North Carolina’s COVID-19 Support Services Program: Lessons for Health Policy Programs to Address Social Needs

By William K. Bleser, Katie M. Huber, Hannah L. Crook, Rebecca G. Whitaker, Jasmine Masand, James J. Zheng, Raman Nohria, Michelle J. Lyn, and Robert S. Saunders

ABSTRACT

The North Carolina Department of Health and Human Services launched its COVID-19 Support Services Program in August 2020 to address multiple pandemic-related social needs in counties with COVID-19 hot spots in four target regions of the state. Lessons from the COVID-19 Support Services Program can inform other states’ and payers’ efforts to address social needs, as well as North Carolina’s soon-to-launch $650 million Healthy Opportunities Pilots, which will pay for and provide social services through Medicaid managed care programs. To study the COVID-19 Support Services Program, we interviewed its administrators and frontline providers across the program’s service regions and partnered with one of the program’s largest grantee organizations to analyze survey data.

We offer key recommendations to health policymakers (e.g., state health officials, commercial payers) creating or administering health policy programs to address social needs in local populations: our findings are also relevant to frontline implementers of such programs. Key recommendations include:

• Building the capacity of historically underfunded community-based human service organizations to handle both a larger service demand and surges in demand
• Creating timely communications and feedback channels for all levels of social service providers
• Employing community health workers, who have skillsets and experience straddling both health and social services
• Partnering with local leaders and “community quarterbacks” to achieve maximum reach and equity

Policy Points

> As states consider expanding or creating health programs that address social needs, analysis of North Carolina’s COVID-19 Support Services offers considerations such as building the capacity of community-based human service organizations, creating feedback channels for all providers, and more

> Working with community health workers and community leaders may also help ensure the success of health programs that address social needs

As states consider expanding or creating health programs that address social needs, analysis of North Carolina’s COVID-19 Support Services offers considerations such as building the capacity of community-based human service organizations, creating feedback channels for all providers, and more. Working with community health workers and community leaders may also help ensure the success of health programs that address social needs.
• Leveraging technology designed for two-way referral and tracking between health and human service providers

• Meeting the technical assistance needs of a complex program that involves many different social support services administered by providers with dissimilar processes and cultures

INTRODUCTION

Across the United States, especially in the wake of the COVID-19 pandemic, there is increased attention to social determinants of health (SDoH) — the structural, social, and economic factors that affect community health — which contribute to inequities in individual-level social needs and health outcomes. The focus on SDoH and unmet social needs is reflected in the recently released strategy for the Centers for Medicare & Medicaid Services (CMS) Innovation Center, including its focus on advancing health equity, delivering whole-person care, and partnering with diverse health care stakeholders.

During the COVID-19 public health emergency, several states, counties, and cities across the United States created new programs to address social needs. The North Carolina Department of Health and Human Services (NC DHHS) launched its COVID-19 Support Services Program (SSP) to address multiple pandemic-related social needs by providing services, such as financial relief and home-delivered groceries, to help people safely quarantine or shelter in place due to COVID-19. Due to similarities in design and service provision, the SSP is informally seen as a smaller-scale preview of the state's soon-to-launch $650 million Healthy Opportunities Pilots, and its lessons can guide implementation of the Pilots. Lessons can also help inform the design and implementation of other state and federal efforts to address health-related social needs, especially as states consider how to leverage recent American Rescue Plan Act (ARPA) funding to build infrastructure to address SDoH and social needs.

OVERVIEW OF NORTH CAROLINA’S COVID-19 SUPPORT SERVICES PROGRAM

Leveraging a combination of funding from the Coronavirus Aid, Relief, and Economic Security (CARES) Act and the state (H.B. 1043), North Carolina’s SSP paid for a suite of support services, including direct financial relief, transportation, food, medications, and COVID-19 protection supplies to help people safely quarantine or shelter in place due to COVID-19. The SSP was implemented in four regions of the state and administered through four contracted organizations, also referred to as grantees or vendors. Three of the four grantees are non-profit health service provider organizations, and the fourth is a non-profit community development corporation. The grantees are responsible for coordinating community health workers (CHWs) and networks of local human service organizations (HSOs), which are responsible for frontline service delivery. These grantee organizations were required to submit plans demonstrating their capacity to: ensure delivery of all covered services; manage invoicing, reimbursement, and reporting; and understand the local community and its needs. During the SSP, grantee organizations were responsible for collecting invoices of services delivered by their HSO networks and sending them to the state each month. The state then provided funding to grantee organizations to retroactively reimburse HSOs for the delivered services based on payment rates set by the state.

This report draws on key informant interviews with 17 different expert stakeholders: 16 involved in the SSP — including state administrators, clinical leaders, local human service organizations, frontline health and social service providers, and community health workers — and one administrator from another state with Medicaid programs to address social needs. We also analyzed two survey datasets from one of the four SSP grantee organizations to understand clients’ access to services and experiences with the program, as well as community health workers’ job satisfaction and roles. Based on these lessons, we offer recommendations for other state and national health policy programs focused on beginning or expanding their efforts to address SDoH and social needs.
CHW program to assist with COVID-19 needs in August 2020, and CHWs were deployed into the SSP. Both programs used NCCARE360, a data platform allowing for closed-loop bidirectional referrals between health and human service providers. After all available funding for the original SSP was spent by May 2021, NC DHHS narrowed the focus of the program in order to sustain it. The NC DHHS Office of Rural Health partnered with the Food Bank of Central & Eastern North Carolina to re-launch the SSP in October 2021 to provide food assistance to residents of 34 counties. Residents are eligible for food box deliveries if they need food access to quarantine, isolate, or shelter-in-place due to COVID-19.

The SSP was unique relative to other states’ COVID-19 programs to address social needs and health equity. The SSP addressed many social needs in one program such as living expenses and food, while many other programs tended to focus on one specific social need. In addition, it was open to any North Carolina resident living in one of the four service areas and attesting to experiencing difficulty with social isolation or quarantine for COVID-19. SSP also intentionally focused on equity by prioritizing grantee organizations led and staffed by historically marginalized populations and targeting communities disproportionately affected by COVID-19. Results from the SSP show that over 70% of support services were delivered to historically marginalized populations.

The SSP is a kind of forerunner to North Carolina’s Healthy Opportunities Pilots, which will provide up to $650 million of Medicaid funding to deliver and evaluate pilot services related to housing, food, transportation, and interpersonal violence and toxic stress for Medicaid enrollees in three regions of the state beginning this year. See the Appendix table for a high-level comparison of the two programs.

**FINDINGS FROM NORTH CAROLINA’S COVID–19 SUPPORT SERVICES PROGRAM**

Both clients and CHWs reported positive experiences. We analyzed multiple survey datasets from an SSP grantee organization, including a survey of clients’ experiences and access to services and a survey of CHWs’ job satisfaction and roles. Notably, 86% of surveyed clients reported that it was very easy or easy to access services through SSP. Additionally, 92% of surveyed CHWs reported feeling like their work with SSP was valued by the community (see Figure 1).

This positive reception may suggest that cross-sectoral health–social service programs like the SSP can strengthen client-provider relationships. Prior studies support this idea; patients offered support addressing social needs in a clinical setting report higher satisfaction with care, improved ratings of individual self-worth in other settings, and better access to care.

---

**Figure 1. Provider and Client Satisfaction with Participation in One Region’s COVID-19 Support Services Program**

<table>
<thead>
<tr>
<th>Community health worker responses to the question: “I feel like my work during the pandemic has been valued by the community”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
</tr>
<tr>
<td>Somewhat Agree</td>
</tr>
<tr>
<td>Neither Agree nor Disagree</td>
</tr>
<tr>
<td>Somewhat Disagree</td>
</tr>
<tr>
<td>Strongly Disagree</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Client rating of how easy it was to...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask for Services</td>
</tr>
<tr>
<td>Plan for the Delivery of Services</td>
</tr>
</tbody>
</table>

Source: Authors’ analysis of one NC COVID–19 Support Services Program grantee organization’s surveys of those who received services and of community health workers providing services.

Note: As with all survey results, there are potential limitations, such as challenges in demonstrating causality, e.g., whether clients who have higher satisfaction with care would be more likely to agree to receive social driver services or whether clinicians who have a stronger therapeutic alliance with clients would report seeing more value in their work.
HSOs needed more upfront capital and capacity-building support than anticipated. The SSP depended on HSOs to coordinate and deliver services, providing an opportunity to build capacity within the human services sector during a time when COVID-related increases in social needs were stretching HSOs’ bandwidth. However, interviewees emphasized that HSOs in SSP had to quickly adapt and build infrastructure capacity for data monitoring and reporting, billing, and referrals that were not a part of their usual operations.

One capacity challenge for HSOs in the SSP centered around available cash reserves. Because the SSP was developed to respond quickly to emergency needs, the model was initially based on retrospective reimbursement after service delivery. As a result, HSOs needed to use their existing capital and personnel to build infrastructure, start service provision, and handle surges in demand. Smaller HSOs, which were the majority of the HSOs in SSP, typically had fewer cash reserves to handle these tasks. Some HSOs managed their capacity by creating waitlists, triaging needs, or referring to other community resources. One SSP region, however, was in the financial position to provide its HSOs with upfront capital immediately, which helped them meet service needs from the outset. Later in the SSP’s provision, the state shifted to provide 50% of HSOs’ budgets as prospective payments in November 2020 and January 2021. Further context about the magnitude of upfront support needed for complex health policy programs to address social needs is evident in the Healthy Opportunities Pilots program, where $100 million of its $650 million budget (>15%) is allocated for upfront capacity-building funding for nine months before its service provision period begins.

**Recommendations**

- States and payers should provide substantial time and upfront funding for capacity-building before service delivery for providers and HSOs to expand infrastructure, hire and train additional staff, and implement new technologies.
- Providers and HSOs should monitor service demand surges, and states and payers should maintain additional capacity-building funds to use during periods of unexpectedly high demand surges.

**The program needed to quickly adapt to feedback and clearly communicate about adjustments.** Most evidence to date on services aimed at SDoH and social needs focuses on time-limited and targeted interventions for subpopulations. Because of this limited evidence, and because coordinating and delivering social support services is still new to many organizations providing health services, these programs must be prepared to adjust iteratively as they learn what does and does not work for their particular circumstances. North Carolina’s SSP was no exception. SSP interviewees frequently noted as challenging the rapid adjustments and resulting communications that were required throughout the program’s evolution.

- **Adjustments.** Interviewees highlighted several service-level issues with the SSP early on that required flexibility. In some cases, the service descriptions were too broad, which resulted in unintended or low-quality services delivered. For example, healthy food boxes were described as “an assortment of nutritious foods,” but one interviewee noted this broad definition allowed some food boxes to only contain canned goods and a starch. In other cases, payment rates were cited as insufficient for certain services. For example, some food box providers said that the initial food box payment rates were too low to cover the cost of food and delivery, and some transportation providers said that initial transportation payment rates were too low to cover rural distances. In both cases, NC DHHS was able to increase the payment rate due to flexibility in the funding sources.
underlying the SSP, and made the same changes to the Pilots fee schedule ahead of launch.

Future programs by other states and payers should consider how to regularly update service definitions and payment rates to account for any arising issues. For instance, North Carolina’s Pilots program has a fee schedule set and approved by CMS, which can be periodically revisited through rapid cycle evaluation findings, but not nearly as quickly or flexibly as the state could for the SSP.24 Commercial payers contracted by North Carolina for Medicaid Managed Care could consider “add-on” or “modifier” funds as part of their voluntary Pilots investments in the short term between rapid cycle evaluations,24,25 but other states should consider regulatory language around how and when they can make adjustments.

“...making sure leadership, decisionmakers are accessible, regularly, to everybody... it’s not enough to just listen; the voice actually has to have an influence.”

**Communication.** Interviewees cited the number and breadth of the SSP’s services as a challenge when the state communicated to partners about program adjustments—as well as the number of adjustments required. The diverse set of sectors involved in the program (e.g., food, transportation, housing and living expenses, medical supplies, and health) complicated two-way conversations with administrators, clinicians, CHWs, and HSO providers involved in the program. In addition, in some instances, the state had to send out messages to administrators of grantee organizations without providing advanced notice and obtaining feedback from frontline providers for logistical or legal reasons. Further, interviewees noted that guidance and general communications from the state were sometimes inaccessible to frontline HSO providers and CHWs who spoke English as a second language.

**Local CHWs supported improved care delivery.** North Carolina was designing a statewide “CHW Initiative” program prior to COVID-19 and began small pilots in early 2020.8 When the COVID-19 pandemic struck, North Carolina utilized CARES Act, CDC, and Medicaid funding to create the CHW COVID-19 Program to rapidly scale the CHW Initiative across the state.8 CHWs were hired and managed by seven contracted organizations, including community-based organizations and health care organizations, across the state.8 The development of the CHW program and SSP happened in parallel, but, over time, the state had the two programs work in tandem.

CHWs in the SSP were charged with functioning as resource navigators who screened clients to identify social needs and make referrals to appropriate resources.8 CHWs fulfilled multiple roles in the SSP (see Figure 2), most notably supporting community engagement and outreach, which interviewees viewed as CHWs’ intended role. CHWs have a range of training and are also often asked to take on numerous roles in referral workflow and program administration, and interviewees expressed that some CHWs felt they were asked to perform more administrative duties than anticipated or desired, which limited their time in communities.

The SSP illustrated how to effectively deploy CHWs in cross-sectoral programs aimed at addressing SDoH.8 First, interviewees reported that more effective CHWs lived in the community being served and knew the local geography, populations, and community resources. Relatedly, completed referrals were more likely for those CHWs and HSOs that had worked together before. In con-

<table>
<thead>
<tr>
<th><strong>Recommendations</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• States and payers should design service definitions and payments to balance specificity with flexibility but should also build in pathways to adjust them as needed.</td>
</tr>
<tr>
<td>• States and payers should create multiple lines of communication and feedback with participating providers (including leadership to the frontline) in appropriate languages and at appropriate reading levels.</td>
</tr>
</tbody>
</table>

---

---
Second, CHWs improved identification and engagement of historically marginalized or isolated community members, according to the SSP interviewees. This finding tracks with others’ experience\(^2,27\) and it shows how CHWs can help improve delivery of needed services\(^2,28\). Interviewees recommended that CHWs not only provide screening but also be integrated into care delivery by providing services, such as patient education.

Finally, technology and human capital must be strategically deployed to maximize the CHW role. In the SSP, CHWs were asked to document referrals and services using the NCCARE360 platform. Interviewees observed that CHWs spent substantial time learning the NCCARE360 technology platform and documenting screening and referrals in the field, which left less time for face-to-face conversation with clients and service delivery. Several interviewees suggested that CHWs would be most valuable if paired with a “CHW helper” in the field to assist with administrative and technology-based tasks, and interviewees suggested the state facilitate credentialing of such a role. Additionally, standardized training programs, like the NC CHW Standardized Core Competency curriculum, are important to defining necessary skills and training for CHWs. More clarity can help ensure that CHWs serve in community-oriented roles\(^29\).

### Recommendations

- Organizations should maximize the role of CHWs by integrating them into care delivery (in addition to community and individual liaising).
- States should develop CHW credentialing programs that include several levels of responsibility from more supportive roles to managers.

### Community leaders fostered equitable community relationships.

Several interviewees highlighted the importance of engaging key community members and organizations, described as “community quarterbacks,” who can facilitate equitable outreach. These informal partners were able to draw on their networks and community knowledge to identify ways to reach clients and mobilize resources that complemented the role played by CHWs\(^30\). Interviewees said that one way to identify community quarterbacks was to attend community events (such as farmers markets or community meetings). Some com-

---

**Figure 2. Roles and Responsibilities of Community Health Workers in One Region’s COVID-19 Support Services Program**

<table>
<thead>
<tr>
<th>Roles and Responsibilities Reported by CHWs</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease Prevention Education</td>
<td>2%</td>
</tr>
<tr>
<td>COVID Assistance</td>
<td>32%</td>
</tr>
<tr>
<td>Community Outreach/Support</td>
<td>40%</td>
</tr>
<tr>
<td>Administrative Duties</td>
<td>28%</td>
</tr>
<tr>
<td>Food Services</td>
<td>11%</td>
</tr>
</tbody>
</table>

Source: Authors’ analysis of one NC COVID-19 Support Services Program grantee organization’s survey of community health workers providing services. *Respondents could select multiple options*
Community quarterbacks mentioned by interviewees that might not be readily apparent to external collaborators included:

- Farmers market organizers
- Food pantries
- Concerned citizens groups
- Churches and other faith leaders
- Health departments
- Local indigenous communities
- Local chapters of the National Association for the Advancement of Colored People
- Community colleges
- Sheriff's offices
- Schools
- Local advocacy organizations with experience canvassing or phone-banking (such as NC Counts Coalition, an organization that assists with accurate Census counts in NC, or Black Voters Matter’s NC group, which works to improve voter registration and turnout)\(^ {31,32}\)

To partner with community quarterbacks, interviewees suggested states, payers, and provider organizations hold “meet and greet” events — disseminated by community quarterbacks — at gathering places like houses of worship, farmers markets, grocery stores, public housing complexes, and major community events. According to interviewees, these partnerships and public events were especially critical for engaging non-English speaking communities that faced barriers to accessing care. Community quarterbacks helped increase community members’ trust and willingness to accept services through the SSP. To encourage engagement of trusted community leaders, future programs, including the Pilots, should incentivize contracting with local HSOs run by and serving a higher share of historically marginalized populations.

### Recommendations

- Provider organizations should identify and informally partner with trusted community leaders to capture hard-to-reach individuals in their networks and improve equitable program reach.
- States, payers, and provider organizations should hold community “meet and greet” events with community leaders to build trust.
- States and payers should incentivize contracting with local HSOs run by and serving a higher share of historically marginalized populations.

### Technology needs to easily facilitate two-way referral between health and human service providers.

Through a public-private collaboration, North Carolina partnered with Unite Us to create NCCARE360, the nation’s first statewide system to facilitate two-way referrals between health and human service providers.\(^ {33}\) NCCARE360 serves as both a centralized directory of community resources and an electronic platform to streamline service delivery—and will also be used for referrals and invoicing in the Pilots program.\(^ {34}\) In June 2020, NCCARE360 launched statewide ahead of schedule to aid in COVID-19 response efforts and was used by the SSP to facilitate cross-sector referrals to services.

NCCARE360 is still evolving, and its accelerated, rapid rollout during the SSP, while necessary, caused challenges for some users who were simultaneously learning, using, and troubleshooting the software. Interviewees reported that support was initially available in near-real-time, but as demand increased, support response times grew to several days. Additionally, NCCARE360 was only available in English during the first phase of the SSP, which created barriers to access for some HSOs and CHWs. Interviewees were interested in more frequent and lay-accessible training on the platform in multiple languages.

Interviewees identified some desired functions of NCCARE360 that could streamline service delivery, including:

- The ability to refer to specific services (e.g., food boxes) rather than to specific HSOs
• Regularly updated information about the services offered by HSOs
• Real-time tracking of referrals and case monitoring to assess implementation success and inform program adjustments
• An accessible, user-friendly dashboard to highlight impact on a regular basis

Interviewees felt conflicted about how sophisticated programs like NCCARE360 should function in the future. If NCCARE360 focused on the minimum data and functionality necessary for cross-sector referrals within the SSP, it would create a simpler structure but at the cost of broader utility. Alternatively, if NCCARE360 were to function as a complete data warehouse for health and social information, it would have broader referral capabilities but become subject to multiple sectors’ laws and regulations concerning the use and exchange of data. There is also a philosophical debate around whether technologies like NCCARE360 might impede building trusted relationships among HSOs and health care providers by replacing person-to-person referral processes with automated referral through the platform.

Future programs that address multiple SDoH domains will need to consider how to provide timely technical assistance with specialized expertise to troubleshoot issues unique to each service domain (e.g., food, transportation, housing) as well as cross-cutting challenges.

Recommendations

Cross-sectoral referral technology should:

• allow for referrals to specific services, not just to specific organizations
• automate processes (such as for billing and program reporting)
• build in opportunities for user feedback
• support capacity to be able to address urgent technology issues in near-real-time and provide substantial technical assistance and training
• support the languages commonly used in the communities in which it is deployed

Multiple types of technical assistance were required.

Because of the rapid design and implementation of North Carolina’s SSP, the state did not establish a formal technical assistance program; instead, the state facilitated venues for communication and learning among grantee organizations as rapidly as they could. The SSP tasked each of the four grantees to coordinate CHWs and a network of local HSOs to deliver a large array of social services. Grantee organizations had to navigate payment and provision nuances for different sectors and operate within social support service delivery guidelines and fees established by the state. Given this complexity, interviewees noted that having multiple technical assistance programs tailored to the array of social services in the SSP would be useful.

Recommendations

• States, payers, or provider organizations should have technical assistance programs for each major human service domain given differences in service delivery.
• Technical assistance should take multiple forms. For example, the technical assistance program for Oregon’s Coordinated Care Organization model (Medicaid accountable care model that requires shared savings investment on interventions addressing health-related social needs and equity) includes guidance documents, convenings, learning collaboratives, office hours, and individualized feedback.
• Real-time or near-real-time technical assistance to troubleshoot emerging issues that may be time-sensitive should be available.
• Technical assistance programs should be accessible to both managers and frontline providers—matching the languages and reading levels of those requesting assistance.
**CONCLUSION**

North Carolina's COVID-19 Support Service Program is perhaps the most expansive health policy program to address social needs to emerge during the COVID-19 pandemic in terms of requirements to directly address many social needs domains. We identified lessons from this program, which not only informs North Carolina's Healthy Opportunities Pilots program that is about to begin to address many social needs through Medicaid managed care, but also other states and payers with health policy programs targeting SDoH and unmet social needs (See Table 1). These lessons may be particularly useful to states as they consider how to how to invest their ARPA funding for building infrastructure to address SDoH and social needs.

**Table 1. Recommendations for States’ and Payers’ Health Policy Programs to Address Social Needs**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Recommendation</th>
</tr>
</thead>
</table>
| Supporting HSO Capacity      | • Provide upfront funding for capacity-building before service delivery begins, recognizing that infrastructure building will require more support than likely anticipated.  
• Reserve some capacity-building funds to use for demand surges. |
| Bolstering Program Adaptability | • Design service definitions and payments to balance specificity with flexibility and build in pathways to adjust them as needed.  
• Create accessible, direct lines of communication with all participating providers. |
| Leveraging CHWs              | • Beyond work on patient engagement, maximize the role of CHWs by integrating them into care delivery model for patient engagement and outreach.  
• Develop CHW credentialing programs that include several levels of roles. |
| Partnering with Community Leaders | • Partner with trusted community leaders to improve equitable engagement.  
• Hold community ‘meet and greet’ events with community leaders to build broad trust in the community.  
• Incentivize contracting with local HSOs run by and serving large proportions of historically marginalized populations. |
| Optimizing Technology        | • Support capacity to address urgent issues in near-real time.  
• Provide substantial training on technology (and opportunities for user feedback).  
• Ensure that technology streamlines aspects of critical program functions (e.g., two-way referrals, billing, and reporting).  
• Make technology available in languages spoken by local communities. |
| Providing Technical Assistance | • Provide multiple forms of technical assistance for each human service domain (e.g., guidance documents, learning collaboratives, help lines, office hours, etc.).  
• Offer real-time technical assistance for time-sensitive, emerging issues.  
• Ensure technical assistance is accessible to managers and frontline providers. |
## Appendix Table: Comparison of NC’s Support Services Program and Healthy Opportunities Pilots

<table>
<thead>
<tr>
<th></th>
<th>NC COVID-19 Support Services Program</th>
<th>NC Healthy Opportunities Pilots</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Time</strong></td>
<td>August 2020 launch, services September 2020 to April 2021, Available funds exhausted in May 2021 but food box delivery was re-launched in October 2021 in partnership with Food Bank of Central &amp; Eastern North Carolina</td>
<td>July 2021 launch for capacity-building with service provision beginning Spring 2022 and lasting through October 2024</td>
</tr>
<tr>
<td><strong>Population</strong></td>
<td>Anyone with COVID-19 social isolation, targeted historically marginalized populations with disproportionate COVID-19 burden</td>
<td>Medicaid enrollees with unmet social needs</td>
</tr>
<tr>
<td><strong>Geography</strong></td>
<td>29 of 100 counties, ~42,000 households</td>
<td>Estimated coverage of up to 50,000 Medicaid enrollees in 3 regions of the state</td>
</tr>
<tr>
<td><strong>Financing</strong></td>
<td>CARES Act ($22.7M) plus state ($15.5M)</td>
<td>CMS and state ($650M; $550M for service provision, $100M for capacity building)</td>
</tr>
</tbody>
</table>
| **Social support services provided** | - **Financial relief**, Direct payments for help with basic living expenses (such as rent, mortgage, bills, medical care, child care).  
- **Transportation**, Non-emergency (to and from doctor appointments or non-congregate shelter)  
- **Food**, Home delivered meals, groceries  
- **Other**  
  - **Medications**, Home-delivered.  
  - **COVID-19 supplies**, like face masks, hand sanitizer | - **Housing**, Navigation, inspections, home remediation, home goods, move-in support, utility set-up, accessibility & safety modifications, post-hospitalization housing, and some direct payments for security deposit or 1st month’s rent  
- **Transportation**, Reimburse non-emergency public or private medical transport or to social needs services case management  
- **Food**, Food access case management, group nutrition class, diabetes prevention class, medically-tailored meal delivery, fruit/vegetable prescription, healthy food boxes and meals  
- **Interpersonal violence and toxic stress**, Case management, violence services, dyadic therapy, parenting curriculum, home visiting services  
- **Other**  
  - Enhanced case management  
  - Medical respite  
  - Link to legal support |
NOTES


27. Menendez T, Barragan NC, Kuo T, Morrison JL. Using Health Navigators to Connect At-Risk Clients to Community Resources. J Public Health Manag Pract JPHMP. Published online June 30, 2021. doi:10.1097/PHH.00000000000001396


ABOUT THE AUTHORS

William K. Bleser, PhD, MSPH, is assistant research director of health care transformation for population health, social needs, and health equity at the Duke-Margolis Center for Health Policy at Duke University. His portfolio includes empirical quantitative, qualitative, mixed methods, and policy analyses related to how accountable care and other alternative payment models, or risk-based contracts, can better address social needs and improve health equity. Before coming to Duke, Dr. Bleser worked at the Pennsylvania State University on grant-funded research studying inequities in preventive health services, evaluating national health quality improvement efforts, and achieving change to the patient-centered medical home delivery reform model. He also previously worked for the Department of Health and Human Services on improving adult influenza vaccine coverage and better understanding rare adverse events to influenza vaccines (and still conducts vaccine research). He earned his PhD from the Pennsylvania State University jointly in health policy and in demography, his MS in public health from the Johns Hopkins Bloomberg School of Public Health in disease epidemiology and control, and his BS from the College of William and Mary in neuroscience.

Katie M. Huber, MPH, is a policy analyst at the Duke-Margolis Center for Health Policy at Duke University. Her research generates evidence on health care delivery and payment reforms to advance whole person health and has particularly focused on issues related to COVID-19 response, health equity, and behavioral health. Ms. Huber obtained her MPH in health behavior from the UNC Gillings School of Global Public Health and her BA in anthropology and interdisciplinary studies from the University of North Carolina at Chapel Hill.

Hannah L. Crook, BSPH, is a first-year PhD student in the department of health policy at Vanderbilt University. Her research centers around value-based payment reform, social drivers of health, state health policy, and other topics. Ms. Crook uses mixed-methods research to generate evidence on how to lower health care costs, improve health status, and reduce inequities. Before coming to Vanderbilt, Ms. Crook was a research assistant at the Duke-Margolis Center for Health Policy at Duke University on the health care payment and delivery system reform team. She earned her bachelor’s degree in health policy and management from the University of North Carolina at Chapel Hill. Ms. Crook’s work on this publication occurred while she was a research assistant at the Duke-Margolis Center for Health Policy.

Rebecca G. Whitaker, PhD, MSPH, is an assistant research director with the Duke-Margolis Center for Health Policy at Duke University. In this role, Dr. Whitaker helps lead the center’s research and policy analysis related to care delivery and payment reform. She focuses on state and regional health care transformation with a particular emphasis on North Carolina’s health reform activities. Dr. Whitaker has extensive experience in health services research, policy analysis, and program and policy implementation focused on value-based care, Medicaid, social drivers of health, safety-net delivery systems, rural health, and populations that have been historically marginalized. Prior to joining Duke-Margolis, Dr. Whitaker served as director of health policy and governmental affairs at the North Carolina Community Health Center Association, where she led the association’s state and federal policy agenda and guided North Carolina health centers through large-scale payment and care delivery reforms, including Affordable Care Act implementation.

Jasmine Masand, MPP, is a presidential management fellow at the U.S. Department of Health and Human Services and a graduate of the Duke Sanford School of Public Policy. As a fellow, Ms. Masand supports budget, policy, and legislative work for public health agencies. At Duke, Ms. Masand explored value-based payment and care delivery reform as part of graduate consulting teams for both public and private payers. Her research has included value-based payment models for high-need populations, Medicaid managed care implementation, and reforms to improve the quality of care for children in the child welfare system. She also completed a master’s thesis on federal reforms to better address adverse childhood experiences through the health care system. As a graduate student, Ms. Masand interned with the U.S. Senate Committee on Health, Education, Labor, and Pensions, where she supported work on a variety of public health issues in the midst of the COVID-19 pandemic. Before pursuing her master’s at Duke, Ms. Masand served
as a consultant to government stakeholders and health systems participating in Center for Medicare and Medicaid Innovation models. She earned her BA in government from Wesleyan University in 2015, where she researched congressional politics and communications. Ms. Masand’s work on this publication occurred while she was a graduate student Margolis Scholar at the Duke-Margolis Center for Health Policy.

James J. Zheng is an undergraduate at Duke’s Pratt School of Engineering, where he studies health through the lens of biomedical engineering. His research interests include health equity, data-driven approaches to precision medicine, and implementation of social needs interventions in clinical settings. Mr. Zheng also volunteers as a community resource navigator for both the Duke Benefits Enrollment Center and the Duke Emergency Department, working with patients to identify and address underlying social needs through referrals to community-based organizations. Prior to matriculating at Duke, he worked as a congressional intern for then-representative Jared Polis of Colorado, where he gained exposure to a variety of policy issues through working in constituent communications and youth engagement. Mr. Zheng’s work on this publication occurred while he was a summer intern at the Duke-Margolis Center for Health Policy.

Raman Nohria, MD, is a medical instructor at the Duke Department of Family Medicine and Community Health and Duke Regional Hospital. In this role, he serves as a teaching hospitalist at Duke Regional Hospital as well as a teaching outpatient family physician at the Duke Family Medicine Center. His expertise and scholarly interests include the social drivers of health, community–healthcare partnerships, and multi-stakeholder collaborations for health promotion and behavioral change. He completed his family medicine residency training with the Lawrence Family Medicine Residency Program and hospital fellowship with the Duke Department of Family Medicine and Community Health.

Michelle J. Lyn, MBA, MHA, has been operationalizing clinical strategic plans, building community, social, and health agency inroads and partnerships, and facilitating actionable research to address health disparities and advance health equity for more than two decades. Currently, as director for the equity and learning health communities pillar of the Duke Clinical and Translational Science Institute, lead for community health strategies in the Duke Population Health Management Office, and chief, division of community health in the Duke Department of Family Medicine and Community Health, Ms. Lyn focuses on the development of value-based care programs and activities that create greater accountability, address the underlying causes of social drivers of health, and utilize community-engaged solutions to advance an equitable healthcare agenda. She manages a multimillion-dollar grants, contracts, tuition, and clinical revenue budget, and provides educational and research oversight to align research with population and community health needs and translate research into practice. Under her leadership, several first-ever and nationally recognized programs, services, and initiatives focused on a whole-person whole-community approach to eliminating health disparities and advancing health equity were introduced.

Robert S. Saunders, PhD, is senior research director, health care transformation, at the Duke-Margolis Center for Health Policy. He is part of the center’s executive team and leads the strategic design, management, and direction of the health care transformation research domain. The strategic goals for his portfolio include generating practical evidence on payment and delivery reforms, identifying lessons learned from COVID, develop new ways to meet people’s social needs and improve health equity, support North Carolina and other states in their efforts to improve health and value, and inform policy through convenings and stakeholder engagement. Prior to joining Duke-Margolis, Dr. Saunders was a senior director and then senior advisor to the president of the National Quality Forum, senior program officer at the Institute of Medicine, and managed health care legislative affairs for Representative Rush D. Holt. He has a PhD in physics from Duke University, where he focused on improving medical imaging for early-stage cancer diagnosis, and an undergraduate degree from William and Mary.
ACKNOWLEDGEMENTS

We would like to thank the following individuals for completing interviews with us during our information gathering stage of this policy brief. They provided crucial insight and answered key questions we had, and we greatly appreciate their time and contributions to this work. The viewpoints expressed in this brief do not necessarily reflect the viewpoints of the individuals below nor their organizations.

**David Allgood**, Pastor, True Worship Ministries

**Sherri Allgood**, Pastor, True Worship Ministries

**Lisa Bennett**, Executive Director North Carolina, Kepro

**Maria L. Brisbon**, MBA, Vice President and COO, Wisdom Care Transportation

**Vaughn Crawford**, MSW, Associate Director, Customer Success, Unite Us

**Chris DeMars**, MPH, Interim Director, Delivery Systems Innovation Office & Director, Transformation Center, Oregon Health Authority

**Andrew Herrera**, MPH, MBA, Executive Director, Curamericas Global

**Fred Johnson**, MBA, Assistant Professor of the Practice in Family and Community Health, Duke University School of Medicine; Director, Medicaid Accounts, Population Health Management Office, DukeHealth

**Liliana Marin**, Program Manager, Division of Community Health, Department of Family Medicine & Community Health, Duke University School of Medicine

**Shemecka McNeil**, Executive Director and Founder, SLICE 325

**Kathy Moore Norcott**, MS, MPA, Executive Director, Piedmont Health Services and Sickle Cell Agency

**Maria Ramirez Perez**, Program Manager, NC Medicaid Strategy Office, North Carolina Department of Health and Human Services

**Maggie Sauer**, MHA, MS, Director, Office of Rural Health, North Carolina Department of Health and Human Services

**Jimmy T. Tate, EdD**, President, Mt. Calvary Center for Leadership Development

**Amanda Van Vleet**, MPH, Associate Director, Innovation, NC Medicaid Strategy Office, North Carolina Department of Health & Human Services

**Lisa Wigfall**, MSW, CEO, Quality Comprehensive Care Center

We would like to thank the members of our broader research team at the Duke-Margolis Center for Health Policy for strategic guidance and input, including Mark McClellan.

Dr. Bleser has previously received consulting fees from Merck for research for vaccine litigation unrelated to this work, from BioMedicallInsights, Inc. for subject matter expertise on value-based cardiovascular research unrelated to this work, from Gerson Lehrman Group, Inc. on health policy subject matter expertise unrelated to this work, and from StollenWerks LLC on health policy delivery system change unrelated to this work. He also serves as Board Vice President (uncompensated) for Shepherd’s Clinic, a clinic providing free healthcare to the uninsured in Baltimore, MD. Dr. Saunders has a consulting agreement with Yale-New Haven Health System for development of measures and development of quality measurement strategies for CMMI Alternative Payment Models under CMS Contract Number 75FCMC18D0042/Task Order Number 75FCMC19F0003, “Quality Measure Development and Analytic Support,” Option Year 2.
Support for this brief was provided by the Robert Wood Johnson Foundation. The views expressed in this brief do not necessarily reflect the views of the foundation.

**About the Duke-Margolis Center for Health Policy**

The Robert J. Margolis, MD, Center for Health Policy at Duke University is both an academic research center and a policy laboratory. Its mission is to improve health, health equity, and the value of health care through practical, innovative, and evidence-based policy solutions. To learn more, please visit healthpolicy.duke.edu.

**For more information about this brief, please contact:**
William Bleser at william.bleser@duke.edu
About the Milbank Memorial Fund

The Milbank Memorial Fund is an endowed operating foundation that works to improve the health of populations by connecting leaders and decision makers with the best available evidence and experience. Founded in 1905, the Fund engages in nonpartisan analysis, collaboration, and communication on significant issues in health policy. It does this work by publishing high-quality, evidence-based reports, books, and The Milbank Quarterly, a peer-reviewed journal of population health and health policy; convening state health policy decision makers on issues they identify as important to population health; and building communities of health policymakers to enhance their effectiveness.