Buying Health in North Carolina

North Carolina ranks:	**81.5%** of children in low-income families are healthy
35th in the country in state health rankings	VS.
44th in the country in health equity	**96.9%** of children in non-low-income homes are healthy

Opportunities for Health

- The opportunity for health begins where people live, learn, work, and play; it begins with our families, neighborhoods, and communities.
- Access to high-quality medical care is critical to a person's health, but research shows that up to 80% of a person's health is determined through social and environmental factors and the behaviors that are influenced by them.
- All North Carolinians should have the opportunity for health. We can't improve health and well-being of North Carolinians without tackling some of the foundational drivers of health.

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.*

North Carolina Department of Health and Human Services is committed to providing the opportunity for health for North Carolinians and addressing the conditions in which people live that directly impact health or "the social determinants of health" (SDOH) through a combination of strategies including:

- Developing a set of **standardized SDOH screening questions** to identify and assist patients with unmet health-related resource needs.
- Building a **statewide resource platform** to connect those with an identified need with community resources.
- Creating a **statewide "hot spot" mapping of SDOH indicators** using a geographic information system (GIS) that can guide community investment and prioritize resources.
- Incorporating SDOH strategies throughout **Medicaid 1115 wavier** including in care management, the quality strategy, through withhold-based incentives, in lieu of services, value-based payments and PHP community investment.
- Developing **Public-Private Pilots** in 2-3 regions around the state to knit together health care and community services and employ evidence-based interventions on a population level that address health factors related to housing, transportation, food and interpersonal violence. The pilots will require rigorous evaluation to understand the implementation of successful interventions on a population level and how to best take them to scale, and incorporate them in a sustainable way into the state-wide Medicaid program.

By investing in an innovative and integrated SDOH portfolio on the population level, North Carolina can be a national leader in driving future health reform. A model of co-investing will best leverage resources, expertise and priorities toward one goal and will allow strategic and synergistic investments. This collaborative work has the potential to be transformative to the health and well-being of our state and our communities and how we deliver and pay for health ongoing.

SDOH Public- Private Regional Pilots

Purpose: To systematically test on a population level whether targeted evidence-based and evidence-informed interventions in one of the four SDOH domains (food, housing, transportation and interpersonal safety) can be delivered in an organized way to Medicaid beneficiaries, improve the health of a population, and lower the cost of medical care.

Study: Pilots are not seeking to test the effectiveness of one intervention for one defined population, but rather wishes to identify a range of promising interventions across several subgroups (e.g. children, pregnant women, high-risk adults), test their efficacy, identify which subgroups benefit from the interventions, and learn how to scale the interventions at the population level across diverse regions throughout the state.

Goal: Learn what interventions and processes worked well for specific populations and incorporate these interventions into the Medicaid program statewide through changes to covered State Plan benefits, payment models, risk adjustment based on social needs, value based payments or other methods.

Impact: SDOH pilots can be a model for other states and a national model on how to incorporate SDOH-interventions into standard healthcare.

Design

- RFP process to choose 2-4 pilot regions. Regions defined as more than one county; covers both urban and rural communities; does not cross Medicaid region.
- In each region, pilots will employ evidence-based and evidence-informed interventions to address beneficiaries' needs related to housing, transportation, food and interpersonal safety.
- Individuals eligible for "pilot services" will have at least one needs-based criteria (e.g. 2 or more chronic conditions or experiencing 3+ adverse childhood experiences) and at least one unmet resource need.
- Pilot activities and services will include prevention and upstream focused investment (e.g. early childhood) and downstream investments (e.g. adults with high cost/high utilization).
- A lead pilot entity (LPE) will build a network of resource providers to deliver services and work with each pre-paid health plan (PHP) and other organizations in the region to coordinate services for beneficiaries.
- Every Pre-Paid Health Plan (PHP) in the pilot region will be engaged in the pilot. The PHPs will be responsible for screening beneficiaries for meeting pilot qualifications and identifying recommended needed SDOH-related services through care management structure.
- Medicaid funding will be partnered with private dollars to cover a full range of activities and community infrastructure.
- Pilots will use an adaptive SMART design methodology, which tailors the intervention intensity to the individual. This intervention structure begins with 'lighter-touch' lower intensity interventions, coupled with ongoing assessments that can escalate the intensity of the intervention based on whether an individual's unmet needs and/or health outcomes have improved. If the initial intervention has been successful, no further escalation is required. Those who have not benefitted from the lighter-touch approach can be identified and moved into higher tiered interventions.

Evaluation

- Pilots will conduct rapid cycle assessments to identify if the interventions are having their intended effects on targeted populations. By using an iterative process, pilots will be able to collect data to test the services, examine the results, and modify services, adopt a different service, or reallocate resources to a more promising intervention as appropriate.
- Pilots will conduct a summative evaluation to assess their impact on beneficiaries, population level improvements, and the Medicaid program.
- Based on evaluation, North Carolina can launch proven interventions statewide to measurably lower Medicaid beneficiaries' costs and improve their health outcomes through the Medicaid program.