Mismatch: We are Buying Healthcare not “Health”

Healthcare Spending
- Direct Medical Care 90%
- Other 10%

Drivers of Health
- Behavior 40%
- Genetics 30%
- Social 15%
- Environment 5%
- Healthcare 10%

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

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/](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

<table>
<thead>
<tr>
<th>Social and Neighborhood</th>
<th>Economic</th>
<th>Housing and Transportation</th>
</tr>
</thead>
<tbody>
<tr>
<td>% &lt; HS Diploma</td>
<td>Household Income</td>
<td>% Living in Rental Housing</td>
</tr>
<tr>
<td>% Households with Limited English</td>
<td>% Poverty</td>
<td>% Paying &gt;30% of Income on Rent</td>
</tr>
<tr>
<td>% Single Parent Households</td>
<td>Concentrated Poverty</td>
<td>% Crowded Household</td>
</tr>
<tr>
<td>Low Access to Healthy Foods</td>
<td>% Unemployed</td>
<td>% Households without a Vehicle</td>
</tr>
<tr>
<td>Food Deserts</td>
<td>% Uninsured</td>
<td></td>
</tr>
</tbody>
</table>


North Carolina Social Determinants of Health by Regions

Overview
North Carolina Social Determinants of Health by Regions

A story on health info...

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
North Carolina Social Determinants of Health by Regions

A story on health in... NC HJ

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
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
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

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**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 your needs, but we will try and help as much as we can.

**Food**

1. Within the past 12 months, did you worry that your food would run out before you got money to buy more? (Y/N)
2. Within the past 12 months, did the food you bought just not last and you didn’t have money to get more? (Y/N)

**Housing**

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)? (Y/N)
4. Are you worried about losing your housing? (Y/N)
5. Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed? (Y/N)

**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? (Y/N)

**Interpersonal Safety**

7. Do you feel physically and emotionally unsafe where you currently live? (Y/N)
8. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by anyone? (Y/N)
9. Within the past 12 months, have you been humiliated or emotionally abused by anyone? (Y/N)
NC Resource Platform

• A series of over 80 stakeholder interviews shed light on the desire to better connect the healthcare and human services sectors to better serve all North Carolinians, but also referenced numerous barriers to doing so.

• The NC Resource Platform is envisioned to provide the infrastructure needed to unite healthcare, human services and community-based organizations in a person-centered way.
NC Resource Platform Goals

- One statewide, shared public utility
  - Program of Foundation for Health Leadership and Innovation
  - Operationalized through NCCARE360

- Open to all communities, providers, care managers, social service agencies

- Across all payers, systems, population health organizations

- Create a Coordinated Network to knit together healthcare and community services to create a Health System

- 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 across payers
  - Significant investment by many for development and on-boarding
  - Cost effective in sharing ongoing expense
## NC Resource Platform

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

Hands on, in-person technical assistance and training to on-board providers and community organizations
Who’s Involved in the Network?

• Network Partners
  – Send and receive referrals, share client updates with the network
  – Actively maintain and update their organizational info, participating staff, and programs

• 211 NC/ United Way
  – Navigators at scale: NC 2-1-1 information and referral teams will serve as the statewide coordination centers for the Platform
  – Data Tram: NC 2-1-1 will work to keep the out-of-network resource directory up to date

• Unite Us Support Team
  – Provide ongoing technology training and support the network, analyze network data, solicit feedback on system
Network Model: No Wrong Door Approach
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
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

- Pilots will test evidence-based interventions designed to reduce costs and improve health by more intensely addressing housing instability, transportation insecurity, food insecurity, interpersonal violence and toxic stress for eligible Medicaid beneficiaries.

- Key pilot entities include:
  - North Carolina DHHS
  - Prepaid Health Plans
  - Care Managers (predominantly located at Tier 3 AMHs and LHDs)
  - Lead Pilot Entities
  - Human Service Organizations (HSOs)
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