

Investing in Whole Person Health: Working Toward an Integration of Physical, Behavioral, and Social Health

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North Carolina is developing a unique and innovative infrastructure to support integrated physical, behavioral, and social health care. Efforts by the North Carolina Department of Health and Human Services, the Foundation for Health Leadership & Innovation, Cone Health, Atrium Health, and the One Charlotte Health Alliance advance our understanding of how to best operationalize the design and payment of integrated services. Best practices such as the collaborative care and primary care behavioral health models reduce inefficiencies and disparities by bringing together teams of primary care and behavioral health care providers.

Statewide Vision and Momentum in North Carolina

There is a unique momentum building in North Carolina around whole person health and the integration of physical, behavioral, and social health. The strategy is informed by best practices and evidence from North Carolina and other states, but is taking the next step of layering complementary approaches and bringing elements to a statewide scale. By creating an environment of learning as part of the work, the experience in North Carolina can add to the evidence base of addressing whole person health, provide learnings for other states, and inform national policy.

Layered initiatives such as NCCARE360 (a health and human services electronic network), a standardized social needs screening tool, and incentives within North Carolina's design for Medicaid managed care provide necessary infrastructure to address the roots of health. Health systems and community partners use these tools to manage individual needs and resolve widespread inequities in social conditions, such as housing and nutritious food access. To do so, institutional partners must listen carefully to communities that have been historically excluded, ask difficult questions, and develop new ways of working together. While North Carolina's unique ecosystem is poised to realize important improvements in health status, we must heed lessons from around the country: the population benefits of stable health care coverage, such as those realized by states that have expanded Medicaid eligibility; the importance of strong oversight capacities within a managed care approach to Medicaid; the need to develop robust integrated care initia-

tives for the elderly and people with disabilities; the critical importance of strong and well-resourced primary care networks; and the alignment of commercial and public payers.

To catalyze statewide change, the North Carolina Department of Health and Human Services (NC DHHS) is executing a comprehensive multiyear effort to buy health, not just health care, across a unified agenda embedded in North Carolina's health care infrastructure. This holistic view of health is exemplified in major cross-sector strategic plans, including Healthy North Carolina 2030 [1], the Opioid Action Plan 2.0 [2], the Early Childhood Action Plan [3], and the design of Medicaid managed care [4].

To enable system transformation and innovation, NC DHHS is developing shared tools and infrastructure that can be leveraged across populations, communities, health systems, and payers to unite health care and human service agencies and build capacity for whole person health and well-being. Standardized screening questions can routinely identify unmet resource needs in an individual, but can also facilitate standardized data collection and risk adjustment that includes social risk factors. NCCARE360, the first ever statewide coordinated network with a shared resource repository and closed loop referral digital platform, will not only more efficiently connect a person to services, but will give more visibility into the two sectors [5].

Financial incentives are being aligned within fee-for-service Medicaid and Medicaid managed care to buy health within Medicaid, but also across payers as part of an accelerated move to value-based payments. Strategic community investments from payers, health systems, and philanthropy, informed by data on individual and community needs, can complement health care financing.

North Carolina also has the unprecedented learning opportunity to test which services provide the highest value and learn how to buy health at a population scale through the

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flexibility to use Medicaid dollars for non-medical services, such as food and housing supports, as part of the Healthy Opportunities Pilots in North Carolina's 1115 Demonstration Waiver [6].

While the state is catalyzing innovation through shared infrastructure, alignment, and initiatives, much of the work, learning, and further innovations have been and will be driven by local providers, communities, partners, and systems, and informed by national trends.

Best Practice Models Informing Integrated Care

North Carolina has made great strides toward recognizing and acting on the paradigm shift to whole person care by implementing strategies that integrate physical and behavioral health to address the disparities and inefficiencies of siloed physical and behavioral services. The Foundation for Health Leadership & Innovation's Center of Excellence for Integrated Care has helped to lead and inform that progress, especially in supporting best practice models of primary care behavioral health integration.

In the collaborative care model of integrated behavioral health care, a registry of primary care patients with a behavioral health condition such as depression is managed by a team consisting of the primary care provider, a behavioral health care manager, and a consulting psychiatrist [7]. Medicare initially piloted collaborative care codes, and in October 2018, NC DHHS took the next step to activate team-based coding and reimbursement for collaborative care for Medicaid beneficiaries. After working with community providers and receiving feedback on implementation barriers, NC DHHS took steps to allow psychiatrists not enrolled in Medicaid to consult with primary care practices via collaborative care, significantly improving primary care providers' access to consulting psychiatric providers.

In the primary care behavioral health model (PCBH), behavioral health providers serve as collaborative members of the primary care team working to support patients' physical, behavioral, and social needs [8]. As a result of continuous collective efforts across the state, approximately 40% of primary care providers in North Carolina are colocated

with a psychologist or social worker [9], and additional colocation is occurring between primary care providers and other behavioral health professionals. NC DHHS supported the PCBH model by offering flexibility in the formal assessment and treatment planning requirements mandated in traditional outpatient behavioral health facilities [10].

North Carolina will further this system change as it moves to Medicaid managed care by dismantling the behavioral health carve out and transitioning physical, behavioral, and social health services to payment by one entity and delivery to patients under the same health plans.

Value-based Care Catalyzing Whole Person Focus

The move to value-based care, as part of health care reform, has accelerated whole person integrated care and an emphasis on prevention. Cone Health (with six hospitals and over 100 physician practices headquartered in Greensboro) has embraced this shift in perspective. Early efforts led by its accountable care organization, Triad Healthcare Network, proved that they could improve care quality, lower health care costs, and alleviate pain and suffering by understanding patients better, improving collaboration, and addressing social needs, like a wheelchair ramp so someone can feel less isolated or a refrigerator to store medications safely.

These experiences have fueled Cone to move from downstream action (for example, providing medical treatment for children whose poor housing quality triggers an asthma attack) to the midstream (working with a local housing agency to remove triggers from the child's home) to go even further upstream (working with partners to improve the availability and quality of affordable housing throughout our communities) (Figure 1). This body of work, focused on housing quality and nutrition access, is moving from pilot stage to becoming standard of care.

A Focus on Equity and Engaging the Community is a Critical Aspect

While shared infrastructure, evidence-based models, and health care reform elements may catalyze whole person care, the need to address the inequities that drive our

FIGURE 1.
One Participant's Experience with Whole Person Health

Madeline Reed, a participant in the first phase of the Aging Gracefully initiative with Community Housing Solutions of Greensboro:

"I am now free to safely come and go from my home. I have a secure handrail and steps that are the right size. I have a secure floor on that little porch. Now I can get back to doing my own grocery shopping and taking out my own garbage. But the greatest gift that it has given me is my freedom, and that means my independence. At the end of the bathroom repairs, which were a shower chair and grab bars, I went to take a shower for the first time. When I got out, I noticed that I had been in there for over 30 minutes. The reason I was in there for so long is that I was sitting on the shower chair crying. I know that sounds mushy, but what was causing me to cry was the realization that this was the first time in ten years that I was able to shampoo and shower using both hands and not just one hand because I was no longer grabbing for the wall. I felt safe and secure and that has made all the difference in the world. This kind of help, what it does, it allows you then to give back. It allows you to be a productive member of the community of Greensboro."

disparities and poor outcomes in the first place is critical. To do so in a meaningful way, health care must engage local communities in this work.

Atrium Health is one of the leading health care organizations in the Southeast. Its mission to improve health, elevate hope, and advance healing for all is foundational to all of its work, drives collaborations and partnerships in the community, and has been the basis for its work over the past three years in addressing whole person needs. One of the critical factors Atrium has identified is the importance of diverse community members understanding how to identify specific community needs, create action plans, support sustainability models, and build advocacy frameworks to address those needs. This community-driven process has resulted in three key learnings:

Look and Listen Outside the Exam Room

In 2016, Atrium completed its first community health improvement study, along with geographic information system (GIS) mapping of 12 social determinant indicators, and developed a strategy around community health. This study laid the foundation for NC DHHS's State Center for Health Statistics interactive map showing social indicators down to the census tract level across all of North Carolina [11].

Working with the communities in the highest social needs areas, Atrium determined that the health care system should focus on two social factors that shape people's health: food and housing insecurity. This information was used to create collaborative strategies to focus on these issues, including partnerships with non-traditional partners.

Ask the Difficult Questions

Based on community feedback, Atrium began a pilot program that asked patients about social factors that were consistently affecting their health, including food access, housing, and transportation.

These questions and others (e.g., work, finances, interpersonal relationships) have been integrated directly into the electronic health records to routinely identify needs, prompting conversations about those needs between clinical care providers and patients, and generating electronic referrals to social service agencies electronically, if needed.

Be Willing to Get Uncomfortable

Since Atrium began to ask patients questions about social needs in its medical practices, the health system has been able to pinpoint some of the most consequential social barriers, including ones that Atrium may have addressed itself. Community feedback consistently mentioned that the local health systems had not invested in health care access points within high social needs neighborhoods [12]. While this feedback was hard to hear, it helped create the One Charlotte Health Alliance (OCHA), an official collaboration of Atrium Health and Novant Health, along with Mecklenburg County (MC) Public Health. This unprecedented collabora-

tion between two historical competitors was designed to address health disparities in underserved communities in Charlotte. OCHA identified primary care access and food insecurity as major issues disproportionately affecting the six zip codes comprising MC's Public Health Priority Areas. Since inception, OCHA has improved primary care access through two mobile health units, community health nurses imbedded with community partners, and two new mobile food pharmacies. This work would not have happened if not for the willingness to listen to community feedback.

Other Lessons to Learn from Outside North Carolina

North Carolina's efforts are the subject of national attention. No other state has thought as systematically as North Carolina about how to routinely identify health-related social needs or coordinate medical and social services with an information technology infrastructure (NCCARE360). No other state Medicaid waiver has gone as far as North Carolina's in defining particular non-medical services to be paid for, the units of service and payment rates, and the accountability of those providers, or proposed as rigorous a rapid-cycle and summative evaluation process with a goal of mid-waiver adjustments and precise learning. But just as other states are learning from the Tar Heel state, North Carolina also has opportunities to continue to learn from them.

The first lesson is that the work of improving population health is easier when people have a steady and reliable source of health care financing and are not challenged to provide care that is uncompensated. States that have expanded Medicaid eligibility have seen the health of their populations improve [13].

A second lesson is to understand what new capacities are needed to develop standards and accountability for managed care organizations. Medicaid managed care is not a new phenomenon for states. Done well, it can improve the health of enrolled populations at lower rates of cost growth. But this takes new skills for the state agencies involved—including contracting, measurement, and oversight. Some states do this work better than others, and the difference is a function of commitment and adequate management resources. Significant cuts to administrative budgets of state Medicaid agencies compromise the ability for meaningful oversight and improvement.

Another lesson has to do with not neglecting the parts of the Medicaid population that continue to consume the majority of the Medicaid budget—the elderly and disabled populations. States are learning how to meet the many and varied needs of these growing populations in the least restrictive setting, how to work with family caregivers, how to facilitate care coordination, and how to integrate care and financing with federal Medicare, which remains an important if not always flexible payer. The state will need to apply the lessons learned elsewhere to learn how to “buy health”

for this population in ways that are both fiscally responsible and family-sensitive.

Further, leaders in North Carolina should be guided by evidence on the centrality of a strong and robust primary care delivery system as the source of coordinated, comprehensive, and patient-centered care. Primary care is the only health care service positively associated with both improved and more equitable health outcomes [14]. The work of improving the health of the entire population is not possible without it, and it is in the state's interest to make sure primary care is strengthened with direct, accountable investments that increase the share of the health system dollars going to primary care. NC DHHS has already taken a step by increasing rates for primary care services to keep these in line with Medicare's physician fee schedule. Further progress can be accomplished with commercial and Medicaid health plan accountability measures.

Finally, while North Carolina Medicaid can lead on these initiatives, it cannot go alone. To transform themselves, providers need aligned efforts across commercial and Medicaid payers. Statewide multipayer collaboratives convened by the employer and government sectors in other states, with accountability and transparency, have aligned improvement priorities and payer activities. It stands to reason that sending common signals to providers across payers results in less provider distress and more improvements for the populations they care for.

The innovations in North Carolina have unleashed a torrent of creativity and optimism in health care sectors in the Tar Heel state. Health policy and health sector leaders elsewhere are watching with great anticipation. **NCMJ**

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References

1. North Carolina Institute of Medicine. Healthy North Carolina 2030. North Carolina Institute of Medicine website. <http://nciom.org/healthy-north-carolina-2030/>. Accessed March 26, 2020.
2. North Carolina Department of Health and Human Services. North Carolina's Opioid Action Plan. NC DHHS website. <https://www.ncdhhs.gov/about/department-initiatives/opioid-epidemic/north-carolinas-opioid-action-plan>. Accessed March 26, 2020.
3. North Carolina Department of Health and Human Services. Early Childhood Action Plan. NC DHHS website. <https://www.ncdhhs.gov/about/department-initiatives/early-childhood>. Accessed March 26, 2020.
4. North Carolina Department of Health and Human Services. North Carolina's Transformation to Medicaid Managed Care. NC DHHS website. <https://medicaid.ncdhhs.gov/transformation>. Accessed March 26, 2020.
5. NCCARE360 website. <https://nccare360.org/>. Accessed March 26, 2020.
6. North Carolina Department of Health and Human Services. Healthy Opportunities Pilots. <https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/healthy-opportunities-pilots>. Accessed March 26, 2020.
7. Unützer J, Katon WJ, Fan MY, et al. Long-term cost effects of collaborative care for late-life depression. *Am J Manag Care*. 2008;14(2):95-100.
8. Strosahl K, Robinson P. The primary care behavioral health model: Applications to prevention, acute care and chronic condition management. In: Kessler R, Stafford D, eds. *Collaborative Medicine Case Studies: Evidence in Practice*. New York, NY: Springer; 2008:85-95.
9. Richman EL, Lombardi B, de Saxe Zerden L, Randolph R. Where is Behavioral Health Integration Occurring? Mapping National Co-location Trends Using National Provider Identifier Data. Ann Arbor, MI: University of Michigan Behavioral Health Workforce Research Center; 2018. http://www.behavioralhealthworkforce.org/wp-content/uploads/2018/12/NPI-Full-Report_Final.pdf. Accessed February 24, 2020.
10. North Carolina Division of Medical Assistance. North Carolina Division of Medical Assistance Behavioral Health Clinical Coverage Policy No. 8C: Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers. Raleigh, NC: North Carolina Division of Medical Assistance; 2017. https://files.nc.gov/ncdma/documents/files/8C_0.pdf. Accessed February 24, 2020.
11. North Carolina State Center for Health Statistics. North Carolina Social Determinants of Health by Regions. North Carolina State Center for Health Statistics website. <http://nc.maps.arcgis.com/apps/MapSeries/index.html?appid=def612b7025b44eaa1e0d7af43f4702b>. Accessed March 26, 2020.
12. Tapp H, White L, Steuerwald M, Dulin M. Use of community-based participatory research in primary care to improve healthcare outcomes and disparities in care. *J Comp Eff Res*. 2013;2(4):405-419. doi: 10.2217/ce.13.45
13. Graves JA, Hatfield LA, Blot W, Keating NL, McWilliams JM. Medicaid expansion slowed rates of health decline for low-income adults in southern states. *Health Aff (Millwood)*. 2020;39(1):67-76. doi: 10.1377/hlthaff.2019.00929
14. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q*. 2005;83(3):457-502.