States are heavily involved in the health and well-being of their residents. Financially, the biggest state investment in health is the provision, in partnership with the federal government, of health care coverage to residents enrolled in Medicaid and Children's Health Insurance Programs. States also provide many other health services including insurance for state employees, family members, and retirees; services and supports for populations with special health needs and some uninsured patients; oversight of insurers, health service providers, and health care facilities; and the provision of services and programs to promote health and well-being and protect communities from communicable diseases, epidemics, and contaminated food and water. As the largest payer of health care coverage in North Carolina, the state has a vested interest in keeping residents healthy. Additionally, a healthy population is needed to keep and attract businesses, which is critical to the economic well-being of the state.

The North Carolina Department of Health and Human Services (NC DHHS) has a vision to "optimize health and well-being for all people by effectively stewarding resources that bridge our communities and our healthcare system.[42]" To do this, NC DHHS has created a statewide framework for healthy opportunities[g] that includes:

1. *Developing standardized screening questions for unmet resource needs,*
2. *Supporting the development of the NC Resource Platform (NCCARE360),*
3. *Mapping social drivers of health indicators,*
4. *Building infrastructure to support the recommendations of the Community Health Worker Initiative,*
5. *Implementing Medicaid transformation through Medicaid Managed Care, and*
6. *Testing public-private pilots of ACC-style models focused on people enrolled in Medicaid.*[42,43]

Realizing the overall vision of NC DHHS to create healthy opportunities will require health care payers and providers, human services organizations, and other stakeholders to work together in new ways. The NC DHHS plan provides a structure for how needs and resources will be identified and connected; however, it does not provide a structure for building the types of relationships and alignment of processes, outcome goals, and financing that will be needed for long-term changes in the nature and delivery of care. The ACC model can address the larger issues of how to change the way health care is perceived and delivered in communities.

Assessing Health-Related Social Needs

Successfully addressing health-related social needs and maximizing opportunities to be healthy will require a system where unmet needs are identified and a process is in place to meet those needs. The first step in such a system typically requires systematic screening to identify unmet needs. The Institute of Medicine[44] and the American Academy of Pediatrics[45] have policy statements supporting the use of screening for health-related social needs. Many health care and social service organizations have incorporated screening into their work, particularly for health behavior issues like tobacco, alcohol, and substance use, physical activity, and diet, as well as behavioral/mental health and social isolation/support.[46]

"CREAT[ING] HEALTHY OPPORTUNITIES WILL REQUIRE HEALTH CARE PAYERS AND PROVIDERS, HUMAN SERVICES ORGANIZATIONS, AND OTHER STAKEHOLDERS TO WORK TOGETHER IN NEW WAYS"

Screening for health-related social needs is not as common in clinical settings; however, some health care providers have begun to incorporate these issues into their screening process. For example, clinical partners of Health Leads, including Johns Hopkins Bayview Medical Center in Baltimore, Maryland, Rainbow Babies & Children's Hospital in Cleveland, Ohio, and Bellevue Hospital Center in New York, New York have incorporated the Health Leads Screening Tool into patient care.[47] The tool covers domains like food insecurity, housing instability, exposure to violence, and utility needs.[46] The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) was developed for use in community health centers. Included in PRAPARE's core measures are housing status/stability, education, employment, income, transportation, social integration/support, and stress.[48] PRAPARE is already in use in several community health centers across the state to help connect patients with identified needs to appropriate resources.

One of the approaches the NC DHHS is taking to incorporate and address the effects of health-related social needs in all patients' care is the development of a set of standardized screening questions. This set of questions, developed by a group of stakeholders representing public health, health care, and sectors related to health-related social needs, incorporates tested and standardized items from existing screening tools (e.g., PRAPARE, Health Leads, and items standardized for use in multiple tools). At this writing, the set of questions is in draft form and is

"SUCCESSFULLY ADDRESSING HEALTH-RELATED SOCIAL NEEDS AND MAXIMIZING OPPORTUNITIES TO BE HEALTHY WILL REQUIRE A SYSTEM WHERE UNMET NEEDS ARE IDENTIFIED AND A PROCESS IS IN PLACE TO MEET THOSE NEEDS."

[g] *More information about NC DHHS Healthy Opportunities is available online at https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities.*

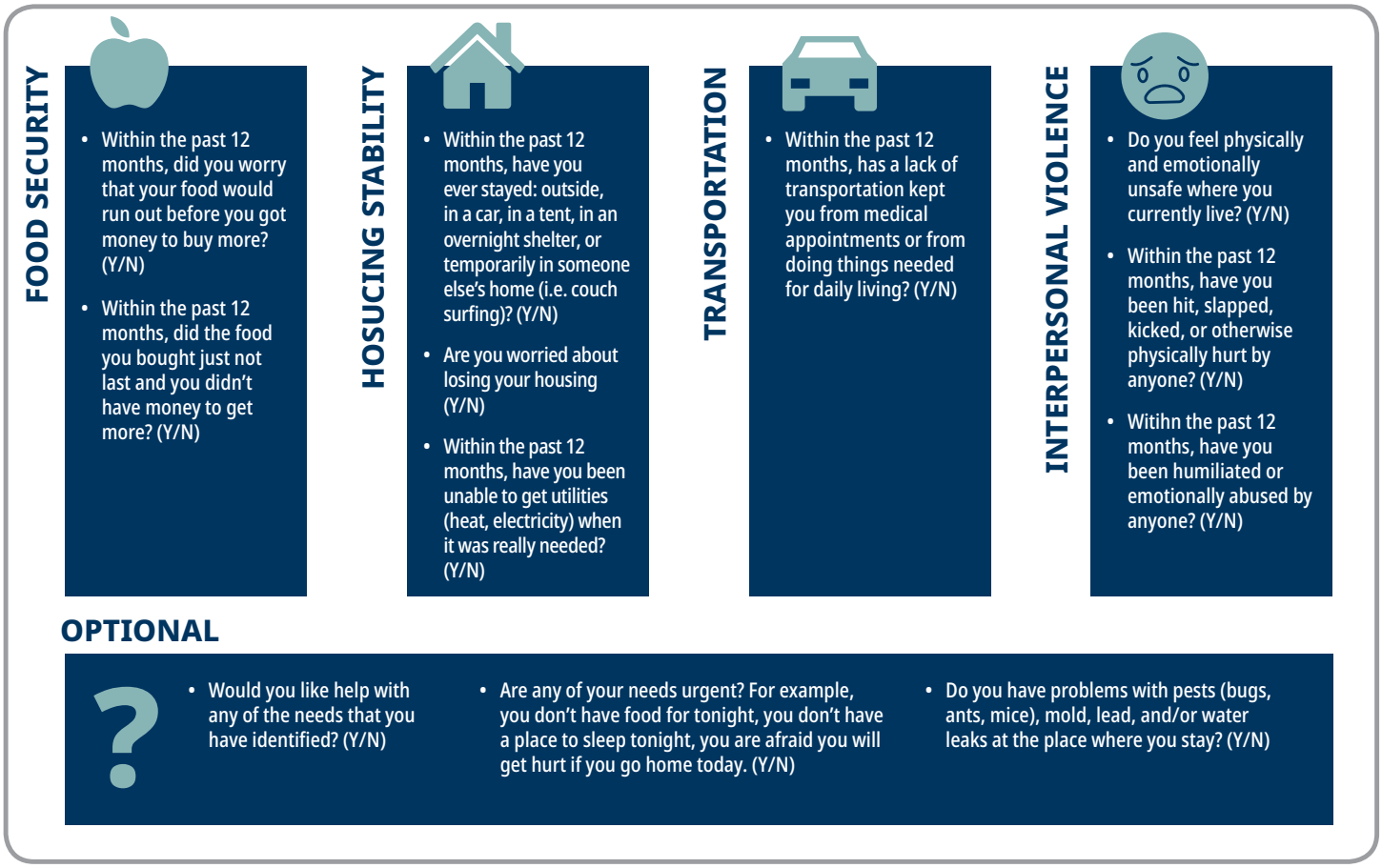
undergoing field testing at 21 clinical sites.[49] The proposed screening tool contains nine questions (see **Figure 5**) across four of the state's priority domains: food, housing/utilities, transportation, and interpersonal safety. There also are three optional questions about the nature of the needs and whether help is wanted to address those needs.[50] Asking about preferences for help is an important way to make the screening process more person-centered and to avoid assumptions about what that individual wants or needs.[51] One study found that as few as 15 percent of people with one or more health-related social needs actually wanted help to address that need.[52]

The NC DHHS also has developed a list of optional screening domains and questions covering community safety, housing quality, health care/medicine, mental health/substance use, family/social supports, child care, emotional wellness/stress, education, health literacy/communication/language/culture, employment, income, immigration, legal/correctional, and secondary assessments of housing needs and intimate partner violence.[53] These serve as optional items for individual providers or organizations to include in their screening protocols based on the populations they serve. NC DHHS intends for health care providers, payers, and human services organizations across the state to incorporate the standardized screening questions into their work with patients and community members.

Referring Individuals for Help Meeting Needs

Once individuals have been screened for health-related social needs, a plan should be in place for helping them find resources to meet those needs. Coordination of referrals for resource needs can span the spectrum from printing out a list of community resources to full case management that includes numerous check-ins on the status of a referral and documentation when a connection to resources has been completed. Many resource referral mechanisms and technologies have been developed to meet these needs, from Aunt Bertha, a customizable web-based platform, to 2-1-1, a call center that uses live call specialists to help connect individuals with resources. This coordination has led to a wide variety of approaches across stakeholders serving people with health-related social needs, even within the same community.

Figure 5. State Standardized Screening Questions



Source: NC DHHS. Updated Standardized Screening Questions for Health-Related Resource Needs. July 9, 2018. https://files.nc.gov/ncdhhs/Updated-Standardized-Screening-Questions-7-9-18.pdf

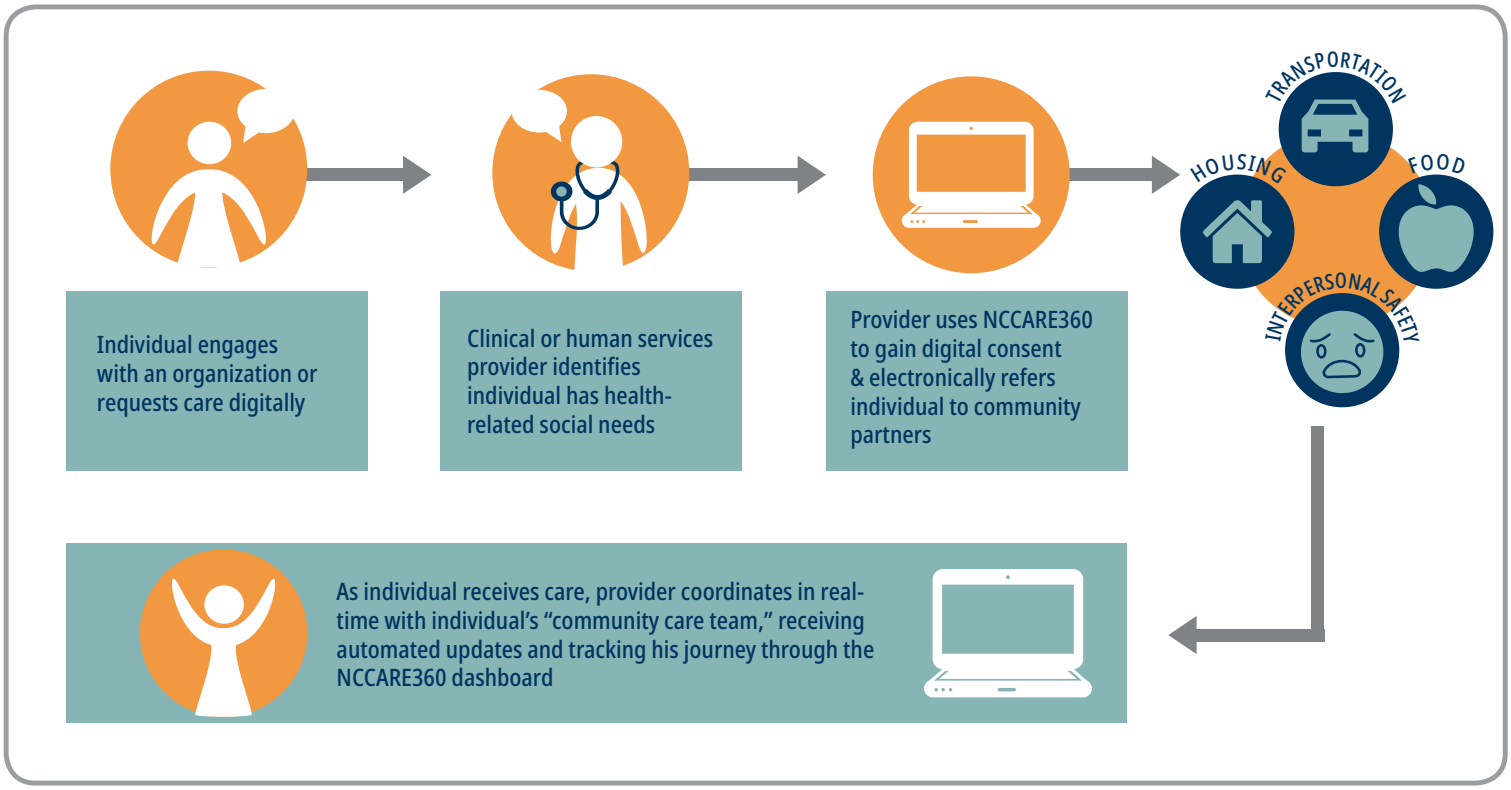
To address this issue, NC DHHS is supporting the development and implementation of the NC Resource Platform called NCCARE360. NC DHHS entered into a public-private partnership with the Foundation for Health Leadership & Innovation to develop and implement NCCARE360. The organizations selected to develop the platform are United Way of NC/ NC 2-1-1, Expound, and Unite Us. Together, the Foundation for Health Leadership & Innovation, NC DHHS, and the developers make up the NCCARE360 partners. The goal is to develop a tool "to make it easier for providers, insurers and human services organizations to connect people with the community resources they need to be healthy."[54] NCCARE360 will be available and subsidized for all communities in North Carolina for at least the first five years. It is intended to initially serve as a web-based portal to connect all types of organizations from large health care systems and insurers to human services organizations and individual human service providers. As implementation progresses, it is anticipated that interfaces will be made with other information technology platforms (e.g., electronic health records, human services software, NC HealthConnex). The platform will integrate NC DHHS' standardized screening questions, a statewide robust resource directory, and a referral and outcome tracking platform. While the full resource directory will be accessible to all users from the beginning, in its first phase, the focus areas for onboarding resources to the referral and outcome platform of NCCARE360 will be the NC DHHS priority domains of food security, housing stability, transportation, and interpersonal safety. More resources will be onboarded onto the referral and outcome platform as implementation proceeds.

NCCARE360 WILL MAKE IT EASIER FOR PROVIDERS, INSURERS AND HUMAN SERVICES ORGANIZATIONS TO CONNECT PEOPLE WITH THE COMMUNITY RESOURCES THEY NEED TO BE HEALTHY.

With the goal of a coordinated, no-wrong-door-style approach, individuals and organizations will be able to access information about community resources. Individuals can even start the referral process on their own. The platform can help organizations engaging clients to address health-related social needs communicate with one another and may help consolidate coordination efforts. Referrals through the platform will require consent by the individual being served and can be made using a variety of methods (e.g., pen and paper, voice recording, text message).[55] The NC 2-1-1 call center will enhance its current services in coordination with the platform to provide text and chat capabilities and employ navigators to assist individuals seeking services. **Figure 6** shows the process of accessing services using the platform when an organization identifies an individual's need(s).

NCCARE360 WILL FACILITATE THE SCREENING AND REFERRAL PROCESS AND DATA TRACKING NECESSARY FOR HIGH-FUNCTIONING ACCS

Figure 6. Process of accessing resources using NCCARE360



Mapping Health-Related Social Needs in Communities

NC DHHS recognizes the need to provide more information to help communities around the state understand the health-related social needs of their citizens. With this in mind, a web-based mapping tool called North Carolina Social Determinants of Health by Regions has been created and is supported by the State Center for Health Statistics.[56]

This tool maps drivers of health, including economic factors, housing and transportation, social and neighborhood resources, and an index measuring overall health-related social needs of communities. **Figures 7a and 7b** show how this tool can depict health-related social need variations from one neighborhood or community to another.

Figure 7a. Overview statistics for NC Local Health Department Regions (e.g., age, gender, race)

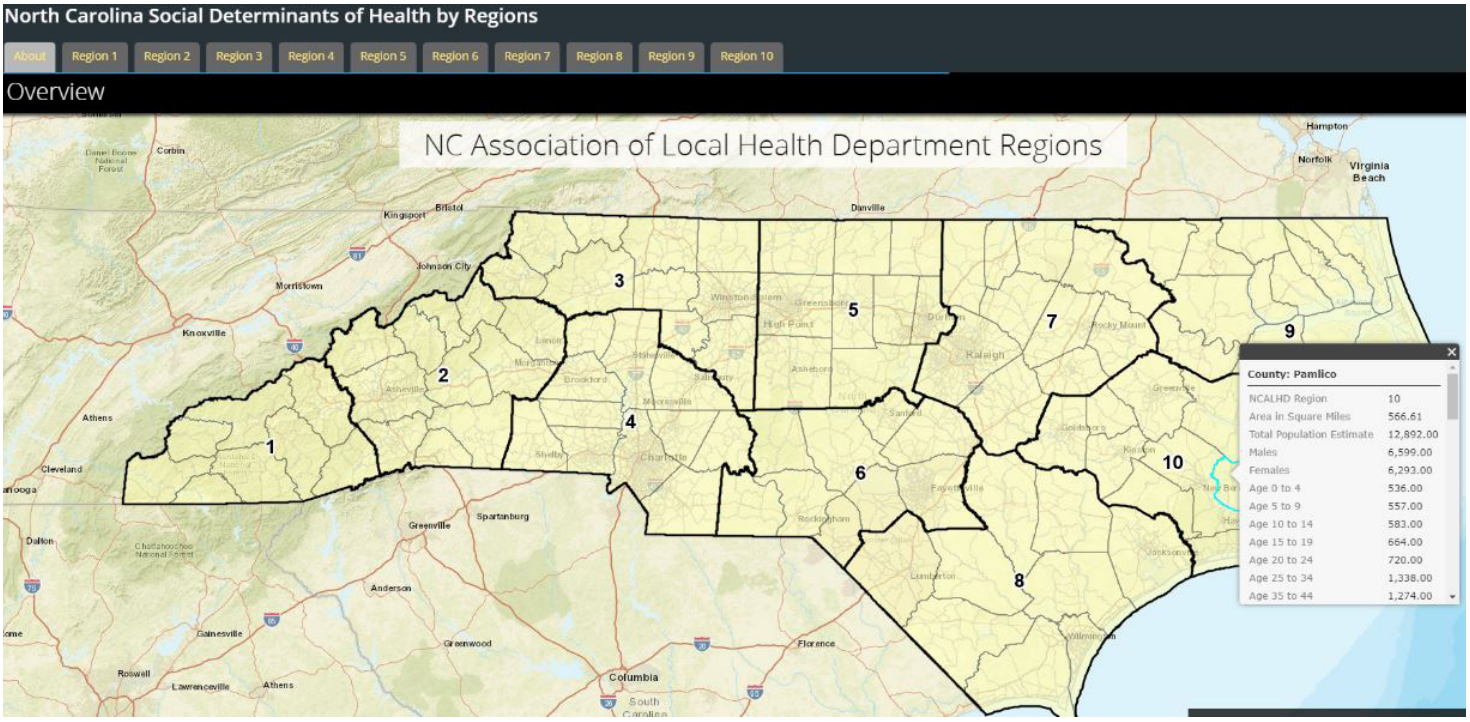
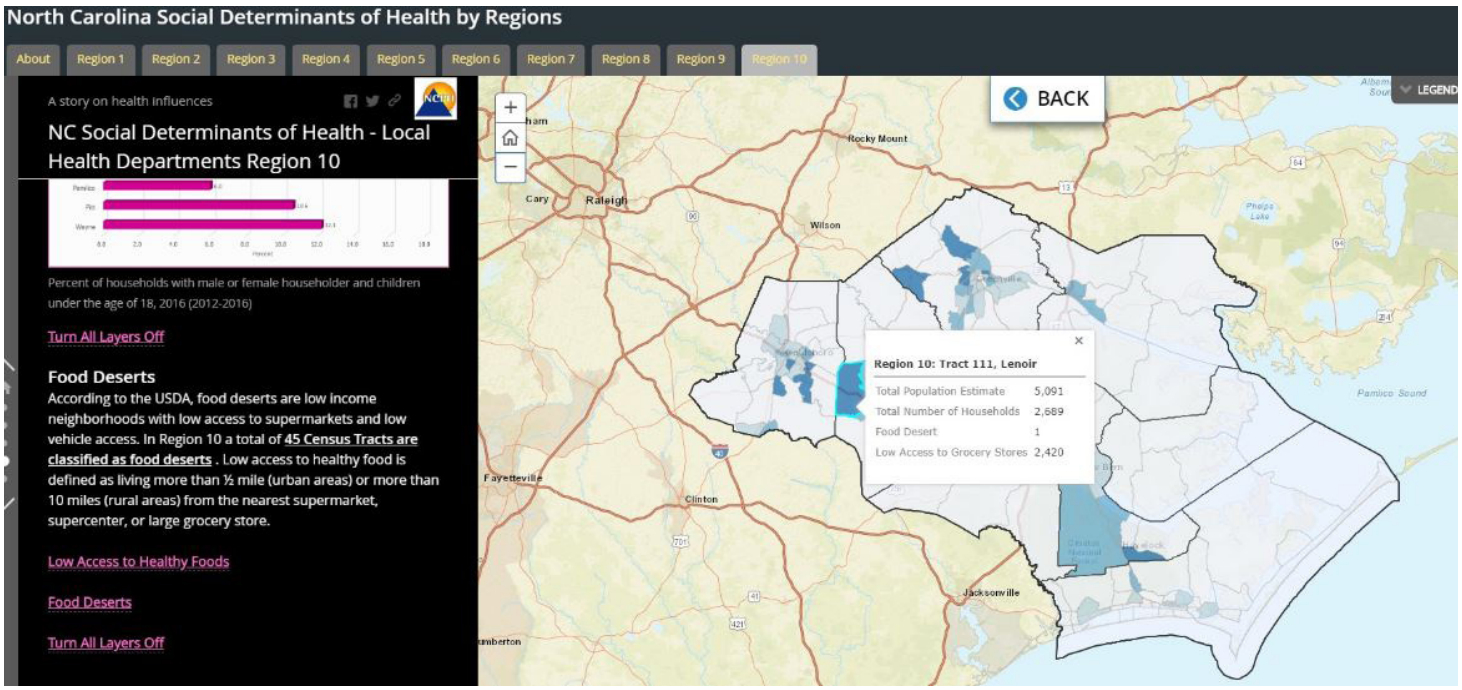


Figure 7b. Specific Social Determinant Data at Census Tract Level (e.g., food insecurity)



Community Health Worker Initiative

Since 2015, NC DHHS has been investigating the status of the community health workforce in the state through the Community Health Worker Initiative. The contributions of community health workers (described in further detail in Chapter 4) can be a great asset when attempting to address individuals' health-related social needs. Starting with identification and description of existing community health worker programs and a survey of workers, the Initiative conducted workgroups, a summit, and listening sessions to develop recommendations for improving and supporting the infrastructure for the profession. In May 2018, the Initiative's final report[57] was published outlining the three primary recommendations:

1. *Defined roles and responsibilities regardless of the setting a community health worker operates in,*
2. *Core competencies that community health workers should have and curriculum integral to their professional education, and*
3. *Certification requirements and processes to help standardize training and increase professional credibility.*

In order to guide the process for accomplishing these goals, the Initiative recommended the creation of a North Carolina Community Health Worker Certification and Accreditation Board.

Medicaid Transformation

In 2015, the North Carolina General Assembly passed legislation[h] to transform the state Medicaid and NC Health Choice programs. The goals of Medicaid transformation were to "(1) Ensure budget predictability through shared risk and accountability. (2) Ensure balanced quality, patient satisfaction, and financial measures. (3) Ensure efficient and cost-effective administrative systems and structures. (4) Ensure a sustainable delivery system." To meet these goals, the NC DHHS submitted a Section 1115 Medicaid Demonstration waiver to the federal Centers for Medicare & Medicaid Services to request permission to shift Medicaid from a "fee-for-service" system to a "managed care" delivery system. A goal of the state's overall Healthy Opportunities vision is to develop innovative approaches to foster "strategic interventions and investments in...food, housing, transportation, and interpersonal safety...[that] will provide short and long-term cost savings and make our health care system more efficient."[58] Strategies to do this have been incorporated into the state's 1115 Medicaid Waiver. The Centers for Medicare & Medicaid Services approved the waiver on October 24, 2018.

Under Medicaid transformation, NC DHHS will remain responsible for the Medicaid and NC Health Choice programs but will contract with Prepaid Health Plans to provide managed care services to most individuals enrolled in Medicaid. Prepaid Health Plans will be required to screen all enrollees using the state's standardized screening questions and use NCCARE360 to connect those with needs to resources.[59] Results will be shared with primary care providers. Prepaid Health Plans will receive per member per month payments that will support the implementation of screening, referral, navigation assistance (in the form of care management for some populations), and follow-up. Plans will be required to track data needed to assess whether interventions to address health-related social needs create positive health outcomes and/or reduce costs.

HEALTHY OPPORTUNITIES PILOTS, WILL ALLOW NC DHHS TO TEST A FORM OF AN ACC-STYLE MODEL WITH A POPULATION ENROLLED IN MEDICAID AND UTILIZE MEDICAID FUNDING TO PAY FOR HEALTH-RELATED SOCIAL SERVICES.

Healthy Opportunities Pilots

North Carolina's 1115 Medicaid Waiver also includes public-private pilots designed to allow more substantial investments in non-clinical health-related services with the explicit goal of learning how to finance 'health' interventions and incorporate them into value-based payments.[60,61] These pilots, referred to as Healthy Opportunities Pilots, will allow NC DHHS to test a form of an ACC-style model with a population enrolled in Medicaid and utilize Medicaid funding to pay for health-related social services. The primary difference from other ACC models is that an ACC typically incorporates a broader network of payers, local government, and organizations that address non-clinical social needs outside of the state's priority domains (i.e., food, housing, transportation, and interpersonal safety).

These pilots will be conducted in two to four "regions" of the state. Funding for each pilot will come from both public and private (e.g., philanthropic) sources. For the purposes of the pilots, a region is defined as at least two contiguous counties that cover both rural and urban areas. Pilot regions will not have to encompass the entirety of any of the six planned Medicaid regions[62] and any one pilot region cannot cross a Medicaid regional boundary. The pilots will involve partnerships and payments to provide medical and non-medical care to address health-related social needs through evidence-based interventions (e.g., housing transition or tenancy sustaining services, targeted meal delivery services, transportation to health-related and social services, and home visiting programs and parent support). The pilots will focus on certain high-risk, high-needs individuals who meet both health risk and social risk factor criteria.[61]

[h] *SL 2015-245 and SL 2016-121*

Pilot funding will cover both capacity-building activities and service provision. Areas participating in the pilots must meet the following objectives:

- *"Increase integration among health and social services entities.*
- *Improve health care service utilization and/or health care costs for target population.*
- *Improve health outcomes for target population.*
- *OPTIONAL: Improve general well-being and reduce non-health care costs for target population."*[60]

Organizational participants in the Healthy Opportunities pilots will include prepaid health plans, health care providers, behavioral health agencies or providers, public agencies (e.g., local health department or department of social services), and community partners (e.g., philanthropies or human services organizations). Prepaid Health Plans will serve several roles in the pilots, including:

1. *Identifying beneficiaries eligible for the pilots through the care management process,*
2. *Assessing beneficiaries for health-related social needs and connecting them to pilot services,*
3. *Managing funds allocated for providing pilot services to enrolled beneficiaries, and*
4. *Collecting and submitting data to assist with rapid-cycle evaluation of the pilots.*[63]

A Lead Pilot Entity for each pilot will serve as an NC DHHS contact and coordinator of pilot partners, finances, and required reports.[61] Lead Pilot Entities will be responsible for:

1. *Developing a network of human services organizations (i.e., organizations that will provide pilot services), including training and management of pilot activities,*
2. *Convening pilot stakeholders, including Prepaid Health Plans, human services organizations, and health care providers,*
3. *Managing payments from Prepaid Health Plans and making payments to human services organizations that provide pilot services,*
4. *Providing technical assistance to human services organizations and*
5. *Collecting and submitting data to assist with rapid-cycle evaluation of the pilots.*[63]

Finally, human services organizations involved in the pilots will have several responsibilities:

1. *Contracting with the Lead Pilot Entity; only organizations that have a contract can provide pilot-related services,*
2. *Participating in educational and training activities related to the pilots and convenings of pilot stakeholders,*
3. *Delivering services to pilot enrollees,*
4. *Tracking and billing for services provided to pilot enrollees and*
5. *Collecting and submitting data to assist with rapid-cycle evaluation of the pilots.*[63]

NC DHHS has released a Request for Information and will release a Request for Proposals in mid-2019. Lead Pilot Entities will be selected toward the end of 2019 and have a year of implementation planning before service delivery begins in late 2020.[63] The pilots will last five years. Over the course of the pilot, payments to Prepaid Health Plans and Lead Pilot Entities for pilot services will increasingly be linked to operational ability, enrollees' health outcomes and healthcare costs through various value-based payment arrangements, including incentives, withholds, and shared savings.[i]

To ensure the success of the Healthy Opportunities pilots, the Task Force recommends:

RECOMMENDATION 3.1:
PROVIDE TECHNICAL ASSISTANCE TO HEALTHY OPPORTUNITIES PILOTS

The North Carolina Department of Health and Human Services, in collaboration with other relevant state agencies such as the Departments of Transportation, Public Instruction, and Commerce, the Housing Finance Agency, and North Carolina philanthropies should provide or support technical assistance for participants in the Medicaid Healthy Opportunities pilots in order to build capacity for cross-sectoral collaborations to improve health including:

a) Network development,

b) Health equity,

c) Methods for implementation, data sharing, outcomes/evaluation,

d) Technology needs,

e) Legal considerations, financing, organizational/administrative needs, and

f) Developing and financing sustainable payment models.

[i] *More information about the Healthy Opportunities Pilots is available in the Healthy Opportunities Pilots Fact Sheet at https://files.nc.gov/ncdhhs/SDOH-HealthyOpptys-FactSheet-FINAL-20181114.pdf."*

Ensuring Cross-Sector Understanding and Support for NC DHHS Vision

NC DHHS efforts to ensure opportunities for health for everyone in North Carolina span a wide range of activities and involve stakeholders across a variety of sectors. To provide shared understanding of the NC DHHS vision for healthy opportunities for all North Carolina residents, the Task Force recommends:

RECOMMENDATION 3.2:
DEVELOP STAKEHOLDER SUPPORT FOR STATE HEALTHY OPPORTUNITIES INITIATIVES

a) The North Carolina Department of Health and Human Services, with other partners, should educate enrollment brokers, payers, health care systems, providers, and human services organizations about the new North Carolina Department of Health and Human Services approach to health-related social needs, the standardized screening questions, and NCCARE360.

b) State health and social service membership organizations should:

i) Ensure there are in-person and virtual training opportunities for health and human service professionals about the new North Carolina Department of Health and Human Services approach to health-related social needs, the standardized screening questions, and NCCARE360.

ii) Partner with the North Carolina Department of Health and Human Services and North Carolina Area Health Education Centers to develop practice supports and implementation plans related to the new North Carolina Department of Health and Human Services approach to health-related social needs, the standardized screening questions, and NCCARE360 for health care systems and providers.