

# Community Health Workers in North Carolina

## Overview of NC CHW Initiative's COVID-19 Response and Future State

DHHS Leadership Strategy Meeting

May 18, 2022



NC DEPARTMENT OF  
**HEALTH AND  
HUMAN SERVICES**



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# Welcome and Introduction

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**2** Community Health Worker Overview

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**Questions?**

**Submit your questions  
via the chat function**

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# Introduction to Community Health Workers

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## Definition

Community Health Workers (CHWs) are **frontline public health workers** who are **trusted members** of and/or have an unusually close understanding of the community served.

- This trusting relationship enables CHWs to **serve as a liaison/link/intermediary** between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.
- CHWs also **build individual and community capacity** by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.



# Introduction to Community Health Workers

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**YVETTE SINGLETON**  
COMMUNITY HEALTH WORKER  
ASHEVILLE BUNCOMBE INSTITUTE  
OF PARITY ACHIEVEMENT

# CHWS are a critical bridge between communities and health systems

**As a bridge between communities and health systems, CHWs are foundational to a sustained health equity response as the groundwork of an endemic COVID-19 state and community-based, public health workforce.** CHWs are well-positioned to ensure that each family receives the right services, at the right time, and in direct support of the State's framework for "whole person care".



## Flexible Community-centered Workforce Providing Equity-focused Care

- Flexible workforce that can easily adapt to the changing needs of the community.
- Work in pandemic response (tracing, testing support, wraparound services, vaccine facilitation) can be leveraged for the endemic COVID response in addition to long-term State goals for whole person health and health equity.



## SDOH Support For Whole Person Care and Family and Child Wellness

- Ability to accurately and precisely identify health care gaps in communities and leverage referral networks like NCCARE360 to address SDOH and whole-person care.
- Provide connections to social support resources including FNS, WIC, TANF, rent/utility assistance, and housing support, among others.



## Primary Care and Behavioral Health Linkages

- Trusted messengers who address barriers to access, from deep-rooted concerns around behavioral health stigma to logistical barriers such as transportation.
- Key link in referrals from social support services to primary care and mental health services.
- Multiple ways to bridge to services, from direct accompaniment to virtual connections (e.g., hotspots and tablets).



## Integration into Healthcare and Public Health Systems

- Essential to connecting communities to public health systems, including integration into Advanced Medical Homes and Healthy Opportunity pilots, among others, that identify and address SDOH.
- Exploring (with DHB/Manatt) inclusion in Prepaid Health Plans, allowing CHWs to have a significant impact on health conditions ranging from chronic disease to behavioral health.

# CHW core skills and competencies

CHWs are trained on these core skills and competencies to better serve their communities



Communication

Be an **effective listener** to learn about individual's needs; Be well versed in **group communication skills** to provide health education and community advocacy to groups served



Interpersonal

Work with diverse groups and **develop relationships** with community members to **improve the lives of their communities and meet the needs of others**



Service

Coordinate the care of their clients; **Create plans to follow for improving health for their client or community** that will require the coordination of services



Capacity Building

Support their communities through **building skills and promoting confidence in their own health**, such as building upon communication skills, **reducing of risk behaviors**, community organization, and advocacy



Advocacy

**Advocate for the** community among agencies, service providers, and support changes to public policies; **Speak up to create change** that would improve the health and well-being of the individual and communities



Education

**Educate** their clients and communities on **how to prevent and manage health conditions**, provide support in developing healthy behaviors, and advocate for social change



Outreach

**Provide outreach to individuals and communities** about services that are available and encourage enrollment of those services



Knowledge

**Know and recognize social determinants of health** and health topics that impact their clients and communities, to be able to give support and provide information on these topics



Personal

**Have personal skills to be more effective in promoting and advocating** for their clients and communities

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# Foundation for CHWs in North Carolina

## Catalysts for CHW Movement



### 2018 CHW Report: CHW Stakeholder Group Formation and Organization

- Wide stakeholder engagement
- Core competency training
- Certification
- Following guidance from:
  - APHA
  - CDC
  - NACHW



NCCARE360



Medicaid Transformation and Whole Person Care



COVID-19 CHW Response



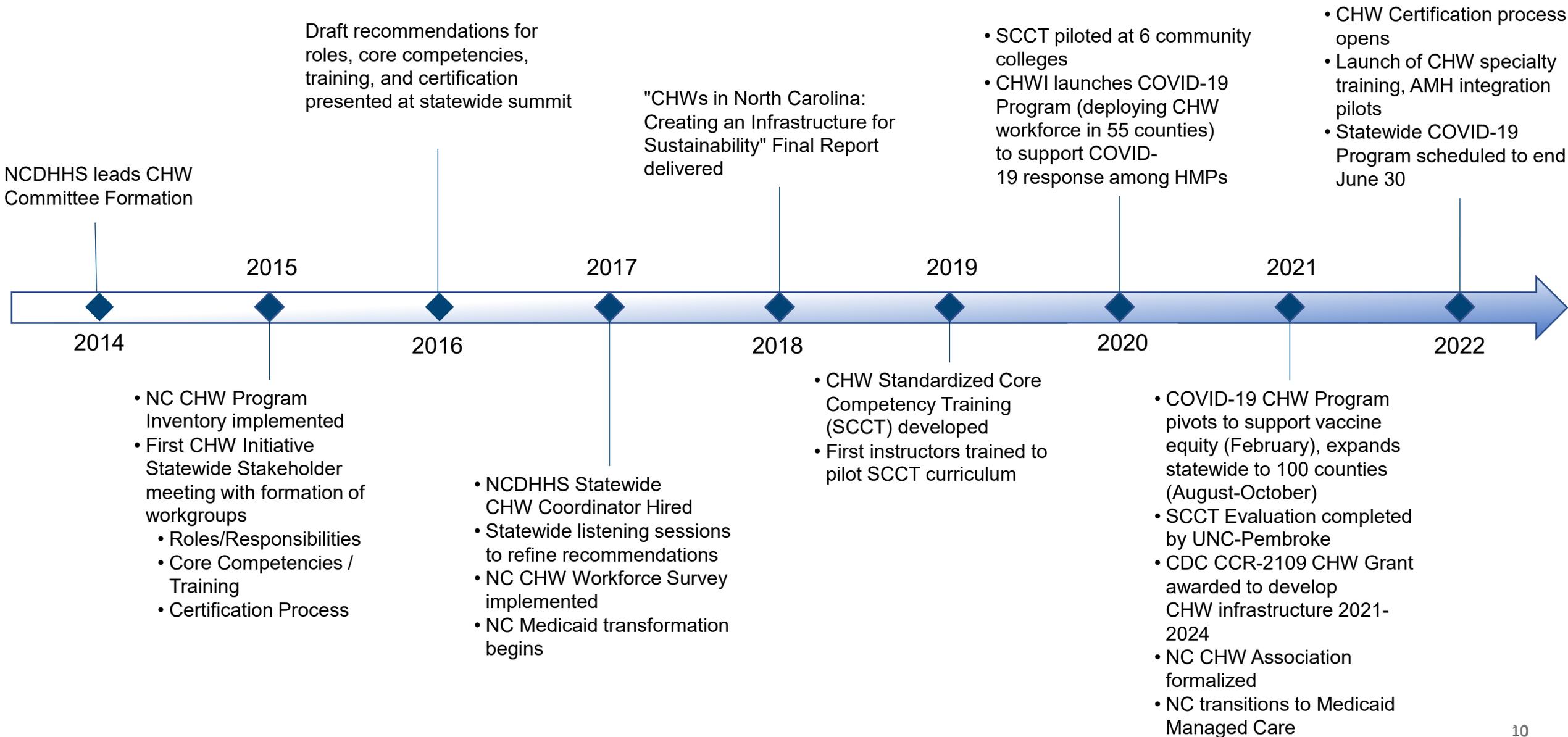
**COMMUNITY HEALTH WORKERS  
IN NORTH CAROLINA:**

**CREATING AN INFRASTRUCTURE  
FOR SUSTAINABILITY**

Final Report and Stakeholder Recommendations of the  
North Carolina Community Health Worker Initiative

May 2018

# Evolution of CHW Initiative in North Carolina



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# Evolution of COVID-19 CHW program as a catalyst from pandemic response to support whole person care in NC

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## 2. Pivot to Vaccination Outreach

*January 2021 - present*

As vaccination availability increases, CHWs re-prioritized efforts to **vaccination outreach and support to reach HMPs** as well-trained, trusted messengers. CHWs initially supported larger vaccine events (Greensboro, Vass) with pivot to community-based outreach and vaccine events.

## 4. Community Health Worker Initiative

*September 2021*

CHW Program became foundation for CHW Initiative (\$9MM funded by CDC CCR 2109) activities including standardized training, certification, practice integration, sustainable funding (e.g., NC Medicaid), and evaluation to **develop statewide infrastructure over 3-year funding period (2021-2024)**



## 1. Prevention-Q&I

*August 2020*

CHW program in 50 counties used to promote prevention via **Quarantine and Isolation (Q&I) support** in conjunction with Support Services Program 1.0.

- CHW and SSP 1.0 vendors provided social supports (financial relief payments, emergency food support, PPE, transportation, medication delivery) to **over 42,000 vulnerable households** between September 2020 and March 2021

## 3. Statewide Expansion Launch

*August 2021*

CHW Program **expansion to 100 counties** launched supported by 8 vendor CHW organizations with continued pandemic response and eye towards pandemic recovery. SSP 2.0 with focus on short-term food insecurity launched shortly thereafter.

## 5. Whole Person Care

*July 2022*

Expand focus of CHW program to look beyond COVID-19 emergency response as the state's **community-based workforce** addressing state priorities for whole person care including 1. Screening and referrals to address SDOH 2. Connections to primary and behavioral healthcare 3.

# The Community Health Worker COVID-19 Program provides access to care and support

Create a robust infrastructure of Community Health Workers (CHWs) that can provide access to primary health care and coordinate social support needs for individuals quarantining and isolating to advance health equity



## Overview

- CHWs are frontline public health workers who are trusted members of the community and trained to support disadvantaged individuals
- CHWs are responsible for connecting North Carolinians to medical and social support resources including diagnostics testing, primary care, case management, nutrition assistance, and behavioral health services
- CHWs coordinate with LHDs, contact tracers, and others to leverage NCCARE360 and to identify and connect individuals with needed services through NCCARE360



## Partners

**NCDHHS selected eight vendors** (Catawba County Public Health, El Centro Hispano, Kepro, Mount Calvary Center for Leadership Development, One to One with Youth, Southeastern Healthcare NC, UNETE, Vidant Health) **to recruit, train, and manage Community Health Workers deployed to areas with high COVID-19-related needs**



## Process

*Community Health Workers will follow this workflow to assist individuals*

- 1 Review notes and triage for high priority cases
- 2 Engage with patient and ask clarifying questions
- 3 Identify available patient resources using NCCARE360 and primary care provider list
- 4 Conduct additional research and advocacy
- 5 Connect patients to available services and resources
- 6 Document that needs are met in NCCARE360 or hand off to PCP or Resource Navigator or work with LHD/NCCARE360 to address resource deficits

# CHWs will support individuals during COVID-19 and beyond

CHWs have focused on providing wraparound services for those impacted by COVID with reach into HMP communities. Their work has expanded to support vaccination efforts and vaccine equity which is foundational to Healthier Together with the hope to serve beyond COVID-19



## Flexible Workforce

CHWs are a flexible workforce that are trained to provide contact tracing, case investigation, and care management support to assist with the State's COVID-19 response and State's public health goals



## Quarantine and Isolation Support

CHWs provide individuals with access to resources to help them effectively quarantine and isolate due to the COVID-19 pandemic



## Leadership Commitment

NCDHHS leadership is committed to continuing providing support to individuals in need living in North Carolina



## Vaccine Support

CHWs can provide valuable COVID-19 vaccine support by connecting individuals to medical care



## Scope Changes

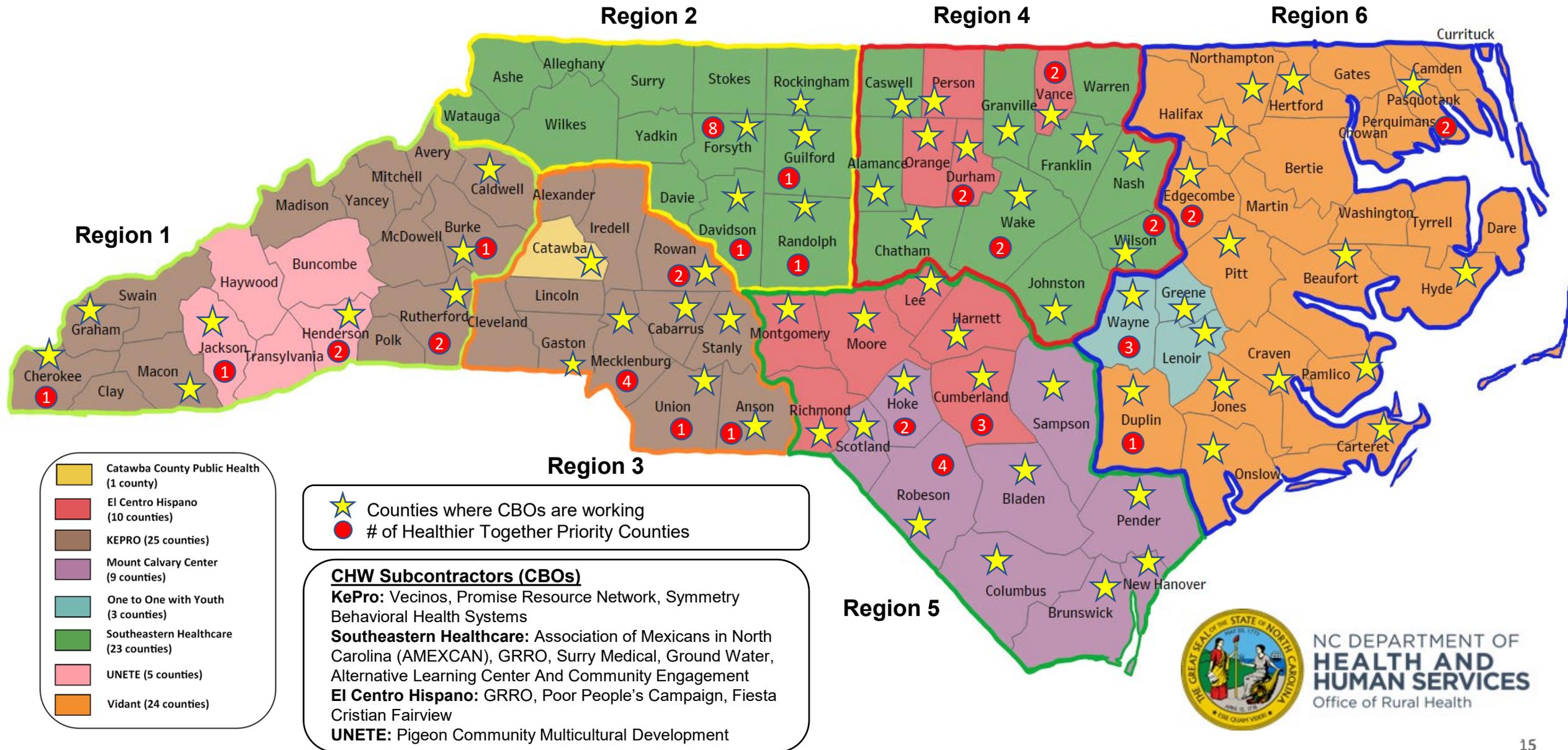
As community needs change post COVID-19 pandemic, CHWs can adapt and provide much needed support



## Primary Care Support

CHWs provide primary care referrals, work with prepaid health plans (PHPs) to assist with Advanced Medical Home, and work to ensure individuals have care coverage from multiple angles

# CHW Program Statewide Coverage (February 2022)



NC DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Office of Rural Health

# The COVID-19 Program CHWs are diverse, trusted members of the community

There are currently **552 Community Health Workers** across 100 counties working to connect individuals with resources and educate their local communities on the COVID-19 vaccine.

## Community Health Workers by the Numbers



**80%** of CHWs identify as women

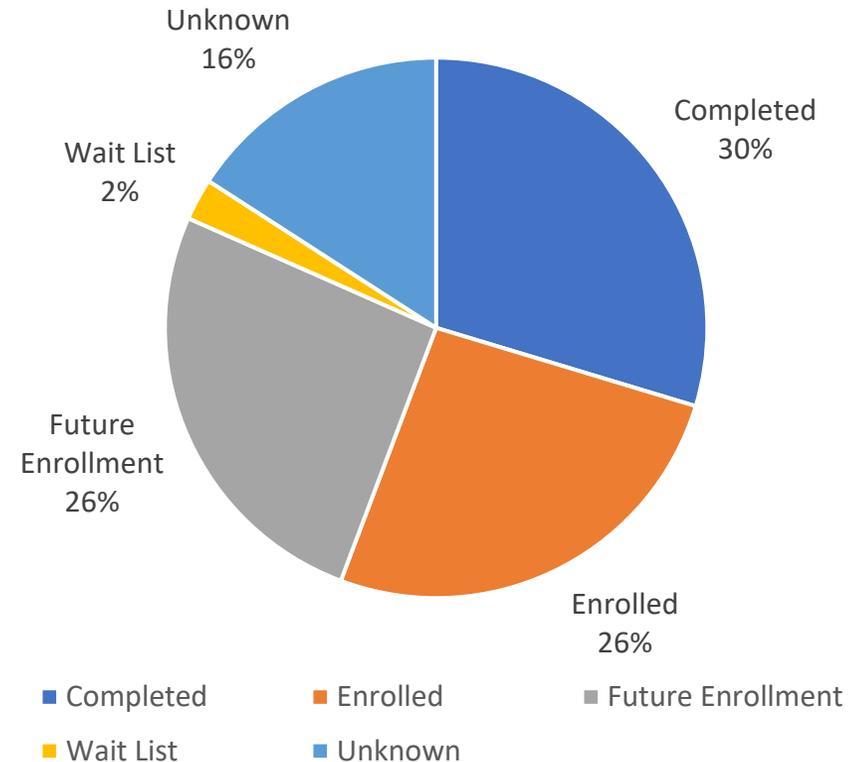


**60%** identify as Black/African American



**25%** identify as Hispanic/Latinx ethnicity  
**135** CHWs speak Spanish

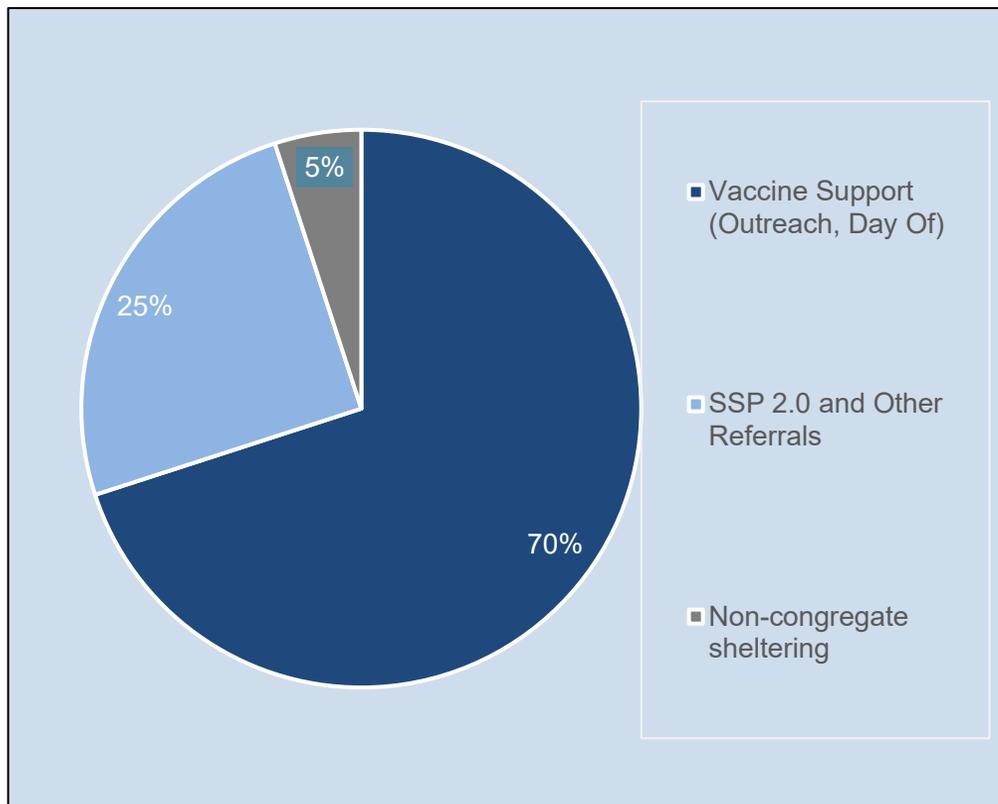
## Standard Core Competency Training



# CHW current level of effort

One of the aspirations of the Healthier Together Regional Health Equity Network infrastructure is to connect with CHWs' current vaccination supports services within HMP communities and streamline services to enhance efforts once the infrastructure is put in place.

## Proposed Breakdown of CHW Time



## CHW Roles in Vaccination Support



**Educate** – Educate and address hesitancy. Town Halls, Q&A sessions, Facebook live events



**Outreach** – Leveraging existing relationships and proactive outreach to HMP communities to generate interested HMP individuals who can be pre-registered in CVMS and/or scheduled for vaccine appts plus any supports that are needed (e.g., transportation)



**Support** – Logistical support for vaccine events (e.g., Calling registered patients/waiting list, marketing, site selection, entering data into CVMS, language support). CHWs can do end to end vaccine support.



**Register** – Register individuals in CVMS for vaccination



**Schedule** – Schedule real-time appointment

# COVID-19 CHW program social support referral and vaccine equity impact since inception

## Social Support Referral Impact (Sep 2020 – Present)

How many **individuals** were served by CHWs?

**2,190,325**

How many **NCCARE360 referrals** were made?

**149,973**

How many **telehealth encounters** did CHWs perform?

**539,323**

How many households received **social supports** (food boxes, financial relief, transportation, medication assistance)?

**42,000+**

## Vaccine Equity Impact (Feb 2021 – Present)

How many community or online **vaccine education events** did CHWs help plan and/or host?

**10,500**

How many **people** attended the education events?

**910,567**

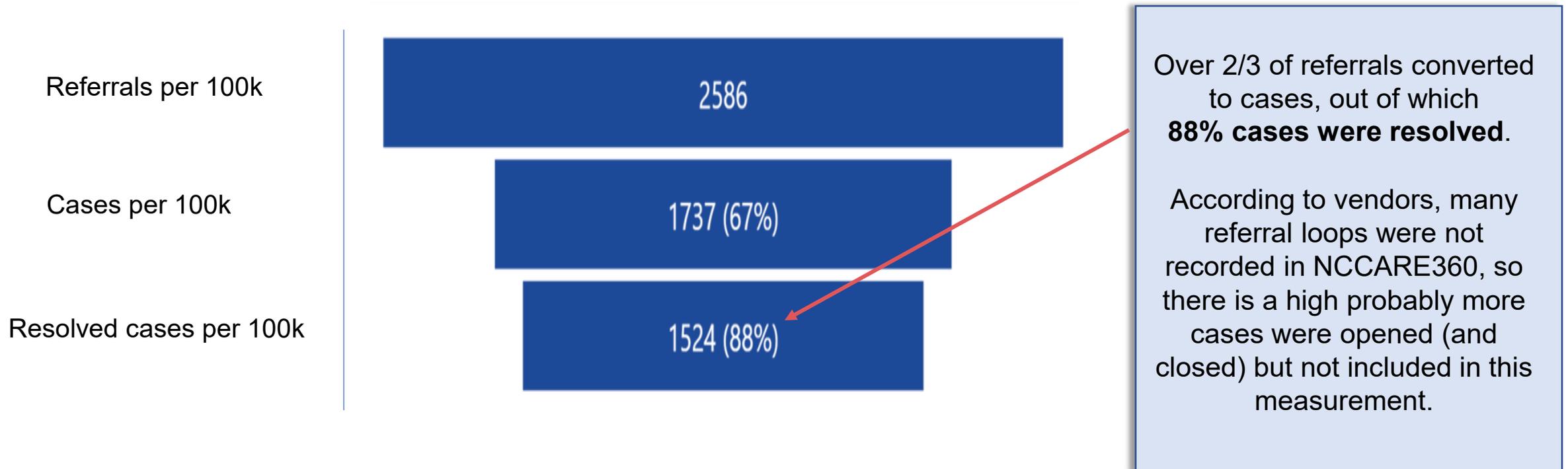
How many **vaccination clinics or events** did CHWs help plan and/or work?

**3,972**

How many people were **scheduled to receive a COVID-19 vaccine**?

**49,586**

# NCCARE360 referrals show a high number of resolved cases per capita (Sep 2020 – Jun 2021)



## Referral Completion Pathway

Referrals are requested social support services from clients to CHW vendors.



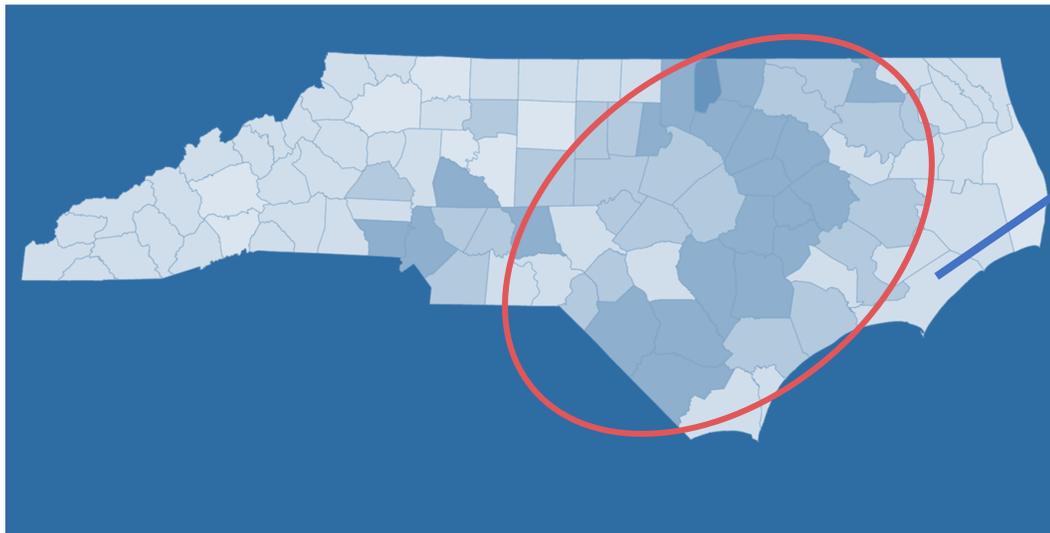
Cases are either accepted referrals submitted by CHWs to vendors OR opened by vendors while serving a client in order to address unmet needs.



Case can be:  
Resolved - received services  
Unresolved - did not receive services  
Open - still being addressed

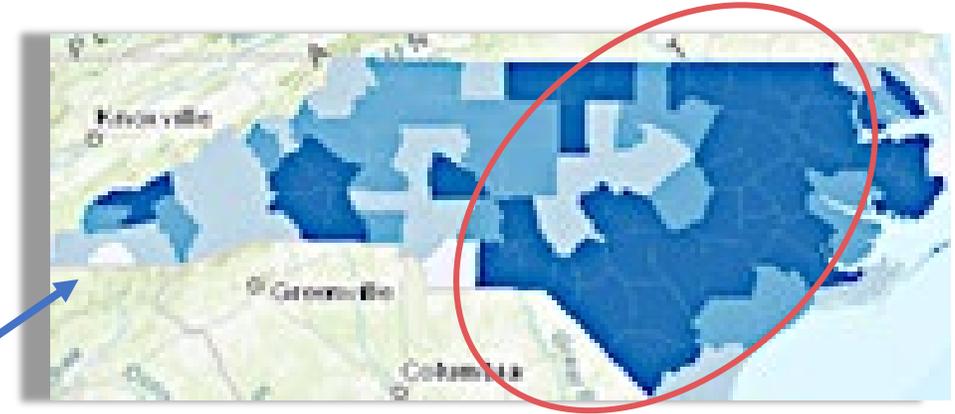
# Counties with top referrals are in counties with a high social vulnerability index (SVI)

Referrals by CHWs are highest in areas with high social vulnerability index (SVI), indicating that reach was greatest in vulnerable communities.



● <100 ● <1000 ● <10k ● >10k

**Referrals per capita for social supports**

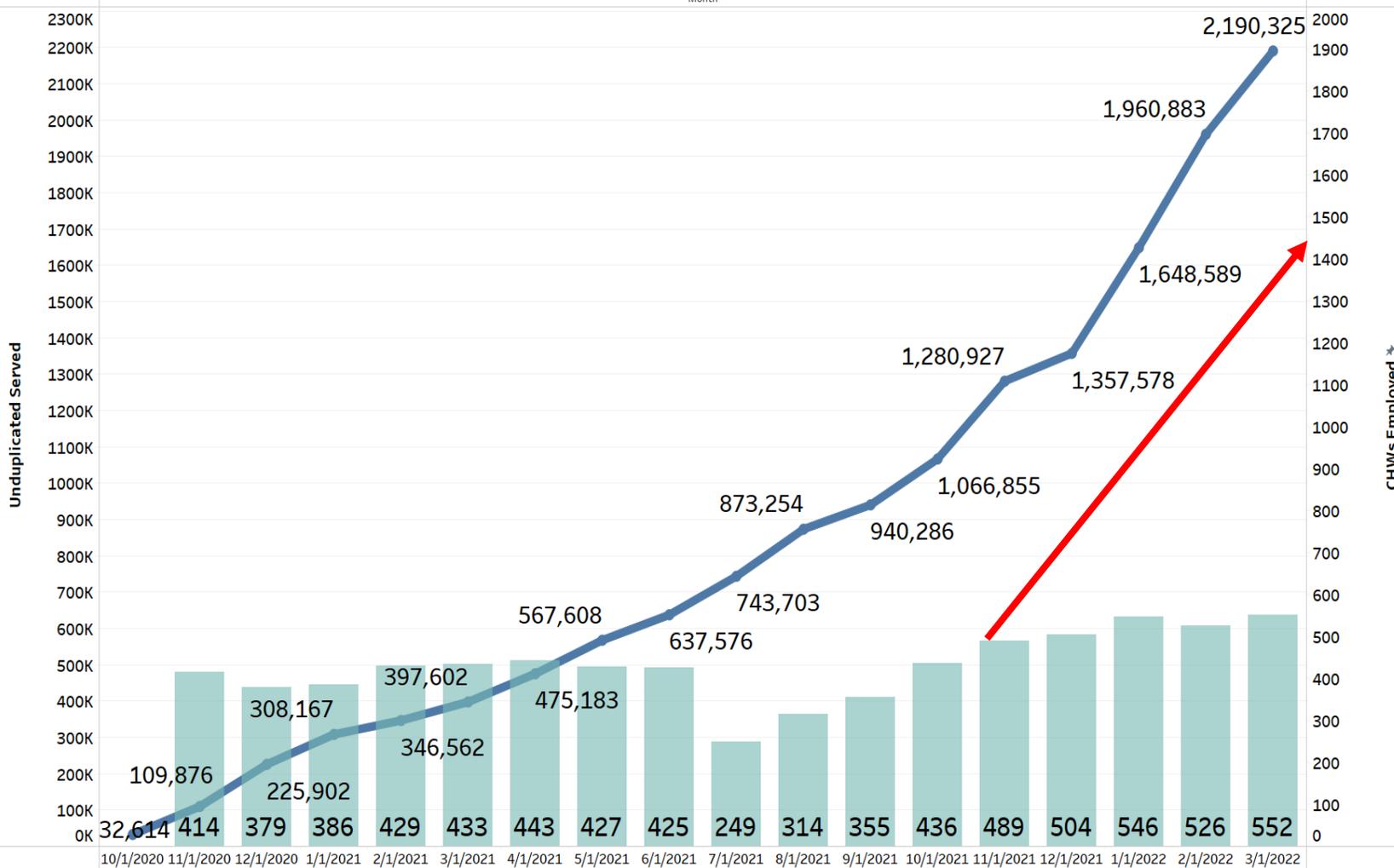


● 0.0-0.25 (lowest) ● 0.25-0.5 ● 0.5-0.75 ● 0.75-1.0 (highest) ● No Data

**CDC Social Vulnerability Index (SVI)**

# COVID-19 CHWs are a skilled and agile workforce rapidly reaching the community

CHWs Employed and Persons Served October 2020 - March 2022



Program start – zero CHWs

Ramp up period – trainings and skill development amid a changing pandemic

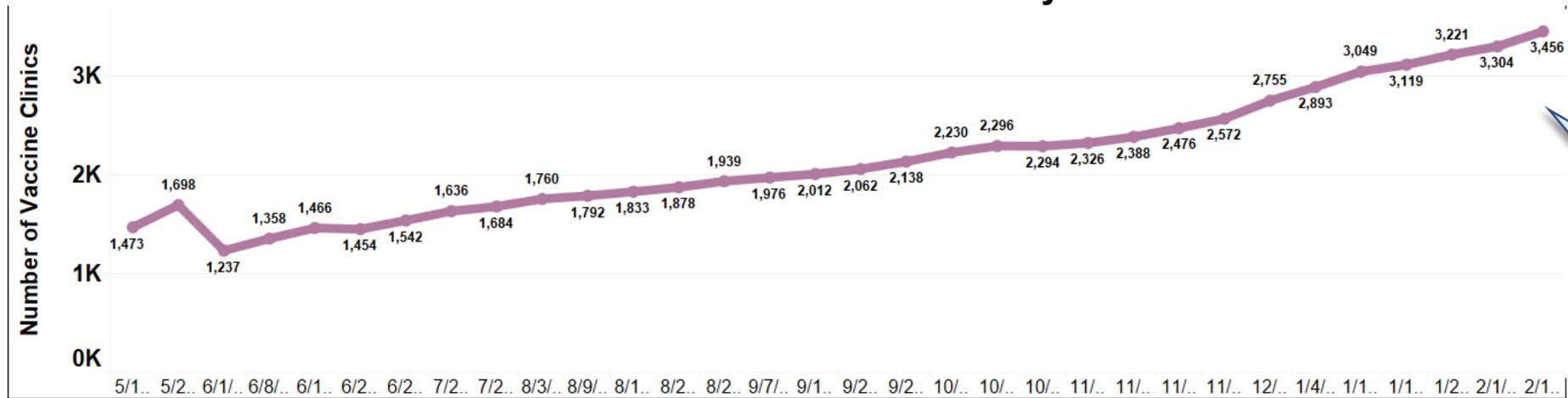
Second iteration in the face of continued surges – a skilled and agile workforce with rapid increase in people served

## CHW Activities Across 100 Counties

- Quarantine and isolation care coordination
- Vaccination
  - Education
  - Community event support
- Covid-related education
- Non-Covid related referrals
  - **Primary care**
  - **Behavioral health**
  - **SDOH**
    - Housing
    - Food insecurity
    - Income assistance
    - FNS/WIC
- Advocacy
- Accompaniment
- Peer-to-Peer learning

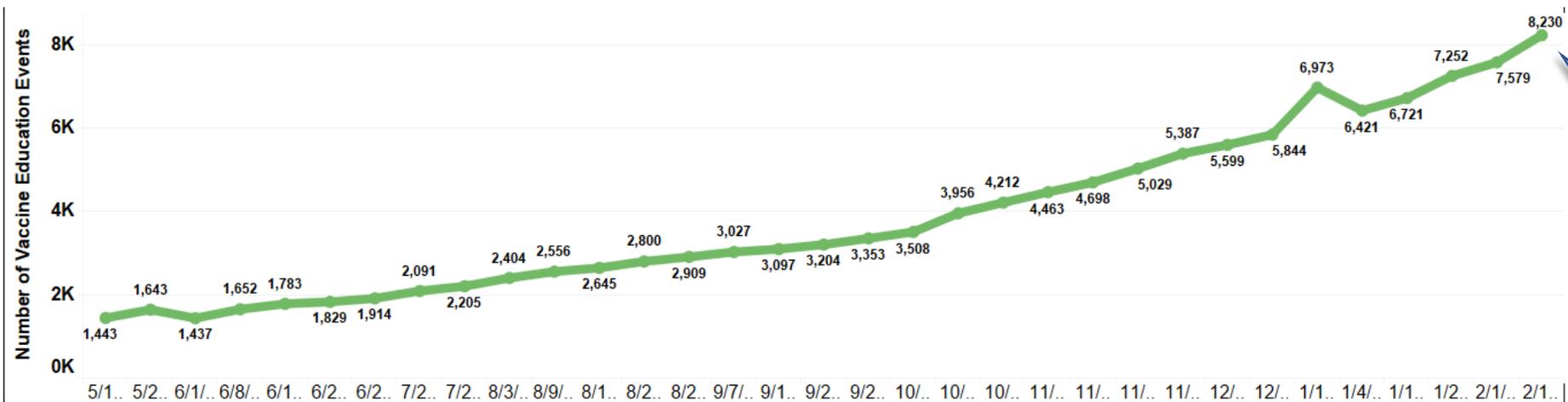
# CHW participation in community vaccine education and vaccine clinics increasing

## Number of CHW Vaccine Clinics May 2021-Feb 2022



**3,456  
Vaccine Clinics  
Conducted**

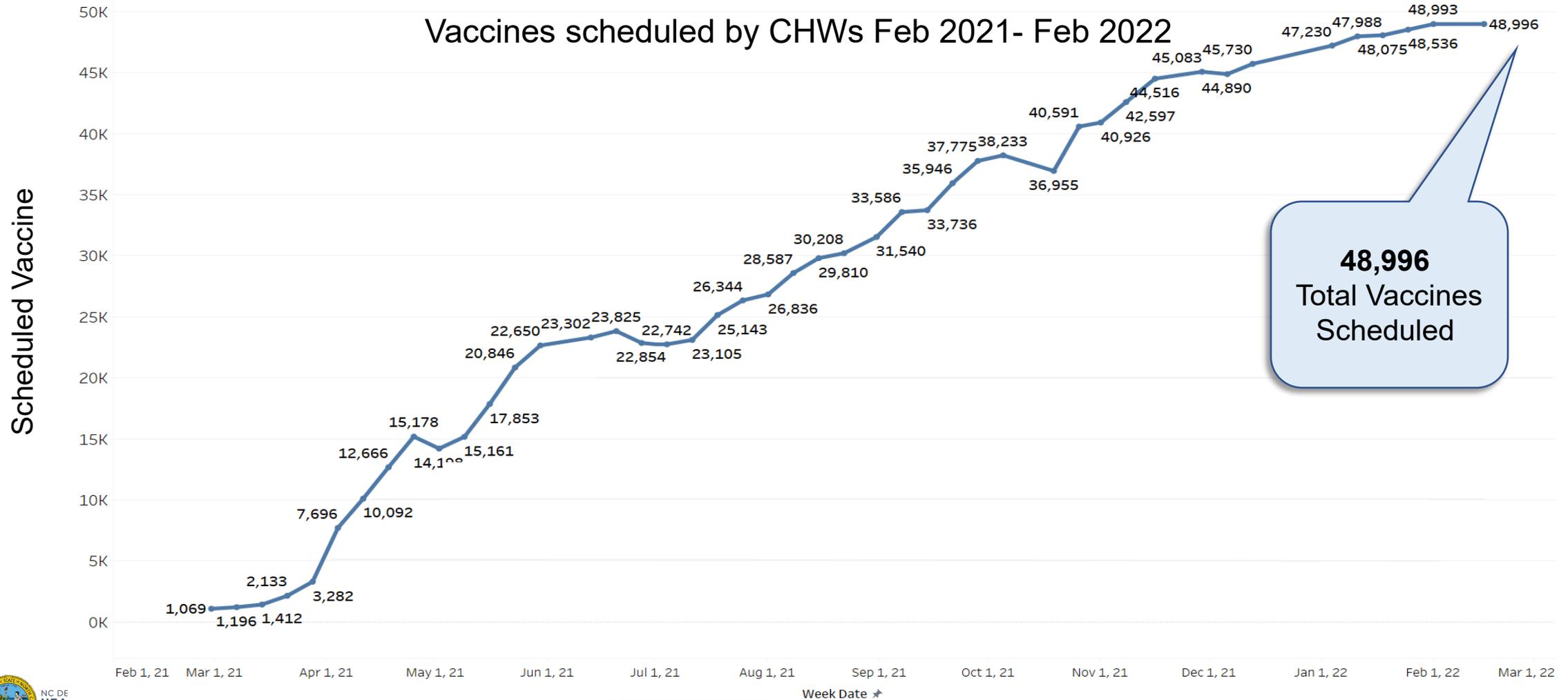
## Number of CHW Vaccine Education Events May 2021-Feb 2022



**8,230  
Vaccine  
Education  
Events  
Organized**

# CHWs and Healthier Together vaccination efforts work synergistically to reach HMPs

CHWS have been a strong partner in COVID-19 vaccination and adapted to the changing needs of the pandemic. They have scheduled vaccines even when faced with barriers including high vaccine/booster hesitancy and difficulty in access.



**48,996**  
Total Vaccines Scheduled



CHWs called on to support community and large-scale vaccine events (e.g., Greensboro, Vass)

Pivot to education activities and community-based vaccine clinics, launch and collaboration with Healthier Together

Addition of booster doses and last mile vaccination with greater time-effort per vaccine

# Requested social support needs as identified by CHW NCCARE360 referrals

## Top 5 requested services across all counties

1. Food Assistance (33%)
2. Income (23%)
3. Individual/Family Support (15%)
4. Housing/Shelter (12%)
5. Utilities (8%)

CHWs identified community needs during the pandemic and linked individuals to resources ranging from food and income support to transportation and healthcare – all aspects of the social determinants of health.

**CHWs are the interface between community and complex systems, helping vulnerable populations to navigate them and successfully address whole person care.**

| Requested Services<br>(Sep 2020 – Jun 2021) | Referrals<br>per 100k | % of Referred<br>Services |
|---|-----------------------|---------------------------|
| Food Assistance                             | 541                   | 32.62%                    |
| Income Support                              | 386                   | 23.30%                    |
| Individual & Family Support                 | 255                   | 15.42%                    |
| Housing & Shelter                           | 193                   | 11.65%                    |
| Utilities                                   | 136                   | 8.19%                     |
| Clothing & Household Goods                  | 62                    | 3.74%                     |
| Employment                                  | 41                    | 2.50%                     |
| Physical Health                             | 18                    | 1.09%                     |
| Transportation                              | 15                    | 0.88%                     |
| Benefits Navigation                         | 5                     | 0.33%                     |
| Education                                   | 3                     | 0.20%                     |
| Spiritual Enrichment                        | 1                     | 0.04%                     |
| Entrepreneurship                            | 0                     | 0.02%                     |
| Money Management                            | 0                     | 0.01%                     |
| Wellness                                    | 0                     | 0.01%                     |
| Social Enrichment                           | 0                     | 0.01%                     |
| Sports & Recreation                         | 0                     | 0.00%                     |
| <b>Total</b>                                | <b>1657</b>           | <b>100.00%</b>            |

# Community members receive much needed support (success stories)



## Emergency food and cleaning supplies Support in Wake

## Vaccination Support in Burke

## Wraparound Support in Johnson

|               |   |
|---------------|---|
| <b>Need</b>   | Household in need of food and cleaning supplies   |
| <b>Action</b> | CHW couldn't find a food pantry that can assist at the time and so decide to use her own food supplies to put together a box of food that can last the family for a week. |
| <b>Impact</b> | Individual now has food and cleaning supplies   |

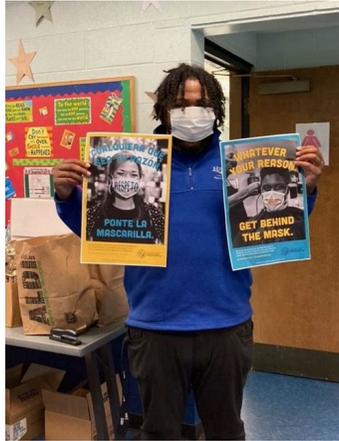
|               |   |
|---------------|---|
| <b>Need</b>   | Event at a middle school where the Guatemalan Consulate had set up vaccination appointments and needed Spanish interpretation |
| <b>Action</b> | Spanish-speaking CHW Supervisors and CHWs were there to give out information and facilitate vaccinations.                     |
| <b>Impact</b> | 800 individuals received education and information on CHWs and Covid-19 Vaccination   |

|               |   |
|---------------|---|
| <b>Need</b>   | Individual lost their job due to COVID-19 and needed support for their family |
| <b>Action</b> | CHW connected them with assistance to provide food and other support          |
| <b>Impact</b> | Individual was able to take care of her family                                |

*"Client was very humble and grateful for the support." – CHW*

*"Within 48 hours the mother called our agency thanking us for helping her family get the food they needed." – CHW*

# Community members receive much needed support (success stories)



## School supplies assistance in Wake

|               |   |
|---------------|---|
| <b>Need</b>   | 3 clients were in need of school supplies for their children                                  |
| <b>Action</b> | CHW were able to support all 3 clients with school supplies and additional sanitary materials |
| <b>Impact</b> | Children were able to get all the supplies they need  |

*“The smile on the children’s faces were priceless.” – CHW*

## Emergency Lodging in Forsyth

|               |   |
|---------------|---|
| <b>Need</b>   | Individual needed emergency lodging while her partner was in the hospital for COVID-19      |
| <b>Action</b> | CHW connected with SECU Family House which provided transportation and financial assistance |
| <b>Impact</b> | Individual had a free, safe place to spend the night  |

*“Someone cared enough to look beyond the fact [I] had no money.” – Individual receiving support*

## Mobility Assistance in Vance

|               |  |
|---------------|--|
| <b>Need</b>   | A senior required a wheelchair but was unable to afford one              |
| <b>Action</b> | CHW connected the senior to an organization that provided the wheelchair |
| <b>Impact</b> | Senior now has the independence to move freely                           |

*“An elderly gentleman that needed a wheelchair was able to connect with an organization that could assist him.” – CHW*

# Challenges and Impacts

## Challenges



### Vaccine Concerns

High reported rates of vaccine concern, hesitancy, or opposition.



### Training

High demand for COVID-19, COVID vaccine, and CHW training across the state



### Resource Coordination

CHWs often face limited ability to connect individuals with all of their resource needs for social support



### Safety

On-the-ground community work inherently raises safety concerns



### Language Resources

Limited resources in Spanish and additional languages spoken by population served

## Impacts

CHW efforts to educate and encourage vaccination could have a limited impact (or at least diminished return for effort). Concern that there may be people who cannot be reached no matter the level of incentives or additional outreach. This could lead to CHW burnout.

Interest in CHWs and their role in the pandemic has created high demand for CHW training. Their role as trusted messengers increased the need for accurate, information. Limited training opportunities could impact ability to reach communities.

While many resources exist (within and outside of NCCARE360), coverage may not reach all communities across the state. Inability to connect vulnerable individuals with resources prevents addressing acute Q&I needs due to COVID-19 and SDoH in the long-term.

CHWs are met with emotionally charged or confrontational situations that can at times put them or the people they are engaging with at risk and can ultimately limit their ability to engage with the community.

Inequity in language-specific resources limits services and resources that CHWs can offer to communities, leading to decreased utilization of existing services and decreased access to educational material and care resource coordination

# CHW activities during COVID-19 and beyond

CHWs have focused on providing wraparound services for those impacted by COVID-19. **Their work is foundational to a sustained health equity response and lays the groundwork to serve an endemic COVID-19 state and a future community-based, public health response.**



## **Flexible, Community-Based Workforce**

CHWs are a flexible workforce that are trained to provide contact tracing, case investigation, testing, vaccination, and care management support to assist with the State's COVID-19 response and public health goals.



## **Equity-focused Vaccine Support**

CHWs provide valuable COVID-19 vaccine support via education, community vaccine events, and connections to appointments. Collaboration with Healthier Together will ensure deeper reach and stronger response in vulnerable communities across the state.



## **Care Resource Coordination Support**

CHWs provide access to social support resources for vulnerable communities during and beyond the scope of COVID-19. CHW can accurately and precisely identify gaps and strengthen referral networks to address SDoH and provide whole person care.



## **Primary Care and Behavioral Health Linkages**

CHWs can increase the number of primary care and mental health referrals made in the community, and can address barriers that prevent individuals from accessing care, ensuring that community members have care coverage from multiple angles.

# CDC CCR 2109 CHW funding award: NC CHW Initiative planned activities

***Builds, reinforces, and integrates a statewide CHW infrastructure with the healthcare system***

## **Amount Awarded**

\$9 million over 3 years

## **Timeframe**

August 31, 2021 – August 30, 2024

### **Training (Train)**

- CHW Standard Core Competency Training (SCCT) Expansion
- CHW Specialty/Advanced Training

### **Statewide CHW Infrastructure (Deploy)**

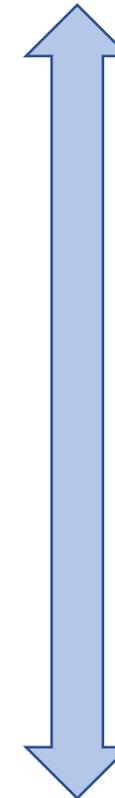
- NC CHW Association formation
- Establishment of a NC CHW Certification
- Capacity expansion to focus on data and Medicaid integrated with Division of Health Benefits

### **Practice and AMH Integration (Engage)**

- Practice and AMH integration support via practice assessment and toolkit
- AMH Integration Learning Collaborative

### **Evaluation**

- Program impact and continuous quality improvement
- Evidence base to support long-term, sustainable investments in CHWs

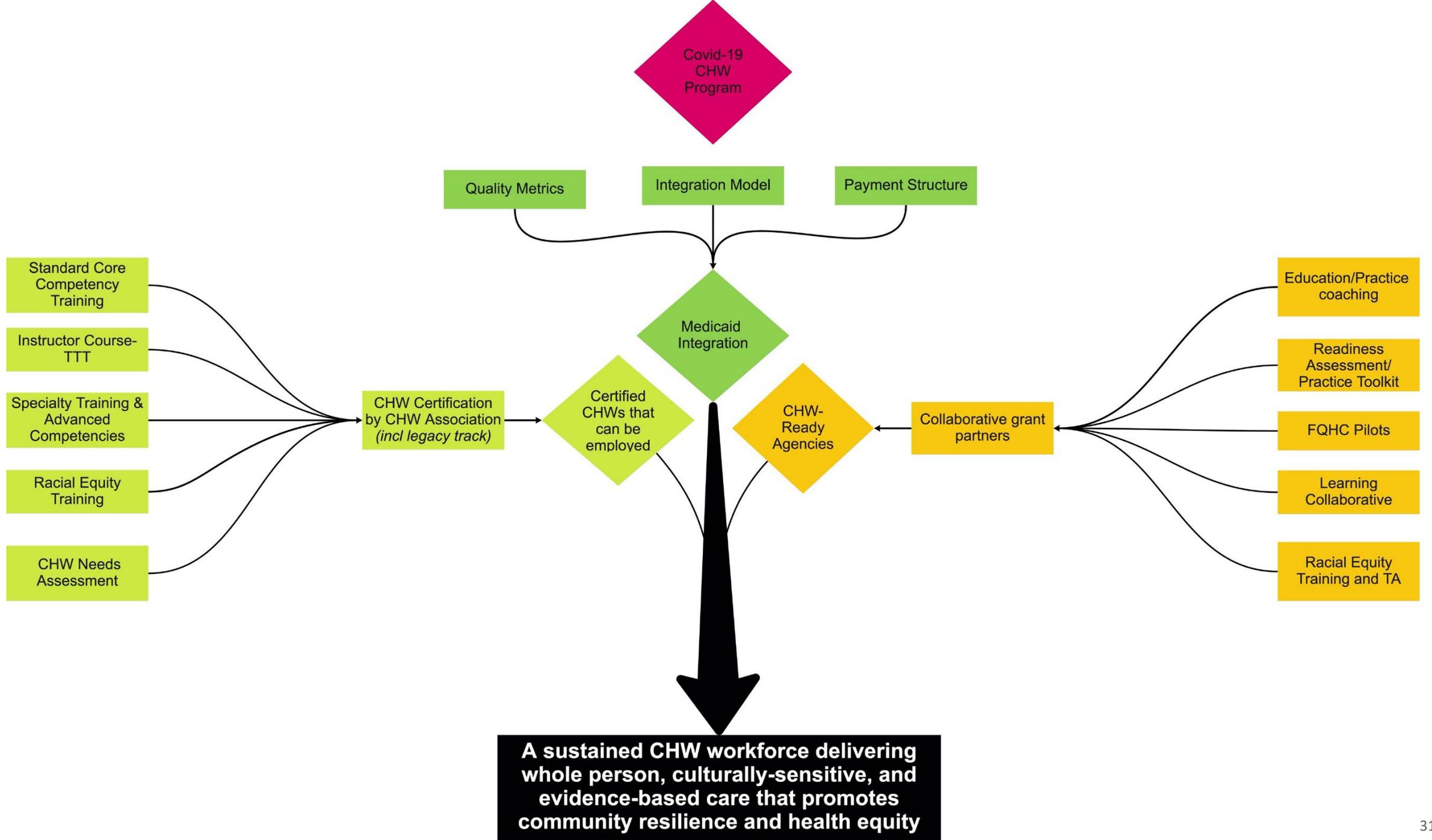


**Racial Equity  
and  
Community  
Focus**

# CDC CCR 2109 partner roles

| Overall Coordination  | Training  | Statewide CHW Infrastructure   | Practice and AMH Integration  | Evaluation  |
|---|---|--|---|---|
| <p>Program Management<br/>Funding</p>                       | <p>CHW Core Competency Training Expansion<br/>CHW Specialty Training</p>                                    | <p>NC CHW Association<br/>CHW Certification<br/>DHB Medicaid Integration</p>             | <p>Practice assessment and toolkit<br/>AMH Integration Learning Collaborative</p> | <p>Program impact, CQI, and evidence base to support long-term, sustainable investments</p> |
| <p>NCDHHS Office of Rural Health<br/>Partners in Health</p> | <p>NC Community Health Worker Association<br/>NC Community Colleges<br/>NC Area Health Education Center</p> | <p>NC Community Health Worker Association<br/>UNC-Pembroke<br/>NC Central University</p> | <p>NC Area Health Education Center<br/>NC Community Health Center Association</p> | <p>UNC Pembroke<br/>Saint Augustine's University<br/>Partners In Health</p>                 |

Foundation of State Level Partners that support the CHW Movement in NC



# Standard Core Competency Training (SCCT) curriculum

**SCCT is a 96-hour curriculum**, offered by NC's **Community College System** and is currently the only pathway to achieve CHW Certification through the NC Community Health Worker Association (NCCHWA). The knowledge base competencies cover health and social issues that impact clients disproportionately including but not limited to diabetes, asthma, and cancer.

## Individual

1. CHW History I
2. Introduction to Public Health
3. Client Advocacy (i.e., Care Management)
4. Counseling Skills & Motivational Interviewing
5. Patient/Social Determinants of Health Navigation and Data Input
6. Introduction to Mental Health, Substance Abuse and Recovery
7. Understanding Violence I
8. Professional Self-Care (i.e., Nutrition and Exercise)
9. Introduction to Disease Processes

## Community

1. Basic Assessment and Community Evaluation
2. Community Advocacy and Racial and Health Equity
3. Community Outreach and Multiculturalism
4. Community Organizing and Consensus Building
5. Public Speaking I
6. Health Promotion/Education
7. Social Determinants of Health and Social Ecological Model
8. Mental Health Promotion
9. Understanding Violence II

## Organizational

1. CHW History II (C3 Roles)
2. Cultural Humility and Sensitivity
3. Leadership
4. Care Team Needs Assessment and Support
5. Public Speaking II
6. Introduction to Care Team Management and Multi-Disciplinary Teams
7. Program Coordination and CHW Supervision
8. Racial and Health Equity I
9. CHWs As Researchers (Community-Based Participatory Research) + Data Input

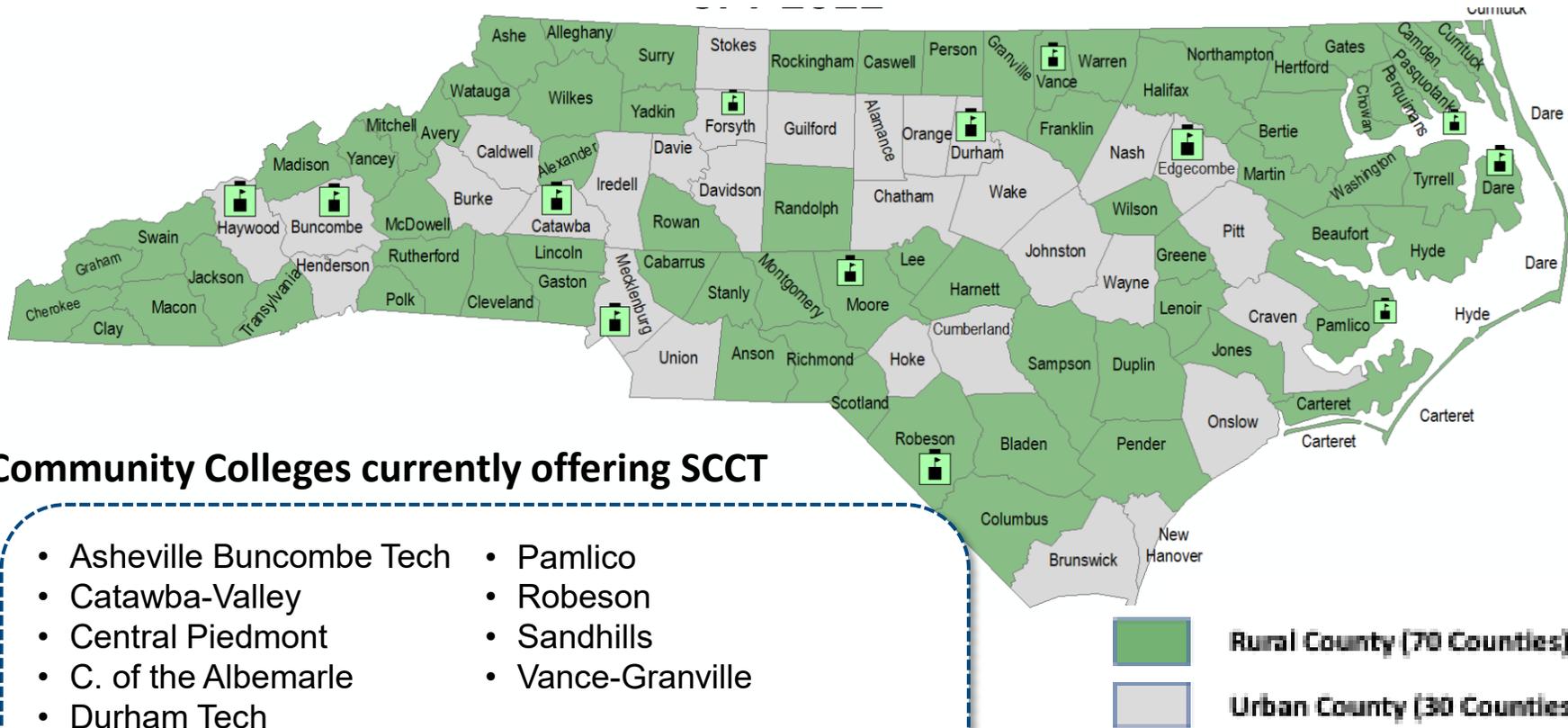
## Policy/Executive

1. Leadership and Authentic Representation
2. Racial and Health Equity II
3. Equitable Policy, Advocacy, and Implementation
4. CHWs and Public Health Policy
5. Shared Language: Health Systems and Communities
6. History of Social Determinants of Health and Policy
7. Multisector Coalition Building
8. Public Speaking III (Effective Communication and Negotiation)
9. Local, State and National Public Health Landscape

The SCCT curriculum has been aligned with the Socio-ecological model and will provide the framework for future CHW certification levels I-IV.

# Community Colleges offering the Standard Core Competency Training (SCCT)

**13 community colleges offer the SCCT for CHWs across the state**, with an online option offered by most colleges. The SCCT was created by NC CHW Initiative stakeholders and will be a requirement for the NC CHW Certification launched in mid-February 2022. **794 individuals have completed training as of February 2022.**



A master list of Community Colleges offering the **Standard Core Competency Training** can be found on the NC ORH Website



A **Spanish-language** course offering from Durham Tech Community College began in Fall 2021

# Area Health Education Centers (AHEC) offering CHW Specialty Training

AHEC offers **5 modules to COVID-19 CHWs**, is developing **up to 50 modules through DHB funding**, and developing **health coaching and CHW supervisor training** with CDC CHWI funding. Training in English and Spanish and mostly online currently. Modules offered with continuing education units (CEUs). [CHW peer learning collaborative](#) training also available.

## 5 Modules Required for COVID-19 Vendors

1. NC Public Health System
2. Cultural Humility
3. Working with Special Populations – Unhoused
4. COVID Prevention and Basic Overview of COVID: Client Centered Communication
5. Overview of COVID: Client Centered Communication

## First 11 Modules (of possible 50) funded by DHB

1. Introduction to Medicaid Managed Care
2. Social Determinants of Health
3. Clients with Behavioral Health Concerns
4. Anxiety and Depression
5. Diversity, Equity, and Inclusion (DEI)
6. Working with Specific Populations – Unsheltered, Living with Disabilities, and Uninsured
7. Working with Specific Populations – Formally incarcerated, LGBT, and Undocumented
8. Resource Coordination
9. Care Management
10. Documentation in Client Record
11. Client Interviewing Skills

### CDC CHWI grant funding

**Health Coaching training:** 6-10 hours of training in key health coaching and behavior change skills

**CHW Supervision training:** 20 hour curriculum, creates 4 levels of supervision competencies for CHWs, partnership between AHEC, CHASM, NCCHWA

# NC CHW Association (NCCHWA) Certification

The CHW Certification process is a collaboration between NC Community College System, UNC Pembroke (UNCP), and NC Community Health Worker Association (NCCHWA). **Students who successfully complete the CHW SCCT** can apply to NCCHWA to be certified as a CHW as of this spring 2022. Additional pathways to certify CHWs through a **legacy track** and at various **levels of certification** will be developed by NCCHWA over the next year (2022-2023).

## Collaboration Roles:

- Students who successfully complete SCCT at **80% passage rate** can apply for certification through an online application process housed at UNCP, **cost is \$40 for 3-year certification**
  - **Over 300 applications received between mid-February to late March 2022**
  - NC Community College system liaison communicated with SCCT instructors to share certification information
  - CHW COVID-19 vendors provided with information about certification availability for students
  - Requesting from NC Community Colleges a CHW passage rate to identify how many of the 784 SCCT students are eligible for certification
- UNCP cleans the data for duplicates and/or incomplete applications, sends completed applications to NCCHWA for review
  - **Of 300 applications submitted, 250 sent to NCCHWA for certification**
- NCCHWA reviews applicants, including review of transcripts, sends certification document electronically or via mail
  - **First 150 applicants certified on April 1st**



# CHWs and Medicaid Transformation: The Set-Up for NC's CHW Vision

NCDHHS plans to implement Medicaid managed care in a way that advances high-value care, improves population health, engages and supports providers, and establishes a sustainable program with predictable costs.

The goal is to improve the health of North Carolinians through an **innovative, whole-person centered and well-coordinated system of care that addresses medical and non-medical drivers of health.**

## CHW Workforce

- Explore integration of a model to address SDoH and allocate flexible funding to address unmet resource needs
- Aim to integrate CHW workforce with Medicaid reimbursement to ensure that workforce is sustainable in the future.

## NCDHHS Healthy Opportunities

- \$650 million in Medicaid funding over 5 years
- Providing evidence-based, non-medical interventions related to housing, food, transportation and interpersonal safety for high-needs Medicaid enrollees.

## Advanced Medical Home (AMH)

- Patient-centered access, team-based care, population health management, care coordination across medical and social settings
- Address social drivers of health and connections to community-based organizations and resources
- Care management for high-risk populations
- CHWs can be integrated into AMHs to help provide comprehensive care, address the social determinants of health, and promote linkages to primary care providers, AMH care teams, & community-based organizations

# Current CHW Program Evaluation

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This is a unique opportunity to better understand the large-scale and rapid deployment of CHWs across the state to meet social and health needs of vulnerable North Carolinians

## **Evaluation Aims**

- 1.** Understand CHW and CHW vendor perspectives on access to social services, health behaviors, community collaborations, and career trajectory
- 2.** Quantify impact of CHW efforts on vaccination and resource coordination as well as COVID-19 outcomes and return on investment
- 3.** Identify network of populations served and resources available as well as gaps across counties, vendors to inform program strengthening
- 4.** Provide data to support long-term investments in CHWs across the state

# CHW Integration into Whole Person Care Framework

**CHWs are advocates who serve as a bridge between community and healthcare, and inherently work through an equity lens. CHWs are well-positioned and have the skills to ensure that each family receives the right services, at the right time, in direct support of the State's framework for "whole person care".**



## **Community-based, Community Voice**

CHWs are members of the communities they serve and can provide specific skills as well as language-specific resources to their communities. They are the best-positioned to identify and represent the needs of their communities, inform health and public health responses in their counties, and improve or expand upon existing programs in order to further an equity agenda.



## **Trained, Supported, Equity-focused Workforce**

Through Standardized Core Competency Training and specialty training as well as adequate mentorship and supervision structures, CHWs will have the necessary support to ensure program success. Expansion of a statewide CHW workforce can meet the diverse needs of HMPs, increase investment into those communities and build community resilience.



## **Resource Coordination and Advanced Medical Home Integration**

CHWs are essential to expanding the network of NCCARE360 social support referrals and informing the need for additional resource availability. Integration into Healthy Opportunities and Advanced Medical Home models via care resource coordination referrals will leverage the proximity of CHWs to screen, refer, and deliver on Social Determinants of Health in the community.



## **Healthcare Integration**

CHWs are crucial to maintaining connections to healthcare including primary care and behavioral health. Inclusion in prepaid health plans (PHPs) and tailored plans will allow CHWs to have significant impact on health conditions ranging from chronic disease to mental health.

# Welcome and Introduction

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1 Welcome and Introduction

2 Community Health Worker Overview

3 The COVID-19 CHW Program

4 NC CHW Initiative

5 Next Steps

6

7

**Questions?**

**Submit your questions  
via the chat function**

# Next Steps

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Work with our local, state, and regional partners to leverage best practices and knowledge share across CHW Programs



Provide any feedback to NCDHHS



Contact Khristian Curry ([Khristian.Curry@dhhs.nc.gov](mailto:Khristian.Curry@dhhs.nc.gov)) with any questions

# Appendix



NC DEPARTMENT OF  
**HEALTH AND  
HUMAN SERVICES**



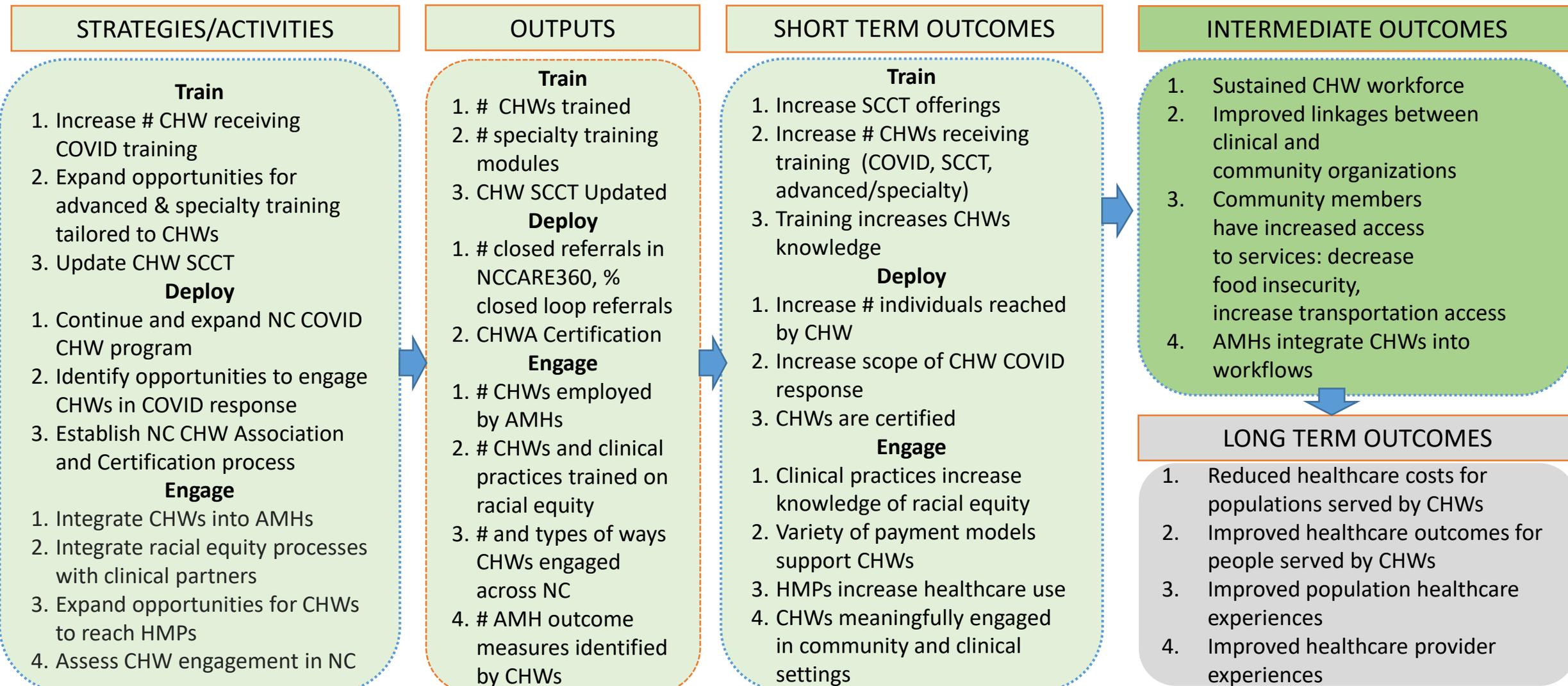
# Additional Funding Opportunities

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1. Federal Funding Opportunities
2. Medicaid/PHPs
3. Additional Insurers
4. Foundations and Philanthropy
5. Health Systems (identify own ROI)

NC CHWs are sustained in delivering whole person, culturally-sensitive, and evidence-based care promoting community resilience and health equity

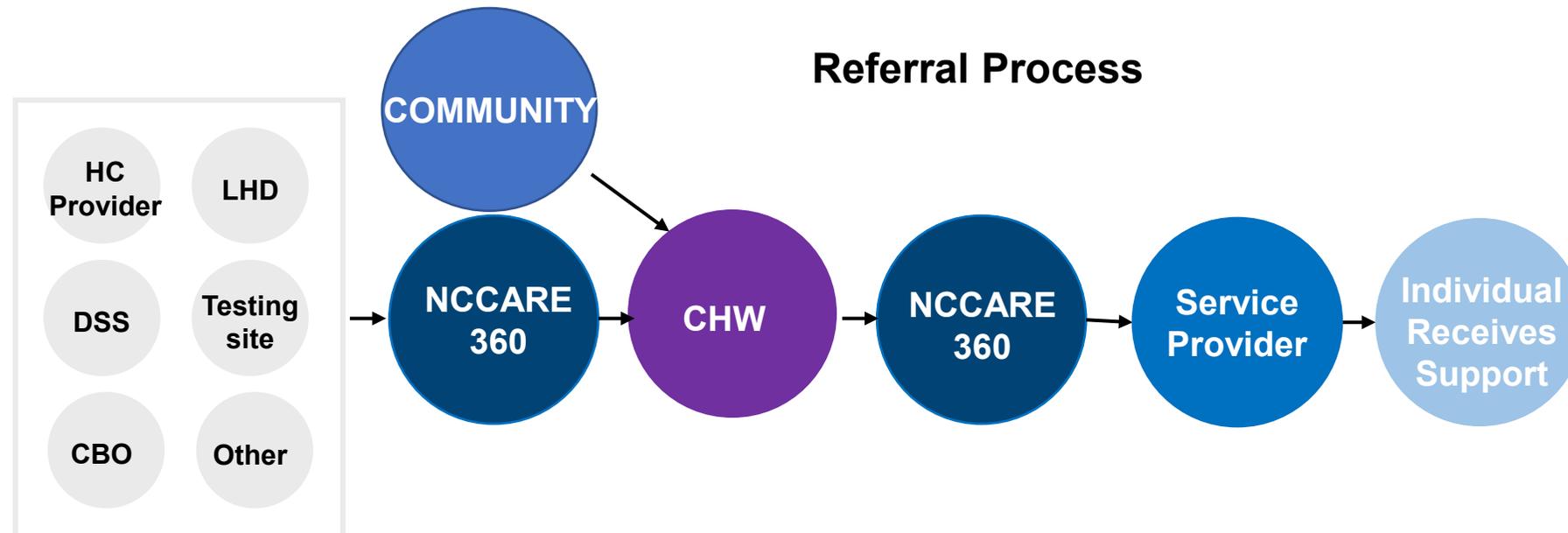
Inputs/Resources: CDC funding, APHA CHW [definition](#), NC CHW Association, NC DHHS Office of Rural Health, Partners in Health, NC AHECs, NC Community Colleges (NCCC), UNCP, HBCUs, NC Community Health Center Association (NCCHCA), CHASM, NC DHHS Division of Health Benefits, NC's 1115 Medicaid Waiver, CHW Standard Core Competency Training (SCCT), Train the Trainer curriculum, Advanced Specialty Training, CHW Clinical Integration Toolkit, AHEC learning platforms, NCCC Virtual Learning Center, NCCARE360 referral platform, COVID-19 CHW work, contracted CHW vendors, ORH CHW Coordinators



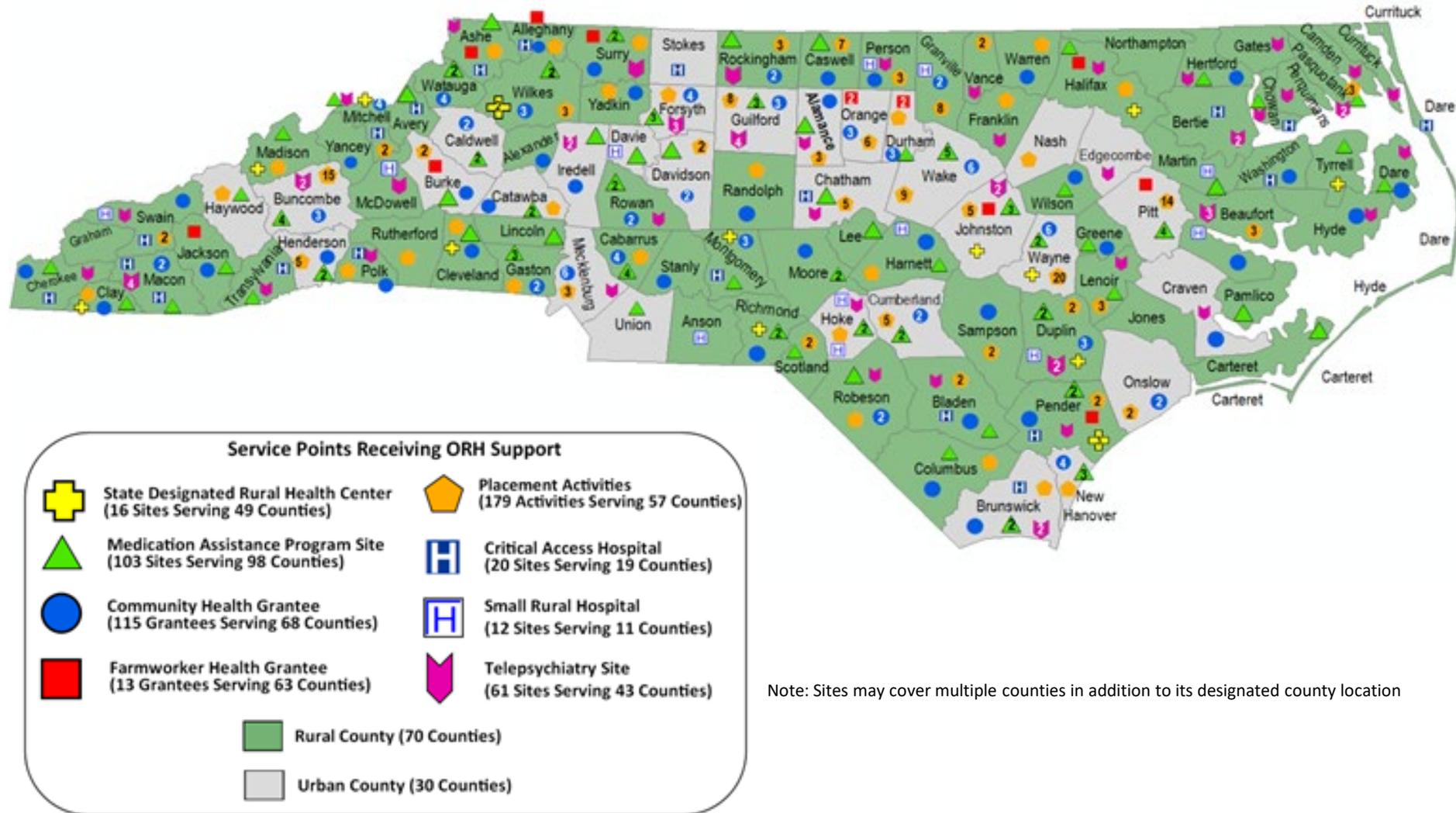
# CHWs Use of NCCARE360 Helps Create Connections to Support

## NCCARE360

- NCCARE360 is the first statewide network that unites health care and human services organizations via a shared technology platform that enables a coordinated, community-oriented, person-centered approach for delivering care in North Carolina
- NCCARE360 helps health and community-based organizations in all 100 North Carolina counties make electronic referrals, communicate in real time, securely share client information, and track outcomes together
- NCCARE360 has a community engagement team located across the state working with community-based organizations, health plans, health systems, and government agencies to create a statewide coordinated network and to train and onboard partners
- **Anyone in North Carolina can request services and be connected to community resources**



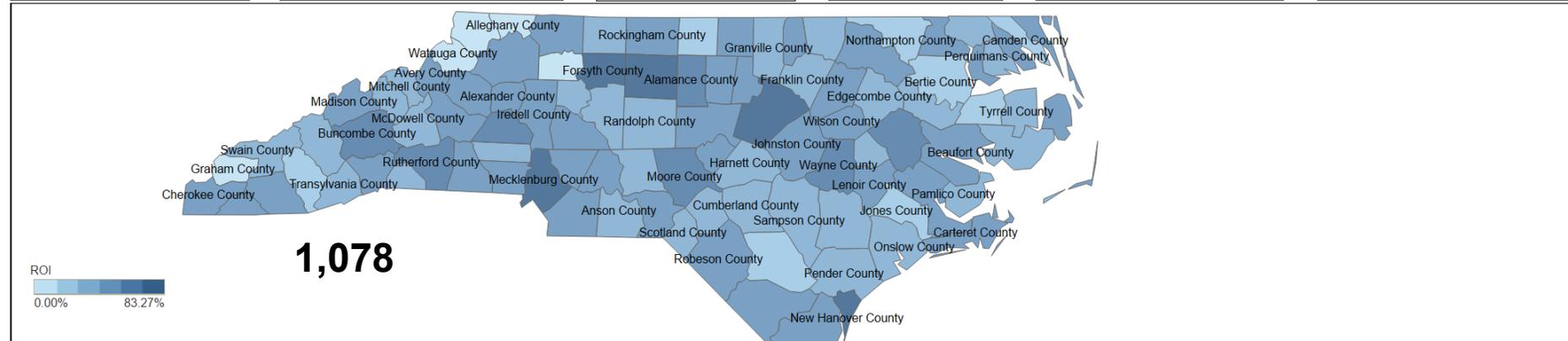
# SFY 2021 Map of ORH Coverage: Possible Linkages to Safety Net for Primary Care



Note: Sites may cover multiple counties in addition to its designated county location

# COVID-19 CHW Program IMPLAN Return on Investment

| Community Health Worker Return on Investment (ROI)  |                         |               |              |                       |                        |
|---|-------------------------|---------------|--------------|-----------------------|------------------------|
| IMPLAN Analysis Results                             |                         |               |              |                       |                        |
| Expenditures from August 2020 through February 2022 |                         |               |              |                       |                        |
| Expenditures  | Created Economic Impact | Average ROI   | Jobs         | State and Local Taxes | Total Impact           |
| <b>\$52,622,084.31</b>                              | <b>\$29,780,953.34</b>  | <b>44.22%</b> | <b>954.6</b> | <b>\$3,082,811.60</b> | <b>\$82,395,523.60</b> |



| Economic Impacts   |                 |                         |                 |        |                 |                       |
|--------------------|-----------------|-------------------------|-----------------|--------|-----------------|-----------------------|
| County             | Expenditures    | Created Economic Impact | Total Impact    | ROI    | Additional Jobs | State and Local Taxes |
| Wake County        | \$3,525,597.70  | \$2,935,716.21          | \$6,461,313.91  | 83.27% | 78              | \$251,468.02          |
| Guilford County    | \$676,602.40    | \$539,786.00            | \$1,216,388.40  | 79.78% | 16              | \$47,129.67           |
| New Hanover County | \$198,363.82    | \$157,304.46            | \$355,668.28    | 79.30% | 4               | \$15,829.58           |
| Mecklenburg County | \$13,778,074.05 | \$10,047,808.57         | \$23,825,882.62 | 72.93% | 134             | \$707,083.47          |
| Forsyth County     | \$1,035,267.42  | \$724,104.47            | \$1,759,371.89  | 69.94% | 27              | \$67,416.56           |
| Catawba County     | \$210,419.19    | \$144,106.96            | \$354,526.15    | 68.49% | 2               | \$-18,062.02          |
| Buncombe County    | \$722,206.29    | \$490,531.63            | \$1,212,737.92  | 67.92% | 14              | \$46,261.50           |
| Moore County       | \$55,102.54     | \$35,432.61             | \$90,535.15     | 64.30% | 2               | \$4,239.30            |
| Pitt County        | \$1,513,139.07  | \$967,963.24            | \$2,481,102.31  | 63.97% | 25              | \$84,270.36           |
| Rutherford County  | \$679,757.97    | \$400,768.23            | \$1,080,526.20  | 58.96% | 10              | \$37,274.11           |
| Alamance County    | \$410,153.49    | \$239,623.86            | \$649,777.35    | 58.42% | 13              | \$29,528.79           |
| Wayne County       | \$1,750,890.06  | \$1,017,138.98          | \$2,768,029.04  | 58.09% | 54              | \$136,619.88          |
| Brunswick County   | \$96,124.05     | \$53,053.23             | \$149,177.28    | 55.19% | 1               | \$6,499.49            |
| Wilson County      | \$626,214.54    | \$345,091.79            | \$971,306.33    | 55.11% | 21              | \$34,634.14           |
| Macon County       | \$83,755.29     | \$45,411.70             | \$129,166.99    | 54.22% | 1               | \$4,608.80            |
| Iredell County     | \$171,171.89    | \$92,625.26             | \$263,797.15    | 54.11% | 2               | \$9,000.45            |
| Cherokee County    | \$22,613.93     | \$12,169.16             | \$34,783.09     | 53.81% | 0               | \$1,155.53            |
| Columbus County    | \$382,498.76    | \$205,504.29            | \$588,003.05    | 53.73% | 8               | \$25,772.67           |
| Avery County       | \$162,868.15    | \$85,958.81             | \$248,826.96    | 52.78% | 3               | \$8,716.18            |
| Cabarrus County    | \$844,804.33    | \$445,677.34            | \$1,290,481.67  | 52.76% | 11              | \$42,846.99           |
| Durham County      | \$1,021,186.41  | \$527,567.58            | \$1,548,753.99  | 51.66% | 25              | \$51,570.39           |
| Craven County      | \$443,027.21    | \$225,329.06            | \$668,356.27    | 50.86% | 12              | \$28,837.89           |

# North Carolina State CHW Workforce

## Number of CHWs

## CHW Employment Status

