



*North Carolina*  
**State Health Plan**  
FOR TEACHERS AND STATE EMPLOYEES



## **Diabetes and Chronic Disease Legislative Reports**

***Board of Trustees***

**November 20, 2014**

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*A Division of the Department of State Treasurer*

# 2013 Legislation

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## **Session Law 2013-192, Senate Bill 336**

An Act requiring the Divisions of Medical Assistance (DMA) and Public Health (DPH) within the Department of Health and Human Services and the State Health Plan Division within the Department of State Treasurer to coordinate the diabetes programs they each administer; To develop plans to reduce the incidence of diabetes, to improve care, and to control complications; and to report to the Joint Legislative Oversight Committee on Health and Human services and the Fiscal Research Division.

## **Session Law 2013-207, House Bill 459**

An Act requiring the Department of Health and Human Services to coordinate chronic disease care; the Department's Division of Public Health, Medical Assistance and the State Health Plan Division within the Department of State Treasurer shall collaborate to reduce the incidence of chronic disease and improve chronic disease care coordination within the State.

Reports due to legislature on or before January 1, 2015, and then progress to be reported on January 1<sup>st</sup> of each odd numbered year (2017).

# Required Components in Reports

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- Financial impact and magnitude of chronic conditions
- An assessment of benefits derived from wellness and prevention programs implemented within the State
- A description of the level of coordination among the Divisions of Public Health, Medical Assistance and the State Health Plan
- Action plans for care coordination of multiple chronic conditions, with specific focus on the following:
  - Adjustment of hospital readmission rates
  - Development of transition of care programs
  - Implementation of comprehensive Medication Therapy Management (MTM)
  - Adoption of standards related to quality and expected outcomes

# Current Coordination in Diabetes Prevention and Control

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- Development of a business case to provide Diabetes Self-Management Education (DSME) and access to Certified Diabetes Educators (CDE) as covered benefits
- Collaboration with DPH and BCBSNC to distribute hypertension and diabetes clinical guidelines to the State Health Plan's network of providers.
- Collaboration in the development of a campaign to raise awareness on pre-diabetes among Plan members and increase early identification and treatment.
- Potential collaboration with DPH on assessment of worksite wellness and the development of sustainable and replicable models of worksite wellness programs.
- Some Diabetes Education Recognition Program (DERP) sites coordinate with DMA's vendor, Community Care of North Carolina to teach classes and to refer patients to DSME.

# Increasing Coordination for Diabetes Management

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## Action Items

- Develop a combined campaign to increase awareness of pre-diabetes and diabetes, and promote evidence-based diabetes self-management education among North Carolinians.
- Evaluate and enhance the benefit design of the State Health Plan and DMA covered plans to impact the identification, and improved management of diabetes and prediabetes.
- Promote third party coverage of Diabetes Prevention Lifestyle Change Programs for persons with pre-diabetes.
- Support and foster a statewide network of recognized DSME providers through training and certification.
- Establish common quality metrics that will monitor the prevalence, impact and complications associated with prediabetes and diabetes across the State.

# Current Coordination in Chronic Disease Management

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- Tobacco Prevention and Control- Utilization of QuitlineNC resources and Nicotine Replacement Therapy (NRT) products
- Plan members have access to Eat Smart, Move More, Weigh Less, a 15-week adult weight management program
- Participation in Justus-Warren Heart Disease and Stroke Prevention Task Force and development of Comprehensive Plan for Management of Heart Disease and Stroke
- Working with Asthma Alliance of North Carolina and the implementation of evidence-based asthma management strategies
- All diabetes related coordination , as detailed on slide 4

# Increasing Coordination in Chronic Disease Management

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## Action Items

- Continue to manage QuitlineNC to Plan and Medicaid eligible tobacco users who want to quit in order for them to have access to evidence-based tobacco cessation services and provide technical assistance to improve the quality of those services.
- Work together with Plan and Medicaid to promote QuitlineNC (1-800-QuitNow) to ensure all Plan and Medicaid eligible tobacco users who want to quit are aware of this service, through clinic referrals, earned media, social media and other communication channels to Plan and Medicaid members.
- Support the continued development and dissemination of a comprehensive statewide “Know your Numbers” campaign for providers, beneficiaries of Medicaid and Plan members.

# Increasing Coordination for Chronic Disease Management

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## Action Items

- Continue to promote and deliver evidence-based weight management programs such as Eat Smart, Move More, Weigh Less among Medicaid beneficiaries, Plan members, and other North Carolinians who are at-risk for chronic conditions due to weight maintenance issues.
- Expand and refine the current transition of care programs offered to members to address inpatient admission, readmission and emergency department admission rates among Plan members.
- Explore continued opportunities for Pharmacists to work in conjunction with Physician practices to support the management of chronic conditions.

# Increasing Coordination for Chronic Disease Management

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## State Health Plan Specific Action Items

- **Value Based Benefit Design Review**—Evaluate opportunities to redesign pharmacy and medical benefits to incentivize effective chronic disease management.
- **Medication Therapy Management (MTM) Vendor Resource Evaluation**—Identify MTM resources and evaluate the capabilities of each to coordinate care within the Patient Centered Medical Home (PCMH) and integrate care across the spectrum of the Plan's services.
- **Financial Analysis**—Evaluate the MTM services identified by the Plan as essential to offer including transitional care support and PCMH coordination, to propose a reimbursement methodology to pay pharmacists and/or vendors based on clinical outcomes and performance.

# Expected Outcomes

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- Increased early detection and screening (breast, cervical cancer, CVD risk factors, renal disease)
- Increased cost savings from reduced hospital and Emergency Department (ED) utilization
- Improved adherence to medication regimens
- Increased referrals to and participation of members in smoking cessation and Active Life Coaching (ALC) programs provided by the Plan's partners and Population Health Management vendor
- Expanded and refined transitional care programs to reduce inpatient readmissions and emergency department admissions among high priority Plan members

# Expected Outcomes

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- Completed environmental scan for medication therapy management (MTM) services and identification of potential value based pharmacy benefit design for chronic disease care among Plan members
- Defined plan for MTM services and initiation of contract procurement for the State Health Plan, if current vendor resources do not support the Plan
- Availability of evidence-based strategies including home assessments for high risk members with Asthma
- Availability of evidence-based strategies for Diabetes Self-Management Education, such as Diabetes Prevention Program, and access to Certified Diabetes Educators for members with diabetes