Division of
Health Care
Finance & Administration

Health Care
Innovation Initiative

Provider Stakeholder Group
December 14, 2016

# Agenda

- Episodes Of Care
- Tennessee Health Link Launch
- Patient-Centered Medical Home (PCMH) Launch
- Population Health Improvement
- Practice Transformation Training Overview-Navigant

# ADHD TAG Meeting- November 15th

## Changes based on feedback

1 **Design Dimension: Exclusions**

- Exclude episodes with disruptive dysregulation mood disorder (DDMD)
- Exclude episodes with Level 1 Case Management (review after 1 year)
- Exclude episodes with homelessness
- Exclude children in custody (DCS)

2 **Design Dimension: Quality Metrics**

- [New] Appropriate medications: Ratio of Long-Acting Stimulants to All Stimulants prescribed [gain sharing]
  - By age:
    - 4 - 5 years [gain sharing]
    - 6 - 11 years [gain sharing]
    - 12 – 20 years [gain sharing]
- [Updated] Utilization of Therapy: Average number of therapy visits per valid episode.
  - By age:
    - 4 - 5 years [gain sharing]
    - 6 - 11 years
    - 12 – 20 years

- Delay the performance period for the ADHD episode to CY 2018.
  - ➢ MCOs will continue to send preview reports in CY 2017.

# Summary of TAG recommendations – ADHD episode (11.15.2016)

| Area | Episode design summary |
|---|---|
| 1 Identifying episode triggers | ▪ An ADHD episode is triggered by a professional claim that has:<br>– A **primary diagnosis of ADHD** (ICD-9 diagnosis code 314 – Hyperkinetic syndrome of childhood), or<br>– A **secondary diagnosis of ADHD and a primary diagnosis of a symptom of ADHD**[1]<br>▪ This professional visit must also have a procedure code that is for assessment, therapy, case management, or physician services |
| 2 Attributing episodes to quarterbacks | ▪ The quarterback is the **provider or group with the plurality of ADHD-related visits** during the episode<br>▪ The contracting entity ID with the plurality of ADHD visits will be used to identify the quarterback |
| 3 Identifying services to include in episode spend | ▪ The length of the ADHD episode is **180 days**. During this time period the following services are included in episode spend:<br>– All inpatient, outpatient, professional, and long-term care claims with a **primary diagnosis of ADHD**<br>– All inpatient, outpatient, professional, and long-term care claims with a **secondary diagnosis of ADHD and a primary diagnosis of a symptom of ADHD**<br>– Pharmacy claims with **eligible therapeutic codes** |
| 4 Risk adjusting and excluding episodes | ▪ Episodes affected by **factors that make them inherently more costly than others are risk adjusted.** The list of factors recommended for testing will be provided in the DBR<br>▪ Episodes which are **not comparable** or affected by factors that make them inherently more costly but that **cannot be risk adjusted for are excluded**. There are three types of exclusions:<br>– Business exclusions: Available information is not comparable or is incomplete[2]<br>– Clinical exclusions: Patient's care pathway is different for clinical reasons:<br>▫ These include age (<4 or >20), attempted suicide, autism, bipolar, BPD, conduct disorder, delirium, dementia, dissociative disorders, homicidal ideation, intellectual disabilities, manic disorders, psychoses, PTSD, schizophrenia, specific psychosomatic disorders (e.g. factitious disorder), substance abuse, **homelessness, disruptive dysregulation mood disorder (DDMD), children in custody (DCS)** and **Level 1 Case Management**[3]<br>– High cost outlier exclusions: Episode's risk adjusted spend is three standard deviations above the mean |
| 5 Determining quality metrics performance | ▪ Quality metrics **tied to gain sharing** are:<br>– Percentage of valid episodes that meet the minimum care requirement. The minimum care requirement is set at 5 visits/claims with a related diagnosis code during the episode window. These may be a combination of physician visits, therapy visits, level I case management visits, or pharmacy claims for treatment of ADHD<br>– **Rate of long-acting medication use by age group (4 and 5, 6 to 11, 12 to 20)**<br>– **Average number of therapy visits per valid episode for the 4 and 5 age group**<br>▪ Quality metrics **not tied to gain sharing** are:<br>– Average number of physician visits per valid episode<br>– **Average number of therapy visits per valid episode by age group (6 to 11, and 12 to 20)**<br>– Average number of level I case management visits per valid episode<br>– Percentage of valid episodes with medication by age group (4 and 5, 6 to 11, and 12 to 20)<br>– Percentage of valid episodes for which the patient has a physician, therapy, or level I case management visit within 30 days of the triggering visit |

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1 Symptoms of ADHD are identified by ICD-9 diagnosis codes 312.30 – Impulse control disorder and 312.9 - Unspecified disturbance of conduct)

2 Episodes with inconsistent enrollment, third-party liability, or dual eligibility; episodes where triggering procedure occurs in a Federally Qualified Health Center or Rural Health Clinic; episodes that cannot be associated with a quarterback ID; episodes with zero triggering professional spend; episodes where total non-risk-adjusted spend is within the bottom 2.5% of all episodes; and episodes where patients expired in the hospital or left against medical advice

3 Level 1 Case Management will be revisited before the 2018 performance period.

# Episodes of Care: Status Report

## Episodes in Performance Period

- Perinatal
- Acute Asthma Exacerbation
- Total Joint Replacement
- Colonoscopy
- Cholecystectomy
- COPD
- Acute PCI
- Non-acute PCI

Wave 1 & 2

## Episodes in Preview Period

**Performance begins January 1, 2017**

- Upper GI Endoscopy (EGD)
- GI Hemorrhage
- Outpatient UTI
- Inpatient UTI
- Respiratory Infection
- Pneumonia
- ADHD*
- ODD
- CHF Acute Exacerbation
- CABG
- Valve Replacement & Repair
- Bariatric Surgery

Wave 3 & 4

## Episodes in Design

**Preview begins Summer 2017**

- Anxiety
- Tonsillectomy
- Non-Emergent Depression
- Mastectomy
- Breast Biopsy
- Breast Cancer Medical Oncology
- Otitis Media
- HIV
- Skin and Soft Tissue Infection
- Neonatal (37+ weeks)
- Neonatal (32-36 weeks)
- Neonatal (31- weeks)
- Pancreatitis
- Acute Diabetes Exacerbation

Wave 5 & 6

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*ADHD will have an additional preview period. Performance will begin CY 2018

# Wave 6 Episodes

## Episodes

- Acute Diabetes Exacerbation
- Pancreatitis
- HIV
- Neonatal: 37+ weeks
- Neonatal: 32-36 weeks
- Neonatal: 31- weeks
- Skin and Soft Tissue Infection

## Timeline*

- *Preview Reports:* Spring 2017
- *Performance Period:* Calendar Year 2018
- *Payments:* August 2019

*This timeline also applies to wave 5 episodes designed in the spring of 2016.

## Documents

- Detailed Business Requirements (DBR): Spring 2017
- Configuration file: Spring 2017

# Acute diabetes exacerbation episode current definition

| Area | Current episode definition | TAG advice |
|---|---|---|
| 1 **Identifying episode triggers** | ▪ An acute diabetes exacerbation episode is triggered by either an **inpatient admission** or **observation outpatient claim** where either:<br>– The primary diagnosis is one of the **defined diabetic ketoacidosis (DKA) or hyperglycemic hyperosmolar state (HHS) trigger codes**, or<br>– The primary diagnosis is one of the **defined diabetes codes with a secondary diagnosis code from the defined DKA or HHS trigger codes** | |
| 2 **Attributing episodes to quarterbacks** | ▪ The quarterback is the **facility where the patient is treated**<br>▪ The contracting entity ID on the facility claim will be used to identify the quarterback | |
| 3 **Identifying services to include in episode spend** | ▪ Services to include in episode spend are:<br>– All services and medications **during the trigger window**<br>– Specific care with relevant diagnosis, specific procedures, specific imaging and testing and specific medications **up to 30 days after discharge** from facility where the diabetes exacerbation was treated | |
| 4 **Risk-adjusting and excluding episodes** | ▪ Episodes affected by **factors that make them inherently more costly than others are risk-adjusted.** For the TennCare population, an example of such a factor is **kidney failure**<br>▪ Episodes which are **not comparable** or affected by factors that make them inherently more costly but that **cannot be risk-adjusted for are excluded**. There are three types of exclusions:<br>– Business exclusions: Available information is not comparable or is incomplete (e.g., third party liability, non-continuous eligibility, left against medical advice, patient age 65 or older)<br>– Clinical exclusions: Patient's care pathway is different for clinical reasons<br>– High cost outlier exclusions: Episode's risk-adjusted spend is three standard deviations above the mean | ▪ **Added four additional risk factors (cancer, HIV, pregnancy, rheumatoid arthritis)**<br>▪ **Added two clinical exclusions (organ transplant, cystic fibrosis)** |
| 5 **Determining quality metrics performance** | ▪ Percentage of episodes with **follow-up care** within 14 days post-discharge[1]<br>▪ Percentage of episode with **diabetes counseling** during the episode[1]<br>▪ Percentage of episodes with a **relevant readmission within** 30 days post-discharge<br>▪ Percentage of episodes with **ICU utilization** during the index admission<br>▪ Percentage of episodes with a **relevant ED visit** within 30 days post-discharge<br>▪ Percentage of episodes with **diabetes-related medications**[2] within 30 days post-discharge<br>▪ Percentage of episodes with **computed tomography (CT)** or **magnetic resonance imaging (MRI) usage** during the index admission<br>▪ **Average length of stay** of the index admission for inpatient-triggered episodes | ▪ **Adjusted follow-up care quality metrics**<br>▪ **Added one additional quality metric** |

1 Quality metrics tied to gain-sharing
2 Includes treatments directly for diabetes such as glycemic control medications and insulin, and treatments for common comorbidities such as blood pressure and cholesterol-lowering medications

# Pancreatitis episode current definition

| Area | Current episode definition | TAG advice |
|---|---|---|
| 1 **Identifying episode triggers** | ▪ A pancreatitis episode is triggered by either an **inpatient admission** or **observation outpatient claim** where either<br>– The primary diagnosis is one of the **defined acute or chronic pancreatitis trigger codes**, or<br>– The primary diagnosis is one of the **defined symptoms, findings, related disorders, or potential etiologies with a secondary diagnosis code from the defined acute or chronic pancreatitis trigger codes** | ▪ **Updated to include additional codes in findings, related disorders, and potential etiologies** |
| 2 **Attributing episodes to quarterbacks** | ▪ The quarterback is the **facility where the patient is treated**<br>▪ The contracting entity ID on the facility claim will be used to identify the quarterback | |
| 3 **Identifying services to include in episode spend** | ▪ Services to include in episode spend are<br>– All services and medications **during the trigger window**<br>– Specific care with relevant diagnosis, specific procedures, specific imaging and testing, specific medications **up to 30 days after discharge** from facility where the pancreatitis was treated | |
| 4 **Risk-adjusting and excluding episodes** | ▪ Episodes affected by **factors that make them inherently more costly than others are risk-adjusted.** For the TennCare population, an example of such a factor is **cholecystitis**<br>▪ Episodes which are **not comparable** or affected by factors that make them inherently more costly but that **cannot be risk-adjusted for are excluded**. There are three types of exclusions:<br>– Business exclusions: Available information is not comparable or is incomplete (e.g., third party liability, non-continuous eligibility, left against medical advice, patient age 65 or older)<br>– Clinical exclusions: Patient's care pathway is different for clinical reasons<br>– High cost outlier exclusions: Episode's risk-adjusted spend is three standard deviations above the mean | ▪ **Added three additional risk factors to test (diabetes, DKA, HIV)**<br>▪ **Added two clinical exclusions (organ transplant, cystic fibrosis)** |
| 5 **Determining quality metrics performance** | ▪ Percentage of episodes with **follow-up care** within 14 days post-discharge[1]<br>▪ Percentage of episodes with **nutritional counseling** during the episode[1]<br>▪ Percentage of episodes with a **new narcotics prescription** within 30 days post-discharge<br>▪ Percentage of episodes with **multiple narcotics prescriptions** within 30 days post-discharge<br>▪ Percentage of episodes with a **relevant readmission** within 30 days post-discharge<br>▪ Percentage of episodes with a **relevant ED visit** within 30 days post-discharge<br>▪ Percentage of episodes with **endoscopic retrograde cholangiopancreatography** performed during the index admission<br>▪ Of the episodes with a cholecystectomy performed, the percentage of episodes with the **cholecystectomy** performed during the index admission<br>▪ Percentage of episodes with **a relevant laboratory test**[2] within 14 days post-discharge | ▪ **Adjusted follow-up care quality metrics**<br>▪ **Added one additional quality metric** |

1 Quality metrics tied to gain-sharing
2 Relevant laboratory tests include Amylase, Lipase and LFTs

# HIV episode current definition

| Area | Current episode definition | TAG advice |
|---|---|---|
| 1 **Identifying episode triggers** | ▪ An HIV episode is triggered by an **outpatient pharmacy claim** for an **HIV-specific anti-retroviral therapy (ART)** with a confirming professional claim for evaluation and management of HIV or an AIDS-defining illness during the episode window | ▪ **Updated timing of confirming diagnosis**<br>▪ **Updated list of AIDS-defining illness confirming diagnosis codes** |
| 2 **Attributing episodes to quarterbacks** | ▪ The quarterback is the **physician** or **physician group** with the **most encounters** for **HIV-related evaluation and management.** Quarterbacks are attributed according to a hierarchy based on the **types of encounters** and **diagnoses**<br>▪ The contracting entity ID on the professional claim will be used to identify the Quarterback. | ▪ **Updated types of encounters to include inpatient visits** |
| 3 **Identifying services to include in episode spend** | ▪ The length of the HIV episode is **180 days**<br>▪ Services to include in episode spend are:<br>– Specific care with relevant diagnoses (e.g., HIV, AIDS-defining illnesses, and other opportunistic infections, co-infections, manifestations of HIV or long-term use of ART); specific procedures; specific testing; specific medications | |
| 4 **Risk-adjusting and excluding episodes** | ▪ Episodes affected by **factors that make them inherently more costly than others are risk-adjusted.** There are two types of risk factors:<br>– For AIDS-defining illnesses; select other opportunistic infections, co-infections, manifestations of HIV or long-term use of ART; and progression of HIV/AIDS as proxied by viral load<br>– For comorbidities (e.g., behavioral health issues, diabetes, hypertension, chronic kidney disorders) and socioeconomic circumstances (e.g., homelessness)<br>▪ Episodes which are **not comparable** or affected by factors that make them inherently more costly but that **cannot be risk-adjusted for are excluded**. There are three types of exclusions:<br>– Business exclusions: Available information is not comparable or is incomplete (e.g., third party liability, non-continuous eligibility, left against medical advice, age 65 or older)<br>– Clinical exclusions: Patient's care pathway is different for clinical reasons, such as that for patients under 1 years of age<br>– High cost outlier exclusions: Episode's risk-adjusted spend is three standard deviations above the mean | ▪ **Added non-diagnosis-based clinical risk factors (homelessness, gender identity dysphoria)**<br>▪ **Explored additional data sources to adjust for mode of acquisition and years since diagnosis**<br>▪ **Added age-based clinical exclusion** |
| 5 **Determining quality metrics performance** | ▪ Percentage of patients who **refill ART at least once in each of the three 60-day intervals**[1]; percentage of episodes with **coding for viral status**[1]; percentage of episodes with **viral load under 200 copies/mL**; percentage of patients who **refill ART at least once in the first 60 days after the triggering claim**; percentage of patients who **fill an ART prescription for the first time in 1 year**; percentage of episodes with **hospitalizations for HIV-related events**; percentage of episodes with **ED visits for HIV-related events**; percentage of patients **14 years or older who receive screening for chlamydia, gonorrhea, or syphilis**; percentage of patients who receive **screening for hepatitis C** | ▪ **Updated refill rate quality metrics**<br>▪ **Added age restriction for sexually transmitted infections screening quality metric**<br>▪ **Added quality metrics for first time HIV care and hepatitis C screening** |

1 Quality metric tied to gain-sharing

# Skin and soft tissue infections episode current definition

| Area | Current episode definition | TAG advice |
|---|---|---|
| 1 **Identifying episode triggers** | ▪ A skin and soft tissue infections episode is triggered by **a professional claim** for evaluation and management that has either:<br>– a **defined diagnosis code for a simple skin and soft tissue infection (SSTI)**; or<br>– a diagnosis of a **sign, symptom, or comorbid presentation of an SSTI** contingent on a **secondary diagnosis of an SSTI** on the same professional claim | ▪ **Updated to remove hidradenitis suppurativa and pilonidal cyst** |
| 2 **Attributing episodes to quarterbacks** | ▪ The quarterback is the **physician or physician group that diagnoses the SSTI**<br>▪ The contracting entity ID on the triggering professional claim will be used to identify the quarterback | |
| 3 **Identifying services to include in episode spend** | ▪ Services to include in episode spend are:<br>– Specific procedures, laboratory testing, imaging, medications, and other medical care relating to the diagnosis and treatment of the SSTI **during the trigger window**<br>– Specific procedures, laboratory testing, imaging, medications, and other medical care relating to follow-up visits and complications **during the 30 days after the initial diagnosis** | |
| 4 **Risk-adjusting and excluding episodes** | ▪ Episodes affected by **factors that make them inherently more costly than others are risk adjusted.** For the TennCare population, an example of such a factor is diabetes mellitus<br>▪ Episodes which are **not comparable** or affected by factors that make them inherently more costly but that **cannot be risk adjusted for are excluded**. There are three types of exclusions:<br>– Business exclusions: Available information is not comparable or is incomplete (e.g., third party liability, non-continuous eligibility, left against medical advice)<br>– Clinical exclusions: Patient's care pathways is different for clinical reasons (e.g., post-surgical infection, admission on initial presentation)<br>– High cost outlier exclusions: Episode's risk-adjusted spend is three standard deviations above the mean | ▪ **Added HIV as a risk factor** |
| 5 **Determining quality metrics performance** | ▪ Percentage of episodes where **bacterial cultures were obtained of the subset that had an incision and drainage (I&D)**[1]; Percentage of episodes where a **first-line antibiotic was prescribed within the seven days after initial diagnosis** out of all episodes receiving an antibiotic[1]; percentage of episodes receiving a **second antibiotic during days 15-30;** percentage of episodes with an **inpatient admission within the 30 days after initial diagnosis**; percentage of episodes with an **emergency department visit within the 30 days after initial diagnosis**; percentage of episodes where **ultrasound imaging was obtained;** percentage of episodes where **non-ultrasound imaging was obtained;** percentage of episodes with an **I&D** | ▪ **Adjusted quality metrics regarding first line antibiotic and imaging**<br>▪ **Added three additional quality metrics** |

1 Quality metric tied to gain sharing

# Gestational age of 37 weeks or greater episode current definition

| Area | Current episode definition | TAG advice |
|---|---|---|
| **1 Identifying episode triggers** | ▪ A neonatal episode is triggered by:<br>– An **inpatient admission** that has one of the **defined diagnosis codes for live birth** and either<br>▫ A diagnosis code of **gestational age of 37 weeks or greater** or<br>▫ **No gestational age** diagnosis code | ▪ **Updated gestational age** |
| **2 Attributing episodes to quarterbacks** | ▪ The quarterback is the **facility** where the newborn was delivered and initial care was received<br>▪ The contracting entity ID on the facility claim will be used to identify the quarterback | |
| **3 Identifying services to include in episode spend** | ▪ Services to include in episode spend are:<br>– All medical services, procedures, laboratory testing, imaging, pathology, medications, and additional care **during the trigger window**[1]<br>– All medical services, procedures, laboratory testing, imaging, pathology, medications, and additional care after discharge except for presentations out of the control of a provider (e.g., accidental trauma) **up to seven days after discharge** from the last facility where the newborn was treated during the trigger admission | ▪ **Updated duration** |
| **4 Risk-adjusting and excluding episodes** | ▪ Episodes affected by **factors that make them inherently more costly than others are risk adjusted.** For the TennCare population, an example of such a factor is neonatal abstinence syndrome<br>▪ Episodes which are **not comparable** or affected by factors that make them inherently more costly but that **cannot be risk adjusted for are excluded**. There are three types of exclusions:<br>– Business exclusions: Available information is not comparable or is incomplete (e.g., third party liability, non-continuous eligibility, left against medical advice)<br>– Clinical exclusions: Patient's care pathways is different for clinical reasons<br>– High cost outlier exclusions: Episode's risk-adjusted spend is three standard deviations above the mean | ▪ **Updated clinical risk factors and exclusions**[2]<br>▪ **Added exclusions (newborns born in ED, length of stay greater than 30 days, birth weight less than 2000 grams, post-term infants)** |
| **5 Determining quality metrics performance** | ▪ Percentage of episodes with a **newborn hearing screen prior to discharge**[3]; percentage of episodes receiving a **critical congenital heart disease screen prior to discharge**[3]; percentage of episodes receiving a **blood spot screen prior to discharge**[3]; percentage of episodes receiving a **hepatitis B vaccination prior to discharge**[3]; percentage of episodes with a **first pediatric visit within the 72 hours after discharge**; percentage of episodes with a **first pediatric visit within the five days after discharge**; percentage of episodes with an **emergency department visit within the 30 days after discharge**; percentage of episodes with a **readmission within the 30 days after discharge**; percentage of episodes **resulting in death** | ▪ **Updated to include non-claims based screening and vaccination QMs**<br>▪ **Updated duration for pediatric visit**<br>▪ **Added mortality rate metric** |

1 During the day or days of the inpatient admission until the newborn is discharged
2 Severe congenital anomalies are generally excluded and common presentations are tested as risk factors
3 Quality metric tied to gain sharing

# Gestational age of 32 to 36 weeks episode current definition

| Area | Current episode definition | TAG advice |
|---|---|---|
| **1 Identifying episode triggers** | ▪ A neonatal episode is triggered by:<br>– An **inpatient admission** that has one of the **defined diagnosis codes for live birth** and a diagnosis code of **gestational age of 32 to 36 weeks** | ▪ **Updated gestational age** |
| **2 Attributing episodes to quarterbacks** | ▪ The quarterback is the **facility** where the newborn was delivered and initial care was received<br>▪ The contracting entity ID on the facility claim will be used to identify the quarterback | |
| **3 Identifying services to include in episode spend** | ▪ Services to include in episode spend are:<br>– All medical services, procedures, laboratory testing, imaging, pathology, medications, and additional care **during the trigger window**[1]<br>– All medical services, procedures, laboratory testing, imaging, pathology, medications, and additional care after discharge except for presentations out of the control of a provider (e.g., accidental trauma) **up to seven days after discharge** from the last facility where the newborn was treated during the trigger admission | ▪ **Updated duration** |
| **4 Risk-adjusting and excluding episodes** | ▪ Episodes affected by **factors that make them inherently more costly than others are risk adjusted.** For the TennCare population, an example of such a factor is neonatal abstinence syndrome<br>▪ Episodes which are **not comparable** or affected by factors that make them inherently more costly but that **cannot be risk adjusted for are excluded**. There are three types of exclusions:<br>– Business exclusions: Available information is not comparable or is incomplete (e.g., third party liability, non-continuous eligibility, left against medical advice)<br>– Clinical exclusions: Patient's care pathways is different for clinical reasons<br>– High cost outlier exclusions: Episode's risk-adjusted spend is three standard deviations above the mean | ▪ **Updated clinical risk factors and exclusions**[2]<br>▪ **Added exclusions (newborns born in ED, birth weight less than 1,000 grams)** |
| **5 Determining quality metrics performance** | ▪ Percentage of episodes with a **newborn hearing screen prior to discharge**[3]; percentage of episodes receiving a **critical congenital heart disease screen prior to discharge**[3]; percentage of episodes receiving a **blood spot screen prior to discharge**[3]; percentage of episodes receiving a **hepatitis B vaccination prior to discharge**[3]; percentage of episodes with a **first pediatric visit within the 72 hours after discharge**; percentage of episodes with a **first pediatric visit within the five days after discharge**; percentage of episodes with an **emergency department visit within the 30 days after discharge**; percentage of episodes with a **readmission within the 30 days after discharge**; percentage of episodes **resulting in death** | ▪ **Updated to include non-claims based screening and vaccination QMs**<br>▪ **Updated duration for pediatric visit**<br>▪ **Added mortality rate metric** |

1 During the day or days of the inpatient admission until the newborn is discharged
2 Severe congenital anomalies are generally excluded and common presentations are tested as risk factors
3 Quality metric tied to gain sharing

# Gestational age 31 weeks or lower episode current definition

| Area | Current episode definition | TAG advice |
|---|---|---|
| 1 **Identifying episode triggers** | ▪ A neonatal episode is triggered by:<br>– An **inpatient admission** that has one of the **defined diagnosis codes for live birth** and a diagnosis code of **gestational age of 31 weeks or lower** | |
| 2 **Attributing episodes to quarterbacks** | ▪ The quarterback is the **facility** where the newborn was delivered and initial care was received<br>▪ The contracting entity ID on the facility claim will be used to identify the quarterback | |
| 3 **Identifying services to include in episode spend** | ▪ Services to include in episode spend are:<br>– All medical services, procedures, laboratory testing, imaging, pathology, medications, and additional care **during the trigger window**[1]<br>– All medical services, procedures, laboratory testing, imaging, pathology, medications, and additional care after discharge except for presentations out of the control of a provider (e.g., accidental trauma) **up to seven days after discharge** from the last facility where the newborn was treated during the trigger admission | ▪ **Updated duration** |
| 4 **Risk-adjusting and excluding episodes** | ▪ Episodes affected by **factors that make them inherently more costly than others are risk adjusted.** For the TennCare population, an example of such a factor is neonatal abstinence syndrome<br>▪ Episodes which are **not comparable** or affected by factors that make them inherently more costly but that **cannot be risk adjusted for are excluded**. There are three types of exclusions:<br>– Business exclusions: Available information is not comparable or is incomplete (e.g., third party liability, non-continuous eligibility, left against medical advice)<br>– Clinical exclusions: Patient's care pathways is different for clinical reasons<br>– High cost outlier exclusions: Episode's risk-adjusted spend is three standard deviations above the mean | ▪ **Updated clinical risk factors and exclusions**[2]<br>▪ **Added exclusions (newborns born in ED, gestational age less than 26 weeks)** |
| 5 **Determining quality metrics performance** | ▪ Percentage of episodes with a **newborn hearing screen prior to discharge**[3]; percentage of episodes receiving a **critical congenital heart disease screen prior to discharge**[3]; percentage of episodes receiving a **blood spot screen prior to discharge**[3]; percentage of episodes receiving a **hepatitis B vaccination prior to discharge**[3]; **participation of the discharging facility in the Vermont Oxford Network (VON)**[3]**;** percentage of episodes with a **first pediatric visit within the 72 hours after discharge**; percentage of episodes with a **first pediatric visit within the five days after discharge**; percentage of episodes with an **emergency department visit within the 30 days after discharge**; percentage of episodes with a **readmission within the 30 days after discharge;** percentage of episodes with **late sepsis or meningitis** in very low birth weight neonates; percentage of episodes less than 30 weeks gestational age **screened for retinopathy of prematurity prior to discharge**; percentage of episodes **resulting in death** | ▪ **Added non-claims based screening and vaccination metrics**<br>▪ **Updated duration for pediatric visit**<br>▪ **Added mortality rate and specific QMs for this at risk population** |

1 During the day or days of the inpatient admission until the newborn is discharged
2 Severe congenital anomalies are generally excluded and common presentations are tested as risk factors
3 Quality metric tied to gain sharing

# Agenda

- Episodes Of Care
- Tennessee Health Link Launch
- Patient-Centered Medical Home (PCMH) Launch
- Population Health Improvement
- Practice Transformation Training Overview-Navigant

# Tennessee Health Link – Program Launch

- Tennessee Health Link launched statewide on December 1, 2016.
- The primary objective of Tennessee Health Link is to 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.
- The twenty-one 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.

# Agenda

- Episodes Of Care
- Tennessee Health Link Launch
- **Patient-Centered Medical Home (PCMH) Launch**
- Population Health Improvement
- Practice Transformation Training Overview-Navigant

# Patient-Centered Medical Homes (PCMH) Launch

- The first wave of Patient-Centered Medical Homes (PCMH) in the TennCare program will launch on January 1, 2017. There will be approximately 30 practices participating in Wave 1 of PCMH for 2017. There will be additional practices added each year to the PCMH program.

- PCMH is a comprehensive care delivery model designed to improve the quality of primary care services for members, the capabilities and practice standards of primary care providers, and the overall value of health care delivered to the population. Each of the TennCare health plans has its own approach to PCMH, but this will be the first time a provider can participate in an aligned approach between all the of the health plans.

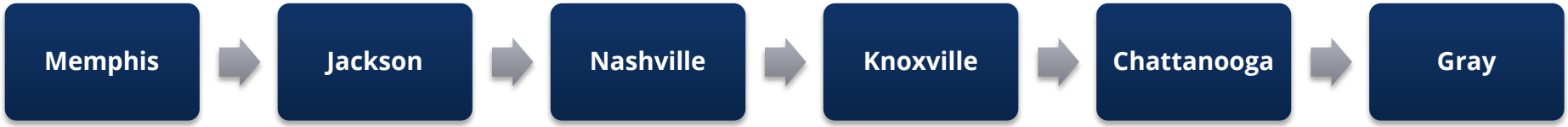
- PCMH providers commit to member centered access, team based care, population health management, care management support, care coordination, performance measurement and quality improvement. Participating providers receive training and technical assistance, quarterly reports with actionable data, and access to the care coordination tool. These providers are compensated with ongoing financial support and an opportunity for an annual outcome payment based on quality and efficiency performance.

# Agenda

- Episodes Of Care
- Tennessee Health Link Launch
- Patient-Centered Medical Home (PCMH) Launch
- **Population Health Improvement**
- Practice Transformation Training Overview- Navigant

# State SIM Population Health Improvement Update

- We are developing a common definition of population health and a way to measure population health improvement in Tennessee.
- We held six public workshops across the state to develop a regional consensus on the key principles and indicators of population health.
- Workshops were held in October & November in the following cities:




- We also held stakeholder-specific workshops for groups that we partner with to get their feedback on defining and measuring population health.
  - Partners included:
    - Tennessee Hospital Association
    - Cumberland Pediatric Foundation
    - Tennessee Association of Mental Health Organizations
    - Hospital Alliance of Tennessee
    - Tennessee Charity Care Network
    - TDH County & Regional Health Directors
    - RHAT Annual Conference Attendees

# State SIM Population Health Improvement Update

- We posed two questions to each group:
  - What are they key principles of population health?
  - What are they key indicators of population health?

## Memphis

### Key Principles

- Protecting vulnerable populations across the life span
- Intervene across the continuum of prevention
- Fundamental belief and action in health equity
- Promoting empathy and cultural humility
- Focusing resources to impact social determinants
- Clinical transformation with population health in mind
- Innovative and evidence based approaches to health improvement
- Developing effective connections and partnerships

### Key Indicators

- Life expectancy and longevity
- Disease prevalence and health outcomes
- Causes of death
- Access, quality, and utilization
- Health and lifestyle behavior
- Mental, behavioral, and emotional health
- Building healthy and safe places
- Social and economic indicators of health
- Community engagement/empowerment

## Gray

### Key Principles

- Universal access to comprehensive affordable care
- Environmental health policies and programs
- Holistic public health
- Regional and cultural health literacy
- Research and surveillance of appropriate health indicators
- Addressing social determinant's of health and health disparities
- Integration and collaboration among community stakeholders
- Long-term investment in primary prevention

### Key Indicators

- Are we moving the needle?
- Key indicators across the lifespan
- Community wellness indicators
- Lifestyle factors
- Resource allocation
- Mental health and substance abuse

# State SIM Population Health Improvement Update

- The results and feedback generated during these workshops will be incorporated into a draft set of measures, which will be disseminated for comment in Spring 2017.

- Once finalized, they will be incorporated into the Tennessee State Health Plan (the SIM PHIP), the state's main health policy tool, and eventually incorporated into a web-based dashboard.

- These indicators will be the main resource of measuring population health of the state of Tennessee, will be used to set state-wide and departmental health goals, and will be used to evaluate progress in improving the health of the state of Tennessee.

# Agenda

- Episodes Of Care
- Tennessee Health Link Launch
- Patient-Centered Medical Home (PCMH) Launch
- Population Health Improvement
- **Practice Transformation Training Overview- Navigant**

# Navigant's Team




Multi-Payer Medical Homes

Health Homes

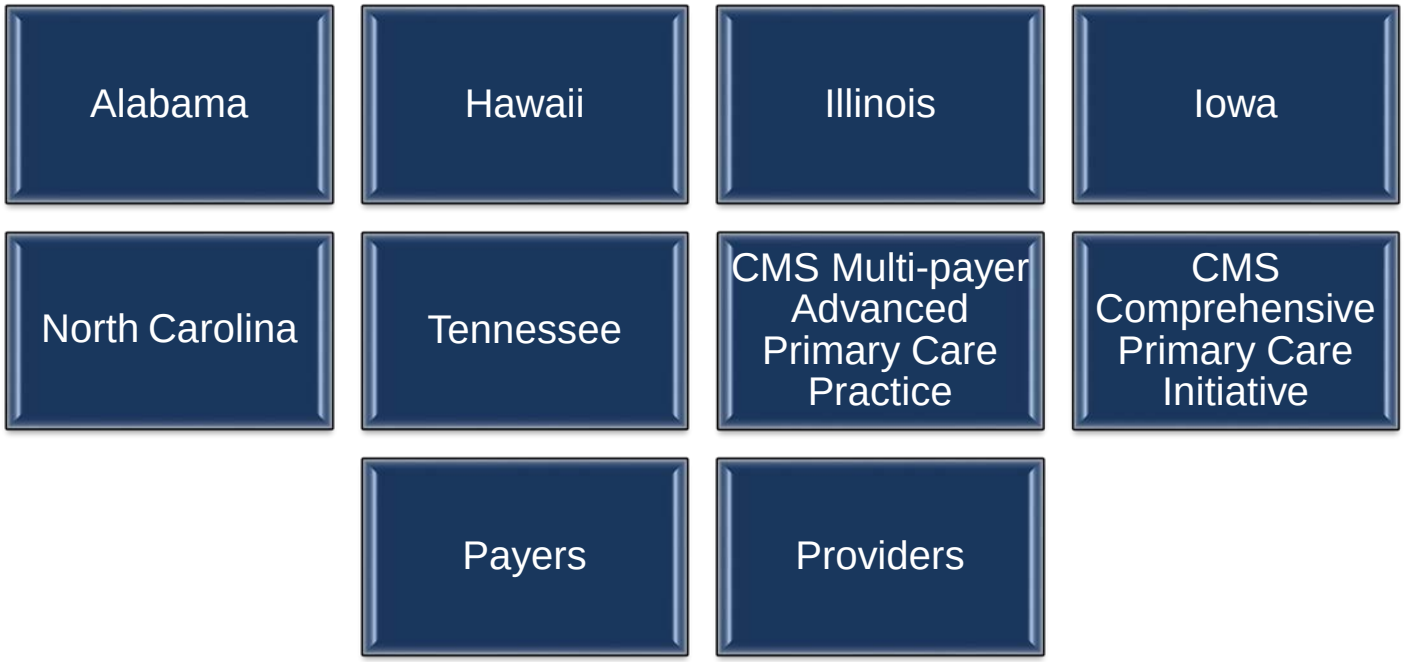
Healthcare Delivery Transformation

Stakeholder Engagement

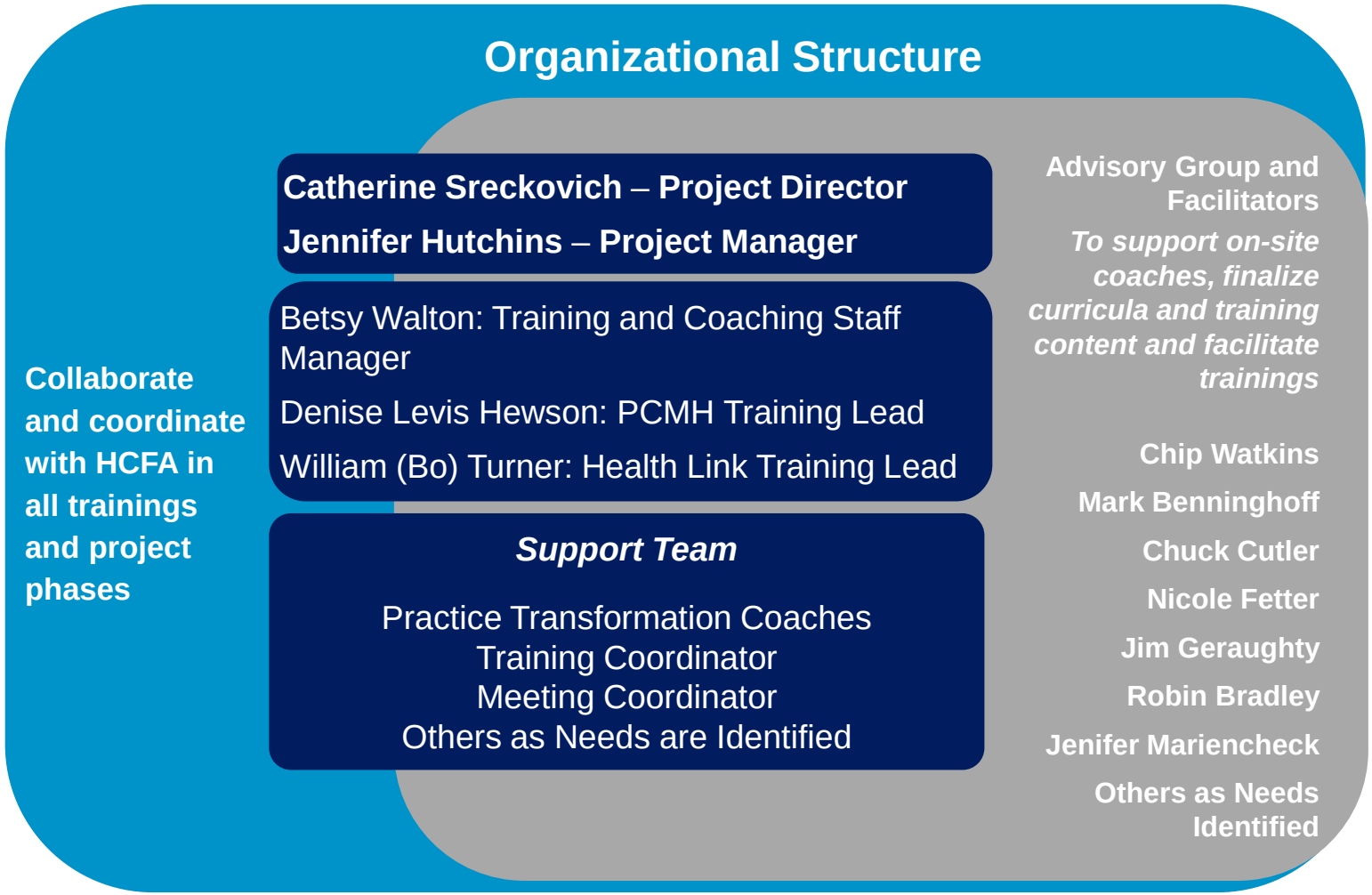
Tennessee's Healthcare Environment

# 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.



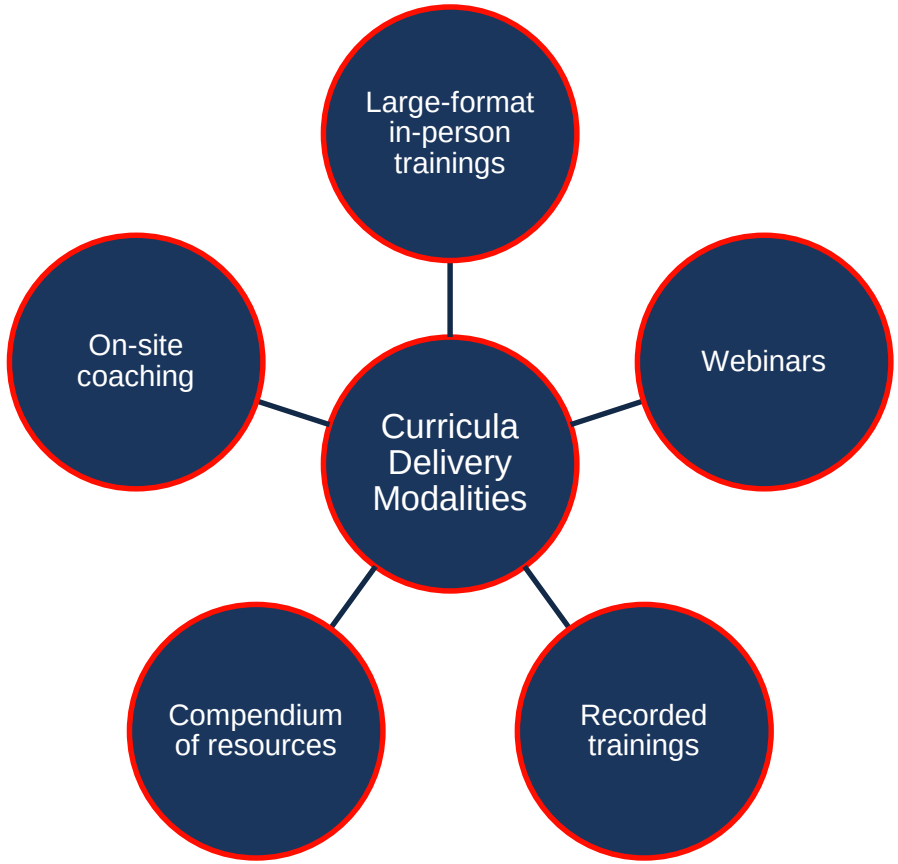
# Navigant's Team



# Transformation, Technical Assistance and Training

- Contracted through January 2020 to provide technical assistance and training to practices participating in the Health Link and PCMH programs.
- Will conduct the following activities:
  - Practice outreach
  - Initial and semi-annual assessments
  - Trainings using various modalities

# Training and Technical Assistance Modalities



# Philosophy and Approach: Initial Assessments

- Practices and sites are at various stages of transformation
- Conduct initial assessments at practice level to develop a baseline of current capabilities
- Estimate each initial onsite assessment will require 2-3 hours
- One to two Navigant team members will attend the onsite assessment
- Will use an Assessment Tool to facilitate discussion with Core Assessment Team

# Philosophy and Approach: Coaching

- Each practice site is eligible for 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
- Individualized curricula to be developed to focus on practice site needs
- One coach will be assigned to support designated sites

# 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
- Evaluate need for any changes to coaching or for corrective actions
- Develop findings reports

# Upcoming Milestones

**December 2016**

- Begin provider outreach
- Conduct first Health Link webinar

**January - April 2017**

- Schedule and conduct initial assessments
- Conduct first PCMH webinar
- Conduct conference

**March - April 2017**

- Begin onsite coaching