



NC Department of Health and Human Services

Healthy Opportunities

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NC Department of Health and Human Services

i2i Conference
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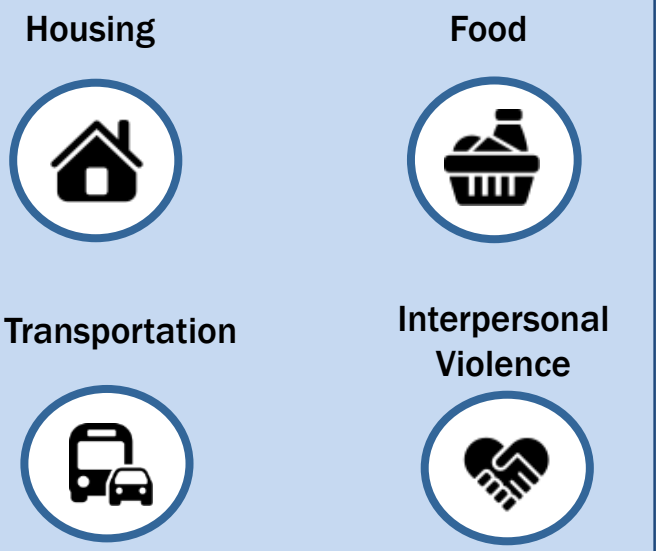
Why Focus on Healthy Opportunities?

"Healthy Opportunities," commonly referred to as the social determinants of health, are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

- Access to high-quality medical care is critical, but research shows up to 80 percent of a person's health is determined by social and environmental factors and the behaviors that emerge as a result.
- Addressing the factors that directly impact health is a key component of meeting DHHS's mission to improve the health, safety and well-being of all North Carolinians while being good stewards of resources.

North Carolina's Healthy Opportunities Priority Domains

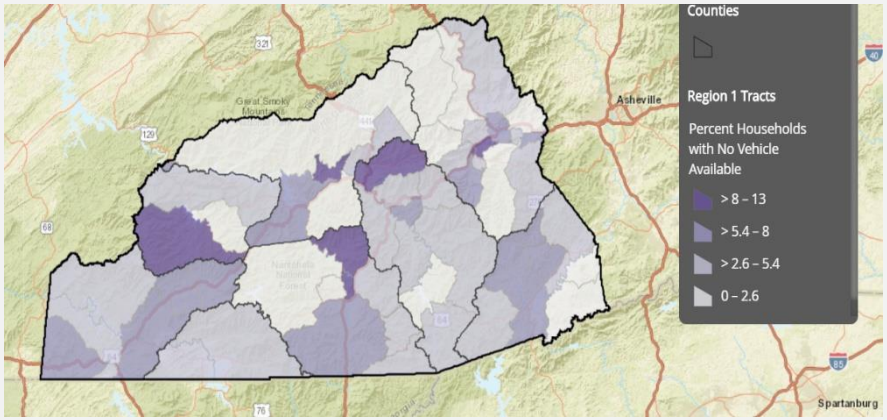


Unmet Health-Related Needs in North Carolina

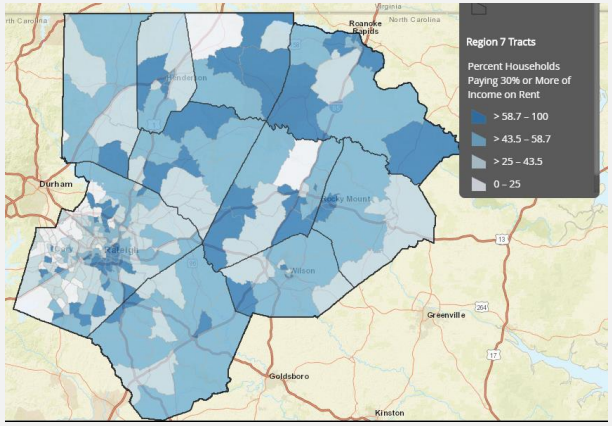
Citizens of North Carolina grapple with the impact of unmet health-related social needs every day:

- Over 1.2 million North Carolinians cannot find affordable housing, and one in 28 of the state's children under age six is homeless.
- NC has the 8th highest rate of food insecurity in the US, with more than one in five children living in food insecure households.
- 47% of NC women have experienced intimate partner violence.
- Nearly 25% of NC children have experienced adverse childhood experiences (ACEs),
- On average 7% of the state population do not have access to a vehicle and report that lack of transportation causes them to delay their medical care.

Percent of Households Without Access to a Vehicle



Percent of Households Pay >30% Income on Rent



Healthy Opportunities Initiatives

Strategy to bridge health care and human services across diverse populations and geography at scale.

Key Healthy Opportunities Initiatives


“Hot Spot” Map


Screening Questions

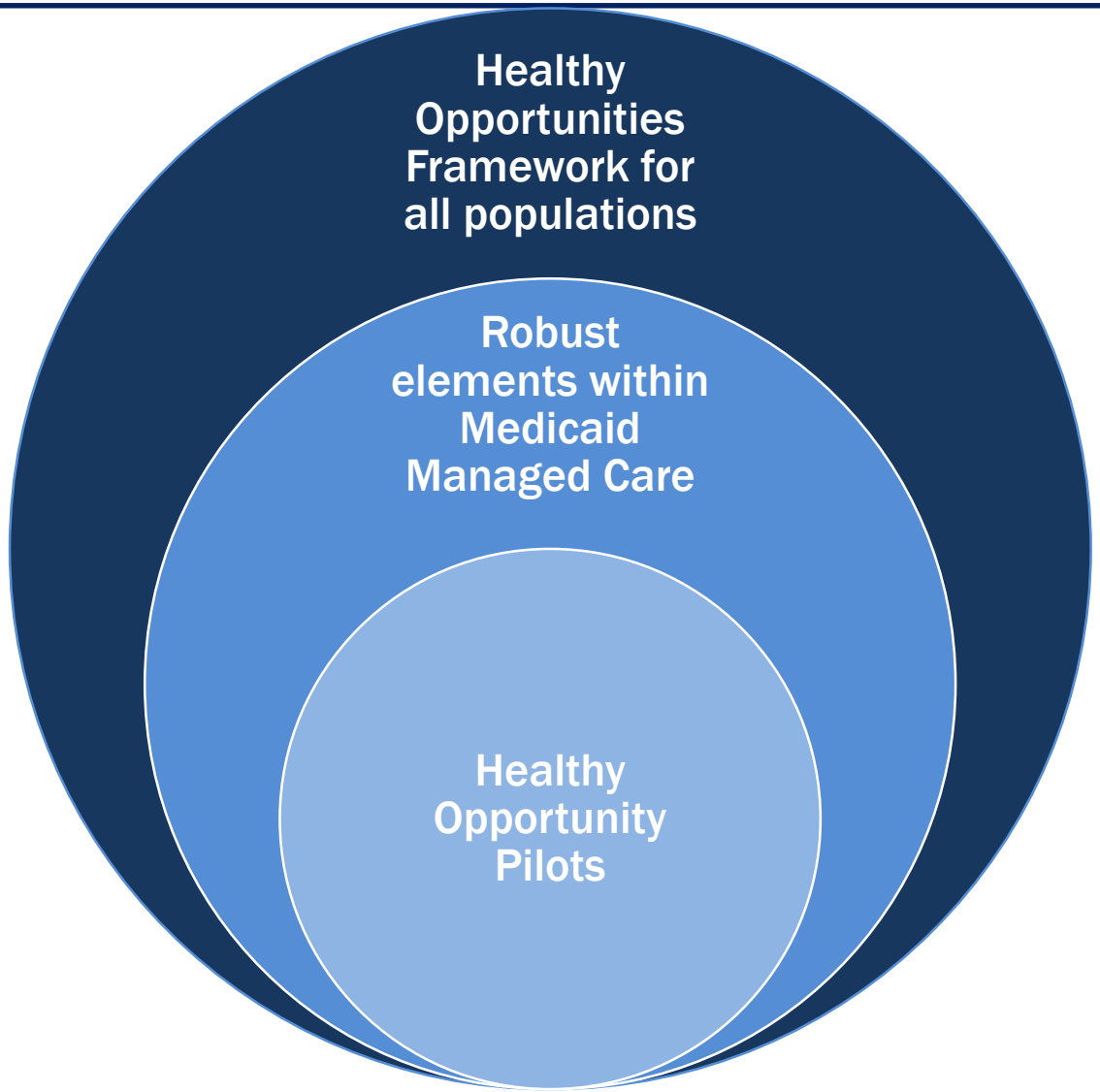

NCCARE360


Medicaid Transformation & Healthy Opportunities Pilots


Workforce


Connecting Resources

Healthy Opportunities Initiatives



NCCARE360

A New Tool for a Healthier North Carolina

Jimmy Fisher
State Director

i2i Conference
4 December 2019

NCCARE360

What is NCCARE360?

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

NCCARE360 Partners:

Foundation for Health Leadership & Innovation
Moving people and ideas into action.

UNITE US

Expound

NCDHHS

NORTH CAROLINA 211

United Way
United Way of North Carolina

NCCARE360

Three Functions

	Functionality	Partner	Timeline
Resource Directory **Call Center**	Directory of statewide resources that will include a call center with dedicated navigators, a data team verifying resources, and text and chat capabilities.	NORTH CAROLINA 211	Ongoing work
Resource Repository	APIs integrate resource directories across the state to share resource data.	Expound	Phased Approach
Referral & Outcomes Platform **Community Engagement**	An intake and referral platform to connect people to community resources and allow for a feedback loop.	UNITE US	Rolled out by county January 2019 – December 2020

Resource Directory

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Building on NC 2-1-1 strength

18,000 organization directory, call centers

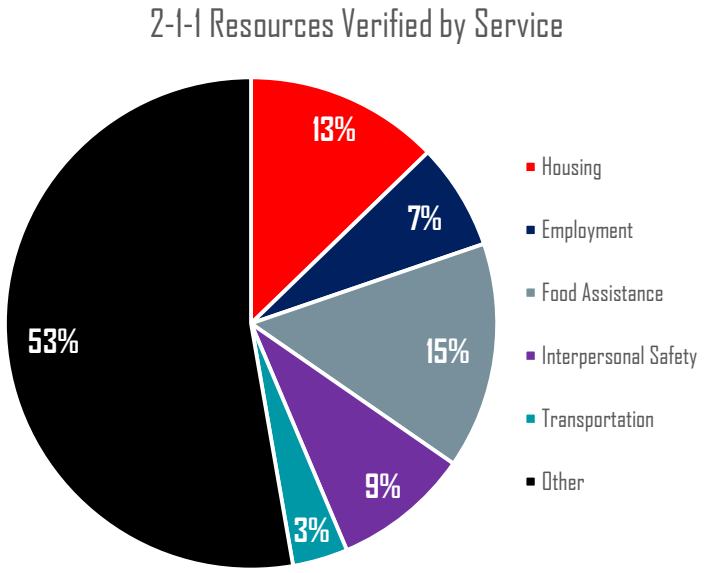
Growing Capacity

- Additional data coordination staff
- Updating listings in current 2-1-1 directory
- Additional call center staff and navigators at scale

Progress

2,898 Organizations verified

8,984 Programs verified



NCCARE360

Your Community Resources in One Place

Out of Network

Organizations that have not been onboarded to the platform

- Searchable and Identifiable as part of Resource Directory/Data Repository
- Not part of the NCCARE360 platform yet
- Do not report outcomes

In Coordinated Network

Organizations onboarded to the platform – Coordinated Network

- Agree to NCCARE360 platform requirements
- Have completed training and on-boarding
- Responsibility to report outcomes

NCCARE360

What is a Coordinated Network?

A coordinated network connects providers (such as health care providers, insurers, or community organizations) through a shared technology platform to:

- Communicate in real-time
- Make electronic referrals
- Securely share client information
- Track outcomes together

Making the Connection

Who is involved in the Network?

Network Partners (Healthcare and Community)

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

NC 2-1-1/ United Way

- Navigators at-scale: NC 2-1-1 information and referral system will serve as the statewide coordination centers for NCCARE360

Unite Us Support Team

- Provide ongoing technology training and support to the network, analyze network data, solicit feedback on system

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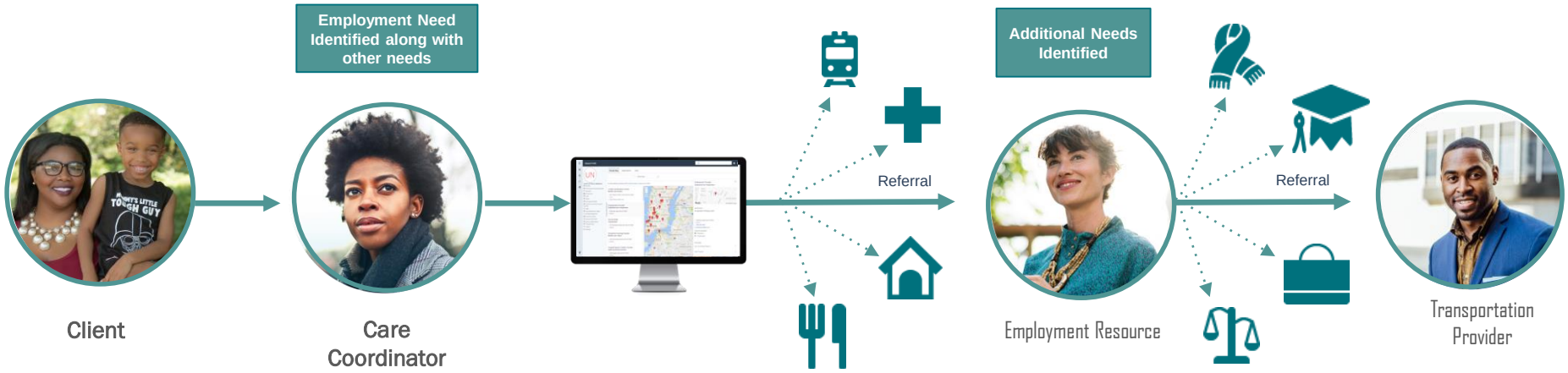
Network Model: No Wrong Door Approach

Understanding Referral Workflows



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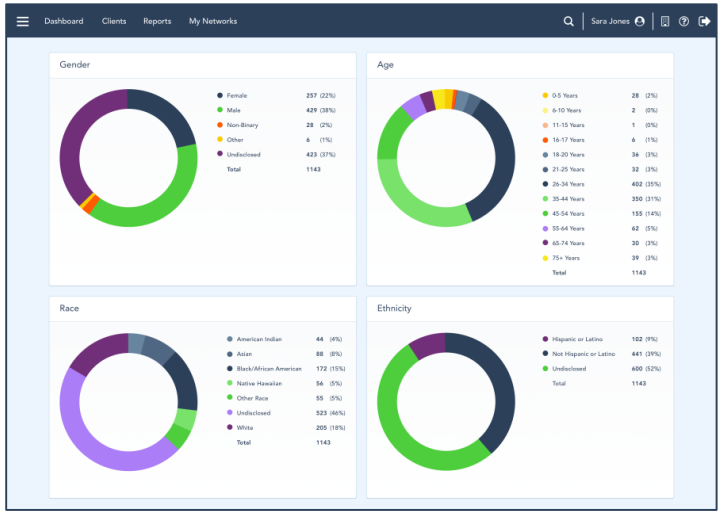
The Data You Need

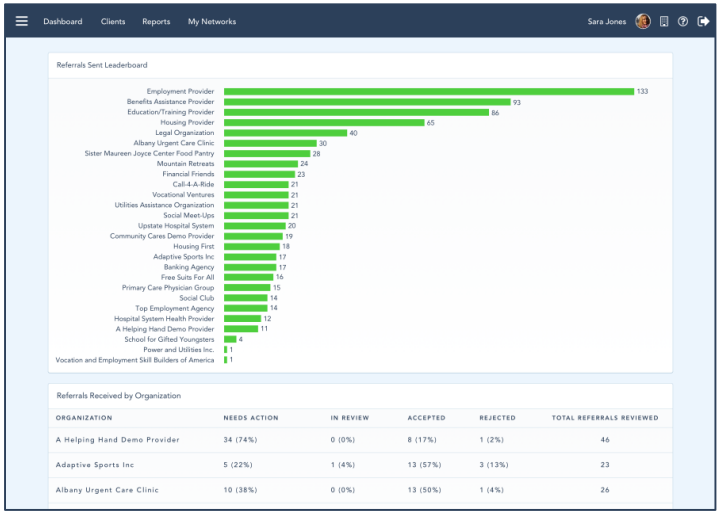
Real-time reporting of outcomes, impact, performance & efficiency

Patient Level Coordination and Tracking



Patient Demographics, Patient Access Points, Service Delivery History, Outcome Breakdowns

Network Level Transparency & Accountability



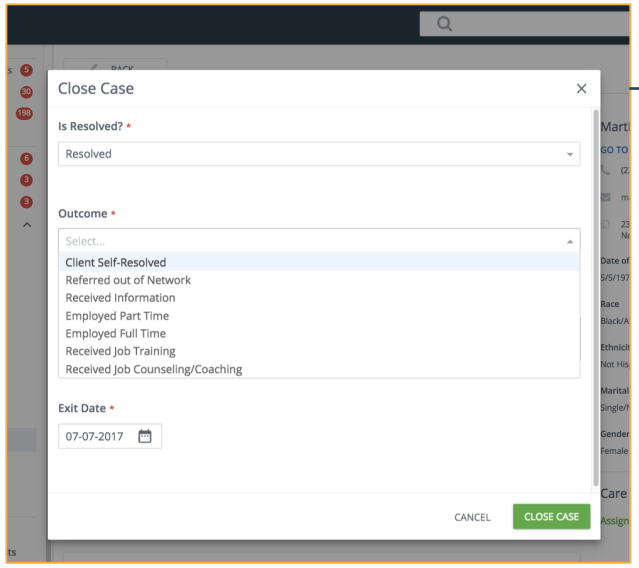
Service Episode history (longitudinal), Referrals Created, Received by, Structured Patient Outcomes for each specific need addressed

NCCARE360

Configurable & Structured Reporting

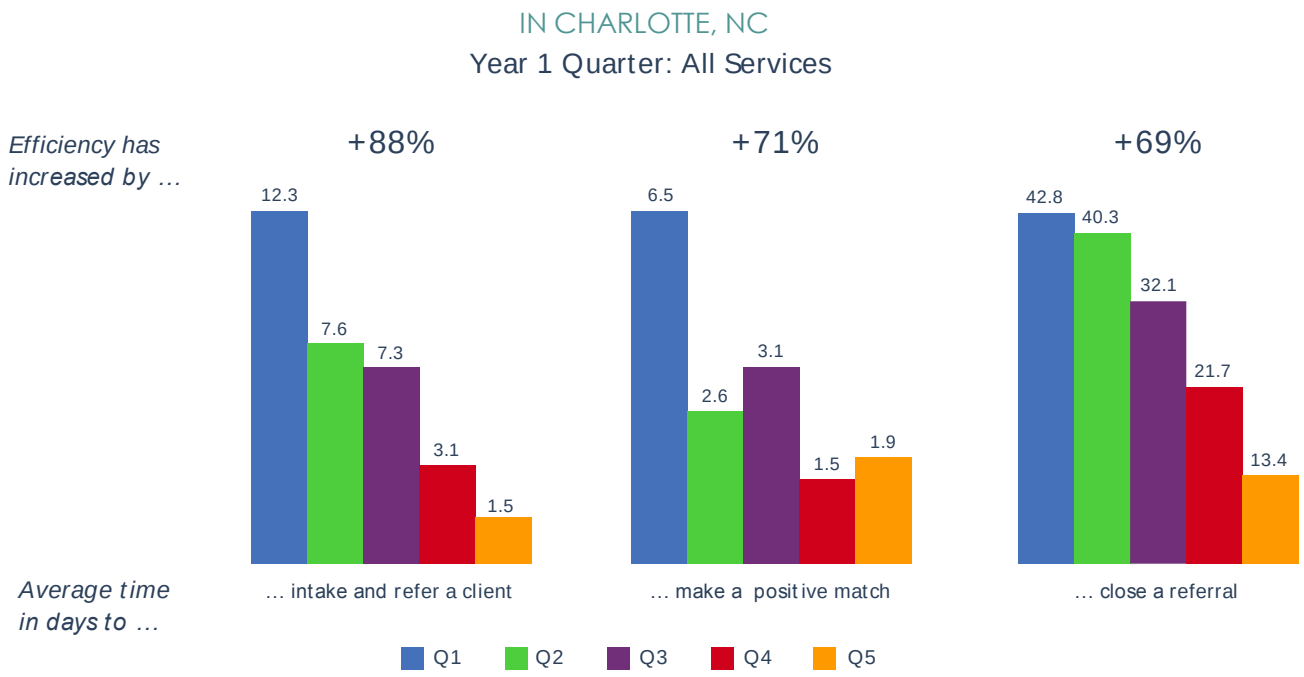
Granular and detailed outcomes for every type of service

Employment Service Type Example

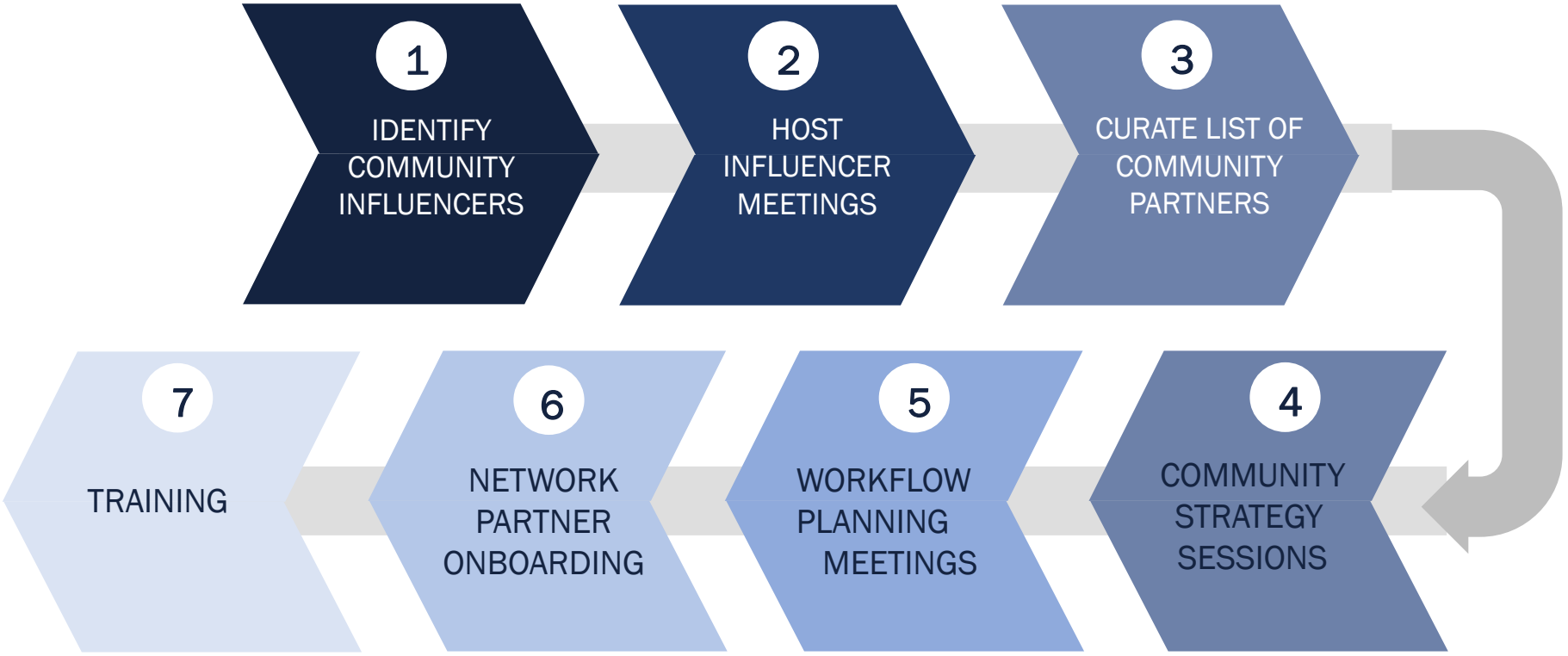


Improved Efficiency in North Carolina

Accelerating intake, referral, and closing the loop



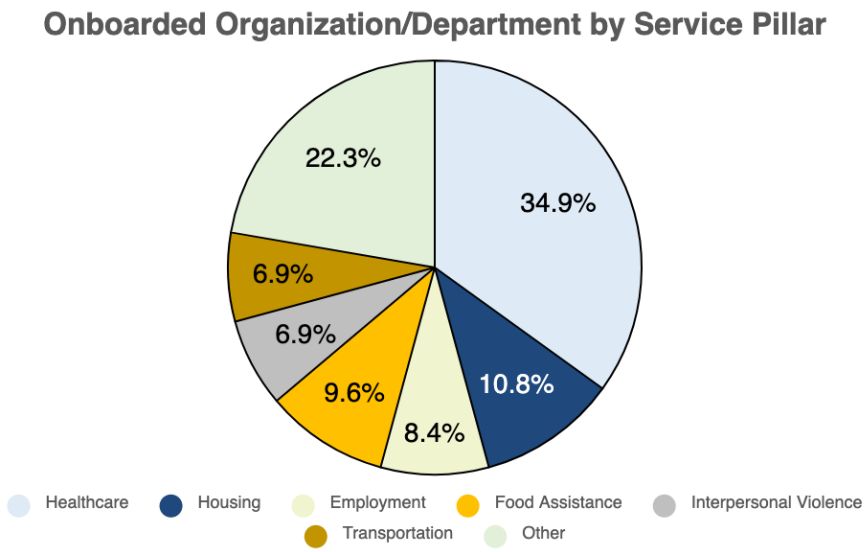
Regional Socialization & Onboarding Process



Status Update

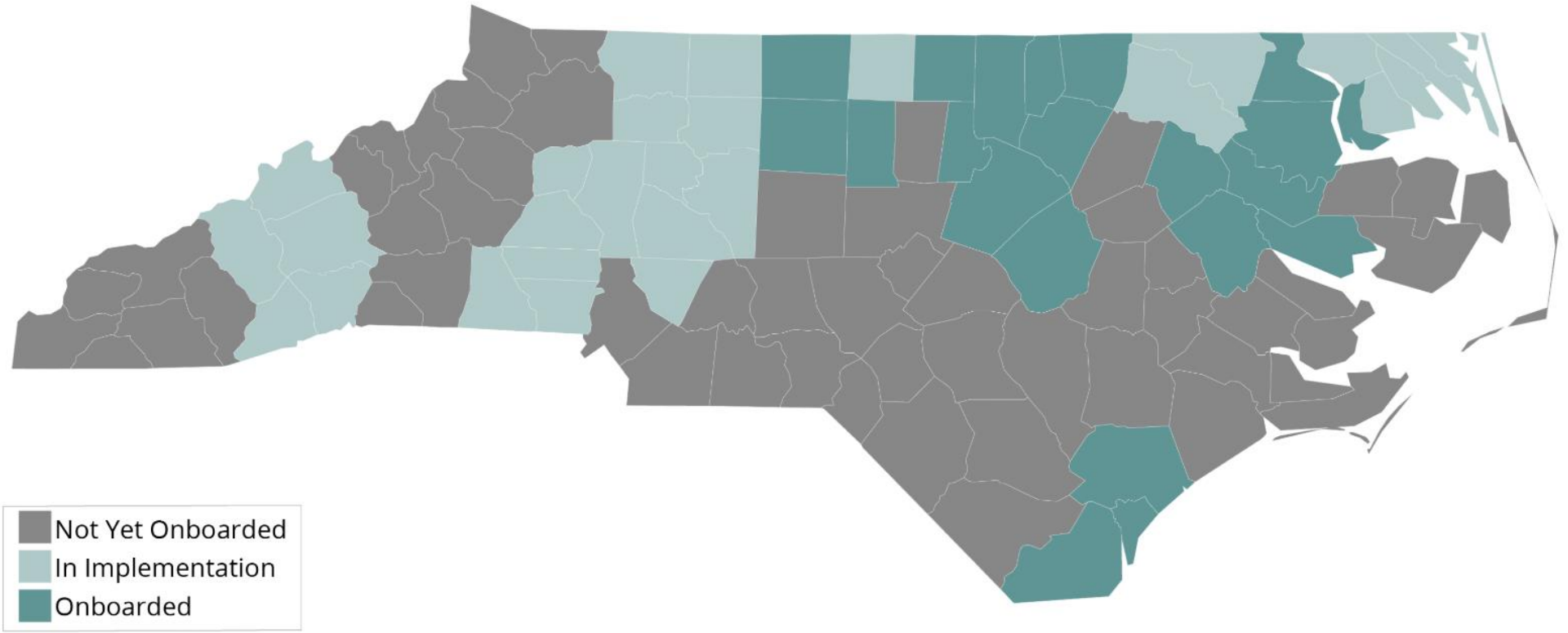
NCCARE360

NCCARE360 Status Update	
23	Counties launched
30	Counties started on implementation
2464	Organizations engaged in socialization process
479	Organizations with NCCARE360 licenses
1859	Active Users



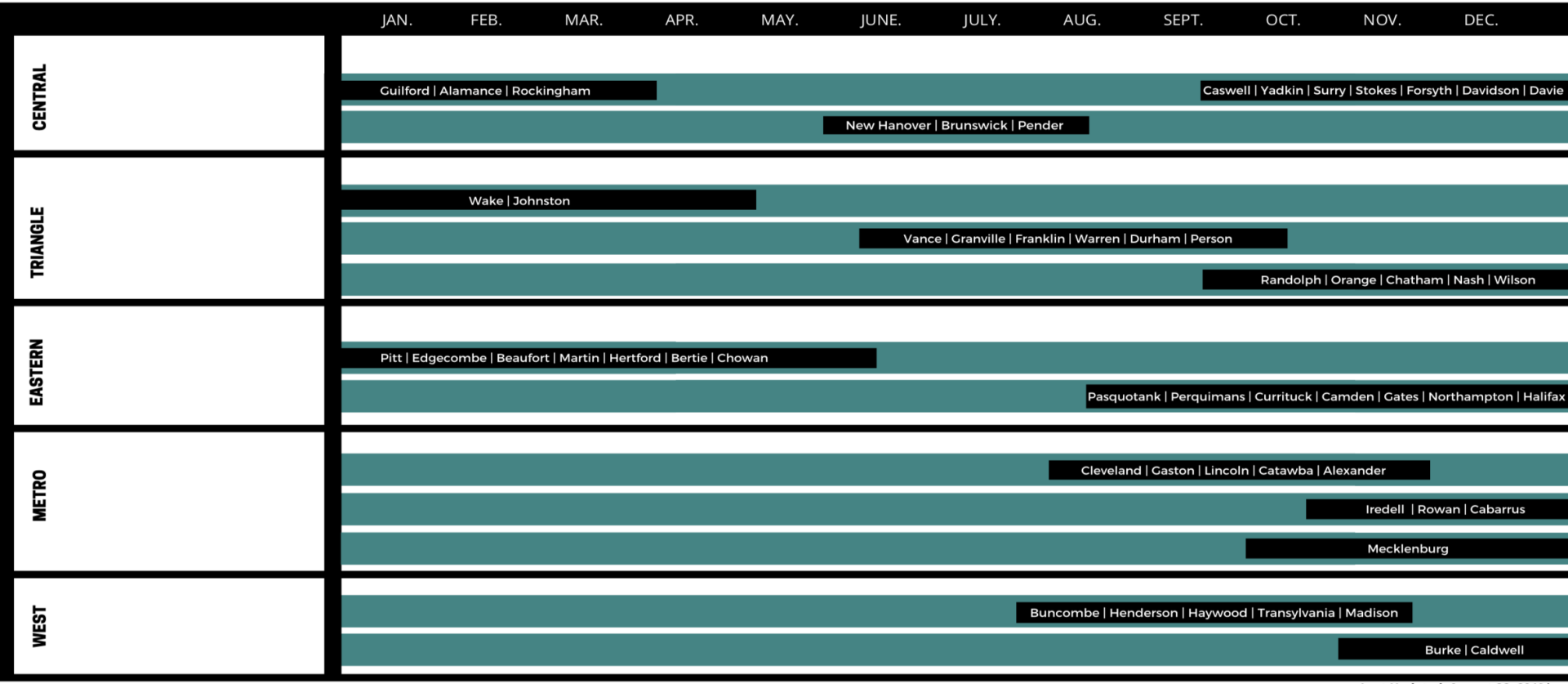
NCCARE360

State Coverage



NCCARE360

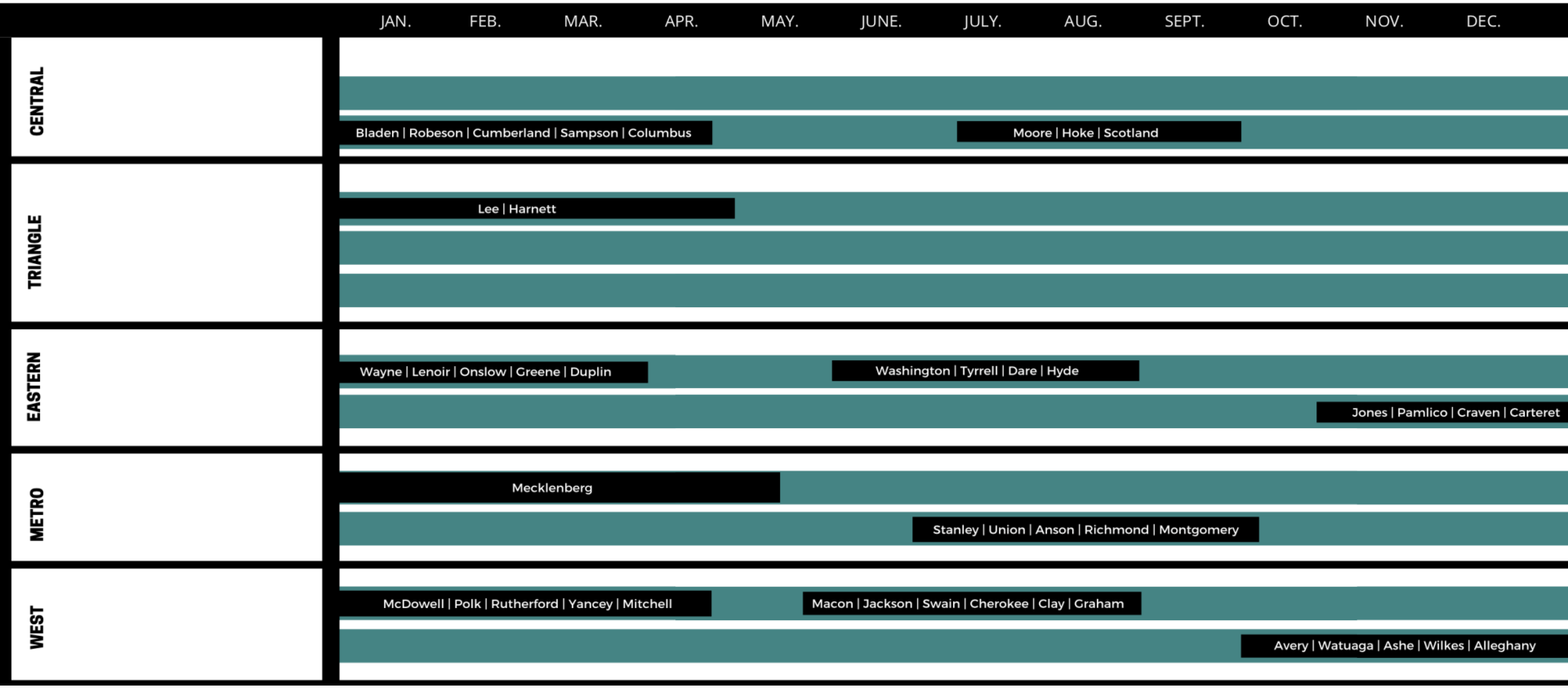
Proposed Implementation 2019



Last Updated: August 22, 2019|

NCCARE360

Proposed Implementation 2020



Medicaid Transformation Vision

“To improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care which addresses both medical and non-medical drivers of health.”

Addressing Social Needs Through Care Management

The care management model requires PHPs and care managers to take steps to address beneficiaries' unmet resource needs.

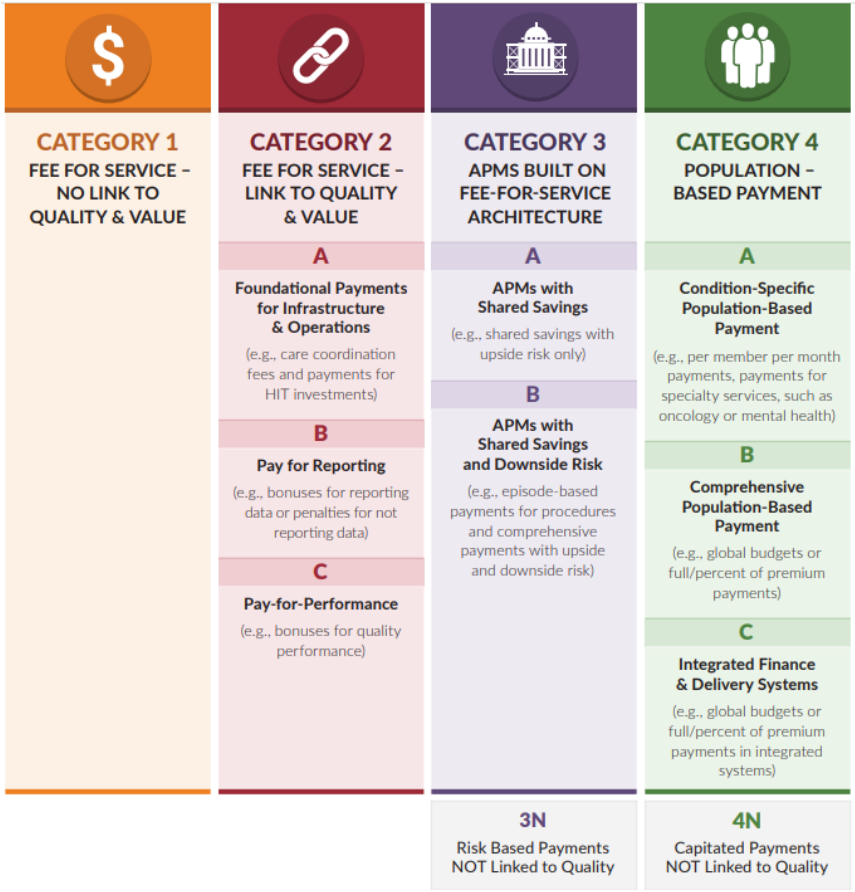
Addressing Unmet Resource Needs through Care Management

- Care management model drives a focus on addressing beneficiaries' unmet resources needs.
- PHPs identify high-needs individuals (including those with significant social needs) and often delegate the provision of care management to qualified local entities—e.g., Tier 3 Advanced Medical Homes and Local Health Departments
- **Care managers and other members of the care team will play a significant role in addressing the non-medical drivers of health.**
  - Identification through use of State **SDOH screening**, analysis of data, or referral.
  - Comprehensive Assessment
  - Accountable for addressing needs, including by:
    - Providing in-person assistance with select applications (e.g. SNAP and WIC)
    - Connecting beneficiaries to community resources leveraging **NCCARE360**
    - Having housing specialist
    - Providing access to medical-legal partnerships.

Healthy Opportunities & Value-Based Payment Strategies

VBP Overview

- Value-based payments give providers flexibility to decide how best to use payments, including by paying for health-related social supports that may be more cost-effective than traditional medical care.
- The State’s VBP strategy will encourage PHPs and other providers to consider how they can incorporate and promote healthy opportunities into their VBP contracts.



Voluntary PHP Contributions to Health-Related Resources

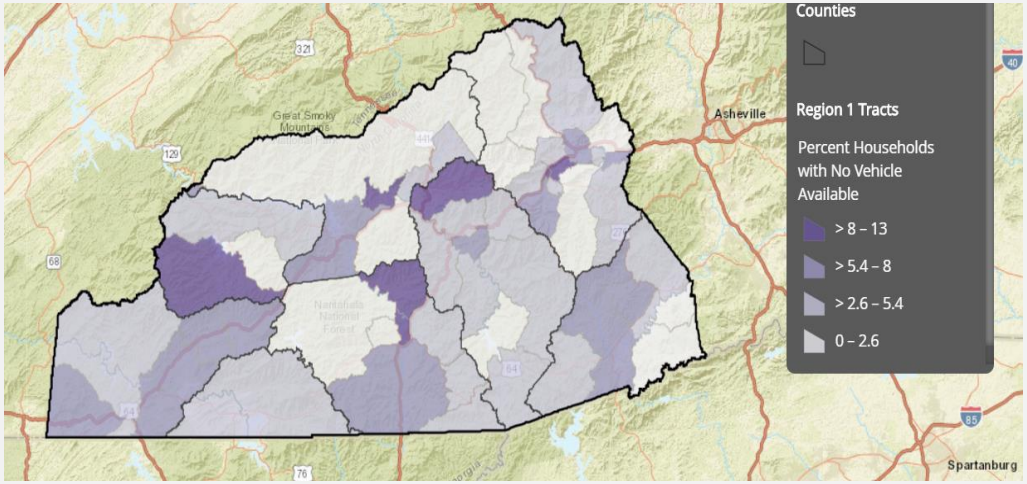
PHPs are encouraged to make contributions to health-related resources that help to address members’ and communities’ unmet health-related needs.

Contributions to Health-Related Resources

- PHPs are encouraged to contribute to health-related resources that improve health outcomes and cost-effective delivery of care in the communities they serve.
- PHPs that voluntarily contribute to health-related resources may count the contributions in the numerator of their MLR.
- A PHP that voluntarily contributes at least one-tenth percent (0.1%) of its annual capitation revenue in a region to health-related resources may be awarded a **preference in auto-assignment** to promote enrollment in each region in which the PHP contributes.

Providers may wish to give input to PHPs on how to direct their contributions in their communities.

Percent of Households Without Access to a Vehicle in Region 1



The NC “Hot Spot” Map uses geographic information system (GIS) technology to map resource needs and other indicators across the state **and can strategically guide contributions to health-related resources.**

What Are the Healthy Opportunities Pilots?

The federal government authorized up to $650 million in state and federal Medicaid funding to test evidence-based, non-medical interventions designed to improve health outcomes and reduce healthcare costs for a subset of Medicaid enrollees.

Pilot funds will be used to:

- Cover the cost of federally-approved Pilot services
  - *DHHS is developing a fee schedule to reimburse entities that deliver these non-clinical services*
- Support capacity building to establish “Lead Pilot Entities” that will develop and manage a network of human service organizations (HSOs), and strengthen the ability of HSOs to deliver Pilot services
  - *DHHS will procure Lead Pilot Entities with deep roots in their community that can facilitate collaboration across the healthcare and human service providers through building partnerships.*

NC’s priority “Healthy Opportunities” domains

Who Qualifies for Pilot Services?

To qualify 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

What Services Can Enrollees Receive Through the Pilots?

North Carolina's 1115 waiver specifies services that can be covered by the Pilot.

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)

Food

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

Transportation

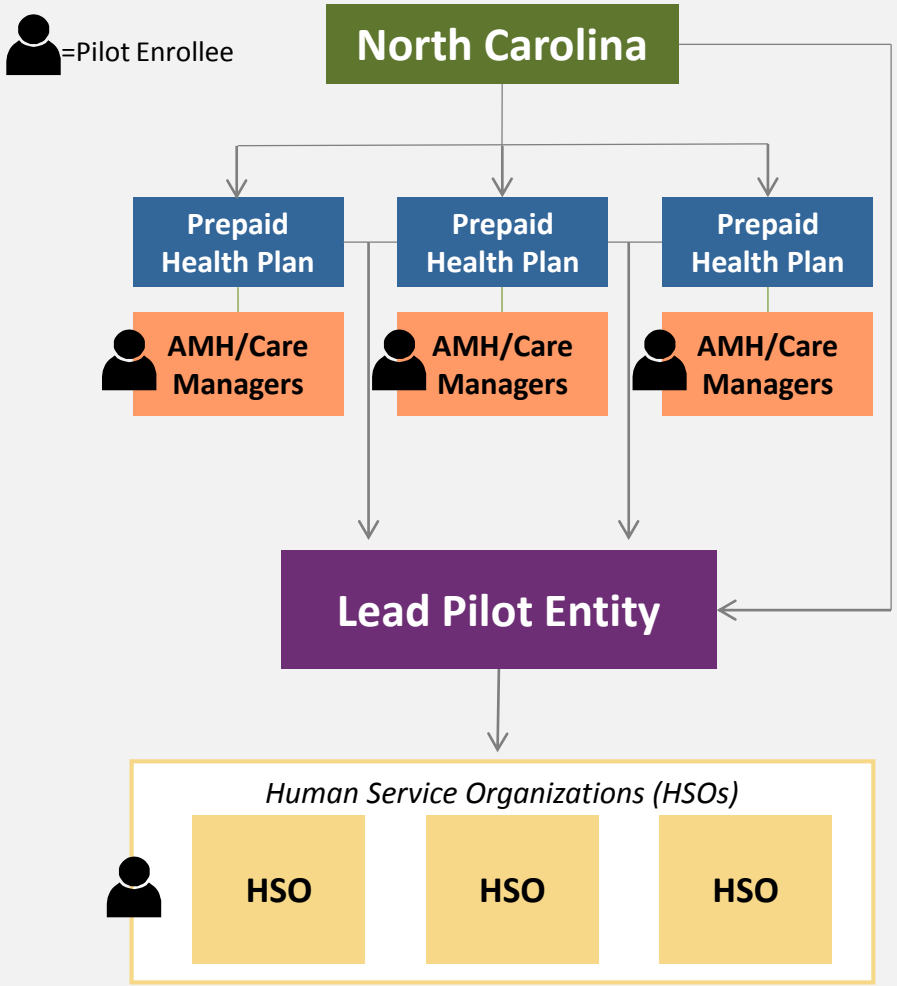
- Linkages to existing public transit
- Payment for transit to support access to pilot services, including:
  - Public transit
  - Taxis, in areas with limited public transit infrastructure

Interpersonal Violence (IPV)

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

What Entities Are Involved in the Pilots?

Sample Regional Pilot



Pilot Entities: Overview

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

Who Will Be Able to Apply to Become a Lead Pilot Entity?

Lead Pilot Entities should be deeply rooted in their communities and able to build partnerships with HSOs to create a smooth experience for Pilot enrollees.

Lead Pilot Entity Applicants

- DHHS anticipates that Lead Pilot Entities will be existing community-based social service or health organizations, or a partnership such organizations.
- Entities that are likely best positioned for the Lead Pilot Entity Role include (but are not limited to):
  - ✓ Community-based organizations
  - ✓ County-based public agencies
  - ✓ Local Health Departments
  - ✓ Social services or multiservice agencies
  - ✓ Community health centers
  - ✓ Community health foundations, or associations
  - ✓ A partnership of agencies who come together to form a Lead Pilot Entity

Lead Pilot Entities should demonstrate meaningful partnerships with a range of community-based organizations and other key Pilot entities in the communities they serve.

- LPEs may partner with health systems, but DHHS anticipates they will not be led by them.
- PHPs and Local Management Entity-Managed Care Organizations (LME-MCOs) may not serve as Lead Pilot Entities.

Accountability and Evaluation

Strategies to ensure accountability for federal and state Pilot funding and to learn how to deliver effective non-medical interventions across a population.

Tools for Accountability and Learning

Rigorous Evaluation:

- **Rapid Cycle Assessments:** To gain “real-time” insights on whether Pilots are operating as intended, if services are having their intended effects, and what mid-course adjustments need to be made to improve delivery of effective services.
- **Summative Evaluation**: To assess the global impact of the Pilots, learn which interventions are effective for specific populations, and plan for incorporation into the Medicaid program.

Value-Based Payments: Payments for Pilot services will increasingly be linked to performance against health outcomes and healthcare cost benchmarks.

Program Integrity: State oversight to ensure funds are spent as intended by Pilot entities.

Timeline

- March 2019: Request for Information (RFI)
- November 2019: Request for Proposals (RFP)
  - RFP will determine LPEs/ Pilot Regions
- Spring 2020: Award LPEs/ Pilot Regions
- 2020: Capacity building for LPEs and regions
- Early 2021: Expected start date of service delivery
- October 31, 2024: End Pilots (at end of 1115 waiver)

Questions

Appendix

“Hot Spot” Map

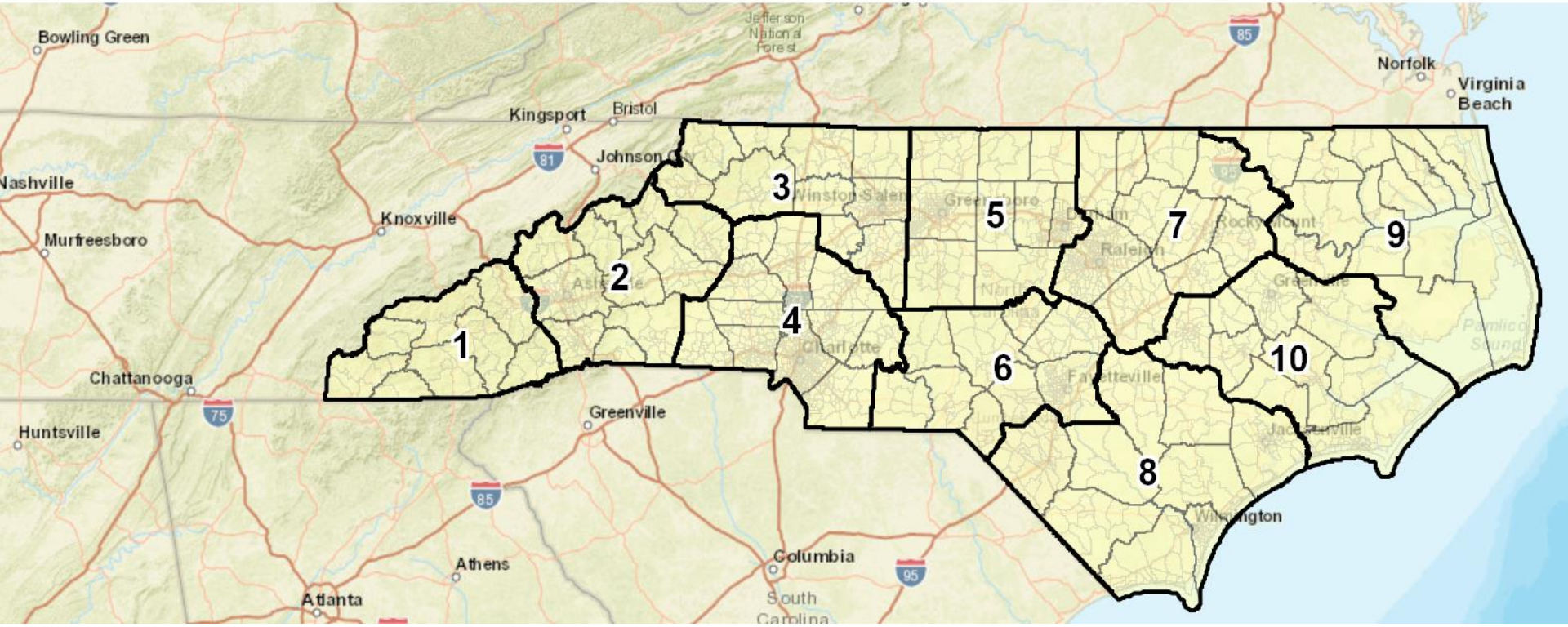
- Statewide map now live: http://www.schs.state.nc.us/data/hsa/
- GIS/ESRI Story mapping of 14 SDOH indicators with a summary statistic
- Displays geographical health & economic disparities

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



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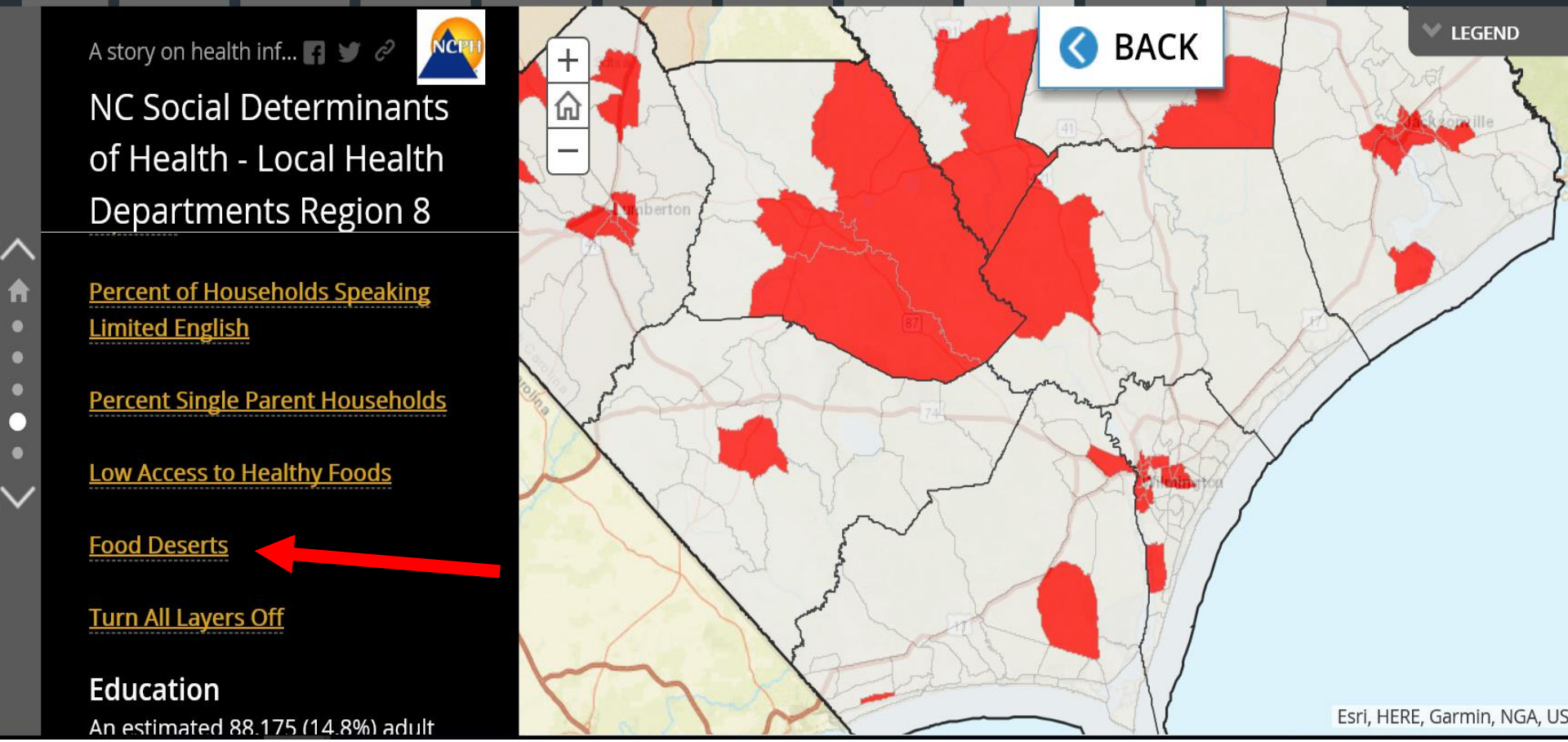

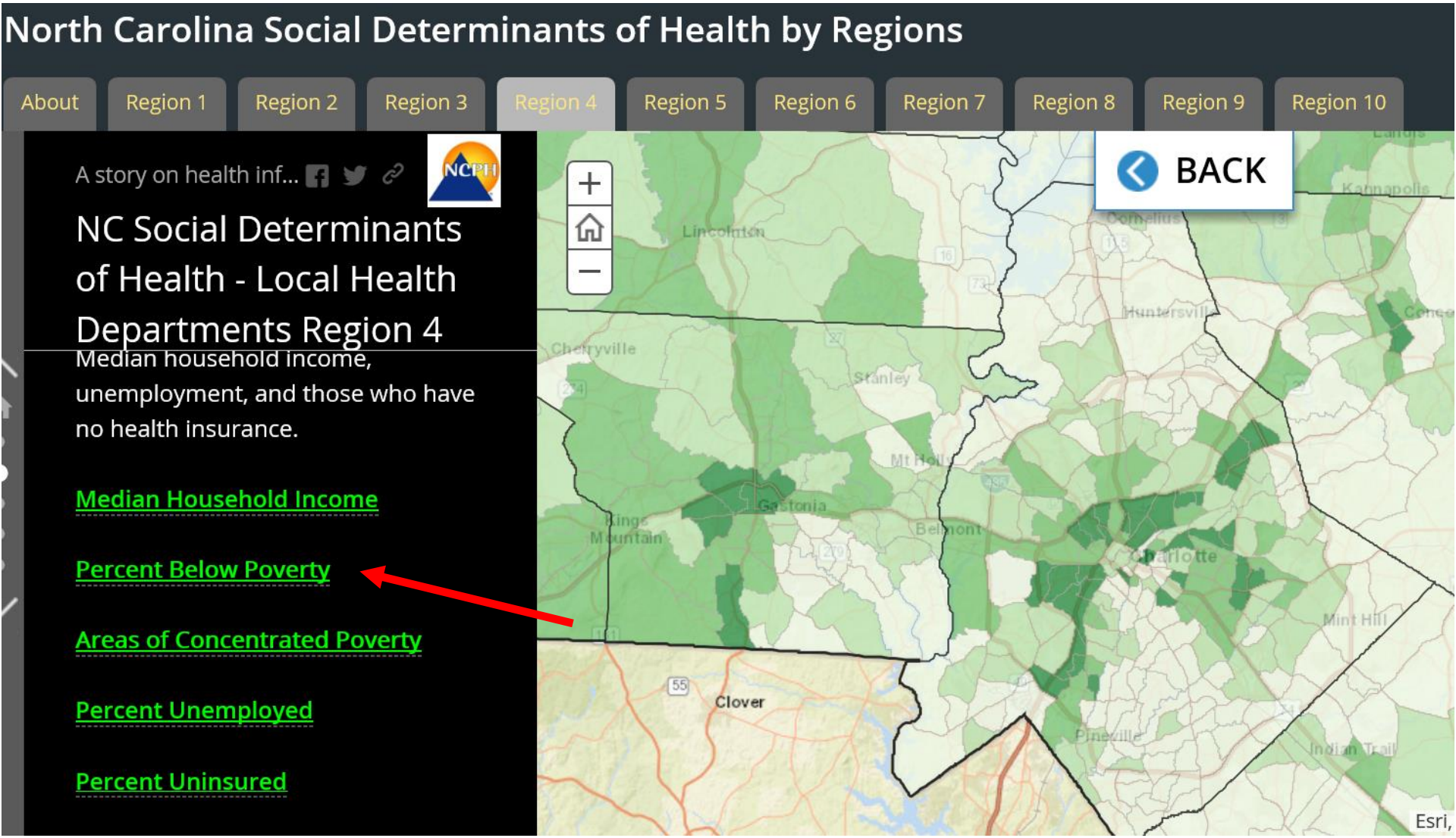
North Carolina Social Determinants of Health by Regions
About
Region 1
Region 2
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A story on health inf...
NCPH
NC Social Determinants of Health - Local Health Departments Region 4
Median household income, unemployment, and those who have no health insurance.
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 tested 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 or 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

NCCARE360 is the first statewide coordinated network that unites healthcare and human services organizations with a shared technology platform allowing for a coordinated, community-oriented, person-centered approach to delivering care in North Carolina.

NCCARE360 Functionalities

	Functionality	Partner	Timeline
Resource Directory & Call Center	Directory of statewide resources that will include a call center with dedicated navigators, a data team verifying resources, and text and chat capabilities.	NORTH CAROLINA 211	Phased update 2019 – Spring 2020 * Currently has verified resources across all counites and all domains
Resource Repository	APIs integrate NCCARE360 directory with resource directories across the state to share resource data in one repository.	Expound	Phased Approach
Referral & Outcomes Platform	An intake and referral platform to connect people to community resources and allow for a feedback loop.	UNITE US	Rolled out by county January 2019 – December 2020

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

NCCARE360 Coordinated Network

A coordinated network connects providers (such as health care providers, insurers, or community organizations) through a shared technology platform to:

- Communicate in real-time
- Make electronic referrals
- Securely share client information
- Track outcomes together

Coordination Platform at Work

Improving coordination efficiency and accuracy

Traditional Referral

Client | Healthcare Provider | Housing Provider

- ✗ 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

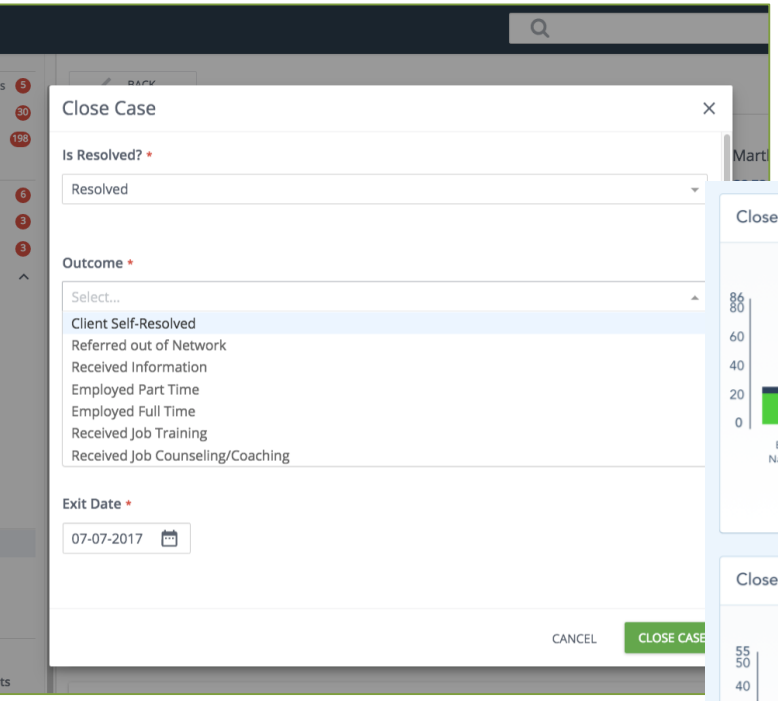
Client | Healthcare Provider | Housing Provider

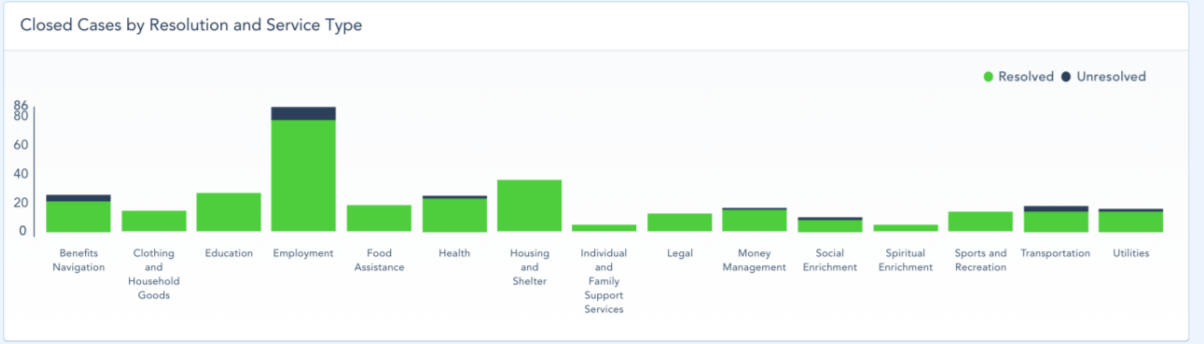
- ✓ All information is stored and transferred on HIPAA compliant platform
- ✓ Client is matched with the provider for which he/she qualifies
- ✓ Client’s information is captured once and shared on his/her behalf
- ✓ Service providers have insight into the entire client journey
- ✓ Longitudinal data is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

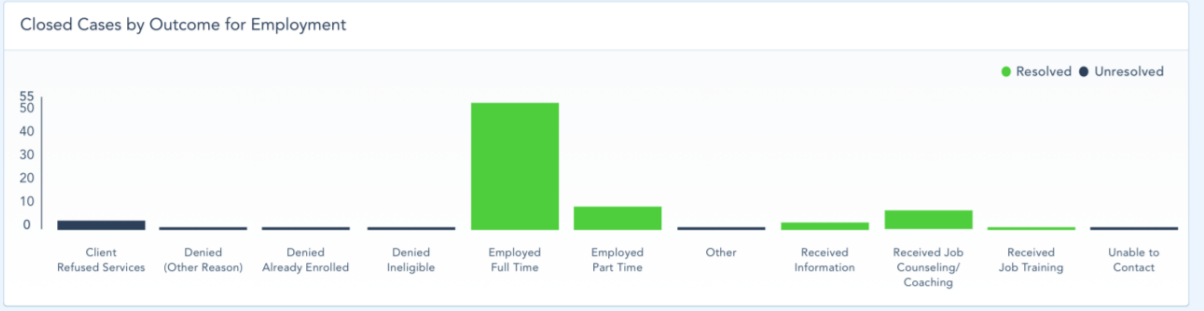
No Wrong Door Approach

Configurable & Structured Data

Real-time reporting of outcomes, performance & efficiency

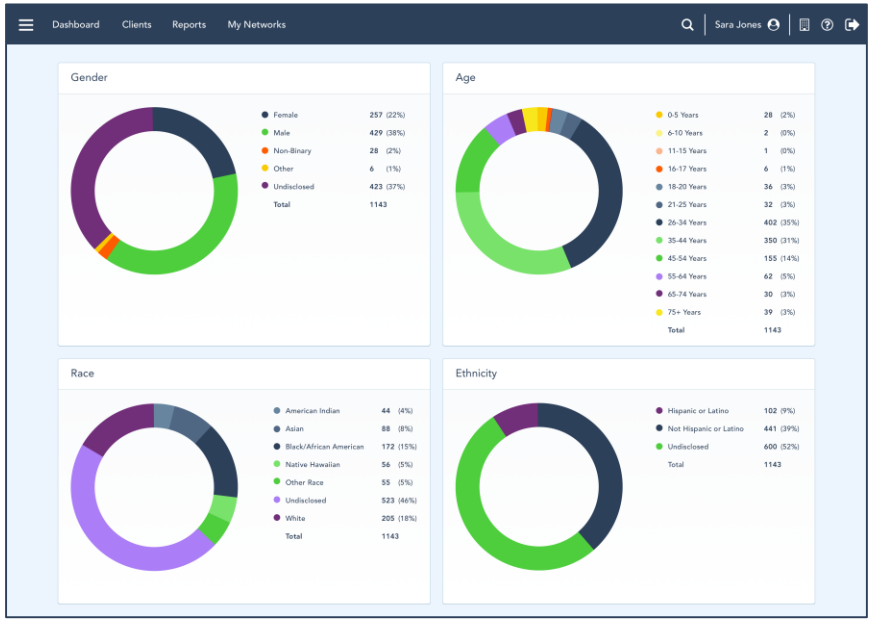


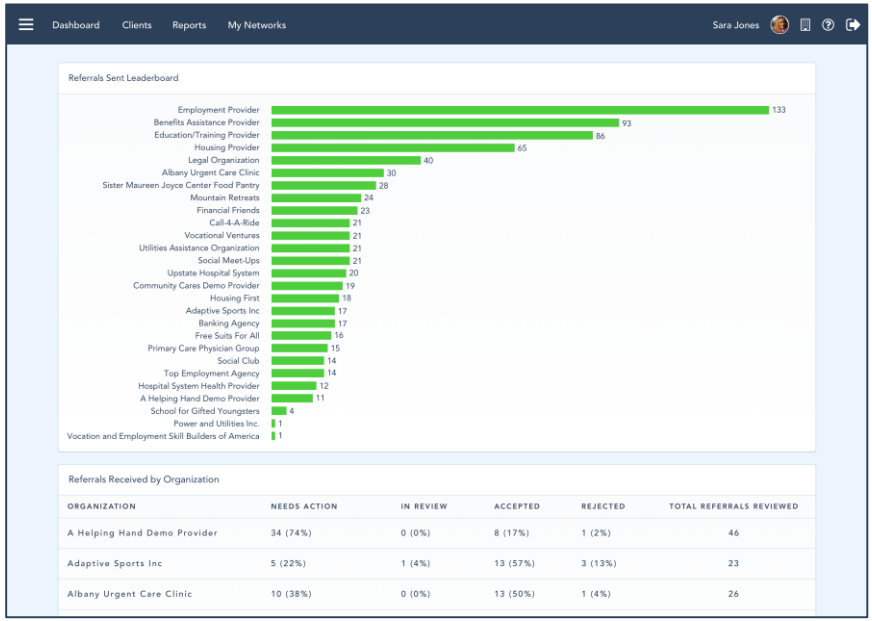




Configurable & Structured Data

Real-time reporting of outcomes, performance & efficiency





Patient Level Coordination & Tracking
Patient Demographics, Access Points, Service Delivery History, Outcomes

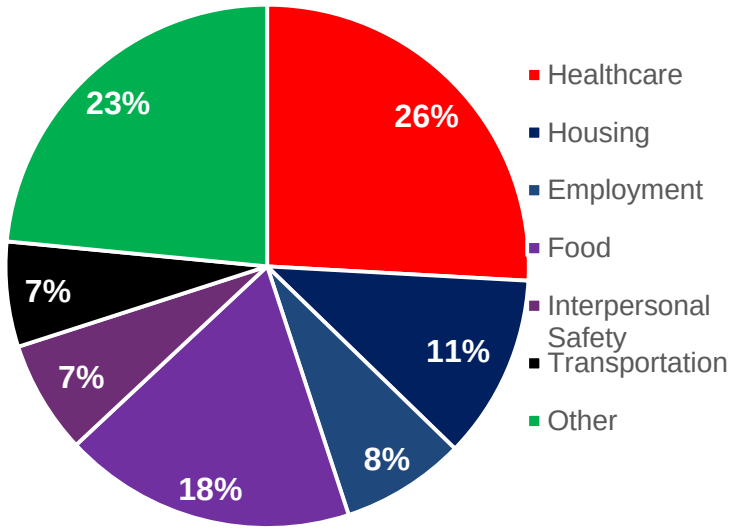
Network Level Transparency & Accountability
Service Episode history, Referrals Created, Structured Patient Outcomes

Status Update (as of 11/18/19)

NCCARE360 Implementation Status Update	
21	Counties launched (Alamance, Beaufort, Bertie, Brunswick, Chowan, Durham, Edgecombe, Franklin, Guilford, Granville, Hertford, Johnston, Martin, New Hanover, Pender, Person, Pitt, Rockingham, Vance, Wake and Warren)
29	Counties started on implementation
2464	Organizations engaged in socialization process
479	Organizations with NCCARE360 licenses
1864	Active Users
1532	Referrals Sent

NCCARE360 Resource Repository	
2,954	Organizations verified
10,736	Programs verified

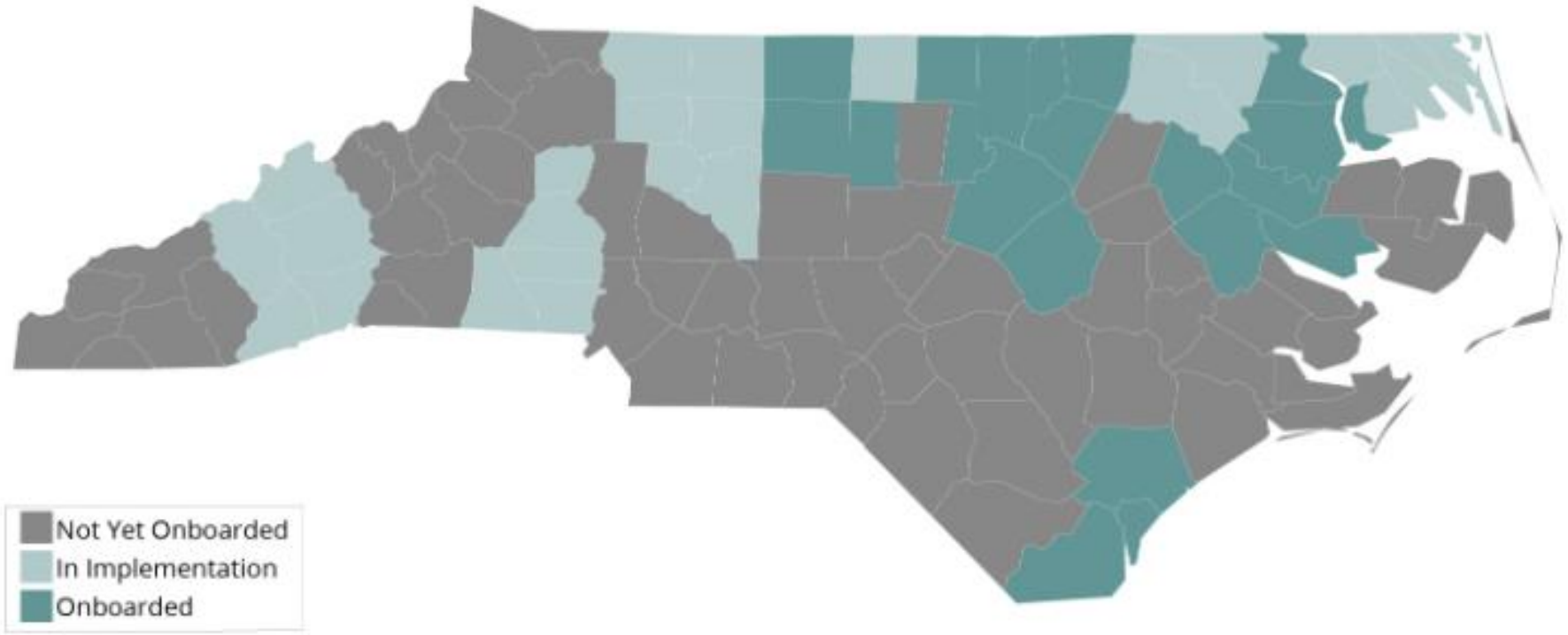
Engaged Organizations by Service Type



NCCARE360 will be implemented statewide by end of 2020

State Coverage

Began rollout January 2019, statewide by December 2020



Medicaid Transformation Vision

“To improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care which addresses both medical and non-medical drivers of health.”

Addressing Social Needs Through Care Management

The care management model requires PHPs and care managers to take steps to address beneficiaries’ unmet resource needs.

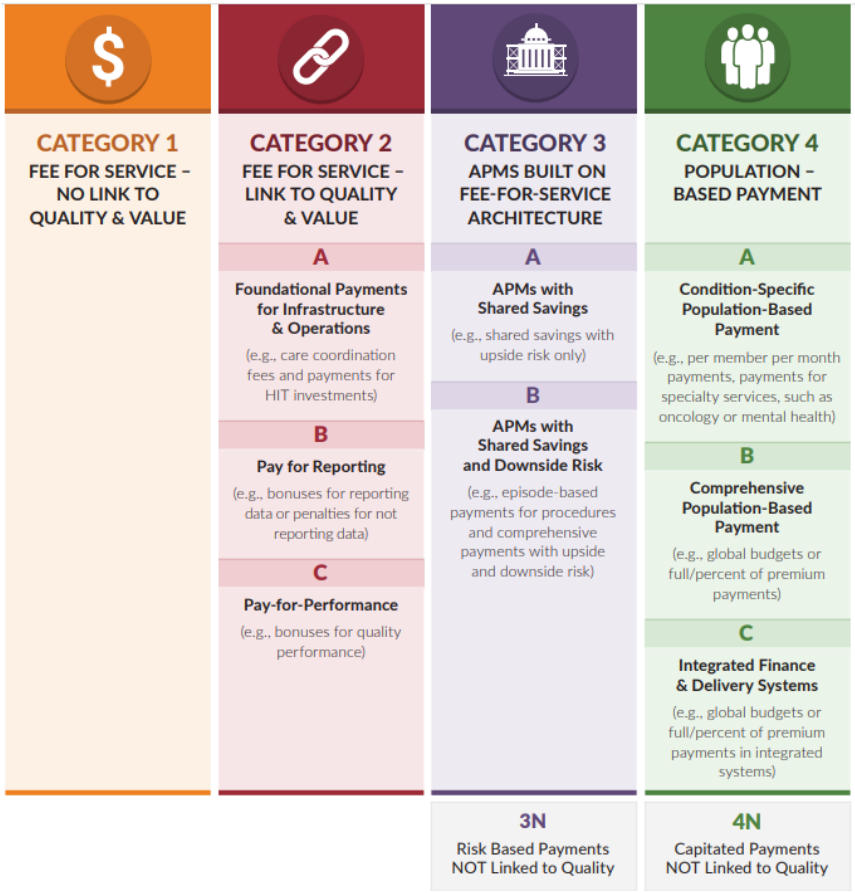
Addressing Unmet Resource Needs through Care Management

- Care management model drives a focus on addressing beneficiaries’ unmet resources needs.
- PHPs identify high-needs individuals (including those with significant social needs) and often delegate the provision of care management to qualified local entities—e.g., Tier 3 Advanced Medical Homes and Local Health Departments
- **Care managers and other members of the care team will play a significant role in addressing the non-medical drivers of health.**
  - Identification through use of State **SDOH screening**, analysis of data, or referral.
  - Comprehensive Assessment
  - Accountable for addressing needs, including by:
    - Providing in-person assistance with select applications (e.g. SNAP and WIC)
    - Connecting beneficiaries to community resources leveraging **NCCARE360**
    - Having housing specialist
    - Providing access to medical-legal partnerships.

Healthy Opportunities & Value-Based Payment Strategies

VBP Overview

- Value-based payments give providers flexibility to decide how best to use payments, including by paying for health-related social supports that may be more cost-effective than traditional medical care.
- The State’s VBP strategy will encourage PHPs and other providers to consider how they can incorporate and promote healthy opportunities into their VBP contracts.



Voluntary PHP Contributions to Health-Related Resources

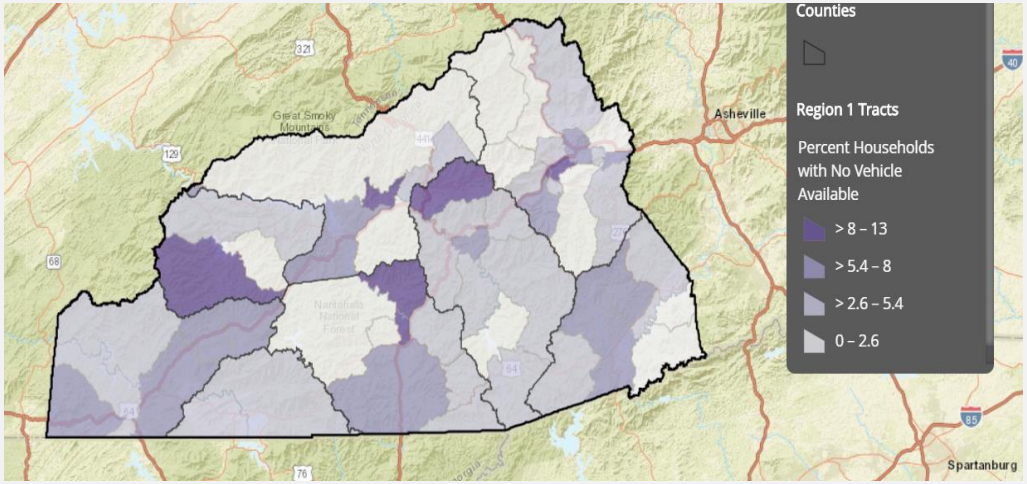
PHPs are encouraged to make contributions to health-related resources that help to address members’ and communities’ unmet health-related needs.

Contributions to Health-Related Resources

- PHPs are encouraged to contribute to health-related resources that improve health outcomes and cost-effective delivery of care in the communities they serve.
- PHPs that voluntarily contribute to health-related resources may count the contributions in the numerator of their MLR.
- A PHP that voluntarily contributes at least one-tenth percent (0.1%) of its annual capitation revenue in a region to health-related resources may be awarded a **preference in auto-assignment** to promote enrollment in each region in which the PHP contributes.

Providers may wish to give input to PHPs on how to direct their contributions in their communities.

Percent of Households Without Access to a Vehicle in Region 1



The NC “Hot Spot” Map uses geographic information system (GIS) technology to map resource needs and other indicators across the state **and can strategically guide contributions to health-related resources.**