Healthy Opportunities Pilots: Standard Plan Roundtable on the Evidence Base

May 12, 2022
Meeting #5

Context & Objectives

Context

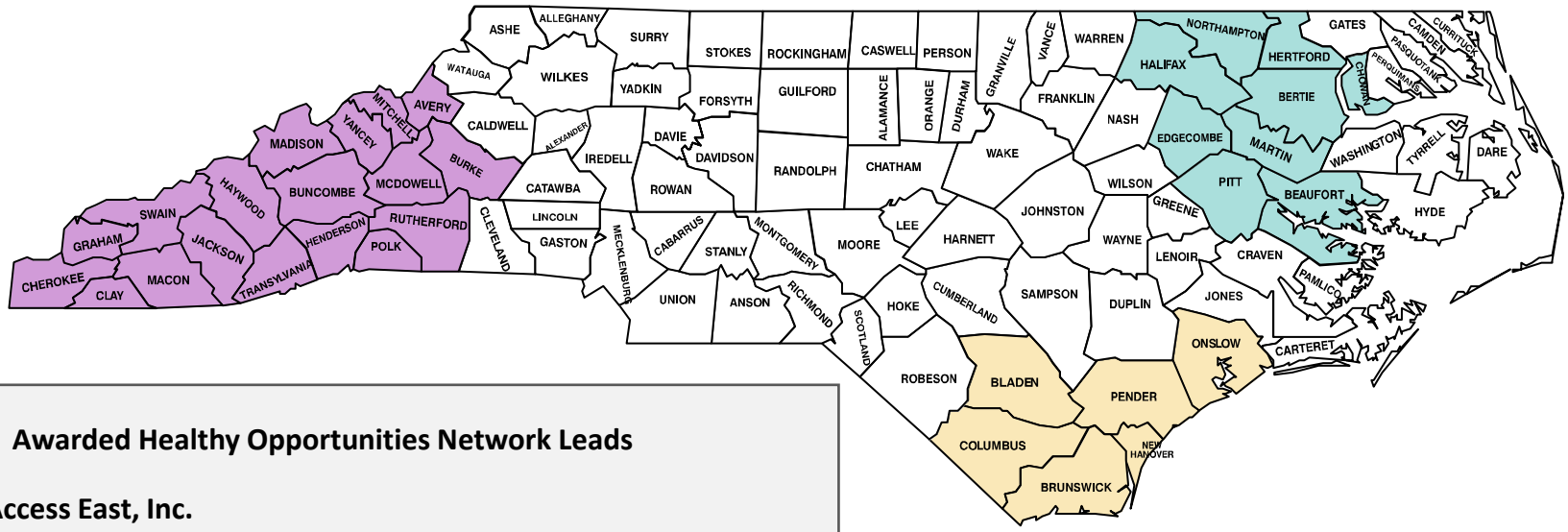
- This is the fifth meeting in the Healthy Opportunities Evidence Based Roundtable Series.
- The roundtable series offers a **forum for the Department, key Pilot entities and local and national experts** to discuss the latest findings and share key resources and insights.
- PHPs must **develop a plan for their Pilot investments, due to the Department on May 31, 2022 (*Revised Date*)**, that reflects the plan's strategic approach to enrolling high priority populations and an evidence-informed understanding of population-level service needs.

Objectives for Today's Meeting

- Have Network Lead representatives provide a high-level overview of each Pilot Region's:
  - Demographics
  - Network (e.g., strengths and potential gaps, at a high level)
  - Other characteristics

Where in North Carolina Will the Pilots Operate?

DHHS has procured Network Leads (NLs) with deep roots in their community that will facilitate collaboration across the healthcare and human service providers. PHPs, Network Leads, and HSOs will work with communities to implement the Pilots.



Awarded Healthy Opportunities Network Leads

Access East, Inc.

Beaufort, Bertie, Chowan, Edgecombe, Halifax, Hertford, Martin, Northampton, Pitt

Community Care of the Lower Cape Fear

Bladen, Brunswick, Columbus, New Hanover, Onslow, Pender

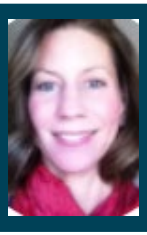
Impact Health

Avery, Buncombe, Burke, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Yancey

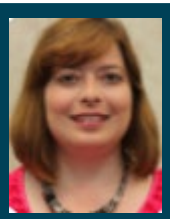
Roundtable Meeting Series Schedule

Working Session #	Timing	Topic	Objective
1	4/6	Introduction to Meeting Series	Provide context for PHPs' role in maximizing the value of the Pilots; review the "Enrolling High-Priority Pilot Populations Plan" report requirements
2	4/12	Introduction to SIREN	General orientation to SIREN to describe the database and search option
3	4/21	Evidence Overview 1 (*Pilot evaluation overview; food)*	Forums to discuss the state of the art and key issues surrounding the evidence base for Pilot service domains with NC and national subject matter experts
4	4/29	Evidence Overview 2 (*housing/medical respite, legal supports and transportation)*	
5	**Today**	**Network Leads Presentation**	**Provide an overview of Pilot region demographics and key considerations for delivering Pilot services**
6	5/16	Evidence Overview 3 (*IPV)*	Forum to discuss the state of the art and key issues surrounding the evidence base for Pilot service domains with NC and national subject matter experts

Today's Presenters



Sarah Rideout
Healthy Opportunities Program Director, Community Care of the Lower Cape Fear



Melissa Y. Roupe
Vice President, Healthy Opportunities, Access East

Dionne Greenlee-Jones
Interim Executive Director, Impact Health

Overview of the HOP Pilot Regions

CAPE FEAR HOP

	Population	Age	Race/ Ethnicity	Below 125% FPL	Unemployed/ Uninsured	Median Household Income	Adults with < than HS education	Monthly Avg. Medicaid Enrollment (2019)
BLADEN COUNTY 	33,407	<5 yrs: 4.9% <18 yrs: 20.3% >65 yrs: 22.8%	Black: 34.7% Hispanic: 7.5% White: 54.7%	10,300 (31%)	5.1% / 20.8%	$36,173	18.7%	7,735
BRUNSWICK COUNTY 	131,815	<5 yrs: 3.7% <18 yrs: 14.7% >65 yrs: 32.6%	Black: 9.8% Hispanic: 4.8% White: 81.9%	20,250 (15.5%)	5.8% / 17.2%	$58,236	8.7%	18,277
COLUMBUS COUNTY 	56,068	<5 yrs: 5.2% <18 yrs: 20.7% >65 yrs: 20.6%	Black: 30.5% Hispanic: 5.3% White: 59.3%	15,310 (28.9%)	6.6% / 20.4%	$37,362	17%	13,997
NEW HANOVER COUNTY 	227,938	<5 yrs: 4.7% <18 yrs: 18.2% >65 yrs: 18.4%	Black: 13.7% Hispanic: 5.6% White: 77.1%	45,823 (20.7%)	5% / 13.7%	$54,891	6.8%	27,164
ONSLOW COUNTY 	195,069	<5 yrs: 8.7% <18 yrs: 24.6% >65 yrs: 9.6%	Black: 14% Hispanic: 12.6% White: 66.1%	32,409 (18.6%)	11.6% / 13.6%	$50,278	8.5%	26,963
PENDER COUNTY 	60,399	<5 yrs: 5.7% <18 yrs: 22.2% >65 yrs: 18.6%	Black: 14.3% Hispanic: 7.1% White: 75.1%	10,938 (18.5%)	7.7% / 15.8%	$57,240	12%	9,596
NORTH CAROLINA 	10,551,162	<5 yrs: 5.8% <18 yrs: 21.9% >65 yrs: 16.7%	Black: 22.2% Hispanic: 9.8% White: 62.6%	14.6%	3.6% / 12.9%	$60,266	11.4%	1,653,622

	Population with Ambulatory Disability	Households with Overcrowding	Households with Cost Burden	Pop. with Obesity / Diabetes	Number of Food Deserts	Households receiving SNAP benefits	Teens not attending school/work	Households with no access to vehicle
BLADEN COUNTY 	3,712 (11.2%)	247 (1.4%)	2,656 (14.8%)	49% / 14%	3 (out of 6 tracts)	3,817 (28%)	13%	1,266 (9.3%)
BRUNSWICK COUNTY 	10,938 (8.4%)	1,031 (1.2%)	10,855 (12.1%)	31% / 9%	2 (out of 32 tracts)	6,355 (11.3%)	6.2%	2,113 (3.8%)
COLUMBUS COUNTY 	6,561 (12.3%)	543 (2.1%)	3,933 (14.9%)	45% / 14%	1 (out of 13 tracts)	5,353 (24.8%)	15.4%	1,511 (7%)
NEW HANOVER COUNTY 	13,233 (5.9%)	1,049 (0.9%)	14,627 (13.2%)	29% / 10%	8 (out of 43 tracts)	9,605 (10%)	6.5%	6,210 (6.5%)
ONSLOW COUNTY 	11,551 (7.3%)	1,084 (1.4%)	8,441 (10.6%)	29% / 11%	8 (out of 31 tracts)	7,804 (12.1%)	7.6%	3,114 (4.8%)
PENDER COUNTY 	4,916 (8.3%)	352 (1.2%)	4,312 (14.9%)	29% / 10%	1 (out of 15 tracts)	2,806 (12.9%)	6.1%	779 (3.6%)
NORTH CAROLINA 	716,908 (7.1%)	91,567 (2%)	513,317 (11.1%)	33% / 11%	153 (out of 2,192 tracts)	498,689 (12.6%)	7%	230,276 (5.8%)

Sector	HSOs live as of 5/13	Services currently live	Total contracted to go live
Food	15	8/9	24
Housing	9	8/9	26
Transportation	4	2/3	14

Note: Some HSOs overlap sectors

Services not live as of 5/12:
Medically Tailored Meals
Reimbursement for Health-Related Public Transportation
Short-Term Post Hospitalization Housing

Potential gaps

- Public transportation in rural counties
- Medical respite/short term post hospitalization housing

Areas to consider

- Pairing/bundling of services
- Complex Care for whole person care in HOP

APPENDIX

Data as of 5/9/22

BLADEN COUNTY

powered by:

HEALTHY OPPORTUNITIES PILOT
CAPE FEAR HOP

Population*: 33,407
Age: <5 years (4.9%), <18 years (20.3%), >65 years (22.8%)
34.7% Black | 7.5% Hispanic | 54.7% White | 3.1% Other
Below 125% of Federal Poverty Level*: 10,300 (31%)
Unemployment: 5.1% | Uninsured: 20.8% | Med. Household Income: $36,173
Adults with < than HS education: 18.7%

Monthly Average Medicaid Enrollment in 2019: 7,735
Est. Pilot Enrollees: 473 | PLANS - Standard (318), Tailored (145), Foster care (10)

Housing

Households With Inadequate Kitchen *
91 (0.5%)

Population With Ambulatory Disability *
3,712 (11.2%)

Households With Overcrowding *
247 (1.4%)

Households With Cost Burden *
2,656 (14.8%)

Interpersonal Violence

Child Abuse Cases Substantiated †
11.7 per 100k population

Reported Violent Crime ‡
223.9 per 100k population

Juvenile Delinquency Incidents †
7.1 per 100k population

Teens (16-19) Not Attending School and Not Working †: 13%

Food

Population With Obesity / Diabetes ℊ
49.1% / 14.1%

Number of Food Deserts ¶
3 (out of 6 tracts)

Households Receiving SNAP Benefits *
3,817 (28%)

Food Environment Index (0 worst, 10 best) ‡
6.8

Transportation

Households With No Access to Vehicle *
1,266 (9.3%)

Households With Access to 1 Vehicle *
3,952 (29%)

Access to Exercise Opportunities ‡
12,135 (36.3%)

Pop. With Independent Living Difficulty *
1,979 (6%)

SOURCES:
* Census ACS 5-Year Subject Tables
† Annie Casey Foundation
¶ USDA Economic Research Service
‡ Robert Wood Johnson, U. of Wisconsin
ℊ Center for Disease Control. PLACES Data

BRUNSWICK COUNTY

powered by:

HEALTHY OPPORTUNITIES PILOT
CAPE FEAR HOP

Population*: 131,815
Age: <5 years (3.7%), <18 years (14.7%), >65 years (32.6%)
9.8% Black | 4.8% Hispanic | 81.9% White | 3.5% Other
Below 125% of Federal Poverty Level*: 20,250 (15.5%)
Unemployment: 5.8% | Uninsured: 17.2% | Med. Household Income: $58,236
Adults with < than HS education: 8.7%

Monthly Average Medicaid Enrollment in 2019: 18,277
Est. Pilot Enrollees: 1,299 | PLANS - Standard (864), Tailored (393), Foster care (42)

Housing

Households With Inadequate Kitchen *
243 (0.3%)

Population With Ambulatory Disability *
10,938 (8.4%)

Households With Overcrowding *
1,031 (1.2%)

Households With Cost Burden *
10,855 (12.1%)

Interpersonal Violence

Child Abuse Cases Substantiated †
10.3 per 100k population

Reported Violent Crime ‡
141.4 per 100k population

Juvenile Delinquency Incidents †
14.4 per 100k population

Teens (16-19) Not Attending School and Not Working †: 6.2%

Food

Population With Obesity / Diabetes ℊ
30.8% / 9.3%

Number of Food Deserts ¶
2 (out of 32 tracts)

Households Receiving SNAP Benefits *
6,355 (11.3%)

Food Environment Index (0 worst, 10 best) ‡
7.6

Transportation

Households With No Access to Vehicle *
2,113 (3.8%)

Households With Access to 1 Vehicle *
16,360 (29.2%)

Access to Exercise Opportunities ‡
104,147 (79%)

Pop. With Independent Living Difficulty *
6,936 (5.3%)

SOURCES: * Census ACS 5-Year Subject Tables; † Annie Casey Foundation; ¶ USDA Economic Research Service; ‡ Robert Wood Johnson, U. of Wisconsin; ℊ Center for Disease Control. PLACES Data

COLUMBUS COUNTY

powered by: HEALTHY OPPORTUNITIES PILOT — CAPE FEAR HOP

Population*: 56,068
Age: <5 years (5.2%), <18 years (20.7%), >65 years (20.6%)
30.5% Black | 5.3% Hispanic | 59.3% White | 4.9% Other
Below 125% of Federal Poverty Level*: 15,310 (28.9%)
Unemployment: 6.6% | Uninsured: 20.4% | Med. Household Income: $37,362
Adults with < than HS education: 17%

Monthly Average Medicaid Enrollment in 2019: 13,997
Est. Pilot Enrollees: 965 | PLANS - Standard (684), Tailored (261), Foster care (21)

Housing

Households With Inadequate Kitchen *
85 (0.3%)

Population With Ambulatory Disability *
6,561 (12.3%)

Households With Overcrowding *
543 (2.1%)

Households With Cost Burden *
3,933 (14.9%)

Interpersonal Violence

Child Abuse Cases Substantiated †
12.6 per 100k population

Reported Violent Crime ‡
388.3 per 100k population

Juvenile Delinquency Incidents †
20.5 per 100k population

Teens (16-19) Not Attending School and Not Working †: 15.4%

Food

Population With Obesity / Diabetes ℊ
45% / 13.6%

Number of Food Deserts ¶
1 (out of 13 tracts)

Households Receiving SNAP Benefits *
5,353 (24.8%)

Food Environment Index (0 worst, 10 best) ‡
7.1

Transportation

Households With No Access to Vehicle *
1,511 (7%)

Households With Access to 1 Vehicle *
6,896 (31.9%)

Access to Exercise Opportunities ‡
25,739 (45.9%)

Pop. With Independent Living Difficulty *
4,254 (8%)

SOURCES:
* Census ACS 5-Year Subject Tables
† Annie Casey Foundation
¶ USDA Economic Research Service
‡ Robert Wood Johnson, U. of Wisconsin
ℊ Center for Disease Control. PLACES Data

NEW HANOVER COUNTY

powered by:

HEALTHY OPPORTUNITIES PILOT
CAPE FEAR HOP

Population*: 227,938
Age: <5 years (4.7%), <18 years (18.2%), >65 years (18.4%)
13.7% Black | 5.6% Hispanic | 77.1% White | 3.6% Other
Below 125% of Federal Poverty Level*: 45,823 (20.7%)
Unemployment: 5% | Uninsured: 13.7% | Med. Household Income: $54,891
Adults with < than HS education: 6.8%

Monthly Average Medicaid Enrollment in 2019: 27,164
Est. Enrollees: 2,065 | PLANS - Standard (1,274), Tailored (699), Foster care (92)

Housing

Households With Inadequate Kitchen *
633 (0.6%)

Population With Ambulatory Disability *
13,233 (5.9%)

Households With Overcrowding *
1,049 (0.9%)

Households With Cost Burden *
14,627 (13.2%)

Interpersonal Violence

Child Abuse Cases Substantiated †
14.3 per 100k population

Reported Violent Crime ‡
447 per 100k population

Juvenile Delinquency Incidents †
11.5 per 100k population

Teens (16-19) Not Attending School and Not Working †: 6.5%

Food

Population With Obesity / Diabetes ℊ
28.6% / 9.5%

Number of Food Deserts ¶
8 (out of 43 tracts)

Households Receiving SNAP Benefits *
9,605 (10%)

Food Environment Index (0 worst, 10 best) ‡
7.4

Transportation

Households With No Access to Vehicle *
6,210 (6.5%)

Households With Access to 1 Vehicle *
33,366 (34.9%)

Access to Exercise Opportunities ‡
203,597 (89.3%)

Pop. With Independent Living Difficulty *
9,537 (4.2%)

SOURCES:
* Census ACS 5-Year Subject Tables
† Annie Casey Foundation
¶ USDA Economic Research Service
‡ Robert Wood Johnson, U. of Wisconsin
ℊ Center for Disease Control. PLACES Data

ONSLOW COUNTY

powered by:

HEALTHY OPPORTUNITIES PILOT
CAPE FEAR HOP

Population*: 195,069
Age: <5 years (8.7%), <18 years (24.6%), >65 years (9.6%)
14% Black | 12.6% Hispanic | 66.1% White | 7.3% Other
Below 125% of Federal Poverty Level*: 32,409 (18.6%)
Unemployment: 11.6% | Uninsured: 13.6% | Med. Household Income: $50,278
Adults with < than HS education: 8.5%

Monthly Average Medicaid Enrollment in 2019: 26,963
Est. Enrollees: 1,202 | PLANS - Standard (1,202), Tailored (482), Foster care (43)

Housing

Households With Inadequate Kitchen *
192 (0.2%)

Population With Ambulatory Disability *
11,551 (7.3%)

Households With Overcrowding *
1,084 (1.4%)

Households With Cost Burden *
8,441 (10.6%)

Interpersonal Violence

Child Abuse Cases Substantiated †
10.4 per 100k population

Reported Violent Crime ‡
209 per 100k population

Juvenile Delinquency Incidents †
13.7 per 100k people

Teens (16-19) Not Attending School and Not Working †: 7.6%

Food

Population With Obesity / Diabetes ℊ
28.6% / 11.0%

Number of Food Deserts ¶
8 (out of 31 tracts)

Households Receiving SNAP Benefits *
7,804 (12.1%)

Food Environment Index (0 worst, 10 best) ‡
6.9

Transportation

Households With No Access to Vehicle *
3,114 (4.8%)

Households With Access to 1 Vehicle *
20,431 (31.7%)

Access to Exercise Opportunities ‡
94,702 (48.5%)

Pop. With Independent Living Difficulty *
7,839 (5%)

SOURCES:
* Census ACS 5-Year Subject Tables
† Annie Casey Foundation
¶ USDA Economic Research Service
‡ Robert Wood Johnson, U. of Wisconsin
ℊ Center for Disease Control. PLACES Data

PENDER COUNTY

powered by:

HEALTHY OPPORTUNITIES PILOT
CAPE FEAR HOP

Population*: 60,399
Age: <5 years (5.7%), <18 years (22.2%), >65 years (18.6%)
14.3% Black | 7.1% Hispanic | 75.1% White | 3.5% Other
Below 125% of Federal Poverty Level*: 10,938 (18.5%)
Unemployment: 7.7% | Uninsured: 15.8% | Med. Household Income: $57,240
Adults with < than HS education: 12%

Monthly Average Medicaid Enrollment in 2019: 9,596
Est. Pilot Enrollees: 639 | PLANS - Standard (419), Tailored (202), Foster care (18)

Housing

Households With Inadequate Kitchen *
89 (0.3%)

Population With Ambulatory Disability *
4,916 (8.3%)

Households With Overcrowding *
352 (1.2%)

Households With Cost Burden *
4,312 (14.9%)

Interpersonal Violence

Child Abuse Cases Substantiated †
11.9 per 100k population

Reported Violent Crime ‡
149.9 per 100k population

Juvenile Delinquency Incidents †
14.3 per 100k population

Teens (16-19) Not Attending School and Not Working †: 6.1%

Food

Population With Obesity / Diabetes ℊ
28.9% / 10.3%

Number of Food Deserts ¶
1 (out of 15 tracts)

Households Receiving SNAP Benefits *
2,806 (12.9%)

Food Environment Index (0 worst, 10 best) ‡
7.9

Transportation

Households With No Access to Vehicle *
779 (3.6%)

Households With Access to 1 Vehicle *
5,740 (26.4%)

Access to Exercise Opportunities ‡
36,359 (60.2%)

Pop. With Independent Living Difficulty *
3,548 (6%)

SOURCES: * Census ACS 5-Year Subject Tables ‡ Robert Wood Johnson, U. of Wisconsin
† Annie Casey Foundation ℊ Center for Disease Control. PLACES Data
¶ USDA Economic Research Service

NORTH CAROLINA

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HEALTHY OPPORTUNITIES PILOT
CAPE FEAR HOP

Population*:10,551,162
Age: <5 years (5.8%), <18 years (21.9%), >65 years (16.7%)
22.2% Black | 9.8% Hispanic | 62.6% White | 7.2% Other
Below 125% of Federal Poverty Level*: 45,823 (20.7%)

Monthly Average Medicaid Enrollment in 2019: 1,653,622
Estimated Pilot Enrollees in 3 HOP regions: 18,338
PLANS - Standard plan: 11,852 | Tailored plan: 5,601 | Foster care: 677

Housing

Households With Inadequate Kitchen *
22,742 (0.5%)

Population With Ambulatory Disability *
716,908 (7.1%)

Households With Overcrowding *
91,567 (2%)

Households With Cost Burden *
513,217 (11.1%)

Interpersonal Violence

Child Abuse Cases Substantiated †
10.2 per 100k population

Reported Violent Crime ‡
351 per 100k population

Juvenile Delinquency Incidents †
16.8 per 100k population

Teens (16-19) Not Attending School and Not Working †: 7%

Food

Population With Obesity / Diabetes ℊ
33% / 11%

Number of Food Deserts ¶
153 (out of 2,192 tracts)

Households Receiving SNAP Benefits *
498,689 (12.6%)

Food Environment Index (0 worst, 10 best) ‡
7.33

Transportation

Households With No Access to Vehicle *
230,276 (5.8%)

Households With Access to 1 Vehicle *
1,255,017 (31.6%)

Access to Exercise Opportunities ‡
7,622,170 (74.3%)

Pop. With Independent Living Difficulty *
473,783 (4.7%)

SOURCES: * Census ACS 5-Year Subject Tables
† Annie Casey Foundation
¶ USDA Economic Research Service
‡ Robert Wood Johnson, U. of Wisconsin
ℊ Center for Disease Control. PLACES Data

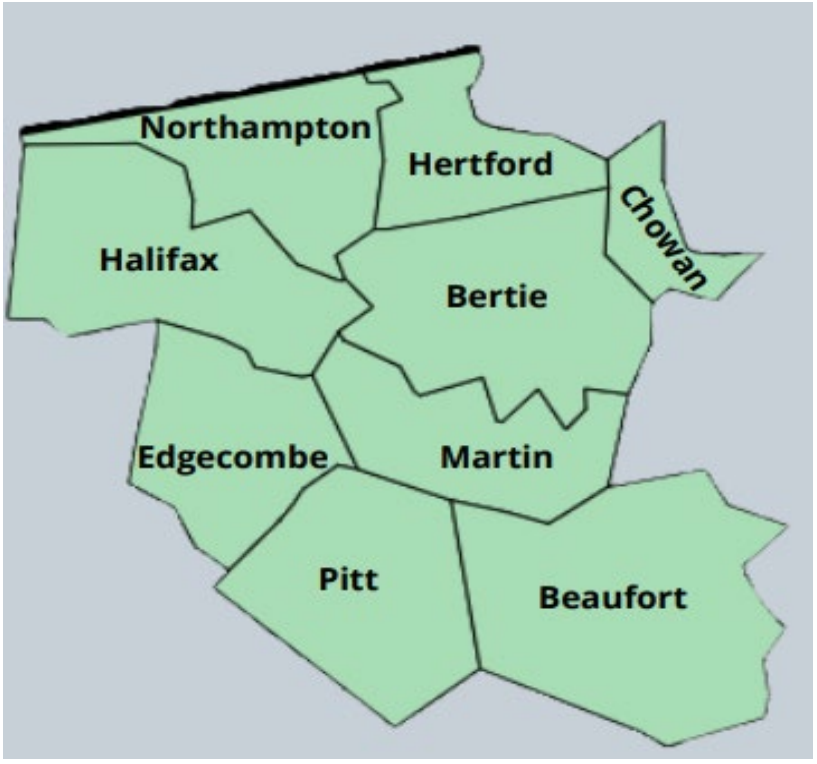
Healthy Opportunities Pilot

Melissa Y. Roupe, MSN, RN
Vice President, Healthy Opportunities

Our Geographic Region

Our Geographic Region currently includes the following counties:

- Beaufort
- Bertie
- Chowan
- Edgecombe
- Halifax
- Hertford
- Martin
- Northampton
- Pitt



Community Demographics

- Race/Ethnicity

Location	White	Black/African American	American Indian	Asian	Multiple Races	Hispanic
Access East NL Region	50.2	46.3	0.8	1.1	1.6	8.0
State of NC	62.2	20.5	1.2	3.3	6.8	10.7

- Linguistics: 94% English; 6% Non-English
  - Non-English speaking households: 92% Spanish; 8% other

Our HSO Network

- We are currently contracted with 11 HSOs serving 9 counties
- Food Services: 9 HSOs
- Housing: 3 HSOs
- Transportation: 4 HSOs
- IPV/Toxic Stress: 3 HSOs
- Additional HSOs coming onboard in next 6 months: 7-10 HSOs
- Anticipated gaps: Our concerns center around IPV/Toxic Stress services because we do not have a true sense of HSO coverage at this time.

Special Considerations

- Our communities are very rural with locations spread significant distances apart
- Resources are very limited and therefore, HSOs cover multiple counties
- Partnerships are critical because community members are frequently distrustful of people they do not know

NCDHHS Evidence-Based Round Table for the

Healthy Opportunities Pilot for WNC

IMPACT HEALTH

DIONNE GREENLEE-JONES

Interim Executive Director,
Impact Health

IMPACT HEALTH TEAM

HANNAH ERICKSON
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RACHEL WALKER
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PUNAM MEDINA
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JESSICA PARK
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AIMEE KING
Account Manager

AMY STEEL
IT Manager

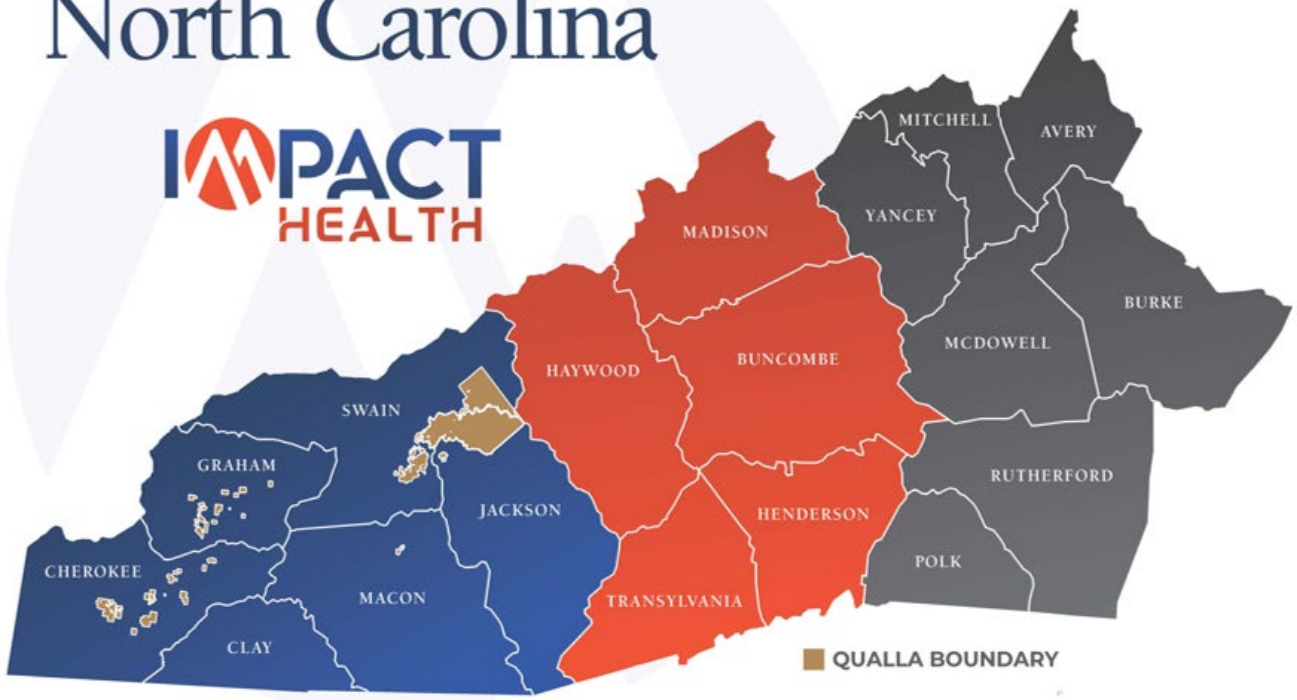
KATE OGDEN
HR Manager

KARL PIERRE-LOUIS
Recruiter


IMPACT
HEALTH

Western North Carolina

IMPACT HEALTH



Region I **Region II** **Region III**

Overarching Synopsis, Part I

Currently,
Impact Health has
38 contracted HSOs
Goal for Additional
HSOs:
40-50 in the next 6 months

Currently, Impact Health has **38 contracted HSOs**

- **Food Domain**
  - **23** live organizations currently
  - **13** provide services in the Food domain only
  - **10** provide services in multiple domains
  - **7/9 Fee Schedule services** currently covered/live
  - **3** additional organizations expected to go live soon (not yet launched)
- **Housing Domain**
  - **13** live organizations currently
  - **5** provide services in the Housing domain only
  - **8** provide services in multiple domains
  - **9/9 Fee Schedule services** currently covered/live
- **Transportation Domain**
  - **9** live organizations currently
  - **3** provide services in the Transportation domain only
  - **6** provide services in multiple domains
  - **3/3 Fee Schedule services** currently covered/live

Overarching Synopsis, Part II

Currently,
Impact Health has
38 contracted HSOs
Goal for Additional
HSOs:
40-50 in the next 6 months

Currently, Impact Health has **38 contracted HSOs**

- **IPV**
  - **7** organizations currently in this domain
  - **3** provide services in the IPV domain only
  - **4** provide services in multiple domains
  - **5/5 Fee Schedule services** currently covered/live

- **Toxic Stress**
  - **8** organizations currently in this domain
  - **2** provide services in the Toxic Stress domain only
  - **6** provide services in multiple domains
  - **3/3 Fee Schedule services** currently covered/live

Region I

Cherokee, Clay, Graham, Jackson, Macon, Swain

HSOs Serving: Food – 7; Housing – 7; Transportation - 8

Greatest County Gaps: Evidence-Based Group Nutrition, Medically Tailored Meals, Evidenced-Base Parenting Curriculum, Home Visiting Services, Medical Respite

Some County Gaps: Fruit and Vegetable Prescription, Short-term Hospitalization, Dyadic Therapy

Estimated HOP Participants – 1,436 or 17% of IH Network

Demographics – Cherokee and Clay counties have over 30% of their population over 65. Graham (7.1%), Jackson (8.9%), and Swain (28.5%) counties have a large American Indian Population. Cherokee (5.2%) and Swain (5.3%) have a large multiracial population.

Region II

Buncombe, Haywood, Henderson, Madison, Transylvania

HSOs Serving: Food – 10; Housing – 9; Transportation - 8

Greatest County Gaps: Evidence-Based Group Nutrition, Medically Tailored Meals, One-Time Payment for Security Deposit and First Month's Rent, Dyadic Therapy

Some County Gaps: Inspection for Housing Safety and Quality, Home Remediation Services, Evidenced-Base Parenting Curriculum, Home Visiting Services, Violence Intervention Services

Estimated HOP Participants – 4,264 or 49% of IH Network

Demographics – Buncombe County (5.6% Black, 8.1% Hispanic, 1.2% Asian) and Henderson County (12.9% Hispanic, 1.1% Asian) are diverse. Madison County also has a Hispanic population of 9.5%. Transylvania has an interesting population related to age. 6.1% are under and 31.4% are over 65 which are both high percentages for the region.

Region III

Avery, Burke, McDowell, Mitchell, Polk, Rutherford, Yancey

HSOs Serving: Food – 14; Housing – 6; Transportation - 6

Greatest County Gaps: Evidence-Based Group Nutrition, Medically Tailored Meals, Inspection for Housing Safety and Quality, One-Time Payment for Security Deposit and First Month's Rent, Medical Respite, Evidenced-Base Parenting Curriculum, Dyadic Therapy

Some County Gaps: Home Accessibility and Safety Modifications, Remediation Services, Home Visiting Services

Estimated HOP Participants – 2,917 or 34% of IH Network

Demographics – Burke County is very diverse (5.4% Black, 8.2% Hispanic, 3.6% Asian) and has a large deaf population. McDowell (5.0% are under 5 and 20.0% are under 18) and Rutherford (5.1% are under 5 and 20.3% are under 18) counties have young populations. Polk County has an older population (32.1% over 65).

Impact Health Demographic Picture

	Avery	Buncombe	Burke	Cherokee	Clay	Graham	Haywood	Henderson	Jackson	Macon	Madison	McDowell	Mitchell	Polk	Rutherford	Swain	Transylvania	Yancey
General Population	17,557	261,191	90,485	28,612	11,231	8,441	62,317	117,417	43,938	35,858	21,755	45,756	14,964	20,724	67,029	14,271	34,385	18,069
Average Monthly Medicaid	2,543	34,208	16,025	5,219	1,839	1,862	10,467	14,308	6,386	5,562	3,734	8,646	2,574	2,577	12,521	3,685	4,825	3,258
Estimated Enrollees	133	2,133	1,018	287	101	108	672	889	386	326	240	499	141	150	809	228	330	166
Race and Ethnicity Estimates																		
White	87.3%	79.7%	78.4%	88.2%	90.6%	85.7%	89.7%	78.9%	76.1%	84.8%	85.2%	90.8%	90.7%	86.5%	80.7%	60.5%	86.5%	90.0%
Black	3.6%	5.6%	5.4%	1.3%	0.5%	0.6%	1.1%	2.8%	1.7%	3.8%	0.7%	0.9%	0.3%	3.6%	9.1%	0.7%	3.1%	0.6%
Hispanic	5.5%	8.1%	8.2%	3.1%	3.9%	2.7%	4.6%	12.9%	7.6%	6.6%	9.5%	3.5%	4.7%	5.3%	5.1%	4.2%	5.1%	5.5%
Multiracial	2.6%	4.4%	3.7%	5.2%	3.9%	3.5%	3.4%	3.5%	4.2%	3.3%	3.3%	3.8%	3.5%	3.8%	4.0%	5.3%	4.0%	3.2%
Asian	0.3%	1.2%	3.6%	0.5%	0.4%	0.2%	0.6%	1.1%	1.2%	0.9%	0.7%	0.4%	0.3%	0.3%	0.5%	0.4%	0.5%	0.2%
American Indian	0.3%	0.3%	0.3%	1.4%	0.4%	7.1%	0.5%	0.2%	8.9%	0.3%	0.5%	0.3%	0.2%	0.3%	0.2%	28.5%	0.3%	0.3%
All Other Races	0.3%	0.7%	0.3%	0.2%	0.3%	0.1%	0.3%	0.6%	0.3%	0.3%	0.3%	0.3%	0.3%	0.2%	0.2%	0.4%	0.4%	0.2%
Age																		
Under 5	3.7%	4.8%	4.8%	4.2%	4.4%	4.8%	4.9%	4.8%	4.4%	4.8%	4.7%	5.0%	4.8%	3.8%	5.1%	6.1%	6.1%	4.7%
Under 18	14.7%	18.2%	18.4%	16.5%	16.7%	19.8%	18.2%	18.7%	16.4%	18.4%	17.5%	20.0%	18.3%	15.7%	20.3%	22.0%	15.4%	18.2%
Over 65	22.9%	20.5%	20.7%	30.5%	31.9%	24.5%	25.0%	26.4%	19.9%	28.9%	23.1%	20.8%	25.5%	32.1%	22.2%	19.6%	31.4%	26.3%
Sex																		
Female	45.8%	52.1%	50.0%	51.3%	51.4%	50.0%	51.7%	52.0%	50.8%	51.5%	50.7%	50.2%	50.6%	52.1%	51.7%	52.1%	51.8%	50.8%

Population: https://www.census.gov/quickfacts/fact/table/US/PST045219
Medicaid Monthly Average Enrollees and Estimated Enrollee Calculations: Sources: • CY2019 Average Medicaid Enrollment determined by combining applicable months from FY2019 and FY2020 data published by the state on Medicaid enrollment by county. The CY2019 Medicaid enrollment
Race and Ethnicity County Estimates: https://www.ncdemography.org/2019/12/05/2018-county-population-estimates-race-ethnicity/

What's Next?

Network Growth Strategy

Factors to consider moving forward beyond initial 38 HSOs
Goal: ***Network Adequacy and 100 HSOs***

- **What is Network Adequacy for Impact Health? Where are our gaps?**
- **What timeframe would Impact Health like to have 100 HSOs?**
- **Targeted HSOs (30+) or ask all? Special consideration/outreach for IPV/Toxic Stress?**
- **When would Impact Health prefer to ask for expansion verses finding a new HSOs to fill a gap? What is the decision-making tree?**
- **What geographic factors should be considered?**
  - Drive Time
  - Factors such as Food Deserts
  - Population
  - Health Care Access
  - Health or Demographic Indicators
- **What domain specific factors should be considered?**
  - Disease Specific Statistics
  - SDoH Statistics
- **Community input on partnerships?**

Q & A

IMPACT HEALTH

Thank You

Learn more at:

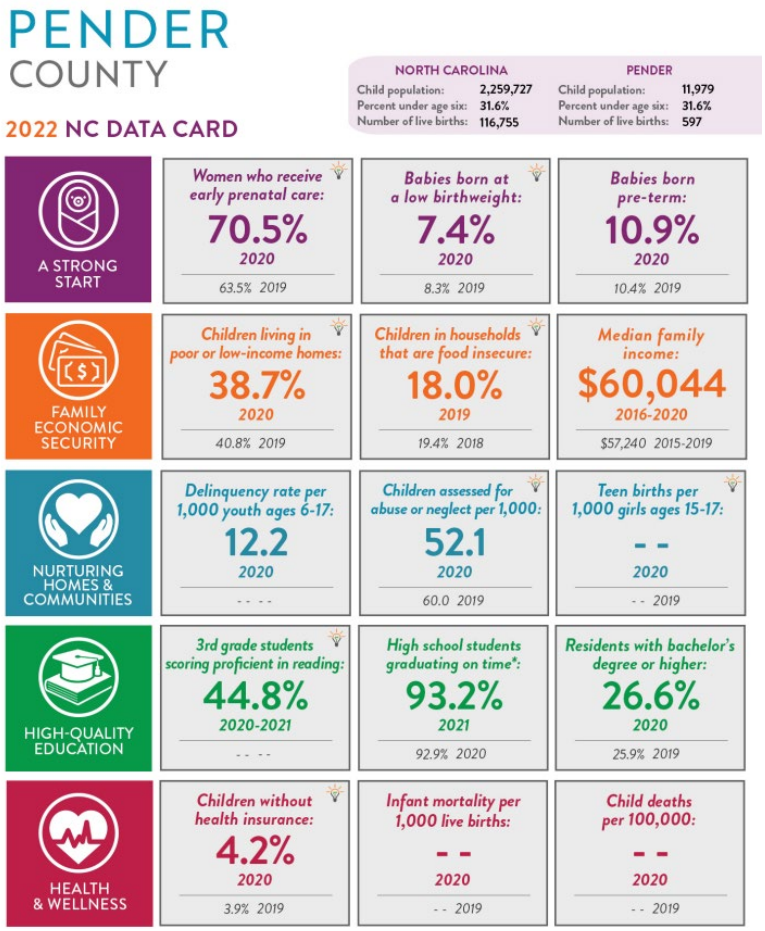
IMPACTHEALTH.ORG

IMPACT HEALTH

PHP Resources

Healthy Blue Evidence Base Resource

NC Child recently released their 2022 County Data Dashboards, which provides county-specific details on several population health areas as shown in the example of Pender County below:



Source: [NC Child 2022 County Data Dashboards]

Q&A

Reminders & Next Steps

- The next Roundtable meeting on **May 16th from 1:00 – 2:00 PM** will cover the evidence base for interpersonal violence/toxic stress-related Pilot services.
    - A reminder that each SP is asked to share at least one evidence base resource, relevant initiative or key question during an "Evidence Overview" meeting. SPs should let DHHS know in advance which Healthy Opportunity domain their contribution will address. Please submit to medicaid.healthyopportunities@dhhs.nc.gov
- The Enrolling High Priority Pilot Populations Report is due to the Department on **May 31, 2022** *(Revised Date).*

Appendix

Who Qualifies for Pilot Services?

To qualify for pilot services, Medicaid managed care enrollees must live in a Pilot Region and have:

At least one Physical/Behavioral Health Criteria:
(varies by population)

- **Adults** (e.g., having two or more qualifying chronic conditions)
- **Pregnant Women** (e.g., history of poor birth outcomes such as low birth weight)
- **Children, ages 0-3** (e.g., neonatal intensive care unit graduate)
- **Children 0-20** (e.g., experiencing three or more categories of adverse childhood experiences)

At least one Social Risk Factor:

- Homeless and/or housing insecure
- Food insecure
- Transportation insecure
- At risk of, witnessing or experiencing interpersonal violence

Meet service specific eligibility criteria, as needed.

Healthy Opportunities Pilots: Qualifying Physical/ Behavioral Health Criteria

Population	Age	Physical/Behavioral Health-Based Criteria
Adults	22+	• 2 or more chronic conditions. Chronic conditions that qualify an individual for Pilot program enrollment include: BMI over 25, blindness, chronic cardiovascular disease, chronic pulmonary disease, congenital anomalies, chronic disease of the alimentary system, substance use disorder, chronic endocrine and cognitive conditions, chronic musculoskeletal conditions, chronic mental illness, chronic neurological disease and chronic renal failure, in accordance with Social Security Act section 1945(h)(2). • Repeated incidents of emergency department use (defined as more than four visits per year) or hospital admissions.
Pregnant Women	N/A	• Multifetal gestation • Chronic condition likely to complicate pregnancy, including hypertension and mental illness • Current or recent (month prior to learning of pregnancy) use of drugs or heavy alcohol • Adolescent ≤ 15 years of age • Advanced maternal age, ≥ 40 years of age • Less than one year since last delivery • History of poor birth outcome including: preterm birth, low birth weight, fetal death, neonatal death
Children	0-3	• Neonatal intensive care unit graduate • Neonatal Abstinence Syndrome • Prematurity, defined by births that occur at or before 36 completed weeks gestation • Low birth weight, defined as weighing less than 2500 grams or 5 pounds 8 ounces upon birth • Positive maternal depression screen at an infant well-visit
	0-21	• One or more significant uncontrolled chronic conditions or one or more controlled chronic conditions that have a high risk of becoming uncontrolled due to unmet social need, including: asthma, diabetes, underweight or overweight/obesity as defined by having a BMI of <5th or >85th percentile for age and gender, developmental delay, cognitive impairment, substance use disorder, behavioral/mental health diagnosis (including a diagnosis under DC: 0-5), attention deficit/hyperactivity disorder, and learning disorders • Experiencing three or more categories of adverse childhood experiences (e.g. Psychological, Physical, or Sexual Abuse, or Household dysfunction related to substance abuse, mental illness, parental violence, criminal behavioral in household) • Enrolled in North Carolina's foster care or kinship placement system

Healthy Opportunities Pilots: Social Risk Factors

Risk Factor	Definition
Homelessness and Housing Insecurity	• Individuals who are **homeless**: defined as an individual who lacks housing, including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and an individual who is a resident in transitional housing. • Individuals who are **housing insecure:** including individuals who, within the past 12 months, have ever stayed outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (i.e. couch surfing); are worried about losing their housing; or within the past 12 months have been unable to get utilities (heat, electricity) when it was really needed.
Food Insecurity	Patients who are experiencing food insecurity—defined as the disruption of food intake or eating patterns because of lack of money and other resources--including those who: • Report reduced quality, variety, or desirability of diet. There may be little or no indication of reduced food intake. This is considered low food security. • Report multiple indications of disrupted eating patterns and reduced food intake. This is considered very low food security. • Report that within the past 12 months they worried that their food would run out before they got money to buy more. • Report that within the past 12 months the food they bought did just not last and they didn't have money to get more.
Transportation Insecurity	Patients for whom, within the past 12 months, a lack of transportation has kept them from medical appointments or from doing things needed for daily living.
At risk of, witnessing, or experiencing interpersonal violence	Patients who report that they feel physically or emotionally unsafe where they currently live; within the past 12 months have been hit, slapped, kicked or otherwise physically hurt by anyone; or within the past 12 months have been humiliated or emotionally abused by anyone.

NC DHHS Healthy Opportunities Standardized Screening Questions. Available: https://www.ncdhhs.gov/screening-tool-english-providers-final/download

PHPs' "Enrolling High Priority Pilot Populations" Report (1/2)

PHPs are required to submit the Healthy Opportunities Pilot Enrolling High-Priority Population Plan by May 31, 2022 (Revised Date).

In the Plan, PHPs must:

1. Identify priority populations; and
2. Describe strategies and operational approaches for ensuring equitable distribution of Pilot investments

1. Identifying Priority Populations

PHPs must report on the anticipated proportion of enrollees for the second Pilot service delivery year (July 1, 2022 – June 30, 2023) who will:

- Be pregnant
- Be children ages 0-21
- Have high health care expenditures as determined by the PHP
    - The PHP must define "high-cost populations", describe the methods the PHP will use to identify high-cost Pilot enrollees and any available evidence-base regarding the impact of Pilot-like services on this population.
- Meet any additional priority population designations the PHP intends to focus on for Pilot enrollment (at the PHP's discretion)
    - The PHP must describe how it will identify and define this population and the evidence-based rationale for focusing on the additional priority populations.

PHPs' "Enrolling High Priority Pilot Populations" Report (2/2)

2. Ensuring Equitable Distribution of Pilot Investments

For the second Pilot service delivery year, the PHP must submit a description of its strategies and operational approaches for:

- Identifying and enrolling members residing in Pilot regions to ensure **inclusive representation of priority populations**.
- Ensuring the **racial and ethnic composition of Pilot enrollees and expenditures** are at least proportional to **Medicaid demographics** in the Pilot region.
- Ensuring that **historically marginalized populations and communities in the Pilot region are proportionally represented** among Pilot enrollees and service expenditures, including at minimum to meet the following goals:
  - Starting in Pilot Service Delivery Period II, the PHP shall direct Pilot services to be distributed to the following groups during each Service Pilot Delivery Period:
    - At least thirty-three percent (33%) of Pilot enrollees are pregnant enrollees or children ages 0-21.
    - At least thirty-three percent (33%) of Pilot enrollees are high-cost populations.
  - The PHP shall ensure that historically marginalized populations and communities in the Pilot region are at least proportionately represented in the delivery of Pilot services and service expenditures.