Evaluation of process and outcomes is an important step in understanding the effect ACC efforts have on the community and the intended health-related metrics. Measuring where an ACC is in the process of addressing community issues and how well programs are working to address needs is vital to knowing what steps should be taken to improve those programs, and thus improve the intended outcomes. Information about the impact that partnerships and programming have on the community's health also can help secure funding opportunities for the short- and long-term financial security of the partnership.

It is important to understand the planned or expected results of the programs an ACC engages in to develop outcome measures and evaluation mechanisms that are relevant. For example, if an ACC's goal is to decrease the percent of families in the community who are food insecure, baseline measures of food insecurity are required, program activities that are addressing the need should be monitored (e.g., how many families were served, their satisfaction with the program, and whether needs were met), and there should be a plan to measure and report changes in these data points. Planning for data collection and continuous monitoring will provide information that can help to improve program effectiveness and show funders the positive results of the work. Indeed, intended outcomes and evaluation should be part of the initial planning process for all ACC work, rather than a later step in the process. With outcomes and evaluation in mind, programs can be built to more effectively target key issues and plan to measure for successes and lessons learned.

Recommendation 2.7.a from Chapter 2 of this report details technical assistance that can be useful for the initial development of an ACC and is also relevant to evaluation planning and process improvement. This recommendation calls on groups across the state to support training on a structured decision-making process, such as Results Based Accountability™. This type of decision-making framework is useful in determining plans for action, as well as process and outcome measures. Additionally, Recommendation 2.7.b. calls on groups across the state to convene learning collaboratives. Again, while these collaborative efforts would discuss ACC development topics, they would also share outcomes and evaluation techniques, along with lessons learned.

Evaluations of State-Led Efforts to Address Health-Related Social Needs

Just as evaluations of community-level ACC activities are important to understand their effectiveness, the North Carolina Department of Health and Human Services (NC DHHS), and their partners should incorporate an evaluation of statewide efforts to address health-related social needs.

> **EVALUATION OF PROCESS AND OUTCOMES IS AN IMPORTANT STEP IN UNDERSTANDING THE EFFECT ACC EFFORTS HAVE ON THE COMMUNITY AND THE INTENDED HEALTH-RELATED METRICS.**

The standardized screening questions for health-related social needs are being piloted (as of this writing) using an in-person process in a clinical setting with the intention of evaluating the wording of the screening questions. Revisions may be made to the questions depending on the findings of the pilot tests. Even with valid screening questions, the method and location for completing the assessment plays an important role in the likelihood of an individual completing the assessment and providing honest answers. NC DHHS, Prepaid Health Plans, and providers must consider the pros and cons of various approaches, such as telephone versus in-person interview, electronic or paper completion, as well as individual literacy levels.[75,76] Additionally, organizations administering the screening questions could benefit from guidance on the best methods for educating individuals about the purpose of the screening. This "priming" process could help to increase the response rate to the screening process by helping individuals understand why the questions are being asked (i.e., the association of health-related social needs to health outcomes) and how they may benefit from responding (i.e., potential referral to services that can meet needs).

Additionally, there should be considerations of the burden of completing the assessment, both on staff and the individual providing responses. A balance needs to be struck between assessing for needs often enough to capture changes in need and linking individuals to resources and over-screening that could lead to screening fatigue for both the individual and staff. Evaluations of these factors could consider whether a pre-screening question would reduce the potential for screening fatigue. A pre-screening question could ask about changes to health-related social needs like access to food, housing, personal safety, or transportation and trigger the standard screening questions if answered affirmatively. Stakeholders, such as Prepaid Health Plans, health care providers, and human services organizations, could benefit from an evaluation and guidance on the standards for completing the screening in a manner that is least invasive, yet most effective. In order to provide consistent guidance on effective screening processes, the Task Force recommends:

RECOMMENDATION 5.1:

EVALUATE METHODS FOR SCREENING FOR HEALTH-RELATED SOCIAL NEEDS

The North Carolina Department of Health and Human Services should provide guidance on optimal frequency, modality, and location for screening individuals for health-related social needs. This guidance should balance concerns about under- or over-screening with the need to gather timely information and engage services to address beneficiary needs. The guidance should also consider and describe best practices for preparing or "priming" individuals for the screening process to help produce the highest rates of screening acceptance and completion as possible. This guidance should:

a) Be published and disseminated to Prepaid Health Plans and other payers, health care providers, human services organizations, educational institutions with health workforce training programs, and other stakeholders through NC DHHS website(s) and other forms of communication (e.g., presentations, training materials).

b) Inform future standards and requirements for Prepaid Health Plans related to screening for health-related social needs.

c) Consider the utility of a pre-screening question to identify individuals who should be screened or re-screened, with the intention of reducing burden to individuals being screened and those assisting with screening processes.

With the variety of providers and organizations that will be implementing the standardized screening questions for health-related social needs, a central repository for this information could enhance the care individuals receive from other providers and organizations. A natural location for this data to be stored is NC HealthConnex, North Carolina's Health Information Exchange. NC HealthConnex is administered by the North Carolina Health Information Exchange Authority, which was established by the General Assembly in 2015 and is housed in the North Carolina Department of Information Technology's Government Data Analytics Center.[77] The purpose of the system is to "connect health care providers to safely and securely share health information through a trusted network to improve health care quality and outcomes for North Carolinians."[78] Data elements available in NC HealthConnex currently include allergies, encounters, medications, problems, procedures, and results. The law mandated that all hospitals, doctors, and mid-level practitioners providing Medicaid or state-funded services and that had technology capabilities should have been connected by June 1, 2018, followed by all other providers of Medicaid or state-funded services that did not have technology capabilities by June 1, 2019. Adding the information gathered through the standardized screening questions to NC HealthConnex would allow the variety of providers that an individual sees to access important information about their health-related social needs.

In addition to hospitals and health care providers, Prepaid Health Plans will amass a wealth of information on the health-related social needs of the beneficiaries enrolled in their plan through required screening for health-related social needs using the standardized screening questions. This information will be used for internal care management purposes and can inform the investments Prepaid Health Plans make in the communities they serve. The data also can help to inform community-based efforts, such as ACCs, to address health-related social needs, and should therefore be collected and analyzed by the state. State-produced public reports of these analyses can help to identify areas in the most need and areas that are making progress in addressing community needs.

To encourage the evaluation of statewide efforts to assess health-related social needs in North Carolina and the dissemination of information learned through those evaluations, the Task Force recommends:

> **ACCS CAN SERVE AN IMPORTANT ROLE IN IDENTIFYING GAPS BASED ON INDIVIDUAL NEEDS AND MAKING THE CASE FOR EXPANDED ACCESS TO SERVICES.**

RECOMMENDATION 5.2:
EVALUATE DATA GATHERED THROUGH THE STANDARDIZED SCREENING PROCESS

a) The Department of Information Technology should explore how NC HealthConnex could be used to collect, aggregate, and share data from the standardized screening question responses collected by Prepaid Health Plans, NCCARE360, and other providers and organizations using the standardized screening questions to screen individuals for health-related social needs.

b) The North Carolina Department of Health and Human Services should:

- **i)** Require Prepaid Health Plans to submit quarterly raw data files with standardized screening question results. Data should include gender, race/ethnicity, age, and geography of screened individuals.
- **ii)** Maintain a Memorandum of Understanding with the Foundation for Health Leadership & Innovation for use of all data collected through NCCARE360.
- **iii)** Release aggregate data reports annually on its website. Information should be disaggregated by gender, race/ethnicity, age, and geography to the smallest degree possible for evaluation and planning. These reports should identify areas where resources are needed in communities.
- **iv)** Work with academic and research partners to use identified data for evaluation.

NCCARE360 partners will be gathering a wealth of information on community needs throughout the state through NCCARE360. This data can inform the quality improvement process for the Platform and also should be analyzed to inform communities on the volume and types of referrals that are being made for service needs. As the platform is used to identify needs and link people to resources, communities can learn where resource gaps or limitations exist. ACCs can serve an important role in identifying gaps based on individual needs and making the case for expanded access to services.

NCCARE360 will use a referral feedback loop so that all parties involved know the status of an individual's referral for resources. This includes whether the individual's needs have been met, if the referred organization does not have capacity to meet needs, or if an individual has not made contact with the organization to which they were referred. With a large variety of stakeholders using NCCARE360 it is possible that an individual could be introduced into the system via more than one organization. In those cases, it will be important to know whether the system is recognizing duplications of individuals being linked to services or if there are duplicative referrals of one individual to the same organization. Evaluating this information can help NCCARE360 partners continue to improve the platform and cut down on potentially confusing and duplicative efforts across multiple organizations.

The overall user experience with NCCARE360 also should be reviewed. Users can be broadly defined as organizations making referrals, organizations receiving referrals, and the individuals being referred. For each of these parties, the experience using the platform and interacting with the other parties in the process should be considered and will determine user engagement and the success of the platform. For organizations making referrals, they may be asked whether the platform has streamlined their referral process (if they had been making referrals previously), whether the platform has allowed them to add referrals to their care, how well resources available on the platform match the needs of their patients/clients, and how accurate the referral feedback loop has been in their experience. For organizations receiving referrals, they may be asked whether they have been able to clearly communicate with the referral source, what issues they have had coordinating with the individual referred, whether they have had any issues with the referral feedback loop, whether they have seen an increase in referrals and have sufficient capacity to meet that increase, and what the cost of implementing the platform into their work and serving new clients has been. Finally, for individuals being served through the platform, they may be asked if the service has been person-centered (i.e., do they feel like part of the decision-making process), how it has been to navigate the referrals made on their behalf, if they have had trouble communicating with either the referral source or organizations to which they were referred, whether their privacy has been respected, and whether they have been denied services to which they were referred.

To encourage the evaluation of statewide efforts to address health-related social needs and the dissemination of information learned through those evaluations and to ensure the utility and user experience of NCCARE360 is maximized, the Task Force recommends:

RECOMMENDATION 5.3:
EVALUATE DATA GATHERED THROUGH NCCARE360

a) The Foundation for Health Leadership & Innovation should:

i) Require regular reports from NCCARE360 developers including:

1. Reports specified in the Resource Platform vendor Request for Proposals.
2. The density of service providers connected to the platform in each of the North Carolina Department of Health and Human Services priority areas (i.e., transportation, housing, food, and interpersonal violence) and in relation to the service needs of a community, as identified with standardized screening questions response data.
3. The volume of referrals, whether the referral loop was closed, and percent of referrals declined by the agency receiving referral, with data aggregated by agency individual was referred to.
4. Referral outcomes (i.e., referral completion or "fill" rate) for an individual referred for services, the referral source, and the organization receiving referrals, in order to evaluate and improve the referral process.

ii) Publish annual reports analyzing the above measures. Data should be provided at the smallest geographic gradation possible (e.g., county, zip code, or neighborhood) to be used by ACCs and individual entities for planning and evaluation. These reports should be published on the Foundation for Health Leadership & Innovation website.

b) NCCARE360 developers should develop a method to assess:

i) The quality of the experience of referrals

ii) Frequency of duplicated referrals and, if high, mechanisms for decreasing referral duplication.

iii) The cost to human services organizations of meeting needs of those referred using the Platform.

See also: Recommendation 6.4 Analyze Data to Determine Costs and Benefits of Health-Related Social Services.