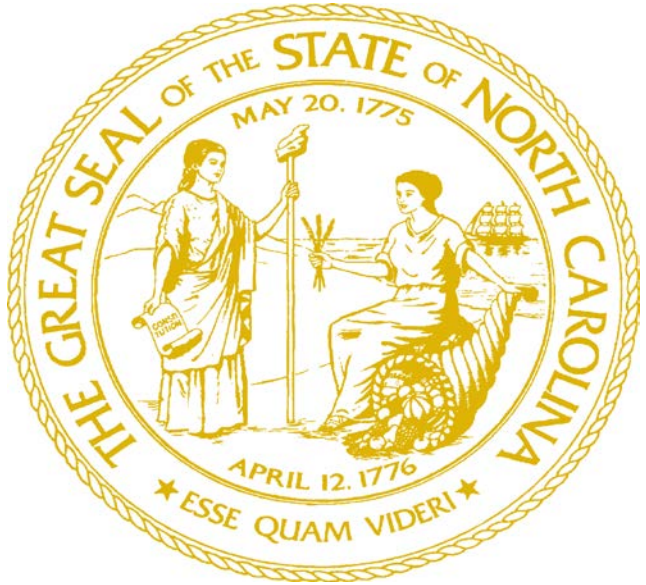

North Carolina Department of Health and Human Services' Vision for Buying Health

NCIOM Task Force on Accountable Care Communities
March 5, 2018

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State Health Director/Chief Medical Officer
NC DHHS

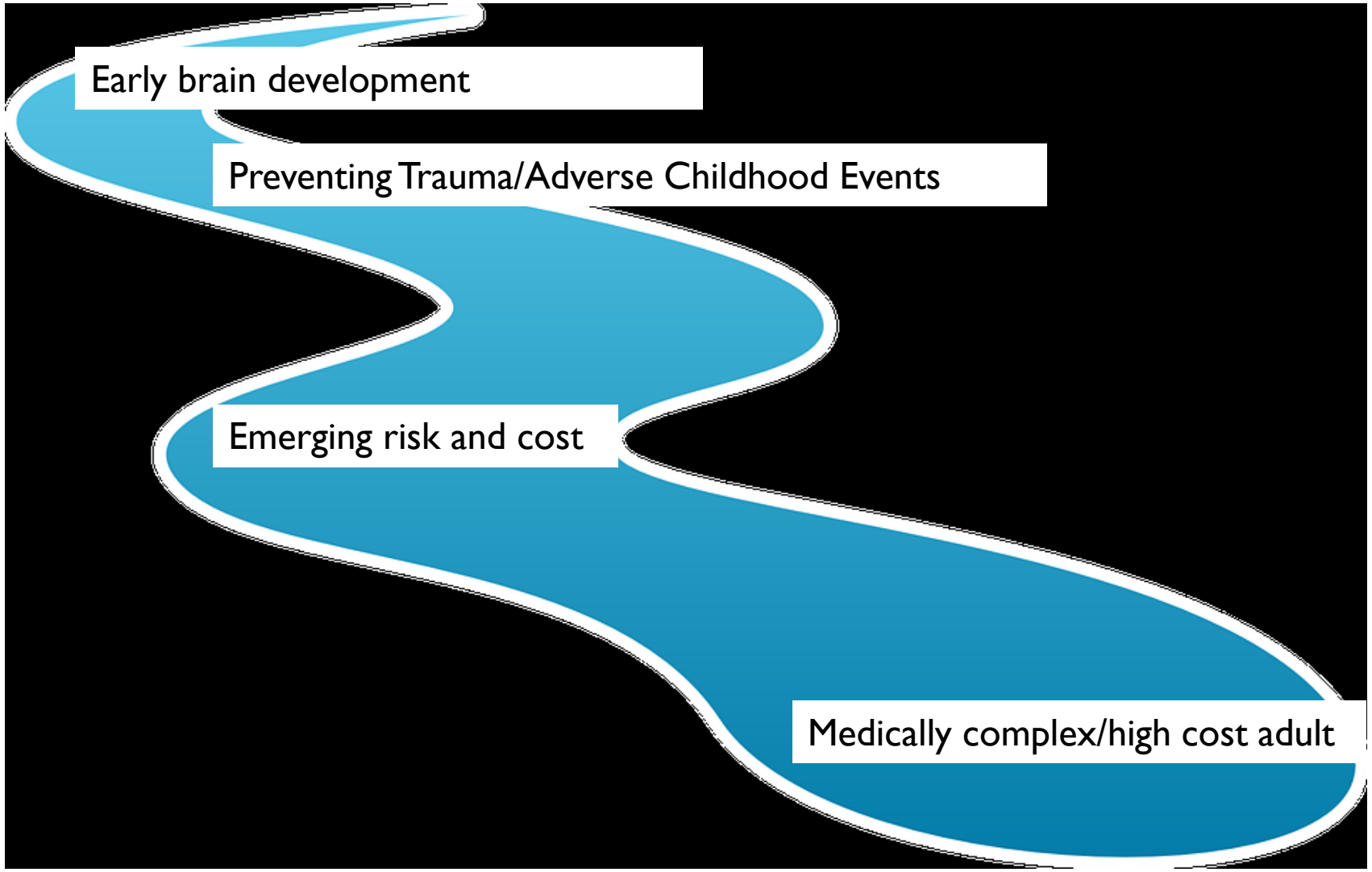
Large body of evidence

- Underlying drivers of health and unmet health-related resource needs leads to poorer health outcomes and increase health care utilization and costs
- Addressing those underlying drivers of health can improve health and lower health care costs
- Good return on investment in both health and economic terms

DHHS Vision

We envision a North Carolina that optimizes health and well-being for all people by effectively stewarding resources that bridge our communities and our healthcare system.

Go as far upstream as we can



Considerations

- Ultimate goal is to have this be baked into how North Carolina addresses health going forward.
  - Intentional, step-wise, additive
  - Sustainable, practical, meaningful, doable
- Medicaid Transformation a big part of this, but not all of it
- Be informed by and build on existing work, efforts, resources
  - May fill a void, augment a project, or be in tension with some elements
- Balance of pragmatic and aspirational
- Develop the language we use to communicate these elements

Multi-layered Approach for Addressing Health-Related Resource Needs

- Mapping of Social Drivers of Health Indicators
- Standardized screening for unmet resource needs
- Statewide Resource Database and Community Resource Integrator
- Medicaid Managed Care – 1115 Innovation Waiver
- Regional Public-Private Pilots
- Work force capacity
- Re-aligning or connecting existing resources where possible

Statewide mapping of SDOH indicators

- Statewide, but able to drill down to a region and to local/census tract level
- Identify and codify areas of disparity to inform and evaluate program planning and investment
- Inform Community Needs Assessments – e.g. Health Departments, Health Systems, LME/MCOs
- Facilitate integration and enhance partnerships between healthcare systems and community organizations

State Center for Health Statistics

- GIS/ESRI Story mapping of 12 SDOH indicators with a summary statistic
  - Social and Neighborhood (% < HS Diploma, % Households with Limited English, % Single Parent Households, Low Access to Healthy Foods, Food Deserts)
  - Economic (Household Income,% Poverty, Concentrated Poverty, % Unemployed, % Uninsured)
  - Housing and Transportation (% Living in Rental Housing, % Paying > 30% of Income on Rent, % Crowded Households, % Households without a Vehicle)

- Current Data Sources
  - American Community Survey five-year estimates
  - U.S. Department of Agriculture

- SCHS completed map for New Hanover Medical Center
  - Similar to one completed for Mecklenburg and Wake County areas by UNC IPH
  - Updated December data to complete statewide one – expected spring 2018
  - Work with UNC Institute of Public Health via AHEC support to refine indicators for mapping

New Hanover Regional Medical Center

New Hanover Regional Medical Center

Social and Neighborhood

People with higher incomes, more years of education, and who live in a safe environment have better health outcomes and generally have longer life expectancies (1) . Persons without a high school diploma, non-English speaking households, single-parent households and limited access to healthy food are key social and neighborhood indicators.

Percent with Less Than High School Diploma

Percent Households Speaking Limited English

Percent Single Parent Households

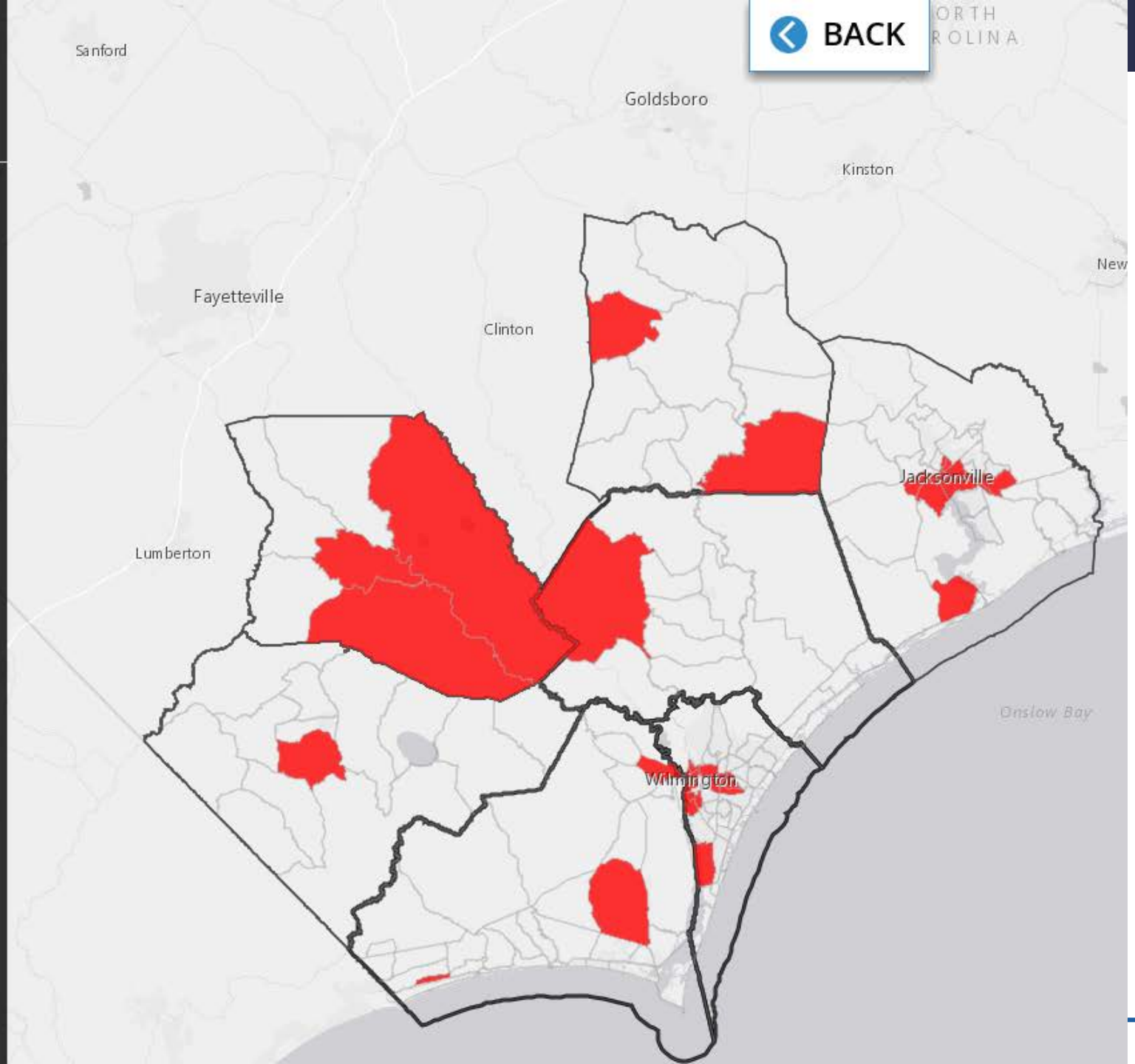
Low Access to Healthy Foods

Food Deserts

Turn All Layers Off

Education

An estimated 73,426 (13.1%) adult residents over the age of 18 did not have a high school diploma in the service region. There are great differences between



New Hanover Regional Medical Center

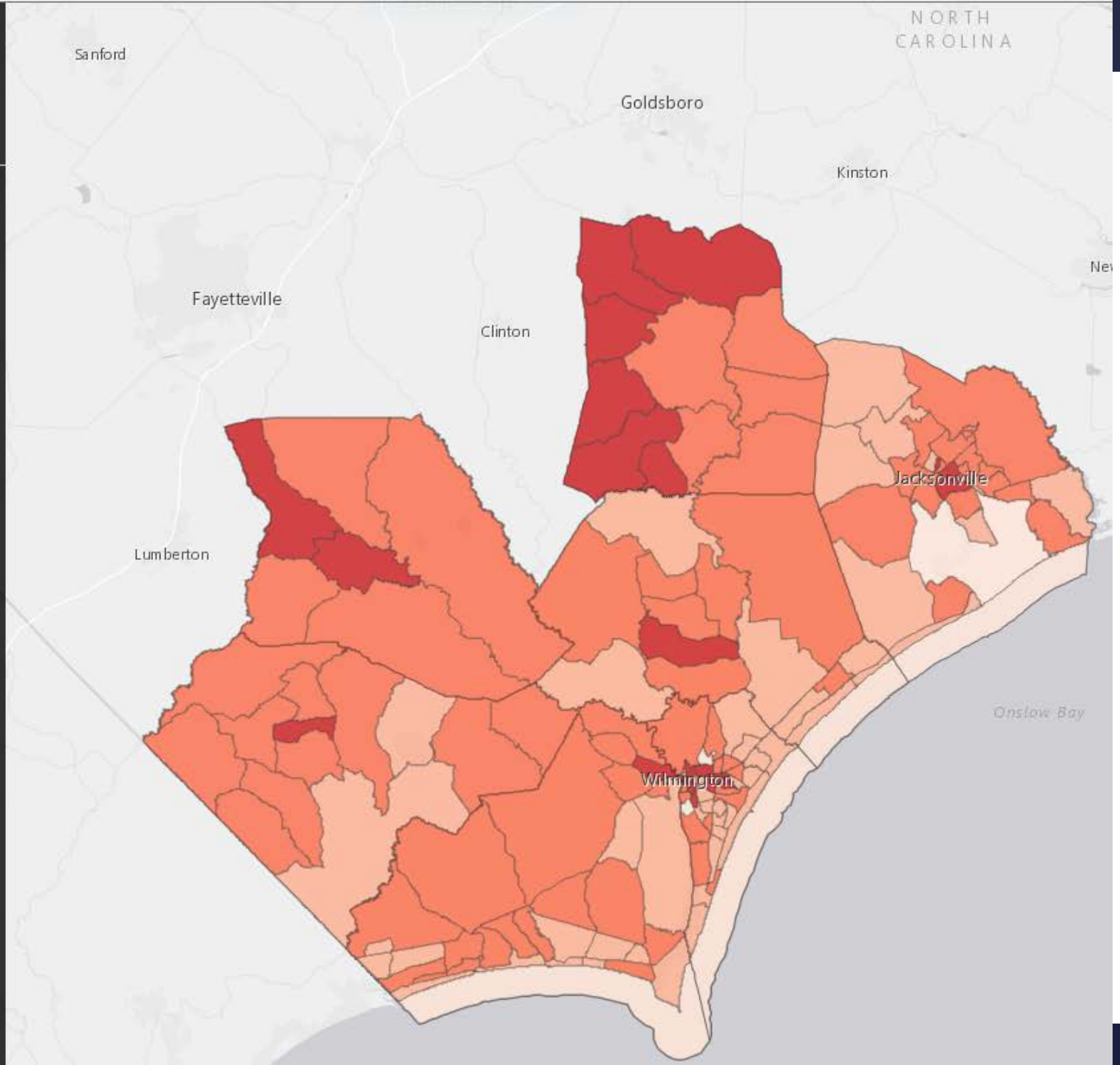
New Hanover Regional Medical Center

Putting it Together

Looking at 12 different maps of the Social Determinants of Health (SDOH) at the same time can be hard. By using an index, the maps can be combined into one map in order to view the indicators together. The SDOH index combines the indicators within the three domains: Social & Neighborhood, Economic, and Housing & Transportation. The overall index is an average of the three domains.

Z-scores were used to create the index, which allows for standardization among all of the variables. A z-score is a measure of how many standard deviations above or below an estimate is from an overall mean. So, the index is a metric of whether the SDOH in a census tract are above or below the regional average and by how much. High values indicate tracts with the highest disparities among the social determinants of health.

(1) NC Institute of Medicine. Healthy North Carolina 2020: A Better State of Health. Morrisville, NC: NC Institute of Medicine; 2011.



Standardized Screening

- Statewide, standardized screening to consistently identify possible unmet health-related resource needs
- Convened a Technical Advisory Group of stakeholders
- Screening domains
  - Housing instability
  - Food insecurity
  - Transportation access
  - Interpersonal safety
- Design Principles
  - Derived from other validated tools (e.g. Health Leads, PRAPARE, Hunger Vital Sign, PMH)
  - Simple & streamlined to be accessible to broadest audience/ settings
  - Consistent to help with data collection, community investment, risk-adjustment
- Implementation Considerations
  - Public Review March 2018
  - Phased in – Piloting first in ready settings
  - PHPs at launch of managed care
  - AMH with advancing capabilities

Statewide Resource Platform

- State-wide, well-curated data base of community resources
  - Centrally standardized and overseen to ensure data quality & consistency
  - Public utility open to communities, people, providers, care managers across payers and systems
  - User-friendly web-site and a Call Center component for “warmer” help
  - Interface capabilities with existing local, regional, agency data bases
- Capacity to do referrals, close the loop, and track the outcome of referrals
- Integration and interface capabilities with EHRs for referral tracking
- Analytic functions to assess demand, timeliness of referrals, unmet need
- Ability for social services providers to use platform internally to manage their internal clients
- Ability to connect to external social service providers, have a shared client record, improve efficiency of resource
- Provide technical assistance and training to providers and community organizations
- Start launch summer 2018

Medicaid Transformation

- **Care management**
  - Training on Trauma Informed Care, Resource Navigation
  - Standardized screen as part of initial care needs assessment upon enrollment into plan
  - Those with unmet resource needs → care management/patient navigation/community health worker to navigate to resources
  - PHP share specific patient data with PCPs and aggregate with state (e.g. % of enrollees screened, % with unmet needs)
- The State's **Quality Strategy** encourages PHPs to focus on their effectiveness in screening for and addressing social issues;
- **Withhold-based** incentives to encourage plans to conduct SDOH required screenings and follow up
- **Use of in lieu of services** and **value-based payments** offer tools and strategies to PHPs for financing health-related services
- **Investment requirements or rewards** to PHPs to make some level of investment in community-based resources
- **Evolving role of AMH and care management platform** in screening and linking to resources
- Possible **risk-stratification** on social factors in futures

Public-Private Pilots Projects

- Investment to test, scale, strengthen and sustain evidence-based, public-private initiatives in ~3 regions to closely link healthcare and social services systems
- Asking for CMS expenditure authority of ~$350- $700 of Medicaid/Medicaid match dollars to support pilots in amended 1115 waiver application
- Combination of DHHS (Medicaid), philanthropic, PHP, health system, county (DSS, LHD, community organization), and other investment and participation
- Focus on core domains (Housing, Food, Transportation, Interpersonal Safety)
- Regions reflect geographic diversity of state (rural/urban)
- Design, evaluation, stakeholder engagement and expertise
- Goal of evaluation and ability to move forward evidence base to sustainable financing

Workforce

- Develop, train and strengthen workforce needed to support SDOH initiatives/Trauma Informed Care

- Community health workers, case managers, staff of AMHs, etc.

Re-aligning or connecting existing resources

- Examine ways to better align existing resources
  - Medicaid, WIC, Head Start, Pre-K, SNAP, Low Income Heat and Energy Assistance Program
  - Can we streamline or improve effectiveness of enrollment strategies

- Identify opportunities
  - E.g. Of the 57,650 births in which NC Medicaid paid for prenatal care and delivery in 2016, 28.8% of women (17,000) did not have prenatal WIC.

- Learn from ongoing efforts
  - Only 1/3 of eligible older NC adults are enrolled in Supplemental Nutrition Assistance Program (SNAP)
  - Starting December 2017, Benefits Data Trust began working with NC DSS to do enhanced outreach and enrollment for dual Medicare/Medicaid recipients

Next steps/Alignment with work of NCIOM Task Force

- Significant investment from the state in creating a statewide framework and infrastructure
- Accountable Care Communities have the potential to accelerate and organize some of the rich work done at the community level
- Will look to Task Force to help guide the work in the context of and beyond this initial investment
- Help coordinate the intersection between the ACCs and the state-wide infrastructure investments

Discussion/Questions?