

Community Health Workers in Rhode Island: Sustaining a growing public health workforce in the pandemic and beyond

Brady Dunklee, MPH
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Message from the Director

Dear Colleagues,

I am pleased to present this updated study of Rhode Island's Community Health Worker (CHW) workforce. The first qualitative study was released in January 2018, and this updated body of work was released in January 2021. The goal of the 2021 study is to build upon the 2018 study by examining what has changed in the past three years, what lessons we've learned, and how COVID-19 has impacted the CHW field. The goal of sustaining and expanding the CHW workforce has remained steadfast and unchanged since 2018.

Now, more than ever before, the CHW's role as a part of the healthcare team and as a part of the community health team is critical. CHWs continue to be a vital part of our healthcare and community health infrastructure, and this vitally important workforce has proven to be invaluable during the pandemic by serving Rhode Island's most vulnerable citizens. At a time when healthcare providers have struggled to connect to their patients, CHWs have been on the frontlines in supporting Rhode Island residents with accessing food assistance; applying for unemployment benefits; securing temporary housing to support the need for quarantine and isolation; educating on the use of technology for telehealth appointments; and lending a loving ear to older adults who are homebound.

The role of CHWs continues to be a proven best practice in addressing preventable differences in health outcomes among socio-demographic groups. As frontline public health workers who are trusted members of, and/or have a unique understanding of, the community, they act as a link between their community and needed health and social services. CHWs oftentimes have walked in the shoes of their fellow community members because they often have similar cultural practices, chronic health conditions, disabilities, and/or life experiences as the people in the communities they serve. CHWs are poised to improve access to, quality of, and cultural responsiveness of, other members of the care team.

RIDOH continues to carry the message resulting from public health data which underscores the fact that health happens in our homes, schools, jobs, and communities. Never has that been clearer than now, during this unprecedented public health crisis. We look forward to continued partnership with employers and other partners across the state to support this vital segment of our public health workforce and to help ensure that every Rhode Islander has access to optimal health, wellness, and social services in their communities.

Sincerely,

A handwritten signature in black ink, appearing to read "Nicole Alexander-Scott". The signature is fluid and cursive, with a large initial "N" and "A".

Nicole Alexander-Scott, MD, MPH
Director, Rhode Island Department of Health

Acknowledgments

The author wishes to express his deep appreciation to Community Health Workers in Rhode Island who are working to support the people who are hardest hit by the pandemic and its economic consequences.

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Executive Summary

Community Health Workers have gained visibility, numbers, and new employers over the past several years in Rhode Island. As frontline public health workers who are trusted members of, and/or have an unusually close understanding of, the community served, community health workers (CHWs) in the United States act as a link between their communities and needed health or social services.

CHWs often have similar cultural beliefs, chronic health conditions, disabilities, or life experiences as the people in the community they service, which puts them in a unique position to help improve access to, quality of, and cultural responsiveness of service providers. They typically work with communities experiencing health inequities and perform activities, such as outreach, community education, informal counseling, social support, and advocacy. (Sources: [APHA](#), [RIDOH](#))

The COVID-19 pandemic has revealed and exacerbated health inequities, presenting a medical and economic crisis that CHWs are simultaneously impacted by, and working to alleviate. But even as the field has grown, and the need for CHW services has come into sharper focus, Rhode Island has not yet achieved sustainability and scale.

This project follows up to a [2017 qualitative study](#) of employers of CHWs in Rhode Island. The study's aim was to share know-how and promising practices and to help drive action in support of the CHW workforce. The original study asked a series of essential questions: Where do CHWs work? What do they do? Who gets CHW services? How are they funded? How are they trained and sustained? How can the CHW workforce grow?

Since 2017, much has changed in the community health field in the state. Rather than attempting to revisit and update the original report, we wanted to build on it by exploring three sets of essential questions:

- What has changed for the Rhode Island CHW field in the past few years? What lessons have we learned?
- How is the pandemic affecting the CHW field in the state?
- What (if any) consensus is emerging about how to sustain the CHW workforce?

This report addresses these questions primarily through the perspective of employers and stakeholders in leadership positions, such as program directors and managers. Some interviewees were CHWs in these leadership positions, but the majority were not CHWs. The Community Health Worker Association of Rhode Island (CHWARI) conducted a survey of CHWs in parallel to this study to gather input on the professional voice of the field with respect to these questions. The results of that study should be read in tandem with this report.

1. Value, Role, Measurement, and Equity

“We don’t have to preach [the value of the CHW] as much now. It’s collectively recognized.” –Sam Salganik, Rhode Island Parent Information Network (RIPIN)

Respondents unanimously expressed a belief in CHWs' value. Since 2017, more CHWs are working, with expanding and deepening roles. Most respondents said their organizations increased the number of CHWs they employ. CHWs' roles generally maintained a focus on patient-centered care that addresses social needs, and in many cases grew their reach to new populations and refined their approach. Community-based organizations, including Health Equity Zones (HEZs), are major employers of CHWs, who often work with vulnerable populations. Healthcare organizations, particularly

Medicaid Accountable Entities (AEs), have hired more CHWs, increasing the number of CHWs in Rhode Island, and have diversified their roles. For example, some CHWs employed by AEs provide care coordination, peer support, community resources, assistance with clinical and ancillary appointments, and close gaps such as food and housing insecurity. Community Health Teams (CHTs), including CHWs serving multiple primary care practices, have expanded clientele and services. Philanthropic and government funders and workforce development organizations have evolved their approach to CHWs with growth in grant-funded programming and apprenticeships. The need to address housing insecurity, substance use disorders, and the value of accompanying clients to appointments were themes that interviewees highlighted. Additionally, interviewees discussed CHWs' connection to larger community health systems. Organizations use diverse strategies to measure CHWs' impact, but they face challenges in evaluation. Equity concerns persist for the workforce, including concerns that CHWs may face low wages, tokenism, and lack of recognition. Peer workforces require workplace supports in order to thrive and be effective.

“Off [the] top of my head, I can think of a number of people who would not be alive if not for that relationship [with a community health worker].”

–Sarah Martino, The Center for Prisoner Health and Human Rights

2. The Pandemic and Community Health Workers

“Maybe we don't have the answer, but we are trying to navigate one day at a time...letting [community members] know whatever happens, we are here to support them, and they are not alone.” –Paola Martinez, Clínica Esperanza

CHWs are confronting the pandemic's socioeconomic and health equity crises, with the pandemic revealing and exacerbating the conditions that CHWs work to alleviate. The communities in Rhode Island that are most served by CHWs have also been the communities hardest hit by the pandemic and its economic consequences. And because CHWs often live in the communities they serve, this means they are experiencing the same vulnerabilities as their neighbors, in addition to having a higher risk of occupational exposure to COVID-19.

CHWs' roles have changed quickly. Remote community health work is happening, but it poses problems for some, as CHWs often rely on face-to-face interactions to build trust and often serve people with barriers to accessing remote technology. CHWs are responding to a crisis of social need, while COVID-19 has presented obstacles and has required adaptation—for example, the need for food assistance has increased, while requiring rapid development of contactless delivery procedures. The pandemic is changing the conversation about sustaining the CHW workforce.

“I think that, if anything, COVID has elevated how vital CHWs are to the community,” – Maria Carvalho, West Elmwood Housing Development Corporation

3. Sustainability and the Path Forward

“I don't know if there's a consensus about how to sustain CHWs, but I think there is a consensus of why it is important to sustain them.” –Laurie Moïse Sears, One Neighborhood Builders.

Financial sustainability of community health workers is a work in progress. Grant funding was the most frequently cited source of financing for CHW services. Four respondents do some level of fee-for-service billing for CHW services now.

On fee-for-service reimbursement, respondents said “Yes, but.” Nearly all thought that the state should pursue policy changes to allow billing for CHW services, but nearly everyone expressed concerns. One concern is that billing could detract from a person-centered approach. Interviewees working at Accountable Entities said they were concerned about complexity and the tension between fee-for-service billing, which incentivizes volume, versus value-based payment, which incentivizes population health outcomes, quality, and cost savings. Interviewees expressed overall concerns that implementing a billing system could increase administrative burden, set up the wrong incentives, and skew access to services according to insurance coverage. Concerns aside, some interviewees mentioned that the billing system currently in place for Peer Recovery Specialists (PRSs) may offer a model, since CHWs and PRSs may provide similar non-clinical services, and generally share lived experience with clients.

Financial sustainability will likely mean more than billing. Global payment, capitation, and payer-blind funding are potential tools. AEs, as currently paid, may not be set up to sustain CHWs for the long term. Grants are likely to remain a key funding source.

Sustainability involves more than financing. CHW visibility has increased, which contributes to sustainability. Along with greater recognition, more effort has been devoted to CHW workforce development and certification, which are key elements of sustainability. Support and access to resources, networks, and information are also important. Finally, incorporating systems that address racial equity is an important consideration for sustainability.

Respondents saw a consensus that the CHW workforce should be sustained—but not a consensus about how. Going forward, health plan-based payment and grant funding were the most popular options for sustainable financing, but there was a broad range of perspectives.

“What I love about CHW programs is they’re so person-centered. They’re about the person they’re taking care of. I wouldn’t want people to become widgets. It needs to be about value, not about quantity.” –Elizabeth Samuels, Rhode Island Hospital’s SMART program

Purpose, Methods and Limitations

The purpose of this project was to follow up on a [2017 qualitative study](#) of employers of Community Health Workers (CHWs) in Rhode Island that focused on sharing promising practices and promoting action to support the CHW workforce. The 2017 study asked a series of questions, including where CHWs work, what they did, who they serve, how they were funded, how they were trained, and how the CHW workforce could grow.

Since 2017, there have been a lot of changes in the community health field in Rhode Island. The goal of the 2021 report is to explore three questions:

- What has changed for Rhode Island CHWs in the past few years? What lessons have we learned?
- How has the pandemic affected CHWs in the state?
- What (if any) consensus is emerging about how to sustain the CHW workforce?

This report focuses on the perspective of employers and stakeholders in leadership positions, although these perspectives do include several CHWs. In order to get the professional perspective of CHWs, the Community Health Worker Association of Rhode Island (CHWARI), conducted a survey of CHWs, and the results should be read in tandem with this report.

Twenty one employer and stakeholder interviews were conducted from August 2020 to December 2020. These interviews were conducted on behalf of Rhode Island College (RIC) and the Rhode Island Department of Health (RIDOH). All organizations that were interviewed for the 2017 study were invited to participate in the 2020 interviews, and 17 organizations agreed to participate again. Five other organizations that had developed CHW programs since 2017 were also invited to participate, and four agencies accepted the invitation. At least one person was interviewed from each organization, and a total of 30 people were interviewed. (See Appendix B for a list of participating organizations.) Interviews ranged from 15 to 60 minutes, were conducted virtually, and included a structured, multiple-choice question survey, and a semi-structured qualitative interview. Both components were administered verbally. The interviewer recorded the conversations, took notes in real time, and shared written summaries with the interviewees for verification. Quotes and descriptions included in this report were extracted from the summaries that were shared with interviewees, but they have not been independently verified. Charts were generated from survey question data recorded during the interview.

The excerpted quotes and descriptions are intended to be representative and diverse, but not exhaustive. Selection bias is certain. Champions of CHWs were intentionally identified and interviewed versus attempting to gauge general opinion. Findings only represent data collected from participating individuals and organizations. No qualitative coding software was used for analysis; themes were developed through interpretive analysis and are not intended to provide a fully objective or comprehensive overview.

Key Findings on Value, Role, Measurement, and Equity

Respondents unanimously expressed a belief in the value of CHWs.

Since 2017, more CHWs are working, and are expanding their roles. Most respondents said their organizations increased the number of CHWs they employ. CHWs' roles and the populations they work with generally maintained a consistent focus, and in many cases, increased their reach and refined their approach. Community Based Organizations, including Health Equity Zones (HEZs), are major employers of CHWs and often work with vulnerable populations. Healthcare organizations have hired more CHWs and have diversified their roles, with particular growth among Medicaid Accountable Entities (AEs). Community Health Teams (CHTs) that serve multiple primary care practices have expanded clientele and services. Funding and workforce development initiatives have adapted their approach to using CHWs, including an increase in grant-funded programming and apprenticeship opportunities. Housing, accompaniment, substance use disorder, and CHWs' connection to larger community health systems were highlighted as key considerations for the field. Organizations use diverse strategies to measure CHWs' impact, but face challenges in evaluation. Equity concerns persist for the workforce, including concerns that CHWs may face lower wages and lack of recognition. Peer workforces require workplace supports in order to thrive and be effective.

Value, Role, Measurement, and Equity

Respondents unanimously expressed a belief in the value of CHWs.

This study engaged a variety of CHW employers and stakeholders (including several CHWs in leadership roles), interviewing people who are deeply involved in and supportive of, community health work. Interviewees' comments were unanimously positive about the value of the work CHWs undertake in Rhode Island.

“I think the CHWs are kind of the lungs of the clinic. I think that the role of the CHW—especially [their ability to be] very empathetic with the community—is needed more than ever right now. We have this community full of fear, not only the community that we serve, [and] they don’t have the stability or immigration stability. They are afraid of losing their jobs, being affected, losing their loved ones—many fears are in the atmosphere. CHWs are being this seed of hope. Letting people know that even though things are upside down, we’ve got them. And they are not alone...they are bridging this gap between fear of the unknown and resources and hope that we actually have. Hope is a requirement right now for surviving—it’s a life requirement.” -Paola Martinez, CHW Supervisor, Clínica Esperanza

“The consensus is that CHWs are a vital part of the bridge between healthcare, the community, and social services. There’s consensus in the value that CHWs bring to member and patient care, and [in] improving health outcomes[...] I like to remind the Accountable Entities (AEs) ‘I know you’re worried about total cost of care, but also that the individuals you’re caring for are connected to the services they need and [are getting] the best care possible.’ I don’t think you can work on addressing some of the social aspects without having a CHW—really your boots-on-the-ground person. They are probably the best person to engage and inform patients and the community at large, and [they are the best person] to educate the practice about the community or why people may not be wanting to come in and engage in care.” –Deborah Morales, Medicaid AE Program Director, Rhode Island Executive Office of Health and Human Services

“We recognize there are lots of different roles CHWs can play. CHWs in the HEZs [Health Equity Zones] work differently than in CHTs [Community Health Teams], and there is an important place for the whole range of CHWs—a place for all. But we’re saying for CHWs on Community Health Teams, that connection to behavioral healthcare and the ability to be closely aligned with community-based resources is unique. **We have evidence of the value demonstrated. It works.**” –Susanne Campbell, Senior Project Director, Care Transformation Collaborative, Rhode Island (CTC-RI)

“CHWs became the change agent for families and communities...they have connections within communities at a really deep level. And they have the compassion, ability, and patience to do the warm handoff and really find resources. Honestly, they never give up. They will put a lot of little together to make a whole for an individual or whole family system in need.” –Marie Palumbo-Hayes, Vice President of Health, Family Service of Rhode Island

CHWs “do great work...the way they connect and earn the trust of members, that’s where it all starts. They are able to connect with them right off the bat. I think when they earn that trust, most [clients] are appreciative of how we’re able to help them; they are incredibly resourceful.” –Matt Harvey, Senior Director of Government Programs, Integra Community Care Network

“I knew the value, the unique role that CHWs could play in meeting the needs of this population, and that a CHW was essential for us in achieving our goals. And our first CHW very quickly proved her value, and the value this role brings. As soon as she left, we started trying to rehire and fill that position, and we were very disappointed with how long it took us to fill that role. It was empty for several

months, and our effectiveness was hurt by that.” –Garry Bliss, Program Director, Prospect Health Systems Rhode Island Accountable Entity Program

*“The biggest advocates for the [community health] team have become the PCPs [primary care providers]. Especially in a community health center setting where we serve such high-need patients. Providers are saying that we have people who haven’t accessed care for so many years, because of coverage, addiction, other social determinants of health—that when they get there, they are so medically complicated. They come in with housing insecurity, food insecurity, [and] intimate partner violence. To get their medical situation in control, if we didn’t have this incredible resource to address need and keep [the patients] connected [to us], we couldn’t do this. **‘There’s no referral I make that’s more impactful than the referral to the community health team.’** When new doctors arrive, they say they need to learn to use this tool because it is the most effective in driving the health outcomes of our marginalized folks. [We can’t maintain] providers in organizations that disproportionately serve the underserved without [community health] teams that work with them. **It’s a retention issue.**”* –Matthew Roman, Chief Operating and Behavioral Health Officer, Thundermist Health Center

*“I have a clearer understanding of the role [of community health workers] now [...a clearer appreciation for the enormous span of activities they undertake. Particularly in terms of picking up on social determinants of health issues...which are all the more important now, given the pandemic, concerns that Black Lives Matter and structural racial inequities having an impact on public health. I have a background in public health, and this is a perfect storm of why we need public health. **[CHWs are] reaching out to the real reasons why people are healthy or sick, which are not primarily due to medical care.**”* –Phillip Clark, Professor of Gerontology; Director of Rhode Island Geriatric Education Center, University of Rhode Island

“[Regarding the] value of the community health worker: we don’t have to preach that as much now. It’s collectively recognized.” –Sam Salganik, Executive Director, Rhode Island Parent Information Network (RIPIN)

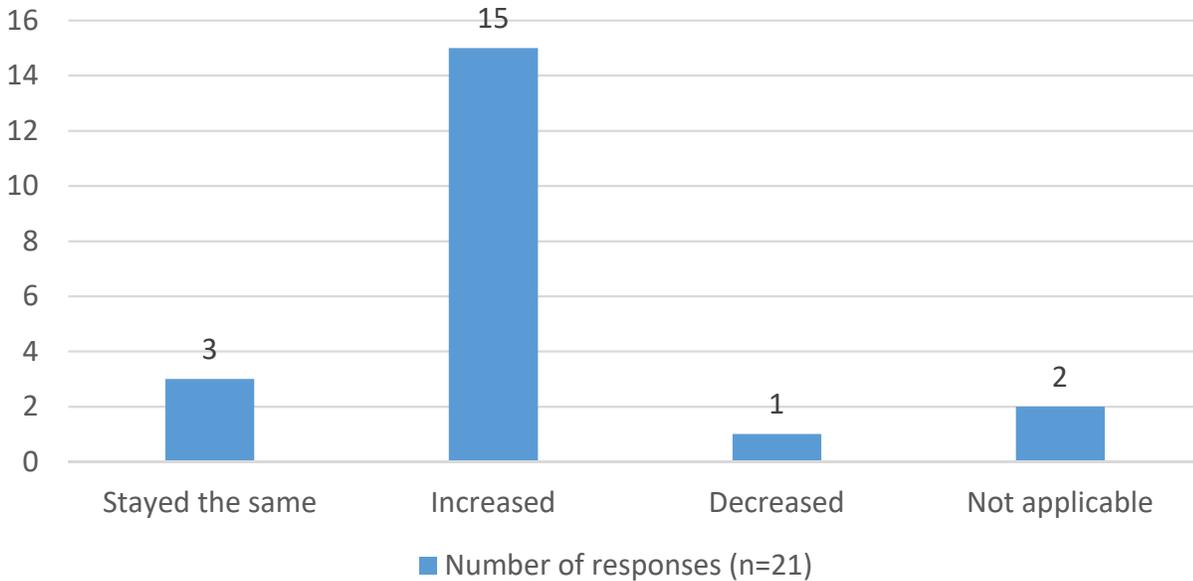
More CHWs are working, and their roles have expanded and deepened.

Most respondents’ organizations increased the number of CHWs they employ.

Thirty individuals participated in the study, representing 21 different organizations. If an agency had more than one person participate in an interview, the interviewer asked them to agree to a response as a group. This means that, in general, each question had 21 responses—one per organization. However, in some cases, interviewees skipped or preferred not to respond to specific questions, so the total number of responses for each question does not always equal 21.

The majority of interviewees (15 of 21) responded that their organization or program had increased the number of CHWs employed since 2017. Several (three of 21) maintained the same level, and one decreased the number (Figure 1). Of the 15 who responded that the numbers of CHWs increased, five had no CHWs at all in 2017, and they had added them to programming more recently. Several respondents who do not employ CHWs directly responded that the numbers of CHWs had increased in initiatives they were involved with as funders or technical assistance providers.

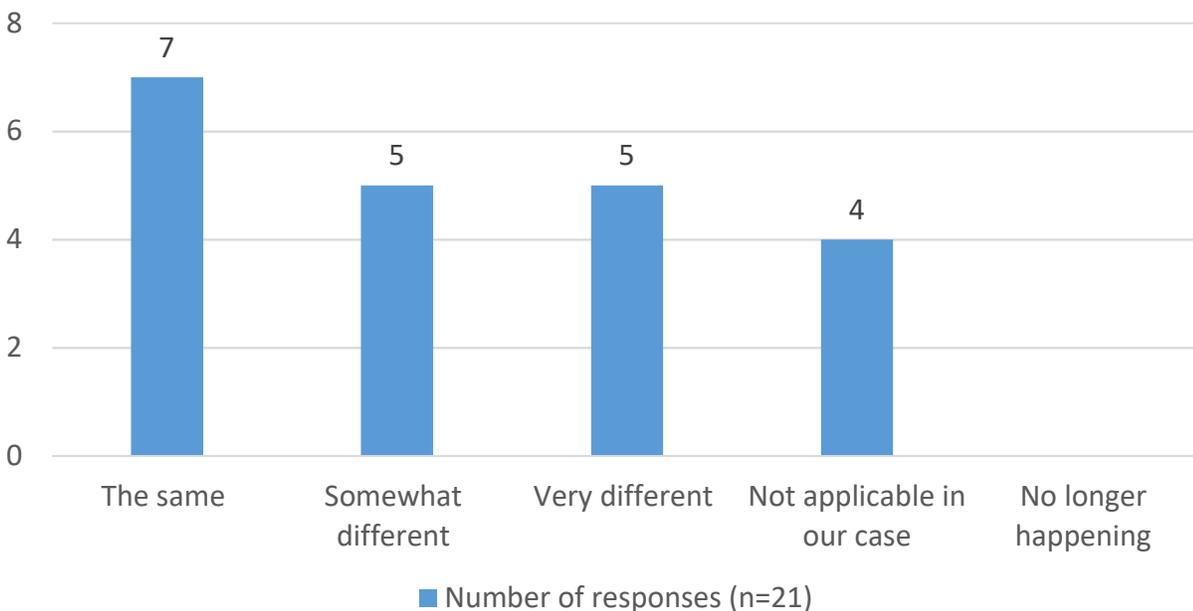
Figure 1: Change in Number of CHWs Employed by Your Organization Since 2017



Source: Interviews conducted August 2020 - December 2020

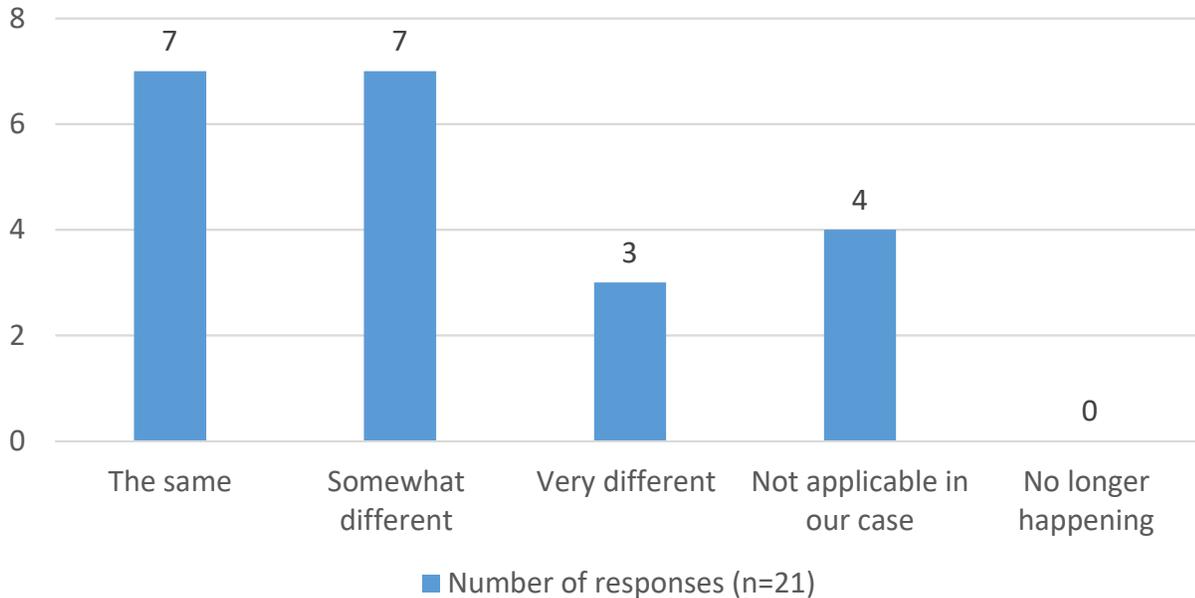
When asked about changes in the CHW role and the client/patient populations served (Figures 2 and 3), the most frequent response was that roles and populations served had stayed the same (seven for both) from 2017 to 2020. However, when combining responses of *somewhat different* and *very different* (10 for both), a majority of respondents for whom these questions were applicable had changed their CHWs' role and the population served, to some extent.

Figure 2: Changes in the Role of the CHW



Source: Interviews conducted August 2020 - December 2020

Figure 3: Change in Patient/Client Populations of CHWs



Source: Interviews conducted August 2020 - December 2020

When discussing changes in CHWs’ role and population served, most emphasized that the core elements and focus of community health workers’ approach had stayed the same, while programs expanded to reach new target populations or provide more intensive or refined services.

“We still have our core secret sauce, to make sure that CHWs are true to our mission and have a level of professionalism and peer support,” said Sam Salganik of the Rhode Island Parent Information Network (RIPIN). “RIPIN’s secret sauce is really about our peer model. That’s what makes us different and unique. We walk the walk. The peer model is entrenched in our culture—many others don’t have that.” The response is different from clients when they see you are a peer. RIPIN’s Senior Program Director Deborah Masland elaborated on the peer connection among CHWs and clients who share the experience of being parents of children with special needs, RIPIN’s target population. “People say ‘you get this because you’re a mom.’ There’s an instant ‘you get it’ kind of thing. You understand how hard it is, the emotional rollercoaster of what it means to be a good mom to a child with special needs.”

Changes, Growth, and Evolution of Community Health Work

Community Based Organizations are major employers of CHWs, who often work with vulnerable populations. As in the previous study, RIPIN remains the employer with the largest number of CHWs in the state, employing about 80 CHWs. At the time of this interview, about 50 of their CHWs were certified and 23 were working toward certification through the apprenticeship program. RIPIN’s client population has retained its core focus on children with special healthcare needs and has added more work with older adults. RIPIN has developed and enhanced the role of Certified Community Health Worker (CCHW) certification and CHW apprenticeship. CHW Registered Apprenticeship standards, which include classroom-based training, on-the-job learning, and certification, are used in all training efforts. In 2017, the certification process was new, and RIPIN had grandfathered in much of its staff. Now RIPIN has had employees go through the certification process as a standard part of the agency-wide human resources process. The expectation is that the agency is hiring CCHWs or that CHWs will attain certification within the first 18 months of employment.

Project Weber/RENEW has expanded its peer-based harm reduction programming. The number of CHWs employed has remained the same, but several CHWs have advanced in their role to become program managers. The client population is still focused on sex workers of all genders and those at risk for sex work but has expanded slightly to include men who use drugs but do not engage in sex work. Naloxone distribution and training, needle exchange, and basic-needs provision have greatly expanded.

Our Journ3i remains focused on Black maternal and child health. Owner-operator Quatia Osorio, who is also a CHW, has not changed her role or client population. For Osorio, being a CHW as well as a birth doula *“allows me to do things like take blood pressure, temperature checks, make referrals to other organizations, and be seen as an identified professional. When I was new to the field, there wasn’t that recognition. Now people know what a CHW is and understand the work. I’m still operating at the bottom level, but the bottom level [is] where you really reach the community.”* By being in the community during home visits and having shared lived experience with clients, Osorio can help address and mitigate distrust and trauma related to law enforcement and Department of Children, Youth & Families (DCYF) involvement, and she can focus on the specific health needs of communities of color. Healthcare staff’s relationship with doulas *“has drastically changed and feels more receptive with more doulas of color going in [to accompany people giving birth]. Some nurses’ attitudes have changed about doulas, to be more supportive.”* Journ3i hosted a doula training in 2018, and Osorio mentored a graduating class of primarily women of color. This evolved into an ad hoc group of eight Black doulas and became the Umoja Nia Doula Collective in 2019. Osorio, currently training to become a midwife, is a founding member. *“We are trying to create a workforce.”*

Housing and CHWs

Several interviews touched on the importance of housing, including two with Community Development Corporations (CDCs) that are the administrative organizations of HEZs. Asked about the fit of CHWs in a CDC, ONE NB’s Director of Community Health Integration, Laurie Moïse Sears, said, *“I think it fits perfectly. Our CDC has two pillars: creating affordable housing options, and keeping folks housed in a healthy manner. It’s not just our job to find places to build homes, sell them, and rent them. We have to make sure folks in the most need have the resources to stay in the home and the community. I don’t think it’s fair to...offer someone affordable housing but not the rest of the stuff that goes into that. Housing is not just a place to sleep, but it’s ‘where is the pharmacy, where do you get your healthcare, where do you go for a walk?’ As landlords we’re not just looking at trying to get the check and keep moving. **CHWs say ‘we want to make sure you’re good as a whole person, not just that you have a place to lay your head at night.’ Lots of folks get housed and don’t make it because they don’t have the supports they need to stay in the home successfully.”***

WEHDC oversees 192 units of affordable housing and operates a home ownership center, while employing CHWs in its HEZ, COVID-19 response and Dunamis Synergy programs. Executive Director Maria Carvalho stated that *“**housing is like a vaccine,**”* attributing the quote to Dr. Nicole Alexander-Scott, Director of the Rhode Island Department of Health. Sarah Martino, deputy director of the Center for Prisoner Health and Human Rights commented on the importance and scarcity of affordable housing, *“I can say all I want that we need more CHWs, and I think that we do, but ultimately you can throw as many people as you want into a system navigating people to resources, and if there are no resources, who cares? In a perfect world you grow the workforce and you grow the resources...**we need to drop everything and get people housed before we try and navigate people to housing that doesn’t exist.”***

Two Health Equity Zones (HEZs) that were interviewed began working with CHWs after the 2017 study and were interviewed for the first time in 2020.

ONE Neighborhood Builders (ONE|NB), as the backbone agency for the Central Providence HEZ, rapidly expanded its CHW programming through a multi-employer apprenticeship. ONE|NB began to employ CHWs in 2018 using a *Fund for a Healthy Rhode Island* grant from the Rhode Island Foundation. Since 2018, ONE|NB has expanded to a total of three CHWs employed directly by the agency, and an additional nine CHWs employed by organizational partners in the Central Providence HEZ convened by ONE|NB, for a total of 12 CHWs involved. This cohort meets biweekly to connect on group trainings, troubleshoot on difficult cases, and share resources and insights about what's happening in the community they serve. Organizational partners who employ the additional nine CHWs include Integra, Providence Community Health Centers, Federal Hill House, Childhood Lead Action Project (past), Providence Housing Authority—and recently added with the support of CARES Act funding from the Rhode Island Department of Health (RIDOH) are Smith Hill Community Development Corporation, Project Weber/RENEW, and the Refugee Dream Center. Each organizational partner devotes one or two CHWs to the HEZ collaborative work. CHWs' scope has expanded significantly, in the original 02909 ZIP code target area to include 02908 and parts of the 02904 ZIP codes. CHWs have allowed the HEZ to move from assessing community needs every one to two years through a formal needs assessment to integrating a constant feedback loop following organizations to course correct.

West Elmwood Housing Development Corporation (WEHDC) is a Community Development Corporation with social services programs. WEHDC is now in its second year as the administrative agency for the HEZ for Providence's West Elmwood (02907) neighborhood. The HEZ has recently finished its community needs assessment. It employs CHWs to support its COVID-19 response (see details in The Pandemic and CHWs section). It has engaged in programming and partnerships related to opioid use, and it has connected with its Dunamis Synergy initiative around a whole-family, whole-health approach. Dunamis Synergy is an initiative to support parents who are first-generation college students and their children. This collective impact model brings together institutes of higher education, community based organizations, State agencies, domestic violence organizations, and others, and it connects housing and education. WEHDC also provides a WIC center and a home ownership center, and it oversees 192 units of affordable housing. Two family coaches, one of them a CHW, are employed by the Dunamis Synergy program, along with a social worker and parent engagement specialist. Family coaches provide wraparound services. Dunamis plans to create affordable housing, noting that when clients have stable housing, their outcomes improve.

Healthcare Organizations have hired more CHWS and diversified their roles.

The number of CHWs has grown substantially at Providence Community Health Centers (PCHC) in the past three years, from three in 2017 to 12 in 2020. At the time of this interview, PCHC was planning to post job announcements for three additional CHW positions. The role of CHWs at PCHC has changed, as well. Initially, CHWs were supporting a nurse-led care management program with translation and social determinants of health (SDOH) supports, and CHWs did not carry their own caseload. Now, they have developed an intake process including SDOH screening, their own caseload, and have moved from an exclusively adult population to one that includes pediatric patients. One is embedded at Women & Infants Hospital, and one supports the Hepatitis C clinic. PCHC will be changing its model from basing a CHW and Nurse Care Manager (NCM) at each of its eight sites, into a program-based model that distributes resources more evenly across sites that have differing patient volumes. PCHC will be launching two new CHW-led programs: a chronic care program focused on hypertension and diabetes and a behavioral health transitions of care program. **They have developed a Senior CHW role.** This person is able to be a peer to CHWs who understands their workflows and

challenges. The senior CHW meets one on one with CHWs, coaches them, reviews cases, ensures interventions are appropriate, reviews and sometimes co-signs notes, trains and onboards new staff, ensures billing is correct, makes resource guides, and otherwise supports the program.

Accompaniment

Matthew Roman, Chief Operating Officer of Thundermist Health Center, made the case for the value of CHW accompanying and transporting patients to appointments and other activities: *“Unequivocally the one most important intervention [CHW] staff does is accompaniment. Meaning, if folks who need service could do it on their own, if they had a sense of self-efficacy, they would, and wouldn’t need intervention. CHWs’ presence, going to the DHS office, the specialist’s office where health literacy gets in the way, being there and present, helping them build self-efficacy, working through health literacy, is the most important thing.”* Roman shared two specific examples, noting that the COVID-19 pandemic has interfered with CHWs’ ability to provide these services.

For patients with no social support network, a CHW might pick them up after a colonoscopy—a procedure that requires sedation. Patients are not allowed to leave in a taxi after a colonoscopy, so if the person has no social supports, how do they get home? Lack of transportation, which is considered to be a social determinant of health, can eliminate someone’s ability to get screened for colorectal cancer. But if there is a CHW with the patient, there is an assumption that something has gone wrong. But if you talk to CHWs, they say *“do you know what we’re talking about in the car?”* Explaining colonoscopy prep to someone with limited health literacy so the patient follows the prep procedures correctly. Without a plain-language explanation of colonoscopy prep, the patient likely won’t do it right, and then cancels the test.

Often, we don’t talk to actual CHWs about what they do, or to patients who are supported by CHWs to learn what’s valuable. We need to understand that when a CHW is providing transportation, they’re having really important discussions. I knew this going back to when I ran a targeted HIV program. When people have regular--or certainly low--health literacy levels, who are they going to see? Fellowship-trained people with the highest literacy level who are trying to explain diagnosis and treatment. The clinicians are national experts. And then they are talking to someone with a health literacy level of 4th grade, and we wonder why there are adherence issues.

I’ve heard time after time from CHWs that they’d get in the car with the patient afterward, and the patient would say *“can you tell me what just happened in that appointment?”* And the whole ride home was breaking down what complicated testing and viral load meant, so they understood it. It was literally the most important intervention that happened. It shouldn’t be surprising something was missed in translation. When people are not empowered to say they don’t understand or don’t feel comfortable talking about something they see as personal or embarrassing—it’s easy to understand how something can, literally, get lost in translation.

Thundermist Health Center has increased the number of CHWs it employs and has maintained the same client population, but the role of CHWs is very different from what it was in 2017. Any adult patient in the Thundermist primary care system has access to a CHW, primarily through Thundermist’s own teams, with the exception of the Wakefield office in the catchment area of the South County Health Community Health Team. Chief Operating Officer Matthew Roman emphasized the importance of accompaniment, which includes CHWs driving clients to appointments and talking with the client after the visit to be sure they understood everything that was discussed at the appointment. Thundermist’s Trans Health Access program provides peer support to transgender people navigating complex healthcare systems, and social needs including housing discrimination.

For Integra Community Care Network, “A lot has changed. We have HSTP [Health System Transformation Project] funding. The Medicaid team has grown from four to 16; and we’ve gone from zero to six CHWs,” said Senior Director of Government Programs Matthew Harvey. CHWs work on interdisciplinary teams with nurse case managers, social workers, a peer recovery coach, and practice office staff. They do outreach and enrollment, SDOH screening and referral, and case management. Integra had thought that CHWs would play a role in finding and engaging disengaged members in the community, but this has not happened in practice. *“We thought going in, and we have seen this in practice, that because social needs and behavioral needs are such huge drivers of risk, cost, and poor outcomes for the Medicaid population, we knew that the program compared to, say, Medicare, would be much more social heavy. Not that we don’t have medical complexity, but the balance is different. CHWs are an incredibly cost-effective way to try to manage social needs of a population.”*

Prospect Health Systems Rhode Island’s Accountable Entity program added its first CHW in 2019, said Program Director Garry Bliss. The program currently employs one CHW. In particular, the CHW’s strengths are *“engaging with patients who have a weak, occasional connection to primary care; helping patients obtain benefits or other supports that will help them; and being a bridge between primary care and that patient and their family.”* **The CHW carries out “a root cause analysis of what was driving ED [emergency department] use....really digging deeply and understanding what was really going on here, and then [the CHW works] with folks to get them ideally to change their ED behavior.”** Prospect Health Systems Rhode Island recently adopted Unite Us, a web-based platform to facilitate referrals to resources that can address social needs. Bliss said that this platform is allowing the program to measure the effect of the AE program on social outcomes, cost, health, and quality outcomes.

Neighborhood Health Plan of Rhode Island (NHPRI) has increased the number of CHWs it employs. The CHWs’ role has evolved somewhat, as has the population they serve. CHWs play a role in obtaining information for quality measures. Some CHWs can also take blood pressure measurements in a home setting, screen for depression, contact primary care offices with requests for lab tests, and support the work of nurse practitioners. *“The needs of the community change—especially around equity and health disparities,”* said Yvonne Heredia. *“We change CHWs’ work on the clinical side of care management, based on the needs of the community. Today it could be housing, but we also have clinical programs, education about diabetes, asthma, chronic conditions. It’s more of a hybrid role: it has to speak to the needs of the community. It can’t stay the same because the needs change. It’s not something that can stay stagnant in any organization; you have to do an assessment of the population, and based on the needs of populations, fit in CHWs’ trainings and opportunities, based on that.”*

Clínica Esperanza/Hope Clinic’s CHWs, called Navegantes (Spanish for navigators) have long focused on providing support and education to uninsured clients. In the past years, their role has grown to include COVID-19 testing; translating information and resources about COVID-19; coaching clients on technology access for telehealth; promoting the Census; and partnering with a local church to provide a food pantry, HIV testing, and information distribution. *“We are growing; we are going a mile extra of our own awareness of our capacity; we’re growing [our] humanity, as professionals, [and] as [a] community,”* said Paola Martinez.

The Center for Prisoner Health and Human Rights was in the process of hiring Lifespan’s first CHWs, when interviewed in the 2017 study, to work at a newly established Transitions Clinic for people being discharged from incarceration. The number of CHWs employed by the Transitions Clinic has stayed the same since 2017, but the number of CHWs employed throughout the Lifespan hospital system has grown. Some CHWs have been employed in disease-specific roles at Lifespan. Much more

recently, CHWs have been hired at the emergency department at Rhode Island Hospital. **The SMART Initiative and ED Care program provide CHW services in Rhode Island Hospital's emergency department, extending into the community.** Both programs are grant funded and began in 2020. The SMART (Substance Misuse Assistance Response Team) team is made up of frontline staff dually trained as CHWs and Peer Recovery Specialists (PRs), who provide navigation around health-related social needs and individualized support, as well as peer recovery support, navigation and linkage to harm reduction, and treatment and recovery services. The ED Care program is a related program for frequent utilizers of emergency services who have chronic medical conditions, rather than substance use disorders (SUDs). SMART has four staff members who split their time between the emergency department and the community. They engage and enroll patients in the emergency department, and they conduct two types of encounters: one-touch encounters, where they see patients only in the ED and provide linkage, and caseload encounters, where they address patient needs through more time-intensive services. They accompany patients to appointments; help them apply for housing, jobs, and treatment; and help them navigate these systems. The goal is a rotating caseload, in which SMART staff members hand patients off to established community health teams accessible through their PCP, a social service agency, or an insurer. The programs do not currently have the staffing capacity to be a consultative service, but they try to provide consultation to ED clinicians informally. Physician Lead Elizabeth Samuels said that hospitals with similar programs tend to be large academic medical centers. Programs at larger hospitals tend to not provide services outside of the emergency department. Instead, they focus on motivational interviewing, engagement, and linkage to services within the ED. But the majority of emergency care is provided in small community hospitals. Samuels speculated that the rationale for sustainability of this kind of program at large academic centers might look different from the model in smaller hospital settings, but people in smaller hospitals still need these kinds of services.

Social Determinants of Health in the Emergency Department

“As ED clinicians, we all know why people come to the ED, we know it’s social determinants of health (SDOH),” said Elizabeth Samuels, physician lead for the SMART and ED Care programs. ***“I know what you need is housing, reliable transportation. We’re trained and equipped to deal with discrete medical problems. We don’t have the time and resources to sufficiently address complex needs.”*** Liz Samuels, Assistant Professor of Emergency Medicine at Alpert Medical School of Brown University, is the consulting assistant medical director to RIDOH’s Overdose Prevention Program, which has supported emergency department-based interventions for Substance Use Disorders (SUDs) for several years. In this capacity, she has focused on implementing State policies and care for people who have experienced opioid overdose. Drug overdose work ***“needs to be thoughtful as it addresses the social and structural determinants of health.”*** To focus on connecting SDOH and SUD services, Dr. Samuels’ team proposed the SMART initiative (Substance Misuse Assistance Response Team), an emergency department-based, CHW/Peer Recovery Specialist intervention.

Addressing SDOH and SUD through harm reduction and recovery are intertwined outcomes. Often in overdose work, the metrics evaluated are limited to overdose, death, and treatment for SUD. ***“But people are not just their substance use. There are other determinants of whether those things happen, and we are trying to take a holistic approach.”***

“It’s a particular kind of skill. The ED isn’t for everybody as a place to work. It’s a challenging place to work. In lots of settings people are seeking out CHWs; this is opposite. It’s outreach on someone’s worst day. It’s a very difficult environment, very stressful. We have done a good job figuring it out. There are lots of issues of culture of the community health work approach and organized medicine.”

Community Health Teams (CHTs) that serve multiple primary care practices have expanded clientele and services. Care Transformation Collaborative (CTC-RI) Community Health Teams have increased the number of CHWs they employ, doubling from two to four CHWs on two of the teams. In addition, all teams also now have Peer Recovery Specialists—some of whom are dually certified as CHWs. *“I can’t tell you how important we feel the work of CHWs is,”* said Senior Project Director Susanne Campbell. CHTs have expanded their focus from only adults, to include families. Some teams are working more closely with RIDOH’s Family Home Visiting programs, including high-risk families, such as those who have a baby with neonatal abstinence syndrome (NAS). CTC-RI is also working with RIDOH and Rhode Island College to train CHWs in diabetes, hypertension, and cardiovascular disease prevention and management. CTC-RI has partnered successfully with MLPB (formerly Medical Legal Partnership Boston) to assist and train CHTs in navigating legal issues such as housing, utility shutoff, and other matters. *“It’s incredible how complex the situations are, and how important that [legal] resource is,”* said Linda Cabral, CHT Project Manager.

Family Service of Rhode Island (FSRI) Community Health Teams (CHTs) continue to work with their original target population of adults with social and behavioral health needs. They have more recently added programming to serve children and families. FSRI also has two CHWs working with RIDOH’s newborn-focused First Connections program (along with a Certified Peer Recovery Coach and a Behavioral Health Clinician).

Funders and workforce development efforts have evolved in their approach to CHWs.

The number of CHW positions supported by the Rhode Island Foundation has increased since 2017, by at least 25%, said Strategic Initiative Officer Zach Nieder. The Foundation continues to fund CHW initiatives that target a broad range of populations. The biggest change has been a focus in developing newer grants that invest in multi-stakeholder, community-based collaborations (e.g., HEZs) through the Fund for a Healthy Rhode Island, which include CHW initiatives. The expansion of the Foundation’s Healthy Lives strategy to include an increased focus on the SDOH and community-clinical linkages has occurred in tandem with the expansion of investments in CHW programs. It has been an iterative process in which the Foundation’s learning from, and understanding of, the impact of early investments in CHWs is reflected in the broader strategy, which, in turn, has led to additional investments in CHWs. *“What was more de facto has become more de jour. It’s part of the strategy,”* said Nieder. CHW projects may start as pilots, but there is an emphasis on moving toward partnerships, and then sustainability. *“We see this transition in projects, even if the grantee remains the same.”*

Community Health Innovations of Rhode Island (CHI) provides training to other organizations, including train-the-trainer programs. It contracts with CHWs formerly trained by the organization to help conduct these trainings. Recently, CHI has worked with HEZs and with the City of Providence Department of Arts, Culture and Tourism, which sponsored a CHW training with an arts focus in 2020. Founder Dannie Ritchie, a Clinical Assistant Professor of Family Medicine at Brown University, noted that the framing of an interview question asking about changes to the patient/client population implied a clinical perspective. *“When people leave the clinic, they’re just people. So you’ve made it a transactional relationship because it’s a ‘client.’”* In training CHWs, CHI takes an “assets-based” approach, meaning that CHWs focus on the strengths of communities rather than deficits. *“We are trying to see CHWs as part of the team of systems of care in communities.”*

Apprenticeship Rhode Island, a program of an organization called Building Futures has worked with employer partners in creating and growing CHW Registered Apprenticeship programs, including three that were particularly active and successful: ONE NB, Parent Support Network (PSN, a recovery community and Peer Recovery Specialist training provider), and RIPIN (the largest employer of CHWs in the state). Each of these three partners increased the number of CHWs in general and their number of CHWs in Registered Apprenticeship programs between 2017 and 2020. At the time of the

interview, RIPIN had more than 20 CHW apprentices and PSN had nearly 40 Peer Recovery Specialists cross-training as CHWs. *“The appetite to sustain this work is much stronger than it was in 2017,”* said Apprenticeship Rhode Island’s Employer Relations Manager Amy Weinstein.

The Rhode Island Geriatric Education Center at the University of Rhode Island does not directly employ CHWs, but since the 2017 interview, training and support for CHWs has grown dramatically. Director Phillip Clark’s original vision of CHWs working with a population of older adults has evolved and become more focused since the first interview. He acted as a subject matter expert for the Rhode Island Certification Board in its development of a specialty endorsement process for CHWs working with older adults. This process was under development at the time of the 2017 interview, and involved other stakeholders, including a number of CHWs. He has become a staunch advocate for the role of CHWs as part of an interprofessional team, particularly in collaboration with other health and social care providers. In developing training, there is a focus on developing connections with community-based resources that provide services to improve quality of life, rather than just medical care. Clark noted that transitions of care are particularly important to consider with older adults.

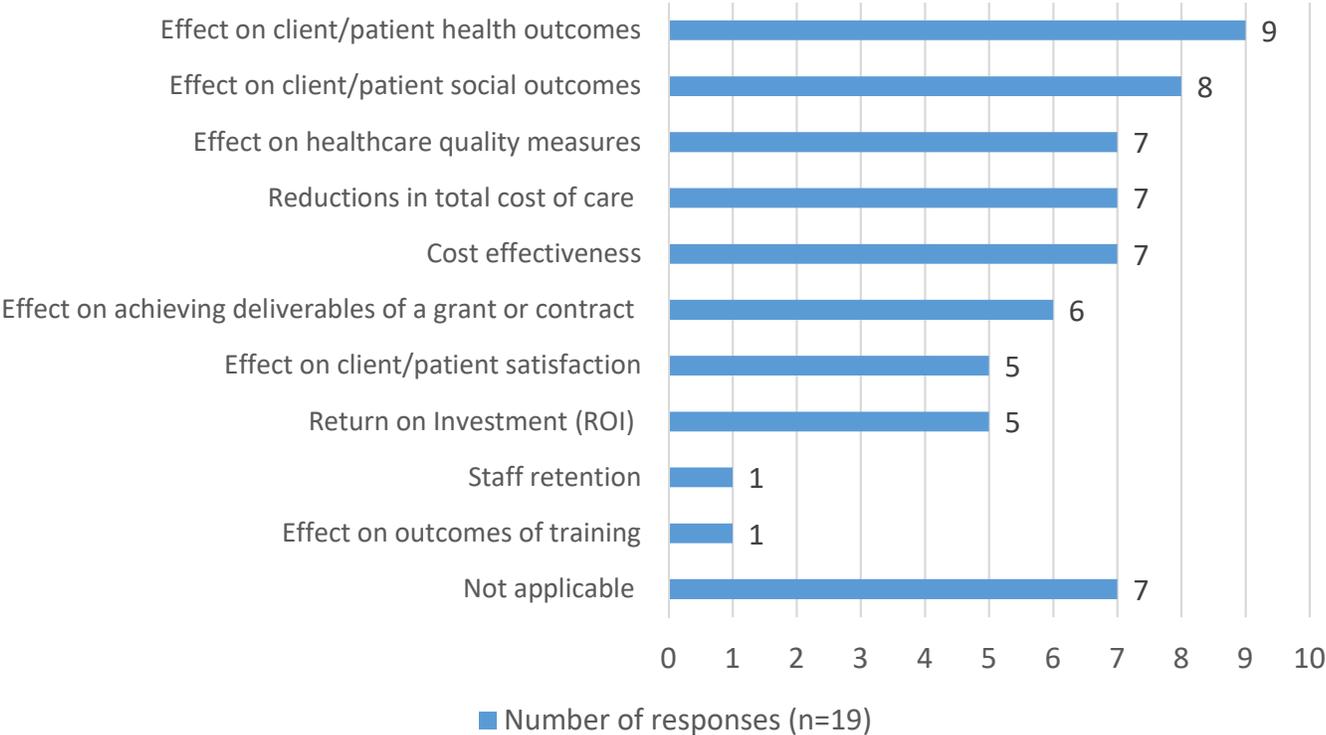
Organizations use diverse strategies to measure CHWs’ impact but have challenges with evaluation. Figures 4 and 5 relate to measurement. Figure 4 focuses on measurements of CHWs specifically, while Figure 5 focuses on measurements of programs that include CHWs. Slightly more respondents said that they measure programs that include CHWs, rather than CHWs specifically—and a few used both frames of measurement. Generally, those who had greater access to data, such as healthcare providers and AEs, measured a greater number of health and cost of care outcomes.

Figure 4: Elements That Organizations Use to Measure Value for CHWs



Source: Interviews conducted August 2020 - December 2020

Figure 5: Elements That Organizations Use to Measure Value for Teams and Programs That Include CHWs



Source: Interviews conducted August 2020 - December 2020

Respondents offered detail on a wide range of evaluation strategies.

CTC-RI’s South County Community Health team, in collaboration with a Brown University researcher, has evaluated cost and utilization among CHT clients and a matched comparison group.

Family Service of RI has adopted SDOH screening throughout the whole organization, a practice which started with CHWs.

Prospect Health Systems Rhode Island’s adoption of the new Unite Us social care platform is allowing the program to measure the effect of the Accountable Entities (AEs) program on social outcomes, along with metrics related to cost, health, and quality outcomes that the AE tracks with other data. Other metrics look at the CHWs’ efforts in contacting patients, including number of calls and the extent of reach, particularly for patients who were frequent emergency department utilizers.

In addition to measuring effects at the individual CHW and at program levels on client health outcomes, social outcomes, achieving grant deliverables, and tracking staff retention, ONE NB’s Central Providence HEZ program is beginning to look at emergency department utilization.

One program at Providence Community Health Centers has measured CHWs’ specific return on investment and cost-effectiveness, but more often, these measurements are evaluated at the program level. One focus is the effect of such interdisciplinary teams on the colorectal screening quality measure.

Community Health Innovations of Rhode Island measures the outcomes of the trainings for CHWs they deliver, such as satisfaction and expectations about how participants will use what they learned. In

some cases, they follow up to evaluate the impact on community programming as a result of training.

Rhode Island Hospital's SMART and ED Care programs are taking a two-part evaluation approach:

1. Measure individual client outcomes in terms of self-efficacy, feelings about their life, things they can do now that they couldn't do before, self-rated health, person-centered outcomes; and
2. Track outcomes that relate to support with housing applications, accompaniment to doctor's appointments, and changes over time.

"I think the CHWs really go above and beyond," said Physician Lead Elizabeth Samuels. Measurement of the programs' effect on client/patient satisfaction includes a focus on self-efficacy. *"Do they feel able to do things they couldn't before? Is their quality of life better? Are things going better for them?"* The evaluation uses validated scales that focus on these measures, performing an assessment at the beginning, which will be repeated. It starts with semi-structured interviews with clients, and repeat assessments are given at intake to measure change. Measurement of the programs' effect on client/patient health outcomes includes mortality, healthcare utilization (repeat ED and inpatient admissions), treatment engagement (at time of ED visit and as an outpatient), and harm reduction services engagement. Measurement of the programs' effect on client/patient social outcomes includes obtaining a GED, housing, a job, transportation, and food security. CHWs also assess social cohesion and supports present in a client's life at intake, and they try to help a client develop a support network; however, the programs do not measure these as outcomes.

The Rhode Island Foundation asks grantees to report on the impact and outcomes of their grant investments, but the Foundation does not ask grantees to measure return on investment or cost-effectiveness. However, grantees are increasingly asking the Foundation for support in helping them to evaluate these types of metrics, because they see them as a means to demonstrate impact and prove that they can be sustainable. *"We are certainly seeing an increase in organizations thinking about these metrics, as they see this as a pathway to sustainability,"* said Zachary Nieder. The outstanding question is when the broader philanthropic sector will consider the matter of return on investment for CHW services settled, which is closely linked to identifying different sustainability strategies.

A number of respondents described limitations in evaluation.

"It's tricky to figure out the value to be able to make the case you should fund programs. Outcomes can be very reductionist, very distal, from things in the moment for the individual person," said Rhode Island Hospital SMART Initiative Physician Lead Elizabeth Samuels. Repeat hospitalization can be a problematic metric. *"What if someone needs to come back to the hospital? It's a short-sighted outcome—it's important on a population and cost level to understand why people do that. It's not necessarily bad that people come back. [I might say, for example] 'If this gets more red, come back!' Problems are dynamic. I don't want people staying home and getting more ill. I want people to have the things they need, get the things they need...it needs to be more nuanced than that."* The hope is to provide services, including outpatient services that help patients' health improve at home. But, in particular for unhoused people, *"it's not rational to think that overnight, they got on the list [for housing], and they're not coming back."*

RIPIN measures several items for their programs, which are conducted primarily by CHWs. RIPIN's work may play a role in healthcare costs savings, but it is not their primary focus, and it is difficult to measure. Said Senior Program Director Deborah Masland, *"We're a part of the puzzle in total cost of care, and we may have an impact on cost or a direct impact on specific data, but we may be removed from seeing this directly. It may be costing the state less to partner with us, but the actual ask is different. Our piece is mostly social determinants of health. So, it's apples and oranges. We hope to have an impact on the greater system, but we might not realize cost savings measures ourselves."* It is

difficult and expensive to measure these outcomes, with different providers' data sets and payers. ***"It's cost prohibitive to do a study that's done correctly."***

In considering the measurement of healthcare cost savings, it is ***"very hard to isolate effects on total cost of care, and determine what bends particular drivers of costs,"*** said Matthew Roman of Thundermist. *"We give it a shot, but I don't think anyone has been effective in saying what intervention is driving [changes in healthcare costs], partially because multiple interventions are happening at once."* A study of healthcare costs among clients of community health teams, including the Thundermist team, found no significant difference in total cost of care, but they did find statistically significant reductions in specific subcategories of spending. *"The costs equaled out, and so people missed the story because they were only looking at total cost of care. What they found was professional services (specialists') costs went up. When we talk about someone with a lot of barriers to care, and a CHT breaks down those barriers, those costs are going to spike. Long term, it's hopefully going to prevent disease—prevention that would not have happened if not for access to the specialist. Is it negative that people go to specialists? They are not going for frivolous things—they are seeing an oncologist, a pulmonologist. That represents access that didn't occur before, because there were so many barriers. In the long term you are saving a life, not saving a dollar. And hopefully the long-term effects are beneficial. The other thing that spiked was pharmacy costs—[...] because they weren't taking meds correctly.' A bottle that should last a month lasts a month instead of three, because the patient is taking it [correctly]. It wipes out ED utilization. So, there is a story there that got glossed over, because there were no changes in total cost of care. But when people are seeing specialists and seeing the trajectory of disease progression escalated to the point where a PCP can't handle it, it needs attention."*

Equity concerns persist for the CHW workforce.

Several participants described similar themes around equity issues for CHWs, related to wages, race and racism, organizational culture, unrecognized skill, fidelity to the model, and the need for supports among peer workforces.

"With CHW jobs paid at low wages and unable to bill, even after a national conversation and workforce development, 'What did we create then? What was the point of developing this workforce?'" asked Quatia Osorio of Our Journ3i. *"We still don't have an independent workforce with autonomy, shifting power back to the community. All we did was give institutions another employee. To capitalize on the resident of a community, now you're [...] tokenized—[expected to] speak on behalf of, or recruit [community members]. [CHWs are] shifted to another powerless position. I love everything CHWs stand for, but I hate the fact it was used as this type of engagement, as essential workers, and created another bottom-tier [of the] pyramid of people who we can say diversified the staff because they look like people from the community...the CHW position is so broad, and able to do so much--does that allow for exploitation of this profession?"*

COVID-19 has revealed some confusion about CHWs' role. People may confuse them with outreach workers or volunteers, and ONE NB has even heard people offering to volunteer as CHWs in hopes of helping with the pandemic. ***"This is a misunderstanding we've seen a lot and had to clarify: that these are skilled (usually) women, who've had lots of training, and are meant to work with people directly and build long-term relationships,"*** said Allegra Scharff. Laurie Moïse Sears said that *"the goal of HEZs throughout the state is to have initiatives based on what we're hearing and learning from community members. The expectation has been that community members would share their time and thoughts and not be financially supported; however, be able to come to the table with people from healthcare and non-profit settings and be able to speak comfortably, and it's just not that easy. Lots of CHWs grew up in the neighborhoods [they serve] and have more confidence speaking about what they're seeing because of the CHW training they have had. [They need to be] financially supported with a living wage to be at the table to speak about this, and not just having to volunteer their*

time to do so. I think that's important...we make clear at collaborative meetings that we'll break off and hear from CHWs about what they're doing and seeing, so people know they should listen—and also [so] CHWs realize that what they're doing is valuable, and they have valuable information to share.”

“One of the biggest changes we made in our hiring protocol and process was that initially [a CHW] needed a bachelor's degree,” said Chelsea DePaula of PCHC, one of the employer partners in ONE NB's apprenticeship program. *“When we started with the apprenticeship program...[we had] someone straight from the community without much formal education— [she] had high school diploma. We really felt that she benefited the organization. She's actually my star CHW; she's amazing. So, we changed the requirement so that no education was required, and we really look for people in the community. We need that connection and that passion. That's a huge change we've made, and kind of big for the organization. It's tricky for a healthcare organization, with [staff members] documenting in the medical record, they need the appropriate literacy level, to be bilingual. We're really invested in training and retaining employees. As organizations invest and onboard CHWs in the future, they need to invest [in training].”*

Deborah Morales of the Executive Office of Health and Human Services of Rhode Island noted that there are concerns about duplication or overlap of care management efforts among practices that have CHWs, ACOs, and Community Health Teams. And there is a concern about over-medicalizing the work CHWs do, and about CHWs potentially being negatively impacted by hierarchies in organizational culture at healthcare organizations.

Community Health Systems and Equity

Dannie Ritchie, Brown University Clinical Assistant Professor of Family Medicine at Brown University and Founder of Community Health Innovations of Rhode Island, offered an analysis of CHWs' role and equity issues they face.

A major focus of the current conversation is measuring social need and how to link people up to organizations that can address those needs. *“But it doesn’t get to the basis of the reason there’s a need, why there is a problem to start out with. **If you can think about CHWs empowering the community to work on changing those conditions---that’s where I think we need to go.** At least we’re getting them in the community. Maybe we’ll be on the way to talk about undoing the baseline institutional, structural, and systemic problems or issues that cause inequity. Then you’re going to have healthier communities. How do we start having that conversation? That’s usually what CHWs are dealing with: what’s the fallout of institutional inequities, and how to help people navigate so they can take care of themselves?”*

The concept of **Community Health Systems** helps us see that there is a *“larger system with healthcare embedded in that and see the CHW as a caretaker in a community system of how we care for ourselves and care for others. If you understand that we have a community health system, and that CHWs are part of that, it starts to make more sense that they need to be in the community, and not sitting in a clinical office, so they can have their ears to ground, and know what services are in the community.”*

*“**This [community health system] is people’s primary care, where they go to take care of issues about where they live, work, learn and play.** This is where you have your first intervention. This is where people see their capacity to take care of themselves. That’s where you have to be placed in the community, that’s the first line. That is your primary care, where people are primarily caring for themselves.”*

The fidelity of the role is the most important thing. *“**CHWs are not little helpers, they are people who actually function and come up with plans to change the conditions for people to be more healthy.** That’s their public health function. In the effort by the government to promote a CHW workforce, you get points on your grant to say you have CHWs--but if you’re not understanding what a CHW is, you’re just getting it for points, and you’re not faithful to, or interested in, what CHW is, it’s demeaning them. It’s looking at them as a low-level kind of worker that doesn’t get paid much, and then supports you to do busy work or something. That’s where I get concerned about the clinical model that doesn’t have a community focus and doesn’t see community health as improved with CHWs.”*

Peer workforces require workplace supports.

*“**We hire folks with significant mental illness, criminal justice backgrounds, intentionally folks in recovery, even medium term,**”* said Colleen Daley Ndoye of Project Weber/RENEW. *“Retention is really important to us, with a very high priority on paying a living wage, giving staff time off. We have policies to support staff who relapse, to get back into recovery, and connect to supports. We don’t want people to have one shot, and then you’re gone. We have a focus on honesty. It takes a lot of effort. And we also promote people. Someone might start at 10-20 hours a week, then become a manager, then a director. Two of our management senior level people started that way.”*

Sarah Martino of the Center for Prisoner Health and Human Rights described lessons learned from

working with CHWs who have been incarcerated themselves and work with people released from prison. **“We have learned a lot about what it means to hire peer staff. We have talked a lot about the fact that folks we’ve hired have gone from having access to public benefits or subsidized housing and lost them because their new salary is more than they were making, but not enough to take care of the things they needed. We are hiring folks who, even if they are further along in their journey than clients, still struggle with some of the same things. I don’t think any of us were truly prepared for how much we were going to have to incorporate the realities of our new team members’ lives into how we support the work. I think that that’s probably a reality in a lot of different organizations that we just don’t talk about. If you’re doing the work correctly and you’re actually hiring people who represent the community they come from and it’s a low-income community, it’s challenging and really hard to think about how to have a compassionate workplace when your workplace is not set up to be compassionate or culturally responsive. That, for me, personally, has been the biggest learning curve. [Is it worth it?] 100%. Specifically, our Transitions Clinic CHWs—the support they are able to provide to their clients. Off the top of my head I can think of a number of [clients] who would not be alive if not for that relationship. They do amazing, amazing, intensive work.”**

Key Findings on the Pandemic and Community Health Workers

Community health workers (CHWs) are confronting the pandemic's socioeconomic and health equity crises, with the pandemic revealing and exacerbating the conditions that CHWs work to alleviate. CHWs are vulnerable to these conditions themselves. CHWs' roles have changed quickly. Remote community health work is happening but poses problems for some. CHWs are responding to a crisis of social need, while COVID-19 has presented obstacles and required adaptation. The pandemic is changing the conversation about sustaining the CHW workforce.

The Pandemic and CHWs

Throughout the interviews, a common theme was that the pandemic has reinforced, demonstrated, or revealed the need for community health work. Respondents pointed to CHWs' ability to reach and successfully engage hard-hit populations with education about COVID-19, to inform public health and healthcare efforts to serve these populations, and to address an avalanche of social need driven by the economic consequences of the pandemic. Many respondents framed these issues through an explicit health equity lens, pointing to racial and ethnic disparities in the pandemic's impacts, and CHWs' position at the interface of institutions and communities of color. CHWs themselves are vulnerable, as members of vulnerable communities. Behavioral health impacts of the pandemic are taking a toll. Virtual approaches to community health work have been rapidly adopted but face a number of challenges. Many respondents expressed that the pandemic highlights the need to achieve sustainability for the CHW workforce.

Impacts of the COVID-19 pandemic reveal and exacerbate conditions CHWs work to alleviate.

“[The pandemic] certainly really underscored the need for that kind of healthcare work,” said Sarah Martino of the Center for Prisoner Health and Human Rights. *“As we begin to understand some of the intersections of health and social needs a little more, because they’ve been thrown in our face with the pandemic, I think it’s really highlighted the need to have healthcare workers who can pull some of those pieces together.”*

“I also think instinctually that the social repercussions from COVID-19 are going to be incredibly numerous, and we haven’t even started to uncover that,” said Amy Weinstein of Apprenticeship Rhode Island. *“You can’t take people’s communities away and expect them not to use substances or fall back into old patterns. The need for touch points is bigger than ever. The need in more communities is bigger than ever. Absolutely it can be done virtually. It’s not ideal, but we’ve seen a lot of success building in our non-profit partners of virtual work being done. [CHWs] are helping people feel like they have a connection in a lonely world.”*

“I think COVID-19 is uncovering a lot of unmet need that can be addressed by CHWs,” said Linda Cabral of Care Transformation Collaborative Rhode Island. *“And likely, since COVID-19 probably isn’t going away soon, long-term effects on mental health and well-being, the ability of CHWs to make referrals to behavioral healthcare, with a clinician on the team, [...] to make referrals very seamlessly, and make a warm handoff happen [is important].”*

“I think if anything, due to the pandemic, much more light is being shone on the critical function of community health workers,” said Deborah Morales of the Rhode Island Executive Office of Health and Human Services. *“I could see where CHWs could be a really key part of the workforce—testing, tracing, having folks in the community helping on that front. And linking individuals who tested positive with quarantine, the services they need, accessing food, etc.”*

The CHW at Prospect Health Systems’ Accountable Entity (AE) program engaged patients at risk of COVID-19, said Program Director Garry Bliss. One of the Medicaid Managed Care Organizations provided the AE program with a member list of patients who were identified as having high risk for poor outcomes with COVID-19. The CHW used these lists to do *“proactive engagement, reviewing with them risk factors and protective factors, providing education on what they could do. And [it] was extremely helpful, that we had someone [a CHW] who was bilingual, able to reach out to...the Latinx community that was experiencing the COVID crisis much more severely than the Rhode Island population in general.”*

Clínica Esperanza/Hope Clinic's (CEHC's) patients have been particularly hard hit by the pandemic. CHW Supervisor Paola Martinez said that the COVID-19 positivity rate at CEHC's testing site was very high, 45%, and was influenced by the language barrier the community faces and by the need to translate into language the community understands and doesn't promote fear and panic. CHWs' role is translating into *"a language of hope."* Martinez explains, *"We human beings, we are very afraid of the unknown. I think [when] the pandemic [arose], we were all afraid; we don't know where it's at; we don't know where it's going to go. But we have a brave healthcare system, not only here but nationwide. We don't know the answer of how to fix the problem in totality, [but] we are at least trying to keep things stable. From my perception as a CHW, working in the gap between the system and the community, I think it will all depend on our perception of things...I think CHWs are working in an amazing way. We are not telling people this is over or we are going back to normality soon, but we are navigating to keep the patients in emotional safety so they're able to perceive the future in a normal way. Maybe we don't have the answer, but we are trying to navigate one day at a time, affirming. Letting them know whatever happens we are here to support them and they are not alone."*

"COVID-19 laid bare existing inequalities—the determinants of social disparities. Are CHWs addressing those?" asked Dannie Ritchie of Community Health Innovations of Rhode Island. *"In looking at social need: we are starting to see and measure it, and [healthcare organizations say] 'let's have CHWs hook people up with programs,' as opposed to asking, 'how do you change that need? How do you address the need?' It's hooking people up to systems versus changing [systems]."*

With the pandemic "we are finding out where the deep divisions and huge gaps in our society are located—and it has certainly brought into sharp relief where we need to be working harder in public health. Why we need healthcare founded on public health over the life course, as the basis for a healthy lifespan. And why it's so hard to achieve for poor people, people of color, all these other things."
—Phillip Clark, University of Rhode Island

CHWs themselves are vulnerable to the pandemic.

"Like other street outreach workers, or anyone who works with marginalized folks, people of color, low income people, [and] CHWs are at high risk for COVID-19 for structural reasons," said Elizabeth Samuels, physician lead of Rhode Island Hospital's SMART Program. *"CHWs are in a direct line of vulnerability. They do one-on-one care with the most vulnerable, and that therefore makes them vulnerable. Our group is constantly thinking about how we keep them safe, and this is one of the most vulnerable times for our clients, who are losing jobs, who are isolated, who are losing housing. It's such a high-risk time socially, personally, economically—and in terms of health risk. There is a need for intensification of services, but we don't want CHWs to get COVID-19. CHWs are also dealing with all of those things...we want CHWs to be comfortable and safe, and we want clients to have what they need during this extra terrible time. In regular times it's hard, and it's even harder with COVID-19."*

Because CHWs at Thundermist come from communities that are disproportionately impacted by COVID-19, they, themselves, have been disproportionately impacted. Chief Operating Officer Matt Roman noted that early in the pandemic, the Thundermist's Community Health Team went from eight CHWs to one, because others were out due to illness or quarantine.

Quatia Osorio of Our Journ3i expressed concern that **CHWs are playing the role of frontline essential workers in healthcare institutions, but it is unclear if they are receiving hazard pay.**

CHWs' roles have changed quickly during the pandemic.

For CTC-RI's Community Health Teams (CHTs), ***“COVID has changed everything. All CHTs demonstrated the ability to work effectively in a virtual way: using texting, phone, and video to do what was face to face. They transitioned successfully to provide support and engagement and even more,”*** said Senior Project Director Susanne Campbell.

Neighborhood Health Plan of Rhode Island (NHPRI) CHWs have been doing much of their work telephonically during the pandemic, responding to rapid changes. For example, homeless shelters and food pantries have changed their operations quickly in this climate. The Health@Home program has had to transition from an intensive face-to-face intervention model to telephone, and the program had to learn to pick up on keys to patients' health without visual cues. Yvonne Heredia, manager of care management, said *“It's been a really big shift. Our CHWs are used to going into the home and seeing with their own eyes and being that investigator in the face-to-face interaction. Now it's a little more difficult because doing it over the phone changes the role quite a bit. Especially when they are trying to support nurse practitioners for findings on difficulty or disparity for the patient, it changes the dynamic completely. You talk to someone on the phone. When you see someone at a doctor's office they present well, but at home it's different. A cabinet full of untaken meds, insulin not in the fridge. You see a different aspect.”*

Only 46% of patients in NHPRI's target population had internet access at the time of the interview, making it very difficult to interact with primary care providers, and secure basic needs like food and medication without going out. CHWs are pivoting to support people with these challenges over the telephone. NHPRI's CHWs made COVID-19 check-in calls, which included questions about social disparities of health, trying to identify any needs from a public health perspective, such as barriers to accessing medication or keeping stable housing. CHWs made more than 5,000 phone calls to the highest-risk members.

For Rhode Island Parent Information Network (RIPIN), *“the CHW role has been invaluable during the COVID-19 crisis,”* said Executive Director Sam Salganik. CHWs have been able to reach out to connect patients with resources and have interactions with patients and families in a very individualized way at a time when healthcare providers have been unable to see them in person. RIPIN has heard from other agencies that they are very grateful for the time-intensive work that CHWs are able to do, tailoring their work to be more verbal on phone. They have helped to connect with an older generation that doesn't always know how to use technology, which has included teaching clients to use smartphones. These types of interactions and services during the pandemic would be impossible without the CHW staff.

Integra CHWs are still doing the same work during the pandemic, but telephonically. Senior Director of Government Programs Matt Harvey said, *“I could imagine that COVID-19 has created additional needs, and that **if resources were scaling up alongside infection rates, we could surge CHW workforces just like we did respirator beds.** If we had done that, we could have done a lot of good work.”* The population served by Integra Medicaid CHWs has been disproportionately affected by the pandemic.

For Thundermist's Community Health Team, the change to remote work is a major shift for a team that has been primarily community based. One benefit of the having the team collocated, or “embedded” in the clinical site, was the warm handoff. A patient facing eviction or food insecurity, for example, could immediately be connected with a team member able to help with those issues, by walking them to another part of the building. Chief Operating Officer Matthew Roman said that *“probably with office-based visits being cut by 50%, and the workforce cut so much, that's seldom*

happening—accompaniment and warm handoffs were core and have been very difficult through the pandemic.”

CHWs are responding to a crisis of social need.

Providence Community Health Centers (PCHC) CHWs undertook home visits, food delivery, and outreach. Manager of Community Integration and SDOH Strategy Chelsea DePaula said, *“I definitely think [the pandemic] highlights the true value of CHWs. Within our organization, they are the only ones that go out to the community and do home visits. Our organization heavily relied on CHWs to respond to patient needs during the pandemic, to make sure they had enough food. Food insecurity was a big thing. CHWs were going to pantries, delivering boxes, meals, going grocery shopping. They were on the frontlines. If care teams needed to bring resources to a patient, they were there and ready. I told them that as we were working remotely, it wasn’t a requirement to go out and do these things. All were willing. Everyone wanted to do that type of work, because patients really need that, and it’s a part of their role in the community.”* CHWs have also played a role in outreach during COVID-19, to ensure information about the pandemic was reaching communities. They were deployed to barbershops, businesses, and restaurants to let people know about testing. PCHC plans to survey a sample of community members to learn where they get information about COVID-19.

CARES Act funding distributed through RIDOH grants allowed the Central Providence HEZ at ONE NB to hire additional CHWs to work on the ground and address the impacts of the COVID-19 pandemic on vulnerable communities. Because of stringent requirements of CARES Act funding, data collection around these efforts has been much more frequent, which has provided much richer and more current information about CHWs’ impact. Rhode Island Foundation funding and RIDOH mini-grants also allowed CHWs to distribute gift cards and other supports to families in need ONE NB interviewees expressed concern about maintaining CHWs’ non-clinical role, having heard others suggest that CHWs should be performing COVID-19 tests, which they did not feel was appropriate.

West Elmwood Housing Development Corporation (WEDC) received CARES Act funds via RIDOH to support the HEZ’s COVID-19 programming. Disparities were magnified in its community due to a lack of accessible testing, a lack of linguistic accessibility, and a lack of targeted resources. These funds have been utilized to employ CHWs and is overseen by a resident health specialist (herself a CHW) to conduct outreach, testing, contact tracing, and provide supports to families in isolation. At the time of the interview the HEZ was also distributing mini-grants to small community-based organizations (CBOs) that are well-positioned to reach underserved communities, many of whom already had CHWs engaged in that kind of work. WEHDC advocated for a testing site and established a permanent testing site.

WEDC has distributed 100,000 masks to residents through the HEZ to CBOs, clinics, and others in this high-density community where, at the time of this interview, COVID-19 numbers were spiking. They have also convened a group of residents to advise on COVID outreach and response strategy. Executive Director Maria Carvalho said, *“With COVID-19 everything feels so reactive. We are building the plane while we’re flying it. We’re going to work with someone to develop an evaluation on the CHW onboarding. I want to know how...at a program level, are we serving folks, meeting goals around testing, contact tracing, supporting folks in isolation, [providing] resources [to] people in need. We submit weekly performance reports. I want to know more about them (CHWs) and how they’re doing in all of this.”*

Family Service of Rhode Island (FSRI) CHWs have played a “heroic role in helping families with basic needs during the pandemic,” said Marie Palumbo-Hayes. CHWs have done food drop offs on lawns and through doorways for isolated people. CHWs also supported families with extremely limited

access to services because of their immigration status, helping to provide basic needs, and in some cases identifying likely COVID-19 cases and coordinating with emergency services, testing, and primary care. COVID-19 is driving food insecurity and complicating services like Early Intervention. CHWs in the First Connections program leverage donations from their personal networks, primarily churches, to support people affected by the pandemic. *“That’s just what they do as CHWs. They serve the community.”*

Substance use has also increased during the pandemic, and FSRI’s Community Health Teams are playing a pivotal role in response. A peer recovery specialist (PRS) on the team has been key in addressing this the increased substance use, and this PRS may pursue cross-training to achieve CHW certification.

“My concerns are the same in terms of keeping a community focus,” said Dannie Ritchie of Community Health Innovations of Rhode Island. *“There are clinical issues in terms of how to support people in communities so they can care for themselves in quarantine. It’s very public health. [CHWs] are frontline public health workers—it’s the definition. [It is] more important because our public health systems have been underfunded for years, and so we are not able to be responsive to this at a community level like in other countries, so you need folks in [the] community [who are] able to talk to people they know and trust. It’s such a divisive climate we’re in, with people not trusting what they’re hearing, and we need the relationship CHWs have with their communities.”*

Project Weber/RENEW (PWR) recently hired two new CHWs focused on COVID-19 response.

These two CHWs are younger and do not have the same lived experience as others on the PWR staff. They connect clients to COVID-19 testing and necessary resources and distribute personal protective equipment (PPE). These new CHWs are tech savvy and help to train and support older staff with technology, while older staff mentor them in knowledge of the community, motivational interviewing skills, and available resources. ONE Neighborhood Builders (ONE NB), acting as the administrative agency of the Central Providence HEZ, provided funding to PWR through for its COVID-19 response. PWR wanted to focus on its existing target population, and ONE NB was supportive.

The pandemic has presented challenges for people living with HIV and for CHWs who work with them.

Colleen Daley Ndoye of PWR noted that CHWs are used to taking care of clients in ways that involve close human touch and contact: sitting with someone, taking their hand, and hugging them. *“COVID-19 has been really a struggle in finding different ways to do this work. People living with HIV had to learn to get over their own or others’ fears of their contagiousness—eating from the same dish, for example. COVID-19 is hard for them in having to experience that same sense of contagion and danger again,”* said Daley Ndoye.

Tom Bertrand of RIDOH’s Center for HIV, Hepatitis, STD, and TB Epidemiology stated that for CHWs funded by RIDOH through PWR, COVID-19 hasn’t changed the focus of their work, but they have taken on more activity related to providing clients with housing support. For clients exposed to COVID-19 who have needed a place to stay in order to quarantine, CHWs have taken on additional roles as housing advocates. Family Service of Rhode Island’s interviewees said that CHWs at FSRI’s AIDS Project RI found that some of their clients were being profiled as high risk for COVID-19 and that landlords were disclosing their HIV status to other tenants. CHWs responded with advocacy and support in relocation when needed.

The pandemic has presented obstacles for CHWs and has required them to adapt.

Rhode Island Hospital’s SMART Program launched during the summer of 2020. Because of the pandemic, there have been challenges related to using technology, engaging clients on the phone, and

transporting clients in cars. Elizabeth Samuels, the emergency department physician who helped to create the program, said that **“trying to establish a normative workflow, when the programs started up during the pandemic, has been challenging.”**

Prospect Health Systems’ Accountable Entity’s approach to onboarding, training, and supporting the CHW has evolved in response to COVID-19. The first CHW was onboarded prior to the onset of the pandemic, and the new person came on board during the pandemic. Before remote work, the CHW benefitted from having a cubicle space adjacent to a lead social worker, who was able to assist with training and collaboration. Working remotely has required adjustments to this approach to onboarding.

From a funder’s perspective, “We’re seeing projects slow down [as a result of the pandemic], and extension requests,” said Zachary Nieder of the Rhode Island Foundation. *“I would say generally we are seeing a challenge in so much of CHW work, that so much of it comes from close interaction between the CHW and the patient, and that became so much more challenging with COVID-19. It is a high touch, essential type of work, and COVID-19 has increased the burden on CHWs.”*

The pandemic changes the conversation about sustaining the CHW workforce.

ONE NB said that historically, CHWs have been important, but largely unacknowledged members of healthcare systems. *“Nowadays they’re being sought out because the importance of cultural understanding and community is in our faces because of COVID-19,”* said Laurie Moïse Sears. CHWs are needed on the ground to educate about the pandemic, provide cultural sensitivity and deal with SDOH issues. *“The momentum is definitely picking up, compared to a year ago. [Previously] residents were even standoffish with CHWs, not knowing who they are or what they do. All of our HEZ calls now ask for input for CHWs. Even on job search sites I’m seeing a lot more CHW positions. I think that’s a great thing, but I’m fearful that once COVID-19 is over, they won’t get their due. We need to keep CHWs on the ground and in the field...I’m hopeful that people will want to sustain CHWs going forward, because of everything they’re doing to address COVID-19.”*

“I think that if anything, COVID-19 has elevated how vital CHWs are to the community,” said Maria Carvalho of WEHDC. *“I think it’s brought that to light. I think in terms of sustainability...I feel like [COVID-19] let us really know how vital CHWs are to the community. It showed [us] that when it comes to responding quickly, they are a great asset for any organization.”*

Key Findings on Sustainability and the Path Forward

Financial sustainability of Community Health Workers (CHWs) is a work in progress. Grant funding was the most frequently cited source of financing for CHW services. Four respondents do some level of fee-for-service billing for CHW services now.

On fee-for-service reimbursement, respondents said “Yes, but.” Nearly all thought that the state should pursue policy changes to allow billing for CHW services, but nearly everyone had caveats. There is concern billing could detract from a person-centered approach. Peer Recovery Specialist (PRS) billing currently in place may offer a model and complementary revenue source. Accountable Entities (AEs) said they were concerned about complexity and the tension between fee-for-service billing that incentivizes volume versus the move to value-based payment. There is concern that billing could increase administrative burden, set up the wrong incentives, and skew access to services according to insurance coverage.

Financial sustainability will likely mean more than billing. Global payment, capitation, and payer-blind funding are potential tools. AEs, as currently paid, may not be set up to sustain CHWs for the long term. Grants are likely to remain a key funding source.

Sustainability involves more than financing. CHW visibility has increased, and that contributes to sustainability. CHW workforce development and certification are key elements. Support, access to resources, networks, and information are also important. Racial equity is a core consideration for sustainability.

Respondents were in agreement that the CHW workforce should be sustained—but there was not a consensus about how. Going forward, health plan-based payment and grant funding were the most popular options for sustainable financing, but there was a broad range of perspectives.

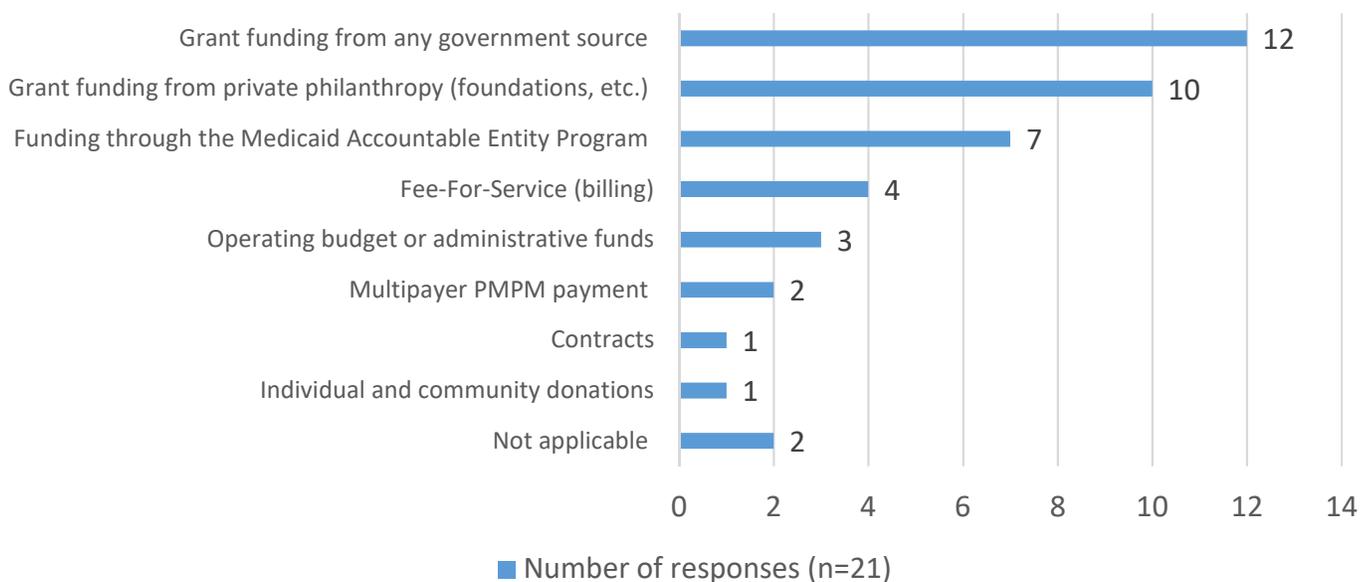
Sustainability and the Path Forward

Financial sustainability is a work in progress.

Interviews focused on financial sustainability asked respondents to comment on current funding sources, potential fee-for-service billing, and other means to financial sustainability. Non-financial elements of sustainability are discussed later in this chapter.

Each organization interviewed was asked to mark all applicable options in how they pay for community health workers (Figure 6). Grant funding from any government source (12), and grant funding from private philanthropy (10) were the most frequent sources. Note that these findings do not reflect the dollar amount of funding, or relative proportion of each funding source.

Figure 6: How Organizations Fund CHWs



Source: Interviews conducted August 2020 - December 2020

Funding through the Medicaid AE program is a substantial source of funds for CHW services, which had not yet begun in 2017. Health System Transformation Project (HSTP) payments to the AEs have been used to employ CHWs, according to interviews with a number of AE leaders. Providence Community Health Centers pays for about 75% of CHW positions through HSTP funds received by its AE program, with per-member-per-month (PMPM) payments from Care Transformation Collaborative, Rhode Island (CTC-RI) PMPM payments also supporting positions in adult and pediatric programming. In Prospect Health Systems of Rhode Island's AE program, their CHW is paid with HSTP funds. Integra's six Medicaid AE CHWs are paid through HSTP funds.

Four respondents do some level of fee-for-service billing for CHW services now.

Rhode Island Parent Information Network (RIPIN) engages in a small amount of fee-for-service billing through the Cedar program, as well as funding through the AE program and philanthropy, but 90-95% of the organization's funding comes from government grant sources.

A Community Health Center’s Experience With Fee-For-Service Billing

Thundermist did a deep dive into understanding sources of financing for their community health team services, said COO Matthew Roman. Two Medicaid MCOs are paying fee-for-service for Thundermist CHW services currently (although the shift to telehealth due the pandemic complicated these arrangements). During the 2017 study year, they had one MCO paying fee for service for CHWs for certain patients, and the resulting net revenue for eight CHWs on the team was only \$40,000--which didn’t even cover the actual salary of one CHW. Providing for the full services of the community health team, including CHWs and behavioral health staff, required an annual investment of slightly more than \$1 million. Behavioral health billing, according to the specifics of federally qualified health centers brings the total revenue generated by the team to roughly \$700,000--leaving Thundermist to provide \$300,000 of operating funds to support the team.

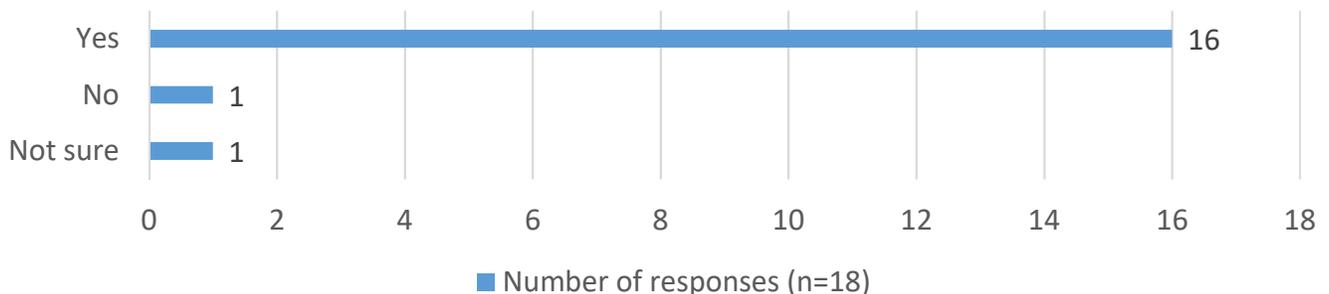
In asking why one of the largest payers was only reimbursing a small portion of CHW services, they saw several challenges. The original contract allowed billing only for a small percentage of patients, the 5% highest-risk group according to the payer’s risk stratification. Additionally, billing is structured in 15-minute increments and has daily unit limits. Roman said *“What we know about our intervention is it’s best to latch onto someone, and go through the day with a person, support them through the day, and not have it be fragmented.”* This means that CHWs often reach the maximum billable amount for a day, with remaining time not reimbursed.

A newer version of the contract with this MCO changes the billable patient population to the first 2,000 Medicaid AE members needing services in a given year. This removes some of the administrative burden. A second MCO has contracted with Thundermist to allow CHW reimbursement, but this MCO only covers a small proportion of the health center’s patient population.

Providence Community Health Centers bills one Medicaid Managed Care Organization (MCO) for CHW services using a billing code for case management services for unlicensed professionals. This MCO only reimburses for these services under specific plans for specific patients.

Family Service of Rhode Island’s First Connections program uses a combination of three funding sources—contractual funding for staff and any services not covered by Medicaid; fee-for-service billing at the same rate as Medicaid; and Medicaid billing as payer of last resort, if the family is not covered.

Figure 7: Should the State Pursue Policy Changes to Allow CHW Services To Be Reimbursable?



Source: Interviews conducted August 2020 - December 2020

There is concern billing could detract from a person-centered approach.

“What I love about CHW programs is they’re so person-centered. They’re about the person they’re taking care of,” said Dr. Elizabeth Samuels of Rhode Island Hospital’s SMART initiative. *“I wouldn’t want people to become widgets. It needs to be about value, not about quantity...a value-based care model would help. You may do [reimbursement] as part of something more comprehensive. Protecting value and quality is really important, and financial incentives can sometimes make things more perverse, and get away from the goal and heart of what a program really offers. Yes [to reimbursement], but not in a way that commodifies the clients. Medicaid could provide support for CHW sustainability, but then there is the issue of differential reimbursement rates. Sometimes healthcare institutions don’t find Medicaid’s incentives and reimbursement rates to be motivating, and there are questions about whether shared savings under Medicaid AEs will be sustainable. Program leadership is exploring a number of avenues related to financial sustainability, including private and public payers. Peer Recovery Specialist (PRS) billing is a planned component in the program’s sustainability strategy, but they are not yet billing for these services, and they anticipate the process may not be easy,”* Samuels said.

Asked about policy change to allow for reimbursement, Sarah Martino of the Center for Prisoner Health and Human Rights said, *“My administrator hat says yes, absolutely. But I don’t know what CHW staff would say. It certainly would change their work a little bit. Every once in a while, I hear something to make me think*

One View: Financing CHWs Using a Public Health Model

Sam Salganik, Executive Director of the Rhode Island Parent Information Network, said, *“Anybody who wants to help pay for CHW services, I’m all for it, the more ways the better. But among the ways it can be funded, health plans tend to pay fee-for-service, think clinically and episodically in ways I don’t think are productive for the way CHWs work when they work best. For the good of the public health, I would prefer for CHWs to be paid for and financed in more of a public health kind of a way-- but I know the health plans are where the money is.”*

“When it comes to rate setting, [...] if it’s going to be a career for people, a true opportunity, it has to be a living wage, and you have to pay the agencies that CHWs are working for. So if it’s reimbursement, it has to be at higher rates than now [...]. You have to make it a real career, not just a stepping stone. Some people are great in the community, and you don’t want turnover to make people move on to something else. And if reimbursement is coming from the health plans, you need admin and finance support to deal with health plans.”

“Health plans have cultures, missions, reasons for existence. CHWs will likely be viewed as a cost center to a health plan. If we set up the structure that way, we will live with that fight for the rest of our life. As an analogy, evidence-based programs like the community-based diabetes program, is largely CDC-funded today; CDC wants us to get health plans to pay, because that’s where the money is, but think for a second: you’re giving classes to the community, and you want local community-based organizations to deal with 17 different payers? Medicare, commercial, fee-for-service for a group activity? It’s really challenging and administratively complex to do it that way, and it doesn’t serve the community well, or save money overall. And are returns on investments in diabetes prevention visible within a year?”

“As a public health thinker, what’s the most effective way to do this? The drive to get health plans to pay is driven by following the money, but it might not result in the most efficient or patient-centered system. I worry it will be similar with CHWs. It’s not a one-size-fits-all answer. The work is so diverse in what we’re doing. Health plans are awesome at bearing actuarial risk and running claims payment. They have far less capacity (or institutional interest) to promote general public health than many people realize.”

they wouldn't love it. Certainly, I see it as valuable. In the absence of that, one of the things we've been thinking about for the Transitions Clinic specifically: since our CHWs have all taken Peer Recovery Specialist training, we have thought about PRS billing as one way to think about billing, because CHW services are not billable."

Peer Recovery Specialist billing may offer a model and complementary revenue source.

Thundermist Health Center's Matt Roman said that **Peer Recovery Specialists (PRS) are much further down the road to sustainability than CHWs, because their services have active fee-for-service billing codes under Medicaid.** At the time of the interview, he said that Thundermist was at the beginning of using PRS billing. Roman reported that PRS billing did not appear to be a heavy administrative burden, and the rate can be sustainable. More financial analysis is needed.

Apprenticeship Rhode Island's Amy Weinstein said that **Medicaid reimbursement of PRS services is being used by Parent Support Network to support combined PRS/CHW roles.** *"There are lots of successful models of CHW programs; I have been kind of surprised to see it grow without a reimbursement model."* Reimbursement has made a great deal of difference in the PRS world and can be seen as proof of concept.

Deborah Morales, of the Rhode Island Executive Office of Health and Human Services, discussed Medicaid's role in CHW sustainability and its relation to PRS billing. Medicaid doesn't pay directly for CHWs, but it does require a level of services to be provided by the health plan. The extent to which plans utilize their administrative capitation rate to pay for such services is the main vehicle by which Medicaid provides for CHWs. A traditional medical CHW might work at an FQHC or at a primary care provider's office, but that is not a covered service at this point. There are internal discussions about whether, and how, this might change. Such a process would start with Medicaid submitting a State Plan Amendment (SPA), in order to allow the work that CHWs do to be a billable service. PRSs currently provide billable services, and there might be underlying commonalities between PRSs and CHWs. Regarding fee-for-service reimbursement, Morales said that she is personally supportive-- **the question is whether to do this on an individual basis or through a population-health approach. Most would lean more toward a global capitation payment.**

Accountable Entities said they were concerned about complexity, and tension between fee for service and the move to value-based payment.

Integra's Matt Harvey, when asked about reimbursement, said, **"Yes, with caveats.** *Obviously from a sustainability perspective a sustainable funding source that is predictable makes a lot of sense. I think the small amount of worry I have would be that once CHWs' services are billable, it puts them in a much more clinical frame, where they would probably need to be employed by the medical group rather than the accountable care organization (ACO)...I think that may not be a problem, but there would be the potential to become medicalized. Right now, we don't think about the work they do through a revenue cycle point of view, and I'm not sure it's the right lens to use. Once you're fee for service, you're trying to pump volume. But if it were through, for example, a PMPM that might be different. If you told me tomorrow I could bill, I'd be excited, I could repurpose other funds, it would be a net win. But I'd have to understand carefully the impacts on how the team functions."*

Providence Community Health Centers' (PCHC) Chelsea DePaula, when asked whether the state should pursue policy change to allow for reimbursement, said, **"Yes; definitely for social services organizations, or organizations that are not part of an AE, should be able to bill Medicaid or plans. But it gets tricky when you are part of an AE because of the funding source. You should be thinking about investing in CHWs to meet your program objectives because that's how most of the outreach**

work is done, looking at addressing SDOH [social determinants of health] and reducing admissions, ED [emergency department] utilization. Most work is done by CHWs, and it makes sense to invest in them in that way. Where billing, and using Medicaid AE funding to support CHWs, it can be double-dipping. PCHC is an AE but also serves patients who are not in the AE (uninsured, commercial, Medicare). Maybe we could be allowed to bill for patients with other insurances.”

Regarding policy change to allow CHW reimbursement by health plans, Garry Bliss, of Prospect Health Systems of Rhode Island is **supportive**, **“but as an interim measure on the way to capitation.”** He noted concerns about moving in the direction of a fee-for-service model for CHWs, when AEs are intended to move away from fee for service. He is supportive of health plans paying for CHWs, but population-based payment (capitation) is the best approach in the long term.

There is concern about administrative burden, setting up the wrong incentives, and ensuring access to services regardless of insurance coverage.

CTC-RI’s Linda Cabral said that the **time-intensive nature of community health work might complicate billing.** *“EOHHS’ intent is to move in the direction of billing for CHWs; I don’t know what that would look like, because CHWs have to spend quite a bit of time per case. You feel like you have to be careful.”* During the interview, Cabral went on to discuss an example of another organization’s program that bills for CHWs but apparently loses money annually and explained, *“You can’t have programs running intense programming at a deficit.”* Susanne Campbell of CTC-RI continued *“I’d be a little concerned if they do go to billing for CHWs, how that would happen, if that would create more administrative burden on the backbone organizations: billing, collection, documentation. **My preference would be to look at PMPM or some kind of case rate, not something tied to minutes. Don’t make it complicated; it would be a nightmare. [Community Health Teams are] working so successfully.**”* She elaborated, saying, *“It depends. If it was very closely mirrored to fee for service, where it’s based on a 15-minute or a 30-minute visit. I would shy away from that, but a case rate, or PMPM, I would absolutely be in favor of that. There are benefits on the Medicaid side to draw down federal funding—obviously that would be good. We would need to make sure the goal in mind is how you want the work to be done and be aware of the admin burden. I’d want to keep that in the forefront—that there shouldn’t be an administrative burden.”* Campbell also noted a concern about access: *“I’m also just a little worried looking at the AE model, there’s a lot of people that aren’t in an AE. **We want to make sure that this is a service that could be available in Rhode Island as kind of a basic utility: everybody who needs it should have an option of getting this important service.** We’ll be supportive of the direction the state wants to go in, but we don’t want to leave patients out that might need this service.”*

Matt Roman of Thundermist expressed a similar concern about whether the people who really need CHW services will be covered by private insurance through a health plan. He advocated that there should be many sources of sustainability for CHWs, of which health plan reimbursement could be one. **“CHWs need to be funded by all primary options of healthcare service funding.”** On fee-for-service billing, he added, *“There are a lot of CHWs that reside in organizations that don’t have capacity for fee for service, so that pushes them against fee-for-service billing.”*

Quatia Osorio of Our Journ3i , said **“being able to bill would be wonderful, but I’m not sure if a [proposed] process allows for independent, cooperative, collective groups of CHWs to come together to create an agency that would shift power back to residents of the community, who are CHWs.”**

Laurie Moïse Sears of ONE NB said of CHW reimbursement by health plans, *“Yes, but that can’t be the only source.”* **CHWs caring for undocumented and uninsured people need to be supported as**

well. Billing is complex enough in a hospital context, that smaller organizations wouldn't have the capacity to track and bill for these hours and manage the red tape involved. ONE-NB's Allegra Scharff illustrated the point, *"I think that one of the most pivotal moments I've had this year [was when] a client [a CHW] met someone in the community they couldn't work with because they had no insurance, and they asked if we [ONE NB] could work with them, and we're like 'yeah--we can work with anyone!' It changed my mind about this whole Medicaid reimbursement stuff. **There are people in need of this kind of assistance who are not attributed to any AE or managed care organization. We can't leave them out just because they don't fit into one of those boxes.**"*

Colleen Daley Ndoye of Project Weber/RENEW said that Medicaid billing may be the future, but **for such a small organization this may not be realistic because the billing process is itself so expensive.** On reimbursement, she was supportive of the larger policy change, but *"it might not help [Project Weber RENEW], because we don't do reimbursement."*

Regarding the breadth of contexts and clientele, Rhode Island Foundation's Zachary Nieder said, *"[There are] important conversations to be had about heterogeneity across positions and programs. **We fund CHW positions, which look very different, and they should—but it is challenging for reimbursement.** A CHW embedded in a community based organization (CBO) without real connections to a health system will look very different to a CHW within an AE—at least for now. It's not a question to be avoided—it's an important conversation."*

Community Health Innovations of Rhode Island's Dannie Ritchie suggested, *"**moving away from reimbursement and looking at global payments.** Medicaid too has been looking at how to encourage clinics to hire CHWs, incentivize them—not necessarily through a reimbursement model. Reimbursement is fee for service. People get paid however they get paid, but [reimbursement] is opening up the potential for CHWs to be used as widgets, just looking at numbers and not outcomes in that case. You want to see the number of people who came through the door, to get more volume and fees; that's why fee for service needs to go. CHWs feel they want to get paid for services—well, OK if it's the only mechanism to get paid for what you do. But you have to have your eyes open about what you're asking for."*

Billing for financial sustainability will likely mean more than billing. Global payment, capitation, and payer-blind funding are potential tools.

"Hospitals won't change behavior unless the financial incentives are aligned," said Dr. Elizabeth Samuels of Rhode Island Hospital's SMART initiative. *"They will change what they offer and what they do, if payers make them. There is culture change in hospitals for CHW programs. **We have a very medicalized system that's frustrated when social factors impact the delivery of medical care, and we're continually mad about it instead of trying to address those social factors.**"* Incentives from payers could drive change, because *"by payers saying, 'you need to set up programs or we're not going to reimburse you,' doing that in a value-based way, is a very strong incentive for hospitals to set up programs. In the long term, it's more sustainable, because it's integrated into the institution. There needs to be a fundamental reframe, because how we're gonna get paid hopefully can align with morals and intentions. It requires significant institutional transformations...really changing the culture means realigning the incentives...I hate to admit. I would love to say this is the right thing to do for people, we should do it anyway...our mission is to care for humans—it's the right thing to do—but that's not what will get them to pay for it."* Samuels continued to say that in both private and public grant funding, much depends on funder priorities, and there can be mismatches between people providing frontline services and the intention of the philanthropy or state agency, but there are opportunities where there is funder alignment. Health Equity Zones (HEZs) have health equity at the center of what they do, but there is somewhat of a gap between HEZs and hospitals, and a potential opportunity [is] there for closer

connection. The Accountable Health Communities program is one example of using financial incentives to drive hospital systems toward social determinants of health (SDOH) programs for frequent emergency department utilizers.

Susanne Campbell of Care Transformation Collaborative (CTC-RI) **emphasized a geographically based, payer-blind approach.** *“We want to get to the endgame of having this available at the community level, supporting the geography of where people live. It seems like a community benefit fund would be helpful. One thing with the AE program is that people change AEs and don’t change where they’re living as much. Another thing we want to be careful about: you could have one patient with a number of CHWs. However, this gets designed and funded, if it could get done in a way that supports a person in the community where they live, and is payer blind, those are the things we want to move toward. It’s complex. A concern around [funding CHW positions through] shared savings in AEs, if it’s going to come out of cost savings: Is an AE going to look at the needs of children and families? That’s more of a long-term benefit. The design is very important, because some of the benefits are long term. If I’m an AE paying for CHWs only through shared savings, I might only go after high utilizers who might not be the high-risk child or family. That’s another really important thing in the design of this...not everybody belongs to an AE, and we really see CHWs as being a public utility. They should be available to all, regardless of insurance or not, or what insurance. Making sure there’s a payer-blind aspect to being able to access CHW service is important.”*

Global payments and value-based payments are the best paths to sustainability within the healthcare system, said Dannie Ritchie of Community Health Innovations or Rhode Island. *“When we’re doing value-based or global payments, we are calculating the CHW as part of a global payment system, so people are sustained. The organization is contracted, and the CHW can be paid as a permanent person [under] general operating costs.”* Dr. Ritchie said she believes that global payment models, in which Medicaid incentivizes CBOs and clinics working with CBOs and CHWs, could also work well to incentivize clinical medicine [institutions] to work in the community. With grant funding, positions may be lost when the funding expires, or CHWs may be asked to switch hats to focus on grant-determined priorities. They may not be paid for other work they do because they are required to focus on topical areas for a grant. An effective option would be an investment-fund model, in which insurance pays into the fund, and pooled per-member-per-month payments are made to primary care.

AEs, as currently paid, may not be set up to sustain CHWs for the long term. **Medicaid AE shared savings payments may not be able to cover the cost of sustaining CHWs.** Deborah Morales, of EOHHS’ Medicaid program said, *“sustainability of CHWs fundamentally has to be part of how Medicaid-covered services are paid for, through our contract with the MCOs. Ninety percent of members are covered through managed care contracts. If we want to be sustainable, that’s the mechanism in the long term. Value-based payment, or other details: that’s the next step of the conversation in detail. Maybe an ACO could get a capitated payment, or something on an ongoing basis to support a set of services for their network of providers. There are different ways to make it work.”*

Integra’s Matt Harvey suggested that sustainability for CHWs employed by AEs might require predictable administrative funds for AEs. *“Right now, there are two funding streams for Medicaid AEs: HSTP and shared savings. HSTP is time limited; shared savings are speculative. So, what I think we need is a third funding stream which would be predictable administrative funds that flow from the state through MCOs to the AEs. If the state thinks AEs are the future, and we have value, we should get paid. MCOs are expected to generate savings, and the state recognizes they need significant administrative funds to keep the lights on. An MCO can operate if it loses money; an AE can’t. **To build programs in the long term, we need predictable AE admin funds. Somewhere in range of 1%-2% of premium (the capitated rate the state pays MCOs).** Massachusetts currently pays an admin rate to Medicaid ACOs.”*

Grants are likely to remain a key funding source. Although a majority of its funds derive from grants, Rhode Island Parent Information Network (RIPIN) interviewees noted sustainability problems with grant funding. Foundation funding has challenges, in that they like to pay for short-term pilots rather than sustained boots-on-the-ground. But it takes time to start programs up, and then funds can go away—just as people start to rely on them. Government funding sources often behave in the same way. But, *“we would love to have funding for these kinds of supports in the community to be a core government and public health function, just like SNAP and schools, that’s the ideal,”* said RIPIN’s Executive Director Sam Salganik.

Often the US is “the land of the demonstration project,” said Phillip Clark of URI’s Geriatric Workforce Education Program. There are frequently resources for temporary pilot projects to test innovations but not funding for implementation—and so innovation becomes a way of ignoring structural problems. *“We are realizing this now—so many problems are structural.”*

As a major private funder of CHW programs, Rhode Island Foundation supports grantees in pursuing sustainability but believes philanthropy can play an ongoing role. *“We are more cognizant, and grantees are much more cognizant that funding from the Foundation is most generally a bridge,”* said Rhode Island Foundation’s Zachary Nieder. *“Projects, CHW positions, are maturing. People are often saying that while we need more soft funding, we are moving toward sustainability. We are trying to hardwire this in. If somebody comes to us with a new CHW project, we do want to talk about sustainability from the outset...we have a certain level of observer bias in that we most closely interact with projects that still require soft costs. We understand that soft funding is still needed for a lot of these positions. We are cognizant and work closely with grantees to figure out what sustainability looks like for you—to sustain and deepen conversations around sustainability...private philanthropy is part of the solution. We’re not going anywhere.”*

ONE NB reconsidered its approach to sustainability, which was originally based on making the case that grant-funded activities yielded Medicaid savings. Allegra Scharff said, *“When we started the Fund for a Healthy Rhode Island [RI Foundation] grant, our goal was to try to measure cost savings to the healthcare system achieved by CHWs working, and then make the argument that MCOs and AEs should reinvest those savings in us—but it’s hard to get that information! I’m not closing the book on it. I think there’s hope there, but...I know from other providers that Medicaid reimbursement is so small that would it adequately sustain CHW jobs? And also, we have a majority of people we’re working with who are undocumented, maybe 60%, so how can we pay for services to them with savings to insurance? It doesn’t make as much sense as it used to.”* Both ONE NB interviewees, Scharff and Laurie Moïse Sears asked whether there can be a **line item in the State budget that provides guaranteed support for CHWs.** The data has validated that CHWs are saving money. Can there be reinvestment from healthcare systems that supports uninsured people? Government funding is also a problem for undocumented or uninsured people, because there are concerns about privacy and negative consequences under public charge.

“Couldn’t we fund CHWs like an Americorps?” suggested Maria Carvalho of West Elmwood Development Corporation. *“They could get certified over a year of service and, maybe, placed [in employment] upon certification. If CHWs are trained up based upon anticipated needs within a community, a pipeline [could be created] for the betterment of the community.”* She said that having clear standards and scaffolding for training would be helpful, rather than a series of trainings in different sites—some of them exclusive to particular employers and with different content.

RIPIN noted concerns about reliable compensation data and pay equity in a changing field. *“A really big issue, a pet peeve of mine, is getting good compensation data for CHWs: ensuring we have a*

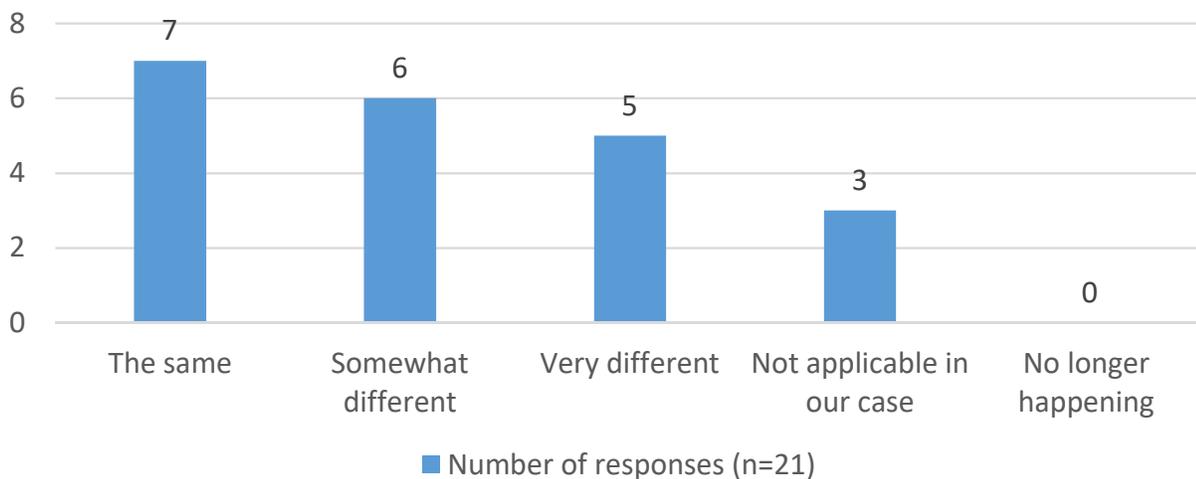
good pulse on market rates, ensuring there is equity among CHWs in general,” said Sam Salganik. “We want to be an employer of choice, walking the walk, and it’s becoming harder and harder to do, as CHWs become a melting pot of different health professions.”

Sustainability involves more than financing.

Respondents mentioned professional visibility, certification, workforce development, access to resources, and racial equity as key considerations for sustainability.

The most frequent response to the survey question (Figure 8) was that respondents’ approach to training and supporting CHWs was the same (seven), but a combined majority (11) was either somewhat different (six) or very different (five). For some, these changes were driven by the implementation of registered apprenticeship and other workforce development programming. For others, these changes were driven by the growing awareness of the CHW field in the state.

Figure 8: Agency Approaches to Training and Supporting CHWs



Source: Interviews conducted August 2020 - December 2020

CHW visibility has increased and contributes to sustainability.

“CHWs are becoming more well known,” said Project Weber/RENEW’s Colleen Daley Ndoye. *“Even [since] three years ago. There has been a tipping point where now if you say, ‘community health worker,’ people know what that is, and similarly with Peer Recovery Specialists. Before, people would say ‘what is that?’ And now 90% of people know.”* She noted that cross-training CHWs in a variety of other skills has helped attract grant funding. Project Weber/RENEW CHWs are trained in a number of overlapping skills, such as [those of] Certified Peer Recovery Specialists, HIV qualified professional test counselors, or Narcan train-the-trainers.

Clínica Esperanza’s Paola Martinez pointed to creating awareness of the CHW role as key to sustainability. CHWs save time and resources for the healthcare system, in part by being bilingual and providing navigation and education, she said. *“I think that sustainability will come with opportunities...the pandemic has increased the necessity of CHWs’ role in places where people don’t have resources and information on how to navigate the healthcare system...by creating opportunities in organizations, schools, churches, many other organizations, there could be a role for creating awareness of the importance of the role...that may bring more funds. **The awareness will bring more resources.**”*

CHW workforce development and certification are key to sustainability.

A credentialing strategy is an important element of sustainability, but there may be barriers to access, said Yvonne Heredia of Neighborhood Health Plan of Rhode Island (NHPRI). *“Some of our best CHWs are ones who live in those communities, have developed relationships. Some don’t speak English well—how do they get a credential?”* Accessible training plays a key role in sustainability. NHPRI CHWs often focus on medical skills development—for example, learning to be able to discuss blood sugar with nurses and nurse practitioners they work with. *“CHWs were ecstatic about learning that information.”* Many NHPRI CHWs have gone through specialized training in diabetes and asthma. *“A lot of CHWs, have this shared life experience with patients...a lot of CHWs may have some of those disorders, or have been familiar with the conditions from family members. The idea is to get more comfortable with the jargon, but also permission to talk about it in a standardized way that makes sense.”*

CTC-RI’s interviewees Susanne Campbell and Linda Cabral said that CHW certification and training efforts by RIDOH and Rhode Island College have been excellent and are important for sustainability.

Integra also cited training and workforce development as important for sustainability. Clinical Program Manager Cindy Scott said that CHWs at Integra are receiving mental health first aid training. They have also completed Screening, Brief Intervention and Referral to Treatment (SBIRT) training and various continuing education classes to develop their skills and maintain CCHW certification for those who are certified.

Apprenticeships have grown as a CHW workforce development strategy. Amy Weinstein of Apprenticeship Rhode Island said *“Registered Apprenticeship is here to stay. It’s not going away.”* Lessons might be drawn from preliminary efforts by the Rhode Island Department of Human Services (DHS) to support early childcare apprenticeships, or by the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) to support apprenticeships for behavioral health case managers. *“We have the ability to be really creative with workforce development. We...don’t have to limit our thinking about CHWs, because we’ve seen that their scope of practice can be valuable with many different communities of people. In some cases, wrapping additional skills around the occupation has been beneficial. One thing I’d love to see is more of a predictable pathway for CHWs, mostly because of the rate of pay—I would like to see people move ahead in careers building on clinical skillsets. But for CHWs, this may be different or more difficult...philosophically, values around being a CHW, feel different to me than being a case manager. Sometimes entities are not as community focused, and don’t adhere to the same values, so it’s more complex.”*

RIPIN expanded its CHW apprenticeship program to become the standard for new hires. They also indicated that they are focusing on recruiting methods, retaining staff, and revisiting base salaries, as they relate to the sustainability of their CHW workforce.

Garry Bliss of Prospect Health Systems of Rhode Island said that there should be a core set of skills and the ability to layer on additional expertise—for example, through an apprenticeship model. Behavioral health competencies are particularly important to build in among the CHW workforce. Among the Medicaid population, there is a huge intersection among behavioral health, cost, and utilization factors. ***“The more folks we have who are able to address the whole person, the better off we are. And the more comfort people have in working with someone with behavioral health issues, the better they will be. We will all be.”***

The involvement of institutions of higher education has been encouraging, said Phillip Clark of URI. Interprofessional team education at the three state institutions has been positive, and moving forward, CHWs can be integrated into these efforts.

Support, access to resources, networks and information are also important.

Information sharing about social resources would be valuable for CHW programs, said Dr. Elizabeth Samuels of Rhode Island Hospital's SMART initiative, suggesting a central hub or dashboard where people can connect, refer clients, coordinate, and skill share. *"Skilled CHWs have extensive networks, knowing who to call at various agencies, but it takes time to build this knowledge base. A technology platform to support this work would be helpful."*

The professional association, Community Health Worker Association of Rhode Island (CHWARI), might take on a stronger community-organizing role, suggested Quatia Osorio of Our Journ3i. From CHWARI, Osorio would like to see an opportunity for CHWs to engage with one another and build power. It has seemed to be *"more of a forum of things, but not necessarily a way to build power within that workforce, which is what I've always hoped a CHW network would be—a powerhouse of people who can give influence and feedback to institutions and communities. I'm not sure if that happened."* She has seen employer-employee feedback but asks if there is a way CHWs can directly touch base with one another from different spaces.

Racial equity is a core consideration for sustainability.

Project Weber/RENEW's Colleen Daley Ndoeye said that integrating CHWs into organizations that have the capacity to do this work is not one size fits all. *"It doesn't work to put them into an organization without the capacity to supervise and support their work. They have to be integrated where they can really be a piece of the puzzle and do this work. Racial, ethnic, and language diversity is super important. Making sure a CHW reflects the community [they] serve—this has to be an intentional piece; it has to be a requirement."*

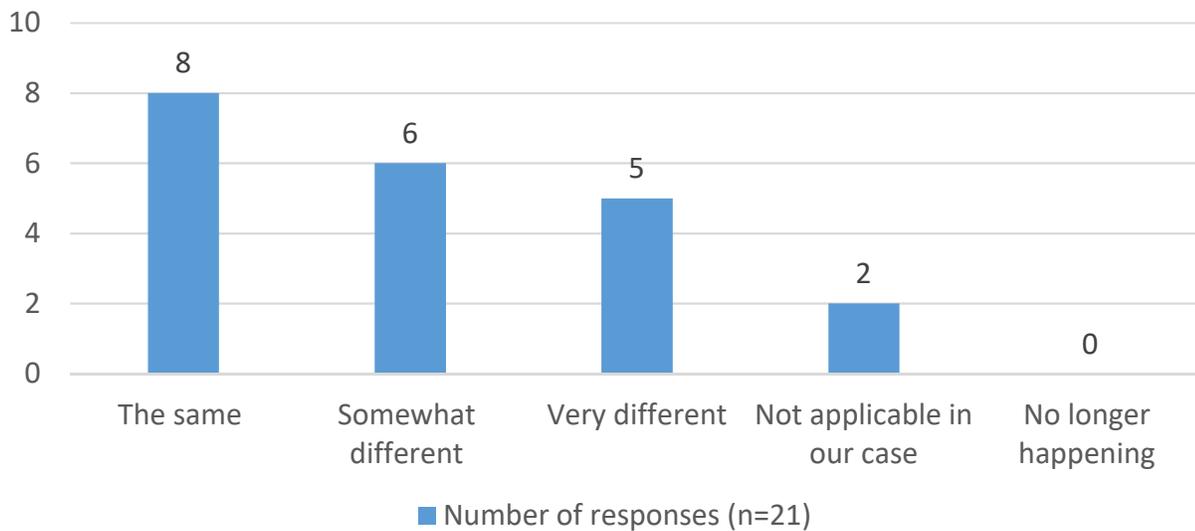
Small organizations doing perinatal, maternal, and child health work face barriers to sustainability, said Quatia Osorio, citing the cost of electronic health records and the administrative burden of seeking payment through healthcare financing. Models developed for larger states and cities don't necessarily fit in the Rhode Island context. She discussed extensive challenges related to compensation for providing perinatal doula services for Black women in hospitals, particularly during COVID. *"The client doesn't have money because she is a Medicaid client. We have to do the grunt work of finding funding, or take a low [reimbursement] rate for the birth, and it becomes an ethical and moral issue for us as Black women: other Black women need us, but we can't work for free. Hospitals say they understand, but no one is coming up with dedicated funding."* She identified barriers in accessing resources related to power, control, white supremacy, and institutional racism.

The Path Forward

Respondents were asked how their perspective on CHW sustainability has changed, their preferred options for financial sustainability, and whether they believe there is a consensus about the way forward.

Responses to the survey question (Figure 9) and details provided in the qualitative portion of the interviews suggested that there has been some evolution and refinement of respondents' perspective on sustainability without evidence for a fundamental shift. The largest single response was that their perspective had stayed the same (eight), but a larger combined total (11) said that their perspective was somewhat different (six) or very different (five).

Figure 9: Respondents' Reported Change in Sustaining CHW Workforce



Source: Interviews conducted August 2020 - December 2020

Future Plans for Sustainable Financing

Each organization interviewed was asked to identify their top three options for sustainable financing (Figure 10). The two top responses related to payments by health plans were changes to how [Medicaid] MCOs pay healthcare organizations (nine respondents) and policy change to allow fee-for-service reimbursement (eight respondents). Also receiving eight votes was grant funding from the state to HEZs, followed closely by grant funding from the state to employers of CHWs with seven respondents. It is notable that grant funding ranked high as an option for sustainability, given that grants are often considered unsustainable soft money. Also of note is that two options that are state government grants ranked much lower (three respondents). Medicaid AE shared savings (five respondents) and healthcare organizations' operating funds (five respondents) ranked in the middle, although one respondent suggested that AEs' shared savings become healthcare organizations' operating funds, so the question may not have been clear. Three respondent-generated *other* answers are included, suggesting pathways forward through capitation, an investment fund capitalized by health plans, and community benefit dollars paid by healthcare organizations to support CHWs and HEZs. In all, a broad range of options were recognized, with greater weight on health plans and public grants.

Figure 10: Respondents' Preferred Options to Sustain Long-Term Growth in the CHW Field



*Full text of option was Medicaid Accountable Entity Program—AEs pay for CHWs out of shared savings.

Source: Interviews conducted August 2020 - December 2020

Sustaining the CHW Workforce

“I think there’s a consensus that it’s a valued resource,” said Marie Palumbo-Hayes of Family Service of Rhode Island. *“I am not sure if all eyes are on the same page of what it is...but I do think that there’s a consensus to do that. Having the certification is huge; having specialties now with the certification is huge. There are huge commitments. The concern I have is that there is still no plan to fund or get a rate for community health workers...the consensus needs to continue, but the vehicle is not quite ironed out.”* CHWs can work in multiple sectors, including community and healthcare settings. Preserving that diversity is valuable.

“[Sustaining CHWs] was urgent before, and it’s still urgent now!” said Susanne Campbell of CTC-RI. *“We’ve demonstrated the value of CHWs from a social, clinical, and cost perspective; we’re more confident to keep on the path of sustainability now that we have solid data to back up the value of sustaining this workforce.”* CTC-RI’s Linda Cabral continued, *“I don’t think there’s consensus. There are different ideas thrown around...the discussion is important to have happen, hash out, and bring together stakeholders to consider the pros, cons, and to find a path forward.”*

“I definitely feel there’s been a groundswell of discussion about the importance of peer workforces, largely driven by the recovery community. I think the overlap in Peer Recovery Specialist and CHW work is interesting and challenging and is going to continue to be a point of contention in discussion for a while,” said Sarah Martino of the Center for Prisoner Health and Human Rights.

“There is consensus that CHWs are an important, integral part of the healthcare system. And a key element to move toward stronger community-clinical linkages,” said Zachary Nieder of the Rhode Island Foundation. *“Sustainability needs to be figured out, by all parties. The challenge is how do you do big picture thinking on a moving train? There is a lot of consensus that we need to figure out the solution. I’m not sure that there is consensus on how.”*

Deborah Morales of EOHHS said, *“For integration of CHWs, the first hoops are in the regulatory process with the Centers for Medicare and Medicaid Services (CMS). After that it’s encouraging, incenting, and mandating plans to provide a payment model for providers. That’s the biggest opportunity or vehicle at this point.”* More has been done in recent years to galvanize people about the role of CHWs in providing critical services and to engage those who may not be engaged in care. *“My feeling is that a CHW really is the best person on that team to do that effectively. Especially, really, ideally, the CHW is from the community that’s being served and really has that trust and relationship and history with the community. **I think that makes a difference.**”*

When asked what, if any, consensus was emerging about how to sustain CHWs, Integra’s Matt Harvey responded, *“To be honest, this is not something I think about a lot. I think about what’s a way to sustain and grow effective population health interventions. CHWs are part of that. But they are a means and not an end. **For me, the answer is how do we sustainably fund effective population health interventions that focus on social and behavioral needs, and I think CHWs are one of them.** An answer would be to continue to incentivize health and social service systems to get the right outcomes. Value-based payment in healthcare, value-based everywhere, pay-for-success models in the non-healthcare space. My gut says the more we are able to focus on this kind of work, the more organizations will identify CHWs as a cost-effective way to do it. It sounds calculating, but it’s the ACO lens on it.”* There is not a consensus about the distribution of CHWs among the various kinds of actors in the community.

*“**I just think that CHWs having the opportunity to work as one has been great.** Having this role develop and being able to come into it and make a difference in a patient’s life in a different way is awesome. Especially learning about diabetes, CHF (congestive heart failure), other medical issues, supporting patients in more of a social relationship has really made a big difference,”* said Yvonne Heredia of NHPRI.

*“**I don’t know if there’s a consensus about how to sustain CHWs, but I think there is a consensus of why it is important to sustain them,**”* said Laurie Moïse Sears of One NB. *“Forward-facing community work isn’t work that everyone wants to do. It’s tough. It’s second-hand trauma; it’s first-hand hearing situations that folks are going through—and not necessarily being at the table to make decisions. . . . We at the Central Providence HEZ work to get our collaborative members in the know about what’s going on. But in other hierarchical structures, CHWs don’t have a voice. Now we’re uplifting that; we’re able to be on the ground, to funnel that information to the powers that be, and we’re in a good place in terms of proving the point that CHWs are an asset and a necessity. Especially in a community that predominantly is undocumented. They don’t have case managers. They don’t have primary care providers in many cases. But they do have a CHW who can give them what they need to keep themselves safe, which is more important than anything right now. Hearing the Governor [and RIDOH Director] Dr. Alexander-Scott, focus on CHWs, the work we’re doing with the HEZ, is awesome. It’s important. And they’re getting to populations that many other organizations can’t touch because of undocumented issues. And other entities couldn’t see otherwise, because they don’t have access [or] connections to these folks. We do hire folks that live in the neighborhood, are culturally sensitive, and understand the need.”*

Garry Bliss of Prospect Health System of Rhode Island said *“**I think that CHWs have proven their value in Rhode Island. I believe that the AEs, at least...know that CHWs are an essential part of even a basic AE program. I wouldn’t even say ‘robust.’ Basic.** I think the AEs all want, and for good reason, to have CHWs who are in their own organizations, working with their patients [and] on their priorities, their strategies, their programs, etc.”* What is less clear, and there is variety, is a sustainability

strategy for CHWs who are not tied exclusively to one AE—for example, CTC-RI’s Community Health

Teams, and place-based teams, such as the Central Providence HEZ. Place-based programs are valuable, and payer-agnostic approaches that care for families together are valuable. A family is going to be healthy or unhealthy together. The path to financial sustainability for place-based and payer-agnostic approaches is less clear but important to consider. What's changed, in terms of perspective on sustainability, is that there is broader recognition of CHWs' value outside of the Medicaid population. *"Now that they've seen what a CHW does, there are more people who say, 'golly gee, we could use this for other patients,' not just Medicaid patients. We could have predicted that."*

CHW programs *"need sustainable funding, networking, information-sharing...it should be expected as a normal part of care,"* said Rhode Island Hospital SMART Initiative Physician Lead Dr. Elizabeth Samuels. *"We should expect that healthcare providers should work with CHWs, whether from ACOs, hospitals, whatever. There should be a culture shift. When I discharge someone from the ED, let's say they broke their arm, I give them a referral to the orthopedist. But it shouldn't be extra special that someone asks if they have transportation to that appointment. It shouldn't be 'oh, you seem extra vulnerable.' Everyone should get an assessment for whether they need extra supports. **It should be normative.**"*

RIPIN is **"happy to see an emerging consensus focused on health: healthy communities, healthy populations, and healthy people,"** said Executive Director Sam Salganik. *"There has been much less focus among healthcare leadership and government agencies on payment incentives and mechanics of the system, and much more on actual health—particularly the health of underserved populations."*

Thundermist's Matt Roman said that there are many stakeholders in community health work, but there is not a coherent vision. There is talk of connecting HEZs and AEs, but no one knows how to operationalize it. HEZs are geographic, by definition, but AEs cut across multiple communities, so there is a risk of fragmentation. There is no long-term plan for sustainability, and particularly with the financial impacts of the pandemic, the picture looks bleak. Even a one-year HSTP plan is just one year. **"I've not heard a singular vision." One consensus, depending on who is in the room, relates to an earlier debate between practice-based and community-based CHWs. There is now a consensus that both have value.** When a bigger practice can have its own CHWs, it should, taking advantage of warm handoffs [and] in-house documentation, but there is a need for smaller practices to have access to community-based teams. *"I have a sense that in the last two and a half to three years, there has been an emerging collaborative consensus that this is a very important role, that we have to grow and sustain,"* said Phillip Clark of URI. *"To me, that's the most promising development...this growing awareness of the importance of educating, training, supporting, sustaining, and paying CHWs."*

"I think it's vital we sustain these efforts because...our CHWs are all from our neighborhood," said Maria Carvalho of West Elmwood Housing Development Corporation. *"People trust them more than the system, so to speak. They know how to navigate the neighborhood. They have resources. They come in very informed."*

Appendix A: Community Health Worker Sustainability Survey for Employers and Stakeholders

Community Health Worker Sustainability Survey for Employers and Stakeholders (all questions are as-applicable)

Background

1. Introductions and background as needed

Multiple choice questions

2. We are following up on a report from 2017 and adding organizations we didn't speak to then. Thinking back over the past three years, and comparing 2017 with today, do you think that for your organization/program
 - a. **CHWs' role** is
 - i. The same
 - ii. Somewhat different
 - iii. Very different
 - iv. No longer happening
 - v. Not applicable in our case
 - b. The **patient/client population** CHWs work with is
 - i. The same
 - ii. Somewhat different
 - iii. Very different
 - iv. No longer happening
 - v. Not applicable in our case
 - c. Our **approach to funding** CHW positions and services is
 - i. The same
 - ii. Somewhat different
 - iii. Very different
 - iv. No longer happening
 - v. Not applicable in our case
 - d. Our **approach to training and supporting** CHWs is
 - i. The same
 - ii. Somewhat different
 - iii. Very different
 - iv. No longer happening
 - v. Not applicable in our case
 - e. Our **perspective on sustaining** the CHW workforce is
 - i. The same
 - ii. Somewhat different
 - iii. Very different
 - iv. No longer happening
 - v. Not applicable in our case

3. Has the **number of CHWs** employed by your organization/program since 2017
 - a. Stayed the same
 - b. Increased
 - c. Decreased
 - d. Not applicable in our case
4. How are you **currently paying** for CHWs? (Check all that apply)
 - a. Grant funding from any government source (not including HSTP)
 - b. Funding through the Medicaid Accountable Entity Program--including HSTP funds and/or shared savings payments
 - c. Grant funding from private philanthropy (foundations, etc.);
 - d. Operating budget or administrative funds
 - e. Fee-For-Service (billing) of some kind
 - f. Other _____
 - g. Not sure/I don't know
 - h. Not applicable
5. Does your organization measure any of the following kinds of value for **CHWs specifically**? (Check all that apply)?
 - a. Return on Investment (ROI);
 - b. Cost-Effectiveness;
 - c. Reductions in Total Cost of Care;
 - d. Effect on Healthcare Quality Measures;
 - e. Effect on Client/Patient Satisfaction;
 - f. Effect on Client/Patient Health Outcomes;
 - g. Effect on Client/Patient Social Outcomes;
 - h. Effect on achieving deliverables of a grant or contract;
 - i. Staff retention
 - j. Other _____
 - k. Not sure/I don't know
 - l. Not Applicable
6. Does your organization measure any of the following kinds of value for **teams or programs that include CHWs**? (Check all that apply)
 - a. Return on Investment (ROI);
 - b. Cost-Effectiveness;
 - c. Reductions in Total Cost of Care;
 - d. Effect on Healthcare Quality Measures;
 - e. Effect on Client/Patient Satisfaction;
 - f. Effect on Client/Patient Health Outcomes;
 - g. Effect on Client/Patient Social Outcomes;
 - h. Effect on achieving deliverables of a grant or contract;
 - i. Staff retention
 - j. Other _____
 - k. Not Applicable
7. Do you think the State should pursue policy changes that would let **CHW services be reimbursed by health plans** (organizations would be able to bill health insurance for CHWs' services)?
 - a. Yes;
 - b. No;
 - c. Not sure

8. Which options do you think would be **most effective to grow and sustain the CHW field** in Rhode Island in the long term? *Please choose up to three:*
 - a. Grant funding from the State to employers of CHWs;
 - b. Grant funding from the State to Health Equity Zones (HEZs);
 - c. Grant funding from private philanthropy (foundations, etc.);
 - d. Healthcare organizations' operating funds;
 - e. Medicaid Accountable Entity Program--AEs pay for CHWs out of shared savings;
 - f. Changes to how Medicaid Managed Care Organizations (MCOs) pay healthcare organizations;
 - g. Policy change to allow Fee-For-Service Reimbursement of CHWs (billing)
 - h. Other
 - i. Not sure / I don't know

Discussion Questions

Interviewees can select the questions that are most relevant and interesting to them, including:

9. Can you tell me more about what's changed in the past few years?
10. Are there any major lessons you think your organization has learned about CHWs' role, value, and sustainability since the report?
11. You said that you measure [summarize responses on measurement above]. Can you tell me more about how you do that?
12. Would you like to say more about how you think about CHWs' role and value for your organization/program?
13. You mentioned that [summarize responses on sustainability above]. Tell me more about why you think those are the right options?
14. What impact do you think COVID will have for the sustainability of the CHW workforce? And what do you think should change to support the workforce in light of the pandemic?
15. What, if any, consensus do you think is emerging about the best way forward to sustain and grow the CHW workforce in Rhode Island?

Appendix B: Participating Organizations and Interviewees

Organization	Department or Program	In 2017 study?	Type of Organization	Interviewee(s)	Title(s)
Building Futures	Apprenticeship Rhode Island	Yes	Community-based organization, training/education/research organization	Amy Weinstein	Employer Relations Manager
Care Transformation Collaborative (CTC-RI)	-	Yes	Misc.	Susanne Campbell Linda Cabral	Senior Project Director SBIRT and CHT Project Manager
Clínica Esperanza Hope Clinic	-	Yes	Community-based organization, Primary care provider	Paola Martinez	CHW Supervisor
Community Health Innovations of Rhode Island and Brown University	-	Yes	Training/Education/Research organization, university	Dannie Ritchie	Founder; Clinical Assistant Professor of Family Medicine
Family Service of Rhode Island	-	Yes	Community-based organization, Social service organization	Marie Palumbo-Hayes Vanessa Cubellis	Vice President of Health Director of Community Health Teams
Integra Community Care Network	Medicaid Accountable Entity Program	Yes	Accountable entity	Matthew Harvey Cynthia Scott	Senior Director of Government Programs Medicaid Clinical Program Manager
Neighborhood Health Plan of Rhode Island (NHPRI)	Health@Home Program; NHPRI Care Management Program	Yes	Insurer/Health plan	Gary Chavez Yvonne Heredia Tanairi Garcia Jayne Daylor	Medical Management Program Liaison Manager of Care Management Program Supervisor of Operations (Health@Home Program) Manager of Clinical Quality (Health@Home)
ONE Neighborhood Builders	Central Providence Health Equity Zone (HEZ)	No	Community-based organization, HEZ	Laurie Moïse Sears Allegra Scharff	Director of Community Health Integration Health Equity and Evaluation Manager
Our Journ3i	-	Yes	Community-based organization	Quatia "Q" Osorio	Owner/Operator; CCHW, CLC
Project Weber/RENEW	-	Yes	Community-based organization	Colleen Daley Ndoeye	Executive Director

Prospect Health Systems RI	Medicaid accountable entity program	No	Accountable entity	Garry Bliss	Program Director
Providence Community Health Centers	-	Yes	Accountable entity, Community health center, Primary care provider	Chelsea DePaula	Manager of Community Integration and SDOH Strategy
Rhode Island Department of Health	Center for HIV, Hepatitis, STD, and TB Epidemiology	Yes	State or municipal government agency	Thomas Bertrand	Center Chief
Rhode Island Foundation	-	Yes	Foundation	Zachary Nieder	Strategic Initiative Officer for Health
Rhode Island Hospital/Brown University Medicine	SMART Initiative; ED Care Program	No	Hospital system, University	Elizabeth Samuels, MD	Physician Lead, SMART Initiative; Assistant Professor of Emergency Medicine
Rhode Island Executive Office of Health and Human Services (EOHHS)	Medicaid accountable entity program	Yes	State or municipal government agency	Deborah Morales	Medicaid Accountable Entity Program Director
Rhode Island Parent Information Network (RIPIN)	-	Yes	Community-based organization, Training/Education/Research organization	Sam Salganik Deborah Masland Emily Garthee	Executive Director Senior Program Director Growth and Development Officer
The Miriam Hospital (Lifespan)	Center for Prisoner Health and Human Rights	Yes	Hospital system, Initiative/Health promotion program	Sarah Martino	Deputy Director
Thundermist Health Center	-	Yes	Accountable entity, Community health center, Primary care provider	Matthew Roman	Chief Operating and Behavioral Health Officer
University of Rhode Island	Gerontology, Rhode Island Geriatric Education Center	Yes	University, Training/Education/Research organization	Philip Clark	Professor and Director
West Elmwood Housing Development Corporation	Dunamis Synergy; West Elmwood HEZ	No	Community-based organization, HEZ	Maria Carvalho	Executive Director