

eHealth Information Exchange

Keep it simple – think big – start small and build on successes

Office of eHealth Initiatives, State of Tennessee

Tennessee Health Care Innovation Initiative



"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

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 physicians

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**

Next Generation Care Coordination



- Real-time Admission, Discharge, Transfer (ADTs) and Emergency Department (ED) admissions
- Integrating participating primary care providers (PCPs) and MCOs in Patient Centered Medical Home (PCMH) and Tennessee Health Link State programs
- Automate typically manual care coordination activities

Tennessee's Three Strategies

	Source of value	Strategy elements	Examples
 <p>Primary Care Transformation</p>	<ul style="list-style-type: none"> ▪ Maintaining a person's health overtime ▪ Coordinating care by specialists ▪ Avoiding episode events when appropriate 	<ul style="list-style-type: none"> ▪ Patient Centered Medical Homes ▪ Health homes for people with serious and persistent mental illness ▪ Care coordination tool with Hospital and ED admission provider alerts 	<ul style="list-style-type: none"> ▪ Encouraging primary prevention for healthy consumers and coordinated care for the chronically ill ▪ Coordinating primary and behavioral health for people with SPMI
 <p>Episodes of Care</p>	<ul style="list-style-type: none"> ▪ Achieving a specific patient objective, including associated upstream and downstream cost and quality 	<ul style="list-style-type: none"> ▪ Retrospective Episodes of Care 	<ul style="list-style-type: none"> ▪ Wave 1: Perinatal, joint replacement, asthma exacerbation ▪ Wave 2: COPD, colonoscopy, cholecystectomy, PCI ▪ 75 episodes by 2019
 <p>Long Term Services and Supports</p>	<ul style="list-style-type: none"> ▪ Provide long-term services and supports (LTSS) that are high quality in the areas that matter most to recipients 	<ul style="list-style-type: none"> ▪ Quality and acuity adjusted payments for LTSS services ▪ Value-based purchasing for enhanced respiratory care ▪ Workforce development 	<ul style="list-style-type: none"> ▪ Aligning payment with value and quality for nursing facilities (NFs) and home and community based care (HCBS) ▪ Training for providers

eHealth Initiative Supporting the CCT

➤ Mission

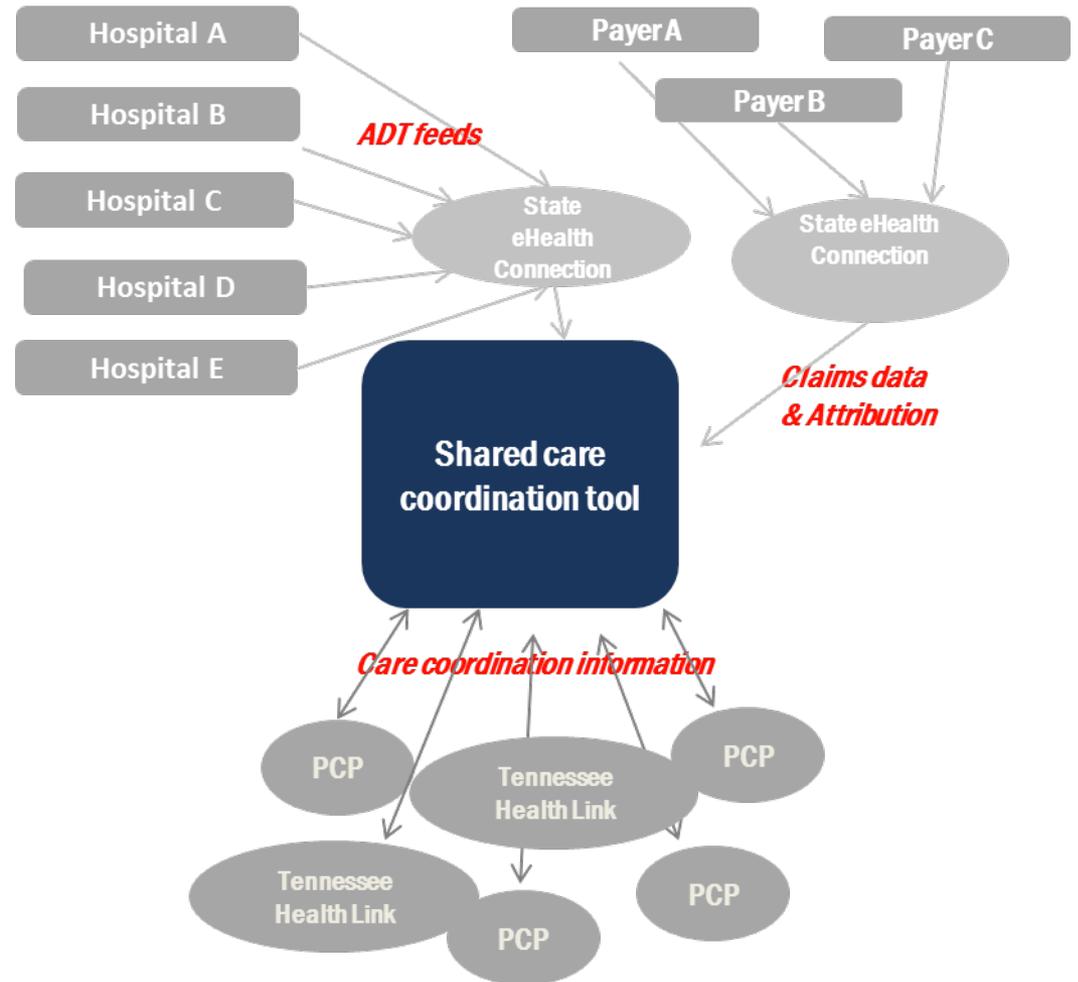
- Develop a centralized repository available to various applications (i.e., care coordination tool) to capture and analyze clinical and financial data in support of improving quality of care
- Support the 1.5M members of the Medicaid population

Project Benefits

- CMS supported Medicaid initiative
- Supports appropriate follow-up care with a potential goal to reduce readmissions, identify gaps in care, and reduce costs
- Provides PCPs more information through the care coordination tool and enables collaboration
- Offerings at no charge to participants
- Expansion plans include additional clinical, ancillary services (lab and radiology), and pharmacy data to hospitals and providers in future phases

How eHealth Connectivity Works

- Supports HCFA patient applications providing baseline data for encounters
- Real time submission of data
- Data received is validated for Medicaid eligibility, only validated information is stored, non validated information is deleted
- Providers see only their patients' information
- ANSI HL7 versions 2.3.1 or 2.5.1
- Web service protocol



Project Cost

- State of Tennessee is:
 - Development of the information exchange platform for the State
 - Responsible for care coordination application development that will be provided at no charge to PCMH and Tennessee Health Link participants
 - Funding infrastructure through the CMS HITECH program
- Hospital/Health System
 - Interface development time (variable by organization)

Project Request

- The ask:
 - For hospitals to send the State ADT messages from hospital emergency room and inpatient settings via real time HL7 standard messages for Tennessee Medicaid patients.

Project Contacts

eHealth Director and Project Sponsor

Mary Moewe

Mary.moewe@tn.gov

(615) 507-6477

eHealth Contacts:

Andrea Renner

Andrea.M.Renner@tn.gov

(615) 253-5438

Erik.Bock@tn.gov

(615) 507-6049

Lovel VanArsdale

Lovel.vanarsdale@tn.gov

(615) 507-6404