





Multipronged Pilot Initiative to Improve Member Health

Board of Trustees Meeting

August 1, 2014





Multipronged Pilot Initiative

- Overview
- Target Area
- Project Plan & Timeline
- Expectations
- Evaluation

Multipronged Initiative: Overview

The Integrated Health Management (IHM) team proposes a two-year targeted pilot initiative for three eastern counties, utilizing a multipronged approach.

- Engage and support providers in delivering a higher level of care to our members
- Develop and strengthen wellness networks and worksite wellness initiatives
- Connect local leadership and resources to worksites
- Engage and empower members in their healthcare

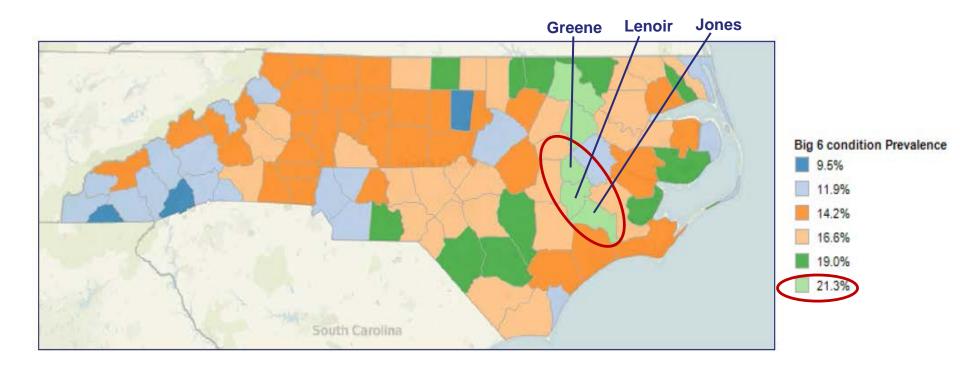
Target counties: Greene, Jones, and Lenoir (Eastern NC)



Why Greene, Jones, and Lenoir Counties?

Major Chronic Conditions

Diabetes, Asthma, Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease (CAD), Congestive Heart Failure (CHF), Hypertension

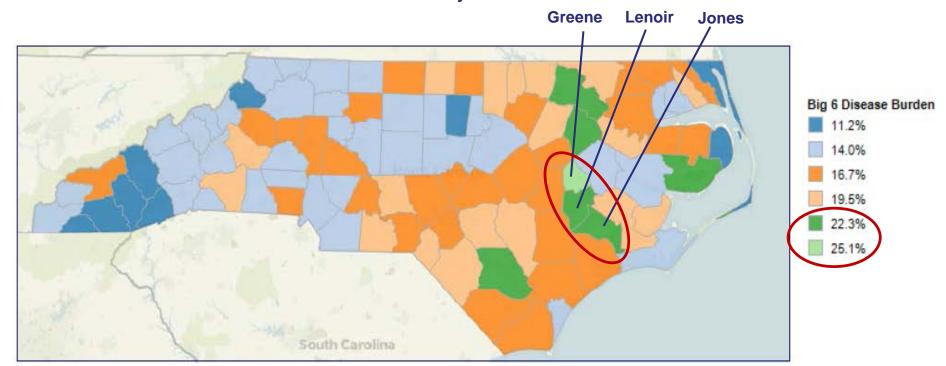




Why Greene, Jones, and Lenoir Counties?

Major Chronic Conditions

Disease Burden = Prevalence x Severity



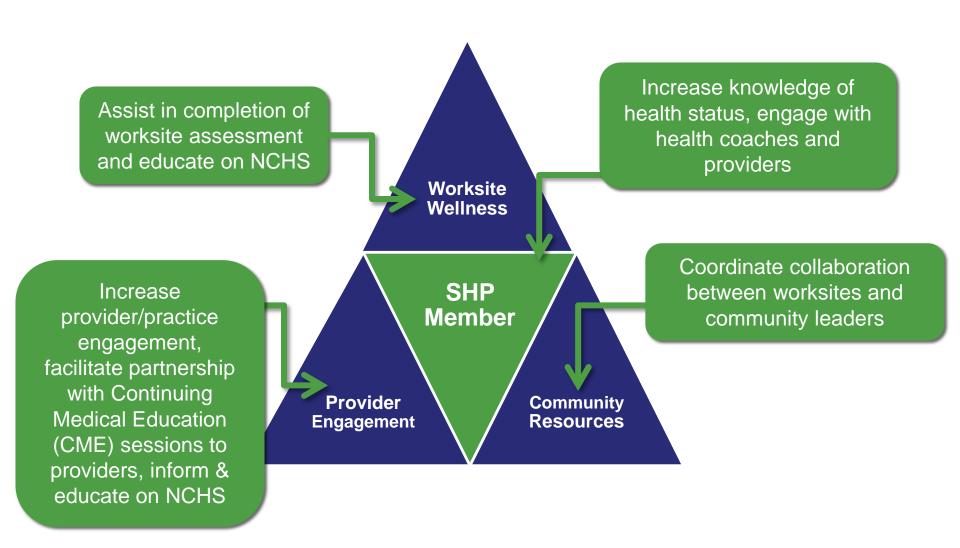


Why Greene, Jones, and Lenoir Counties?

					Disease Prevalence		
County	Jan. 2014 Member Count	Community College	School System	Agencies	Diabetes	Asthma/ COPD	Cardiovascular Disease
Greene	1,558	Lenoir CC	Greene County Schools	Greene Correctional	13.4%	8.2%	4.6%
Jones	692	Lenoir CC	Jones County Schools	Unknown	11.6%	8.7%	5.7%
Lenoir	5,968	Lenoir CC	Lenoir County Public Schools; Charter schools	Caswell Center	11.9%	8.0%	6.2%
All State Health Plan Members					8.25%	6.19%	3.37%



Multipronged Approach





Multipronged Initiative: Project Plan and 2 Year Timeline

Preliminary Phase: July-Dec 2014

Environmental assessment, engagement with wellness leaders & HBRs at worksites, participate in community meetings, provider focus groups, conduct NC Health Smart (NCHS) webinars and presentations to build awareness

Phase 1: Jan-March 2015

Train wellness leaders to deliver NCHS presentations; assess worksites and develop worksite wellness initiatives (organize committees and help build wellness programs); engage providers through CMEs and provider meetings (support awareness of NCHS resources and referrals)

Phase 2: April-July 2015

Increase member awareness of health status through biometric screenings (ensure validated screening results for Health Assessment); connect to NCHS and community resources to support healthy lifestyle

Phase 3: June 2015-July 2016

Engage members in care of chronic conditions, build on-site coaching for worksites with wellness programs, continue provider engagement and awareness

Phase 4: July-Sept 2016

Members participate in follow-up biometric screenings and outcomes evaluation, ensure worksites have resources to maintain sustainable worksite wellness programs



Multipronged Initiative: Expectations

- Support member awareness of NC Health Smart (NCHS) services to create more proactive members
 - Offer multiple NCHS presentations; Train the Trainer on NCHS presentations
 - Utilization of Health Coaches
 - Health status awareness through biometric screenings
- Develop and strengthen wellness networks and worksite wellness programs
 - Offer Prevention Partners assessment and assistance to active worksite wellness programs
 - Outreach to worksites without current programs to facilitate creation of worksite wellness
 - Use CDC Scorecard, Worksite Wellness Toolkit (revised), and assistance of SHP Wellness Coordinators
- Engage local providers to deliver a higher level of care to SHP members
 - Partner with CCME/AHEC to offer CME opportunities to providers on Diabetes and Asthma, including information on NCHS at each session
 - Support provider meetings in Lenoir, Greene and Jones counties to create Provider Champions
 - Encourage provider meetings between AHM, SHP, and local providers to determine how best SHP can engage their individual practices



Multipronged Initiative: Evaluation

Utilization

- Wellness Programs
 - Number of wellness champions
 - Established wellness programs
- NCHS resources
 - Health Assessment completion
 - Engagement in DM/CM/ALC
 - Participation in on-site coaching sessions

Population Measures

- Chronic disease management based on medical claims
 - Heart disease (hypertension, CAH, CHF, stroke)
 - Diabetes/Prediabetes
 - Asthma/COPD

Utilization patterns

- PCP visits
- ER and inpatient hospital admissions/readmissions/avoidable admissions
- Medication adherence based on refills

