



Lessons Learned from Incorporating Social Determinants of Health into Clinical Care

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NCCHCS Conference

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Opening Discussion

- What are you currently doing, or do you wish you could do, to incorporate social determinants of health into your clinical practice?

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Pilots in North Carolina's Medicaid Managed Care System

The Pilots present an unprecedented opportunity to provide selected evidence-based, non-medical interventions to Medicaid enrollees to address social needs within Medicaid managed care.

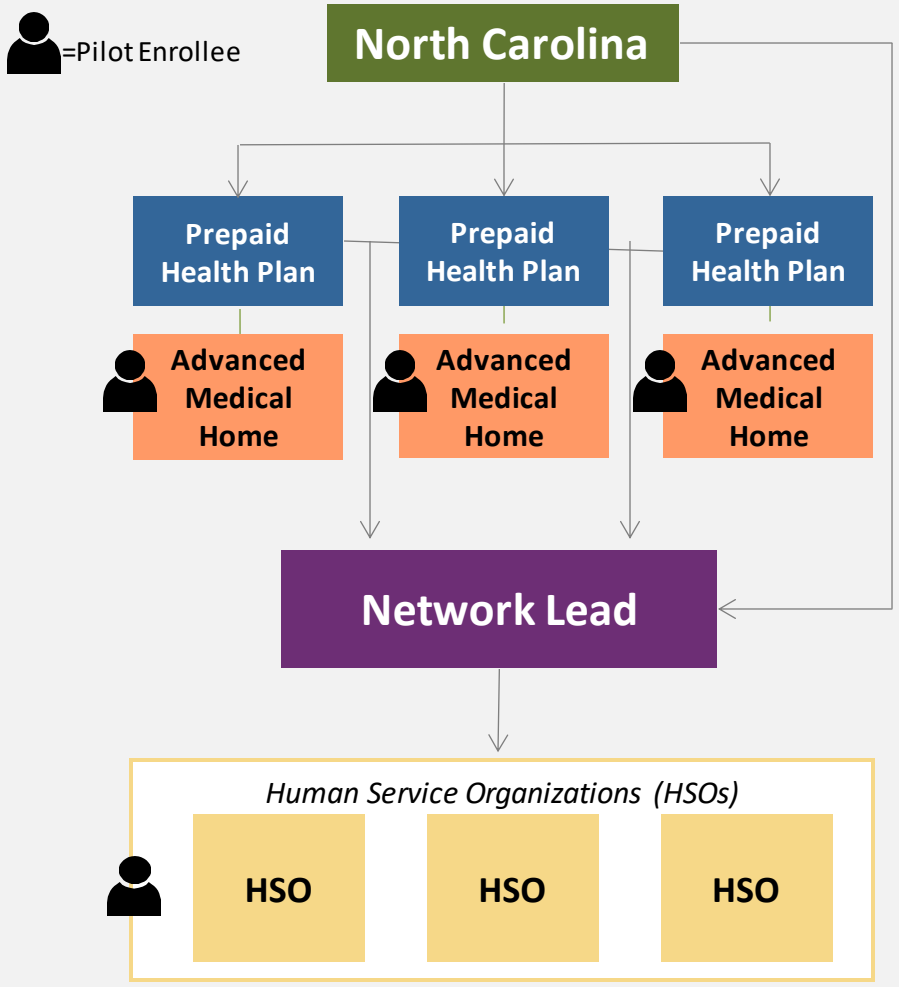
- Social and economic factors have a significant impact on individuals' and communities' health—driving as much as 80% of health outcomes
- The Pilots will facilitate coordination and collaboration between different Pilot entities, including individual care managers and care teams (referred to as care management teams throughout) and Human Service Organizations (HSOs), to provide "whole person care" to Pilot enrollees
- The Pilots will help evaluate the effectiveness of non-medical services on health outcomes and costs, with the ultimate goal of making successful Pilot services available statewide through the Medicaid managed care program

Priority Domains for All Healthy Opportunities Initiatives

Housing	Food	Transportation	Interpersonal Violence

Healthy Opportunities Pilots: Overview

Sample Regional Pilot

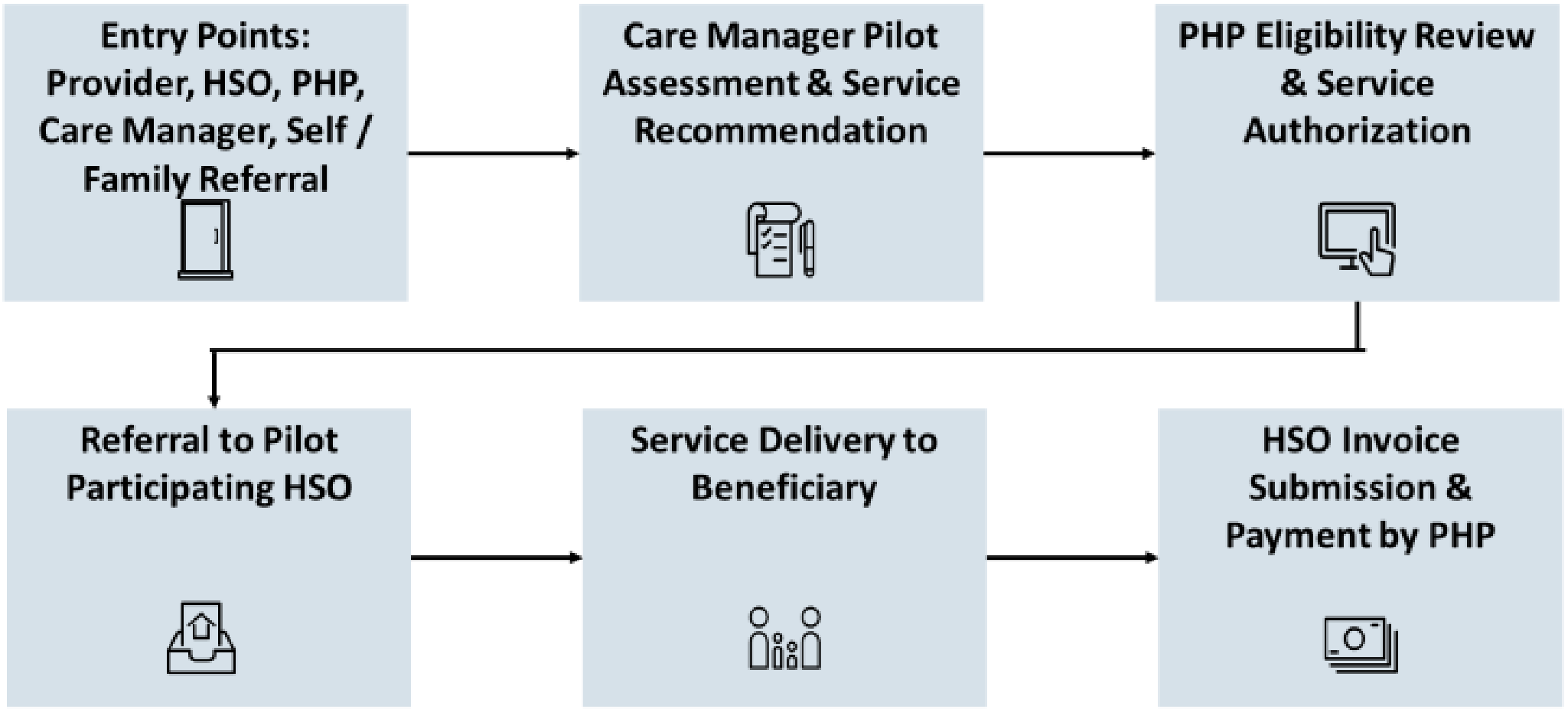


Healthy Opportunities Pilot Overview

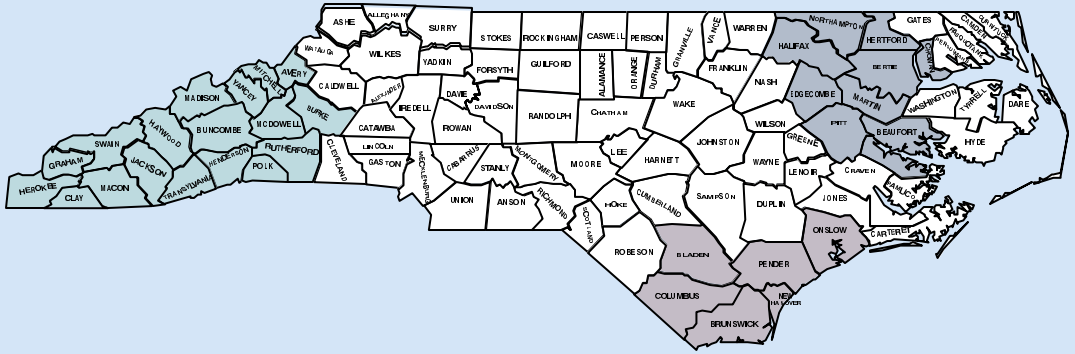
- **NC's 1115 Medicaid transformation waiver** authorizes **up to $650M** in state and federal Medicaid funding for the Healthy Opportunities Pilots
- **Pilot funds are used to:**
  - Pay for 29 **evidence-based, federally-approved, non-medical services** defined and priced in NC DHHS' Pilot fee schedule
  - **Build capacity of local community organizations** and **establish infrastructure** to bridge health and human service providers[1]
- **Pilot Vision and Goals:**
  - Integrate evidence-based, non-medical services into Medicaid to:
    - **Improve health outcomes** for Medicaid members
    - **Promote health equity** in the communities served by the Pilots
    - **Reduce costs** in North Carolina's Medicaid program
  - **Evaluate** which services are highest value & impact for which populations
    - CMS-approved SMART design (randomized trial) to provide rapid-cycle feedback, concluding in a summative evaluation
  - Create **accountable infrastructure**, **sustainable partnerships** and **payment vehicles** that support integrating highest value non-medical services into the Medicaid program sustainably **at scale**

[1] Administrative, care management, and value-based payments are also being made to support and incentivize Pilot entities to perform optimally

Workflow Across the Network



Healthy Opportunities Pilots: Selecting Priority Outcomes and Populations

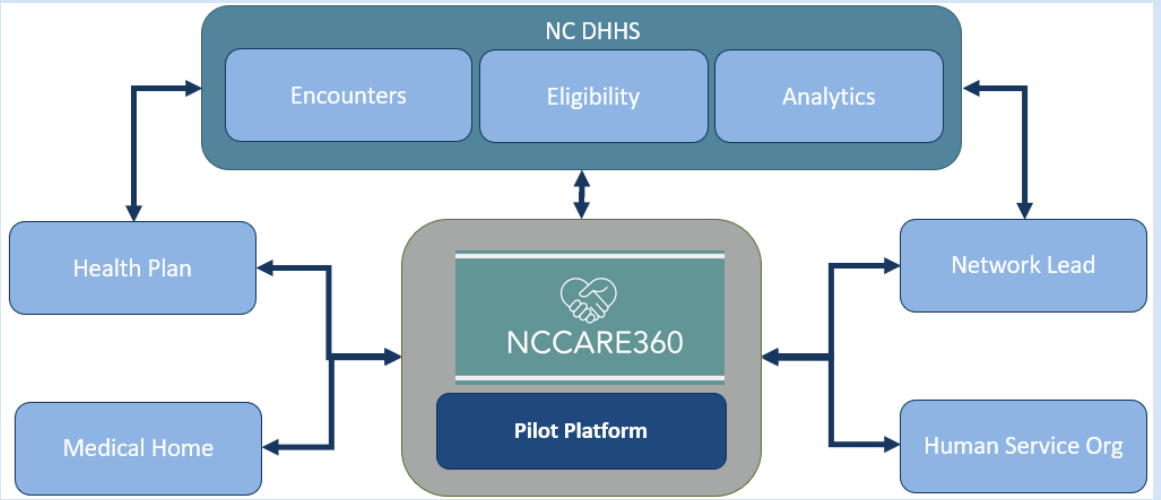


- **Focused on sustainable financing:** making the initial investment
- **Took a data-driven approach:**
  - 4 priority domains: food, housing, transportation, interpersonal violence/toxic stress
  - 29 pilot services
- **Aimed to be good stewards of State resources:**
  - Focus on high-need, high-cost enrollees (one physical or behavioral health condition and one social need)
  - 3 regions of North Carolina (3 Network Leads: Access East, Community Care of Lower Cape Fear, Impact Health)
- **Embedded pilot into managed care** with PHPs responsible for budget management and oversight
- **Took a broad view of success**
  - CMS Evaluation:
    - **Medicaid program** – must demonstrate that using Medicaid dollars improves health outcomes and utilization and lowers health care costs
      - Specifically, what individual services are most impactful for defined populations
    - **Non-medical impact** – rates of screening and connection to non-medical services; improvement in social risk factors
  - Additional Definitions of Success:
    - Member and community impact
    - Sustainable infrastructure and partnerships
    - Impacts to sectors outside of health care (e.g. enrollment in SNAP and WIC, school attendance)

Early Successes in First Six-Months

NC DHHS developed and launched a roadmap to create an ecosystem model of addressing unmet social needs.

- **Generated partnerships and collaboration across health and human service sectors:** 5 health plans, 5 clinically integrated networks (23 care management organizations), 3 Network Leads, 100 HSOs
- **Created SDOH service definitions, fee schedule, billing codes, invoicing, claims, and encounters**
- **Established Network Lead "hubs"** to connect health and human service organizations and **model contracts** to govern relationships
- **Built a technology system** to link the medical and non-medical sectors
- **Established additional, predictable funding source to local HSOs**
- **Capturing data to evaluate**

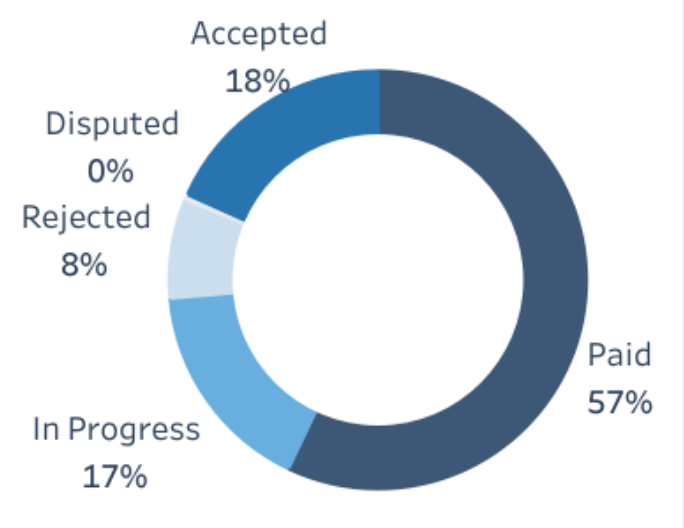


[1] Administrative, care management, and value-based payments are also being made to support and incentivize Pilot entities to perform optimally

Healthy Opportunities Pilots: Operations Status Overview

- **Enrollment:**
  - 95% of enrollment requests approved
  - Average days to enrollment is <1 day
- **Service Authorization:**
  - 97% of authorizations approved
  - Average days to service authorization is <1 day
- **Referrals:**
  - 96% of referrals accepted
  - Average of 1.1 day for referral to be accepted
  - 90% of organizations accepted referrals within 3 days
  - 99% of organizations closed cases within 5 days

Invoices



10,742 Invoices Submitted

Healthy Opportunities Pilots: Success Stories

- **Currently homeless family secured housing near hospital for life-saving surgery**
  - A single mom, Michelle, had been staying at a local shelter with her children but needed life-saving surgery. Her children couldn't remain in the shelter without her, which left her in an impossible position. Mom had secured an emergency housing voucher, but it wasn't enough to cover rent in the county where she'd be receiving treatment. Through HOP, her care managers were able to help her transfer her housing voucher and secure income-based housing near the hospital. They also helped her access financial support for her security deposit and utility setup fees – all services covered through HOP. Now mom can focus on her health, schedule needed medical care, and keep her family together under one roof with a little help from her friends and HOP.
- **Donna's diabetes level managed; avoided emergency due to healthy food through HOP**
  - "I feel so passionate about the differences we are already making in people's lives. A few weeks ago, a participant shared that their HbA1C is down from 11 percent to 7 percent. That's down from an emergency to almost normal. When their healthcare provider asked what they were doing differently, they said it was the healthy food we bring them. I am so honored to get to do this work in the community that raised me. I really appreciate all the guidance and support you give to us!"
- **Car repair enabled Robert to get to health appointments, pick up food, and reengage with community, helping his depression**
  - During a routine doctor's appointment, Robert identified as having a few different health-related social needs. The most pressing was transportation, as he had not had reliable transportation in 5 years (he lives in a rural county that does not have set public transit) due to his car always needing a repair. Through HOP, he was able to have his brakes repaired, which has allowed him to re-connect with friends, and keep medical appointments. All of these factors have helped with managing his depression. In addition to the car repair, Robert is also receiving a Fruit and Vegetable Prescription and his wood burning furnace is being repaired just in time for winter. When asked about how HOP has impacted him, he shared that "HOP has literally changed my life."
  - Local HSO that provided car repair was able to expand the number of counties it serves from 1 to 6 (with plans to grow further!)

Healthy Opportunities Pilots: Challenges and Solutions

Challenges	Solutions
HSOs Fitting into the Healthcare Ecosystem and Contracting	Network Leads, Model Contacts, State-defined Service Definitions and Rates, Simplified Invoicing and Payment Process, Technical Assistance, Phased Launch
HSO Enrollment and Network Adequacy	*Enrollment*: Created New, Customized Provider Type for HSOs, Intensive HSO Training and Technical Assistance *Network Adequacy:* Application Process, Network Efficiency, Monitoring
Member Awareness, Enrollment and Consent	Simplified and Streamlined Member Enrollment and Consent Process, Identifying Eligible Members, Outreach Campaigns, No Wrong Door
Providing services to families experiencing interpersonal violence	Engagement with NC Coalition Against Domestic Violence, Technological Enhancements, Data and Privacy Protections, Trainings
Invoicing and Payment	Capacity Building Funds, Leverage Existing PHP and State IT Systems, Simple Invoicing, Network Lead Assistance, Transitioning Invoices to Claims, Encounters, Remittance Advice Guidance
Technology and Data	Phased Approach to Building Functionality

Healthy Opportunities Pilots: Key Success Factors

NC DHHS sees the following as being critical for the successful launch of integrated medical and SDOH programs.

Identify KPIs – What is success?

Use Data to Consistently Evaluate and Improve

Stakeholder Engagement and Transparency

Phased Implementation Approach

Always Align to Guiding Principles:

1. Goal is to learn
2. Simplify
3. Keep members and communities top of mind
   a) Prioritize getting members services and getting HSOs paid.
   b) When needed, prioritize the least-resourced organization
4. Start somewhere; enhance capabilities along the way.

Focus on Scaling and Sustainability

Align Payment Models to CBO Needs

Strong Department Role as Planner and "Train Conductor"

HSO Management and Technical Assistance (Network Leads)

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NCDHHS
NC Medicaid
Division of Health Benefits

NC Medicaid and NC Integrated Care for Kids (NC InCK)

An Innovative Partnership to Promote Child and Family Wellbeing

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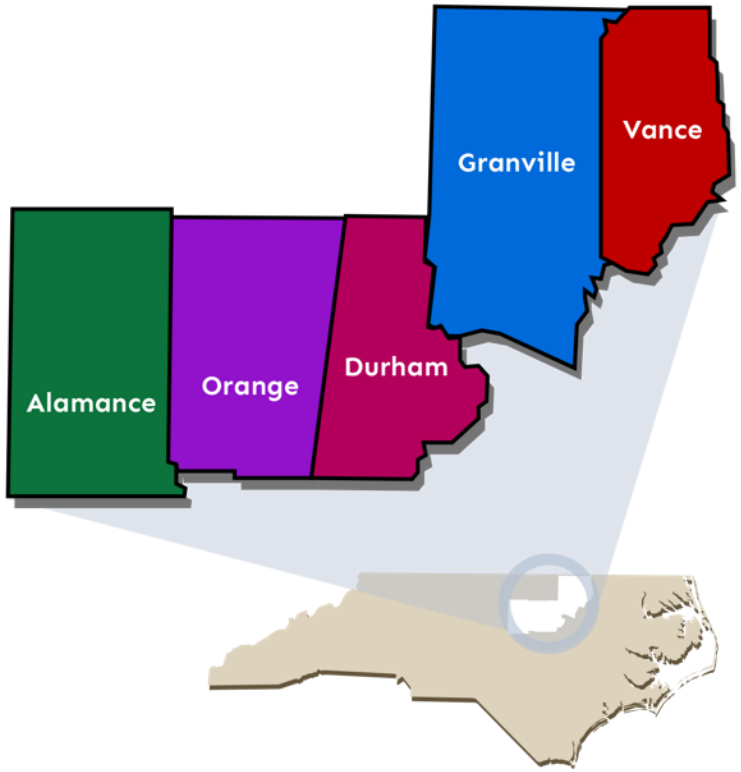
NC InCK: Brief Overview

- **Population: All Medicaid and CHIP-insured children in this 5-county area**
  - Birth to age 20
  - Regardless of where they receive medical care
  - ~95,000 children



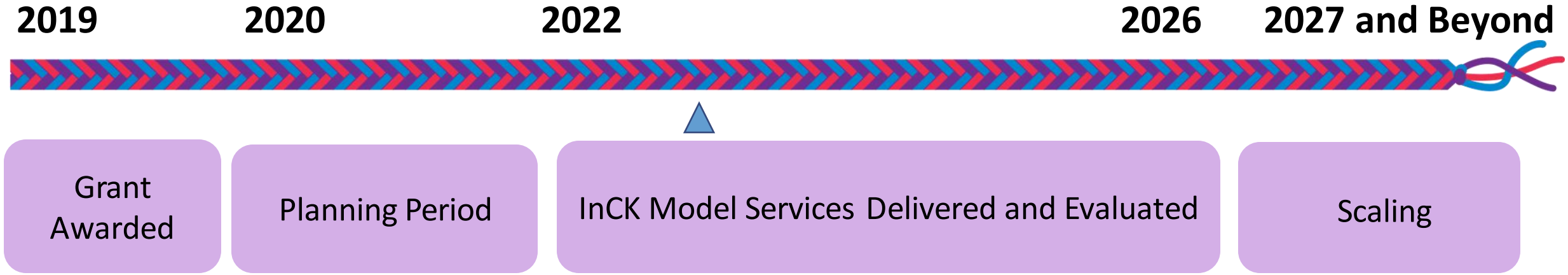
- **Funding: A 7-year, $16M grant from CMS to the following institutions:**

Duke UNIVERSITY

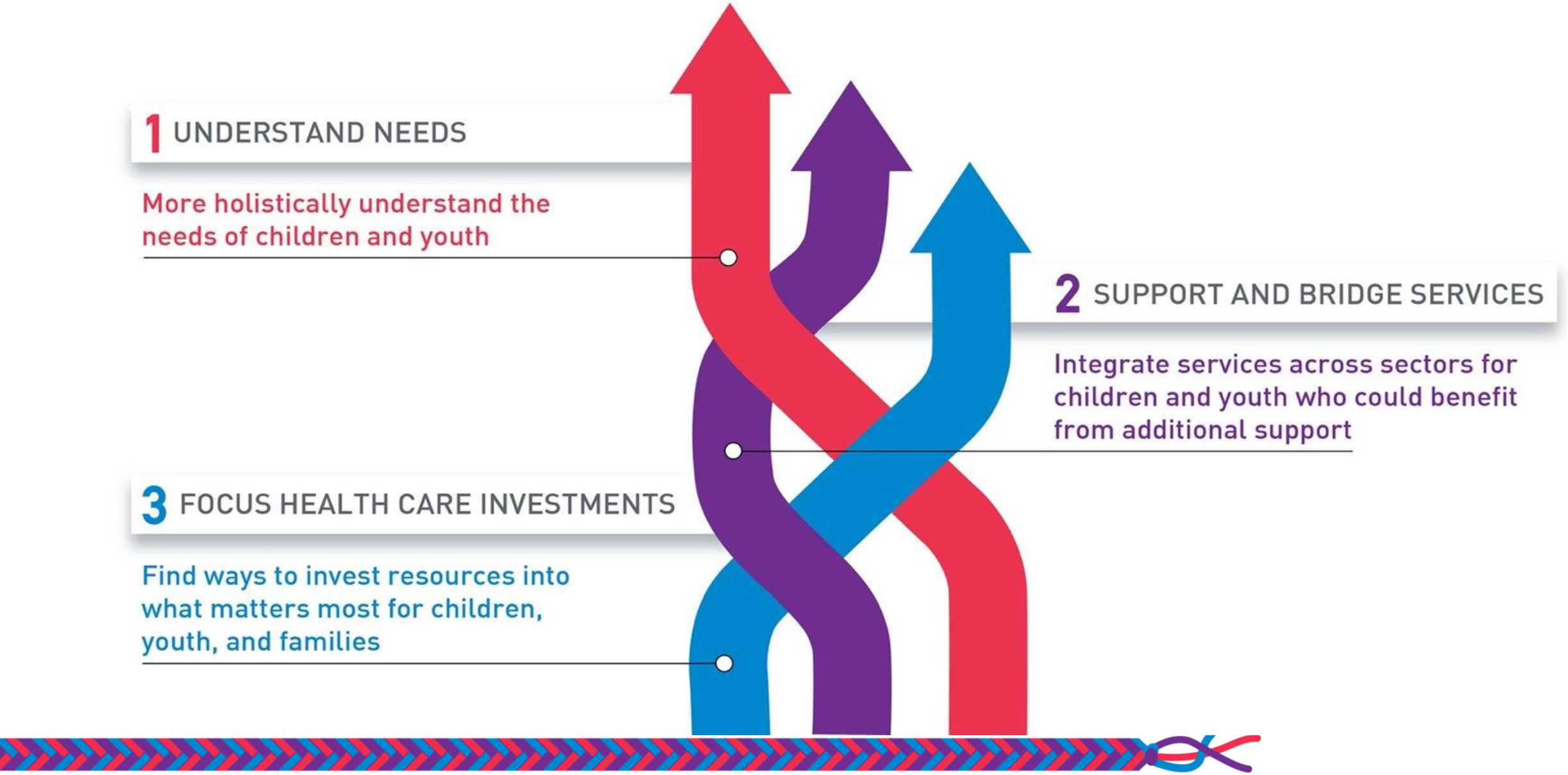
THE UNIVERSITY of NORTH CAROLINA at CHAPEL HILL

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

The NC InCK Journey



Three Key Strategies to Integrate Care for Children in NC InCK



Understand Needs

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Administrative Data Sharing for InCK

2 Data Use Agreements anchored by Medicaid identifier link data across DPS, DPI and DHB for stratification of children

NCDHHS

- Healthcare utilization
- Tailored Plan Eligibility
- Foster Care Status
- Guardian Health Status
- Social Drivers of Health
- Medical Complexity

NORTH CAROLINA DEPARTMENT OF PUBLIC SAFETY

- Detention Stays
- Youth Development Center Stays
- Probation
- Diversion
- Intake Status

North Carolina Department of PUBLIC INSTRUCTION

- Attendance & Absences
- In School Suspensions
- Out of School Suspensions
- Expulsions
- Enrollment

NCDIT NORTH CAROLINA DEPARTMENT OF INFORMATION TECHNOLOGY

← Merges data and produces score

Overview: NC InCK Stratification- Service Integration Levels

The Child's Health and Health Care Experiences

Physical, behavioral, and developmental diagnoses

Health care utilization

The Child's Context

Socioeconomic, educational, developmental, and parent/guardian factors

Out-of-Home Placement

Prior or current out-of-home placement or markers of risk of future out-of-home placement

Implementation Update: As of 10/18, 11,000 children have been stratified with goal of reaching 15,000 by End of Year.

SIL-3: ~5% of children

Children who are out-of-home or have high risk of out-of-home placement.

Children experiencing multiple, complex health and education, JJ, CW, social determinant needs.

SIL-2: ~10% of children

Children experiencing multiple, moderate-severity health, social determinant, education or guardian needs.

Focus is on impactable rising risks to improve well-being and reduce future out-of-home placement

SIL-1: ~85% of children

All other children in NC InCK counties.

May have isolated health and contextual risks.

Offered Care Management

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Lesson Learned: The Need for Manual Elevation

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Manual Elevation Pilots

Background

- Our data-driven approach offers broad reach and is efficient and sustainable however, it is limited as a whole by the limitations of its individual data sources
- Key issues that *could* be mitigated by direct referrals
  - Limitations around timeliness of identification
  - Blind spots in our current approach
  - Challenges around engagement of families
  - Little insight into who is inadequately supported by existing services
  - Direct referral is a common felt need among stakeholders

Starting in January, 2023, InCK will take referrals from:

- **5 local DSS offices** → families involved with Child Protective Services
- **Family Navigators** → siblings or family members with need for year-long CM
- **Schools** → school social worker or nurse from 2 pilot schools
- **Juvenile Justice** → youth receiving voluntary support from Court Counselors

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Support and Bridge Services

A Child's NC InCK Journey

Understand a child's needs | **Integrate services** | Invest in what matters most

Child is identified through NC InCK's integrated **cross-sector data** as needing additional supports

Child is assigned a **Family Navigator** to serve as their care manager

Family and Family Navigator form **Integrated Care Team** of trusted cross-sector individuals

Family, Family Navigator, and Care Team collaborate to create a **Shared Action Plan**

Family and Family Navigator meet at least **quarterly** to discuss unmet or emerging needs

Integrated care consultation, education, ongoing training and support by the InCK Integration Consultant

Implementation Update: As of 10/18, 60 Family Navigators have outreached ~1,500 children and co-created ~350 Shared Action Plans.

INTEGRATION CONSULTANT
Team of 16 NC InCK clinical staff available to support a child

Integrate Services Across Core Child Services

1. Schools
2. Early Care and Education
3. Food – SNAP, WIC, Food banks
4. Housing
5. Physical and Behavioral Healthcare
6. Maternal and Child Services – Title V
7. Social Services – Child Welfare
8. Mobile Crisis Response
9. Juvenile Justice
10. Legal Aid

Public Schools of North Carolina
State Board of Education
Department of Public Instruction

smart start
Each Child. Every Community.

LEGAL AID NC

N★C DPS
DEPARTMENT OF PUBLIC SAFETY
PREVENT · PROTECT · PREPARE

SNAP Supplemental Nutrition Assistance Program

DAYMARK
Recovery Services

Lesson Learned: Continual Need for Refocusing on SDOH

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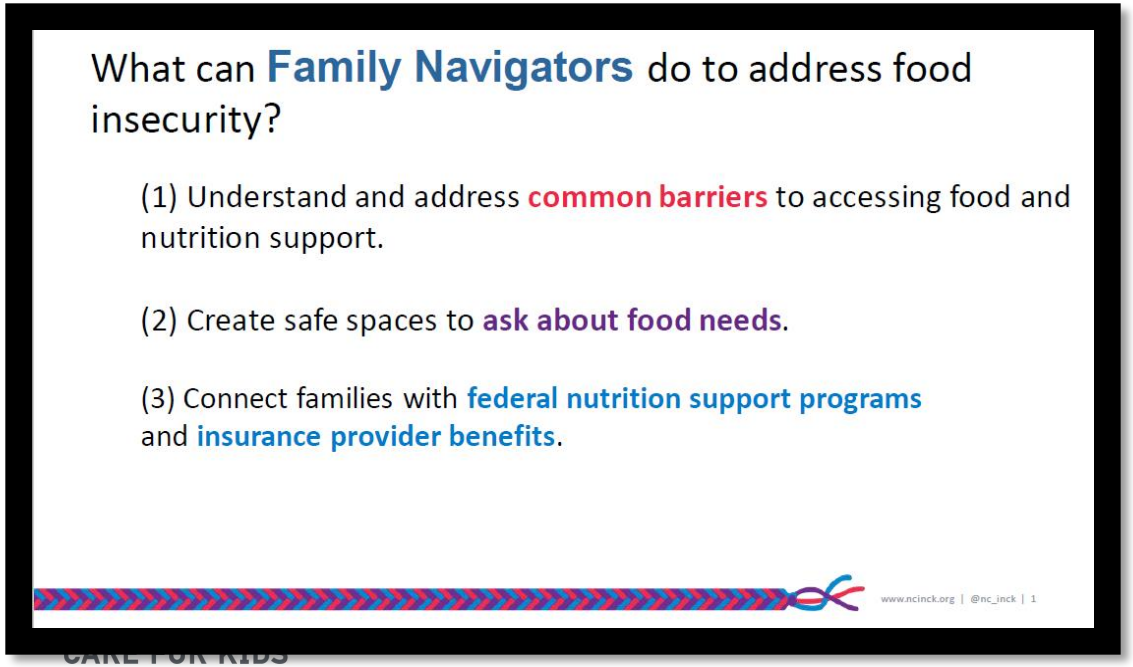
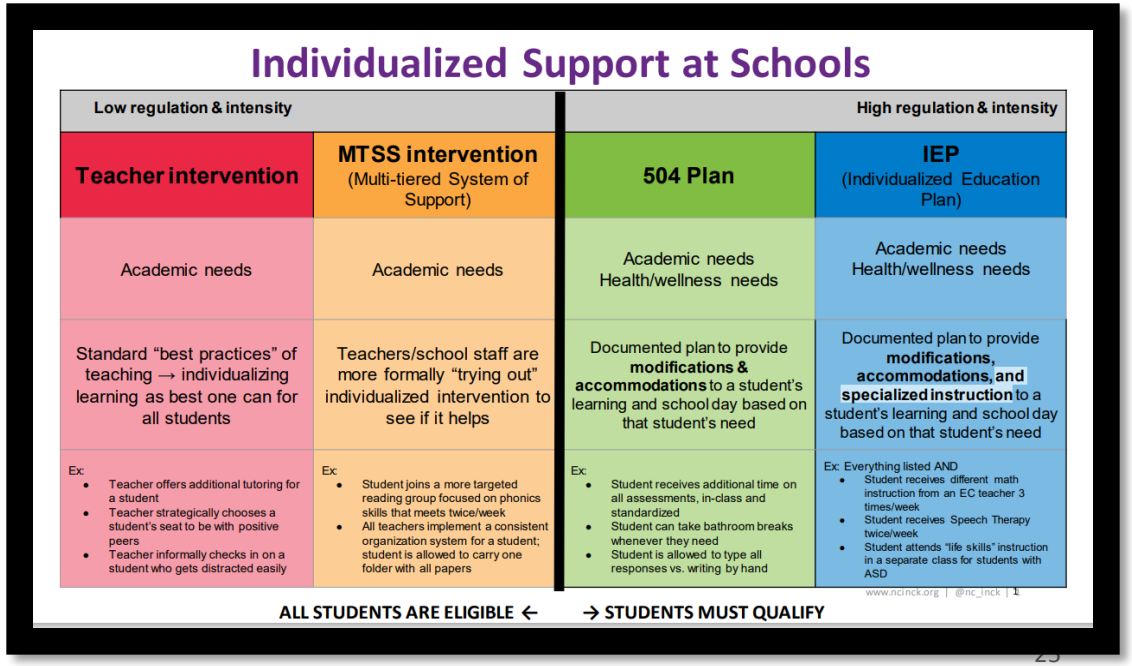
Building Capacity of Family Navigators

- Role of Integration Consultant
- Integrated Care Rounds (ICR)
  - Learning spaces that convene monthly, designed to support care managers serving children in building capacity in specialized pediatric care management, all available through our website (e.g., Food and Nutrition)
- Resource Guides created for each core child service area, including Housing and Food

June Integrated Care Rounds on Food



April Integrated Care Rounds on Schools



Focus Healthcare Investments: Alternative Payment Model

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Investing in Health: NC InCK's Alternative Payment Model

- Together, leadership across Pre-Paid Health Plans (PHPs), Clinically Integrated Networks (CINs), NC Medicaid & NC InCK have met ~monthly for 2+ years to design a payment model that:
  - Supports whole child health by linking incentive payments to **meaningful measures of child well-being**
  - **Embeds equity** in the care delivery + payment model
  - Creates a coalition to **advance child health and well-being via payment innovation**
- **Our Collective Goal for the InCK APM**: To meet cross-sector needs of patients and improve health and well-being outcomes for children through opportunities for increased resources, flexibility, and access to actionable data for health care providers
- The InCK APM uses **standardized benchmarks** and **pooled performance measures** across PHPs with some variation in incentive amounts by PHP

The NC InCK APM is an important start, bringing to life the type of pediatric payment innovation that has been contemplated and requested for decades

Year 1 APM Performance Measures

	NC InCK Foundation APM Measures	
Cross-sector child well-being metrics	**Kindergarten Readiness Promotion Bundle**	Pay-for-Reporting For Documenting Kindergarten Readiness Bundle
	Food Insecurity and Housing Instability Screening	Pay-for-Reporting For Documenting Screenings Performed
	Shared Action Plan (SAP) Completion	Pay-for-Reporting For Documenting the Completion of a SAP
Health care metrics	**Screening for Clinical Depression & Follow-Up**	Pay-for-Reporting For Documenting Clinical Depression Screening & Follow-up Plan
	Rate of Emergency Dept Visits	Pay-for-Performance For Reducing Rate
	Equity: Reduction in disparity in Infant Well Child Visits	Pay-for-Performance For Reducing Black-White Disparity

Additional Rates Shared for Awareness without Incentive: Kindergarten Readiness; Housing Instability; Food Insecurity

Lesson Learned: Health systems cannot stop at screening, but must determine effective ways to intervene after screening takes place

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Potential Clinic-Based Interventions

- Direct referral to PHP housing specialists *
- Enhanced Medical Legal Partnerships
- Cash assistance for families distributed by clinics to meet acute housing needs

*NC Medicaid requires each Pre-Paid Health Plan to employ at-least one housing specialist to support families in combatting housing instability

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Closing Discussion

- What lessons do you hope to learn from HOP and NC InCK implementation that can inform your work at incorporating social determinants of health into clinical care?
- What ideas do you have for combatting food insecurity and housing instability that you would like to see reflected in HOP or NC InCK?
- As you imagine your own clinic, and your own patients, what questions are you left with about the work that Medicaid can do to better support social determinants of health?

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