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2018 Population Health Management Services

Board of Trustees Meeting

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A Division of the Department of State Treasurer

2018 Population Health Management Services

- The Plan is adopting a more focused approach to Population Health Management (PHM) services for 2018.
- **Disease Management** – Instead of casting a wide net of disease management services, the Plan will focus on the following:
 - Chronic Obstructive Pulmonary Disease (COPD)
 - Coronary Artery Disease (CAD)
 - Heart Failure
 - Peripheral Vascular Disease (PAD)
 - Cerebrovascular Disease (CVD)
 - Diabetes
 - Asthma
- **Case Management** – Telephonic case management for chronic kidney disease, end stage renal disease, transition of care with medication therapy management, and other poorly controlled health conditions

2018 Population Health Management Services

- The Plan will continue to offer online resources for members including:
 - **Health Assessment** – a health and lifestyle questionnaire that provides members with their health risk status
 - **Health Trackers** – a variety of wellness and condition trackers ranging from weight to cholesterol trackers
 - **Digital Health Coaching** – self-paced health and lifestyle modules on a variety of topics to help members live a healthier, happier life
 - **Health Library** – wellness webinars, healthy recipes, videos, interactive tools and audio files on a wide range of topics

2018 Population Health Management Communications

Communications: The Plan will also continue to send targeted communications to members about important health information such as age and gender specific preventive screenings.



2018 Population Health Management Initiatives

Partnerships: The Plan will also continue to partner with other entities to bring valuable services to our members at the local level. An example of a new partnership currently in the works is the Check. Change. *Control.*® Self-Monitoring Blood Pressure Control Program with the American Heart Association.



- **Purpose:** Identify members who are undiagnosed and at risk for developing hypertension, promote heart healthy behaviors, and help members with hypertension achieve target blood pressure results.
- **Goal:** Emphasize the importance of blood pressure control and to provide opportunities for action to Active members in their workplace.
- **Delivery:** Leverage existing workplace wellness interests to deliver hypertension messages, provide worksite wellness leader training, help worksites create a blood pressure monitoring station, provide members with an electronic-based blood pressure tracking tool, use tracking tool entries to intervene early with members, and measure program success.
- **Outcome:** Identify new members with prehypertension and hypertension and for members to achieve target blood pressure results.