The North Carolina Community Health Worker and Support Services Programs

PROMOTING SAFE QUARANTINE AND ISOLATION FOR COVID-19 IN MARGINALIZED POPULATIONS

CASE STUDIES ON CARE RESOURCE COORDINATION IN COVID-19

Outreach workers at a community food distribution event hosted by La Semilla, a non-profit organization serving the Hispanic/Latinx community working with CHW vendor Curamericas Global in Durham, North Carolina and the surrounding area. *Photo courtesy of Curamericas*

This case study is part of a PIH series on care resource coordination for COVID-19. Care resource coordination facilitates the social, material, and other supports that COVID-19 cases and contacts need to safely isolate or quarantine. Today, millions in the US struggle to meet basic needs and not everyone can quarantine and isolate equally. Resource coordination is an essential part of an equitable pandemic response and can be applied far beyond COVID-19.

Each case study in this series is an example of how resource coordination programs have been designed and rolled out in a specific context and is written in collaboration with the program. Implementers reflect on successes, challenges, and share key lessons learned from their experience. There is some variation in terminology across case studies in the series, reflecting each program's unique work. For example, "care resource coordinators," "resource navigators," and "community health workers" can all fulfill a similar function: identifying needs and coordinating resource provision.

In **North Carolina**, resource coordination is done by the NC **Community Health Worker (CHW) Program** and **Support Services Program (SSP).** This case study describes the programs' operations, then analyzes key factors to their success, as well as challenges and lessons learned. These programs are a model for jurisdictions seeking to support isolation and quarantine in partnership with community-based organizations (CBOs). **North Carolina's resource coordination is unique in its use of multiple interrelated programs, direct financing of social supports, and support of COVID-19 cases and contacts without directly integrating with contact tracing systems.**

BACKGROUND

North Carolina has largely avoided becoming one of the hardest-hit states in the United States COVID-19 pandemic. As of March 2021, the state ranked 36th for most cases per capita and 40th for most deaths per capita (The New York Times, 2021). This case study outlines one aspect of North Carolina's COVID-19 response (*Box 1*) that may have helped slow the spread of the virus to reduce cases and deaths: promoting safe quarantine and isolation for COVID-19 in marginalized populations.

North Carolina is the 9th most populated state in the U.S. with a 2019 population of approximately 10.5 million people (United States Census Bureau, 2021), including 2.2 million residents living in rural areas. The state's residents are 71% white, 22% African-American, 10% Latinx of any race, 3% Asian-American, and 1.6% Native American (United States Census Bureau, 2019). According to the North Carolina Department of Commerce, the state also welcomes approximately 75,000 migrant and seasonal farmworkers each year, the majority of whom are Hispanic, and employs over 30,000 poultry/meatpacking workers (U.S. Bureau of Labor Statistics, 2019).

As the COVID-19 pandemic spread, the North Carolina Department of Health and Human Services (NC DHHS) mobilized its decentralized public health system, which includes 86 local health departments (LHDs) covering NC's 100 counties. NC DHHS mapped out a four pillar response strategy (*Figure 1*): First, **prevention**, which initially focused on mask wearing, hand washing, and social distancing and were shared via social media, videos, and flyers. Second, **testing**: NC DHHS developed a statewide testing infrastructure that expanded over time from testing at LHDs and healthcare facilities to a statewide network of testing providers and events. Third, **contract tracing**: NC DHHS contracted with Community Care of North Carolina (CCNC) to provide contact tracing surge capacity through the **Carolina Community Tracing Collaborative** (CCTC) in partnership with NC Area Health Education Centers (AHEC), who coordinate training. Contact tracing implementation and structure in each county is ultimately up to each LHD, though all partner with CCTC to increase contact tracing capacity. And fourth, **supported quarantine and isolation**, the focus of this case study.

BOX 1

PROGRAM OVERVIEW

CONTACT TRACING: Decentralized; done by Local Health Departments (LHDs) and the Carolina Community Tracing Collaborative (CCTC)

CCTC CONTACT TRACERS: 850 (October 2020) – 1,600 (January 2021)

CARE RESOURCE COORDINATION MODEL: 435 CHWs employed in a CBO/healthcare organization-based model with 7 vendors in 55 counties; not directly linked to contact tracing but with multiple points of entry. Also includes **direct supports** delivered by the Support Services Program (SSP) through 4 vendors in 29 of the 55 CHW counties

IT PLATFORM: NCCARE360

PROGRAM FUNDING:
- CHW: Aug-Dec 2020 $14.7M CARES Act, Jan–June 2021 $16.0M State and CDC funds
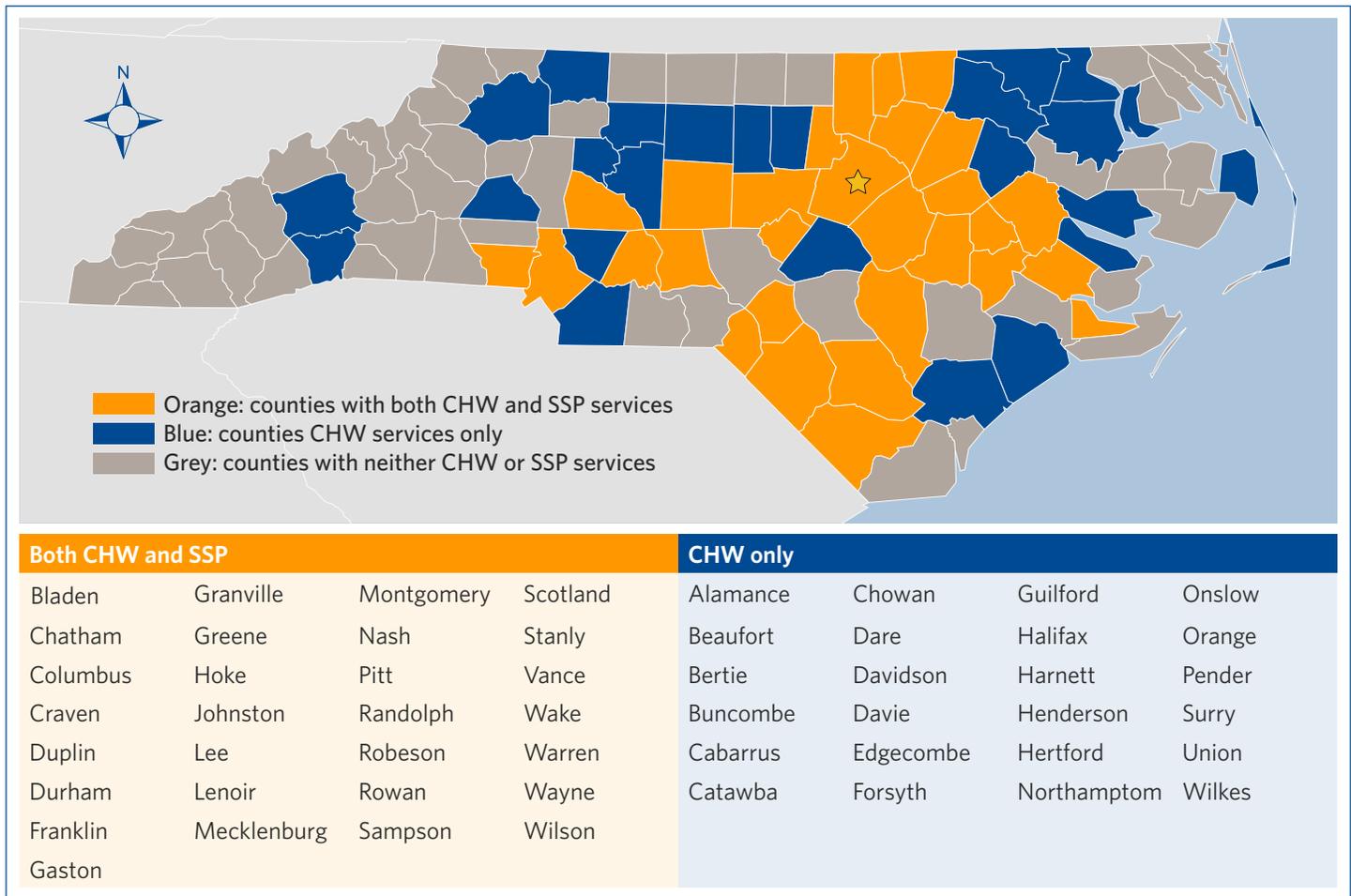- SSP: Sept-Dec 2020 $22.7M CARES Act, Jan–March 2021 $15.5M State funds

TOP 3 SERVICE NEEDS: Food assistance (34%), financial relief (29%), housing and shelter (10%)

PROGRAM IMPACT: As of March 2021:
- the CHW program served over **385,000 individuals** and made **121,000 referrals** to short- and long-term resource supports
- the Support Services Program delivered over **171,000 services** to **38,000 households**
- almost all of these households received food assistance, PPE, and cleaning supplies and 70% received financial relief payments
- of 236 surveyed SSP recipients, **88%** reported that they were **able to fully quarantine and isolate** because of the services provided through SSP

FIGURE 1: The four pillars of NC DHHS' COVID-19 Program Response

Prevention	Testing	Contact Tracing	Wraparound Services
Masking, Social Distancing, Handwashing, and Vaccination	Know Who Has COVID-19	Know Who Has Been Exposed	Support People to Stay Home

Prioritizing Historically Marginalized Populations

FIGURE 2: County Distribution of Community Health Worker and Support Services Programs

Orange: counties with both CHW and SSP services
Blue: counties CHW services only
Grey: counties with neither CHW or SSP services

Both CHW and SSP				CHW only			
Bladen	Granville	Montgomery	Scotland	Alamance	Chowan	Guilford	Onslow
Chatham	Greene	Nash	Stanly	Beaufort	Dare	Halifax	Orange
Columbus	Hoke	Pitt	Vance	Bertie	Davidson	Harnett	Pender
Craven	Johnston	Randolph	Wake	Buncombe	Davie	Henderson	Surry
Duplin	Lee	Robeson	Warren	Cabarrus	Edgecombe	Hertford	Union
Durham	Lenoir	Rowan	Wayne	Catawba	Forsyth	Northamptom	Wilkes
Franklin	Mecklenburg	Sampson	Wilson				
Gaston							

The need for supported quarantine and isolation was apparent early in the pandemic and became a clear priority for NC DHHS. The first surge of COVID-19 in June and July 2020 disproportionately affected historically marginalized populations across the state, including and Latinx communities who were more likely to be diagnosed with COVID-19 than white residents (The COVID Tracking Project, 2021), (NCDHHS COVID-19 Response, 2021). Many LHDs connected individuals to social support resources as they were able, but were overwhelmed as needs increased during the surge. NC DHHS mobilized a cross-pillar response to address these inequities, building upon an existing framework termed **"buying health"** to address nonmedical drivers of health to create an ecosystem of support in responding to the pandemic. Initially leveraging CARES Act funding, NC DHHS developed a resource coordination program to slow the spread of COVID-19 by providing resources to help people quarantine or isolate. The model has two main components linked by a technology platform: a Community Health Worker (CHW) program and a complementary Support Services Program (SSP), with CHWs acting as resource navigators and SSP organizations delivering an array of social supports. NC DHHS also operates a non-congregate shelter program for individuals who need a safe space to quarantine or isolate.

PROGRAM MODEL

A STATE-FUNDED, DECENTRALIZED CHW AND SUPPORT SERVICES PROGRAM

To rapidly stand up a resource coordination program that effectively reaches vulnerable populations, NC DHHS strategically layered interventions that built on the state's successful, pre-existing investments and work. For example, the state drew on lessons from its ongoing **Healthy Opportunities Pilots** which address nonmedical drivers of health and combine identification of social support needs with dedicated financing to address them. NC also prioritized a growing trusted and culturally competent CHW workforce with recognized success in reaching marginalized communities and leveraged a statewide technology platform called NCCARE360 to facilitate referrals to social supports.

NC CHW COVID-19 PROGRAM

North Carolina has long been developing a statewide Community Health Worker Initiative and building a sustainable infrastructure to support CHWs. In 2018, NC DHHS Office of Rural Health (ORH) issued a **report** and recommendations for an infrastructure to support CHWs, then piloted a CHW curriculum at six community colleges in early 2020. When ORH saw the impact of COVID-19 on historically marginalized populations, it recognized the benefit CHWs could have as trusted members of those communities. ORH designed the NC CHW COVID-19 Program in which CHWs connect North Carolinians affected by the pandemic with necessary services and supports. From August through December 2020, the program utilized $14.7 million in federal CARES Act funding to hire and manage over 400 CHWs and over 50 outreach workers through seven CHW organizations in 55 targeted counties (with an additional $16 million in State/CDC funding allocated for January-June 2021).

Counties were selected based on impact of COVID-19 and measures of vulnerability (*Figure 2* on previous page). NC DHHS issued an RFP for vendors (CBOs and healthcare organizations) and selected organizations based on technical management capability (including the ability to hire and train a culturally and linguistically diverse CHW workforce, ability to connect to community resources, and use of technology for referrals), prior performance with an emphasis on organizations already employing CHWs, and total cost to the state (for a list of contracted organizations see *Appendix A*). To ensure a living wage, DHHS contracts stipulate a $20 hourly rate for CHWs paid by vendors. While many of the contracted organizations already utilized CHWs, most of the CHWs employed as part of this program are new hires. CHW organizations leveraged job descriptions tailored specifically to their communities, like the example from a CHW organization in Eastern North Carolina (*Appendix B*).

COVID-19 SUPPORT SERVICES PROGRAM

The COVID-19 Support Services Program (SSP), funded with $38.2 million dollars ($22.7 million CARES Act from September-December 2020, $15.5 million State funding for January-March 2021), complements the NC CHW COVID-19 Program by providing direct financial, material, and other supports in 29 of the 55 counties. While CHWs act as resource navigators to identify needs and refer individuals to social supports, SSP directly funds and delivers vital supports for safe isolation and quarantine. The Department strategically funds the most necessary services in the neediest parts of the state with the highest case rates of COVID-19. NC DHHS conducted a gap analysis and surveyed community members to identify the services

needed to effectively isolate and quarantine. The most requested types of assistance were home-delivered meals and flexible financial relief payments to offset lost wages or spend on child care or medical bills. The Department covers these services and others for eligible individuals and families (*Box 2*). SSP is administered through vendors (CBOs and community healthcare organizations) selected based on their relationships with the local community and their ability to provide support services to historically marginalized populations, manage invoicing and reimbursement, meet reporting requirements, and provide services in the hardest hit counties (for a list of contracted vendors see *Appendix A*).

BOX 2

SSP SERVICES AND ELIGIBILITY

Services Delivered

1) Nutrition assistance, including home-delivered meals and food boxes; **2)** A one-time COVID-19 relief payment to help supplement lost wages or the inability to look for work while in isolation/quarantine ($400 for individuals and $800 for families), to be used on basic living expenses; **3)** Private transportation to/from testing sites, medical visits, vaccination sites (new in 2021), and to acquire food; **4)** Medication delivery (with prescription); **5)** COVID-related over-the-counter supplies (e.g. face masks, hand sanitizers, thermometers, and cleaning supplies); **6)** Access to primary health care telehealth services to manage COVID recovery, in conjunction with the CHW program.

Eligibility

Individuals must live in one of the 29 Support Services counties and have been directed by a health care professional, health department, or contact tracer to quarantine or isolate due to one of the following reasons:

a) Tested positive for COVID-19; **b)** Taken a COVID-19 test and is waiting for the results; **c)** Been exposed to someone who has tested positive for COVID-19; **d)** As a precautionary measure because the individual is in a high-risk group (per CDC guidelines available online here: **People at Increased Risk**)

PROGRAM OPERATIONS

SCREENING AND REFERRAL PROCESSES

While the CHW and Support Services Programs were intended to integrate with contact tracing, a legal interpretation of communicable disease law prevents case investigators (CIs) and contact tracers (CTs) from directly referring cases or contacts to CHWs. CIs and CTs still screen individuals for the ability to safely quarantine or isolate via scripts suggested by NC DHHS and adapted at the LHD level. When a need is identified, CIs and CTs inform individuals about the CHW program, provide the CHW program contact information, and encourage individuals to reach out themselves. North Carolinians can also be referred to CHWs via other pathways: self-referral, CHW outreach at testing events and food drives, referral from CBOs (including SSP vendors), and referral from healthcare providers.

After receiving a referral, CHWs screen individuals for needs during quarantine or isolation, as well as for long-term support needs. Although not initially standardized, CHWs are encouraged to assess for needs across multiple domains: shelter, financial security, food security, medication assistance, COVID-related supplies, transportation assistance, access to primary care, and safety. Utilization of standardized screening for social determinants of health in NCCARE360 (*Appendix C*) is planned for Spring 2021. In counties with SSP, CHWs also

complete a screening and **attestation form** to confirm financial or resource need and program eligibility, which the individual then signs (electronically, verbally, or in-person). CHW counties without SSP refer to local organizations who provide similar resources, especially food support.

Once a need is identified, the CHW uses North Carolina's NCCARE360 system (*Box 3*) to electronically refer clients to resources (including to SSP service vendors), communicate across organizations, securely share client information, and track referral outcomes. CHWs also refer to local resources, other emergency and long-term state-level programs, and acute and primary care. State-level emergency programs during the pandemic include non-congregate shelter referral, utility assistance, pandemic electronic benefit transfer for families with children, and rent/mortgage assistance. Long-term referrals include SNAP/WIC benefits, housing assistance, job placement, disability benefits, and health insurance.

In counties without CHW or SSP services, employees within the LHDs facilitate resource coordination when able. They may refer to state-level emergency programs and local organizations to meet immediate needs (e.g., food pantries) but typically do not have the capacity to facilitate long-term referrals.

FOLLOW UP

SSP vendors provide the identified services for the duration of quarantine or isolation. With the exception of financial relief, all services may be recurring as needed. CHWs follow

up with individuals at the end of quarantine or isolation to ensure that needs are met and continue to support long-term referrals until those are successfully completed.

BOX 3
NCCARE360

NCCARE360 is a statewide, coordinated care network developed by Unite Us. The platform aims to unite health care and human services organizations with a shared technology. NCCARE360 allows CHWs to make referrals electronically, communicate with other organizations, securely share client information, and track referral outcomes. Within the NC CHW COVID-19 Program, CHWs use NCCARE360 to search for service organizations, then refer individuals for services, including those within SSP.

Almost all vendors within the CHW Program and SSP were rapidly onboarded to NCCARE360 with staff training and continued technical support from Unite Us. While NCCARE360 covers all 100 of North Carolina's counties, the state is currently working on increasing the number of CBOs in each county that can make electronic referrals. NCCARE360 has a community engagement team working with CBOs, health plans, health systems, and government agencies to create a statewide coordinated network and to train and onboard partners to expand its reach. NCCARE360 allows monitoring and evaluation of referral processes and outcomes.

NCCARE360 is the result of a strong public-private partnership between NC DHHS and the Foundation for Health Leadership & Innovation. The NCCARE360 implementation team includes United Way of NC/2-1-1, Expound Decision Systems, and Unite Us.

MONITORING AND EVALUATION

Regular monitoring and evaluation ensures that the CHW and Support Services Programs incorporate data to inform program decisions. NCCARE360 tracks service referrals inside and outside of SSP. Key metrics include the number of unduplicated individuals served, number of referrals, type of referral or service provided, and percentage of referrals completed and closed. Metrics are analyzed on a weekly basis, with more in-depth analysis occurring monthly. Data is disaggregated by county, race/ethnicity, and gender with monthly analysis to ensure equity and guide changes.

Weekly individual and program-wide meetings with CHW and SSP organizations allow incorporation of feedback (including into other DHHS COVID-19 response pillars), troubleshooting, and vendor alignment. Informal listening sessions with CHWs provide additional feedback to influence programmatic changes. For example, community feedback and data analysis allowed the program to identify a greater need for bilingual Spanish-speaking CHWs, resulting in increased hiring and subcontracting to expand program reach and ensure equity. Vendor feedback found that attestation form signature requirements were not a barrier to accessing resources. Feedback from CHWs has helped to inform program changes in testing and contact tracing.

ENABLERS OF SUCCESS

CHW and Support Services Programs were rapidly developed and have accomplished a great deal in a short period of time. Five key decisions and strategies stand out as essential to the programs' success:

1. **Layering initiatives to build an ecosystem of support:** To successfully support individuals and families, NC DHHS' holistic response layered multiple interrelated initiatives: 1) meeting individuals where they are in the community by relying on trusted local partners; 2) leveraging a technology infrastructure supported by a compassionate and skilled workforce to manage a consistent, closed-loop screening and referral system; and 3) funding provision of direct social supports to those most in need. The combination of these interventions created an "ecosystem" of support and ensured that referrals for social supports were backed by funding for those resources and that technology solutions were accompanied by a person-centered workforce. In addition, it maximized impact by combining different funding streams into interlinked programs and allowing common metrics to promote information sharing and programmatic improvement. The success of this approach is evident by the high percentage of referrals fulfilled by SSP, with almost all referrals receiving food assistance and 70% receiving financial relief. These fulfilment rates would not have been possible without directly funded social supports.

2. **Building on local capacity, trusted partners, and longstanding relationships:** Trusted local organizations are an essential component of the NC DHHS response. Local social service and health organizations earned the trust of communities over years, positioning them to immediately reach vulnerable populations. DHHS selected CHW and SSP organizations with longstanding ties to specific communities, but some geographic areas were left with gaps in coverage. The program found further success by allowing vendors to subcontract to additional CBOs rooted in communities where initial reach was limited. Partnerships between CBOs and communities facilitated hyperlocal outreach and increased awareness and utilization of the CHW and Support Services Programs.

3. **Prioritizing historically marginalized populations in program design, implementation, and ongoing monitoring:** The North Carolina resource coordination programs were established in response to a disproportionate impact of the first COVID-19 surge among historically marginalized populations. Prioritization of these communities is documented in contracts and all program guidance. Community partners include CBOs who often both serve and are staffed by members of historically marginalized populations, so the vendors linguistically and culturally resemble the communities they serve. NC DHHS required vendors to hire multilingual CHWs and translated materials to enable clear communication across diverse communities. At the height of the program when all CHW organizations were fully staffed and operational, of the 435 employed CHWs, 91% identified as African American or Hispanic/Latinx, 25% spoke Spanish and 85% identified as women. At the individual client level, the program reduced barriers to entry by broadening eligibility for services (e.g., no ID requirement). A working group advising the NC DHHS response for historically marginalized populations ensured that issues were quickly raised and feedback incorporated. Monitoring and evaluation with a focus on disaggregating data by race and ethnicity facilitated program responsiveness to better serve marginalized communities.

4. **Promoting communication and knowledge sharing:** Communication harmonizes and strengthens two decentralized programs. Frequent one-on-one and program-wide vendor meetings align practices and address questions. Given the two-program structure, communications between CHW and SSP vendors are essential. To facilitate this, CHWs join SSP calls to understand barriers and collectively develop solutions. Additionally, perspectives of program staff—from finance to front-line CHWs—are valued and used to address issues across the full scope of the program. Best practices and frequently asked question documents are generated and shared across partners.

5. **Embracing growth through monitoring, evaluation, and adaptation:** Solicitation and incorporation of feedback help the program constantly improve. In addition to qualitative feedback, use of a standardized reporting mechanism for services provided and money spent allows for straightforward and timely data monitoring. Analysis of race/ethnicity data across the program allows the program to identify populations needing increased outreach and has already resulted in subcontracting to additional CBOs embedded within those communities.

ADDRESSING CHALLENGES

All programs face challenges, particularly those started during a crisis. North Carolina addressed challenges with innovation, partnerships, flexibility, and communication. Solutions and lessons learned include:

1. **When CBO capacity varies, adapt protocols, provide technical assistance, and support diverse outreach:** While CBOs have the strength of deep integration into their community, smaller CBOs often lack the capacity for larger organizational endeavors. North Carolina saw these capacity challenges play out across four major areas: financing, technology access, language accessibility, and population reach.

    Financing: North Carolina generally finances state contracts on an invoice reimbursement basis. While the state provided advances for start-up costs, the reimbursement-based model still posed a major hurdle to small CBOs with limited reserve funds. Within two months of the program running and slow reimbursement from the state, several CBOs were at risk of running out of money. This resulted in delaying services to eligible residents and a backlog of referrals. After recognizing this issue for the vendors, NC DHHS made an exception to their usual business practices and gave vendors up to 50% advances for their contracts.

    Technology Access: The cornerstone of the NC resource coordination efforts was the expedited roll-out of NCCARE360 as a referral hub to social supports (*Box 3*). CHW and SSP vendors had variable levels of technology use in their existing operations, and some lacked the technological expertise necessary to easily transition to this fully electronic referral method. Exclusion of less tech savvy vendors at the start of the program would have worsened inequity and was deliberately avoided. Instead, DHHS and Unite Us quickly recognized these technology barriers and prioritized onboarding and training all program vendors on the platform and electronic referrals. Though this proved useful, some organizations still

lacked the level of technology integration necessary to operate fully within this portal, particularly smaller CBOs that vendors subcontracted to. Additionally, when the CHW and SSP programs launched, several of the service organizations receiving referrals did not use NCCARE360. This resulted in higher rate of referrals outside of NCCARE360, which posed greater barriers to follow-up (e.g., frequent phone calls) and limited data tracking and follow-up by referring organizations. To address these challenges, training and technical assistance are ongoing and supported by NCCARE360 community engagement teams, as well as the NC Office of Rural Health's Health Information Technology team. Together, these teams became the designated support team. Ongoing efforts will embed technology support within these organizations to standardize the response and build local capacity.

Additionally, CHWs used hot spots, tablets and computers to safely connect community members with healthcare and other resources. During the pandemic, some community members lacked the infrastructure to enroll in or access valuable resources, or were hesitant to utilize telehealth and other technologies. In these cases, CHWs brought the technology to the community.

Language Accessibility: To prioritize and reach historically marginalized populations, NC DHHS knew a multilingual response was needed. A CHW and SSP workforce that was able to linguistically and culturally meet the needs of their clients was required by contract; however, practical implementation of this proved more challenging. While many vendors had deep ties to African American communities, many (but not all) vendors had limited bilingual, and specifically Spanish-speaking, staff (Spanish is the

second most common language in North Carolina). Furthermore, rapidly-developed program documents were created in English. To address these issues, CHW and SSP vendors were encouraged to hire and train more bilingual staff, translation services were encouraged and reimbursed, and translation of essential documents was prioritized. Though these efforts have improved the cultural responsiveness of the program, NCCARE360 remains only in English, which can be a limiting factor for employees proficient in spoken but not written English.

Population Reach: While contracted vendors were generally well-established in local communities, assigned coverage areas did not align perfectly with their areas of expertise. The need to reach diverse marginalized populations across multiple counties resulted in initial coverage gaps. As above, subcontracting to local, trusted organizations was successful in reaching some additional communities. This subcontracting model was not standardized and saw variable implementation across vendors. Additionally, mistrust of government-sponsored programs, including fear of government tracking and public charge, was identified as a barrier to program reach among vulnerable communities. Subcontracting to trusted CBOs helped address this, and the program continues to explore messaging campaigns and other solutions.

2. **When referral from contact tracing to resource coordination cannot be direct, prioritize diverse points of entry and community outreach:** As noted, legal interpretations by NC DHHS prevented CIs/CTs from referring directly to CHW vendors. This represented a potential barrier to addressing quarantine/isolation needs identified during contact tracing. In spite of this, DHHS still prioritized incorporating needs

assessments into the CI/CT scripts, recognizing that CIs/CTs could give clients the CHW vendor contact information or connect individuals with resources via their LHD. Importantly, DHHS recognized that more vulnerable individuals may find these routes difficult to navigate, and thus encouraged a resource coordination program with multiple points of entry. Expanded presence at testing events for direct referral, as well as referral from healthcare providers, attempted to reduce barriers to awareness and access. Vendors also reached out to organizations within their communities, like churches, community groups, schools, farmworker organizations, etc., to describe the program and services it offered. Vendors also advertised through flyers, local news media, and social media.

3. **When rapid changes are needed, promote flexibility through communication, coordination, and partnerships:** Supporting a program that required maximal flexibility and constant iteration to roll out rapidly enough to meet demand posed a potential challenge for typically slower government agencies. A crucial component of success was a coordinated roll-out plan with engagement of stakeholders during that process. As noted above, cash advances, not typically provided by government agencies, were essential to support smaller CBOs as they rapidly scaled the program. These necessary changes, however, required contract amendments, which take time and multiple approvals across government agencies. Coordination across departments, including daily standup meetings and regular department-wide calls, was essential to program flexibility and speed. This level of coordination allowed for rapid procurement, technology implementation, and iterative changes.

CONCLUSION: LOOKING AHEAD

Between September 4, 2020 and March 22, 2021, NC DHHS-sponsored programs reached over 385,000 individuals (including over 295,000 virtual encounters), made 121,000 referrals to short- and long-term resource supports, and directly financed and delivered social supports to over 38,000 households. An initial impact evaluation demonstrated correlation between CHW/SSP and lower COVID-19 positivity rates as compared to counties without those programs, with additional quantitative and qualitative analysis underway. While not robust enough to infer causation, it provides support for future investments at scale to identify, refer, and fund social support needs for vulnerable populations as a critical public health strategy to control the spread of a pandemic.

DHHS continues to strengthen and maximize the programs' reach. For example, within the current program structure, CHWs have been trained to provide education and schedule appointments for individuals to receive the coronavirus vaccine and will be key components of the state's Healthier Together program initially focused on vaccine equity. To meet ongoing needs across the state, the CHW Program will be scaled to cover all 100 counties and supported by additional funding through June 2022. As initial funding for SSP is exhausted, DHHS is strategizing on the integration of supports within the CHW Program and exploring a payment structure for social supports advanced by the state and reimbursed by FEMA. To expand the network of social supports available across the state, organizations will continue to be onboarded to NCCARE360 and supported by Unite Us.

Long-term planning for CHW programming is underway across North Carolina, with NC DHHS uniting stakeholders to form a statewide advisory and certification body, standardizing basic training for CHWs via community colleges, developing continuing education opportunities tailored to CHWs with the state's Area Health Education Centers, and engaging with payers to reimburse CHW services and pay CHWs a living wage. These plans position CHWs as essential components of the health system as trusted members embedded within communities as statewide efforts transition from COVID-19 response to a sustainable healthcare infrastructure. COVID-19 increased understanding of the digital divide in vulnerable communities and historically marginalized populations. The knowledge and connection CHWs bring to communities can create an initial connection and familiarity with these tools.

In addition to supporting this statewide community based workforce, NC DHHS will continue to invest in and implement complementary initiatives to advance the health of all North Carolinians. The state will continue roll-out of the Healthy Opportunities Pilots to utilize Medicaid dollars to fund interventions in food, housing, transportation, and interpersonal violence/toxic stress. NC will also implement a standardized screening process across the healthcare system to identify and address unmet social support needs. To promote long-term sustainability, NC DHHS is working to better align financial incentives for health care providers and Medicaid health plans when addressing these nonmedical drivers of health (Wortman, Cuervo Tilson, Krauthamer Cohen, 2020).

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APPENDIX

APPENDIX A: CHW AND SSP VENDORS

CHW Vendors:

[Curamericas Global](#), [Keystone Peer Review Organization (KEPRO)](#), [Mt. Calvary Center for Leadership Development](#), [One to One with Youth](#), [Catawba County Public Health](#), [Southeastern Healthcare of North Carolina](#), [Vidant Health](#)

SSP Vendors:

[ADLA, Inc.](#), [Duke University Health System](#), [Piedmont Health Services and Sickle Cell Agency](#), [Quality Comprehensive Health Center](#)

APPENDIX B: CHW JOB DESCRIPTION

SUMMARY: Work to improve community resilience, quality of life and cultural and linguistic competence of service delivery. CHWs will participate in community capacity building through health knowledge and self-reliance and activities such as outreach, community education, informal counseling, social support, and advocacy. Community/county connection resources will include: testing/contact tracing, local health departments, primary care, case management, nutrition assistance, mental health services, and related social support services through face-to-face encounters and telehealth, when appropriate.

EDUCATION REQUIREMENT:

REQUIRED: High School Diploma or equivalency.

RECOMMENDED: Bachelor Degree in Healthcare or related field. Community and public service in additional to a high school diploma may be considered in lieu of recommended education requirement.

ESSENTIAL JOB DUTIES:

- Serve as an agent of engagement for assigned geographical territories. Service in multiple counties may be required.
- Work with local health department and healthcare providers to monitor COVID-19 statistical data and community resources.
- Serve as an advocate for persons with healthcare needs.
- Create connection between residents and healthcare systems for testing and treatment.
- Ensure cultural competence among healthcare professionals serving vulnerable populations.
- Educate health system providers and stakeholders about community health needs.
- Provide culturally appropriate health education on topics related to chronic disease prevention, physical activity and nutrition.
- Advocate for underserved individuals to receive appropriate services
- Aid individuals, families, and groups receive healthcare intervention measures in relation to pandemic related issues.
- Serve as liaison between clients and community based agencies to ensure services are readily available to meet their healthcare needs.
- Monitor and enter data in NCCARE360 database.
- Assist in development of reports as required by the North Carolina Department of Health and Human Services.
- Monitor, link and coordinate services.

ADDITIONAL PRE-EMPLOYMENT REQUIREMENTS:

- Valid Driver's License
- Proof of Eligibility to Work
- Basic Computer Literacy Skills
- Demonstration of proficiency in English and/or Spanish; written and oral fluency is preferred.

*All candidates for hire must complete a driving record and criminal background evaluation.

APPENDIX C: NCCARE360 SOCIAL DETERMINANTS OF HEALTH SCREENING

We believe everyone should have the opportunity for health. Some things like not having enough food or reliable transportation or a safe place to live can make it hard to be healthy. Please answer the following questions to help us better understand you and your current situation. We may not be able to find resources for all of your needs, but we will try and help as much as we can.

	Yes	No
Food		
1. Within the past 12 months, did you worry that your food would run out before you got money to buy more?		
2. Within the past 12 months, did the food you bought just not last and you didn't have money to get more?		
Housing/Utilities		
3. Within the past 12 months, have you ever stayed: outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (i.e. couch-surfing)?		
4. Are you worried about losing your housing?		
5. Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?		
Transportation		
6. Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living?		
Interpersonal Safety		
7. Do you feel physically or emotionally unsafe where you currently live?		
8. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by anyone?		
9. Within the past 12 months, have you been humiliated or emotionally abused by anyone?		
Optional: Immediate Need		
10. Are any of your needs urgent? For example, you don't have food for tonight, you don't have a place to sleep tonight, you are afraid you will get hurt if you go home today.		
11. Would you like help with any of the needs that you have identified?		