



North Carolina State Profile: Public Health and Primary Care Collaboration

Background

North Carolina has a decentralized public health system where local public health departments operate independently from the North Carolina Department of Health and Human Services (NCDHHS). Due to this structure, collaboration between public health and primary care occur mainly at two distinct levels in North Carolina: 1) relationships between health systems and NCDHHS, and 2) relationships between local health departments and health care providers in their communities.

[Community Care of North Carolina](#) (CCNC) is the state's largest community-based independent primary care practice partner. The collaborative framework that would develop into CCNC began in the 1980's with multisector partnerships between the North Carolina Office of Rural Health and Community Care, the North Carolina Division of Medical Assistance, the North Carolina Foundation for Advanced Health Programs, Inc., and the Kate B. Reynolds Health Care Trust. In 2001, the [CCNC expanded as a statewide initiative](#) supported by NCDHHS to manage the state's most complex Medicaid patients. In 2007, CCNC became a separate non-profit entity and now supports the state's transition to and implementation of Medicaid managed care.

In 2015, the North Carolina General Assembly enacted legislation to begin the process of transforming the state's Medicaid system to managed care, which was officially authorized in 2020 and began operating in 2021. In 2018, CMS approved a North Carolina Medicaid section 1115 demonstration waiver to pilot the delivery of social services with Medicaid dollars (the [Healthy Opportunities Pilots](#)). The introduction of managed care organizations (MCOs) provided improved access for Medicaid beneficiaries to wrap around, non-medical services offered by public health and social service organizations. This work expanded the slate of services available to Medicaid beneficiaries beyond traditional medical care—including for wrap around services and coordinated care—to address health and wellbeing more broadly.

In spring of 2023, North Carolina became the 40th state to enact Medicaid expansion – partially attributable to the [unwinding of the Public Health Emergency](#) (PHE) that is estimated to result in loss of coverage for over 370,000 North Carolinians.

How is collaboration operationalized in North Carolina?

Collective impact

Leaders in North Carolina work to engage a diverse group of stakeholders to address community needs in a collaborative way. This [collective impact](#) framework brings together leaders from public health, primary care, and community-based organizations (CBOs) across rural and urban parts of the state to work together to improve the public's health. These multi-stakeholder cross-sectoral partnerships are supported by organizations such as CCNC and the [Foundation for Health Leadership and Innovation](#) (FHLI), both of which have a long history of providing integrated care to vulnerable residents in the state. Creating a broader formalized structure for health promotion and collaboration through CCNC and FHLI with multiple leaders and multisector partnerships has been important for success and sustainability. Notably, FHLI manages [NCCARE360](#), North Carolina's integrated data platform, for NCDHHS and thousands of partners across the state, which helps providers connect patients with the social services they need and informs providers when those connections are made.



Care coordination supported by collective impact can provide opportunities for state Medicaid funds to flow between public health and primary care. For example, in North Carolina, primary care leads the care coordination of prenatal services for Medicaid enrollees and partners with public health for [Centering Pregnancy](#) services, which deliver patient-centered prenatal care in a group setting.

State Medical Societies

In North Carolina, the state medical specialty societies play an important role in collaboration with state leaders in the Division of Public Health. Mechanisms for collaboration include the Immunization Branch, the North Carolina Cancer Coordination and Control Advisory Committee, and the Justus-Warren Heart Disease and Stroke Prevention Task Force—in which leaders from North Carolina’s medical specialty societies play a significant role to inform disease prevention and population health goals in the state.

Medicaid 1115 waiver

The [Healthy Opportunities Pilots](#)—championed by the then [deputy secretary for North Carolina Medicaid](#) and approved in 2018—provide eligibility to Medicaid enrollees for certain non-medical services that address social needs. Enrollees also receive enhanced care coordination. Community-based organizations work with primary care providers to enhance medical care while addressing social needs, focusing particularly on housing, food security, interpersonal violence, and transportation.

The state’s Medicaid 1115 demonstration also built a [mechanism for connecting data](#) between health care, public health, and social services through the creation of NCCARE360. This shared data network of over 3,000 organizations allows for person-level tracking of health and human services data, along with a mechanism for referral follow-up to ensure clients are receiving the coordinated care they need.

State Medicaid funding allocations

As Secretary of NCDHHS, Dr. Mandy Cohen reallocated the flow of state Medicaid dollars for prenatal and pediatric complex case management from public health to primary care. As a result, public health no longer received funding to deliver clinical safety net services for Medicaid enrollees. Instead, local public health departments were encouraged to partner with primary care to deliver community-based services that enhance primary care to receive Medicaid funding. The justification for this reallocation was to ensure primary care physicians were responsible for prenatal and pediatric complex case management, thereby greater accountability for Medicaid dollars. Previously, these services were offered by both primary care and local public health, which led to perceived inefficiencies in Medicaid spending. Instead of these two sets of providers operating in silos, funding reallocation presented an opportunity for public health and primary care to provide complementary and not duplicative services.

Impact

Equity

Utilizing a collective impact model was especially valuable during the COVID-19 pandemic, when the NCDHHS was able to identify communities that were lacking adequate testing and vaccination sites. Once these needs were identified, the state contacted local health systems and primary care organizations to provide services to populations in need. Community organizations are also encouraged to alert local and state public health leaders about health inequities and disparities in access.

Accountability

NCDHHS emphasizes accountability at the organizational level for referral follow-up and case management—two major pieces of the Healthy Opportunities Pilots. In addition, person-level accountability for data ensures that every

organization who is responsible for managing the care of a patient (including public health, primary care, and social services) has access to shared data from all partner organizations through NCCARE360.

Establishing trust

Existing bipartisan partnerships were an effective mechanism for collaboration during the pandemic and allowed public health, primary care, and legislative leaders to engage in productive discussions about the needs of North Carolina residents. Combatting the misinformation surrounding COVID-19 required trust between state leadership and local health departments. To that end, NCDHHS hired several retired former local health department leaders to serve as consultants and liaisons for the state. These “ambassadors” helped promote the state’s message for a unified approach to the pandemic in a way that built on existing trusted relationships between ambassadors and their communities.

Learnings and recommendations for other states

Leaders in North Carolina offered suggestions for other states interested in pursuing the approaches taken in North Carolina. These suggestions include:

- Building and maintaining relationships pre-COVID was essential. This allowed state leadership to easily reengage retired local public health leaders to support COVID-19 response efforts. Formalized relationship-building structures, such as FHLI, also contributed to effective partnerships during the pandemic. It is more difficult to try to build relationships during a crisis.
- Decentralized public health can result in under resourced county-level health departments. Sharing infrastructure, staffing, and leadership can build capacity at the local level, freeing up funding for the delivery of essential public health services.
- Collaborations perform best when organizations work within their areas of expertise and partner with organizations that can fill gaps in care.