Rhode Island
Community Health Worker Assessment:
Exploring Opportunities for Sustainability

MAY 2021

Table of Contents

List of Tables and Figures

Acknowledgements

Thanks to the collaborative partnership and contributions of

Rhode Island Department of Health (RIDOH)
Randi Belhumeur, MS, RD, LDN, CDOE
Carol Pari Votta, MPH

Unity Health Engagement, LLC.
Michael Marosits, CEO

The Community Health Worker Association of Rhode Island
Sarah Lawrence, MSW, PhD

Rhode Island College - Institute for Education in Healthcare
Tonya Glantz, MSW, PhD
Marianne Raimondo, MSW, PhD
David Zuleta, BA

Executive Summary

In Rhode Island, medical and community-based organizations rely on the services provided by community health workers (CHW). *CHW* is an inclusive term that gives context to the diverse roles and contributions that CHWs provide to individuals, communities, and organizations. This assessment offers a point-in-time reference of Rhode Island's CHW workforce, demographics, assets, and challenges with the intent of identifying meaningful strategies to leverage support for this important health and human service resource.

The information contained in this report reflects the preliminary findings of the Rhode Island Community Health Worker Assessment. This project was supported with funding from the Rhode Island Department of Health (RIDOH) and Rhode Island College's (RIC) Institute for Education in Healthcare (IEH). The Community Health Worker Association of RI, Unity Health Engagement, LLC, and the IEH supported data collection and analysis. This assessment invited multiple stakeholder perspectives (employer, CHW, and CHW-supervisor) to better understand and support Rhode Island's CHW workforce.

Areas of Focus

The data reported in this assessment include three core areas of focus that when combined, provide a comprehensive picture of Rhode Island's CHW workforce. The focus areas were chosen to provide:

- Insight into characteristics of the Rhode Island CHW workforce
- Information related to key stakeholders' perceptions of the value of CHWs regarding
  - Overall organizational value
  - Value associated with the provision of services and supports
  - Value to achieving client outcomes
- Suggestions to support the sustainability of the CHW workforce with attention to
  - Extrinsic resources (i.e., salary, benefits, and career ladder opportunities)
  - Intrinsic resources (i.e., factors promoting self-efficacy and retention)

These focus areas provide insight into viability of Rhode Island's CHW workforce as well as external forces that threaten it, such as employment criteria, salary, and workforce changes over time.

Intent

In an effort to build a comprehensive picture of Rhode Island's CHW workforce, this assessment invited feedback from Rhode Island organizations with connections to CHWs through employment, contracted projects, volunteer relationships, and research/training contexts. The data in this assessment represent multiple stakeholder voices that together create a more comprehensive picture of Rhode Island's CHW workforce during the summer and fall of 2020. While the data offer opportunities to understand changes in the CHW workforce, perceived impacts, and sustainability needs, the findings must be considered within the context of the subset of stakeholders that participated in the assessment. This assessment includes rich data that complement what is known about CHWs in Rhode Island. However, the content reflects the responses of a limited 102 participants, which may not be a representative sample of Rhode Island's entire CHW workforce. In an effort to account for this limitation, data analyses were informed by CHW literature and prevailing research on the topic. Understanding Rhode Island's CHWs is possible when we include the perspective of key stakeholders.

Introduction

Participant Selection and Data Collection

The assessment used three stakeholder surveys to gain insight into Rhode Island's CHWs, each constructed with overlapping questions and points of inquiry, intended to capture and unite core stakeholder voices. These stakeholders included the following groups:

1. Practitioners who self-identified as CHWs (n=68) based on work roles, job titles, and for some possession of CHW certification;
2. Organizational Leaders (n=22) whose services and supports intersected with CHWs based on diverse health settings, community-based and social service agencies, faith-based organizations, and those organizations that were involved in CHW research and training; and
3. Supervisory Staff (n=12) whose names were provided by the participants from the CHW stakeholder group.

Selection of Participants

CHWs were identified through the membership lists of the Community Health Worker Association of Rhode Island (CHWARI) and the Rhode Island Certification Board (RICB). Email correspondence containing consent and survey links were sent to approximately 300 individuals who identified themselves as CHWs. Seventy CHW surveys were received; however, two of the survey respondents indicated that they were not CHWs and their responses were removed from the data, resulting in 68 CHW responses.

Organizations' leaders in the roles of employer partners were selected based on their existing relationships with the CHW workforce. Employer partners (i.e., Directors, CEOs, Program Directors/Managers, Human Resources) were contacted by phone to inform them of the assessment and to invite their participation. Following the phone calls, emails were sent with consent information and a survey link. Of the 74 organizations targeted in the assessment, 44 different organizations were represented and 22 organizational leaders (employer partners) submitted surveys.

CHW supervisors were solicited directly from CHW respondents whose survey questions invited them to share the names and contact information of their supervisor(s). Of the 68 CHWs that participated in this assessment, more than half (n=36; 53%) shared information regarding their supervisor(s). Because of this selection method, 29 CHW supervisors were identified; some CHWs offered the same supervisor names. These CHW supervisors were emailed consent information and a survey link. Of the 29 invited to participate, 12 CHW supervisors completed the assessment.

This assessment represents the responses of 102 stakeholders: CHWs (n=68; 23% response rate), employer partners (n=22; 30% response rate), and CHW-Supervisors (n=12; 41% response rate). The collective survey responses provide insight into 44 Rhode Island organizations that are directly involved with CHWs.

Table 1: *Comprehensiveness of Organizational Responses*

Level of Responsiveness by Organization	Percentage (n=44)
Full Stakeholder Perspectives (responses from all stakeholder groups)	5 (12%)
Dual Stakeholder Perspectives (responses from at least two stakeholder groups)	10 (23%)
Single Stakeholder (responses from one stakeholder group)	29 (65%)
Total	**44**

Within the 44 organizations represented, 35% of the surveys submitted represented two or more stakeholder voices from 15 organizations. The largest stakeholder group to respond were CHWs whose singular voices illuminated their experiences across an additional 29 organizational settings.

In 2007, US Department of Health and Human Services, Health Resources and Services Administration (HRSA) Bureau of Health Professions released a seminal report on CHWs, *Community Health Worker National Workforce Study*.[18] The report was inspired by the need to explore the intersection of rising healthcare costs with the fiscal and practical benefits associated with the presence of CHWs. It was the first comprehensive study of CHWs across all 50 states and analyzed data from more than 900 CHWs. The data provide a historic frame from which to compare the characteristics of Rhode Island's 2020 CHW workforce. For the purpose of this assessment, the human service workforce is a secondary lens that is used to consider CHWs and the work they do. In the 2020 Hassenfeld Institute's report, *The Human Services Workforce in Rhode Island*, connections between the CHW and human service workforces are established and six workforce categories are identified:[5]

1. ***Outpatient mental health and substance abuse centers;***
2. ***Residential intellectual or developmental disabilities, mental health, and substance abuse facilities;***
3. ***Individual and family services;***
4. ***Community food, housing, emergency, or other relief services;***
5. *Vocational rehabilitation services; and*
6. *Child care centers.*

The first four workforce categories, in bold, are reflected across the diverse roles of Rhode Island's CHWs. Notably, the Hassenfeld report does not reference the wide variety of physical healthcare centered CHW roles, in areas such as breast cancer, cardiovascular health, asthma, and diabetes. Still, the report's importance to better understand the expansiveness of CHWs is reflected in how it highlights economic and employment perils facing the broadly conceived human service workforce.[5]

CHWs, in this assessment, are identified by a myriad of titles, which reflect their diversity and depth of impact. The section that follows creates a profile of some of Rhode Island's CHWs. It also affords the opportunity to reflect on what their presence means to the community health and human service workforces.

Demographic Profile: Gender, Diversity, and Age

Within the current assessment, CHWs shared gender and age characteristics with the 2007 HRSA sample.[18] Rhode Island CHWs who participated in this assessment were overwhelmingly female (88%), which is similar to the 2007 sample. The similarity extended to the ages of Rhode Island's CHW

workforce where the two largest groups were between the ages of 25 and 54 (68%) and 55 to 64 (26%) years old.

Table 2: *CHW Workforce Diversity*

Gender	Race/Ethnicity	Age
• **88% - Female** • 10% - Male • 1% – Gender variant/ non-conforming • 1% - Other	**Race** • **60% - White** • 19% - Black/African American • 5% - Native American • 8% - Multiracial **Ethnicity** • **53% - Non-Hispanic** 44% - Hispanic	• 5% - 18-24 • **27% - 25-34** • 17% - 35-44 • 24% - 45-54 • **26% - 55-64**

The similarity ends here because unlike the 2007 sample, the majority of Rhode Island CHWs identified as White (60%), with 54% of them also identifying as non-Hispanic. Historically, the diversity of CHWs has been attributed to the practice of having CHWs reflect the communities they serve.[1,18] In Rhode Island, clients of communities in which CHWs work are predominantly people of color. It is unclear if the under-representation of communities of color in the Rhode Island sample of CHWs is due to the sample size or some other trend related to the training and hiring of the current CHW workforce.

Employment Characteristics

The 2007 HRSA workforce study called attention to traditional CHW employment settings of physical health/medical and community-based organizations.[18] The work settings of Rhode Island CHWs reflect these traditional settings: physical health/medical (36%) and community-based organizations (33%). In addition, smaller groups of CHWs identified specialized settings associated with advocacy and behavioral health settings with a focus on addiction and recovery. Within this sample, 43 CHWs chose chronic health conditions as one of the main areas they focus on when providing services to their clients.

For the purpose of managing and categorizing the assessment data, the organizations identified by respondents were grouped into six categories, two of which could have been grouped under the community-based organization category. However, because respondents emphasized the distinction, the labels were honored in the categorization of the data in Figure 1.

Figure 1: *CHW Workplace Settings*

Physical Health/Medical	Community-Based Org.	Insurer	Training	Behavioral Health	Housing
30 (44%)	28 (41%)	3 (4%)	3 (4%)	2 (3%)	2 (3%)

The category of *Physical Health/Medical* represents collective community health settings, hospitals, accountable entities, federally qualified health centers (FQHC), and Health Equity Zones (HEZ). Sometimes CHWs' roles transcend across these entities, such as the Home Asthma Response Program (HARP) that is comprised of RIDOH, a hospital-based clinic, an accountable entity primary

care practice, and Hasbro Children's Hospital. CHW work may be provided in sub-programs within a physical health center, as with the Vida Sana and Diabetes Prevention programs within Clinica Esperanza, a clinic focused on Spanish-speaking and undocumented clients. In addition, this category also includes organizations explicitly associated with physical health/medical, such as programs for maternal health or chronic health monitoring. The next largest category, *Community Based Organizations,* encompassed social and human service organizations. This category included Rhode Island's community action programs, senior centers, and direct service sites. The four smaller categories of *Insurer, Training, Behavioral Health, and Housing*, were kept separate to depict CHW's diverse employment settings.

There is evidence to support the continued role of Rhode Island's CHWs in services related to chronic health conditions delivered across different work settings. The work settings, related practice areas, and workforce roles and duties that intersect with chronic health conditions services cited in this assessment are supported by CHW literature.[1] According to survey responses from Rhode Island CHWs, there is evidence supporting the concentration of CHW services for chronic health conditions related to work in physical/medical health (54% of CHWs surveyed) and resources and planning (85% of CHWs surveyed). Physical/medical health practice areas (Figure 2) reflect strong evidence of CHW support for chronic health conditions.

Figure 2: *Physical/Medical Health, Chronic Health Services*

Physical/Medical Health Practice Areas

Practice Area	Value
X-ray services	1
Wellness checks	32
Vaccinations and injections	10
Trans* health access	2
Screening and monitoring	23
School-based health services	4
Outpatient care (medical)	10
Obstetrical care	10
Inpatient care (medical)	5
HIV care	0
Geriatric and senior medicine	9
Emergency medical services	11
Dental services	5
Chronic disease management	34
Not applicable	17

Based on the responses of 68 CHWs, slightly more than one-third of CHWs reported that part of their routine involvement at their practice included screening and monitoring (34%); slightly less than half of CHWs participated in wellness checks (47%), and half of the CHWs surveyed supported chronic disease management (50%) in their work.

Figure 3: *Resources and Planning Practice, Chronic Health Services*

Resources and Programming Practice Areas

Practice Area	Value
Consumer education and wellness	49
Care connections	43
Advocacy (consumer)	63
Not applicable	3
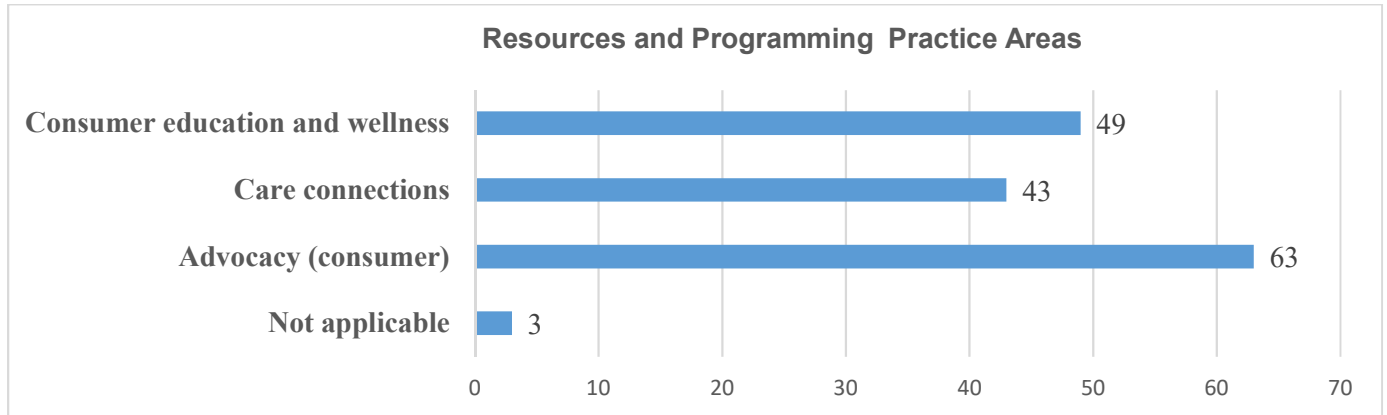
The Resources and Programming data in Figure 3 includes activities related to supporting client health, which extends to chronic health conditions, through a variety of practices focused on wellness and prevention, diagnosis, and care for chronic conditions. Figure 3 reveals those areas of CHW practice that accounted for more than one-third of CHWs support for wellness and chronic health conditions. Within this area of practice, the following duties reflected support for chronic health conditions: consumer education and wellness (72%), care connections (63%), and advocacy (consumer) (93%). These services represent critical CHW support for prevention, diagnosis, and treatment of chronic health conditions. In addition to those duties aligned with CHWs areas of practice based on workforce settings, CHW literature provides a scope of practice for CHWs and corresponding duties that affords another lens from which to assess Rhode Island's CHW connections to chronic health conditions.[1]

This scope of practice for CHWs defines five core roles of CHWs across organizational settings, each with its own set of corresponding duties.[1] CHWs' survey responses confirm the identification with these roles and duties, where the roles of *Navigating* and *Direct Service* were most closely aligned with service and support for chronic health conditions.

Table 3: *Intersection of CHW Organizational Roles and Chronic Health Conditions*

CHW Organizational Role	Number of Participants	Percentage (N=68)
Bridging the gap between communities and health/social service systems	53	78%
Navigating the health and human services systems (access to care)	**42**	**62%**
Advocating for individual and community needs	**53**	**78%**
Providing direct services (supporting nurse case management services, etc.)	**23**	**34%**
Building individual and community capacity	38	56%

*Rows with gray shading reflect CHWs' intersection with chronic health conditions

Each of these five roles has corresponding duties that CHWs utilize to meet outcomes. Across this sample, it was common for CHWs to occupy more than one role at a time and within the *Navigating and Direct Service Roles* there was evidence of significant interest with chronic health conditions. From these data, an estimated 34% to 62% of CHWs are engaged in various levels of work related to chronic health conditions.

Figure 4: *CHW Duties Supporting Chronic Health Conditions*

Navigating (N) and Direct Service (DS) Duties that Support Chronic Health Conditions
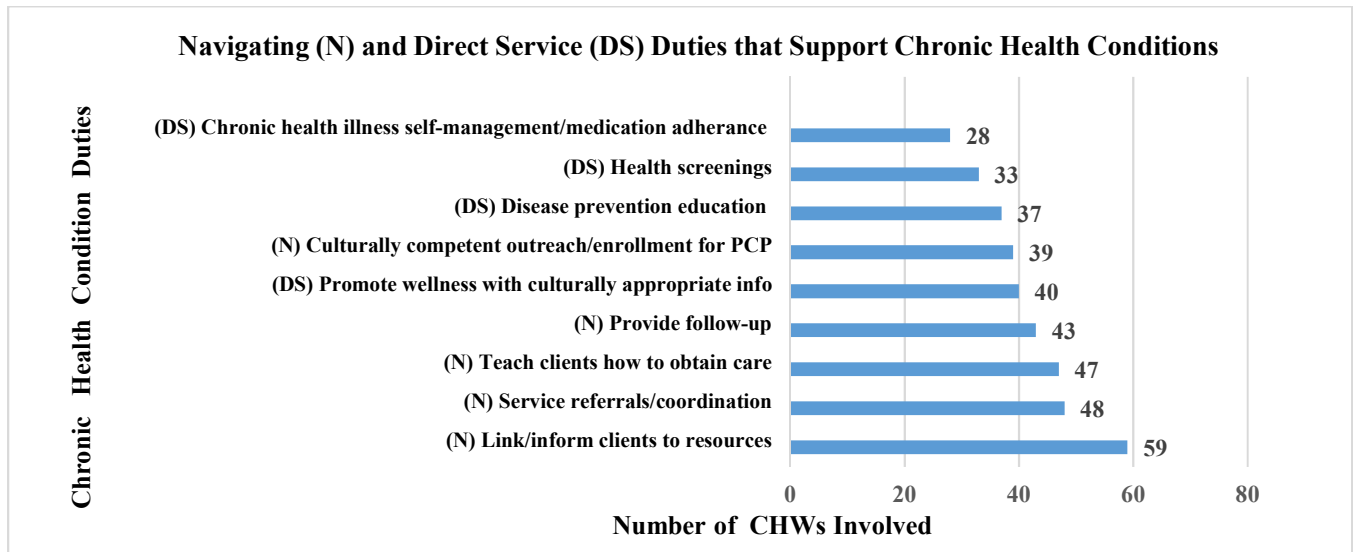
Data in Figure 4 depict CHW navigation and direct service duties related to the prevention and treatment of chronic health conditions. For example, some of the CHW prevention duties are reflected in *health screenings, disease prevention education*, and *teaching clients to obtain care*. Likewise, CHW efforts to support appropriate diagnosis and treatment are evident in duties including, but not limited to, *chronic health self-management and medication adherence*, *providing follow-up*, and *service referrals and coordination*. The role of CHWs' support for prevention, diagnosis, and treatment of chronic health conditions represents a traditional practice whose relevance continues a critical component of the CHWs responding to this survey.

Workforce Expansion into New Practice Areas

The diverse work settings identified by CHWs in this assessment suggest a small expansion of CHWs into broader fields of practice, which may reflect how CHWs are responding to shortages across segments of human service workforce. One avenue that CHWs are branching into is that of chronic disease prevention and management, through programming that integrates the preventive and educational strategies right into community-based services and resources. Many HEZs, for example, have created special programs around healthy and accessible food, increasing physical activity, and creation of safe, open spaces for activity. Another area where CHWs are increasingly deployed is behavioral health. Within the CHWs responding to this survey, 35% identified a practice connection with behavioral health.

The Substance Abuse Mental Health Services Administration's (SAMHSA) report in 2012 raised the alarm for the waning human service workforce.[17] This report projected likely impacts to service delivery, within the fields of behavioral health, all human services, and within social service settings that specialize on behavioral health and the country's aging population.

Figure 5: *Behavioral Health Practice Areas*

Behavioral Health Practice Areas
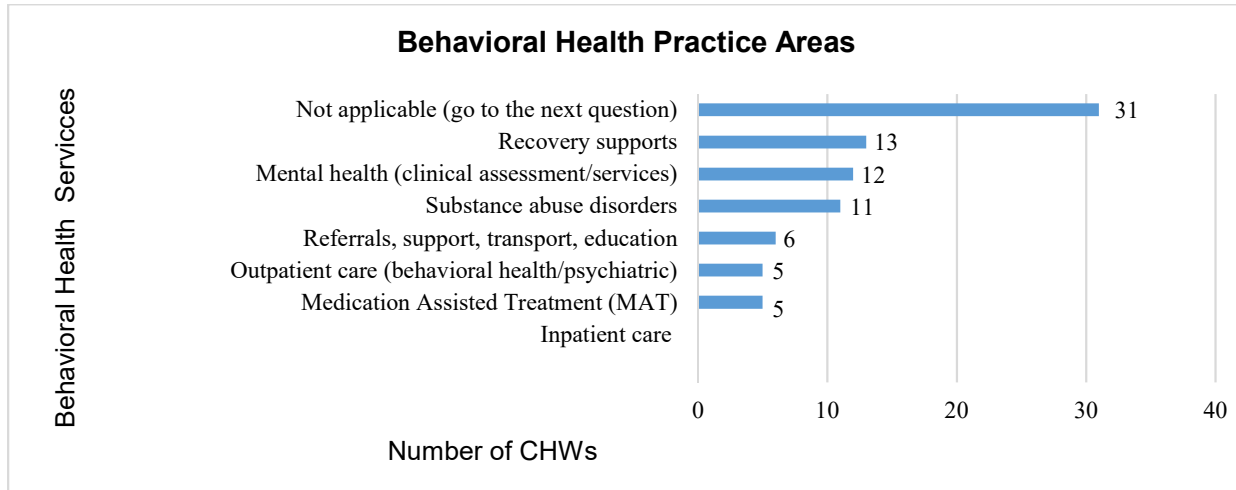
Within Rhode Island, CHWs are actively being recruited to work within behavioral, varied long-term care and human service agencies whose focus is children, adolescents, and families. The services depicted in Figure 5 are transferrable across populations and enhance a CHW's scope of practice.

Educational Credentials

When evaluating employment characteristics of the CHWs in this assessment, education, longevity, and average income offered opportunities to consider changes in this workforce over time as well as the need to evaluate Rhode Island's existing recruitment and retention strategies. Rhode Island CHWs were more likely to possess higher educational credentials than CHWs in earlier workforce studies.[18]

Table 4: *Educational Credentials of CHWs*

College Degree	
• **Associate degree**	**21% (n=14)**
• **Bachelor's degree**	**46% (n=31)**
• Graduate degree	4% (n=3)
• Some college	3% (n=2)
GED/High school diploma	**21% (n=14)**
Trade/Technical/Cert program	4% (n=3)
Prefer not to answer	1% (n=1)

This trend toward a more academically credentialed CHW workforce could have implications for future employment opportunities for CHWs. How does the absence of a college degree affect the 25% of the CWH workforce who does not have any college education?

When asked to rate the importance of a bachelor's degree, CHW (61%) and employer partners (50%) agreed that the credential was important for CHW career opportunities. While the assessment's small sample size could be skewing the educational data, it is important to understand why Rhode Island's CHW workforce appears to be moving toward more traditional educational credentials.

Figure 6: *The Importance of a College Degree*

How Important Is a College Degree for Career Opportunities?
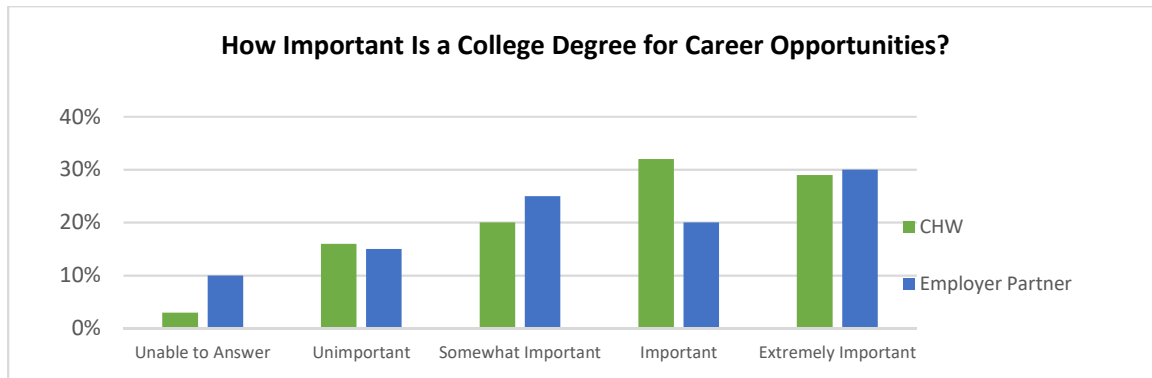
The presence of a largely White, college-educated CHW workforce in this assessment calls for a deeper exploration to understand the origins and implications of these demographic changes. Equally important is understanding the extent to which Rhode Island's CHW workforce maintains its connection to traditional practices and client and community level outcomes.[1,14] Rhode Island's CHW workforce may need to pursue higher education and other credentialing opportunities to be able to compete with Rhode Island's changing workforce. The dual certification of CHW and Peer Recovery Specialist is one idea that is worthy of exploration.

Peer Recovery Specialists (PRS)

Across Rhode Island, PRS have gained attention and are playing a critical role in supporting individuals with behavioral health and other related challenges.[12] PRSs represent individuals' lived experience in their own recovery or experience as a family member or loved one living in recovery. Employment as a PRS requires specialized training and certification. They are typically employed in health and mental health centers, behavioral health programs, substance use treatment facilities, peer-run organizations, community-based organizations, emergency rooms, courts, homeless shelters, and outreach programs. According to the Rhode Island Certification Board, there are currently 147 certified PRSs in the state. An additional benefit associated with PRSs is the ability their employer has to receive Medicaid reimbursement for mental health and substance abuse services delivered to clients and groups.[13] An additional benefit afforded to PRSs by some human service agencies includes the waiving of the college degree requirement in lieu of a PRS certification credential and credit for their lived experience.

The benefits of Medicaid reimbursement and removal of educational requirements are not extended to CHWs, even when their work intersects with populations affected by behavioral health needs. Interestingly, there is a growing trend toward dual certification of CHWs as PRSs. Among the CHWs (N=68) who responded to the assessment, 19% were certified as and/or working toward certification as a PRS. Of the CHWs (79%) that were not certified or pursuing PRS certification, 42 of them (62%) were interested in obtaining PRS certification.

The dual CHW-PRS certification could serve CHWs and organizations well because the certification opens employment options for CHWs while concurrently allowing organizations to explore Medicaid reimbursement for CHW services that intersect with mental health and addiction-recovery services. In Rhode Island, at least two organizations, the Parent Support Network and Rhode Island College, currently support dual certification training for CHWs and PRSs. In Rhode Island, certified PRSs earn an average of $37,277 annually with a range between $33,266 and $41,561.[15] It is unclear how dual certification of a CHW as a PRS might improve the job market and overall salary for CHWs.

CHW Employment and Wages

The CHWs in this assessment represented different levels of participation in Rhode Island's diverse workforce. The majority of CHWs were working as full-time paid CHWs (81%), and 15% had part-time employment (Figure 7).

Figure 7: *Employment Status*

CHW Employment Status

- Conracted/Non-Employee: 1%
- Volunteer: 3%
- Part-Time: 15%
- Full-Time: 81%
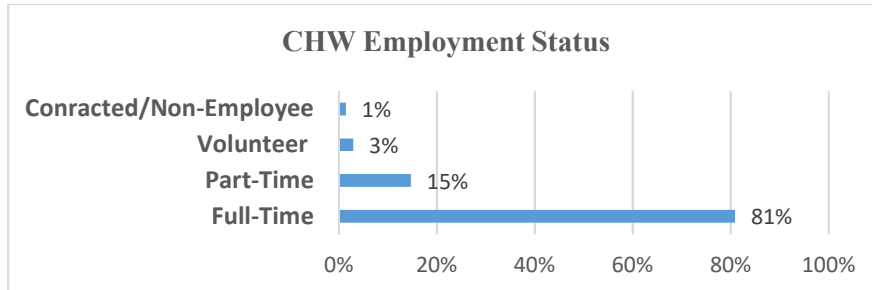
Full-time employment includes benefits such as health insurance and paid leave. The human service workforce plays a critical role in providing services and supports to the state's most vulnerable and underrepresented clients, where issues of equity related to economics, minority status, and limited access to resources are common challenges. CHWs' experiences with underemployment, limited access to resources (health insurance), being in a female dominated industry, and potential affiliation with minority and under-represented communities exposes CHWs to many of the same challenges faced by the clients they serve.[5] The 2020 Hassenfeld Institute report said, *"6.14% of human services employees are uninsured, compared to 5.81% of the total workforce. Another 20.65% rely on Medicaid or similar programs, compared to just 11.21% of the total workforce."*[5]

According to the CHWs' survey responses, almost two-thirds of Rhode Island's CHWs earned less than $36,310 annually, and 33% of them earned less than $31,900 (see Table 5). While salary data from the HRSA study is almost 15 years old, the historical depiction of the CHW as an under-compensated segment of the workforce continues. In addition, concerns for the salaries of the human service workforce, which includes CHWs, reinforce issues of pay equity and the reciprocal implications for the workforce and those they serve.[5]

Table 5: *Annual Average Salary for CHWs*

Estimated Salary	Estimated Hourly Rate (40 hours/week)	Percentage of CHWs (N-68)
Less than $31,900	Less than $15.34	**33%**
$31,900-$36,310	$15.34-$18.16	30%
$36,311-$44,360	$18.16-$21.23	24%
$44,361-$52,480	$21.23-$25.23	9%
$52,481-$63,670	$25.35-$30.61	2%
More than $63,670		
No response		2%

According to the Economic Progress Institute (EPI), Rhode Islanders' abilities to meet their basic needs are hindered by low wages.[4] The EPI estimates for the minimum pre-tax income required for individuals

($30,600), single parents ($66,057), and a two-parent family of four ($73,646), raise concerns about the average salary of many of Rhode Island's CHWs.[4]

Figure 8: *Estimated Hourly Wage*

CHW Estimated Hourly Wage Based on Reported Annual Salary Range

Salary Range	Percentage
< $15.34	33%
$15.34 to $18.16	30%
$18.16 to $21.23	24%
$21.23 to $25.23	9%
$25.35 to $30.61	2%
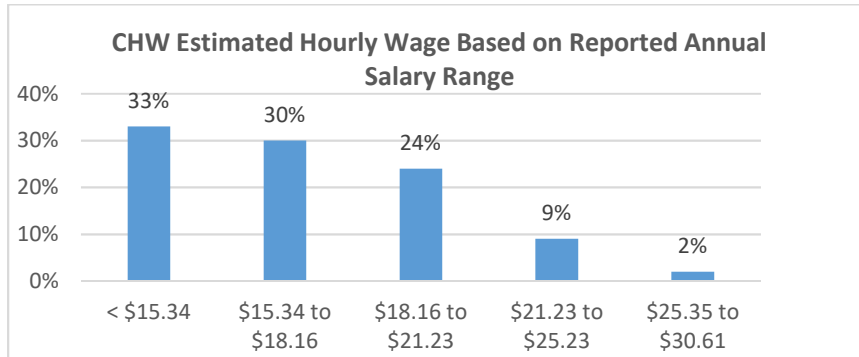
As indicated in Figure 8, almost two-thirds of the CHWs reported earning less than $44,361 annually or less than $18.17 an hour. This information suggests that Rhode Island's CHWs are at risk for not being able to meet their own or their family's basic needs. Because the CHWs in this assessment were more likely to be female and were mostly between the ages of 25 and 64, it is likely that these CHWs are responsible for caring for others. Issues of pay equity for women are prevalent in the human service workforce, where 80% of the workforce is female.[5] The value of financial incentives represents a critical component of sustaining the CHW workforce and advocated their importance: "…introducing and/or sustaining a form of financial incentive seems key towards strengthening CHW motivation. Such remuneration should then be fair (commensurate to the job demands) and consistent (over time as well as across CHW groups with similar job demands)".[11] Because the CHWs in this assessment reported salaries that were comparatively lower than Rhode Island's projected standard of need, CHW compensation requires additional attention to inform sustainability.

Longevity

Rhode Island CHW employment trends related to longevity suggest the potential for turnover and retention challenges. According to assessment data, 50% of the CHW respondents' employment as CHWs is limited to two years or less. Another third of CHWs' length of employment was between three and five years. The minority of CHWs (16%) had careers as CHWs for six or more years. Employment variables related to longevity, education, age, and annual income suggest areas worthy of consideration as Rhode Island moves to sustain its CHW workforce. A recent human service workforce study raised concern for barriers to the retention of human service workforce, "Rhode Island's human services sector is at risk of increased turnover and lengthy position vacancies. Employers in this sector are in need of solutions to recruit and retain a highly competent, skilled, and diverse workforce to serve its high-risk, vulnerable client population." [5]

As Rhode Island explores opportunities to sustain its CHW workforce, it is imperative to explore the consequences of turnover for organizations and clients and the extent to which the income disparity and education credential data reported in this assessment are contributing to problems with retention.

CHW Scope of Work and Employment Impacts

CHW Scope of Work
Defining the scope of practice for Rhode Island's CHWs is an important component of understanding how CHWs add value to the workforce landscape and provides insight into challenges for sustainability. Within this assessment, the scope of CHWs' work was informed by the *CHW Toolkit: A Guide for Employers*, where the diverse aspects of CHWs' practice were captured using a framework of five core areas of work.[9] Rhode Island CHWs were invited to select those areas of practice that defined their individual scope of work.

Table 6: *CHW Scope of Work*

Advocating for individual and community needs	**79%**
Bridging the gap between communities and health/social service systems	**77%**
Navigating the health and human services systems (including assistance with access to insurance and care)	**61%**
Building individual and community capacity	**54%**
Providing direct services (including supporting nurse case management services, etc.)	**33%**

From these responses, traditional foundations of CHW are clearly represented in the scope of work of Rhode Island's CHWs. The scope of work for the majority of Rhode Island's CHWs (78%) included multiple roles, which suggests that Rhode Island's CHWs fulfill multiple roles in support of the individuals and communities they serve.

Populations Served by CHWs
CHWs are known to serve vulnerable communities.[18] True to the tradition of CHWs, assessment data from Rhode Island's CHWs support the presence of CHW services and supports across the lifespan, diverse areas of needs, and target special populations, which have expanded to include behavioral health, patients with chronic diseases, addiction, people with histories of incarceration, and the LGBTQI population (Figure 9).

Figure 9: *Populations Served by CHWs*

Populations Served

Population	Percent
Other...	7%
(Living with and/or at risk for)	19%
Geographically Isolated Communities	20%
Gender Specific Services	23%
Incarcerated/History with Incarceration	26%
Infants/young children (birth-5)	33%
Uninsured/Under-insured	33%
Children (6-12)	35%
LGBTQI+	35%
Low-Income Children	36%
Adolescents (13-17)	41%
Racial & Ethnic Minorities	42%
Substance Abuse Disorders/Recovery	42%
Domestic Violence	45%
Immigrants/Undocumented	45%
Economically Disadvantaged	48%
Mental Illness	49%
Housing Instability/Homelessness	52%
Chronic Health Conditions	62%
Young Adults (18-21)	64%
Older Adults (65+)	71%
Adults Middle-Aged (50-64)	78%
Adults (22-49)	80%

Within the diverse roles and populations that inform Rhode Island's CHWs, it is possible to explore specific contexts of work provided by Rhode Island's CHWs. Service and support categories, as well as the unique tasks for each category were informed by the *CHW Toolkit: A Guide for Employers*.[9] Based on the assessment responses depicted in Figure 10, data suggest that the traditional CHW roles, providing *resources and planning* (85%) and *physical/medical health* (54%), were shared across many of the CHWs participating in the assessment process. An example of the intersection of these categories is suggested by the CHW who had trained at Rhode Island College in its Cardiovascular Health/Diabetes Management training toward the State's associated specialty certification. She captured the importance of her work when she "realized that there are so many groups of people that are affected by pre-diabetes and diabetes and the importance of being educated on the topic as well as having access to healthcare. Many programs and resources are available. It is just a matter of getting the information out to the different groups."

Figure 10: *Service and Support Contexts of CHWs' Work*

Core Focus of CHWs' Work

Category	Percent
Resources and planning	85%
Physical/Medical health	54%
Behavioral health	35%
Workforce development	26%
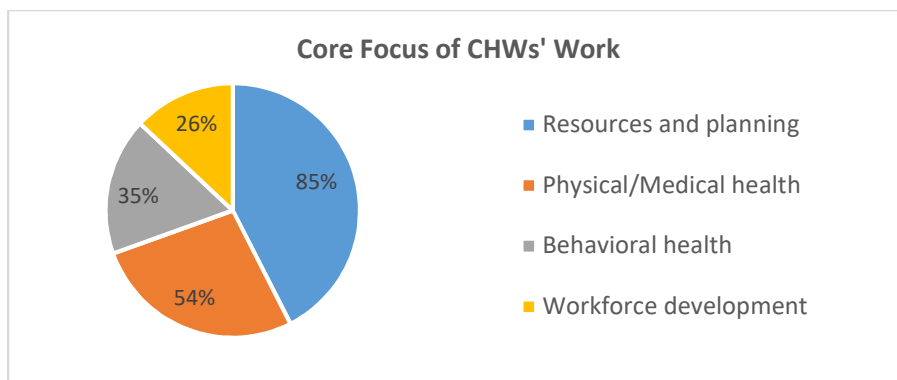
Within these dominant service categories, unique tasks were identified. Tasks reflect categories identified and evaluated in the *CHW Toolkit: A Guide for Employers*.[9] These tasks were transferable to Rhode Island's CHW workforce and did not require any adaptation. With the exception of the bolded tasks under the Physical/Medical Health category, CHW services and related tasks were consistent with traditional CHW roles. The three bolded tasks in Table 7 under this category represent population and workforce areas of special opportunity for Rhode Island CHWs.

Table 7: *Overview of Tasks for Resource and Planning and Physical/Medical Services*

Resources and Planning Services		Physical/Medical Health Services	
Most Common Tasks Responses from 65 CHWs	**Percentage**	**Most Common Tasks** Responses from 51 CHWs	**Percentage**
Referrals for supports/services	84	Chronic disease management	54
Consumer advocacy	78	Wellness checks	51
Consumer education/wellness	72	Screening and monitoring	36
Care connections	63	Emergency medical	17
Health insurance access	46	Outpatient care (medical)	16
Pharmacy services	9	Vaccinations/Injections	16
Laboratory services	4	**Geriatric/Senior medicine***	**14**
		Inpatient care (medical)	8
		School-based health services*	**6**
		Obstetrical care	5
		Trans health access*	**3**

*CHW support to specialized populations and workforce opportunities

The Rhode Island Certification Board recently approved a specialized certificate, *Building Holistic Partnerships with Older Adults: A Community Health Work, Person Centered and Social Determinants of Health Approach*, in support of community health work with older adults. In support of the expansion into this population, Rhode Island College received State and foundation grants to fund the co-location of CHWs in long-term care facilities. In addition, Rhode Island College is pursuing projects that support the placement of CHWs in schools and in organizations servicing children, adolescents, and families.

Table 8*: Overview of Tasks for Behavioral Health and Workforce Development*

Behavioral Health Services		Workforce Development Services	
Most Common Tasks Responses from 31 CHWs	**Percentage**	**Most Common Tasks** Responses from 42 CHWs	**Percentage**
Maternal Health Clinical Assessment/Services	22	Healthcare/workforce advocacy	47
Recovery supports*	22	Research and evaluation	32
Work with addiction*	20	Workforce development/training	30
Medication Assisted Treatment (MAT)*	8	Project promotion	18
Outpatient behavioral healthcare	8		

*Supports linked to addiction/recovery is a common theme

Fewer CHWs claimed the service categories associated with *Behavioral Health* and *Workforce Development*. However, the inclusion of *behavioral health* and *workforce development* by Rhode Island's CHWs provides opportunities to consider the role of CHWs beyond more traditional contexts. CHWs' presence in behavioral health workforce contexts suggest that CHWs may be playing a role to ameliorate the human service shortages.[5,17] Interestingly, of the core tasks identified under *Behavioral Health Services*, the majority relate to work in the field of addiction and recovery, which has implications for the overlapping roles of CHWs and PRSs. The inclusion of Rhode Island's CHWs to support workforce development through training, data collection, advocacy, and the promotion of projects and practices suggests the benefit of having CHWs as leaders to support the development of their peers as well as informing the expansion of CHWs across new settings and with new populations.

What is the Value of CHWs?
Employer partners and CHWs were invited to reflect on their perceptions of CHWs' value across three contexts--organizational success, supporting client needs, and promoting client outcomes. The responses of CHWs and employer partners were assessed by comparing the responses of negatively framed categories (not at all valuable and somewhat valuable) and the positively framed categories (valuable and very valuable). For both groups, the responses skewed in a positive direction. However, there was an interesting difference in the two groups: CHWs (88%) and employer partners (100%) differed in their ratings regarding CHWs' value to organizational success as depicted in Figure 11. This difference, while small, offers an opportunity to consider the importance of broadly communicating the important role that CHWs play in supporting the success of the organizations that employ or contract with them. If organizational leaders communicate the value of CHWs to their CHW workforce, it could positively influence CHWs' self-efficacy and retention.

Figure 11*: Perceptions of CHWs' Organizational Value*

However, when given the opportunity to rate the value of CHWs in supporting clients' needs and outcomes, CHW and employers were very similar in their overall rating of CHWs' value to clients (see Figure 12). Ninety five percent of employers and CHWs said CHWs were important or extremely important to supporting clients' needs. All employers and 96% of CHWs said that CHWs were either valuable or very valuable to client outcomes.

Figure 12: *Perceptions of CHWs' Value to Clients*
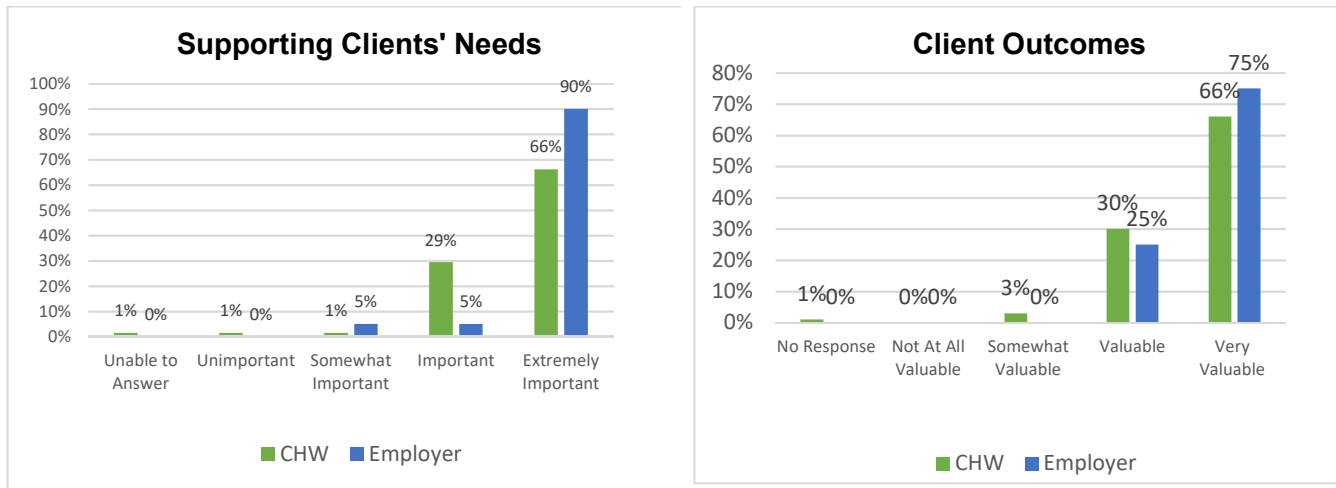
Employers have long recognized and valued the contributions of CHWs to organizations and client level outcomes.[1,18] The shared perception of high value related to CHWs and impacts on clients affords an opportunity to understand what motivates CHWs. Understanding CHW motivation is essential to developing strategies to support and sustain the CHW workforce.

CHWs' awareness of their value and the difference they make with clients was illuminated through the CHWs' comments regarding the most satisfying part of their job. Thirty-nine CHWs responded and 100% of the responses were focused on the feelings of satisfaction that came from their direct work with clients and knowing that they were making a difference in others' lives. One response in particular captures the sentiment expressed across the collective narratives, "Being able to educate those on services, they never knew they may qualify for or even existed. Networking and finding resources is also an amazing part of this field. The workdays are different every day, and although it is very tough, especially with the dramatic increase in caseload since this pandemic, it feels amazing to be able to give back to my community."

Qualitative analysis of CHW responses was conducted using thematic coding.[10] CHWs' responses indicated a recognition of their value at the client level and provided insight into factors that motivate CHWs.

There are two forms of motivation, intrinsic and extrinsic. Intrinsic motivation reflects the joy, job satisfaction, and curiosity that inspires a person to pursue and remain involved in a role or job.[2] Extrinsic motivation exists when a person engages in a role or job for the reward that they receive, such as salary or tangible benefits.[2] CHWs' responses related to job satisfaction strongly reflect intrinsic motivators. These quotes from CHWs help to convey their sources of motivation:

- "The relief that a patient expresses as a result of connections or referrals that I have helped to facilitate,"
- "It is the capacity that I have to provide information needed to clients in a way that affects their health outcomes, improve food insecurity, and support their housing and services needs so they can remain safely at home,"
- "When you see the look on a member's face when you actually help them and get the answers they wanted or finding resources for them. It's a great feeling when you help someone out."

- "When something 'falls into place' - when the referrals, education, etc. come together and something goes right - a patient learns something new, reaches a goal or grows in some way,"
- "Sometimes I help extend the life of vulnerable individuals. I bring hope to desperate people. I observe people's life change due to our interactions. I help individuals remain in their own home and avoid hospitalization versus going into a nursing home. Through my work I have observed individuals go from severely depressed to content, happy individuals!"

Figure 13: *CHWs and Work Satisfaction*

The Most Satisfying Part of CHWs' Work

- 74% Satisfaction from Helping Clients
- 13% Connect Clients & communities to services
- 10% Relationship Building (Clients & Communities)
- 2% Ongoing Learning
- 2% System Change
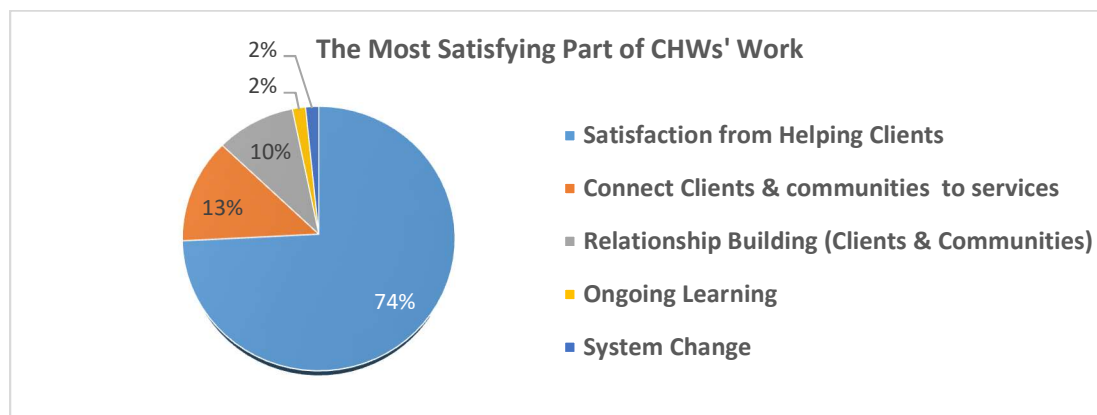
Understanding what motivates CHWs is essential to sustaining and retaining this workforce. Figure 13 provides insight into sources of work satisfaction for CHWs. When these narrative responses are paired with CHWs' value ratings associated with supporting clients' needs and outcomes, a sense of confidence and competence is conveyed in the data. The exploration of CHWs' value and sources of motivation presented in this data are helpful to inform strategic sustainability, where the focus includes attention to both intrinsic and extrinsic rewards.

Considerations for Sustaining the CHW Workforce

Within this assessment, the role and diversity of work settings and CHW roles presented is a testament to the many contributions of Rhode Island CHWs. In addition, there has been shared CHW and employer partner recognition of the value that CHWs bring to their organizations and the individuals and communities they serve. Surely, these data support what is already known about CHWs, that they add value and make a difference. Therefore, the question is not if this critical part of Rhode Island's health and human service workforce should be sustained, but the question is how it can be sustained. Sustaining the CHW workforce requires attention to both fiscal resources and practitioner supports. The data contained in this section of the report are by no means exhaustive. In fact, the data should raise more questions than answers.

This section is intended to inspire reflection and innovation. When employer partners and CHWs were asked what factors were most crucial to sustaining the CHW workforce, they responded with a mixture of supports that were both extrinsic and intrinsic. Their responses are included side by side in Table 9 to allow for comparisons of perspectives and identification of viable options as Rhode Island frames its CHW sustainability strategies. While there was some minor variability in how CHWs and employer partners rated those resources, they agreed on what was most important. There was mutual agreement on the top three resources. CHWs' choice of *Training or Professional Development* as the most

important resource to sustain them was consistent with their alignment with intrinsic factors. In contrast, employer partners chose an extrinsic resource, competitive salary, as their top choice.
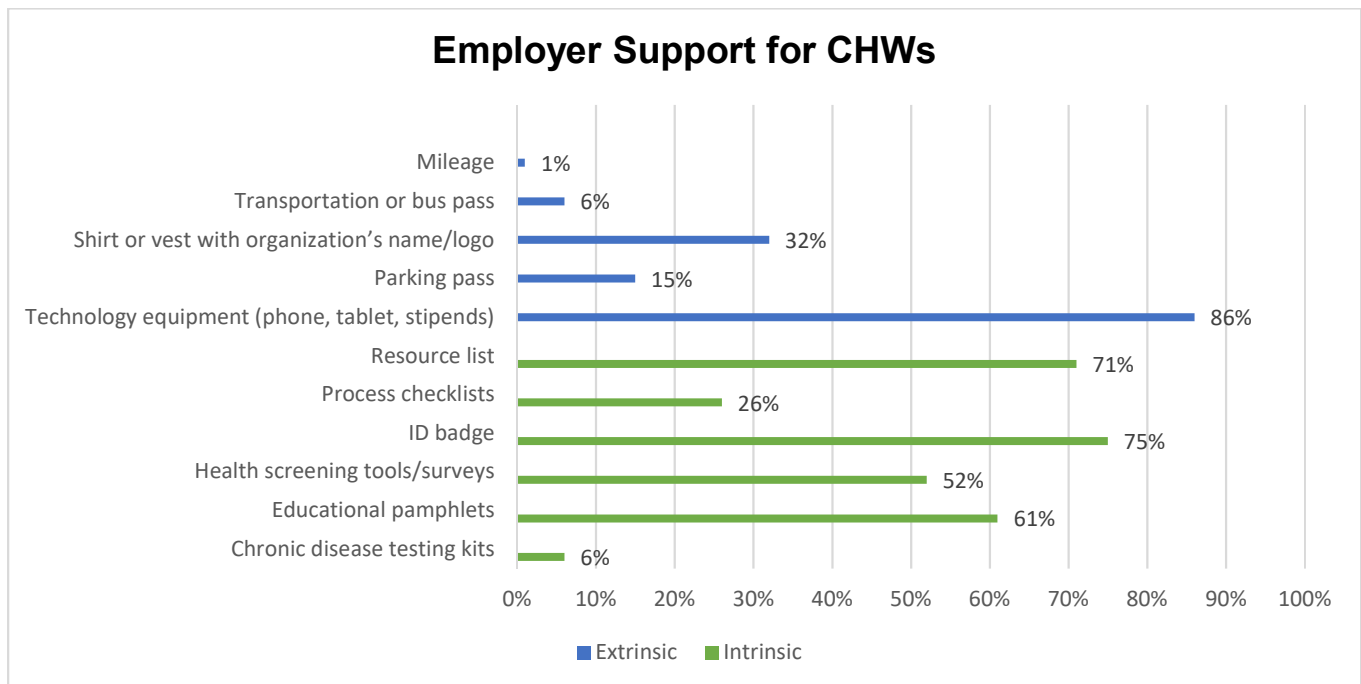
Table 9: *Resources to Sustain CHWs*

CHW Top Sustainability Resources	Percentage	Employer Partners Top Stainability Resources	Percentage
1. Training/Professional development	78	1. Competitive salary and benefits	70
2. Competitive salary and benefits	77	2. Training/Professional development	65
3. Career advancement	66	3. Career advancement	60

*Participants cold reply to more than one option

A list of workplace resources supported by CHW literaure was included in both the CHW and employer partner surveys.[1,18] Both stakeholders were invited to identify the resources that employers provided to support the work of CHWs. The list in Figure 14 is organized by two categories—extrinsic resources (tangible material incentives or rewards) and intrinsic resources (personal rewards linked to use of self and impacts on individuals and commuites). Figure 14 provides a categorical comparision of all resources that were selected by 50% or more of the CHWs to provide insight into the types of resources that were most common for Rhode Island CHWs. The highest scored resource (86%) was related to technology equipment (tablets, phones, or stipends to cover the costs of these items) and was cataegorized as an extrinsic reward because of the associated cost and the potential for transferability beyond work use. The other four top scoring resources were defined as intrinsic-- identification badge (75%); resources list (71%); educational pamphlets (61%), and health screening tools (52%).

Figure 14: *How Employers Support CHWs*

Employer Support for CHWs

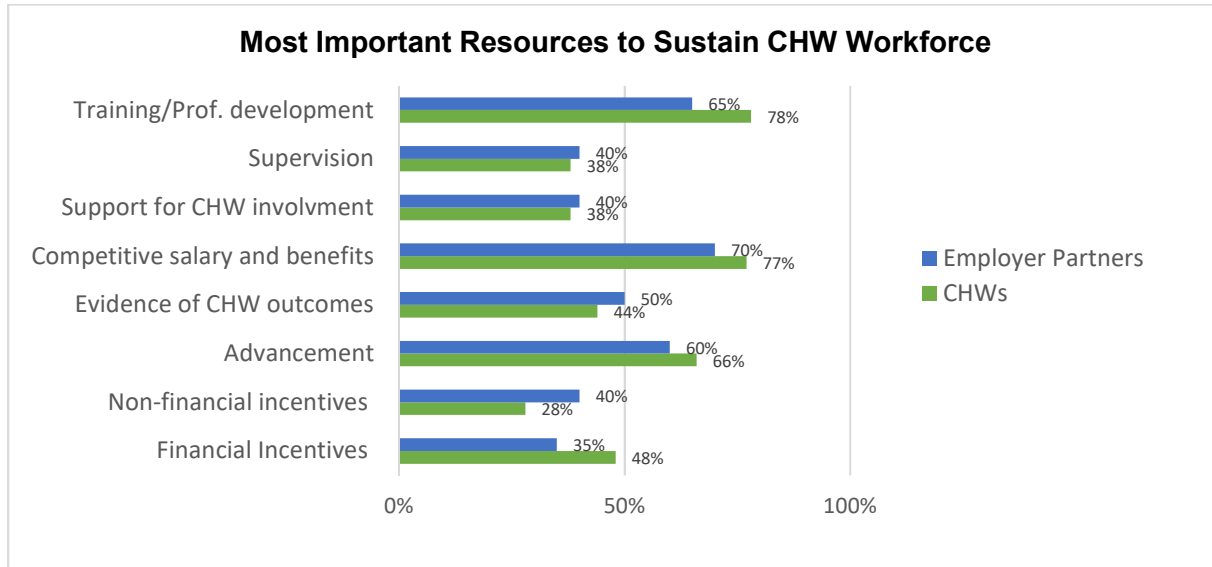| Resource	Percentage
Mileage	1%
Transportation or bus pass	6%
Shirt or vest with organization's name/logo	32%
Parking pass	15%
Technology equipment (phone, tablet, stipends)	86%
Resource list	71%
Process checklists	26%
ID badge	75%
Health screening tools/surveys	52%
Educational pamphlets	61%
Chronic disease testing kits	6%

■ Extrinsic ■ Intrinsic

Once again, we see CHWs valuing those things that further solidify their professional identities and facilitate their interaction with, and service to, client systems.

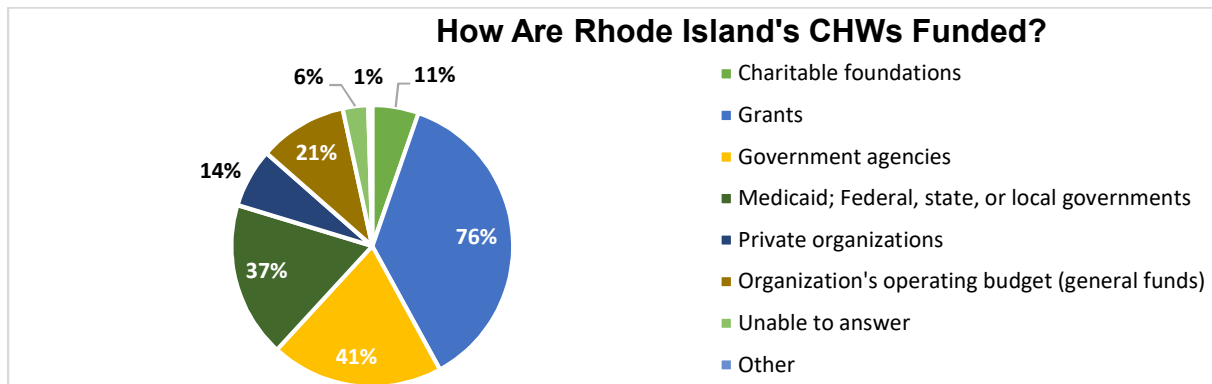**Consideration for Extrinsic Reward**
The full set of responses revealed a shared recognition that for sustainability to be successful, both extrinsic and intrinsic resources are critical.

Figure 15: *Resources for Sustainability*

Most Important Resources to Sustain CHW Workforce

	Employer Partners	CHWs
Training/Prof. development	65%	78%
Supervision	40%	38%
Support for CHW involvment	40%	38%
Competitive salary and benefits	70%	77%
Evidence of CHW outcomes	50%	44%
Advancement	60%	66%
Non-financial incentives	40%	28%
Financial Incentives	35%	48%

When considering extrinsic resources like competitive salary and benefits, financial incentives, and resources to document and evaluate CHW outcomes, it is crucial to reflect on the funding sources for many of the organizations that work with CHWs.

Figure 16: *CHW Funding Sources*

How Are Rhode Island's CHWs Funded?

- Charitable foundations
- Grants
- Government agencies
- Medicaid; Federal, state, or local governments
- Private organizations
- Organization's operating budget (general funds)
- Unable to answer
- Other

76% 41% 37% 14% 21% 6% 1% 11%

It is imperative that Rhode Island's sustainability plan address the issue of funding because it has a direct impact on retention of CHWs whose positions may be time-limited due to grant funding. In addition, when CHW positions are not tied to a stable funding source, there are likely implications for the limited access or lack of longevity and benefit increases that are afforded to employees whose salaries are embedded in organizations' operating budgets. Employer partners shared their funding

sources and the majority (42%) of organizations relied on more than three sources of funding, and grants or soft money was the most common source of funding. CHWs' awareness of funding challenges, as it directly impacts their ability to do their work, were linked to an open-ended question related to additional resources needed to stabilize the workforce:

- More grants;
- Have jobs be long-term *and* permanent;
- Increase in wages would be fair with the proven value [of CHWs] and
- increased revenue the CHWs bring to the organization
- Overtime to allow catch up with the work
- Promotions and incentives for hard workers.

Consideration for Intrinsic Resources

The pull of fiscal resources needed to sustain CHWs cannot be ignored; however, it is equally important to address intrinsic factors that motivate CHWs. Studies on self-efficacy and retention within the human service workforce support the correlation between the intrinsic resources of professional development and quality supervision with employee self-efficacy and retention.[16,19] These findings appear to be equally critical for the CHW workforce, whose focus on intrinsic rewards was consistent across the assessment data. Two opportunities to support intrinsic resources that motivate CHWs are professional development and quality supervision.

Professional Development

CHWs' desire to continue to expand their knowledge and skills to better serve their clients is a value that is expressed consistently by all stakeholders. One way to continue to grow professionally involves specialized training and ongoing professional development. These responses are examples of how CHWs perceive professional development as critical to employers supporting CHWs' work.

- "Support professional and personal development."
- "Offer more training on leadership and organizational change for supervisors and managers."
- "Define multiple career paths past certification (linked to expected pay with advancement)."

This last narrative offers an opportunity to merge the intrinsic and extrinsic resources in a way that can sustain CHWs with career advancement opportunities that increase compensation and levels of practice. Rhode Island is making progress in the number of trainings available to support CHWs and this may help boost CHWs' understanding of how their value is tied to the larger healthcare and social service system value. For instance, one CHW emerging from Rhode Island College's Cardiovascular Health/Diabetes Management training noted, "The more that we can educate and help our clients manage their prediabetes/diabetes we can help them live a healthy lifestyle, decrease medical costs, lost work and wages." However, the commitment of employer partners to compensate CHWs for new credentials and skills is needed to fully address sustainability.
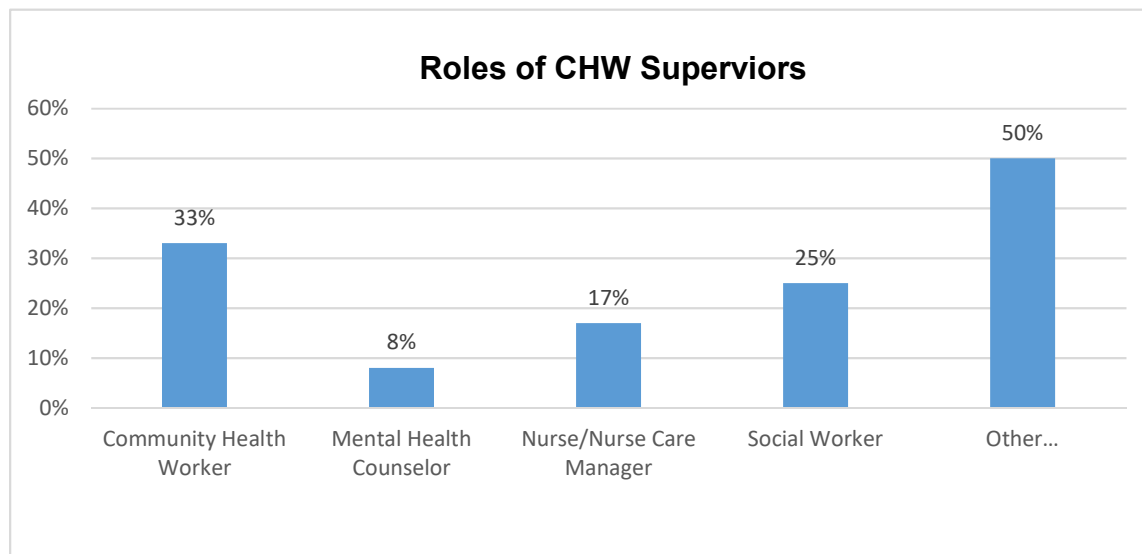
Supervision

Within the assessment process, questions targeting supervisory practices for CHWs were explored to gain insight into roles of CHW supervisors and its implication for CHW self-efficacy and retention of staff. Best-practice models of supervisory inform this section of the assessment (see Appendices A through C for more specific details of best-practice models and corresponding supervisory practices). Analysis of the survey results revealed interesting insights related to who supervisors are, what supervision looks like, and how frequently it is delivered. This information affords the opportunity to compare Rhode Island's practices to best-practice models. In addition, the supervisory data also serves as a reminder that both CHW and supervisors' voices are needed to understand the role of supervision in sustaining the CHW workforce.

Through this comparison, we can identify inconsistencies in supervision delivery that compromise effective supervision of CHWs. The construct of this analysis affords opportunities to celebrate the existing strengths of CHW supervisory practices and the development of future resources that can address the identified inconsistencies. Research in the field of human services indicates that when staff are supported, guided, and celebrated for their progress in demonstrating desired practices, the result is worker confidence and satisfaction (self-efficacy) with higher rates of retention.[16,19]

Defining Supervision of CHWs in Rhode Island
A vital component for the successful integration and utilization of CHWs in the workplace is proper CHW supervision. The articles summarized in Appendix A provide evidence-based recommendations and tools for organizations that stress the importance of CHW supervision and CHW supervisory practices. Based on each articles' findings, organizations must begin by establishing a common understanding of the CHW by defining their role and significance in the workplace. In the first section, the data suggested that CHWs' awareness of their value to organizational success was lower than that of employer partners. Within the organization, the CHW supervisor should serve as a supportive mentor, advocate, coach, and counselor who champion their CHWs. Across Rhode Island organizations, there is no set role or credential associated with supervising CHWs.

Figure 17: *Identifying CHW Supervisors*

Participants identified that supervision was being performed across their organizations by a mix of supervisory, managerial, and directorial positions (Figure 17). Participants were invited to select all positions that applied. Research and best-practice models support the value of experienced CHWs and recognize that CHWs are best equipped to supervise other CHWs. In the assessment responses, it is encouraging that one-third of CHW supervisors are also CHWs. This trend serves as a local example that could be expanded to create a career advancement opportunities for CHWs to become supervisors.

Organizations must use caution when placing primary care providers (PCPs), registered nurses (RNs), licensed vocational nurses (LVNs), and medical assistants (MAs) into CHW supervisory roles since CHWs are neither clinical or administrative personnel. A critical aspect to consider once organizations

have appointed their CHW supervisor is deciding how they will actively monitor their CHWs through either external, group, community, or peer supervision.

Figure 18: *What Is CHW Supervision Style?*
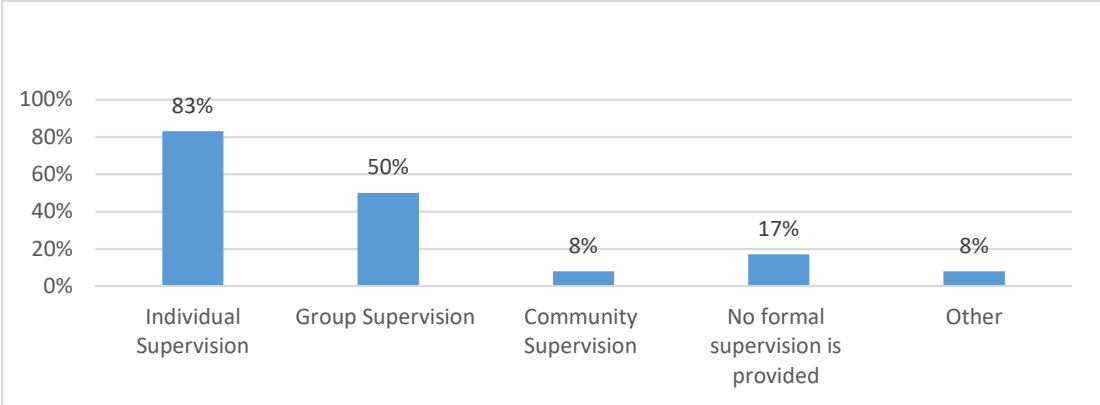
Best practices indicate that the right supervision delivery method or supervision style as depicted in Figure 18 is dependent upon the individual organization's area of focus and internal resources. The best supervision delivery method for an organization is the one that works for the staff and for the organization and is feasible to implement. CHW positions are as diverse as the people who fill them, but the benefits of consistent reflective supervision are consistent across the employment continuum.

In addition to the style of supervision provided, the issue of how frequently supervision is conducted requires consideration because the absence of supervision could jeopardize support and the development of self-efficacy of CHWs. Participants identified varied frequency of supervision at their organization, ranging from none to two hours per week. In both the CHW and CHW supervisory groups, 50% responded that supervision is delivered as needed based on individual situations (see Figure 19). In order for supervision to be meaningful, it needs to be planned and embraced as a critical part of a CHW's' practice.

Figure 19: *How Frequently Do CHWs Receive Supervision?*
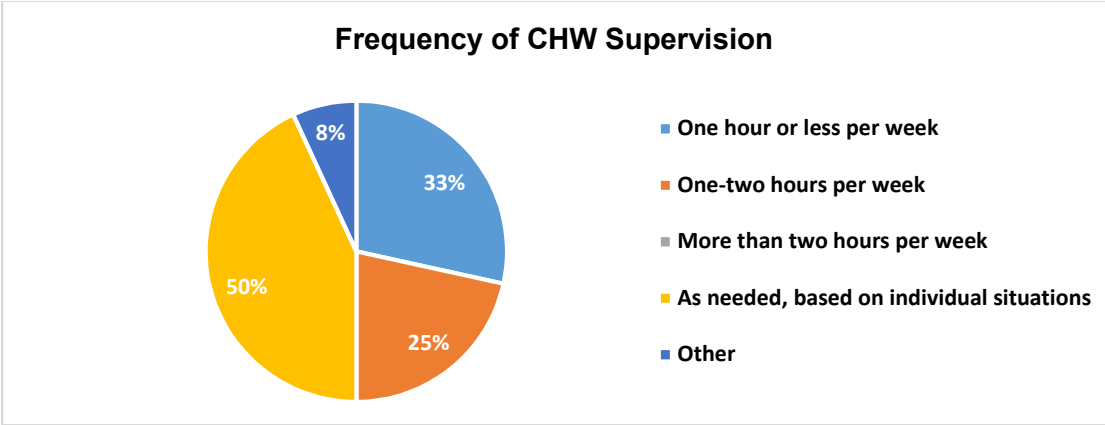
In the absence of intentional supervision, opportunities to celebrate successes and to learn new skills are not actualized, and it can affect the CHW's confidence and feelings of competence.

Assessing the Impact of CHW Supervision

The absence of supervision and the misperception of supervision as an intervention only when things are going wrong sets CHWs and organizations up for failure and can have dire consequences for clients. Some responses that highlight healthy supervisory practices include:

- "…able to speak freely about any concerns and know I will not be punished as with previous employers. Advocates for her CHWs with the organization and State on fair wages, realistic work expectations, and any other concerns we express."
- "She is always with me to encourage my work, take time to work and share ideas, so that my work with the community is much better every day."
- "1:1: helps me navigate internal systems - group supervision: helps me prioritize."

The last response supports the importance of integrating individual and group opportunities for supervision that weave in peer feedback and support from a superior.

The frequency of supervision is critical to assessing performance, goal setting, and identifying areas of strength and opportunities for improvement. Examples of providing CHWs with reliable supervision can come from shadowing other CHWs, patient feedback auditing, and providing one-on-one feedback. The material in Appendix A serves as a standard for best-practice approaches to CHW supervision in the workplace. As organizations begin to investigate their CHW programs, it is essential that they take the opportunity to review evidence-based practices related to the supervision of CHWs.

When exploring the issue of CHW-supervision, it is important to consider the perceptions and experiences of both CHWs and those who supervise them.

Figure 20: *Supervisory Roles-Clearly Defined and Integrated Into Job Descriptions*
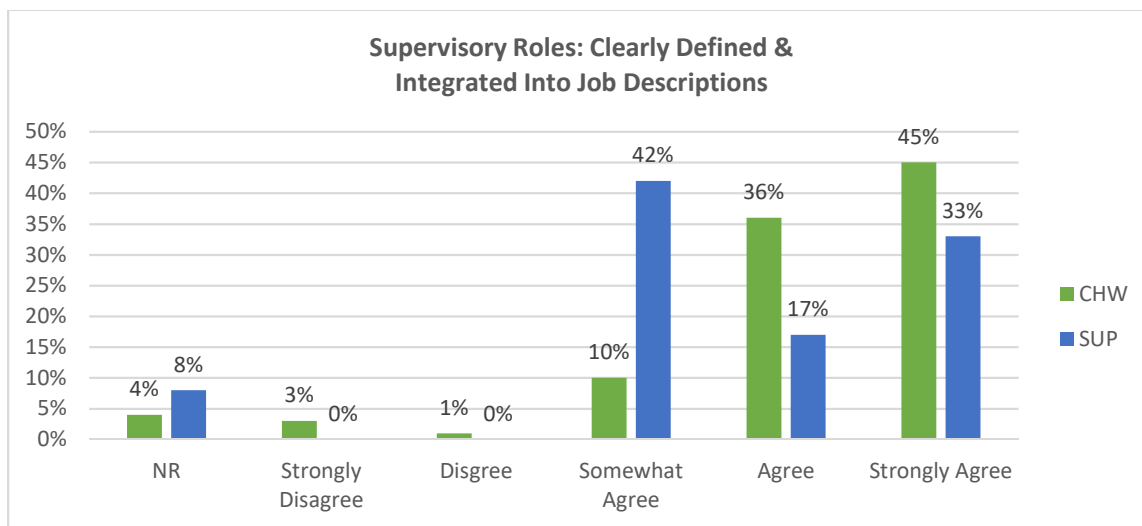
Both CHWs and supervisors were invited to respond to three questions related to the clear definition of supervisory role in job descriptions (Figure 20); the specialized training of supervisors to prepare them to support CHWs (Figure 21); and the presence of CHW experience as part of supervisors' work experiences (Figure 23). The responses were interesting and suggested that CHWs have more faith in the skills and abilities of their supervisors than supervisors may have in themselves. For example, Figure 20 indicates that 81% of CHWs agreed or strongly agreed about the thoughtfulness and intentionality of supervisory roles as compared to only 50% of supervisors. Another 42% of supervisors

were only in somewhat of agreement about the clarity and integration of their roles as supervisors in their job descriptions. In the absence of defining the role of supervisor and carving out specific duties related to CHW supervision, the importance of the supervisory relationship to CHWs' work is likely to be impacted.

When invited to reflect on specialized training to supervise CHWs (see Figure 21), this same dichotomy existed as evidenced by of CHWs' belief (71%) that their supervisors are well prepared as compared to only 42% of supervisors believe they are prepared. One-third of supervisors indicated that supervisors were only somewhat trained to oversee CHWs.

Figure 21: *Supervisors Training/Professional Development to Support CHWs*
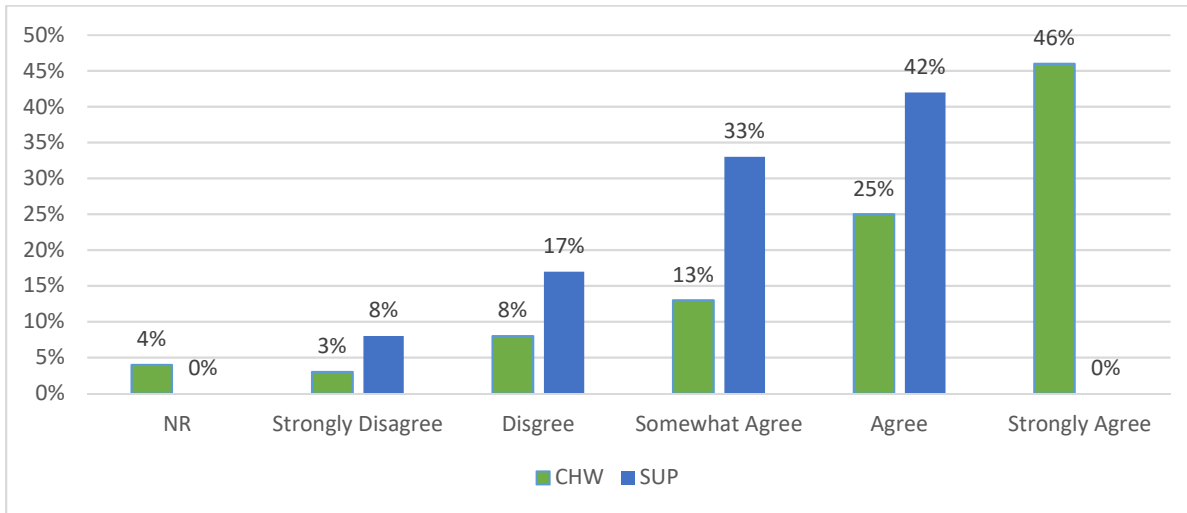
Earlier in this section, the importance of resources to support the self-efficacy of CHWs was emphasized. These supervisory data suggest that self-efficacy for supervisors should be of equal concern as Rhode Island moves forward to sustain its CHW workforce. Based on the responses to this survey and the existing literature related to best supervisory practices in CHW, training for current supervisors of CHWs should be considered as a resource for increasing understanding of the CHW workforce and setting an example for critical supervisory practices. The outline in Figure 22 includes and reflects critical content areas supported by survey responses and best practice approaches.

Figure 22: *Rhode Island College CHW Supervisor Training Outline*

Module 1: CHW role and responsibilities
Learning themes:
- Refresher of CHW core values
- Review common CHW roles and duties
- Review Certified Community Health Worker (CCHW) credential

Module 2: Reflective supervision
Learning themes:
- Why "reflective" supervision?
- What types of effective supervision exist?
- Who practices reflective supervision?
- When is it warranted?
- How often should it be done?

Module 3: Community health work ethics
Learning themes:
- Refresher of foundational ethics curriculum

Module 4: Restorative practices and conflict resolution
Learning themes:
- Conflict resolution theory and practice (with scenarios unique to the CHW workforce)
- Trauma-informed leadership
- Restorative practices lesson, can borrow from COEXIST and adapt from Youth Restoration Project

Module 5: Building community partnerships
Learning themes:
- Formalized referral systems
- Building a referral network
- Case studies of formalized CHW workforce partnerships

Module 6: Keeping your CHWs safe
Learning themes:
- Adaptation of safety and self care module for CHW foundations, with emphasis on safety while home visiting and out in the field
- Addressing health and safety as a supervisor

Module 7: Hiring and onboarding CHWs
Learning themes:
- Examining CHW job descriptions
- What to look for in a successful CHW candidate (criteria from the surveys)
- What infrastructure needs to be in place to support CHW team success (using guidelines from the best-practice supervisory model grid)
- How to promote CHW professional satisfaction (based on narrative data from surveys)

Lastly, the issue of whether supervisors possess their own CHW work experience was explored (see Figure 23). In this final question, slightly more than three-quarters of CHWs embraced the idea that the person who supervises them should have a CHW background. CHWs in this assessment have been vocal about wanting their supervisors to understand their work.

Figure 23: *Supervisors Possess Experience as CHWs*

Supervisors Possess Their Own Experience As CHWs

Category	CHW	SUP
No response	6%	8%
Strongly disagree	3%	17%
Disgree	3%	8%
Somewhat agree	10%	8%
Agree	24%	17%
Strongly agree	54%	42%
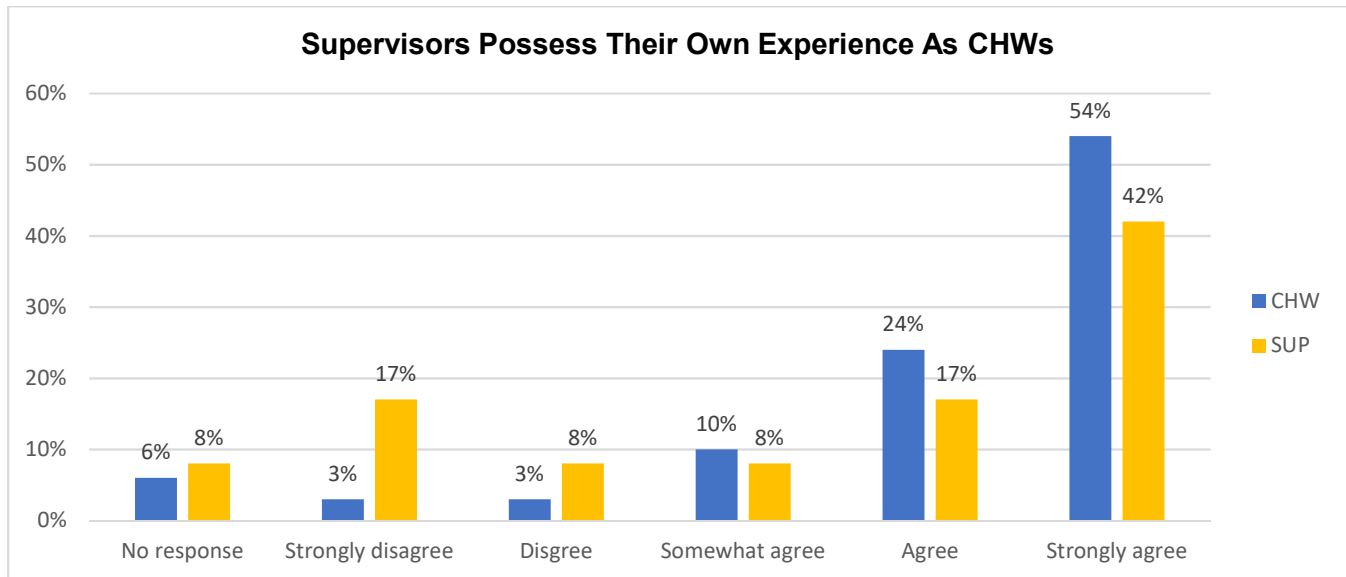
The sample of supervisors who participated in this assessment are comprised of one-third who identify as CHWs. Supervisors (59%) responding to the question about CHW backgrounds for supervisors agreed that supervisors should possess a CHW background. These data are consistent with supervisors' statements that there should be career advancement opportunities for CHWs to become supervisors. One supervisor shared, "I would like to fund more CHWs so there is a career path for them to supervisory positions".

Much can be learned from Rhode Island as it moves toward uniform best practices for CHW supervision. An investment in quality supervision is an investment in CHWs. The data in this assessment provide additional insight into areas where Rhode Island would benefit from improvements. As identified in Table 10, when invited to reflect on opportunities for improvement, CHWs and CHW supervisors thoughtfully identified how improvements could be achieved.

Table 10: *CHW and Supervisor Perspectives on Improvement of Supervision*

CHW Reflections	Overlapping Reflections	CHW-Supervisor Reflections
• Clarity of roles and delegation of tasks • More frequent supervision • Supervisors competent as CHW • Reflective supervision	• Access to formal supervisory training • Data tools to inform practice • More money for resources (including hours for supervision and hiring more CHWs)	• Promotion of CHWs to supervisors • Reinstate CHW group supervision (after the pandemic)

Perhaps these overlapping reflections for how to improve CHW supervision offer an opportunity to consider how Rhode Island might use these ideas to build on its strengths. These reflections offer some suggestions worthy of exploration as a professional community. Furthermore, these responses support the necessity of aligning Rhode Island's definition of CHW supervision with the national benchmark.

As we continue to analyze the results across our three surveys, it is helpful to continue to reflect on broader practices and to be mindful of how CHWs need a place to process their challenges and successes. CHWs have a demanding job, requiring them to empathize with the pain experienced by others and to explore the limits of human vulnerability on a daily basis. Supervisees who understand and address the second-hand trauma that CHWs experience in their line of work is undeniably necessary for supporting each individual CHW so that they can commit to the role long enough to earn a supervisor position themselves.

When reflecting on supervision practices shared in this assessment, there is a great deal to celebrate. Rhode Island has some critical components of CHW supervision to build upon. The participants in this survey are evidence of the integrity, passion, and dedication of our CHW workforce. When given the chance to share how supervision delivery at their organization is most helpful to CHWs, they responded:

- "Our CHWs collect extensive data for both time working with families and community trainings they complete. Evaluations of both inform us about the community needs and what our next steps could or should be to expand our reach, improve our cultural competence, and/or meet a training need for families."
- "I am always available for any questions that [CHWs] may have."
- "During the pandemic, simply connecting with one another has been critical. When the weather was nice, we met in person, outside, and otherwise we met on Zoom. Whenever we connect, we make sure to discuss self-care strategies and topics other than work."
- "[We] Develop personal and professional goals and support [CHWs] in achieving them."
- "[Our CHW supervisors] have experience in the role and connect CHWs to appropriate training and community based resources."

Recommendations

The data collected for this assessment process are intended to inform Rhode Island's CHW sustainability effort. It is important that the data and analysis presented in this report be considered within the context of those 102 stakeholders who participated in the assessment. Given the small sample size and some of the anomalies that emerged regarding the demographics of the CHW group, additional inquiry into Rhode Island's CHW population is merited to assess if the race/ethnicity and education status reported in this assessment are reflected in the larger Rhode Island CHW population.

Based on the assessment data, there are four overarching recommendation categories to consider as part of Rhode Island's sustainability effort:

1. **Confirm the demographics of Rhode Island's CHW workforce**
    a. Have the racial/ethnic and educational characteristics shifted away from communities of color and grassroots-recruited CHWs?
    b. If the demographic shift is valid, what are the employment implications for Rhode Island's CHWs who represent the traditional demographic profile?

2. **Build a communication strategy regarding the value and positive impact of CHWs.**
    a. The value of CHWs was articulated by all three stakeholder groups; however, CHWs' lower rating of their own value raises opportunities to assess organizational and employer strategies for communicating CHWs' value inside the organization and to the broader health and human service communities.

    b. This assessment was limited in its exclusion of consumer or client voices to share first-hand experiences regarding how CHWs have affected their lives. Holding focus groups with the consumers/clients of CHWs and ensuring that they represent the core work settings will provide a missing voice that is critical to advocacy strategies related to financial and workforce development opportunities for Rhode Island's CHWs.

3. **Advocate for extrinsic resources to sustain Rhode Island's CHW workforce**
   a. Pay equity is needed to maintain the employment of CHWs, and achieving equity will likely require attention to several issues.
      i. Explore reimbursement models for CHWs that mirror the PRS system but that represent a valid rate of reimbursement reflecting the true value and cost of CHW services.
      ii. Explore the emerging interest in CHW/PRS dual certification as a strategy to increase CHW employment opportunities and organizations' abilities to reimburse for CHW-PRS services.
   b. Build certificate programs with career advancement opportunities that
      i. Increase CHWs' knowledge and skills;
      ii. Advance CHWs' marketability; and
      iii. Increase wages for each specialization certificate obtained.

4. **Advocate for intrinsic resources to motivate Rhode Island's CHW workforce**
   a. Increase the availability of training and professional development opportunities to support enhancement of CHWs' knowledge and skills.
   b. Support CHW/PRS dual certification.
   c. Create a CHW Leader/Supervisor Certificate program to allow CHWs to ascend to a tier 1 or tier 2 peer supervisor (include financial incentives).
   d. Provide CHW supervision support training for supervisors who have not previously been in a CHW role.

Appendix A: *Annotated Bibliography of Best Supervisory Practices*

1. **US Department of Health & Human Services. (2016, January 25).** *Promoting Policy and Systems Change to Expand Employment of Community Workers (CHWs) Session 1: Introduction to Community Health Workers (CHWs).*
   http://www.cdc.gov/dhdsp/chw_elearning/s1_p1.html
   In *Promoting Policy and Systems Change to Expand Employment of Community Workers (CHWs)*, the Center for Disease Control and Prevention (CDC) explores the CHW's role in the healthcare system and the unique challenges presented in managing and supervising CHWs. In particular, CDC highlights that since the CHW role is unlike any other, being neither clinical nor administrative, it, therefore, must not be supervised in the same manner as other healthcare professionals. To effectively supervise CHW's, CDC recommends that employer organizations become aware of the unique demands and responsibilities of supervising CHWs. The CDC also cautions employer organizations not to assume that an individual with a clinical background and basic supervisory skills is qualified to supervise CHWs. Ultimately, CDC highlights the need for a formalized training emphasizing the crucial roles, skills, and methods supervisors must have to supervise CHWs appropriately.

2. **Muso. (2018, July 26). 360 https://www.musohealth.org/360-supervision-model/**
   Muso, a proactive healthcare system, developed a 360° supervision model with four steps to actively monitor CHWs and improve CHW performance rates and quality of care. The first step in the model begins with group supervision, which includes the supervisor conducting group meetings with their CHWs to assess their everyday challenges and propose potential solutions. During the group discussion, the supervisor's role is to review and reinforce key competencies and skills for CHWs to improve upon each month. The second step is patient feedback auditing, where the supervisor conducts home visits without the CHW present to evaluate the CHW's performance. The third step is CHW shadowing, which takes place once a month and provides the supervisor with the opportunity to directly observe how the CHW provides care during their home visits. The fourth step is one-on-one feedback, where the supervisor can sit down with their CHW, assess their performance, set goals, and identify areas of strength and improvement. Muso illustrates that during the first six months of enacting this model, there was a 47% increase in the number of home visits, a 20% increase in the speed of care, and a 22% increase in the quality of care given.

3. **Minnesota Department of Health. (2013).** *Community Health Worker (CHW) Toolkit: A Guide for Employers.*
   https://www.health.state.mn.us/facilities/ruralhealth/emerging/chw/docs/2016chwtool.pdf
   In *Community Health Worker (CHW) Toolkit: A Guide for Employers*, the Minnesota Department of Health (MDOH) created a toolkit to provide prospective and current employers with a guide on how to successfully integrate and champion CHWs in the workplace. Within the toolkit, MDOH highlights the importance of proper CHW supervision and its profound impact on CHW motivation and confidence within the care team. For proper CHW supervision to occur, it is vital for CHW supervisors to clearly define the CHW role within the care team to ensure that all staff understands the essence of the CHW in the workplace. Moreover, MDOH dictates that supervisors may require on-the-job training with additional time to learn how to effectively communicate with CHWs coming from different cultural and educational backgrounds. To understand who should supervise CHWs, MDOH reviewed various supervision models and indicated the usage of a Senior CHW model where a more experienced CHW provided mentorship and support for CHWs. Through the proper usage of this toolkit and its

recommendations on CHW supervision, MDOH argues that CHW participation within the care team could improve and lead to higher productivity.

4. **Crigler, L., Gergen, J., & Perry, H. (2013). Supervision of Community Health Workers. In Maternal and Child Health Integrated Program,** *Developing and Strengthening Community Health Worker Programs at Scale* **(pp. 9.1-9.24). United States Agency for International Development.**
Authors Lauren Crigler, Jessica Gergen, and Henry Perry examined the challenges, responsibilities, and overall impact the CHW supervisor has in creating and maintaining a supportive work environment for the CHW in their chapter on CHW supervision. One major challenge presented throughout the chapter discusses how CHW supervision is virtually non-existent or questionable when taken into effect. More so, the authors argue that poor CHW supervision is comparable to being as ineffective as having no supervision at all. To combat these challenges to supervision, the authors provide an overview of how to properly supervise CHWs. Specifically, they discuss the various objectives, approaches, standards, and guidelines for external, group, community, and peer CHW supervision. In addition, they question who and how often CHW supervision should take place and include key considerations for the successful implementation of CHW supervision.

5. **Tulenko, K. (2016, June 7).** *Supervision of Community Health Workers.* **https://chwcentral.org/supervision-of-community-health-workers/**
In *Supervision of Community Health Workers (CHW)*, Kate Tulenko summarized and reviewed Chapter 10 of the *CHW Reference Guide* to understand the complex issues surrounding CHW supervision and implementation. Tulenko's review highlights various key takeaways, including solutions to even the most persistent challenges to CHW supervision. She further uses the guide to emphasize the critical role CHWs play in aiding and representing the communities they serve. To avoid high levels of burnout in CHWs, Tulenko advises CHW programs to invest in high-quality CHW supervision that focuses on uplifting CHWs to reach their full potential through constructive feedback. Although various other challenges must be explored, Tulenko emphasizes that the reference guide is a starting point for CHW programs to begin understanding how to administer proper CHW supervision.

6. **Health Resources and Services Administration (HRSA). (n.d.).** *Supervision Manual for Promotor(A) De Salud Programs.* **http://2ow7t71bjuyu4dst8o28010f.wpengine.netdna-cdn.com/wp-content/uploads/2010/07/Supervision-Manual-for-Promotora-de-Salud-Programs.pdf**
MHP Salud, a national leader in CHW, composed a brief report outlining the key elements of meaningful CHW supervision and planning considerations for an effective supervision system. The first key element MHP Salud begins with is laying down the basic framework for successful CHW supervision. Within the framework, MHP Salud addresses the supervisor's responsibility in regularly scheduling individual or group meetings with their CHWs to discuss and review the CHW's work. According to MHP Salud, the CHW supervisor must serve as a supportive mentor, advocate, coach, and counselor for their CHWs during these meetings. The next element MHP Salud examines is planning considerations to create an effective supervision system. Key planning considerations include budgeting, recruiting, training and support, and developing standards that ensure the construction of a successful CHW supervision system.

7. **Chapman, S., Schindel, J., & Miller, J. (2017).** *Supporting the Integration of Community Health Workers into Health Care Teams in California.* **2017. healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-**

pdf/Supporting%20the%20Integration%20of%20Community%20Health%20Workers%20in to%20Health%20Care%20Teams_2017_06_26.pdf.

In *Supporting the Integration of Community Health Workers (CHW) into Health Care Teams in California*, authors Susan Chapman, Jennifer Schindel, and Jacqueline Miller proposed a systematic model to inform organizations on how to optimally utilize and integrate CHWs into traditional models of care. The authors use the theory of change, which is essentially a process where stakeholders identify the necessary steps they must first accomplish before reaching their long-term goals, as the framework for their model. To understand how to use the model, the authors share various pre-conditions necessary for the theory of change to succeed in employing and integrating CHWs. One key pre-condition on CHW supervision emphasized the importance of properly integrating CHWs into a mentoring relationship with team members who are the best equipped to support the unique needs of the CHW role. To understand who is best fit to supervise CHWs, the authors propose that organizations develop models that allow for CHWs to grow into supervisory roles. The authors reinforce their proposal by noting a growing concern from Primary Care Providers (PCP), Registered Nurses (RN), Licensed Vocational Nurses (LVN), and Medical Assistants (MA) who do not believe they are the appropriate personnel and feel distracted from their work to supervise non-clinical CHWs. After repeatedly applying the theory of change to multiple other pre-conditions, the authors emphasize that organizations use their model as a stepping stone for creating a sustainable community health workforce.

8. **mhpsalud.org. (2016, January).** *Six Tips for CHW Supervision Success.*
   https://mhpsalud.org/6-tips-for-chw-supervision-success/
   MHP Salud's article on CHW supervision shares six tips to help organizations strengthen their CHW model and succeed in CHW supervision. The six tips for succeeding in CHW supervision includes: not everyone is right for the role, it is different from other supervisory roles, good CHW supervisors champion the work of their staff, there is more than one way to run and supervise a program, initial plans do not always pan out, and that is okay, and support is out there. Within each of these tips, MHP Salud offers various solutions to common problems with CHW supervision. Moreover, MHP Salud includes several recommendations from healthcare professionals on ways organizations can clarify the CHW supervisor's role, stressing the importance of the supervisor's role as a mentor and supportive figure for CHWs. In short, MHP Salud strives for organizations to use these six tips to strengthen, solidify, and promote successful CHW supervision in the workplace.

9. **Brooks, B.A., Davis, S., Frank-Lightfoot, L., Kulbok, P.A., Poree, S., & Sgarlata, L. (2018, July).** *Building a Community Health Worker Program: The Key to Better Care, Better Outcomes, and Lower Costs (Rep.).* **https://www.aha.org/system/files/2018-10/2018-chw-program-manual-toolkit.pdf**
   In *Building a Community Health Worker (CHW) Program: The Key to Better Care, Better Outcomes, and Lower Costs*, the American Heart Association (AHA) presents a toolkit to help organizations understand how to implement successful and sustainable CHW programs. Within the toolkit, the AHA draws out what CHW programs are and outlines six evidence-based, best-practice domains to help organizations understand how to implement a successful CHW program. The six domains include education, performance management and supervision, tools and job aids, workload, financial reimbursement, and outcomes. When outlining the performance management and supervision domain, the AHA stresses the importance of providing regular feedback and reliable supervision for CHWs within the healthcare team. In particular, the AHA highlights how CHWs are more likely to stay motivated and excel in their roles through ongoing mentorship and support. After analyzing the six domains, the AHA

provides detailed descriptions about funding considerations, talking points for strategic stakeholders, and program implementation considerations for prospective organizations. The AHA strives for administrative and clinical leaders to use this toolkit as a resource when implementing successful and sustainable CHW programs.

10. **Gutierrez Kapheim, M. & Campbell J.(2014, January).** *Best Practice Guidelines for Implementing and Evaluating Community Health Worker Programs in Health Care Settings.* **Chicago, IL: Sinai Urban Health Institute.**
Section 3 of *Best Practice Guidelines for Implementing and Evaluating Community Health Worker Programs in Health Care Settings*, by the Sinai Urban Health Institute, offers recommendations from available professional literature and CHW practice on the structure and role of CHW supervision. The Sinai Urban Health Institute first makes recommendations on the structure of CHW supervision, stating that organizations should choose a supervisor who believes and supports the CHW model and role. Moreover, the CHW supervisor is responsible for providing CHWs with adequate supervision through regular individual and team meetings. Next, the Sinai Urban Health Institute makes recommendations on the CHW supervisor's role, advocating that supervisors serve as mentors for CHWs and provide CHWs with adequate autonomy to recognize their unique contribution in their respective communities. In addition, CHW supervisors should clearly define the CHW role and communicate it through the organization for common understanding. The Sinai Urban Health Institute ultimately aims for organizations to use these recommendations as a guideline for promoting successful CHW.

Appendix B: *Best Practices Models of CHW Internal Supervision*

	Supporting the integration of CHWs into healthcare teams in California	CHW reference guide: supervision of CHWs	MUSO 360 supervision model	Building a CHW program: the key to better care, better outcomes, and lower costs	Promoting policy and systems change to expand employment of CHWs	Developing and strengthening CHW programs at scale, Chapter 9: Supervision of CHWs	MHP Salud six tips for CHW supervision success	MHP Salud supervising CHW's educational tool	CHW toolkit: A guide for employers	Best practice guidelines for implementing and evaluating CHW programs in healthcare settings
Supervisory delivery: individual supervision		✓	✓	✓		✓	✓	✓		
Supervisory delivery: group supervision		✓	✓			✓	✓	✓		✓
Supervisory delivery: community supervision		✓	✓			✓				
Supervision frequency		✓	✓			✓	✓	✓	✓	✓
Supportive feedback	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Coaching/ Skill development			✓	✓	✓	✓	✓	✓	✓	✓
Problem solving	✓			✓	✓	✓			✓	✓
Mentorship	✓		✓	✓	✓	✓	✓	✓	✓	✓
Data review				✓		✓			✓	✓
Recognition/ incentivization				✓		✓			✓	✓

Appendix C: Best-Practice Models for HCW Supervision

	Supporting the integration of CHWs into healthcare teams in California	CHW reference guide: supervision of CHWs	MUSO 360 supervision model	Building a CHW program: the key to better care, better outcomes, and lower costs	Promoting policy and systems change to expand employment of CHWs	Developing and strengthening CHW programs at scale, chapter 9: supervision of CHWs	MHP Salud six tips for CHW supervision success	MHP Salud supervising CHW's educational tool	CHW toolkit: A guide for employers	Best practice guidelines for implementing and evaluating CHW programs in healthcare settings
Recruitment		✓	✓	✓		✓	✓	✓		
Training		✓	✓			✓	✓	✓		✓
Incentives		✓	✓			✓				
Evaluation		✓	✓			✓	✓	✓	✓	✓
Equipment/supplies: technology/phone	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Equipment/supplies: ID badges			✓	✓	✓	✓	✓	✓	✓	✓
Equipment/supplies: branded clothing	✓			✓	✓	✓			✓	✓
Equipment/supplies: testing kits	✓		✓	✓	✓	✓	✓	✓	✓	✓
Equipment/supplies: needle exchange kits				✓		✓			✓	✓
Equipment/supplies: blood pressure self-monitoring devices				✓		✓			✓	✓
Equipment/supplies: health screening tools	✓			✓				✓	✓	
Equipment/supplies: resource lists/ educational pamphlets or checklists	✓			✓	✓	✓	✓	✓	✓	✓
Use of data	✓			✓				✓	✓	
Referral systems	✓			✓				✓	✓	

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