REPORT | July 2026 (Updated)

Community Voices from North Carolina's Healthy Opportunities Pilots Program:

Implications for Designing and Evaluating Programs to Address Upstream Drivers of Health

BY ALIDA AUSTIN, KATIE HUBER, BRIANNA VAN STEKELENBURG, KODY KINSLEY, AND REBECCA WHITAKER

Milbank Memorial Fund
Using evidence to improve population health

Duke | MARGOLIS INSTITUTE *for* Health Policy

CONTENTS

About the Milbank Memorial Fund

The Milbank Memorial Fund works to improve population health and health equity by collaborating with leaders and decision makers and connecting them with experience and sound evidence. Founded in 1905, the Milbank Memorial Fund advances its mission by identifying, informing, and inspiring current and future state health policy leaders to enhance their effectiveness; convening and supporting state health policy decision makers to advance strong primary care and sustainable health care costs; and publishing high-quality, evidence-based publications and *The Milbank Quarterly*, a peer-reviewed journal of population health and health policy. For more information, visit **www.milbank.org**.

About the Duke-Margolis Institute for Health Policy

The Robert J. Margolis, MD, Institute 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**.

© 2026 Milbank Memorial Fund. All rights reserved. This publication may be redistributed digitally for noncommercial purposes only as long as it remains wholly intact, including this copyright notice and disclaimer.

Milbank Memorial Fund
1001 Avenue of the Americas, Suite 503
New York, NY 10018
www.milbank.org

ABSTRACT

North Carolina's Healthy Opportunities Pilots (HOP) program, which was paused in July 2025 due to state funding constraints but will resume in TK, tested whether providing evidence-based services to address upstream drivers of health for eligible Medicaid members could improve health outcomes, reduce costs, and address disparities in three predominantly rural regions of the state. Summative program evaluation findings released in June 2026 estimated Medicaid savings of $164 per enrollee per month. Yet programs addressing upstream drivers of health often show benefits that extend beyond the health care utilization and cost metrics captured in traditional evaluations. Drawing on qualitative analysis of 270 stories collected between 2022 and 2025 — including stories from before and after the program pause — this report explores the experiences of people who participated in HOP, including enrollees, care managers, and staff at community-based organizations. The analysis finds that meeting people's holistic needs can improve health and well-being — and have positive effects on their families, communities, and regional economies.

POLICY POINTS

- Programs addressing upstream drivers of health often show benefits that extend beyond the health care utilization and cost metrics captured in traditional evaluations.
- The experiences of Healthy Opportunities Pilots participants can inform approaches to program design, evaluation, sustainability planning, and future policy investment to address upstream drivers of health.

INTRODUCTION

Upstream drivers of health — such as access to food, housing, transportation, and interpersonal safety — play a significant role in shaping health outcomes. People with unmet needs in these areas are more likely to utilize costly services,[1] such as emergency department care and inpatient hospitalizations, contributing to higher health care spending and avoidable strain on public systems.

Interventions to address upstream drivers have gained momentum across the political spectrum and are supported by a growing evidence base. For example, the Trump administration's Make America Healthy Again agenda includes a focus on upstream drivers of health like nutrition. Evidence shows that targeted interventions to address upstream drivers of health can reduce health care utilization and, in some cases, total cost of care. Recent systematic reviews show that interventions targeted to specific populations — such as pregnant women and families with young children, or people with mental health conditions experiencing homelessness — can reduce costly use of health care services.[2,3] Additional studies show that patients report positive perceptions of interventions to address needs like food insecurity.[4,5]

North Carolina has emerged as a national leader in testing these approaches through its Healthy Opportunities Pilots (HOP) program.[6] As part of the state's Section 1115 waiver, initially approved by the Trump administration in 2018, HOP tested the impacts of providing evidence-based services to eligible Medicaid members to address upstream drivers of health in three predominantly rural regions of the state, with the goals of improving health outcomes, lowering costs, and reducing disparities in a sustainable way.[7] The program was delivered through partnerships between the state Medicaid agency, hub organizations known as Network Leads, community-based organizations (CBOs), Medicaid health plans, and care management entities.

Overview of Key Entities Involved in HOP

- **North Carolina Medicaid:** Oversees HOP design and implementation.
- **Network Leads:** Community care hub organizations that develop, manage, and build capacity of regional networks of community-based organizations that provide HOP services. In HOP, each Network Lead covers one rural region of the state, with a total of three regions covering one-third of the state's counties.
- **Community-based organizations (CBOs):** Organizations that are contracted to deliver HOP services. CBOs that participated in HOP were also called human service organizations.
- **Medicaid health plans:** Managed care plans responsible for managing HOP enrollees' physical, behavioral, and social needs and overseeing funding for HOP services.
- **Care managers:** Work with Medicaid health plans to identify people who would benefit from and qualify for HOP services; propose services that may be beneficial; and coordinate, track, and manage HOP services over time to promote whole-person health.

Section 1115 waiver initiatives are required to be independently evaluated for their impacts on health care access, quality, and costs. North Carolina's Section 1115 waiver is being evaluated by the Cecil G. Sheps Center for Health Services Research at the University of North Carolina. The summative HOP evaluation, released in June 2026, showed Medicaid spending for HOP enrollees decreased by an average of $164 per person per month, with increasing savings over time; shifts towards more cost-effective, preventive care; reduced barriers to health and well-being; and improvements in enrollees' health and quality of life.[8]

Despite these promising results,[9] service delivery for HOP has been paused[10] since July 2025 due to insufficient state funding. However, on July 7, 2026, North Carolina Governor Josh Stein enacted the state's first full budget since 2023. The North Carolina General Assembly appropriated $9 million in nonrecurring state funds, which will be paired with $16 million from federal Medicaid funds, to resume the Healthy Opportunities Pilots program.

On July 7, 2026, North Carolina Governor Josh Stein enacted the state's first full budget since 2023. The North Carolina General Assembly appropriated $9 million in nonrecurring state funds, which will be paired with $16 million from federal Medicaid funds, to resume the Healthy Opportunities Pilots program.

Programs addressing upstream drivers of health often show benefits that extend beyond impacts on enrolled individuals that are captured in traditional waiver evaluations. These impacts may include improvements in individuals' stability and self-sufficiency, health and economic spillover effects for family members, and broader community and economic impacts — many of which unfold over time and are difficult to quantitatively measure.

Accordingly, this report is intended to complement the waiver evaluation by providing additional context on how and why such impacts may occur. To do this, the Duke-Margolis Institute for Health Policy analyzed 270 stories collected by the three HOP Network Lead organizations, reflecting experiences with HOP reported by enrollees, care managers, and CBO staff between 2022 and 2025. The stories covered a range of topics, from implementation strategies to impacts. While our analyses do not establish causal pathways, these implementation strategies are linked to impacts at multiple levels. More details on the research approach are included in the "About This Study" section at the end of this report.

In this report, we highlight key themes from the experiences of HOP enrollees and implementers, showing how the program affected individuals, families, communities, and local economies. Told in the enrollees' and implementers' own words, these stories capture the effectiveness and impact of a novel program designed to address upstream drivers of health. We complement these perspectives with relevant findings from the literature. Together, these insights are intended to help states better understand and capture the value of addressing upstream drivers of health, while informing timely, evidence-based policy decision-making and enabling the projection and evaluation of cost savings for the Medicaid program and the broader state budget.

HOP STORY THEMES

Our analyses of stories shared by enrollees, care managers, and CBO staff revealed three connected themes that can inform how other states design and evaluate similar programs to address upstream drivers of health. First, providing meaningful support to meet individuals' holistic needs was foundational to the success of HOP. Having care managers help individuals find and access the right care at the right time and in the right place made it possible for enrollees to engage with essential clinical and social services. Second, as care managers partnered with individuals and families to meet their holistic needs, people experienced greater stability, improved health and well-being, and increased confidence to manage

their lives and plan for the future. Third, these individual gains often extended outward, strengthening families, easing strain on systems, and contributing to broader health and economic benefits. Finally, the program pause has already had an impact on individuals and families. The following sections explore each theme in greater detail.

"Thank you so much for helping me eat healthy while in cancer treatment. Putting away the groceries brought me to tears — it felt like opening up a surprise gift, but more so, reminded me that someone cares!"
—HOP enrollee

1. HOP helped people meet their holistic needs

Integrating clinical and social care. A primary focus of HOP was helping people meet their holistic needs by integrating clinical and social care. Many enrollees entered HOP while managing chronic physical and/or mental health conditions alongside needs related to food, housing, interpersonal violence, and/or transportation. HOP offered 29 services,[11] including food supports, housing stabilization services, home repairs, transportation assistance, and safety-related supports that directly addressed urgent needs. Stories consistently showed how having these needs met was foundational to enabling people to manage their health, engage in care, and navigate daily life. For many, access to these services brought immediate relief from stress.

Care managers are trusted guides. Care management and navigation were critical to connecting HOP enrollees with these services. North Carolina Medicaid's care management approach[12] provides each enrollee with a care home designed to respond to holistic needs, and across stories, care managers were consistently described as trusted guides. Care managers helped enrollees understand their options and navigate complex clinical and social systems, aiding in improving health and well-being. Care managers' work extended beyond single referrals to include assessing needs, coordinating services across multiple providers, following up over time, and adjusting care plans as circumstances changed.

CBOs provide services and community. Care managers often helped connect enrollees with local CBOs, which played an essential role in service delivery. For example, in one story, a care manager helped an enrollee find an affordable home, coordinated an inspection to ensure its safety, and connected the enrollee with food services. Another story highlighted support for an enrollee leaving an abusive relationship, including assistance with car repairs to maintain employment and coordination of housing services. Ongoing support and coordination were particularly important for enrollees facing overlapping challenges, such as housing instability combined with safety concerns. Together, interactions between care managers, CBOs, and enrollees fostered meaningful connections and support. As one HOP CBO employee reflected, "Thanks to the work of [the enrollee's] care manager, she has the help she needs to live her healthiest life."

In addition, CBOs built trust with enrollees by strengthening community connections. Stories depicted meaningful opportunities for relationship-building, illustrating how HOP fostered connection, trust, and sustained engagement. One food delivery driver from a CBO described how helping an enrollee put away his groceries during a delivery was a way of building relationships. Several CBO employees described the fulfillment of providing services in the communities they are part of and, in some cases, grew up in. Through service delivery and community presence, HOP created new avenues for human connection. As one CBO employee shared, "It is truly incredible how a community of human connection is growing out of these simple bags of food each week. The trust that clients extend to us in sharing the stories of their lives is breathtaking. We hear about the birth of a new grandchild, a brave visit to the hospital, the celebration of being cancer-free for the first time in two years … we genuinely care about the people in our network."

Stories frequently illustrated how these supportive relationships contributed to improvements in enrollees' health and well-being. For example, a CBO employee described an individual who was caring for a friend and struggling with her health before enrolling in HOP. The employee recounted, "When [the enrollee's] life became sedentary, she became overweight for the first time in her life. She is thrilled that HOP is helping regain her health." In another story, a care manager shared, "HOP gave members hope and [a] way to improve their lives. So many of our patients had never had anyone reach out to them and offer them help [before]."

"This program has been more than just assistance — it's been a true lifeline. The access to healthy food, the care, and the dignity behind it have brought so much relief and stability to our home. It's allowed us to focus on other areas of growth and healing without the constant stress of food insecurity." —HOP enrollee

Takeaway. As states design future programs, they should consider the role of care managers in helping enrollees navigate complex systems and serving as trusted partners in care. States may also consider the value of engaging local CBOs, which contribute to the local economy and are responsive to community needs, to deliver services that address upstream drivers of health for enrollees.

2. HOP improved stability for individuals and families

Fewer emergencies, more time for health. Many stories illustrated how HOP services and care management not only helped reduce health and social needs, but also fostered education and empowerment. These supports helped to reduce and prevent urgent crises and stabilize the lives of HOP enrollees and their families through several interconnected pathways.

First, interventions to address upstream drivers of health helped people stabilize, regain independence, and pursue longer-term health management. By helping to address holistic needs, HOP services increased enrollees' ability to spend their time, energy, and resources on other priorities. Supports such as first month's rent, security deposits, and reliable transportation enabled people to secure stable housing, get to work, maintain employment, and participate in their communities. As one story highlighted, "[an enrollee] secured a safe apartment, received healthy food and home essentials, and found stable employment. Now with a renewed sense of stability and support, he's working toward his next big goal."

HOP also supported enrollees in managing and stabilizing physical and mental health conditions. With this support, many enrollees in the stories experienced less stress, improved chronic condition management, and fewer emergency needs. For example, one enrollee, who was diagnosed with anxiety and depression, had the support of a care manager to stabilize their housing, which aided in their recovery. Their care manager reported that their anxiety and depression assessment scores improved significantly with the support of a new, stable housing arrangement.

Second, HOP services and care management helped people adopt healthier behaviors and build skills to care for themselves and their families. For example, some HOP food services included recipes and nutrition information to help people learn how to shop for and prepare foods and eat a healthy, balanced diet. Stories showed how many enrollees were introduced to new foods through HOP food boxes. Other stories illustrated how housing navigation, a HOP service, provided education and support to promote self-sufficiency, including budgeting skills.

Benefits for family members. In many stories, these impacts were seen not only among individual enrollees, but also among their family members. For example, as one person explained, "As a result of the healthy [food] options through HOP, the [enrollee] started to lose

weight, found a new liking to healthier foods and the entire family is eating healthier." Many stories also revealed how addressing children's holistic needs helped reduce their parents' stress. This is a novel addition to the waiver evaluation findings, as program evaluations often focus on outcomes for enrolled individuals, potentially overlooking the natural spillover benefits that extend beyond the individual enrollee, in this case to the broader household.

Over time, increased stability and healthier behaviors allowed some enrollees to transition off of supports altogether. As one enrollee shared, "I don't want a handout — I just want a chance to stand on my own two feet again. And when I do, I plan to give back."

Takeaway. As states design future programs, they may consider analyzing outcomes and impacts not only among individual enrollees, but also at the household level. Additionally, states may consider including measures of stress and well-being alongside clinical outcomes and utilization metrics. These measures of well-being can be used as intermediate indicators that could translate to longer-term cost savings. Lastly, findings suggest that pairing services with education can support longer-term success, pointing to opportunities to promote sustained behavior change.

"The HOP program is a long-term investment in the health of the people of [North Carolina]. When members have their [holistic] needs met, they are healthier, able to be more productive at work, and have fewer emergency needs. This investment will save money and improve the lives of North Carolinians in the long run, as well as improve our economy through a healthier and more engaged workforce."
—Care manager

3. HOP benefits extended to communities, systems, and economies

Economic development. Beyond benefits to individual enrollees and families, HOP's impact extended to communities, systems, and local economies. The HOP Network Leads' analysis of the program's economic and workforce impacts found an estimated total economic impact of $384 million and more than 2,900 jobs created in rural communities.[13] Stories reinforced these impacts by showing how HOP drove regional economic development through investments in local farms, providers, and workforce. For example, stories detailed some of the new jobs that were created through HOP, such as community health workers, care managers, food providers, housing specialists, and transportation partners. As one person noted, "HOP provided fulfilling employment opportunities for many and gave [North Carolina] farms a reliable source of income." With HOP operating in three predominantly rural areas, these workforce and economic gains were particularly meaningful for communities where job growth is limited.

Less need for public programs. In addition to economic benefits, stories indicated that as enrollees' holistic needs were met and their lives became more stable, some were able to reduce or transition off public benefit programs, potentially generating additional savings for the state. As a care manager stated in one story, "[Enrollees] were becoming more productive and independent so they would no longer [need] services like HOP, because they could provide for themselves."

More cross-sector collaboration. HOP also strengthened trust and collaboration among CBOs, Medicaid health plans, Network Leads, and the state Medicaid program, which was critical to successful implementation of the program and may support future efforts in the state to address upstream drivers of health and other health priorities. As one story emphasized, "HOP provided resources and growth for the community agencies. It put money into the community. It built trust and relationships between the [Medicaid health plans] and [CBOs]."

Takeaway. Understanding the broader impact of programs like HOP gives states a better understanding of how program design and investments in one area may generate meaningful impacts elsewhere. In future efforts, states may choose to adjust program designs more directly on targeted health outcomes rather than broader community impacts, particularly given concerns that achieving goals beyond health is not the most efficient use of health care dollars.

4. The pause in HOP services has already had an impact

Disrupted services. HOP service delivery has been paused since July 2025 due to insufficient state funding. Ninety-three (34%) of the stories we reviewed were collected shortly after the pause, allowing us to examine its impacts on both enrollees and those delivering care. Across stories, HOP was described as filling a critical gap in services, with the pause leaving many individuals without the supports needed to stabilize housing, food access, and safety. Nearly all post-pause stories anticipated disruptions to services and increases in unmet needs, with many people expressing concern about limited resources to address upstream drivers of health and heightened stress among enrollees. Care managers, in particular, voiced concerns that the pause in services would result in worsened health outcomes.

Increased risks for individuals. Stories suggested that the absence of HOP may increase risks of housing instability, food insecurity, and unmet mental health needs, with resulting impacts on both enrollees and public systems. In the stories, people noted that HOP helped enrollees secure stable housing and prevent unsafe living situations (particularly for individuals experiencing interpersonal violence), maintain access to healthy foods, and better manage chronic conditions. As one enrollee noted, "This program means everything to me and my baby. We are trying so hard to find a safe place to live, and HOP has been helping us with that. Without it, I don't know what we would do." Care managers anticipated that the pause in services would bring setbacks in physical and mental health, emphasizing that individuals struggle to focus on health when they are unsure about where they will sleep or get their next meal.

System-level impacts. These individual impacts were closely linked to system-level concerns. Stories showed that the pause in HOP would lead to higher health care utilization and increased strain on public systems, including anticipated increases in emergency department visits and hospital readmissions, particularly readmissions driven by unstable housing. Care managers, in particular, reflected that HOP helped reduce costly hospital visits and long-term needs, and raised concerns that the pause may shift strain to other public systems, such as crisis services, food banks, and shelters. Across stories, there was a consistent theme that individuals cannot meaningfully engage in health management when they have unmet basic needs. One person shared, "HOP filled the gaps between medical care and daily life challenges that would often keep [enrollees] from getting or staying healthy. HOP has shown that when we invest in [enrollees'] basic needs, we also strengthen communities and reduce costs down the line. HOP is smart, preventative care."

"The pause of HOP services has already had strong impacts on the populations we work with. We are seeing lower [engagement] rates as members are no longer receiving HOP services. People do not have the capacity to work on improving their health outcomes or conditions if they are more worried about where their next meal is coming from or where they are going to sleep tonight." —Care manager

Takeaway. While the pause has highlighted the critical role HOP played in addressing upstream drivers of health, it also underscores challenges related to individual sustainability and supporting enrollees beyond addressing their short-term needs. The pause reinforces that sustainability must be embedded from the outset. As future programs are designed to address upstream drivers of health, they should include a clear plan for what happens when funding ends, such as defined transition plans for enrollees and strategies to support the long-term sustainability of the CBOs providing these services.

FUTURE DIRECTIONS

As states increasingly seek opportunities to generate cost savings while improving health outcomes, the stories shared by HOP enrollees, care managers, and community partners bring to life the value of addressing upstream drivers of health beyond what is typically captured in traditional program evaluations. These lived experiences illustrate how meeting people's holistic needs can improve health and well-being, with impacts that extend beyond individuals to their families, communities, and regional economies.

Together, these findings suggest that evaluations may underestimate both the short- and long-term value of upstream investments when focused only on health care utilization. A mixed-methods approach captures early indicators of cost savings and provides a more complete understanding of program impacts, including family spillover effects, changes in economic stability, workforce impacts, and system-level benefits. Evaluations could better reflect the full value of upstream interventions by incorporating enrollee and service provider perspectives, measuring household impacts, tracking transitions off services or public benefits, and examining regional economic effects. Designing evaluations with these outcomes in mind from the outset can help produce more actionable evidence for policymakers to inform state policy and budget decisions.

Overall, HOP demonstrates that investments in upstream drivers of health can yield meaningful benefits that extend beyond traditional health care outcomes, including improved stability and strengthened communities and systems. By expanding how success is defined and measured, and by embedding sustainability into program design, states can better capture the full value of upstream investments and make more informed decisions about the future of these initiatives.

ABOUT THIS STUDY

We analyzed 270 stories collected by the three HOP Network Lead organizations, reflecting experiences with HOP reported by enrollees, care managers, and CBO staff between 2022 and 2025. Of those stories, 119 (44%) were sourced from responses to a survey[14] of care managers conducted by one of the Network Lead organizations in July and August 2025. Stories ranged in length from a sentence to three paragraphs. The shorter stories were often responses to the survey, whereas longer stories were often from CBO staff or enrollees themselves. A limitation of this study is that stories were self-reported to the Network Lead organizations, so they are not necessarily representative of all experiences with HOP.

We analyzed the stories using qualitative content analysis methods. First, we developed a preliminary set of codes informed by our prior research and an initial review of the stories. A team of three researchers applied these codes to the stories, starting by independently coding a subset of stories and comparing codes across team members to ensure consistency. The team met to review the codebook, refine definitions, and establish consensus on coding rules. As coding progressed, the team also identified new ideas and recurring concepts that emerged from the stories; these were added to our list of codes, and stories were re-coded as necessary. The team held regular meetings to resolve any interpretation differences and discuss emerging themes. Following coding, the research team synthesized findings by grouping frequently co-occurring codes and identifying overarching themes that captured the central experiences and impacts described in the stories.

NOTES

[1] Sidebottom AC, Martins S, Vacquier MC, Dechaine C, Behrens D. Health-related social needs and health care utilization in the Accountable Health Communities model. *JAMA Netw Open.* 2025;8(12):e2548036. doi:10.1001/jamanetworkopen.2025.48036

[2] Merchant T, Soyemi E, Roytman MV, et al. Healthcare-based interventions to address food insecurity during pregnancy: a systematic review. *Am J Obstet Gynecol* MFM. 2023;5(5):100884. doi:10.1016/j.ajogmf.2023.100884

[3] Davis RA, Lookabaugh M, Christnacht K, Stegman R. Strategies to reduce frequent emergency department use among persons experiencing homelessness with mental health conditions: a scoping review. *J Urban Health.* 2024;101(5):968-978. doi:10.1007/s11524-024-00917-0

[4] Mass J, Anselin E. Evaluating the impact of a pediatric clinic-based food pantry: a qualitative study. Clin Pediatr (Phila). 2026;65(3):338-348. doi:10.1177/00099228251387541W

[5] Allen SE, Bielaski T, Canavan CR. Exploring a food is medicine pilot program to improve dietary quality among rural perinatal patients. BMC Nutr. 2025;11(1):152. doi:10.1186/s40795-025-01134-x

[6] North Carolina Department of Health and Human Services (NCDHHS). Healthy Opportunities Pilots. Accessed May 31, 2026. https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/healthy-opportunities-pilots

[7] Huber KM, Blesser WK, Whitaker RG, et al. Addressing Social Needs through Medicaid: Lessons from Planning and Early Implementation of North Carolina's Healthy Opportunities Pilots. Milbank Memorial Fund. Published September 2023. https://www.milbank.org/publications/addressing-social-needs-through-medicaid-lessons-from-planning-and-early-implementation-of-north-carolinas-healthy-opportunities-pilots/

[8] NCDHHS. Summative Evaluation Summary. Published June 1, 2026. https://www.ncdhhs.gov/hop-evaluation/download?attachment

[9] Kenen J. The Future of North Carolina's Healthy Opportunities Pilots and What it Means for Other Medicaid Programs Considering Social Needs Programs. Milbank Memorial Fund. Published December 1, 2025. https://www.milbank.org/news/the-future-of-north-carolinas-healthy-opportunities-pilots-and-what-it-means-for-other-medicaid-programs-considering-social-needs-programs/

[10] NCDHHS, North Carolina Medicaid Division of Health Benefits. Healthy Opportunities Pilots Update. Published June 2, 2025. https://medicaid.ncdhhs.gov/blog/2025/06/02/healthy-opportunities-pilots-update

[11] NCDHHS. Updated Healthy Opportunities Pilots Fee Schedule. Effective July 1, 2024. https://www.ncdhhs.gov/healthy-opportunities-pilot-fee-schedule-and-service-definitions/open

[12] NCDHHS, North Carolina Medicaid Division of Health Benefits. Care Management. Accessed May 31, 2026. https://medicaid.ncdhhs.gov/care-management

[13] Community Care of Lower Cape Fear. Health is Wealth. Accessed June 2, 2026. https://carelcf.org/sometimes-impact-is-too-important-to-tell-through-words-alone-so-heres-the-data/

[14] Cape Fear Healthy Opportunities Pilot. Voices from the Frontlines of the Healthy Opportunities Pilot: Survey insights from Care Managers (July 22–August 2, 2025). Accessed May 31, 2026. https://capefearhop.org/voices-from-the-frontlines-the-effect-of-hop-pausing-for-care-managers/

ABOUT THE AUTHORS

Alida Austin is an assistant policy analyst at the Duke-Margolis Institute for Health Policy, where she supports projects on integrating health and social care, improving care systems for older adults, and Medicare Advantage. Prior to joining Duke-Margolis, Alida worked at the National Network of Public Health Institutes to support public health evaluation projects. She holds a bachelor's degree in Public Health & Political Science from American University.

Katie Huber, MPH, is a policy research associate with the Duke-Margolis Institute for Health Policy, where she helps lead research and policy work focused on integrating health and social care to advance whole-person health. Since joining Duke-Margolis, she has contributed to projects focused on a range of state, federal, and international health policy issues, including Medicaid, social drivers of health, health equity, specialty care reform, and pandemic response. Prior to joining Duke-Margolis, Katie held research roles at the Carolina Population Center and the Duke Division of Child and Family Mental Health and Community Psychiatry. She earned her Master of Public Health from the UNC Gillings School of Global Public Health and her undergraduate degree from the University of North Carolina at Chapel Hill.

Brianna Van Stekelenburg, MPP, is a research associate with the Duke-Margolis Institute for Health Policy supporting health care delivery and payment reform projects with a particular emphasis on North Carolina's health care transformation and helping lead the Institute's maternal and child health efforts. Brianna brings extensive research and policy experience related to Medicaid, value-based care, social drivers of health, and women and families. Prior to joining Duke-Margolis, Brianna served in various research and policy roles at the NC Office of State Budget and Management on the health and education team, the NC Council for Women, and the Duke Center for Child and Family Health. She also has experience working with children and families to study factors that influence child development. Brianna received her master's in public policy from the Sanford School of Public Policy at Duke University and her bachelor's degree in international studies and Spanish from the University of Mississippi.

Kody Kinsley, MPP, served as North Carolina's 18th Secretary of Health and Human Services under Governor Roy Cooper, unanimously confirmed by the North Carolina Senate. Kinsley played a pivotal role in expanding Medicaid through bipartisan collaboration with the General Assembly, resulting in over 600,000 North Carolinians gaining coverage in the first year—twice the expected pace. He secured one of the largest behavioral health investments in state history — $835 million — and major policy reforms to expand access to mental health and substance use services. He implemented North Carolina's groundbreaking Healthy Opportunities Pilots — the nation's first large-scale experiment proving that paying for non-medical health needs, like food and housing improves health and lowers cost. In partnership with all of the state's hospitals, Kinsley provided $6.5 billion in medical debt relief for 2.5 million North Carolinians. His career includes roles at the White House, the U.S. Department of Health and Human Services, and the U.S. Department of the Treasury, where he was appointed by President Barack Obama and continued under President Donald Trump as Assistant Secretary for Management. Secretary Kinsley currently serves as a senior consultant at the Duke-Margolis Institute for Health Policy and senior policy advisor at Johns Hopkins University Institute of Policy Solutions.

Rebecca Whitaker, PhD, MSPH, is a research director of North Carolina Health Care Innovation and Medicaid Transformation with the Duke-Margolis Center for Health Policy at Duke University. She provides strategic direction and management of the center's research and policy analysis related to state-based care delivery and payment reforms with a particular emphasis on North Carolina's health reform activities. Her portfolio generates and translates evidence for state-led health reform activities, public-private partnerships to improve child and family well-being, and multi-stakeholder initiatives to improve health, health equity, and the value of health care.

Prior to joining Duke-Margolis, Dr. Whitaker served as director of Health Policy & 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. She has a PhD and MSPH in health policy from the UNC Gillings School of Global Public Health and an undergraduate degree from Princeton University.