NC HealthConnex
Powering Health Care Outcomes

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Health Benefits

HIE Medicaid Services Program
Health-Related Social Needs Screening Use Case

What is the HIE Medicaid Services Program?

The HIE Medicaid Services (HMS) Program is a joint effort between the North Carolina Health Information Exchange Authority (NC HIEA) and the North Carolina Department of Health and Human Services (NCDHHS) Division of Health Benefits (DHB). The goal of this partnership is to leverage NC HealthConnex, North Carolina's state-designated health information exchange, to support NC Medicaid's quality, population health and care management efforts by improving data exchange. Currently, this work focuses on three main use cases:

1. **Digital Quality Measures (dQMs)**
2. **Health-Related Social Needs (HRSN) Screening**
3. **Care Management Data**

What is the Value of the HRSN Use Case?

1. **Increase Access to HRSN Screening Data:** Develop the capabilities to access and integrate Medicaid beneficiaries' HRSN data across health plans, providers and NC Medicaid.

2. **Reduce Administrative Burden:** Reduce the need for care managers and providers to conduct potentially duplicative HRSN screens.

3. **Improve Patient Experience:** Support Medicaid beneficiaries by minimizing the number of times sensitive questions are asked while gaining a deeper understanding of their HRSN to connect them with the necessary services.

What are Health-Related Social Needs?

Health-related social needs, also commonly referred to as social determinants of health (SDOH) or health-related resource needs (HRRN), refer to the social and economic needs that individuals experience that affect their ability to maintain their health and well-being (e.g., housing, transportation, food, etc.).[1]

Vision for the HRSN Screening Use Case: Leverage NC HealthConnex to improve the availability, accuracy and timeliness of NC Medicaid beneficiaries' HRSN screening information across data sources.

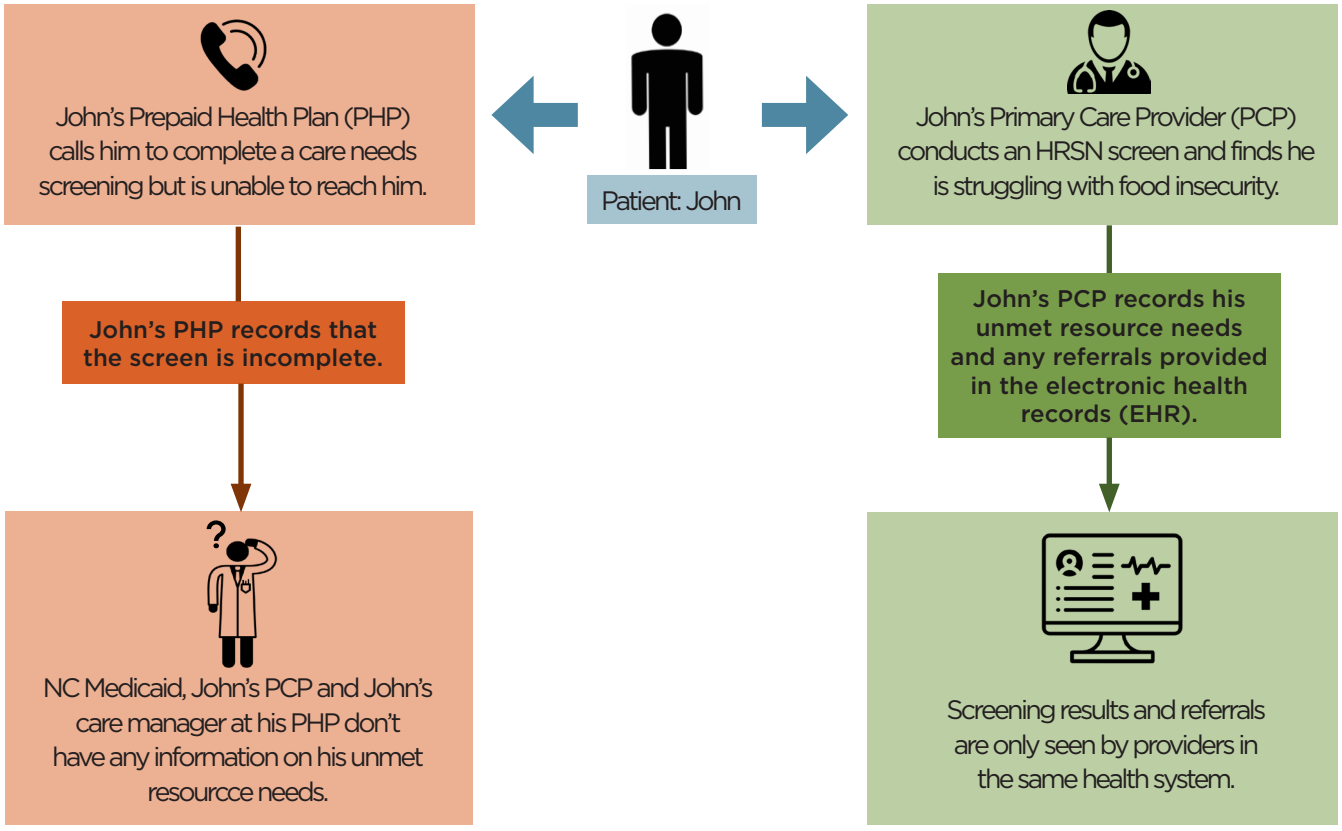
[1] For more information about HRSN, see the U.S. Health and Human Services page Call to Action: Addressing Health-Related Social Needs in Communities Across the Nation (hhs.gov).

Understanding and addressing HRSN is a key focus for NCDHHS and NC Medicaid. Complete and up to date data on a patient's HRSN can help patients get connected to the resources they need to thrive, help providers improve clinical decision-making and help policymakers evaluate the effectiveness of programs and policies focused on HRSN.

The Current State of HRSN Screening?

Currently, NC Medicaid providers and health plans collect information on Medicaid beneficiaries' HRSN and store that information in their respective environments. This may be the provider's electronic health record (EHR) or the health plan's care management system. These entities may also be using different screening instruments, leading to variation in the wording of HRSN questions and potential fluctuations in a beneficiary's response. Overall, this makes it difficult for all stakeholders to understand the full picture of a beneficiary's health and can lead to duplicative HRSN screens or missed opportunities to connect an individual to services (see Figure 1).

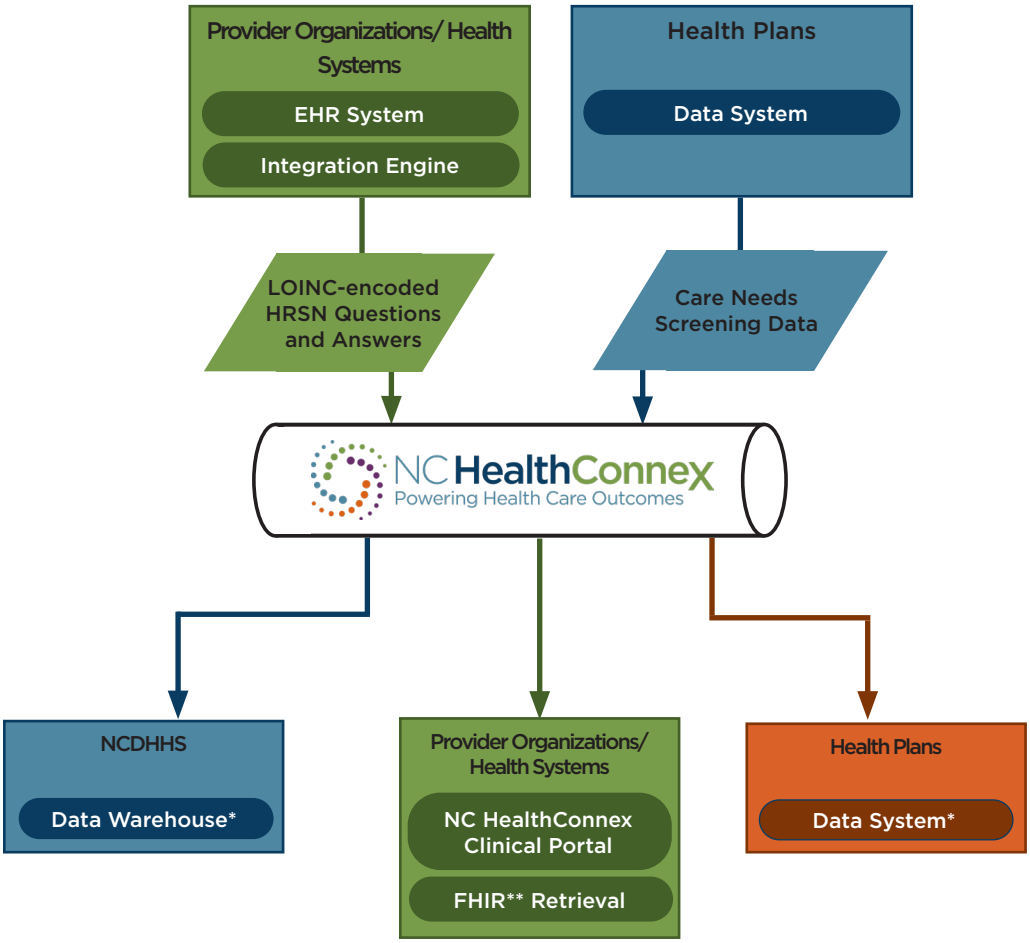
Figure 1. The Current State of HRSN Screening Data Exchange



What is the HRSN Screening Use Case?

The initial focus of the HRSN screening use case is on transmitting screening data for six of NCDHHS's eleven standardized screening questions covering food, housing/utilities and transportation (see Figure 2).[2] While this use case leverages NCDHHS's standardized HRSN screening questions, it does not require providers to use a specific assessment instrument, nor does it dictate which data systems providers use to collect and store the HRSN screening results.

Figure 2. The Future State of the HRSN Use Case



*HRSN data to be transmitted via the Priority Data Element Files

**Fast Healthcare Interoperability Resources (FHIR)[3]

[2] View the full NCDHHS Screening Tool on their website.

[3] Learn more from the Office of the National Coordinator for Health Information Technology page What is HL7 FHIR?

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This use case will occur in three phases:

Phase One: Collecting Providers' HRSN Screening Information

1. Providers collect HRSN screening results and store them in their EHR.

2. Provider organizations encode the HRSN screening questions from their source system and patient responses in Logical Observation Identifiers Names and Codes (LOINC) either via their EHR or an Integration Engine.

3. This information is transmitted to NC HealthConnex via ZPV segments of Health Level Seven (HL7) Admission, Discharge and Transfer (ADT) messages. Specifications for provider organizations' transmission of this LOINC-encoded HRSN screening information will be shared with participants as part of the onboarding process to this use case. In later phases of this work, the team aims to develop the capabilities to receive HRSN screening information from providers via Continuity of Care Documents (CCDs).

4. NC HealthConnex stores the incoming HRSN screening information from providers.

Phase Two: Sharing Providers' HRSN Screening Information with Providers, Medicaid Health Plans and NC Medicaid

1. NC HealthConnex makes HRSN results available to authorized provider staff via the NC HealthConnex Clinical Portal.

2. NC HealthConnex transmits HRSN data in response to providers' FHIR query, allowing providers to retrieve results and integrate them into a data warehouse and/or the EHR.

3. NC HealthConnex transmits HRSN screening data to NC Medicaid and the Medicaid health plans via a monthly file (known as the Priority Data Elements).

Phase Three:

Collecting and Sharing Medicaid Health Plans' HRSN Screening Information

1. Medicaid health plans collect HRSN screening results and store them in their data systems.

2. Medicaid health plans transmit HRSN screening information to NC Medicaid via a quarterly file (known as BCM026) and to NC HealthConnex (format and transmission method under development).

3. NC HealthConnex presents this data from the health plans in the formats described in phase 2 above.

At this time, HRSN referral information is not in scope. This use case focuses on the transmission of HRSN screening information and does not address the creation, transmission or management of HRSN-related referrals through closed-loop referral systems like NCCARE360.[4]

Alignment with Other Statewide Initiatives

Healthy Opportunities Pilots

North Carolina's Healthy Opportunities Pilots (HOP) is a first in the nation initiative designed to assess the impact of offering targeted, evidence-based, non-medical services for HRSN in the domains of housing, food, transportation and interpersonal safety and toxic stress to eligible Medicaid beneficiaries.[5] While the initial focus of the HRSN screening use case is on securely sharing screening data with authorized providers and health care entities, one of the broader goals is to develop a robust system capable of supporting HOP. Expanding access to screening data will facilitate HOP eligibility determinations, enhance the evaluation of program outcomes and alleviate the administrative burden on care managers and program administrators in monitoring patient progress. Future phases aim to integrate referral and outcome information from NCCARE360 to help close the loop for individuals with identified needs.

North Carolina State Transformation Collaborative

Launched in February 2023, the North Carolina State Transformation Collaborative (NC STC) fosters multi-stakeholder collaboration to advance value-based and whole-person care across North Carolina.[6] Central to the NC STC's strategy are enhancing health disparities data – including HRSN – and improving data sharing and infrastructure. The NC STC is convened by the Duke-Margolis Institute for Health Policy and supported by NCDHHS, with active involvement from NC HIEA in various alignment initiatives and forums. Ongoing insights and learnings from the HRSN use case are shared through these NC STC platforms to ensure continued alignment in our collective efforts to enhance interoperability and optimize the collection, sharing and utilization of HRSN data.

[4] NCCARE360 is a statewide coordinated care network that electronically connects those with identified needs to community resources. For more information, visit Building Connections for a Healthier NC.
[5] More information about HOP can be found on the Healthy Opportunities Pilots website.
[6] More information about the NC STC can be found on the North Carolina State Transformation Collaborative website.

Center for Medicare and Medicaid Innovation's Making Care Primary Model

North Carolina was selected as one of eight states to participate in the Center for Medicare and Medicaid Innovation's (CMMI's) Making Care Primary (MCP) model.[7] Launched in July 2024, the 10.5-year multi-payer model aims to improve care management and care coordination by focusing on the delivery of advanced primary care services. A key aspect of this model is identifying and addressing patients' HRSN, as participants in the model are required to implement HRSN screening and referrals. The exchange of HRSN screening data through the HRSN use case aims to support model participants by increasing the availability of this screening data via NC HealthConnex.

[7] For more information about CMMI's MCP Model, see this page on the Making Care Primary (MCP) Model.