



Healthy Opportunities Pilots:
*How Care Managers Can Choose
Appropriate Food Services within the
Healthy Opportunities Pilot Program*

For Discussion: May 2022

Goals for Today's Session






Goals

Following today's session, learners will be able to:

- Define Pilot food service eligibility
- Understand how to connect members with select food services outside of Pilot
- Integrate basic Motivational Interviewing (MI) skills to support food resource linkage
- Understand the services provided in the Pilot food domain
- Identify which Pilot services may be appropriate given member needs

Reminder: What Services Can Members Receive Through the Pilots?

North Carolina's Pilot Service Fee Schedule defines and prices 29 services that HSOs can offer as part of the Pilot. Examples include:

 <p>Food</p> <ul style="list-style-type: none"> • Nutrition and cooking education • Fruit and vegetable prescriptions and healthy food boxes/meals • Medically tailored meal delivery 	 <p>Housing</p> <ul style="list-style-type: none"> • Housing navigation, support and sustaining services • Housing quality and safety inspections and improvements • One-time payment for security deposit and first month's rent • Short-term post hospitalization housing 	 <p>Transportation</p> <ul style="list-style-type: none"> • Linkages to existing transportation resources • Payment for transportation to support access to pilot services, (e.g., bus passes, taxi vouchers, ride-sharing credits) 	 <p>Interpersonal Safety</p> <ul style="list-style-type: none"> • Case management/advocacy for victims of violence • Evidence-based parenting support programs • Evidence-based home visiting services 	 <p>Cross-Domain</p> <ul style="list-style-type: none"> • Holistic high intensity enhanced case management • Medical respite • Linkages to health-related legal supports
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Pilot service definitions and fee schedule: https://www.manatt.com/Manatt/media/Documents/Articles/NC-Pilot-Service-Fee-Schedule_Final-for-Webpage.pdf

Reminder: Key Pilot Entities and their Roles

<p>Care Management (CM) Teams</p> <ul style="list-style-type: none"> • Frontline care managers interacting with Members • Assess member eligibility for the Pilots and coordinate Pilot services as part of ongoing care management, in addition to managing physical and behavioral health needs • Manage members' care plan, inclusive of Pilot services, and track enrollee progress over time 	<p>Prepaid Health Plans (PHP)</p> <ul style="list-style-type: none"> • PHPs maintain ultimate responsibility for all Pilot activities • Approve which members qualify for Pilot services and which services they qualify to receive—based on care manager recommendations • Pay for Pilot services delivered by HSOs 	<p>Network Leads</p> <ul style="list-style-type: none"> • Organizations that serve as the essential connection between PHPs and HSOs • Develop, manage, and oversee a network of HSOs • Provide support and technical assistance for HSO network • Convene Pilot entities to share best practices 	<p>Human Service Organizations (HSO)</p> <ul style="list-style-type: none"> • Frontline social service providers that contract with the Network Lead and deliver authorized, Pilot services to Pilot enrollees • Coordinate with care management teams on the delivery of Pilot service to enrollees
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Source: <https://medicaid.ncdhhs.gov/media/10916/download?attachment>

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Reminder: Who is Eligible to Receive Pilot Services?

Individuals must have co-occurring physical/behavioral and social needs in order to receive Pilot services.
Individuals will not receive Pilot services based on social needs alone.

To qualify for Pilot services, Standard Plan members 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**  =focus for today
- Transportation insecure
- At risk of, witnessing or experiencing interpersonal violence

Pilot services also have minimum eligibility criteria and other restrictions. For example, the "Housing Move-In Support Service" is only available for members who are receiving concurrent housing case management and moving for a qualifying reason, such as transitioning from homelessness to stable housing.

Pilot Food Service Qualifying Social Risk Factors

- 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.

Report multiple indications of disrupted eating patterns and reduced food intake.

Ref: [USDA ERS - Definitions of Food Security](https://www.ers.usda.gov/definitions-of-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

Connecting Members to Existing Federal and State Food-Related Resources

All Medicaid members, including Pilot enrollees, should be connected to federal and state resources for which they are eligible to receive.

- It is the Department’s expectation that Medicaid Care Managers will
 - assist all eligible individuals to enroll in SNAP and WIC, if eligible

- SNAP application:
 - ePASS online
 - In person at county DSS
 - By mail or turn into local DSS

HOUSEHOLD SIZE	130% MAXIMUM GROSS INCOME LIMIT	200% MAXIMUM GROSS INCOME LIMIT	MAXIMUM BENEFIT ALLOTMENT
1	\$1,383	\$2,128	\$234
2	\$1,868	\$2,874	\$430
3	\$2,353	\$3,620	\$616
4	\$2,839	\$4,368	\$782

Source: <https://www.ncdhhs.gov/divisions/child-and-family-well-being/food-and-nutrition-services-food-stamps/apply-food-and-nutrition-services-food-stamps-ncmaximum-monthly-income-and-allotment-table>

– See Appendix for NC SNAP link

Source: <https://medicaid.ncdhhs.gov/media/10916/download?attachment>

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Women, Infants & Children (WIC) Program

- The WIC program is designed to provide food and nutrition education to low-income pregnant and postpartum breastfeeding women and infants/children until age five
- Applicant must meet four eligibility criteria:
 1. Live in North Carolina
 2. Be categorically eligible: must be a pregnant woman, a non-breastfeeding woman up to six months postpartum, a breastfeeding woman up to one year postpartum, an infant, or a child up to the fifth birthday.
 3. Must have a gross annual income at or below 185% of the federal poverty line. All Medicaid, TANF (Work First), and Food and Nutrition Services recipients are automatically income-eligible for WIC
 4. Have an identified medical/nutritional risk problem
- See Appendix for WIC resources

Source: <https://www.nutritionnc.com/wic/>

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Motivational Interviewing – Core Skills

MI is based on a respectful and curious way of being with people that facilitates the natural process of change and honors client autonomy

- **Open questions** draw out and explore the person’s experiences, perspectives, and ideas.
- **Affirmation** of strengths, efforts, and past successes help to build the person’s hope and confidence in their ability to change.
- **Reflections** are based on careful listening and trying to understand what the person is saying, by repeating, rephrasing or offering a deeper guess about what the person is trying to communicate.
- **Summarizing** ensures shared understanding and reinforces key points made by the client.
- Attending to the **language of change** identifies what is being said against change (sustain talk) and in favor of change (change talk).
- **Exchange of information** respects that both the clinician and client have expertise. Sharing information is considered a two-way street and needs to be responsive to what the client is saying

Source: <https://motivationalinterviewing.org/understanding-motivational-interviewing>

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Motivational Interviewing – Fundamental Processes

Engaging: The goal is to establish a productive working relationship through careful listening to understand and accurately reflect the person’s experience and perspective while affirming strengths and supporting autonomy.

Focusing: In this process an agenda is negotiated that draws on both the client and practitioner expertise to agree on a shared purpose, which gives the clinician permission to move into a directional conversation about change.

Evoking: In this process the clinician gently explores and helps the person to build their own “why” of change through eliciting the client’s ideas and motivations.

Planning: Planning explores the “how” of change where the MI practitioner supports the person to consolidate commitment to change and develop a plan based on the person’s own insights and expertise.

Source: <https://motivationalinterviewing.org/understanding-motivational-interviewing>

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Applying MI to Food Resource Coordination

Engaging	Focusing	Evoking	Planning
<ul style="list-style-type: none"> • Diet education • Diet related to disease management • Access to healthy food • Knowledge of how to prepare diet appropriate foods • Eliciting reports of reduced quality, variety, or desirability of diet 	<ul style="list-style-type: none"> • Identifying goals • What does success look like • Knowing long term goals • Short term steps to get there • What's reasonable and doable 	<ul style="list-style-type: none"> • Source of motivation <ul style="list-style-type: none"> ○ Weight ○ Health ○ Mobility ○ Family ○ Longevity ○ Feeling well 	<ul style="list-style-type: none"> • What's available that may work • Understand next steps • Discuss appropriate food resources • Agree upon responsibilities • Discuss next steps • Schedule follow up

•AHEC trainings provide further information
See Appendix for course link

Healthy Opportunities Pilots Services and Eligibility

Food Services within the Pilots

- 1) Food and Nutrition Access Case Management Services
- 2) Evidence-Based Group Nutrition Class
- 3) Diabetes Prevention Program (DPP)
- 4) ★ Fruit and Vegetable Prescription
- 5) ★ Healthy Food Box (Delivery and/or Pick-up)
- 6) ★ Healthy Meal (Delivery and/or Pick-up)
- 7) Medically Tailored Home Delivered Meals

★ = Healthy Opportunities Passthrough Service for expedited referral

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Service-Specific Eligibility Criteria for Most Food Services

In addition to meeting Pilot physical/behavioral eligibility criteria and meeting the food-related social risk factor, members must also meet eligibility criteria associated with the Pilot food services.

- Services are authorized in accordance with PHP authorization policies (including the service being indicated in the member's care plan)
- Member is not currently receiving duplicative support through other federal, state, or locally-funded programs.
- Be enrolled in SNAP and/or WIC

If potentially eligible for SNAP and/or WIC, the member must either:

- Have submitted a SNAP and/or WIC application within the last 2 months, or
- Have been determined ineligible for SNAP and/or WIC within the past 12 months
 - Member's attestation acceptable

Source: <https://www.ncdhhs.gov/media/14071/download?attachment>

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Member Management

Care Manager

- Based in Provider offices, Health Plans, Provider Networks, and Health Departments
- Integrated medical and Patient care management
- Coordination of services

Case Manager

- Based in Human Service Organizations
- Specializes in domain expertise
- May identify and recommend additional food or other services to Care Manager



Source: pixabay.com

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1 | Food and Nutrition Access Case Management Services

Food and Nutrition Access Case Management Services	
Services	<ul style="list-style-type: none"> • Linkage to school meals or summer lunch programs, including but not limited to: <ul style="list-style-type: none"> – Assessing eligibility – Assisting with application completion – Coordinating with school staff • Assisting in accessing other community-based food and nutrition resources, such as food pantries, farmers' market voucher programs, cooking classes, Child and Adult Care Food programs, or other resources, including but not limited to: <ul style="list-style-type: none"> – Helping to identify resources that are accessible and appropriate – Accompanying member to community sites • Advising member on transportation-related barriers • Support linkage to other food services, such as SNAP or WIC, although Medicaid care manager expected to be primary
Setting	<p>May be offered: In community setting</p> <ul style="list-style-type: none"> • community center • health care clinic, • Federally Qualified Health Center (FQHC) • food pantry • food bank <p>At member's home</p> <ul style="list-style-type: none"> • for home-bound individuals – By telephone or other modes of direct communication
Frequency	<ul style="list-style-type: none"> • Ad hoc sessions as needed • It is estimated that on average individuals will not receive more than two to three sessions with a case manager
Eligibility	Member is not currently receiving duplicative support through other Pilot services

Source: <https://www.ncdhhs.gov/media/14071/open>

Food and Nutrition Case Management Examples

- Family needing summer food programs for children
 - Understanding variety of services available
 - Accessing services
- Complex nutrition needs
 - Identifying appropriate educational support programs
 - Specific needs regarding health conditions
 - Knowledge and ability to cook
- New medical diagnoses
 - Learning about disease specific diets
 - Combination of dietary restrictions
 - Combination of educational, medical, and social needs



Source: pixabay.com

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2 | Evidence-Based Group Nutrition Class

Evidence-Based Group Nutrition Class	
Services	<p>Evidence-based or evidence-informed nutrition related course with a group</p> <p>Provide hands-on, interactive lessons on topics including but not limited to:</p> <ul style="list-style-type: none"> - Increasing fruit and vegetable consumption - Preparing healthy, balanced meals - Growing food in a garden - Stretching food dollars and maximizing food resources <p>Programs have evidence-based curricula that is approved by DHHS, in consultation with the Network Lead and PHPs.</p> <p>HSO curriculum will be listed on HSO's NCCARE360 description of who the curriculum is targeted to and goals of program.</p>
Setting	<p>Classes may be offered virtually and in variety of community settings, including but not limited to :</p> <ul style="list-style-type: none"> • Health clinics • Schools • YMCAs • Head Start centers • community gardens • community kitchens
Frequency	Typically weekly ; Duration - for six weeks
Eligibility	<p>Member has a diet or nutrition-related chronic illness, including but not limited to:</p> <ul style="list-style-type: none"> • Underweight • Overweight/obesity • Nutritional deficiencies • Prediabetes/diabetes • Hypertension • Cardiovascular disease • Gestational diabetes or history of gestational diabetes • History of low birth weight • High-risk pregnancy

Source: <https://www.ncdhhs.gov/media/14071/open>

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Source: pixabay.com

3 | Diabetes Prevention Program

Diabetes Prevention Program	
Services	<ul style="list-style-type: none"> • A healthy living course delivered to a group of individuals by a trained lifestyle coach designed to prevent or delay type 2 diabetes. • The program focuses on healthy eating and physical activity for those with prediabetes. • The program must comply with CDC Diabetes Prevention Program Standards and Operating Procedures.
Setting	Intervention is offered at a community setting, clinical setting, or online , as part of the approved DPP curriculum.
Frequency	<ul style="list-style-type: none"> – Minimum of 16 sessions in Phase I – Minimum of 6 sessions in Phase II <ul style="list-style-type: none"> • according to CDC Standards and Operating Procedures <p>Duration: Typically, one year, contingent on determination of continued Pilot eligibility</p>
Eligibility	<p>Members must</p> <ul style="list-style-type: none"> • Be 18 years of age or older • Have a BMI ≥ 25 (≥ 23 if Asian) • Not be pregnant at the time of enrollment • Not have a previous diagnosis of type 1 or type 2 diabetes prior to enrollment <p>Have one of the following:</p> <ul style="list-style-type: none"> • A blood test result in the prediabetes range within the past year • A previous clinical diagnosis of gestational diabetes, or • A screening result of high risk for type 2 diabetes through the "Prediabetes Risk Test"
<p>Source: https://www.ncdhhs.gov/media/14071/open 22</p>	



4 | Fruit and Vegetable Prescription

Fruit and Vegetable Prescription	
Services	<p>Food voucher to be used by a member with a diet or nutrition-related chronic illness to purchase fruits and vegetables from a participating food retailer.</p> <p>A voucher transaction may be facilitated manually or electronically. Members spend vouchers at food retailers.</p>
Setting	<p>HSOs can administer and coordinate services by telephone or in the community. Details of participating retailers will be clarified by HSO administering services</p> <p>Food retailers may include but are not limited to:</p> <ul style="list-style-type: none"> - Grocery stores - Farmers markets - Mobile markets - Community-supported agriculture (CSA) programs - Corner stores
Frequency	<p>One voucher per member.</p> <p>Each voucher will have a duration as defined by the HSO providing it.</p> <ul style="list-style-type: none"> • Some HSOs may offer a monthly voucher while others may offer a weekly voucher. • Total value would be up to \$210/mo regardless of voucher frequency <p><u>Duration</u> 6 months (on average) contingent on determination of continued Pilot eligibility</p>
Eligibility	<p>Member has a diet or nutrition-related chronic illness, including but not limited to</p> <ul style="list-style-type: none"> • Underweight • overweight/obesity • nutritional deficiencies • prediabetes/diabetes • Hypertension • cardiovascular disease • gestational diabetes or history of gestational diabetes • history of low birth weight, or • high-risk pregnancy

Source: <https://www.ncdhhs.gov/media/14071/open>

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Fruit and Vegetable Prescription Example

- George is 72 years old and has SNAP, but it is not enough to cover all his food needs. He was advised by his doctor recently that he needs to eat more fruits and vegetable in his diet. He typically eats meats and breads for most of his meals. He said he would like to cook with more fruits and vegetables, but he finds they are more expensive than he can afford. He would like to shop for healthy food and has transportation to get to stores.



Source: pixabay.com

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Source: pixabay.com



5 | Healthy Food Box (Pick-up or Delivery)

<h2>Healthy Food Box</h2>	
Services	<ul style="list-style-type: none"> A healthy food box consists of an assortment of nutritious food aimed at promoting improved nutrition for the individuals with diet or nutrition-related chronic illness. This service does not constitute a full nutritional regimen (three meals per day per person). Healthy food boxes should be furnished using a client choice model (allowing member to pick food) when possible and should be provided alongside nutrition education materials related to topics including but not limited to healthy eating and cooking instructions.
Setting	<p>For Pick-Up: Food is offered for pick-up by the enrollee in a community setting, for example at a food pantry, community center, or a health clinic.</p> <p>For Delivery: Food boxes are delivered to member's home</p>
Frequency	<p>Typically, weekly</p> <p><u>Duration</u></p> <ul style="list-style-type: none"> On average, this service is delivered for 3 months Service would continue until services are no longer needed as indicated in an individual's person-centered care plan
Eligibility	<p>For Delivery: Member does not have capacity to shop for self or get to food distribution site or have adequate social support to meet these needs.</p> <p>Enrollee has a diet or nutrition-related chronic illness, including but not limited to:</p> <ul style="list-style-type: none"> Underweight overweight/obesity nutritional deficiencies prediabetes/diabetes Hypertension cardiovascular disease gestational diabetes or history of gestational diabetes history of low birth weight, or high-risk pregnancy
<small>Source: https://www.ncdhhs.gov/media/14071/open 27</small>	

<h2>Healthy Food Box Examples</h2>	
<ul style="list-style-type: none"> Janeen receives SNAP/FNS and was recently determined ineligible for WIC and has trouble stretching her paycheck to buy enough food to last the month. The CM determines that a healthy food box would help meet her needs and determines that Janeen has transportation to pick it up at one of the HSO's. 	
<ul style="list-style-type: none"> Why would this be better for some than a Fruit and Vegetable Prescription? <ul style="list-style-type: none"> Lack of ability/desire to shop May have wider variety of foods beyond fruit and vegetables Need for delivery 	
<ul style="list-style-type: none"> Delivery vs. pick-up <ul style="list-style-type: none"> Transportation limitations <ul style="list-style-type: none"> HSOs nearby are not on bus line 	
 <p style="text-align: center;"><small>Source: pixabay.com</small></p>	
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Source: pixabay.com



6 | Healthy Meal (Pick-up or Delivery)

Healthy Meal	
Services	<ul style="list-style-type: none"> A healthy, home-delivered meal consists of <ul style="list-style-type: none"> a hot, cold, or frozen meal aimed at promoting improved nutrition for the service recipient This service includes preparation of the meal Meals may be tailored to meet cultural preferences and specific medical needs This service does not constitute a full nutritional regimen (three meals per day per person)
Setting	Delivered to home, or Pick-up in a community setting, for example: <ul style="list-style-type: none"> at a food pantry, community center, or a health clinic.
Frequency	Frequency <ul style="list-style-type: none"> On average, individuals receive 2 meals per day (or 14 meals per week) <u>Duration</u> <ul style="list-style-type: none"> Service would continue until services are no longer needed as indicated in an individual's person-centered care plan, contingent on determination of continued Pilot eligibility
Eligibility	For Delivery: Member does not have capacity to shop and cook for self or have adequate social support to meet these needs. Member has a diet or nutrition-related chronic illness, including but not limited to <ul style="list-style-type: none"> Underweight overweight/obesity nutritional deficiencies prediabetes/diabetes Hypertension cardiovascular disease gestational diabetes or history of gestational diabetes history of low birth weight, or high risk pregnancy

Source: <https://www.ncdhs.gov/media/14071/open>

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Healthy Meal Examples

- Why a Healthy Meal instead of a Food Box?

- Consider cooking ability
 - Ability to stand for long periods of time
 - Dementia or other mental challenges that makes cooking unsafe
 - No refrigerator or stove
- Cooking knowledge
 - Has never cooked for self
 - Doesn't know how to cook "healthy"
- Eating habits
 - Tends to snack instead of having full meals
 - Eats mostly carbs and frozen meals
- Living arrangements
 - Lives alone
 - Rural area
 - Transportation



Source: pixabay.com

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Source: pixabay.com

7 | Medically Tailored Home Delivered Meal

<h2 style="text-align: center;">Medically Tailored Home Delivered Meal</h2>	
Services	<p>Home delivered meal medically tailored for a specific disease or condition</p> <p>This service includes:</p> <ul style="list-style-type: none"> - an initial evaluation with a Registered Dietitian Nutritionist (RD/RDN) or Licensed Dietitian Nutritionist (LDN) to assess and develop a medically-appropriate nutrition care plan - the preparation and delivery of the nutrition care regimen - regular reassessment at least once every 3 months <ul style="list-style-type: none"> • Meals may be tailored to meet cultural preferences. • An organization must follow a widely recognized nutrition guideline approved by the LPE. • This service does not constitute a full nutritional regimen (three meals per day per person).
Setting	<ul style="list-style-type: none"> • Nutrition assessment is conducted in person, in a clinic environment, the enrollee's home, or telephonically as appropriate. • Meals are delivered to enrollee's home.
Frequency	<p>Services will differ based on the severity of the individual's needs.</p> <p>On average, individuals receive 2 meals per day (or 14 meals per week).</p> <p><u>Duration</u> Service would continue until services are no longer needed as indicated in an individual's person-centered care plan, contingent on determination of continued Pilot eligibility</p>
Eligibility	<ul style="list-style-type: none"> • Member does not have capacity to shop and cook for self or have adequate social support to meet these needs. • Eligible disease states include but are not limited to <ul style="list-style-type: none"> - Obesity - failure to thrive - slowed/faltering growth pattern - gestational diabetes - pre-eclampsia - HIV/AIDS - kidney disease - diabetes/pre-diabetes - heart failure • Member is not currently receiving duplicative support through other Pilot services.

Source: <https://www.ncdhhs.gov/media/14071/open> 33

Medically Tailored Home Delivered Meal

Why a Medically Tailored Home Delivered Meal instead of a Healthy Meal

- Complex medical needs
 - Multiple medical conditions
 - Advanced illness
 - Nutrition education needs beyond scope of Care Manager
 - Specific eating restrictions that can't be met by healthy meal delivery
- Includes assessment and direction by trained nutritional expert
 - Care managers have varying degrees of diet knowledge
 - Identify member knowledge deficits and myths about food and eating
 - Take into consideration medical and cultural needs
- Wider range of medically complex choices
 - High caloric needs
 - Kidney disease
 - HIV/AIDS



Source: pixabay.com

Conclusion

Picking the right food/nutrition service for your member:

Understand the member's goals, barriers, and motivation

- Member's location
- Cultural awareness
- Ability to travel
- Ability to cook
- Ability to chew food
- Knowledge of cooking for medical conditions
- Medical complexity
- Health literacy



Source: pixabay.com

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Appendix

Helpful Tools

- SNAP application information
 - <https://www.ncdhhs.gov/divisions/child-and-family-well-being/food-and-nutrition-services-food-stamps/apply-food-and-nutrition-services-food-stamps-nc>
- SNAP Ed library resource for Food related Evidence Based curriculum
 - <https://snapedtoolkit.org/interventions/find/>
- WIC application information
 - <https://www.nutritionnc.com/mywic/index.htm>
- To learn more about Motivational Interviewing:
 - Go to <https://www.ncahec.net/courses-and-events/64802>
 - You will be asked to create a MyAHEC account if you do not have one already

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Healthy Opportunities Pilots: Qualifying Physical/ Behavioral Health Criteria

Population	Age	Physical/Behavioral Health-Based Criteria
Adults	22+	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 %ile 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	<ul style="list-style-type: none"> 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	<p>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:</p> <ul style="list-style-type: none"> 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>

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Timelines for Pilot Service Authorization: Housing

Domain	Pilot Service Name*	Timelines for Pilot Service Authorization		
		Pre-Approved; Expedited Referral	3 business days	7 business days or less
Housing Services	Housing Navigation, Support and Sustaining Services		X	
	Inspection for Housing Safety and Quality			X
	Housing Move-In Support			X
	Essential Utility Set-Up		X	
	Home Remediation Services			X
	Home Accessibility and Safety Modifications			X
	Healthy Home Goods			X
	One-Time Payment for Security Deposit and First Month's Rent			X
	Short-Term Post Hospitalization Housing		X	

Timelines for Pilot Service Authorization: Food

Domain	Pilot Service Name	Timelines for Pilot Service Authorization		
		Pre-Approved; Expedited Referral	3 business days	7 business days or less
Food Services	Food and Nutrition Access Case Management Services			X
	Evidence-Based Group Nutrition Classes			X
	Diabetes Prevention Program			X
	Fruit and Vegetable Prescription	X		
	Healthy Food Box (For Pick-Up)	X		
	Healthy Food Box (Delivered)	X		
	Healthy Meal (For Pick-Up)	X		
	Healthy Meal (Home Delivered)	X		
	Medically Tailored Home Delivered Meal			X

Timelines for Pilot Service Authorization: IPV, Transportation and Cross-Cutting

Domain	Pilot Service Name	Timelines for Pilot Service Authorization		
		Pre-Approved; Expedited Referral	3 business days	7 business days or less
IPV Services	IPV Case Management Services			X
	Violence Intervention Services			X
	Evidence-Based Parenting Curriculum			X
	Home Visiting Services			X
	Dyadic Therapy			X
Transportation Services	Reimbursement for Health-Related Public Transportation	X		
	Reimbursement for Health-Related Private Transportation	X		
	Transportation PMPM Add-On for Case Management Services			X
Cross-Cutting Services	Holistic High Intensity Enhanced Case Management			X
	Medical Respite		X	
	Linkages to Health-Related Legal Supports			X