Strategic Planning Discussion
1/25/13

DRAFT

1. Approval of Mission Statement

   Our mission is to improve health and healthcare of North Carolina teachers, state employees, retirees, and their dependents, in a financially sustainable manner, thereby serving as a model to the people of the State of North Carolina for improving their health and wellbeing.

2. Draft Operating Principles

   a. With Respect to Plan Members
      i. Outreach and education will lead to patient satisfaction and better use of the plan. A key of our strategy will be to emphasize communication as much as possible.
      ii. We are at the limit of what we can manage by increasing copays. Restricting utilization has gone too far and it's beginning to alter health behavior.
      iii. Chronic diseases and combinations of chronic diseases will drive the growth of expense over the next number of years and we need to deal with this core driver of cost and patient experience.
      iv. Lack of coordination of care with multiple sites of care and overly intense emergency room, hospitalization and subspecialty care is a key cost driver.

   b. How We Will Do Business
      i. Transparency to plan members and doctors has to be an element.
      ii. Education and engagement of our population of employees will be the key to our future.
      iii. We must continue to focus on the longer term – the 4-8 year period and not just the short term (the next biennium).
      iv. We must put in place interventions that have an impact on the longer term bottom line.
      v. We will guide but not force patient choices through benefit structure, copays and others.
      vi. We are stewards of the availability and appropriateness of the health care services available to our members across the state.
      vii. On behalf of our members, and working with our providers, the SHP will take responsibility for improving the patient experience, quality and cost effectiveness of care it makes possible.

3. Environmental Scan/External – Key Issues and implications for SHP time should be spend on discussion of implications for our SHP strategic plan:
    a. ACA implementation in NC—key issue and implications
        i. Medicaid Expansion; implications for SHP
        ii. ACO spread
        iii. Health insurance exchange
    b. Health care consolidation and implications for members
    c. Multipayer and Beacon projects—intent, current status and design; SHP data participation in multipayer projects
    d. Health information exchange—current status
    e. Relationship with existing partners, including CCNC, BCBS, and Active Health
    f. New partners—Insurance Commissioner, other organizations

4. Environmental Scan/Internal—
    a. Quality of Care (Hedis results compared to other BCBS commercial contracts, Medicaid, plus other measures)
    b. Patient experience
        i. Geographic dispersion for primary, specialty care and hospitals
        ii. Ability to get in same day (or whatever patient experience numbers are)
        iii. Copays, coinsurance compared to benchmarks, over time
    c. Cost of care
        i. Where total (plan plus patients) dollars go (hospital (IP/OP), pharm, primary care, specialty care, ED, urgent care, dme, etc)
        ii. Trends, comparison to benchmarks and other insurance plans
        iii. "SHP fiscal cliff"—projected cost increases in biennium 2 and 3

5. Additional Policy Options
    a. In December, we asked for further study of several modest steps to promote prevention and better coordination of care through support of wellness services, reduced fees for Patient Centered Medical Homes ("PCMH"), for clients identifying a PCMH and for chronic disease meds.
    b. To address the SHP fiscal cliff we need to consider bolder steps
        i. Support PCMH with care management and data
            1. Recommend SHP data be combined with Medicaid and Medicare data and made available to
            2. Use care management system (*e.g.,* CCNC)
            3. Consider payment reform
        ii. Payment reform
            1. Explore payment structure, and alter payment structure across physicians, hospitals and other providers. How much money is there here?
            2. Stop incenting volume; rather, incent patient experience, quality and cost effectiveness
            3. Combined strategy: incent PCMH care management and explore aggressive implementation of value based purchasing for major procedures.

4. Consider absolute cap on expenditures (like NY Medicaid)

iii. Delivery system reform
    1. Explore aggressive consumer based health care, with protection for primary care and prevention.
    2. Self-management incentives
    3. What changes do we want to create in the delivery system over the next 4-6 years?