



NCCARE360

**STRENGTHENING
SYSTEMS OF
CARE**

NCCARE360

5-Year Report



FOUNDATION FOR HEALTH LEADERSHIP & INNOVATION

MOVING PEOPLE AND IDEAS INTO ACTION

NCCARE360 is the result of a public-private partnership between the NC Department of Health and Human Services (DHHS) and the Foundation for Health Leadership & Innovation (FHLI). NCCARE360 is integral to DHHS's mission is to improve the health, safety, and well-being of all North Carolinians. The NCCARE360 implementation team includes United Way of North Carolina, NC 211, and Unite Us.



NCDHHS



United Way of North Carolina



North Carolina



UNITE US

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Introduction



In 2019, NCCARE360 launched as the nation's first statewide coordinated care network, founded on the belief that health begins where we live, work, and play.

Our vision was bold yet simple: **to connect North Carolinians to the services and resources they need**—clinical or community-based—through a shared technology platform and a commitment to collaboration.

Five years later, that vision has translated into real, measurable impact. With thousands of providers across all 100 counties and more than **718,341** referrals facilitated, NCCARE360 has become a vital component of the state's health and human services landscape.

This report reflects on the journey thus far: the partnerships forged, the challenges overcome, and the lives touched through coordinated care.

Most Frequently Requested Services Across The State:

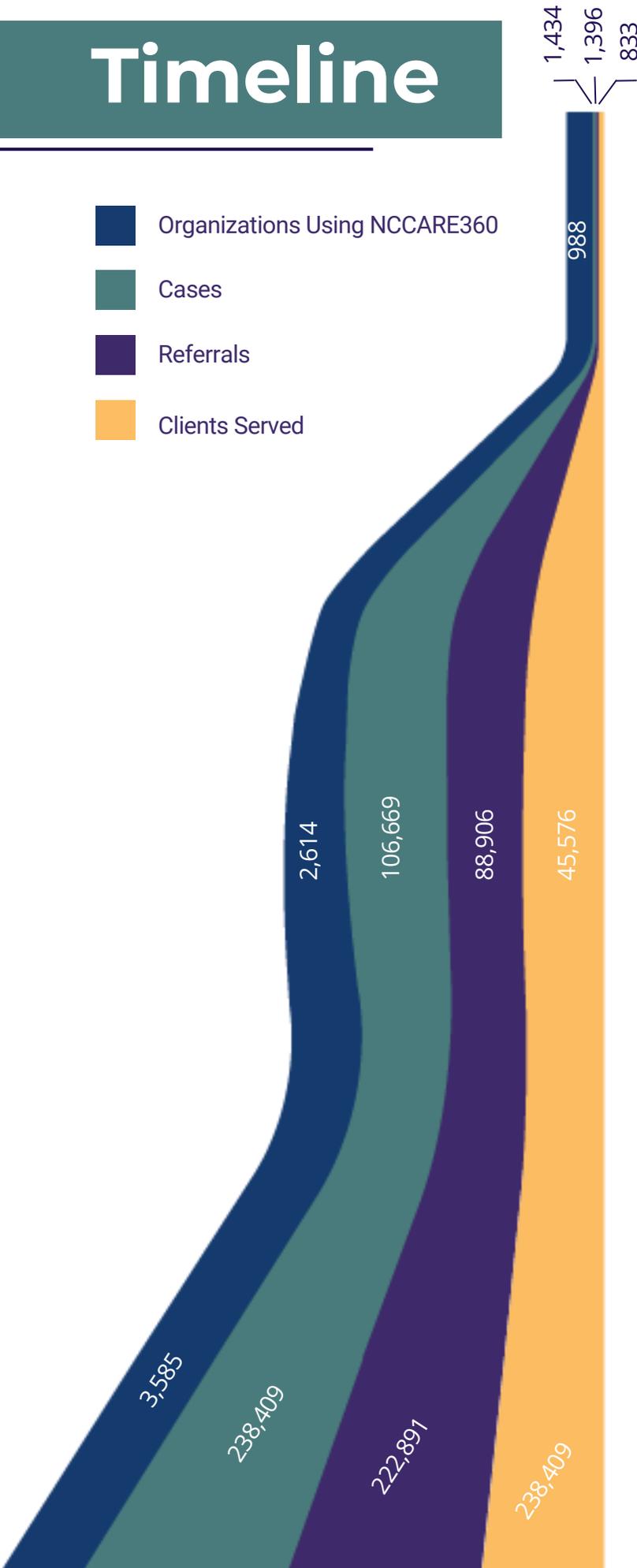
- Food assistance
- Housing and shelter
- Utilities assistance
- Individual and family support (e.g., social service case management, childcare, and caregiving services)
- Clothing and household goods
- Income support
- Transportation access

The following pages detail our impact, highlight stories from the field, and explore the evolving needs of North Carolinians. We also examine lessons learned and share our path forward towards improved access, innovation, and community resilience.

This milestone would not have been possible without the dedication of our partners, funders, and users who believed in a better, more connected system of care. As we look to the future, we remain committed to driving better health outcomes for all North Carolinians.

Timeline

- Organizations Using NCCARE360
- Cases
- Referrals
- Clients Served



2019

- Formation of NCCARE360's implementation team
- NCCARE360 launches in 3 North Carolina counties

2020

- NCCARE360 onboards 1,000 network partners
- Platform reaches 2,000 electronic referrals
- Operational in all 100 counties

2021

- 2,500 organizations live on the platform
- NCCARE360 partners with NCServes to support service members and military families

2022

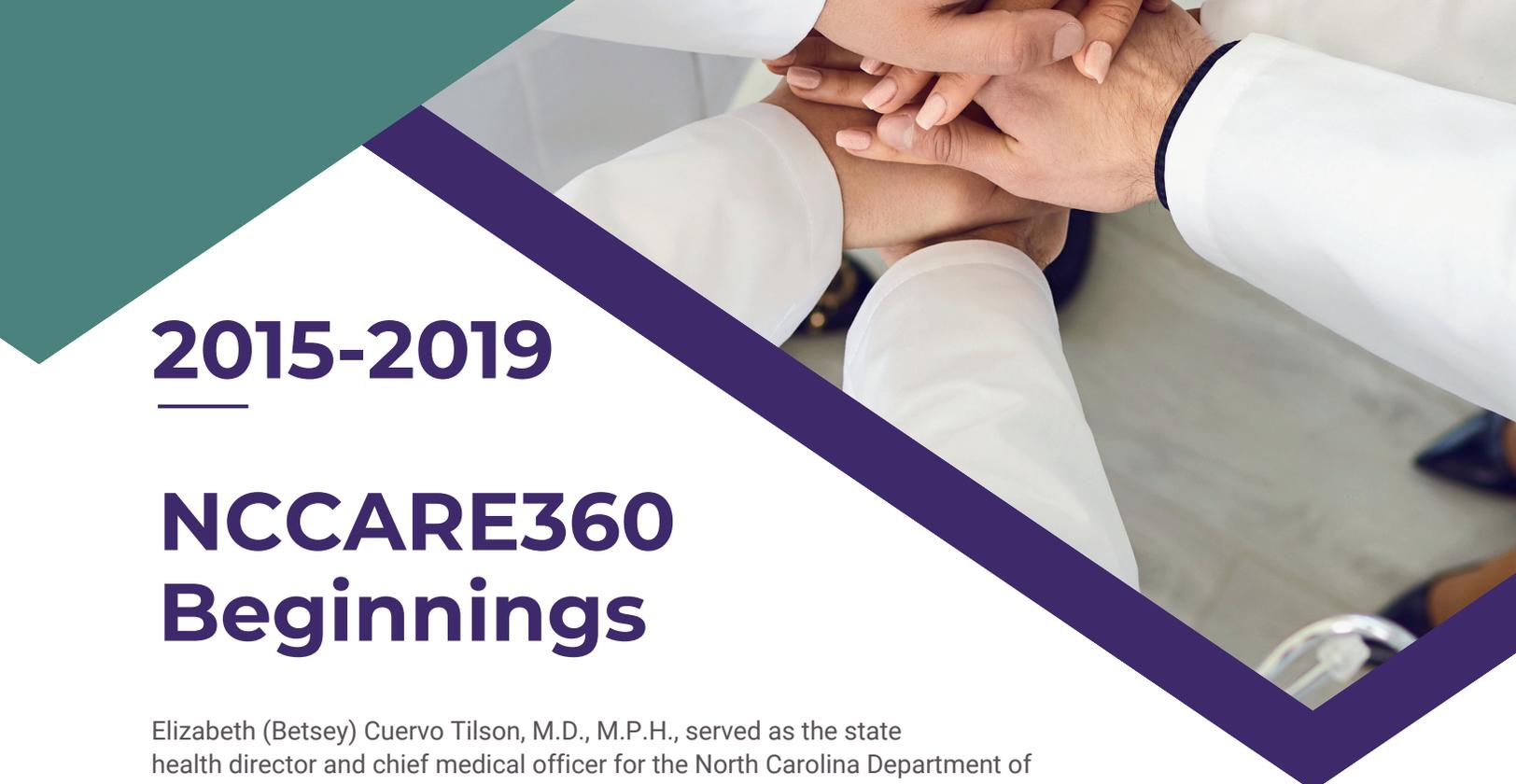
- Launch of social care payments
- North Carolina launches the Healthy Opportunities Pilot (HOP), run on the NCCARE360 platform

2023

- NCCARE360 platform supports its 100,000th referral

2024

- NCCARE360 and NCDHHS conclude a \$25 million grant program, having awarded 21 CBOs funding to increase capacity to address social drivers of health



2015-2019

NCCARE360 Beginnings

Elizabeth (Betsey) Cuervo Tilson, M.D., M.P.H., served as the state health director and chief medical officer for the North Carolina Department of Health and Human Services (NCDHHS) for nearly eight years. During that time, she was instrumental in bringing NCCARE360 to life.

“When I came to the department in 2017, we really had this vision of whole-person health and thinking through how do we connect health care and human services,” she said.

Then, in 2015, new data and technology emerged that could connect health and human service systems. Dr. Tilson said the department wanted to explore ways to build an integrated infrastructure.

“Our health care and our human service sectors weren’t connected. They were in silos. So, we wanted to think about how we create a statewide infrastructure to connect those sectors in service of whole-person health. And it was that vision out of which NCCARE360 was born.”

She said addressing social drivers of health was foundational to their strategy. *“We know that high-quality clinical care is exceedingly critical but sometimes not sufficient. We also know things like food, housing, and safety are also critical to health outcomes.”* Drawing on the data, the team prioritized food, housing, transportation, and interpersonal safety.

Brandon Wilson is the chief operating officer for the Asheville Buncombe Community Christian Ministry (ABCCM), a nonprofit in Western North Carolina that utilizes the platform. He is also a Marine veteran and an early champion for NCCARE360 and NCServes, a partner program providing veterans services.

Wilson said, “What we learned in those early days is you have to have local buying. You have to have local impact. You have to have local people coming to the table. Because every community is very unique and very different.”

Dr. Tilson said after the NCServes pilot in 2015, *“We (NCCARE360) launched with one county in 2019, and then we were fully statewide by mid 2020. Now, the pandemic helped to accelerate that because we had so much need that we went statewide ahead of schedule to try to meet those needs.”*



NCCARE360 Success Story

Jane spoke with an NCCARE360 Navigator on behalf of Betsy, her 70-year-old mother. Betsy was referred to NCCARE360 for medical expense assistance. Upon speaking with Jane, the Navigator learned that Betsy also needed help with respite care, home-based care, and utility bill assistance. **The Navigator was able to send referrals for all of Betsy's additional needs.** When following up with Jane a few weeks later, the Navigator learned that Betsy had received some utility bill assistance and soon would be receiving home health services. However, she still needed some help with an outstanding utility bill. Jane was very grateful when the Navigator provided additional out-of-network referrals for utility assistance.

A black stethoscope with a silver chest piece is positioned in the upper right corner of the page. The background features a large, stylized graphic of a stethoscope's tubing in shades of teal, orange, and purple.

2020-2022

Evidence for Success and the COVID-19 Pandemic

Over time, the data has shown that with NCCARE3060, *“We decrease social needs, we decrease emergency department visits, hospitalizations, and have significant savings for people who are getting these social services as well as health care,”* said Dr. Betsey Tilson, former state health director and chief medical officer for NCDHHS.

As a community-based nonprofit leader and NCCARE360 platform user, Brandon Wilson said, ***“It improves the ability for you as a provider to send a referral to another community provider in a platform and in a system that’s closed loop. You know that need actually got met.”***

He stated that utilizing the platform can have an even greater impact in rural communities, where resources may be scarcer. *“It’s really important for some of our rural pockets to have this network because we have so many resource deserts, lack of transportation, lack of funding for nonprofits, and lack of affordable housing.”*

This became particularly evident during the COVID-19 pandemic.

Dr. Tilson said, *“NCCARE60 really helps to address the core needs of people, which then will lend itself well to whatever emerging new issue comes, because we still will be addressing those core foundational needs. No matter what the new shiny public health threat is, we are going to have to address people’s core needs in order to respond to that.”*

Reflecting on her long-term vision for NCCARE360, she said, *“North Carolina has been a leader in thinking about whole-person health and operationalizing wholeperson health. **And now we have great data to show that if you do that, you can improve health and decrease health care costs.**”*

She anticipates that other states will adopt similar measures and hopes that the program’s success can shape national policy to support whole-person health for individuals throughout the country.

Looking ahead, Wilson said, ***“We have this window of opportunity to really change the dynamic, and the paradigm of how we deliver services to people in the community, as well as how we target our funding and resources allocation better than ever before.”***

NCCARE360 and the Healthy Opportunities Pilot (HOP)

In 2022, NC Medicaid launched the Healthy Opportunities Pilots (HOP), the first program of its kind in the U.S. to test and evaluate how providing high-need Medicaid enrollees with services like housing, food, transportation, and support for safety and stress can impact health outcomes.

While NCCARE360 and HOP are funded and operated separately, **HOP runs on the NCCARE360 platform**, leveraging the statewide coordinated network to provide care and resources to Medicaid beneficiaries.

“Addressing people’s social needs, it’s not a fad, right? People need **food**. People need **housing**. People need **safety**. We’re going to need to continue to work with our communities to address these core, fundamental needs of people.”

— Dr. Betsy Cuervo Tilson

NCCARE360

- Funded by the North Carolina Department of Health and Human Services
- Available to all North Carolinians
- A digital tool to coordinate health and social services

Healthy Opportunities Pilots

- Funded through a Federal Medicaid 1115 Waiver
- Available to Medicaid beneficiaries in rural pilot regions
- A program to study the impact of providing non-medical services powered by the NCCARE360 platform

While NCCARE360 and HOP are separate in many ways, HOP pilot data has proven that, by using the NCCARE360 platform, providing support for non-medical drivers of health reduces emergency department visits, decreases in-patient hospitalizations, and saves around \$85 per person per month.

2023

92%

year-over-year
increase in referral
activity in 2023

NCCARE360's 100,000th Referral

In 2023, NCCARE360 reached a major milestone with its 100,000th connecting people to local services and resources.

The referral for the 100,000th person was part of the rollout of the Healthy Opportunities Pilots (HOP), the nation's first comprehensive program to pay for non-medical services, such as food and housing, for Medicaid enrollees. A community-based nonprofit that inspects housing for safety and quality was able to make important accessibility and safety repairs, thanks to a secure referral through the platform.

In addition to serving over 100,000 people statewide, the NCCARE360 team continued to grow and support the network—especially in rural and under-resourced areas—throughout 2023.

Top 5 Service Needs by Volume in 2023:

- Food assistance
- Housing and shelter support
- Individual and family support (ie. Child Care Assistance)
- Income support (ie. emergency and one-time financial assistance)
- Utility bill payment assistance

By The End of 2023:

- 3,333 organizations were on the NCCARE360 platform.
- 471,230 cases were supported since the platform's launch in 2019.
- 414,594 referrals were made.
- 179,534 clients were served.



NCCARE360 Success Story

October 2023

A 14-year-old client needed a nutritional supplement that was previously being purchased with the family's FNS/SNAP benefits. Due to a federal decrease in those benefits, the family could no longer afford the supplement and the client was at risk of experiencing health complications. **The client was referred to an NCCARE360 Resource Navigator who advocated on the family's behalf to an out-of-network resource, resulting in the client receiving a case of the needed supplement at a discounted price.**

“With your support, we have been able to change many people’s lives.”

— Felix Iyoko
Director, Raleigh Immigrant
Community, Inc

2024

Health Equity Grants

In 2024, the Foundation for Health Leadership and Innovation (FHLI), in partnership with the North Carolina Department of Health and Human Services (NCDHHS), concluded a two-year, \$2.5 million capacity building grants program, providing funding to 21 community-based organizations (CBOs) across the Triangle and Triad regions of North Carolina.

These grants supported the growth of NCCARE360 and increased CBO capacity to address social drivers of health (SDOH).

7,878

Managed cases throughout the grant period, up from just 753 prior to 2022

Top 5 Service Needs by Volume in 2024:

- Food assistance
- Housing and shelter support
- Individual and family support (ie. Child Care Assistance)
- Income support (ie. emergency and one-time financial assistance)
- Utility bill payment assistance

70%

Resolution rate despite adapting to a higher referral volume and post-COVID staffing shortages



NCCARE360 Success Story

February 2024

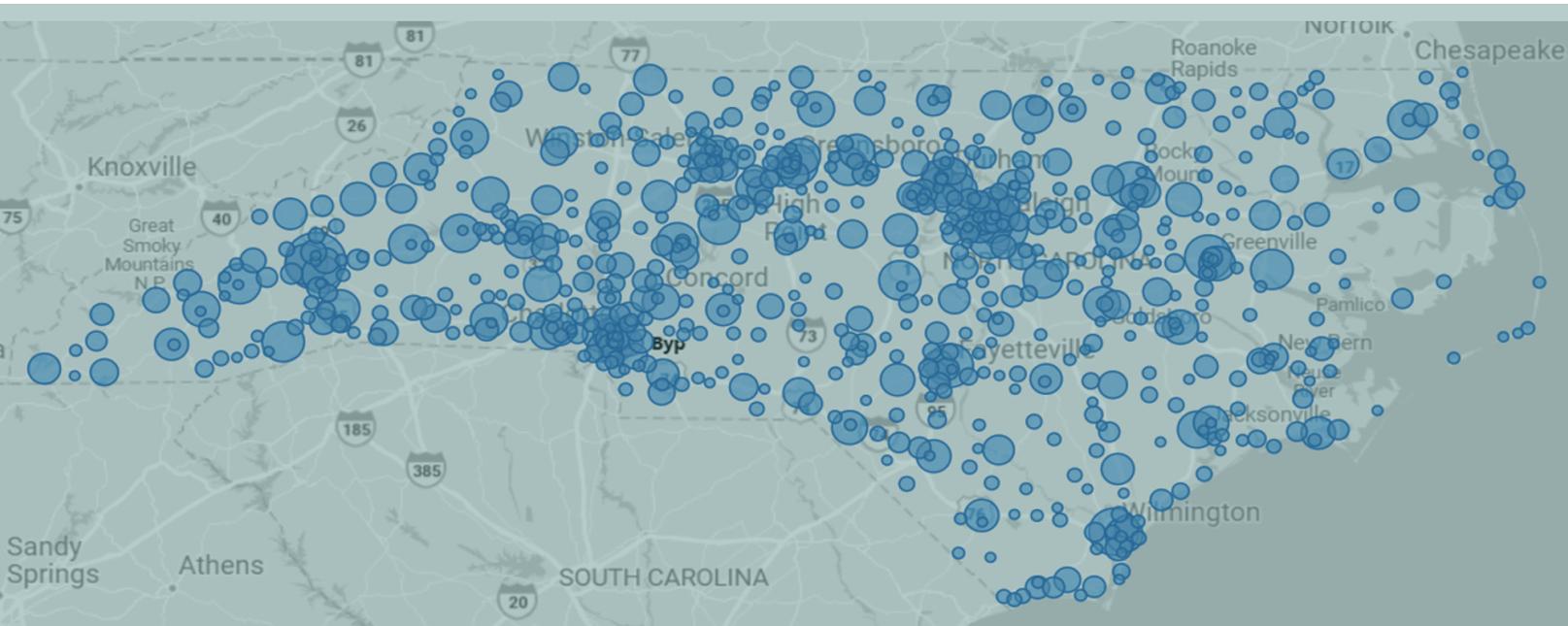
Helen was an elder patient whose many financial barriers were causing her to experience food insecurity. **Her health care provider sent a referral to an NCCARE360 Resource Navigator to get her connected to food resources.** The Navigator contacted Helen right away and, through an eligibility screening, referred her to Meals on Wheels and several other community-based support systems. Helen's food-related needs were met quickly and compassionately with the help of a Navigator, and she was very grateful to have someone looking out for her.

NCCARE360 in Action:

Expanding Access, Driving Impact

Improving North Carolinians' access to resources isn't accomplished alone. It takes a connected system of healthcare providers, care coordinators, community-based organizations, and more working together to identify needs and coordinate services.

Over the past five years, NCCARE360 has served as the backbone of this system, enabling cross-sector collaboration and streamlining referrals to essential health and social services. With more than **3,689 organizations, 8,430 programs, and 234,871 clients** served across all 100 counties, this collective impact reflects the strength of our partnerships with health systems, resource navigation teams, and community organizations across the state. NCCARE360 continues to expand both its internal functionality and external engagement to offer the most comprehensive, responsive, and accessible network possible.



“Once we have (NCCARE360), we don't just need people sitting behind a desk once again just using it for resources. We need community health workers serving the community by being in the community, going out and seeing what people need, and not expecting them to come to you.”

— Kathey Avery, RN, BSN

Kathey Avery, RN, BSN, is the founder and CEO of the Institute for Preventive Healthcare and Advocacy (IFPHA) in Buncombe County. As a dedicated health advocate, she works throughout Western North Carolina to assist individuals who face barriers to accessing care.

“I’m actually a community nurse,” Avery explains. “It’s kind of like being a community health worker, but you get to do more things because you can take care of clinical issues as well as the social determinants of health.”

Since 2008, Avery has been deeply involved in community work. Early on, she recognized that traditional methods often fail to reach underserved populations. In response, she setting up outside public housing complexes, engaging residents in conversations about their health. By meeting people where they are, she builds trust by listening to their stories and addressing their comprehensive needs.

For Avery, NCCARE360 serves as a vital tool in this work, allowing her and other community-based providers to coordinate care more effectively and connect individuals with essential services.

For José Infanzón Chávez, the community health worker regional coordinator for UNETE, NCCARE360 helps create connections to get resources where they need to be. “Utilizing NCCARE360 to connect those resources and services with the families who actually need it has been huge. It has been a great connector for us,” he said.

UNETE is a grassroots organization that employs a team of community health workers focused on serving Buncombe, Henderson, Haywood, Jackson, and Transylvania Counties. A community health worker, Chávez works with many different organizations to weave a network of care that provides resources for unmet needs. “We work in collaboration, and it’s important to highlight the collaboration part because it is in the same spirit as NCCARE360,” he said.

“In our case, one organization cannot do everything. It’s about starting new relationships, being able to amplify the services and support you provide your community, and being able to pick up the phone and say, ‘hey I have this client, can you help them with this?’ It opens doors to everybody.”

3,689

active organizations serving clients on the NCCARE360 platform

55,451

individual administrators actively using the NCCARE360 platform to send and receive referrals

8,430

unique programs offering services to NCCARE360 platform clients

234,871

clients on the NCCARE360 platform

Partnering with Health Systems to Drive Coordinated Care

Since its launch, NCCARE360 has become a critical tool for North Carolina's healthcare ecosystem, bringing together clinical and community providers to bridge the gap between clinical care and social care needs. NCCARE360 allows health systems to improve patient outcomes, close the loop on referrals, enhance case management and care coordination, and align with equity and population health goals. Health systems across the state have embraced the platform, integrating it into workflows to support patients' non-medical needs and improve health outcomes.

By the Numbers: Health System Engagement with NCCARE360

11 health systems are actively participating in the NCCARE360 network:

Atrium Wake Forest University Baptist Hospital

Cone Health

Duke Health

ECU Health

UNC Health

WakeMed Hospitals and Health Systems

Cape Fear Valley Medical

Appalachian Regional Healthcare Systems

Haywood Regional Medical – Duke Lifepoint Hospital

St. Luke's Hospital– now called AdventHealth Polk

Mission Health Partners

- Over **73,459 referrals** have been initiated by healthcare providers since launch, serving more than **20,873 clients**
- **71.3%** of referrals made by health systems are successfully resolved, meaning the individual was successfully connected to a community-based resource.
- Top needs addressed include food assistance, housing stability, utility assistance, transportation, and behavioral health services.
 - **64,320 cases** impacting **21,035 clients**
 - **35,278 managed cases** impacting **14,618 clients**



Transforming Systems Through Technology and Trust

“NCCARE360 has fundamentally changed how we think about connecting patients to community resources. It helps our care teams move beyond just identifying a need by providing a way to make referrals and then having the data to confirm that support was provided. That level of transparency and accountability did not exist before the NCCARE360 integration within our EHR.”

- Dr. Eugenia McPeck Hinz, Associate Chief Medical Information Officer, Duke University Health System

Health systems continue to evolve how they use NCCARE360—from embedding it in electronic health records (EHRs) to launching collaborative regional networks with community-based organizations. This integration ensures that no patient falls through the cracks, and that medical care is complemented by timely, effective social support.

As we look at the next phase of NCCARE360, our goal is to deepen these partnerships and further align clinical and community ecosystems. The past five years have proven that when health systems commit to coordinated care, communities can thrive.

Health System Spotlight:

Duke Health – A Model of Strategic Integration

As one of the strongest champions of NCCARE360, **Duke Health** has played a pivotal role in demonstrating how large, integrated health systems can leverage coordinated care technology to address social drivers of health. Duke Health has integrated NCCARE360 across multiple care management teams including outpatient clinics, hospital settings, and community outreach units. To date, **Duke Health has initiated almost 30,000 referrals** impacting more than 10,000 clients. **Top referral categories** from Duke Health include food assistance (35.2%), housing and shelter (13.7%), and mental/behavioral health services (9.2%).



“Having a platform like NCCARE360 that accurately identifies organizations that are able to provide food, transportation, utility support, and other social services to our patients with health-related social needs, facilitates referrals, and tracks whether the patient received the resource or not is essential to our being able to understand what social care delivery impacts health so that we can write better policy for what services should be covered.”

We could not have done our evaluation of Meals on Wheels Hospital Discharge Program without NCCARE360. It allowed us to know of those referred, who got meals and who didn't. Those that received meals were two-thirds less likely to be readmitted at 14 days.

But I would be remiss not to add this: Without funding of social services and the social safety net, a bridge to connecting patients to resources is only as strong as volunteer dollars will go. We need government support to make NCCARE360 fully functional. A Bridge without funding is a Bridge to nowhere. And NCCARE360's closed loop rate isn't based on patients receiving a resource. That needs to change.”

-Dr. Susan E. Spratt, Diabetes and Metabolism Specialist, Endocrinologist, Duke University Health System

Integrating Evidence-Based Practice with Real-World Impact

In 2022, Duke pioneered the integration of NCCARE360 into clinical workflows by leveraging long ER wait times to connect patients with essential social needs. An initiative called ParalleLED, led by emergency medicine physician Dr. John Purakal and supported by trained undergraduate volunteers, embedded social needs screening directly into the emergency department.

Initial data from ParalleLED showed **80% of the 172 patients screened had at least one unmet need**, and 67% had more than one. Of the referrals made, **84% connected patients to food, housing, transportation, or utility resources**. One patient disclosed isolation as well as food and housing insecurity after a personal crisis, immediately leading to a referral sent in NCCARE360. Dr. Purakal emphasized that addressing social needs in parallel with medical care enhances outcomes and relieves pressure on clinical staff. He notes that non-medical issues frequently arise at the end of visits, leading to delays and stress, but early intervention flips that dynamic.

Duke Health's early adoption and scale-up of NCCARE360 underscore the platform's flexibility and effectiveness, exemplifying how NCCARE360 can seamlessly integrate into hectic clinical workflows, yielding measurable impact while addressing the root causes of poor health.



Community Snapshot: UNETE

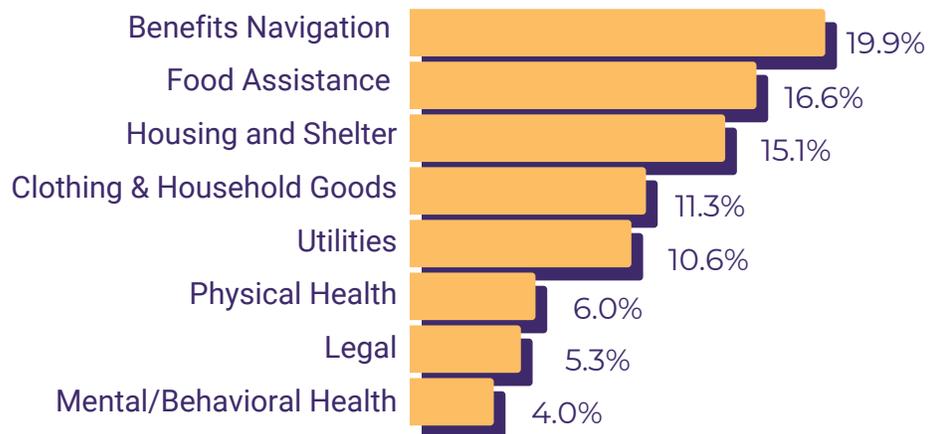
301
clients served

659
referrals made

278
cases managed

70.7%
managed case
resolution rate

Case Volume by Service Type



Top recurring needs:

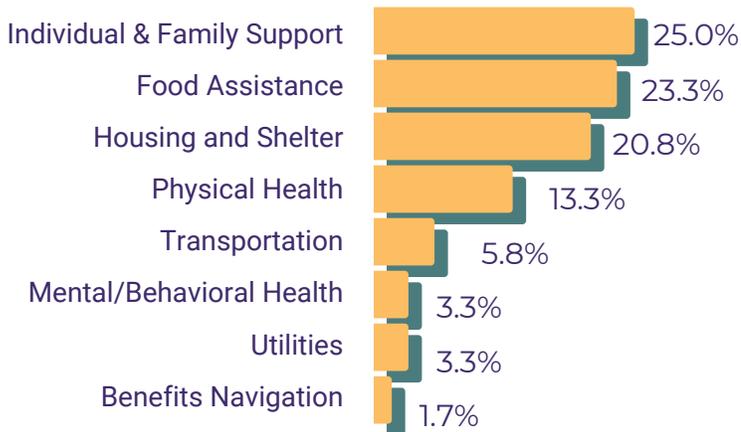
- Mental/behavioral health
- Social enrichment
- Physical health
- Sports and recreation
- Housing and shelter

Community Snapshot:

Meals on Wheels



Case Volume by Service Type



Top recurring needs:

- Mental/behavioral health
- Food assistance
- Housing and shelter
- Transportation
- Physical health

97
clients served

152
referrals made

37
cases managed

64.9%
managed case
resolution rate

Note: This data represents an aggregate of the following four Meals on Wheels agencies onboarded on the platform: Meals on Wheels of Durham, Meals on Wheels of Asheville/Buncombe, Meals on Wheels of North Carolina, and Meals on Wheels of Wake County.

NCCARE360 Resource Navigators

Bridging Gaps, Guiding Care

At the heart of NCCARE360's statewide infrastructure is a team of NCCARE360 Resource Navigators dedicated to ensuring a no-wrong-door approach to care coordination and helping ensure no one falls through the cracks. Housed within the NC 211 Coordination Center, they play a critical role in supporting individuals and organizations across North Carolina by providing general information and referral (I&R) services through the NCCARE360 platform.

The Navigators serve as at-large care coordinators, stepping in to support hospitals, physician practices, and community-based organizations (CBOs) that are not yet part of the NCCARE360 network or lack the capacity to stay with clients throughout the referral process. They ensure that even in the absence of a connected partner organization, individuals still receive **timely, compassionate, and coordinated care**.

They also respond directly to public inquiries submitted through the online NCCARE360 assistance request form, assisting individuals seeking services independently without the support of a provider, agency, or other referral partner. This direct-to-client support enhances the network's accessibility and responsiveness for individuals navigating social needs on their own.

Navigators often manage complex referral cases with interconnected challenges, such as securing sustainable housing, accessing emergency shelter, and obtaining financial assistance. These cases typically encompass multiple, overlapping needs that require persistence, problem-solving, and a comprehensive understanding of resources. Whether the referral comes from an individual, a CBO, or a provider who is unable to fully assist, Navigators step in to coordinate care with empathy and efficiency.

In addition to supporting complex needs, Resource Navigators play a crucial role in addressing gaps in referral resources, such as transportation assistance, prescription support, utility aid, and more. By doing so, they help ensure a more comprehensive and connected continuum of care, particularly for North Carolinians facing barriers to accessing services.

Through their work, the NCCARE360 Resource Navigators serve as a vital safety net, enhancing network functionality, expanding access, and ensuring that more individuals receive the support they need. They embody the spirit of coordinated care by meeting people where they are, navigating challenges alongside them, and connecting them to the resources they need to thrive.



NCCARE360 Resource Navigators



In March 2025, Resource Navigators managed a total of **1,237 service episodes and cases**.



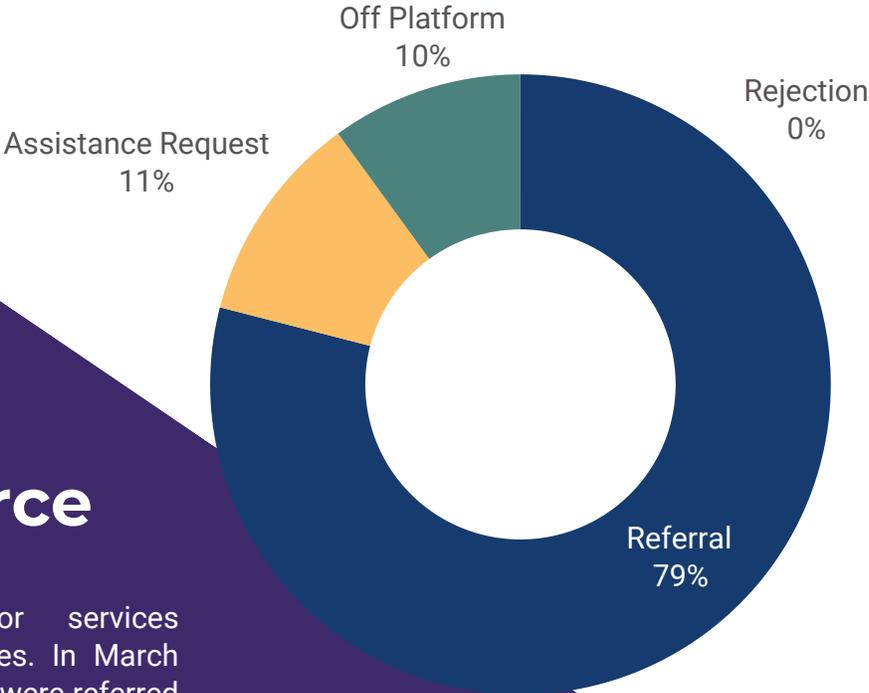
Since consumers often have multiple referrals, a single case may encompass more than one need. In March 2025, **818 consumers presented a total of 1,153 needs**, reflecting a 15% year-over-year increase in volume.



In 2025, 107 organizations submitted referrals to NCCARE360 Resource Navigators. A total of 3,371 referrals have been directed to Navigators, enabling us to assist and serve **2,517 clients throughout the year**.



101 referrals were sent in-network by Navigators, impacting 80 consumers in 2025.

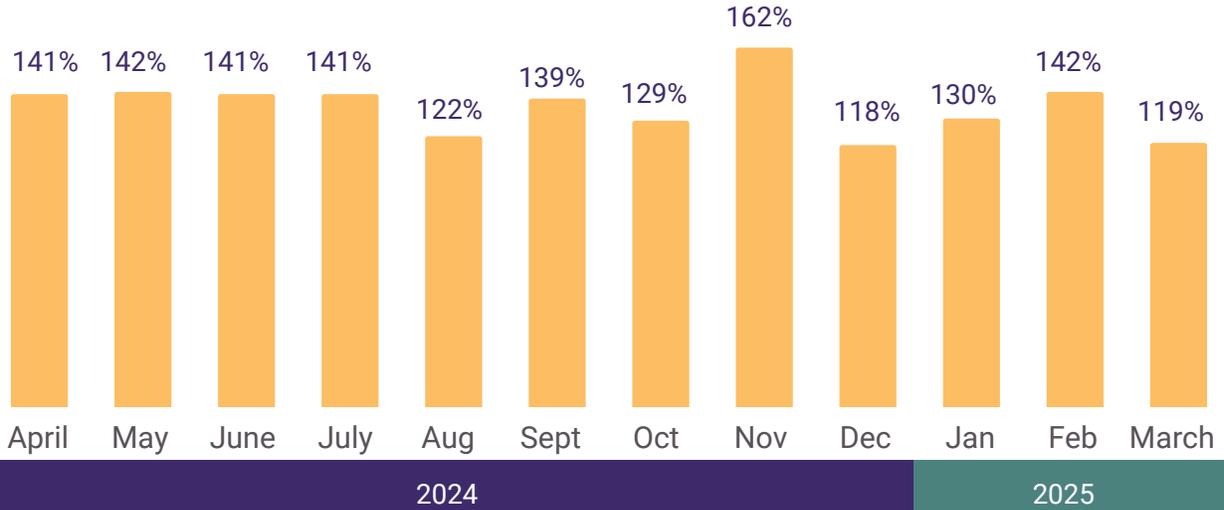


Referral Source

Consumers access Navigator services through multiple referral avenues. In March 2025, the majority of consumers were referred through platform-based channels. 24% of individuals were returning consumers, and 77% were new to Navigators.

Additional Needs

In March 2025, NCCARE360 successfully provided referrals for 133 additional client needs. On average, Navigators have served 130% of client needs throughout 2025, demonstrating their continued ability to connect individuals with multiple essential resources.



NC 211 Database Snapshot

March 2025

of



Lessons Learned

Over the past five years, NCCARE360 has evolved from a bold idea into a robust statewide network; however, the journey has not been without challenges. Each step has provided new insights that continue to shape how we build, sustain, and evolve this critical infrastructure. These lessons have informed our strategy and reinforced the values at the core of our work.



Technology is only part of the solution.

While a robust technology platform is foundational, we learned early on that **systems alone do not drive change; people do**. Meaningful use requires building trust, providing tailored training, and maintaining responsive support. Ensuring that users feel confident and valued is essential for sustained engagement.

The people closest to the work know it best.

Some of our most impactful innovations came directly from those who use the platform daily and understand the unique needs of their communities. We learned that **regular, structured opportunities for feedback and a willingness to quickly act on that feedback are vital to improving the system for everyone**.

Cross-sector collaboration requires time, patience and trust.

Bringing together health care providers, community-based organizations, state agencies, and others has always been central to NCCARE360's mission; however, aligning these sectors requires intentional relationship-building. We learned that **collaboration cannot be assumed; it must be cultivated**.

Standardizing data across partners is challenging, but necessary.

Accurate, timely data is the backbone of coordinated care; however, collecting and managing it across organizations with different systems and workflows has proven complex. We recognized the **need to invest in shared definitions, streamlined data entry processes, and rigorous quality control to ensure that data drives effective action**.

It requires intentional effort. We've learned that simply having a network in place is not enough. **Participation must be built into every layer of the system, from who is involved in decision-making to how tools are developed and which outcomes are tracked.** As we plan for the future, we remain committed to creating a system that serves all communities effectively and responsively.

Early success was often measured by volume—of users, referrals, and organizations. However, we learned that **meaningful utilization is a more important indicator of impact.** Closed-loop referrals, service outcomes, and user satisfaction now guide our understanding of effectiveness.

Pilots and short-term funding helped us launch, but long-term success depends on integration, shared ownership, and financial sustainability. We learned the importance of aligning with broader state and health system initiatives and building in the capacity for ongoing support.



Fair access and meaningful impact doesn't happen by accident.

High numbers do not always equal high value.

Sustainability must be planned from the beginning.

These lessons have shaped our vision for the next phase of NCCARE360 that is grounded in fairness, informed by data, and driven by the voices of those we serve. As we move forward, we carry these insights with us to strengthen our collective impact across North Carolina.

NCCARE360 *Future and Goals*



As NCCARE360 marks five years of statewide implementation, we stand at a pivotal moment shaped by reflection and renewal. The progress we've made together shows what is possible when clinical and community organizations collaborate to meet people's full range of needs. Yet, our work is also far from finished.

NCCARE360 is committed to deepening our impact through a focused strategic direction centered on three core priorities:

1) increasing meaningful utilization

2) improving data accuracy and strategy, and

3) strengthening quality assurance

We aim to ensure that every use of the platform translates into meaningful outcomes, from helping families access housing and coordinating follow-up care to addressing social drivers of health in real time. To achieve this, we are investing in enhanced user support, engagement, and training to equip partners with the necessary tools and confidence to utilize the network effectively.

We are also enhancing our data infrastructure to improve accuracy, timeliness, and the strategic use of insights. This will allow us—and our partners—to make smarter, faster decisions grounded in real-world needs and trends.

Ultimately, we are fostering a culture of continuous improvement through robust quality assurance. This involves regularly reviewing and refining our processes, platform performance, and community feedback to ensure NCCARE360 remains not only functional but also exceptional.

Together, these priorities reflect our commitment to a future where data is actionable, connections are impactful, and care is truly coordinated. **We are grateful to everyone who has contributed to NCCARE360's first five years, and we are excited about what we can accomplish together in the next five years and beyond.**

By helping more people address nonmedical drivers of health, NCCARE360 reduces the overall cost burden of health care across the system. When needs like food, transportation, and housing are met, people have more opportunities to access stability and live healthy, happy, and productive lives.

Acknowledgements

We are deeply grateful to our partners whose collaboration and commitment have been essential to NCCARE360's success. We would like to thank the North Carolina Department of Health and Human Services (NCDHHS), United Way of North Carolina, NC 211, and Unite Us for their support and contributions over the past five years. These partnerships have been vital in building and sustaining a coordinated care network that continues to improve lives across North Carolina.



NCDHHS



United Way of North Carolina



UNITE US

THANK YOU



NCCARE360

**Building Connections for a
Healthier North Carolina**

www.nccare360.org