North Carolina Community Health Worker Initiative

Stakeholder Recommendations

September 2016

Introduction

As North Carolina's (NC) healthcare and public health systems maneuver through this current time of transition, the coordination of those who are addressing population health is critical. Value-based pricing, as well as the call for more integrated team-based care, will affect the state's future workforce needs. The discussion about North Carolina's workforce needs must include the role of community health workers (CHWs). CHWs work with both individuals and communities to improve health and address the social determinants of health. As other states have done, North Carolina has an opportunity to develop this community-based resource as an integral component of the primary and preventive care system.

Recent changes to healthcare laws encourage the use of CHWs to promote healthy behaviors and improve health outcomes. Furthermore, several studies acknowledge that CHWs have been able to provide cost savings to health care systems. This increased support for CHWs provides an opportunity to impact population health, reduce disparities and engage patients and communities in a new healthcare delivery model. This model will require an investment in CHWs and the development of reimbursement strategies for their services.

The mission of the North Carolina Community Health Worker Initiative is to establish a sustainable infrastructure that acknowledges the value of CHWs, supports their professional identity and integrates their role in the healthcare team. The purpose of the Initiative is to improve the health of the public by formalizing an existing long-term practice and to develop an infrastructure for a burgeoning CHW workforce wherever they serve. To this end, the NC CHW Initiative aims to:

- identify core competencies for NC CHWs;
- recommend a training curriculum;
- develop individual certification and program accreditation processes; and
- identify strategies for reimbursement of CHW services.

Background

In October 2014, representatives from the NC Department of Health and Human Services (DHHS) formed a CHW Committee (See Appendix A for list of members). 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 CHWs. Information collected included organizational demographics, CHW scope of services, skills and abilities, funding sources, as well as the challenges and benefits of CHW services. Approximately 290 program managers and supervisors received the survey, and a total of 117 participants completed it.

A CHW Stakeholder Meeting was held on April 29, 2015. Seventy-two people attended the meeting representing a variety of stakeholder groups, including health associations, statewide organizations, academic settings, healthcare settings and state agencies,

among others. The CHW Program Inventory results were distributed at the meeting and organizational leaders shared their perspectives on the statewide systems needed to support CHWs. Robust conversation occurred about the benefits of and opportunities for developing statewide support for the CHW workforce in NC.

CHW stakeholders began meeting regularly in December 2015. They adopted the American Public Health Association's definition of CHWs, which is "*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".*

Stakeholders formed workgroups to (1) identify roles and responsibilities of CHWs; (2) identify core competencies and recommend a training curriculum to address them; and (3) develop the requirements and process for certifying CHWs and accrediting programs (See Appendix D for List of Workgroup Members and meeting dates).

Community Health Workers occupy a unique space along the continuum of healthcare. The duality of being an outward and inward facing healthcare worker provides an opportunity to reach underserved and uninsured populations that lack trust in mainstream healthcare providers.

The workgroups developed the following principles to guide the development of the recommendations presented in this document.

1. Community Health Workers 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 health care systems, participating in hospital to home transitional care, primary and specialty care, and community-based chronic disease and preventive services.
3. Community Health Workers 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 environment.
4. Community Health Workers can and will play a critical role in implementing the triple aim of the Institute of Healthcare Improvement, improving the experience of healthcare, improving the health of populations, 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 part Community Health Workers play in helping North Carolinians achieve optimal health status, the state would benefit from a system that formally recognizes the occupation of Community Health Worker and creates opportunities for a career path and reimbursement for their services.
6. North Carolina should have a system for certifying Community Health Workers and supporting their continuing education. Organizations using this system will be able to identify certified Community Health Workers that can serve as valuable members of multi-disciplinary teams, who are committed to quality improvement and quality assurance
7. The curriculum used to certify Community Health Workers should be standardized across the state, so that certification is portable between counties and employers. Organizations providing certification training should be accredited to do so.
8. At the initiation of the certification system, there should be a mechanism to "grandparent" in Community Health Workers with extensive prior experience.
9. Employers should have flexibility in how they utilize Community Health Workers to achieve their organizational goals.
10. Community Health Workers, through social and health and wellness competence, exhibit service and adherence to the NC CHW Code of Ethics.
11. The recommendations of the NC Community Health Worker Initiative Workgroups are the first of multiple phases to create a coordinated NC Community Health Worker workforce through training and certification.

It is important to reassure interested stakeholders that the certification of NC CHWs is not an attempt at licensure. In fact, there are multiple states that warn against the licensing of CHWs as professionals; rather, they suggest standardized and/or accredited trainings leading to certification (See Community Health Worker White Paper: Report and Recommendations. Foundation for Healthy Generations Creating Enduring Health Equity, 2013.Appendix C for References). The recommendations that follow are submitted for stakeholder review and comment.

Recommendation I: Roles and Responsibilities

In order to develop a framework related to CHW roles and responsibilities, several benchmark documents from various states and studies were reviewed. Each of those documents referred to CHW roles in different terms, including standards of practice, core roles, and roles and responsibilities (See Appendix C for References). The language below draws heavily upon the text, *Foundations for Community Health Workers* (Berthold, Miller and Avila-Esparza, 2009). To ensure alignment between the recommended roles and sub-competencies (listed in Recommendation II), a crosswalk was developed that mapped sub-competencies to roles. The recommended roles as outlined below are fundamental to CHWs and are meant to provide a parameter of practice. Expanded roles and responsibilities will be defined by individual employers based upon the services or programs provided.

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 use various approaches to support clients in reducing health-related risk behaviors in ways that communities will understand and accept. They recognize the importance of addressing the social 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 the community to ensure that clients are treated respectfully and given access to the services and basic resources that they need in order to live healthy lives. They support clients and community members to develop the skills and the confidence to advocate for their own health and well-being and that of their communities. CHWs are also advocates for the CHW profession.

Roles of Community Health Workers in North Carolina

Cultural Liaison	Health Navigator	Health & Wellness Promoter	Advocate
Serve as cultural liaisons between their clients and health and social service systems Ensure that clients receive culturally and linguistically appropriate quality care and services	Provide direct care to clients through services they are trained and qualified to provide Link clients to services by knowing what services exist and referring clients appropriately	Provide information about healthy behaviors and use various approaches to support clients in reducing health-related risk behaviors in ways that communities will understand and accept Recognize the importance of addressing the social determinants of health in guiding, supporting and assisting clients to live healthier lives	Advocate with and on behalf of the community to ensure that clients are treated respectfully and given access to the services and basic resources they need to live healthy lives Support clients and community members to develop skills and the confidence to advocate for their own health and well-being Advocate for the CHW profession

Recommendation II: Core Competencies and Training Curriculum

Members of the Core Competencies and Curriculum (CCC) Workgroup reviewed materials from the states of New York, Minnesota, Texas and Ohio. They also referenced materials from the text, *Foundations for Community Health Workers,* and drew heavily upon documents produced by the CHW Core Consensus (C3) Project coordinated by the University of Texas - Houston School of Public Health and the Texas Tech University Health Sciences Center.

Core Competencies

Certified CHWs in NC should be able to demonstrate all of the nine competencies and 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.

Communication Skills

Learning Outcomes

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

Sub-competencies

a) Ability to use language effectively
b) Ability to use language in ways that engage and 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

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

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. Assesses progress of client referrals
5. Effectively utilizes the referral process

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

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

Advocacy Skills

Learning Outcomes

1. Demonstrates the ability to advocate for individuals
2. Demonstrates the ability to advocate for communities
3. Promotes the community health worker

Sub-competencies

a) Ability to speak up for individuals and communities
b) Ability to advocate for the Community Health Worker profession

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. Establishes and 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 [ADA], Health Insurance Portability and Accountability Act [HIPAA])
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

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 demonstrate and practice skills necessary 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

Education and Facilitation Skills

Learning Outcomes

1. Educates clients about preventive health
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 reinforce learner-centered teaching strategies
b) Ability to use effective education strategies
c) Ability to facilitate group discussions
d) Ability to seek out appropriate information and respond to questions

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 their own knowledge and seek 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 socials 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

Training Curriculum

In developing the recommendations above, the CCC Workgroup reviewed curricular components from Minnesota, New York, Ohio and Texas. While information was drawn from all four states, the Workgroup recommends that North Carolina consider using the materials from Minnesota's CHW curriculum as a template for training and certifying CHWs. Minnesota's curriculum aligns with the core competencies, sub-competencies and learning objectives listed above.

Recommendation III: Certification Requirements and Process

The Certification Requirements and Process (CRP) Workgroup reviewed several states' processes to train and certify CHWs, including Florida, Massachusetts, Minnesota, New York, Ohio and Texas, along with those of the C3 Project. Each state's process is based upon a set of identified competencies that align with the roles of CHWs as identified by the individual states.

The aim of the NC certification process is twofold: (1) to standardize training of CHWs as a means to promote reimbursement of their services; and (2) to recognize the CHW's value on an integrated health care team.

The Workgroup considered the *Community Health Worker Career Pathway Model* from the *Community Health Worker Initiative of Boston* as the basis of its recommendation. The intent of the proposed pathway is to incentivize CHWs who are interested in a long-term career to expand their training. It also acknowledges the varying degrees of experience and education that presently exist among CHWs.

It is important to note that the proposed system does not require CHWs to become certified in order to call themselves CHWs. CHWs would, however, have to become certified in order to call themselves "Certified CHWs." CHWs can continue to play a role in health care delivery regardless of their certification status.

Certification of Individual Community Health Workers

Based on the aforementioned considerations, the CRP Workgroup recommends the following certification levels for individual CHWs. First, in order to become a certified CHW I, an individual would be required to demonstrate knowledge of all nine core competencies; have field experience gained through an accredited training program and have a 9th grade literacy level. A certified CHW II (experienced) would have to have two years of experience at a 1.0 Full Time Equivalent (FTE); demonstrate knowledge of all nine core competencies along with specialized training in a topic area, and possess a high school diploma or equivalent. Finally, the certified CHW III (senior) would have to have three years of experience at a 1.0 FTE, demonstrate knowledge of all nine core competencies along with specialized training in a topic area, demonstrate management and leadership skills and have an Associate's Degree.

"Grandparenting" allows individuals to be considered certified and to bypass the need for taking a formal Certified CHW training course. Organizations who support a CHW who is grandparented, must provide evidence of the CHW's ability to demonstrate the core competencies, experience, education, and qualities (listed in Principle 10). Grandparenting is allowed for CHW I and CHW II, but not for CHW III. Grandparenting is designed to be flexible and honor those CHWs with previous experience. However, it is time-limited and will only be allowed for the first five years of the North Carolina

certification process. After that time, CHWs would be required to follow the certification process described above.

Certification would last three years and CHWs would be required to participate in eight hours of continuing education annually to maintain the certification.

The table below summarizes the proposed career pathway for CHWs in NC.

CHW Level	Competencies	Experience (Hours)	Recommended Education**
Certified CHW I "Certified CHW"	9 competencies (via course or grandparenting)	Hours included in coursework	9th grade literacy level + continuing education requirements every three years
Certified CHW II "Experienced CHW"	9 competencies (via course or grandparenting) **+** In-depth proficiency or merit badge (as documented in a letter of support)	2 years at 1 Full Time Equivalency (FTE) with letter of support*; or equivalent	HS degree or HS equivalency + continuing education requirements every three years
Certified CHW III "Senior CHW"	9 competencies (via course) **+** In-depth proficiency or merit badge (as documented in a letter of support) **+** Management/Leadership (evidence of experience, performance, mentoring other CHWs as documented in a letter of support)	Total of at least 3 years at 1 FTE with letter of support*; or equivalent	Associate's Degree + continuing education requirements every three years

* The letter of support should highlight how the Community Health Worker exhibits the qualities listed in Principle 10.

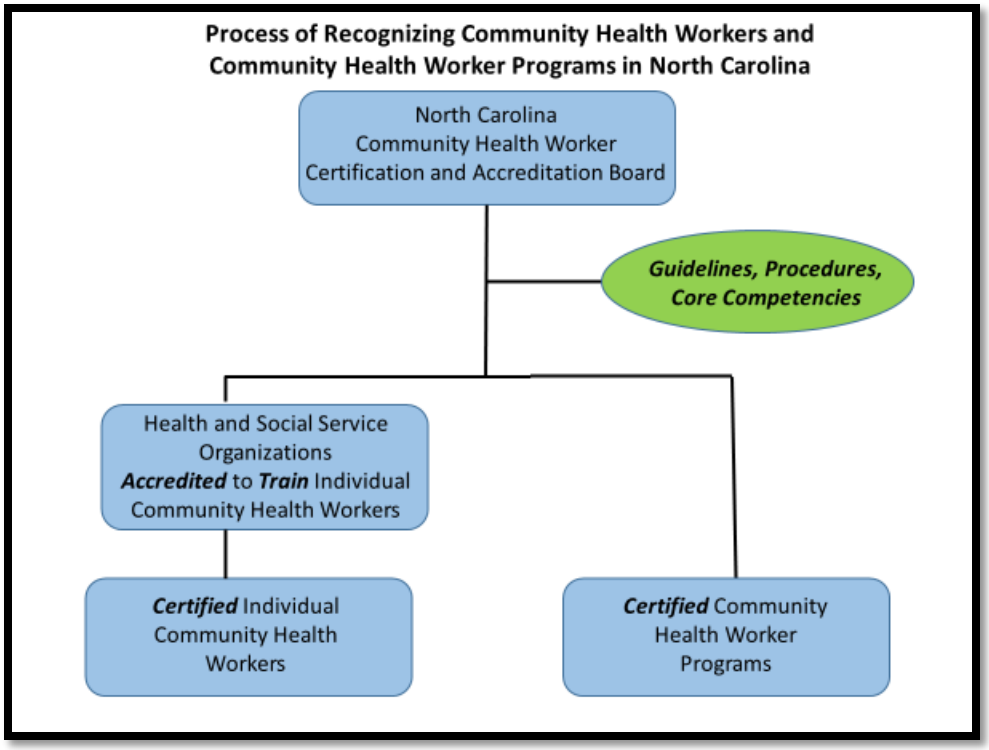
**The recommended education levels are intended to be flexible enough to accommodate experienced CHWs without a high school degree (or those educated in countries other than the US) and rigid enough to satisfy organizations that will be asked to reimburse CHWs for their services.

Accreditation of Organizations to Train Community Health Workers

Organizations can be accredited to train and certify individual CHWs through the proposed system. In order to be accredited, the organizations would have to: provide evidence that the training addresses the nine core competencies, issue certificates of training completion to CHWs, and submit appropriate documentation to the NC Community Health Worker Accreditation Board, discussed further below. As previously noted, a critical component for the certification process is the flexibility to accommodate the needs of CHWs and employers. As such, we recognized that some organizations interested in training and certifying CHWs will have formal processes for professional development and other organizations may follow oral traditions when training employees.

Certification of Community Health Worker Programs

The CRP workgroup recognized that a strength of CHWs is the flexibility and breadth of their roles. The CHW workforce continuum includes part-time and volunteer peer supporters working in programs in which there may be substantial turnover of CHWs, making their individual certification impractical. In recognition of this reality, the CRP Workgroup recommends a model in which CHW programs can earn certification of the program itself, rather than for the individuals working within the program. Certified CHW programs could then seek reimbursement for services provided by CHWs working under their auspices. CHWs working under certified CHW programs ***would not gain a portable, individual CHW certification unless they went through the process to obtain individual certification discussed above***.



In conclusion, CHWs working for certified CHW programs may or may not be individually certified; however, a baseline quality of their services could be expected—facilitating their compensation, due to the training and supervision provided by the CHW programs within which they work.

The CRP workgroup recommends the following approach to the approval of certification applications of CHW programs:

Training: Applications for program certification would need to document training for its CHWs on the same Core Competencies required for certification of individual CHWs. However, the application could justify tailoring the training to the specific scope and foci of individual programs. Training would have to be provided by persons with appropriate training and experience. It would have to include documentation of methods for evaluation of trainees, sufficient dedication of time of staff responsible for coordination and administration of the training program, and other characteristics as may be deemed appropriate.

Continuing Education: Programs would have to provide continuing education for CHWs. Plans for continuing education would have to be approved by the NCCHW Certification and Accreditation Board.

Designated Coordinator: Programs would have to 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 ("Senior CHW") or have a masters or equivalent degree in nursing, social work, public health, education, psychology, or other appropriate field. Waivers to this requirement would be approved.

Organizational Structure: There would have to be an organizational chart or other suitable documentation of reporting relationships within the program and linking the program to the overall management of the host organization.

Clinical Input: Appropriate to the scope and objectives of the program, there would have to be individuals with clinical training available to the program for advice and guidance.

Back-Up: Appropriate to the services provided and those served, the program would have to document plans for back-up of CHWs as part of its application for approval. Plans for back-up would have to include the source and mode of back-up, qualifications of those providing back-up and the pertinence of those qualifications to issues for which back-up may be necessary. The application would have to describe specific means by which CHWs could secure back-up (e.g., telephone number staffed 24 hours a day by back-up staff).

As proposed, certification of CHW programs would last five years, with annual reporting requirements to confirm that appropriate processes remain in place. Programs in good standing after the initial five years would renew every seven years.

Certification and Accreditation System

The Certification Requirements and Process Workgroup recommends oversight of the CHW certification and organization accreditation processes by a proposed NC Community Health Worker Certification and Accreditation Board. It has yet to be determined where this independent body would be located.

Certification and Accreditation Board Roles and Responsibilities

The responsibilities of the proposed NC Community Health Worker Certification and Accreditation Board would include the activities below:

- Sets rules and processes for certification of individual CHWs and CHW programs
- Approves standards for accreditation of training organizations
- Adopts a 'certificate' examination or other means to assess CHW competency in connection with certification
- Sets a code of ethics for CHWs
- Sets fees for certification and accreditation
- Sets renewal period for continued certification and accreditation
- Creates and maintains a NC CHW Registry
- Establishes procedures for disciplinary action against CHWs

Certification and Accreditation Board Composition

The size of the Board would be between 12 to 15 people. Recommended membership includes the following types of organizations and sectors:

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

Community Health Workers have been providing valuable services for decades. The changing landscape of the healthcare environment has created the opportunity to formally recognize their contributions to the integrated healthcare team. These recommendations will help to establish an infrastructure to maximize the ability of CHWs to cost effectively improve community health outcomes.

The plan is to seek feedback on these recommendations that will be gathered through regional listening sessions in early 2017. This input will guide the development of a strategic plan for establishing the infrastructure to support CHWs in North Carolina.

For more information related to this document, please contact Tish Singletary at tish.singletary@dhhs.nc.gov or Sharon Nelson at sharon.boss.nelson@dhhs.nc.gov.

Appendices

Appendix A NC Department of Health and Human Services CHW Committee

Appendix B NC CHW Workgroups and Subcommittees Members and Meetings

Appendix C References and Source Documents

Appendix A

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
Courtney Cantrell
Jacquelyn Clymore
Elizabeth Freeman
Nancy Henley
Nicole Miller
Sharon Nelson
Ruth Petersen
Belinda Pettiford
Holly Riddle
Jill Rushing

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 2015
NC Division of Public Health

Appendix B

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

NC CHW Stakeholder Participants and Meeting Dates

Griselda Alonso Rojas
Alice Ammerman
Anna Boone
Barbara Boyce
Dorethea Brock
Lori Carter-Edwards
Jacqueline Cavadi
Chris Collins
Carolyn Crump
Zoe Cummings
Alexandra Dest
Dionne Dockery
Sharon Elliot Bynum
Katie Eyes
Tara Fields
Ed Fisher
Debby Futrell
Heather Garrity
Celita Graham
Sarah Gray
Gayle Harris
Sherry Hay
Nancy Henley
Sally Herndon
Fred Johnson
Mary Johnson Rockers
Anna Jones
Maya Kiel
Elizabeth Lambar
Freeman
Jennifer Leeman
Ann Lefebvre
Robert Letourneau
Allison Lipscomb
Beth Lovette
Jan Lowery
Norma Marti
Tammie Mclean
Nidu Menon
Patricia Morales
Rosa Navarro
Debi Nelson
Sharon Nelson
Warren Newton
Elaine Owens
Ruth Petersen
Belinda Pettiford
Joseph Pino
April Reese
Holly Riddle
Margaret Roberton
Phyllis Rocco
Sharon Rhyne
Judy Ruffin
Jill Rushing
Anita Schambach
Tish Singletary
Jean Sellers
Allen Smart
Glorina Stallworth
Bill Stewart
Stephanie Stewart
Jim Straight
Karen Suess
Joyce Swetlick
Peggy Terhune
Rachel Valentine
Sheree Vodicka
Franklin Walker
Jennifer Wehe
Cornell Wright
Jacqueline Wynn
Amanda Zabala
Adam Zolotor

April 29, 2015
American Cancer Society
Raleigh, North Carolina
9:00am-3:00pm

Sallie Allgood
Milton Butterworth
Annie Carpenter
Laura Clark
Ava Crawford
Zoe Cummings
David Ezzell
Ed Fisher
Debby Futrell
Ana Luisa Gutierrez-Lozano
Gayle Harris
Sally Herndon
Balbina Cerro Jahuey
Takeila Johnson
Kristin Kearns
Randy Kearns
Carol Lucas
Norma Marti
Lori Meads
Rosa Navarro
Debi Nelson
Sharon Nelson
Warren Newton
Ruth Petersen
Joanne Pierce
Alice Pollard
April Reese
Margaret Roberton
Judy Ruffin
Jill Rushing
Jean Sellers
Tish Singletary
Lori Skinner-Campbell
Karen Stanley
Stephanie Stewart
Pat Tang
Franklin Walker
Marti Wolf
Jacqueline Wynn

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
Griselda Alonzo-Rojas
Alma Atkins
Kathey Avery
Erin Barlow
Tuere' Bowles
Milton Butterworth
Annie Carpenter
Lori Carter-Edwards
Laura Clark
Timmery Cook
Ava Crawford
Zoe Cummings
Ed Fisher
Debby Futrell
Je'Wana Grier-McEachin
Ana Luisa Gutierrez-Lozano
Gayle Harris
Rochelle Howard
Maria Jimenez
Fred Johnson
Allison Lipscomb
Carol Lucas
Norma Marti
Dawn Morriston
Rosa Navarro
Debi Nelson
Sharon Nelson
Warren Newton
Ruth Petersen
Joanne Pierce
Jennifer Poore'
April Reese
Margaret Roberton
Debbie Royster
Jill Rushing
Tish Singletary
Yvette Singleton
Lori Skinner-Campbell
Karen Stanley
Anna Stein
Stephanie Stewart
Pat Tang
Franklin Walker
Melanie Watkins
Kenny Weatherington
Jacqueline Wynn

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 Allen
Sallie Allgood
Alma Atkins
Kathey Avery
Erin Barlow
Tuere' Bowles
Lori Carter-Edwards*
Laura Clark
Gayle Harris
Carol Lucas*
Dawn Morriston
Debi Nelson
Jennifer Poore'
Debbie Royster
Jill Rushing
Tish Singletary
Melanie Watkins
Jacquelyn Wynn

***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
June 10, 2016

May 12, 2016
Blue Jeans Meeting Platform
10:00am-2:00pm

July 15, 2016
Blue Jeans Meeting Platform
10:00am-3:00pm

NC CHW Certification Requirements and Process Workgroup Members and Meetings Dates

Teretha Bell
Milton Butterworth *
Annie Carpenter
Ava Crawford
Zoe Cummings
Ed Fisher
Debby Futrell
Balbina Cerro Jahuey
Fred Johnson
Je'Wana Grier-McEachin
Ana Luisa Gutierrez-Lozano
Carol Lucas
Norma Marti
Rosa Navarro
Sharon Nelson
Warren Newton *
Joanne Pierce *
Ruth Petersen
April Reese
Margaret Roberton
Debbie Royster
Jill Rushing
Tish Singletary
Yvette Singleton
Lori Skinner-Campbell
Stephanie Stewart
Pat Tang
Franklin Walker
Kenny Weatherington

***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 Butterworth
Lori Carter-Edwards
Ed Fisher
Je'Wana Grier-McEachin
Carol Lucas
Norma Marti
Dawn Morriston
Rosa Navarro
Sharon Nelson
Warren Newton
Ruth Petersen
Joanne Pierce
Lori Skinner-Campbell
Tish Singletary
Anna Stein

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

Appendix C

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