

New England Region Community Health Worker (CHW) Models Group Interviews of Stakeholders by State and Environmental Scan

Summary of Findings



August 2016



Table of Contents

Background	1
Methodology	1
Limitations	2
Results	3
Results Part 1: Results Across All New England States	4
Definitions (includes roles/designations)	5
Organizations	6
Legislation	7
Certification.....	8
Education	9
Financing	10
Results Part 2: Results by New England State	11
Connecticut	12
Maine	16
Massachusetts.....	20
New Hampshire.....	26
Rhode Island.....	30
Vermont	35
Implications for NEPHTC	38

1. Background

The [New England Public Health Training Center](#) (NEPHTC) conducted an environmental scan of the status of Community Health Worker (CHW) workforce development in the six New England states in May and June of 2016. The purpose was to help the Center better understand the evolving CHW workforce model in each state and identify potential roles NEPHTC might play in future development of the CHW workforce. NEPHTC has existing expertise in CHW training through its local performance site (LPS) at [UMASS Amherst](#) School of Public Health and Health Sciences. The scan was conducted by the Yale School of Public Health (YSPH), another NEPHTC LPS, which conducts needs assessments for the regional center.

NEPHTC is one of 10 regional centers that provide continuing education to the public health workforce through a grant from the Health Resources and Services Administration (HRSA). The goal of the PHTC program is described by HRSA as “improving the Nation’s public health system by strengthening the technical, scientific, managerial, and leadership competence of the current and future public health workforce.” Emphasis is placed on developing the existing public health workforce as a foundation for improving the infrastructure of the public health system.

The New England States served by NEPHTC and covered in this environmental scan are:

- Connecticut (CT)
- Maine (ME)
- Massachusetts (MA)
- New Hampshire (NH)
- Rhode Island (RI)
- Vermont (VT)

PHTCs are authorized to regularly conduct training needs assessments to identify training needs on the individual, agency and workforce/discipline levels. From these assessments PHTCs can work with partners to identify and prioritize training needs the Center can address by developing new trainings or providing access to/adapting existing trainings available from the PHTC network.

2. Methodology

YSPH worked with the [New England CHW Coalition](#) during the fall of 2015 and winter of 2016 to identify key stakeholders from each of the NE states and develop a methodology for the scan that would be feasible for participants. To gain overall knowledge of the region and CHW workforce development, interviews were held with NE health leaders active in CHW workforce development, including the Region 1 Director for the US Department of Health and Human Services, the Director of the Massachusetts (MA) Office of CHWs and a CHW who is currently working as a consultant for John Snow, Inc. and has been active on the national scene as an advocate for CHWs.

Based on those consultations, it was decided that a group interview format by state of CHW stakeholders, at a length not to exceed 90 minutes, would be most practical. This would be supplemented by internet research on CHW workforce development activities in each state.

A key contact person or organization was identified for the six states based on NE CHW Coalition membership. The contact provided names of five to 10 key stakeholders, including some CHWS. Invitations to participate were sent by YSPH, with the exception of one state. A doodle poll was used to identify the best time for each interview. CHW organizations providing coordination services were paid, as were any CHWs who participated in the interview who were not being paid by their employers during the interview period.

The foundation of the interviews was to update information on the state CHW model maintained by the [National Academy for State Health Policy](#) (NASHP) and available publicly on the Academy's website. Using the NASHP categories, the group interview topics were CHW: definitions (includes roles); organizations; legislation and policy; certification; education and financing. Prior to the interview, participants were provided with a word document containing the NASHP data on their state. (See Appendix A for the CHW model data for each state from NASHP and the interview questions.) The group interviews were held by phone. A video option was available so participants could view the state data and interview question being discussed as the interview progressed. Calls were recorded for note taking purposes only.

Following the interview, information shared by respondents was used to update the descriptive information in each CHW model category for each state. Themes from discussions were also captured and added to reports. A number of respondents provided additional information and links to resources or documents which were added to the report for each state.

3. Limitations

There are a number of limitations to this environmental scan. Information captured in the report was largely dependent upon the knowledge of the participants from each state. While every attempt was made to recruit individuals that were highly knowledgeable about CHW workforce development activities to participate, it is possible that the most accurate and up to date information was not known by the participants and therefore missed by the scan.

Practicing CHWs were invited as participants from each state. However, it was challenging for CHWs to participate. CHWs are generally hourly workers supported by grants and participation in an activity outside their prescribed job role during working hours is often prohibited. In one state, Vermont, there was no CHW on the interview.

Another limitation is the highly dynamic and rapidly changing policy environment around CHW workforce development in the New England states. Policy change is largely driven by healthcare reform and health equity initiatives at the national, state and local levels, such as the Affordable Care Act. Additionally, CHWs are a relatively new workforce in NE and there is little policy or regulation. Therefore, environmental scans contained in this report could be rapidly outdated due to the development and implementation of new policies by states, such as certification.

4. Results

Six 90-minute group interviews were held by phone in May and June 2016. A total of 45 CHW stakeholders participated. The range was five (5) to 11 participants. Results from these interviews are presented across all states (Part One) and then for each individual state (Part Two). Part One describes major commonalities and differences in the CHW model across the states. Part Two presents each state's individual CHW model and includes more state-specific information on policies and financing.

CHW model categories covered in the scan

- Definitions (includes roles/designations)
- Organization
- Legislation (includes policy and role of the state health department)
- Certification
- Education
- Financing

**Results Part One:
Results Aggregated Across All New
England States**

CHW Definitions

Four (4) states, Maine, Massachusetts, New Hampshire and Rhode Island, have adapted a definition and/or a description of CHW roles (scope of practice). Two have regulatory significance.

Statutory/Regulatory

- The Massachusetts Department of Public Health (DPH) adopted a “[functional definition](#)” of CHWs that has been used for over 20 years in its community-based contracts and for CHW policy development, including certification.
- The Rhode Island Certification Board conducted a Job Analysis in 2016 and adopted a [definition of the CHW role](#) as a component of their voluntary CHW certification program.

Advisory

- Maine: The Maine Community Health Worker Initiative adopted a [definition](#) and set of [core roles](#) to inform CHW scope of practice. These roles and definitions have been used for CHW projects funded under the ME State Innovation Model (SIM).
- The New Hampshire Community Health Worker Coalition voted to formally accept the [American Public Health Association \(APHA\) definition of CHWs](#) for their efforts to promote CHW workforce development in NH.

One (1) state, Connecticut, has a governmental committee currently developing a CHW definition and scope.

- Connecticut: [The State Innovation Model \(SIM\) CHW Advisory Committee](#) is charged with making recommendations on the design, certification and sustainability of the Community Health Workers (CHWs) in CT. Development of a definition and scope of work for CHWs is part of their charge. The committee has been using the (C3) Project as the foundation for discussion.

One (1) state, Vermont, does not have any formal or recommended definition being used to direct CHW workforce development or policy.

CHW Organizations

Three (3) states have a CHW professional association: Connecticut, Massachusetts and Rhode Island. These professional associations have all adopted a definition of a CHW.

- Connecticut: A core group of CHWs have been working for the past few years to formalize the Community Health Worker Association of CT (CHWACT). At this time, CHWACT is in the final stages of becoming a section within the CT Public Health Association (CPHA).
- Massachusetts: [Massachusetts Association of Community Health Workers](#) (MACHW) was created in 2000 by a group of key partners, including MA DPH and CHW leaders. MACHW has been in fiscal (fiduciary) partnership with Massachusetts Public Health Association and Center for Health Impact (CHI).
- Rhode Island: [Community Health Worker Association of Rhode Island](#) had been active as a CHW professional association for many years and, until recently, received funding from RIDOH. Their role included convening CHWs, developing a core competency CHW curriculum, overseeing a voluntary certification program and providing training. The association is not currently active, due primarily to a lack of funding, but there is a current effort to reinvigorate it. In the absence of a CHW professional association [Community Health Innovations](#) serves as a leading CHW organization.

Two (2) states have a formal CHW coalition: Maine and New Hampshire. Both coalitions have adopted a CHW definition.

- Maine Community Health Worker Initiative (MECHWI) Stakeholder Group is supported by the ME State Innovation Model (SIM). Membership in the MECHWI Stakeholder Group is open to anyone interested in the process of informing how Maine develops infrastructure to support CHWs. The Stakeholder Group is led by a partnership of the [ME Migrant Health Program](#), [MCD Public Health](#), and [Maine CDC](#). A [website](#) with information on activities is maintained by the group.
- The New Hampshire CHW Coalition formed in 2015 and had its first meeting in November 2015. The coalition is spearheaded by the Southern and Northern NH AHECs. There is no funding for the coalition. Members include CHWs and others that want to promote CHW workforce development.

One (1) state, Vermont, has an organization leading efforts on an informal basis, the University of Vermont (UVM) Center on Aging.

CHW Legislation

Three (3) states have legislation impacting CHW workforce development: Maine, Massachusetts and Rhode Island

- Maine: Legislation: [HP 972, An Act Regarding the Maine Registry of Certified Nursing Assistants and Direct Care Workers](#), was passed in 2015 and was referred to as the “background check law.” CHWs are included in the list of “direct care workers” covered by the legislation. CHWs can voluntarily register for training, education or compliance purposes. Regulations for the Registry have not been developed yet.
- Massachusetts: [Chapter 58, Acts of 2006 Section 110](#); and [Chapter 224, Acts of 2012](#) are two Massachusetts health reform laws that both included CHW components owing to advocacy by MACHW and other key partners. [Chapter 322, Acts of 2010](#) (passed in 2010; took effect in 2012) establishes a board in the Department of Public Health to certify CHWs and approve CHW training programs. A [law in 2007](#) restructured the Public Health Council, creating a slot for a representative from the MA Association of Community Health Workers.
- Rhode Island: [H 5633](#) (enacted 2011) established the Commission for Health Advocacy and Equity. The Commission must make recommendations for increasing the diversity of the health care workforce, which may include recruitment, training and employment of CHWs.

Major Policy Initiatives

All six states are implementing a wide variety of projects and programs involving use of CHWs in roles to bridge the primary/acute/behavioral care health systems with the community to promote appropriate use of medical and community services and improve health outcomes. See Part Two for descriptions.

State Innovation Models (SIM): Two (2) states are using SIM to fund CHW workforce activities.

- Maine: SIM has been the primary mechanism to advance ME CHW workforce development. ME’s [SIM narrative](#) (p. 17) includes the [Community Health Workers Pilot](#) which funds the MECHWI (above) to develop a system of CHWs as part of Maine’s transformed healthcare system. This is being accomplished through support of four SIM-funded CHW pilots.
- Connecticut: [The State Innovation Model \(SIM\) CHW Advisory Committee](#) is charged with making recommendations on the design, certification and sustainability of CHWs in CT.

Involvement of State Health Department

Two (2) states, Massachusetts and Rhode Island, have an individual or program/board/commission responsible at their State Health Department for CHW workforce development.

- [Massachusetts Office of Community Health Workers](#) and [Massachusetts Board of Certification of Community Health Workers](#)
- [Rhode Island Commission for Health Advocacy and Equity](#)

The two (2) states advancing CHW workforce development through their SIM, Connecticut and Maine, have the State Health Department represented on SIM committees advancing CHWs.

Certification

Two (2) states are in the process of implementing certification: Massachusetts and Rhode Island

- Rhode Island is in the process of implementing a [voluntary CHW Certification](#). The effort was spearheaded by the RI Department of Health. The RI Certification Board (RICB) conducted a job analysis to support certification and is the authorizing grantor. There are requirements for training (70 hours) and internship (1000 hours). RIDOH is working with partners to set up a training Applicants will have to pass an exam, details of which are unclear at this time. Continuing education is required (20 hours every 2 years). The period for grandfathering in of existing CHWs has begun and ends November 17, 2017.
- The MA [Board of Certification of CHWs](#), located in the MA DPH (Division of Health Professions Licensure) and authorized by [state statute](#), has drafted regulations for voluntary certification for both paid and volunteer CHWs and approval of core training programs. The regulations are undergoing administrative and public review before becoming operational. The anticipated certification process will consist of a paper or online application, submission of three professional references, completion of an approved training program and 2000 hours of relevant work experience. There will also be a grandfathering period for the first three years of certification when CHWs with 4000 hours of relevant work experience will be eligible to apply for certification without attending formal training.

One (1) state, Maine, will be instituting a CHW registry to be maintained by the ME Department of Health and Human Services Division of Licensing and Regulatory Services (DLRS).

- The ME Registry will list individuals who are either (1) *ineligible* for employment due either to “disqualifying offences” identified during employer background checks or substantiated complaints or (2) *eligible* and qualified for employment by voluntarily registering for training, education or compliance purposes. CHW advocates are preparing comments for rule-making for the registry. Advocates feel it is possible the registry will function well for CHW workforce development purposes and certification in ME will not be needed.

One (1) state, Connecticut, has a SIM Committee that will be making recommendations on CHW certification in 2016.

Two (2) states, Maine, New Hampshire and Vermont, are not currently considering certification.

- New Hampshire: New Hampshire Community Health Worker Coalition has decided to devote its energy into building more of a CHW network with active participation of CHWS before further exploration of certification.
- Vermont: State law only requires certification if the occupation can pose a risk of injury to another. While certification has been discussed among CHW advocates, there is no momentum to pursue it at this time.

Education

Four (4) states have an infrastructure for CHW core competency training that uses a common standard for curricula. The standard may be national (Connecticut, New Hampshire) or established by the state with input from CHWs (Massachusetts, Rhode Island). The most commonly used training provider across all four states are community colleges. States also use non-academic training organizations, most commonly AHECs and other community-based training organizations. Learners may or may not be employed as a CHW while participating in the training program. Job placement following training was noted as a challenge.

- Massachusetts: Training programs address the 10 core competencies adopted by the MA Board of Certification in 2014. Core competency training is 80 hours. MA has a wide variety of training providers, including both academic institutions and community-based organizations. More advanced training and training on specialized topics is also offered by some providers. A list of training programs and providers can be found on the MA [Office of CHW website](#) and the [MACHW website](#).
- Connecticut: Major training providers are three Community Colleges (Housatonic, Capitol and Gateway) and the CT AHEC Network, with Southwest AHEC as the lead. All the CT groups are using the Foundations for Community Health Workers [text book](#) and the newly developed [training guide](#). Community college training programs offer 160 hours of training plus an internship/job shadowing component of 40 – 50 hours. The AHEC training program is 60 hours plus job shadowing and often provided to learners who are already working as CHWs.
- New Hampshire: The Southern NH AHEC and Northern NH AHEC offer [CHW training programs](#). Both use the same curricula based on the national CHW core competencies but deliver the training using different delivery formats. SNHAHEC offers a 56 hour face-to-face program and NNHAHEC offers a hybrid program. Graduates receive a certificate of completion. There is no internship component.
- Rhode Island: CHWARI developed a [standardized curriculum](#) for CHW training and certification, known as “Essential Skills for Community Health Workers” in 2012 that can be used by any training organization. RI College Outreach Program has been offering the training as a certificate program with 150 hours of classroom time and 80-100 hours of internship, overseen by Community Health Innovations. Currently, the curriculum is being updated by RI College to meet the needs of the new certification program.

Two states have an employer -driven training core training model (Maine, Vermont).

- Maine: MECHWI Stakeholder Group has developed a core competency/skills/roles cross-walk to inform the development of training recommendations. Currently, training is provided by employers or tied to specific grant-funded projects. There is no ongoing/continuous funding source to support CHW training; it is pieced together from various grant sources. Currently, the MECHWI Stakeholder Group is exploring development of a CHW training infrastructure to support the CHW Registry.
- Vermont: Core training for CHWs has been directly provided by employers, who are generally health care systems and accountable care organizations (ACO). There is no standardization of

training, with exception of the [SASH](#) Coordinator position which has a statewide standardized training program. It is eight weeks and covers topics such as care planning, healthy living planning, confidentiality, database training and team facilitation, with some interdisciplinary components. SASH Coordinators also receive continued training on the job. Of note, there is also a small pilot to train CHWs to work with nurses at the Community College of Vermont.

Training outside of the core competency areas on more advanced or specialized topic areas takes many forms in each of the states. Some core CHW training providers also offer specialized training courses and workshops. CT, RI and VT specifically mentioned sending CHWs to specialized training programs offered in MA. As only two states are in the process of implementing certification, there is no formal continuing education infrastructure with contact hours in any state at this time.

Financing

Most states report that CHW positions are grant or contract funded. Grants can be federal, state or private. Less common is paying CHWs with general operating funds. Stakeholders from all states report that paying CHWs through the traditional fee-for-service model is not practical and they are hopeful that healthcare payment reform models based on the value of care will provide a sustainable method to support CHW employment. Thanks to federal support, all states are exploring or piloting various payment reform initiatives under Medicare and Medicaid which can be used to support CHWs.

All stakeholders discussed the challenges of financing training programs for CHWs and creating a sustainable training infrastructure. In general, CHW students have not had the resources to pay for training without assistance. The cost of training development and delivery has largely been paid for by grants, employers or CHWs themselves. Training providers have also worked to make financial aid available. A number of states have used Department of Labor grants to fund curricula development or to subsidize tuition.

Results Part Two:
Results by New England State

CONNECTICUT (CT) CHW Model

Based on discussion held June 14, 2016 from 9 – 10:30 am

Participants:

- Elena Padin: CHW at Southwest Community Health Center; Board member, CHW Association of CT (CHWACT)
- Liza Estevez: Patient Navigator, North East Medical Group, Yale New Haven Health System; Member, State Innovation Model (SIM) CHW Workgroup
- Loretta Ebron: Senior CHW, Optimus Health Care; Vice President, CHWACT; Member, SIM CHW Advisory Committee; CHW Instructor, Housatonic Community College (HCC)
- Milagrosa Sequinot: CHW Project Coordinator, SW Area Health Education Center (AHEC), President, CHWACT, Member, SIM CHW Committee.
- Meredith Ferraro: Executive Director, SW AHEC, Member, SIM CHW Advisory Committee
- Bruce Gould: Internist; Associate Dean for Primary Care, UConn Health Center; Director, CT AHEC Program; Medical Director, Hartford Health Department; PI SIM CHW Initiative; Medical Director, Community Health Center Association of CT, Patient Transformation Grant

CHW Roles

There is no official CHW definition used by the state. The Community Health Worker Association of CT (CHWACT) has adopted the [American Public Health Association's definition of CHW](#), with a slight modification.

[The State Innovation Model \(SIM\) CHW Advisory Committee](#) is charged with making recommendations on the design, certification and sustainability of CHWs in CT. Development of a definition and scope of work for CHWs is part of their charge. CHWACT participated in [the CHW Core Consensus \(C3\) Project](#) C3 project, which offered a set of national recommendations on CHW core roles (scope of practice) and core competencies. The SIM Advisory Committee received permission from the C3 study to use the C3 recommendations pre-publication for their preliminary work on CHW workforce development.

Other comments:

- CHWs work in the [CT Migrant Farm Worker Clinics](#)
- CHWs are now attached to all Federally Qualified Health Centers (FQHCs) in CT
- Cigna Foundation is one of the funders of the [North East Hartford Partnership](#), which is conducting a pilot program utilizing Community Health Workers for patients requiring complex care.
- CHWS are used in Medicaid Transformation's Medical and Behavioral Health teams.

General comments

- CHWs are generally funded through grants. This can prohibit them from using knowledge/skills that fall outside the narrow framework permitted by the grant.
- Many CHWs in communities are volunteers and should be recognized for the important role they play. CHW volunteers include practicing CHWs that find they have to deliver additional services to clients on their own time because of grant restrictions (see above).

CHW Organizations

The Community Health Worker Association of CT (CHWACT) is CT's CHW professional association. A core group of CHWs have been working for the past few years to formalize the association. At this time, CHWACT is in the final stages of becoming a section within the CT Public Health Association (CPHA). Final approval of CHWACT bylaws as a CPHA section is expected in the near future. Through the SIM grant, CHWACT has some funding to develop a marketing plan and materials to engage in a statewide education and outreach campaign promoting the role of CHWs.

Other key supporting organizations in CT

- [Hispanic Health Council](#): Has promoted and evaluated the use of CHWs and they recently hosted a major symposium in CT on CHW developments and issues.
- [KHMER Health Advocates](#): Mission is to care for the health needs of survivors of the Mahandorai (the Cambodian holocaust), and their families. Has promoted and used CHWs, especially for medication therapy management.
- [Southwestern AHEC](#): Has provided leadership and training for CHWs. Worked with MPH students from Yale School of Public Health to conduct surveys of CHWs and their employers as well as research on CHW models.
- Community Colleges: Housatonic, Capitol and Gateway have developed training programs for CHWs (see Education section)
- CT Department of Labor: Now has information about [CHW employment](#) on their website.

State CHW Legislation and Policy

Legislation: No CHW legislation

Policy Initiatives:

- [SIM CHW Advisory Committee](#)
 - Formed and supported by CT's State Innovation Model grant, the Committee "...will develop recommendations with respect to the training, promotion, utilization and certification of Community Health Workers (CHWs) as well as establishing a framework for sustainable payment models for compensation. The Committee will also examine critical issues for employers with regard to CHWs relating to hiring, supervising, and technical support. Specific recommendations and deliverables may include a definition and scope of work for CHWs, a process for certification, and recommendations for sustainable payment."
 - Recommendations from the committee will go to the SIM Steering Committee and then to the Governor for consideration. There is hope that legislative proposals will be generated.
- [Health Equity Solutions](#): A newly formed organization with a mission to catalyze policy programs and practices that advance and sustain health equity in Connecticut, the group has shown interest in promoting CHW legislation.
- Various demonstration projects on chronic disease control using CHWs. Example: Parish nurses are doing a "Know your Numbers" campaign with CHWs in Bridgeport CT as a part of the Community Health Improvement Plan.

- CT Medicaid (also see financing): CHWS are part of [Intensive Care Management \(ICM\) teams](#), and as [peer supports for the Connecticut Behavioral Health Partnership](#)

State Health Department Role

CT Department of Public Health (DPH) does not have a central coordinating office or individual responsible for promoting CHWS. CT DPH does have a representative on the SIM CHW Advisory Committee and has promoted use of CHWs in various programs, including Chronic Disease Management.

Certification

No certification exists at this time. However, the [SIM CHW Advisory Committee](#) is charged with exploring certification and making recommendations. Six members of the committee are CHWs. The CT AHEC Network, through SIM funding, has national experts Carl Rush and Joanne Colista as consultants to the Committee. The SIM CHW Advisory Committee has just recently begun meeting and has an aggressive timetable for developing recommendations, hopefully by fall 2016.

Education

Major training providers are three Community Colleges ([Housatonic](#), [Capitol](#) and [Gateway](#)) and the CT AHEC Network, with SW AHEC as the lead. All the CT groups are using the Foundations for Community Health Workers [text book](#) and the newly developed [training guide](#) (just released with the 2nd edition) developed by faculty who teach in the Community Health Worker (CHW) Certificate Program at City College of San Francisco (CCSF). The guide contains training activities and learning assessments. The training program also includes a required internship. CHWs completing the program receive a certificate of completion. Additionally, these training organizations have teamed up with other training providers, such as the American Heart Association, to offer CHW learners training in specialized areas, i.e., first aid, safety and HIPPA. In some cases, CHWs may get certificates from these providers.

The three Community Colleges developed training programs for CHWs in 2014.

- The three colleges consulted with CT CHWs as they developed their programs. Each program is unique.
- Programs have 160 hours of training and have an internship/job shadowing component of 40 – 50 hours.
- It has been challenging for the schools to find internship opportunities for students.
- Development of community college programs was supported by CT Regional Workforce Investment Boards and Federal Dept. of Labor grants.
- Labor grants will end in 2016 and then fees will be the same as any other community college course.

The SW AHEC training program was developed for employers to train newly hired CHWs. It is supported largely by employers and/or grants. Scholarships are pursued through fundraising activities and partnerships. The training is 60 hours plus job shadowing. As employers are paying for the training, many of the learners are already on the job. SW AHEC also provides direct observation of interns in the practice setting to assess skills on a confidential basis (individual results are shared only with the

student, not with employers). This methodology is also used to evaluate curriculum. AHEC also provides ongoing mentoring and support to CHWs who are new to practice. AHEC has collaborated with instructors at a community college to provide support for their internship program. Currently, SWAHEC is training CHWs for use in the Northeast Hartford Partnership in partnership with [Community Solutions](#), using funding from a Connecticut Health Education and Facilities Authority grant to the UCONN Foundation.

CT has also contracted with MA Center for Health Impact/MACHW to provide trainings to CT CHWs. Through the SIM grant, CT is also pursuing designation as an apprenticeship program from CT Department of Labor. To meet the standard as an apprenticeship program, there would need to be 172 hours of training.

Financing

CHWs in CT are generally grant funded.

CT Medicaid is using the self-insured fee-for service model under which they contract with four administrative services organizations (ASOs) to manage medical, dental, behavioral health and emergency medical transportation. CHWs are incorporated into the Intensive Care Management (ICM) teams for medical and behavioral health ASOs. ([McEvoy Presentation, Feb 11, 2014](#)).

SIM Model Test Grant: Medicaid will move to a more local model and implement a shared savings initiative. Through the Medicaid Quality Improvement and Shared Savings Program (MQISSP) developed through the SIM grant, Medicaid is targeting specific providers, including Federally Qualified Health Centers (FQHCs), to respond to the [current RFP](#). The program envisions CHWs as being incorporated into more care teams. There will be shared savings payments dependent upon patient improvement and outcomes.

In addition, the SIM Test Grant has developed the [Community Clinical Integration Program \(CCIP\)](#). This program seeks to develop Community Care Teams consisting of nurses, Social Workers/Behavioral Health personnel and Community Health Workers to focus on health equity, behavioral and mental health, and patients who require complex care.

As the SIM Test Grant progresses, CHWs will be incorporated into care teams and assist in the transition of health care to include the social determinants of health and population health.

MAINE (ME) CHW Model

Based on discussion held May 23, 2016 from 1:30 – 2:45 pm

Participants:

- **Joan Dolan:** Maine Department of Labor
- **Betty St. Hilaire:** Care Navigator for an insurance company (Trained as a CHW and CHE supervisor)
- **Barbara Ginley:** Project Director for ME CHW Initiative under SIM; Chief Technical Officer for the Maine Migrant Health Program
- **Kirsten Thomsen:** Physician Assistant and Adjunct at University of New England; Immediate Past President of ME Association of Physician Assistants; active on local, state and national level with healthcare issues, particularly underserved populations
- **Karen O'Rourke:** Director of the Maine AHEC Network and Assistant Professor of Public Health in the School of Community and Population Health, University of New England; ME Local Performance Site (LPS) Coordinator for NE PHTC

CHW Roles

The Maine Community Health Worker Initiative (MECHW) adopted a definition and set of core roles to inform CHW scope of practice in 2014.

Definition of the Maine Community Health Worker

- A trained and trusted public health worker who is respected by the people s/he serves and applies his/her unique understanding of the experience, socio-economic needs, language and/or culture of the communities served to:
- Act as a bridge between providers and individuals to promote health, reduce disparities, and improve service delivery; and
- Advocate for individual and community needs

CHWs are distinguished from other health professionals because they:

- Are hired primarily for their understanding of the populations and communities they serve;
- Conduct outreach a significant portion of the time; and
- Have experience in providing services in community settings

Core Roles of Community Health Workers

- Role 1: Bridge the gap between communities and the health/social service systems.
- Role 2: Promote wellness by providing culturally appropriate health information to clients and providers.
- Role 3: Assist in navigating the health and human services system.
- Role 4: Advocate for Individual and Community Needs.
- Role 5: Provide Direct Services.
- Role 6: Build Individual and Community Capacity

Source <http://www.mechw.org/resources.php> Document: MECHW Definition and Roles 031714.

In 2013, the ME CHW Initiative conducted an [inventory](#) of CHWs and identified agencies employing CHWs and characteristics of their CHW programs. This inventory has not been updated.

CHW Organizations

Maine Community Health Worker Initiative (MECHWI)

The MECHWI is one of the key workforce development strategies under the ME State Innovation Model (SIM). The Initiative maintains a [website](#), develops resources and recommendations and supports CHW activities. In addition to the ME CHW definition and roles previously described, the initiative has conducted an inventory of programs that employ CHWs (2013); developed recruitment recommendations (2014) and conducted a literature review of CHW best practice models (2016). As part of the Initiative, a stakeholder group was launched in the fall of 2013. Membership in the MECHWI Stakeholder Group is open to anyone interested in being involved in the process of informing how Maine develops infrastructure to support CHWs. The Stakeholder Group is led by a partnership of the [ME Migrant Health Program](#), [MCD Public Health](#), and [Maine CDC](#) (ME's State Health Department). MECHWI and the Stakeholder Group are funded through the SIM grant.

State CHW Legislation and Policy

Legislation: [HP 972, An Act Regarding the Maine Registry of Certified Nursing Assistants and Direct Care Workers](#), was passed in 2015 and was referred to as the “background check law.” CHWs are included in the list of “direct care workers.” The Registry will be maintained by the ME Department of Health and Human Services Division of Licensing and Regulatory Services (DLRS). The registry serves two functions. It will list individuals who are

- 1) ineligible for employment due either to “disqualifying offences” identified during employer background checks or substantiated complaints or
- 2) eligible and qualified for employment by voluntarily registering for training, education or compliance purposes.

The rule making for the registry has not started yet. The Stakeholder Group is discussing recommendations on CHW Registry regulations. The Stakeholder Group may also submit further recommendations collectively or individually. Looking to the future, the Stakeholder group will see if the law helps to sustain ME CHW workforce development without additional legislation; there may be no added advantage to certification over a registry.

Policy: State Innovation Model (SIM)

SIM has been a primary mechanism to advance ME CHW workforce development. ME's [SIM narrative](#) (p. 17) includes the [Community Health Workers Pilot](#) which funds the MECHWI (above) to develop a system of CHWs as part of Maine's transformed healthcare system. This is being accomplished through support of four SIM-funded CHW pilots (see below) to: demonstrate the value of integrating CHWs into the health care team; provide models for state-wide replication and build a core group of experienced CHWs who can provide leadership for ongoing development of the system

CHW SIM Pilot Projects:

1. DFD Russell Medical Center will embed CHW(s) within their patient-care team to engage patients in the management of asthma and to link patients to breast cancer screening. CHWs

will provide education, assist with navigation of the healthcare system and make referrals to other healthcare and community resources.

2. Maine General will add CHW services to their Prevention Center to provide education and linkages to: medical homes, behavioral health services, cancer screenings and other healthcare and community services. The focus will be on patients who: do not have a medical home, use urgent care/ED for basic care services, opt out of cancer screenings and need medication safety education, and/or need diabetes prevention and support in the management of their chronic disease(s).
3. City of Portland, Public Health Division will integrate two CHWs into local community care teams (CCTs) affiliated with CarePartners and other partner sites to target individuals without medical homes to reduce gaps in care; enroll patients in health insurance; reduce hospitalizations; incorporate patient-reported outcomes and assess impact of CHW/CCT model on patient's health.
4. Spectrum Generations will improve care for high-risk, older, disabled and/or care giving adults who have chronic conditions by reducing their risk/need for high cost interventions and resources through the integration of CHWs within their agency and SeniorsPlus. The CHWs will link clients to community and primary care provider/patient centered medical home care and promote wellness, medication adherence and self-management through group and individual-level interventions and education.

Source: <http://www.mechw.org/news.html>

Community Care Teams (CCTs): CCTs are a part of MaineCare (Medicaid) Health Homes and Accountable Communities programs; ME has a State Plan Amendment that delineates that CHWs could be included as team member.

State Health Department Role: ME Centers for Disease Control (CDC)

The Division of Population Health in ME CDC is lead for the MECHWI, has representation on the SIM leadership team and the MECHWI Stakeholder Group. At this time, ME CDC does not have staff/office that provides centralized coordination of community health worker activities within their health department.

Certification

CHW certification does not exist and is not being pursued at this time. See CHW Legislation section above and discussion of ME Registry.

Education

MECHWI Stakeholder Group has developed a core competency/skills/roles cross-walk to inform the development of training recommendations. From this, the Stakeholder group has adopted core competencies to be used for standardized training recommendations. Currently, training is provided by employers or tied to specific grant-funded projects. There is no ongoing/continuous funding source to support CHW training; it is pieced together from various grant sources.

Presently, the CHWI Stakeholder Group is discussing recommendations for the training standards/rules for the new ME CHW Registry that will be forwarded to DLRS. The aim is to assure quality while not

imposing any unnecessary barriers to training. The CHW group is evaluating use of a standardized “train the trainer” program to assure that CHW trainers are qualified and standardization of training content. The aim is to have multiple CHW training providers (as opposed to a single provider for the state) and to establish standards for: 1) the number of training hours; 2) competencies for core training; 3) a competency assessment and 4) successful completion of the training program.

Developing models for financial sustainability of CHW training programs is also a priority of the Stakeholder Group.

Financing

Practices involved in Maine’s [Health Homes](#) program must include a Community Care Team (CCT) and CHWs are [explicitly listed](#) (p.4) as potential team members. Grant funding for the teams expires at the end of 2016. Some private payers are now paying for CCTs. ME also has an [Accountable Communities Initiative](#) which encourages delivery and payment innovation. Four CHW pilot sites are funded through the SIM grant. The SIM project is also working on developing financing models based on the estimated real cost of employing/supporting CHWs. The model factors in the patient cost savings produced by CHWs which could be utilized by employers and payers in their business plans. CHWs are also paid through Federal and private grants and private payers. ME is not seeking a 1115 Waiver. The Stakeholder group is also exploring financial support for CHWs under the payment reform models enabled under the [Medicare Access and CHIP Reauthorization Act of 2015](#)

MASSACHUSETTS (MA) CHW Model

Based on discussion held Wednesday, May 18 from 1 - 2:30 PM

Participants

- Jackie Toledo: Director of Leadership Development, Massachusetts Association of Community Health Workers (MACHW)
- Jamie Berberena: CHW Supervisor, [Southeastern Health Initiative for Transformation \(SHIFT\) Program](#), New Bedford Health Department
- Katharine London: Principal, [Center for Health Law and Economics](#), University of Massachusetts Medical School
- Jackie Gelb: Community Ventures Consulting; involved with CHWs and [MassHealth Children's Behavioral Health Initiative](#).
- Lisette Blondet: Director, MACHW
- Gail Hirsch: Co-Director of the Office of Community Health Workers. MA Department of Public Health
- Rainelle White: Family Van mobile unit for health screenings; Advisory Board member, MACHW; CHW for 22 years.
- Terry Mason: Independent Policy Research Consultant with expertise on CHWs
- Peggy Hogarty: Director, [Community Health Education Center](#) (CHEC) Boston Public Health Commission; CHEC provides core and continuing education training to CHWs in MA and the greater New England area.

CHW Roles

The Massachusetts Department of Public Health (DPH) developed, with broad input, and has used the following [functional definition](#) of CHWs for over 20 years in its community-based contracts and for policy development, including certification.

Massachusetts Department of Public Health CHW Functional Definition

CHWs are public health workers who apply their unique understanding of the experience, language, and/or culture of the populations they serve in order to carry out one or more of the following roles:

- Providing culturally appropriate health education, information, and outreach in community-based settings, such as homes, schools, clinics, shelters, local businesses, and community centers;
- Bridging/culturally mediating between individuals, communities, and health and human services, including actively building individual and community capacity;
- Assuring that people access the services they need;
- Providing direct services, such as informal counseling, social support, care coordination, and health screenings; and
- Advocating for individual and community needs.

CHWs are distinguished from other health professionals because they:

- Are hired primarily for their understanding of the populations and communities they serve;
- Conduct outreach a significant portion of the time in one or more of the categories above;
- Have experience providing services in community settings

MACHW has adopted a CHW definition very similar to DPH: “A community health worker is a public health professional who promotes full and equal access to necessary health and social services by applying his or her unique understanding of the experiences, language and culture of the communities he or she serves.”

Themes from group interview:

- Leaders: CHWs are the frontrunners and catalysts who advance a program’s goals and objectives and assure effective implementation in communities; they “make sure that things get done.”
- As important as definitions/roles are the qualities and attributes of CHWs, which include the following
 - CHWs need to share experience with the populations they serve.
 - Emphasis on “lived experience” with the competencies. A CHW needs to be more than someone who can demonstrate competency – they must also have the ability to build trust.
 - Do not want to “medicalize” the profession.
- If CHWs are going to be paid in a fee-for service model, then documentation skills are critical. More training may be needed for CHWs on this skill.
- Behavioral health: Because of a law suit called “[Rosie D](#)” there are children’s behavioral health workers who are CHWs and are being paid by Medicaid. This is one of the few examples in MA of CHWs being paid directly by Medicaid.

CHW Organizations

[Massachusetts Association of Community Health Workers](#) (MACHW) was created in 2000 by a group of key partners, including DPH and CHW leaders. During its 16- year tenure, MACHW has been in fiscal partnership with the Massachusetts Public Health Association (MPHA) and the Center for Health Impact (CHI). For a brief period in 2013-2014, MACHW was a 501c3 organization. [MACHW’s mission](#) is to: 1) strengthen the professional identity of community health workers (CHWs); 2) foster leadership among CHWs; and 3) Promote the integration of CHWs into the health care, public health and human service workforce.

[MA DPH Office of Community Health Workers](#) (see [Legislation and Policy](#) for description)

Blue Cross Blue Shield of Massachusetts Foundation has been a key supporter of multiple MACHW programs and policies since it was established in the early 2000s.

State CHW Legislation and Policy Initiatives

[Chapter 58, Acts of 2006 Section 110](#) and [Chapter 224, Acts of 2012](#) are two groundbreaking health reform laws that included CHW components brought about by advocacy efforts from MACHW and other key partners. Also critically important to CHW workforce development is Massachusetts [Chapter 322, Acts of 2010](#), legislation that was passed in 2010 and took effect in 2012, to establish a board in the Department of Public Health to certify CHWs and approve CHW training programs. A [law in 2007](#) restructured the Public Health Council, creating for representation from the MACHW. See text box below for more details.

Overview of Significant CHW Legislation

The 2006 Massachusetts health reform law (Chapter 58), Section 110, required DPH to convene a statewide CHW advisory council to investigate the workforce and report its finding and recommendations to the legislature. Thirty-four recommendations were made in four key categories: strengthen CHW professional identity; strengthen CHW workforce development, (including training and certification); expand financing mechanisms and establish a state infrastructure.

In response, the [Office of Community Health Workers](#) at the MA DPH Health was established in 2009. It sits within the Division of Prevention and Wellness. The Office helps to coordinate CHW workforce development activities. In addition, it supports the work of the Division in promoting the use of CHWs in chronic disease prevention and management.

Recommendation #2.6 called for the establishment of a certification process for CHWs, based on diverse cross-sector support. The Massachusetts Association of Community Health Workers (MACHW) held forums for CHWs around the state to hear their views on certification. CHWs generally supported certification, provided that it would be voluntary and that CHWs be included on the certification board. Together with experts at DPH, MACHW wrote the legislation to establish the Board of Certification of CHWs, and MACHW, joined by key partner organizations, led a statewide campaign to get the legislation passed.

The following year, Chapter 322, Acts of 2010, "[An Act Establishing a Board of Certification of Community Health Workers](#)," was signed into law, and took effect in 2012. The law calls for voluntary certification. The intent of the law is to create a competency-based process that recognizes and strengthens the work of CHWs while simultaneously avoiding the creation of barriers for effective CHWs to get certified. Since 2012, the Massachusetts Board of Certification of CHWs, located at the DPH Division of Health Professions Licensure, has been making policy decisions to inform the regulations on 1) certification of individual CHWs and 2) approval of CHW training programs. The Board is appointed by the governor and has eleven seats, four of which are CHWs. The chair is the Commissioner of Public Health or his or her designee.

Source: [MA Office of CHW, MA DPH](#)

Policy

- CHWs are not involved in the State Innovation Model (SIM) Grant in MA.
- Medicaid and CHWs: See Section 6, Pages 5 and 6, Financing.
- Children's behavioral health and CHWs: See Section 6, Pages 5 and 6, Financing.

Themes from group interview:

- Policy initiatives for CHW sustainability are determined by a coalition convened by the state health department, with leadership from the MA Public Health Association and MACHW as well as other key stakeholders.
- Community health workers and providers have a key interest in expanding funding mechanisms.

4. Certification

The [Board of Certification of CHWs](#), located in the MA DPH (Division of Health Professions Licensure) and authorized by [state statute](#), has drafted regulations for 1) voluntary certification for both paid and volunteer CHWs; and 2) approval of core training programs. The regulations are undergoing administrative and public review before becoming operational. The anticipated certification process will consist of a paper or online application, submission of three professional references, completion of an approved training program and 2000 hours of relevant work experience. There will also be a grand-parenting period for the first three years of certification. See more on draft recommendations below.

Summary of DRAFT CHW Certification Recommendations

Core competencies to serve as the foundation for competency-based certification:

- Outreach Methods and Strategies
- Individual and Community Assessment
- Effective Communication
- Cultural Responsiveness and Mediation
- Education to Promote Healthy Behavior Change
- Care Coordination and System Navigation
- Use of Public Health Concepts and Approaches
- Advocacy and Community Capacity Building
- Documentation
- Professional Skills and Conduct

There will initially be two pathways for individual CHWs to become certified. (1) A combination of training and work experience: 80 hours of training from a state-approved training program covering a combination of core competencies and special health topics plus 2000 hours of relevant work experience over the 10 years prior to application. Or (2) 4000 hours of relevant work experience over the 10 years prior to application. (This is a “grandfathering” option for experienced CHWs who didn’t graduate from a core competency training program; this “work only” pathway will be phased out three years after the state certification program actually begins.)

[Source: MACHW](#)


Education

Training is offered by community-based organizations, a community health center, local health departments, a university school of public health and community colleges. A listing of programs can be found on the [Office of CHW website](#) and the [MACHW website](#). Training programs address ten [core competencies](#), which were adopted by the MA Board of Certification in 2014. Core competency training is 80 hours (can be either in-person or a hybrid online/in-person combination) and CHWs applying for certification must have 2000 hours of relevant work experience. Graduates of training programs will then be eligible to apply for state CHW certification.

Training Programs Offering Core Competency Trainings for CHWs

- [CHEC Boston](#) - Community Health Education Center at the Boston Public Health Commission has been providing CHW trainings since 1993.
- [CHEC Lowell](#) - Community Health Education Center at Lowell Community Health Center provides trainings for CHWs.
- [DPH Patient Navigator training course](#) is a hybrid model CHW training, and includes 11 online modules as well as 16 hours of in-class training.
- [Holyoke Community College](#) offers a CHW certificate program with college credit.
- [OWTI](#) - Outreach Worker Training Institute is a CHW training center based at Central Massachusetts AHEC in Worcester, Mass.
- [Western Massachusetts Public Health Training Center](#): Offers training programs for frontline public health workers.

2 and 4 Year College - Programs that Offer Courses for CHWs that Are Designed to Complement Core Competency Training

- [MassBay Community College](#)  offers both a certificate and an Associate's Degree in Community Health.

Sources: [Office of CHW website](#) and the [MACHW website](#)

Themes from group interview:

- CHW training programs need to utilize trainers that have experience as practicing CHWs. Draft certification regulations call for a CHW co-trainer to participate in core training.
- CHW training programs need to be connected to the community.
- Involve CHWs: Assess their needs and hear from them about what would be best for their training and professional development. Acknowledge life skills/experience in the training.
- Need to distinguish core training vs continuing education/professional development.
- Draft MA certification recommendations call for renewal of certification every two years and will require 15 hours of continuing education.
- Concern was expressed about use of distance learning.
 - Some feel this workforce needs training based on adult learning principles done in an interactive, face to face environment.
 - What is a good online training for CHWs? Are there some best practices/validated quality online training programs? Possible role for NEPHTC.
- Concern about financing of training:
 - CHEC has moved to fees. Employer is asked to share the responsibility for training cost. The fees are affordable but do not reflect the total cost of training. Moreover, even small fees can be unaffordable and create a barrier. CHEC gets other municipal funding to subsidize training; other training vendors do not have access to that.
 - Other training programs rely on grants; grants not reliable year to year.
- Accessibility: Lack of transportation to training and other training accessibility issues could be a barrier for expanding the workforce.

- Presently no programmatic evaluation of training programs.
- Behavioral health: [Children's Behavioral Health Worker Certificate Program](#) had been receiving funding to support the cost of training. Now looking for alternative sources. Note: This training aligns with the MA CHW core competencies and will integrate with the training standards for CHW certification.

Financing

Currently, the principal mechanism for funding CHW positions in MA is through grants. Grant sources include federal, state and local governments, private foundations, other nonprofit funding. There is a limited degree of private health plan financing for CHWs. Less common is a combination of grants, core organizational operating funds and other resources. The state Office of Community Health Workers anticipates that the shift to global and other alternative payment systems by health care providers/systems will expand opportunities to financially support a greater number of CHW services. For several years, Medicaid has supported CHW services through a 1115 waiver for children's behavioral health services and a federal/state [demonstration program for adults dually eligible for Medicare and Medicaid, known as One Care](#). Community health workers were explicitly mentioned in the 2012 payment reform law ([Chapter 224](#)). Opportunities created for CHWs as a result of Chapter 224 include the following: 1) healthcare organizations that moved at least partly to non-fee-for-service payment systems could more easily cover CHWs linked to or part of multidisciplinary care teams; 2) The Prevention and Wellness Trust Fund established by the law and administered by the MA DPH (\$60 million over a 4-year period) supports CHW services in all nine of its projects across the state; and 3) the establishment in the law of the [Health Care Workforce Transformation Fund](#), designed to support the training of emerging health care workforces, has funded multiple CHW trainings throughout the Commonwealth. In September, 2016 the state submitted a Medicaid 1115 Waiver request to hold ACOS responsible for the quality, coordination and total cost of members' care. If approved, the waiver would expand MassHealth authority to fund ACOs that will be more likely to cover CHWs to help achieve the goals of better integrated, more patient-centered care.

NEW HAMPSHIRE (NH) Model

Based on discussion held June 7, 2016 from 9 to 10:30 am

Participants:

- **Paula Smith:** Director, Southern NH Area Health Education Center (SNAHEC)
- **Nancy Frank:** Executive Director, North Country Health Consortium/Northern NH AHEC (NNHAHEC)
- **Jazmin Miranda:** Community Health Worker, Manchester Community Health Center, Southern AHEC
- **Rafael Calderon:** Community Health Worker, Bell Tower Home Health Care
- **Sue Giglioti:** Community Health Worker, Lamprey Health Care (FQHC with 3 locations)
- **Carrie Chooljian:** Community Health Worker Supervisor, Lamprey Health Care
- **Selma Tarahija:** Community Health Worker, Manchester Community Health Center, Health Equity

CHW Roles

In November 2015, the New Hampshire Community Health Worker Coalition (NH CHW Coalition) voted to formally accept the [American Public Health Association's definition of CHW's](#) for their efforts to promote CHW workforce development in NH.

Roles

- Roles are tied directly to the funding source (grants) and often compartmentalized. There has been more grant funding available to support CHWs in the southern part of the state which is more densely populated and demographically diverse. CHWs are largely employed by Community Health Centers and hospital systems. Roles have CHWs targeting social determinants of health and special populations and/or specific health concerns.
- Major roles: 1) Chronic disease prevention and management, including [cancer](#) (including breast and cervical cancer screening programs), heart disease and diabetes. Example: [Better Choices, Better Health](#) program which uses the Stanford Chronic Disease Self-Management Model. 2) Project LAUNCH: Working with at-risk children to assure young children can access the services they need so that they can thrive in school and beyond. 3) Substance abuse prevention and behavioral health: 4) elderly populations, including home visits and 5) appropriate utilization of health care services and avoidance of emergency room visits.

CHW Organizations

The NH CHW Coalition was formed in 2015 and had its first meeting in [November 2015](#). The coalition is spearheaded by the Southern and Northern NH AHECs. There is no funding for the coalition. Members include CHWs and others that want to promote CHW workforce development. The Coalition has had two meetings with speakers and workshops: November 2015 and March 2016. Another meeting is planned for fall 2016. Coalition members participated in the [CHW Core Consensus Project \(C3\) Project](#),

which is working to build a national consensus on CHW core roles, skills and qualities. At the next meeting, the Coalition plans to look at the C3 report and determine the best relationship between CHW competencies and skills for NH.

A priority of the Coalition is to make sure that CHWs have a strong voice in defining their roles and in workforce development.

State CHW Legislation and Policy

None currently.

CHW advocates had been considering pursuing CHW legislation around reimbursement for services in 2015, but decided more education and clarification was needed on CHWs and their roles before moving on the legislative front. Also, NH is exploring other reimbursement models, such as value based reimbursement, which will impact how CHWs can be paid.

Policy initiatives:

1. [New Hampshire Coordinated Strategic Plan for Chronic Disease Prevention and Health Promotion](#) (August 2013) page 17 “Expand the use of community health workers and patient navigators to ensure the utilization of screening services.”
2. [NH State Health Improvement Plan](#) 2013-2020: CHWs are mentioned as a target for professional education activities (page 19) and as part of a diverse care team for obesity/diabetes (page 22); heart disease and stroke (page 28); healthy mothers and babies (page 36); cancer prevention (page 46); asthma (page 54) and infectious disease (page 70).
3. [2015-2017 North Country Regional Community Health Improvement Plan](#) – Goal # 3 (page 36): Goal # 3 Heart Disease and Stroke Integrate Community Health Workers (CHW) into health care teams.
4. NH Department of Health and Human Services announced a RFP on May 16, 2016, “[Building Community Health Worker Capacity to Improve Chronic Disease Prevention and Management.](#)” \$280,000; priority will be given to health care systems and community organizations in the North Country Public Health Region
5. [Project LAUNCH NH](#) – 2015 - Building integration of behavioral health into primary care settings through implementation of a Child Development Specialist/Care Coordinator (CDS/CC) and Community Health Workers (CHWs) will improve the success of the referrals and linkages to behavioral health services, as well as reduce barriers to patients accessing behavioral health services, such as transportation and stigmas related to receiving services.
6. The SIM grant has not been a major driver of CHW policy thus far. However, the state’s approved [SIM Plan](#) does specially mention CHWs as one of the plan’s five “prioritized efforts” and calls for “focus and investments in efforts to train a non-traditional workforce” to better align community and clinical resources. (page 72)
7. Center of Excellence for Culturally Effective Care at [Manchester Community Health Center](#) . This description appears on their website. “In response to the growing and spreading diversity in Manchester and throughout the state, MCHC is building a Center of Excellence for Culturally Effective Care to target health disparities. The first phase includes implementation of

Community Health Workers to help patients access appropriate health services, (emphasis is placed on health education and chronic disease self-management). The Center of Excellence for Culturally Effective Care is generously supported by grants from the Endowment for Health and the Norwin S. and Elizabeth N. Bean Foundation.”

NH Department of Health and Human Services has played a limited role to date in developing the CHW workforce. The NH Office of Minority Health participates on planning calls when possible. The Asthma Control Program provided scholarship funds to train CHWs. They are currently in the process of working with the health departments in Manchester and Nashua to provide funding support for CHWs and have released an RFP to fund CHWs in the North Country (see #4 above).

Certification

Not currently. Credentialing has been discussed as an option but has not been determined to be a priority at this time.

Participants said the CHW network is new and an infrastructure needs to be built that includes more informed involvement by CHW’s before there will be discussion of certification. Also, the state is not pushing for certification.

Education

The Southern and Northern NH AHECs offer [CHW core training programs](#). Both use the same curricula based on the national CHW core competencies but deliver the training using different delivery formats. The course emphasizes motivational interviewing skills as well as health related competencies such as chronic disease, mental health/ substance misuse, and oral health. Students receive a certificate of completion if they complete all classes; partial if they do not. Students with an incomplete may come back and take missing modules the next time program is offered. There is no internship or field placement with the training program.

SNHAHEC offers a 56-hour face-to-face program -- seven days of eight hour classes offered over a seven-week period. Cost is \$1,200, which includes training materials and lunch. Participants have their learning assessed at various stages in the course with weekly “homework” and activities such as presentations. Two tests are required, one midcourse and one final.

North Country Health Consortium/NNHAHEC has developed a hybrid course. This format was chosen because travel to attend classes was a barrier for some students. Online modules have learning assessments that must be met before a learner can move to the next unit. Training was developed with Federal funding (HRSA office of Rural Health Policy).

AHECs also offer additional professional development classes that are relevant to CHWs, for example, motivational interviewing, chronic disease peer support, and HIPAA.

Financing: Some organizations have grant funding/mixed funding to send workers. The state health department has offered scholarships for training. There were two Federal training grants in the state that people could qualify for which provided tuition support. Some students arranged a payment plan. The AHECs are beginning to receive requests from employers for training cohorts of workers.

SNHAHEC is in the process of conducting follow-up evaluations of their training program modules with students that have taken the training.

Financing

New Hampshire does not have a state financing mechanism for CHWs. They are primarily grant-funded by both Federal and private grants.

The state is in the very early stages of building integrated delivery networks (IDNs), integrating primary care and behavioral health through the Medicaid 1115 waiver process. Several IDNs have expressed interest in including CHWs as part of the health care team when implementing IDN activities. The major CHW employers – FQHCs and health care systems – are looking for ways to continue to employ CHWs and incorporate them into their operating budgets after the grant funding ends.

RHODE ISLAND (RI) CHW Model

Based on discussion held May 17, 2016 1 - 2:30 pm

Participants

- Lori Bettencourt, Resource Specialist, [RI Parent Information Network](#)
- Laura Jones, RI Parent Information Network
- Nicole Hebert, RI Parent Information Network
- Nancy Silva, RI Parent Information Network
- Damaris Morales, CHW, Clinica Esperanza Navegante Program
- Jennifer Giroux, RI College Outreach Program
- Marianne Raimondo, Real Jobs Project, RI College,
- Dona Goldman, Chronic Disease Coordinator, Rhode Island Department of Health (RIDOH)
- Dannie Ritchie, Founder, Community Health Innovation and Adjunct Assistant Professor of Family Medicine, Brown University
- Deborah Powers, Providence Community Health Centers
- Deborah Garneau, Office of Special Needs, RIDOH

CHW Roles in State

RI has a formal definition of the CHW role which was adopted as a component of their revised voluntary CHW certification program. See text box below containing the CHW role from the “Certified Community Health Worker, Job Analysis & Standards 2016” report.

THE ROLE OF THE COMMUNITY HEALTH WORKER

Community Health Workers are frontline public health workers who are trusted members of the community they serve. This trusting relationship enables them 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 responsiveness of service delivery.

Community Health Workers build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as engagement, community education, social support and advocacy. Community Health Workers hold a unique position within an often rigid health care system in that they can be flexible and creative in responding to specific individual and community needs.

The unique strength of Community Health Workers is their ability to develop rapport with people and other community members due to shared culture, community residence, chronic condition, disability, language, and life experiences. They are also able to enhance the cultural and linguistic appropriateness of care and help to counteract factors such as social exclusion, poverty, and marginalization. An important role of the Community Health Worker is to advocate for the socioeconomic, environmental, and political rights of individuals and their communities.

Community Health Workers often link people to needed health information and services. Community Health Workers address the social and environmental situations that interfere with an individual or community achieving optimal health and well-being.

Source: “Certified Community Health Worker, Job Analysis & Standards 2016” (RI Certification Board, April 2016).

Community Health Worker is an umbrella term for the following position titles in RI, which were collected as a part of the job analysis. Note: this list is not exhaustive (Source: Provided by RIDOH on 5/17/16 by e-mail):

- patient navigator
- peer navigator
- peer recovery coach
- consumer assistance counselors
- community resource specialists
- cultural brokers
- peer resource specialists
- parent consultants
- peer consultants
- disability navigators
- doulas
- lay health educators
- Navagantes
- violence prevention workers
- STD/HIV case managers
- lactation consultant

CHW Organizations

[Community Health Worker Association of Rhode Island](#) had been active as a CHW professional association for many years and received funding from RIDOH until recently. The Association did convening work, developed a core competency CHW curriculum, oversaw a voluntary certification program and provided training. It is currently not active, due primarily to a lack of funding. The RI Dept. of Health and other partners see this as a gap and are working to reinvigorate the organization.

In the absence of a CHW professional association, [Community Health Innovations](#) of Rhode Island serves as a leading CHW organization. CHI-RI develops community directed health solutions to improve the health of the state through the application of a Community Health Worker (CHW) model. The Director has been involved with research and planning on CHW workforce development, including formal recognition of CHWs as a profession by governmental agencies, since 2003.

Additionally, the [Commission for Health Advocacy and Equity](#), is an advisory board to the state on achieving health equity that has some oversight for CHW work (see below).

State CHW Legislation and Policy

Legislation: [H 5633](#) (enacted 2011) established the Commission for Health Advocacy and Equity in the RIDOH. The Commission must make recommendations for increasing diversity of the health care workforce, which may include recruitment, training and employment of CHWs.

Policy Initiatives:

[Real Jobs Rhode Island](#) (which is funded with a mix of Federal and state funds) is supporting a project with RI College to develop a CHW training infrastructure and train CHWs (see Education section)

[Care Transformation Collaborative](#) is a pilot program which took place with two community health teams – South County Hospital and Blackstone Valley CHC. The two teams support 8 to 11 primary care provider offices in each of those areas. Patients served by community health teams are high health services utilizers who need extra support out in the community. Teams at these sites have a CHW that is a RI Parent Information Network (RIPIN) employee. The CHW role in that team is to work with individuals in the community, identify the social determinants of health, work with clients to identify

needs and priorities and identify how to do wrap around services to meet goals. This is a community-level patient centered medical home model.

[Providence Community Health Center](#) utilizes CHWs, referred to as Community Health Advocates, to work with center care teams (particularly nurse case managers) to identify and remove barriers to obtaining quality health care. As a member of the local community, CHWs assist the care team by providing care coordination, peer support, community resources, assistance with appointments and closing gaps in regards to social barriers (food, housing resources, utilities etc.). These CHWs are part of the staffing profile and are not grant funded.

[Communities of Care Program](#): for Medicaid patients who are high utilizers of the emergency room (four or more times a year). Neighborhood Health Plan of RI identifies participants who are placed with a “Communities of Care” team. Teams include a CHW (peer navigator) who works with patients to identify social determinants/barriers, educates on appropriate use of ER and works with the health plan to identify a Primary care provider and connect patients to wrap around coverage. [Neighborhood Health Plan](#) has also trained many staff as CHWs and uses them throughout the organization, for example as sales associates in marketing and as medical and social case managers.

[Clinica Esperanza](#): The clinic provides free, culturally attuned, linguistically appropriate medical care to uninsured adults living in Rhode Island. They primarily serve the Guatemalan community and non-insured individuals. They leverage the altruism of more than 250 volunteers as outreach workers/navigators to help patients to eliminate barriers to accessing healthcare. Their focus is on peer-to-peer education and prevention. Esperanza provides training to their volunteers, many of whom have some medical background (CNA/MA). This clinic is funded through a variety of different grants.

[Integrated Care Initiative](#) is a model program designed to improve care for Rhode Islanders eligible for both Medicaid and Medicare. This is a joint effort between the state of Rhode Island, the Centers for Medicare and Medicaid Services and Neighborhood Health Plan of Rhode Island. CHWs are used as part of care teams to provide personalized and coordinated care in the community, based on the patient centered medical homes (PCMH) model. Programs include [Neighborhood INTEGRITY](#) and [PACE](#). One of their first efforts in fee for service billing, may provide some interest for future training.

RIDOH’s [Community Health Network](#) (CHN) provides a program clearinghouse and forum for administrators of evidenced-based disease self-management education programs as well as skill building programs for people with chronic conditions and disabilities. The network integrates a workforce of over 475 health professionals and community members, which includes community health workers. Evidenced-based programs in the network include chronic disease self-management programs (Living Well RI; weight management (We Can), pre diabetes (Diabetes Prevention Program) and smoking cessation (smoking cessation specialists/ Quitworks). The network provides opportunities to cross train; cross market services to health care providers; align health care, non-health care, and community health workforces to similar goals. It can also serve as a channel for knowledge or advocacy for policy changes to improve health, and work towards sustainability of services. Training targeted at CHWs includes

- Training non-health professionals to provide evidence-based workshops to people with chronic disease on self-management of their condition(s) based on the model developed by the [Stanford Patient Education Research Center](#). The State hopes this new workforce will become certified CHW's; some are CHWs already.
- Training for patient navigation in health care services. RIDOH hopes to add specialty areas such as cancer screening and hypertension that can build the career ladder for CHW's by helping them to obtain extra credentials and expertise.

RIDOH is innovating in the realm of community engagement and addressing social determinants of health at the community level through the creation of [Health Equity Zones](#) (HEZ). The HEZ are funded through the CDC Integrated Chronic Disease grant, HRSA's Maternal and Child Health Block Grant, state Minority Health appropriation funds, and Prevention Block Grant funds. There are 10 geographically unique HEZs representing every county in RI. The HEZs have identified their residents with health disparities including people with disabilities, racial and ethnic minorities, elders, and people of low income. HEZs train and employ community health workers in their strategy to address social determinants of health.

Role of State Health Department: RIDOH does have a point person whose duties include oversight of CHW workforce development who resides within the Office of Special Needs. Additionally, the [Commission for Health Advocacy and Equity](#) has some oversight for CHWs.

Certification

As of May 2016, RI is implementing a new, voluntary CHW Certification program in an effort spearheaded by the RIDOH. See program outline below. The [RI Certification Board](#) (RICB) is the

2016 RI CHW Voluntary Certification Program	
•	Experience: Six months or 1000 hours of paid or volunteer work experience within five years.
•	Supervision: 50 hours of supervision.
•	Education: 70 hours of education relevant to the domains.
•	Recertification: Every 2 years requiring 20 hours of education relevant to the domains.
•	Examination: 100 questions.
•	Grand parenting: 18 months (November 17, 2017)
"Certified Community Health Worker, Job Analysis & Standards 2016" (Rhode Island Certification Board, April 2016).	

authorizing grantor. The RIBC conducted a job analysis, released in April 2016, to define the role of the CHW as the foundation of establishing a "valid, reliable and legally defensible" professional certification program. The Board also adopted a content outline for training to CHW roles in nine competency domains. The process of developing the certification standards involved an advisory group that included CHWs. [The application](#) for certification of CHWs currently practicing in the workforce is now available.

Education

RI developed a [standardized curriculum](#) for CHW training and certification, titled “Essential Skills for Community Health Workers” in 2012 through a grant to CHWARI. It was based on standards approved by national CHW interest groups, as well as needs defined by RI stakeholders. Currently, RIDOH provides this curriculum to providers at no charge in order to train CHWs.

With the advent of the new CHW training requirements set by the RICB, RI College has a grant from Real Jobs Rhode Island to [update the curricula](#) to meet the needs of RI CHWs. The curricula will prepare those seeking CHW certification to meet the standards for application. The Real Jobs grant will also fund a pilot project in Central Falls, RI that will offer the new CHW core competency training program at no charge and help non-English speaking applicants prepare for certification.

CHW training organizations include RI College Outreach programs, Clinica Esperanza, Roger Williams University, Dorcas Internal Institute and the RI Parent Information Network (RIPIN). Additionally, an apprenticeship program for CHWs is overseen by Community Health Innovations of RI. Also, RIDOH recently arranged for the Patient Navigator and Community Health Care training programs taught in MA to be delivered to a group of RI CHWs.

Training Delivery: Trainings have been offered in-person and classroom style. There is willingness to discuss distance learning options, but as a small state the face-to-face has been the most efficient and effective.

Prior trainings were grant funded or fee based. There were challenges filling slots at fee based programs. There has been some support through training programs from RI Department of Labor from unemployment/retraining programs.

RI Department of Labor also provides some program/outcomes level evaluation of training – completion rates, employment after training, retention rates, etc.

Professional development: In the past, CHWARI had provided trainings in a variety of areas beyond the core competency training. Their last offerings were in 2015. As the new certification has a requirement for 20 hours of continuing education (CE) for recertification, there will be a need for CE infrastructure and accessible opportunities for earning CE credits. It is hoped that a reinvigorated CHWARI can play a role in providing a CE infrastructure in the future.

Financing

The majority of CHW positions are generally either grant/contract funded (especially those working on disease-specific programs) or incorporated into the operating budgets of agencies. CHWs are a part of the PCMH team projects in RI, which are funded by grants/contracts and health plans. Some projects have been privately funded (example Tufts Foundation: two year grant to use CHWs around evidence based programs). There has been some direct billing to health plans for CHW services. However, RI’s experience is that billing has been complex for agencies and there are often delays in payment. Small agencies may not have the cash flow to support the fee-for-service model. Rhode Island is exploring various payment reform models that along with CHW certification may open up avenues for CHW payment for services. They are also pursuing Medicaid payments for CHW services at this time.

VERMONT (VT) CHW MODEL

Based on discussion held May 26, 2016 from 2 – 3:30 pm

Participants:

- Janet Nunziata: Center on Aging at University of VT (UVM).
- Laural Ruggles: Northeastern VT Regional Hospital, where they have worked with Community Health Workers since 2002.
- Marie Gilmond: Rutland Regional Medical Center, Community Health Improvement Department
- Stefani Hartsfield: Operations Manager with SASH (Support and Services at Home), Cathedral Square Corporation
- Jeanne Hutchins: Exec. Director of the Center on Aging at UVM.
- Mary Val Palumbo, Associate Professor, College of Nursing and Health Sciences at UVM,
- Molly Dugan: Director of Support and Services at Home (SASH), Cathedral Square Corporation

CHW Roles/Definitions in State

No formal definition of CHWs used by the state. [VT Department of Labor does promote CHWs.](#)

While there is no formal definition or scope of practice (roles), CHWs are a part of VT healthcare reform in the Blueprint for Health (see CHW legislation and policy). CHWs are approved as a part of [Community Health Teams](#) (CHT), interdisciplinary teams of health professionals that provide patient support and serve as the link between primary care and community-based services. The composition of professionals on the teams is determined at the community (Health Services Area) level, therefore, not every CHT in VT utilizes a CHW. Job titles for CHWs are determined by the CHT employer, so individuals employed in CHW roles may not consider themselves CHWs.

CHW roles can vary depending on the CHT region and include: linking clients to state and community-based service providers; assisting patients with insurance applications, following treatment plans, managing stress/behavioral health concerns and working toward personal wellness, prevention and disease-management goals. CHWs may accompany patients to appointments and assist them in finding transportation or childcare.

CHWs are also employed in “extended CHT” initiatives that are focused on specific health problems or populations. One program created in 2011, [Support and Services at Home \(SASH\)](#), explicitly uses CHWs in their model. SASH connects Medicare patients (elderly and disabled) with services and programs to allow them to live safely at home. It was originally developed for residents in congregate housing but all Medicare fee-for-service beneficiaries are eligible ([SASH Second Annual Report](#), page vi). CHWs in the program are titled SASH Coordinators These CHWs develop relationships with their clients and assess client strengths and challenges in order to help them remain safely at home. Another initiative, [Hub and Spoke](#), focuses on opiate and complex drug addiction and may employ CHWs as peer counselors.

CHW Organizations

No advocacy organization or coalition exists currently in VT. However, the University of Vermont (UVM) Center on Aging has been leading a loosely formed CHW advocacy group and has been sponsoring

conversations across the state with stakeholders on CHW workforce development. Interview participants commented that it is difficult to engage CHWs in organizing because they are usually paid hourly and generally cannot engage in professional association activities while at work.

State CHW Legislation and Policy

Legislation: [BluePrint for Health Legislation](#) has been the policy driver for use of CHWs. The law allows for integration of CHW's as a part of the Community Health Team, although their role on the team is not specifically delineated.

Policy:

[Governor's Commission for Successful Aging](#) has looked at the role of CHWs in healthy aging programs and healthcare reform. Commission members have met with legislators to talk about promoting the CHW workforce and were encouraged to meet with the VT Department of Health.

The VT SIM grant ([VT Health Care Innovation Project](#)) has not been a driver for CHW policy. The SIM grant did support hiring of some CHWs, however.

State Health Department Role: VT Department of Health does not have a lead role or have a point person on CHWs within their agency.

Certification

No certification currently exists in VT. Participants said that VT state statute only requires certification of professions where there is potential for harm to the public.

In recent statewide conversations on CHWs led by UVM Center on Aging, certification has been discussed. The "take away" was a fear about potential risks of certification and a feeling it is unnecessary. Interview participants said the general planning assumption in VT is that fee-for-service will be replaced with other payer models, notably incentive-based payments, reducing the pressure for certification so that CHW services could be reimbursed.

Education/Training

Training for CHWs has been provided by employers, who are generally the Health Homes for the CHTs – health care systems and ACOs. No standards for CHW training or competencies exists at this time.

An exception is the SASH Coordinator position which has a statewide [standardized training](#) program. It is eight weeks and covers topics such as care planning, healthy living plans with participants, confidentiality, database training and team facilitation. It also contains some interdisciplinary components. There is continued training throughout the year on topic/skill areas related to the populations served, (Example: fall prevention, Tai Chi, evidence based programs). No certificate is provided for completion. The training program is evaluated after each session. SASH Coordinators have regular meetings by webinar and there is a system for feedback, identifying individual training needs and obtaining help for challenges encountered in practice. Training is supported through the State of VT and Department of Disabilities, Aging and Independent Living. Other sources for support are BluePrint for Health and housing organizations.

Also, VT has a small pilot program training “new Americans” as CHWs. It was a collaboration among the Community College of Vermont, College of Nursing at UVM; Visiting Nurses Association and the Center on Aging at the Community College of VT. The program trains members of immigrant communities to serve as CHWs who work as a team with a nurse. This seven week, 42-hour course was developed through a curricula review from across the state. One cohort has graduated and another cohort is planned. Students take a final exam and receive a certificate. Some graduates are employed by the VNA but others are still looking for jobs.

Some CHWs have been sent to trainings offered in MA (example: CHW home-assessment training). CHWs also take advantage of local and regional trainings relevant to their work. Example given was training in trauma.

Also, at the statewide conversations CHWs led by UVM Center on Aging, there was discussion about the need to share curriculum and training resources throughout the state.

Financing

CHWs are a standard part of [Vermont's Community Health Teams](#) (CHTs), which are an integral part of the Blueprint for Health. The CHTs are paid for by Vermont’s [Multi-Payer Advanced Primary Care Practice Demonstration](#) pilot, which involves a monthly care management fee for beneficiaries receiving primary care from advanced primary care (APC) practices. Costs are shared among Vermont’s major insurers, as well as Medicare and Medicaid. SASH staff is funded through Medicare alone. This has provided sustainable funding for CHWs.

Some health systems are supporting additional CHWs through general operating expenses because demonstration projects were so successful.

5. Implications for NEPHTC

Workforce development efforts for CHWs in the six NE states share many commonalities and provide numerous opportunities for NEPHTC to contribute. Momentum towards credentialing has been gathering strength. Four states are implementing or exploring establishment of voluntary credentialing, or in the case of ME, a registry. RI has already begun the process of grandfathering in existing CHWs to its new voluntary credentialing program. These developments will establish state standards for CHW roles, competencies, skills, a common knowledge base and training, as well as foster a clearer professional identity for CHWs. Moreover, credentialing will create a need for a continuing education infrastructure, training activities and professional development opportunities for CHWs.

NEPHTC can also build on the solid networking between CHW allies in NE as well as the robust sharing of best practices and lessons learned on CHW workforce development on the national level. The New England CHW Coalition remains a vital platform for communication between the six states and has been sustained for years on the in-kind efforts of its members. There has already been some sharing of training programs, most notably CHW training programs developed in MA which have been taken by CHWs in CT and RI. The Region 1 Office of the Department of Health and Human Services has been proactive in supporting CHW workforce development in each of the states in furtherance of the [HHS strategic plan](#) as well as implementation of the Affordable Care Act. As a result of these efforts, it is likely there will be commonalities in the credentialing standards and future workforce development strategies in NE that will facilitate sharing of training resources.

Within each state, NEPHTC also has CHW allies with which to partner and, in five of six states, a CHW association or coalition. States are requiring inclusion of practicing CHWs in CHW workforce development activities to assure the new profession is engaged in the determination of standards and policies that impact the practice of their profession. The level of energy and passion demonstrated by participants on the six facilitated interviews is a signal of the strong level of commitment that CHW partners could bring to future collaborations with NEPHTC to meet training needs.

Another area of training need voiced in some interviews was to educate health care system partners and communities on the benefits of the CHW model. Every NE state has examples of highly innovative CHW programs. NEPHTC webinars could help disseminate these best practices to a broad audience. Training CHW employers and supervisors on managing CHWs was another training need expressed by a number of participants, particularly CHWs.

This future is not without challenges. All states are struggling with options for paying for CHWs services outside the traditional funding mechanism of grants. There are numerous payment reform models being piloted in the states but there is no assurance that these efforts will result in policy changes. States are also challenged with developing a sustainable, high quality training infrastructure for core and continuing education programs that has adequate funding for low cost tuition and is accessible for students with transportation or language barriers. Use of technology, such as distance learning, is viewed as a possible option to reduce cost and improve access. CHW training organizations want validation that the learning outcomes using distance learning are the same or higher than face-to-face

learning. One participant suggested NEPHTC might explore the area of technology and quality CHW training.

In summary, while NEPHTC resources are limited, there are many prospects for NEPHTC to partner with CHWs, their allies and stakeholders to advance the CHW profession and improve the public's health, particularly underserved populations. First, NEPHTC already has subject matter expertise, training products and trainers for CHWs through its LPS at the UMass Amherst. Second, there is an existing regional group for potential NEPHTC partnerships: the NE CHW Coalition brings together a group of CHW organizations from around the region with a history of collaboration. Lastly, the timing for NEPHTC partnerships and projects for CHW workforce development is right. All NE states are looking to improve their CHW training infrastructure, including continuing education programs. State and federal resources to support CHW training development and delivery are severely limited. Four states are either exploring or in the process of implementing voluntary CHW certification, which will necessitate a training infrastructure. Owing to all these factors, NEPHTC has the opportunity to be a valued CHW partner and training resource for the NE region.