state share for funding</td>
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<td><strong>State Requirement</strong></td>
<td>• State required ADT reporting to qualify for hospital supplemental payment</td>
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Thank you.