



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

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

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“The aim of the North Carolina Community Health Worker (CHW) Initiative is to build a sustainable infrastructure to support CHWs.”

FOREWORD

The evolving landscape of health care in the United States provides multiple stakeholders the opportunity to create new approaches and refine older concepts to address individual and population health. The first order is recognizing that the problems faced by communities are vast and complex. The concept of health and health behaviors in relation to daily living circumstances can be challenging; particularly amongst those who are least resourced.

Health, in and of itself, is not just an isolated physical or mental manifestation. It is impacted by the social and environmental systems and policies where people reside, work, learn, play and pray. To improve health outcomes, it will take a multifaceted approach including a variety of health care providers, licensed and unlicensed to serve communities. One group of individuals that has been recognized for their ability to address the needs of communities that are most impacted by poor health are Community Health Workers (CHWs).

For the past three years, stakeholders have been engaged in the North Carolina Community Health Worker Initiative. This work started by identifying and describing how existing programs across the state utilize CHWs. Through a series of meetings, development of workgroups, a Summit and several community listening sessions, a set of recommendations has been developed to support a coordinated infrastructure for CHWs. It proposes that CHWs' roles and competencies should be codified and that standardized training should be developed. There is also a proposed certification process for CHWs to enhance potential employment opportunities.

Throughout the process many lessons were learned from other states that are pursuing this work. At each turn, we gleaned the successes and barriers encountered in creating a framework for CHWs when there is not a national standard for what they do. Additionally, the North Carolina Community Health Worker Initiative was privileged to be chosen among 4 other states to receive technical assistance from Community Health Worker experts through the Association of State and Territorial Health Officials (ASTHO). Through this assistance we learned more about certification processes and funding models developed by other states.

The Final Report and Stakeholder Recommendations are the results of what has been learned through the North Carolina CHW Initiative. To reflect some of the current CHW efforts, success stories are included as a part of this report. These include stories shared by the Formerly Incarcerated Transition (FIT) Project, the Carolina Heart Alliance Networking for Greater Equity (CHANGE) Project, Wake Forest Baptist Medical Center and the North Carolina Community Health Center Association. We the members of the North Carolina CHW Initiative, thank everyone who contributed to its' development. It is our hope that the information will provide valuable guidance in developing a coordinated NC CHW infrastructure that recognizes and supports the unique skills and abilities of the profession.

We also thank the Kate B. Reynolds Charitable Trust and the North Carolina Foundation for Health Leadership and Innovation for their support.



WHAT IS A COMMUNITY HEALTH WORKER?

Community Health Worker

“A frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker 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. A community health worker also builds 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.”

- American Public Health Association Community Health Worker Section, 2010.

CHWs responding to the NC CHW Workforce Survey, July 2017 reported they worked in:

Community Organizations
Religious Organizations
Community Health Centers

Hospitals
Local Health Departments

Physician's office
Other unidentified settings

CHW job titles in the United States number over 150. These are just a few:

Asthma Outreach Worker
Addiction Treatment Specialist
Bilingual Family Advocate
Care Coordinator
Certified Application Assistant
Close-to-Community-Providers
Community Aide
Community Care Worker
Community Connector
Community Health Coordinator
Community Health Navigator
Community Health Representative
Community Liaison
Community-Clinical Linkage Specialist

Cultural Case Manager
Cultural Mediator
Diabetes Navigator
Enrollment Worker
Family Advocate
Family Support Worker
Frontline Health Worker
Health Communicator
Health Extension Worker
Health Facilitator
Health Information Specialist
HIV Peer Advocate
Home Visitor
Homeless Advocate
Lay Health Advisor
Medical Representative

Mental Health Worker
Multicultural Health Brokers
Neighborhood Health Advocate
Outreach Coordinator
Parent Liaison
Peer Advocate
Peer Leader
Promotora de Salud
Social Determinant of Health Specialist
Wellness Ambassadors
Youth Worker



INTRODUCTION

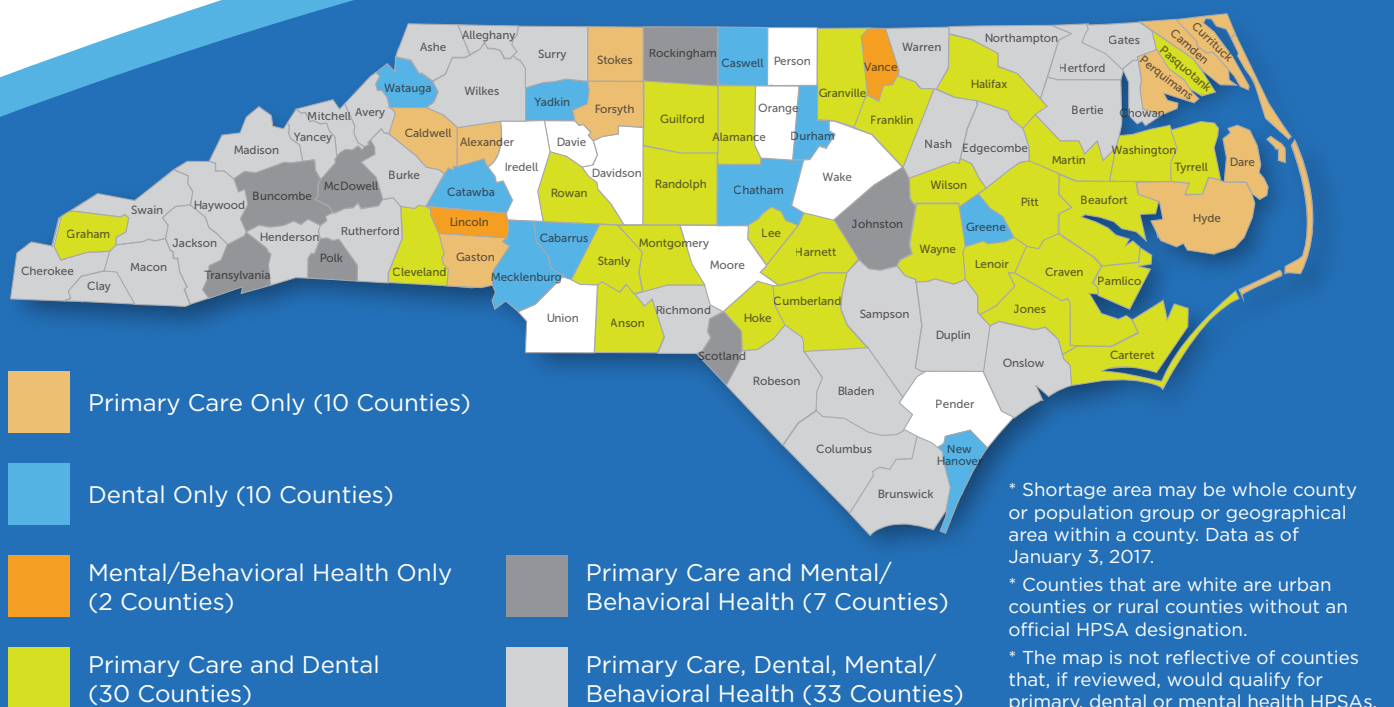
As NC's healthcare and public health systems maneuver through the transition to managed care, coordinating efforts to address population health is critical. Value-based pricing, as well as the call for more integrated team-based care, will affect the state's future healthcare workforce needs. The discussion about NC's workforce needs must include the role of Community Health Workers. They work with both individuals and communities to improve health and address the social determinants of health. As other states have done, NC has an opportunity to develop this community-based resource as an integral component of the primary and preventive care system.

Nationally, attention has focused on the way that CHWs can participate in a new healthcare delivery model. Changes to healthcare laws encourage the use of CHWs to promote healthy behaviors and improve health outcomes. Furthermore, several studies have demonstrated that CHWs provide cost savings to healthcare systems through reduced emergency room visits, hospitalizations and readmissions. CHWs can help health systems and providers improve population health, manage cost, and reduce disparities in health outcomes. This new approach will require an investment in CHWs and the development of strategies to pay for their services.

The aim of the NC CHW Initiative is to develop strategies for building a sustainable infrastructure to support CHWs. These strategies acknowledge the value of CHWs, support their professional identity and integrate their role in the healthcare team. The purpose of this document is to describe the process of the NC CHW Initiative, share lessons learned and recommend key steps for moving forward. The following infrastructure components are included:

- Key roles and responsibilities;
- Core competencies and training; and
- Certification requirements and process.

North Carolina Counties Designated Health Professional Shortage Areas SFY 2017



NORTH CAROLINA COMMUNITY HEALTH WORKER INITIATIVE PROCESS

In October 2014, representatives from the NC Department of Health and Human Services (DHHS) formed a CHW Committee (Appendix A). This committee worked with the Healthy Solutions team from UNC-Chapel Hill to develop the CHW Program Inventory, which was implemented in January 2015. The goal of the inventory was to identify and describe existing programs in NC that utilize CHW services. Information collected included organizational demographics, CHW scope of services, skills and abilities, and funding sources. The inventory identified the challenges and benefits of providing CHW services. Approximately 290 program managers and supervisors received the survey, and a total of 117 (40%) completed it.

A meeting was held on April 2015 to share the results of the Program Inventory with stakeholders across the state. Seventy-two people attended the meeting representing a variety of stakeholder groups, including health associations, academic institutions, healthcare systems, state agencies and community health workers, among others. Participants discussed the benefits of and opportunities for developing statewide support for the CHW workforce in NC. With these new benefits and opportunities in mind, the members of the DHHS CHW Committee joined with members from the various stakeholder groups to form the NC CHW Initiative.

NC CHW Initiative members began meeting regularly in December 2015 and formed workgroups to (1) determine key roles and responsibilities of CHWs; (2) identify core competencies and recommend a training curriculum; and (3) develop the requirements and process for the certification of CHWs.

“CHW = good healthcare for all people, not cheap health care for poor people.”

- Attendee at the NCCHW Summit 2016

Guiding Principles:

1. CHWs have long played a role in the American healthcare system and operate under a diverse set of labels, including promotor(a) de salud, outreach educator, patient navigator, home visitor, parent aide, family service coordinator, and peer support worker.
2. They work in multiple settings, including health departments, non-profit organizations, primary care practices, hospitals, Federally Qualified Health Centers and healthcare systems, participating in hospital to home transitional care, primary and specialty care, and community-based chronic disease and preventive services.
3. CHWs bring a valuable perspective to the multi-disciplinary teams in which they work, in that they are members of or have an unusually close understanding of a particular culture or community.
4. CHWs can play a critical role in implementing the Institute for Healthcare Improvement's Triple Aim: improving the health of the population, enhancing the experience and outcomes of the patient, and reducing the cost of healthcare. With their specialized knowledge of populations experiencing poorer health outcomes, they will also play a role in reducing health disparities.
5. Given the role they play in helping North Carolinians achieve optimal health status, the state would benefit from a system that formally recognizes the occupation of CHWs and creates opportunities for a career path and payment for their services.
6. NC should have a system for training CHWs and supporting their continuing education. A registry of CHWs who have completed the training should be maintained.
7. The curriculum used to certify CHWs should be standardized across the state, and organizations providing training should be accredited to do so.
8. CHWs with documented experience should be "grandparented" into the process and not required to complete the training to achieve certification.
9. Employers should have flexibility in how they utilize CHWs to achieve their organizational goals.
10. A North Carolina CHW Code of Ethics should be created.

With these key principles identified, the workgroups of the NC CHW Initiative began developing initial recommendations. These recommendations were presented to key stakeholders through a statewide summit in November 2016. Topics included the specific components (roles, core competencies and certification requirements), along with general issues such as sustainability by engaging payers, hospitals and health systems. Feedback was gathered at the summit through focus group discussions and individual comments and suggestions.

Following the summit, six listening sessions were held across the state. These sessions provided opportunities to gather additional feedback on the recommendations through in-depth discussions about the roles, core competencies and value of certification for CHWs and employers. Additionally, the NC CHW Initiative was privileged to be chosen among 4 other states to receive technical assistance from CHW experts through the Association of State and Territorial Health Officials (ASTHO).

The final recommendations, that follow, are based on input from stakeholders across the state and can provide the foundation for a coordinated CHW workforce through training and certification in NC.

Recommendation 1: Roles and Responsibilities

The roles outlined below by the Roles and Responsibilities workgroup are fundamental to CHWs regardless of the settings in which they work or the health issues they address. The roles are meant to provide a general parameter of practice, and specific responsibilities will be defined by individual employers based upon the services or programs provided. Individual employers and organizations will define the roles their CHWs play among those listed below.



Role 1: Cultural Liaison

CHWs have first-hand knowledge of the communities with which they work, permitting them to serve as cultural liaisons between their clients and health and social service systems. They serve as a bridge ensuring that clients receive culturally and linguistically appropriate quality care and services.



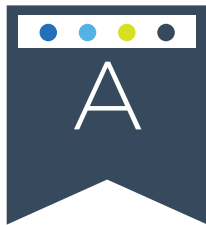
Role 2: Health Navigator

CHWs link clients to services by knowing what services exist and referring clients appropriately. They may also provide direct care to clients through services they are trained and qualified to provide.



Role 3: Health and Wellness Promoter

CHWs provide information about healthy behaviors and support clients in reducing health-related risk behaviors in ways that communities understand and accept. They recognize the importance of addressing the determinants of health in guiding, supporting and assisting clients to live healthier and better lives.



Role 4: Advocate

CHWs advocate with and on behalf of communities to ensure that clients are treated respectfully and given access to the services and resources that they need to live healthy lives. They support clients and community members to develop the skills and confidence to advocate for their own health and well-being and that of their communities. CHWs educate healthcare providers about the clients they serve to improve the services provided.



Recommendation II: Core Competencies and Curriculum

CHWs should possess a set of core skills to effectively meet the demands of their positions. CHWs in NC should be able to demonstrate **each of the nine competencies and accompanying sub-competencies below**. Any training developed to certify CHWs in NC should fulfill the associated learning outcomes and include field experience as part of the training process. The Core Competency and Curriculum (CCC) workgroup members reviewed materials from several states and drew heavily upon a few national projects to identify these core competencies

Communication Skills

Learning Outcomes

1. Effectively interacts with a variety of clients
2. Utilizes communication skills grounded within the context of individual and community culture
3. Provides accurate and relevant information
4. Properly documents pertinent information

Sub-competencies

- a. Ability to use written and spoken language effectively
- b. Ability to use language in ways that engage and self-motivate
- c. Ability to communicate using plain and clear language
- d. Ability to communicate with empathy
- e. Ability to communicate with the community served (may not be fluent in language of all communities served)
- f. Ability to listen actively
- g. Ability to provide accurate and relevant information/documentation

Capacity Building Skills

Learning Outcomes

1. Mobilizes community entities
2. Engages individuals to maximize strengths to achieve goals

Sub-competencies

- a. Ability to network, build community connections, and build coalitions
- b. Ability to assist individuals to maximize strengths and achieve goals

Service Coordination Skills

Learning Outcomes

1. Identifies appropriate community resources for clients
2. Demonstrates ability to connect clients to community resources
3. Serves as a liaison between the interdisciplinary team and community
4. Effectively utilizes the referral process
5. Assesses progress of client referrals

Sub-competencies

- a. Ability to identify resources
- b. Ability to share appropriate resources
- c. Ability to facilitate access to resources
- d. Ability to coordinate with clinical and other community services
- e. Ability to follow up and track care and referral outcomes
- f. Ability to leverage individual and community assets

Interpersonal Skills

Learning Outcomes

1. Develops positive relationships with diverse populations
2. Maintains positive relationships with diverse populations
3. Utilizes conflict management techniques
4. Applies critical thinking and problem solving
5. Actively engages as a member of an interdisciplinary team
6. Maintains professional boundaries
7. Utilizes interviewing techniques to effectively engage with clientele

Sub-competencies

- a. Ability to demonstrate understanding of dimensions of diversity
- b. Ability to provide peer and social support
- c. Ability to use interviewing techniques
- d. Ability to manage conflict
- e. Ability to engage people in partnerships as equals
- f. Ability to build trust and rapport
- g. Ability to work as part of a team
- h. Ability to problem solve

Advocacy Skills

Learning Outcomes

1. Demonstrates the ability to advocate for individuals
2. Demonstrates the ability to advocate for communities
3. Promotes the profession of Community Health Worker

Sub-competencies

- a. Ability to speak up for individuals and communities
- b. Ability to advocate for the Community Health Worker profession
- c. Ability to build clients' capacities to advocate for themselves
- d. Ability to advocate for cooperation between clients and health systems for optimal health outcomes

Knowledge Base

Learning Outcomes

1. Describes the community and its health issues
2. Recognizes the social determinants of health and how they impact the community's health
3. Understands the network of available resources and seeks solutions to gaps in services
4. Identifies gaps in his or her own knowledge and seeks out continuing education
5. Identifies the elements of healthy lifestyle behaviors and understands the importance of self-management

Sub-competencies

- a. General knowledge about community resources and services
- b. General knowledge of behavior change
- c. Knowledge about social determinants of health and health equity
- d. General knowledge of health issues and mental/behavioral health
- e. Knowledge about healthy lifestyle and the importance of self-management
- f. Knowledge about the community served

Outreach Skills

Learning Outcomes

1. Effectively connects with community and facilitates client connections
2. Properly documents outreach activities and observations

Sub-competencies

- a. Ability to engage individuals and move them into action by providing clear and accurate resource information
- b. Ability to build relationships with respect to diversity, using active listening, casual counseling, and encouragement
- c. Ability to make observations of community contexts, determine relevance to client success and document appropriately
- d. Ability to carry out an effective home visit and/or community event with respect to personal safety, safety of client, professional boundaries, and time/conflict management
- e. Ability to inquire for follow-up data regarding successful client progress and/or continued barriers

Personal Skills and Development

Learning Outcomes

1. Employs time management skills
2. Demonstrates basic clerical computing and office skills
3. Participates in continuing professional development
4. Demonstrates strong personal safety awareness and practices
5. Adheres to legal and ethical standards in practice
6. Practices safe boundaries

Sub-competencies

- a. Ability to set goals
- b. Ability to balance priorities and to manage time
- c. Ability to use pertinent technology
- d. Ability to pursue continuing education and life-long learning opportunities
- e. Ability to maximize personal safety while working in community and/or clinical settings
- f. Ability to observe ethical and legal standards (e.g., CHW Code of Ethics, Americans with Disabilities Act, Health Insurance Portability and Accountability Act)
- g. Ability to identify situations calling for mandatory reporting and carry out mandatory reporting requirements
- h. Ability to participate in professional development of peer CHWs and in networking among CHW groups
- i. Ability to set boundaries and practice self-care
- j. Ability to recognize established boundaries



Education and Facilitation Skills

Learning Outcomes

1. Provide preventive health information to clients
2. Educates clients on self-management of health conditions
3. Supports clients in developing healthier habits
4. Facilitates small group discussions

Sub-competencies

- a. Ability to use effective education strategies
- b. Ability to facilitate group discussions
- c. Ability to seek out appropriate information and respond to questions

Training Curriculum

In developing the recommendations above, the CCC workgroup reviewed curricular components from four states. While information was drawn from all four states, the materials from Minnesota's CHW curriculum most closely align with the identified core competencies. This curriculum is based on the 2007 textbook *Foundations for Community Health Workers* (Berthold, Miller and Avila-Esparza).

Members of the workgroup also noted that the CHW training offered through the City College of San Francisco may be appropriate for North Carolina. The faculty of the program are the authors of *Foundations for Community Health Worker*. This program offers three different CHW certificates with the focus of the trainings being the Core Competencies. The program has created a YouTube channel with mini-tutorials covering foundational CHW skills and role play. These tutorials are free of charge. However, they do not cover the entire curriculum.

COMMUNITY HEALTH WORKERS HELPING TO COORDINATE CARE

With funding from the Blue Cross Blue Shield of NC Foundation, the North Carolina Community Health Center Association's Data Informed Outreach Program supports the placement of CHWs in five community health center care teams across the state to enhance care coordination efforts for high need patients. Advance Community Health Center, Piedmont Health Services, Gaston Family Health Services, Rural Health Group and Roanoke Chowan Community Health Center are the 2017 cohort of participating sites.

- The CHWs have been well integrated into the clinical team. CHWs offer follow-up to assigned patients via a home visit or meeting in the clinic.
- The CHW uses PRAPARE, a social determinants of health tool, to identify and document the patient's social needs. The CHW attends provider appointments with patients and serves as a liaison for the patient and provider care team.
- Since initiating the program, the patients and providers have expressed appreciation and satisfaction for the services rendered by the CHW.

UNC-led Formerly Incarcerated Transition program helps former prisoners take on chronic illnesses

Returning to the community after incarceration is a process filled with challenges – finding a job, finding a place to live, reconnecting with the remnants of a former life. For many individuals, this return is made more difficult by chronic health problems like heart disease, diabetes, kidney disease, or mental illness. Because there are so many other obstacles to overcome, these individuals are often unable to access needed health care and simply go without regular care.

Evan Ashkin, MD, a professor of family medicine at the UNC School of Medicine, founded the Formerly Incarcerated Transition (FIT) program to help chronically ill former prisoners connect with primary care services that they can access regularly. Ashkin saw the need for a program like FIT while working at Piedmont Health Services' Prospect Hill Community Health Center, which serves vulnerable populations in the community. "Patients were coming into the clinic that hadn't seen a primary care provider for long periods of time, more than two years in some cases," Ashkin said. "Many had diabetes and other chronic conditions that required regular clinic visits."

Direct and timely connection to medical care is essential as there is a 12 times higher risk of death in the first two weeks after release from prison. It also reduces overall health care costs, which means it could cost the state less to provide regular primary care visits than it would to provide catastrophic care to those without consistent access to a provider.

Working in partnership with the Durham Criminal Justice Resource Center, the Lincoln Community Health Center and the Durham County Department of Public Health, Ashkin launched the FIT pilot program in Durham based on the national Transitions Clinic Network model. Transitions Clinic Network trains formerly incarcerated individuals to become community health workers who assist others to successfully reenter the community by linking them to care and helping them find housing and job training.

FIT hired Torrey Green to begin assisting clients. Torrey – who splits his time between offices in the Durham Health Department and the Durham County Criminal Justice Resource Center – helps those transitioning back into the community navigate the sometimes rocky terrain of health care. He also helps connect individuals to additional resources available in the Durham area.

Not only are FIT clients dealing with one or more chronic conditions, they also often face food, housing, and job insecurity. "These guys that come into my office face so many hurdles," Green explained. "What I do, what FIT does, is take one very important thing off their plate."

Green was raised in a low-income neighborhood in Durham and turned to selling drugs when times were tough. Though never incarcerated, he had a misdemeanor drug charge on his record that made it difficult to get or keep a desk job. A life-long Durham resident, he has watched many in his community cycle through the "revolving door" of incarceration.

Green eventually turned to community work as a way to help others turn their lives around, volunteering with organizations such as Bull City United, an outreach

program that reaches out to individuals affected by violence and encourages them to resolve their conflicts peacefully.

"For those working to make FIT happen, this isn't just a paycheck job," Torrey said. "It's people who really care, trying to make a difference."

In May 2017, the FIT program received a grant from The Duke Endowment. With these funds, the FIT program will be expanded to Orange County where it will work in partnership with the Orange County Health Department, the Orange County Criminal Justice Resource Office, and Piedmont Health Services.

The North Carolina Department of Public Safety, which runs the prison system, is keen to spread this model even further with help of groups like FIT. The North Carolina Community Health Center Association, under the leadership of CEO Ben Money, is also actively involved in helping to develop the FIT model here in North Carolina.

FIT is just getting started. The problems it tries to help overcome are daunting, but Green and Ashkin nevertheless remain hopeful. "Every year in North Carolina, more than 20,000 people are released from state prisons and they're not given any transition help related to health care; no wonder there's a revolving door," Green said. FIT bridges the gap between the help formerly incarcerated individuals are currently receiving and what they need to be successful.

Providing health care to this especially vulnerable population more effectively is a statewide challenge and Ashkin is hopeful that the FIT program will expand throughout North Carolina. According to Ashkin, providing continuous care for former prisoners is both a moral and an economic responsibility. "I think we have a societal obligation to help formerly incarcerated people become productive, fulfilled members of the community," said Ashkin. "But even from a purely economic standpoint, linking people with chronic illness to medical care and preventing serious medical complications is a public health priority."



◀ *Transitions
Clinic Network*

Recommendation III: Certification Requirements and Process

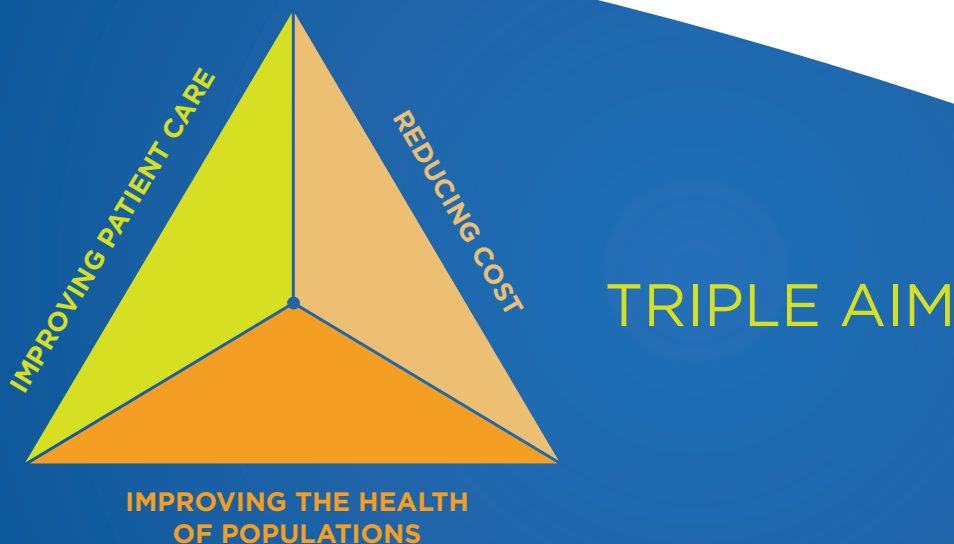
Creating a certification process for CHWs in NC can assist in (1) standardizing training for CHWs and (2) increasing the credibility of their role on an integrated healthcare team. The Certification Requirements and Process (CRP) workgroup identified two possible routes for the certification process. The first route is to certify individual CHWs who demonstrate the core competencies and meet criteria for education and experience. The second route certifies the organizations that provide CHW services in lieu of having individually certified staff. Programs would need to meet criteria related to training and supporting CHWs in their organizations. Both options could be supported by a proposed North Carolina Community Health Worker (NC CHW) Certification and Accreditation Board as described in more detail below.

Certification of Individual Community Health Workers

First, it is important to note that the certification of NC CHWs is not an attempt at licensure. Lessons learned through the experiences in several states discourage the licensing of CHWs. Additionally, it is not intended that certification become mandatory for CHWs. Certification would be a voluntary process that would provide the opportunity for CHWs to demonstrate they have met particular criteria related to education, experience and training. Regardless of certification status, CHWs will continue to play a role in healthcare delivery in North Carolina.

The workgroup considered the Community Health Worker Career Pathway Model from the Community Health Worker Initiative of Boston as the basis of the proposed certification process. The pathway acknowledges the varying degrees of experience and education that presently exist among CHWs, while promoting professional development. The certification process includes three levels that allow the CHWs to advance.

The first certification level is CHW I, which requires a 9th grade literacy level and completion of a training program that addresses the nine core competencies and includes supervised field experience. The second certification level is CHW II, which requires a high school diploma or equivalent, two years of experience



at a 1.0 Full Time Equivalent (FTE) and demonstrated knowledge of all nine core competencies along with specialized training in a topic area. Finally, the third level of certification, CHW III requires an Associate's Degree, three years of experience at a 1.0 FTE, demonstrated knowledge of all nine core competencies along with specialized training in a topic area, and demonstrated management, leadership or supervisory skills. The NC CHW Certification and Accreditation Board would accept documentation of a CHW's education level, training, and experience and confer certification at the appropriate level.

It is essential to acknowledge the skills and abilities of those CHWs who have been providing services for many years. "Grandparenting" allows individuals to be considered certified and to bypass the need for taking formal certification training. Organizations that choose to support a CHW to be "grandparented" would need to provide evidence of the CHW's education, experience, and ability to demonstrate the core competencies. "Grandparenting" would be allowed for CHW I and CHW II, but not for CHW III. The "grandparenting" process would be time-limited and only be allowed for the first five years of the proposed process. After that time, CHWs would be required to follow the certification process described above.

CHWs who undergo individual certification would be required to seek continuing education that can be offered through employers or other approved organizations as defined by the NC CHW Certification and Accreditation Board. Anyone who has completed the individual certification would be listed in a CHW Registry maintained by the Board.

Individual certification has the benefit of being portable between employers across the state. The CHW can then work for any employer who seeks a certified CHW.



Accreditation of Community Health Worker Programs

A primary strength of CHWs is the flexibility and breadth of their roles. The CHW workforce includes part-time and volunteer positions working in programs in which there may be substantial turnover, making their individual certification impractical. The second proposed certification route can address this need by allowing CHW programs to be accredited, rather than certifying individuals working within the program. Accredited CHW programs could then seek reimbursement for services provided by CHWs working under their auspices. CHWs working under accredited CHW programs would not gain a portable, individual certification unless they went through the process to obtain individual certification discussed above.

Accreditation of CHW programs could be overseen by the NC CHW Certification and Accreditation Board. Once established the Board would ensure that accreditation would be based upon evidence that the programs have in place procedures and practices appropriate to their goals and the populations they serve, which would vary between programs.

To gain accreditation, programs would need to submit documentation to the NC CHW Certification and Accreditation Board of their procedures and program operations in the following areas:

1. Recruitment: A process for CHW recruitment and the criteria by which they will be selected should be clearly defined.
2. Training: Training should address the core competencies as previously outlined. Other competencies may be included to meet the program goals, objectives, and specific services.
3. Intervention Protocols: The protocols for CHW services should match the program objectives and the recruitment and training of CHWs who will execute them.
4. Organizational Support: Programs should have a designated coordinator who is responsible for the overall recruitment, training, supervision, and monitoring of CHWs and for assuring appropriate back-up for them. Generally, this coordinator would be a certified CHW III or other senior health professional.
5. Technical Input: There should be individuals with technical expertise available to provide the program advice and guidance appropriate to the scope and objectives of the program.
6. Continuing Education: Programs should provide continuing education for CHWs. Plans for continuing education would be approved by the NC CHW Certification and Accreditation Board.
7. Program Monitoring and Quality Assurance: There should be documentation of procedures for monitoring implementation, outcomes, possible adverse events, and for both enhancing quality and addressing problems with individual CHWs or with the services provided.

Training Accreditation System

Organizations could be accredited by the NC CHW Certification and Accreditation Board to train individual CHWs through the proposed accreditation system. To be accredited, the organizations would have to: provide evidence that their training addresses the nine core competencies, issue certificates of training completion to CHWs, and submit appropriate documentation to the Board.

IF CHWS IN NC WERE RECOGNIZED ACROSS THE STATE, I FEEL THAT IT WOULD MAKE US FEEL LIKE WE HAVE A SENSE OF ACCOMPLISHMENT AND GRATITUDE FOR THE WORK WE DO.

- Jennifer Pooré , Asheville Buncombe Institute of Parity Achievement

NC CHW CERTIFICATION AND ACCREDITATION BOARD

NC CHW Certification and Accreditation Board Duties and Composition

As described above, the CHW certification and training accreditation processes would be directed by a NC CHW Certification and Accreditation Board.

This board could be responsible for the following activities:

- Set rules and processes for certification of individual CHWs and CHW programs
- Approve standards for accreditation of training organizations
- Adopt a means to assess CHW competency in connection with certification
- Set a code of ethics for CHWs
- Set fees for certification and accreditation
- Set renewal period for continued certification and accreditation
- Create and maintain a registry of certified CHWs
- Establish procedures for disciplinary action against CHWs

The size of the Board would be between 12 to 15 people. Potential members could include the following types of organizations, sectors, and individuals:

- Post-secondary educational institutions
- Public and private insurers
- Employers: safety net providers, health systems, community-based organizations
- Community health workers (volunteer, employed, differing ranges of experience)
- Health and human service agencies
- Active/former CHW clients
- CHW supervisors
- Evaluators



CHANGE

The Carolina Heart Alliance Networking for Greater Equity Project (CHANGE) began in October 2014 with Centers for Disease Control and Prevention funding through UNC Center for Health Promotion and Disease Prevention (HPDP). CHANGE is designed to prevent heart attacks, strokes, and related deaths by strengthening clinical-community linkages and by implementing Heart to Health, an evidence-based intervention developed by HPDP researchers.

HPDP is partnering with the Roanoke Chowan Community Health Center and Hertford County Public Health Authority to (1) reduce risk of cardiovascular disease in rural and medically underserved communities; (2) strengthen linkages between public health and clinical practice to enhance community outreach, care coordination, and delivery of a behavior change strategy to reduce cardiovascular disease risk; and (3) support adoption of evidence-based approaches in public health and clinical settings.



As part of the CHANGE strategy, two community health workers (CHWs) have joined the teams at Roanoke Chowan Community Health Center and Hertford County Public Health Authority. The trained CHWs and their colleagues at the community health center and health department collaborate to:

- Reach underserved populations by engaging existing social networks
- Use new technology to deliver an evidence-based program, Heart-to-Health, and other resources to clinic patients and community members
- Link community members to clinic, public health, and community-based services that promote heart health
- Improve coordination of care across clinical and public health settings
- Support culturally relevant and heart healthy changes in community environments where people live and work

In Year 1 of the project, the team worked to refine the CHANGE strategy in Hertford County. Efforts focused on inventorying existing clinic and community services and assessing barriers to using them and integrating the CHANGE strategy into current clinical and public health practice.

Efforts then moved to identifying best process for engaging partners and building capacity to plan and implement the CHANGE strategy and increasing the project's reach and effectiveness.

The team hopes to replicate the CHANGE strategy in other communities and create an implementation toolkit.

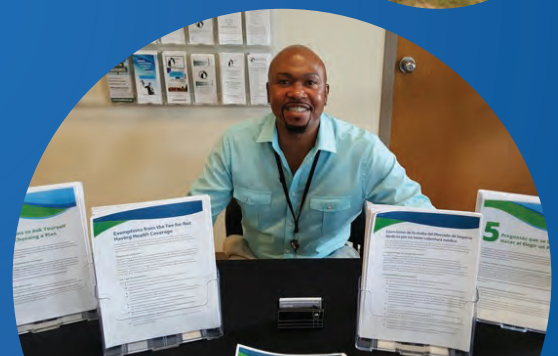
Preliminary results of the project include:

- 71 of 120 (59%) of patients completed intervention
- 25% of patients with uncontrolled hypertension came under control
- Average weight loss in 4 months was 4.2 lbs
- Increase in physical activity by 71 minutes per week
- Increase in fruits and vegetables by 1 serving

For more information about the CHANGE Project, contact:

Email Change@unc.edu

Phone **888-987-8191**



Smarter Community Healing: Former hospital environmental workers support neighborhood health

In the small but neatly appointed living room of Shirley Gray's home in east Winston-Salem, Annika Archie and Vernita Frasier gently ask Gray questions and offer reminders.

"How's your blood sugar?"

"Are you eating well at home?"

"Do you feel like you're healing?"

"Do you have any family members to help you?"

"You look so pretty in that."

The last comment was Archie's compliment for the deep red dress Gray was wearing on the afternoon that Archie and Frasier visited. The two women, both longtime employees at Wake Forest Baptist Medical Center, used to clean rooms as part of the hospital's Environmental Services team.

Today, Archie and Frasier work full time for FaithHealthNC, reaching into the community to help dozens of patients with assistance after a hospital stay — everything from making sure their medicines are taken in the right dosages and at the right time to connecting them with resources that might help them pay utility bills or rent.

A program takes shape

In late 2012, Wake Forest Baptist Medical Center, like many other hospitals, was facing unprecedented financial challenges, yet looking for every way to preserve its triple mission of care, research and education.

Gary Gunderson had just arrived as vice president of faith and health ministries from Memphis, where he had seen hundreds of congregations help the hospital control the cost of its care to the most vulnerable neighborhoods. "Who could do such work on the

streets in Winston-Salem?" he wondered.

The answer fell on the table when Gunderson found himself in a meeting discussing the Medical Center's environmental services workers, some of whom lived in the very neighborhoods where need was concentrated.

Gunderson proposed a partnership between his division and environmental services, promising to save the hospital money in charity care by making use of the environmental services workers in new ways.

"Everyone knew that proactive is better — and cheaper — than reactive," Gunderson says. "This is how to be proactive."

With the support of Karen Huey, the Medical Center's vice president for facilities, it was decided to train the employees to assist FaithHealthNC. Over the next few months, Archie and Frasier became full-time members of FaithHealthNC, while two other Environmental Services employees began working part time for FaithHealthNC.

Close to 200 patients and families have been served by the initiative already, says Jeremy Moseley, project administrator of community engagement for FaithHealthNC.

"It's all about building trust and showing people we are part of the mission as well," he says.

Perhaps most important, all Environmental Services employees are encouraged to talk with patients and share their needs with appropriate people in the Medical Center, most often chaplains or nurses. Today, helping patients get on track with follow-up care and avoiding readmittance is critical for both patients and hospitals.

Milander Smallwood, education manager for Environmental Services, says his team's members had long spoken with patients, but didn't always know what to do with the information they gained.

"Now they know they can help," Smallwood says.



PATH FORWARD

The changing landscape of the healthcare environment has created the opportunity to formally recognize Community Health Worker contributions to the integrated healthcare team. The recommendations of the NC CHW Initiative workgroups will help to establish an infrastructure to maximize the ability of CHWs to cost-effectively improve population health outcomes.

To further this work, NC CHWs and stakeholders should (1) establish a board to certify CHWs and accredit organizations to train them; (2) implement a standard training curriculum through community colleges, Area Health Education Centers or other agencies; (3) integrate CHWs into Medicaid Managed Care and team-based care; and (4) establish a CHW Network to lead these efforts.

First, it will be critical to identify where the Certification and Accreditation Board could reside, whether in a state agency or in a non-governmental organization. CHWs can present evidence that they have completed training to employers to demonstrate they have skills valuable to the healthcare team. If the creation of an official board is not currently feasible, an organization should be identified that is willing to oversee CHW training in the state and determine whether individual training programs have voluntarily met the standards outlined in this document. The creation of more training opportunities and—importantly—standardized training opportunities will bolster the profession of the CHW in this state.

Second, educational institutions and other organizations can begin creating or adapting training that incorporates the core competencies identified in this document. The curriculum for this training should be offered across the state in multiple modalities to accommodate the time, costs and work schedules of CHWs. Any standardized core competency training should meet the requirements of the recommendations previously outlined in this document. All training sessions should include CHWs as trainers/instructors. Primary homes for this training could be the Community Colleges, NC Area Health Education Centers, high schools and Community Based Organizations.

Third, the current Amendment to the Medicaid Waiver seeks to advance high-value care and improve population health through a well-coordinated system of care that addresses both medical and non-medical drivers. CHWs provide a critical link between patients and available community resources to address food insecurity, transportation needs, and housing instability to name a few. Those who provided feedback to the Medicaid Waiver whitepaper have identified CHWs as part of the solution to bridge these determinants of health and have expressed support for providing CHW certification and reimbursement. With Medicaid reform underway in NC, CHWs could play a vital role in the multi-disciplinary workforce of Provider Led Entities and Managed Care Organizations to ensure coordinated access to services and improved health for populations.

MY DECISION TO PURSUE THIS LINE OF WORK WAS INSPIRED BY THE AWARENESS I HAVE IN REGARDS TO THE MANY DISPARITIES THAT EXIST DUE TO THE SOCIAL DETERMINANTS OF HEALTH.

- Yvette Singleton, Asheville Buncombe Institute of Parity Achievement

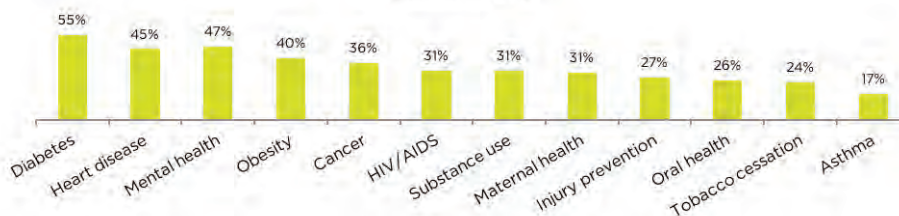


Efforts should focus on evaluating CHW programs in NC to identify successful models and demonstrate Return on Investment (ROI). Nationally, CHWs are included in the Diabetes Standards of Care, and there is documented ROI for their services related to asthma and hypertension management. Studies have shown impact in the areas of mental health as well as maternal and child health. CHWs are also helping to address patients' unmet social needs in NC. CHWs are recognized for their ability to identify resources for individuals and communities to address underlying contributors to poor health. Other examples of NC efforts are highlighted in this document to reflect the impact of their work and the types of organizations in which they either volunteer or are employed. These models include settings such as faith-based organizations, community health centers, health departments and area health education centers. This information should be used to inform efforts to engage CHWs in team-based care.

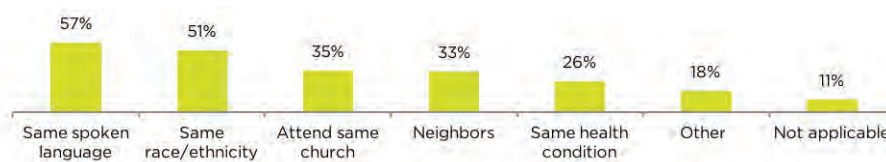
Finally, CHWs should create a state-level CHW professional network. States with successful CHW training programs have organized groups of CHWs/Promotoras. While there are many names for these groups including association, coalition, alliance or network, their purpose is to aid CHWs in their ability to align efforts related to training, advocacy, communication, and workforce/professional development. NC CHWs should lead this process with assistance from supportive stakeholders. The network should be assessable to CHWs, stakeholders, and allies. Movement has already begun to form a coordinated group. Ideally, the group would be housed in an umbrella organization as it develops and seeks funding to support and sustain itself.



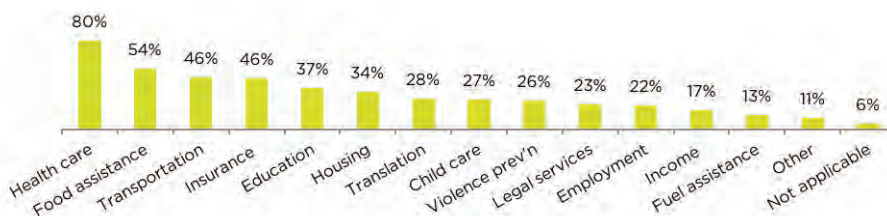
Health Issues



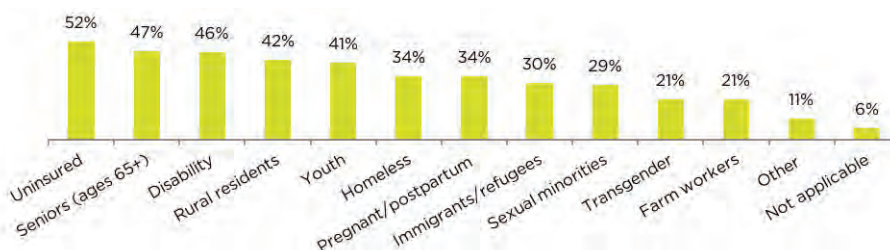
Relation to Clients



Resource Connections



Work with Specific Populations





APPENDICES

Appendix A.....NC Department of Health and Human Services
CHW Committee

Appendix B.....NC CHW Workgroups, Subcommittees
Members and Listening Session Participants

Appendix C.....References and Source Documents

APPENDIX A

NC Department of Health and Human Services CHW Committee

North Carolina Department of Health and Human Services CHW Committee Members and Meeting Dates

This group met every other month from October 2014 through June 2015. Their responsibilities included initiating and coordination of the NC CHW Program Inventory and April 2015 Stakeholder Meeting.

- Anna Boone.....Community Care of North Carolina
- Courtney Cantrell.....Mental Health, Developmental Disabilities, and Substance Abuse
- Jacquelyn Clymore.....Division of Public Health Epidemiology Section
- Elizabeth Freeman.....Office of Rural Health
- Nancy Henley.....Division of Medical Assistance
- Nicole MillerDivision of Aging and Adult Services
- Sharon NelsonChronic Disease and Injury Section -DPH
- Ruth Petersen.....Chronic Disease and Injury Section - DPH
- Belinda PettifordWomen and Children’s Health - DPH
- Holly Riddle.....Mental Health, Developmental Disabilities, and Substance Abuse
- Jill Rushing.....Chronic Disease and Injury Section - DPH

Meeting Dates

- October 14, 2014**
NC Division of Public Health
- December 3, 2014**
NC Division of Public Health
- December 15, 2014**
NC Division of Public Health
- March 2, 2015**
NC Division of Public Health
- April 7, 2015**
NC Division of Public Health
- June 5, 2015**
NC Division of Public Health



APPENDIX B

NC CHW Workgroups, Subcommittees Members and Listening Session Participants

North Carolina CHW Stakeholders, Participants, Workgroups and Subcommittee Members and Meeting Dates

NC CHW Stakeholder Participants and Meeting Dates

| | |
|-------------------------------|--|
| Griselda Alonso Rojas | El Pueblo, Inc. |
| Alice Ammerman | UNC Chapel Hill Health Promotion and Disease Prevention |
| Anna Boone..... | Community Care of North Carolina |
| Barbara Boyce..... | NC Community College System |
| Dorethea Brock..... | American Heart Association |
| Lori Carter-Edwards..... | UNC Chapel Hill Public Health Leadership Program |
| Jacqueline Cavadi..... | Easter Seals UCP North Carolina |
| Chris Collins..... | Office of Rural Health |
| Carolyn Crump..... | UNC Chapel Hill Healthy Solutions Team |
| Zoe Cummings..... | Office of Rural Health |
| Alexandra Dest..... | El Pueblo, Inc. |
| Dionne Dockery | Pitt County Health Department |
| Sharon Elliot Bynum* | Healing with CAARE, Inc. |
| Katie Eyes..... | Blue Cross Blue Shield of North Carolina Foundation |
| Tara Fields..... | Benchmarks, NC |
| Ed Fisher..... | UNC Chapel Hill Peers for Progress |
| Debby Futrell..... | AREA L Area Health Education Center |
| Heather Garrity | Coalition for Families in Lee County |
| Celita Graham..... | Wayne County Health Department |
| Sarah Gray | Columbus County Public Health Department |
| Gayle Harris..... | Durham County Public Health Department |
| Sherry Hay | UNC Chapel Hill Department of Family Medicine |
| Nancy Henley..... | Division of Medical Assistance |
| Sally Herndon | Tobacco Prevention and Control Branch - DPH |
| Fred Johnson..... | Duke University Health System |
| Mary Johnson Rockers..... | Office of Rural Health |
| Anna Jones..... | American Cancer Society |
| Maya Kiel | NC Area Health Education Center |
| Elizabeth Lambar Freeman..... | Community Care of North Carolina |
| Jennifer Leeman..... | UNC Chapel Hill Health Promotion and Disease Prevention |
| Ann Lefebvre | NC Area Health Education Center |
| Robert Letourneau | UNC Chapel Hill Healthy Solutions Team |
| Allison Lipscomb..... | NC Community Health Center Association |
| Beth Lovette | Appalachian Health District |

* Deceased - January 2017

Jan LoweryUNC Pembroke
 Norma MartiChildren and Youth Branch - DPH
 Tammie McleanCommunity Care of the Sandhills
 Nidu MenonBlue Cross Blue Shield -State Health Plan
 Patricia Morales.....Piedmont Health Services
 Rosa NavarroNC Community Health Center Association
 Debi Nelson.....Cancer Prevention and Control Branch - DPH
 Sharon NelsonChronic Disease and Injury Section - DPH
 Warren Newton.....NC Area Health Education Center
 Elaine OwensWake Area Health Education Center
 Ruth Petersen.....Chronic Disease and Injury Section - DPH
 Belinda PettifordWomen and Children’s Branch - DPH
 Joseph Pino.....South Eastern Area Health Education Center
 April ReeseCommunity and Clinical Connections for Prevention
 and Health Branch - DPH
 Holly RiddleDivision of Mental Health, Developmental Disabilities
 and Substance Abuse
 Margaret RobertonNC Community College System
 Phyllis Rocco.....Local Technical Assistance and Training Branch - DPH
 Sharon RhyneChronic Disease and Injury Section - DPH
 Judy RuffinWomen and Children’s Branch-DPH
 Jill Rushing.....Chronic Disease and Injury Section - DPH
 Anita Schambach.....Community Care of North Carolina
 Tish Singletary.....Chronic Disease and Injury Section - DPH
 Jean SellersUNC Chapel Hill Lineberger Cancer Institute
 Allen Smart.....Kate B. Reynolds Charitable Trust
 Glorina StallworthInjury and Violence Prevention Branch - DPH
 Bill Stewart.....Community Care of the Sandhills
 Stephanie Stewart.....Land of Sky Regional Council
 Jim Straight.....American Diabetes Association
 Karen Suess.....Carolina Collaborative Community Care
 Joyce Swetlick.....Tobacco Prevention and Control Branch - DPH
 Peggy TerhuneMonarch, Incorporated, Inc.
 Rachel Valentine.....Orange County Rape Crisis Center
 Sheree VodickaNorth Carolina Alliance of YMCAs
 Franklin WalkerNorth Carolina Medical Society
 Jennifer WeheCommunity Care of Western North Carolina
 Cornell Wright.....Office of Minority Health and Health
 Disparities - DPH
 Jacqueline Wynn.....NC Area Health Education Center
 Amanda Zabala.....Office of Minority Health and Health Disparities - DPH
 Adam ZolotorNC Institute of Medicine

April 29, 2015

American Cancer Society
 Raleigh, North Carolina
 9:00am-3:00pm

Sallie Allgood.....UNC Chapel Hill Health Promotion and Disease Prevention

Milton ButterworthBlue Ridge Community Health Services

Annie CarpenterCommunity Care of Western North Carolina

Laura Clark.....Edgecombe Community College

Ava Crawford.....Cancer Prevention and Control Branch - DPH

Zoe Cummings.....Office of Rural Health

David Ezzell.....Office of Emergency Medical Services - DHHS

Ed Fisher.....UNC Chapel Hill Peers for Progress

Debby Futrell.....Area L Area Health Education Center

Ana Luisa Gutierrez-LozanoEl Pueblo, Inc.

Gayle Harris.....Durham County Health Department

Sally HerndonTobacco Prevention and Control Branch - DPH

Balbina Cerro JahueyEl Pueblo, Inc.

Takeila Johnson.....Office of Minority Health and Health Disparities - DPH

Kristin Kearns.....Johnston County Public Health Department

Randy Kearns.....Mount Olive College

Carol Lucas.....UNC Greensboro

Norma MartiChildren and Youth Branch - DPH

Lori MeadsMonarch, Incorporated, Inc.

Rosa NavarroNC Community Health Center Association

Debi Nelson.....Cancer Prevention and Control Branch - DPH

Sharon Nelson.....Chronic Disease and Injury Section - DPH

Warren Newton.....NC Area Health Education Center

Ruth Petersen.....Chronic Disease and Injury Section - DPH

Joanne PierceDurham County Health Department

Alice Pollard.....NC Community Health Center Association

April ReeseCommunity and Clinical Connections for Prevention and Health Branch

Margaret RobertonNorth Carolina Community College System

Judy RuffinWomen and Children's Branch - DPH

Jill Rushing.....Chronic Disease and Injury Section - DPH

Jean SellersUNC Chapel Hill Lineberger Cancer Institute

Tish Singletary.....Chronic Disease and Injury Section - DPH

Lori Skinner-CampbellGoshen Medical Center

Karen Stanley.....Chronic Disease and Injury Section - DPH

Stephanie Stewart.....Land of Sky Regional Council

Pat TangUNC Chapel Hill Peers for Progress

Franklin WalkerNC Medical Society

Marti Wolf.....NC Community Health Center Association

Jacqueline Wynn.....NC Area Health Education Center

December 14, 2015

North Carolina Division of Public Health
 Six Forks Campus, Cardinal Room, Raleigh
 1:00pm-4:00pm

NC CHW Joint Workgroup Members and Meeting Dates

Sallie Allgood.....UNC Chapel Hill Health Promotion and
Disease Prevention

Griselda Alonzo-Rojas.....El Pueblo, Inc.

Alma AtkinsBuncombe County Department of Human Services

Kathey AveryAsheville Buncombe Institute of Parity Achievement

Erin YatesKate B. Reynolds Charitable Trust

Tuere' Bowles.....NC State University

Milton ButterworthBlue Ridge Community Health Services

Annie CarpenterCommunity Care of Western NC

Lori Carter-Edwards.....UNC Chapel Hill Public Health Leadership Program

Laura Clark.....Edgecombe Community College

Timmery Cook.....East Carolina University

Ava Crawford.....Cancer Prevention and Control Branch

Zoe Cummings.....Office of Rural Health

Ed Fisher.....UNC Chapel Hill Peers for Progress

Debby Futrell.....Area L Area Health Education Center

Je'Wana Grier-McEachinAsheville Buncombe Institute of Parity Achievement

Ana Luisa Gutierrez-LozanoEl Pueblo, Inc.

Gayle HarrisDurham County Health Department

Rochelle HowardOffice of Minority Health and Health Disparities

Maria Jimenez.....El Pueblo, Inc.

Fred Johnson.....Duke University Health System

Allison Lipscomb.....NC Community Health Center Association

Carol LucasUNC Greensboro

Norma MartiChildren and Youth Branch - DPH

Dawn Morrison.....East Carolina University

Rosa NavarroNC Community Health Center Association

Debi Nelson.....Cancer Prevention and Control Branch - DPH

Sharon Nelson.....Chronic Disease and Injury Section - DPH

Warren Newton.....NC Area Health Education Center

Ruth Petersen.....Chronic Disease and Injury Section - DPH

Joanne PierceDurham County Health Department

Jennifer Poore'Asheville Buncombe Institute of Parity Achievement

April ReeseCommunity and Clinical Connections for Prevention
and Health Branch

Margaret RobertonNC Community College System

Debbie RoysterDuke University Health System

Jill Rushing.....Chronic Disease and Injury Section - DPH

Tish Singletary.....Chronic Disease and Injury Section - DPH

Yvette SingletonAsheville Buncombe Institute of Parity Achievement

Lori Skinner-CampbellGoshen Medical Center

Karen Stanley.....Chronic Disease and Injury Section - DPH

Anna Stein.....Chronic Disease and Injury Section - DPH

Stephanie Stewart.....Land of Sky Regional Council

Pat Tang.....UNC Chapel Hill Peers for Progress

Franklin WalkerNC Medical Society

Melanie Watkins.....NC Community Health Center Association

Kenny WeatheringtonNC Community College System
Jacqueline Wynn.....NC Area Health Education Center

February 12, 2016

North Carolina Division of Public Health
Six Forks Campus, Cardinal Room, Raleigh
10:00am-2:00pm

August 1, 2016

North Carolina Division of Public Health
Six Forks Campus, Cardinal Room, Raleigh
1:00pm-5:00pm

September 14, 2016

North Carolina Medical Society
222 North Person Street, Raleigh
11:00am-3:30pm

**NC CHW Core Competencies and Curriculum Workgroup Members
and Meeting Dates**

Christina AllenMonarch, Incorporated, Inc.
Sallie Allgood.....UNC Chapel Hill Health Promotion and
Disease Prevention
Alma AtkinsBuncombe County Human Services
Kathey AveryAsheville Buncombe Institute of
Parity Achievement
Erin YatesKate B. Reynolds Charitable Trust
Tuere' Bowles.....NC State University
Lori Carter-Edwards*UNC Chapel Hill Public Health Leadership Program
Laura Clark.....Edgecombe Community College
Vicki Deem.....Chronic Disease and Injury Section - DPH
Gayle HarrisDurham County Health Department
Cynthia HerndonChronic Disease and Injury Section - DPH
Carol Lucas*UNC Greensboro
Dawn Morriston.....East Carolina University
Debi NelsonCancer Prevention and Control Branch - DPH
Jennifer Poore'Asheville Buncombe Institute of Parity Achievement
Debbie RoysterDuke University Health System
Jill Rushing.....Chronic Disease and Injury Section - DPH
Tish Singletary.....Chronic Disease and Injury Section - DPH
Stephanie Stewart*Land of Sky Regional Council
Melanie Watkins.....NC Community Health Center Association
Sherry WrightChronic Disease and Injury Section - DPH
Jacqueline Wynn.....NC Area Health Education

**Indicates Co-Chairs*

March 10, 2016

University of North Carolina - Greensboro
10:00am-3:00pm

April 13, 2016

Hemphill Public Library
2301 West Vandalia Road, Greensboro
10:00am-3:00pm

May 12, 2016

Blue Jeans Meeting Platform
10:00am-2:00pm

June 10, 2016

Blue Jeans Meeting Platform
10:00am-3pm

July 15, 2016

Blue Jeans Meeting Platform
10:00am-3:00pm

August 29, 2017

Conference Call
10:00am-11:00am

September 26, 2017

North Carolina Division of Public Health
Six Forks Campus, Robin Room, Raleigh
10:00am-2:00pm

**NC CHW Certification Requirements and Process Workgroup
Members and Meetings Dates**

- Teretha Bell.....NC Community College System
- Milton Butterworth *Blue Ridge Community Health Services
- Annie CarpenterCommunity Care of Western North Carolina
- Ava Crawford.....Cancer Prevention and Control Branch - DPH
- Zoe Cummings.....Office of Rural Health
- Ed Fisher.....UNC Chapel Hill Peers for Progress
- Debby Futrell.....Area L Area Health Education Center
- Balbina Cerro JahueyEl Pueblo, Inc.
- Fred Johnson.....Duke University Health System
- Je’Wana Grier-McEachinAsheville Buncombe Institute of Parity Achievement
- Ana Luisa Gutierrez-LozanoEl Pueblo, Inc.
- Carol Lucas.....UNC Greensboro
- Norma MartiChildren and Youth Branch - DPH
- Rosa NavarroNC Community Health Center Association
- Sharon NelsonChronic Disease and Injury Section - DPH
- Warren Newton *NC Area Health Education Center
- Joanne Pierce *Durham County Health Department
- Ruth Petersen.....Chronic Disease and Injury Section - DPH
- April ReeseCommunity and Clinical Connections for Prevention
and Health Branch
- Margaret RobertonNC Community College System
- Debbie RoysterDuke University Health Systems
- Jill Rushing.....Chronic Disease and Injury Section - DPH
- Tish Singletary.....Chronic Disease and Injury Section - DPH
- Yvette SingletonAsheville Buncombe Institute of Parity Achievement
- Lori Skinner-CampbellGoshen Medical Center
- Stephanie Stewart.....Land of Sky Regional Council
- Pat Tang.....UNC Chapel Hill Peers for Progress

Franklin WalkerNC Medical Society
Kenny WeatheringtonNC Community College System

**Indicates Co-chairs*

April 4, 2016

North Carolina Division of Public Health
Six Forks Campus, Cardinal Room, Raleigh
1:00pm-5:00pm

May 10, 2016

North Carolina Division of Medical Assistance
Six Forks Campus, Conference Room 2A-B, Raleigh
8:00am-12:00pm

July 27, 2016

North Carolina Medical Society
222 North Person Street, Raleigh
11:00am-3:30pm

August 26, 2016

Blue Jeans Meeting Platform
10:00am-12:00pm

August 30, 2016

North Carolina Division of Public Health
Six Forks Campus, Robin Room, Raleigh
8:30am-11:00am

North Carolina Advisory Team Members and Meeting Dates

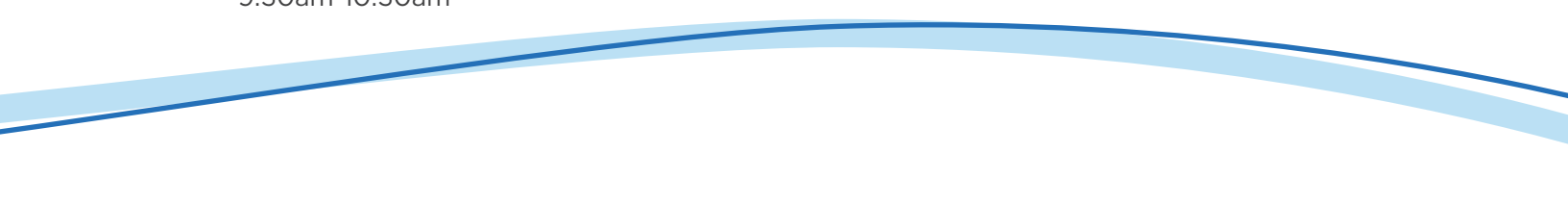
Milton ButterworthBlue Ridge Community Health Services
Lori Carter-Edwards.....UNC Chapel Hill Public Health Leadership Program
Ed Fisher.....UNC Chapel Hill Peers for Progress
Je’Wana Grier-McEachinAsheville Buncombe Institute of Parity Achievement
Carol Lucas.....UNC Greensboro
Norma MartiChildren and Youth Branch - DPH
Dawn Morriston.....East Carolina University
Rosa NavarroNC Community Health Center Association
Sharon NelsonChronic Disease and Injury Section - DPH
Warren Newton.....NC Area Health Education
Ruth Petersen.....Chronic Disease and Injury Section - DPH
Joanne PierceDurham County Health Department
Lori Skinner-CampbellGoshen Medical Center
Tish Singletary.....Chronic Disease and Injury Section - DPH
Anna Stein.....Chronic Disease and Injury Section - DPH

May 24, 2016

Conference Call
2:00pm-3:00pm

June 21, 2016

Conference Call
9:30am-10:30am



July 28, 2016
Conference Call
4:00pm-5:00pm

August 16, 2016
Blues Jeans Meeting Platform
8:30am-10:00am

August 22, 2016
Blue Jeans Meeting Platform
1:00pm-4:30pm

NC CHW Listening Session Participants

Richmond County

Richmond Community College
May 2, 2017

Mary BetheaCommunity Care of the Sandhills
Allison CampbellRichmond County Health Department
Sabrina LocklearRobeson Healthcare Corporation
Kimberly Mack.....Robeson Healthcare Corporation
Norma MartiNorth Carolina Division of Public Health
Nancy PorterRichmond County Health Department
April ReeseNorth Carolina Division of Public Health
Jill Rushing.....North Carolina Division of Public Health
Tish Singletary.....North Carolina Division of Public Health
Karen Stanley.....North Carolina Division of Public Health
Cheryl Speight.....Richmond County Health Department
Kelsey WhiteUNC Greensboro Center for New North Carolinians

Lincoln County

Lincoln County Senior Center
May 9, 2017

Donyel Barber.....Gaston Family Health Center
Honey Estrada.....Catawba Valley Medical Center
Adriana Gonzalez.....Gaston Family Health Center
Emily KillianCatawba County Public Health
Krystal MayberryGaston Family Health Services
Kimberly MetzlerAccessCare
Sharon NelsonNorth Carolina Division of Public Health
Jill Rushing.....North Carolina Division of Public Health
Kandyce Schofield.....Charlotte AHEC
Tish Singletary.....North Carolina Division of Public Health
Karen Stanley.....North Carolina Division of Public Health
Susan VaudreuilAccessCare

Wilkes County

Wilkes County Agricultural Center
May 16, 2017

Kimberly GarnerAppHealthCare
Debbie Nicholson.....Wilkes County Health Department
Alexandra Noriega.....High Country Community Health

Jesus Padilla.....Ashe Memorial Hospital Farmworker Program
 Jill Rushing.....North Carolina Division of Public Health
 Renee Rutherford.....Wilkes FaithHealth
 Tish Singletary.....North Carolina Division of Public Health
 Karen Stanley.....North Carolina Division of Public Health
 Anna Stein.....North Carolina Division of Public Health
 Rachel WillardWilkes County Health Department

Nash County

Area L AHEC

June 5, 2017

Sallie Allgood.....University of North Carolina Chapel Hill
 Marvis DancyEdgecombe Community Member
 Dorothy Davis.....Community Enrichment Organization
 Brenda EdwardsConetoe Family Life Center
 James Farmer.....St. James Temple MBC
 Debby Futrell.....Area L Area Health Education Center
 Ricardo Garcia.....Rural Health Group
 Pat Harris.....Saving Hearts and Hands
 Denise Harrison-Johnson.....Community Enrichment Organization
 Derrick HaskinsFoundation for Health Leadership and Innovation
 Carolyn HemricNorth Carolina Division of Public Health
 Marian Jenkins.....Community Enrichment Organization
 Rosa Joyner Steele.....Conetoe Family Life Center
 Liz Lord.....Harrison YMCA
 Norma MartiNorth Carolina Division of Public Health
 Alyssa Matthews.....Harrison YMCA
 Virginia McClary.....Northampton County Health Department
 Jackie MetivierBilingual Communications
 Yasmin MetivierBilingual Communications
 Cynthia Pittman.....Edgecombe Community Member
 Deneen RobbinsRoanoke Chowan Community Health Center
 Rotunda Rush.....From Start to Finish Counseling Services
 Jill Rushing.....North Carolina Division of Public Health
 Alice SchenallArea L Area Health Education Center
 Renee SchoolfieldRoanoke Chowan Community Health Center
 Gwen ShawEdgecombe County Health Department
 Marica SimmsProject Momentum, Inc.
 Tish Singletary.....North Carolina Division of Public Health
 Gloristine SmithEdgecombe County Health Department
 Karen Stanley.....North Carolina Division of Public Health
 Doris StithCommunity Enrichment Organization
 Gwenetta Themes.....Edgecombe County Health Department
 Victoria ViveretteUNC Eshelman School of Pharmacy
 Merdikae Williams.....Conetoe Family Life Center
 Erin YatesKate B. Reynolds Charitable Trust
 Amanda YoungThe Institute for Advanced Learning and Research

Buncombe County

YMCA Mission at Pardee Campus

June 19, 2017

Maggie AdamsMountain Area Health Education Center
Kathey AveryAsheville Buncombe Institute of Parity Achievement
Atiziri Barboza.....Blue Ridge Community Health Services
Annie CarpenterCommunity Care of Western North Carolina
Yessican ChavezBlue Ridge Community Health Services
Amanda GarlandCommunity Care of Western North Carolina
Lance GollierBlue Ridge Community Health Services
Je’Wana Grier-McEachinAsheville Buncombe Institute of Parity Achievement
Megan Hauser.....Haywood County Health and Human Services
Shaneka HaynesWestern Carolina Medical Society
Beth Hyatt.....Transylvania Public Health
Justin JonesCommunity Care of Western North Carolina
Sherry NotoCommunity Care of Western North Carolina
Emma Olson.....North Carolina Health and Wellness Center at
UNC Asheville
Jim Pitts.....Asheville Buncombe Institute of Parity Achievement
Sharon Pitts.....Asheville Buncombe Institute of Parity Achievement
Ruth RamirezThe Free Clinics
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June 27, 2017

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APPENDIX C

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LATCH (Local Access To Coordinated Health Care)

Durham Diabetes Coalition

El Pueblo

North Carolina Community Health Center Association

Office of Rural Health, NC Farmworker Health Program

Peers for Progress, Gillings School of Global Public Health, UNC-Chapel Hill



I FEEL EXTREMELY PROUD WHEN I HEAR OUR CLIENTS TELL MY COWORKER AND I “THANK YOU FOR BEING THERE” OR “YOU JUST DON’T KNOW HOW THIS FOOD BOX HELPS ME, ESPECIALLY WHEN MY FOOD STAMP IS GONE.”

- Jennifer Poore, CHW





The **top third of health issues** of CHW clients include diabetes, heart disease, mental health, and obesity.



The **top ways CHWs relate to their clients** include speaking the same language, having the same race/ethnicity, and attending the same church.



The highest areas of need that **CHWs connect their clients** to resources include health care, food assistance, transportation, insurance, and education.



The top three **populations that CHWs work with** are the uninsured, seniors (ages 65+), and people with a disability.

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