Welcome

Announcement

Meeting will begin in 10 minutes

Welcome

Executive Committee Members

Melissa Roupe, Chair

Joanne Lee, Vice Chair

Sherée Vodicka, Past Chair

David Gardner, Member at Large

Jayne McBurney, Member at Large

Richard Rairigh, Member at Large

Meeting Agenda

1:05 – 1:45	Draft of new Eat Smart, Move More NC Plan for review and discussion	Carolyn Dunn, PhD, RDN, LDN
1:50 – 2:30	NC Institute of Medicine's Task Force on Accountable Care Communities	Adam Zolotor, MD, DrPH
2:35 – 3:15	NCCARE360 / Unite Us	Georgina Dukes, MHA
3:15 – 3:30	Announcements	Melissa Roupe

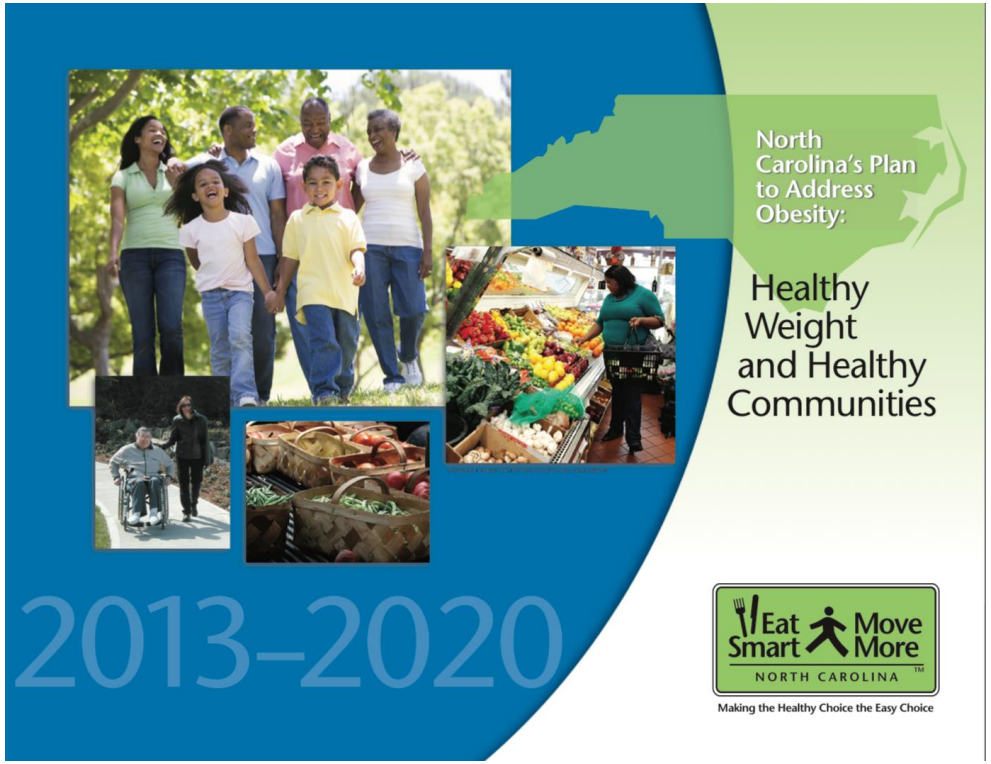
Update from our Writing Team

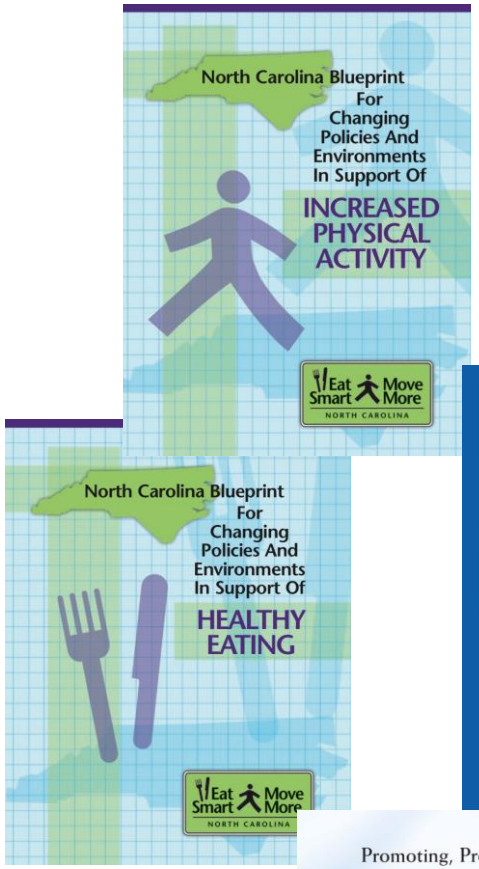
Sharing a draft of the new Eat Smart, Move More NC Plan for discussion and feedback

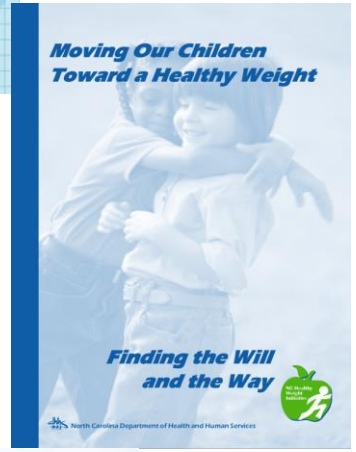
Carolyn Dunn, PhD, RDN, LDN

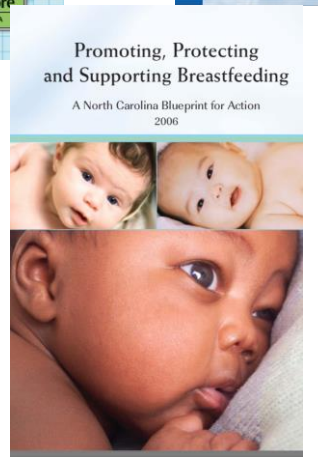
A NEW State Plan to guide our work in the area of obesity and chronic disease.

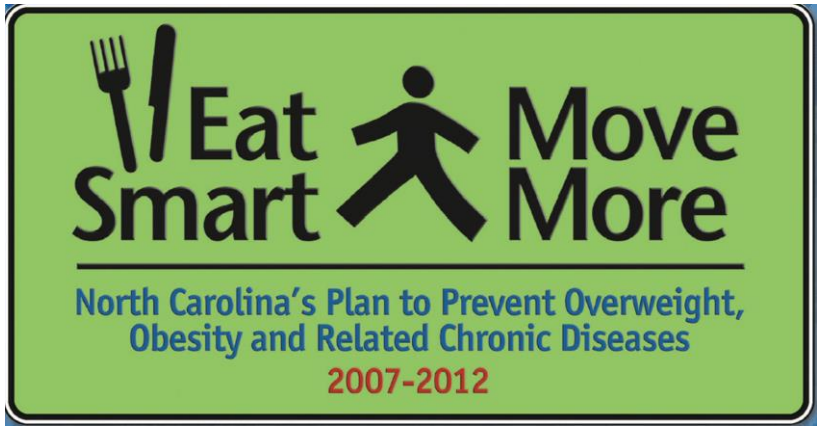
Working together to reverse the rising tide of obesity and chronic disease among North Carolinians by helping them to eat smart, move more and achieve a healthy weight.


North Carolina's Plan to Address Obesity:
Healthy Weight and Healthy Communities
2013–2020
Eat Smart Move More
NORTH CAROLINA
Making the Healthy Choice the Easy Choice


North Carolina Blueprint For Changing Policies And Environments In Support Of
INCREASED PHYSICAL ACTIVITY
Eat Smart Move More
NORTH CAROLINA
North Carolina Blueprint For Changing Policies And Environments In Support Of
HEALTHY EATING
Eat Smart Move More
NORTH CAROLINA


Moving Our Children Toward a Healthy Weight
Finding the Will and the Way
North Carolina Department of Health and Human Services


Promoting, Protecting and Supporting Breastfeeding
A North Carolina Blueprint for Action
2006


Eat Smart Move More
North Carolina's Plan to Prevent Overweight, Obesity and Related Chronic Diseases
2007-2012

Why a new plan NOW?

- New State Plan
- New Website
- New Data Plan

The Writing Team

Kathy Kolasa, PhD, RDN, LDN
Professor Emeritus
Brody School of Medicine, East Carolina University

Sheree Vodicka, MPH, RDN, LDN
Chief Executive Officer
NC Alliance of YMCA's

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Worksite Wellness and Early Care and Education Coordinator
NC Division of Public Health

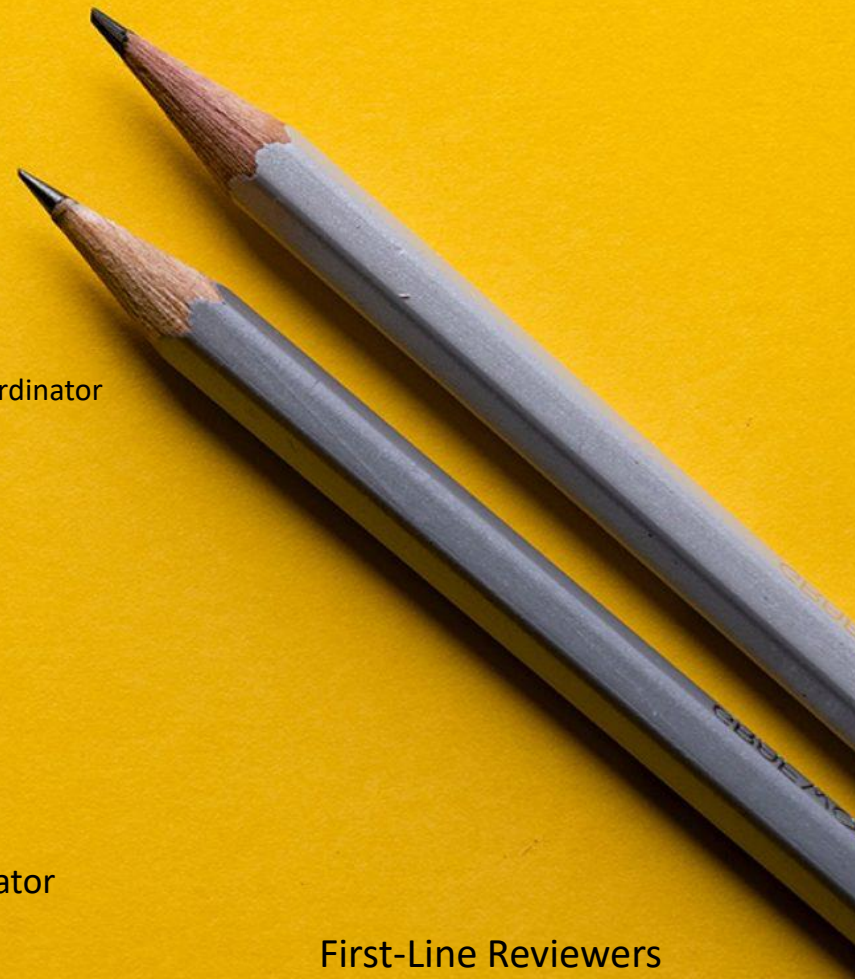
Cathy Thomas, MAEd
Branch Manager
NC Division of Public Health

Melissa Rockett, MPA
Built Environment Coordinator
NC Division of Public Health

Catherine Hill, MS, RDN, LDN
Healthy Eating and Communications Coordinator
NC Division of Public Health

Carolyn Dunn, PhD, RDN, LDN
William Neal Reynolds Distinguished Professor and Head
NC State University

Jenni Albright, MPH, RDN, LDN
Eat Smart, Move More Coordinator



First-Line Reviewers

Tekeela Greeen, PhD, MPH, CHES
Consultant

Diane Beth, MS, RDN, LDN
Nutrition Program Consultant
NC Division of Public Health

Time Line

- Request for writing team members.
- Writing team works to create draft (first of 3 meetings March
- Draft goes to first-line reviewers (mid July).
- Draft to Executive Committee (week of July 22).
- ESMMNC meeting presentation (Sept 12).
- Plan goes out to entire membership. (Sept 15).
- Plan goes to several key leaders in medicine, CDC, USDA.
- Comments due back from all October 11.
- Writing team reconvenes to edit based on comments.
- Plan goes to print in time for December 5, 2019 release.

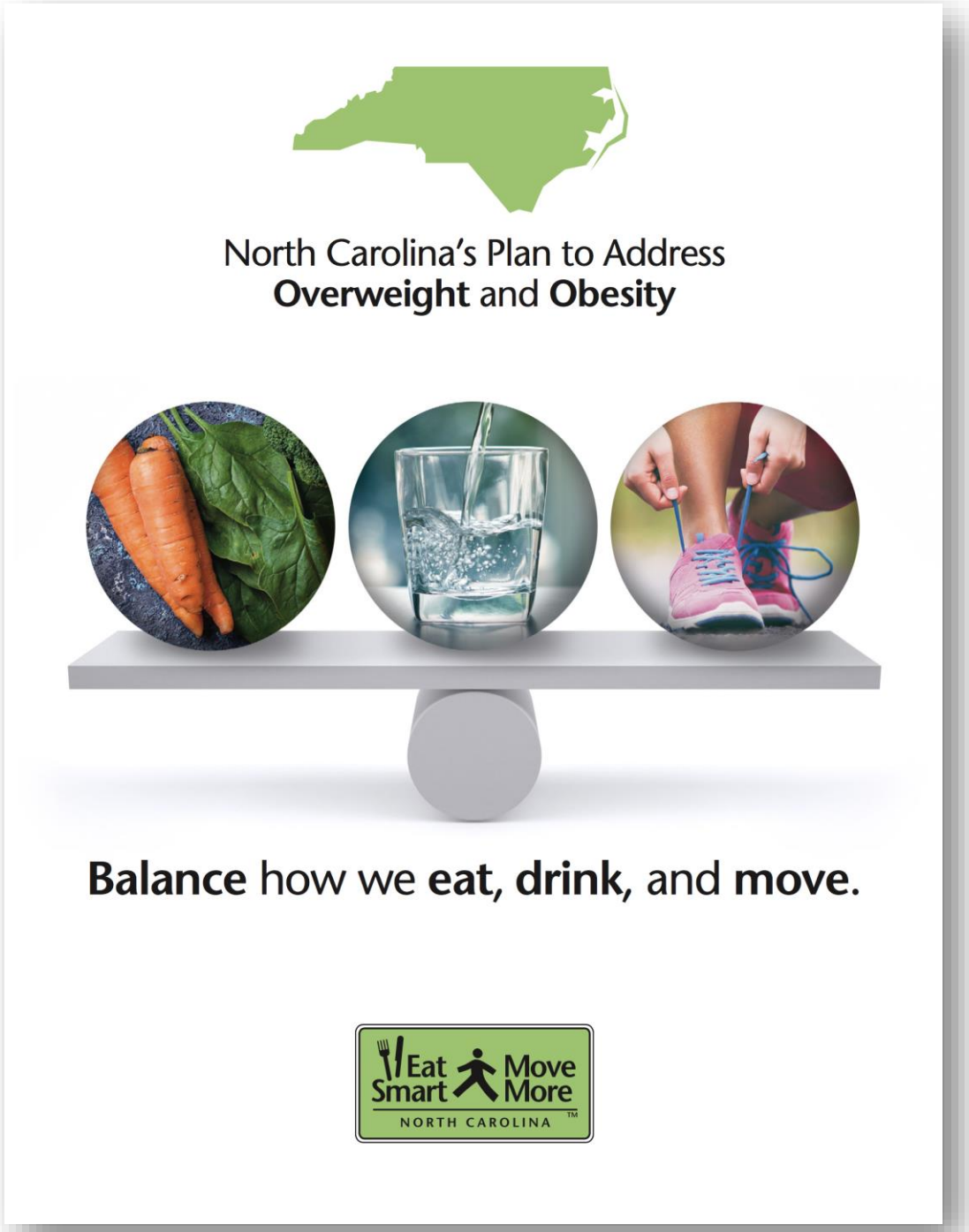
How to submit your REVIEW

- Email a list of suggestions.
- Use place sticky notes or other editing tools in the pdf.
- Cut and paste sections into MS Word and use track changes.

We need your input: choose YOUR way to provide feedback.

Due back to **Carolyn_Dunn@ncsu.edu** on or before **OCTOBER 11.**

Be as detailed as you want, as high level as you want, as brief or long as you want…just PLEASE review.



Our NEW State Plan
DRAFT

Overweight and Obesity **Defined**

Overweight

Adults (aged 20 years and older):
BMI* between 25 and 29.9

Children (aged 2–19 years):
BMI ≥ 85th percentile and < 95th percentile for children of the same age and sex

Obese

Adults (aged 20 years and older):
BMI 30 or higher

Children (aged 2–19 years):
BMI ≥ 95th percentile for children of the same age and sex

*BMI = body mass index, an approximate index of body fat. The formula for calculating BMI is:
weight (kg) / [height (m)]^2
or weight (lb) / [height (in)]^2 x 703

2 out of 3 adults in North Carolina are overweight or obese.[1]

5 million adults in North Carolina (67%) are overweight or obese.

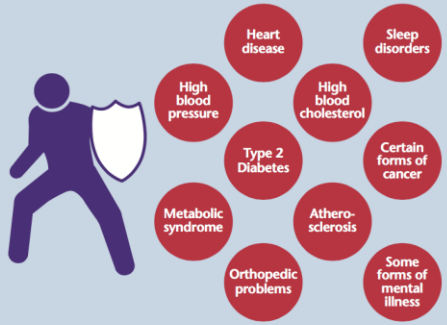
An estimated 30% of children ages 10 to 17 in North Carolina are overweight or obese.[2]

PREVENTABLE COST OF Obesity

Obesity and Obesity-related Conditions

Practicing a healthy lifestyle is linked to decreasing the leading causes of preventable death.[3]

A healthy lifestyle can decrease the risk of:[4]



Type 2 Diabetes in North Carolina

Over 50,000 adults in North Carolina are newly diagnosed with Type 2 diabetes each year.

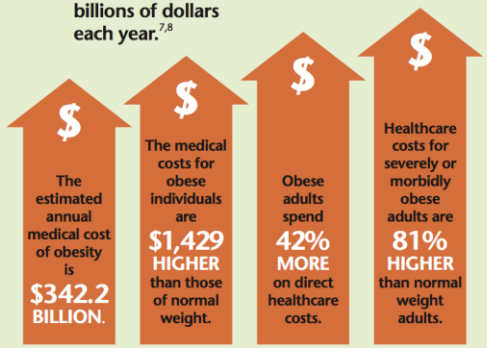
87% of adults in North Carolina with Type 2 diabetes are overweight or obese.[5,6]

NEW CASES OF TYPE 2 DIABETES EVERY YEAR IN NC

87% OF ADULTS IN NORTH CAROLINA WITH TYPE 2 DIABETES ARE OVERWEIGHT OR OBESE

Obesity Increases Medical Costs

Obesity and its associated preventable conditions cost the United States billions of dollars each year.[7,8]



Impact on Employer Productivity

Obesity contributes to an increase in both job absenteeism and presenteeism.

Job presenteeism costs employers 10 times more than absenteeism.[9,10]

Core Behaviors

Core Behaviors

Move More[11]

Physical activity is critical for lifelong weight management and overall health. Physical activity refers to any bodily movement that requires energy expenditure, whether it's for work or play, daily chores, or daily commuting. Because of its role in energy balance, physical activity is a critical factor in determining whether a person can maintain a healthy weight, lose excess weight, or sustain weight loss. Adults need at least 150 minutes of moderate-intensity physical activity per week and should perform muscle-strengthening activities at least two days a week. Adults who want to maintain weight loss or lose more than 5% of their body weight should increase their moderate-intensity aerobic physical activity to at least 300 minutes per week. People with chronic conditions or disabilities who are not able to follow the key guidelines for adults should adapt their physical activity program to match their abilities, in consultation with a healthcare professional or a physical activity specialist. Children ages 6 to 17 need at least 60 minutes of physical activity every day and should get a mix of bone strengthening, muscle building, and aerobic activities.

MOVE YOUR WAY

Adults need a mix of physical activity to stay healthy.

Walk. Run. Dance. Play.

What's your move?

Moderate-intensity aerobic activity*

Anything that gets your heart beating faster counts.

at least **150** minutes a week

AND

Muscle-strengthening activity

Do activities that make your muscles work harder than usual.

at least **2** days a week

*If you prefer vigorous-intensity aerobic activity (like running), aim for at least **75 minutes a week.**

If that's more than you can do right now, **do what you can.** Even 5 minutes of physical activity has real health benefits.

Eat more healthy foods, less junk and fast food[12-14]

Today's typical American diet is often higher in calories than needed and consists of food and beverage choices that lack nutrient-density. These empty calories are mostly from unhealthy fat and sugar. Similar to a financial budget, food choices can be evaluated by their cost to a daily calorie budget. In these terms, foods high in empty calories are also "expensive" calorie choices that may not fit into a daily calorie budget. Tracking food choices can help determine when and how many calories to spend. To meet vital nutrient needs while staying within a calorie budget, choose more nutrient dense foods, close to their natural state such as fruits, vegetables, nuts, seeds, lean meats, and low-fat dairy, and limit empty calorie foods.

Eat more fruits and vegetables[13-16]

Fruits and vegetables in their natural state are low in calories and high in vitamins and minerals. Eating a diet rich in fruits and vegetables makes it easier to consume fewer calories. The consumption of low-calorie foods such as fruits and vegetables is associated with better weight management. It is recommended to eat 2 cups of fruit and 2½ cups of non starchy vegetables each day, whether fresh, frozen, canned or dried. It is important to choose a variety of colors, with an emphasis on deep green and orange fruits and vegetables, such as spinach, kale, collards, turnip greens, arugula, cantaloupe, and carrots.

Drink more water[13,17-23]

Sugar sweetened beverages include any drink that is sweetened with any form of sugar: i.e., corn sweetener, corn syrup, dextrose, fructose, high-fructose corn syrup, honey, or sugar. This includes but is not limited to lemonade, sweet tea, cola, sports drinks, energy drinks. Sugar-sweetened beverages are the leading source of added sugar in the American diet. Sugar-sweetened beverages are ubiquitous in our society and are consumed by an estimated 49% of adults and 63% of children daily. Drinking sugar-sweetened beverages is associated with weight gain, obesity, and type 2 diabetes. Limiting sugar-sweetened beverages can help maintain weight and protect against weight gain. Make water your go-to beverage.

Sit less[11,24]

One in four adults sits for over eight hours per day. This sedentary lifestyle, regardless of physical activity, can increase the risk of cardiovascular disease and all-cause mortality in adults. The more sedentary a person is, the less likely they are to maintain a healthy weight. Moving more and sitting less, even short episodes of physical activity, has proven immediate and long-term health benefits. Light-intensity physical activity can be a beneficial first step in replacing sedentary behavior. Given the high levels of sitting and low levels of physical activity in the US population, most people would benefit from sitting less and moving more. When adults with chronic conditions or disabilities are not able to meet the above key guidelines, they should engage in regular physical activity according to their abilities and should avoid inactivity.

Start and continue to breastfeed[25-28]

The health benefits of breastfeeding are well documented. Breastfeeding is associated with a decreased rate of childhood, adolescence, and adulthood overweight and obesity. The duration (the length of time a child is breastfed) and exclusivity (providing only human milk) of breastfeeding are both linked to reducing childhood obesity risk by up to 25%.

Get enough sleep[29-33]

Insufficient sleep is a widespread problem in the US with as many as one in three adults not getting at least seven hours. Sleep is a restorative process and plays an important role in overall health of the entire body and mind. There is a growing body of evidence on the importance of sleep as it relates to increased risk of obesity. There is a link between low sleep quality and short sleep duration (less than 7 hours) to increased risk of obesity and poor obesity treatment outcomes. Poor sleep (either duration or quality) results in many metabolic and endocrine alterations that can impact risk of obesity. Improving sleep quality and quantity is important in addressing overweight and obesity.

Manage stress[34-37]

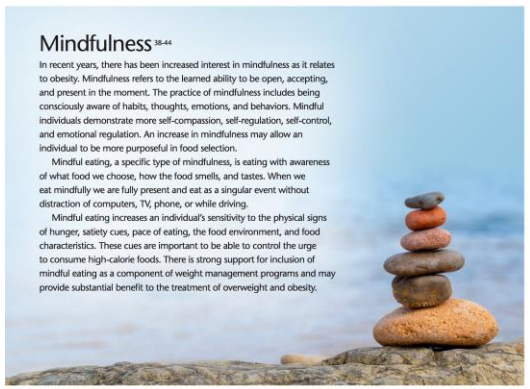
High levels of stress are common in our society. Demands from work and family may cause stress. There are added stress burdens in those who are living in poverty or are food insecure. Stress has been linked to overweight and obesity through multiple interactions. The stress hormone cortisol is secreted during times of stress. This hormone causes higher levels of insulin and can trigger overeating. Stress also interferes with cognitive processes including self regulation. Stress also causes physiological changes that may be related to overweight and obesity, including changes to hunger and satiety hormones as well as changes to the gut microbiome. Studies have shown a relationship between stress and weight in children and adults. Managing stress through mindfulness, physical activity, or other means is an important part of addressing overweight and obesity.

Mindfulness[38-44]

In recent years, there has been increased interest in mindfulness as it relates to obesity. Mindfulness refers to the learned ability to be open, accepting, and present in the moment. The practice of mindfulness includes being consciously aware of habits, thoughts, emotions, and behaviors. Mindful individuals demonstrate more self-compassion, self-regulation, self-control, and emotional regulation. An increase in mindfulness may allow an individual to be more purposeful in food selection.

Mindful eating, a specific type of mindfulness, is eating with awareness of what food we choose, how the food smells, and tastes. When we eat mindfully we are fully present and eat as a singular event without distraction of computers, TV, phone, or while driving.

Mindful eating increases an individual's sensitivity to the physical signs of hunger, satiety cues, pace of eating, the food environment, and food characteristics. These cues are important to be able to control the urge to consume high-calorie foods. There is strong support for inclusion of mindful eating as a component of weight management programs and may provide substantial benefit to the treatment of overweight and obesity.



Be Part of the SOLUTION

Hunger-Obesity Paradox[45]

Hunger, food insecurity, and obesity can co-exist in the same individual, family, or community. Low-income individuals and families are particularly vulnerable to both food insecurity and obesity. While researchers continue to examine this relationship, several reasons for this paradox have emerged:

- Lack of access to affordable, healthy foods
- Cycles of food deprivation and overeating
- High levels of stress, anxiety, and depression
- Fewer opportunities for physical activity
- Greater exposure to marketing of obesity-promoting products
- Limited access to health care

You

Eat smart and move more to achieve and maintain a healthy weight. Track your steps or minutes of exercise each day. Include fruits and vegetables at every meal. Set a specific goal, accomplish it, and set another one. Focus on progress, not perfection.

Your Family and Friends

Plan and fix simple healthy meals make healthy snacks easy to "grab and go." Meet a friend for a walk, or start a walking group in your neighborhood or workplace. Explore local parks and playgrounds. Find outdoor or indoor recreational activities that are fun for you and your family.

The Places You Go

Make it easier and safer for people to walk, whether at the office, in the neighborhood, or to and from school. Advocate for more walking paths, trails, sidewalks and greenways. Help make fruits and vegetables accessible to all including mobile markets and farmers markets. When serving meals or snacks, offer water and healthy food options. Make healthy choices possible for your employees, clients, patients, or students.

Strategies

Strategies are presented that represent the best available evidence. An extensive review was conducted to assure that the most up to date resources were used. This included personal contacts with national leaders at CDC and USDA. See page 20 for the documents used.

Healthcare
Caring for others

Childcare
Caring for the children

Schools
Caring for students, teachers, and staff

Worksite
Caring for employees

Colleges and Universities
Caring for students, staff, and faculty

Community
Caring for its members

Local and State Government
Caring for residents

Food and Beverage Industry
Make healthy choices possible

Media and Entertainment Industry
Promote healthy lifestyles

Determinants of Health Model

If we are going to be successful at preventing or treating obesity, we must find solutions to challenges facing individuals, families and communities that directly correlate to where and how they live. We have learned that a person's zip code is as much a predictor of their health and lifespan as their genetic code—or more so. **We must consider:**

NEIGHBORHOOD DESIGN including housing, transportation, safety, parks, and walkability

EDUCATIONAL OPPORTUNITIES that lead to greater economic prosperity

ACCESS TO HEALTHY FOOD that leads to reduced hunger and food insecurity

THE EFFECT OF TOXIC STRESS created by social dynamics

Individuals' and families' SUPPORT SYSTEMS and social connections

ACCESS TO HEALTH CARE and how the quality of that care impacts individuals' and families' ability to achieve and maintain overall good health, leading to healthy, active lifestyles

EMPLOYMENT OPPORTUNITIES that provide a living wage for individuals and families.

How to submit your REVIEW

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NC Institute of Medicine

Task Force on Accountable Care Communities

Adam Zolotor, MD, DrPH

Task Force on Accountable Care Communities

Adam Zolotor, MD, DrPH

President & CEO

September 12, 2019

Eat Smart Move More Quarterly Meeting

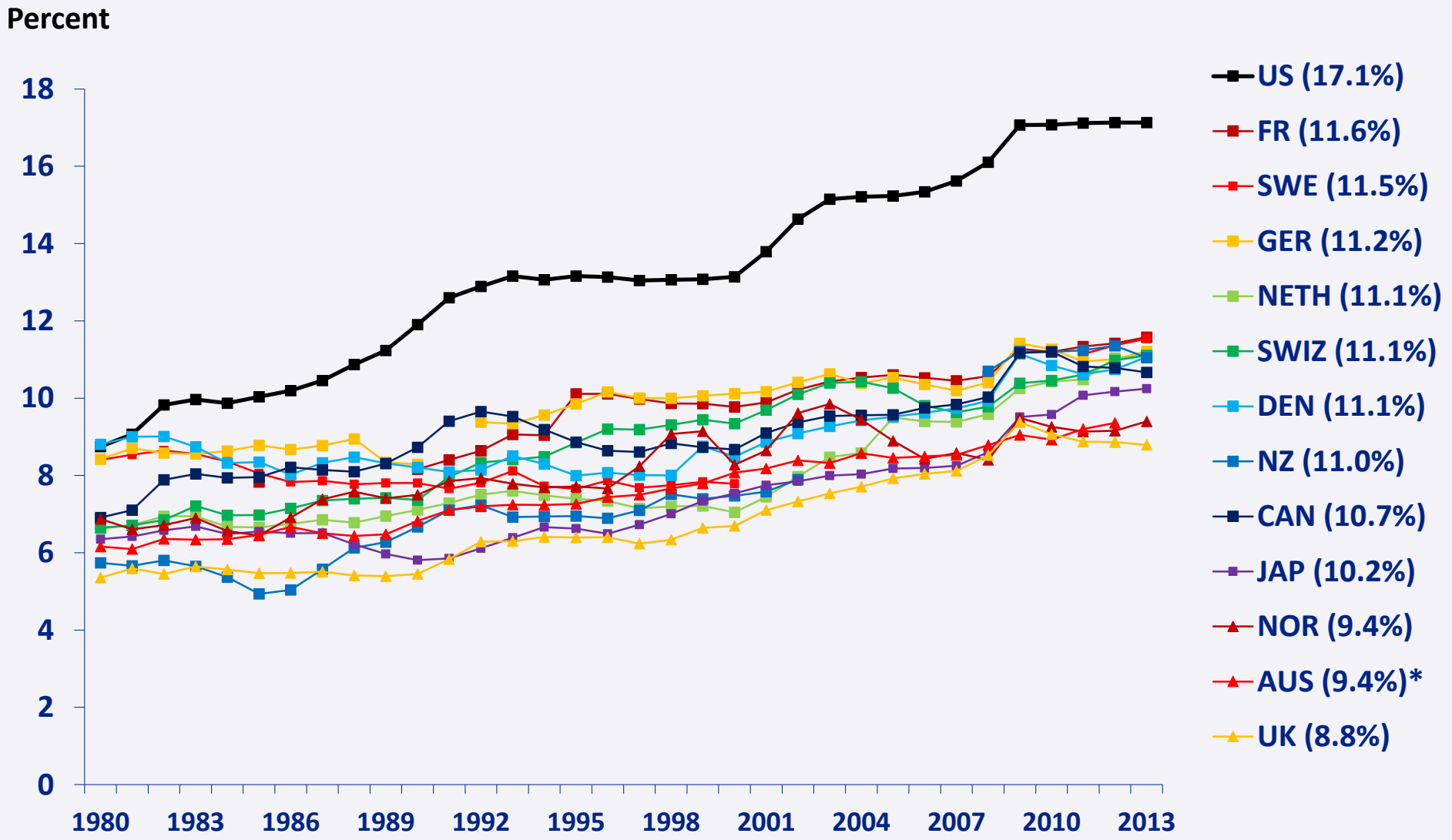
NC Institute of Medicine

- Quasi-state agency chartered in 1983 by the NC General Assembly to:
  - Be concerned with the health of the people of North Carolina
  - Monitor and study health matters
  - Respond authoritatively when found advisable
  - Respond to requests from outside sources for analysis and advice when this will aid in forming a basis for health policy decisions

NCGS §90-470

NCIOM

Exhibit 1. Health Care Spending as a Percentage of GDP, 1980–2013



* 2012.

Notes: GDP refers to gross domestic product. Dutch and Swiss data are for current spending only, and exclude spending on capital formation of health care providers.

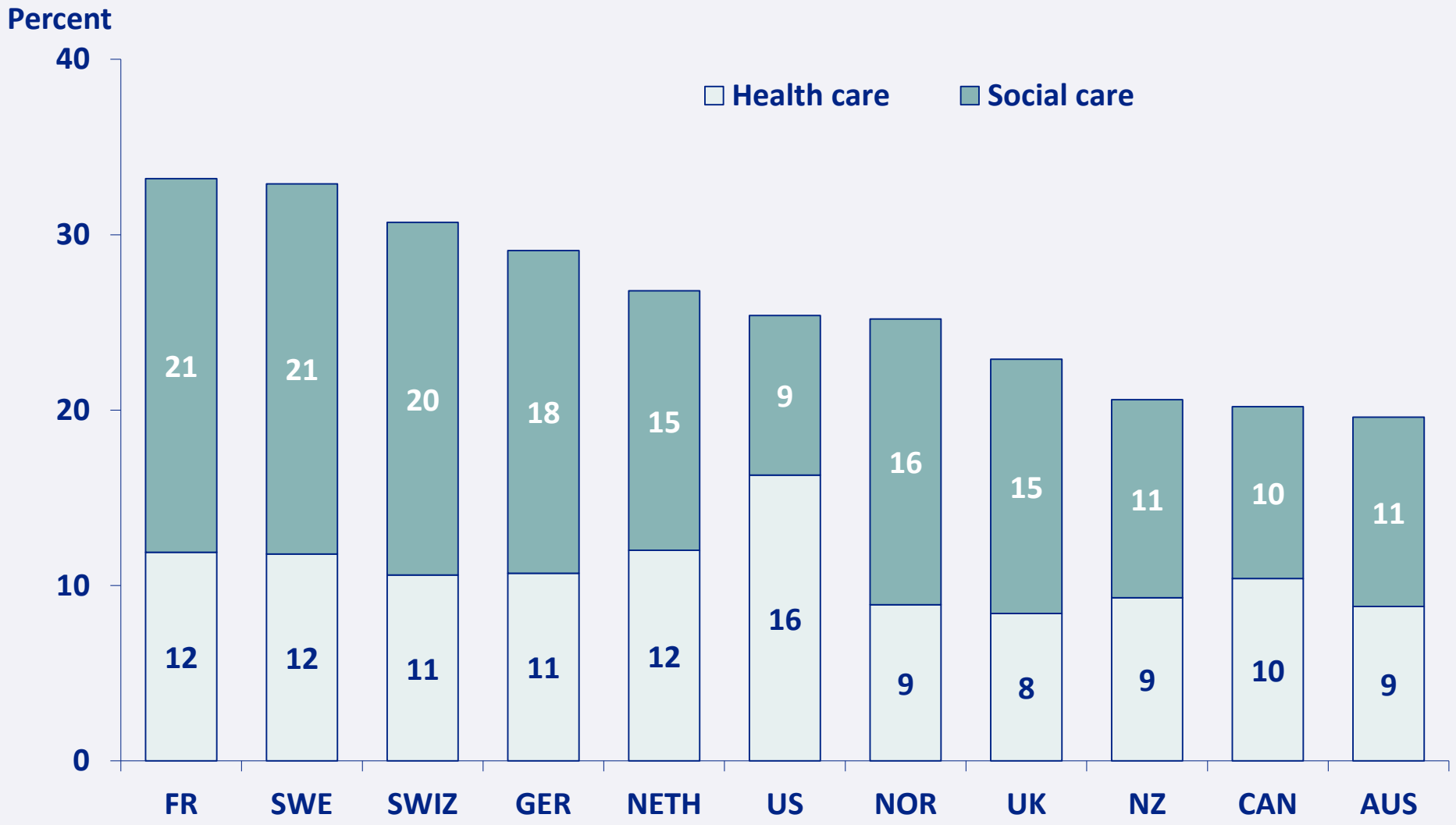
Source: OECD Health Data 2015.

Exhibit 9. Select Population Health Outcomes and Risk Factors

	Life exp. at birth, 2013[a]	Infant mortality, per 1,000 live births, 2013[a]	Percent of pop. age 65+ with two or more chronic conditions, 2014[b]	Obesity rate (BMI>30), 2013[a,c]	Percent of pop. (age 15+) who are daily smokers, 2013[a]	Percent of pop. age 65+
Australia	82.2	3.6	54	28.3[e]	12.8	14.4
Canada	81.5[e]	4.8[e]	56	25.8	14.9	15.2
Denmark	80.4	3.5	—	14.2	17.0	17.8
France	82.3	3.6	43	14.5[d]	24.1[d]	17.7
Germany	80.9	3.3	49	23.6	20.9	21.1
Japan	83.4	2.1	—	3.7	19.3	25.1
Netherlands	81.4	3.8	46	11.8	18.5	16.8
New Zealand	81.4	5.2[e]	37	30.6	15.5	14.2
Norway	81.8	2.4	43	10.0[d]	15.0	15.6
Sweden	82.0	2.7	42	11.7	10.7	19.0
Switzerland	82.9	3.9	44	10.3[d]	20.4[d]	17.3
United Kingdom	81.1	3.8	33	24.9	20.0[d]	17.1
United States	78.8	6.1[e]	68	35.3[d]	13.7	14.1
OECD median	81.2	3.5	—	28.3	18.9	17.0

[a] Source: OECD Health Data 2015.
[b] Includes: hypertension or high blood pressure, heart disease, diabetes, lung problems, mental health problems, cancer, and joint pain/arthritis. Source: Commonwealth Fund International Health Policy Survey of Older Adults, 2014.
[c] DEN, FR, NETH, NOR, SWE, and SWIZ based on self-reported data; all other countries based on measured data.
[d] 2012. [e] 2011.

Exhibit 8. Health and Social Care Spending as a Percentage of GDP



Notes: GDP refers to gross domestic product.

Source: E. H. Bradley and L. A. Taylor, *The American Health Care Paradox: Why Spending More Is Getting Us Less*, Public Affairs, 2013.

ACC Task Force

- Co-Chairs: Secretary Mandy Cohen, Mr. Reuben Blackwell, Dr. Ron Paulus, Mayor Miles Atkins
- Funded by The Duke Endowment and Kate B. Reynolds Chartable Trust
- 12 meetings through 2018.
- Task force: 53 members, broad constituencies: health, health care, faith, transit, housing, food, faith, wellness

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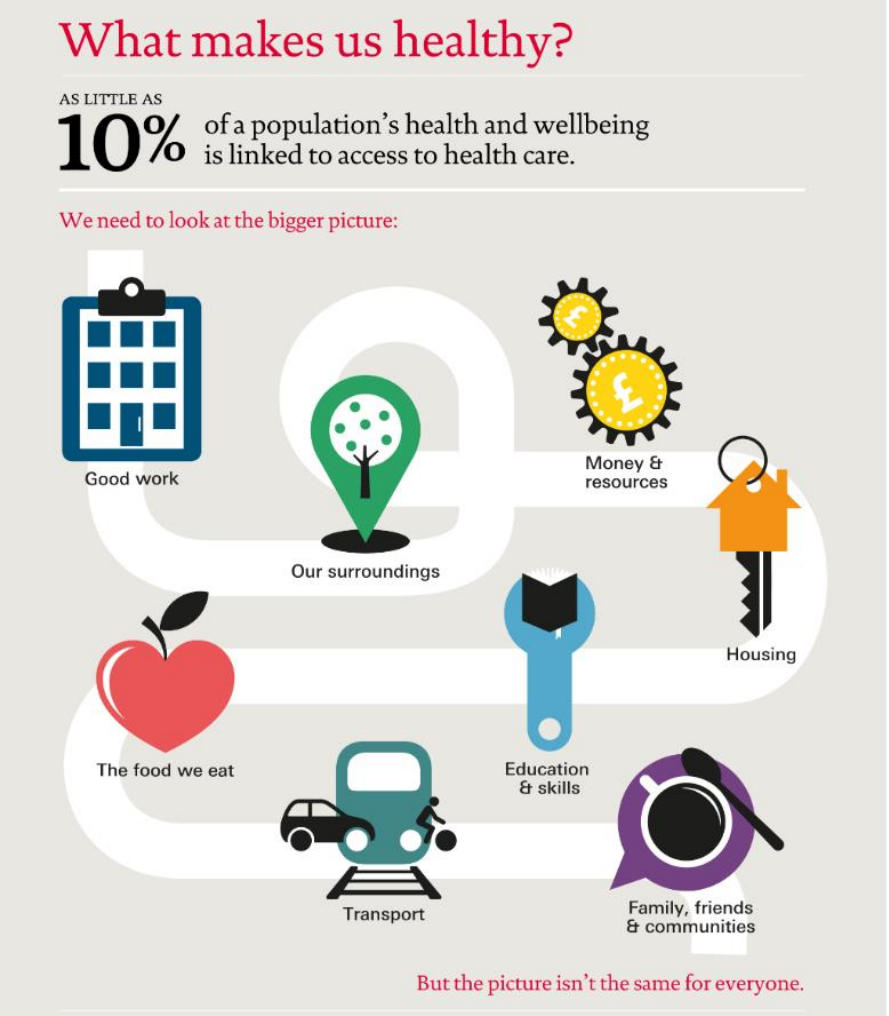
Public Health 3.0

US DHHS Public Health 3.0

Model in which **leaders serve as Chief Health Strategists, partnering across multiple sectors** and leveraging data and resources **to address social, environmental, and economic conditions that affect health and health equity**[28]



Health Begins Where We Live, Learn, Work and Play

National Association of County Health Officials

Putting Public Health 3.0 into Action, Recommendation 2

Cultivate Cross-Sector Partnerships

- Engage with public and private community partners to diversify resources and foster collective action

Cross-sector Partnerships to Address Barriers to Health

Accountable Care Community model:

- bring together
  - traditional health care with its focus on preventing and treating illness,
  - community-based partners whose focus is on creating the conditions necessary for good health, and
  - those who purchase and pay for health care

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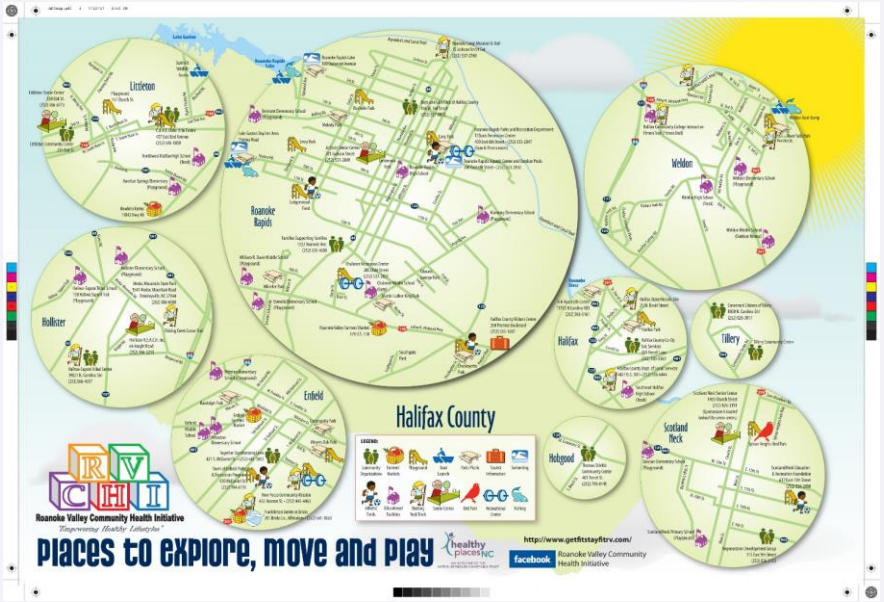
Accountable Care Communities

Accountable Care Communities (ACCs) address health from a community perspective. ACCs bring together a coalition of cross-sector stakeholders that share responsibility to address the drivers of health while reducing, or holding steady, health spending.



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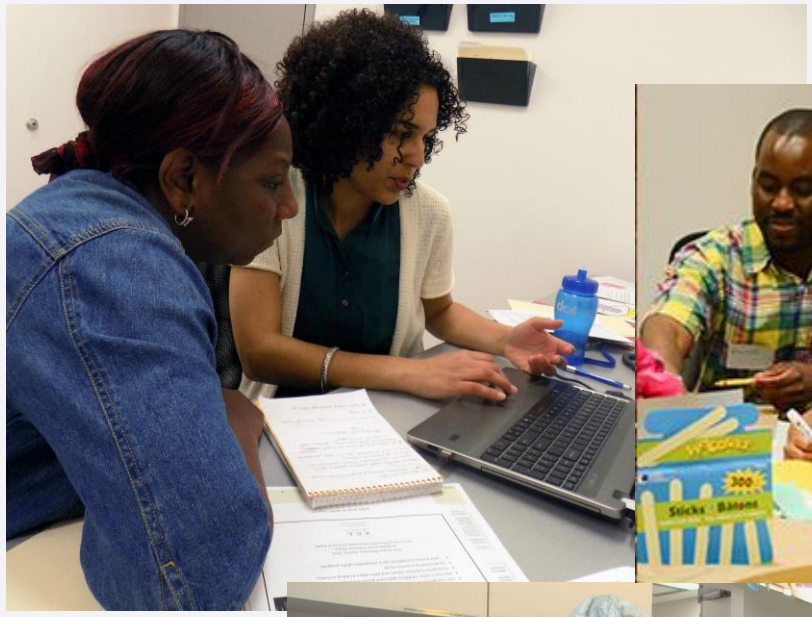
Examples of Accountable Care Communities

DC P★A★C★T
POSITIVE ACCOUNTABLE COMMUNITY TRANSFORMATION

DC PACT (Positive Accountable Community Transformation) is a coalition effort of community providers, including social service non-profits, faith institutions, behavioral health providers, hospitals, and community health centers, in partnership with multiple District government agencies including the Department of Health Care Finance, Department of Human Services, Department of Behavioral Health, and Department of Disability Services.

- DC Primary Care Association serves as the Collective Impact "backbone" organization, guided by an Advisory Council.
- DC PACT seeks to identify and address social challenges that create health disparities by linking safety net provider organizations in the District.



Examples of Accountable Care Communities

CABARRUS HEALTH ALLIANCE

CHA unified diverse organizations—from the local hospital system to county parks and recreation programs, school districts, and the Faith Community Health Ministry—to deliver environmental health services, clinical services, and community education to people who are considered to be at risk for developing preventable health conditions.

- working in the domains of healthy behaviors and built environment to decrease both the percentage of adults who consume fewer than 5 servings of fruits and vegetables per day, and who report no exercise
  - working to increase the number of healthy corner stores, farmers markets accepting SNAP/EBT (Supplemental Nutrition Assistance Program/Electronic benefit transfer) benefits, facilities with joint use agreements, and physicians providing exercise prescriptions and referrals to local physical activity locations

Any community can form an ACC

- Existing groups that do similar work could choose to expand their mission to incorporate the goals of an ACC
  - Roanoke Valley Community Health Initiative, joint effort of area businesses, child and family agencies, and community-based organizations dedicated to addressing healthy eating habits and physical activity opportunities in the community that will have a lasting impact on health outcomes
- Local health departments are natural leaders
  - Cabarrus Health Alliance
  - US DHHS: local health department leaders should be Chief Health Strategists, partnering across multiple sectors
- Community organizations could spearhead
  - United Way, OIC, Housing Coalition, Ashe County Sharing Center
- Health Systems
  - Carolinas HealthCare System, Novant Health, and the Mecklenburg County Health Department decided to collaborate and focus on the public health priority areas within Mecklenburg County, also partnering with community organizaitons, such as the YMCA of Greater Charlotte, Project 658, and the Renaissance West Community Initiative

NCIOM

Any community can form an ACC

Potential Partners at the Table

- **Traditional health care**
  - Local health departments
  - Health care systems and providers
  - Safety net providers
  - ACOs
- **Community-based partners**
  - City and county government (Transportation, Parks and Rec, city council)
  - Local Education Agencies
  - Food banks, Area Agencies on Aging, Partnerships for Children,
- **Those who purchase and pay for health care**
  - Insurers (private insurance, Medicaid Prepaid Health Plans)
  - Employers (including county and city governments)
  - ACOs
  - LME/MCOs

Start where you are

- Ideally have all three buckets represented, BUT
- Every ACC will not start with all the necessary partners
- Any coalition can get ACC work started

Core Features of Accountable Care Communities

- **Assessment of Community Health:** analysis of community health issues to determine priorities
- **Education and Advocacy:** a plan and mechanism to advance community health and health equity by advocating for local policies and communicating with local government agencies about the health effects of policy across sectors.
- **Screening Tool:** a questionnaire to screen for health-related social needs.
- **Referral Process:** protocols to refer clients for services that can help meet their needs.
- **Navigation Services:** assistance for clients who have trouble accessing community services.
- **Tracking System:** ability to capture information about whether needs were met.
- **Outcomes Data and Analysis:** data at the individual or population level tracking health outcomes (e.g., number of hospital visits; school days missed); and analysis of the data to determine what programs and services work and have positive return on investment.
- **Financing:** analysis of return on investment can be used to develop financial models to support service delivery of both clinical and non-clinical services.
- **Governance:** collaborative organizations in an ACC should have a shared governance structure that affords shared decision-making, shared risk, and shared reward.

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Chapter 2 – Collaborating for Better Health

- **Rec 2.2 – Evaluate Health Equity Effects of ACCs and County-Based Programs and Activities**
  - NC Office of Minority Health and Health Disparities, ACCs, County departments
- **Rec 2.3 – Provide Guidance on Cross-Agency Collaboration to Address Drivers of Health**
  - Office of the Governor, ACCs
- **Rec 2.4 – Support Local Health Departments to be Leaders in ACCs**
  - **DPH, Association of LHDs, NCIPH**
- **Rec 2.5 – Report Results of Hospital and Health Care System Community Benefits**
  - **NCHA Foundation**
- **Rec 2.6 – Align Policies for State DHHS Regions and Understand Implications of Regionalized Programs on ACC Partner Participation**
  - **DHHS**
- **Rec 2.7 – Provide TA to ACCs and convene learning collaborative**

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Chapter 3 – NC Opportunities for Health

- **Rec 3.1 – Provide TA to Healthy Opportunities Pilots**
  - NC DHHS, with other state agencies and philanthropies, should provide or support TA for pilot participants to build capacity for cross-sector collaboration
- **Rec 3.2 – Develop Support for State Healthy Opportunities Initiatives**
  - NC DHHS, with partners, should educate enrollment brokers, payers, health care systems, providers, and human services orgs about the NC DHHS approach to health-related social needs, standardized screening questions, and NCCARE360

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Chapter 4 – Implementing Opportunities for Health

- **Rec 4.1 – Develop and Deploy the Standardized Screening Questions and NCCARE360**
- **Rec 4.2 – Ensure Individuals are Informed about Personal Data Collection and Sharing**
- **Rec 4.3 – Implement Screening and Referral Process Across Health Care Payers, Providers, Human Services, and Social Services Entities**
- **Rec 4.4 – Facilitate Data Sharing and Compatibility**
- **Rec 4.5 – Develop, Expand, and Support the Health Care Workforce to Better Address Health-Related Social Needs and Health Equity**
  - DHHS, NC AHEC, Community College System and others
- **Rec 4.6 – Strengthen the Human Services Sector**
  - Philanthropy and DHHS

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Chapter 5 – Evaluation and Process Improvement

- **Rec 5.1 – Evaluate Methods for Screening for Health-Related Social Needs**
  - DHHS
- **Rec 5.2 – Evaluate Data Gathered Through the Standardized Screening Process**
  - DIT and DHHS
- **Rec 5.3 – Evaluate Data Gathered Through NCCARE360**
  - NCCARE360 partners

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Chapter 6 – Funding and Financing Models

- **Rec 6.1/6.2/6.5 – Support Initial (transition/sustainability) Development of Local ACCs**
  - Philanthropy with support from PHPs, Medicaid, other payers, health systems, local businesses, local government.
- **Rec 6.3 – Support Medicaid Healthy Opportunities Pilots**
  - DHHS, NCGA, Philanthropy
- **Rec 6.4 – Analyze Data to Determine Costs and Benefits of Health-Related Social Services**
  - DIT, DHHS, PHPs

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How Accountable Care Communities Fit into North Carolina's Evolving Health Care System

NC Department of Health and Human Services

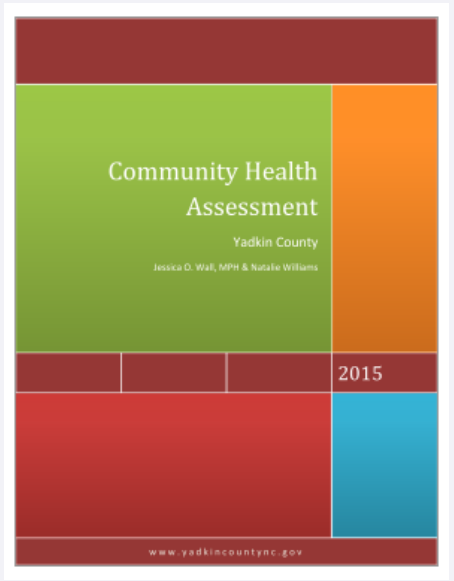
The Opportunity for Whole Person Health

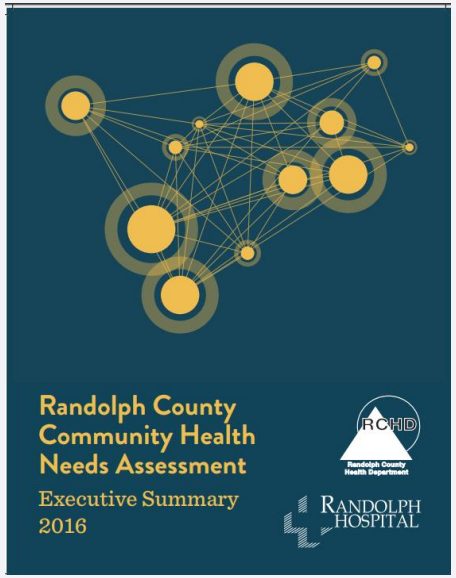
NC DHHS has developed a framework for providing "Healthy Opportunities" to all North Carolinians that will build much of the infrastructure needed for accountable care communities

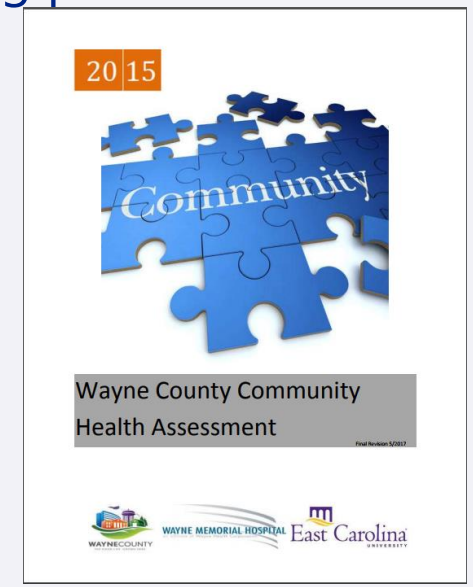
Assessment of Community Health

Community Health Assessments

- Conducted every 3-4 years by local health departments (LHD)
- Required as part of accreditation for LHD
- Have been conducted in North Carolina for more than 40 years
- Assessment and improvement planning process







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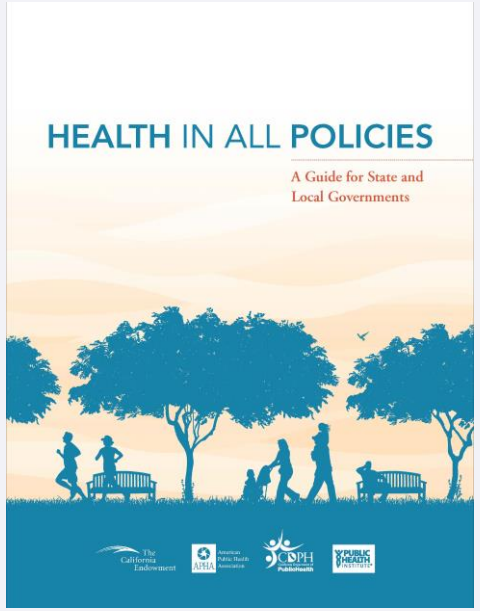
Education and Advocacy

Plan and mechanism to advance community health and health equity by advocating for local policies and communicating with local government agencies about the health effects of policy across sectors.

- Health in All Policies
  - Promote health, equity, and sustainability
  - Support intersectoral collaboration
  - Benefit multiple partners
  - Engage stakeholders
  - Create structural or process change



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Screening Tool

NC DHHS Standardize Screening Tool

Health Screening

We believe everyone should have the opportunity for health. Some things like not having enough food or reliable transportation or a safe place to live can make it hard to be healthy. Please answer the following questions to help us better understand you and your current situation. We may not be able to find resources for all of your needs, but we will try and help as much as we can.

	Yes	No
Food		
1. Within the past 12 months, did you worry that your food would run out before you got money to buy more?		
2. Within the past 12 months, did the food you bought just not last and you didn't have money to get more?		
Housing/ Utilities		
3. Within the past 12 months, have you ever stayed: outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (i.e. couch-surfing)?		
4. Are you worried about losing your housing?		
5. Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?		
Transportation		
6. Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living?		
Interpersonal Safety		
7. Do you feel physically and emotionally unsafe where you currently live?		
8. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by anyone?		
9. Within the past 12 months, have you been humiliated or emotionally abused by anyone?		
Optional: Immediate Need		
10. Are any of your needs urgent? For example, you don't have food for tonight, you don't have a place to sleep tonight, you are afraid you will get hurt if you go home today.		
11. Would you like help with any of the needs that you have identified?		

Medicaid Prepaid Health Plans will be required to use

NC DHHS encouraging statewide adoption

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Referral Process

NCCARE360

NCCARE360 is the first statewide coordinated network that includes a robust data repository of shared resources and connects healthcare and human services providers together to collectively provide the opportunity for health to North Carolinians.

NCCARE360 Partners:

Foundation for Health Leadership & Innovation
Moving people and ideas into action.

UNITE US

Expound

NCDHHS

NORTH CAROLINA 211

United Way
United Way of North Carolina

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Navigation Services

Assistance for clients who have trouble accessing community services

- Within Medicaid Prepaid Health Plans
  - Prepaid Health Plans will receive per member per month payments that will support the implementation of screening, referral, navigation assistance
- Many health systems and larger health care provider practices, as well as human service organizations, have care managers who may be able to meet some of the need for navigation services.

Tracking, Outcomes, Financing and Governance: Non-Medicaid

- Tracking, outcome measurement, financing and governance will vary greatly across ACC models
  - Hope that NC Health Connex will be able to fill the tracking and outcomes piece of this work to some degree.

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Tracking, Outcomes, Financing and Governance: Medicaid

- Under Medicaid Transformation, NC DHHS will track:
  - Health and health-related service receipt
  - Costs
  - Standardized screening tool data
  - Measure outcomes
- Within the Healthy Opportunities pilots, will also:
  - Experiment with new payment models
  - Develop a governance structure at the local level

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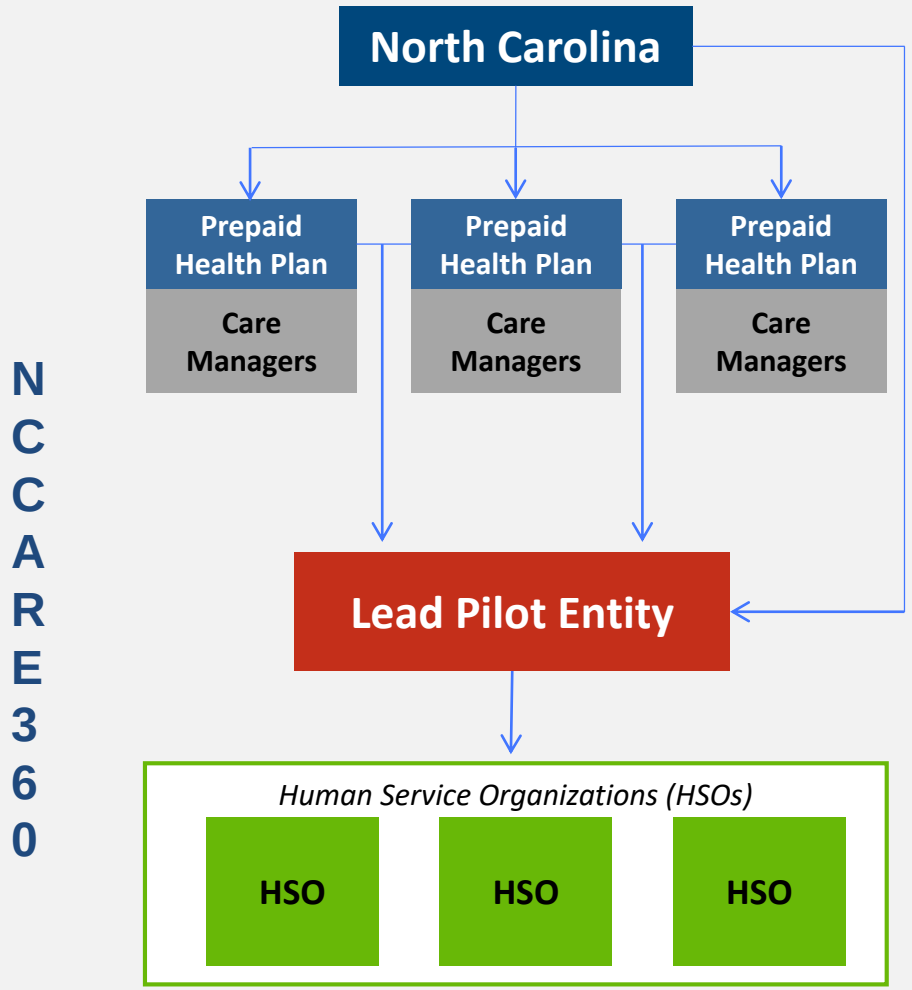
Healthy Opportunities Regional Pilots

Sample Regional Pilot



Pilot Overview

- Authorization to spend up to $650 million in 2-4 regions
- Test and scale to a population level evidence-based interventions designed to improve health and reduce costs more intensely addressing food insecurity, housing quality and instability, transportation insecurity, interpersonal violence and toxic stress
- For eligible Medicaid beneficiaries (health and social risk)
- Key pilot entities include:
  - North Carolina DHHS
  - Prepaid Health Plans (PHPs)
  - Care Managers (predominantly located at Tier 3 AMHs and LHDs)
  - Lead Pilot Entities
  - Human Service Organizations (HSOs)
- NCCARE360 part of the infrastructure

Overview of Approved Pilot Services

North Carolina's 1115 waiver specifies services that can be covered by the Pilot. Pilots will not be required to offer all approved services.

Housing

- Tenancy support and sustaining services
- Housing quality and safety improvements
- One-time securing house payments (e.g., first month's rent and security deposit)
- Short-term post hospitalization housing

Food

- Linkages to community-based food services (e.g., SNAP/WIC application support, food bank referrals)
- Nutrition and cooking coaching/counseling
- Healthy food boxes
- Medically tailored meal delivery

Transportation

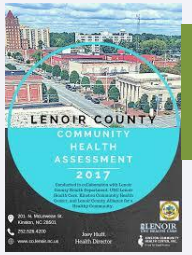
- Linkages to existing public transit
- Payment for transit to support access to pilot services, including:
  - Public transit
  - Taxis, in areas with limited public transit infrastructure

Interpersonal Violence

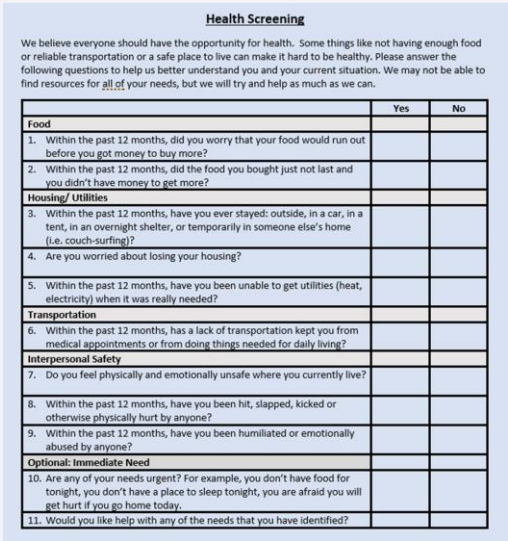
- Linkages to legal services for IPV related issues
- Evidence-based parenting support programs
- Evidence-based home visiting services

ACC Core Features Supported by NC DHHS

- ✓ **Assessment of Community Health**
- ❑ **Education and Advocacy**
- ✓ **Screening Tool**
- ✓ **Referral Process**
- ✓ **Navigation Services**
- ✓ **Tracking System**
- ✓ **Outcomes Data and Analysis**
- ✓ **Financing**
- ❑ **Governance**



Community Health Assessments



Health Screening

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MEDICAID

MEDICAID

Medicaid Managed Care core program element: Care Management

MEDICAID

HIE and Medicaid Transformation Evaluation

MEDICAID

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Medicaid Managed Care-Regional Pilots

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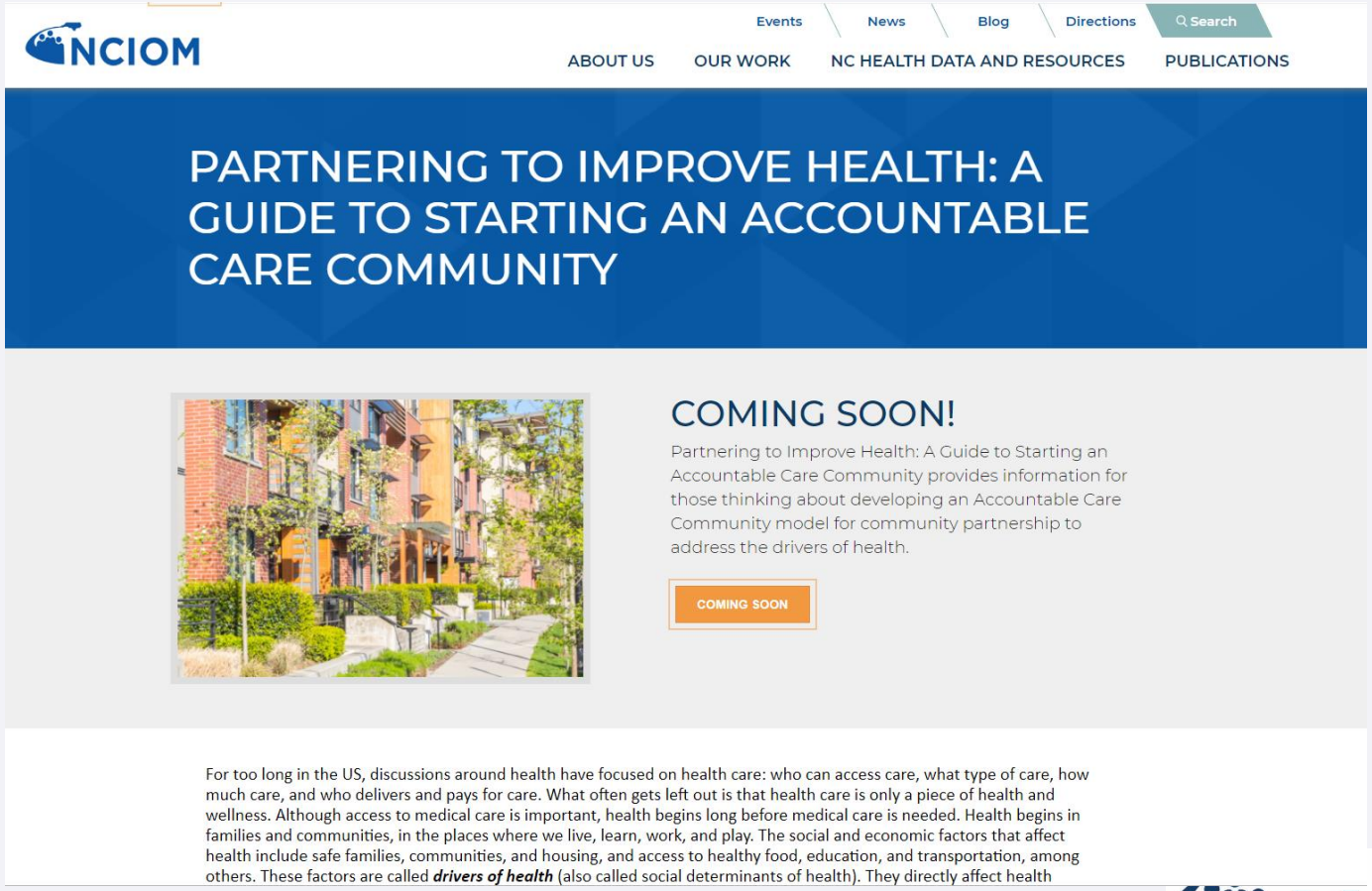
ACCs: A Guide to Getting Started

www.nciom.org/nc-health-data/guide-to-accountable-care-communities/



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ACCs: A Guide to Getting Started

- What is an ACC: core features and examples
- Building partnerships and engaging community
- Structure and governance
- Financing and sustainability
- Quick reference:
  - Screening
  - Referral
  - Workforce
  - IT infrastructure
  - Legal considerations
  - Assessment and evaluation
- Lots of helpful resources!

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For more information

- Websites: www.nciom.org
  www.ncmedicaljournal.com

- Key contacts:
  - Adam Zolotor, MD, DrPH, President and CEO, NCIOM
    919-445-6150 or adam_zolotor@nciom.org
  - Berkeley Yorkery, MPP, Associate Director
    919-445-6151 or berkeley_yorkery@nciom.org
  - Brieanne Lyda-McDonald, MPH, Project Director
    919-445-6154 or blydamcd@nciom.org

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NCCARE360 / Unite Us

Statewide Implementation Plans

Laura Marx
Megan Carlson

NCCARE360

A New Tool for a Healthier North Carolina

Laura Marx
CEO
United Way of NC/ NC 211

Megan Carlson
Community Engagement Manager
Unite Us

Abi Bussone
Community Engagement Manager
Unite Us

Building a Healthier North Carolina

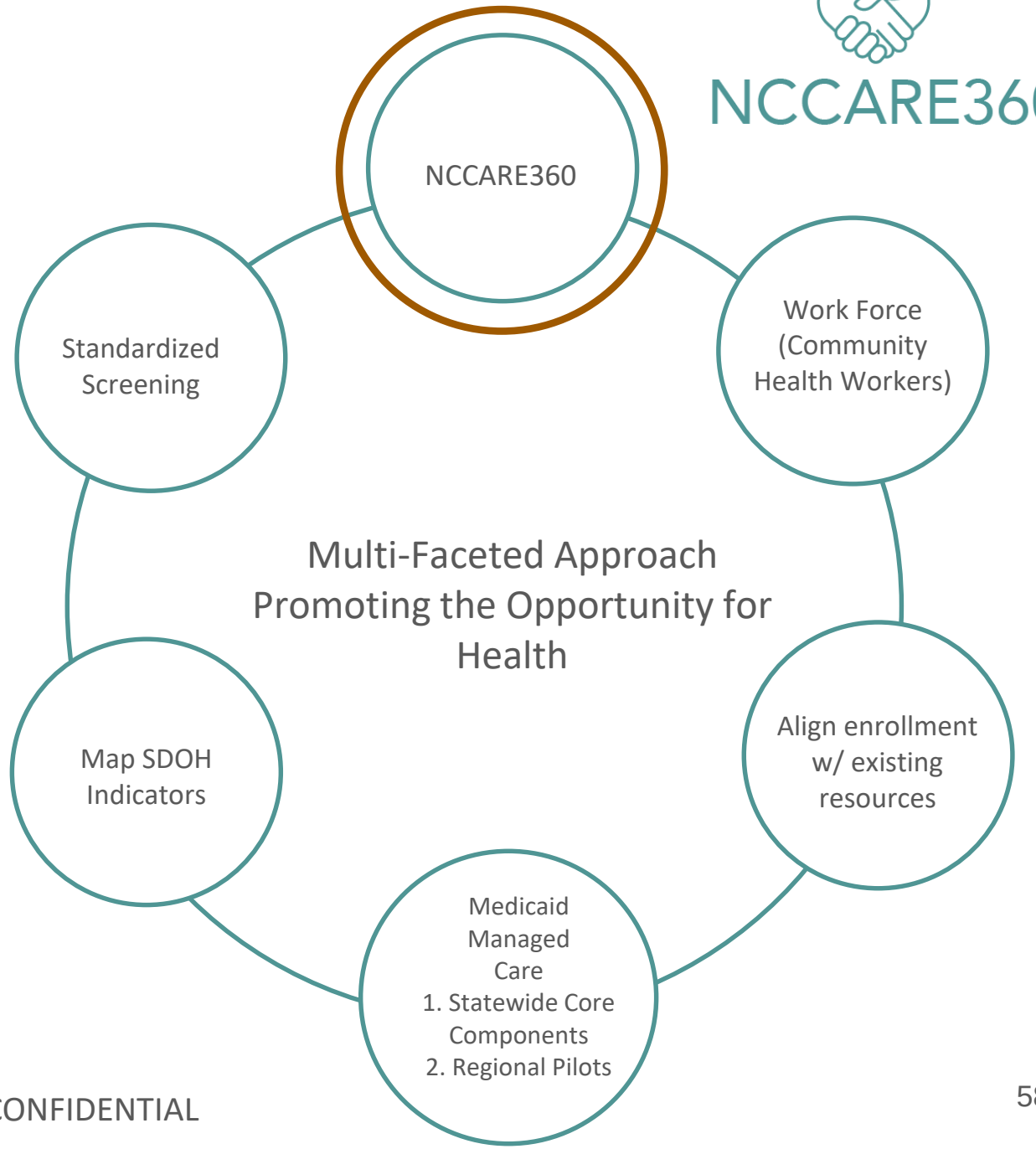
Part of a Broader Statewide Framework

The Problem:

Connecting people to community resources is inconsistent, not coordinated, not secure, and not trackable.

The Solution:

Uniform system for providers, insurers, and community organizations to coordinate care, collaborate, and track progress and outcomes. Tool to make it easier to connect people with the community resources they need to be healthy.



What is NCCARE360?

NCCARE360

NCCARE360 is the first statewide coordinated network that includes a robust data repository of shared resources and connects healthcare and human services providers together to collectively provide the opportunity for health to North Carolinians.

NCCARE360 Partners:

Foundation for Health Leadership & Innovation
Moving people and ideas into action.

UNITE US

Expound

NCDHHS

NORTH CAROLINA 211

United Way
United Way of North Carolina

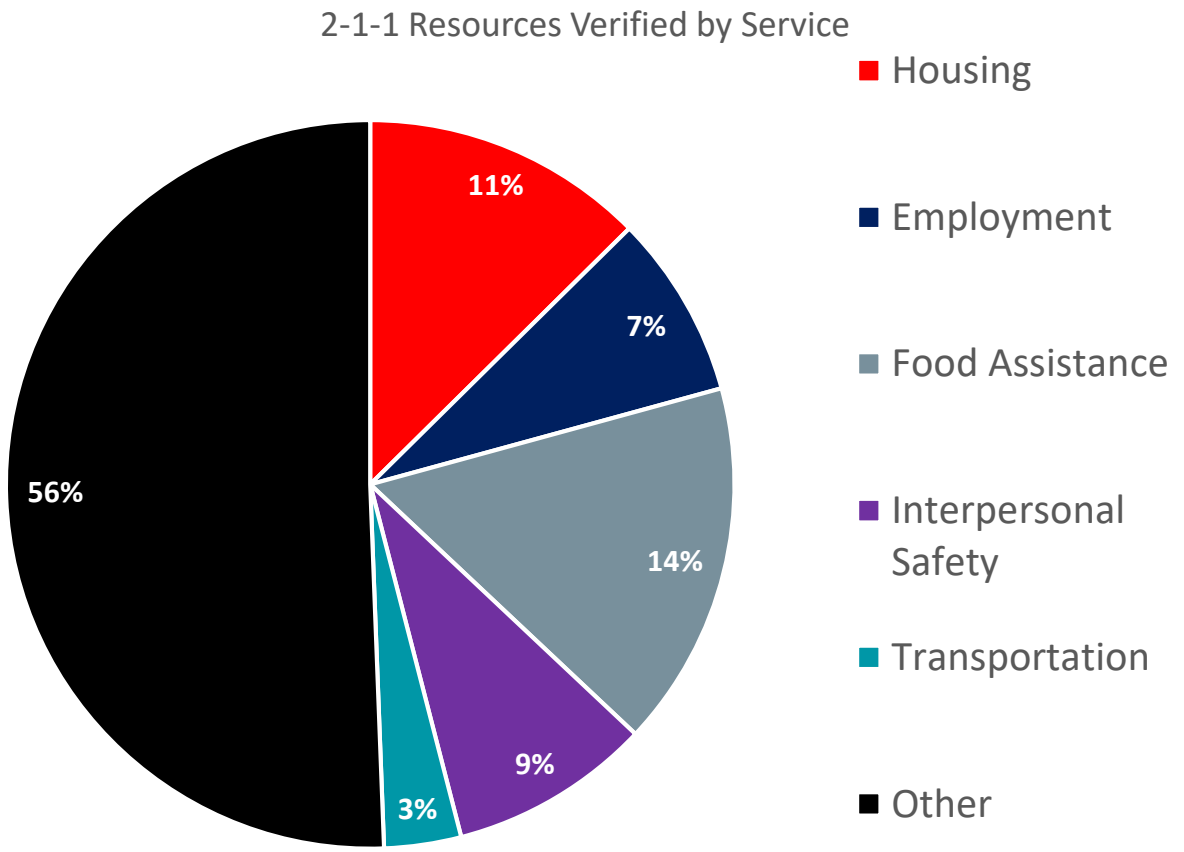
Three Functions

NCCARE360

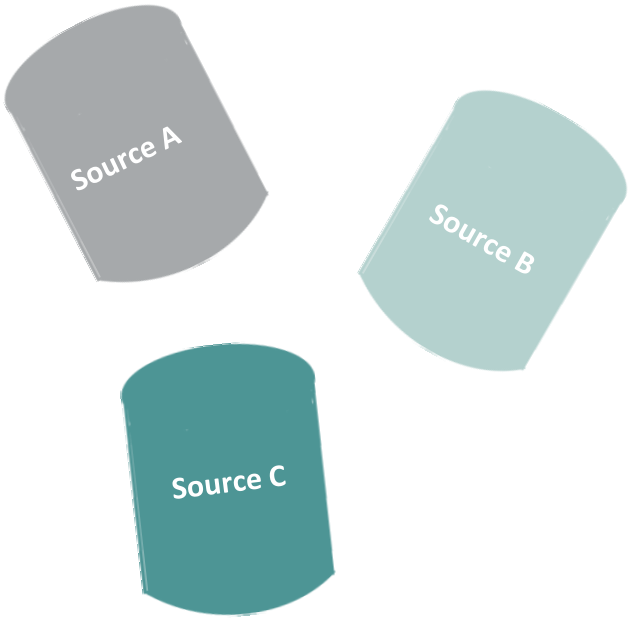
	Functionality	Partner	Timeline
Resource Directory	Directory of statewide resources verified by a professional data team adhering to AIRS standards	NORTH CAROLINA 211	Ongoing work
Call Center Support	24/7/365 call center with a team of NCCARE360 Navigators, and the addition of text and chat capabilities.		
Resource Repository	APIs integrate resource directories across the state to share resource data.	Expound	Phased Approach
Referral & Outcomes Platform **Community Engagement Managers**	Referral platform with closed loop functions. Community Engagement Managers for workflow, change management, continued in person support.	UNITE US	Rolled out by county January 2019 – December 2020

Resource Directory

- Building on NC 2-1-1 strengths
  - Robust 18,000 organization directory, call centers
- Growing Capacity
  - Additional data coordination staff Updating listings in current 2-1-1 directory
  - Additional call center staff navigators at scale
- Progress
  - 1699 Organizations verified
  - 4641 programs verified



Data Repository

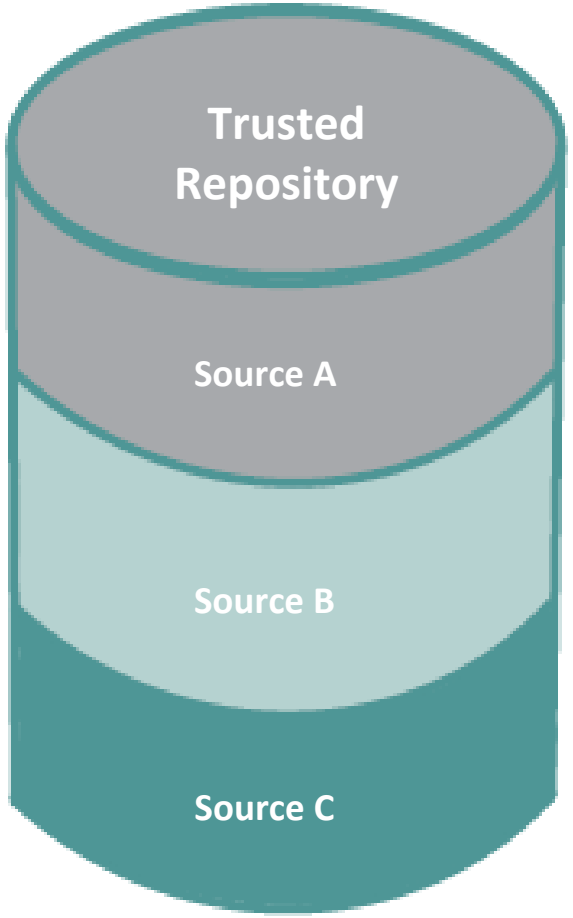


- Multiple Directories
- Multiple Vendors
- Proprietary Formats
- Non-Standardized content
- Unique ways to transmit data
- Hard to keep updated

?

- No Universally accepted schema
- No authoritative “aggregator”
- Industry incentivized to disaggregate
- No easy way for users to consume data
- Current way: technically complex & costly

The Data Solution



Your Community Resources in One Place

NCCARE360

Out of Network

Organizations that have not been onboarded to the platform

- Searchable and Identifiable as part of Resource Directory/Data Repository
- Not part of the NCCARE360 platform yet
- Do not report outcomes

In Coordinated Network

Organizations onboarded to the platform – Coordinated Network

- Agree to NCCARE360 platform requirements
- Have completed training and on-boarding
- Responsibility to report outcomes

NCCARE360

Joint Vision:

1. **Build a system of health** that is person-centered, increases access along the continuum, and improves health outcomes for all North Carolinians.

2. **Leverage existing and new infrastructure** to enable meaningful partnerships to connect people to health and social services, improve system wide efficiency, and deliver measurable ROI.

3. **Provide visibility and accountability** around organizations to narrow the gap between clinical and social services.

Ours is a **Vision,** not just a product.

NCCARE360
Creating a Collaborative Network through Shared Technology Platform

A coordinated network connects providers (such as health care providers, insurers, or community organizations) through a shared technology platform to:

- Communicate in real-time
- Make electronic referrals
- Securely share client information
- Track outcomes together

Coordination Platform at work

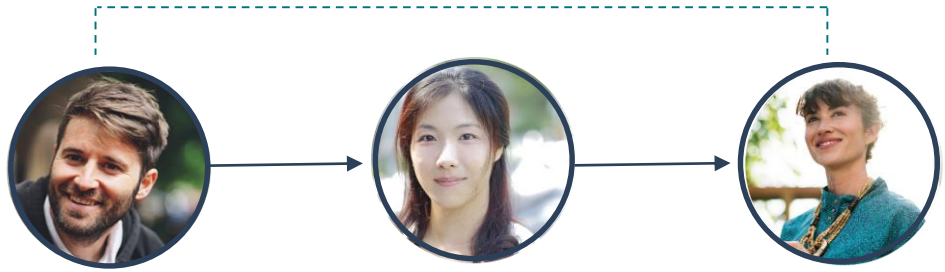
Improving coordination efficiency and accuracy

NCCARE360

Traditional Referral

Client | Healthcare Provider | Food Provider

Through NCCARE360



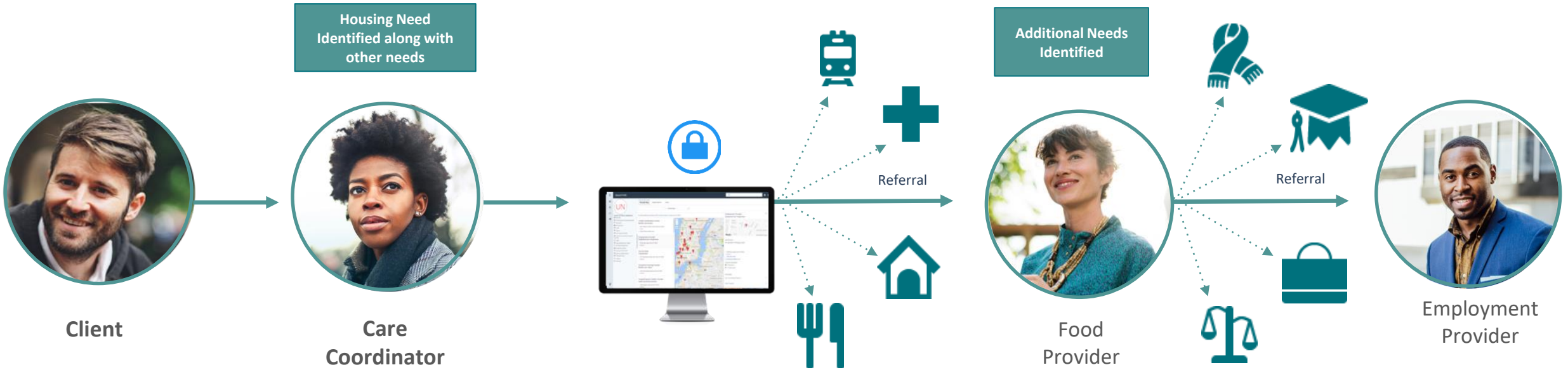
Client | Healthcare Provider | Food Provider

- ✗ Service provider cannot always exchange PII or PHI via a secure method
- ✗ Limited prescreening for eligibility, capacity, or geography
- ✗ Onus is usually on the client to reach the organization to which he/she was referred
- ✗ Service providers have limited insight or feedback loop
- ✗ Client data is siloed & transactional data is not tracked

- ✓ All information is stored and transferred on HIPAA compliant platform
- ✓ Client is matched with the provider for which he/she qualifies
- ✓ Client's information is captured once and shared on his/her behalf
- ✓ Service providers have insight into the entire client journey
- ✓ Longitudinal data is tracked to allow for informed decision making by community care teams

Network Model: No Wrong Door Approach

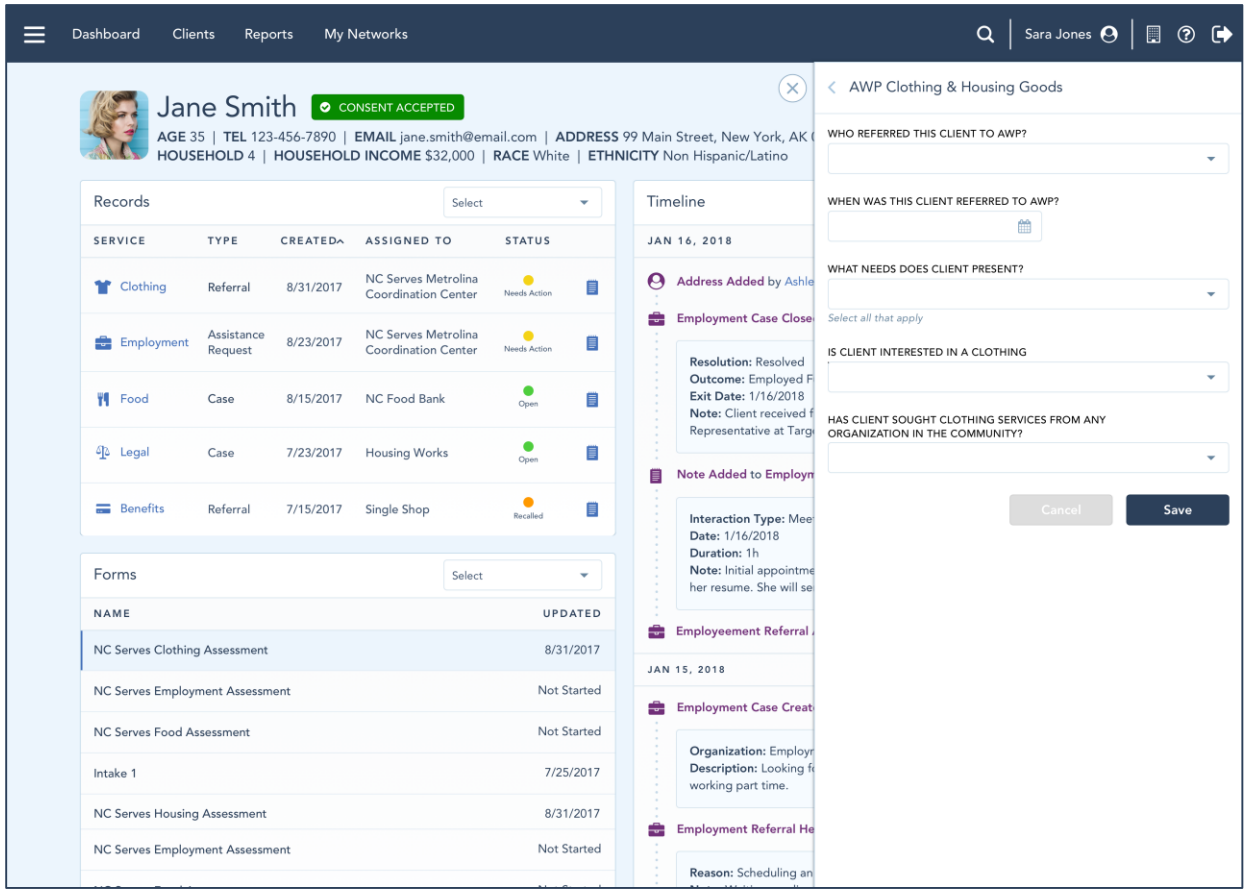
Understanding Referral Workflows



From Hello to Outcome, You are Connected

Automated workflows between your external partners at scale

NCCARE360



Configurable Screening:
Patient and/or provider facing algorithmic screenings to stratify risk and identify specific co-occurring needs

Electronic Referral Management:
Seamless referral workflow sends the right data to the right provider(s) to address specific needs

Assessment/Care Plan Management:
Custom care plans for each service need that are attached to referrals so receiving providers get a head start

Bi-Directional Communication/Alerts:
Automated notifications keep all organizations up to date, while care team members can securely communicate with each other

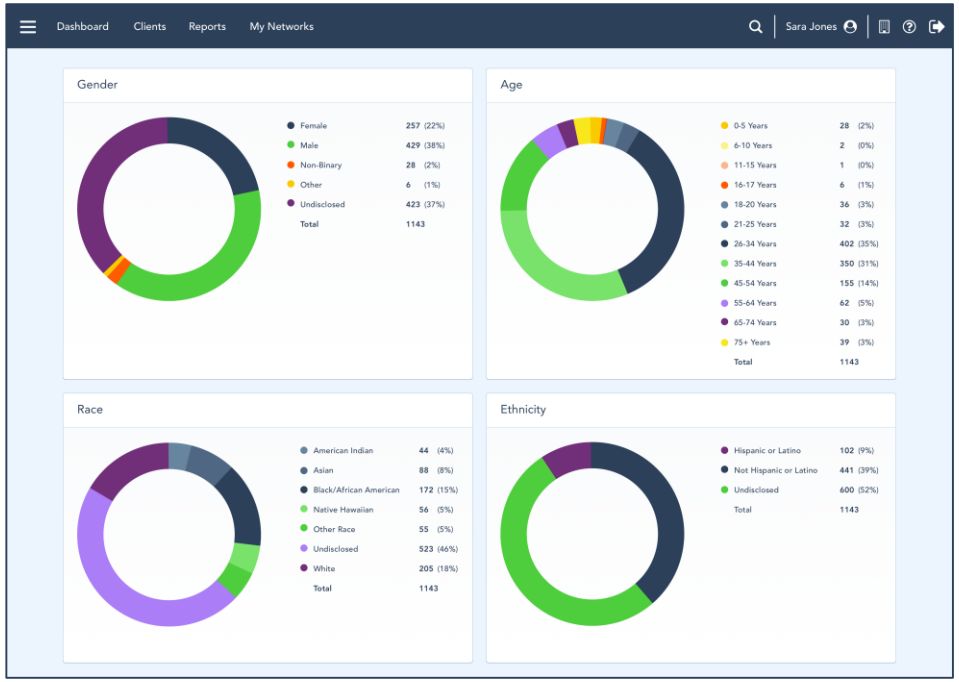
Outcomes:
You get to know exactly what services were delivered, and the entire history for every intervention by your external partners

The Data You Need

Real-time reporting of outcomes, impact, performance & efficiency

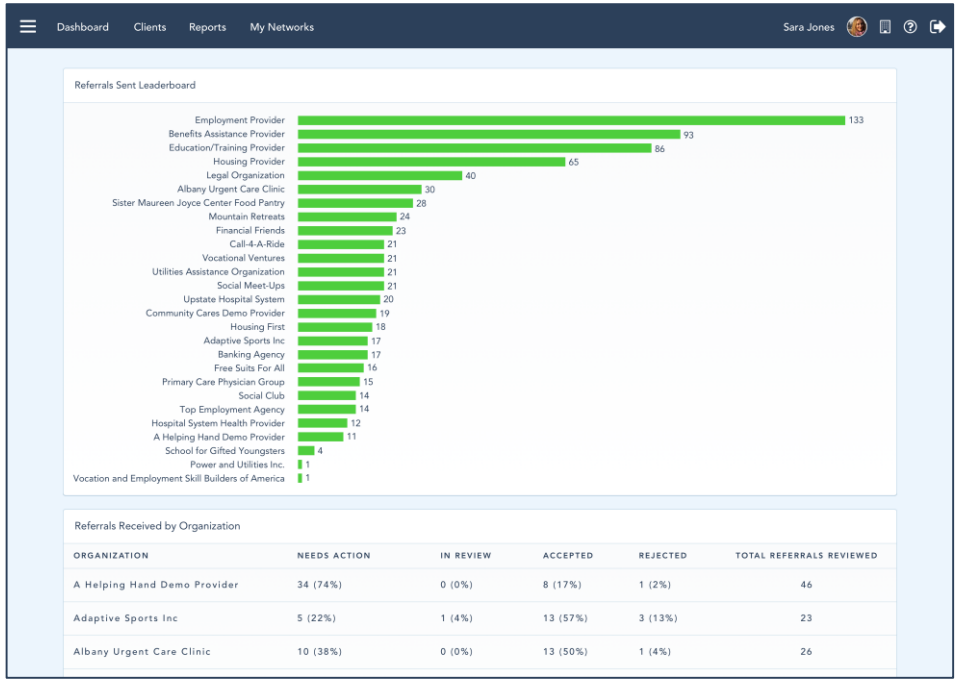
NCCARE360

Patient Level Coordination and Tracking



Patient Demographics, Patient Access Points, Service Delivery History, Outcome Breakdowns

Network Level Transparency & Accountability



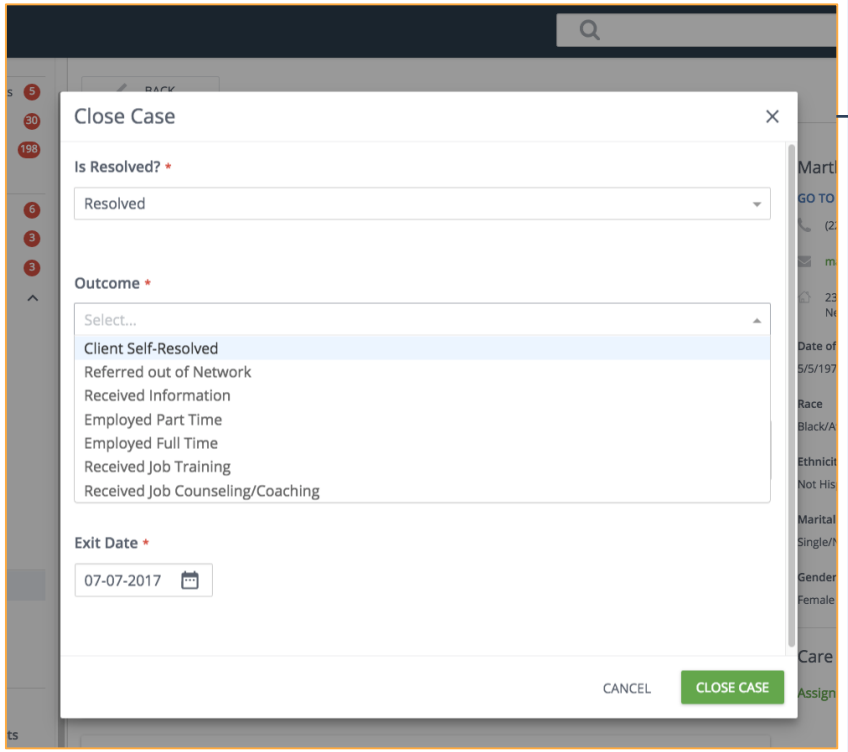
Service Episode history (longitudinal), Referrals Created, Received by, Structured Patient Outcomes for each specific need addressed

Configurable & Structured Reporting

Granular and detailed outcomes for every type of service

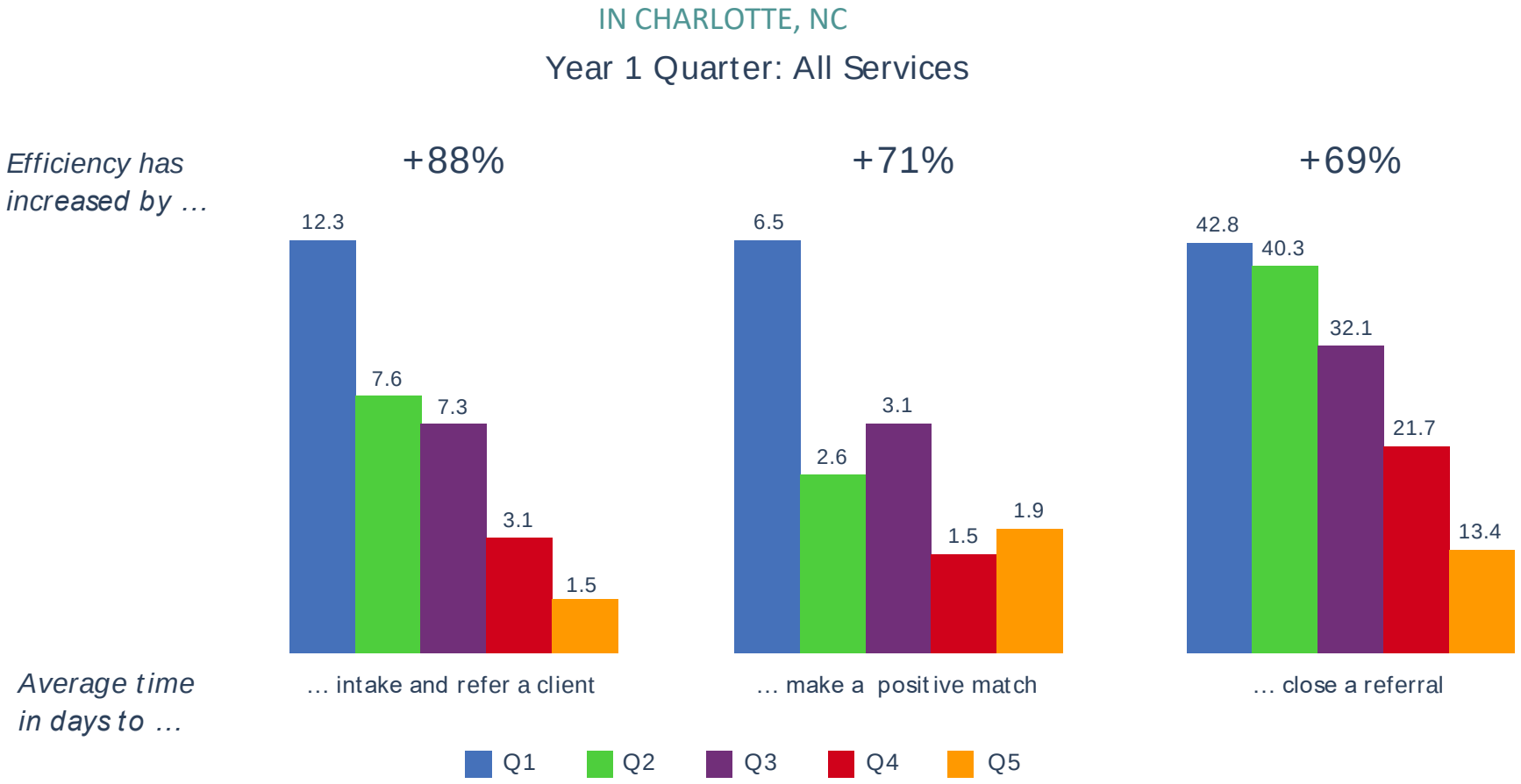
NCCARE360

Employment Service Type Example



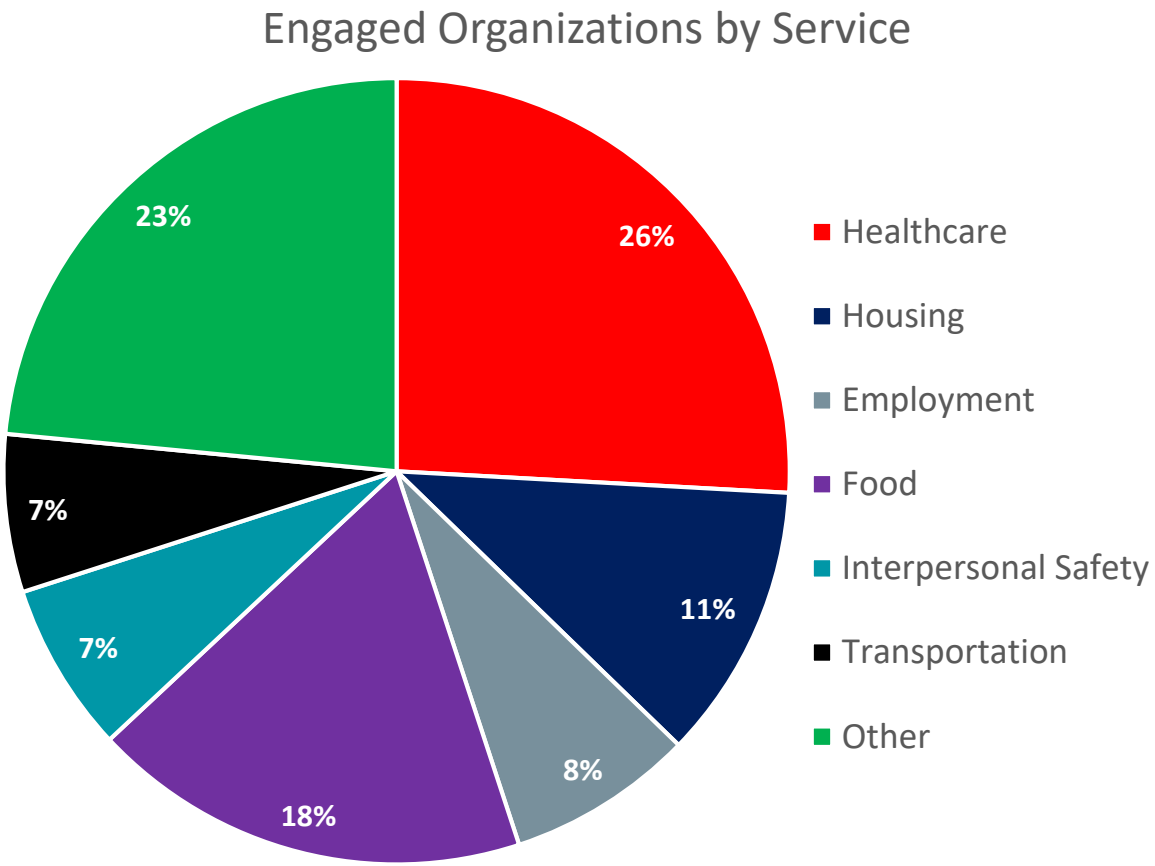
Improved Efficiency in North Carolina

Accelerating intake, referral, and closing the loop



Status Update

NCCARE360 Status Update	
15	Counties launched
30	Counties started on implementation
1570	Organizations engaged in socialization process
321	Organizations with NCCARE360 licenses
1260	Active Users
306	Lives Impacted



Announcements

Accepting Applications to Serve as Member-at-Large on Executive Committee, 2020 - 2022

Email info@eatsmartmovemorenc.com with the subject line "Application for Executive Committee" and provide the following information by **Friday, October 11, 2019**:

Your name, credentials, and job title
Your organization/company name, if applicable
One paragraph summarizing your experience with Eat Smart, Move More NC
One paragraph describing how you would be an asset to the Executive Committee

Next Eat Smart, Move More NC Meeting

December 5, 2019
JC Raulston Arboretum
12:00 Lunch
1:00 – 3:30 Meeting

We plan to launch our new website, release our new plan, and take a look at the latest obesity data for our state.

We hope to see you there!

Thank you for all you do.