



NC Department of Health and Human Services

Healthy Opportunities

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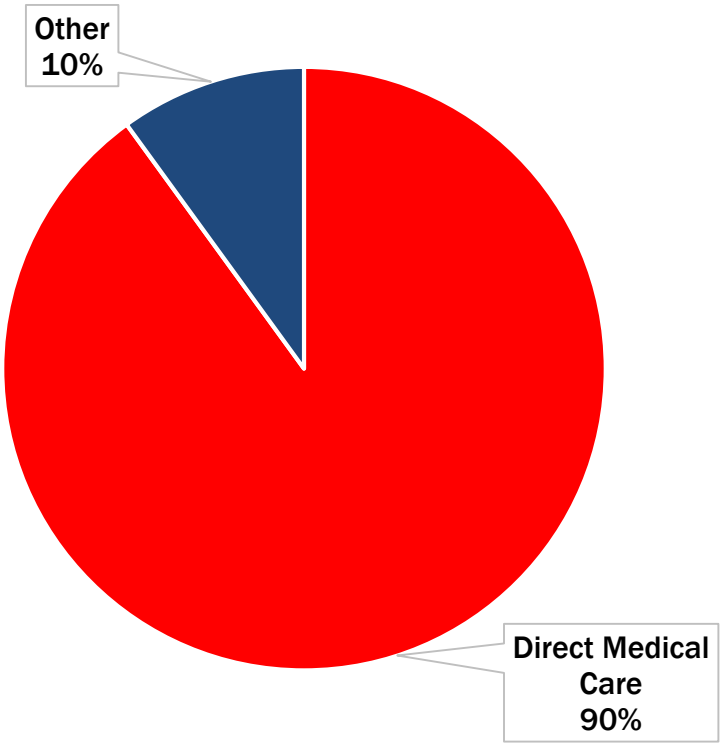
Director, Healthy Opportunities

System of Care Breeze Call

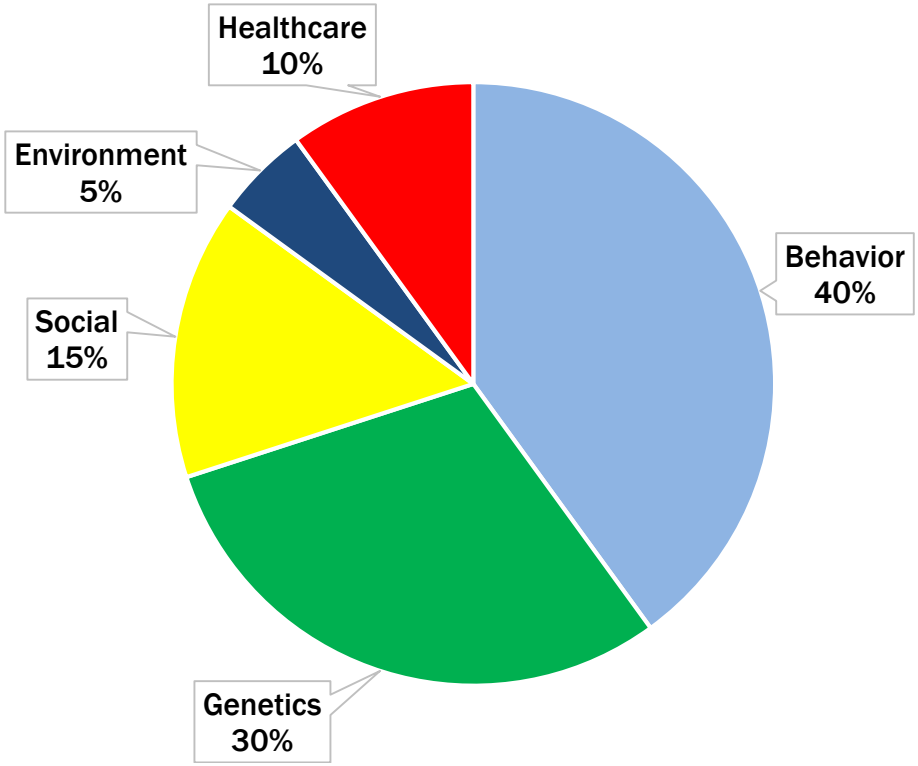
February 4, 2019

Mismatch: We are Buying Healthcare not "Health"

Healthcare Spending



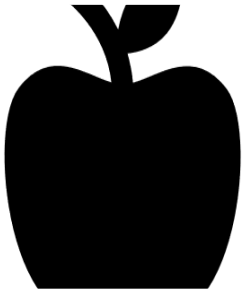
Drivers of Health



The greatest opportunity to improve health lies in addressing a person's **unmet essential needs**.

SOURCE: Schroeder SA. N Engl J Med 2007

Initial Domains

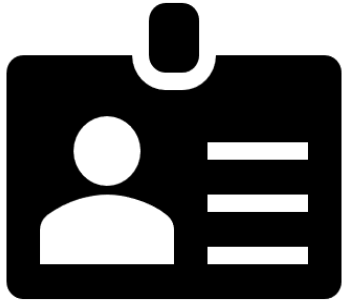


Food Security

Housing Stability

Transportation

Interpersonal Safety



Employment

Opportunities for Health Initiatives

1. “Hot Spot” Map
2. Screening Questions
3. NC Resource Platform
4. Medicaid Transformation & Pilots
5. Workforce
6. Connecting Resources

"Hot Spot" Map

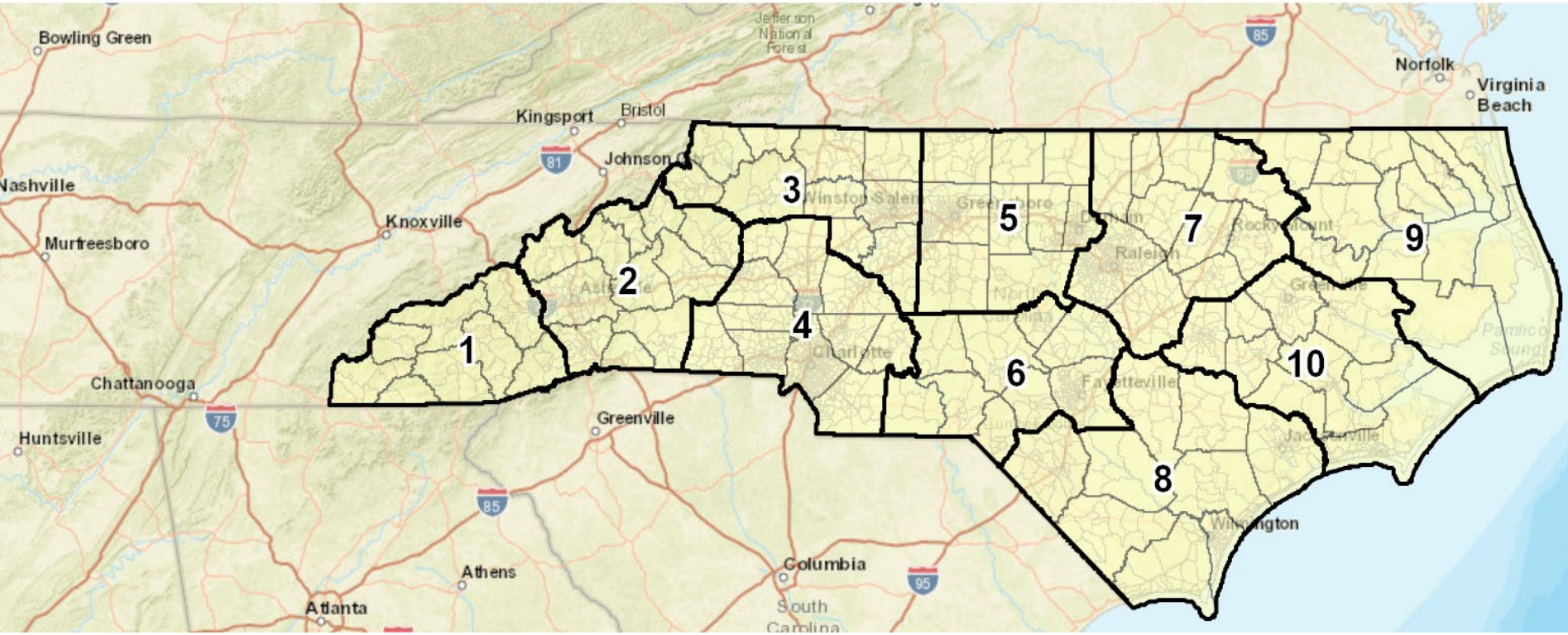
- Statewide map now live: http://www.schs.state.nc.us/data/hsa/
- GIS/ESRI Story mapping of 14 SDOH indicators with a summary statistic
- Displays geographical health & economic disparities

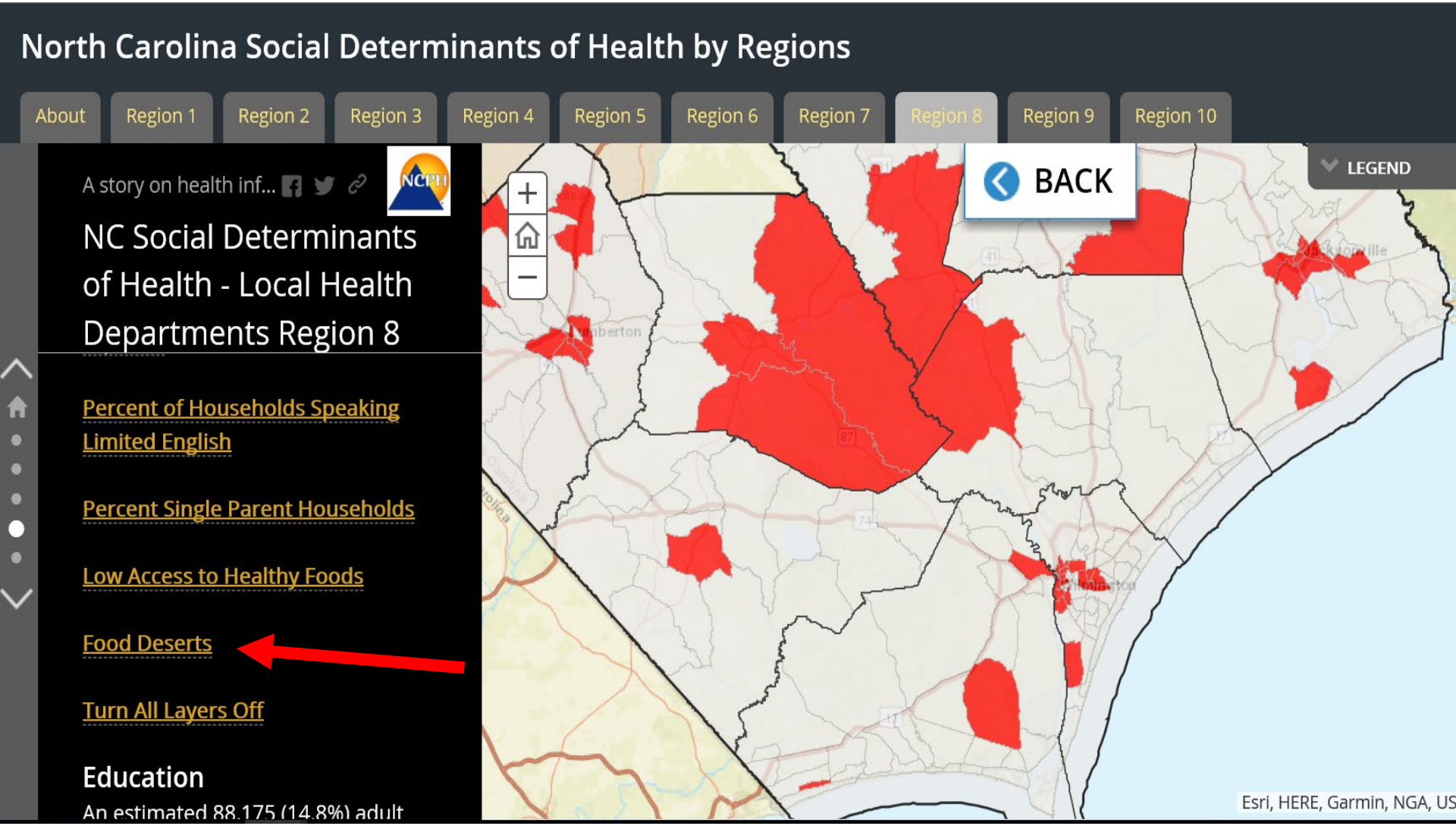
Social and Neighborhood	Economic	Housing and Transportation
% < HS Diploma	Household Income	% Living in Rental Housing
% Households with Limited English	% Poverty	% Paying >30% of Income on Rent
% Single Parent Households	Concentrated Poverty	% Crowded Household
Low Access to Healthy Foods	% Unemployed	% Households without a Vehicle
Food Deserts	% Uninsured	

North Carolina Social Determinants of Health by Regions

About | Region 1 | Region 2 | Region 3 | Region 4 | Region 5 | Region 6 | Region 7 | Region 8 | Region 9 | Region 10

Overview




North Carolina Social Determinants of Health by Regions
About
Region 1
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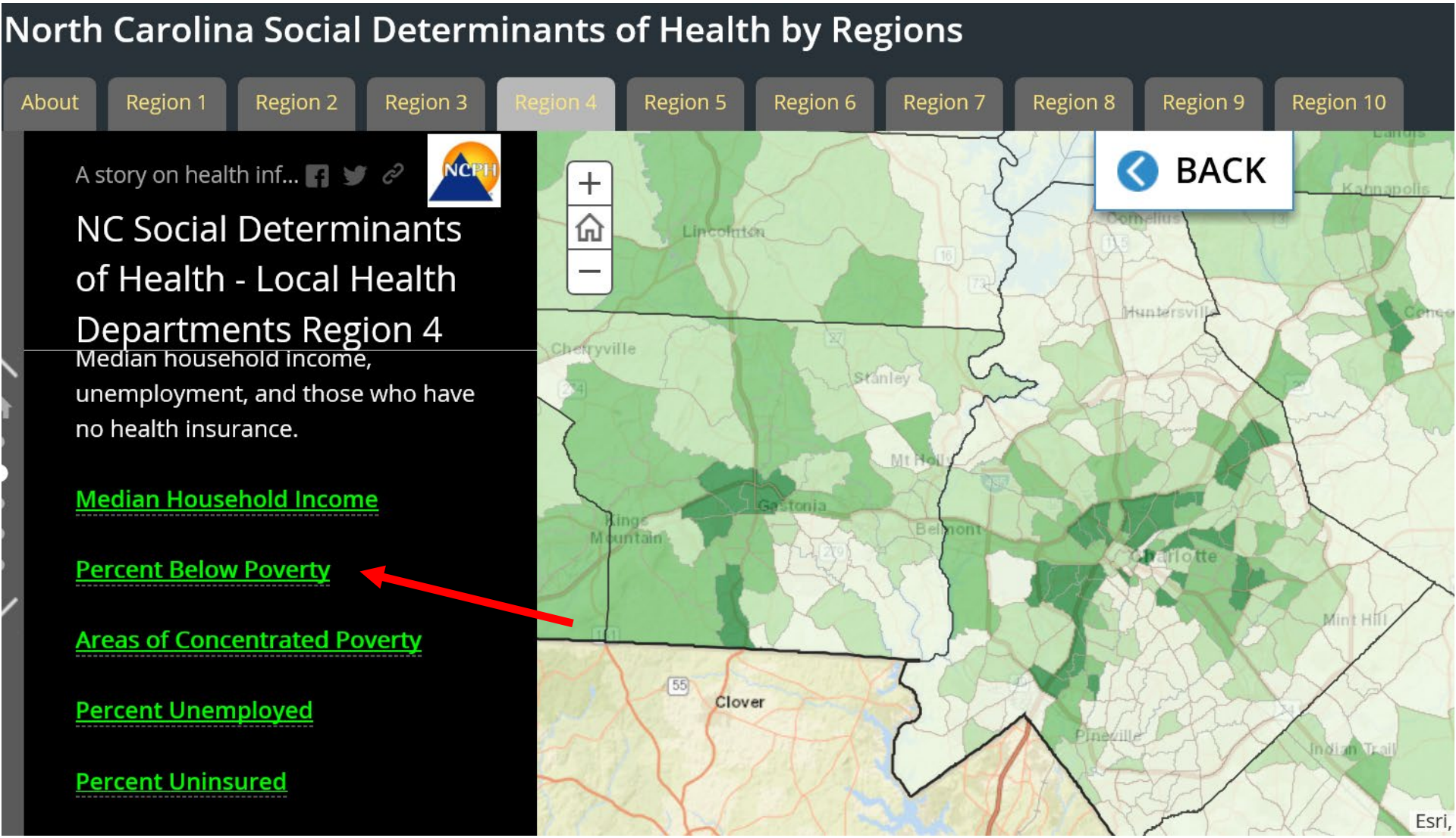
A story on health inf...
NCPH
NC Social Determinants of Health - Local Health Departments Region 8
Percent of Households Speaking Limited English
Percent Single Parent Households
Low Access to Healthy Foods
Food Deserts
Turn All Layers Off
Education
An estimated 88,175 (14.8%) adult
BACK
LEGEND
Esri, HERE, Garmin, NGA, US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A story on health inf...
NCPH
NC Social Determinants of Health - Local Health Departments Region 4
Median household income, unemployment, and those who have no health insurance.
Median Household Income
Percent Below Poverty
Areas of Concentrated Poverty
Percent Unemployed
Percent Uninsured
BACK
Lincolnton
Cherryville
Stanley
Gastonia
Belmont
Clover
Mint Hill
Esri,

Screening Questions

- Goals
  - Routine identification of unmet health-related resource needs
  - Statewide collection of data
- Development
  - Technical Advisory Group
  - Released April 2018 for Public Comment
  - Field testing in 18 clinical sites
- Implementation
  - Recommended to be used across settings and populations
  - Launch of Managed Care: PHPs Required to Include in Care Needs Assessment

Health Screening

We believe everyone should have the opportunity for health. Some things like not having enough food or reliable transportation or a safe place to live can make it hard to be healthy. Please answer the following questions to help us better understand you and your current situation. We may not be able to find resources for all of your needs, but we will try and help as much as we can.

	Yes	No
Food		
1. Within the past 12 months, did you worry that your food would run out before you got money to buy more?		
2. Within the past 12 months, did the food you bought just not last and you didn't have money to get more?		
Housing/ Utilities		
3. Within the past 12 months, have you ever stayed: outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (i.e. couch-surfing)?		
4. Are you worried about losing your housing?		
5. Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?		
Transportation		
6. Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living?		
Interpersonal Safety		
7. Do you feel physically and emotionally unsafe where you currently live?		
8. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by anyone?		
9. Within the past 12 months, have you been humiliated or emotionally abused by anyone?		
Optional: Immediate Need		
10. Are any of your needs urgent? For example, you don't have food for tonight, you don't have a place to sleep tonight, you are afraid you will get hurt if you go home today.		
11. Would you like help with any of the needs that you have identified?		

NCCARE360

- **The Problem:** *Connecting people to community resources is inconsistent, not coordinated, not secure, and not trackable.*
- **The Solution:**
  - Uniform system for providers, insurers, and community organizations to coordinate care, collaborate, and track progress and outcomes.
  - Tool to make it easier to connect people with the community resources they need to be healthy.
  - Track statewide, regional, and community-level data on service delivery and outcomes achieved.

NCCARE360

NCCARE360 is the first statewide coordinated network that includes a robust data repository of shared resources and connects healthcare and human services providers together to collectively provide the opportunity for health to North Carolinians.

- One statewide, shared public utility open to all communities, providers, care managers, social service agencies
- Benefits of collaboration and statewide consistency
  - Uniform system for providers, communities to on-board
  - Coordinated info as people move across the state
  - State-wide, regional, community level data
  - Significant investment by many for development and on-boarding

NCCARE360 Partners:

NCCARE360 Functionalities

Resource Database	Referral Platform
- Public facing, user-friendly website - Call Center - Robust, statewide database of resources - Resource Depository: interface capabilities with local directories to send and receive information	• Allows users to refer and connect people directly to community resources • Track connections and outcomes through “closed loop” referrals • Shared person record • Connects healthcare provider to CBO and CBO to CBO • Flexible architecture with integration/ interface capabilities

Hands on, in-person technical assistance and training to on-board providers and community organizations

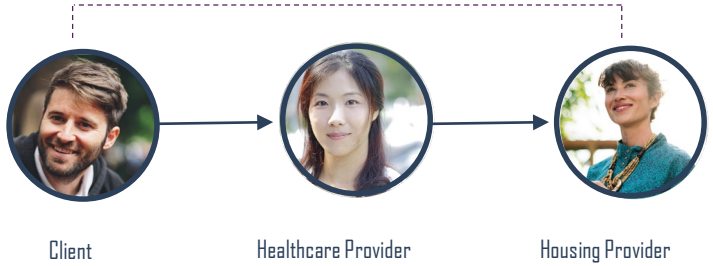
Network Model: No Wrong Door Approach

NCCARE360: Coordination Platform at Work

Traditional Referral

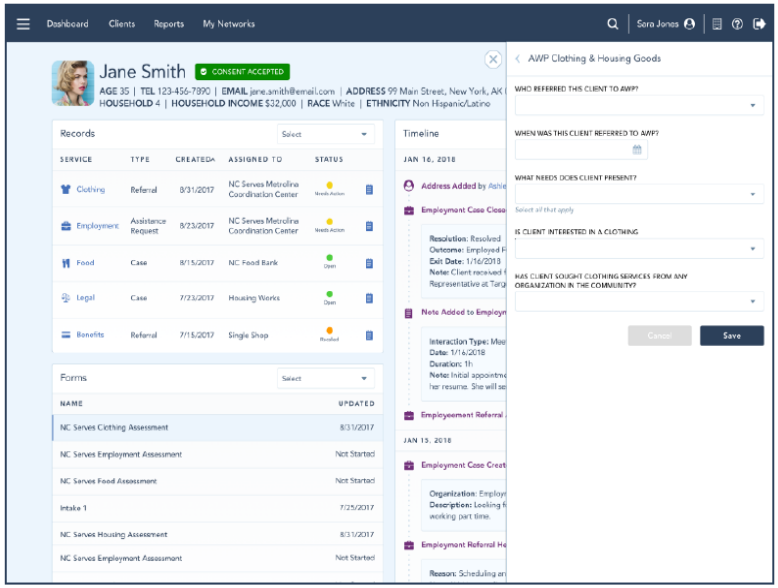
- ✕ Service provider cannot always exchange PII or PHI via a secure method
- ✕ Limited prescreening for eligibility, capacity, or geography
- ✕ Onus is usually on the client to reach the organization to which he/she was referred
- ✕ Service providers have limited insight or feedback loop
- ✕ Client data is siloed & transactional data is not tracked

Through NCCARE360



- ✓ All information is stored and transferred on HIPAA compliant platform
- ✓ Client is matched with the provider for which he/she qualifies
- ✓ Client's information is captured once and shared on his/her behalf
- ✓ Service providers have insight into the entire client journey
- ✓ Longitudinal data is tracked to allow for informed decision making by community care teams

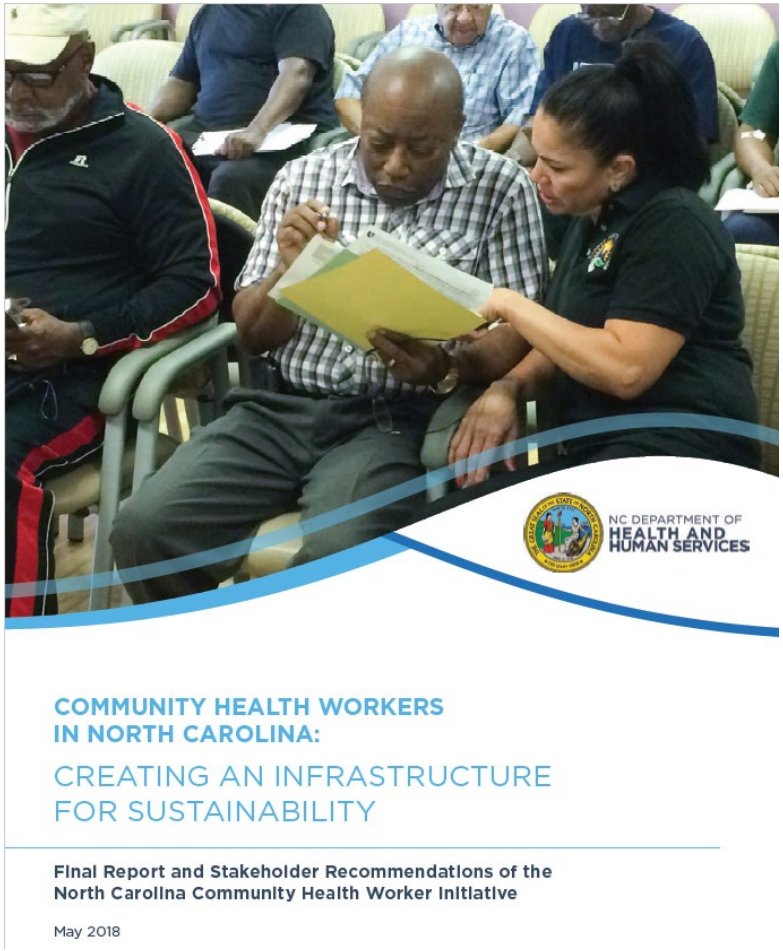
Automated Workflows with Partners



- Configurable Screening
  - Will include statewide screening tool
  - Can add additional screening questions/ tools as needed
- Electronic Referral Management
  - Seamless referral workflow sends the right data to the right provider(s) to address specific needs
- Assessment/Care Plan Management
  - Custom care plans for each service that are attached to referrals so receiving providers get a head start
- Bi-Directional Communication/Alerts
  - Automated notifications keep all organizations up to date, while care team members can securely communicate with each other
- Outcomes
  - You get to know exactly what services were delivered, and the entire history for every intervention by your external partners

Workforce

- Develop, train and strengthen workforce needed to support SDOH initiatives/Trauma Informed Care
- Community health workers, case managers, etc.
- Released report on Community Health Workers, May 2018
  - Community Health Workers in North Carolina: Creating an Infrastructure for Sustainability

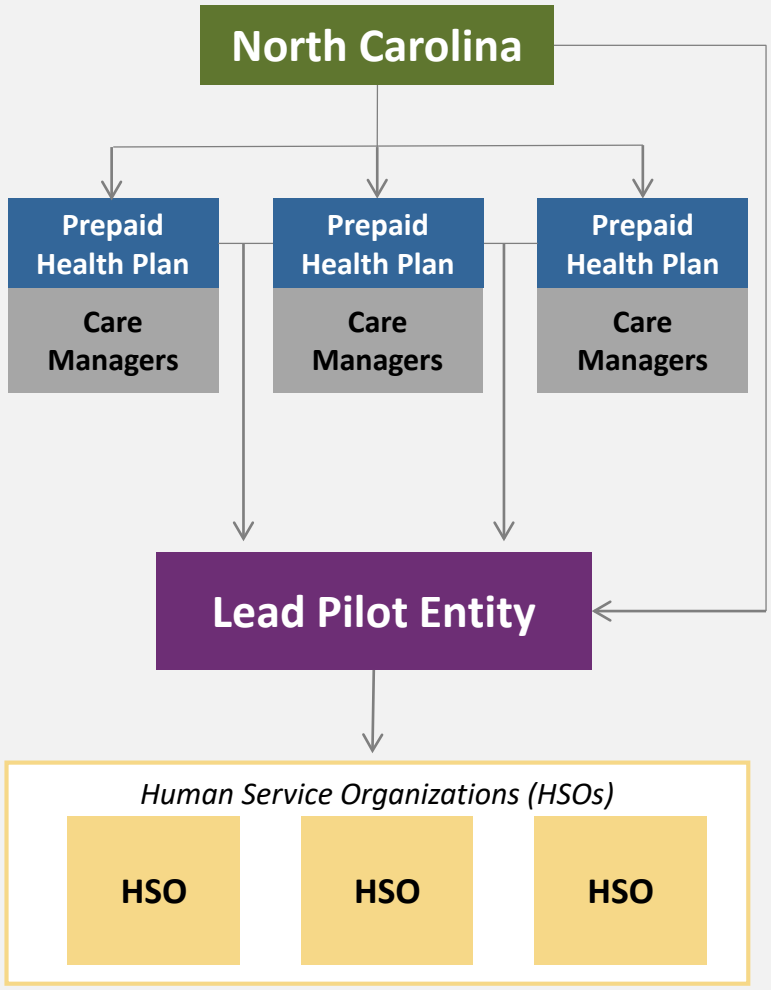


Medicaid Transformation

- Care management
  - Training on trauma informed care
  - Standardized screening questions
  - Navigation to resources – Requirement to connect to NC Resource Platform
- Quality Strategy
  - Withhold-based incentivizes to PHPs to focus on screening for and addressing unmet social needs
  - Increasing expectations over time
- Allow health-related services (e.g. food) to count as patient care (i.e. in the numerator of the Medical Loss Ratio (MLR))
- In lieu of services and value-based payments offer opportunities to pay for resource needs that affect health.
- Possible risk-adjustment or stratification on social risk in future

Healthy Opportunities Pilots: High-Level Overview

Sample Regional Pilot



Pilot Overview

- The Healthy Opportunities Pilots will test the impact of providing selected evidence-based interventions to Medicaid enrollees.
- Over the next five years, the pilots will provide up to $650 million in Medicaid funding for pilot services in two to four areas of the state that are related to housing, food, transportation and interpersonal safety and directly impact the health outcomes and healthcare costs of enrollees.
- Pilots will allow for the establishment and evaluation of a systematic approach to integrating and financing evidence-based, non-medical services into the delivery of healthcare.

Deeper Dive: Healthy Opportunities Pilots

North Carolina's 1115 waiver provides important flexibility to implement the groundbreaking Healthy Opportunities Pilot program in two to four areas of the state over a five-year period.*

PHPs' & Care Managers' Roles & Responsibilities**

- **PHPs:**
  - Must participate in pilot operating within their region
  - Must work with the LPE and its network of providers to implement the program.
  - Must manage a capped amount of funding for pilot services
  - Must make final determinations of pilot eligibility and service authorization.
  - Will have discretion to authorize or deny services for eligible individuals, within guardrails defined by State.
- PHPs will leverage **care managers predominantly at Tier 3 AMHs and LHDs** to:
  - Help identify eligible beneficiaries based on State-developed eligibility criteria
  - Assess and reassess need for pilot services on an ongoing basis
  - Refer beneficiaries to and coordinate with human services organizations
  - Track beneficiaries' progress

LPEs' & HSOs' Roles & Responsibilities**

- North Carolina will procure through a competitive bid **Lead Pilot Entities** (LPEs), that will:
  - Develop, manage, provide technical assistance to and oversee the network of community-based organization and social service agencies
  - Convene pilot and community entities to support communication, relationship-building and sharing best practices
- **Human services organizations** (HSOs) that contract with the LPE:
  - Will deliver cost-effective, evidence-based interventions addressing housing instability, transportation insecurity, food insecurity, interpersonal violence and toxic stress.
  - Must be determined qualified to participate in the pilot by the LPE
  - Will be paid by the LPE.

**For more information on the Healthy Opportunities Pilots, please see the Pilot Fact Sheet*

***All entities must participate in data collection and reporting activities to support evaluation and oversight efforts.*

Role of A Newly Established Lead Pilot Entity

Lead Pilot Entities (LPEs) will serve as the essential connection between PHPs and HSOs. Two to four LPEs will be selected by DHHS in 2019 through a competitive bidding process.

Key LPE Roles & Responsibilities include:

- **Developing an HSO Network:** Recruiting, training, managing and overseeing the network of organizations that deliver pilot services within its pilot area.
- **Advising Care Management Teams**: Advising care managers during care plan development on availability of services and capacity of in-network HSOs
- **Paying HSOs and Providing Financial Oversight:** Receiving payment from PHPs and, in turn, paying HSOs for services rendered.
- **Convening Key Pilot Stakeholders:** Convening key pilot entities and other stakeholders to promote communication and coordination across partners.
- **Providing Technical Assistance:** Providing technical assistance and expertise to HSOs to ensure their successful participation in the pilot.
- **Collecting and Submitting Data:** Collecting and submitting data for evaluation and program oversight.

Overview of Eligibility For Pilot Services

To be eligible for pilot services, Medicaid managed care enrollees must have:

✓ At least one Needs-Based Criteria:

Physical/behavioral health condition criteria vary by population:

- Adults (e.g., 2 or more chronic conditions)
- Pregnant Women (e.g., multifetal gestation)
- Children, ages 0-3 (e.g., Neonatal intensive care unit graduate)
- Children 0-21 (e.g., Experiencing three or more categories of adverse childhood experiences)

+

✓ At least one Social Risk Factor:

- Homeless and/or housing insecure
- Food insecure
- Transportation insecure
- At risk of, witnessing or experiencing interpersonal violence

*See appendix for full list of eligibility criteria.

Overview of Approved Pilot Services

North Carolina's 1115 waiver specifies services that can be covered by the Pilot. Pilots will not be required to offer all approved services.

Housing

- Tenancy support and sustaining services
- Housing quality and safety improvements
- One-time securing house payments (e.g., first month's rent and security deposit)
- Short-term post hospitalization housing

Food

- Linkages to community-based food services (e.g., SNAP/WIC application support, food bank referrals)
- Nutrition and cooking coaching/counseling
- Healthy food boxes
- Medically tailored meal delivery

Transportation

- Linkages to existing public transit
- Payment for transit to support access to pilot services, including:
  - Public transit
  - Taxis, in areas with limited public transit infrastructure

Interpersonal Violence

- Linkages to legal services for IPV related issues
- Evidence-based parenting support programs
- Evidence-based home visiting services

*See appendix for full list of approved pilot services.

Process/ Timeline

- Early 2019: Request for Information (RFI)
- Mid 2019: Request for Proposals (RFP)
  - RFP will determine LPEs/ Pilot Regions
- Late 2019: Award LPEs/ Pilot Regions
- 2020: Full year of capacity building for LPEs and regions
- January 1, 2021: Begin Service Delivery
- October 31, 2024: End Pilots (at end of 1115 waiver)

Questions

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