Cape Fear Collective

MFP Lunch & Learn



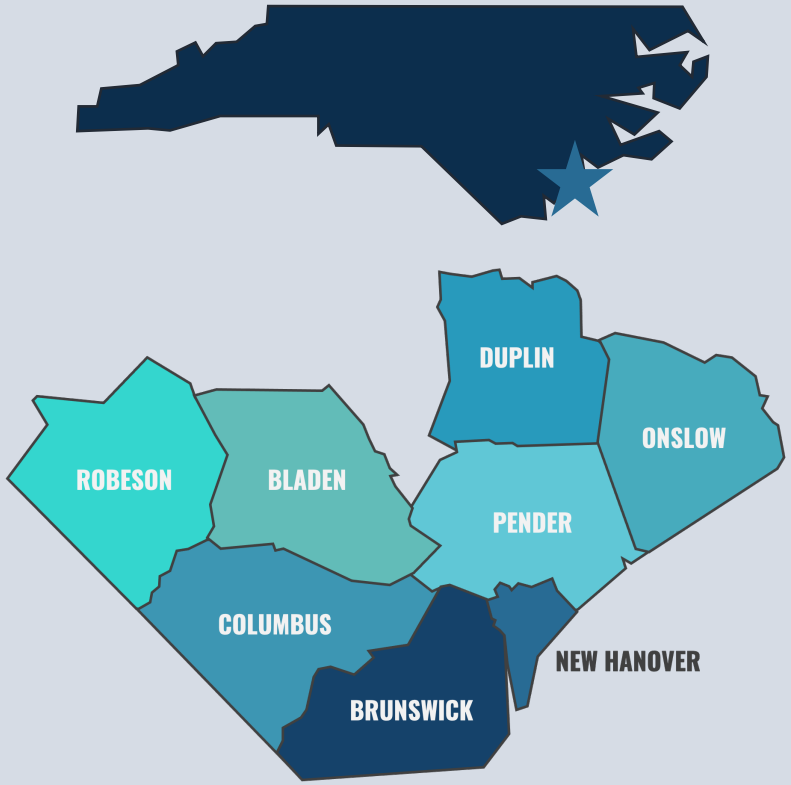
Cape Fear Collective

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What do we do?

By merging cutting-edge data science with an emphasis on equity and the lived experience of our most marginalized communities, the Cape Fear Collective supports Southeastern North Carolina's front-line organizations in combating poverty, racism, poor health and education outcomes, and socio-economic disparities.

Increasingly, we have been approached by sponsors across the state, and will be deploying our Community Data Platform and Healthy Communities Dashboard statewide by May 2022.

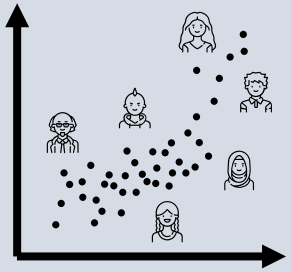


Cape Fear Collective Data Science Methodology



Community Engagement

- Seek to tap into the wealth of experience and knowledge in the community
- Pair tools and methodology with local resources already in existence
- Support and empower local organizations through true democratization of data, insights, and visualizations



Human-Centered Approach

- Incorporate the “lived experience” in analyses and data storytelling
- Advocate for equity, providing insight into disparities present in race, ethnicity, gender, and age
- Data security, including HIPAA and FERPA are non-negotiable and foundational to our data architecture



Hyper Localized Data

- Provide neighborhood level statistics (census tract or block group), allowing deeper look at county populations
- Triangulate multiple data sources to strengthen accuracy of models and analyses, making the data more actionable
- Utilize local partner data through Data Usage Agreements



Deep Technological Expertise

- Leverage years of experience in technical and consulting sectors
- Robust toolbox, including R, Python, SAS, ArcGIS, SQL, AWS, Full Stack Dev, and Tableau
- Academic and professional experience in Mathematics, Statistics, Computer Science, and Machine Learning
- Start up approach: innovative, comfort in ambiguity, aim high, and fail fast

COMMUNITY DATA PLATFORM

Centralizing disparate data to create common understanding and aligned strategy

Cape Fear Collective

Community Data Platform

Cloud-based*, public, free and open-source aggregation of impact indicators



- 1,300 community metrics across 9 categories
- Neighborhood level (census tract) for entire state of NC
- Sourced from a variety of public and partner sources including, but not limited to:

Census Bureau	Annie E Casey Foundation	Robert Wood Johnson Foundation	Opportunity Insights
Federal Housing Finance Agency	Center for Disease Control	Bureau of Labor Statistics	US Department of Agriculture

- Data disaggregated at race, ethnicity, gender, and age
- Free to download
- **User-friendly interface deployed May 1, 2020**

*Encrypted AWS MySQL database with private/public schemas and S3 storage buckets allowing storage of structured and unstructured raw data

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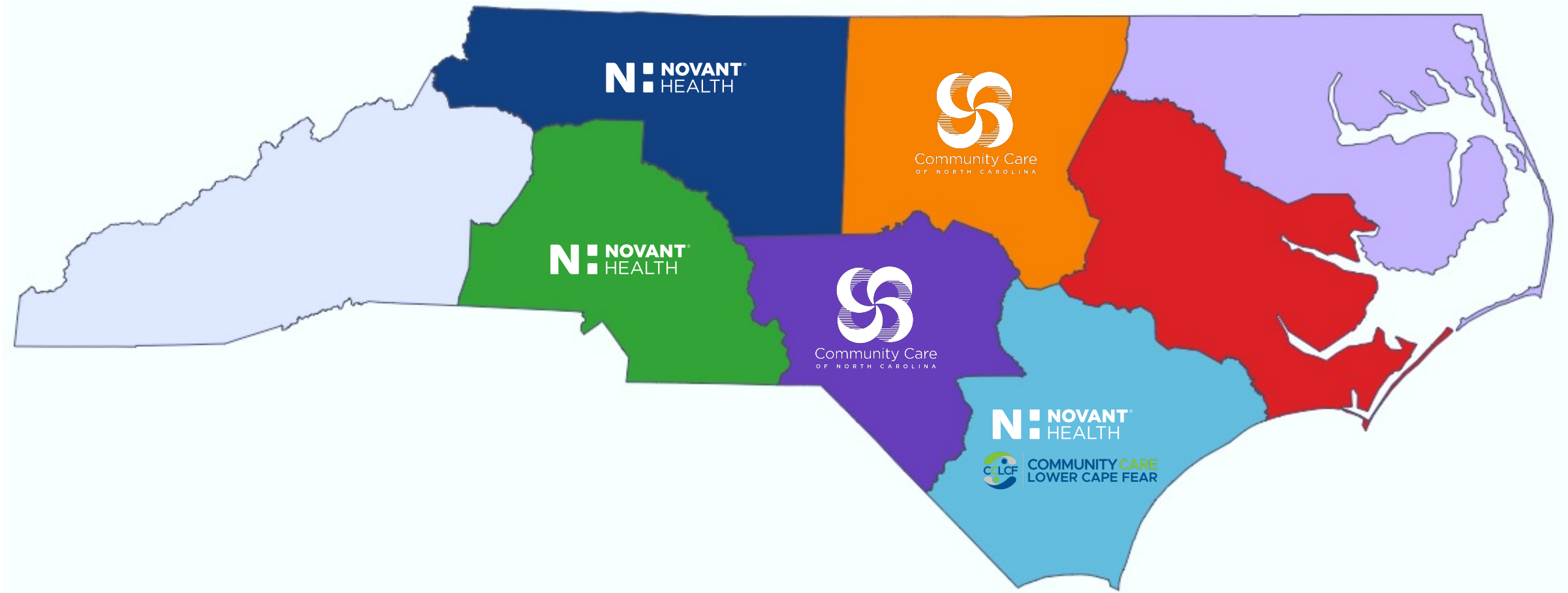
Healthy Communities NC

Providing hyperlocal insights and goals on the social determinants of health

Cape Fear Collective

Healthy Communities NC

Providing hyperlocal insights and goals on the social determinants of health for regions in North Carolina. Healthy Communities NC builds upon the 21 indicators presented in the NCIOM & NCDHHS led HealthyNC 2030 initiative adding regional-specific targets and context.



Cape Fear Region launches February 22. Other 7 regions targeted for May 1 Deployment.

Built by Datawheel | Powered by Cape Fear Collective

Healthy Cape Fear



Search

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What is Healthy Cape Fear?

Sponsored by NOVANT HEALTH | Built by Datawheel | Powered by Cape Fear Collective

The **Healthy NC 2030** taskforce, led by NCIOM and NCDHHS, brought together experts and leaders from multiple fields to develop a **common set of public health indicators and targets for the state over the next decade.** The full report, released in January of 2020, established a north star for localities and organizations to mobilize to accomplish North Carolina's most pressing goals across housing, education, public health, and economic opportunity.

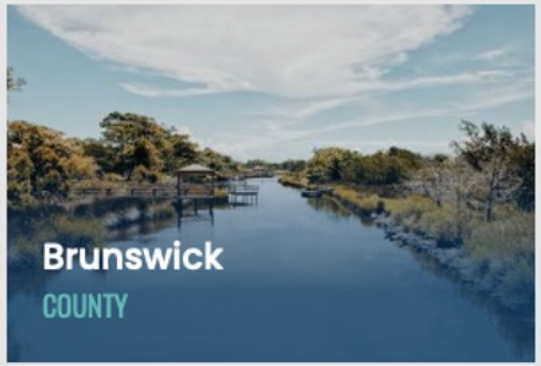
Cape Fear Collective is committed to helping partner organizations set and measure local goals through its expertise in **data & analytics.** Our **Healthy Cape Fear Dashboard** enables alignment of community data collection and analysis to the Healthy NC 2030 initiative in order to empower shared hypothesis generation, goal setting, and program measurement.

- Overview
- Social & Economic Factors
- Health Behaviors
- Clinical Care
- Physical Environment

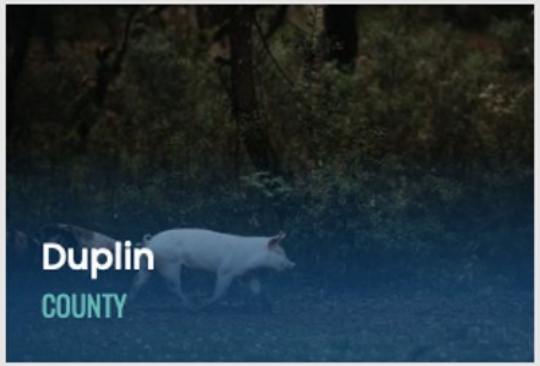
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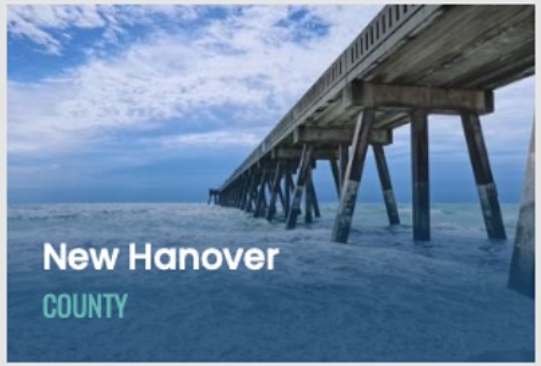












POVERTY

Poverty in the Region

YEAR 2019

VALUE RATE | GROWTH

73.3%
New Hanover Tract 000
HIGHEST PERCENTAGE OF INDIVIDUALS BELOW 200% FPL, 2019

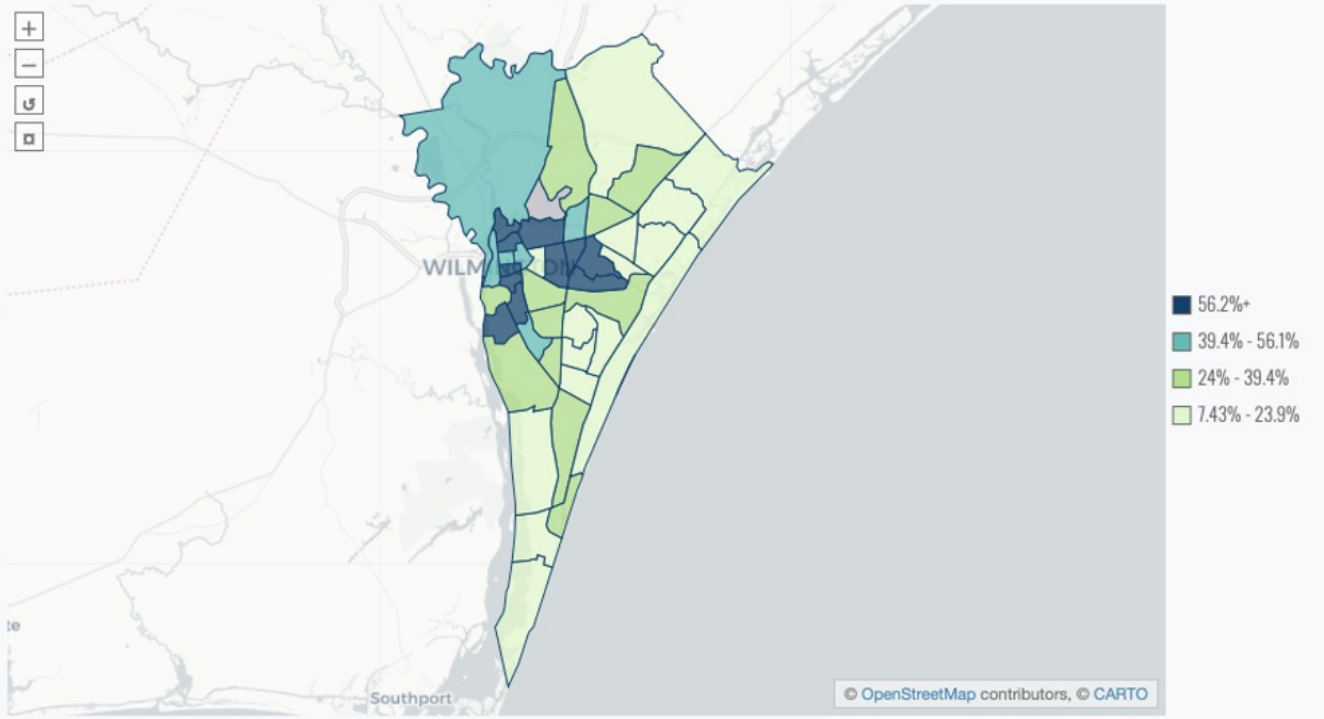
7.43%
New Hanover Tract 004
LOWEST PERCENTAGE OF INDIVIDUALS BELOW 200% FPL, 2019

The map shows the percentage of individuals below 200% Federal Poverty Level (FPL) in New Hanover County and how it has changed over time.

In 2019, the percentage of individuals below 200% FPL in New Hanover County was 33.5%. The tract with the highest percentage of individuals below 200% FPL was New Hanover Tract 000 (73.3%), while the tract with the lowest was New Hanover Tract 004 (7.43%).

Data provided by Cape Fear Collective Population Living in Poverty.

RATE OF INDIVIDUALS BELOW 200% FPL BY TRACT, 2019



VIEW DATA | SAVE IMAGE | SHARE

Healthy Communities NC Dashboard

(Cape Fear Region in development -- released to the public February 2022)

- Partnership with Novant Health
- Utilizes Cape Fear Collective's Community Data Platform
- Variety of data visualizations (bar, line, map)
- Aligned to the 21 statewide HNC 2030 indicators
- Local insights (county, tract) for 8 counties in the Cape Fear region
- **Targeting statewide implementation by May 1, 2022**
- Focus on health equity (data available for race/ethnicity, age, gender)
- User capabilities include:
  - View or download underlying data for any visualization
  - Save any visualization as an image
  - Download entire county profile as pdf
  - Quick share option saves user's selection and page location

TABLE 1

HEALTH INDICATORS AND DATA

(TOTAL NC POPULATION, 2030 TARGET, AND DATA BY RACE/ETHNICITY, SEX, AND POVERTY LEVEL)

			TOTAL POPULATION	
	HEALTH INDICATOR	DESIRED RESULT	CURRENT (YEAR)	2030 TARGET
1	INDIVIDUALS BELOW 200% FPL	Decrease the number of people living in poverty	36.8% (2013-17)	27.0%
2	UNEMPLOYMENT	Increase economic security	7.2% (2013-17)	Reduce unemployment disparity ratio between white and other populations to 1.7 or lower
3	SHORT-TERM SUSPENSIONS (PER 10 STUDENTS)	Dismantle structural racism	1.39 (2017-18)	0.80
4	INCARCERATION RATE (PER 100,000 POPULATION)		341 (2017)	150
5	ADVERSE CHILDHOOD EXPERIENCES	Improve child well-being	23.6% (2016-17)	18.0%
6	THIRD GRADE READING PROFICIENCY	Improve third grade reading proficiency	56.8% (2018-19)	80.0%
7	ACCESS TO EXERCISE OPPORTUNITIES	Increase physical activity	73% (2010/18)	92%
8	LIMITED ACCESS TO HEALTHY FOOD	Improve access to healthy food	7% (2015)	5%
9	SEVERE HOUSING PROBLEMS	Improve housing quality	16.1% (2011-15)	14.0%
10	DRUG OVERDOSE DEATHS (PER 100,000 POPULATION)	Decrease drug overdose deaths	20.4 (2018)	18.0
11	TOBACCO USE	Decrease tobacco use	YOUTH 19.8% (2017) ADULT 23.8% (2018)	9.0% 15.0%
12	EXCESSIVE DRINKING	Decrease excessive drinking	16.0% (2018)	12.0%
13	SUGAR-SWEETENED BEVERAGE CONSUMPTION	Reduce overweight and obesity	YOUTH 33.6% (2017) ADULT 34.2% (2017)	17.0% 20.0%
14	HIV DIAGNOSIS (PER 100,000 POPULATION)	Improve sexual health	13.9 (2018)	6.0
15	TEEN BIRTH RATE (PER 1,000 POPULATION)		18.7 (2018)	10.0
16	UNINSURED	Decrease the uninsured population	13% (2017)	8%
17	PRIMARY CARE CLINICIANS (COUNTIES AT OR BELOW 1:1,500 PROVIDERS TO POPULATION)	Increase the primary care workforce	62 (2017)	25% decrease for counties above 1:1,500 providers to population
18	EARLY PRENATAL CARE	Improve birth outcomes	68.0% (2018)	80.0%
19	SUICIDE RATE (PER 100,000 POPULATION)	Improve access and treatment for mental health needs	13.8 (2018)	11.1
20	INFANT MORTALITY (PER 1,000 BIRTHS)	Decrease infant mortality	6.8 (2018) Black/white disparity ratio = 2.4	6.0 Black/white disparity ratio = 1.5
21	LIFE EXPECTANCY (YEARS)	Increase life expectancy	77.6 (2018)	82.0

Download the full report

Thank you!

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Cape Fear Collective



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MEET YOUR HSO NETWORK CARE TEAM

CAPE FEAR HEALTHY OPPORTUNITES PILOT
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CCLCF COMMUNITY CARE LOWER CAPE FEAR

Cape Fear Collective
EQUITY FOCUSED. DATA DRIVEN. HUMAN CENTERED.

HEALTHY OPPORTUNITIES PILOT

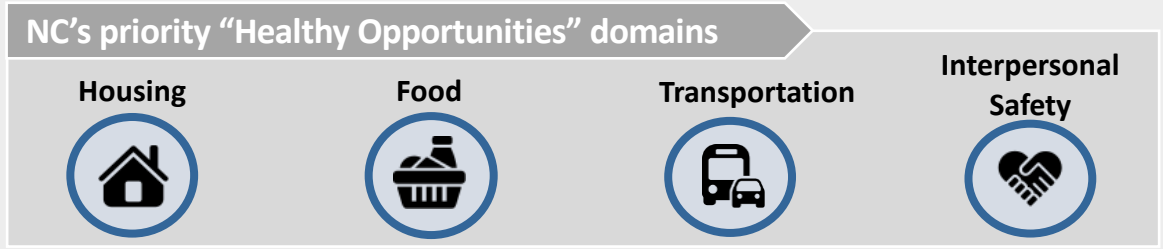
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Healthy Opportunities Pilots

CMS authorized up to $650 million in state and federal Medicaid funding to test evidence-based, non-medical interventions designed to improve health outcomes and reduce healthcare costs for a subset of Medicaid enrollees.

Pilot funds will be used to:

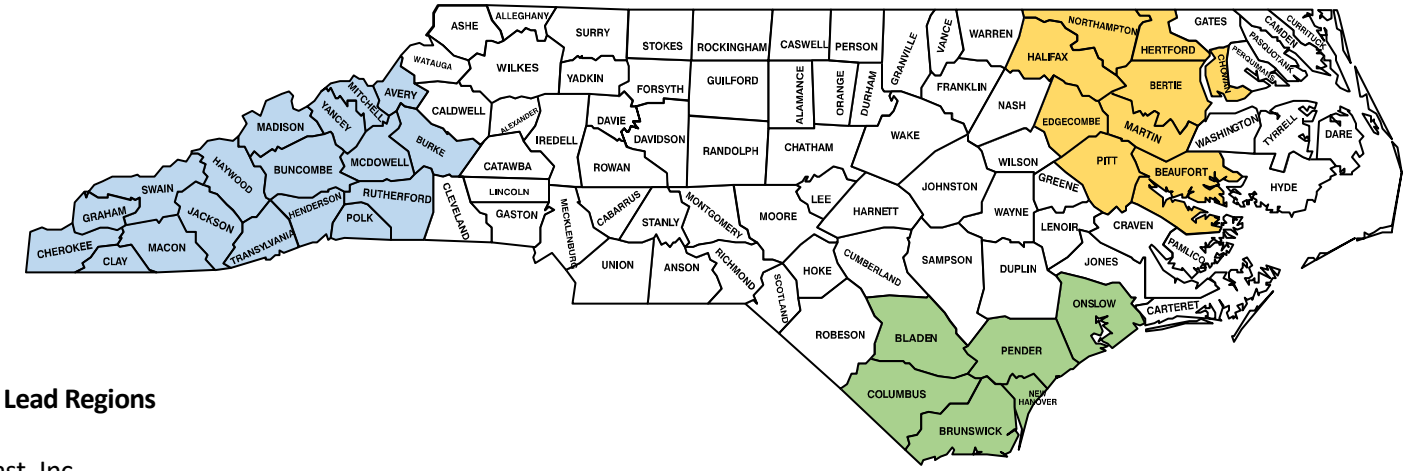
- **Cover the cost of federally-approved Pilot services**
  - *NC DHHS has developed service definitions and a fee schedule to reimburse entities that deliver these non-clinical services*
  - *The fee schedule will promote value and increasingly link payment to outcomes*
- **Support capacity building to establish Network Leads and strengthen the ability of human service organizations (HSOs) to deliver Pilot services**
  - *NC DHHS procured three Network Leads with deep roots in their community to facilitate collaboration across the healthcare and human service providers through building partnerships.*



Primary Pilot Goal: Learning

- **Evaluate the effectiveness** of select, evidence-based, non-medical interventions and the role of the Network Lead in improving health outcomes and reducing health care costs for high-risk NC Medicaid Managed Care members.
- **Leverage evaluation findings** to embed cost-effective interventions that improve health outcomes into the Medicaid program statewide, furthering NCDHHS' goals for a sustainable Medicaid program.
- **Support the sustainability** of delivering non-medical services identified as effective through the evaluation, including by strengthening the capabilities of HSOs and partnerships with health care payers and providers.

Pilot Regions



Network Lead Regions

Access East, Inc.

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

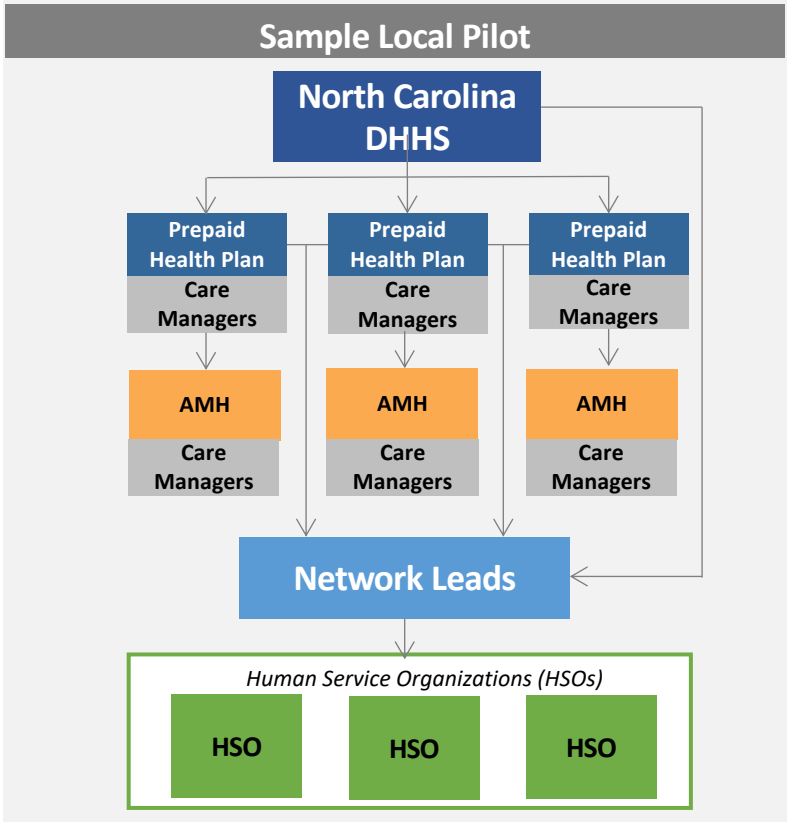
Community Care of the Lower Cape Fear

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

Dogwood Health Trust

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

How Will the Pilots Work?

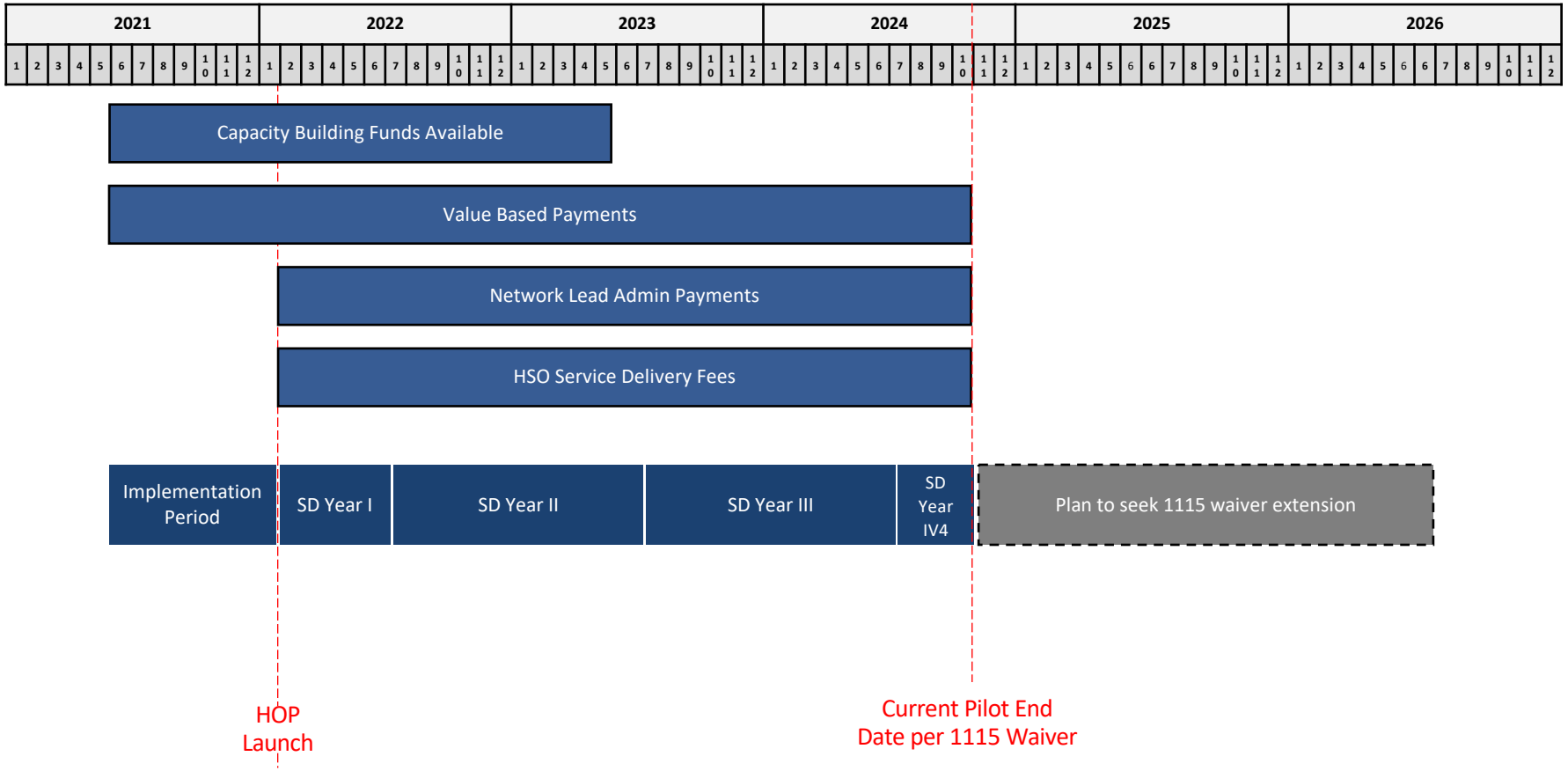


Key Entities' Roles in the Pilots

- **Prepaid Health Plans (PHPs):**
  - Manage a Pilot budget
  - Approve member eligibility for Pilot services and authorize services
  - Ensure the provision of care management to members
  - Ensure individuals are enrolled in other federal/ state programs if eligible (e.g. SNAP and TANF)
  - Pay HSOs for Pilot services delivered and submit payment information to DHHS as encounters
- **Care Managers:**
  - Interface with members to conduct care management at PHPs, Tier 3 AMHs, AMH+s, LHDs, and CMEs/CMAs*
  - Assess beneficiary eligibility for Pilot services (approved by PHP); track member progress
- **Network Leads:**
  - Define the geographic area they serve
  - Develop, manage, and oversee a network of HSOs
  - Serve as a connection between PHPs and HSOs
  - Provide technical assistance to HSOs; convene Pilot entities to share best practices
  - Review and submit HSO invoices to PHPs; work on behalf of HSOs to resolve any payment disputes
  - Collect and report data to DHB to assist in evaluation and oversight
- **Human Service Organizations:**
  - Frontline social service providers that contract with the Network Lead to deliver Pilot services to Pilot members
  - Submit invoices and receive reimbursement for services delivered

* Tier 3 Advanced Medical Homes (AMHs), AMH+s, Local Health Departments (LHDs), and Care Management Entities (CMEs)/Care Management Agencies (CMAs) are all entities that may provide local care management if delegated by the PHP as part of Medicaid Managed Care

Revised Healthy Opportunities Pilots Timeline



Healthy Opportunities Phased Approach

- **Feb 1, 2022: Engagement and NCCARE360 Functionality**
  - Pilot/Unite Us Payments functionality to be ready in NCCARE360. NLs and HSOs will have access to training environment. HSO onboarding status to Pilot/Unite Us Payments functionality, including services offered, to be communicated to SPs.
  - The Department is working with the PHPs on developing an engagement strategy for working with the Network Leads and HSOs. NLs are encouraged to communicate PHP engagement preferences/feedback to the Department.

- **Mar. 15, 2022: Launch food services and 3 CINs**
  - Launch service delivery in all three Pilot regions, but only with food services.
  - Capacity building process should continue for all other service domains
  - Members will only be enrolled into the Pilot from 3 CINs: Access East, Mission Health Partners, and CCPN.
  - PHPs will not be assessing eligibility, enrolling, and recommending services for members assigned to Tier 1 and 2 AMHs or to members assigned to Tier 3 AMHs not affiliated with the above 3 CINs
  - If needed, the Department could consider setting expectation or limiting the 3 CINs to only enroll 100 - 250 members each in the first 45 days.

- **May 1, 2022: Launch housing and transportation services and additional CINs**
  - Launch delivery of housing and transportation services.
  - Add any AMH Tier 3s or CINs that are ready to enroll (AMM, Carolina Medical Home Network, etc).
  - No enrollment limits will be applied.

- **June 15, 2022: Launch toxic stress cross-domain services**
  - Launch delivery of toxic stress and cross-domain services. IPV and certain cross-domain "sensitive" services may not yet be live.
  - PHPs begin “Care Manager” role of assessing eligibility, enrolling and recommending services for members assigned to Tier 1 and 2 AMHs and members assigned to Tier 3 AMHs not conducting Pilot care management

Pilot Eligibility: Physical/Behavioral Health Criteria

Medicaid members must meet at least one physical/behavioral health criteria and one social risk factor to be eligible for the Pilot program.

Eligibility Category	Age	Physical/Behavioral Health Criteria (at least one, per eligibility category)
Adults	21+	• 2 or more chronic conditions. Chronic conditions that qualify an individual for pilot 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
	0-20	• 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 85th %ile for age and gender, developmental delay, cognitive 67 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

Pilot Eligibility: Social Risk Factors

Medicaid members must meet at least one physical/behavioral health criteria and one social risk factor to be eligible for the Pilot program.

Risk Factor	Definition
Homelessness and housing insecurity	Homelessness, as defined in U.S. Department of Health and Human Services 42 CFR § 254(h)(5)(A), and housing insecurity, as defined based on questions used to establish housing insecurity in the Accountable Health Communities Health Related Screening Tool.
Food insecure	As defined by the US Department of Agriculture commissioned report on Food Insecurity in America: • Low Food Security: reports of reduced quality, variety, or desirability of diet. Little or no indication of reduced food intake. • Very low food security: Reports of multiple indications of disrupted eating patterns and reduced food intake
Transportation insecure	Defined based on questions used to establish transportation insecurities in the Accountable Health Communities Health Related Screening Tool.
At risk of, witnessing or experiencing interpersonal violence	Defined based on questions used to establish interpersonal violence in the Accountable Health Communities Health Related Screening Tool.

Pilot Services and Fee Schedule

Healthy Opportunities Pilots Fee Schedule		
Service Name	**Unit Of Service/Payment**	**Rate or Cap**
Housing		
Housing Navigation, Support and Sustaining Services	PMPM	$400.26
Inspection for Housing Safety and Quality	Cost-Based Reimbursement Up to A Cap	Up to $250 per inspection
Housing Move-In Support	Cost-Based Reimbursement Up to A Cap	• 1 BR: Up to $900 per month • 2 BR: Up to $1,050 per month • 3 BR: Up to $1,150 per month • 4 BR: Up to $1,200 per month • 5+ BR: Up to $1,250 per month
Essential Utility Set-Up	Cost-Based Reimbursement Up to A Cap	• Up to $500 for utility deposits • Up to $500 for reinstatement utility payment • Up to $500 for utility arrears
Home Remediation Services	Cost-Based Reimbursement Up to A Cap	Up to $5,000 per year[1]
Home Accessibility and Safety Modifications	Cost-Based Reimbursement Up to A Cap	Up to $10,000 per lifetime of waiver demonstration[2]
Healthy Home Goods	Cost-Based Reimbursement Up to A Cap	Up to $2,500 per year

- 69 HSO applications;
  50 in final network (72.5%)
- 40 nonprofits (77%);
  9 for profit; 1 government
- 19 speak 2+ languages (38%)
- 23 plan to use subcontractors (42%)
- Median years in service: 15

❑ ≤2 years: 18% of HSOs

❑ 3-9 years: 18%

❑ 10-29 years: 42%

❑ >30 years: 22%



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https://www.carelcf.org/healthy-opportunities/

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