North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Patient Centered Medical Homes: State Health Plan Program Design and Approach

Board of Trustees

March 28, 2014

Presentation Overview

State Health Plan

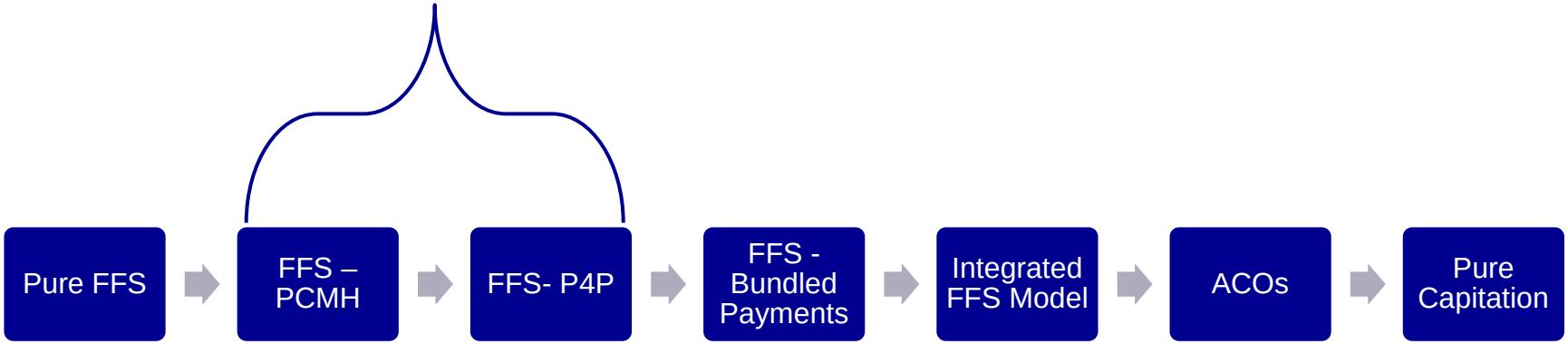
- Defining a Patient Centered Medical Home (PCMH)
- Value of National Committee for Quality Assurance (NCQA) Recognition
- Member and provider expectations of a PCMH
- State Health Plan's history with PCMH
- State Health Plan PCMH program purpose

ActiveHealth Management

- 2014-15 PCMH pilot initiative

January 2014 BOT Presentation

Focus on not just payment but also **access, quality, beneficiary experience and outcomes**



At the January BOT meeting the discussion centered on payment models and strategies. Payment is a component of an overall strategy to attain the goals of access, quality, experience and health outcomes.

The Patient Centered Medical Home (PCMH) is part of the clinical strategy of the Plan to achieve the triple aim.

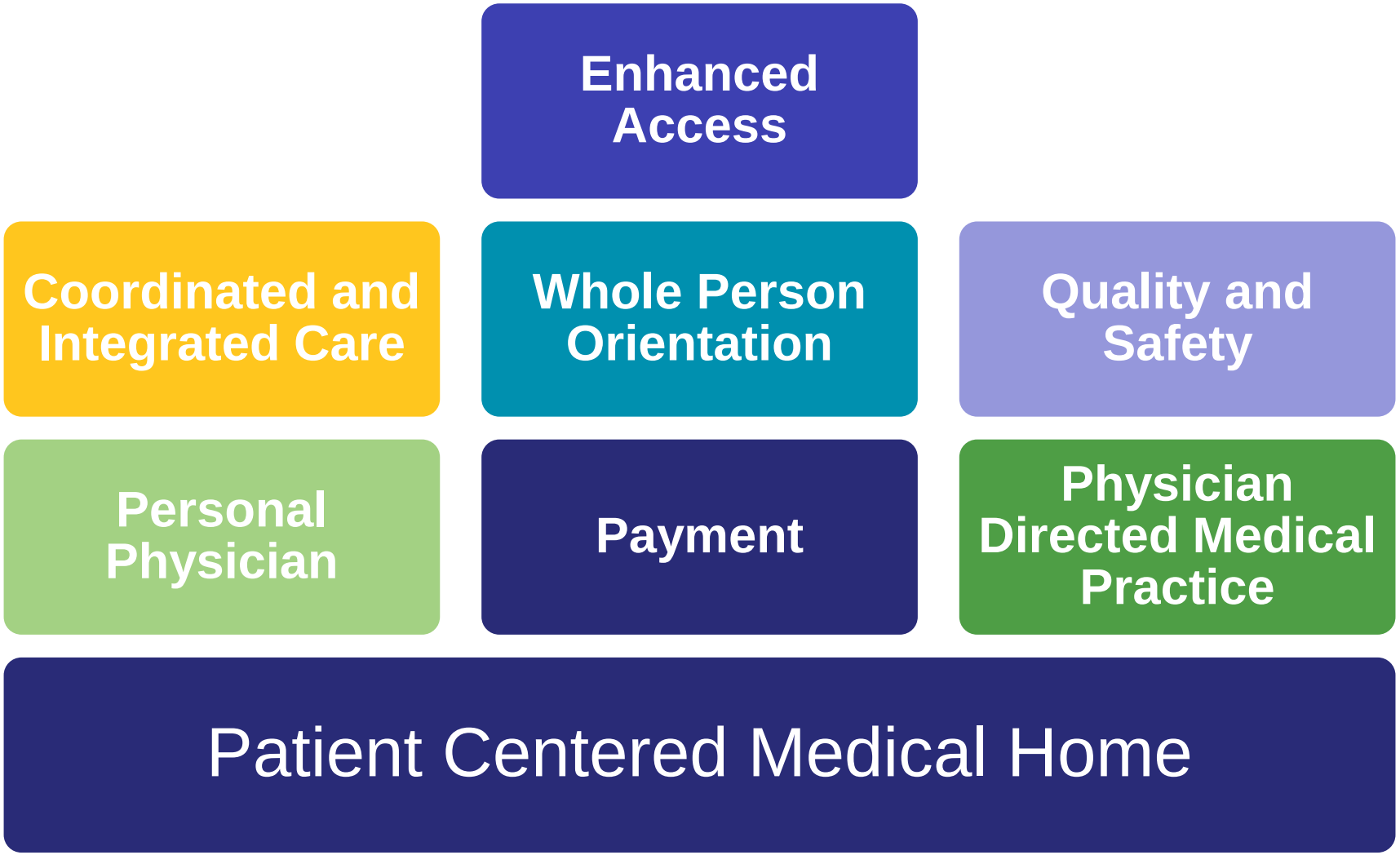
FFS: Fee for Service, PCMH: Patient Centered Medical Home, P4P: Pay for Performance, ACO: Accountable Care Organizations

Patient Centered Medical Home (PCMH)

There are many definitions of a PCMH, but for purposes of the SHP, this is the definition we will use:

A model of care that strengthens the **patient-physician relationship** by replacing ***episodic care*** with ***coordinated care*** and a long-term relationship.

Building Blocks of a PCMH



Expected Outcomes from a PCMH

High level of accessibility to care (Access)	Timely care within appropriate settings (Quality)	Excellent timely communication (Experience)	Access to latest technology (Health Outcomes)
• Open scheduling • Expanded hours • 24/7 telephonic access	• Timely preventive care • Avoidance of ER • Preventable hospital admissions	• Comprehensive health assessments • Established plan (goals) of care • Transition of care	• E-prescription • Medication reconciliation • Obtain clinical support • Timely sharing of information • Track results

NCQA PCMH Recognition

National Committee for Quality Assurance (NCQA) developed a recognition process, as the concept of PCMH evolved, to standardize and operationalize the model:

- NCQA PCMH recognition process supports and guides physicians in achieving levels of competency to enhance quality of care through systematic processes and use of information technology
- NCQA PCMH recognition demonstrates that systems and processes are in place to meet nationally recognized standards for delivering high quality of care enabling providers to take advantage of ***financial incentives*** offered by payers, employers and health plans

What does it mean to be part of a PCMH?

Member	Provider
I know who to call if I need help or have questions, anytime of the day or night.	I am the first point of contact for my patients when there is a health concern. I make access to care easy for my patient through flexible scheduling.
I am comfortable asking questions and discussing my goals and preferences with my medical home team.	I create an environment where a patient can openly ask questions and discuss their concerns regarding their health care.
I have a primary care provider and his team who know my needs and help me navigate my care with specialists.	I coordinate care between specialists for my patients when appropriate.
My important health information is available to me and I have help understanding what it means.	I communicate effectively with my patients and help them become informed consumers of healthcare.
My medical home helps make sure everything is in place when I get out of the hospital.	I have information technology available to give my team access to real-time data so I can assist in the transition of care of my patient.

What does it mean to be part of a PCMH?

Member	Provider
I have help with my medications and understand how and when to take them.	My clinical team will help manage the medications of my patients through periodic medication review and management, especially during transitions of care.
When I have a change in my health, my medical home team provides me with support.	I deliver care in the most appropriate setting for my patients. My team will monitor the care of my patients to identify gaps in care.
I have access to my personal health portal and can grant my provider access to it as well.	I have technological supports that are needed to appropriately monitor the care of my patients.
I know what a medical home team is and I am a part of mine.	I create and lead the medical home for my patients.

Partially sourced from NORTH CAROLINA STATE DEMONSTRATION TO INTEGRATE CARE FOR DUAL ELIGIBLE INDIVIDUALS, Submitted to CENTER FOR MEDICARE AND MEDICAID INNOVATION, Contract Number: HHSM-500-2011-00037C

State Health Plan History with PCMH

January 2012

- ActiveHealth (AHM) launches PCMH Model with Community Care of North Carolina (CCNC)
- Multi-payer (MAPCP) demonstration project through CCNC includes 7 of 10 counties first launched

December 2013

- AHM live with PCMH in 54 counties
- Contract concluded between AHM and CCNC
- No impact on any outcomes of interest

January 2014

- AHM launches PCMH Practice Support model
- SHP continues participation in MAPCP project through direct contract with CCNC

Sept/Dec 2014

- AHM continues with PCMH Practice Support Model
- MAPCP project ends in Sept. 2014, with possibility of a federal extension till December with evaluation in 2015

State Health Plan's PCMH Program Purpose

Engage & collaborate with physicians to enhance the delivery of comprehensive, high quality, multi-disciplinary, patient-centered medical care within a primary care setting utilizing timely data; measured through quality, efficiency and member satisfaction.

2014 NC PCMH Practice Support Pilot

Scott Money

2014 PCMH Practice Support Model

Evolving Model Design

Integrated, Member-Centric Care Management Model, with Physician Leadership

Enhance provider engagement with SHP members to support PCMH program across the state to improve member experience, health outcomes and reduce costs

- Explore various PCMH Fee for Service (FFS) and Pay for Performance (P4P) payment models that support the PCMH clinical model and service features
- Explore integrated practice/care management workflows
- Assist practices with transformation and PCMH recognition
- Develop case management model with embedded care managers
- Develop performance measures for care management services
- Target 'Triple Aim'

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2014 PCMH Practice Support Model

PCMH Collaboration Model

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NC State Health Plan
PCMH Program

ActiveHealth

- Member Stratification/ Identification
- Onsite Care Management
- Onsite Health Coaching
- Data Integration
- Provider Integration
- Data Analysis
- Program Evaluation

Participating Practices

- Patient Referrals/ Engagement
- Coordination of Care
- Quality Measures/ Care Alerts
- Care Plan Follow Up

Collaboration

BCBSNC ESI Quest/Solstas Labcorp NCHA Value Options Fresenius ESMMWL BenefitFocus BEACON

2014 PCMH Practice Support Model

Practice Identification Criteria

- **Population Demographics**
  - Attributed Members in County/Region
  - Attributed Members in Practice
- **Practice Demographics**
  - NCQA PCMH Recognition
  - Rural and Urban locations
  - Connection to Health System
  - Use of Electronic Medical Records (EMR) and Health Information Exchanges (HIE)
- **Clinical Demographics**
  - % of Attributed Members Targeted for Programs
  - Top Conditions
  - High Cost Utilizers
  - Care Alerts and QMs Attributed to Practice
  - Admissions/30 Day Re-admissions/ER Visits
  - Polypharmacy
  - Healthcare Costs

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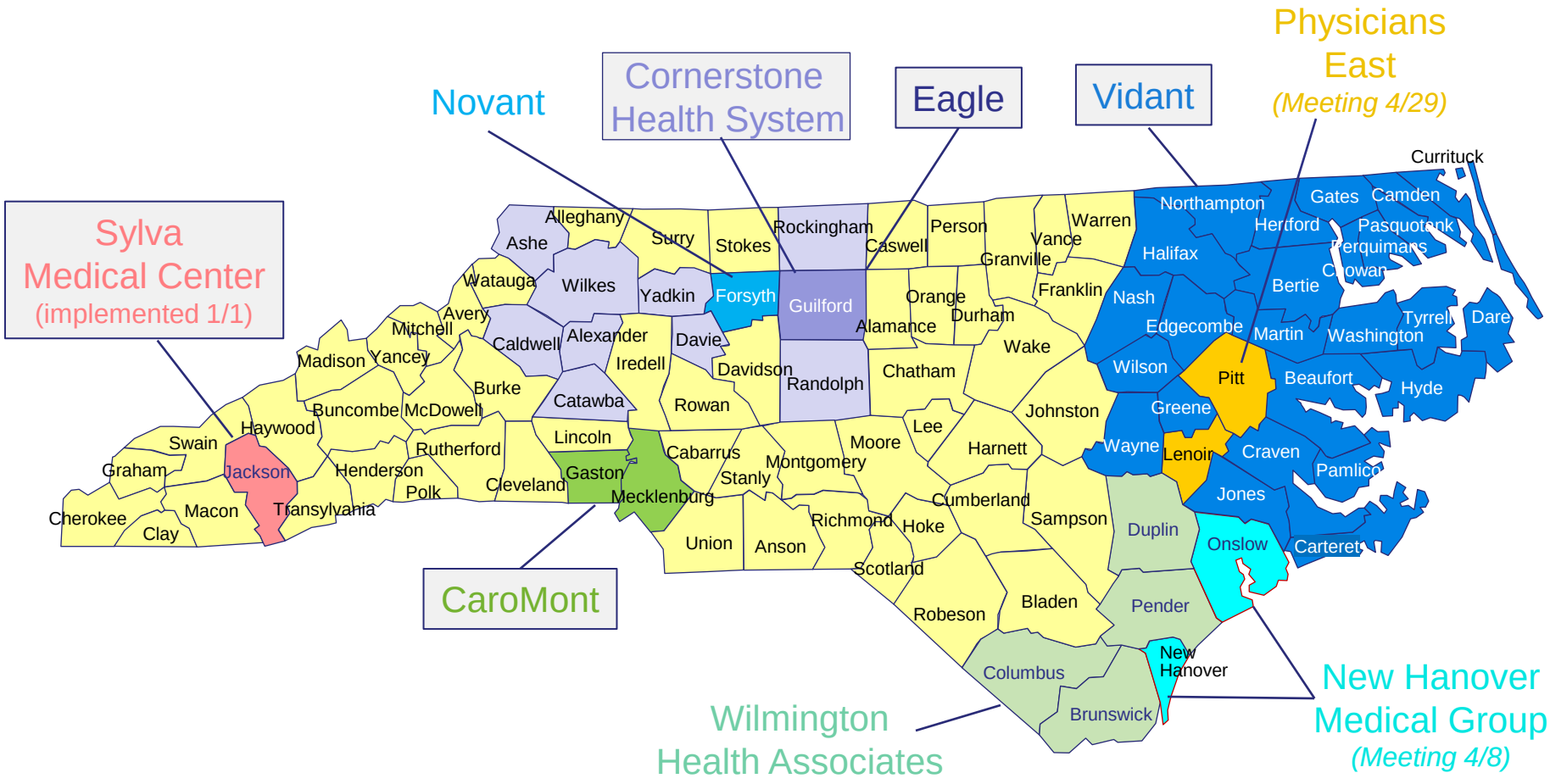
PCMH Practices & Locations



ActiveHealth (AHM) has spoken with all practices

Practices SHP and AHM have met with already

PCMH Practice Model

Practice Analysis – Practice Considerations

Information	Practice		
	Sylva Medical Center	Vidant Health	CaroMont Health
Practice National Provider Identifier (NPI)	1982831574	Multiple	Multiple
Health System	YES	YES	YES
NCQA PCMH	NO	NO	YES
Region	West	East	West
State Health Plan Patients attributed	549	3538	1781
% SHP Members in County	15.80%	19.99%	3.98%
Disease Mgmt Targeted/% of Total Pop	256 / 46.60%	1548 / 43.75%	644 / 36.16%
Case Mgmt Targeted/% of Total Pop	5 / .90%	53 / 1.49%	13 / 0.73%
Lifestyle Coaching Targeted/% of Total Pop	170 / 30.96%	1027 / 29.02%	431 / 24.20%
Average Cost per member	$3,140.46	$3,309.35	$2,839.63
Average Cost per member (medical and rx)	$4,119.62	$4,339.66	$3,670.78

Information	Practice		
	Eagle Family Physicians	New Hanover Medical Group	Physicians East
Practice National Provider Identifier (NPI)	Multiple	Multiple	1598761967
Health System	YES	YES	YES
NCQA PCMH	NO	YES	NO
Region	West	East	East
State Health Plan Patients attributed	5056	1506	3700
% SHP Members in County	19.62%	13.61%	20.90%
Disease Mgmt Targeted/% of Total Pop	1794 / 35.48%	636 / 42.23%	1834 / 49.57%
Case Mgmt Targeted/% of Total Pop	88 / 1.74%	19 / 1.26%	75 / 2.02%
Lifestyle Coaching Targeted/% of Total Pop	1067 / 21.10%	452 / 30.01%	1189 / 32.13%
Average Cost per member	$2,535.60	$3,336.93	$4,149.82
Average Cost per member (medical and rx)	$3,419.91	$4,343.43	$5,477.62

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PCMH Practice Model

Practice Analysis – Practice Considerations (continued)

Information	Practice		
	Wilmington Health Associates	Cornerstone Health System	Novant Health (Forsyth Only)
Practice National Provider Identifier (NPI)	Multiple	Multiple	Multiple
Health System	YES	YES	YES
NCQA PCMH	NO	YES	YES
Region	East	West	West
State Health Plan Patients attributed	3599	2685	8031
% SHP Members in County	32.52%	0.75%	51.76%
Disease Mgmt Targeted/% of Total Pop	1249 / 34.70%	735 / 27.37%	2439 / 30.37%
Case Mgmt Targeted/% of Total Pop	49 / 1.36%	30 / 1.11%	82 / 1.02%
Lifestyle Coaching Targeted/% of Total Pop	876 / 24.34%	468 / 17.43%	1377 / 17.15%
Average Cost per member	$2,935.14	$2,697.97	$2,999.69
Average Cost per member (medical and rx)	$3,980.30	$3,493.15	$3,790.05

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PCMH Practice Model

Initial Understanding of Practice Payment Models

Meetings Held with SHP

Sylva Medical Center

Eagle Family Physicians

Vidant Health

CaroMont Health

Meetings To Be Held

New Hanover Medical Group

Physicians East

Cornerstone Health

ActiveHealth (AHM) has spoken with all 9 practices

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Sylva Medical Center

Practice Accomplishments

- Live with integrated workflows 1/1/2014
- Care Manager embedded in practice
- Mailed postcard announcement to SHP members in Sylva
- Physician referrals into NC Health*Smart* programs
- Sharing patient care plans between Embedded Care Manager and physicians
- Weekly huddles with practice staff to close care gaps and address quality measures
- Partnering with Eat Smart, Move More, Weigh Less (ESMMWL) to offer onsite course(s) for Sylva members

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2014 PCMH Practice Support Model

Data Enhancements

NC Hospital Association (NCHA)

- 100% of NC Hospitals Connected
  - Standard admission/discharge data in daily flat file
  - Enhancements to HL7* format on NCHA roadmap
- Data is real-time
  - NCHA uses state ER/Hospital surveillance systems
  - Ability to transmit in real-time, or 1-3 times daily
  - ActiveHealth to receive via file transfer protocol (FTP) once daily for Transition of Care efforts

NC HIEs

- Building relationships with State Health Information Exchanges (HIEs)
  - We will pursue more connectivity via NC HIEs once HIE connectivity is established with physician electronic medical records (EMRs)

***Health Level 7** is an international community of healthcare subject matter experts and information scientists collaborating to create standards for the exchange, management and integration of electronic healthcare information.

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2014 PCMH Practice Support Model

AHRQ Evaluation Methodology: Triple Aim

Component*	Services
Experience	▪ Combine AHM member and provider surveys with CAHPS survey ▪ Administer new PCMH/CAHPS survey to members and providers
Quality	▪ Determine care management and practice operational measures to measure quality of care, i.e. use of ACTS, care alerts ▪ Determine PCMH specific clinical outcomes to measure against HEDIS standards
Cost	▪ Determine specific utilization measures that drive cost, i.e., inpatient admits/readmits and ER Visits ▪ Study cost trends for PCMH eligible population vs. non PCMH eligible population

* Based on Agency on Healthcare Research and Quality (AHRQ) Recommendations

PCMH Practice Model

Evaluation Methodology

- Modeled After the Agency for Healthcare Research and Quality (AHRQ) Guidelines
  - Evaluations of the medical home should measure three outcomes:
    - Quality, cost, and experience
- Study Design
  - Propensity matched comparison study
    - Individual matching practices will be selected based on specialty, practice size, patient volume, and demographics for comparison to each participating practice
  - Pre-post evaluation
    - A comparison of various measures will be conducted from baseline to follow-up
- Potential Measures
  - 2014 clinical measures
  - Utilization measures
  - Member and provider satisfaction
  - Operational measures
- Validation
  - Exploring validation of evaluation methodology by 3rd party

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PCMH Practice Model Metrics

Clinical Measures	Utilization Measures	Performance Metrics

▪ Asthma
  ▪ Use of Appropriate Medications
  ▪ Medication Management for People with Asthma
▪ Congestive Heart Failure
  ▪ Readmission Rate
  ▪ Use of ACEi/ARB
  ▪ Use of β-blocker
▪ Chronic Obstructive Pulmonary Disease
  ▪ Use of Spirometry
  ▪ Pharmacology of Exacerbation – Systemic Steroids
  ▪ Pharmacology of Exacerbation - Bronchodilator
▪ Diabetes
  ▪ HbA1c Monitoring
  ▪ LDL Monitoring
  ▪ Nephropathy Monitoring/Treatment
▪ Cancer Screening
  ▪ Breast Cancer Screening
  ▪ Cervical Cancer Screening
  ▪ Colorectal Cancer Screening
▪ Well Care
  ▪ Preventive or ambulatory care visit during reporting period (≥ 20 yrs of age)
	▪ All Cause Readmissions
	▪ All Cause Admissions
	▪ IP Admissions/1000
	▪ ER Visits/1000
	▪ PCP Preventive Care Visits/1000
	▪ PCP Medical Care Visits/1000
		▪ Engagement
		▪ Transition of Care
		  ▪ Medication Reconciliation
		  ▪ Post Discharge Planning
		  ▪ Facility based planning
		▪ Member Satisfaction
		▪ Provider Satisfaction

2014 PCMH Practice Support Model

Timeline

2014

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
1st Practice Live											
Practice Recruitment											
Practice Implementations											
Monitoring & Performance Evaluation											

2015

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Practice Recruitment											
Practice Implementations											
Monitoring & Performance Evaluation											
									Program Evaluation & Lessons Learned		

In Conclusion

- Patient Centered Medical Homes continue to be the most appropriate strategy, in the short term, to influence quality, experience and cost
  - Considerable evidence on success of PCMH in delivering outcomes
- 2014-2015 are exploratory years as the Plan defines and develops the role of the payer in supporting PCMH practices
  - Data and quality improvement support
  - Care coordination and management support
  - Ancillary services such as Quitline (tobacco cessation) and ESMMWL (weight loss program)
  - Alternate payment strategies including pay for performance
- The Plan is taking a staged approach identifying practices of varying levels of capacity and experience