North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

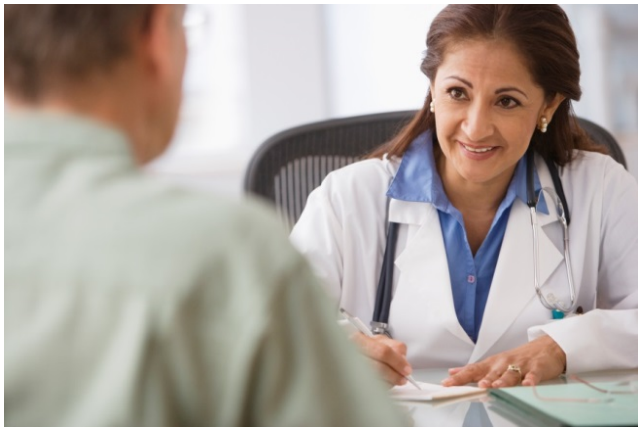
Patient-Centered Medical Home Pilot Update

Board of Trustees Meeting

August 28, 2015

Patient-Centered Medical Home (PCMH) Pilot Vision

- Complement an overall provider engagement strategy
- Engage physicians in the care of Plan members through an alternate payment strategy, data driven, coordinated supports
- Achieve better health outcomes and improve the member's experience in a complex health care environment



Patient-Centered Medical Home Status

- Contracts have been signed with 4 provider groups:
  - CaroMont, May 2015
  - Eagle, May 2015
  - Carolinas HealthCare (New Hanover), May 2015
  - Novant, August 2015
- Baseline and target metrics established for 3 of 4 practice groups

PCMH Status	CaroMont	Eagle	Carolinas HealthCare	Novant
Practices	10	7	3	41
Physicians	95	42	27	778
Members	2,810	4,537	1,593	12,428
Onboarding Tier Level	2	4	4	2

Core Metrics for All Practices

	Measure Name	CaroMont	Eagle	Carolinas Healthcare (NHMG)	Novant Health Systems
	Diabetes Composite	X	X	X	X
Diabetes Composite Measures	HBA1c Test 2x Year				
	LDL Screening				
	Blood Pressure every visit				
	Diabetes Tobacco Assessment				
	Aspirin Therapy				
Asthma Management	Persistent Asthma on ICS	X	X	X	X
Utilization Measures	Rate of ED (Visits per 1000)	X	X	X	X
	Rate of Inpatient Avoidable Hospitalizations (Admits/1000)	X	X	X	X
	Rate of Readmissions	X	X	X	X
	Radiology Costs (PMPY)	X	X	X	X
	Engagement	X	X	X	X

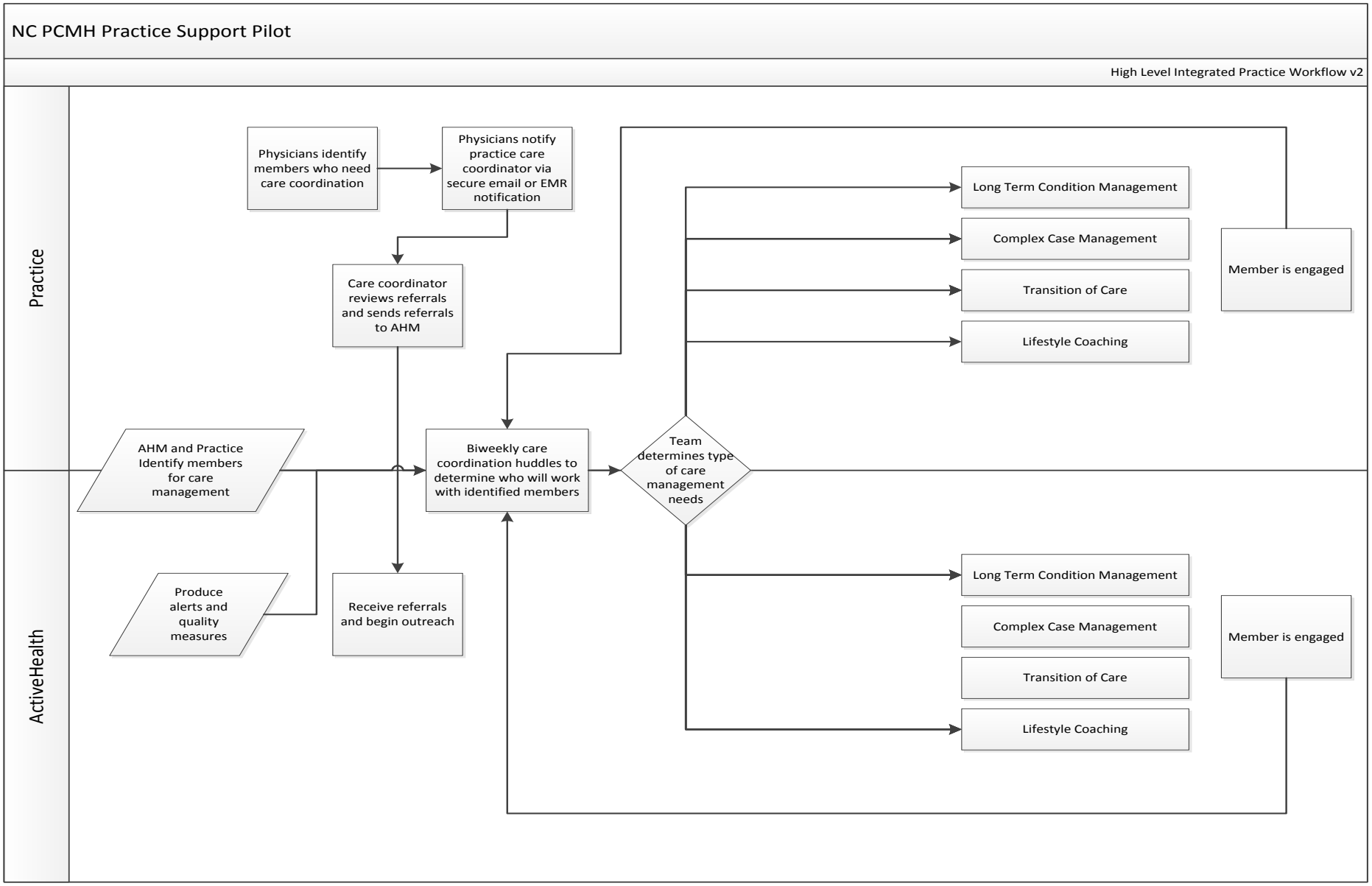
Optional Metrics (Selected by Practices)

Measures		CaroMont	Eagle	Carolinas Healthcare (NHMG)	Novant
Preventive Health	Influenza Vaccine			X	
	Tobacco Screening	X		X	X
	Screening for Clinical Depression and Follow-Up Plan			X	
	Mammogram	X	X		
	Colorectal Cancer	X	X	X	X
CAD Composite*	Ace/ARB for CHF				X
Heart Failure	Beta Blocker for CHF				X
HTN	BP Control (<140/90)	X	X		X
Diabetes	Medical Attention for Nephropathy	X	X	X	X
	Diabetes - HBA1c <7%		X		

Practice Quality Metrics: Baseline (2014)

Core Metrics	Measure Name	CaroMont	Eagle	Carolinas HC	Novant (N.Chlt.)	Novant (WS)
Diabetes Composite Measures	HBA1c Test 2x Year					
	LDL Screening					
	Blood Pressure every visit					
	Diabetes Tobacco Assessment					
	Aspirin Therapy					
	Composite	66%	55%	70.5%	TBD	TBD
Asthma Management	Persistent Asthma on ICS	96.4%	93.50%	95.00%	98.5	95.5
Utilization Measures	Rate of ED Visits per 1000	95.3	101.8	93.6	115.6	116.8
	Rate of Inpatient Avoidable Hospitalizations (Admits/1000)	0.8	1.4	2.7	1.6	2.3
	Rate of Readmissions	8.8%	3%	7.10%	10.6%	9.3%
	Radiology Costs PMPY	$146.17	$83.51	$162.86	$121.7	$151.3
Optional Metrics						
	Influenza Vaccine			47.77%		
	Tobacco Screening	66.40%	82%	90.34%	XX	XX
	Screening for Clinical Depression, follow up			58.9%		
Preventive Health	Mammogram	84.3%				
	Colorectal Cancer	54.8%	58%	TBD	56%	56%
CAD	Ace/ARB for CHF				57.1%	71.4%
Heart Failure	Beta Blocker for CHF				100%	71.4%
HTN	BP Control (<140/90)	65.0%	71%		70%	70%
Diabetes	Medical Attention for Nephropathy	79.3%	91.10	87.60%	84.2	91.3
	Diabetes HBA1c<7%		46%			

Workflow Diagram



Summary and Next Steps

Summary

- PCMH pilot is impacting 21,368 Plan members and over 60 primary care practices
- Establishing EMR based quality metrics (baselines and targets) prove to be the most challenging task
- The PCMH pilot allows a unique collaboration between practices, the Plan and Active Health Management

Next Steps

- Finalize quality metric targets for Novant
- First onsite quarterly Stakeholder meetings at each practice to review operations, accomplishments, and performance results