Essential Partnerships: Healthier Together and Community Health Workers in North Carolina's COVID-19 Equity Efforts

Overview of CHW Initiative and COVID-19 Response

Carolinas Pandemic Task Force Meeting

February 2022

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Photo credit: PIH-US

Healthier TOGETHER

A PUBLIC-PRIVATE PARTNERSHIP

February 2022

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

NC COUNTS COALITION

WHAT IS HEALTHIER TOGETHER?

Healthier Together is a public-private partnership between NCDHHS and NC Counts Coalition (a 501(c)3 nonprofit) to increase the number of individuals who are Black, Indigenous, and People of Color (BIPOC) and from other historically marginalized populations receiving COVID-19 vaccinations across the state of North Carolina.

- Immediate Goals: Vaccine Equity
  - Build and earn trust between trusted messengers (nonprofit/grassroot orgs) and HMPs
  - Education, outreach, and eliminating barriers to vaccination
- Long-Term Goal: Advance Health Equity

WHY HEALTHIER TOGETHER?

While vaccine equity has been a priority for NCDHHS and some progress has been made, more work and investment is needed:

ADDRESSING SYSTEMIC INEQUITIES

Inequities are driven by many factors that are rooted in centuries of systemic racism and structural inequity

INVESTING LONG TERM IN HEALTH EQUITY

Healthier Together is a down payment on a long-term Departmental commitment to health equity, with an initial focus on vaccine equity

RESOURCING COMMUNITY ORGANIZATIONS

Communities know best – and need capacity (people, funds, resources) to act on locally developed solutions

SERVING BIPOC/HMP COMMUNITIES

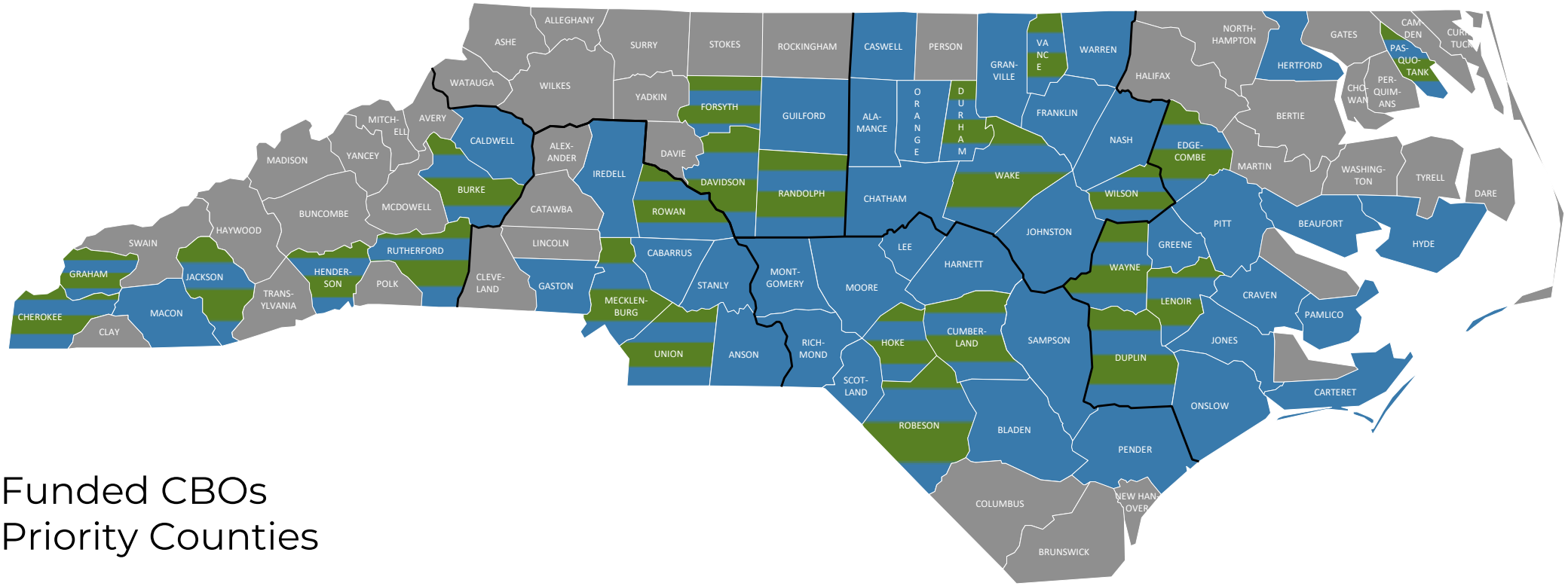
We are investing in state, regional, and local community partners led by and serving Black, Indigenous, and People of Color (BIPOC) and other historically marginalized communities

HEALTHIER TOGETHER: CURRENT FOCUS

- Co-create strategies in collaboration with nonprofit, grassroots, and community partners rooted in BIPOC and other historically marginalized communities
- Fund and build capacity at community-based organizations (CBOs)
- Mobilize CBOs to do outreach/scheduling in priority communities
- Build and earn trust on the ground with BIPOC and other historically marginalized communities and the organizations that are led by and support them
- Reduce access barriers and engage in strategies to increase acceptance and confidence
- Use data on vaccination efforts to inform planning and investment of resources
- Engage providers and communities to increase child vaccination rates

Priority Counties & Funded CBOs

Updated October 22, 2021

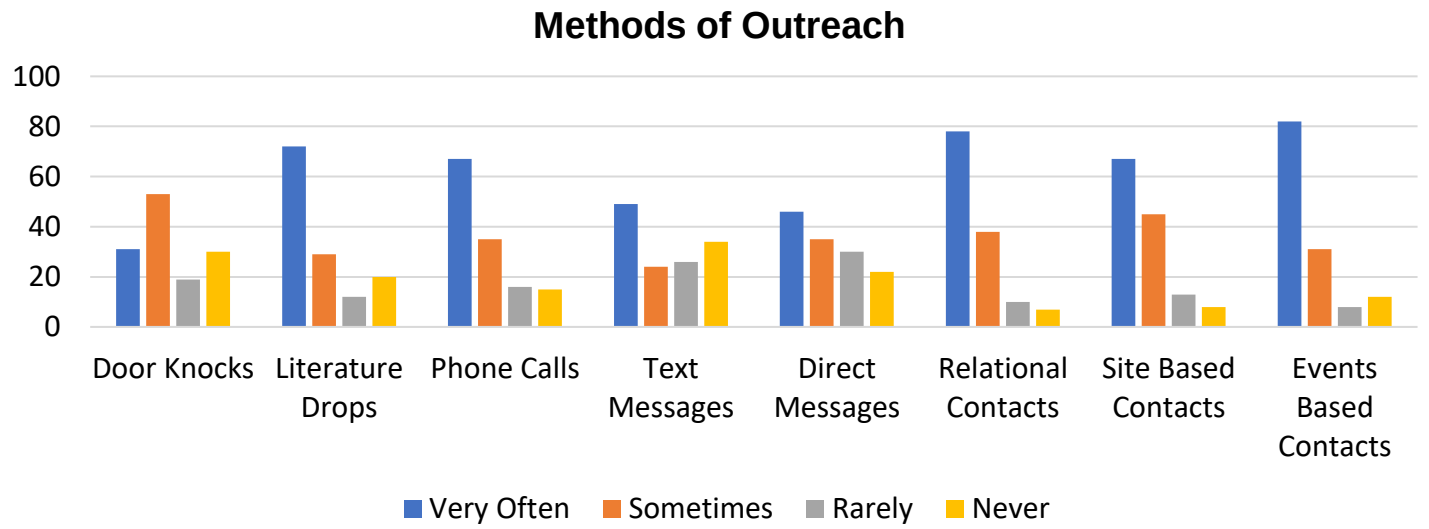


- Funded CBOs
- Priority Counties

Cumulative HT Status Report – demand (Nov 2021 – Jan 2022)

TOTAL # OF INTERACTIONS, CONTACTS, OR TOUCHES ENGAGED:	368,903

PRIMARY SUBJECTS OF COMMUNICATIONS
Vaccination safety, side effects & necessity
Child Vaccines and Booster Shots
Do mask protect you from the omicron variant?
Education on vaccine, COVID testing, and importance of booster
Covid-19 Vaccine and N95 Masks



INDIVIDUALS SCHEDULED FOR APPOINTMENTS

14,229

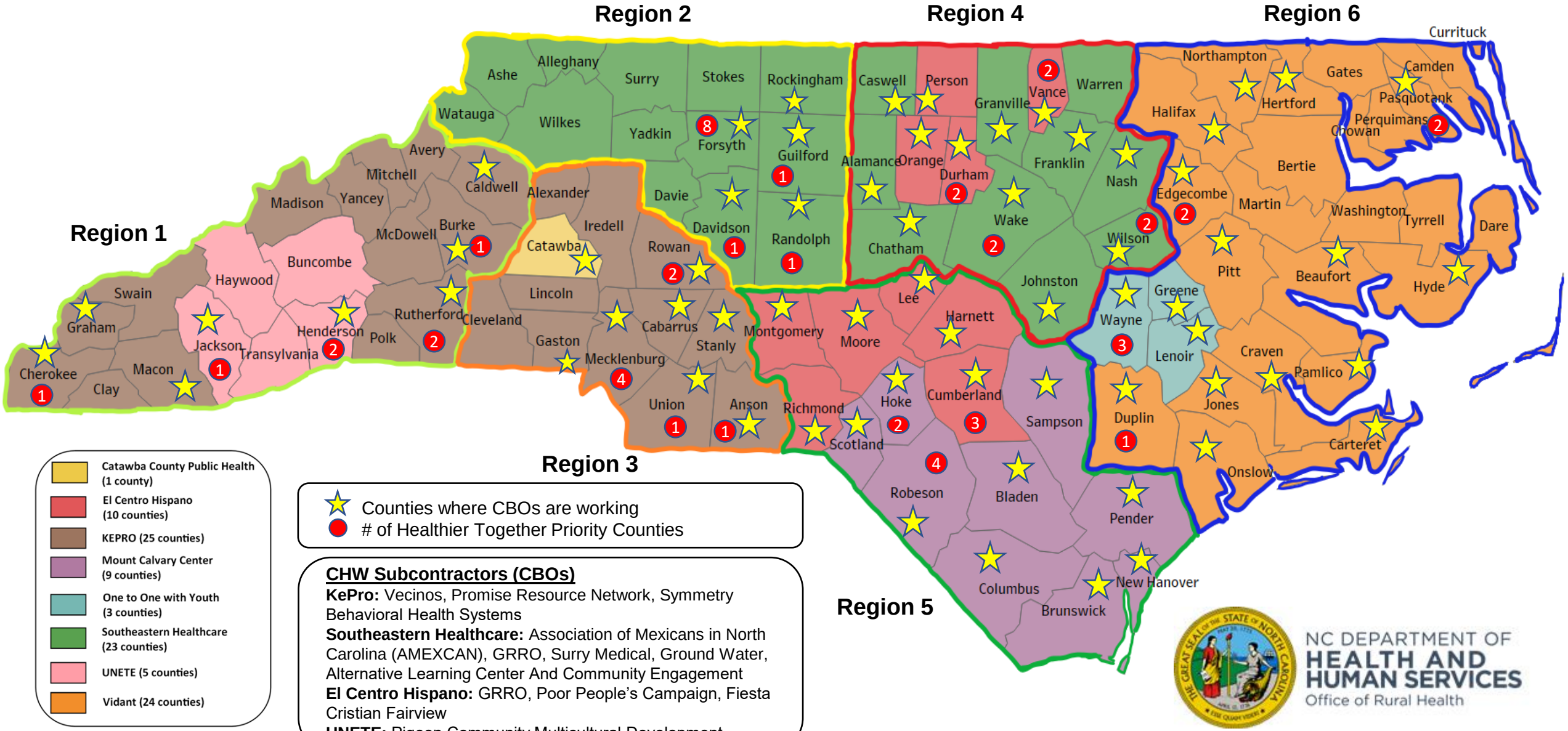
NUMBER OF INDIVIDUALS CONNECTED TO TRANSPORTATION

1,611

NUMBER OF INDIVIDUALS CONNECTED TO CHWS

8,413

CHWs and Healthier Together (February 2022)



CHW Subcontractors (CBOs)

KePro: Vecinos, Promise Resource Network, Symmetry Behavioral Health Systems

Southeastern Healthcare: Association of Mexicans in North Carolina (AMEXCAN), GRRO, Surry Medical, Ground Water, Alternative Learning Center And Community Engagement

El Centro Hispano: GRRO, Poor People's Campaign, Fiesta Cristian Fairview

UNETE: Pigeon Community Multicultural Development

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Rural Health

Introduction to Community Health Workers

Definition

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

CHWs also **build individual and community capacity** by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.

American Public Health Association

CHWs are diverse, trusted members of the community

There are **526 Community Health Workers** working to connect individuals with resources and educate their local communities on the COVID-19 vaccine.

Community Health Workers by the Numbers

82% of CHWs are women

98% are dedicated to vaccine work (registration, scheduling, education)

91% identify as Hispanic/Latinx or African American

81% of CHWs have received the vaccine

158 CHWs speak Spanish

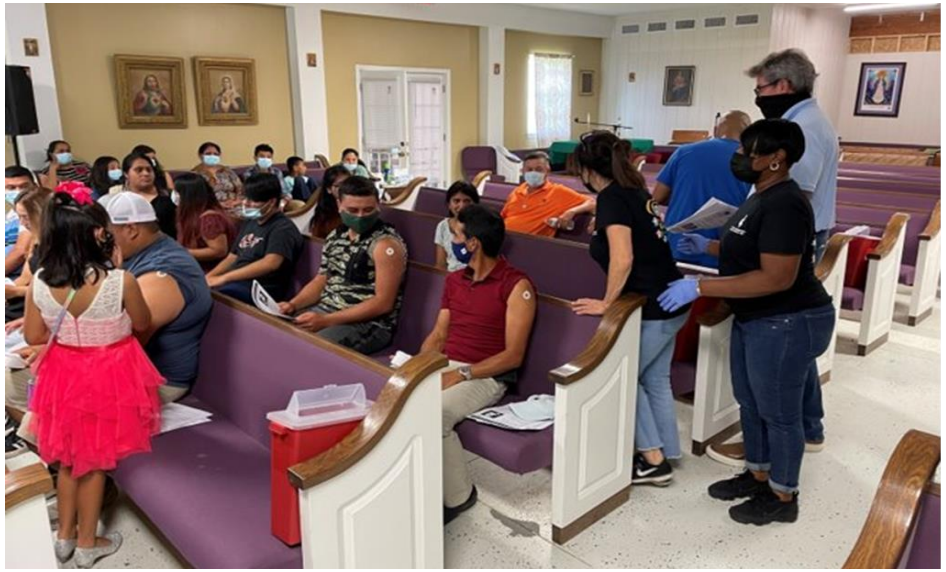
80% completed, enrolled, or future-enrolled for SCCT

Data as of February 25, 2022

CHW Roles and Skills

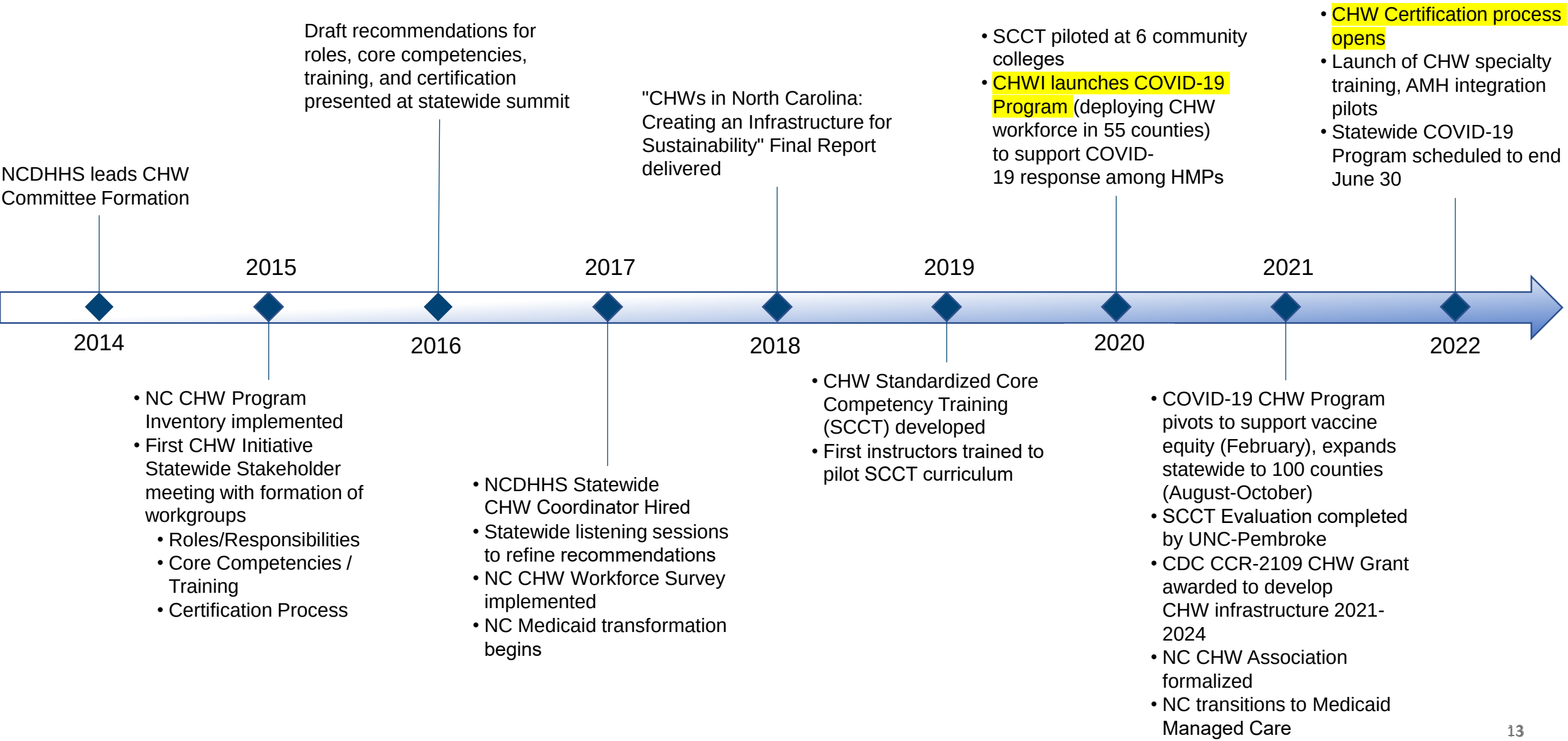
General Roles/Skills

- Screen for **Social Determinants of Health** needs and connect individuals with necessary social support resources
- Serve as **linkages to healthcare** (connection to medical home, facilitate appointment attendance)
- Provide **culturally and linguistically appropriate context** for health decisions and education
- **Meet people where they are** (e.g., in their homes, communities) to understand social vulnerability and barriers to care
- Provide **individualized support to health goals** and help to identify and address environmental factors that affect health
- Help people to **manage chronic conditions**
- Provide COVID-19-related **support for vulnerable populations** (including Medicaid recipients)



Smith O, Wennerstrom A. *Health Affairs Blog*. 2020.

Evolution of CHW Initiative in North Carolina



CHWs have been trained on the following tools and capabilities

CHWs are trained on core tools and capabilities to best serve their communities

NCCARE360

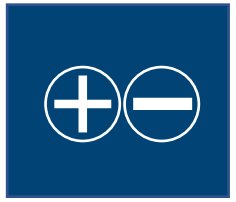
Vaccine site support experience

COVID-19 Vaccine Management System (CVMS - statewide location managers)

CHW training (Through AHEC and a 96-hour Core Competency training at Community Colleges)

Vaccine 101 education (monthly)

COVID-19 Community Team Outreach (CCTO - Contact Tracing)



Testing site support experience

Support Services Program 2.0 Referrals (food insecurity)

Requested social support needs as identified by CHW NCCARE360 referrals

Top 5 requested services across all counties

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

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

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

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

COVID-19 CHW program impact data since inception (August 2020-February 2022)

Referral Impact

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

1,811,988

How many **NCCARE360 referrals** were made?

148,887

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

486,842

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

42,000+

Vaccine Impact

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

8,322

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

801,623

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

3,508

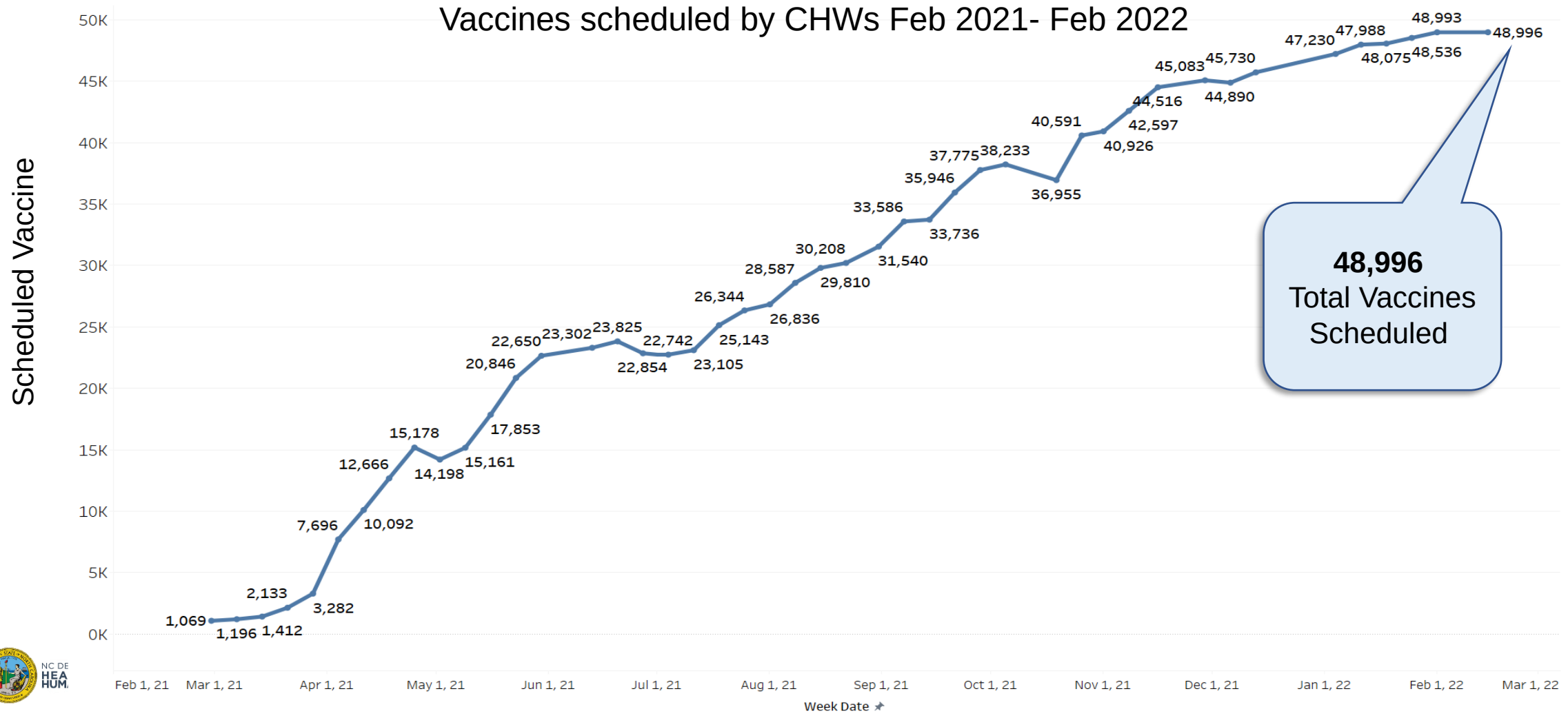
How many people were **scheduled to receive a COVID-19 vaccine**?

48,996

Updated February 15, 2022

CHWs and Healthier Together vaccination efforts work synergistically to reach HMPs

CHWS have been a strong partner in COVID-19 vaccination. They have scheduled for vaccines even when faced with barriers including high vaccine and booster hesitancy and difficulty in access



CHW Program Evaluation

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

Evaluation Components

1. Qualitative/Quantitative Program Analysis
Duke and UNC-Chapel Hill collaborators

2. Impact Analysis
Partners In Health collaborators

3. Gap Analysis
Partners In Health collaborators

4. Training and AMH Integration Evaluation
CDC grant collaborators (UNC-P, CHASM, PIH)

Evaluation Aims

1. Understand CHW and CHW vendor perspectives on access to social services, health behaviors, community collaborations, and career trajectory

2. Quantify impact of CHW efforts on vaccination and resource coordination as well as COVID-19 outcomes and return on investment

3. Identify network of populations served and resources available as well as gaps across counties, vendors to inform program strengthening

4. Provide data to support long-term investments in CHWs across the state

CHW activities during COVID-19 and beyond

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

Flexible, Community-Based Workforce

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

Equity-focused Vaccine Support

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

Care Resource Coordination Support

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

Primary Care and Behavioral Health Linkages

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

CHW Integration into Whole Person Care Framework

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

Community-based, Community Voice

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

Trained, Supported, Equity-focused Workforce

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

Resource Coordination and Advanced Medical Home Integration

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

Healthcare Integration

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

CHWs and Connections to Care and SDoH