North Carolina Institute of Medicine
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Task Force on Accountable Care Communities

TASK FORCE ON ACCOUNTABLE CARE COMMUNITIES

MEETING SUMMARY

March 5, 2018

10:00 am – 3:00 pm

North Carolina Institute of Medicine

630 Davis Drive

Morrisville, NA 27560

Attendees:

- *Co-Chairs:* Miles Atkins, Reuben Blackwell, Ronald Paulus; *Via phone*: Sec. Mandy Cohen
- *Steering Committee:* Jason Baisden, Chris Collins, Allison Owen, Melanie Phelps, Jeff Spade
- *Task Force Members*: Donna Albertone, Paula Swepson Avery, Blair Barton-Percival, Brett Byerly, Heidi Carter, Giselle Corbie-Smith, Al Delia, Howard Eisenson, Robert Feikema, Peter Freeman, Kim Green, Shauna Guthrie, Mark Gwynne, Nicole Johnson, Dee Jones, Ruth Krystopolski, Lisa Macon Harrison, Nicolle Miller, Kevin Moore, Barbara Morales Burke, Kristin O'Connor, Abbey Piner, Kim Schwartz, Linda Shaw, Pam Silberman, Tish Singletary, Steven Smith, Anne Thomas, Sheree Vodicka, Mary Warren, Ciara Zachary; *Via phone*: Kathy Colville, Tracy Linton

Introductions:

Task Force Co-Chair Reuben Blackwell opened the meeting and asked Task Force members to introduce themselves. Task Force co-chairs, steering committee members, Task Force members, and guests introduced themselves, including their position and the organization they represent.

Determinants of Health

Robert Strack, Associate Professor, Department of Public Health Education, UNC Greensboro

Dr. Strack began his presentation by comparing the World Health Organization and Centers for Disease Control (CDC) definitions of social determinants of health, noting that the CDC definition includes distribution of money, power, and resources. He used the social/ecological model, which includes population-level and individual-level determinants of health, to explain the problem that is created when public health interventions focus on individual-level interventions and ignore environmental factors. With individuals at the center of the circular depiction of the social/ecological model, this creates a "donut hole" problem. The American value of rugged individualism was introduced and used to underscore the importance of narrative and frame used when discussing determinants of health with people from different political perspectives. The Robert Wood Johnson Foundation's report, A New

Way to Talk About the Social Determinants of Health, outlines research done with focus groups from different political perspectives on language to use when discussing social needs. He used the Sisyphus Model of rolling a boulder up a hill to depict how individuals' level of social/physical/environmental challenges impacts how difficult it is for them to make healthy choices (it is more difficult to roll the boulder as the hill gets steeper with increasing societal challenges). Communities need to consider how important and how changeable different needs are to understand where opportunities for innovation are and where the "quick wins" may be. The conclusions of this presentation were that we need to have a better way to tell the story of determinants of health, new partners and advocates, and to target the most important and changeable factors in a community guided by theory, evidence, and practice.

Questions/Discussion:

Question: We can't get away from poverty and wealth disparity as a key driver of health. Is there a way we can inch toward reducing wealth disparities, and isn't it appropriate for us in the health sector to be familiar with that?
Response: Eliminating poverty may not be feasible goal for the group, but there are certainly strategies for dealing with poverty. Within the wedge environmental factors in the Sisyphus Model there is a reverse wedge that has protective factors and strategies. An example might be that in Greensboro, one challenge in getting people to health care is transportation so Triad Health Network has been looking at strategies to use Uber to pick people up to take them to appointments.

Question: What about racial equity? Structural barriers still exist that enable racial inequity to persist; especially in the school system with having more white, higher income children in private schools, leaving public school to be poorly funded. When we are addressing these environments, how do we keep equity at the forefront?
Response: This goes back to what I was saying about the language we use and making sure that we don't put people into camps or create a "them and us" mentality. For education, the best argument might be economic.

Question: Is there evidence about how to effectively marry the group and individual values in order to get to some middle ground?
Response: Research I have seen shows that it is most effective to find the common ground you have with someone first before trying to pull them in a direction they may be less open to.

Question: We can accept the truths that we should create platforms that all of us are comfortable having conversations on, but it rings a little hollow at the same time. There is an element of disenfranchised communities being told to wait by those who have the power to influence policy.
Additional observation from Task Force member: In her experience working with students, there is a rejection of the Robert Wood Johnson Foundation language around SDoH.
Response: One message isn't going to move every audience, so it's about paying attention to the audience.

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Strack presentation here.

NC DHHS Statewide Framework for Addressing Determinants of Health
Betsey Tilson, State Health Director & chief Medical Officer, North Carolina Department of Health and Human Services

Dr. Tilson outlined the North Carolina Department of Health and Human Services (DHHS) vision for "a North Carolina that optimizes health and well-being for all people by effectively stewarding resources that bridge our communities and our healthcare system." She stated that DHHS is looking to move more upstream in their work and not only focus on high risk/high cost individuals. Medicaid transformation is providing a key opportunity for this. DHHS will be informed by and build on existing work at the community level and hopes to develop a common language. Their multi-layer approach to addressing health-related resource needs includes: 1) mapping social drivers of health indicators, 2) developing a standardized screening (available for public review in mid-March) that will be mandated for pre-paid health plans (PHPs) under Medicaid, 3) a statewide platform providing a database for community resources, 4) Medicaid transformation, including training care managers, a State Quality Strategy, and incentivizing PHP community investment, 5) public/private regional pilot projects, 6) workforce development, and 7) re-aligning or connecting existing resources

Questions/Discussion:

Question: Has DHHS heard from CMS yet and what is CMS' timeline in determining what we are/are not able to do with Medicaid funds? Will all those decisions come down at once?
Response: A big question we are waiting on is what we can use the pilot funds on; our goal is for CMS to approve everything at once, but that doesn't always happen.

Question: What can you do with community organizations to help prepare them for the flood of people who will be needing services?
Response: Providing assistance with an IT platform will be a key strategy.

Tilson presentation here.

Discussion: Addressing Determinants of Health in our Communities – Impact and Challenge Analysis
Facilitators: Maggie Bailey, Brieanne Lyda-McDonald, Michelle Ries, Berkeley Yorkery, Adam Zolotor

Meeting attendees divided into 5 small groups and engaged in a qualitative exercise to understand the challenges in discussing and prioritizing community needs around social determinants of health. Each table was assigned four domains of social determinants. Group members individually placed the categories on a grid to indicate the level of need for action in their communities and the level of challenge to address those needs. Participants then engaged in discussion about the process of organizing the determinants and the considerations they made to do so.

Atrium Health and Aunt Bertha
Alisahah Cole, System Medical Director, Community Health, Atrium Health

Dr. Cole explained Atrium Health's mission, goals and strategic priorities. Their community health assessment found a consistent need in the areas of mental health/substance use, tobacco use, obesity, access to primary care and dental services, and social determinants of health. Atrium Health worked with the UNC Institute of Public Health from UNC Chapel Hill two years ago to determine the social determinants that most impact the health of their patients and a total of 12 determinants emerged. Using hot-spotting maps, they created a score for those social determinants across their service area. The maps consistently showed corresponding areas of need. A primary consideration of this work has been the fact that communities are identifying what they need for themselves, but there are not necessarily mechanisms in place to communicate those needs. Atrium is working with community partners to see what overlap in priorities exists, for example crime reduction through partnerships with YMCAs. They are partnering with One Charlotte Health Alliance, Mecklenburg County Public Health, and Novant to address healthcare deserts in the region. Atrium implemented a standardized screening for social determinants and partnered with Aunt Bertha to create a community resource hub. With a process in place, community partners sign up, patients consent to information being shared, and partners can access the information. Atrium is able to track searches by community members and has found that food assistance is the number one searched item. They are currently working on development of a single application form for services.

Questions/Discussion:
Question: How are you marketing this community resource hub to partners and the public?
Response: It is on our website, community partners help spread the word to populations they serve, and clinics hand out cards to patients that they can take with them with information.

Question: Is there any coordination with DSS to support this work?
Response: There is a high-level of coordination. Screenings can help people recognize they may be eligible for services and Atrium can help facilitate patients applying for public benefits.

Cole presentation here.

NC 2-1-1
Heather Black, NC 2-1-1 Statewide Strategy Director, United Way of North Carolina
Laura Zink Marx, President & CEO, United Way of North Carolina

Ms. Black and Ms. Zink Marx gave an overview of the NC 2-1-1 infrastructure and their new partnership with Unite Us to close the loop on the referral process in order to answer the question: "Can we prove the patient received the service they needed?" NC 2-1-1 addresses determinants of health by providing access to community resources via phone, chat, and text; increases the searchability of online resources; and connects patients to services, which is particularly important in rural communities or areas with

limited resources for health navigators or care managers. With Unite Us, call specialists can gain digital consent to view the patient's personal information and electronically refer patients to multiple community partners. Community partners only receive personal information relevant to the service they provide. Currently, 257 organizations are coordinated using Unite Us and United Way is leading efforts to form a data collaborative.

Questions/Discussion:
Question: When you first created 2-1-1, for-profit organizations were not included in the system, is that still the case?
Response: On the public-facing side yes, as we must remain accredited. Call specialists have more information about for-profit organizations.

Question: Can anyone provide a referral in this system?
Response: Yes, 2-1-1 as a confidential service might be useful for someone that might not want to be tracked in a larger system, so referrals don't have to be from providers.

Question: Do you interface with NC FAST?
Response: No

Black/Zink Marx presentation here.

Screening & Referral for Social Needs: Health Leads
Mary Carl, Principal of West Coast Partnerships, Health Leads
Jenn Valenzuela, Principal of Programs, Health Leads

Ms. Carl and Ms. Valenzuela explained that to successfully address patients' social needs by increasing access to community resources as a standard part of quality care there should be: 1) screening of eligible patients for social health priorities and 2) established care pathways to support positive screens. They explained that patients should be part of the conversation health systems have when determining when and how to screen patients. There are differences between the intake and screening process, where intake is about assessing eligibility, frequency, and severity, and screening is about uncovering the presence of need. Screening is not about getting all the answers, but about starting the conversation. When establishing an intervention, health systems need to consider the depth of the intervention based on patient population need and staff capacity and the process of implementing the intervention into the workflow. There needs to be thought into what success looks like for the provider and patient and clear definitions and measures for each. When patients are screened for a need, that does not always mean action is required by the provider. Typically, the less immediate the need, the less likely someone is to accept assistance in that area. Health systems should be aware of unintended consequences of screening, including legal issues, and should provide scripts to support staff in how to address those issues.

Questions/Discussion:
Question: When you're talking about a universal tool, is this only something to be used across the board in a medical setting?
Response: No, we need to be considering how we can be screening outside of the health care setting so that people don't need to enter the system to have their needs met.

Question: What happens if all the screening leads to hitting capacity in the community organizations that are servicing these needs?
Response: That is often a fear, but communities often know the gaps that exist in the community, so you're probably not going to be inundating the smaller CBOs like you think you might. But it is very important to be engaging in conversations with community partners to make sure that isn't happening.

Question: How are organizations sharing the results of screening among each other? What do you do when you're working as a coalition and you want to screen in multiple places, how do you coordinate so you aren't asking the same questions over and over again?
Response: We're looking a screening in multiple places and creating a central repository so partners can look to see who has been screened. With so many moving parts, it's probably better to ask the questions, as needs can change over time, and having ongoing conversations with patients.

Carl/Valenzuela presentation here.

Discussion: Referral Mechanisms, Tools, and Resources
Facilitators: Maggie Bailey, Brieanne Lyda-McDonald, Michelle Ries, Berkeley Yorkery, Adam Zolotor

Meeting attendees divided into 5 small groups and engaged in a discussion of referral mechanisms and screening tools in their communities, successes and challenges with using these tools, and primary considerations for health systems and communities considering developing and/or implementing these tools.

Task Force Charter and Next Steps
Brieanne Lyda-McDonald, Project Director, NCIOM

Brieanne gave a brief presentation on the changes to the Task Force charter based on member feedback, upcoming meeting dates, and topics we will cover.

Lyda-McDonald presentation here.